Current as of 2/25/13

APPLICATION FOR PARTICIPATION (AFP)

QUESTIONS

AFP Reference	Question	Response
Questions with Applicability to Multiple Sections	Please clarify check boxes, or, and system. To clearly identify when a checkbox is mandatory verses when there is a selection between multiple options in all sections including, but not limited to: QAPI, UM. To clarify the instructions so no item is missed, please clarify what items the "OR" options relate to (i.e.: pg. 34 – It is not clear how items in this section (4.1.1 – 4.6) are grouped together as options vs. individual items that must be checked) To clarify, an "or" in the AFP applies to the immediately preceding and subsequent sections? Clarify: Please look at sections 5.3.1.8, 5.3.1.9 and 5.3.1.10 on page 43-44. Pick one of three.	In Section 2.5 Utilization Management, check box 2.5.2 OR 2.5.3. Check box 2.5.4, then check box 2.5.5 OR 2.5.6 In Section 2.7 Quality Management, check boxes 2.7.1, check box 2.7.2 OR 2.7.3; check box 2.7.4 OR 2.7.5; check box 2.7.6; check box 2.7.7 OR 2.7.8 In Section 4, External Quality Review, check box 4.1.1 OR 4.2; check box 4.3 OR 4.4; check box 4.5 OR 4.6 In Section 5.3.1, Olmstead Compliance Community Living, check box 5.3.1.8 OR 5.3.1.9 OR 5.3.1.10
Links not working in the current AFP Document	Please provide a link to the referenced EQR Protocols; they were recently revised. MDCH and the system need to work from the same documents. Please provide a working link to the document "Establishing Administrative Costs across CMHSPs within and across CMHSPs." The link	This is not necessary. All the existing PIHPs have the current EQR protocols that are being used by HSAG with this year's BBA standards review. This document is available at www.michigan.gov/mhsa click on "Reporting

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	referenced in the AFP does not work, yet this document is critical for Administrative Function clarification. This document is currently unavailable on the MDCH/BHADD website, and the "documents" site of MDCH is not available to the public. The link for Administrative Functions does not work. Many links do not work including but not limited to Coordinating Agency contract and references to documents/locations are unclear. Can MDCH remedy this? In Section 2.0, MDCH refers to its Establishing Administrative Costs within and across CMHSPS document link not working. The link to HSAG Report in Health section does not seem to be working. Page 38 5.2.1-the link here appears to be broken? As of 2/8, none of the links worked.	Requirements," scroll down to "Administrative Cost Reporting" This document is available at www.michigan.gov/mhsa click on Mental Health and Developmental Disabilities, then "Mental Health Statistics and Reports", scroll down to External Quality Review of PIHPs
Page 4	The AFP is fairly clear that the PIHP must have common policies and procedures across its	The policies should commence January 1, 2014,

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4th Paragraph	CMHSPs and provider partners. While PIHPs will likely be able to report on regional policy development by April or July 2013, it is assumed that the timeframes for actually implementing those policies across a region will be more flexible and will require a phased-in approach.	unless otherwise noted in the AFP.
Page 4 2nd Paragraph	Regional Entity statute does not require a section on functional consolidation of administrative activities. Thus, will MDCH consider a separate statement on this topic rather than in By Laws or related legal agreements? Many regions have already drafted or finalized their By Laws for CMHSP Board review. This request applies to any item in Governance legal agreements, i.e., only items required under the law(s) or by mutual agreement of the Participants ought to be in legal agreements, unless legal agreements also means Operating Agreement.	It is acceptable for additional functional clarity to be contained in Operating Agreements instead of the bylaws. However, the applicant needs to specify the common policies and procedures to be utilized throughout the region in every place indicated in the AFP.
Page 4 3rd Paragraph	Please provide the official relevant version of the so-called November 26, 2012 "Discussion Draft".	It is posted at www.michigan.gov/mhsa click on Mental Health and Developmental Disabilities, then 2013 Application for Participation, this document is posted there. There is no "final"

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		version of the document.
Page 5 1. Capitation Payments and Data Files Last sentence of first paragraph	Will Hab Waiver be number based or severity based? Will the new region retain the current allocation of HS/W slots? What will happen to the slots if they are not all currently filled? Will they be reallocated to a different region? Is there going to be a PIHP review dialogue with PIHP of the rebasing analysis is submission of Waiver/CMS? What is the implementation calendar related to changing Hab Waiver allocation?	MDCH plans to redistribute HSW certificates to the new PIHPs based on morbidity, with consideration of previous PIHP regions where certificates have been unused as well as previous PIHP regions where there has been high demand but insufficient certificates to meet the needs. The new regions will not necessarily retain the current allocation of certificates. Yes, as in the past, there will be a review dialogue of the January 2014 actuary rebasing analysis with the PIHP regions In addition to the reallocation of HSW certificates, the payment methodology must be changed to meet new CMS reporting requirements. MDCH will have further discussions with PIHPs related to proposed changes to the enrollment process, retrospective payments and recoupments for lack of service. If possible, final decisions will be made in time to submit a HSW amendment to correspond to the 1915(b) renewal effective date of January 1, 2014. Any changes not completed by that date will be no later than the next HSW

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		renewal due September 30, 2015.
Page 5 1. Capitation Payments and Data Files	When do you expect actuaries to develop FY13 capitation rates for new regions?	We will be submitting the data to Milliman in April/May to begin their rate analysis.
Page 5 1. Capitation Payments and Data Files	Single CMHSP PIHPs will be required to report both the administrative cost of PIHP functions borne directly by the PIHP and those PIHP functions carried out by the CMHSP, CMHSP core providers, and MCPNs (2013 AFP, page 5). Will PIHP jointly governed by a number of CMHSPs have the same requirements?	Yes
Page 5 1. Capitation Payments and Data Files	Does MDCH intend to place a cap on the administrative cost percentage for PIHP? Can DCH provide what the administrative cap is going to be for the CMHSP direct operated programs or what it will be based on? Does MDCH have an implementation calendar for increasing the percentage of the ratio that reflects morbidity each year? What is the	Conversations with Milliman are in progress, and future morbidity ratio, administrative cap will be discussed. No definitive time line as of yet.

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	implementation calendar related to placing a cap on admin cost percent for direct services?	
Page 5 1. Capitation Payments and Data Files	"MDCH will be moving to methodologies that are built on a common statewide rate structure where adjusters are entirely based on morbidity differences or cost of living methodologies common to other areas of healthcare". Does this mean that DCH will be comparing physical health with behavioral health and/or does it mean public will be compared to private?	MDCH will continue to discuss with MSA as well as Milliman and will provide additional information at a future date.
Page 6 2. Sub-Capitation	Subcapitation $. We will need to know to facilitate distribution. DCH has indicated that they will disapprove any sub cap arrangement that is determined not to be actuarially sound. How will this be determined? Will DCH be using an actuary? Applicant may sub-capitated for shared risk with its provider network… So, will CMHSP be allowed to hold a risk reserve? If not, how will it resource the shared risk?	Sub-capitation arrangements will need to be approved by MDCH and must be actuarially sound It will be the responsibility of the PIHP Region to determine actuarially sound sub-capitation arrangements and disclose to MDCH. To be determined.
Page 6	How long does MDCH anticipate before the rates are solely based on morbidity? If the rates	MDCH is currently in discussions with Milliman for rate structure timeline.

