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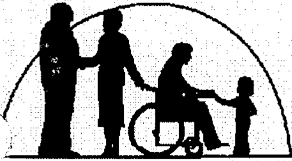

Minnesota Department of Human Services Health Care

Mission Statement

The Department of Human Services, in partnership with the federal government, county and other public, private, and community agencies throughout Minnesota, is a state agency directed by law to assist those citizens whose personal or family resources are not adequate to meet their basic human needs. It is committed to helping them attain the maximum degree of self-sufficiency consistent with their individual capabilities. To these ends, the Department will promote the dignity, safety, and rights of the individual, and will assure public accountability and trust through responsible use of available resources.

A Report to the 2000 Minnesota Legislature as required by Laws of Minnesota 1999, chapter 245, article 4, section 115

Prepaid Medical Assistance Program

February 2000

1999 Minn. Laws Chap. 245
Art. 4 Sec. 115

Legislative Requirements

Laws of Minnesota 1999 Chapter 245, Article 4, Section 115. [REPORT ON PREPAID MEDICAL ASSISTANCE PROGRAM.] The commissioner of human services shall present recommendations to the legislature, by December 15, 1999, on methods for implementing county based authority under the prepaid medical assistance program.

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Cost of completing this report:

Minnesota Statutes, section 3.197, requires the disclosure of the cost of preparing this report.

Staff time:	$800
Administrative costs:	100
Total:	$900

PREPAID MEDICAL ASSISTANCE PROGRAM REPORT

February 2000

Introduction

This report summarizes the authority for county board involvement in the Prepaid Medical Assistance Program (PMAP), outlines current county board activities in PMAP development, contract negotiation, and ongoing program monitoring and improvement. Recommendations for continued county board involvement are offered.

Current status of county board involvement

Parameters for county board authority

The scope of county board authority under the Prepaid Medical Assistance Program are outlined in Minnesota Statutes 256B.69, subd. 3a (see attachment A). These parameters including involvement in the following:

The Commissioner of Human Services and the county board develop a mutually agreeable timeline prior to the issuance of a Request for Proposals,

Development, approval, and issuance of the request for proposals to provide services to eligible individuals within the proposed county;

Review of each proposal based on the identification of community needs under chapters 145A and 256E and county advocacy activities;

Recommendations regarding the approval of local networks and their operations to ensure adequate availability and access to covered services;

Recommendations for a maximum number of participating health plans;

Selection of health plans for participation at the time of initial implementation and at the time of contract renewal; and

Development of contract requirements related to the achievement of local public health goals.

County board involvement in the PMAP development process

Time line for PMAP development. The milestones for PMAP development are detailed in Attachment B. Prior to PMAP implementation in a county, Department of Human Services (DHS) staff begin meeting with the county director and their staff, followed by presentations to the county board. Once a county board approves expansion of PMAP into their county, the County Development Team is formed

County development team. The county development team (CDT) provides leadership at the local level in the implementation of PMAP. The CDT is responsible for educating and preparing county commissioners and county staff who will be affected by PMAP. The CDT assists in assembling the organizational structure and communication links necessary to support PMAP that are tailored to achieve the best fit within the county's existing way of doing business. The CDT is convened early in the planning phases of PMAP implementation and functions for approximately three months, usually through the DHS Request for Proposals (RFP) response and evaluation phase.

Counties which have implemented PMAP have found that key representatives from the following areas are necessary for an effective CDT: social services, public health, and income maintenance. The county human services director appoints one person from each of these three areas to represent their county. Each CDT member (or their alternate) commits to attend approximately six half-day (or three full day) meetings.

CDT meetings are scheduled by DHS staff. These meeting provide communication between state and local officials. DHS shares information counties need to make PMAP operational, county officials provide input to DHS to assure that PMAP is responsive to local needs. DHS develops the agenda, schedules, and facilitates CDT meetings. Topics addressed include an overview of PMAP, funding allocation for enrollment and advocacy, RFP local input, chemical dependency, mental health, public health, and advocacy and ombudsman services.

Development of the request for proposals and review of the responses. DHS staff develops the RFP jointly the with CDT. Some sections of the RFP are "boiler plate," as they directly correlate with the PMAP model contract, but the section that describes the county's health care system, issues, and priorities is written largely by county staff. For an example of county section from the most recent RFP issued by DHS (for Olmsted County), see Attachment C. This latest example represents greater input into the RFP process than in previous county development efforts, and reflects new partnerships between the county, health plans, and DHS in the areas of public health and behavioral health. Olmsted County representatives also spoke at the Bidder's Conference, describing their county's health care system and needs to the health plans in attendance. The County Board makes recommendations to DHS on the final draft of the RFP prior to publication in the State Register.

The CDT and DHS review the responses to the RFP, usually finishing five to six months before implementation. CDT members review each response to the RFP. The County Board may make recommendations to DHS on improvements needed in the proposed health plan networks, and may make final recommendations to DHS on which plans to contract with, and the total number of plans to offer to the county's recipients. Disputes between the County Board and DHS may be taken to a mediation panel for resolution. To date, no disputes have been taken to this panel.

Implementation. Once the RFPs are reviewed and health plans are selected, based on county board recommendations, DHS begins its systems work, rates and contracts are loaded in the MMIS system, informational meetings for providers and county staff occur and enrollment materials are distributed.

Managed Care Expansion Team (MCET) meetings typically begin four months prior to implementation. The MCET is comprised of county staff and supervisors responsible for managed care education and enrollment (usually income maintenance staff) and the regional DHS Managed Care Enrollment Coordinator. These meetings provide open communication between county implementation staff and DHS. Meetings include an overview of PMAP; discussion of county needs (staffing, equipment, printing capability, etc.); a review of the education and enrollment process; time lines; exclusions; MMIS tracking; a review of the model contract and the PMHCP manual; reports and adjustments. One month prior to implementation, county staff responsible for client managed care enrollment will attend a full day MMIS PMAP training. This training teaches county staff how to enroll, exlcude and track clients in MMIS. The county is also responsible for creating and distributing county specific education materials along with the DHS managed care enrollment materials to clients. See Attachment D for MCET time lines.

Post-implementation. Typically, three post-implementation meetings are scheduled after the first month of recipient education about PMAP. The purpose of these meetings is to further acquaint county staff with PMAP, resolve any issues that arise, and help establish the necessary county-health plan relationships. The meetings present the opportunity for county staff to ask questions and work through issues that may occur as county MA recipients are converted from fee-for-service to managed care. Each meeting features a major topic area (e.g., nursing homes, mental health, dental, public health), but other issues are covered as necessary. DHS facilitates these meetings and health plans participate for up to six months after implementation. Additional meetings are scheduled as needed.

County Board Development in the PMAP Contract Process

Contract negotiations. For the last three years of contract negotiations, representatives from metro and non-metro counties have participated in health plan contract negotiations.

Public health goals. County boards have joined into regional groups working with health plans to make recommendations to DHS regarding public health goals for inclusion in PMAP contracts. These groups include the PMAP Public Health Goals Workgroup; Northeast Minnesota Public Health Cooperative; Collaboration for a Healthy Population Southeast Minnesota; Southern Minnesota Health Improvement Partnership; and the Minnesota-North Dakota Public Health Cooperative.

