MINNESOTA

DEPARTMENT OF HUMAN SERVICES

MANAGED CARE AND PAYMENT POLICY DIVISION

REQUEST FOR PROPOSALS

FOR

A QUALIFIED GRANTEE(S) TO

Provide Medicare-Medical Assistance Integrated Health Care and Long Term Care Services for Seniors Under the Minnesota Senior Health Options Program and Provide Integrated Health Care Services for People with Disabilities for Medical Assistance Under the Special Needs Basic Care Program in

Carlton, Cook, Koochiching, Lake, and St. Louis Counties

For communication assistance, contact Minnesota Relay Service at 7-1-1 or 1-800-627-3529. If you ask, we will give you this information in another form, such as Braille, large print, or audiotape.

April 20, 2009
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I. **INTRODUCTION**

A. **PURPOSE OF REQUEST**

The Minnesota Department of Human Services, through its Managed Care and Payment Policy Division (State), is seeking additional Proposals from qualified managed care organizations (MCOs) sponsoring Medicare Advantage Special Needs Plans (SNPs) to provide prepaid health care and long term care services to seniors who are eligible for Medicare and Medical Assistance under the Minnesota Senior Health Options (MSHO) in Carlton, Cook, Koochiching, Lake, and St. Louis Counties. Whenever the term “counties” is used in this document it refers to these five counties.

In addition, the Minnesota Department of Human Services, though its Managed Care and Payment Policy Division (State), is seeking additional Proposals from qualified MCOs sponsoring Medicare Advantage Special Needs Plans (SNPs) to provide prepaid health care to people with disabilities age 18-64 who are eligible for Medical Assistance under the Special Needs Basic Care (SNBC) program in Carlton, Cook, Koochiching, Lake, and St. Louis Counties. Whenever the term “counties” is used in this document it refers to these five counties.

Enrollment into MSHO and SNBC is voluntary.

For MSHO, to be a successful responder, an MCO must have an existing Medicare dual eligible SNP approved by the Centers for Medicare & Medicaid (CMS) or have a service area expansion application pending which: 1) is expected to be approved for January 1, 2010, and 2) which allows them to serve the dual eligible subset for seniors as defined by the State and will be expected to integrate Medicare and Medicaid services as specified in this RFP for MSHO. **MCOs currently providing MSHO in these counties do not need to respond.**

For SNBC, to be a successful responder, a MCO must have an existing Medicare dual eligible SNP approved by the Centers for Medicare & Medicaid (CMS) or have an application or service area expansion application pending which: 1) is expected to be approved for January 1, 2010, and 2) which allows them to serve the dual eligible subset of people with disabilities as defined by the State, must currently participate in MSHO in Minnesota and will be expected to integrate Medicare and Medicaid services as specified in this RFP for SNBC. **MCOs currently providing SNBC in these counties do not need to respond.**

Responders may respond for MSHO only, for SNBC only or for both MSHO and SNBC.

**This RFP does not include procurement for the Prepaid Medical Assistance Program (PMAP), Minnesota Senior Care Plus (MSC+) and Minnesota Disability Health Options (MnDHO) programs.**

B. **OBJECTIVE OF THIS RFP**

For MSHO, the objective of this RFP is to contract with a qualified Responder(s) to perform the tasks and services set forth in this RFP. It is anticipated that any contract awarded under this RFP will have a start date of **January 1, 2010.** Thereafter, the Commissioner of Human Services may choose to renew any contract awarded under this RFP annually.
For SNBC, the objective of this RFP is to contract with a qualified Responder(s) to perform the tasks and services set forth in this RFP. It is anticipated that any contract awarded under this RFP will have a start date of **January 1, 2010.** Since SNBC is voluntary, the State may choose a single entity to provide services in any of the 5 counties, but is not obligated to do so. The recommendation of the Department of Human Services Managed Care Advisory Committee for People with Disabilities is to assure choices in managed care options for people with disabilities wherever possible. Thereafter, the Commissioner of Human Services may choose to renew any contract awarded under this RFP annually.

Proposals must be submitted by **4:00 p.m. Central Time on May 11, 2009.** This RFP does not obligate the State to award a contract or complete the project, and the State reserves the right to cancel the solicitation if it is considered to be in its best interest. All costs incurred in responding to this RFP will be borne by the Responder.

**D. BACKGROUND**

**1. MSHO General**

Under the authority of Minnesota Statutes, section 256B.69, subdivision 23, the State is soliciting proposals for provision of specified health care services in the 5 identified counties to serve dual eligible seniors over the age of 65 in the Minnesota Senior Health Options program. The State will contract with qualified MCOs that have CMS Medicare Advantage dual eligible SNP contracts in counties where MCOs propose to provide services. MCOs must agree to enroll a subset of the dually eligible population as defined by DHS and approved by CMS, and to integrate Medicare and Medicaid services to the extent allowable by CMS and as defined in the State’s Medicaid contract.

In 1997, DHS began offering MSHO which is a voluntary managed care program that combines Medicare and Medicaid financing and services for seniors age 65 and over who are eligible for Medical Assistance. MSHO operates under Medicaid State Plan authority (1915 (a)) for voluntary enrollment of all Medicaid dual eligibles age 65 and older, and under Medicare Advantage authority for Medicare SNP services to those dual eligibles included in the State’s dual subset approved by CMS.

MSHO began in the seven metropolitan counties with three health plans and expanded in 2005 to include nine health plans providing coverage in 83 counties. An RFP is currently pending to reprocure state wide and also to add the remaining four counties. Subsequent to the issuance of that RFP, DHS was notified that one MCO serving these 5 counties intends to cease operations at the end of 2009. This RFP offers the opportunity to replace that MCO. MSHO offers the same Medicaid State Plan Services and EW services covered under MSC+, and for dual eligibles, all Medicare services including prescription drugs covered by the Medicare Prescription Drug Program (Part D). MSHO covers all Medicaid and Medicare drugs under the same health plan. The health plan also pays for the first 180 days of nursing facility care to enrollees who enter a nursing facility after enrollment. Enrollment into MSHO is voluntary.

MSHO includes: 1) all Medicare and Medicaid coverage for acute and primary care; 2) Medicare cost sharing; 3) prescription drugs under Medicare Part D and those covered by Medicaid; 4) supplies, equipment, therapies and other ancillary services; 5) transportation; 6) interpreter; 7) State Plan home care services including private duty nursing and personal care services 8) Elderly Waiver services; and 9) 180 days of Medicare and/or Medicaid nursing home coverage.
To begin serving the MSHO population in the 5 counties, MCOs must successfully respond to this RFP.

DHS has notified counties of the opportunity to provide input into this RFP. Counties will participate in review of responses to this RFP.

2. SNBC General

Under the authority of Minnesota Statutes, section 256B.69, subdivision 28, the State is soliciting proposals for provision of specified health care services in the 5 listed SNBC counties to serve people with disabilities age 18-64 in the Special Needs Basic managed care program. The State will contract with qualified MCOs that have CMS Medicare Advantage dual eligible SNP contracts in counties where MCOs propose to provide services. MCOs must agree to enroll a subset of the dually eligible population as defined by DHS and approved by CMS, and to integrate Medicare and Medicaid services to the extent allowable by CMS and as defined in the State’s Medicaid contract.

Legislation passed in 2006 created SNBC to combine the acute, primary and Part D prescription drug coverage under Medicare, with related services included under Medicaid and to provide additional coordinated service delivery options for all Medicaid eligibles with disabilities. SNBC operates under Medicaid State Plan authority (1915 (a)) for voluntary enrollment of all Medicaid eligibles with disabilities ages 18-64, and under Medicare Advantage authority for Medicare SNP services to those dual eligibles included in the State’s dual subset approved by CMS. A separate RFP is currently pending to expand SNBC to the four remaining counties and to seek additional MCOs in the seven county Metro area. Subsequent to the issuance of that RFP, DHS was notified that one MCO serving these 5 counties intends to cease operations at the end of 2009. This RFP offers the opportunity to replace that MCO.

SNBC includes: 1) all Medicare and Medicaid coverage for acute and primary care; 2) Medicare cost sharing; 3) prescription drugs under Medicare Part D and those covered by Medicaid; 4) supplies, equipment, therapies and other ancillary services; 5) transportation; 6) interpreter; 7) home health aide; 8) skilled nurse visits; and 9) 100 days of Medicare and/or Medicaid nursing home coverage. SNBC will not include private duty nursing, personal care services or home and community based waiver services. Those eligible will continue to receive those services on a fee-for-service basis.

To begin to serve people with disabilities under this program MCOs must successfully respond to this RFP. This RFP seeks detailed information related to purchasing requirements developed in cooperation with the Stakeholder’s Advisory Committee on Managed Care for People with Disabilities. Successful responders will indicate how they intend to comply with those purchasing requirements in addition to other standard requirements of the State’s managed care program. The SNBC program is also based on a number of broader principles adopted by that Committee. A document containing those principles is found in Appendix O. Successful responders must also indicate how their SNBC product will address those principles.
To begin serving the SNBC population in the 5 counties, MCOs must successfully respond to this RFP.

DHS has notified counties of the opportunity to provide input into this RFP. Counties will participate in review of responses to this RFP.

3. Enrollment Data

Enrollment date for number of recipients enrolled in MSHO, MSC+, MnDHO and SNBC statewide and by county can be found at the following link:

http://www.dhs.state.mn.us/main/dhs16_141529

Appendix R contains the number of Medical Assistance recipients with disabilities statewide and by county, arranged by a number of service categories. Approximately 300 people with disabilities receiving services through Medicaid become eligible for Medicare each month.

4. Managed Care Education and Enrollment Process

Enrollment in the MSHO and SNBC programs are voluntary for both Medicare and Medicaid. MCOs participating in the MSHO and SNBC programs will be conducting their own marketing, education and enrollment and must meet all requirements for Medicare and Medicaid marketing as outlined in the current SNBC and MSHO programs. For MSHO, seniors may choose to enroll into MSHO through the county enrollment process as an alternative to MSC+. For SNBC, since people with disabilities are not enrolled currently in a mandatory managed care program, the county enrollment process is not available and will only be enrolled though the MCO.

All member and marketing materials must be approved by the State and are subject to the joint State and CMS regional office review process currently in effect for SNBC and MSHO. There will be a single enrollment form and process for Medicare and Medicaid and CMS enrollments must be verified for Medicaid/Medicare eligibility and coordinated with the State according to current processes used in SNBC and MSHO.

5. Eligibility for MSHO

A. Service Area. Only those eligible persons who are enrolled in Medical Assistance residing within the counties of the State of Minnesota as approved as a service area under the contract with the MCO shall be eligible for enrollment in MSHO.

B. Eligible Persons. Any Recipient who resides within the Service Area may enroll in the MCO at any time during the duration of the MCO’s Contract, subject to the limitations contained in the Contract.

C. Eligibility Determination. Eligibility for Medical Assistance will be determined by the Local Agency. Eligibility for Medicare will be determined by CMS. All persons who receive Medical Assistance and reside in the Service Area will participate in MSC+, except for residents described in the Enrollment Exclusions section below. Person eligible for MSC+ may
voluntarily enroll in MSHO, subject to the limitations contained in the contract.

D. **Enrollment Exclusions.** The following populations are excluded from enrollment in the MCO.

1. Recipients eligible for the Refugee Assistance Program pursuant to 8 U.S.C. 1522(e).

2. Residents of State Regional Treatment Centers, unless the MCO approves placement. For purposes of this Contract, approval by the MCO would include a placement that is court-ordered within the terms described in Section 6.1.22.V. For purposes of this Section, Woodhaven Senior Community is not considered a State Regional Treatment Center.

3. Individuals who are Qualified Medicare Beneficiaries (QMB), as defined in Section 1905(p) of the Social Security Act, 42 U.S.C. 1396d(p), and who are not otherwise eligible for Medical Assistance.

4. Individuals who are Specified Low-Income Medicare Beneficiaries (SLMB), as defined in Section 1905(p) of the Social Security Act, 42 U.S.C. 1396a(a)(10)(E)(iii) and 1396d(p), and who are not otherwise eligible for Medical Assistance.

5. Recipients, who at the time of notification of mandatory enrollment into MSC+ or voluntary enrollment in MSHO have a communicable disease whose prognosis is terminal and who primary care physician is not a Participating Provider in the MCO, and that the physician certifies that disruption of the existing physician-patient relationship is likely to result in the patient becoming noncompliant with medication or other health services.

6. Recipients who are eligible while receiving care and services from a non-profit center established to serve victims of torture.

7. Individuals who have Medicare coverage through United Mine Workers.

8. Individuals with a diagnosis of End Stage Renal Disease (ESRD) prior to enrollment in the MCO.

9. Undocumented and non-immigrant non-citizen Medical Assistance Recipients who are eligible only for emergency Medical Assistance under Minnesota Statutes, section 256B.06, subd. 4.

10. Non-citizens eligible for Medical Assistance according to Minnesota Statutes, section 256B.06, subd. 4(e), under program “NM”.
11. Persons who are eligible for Medicare Part A only, or Medicare Part B only.


E. **MSHO Eligibility Determinations.** In order to be eligible to enroll in the MCO for MSHO as of January 1, 2010, the individual must be:

1. Age sixty–five (65) years of age or older or turning sixty-five years of age within the month they are requesting enrollment ; and

2. Eligible for Medical Assistance and Medicare Parts A and B; and

3. Eligible to enroll in MSC+ within the MCO’s Service Area as defined in Section 3.1.1(A) of this Contract.

F. **Additional Eligibility Parameters.**

1. **Nursing Facility and Community Residents.** Nursing Facility residents and persons living in the community are eligible to enroll in the MCO for MSHO.

2. **Hospice.** Enrollees who elect to enroll in the Medicare Hospice program while enrolled in MSHO are not required to disenroll from the MCO’s MSHO product.