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2. Sub-Capitation	are set actuarially, and in accordance with federal standards, sub-capitation by its very nature should be actuarially sound. I don't understand that we would have to provide actuarially sound methodology for a true sub-capitation payment methodology. Can MDCH please explain what they meant by this? Sub-capitation: arrangements require review by MDCH. These arrangements will require actuary development – who is going to pay for that? If a sub capitation is a straight sub cap of the actuarial rates set by MDCH will a separate actuarial analysis still be required? The state rates, by their nature, should be actuarially sound.	The PIHP Region. See Above.
Page 6 3. Internal Service Fund	When do you expect actuaries to determine the percentage of the ISF that shall move to the new PIHP for purpose of servicing the enrollees that move to the new PIHP region? When do you expect current PIHPs to transfer ISF to the new PIHP? The AFP is silent as to Medicaid Savings. What	We are still in discussions with Milliman regarding Medicaid and ISF savings. MDCH will address in contract negotiations. See Above

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	happens to that? Is a PIHP required to transfer Medicaid savings to the ISF? What about 1st quarter of FY14?	See Above
	What happens to a funding/cost settlement when the new regions are formed? How will this occur? Can the option be available for prior PIHPS to transfer ISFs (that had been established within prior PIHPs regions) to the new PIHP - or - allow them to maintain these ISFs within the prior PIHP regions, if understood that the prior PIHP ISF funds would be used first?	See Above
	Is it likely or possible that the ISF for the newly forming regions will be less than the combined ISFs of the existing PIHPs?	See Above
	ISF transfer using enrollee data summarized by diagnosis...do you mean disability? Hard to imagine meaningful summarization by diagnosis.	See Above
	For PIHP's that are not changing geography (members remain same-Like in Region 10) why would the ISF be re-evaluated? Why wouldn't we just combine them?	See Above
	The PIHPs, as opposed to the MHPs, cannot	

AFP Reference	Question	Response
	contribute to their ISFs without showing these as unspent Medicaid funds. Thus reducing their rebasing revenue in the future. Given this PIHP ISFs in many cases are small. These small ISFs will make it difficult for these PIHPs to withstand the cash flow problems caused by withholds and sanctions. These same cash flow problems do not occur for MHPs who can contribute to ISFs and count those dollars toward Medicaid rebasing. Given this PIHPs need to be able to contribute to their ISFs and have those ISF contributions count as Medicaid expenditures and they count in the rebasing process.	See Above
Page 6 4. Integrated Care	Can we assume that there is some flexibility in terms of implementing and executing the new uniform agreements for the MHPs for the new PIHP? (Our experience is that it can take many months to get a new MHP agreement executed with a health plan.) The AFP states: "other regions may be selected to participate in the integrated care opportunities." What are these opportunities? Are we just selected or is there another RFP	Can be addressed in contract negotiations. There will not be another RFP process for the PIHPs in the four dual demonstration regions. The ICOs selected for each region will be required to have a signed agreement with that region's PIHP. "Other integrated care opportunities" may

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	process? PIHP's are being required to have signed agreements with the MHP's and our issue is we cannot force a contract with anyone. Is DCH requiring the MHP's to have a signed agreement with the PIHP's? The paragraph states that the MHPs will have this requirement same as us. This section also says that the PHIP's and MHP's are supposed to use the new model agreement and we are currently getting push back from the MHP's not to use it. PIHP's are required to have contracts with the ICO's. Again you cannot force a contract, so is DCH going to require same of ICO? Does this refer only to Regions 1, 4, 7, and 9?	include health homes, and/or statewide expansion of the duals integration following the demonstration period. Yes, MDCH is requiring the MHPs to have signed agreements with PIHPs Yes, ICOs will be required to have a signed agreement with the PIHP in the duals region. Yes, the duals regions are 1, 4, 7 and 9.
Page 7 5. Performance Monitoring and Incentives	Do withholds begin year 1? Related to Performance Monitoring and Incentives and completeness of QI health conditions and I/DD characteristic data is MDCH aware that many of these fields are available	Yes BHDDA does have access to physical health care encounters, claims and diagnoses in the data warehouse. To the extent that data provides important information for performance

AFP Reference	Question	Response
	and likely more accurate from physical health claims and encounter files? Please be cautious of incenting duplicate work and completeness of data fields over accuracy of data fields. What happens to the withhold if a PIHP doesn't achieve the performance award? How is it determined or handled if part of the PIHP region achieves the performance targets but some other part of the PIHP region does not achieve same set targets? Will the withhold dollars come from all funding streams and if out of Medicaid funds will the reimbursement effect lapsed funds? The AFP states that MDCH will withhold a portion of the approved capitation payment from each PIHP (between .02 and .015) to be used for performance incentive awards. For some PIHP regions, this could be $6-8 million. Need more information on this. MDCH will withhold a percentage of the capitation payment that will be later used as incentive payments. If we have to earn part of our capitation then is this really a true	monitoring, it will be used. However, much that is in the QI file are data fields that are required by SAMHSA or provide important individual-level information (especially for people with I/DD) that is not otherwise available through encounters, claims and diagnoses. If all of the CMHPs within the region do not meet the performance award standard, the PIHP does not receive the performance award. MDCH is working with Milliman and CMS on the withhold dollars for Medicaid. No GF will be used. Yes - it will be a different total dollar amount but a standard percentage. If you have a large budget, .0005% is a bigger amount than a smaller budget - but the process is the same. Withhold performance functions differently from sanction (page 7). #5, #7. For example, timely and complete data submission will result in distribution of withhold amounts. PIHPs will know at the beginning of the year what the withhold amount is and what they will need to do to get it back. Process of submitting complete data will be

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	capitation? Earlier DCH described a methodology for determining cap rates based a variety of factors, so if our rate is based on what we need then having to "earn" a percentage of it back means we are potentially getting less than what we need. If incentive payments are withheld upfront and not paid until the end, have we actually been given a current year cut with an ability to earn carry forward for next year? What is the delay period to "earn back" the full [payment that we really needed at the start of the year?	part of first phase. 42 CFR 438 clearly states that sanctions can be utilized by the State. MDCH will provide additional sanctioning language in the final contract. BHDDA is using this opportunity to operate in a similar fashion to MSA requirements imposed on the health plans, such as data in on time, adequate network, adequate services, etc.
Page 7 6. Program Integrity and Compliance	Can you clarify why full or partial delegation of QAPI and Compliance functions is provided as an optional approach for the RE on page 32 in the quality management section when # 6 on page 7 indicates that the PIHP will "own" key functions such as: "designation of a compliance officer for the PIHP……" The PIHP would have region wide policy and procedures showing commitment to comply with federal and state laws. What does this	Please see the response to the question for "Page 32 2.7 Quality Management" below.