County input into contract negotiations. Each fall, prior to the beginning of contract negotiations, DHS schedules meetings with county representatives from across the state, including video conferences as requested by some counties. These meetings offer counties the opportunity to provide DHS development managers, contract managers, and contract attorneys with input about all aspects of PMAP. These suggestions are then incorporated into the contract negotiations process as much as possible, with priority given to suggestions given by more than one county or group of counties. After contract negotiations are completed, DHS follows up with the counties to describe the changes made to the contract that year based on their input (see Attachment E for a sample letter).

Other County Board Involvement

Much of the county board input into the process of ensuring that PMAP works for recipients occurs outside of the contract development process. For example, the Metro Counties Publicly Funded Health Care Programs Committee has been working with DHS staff to identify and resolve areas of mutual concern through the contract development and management and ongoing communication between the counties and DHS (see Attachment F)

Advocacy/enrollment grant options. County managed care administrative allocation is money given to the county to help offset costs associated with the education, enrollment and advocacy of managed care enrollees. County allocation begins four months prior to implementation and continues for 16 months. County boards are given broad discretion about structuring advocacy and enrollment. For example, a county may have financial workers act as advocates for enrollees on their caseload, or have one individual act as advocate for all county enrollees, or combine advocacy across counties. Similarly, enrollment can be done by individual financial workers or by a worker who just does enrollment.

Review of network changes. One crucial area of concern for county boards and DHS is the availability of sufficient local providers to meet the needs of enrollees. When, during ongoing contract management, DHS sees that there may be substantial changes to health plan networks, counties are notified and asked to review the proposed changes.

Recommendations for continued county board involvement

1. Continue to provide county boards with an enhanced role in the PMAP contracting process, including attendance of one county representative in contract negotiations meetings. This involvement has provided county boards with greater insight into the PMAP contracting process and the role of contract negotiation and management in the PMAP program.

2. Involve county boards in evaluating major changes that result from the contract negotiation and management process. While this evaluation has occurred on an individual county basis, this needs to be systematized.

3. Use the Metro Counties Publicly Funded Health Care Programs Committee as a model for developing, with county boards, mutually acceptable public health goals across the state. The process of multi-county groups working with health plans to develop local public health goals, which become part of state-wide PMAP contracts, has enhanced the contract negotiation process and should enhance the health status of PMAP recipients.

4. Expand statewide the process for soliciting input from county boards, used in the Metro Counties Publicly Funded Health Care Programs Committee. While the process of meeting with counties prior to contract negotiations has enhanced the contract negotiation process, more systematic input from county boards will assure that county needs are being met and that recipients are receiving the highest quality service possible.

5. Re-issue Requests for Proposals for areas of the state that already have PMAP, including the metropolitan area, in 2000. The existing county board authority should be implemented during this process to assist in the development of the new RFPs, evaluation of responses to those RFPs, and selection of health plans. This will allow many county boards to take advantage of this review, evaluation, and selection process for the first time and should result in a more responsive process.

Attachment A

Minnesota Statutes 256B.69, Subd. 3a., County authority. (a) The commissioner, when implementing the general assistance medical care, or medical assistance prepayment program within a county, must include the county board in the process of development, approval, and issuance of the request for proposals to provide services to eligible individuals within the proposed county. County boards must be given reasonable opportunity to make recommendations regarding the development, issuance, review of responses, and changes needed in the request for proposals. The commissioner must provide county boards the opportunity to review each proposal based on the identification of community needs under chapters 145A and 256E and county advocacy activities. If a county board finds that a proposal does not address certain community needs, the county board and commissioner shall continue efforts for improving the proposal and network prior to the approval of the contract. The county board shall make recommendations regarding the approval of local networks and their operations to ensure adequate availability and access to covered services. The provider or health plan must respond directly to county advocates and the state prepaid medical assistance ombudsperson regarding service delivery and must be accountable to the state regarding contracts with medical assistance and general assistance medical care funds. The county board may recommend a maximum number of participating health plans after considering the size of the enrolling population; ensuring adequate access and capacity; considering the client and county administrative complexity; and considering the need to promote the viability of locally developed health plans. The county board or a single entity representing a group of county boards and the commissioner shall mutually select health plans for participation at the time of initial implementation of the prepaid medical assistance program in that county or group of counties and at the time of contract renewal. The commissioner shall also seek input for contract requirements from the county or single entity representing a group of county boards at each contract renewal and incorporate those recommendations into the contract negotiation process. The commissioner, in conjunction with the county board, shall actively seek to develop a mutually agreeable timetable prior to the development of the request for proposal, but counties must agree to initial enrollment beginning on or before January 1, 1999, in either the prepaid medical assistance and general assistance medical care programs or county-based purchasing under section 256B.692. At least 90 days before enrollment in the medical assistance and general assistance medical care prepaid programs begins in a county in which the prepaid programs have not been established, the commissioner shall provide a report to the chairs of senate and house committees having jurisdiction over state health care programs which verifies that the commissioner complied with the requirements for county involvement that are specified in this subdivision.

(b) The commissioner shall seek a federal waiver to allow a fee-for-service plan option to MinnesotaCare enrollees. The commissioner shall develop an increase of the premium fees required under section 256L.06 up to 20 percent of the premium fees for the enrollees who elect the fee-for-service option. Prior to implementation, the commissioner shall submit this fee schedule to the chair and ranking minority member of the senate health care committee, the

senate health care and family services funding division, the house of representatives health and human services committee, and the house of representatives health and human services finance division.

(c) At the option of the county board, the board may develop contract requirements related to the achievement of local public health goals to meet the health needs of medical assistance and general assistance medical care enrollees. These requirements must be reasonably related to the performance of health plan functions and within the scope of the medical assistance and general assistance medical care benefit sets. If the county board and the commissioner mutually agree to such requirements, the department shall include such requirements in all health plan contracts governing the prepaid medical assistance and general assistance medical care programs in that county at initial implementation of the program in that county and at the time of contract renewal. The county board may participate in the enforcement of the contract provisions related to local public health goals.

(d) For counties in which prepaid medical assistance and general assistance medical care programs have not been established, the commissioner shall not implement those programs if a county board submits acceptable and timely preliminary and final proposals under section 256B.692, until county-based purchasing is no longer operational in that county. For counties in which prepaid medical assistance and general assistance medical care programs are in existence on or after September 1, 1997, the commissioner must terminate contracts with health plans according to section 256B.692, subdivision 5, if the county board submits and the commissioner accepts preliminary and final proposals according to that subdivision. The commissioner is not required to terminate contracts that begin on or after September 1, 1997, according to section 256B.692 until two years have elapsed from the date of initial enrollment.

(e) In the event that a county board or a single entity representing a group of county boards and the commissioner cannot reach agreement regarding: (i) the selection of participating health plans in that county; (ii) contract requirements; or (iii) implementation and enforcement of county requirements including provisions regarding local public health goals, the commissioner shall resolve all disputes after taking into account the recommendations of a three-person mediation panel. The panel shall be composed of one designee of the president of the association of Minnesota counties, one designee of the commissioner of human services, and one designee of the commissioner of health.

(f) If a county which elects to implement county-based purchasing ceases to implement county-based purchasing, it is prohibited from assuming the responsibility of county-based purchasing for a period of five years from the date it discontinues purchasing.

