**QA Document**
**RFI – 180000000003**
**298 Pilot(s) – Medicaid Physical-Behavioral Health Full Financial Integration**

# STATE OF MICHIGAN

Department of Health and Human Services

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| 1. | RFI Instructions - Section 5 (page 2): Requiring the support of at least 50% of the MHPs in the pilot community is impractical given the timeframe for the RFI response and the time consuming and complex nature of the discussions/negotiations that would be required, with a large number of MHPs, within the applicant pilot community, all with diverse interests and modes of operations. This Association recommends that the RFI response contain the written support of one MHP with the involvement of the other MHPs in the community to be developed once the pilot community is selected. | In November, the Michigan Department of Health and Human Services (MDHHS) issued a document entitled Expectations and Parameters for Section 298 Pilots. This document was the product of several meetings with MHPs, CMHSPs, and other providers and was intended to serve as a guide for such discussions. It is recognized that final determination of processes and structures will occur after the identification of pilot sites. However, it is essential that at least 50% of MHPs within the pilot region have been involved in the development of the application. This Memorandum of Support is NOT a binding agreement on the part of the MHP.<br><br>For access to the referenced document, please visit www.michigan.gov/stakeholder298. |
| 2. | Response Preparation (pages 7 – 15): Throughout the main body of the RFI, responses are expected from the applicant CMH that would need to be developed jointly by the CMH and the MHPs in the community. Given this, the recommendation is that the applicant should be instructed to provide responses to the following questions that reflect the proposed approach by the applicant CMH and its identified MHP partner, with the recognition that the complete answer to these questions will come as the full set of CMH-MHP relations are developed: 4, 6, 7, 8, and 9. | It is recognized that final determination of processes and structures will occur after the identification of pilot sites. The RFI is seeking the CMHSPs current plans and considerations based on discussions with the MHPs in its geographic region. It is understood that these answers are not final commitments. |

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| 3. | Response Preparation – question 8 (page 10): The movement of the management of the behavioral healthcare benefit for persons not enrolled in a Medicaid Health Plan, from the PIHP, where they have their care managed, to a Managed Behavioral Health Organization (MBHO) or an Administrative Service Organization (ASO) unnecessarily disrupts the care for these persons, inflicts considerable and unnecessary fiscal harm to the PIHP serving the pilot community, does nothing to better integrate care, and adds another extraneous variable to the pilot.<br>The recommendation is to revise this section of the RFI with the following additions, which are underlined, and the deletions, which are struck out:<br><br>"Approximately forty-percent of the behavioral health expenditures are directed to individuals who are not enrolled in a Medicaid Health Plan. This specific population includes a higher percentage of individuals with significant behavioral health needs receiving multiple services. It is MDHHS' intent to continue to contract with the Prepaid Inpatient Health Plan (PIHP) that currently manages the behavioral health care benefit for this population. a Managed Behavioral Health Organization (MBHO), or an Administrative Service Organization (ASO). The contracted entity will serve as an extension of the state to provide payment, encounter reporting, monitoring and oversight, and as necessary other managed behavioral health care functions. Pilot(s) will receive payment from and be required to report claims and encounter data to the contracted MBHO/ASO. | It is the intent of the MDHHS that the payment for individuals within a pilot region, but not enrolled in an MHP, will go to a contracted ASO or MBHO. The contracted entity will act on behalf of the state to ensure services are delivered in an appropriate manner. |
| 4. | Response Preparation – question 10 (page 15): All of the segments of this question, relative to the pilot project evaluation, should be not be answered by the applicant CMH nor its MHP partner. Rather, the RFI should indicate that these evaluation-related questions will be developed jointly by University of Michigan's Institute for Healthcare Policy and Innovation, MDHHS, and the pilot community CMHs, MHPs, PIHPs, and stakeholder groups. | Section 10: Pilot Project Evaluation of the RFI is intended to solicit the applicant CMHSPs input regarding the evaluation process, necessary data collection and reporting, and savings identification. This information will be used when working with the selected sites to develop the evaluation process. |

