QUESTIONS AND ANSWERS
TO THE
APPLICATION FOR PARTICIPATION

Procurement of
Specialty
Prepaid Health Plans

PART II
January 28, 2002

This is the second 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. Any corrections to this document will be included in future question and answer documents.

General Information on Application Requirements

1. The Bonus Item under Employment (2.4.5) on page 35 of the AFP reads "Provide, in a maximum of three pages inserted below, the number of persons with mental illness, developmental disabilities, and substance use disorders employed by the applicant in each of the last two years, their work status (full-time or part-time), pay scales, fringe benefits, and a brief job description for each consumer employed by the applicant."

A. First, the substance abuse part of Pathways is already a managed care entity (through its CDR, or Central Diagnostic and Referral program). The CDR department authorizes publicly-funded services for 22 licensed and accredited Providers, but it does not offer direct treatment services itself. A number of the Provider agencies employ substance abuse counselors and/or supervisors who are in recovery from alcohol or drug addiction. Since we provide funding that helps pay salaries to recovering counselors/supervisors, would they count in the context of the bonus item?

Do not include contract agencies in the count.

B. For the mental health and developmental disability areas, can Pathways in its Provider role use agency experience as representative of the region, or is it a requirement to collect information from each of the individual CMH's involved in the PHP process?

Information from all affiliate members is also necessary.

C. Can the pay scales and fringe benefits be reported within aggregate ranges? For example, would it be acceptable to note that "x number of persons with mental illness were employed (# full-time and # part-time) at salary levels ranging from $x,xxx to $xx,xxx yearly, with % fringes, in positions ranging from janitorial work to professional positions"? If not, can you suggest ways we can supply sufficient information within the three-page space limitation?

Provide detailed information for employees who provide consumer-operated or consumer-directed services. Since employees cannot be expected to disclose disability status to their employers, estimates and ranges are appropriate for other positions

within applicant and affiliate member organizations.

2. **Item 2.6.1, page 37 – If the rights services are provided via contract with another CMH, does this fulfill the requirement in this section?**

   Yes, so long as the identified contractual entity represents the applicant and the applicant's entire service delivery system.

3. **Item 7.4.2.1 – GF formula funds redistribution references item 8.4.4 of the contract, which does not exist. What is item 8.4.4?**

   There are three corrections to identify here. First the reference should be 7.4.4, not 8.4.4. Second, the dollar amount should be $1.4 million. Third, the last two sentences of 7.4.2.1 should have been deleted. The $1.4 million MDCH risk authorization funds will not be restricted under the fiscal year 2002/03 contract, but will continue to be distributed to CMHSPs as part of the general fund formula.

4. **Self-determination – requirement of the AFP 10/01/02, but not required until 10/01/03. To what extent are the hub and spokes to have implemented self-determination by 10/01/02?**

   Prepaid Health Plans and affiliates must begin offering self-determination as an option no later than October 1, 2002.

5. **When it refers to "applicant" does the same requirement apply to each affiliate? Or just to the applicant? E.g., 2.3.3. – is service area CEI's service area, or each individual affiliate's service area? Does the affiliation need separate proofs than the summary of the individual's boards?**

   All requirements apply to the entire geographic service area which the applicant is making application to serve. We will be verifying and monitoring the applicant's ability to meet those requirements across the applicant's entire geographic service area.

6. **If the spoke does not have a current Medicaid contract, will MDCH still maintain contractual relationships for the settlement of past issues? What about current service delivery questions post 10/01/02? Will questions have to be submitted through the PHP, or can a "spoke" contact MDCH directly for assistance or questions.**

   MDCH does not expect to hold or retain a contractual relationship with any entity <u>just</u> for the purpose of settling past issues. Such settlements are guided by the contract that was in effect for the period being settled. As to questions, it will generally be necessary for questions to

come through the Prepaid Health Plan, simply because the answer will most often depend on the conditions specified in the legal and contractual arrangements within the affiliation.