(g) Notwithstanding the requirement in this subdivision that a county must agree to initial enrollment on or before January 1, 1999, the commissioner shall grant a delay in the implementation of the county-based purchasing authorized in section 256B.692 until federal waiver authority and approval has been granted, if the county or group of counties has submitted a preliminary proposal for county-based purchasing by September 1, 1997, has not already implemented the prepaid medical assistance program before January 1, 1998, and has submitted a

written request for the delay to the commissioner by July 1, 1998. In order for the delay to be continued, the county or group of counties must also submit to the commissioner the following information by December 1, 1998. The information must:
(1) identify the proposed date of implementation, as determined under section 256B.692, subdivision 5; (2) include copies of the county board resolutions which demonstrate the continued commitment to the implementation of county-based purchasing by the proposed date. County board authorization may remain contingent on the submission of a final proposal which meets the requirements of section 256B.692, subdivision 5, paragraph (b);

(3) demonstrate actions taken for the establishment of a governance structure between the participating counties and describe how the fiduciary responsibilities of county-based purchasing will be allocated between the counties, if more than one county is involved in the proposal;

(4) describe how the risk of a deficit will be managed in the event expenditures are greater than total capitation payments. This description must identify how any of the following strategies will be used:

(i) risk contracts with licensed health plans;

(ii) risk arrangements with providers who are not licensed health plans;

(iii) risk arrangements with other licensed insurance entities; and

(iv) funding from other county resources;

(5) include, if county-based purchasing will not contract with licensed health plans or provider networks, letters of interest from local providers in at least the categories of hospital, physician, mental health, and pharmacy which express interest in contracting for services. These letters must recognize any risk transfer identified in clause (4), item (ii); and

(6) describe the options being considered to obtain the administrative services required in section 256B.692, subdivision 3, clauses (3) and (5).

(h) For counties which receive a delay under this subdivision, the final proposals required under section 256B.692, subdivision 5, paragraph (b), must be submitted at least six months prior to the requested implementation date. Authority to implement county-based purchasing remains contingent on approval of the final proposal as required under section 256B.692.

(i) If the commissioner is unable to provide county-specific, individual-level fee-for-service claims to counties by June 4, 1998, the commissioner shall grant a delay under paragraph (g) of up to 12 months in the implementation of county-based purchasing, and shall require implementation not later than January 1, 2000. In order to receive an extension of the proposed date of implementation under this paragraph, a county or group of counties must submit a written request for the extension to the commissioner by August 1, 1998, must submit the information required under paragraph (g) by December 1, 1998, and must submit a final proposal as provided under paragraph (h).

(j) Notwithstanding other requirements of this subdivision, the commissioner shall not require the implementation of the county-based purchasing authorized in section 256B.692 until six months after federal waiver approval has been obtained for county-based purchasing, if the county or counties have submitted the final plan as required in section 256B.692, subdivision 5.

The commissioner shall allow the county or counties which submitted information under section 256B.692, subdivision 5, to submit supplemental or additional information which was not possible to submit by April 1, 1999. A county or counties shall continue to submit the required information and substantive detail necessary to obtain a prompt response and waiver approval. If amendments to the final plan are necessary due to the terms and conditions of the waiver approval, the commissioner shall allow the county or group of counties 60 days to make the necessary amendments to the final plan and shall not require implementation of the county-based purchasing until six months after the revised final plan has been submitted.

Attachment B

PMAP Implementation Time Line

Task	Approximate Time Allocations		
	County	**State**	**Health Plans**
Review CDT Information	.5 day	1 day	NA
Develop mutually agreeable time line	.5 day	.5 day	NA
Develop county RFP input	4 weeks	1 day	NA
Prepare RFP	NA	12 weeks	NA
RFP Published in State Register			
Prepare responses to RFP	NA	NA	6-8 weeks
Review responses to RFP	6 weeks	6 weeks	NA
County contracting recommendations	.5 days	1 day	NA
Contract amendment negotiations	NA	4 weeks	4 weeks
Contracts Amendments Signed			
Education and enrollment training for county PMAP staff	4 days	4 days	NA
Systems training for financial workers	1 day	1 day	NA
Advocacy training for county staff	1 day	1 day	NA
Local provider information session(s)	.5 days	1 day	1 day
All-staff county information session(s)	.5 days	1 day	1 day
Enrollment Begins			

V. COUNTY SERVICE DEVELOPMENT AND ACCESS ISSUES:

Following is specific information about Olmsted County, compiled by its County Development Team (CDT). To assure consistency for the responders to this RFP, DHS provided the CDT with a suggested list of basic information about the county human services and public health agencies which DHS deemed would be important to the respondents. The county was also instructed to describe service development and access issues that affect its population, and to write corresponding specifications for the respondents to address their proposals. These specifications are found in this section as well as section V of Appendix A.

This information is meant to emphasize the unique issues in each county and to allow the respondents to prepare their proposals accordingly.

IV. County Information: Contact Persons, Local Health Care Resources, Service Delivery and Access Issues. County: OLMSTED

A. County administration:

Human Services		Public Health	
Agency name:	Olmsted County Community Services	Agency name:	Olmsted County Public Health
Director's name:	Patricia L. Carlson	Director's name:	Mary Wellik
Address:	Olmsted County Community Services 151 4th Street SE Rochester, MN 55904-3711	Address:	Olmsted County Public Health 1650 4th Street SE Rochester, MN 55904

B. County agency contacts:

Area of Responsibility	Name	Title	Phone #
Social Services	Patricia Carlson Paul Fleissner Rob Sawyer	Director of Community Services Associate Director Adult Services Associate Director Child & Family	(507) 285-8402 (507) 287-2242 (507) 285-8405
Community Support & Assistance	Mina Wilson	Associate Director Community Support & Assistance	(507) 285-8425
Public health	Mary Wellik	Director of Public Health	(507) 285-8370
Mental Health - Adult	Nancy Kolaas	Program Manager	(507) 285-2243
Mental Health - Children	Patrick McEvoy	Program Manager	(507) 287-1564
Chemical Dependency	Carol Cunningham	Program Manager	(507) 285-8488
Transportation	Linda Bradford	Clerical Supervisor	(507) 287-2259
Others : Home & Community Care (HACC)	Charity Floen	Program Manager	(507) 287-2392
Developmental Disabilities: Adult	Robin Sommer	Program Manager	(507) 287-2236
Developmental Disabilities: Children	Julie Hanson	Program Manager	(507) 285-8752

C. Education And Enrollment Process. The enrollment of eligible managed care recipients in Olmsted County will begin November 1, 1999. The effective date of initial coverage will be December 1, 1999. The education and enrollment process will occur over a three month period of time with full enrollment expected to be completed by February 1, 2000. New MA/GAMC applicants will be enrolled in the managed care system at the time eligibility is established.

rural, with small towns and farms, although the population is concentrated centrally in and around the city of Rochester.

