HOUSE BILL NO. 4576

May 16, 2023, Introduced by Rep. VanderWall and referred to the Committee on Health Policy.

A bill to amend 1939 PA 280, entitled

"The social welfare act,"

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

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

Sec. 105d. (1) The department shall 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 upon approval of the waiver shall do, all of the following:

(a) Enroll individuals eligible under section 1396a(a)(10)(A)(*i*)(VIII) of title XIX who meet the citizenship provisions of 42 CFR 435.406 and who are otherwise eligible for the medical assistance program under this act into a contracted health plan that provides for an account into which money from any source, including, but not limited to, the enrollee, the enrollee's employer, and private or public entities on the enrollee's behalf, can be deposited to pay for incurred health expenses, including, but not limited to, co-pays. The account shall be administered by the department and can be delegated to a contracted health plan or a third party administrator, as considered necessary.

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

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

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

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

on uniform standards developed by the department in consultation with the contracted health plans. The uniform standards ~~shall~~ **must** include healthy behaviors such as completing a department approved annual health risk assessment to identify unhealthy characteristics, including alcohol use, substance use disorders, tobacco use, obesity, and immunization status. Except as otherwise provided in subsection (20), co-pays can be reduced if healthy behaviors are met, but not until annual accumulated co-pays reach 2% of income except co-pays for specific services may be waived by the contracted health plan if the desired outcome is to promote greater access to services that prevent the progression of and complications related to chronic diseases. If the enrollee described in subdivision (a) becomes ineligible for medical assistance under the program described in this section, the remaining balance in the account described in subdivision (a) shall be returned to that enrollee in the form of a voucher for the sole purpose of purchasing and paying for private insurance.

(f) Implement a co-pay structure that encourages use of high-value services, while discouraging low-value services such as nonurgent emergency department use.

(g) During the enrollment process, inform enrollees described in subdivision (a) about advance directives and require the enrollees to complete a department-approved advance directive on a form that includes an option to decline. The advance directives received from enrollees as provided in this subdivision shall be transmitted to the peace of mind registry organization to be placed on the peace of mind registry.

(h) Develop incentives for enrollees and providers who assist the department in detecting fraud and abuse in the medical

assistance program. The department shall provide an annual report that includes the type of fraud detected, the amount saved, and the outcome of the investigation to the legislature.

(i) Allow for services provided by telemedicine from a practitioner who is licensed, registered, or otherwise authorized under section 16171 of the public health code, 1978 PA 368, MCL 333.16171, to engage in his or her health care profession in the state where the patient is located.

(j) Allow for contracted entities to manage and arrange for the delivery of comprehensive physical health care services and the full array of behavioral health specialty services and supports for eligible Medicaid beneficiaries as described in section 109f(3).

(2) For services rendered to an uninsured individual, a hospital that participates in the medical assistance program under this act shall accept 115% of Medicare rates as payments in full from an uninsured individual with an annual income level up to 250% of the federal poverty guidelines. This subsection applies whether or not either or both of the waivers requested under this section are approved, the patient protection and affordable care act is repealed, or the state terminates or opts out of the program established under this section.

(3) Not more than 7 calendar days after receiving each of the official waiver-related written correspondence from the United States Department of Health and Human Services to implement the provisions of this section, the department shall submit a written copy of the approved waiver provisions to the legislature for review.

(4) The department shall develop and implement a plan to enroll all existing fee-for-service enrollees into contracted

