

PERFORMANCE AUDIT  
OF THE  
  
REQUEST FOR PROPOSAL FOR THE  
SOUTHEAST MICHIGAN  
COMPREHENSIVE HEALTH CARE PROGRAM

DEPARTMENT OF COMMUNITY HEALTH  
AND  
DEPARTMENT OF MANAGEMENT AND BUDGET

June 1998

## EXECUTIVE DIGEST

# REQUEST FOR PROPOSAL FOR THE SOUTHEAST MICHIGAN COMPREHENSIVE HEALTH CARE PROGRAM

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INTRODUCTION	This report, issued in June 1998, contains the results of our performance audit* of the Request for Proposal (RFP) for the Southeast Michigan Comprehensive Health Care Program for five counties (Wayne, Oakland, Macomb, Washtenaw, and Genesee) developed by the Department of Community Health (DCH) and the Department of Management and Budget (DMB).
AUDIT PURPOSE	This performance audit was conducted in response to a legislative request and as part of the constitutional responsibility of the Office of the Auditor General. Performance audits are typically conducted on a priority basis related to the potential for improving effectiveness* and efficiency*.
BACKGROUND	DCH and DMB developed the RFP to solicit bids from qualified health plans to provide managed care* programs delivering comprehensive health care services to Medicaid* recipients in the five Southeast Michigan counties.

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\* See glossary on page 41 for definition.

Proposals submitted pursuant to the RFP were evaluated by an eight-member joint evaluation committee\* (Committee), which used a four-step process to evaluate proposals received from 24 health plans. Upon the completion of its evaluation process, the Committee recommended that the DMB Office of Purchasing award contracts to 13 of the 24 health plans. The Office of Purchasing received written appeals from 11 unsuccessful health plans and from 1 health plan that was successful in one county but unsuccessful in another county. These appeals and related proposals were reevaluated by the Committee, and it found that the 12 health plans still did not meet all of the RFP's minimum requirements for qualified health plans. However, the Office of Purchasing reviewed the appeals and related proposals and determined that 5 of the 12 health plans that submitted appeals met the minimum requirements for qualified health plans, which allowed them to proceed through the health plan selection process and be recommended for contract awards.

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AUDIT OBJECTIVES,  
CONCLUSIONS, AND  
NOTEWORTHY  
ACCOMPLISHMENTS

**Audit Objective:** To assess DCH's and DMB's effectiveness in the RFP development, health plan selection, and contract awards recommendation processes.

**Conclusion:** We concluded that DCH and DMB were generally effective in the RFP development, health plan selection, and contract awards recommendation processes. However, our audit disclosed one material condition\*:

- The Southeast Michigan Comprehensive Health Care Program RFP's "best and final bid process" was not

\* See glossary on page 41 for definition.

effective in ensuring competitive bidding. DMB publicly disclosed the amount of the highest acceptable bid received prior to completing the best and final bid process. This provided the opportunity for two health plans to subsequently submit their best and final bids after knowing, in advance, the amount of the highest acceptable bid received. (Finding 1)

DCH and DMB agreed with our related recommendation and informed us that they have already taken steps to ensure that the methodology of future RFPs will ensure increased competitiveness.

We also noted reportable conditions\* related to qualification standards, documentation of evaluations, and planning for the readiness review\* process (Findings 2 through 4).

**Noteworthy Accomplishments:** DCH and DMB developed the RFP as 1 of 5 health care initiatives designed to restructure the delivery of health care services to the Medicaid population. The health care initiatives are intended to improve recipient health care Statewide and result in multimillion dollar savings to the State. DCH estimates that the implementation of the Comprehensive Health Care Program for the five Southeast Michigan counties will result in savings of over \$100 million in fiscal year 1997-98.

**Audit Objective:** To assess DCH's and DMB's compliance with State and federal laws and regulations in the RFP development, health plan selection, and contract awards recommendation processes.

\* See glossary on page 41 for definition.

**Conclusion:** We concluded that DCH and DMB were generally in compliance with State and federal laws and regulations in the RFP development, health plan selection, and contract awards recommendation processes. However, our assessment disclosed a reportable condition related to the medical care advisory committee (Finding 5).

**Audit Objective:** To assess the adequacy of financial requirement provisions of the RFP.

**Conclusion:** We concluded that financial requirement provisions of the RFP were generally adequate. However, our assessment disclosed a reportable condition related to RFP financial viability standards (Finding 6).

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<b>AUDIT SCOPE AND METHODOLOGY</b>	<p>Our audit scope was to assess the development of the request for proposal and the related health plan selection and contract awards recommendation processes for the Comprehensive Health Care Program for five Southeast Michigan counties (Wayne, Oakland, Macomb, Washtenaw, and Genesee). Our audit was conducted in accordance with <i>Government Auditing Standards</i> issued by the Comptroller General of the United States and, accordingly, included such tests of the records and such other auditing procedures as we considered necessary in the circumstances.</p> <p>Our objectives were designed primarily to answer the following eight legislative questions:</p> <ol style="list-style-type: none"><li>1. What qualification standards were used to evaluate the health plans?</li><li>2. What outcome measurements were included in the RFP?</li></ol>
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3. How do the terms of the RFP compare with similar provisions of RFPs issued by other states which have preceded Michigan in managed care initiatives?
4. Did the terms of the RFP comply with requirements of the Health Care Financing Administration, U.S. Department of Health and Human Services?
5. What level of services was required?
6. What involvement was there from the DMB Office of Purchasing?
7. Were the health plans required to submit audited financial statements and, if so, who evaluated them?
8. Do the terms of the RFP allow State and federal agencies to audit contractors' financial and performance practices?

Specific answers to these questions are included in this report as supplemental information.

Our audit methodology included examinations of the Comprehensive Health Care Program records and activities for the period May 1997 through January 1998.

To accomplish our first objective, we reviewed methods and standards used to evaluate health plans and to measure outcomes. Also, we compared provisions of the RFP with government contracting standards and RFPs issued by four other states. In addition, we interviewed DCH and DMB staff involved in the development and implementation of the RFP.

To accomplish our second objective, we evaluated various features of the RFP for compliance with State and federal laws and regulations for the Medicaid Program and State procurement rules and contracting laws and regulations.

To accomplish our third objective, we evaluated the RFP provisions related to health plans' financial practices. Also, we evaluated criteria used in assessing health plans' financial data.