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| 5. | P. 10, Item 8, enrolling non-MHP MA beneficiaries in an ASO or MBHO: This goes beyond the requirements in the Legislature's 298 language and has the potential to disrupt continuity of care. At minimum, these beneficiaries should be given a choice of whether they want to continue with CMH management or move to the ASO/MBHO. The second paragraph on p. 5 says the document is "informed by values defined by the 298 Facilitation Workgroup and input solicited from current system respondents." That statement is incorrect if the non-MHP MA beneficiaries aren't at least given their choice of service manager. (It is further hoped and suggested that MHP enrollees in the pilot areas be given a choice of behavioral manager. It would be unfortunate if they are forced into something they don't want.) During last fall's statewide affinity groups, most consumers and family members said they would prefer to stick with the manager they know, and if there are other possibilities, they want to make the choice among the various options. It should further be noted that monitoring & enforcement of service to non-MHP beneficiaries in a small number of pilots/demonstrations is a perfectly reasonable and expected role for MDHHS. Money that would otherwise go to the ASO/MBHO could support additional department staff for such work. | Under the current specialty behavioral health waiver, Medicaid recipients do not have a choice in the CMHSP or the PIHP in which they are enrolled: Medicaid recipients are currently afforded choice at the provider level. MDHHS is early in its decision on managing the specialty behavioral health benefit for persons not enrolled in a health plan, but the department is expecting the level of choice to remain consistent with current practice. The local CMHSP is expected to retain a similar role under any newly defined approach to managing this eligible population. |
| 6. | Coordinating dispute resolution mechanisms between MHPs and CMHSPs: These two entities do not have the entirely same set of mechanisms for consumer & family complaints. The last thing needed is for consumers and families to be confused about more dispute resolution bureaucracy. The RFI should ask applicants how MHPs and CMHSPs will coordinate their various mechanisms to best match up with particular complaints received. | Pilot participants, which includes both the CMHSPs and the MHPs, are required to comply with applicable statutes and regulations relating to dispute resolution mechanisms. These requirements include the Recipient Rights provisions of the Mental Health Code and subsequent administrative rules. CMHSPs are required to operate rights systems to protect the rights of all service recipients. Medicaid Health Plans and Prepaid Inpatient Health Plans are required to comply with the grievance and appeal provisions of the federal managed care rules. While these are two distinct sets of requirements, they are applied in the same way to the pilot sites and non-pilot sites. Additionally, through customer service requirements that apply to the MHPs and CMHSPs, individuals are informed of their rights and how to access assistance. It is the expectation that the CMHSPs and MHPs in the pilot sites will collaborate to provide uniform information on dispute resolution mechanisms. |

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| 7. | P. 13, SUD: It makes no sense to give MA SUD money to the MHPs and then have them turn it over to the CMHSPs. As with non-MA SUD funds, the MA SUD appropriations should go straight to the CMHSPs. Why is a middleman needed, and what guidelines will the middlemen operate under? Can they take some money off the top? Will they decide what amount to give the CMHSPs, or will that be fixed by the State? | The Mental Health Code requires that publicly funded SUD services be managed by a department designated community mental health entity. In the pilot sites, the CMHSP will serve this function. Medicaid funding in a managed care structure must be paid through a managed care entity as defined in the federal managed care regulations. The Section 298 boilerplate language requires that MDHHS shall execute a single contract with the MHPs to manage all Medicaid funding for physical health and behavioral health services. For these reasons, the Medicaid SUD funding will go to the MHP. |
| 8. | "Cost savings": This phrase comes up at least a couple of times, with applicants asked to operationalize how they'll calculate and deal with reinvestment of savings. Applicants should be informed that this area will be defined and operationalized by the State, and that administrative expenses deemed excessive by DHHS or the U-M evaluators will be moved into the "savings" column for service reinvestment. | MDHHS and the project evaluator will develop the method for identifying savings and establish parameters for the use of any identified savings. This process will be informed by information provided in the RFI responses. The pilot participants will have an opportunity to further define how the savings will be used within the established parameters. |
| 9. | Attachment B (p. 17), last paragraph: This reads as if the mild-to-moderate MH benefit through MHPs will continue indefinitely. Given the questionable performance of MHPs in this area (and the interest of many 298 Workgroup members in having the benefit reside elsewhere), I respectfully suggest that this paragraph recognize what the current situation is, while also committing the department to an examination/analysis of how to best structure it in the future. | Attachment B - Description of the Current Financing System for Behavioral Health Services provides a description of the current system and is not intended to describe any future state. Pilot participants may determine how services to persons with mild or moderate mental health needs are delivered. |
| 10. | The pilot RFI should refer more directly to core 298 values. For example: Utilization management must be driven by a person's self-determined needs, which differ from the needs of others and change over time, rather than a set menu of services driven by a "hoarding" mentality and traditional measures of medical necessity. | Paragraph (3) (C) of Section 298 of Public Act 107 of 2017 reads: in part: "That the project is consistent with the stated core values as identified in the final report of [the Section 298 workgroup]." It is expected that the applicants will propose pilots which are consistent with those values. |
| 11. | The pilot RFI should refer more directly to core 298 values. For example: Integration of care must include integration of classic medical services and non-traditional Medicaid supports such as supported employment, self-advocacy, and transitional housing assistance. | Merged with question 10, above. |
| 12. | The pilot RFI should refer more directly to core 298 values. For example: Reinvestment of savings and elimination of administrative layers must be adjudged consistently using criteria developed by MDHHS. | Merged with question 10, above |
| 13. | The pilot RFI should refer more directly to core 298 values. For example: Case management, dispute resolution and accountability must be conflict-free and independent, operating at the state level but independent of the state itself. | Merged with question 10, above |