7. If payments to PHPs, who are in affiliations, reflect a regional/affiliation-wide intensity factor, will PEPM payments for new Medicaid eligibles, in a given county, be paid using the regional intensity factor or the county's prior intensity factor?

The regional intensity factor.

8. Regarding the June 1, 2002, requirement for the plan meeting standard on page 10, item 4; so unless another specific time frame is given, all plans must have an end date of June 1 no matter what?

Yes, unless otherwise noted, standard must be achieved by June 1, 2002.

9. Please clarify item 2.4.3 under Employment on page 35.

The item asks whether the applicant has an organizational unit that is specifically dedicated to consumer interests and staffed by individuals with disabilities and/or family members.

10. Regarding item 2.9.8 on page 41 under Coordination and Collaboration, third bulleted item, is this meant to say "Medicaid" or "medical"?

A correction will be listed in a MDCH issued letter. This should read "medical".

11. Regarding item 2.9.9 on page 41 under Coordination and Collaboration, what benefits are meant here, "specialty care" benefits, or "health care" benefits?

The assurance we are looking for is the coordination of all benefits for children enrolled in the MIChild Program.

12. Regarding item 3.3.2 on page 54, by use of the term "individuals," does this mean consumers?

The term "individuals" is defined in the glossary on page 96 of the Application for Participation.

13. Regarding item 3.4.6 on page 56 under Case Management and Supports Coordinator, is only "Case Management" intended here?

Yes, Case Management is an enrolled program that is reviewed by the MDCH review teams.

14. Regarding item 3.9.9 on page 70 under Quality Management, please expand on the use of the adjective "credible".

If a standardized instrument is not used, the Prepaid Health Plan should have developed and tested an instrument that yields defensible results.

15. Regarding item 3.11.8 on page 75 under Financial Management, does "uniform billing" refer to the MDCH 7/13 memo?

Yes.

16. Regarding item 3.11.11 on page 76 under Financial Management, by "recipient" reports, is what is meant here "recipient rights" reports?

This is corrected in a MDCH letter regarding Application for Participation clarifications and corrections. It should read, "including recipient rights and grievance/appeal processes, ...".

17. Regarding item 3.11.17 on page 76 under Financial Management, please provide more detail on what is meant by "organizational plan… to achieve efficiencies".

Recognizing that a plan can take many forms and shapes, this item expects that a plan for generating efficiencies does exist, and is known within the organization and across organizations in the case of affiliations. If the plan exists as part of a larger organizational plan, provide only that portion related to this item. If the plan does not detail the efficiencies gained over fiscal year 2000 and fiscal year 2001, the Prepaid Health Plan must address that item separately.

18. Regarding length of explanations and plans to be submitted on page 10 and 11, items 5-7, is the two-page length for each separately?

No, the two-page length is for the explanation and plan combined.

19. Regarding item 2.8.1, is the use of the term "crisis stabilization" meant to describe specifically an enrolled MDCH program, or a more general use of the term/definition?

The enrolled program.

20. Regarding item 3.6.2, what is the definition of medically-necessary services here, general physical health related or specifically mental health specialty service with medical aspects?

Medically-necessary services include both physical health services and specialty services.

21. Regarding 3.6.10, can we assume rather than a person's "name" on a poster, etc., the job title would be acceptable?

The standard requires the name of the person on the poster.

22. Regarding 3.6.11, does "customer service" staff mean specific to a customer service unit only or may it apply to any staff/network customer-service-related response?

For purposes of this section, "customer service" refers to a function rather than a discrete organizational unit of the applicant.

23. Regarding 3.12.4, does this refer to funds managed by the coordinating agency, or funds between the CA and the CMHSP?

Because individuals move between funding streams, coordination and continuity is needed between both Prepaid Heath Plan substance abuse services and substance abuse services managed by Coordinating Agencies.

24. Regarding item 3.12.5, since the definition of the applicant is the CMHSP, may we assume delegation to the affiliate/contracted CA of these functions within the CA network is allowable?

Yes, the applicant may delegate the responsibility; however, the applicant remains responsible and accountable for these functions.