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	mean exactly and what would be evidence of that “commitment”? Genesee, for example, has a fully compliant corporate compliance program per the federal integrity standards. Does DCH intend for this to be duplicated? Genesee does not need two compliance programs, two officers, etc.	
Page 8 7. Sanctions	Please define "failure to provide services". Is this a missing service element identified by site review, or denials based on Medical Necessity appealed and found in favor of the beneficiary, failure at the individual level or at the aggregate level. What is "substantial inappropriate denials"? What if ALJ supports those denials?	Failure to provide services includes the unavailability of a covered Medicaid service in an area; and inappropriate denials of services as determined by the state fair hearing process (when ruling in favor of the beneficiary). “Substantial” could be defined as a PIHP being a statistically extreme outlier on the statewide average percent of state fair hearings found to substantiate beneficiaries’ appeals of denials of service.
Page 10 3rd paragraph	Can MDCH acknowledge that the July 1 due date for Entity formation and greater detail still may leave some Entities with less than full ability to certify certain details? If the legal entity is formed in late June the Board and CEO may not be active until July, thus may revise some	July 1, 2013 is a firm date for new legal entities to be formed, including all enabling resolutions passed in CMHSPs in the region, and required filings completed. If legal entities are not in place by July 1, the State will proceed to open the region for competitive bid for PIHP function. The AFP allows clarity of milestone dates for

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	portions of plans.	functional details that may require more time; resulting in, at best, a conditional award.
Page 10 5th Paragraph	Regarding the labeling instructions; we just want to clarify that DCH wants 1 document and the labeling of attachments are within the 1 document.	Yes, the PIHP should submit one pdf document. Within the document each attachment should be labeled as instructed in the section.
Page 11 1. Award without conditions	Should it be stated early June 2013 (not early June 2 1. Appears to be an incorrect date-year) should be June 2013.014) in item 1 on page 11 of 2013 AFP? There appears to be a typo in the second sentence …June 2014 (should be 2013).	Yes, June 2013.
Page 13 D.1. Governance	It seems a bit rigid to not allow for the opportunity to explain or correct an area prior to DCH making the determination that the application is done. FAILED. What if you just forgot to check a box?	MDCH advises applicants to conduct quality control measures to catch any omissions prior to submitting the AFP. MDCH has no preference on location. However,

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	Are there any expectations as to where the new PIHPs have to be physically housed (i.e., within or separate from CHMSPs)? Or could PIHP functions be housed in various locations (i.e., not centrally)? Please clarify the PIHP Board action required for submission of the AFP.	care needs to be taken that there is clear distinction between the PIHP and its operations from the organization with which it is co-located. Minimally all CMHSPs in the region must have approved enabling resolutions, and all required filings with County Clerks also need to be complete. The additional specific steps required may vary depending on the type of entity being sought and the CMHSP type enabling the action. CMHSPs and entities should consult legal.
Page 14 1.4.6	Can "relevant to the contract and managing entity" be added to this statement?	No
Page 14 1.4.7	Regarding Local Match Medicaid obligations – Is MDCH intending to change the local Medicaid match calculations as they have no current relevance to funding, or is each CMHSP going to keep the same amount of local match Medicaid obligation as they still have? Regarding the local match obligations related to Medicaid. CMHSPs have been paying a flat, locked rate to the PIHPs for years. The state has used that to draw down additional Medicaid.	MDCH intends to evaluate the historic method used to allocate CMHSP Medicaid match requirements and determine if any changes in the process are necessary. MDCH will share information concerning the outcome of that evaluation and any related changes in the allocation process.

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	Are you revising that amount? Will it have a growth factor?	
Page 14 1.6	Section 1.6 says there is a list of PIHP board member categories in the AFP; there seems to be no such list in the AFP. Also, the board member categories are found in statue, thus additional requirements seem over-reaching (see above) especially if not crystal clear. Within Section 1.6, if the requirements remain, will MDCH provide a table that is desires to have populated, or will each PIHP create its own for the submission? Regarding who can be a PIHP Board member; wouldn't it be a conflict of interest to have a county commissioner on the PIHP board because they are in an elected position with their primary fiduciary responsibility to the county that elected them?	Yes, many of the AFP requirements exceed the statute. The board members for the PIHP are not defined in statute; therefore, there is more leeway to locally determine the kinds of categories of representation and the numbers of people who will fill each category. County commissioners are not prohibited from serving on a PIHP governing board. When acting in the capacity of a PIHP board member, a board member who is a county commissioner is obligated to act in the best interest of the PIHP. If a situation arises in which regard for one duty leads to disregard of another, then a conflict of interest exists with regard to that situation.
Page 14	Section 232 doesn't have anything to do with certification, we think you mean 232A and	Section 232A requires that CMHSPs be certified in order to receive public funds. If a CMHSP is

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Last Paragraph	whatever happened to deemed status? What can a PIHP that doesn't yet exist do about a CMH that has an issue with certification?	accredited, the site review portion of the Mental Health Code mandated certification process is waived (i.e., "deemed status"). There are no CMHSPs that currently have an issue with certification.
Page 16	Detroit Wayne MCPNs: Page 16: Is it MDCH intent is that MCPNs serve all populations?	Wording may not have been very clear. Our intent is that there should be at least 2 for each population: MH/SUD (2) and I/DD (2)
Page 19 1st Paragraph	In Section 2.0, MDCH refers to its Establishing Administrative Costs within and across CMHSPS document. Can MDCH clarify how this document impacts the formal delegation requirements of a PIHP? For example, the Delegation Component of 42 CFR 438.230 only applies to CFR statutes contained in 42 CFR § 438. It is on these "delegations" that the EQRO holds the PIHP accountable to meet all six conditions of 438.230. However, if this MDCH document is also imposed as formal guidance, will the EQRO (HSAG) review protocol get adjusted and/or will MDCH begin to review the PIHP for any formal delegations of the various sub-functions contained in this document as	The document referenced was developed by PIHP and CMHSP finance officers via the MACMHB to assist PIHPs and CMHSPs in allocating administrative costs. It is true that the AFP, and ultimately the contract, have additional requirements of PIHPs beyond 42 CFR 438. The External Quality Review will continue to focus on BBA compliance. MDCH will use other methodologies to monitor compliance with its contractual agreement with PIHPs.

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	well, many of which transcend the specified PIHP requirements of 42 CFR 438.	
Page 19 Section 2 1st Paragraph	In light of the above referenced document (i.e. Establishing Administrative Costs….), does MDCH have any plans to modify this document to align it with the new CFR rules on Medical Loss Ratio (MLR), and how a health plan (i.e., PIHP) must classify and document its administrative costs, including functions pertaining to Quality Improvement (i.e. 45 CFR 158)? Currently this document is not aligned with federal statute on the costing of administrative functions for federally funded health plans. If no plan exists to amend this document, can MDCH clarify what statute or document takes precedence for Michigan PIHPs to document and submit its "administrative" vs. "MLR" costs to the Michigan MSA?	The document was developed by CMHSP and PIHP finance officers through the MACMHB. MDCH invites them to revisit the document and make modifications as necessary.
Page 19 Section 2	The Compliance and Program Integrity is another function of the PIHP (438.600-610). Why doesn't this administrative subsection have its own section; and are there any functional responsibilities that cannot be delegated? The current AFP is mainly silent on this important	The PIHPs must adhere to all functions required by 42 CFR 438 regardless of whether the AFP specifically addressed all of them.