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| 14. | The pilot RFI should refer more directly to core 298 values. For example: Evaluation must look at much broader quality of life outcomes such as integrated employment, community inclusion, and other measures, and must reference federal requirements such as home- and community-based services standards. | Merged with question 10, above |
| 15. | The abbreviated duration of the pilot period is a barrier to Medicaid Health Plans implementing the required process and systems changes to support BH services in compliance with current legal, contractual and policy requirements, compelling the CMHSPs to continue providing many functions in a delegated arrangement. This was not specifically addressed in MDHHS' Barriers document. Can MDHHS provide any additional guidance to potential pilot regions regarding how to reconcile these conflicts? | The Section 298 boilerplate stipulated that the pilots shall be designed to last at least 2 years. MDHHS recognizes that a longer duration for the pilots is preferred in order to fully operationalize and effectively evaluate the pilots. MDHHS is planning to provide technical assistance and support through the duration of the pilots to help address challenges and barriers that may arise. |
| 16. | The existing Medicaid Health Plan (MHP) accreditation requirements (NCQA) are based on national standards, some of which conflict with required policy initiatives that the Community Mental Health Service Programs (CMHSP) are responsible to carry out to maintain administrative efficiency (e.g. Reciprocity Policy). This will challenge the attainment of administrative efficiencies which are one of MDHHS' stated reasons for integrated funding. Can MDHHS provide any additional guidance to potential pilot regions regarding how to reconcile these conflicts? | Reciprocity does not, necessarily conflict with NCQA. More specific concerns will be addressed with selected sites. |

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| 17. | Several managed care functions are currently carried out by CMHSPs under complex and specific requirements inured in the Michigan Mental Health Code and/or delegations from Prepaid Inpatient Health Plans as compelled by the Medicaid Specialty Supports and Services Contract. MHPs have indicated to RFI applicants that their accreditation requirements do not support delegations to non-accredited entities and/or would require extensive costs to centralize or provide review, oversight and monitoring of CMHSP processes to allow for them to be carried out locally. These include:<br><br>a. Provider Network<br>b. Credentialing<br>c. Access & Eligibility<br>d. Utilization Management and Review<br>• *MHPs noted that they have only delegated UM to large, NCQA-accredited organizations such as hospital systems, and would not consider doing this with a provider that did not have a large MHP beneficiary base*<br>• *Managing both the philosophy and policy of person centered planning required in Michigan and the standardization required under health plan systems create inherent complications for implementation of a cohesive utilization management process for the pilot.*<br>e. Customer Service<br>f. Quality<br>g. IT Systems to include complex claims rules and unique reporting that do not exist in MHP systems (e.g. MMBPIS, MUNC, SECR, BH TEDS, individual service rates, bundled services, etc.)<br><br>Can MDHHS provide any additional guidance to potential pilot regions regarding how to reconcile these conflicts? | Delegation of managed care functions are addressed in the federal managed care rules. NCQA accreditation, consistent with federal regulations, requires that there be a written delegation agreement. It is not required that the entity to which a function is delegated also be accredited. NCQA requirements for delegation are included in each appropriate chapter. Federal regulations, specifically 42 CFR Part 438.230, still apply. |
| 18. | ISSUE: As competitive entities, MHPs are prohibited by Anti-Trust regulations from collaborating on rate-setting opportunities. This would impede cost efficiencies that PIHPs/CMHSPs have in negotiation rates with large providers for behavioral health services (e.g. Inpatient, etc.). Would the MHPs be allowed to maintain these current efficiencies in a pilot model while being compliant with these regulations? Would the State consider establishing a rate schedule for some behavioral health services for the pilot? | Anti-Trust regulations may prohibit multiple MHPs from negotiating a single rate with a hospital. These regulations would not prohibit a CMHSP from negotiating a rate. Currently, negotiation of rates between PIHPs or CMHSPs and providers, vary across the state. If the MHP delegates this network management function to the CMHSP, there is no change. The state does not intend to develop a rate schedule. |

