MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

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REVISED PLAN FOR PROCUREMENT OF MEDICAID SPECIALTY PREPAID HEALTH PLANS

August 2000

STATE OF MICHIGAN

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DEPARTMENT OF COMMUNITY HEALTH

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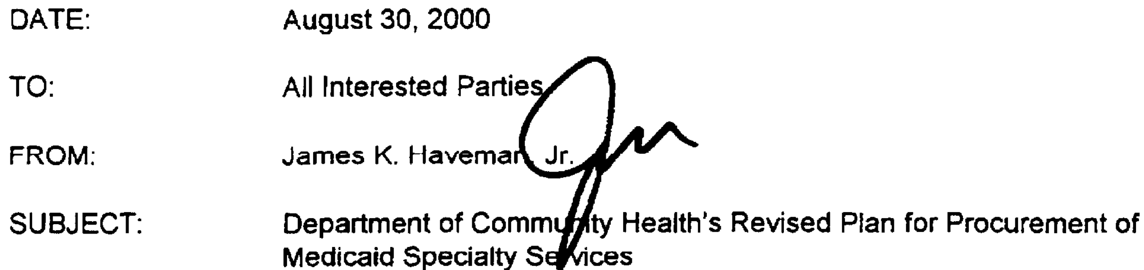

DATE: August 30, 2000

TO: All Interested Parties

FROM: James K. Haveman, Jr.

SUBJECT: Department of Community Health's Revised Plan for Procurement of Medicaid Specialty Services

I am pleased to distribute the Department of Community Health's "Revised Plan for Procurement of Medicaid Specialty Prepaid Plans". For the past eighteen months, the department has diligently worked to develop a plan for competition that would conform to federal requirements while maintaining our commitment to enhancing the abilities of persons with mental illness, developmental disabilities and addictive disorders to make choices and be fully included in their communities.

The attached document reflects the department's extensive research into the federal regulations and the economic principles related to competitive procurement. More importantly it reflects the unique nature of our great state and the hundreds of comments received from stakeholders of the public mental health and substance abuse system.

The attached document presents an overview of the department's conclusions regarding competition and provides the structural outline of the future design of the system. Additional copies of the document may be obtained through the department's website, www.mdch.state.mi.us or by calling Barbara Mongeau at (517) 373-6440.

The department previously announced a public hearing to be held in Lansing on September 6, 2000, at the Michigan Library and Historical Center Auditorium, 717 West Allegan, Lansing, Michigan. There will be two hearings (1:00 - 5:00 p.m. and 6:30 - 8:30 p.m.). Public comments received during that time and written comments received through September 22, 2000, will be considered in the development of the final document to be submitted to the Health Care Financing Administration on October 1, 2000. Written comments may be mailed, faxed or e-mailed to Patrick Barrie at the Michigan Department of Community Health, Lewis Cass Building, 6th Floor, 320 South Walnut Street, Lansing, Michigan, 48913; Fax: (517) 335-6775; E-mail: barriep@state.mi.us.

JKH/bam

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MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

REVISED PLAN FOR PROCUREMENT OF SPECIALTY SERVICE PREPAID HEALTH PLANS

INTRODUCTION

Since October 1998 - when the state implemented a ground-breaking managed care program - nearly all Medicaid state plan specialty mental health, developmental disabilities and substance abuse services have been managed by and arranged through designated specialty Prepaid Health Plans. A specialty Prepaid Health Plan (PHP) is a managed care entity that provides Medicaid covered specialty services - under a contract with the state and on the basis of prepaid capitation fees - to beneficiaries who need such care.

Under special arrangements between the state and the federal Health Care Financing Administration (HCFA), MDCH has contracted - on a sole source basis - with Michigan's 49 county-sponsored Community Mental Health Services Programs (CMHSPs) to serve as the specialty PHPs for their designated service areas. Since this special arrangement diverges from federal regulations that require managed care contracts to be procured through "open and full" competition, HCFA stipulated, and the state agreed, that it must develop a plan to transition from sole-source contracts for specialty PHPs to competitive procurement.