25. Regarding item 3.12.4, may we also assume delegation to the CA by the CMHSP applicant is allowable as appropriate?

Yes, the applicant may delegate responsibility; however, the applicant remains accountable.

26. Regarding item 3.10.3, please define "process utilization".

The bulleted statement in which this term is located refers to the need to have documentation that you have a review process for identifying claims payment rates and that you have evidence that shows you have used the process and for how long (history).

27. Regarding items 3.8.4 and 3.8.5, what does the use of the word "common" mean? Does item 3.8.5 mean in essence existence of a provider network management policy?

The use of common means consistent as stated further in 3.8.4; "These policies and procedures are applicable throughout the network...". Underline added for emphasis. Yes, 3.8.5 means an established policy.

28. Item 3.8 – Provider Network: To what extent does a board which is primarily a direct service board have to comply with this section. E.g., Item 3.8.1 – would current employees be considered part of the provider network and have to review the FY02/03 contract and express in writing their agreement to participate in the provider network? Can MDCH give further clarification as to the obligation of direct provider boards to comply with this language that appears to refer to contracted providers vs. employees?

Employees are not a network provider. This is related to a contract, legal agreement, between two entities.

29. Can the ITFRA reference bylaws or other documents outside the ITFRA to define the "financial arrangement and interest of each party," as opposed to detailing the particulars within the body of the ITFRA? In other words, is it sufficient that the ITFRA itself require the Administrative Board to determine, document and specify the financial arrangement and interest of each party? Or must these arrangements be specified in the ITFRA itself?

This is a determination of each CMHSP Board and their legal counsel. MDCH will require all documents be available for review that are referenced in the affiliation agreement. MDCH has to express concerns regarding items, if referenced, in an affiliation agreement that would not require formal Board review and approval. Such items could significantly have an impact which a Board may not have intended.

30. Will MDCH require settlement on the ISF's of each CMHC in an affiliation BEFORE the ISF's are "rolled up" to the level of the PHP? In other words, is the transfer based on ISF balances prior to October 1, 2002, or after the fiscal year settlement with MDCH has occurred.

Yes, the timing of the transfer allows final determination of the amount available after final close out of fiscal year 2001/2002 contract requirements.

31. Page 41, item 2.9.9 - coordination of benefits for children enrolled in the MIChild Program. Question: Will this funding continue to go directly to the CMHSP or the PHP?

MIChild payments will continue to go to CMHSPs.

32. Page 54, item 3.3.1, 5th bullet - claims management to assure that unauthorized services are not paid, and authorized services are not rejected by claims management. Question: Would this occur in a sub-capitation arrangement? Is this item expected to be addressed by all applicants?

This is not a sub-capitation issue. The applicant must have an authorization policy and procedure in place for its entire geographic service area.

33. Page 64, item 3.8.2 - Do we need to sub-capitate by service? Do we need to develop our own actuarial basis for sub-capitation or is the state method acceptable?

A Prepaid Health Plan does not "need" to sub-capitate. MDCH allows but does not endorse sub-capitation. CMHSPs need to establish their own actuarial basis for sub-capitation.

34. Page 74, item 3.11.2 - What are your expectations for episodes of care tracking? How often do you expect reconciliation?

The expectations for reporting to MDCH on episodes and costs are addressed in the expected contract attached to the Application for Participation. The expectations of the Prepaid Health Plans' utilization of that information for tracking episodes of care and costs are that it will occur at a frequency sufficient to enable the Prepaid Health Plan to effectively manage the care and cost responsibilities they assume under the contract.

35. Authorization process - If we only authorize inpatient and residential prospectively, can we review all other services retrospectively?

All services of a Prepaid Health Plan must be authorized either prospectively, concurrently, or retrospectively.

36. Page 75, item 3.11.7 - Are we expected to track all other sources of insurance coverage at the PHP level, or can this be pushed down to the provider level?

The Prepaid Health Plan is responsible for assuring all third party revenues are identified and pursued. How this is accomplished and who does it within the Prepaid Health Plan organization is up to the Prepaid Health Plan.