AFP Reference	Question	Response
	function.	
Page 19 Section 2.1	Can MDCH clarify the intent of Section 2.1 vs the MH Code Statute language and what takes precedence? The Mental Health Code stipulates the CEO and CFO must be employees of the Regional Entity; yet the AFP seems to imply some of these Chief Officer positions may be leased, including the CFO. The AFP identifies the CEO/COO/CFO and CIO under General Management as well as the Medical Director, SA Director, HR Director, and Compliance Officer. General Management as described in MDCH's, "Establishing Administrative Costs Within and Across the CMHSP System" dated February 2010 (AFP pg 19) doesn't list the CFO, CIO or Compliance Officer under this General management function of administration. Does that mean there will be a modification to this Administrative Cost document – or was it presented this way to provide clarity within the AFP? In 2.1 General Management the requirement that four Chief Officers shall be 100% dedicated	The question is unclear. Please provide a specific Mental Health Code reference and related question and an answer will be provided in future Q&A. The use of the term "General Management Functions" in the AFP and the use of a similar term in the Administrative Cost Report document are not necessarily synonymous. MDCH will assess the need to modify the Administrative Cost document and communicate the results at a future date. See above.

AFP Reference	Question	Response
	to the general management functions of the PIHP only is problematic. We believe MDCH means they will be dedicated 100% to the Regional Entity, for which PIHP is one contract/business line inside the Regional Entity/UCA. We do not believe MDCH wants, nor do we recommend then additional Chiefs for the Coordinating Agency role and for some, the MME Demonstration role which, as we understand it will be a separate Agreement with varying terms and conditions. Is there a specific issue with the IRS that we should be aware of or are you referring to the 20 point check list? Please discuss how this applies to single county regions. Not sure how to check the boxes since PIHP/CMH is same organization. Macomb County CMH as a stand-alone PIHP and CMHSP has a: - Single Board of Directors - Single Executive Director - Single COO - Single CFO	Please be aware of all IRS regulations. MDCH agrees with the Macomb example for a single county region in response to 2.1.1.1: 2.1.1.1. [X] The Chief Executive Officer is 100% dedicated to the applicant PIHP functions.

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	- Single CIO Our response to the AFP will include: 2.1.1.1. [X] The Chief Executive Officer is 100% dedicated to the applicant PIHP functions. (We will check this response as affirmative, and by taking the position we have a Program Director of Internal CMH Services, albeit, I also have some CMHSP oversight).	
Page 21 2.1.5 Other Executive Staff	We would ask MDCH to allow for flexible models for how some of these functions are managed across different regions and not be prescriptive in terms of which staff roles must exist at the PIHP level – and whether these functions are delegated, purchased, or directly staffed by the PIHP. If the CA is to be fully integrated, why is a "Substance Use Disorder Prevention & Treatment Director" required? What is that person to do, and what is their authority? Why would a region that is leasing all of its	The AFP requires common policy and procedures across the entire region. The common policies and procedures for the PIHP functions are not flexible. What is flexible is whether those functions are to be performed on behalf of the full region directly by PIHP staff or purchased or delegated. The applicant is required to have a central authority for substance abuse disorder prevention and treatment. The State is not specifying the level of staff or title. This is flexible based on the needs of the region. The regional substance abuse authority is important to ensuring the protections listed in PA 500 and PA 501 of 2012 (Poleski Bills). The AFP does not require an HR director, but an

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	employees from constituent CMHs need an HR Director? Executive staff part still very confusing. HR Director of PIHP makes no sense, HR is employer. HR Network, QAPIP/Sentinel Events. Also, isn't medical director a CMHSP function per code?	HR function. The HR function for the PIHP needs to be separate from the HR functions of the individual CMHSPs in a region. It is the function that is required to manage those human resources, whether by contract or by direct employment, that needs to be clarified in the AFP. The applicant needs to consider the very separate functions of CMHSPs and PIHPs in multi-CMH regions. Both require a lead medical director function. Note this is a function not a person, and may or may not be full-time. In single CMH regions it is allowable for the medical director, HR director, and all executive staff to be the same for the PIHP and CMHSP functions.
Page 21 2.1.5.2	Please clarify what "one set of common General Management function policies and procedures (among member CMHSPs…)" means. What types of policies is this item intended to reference?	The use of the term was intended to apply to any area where lack of standard policies and procedures across the PIHP's geographic region could result in unequal access or service quality.
Page 23 2.2 Financial Management Functions	Explain the 4th function: "service unit and recipient-centered." Could you please clarify financial management function 4 "service unit and recipient-	Please refer to "Establishing Administrative Costs within and across the CMHSP System, December 2011" See Above

AFP Reference	Question	Response
	centered"? Could you please clarify the difference between supervision of audit (financial management function 8) and audits (financial management function10)? Please clarify what "one set of common Financial Management function policies and procedures" means. Is the regular processes of claims adjudication and payment at the CMHSP level considered to be allowable delegation of this PIHP function related to Financial Management as described in MDCH's, "Establishing Administrative Costs Within and Across the CMHSP System" dated February 2010? Likewise, is it true if new PIHPs provide a sub-cap funding arrangement to CMHSPs within the region based on the enrollment file – the recognition of fee for service revenue related to sub cap arrangement would be considered a delegated PIHP administrative function vs. a direct administration function of billing and collection from 1st and 3rd parties?	See Above It means that in a region of more than one CMHSP, there is one set of financial management policies and procedures that each CMHSP follows. Yes, the CMHSP may process and pay claims from providers.

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	For a standalone, is anything more than an org chart required? One existing set of policies will be used.	For standalones the only document in the financial section required is the org chart. The past performance of the PIHP, as verified by the External Quality Review and performance monitoring systems, is sufficient for meeting the other policy attestations.
Page 24 2.3 Information systems Management	In 2.3 Information Systems Management will MDCH be providing detailed data flow diagrams on the role they will play on data-sharing and healthcare data analytics across PIHPs, MHPs, ICOs and the like? This will be germane to the design of PIHP AFP responses for this area. Will MDCH be requiring HL7 CCD compliance for MHPs, ICOs and others? If so, whom and by when? Please be specific about 2.3.8b. "National standards". Which national standards? Many of the data field information requests are not regularly collected and calculated, or are already available to MDCH in their data warehouse. Will MDCH concede that regions, especially those who are integrating PIHPs with varying information systems will perform a	MDCH will not be providing detailed data flow diagrams as pilots are still underway. MDCH simply requests applicants do their best to highlight efforts that are currently underway or in development in each of the areas. Applicants are requested simply to state their ability to transfer and interface data based on national standards such as HL7 (as example). MDCH is not requiring HL7 or particular standards at this time. MDCH will continue to work to clarify expectations through collaborative work with the CIO Forum and TSG. The State is interested in current capabilities of regional entities in these areas. Ability to work toward interface and efficient transfer of data is an

