QUESTIONS AND ANSWERS
TO THE
APPLICATION FOR PARTICIPATION

Procurement of
Specialty
Prepaid Health Plans

PART I
January 24, 2002

This is the first in a series of answers to questions received in response to the Application for Participation issued by the Michigan Department of Community Health on January 3, 2002. Additional answers to questions received will be issued as they are available. Any corrections to this document will be included in future question and answer documents.

General Information on Application Requirements

1. How can the CMH affiliates (non-PHPs) be assured of continued CMH certification (per the Mental Health Code) if we relinquish our state general funding and critical administrative functions to the regional PHP? Would a CMH be in violation of certification provisions of the Mental Health Code if the CMH chose to relinquish its authority over state general funding and critical administrative functions to the regional PHP?

There are certain complexities within this issue, but on the whole a CMHSP can have another agency fulfill a required function on its behalf and not jeopardize its certification. This is typically done through a contract, or an Intergovernmental Transfer of Functions and Responsibilities Act (ITFRA), Intergovernmental Contracts Between Municipal Corporations Act (ICA), or Urban Cooperation Act (UCA). For example, many CMHSPs contract out parts or entire functions and have not jeopardized their certification status in doing so. It does become more complex when a certification regulation requires the CMHSP to have specific local committees or oversight groups. These are situations where the CMHSP needs to assess the regulation carefully concerning its intent, and perhaps make an inquiry to MDCH on that specific issue.

2. Is it the expectation that affiliations will likely be working with more than one Coordinating Agency or that they will try to move them all into one CA?

The expectation continues to be that a local determination will be made as to the best approach to manage and deliver public services to individuals in need or who would benefit from such services and a supported plan to attain that objective be submitted. Such local determination should minimally include dialogue among existing Coordinating Agencies, CMHSPs, and county commissioners with additional consideration for participation of individuals and providers that would be affected. There have intentionally not been constraints placed on "how" this is done, but emphasis placed on assurance that individuals in treatment, seeking treatment, or that would benefit are not adversely impacted and that any agency that might seek designation under P.A. 368 of 1978, as amended, has a sufficient readiness and understanding of non-Medicaid federal and state program requirements.

3. On page 152 (7.4.2, 7.4.2.1) of the recent AFP document sent to the CMHs, it implies that General Funds currently going to each CMH will be sent to

the PHP for those counties in affiliations. It is our understanding that the AFP relates to Medicaid funding and that MDCH will contract individually with each current CMHSP for their General Funds. Please clarify!

The reference on page 152 is the General Fund Formula sections of the expected contract requirements for FY 03. This document is attached to the Application for Participation because it reflects what we expect will apply to applicant Prepaid Health Plans. In this context, the document does not address the matter of General Fund financing except for the Prepaid Health Plan. The treatment of General Fund financing for affiliate CMHSPs will be addressed once it is clear what arrangements have been made by affiliations through their legal agreements. It is certainly possible that individual contracts for non-Medicaid financing will need to be developed, but that has not begun as of this writing.

4. **Is the PHP now responsible for provision of Basic Mental Health Services to persons with Medicaid insurance previously managed by the QHP's? The definition of SMI outlined in the proposed contract for FY 2003 defines SMI as a DSM IV diagnosis that has resulted in functional impairment that substantially interferes with or limits one or more major life activities. This is a significant change in definition from the 1998 contract definition. The 1998 contract defined SMI in terms of degree of disability, duration of illness & or prior service utilization. For example, the definition of Degree of Disability was – "substantial disability/functional impairments in three or more primary aspects of daily living such that self-sufficiency is markedly reduced". The proposed definition of SMI for FY 2003 will include all of the people currently served by the Basic Plan managed by the QHP.**

The different provider responsibilities and service priorities mentioned in the question exist because there are two distinct groups of consumers being served by CMHSPs - Medicaid eligible recipients and non-medicaid eligible recipients. For purposes of the Application for Participation, Prepaid Health Plans are responsible for the provision of mental health services to all medicaid eligible recipients. Urgency or severity of need is not a consideration. While it is correct that basic mental health outpatient counseling services are also a benefit under the comprehensive Medicaid plan from Qualified Health Plans, it is up to Prepaid Health Plans to work with Qualified Health Plans to maximize the use of existing resources and avoid duplication.

5. **In the proposed FY 2003 contract, you eliminated the Quality Improvement Director from the list of senior management staff positions that you require notice of change or vacancy (page 126 section 6.2). However, on page 141, section 6.8.1 you note that the QAPIP must have a designated senior official responsible for the implementation. Was it your intent to omit that office for your list requiring notification of change or vacancy?**

Yes.

6. It has been mentioned that MDCH is considering a funding methodology of "regional rates based on history."

A. Is this, in fact, being considered, and

B. If so, how many regions will there be and how will variations in funding levels be dealt with?

The Application for Participation and attachments identify the planned funding methodology for FY 03. There is no intent to create a new regional methodology for the system. If the question is addressing affiliations, the capitation of the CMHSPs making up the affiliation will be consolidated into one and this will be issued to the Prepaid Health Plan. The consolidation entails establishing a new intensity factor that pushes the same level of funding as the individual factors. In other words, the affiliation should receive the same Medicaid capitation dollars (within rounding limitations) as the affiliation CMHSPs would have individually.