37. Item 3.1.2, page 49 - Last line before the bullet states "or co-occurring MH and SA services." Wonder if this should have stated SA services *generally,* not only co-occurring. If not, why not?

A correction will be listed in a MDCH issued letter. This should have read "...in need of mental health, developmental disability, or substance abuse services".

38. Item 3.5.2, page 57 - What is the "geographic standard" as it applies to SA for each level of care?

The geographic standard is 30 minutes or 30 miles in urban areas; 60 minutes or 60 miles in rural areas.

39. Item 3.6, page 59 - The term customer services is used in both the Implementation Guide and the AFP. However, interchangeable phrases such as beneficiary services and member services have also been used. Is "customer services" the final answer?

Yes, it is customer services.

40. Item 3.6.10, page 61 - What is the distinction between the "Hearing Officer" role and the "Appeal and Grievance Coordinator" role?

A "hearing officer" is the person who renders an administrative decision in a formal appeals process. An Appeal and Grievance Coordinator is a counselor or advisor to the individual on matters having to do with appeals and grievances.

41. Item 3.8.1, page 64, last bullet point - Is it MDCH's intent that applicants have signed agreements from all providers regarding their participation in the network before the MDCH Site Review Visit for the AFP?

No, but there should be evidence that such agreements are in the process of being established and can reasonably be expected to be in place before October 1, 2002.

42. Item 3.10.5, page 72 - Is the definition of "beneficiary" in bullet point number two, Medicaid eligible?

Yes, it means Medicaid eligible.

43. Item 3.12.4, page 80, bullet point #10 - Is the applicant, PHP, expected to credential and privilege all providers in the coordinating agency network?

Yes. The credential and privileging process must include substance abuse licensing and accreditation requirements.

44. We subcontract management of all SA business to our SACA; they manage their own IS and are responsible for all data reporting to MDCH. We have no input, data access, or procedural control of SACA IS. What is our responsibility in responding to the AFP questions, and to describing and documenting the SACA IS in the AFP response and at the site visit?

Whereas in the past a CMHSP may have had only a funding pass-through relationship with its Coordinating Agency (CA), Prepaid Health Plans are responsible for the management of all Medicaid substance abuse services provided in their geographic area. Therefore, the Prepaid Health Plan is responsible for data reporting.

45. Would MDCH please make the complete SACA Contract Reporting Specifications available to CMHs who are not SACAs?

Yes, we will place this document on the web site.

46. Item 3.10.8, bullet 1 - Will MDCH please clarify all the requirements for full compliance with HIPAA Transaction standards by 7/1/02, beyond the requirement to do MDCH Encounter Reporting using the 837v4010 claim format? Specifically, are we required to accept the 837v4010 professional claim from our providers by 7/1/02? If not by 7/1/02, then what is the due date?

The 2001 extension of the MDCH/CMHSP contract requires that CMHSPs be ready to collect HIPAA-compliant data by July 7, 2002, in order to report the data for the quarter at the end of October 2002. The law requires that you be able to accept the 837v4010 professional claim by October 16, 2002.

47. Are we required to accept the 837v4010 institutional claim from our providers by 7/1/02? If not by 7/1/02, then what is the due date?

The law requires that you be able to accept the 837v4010 institutional claim by October 16, 2002.

48. Will MDCH give us a standard procedure code list by 2/1/02, or if not, what procedure codes will meet the standard?

The standard national (HCPCS) procedure codes for mental health, developmental disabilities, and substance abuse that Michigan and other states proposed have not yet been approved by the Centers for Medicare and Medicaid Services. The department will issue "local" codes to use temporarily if it appears that the standard codes will not be approved in time for the July 1 start up.

49. Is the PHP or the Qualified Health Plans responsible for managing the mental health portion of co-occurring disorders for a Medicaid receipt who is NOT SMI? The RFP seems to indicate that the PHP is responsible for ALL Medicaid recipients with co-occurring disorders regardless of the level of functional impairment.

