MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

James K. Haveman, Jr., Director

Jeff Patton, Deputy Director
Mental Health and Substance Abuse Services

REVISED PLAN FOR PROCUREMENT OF MEDICAID SPECIALTY PREPAID HEALTH PLANS

FINAL VERSION

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PREFACE

This document presents the revised plan of the Michigan Department of Community Health (MDCH) for procurement of Medicaid specialty Prepaid Health Plans (PHP). The state has been working on a plan for procurement for the last eighteen months and previously issued (in September 1999) a preliminarily proposal regarding competition for management of publicly-funded specialty services.

During this period, MDCH has had extensive discussions with beneficiaries, family members of disabled individuals, advocacy organizations, public officials, providers and CMHSPs regarding procurement of specialty PHPs. We have learned much from these discussions and from the public dialogue that has emerged around this topic. MDCH has thoroughly examined the application of competitive procurement to specialty services, with particular attention to the basic objectives of the specialty services system, certain economic characteristics of specialty care, and the outcomes of competitive managed specialty arrangements in other states.

The analysis presented, arguments made and conclusions arrived at in this paper are admittedly technical, arcane and - for the general reader - somewhat cumbersome. A degree of complexity is unavoidable, given the nature of the topic and the important considerations involved. To compensate for this, the department previously issued a summary version of this paper, which condensed the basic reasoning and concisely described the revised plan for procurement.

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

In examining possibilities for competitive procurement, MDCH has maintained its focus on enhancing the capability to function, freedom to choose and the opportunity to achieve for persons with mental illness, developmental disabilities and addictive disorders. The touchstone for evaluating various procurement options has been how well each alternative comports with the basic principles and objectives of a publicly-funded specialty service system. In earlier papers on specialty-managed care, the state has outlined these core principles and aspirations and it is appropriate that we reiterate these values in the preface to the state's revised plan for procurement. The state has previously noted that in a modern specialty service system, disabled individuals should be:

- Empowered to exercise choice and control over their lives, including the purchase of services or supports and the choice of providers;
- Involved in meaningful relationships with family and friends;
- Supported to live with family while children and interdependently as adults;
- Engaged in daily activities that are meaningful, such as school, work, social, recreational and volunteering;
- Fully included in community life and activities;
- Afforded all rights guaranteed in law, including confidentiality of service information;
- Afforded access to effective services and supports intended to reduce the personal, social, and economic consequences of their disabilities;
- Committed to the ordinary obligations of citizenship and the responsibilities of community membership.

We believe the solution that the state has devised for procurement of specialty services honors and preserves these basic principles and aspirations.

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1. BACKGROUND

On June 26, 1998, the Michigan Department of Community Health (MDCH) received approval from the Health Care Financing Administration (HCFA) to implement a Medicaid managed care program for specialty mental health, substance abuse and developmental disability services. Under the approved plan, nearly all Medicaid state plan specialty services related to mental health and developmental disability services, as well as outpatient substance abuse services, were "carved out" (removed) from Medicaid primary physical health care plans and arrangements and placed under the management of specialty care Prepaid Health Plans (PHPs). A specialty Prepaid Health Plan (PHP) is a managed care entity that provides Medicaid covered specialty services - under a contract with the state and on the basis of prepaid capitation fees - to beneficiaries who need such care.

In approving the waiver, HCFA granted the state a time-limited exemption from federal procurement rules so that MDCH could contract - on a sole source basis - with Michigan's 49 county-sponsored Community Mental Health Services Programs (CMHSPs) to serve as the specialty PHPs and manage Medicaid specialty mental health, substance abuse and developmental disabilities services on a prepaid, shared-risk basis.

2. THE BENEFITS OF THE WAIVER AND MEDICAID MANAGED SPECIALTY CARE

The implementation of managed care for Medicaid specialty service was consistent with long-held system reform objectives in Michigan. For over thirty years, the state has pursued the development of community-based specialty care systems to facilitate integration and inclusion for persons with serious mental illness, developmental disabilities and addictive disorders. A persistent obstacle to comprehensive community care systems has been the various and disparate policies, service arrangements and funding streams that support community integration and inclusion efforts. With the managed care program and the designation of CMHSPs as the specialty Prepaid Health Plans, the state had achieved unified system management for specialty services at a local level, under a single contract that brought together multiple policies, programs, and payment sources. This arrangement permitted the county-sponsored entities to reconcile different eligibility requirements and to provide comprehensive and flexible rehabilitation and support services for persons with mental illness, developmental disabilities and addictive disorders, using appropriate resource streams.

3. THE MEDICAID WAIVER AND UNIFIED SYSTEM MANAGEMENT AS A MEANS TO A LARGER END

Achieving consolidated management of all publicly-funded specialty services - Medicaid benefits as well as other services and supports paid for through alternative funding arrangements – was not merely an exercise in administrative simplification. Rather, the goal of unified system management was a *means* to a much larger *end* – that of enhancing the freedom and capability of persons with behavioral or developmental disabilities to make choices among service and support arrangements.

Instead of being regarded as a passive recipient of dispensed benefits, the person's direct involvement in considering and choosing among different service and support alternatives affirms one of the most cherished aspects of everyday life: the ability to pursue individual life objectives and to participate in activities that one regards as having value. Visualizing possibilities and considering alternatives are much easier when all resources relevant to the person's choices are in the same "basket" (i.e., under unified or consolidated management).

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

4. Federal Requirements and the Rationale for Competitive Procurement

In approving Michigan's waiver, HCFA stipulated that within two years the state must submit "… a detailed plan to shift from sole source procurements for its Prepaid Health Plan (PHP) contracts to full and open competitive procurement which comply with the Federal procurement rules at 45 CFR Part 74". MDCH accepted this condition.

The federal position on competitive procurement, as stated in 45 CFR Section 74.43, is that "… all procurement transactions shall be conducted in a manner to provide, *to the maximum extent practical*, open and free competition" (emphasis added). The rationale for requiring competition is that it provides an equitable opportunity for qualified bidders to contend for governmental contracts. Beyond basic fairness, competitive contracting presumably puts economic incentives into place that assure that the purchaser will obtain the best possible product at the lowest possible price (best value). HCFA's stipulation that Michigan competitively procure specialty care PHP contracts was consistent with federal regulations and with the general premise that market arrangements ensure equity and efficiency.

5. Development of a Plan for Competition

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

Specifically, MDCH was concerned that competitive selection of Medicaid specialty Prepaid Health Plans posed the risk that one of the ingredients of a comprehensive community care system - Medicaid specialty service benefits - might be split off and placed under separate governance. Such a separation would reintroduce the inefficiencies, service fragmentation and coordination problems that have historically hindered effective care for beneficiaries with serious mental illness, developmental disabilities and addictive disorders.

