QUESTIONS AND ANSWERS
TO THE
IMPLEMENTATION GUIDE

Revised Plan for Procurement of
Specialty
Prepaid Health Plans

PART I
December 20, 2001

This is the first in a series of answers to questions received in response to the Implementation Guide - Revised Plan for Procurement, issued by the Department of Community Health on October 11, 2001. Additional answers to questions received will be issued as they are available. Any corrections to this document will be included in future questions and answers documents.

General Information on Application Requirements

1. What is the process and time line for the AFP release, MDCH staff review, state advisory panel review, selection and PHP applicant notification?

The following is a summary of time lines.

1/03/02	Send AFP to CMHSPs
Mid-February	Receive applications from CMHSPs
By the end of February	Internal review of applications by MDCH expert teams of three
End of February	Notice to failed applicants (did not meet a numerical threshold); or feedback to applicants who need to re-submit plans, information
March	Site visits to all applicants except those who failed
Mid-March	Revised applications due back from failed applicants
By the end of March	Selection panel reviews applications, and validates internal scoring
April	Selection panel develops recommendations to director for awards
Early May	Awards announced
Summer 2002	Plans of corrections submitted and approved
Mid-September	Contracts signed

2. What are the Evaluation Criteria that will be used to assess the completed AFP applications? If not known now, will the evaluation criteria be issued before and/or with the AFP application?

The Readiness Checklist is a good guide to what MDCH will be looking at in the AFP process. The AFP will indicate the percent of the total score for each major section, and the relative weighting of the section.

3. Will there be a glossary of terms issued with the AFP Application that provides operational definitions for required items (e.g., principal agent conflicts, PCP facilitator)?

A glossary of terms will be included in the AFP.

4. The Implementation Guide refers to a number of documentation requirements in the Readiness checklist. Does this documentation all need to be prepared for inclusion in the AFP application when it is completed? Or is the PHP applicant going to be only required to have it available on site at the PHP for review, if and when requested by the state? Will the state be conducting Site Reviews as a part of this AFP Application Review Process? If so, when would they occur? Who and what would be involved in any such Site Reviews?

Some documentation that is referenced in the Readiness Checklist will be submitted with the application. Other documentation must be available for review by MDCH when it conducts site visits. Teams of MDCH staff will be conducting the site review of each scored applicant to verify information presented in the application and to interview the consumer/advocate/stakeholder group that assisted with the development of the application. The reviews will likely take place the month of March.

5. If a CMHSP's application is rejected, will the RFP for the region have the same requirements as the AFP?

The requirements of the system will be the same, but the process will be different.

6. Will the CMHSP whose application was rejected be eligible for competitive bid?

Yes.

7. What role will the single state Medicaid Authority have in the evaluation of the AFP document, AFP response, and PHP start up and ongoing?

MDCH is the single state Medicaid Agency and as such will evaluate the application and have ongoing responsibility for monitoring the PHP's performance.

8. Will MDCH maintain a library and, if yes, what data will be available?

MDCH will provide some documents on its web site (www.mdch.state.mi.us) or links to sites where critical information is available. The Michigan Association of CMH Boards (www.macmhb.org) will also provide information and links. These resources will be noted in the AFP.

9. In what formats must the electronic version of the AFP be submitted?

Responses must be inserted into the electronic version of the application which will be sent in Microsoft Word 2000. Responses must be submitted in Adobe Acrobat format in "read only"

CDs. All attachments should be converted to Adobe Acrobat PDF and merged into the appropriate PDF document.

10. Who should be represented on the consumer/stakeholder group required for the AFP?

The group must consist of representatives from the target populations of the specialty services program including: individuals with serious mental illness, serious emotional disturbance, developmental disabilities, and substance use disorders as well as family members or community representatives. At least 50% of the group should be comprised of primary consumers.

11. Will the Speciality Services Panel have the final authority to select PHPs?

The panel will review the application and make recommendations to the MDCH director.

12. Who will develop the scoring criteria that the Specialty Services Panel will be using and how will it be developed and what is its composition?

The scoring criteria that MDCH staff will use is being developed internally. Relative weighting of the AFP sections will be made known in the AFP.