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| 19. | CMHSP RFI applicants have been working with their PIHPS and others across the state to develop common oversight and monitoring functions for inpatient services/contracts and have agreed to "reciprocity" agreement strategies to recognize the results from these oversight activities vs needed to have all CMHSPs conduct their own reviews. MHPS have indicated that they do not delegate this oversight responsibility nor do they recognize such oversight by other organizations not NCQA accredited. What guidance will the State offer in this regard? | Federal regulations allow for the delegation of managed care functions. The NCQA does not specifically require that the entity to which a function is delegated be accredited. The regulations do require that functions be completed in a manner consistent with the accreditation standards. Specific requirements are included in the NCQA Standards. |
| 20. | What type of technical assistance will be provided by MDHHS to clarify and define what is meant by "Savings" that would be returned to the CMHSPs? By what time will MDHHS provide such technical assistance to inform potential pilot partners of the risk that would be assumed? Should 298 pilot expenses include calculations of MHP and CMHSP opportunity or setup costs? | Technical assistance regarding the definition and use of savings will be provided (1) when MDHHS has determined the parameters and (2) after pilot participants have been identified. It is not assumed that any CMHSP will bear risk, and any proposed risk sharing will require review and approval by MDHHS. This issue will be addressed during contract finalization. No additional funds have been appropriated for "startup" costs. It is anticipated that administrative expenses are covered through Medicaid capitation payments. |
| 21. | For CMHSP development costs to implement a CCBHC Plus clinical model, MHPs would be willing to consider an initial investment based on potential savings gained as part of a shared-risk arrangement with the CMHSP. Would this be allowed? | Pilot participants will define the appropriate clinical model. Identified savings are to be re-invested in services. Question 8, above, addresses the Department's plans for defining savings. |
| 22. | What will the PMPM be for the shared MHP/CMHSP population? If combined, how will 298 Pilot Model Participants know the amount of the PMPM that comprises the BH benefit? If unknown, when will this be determined? | MDHHS will work with its contractor for actuarial services to develop actuarially sound rates for the pilot sites. It is expected that the behavioral health payment will be a defined payment separate from the current physical health payment and therefore easily identified as such. It is not known when rates will be finalized. |
| 23. | For the non-enrolled Medicaid population, would the ASO/MBHO be responsible for *all* costs of the served beneficiary (e.g. physical healthcare, care coordination, behavioral health, etc.)? | MDHHS is in early stages of assessing and defining how the non-enrolled Medicaid population will be managed for the pilot geographic regions. Any MBHO/ASO RFP is expected to define benefit management for specialty behavioral health services. The financing and payment methods will be established through a separate RFP and contract negotiation process, in accordance with applicable regulatory requirements and managed care rules. |