In addition, in contemplating possible new managers for specialty services, MDCH was also intent upon preserving the principles of freedom, participation, choice and inclusion described above, and on maintaining highly valued statutory achievements (e.g., person-centered planning, participation of consumers on governing boards, etc.) that promote and facilitate the application of those principles to individuals with mental illness, developmental disabilities and addictive disorders.

5.1. The Initial MDCH Plan for Competition

In September 1999, MDCH published a preliminary plan for competition that attempted to address these legal and public policy dilemmas while sustaining some form of market-driven selection process (competitive procurement) for specialty PHPs, consistent with federal requirements. In the preliminary plan, MDCH proposed:

> "… to extend competitive procurement to include all service populations (state priorities, eligible beneficiaries, federally mandated groups), all management responsibilities, all service options and settings, and all available funding for specialty services.
>
> Under this proposition, the department would bid out management of both the Medicaid funds for specialty services and other funds currently assigned by state statute or practice exclusively to county-sponsored entities. In a competitively "neutral" process (level playing field), the department would award management contracts for each designated service area to a single public, private, or public-private partnership organization in that locality or region which submitted a proposal most responsive to the purchasing specifications outlined in the bid packet.
>
> A competitively neutral process means designing the procurement so that all qualified bidders - public, not-for-profit and private for-profit - are treated in an equal fashion in the bidding process. To the extent possible, all barriers to the public entity flexibility are removed, as are some special privileges or protections currently afforded these entities. Similarly, private entities are required - if they are successful bidders - to take on legal responsibilities and procedural obligations currently borne only by public sector entities." ("Competition for Management of Publicly-Funded Specialty Services", page 25).

5.2. Public Reaction to the Preliminary Plan

Following the release of the paper, MDCH held ten public hearings to solicit input on the preliminary plan and the department received over 750 written comments from stakeholders regarding the document.

An analysis of stakeholder comments revealed considerable concern among all respondent groups that competition would diminish *local control and oversight* of community-based service systems. Remarks received indicated that stakeholders valued certain characteristics and processes of the current system that promote freedom, equity, and community participation for persons with behavioral or developmental disabilities. Respondents feared that these characteristics and processes (e.g., open meetings, consumer participation on governing boards, efforts to reduce stigma, self-determination, person-centered planning, etc.) would be lost under market arrangements that stress efficiency over freedom and equity considerations.

Stakeholders also expressed great reservations about the *high-powered incentives* characteristic of competitive environments. There was apprehension that profit considerations would compromise access and quality, encouraging managing entities to expropriate (in a revenue/profit stream) funds that should go to enhance services or to promote independence for disabled beneficiaries.

Other concerns expressed by all respondent groups were that there would be *disruptions in care continuity* if new managers were selected, and that competition – especially if it were narrowly focused upon price considerations - would result in the

elimination or reduction of certain highly valued services that promote the freedom to achieve, choose and participate in society. Finally, a number of respondents questioned the premise that competition should be applied to management of these services at all.

Stakeholders responded positively to some parts of the preliminary plan. In particular, they endorsed the guiding principles and service paradigms (recovery, strength-based ecological approach, self-determination) set forth in the plan and they applauded efforts to ensure accountability of managing entities (including replacing poorly performing organizations). Most stakeholders also agreed that the resource streams supporting local systems of specialty care *should not* be split apart (bifurcated).

5.3. LESSONS LEARNED

In working on the preliminary plan for competition, MDCH had come to recognize that competitive procurement for Medicaid specialty PHPs would be problematic for a number of reasons. Medicaid beneficiaries receiving services from the specialty PHP also needed seamless access to a range of other services supported through different funding streams. Some beneficiaries with special needs move in and out of Medicaid eligibility, and these status changes complicate the situation even further. If Medicaid specialty services were administered separately from these other services, care coordination and cost-shifting problems could intensify. In addition, while contractual provisions could be employed to compel compliance, non-governmental entities selected as the Medicaid specialty PHP would not be under statutory obligation to implement certain activities that facilitate participation, integration and inclusion of persons with mental illness, developmental disabilities and addictive disorders.

As indicated above, the state's proposed solution to these problems – an open competitive bid for Medicaid specialty PHPs and all other service funds and responsibilities – was cautiously received by system stakeholders. Feedback from stakeholders suggested that important aspects of local governance - processes that facilitate equity and inclusion - had been neglected in the MDCH analysis and subsequent plan. Comments received also indicated strong reservations about the incentive intensity of market arrangements, and worry that competition would cause disruptions in care or reductions in services. Stakeholders were, however, positively inclined toward certain service paradigms (e.g., self-determination) and measures to hold managing entities accountable.

For the last ten months, the state has pondered how to best address concerns raised by stakeholders, while maintaining elements of the preliminary plan that were widely endorsed. During this time, MDCH continued to engage in dialogue with interested parties, and the state initiated discussions with HCFA about possible alternative arrangements. In the course of these deliberations, MDCH considered various alternatives (e.g., two-plan option) to safeguard beneficiaries and to mitigate certain incentive problems associated with market selection. While these options appeared to satisfy federal requirements, none of these alternatives seemed to make economic sense, nor did they represent a better solution than current arrangements. In short, while sole-source contracts for Medicaid specialty PHP contracts are problematic, the state was not able to identify a superior alternative arrangement that could be implemented with net gain to the beneficiary.

In struggling to define a workable approach for competitive procurement of PHPs, MDCH began to suspect that adopting a *rigid* interpretation of federal requirements for competitive procurement could be forcing specialty care into an unnatural scheme or

pattern. Perhaps specialty services have certain characteristics that cannot be easily fitted into the simple competitive market model.

6. RETHINKING COMPETITIVE PROCUREMENT

Rather than develop increasingly more intricate models to make competitive procurement work, MDCH gradually began to question whether classic competitive selection of specialty PHPs was actually feasible or desirable. Determining the feasibility of competition required a rather detailed consideration of economic issues. Establishing whether competition was desirable required an assessment of which arrangements best facilitate freedom, equity, opportunities for achievement, community integration and inclusion for beneficiaries with serious mental illness, developmental disabilities and addictive disorders.

6.1. UNDERSTANDING COMPETITION

As noted previously, federal regulations requiring competition presume that market mechanisms promote equity and best value. It is fair to inquire, however, whether this is true under all conditions and circumstances.