3. **End Stage Renal Disease.** Enrollees who are identified by CMS as having ESRD after enrollment in MSHO are not required to disenroll from the MCO’s MSHO product.

4. **Spenddown.** Non-institutional Recipients who are eligible for MSHO but are not required to enroll in MSC+ due to a Spenddown may enroll in the MCO for MSHO. Until further notice, the State is not currently enrolling new Enrollees who have Medical Spenddowns into MSHO with the exception of people who are coded with a Medical Spenddown and have elected hospice. Enrollees who are enrolled into MSHO prior to acquiring a Medical Spenddown are not required to disenroll from MSHO provided the Enrollee agrees to pay the Medical Spenddown to the State on a monthly basis.

6. **Eligibility For SNBC**

Eligibility parameters for enrollment and enrollment exclusions from section 3.1- 3.6.11 of the 2009 model SNBC contract are listed below.

**Section 3.1 Eligibility**
3.1.1 **Service Area.** Only those eligible persons residing within counties of the State of Minnesota shall be eligible for enrollment in SNBC.

3.1.2 **Eligible Persons.** Any Recipient who resides within the Service Area may enroll in the MCO at any time during the duration of this Contract, subject to the limitations contained in this Contract.

3.1.3 **Eligibility Determination.** Eligibility for Medical Assistance will be determined by the Local Agency. Eligibility for Medicare will be determined by CMS.

3.1.4 **Enrollment Exclusions.** The following populations are excluded from enrollment in the MCO under the SNBC program:

A. Recipients eligible for the Refugee Assistance Program pursuant to 8 U.S.C. 1522(e).

B. Residents of State Regional Treatment Centers, unless the MCO approves placement. For purposes of this Contract, approval by the MCO would include a placement that is court-ordered within the terms described in Section 6.20.3. For purposes of this section, the Woodhaven Senior Community is not considered a state institution.

C. Individuals who are Qualified Medicare Beneficiaries (Q.M.B.), as defined in § 1905(p) of the Social Security Act, 42 U.S.C. § 1396d(p), and who are not otherwise eligible for Medical Assistance.

D. Individuals who are Specified Low-Income Medicare Beneficiaries (S.L.M.B.), as defined in § 1905(p) of the Social Security Act, 42 U.S.C. § 1396a(a)(10)(E)(iii) and § 1396d(p), and who are not otherwise eligible for Medical Assistance.

E. Undocumented and non-immigrant non-citizen Medical Assistance Recipients who are eligible only for emergency Medical Assistance under Minnesota Statutes, 256B.06, § subd. 4.

F. Persons up to eighteen (18) years of age or over sixty-five (65). Enrollees who turn 65 years of age while already enrolled may choose to remain in SNBC. See enrollment parameters outlines in section 3.3.5.

G. Any person committed to a regional treatment center with a diagnosis of sexual psychopathic personality as defined by Minnesota Statutes, § 253B.02, subd. 18b, or a diagnosis of sexually dangerous person as defined by Minnesota Statutes, § 253B.02, subd. 18c.

H. Persons living in an acute, long-term care hospital or rehabilitation hospital. These individuals may be eligible to enroll upon discharge, if they meet other eligibility criteria.
I. Persons with a diagnosis of End Stage Renal Disease (ESRD) prior to enrollment in the MCO.

J. Individuals who have Medicare coverage through United Mine Workers.

K. Enrollees who become Medicare eligible after enrollment in the MCO and who refuse to receive their Medicare benefits through the MCO.

L. Persons who are eligible for Medicare Part A only, or Medicare Part B only.

M. Medical Assistance Recipients who are eligible while receiving care and services from a non-profit center established to serve victims of torture.

N. Recipients eligible for the emergency Medical Assistance program.

O. Women receiving Medical Assistance through the Breast and Cervical Cancer Control Program.

3.2 **SNBC Eligibility Determinations.** In order to be eligible to enroll in the MCO for SNBC, the individual must:

3.2.1. Be age eighteen (18) through age sixty-four (64);

3.2.2 Be eligible for Medical Assistance;

3.2.3. Be residing within the Service Area; and

3.2.4. Be either of the following
   A. Certified as disabled through the Social Security Administration (SSA) or the State Medical Review Team (SMRT); or
   B. A Person with Developmental Disability for purposes of the DD waiver, as determined by the Local Agency.

3.3 **Additional Eligibility Parameters.**

3.3.1 **Hospice.** Enrollees who elect to enroll in the Medicare Hospice program while enrolled are not required to disenroll from the MCO’s SNBC product.

3.3.2 **End Stage Renal Disease.** Enrollees who are identified by CMS as having ESRD after enrollment are not required to disenroll from the MCO’s SNBC product.

3.3.3 **Spenddown.** Medical Assistance Recipients who otherwise meet all the enrollment requirements for SNBC are eligible to enroll in the
MCO if they agree to pay their Spenddown as required on a monthly basis. The value of the first three (3) months of Spenddown obligation is deducted from the Capitation Payment.

3.3.4 **MA-EPD.** For persons who are on Medical Assistance for Employed Persons with Disabilities (MA-EPD), are eligible to enroll.

3.3.5 **Enrollees Over Age 65.** SNBC Enrollees who enrolled in the MCO’s SNBC product before reaching age sixty-five (65) may remain enrolled in the MCO’s SNBC product after reaching age sixty-five (65), only if they maintain eligibility for Medical Assistance, are not accessing any EW services, or choose not to access EW services. Enrollees who do not have a Spenddown, may choose to enroll in the MCO’s MSHO or MSC+ product.

3.3.6 **Persons in Excluded Time.** Persons with a disability who establish Medicaid eligibility in one county and then move to another county may be considered to be in Excluded Time, if they are receiving designated Excluded Time services or reside in a designated Excluded Time facility. Persons in Excluded Time as defined in this Section may enroll in SNBC.

3.3.7 **County of Residence.** Eligibility for SNBC is based on county of residence. Persons in Excluded Time status will be eligible to enroll in the product as long as they continue to reside in the service area and meet all other enrollment criteria. The capitation rate for an Enrollee in Excluded Time will be based on the Enrollee’s current county of residence.

3.3.8 **Waiver Status.** People who are receiving services under the CADI, TBI, CAC, or DD waiver are eligible to enroll in SNBC. Once Enrollees reach age sixty-five (65), the Enrollee is no longer eligible for the SNBC program if they choose to receive EW services. If the Enrollee chooses to continue with services under the CADI, TBI, CAC or DD waiver, they may continue to receive services through SNBC provided they maintain eligibility for Medical Assistance.

3.3.9 **Medicare Status.** Only Medicare eligibles who are eligible for both Medicare Parts A and B, or Recipients who are eligible for Medical Assistance without Medicare, may enroll.

**Section 3.4. Enrollment**

3.4.1 **Nondiscrimination.** The MCO will accept all eligible Recipients who select the MCO. The MCO will enroll all eligible Recipients who select the MCO, without regard to physical or mental condition, health status or need for or receipt of health care services, claims experience, medical history, genetic information, disability (if eligible), marital status, age, sex, sexual
orientation, national origin, race, color, religion or political beliefs, and shall not use any policy or practice that has the effect of such discrimination.

3.4.2 **Order of Enrollment.** The MCO shall enroll Recipients in the order in which they apply.

3.4.3 **Timing of Enrollment.** Recipients may enroll with the MCO at any time during the duration of this Contract, subject to the limitations of this Article.

3.4.4 **Period of Enrollment.** The MCO agrees to retain Medicare eligible Enrollees for three months after losing their Medicaid eligibility in the MCO, including Enrollees who no longer meet the requirements for managed care enrollment, as part of the MCO’s Medicare Special Needs Plan enrollment.

**Section 3.5 Single MCO Entity Provide.** If the MCO is a single entity Provider in a Rural Area, the MCO must allow Recipients: 1) to choose from at least two Participating Providers; and 2) to obtain services from any other Provider when the circumstances allow pursuant to 42 CFR § 438.52(b0(2)(ii

**Section 3.6 MCO Enrollment Responsibilities.** The MCO shall:

3.6.1 Utilize integrated enrollment forms and processes as defined under this contract for enrollment under both Medicare and Medicaid. The form shall include primary language spoken by the member, including American Sign Language and preferred modes for those who use assistive devices, including email, for communications.

3.6.2. Assure that prospective Enrollees are eligible for Medical Assistance by checking the Medicaid eligibility verification system (EVS) or MN-ITS, before having the Recipient complete an enrollment form. Persons who are found to be ineligible for Medical Assistance are ineligible for enrollment in SNBC.

3.6.3 Prior to submitting to the STATE, or entering enrollment on MMIS, the MCO must verify Medicare status of the Potential Enrollee via the Medicare Advantage and Prescription Drug User Interface (MARx) or other system as directed by the STATE and CMS. A copy of the CMS eligibility screen print must be included with any enrollment form submitted to the STATE.

3.6.4 The MCO must ensure that appropriate MCO staff has access to the MN-ITS and appropriate Medicare eligibility and managed care systems or case management systems as directed by the STATE and CMS including MARx.

3.6.5 The MCO must have Recipients sign an enrollment form which incorporates a Statement of Informed Enrollment and Enrollee Rights.

3.6.6 This Statement of Informed Enrollment shall include, but is not limited to the following:
(A) An explanation that the Enrollee is assigning their Medicaid benefits, and for Dual Eligibles, also their Medicare benefits to the MCO.

(B) The Enrollee’s right to disenroll on a monthly basis and that upon disenrollment, they will return to the fee-for-service, unless they are otherwise required to enroll in PMAP or MSC+.

(C) Unless requested by the Enrollee, the MCO may not disenroll any Enrollee who is part of the eligible population, as long as the Enrollee meets enrollment criteria.

(D) For Recipients or Enrollees who are under Adult Guardianship, the MCO must ensure that the State Legal Guardian signs the enrollment form.

**Section 3.6.7 Supplemental Enrollment Application.** For Enrollees who become eligible for Medicare coverage after enrollment in the MCO, the MCO must obtain a signature on the MCO’s supplemental enrollment application that will be mailed by either the STATE or the MCO, as determined by the TPA contract procedures.

**Section 3.6.8 Screening Document Entry.**

(A) The MCO will be responsible to enter specified fields from screening documents into MMIS for community non-waiver Enrollees, excluding people who have DD but are non-waiver Enrollees. The MCO may enter the information or may contract with a Local Agency or Care System to enter screening documents. The MCO shall submit to the STATE’s security liaison a signed data privacy statement for all MCO employees and subcontractors who will be responsible for entering specified fields from screening documents into MMIS.

(B) The STATE shall offer training to MCOs and its subcontractors on this process.

(C) The MCO shall download and install the required internet access software “Blue Zone” onto workstations for those staff that will be responsible for entering Screening Documents. “Blue Zone” is an internet-based application.

(D) The MCO shall be responsible for entering screenings for non-waiver community Enrollees.

E) The MCO may submit prior to July 1, 2009, a transition plan for review and approval by the STATE that facilitates a phase-in process for this requirement throughout the Contract Year.
Section 3.6.9 Remedies. If the MCO does not comply with the requirements of this STATE may seek remedies including, but not limited to, the partial breach remedy specified in section 5.4.3 of this contract.

Section 3.6.10 Enrollment Limitation.

(A) The STATE may further limit the number of Enrollees in the MCO if in the STATE or CMS’s judgment, or by MCO request, the MCO is unable to demonstrate a capacity to serve additional Enrollees. Enrollees already enrolled in the MCO shall be given priority to continue that enrollment if the STATE and CMS determine that the MCO does not have the capacity to accept all those seeking enrollment in the MCO’s SNBC product.

(B) The MCO shall enroll any eligible Recipients during any open enrollment period required by the STATE or CMS.

Section 3.6.11 Voluntary Enrollment. Recipient enrollment in the MCO for the SNBC program shall be voluntary.

7. Rates

Minnesota pays MCO(s) a capitated rate which includes Medicare cost sharing to the extent it is provided through Medical Assistance.

MSHO- the rate consists of three main components, all of which are developed independently:

a) Basic Care Component – Rates for the Basic Care component for MSHO were developed from actual MCO financial experience using the same methodologies as PMAP. This component pays for the state plan services included in MCO contracts, excluding nursing facility services. In previous years, this component has been identified as the PMAP or acute care component. Rates for Medicare-eligible enrollees are 100% demographically based.

b) Nursing Facility (NF) Add-On – This component is applied to all community members to cover 180 days of nursing home care for community members admitted to nursing homes after enrollment. It is based on historical FFS experience, adjusted by factors based on age, gender, region, and statewide nursing facility cost experience.

c) Elderly Waiver Add-On – This component is currently based on historical FFS experience, adjusted by factors based on age and gender relationships. For 2010, the State will be developing a new methodology based on a risk based system.

SNBC Disability Risk Adjusted Payment System

The State will issue a single monthly payment to the MCO for which the health plan must provide the SNBC benefits set forth in the contract for all enrolled persons. The amount of the monthly payment will be equal to the product of the base rate multiplied by the health plan average risk factor for each person enrolled in the health plan, updated on a rolling quarterly basis.
Base Rates

Base rates for the SNBC program are based on projections of historical fee-for-service Medicaid data for eligibles with disabilities. The base rates are adjusted to reflect differences in the fee-for-service cost data for geographical region, institutional status, benefit changes, and eligibility for Medicaid only vs. eligibility for both Medicare and Medicaid.

Risk Adjustment Methodology

In order to account for the potential of systematic adverse selection of enrollees with higher or lower than average basic care costs, the STATE incorporates the Chronic Disability Payment System (CDPS) in calculating, on a quarterly basis, an MCO specific risk adjustment score which is applied to the Medicaid portion of the acute care rates. The risk adjustment method utilizes two sets of weights, one for Medical Assistance only (or non-dual enrollees), and one for dual eligible enrollees. These two models are identical in structure, but distinct with respect to specific values of the risk factor weights.

