QUESTIONS AND ANSWERS
TO THE
IMPLEMENTATION GUIDE

Revised Plan for Procurement of Specialty Prepaid Health Plans

PART III
January 22, 2002

This is the third and final 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. Any corrections to this document will be issued with specific reference to the Implementation Guide since the Application for Participation has been issued and responses to questions on that document will follow shortly.

General Information on Application Requirements

Corrections to responses to questions number 29 and 57 in Part I of the Questions and Answers to the Implementation Guide.

Question 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 Prepaid Health Plan (PHP) must assure that all individuals eligible for services, except substance abuse services, are offered a choice of case manager or supports coordinator. The PHP must assure that the case manager acts on behalf of the individual rather than the PHP, CMHSP, or provider. Case management and supports coordination are not required Medicaid services for individuals eligible for substance abuse services only. These individuals may receive case management during assessment and/or as part of the individualized treatment plan. Case management/supports coordination would of course be available for individuals with a mental illness and/or developmental disability who have a co-occurring substance use disorder.

Question 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?

Pages 52 - 53 of the Application for Participation, item 3.2.4, contains the requirements of applicants related to independent facilitation of person-centered planning. To avoid a conflict of interest, the independent facilitator must be external to both the Prepaid Health Plan and its contracted providers.

1. **If a PHP delegates a managed care administrative function, does the PHP calculate cost by combining its cost plus the delegated entity's cost?**

   Assuming the question relates to reporting of managed care administrative costs, the answer is yes. The Prepaid Health Plan (PHP) managed care administrative costs are those provided by the PHP plus those the PHP provided through another entity, presumably through a contractual arrangement.

2. **Does a provider network belong to the PHP or the individual CMHSP affiliates?**

   The Prepaid Health Plan is the responsible entity.

3. **Does "ALL" insure help for those with no insurance coverage (pg 29; 1.3.16.7.)?**

   The customer service operation should be capable of assuring access for anyone in the service area with questions regarding Prepaid Health Plan operations and services. Also, MDCH does not expect to see different customer service operations for Medicaid eligibles as opposed to non-Medicaid eligibles.

4. **Has MDCH finalized the formula to split out current CA Substance Abuse funding county by county?**

   There has been no revised allocation methodology adopted.

5. **Will the AFP document more clearly define expectations for Medicaid eligibles who are enrolled but are not "users?" Will it clearly define who is a "member" for whom the PHP has responsibility? Are you going to provide a definition for consumer vs. member - are all covered lives (members) considered consumers? Are the terms considered interchangeable?**

   Please note that Medicaid eligibles are not identified as "members." They do not have to enroll to participate. They are entitled to medically necessary specialty services as indicated in the Application for Participation and contract.

6. **Will MDCH have guidelines or limitations on the use of case rates as a financing mechanism?**

   No, but there are two important considerations. First, to determine financially sound case rates requires having and using a very good historical data pool. Second, if the use of case rates includes the assumption of risk by the provider, MDCH must review the arrangement prior to its implementation and can disallow it if it appears to put MDCH at increased risk, or put the

Prepaid Health Plan at risk of not being able to fulfill the contract obligations.

7. Regulatory managements "regional" function, define regional (pg 21).

The concept of "region" is primarily directed at affiliations or consolidated CMHSP service areas (regions), but it can also apply to other CMHSPs or multiple affiliations that are seeking efficiencies.

8. In 1.1.7.2 and 1.1.8.1.5, define functional integration/consolidation.

Functional integration/consolidation is bringing similar administrative activities for several agencies under the responsibility of one agency.

9. MDCH plans to enter into shared risk arrangements with PHPs. At what level? Same for all affiliations or individually negotiated?

It is expected that risk corridors will remain as they are now.

10. What is the definition of independent/external facilitation? What are the tasks/roles of an independent/external facilitator?

An independent/external facilitator is a person-centered planning process facilitator who is external to the PHP and/or its service provider organizations. The facilitator will be responsible for maintaining the fidelity and integrity of the person-centered planning process and for assuring that the needs and desires of the individual are fully identified in a process directed by the individual. The PHP remains responsible for the identification and description of available resources and service/support options, as well as the actual development of the written plan and the dissemination of due process information.

11. What is the definition (components) of "characteristics" in 1.3.18.1.3?

The pertinent characteristics of the provider network to be articulated are identified in Section 3.8 of the Application for Participation.

12. Item 1.4.4 - What are you seeking for this section? We do not understand how to best answer this.

After assessing the organization's risk in such areas as noted in 1.4.3, how will the Prepaid Health Plan address those risks: what will it do to monitor those areas and reduce the likelihood of exceptions?

13. **Items 1.3.21.7.1 &.2 - Will you define what information you're seeking from "demographics?" Population groups (SMI, DD, etc.) Or Ethnic?**

Information includes population groups that are being served and cultural and ethnic characteristics of the residents of the service area.