In rethinking competition, MDCH applied a particular analytic framework - transaction-cost economics - to the problem of competitive procurement for specialty services. Transaction-cost economics is an innovative perspective that examines the institutional context and economic reasons why certain activities are organized or conducted under different forms or arrangements. It seeks to identify the conditions or circumstances that produce market solutions, hierarchies (internal organization of activities) or hybrid arrangements.

From the transaction-cost perspective, all economic activities occur within the context of certain formal rules (laws) and informal constraints (customs, tradition, codes of conduct). These rules and constraints are collectively referred to as the institutional environment. The institutional environment reduces uncertainty and provides a stable structure for certain activities to be carried out. The formal institutional framework (the law) may purposely and deliberately limit the types of organizations that can carry out certain activities.

While the institutional environment significantly shapes economic activity, it is not the only factor influencing whether economic transactions are conducted through classical markets, hierarchies or hybrid contracting arrangements. The differing characteristics of certain economic activities or transactions favor different "governance" structures. Transactions of a specific kind readily lend themselves to "market" governance (classic competitive model). For other kinds of transactions, however, market arrangements may not be the most efficient means of organizing the production and transfer of a particular good or service.

6.1.1. The Simple Competitive Market Model

As indicated, federal regulations requiring competitive procurement presume that market arrangements are the best means to assure fairness and efficiency. However, to reap the benefits of competition (equity and best value), certain conditions must prevail in the marketplace. Competition tends to work best when there is a large number of equally informed parties engaged in the exchange, all the relevant characteristics of the goods or services to be acquired are readily discernible, and the transaction is a discrete event (i.e., after the transaction each party - buyer and seller - can go its own way at negligible cost to the other). In situations where the conditions of the simple competitive market model

(complete contracting) do not prevail, the presumed benefits of competitive procurement may not materialize.

6.1.2. More Complex Situations: Adjustments and Modifications

It is more difficult to competitively structure an exchange when there is a limited number of sellers, information is inadequate or unequally distributed, the activity or service being procured is rather involved and difficult to fully specify at the outset, and the transaction entails an ongoing relationship between the parties. Even under these circumstances, however, competition may still be feasible, *if the activity or service sought by the purchaser and provided by the seller has general-purpose use and the exchange does not require significant relation-specific investment.* In these circumstances, a sufficient number of sellers can be attracted for the exchange, and if the transaction deteriorates after the exchange, each party (buyer and seller) can redeploy their respective resources (albeit at some cost) for other uses.

These types of exchange situations are challenging, and often entail complex contracts (to define the conditions of exchange) and significant monitoring arrangements (to ensure compliance).

6.1.3. Circumstances not Conducive to Competitive or Market Arrangements

Transaction-cost analysis suggests that classic competition or market approaches may not work well under the following circumstances:

a) the purchaser needs the seller to make significant *asset-specific* investments (e.g., specialized facilities, dedicated programs, distinctive workforce, etc.) to organize, produce and/or deliver certain unique goods or services;
b) frequent interaction and close collaboration between the parties is required to achieve certain common objectives; and
c) continuous adaptations or adjustments to the arrangement must be made in response to changing circumstances or unanticipated contingencies.

Under these circumstances - when the purchaser and supplier have made durable specialized investments (that are not easily redeployable) in support of one another and to facilitate certain activities and common objectives - the parties are said to be in a condition of *bilateral dependency*.

Under this set of circumstances, classic competitive (market) arrangements are generally not practical or sustainable. In some situations, there is not a market for the particular activity or service: no supplier will make the necessary specialized investments without some assurances from the outset that there will be a continuing relationship with the purchaser. In other situations, there may be competition at the outset, but the purchaser and successful bidder - after making the durable specialized investments and acquiring particular technical abilities - eventually develop an ongoing dependency that undermines the practicality or utility of future competition.

When conditions of bilateral dependency obtain - either from the outset or over time - this dependency poses certain contractual hazards for both parties. Each party has incomplete information about future contingencies and the appropriate adjustments that may need to be made to the agreement down the road. In addition, either of the parties may exhibit opportunism, and attempt to mislead or

deceive the other party regarding necessary adjustments in order to extract unwarranted concessions or to expropriate unjustified economic increases.

To mitigate these hazards, contractual safeguards are commonly devised. In many situations, these contractual safeguards become elaborate and convoluted, with strenuous ex ante (before execution of the agreement) efforts to intricately define in the contract all possible scenarios, and laborious ex post (after execution) mechanisms to monitor the agreement and deter opportunism.

The high transaction costs involved in devising and implementing these types of safeguards often result in bilateral dependent parties eschewing the traditional arm-length adversarial contracting process and costly haggling in favor of *relational contracting*. In this type of hybrid arrangement, the parties recognize that to reach a common objective they must work cooperatively, and it is, therefore, in each party's interest to adjust flexibly to one another's concerns. The formal contract describes the basic parameters of the exchange, but it is the entire context of the relationship over time and the incentives that each party has to sustain *valued transaction-specific efficiencies* that accrue from the relationship, which facilitate equitable dispute resolution and discourages opportunism.

It is important to note that the relational contract is not necessarily an inferior or inefficient method of organizing certain economic activities. Indeed, under conditions of bilateral dependency, the relational contract *may well be the most efficient means* to acquire services and to minimize transaction costs.

6.1.4. Summary of MDCH Considerations Regarding Competition

Below, in table form, is a brief summary of the types of exchange that are conducive either to classic market competition, complex competitive contracting or relational contracting (bilateral dependency).

Attributes of the Particular Good/Service and Investment Characteristics to Support the Exchange

Exchange Frequency	Standard Good/Service Non-Specific Investment to Support Transaction	Complex Good/Service General Purpose Use Some Specific Investment	Highly Specific Good or Service Significant Specialized or Relation-Specific Investment
Occasional	Market	Market	Complex Competitive Contracting
Recurrent or Ongoing	Market	Complex Competitive Contracting	Bilateral Dependency **Relational Contracting**

6.2. APPLYING THE ANALYSIS TO COMPETITION FOR SPECIALTY PREPAID HEALTH PLANS

MDCH has concluded that the characteristics of specialty Prepaid Health Plans are such that neither the simple market model, nor more complex forms of competitively organized exchange are applicable to these contracts. In contracting with specialty PHPs, the state must obtain an agent that is committed to the objectives of integration and inclusion for beneficiaries with serious mental illness, developmental disabilities, and addictive disorders. The PHP must make certain relation-specific highly specialized investments to support this objective, including specialized management

strategies and possible direct operation of certain unique or highly individualized programs if necessary suppliers cannot be found. A specialty PHP must frequently interact with the state regarding beneficiaries that are placed in state facilities, and must collaborate with the state in returning individuals from segregated settings to community placements - without costly haggling that might delay reintegration. The PHP must establish and sustain close and cooperative long-term ties with other community agencies that fund or provide certain ancillary services and supports needed by beneficiaries.