The STATE utilizes diagnoses from fee-for-service and/or encounter claims for all MCO enrollees with one or more months of Medical Assistance eligibility in the assessment period, and applies the CDPS grouper software to these diagnoses, and the risk adjustment method in order to determine an individual risk adjustment score utilizing applicable weights for each Enrollee. The amount of the monthly payment will be equal to the product of the base rate multiplied by the health plan average risk factor.

Nursing Facility Costs

Nursing facility institutional costs are accounted for in the nursing facility add-on rate, which is only applicable to the community population. Nursing facility costs for persons who resided in a nursing facility prior to enrollment in SNBC will be paid on a fee-for-service basis. Additionally, nursing facility costs after the health plan’s 100-day nursing facility liability period will be paid on a fee-for-service basis.

8. Certificates of Coverage (COC) or Evidence of Coverage (EOC)

MCO(s) must develop combined Medicare and Medicaid EOC/COCs to meet their needs, based on models available from the State. All EOC/COC’s must contain the following elements: specific information on benefits including any limitations and exclusions; cost-sharing (or co-pays), what services require authorization or approval, American Indian access to Indian Health Services, enrollee rights and protections, information on prescription drug coverage and information on how enrollee’s grievances and appeals are resolved. Minnesota Statutes, section 256B.69, subd. 27 requires MCO(s) provide language assistance to enrollees that ensures meaningful access to its programs and services according to Title VI of the Civil Rights Act and federal regulations adopted under that law or any guidance from the United States Department of Health and Human Services. Model COC/EOCs for MSHO and SNBC are available on the DHS public website: http://www.dhs.state.mn.us/dhs16_139709

9. Other Information

a.). Minnesota Health Care Fact Sheet
http://edocs.dhs.state.mn.us/lfserv/Legacy/DHS-5153-ENG
b.) Medically Underserved Regional Listing
   http://muafind.hrsa.gov/

c.) Public Health Nursing Agencies Listing
   http://www.health.state.mn.us/divs/cfh/ophp/system/administration/counties.html

d.) Community Health Clinics Listing -
   http://www.health.state.mn.us/divs/cfh/ophp/system/administration/counties.html
   http://ask.hrsa.gov/pc/

e.) Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHC) –
   http://www.health.state.mn.us/divs/orhpc/shortage/fqhcs330.html

f.) Regional Treatment Centers Listing - http://www.dhs.state.mn.us/SOS/default.htm

g.) Chemical Dependency Rule 31 Facilities Listing –
   http://www.dhs.state.mn.us/id_017167

h.) Gaps Analysis –
   http://www.dhs.state.mn.us/main/dhs16_141764

i.) Rates for specific programs - Contact Cara Bailey at 651-431-2515.

II. SCOPE OF WORK

A. OVERVIEW

A MCO is required to submit a proposal in good faith that meets the requirements of the RFP provided
that the requirements can be reasonably met by a MCO to serve individuals eligible for the programs in
a geographic region of the state. For purposes of this RFP, the geographic region consists of Carleton,
Cook, Koochiching, Lake and St. Louis counties. To be eligible as a successful Responder, a MCO
must meet all of the following criteria for MSHO and SNBC.

1. Managed Care Organization

To be considered a qualified MCO for purposes of responding to this RFP, a successful Responder
must meet the definition of a Managed Care Organization. Under the Minnesota Medical Assistance
State Plan, an MCO means an entity that has, or is seeking to qualify for, a comprehensive risk
contract, and that is:

a) Federally Qualified HMO that meets the advance directives requirements of 42 CFR
   489.100-104; or

b) Any public or private entity that meets the advance directives requirements and is
determined to also meet the following conditions: a) makes the services it provides to its
   Medicaid Enrollees as accessible (in terms of timeliness, amount, duration, and scope) as those
services are to other Medicaid Recipients within the area served by the entity, and b) meets the solvency standards of 42 CFR 438.116.

In determining whether an entity meets the definition of a qualified MCO, the Commissioner has discretion to explore various provider options that will be most advantageous to the population eligible for enrollment in the managed care program. Providing the above requirements are met, the Commissioner may contract with any non-profit managed care entity that is not a health maintenance organization (HMO) licensed under Minnesota Statutes, chapter 62D. Other non-profit managed care entities include, but are not limited to county-based purchasing entities that meet applicable requirements under Minnesota Statutes, chapter 62D or Community Integrated Service Network or "community network” under Minnesota Statutes, chapter 62N, or an accountable provider network as defined under Minnesota Statutes 62T.01, subd.3.

2. Medicare Advantage Special Needs Plan Status Requirement

For MSHO, qualified MCOs must have an existing Medicare Advantage dual eligible Special Needs Plan approved by the Centers for Medicare & Medicaid (CMS) or have a service area expansion application pending which is expected to be approved for January 1, 2010, which allows the MCO to serve the dual eligible subset of seniors as defined by the State for MSHO and will be expected to integrate Medicare and Medicaid services as specified in this RFP.

For SNBC, qualified MCOs must have an existing Medicare Advantage dual eligible Special Needs Plan approved by the Centers for Medicare & Medicaid (CMS) or have an application or a service area expansion pending which is expected to be approved for January 1, 2010, which allows the MCO to serve the dual eligible subset of people with disabilities as defined by the State for SNBC and will be expected to integrate Medicare and Medicaid services as specified in this RFP.

3. Participation Requirements

Only MCOs currently providing services under PMAP may respond to this RFP. For MSHO, qualifying MCOs must be providing services under MSHO or MSC+. For SNBC, qualifying MCOs may respond to provide services in counties they are not currently providing PMAP, MSC+ or MSHO.

In addition, HMOs, Community Integrated Service Networks (CISNs), county-based purchasing (CBP) entities, and other qualified provider types must participate in Minnesota Health Care Programs, including Medical Assistance, GAMC and MinnesotaCare, as a condition of licensure by the Minnesota Department of Health pursuant to Minnesota Statutes, sections 62D.04, subdivision 5 and 62N.25, subdivision 2. However, due to the nature MSHO and SNBC and the requirement for Medicare Advantage SNP participation, MCOs participating in MHCP are not required to submit proposals to this RFP to meet this provision.

4. Disclosure of Ownership

Federal law requires that the MCO not knowingly have a director, officer, managerial employee, or person with beneficial ownership of five percent (5%) or more of the entity’s equity or a person with an employment, consulting, or other agreement with a person for the provision of items and services that are significant and material to the entity’s obligation under its contract with the State, that has been debarred, suspended, or otherwise excluded from participating in procurement activities under the
Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued pursuant to Executive Order No. 12549 or under guidelines implementing such order. Refer to the Disclosure of Ownership statement in Appendix G.

5. Conflict of Interest Safeguards

The Balanced Budget Act of 1997 extends federal conflict of interest regulations to contractors and requires them to have safeguards in place regarding conflict of interest for purchases involving Medicaid funds. These safeguards must be as strict as those in federal purchasing statutes, in accordance with 41 U.S.C. 423, and 18 U.S.C. 207 and 208. Minnesota Statutes, section 256B.0914 requires respondents to certify they have conflict of interest safeguards.

6. Administrative Simplification, Security and Privacy Requirements

The MCO must comply with the Administrative Simplification, Security and Privacy requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), any rules promulgated thereunder, the Minnesota Health Care Simplification Act of 1994, Minnesota Statutes, section 62J.50 et.seq., including but not limited to, compliance with 45 CFR, Parts 160 and 162. Administrative Requirements: Electronic Transaction Standards and Part 164 Security and Privacy requirements. The MCO shall be in compliance with these requirements consistent with the applicable effective dates contained in state or federal law.

7. Financial Solvency

All MCOs must meet the solvency standards established by the State for health maintenance organizations (HMOs) or be licensed or certified by the State as a risk bearing entity.

B. TASKS/DELIVERABLES

The combined Minnesota Senior Care Plus (MSC+) and Minnesota Senior Health Option (MSHO) model contract covers persons age 65 and older and who are eligible for Medical Assistance. The Special Needs Basic Care model contract covers people with disabilities age 18-64 and who are eligible for Medical Assistance. These contracts provide public health benefits intended to provide enrollees with access to cost-effective health care options.

The contracts include comprehensive, preventive, diagnostic, therapeutic, and rehabilitative health care services as specified in Article 6 of the contract. The model contract includes requirements for eligibility and enrollment, MCO and enrollee communications, marketing and enrollee education, reporting requirements, access standards, transition services, service authorization, quality assessment and performance improvement, the grievance system: denials, terminations and reduction (DTRs), grievances, appeals, and state fair hearings, and other required provisions including compliance with state and federal laws and regulations. The MCOs must comply with all the contract requirements specified in the model contracts. See the link below for access to the model contract and other information.

Model Contracts - [http://www.dhs.state.mn.us/dhs16_139710](http://www.dhs.state.mn.us/dhs16_139710)
III. PROPOSAL FORMAT

Proposals must conform to all instructions, conditions, and requirements included in the RFP. Responders are expected to examine all documentation and other requirements. Failure to observe the terms and conditions in completion of the Proposal are at the Responder’s risk and may, at the discretion of the State, result in disqualification of the Proposal for nonresponsiveness. Acceptable Proposals must offer all services identified in Section II - Scope of Work and agree to the contract conditions specified throughout the RFP.

A. REQUIRED PROPOSAL CONTENTS

Responses to this RFP must consist of all of the following components (See following sections for more detail on each component). Each of these components must be separate from the others and uniquely identified with labeled tabs. MCOs responding for only MSHO must complete only the MSHO portions of the RFP. MCOs responding for only SNBC must complete only the SNBC portions of the RFP. MCOs responding for both MSHO and SNBC must complete both the MSHO and SNBC portions of the RFP.

1. Table of Contents

2. Proposal Requirements
   a. Executive Summary
   b. Description of the Applicant Organization
   c. Plan Design for MSHO
   d. Plan Design for SNBC
   e. Quality Assessment and Performance for MSHO and SNBC
   f. MSHO – Provider Network by county
   g. SNBC – Provider Network by county

3. Required Statements
   a. Responder Information and Declarations
   b. Exceptions to RFP Terms and Conditions
   c. Affidavit of Noncollusion
   d. Trade Secret/Confidential Data Notification
   e. Affirmative Action Data Page
   f. Certification and Restriction on Lobbying
   g. Disclosure of Ownership
   h. Assurances

4. Appendix (If Applicable)

Any additional information thought to be relevant, but not applicable to the prescribed format, may be included in the Appendix of your Proposal.

B. PROPOSAL REQUIREMENTS

The following will be considered minimum requirements of the Proposal. Emphasis should be on completeness and clarity of content.
1. **Executive Summary**: This component of the proposal should demonstrate the Responder's understanding of the services requested in this RFP and any problems anticipated in accomplishing the work. The Executive Summary should also show the Responder’s overall design of the project in response to achieving the deliverables as defined in this RFP. Specifically, the proposal should demonstrate the Responder's familiarity with the project elements, its solutions to the problems presented and knowledge of the requested services. For SNBC, it should also indicate how the MCO has taken into consideration the Guiding Principles provided in Appendix O.

2. **Description of the Applicant Organization**: This section must include information on the programs and activities of the organization, the number of people served, geographic area served, staff experience, and/or programmatic accomplishments. Include reasons why your organization is capable to effectively complete the services outlined in the RFP. Include a brief history of your organization and all strengths that you consider are an asset to your program. The Responder should demonstrate the length, depth, an applicability of all prior experience in providing the requested services. The Responder should also demonstrate the skill and experience of staff and the length, depth and applicability of all prior experience in providing the requested services.

3. **Project Activities and Implementation**: All proposals submitted under this RFP must address, in sufficient detail, how the Responder will fulfill the expected outcomes and features set forth above. Simply repeating the outcomes and features and asserting that they will be performed is not an acceptable response. The fulfillment of this Section includes the Responder addressing each item listed in Appendices H-K and Q for MSHO and Appendices L-Q for SNBC.

4. **List of Providers for MSHO** – Responder must submit a list of network providers including Elderly Waiver, Personal Care Provider Organizations and Nursing Facility providers by county and must conform to the specifications in Appendix K. Participating providers are those providers who have signed contracts with the MCO or for Elderly Waiver providers meet the requirements in the 2009 Model contract section 9.3.23 regarding subcontracting. A final list of participating providers must be available at the time of contract negotiations.

5. **List of Providers for SNBC** – Responders must submit a list of network providers and must conform to the specifications listed in Appendix P. A final list of participating providers must be available prior to the start of contract negotiations in 2009.

**C. REQUIRED STATEMENTS**

The following are required statements that must be included with your Proposal. Complete the correlating forms found in the RFP Appendix and submit them as the “Required Statements” section of your Proposal.

1. **Responder Information and Declarations** – (Appendix A)

   Complete and submit the attached “Responder Information and Declarations” form. If you are required to submit additional information as a result of the declarations, include the additional information as part of this form.
2. **Exceptions to RFP Terms – (Appendix B)**

The contents of this RFP and the Proposal(s) of the Successful Responder(s) may become part of the final contract if a contract is awarded. Each Responder's Proposal must include a statement of acceptance of all terms and conditions stated within this RFP or provide a detailed statement of exception for each item excepted by the Responder. Responders who object to any condition of this RFP must note the objection on the attached “Exceptions to RFP Terms” form. If a Responder has no objections to any terms or conditions, the Responder should write “None” on the form.

Responder should be aware of the State’s model contract terms and conditions in preparing its response. Model contracts can be found at [http://www.dhs.state.mn.us/dhs16_139710](http://www.dhs.state.mn.us/dhs16_139710). Much of the language reflected in the contract is required by statute. If you take exception to any of the terms, conditions or language in the contract, you must indicate those exceptions in your response to the RFP. Only those exceptions indicated in your response to the RFP will be available for discussion or negotiation.

