Minnesota Department of
Human Services

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Health Care

Our Mission

The Minnesota Department of Human Services, working with many others, helps people meet their basic needs so they can live in dignity and achieve their highest potential.

Our Values

- We focus on people, not programs.
- We provide ladders up and safety nets for the people we serve.
- We work in partnership with others; we cannot do it alone.
- We are accountable for results, first to the people we serve, and ultimately to all Minnesotans.

We practice these shared values in an ethical environment where integrity, trustworthiness, responsibility, respect, justice, fairness and caring are of paramount importance.

Advisory Committee on Managed Care for People with Disabilities

Minnesota Statutes 2006
Chapter 256B, section 256B.69, subdivision 28

Report to the Legislature
February 2007

DHS-4357-ENG (1/05)

Advisory Committee on Managed Care for People with Disabilities

Cost of completing this report:

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Summary

During the 2005/2006 session of the Minnesota State Legislature, legislation was passed which allowed the Minnesota Department of Human Services (DHS) to contract with qualified Medicaid approved special needs plans (SNPs) to provide basic health care services to people with disabilities, including those with developmental disabilities, on a voluntary basis. This legislation also required DHS to consult with a stakeholder group in developing managed care options for serving people with disabilities. DHS satisfied this requirement by convening the Advisory Committee on Managed Care for People with Disabilities (Advisory Committee). The Advisory Committee is charged with providing input on various managed care programs impacting people with disabilities.

The authorizing legislation reads:

Minnesota Statutes 2006, chapter 256B, section 256B.69, subdivision 28, Medicare special needs plans and medical assistance basic health care for persons with disabilities:

The commissioner shall establish a state-level stakeholder group to provide advice on managed care programs for persons with disabilities, including both MnDHO and contracts with special needs plans that provide basic health care services as described in paragraphs (a) and (b). The stakeholder group shall provide advice on program expansions under this subdivision and subdivision 23, including:

(1) implementation efforts;

(2) consumer protections; and

(3) program specifications such as quality assurance measures, data collection and reporting, and evaluation of costs, quality, and results.

This report discusses the implementation and work of the Advisory Committee, as well as the need for increased funding for the ombudsman for managed care, consumer assistance and protections needed due to the enrollment in managed care of people with disabilities and consideration of expanding MnDHO.

Background

In 2003, Congress created a new Medicare program aimed at serving special needs individuals.[1] Medicare Advantage Special Needs Plans (SNPs) encourage access to managed care, with the goal of improving care coordination and health outcomes by allowing plans to specialize in care for beneficiaries with special needs.[2] Additionally, SNPs are believed to present an opportunity to integrate Medicare and Medicaid funding, and care options. SNPs can enroll individuals who are institutionalized, dually eligible or who have severe or disabling chronic conditions.[3] A number of states are contracting with SNPs for Medicaid services for dual eligibles in order to better coordinate Medicare and Medicaid services.

SNPs are required to provide Part D prescription drugs along with other Medicare benefits. In particular, it may be advantageous and less complex for people who are dually eligible for both Medicare and Medicaid to enroll in SNPs that have contracts with Medicaid agencies and to be able to receive all Medicare and Medicaid drugs through one health plan. About 55% of people with disabilities on Medicaid in Minnesota are dually eligible. Currently most dually eligible people with disabilities in Minnesota are enrolled in separate freestanding Part D Medicare Drug Plans (PDPs.) They must work with three different financing systems (Medicare fee for services, Medicare Part D and Medicaid fee for service) in order to access all of their prescription drugs. Enrollment in an integrated SNP may simplfy access and accountability for all drugs they receive. Recently CMS has changed its policy to allow SNPs to establish separate programs for people with disabilities and seniors in conjunction with populations served under Medicaid contracts with States.

Minnesota has experience developing managed care products which are uniquely tailored to the population they are designed to serve. Specifically, Minnesota Senior Health Options (MSHO) provides an existing model to work with. MSHO, along with its sister plan, Minnesota Disability Health Options (MnDHO), integrate Medicare and Medicaid financing and service delivery for primary, acute and long term care services including home and community based waiver services, providing additional care coordination. Health plans offering MSHO converted to Medicare SNPs in 2006. MnDHO is a program that provides Medicare and Medicaid primary, acute and long term care and care coordination to people with disabilities in partnership with DHS, UCare Minnesota , a SNP, and AXIS Healthcare, a care management organization. MnDHO serves enrollees who are eligible for Medical Assistance (MA) and/or Medicare, and who voluntarily chose to enroll in MnDHO.