health plans if allowable by law, if the medical assistance program is the primary payer and if that enrollment is cost-effective. This includes all newly eligible enrollees as described in subsection (1)(a). The department shall include contracted health plans as the mandatory delivery system in its waiver request. The department also shall pursue any and all necessary waivers to enroll persons eligible for both Medicaid and Medicare into the 4 integrated care demonstration regions. The department shall identify all remaining populations eligible for managed care, develop plans for their integration into managed care, and provide recommendations for a performance bonus incentive plan mechanism for long-term care managed care providers that are consistent with other managed care performance bonus incentive plans. The department shall make recommendations for a performance bonus incentive plan for long-term care managed care providers of up to 3% of their Medicaid capitation payments, consistent with other managed care performance bonus incentive plans. These payments ~~shall~~ **must** comply with federal requirements and ~~shall~~ **must** be based on measures that identify the appropriate use of long-term care services and that focus on consumer satisfaction, consumer choice, and other appropriate quality measures applicable to community-based and nursing home services. Where appropriate, these quality measures ~~shall~~ **must** be consistent with quality measures used for similar services implemented by the integrated care for duals demonstration project. This subsection applies whether or not either or both of the waivers requested under this section are approved, the patient protection and affordable care act is repealed, or the state terminates or opts out of the program established under this section.

(5) The department shall implement a pharmaceutical benefit that utilizes co-pays at appropriate levels allowable by the Centers for Medicare and Medicaid Services to encourage the use of high-value, low-cost prescriptions, such as generic prescriptions when such an alternative exists for a branded product and 90-day prescription supplies, as recommended by the enrollee's prescribing provider and as is consistent with section 109h and ~~sections 9701 to 9709~~ **part 97** of the public health code, 1978 PA 368, MCL 333.9701 to 333.9709. This subsection applies whether or not either or both of the waivers requested under this section are approved, the patient protection and affordable care act is repealed, or the state terminates or opts out of the program established under this section.

(6) The department shall work with providers, contracted health plans, and other departments as necessary to create processes that reduce the amount of uncollected cost-sharing and reduce the administrative cost of collecting cost-sharing. To this end, a minimum 0.25% of payments to contracted health plans shall be withheld for the purpose of establishing a cost-sharing compliance bonus pool beginning October 1, 2015. The distribution of funds from the cost-sharing compliance pool shall be based on the contracted health plans' success in collecting cost-sharing payments. The department shall develop the methodology for distribution of these funds. This subsection applies whether or not either or both of the waivers requested under this section are approved, the patient protection and affordable care act is repealed, or the state terminates or opts out of the program established under this section.

(7) The department shall develop a methodology that decreases

the amount an enrollee's required contribution may be reduced as described in subsection (1)(e) based on, but not limited to, factors such as an enrollee's failure to pay cost-sharing requirements and the enrollee's inappropriate utilization of emergency departments.

(8) The program described in this section is created in part to extend health coverage to the state's low-income citizens and to provide health insurance cost relief to individuals and to the business community by reducing the cost shift attendant to uncompensated care. Uncompensated care does not include courtesy allowances or discounts given to patients. The Medicaid hospital cost report shall be part of the uncompensated care definition and calculation. In addition to the Medicaid hospital cost report, the department shall collect and examine other relevant financial data for all hospitals and evaluate the impact that providing medical coverage to the expanded population of enrollees described in subsection (1)(a) has had on the actual cost of uncompensated care. This shall be reported for all hospitals in the state. By December 31, 2014, the department shall make an initial baseline uncompensated care report containing at least the data described in this subsection to the legislature and each December 31 after that shall make a report regarding the preceding fiscal year's evidence of the reduction in the amount of the actual cost of uncompensated care compared to the initial baseline report. The baseline report shall use fiscal year 2012-2013 data. Based on the evidence of the reduction in the amount of the actual cost of uncompensated care borne by the hospitals in this state, the department shall proportionally reduce the disproportionate share payments to all hospitals and hospital systems for the purpose of producing general

fund savings. The department shall recognize any savings from this reduction by September 30, 2016. All the reports required under this subsection shall be made available to the legislature and shall be easily accessible on the department's website.

