

Legislative Analysis



BEHAVIORAL HEALTH OVERSIGHT COUNCIL / ADMINISTRATIVE SERVICES ORGANIZATIONS

Phone: (517) 373-8080
<http://www.house.mi.gov/hfa>

House Bill 4925 as introduced
Sponsor: Rep. Mary Whiteford

Analysis available at
<http://www.legislature.mi.gov>

House Bill 4926 as introduced
Sponsor: Rep. Abdullah Hammoud

House Bill 4928 as introduced
Sponsor: Rep. Sue Allor

House Bill 4927 as introduced
Sponsor: Rep. Phil Green

House Bill 4929 as introduced
Sponsor: Rep. Shri Thanedar

Committee: Health Policy
Complete to 6-3-21

SUMMARY:

House Bill 4925 would amend the Mental Health Code to create the Behavioral Health Oversight Council within the Department of Health and Human Services (DHHS) to advise DHHS in developing and executing public behavioral health policies, programs, and services. It would also authorize DHHS to contract with an administrative services organization (ASO), which would assume certain responsibilities from DHHS and DHHS-designated community mental health (CMH) entities. The other four bills are complementary and amend other acts to account for changes in HB 4925.

HOUSE BILL 4925

Composition of the council

The Behavioral Health Oversight Council proposed by HB 4925 would have to equitably reflect the geographic and demographic characteristics of individuals served by the public behavioral health system, with at least 33% of the membership being primary recipients of the system, their families, or individuals in recovery from behavioral health conditions served by the system.

The council also would have to reflect experience and expertise in administering and delivery public-funded behavioral health services to children and adults with mental illness, emotional disturbance, intellectual or developmental disability, or substance use disorder (SUD). The council would have to include a behavioral health or physical health medical professional.

The council would consist of the following members:

- Fifteen voting members:
 - Five members who are recipients of the public behavioral health system, their families, or former recipients in recovery. (At least three would have to be current recipients.)
 - Ten members, with one from each of the ten prosperity regions identified by the Department of Technology, Management, and Budget (DTMB).

- Up to four nonvoting members appointed by the DHHS director to represent DHHS and departmental agencies pertinent to delivering public behavioral health and intellectual or developmental disability services.

The governor and the majority and minority leaders of both legislative houses would each appoint three voting members. Appointments of voting members would have to be made within 60 days after the bill's effective date. Members would serve three-year terms or until a successor is appointed, whichever is later, and could serve up to two terms. The bill provides for the filling of vacancies and removal of members for such issues as incompetence and dereliction of duty.

The DHHS director or his or her designee would have to call the first meeting within 90 days after the bill's effective date. The council would elect a chairperson and officers at the first meeting and would meet quarterly thereafter (or more frequently at the call of the chair or if requested by at least two-thirds of members). A majority of the members would constitute a quorum for the transaction of business at a meeting, and a majority of the members present and serving would be required for official action. Meetings would have to be held in compliance with the Open Meetings Act and writings made available to the public in compliance with the Freedom of Information Act. Further, council members would serve without compensation but could be reimbursed for actual and necessary expenses incurred in the performance of official duties as members of the council.

Function of the council

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

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

Administrative services organization would mean a contracted third-party organization with special expertise in behavioral health systems management that contracts with DHHS to provide certain specified administrative services necessary to manage the public behavioral health system, including Medicaid specialty supports and services on the state's behalf.

Standing and ad hoc committees

The council would be charged with establishing standing and ad hoc committees to fulfill its duties, including an SUD oversight policy committee, a clinical oversight committee (including independent experts in various specialties), a financial oversight committee, and a consumer oversight committee. The composition and required functions of those committees are specified in the bill.

Priorities of DHHS regarding behavioral health

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

Currently, the code states that DHHS should shift primary responsibility for the services from the state to a community mental health services program (CMHSP) if the program is willing and able. The bill would provide that DHHS should shift primary responsibility to a CMHSP, approved services program, or other public behavioral health service provider. DHHS or the single ASO described below could provide or contract for any services to ensure an adequate network of public behavioral health services.

To carry out these powers and duties, DHHS would have to use a self-insured financing and delivery system structure to administer and provide services. DHHS would provide operational oversight of the ASO, including developing a comprehensive plan for monitoring their performance, establishing policies to coordinate public behavioral health benefits with other benefits received under Medicaid, and developing consumer and provider appeal procedures.

DHHS would have to develop policies and procedures for the reimbursement of public behavioral health services, including developing initial rates, reducing existing rates, and changes in rate methodology.

Contracting with an ASO

DHHS could contract with a single administrative services organization to carry out the powers and duties described above by issuing a request for proposal. The single ASO would have to be organized as a nonprofit organization or a public or quasi-public entity. It could not be a CMHSP, a group of CMHSPs under the Urban Cooperation Act, or any other group or confederation of CMHSPs. The ASO would have to have a full-time medical director.

The contract would have to require the ASO to perform specific functions, including at least all of the following:

- Eligibility verification.
- Utilization management.
- Intensive care management.
- Quality management.
- Coordination of medical and behavioral health services.
- Provider network development and management.
- Recipient rights and provider services and reporting.
- Customer services.
- Corporate compliance that includes adherence to all applicable state and federal civil rights statutes and regulations.
- Clinical management services not retained by DHHS.

