#3 AFP Questions – March 22, 2013

AFP Reference	Question	Response
Page 6 2. Sub-capitation	The AFP states: "An applicant may sub capitate for shared risk with its provider network, including CMHSPs, MCPSs, and core providers. The actuarially sound methodology and rates for sub-capitation, by contractor, must be submitted to MDCH. MDCH retains the right to disapprove any sub-capitation arrangement that is determined not to be actuarially sound or where the arrangement has a high probability to adversely impact the State's risk-sharing." If a PIHP pays the CMHSPs through a sub-capitated arrangement, the sub-capitated arrangement must be actuarially sound. Correct?	Yes. If a PIHP pays CMHSPs through a sub capitated arrangement, it must be actuarially sound. Please note though, the state PEPM paid to the regional entity/PIHP will already be actuarially sound as determined by state and its actuaries. Sub cap rates for categories of need (TANF/DAB/ET), must be consistently distributed based on the Medicaid population within the individual CMHSP.
	To determine actuarial soundness, can the PIHP have an actuary do an analysis for the region determining the appropriate sub-capitated rate per CMHSP?	Again, any sub cap rate needs to be consistent with the rates paid to the PIHP/regional entity, and follow to the CMHSP based on its Medicaid population. That said, the PIHP can have an actuarial analysis done if it determines it wishes to employ some sort of additional withhold or shared savings models to be applied consistently (based on Medicaid population) across CMHSPs. As stated in the AFP, the state reserves the right to disapprove of any sub capitation or shared savings model.

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	To determine actuarial soundness, must the PIHP have an actuarial analysis done, or can the PIHP use the regional factor used by the State?	Assuming the PIHP sub capitates the CMHSPs consistent with the rates it receives for the region, (based on the size of the Medicaid population in the individual CMHSPs), then an additional actuarial analysis will not be necessary.
	Can a previous hub PIHP still receive the same amount of Medicaid it has been receiving (from the new RE) and manage its previous spoke boards on behalf of the RE, using its own claims and contracting system?"	No. "Previous hub CMHSP/PIHPs" shall receive sub capitation based on that individual CMHSP's Medicaid population, solely. The former hub CMHSP may not receive sub capitation inclusive of "Medicaid population of the former hub CMHSP plus the Medicaid population of its former spoke CMHSPs". This "super PIHP" and "sub-PIHP" model will not be acceptable.
Page 14 Item 1.6	This section requires that the region report the number of PIHP Board members in each category, e.g., person who receives service, family member, advocate, etc. Can this be a duplicated count? It is quite possible that a Board member may be an advocate and a Commissioner, etc. Or should each Board member be counted only once?	Yes. Individual board members may represent more than one category.
Other/General	Are we correct to assume that current PIHPs may expend Medicaid monies for start-up and organizational costs for the new PIHP?	It is understood that transition will be much smoother if regional entity leadership can be hired and begin transition work soon after the regional entity is created, well in advance of the

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		January 1, 2014 start. Start-up, employee and organizational costs for the new regional PIHPs should be considered "pre-award costs" that are eventually reported as costs by the new regional PIHP entity. These costs cannot be allocated to the current PIHP's Internal Service Fund. In addition, the restrictions, requirements, and approvals necessary to use current PIHP Medicaid savings for these costs present barriers that prevent the use of existing Medicaid savings from being an effective solution to the start-up funding problem. The suggested approach is for existing PIHP(s) to pay start-up costs, record them as receivables, and bill the new regional PIHP once it is established and funded. The new regional PIHP would then pay the bill and subsequently record/report the expense to MDCH.
Other/General	Is it allowable for the new PIHP staff (those carrying out CEO, CIO, CFO functions) to be hired by a participating CMH in the new PIHP region prior to January 1, 2014 (so as to carry out the functions necessary to have the new PIHP operational on that date), with the	To ensure smooth transition planning, the new PIHP staff should be hired by the new regional entity, not by participating individual CMHSPs in the new region. Start-up, employee and organizational costs for the new regional PIHPs should be considered

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	employment relationship changing to the new PIHP, on January 1, 2014?	"pre-award costs" that are eventually reported as costs by the new regional PIHP entity. These costs cannot be allocated to the current PIHP's Internal Service Fund. In addition, the restrictions, requirements, and approvals necessary to use current PIHP Medicaid savings for these costs present barriers that prevent the use of existing Medicaid savings from being an effective solution to the start-up funding problem. The suggested approach is for existing PIHP(s) to pay start-up costs, record them as receivables, and bill the new regional PIHP once it is established and funded. The new regional PIHP would then pay the bill and subsequently record/report the expense to MDCH.
Other/General	If it is not possible for a CEO to be identified for the July 1, 2013 deadline stated in the AFP, would it be possible to submit instead the job description, the bylaws and/or operating agreements that describe the role of the CEO and demonstrate that the CEO will not an employee of any of the CMHSPs that created the new regional entity.	Yes. If it is not possible for the name of the CEO to be identified by the July 1, 2011 deadline, it is acceptable for the applicant to submit instead the job description, the bylaws and/or operating agreements that describe the role of the CEO and demonstrate that the CEO will not be an employee of any of the CMHSPs that created the new regional entity.
Other/General	In Section 2.4 it says, "It is the responsibility of the PIHP to perform the functions above and to assure that its provider network performs these	First, for items in section 2.4, a uniform set of policies and procedures is required to be utilized across the entire region. This can be done: directly by the PIHP centrally managed, OR, can

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	functions in the management of any providers it procures". This section is being interpreted to suggest that the department approves of delegation of PIHP functions to the CMHSPs as long as there is monitoring. It also suggests that CMHSPs can hold provider network contracts as opposed to being centrally managed. Please clarify.	be delegated to a single CMHSP to manage on behalf of ALL CMHSPs in the region. In either case, some of the work can be distributed amongst the CMHSPs in the region, but there needs to be a central authority ensuring consistency across the entire region with clear accountability to the PIHP regional entity, not to an individual CMHSP within the regional entity. The important issue here is consistency across all CMHSPs in the region and clear and ultimate authority resting with the PIHP, regardless of whether an individual CMHSP does the work on behalf of the regional entity. Regarding contracting: A PIHP shall not require a provider to apply to be on the region's provider network more than once, simply because the provider serves more than one geographic area within the PIHP region. It is also understood that a provider may be contracted to provide both Medicaid and general fund services, and that the execution of the payment portion of a contract would generally be done by an individual CMHSP for both Medicaid and non-Medicaid funded services.