(9) The department of insurance and financial services shall examine the financial reports of health insurers and evaluate the impact that providing medical coverage to the expanded population of enrollees described in subsection (1)(a) has had on the cost of uncompensated care as it relates to insurance rates and insurance rate change filings, as well as its resulting net effect on rates overall. The department of insurance and financial services shall consider the evaluation described in this subsection in the annual approval of rates. By December 31, 2014, the department of insurance and financial services shall make an initial baseline report to the legislature regarding rates and each December 31 after that shall make a report regarding the evidence of the change in rates compared to the initial baseline report. All the reports required under this subsection shall be made available to the legislature and shall be made available and easily accessible on the department's website.

(10) The department shall explore and develop a range of innovations and initiatives to improve the effectiveness and performance of the medical assistance program and to lower overall health care costs in this state. The department shall report the results of the efforts described in this subsection to the legislature and to the house and senate fiscal agencies by September 30, 2015. The report required under this subsection shall also be made available and easily accessible on the department's website. The department shall pursue a broad range of innovations

and initiatives as time and resources allow that shall include, at a minimum, all of the following:

(a) The value and cost-effectiveness of optional Medicaid benefits as described in federal statute.

(b) The identification of private sector, primarily small business, health coverage benefit differences compared to the medical assistance program services and justification for the differences.

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

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

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

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

(11) By December 31, 2015, the department shall review and report to the legislature the feasibility of programs recommended by multiple national organizations that include, but are not limited to, the ~~council of state governments, the national conference of state legislatures, and the American legislative exchange council,~~ **Council of State Governments, the National Conference of State Legislatures, and the American Legislative Exchange Council,** on improving the cost-effectiveness of the medical assistance program.

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

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

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

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

(13) The performance bonus incentive pool for contracted health plans that are not specialty prepaid health plans shall include inappropriate utilization of emergency departments, ambulatory care, contracted health plan all-cause acute 30-day

readmission rates, and generic drug utilization when such an alternative exists for a branded product and consistent with section 109h and ~~sections 9701 to 9709~~ **part 97** of the public health code, 1978 PA 368, MCL 333.9701 to 333.9709, as a percentage of total. These measurement tools ~~shall~~ **must** be considered and weighed within the 6 highest factors used in the formula. This subsection applies whether or not either or both of the waivers requested under this section are approved, the patient protection and affordable care act is repealed, or the state terminates or opts out of the program established under this section.

(14) The department shall ensure that all capitated payments made to contracted health plans are actuarially sound. This subsection applies whether or not either or both of the waivers requested under this section are approved, the patient protection and affordable care act is repealed, or the state terminates or opts out of the program established under this section.

(15) The department shall maintain administrative costs at a level of not more than 1% of the department's appropriation of the state medical assistance program. These administrative costs shall be capped at the total administrative costs for the fiscal year ending September 30, 2016, except for inflation and project-related costs required to achieve medical assistance net general fund savings. This subsection applies whether or not either or both of the waivers requested under this section are approved, the patient protection and affordable care act is repealed, or the state terminates or opts out of the program established under this section.

(16) The department shall establish uniform procedures and compliance metrics for utilization by the contracted health plans

to ensure that cost-sharing requirements are being met. This shall include ramifications for the contracted health plans' failure to comply with performance or compliance metrics. This subsection applies whether or not either or both of the waivers requested under this section are approved, the patient protection and affordable care act is repealed, or the state terminates or opts out of the program established under this section.

(17) The department shall withhold, at a minimum, 0.75% of payments to contracted health plans, except for specialty prepaid health plans, for the purpose of expanding the existing performance bonus incentive pool. Distribution of funds from the performance bonus incentive pool is contingent on the contracted health plan's completion of the required performance or compliance metrics. This subsection applies whether or not either or both of the waivers requested under this section are approved, the patient protection and affordable care act is repealed, or the state terminates or opts out of the program established under this section.

(18) The department shall withhold, at a minimum, 0.75% of payments to specialty prepaid health plans for the purpose of establishing a performance bonus incentive pool. Distribution of funds from the performance bonus incentive pool is contingent on the specialty prepaid health plan's completion of the required performance of compliance metrics that shall 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. This subsection applies

whether or not either or both of the waivers requested under this section are approved, the patient protection and affordable care act is repealed, or the state terminates or opts out of the program established under this section.