7. Explain the scoring methodology. Are there 100 points for sections 1 - 5 and additional points for the Bonus questions, or are the Bonus question points included in the scoring for each section? If there are 100 possible points, what is the threshold the applicant needs to achieve to receive the contract award? Does the scoring deal with both percentages and points?

There are 100 points for sections 2, 3, and 4. The Bonus question points add up to 10 points and the data submissions add up to 10 points, with a grand total of 120 points. The minimum threshold for a successful application is 80.

8. Can you provide additional clarification on the weighting of individual sections and items?

The sections are weighted thus: Section 2 = 40%, Section 3 = 40%, and Section 4 = 20%. MDCH will not share the weighting for the individual items.

9. Will MDCH share a standardized review protocol prior to the site visits? How will inter-rater reliability be assured?

No protocol will be provided prior to the site visits. The focus of the visits will be to verify the statements made in the applications and to interview the consumers and advocates who assisted in the development of the application. The people who conduct the site visit will not be scoring any items. However, if they determine that the statements made in the application are incorrect they may recommend that the scores be lowered. If they see evidence that a score should be

increased they may recommend that as well.

10. What is the process for resolution of differing scores across reviewers?

There will be three people who independently score each section. If all three give the same score (e.g., 2, 2 and 2), that score (2) will be used. If two scores are the same (e.g., 1 and 1), and the third different (e.g., 2), the common score will be used (1). If all three scores are different (e.g., 0, 1, and 2), the reviewers will meet to resolve their differences in order to arrive at a common score.

11. When will the names/affiliations of the persons on the review panel be shared?

As soon as the Governor appoints the selection panel members, the names will be published. We are hoping that will take place by the middle of February.

12. There are a number of items in the AFP for which plans and dates are being requested. Several of these are contract negotiation items. Does MDCH anticipate that submission of a plan with target dates for these items eliminates the negotiation process or can the Board insert qualifying language that these items remain subject to contract negotiation? Should the applicant do the latter would this be cause for a rejection of the bid?

This question appears to be aimed at bringing the issue of negotiation into the Application for Participation process. The issue of negotiating the contract is not part of the Application for Participation. To the extent that applicants seek to modify Application for Participation conditions as part of their response, they should be sensitive to the fact that it could jeopardize their score on that item. Reviewers will not be adjusting their expectations to accommodate such conditions.

13. Are bulleted lists within the AFP mandatory elements, or are they examples of how one may satisfy the item? (Example: Bulleted list in Section 2.3.4 - Are all bullets required?)

Each bulleted item is mandatory unless otherwise noted.

14. Section 2.3.4 - Define "service area". Does this refer to population groups to be served or geographic area?

The "service area" refers to the geographic service area served by the Prepaid Health Plan.

15. Section 2.10.1 - 2.10.4 - Is a one page description required/allowed for each of the four elements or one page which addresses all four? Does Section 2.10.5 require a one

page description since it states, "evidence is available..."?

The item requires a one page description for each of the four elements.

16. Section 3.4.4 - Define "incentives" in this context.

The use of the term "incentives" in this context is intended to reflect supportive, encouraging factors or processes in contrast to negative factors and limitations. Item 3.4.4 is reflecting the expectation that the Prepaid Health Plan has created an environment that not only enables case managers and supports coordinators to act in the best interest of the individuals and families they are serving, but encourages and supports them in doing so.

17. Section 3.4.6 - If this was included as a part of a Plan of Correction to MDCH, is a plan still required with this AFP item?

Yes, if you want your score to reflect that you have a plan for correcting the situation. You must be certain that your existing plan, even though approved, does in fact achieve the level of compliance sought by the Application for Participation item if you import that plan into the Application for Participation.

18. Section 2.5.5, 3.6.10 - Define "alternative formats" in this context.

"Alternative Formats" means presenting information about services, access, appeals, and grievances in a manner that takes into consideration the ethnicity, cultural diversity, limited English proficiency, reading abilities, and sensory impairments of those who are seeking or receiving services from the Prepaid Health Plan.

19. Section 3.8.1 (last bullet) - Clarify "provider master contract(s)." What contracts are being referred to: local provider agreements or the MDCH master contract?

Reference is made to agreements between the applicant and local providers. If there are affiliates, then agreements between affiliates and their providers also need to be provided, if these agreements are different from the applicant's agreements with providers.

20. Currently, the total CMHSP shared risk exposure (7.5%) includes both the general fund and Medicaid portions of the Specialty Managed Care program. The Department has indicated that the ISF will be transferred from affiliate CMHSPs to the designated Prepaid Health Plan on October 1, 2002. Because general funds remain with each affiliate CMHSP under ICA agreements, does the Department still intend to transfer non-Medicaid ISF funds to the PHP?