14. **How will the Performance Indicator data from last year be scored? Pass/Fail? Positive outliers = Bonus Points...Negative Outliers = Penalty Points. How will this work?**

The reviewers will be looking at the record of compliance on performance indicators with standards and at the record of positive and negative outliers over a one year period. This will be scored as indicated in the Application for Participation.

15. **Clarify reference to grievance and appeals specific to customer service.**

The question seems to inquire why grievance and appeal are under the heading of customer services rather than a stand-alone category. The reason is that grievance and appeal functions are typically coordinated within customer service operations. Such an umbrella approach facilitates customer access. This was a significant issue in the last federal review of the waivers. Customers have a single source where they can get skilled assistance on a variety of questions or concerns, including initiation of complaints, grievances or even rights concerns. The intent is to assure ready access and hopefully be able to resolve concerns before they develop into substantial problems leading to more formal resolution mechanisms.

16. **Do the MDCH block grants (wraparound, diversion, etc.) stay with the affiliate or move to the PHP?**

In the case of affiliations, MDCH block grants will remain with the CMHSP the grant was awarded to, unless the affiliation legal agreement shifts responsibility for such grants to the lead CMHSP. If the latter occurs, the CMHSP probably needs to request that MDCH amend the grant contract to shift responsibility to the lead CMHSP.

17. **Do you have an example of a best value model that could be used for PHP affiliate types?**

Some examples can be found at the following web site along with additional information: www.dscp.dla.mil/contract/bvch1.htm and www.ntsc.navy.mil/Resources/Library/Acqguide/tradeoff.htm

18. **Will the AFP contain specifics encompassing the work group's input and housing and**

quality requirements (including use of ISO 9000 Quality Process)?

The Application for Participation contains recommendations from the consumer/advocate work groups throughout the document. Requirement for use of the ISO 9000 is not included.

19. **Re: the relevance of historical analysis on the AFP. For what purpose does such an analysis exist in the AFP? Will it be scored? Will recommendations fall out from such analysis? Why do it in an AFP? Since this is the creation of PHPs and any historical work has been done under the auspices (and responsibility) of MDCH directly what possible relevance does any retrospective analysis have in the AFP process?**

Information on applicants' past performance, especially from 10/1/98 forward, under conditions similar to those which will exist on 10/1/02, provides useful information regarding an applicant's performance capability under the new plan.

20. **There is an implication that we must show increased flexible options. That means expanding the "covered services"- where is such expansion of "covered services allowed?"**

"Increased flexible options" does not mean expanding covered services. The flexibility is reflected in the choice and combinations of covered services to meet specific needs and conditions of each individual. The contract also enables pooled funding arrangement which enables collaboration with other agencies in providing wraparound services.

21. **What parameters, policies or liabilities will the state assume in those social services not currently in the "covered services"?**

The Implementation Guide makes clear that several of the characteristics that enabled the CMHSPs to be granted a first right of refusal in the procurement process are functions and arrangements related to a Public Interest responsibility of CMHSPs. This stems in part from being a governmental organization. If these are what the question labels "social services," they are the responsibility of the CMHSP.

22. **State Hospitals: Will the Medicaid portion funding state hospitals be managed by the PHP; or will these costs remain separate? How will MDCH contractually manage the state (GF) and local fund matching components to these Medicaid dollars?**

CMHSPs should expect no change in the way state services are financed through the contract.

23. **ORR: The Implementation Guide is silent on Office of Recipient Rights (ORR) requirements of the PHP? Will the ORR certification requirements be specified in the**

AFP? Comment: It is presumed that all Mental Health Code requirements of ORR will be imposed upon the PHP. Conversely, it is presumed that MDCH is seeking Administrative efficiencies in the region, wherever possible. Therefore, with MDCH contracting directly with forty-eight (48) CMHs for GF funds, can a CMH centralize their ORR management responsibilities (including CRC responsibilities) to the PHP; or must each CMH still have its own ORR and CRC to maintain its ORR Certification? Please clarify the MDCH expectations and PHP/CMHs flexibility on this issue; and how the MDCH-ORR Department will view this area when it conducts its audits?

CMHSP certification of Recipient Rights will continue to be a code requirement. The Implementation Guide and Application for Participation reflect the expectation of consolidating functions to gain efficiency and effectiveness. That applies to the Rights System as well, although there will likely be limits. MDCH has not had an opportunity to complete an analysis of this issue, but will do so over the next few months. At a minimum, it is feasible for an affiliation to utilize one Rights Officer and a common set of policies and practices.

Regarding integration/consolidation of any administrative function, we recommend CMHSPs develop plans for executing and, if specific aspects of a plan appear to conflict with certification regulations, etc, submit the matter to MDCH for review and comment. Since CMHSPs can contract for numerous functions, there should be few issues that would need a MDCH review.