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

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

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

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

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

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

(23) If a new or amended waiver requested under subsection (20) is denied by the United States Department of Health and Human Services, medical coverage for individuals described in subsection (1)(a) shall remain in effect for a 16-month period after the date of submission of the new or amended waiver request unless the United States Department of Health and Human Services approves a new or amended waiver described in this subsection within the 12 months after the date of submission of the new or amended waiver request. A request for a new or amended waiver under this subsection must comply with the other requirements of this section and must be provided to the chairs of the senate and house of representatives appropriations committees and the chairs of the senate and house of representatives appropriations subcommittees on

the department budget, at least 30 days before submission to the United States Department of Health and Human Services. If a new or amended waiver request under this subsection is not approved within the 12-month period described in this subsection, the department must give 4 months' notice that medical coverage for individuals described in subsection (1)(a) shall be terminated.

(24) If a new or amended waiver requested under subsection (20) is canceled by the United States Department of Health and Human Services or is invalidated, medical coverage for individuals described in subsection (1)(a) shall remain in effect for 16 months after the date of submission of a new or amended waiver unless the United States Department of Health and Human Services approves a new or amended waiver described in this subsection within the 12 months after the date of submission of the new or amended waiver. A request for a new or amended waiver under this subsection must comply with the other requirements of this section and must be provided to the chairs of the senate and house of representatives appropriations committees and the senate and house of representatives appropriations subcommittees on the department budget at least 30 days before submission to the United States Department of Health and Human Services. If a new or amended waiver under this subsection is not approved within the 12-month period described in this subsection, the department must give 4 months' notice that medical coverage for individuals described in subsection (1)(a) shall be terminated.

(25) If a new or amended waiver request under subsection (23) or (24) is approved by the United States Department of Health and Human Services but does not comply with the other requirements of this section, medical coverage for individuals described in

subsection (1)(a) shall be terminated 4 months after the new or amended waiver has been determined to be in noncompliance. The department must notify individuals described in subsection (1)(a) at least 4 months before the termination date that enrollment shall be terminated and the reason for termination.

(26) Individuals described in 42 CFR 440.315 are not subject to the provisions of the waiver described in subsection (20).

(27) The department shall make available at least 3 years of state medical assistance program data, without charge, to any vendor considered qualified by the department who indicates interest in submitting proposals to contracted health plans in order to implement cost savings and population health improvement opportunities through the use of innovative information and data management technologies. Any program or proposal to the contracted health plans must be consistent with the state's goals of improving health, increasing the quality, reliability, availability, and continuity of care, and reducing the cost of care of the eligible population of enrollees described in subsection (1)(a). The use of the data described in this subsection for the purpose of assessing the potential opportunity and subsequent development and submission of formal proposals to contracted health plans is not a cost or contractual obligation to the department or the state.

(28) This section does not apply if either of the following occurs:

(a) If the department is unable to obtain either of the federal waivers requested in subsection (1) or (20).

(b) If federal government matching funds for the program described in this section are reduced below 100% and annual state savings and other nonfederal net savings associated with the

implementation of that program are not sufficient to cover the reduced federal match. The department shall determine and the state budget office shall approve how annual state savings and other nonfederal net savings shall be calculated by June 1, 2014. By September 1, 2014, the calculations and methodology used to determine the state and other nonfederal net savings shall be submitted to the legislature. The calculation of annual state and other nonfederal net savings shall be published annually on January 15 by the state budget office. If the annual state savings and other nonfederal net savings are not sufficient to cover the reduced federal match, medical coverage for individuals described in subsection (1)(a) shall remain in effect until the end of the fiscal year in which the calculation described in this subdivision is published by the state budget office.