In short, contracting conditions for specialty Prepaid Health Plans constitute a situation of bilateral dependency. Even if a competitive environment could be established for an initial bid, the nature of the ongoing relationship – necessary to facilitate the objective of integration and inclusion – quickly erodes the initial competitive environment.

Since most CMHSPs already have many of the characteristics that the state would be seeking in a competitive bid for a specialty PHP, there seems little utility in conducting a procurement in which CMHSPs would almost certainly be the successful bidders. Nor can one easily argue that there is a vigorously competitive private market for specialty PHP services and that limiting procurement is therefore unfair. Due to consolidation in the for-profit managed behavioral health care sector, competitive procurement in other states has degenerated from the standard market model into an oligopolistic market situation, in which a few large organizations dominate the bid process.

6.3. Competition for Physical Health, Long-Term Care and Specialty Services

Medicaid has been described as a program that essentially has three component parts: a health insurance program for low-income individuals (physical health care); a long-term care program for elderly and physically disabled persons; and a specialized service program for persons with developmental disabilities and mental illness/addictive disorders.

The state has utilized competitive contracting in managed care arrangements for Medicaid physical health care services and has proposed a competitive framework to implement managed care for long-term care services. Why does the state believe that competitive contracting is feasible for managed physical health care services and for long-term care but is impractical for specialty services for persons with developmental disabilities, mental illness and addictive disorders?

6.3.1. Competition for Management of Physical Health Care Services

Procurement of Health Maintenance Organizations (HMOs) to manage physical health services for Medicaid beneficiaries is a situation of complex competitive contracting. There are a limited number of sellers, the activity or service being procured is somewhat involved and difficult to fully specify at the outset, and the transaction entails an ongoing relationship between the parties (contracts are let for multi-year periods).

It is important to note, however, that in regard to Medicaid physical health care services, HMOs represent a *general-purpose application or technology*. The care management strategies and provider network components that an HMO uses to manage physical health care for Medicaid beneficiaries can also be utilized to manage physical health care for other insured populations sponsored by other payers. While some "transaction-specific" investments are required if the HMO contracts with the state to manage physical health care for Medicaid beneficiaries, these investments can be redeployed to alternative uses (i.e., to

manage physical health care for other insured populations) should the HMO or the state elect to terminate the arrangement.

Categorizing HMOs as a general-purpose managed care technology does not mean that there are no differences in managed physical health care for Medicaid beneficiaries and for commercial populations. Medicaid does have some distinctive features as a program that differs from insurance principles used in commercial plans. These distinctive features introduce additional complexities into the competitive procurement process and contract execution activities.[1] The designation of HMOs as general-purpose technology does point to the fact that management of physical health care for Medicaid beneficiaries is not an *asset-specific* endeavor. This lack of asset-specificity (the HMO can redeploy its managed care activities and investments to serve other insured populations) is the principal reason that a variety of sellers can be induced to compete for contracts, and why a competitive market place can be sustained over repeated contracting cycles.

6.3.2. Competition for Management of Long-Term Care Services

Long-term care consists of many different services aimed at helping elderly individuals and persons with chronic physical conditions secure appropriate medical services and compensate for limitations in their ability to function independently. As indicated in the recent report from the Michigan Long-Term Care Work Group, existing long-term care services in Michigan for these populations "…are not integrated into a coordinated system of care. There are no incentives for planning and use of private resources, and dual public funding streams (Medicaid and Medicare) create confusion and impede efficiency".[2]

Various managed care models for long-term care in Michigan have been identified and efforts to pilot these approaches are underway. All of the models - to a greater or lesser degree - seek to consolidate and decentralize administrative responsibilities for care, allow greater flexibility and individualization in care arrangements, and integrate various service components (e.g., acute care, general aging and advocacy services, long-term supports, etc.).

Because existing long-term care services are not highly organized and since numerous demonstration models are proposed, the state is using competitive solicitation as a means to induce new forms of coordination and integration among existing service components. Competition and capitation are regarded as catalysts for creation of organized systems of long-term care.

Competition to demonstrate and implement various forms of managed long-term care for the elderly and physically disabled is possible at the outset since the state (as purchaser) is attempting to persuade suppliers to organize and offer a new "product" (i.e., integrated, risk-based, long-term care services). It is difficult to determine at this point whether competitive contracting for long-term care will transform over time from the initial (ex ante) large number supply situation (many bidders) to an eventual (ex post) small number situation (bilateral dependency).

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[1] See "Negotiating the New Health System: A Nationwide Study of Medicaid Managed Care Contracts", by the Center for Health Policy Research, George Washington University.

[2] "Long-Term Care Innovations: Challenges and Solutions", page 2.

6.3.3. Differences Between Physical Health, Long-Term Care and Specialty Services

In contrast to managed care for physical health care, managed specialty services for persons with serious mental illness, developmental disabilities and addictive disorders requires a *special-use managed care application or technology* with significant, transaction-specific investment in specialized techniques, facilities, programs and workforce. Unlike emerging managed models for long-term care, specialty services are already highly organized and previously experienced a *fundamental transformation* to a condition of bilateral dependency.

6.3.3.1. Special Use Characteristics and Asset-Specificity

Beneficiaries with serious mental illness, developmental disabilities and addictive disorders need special assistance, distinctive care management strategies, specialized interventions, and highly individualized support arrangements that are not typically available from or covered by other payers and managed care systems. Also, as the Institute of Medicine noted in a recent report on behavioral health:

> "…a significant portion of the public care system for individuals with the most disabling conditions extends beyond health care services to rehabilitation and support services, including housing, job counseling, literacy, and other programs. The coordination of these services requires collaboration and cooperative relationships among many agencies, including public health, social services, housing, education, criminal justice, and others. Most of these services are not covered by private insurance and have not been developed by most private behavioral health care companies."[3]

Management of specialty services for behaviorally or developmentally disabled beneficiaries is an activity characterized by a high degree of asset-specificity - the managing entity must invest in singular care management strategies, dedicated programs, transaction-specific facilities and a specialized workforce. These special-use characteristics mean that these investments cannot be shifted to alternative uses or redeployed for alternative payers. Accordingly, such investments would never be made at all without credible commitments regarding a sustained relationship between the purchaser and the supplier.

The special-use characteristics of managed specialty service activities and the high degree of transaction-specific investment required constrains the use of market mechanisms and distinguishes specialty PHPs from general-use managed care technology applied to physical health care services. In addition, the critical need for close and persistent collaboration between the managing entity and other human service agencies further limits the applicability of competitive contracting in these situations.