Responders are cautioned that any exceptions to the terms of the standard State contract which give the Responder a material advantage over other Responders may result in the Responder’s Proposal being declared nonresponsive. Proposals being declared nonresponsive will receive no further consideration for award of the Contract. Also, Proposals that take blanket exception to all or substantially all boilerplate contract provisions will be considered nonresponsive Proposals and rejected from further consideration for contract award.

3. **Affidavit of Noncollusion (Appendix C)**

Each Responder must complete and submit the attached “Affidavit of Noncollusion” form.

4. **Trade Secret/Confidential Data Notification (Appendix D)**

All materials submitted in response to this RFP will become property of the State and will become public record in accordance with Minnesota Statutes, section 13.591, after the evaluation process is completed. Pursuant to the statute, completion of the evaluation process occurs when the government entity has completed negotiating the contract with the Successful Responder. If a contract is awarded to the Responder, the State must have the right to use or disclose the trade secret data to the extent otherwise provided in the Contract or by law.

If the Responder submits information in response to this RFP that it believes to be trade secret/confidential materials, as defined by the Minnesota Government Data Practices Act, Minn. Stat. §13.37, and the Responder does not want such data used or disclosed for any purpose other than the evaluation of this Proposal, the Responder must:

a. clearly mark every page of trade secret materials in its Proposal at the time the Proposal is submitted with the words “TRADE SECRET” or “CONFIDENTIAL” in capitalized, underlined and bolded type that is at least 20 pt.; the State does not assume liability for the use or disclosure of unmarked or unclearly marked trade secret/confidential data;
b. fill out and submit the attached “Trade Secret/Confidential Information Notification Form”, specifying the pages of the Proposal which are to be restricted and justifying the trade secret designation for each item. If no material is being designated as protected, a statement of “None” should be listed on the form;

c. satisfy the burden to justify any claim of trade secret/confidential information. In order for a trade secret claim to be considered by the State, detailed justification that satisfies the statutory elements of Minn. Stat. §13.37 and the factors discussed in Prairie Island Indian Community v. Minnesota Dept. of Public Safety, 658 N.W.2d 876, 884-89 (Minn.App.2003) must be provided. Use of generic trade secret language encompassing substantial portions of the Proposal or simple assertions of trade secret interest without substantive explanation of the basis therefore will be regarded as nonresponsive requests for trade secret exception and will not be considered by the State in the event of a data request is received for Proposal information; and

d. defend any action seeking release of the materials it believes to be trade secret and/or confidential, and indemnify and hold harmless the State, its agents and employees, from any judgments awarded against the State in favor of the party requesting the materials, and any and all costs connected with that defense. This indemnification survives the State’s award of a contract. In submitting a response to this RFP, the Responder agrees that this indemnification survives as long as the trade secret materials are in the possession of the State. The State is required to keep all the basic documents related to its contracts, including selected responses to RFPs, for a minimum of six years after the end of the contract. Non-selected RFP Proposals will be kept by the State for a minimum of one year after the award of a contract, and could potentially be kept for much longer.

The State reserves the right to reject a claim if it determines Responder has not met the burden of establishing that the information constitutes a trade secret or is confidential. The State will not consider prices or costs submitted by the Responder to be trade secret materials. Any decision by the State to disclose information designated by the Responder as trade secret/confidential will be made consistent with the Minnesota Government Data Practices Act and other relevant laws and regulations. If certain information is found to constitute a trade secret/confidential, the remainder of the Proposal will become public; only the trade secret/confidential information will be removed and remain nonpublic.

The State also retains the right to use any or all system ideas presented in any Proposal received in response to this RFP unless the Responder presents a positive statement of objection in the Proposal. Exceptions to such Responder objections include: (1) public data, (2) ideas which were known to the State before submission of such Proposal, or (3) ideas which properly became known to the State thereafter through other sources or through acceptance of the Responder's Proposal.

5. Human Rights Compliance (Appendix E)

For all contracts estimated to be in excess of $100,000, Responders are required to complete and submit the attached “Affirmative Action Data” page. As required by Minn. R. 5000.3600, “It is hereby agreed between the parties that Minn. Stat. §363A.36 and Minn. R.5000.3400 - 5000.3600 are incorporated into any contract between these parties based
upon this specification or any modification of it. A copy of Minn. Stat. § 363A.36 and Minn. R.5000.3400 - 5000.3600 are available upon request from the contracting agency.”

6. **Certification Regarding Lobbying (Appendix F)**

Federal money will be used or may potentially be used to pay for all or part of the work under the contract, therefore the Responder must complete and submit the attached “Certification Regarding Lobbying” form.

7. **Disclosure of Ownership (Appendix G)**

The MCO must complete and submit the attached Disclosure of Ownership form.

8. **County Specific Information (Appendix H for MSHO and Appendix L for SNBC)**

9. **Assurances (Appendix I for MSHO and Appendix M for SNBC)**

Each Responder must complete and submit the appropriate attached “Assurances” forms for MSHO and/or SNBC.

10. **Plan Design (Appendix J for MSHO and Appendix N for SNBC)**

Each Responder must complete and submit the appropriate detailed description of the program activities and plan design for MSHO and/or SNBC.

11. **Provider Network for MSHO**

Each Responder must complete and submit provider network for MSHO as prescribed in Appendix K.

12. **Provider Network for SNBC**

Each Responder must complete and submit provider network for SNBC as prescribed in Appendix P.

13. **Quality Assessment and Performance Improvement Program (Appendix Q)**

Each Responder must complete for MSHO and/or SNBC.
IV. RFP PROCESS

A. TIMELINE

<table>
<thead>
<tr>
<th>ACTIVITY</th>
<th>DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>State Register Notice</td>
<td>April 20, 2009</td>
</tr>
<tr>
<td>All RFP Questions Received</td>
<td>April 24, 2009</td>
</tr>
<tr>
<td>RFP Questions Answered and Posted on DHS Website</td>
<td>April 30, 2009</td>
</tr>
<tr>
<td>RFP Responses Due</td>
<td>May 11, 2009</td>
</tr>
<tr>
<td>County RFP Review Feedback Due</td>
<td>May 20, 2009</td>
</tr>
<tr>
<td>RFP Review Completed</td>
<td>May 22, 2009</td>
</tr>
<tr>
<td>Notice of Intent to Contract</td>
<td>May 26, 2009</td>
</tr>
<tr>
<td>SNBC Contract Negotiations (new plans only)</td>
<td>August/September, 2009</td>
</tr>
<tr>
<td>Contracts to CMS (new plans only)</td>
<td>October 1, 2009 (new plans only)</td>
</tr>
<tr>
<td>Agreement to CMS</td>
<td>October 1, 2009 (existing plans SAEs, both MSHO and SNBC)</td>
</tr>
</tbody>
</table>

B. ACCESS TO THE RFP

To access the RFP, go to the DHS public website on or after noon (Central Time) on April 20, 2009.

http://www.dhs.state.mn.us/id_000102

To obtain a paper copy of the RFP or to request a copy of the document in a Microsoft Word format, please contact Cara Bailey at cara.bailey@state.mn.us or call 651-431-2515.

C. RESPONDERS’ CONFERENCE – No Responder’s Conference will be held. Responders should submit their questions as indicated below.

D. RESPONDERS’ QUESTIONS

Responders’ questions regarding this RFP must be submitted in writing, email or fax prior to 4:00 p.m. Central Time on April 27, 2009. All questions must be addressed to:

Request for Proposal Response
Attention: Cara Bailey
Managed Care and Payment Policy Division
Department of Human Services
P.O. Box 64984
St. Paul, MN 55164-0984
Phone (651) 431-2515
FAX #: (651) 431-7426
Email: cara.bailey@state.mn.us
Other personnel are NOT authorized to discuss this RFP with Responders before the proposal submission deadline. **Contact regarding this RFP with any State personnel not listed above could result in disqualification.** The State will not be held responsible for oral responses to Responders.

Questions will be addressed in writing and posted on the DHS website. Every attempt will be made to provide answers timely, with the intent that they are posted no later than April 30, 2009.

E. PROPOSAL SUBMISSION

**One (1) original paper copy** of the Proposal must be submitted, along with a CD with a copy of the Proposal submitted in a PDF version with the capability for the State to select and copy specific text from the PDF document. **In addition, a CD (or CDs) containing a complete proposal must be included for each county that the MCO is submitting a proposal.** Proposals must be physically received (not postmarked) by **4:00 p.m. Central Time on May 11, 2009** to be considered.

Late Proposals will not be considered and will be returned unopened to the submitting party. **Faxed or e-mailed Proposals will not be accepted.**

Clearly label the original "Proposal – Original" and CDs with the name and submission due date for this RFP. All Proposals, including required electronic copies, must be submitted in a single sealed package or container. The original proposal should be in a three-ring binder or spiral bound binder with **each section indexed with tabs.** The main body of the Proposal pages must be numbered and submitted in 12-point font on 8 ½ X 11 inch paper, single spaced. The size and/or style of graphics, tabs, attachments, margin notes/highlights, etc. are not restricted by this RFP and their use and style are at the Responder’s discretion.

The above-referenced packages and all correspondence related to this RFP must be delivered to:

**Attention: Cara Bailey - 0984**  
Managed Care and Payment Policy Division  
Department of Human Services  
444 Lafayette Road North  
St. Paul, MN 55155  
Phone (651) 431-2515

It is solely the responsibility of each Responder to assure that their Proposal is delivered at the specific place, in the specific format, and prior to the deadline for submission. **Failure to abide by these instructions for submitting Proposals may result in the disqualification of any non-complying Proposal.**

V. PROPOSAL EVALUATION AND SELECTION

A. OVERVIEW OF EVALUATION METHODOLOGY

1. All responsive Proposals received by the deadline will be evaluated by the State. Proposals will be evaluated on “best value” as specified below, using a 100 point scale. The evaluation will be conducted in three phases:
a. Phase I Required Statements Review
b. Phase II Evaluation of Proposal Requirements
c. Phase III Selection of the Successful Responder(s)

2. During the evaluation process, all information concerning the Proposals submitted, except identity, address, and the amount requested by responder, will remain non-public and will not be disclosed to anyone whose official duties do not require such knowledge.

3. Nonselection of any Proposals will mean that either another Proposal(s) was determined to be more advantageous to the State or that the State exercised the right to reject any or all Proposals. At its discretion, the State may perform an appropriate cost and pricing analysis of a Responder's Proposal, including an audit of the reasonableness of any Proposal.

B. EVALUATION TEAM

State staff will select evaluators for the evaluation team to review and evaluate RFP responses. Each county was invited to select a representative to participate on the evaluation team. State and professional staff (such as staff from DHS policy areas such as mental health, children’s mental health, chemical dependency, transportation, and quality assurance) in addition to state staff who participates on the evaluation team, may also assist in the State’s evaluation process. The State reserves the right to alter the composition of the evaluation team and their specific responsibilities.

The State as a participant in the federal Medicaid program must safeguard against conflicts of interest in the Medicaid procurement process. See U.S. Code, title 42, sections 1396(a)(4) and 1396u-2(d)(3); Minnesota Statutes, section 256B.0914. The State must ensure that a person who participates in the evaluation of the RFP responses does not have a conflict of interest. Therefore, all evaluators and other staff will be required to sign a conflict of interest statement and confidentiality agreement in order to participate as a member of the evaluation team.

County representatives who participate on the RFP evaluation team may not:
- be or have been involved in discussions regarding becoming a member of a county-based purchasing entity;
- be or have been involved in direct or indirect negotiations with a MCO;
- provide or supervise any Minnesota Health Care Program services under a contract with a MCO;
- disclose contractor bid or proposal information, or source selection information, as defined in Minnesota Statutes, section 256B.0914, before the award decision has been made by the State. (This prohibition against disclosure does not apply to discussions between evaluation team members as part of the deliberative process, or as otherwise permitted by law.)
- disclose proprietary, aka “trade secret” information (see Minnesota Statutes, section 13.37), even after the award decision, unless permitted by law.
- extend an offer or accept employment by procurement bidders and bid evaluators, respectively.

Pursuant to Minnesota Statutes, section 256B.0914: Failure to abide by the above restrictions could result in criminal prosecutions or a fine of $50,000, or both, for each violation.
The county role in seeking MCO(s) to provide services to eligible individuals within the proposed county for Medical Assistance recipients is important in the development, approval and issuance of the RFP. The county may make recommendations regarding the development, issuance, and changes needed in the RFP. The county also has the opportunity to review each proposal based on the identification of community needs and county advocacy activities, and can advise the State on the approval of local networks and their operations to ensure adequate availability and access to covered services.

Counties are delegated the duty of developing the county section of the RFP including identification of service development and access issues as described in Appendix H for MSHO and Appendix L for SNBC. Please note that the county information will need to be addressed as part of the RFP process.

C. EVALUATION PROCESS

Evaluation of RFP responses include, but are not limited to, the following:

1) Assessment of the proposal and the MCO provider network according to the approved RFP timeline.
2) Assessment of the availability and access to covered services provided through the MCO’s network.

Any dispute between the State and the counties about the MCO selection process will be reviewed by a three person mediation panel as provided in Minnesota Statutes, section 256B.69, subdivision 3a(d). The Commissioner of the Minnesota Department of Human Services will resolve any disputes taking into account the recommendations of this panel.

D. EVALUATION PHASES

At any time during the evaluation phases, the State may, at the State’s discretion, contact a Responder to (1) provide further or missing information or clarification of their Proposal, (2) provide an oral presentation of their Proposal, or (3) obtain the opportunity to interview the proposed key personnel. Reference checks may also be made at this time. However, there is no guarantee that the State will look for information or clarification outside of the submitted written Proposal. Therefore, it is important that the Responder ensure that all sections of the Proposal have been completed to avoid the possibility of failing an evaluation phase or having their score reduced for lack of information.

1. Phase I – Required Statements Review

The Required Statements will be evaluated on a pass or fail basis. Responders must "pass" each of the requirements identified in these sections to move to Phase II.