13. DMB Role: What role will DMB play in the AFP process, if any? Comment: *It is assumed that DMB will play no role in the Department's AFP process. It is also assumed that should a PHP not meet the requirements of the AFP, then under the competitive bid scenario, that DMB would manage the RFP process. Are these assumptions correct?*

DMB will play a role in two ways: 1) a representative will sit on the selection panel; 2) in the event a region must be competitively bid out, DMB will manage the process.

14. How much time will the PHP be granted to make all AFP commitments fully functional from time of bid award (i.e., 90, 120 or 180 days)?

Some AFP commitments will need to be in place prior to contracting. Others will allow a later implementation date, as approved by the department.

15. Will MDCH send the electronic version to all CMHs or does the applicant need to request it from MDCH? In other words, how will MDCH know who to send the AFP to? Will the AFP be on the web site?

MDCH will send the electronic version to all CMHs and it will be posted on the web site.

16. What process, if any, will be in place for applicants to ask questions about the AFP once it has been distributed?

A bidder's conference will be held approximately one week following issuance of the AFP. In addition questions can be forwarded to MDCH and they will be answered on the web site.

17. Will the site visits to verify AFP responses be to the "hub" board only or to all participating affiliate boards?

The site visits will be made to the applicant and each of its affiliates.

Organizational Status and Configuration

18. Will the AFP instruct applicants to address everything related to substance abuse in the SA section, or should SA also be addressed in other sections as appropriate? The answer to the question has obvious workload implications for how people prepare their responses based on the Implementation Guide.

Substance abuse should be addressed in all applicable areas of the AFP.

19. The introduction paragraphs to Section 1.1. stipulate in paragraph #2 that CMHSPs making or participating in an application must comply with the Code and various other MDCH Certifications, yet these requirements do not appear to be stipulated in the required standards. Therefore, what specifically will be required of applicant CMHs as part of an Affiliation?

Each CMHSP participant within an application will be required to meet: 1) Board composition under Sections 212, 214, 216, 219, and/or 222, as applicable, of the Mental Health Code; 2) Certification criteria based in Section 232(a) of the Mental Health Code; 3) Recipient Rights based in MCLA 330.1232a(6); and 4) all other state and federal requirements.

20. Item 1.1.1. stipulates that an individual CMH making application that plans to out source some ASO functions, must have a competitive procurement plan. This does not show up in Item 1.1.2. Why not? Will it apply to affiliated PHPs?

Inclusion of the same statement for out-sourcing external to the affiliation would be applicable for this provision pursuant to federal requirements.

21. Item 1.1.1.stipulates that an individual CMH making application that is also providing direct services must have a firewall that contains structural integrity to maintain the integrity of beneficiary interests and organizational vs. public policy interests. This Standard does not show up in Item 1.1.2. Why not? Will it apply to affiliated PHPs?

Inclusion of the same statement would generally be true and should be considered and evident in organizational structure and policies which translate into practice. The legal affiliation agreement could impact greatly on applicability for this item.

22. Item 1.1.2. makes reference to "cost allocation methodologies" and "resource/assets claims." Please provide an operational definition and criteria for these terms?

Cost allocation methodologies are the processes used to distribute non-direct costs between/amongst participating agency programs or within an organizational entity. Specifically,

this is a requirement for reporting of program administrative costs pursuant to OMB Circular A-87 and the principles for cost accounting in OMB Circular A-133, which require the reporting of cost by program and set standards for the allocation of overhead and shared administrative costs. For affiliation, there will likely be a higher level of applicability of formula(s) based on the legal and operational structures.

Resources/assets claims involve financial arrangements including funding distribution methodologies for revenue allocations and asset commitments at the time of entry, during, and at dissolution of the arrangement.

23. Item 1.1.3 Verifying Covered Lives. What was the consideration for reducing the variance percentage?

The covered lives will be 20,000 without a variance percentage. This is consistent with the waiver renewal.

24. Exactly when and how (prior to formal AFP submission) can applicant CMHSPs obtain verification that their affiliation will or will not be determined to "meet applicable contiguity standards?"