Olmsted County as a whole, has an approximate population of 120,000 persons. The county seat, Rochester, has an estimated population of 79,000. The area is experiencing growing diversity, particularly from in-migration. There are now 52 countries represented among the students in the Rochester School District. Rochester is the hub for many activities and services in southeastern Minnesota. This is particularly evident in provision of medical care and services to the populations with disabilities. Mayo Medical Center and Olmsted Medical Center are the usual sources of primary medical for residents of the area. Both organizations have satellite offices in the surrounding communities and counties. In addition, Mayo Medical Center is a teaching hospital and is internationally known for its specialty care. Significant numbers of foreign nationals come to Rochester for medical care at Mayo. Because we are located only 1 2 hours drive to Minneapolis/St. Paul and slightly less from LaCrosse, WI, our residents are able to take advantage of Centers of Excellence in those two locations.

There is a positive productive relationship between acute care providers and Olmsted County Public Health Services (OCPHS) evidenced by the joint efforts in population based prevention outcomes. Currently collaborative outcomes relate to the following areas: Disease Surveillance, Immunizations, Children' s Tobacco Use Prevention, Domestic Violence, Multicultural Health Care, and Healthy Behaviors. Providers of continuing care have been involved with Olmsted County Social Services in developing client outcomes that have been useful in achieving quality improvement as well as client results.

Health maintenance organizations have not penetrated into this geographic market to any great extent. Mayo Medical Center has a great deal of influence on the community, economically and culturally. Historically Mayo has not accepted capitation. Past efforts to interest other health plans in Minnesota's Prepaid Medical Assistance Program for Olmsted County failed due to lack of sufficient responses. Publicly funded managed care, begun here in 1997, covers a relatively small number of individuals enrolled in Minnesota Care. TANF recipients are still in fee for service delivery systems.

There are significant issues for persons with chronic conditions. The complexity of our medical services often requires consumer/family to spend inordinate amounts of time getting to and waiting for and coordinating their medical services. All of publicly funded consumers with chronic conditions are on fee for service; there is insufficient primary care coordination of acute care for these individuals, the specialty care continuing care services, and County social services.

Examples of areas where integration does occur is with screening for nursing home care, public health participation in neonatal discharge planning conferences, and the Mental Health Consortium where acute and community mental health professionals collaborate on planning services for SPMI clients in the community. Hospital discharge planners also coordinate discharge planning system changes through SE MN Home Care Association.

highly vulnerable or unable to get services from other agencies.

Home Care Services - A strong economy and increased regulation has reduced availability of home care and nursing home staffing. A recent survey of SE MN nursing homes indicates 61% with limited admissions due to lack of staff and 86% needing nursing staff. Some clients are not receiving authorized or adequate service; hospital costs have increased due to the inability to discharge patients to community-based care.

The Children's Mental Health Resource Center served 155 severely emotionally disturbed children in 1998 through coordinated, community-based care.

IEIC (Interagency Early Intervention Committee) - Approximately 75 referrals of children (birth to 3 yrs.) with suspected developmental delays were processed by the Rochester Intake Team for consideration for Early Childhood Special Education services or community resource referral.

Undocumented persons (for purposes of citizenship or alien status) not able to qualify for medical assistance coverage (pregnancy, accident injury-related medical care, or otherwise not meeting an MA basis of eligibility) are most frequently seen by the Salvation Army acute care clinic or at Migrant Health.

3. Barriers to Health Care Services. The complex health care system in Olmsted County is difficult to access and navigate for any of our citizens, but especially for families of children with special needs, with serious emotional disturbance, and with chemical use problems and language barriers. The shortage of primary care and dental care, lengthy waiting times for non-acute care, issues of language, and familiarity with the process all add to the difficulties of accessing appropriate medical care. Other factors contributing to the complications are services located in multiple buildings, required scheduling for interpreter services, lack of a single medical case manager, and a primary care system imbedded in a specialty care organization.

4. Limited or Unavailable Health Care Services. We lack adequate dental services, local in-patient care for persons with Serious and Persistent Mental Illness, adequate numbers of personal care attendants, home health aides, nursing assistants, and other continuing care staff.

Access to dental care is a priority unmet need, identified by the multi-cultural population and for persons on public assistance, despite the availability and broad distribution of dentists throughout the county. No viable, local options exist for clients with dental treatment needs. Multiple factors contribute to this: provider standards, pt. compliance, cultural expectations, MA regulations, etc.

Because of an unemployment rate near 1%, providers of continuing care are having great difficulty finding appropriate job applicants. One home care agency has significantly reduced services and several nursing homes have stopped new admissions. Many continuing care agencies are experiencing staffing crises. As a result, agencies are not responding to Requests for Proposal to develop new and/or alternative services. Please see Appendix D.5. which is the

7. **Local Resources.**

Mental Health Services. Health plans are asked to consider continuity of care for individuals receiving care in the County, and to incorporate as providers in their networks the providers presently being used by clients and those contracted with by the County.

a. **Children's Mental Health.** Olmsted County Community Services is committed to helping children and their families with mental health concerns within the individual, family and community. This commitment is reflected through services provided through Olmsted County community Services, Child and Family division, through private agencies associated with Olmsted County Community Services and in all collaborative and partner relationships established in the county. Our goal is to protect children while providing appropriate services that will empower families and children in facing the challenge of mental illness.

CHILDREN'S MENTAL HEALTH COLLABORATIVE was established to assist member agencies to better meet the needs of mentally ill children through coordination and collaboration. The Children's Mental Health Collaborative has established or partnered in the following programs:

LOCAL MENTAL HEALTH ADVISORY COUNCIL is made up of consumers and mental health professionals whom advise and provide direction for mental health services in Olmsted County.
FACES, a service collaborative is made up of consumers and professionals whom share a common concern regarding the well being of children and families. Focus on early intervention and prevention services for children and families.
***CHILDREN'S MENTAL HEALTH RESOURCE CENTER** is a private/public co-located collaborative approach to working with severely emotionally disturbed (SED) children and their families. Partner agencies include Olmsted County Community Services, Family Service Rochester, Omnia Family Services and Zumbro Valley Mental Health Center. Services provided are in-home family therapy, case management services and family support services.
* **EARLY INTERVENTION PROJECT** anticipates serving emotionally disturbed children, ages 3-5, in there home and school environment.
SELF PROGRAM is an alternative to day care summer project, which addresses the need for structure for 20 SED children throughout the summer months.
* **WHIPPLE HIEGHTS DAY TREATMENT** is a level 5 day treatment facility providing therapeutic and school services to behaviorally challenged adolescents.

Other community services providing therapeutic assistance to children and families:

* **PASSAGE DAY TREATMENT** is a level 5 day treatment facility providing therapeutic and school services to behaviorally challenged adolescents.

P.A.S.S./ZVMHC truancy intervention and programs providing early intervention to adolescents exhibiting truant behaviors.

MAYO CLINIC

***GENEROSE UNIT** provides in-patient mental health treatment to children. Individual psycho-therapy and family groups are typical. Referrals to Community Services are common.

***PHP** is a day treatment program through the Mayo Clinic. Typically children remain in this structured environment until suitable community resources are engaged.

*** MA REIMBURSEABLE**

b. Adult mental health. Health plans are asked to consider continuity of care for individuals receiving care in the County, and to incorporate as providers in their networks the providers presently being used by clients and those contracted with by the County.

There are many behavioral health providers in Olmsted County. The three main providers include Zumbro Valley Psychological Services, Mayo Medical Center and Olmsted Medical Group.