2. Phase II - Evaluation of Technical Requirements of Proposals

   a. Points have been assigned to these component areas. The total possible points for these component areas are as follows:
For MSHO

<table>
<thead>
<tr>
<th>Component</th>
<th>Total Possible Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive Summary</td>
<td>5 points</td>
</tr>
<tr>
<td>Description of the Applicant Agency</td>
<td>10 points</td>
</tr>
<tr>
<td>Project Activities and Implementation</td>
<td></td>
</tr>
<tr>
<td>Appendix I – Assurances</td>
<td>10 points</td>
</tr>
<tr>
<td>Appendix J – Plan Design</td>
<td>50 points</td>
</tr>
<tr>
<td>Appendix K – Provider Network</td>
<td>20 points</td>
</tr>
<tr>
<td>Appendix Q – Quality</td>
<td>5 points</td>
</tr>
</tbody>
</table>

Total: 100 points

For SNBC

<table>
<thead>
<tr>
<th>Component</th>
<th>Total Possible Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive Summary</td>
<td>5 points</td>
</tr>
<tr>
<td>Description of the Applicant Agency</td>
<td>10 points</td>
</tr>
<tr>
<td>Project Activities and Implementation</td>
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</tr>
<tr>
<td>Appendix M – Assurances</td>
<td>10 points</td>
</tr>
<tr>
<td>Appendix N – Plan Design</td>
<td>50 points</td>
</tr>
<tr>
<td>Appendix P – Provider Network</td>
<td>20 points</td>
</tr>
<tr>
<td>Appendix Q – Quality</td>
<td>5 points</td>
</tr>
</tbody>
</table>

Total: 100 points

b. The evaluation team will review the components of each responsive Proposal submitted. Each component will be evaluated on the Responder's understanding and the quality and completeness of the Responder's approach and solution to the problems or issues presented.

c. After reviewing the Proposals, the members of the evaluation team will rate each Proposal component using the following formula:

Each Proposal component will receive one of the following ratings based on how well the team member feels the component met the RFP requirements. Upon determining which of the following ratings best describes the component being rated, the total possible points available for the component will be multiplied by the corresponding point factor

<table>
<thead>
<tr>
<th>Component Rating</th>
<th>Point Factor to be Applied to Total Possible Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Excellent</td>
<td>1.0</td>
</tr>
<tr>
<td>Very Good</td>
<td>.75</td>
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<td>Good</td>
<td>.50</td>
</tr>
<tr>
<td>Fair</td>
<td>.25</td>
</tr>
<tr>
<td>Poor</td>
<td>0.0</td>
</tr>
</tbody>
</table>
Other factors upon which the proposals will be evaluated by the State include, but are not limited to, the following:

- Can demonstrate their ability to integrate health services with community, public health, and social services.
- Clinical systems and networks designed for seniors for MSHO and for people with disabilities for SNBC.
- Incorporation of the Guiding Principles for SNBC
- How the organization has addressed the State purchasing requirements for seniors for MSHO and for people with disabilities for SNBC
- Whether the organization meets the State Plan definition of an MCO.
- Completeness of the response and ability to meet all requirements contained in this RFP, which includes providing all services and tasks required in the model contract.
- Qualifications of the organization and its personnel.
- MCO’s performance under other contracts with the State involving the Medical Assistance population.
- MCO’s ability to provide accessible, quality, and timely medical care to Medical Assistance recipients.
- Access to, and availability of covered services within the potential MCO’s licensed service area that meets provider network standards and community needs, such as Public Health goals
- Any contract issued under this RFP will be subject to approval from CMS.

3. Phase III - Selection of the Successful Responder(s)
   a. Only the Proposals found to be responsive under Phases I and II will be considered in Phase III.
   b. The evaluation team will review the scoring in making its recommendations of the Successful Responder(s).
   c. The State may submit a list of detailed comments, questions, and concerns to one or more Responders after the initial evaluation. The State may require said response to be written, oral, or both. The State will only use written responses for evaluation purposes. The total scores for those Responders selected to submit additional information may be revised as a result of the new information.
   d. The evaluation team will make its recommendation based on the above-described evaluation process. The Successful Responder(s), if any, will be selected no later than May 11, 2009.
   e. The final award decision will be made by the Commissioner or authorized designee. The Commissioner or authorized designee may accept or reject the recommendation of the evaluation team.

E. CONTRACT NEGOTIATIONS AND UNSUCCESSFUL RESPONDER NOTICE
If a Responder(s) is selected, the State will notify the Successful Responder(s) in writing of their selection and the State’s desire to enter into contract negotiations. Until the State successfully completes negotiations with the selected Responder(s), all submitted Proposals remain eligible for selection by the State.

In the event contract negotiations are unsuccessful with the selected Responder(s), the evaluation team may recommend another Responder(s). The final award decision will be made by the Commissioner or authorized designee. The Commissioner or authorized designee may accept or reject any subsequent recommendation of the evaluation team.

After the State and chosen Responder(s) have successfully negotiated a contract, the State will notify the unsuccessful Responders in writing that their Proposals have not been accepted. All public information within Proposals will then be available for Responders to review, upon request.

VI. REQUIRED CONTRACT TERMS AND CONDITIONS

A. **Requirements.** All Responders must be willing to comply with all state and federal legal requirements regarding the performance of the Contract. The requirements are set forth throughout this RFP and are contained in the attached Draft Contract.

B. **Governing Law/Venue.** This RFP and any subsequent contract must be governed by the laws of the State of Minnesota. Any and all legal proceedings arising from this RFP or any resulting contract in which the State is made a party must be brought in the State of Minnesota, District Court of Ramsey County. The venue of any federal action or proceeding arising here from in which the State is a party must be the United States District Court for the State of Minnesota.

C. **Travel.** Reimbursement for travel and subsistence expenses actually and necessarily incurred by the grantee as a result of the grant contract will be in no greater amount than provided in the current "Commissioner’s Plan” promulgated by the commissioner of Employee Relations. Reimbursements will not be made for travel and subsistence expenses incurred outside Minnesota unless it has received the State’s prior written approval for out of state travel. Minnesota will be considered the home state for determining whether travel is out of state.

D. **Preparation Costs.** The State is not liable for any cost incurred by Responders in the preparation and production of a Proposal. Any work preformed prior to the issuance of a fully executed contract will be done only to the extent the Responder voluntarily assumes risk of non-payment.

E. **Contingency Fees Prohibited.** Pursuant to Minn. Stat. §10A.06, no person may act as or employ a lobbyist for compensation that is dependent upon the result or outcome of any legislation or administrative action.

F. **Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion.** Federal money will be used or may potentially be used to pay for all or part of the work under the grant contract, therefore the Responder must certify the following, as required by the regulations implementing Executive Order 12549:

Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion -- Lower Tier Covered Transactions

Instructions for Certification
1. By signing and submitting this proposal, the prospective lower tier participant is providing the certification set out below.

2. The certification in this clause is a material representation of fact upon which reliance was placed when this transaction was entered into. If it is later determined that the prospective lower tier participant knowingly rendered an erroneous certification, in addition to other remedies available to the Federal Government, the department or agency with which this transaction originated may pursue available remedies, including suspension and/or debarment.

3. The prospective lower tier participant shall provide immediate written notice to the person to which this proposal is submitted if at any time the prospective lower tier participant learns that its certification was erroneous when submitted or had become erroneous by reason of changed circumstances.

4. The terms covered transaction, debarred, suspended, ineligible, lower tier covered transaction, participant, person, primary covered transaction, principal, proposal, and voluntarily excluded, as used in this clause, have the meaning set out in the Definitions and Coverages sections of rules implementing Executive Order 12549. You may contact the person to which this proposal is submitted for assistance in obtaining a copy of those regulations.

5. The prospective lower tier participant agrees by submitting this response that, should the proposed covered transaction be entered into, it shall not knowingly enter into any lower tier covered transaction with a person who is proposed for debarment under 48 CFR part 9, subpart 9.4, debarred, suspended, declared ineligible, or voluntarily excluded from participation in this covered transaction, unless authorized by the department or agency with which this transaction originated.

6. The prospective lower tier participant further agrees by submitting this proposal that it will include this clause titled “Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion--Lower Tier Covered Transaction,” without modification, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

7. A participant in a covered transaction may rely upon a certification of a prospective participant in a lower tier covered transaction that it is not proposed for debarment under 48 CFR part 9, subpart 9.4, debarred, suspended, ineligible, or voluntarily excluded from covered transactions, unless it knows that the certification is erroneous. A participant may decide the method and frequency by which it determines the eligibility of its principals. Each participant may, but is not required to, check the List of Parties Excluded from Federal Procurement and Nonprocurement Programs.

8. Nothing contained in the foregoing shall be construed to require establishment of a system of records in order to render in good faith the certification required by this clause. The knowledge and information of a participant is not required to exceed that which is normally possessed by a prudent person in the ordinary course of business dealings.

9. Except for transactions authorized under paragraph 5 of these instructions, if a participant in a covered transaction knowingly enters into a lower tier covered transaction with a person who is proposed for debarment under 48 C.F.R. 9, subpart 9.4, suspended, debarred, ineligible, or voluntarily excluded from participation in this transaction, in addition to other remedies available to the federal government, the department or agency with which this transaction originated may pursue available remedies, including suspension and/or debarment.
Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion - Lower Tier Covered Transactions

1. The prospective lower tier participant certifies, by submission of this proposal, that neither it nor its principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any Federal department or agency.

2. Where the prospective lower tier participant is unable to certify to any of the statements in this certification, such prospective participant shall attach an explanation to this proposal.

G. Insurance Requirements

1. Grantee shall not commence work under the grant contract until they have obtained all the insurance described below and the State of Minnesota has approved such insurance. All policies and certificates shall provide that the policies shall remain in force and effect throughout the term of the grant contract.

2. Grantee is required to maintain and furnish satisfactory evidence of the following insurance policies:

a. **Workers’ Compensation Insurance**: Except as provided below, Grantee must provide Workers’ Compensation insurance for all its employees and, in case any work is subcontracted, Grantee will require the subcontractor to provide Workers’ Compensation insurance in accordance with the statutory requirements of the State of Minnesota, including Coverage B, Employer’s Liability. Insurance **minimum** amounts are as follows:

   $100,000 – Bodily Injury by Disease per employee  
   $500,000 – Bodily Injury by Disease aggregate  
   $100,000 – Bodily Injury by Accident

   If Minnesota Statute exempts Grantee from Workers’ Compensation insurance or if the Grantee has no employees in the State of Minnesota, Grantee must provide a written statement, signed by an authorized representative, indicating the qualifying exemption that excludes Grantee from the Minnesota Workers’s Compensation requirements.

b. **Commercial General Liability**: Grantee is required to maintain insurance protecting it from claims for damages for bodily injury, including sickness or disease, death, and for care and loss of services as well as from claims for property damage, including loss of use which may arise from operations under the grant contract whether the operations are by the Grantee or by a subcontractor or by anyone directly or indirectly employed by the Grantee under the grant contract. Insurance **minimum** amounts are as follows:

   $2,000,000 – per occurrence  
   $2,000,000 – annual aggregate  
   $2,000,000 – annual aggregate – Products/Completed Operations
The following coverages shall be included:

Premises and Operations Bodily Injury and Property Damage  
Personal and Advertising Injury  
Blanket Contractual Liability  
Products and Completed Operations Liability  
Other; if applicable. please list _____________________.  
State of Minnesota named as an Additional Insured

c. **Commercial Automobile Liability:** Grantee is required to maintain insurance protecting the Grantee from claims for damages for bodily injury as well as from claims for property damage resulting from ownership, operation, maintenance or use of all owned, hired, and non-owned autos which may arise from operations under this grant contract, and in case any work is subcontracted the Grantee will require the subcontractor to provide Commercial Automobile Liability. Insurance **minimum** amounts are as follows:

$2,000,000 – per occurrence Combined Single limit for Bodily Injury and Property Damage

In addition, the following coverages should be included:

Owned, Hired, and Non-owned Automobile

d. **Professional/Technical, Errors and Omissions, and/or Miscellaneous Liability Insurance (if applicable)**

This policy will provide coverage for all claims the Grantee may become legally obligated to pay resulting from any actual or alleged negligent act, error, or omission related to Grantee’s professional services required under the grant contract.

Grantee is required to carry the following **minimum** amounts:

$2,000,000 – per claim or event  
$2,000,000 – annual aggregate  

Any deductible will be the sole responsibility of the Grantee and may not exceed $50,000 without the written approval of the State. If the Grantee desires authority from the State to have a deductible in a higher amount, the Grantee shall so request in writing, specifying the amount of the desired deductible and providing financial documentation by submitting the most current audited financial statements so that the State can ascertain the ability of the Grantee to cover the deductible from its own resources.

The retroactive or prior acts date of such coverage shall not be after the effective date of this grant contract and Grantee shall maintain such insurance for a period of at least three (3) years, following completion of the work. If Grantee discontinues such insurance, then extended reporting period coverage must be purchased to fulfill this requirement.
e. **Blanket Employee Theft/Employee Dishonesty Insurance.**

Grantee is required to obtain a blanket employee theft/employee dishonesty policy in at least the total amount of the first year’s grant award as either an addendum on its property insurance policy, or if it is not feasible to include it as an addendum to a property insurance policy, as a stand-alone employee theft/employee dishonesty policy. The State will be named as both a joint payee and a certificate holder on the property insurance policy addendum or on the stand-alone employee theft/employee dishonesty policy, whichever is applicable. Only in cases in which the first year’s grant award exceeds the available employee theft/employee dishonesty coverage may Grantees provide blanket employee theft/employee dishonesty insurance in an amount equal to either 25% of the yearly grant amount, or the first quarterly advance amount, whichever is greater. Upon execution of a grant contract, the Grantee must furnish the State with a certificate of employee theft/employee dishonesty insurance. This requirement does not apply to grant contracts with the University of Minnesota, counties, school districts or reservations.

