

**QUESTIONS AND ANSWERS  
TO THE  
IMPLEMENTATION GUIDE**

**Revised Plan for Procurement of  
Specialty  
Prepaid Health Plans**



**PART II  
January 7, 2002**

*This is the second 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 question and answer documents.*

## **General Information on Application Requirements**

- 1. Will Medicaid dollars be given to PHPs on a regional PEPM (for that affiliation) or be given to PHPs on each individual county's PEPM? Will further dollars be on regional PEPM for new eligibles? PEPM Rate Structure: The Implementation Guide is silent on how "pricing" will be handled in the upcoming AFP. How will the Department develop the "regional PEPM rate structure" for the Medicaid program?**
  - A) Is it the intent of the Department to set the Medicaid regional rate structure for each PHP? If yes, then on what basis and formula? How will historical formula factors be merged into the new regional rate structure? What actuarial data will be utilized, and by what date will this data/information be presented to the PHP, so it can determine "if" there is an actuarial soundness to the proposed rate structure for its contract negotiations with MDCH? OR**
  - B) Will the Department expect each PHP to submit its own PEPM regional rate structure proposal. If yes, then what factors or formula assumptions will be required of the PHP in its cost submission (i.e. formula factors for rate determination; actuarial rate verification; etc.)? AND**
  - C) What process does MDCH intend to use to negotiate the PEPM rate structure, before it deploys the final Medicaid procurement option of "best and final offer" to each PHP, should disagreement over the regional rates exist? AND**
  - D) Will the proposed regional rates be expected to be obtained (or submitted) at some reduced value over historical average costs, similar to how MDCH/DMB managed the Health Plan RFP? If so, what is the target formula being projected (i.e. 98%; 95%; 90% of historical costs)? Conversely, if a region's rate structure is below state averages, can it expect the PEPM rate structure to upwardly adjusted (i.e. 102%; 105% or 110% of historic payments)?**

The base capitation rates and methodology will remain unchanged for fiscal year 2003. The intensity factors will change as required by the contract. Affiliation capitation payments will be derived from a new intensity factor for the consolidated service area that will push the same

level of funding (within rounding limitations) as the sum of the current individual rates. The data files distributed through the Data Exchange Gateway will be a single file for each consolidated service area. This file will be available only to the PHP.

**2. Who will be on the site visit teams? Is that the same as the statutory selection panel?**

It is planned that MDCH staff will be on the site visit teams. The teams are not the same as the selection panel. The teams' findings from their site visits will be provided to the selection panel for their consideration.

**3. How will DCH assure that the affiliation agreement documents meet legal standards/law (i.e., affirmative letters from corporate counsel)? What is required as "legal proof" for an affiliation at time of AFP (i.e., is a JOA adequate? A hub and spoke contract?)?**

One of the three formal legal agreements identified in the Implementation Guide is required. A "joint operating agreement" has no legal reference and is generally used in situations where efficiencies can be attained on goods, supplies, or services which are not as technical as this undertaking. Written documentation from corporate counsel must exist for the state to review. MDCH may also request Attorney General consultation should issues arise.

**4. In cases where a hub board is administering the Medicaid contract for an affiliation, is it advisable, expected, and appropriate for the ITFRA contract to provide for the general fund dollars to also be transferred to the hub to administer the program uniformly?**

This will depend on local determination. It is strongly encouraged that affiliations consider this as a significant opportunity to achieve financial and organizational efficiencies and financial and operational benefits in managing the application of funding streams to address service needs.

**5. In a hub and spoke can one compliance officer function as CO for the PHP and its affiliates? Can the CFO?**

Yes, one individual can function as the compliance officer for the PHP and its affiliates. The same is true for the chief financial officer and other administrative positions.

**6. Can a PHP in an affiliation sub cap CSSNs? PHP/Provider Payment Methodology: The AFP is silent upon what payment methodologies the PHP can or cannot use with its provider panel, and its CSSNs in specific. In an Alliance affiliation that exceeds**

**20,000 lives in total, will sub-capitation payment structures be available to the PHP, even if the CSSN for their geographic catchment area falls below the 20,000 covered lives threshold?**

- A) What will be the pricing and payment methodology parameters of the AFP, so the PHP's can adequately plan its configuration and subsequent response? When will MDCH inform CMHs of any payment methodology limitations, parameters or threshold requirements?**
- B) Should sub-capitation under a less than 20,000 covered life scenario be considered "illegal," then it is presumed that "global rate contracting" is a viable alternative. Is this assumption accurate?**

An applicant may sub-capitate for shared risk with affiliates or established risk-sharing entities. An actuarially-sound methodology and rates for sub-capitation, by contractor, must be submitted to MDCH. 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 percent) 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.