(29) The department shall develop, administer, and coordinate with the department of treasury a procedure for offsetting the state tax refunds of an enrollee who owes a liability to the state of past due uncollected cost-sharing, as allowable by the federal government. The procedure shall include a guideline that the department submit to the department of treasury, not later than November 1 of each year, all requests for the offset of state tax refunds claimed on returns filed or to be filed for that tax year. For the purpose of this subsection, any nonpayment of the cost-sharing required under this section owed by the enrollee is considered a liability to the state under section 30a(2)(b) of 1941 PA 122, MCL 205.30a.

(30) For the purpose of this subsection, any nonpayment of the cost-sharing required under this section owed by the enrollee is considered a current liability to the state under section 32 of the

McCauley-Traxler-Law-Bowman-McNeely lottery act, 1972 PA 239, MCL 432.32, and shall be handled in accordance with the procedures for handling a liability to the state under that section, as allowed by the federal government.

(31) By November 30, 2013, the department shall convene a symposium to examine the issues of emergency department overutilization and improper usage. The department shall submit a report to the legislature that identifies the causes of overutilization and improper emergency service usage that includes specific best practice recommendations for decreasing overutilization of emergency departments and improper emergency service usage, as well as how those best practices are being implemented. Both broad recommendations and specific recommendations related to the Medicaid program, enrollee behavior, and health plan access issues shall be included.

(32) The department shall contract with an independent third party vendor to review the reports required in subsections (8) and (9) and other data as necessary, in order to develop a methodology for measuring, tracking, and reporting medical cost and uncompensated care cost reduction or rate of increase reduction and their effect on health insurance rates along with recommendations for ongoing annual review. The final report and recommendations shall be submitted to the legislature by September 30, 2015.

(33) For the purposes of submitting reports and other information or data required under this section only, "legislature" means the senate majority leader, the speaker of the house of representatives, the chairs of the senate and house of representatives appropriations committees, the chairs of the senate and house of representatives appropriations subcommittees on the

department budget, and the chairs of the senate and house of representatives standing committees on health policy.

(34) As used in this section:

(a) "Contracted entity" means a contracted health plan or a single statewide entity.

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

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

(d) "Single statewide entity" means an entity that meets all of the requirements in section 109f (1)(a) to (e) and holds a contract with the department.

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

(f) ~~(d)~~ "Telemedicine" means that term as defined in section

3476 of the insurance code of 1956, 1956 PA 218, MCL 500.3476.

Sec. 109f. (1) The department shall support the use of Medicaid funds for specialty services and supports for eligible Medicaid beneficiaries with a ~~serious~~ mental illness, **intellectual or** developmental disability, serious emotional disturbance, or substance use disorder. **Except as otherwise provided in this subsection and until the provisions described in subsection (5) are implemented,** Medicaid-covered specialty services and supports shall be managed and delivered by specialty prepaid health plans chosen by the department ~~. The specialty services and supports~~ **and** shall be carved out from the basic Medicaid health care benefits package. **Not later than 120 days after the effective date of the amendatory act that added this sentence, the department must create and submit an implementation plan and timeline to execute the provisions added to this section to the legislature for review. After legislative review, unless otherwise specified, the department must fully implement the provisions of this section in accordance with the implementation plan no later than 2 years after the effective date of the amendatory act that added this sentence. The department must consolidate the 10 regional specialty prepaid health plans existing on that date into a single statewide entity that must manage Medicaid-covered specialty services and supports for Medicaid beneficiaries described in subsection (5). Within the implementation plan created under this subsection, the department must establish the minimum requirements for state operations to be considered in the selection of the consolidated single statewide entity. These requirements for state operations must include the following:**

(a) Scope of practice that does not exceed the operational

oversight and administration of the public behavioral health benefits, services, and supports.

(b) Licensure requirements to obtain and retain a valid license or certificate of authority issued by the department of insurance and financial services and to comply with all the terms and conditions set forth in sections 3505 and 3509 of the insurance code of 1956, 1956 PA 218, MCL 500.3505 and 500.3509, and all other applicable laws of this state.

(c) Compliance requirements to ensure adherence to contract provisions and applicable provisions of federal and state laws, policies, regulations, guidance waivers, and standards.