It is important to emphasize that the line of reasoning pursued in the paper and the conclusions drawn *apply specifically to specialty services for persons with serious mental illness, developmental disabilities and addictive disorders*. These populations were historically confined in segregated state-operated hospitals and centers. The long journey from confinement in state-operated facilities to community-care settings has required enormous cooperation and collaboration between the state and local governments. In short, the considerations regarding competition for specialty services *are not directly applicable or comparable* to other circumstances and situations, such as competitive procurement for Medicaid *physical health services or long-term care services for other groups of disabled beneficiaries.*

THE BENEFITS OF THE SPECIALTY SERVICE WAIVER

The implementation of managed care for specialty services and the utilization of CMHSPs as Prepaid Health Plans were consistent with long held values and reform objectives in Michigan. For more than 30 years, the state has pursued the development of community-based specialty care systems to facilitate the integration, inclusion and recovery of persons with mental illness, developmental disabilities and addictive disorders. With the managed care program the state finally achieved unified system management for specialty services at a local level, under a single contract that brought together multiple policies, programs, and payment sources.

This achievement - consolidated management of all publicly-funded specialty services (Medicaid benefits as well as other services and supports paid for through alternative funding arrangements) - was not merely an exercise in administrative simplification. Rather, the goal of unified system management was a *means* to a much larger *end:* that of enhancing the capabilities to function, the freedom to choose and the opportunity to achieve for persons with behavioral or developmental disabilities.

Individuals with severe mental illness, developmental disabilities and serious addictive disorders require various services and supports arrangements that are financed through different

resource streams. As the specialty system has evolved toward increased consumer choice and control, it became essential that the resource streams that support these choices be brought under unified management. Considering possibilities and alternatives are much easier when all resources relevant to the person's choices are in one place.

The freedom to achieve – the ability to make decisions and to utilize services to support the life one desires and values – has become a core principle within Michigan's specialty service system. In 1996, Michigan law was amended to require "Person-Centered Planning" (PCP) within the specialty service system. PCP is the vehicle through which the freedom to achieve, to participate and to choose is realized.

FEDERAL REQUIREMENTS AND THE RATIONALE FOR COMPETITIVE PROCUREMENT

The federal position on competitive procurement, as stated in 45 CFR Section 74.43, is that "…all procurement transactions shall be conducted in a manner to provide, *to the maximum extent practical*, open and free competition" (emphasis added). The rationale for requiring competition is that it provides an equitable opportunity for qualified bidders to contend for governmental contracts. Beyond basic fairness, competitive contracting presumably puts economic incentives into place that assure that the purchaser will obtain the best possible product at the lowest possible price (best value).

DEVELOPMENT OF AN INITIAL PLAN FOR COMPETITION

For the past eighteen months, MDCH has diligently worked to develop a plan for competition that would conform to federal requirements. In approaching competition, Michigan did not want to compromise certain system design features and legal safeguards which have greatly facilitated freedom, participation, integration and inclusion for persons with serious mental illness, developmental disabilities and addictive disorders.

In September 1999, MDCH published a preliminary plan for competition that attempted to address these considerations while sustaining some form of market-driven selection process (competitive procurement) for specialty PHPs. In the preliminary plan, MDCH proposed to:

> "…bid out management of both the Medicaid funds for specialty services and other funds currently assigned by state statute or practice exclusively to county-sponsored entities. In a competitively neutral process (level playing field), the department would award management contracts for each designated service area to a single public, private, or public-private partnership organization in that locality or region which submitted a proposal most responsive to the purchasing specifications outlined in the bid packet."

Following the release of the paper, MDCH held ten public hearings to solicit input on the preliminary plan and the department received over 750 written comments from stakeholders regarding the document. An analysis of stakeholder comments revealed that many responded positively to some parts of the preliminary plan. In particular, they endorsed the guiding principles and service paradigms (recovery, strength-based ecological approach, self-determination) set forth in the plan and they applauded efforts to ensure accountability of managing entities (including replacing poorly performing organizations). Most stakeholders also agreed that the resource streams supporting local systems of specialty care *should not* be split apart (bifurcated - put under different management).