The answer to this question is addressed on page 5 in item number 3 within the Internal Service

Fund paragraph. "The portion of funds eligible for transfer will depend on the scope of financial management transferred by affiliation agreement to the Prepaid Health Plan which may be limited or inclusive of general fund and corresponding local funds."

21. Please provide clarification as to whether signatures are needed on individuals and/or advocacy groups involved in the AFP process (page 12 - #2 under signatures).

The signatures of the individual persons who participated in development of the application are needed. The names of the consumer/advocate groups that were represented are also needed. The group affiliation of participating individuals should be identified; that is, give the name of the consumer/advocacy group of which each participant is a member.

22. Can you better explain the use of individuals and advocates in the review and impact of service authorizations (3.3.2, page 54)? What is meant by impacts of service authorization?

This item needs to be viewed in the context of quality improvement and utilization management. It is not involving individuals and advocates in the review of individual case authorizations. It is indicating that the Prepaid Health Plan needs to collect and review information on the operation and impacts of the various service authorization processes used, and that individuals and advocates should be a part of reviewing this information. How effective are authorization processes? How much of a delay does each process cause for individuals? How many rejections occur and what are characteristics of them? What did rejects lead to in terms of alternatives and outcomes? And so on.

23. How soon will a CMH know the specific date of the site reviews?

A schedule will be established following receipt of the applications, with notice to be provided to the applicant by the end of February.

24. Chapter III of the Medicaid bulletin and the MDCH contract covered services are both mentioned in section 3.5 on page 57. We are attempting to be able to crosswalk the MDCH contract matrix with the Medicaid Chapter III in order to adequately describe covered services within the document. It is our conclusion that the MDCH contract and Chapter III are not a perfect match. Since they do not match, which should we lead with in our response? Where do the MI covered services for Nursing Home/Mental Health monitoring map to within the MDCH contract matrix? Where do the DD covered services for personal emergency response systems – HAB map to within the MDCH contract matrix?

The services listed in the expected contract requirements are the same services identified in the current contract. The current contract list of services and the current Chapter III services are not a perfect match. CMHSPs already report the current Chapter III services using the current contract list. For example, Personal Care is reported under Community Living Support Staff, Nursing Home/Mental Health monitoring maps to Assessment and Evaluation, and Personal Emergency Response Systems maps to equipment.. For the purposes of the application, use the contract list of services.

25. Page five of the AFP indicates that "The base capitation rates and methodology will remain unchanged for fiscal year 2003." It further indicates that, "The intensity factors will changes as required." How can this be since changing intensity factors changes rates and since legislative action determines rates?

The base capitation rate is the statewide rate which is not expected to change for FY 03. This is independent of the intensity factor. The intensity factor will continue to change for CMHSPs in relation to movements into and out of State DD Centers. It will also change on October 1, 2002, for affiliations as noted in a previous answer.

26. Page 32, item 2.2.1, what is the source requirement to have the Person-Centered Planning policy and operation approved by the Department between 10/1/98 – 9/30/01?

CMHSP Site Review Protocols revised March 1999, page 18.

27. Page 43, item 2.10.5, does the bullet pertaining to outreach apply to information outreach or service outreach?

Service outreach.

28. Page 33, item 2.3.4, asks for a written plan on 6 topics (6 bullets). Is the Department looking for one plan that includes all six topics or six plans, one for each topic?

One for each topic.

29. On page 13, regarding the AFP due date, it states that hard copies must be received by 5:00 p.m., at MDCH on February 22, 2002; or, if mailed, post marked by midnight. This conflicts. Please clarify the actual due date and time for receipt.

The due date and time for receipt are as stated in the Application for Participation.

30. From our perspective, the AFP is not consistently clear on what Appendixes must be electronically attached; and what Appendixes do not have to be electronically attached, but can just accompany the hard copy. As such, can MDCH clarify, through

an Exhibit, what Appendixes it is expecting to receive, and of those which ones can be hard copy (and not electronic); and which Appendixes must be both?

The appendices required are listed in the Table of Contents. The appendices that can be attached by hard copy are listed within the items.

31. **The word "applicant" is used on many items throughout the document (e.g., 2.8.2.; 2.9.1.; 2.9.3; 2.9.4.; 2.10.1-4; etc.). In an Affiliation, the Hub CMH Board is the only applicant. It is very difficult to discern which items are being answered by the prepaid health plan alone; and which questions pertain to all parties of the Affiliation (including the Substance Abuse CA Office), where local documentation will also be expected. Therefore, please clarify which questions pertain to "all" parties (assuming this includes the CA Office too); and which questions pertain only to the "applicant" CMH which will designated the regional PHP?**

The term "applicant" always refers to the CMHSP which is applying to be responsible for the provision of all mental health and substance abuse specialty services within a defined geographic area of the state. The documentation referred to is expected to be available at the applicant's business office for its entire service area unless the applicant has made arrangements for its system-wide information to be made available at another specified location.