Zumbro Valley Psychological Services in Olmsted County provides the following services:

Crisis Receiving Unit, provide short term mental health stabilization and detox services.
Thomas House, a Rule 36 facility for persons with SPMI
Psychological Services, Psychological and Psychiatric evaluations, medication Management, individual, group and family therapy.
Day Treatment Program
CSP services
Supported Employment Program for persons with SPMI
Circle Center, a clubhouse model drop-in recreation center
Housing Options programs for persons with SPMI

Mayo Clinic provides inpatient and outpatient psychiatric and psychological services. They employ a number of Allied Health Professionals with expertise in social work, chemical dependency and, of course, nursing. Mayo also has an Emergency Trauma Unit and a 23 hour Observation Unit for mentally ill individuals. They also offer individual, group, marital and family therapy, plus a partial hospital program.

Region 10 has a Crisis Project for Developmentally Disabled individuals in Olmsted County. (and 9 other surrounding counties)

Olmsted Medical Group provides outpatient psychiatric and psychological services. They provide individual, group and family therapy. Biofeedback programs are available.

St Peter Regional Treatment Center (RTC) is our state hospital for committed patients with

Olmsted County offers a Treatment Readiness Program to individuals incarcerated in the county jail whose offense was drug or alcohol related.

9. Services to persons with developmental disabilities. Health plans are asked to consider continuity of care for individuals receiving care in Olmsted County, and to incorporate as providers in their networks the providers presently being used by clients and those contracted with by Olmsted County.

The number of persons with developmental disabilities receiving services in Olmsted County is approximately 750. Currently, about 200 children with developmental disabilities are served by community services. Olmsted County is a regional hub for services to persons with developmental disabilities (DD). There are a wide variety of services in Olmsted County with most of them located in Rochester. Olmsted County has several residential service providers, but only two work services providers. Below is a listing of service providers.

ICF/MR Service Providers

Hiawatha Homes
Bear Creek Services
Eastern Minnesota State Operated Community Services
REM

Supported Living Services Providers

Hiawatha Homes
BearCreek Services
Eastern Minnesota State Operated Community Services
REM
Cardinal
Multiple individual foster care providers
Work Services Providers
ABC
PossAbilities of Southern Minnesota

Semi-Independent Living Services Providers

REM
Cardinal
Bear Creek Services

Olmsted County Community Services is involved in three unique projects with this population.

- The Region 10 Quality Assurance Initiative is a regional project that is demonstrating an outcome based system for licensing providers of services to persons with DD.
- The Self-Determination Project is demonstrating the efficiency and effectiveness of giving persons receiving services more control over the resources used to serve them as well as more

providers in their networks the providers presently being used by clients and those contracted with by the County.

The elderly population of Olmsted County is projected to increase by 116% between 1990 and 2030. In 1990 the population was 10,604 by 2030 it will be 22,930. Of particular interest is the increase of those 85 and older as they represent the population most likely to need supportive services. That number is expected to climb from 1,494 to 2,830.

Olmsted County Social Services is the lead agency for Pre-admission Screening (PAS), Elderly Waiver (EW), Alternative Care (AC), Community Alternatives for Disabled Individuals (CADI), Community Alternative Care (CAC), and Traumatic Brain Injury (TBI) Waivers.

Due to the volume of referrals from the Mayo Clinic we conducted over 1500 Preadmission Screenings for nursing home placement during the last year. These placements are for facilities located throughout the entire state of Minnesota.

Allied Health Alternatives, Inc.
Comfort Home Health Care
New Horizons - Shamrock
Olmsted County Public Health
Prairie River Inc.
Samaritan Bethany Home Health Services
SEMCIL
Stanley Jones & Associates

Residential Providers

Adult Foster Care Providers
Karrington Cottages

The overall goal of the waiver programs is to avoid or delay nursing home placement. As a result we make frequent use of our residential providers. We have 54 private homes licensed as Adult Foster Care. Out of the 129 individuals cared for in these homes 45 are elderly. Karrington Cottages, a residential provider for dementia care and assisted living, currently serves over 60 EW clients.

Olmsted County does participate in a ten-county SAIL (Seniors Agenda for Independent Living) Project in Southeastern Minnesota. One of the initiatives begun through the SAIL project has been the assignment of PHNs to each of the nursing homes located in Olmsted County. These PHNs work with the nursing homes to identify residents who have good discharge potential. They work collaboratively with PAS intake to facilitate their return to the community whenever possible.

There are seven MA certified nursing facilities in Olmsted County with a total of 743 beds.

Bear Creek

Deliver individually appropriate services at the appropriate time
Improve access and availability of basic services
Expand alternative service offerings
Ensure consumer involvement in system design and operations
Coordinate and integrate service planning and delivery
Increase and maintain consumer satisfaction
Increase provider commitment to quality care across the acute and continuing care systems.

We expect that any health plan providing PMAP services to the non-disabled population demonstrate the capacity to coordinate services with Olmsted County Community services and participate in developing transition protocol and procedures from the plan to the demonstration project.

Please reference Appendix D.3. for projections on the demo project.

13. Transportation. Public transportation in Olmsted County consists of one taxi service and the city bus lines within the Rochester city limits. Other resources in the county are volunteer drivers (the number of drivers is extremely limited), Veteran Services van (which transports veterans to Fort Snelling) and Wheelchair service transportation. Transportation for recipients living outside of Rochester City limits who do not have their own form of transportation is extremely limited. Transportation offered through the heath plan, especially for these individuals, is important for the entire county.

There is an inadequate amount of low cost portal- to-portal transportation available. It primarily is available through: 1) The ZIPS city service, with special request for the door to door service; 2)limited service from Family Services Rochester Volunteer Transportation program; and 3) J.S.S.V.P. volunteer program for Olmsted County Community Services recipients.

ZIPS bus is difficult for many elderly and disabled to ride due to long rides and long waits. No 24-hour mass transit available in Rochester and Olmsted County. The Rochester City bus service runs only from 6 a.m. through 6 p.m., except for evening runs to the college and Apache Mall through 9:55 p.m. Weekend service is only on Saturdays from 8 a.m. through 6 p.m. Rochester City bus service serves the four surrounding townships, but has limited use. Our primary service destination for transport is Rochester.

Yellow Cab
3731 Enterprise Dr. SW
Rochester MN
(507) 282-2222

Rochester City Lines
1928 32 Ave. NW
Rochester MN 55901
(507) 288-4353

Healthy Behaviors Coalition Ba community coalition focused on promotion of healthy lifestyles including nutrition and activity across the lifespan

Save Our Children From Tobacco Coalition a community coalition formed to prevent youth from using tobacco products

Teen Life Concerns. A peer education program in local high schools in which students are trained to teach other students about health issues important to teens.

Health Education. Planning and implementing programs with and for the community relative to health issues chronic and preventative, promotion for worksites, training programs.

Community Nutrition. Consultation regarding nutrition and health promotion for worksites and education throughout the community.

School-Based Public Health Nursing Services. Public Health Nurse services to students, staff and families in all Olmsted County schools, public and private.

b. HEALTHY CHILDREN AND FAMILIES The HCF division provides individual visits, classes and groups in the home, clinic or community setting to families with infants and preschool children. Information, support and referral to community resources is provided by the Public Health Nurse in the following programs:

* **Improved Pregnancy Outcome** provides early pregnancy identification and prenatal information to help pregnant women have positive birth outcomes

* **Parent Child Health** Promotion provides parenting and child health information to help parents provide a healthy and stimulating environment for their babies and preschool children.