3. Additional Insurance Conditions:

- Grantee’s policy(ies) shall be primary insurance to any other valid and collectible insurance available to the State of Minnesota with respect to any claim arising out of Grantee’s performance under this grant contract;

- Grantee’s policy(ies) and Certificates of Insurance shall contain a provision that coverage afforded under the policies shall not be cancelled or non-renewed without at least thirty (30) days advanced written notice to the State of Minnesota;

- Grantee is responsible for payment of grant contract related insurance premiums and deductibles;

- If Grantee is self-insured, a Certificate of Self-Insurance must be attached;

- Include legal defense fees in addition to its liability policy limits, with the exception of G.2.d. above; and

- Obtain insurance policies from an insurance company having an “AM BEST” rating of A- (minus); Financial Size Category (FSC) VII or better and must be authorized to do business in the State of Minnesota.

4. The State reserves the right to immediately terminate the grant contract if the Grantee is not in compliance with the insurance requirements and retains all rights to pursue any legal remedies against the Grantee. All insurance policies must be open to inspection by the State, and copies of policies must be submitted to the State’s authorized representative upon written request.

5. The successful responder is required to submit acceptable evidence of insurance coverage requirements prior to commencing work under the grant contract.
H. Contingency of Operations Planning Requirement

Functions identified under this request for proposal have been designated as Priority 1 or Priority 2 services under the Minnesota Department of Human Service’s Continuity of Operations Plan. Due to this designation, the successful responder will be required to develop a continuity of operations plan to be implemented in the event of a gubernatorial or commissioner of the Minnesota Department of Health declared health emergency. The successful responder will be expected to have a continuity of operations plan available for inspection by the State upon request. The continuity of operations plan shall do the following:

(a) ensure fulfillment of Priority 1 or Priority 2 obligations under the contract;

(b) outline procedures for the activation of the contingency plan upon the occurrence of a governor or commissioner of the Minnesota Department of Health declared health emergency;

(c) identify an individual as its Emergency Preparedness Response Coordinator (EPRC), the EPRC shall serve as the contact for the State with regard to emergency preparedness and response issues, the EPRC shall provide updates to the State as the health emergency unfolds;

(d) outline roles, command structure, decision making processes, and emergency action procedures that will be implemented upon the occurrence of a health emergency;

(e) provide alternative operating plans for Priority 1 or Priority 2 functions;

(f) include a procedure for returning to normal operations; and

(g) be available for inspection upon request.

VII. STATE’S RIGHTS RESERVED

Notwithstanding anything to the contrary, the State reserves the right to:

A. Reject any and all Proposals received in response to this RFP;

B. Disqualify any Responder whose conduct or Proposal fails to conform to the requirements of this RFP;

C. Have unlimited rights to duplicate all materials submitted for purposes of RFP evaluation, and duplicate all public information in response to data requests regarding the Proposal;

D. Select for contract or for negotiations a Proposal other than that with the lowest cost or the highest evaluation score;

E. Consider a late modification of a Proposal if the Proposal itself was submitted on time and if the modifications were requested by the State and the modifications make the terms of the Proposal more favorable to the State, and accept such Proposal as modified;
F. At its sole discretion, reserve the right to waive any non-material deviations from the requirements and procedures of this RFP;

G. Negotiate as to any aspect of the Proposal with any Responder and negotiate with more than one Responder at the same time, including asking for Responders’ “Best and Final” offers;

H. Extend the grant contract, in increments determined by the State, not to exceed a total contract term of five years; and

I. Cancel the Request for Proposal at any time and for any reason with no cost or penalty to the State.

J. Correct or amend the RFP at any time with no cost or penalty to the State. If the State should correct or amend any segment of the RFP after submission of Proposals and prior to announcement of the Successful Responder, all Responders will be afforded ample opportunity to revise their Proposal to accommodate the RFP amendment and the dates for submission of revised Proposals announced at that time. The State will not be liable for any errors in the RFP or other responses related to the RFP.
**REQUEST FOR PROPOSALS**  
**STATE OF MINNESOTA**  
**PREPAID HEALTH CARE**  
**MINNESOTA SENIOR HEALTH OPTIONS**  
*Face Sheet: Required Information*

<table>
<thead>
<tr>
<th>Name of Health Plan:</th>
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<table>
<thead>
<tr>
<th>Principal Place of Business:</th>
</tr>
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<tbody>
<tr>
<td>Address:</td>
</tr>
<tr>
<td>City: ______________________ State _________ Zip Code:</td>
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<table>
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<tr>
<th>Name of Health Plan Contact Person:</th>
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<tbody>
<tr>
<td>Title: ___________________________ Telephone Number:</td>
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<tr>
<th>Federal Employer's I.D. Number:</th>
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</thead>
</table>

Check the applicable boxes for the license held by your health plan:

- [ ] HMO
- [ ] CISN
- [ ] Other

(Explain)__________________________________________________________

**DEADLINE:** May 11, 2009 at 4:00 p.m. Central Time

We hereby agree to furnish services in accordance with the specifications contained in this Request for Proposals.

Company Name:

Authorized Signature:

Title:

Telephone Number (Including Area Code):
**REQUEST FOR PROPOSALS**  
**STATE OF MINNESOTA**  
**PREPAID HEALTH CARE**  
**MINNESOTA SENIOR HEALTH OPTIONS**  
*Face Sheet: Required Information*

**Name of Health Plan:**

List and check the applicable boxes for the counties within this health plan’s current licensed service areas FOR WHICH CMS SNP APPROVALS ARE IN PLACE OR EXPECTED TO BE IN PLACE EFFECTIVE JANUARY 2010, and the counties this health plan is proposing to serve in this proposal.

<table>
<thead>
<tr>
<th>County</th>
<th>Licensed</th>
<th>CMS SNP Approved</th>
<th>CMS SNP Application</th>
<th>Proposing for MSHO</th>
</tr>
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<td>Carleton</td>
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<tr>
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</tbody>
</table>

**Required Information Page 2 of 2**

Name(s) of individuals involved with the preparation of this Proposal (to assist in determining potential conflict of interest):

The above-named Responder submits the attached Proposal in response to the following Minnesota Department of Human Services Request for Proposals for health care services in

__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________

___________County(ies).
By submission of this Proposal, Responder warrants that:

1. The information provided is true, correct and reliable for purposes of evaluation for potential contract award. Responder understands that the submission of inaccurate or misleading information may be grounds for disqualification from selection as well as subject the Responder to suspension or debarment proceedings as well as other remedies available by law.

2. It is competent to provide all the services set forth in its Proposal.

3. Each person signing a section of this Proposal is authorized to make decisions as to the prices quoted and/or duties proposed and is legally authorized to bind the company to those decisions.

4. If it has relationships that create, or appear to create, a conflict of interest with the work that is contemplated in this request for proposals, Responder will provide, along with this form, a list containing the names of the entities, the relationship, and a discussion of the conflict.

5. To the best of its knowledge and belief, and except as otherwise disclosed, there are no relevant facts or circumstances which could give rise to organizational conflicts of interest. An organizational conflict of interest exists when, because of existing or planned activities or because of relationships with other persons, a vendor is unable or potentially unable to render impartial assistance or advice to the State, or the vendor’s objectivity in performing the contract work is or might be otherwise impaired, or the vendor has an unfair competitive advantage. Responder agrees that, if after award, an organizational conflict of interest is discovered, an immediate and full disclosure in writing will be made to the Assistant Director of the Department of Administration’s Materials Management Division (“MMD”) which will include a description of the action which Responder has taken or proposes to take to avoid or mitigate such conflicts. If an organization conflict of interest is determined to exist, the State may, at its discretion, cancel the contract. In the event the Responder was aware of an organizational conflict of interest prior to the award of the contract and did not disclose the conflict to MMD, the State may terminate the contract for default. The provisions of this clause must be included in all subcontracts for work to be performed similar to the service provided by the prime contractor, and the terms “contract,” “contractor,” and “contracting officer” modified appropriately to preserve the State’s rights.

6. No attempt has been made or will be made by Responder to induce any other person or firm to submit or not to submit a Proposal.

7. If there is a reasonable expectation that the Responder is or would be associated with any parent, affiliate, or subsidiary organization in order to supply any service, supplies or equipment to comply with the performance requirements under the resulting contract of the RFP, Responder must include with this form written authorization from the parent, affiliate, or subsidiary organization granting the right to examine directly, pertinent books, documents, papers, and records involving such transactions that are related to the resulting contract. This right will be given to the Minnesota Department of Human Services, U.S. Department of Health and Human Services, and Comptroller General of the United States.

8. If, at any time after a Proposal is submitted and a contract has been awarded, such an association arises as described in the paragraph above, Responder will obtain a similar certification and authorization from the parent, affiliate, or subsidiary organization within ten (10) working days after forming the relationship.
By signing this statement, you certify that the information provided is accurate and that you are authorized to sign on behalf of, and legally bind, the Responder.

Authorized Signature: ____________________________________________

Printed Name: __________________________________________________

Title: __________________________________________________________

Date: ____________________  Telephone Number: ____________________
REQUEST FOR PROPOSALS  
STATE OF MINNESOTA  
PREPAID HEALTH CARE  
SPECIAL NEEDS BASIC CARE  
*Face Sheet: Required Information*

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**DEADLINE: May 11, 2009 at 4:00 p.m. Central Time**

We hereby agree to furnish services in accordance with the specifications contained in this Request for Proposals.

Company Name:

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List and check the applicable boxes for the counties within this health plan’s current licensed service areas FOR WHICH CMS SNP APPROVALS ARE IN PLACE OR EXPECTED TO BE IN PLACE EFFECTIVE JANUARY 2008, and the counties this health plan is proposing to serve in this proposal.

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**Required Information Page 2 of 2**

Name(s) of individuals involved with the preparation of this Proposal (to assist in determining potential conflict of interest):

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The above-named Responder submits the attached Proposal in response to the following Minnesota Department of Human Services Request for Proposals for health care services in

__________________________________________________________________________________________ County(ies).

By submission of this Proposal, Responder warrants that:

1. The information provided is true, correct and reliable for purposes of evaluation for potential contract award. Responder understands that the submission of inaccurate or misleading information may be grounds for disqualification from selection as well as subject the Responder to suspension or debarment proceedings as well as other remedies available by law.
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3. Each person signing a section of this Proposal is authorized to make decisions as to the prices quoted and/or duties proposed and is legally authorized to bind the company to those decisions.

4. If it has relationships that create, or appear to create, a conflict of interest with the work that is contemplated in this request for proposals, Responder will provide, along with this form, a list containing the names of the entities, the relationship, and a discussion of the conflict.

5. To the best of its knowledge and belief, and except as otherwise disclosed, there are no relevant facts or circumstances which could give rise to organizational conflicts of interest. An organizational conflict of interest exists when, because of existing or planned activities or because of relationships with other persons, a vendor is unable or potentially unable to render impartial assistance or advice to the State, or the vendor’s objectivity in performing the contract work is or might be otherwise impaired, or the vendor has an unfair competitive advantage. Responder agrees that, if after award, an organizational conflict of interest is discovered, an immediate and full disclosure in writing will be made to the Assistant Director of the Department of Administration’s Materials Management Division (“MMD”) which will include a description of the action which Responder has taken or proposes to take to avoid or mitigate such conflicts. If an organization conflict of interest is determined to exist, the State may, at its discretion, cancel the contract. In the event the Responder was aware of an organizational conflict of interest prior to the award of the contract and did not disclose the conflict to MMD, the State may terminate the contract for default. The provisions of this clause must be included in all subcontracts for work to be performed similar to the service provided by the prime contractor, and the terms “contract,” “contractor,” and “contracting officer” modified appropriately to preserve the State’s rights.

6. No attempt has been made or will be made by Responder to induce any other person or firm to submit or not to submit a Proposal.

7. If there is a reasonable expectation that the Responder is or would be associated with any parent, affiliate, or subsidiary organization in order to supply any service, supplies or equipment to comply with the performance requirements under the resulting contract of the RFP, Responder must include with this form written authorization from the parent, affiliate, or subsidiary organization granting the right to examine directly, pertinent books, documents, papers, and records involving such transactions that are related to the resulting contract. This right will be given to the Minnesota Department of Human Services, U.S. Department of Health and Human Services, and Comptroller General of the United States.

8. If, at any time after a Proposal is submitted and a contract has been awarded, such an association arises as described in the paragraph above, Responder will obtain a similar certification and authorization from the parent, affiliate, or subsidiary organization within ten (10) working days after forming the relationship.

By signing this statement, you certify that the information provided is accurate and that you are authorized to sign on behalf of, and legally bind, the Responder.

Authorized Signature: ____________________________________________

Printed Name: ____________________________________________________

Title: __________________________________________________________________

Date: ___________________________ Telephone Number: ________________________
APPENDIX B  
EXCEPTIONS TO TERMS AND CONDITIONS

A Responder shall be presumed to be in agreement with the terms and conditions of the RFP unless the Responder takes specific exception to one or more of the conditions on this form.

RESPONDERS ARE CAUTIONED THAT BY TAKING ANY EXCEPTION THEY MAY BE MATERIALLY DEVIATING FROM THE RFP SPECIFICATIONS. IF A RESPONDER MATERIALLY DEVIATES FROM A RFP SPECIFICATION, ITS PROPOSAL MAY BE REJECTED.

A material deviation is an exception to a specification which 1) affords the Responder taking the exception a competitive advantage over other Responders, or 2) gives the State something significantly different than the State requested.

INSTRUCTIONS: Responders must explicitly list all exceptions to State terms and conditions (including those found in the model contract, if any. The model contract can be found at http://www.dhs.state.mn.us/dhs16_139710 Reference the actual number of the State's term and condition and page number for which an exception(s) is being taken. If no exceptions exist, state "NONE" specifically on the form below. Whether or not exceptions are taken, the Responder must sign and date this form and submit it as part of their Proposal. (Add additional pages if necessary.)