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[1] Medicare Prescription Drug, Improvement and Modernization Act of 2003.
[2] National Health Policy Forum, No 808, Nov 11, 2005.
[3] Department of Health & Human Services, Centers for Medicare and Medicaid Services, Special Needs Plan – Fact Sheet & Data Summary, February 14, 2006.

Enrollment in MnDHO (known as UCare Complete) is currently limited to people with physical disabilities 18-64 residing in the seven county metropolitan area. In addition, MnDHO includes a small pilot project for people with developmental disabilities in Scott, Carver and Hennepin counties. Enrollment in this project is limited to 120 people served by the Mount Olivet Rolling Acres Partnership in Care Network under an agreement with UCare Minnesota.

Minnesota can draw on these experiences to implement additional options for people with disabilities. During the 2005/2006 session of the Minnesota State Legislature, legislation was passed which allowed DHS to contract with qualified Medicaid approved special needs plans (SNPs) to provide basic health care services to people with disabilities, including those with developmental disabilities on a voluntary basis.

Implementation Efforts

The implementation of Medicaid contracting with SNPs for people with disabilities in Minnesota is planned to occur in three stages.

During phase one, DHS will start with basic care with existing the SNPs (UCare and South Country Health Alliance) already experienced in serving people with disabilities in 2006 and 2007, with planned implementation January 2008. In phase two, DHS will phase in basic care with other new SNPs and for non dual eligible enrollees on or after January 2008, depending on the readiness of plans to begin. Finally, in phase three, DHS will consider expanding MnDHO (including long term care) on a strategic basis after 2008 with stakeholder input.

Minnesota is currently in phase one, and is gathering input from the Advisory Committee in order to develop the requests for proposals and contract specifications for the new SNPs product. Requests for proposals for the SNPs product will be solicited during the first part of 2007, to be followed by contract negotiations. The RFP will likely include both stages one and two, however timelines for the two phases may be different.

Phase two of the SNPs implementation will expand the availability of the plan by offering services on a voluntary basis to non-dual enrollees through new SNPs and is intended to integrate Medicare and Medicaid as much as possible.

During phase three, DHS will consider expanding MnDHO some time after 2008. In advance of this, DHS will engage its stakeholders in discussion about the possibility of expanding the original MnDHO model, which includes long term care and home and community based services.

The Advisory Committee on Managed Care for People with Disabilities

DHS has solicited input from stakeholders regarding the request for proposals and contract specifications for the new SNPs product as well as other managed care product options for people with disabilities through the formation of the Advisory Committee. The Advisory Committee on Managed Care for People with Disabilities (Advisory Committee) began meeting in November of 2005. The Advisory Committee includes fifteen appointed members in addition to a public attendee distribution list of over one hundred additional members, including advocates, providers, counties and health plans. The group has been meeting on a monthly basis in addition to meetings on special topics. As the work of the group progresses, it is anticipated the meeting schedule will be scaled back to bi-monthly or quarterly meetings. The meetings are open to the public and are well attended by public official appointees as well as non-appointee public members.

The legislation required DHS to consult with stakeholder groups through its Advisory Committee to provide input regarding the program specifications to implement the new SNPs managed care product. In order to do this, DHS dedicated the July through August of 2006 Advisory Committee meetings to walking through the requirements and protections contained in an existing basic care PMAP contract. This was performed with the recognition that the new contract specifications would be tailored to the unique needs of people with disabilities.

This process served two goals: one, to educate the committee about the existing requirements for managed care organizations contained in contacting language and second, to solicit feedback and input from the committee about the contracting specifications in order to inform the department's process of developing the request for proposals and contract for the SNPs program. In going through existing basic care contract requirements, DHS focused on the following areas critical to the community:

- Covered services/provider networks;
- Care management, service authorization, special needs;
- Coordination with county social services;
- Quality, oversight, evaluation, incentives and data;
- Enrollment process, member materials and customer services;
- Consumer protections; and
- Special regional and local issues.