[3] Managing Managed Care: Quality Improvement in Behavioral Health, Institute of Health, 1997, Page 3.

6.3.3.2. Fundamental Transformation and Specialty Services

Michigan's specialty care system for persons with serious mental illness, developmental disabilities and addictive disorders is a highly organized and integrated managed delivery system. The high degree of organization and integration is the result of focused and persistent state policy over the last two decades.

Michigan, like many states, had a long history of placing persons with mental illness, developmental disabilities and addictive disorders in segregated state-operated facilities. Even into the early 1970s, there were very few community services available for these special populations.

To reduce the use of segregated state facilities, the state needed to develop community-based service and support arrangements. However, developing such alternatives required highly specific investments in dedicated programs, local facilities, distinctive service management strategies and a specialized workforce.

The state legislature recognized that - due to the condition of asset specificity - investments for community alternatives to state facilities *would never be made* unless there were credible commitments regarding the future. To provide such assurances, the legislature passed statutory changes that transferred primary responsibility for management and delivery of specialty services from the state to county-sponsored public entities. These changes greatly accelerated Michigan's transition from a facility-based segregated care system to a community-based service and support model. The law provided assurances and incentives for counties to invest in dedicated, population-specific programs and care settings, and to attract the necessary specialized managerial and professional workforce.

In the 1980s, the state elected to expand the scope of Medicaid coverage to include several optional benefits specifically tailored to the needs of beneficiaries with serious mental illness, developmental disabilities or addictive disorders. The state tightly coordinated the provision of these Medicaid services with the programs and service activities of the existing county-based systems of care, to ensure that these benefits would contribute to community integration and inclusion for disabled beneficiaries.

Thus, the specialty services system in Michigan has already experienced what has been referred to as a *fundamental transformation* (Williamson, 1985[4]). Fundamental transformation refers to circumstances in which a possible market situation (large number of potential bidders) has been transformed into an exchange situation of bilateral dependency between purchaser and dedicated suppliers. This transformation occurs *when an exchange situation requires significant, specialized, durable investments in transaction-specific human or physical assets.* When this happens, future parity (for bidding purposes) is upset and what might have been potentially or initially a

[4] The Economic Institutions of Capitalism, by Oliver Williamson, Free Press, 1985

situation of large number bidding is transformed into a situation of bilateral supply.

As noted previously, the state is planning to implement several models to manage long-term care for elderly and disabled individuals. Because existing long-term care services are not "…integrated into coordinated systems of care", competition to implement these models is still possible. A large number of bidders may vie - at the outset - for the right to implement these models*. Long-term care - in contrast to specialty services for persons with serious mental illness, developmental disabilities, and addictive disorders - has not yet gone through a fundamental transformation to the condition of bilateral dependency*. Whether competitive parity can be maintained in future contracting periods is, however, still to be determined.

6.4. WHY CLASSIC COMPETITIVE PROCUREMENT FOR SPECIALTY PHPS IS NOT DESIRABLE

Even if the economic obstacles to classic competitive procurement could be surmounted, it is also important to consider whether market selection of specialty PHPs would be desirable. Specialty PHPs must assume an important role in the protection of vulnerable populations and in securing full participation, integration and inclusion for these individuals. In short, specialty PHPs have responsibilities for ensuring freedom, opportunities for achievement, equity and participation that go far beyond the usual and customary obligations of a managed care entity.

Transaction-cost economics draw attention to the institutional (legal) framework in which economic activities take place. In relation to specialty services, the institutional framework encompasses all aspects of public law that impose a duty upon government to both protect vulnerable populations and to ensure the full participation of disabled individuals in society. These legal considerations have impelled state and local government to become heavily involved in the organization, management, production and delivery of specialty services and supports. Under the Americans with Disabilities Act and the subsequent Olmstead decision, the state also has an affirmative obligation to utilize Medicaid to promote community integration for disabled beneficiaries.

There is a plausible argument that competitive selection of specialty PHPs might undermine, rather than strengthen, the state's legal obligation to pursue community integration for beneficiaries with mental illness, developmental disabilities and addictive disorders. Unlike HMOs responsible for physical health, specialty PHPs serve beneficiaries that still struggle to realize the basic rights of citizenship. Competitive procurement introduces some significant new principal-agent problems and incentives that might lead PHPs to overemphasize efficiency objectives in relation to other considerations.

7. THE CURRENT MDCH PERSPECTIVE: CLASSIC COMPETITIVE PROCUREMENT IS NOT PRACTICAL

After eighteen months of analysis, an exhaustive examination of different options, and extensive discussion with stakeholders, MDCH now believes that classic "open and full" competition for specialty PHP contracts - required by HCFA and previously agreed to by the state - is not practical, for the reasons outlined above. The state also contends that, beyond the issue of the impracticality of competitive procurement, a deviation from the procurement requirements would "facilitate comprehensive or integrated service delivery" as stipulated in 45 CFR 74.4 ("Deviations"). Specifically, permitting non-competitive procurement would

allow the state to maintain an integrated community-based service delivery system for beneficiaries with serious mental illness, developmental disabilities and addictive disorders.

The state believes that organizing the production of necessary services and supports and managing the smooth transfer of these goods to vulnerable beneficiaries is a difficult undertaking, fraught with significant issues of social equity and involving important "externalities" of consumption that affect the community as a whole. We now believe that the traditional non-market method for designating the managing entity - with some refinements - may in fact represent the *least costly* institutional arrangement for managing specialty service transactions.

In short, MDCH contends that both the formal institutional (legal) framework and the specific circumstances of specialty service management and care delivery (bilateral dependency) make the standard market model of "open and full" competition for Medicaid specialty PHPs impractical and possibly detrimental to the goal of full community inclusion for behaviorally or developmentally disabled beneficiaries.

In arguing against the feasibility of classic competitive procurement, the state has carefully analyzed the structure of the relevant market and has compared this analysis to previously issued guidance by HCFA on sole-source contracting.[5] The state has also considered its argument for a non-competitive procurement process in relation to provisions of the Balanced Budget Act of 1997.

While MDCH maintains that classic competitive procurement for specialty PHP contracts is impractical, it is not suggesting that all competitive aspects be eliminated from the PHP selection process, nor does it claim that all current specialty PHPs should be retained in the future. Rather, the MDCH plan, outlined next in this document, calls for a different kind of competition, a reduction in the number of specialty PHPs, and a rigorous qualification process to select PHPs from a restricted pool of initial applicants. While ensuring that specialty PHPs meet high standards and represent the least-costly feasible structure for managing specialty care, the revised MDCH plan also introduces mechanisms to assure "best value" in the selection of providers and to afford beneficiaries adequate choice in service and support arrangements.