However, this analysis also revealed considerable concern among all groups that competition would diminish *local control and oversight* of community-based service systems, including important characteristics and processes of the existing system (e.g., open meetings, consumer participation on governing boards, efforts to reduce stigma, self-determination, person-centered

planning, etc.). Stakeholders expressed reservations about the *high-powered incentives* characteristic of competitive environments and feared that profit considerations would compromise access and quality, encouraging managing entities to retain funds that should go to enhance services or to promote independence for disabled beneficiaries. Other concerns expressed by all groups were that there would be *disruptions in care continuity* if new managers were selected, and that competition - especially if it were narrowly focused upon price considerations - would result in the *elimination or reduction of certain highly valued services that promote the freedom to achieve, choose and participate in society*.

DEVELOPMENT OF THE REVISED PLAN

For the last ten months, the state has considered how to best to meet the requirements of federal law while simultaneously addressing the concerns raised by stakeholders and maintaining elements of the preliminary plan that were widely endorsed. During this time, MDCH continued to engage in dialogue with interested parties, and the state initiated discussions with HCFA about possible alternative arrangements. In the course of these conversations with HCFA, it became apparent that if the state were to request consideration of a plan which did not contain full and open competition, it would need to develop a plan that: 1) made a logical and defensible case that classic competitive procurement was not practical, 2) met the fundamental principles and intent of competition (i.e., fairness and best value) and 3) delineated safeguards against possible negative effects of a lack of competition (collusion, conflict of interest, and lack of efficiency).

These considerations have required the state to develop a set of very technical economic arguments regarding competition and the delineation of a set of proposed safeguards to specifically address HCFA's concerns. Those arguments will be fully described in the department's waiver renewal application to HCFA, due October 1, 2000.

The essential conclusion of that document is that after a careful consideration of: a) the unique characteristics of Michigan's public specialty service system; b) the specific market environment for the purchase and delivery of specialty mental health and substance abuse services; and c) the state's affirmative obligation to assure that persons with behavioral and developmental disabilities are fully integrated in community settings, the standard market model of open and full competition *is not practical* for selection of specialty PHPs, and might possibly be detrimental to the goal of full community inclusion of beneficiaries.

Revised MDCH Plan for Procurement of Specialty PHPs

1. Introduction

MDCH plans to *retain the fundamental structure* of the current waiver program and procurement model while simultaneously *introducing certain significant alterations* to address particular areas of concern. In this section, the basic strategy is directly applied and described with greater specificity.

2. Basic Structural Configuration and Plan Dimensions

The state's revised plan for procurement retains the basic structural configuration of the state approved managed specialty services waiver, but limits CMHSP prerogatives within this structure.

2.1. Preservation of the Carve Out, Retention of Eligibility & Single PHP Model

The state will maintain the carve out for Medicaid specialty mental health, developmental disability and substance abuse services. Any Medicaid beneficiary in a given area that needs specialty services may obtain such care from the designated specialty PHP that serves that area. MDCH will designate a single entity within each area to operate as the specialty PHP.

2.2. Role of Community Mental Health Services Programs (CMHSPs)

The institutional (legal) environment, experience considerations, equity functions, economic features and particular output (community inclusive outcomes) characteristics make competition for specialty PHPs - that manage mental health, developmental disabilities and substance abuse services - impractical.

Therefore, the state will afford *qualified* CMHSPs an *initial consideration* to operate as the specialty PHP for a designated service area. However, the state *will not offer this initial consideration to all existing CMHSPs* as individual, stand-alone organizations.

The state will not be precluded from obtaining specialty PHP services from private organizations if a CMHSP cannot meet state specifications.