* **Newborn Postpartum** Promotion provides information about caring for an infant and support to new parents after hospital discharge.

* **Children with Special Needs** provides early intervention and coordination of services to help families receive a range of health, social, and educational services for their special needs child.

* **Follow Along Program** offers parents a periodic assessment of their child=s development and ideas for encouraging their development through a computer assisted tracking program.

* **Family Planning** provides individual family planning education and counseling, and follow up.

* **Medication Clinic for the Mentally Ill** provides assessment and injectable or oral medications to serious and persistent mentally ill clients who are suitable to receive services in the public health clinic setting.

* **Medication Options Services** is a home-based medication management service for clients with serious and persistent mental illness. Medications are administered on a regular basis for those with a history of repeated hospitalizations or exacerbation of illness.

* **Home Care for Underserved Adults** is a home care service targeted to those not served by other community home care agencies and may include nursing, home health aide care, and physical and occupational therapy. Targeted groups include those with cultural/language barriers, mentally ill, and those lacking financial resources.

* **Pre-Admission Screening** by a public health nurse and social worker team determines the appropriateness of home care alternatives to nursing home placement as well as the level of care required.

  * **Case Management for Alternate Care/MA Waivered Services** are visits and follow-up by a public health nurse or social worker to assess home care and related service needs and to monitor the quality of care provided to clients on these services.

d. <u>DISEASE PREVENTION AND CONTROL</u> This division focused on detecting and preventing the spread of communicable diseases. Programs include:

* **Refugee Health Services**. Complete medical and public health assessments of new refugees according to Minnesota Department of Health guidelines. Also, provide Civil Surgeon assessment of immunization records and when necessary physical examinations for "Green Card" applicants.

* **Interpreter Services.** Employs trained medical interpreters who interpret for public health clients. Currently support Spanish, Vietnamese, Cambodian, Somali and Bosnian languages.

* Tuberculosis Control. Identifies, treats, and case manages persons with active tuberculosis. Activities include Mantoux testing, case investigation, directly observed therapy, and contact investigation.

* **Immunization Services**. Provides childhood and adult immunizations in a walk-in clinic, two correctional facilities, high-rises and schools.

* **STD/HIV Services.** Screens, counsels and refers for STDs and HIV and treat most STDs in a clinic three days a week. Also provides community education.

Seniors Agenda for Independent Living (SAIL)
Start Smart
Third Judicial District Family Violence Committee

16. 1996-1999 Local Public Health Goals. Olmsted County proposes that coordination and implementation of mutually agreeable public health goals be carried out collaboratively by OCPHS and the health plan(s) contracted to do Olmsted County PMAP. The County will value proposals which use local resources and personnel for such coordination and implementation.

Public Health Goals for Olmsted County, as identified in the 1996-99 Community Health Services (CHS) Plan, are based upon a 1995 community needs assessment. Updated public health goals for Olmsted County, based upon the 1999 assessment will be available July 1, 1999.

Olmsted County worked with a regional group to establish common public health goals and objectives. Partners include the eleven SE Minnesota counties, and five health plans with SE Minnesota enrollees. The two primary areas of emphasis have been reduction of domestic violence and reduction of tobacco use.

GOAL: Olmsted County CHS	CATEGORY
Reduce health problems due to use and misuse of alcohol, tobacco and other drugs by youth and adults.	Alcohol/Tobacco/ Other Drugs
Reduce violence in Olmsted County	Violence
Reduce premature morbidity and mortality from Cardiovascular diseases, cancer and other chronic Illnesses.	Chronic/ Noninfectious Disease
Reduce the incidence of unintended pregnancies and premature childbearing in Olmsted County.	Unintended Pregnancy
Decrease susceptibility and/or exposure to vaccine preventable disease, TB, sexually transmitted and bloodborne diseases and emerging or re-emerging infections.	Infectious Disease
Promote healthy growth and development of children by supporting coordinated community initiatives which value children and families and improve services to parents and children.	Child Growth and Development
Enhance the emotional/physical well-being of family caregivers.	Mental Health

V. DEVELOPMENT AND ACCESS SPECIFICATIONS FOR OLMSTED COUNTY

ASSURANCES: The Health Plan assures the following by initialing in the box on the left of each item.

____ V. a. This Health Plan assures to meet with State and county staff at least monthly during the first six months of implementation and be available as requested on a quarterly basis thereafter to discuss and resolve service delivery issues or enrollment issues specific to the county.

____ V. b. The Health Plan will clearly delineate the criteria for referral of clients to Olmsted County Public Health Services (OCPHS), the specific delegated treatment and observation service that OCPHS is authorized to provide, and the process for timely reimbursement.

____ V. c. The Health Plan will assure that all children receive regular well child care with comprehensive screening and follow-up treatment when problems are identified

____ V. d. The Health Plan will assure that C&TC providers follow the recommended guidelines for well child screening.

____ V. e. The Health Plan assures to explore the feasibility of developing contractual relationships with the county's existing providers of mental health and chemical dependency services.

____ V. f. The Health Plan assures to work in collaboration with the county public health agency to comply with the Minnesota Vaccines for Children Program.

____ V. g. The Health Plan will refer enrollees to the county preadmission screening team when indicated for Elderly Waivered Services and nursing home placement.

____ V. h. The Health Plan assures it will coordinate with the MA/GAMC enrollees county social services staff when the enrollee is in need of any of the following services: case management for serious and persistent mental illness, case management for seriously emotionally disturbed children, case management for persons with developmental disabilities, prepetition screening, preadmission screening or elderly waiver services, extended care or halfway house services funded through the Consolidated Chemical Dependency Treatment Fund, child protection, court ordered treatment and the State Medical Review Team or social security disability determination.

____ V.i. The Health Plan assures it will explore the feasibility of a contract with Olmsted County Community Services to provide behavioral health services, including in-home family based services and therapeutic support of foster care.

____ V. j. The Health Plan will provide or arrange for common carrier transportation for its enrollees to obtain public health, medical and dental services in a manner that does not delay or discourage enrollees from getting to appointments on time.

____ V. k. The Health Plan assures that it will provide training to providers to increase cultural competency to serve minority and refugee populations.

____ V. l. The Health Plan will collaborate with Olmsted County in collection of data related to mutually agreed upon special projects of targeted groups within its population (ex.: increase C&TC screening) .

____ V. j. Describe how the plan will coordinate functions between the two separate networks Mayo Medical Center and Olmsted Medical Center and how they will coordinate services with the County.

____ V. k. Describe the process used by the health plan to negotiate a contract and to reimburse OCPHS for the delivery of the following services: STD diagnosis, treatment and counseling, HIV testing and counseling, tuberculosis control, refugee health screening, immunization administration, family planning methods, and counseling, and child and teen check-ups

____ V. l. Describe guidelines for collecting and sharing information about Olmsted County residents receiving health care services relevant to public health.

____ V. m. Describe a process for developing criteria for client referral to OCPHS, authorization for treatment and observation, and process for timely reimbursement.