AFP Reference	Question	Response
	"good faith effort" to collect and report the requested information and that a standard beyond this is likely unachievable in the timeframe required? For all data requests and tables are these for only some funding sources (i.e. Medicaid only) and also what time period is data for (last Fiscal Year, 3 months, 6 months, a snapshot)? Item 2.3f references the PIHP's ability to analyze and report costs by regions and CMHSP/CA sources and providers. Will MUNC cost reports be eliminated once monetary amounts are reported in Encounter Data? Will the expected cost analysis be within monetary amount encounter level data or require a drill deeper into CMHSP costs?	important functional capability as integrated population health continues to evolve nationally and in Michigan. The data requests, tables and timeframes will be clarified in the contract. The funding sources are the same as currently required of PIHPs. MUNC reports will not be eliminated as they provide important information for validating the encounters and cases that are reported to the data warehouse. In addition, the MUNC provides information about what a service costs the PIHP to manage, whereas the monetary amount reflects the amount the PIHP paid the provider.
Page 25 2.3.2	Will CMHs still be sending "CMH" data to DCH? Does data encounter reporting include SA Block Grant encounters?	MDCH expects that all encounter, QI and TEDS data from all funding sources (Medicaid, GF, MI Child, Block Grant) will come from no more than one entity in each of the 10 regions. Yes.

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AFP Reference	Question	Response
Page 25 Response Criteria	Is there supposed to be an "OR" between 2.3.4 and 2.3.5? Or is it that 2.3.4 – 2.3.10 were all supposed to have another box that says that the work will be completed by July 1st? It looks like perhaps they just left those boxes out. They just listed the numbered section again with no box?	Yes, there should be an OR between 2.3.4 and 2.3.5
Page 26 2.3.6.a.	Risk Mitigation and Management Procedures - Does the language in this requirement refer to how the PIHP will comply with the Hi-Tech provisions of HIPAA for e-PHI held by the PIHP? The PIHP cannot perform the notifications for a covered entity – i.e., it would not be appropriate for a HIPAA covered entity to delegate "up" its HIPAA responsibilities to its payer. If the PIHP provided this as a service to the covered entity, the PIHP would become a vendor/contractor of the CMHSP, which creates difficulties relative to conflict of interest as a payer and payee. b. If the answer to "a" is yes, then "b" does not make sense.	The PIHP functions for IT are separate from the IT functions of the CMHSP in multi-CMHSP regions. Both entities need to comply with all applicable data security and privacy rules. The State is not suggesting that a CMHSP "delegate up" any responsibilities to a payer. Please think carefully about the two very separate and important IT related functions between the CMHSP and its provider network, and the Medicaid payer (the PIHP) and the unique functions and risk management requirements.
Page 26 2.3.7	Why is the "CA" included as in "CMHSP/CA" when in most sections, CA isn't mentioned, and in general the CA is to be integrated?	The reason "CMH/CA" is listed in some parts of the AFP is because there is a possibility that all CAs may not be dissolved and fully merged into

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AFP Reference	Question	Response
	Why are CMHSP/CAs referenced, when the Poleski bills eliminate CAs and make their function part of the new regional PIHP structures?	the PIHP until October 2014. Therefore, some of the data requirements, etc., may need to include not just data from the CMHs to the PIHPs, but also from the CAS to the PIHPs until they are fully merged with the PIHP.
Page 26 2.3.7.d-g	Should we assume the responses to these items should be oriented toward compliance with managed care standards – i.e., primarily the ISCAT?	These are the same items that have been required for PIHPs in Michigan up through 2013. These are not new requirements and are related to managed care plan functions.
Page 26 Functions supporting Integrated Care	2.3.8.a-b. Health information exchange is a CMHSP role as it involves provider to provider communications. The PIHP would not reach around the CMHSP to communicate with local/community partners. Also, sub-state HIE engagement varies by medical trading area. How does MDCH see a role for the PIHP in these areas beyond ensuring that the CMHSP's are engaged at a local level? What does the department see as the PIHPs role in the health insurance exchange or information exchange with physical health care vis-a-vis the CMHSPs role?	Careful attention should be paid to the differences between what 42 CFR 438 may require in terms of information exchange by the PIHP and what information may need to be exchanged at the CMHSP level with other providers. It is understood that these needs for information exchange will be different between the two entities. It is understood that sub state HIE engagement varies by region. The State is simply requesting information from the PIHP as to the status of these capabilities and functions in your particular region. The State does not have definitive information at this time on the role of the PIHP in the health insurance exchange.

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AFP Reference	Question	Response
Page 27 2.3.9	What data sources will PIHP's have available from the state to analyze?	This is still in the design and pilot phases. The data analytics pilots are looking to exchange encounter information between physical and behavioral health systems for purposes of improved population health. Specific sources cannot be provided until pilots have been completed.
Page 27 2.3.10	What does "engaging standards" mean? Again, meaningful use is a local, EMR product specific endeavor. Is MDCH looking to have PIHP's establish regional metrics that are chosen from the required menu or clinical metrics for Meaningful use? This will be difficult and expensive with diverse EMR's in place in this large 21 county region and without the ability to require use of a specific EMR across provider networks. The PIHP could "ensure" the CMHSP follows through with meaningful use.	It is agreed that "the PIHP requiring CMHSP following through with meaningful use" is an appropriate summary of what is hoped to be covered in this item.
Page 27 Table 2.3.11	The AFP references 'core providers' relative to the EHR Table. What is the definition of core providers, or is the AFP asking for any and all providers who have their own EHR, in addition to CMHSP EHR?	Core Providers was used as reference to Oakland County CMHSP's use of the term with regards to their service delivery system and may not have broader application beyond that use.

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AFP Reference	Question	Response
	The AFP references "compliant formats as specified by MDCH". Since there is no established standard, what format should the PIHP anticipate? Does MDCH consider any formats "standard" other than Ansi X12N?	Standard formats will continue to be specified in contracts and other mechanisms (such as websites) as has been the case up to this point in time. The PIHP should anticipate standards similar to those required today, working toward improved standard data fields and elements as are being discussed in the CIO Forum, TSG and other groups.
Page 28 2.4 Provider Network Management	Will MDCH require a uniform contract across affiliations? For all types of contracts? How will the administrative cap for direct service for CMHSPs be determined? Will this be applied to core providers as well as contract providers of the CMHSP as well? We would like clarification that DCH means "direct service staff" with the reference "non-credentialed staff"" and you do not mean clerical or other administrative support staff? Clarify last sentence – responsibility of the PIHP to perform…versus "oversee" in next paragraph. What is the definition of "assure that its	MDCH will not require that a uniform contract be utilized by the PIHP with its provider network. However, MDCH will continue to identify in its contract with the PIHP any areas where the PIHP is obligated to ensure that their subcontracts mandate compliance with MDCH requirements. Yes, non-credentialed staff refers to direct service staff. MDCH expects that there be common policies

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	Provider Network performs these functions"? Can we review the monitoring processes; do we have to review all their monitoring reports, etc.?"	and procedures across the Region to assure all providers utilized within the network meet the requirements of that region.
Page 29 2.4.11	"Assure the health and welfare" this seems very broad and outside the scope of the PIHP.	Please refer to 42 CFR 438, the 1915(b) waiver application, and the 1915(c) waiver application. Each of these references the responsibility of the managed care organization to assure the health and welfare of its beneficiaries.
Page 30 2.5 Utilization Management	The AFP indicates these functions may be delegated in part or fully to the PIHPs provider network. Does this presume that those provider contracts would be held by the PIHP?	No, some PIHPs may contract directly with providers; other PIHPs may contract with CMHSPs, MCPNs or core providers that, in turn, have subcontracts with providers.
Page 32 2.7 Quality Management	Section 2.7 states, "PIHP will not delegate these functions," and then 2.7.3. says which functions will be delegated. Which is it? Page 32 references the compliance program in the information about quality management. In this section, it specifically states, "MDCH expects that the PIHP will not delegate these function and understands that some of the functions will be performed in addition by the provider	While MDCH prefers that the Quality Management functions would not be delegated, there is no prohibition to delegating the functions. There also may be some duplication of some quality management functions between the PIHP and member CMHSPs.