There might be two different occasions, once at the time of intent status (December 1) and once at the time of application. In either case, the department expects to notify the applicant of not meeting the criteria within one week of the applicant's submission.

25. When is the 20,000 Medicaid covered lives requirement to be measured/applied, as of: (a) the date of the issuance of the AFP? (b) the date of the submission of the AFP? (c) the date of the "determination" made by the Public Act 409 panel? (d) the beginning of the contract period? or (e) continuously throughout? If (e) what effect would reduction of the number of covered lives below 20,000 have on the capitated PHP contract in effect?

The number of Medicaid eligibles will be the highest value in FY 01-02 , including individuals who are categorized as retroeligibles. It will also include any spend downs if they met the spend down requirement, therefore becoming retroeligible.

26. The MDCH site reviews and recipient rights reports on our most recent reviews have not been received. When can we expect written confirmation that we have passed those reviews?

MDCH commits to completing and distributing reports for any review completed during the FY 00-01 by the beginning of January 2002.

Public Policy Management and Public Interest Considerations

27. Item 1.2.1. requires full compliance with Person-Centered Planning (PCP) Guidelines, which currently contain 17 of 17 standards. Currently, only one (1) CMH in Michigan is in "full compliance." The current baseline of "full compliance" is totally subjective, with no objective measurement criteria provided the CMH system. Will MDCH issue objective measurement criteria to illustrate full compliance at time of AFP issuance? What are the 17 elements of person-centered planning? We do not believe those are specifically identified in the Department's Person-Centered Planning Policy.

The MDCH looks for evidence of compliance with the 17 standards when reviewing individual clinical records during the annual site visit. If evidence is present in all clinical records, a CMHSP is given compliance with the standard. The protocols being used to measure PCP are the objective criteria. There is no intent to change the process or protocols at this time. The site review protocols are taken directly from the Person-Centered Planning Guideline, issued by the Department of Community Health. Future performance on person-centered planning will be judged by the updated guideline which will be attached to the AFP. The 17 elements of person-centered planning are the minimum standards that are cited in the site review protocols (Section C of the MDCH site review protocols). The 17 elements are based on the Person-Centered Planning Practice Guideline.

28. Item 1.2.1. uses words such as "conflict of interest provisions" and "principle agent problems" in defining supports coordination and case management. What principle agent problems are you referring too? Can you please identify and list?

Michigan's "Revised Plan for Procurement of Medicaid Specialty Prepaid Health Plans" (September, 2000) identified principle-agent issues in the proposed model for procurement. This AFP process is based on an eligibility model for specialty services with a single PHP per area approach. Under this model the selected PHP is the "agent" charged with acting on behalf of the "principle" who is the beneficiary with a serious mental illness, serious emotional disturbance, developmental disability or substance use disorder. Principal-agent problems arise when the agent acts primarily for its own benefit or interest, rather than in the interest of the beneficiary whom it is supposed to serve. Within this framework for specialty PHPs three problematic principle-agent situations are anticipated:

----Access and Eligibility Decisions

----Application of Person-Centered Planning

----Plan Implementation (including disclosure of options and resource allocation)

The Applicant is also expected to have policy in place which is in compliance with Public Acts 317 and 318 which deal with conflict of interest.

29. The Guide discusses concerns regarding "principal agent" issues relative to the "enabling" services of case management and supports coordination. Is a subcontracted CSSN/CMHSP precluded from providing such services as part of the full service array to those beneficiaries it serves under its subcontract to the PHP?

The PHP must assure that all individuals eligible for services are offered a choice of case management and supports coordination provider agency, as well as choice of case manager. The PHP must assure that the case manager acts on behalf of the individual rather than the PHP, CMHSP or provider.

30. Item 1.2.1. references "plans for full compliance for the Olmstead Decision." Can MDCH provide its plan(s) for full compliance before, or as part of the AFP, so a PHP can be consistent with state public policy in its submittal?

State public policy, as outlined in the Mental Health Code, requires CMHSPs to develop plans for providing community-based alternatives for persons who no longer need institutional care. AFP responses are expected to provide information as to the status of such plans.