32. **The AFP is not very clear on where the documentation and supporting evidence needs to be located for the site review? Must all evidence, policies, exhibits be on file at the PHP (Hub CMH), including documentation from the CA Office; or will the MDCH site review team visit each spoke CMH and CA Office of an affiliation to examine evidence? Please clarify, which items must be centrally aggregated; and which items can be documented/maintained at the local level?**

Information needs to be centrally aggregated but not at the Prepaid Health Plan. MDCH will be visiting the location where delegation of centralized administrative functions exists, application information dictates, and/or MDCH determines appropriate to comprehensively conclude our task.

33. **A one week site visit seems very long to verify if documentation exists. Please clarify the purpose and scope of the site review visit; elements of the review; and how the review will be conducted.**

The length of the visit will depend on the number of affiliates in an affiliation, the size of a stand-alone applicant, and the number of items that need to be verified based on the submission of the application. The review will focus on a core set of items for every applicant, and additional items that need clarification based on an individual application. In addition, the consumers and

advocates who assisted in the development of the application will be interviewed. A team of four to five MDCH staff will conduct the review.

34. In light of the above question, is it MDCH's intent to replicate any portion of the state-certification audit reviews (e.g., case chart reviews; consumer interviews; community interviews; etc.); or will the AFP review be confined to the specific written evidence that the AFP is requiring?

MDCH is not intending to replicate the certification or annual Medicaid clinic reviews. MDCH will review any aspect of the application submission without limitations to written evidence required. There will not be chart reviews or interviews with individual recipients, only those consumers and advocates who assisted in the development of the application.

35. What documentation or evidence are you looking for in question 3.8.1, in order to receive a score of "2" points? By what review criteria will this question be evaluated?

The applicant might ask themselves, how can we demonstrate (to ourselves, to MDCH, to consumers and advocates, etc.) that we have assured our provider network covers the stated characteristics. It will likely be a combination of reports, policies, communications, certifications, and so on depending on the specified characteristic.

36. In terms of question 3.12.4, currently the PHP has: i) Coordination of Services Agreement; and ii) Sub-Contract for ASO/services with the CA Office. Will a written plan be necessary in addition to these documents, if all requirements are currently addressed?

Unless the applicant and the coordinating agency are one and the same for the entire geographic service area, a coordinated plan is required.

37. If the PHP is planning to subcontract with the CA, please clarify how section 3.12.5 applies to this arrangement.

All applicants are required to respond to this, including those that will contract with existing Coordinating Agencies, because the requirements in the Application for Participation could very easily lead to changes in these processes even if contractual relationships and regional boundaries do not change. If no material changes are anticipated in the processes listed in 3.12.5, the applicant should not mark the box and enter an explanation.

38. The AFP document encourages CMH Boards to use the ITFRA Agreement as the legal document to transfer responsibility to a Hub Board for GF funds, as a means of achieving administrative efficiency. In light of the current Mental Health Code terms, has MDCH obtained legal opinion permitting this option?

The Application for Participation document does not encourage the CMHSPs to enter into ITFRA agreements. MDCH encourages formal mergers of CMHSPs. The use of ITFRA agreements is a local decision and one that requires CMHSPs to seek their own legal advice.

39. Page 5 of the AFP permits "sub-capitation." In light of the current state plan submitted to CMS, requiring regions be not less than 20,000 covered lives, has MDCH obtained approval from CMS that this is a legal and viable option for PHPs/Affiliations?

No, and the Center for Medicare and Medicaid Services' (CMS) prior approval in the context of the Application for Participation is not required. We expect that CMS will include review of this matter as part of their reviews of our implementation and administration of the waiver, and we have incorporated necessary safeguards and assurances into our administration of the waiver. Also, please note for clarification purposes that what MDCH submitted and CMS approved last year was the 1915(b) waiver renewal request enabling the specialty managed care initiative. The MDCH State Plan is a very different document.

40. Our PHP bid award has not yet been made, therefore, our PHP, as a separate Division within our CMH for our Affiliation has not been made fully functional (fire-wall structure). Yet, as a CMH Board, we have many policies already in place, such as required by question 2.2.1. (i.e., person-centered planning via MDCH review/approval). Therefore, will it be permissible to use existing CMH Policies that the Hub Board has, and apply them to the region; or must each party still have its own separate policy in operation, as required by question 2.2.1., for example?

The applicant is responsible for the consistent and consolidated delivery of services within its geographic service area. The applicant's policies must be formally adopted by contract or affiliate board action and implemented by the administrators of each affiliate.

41. Please clarify which questions pertain to the CA Office, that they too must provide evidence to either the PHP, and/or make available to the MDCH site review team (e.g., 2.10.2.; 2.11.1; etc.)?