(d) Accountability requirements that provide detailed specifications for oversight and administrative requirements, and subsequent penalties for noncompliance.

(e) Financial solvency requirements consistent with section 1903(m) of title XIX, 42 USC 1396b, and the provisions of sections 3551 and 3569 of the insurance code of 1956, 1956 PA 218, MCL 500.3551 and 500.3569, and 42 CFR 438.116.

(2) The department must establish the administrative board structure requirements for the single statewide entity. The administrative board structure must include, at a minimum, that the composition includes the following:

(a) Individuals who are recipients of services or recipients' family members.

(b) Representatives from network providers in this state.

(c) Representatives from a community mental health services program.

(d) Individuals who provide behavioral health and medical services.

(e) Individuals who are representative of the general public.

(3) Before a contract is effective between the department and a single statewide entity, a state-conducted readiness review must be performed that includes an on-site evaluation, and a thorough review of the entity's operations to successfully demonstrate compliance with and capabilities of the following minimum requirements:

(a) Staffing capabilities, including key personnel and functions directly impacting eligible Medicaid beneficiaries to adequately support the contractual responsibilities of the single statewide entity, not limited to beneficiary services, oversight monitoring, and compliance.

(b) Contracts with, and responsibilities of, any delegated contracted entities.

(c) Network provider composition and access, including content of provider contracts and any provider performance incentives.

(d) Care management and care coordination capabilities.

(e) Enrollee and beneficiary services capabilities, including beneficiary materials, processes, and internal systems and infrastructure.

(f) Experience in the management of self-determination contracts and local self-directed service programs.

(g) Comprehensiveness of quality management program and quality improvement strategies.

(h) Comprehensiveness of a utilization management program.

(i) Internal grievance and appeal policies and procedures.

(j) Fraud and abuse and program integrity policies and procedures.

(k) Information systems, including the claims payment system

performance, enrollment and eligibility system and performance, reporting capabilities, encounter data validity, information technology testing and security assurances, and system coordination with electronic medical records, Michigan health information network shared services (MiHIN), and all contracted health plans.

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

(5) ~~(3) This section does not apply to a pilot project authorized under section 298(3) of article X of 2017 PA 107.~~**In addition to the requirements specified in subsection (3) for establishing a single statewide entity, the department must establish a competitive contract and procurement process that fully integrates the administration of physical health care services and behavioral health specialty services and supports for all eligible Medicaid beneficiaries served by a contracted health plan, and as specified under subsection (10). The department may utilize or leverage the upcoming renewal and rebid of the currently contracted health plans to satisfy this requirement, as long as the newly effectuated contracts for the contracted health plans go into effect by no later than September 1, 2024.**

(6) The department's procurement process for contracted health plans to administer the integrated and comprehensive Medicaid health care benefit package must incorporate, but is not limited

to, requirements pertaining to all of the following:

(a) Network adequacy.

(b) Staffing.

(c) Financial plans and risk-sharing.

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

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

(f) Five years of behavioral health experience.

(g) Five years of physical health experience.

(h) Five years of managed care experience.

(7) This act does not prohibit a public entity from partnering with a private entity to collectively meet the requirements prescribed in subsection (6)(a) to (h).

(8) The implementation plan developed by the department, as required under this section, must also satisfy each of the following:

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

(b) Require a contracted entity to contract with each community mental health services program within its service area for the provision of behavioral health specialty services and supports, including, but not limited to, specialized residential services, respite care, community living supports, peer supports, respite and single point of entry crisis center intake services, and other services. This subdivision does not prohibit a contracted entity from contracting with another behavioral health provider as part of developing or maintaining the contracted entity's provider network.

(c) Require a community mental health services program to contract with each contracted entity within its service area to provide, directly or indirectly through the use of contracted providers, behavioral health specialty services and supports, including, but not limited to, specialized residential services, respite care, community living support services, peer supports, and other services. Community mental health services program reimbursement for contracted services shall be at the standardized fee schedule established in subdivision (o) with the opportunity for additional payments under value-based contracting incentive arrangements.