Qualified Health Plan contracts include a limited mental health benefit; they do not include a substance abuse benefit. Please refer to the Medical Services Administration Bulletin on clarification of the mental health services responsibility of health plans and Community Mental Health Services Programs for Medicaid beneficiaries enrolled in health plans. The decision of which entity has responsibility for a given beneficiary is not simply a question of whether the mental illness is "serious" or not.

Where co-occurring psychiatric and substance use disorders exist, the preferred treatment is an integrated approach in which treatment for the combined disorders is provided within a single program. If integrated treatment is not available, and the beneficiary's mental health need can be addressed by the Qualified Health Plan, the PHP would be responsible for providing substance abuse treatment and for communicating with the Qualified Health Plan provider to assure coordination of care.

50. In "Submission of the Document," page 12, instructions state that two hard copies of the application must be submitted on white paper measuring 8.5 x 11 inches. Does MDCH require that these hard copies (economically prepared) be presented on three-hole punched paper in binders or just stapled together?

Submit the hard copies three-hole punched in binders.

51. In Attachment C of the AFP, "Expected Contract Requirements," Beginning October 1, 2002, on page 130, the last bullet point for Section 6.2 Administrative Personnel, says:

- **Customer Services Director and Recipient Rights Officer**

Is this meant to be one position or two? We interpret this to mean two separate individuals with distinct responsibilities.

Depending upon work load this could be either one shared, or two distinct positions. Their responsibilities do differ but in some remote locations it may make administrative sense to combine the duties and functions in a single position.

52. Would you please indicate if we have interpreted this section correctly?

We intend to identify "placement needs" in the PASSAR Level II document for only persons who have received a DETERMINATION from the Department of Community Health-OBRA program indicating "No Nursing Facility" and either "Specialized Mental Health Services" or "Other Mental Health Services".

The PASSAR process does not establish a Care Management relationship between CMH and the person being evaluated. The nursing facility has the primary responsibility for discharge planning and is paid for case management through the Medicaid payment process. Given this, we are uncertain how to outline the "time lines" part of the AFP section referenced. Any clarification of this component would also be appreciated.

Although case management is a function of the nursing facility staff, the Prepaid Health Plan should coordinate efforts with the nursing facility staff for discharge planning, particularly for those individuals receiving specialized services who may require a specialized residential setting. The Prepaid Health Plan should have an individual plan of services developed using the person-centered planning process, in which community placement issues have been discussed in accordance with the individual's desires, needs, and interests. Estimated time frames for discharge can be developed in conjunction with the nursing facility and included in the Application for Participation response.

53. Recognizing that many of the items in Fin. Mgmt. 3.11 are specific to CMHs and their functions as service providers, how is it expected for CAs that are part of affiliates to respond to these items?

The applicant is responsible for responding to the Application for Participation. The applicant must work with the Coordinating Agency in identifying and collecting information needed for the Application for Participation.

54. Would LCC be considered an affiliate? According to the definition in the AFP, it would not because we are not a CMHSP. However, at the bidders' meeting you stated it would depend on our agreement. In the Lakeshore Behavioral Health Alliance agreement, which establishes MCCMH as a PHP, LCC is not mentioned. There is a secondary agreement between Lakeshore Behavioral Health Alliance and LCC for the substance abuse Medicaid funding. Please clarify.

No, Lakeshore Coordinating Council can not be an affiliate. There is only one possibility that a Coordinating Agency would be part of an affiliation; where a current CMHSP that is also a Coordinating Agency is an affiliate under another CMHSP applicant.

55. MDCH stated Parts 1-6 must be done for the application to be complete. I only count 4 parts. Please clarify.

Sections 1 through 4 of the application, plus the appendices (5), and the attachments (6).

56. Regarding capitation payments - It says that this file will be available only to the PHP. Will the PHP receive a distinct/separate PEPM calculation for substance abuse services?

Yes, there will be a distinction to the Prepaid Health Plan. There is no change in the requirement that substance abuse and mental health funding, risk, internal service funds, etc. be maintained separate and distinct.