31. Item 1.2.1. does not clarify the data requested on all "source areas" as being only Medicaid program specific. The PHP is only making application to manage the Medicaid program, and does not have access to GF or "other" types of data, nor does it care about these areas as a specific fund manager. Therefore, please clarify what data is being requested, from what program funding streams? It is presumed the data requested in this section only applies to Medicaid program data. Is this assumption accurate?

Both general fund and Medicaid data are relevant to the application. This application for participation is targeted exclusively to Michigan CMHSPs in compliance with Michigan's Section 1915 (b) Capitated Waiver Program-Waiver Renewal Submission to the Centers for

Medicare and Medicaid Services (CMS) in September 2000 and in the waiver approval letter from CMS received in February 2001. In its application, Michigan proposed that a first opportunity should be afforded to CMHSPs since these entities sustain local systems of care and have: the necessary expertise with the target populations; strong coordination linkages with other community agencies; control of other resource streams (i.e., state funds); already made durable investments in specialized care management strategies and unique service/support arrangements; and statutorily prescribed protection, equity, and justice functions.

32. Item 1.2.1. references "community benefit." This is not a defined Medicaid benefit as either a mandatory or alternative service(s). Please clarify how this pertains to the AFP?

In its effort to obtain approval from the Centers for Medicare and Medicaid Services (CMS) for a continued deviation from federal open procurement requirements, MDCH proposed to restrict initial consideration as a PHP to CMHSPs. As part of its argument to provide this unique opportunity to CMHSPs, MDCH noted that CMHSPs had historically provided many "community benefits" that would not be provided by other potential bidders if the state were required to shift to a full and open competitive procurement process in selecting PHPs. The AFP, therefore, will need to document that "community benefits" are occurring.

33. Item 1.2.19.4 uses the term "relapse prevention." Can this term be operationally defined, in terms of the Medicaid benefit plan?

Relapse prevention is a systematic method of teaching individuals in recovery to recognize and manage relapse warning signs encouraging association with others is recovery, employment assistance, preventive counseling and other activities that support recovery. The AFP will request that applicants have policies and practices that address "relapse prevention" as a value and an agency philosophy rather than as a specific Medicaid benefit.

34. Item 1.2.20. refers to a number of ancillary or non-covered services. Can these activities be operationally defined; and how do they fit into the context of the existing Medicaid Benefit Plan?

Figure one on page 7 of the guide describes the AFP qualification requirements in four domains. Activities listed in item 1.2.20 are an important part of the public policy management roles of a PHP.

35. **Item 1.2.4.2. - The dialogue is confusing in an AFP. Is there an expectation that site visits will look for these "seven questions"? Is there free range on allowed covered services? How far should the PHPs take person-centered planning?**

The seven questions were provided to assist CMHSPs to assess their own organizations in identifying gaps that prevent the implementation of person-centered plans. If a question was answered with a "no," the CMHSP could target organizational changes, administrative improvements, or training activities to assure person-centered plans are being implemented.

36. **Item 1.2.6.3 - How do we show "greater choice"?**

Choice is based on the number of providers within reasonable distance that offer equivalent services that meet the needs of the individual. "Need" can be clinical or related to gender, ethnicity, LEP, or other factors. Beyond this, the initial MDCH proposal to CMS provided for no choice in selecting specialty prepaid health plans and the department is required to assure choice of providers within plans.

37. **Item 1.2.20 - Is there an implication that as a PHP these activities should have occurred?**

In its effort to obtain approval from the Centers for Medicare and Medicaid Services (CMS) for a continued deviation from federal open procurement requirements, MDCH proposed to restrict initial consideration as a PHP to CMHSPs. As part of its argument to provide this unique opportunity to CMHSPs, MDCH noted that CMHSPs had historically provided many benefits that went beyond the typical covered Medicaid benefits including the activities listed under 1.2.20 that would not be provided by other potential bidders if the state were required to shift to a full and open competitive procurement process in selecting PHPs. The AFP, therefore, will need to document that these activities are occurring.