2.3. Safeguards Regarding Medicaid Funds

Capitation payments to the specialty PHPs are for Medicaid covered state plan specialty services (or approved alternative) for eligible Medicaid beneficiaries. Capitation payments to specialty PHPs will not be returned to the state as an intergovernmental transfer.

The specialty PHP will manage Medicaid specialty services for eligible beneficiaries on a prepaid, shared-risk basis. Savings achieved by the specialty PHP within the approved risk corridor, must be reinvested back into services for Medicaid beneficiaries and may not be diverted to purchase services for non-Medicaid recipients.

3. Alterations and Adjustments

While the basic dimensions of the specialty service plan remain intact, MDCH is introducing a significant new capacity requirement, with options for CMHSPs that are unable – as individual stand-alone organizations - to meet the standard.

3.1. Minimum Covered Lives Criteria

Single CMHSPs that have at least 20,000 Medicaid beneficiaries (covered lives) within their respective catchment area boundaries will be eligible (as individual stand-alone organizations) to apply for designation as a specialty Prepaid Health Plan for their catchment area. CMHSPs that do not meet the covered lives criteria will be afforded a range of options for program participation, including an opportunity for *multiple contiguous CMHSPs to make a consolidated application* for PHP designation.

The state has determined that an eligibility base of roughly 20,000 is the point at which scale economies for PHP administrative activities begin to develop. Since specialty PHPs will have enhanced administrative responsibilities in the future (as promulgated regulations related to several federal statutes take effect), achieving some measure of scale economies becomes more important than in previous contracting periods.

3.1.1. Options for CMHSPs with Less Than 20,000 Medicaid Beneficiaries

Single CMHSPs with less than 20,000 Medicaid covered lives may choose among several options for participation in the Medicaid managed specialty services program.

3.1.1.1. Affiliation & Consolidated Application for PHP Designation

Multiple CMHSPs - with contiguous boundaries - that collectively have at least 20,000 Medicaid beneficiaries in their combined catchment areas may submit a consolidated application for PHP designation. The consolidated application must describe the relationship that exists among the affiliated entities, including any legal agreements that define or circumscribe these relationships.

MDCH will accept consolidated applications that conform to one of the following structural arrangements:

- The affiliated CMHSPs submitting a consolidated application identify one CMHSP in the affiliation to serve as the "hub" for regional efforts*. This CMHSP would serve as the Prepaid Health Plan for the region*. The affiliated CMHSPs may designate the hub CMHSP formally (through the Intergovernmental Transfer of Functions and Responsibilities Act) or simply by informal agreement. In any case, *only the hub-CMHSP will be considered for designation as the specialty PHP for the region*, *and it must meet all other qualifications established by MDCH to be awarded this status*. The other CMHSPs in the affiliation would be eligible for a special provider designation – that of "Comprehensive Specialty Service Network" (CSSN) – that affords them special consideration in the provider network and qualifies them to receive a sub-capitation from the PHP or hub-CMHSP.
- The affiliated CMHSPs may submit a consolidated application along with a declaration - supported by legal documentation - that they have, or are in the process of creating, a new organizational entity (under the Urban Cooperation Act) which they are nominating for consideration as the specialty PHP for the region. The new entity

would have to meet all qualifications established by MDCH before it could be designated as the specialty PHP for the region.

3.1.1.2. Inability of CMHSPs to Form Affiliations or Select an Option

In the event that various contiguous CMHSPs cannot form affiliations or PHP regions that meet the minimum covered lives standard, or if a CMHSP does not indicate its preferred participation option for the Medicaid managed specialty services program, the department may open the region for competitive procurement or designate an adjacent qualifying CMHSP to serve as the specialty PHP for the region.

3.2. Qualification Requirements for PHP Designation: Application for Participation

An individual, stand-alone CMHSP - or an affiliated group of CMHSPs - that meets the minimum covered lives criteria, may complete an "Application for Participation" (AFP), developed by MDCH in conjunction with consumers, family members and advocacy organizations. The AFP contains all pertinent technical requirements and conditions of participation that CMHSPs must meet in order to be designated as the specialty PHP for a particular area. The AFP will require the CMHSP to describe its administrative and managerial capabilities related to managing care and its processes and accomplishments in areas related to community inclusive practices and outcomes.