In general, unless stated otherwise, each item in the Application for Participation applies to mental health, developmental disabilities, and substance abuse. With regard to evidence (documentation) that must be made available to the site review team: the site review team may ask for specific evidence to show that the applicant meets the requirements for an item for all three areas (mental health, developmental disabilities, substance abuse). Evidence provided by the Coordinating Agency (CA) to the applicant would, therefore, be important during the site review phase. Further, if the applicant plans to delegate certain Prepaid Health Plan

responsibilities to the CA, then the site visit team will visit the CA to directly review evidence of compliance, as regards these responsibilities.

With respect to specific items, items 2.10.1 through 2.10.4 would all apply to substance abuse. Items 2.11.1 through 2.11.3 do not apply to substance abuse, as is noted in the last sentence in the introduction.

42. Please provide and/or clarify the review criteria and rating criteria that will be used in scoring each question?

The review criteria will not be shared. Please refer to page 17 of the Application for Participation scoring information.

43. Section 2.11 - Has MDCH determined the legality of its self-determination requirements?

The department had an obligation to provide the Centers for Medicare and Medicaid Services with a copy of our self-determination policy and choice voucher system. That obligation has been met.

44. Section 3.1.7 - Our service penetration rates for persons under 18 and for those over 65 are <u>slightly</u> below the proportion of those groups in the service area population (not an "extreme negative statistical outlier"). Are we required to write an explanation and plan for addressing? (This section implies that only those with extreme negative outliers are required to do so.)

Only those who are extreme negative outliers should provide an explanation and plan.

45. Section 3.2.1 - This requires that the applicant have received no citations in the MDCH site review process conducted during FY 01 for the 17 essential elements of person-centered planning. To the best of our knowledge, only one CMHSP met all 17 essential elements. What is the intent in including this requirement?

The intent is to find out what the current status is on meeting the 17 standards, and what the plan is for achieving compliance.

46. Is it permissible to offer alternative services in lieu of covered, not required services (e.g., day treatment)?

Yes.

47. Section 3.8.2 - This section requires the applicant to include provider payment rates for FY 03. If an applicant's rate setting procedure involves using current year costs, it will not be possible to determine FY 03 rates by 2/22/02. Please clarify.

In addition to the material required for Appendix 3.8.2, this sections calls for a response in table format. The information requested for column 1 can be provided per the instructions. For column 2, enter current year payment rates, and be sure to note this exception in your response. In column 3, indicate the method(s) that will be used to establish the new FY 2003 rates. In column 4, enter '2002' assuming that the new FY 2003 rates will all be determined in 2002.

48. Section 3.8.6 - Some of the required information in this section is included in our provider contract. The remaining information is included in our provider manual, which is an attachment to the provider contract. Our provider manual is approximately 500 pages long. How should we handle this? Our Provider Manual is available on disk. Should we submit the disk?

Appendix 3.8.1 should include excerpts from the provider manual needed to give evidence of compliance with the requirements in item 3.8.6. Be sure to make clear that you are providing excerpts, not the entire manual. The entire manual must be available for review during the site visit.

49. Would MDCH approve a sub-capitation to the local coordinating agency for Medicaid substance abuse services? If so, would that relieve the PHP from some of the direct compliance and monitoring responsibilities, and all of the risk?

No, please refer to page 5 item 2 "sub-capitation" and page 22 item 1.0 for Organizational Status and Configuration.

50. Section 3.12, Substance Abuse, states that applicants that will contract with existing CAs for the management of substance abuse do not need to complete items 3.12.2. and 3.12.3. Should qualified applicants leave these two items blank?

If the applicant is contracting with the current Coordinating Agency for management of substance abuse services, do not mark the boxes for these items, but enter an explanation.

51. We hear a lot about retaining ISFs or movement of ISFs through sub-capitation to affiliate agencies; yet we believe this creates less flexibility for the utilization of funding during application of funding/services, including year-end close out, and if the risk corridor(s) are reached. Are we correct that more flexibility exists for the lead PHP by maintaining the ISF at the PHP level?

MDCH concurs with the statement there is more flexibility by maintaining the Internal Service Fund(s) (ISF) at the Prepaid Health Plan. Where ISFs exist for multiple agencies, the Governmental Accounting Standards Board Statement 10 criteria are applicable for each CMHSP individually. These funds can not be moved indiscriminately around the Prepaid Health Plan network once individual ISFs are created. If using sub-capitation has the primary purpose of pushing funding to affiliates in an attempt to maintain a "flow-through" funding level, this prevents opportunities that would exist for effective administration of the funding.

52. Will affiliates have reinvestment strategy plans and retain funding for them?

No. Only the applicant will have the authority to retain and submit a regional reinvestment strategy.

53. 2.3.3 - What does "consistency" mean in regard to the service area? Are we expected to standardize the array of services across the PHP?

The array of services must be available to all people living in the service area of the Prepaid Health Plan, and/or the affiliation. Services must meet the standards of the contract and requirements of the Medicaid Bulletin.

54. Page 23 has a list of items to be included in legal documents. Are legal documents only the ICA, ITFRA or UCA or are other documents considered legal documents where these items may appear?

No, contracts are legal agreements which may contain or elaborate on the items listed.