[5] Letter from Rodney Armstead to State Medicaid Directors dated August 11, 1995, and a subsequent letter from Bruce Merlin Fried to State Medicaid Directors, dated December 7, 1995.

PART TWO: THE MDCH PROCUREMENT FRAMEWORK

1. INTRODUCTION: RESTATING THE CASE FOR NON-COMPETITIVE PROCUREMENT

In the previous section, MDCH argued that trying to fit specialty PHPs into the standard "open and full" competitive market model is a procrustean bed situation - the rigid imposition of a standard that ignores important characteristics of specialty PHPs.

The discussion in Part One called attention to the basic purpose of the state's managed care waiver – to achieve unified local system management for both Medicaid benefits and the specialty services/supports paid for through other funding arrangements. We indicated that this objective – unified system management at a local level – was essentially a *means* to a larger *end:* facilitating the freedom to participate, choose and achieve for beneficiaries with serious mental illness, developmental disabilities and addictive disorders. We noted that specialty PHPs operate within a unique institutional (legal) framework, employ particular processes and practices that promote freedom, equity, empowerment and participation, and pursue distinctive (support, accommodation, community inclusion) kinds of outcomes for beneficiaries. Finally, we pointed out that specialty PHPs also have singular economic characteristics – the condition of *bilateral dependency* between purchaser and supplier - that make classic market competition for these contracts unfeasible or of little utility.

We also described in Part One the extensive public process that the state engaged in as it sought to devise a workable market solution for specialty PHP procurement. We noted that despite all of these efforts, the state was not able to arrive at any plan which seemed to represent a superior or more efficient alternative than the current form of procurement and the relational contracting arrangement, and we indicated that our market selection options were not generally supported by system stakeholders.

2. PROPOSED FRAMEWORK: RETAIN BUT REFINE THE CURRENT SELECTION PROCESS

Elaborate attempts to make management and delivery of these services conform to the standard market model have not been successful. Rather than continue down this road, MDCH believes that *refining the state's current selection method* is a more promising vehicle for attaining the outcomes (efficiency, choice and community inclusion) sought by the state, HCFA and system stakeholders. If we set aside a procrustean interpretation of federal regulations, we can readily discern opportunities for pragmatic system reform that lie just outside the classic competitive paradigm.

MDCH is very much aware of the strong legislative preference - expressed in federal statute and regulations - for competitive procurement. In regard to Medicaid managed care, provisions of the Balanced Budget Act of 1997 have reinforced this preference for competition and for beneficiary choice.

However, federal regulations give the Secretary of Health and Human Services discretion to approve non-standard forms of procurement. We believe that the exercise of this discretion in regard to Michigan's managed care program for Medicaid specialty services would be in the best interest of beneficiaries with serious mental illness, developmental disabilities and addictive disorders.

While the intent of federal regulations regarding competition is to achieve fairness for qualified bidders, and efficiency (best value in terms of price and quality) and choice for beneficiaries, the state believes that the particular circumstances of specialty care expose the limitations of the classic competitive model as a vehicle to attain these aims.

Specifically, the state contends that the basic objective of Michigan's Medicaid managed specialty care program is to facilitate the beneficiary's freedom and ability to fashion services and support arrangements consistent with personal choices and individual life objectives. This objective can best be accomplished through a managed system in which the beneficiary has access – through a single local entity – to all resource streams (Medicaid and non-Medicaid) that finance services and supports required for accommodation and community inclusion. The state also believes that beneficiary freedom, participation and integration can best be promoted through a local managing entity (the specialty PHP) that has specific *statutorily proscribed equity and justice functions*.

The state acknowledges that limiting the applicant pool for specialty PHPs to CMHSPs does restrict other entities that might wish to participate. However, we believe that this restriction must be viewed against the essential purposes of the waiver: to facilitate beneficiary freedom, participation, choice, achievement, integration and community inclusion. The state contends that fairness must ultimately be judged in relation to what is most equitable for the beneficiary and not merely by what seems an equitable situation for specific interested entities.

The state has also made the case that the economic characteristics of specialty PHPs do not easily lend themselves to the classic market approach and, hence, we cannot presume that competitive procurement will produce the most economically efficient (best value) outcome. Certain economic activities are organized outside of markets precisely because these non-standard arrangements are a more efficient (economize on transaction costs) mode of organization for the particular activity, good or service.

For these reasons, the state proposes to retain the central dimensions of the waiver program (eligibility model for specialty services, designation of a single-specialty-PHP per area) and the basic framework for specialty PHP selection (restrict initial consideration to CMHSPs). We will describe the revised procurement plan in detail later in the document. But first, the state will identify problematic aspects of the proposed approach to procurement and indicate safeguards that might be applied to compensate for these limitations.

3. LIMITATIONS AND COMPENSATIONS

The state's proposal to use a non-standard procurement process, with a restricted pool of initial applicants (CMHSPs) and the selection of a single PHP for each designated area, carries with it hazards that must be recognized and remedied. In the sections below, the state examines some of the weaknesses and liabilities of the proposed procurement framework and identifies methods to compensate for these vulnerabilities.

3.1. OPPORTUNISM AND POTENTIAL FOR COLLUSION

In previous discussions, HCFA has raised the general caution that sole-source procurement and relational contracting between the state and county-sponsored entities may gradually tilt toward opportunism and unintended collusion, to the detriment of the federal government. If incentives, risk arrangements and contractual provisions are poorly structured, county-sponsored entities could accumulate significant savings from Medicaid specialty PHPs activities, and these savings could be used to supplant or reduce state general fund obligations and local contributions for services to non-Medicaid, state-defined priority populations.

The state has already taken necessary steps to eliminate these risks (opportunism and collusion) to our federal partners. Capitation rates for specialty services were based upon fee-for-service or claims data for beneficiaries that have fairly predictable

expenditure histories for specialty care. Capitation payments to the specialty PHPs under the waiver must be used to provide Medicaid covered state plan specialty services (or approved alternatives) to eligible Medicaid beneficiaries. Savings achieved by the specialty PHP within the approved risk corridor *must* be reinvested back into services for Medicaid beneficiaries and may not be diverted to purchase services for non-Medicaid recipients. Finally, the state agreed that no capitation payments to specialty PHPs would be returned to the state as an intergovernmental transfer.

3.2. THE NUMBER OF SPECIALTY PHPS: ADMINISTRATIVE CAPABILITIES AND EFFICIENCIES

Under the current arrangement, MDCH contracts with each of the 49 Community Mental Health Service Programs to serve as the specialty PHP within their designated service area. The number of Medicaid beneficiaries covered by a specialty PHP ranges from over 300,000 in the largest CMHSP-PHP, to less than 3,000 in the smallest CMHSP-PHP.