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| 24. | MDHHS estimates of 20% population/44% cost for non-enrolled Medicaid recipients seems to be low based on current CareConnect 360 data sources. CMHSP's estimates are between 40-60% of their served populations are not covered by an MHP. This would significantly impact the opportunity for an MHP to improve care and financial integration for a larger percentage of the population. The RFI indicates this population will be managed by an ASO/MBHO. Would the State consider:<br>a. Allowing for an auto-enrollment for current non-enrolled Medicaid beneficiaries to the existing MHPS in the pilot region with an ability to opt out or change MHPs, pending analysis of Medicaid eligible individuals not enrolled in Managed Care.<br>b. For those beneficiaries that would be auto-enrolled, would a rate adjustment based on an actuarial analysis be conducted on the costs of the non-enrolled population to consider alternative PMPM rates for these high-need/-cost individuals? | It is beyond the scope of the pilots, as specified in legislation, to change the managed care enrollment populations. It is not intended that these individuals will be auto-enrolled in an existing Medicaid Health Plan. |
| 25. | Does MDHHS expect the MHPs to concur on a single Performance Improvement Project? | Current MHP contracts include the PIP requirements for the current year. Any future PIP requirements involving the pilot sites will be determined at a future date with input from all pilot participants. |
| 26. | When and how will the State provide for or provide resources to fund technical assistance for:<br>a. Defining how savings will be consistently defined, calculated, and proscribe how it will be returned to the public behavioral healthcare system (CMHSPs)<br>b. Define any rules or guidance on CMHSP risk or incentives<br>c. Defining actuarially-sound rates<br>d. Supporting changes in process and IT systems to meet the intentions of the 298 Pilot in achieving integration of fiduciary and care responsibilities for CMHSPs, ASO and MHPs<br>e. Rate-setting for care coordination and care management functions that are new to CMHSPs, including identification of corresponding billing/reporting (HCPCS) codes | MDHHS has requested pilot applicants to identify training and technical assistance needs. MDHHS expects to provide training and technical assistance post pilot site selection, during start-up, and throughout the duration of the pilots (including IT system changes and implementation of any new billing codes); MDHHS has requested pilot applicants to propose a method to calculate and reinvest savings. MDHHS will work with selected pilot sites to assure adoption of a uniform methodology. Guidance for CMHSP risk and incentives should be defined in MHP-CMHSP contracts. Actuarially sound rates, based on appropriate methodologies, will be determined once pilot sites are identified. |
| 27. | How will the State ensure financial solvency issues are resolved prior to MHPs entering into pilots with willing CMHSPs? | Any financial settlements between CMHSPs and current PIHPs should be resolved based upon current MDHHS-PIHP and PIHP-CMHSP contracts. |

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| 28. | How does MDHHS (and by extension, the legislature) expect to gain efficiencies by going from one oversight/monitoring entity (PIHP) to 5-to-7 entities (MHPs and ASO/MBHO)? | The Request for Information for the pilot requires applicants to describe their approach to achieving administrative efficiency across the region. Approaches may include:<br><br>• Consistent utilization management practices;<br>• Reciprocity and coordination in network management and related functions (including credentialing);<br>• Streamlined and uniform reporting; and<br>• Coordinated quality management activities.<br><br>MDHHS is also working internally to integrate and simplify reporting requirements. |
| 29. | Will pilot CMHSPs receive EDI eligibility and payment files (834, 820, 207, and 271) from MDHHS? | It is expected that the CMHSPs in the pilot sites will receive eligibility and payment files from each Medicaid Health Plan in the geographic area. For the fee for service population, it is expected that this will be provided by the ASO/MBHO. The department will assist and provide technical assistance to the MHPs and the CMHSPs within the pilot sites on ensuring appropriate transmission of eligibility and payment files. |
| 30. | Will such files be provided discreetly by MHPs and the MBHO/ASO for unenrolled beneficiaries? CMHSP pilots will need such file access by plans to inform and check them at least initially to determine MHP and MBHO/ASO downstream payments to CMHSP were made correctly. | See answer to question 29 above. |
| 31. | What thought if any has been given to the orientation / decision about the size of enrollee populations by MHP and MBHO/ASO with regard to quality reporting calculation denominator? For example, will the CMHSP report to each plan separately MMBPIS indicators with the denominator being unique to MHP and the MBHO/ ASO enrollment which for some MHPs could be quite small numbers, or will or could pilots report a composite Medicaid (MHPs & ASO) number? | MDHHS has initiated efforts to define reporting requirements for the pilot sites. Issues such as population size and reporting through multiple payers are being addressed. It is intended that selected pilot sites will participate in finalizing the requirements. |