55. Page 74 - 3.11.1 - Must a "plan" be developed or would policies covering a-f be sufficient.

This item reflects the expectation that the Prepaid Health Plan operates a financial management system according to a structured process authorized and reviewed by management, including the Board. It does not specify a format for such a plan. The Prepaid Health Plan should respond to this item accordingly.

56. CSSN is not in AFP - Is it the same as PSSN in the AFP?

No, the term Comprehensive Specialty Services Network is not used in the Application for Participation or contract attached to the Application for Participation. CMHSPs that are part of an affiliation are generally referred to as affiliate CMHSPs or some variation thereof. The term Provider-Sponsored Specialty Networks is defined in the glossary to the Application for Participation (page 97), and applies only to Prepaid Health Plans with total covered lives over 100,000.

57. Section 1.2, page 23 - Is it correct that this item pertains only to affiliation applicants and not stand-alone applicants? At the bidders conference, it was stated that this section was intended to apply to all applicants. Is legal review required? Does MDCH want a copy of the letter received by the applicant which certifies its status as a CMHSP?

No, because of how the Application for Participation is structured. All items need either to be checked or have an explanation entered. This includes even the non-scored items. In the case of stand-alone CMHSPs, an entry should be made in the narrative box indicating that this item is not applicable. Yes, a legal review is required by an applicant's legal counsel of their legal documents. No, the department does not need a copy of the letter which certifies status of a CMHSP.

58. The AFP requires signatures of consumers that have participated in the development of the AFP. If a consumer chooses not to disclose - but participates - how should this be reflected that would assure credit for their participation?

Provide initials, and ask the consumer to initial it. MDCH will validate during the site review when the consumers involved will be interviewed.

59. When policies are being requested and it exceeds two pages where do you put them?

Provide a summary of the policy and indicate the entire policy is available locally for review.

60. What is the relationship of the Implementation Guide to the AFP document? Has a crosswalk been developed and is it available? Will anything from the Implementation Guide be applied in the site visit, evaluation and/or scoring?

The Application for Participation (AFP) was derived directly from the Implementation Guide. A crosswalk will not be provided. However, the Readiness Checklist in the Guide corresponds quite well to the AFP. Only items in the AFP will be used for scoring and the site visit review.

61. Performance Improvement - If the applicant as a provider was assigned a specific PI study must the PHP do that one as the second study even if it does not apply to the affiliates?

The performance improvement project assigned to a CMHSP must stay with the CMHSP regardless of whether the CMHSP becomes a Prepaid Health Plan or an affiliate. The affiliation could voluntarily adopt the project.

62. In Section 1.0, page 22, of the AFP, certain items will not apply to stand-alones. Instructions state that all items not marked with an X must have an explanation.

Please confirm that leaving those boxes blank with "N/A, _____CMH is a stand-alone PHP" is the appropriate way to answer without losing points.

Yes, that is appropriate. Keep in mind there are no points attributable to Section 1.0.

63. Will site reviewers let the PHP know, for the PHP to clarify, if site reviewer thinks something is missing that the PHP thinks it has leading to checked box?

Yes, the site reviewers will discuss their preliminary findings with the Prepaid Health Plan on site, thus enabling the Prepaid Health Plan to provide additional evidence at that time.

64. While an affiliation agreement can be signed prior to submission of the AFP, the Medicaid sub-contract between the hub and the spokes cannot be signed prior to awarding the contract with the hub. Is the affiliation agreement sufficient for the AFP?

Yes.

65. If the PHP, in an affiliation, is not assuming the general funds of its affiliates, how is MDCH to be notified of this plan and the fact that each affiliate will need to have a contract with MDCH for GF funds?

If MDCH has questions on this issue after reviewing the legal agreement that establishes the affiliation, the CMHSPs will be contacted for clarification.

66. Will individual counties continue to receive state GF dollars through a contract with MDCH separate from the PHP agreement?

At this time, MDCH expects Prepaid Health Plan contracts will include Medicaid and general fund Formula funds much the way current contracts do. If affiliate CMHSPs have not transferred responsibility for general fund formula funds to the Prepaid Health Plan through the affiliation legal agreement, MDCH will design a contract with the affiliate CMHSP regarding the general fund formula financing.

67. What about redirect dollars as addressed on page 6 of the AFP? If counties maintain their GF dollars separate from the PHP agreement, will they lose the ability to redirect state dollars that are part of the Medicaid capitation rate?

Yes. The only way an affiliate CMHSP can benefit from the general fund redirect provision that will remain available to the Prepaid Health Plan is through transferring the responsibility for general fund formula funds to the Prepaid Health Plan as part of the legal agreement.

68. Page 57 (Service Array) states that all mental health and developmental disability coverable, alternative, and allowable services must be available (3.5.2). Does this imply that alternative (and allowable) services become "de facto" state plan services (an entitlement under Medicaid) subject to Fair Hearing and disputes on amount, scope, duration?

No, it is not our intent that the alternative and allowable services will become state plan services.