(d) Require that the physical health care services and behavioral health specialty services and supports provided by a contracted entity be person-centered.

(e) Include a process to ensure the readiness of all contracted health plans under this subsection, to administer the integrated and comprehensive Medicaid health care benefit package that includes the physical health care services and behavioral health specialty services and supports for all of the eligible Medicaid beneficiaries specified under subsection (10).

(f) Include a process to ensure the readiness of the single statewide entity to administer the behavioral health specialty services and supports for all of the eligible Medicaid beneficiaries specified under subsection (10) and ensure the evaluation is completed to satisfy the requirements set forth in subsection (3)(a) to (k).

(g) Reduce inefficiencies in funding, coordination of care, and service delivery.

(h) Generate uniformity with benefits, contracts, training

reciprocity, outcome measurement, care coordination, and utilization management such as screenings and authorizations.

(i) Allow for portability throughout this state without a change in access or benefits.

(j) Increase eligible Medicaid beneficiary choice of service provider and delivery method.

(k) 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. At a minimum, during a period of time that does not exceed 5 years, savings shall be actualized through the use of the risk corridor, and any amount of money that is returned from the contracted entity to the state as part of the corridor reconciliation process is considered savings.

(*l*) Allow for increased coordination, including data and information sharing, with other providers, agencies, and organizations that are part of an eligible Medicaid beneficiary's plan of care.

(m) Standardize and centralize accountability for administering and managing physical health care services and behavioral health specialty services and supports services.

(n) Increase transparency and budget predictability.

(o) Establish a 2-way risk corridor for the plan implemented under this section under which contracted health plans participate in a payment adjustment system. In establishing the 2-way risk corridor under this subdivision, medical expenses used in the risk corridor must include covered services and approved in-lieu-of

services, benefit expenses including incurred but not reported expenses within a time frame developed by the department, as well as health care quality improvement expenses as defined in 42 CFR 438.8(e)(3).

(p) Establish a Medicaid loss ratio that is based on actuarially sound capitation rates and built on a standardized fee schedule for all covered Medicaid behavioral health services.

(q) Require covered telehealth behavioral health services provided to Medicaid beneficiaries by health care providers to be paid at the same reimbursement rate as in-person behavioral health services.

(9) During development of the implementation plan described in subsection (1), the department shall consider incorporating the collaborative care model into the benefit delivery system for the single statewide entity and contracted health plans.

(10) The implementation plan required under this section must provide for the transition and enrollment of all eligible Medicaid beneficiaries who are receiving behavioral health specialty services and supports from 1 of the 10 regional specialty prepaid health plans to be conducted as follows:

(a) By September 1, 2024, or upon completion of the procurement process described in subsection (5), whichever is sooner, the awarded contracted health plans are responsible for administering physical health care services and behavioral health specialty services and supports for all eligible Medicaid beneficiary children as provided within the respective Medicaid programs, including children in foster care, and children who have a mental illness, serious emotional disturbance, intellectual or developmental disability, or substance use disorder.

(b) By September 1, 2024, or upon completion of the procurement process described in subsection (5), whichever is sooner, the awarded contracted health plans are responsible for administering physical health care services and behavioral health specialty services and supports for all adult eligible Medicaid beneficiaries within their respective Medicaid program who have a mental illness considered mild or moderate or substance use disorder.

(c) By September 1, 2024, the single statewide entity established under subsection (1) is responsible for administering behavioral health specialty services and supports for uninsured non-Medicaid individuals and all eligible adult Medicaid beneficiaries within their respective Medicaid program who have a severe mental illness or an intellectual or developmental disability. The single statewide entity is responsible for coordinating the public behavioral health benefits for the individuals specified in this subdivision.

(d) For all eligible Medicaid beneficiaries, served by the single statewide entity, the single statewide entity must cooperate and coordinate with the contracted health plans, hospitals, and public and private providers, in accordance with appropriate state and federal privacy protections.