38. **Item 1.3.2. does not reference the term "CSSN." Will this be a term used in the AFP as it was in the previous Guide to Procurement document? If yes, can MDCH provide an operational definition and measurement criteria on the use of this term?**

The term will not be used in the AFP. The term reflects a concept of affiliation among a group of CMHSPs, and that concept is addressed in the AFP. MDCH does not intend to use or reference this term in the final AFP.

39. Within the context of 1.3.2.1., should the PHP permit the CMHs to continue to manage their own local networks, must this PHP administrative function be subject to procurement guidelines, as contained in Section 1.1.1.?

The answer to the above question depends on the degree to which the legal arrangement (ICA or ITFRA) that establishes an affiliation specifies the responsibility for those functions, and the degree to which MDCH determines through the AFP process that the arrangement reflects sound practice with regard to efficiency and effectiveness. If these are affirmative, the answer regarding procurement is no.

40. Item 1.3.1.2. refers to a "network plan." Can MDCH provide an operational definition for this term; and the criteria on how will it be measured in the AFP?

The "network" is the constellation of contractual service providers and those services provided directly by the PHP and affiliated CMHSPs, that assure access to the full service array within the service area in accordance with time and distance standards. The network development plan is described in some detail in sections 1.3.2.1 and 1.3.2.2 of the guideline. The guideline gives special attention to the need for and value of such a plan. A similar plan must exist concerning the management of the provider network to assure that expected outcomes are being achieved. This is also noted in the guideline and may have been overlooked by some CMHSPs because it mistakenly became part of section 1.3.2.2. which pertains to PHPs with more than 100,000 lives. Please be aware that the Network Management Plan provision at the end of Section 1.3.2.2 in the guideline is intended to apply to all applicants.

41. What defines an "out of network" (i.e., not on our panel), from an "out of area" provider (i.e., no jurisdiction)? Can MDCH define these two terms on how they are similar/different?

An out of network provider is a provider within the service area that has not been empanelled by the Applicant. An out of area provider is a provider located outside the service area. It is important that the Applicant have mechanisms in place to assure that people needing a service from an out of network provider or out of area provider can have that issue addressed in a fair and timely manner. These mechanisms must be able to address medically necessary services that the Applicant cannot provide within the network or service area, and specific requests from recipients/families for out of network or out of area providers.

42. **Item 1.3.15.1 & .2 - services delivered by MDCH providers (consumer run programs and clubhouse), how does their inclusion or funding fit into this waiver? What part of General Funds will be in PHP waiver?**

The above-named services and additional services to be provided are described in Chapter III of the Medicaid Manual and in the MDCH contract.

43. **Is "specialty mental health or substance abuse services" simply an implied term throughout the document, when the document itself simply mentions "medically necessary services?" Is this term distinguished from QHP responsibilities?**

It is important to recognize the context for the procurement plan and AFP document is the MH/SA carve out.

44. **The Guide states that "the PHP will be required to submit audited financial statements to establish financial status, solvency, and future viability." What standards/amounts will have to be met by an applicant PHP to comply with these requirements? Where can these be found?**

Applicants and affiliates will need to demonstrate their financial position from existing documentation and practices. New requirements are not planned unless MDCH findings reveal the need for additional precautions.

45. **The Guide states: "The specialty PHP must certify that budgeting, accounting, and costing systems comply with applicable state and federal laws and regulations, and are consistent with established professional standards? Can MDCH direct applicant PHPs to the major applicable state or federal laws or otherwise indicate where the standards to be met can be found?**

The standards are identified in state and federal statutes and regulations that impact CMHSPs, including the Mental Health Code and Medicaid manuals. Also, those noted in the contract, and those identified in documents referenced in the contract.

46. **Item 1.3.23 - What requirements will be established about risk reserves? How will affiliates be allowed to shift risks into the PHP? Item 1.3.23 on p. 33 of the Guide states: "The PHP must submit a risk management plan … for controlling risk, … (to)**

include … fiscal mechanisms (e.g. internal service fund, reinsurance, risk pools, etc.) utilized to monitor and manage uncertainty." Will the PHP have access to the balance of CMHSP internal service funds in existence at the beginning of the contract? Will there be prescribed "fiscal mechanism" or standards that will be required? If so, what are these standards and/or where can they be found? Will they include specified reserves, etc.?