57. If the PHP sub-capitates for shared risk to its affiliates and CA, please clarify what is meant by "the actuarially-sound methodology and rates for sub-capitation, by contractor, must be submitted to MDCH".

The Prepaid Health Plan can not do sub-capitation with the Coordinating Agency. MDCH strongly encourages CMHSPs to understand the requirements of capitation and the process needed to validate rates. Information is available at CFR 42.434.

58. On page 73, item 3.10.9, what specifically is "the current phase of the MDCH Uniform Billing Project for Medicaid?"

If you have a Children's Waiver Program, you should be compliant with the Uniform Billing Project by February 1, 2002, which is the current phase.

59. Regarding the DEG file: Will a DEG file copy be extractable for subcontracted substance abuse services management use? Will MDCH directly support this as they do now (a separate DEG file is created, multi-county, and allowed to be separately downloaded).

There is no plan to alter the creation and availability of the Data Exchange Gateway files.

60. Will existing CAs be notified (right away) if AFP proposals are received at MDCH which proposes replacement or change in alignment of CAs, without CA involvement or documentation?

No, MDCH will not commit to this.

61. Item 3.11.17 - Question appears to be relevant to affiliations. Is it meant to apply to stand-alone Boards? What is the pertinence of administrative efficiencies already realized to the AFP selection?

This item pertains to all applicants.

62. Item 2.3.4. requires a written plan. Please clarify the elements that must be contained in this Plan; and the criteria by which it will be evaluated?

The plan must describe the applicant's capacity in each item across the service area, goals to increase this capacity, and implementation steps with time lines.

63. Item 2.4.3. refers to an Ombudsman-like office, staffed by primary consumers and/or family members. Our Alliance is looking to install such a capacity as part of our proposal, if given the bid award. However, the capacity is not yet in place. Therefore, should we check yes to this item; or leave it blank, and submit an explanation?

The section should be NOT be checked and an explanation and work plan should be provided.

64. Item 1.13.1 - In the case of an affiliate CMHSP that also provides provider network functions (in an area of less than 100,000 covered lives) do the requirements listed under "Provider Sponsored Specialty Networks" (1.13.1 – 1.13.5) apply?

The requirements listed in 1.13.1 through 1.13.4 apply only to applicants with more than 100,000 covered lives.

65. Item 2.5 - This section requires that the applicant demonstrate that policies have been implemented that assure accommodation of persons who speak languages other than English. We noticed that the contract attached to the AFP (page 131) indicates that "materials shall be available in any language alternative to English when an alternative language-related population comprises one percent of the PHP service area." The required threshold was formerly five percent. On what basis was this change made? What language-related accommodations is the applicant expected to have in place to meet the needs of a sub-population that makes up one percent of its population (e.g., Pacific Islanders)?

The standard for the Application for Participation is the federal limited English proficiency guidance. Please refer to the Department of Health and Human Services Office of Civil Rights guidance published in the Federal Register Vol. 65 on August 30, 2000.

66. Item 3.4.2 - What is meant by "options related to case management arrangements"? Item 3.4.3 - We would like clarification regarding what the expectations are regarding the type of information we are required to provide to a consumer so that he/she can make an informed choice of case manager.

Mechanisms must be in place to assure that consumers are provided information about the role of the case manager**,** have opportunities to meet case managers if desired, have opportunities to choose their case manager, and be informed about how to make a request to change their case manager, if desired.

67. In item 3.8.4 applicants are asked to have policies and procedures including assurances that services (mental health and substance abuse) for the co-occurring population are provided concurrently, continuously, and/or integrated as appropriate. Can you explain the difference and is one method better than the others?

Integrated refers to a service which addresses the mental health and substance use disorders, as well as the combined disorder, within one program, usually with one person responsible for the care. Research shows that outcomes are best when an integrated approach is used. Concurrent treatment refers to mental health and substance abuse treatment being provided at the same time but by different providers. If this approach is used, communication between the two providers is critical to assure coordination of care. Consecutive (not continuous) treatment refers to providing either mental health or substance abuse treatment first, followed by the other. This approach shows the poorest results.