(11) The department may promulgate rules and establish Medicaid policy to carry out the duties established under this section. This section does not prohibit future amendments providing reforms for the adult Medicaid beneficiaries who have a severe mental illness or an intellectual or developmental disability to have their physical health care services and behavioral health specialty services and supports managed through the contracted

health plans.

(12) In developing the key metrics, it must be ensured that the metrics are or do all of the following:

(a) Are tailored to each of the populations included in the transition.

(b) Take into consideration lessons learned from any past implementation efforts that may be applicable, including, but not limited to, certified community behavioral health clinics, behavioral health homes, and opioid health homes.

(c) Are developed and made publicly available at least 30 days before the transitions occur.

(d) Focus on assessing individuals with behavioral health diagnoses or physical and behavioral health comorbidities.

(e) Include measures related to patient-centered care, including shared decision-making, patient education, provider-patient communication, and patient or family experiences of care.

(f) Include evidence-based metrics to assess health outcomes, coordination and continuity of care, utilization, cost, efficiency, patient safety, and access to care.

(g) Include measures that utilize real-time performance data of contracted entities.

(h) Leverage standards from national resources, including, but not limited to, the Centers for Medicare and Medicaid Services, National Committee for Quality Assurance, Substance Abuse and Mental Health Services Administration, and Agency for Healthcare Research and Quality.

(13) The department, in consultation with the behavioral health accountability council, must routinely monitor the progress of the transition efforts described in subsection (10) for the

contracted entities. The behavioral health accountability council is responsible for the following:

(a) Completing an annual evaluation of the collective performance of the contracted health plans managing the physical health care and behavioral health care services and supports following transition of eligible Medicaid beneficiaries as provided in subsection (10).

(b) Completing an annual evaluation of the collective performance of the single statewide entity managing the public behavioral health benefit as provided in subsection (10).

(c) Providing the evaluations to the behavioral health ombudsman and the department, with any findings and recommendations by no later than December 15. The first reporting is due from the behavioral health accountability council by December 15, 2025. Evaluations must be conducted by the behavioral health accountability council for the first 2 years following the transitions, unless the department determines that further evaluation is necessary.

(14) Except in a case of malfeasance or misfeasance, the department must require the prepaid inpatient health plan system and community mental health services programs to maintain all current provider contractual arrangements throughout the duration of the transition period. A prepaid inpatient health plan or community mental health services program shall not reduce provider choice within the service networks by restructuring delegated services or altering reimbursement rates during the transition period. A prepaid inpatient health plan or community mental health services program that reduces choice within the current provider network or otherwise tampers with the structure of the current

network or its ability to continue providing services is subject to economic sanctions, up to and including disqualification from participating in a contracted entity's network.

(15) The department must ensure that all capitated payments made to contracted entities are actuarially sound as provided under section 1903(m)(2)(A)(*iii*) of title XIX, 42 USC 1396b.

(16) The department must establish an annual reporting requirement for contracted entities. The reporting requirement must be posted publicly and provided to the legislature in order to annually evaluate the success and efficacy of the contracted entities. Five years after implementation of the program, the legislature may review the program's success and efficacy to determine if the program shall continue.

(17) As used in this section:

(a) "Collaborative care model" means 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, but is not limited to, the following elements:

(*i*) Care directed by the primary care team.

(*ii*) Structured care management.

(*iii*) Regular assessments of clinical status using validated tools.

(*iv*) Modification of treatment as appropriate.

(b) "Community mental health services program" means that term as defined in section 100a of the mental health code, 1974 PA 258, MCL 330.1100a.

(c) "Contracted entity" means a contracted health plan or a

single statewide entity.

(d) "Foster care" means that term as defined in section 115f.

(e) "Interested parties" means 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 Care 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.

(f) "Single statewide entity" means an entity that meets all of the requirements in subsection (1)(a) to (e) and holds a contract with the department.