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**AGENCY RESPONSES**

Our audit report includes 6 findings and 6 corresponding recommendations. DCH and DMB agreed with all 6 recommendations.

Mr. James K. Haveman, Jr., Director  
Department of Community Health  
and  
Ms. Janet E. Phipps, Director  
Department of Management and Budget  
Lewis Cass Building  
Lansing, Michigan

Dear Mr. Haveman and Ms. Phipps:

This is our report on the performance audit of the Request for Proposal for the Southeast Michigan Comprehensive Health Care Program for five counties (Wayne, Oakland, Macomb, Washtenaw, and Genesee) developed by the Department of Community Health and the Department of Management and Budget.

This report contains our executive digest; description of program; audit objectives, scope, and methodology and agency responses; comments, findings, recommendations, and agency preliminary responses; responses to legislative questions and a schedule of accepted rates by county and plan, presented as supplemental information; and a glossary of acronyms and terms.

Our comments, findings, and recommendations are organized by audit objective. The agency preliminary responses were taken from the agencies' responses subsequent to our audit fieldwork. The *Michigan Compiled Laws* and administrative procedures require that the audited agencies develop a formal response within 60 days after release of the audit report.

We appreciate the courtesy and cooperation extended to us during this audit.

AUDITOR GENERAL

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## **TABLE OF CONTENTS**

# **REQUEST FOR PROPOSAL FOR THE SOUTHEAST MICHIGAN COMPREHENSIVE HEALTH CARE PROGRAM DEPARTMENT OF COMMUNITY HEALTH AND DEPARTMENT OF MANAGEMENT AND BUDGET**

## **INTRODUCTION**

	<u>Page</u>
Executive Digest	1
Report Letter	7
Description of Program	11
Audit Objectives, Scope, and Methodology and Agency Responses	13

## **COMMENTS, FINDINGS, RECOMMENDATIONS, AND AGENCY PRELIMINARY RESPONSES**

Effectiveness in Development and Implementation	16
1. Best and Final Bid Process	18
2. Qualification Standards	22
3. Documentation of Evaluations	24
4. Planning for the Readiness Review Process	25
Compliance With Laws and Regulations	27
5. Medical Care Advisory Committee	28
Adequacy of Financial Requirement Provisions	29
6. RFP Financial Viability Standards	29

## **SUPPLEMENTAL INFORMATION**

Responses to Legislative Questions	33
Schedule of Accepted Rates by County and Plan	39

## GLOSSARY

Glossary of Acronyms and Terms

41

## Description of Program

The Medicaid Program (Title XIX of the federal Social Security Act) is a national health assistance program for families in need of temporary assistance and low-income individuals who are aged, blind, disabled, or members of at-risk groups.

The federal government establishes regulations, guidelines, and policy interpretations which describe the broad framework within which states can tailor their individual programs. Each state operates Medicaid programs under a "state plan" which is developed within this broad framework. Michigan's Medicaid Program is administered by the Medical Services Administration, Department of Community Health (DCH). During fiscal year 1995-96, the Medicaid Program incurred expenditures of \$5.4 billion, of which \$3.1 billion was federally funded and \$2.3 billion was funded by the State. The Program provided medical services to 1,171,622 recipients Statewide.

Under federal authorization granted by the State Medicaid Plan and waiver provisions and Act 352, P.A. 1996, DCH continued to implement mandatory managed care enrollment for Medicaid recipients residing in counties with managed care options. Contracts issued pursuant to Act 352 would result in capitated rates\* based on a competitive bid process as opposed to traditional "fee-for-service" provider enrollment.

In fiscal year 1995-96, DCH announced plans to restructure its health care delivery system and become a value purchaser\* of specified health services for the State's Medicaid population. DCH and the Department of Management and Budget (DMB) developed a request for proposal (RFP) to solicit bids from qualified health plans to provide a Comprehensive Health Care Program for each of five Southeast Michigan counties (Wayne, Oakland, Macomb, Washtenaw, and Genesee). DMB issued the RFP on November 7, 1996. The RFP is intended to result in contracts for managed care programs delivering comprehensive health care services to approximately 470,000 Medicaid recipients in the five Southeast Michigan counties at an estimated cost of \$1.2 billion for the contract period of July 1, 1997 through December 31, 1998.

\* See glossary on page 41 for definition.

In order to implement its managed care initiatives, DCH obtained a Medicaid waiver from the Health Care Financing Administration, U.S. Department of Health and Human Services. The waiver, which was granted on May 30, 1997, authorizes DCH to implement mandatory managed care enrollment and waives sections of the Social Security Act applicable to Medicaid requirements for freedom of choice, comparability of services, and Statewide coverage.

## Audit Objectives, Scope, and Methodology and Agency Responses

### Audit Objectives

Our performance audit of the Request for Proposal (RFP) for the Southeast Michigan Comprehensive Health Care Program developed by the Department of Community Health (DCH) and the Department of Management and Budget (DMB) had the following objectives:

1. To assess DCH's and DMB's effectiveness in the RFP development, health plan selection, and contract awards recommendation processes.
2. To assess DCH's and DMB's compliance with State and federal laws and regulations in the RFP development, health plan selection, and contract awards recommendation processes.
3. To assess the adequacy of financial requirement provisions of the RFP.

### Audit Scope

Our audit scope was to assess the development of the request for proposal and the related health plan selection and contract awards recommendation processes for the Comprehensive Health Care Program for five Southeast Michigan counties (Wayne, Oakland, Macomb, Washtenaw, and Genesee). Our audit was conducted in accordance with *Government Auditing Standards* issued by the Comptroller General of the United States and, accordingly, included such tests of the records and such other auditing procedures as we considered necessary in the circumstances.

Our objectives were designed primarily to answer the following eight legislative questions:

1. What qualification standards were used to evaluate the health plans?
2. What outcome measurements were included in the RFP?

3. How do the terms of the RFP compare with similar provisions of RFPs issued by other states which have preceded Michigan in managed care initiatives?
4. Did the terms of the RFP comply with requirements of the Health Care Financing Administration, U.S. Department of Health and Human Services?
5. What level of services was required?
6. What involvement was there from the DMB Office of Purchasing?
7. Were the health plans required to submit audited financial statements and, if so, who evaluated them?
8. Do the terms of the RFP allow State and federal agencies to audit contractors' financial and performance practices?

Specific answers to these questions are included in this report as supplemental information.