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| 32. | **RFI Question 8: Scope of the New MBHO/ASO**<br>In the second paragraph of the question 8 introduction, there is discussion of an MBHO or ASO serving as an "*extension of the state to provide payment, encounter reporting, monitoring and oversight and as necessary other managed behavioral healthcare functions. Pilot(s) will receive payment from and be required to report claims and encounter data to the contracted MBHO / ASO.*"<br>a. Is this text suggesting that the CMHSP Pilots must move to claims submissions for service payment for unenrolled beneficiaries? Is the "report claims" reference intended to convey post service reimbursement for the specialty BH carve out benefit and a return to fee-for-service billing for this subpopulation, or is this reference we hope, just a way for MDHHS to indicate funding for the unenrolled will be through the MBHO/ASO as will the reporting of encounters quality data monitoring oversight and so on?<br>b. Regarding this same introduction paragraph in question 8, concerning the full scope and responsibilities, please clarify if the new MBHO/ASO will be taking on the FFS claims payment responsibility from MDHHS for payment to physical health care providers and hospitals or just the funding to the CMHSP Pilots for behavioral health both for the carve out specialty population and mild moderate benefit?<br>c. Will MDHHS allow the MBHO/ ASO to work on value based payments for integration activities with the CMHSP Pilots? In other words, is the approach to pilot design with regard to payment model innovation also being promoted for the MBHO/ASO and their unenrolled populations?<br>d. Is MDHHS open to the MBHO or ASO taking on more responsibility from MHPs if they so desire with an eye on efficiency, especially for those plans with small market share enrollment of beneficiaries in the county and of cases served by the pilot CMHSP? | MDHHS is in early stages of assessing and defining how the non-enrolled Medicaid population will be managed for the pilot geographic regions. Financing and payment models will be defined through a future RFP for the ASO/MBHO and contract negotiation process (inclusive of proposed value-based payment models). The payment relationship between an ASO/MBHO and a CMHSP will be defined by their contract inclusive of payment and reporting obligations. The referenced ASO/MBHO is expected to cover the specialty behavioral health benefit for the unenrolled population in the selected pilot regions. MDHHS is open to innovation that increases efficiency while minimally maintaining or improving specialty behavioral health service access and quality. |

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| 33. | **Managed Care Functions and Delegations to CMHSP Pilots:**<br>In dialogue with the MHPs there seems to be an obstacle to their delegation of any aspect of managed care functions to CMHSPs unless they are NCQA accredited and CMHSPs are not NCQA accredited.<br>a. Is MDHHS willing to waive the requirement of the MHPs to be NCAQ accredited as it pertains to the behavioral health carve out portion of pilot responsibilities? There are barriers to the MHPS delegating managed care functions to the CMHSPS because they are not NCQA Accredited. This is problematic to reconcile with regard to a number of MDHHS policy requirements and efficiency goals for the pilot.<br>b. Will the CMHSP be subject to HSAG Oversight and Monitoring or will this be done at the MHP, MBH/ASO level? Or, was this oversight only necessary as the PIHP system is sole sourced?<br>c. Once the new 1115 Waiver is approved, will the MHPs and MBHO/ASO be subject to the same regulatory requirements of PIHPs or will there be some regulatory relief as the MHPS in particular are not sole sourced? | a. See answers to questions 17 and 19 above. MDHHS views the accreditation requirements as greatly important, however, as noted above, NCQA accreditation does not prohibit delegation. MDHHS expects this will be an area of further discussion between the CMHSPs and the MHPs in the region once the pilot sites are identified.<br>b. As the CMHSP will now contract with the MHP and not the PIHP, the MHP EQR is required. It is not yet clear how this will impact the MDHHS contract with HSAG.<br>c. It is unclear what "regulatory requirements" are meant. The applicable federal managed care regulations apply to PIHPs and MCOs. The MHPs are subject to all MCO requirements. |
| 34. | Is there any limit to the number or format considerations of attachments to the RFI submission not included in the "Request for Information Instructions" in the "Delivery of Response" section? | As long as the total pages, including attachments are 50 pages or less there is no arbitrary limit on the number of attachments. |
| 35. | In other words, should the RFI submission document be a stand alone submission under 6 gigabytes and Microsoft Office Suite 97 compatible or can electronic links in the RFI submission be used? | External links will not be reviewed. |
| 36. | Is there a prohibition for including letters of support for the RFI from local State legislators? | There is no prohibition for including letters of support for the RFI from Local State Legislators. Any letters would be included within the 50 page limit. |
| 37. | Are attachment pages included in the 6 gigabyte size limit? | Yes, the 6 gigabyte size limitation is intended to cover attachment pages. |