The ASO would have to authorize services based on policy and guidelines set forth by DHHS. Exceptions could be made when requested by a recipient of public behavioral health services or a recipient's legal guardian or services provider and determined by the ASO to be in the recipient's best interest. ASOs would have to ensure that service providers and individuals seeking services have timely access to information and timely responses to inquiries.

The ASO would have to oversee and utilize the Michigan Crisis and Access Line (MiCAL)¹ to fulfill those duties and functions on behalf of DHHS. (MiCAL is the statewide crisis and access line accepting all calls and dispatching support based on the assessed need of the caller.)

The ASO's business and that of any of its committees would be subject to the Open Meetings Act, and their writings would be subject to the Freedom of Information Act.

Functions of a CMHSP

The bill would add all of the following to the description of mental health services provided by a CMHSP:

- Coordination with MiCAL.
- Providing mobile crisis teams staffed or contracted by CMHSPs that are dispatched at the direction of MiCAL.
- Providing crisis stabilization units that serve everyone in need from all referral sources.

Incorporating ASOs throughout the code

The bill would also incorporate reference to ASOs and their proposed ability to provide services throughout the code, generally in places where the code currently requires that oversight, coordination, and reporting be done by DHHS or a DHHS-designated CMH entity.

Repealers

Finally, the bill would repeal four sections of the code: one creating the Citizens Mental Health Advisory Council, one specifying the purpose of a regional entity (a combination of CMH organizations or authorities), one setting standards for specialty prepaid health plans, and one describing the purpose of DHHS-designated CMH entities.

House Bill 4925 is tie-barred to HB 4926, which means that it could not take effect unless HB 4926 were also enacted.

MCL 300.100a et seq.

HOUSE BILLS 4926 TO 4929

House Bill 4926 would amend the Social Welfare Act to mirror the description of DHHS's provision of behavioral health services in HB 4925. Currently, the act requires DHHS to support the use of Medicaid funds for specialty services and supports for eligible Medicaid beneficiaries with serious mental illness, developmental disability, serious emotional disturbance, or SUD. The bill would add intellectual disability to the list and remove both instances of the word "serious."

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

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

House Bill 4926 is tie-barred to HB 4925, which means that it could not take effect unless HB 4925 were also enacted.

MCL 400.109f

House Bill 4927 would amend the Public Health Code to remove a reference to a "DHHS-designated CMH entity," which is an entity whose function would be assumed by the ASO proposed by HB 4925.

MCL 333.7408a

House Bill 4928 would amend the Michigan Liquor Control Code to provide that a minor who purchases, consumes, or possesses alcohol, attempts to do so, or has any bodily alcohol content must undergo screening and assessment by a person or agency designated by the ASO (rather than a person or agency designated by a DHHS-designated CMH entity) to determine whether the minor would benefit from rehabilitative services.

MCL 436.1703

House Bill 4929 would amend the Social Welfare Act to require that certain functions, such as SUD treatment, be performed by an ASO rather than by a DHHS-designated CMH entity.

MCL 400.57z

FISCAL IMPACT:

House Bills 4925 through 4929 would have a significant fiscal impact on the state and local units of government by increasing access to, and corresponding utilization of, specialty behavioral health supports and services and by reducing administrative costs by moving to an ASO instead of utilizing 10 prepaid inpatient health plans (PIHPs).

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

After a first year that may cost the state \$3.0 million gross (\$1.0 million GF/GP) due to transitional costs for DHHS to enter into a contract with an ASO, along with policy planning and any possible rule promulgation, the second year would see a significant reduction in administrative costs, with the following years' administrative costs remaining fairly static. In

general, ASOs have lower administrative costs than managed care organizations (such as PIHPs). This fiscal analysis assumes that administrative costs will be reduced by at least 2.0 percentage points, reducing administrative costs paid through the state Medicaid program by approximately \$70.0 million Gross (\$20.0 million GF/GP).

These bills would increase access to specialty behavioral health supports and services by no longer specifically providing that supports and services are available to individuals with “serious” mental illness, developmental disability, emotional disturbance, or substance use disorder, but instead allowing those services and supports to be available to any individuals with mental illness, emotional disturbance, intellectual or developmental disability, or substance use disorder. This change would allow an individual with mild to moderate mental illness to access specialty behavioral health supports and services as long as a medical provider determines that the services are medically necessary. This fiscal analysis assumes that, after a year of administrative planning and contracting with an ASO, the average annual growth in Medicaid behavioral health utilization and its related costs would increase by 0.5 to 1.0 percentage points or from \$18.0 million Gross (\$5.0 million GF/GP) to \$36.0 million Gross (\$10.0 million GF/GP) annually. This increase in Medicaid behavioral health utilization would gradually return to historic averages over a number of years, once provider capacity and behavioral health utilization requests equalize. Medicaid is a state and federally administered health care program, with the federal government reimbursing the state for approximately 75% of the gross cost.

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

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