#### Audit Methodology

Our audit methodology included examinations of the Comprehensive Health Care Program records and activities for the period May 1997 through January 1998.

To accomplish our first objective, we reviewed methods and standards used to evaluate health plans and to measure outcomes. Also, we compared provisions of the RFP with government contracting standards and RFPs issued by four other states. In addition, we interviewed DCH and DMB staff involved in the development and implementation of the RFP.

To accomplish our second objective, we evaluated various features of the RFP for compliance with State and federal laws and regulations for the Medicaid Program and State procurement rules and contracting laws and regulations.

To accomplish our third objective, we evaluated the RFP provisions related to health plans' financial practices. Also, we evaluated criteria used in assessing health plans' financial data.

### Agency Responses

Our audit report includes 6 findings and 6 corresponding recommendations. DCH and DMB agreed with all 6 recommendations.

The agency preliminary response which follows each recommendation in our report was taken from the agencies' written comments and oral discussion subsequent to our audit fieldwork. Section 18.1462 of the *Michigan Compiled Laws* and Department of Management and Budget Administrative Guide procedure 1280.02 require DCH and DMB to develop a formal response to our audit findings and recommendations within 60 days after release of the audit report.

# **COMMENTS, FINDINGS, RECOMMENDATIONS, AND AGENCY PRELIMINARY RESPONSES**

## **EFFECTIVENESS IN DEVELOPMENT AND IMPLEMENTATION**

### **COMMENT**

**Background:** Proposals submitted pursuant to the request for proposal (RFP) for the Southeast Michigan Comprehensive Health Care Program were evaluated by an eight-member joint evaluation committee (Committee), which consisted of staff from the Department of Community Health (DCH), Department of Management and Budget (DMB), Department of Civil Service, and Department of Consumer and Industry Services. The Committee included a nonvoting chairperson who was an employee of the DMB Office of Purchasing. The Committee used a four-step process to evaluate proposals received from 24 health plans:

1. Proposals were reviewed to determine if they were submitted in accordance with RFP instructions.
2. Proposals were evaluated and scored to determine if the health plans met standards necessary to become "qualified health plans."
3. Proposals were evaluated and scored to determine if they contained attributes applicable to the unique needs of the Medicaid population.
4. Price proposals were opened and used to calculate "proposal scores," which included bid prices and the scores awarded in Steps 2 and 3.

Upon the completion of its evaluation process, the Committee recommended that the DMB Office of Purchasing award contracts to 13 of the 24 health plans. The Office of Purchasing concurred with the Committee recommendations for these 13 health plans. DMB received written appeals from 11 unsuccessful health plans and from 1 health plan that was successful in one county but unsuccessful in another county. These appeals and related proposals were reevaluated by the Committee, and it found that the 12 health plans still did not meet all of the RFP's minimum requirements for

qualified health plans. However, the Office of Purchasing reviewed the appeals and related proposals and determined that 5 of the 12 health plans that submitted appeals met the minimum requirements for qualified health plans, which allowed them to proceed through the health plan selection process and be recommended for contract awards.

In summary, 18 of the 24 health plans completed the health plan selection process and were recommended for contract awards. On August 5, 1997, the State Administrative Board granted approval for the State to contract with these 18 health plans. Prior to contract finalization, DCH planned "readiness reviews" of all recommended contractors to ensure that they were prepared to meet the conditions of the contract as stipulated in the RFP.

**Audit Objective:** To assess DCH's and DMB's effectiveness in the RFP development, health plan selection, and contract awards recommendation processes.

**Conclusion:** We concluded that DCH and DMB were generally effective in the RFP development, health plan selection, and contract awards recommendation processes. However, our audit disclosed one material condition. The Southeast Michigan Comprehensive Health Care Program RFP's "best and final bid process" was not effective in ensuring competitive bidding. DMB publicly disclosed the amount of the highest acceptable bid received prior to completing the best and final bid process. This provided the opportunity for two health plans to subsequently submit their best and final bids after knowing, in advance, the amount of the highest acceptable bid received.

We also noted reportable conditions related to qualification standards, documentation of evaluations, and planning for the readiness review process.

**Noteworthy Accomplishments:** DCH and DMB developed the RFP as 1 of 5 health care initiatives designed to restructure the delivery of health care services to the Medicaid population. The health care initiatives are intended to improve recipient health care Statewide and result in multimillion dollar savings to the State. DCH estimates that the implementation of the Comprehensive Health Care Program for the five Southeast Michigan counties will result in savings of over \$100 million in fiscal year 1997-98.

## **FINDING**

### **1. Best and Final Bid Process**

The Southeast Michigan Comprehensive Health Care Program RFP's best and final bid process was not effective in ensuring competitive bidding.

As a component of the overall health plan selection process, DMB used a best and final bid process to help ensure that the State obtained the best combination of price and quality while providing health plans, whose bids exceeded DCH's confidential price ceiling, a second chance opportunity to obtain a State managed health care contract. However, DMB publicly disclosed the amount of the highest acceptable bid received prior to completing the best and final bid process. This provided the opportunity for two health plans to subsequently submit their best and final bids after knowing, in advance, the amount of the highest acceptable bid received.

In the proposal evaluation process, seven health plans met the qualification standards but submitted bids that exceeded the confidential price ceiling in one or more counties. On April 16, 1997, DMB requested the seven health plans to submit best and final bids for the respective counties by April 25, 1997. Five of the seven health plans' best and final bids were below the price ceiling for the respective counties, and one health plan's bid was below the price ceiling for two of the three counties for which it bid on. The six health plans were permitted to proceed through the health plan selection and contract awards recommendation processes.

On May 5, 1997, DMB sent notification of the bidding results to the bidding health plans and included the bid amounts of the successful bidders. DMB established an appeals window which was open from May 5, 1997 through May 19, 1997. Eleven health plans that did not qualify in the proposal evaluation process submitted appeals based on qualification issues.

Two of the appellant health plans successfully qualified in the appeals process but had submitted bids that exceeded the price ceiling for the respective counties. On July 23, 1997, DMB requested the two health plans to submit their best and final

bids by July 24, 1997. The two appellant health plans each submitted best and final bids which were at or near the highest acceptable bid amounts for the respective counties:

County/Plan	Range of Acceptable Bids	Best and Final Bid From Appellant Health Plans
<u>Wayne County</u>	\$135.35 to \$164.00	
Health Plan A		\$164.00
Health Plan B		\$162.78
<u>Macomb County</u>	\$132.16 to \$146.00	
Health Plan B		\$145.31

Note: Amounts presented are per recipient per month.