In addition to input from the Advisory Committee, DHS has kept stakeholders advising the Minnesota Mental Health Action Group (MMHAG) and the department on the Governor's Mental Health Initiative abreast of its activities. The MMHAG Statewide Mental Health Payment Model and DHS/County workgroups reviewed the Advisory Committee and DHS products and provided additional input on how the managed care for people with disabilities products could best provide basic health care services for

persons with mental illness. Conversely, the work of the Advisory Committee has also informed and impacted the ongoing development of the Governor's Mental Health Initiative.

Advisory Committee Input and Consumer Protections

The Advisory Committee strongly supports the voluntary nature of the program and emphasizes that the ability of members to enroll and disenroll or change health plans at their choice is a major consumer protection. They point out that their input has been predicated on the voluntary nature of the program and that they would have requested additional modifications if the program were not voluntary.

Even with the voluntary nature of the new SNPs basic care product, the Advisory Committee expressed concern that due to the unique vulnerabilities of the population with disabilities, increased resources to increase access are needed including ombudsman, education, outreach and care coordination functions. In addition, a working group of stakeholders, including many of the Advisory Committee members, met informally over several months developing suggested principles to guide the future design, implementation, evaluation and improvement of services for persons with disabilities. These principles were discussed during the January 2007 meeting of the Advisory Committee and the Advisory Committee members present expressed support for the principles. The principles developing by the working group encouraged DHS to consider the following when designing or implementing services for people with disabilities:

- The importance of caregivers being able to develop nurturing relationships with people with disabilities;
- Coordination among services;
- Authority and responsibility;
- Equity;
- Health and safety;
- Flexibility;
- Cultural Diversity; and
- Transparency and administrative simplification.

When the Advisory Committee discussed consumer protections, the committee raised specific concerns regarding the sufficiency of existing managed care ombudsman and advocate services and as DHS expands managed care options for people with disabilities, it will need additional funding for managed care ombudsman. The Advisory Committee suggested that to better serve the increased number of enrollees, the ombudsman should have increased resources to allow for additional staff to respond to the increased number of enrollees with disabilities in managed care plans.

In addition to the state managed care ombudsman function, the committee discussed the county role of advocating for its consumers during the November 2006 meeting of the Advisory Committee. The committee recognized that counties play a critical role in consumer protection for people with disabilities but that counties do not have sufficient

resources to be effective advocates, in part due to 2003 budget cuts. To further explore this issue, ten counties responded to an informal questionnaire inquiring what functions counties perform, how many full-time equivalent employees they have dedicated to these functions, whether these functions were compromised by the 2003 budget cuts, and what is expected to change once more people with disabilities enroll in managed care.

The county responses were varied, but the consensus was that there is currently an unmet need for the county advocate function and that this need will be much greater as more people with disabilities enter managed care. Largely in response to budget cuts, many counties have reduced by 50% their full time employees working on advocacy functions, even while the client load has been increasing. Other counties reported absorbing these cuts but maintaining the same service level with county funding and some Medicaid matching dollars. In addition, some counties reported transferring advocate type functions to county financial workers, who may not have expertise in this area and already have other duties to perform. These methods concern counties as they begin enrolling larger numbers of people with developmental disabilities are enrolled into managed care. The counties who were solicited for feedback also expressed concern about meeting the educational and advocacy needs of increased numbers of people with disabilities as they are enrolled into managed care.

Program Specifications

The new SNPs basic care product will be offered on a voluntary basis. In addition, during the December 2006 meeting of the Advisory Committee, the committee had the opportunity to review some proposed contract specifications prepared by DHS staff for this new voluntary product. The draft specifications were drafted in response to committee feedback and tailored specifically to the population with disabilities as specifications in addition to the ordinary requirements of a basic care contract. The additional proposed specifications included:

- Enrollment choice education;
- Enrollment forms capturing special communication modes in addition to primary language;
- A Medicare and Medicaid integrated enrollment process;
- Risk screening;
- Extended health case management;
- Dedicated member services;
- Use of a medical home model;
- Extended specialty, transportation and durable medical equipment networks;
- Special criteria/protocols for prior authorization and referral;
- Blanket enrollee classification as special needs;
- Additional outcome, evaluation and data measurement systems;
- A process to evaluate consumer satisfaction, reasons for disenrollment and timeliness of enrollment, prior authorization and referrals;
- Reporting of encounter data to DHS;

- Requirement that Part D formularies be appropriate to serve needs of people with disabilities;
- Tracking of key utilization measures;
- Disease management programs tailored to meet the unique needs of people with disabilities;
- Access to PMAP Ombudsman process for enrollees and extended Medicaid protection/continuation of service during any service appeals;
- Process and/or workgroup for administrative simplification;
- Inclusion of Medicare notification and reporting systems found in MSHO/MnDHO products;
- Requirement that SNPs establish local/regional stakeholder groups; and
- Risk adjusted payment system.

Extension of MnDHO Developmental Disability Managed Care Pilot

As mentioned above, the current MnDHO program includes a small pilot project for people with developmental disabilities in Scott, Carver and Hennepin counties. Enrollment in this project is limited to 120 people served by the Mount Olivet Rolling Acres Partnership in Care Network under an agreement with UCare Minnesota.

Minnesota Statutes 256B.69, Subdivision 23.(b) provides authority for this pilot project and requires that the Commissioner report to the legislature prior to the expansion of this pilot. However, that same section also provides that authority for the pilot project expires two years after the implementation date of the pilot. The pilot began in February 2006 and thus would expire in February 2008. However, initially enrollment was been slower than expected and 2006 enrollment numbers have been too low to begin the required evaluation.

The department recommends that this pilot be extended for an additional two years in order to conduct a meaningful evaluation.

Single Plan Versus Plan Choice

Minnesota Statutes 256B.69, Subdivision 4(b)(2)(2006) also requires the Commissioner to consider whether enrollment in new managed care programs for people with disabilities should be limited to a single County Based Purchasing (CBP) plan, or whether choice of plans should be offered. The Department has determined that limiting Medicaid contracts with SNPs for people with disabilities only to CBPs in areas where CBPs are operating would reduce the potential choices and options available to people with disabilities. Competition among both CBP and non-CBP choices in CBP service areas will provide maximum choice of health plans for people with disabilities and is consistent with CMS policy for Medicare plan options as well as DHS goals of better coordination of Medicare and Medicaid services.

Discussion

Dual eligibles must enroll in Medicare managed care for Part D, and must choose among several types of Medicare Part D plan options including freestanding Medicare Part D only plans and SNPs. SNPs provide all Medicare services, not just drugs. Medicare options, including SNPs are approved by CMS. Currently States do not have control or input into which plans will be approved in Minnesota, or in which service areas they will operate.

SNPs must abide by State provisions for risk bearing entities to maintain non-profit status (either CBP or HMO), though other Medicare plan choices do not have to meet these requirements. Since Medicare now will control Medicare plan options in Minnesota, and since those plan options are expanding, the State must consider the impact of those Medicare plan options on its purchasing strategies for people with disabilities. 55% of people with disabilities receiving Medical Assistance are dually eligible for both Medicare and Medicaid. In addition, about 300 people with disabilities become dual eligible each month. As described above, the goal of the State in establishing Medicaid contracts with SNPs is to encourage more coordination between Medicare and Medicaid services and to make care simpler by covering both Medicare and Medicaid drug coverage under the same plan. The State wants to encourage health plan choices and options which coordinate with Medicare and to choose the plans best equipped to serve people with disabilities to participate in that integrated program.
DHS competitively procures for Medicaid health plan participation as required by State law. In addition, the Centers for Medicare and Medicaid Services (CMS) requires that States provide choice of Medicaid managed care plans to enrollees in Metropolitan Statistical Areas. In non-metropolitan areas, States are allowed to offer a single plan choice. Currently CBPs operate in 23 non-metro counties as a single plan choice for Medicaid. CMS has also approved CBPs to operate as SNPs to serve dual eligibles in their service areas.