3.2.1. Administrative Capabilities

The CMHSP must describe its capacity to carry out standard managed care administrative functions and its ability to perform certain enhanced functions for managed care organizations stipulated under proposed rules to the Balanced Budget Act and other federal legislation.

If the CMHSP does not have sufficient administrative capabilities to perform necessary managed care functions or to meet the enhanced criteria, the CMHSP must acquire these capabilities by contracting with another organization (e.g., a private sector managed care organization). If the CMHSP fails to develop or acquire the necessary capabilities to function as the PHP, it will not qualify for designation as the specialty PHP for the area.

Administrative capabilities include, but are not limited to:

- Governance inclusive of consumer members
- Access and authorization systems responsive to beneficiary demand
- Care management and monitoring responsive to beneficiary choice
- Utilization management systems which assure medically necessary services and due process notifications
- Internal quality improvement program consistent with federal rule and/or state requirements
- Grievance and appeal procedures consistent with federal regulations
- Member services
- Provider network management
- Information systems
- Claims processing capabilities, including electronic data exchange
- Financial management, solvency and stability

3.2.2. Administrative Costs

In addition to describing administrative capabilities against the standard and enhanced requirements, the CMHSP will be required to identify the portion or amount of their current premium payment (PEPM payments) that is used to underwrite or support existing managed care administrative capabilities and functions.

As noted previously, MDCH intends to change the way capitation payments are made in the future. It will split PEPM payments into an administrative-capitation portion and a service-capitation allotment. This adjustment will allow MDCH to limit administrative costs to a particular level, and to impose any monetary sanctions that might be necessary against the administrative portion of the CMHSP's payments.

Information on current administrative costs acquired through the AFP will be the first step in the state's process for setting administrative cap rates.

The CMHSP will also be required to certify the amount of Medicaid funds currently allocated to the organization's risk reserve account. As a condition of participation, the organization must agree that in the event of contractual default, these reserve funds will be returned to the state to pay accumulated obligations and to assist with start-up costs of the successor PHP.

3.2.3. Equity Functions and Community Inclusive Practices and Outcomes

MDCH has argued that one rationale for sole-source arrangements with CMHSPs for specialty PHP services is that CMHSPs have certain legal obligations and engage in particular processes and activities which affirmatively assist persons with mental illness, developmental disabilities and addictive disorders in community participation, integration and inclusion. If a CMHSP is not adequately fulfilling these functions, this undermines the case that the organization should receive preferential consideration for PHP designation.

The AFP will require the CMHSP seeking designation as the specialty PHP to thoroughly describe all aspects of their organization, operation and practice which facilitate integration, inclusion and participation for beneficiaries with behavioral or developmental disabilities. CMHSPs must provide relevant information regarding governing board and advisory committee composition, the number of consumers employed by the organization or sub-contractor agencies, percentage of funds spent on consumer operated or directed services and on self-determination arrangements, the organization's use of segregated living arrangements and programs, state facility utilization and placement history, language and communication accommodation capabilities, efforts to ensure cultural competency, and similar items.

In assessing CMHSP performance of equity-related functions and achievement of community inclusive outcomes, MDCH will - whenever possible - utilize available current and historical performance data on the CMHSP.

3.2.4. Service Array

The CMHSP must assure that all currently defined Medicaid state plan specialty services and approved alternatives are available to beneficiaries.

In addition, the CMHSP must assure that certain state designated covered services meet "structural integrity" criteria. These services would include Assertive Community Treatment, Psychosocial Clubhouses, Home-Based Service Programs for children and adolescents, Consumer-Run Drop-In Centers, Methadone Maintenance Clinics, and Intensive Outpatient Programs (IOP).