The applicant will be required to document risk protection mechanisms such as ISF funds and reinsurance. The internal service fund risk reserves that exist on September 30, 2002, may be continued under the new contract, up to the level justifiable by Governmental Accounting Standards Board 10 and the current internal service fund technical requirement in the contract. For affiliated CMHSPs, established internal service fund risk reserves shall be transferred to the prepaid health plan between October 1, 2002 and March 31, 2003, up to the level justified by the Governmental Accounting Standards Board 10 and pursuant to the affiliation agreement. The portion of funds eligible for transfer will depend on the scope of financial management transferred by affiliation agreement to the prepaid health plan which may be limited or inclusive of general fund and corresponding local funds. A three party agreement consistent with that used for the coordinating agency internal service fund transfers will be employed. The portion of MDCH risk reserve funds not transferred by March 31, 2003, will need to be returned to the MDCH unless they are enabled by the CMHSP contract with MDCH.

47. **The AFP Readiness Checklist acts "as if" rates and arrays of covered services and eligible members will be negotiated. Is it true that funding will be received predicated on historical amounts, cover essentially the same services during a time in our state where eligible plan members are likely to grow? If it is, what can be done to encourage improvements in our performance? Will historical rates be adjusted for capitation or clients seen to move dollars to historically underfunded areas?**

The current perspective is to expect no change in current capitation rates. This will be addressed in the AFP.

48. **Are there any limitations on how risk can be delegated? How small a coverage area will be allowed for sub-capitation?**

Risk delegation and risk sharing within affiliations are issues that ICA and ITFRA agreements need to address in a clear manner. An applicant may sub-capitate for shared risk with affiliates

or established risk-sharing entities. The actuarially-sound methodology and rates for sub-capitation, by contractor, must be submitted to the MDCH. The MDCH retains the right to disapprove any sub-capitation arrangement when it is determined that the arrangement has a high probability to adversely impact the state's risk-sharing. Sub-capitation rates shall be reasonable when compared to other service rates for similar services. Sub-capitation shall not contribute to risk reserve accumulation that exceeds seven and one-half percent (7.5%) of annual per eligible/per month, or an amount consistent with Governmental Accounting Standards Board Statement 10, whichever is less, within the applicant's region.

49. Item 1.3 - The various Department's administrative requirements contained in the original revision of procurement guidelines are not contained in this Section. Please clarify MDCH functional requirements for the following administrative areas in lieu of its pending MDCH contract for FY 03:

--Care management (including Access, UM and UR)

--Quality Management

MDCH issued only one version of the Implementation Guide dated 10-11-01. Please refer to this document.

50. Item 1.3.1. to 1.3.1.4. describes access capabilities in terms of "timeliness" in terms of federal and state standards. Can MDCH clarify how federal and state "timeliness" standards are different, and which will be the most restrictive the PHP will be expected to adhere?

We are not aware of any "timeliness" standard differences but, if they exist, federal requirements always supercede state requirements.

51. Page 27 of the Guide's AFP Readiness Checklist indicates that PHP applicants must have complied with the 17 elements of person-centered planning in the past three years. What does "have complied" mean? When the MDCH Report Card was issued earlier this year, there were four categories of rating: excellent, good, fair, and poor. Does "have complied" in the past three years mean a rating of fair, good, or excellent?

The Readiness Checklist references compliance with the 17 elements of person-centered planning as found in MDCH's site review process, not the draft report card. Scores in the site

review process are full compliance (all standards are met), partial compliance (at least one standard is out of compliance), and non-compliance (all standards are out of compliance).