24. Item 1.3.8.3 - there is the implication that problems seem to go beyond what may be discovered in a "grievance and appeals" process. Can the concerns be more directly addressed (or implied remedies)?

This item indicates the CMHSP must understand the ways that the organization can intentionally or unintentionally create a situation where the case manager or supports coordinator is not representing the best interest of the consumer, but is really reflecting the best interest of the organization or the case manager/supports coordinator. With that understanding, it is essential that the organization put in place safeguards that assure such problems do not develop. The Implementation Guide is indicating the need for Prepaid Health Plans to have such safeguards in place.

25. Has the state identified bureaucratic process regulations relating to prior contractual requirements for service delivery and documentation that are no longer required or relevant to the PHP contract? Will these be made available at the time of AFP issuance?

An analysis done in spring 2001 of the quality management data determined that all were required by either a federal agency (Centers for Medicare and Medicaid Services, Center for

Mental Health Services, Center for Substance Abuse Prevention, and Center for Substance Abuse Treatment) or the Michigan legislature. Currently Chapter III of the Medicaid Bulletin is being examined for processes and documentation that might be redundant or no-longer required. Chapter III revisions will go out for public review in early 2002. Final changes in Chapter III would impact the annual site review process.

26. Where are the MDCH repeals of process regulations? The entire method of public procurement is being shifted. Risk is also shifted onto the local administrators. Where is the reorganization of MDCH that reflects that shift? What process regulations are no longer appropriate with responsibility shifted? Which ones are you going to do away with? If we take the risk what bureaucratic impediments can be eliminated to encourage improved effectiveness? Are there any limitations on how risk can be delegated? How small a coverage area will be allowed for sub-capitation?

This is clarified in the Application for Participation. More broadly, risk delegation and risk sharing within affiliations are issues that ICA and ITFRA agreements need to address in a clear manner or the applicant will be exposed to substantial financial risk. Payment methodologies used by applicants through subcontracts need to conform with state and federal regulations and need to be justified in relation to cost and value. Prudent purchasing is a fundamental basis underlying state and federal regulations.

27. What "audit tools" will the State itself use to assess/measure Corporate Compliance? Will these be made available at the time of AFP issuance, either as an attachment to the AFP, or as an Attachment to the MDCH Contract?

The state will develop protocols to measure performance and issue them in the summer of 2002.

28. Must the name of our multi-county ITFRA affiliation be registered with the state, county, or other entity?

MDCH will contract for services with the lead CMHSP (applicant), not an ITFRA. Where an applicant desires to enter into a contract with MDCH under an assumed name, the applicant must register the assumed name appropriately.

29. Specifically, what (CIS-Insurance) requirements are going to apply? Is a waiver required and if so, how does the PHP obtain it? Has there been a coordination with the State Insurance Commissioner's offices regarding the capitalization requirements for the PHP? If no, what waiver(s) are MDCH and/or the state willing to provide prospective PHPs of these obligations? What is the deemed status of a PHP in regards to AFDS requirements to act as a benefits management entity? Will any

specific Department of Insurance or other licensure requirements be applicable?

MDCH has resubmitted information on this topic to the Department of Consumer and Industry Services to assure their opinion of 1998 is still valid.

30. Can you provide specific citations for applicable Federal Procurement Standards?

Medicaid provisions are found in 45 CFR Subtitle A (10-1-99) Edition in 74.44 Procurement procedures. Other federal procurement standards can be found at www.whitehouse.gov/ (OMB/circulars). Depending on the nature of the financial award/grant/contract and the flow of funding, through the state or direct, the most pertinent documents are federal Circular A-110, subpart C, procurement standards (.40 through .48) and federal Circular A-102, Post-award Policies (i) Procurement of Goods and Services.

31. Item 1.3.21.4.2.3 - How do you evaluate or what are the indicators for "community inclusion" and "recovery outcomes"?

Community inclusion and recovery incorporate key values and principles described throughout the document. Excellent resources for individuals seeking to learn about these concepts are included on the website of the Substance Abuse and Mental Health Administration at: http://www.samhsa.gov. This site also provides links to additional sites providing information on recovery and community inclusion. Applicants should also review the department's practice guideline on community inclusion which is Attachment 3.11.2 to the current contract between the department and CMHSPs.

32. Item 1.3.21.4.2.4 - What information are you seeking relative to recovery outcomes?

The applicant's AFP response should include how organizational policies and practices promote recovery of individuals served.

33. How do you "assess community concerns or complaints related to protection, safety and security?" (1.2.15) What does this cover - scope?

Community concerns and complaints are often voiced in board meetings through public comment, telephone calls, e-mails, letters or other communications from community members, coordination/communications with law enforcement entities, newspaper articles, t.v. features and other media venues.