However, CMS has also already approved some non CBP SNPs to serve dual eligibles in areas where CBPs currently operate as a single plan for Medicaid. At issue is whether the State will contract with only with CBP SNPs, for services for people with disabilities, or should also contract with other SNPs to allow choice of plans in those areas.

While SNPs offered by CBPs have advantages in their ability to connect to county social services, other SNPs offered by local HMOs may have other strengths in terms of clinical models, or networks. All SNPs should be required to develop models for coordinating with social services, since that is a necessary component of serving people with disabilities.

Limiting Medicaid contracts with SNPs for people with disabilities to CBPs would reduce the potential choices and options available to people with disabilities. SNPs would be able to operate for Medicare in CBP areas, enrolling dual eligibles outside of any State contract with Medicaid in a non integrated program. It is better for DHS to evaluate all plan options and choose to contract with those plans that can best provide integrated service options, rather than precluding those options at the outset by limiting choice in CBP areas.

Next Steps

Advisory Committee members informed DHS that the process has been valuable and that committee members hope the Advisory Committee will continue meeting in order to inform DHS' thinking about how best to serve people with disabilities. At minimum, the Advisory Committee will continue meeting through June of 2008. During 2007, the committee will continue to discuss implementation of the new SNPs basic care product as well begin discussing enrollment of non-duals and the potential expansion of MnDHO. In addition, DHS will be developing an RFP, contract language and a risk adjusted payment system required for implementation of this project.

Attachments

Committee list
Agenda outlines (2006 & 2007)

MEMBER LIST

Official Appointees	Organization	Title
Sue Abderholden	NAMI	Executive Director
Glen Andis	Medica	Senior Vice President
Barbara Burandt	MN Home Care Association	Government Relations Director
David Doth	REM MN	Vice President of Operations
Kris Flaten	State Advisory Council on Mental Health	
MayKao Hang	Ramsey County Human Services	Adult Programs Director
Debbie Harris	Advocate-Consumer	
Anne Henry	MN Disability Law Center	Staff Attorney
Dr. Paul Johnson	AXIS Health Care	Medical Director
Sheryl Larson, PhD	Institute for Community Integration	Research Director
Steve Larson	ARC MN	Executive Director
Amelia Mata	Hennepin Home Health Care	President
Jeff Nachbar	Brain Injury Assoc. of MN	
Jim Peterson	Waseca County	County Commissioner
John Tschida	Courage Center	Vice President Public Affairs
Joel Ulland	MS Society of MN	Director Public Policy
Ghita Worcester	UCare Minnesota	Vice President Public Affairs
Alternates		
Julie Faulhaber	Medica	Director Duel Eligible Programs
Beth Fondell	ARC Greater Twin Cities	
Lorene Magnuson	ARC Greater Twin Cities	Mgr. Planning/Contract Evaluation

Gene Martinez		
Lynne Morishita	AXIS	Clinical Program Director
Bud Rosenfield	MN Disability Law Center	Staff Attorney
Stacey Vogele	Minnesota Justice Foundation (MJF)	Staff Attorney

Public Attendees

Brian Abery		
Jeff Bangsberg	MN Home Care	
Alexandra Bartolic	Hennepin County	
Melody Bialke		
Mary Blegen	AXIS	
Bill Blom	Freedom Health Care	
Ron Brand	MN Assoc of Comm..Mental Health Programs	Executive Director
Christine Boyer	MNSCHA	Ability Care Program Manager
Barb Case	MACSSA- Anoka County	
Theresa Carufel	Tasks Unlimited	Dir.Dvlpt./Community Relations
Patricia Coldwell	Association of MN Counties	Policy Analyst
Karen Conrath	Dakota County	
Liz Conway	Blue Cross and Blue Shield of Minnesota	Sr. Mgr., Product & Program Mgm't
Patti Cullen	Care Providers	
Angela Debettignies	MN Blue Cross	
Chris Duff	AXIS	CEO
Judy Elling	People Enhancing People	
Emie Engholm	UCare	
Barb Fraley	ARRM	Research Director
Cea Grass	South Country Health Alliance	Director of Care Coordination
Stan Groff	South Country Health Alliance	Consultant- Ability Care