We concluded that DMB's disclosure on May 5, 1997 of the bid amounts of the successful bidders provided the opportunity for the two health plans to have a competitive advantage by submitting their best and final bids knowing, in advance, the amount of the highest acceptable bid received. Although it is unknown what best and final bids the two health plans would have submitted had the bid amounts of the successful bidders not been disclosed, it is likely that the disclosure resulted in a significant cost to the State. For example, if Health Plan A had submitted a best and final bid of \$155.65 (the average acceptable bid for Wayne County), the first 6-month contract, covering the period July 1 through December 31, 1997, would have been approximately \$1.1 million less.

DCH and DMB staff informed us that the Freedom of Information Act requires DMB to publicly disclose bids, and they could not foresee a procedural remedy to ensure that similar incidences would not recur in processing future RFPs. However, one possible alternative for future RFPs would be to simultaneously solicit best and final bids from all health plans whose bids are above the price ceiling, regardless of each plan's standing in the qualification evaluation process.

We are aware of at least four health plans that were successful in the proposal and bid process but subsequently filed written complaints regarding the best and final bid process. The four health plans requested that their contracts be increased to the highest acceptable price retroactive to July 1, 1997. DMB informed us that it did not consider the four complaints because they were not filed timely within the appeals period, even though the complaints were based on an event occurring after the appeals period. However, in correspondence to the attorney for one complainant health plan, DMB stated that the issue will be taken into consideration during the price negotiation process for calendar year 1998.

In an attempt to redress concerns related to the 1997 best and final bid process, DMB issued an instructional letter outlining the price negotiation process for calendar year 1998 and included the highest acceptable price for each county. DCH and DMB regarded this as a normal negotiation process. However, announcing the highest acceptable price prior to accepting bids removed the competitiveness feature typically present in an RFP process. Based on February 1998 enrollment data, the contracts were increased approximately \$18 million annually for 1998 over 1997 contracts (approximately \$807 million annualized cost for comparison purposes) because most health plans submitted bids at the highest acceptable price.

The following exhibit compares the bid rates accepted for 1998 and 1997 by county (see supplemental information for accepted rates by county and plan):

County	1998			1997
	Number of Bids Accepted	Number of Bids Accepted at Highest Rate	Range of Accepted Rates (A)	Range of Accepted Rates (A)
Wayne	16	12	\$155.00 - \$162.95 (B)	\$135.35 - \$164.00
Oakland	14	11	\$141.95 - \$148.79 (B)	\$132.16 - \$151.52
Macomb	13	12	\$137.75 - \$138.21 (B)	\$132.16 - \$146.00
Washtenaw	6	5	\$138.59 - \$138.89 (B)	\$132.16 - \$150.00
Genesee	5	4	\$136.18 - \$140.24 (B)	\$139.74 - \$145.00

(A) Amounts presented are per recipient per month.

(B) Highest acceptable rate.

Also, DCH removed substance abuse services from the Southeast Michigan Comprehensive Health Care Program contracts beginning January 1, 1998 without mandating related price reductions. DMB instructions to health plans stated that 1998 prices should reflect removal of this responsibility. However, only 1 of the 18 health plans submitted a bid identifying a reduction for substance abuse services. DCH informed us that it plans to include substance abuse services in future contracts for behavioral health services but had not determined the related value. We plan to consider this issue in a future audit of the managed care program.

### **RECOMMENDATION**

We recommend that DMB develop an effective methodology for ensuring competitive bidding in the best and final bid processes of future RFPs.

### **AGENCY PRELIMINARY RESPONSE**

DCH and DMB agreed with the recommendation and informed us that they have already taken steps to ensure that the methodology of future RFPs will ensure increased competitiveness. However, both DCH and DMB indicated that, as designed, the RFP that was reviewed for this audit was implemented in as competitive a manner as possible and was procedurally irreversible. DCH and DMB stated that the alternative approach has already been employed in the RFP being implemented for the remainder of the State.

In addition, DCH and DMB stated that it is also conjecture that the successful appellant health plans would have submitted a different bid under the best and final offer process and that the estimate provided in the audit report of further potential savings is only an estimate.

DCH and DMB further stated that the statement that the State removed the competitive pricing feature of the RFP for 1998 ignores the feature in the RFP that the initial pricing is the competitive feature and subsequent annual pricing is negotiated based upon available appropriated dollars. Further, the statement that the State is paying \$18 million more in 1998 capitation payments than necessary is based solely on February 1998 enrollment data. Total enrollment in health plans covered by this RFP has fluctuated as represented by the following total target enrollment numbers: January 1998 - 431,691; February 1998 - 441,767; March 1998 - 433,049; and April 1998 - 438,365.

## **FINDING**

### **2. Qualification Standards**

The RFP qualification standards for financial viability, reinsurance, and administrative structure contained subjective criteria to evaluate health plan proposals. Consequently, in the appeals process, the joint evaluation committee (Committee) and the Office of Purchasing differed in their interpretation of some RFP qualification standards. Our review disclosed:

#### a. **Financial Viability**

The RFP did not specify the documentation required to support the financial viability standard for health plans. The RFP required the health plans to be financially and actuarially sound and have working capital of \$250,000, which could be acquired through equity or debt.

The Committee found that 9 health plans did not meet minimum financial standards for qualified health plans for various reasons. For example, the RFP did not address lines of credit. However, on appeal, the Office of Purchasing found that 4 of the 9 health plans met minimum financial standards when considering a health plan's line of credit. Based on this determination, the Office of Purchasing permitted the 4 appellant health plans to proceed through the health plan selection and contract awards recommendation processes. Additional concerns related to health plans' lines of credit are addressed in Finding 6.

#### b. **Reinsurance**

The RFP did not address the method for submitting evidence of reinsurance. The RFP required health plans to submit a reinsurance contract from an insurer authorized to do business in the State or to establish a self-insurance plan prior to readiness review. Health plans' proposals were also required to include a description and documentation of how the reinsurance requirement would be met.