3.2.5. Service Eligibility

The CMHSP must describe all processes utilized to determine beneficiary eligibility for specialty services. It must provide copies of any written information or promotional materials that describe the Medicaid specialty services program and eligibility considerations. Finally, the CMHSP must indicate how it routinely "tests" its internal systems and processes (including sub-contractors) to ensure that beneficiaries are properly evaluated for service eligibility.

MDCH will require, as a condition of participation, that the CMHSP - through its customer or member service program - monitors access and eligibility determination processes to assess the prevalence of both informal and formal denials of service eligibility. The CMHSP will be required to utilize a variety of monitoring and testing techniques - including "mystery shopper" programs - and to document corrective actions taken when problems are detected.

MDCH will also require CMHSPs that wish to be designated as PHPs to regularly communicate - using a variety of media - information to the community regarding eligibility for specialty services. MDCH will establish a specialty service eligibility hotline for beneficiaries to provide an additional available source of accurate information on specialty service eligibility and PHP responsibilities.

3.2.6. Provider Network Selection, Composition and Configuration

Earlier in this document, the state indicated that while it planned to use a non-competitive procurement process to select specialty PHPs, it intended to inject mechanisms into that process to achieve the basic objectives of federal requirements (best value and beneficiary choice).

One of these mechanisms is a new MDCH requirement that the PHP provider network be assembled either through competitive contracting, or through a comparative cost method that demonstrates network selection processes were equitable to all interested entities and that the providers selected represent “best-value” from a price and quality perspective.

3.2.6.1. <u>Single CMHSPs with over 75,000 Medicaid Covered Lives</u>

CMHSPs with over 75,000 Medicaid beneficiaries in the service area must assemble the provider network through a competitive selection process. Bids or proposals received in response to the procurement must be reviewed *by a joint evaluation panel composed of CMHSP officials, MDCH representatives and beneficiaries and/or their family members*.

The purpose of the procurement process for CMHSPs with over 75,000 covered Medicaid lives is not to select large numbers of unaffiliated individual practitioners, agencies and programs. Rather, the CMHSP should design the procurement process to attract competing proposals from vertically integrated, comprehensive, Provider Sponsored Specialty Networks (PSSN). PSSNs are organized and operated by affiliated

groups of providers and offer relatively complete "systems of care" for beneficiaries with particular conditions.

A CMHSP with more than 75,000 covered Medicaid lives must select at least two PSSNs for each special population (i.e., adults with mental illness and/or addictive disorders; children with emotional disturbances and/or addictive disorders, and persons with developmental disabilities). Beneficiaries would have a choice regarding which PSSN they elected to use for specialty care, and could move between these networks if dissatisfied. The CMHSP-PHP may use prospective and risk-based payment arrangements with the PSSNs, as long as it is recognized that PSSNs are not "plans" (no beneficiary enrollment) and appropriate adjustments are made to reflect beneficiary movement and service use variation.

The CMHSP selection process may exempt certain highly specialized or cultural specific agencies from inclusion in the PSSN organizations, to maintain unimpeded beneficiary access to these unique providers.

3.2.6.2. CMHSPs with 20,000 to 75,000 Medicaid Covered Lives

Single CMHSPs (or affiliated group of CMHSPs) with 20,000 to 75,000 Medicaid covered lives within the catchment area would be required to develop a plan for the selection of network providers that defined and assured “best value” for the Medicaid program and for beneficiaries.

- If the CMHSP (or affiliated group of CMHSPs) does not directly operate any services or programs, this selection plan will typically be some form of competitive solicitation, with consumers and advocates serving on the selection panel.
- If the CMHSP (or affiliated group of CMHSPs) is a direct provider of services, the situation becomes more complex and the conflict-of-interest potential becomes more pronounced. In these circumstances, the state will *directly* assist the CMHSP in the selection methodology and process, to ensure that: a) non-CMHSP providers are afforded an equitable opportunity to participate in the network; b) the CMHSP applies a “best-value” analysis to any direct-run or in-house program considered for inclusion in the network; and c) safeguards are devised to prevent the CMHSP from steering consumers to direct-run operations.