**7. Can PHP bid on CSSN contiguous but not participating?**

The two factors are contradictory; "Comprehensive Specialty Services Network" and "not participating". A Comprehensive Specialty Services Network by definition requires participation. The Application for Participation process is voluntary for CMHSPs.

**8. Who will be available for consultation when we have questions?**

Questions will be answered in the bidders' conference to be held on January 10, 2002, at 10:00 AM in the G. Mennen Williams Building auditorium in Lansing. MDCH staff will answer questions and post questions and answers on the web site. Consultation and technical assistance will not be available until after awards are announced in May.

**9. For contracts covering multi-CMHSP affiliations, will the contract holder report financial and other data on the covered area as a whole or will financial and other data need to be reported, segregated, by CMHSP areas?**

It is preferred that all performance indicator, consumer level demographic and service use, and

sub-element cost data be reported by the PHP. Sub-element cost data will need to be disaggregated by CMHSP as it is required to be reported at that level by the Appropriations Act boilerplate language.

**10. Will Medicaid funds be limited to direct and indirect prevention activity only for persons on Medicaid who meet medical necessity criteria?**

The Implementation Guide does not change present practice on this issue. For direct prevention the funds must be directed to the Medicaid population. For indirect prevention, Medicaid funds can be used in proportion to the target population that is Medicaid eligible (estimated proportion in the absence of other indicators).

**11. Can such prevention activity be targeted to all persons on Medicaid and if so what type of proof should we have to support this expenditure of Medicaid funds?**

All Medicaid beneficiaries are eligible to receive prevention services, within the boundaries of policy and contract. The type of documentation showing that prevention services were provided to eligible individuals would depend on circumstances. If direct prevention services are provided to individuals or to small groups, then evidence of Medicaid eligibility (such as a copy of the individuals' monthly Medicaid cards) should be placed in the file. If indirect prevention services are provided face-to-face in large group settings or are provided via mass mailings, then other documentation (such as meeting agendas, invitation lists, sources of mailings lists) could be appropriate if it shows that Medicaid eligible individuals were targeted.

**12. Will Qualified Health Plans continue to manage part of the behavioral health benefit? Has this policy decision been made? If they will, is there an expectation that they will also engage in behavioral health prevention services?**

Qualified Health Plans will continue responsibility for the limited mental health outpatient benefit (up to 20 visits). CMHSPs should coordinate such services, including prevention, with Qualified Health Plans in their service areas.

**13. MDCH Specialty Contract for FY 03: Will the proposed Medicaid Specialty Contract be made available at the time of AFP release? Will this be a contract negotiated with the MACMHB-CFI Committee prior to AFP release; or is it the intent of MDCH to negotiate the contract with each PHP, as part of the AFP bid/award process? What additional requirements will be in the MDCH Contract that are not delineated as PHP management requirements in the AFP; or, will the AFP contain all specified requirements?**

The Application for Participation includes (in Attachment C) contract requirements expected for the contractor. The Application for Participation will also be considered part of the contract. The contract requirements will be similar to the contract sent to CMHSPs last August, with some changes based on feedback for CMHSPs.

- 14. Medicaid/GF Fund Conversion: Currently the CMH Contract allows PHPs to “unbundle” their GF matching funds from their PEPM rates, if at year end it appears that Medicaid lapse exists, and insufficient GF funds are available. Will this practice continue in the FY 03 Contract? If yes, with the Department contracting directly with CMHs in FY 03 for GF, how will this practice occur at the regional/local level?**

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.

- 15. ISF Accounts: With forced PHP regionalization, what parameters/guidelines is MDCH planning to issue regarding the already existing ISF accounts that are configured with Medicaid, GF and local funds? Will the Medicaid ISF account funds be handled similar to when CMHSPs assumed management of the Substance Abuse-Coordinating Agency ISF accounts? Will MDCH play a similar role in the transfer of these funds (i.e. development of a master agreement; third party to the Agreement; coordinate transfer process; etc.)? Comment: It is currently presumed that MDCH will facilitate a pass-through and fund-transfer arrangement of these ISF Medicaid funds from each CMH to the regional PIHP, similar to how Substance Abuse ISF account transfer occurred back two fiscal years ago? Is this assumption accurate? If not, what guidelines or process is MDCH planning to use, and will this process be made available at the time of AFP issuance?**

The Application for Participation does not force regionalization. It is a voluntary application process in which Community Mental Health Service Programs are offered a first opportunity to apply.

The internal service fund risk reserves that exist on September 30, 2002, (this date listed incorrectly in the Application for Participation) may be continued under the new contract, up to the level justifiable by Governmental Accounting Standards Board Statement 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 Statement 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. See also Part 1 question and answer number 46.

- 16. If a CMH drops out of an affiliation but the counties it serves are within the 45 mile contiguity requirements, can the affiliation “bid” on those counties and identify the CMH as a proposed provider?**

No.