The Committee found that 5 health plans did not meet the reinsurance requirement because they did not include documentation of how they planned to meet reinsurance requirements. However, because the RFP did not specify the method for submitting evidence of reinsurance, the Office of

Purchasing, on appeal, found that this requirement would not be used as a basis for qualified health plan determination for any of the 24 health plans. As a result, the Office of Purchasing permitted 1 of the 5 health plans to proceed through the health plan selection and contract awards recommendation processes. The remaining 4 health plans were not allowed to proceed because they did not meet other requirements of the RFP.

c. Administrative Structure

The Office of Purchasing permitted 2 health plans to proceed through the health plan selection and contract awards recommendation processes that did not meet minimum administrative structure standards as stated in the RFP.

The RFP required that three of a health plan's key personnel (the chief executive officer, chief financial officer, and management information system director) be full-time employees.

A fourth key person (the medical director) was to devote sufficient time to the health plan to ensure timely medical decisions, including after hours consultation as needed.

Of the 11 health plans not recommended by the Committee, 8 health plans did not meet the administrative structure standard. One of these health plans combined the positions of chief executive officer and medical director. Another health plan assigned the position of medical director to two physicians who were also part-time primary care providers. However, on appeal, the Office of Purchasing concluded that the combined positions offered the advantage that administrative decisions would be influenced by medical appropriateness and that the RFP did not prohibit the sharing of responsibilities for the medical director position. Therefore, the Office of Purchasing permitted the 2 health plans to proceed through the health plan selection and contract awards recommendation processes.

We concluded that some health plans proceeded through the health plan selection and contract awards recommendation processes based on subjective interpretations of qualification requirements. Objective evaluation criteria helps to

ensure uniformity and fairness in the evaluation process. Subjective interpretations of the RFP language can result in broadening the RFP requirements.

## **RECOMMENDATION**

We recommend that DCH and DMB exercise care to ensure that managed care RFPs include objective criteria to evaluate health plan proposals.

## **AGENCY PRELIMINARY RESPONSE**

DCH and DMB agreed with the recommendation and will continue to take the necessary steps to ensure that all proposals are evaluated based on the most objective criteria possible.

## **FINDING**

### **3. Documentation of Evaluations**

The Office of Purchasing did not initiate sufficient oversight to ensure that the Committee uniformly documented its evaluation of criteria used to determine if health plans met qualification standards.

DMB Administrative Guide procedure 0510.07 requires the Committee members to document the rationale used to support the numeric evaluations assigned to the various components of an RFP. In the Committee's four-step process, health plans that met all requirements for qualified health plans (step 2) received a score of 70 points per evaluator.

We reviewed evaluation forms and related documentation used to assess health plan qualifications for 4 of the 24 health plans:

- a. The Committee did not document its evaluation of the 25 criteria for the "organizational and administrative structure" standard and the 7 criteria for the "administrative requirements" standard for any of the 4 health plans.

In the evaluation process, Committee members indicated whether health plans met the broad standards. However, affirmation that each specific

criteria was reviewed is needed to provide documented assurance that the Committee members considered all criteria in reaching their determinations.

The two standards required assessments of various items, such as the health plans' organization charts; disclosure statements; administrative personnel; written policies, procedures, and guidelines; provider services; member services; quality improvement programs; and utilization management.

- b. The Committee did not document its evaluation of some of the criteria for the "ability to meet levels of service" standard and the "accessibility" standard. Evaluation forms prepared by Committee members for 2 of the 4 health plans indicated favorable votes for these standards even though summary work sheets indicated that DCH staff could not determine if the plans met 3 of the 8 necessary criteria. Committee members informed us that, as a group, they discussed and verified that all criteria for these standards were met. However, this discussion and verification was not documented.

Uniformity in documenting the Committee's evaluation process is essential to ensure the integrity of the health plan selection process and to ensure that selected health plans meet standards established for qualified health plans.

## **RECOMMENDATION**

We recommend that the Office of Purchasing initiate sufficient oversight to ensure that the Committee uniformly documents its evaluation of criteria used to determine if health plans met qualification standards.

## **AGENCY PRELIMINARY RESPONSE**

DCH and DMB agreed with the recommendation and informed us that they have taken steps to implement it.

## **FINDING**

### **4. Planning for the Readiness Review Process**

DCH did not formalize a methodology to conduct the financial readiness review of all health plans until after it obtained State Administrative Board approval to award contracts to the 18 selected health plans.

The RFP required readiness reviews to assess the qualified health plans' degree of preparedness in areas of organizational and administrative structure, administrative requirements, financial viability, ability to meet levels of service, accessibility, management information system, accreditation, licensing, incorporation, governing body, and reinsurance.

The readiness review process was implemented by two independent consulting firms in coordination with DCH's licensing officers and systems support staff and consumer advocates. As of June 30, 1997, these reviews were completed for the 13 health plans originally selected by the Committee but did not include verification of the health plans' financial requirements. As a result, DCH's ability to implement the Comprehensive Health Care Program was delayed until it completed this final stage of the readiness review.

DCH informed us that it excluded verification of financial requirements from the readiness review process performed by an outside entity because it planned to use DCH audit staff to conduct this final stage of the readiness review process. However, DCH later decided to request its primary contractor to subcontract with an accounting firm to provide the technical expertise required for the verification of financial requirements. DCH did not make this request until after August 5, 1997 when DCH obtained approval from the State Administrative Board. The related subcontract with the accounting firm was effective September 8, 1997.

As a result of the delay in formalizing a methodology to conduct the financial readiness reviews, DCH did not finalize confirmation of the financial readiness of all 18 health plans until January 1998. (DCH confirmed the financial readiness of 6 of the 18 health plans on September 22, 1997; confirmed 9 more plans on September 29, 1997; confirmed 2 more plans on November 17, 1997; and finally confirmed the remaining plan in January 1998.) DCH did not confirm the financial readiness of one health plan until January 1998 because the health plan had not previously satisfied the minimum working capital requirement. However, DMB finalized the contract for this health plan on November 17, 1997 without confirmation of financial readiness because DCH believed that the health plan would eventually satisfy the working capital requirement. DMB finalized the last contract on February 11, 1998, after a delay related to the health plan furnishing DMB with copies of the required insurance forms.

The purpose of the readiness review process is to provide assurance that each successful health plan is administratively and organizationally prepared to provide the full range of comprehensive services to the Medicaid-eligible population in the contracted areas. Thus, completion of the financial readiness reviews prior to obtaining State Administrative Board approval would have provided timely assurance that the health plans were financially prepared to participate in the implementation of the Comprehensive Health Care Program.