David Hancox	Metropolitan Ctr. Independent Living, Inc.	Executive Director
Karen James	MnDACA, Henn. Cty.	
Julie Johnson	Hennepin County	
Kim Kang	Brain Injury Assoc. of Minnesota	
Julie Kenny		
Regina Kiser	MN State Council on Disability	
Diane Klimowicz		
Kathryn Kmit	MN Council of Health Plans	
Christian Knights	Courage Center	
Mary Kummer		
Kathy Lamp	Hennepin County	
Wayne Larson	PCN DD-MnDHO	
Kate Lerner	MACSSA	Director
Margi Lindberg	UCare	
Jon Lips	Care Providers	
Eric E. Locher		
Sue Margot	MN Department of Health	Managed Care
Ruth McVay	Public Health Department	Social Work Unit Supervisor
Elissa Meyer	AXIS	
Ned Moore	MN Department of Health	
Jerry Mueller	MNDACA	
Norm Munk	Partnership Resources, Inc./MHC	Executive Director
Bruce Nelson	ARRM	Executive Director
Lynn Noren	Rise	
Darrell Paulsen	Paulsen & Co.	

Jerry Peterson		
Steve Piekarski	UCare	Disability Program Specialist
Abbey Raleigh	Blue Cross MN	
Terri Ricci	State Council on Disability	
Dan Rietz	TSE Inc.	Vice President
Cindy Rupp	MACSSA- Washington County	
Michael Scandrett		
Vera R. Seegler	Hennepin County	Hennepin County Advocate
Pam Selvig	MACSSA- Scott County	
Ed Sheehy	UCare	
Patricia Siebert	MN Disability Law Center	Staff Attorney
Susan Sommers	MHP	
Deb Smith	South Country Heath Alliance	Director of Medical Services
Rachel Tschida	AXIS	Dir. Community Relations
Judy Wakershauser	Health Partners	
Susan Warweg	Minnesota Habilitation Coalition	
Will Wilson	Minnesota Mental Health Association	
Donna Zimmerman	Health Partners	Vice Pres. Gvmt.& Comm. Relations
Pamela Zolik	Hennepin County	Hennepin Co. Advocate

DHS Attendees

Don Allen	Mental Health	Legislative and Budget Coordinator
Sharon Autio	Chemical and Mental Health Services	Mental Health Director
Michelle Basham	Health Care	Administrator Stakeholder Relations
Christine Bronson	Agency Wide Functions	Deputy Comm./Medicaid Director
Loren Colman	Continuing Care Health Care	Assistant Commissioner Student Worker

Lauren Demmer		
Annemarie Ellig	Health Care	Student Worker
Pam Erkel	Continuing Care	Community Supports Supervisor
Rebecca Godfrey	Disability Services	Policy Analyst
Sue Kvendru	Health Care	Special Needs Purchasing Coord.
Barbara J. Lindberg	Health Care	Attorney
Deb Maruska	Health Care	Special Needs Purchasing Coord.
Brian Osberg	Health Care	Assistant Commissioner
Pam Parker	Health Care	Mgr. Special Needs Purchasing
Karen Peed	Health Care	Director, Managed Care Purchasing
Ginny Prasek	Health Care	Managed Care Ombudsman
Chris Reisdorf	Health Care	Manager
Karen Russell	Health Care	Legislative Liaison
Richard Seurer	Mental Health	Mental Health Program Consultant
Angela Urbanek	Health Care	Health Care Policy Analyst
Shirley York	DHS Disabilities Services Division	Director
John Zakelj	Mental Health	Operations Manager

ADVISORY COMMITTEE ON MANAGED CARE FOR PEOPLE WITH DISABILITIES
AGENDA OUTLINE

Phases One & Two Committee Goals:
To provide input to DHS on design and implementation of Medicaid basic care managed care contracting specifications for Medicare Advantage Special Needs Plans providing services to people with disabilities.

Tuesday, July 11, 2006, 1:30 – 5:00pm:
Objectives:
To re-affirm the group's charge and goals as well as to start learning about existing federal and state requirements and contracting specifications for provider networks.

Agenda:
1. Key Domains & What Is Basic Care
2. Overview of Federal & State Contracting Requirements
3. Basic Care Contract Specifications Part One:
    - Provider Networks
    - Covered Services

Friday, August 4, 2006, 1:00 – 3:00pm: Special Meeting – *Home Care*
Objectives:
To learn more about coverage criteria for Home Care Services under Medicaid.