68. When affiliations do not transfer responsibility for GF to the PHP, what will the GF contract look like?

A general fund only contract has not been drafted. If it is necessary, it will be based on the expected contract included with the Application for Participation, but with changes related to financing, along with other provisions.

69. Item 2.41-2.44 applies to all disabilities, including those that may not meet MH Code MI/DD/SED criteria. 2.4.5 refers to MI/DD/SED only. Is this correct?

No, for the purpose of this section only the definition of disability for both items is mental illness, developmental disability, and substance use disorders.

70. If all affiliate members of a PHP meet the contiguity standard of 45 miles, will MDCH consider geographical distance of an affiliate from the PHP when scoring the application? In other words, will distance hurt affiliate/PHP application?

There is a 45-mile condition specified with the contiguity standard. There is also a geographical distance standard in relation to services to individuals in the service area. Both standards must be met.

71. What are the specific restrictions or guidelines as to how the PHP sub-capitates with other county CMHSPs? Capitation payments to the PHP appear to be based on regional intensity factors within affiliations. Therefore, there is a historical funding base that must be protected. In sub-capitation systems, will there be a requirement for transition to a blended rate? If so, what will that requirement be?

A capitation methodology must be based on costs, and be actuarially sound. Section 434.61 of the CFR addresses this issue, and state and federal regulations regarding cost and matchable cost are pertinent as well. The Prepaid Health Plan (PHP) will be responsible for assuring this. Of equal concern are risk factors that are often associated with capitation. If the sub-capitation includes the delegation of risk, it is important that the PHP do so in a way that does not put the individuals needing service at risk, or increase the risk to the MDCH.

72. Please describe how the AFP responses should include activities for subcontractors and their subcontractors for PHPs who delegate direct service responsibility in all or some areas (e.g., evidence of PCP training). Do you want evidence from PCP providers and their subcontractors? When some or all services are subcontracted should the provider role be included each time, when we feel it is applicable, or only in certain areas? Please specify.

The applicant needs to provide evidence of person-centered planning and related activities at all levels.

73. What is the legal basis for utilizing vouchers and/or individual budgets for Medicaid services? How are individual budgets set and can the amount/extent of the budget be appealed under the fair hearing provision?

This information is included in the MDCH Choice Voucher Technical Manual issued in draft form in November 2001. Vouchers are a payment mechanism, not a covered service and not subject to appeal.

74. Page 6 - Applicant term is used intermittently but sometimes the applicant is also a provider and clarification is needed as to when the applicant can respond as the PHP alone (i.e., data flow - must it show the detail for the affiliate regarding authorization or just the PHP system - for instance 3.10.2 linking authorization process is provided).

This question appears to focus on applicants that are part of an affiliation. The directions in the Application for Participation indicate the applicant must respond on behalf of the entire affiliation, which in most cases will mean assuring or providing evidence for each affiliate as well as the applicant. The applicant is responding to the AFP as the responsible managed care entity, not as a service provider.

75. Jail diversion documentation requirements go back to 1998. Will documentation with regards to agreements, cross training need to go back that far or only when that cross training and agreements are available? Does impact of diversion mean summary of what happened to those diverted?

CMH requirements for jail diversion were established in 1996 revisions to the Mental Health Code. Indicate the date when signed agreements were first available and current status. Yes, impact of diversion means summary of what happened to those diverted.

76. The AFP requires that service authorization be performed by someone who is completely outside a service provision chain of command. Will affiliates be allowed to authorize the service they are at risk for or must they contract with an independent authorization entity?

The Application for Participation does not require independent service authorization.

77. What about when Medicaid dollars are de-federalized? When GF dollars are federalized?

Federalizing and de-federalizing dollars impacts Medicaid and general fund formula dollars. This is a routine process in Prepaid Health Plans where all of these funds are within one contract. When it occurs in affiliations where affiliate CMHSPs have not transferred responsibility for general fund formula funds to the Prepaid Health Plan, the general fund formula contract of the affiliate CMHSP will be impacted.