### **RECOMMENDATION**

We recommend that DCH formalize its methodology to conduct readiness reviews of health plans' financial requirements prior to obtaining State Administrative Board approval to award contracts to the health plans.

### **AGENCY PRELIMINARY RESPONSE**

DCH and DMB agreed with the recommendation and informed us that they have taken steps to implement it.

## **COMPLIANCE WITH LAWS AND REGULATIONS**

### **COMMENT**

**Background:** Act 352, P.A. 1996, required DCH to continue to implement mandatory managed care enrollment for Medicaid recipients residing in counties with managed care options. The federal government establishes regulations, guidelines, and policy interpretations that describe the broad framework within which states can tailor their Medicaid programs.

**Audit Objective:** To assess DCH's and DMB's compliance with State and federal laws and regulations in the RFP development, health plan selection, and contract awards recommendation processes.

**Conclusion:** We concluded that DCH and DMB were generally in compliance with State and federal laws and regulations in the RFP development, health plan selection, and contract awards recommendations processes. However, our assessment disclosed a reportable condition related to the medical care advisory committee.

## **FINDING**

### **5. Medical Care Advisory Committee**

DCH did not provide for a medical care advisory committee to participate in Medicaid policy development and program administration subsequent to September 1996.

Title 42, Part 431, section 12 of the *Code of Federal Regulations* states that a state plan must provide for a medical care advisory committee and that the committee must have the opportunity for participation in policy development and program administration.

Until September 1996, the Medical Care Advisory Council (MCAC) met monthly to advise the Medical Services Administration about health and medical care services and was included in the consultation process for Medicaid policy. However, in December 1996, the Council was dissolved so that DCH could restructure its advisory process and align it with the new managed care initiatives.

DCH informed us that it is in the process of establishing a new Health Plan Advisory Committee and that former MCAC members still received mailings for consultation on proposed Medicaid policy bulletins. However, a medical care advisory committee has not formally met to consult and participate in the development of Medicaid policy bulletins issued as a result of the new managed care initiatives.

## **RECOMMENDATION**

We recommend that DCH provide for a medical care advisory committee to participate in Medicaid policy development and program administration for the new managed care initiatives.

## **AGENCY PRELIMINARY RESPONSE**

DCH agreed with the recommendation and informed us that it has established a medical care advisory committee to participate in Medicaid policy development and program administration for the new managed care initiatives. However, DCH disagrees with the assertion that MCAC did not participate in Medicaid policy development for the managed care initiatives. Prior to MCAC being dissolved, policy bulletins and State Medicaid Plan amendments regarding managed care initiatives were developed and provided to MCAC for discussion. MCAC was involved during the development of the RFP and consultation bulletins that

established the policy for managed care. DCH made several presentations to and engaged in discussions with MCAC at several meetings during this time period. All subsequent discussions and policy issues have originated from those decisions made while MCAC was in existence.

## ADEQUACY OF FINANCIAL REQUIREMENT PROVISIONS

### **COMMENT**

**Background:** Standards used to evaluate health plans' qualifications were based on health maintenance organization licensing standards, which include requirements for financial viability.

**Audit Objective:** To assess the adequacy of financial requirement provisions of the RFP.

**Conclusion:** We concluded that financial requirement provisions of the RFP were generally adequate. However, our assessment disclosed a reportable condition related to RFP financial viability standards.

### **FINDING**

#### **6. RFP Financial Viability Standards**

The Office of Purchasing allowed 4 appellant health plans to proceed through the health plan selection and contract awards recommendation processes without having documented in their proposals that they met the minimum financial viability standards.

This decision was premised on the concept that the appellant health plans' status in meeting minimum financial standards could be subsequently determined in a readiness review.

In order to ensure that contracted health plans were financially and actuarially sound with the ability to provide continuation of care to Medicaid enrollees, the RFP required that health plans have adequate working capital of \$250,000, which could be acquired through equity or debt. Health plans were also required to provide written financial plans describing their insolvency protection, provisions for

retirement of existing or proposed debt, provisions for maintaining an appropriate amount of working capital, and means for achieving and maintaining positive cash flow.

Our review of bid proposals and successful appeals from 4 appellant health plans disclosed:

- a. The 4 health plans had not submitted evidence that they had the required \$250,000 in working capital. However, the Office of Purchasing permitted the health plans to proceed through the selection and contract awards recommendation processes because they indicated that they had "access" to lines of credit or assets from various sources (see Finding 2).
- b. Although required by the RFP, the 4 health plans had not adequately disclosed provisions for retirement of existing or proposed debt. Therefore, it was unclear whether the health plans could meet the working capital requirements even if draws were made on their lines of credit.
- c. Three of the 4 health plans did not submit evidence of lending agency loan commitments to support assertions that they had access to lines of credit in amounts ranging from \$150,000 to \$1,000,000.

The joint evaluation committee reevaluated the 4 appellant health plans' proposals and found that they did not have sufficient working capital to meet the financial requirements of the RFP; however, the Office of Purchasing permitted the health plans to proceed through the selection and contract awards recommendation processes. The Office of Purchasing allowed them to submit evidence during the financial readiness review process to support their ability to meet financial requirements.

## **RECOMMENDATION**

We recommend that the Office of Purchasing require health plans to comply with the terms of the RFP that require proposals to include documentation that the plans meet the minimum financial viability standards for qualified health plans.

### **AGENCY PRELIMINARY RESPONSE**

DMB agreed with the recommendation and noted that no contracts were issued to health plans that did not meet the minimum financial viability standards. DMB does agree that it is important that the documentation of the minimum financial viability standards appears in the written response to the request for proposal.

## SUPPLEMENTAL INFORMATION

## RESPONSES TO LEGISLATIVE QUESTIONS

### **Summary Overview**

The following eight questions were included in the legislative request to audit the request for proposal (RFP) for the Comprehensive Health Care Program (Program) for five Southeast Michigan counties (Wayne, Oakland, Macomb, Washtenaw, and Genesee) developed by the Department of Community Health (DCH) and the Department of Management and Budget (DMB). Each question is followed by our response:

**Question 1:** What qualification standards were used to evaluate the health plans?

**Response:** Standards used to evaluate the health plans' qualifications were based on the following health maintenance organization licensing standards:

(1) Organizational and Administrative Structure

The health plan has corporate qualifications and experience as a managed care organization and has senior level managers and skilled clinicians for medical management activities.