There are certain efficiencies or returns to scale in PHP administrative activities as the number of covered lives increases. Beyond efficiency considerations, larger size confers other advantages, including greater adaptive capabilities (i.e., the ability to meet enhanced PHP administrative requirements, particularly those related to data management and quality monitoring systems) and better ability to absorb risk (including chance variations in utilization).

In short, efficiency characteristics, administrative capacity requirements and risk management considerations all imply that the state should *reduce the number of specialty PHPs* in future procurements. The state's revised plan for PHP selection directly addresses the need for reduction by imposing a *minimum number of covered lives criteria* as a pre-qualification standard for specialty PHPs.

3.3. CONFLICT OF INTEREST SAFEGUARDS

MDCH has argued that, in general, CMHSPs with certain characteristics are the entities best qualified to serve as the specialty PHPs. This implies, however, that the administrative or management role of the CMHSP is primary, and that this function be distinguished from the CMHSPs activities as a direct provider of services.

Conflict of interest issues related to CMHSPs as specialty PHPs can develop at both the administrative (managerial) and the direct-service levels. Since CMHSPs (if selected as the specialty PHP) will manage both Medicaid and non-Medicaid resources, they may be tempted to *disproportionately* apply Medicaid funds (imprecise cost allocation) to support their overall administrative burden. At a direct provider level, the CMHSPs may prefer to maintain existing direct operations, even when outside suppliers may be more efficient or offer higher quality.

The state believes that it can promote administrative efficiencies within specialty PHPs (beyond those efficiencies garnered through a reduction in the number of specialty PHPs) and reduce conflict-of-interest temptations by imposing a limit on administrative payments to PHPs. To this end, the state intends to make Medicaid capitation payments that are comprised of "administrative" and "service" components. The specialty PHP may only use the administrative component of the capitation payments to underwrite the cost of contractually defined PHP administrative activities.

To assure the primacy of the CMHSP managerial role and to reduce potential conflict-of-interest regarding direct program operation, MDCH will require that the provider network of the specialty PHP be assembled either through competitive contracting, or

through a comparative cost method that demonstrates network selection processes were equitable to all interested entities and that the providers selected represent “best-value” from a price and quality perspective.

3.4. Principal-Agent Problems in an Eligibility-Based, Single Plan Model

Michigan has employed an eligibility model rather than an enrollment model for Medicaid specialty services. Any Medicaid beneficiary in a given area that needs specialty services may obtain such care from the designated specialty PHP that serves that area. MDCH designates a single entity within each area to operate as the specialty PHP.

The state believes that the eligibility model and the single-PHP-per-area approach have important benefits in a specialty service system of care. Enrollment models for specialty care present substantial administrative complexities and entail significant transaction costs. Similarly, several specialty PHPs in an area multiples administrative costs and presents adverse selection problems that are difficult to anticipate and counteract.

Beyond the costs and complexities, the state contends that enrollment models and multiple plans do not provide beneficiaries with the kinds of choices they value the most. The economic characteristics of specialty service provision impose some natural limits on the number and types of supplier organizations. In multiple plan situations, competing managing entities frequently contract with the same, relatively stable, network of community providers. The ability to choose between managing organizations that have very similar or identical provider arrangements does not materially increase the beneficiary’s true freedom to choose and the opportunity to achieve.

While the state believes that there is a compelling case for an eligibility approach and a single-PHP-per-area model, it does acknowledge that this arrangement presents some nettlesome *principal-agent problems* for beneficiaries. Under the MDCH model, a CMHSP (if selected as the specialty PHP) is the "agent" charged with acting on behalf of the "principal" - the beneficiary with a serious mental illness, developmental disability and/or addictive 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 the MDCH framework for specialty PHPs, three problematic principal-agent situations can be anticipated:

- Access and Eligibility Decisions
- Application of Person-Centered Planning
- Plan Implementation (including disclosure of options and resource allocation)

In Part Three of this document, MDCH will suggest specific remedies for each of these potential principal-agent problems. In general, state solutions involve reducing information asymmetries (providing beneficiaries better information about access, eligibility and service alternatives), tighter monitoring, and introduction of an external facilitation option (for person-centered-planning).

3.5. Dealing with the Possibility of Non-Market Failure

Since MDCH has proposed that county-sponsored governmental entities be afforded initial consideration as specialty PHPs, it is fair to ask what the state will do if a CMHSP

does not meet qualification standards for selection, or if a selected CMHSP does not fulfill performance requirements.

There is a legitimate concern that granting initial consideration to CMHSPs for specialty PHP designation could degenerate - under political pressures - into a perfunctory process that virtually guarantees approval for incumbent entities even if they have serious deficiencies.

To preclude this possibility, MDCH will employ rigorous and objective qualification criteria and utilize a special procurement committee (with beneficiaries, family and advocacy representation on the committee) to select specialty PHPs. If a CMHSP does not meet the qualifications set by MDCH and as adjudged by the committee, the area will be declared vacant in regard to a specialty PHP and open for competitive solicitation. Both public entities and private organizations will be permitted to bid in these open regions.

If the procurement committee does certify that a CMHSP meets the qualifications for specialty PHP designation, the state will retain the option to sanction, temporarily operate or replace a poorly performing CMHSP-PHP. Replacement of the CMHSP-PHP, if necessary, would be accomplished through competitive solicitation.

In the event that a CMHSP-PHP must be replaced, the state will insist upon recovery of reserve funds and assets related to the Medicaid managed specialty service program, to satisfy residual obligations of the old PHP and to assist with start-up costs for the replacement entity.

4. A Final Perspective on these Limitations and Remedies

These imperfections in the proposed procurement framework may seem daunting at first glance. It is important to reiterate, however, an important consideration previously noted in this document. *All methods* for selecting specialty PHPs - both competitive models and other arrangements - have problems and imperfections. In the comparative analysis of procurement options, MDCH concluded that competitive or market selection of PHPs posed more serious and irremediable problems - *in relation to the primary objectives of the state's managed specialty services program* - than did non-competitive procurement and sole-source contracting. In short, the state could not identify any superior feasible alternative arrangement (to the current procurement method) that could be devised and implemented with a net gain for disabled beneficiaries. The state believes that its refined or adjusted procurement model is the best *feasible* method to ensure that selected specialty PHPs are committed *to the larger end or greater goal* of the managed care program: that is, enhancing the beneficiary's freedom and opportunity to select services and support arrangements that are consistent with personal preferences, identified needs and individual life objectives.