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| 38. | **Financials, PIHP Reserves (Savings and ISF), PA2 Funds and SUD and MH Block Grant**<br>In questions to MDHHS prior to the release of the RFI it was made clear that the ISF and Savings at the PIHP attributed to CMHSPs would remain at the PIHP and that such funds will not be proportionally moved to any CMHSP Pilot.<br>a. Will any PA2 fund balance attributed to the counties where CMHSPs are located be moved to the CMHSP Pilot or will only future PA2 revenue be moved to the CMHSP Pilots assuming endorsement for doing so by county government?<br>b. Will SUD Block Grant funds be cost settled with MDHHS at the close of each pilot year or may saving be retained or carried forward during the period years of the pilot?<br>c. Will CMHSP Pilots be eligible to apply for new MH Block grants (Adult and Child) during the period of the pilot?<br>d. Will the MHPs bare full risk for the specialty benefit provided by the CMHSP Pilot? What About the MBHO/ASO and the unenrolled population?<br>e. Upon what basis will funding to the MHPs and in turn CMHSP Pilots be based understanding that the pilots are intended to be budget neutral for the MHPS?<br>f. Is the universe for the actuarial considerations going to be unique to the CMHSPs historic spending in providing the specialty benefit and served beneficiaries or will it also include the physical health care cost and utilization of the MHPS claims history? Assuming CMHSP spending will be apart of the consideration, what will be the base year…2017?<br>g. What consideration contract wise will be given to ensure timely payments by MHPS to Pilot CMHSPs?<br>h. Where will first dollar assignment go for CMHSP consumers in specialty waiver programs, will it be to the MBHO/ACO or will there be an assignment to MHPs?<br>i. Will CMHSPs Pilots have access to new SED and HSW Waivers?<br>j. Will there be any caps placed on CMHSP Pilots for retained “Medicaid Savings” and is the identity of savings truly local such that it could be used to support services to uninsured and underinsured eligible persons? | a. PA2 funds are attached to the specific County from which they are paid. This would apply to current as well as any reserve PA2 funds.<br>B. SUD Community Grant and General Fund dollars for the pilot CMHSPs will be subject to the same cost settlement arrangements currently in place.<br>c. Pilot participation will not impact a CMHSPs ability to apply for future MH Block Grant funds.<br>d. MHPs operate under full risk contracts. This will continue in the pilot arrangements. MDHHS is still exploring the ASO/MBHO arrangement options and it is not yet determined what risk the contracted entity will bear.<br>e. It is anticipated that the rate setting process will be consistent with the current methodology. This utilizes multiple factors with increasing emphasis on population characteristics.<br>f. See answer e above.<br>g. This is a contract issue between the MHPs and the CMHSPs. All contracts must comply with federal and state rules as applicable.<br>h. For individuals enrolled in an MHP, the Medicaid funds will be paid to the MHP. For individuals not enrolled in an MHP, the Medicaid funds will be paid to the ASO/MBHO entity.<br>i. The 1115 Waiver will replace the current waivers. It is intended that Medicaid beneficiaries served in the pilot regions will still be eligible for the funding arrangements as designed in the 1115 Waiver.<br>j. It is anticipated that pilot related savings experienced by the MHPs will be subject to the provisions of the MHP contract and Section 298 language, which currently do not place a cap on savings. Pilot related savings experienced by the ASO/MBHO entity will be subject to provisions of Section 298 and dependent on the structure of the contractual arrangement between the State and the entity. |
| 39. | Will it be possible for the CMHSP pilots to negotiate for higher transportation costs to Medical appointments (currently $0.19 cents/mile) with the MBHO/ASO for the unenrolled population of beneficiaries or is this rate fixed by MDHHS? | CMHSPs who are pilot participants can negotiate the terms of reimbursement and contracting with the MHPs who are within the pilot sites. |
| 40. | Who will pay the HRS and HICA taxes, will it be the MHPs and MBHO/ASO or the CMHSP Pilots? If these funds are passed down to CMHSPs, to pay, it would ease cash flow issues and provide some cushion for late MHP or MBH/ASO payments. | The entity that receives the Medicaid funds from the state is responsible for the paying the HRS and HICA taxes. |