- 17. Is there an expectation that there be the same “benefit package” across the affiliation?**

The MDCH will expect that people throughout the consolidated service area have access to the full array of services that meet program and access standards as specified in the contract.

- 18. Can PHPs also fulfill the role of providers of direct services (pg 9)?**

PHPs are not prohibited from being service providers within the provider network. However, those that choose to do so must have an organizational arrangement that enables clear separation of the managed care and service provider responsibilities. Such separation is essential in avoiding principal-agent problems, the appearance of conflicts of interest, assuring uniform network management, and for costing purposes.

- 19. Paragraph 1.2 - last paragraph states: “Description of how state general fund and Medicaid savings were reinvested over the past three years...” a) State general fund is required to be the first GF dollar out in the following year. It is not specifically directed at anything in particular and is not a part of the “reinvesting strategy”. Clarification?**

If the above statement reflects the manner in which your general fund carry-forward was used, then that will presumably be included in your answer to questions about reinvestment.

- 20. Does the “last three years” mean FY 99, 00, and 01? If so, the 2001 Medicaid savings may still be in the process of reinvestment rather than “reinvested” since we will be filling the AFP during FY2002.**

Yes, it means FY 99, 00, and 01. MDCH understands the issue regarding implementation of fiscal year 01 savings. We recommend the reader focus on what the statement is intending, not the tense (reinvested). If you are asked, provide the clearest perspective you can regarding what you have done.

- 21. There are currently 15 CAs. Will this remain a cap or will the number be allowed to rise as CMHSPs take on the CA responsibilities?**

There is no cap or minimum number of Coordinating Agencies. This will be determined by the quality of applications within the criteria of Public Acts 368 of 1978, as amended.

- 22. Can you indicate an intention to become the CA even if the existing CA does not want to become part of the PHP/affiliation?**

Yes, the Application for Participation is flexible in this regard.

- 23. Pursuant to the note under substance abuse in the Implementation Guide, if the PHP wants to develop local provider options but wants to have “oversight” by a Coordinating Agency (CA) different than has historically been the CA in that area, is that a viable option?**

The Application for Participation allows for flexibility as long as the criteria are met.

- 24. How can DCH strongly encourage substance abuse be included in the application and plan and yet not allow new Coordinating Agencies?**

This is a matter of timing. The DCH memo to CMHSPs stated that designation changes would not be considered until after the Application for Participation awards are made. This is to prevent unnecessary disruption to those in need of services should an application not meet established criteria and therefore fail.

- 25. Item 1.2.21 - Question seems to be what is the plan for PHP to reinvest Medicaid funds. How are General Funds relevant to this PHP plan at all?**

The Implementation Guide makes reference to reinvestment of both Medicaid and general fund savings, in the context of public policy and public interest considerations. In this regard, both forms of reinvestment reflect on CMHSP values and performance.

- 26. What will be the basis for determining best value (direct provision of services or contracting) and control/reduction of Administrative Costs?**

The applicant will be determining best value (a process used in competitive negotiated contracting to select the most advantageous offer by evaluating and comparing factors in addition to price) which is a process that must be identified locally.

Regarding administrative costs, the Revised Plan for Procurement introduced the concept of a separate capitation for managed care administration. The Implementation Guide recognizes the importance of determining these administrative costs, and identifies eight (8) key administrative functions as a beginning point (see figure 1 in the Guide). MDCH is presently focusing on service and administrative outcomes more so than setting administrative limitations so there will not be a separate administrative capitation in fiscal year 2003. However, we do intend to require PHP collection and reporting of managed care administrative costs, and in this context we will need to work on definitions. We anticipate working with some CMHSPs in this regard.

- 27. Regarding Scoring Criteria, the Guide states that “PHPs that are affiliations must be prepared to specify how (required) functions will be ... consolidated across the affiliation regardless off funding streams (Medicaid, block grants, general funds, etc.) ... .” Does this mean that a PHP will be required to exercise authority or oversight for the administration or provision of CMHSP services that are provided by CMHSPs but paid from general fund, block grant or other funding streams?**

No, not necessarily, but it’s extremely important to recognize the message that is repeated throughout the Implementation Guide relative to affiliations. The lead CMHSP is the responsible agent through the contract with MDCH, and the affiliation is expected to reflect efficiencies across managed care administrative functions and hopefully service delivery as well. In this regard, it is important that affiliations demonstrate consolidation of certain functions where consolidation can be expected to result in improved efficiency and/or effectiveness. Such improvements serve to benefit the entire affiliation and the individuals served.

This particular question suggests it may be feasible to partially consolidate some functions, i.e., consolidate a function in relation to Medicaid, but not in relation to general fund, block grant, and so on. While theoretically possible, a partial consolidation is not likely to achieve the potential improvements in efficiency and/or effectiveness. Affiliations need to look for real gains in this regard. That is the intended message within the Implementation Guide.