69. What are the scores for (1) fully approved and (2) provisional approval on the AFP review?

The minimum threshold is 80. Applicants with scores from 80 to 120 may require plans of correction, or corrective action to be implemented, before a contract is signed.

70. What is the rational financial agreement that supports use of one-time Medicaid savings to fund new programs?

CMHSPs have demonstrated excellent and creative uses of earned Medicaid savings. Many of these are one-time expenditures that enrich or extend a service opportunity on a time-limited basis, such as respite care, psycho-education opportunities, and prevention services. CMHSPs have also recognized that the Medicaid savings reflected an excess of revenue, and opted to initiate needed on-going service expansion, recognizing that doing so would theoretically reduce expected savings the following year. In other words, it shifted a savings expenditure to an operating budget expenditure over subsequent years. All of these are appropriate uses of Medicaid savings. What is not in keeping with the intent of the Medicaid savings provision is managing for savings as part of financial risk protection. Other vehicles are available for that purpose, including reinsurance and creation of an Internal Service Fund.

71. MDCH has stated that capitation rates will remain the same. However, the CMS waiver approval letter requires MDCH, prior to implementation of a new contract, to engage in a public process regarding the adequacy of the capitation rates and to get CMS approval of the rates prior to implementation. How does MDCH plan to address this condition?

MDCH will comply with the terms of the federal Waiver.

72. 3.1.7 on page 50 - Are there two standards to respond to (i.e., "representative penetration rate" and "statistical outlier") or are they both part of the same standard?

If the penetration rates for both populations are equal to or greater than their representation, you may check the box. Otherwise, provide explanations and plans as indicated in the item, as applicable, to your situation.

73. Can a PHP spend some of their capitation funds on services other than the specific covered, alternative, and allowable services listed or must they wait until the next year and then pay for these with their five percent savings?

The answer is the Prepaid Health Plan must wait until the next year. This matter is described in some detail in the Version 2.0 Plan Requirements and Technical Information published November 1, 1998 (see page 60).

74. Is it correct to say if sub-capitation occurs between the PHP and affiliates that ISF funds do not need to be transferred to the PHP by 3/30/03 as stated in the document?

No, that is not correct. MDCH will address this issue with successful applicants. This is an area that is extremely complicated and will depend on individual applicant's affiliation agreements, contracts, and how the Prepaid Health Plan approaches service, risk, and management practices.

75. 3.8.2, page 64 - Is this to be developed for all services provided by the affiliate either directly or through contract? Is it allowable to present the methodology used or must the applicant incur the high expense of having an actuary sign off on the table numbers?

The format must include all services provided by the applicant and affiliates whether directly or through contract. There is no requirement for actuary or third-party validation.

76. MDCH sent one original CD to each CMHSP. Two CDs are required with the AFP submission. Does MDCH want the original CD returned plus one copy made by the CMH or two copies?

MDCH does not want the original CD returned. Make two electronic copies on CDs of the completed application.

77. Will annual site visits (e.g., children's diagnostic, Medicaid, RR) be going on during February - April when AFP site visits and preparation are going on?

The site reviews (for Children's Diagnostic and Medicaid) for the month of March will be suspended. Only one Office of Recipient Rights visit is planned for March. It will not be canceled, but we will try to schedule the Application for Participation visit on another week.

78. Meeting HIPAA mandates by 7/1/02 as proposed by the state rather than the later date established by federal guidelines - is this negotiable due to our heavy workloads in preparing for the AFP transition?

MDCH will not pursue a waiver for delaying implementation of HIPAA because so much work has been done already to prepare for it. Third party payers will be implementing 10/02, so it is in the best interests of CMHSPs that want to be paid to be ready for HIPAA then.

79. MDCH staff stated that MDCH will not be visiting provider site and that MDCH wants the documentation located at the affiliate where responsibility has been delegated (i.e., access). Need help in reconciling: we have delegated functions to core contract-provider agencies.

If functions have been delegated to an affiliate or a provider, we will visit where the function is located.

80. 3.1.6 , page 50 - What specifically is MDCH's definition for what constitutes a site visit citation? Is it a written formal letter or a "no" on the site visit report?

A site visit citation is a "no" on a site visit report.

81. General Fund Redirect - Does the department have a formal legal opinion with regard to this issue and will one be made available?

There is no basis for seeking such an opinion. Federal dollars can be matched with either state or local funds. It is the use of local funds as match for federal dollars that enables the redirect of state general funds under the MDCH/CMHSP contract.

82. Should an annual site visit be scheduled for a CMHSP in February, will the department consider scheduling the AFP site visit in April?

No, only the site visits planned for March will be suspended.

83. If for some unknown reason the electronic version is not readable but is received on time along with hard copies, will it be considered as being in submission compliance? Can the electronic version be delivered early and tested by MDCH and certified as being readable?

The reason for sending two copies of the CD is to assure that at least one of them is readable. In the unlikely situation that both would be unreadable, as long as the hard copy was received on time, it would be accepted. A CD can be delivered early and tested for readability.