AFP Reference	Question	Response
	network". Need clarification on the last sentence of the first paragraph where it says "MDCH expects the PIHP will not delegate these functions and understands that some of the functions will be performed in addition by the provider network." It appears that this is either delegation or it is redundant work. In the intro paragraph, DCH states "that the PIHP will not delegate these [Quality Management] functions…' but goes on to allow a checkbox and narrative describing its delegation. Is delegation allowed or not? Says function will not be delegated, but 2.7.3 gives that option. Can it be delegated? The AFP indicates that "MDCH expects that the PIHP will not delegate these functions" but there is no requirement for a Quality Executive at the PIHP. This seems inconsistent.	There is not a requirement for a Quality Executive at the PIHP level. Some PIHPs will decide that is a position that could be less than 100% dedicated to the PIHP, and therefore shared with another CMHSP(s) These terms came from "Establishing Administrative Costs within and across the CMHSP System, December 2011"

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	Please clarify "facility quality improvement process" and "facility provider education" under the general description of Quality Management functions.	
Page 32 2.7.4	The October 1, 2013 deadline seems out of line because the new PIHP may not exist until January 1, 2014?	The Quality Assessment and Performance Improvement Plan must be effective by January 1, 2014, that is why is must be submitted ahead of time for MDCH review and approval.
Page 33	Accreditation Status should be labeled as 3 and on the next page External Quality Review should be numbered as 4.	Thank you for your observation. You are correct.
Page 35 5. Public Policy Initiatives	Item 5.1.1-3- These items appear to be redundant to 5.2.2.3.a.	These are not redundant. In this section, MDCH is interested in how the PIHP will prevent, and respond to, behavioral or medical crises for a small segment of the population served. Section 5.2.2 is about assuring the health and welfare of all people served through the PIHP.
Page 35 5.1 Regional Crisis Response Capacity	What is the status in the new PIHPs of any alternate models (e.g., intensive crisis stabilization) enrolled by MDCH for current	Any programs (crisis res, intensive crisis stabilization) enrolled by PIHPs in the past will continue to be enrolled.

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	PIHPs? Will the CPLS continue to be funded? Crisis home has been inaccessible. Will there be capacity to contract with them for services outside of the DCH contract? Describes crisis response capacity to be available by 1/1/2015, should it be 1/1/2014?	CPLS funding will probably continue. It is anticipated that CPLS will continue to have a capacity to contract for services outside of the DCH contract. Date of 1/1/15 is correct. It allows time for the development of the capacity.
Page 36 Table 5.1.4	The AFP requires PIHPs to determine within the last 6 months persons experiencing "more than one visit to the ER for behavioral episode". MDCH has required tracking of Critical Incidents leading to an ER visit for injury and med errors and Risk Events leading to an ER visit due to self-harm. Incident reports have not been coded as "behavioral episodes" so the closest approximation to this data from current required coding would be ER visit due to self-harm if the intent is to keep the data from 5.1.5.2. (injury due to emergency physical intervention) separate. Is this acceptable? Otherwise we are looking at re-reviewing 6 months of incident reports and will need a	The purpose of these tables is for the regions to engage in a comprehensive self-analysis of the crises that occur, the kinds of responses that occur today, and what kinds of responses need to be put in place by 1/1/15. The information required in these tables does exceed, or duplicate, what is already reported. The utility of this data is primarily to provide information for regional decision-making.

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	specific definition of "behavioral episode". It would be helpful if the MDCH could use existing data elements from the QI Dataset, Critical Incident or Risk Event reporting system so that existing data definitions and data gathering tools can be used. Otherwise this data will have little utility either as a quality improvement baseline or for program development. "911 calls" for what purpose? Behavioral response only? By families in private homes or licensed homes/supported independence settings also? Does crisis home mean a Crisis Residential Home? Does "ER visits" include inpatient hospitals only or does it include after-hours emergency care clinics? MDCH should already have data related to how many requests have been made for admission to a state facility.	The paragraph above the table answers the questions about 911 calls and ER visits. Crisis home can mean a crisis residential program or some other licensed home that is used for temporary crisis de-escalation.
Page 37 5.1.5	For the data requests relating to the Public Policy Initiatives, where it requests counts for a twelve month period, what is the 12 month period? Most recent 12 months, last fiscal year, last calendar year?	The important point is that this be a twelve month period as reasonably close to the present point as possible. The state is flexible in terms of the exact date range as long as it includes the required amount of months (12), and is

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		consistent across the region.
Page 37 5.1.6	Do we check this box only if the beds described are available in the region? Anywhere in the region, regardless of geographic distance?	The beds are available to people within the region within reasonable geographic distance from their county of residence.
Page 37; Page 40 5.1.7 5.2.2.2	Can we assume that for Culture of Gentleness/Working with People and Trauma-Informed Training that any relevant content training in these areas applies, or is MDCH asking for only a specific training program being named in each or both Items? Also, there is reference to text boxes to be completed below in each Item, but there are no text boxes included.	MDCH has supported the Culture of Gentleness/Working with People and Trauma-Informed training; however, we are not limiting this as the only training if your PIHP can attest to other comparable training. Yes, the text boxes were inadvertently omitted. Please complete the information separately, label as Attachment 5.1.7 and include it in the attachments document.
Page 37 5.1.8	It is our understanding that this agreements should be in place between CMHSP's and the local provider. Should we respond regarding how the PIHP will ensure the CMHSP complies, such as through monitoring, setting benchmarks or policy?	In most cases, there will be agreements between the local CMHSPs and their local hospitals. If so, then MDCH is asking for how the PIHP will assure those agreements are in place and are used.