  In circumstances where the CMHSP has established that a directly operated service or program represents "best-value" it must still assure that a consumer has an option - for certain state designated services - to use either the CMHSP service or an alternative outside supplier of that service.

3.2.7. Facilitating Consumer Choice and the Opportunity to Achieve

Specialty PHPs are responsible for promoting community inclusive outcomes for beneficiaries with serious behavioral or developmental disabilities. In Michigan, person-centered planning (PCP) is considered the key “tool” for fostering community inclusive practices and outcomes. Beneficiaries, family members and advocates have indicated that this vital process is not always implemented in accordance with statute and MDCH practice guidelines.

3.2.7.1. Service Plan Development

The CMHSP must offer beneficiaries - as a covered benefit - the option to choose a person-centered planning (PCP) facilitator who is external to the CMHSP-PHP and/or its service provider organizations.

Requirements for or certification of PCP facilitators will be established by MDCH. The facilitator will be responsible for maintaining the fidelity and integrity of the PCP process and for assuring that the needs and desires of the beneficiary are fully identified in a process directed by the beneficiary.

The CMHSP-PHP remains responsible for the identification and description of available resources and service/support options, as well as the actual development of the written plan and the dissemination of due process information.

3.2.7.2. Service Array and Provider Choice Accommodations

The CMHSP-PHP must assure the availability of choice among provider agencies or individual providers for selected services identified by MDCH. This includes, but is not limited to, case management, supports coordination, physician-psychiatry services, and personal care assistance.

The CMHSP-PHP must allow the beneficiary to utilize out-of-network providers under special circumstances:

- The PHP has only one choice of a provider organization or practitioner for a department designated service.
- The beneficiary has a special need for which the PHP does not have a qualified provider.
- The beneficiary has specific cultural needs or requires accommodations due to special communication circumstances.
- The beneficiary desires to retain a valued, long-standing relationship with a practitioner (psychiatrist) or personal care attendant, and these providers meet network participation qualifications (these should be flexibly adapted to meet particular circumstances or types of services).

4. SELECTION PROCESS FOR SPECIALTY PREPAID HEALTH PLANS

CMHSPs (or an affiliated group of CMHSPs) that wish to be considered for designation as the specialty PHP in their respective areas must submit the completed Application for Participation (AFP) to a *special state-level selection panel* comprised of state officials *and consumer, family and advocacy representatives*.

The panel will establish evaluation criteria for the AFP and due process principles that will be applied to applicants. If a CMHSP applicant for specialty PHP designation is not certified as meeting basic requirements, and necessary corrective action is deemed too extensive for timely remediation of deficiencies, the panel will reject the application and designate the service area as "unfilled" in regard to a specialty PHP and hence available for an immediate competitive selection process.

5. Contract Management, Quality Management and Enforcement Action

MDCH will enter into a prepaid risk contract for management of Medicaid special services with those entities designated by the selection panel as the specialty PHP for a given service area.

The quality management system for monitoring PHP performance will be enhanced to comply with officially promulgated final federal rules related to the Balanced Budget Act of 1997, and to incorporate the finding and recommendations that emerged from HCFA monitoring visits conducted during June and July of 2000.

Specialty PHPs that fail to meet contractual and performance obligations will be subject to remedial actions and sanctions, up to and including monetary penalties applied to the administrative capitation payments to the PHP, temporary MDCH management of the PHP's operations, and/or cancellation of the contract and replacement by a different or newly selected PHP.

Concluding Remarks

This document summarizes the state's efforts to meet federal requirements for competitive procurement of specialty PHP contracts. In the course of its explorations, the state concluded that certain important considerations and characteristics made market selection of specialty PHPs impractical and undesirable. In the paper, the state explained the basic structure for procurement, the proposed criteria for PHP designation, and provided details regarding the selection process and panel.

MDCH will hold a public meeting to obtain stakeholder reactions and feedback related to this document. Suggestions obtained through this meeting will be considered in developing the plan that must be submitted to the Health Care Financing Administration by October 1, 2000.