<table>
<thead>
<tr>
<th>Responder Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Term &amp; Condition Number/Provision</td>
</tr>
</tbody>
</table>

By signing this form, I acknowledge that the above named Responder accepts, without qualification, all terms and conditions stated in this RFP (including the sample contract) except those clearly outlined as exceptions above.

________________________________ _______________________________ _______________  
Signature         Title   Date
I swear (or affirm) under the penalty of perjury:

1. That I am the Responder (if the Responder is an individual), a partner in the company (if the Responder is a partnership), or an officer or employee of the responding corporation having authority to sign on its behalf (if the Responder is a corporation);

2. That the attached Proposal submitted in response to the ______________________ Request for Proposals has been arrived at by the Responder independently and has been submitted without collusion with and without any agreement, understanding or planned common course of action with, any other Responder of materials, supplies, equipment or services described in the Request for Proposal, designed to limit fair and open competition;

3. That the contents of the Proposal have not been communicated by the Responder or its employees or agents to any person not an employee or agent of the Responder and will not be communicated to any such persons prior to the official opening of the Proposals; and

4. That I am fully informed regarding the accuracy of the statements made in this affidavit.

Responder’s Firm Name: ___________________________________________

Authorized Signature: _____________________________________________

Date: __________________

Subscribed and sworn to me this ______ day of ___________

____________________________________________
Notary Public

My commission expires: ___________
Appendix D -- Trade Secret/Confidential Data Notice

Responder/Company Name: ________________________________

It is the position of the above-named Responder that certain data contained in the following page(s) of the attached Proposal have been submitted in confidence and contain trade secrets and/or privileged or confidential information (list pages -- If no protected information has been submitted, state “NONE”):

___________________________________________________________________________________

The justification for the Trade Secret/Confidential data designation is (be specific, do not make general statements of confidentiality. Include reference to specific facts, licenses, trademarks, etc., and any relevant statutes or other law, such as how the data meets the requirements of Minn. Stat. §13.37, subd. 1(b). Add additional pages if necessary):

___________________________________________________________________________________

The Responder acknowledges that, in accordance with Minn. Stat. §§ 13.591 and 16C.06, Subd. 3, upon completion of contract negotiations, all materials submitted in response to this RFP will become the property of the STATE and will become public record, with the exception of any portion(s) of an RFP or supporting data that are determined to be nonpublic “trade secret information.”

The Responder asserts that it has clearly marked every page of trade secret or confidential materials in the attached Proposal at the time the Proposal was submitted with the words “TRADE SECRET” or “CONFIDENTIAL” in capitalized, underlined and bolded type that is at least 20 pt. Responder acknowledges that the State is not liable for the use or disclosure of trade secret data or confidential data that Responder has failed to clearly mark as such.

Responder agrees to defend any action seeking release of the materials it believes to be trade secret or confidential, and indemnify and hold harmless the STATE, its agents and employees, from any judgments awarded against the STATE in favor of the party requesting the materials, and any and all reasonable costs connected with that defense. This indemnification survives the STATE’s award of a contract and remains as long as the trade secret and/or confidential materials are in the possession of the STATE.

Responder acknowledges that the STATE is required to keep all the basic documents related to its contracts, including selected responses to RFPs, for a minimum of six years after the end of the contract. Non-selected RFP Proposals will be kept by the STATE for a minimum of one year after the award of a contract, and may be kept for much longer. **Responder acknowledges that prices submitted by the Responder will not be considered trade secret materials.**

The Responder acknowledges that the STATE reserves the right to reject Responder’s claim of trade secret/confidential data if the STATE determines that the Responder has not met the legal burden of establishing that the information constitutes a trade secret or is confidential. The Responder also acknowledges that if certain information is found to constitute a trade secret or is confidential, the remainder of the Proposal will become public; only the protected information will be removed and remain nonpublic.

________________________________ ____________________________ _________________
Signature     Title   Date

* Whether or not protected information is provided, the Responder must sign and date this form and submit it with the “Required Statements”. 
Appendix E - State Of Minnesota – Affirmative Action Data Page

If your response to this solicitation is in excess of $100,000, complete the information requested below to determine whether you are subject to the Minnesota Human Rights Act (Minnesota Statutes 363A.36) certification requirement, and to provide documentation of compliance if necessary. It is your sole responsibility to provide this information and—if required—to apply for Human Rights certification prior to execution of the contract. The State of Minnesota is under no obligation to delay proceeding with a contract until a company receives Human Rights certification.

**BOX A** – For companies which have employed more than 40 full-time employees within Minnesota on any single working day during the previous 12 months. All other companies proceed to **BOX B**.

Your response will be rejected unless your business:

- has a current Certificate of Compliance issued by the Minnesota Department of Human Rights (MDHR)
- or-
- has submitted an affirmative action plan to the MDHR, which the Department received prior to the date and time the responses are due.

Check one of the following statements if you have employed more than 40 full-time employees in Minnesota on any single working day during the previous 12 months:

- [ ] We have a current Certificate of Compliance issued by the MDHR. **Proceed to BOX C. Include a copy of your certificate with your response.**
- [ ] We do not have a current Certificate of Compliance. However, we submitted an Affirmative Action Plan to the MDHR for approval, which the Department received on [date]. [If the date is the same as the response due date, indicate the time your plan was received: [time]]. **Proceed to BOX C.**
- [ ] We do not have a Certificate of Compliance, nor has the MDHR received an Affirmative Action Plan from our company. **We acknowledge that our response will be rejected. Proceed to BOX C. Contact the Minnesota Department of Human Rights for assistance.**

Please note: Certificates of Compliance must be issued by the Minnesota Department of Human Rights. Affirmative Action Plans approved by the Federal government, a county, or a municipality must still be received, reviewed, and approved by the Minnesota Department of Human Rights before a certificate can be issued.

**BOX B** – For those companies not described in **BOX A**

Check below.

- [ ] We have not employed more than 40 full-time employees on any single working day in Minnesota within the previous 12 months. **Proceed to BOX C.**

**BOX C** – For all companies

By signing this statement, you certify that the information provided is accurate and that you are authorized to sign on behalf of the responder. You also certify that you are in compliance with federal affirmative action requirements that may apply to your company. (These requirements are generally triggered only by participating as a prime or subcontractor on federal projects or contract. Contractors are alerted to these requirements by the federal government.)

Name of Company: ____________________________

Date: ____________________________

Authorized Signature: ____________________________

Telephone number: ____________________________

Printed Name: ____________________________ Title: ____________________________

For assistance with this form, contact:

Minnesota Department of Human Rights, Compliance Services Section

Mail: 190 East 5th St., Suite 700 St. Paul, MN 55101
TC Metro: (651) 296-5663
Toll Free: 800-657-3704
Fax: (651) 296-9042
TTY: (651) 296-1283

Website: www.humanrights.state.mn.us
Email: employerinfo@therightsplace.net
APPENDIX F

CERTIFICATION REGARDING LOBBYING
For State of Minnesota Contracts and Grants over $100,000

The undersigned certifies, to the best of his or her knowledge and belief that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

(2) If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, A Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, Disclosure Form to Report Lobbying in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by 31 U.S.C. 1352. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

__________________________________________
Organization Name

__________________________________________
Name and Title of Official Signing for Organization

By: _______________________________________
Signature of Official

__________________________________________
Date
APPENDIX G
DISCLOSURE OF OWNERSHIP

☐ NOT APPLICABLE

☐ APPLICABLE. PLEASE COMPLETE THE FOLLOWING:

1. The name and address of each Person with an Ownership or Control Interest in the MCO or in any subcontractor in which the MCO has direct or indirect ownership of five percent (5%) or more;

2. A statement as to whether any of the persons with Ownership or Control Interest is related to any other Person with Ownership or Control Interest such as spouse, parent, child, or sibling; and

3. The name of any other Disclosing Entity in which a Person with an Ownership or Control Interest in the MCO also has an ownership or control interest in the named Disclosing Entity, consistent with 42 CFR § 455.104 (A)(3).

By signing this statement, you certify that the information provided is accurate and that you are authorized to sign on behalf of, and legally bind, the Responder.

Authorized Signature: ___________________________________________________________

Printed Name: _________________________________________________________________

Title: ______________________________________________________________________

Date: ______________________________ Telephone Number: _________________________
Carlton County Information: Contact Persons, Service Development and Access Issues

1. County administration:

<table>
<thead>
<tr>
<th>Agency name:</th>
<th>Carlton County</th>
</tr>
</thead>
<tbody>
<tr>
<td>Director's name:</td>
<td>Dave Lee</td>
</tr>
<tr>
<td>Address:</td>
<td>30 10th Street North, Cloquet, MN 55720</td>
</tr>
<tr>
<td>Telephone #:</td>
<td>218/879-4511</td>
</tr>
<tr>
<td>Fax #:</td>
<td>218/878-2845</td>
</tr>
</tbody>
</table>

2. County agency contacts:

<table>
<thead>
<tr>
<th>Area of Responsibility</th>
<th>Name</th>
<th>Title</th>
<th>Telephone #</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Services</td>
<td>Brenda Carlson</td>
<td>Supervisor</td>
<td>218-878-2588</td>
</tr>
<tr>
<td>SS &amp; Children’s Mental Health &amp; Family School Support Workers</td>
<td>Karen Milbrath</td>
<td>Supervisor</td>
<td>218-878-2503</td>
</tr>
<tr>
<td>Public Health</td>
<td>Terri Allen</td>
<td>Supervisor</td>
<td>218-878-2858</td>
</tr>
<tr>
<td>Public Health-Long Term Care</td>
<td>Patti Martin</td>
<td>Supervisor</td>
<td>218-878-2859</td>
</tr>
<tr>
<td>Mental Health – Adult/Chemical dependency</td>
<td>Pam Brumfield</td>
<td>Supervisor</td>
<td>218-878-2842</td>
</tr>
<tr>
<td>Social Services – Disability Services Unit</td>
<td>Annie Napoli</td>
<td>Supervisor</td>
<td>218-878-2899</td>
</tr>
<tr>
<td>Transportation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eligibility - SIS EW and Spousal Impoverishment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Income Maintenance</td>
<td>Jan Rabideaux</td>
<td>Supervisor</td>
<td>218-878-2502</td>
</tr>
<tr>
<td>Managed Care Advocate</td>
<td>Patti Hart</td>
<td>Advocate</td>
<td>218-878-2523</td>
</tr>
</tbody>
</table>

3. County Geographic and Demographic Characteristics

Describe the county geographic and demographic characteristics
We are a rural community with sparsely populated areas without services. This results in transportation issues.
Carlton County has a growing population. The Moose Lake area in particular is growing population at least partially as a result of the expansion of the State Regional Treatment Center and Correctional Facility.

Carlton County has an aging population.

De-institutionalization for aging and disabled individuals places a burden and an opportunity on the community.

We have only two full service clinics and two hospitals in the county. Outlying areas find accessing these services difficult.

Carlton County is predominately Caucasian with a fairly sizeable Native American community.

Part of the Fond du Lac Indian Reservation is in Carlton County. It is important to us to maintain our excellent working relationship with Indian Public Health and Min No Aya Win Clinic.

Indian Public Health bills MA and health plans. Indian Public Health dollars will cover what MA or a health plan will not pay for.

There is a small population of individuals with Somali, Chinese and Mexican ethnicity.

4. County Service Delivery and Access Issues

Describe any specific service delivery and access issues pertaining to the population eligible for MSC+ (MA eligible, 65+ years old) in your county

Streamlining and uniformity between plans for requirements in this program similar to MSHO.

It is difficult to meet the needs of those that have no family or others who can take care or assist them in routine matters.

We have isolated seniors.

At times have some black holes when need to provide home care services in outlying areas due to distance and staffing with agencies.

Transportation, chore and/or moving services can be difficult finding providers. In addition for these types of services we need a simplistic way for small providers to be in networks for DHS and Health plans so they can submit for payment in an easy efficient manner. In our areas many of these providers do not have computer access readily available.

5. Describe the services provided by the county for the eligible population in the following categories. Be sure to describe the network of providers for each category of service.

   A. Mental Health Services – Adult
      Not good identification of mental health issues for the elderly and a lack of integration with primary care.

      We need better integration between mental health and primary care.
Early intervention and crisis services are limited. There is also lack of preventative care and early assessments for adults with mental health needs.

**List mental health provider(s) with which county currently contracts**

Human Development Center  
Carlton County Rule 79 Case Management

**Explain exactly how a new MCO can provide assistance in this area.**

Would be a good idea to have comprehensive physical including dental and mental health component when participants are added to the plan.

All MCOs need to contract with Carlton County case managers so mental health clients receive coordinated, integrated care.

**Special Programs:**

Developing Assertive Community Treatment Teams for adults with mental illness. (Intensive Community Services)

B. Chemical Dependency Services  
Outpatient Treatment: Haven, Community Addiction Recovery Enterprise (CARE) of Carlton  
Inpatient: CARE, Mash Ka Wisen

What are the issues? Is there a lack of providers, lack of transportation, lack of specialists?

PMAPs give very little time for inpatient treatment, then the facility recommends a half-way house to provide additional support. Half-way services are county funded. This is a good example of cost shifting.

There is no inpatient adolescent program in the area for non-native residents.

Detox is funded primarily by County dollars.

There is a lack of services for individuals with a dual diagnosis of mental illness and chemical dependency.

Integration with primary care, mental and chemical health services is limited.

List the chemical dependency treatment provider(s) with which county currently contracts (including Rule 25 assessments, inpatient and outpatient):

Mash Ka Wisen--The Haven—  
Community Addiction Recovery Enterprise (CARE) of Carlton

**Explain exactly how a new MCO can provide assistance in this area.**
Length of treatment is very short. Need PMAPs to expand length of treatment to meet industry standards.