____ V. n. A description of circumstances under which individuals will be referred to Public Health and specific services which the Health Plan will authorize Public Health to provide.

____ V. o. A description of how the Health Plan will assure access to public health clinics and medical and dental clinics (e.g. transportation, interpreters assistance etc.).

____ V. p. A description of how services for adults with mental illness and children with serious emotional disturbance will be coordinated with social services and public health and when appropriate the school.

____ V. q. How will the Health Plan assure that immunizations are administered following MDH recommended schedules.

____ V. s. A description of how the plan will participate in the Children's Mental Health Collaborative and the Family and Children Collaborative.

____ V. t. A description of how this Plan will provide timely interpreter services. Because of the variety of languages spoken, the county will value proposals which make use of the wealth of local interpreter resources.

____ V. u. A description of how this Plan will facilitate the reporting of necessary medical and epidemiological information regarding Olmsted County cases of active tuberculosis to OCPHS in a timely manner, and reimburse OCPHS for the diagnosis, treatment and management of tuberculosis

____ V. v. A description of how the plan will facilitate the process of screening eligible refugees according to the guidelines recommended by the Minnesota Department of Health.

____ V. w. A description of how transportation on common carriers will be effectively arranged for enrollees needing the service.

____ V. x. A description of how the Health Plan will provide access to in-home family based services for children and youth identified by the County as at-risk of placement outside their family home.

____ V. y. A description of how the Health Plan will provide individual, group and family treatment for juvenile sex offenders referred by the County. Indicate commitment to long term treatment and relapse intervention.

____ V. z. A description of how the Health Plan will work with County child protection to insure mental health services and chemical dependency services are provided within the child protection

PMAP Education & Enrollment Process

Activity/Task	Who's Involved	Time Line
First Managed Care Expansion Team (MCET) Meeting - Discussion	DHS Enrollment Coordinators and County Income Maintenance (IM) Supervisor(s)	Four months prior to education begin date
Determine staffing, equipment, printing capability, system requirements, etc.	DHS Enrollment Coordinator and County IM Supervisors	Four months prior to education begin date
County profile due to DHS	County IM Supervisors and DHS Enrollment Coordinators	Four months prior to education begin date
County Decision Tool answers due to DHS	County IM Supervisors and DHS Enrollment Coordinators	Four months prior to education begin date
Second MCET Meeting PMAP overview and education & enrollment overview	DHS Enrollment Coordinator, County IM Staff and County Advocate	Three months prior to education begin date
Request list of potential excludable clients from Social Services	County IM Supervisor	Three months prior to education begin date
County education materials due to DHS for approval	County IM Supervisor and DHS Enrollment Coordinator	Three months prior to education begin date
60 Day "Heads Up" letter sent to clients	DHS	Two months prior to education begin date
Social Services list of potential excludables due to IM	County Social Services and IM Supervisor	Two months prior to education begin date
DHS education materials ordered	County IM supervisor (DHS Enrollment Coordinator if problems)	Two months prior to education begin date
Third MCET Meeting Exclusioins and tracking	DHS Enrollment Coordinator, County IM Staff and County Advocate	One month prior to education begin date
PMAP MMIS Training	County IM Staff and DHS Enrollment Coordinator	One month prior to education begin date

Activity/Task	Who's Involved	Time Line
DHS education materials due to county	DHS Enrollment Coordinator and DHS Mail Room	One month prior to education begin date
Fourth MCET Meeting PMAP model contract and manual review	DHS Enrollment Coordinator, County IM Staff and County Advocate	One month prior to education begin date
Labels for mass mailing ordered (if required)	DHS Enrollment Coordinator	One month prior to education begin date
Primary Care Network List (PCNL) due to county	Health Plan	Ten days prior to education begin date
Education and enrollment begins	County IM Staff, County Advocate and DHS Enrollment Coordinator	That month
Access begins	County IM Staff, County Advocate and DHS Enrollment Coordinator	Month following education begin date
Fifth MCET Meeting Reports and adjustments	DHS Enrollment Coordinator, County IM Staff and County Advocate	Two months following education begin date
Advocate training	DHS Ombudsman and County Advocate	Two months following education begin date

Attachment E

RANDY JOHNSON
CHAIR

PHONE: 612-348-7885
FAX: 612-348-5295
TDD: 348-7708

BOARD OF HENNEPIN COUNTY COMMISSIONERS
A-2400 GOVERNMENT CENTER
MINNEAPOLIS, MINNESOTA 55487-0240

October 28, 1999

Commissioner Michael O'Keefe
Minnesota Department of Human Services
444 Lafayette Road
St. Paul, Minnesota 55155

Dear Commissioner O'Keefe:

On October 26, 1999 the Hennepin County Board of Commissioners unanimously approved Resolution 99-10-766R1 authorizing the formal communication of key issues of concern related to PMAP contracts with health plans for the year 2000. The Metro Counties Publicly Funded Health Care Programs Committee has been working with your staff for the past few months to identify these key issues of concern for the seven metro counties.

Let me emphasize that while the Hennepin County Board of Commissioners fully supports the resolution of issues common to all metro counties, we have included two additional areas of concern specific to Hennepin County. We specifically request that DHS develop contract language and monitoring systems to assure that PMAP enrollees have timely and effective access to mental health and chemical health services in order to successfully complete county programs such as MFIP, Drug Court, and IRIS (Integrated Resources for Independence and Self-Sufficiency). We also request that DHS provide Hennepin County with encounter data and annual revenues and expenditures data by health plans for chemical health and mental health services to PMAP clients. Dan McLaughlin, Director of the Hennepin County Health & Human Services Policy Center, will continue to be the primary liaison working with DHS staff to ensure that these requests are addressed.

We are aware that contract negotiations are well underway and have included Hennepin County representation. We are equally aware that your staff have indicated that not all issues will be addressed directly in the contract negotiation process, and that another process for the state, counties, and health plans to work together to resolve these concerns will be developed. We support a continued and increasing partnership between DHS and Hennepin County to ensure that Enhanced PMAP is managed in such a way that publicly funded health care programs work in conjunction with other services for low-income citizens.

E-MAIL ADDRESS:
[illegible]

WEB PAGE:
[illegible]

Attachment F

Dear :

Enclosed is a copy of the 1999 PMAP, PGMAC and prepaid MinnesotaCare programs model contract, and copies of the 1999 PMAP, PGMAC, and prepaid MinnesotaCare health plan contracts that apply to enrollees in your county.

As you may recall, the Department of Human Services (DHS) met with you and your staff last summer to talk about the prepaid health plans operating in your county and to get your input into the PMAP, PGMAC, and prepaid MinnesotaCare contracting process. At these meetings, you raised several issues that you felt DHS should address during contract negotiations. A summary of the issues you raised, along with an explanation of how DHS addressed them, is provided below:

- **Mental Health Issues**

  During last summer's meetings, DHS understood that you had continuing concerns about the mental health services provided to enrollees in your county. To address your concerns, DHS negotiated changes to this year's contract designed to improve enrollee access to and the quality of mental health services. For example, Section 9.1 of the 1999 model contract now requires health plans and their subcontractors to comply with all applicable federal and state statutes, including Minnesota Statutes §62Q.47 (mental health parity), §62Q.53 (mental health medical necessity) and §62Q.19 (essential community providers). This section will help to ensure that all health plans contracting with the state are subject to the same service and credentialing requirements.