52. **The Implementation Guide does not delineate the specific Benefits for the various Medicaid Plans that are contained in the State Plan; nor does it specify the eligibility requirements for the Medicaid populations to these respective Plans. As such, will the Plan(s) Benefits and population eligibility criteria be specified and delineated in the AFP? Otherwise PHPs are being asked to bid on "open plans" that can be modified by the State up to and/or during the AFP bid process; or, benefits that are open to interpretation on a regional basis. Our Alliance CMHs have realized through Administrative Law Judges, and the Fair Hearing process, that the Judges believe there exists expanded benefits in the State Plan, from those benefits detailed in the MSA Chapter III Bulletin and/or current CMH Contract. Therefore, they use the State Plan as their definition. As such, will MDCH specifically delineate the Benefits of each Plan(s) and the respective Plan(s) consumer eligibility requirements in the AFP? Will MDCH provide each bidding PHP the most recent copy of the Medicaid State Plan at the time of the AFP issuance? In light of the above question, specifically, are Housing Subsidies a mandated sub-benefit under the "Housing Assistance Benefit?" Is Housing Subsidy a required (or optional) benefit? If required, can the PHP put any limits on the amount a participant can request per year *(e.g. Medicaid is program for the "poor." Can consumer's request middle and upper class benefit payments that exceed local market averages)*? In light of the above, can MDCH please define "Housing Subsidy" and "Housing Assistance," for the PHP and CMHSP system?**

Services to be provided are those included in Chapter III of the Medicaid Manual and the MDCH contract. Housing assistance is an alternative to the state plan benefits. The assistance includes a number of flexible options to be considered by the consumer and CMHSP, depending upon his/her medical need. The Medicaid program is considered payer of last resort after all other resources have been exhausted.

53. **Children's Waiver: Will the PHP be expected to manage the FFS Children's Model Waiver Program as part of its fixed PEPM base; or will this historic FFS system remain outside the funding purview of the PHP, and be a direct contract to each CMH, as a freestanding FFS program?**

Children's Waiver remains FFS outside this capitation.

54. Item 1.3.1. stipulates "enabling services." Can MDCH provide an operational definition and criteria for this term and how it will be used in the AFP?

This term deals with having systems in place which promote or make it easier for consumers to access services. We will either provide an operational definition in the final AFP or we will not use the term in the final document.

55. Item 1.3.1. stipulates "provision of all covered services to eligible populations." Again, can MDCH define all "covered services" they expect the PHP to provide; and an operational definition of "eligible populations." Can MDCH provide detail on how this requirement will be measured and assessed?

Covered services and eligible populations are as defined in Chapter III of the Medicaid Manual.

56. Item 1.3.1. stipulates the PHP must provide assurance that covered services meet "structural integrity" and "model fidelity" criteria developed for those programs. Can MDCH provide an operational definition of these two terms, and the criteria they are referencing?

The criteria are as defined in Chapter III of the Medicaid Manual.

57. Item 1.3.1. uses the term "PCP Facilitator." The Guide states that "the PHP must offer beneficiaries the option to choose a PCP facilitator who is external to the specialty PHP *or* its provider network? Can a beneficiary be offered a PCP facilitator that is external to *either* the specialty PHP *or* its provider network, but not necessarily both?

Yes. Please refer to the MDCH Person-Centered Planning Guideline for more information.

58. Item 1.3.2. does not reference the term "best value." Will this be an imposed concept that the PHP must adhere to in its AFP submission? If yes, can MDCH provide both an operational definition and measurement criteria on this term?

Yes, obtaining best value will be expected and an operational definition will appear in the AFP glossary.

59. **Item 1.3.10 - If we are at risk for service delivery, why aren't we organizing and overseeing the EPSDT screeners? Since we are not currently coordinating their understanding of their (or our) jobs, what are the parameters of our financial exposure to their recommendations?**

EPSDT screening is much broader than just mental health and substance abuse services.

If a person was screened and believed to be at risk, the PHP has an obligation to screen (evaluate) and, if appropriate, provide them with the mental health and substance abuse services they require.

60. **Item 1.3.21.4.2 - outcome data - Will there be separate funding for such outcome studies, since such independent evaluation is a requirement of CMS?**

No, there is no separate funding for PHP outcome studies. The MDCH pays for and conducts independent evaluations.

61. **The Guide states: "certain roles and activities are (from a contractual perspective) primary and *cannot be delegated or diluted*." Can you identify or indicate how an applicant CMHSP can identify these?**

Contractually the applicant will be responsible for all terms and conditions of the state contract. Therefore, an applicant cannot "delegate responsibility" for any provision and must exercise diligence in what roles and activities they delegate or share externally which could increase the possibility of failure; financially or otherwise. The applicant must know what can create adverse impact and related risk/benefit of such action.