(2) Administrative Requirements

The health plan has policies, procedures, clinical guidelines, medical records, reporting formats, liability coverage, and provider network information specific to delivering Program services.

(3) Financial Viability

The health plan is financially and actuarially sound with adequate working capital and required trust indenture deposits.

(4) Ability to Meet Levels of Service

The health plan has a network of participating health care providers and agreements with local health departments.

(5) Accessibility

The health plan has adequate locations of primary care physicians and hours of availability.

(6) Management Information System

The health plan has a system capable of collecting, processing, reporting, and maintaining data in accordance with the RFP requirements.

(7) Accreditation

The health plan has or will obtain accreditation from an appropriate accrediting organization.

(8) Licensing

The health plan is a licensed health maintenance organization or will apply for license within the first year of contract.

(9) Incorporation

The health plan is a Michigan corporation.

(10) Governing Body

The health plan's governing body has at least 33% of its membership consisting of adult enrollees of the bidding health plan.

(11) Reinsurance

The health plan has a reinsurance contract from an authorized insurer or is established as a self-insured health plan.

In accordance with DMB Administrative Guide procedure 0510.07, these qualifications were evaluated by an eight-member joint evaluation committee (Committee) which included staff from DCH, DMB, the Department of Civil Service, and the Department of Consumer and Industry Services. An independent contractor and staff from DCH assisted the Committee in evaluating certain standards. Prior to contract finalization, DCH will complete "readiness reviews" of each health plan to ensure that it is prepared to meet the conditions of the contract as stipulated in the RFP.

**Question 2:** What outcome measurements were included in the RFP?

**Response:** The RFP included the following six minimum outcomes that successful health plans are expected to achieve during the contract period:

- (1) An immunization rate of 100% for infants.
- (2) Age-appropriate immunizations for 90% of all 2-year-olds.
- (3) Age-appropriate Early and Periodic Screening, Diagnosis, and Treatment screenings for at least 90% of the children.
- (4) Cholesterol and blood pressure screenings for 75% of the adults over 40 years old.
- (5) Maternal support for at least 60% of at-risk pregnant women.
- (6) Mammography screenings for at least 60% of the women over 40 years old.

Additional requirements complementing the six minimum outcomes include: an "encounter data reporting system," which requires the successful health plans to provide DCH with data on the services provided to enrollees; a "Grievance/Complaint Coordinator" and management information system capabilities for processing enrollee grievances and complaints; submission of quarterly reports on quality improvement programs; and annual enrollee satisfaction surveys conducted in collaboration with DCH.

**Question 3:** How do the terms of the RFP compare with similar provisions of RFPs issued by other states which have preceded Michigan in managed care initiatives?

**Response:** We obtained managed care RFPs from other states (Indiana, Pennsylvania, Missouri, and Arizona) that recently implemented similar RFPs and compared them with the Michigan RFP. Our comparison included provisions for evaluation standards, performance measures, outcome measurement reporting, level of services, involvement of state purchasing offices, financial and postaudit

requirements, and compliance with federal Health Care Financing Administration (HCFA) requirements. We found that the provisions of the Michigan RFP did not differ significantly from those of the other four states.

**Question 4:** Did the terms of the RFP comply with HCFA requirements?

**Response:** The terms of the RFP complied with HCFA requirements. The RFP was reviewed by HCFA in connection with the State's request for a waiver of Social Security Act sections 1902(a)(1) "Statewideness," 1902(a)(10)(B) "Comparability of Services," and 1902(a)(23) "Freedom of Choice." On May 30, 1997, HCFA approved DCH's request for a 2-year waiver program effective July 1, 1997 and ending June 30, 1999. The waiver approval is conditioned on requirements that DCH provide HCFA with reports on reimbursement and access issues for federally qualified health centers, reports on quality assurance, and data related to provider capacity.

**Question 5:** What level of services was required?

**Response:** The level of services required by the RFP is the same as that provided under traditional fee-for-service arrangements:

- (1) Inpatient and outpatient hospital care.
- (2) Emergency services.
- (3) Physician, optometrist, and oral surgeon services.
- (4) Chiropractic and podiatry services.
- (5) Transplant services.
- (6) Family planning and pediatric services.
- (7) Pharmacy services.
- (8) Certified nurse midwife and family nurse practitioner services.

- (9) Vision, hearing, and speech services.
- (10) Home health services.
- (11) Mental health care (up to 20 outpatient visits per contract year).
- (12) Substance abuse services through accredited providers.

The RFP excluded those services that are covered outside of the Program, such as inpatient hospital psychiatric, certain outpatient psychiatric, nursing home, and dental services.

**Question 6:** What involvement was there from the DMB Office of Purchasing?

**Response:** The Office of Purchasing was involved in the development and implementation of the RFP. The Office of Purchasing issued the RFP and was named as the sole point of contact for all procurement and contractual matters. Also, the Committee was chaired by an Office of Purchasing employee.

**Question 7:** Were the health plans required to submit audited financial statements and, if so, who evaluated them?

**Response:** Health plans were not required to submit audited financial statements with their bids. However, they were required to be financially and actuarially sound with a minimum net worth of \$100,000, adequate working capital of \$250,000, and required trust indenture deposits. The financial plans were to include the health plan's means of achieving and maintaining a positive cash flow, provisions for retirement of existing or proposed debt, an insolvency protection plan, and provisions for an appropriate amount of working capital.

All financial information was evaluated by the Committee and DMB and was verified during the readiness review process. Also, the RFP specifies that successful health plans are required to submit quarterly financial reports in accordance with the standards of the Michigan Insurance Bureau, Department of Consumer and Industry Services, and to submit annual audited financial statements.

**Question 8:** Do the terms of the RFP allow State and federal agencies to audit contractors' financial and performance practices?

**Response:** The RFP specifies that accounting records are to be maintained for a period of six years and are subject to audit by HCFA, the Attorney General, the Auditor General, and other designated State agencies. The RFP also indicates that medical records, policies, procedures, and guidelines are subject to review by DCH and HCFA or their designated agents.