Agenda:
1. Covered service criteria for Home Care Services.
2. Discussion.

Monday, August 7, 2006, 11:00am – 3:00pm:
Objectives:
To discuss and learn about contracting specifications regarding care management, service authorization, special needs, coordinating with county social services and network capacity, development and stability.

Agenda:
1. Review minutes from last meeting
2. Report regarding Home Care Special Meeting
3. Follow up Provider Networks
4. Basic Care Contract Specifications Part One Continued: network capacity, development and stability.

5. Basic Care Contract Specifications Part Two:
    - Break-Out Group One Care management, service authorization and special needs.
    - Break-Out Group Two: Coordination with county social services.
5. Wrap-Up & Reports from Break-Out Groups

Thursday, September 7, 2006, 1:00 – 4:30pm:
Objectives:
To discuss and learn about contracting specifications regarding quality, oversight/data, the enrollment process, member materials and customer services.

Agenda:
1. Follow-up Enrollment Process, etc.
2. Review Minutes from Last Meeting
3. Presentation on Enrollment Process, Member Materials and Customer Services.
4. Presentation on Quality, Oversight, Evaluation, Incentives & Data.
5. Basic Care Contracting Specifications Part Three:
    - Break-Out Group One: Quality, Oversight, Evaluation, Incentives and Data.
    - Break-Out Group Two: Enrollment Process, Member Materials and Customer Services
6. "Name that SNP's" Announcement
7. Wrap-Up & Reports from Break-Out Groups

Tuesday, October 10, 2006, 1:00 – 4:30pm:
Objectives:
To discuss and learn about contracting specifications regarding consumer protections and special regional/local issues.

Agenda:
1. Follow-up Service Authorization, etc.
2. Review Minutes from Last Meeting
3. Overview on Consumer Protections
    - Ombudsman for State Managed Health Care Programs
    - Appeals/Fair Hearings
4. Basic Care Contracting Specifications Part Four:
    - Break-Out Group Two: Consumer Protections
    - Break-Out Group One: Special Regional/Local Issues
5. Wrap-Up & Reports from Break-Out Groups

Friday, October 20, 2006, 9:00 – 11:30am: Special Meeting – Get To Know the Plans.

Tuesday, November 7, 2006, 1:00 – 4:30pm:
Objectives:
To discuss Advisory Committee process for 2007.

Agenda:
1. Follow-up Consumer Protections and Special Regional/Local Issues
2. Announcements and Review Minutes from Last Meeting
3. Discuss Legislature Report and Advisory Committee Process for 2007: expansion of MnDHO, managed care Ombudsman resources and future meeting schedule/agenda outline.
4. Risk Adjustment.

Tuesday November 21, 2006, 9:00-12:00pm: Special Meeting – The Providers.

Thursday, December 7, 2006, 12:00 – 3:30pm:
Objectives:
To discuss priorities for basic care contracting.

Agenda:
1. Follow-up from Last Month.
2. Discuss summary of input document/proposed purchasing specifications.
3. Announcement and Review Minutes from Last Meeting

Thursday, Jan. 4th, 2007, 1:00-3:30pm
Objectives:
To learn about the legislative report, federal policy and the work of other groups.

Agenda:
1. Report to the Legislature
2. Department Update Concerning DRA
3. Report from *Developmental Disabilities Working Group*
4. CMS SNP Subset Timeline Changes

Friday. March 9th , 2007, 1:00-3:30pm
Tentative Agenda:
1. Cost and Risk Adjustment Update
2. Update on Governor's Mental Health Initiative
3. Additional Discussion:
    a. Consumer Protections and Education

b. Administrative Simplification & Billing
c. Evaluation & Data Collection
d. Medical Necessity

Thursday June 7th, 2007, 1:00-3:30pm
Tentative Agenda:

1. Begin Enrollment of Non-Duals Discussion
2. Begin MnDHO Long-Term Care Discussion

Friday, September 7th, 2007, 1:00-3:30

Friday December 7th, 2007, 1:00-3:30