  DHS is also following many issues related to the appropriate use of day treatment services. We have organized several meetings with counties and health plans designed to discuss the problem and to help facilitate discussions between the two parties.

- **Chemical Dependency**

  During our discussions, you also impressed upon us the need for DHS to ensure that health plans provide appropriate chemical dependency treatment to public enrollees. As described above, this year's PMAP, PGMAC and prepaid MinnesotaCare contract contain several provisions that encourage health plans to improve access to mental health/chemical dependency services. These provision should help to ensure that appropriate chemical dependency services continue in your area.

- **Inclusion of Long Term Care/Elderly Waver Services Into PMAP Contract**

  During discussions, you expressed concern about how DHS intended to implement Minnesota Statutes §256B.69, Subdivisions 6a and 6b. As a direct result of this concern expressed by yourself and by other counties, DHS decided to take incremental steps toward implementing this statute.

  DHS based its steps upon an assessment of the administrative feasibility within DHS, the health plans and the counties. As a first step, DHS returned to its previous policy of including 90 days of nursing home care in its PMAP contracts effective July 1, 1999. PMAP contracts had included this provision until 1990 when DHS dropped it in response to Congress' passage of the Catastrophic Health Care Act. Although Congress later repealed the Catastrophic Health Care Act, DHS had not reinstated the 90 days of nursing facility liability until this year.

As a second step, DHS published a *Request for Comments on the Provision of Nursing Facility, and Home and Community Based Services Under Capitated Financing Arrangements (RFC).* The RFC outlined DHS' long range plans for serving the elderly and requested counties, health plans and professional associations to comment on the proposal. DHS also met with several counties to conduct case studies to find the best method for implementing §256B.69, subdivisions 6a and 6b.

Finally, as a third step, DHS has closely monitored all of this year's legislative activities relating to adding long term care benefits to PMAP. Legislation was introduced to repeal the requirements of §256B.69, subdivisions 6a and 6b. This legislation could affect DHS' proposal as outlined it the *Request for Comment*, but repealing the 90 days of nursing facility liability already provided for in the 1999 PMAP, PGMAC and MinnesotaCare programs contract is unlikely.

- **Administrative Issues**

  You expressed concern that the health plans operating in your county did not contract with Canadian providers, especially in Fort Frances. You explained that if DHS required health plans to contract with Canadian providers there would be more geographically accessible providers in your areas.

  Although DHS understands your concerns, we cannot force a health plan to contact with providers practicing outside the country. We have, however, contacted each of the health plans to voice your concerns and to encourage them to contract with additional providers in your area. Also, DHS will continue to monitor the health plans operating in your county to ensure that they have an appropriate number of geographically accessible providers.

  Besides the provider contracting issue stated above, you expressed concern about receiving grids and reports from the health plans operating in your area. Again, DHS contacted each of the health plans in your area to voice your concern and to encourage the health plans to work with you to resolve this issue. The health plans have assured us that they intend to work to ensure you receive all information in a timely manner.

- **Public Health Clinics**

  During our meetings last summer, you stated that, although public health clinics provide covered services and contract with health plans, these clinics have not gotten referral. These clinics also have some billing issues with the health plans. DHS has discussed the two issues with the health plans and have strongly encouraged to resolve these issues with you directly.

- **EPSDT Screening**

  Based on your suggestions and suggestions from other counties, DHS has incorporated a performance incentive into this year's contract. The contract makes health plans eligible for a financial performance incentive payment in an amount based on their reported participation rate for C&TC/EPSDT screenings. The State will withhold 1% of certain MA and MinnesotaCare capitation rates paid to the health plan. If the health plan meets its performance goals, it can "earn" back the 1% of the withheld capitation rates. If the plan exceeds its minimum performance goals, it may also receive up to an additional 1% of the rates. By incorporating this performance incentive into this year's contract DHS hopes to incent providers to meet or exceed C&TC/EPSDT screenings goals.

- **Public Health Goals**

  In 1997, the State Legislature passed a law that allows county boards to develop contract requirements related to public health goals. The public health goals included in this year's PMAP, PGMAC and prepaid MinnesotaCare contracts can be found in Section 6.24.4 of the model contract. The goals listed specifically include suggestions from your county, such as: reducing violence in our society; increasing immunizations rates; reducing tobacco use; and meeting C&TC screening goals.

Besides the specific issues raised by you, DHS has made many other significant changes to this year's PMAP, PGMAC and prepaid MinnesotaCare contract. Input from other counties prompted many of these changes. Below is

a brief summary of the most significant changes made to this years contact:

- **Tribal Services**

  Beginning this year, pending federal approval, the State will begin enrolling American Indians living on reservations into PMAP and PGMAC. American Indian enrollees will have direct out-of-network access to Indian Health Services facilities and facilities operated by a tribe or tribal organization. Health plans many not require prior approval or restrict the access of qualified individuals to services at these types of facilities.

- **Abortion Coverage**

  Amendments made last year to the HYDE Act severely restrict the circumstances where a state may use federal funds to pay for abortion services. As a result, DHS has changed its abortion services coverage policy and will no longer require health plans to cover these types of services. Health plans may still provide abortion services, but the provision of the services will not affect the calculation of a health plan's payment rate.

- **Special Education Funding**

  Beginning July 1, 1999, Section 4.4 of the contract will require health plans to assume responsibility for medically necessary MA services provided by school districts and identified in an enrollee's Individual Education Plan (IEP) or an Individual Family Service Plan (IFSP).

- **Translation and Language Services**

  DHS has incorporated into this year's contract several provisions designed to encourage health plans to better serve people for whom English is a second language. These provisions require health plans to increase their use of bilingual staff (Section 6.1.11), to add language blocks to certain member notices (Section 8.2.2), and to translate, upon request, Certificates of Coverage into Spanish, Laotian, Hmong, Cambodian, Vietnamese, Russian and Somali (Section 3.2.3 A(d)).

- **Balanced Budget Act (BBA) Requirements**

  The Balanced Budget Act (BBA) of 1997 and subsequent regulations, required DHS to make several changes to this years contract. These changes include, incorporating a prudent layperson standard of a medical emergency into the contract (Section 2.29); adding a definition of Post-Stabilization Care Services (Section 2.48); updating the contract to allow criminal penalties for violations of Section 1128B(d)(1) of the Social Security Act (Section 9.2.5); and introducing a conflict of interest policy that prohibits former state employees who participate in Medicaid procurement from working, in certain capacities, for a competing contractor (Section 3.7).

As you can see, many of your comments and comments from other counties have prompted contract changes and commitments by health plans to improve services and communication. Indeed, input from you and your staff was crucial to the development of this year's PMAP, PGMAC and prepaid MinnesotaCare contracts.

I sincerely thank you for your continued commitment to ensuring that enrollees of DHS' prepaid programs receive the care and service they need and deserve. If you have any questions or concerns regarding this letter or the attached documents, please contact Kimberly Halva, Purchasing and Service Delivery staff, at 651/297-7968.

Sincerely,

James A. Chase

Director, Purchasing and Service Delivery

cc: Sandy Burge, DHS

Karen Peed, DHS