### Schedule of Accepted Rates by County and Plan

Plan	Wayne County Accepted Rate*		
	1998	1997	Difference*
Care Choices	\$ 162.95 **	\$ 164.00	\$ (1.05)
Select Care	\$ 162.95 **	\$ 163.50	\$ (0.55)
Wellness Plan	\$ 162.95 **	\$ 162.82	\$ 0.13
PrimeCare	\$ 162.95 **	\$ 162.04	\$ 0.91
Health Alliance Plan	\$ 162.95 **	\$ 162.00	\$ 0.95
Omnicare	\$ 162.95 **	\$ 159.85	\$ 3.10
Cape Medical	\$ 162.95 **	\$ 157.89	\$ 5.06
Ultimed	\$ 162.95 **	\$ 156.87	\$ 6.08
M-Care	\$ 162.70	\$ 155.16	\$ 7.54
Oakwood Health Plan	\$ 155.00	\$ 155.00	\$ 0
Detroit Medical Center	\$ 162.95 **	\$ 150.00	\$ 12.95
Total Health Plan	\$ 155.50	\$ 149.94	\$ 5.56
Midwest Health Plan	\$ 162.95 **	\$ 144.70	\$ 18.25
First Care	\$ 162.95 **	\$ 164.00	\$ (1.05)
Michigan Managed Care	\$ 162.95 **	\$ 162.78	\$ 0.17
Botsford Clinic Plan	\$ 155.00	\$ 135.35	\$ 19.65

Plan	Oakland County Accepted Rate*		
	1998	1997	Difference*
Wellness Plan	\$ 148.79 **	\$ 151.52	\$ (2.73)
Michigan Managed Care	\$ 148.79 **	\$ 149.95	\$ (1.16)
Cape Medical	\$ 148.79 **	\$ 149.28	\$ (0.49)
Care Choices	\$ 148.79 **	\$ 148.00	\$ 0.79
Detroit Medical Center	\$ 148.79 **	\$ 146.00	\$ 2.79
Ultimed	\$ 148.79 **	\$ 145.49	\$ 3.30
Oakwood Health Plan	\$ 145.00 **	\$ 145.00	\$ 0
Health Alliance Plan	\$ 145.00 **	\$ 142.00	\$ 3.00
Select Care	\$ 148.79 **	\$ 140.77	\$ 8.02
First Care	\$ 148.79 **	\$ 138.00	\$ 10.79
Botsford Clinic Plan	\$ 148.79 **	\$ 135.57	\$ 13.22
Total Health Plan	\$ 141.95 **	\$ 132.16	\$ 9.79
Omnicare	\$ 148.79 **	\$ 143.00	\$ 5.79
Midwest Health Plan	\$ 148.79 **	\$ 144.70	\$ 4.09

Macomb County  
Accepted Rate\*

Plan	1998	1997	Difference*
Detroit Medical Center	\$ 138.21 **	\$ 146.00	\$ (7.79)
Cape Medical	\$ 138.21 **	\$ 145.81	\$ (7.60)
Ultimed	\$ 138.21 **	\$ 145.49	\$ (7.28)
Midwest Health Plan	\$ 138.21 **	\$ 144.70	\$ (6.49)
Community Choice Michigan	\$ 138.21 **	\$ 143.93	\$ (5.72)
Care Choices	\$ 138.21 **	\$ 143.00	\$ (4.79)
Health Alliance Plan	\$ 138.21 **	\$ 142.00	\$ (3.79)
Prime Care	\$ 138.21 **	\$ 139.23	\$ (1.02)
First Care	\$ 138.21 **	\$ 138.00	\$ 0.21
Wellness Plan	\$ 138.21 **	\$ 135.37	\$ 2.84
Total Health Plan	\$ 137.75	\$ 132.16	\$ 5.59
Michigan Managed Care, Inc.	\$ 138.21 **	\$ 145.31	\$ (7.10)
Select Care	\$ 138.21 **	\$ 132.16	\$ 6.05

Washtenaw County  
Accepted Rate\*

Plan	1998	1997	Difference*
Care Choices	\$ 138.89 **	\$ 150.00	\$ (11.11)
Midwest Health Plan	\$ 138.89 **	\$ 144.10	\$ (5.21)
Select Care	\$ 138.89 **	\$ 143.65	\$ (4.76)
Health Alliance Plan	\$ 138.89 **	\$ 142.00	\$ (3.11)
First Care	\$ 138.89 **	\$ 138.00	\$ 0.89
M-Care	\$ 138.59	\$ 132.16	\$ 6.43

Genesee County  
Accepted Rate\*

Plan	1998	1997	Difference*
Health Plus	\$ 140.24 **	\$ 145.00	\$ (4.76)
Community Choice Michigan	\$ 140.24 **	\$ 140.98	\$ (0.74)
M-Care	\$ 140.24 **	\$ 139.74	\$ 0.50
Wellness Plan	\$ 140.24 **	\$ 138.46	\$ 1.78
Total Health Plan	\$ 136.18 **	\$ 132.16	\$ 4.02

\* Amounts presented are per recipient per month.

\*\* Highest acceptable rate.

## Glossary of Acronyms and Terms

capitated rate	A fixed per person monthly rate payable to the contractor by DCH for provision of all covered services defined within the RFP.
DCH	Department of Community Health (formerly the Departments of Mental Health and Public Health).
DMB	Department of Management and Budget.
effectiveness	Program success in achieving mission and goals.
efficiency	Achieving the most outputs and outcomes practical for the amount or resources applied or minimizing the amount of resources required to attain a certain level of outputs or outcomes.
HCFA	federal Health Care Financing Administration.
joint evaluation committee (Committee)	A body that serves in an advisory capacity to evaluate proposals in response to a request for proposal.
managed care	An approach to health care cost containment that enables the State to prospectively influence the delivery of health services.
material condition	A serious reportable condition which could impair the ability of management to operate a program in an effective and efficient manner and/or could adversely affect the opinion of an interested person concerning the effectiveness and efficiency of the program.
MCAC	Medical Care Advisory Council.

Medicaid	Michigan's Medical Assistance Program operated under the authority of Title XIX of the federal Social Security Act.
performance audit	An economy and efficiency audit or a program audit that is designed to provide an independent assessment of the performance of a governmental entity, program, activity, or function to improve public accountability and to facilitate decision making by parties responsible for overseeing or initiating corrective action.
readiness review	A review conducted by DCH and independent contractors to assess the degree of preparedness of qualified health plans prior to contract finalization.
reportable condition	A matter coming to the auditor's attention that, in his/her judgment, should be communicated because it represents either an opportunity for improvement or a significant deficiency in management's ability to operate a program in an effective and efficient manner.
RFP	request for proposal.
value purchaser	An entity that purchases specified services and ensures accountability for quality outcomes while operating within a fixed budget.