PART THREE: REVISED MDCH PLAN FOR PROCUREMENT OF SPECIALTY PHPS

1. INTRODUCTION

As previously indicated, MDCH plans to *retain the fundamental structure* of the current waiver program and procurement model while simultaneously *introducing certain significant alterations* to address particular areas of concern. The basic strategy for compensatory modifications has been briefly described in Part Two of this document. In this section, the basic strategy is directly applied and described with greater specificity.

2. BASIC STRUCTURAL CONFIGURATION AND PLAN DIMENSIONS

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

2.1. PRESERVATION OF THE CARVE OUT, RETENTION OF ELIGIBILITY & SINGLE PHP MODEL

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

2.2. ROLE OF COMMUNITY MENTAL HEALTH SERVICES PROGRAMS (CMHSPS)

As noted previously, the institutional (legal) environment, experience considerations, equity functions, economic features and particular output (community inclusive outcomes) characteristics make competition for specialty PHPs impractical.

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

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

2.3. SAFEGUARDS REGARDING MEDICAID FUNDS

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

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

3. ALTERATIONS AND ADJUSTMENTS

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

3.1. MINIMUM COVERED LIVES CRITERIA

Single CMHSPs that have at least 20,000 Medicaid beneficiaries (covered lives) within their respective catchment area boundaries will be eligible (as individual stand-alone

organizations) to apply for designation as a specialty Prepaid Health Plan for their catchment area. CMHSPs that do not meet the covered lives criteria will be afforded a range of options for program participation, including an opportunity for *multiple contiguous CMHSPs to make a consolidated application* for PHP designation.

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

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

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

3.1.1.1. Affiliation & Consolidated Application for PHP Designation

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

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

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

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

In the event that various contiguous CMHSPs cannot form affiliations or PHP regions that meet the minimum covered lives standard, or if a

CMHSP does not indicate its preferred participation option for the Medicaid managed specialty services program, the department may open the region for competitive procurement or designate an adjacent qualifying CMHSP to serve as the specialty PHP for the region.

3.2. Qualification Requirements for PHP Designation: Application for Participation

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

3.2.1. Administrative Capabilities

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

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

Administrative capabilities include, but are not limited to:

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

3.2.2. Administrative Costs

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

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

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

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

3.2.3. Equity Functions and Community Inclusive Practices and Outcomes

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

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

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

3.2.4. Service Array

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

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

3.2.5. Service Eligibility

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

MDCH will require, as a condition of participation, that the CMHSP - through its customer or member service program - monitors access and eligibility determination processes to assess the prevalence of both informal and formal denials of service eligibility. The CMHSP will be required to utilize a variety of monitoring and testing techniques - including "mystery shopper" programs - and to document corrective actions taken when problems are detected. These local requirements do not preclude additional monitoring at the state level.

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

3.2.6. Provider Network Selection, Composition and Configuration

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

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

3.2.6.1. Single CMHSPs with over 100,000 Medicaid Covered Lives

CMHSPs with over 100,000 Medicaid beneficiaries in the service area must assemble the provider network through a competitive selection process. Bids or proposals received in response to the procurement must be reviewed *by a joint evaluation panel composed of CMHSP officials, MDCH representatives and beneficiaries and/or their family members*.

The purpose of the procurement process for CMHSPs with over 100,000 covered Medicaid lives is not to select large numbers of unaffiliated individual practitioners, agencies and programs. Rather, the CMHSP should design the procurement process to attract competing proposals from vertically integrated, comprehensive, Provider Sponsored Specialty Networks (PSSN). PSSNs are organized and operated by affiliated groups of providers and offer relatively complete "systems of care" for beneficiaries with particular conditions.

A CMHSP with more than 100,000 covered Medicaid lives must select at least two PSSNs for each special population (i.e., adults with mental

illness and/or addictive disorders; children with emotional disturbances and/or addictive disorders, and persons with developmental disabilities). Beneficiaries would have a choice regarding which PSSN they elected to use for specialty care, and could move between these networks if dissatisfied. The CMHSP-PHP may use prospective and risk-based payment arrangements with the PSSNs, as long as it is recognized that PSSNs are not "plans" (no beneficiary enrollment) and appropriate adjustments are made to reflect beneficiary movement and service use variation.

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

3.2.6.2. CMHSPs with 20,000 to 100,000 Medicaid Covered Lives

Single CMHSPs (or affiliated group of CMHSPs) with 20,000 to 100,000 Medicaid covered lives within the catchment area would be required to develop a plan for the selection of network providers that defined and assured “best value” for the Medicaid program and for beneficiaries.

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

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

3.2.7. Facilitating Consumer Choice and the Opportunity to Achieve

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

3.2.7.1. Service Plan Development

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

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

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

3.2.7.2. Service Array and Provider Choice Accommodations

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

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

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

3.2.7.3. Consumer Operated Services and Consumer Directed Support Models

MDCH, consumers, family members and advocacy organizations have promoted consumer involvement in all aspects of the specialty service system, including governance, needs assessment, service planning, provider recruitment and selection, and quality oversight. The department strongly endorses the principle that consumers should be involved in all decisions that affect their lives, and MDCH supports program models that increase beneficiary participation in service delivery, and which afford individuals greater choice and control over service and support arrangements.

In keeping with this principle and emerging service paradigms, CMHSPs must develop and promote the use of consumer operated service models and consumer-directed support options that are

consistent with the desires, preferences, health and welfare needs of beneficiaries and compatible with existing regulations.

4. SELECTION PROCESS FOR SPECIALTY PREPAID HEALTH PLANS

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

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

5. CONTRACT MANAGEMENT, QUALITY MANAGEMENT AND ENFORCEMENT ACTION

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

The quality management system for monitoring PHP performance will be enhanced to comply with officially promulgated final federal rules related to the Balanced Budget Act of 1997, including the requirement for PHPs to have internal quality improvement programs consistent with HCFA's Quality Improvement System in Managed Care (QISMC) guidelines. It will also incorporate the finding and recommendations that emerged from HCFA monitoring visits conducted during June and July of 2000.

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

CONCLUDING REMARKS

This document summarizes the state's efforts to meet federal requirements for competitive procurement of specialty PHP contracts. In the course of its explorations, the state concluded that certain important considerations and characteristics made market selection of specialty PHPs impractical and undesirable. The state provided a detailed rationale for this conclusion and described the benefits of a different type of procurement process. The state also took note of the problematic aspects of this alternative procurement method and suggested different remedies and compensations for these problems. Finally, in the last section of the paper, the state explained the basic structure for procurement, the proposed criteria for PHP designation, and provided details regarding the selection process and panel.