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| 41. | **Assurances for New Project Participation**<br>a. Will MDHHS provide assurances to 298 CMHSP Pilots that are CCBHC Certified that they will not be prohibited from participation should the state be funded by SAMHSA for CCMHC implementation?<br>b. Will MDHHS provide assurances to [ORGANIZATION NAME] that should they be funded for the SAMHSA PIPBHC submission, that [ORGANIZATION NAME] one of the three sites selected by MDHHS as an implementation partner would continue to be included in the initiative? | MDHHS does not expect referenced practices to change with respect to 298 Pilot participating CMHSPs. |
| 42. | How will person-centered planning competence be determined and monitored? | Per the RFI, MDHHS will administer the pilot contracts consistent with the core values of the 298 Workgroup. All current specialty behavioral health public policies and treatment requirement applicable to Prepaid Inpatient Health Plan and Community Mental Health Service Program contracts will apply to the pilot sites inclusive of person-centered planning and self-determination. |
| 43. | How will the Department make sure people are able to direct their own services and manage their support budgets? | See answer to question 42 above. |
| 44. | Page 10, Item 8: Enrolling non-MHP Medicaid beneficiaries in an ASO or MBHO is outside the requirements in the Legislature's 298 language and has the potential to disrupt continuity and delay services. At the very least, beneficiaries must have a choice of whether they want to continue with CMH management or move the ASO/MBHO. The background information provided on page five of the RFI claims that the RFI was informed by the values defined by the 298 Facilitation Group. If the Department restricts choice and individual control over services and supports in the pilots, then the values did not inform the RFI process, nor did the feedback received from people with disabilities and their family members during the affinity group process.<br><br>Why doesn't the Department perform the role that's being proposed for the ASO/MBHO? The money used to contract with these organizations could be used to support additional staff.<br><br>Page 11, 8 d: Whether or not "the financial arrangements of a pilot will address the various "community benefit" functions of the CMHSP…" needs to be tested as part of the evaluation process. | See answers to questions 5, 27, 23 and 32 above.<br><br>MDHHS does not have the capacity to perform the required managed care functions and does not seek to build capacity given the time-limited nature of the pilots.<br><br>MDHHS has contracted with an independent evaluator to develop process and outcome measurement criteria for the pilot(s) and demonstration project sites. The evaluator will seek input from the pilot/demonstration sites and other key stakeholders as part of the design plan. |
| 45. | How will dispute resolution mechanisms be coordinated between the MHPs and CMHSPs? What kind of process will be deemed acceptable and how will the Department determine whether the dispute resolution process is effective? | See answer to question 6 above. |
| 46. | Page 12, 9 b: Testing whether the MPH demonstrates "competency to administer customer service functions for the specialty behavioral health population" should be tested during the MDHHS evaluation process. | Thank you for your input. It is expected that the Applicant will describe how each function may be accomplished and/or monitored in the pilot arrangement. |

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| 47. | Page 15, 10 Pilot Project Evaluation: As has been strongly recommended by the Arc Michigan in the past, if person-centered planning is the method by which services are provided, why doesn't MDHHS conduct a longitudinal evaluation of individuals' progress to their desired life, based on their person-centered plan? | The recommendation for longitudinal study is outside the scope of this RFI and the resulting pilots. The 298 Pilot period is time-limited. |
| 48. | It is my understanding that RFI must have at least 50% MHP support letters and that in Pilot 100% MHPs must participate. | Each applicant must obtain a letter of support from at least 50% of the MHPs in their region in order to meet the minimum criteria. Once the pilot regions are selected, all of the MHPs within selected pilot regions must participate in the pilot. |