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Page 38 5.2.1.3	Since the PIHP does not draft the person-centered plan, shall we assume that we should respond regarding how the PIHP will ensure CMHSP and provider compliance on this indicator? What if the IPOS isn't' due yet and/or what if the person doesn't want to address physical health conditions? I assume a statement to this effect will be sufficient! Otherwise it flies in the face of PCP.	Yes, how the PIHP will assure that its provider network is in compliance. It is expected that when the IPOS is due, person-centered planning will address physical health conditions. If an individual refuses to discuss, or refuses a referral to a primary care practitioner, then a statement to that effect and signed by the individual would be in order.
Page 38-39 5.2.1. Health 5.2.1.4	While we fully support the integration of behavioral health and physical health we are not sure how the PIHP can assure that primary care physicians are knowledgeable in how to approach and treat individuals with MI or DD. We can CONTINUE to offer relevant trainings but we CANNOT MAKE THEM ATTEND OR MONITOR THEIR INTERACTIONS TO ENSURE IT IS HAPPENING! Additionally, 5.2.1, para #3 where PIHPs are to "assure that individuals […] receive […] healthcare" and 5.1.2.4. requiring	The Michigan Mental Health Code, Chapter 7, requires person-centered planning and the components that must be addressed, including health care. Medicaid Targeted Case Management and Supports Coordination require that health care be addressed and that if necessary, linkages to the primary care practitioner be made.

AFP Reference	Question	Response
	attachment 5.2.1A wherein the PIHP describes how it plans to "assure coordination" […] "to assure that […] preventive and ambulatory care are provided…" etc., are overreaching and outside of any PIHP's control unless it directly provides physical health care. DCH notes on Page 38 that "PIHPs are not paid to provide primary health care."	
Page 39 5.2.1.4	Coordination with Primary Care - Coordination must occur in local communities and it would not be appropriate for the PIHP to reach around the CMHSP to intervene with local practitioners. We are assuming we should respond regarding how the PIHP will ensure CMHSP compliance.	Yes.
Page 39 5.2.2 Welfare	We have much the same concerns here as noted above in number 20. A lot of this appears to be DHS responsibility rather than CMH/PIHP responsibility. How are we funded to do this?	One functions of a case manager or supports coordinator is to monitor services provided to the beneficiary. MDHS is responsible for reviewing components of AFC licensing, once every three years. That is insufficient oversight to assure the health and welfare of PIHP beneficiaries
Page 40 5.2.2.1	We cannot force DHS to have a contract with us.	Section 5.2.2.1 of the AFP does not require a CMHSP to have a contract with MDHS. What is required is an interagency agreement between

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		each CMHSP and MDHS-APS and MDHS-BCAL that outlines how the agencies will work together and share relevant information concerning investigations. MDHS participated in the drafting of the model agreement. MDCH does not anticipate any difficulties in CMHSPs obtaining the required signed agreements.
Page 41 5.3.1	Not sure what at we are supposed to be focusing on with regards to the referenced Olmsted compliance webpage. Please provide more specific information.	The focus of this section is providing opportunities for community living and competitive employment.
Page 42 5.3.1.5	Planning with Local Housing Agencies - Planning for housing must occur in local communities and it would not be appropriate for the PIHP to reach around the CMHSP to intervene. We assume our response will relate to how the PIHP will ensure CMHSP compliance.	Yes.
Page 42 Tables 5.3.1.6.A-C	It would be helpful if the MDCH could use existing data elements from the QI Data reporting system or the CMHSP Annual Submission so that existing data definitions and data gathering tools can be used. Otherwise this	The utility is to the newly-forming regions.

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	data will have little utility either as a quality improvement baseline or for program development. Does the request for data include both specialized and general licensed residential setting? We do not necessarily place people in AFCs; people may however choose to live in them. What are you actually looking for? Is info in Table 5.3.1.6.B a subset of people counted in 5.3.1.6.A? Table 5.3.1.6C asks about living arrangements. What is the population in question? All people served? For those in less intensive services, i.e., no case management, it may not be known whether they have roommates or housemates.	Yes. MDCH expects the PIHP to respond regarding all the people served in the region who reside in AFCs. Yes. MDCH expects the PIHP to respond regarding all people served in the region
Page 44 5.3.1.8.c-d	How can we guarantee these opportunities? In conjunction with c, in item d why can't we rely on licensing? This doesn't mean if we see a problem we wouldn't address it but we are not	It is in the contractual agreements between CMHSPs and licensed AFCs that there can be requirements for the provider to make opportunities available. BCAL is responsible to

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	the primary responsible party- BCAL is.	monitor AFCs relative to their licenses, once every three years. BCAL is not responsible to assure that the provider is making opportunities for community integration, inclusion or productivity available.
Page 45 5.3.1 Employment and Community Activities	We think 5.3.1 is mislabeled and should be 5.3.2. Requiring specific items in this case, pre-voc and SE to be addressed in every IPOS at least annually flies in the face of PCP. What about people who are "retired" and do not want to work? What about individuals who are physically/mentally unable to work in any capacity? In some cases it is hurtful to family members to keep bringing this up.	Thank you for your observation. You are correct. Please note that there is a column that includes people who are retired. Also, please refer to the Michigan Mental Health Code, Chapter 7, that requires person-centered planning and all that should be addressed during the process.
Page 45 5.3.2.2	Is the date listed (January 1, 2013) a typo? The date should be January 1, 2014.	Yes. The date should be January 1, 2014.
Page 46 Table 5.3.2.4. B	There is no reference to duplicate count as there is in the table A above. There will be a duplicate count of consumers in this table as well. How should that be handled? This is currently not something tracked in most systems' data fields and will have to be obtained manually and/or	5.3.2.4 B There will be duplicates in this table and DCH is aware of that. It is the number of people involved in those activities.

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	estimated.	
Page 47 5.3.2.6	Define the term determinants. It is used throughout the document. What are you actually looking for?	The Applicant defines.
Page 48 Section 5.4	Please clarify the intent related to CA services and SUD services. For example on page 4 related to SUD services and CA services are a CMH function but on page 48 functions are assigned to the PIHP are these the same functions, different, or overlap and where should they be "owned"?	Checking this box attests that all functions/services/responsibilities in the current CA contract are included in the merger implementation plan. The link was included for reference of what must be in the merger implementation plan. The link should have been: http://egrams-mi.com/dch/user/home.aspx, choose Substance Abuse under Current Grants.
Page 48 5.4.3	What specifically are we looking at and responding to that can be found at this link? It says "for reference see the contract" and gives a link to a general page in egrams. What are we looking at within our contract (or a	See Above.

AFP Reference	Question	Response
	general/nonspecific SUD contract) that we can use to respond in this area?	
Page 48 5.4.9	Separate RR Process for SUD service recipients. How is this integration of SUD and CMH System? There are currently no Mental Health Recipient Rights oversight standards for the RE. Is this going to be true moving forward? (Since the PIHP currently has some RR obligations.) Recipient Rights are discussed in 5.4.9 (SUD Section). If there are mental health Recipient Rights will the requirements be standardized to minimize administrative and duplicative process work? If the RE does not what does "separate" mean related to section 5.4.9? Any regional ORR responsibilities, standardization process or CMH responsibilities? State laws can or change.	The separate process will continue. The law did not change. Chapter 7 has not changed. AFP is intended to make clear what the PIHP does and what the CMH does. The CMH will continue to do what Chapter 2 and Chapter 7 require. Sharing of resources for ORR can be done but Recipient Rights is still the CMHSP responsibility.
Page 51	Individuals are employees regardless of whether they receive service or not. Unless they are in	The intent is to encourage and incorporate 'persons with lived experience' in position

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5.5.3	actual peer position, they don't have to disclose so we could only report on peer positions.	descriptions, not to question individuals.
Other	Will a CMHSP be able to change regions in the future?	No.
	Does DCH expect savings year 1? With the cost of setting up new entity and transitioning across entities? May not be realistic. Functions at old PIHP will have to be maintained for at least 1 year because of reporting time periods, etc.	DCH has not determined a targeted savings year one, though the expectation is that every effort is made to maximize efficiency and effectiveness. The State disagrees that all functions at the old PIHP need to be maintained for a full year due to reporting periods.
	QAPIP timeframes. Most recent memo indicted that the current PIPs will continue through 2013. Does this imply (as it previously has) submission of these PIPs with current PIHP in January/February 2014.	Yes, the current QAPIP timeframes will continue through 2013.
	How will DCH handle reporting requirements for annual requirements on things that will be associated with the current PIHP for one quarter and a new PIHP for the remaining 3 quarters? The old PIHP will have to maintain a certain amount of infrastructure to complete these functions in old configuration for a period of	See Above.