84. If a PHP intends to contract with a single CA in a region with multiple CAs, has MDCH completed the allocation formula for movement of funding effective with the new PHP 10/02 contract? If not, when and where will this be available?

No, we have not completed a formula and will not until regional affiliations are better known. Additionally, there are a variety of other factors, including budget impact, that will not be known until later this fiscal year. The formula will be addressed at an appropriate time later this fiscal year.

85. What if the applicant is handling the PHP function/standard in February but expects plans to handle differently by October 1. How do you want the applicant to respond?

Indicate how the Prepaid Health Plan is currently handling the function/standard and how it will change in October.

86. How does the AFP facilitate/encourage the continued integration of substance abuse and mental health services?

The Application for Participation is permissive to allow for a variety of ways to integrate; it's not specific to any one focus. MDCH's general direction is for as much alignment as possible for consolidation of mental health and substance abuse services. MDCH welcomes redesignation of regions but it is not a unilateral determination by the state; it requires local planning and work.

87. Is Person-Centered Planning required for providers of substance abuse services? Page 32 paragraph 1 says, " Person-Centered Planning is not a current legislative requirement for individuals with a substance use disorders." However, paragraph 2 says "Person-Centered Planning is required for persons with mental illness developmental disabilities , and substance use disorders and for children with serious mental illness."

Person-centered planning is not a requirement for providers of substance abuse services. However, the members of the consumer and advocate group that provided advice and guidance to the AFP noted that person-centered planning is important to individuals being served by substance abuse providers as well as individuals receiving services in the public mental health system.

88. Section 3.1 - Define "responsive presence" as related to outreach.

Examples of responsive presence include outreach to community organizations and locations where individuals who may likely require services have some connection such as homeless

shelters, community sites tailored to meet the needs of ethnic groups, senior centers, schools and other community locations.

89. What is the rationale for 50 percent primary consumer representation given that many of these are DD consumers with communication difficulties?

Consumer choice, voice, and participation are basic values of the public mental health system. A minimum of 50 percent participation assures stronger consumer voice. The public mental health system has demonstrated exemplary models for inclusion of individuals with a variety of disabilities. Knowledge and demonstrated experience in assisting consumer involvement as described in the question above is a basic expectation of the specialty service system.

90. Do the bullets on page 53 represent the PCP external facilitation guidelines promised by MDCH? Plans have not been developed since these guidelines have not been issued.

The bullets on page 53 represent the departments first steps in issuing final guidelines.

91. Section 3.5.6 - Define "process in place" in this context.

Applicants should have a process in place to foster development of consumer-run initiatives that is tailored to the needs of the service area. For example, applicants may identify individual(s) who are in the lead to support the development of consumer run initiatives; provide funding to programs; provide support to develop leadership skills of consumers through training and ongoing technical assistance; and work with consumers to identify other strategies that will foster growth of these initiatives.

92. Page 33, item 2.3.1, asks for a description of community placement needs of persons in the service area currently residing in state mental health hospitals and DD centers. The previous draft only asked for this information for individuals that did not meet the criteria for the state mental health hospital. Does MDCH want to see this description for every individual in the state hospital, or only those individuals ready for discharge and no longer meeting criteria for the services?

The plan should include all individuals in state facilities except those who are under Incompetent to Stand Trial status.

93. Section 3.4.5 - The first bullet point requires the applicant to identify and routinely update resources available in the community including formal and informal supports. Please clarify what is meant by "informal supports."

Informal supports are those supports that may be provided by friends, family members, religious organizations, community organizations, and any other entity that supports the goals identified in the person-centered plan.

94. Does 2.3.1 include state institution residents who are I.S.T status or N.G.R.I?

Individuals under a probate court Not Guilty by Reason of Insanity are included. Individuals under Incompetent to Stand Trial are not included.

95. There does not seem to be much in the AFP for consumer-run services. Can you please comment on this lack?

Consumer-run services are a focus of the Application for Participation and should be reflected in all of the appropriate items in the Application for Participation including but not limited to items 2.3.4, 3.1.1, 3.1.10, 3.2.2, 3.4.2, 2.4, and 3.5.

96. No emphasis was put on the coordination with QHPs. What is the expectation?

The Application for Participation emphasizes coordination with Qualified Health Plans. See section 2.9.

97. Does the requirement that all covered and alternative services be available in the area mean that "day programs" are available? Does "in the area" mean physically located in the area or "available to all consumers who need them"?

Yes. Day programs must be available to all consumers who need them.

98. Has the standard of two CSSNs for each service population for stand-alones with 100,000 covered lives (as reflected in the Implementation Guide) changed to only require two CSSNs in the entire service area?

No, this requirement has not changed. This will be addressed in a letter clarifying and correcting specific Application for Participation items.

99. Item 2.9.3 on page 40 - Please define "formal" linkages.

Formal linkages include written agreements, identification of key contact staff, and routine mechanisms for coordination.