62. **The Guide states: "The AFP will require (and verify) that applicant CMHSPs have sufficient administrative capabilities and operational expertise … ." Since investing in the fully operational administrative capabilities that will be required if approved as a PHP will necessarily divert these "investment" funds from other uses, will applicant CMHSPs be penalized or precluded from AFP approval if they wait until such approval before spending these funds? Reworded, when will the AFP require on-site**

“verification” of fully operational administrative capabilities and operational expertise?

The AFP will contain expected dates for the applicant to have operational expertise.

63. How will Public Act 423 funds, earned interest and general fund redirect arrangements be handled in stand-alone and affiliation arrangements?

Public Act 423

Public Act 423 grant funds will continue to be earned by participating CMHSPs that bill and collect first and third party revenues. For affiliated CMHSPs, those grant funds may be transferred among the affiliated CMHSPs that are enrolled Public Act 423 participants if methods and procedures are clearly specified in the affiliation agreement.

Earned Interest

Earned interest will continue to be available to CMHSPs as a source of local match. For affiliations, interest earned by the prepaid health plan can be transferred to affiliated CMHSPs to the extent that methods and procedures are clearly specified in the affiliation agreement.

General Fund Redirect

General fund redirect of Medicaid state match will continue to be an available option for CMHSPs that overspend general fund finances. However, for affiliations, this option is limited to the applicant unless the affiliation agreement transfers responsibility for the general fund dollars to the prepaid health plan and MDCH contracts for affiliate(s)’ general fund dollars with the applicant.

Regulatory Management

64. When describing the "tools" the Guide states that a PHP might use "voluntary commitments." Could MDCH operationally define these two "terms" and the criteria by which the PHP will be evaluated?

The PHP should have a plan for how it monitors the issuance of new rules and regulations; and how it will assure that affiliates and providers are in compliance with regulations (e.g., via contract, voluntary commitment, monitoring).

65. As a means of increasing administrative efficiency, can an Alliance/Affiliation create a central Corporate Compliance Office for the region; or will CMHs still be expected to have their own local capacities, per the terms of their GF contract with the State?

An affiliation can have a central corporate compliance office or one corporate compliance officer for the region or affiliation. Regulatory management is a PHP function whether the PHP is a stand alone or the lead in an affiliation.

66. How does the Department know if the PHP/CMHSP is in compliance with federal regulations?

The Department conducts annual site reviews of the CMHSP during which compliance with selected federal regulations is reviewed. Federal agencies from time to time also conduct reviews of entities receiving federal funds.

67. What is the State's own Corporate Compliance Plan, and how does it implicate/commit PHPs as part of its structural response? Will these implications and/or commitments be provided in advance to the PHPs, as part of the AFP issuance?

Compliance is routinely assessed through MDCH internal audit, Office of Auditor General audits, routine inventory by federal agencies, such as the Centers for Medicare and Medicaid Services, Community Mental Health Services Administration and other state and federal agencies.

68. **If the proposed BBA-CMS rules become Final Rule between now and the AFP release, what changes to either the AFP and/or MDCH Contract does MDCH envision?**

The department will review the Rule when it becomes final, and then take appropriate steps to assure that all applicable entities are in compliance.

69. **Accreditation: The Implementation Guide is silent on MBHO Accreditation for the PHP. Will national Accreditation be required of the PHP for its MCO/MBHO component? If yes, what Accreditation organizations will be recognized by MDCH for MCO functions, and by what date will Accreditation be required of the PHP's MBHO/MCO component?**

At this time, the department has no plans to require MBHO accreditation for the PHP.

70. **The tools to promote compliance are not clear. Can this be clarified in the final AFP? (Example: voluntary commitment to compliance, surveys - how is that different from audits?)**

Applicants will be asked to have a plan that spells out the strategies they will employ to assure that affiliates and providers are compliant with regulations. The obvious strategies are contract language and periodic monitoring, but there may be others that the applicant develops.