AFP Reference	Question	Response
	time.	
	Can we assume that the final MDCH-PIHP Agreement will contain all applicable terms and conditions and avoid reference to the AFP or NOIA? The AFP and NOIA are multi-variant with not all items applicable to all PIHPs. Thus, it is highly recommended that the January 1, 2014 PIHP Agreement contain all applicable terms and conditions. If documents are included by reference, we ask that MDCH include them in the Agreement package.	Yes, MDCH will attempt to include all applicable terms and conditions in the final contract. Where this proves to be not possible or practical, and documents are included in the contract by reference, MDCH will include the documents in the Agreement package.
	Regarding Application for Renewal and Recommitment as "part of the contracts between MDCH and the new PIHPs" can MDCH acknowledge that where two PIHPs are assimilating into one PIHP the two prior ARRs are null and void as of December 31, 2013? And that a process can occur in Calendar Year 2014 to assimilate the ARR goals? It is critical that the MDCH-PIHP Agreement be crystal clear and specific on Terms & Conditions with specificity, documentation and customized attachments for each PIHP.	The ARR plans of improvement are null and void. It is the public policy elements in the ARR that will continue to be addressed in contract, as they are now.

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	Will MDCH formally disavow the terms and conditions from the 2001-2002 AFP as obsolete? Some statements have been made by MDCH that these terms and conditions apply.	The 2002 AFP has been for the most part assimilated into the MDCH/PIHP contract and/or the Balanced Budget Act requirements. The terms and conditions will not apply to future MDCH/PIHP contracts.
	Please clarify specifically which Programs and funding streams will be placed with the PIHP. We assume it will be Medicaid Specialty Supports and Services, Medicaid ABW (or Medicaid expansion), Medicaid Autism, MiChild, and substance abuse prevention and treatment. And, which service lines will be separate versus combined Agreements with the PIHP. Medicaid mild-to-moderate MH 20 visits seems unclear at this time. This is all relevant to for responding to the AFP. To date, MDCH has been silent about other Medicaid Waiver fund streams, such as the Children's SED Home and Community-based Services Waiver, Children's-Community Living Supports Waiver; Children's. Can MDCH clarify if the PA2 Liquor Tax Funds management will become part of the new RE/PIHP contract?	This AFP includes Medicaid and ABW. The 20 outpatient visits for people with mild to moderate mental illness are not included. However, in the four Regions for Duals, MDCH will demo the PIHP taking responsibility for the 20 outpatient visits. MDCH will clarify further in contracts. The Children's Waiver Programs are fee-for-service waivers through the CMHSPs.

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	In regards to the above question, can MDCH clarify if the PIHP is assuming the Medicaid Expansion Population for persons with mild-to-moderate conditions come January 1, 2014; and if it is the intent of MDCH to modify the Waiver to transfer the MH 20 OP Visit benefit from MHPs to the PIHPs, and by what date this might occur? In regards to the previous questions, will it be the intent of MDCH to have one integrated PIHP contract with all fund streams and service lines integrated, instead of separate Agreements?	
	With parity, will the MHPs have to expand beyond the 20 outpatient visits?	BHDDA is working closely with MSA to determine if and how parity requirements will impact MHPs and the delivery of the 20 outpatient visits.
Contract Related	Will MDCH contract with PIHP remain risk sharing? Will PIHP risk exposure be limited to 7.5% of annual per eligible / per month capitation payments? What is MDCH going to require for the three month period for those CMHSPs that are transferring to a PIHP region?	It is anticipated that the PIHP contract will remain a shared risk arrangement with MDCH and that the PIHP risk exposure will be limited to 7.5% of capitated payment. The remaining questions relate to winding down of existing contracts and are not germane to AFP submission.

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	How will cost settlements for that three month period be done? What will be the due date of any reports for these three months? How will existing PIHPs be involved with actuaries for those that have CMHSPs that are transferring to another PIHP region?	
MEDICAID EXPANSION	1. What is the impact of the expansion on General Fund (GF)? 2. Will the State be able to use some of this GF to pay the match for the Medicaid expansion? 3. What is the impact of expansion on the local county appropriations? 4. Will the Medicaid expansion population be assigned to a Medicaid Health Plan (MHP)? If so, doesn't that imply that the mild to moderate population will be services provided (the 20 outpatient visits) by the MHP? 5. Please clarify the 20 outpatient sessions	All questions in this section will need to be clarified at a later point as these answers are dependent on budget process. If the Expansion is supported by the legislature the GF will decrease and Medicaid increase in order to serve more individuals. It is too early to provide details at this time. The 20 outpatient visits for existing Medicaid have not been moved to the PIHP for purposes of this AFP. It is possible that the PIHPs in the four duals regions may be able to pilot the PIHP being responsible for the mild to moderate benefit, but that is yet to be determined.

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QUESTIONS

AFP Reference	Question	Response
	being provided by the MHPs and expansion populations funding that PIHPs will get. 6. Can you expand on the opportunities to move to state-wide rates because of Medicaid expansion? 7. With 20 outpatient visits staying with the MHPs, will there be more efforts to require MHPs to provide psychiatric services for those recovering from SUD and mild/moderate mental health conditions?	Due to the number of persons covered and scope of benefits and federal match, this may allow the State to move to statewide rates much more quickly with minimal hardship to those at higher than average rates. BHDDA is working closely with MSA to determine how to improve MHP delivery of the 20 outpatient visits.
MME Questions	1. Can we assume that MME Demonstration Regions need not yet consider or reply to this AFP with MME related responses? 2. Has MDCH BHADD shared the Integrated Care expectations with MDCH MSA including IS-IT and MAHP? It is important that partnerships needed to fulfill these mutual and reciprocal relationships are engaged sooner rather than later. 3. Will MDCH do a seminar on the MME	1. Yes, you can assume that. 2. We have shared the AFP with MSA but not with MAHP at this time. The AFP is available on the MDCH website. 3. Yes, a seminar will be done.

APPLICATION FOR PARTICIPATION (AFP)

QUESTIONS

AFP Reference	Question	Response
	MOU and Care Bridge details once inked with CMS?	