Better coordination with county case managers and the tribe. Adolescent services (inpatient, etc.) are limited.

C. Elderly Waiver Services, including external case management services (i.e., case management provided by county contracted case management service providers)

Carlton County provides case management and care coordination for EW and contracted with 3 health plans in Carlton County and 1 in Pine County to provide Care coordination across all populations 65+ community, elderly waiver and nursing facility clients. Within these programs we have a network of homecare, Assisted Living, PCA, companion, MOW, supply and transportation providers.

It is difficult to meet the needs of those that have no family or others who can take care or assist them in routine matters. Some isolated elderly.

Carlton County Public Health enjoys an important symbiotic relationship with Social Services regarding vulnerable adults.

Billing MSHO – multiple MCOs with multiple standards. Excessive administrative costs and procedures.

Streamline the administrative services for the elderly.

Contract with Carlton County Case Managers for coordinated and integrated care.

D. Transportation

People can drive themselves, and they will be reimbursed for their mileage. This is not helpful for those that cannot drive or have no friends, neighbors or family members that can drive for them. HDC is providing Volunteer Driver transportation. Volunteer Services also provide volunteer driver services.

Health plan enrollees should go through the health plan, HP will provide/pay for a volunteer driver for this service area which includes Duluth. The client always has the option of driving themselves whether or not they are in a health plan, and MA reimburses for mileage...

Med A Van: they bill MA or a health plan directly.

MCO’s could also explore a contract with a local taxi service or Volunteer Services.

Needs in this area:

Handicapped accessible transportation and transportation in evening hours. We have no public transportation in the out lying areas

Coordinated EMS services. Public transportation is very limited.

Simplify the provider and billing process for the small providers of this service,
Strengthen breadth of transportation opportunities.

E. Public Health Services

Long Term Care Consultation
Public Health Nurses provide Care Coordination for MSHO and MSC+ with 4 MCO’s
Medication monitoring
Home care services--Health fairs--Caregiver support and Education
Toes R Us clinic for seniors------------------------Suicide Prevention activities.

Clinic Liaison – Public Health connection to physicians and clinics for education and
Assessment/Monitoring of immunization practices, emergency preparedness, infectious disease
reporting, best practices.
Jail Health--Jail Mental Health Assessments
Dental Hygienist at Public Health--
Immunizations and public clinics, immunization registry.
Screenings: Blood pressure, mantoux, hearing, vision, alcohol and drug abuse.
Smoking Cessation classes/Tobacco Diversion

Providers:
Please provide a list of all health care providers that your recipients use, both in and out of your
county.

Raiter Clinic --Gateway Clinic-- Min No Aya Win Clinic
Community Memorial Hospital--Mercy Hospital
SMDC--St. Lukes--Northland Clinic
Human Development Center__Lutheran Social Services
All CD services listed elsewhere
Carlton County Health Services--Mercy Home Care--Senior Friend Home Care
Interim Home Care--Gentiva Home Care—Home Instead
Volunteer Services

6. Identification of Limited or Unavailable Services
   Gaps in Service:

   There are some service gaps on the Aitkin County/Carlton County border.
   Lack of hospice/palliative care.
   Lack of home care—maintaining adequate staffing especially outlying areas.
   Lack of dental providers in Carlton County.
   Limited transportation, chore, and money management providers.
   Growth in this aging population has put an increased demand on Public Health staff, financial
   workers, and vulnerable adult staff.
   Issue: Work force issue with Public Health Nurses.

7. Identification of Community Health Care Planning Efforts and Other Local Projects
   Senior Event annually to provide fall and mental health screenings for seniors.
   Emergency Preparedness planning for Long Term Care including nursing homes, assisted living, foster
   care and home care.
   Home care continues to be a service that we provide from County Public Health.
   Ongoing collaboration with assisted livings, home care telehealth,
Fond du lac Tribal and Community College, UMD School of pharmacy and Center for Rural Mental Health Studies, along with College of Scholastica nursing students.

8. Identification of Local Public Health Goals
We have been involved with the CHAAP process - Community Health Assessment and Activity Planning. We have already completed Infectious Disease, Environmental Health, Emergency Preparedness, and Infrastructure. We plan by 2010 to also complete Healthy Communities and Healthy Behaviors and Quality and Accessibility of Health Services.

9. Other relevant information related to basic health care services for older adults in your county. We presently have 11 Assisted Living providers some with Memory care and 4 Nursing facilities (319 beds of which 51 beds will be transitioning to Assisted Living). In addition we have several Foster Care homes for elderly and 3 Medicare Certified Home care providers. There will continue to be some transition with providers as nursing home beds close and more clients live in the community.

Volunteer services also provides some transportation and other services.
COOK COUNTY

MSHO

COUNTY SERVICE DEVELOPMENT AND ACCESS ISSUES

Cook County Information: Contact Persons, Service Development and Access Issues

1. County administration:

<table>
<thead>
<tr>
<th>Agency name</th>
<th>Cook County Public Health and Human Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Director's name</td>
<td>Sue Futterer</td>
</tr>
<tr>
<td>Address</td>
<td>411 West 2nd Street, Grand Marais, MN 55604</td>
</tr>
<tr>
<td>Telephone #</td>
<td>218-387-3620</td>
</tr>
<tr>
<td>Fax #</td>
<td>218-387-3020</td>
</tr>
</tbody>
</table>

2. County agency contacts:

<table>
<thead>
<tr>
<th>Area of Responsibility</th>
<th>Name</th>
<th>Title</th>
<th>Telephone #</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social services</td>
<td>Grace Bushard</td>
<td>Social Services Supervisor</td>
<td>218-387-3624</td>
</tr>
<tr>
<td>Public health</td>
<td>Joni Kristenson</td>
<td>Public Health Nurse</td>
<td>218-387-3605</td>
</tr>
<tr>
<td>Mental health – Adult</td>
<td>Martina Schoettmer</td>
<td>Social Worker</td>
<td>218-387-3617</td>
</tr>
<tr>
<td>Chemical dependency</td>
<td>Kristine Swanson</td>
<td>Social Worker</td>
<td>218-387-3608</td>
</tr>
<tr>
<td>Transportation</td>
<td>Pat Strand</td>
<td>Financial Worker</td>
<td>218-387-3607</td>
</tr>
<tr>
<td>Eligibility - SIS EW</td>
<td>Pat Strand</td>
<td>Financial Worker</td>
<td>218-387-3607</td>
</tr>
<tr>
<td>and Spousal Impoverishment</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2. County Geographic and Demographic Characteristics

Cook County is geographically the second largest county in Minnesota with a population of 5,600. In the 2000 census Cook County had the largest percentage increase in the elderly population in the region. Approximately 90% of the people living in Cook County are of European descent and 8% are American Indian. The primary spoken language is English.
3. General County Service Delivery and Access Issues

Transportation

Transportation challenges create significant barriers to health care access for residents of Cook County. People often must travel great distances for health care, 300 miles or more round trip. People on limited incomes are also challenged with lack of working vehicles and the escalating price of fuel. All residents need to deal with unpredictable weather that can make travel hazardous and restrict access to needed services. Conversely, specialty service providers may not be able to travel to Cook County to provide services due to weather and distance.

There is limited public transportation through the Arrowhead Economic Opportunity Agency (AEOA) bus. This bus provides services primarily within the city of Grand Marais and operates only during daytime hours. The bus also makes two monthly trips to Duluth. This transportation option provides limited benefit since residents needing to use public transportation to Duluth for medical services are often too ill or require special assistance to take the bus safely. It is also difficult to schedule appointments on the days designated by AEOA for travel to Duluth.

Number of Providers

There is one Federally Qualified Health Clinic and one hospital serving Cook County. Four Family Practice physicians and one Nurse Practitioner staff the medical clinic. All other medical specialists are accessed in Duluth or communities beyond.

Specialty Providers

Cook County has a limited number of specialty providers. The following is a list of specialty services available: physical therapy, colonoscopy, mammograms, dxa-scans, and basic radiological services. There are no specialized dental services within the county. There are no vision services within the county. There are limited hearing services available.

The Human Development Center (HDC) headquartered in Duluth provides a satellite office in Grand Marais to serve the mental health needs of Cook County residents. HDC staff includes two therapists and two community support workers. Psychiatric services are provided either face-to-face or via ITV. There are two therapists in private practice in the county. Only one therapist in the county has the licensure to bill Medicare.

4. Describe the services provided by the county for the eligible population in the following categories. Be sure to describe the network of providers for each category of service.

A. Adult Mental Health Services

Cook County provides case management services for adults coping with mental illness. The county also provides information and referral, crisis and emergency services. The network of providers includes the Human Development Center and private practice mental health workers. The county also works with the Grand Portage mental health worker and service providers in other counties as indicated.

B. Chemical Dependency Services
Cook County provides case management and referrals to inpatient and outpatient services for adults coping with chemical dependency issues. Cook County contracts with Swift and Associates for licensed chemical dependency Rule 25 assessments, outpatient services, treatment, and aftercare.

C. Elderly Waiver Services

Cook County provides case management services to adults who are eligible for and elect the Elderly Waiver. The network of providers includes the Cook County North Shore Hospital, Hillhaven LLC (adult foster care), Center for Independent Living of Northeastern Minnesota, and Arrowhead Economic Opportunity Agency (AEOA).

D. Transportation Services

Cook County provides information to the eligible population regarding health care access. Care coordinators work with financial workers, family members and the Senior Center to coordinate medical transportation.

E. Public Health Services

Cook County Public Health is responsible for creating and maintaining conditions that keep all Cook County residents healthy and safe. Networking with community individuals, the public and private entities are strengths of the department that helps us achieve our goals. We are able to assure that conditions are in place to promote and improve the physical, behavioral, environmental, social, and economic conditions that improve health and well-being; prevention of illness, disease, injury and premature death; and to eliminate health disparities.

County nurses work with agency social workers, seniors and their families in cooperation with physicians, North Shore Home Care, community partners and health plans. The coordination of services help seniors find the resources they need to continue living in their homes and stay connected to their families and communities for as long as possible.

The Long Term Care staff administers programs such as Long Term Care Consultation (LTCC), Elderly Waiver (EW), Alternative Care (AC), Minnesota Senior Health Options (MSHO), MSC+ and Personal Care Assistance (PCA) Program.

Service coordination by county nurses includes:

- visits by a skilled nurse, home health aide or physical therapist, homemaker services, in-home support visits, personal care assistant or foster care. As well as coordination of: transportation, medication management, home delivered meals, supplies/equipment and home modifications.

5. Identification of Limited or Unavailable Services

- There are no customized living services in Cook County.
- There is no PCA provider agency in Cook County. The county cannot provide 24/7 supervision or assistance to residents who need this level of care in their own homes.
- There is one licensed adult foster care provider in Cook County who serves frail elders who are “almost independent” with self-cares.
- There is no community-based hospice service at this time.
- There is no adult day care service.
• Mental health services for the eligible population with Medicare are limited to one therapist.
• Transportation services are limited.
• Medical health specialists are unavailable in the county.
• Residents with dementia and related behavioral management needs must be relocated out of the county.
• There is no in-patient chemical dependency or local detoxifications service available.
• Most services are provided within the city of Grand Marais.
• There is one Medicare certified Home Care agency.

6. Identification of Community Health Care Planning Efforts and Other Local Projects

• Cook County Public Health and Human Services coordinate the Adult Care Team that meets monthly.
• Caregiver support group meets monthly.
• Active participant in monthly Health Care Planning committee with local health providers.
• Co-Coordinator with local Emergency Preparedness committee.
• Facilitate Hospice Foundation annual teleconference.
• Provide “Topic of the Month” education to community.
• Coordinate the North Shore Initiative Caring for Seniors(NICE) grant thru DHS.
• Monitor contract with North Shore Home Care to provide skilled nursing services on a sliding fee basis to low-income individuals.
• Monitor contract with Sawtooth Mountain clinic to provide: health education, blood pressure screening, cholesterol and blood sugar screenings, foot care and senior mini clinics.

7. Identification of Local Public Health Goals:

Cook County Public Health Goals for elders include:

• Adults will live a life free from abuse and neglect and will have a safe living arrangement.
• Adults will make healthy choices by reducing the use and effects from tobacco, alcohol and other chemicals.
• Adults will live in the least restrictive living arrangement that meet their health and safety needs.
• Adults will reduce the prevalence of obesity and lack of exercise that contributes to unhealthy lifestyles, morbidity and mortality.
• Our community will make healthy life choices to promote and maintain safe food, water and air for our elders.
• Our community will be prepared for emergencies and all hazards/incidents and will be at low risk of epidemics, and the spread of disease. We will be able to protect our elders during fire, ice, wind or other emergencies.
• Our community will strive for optimal health for all residents.
• Adults will see decreased stigma with mental illness.
• Our community will maintain low rates of infectious disease.

8. Other relevant information related to basic health care services for older adults in your county.

The geography of Cook County presents challenges related to health care services for older adults. While most of the county residents are located in the Grand Marais area and in smaller communities along the north shore, it is possible to have clients who live in remote areas that are far removed from formal health
care supports. This requires extensive travel and innovative services. The Grand Portage reservation also provides health services to band members. The relationship between the county and Grand Portage Health Services is complementary and has been long-standing.

Cook County’s strength in providing services to the eligible population is based on the commitment of community partners to work together.
KOOCHICHING COUNTY

MSHO

COUNTY SERVICE DEVELOPMENT AND ACCESS ISSUES

Koochiching County Information: Contact Persons, Service Development and Access

1. County administration:

<table>
<thead>
<tr>
<th>Agency name:</th>
<th>Koochiching County Community Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Director's name:</td>
<td>Terry Murray</td>
</tr>
<tr>
<td>Address:</td>
<td>1000 Fifth Street, Int'l Falls, MN 56649</td>
</tr>
<tr>
<td>Telephone #:</td>
<td>218-283-7000</td>
</tr>
<tr>
<td>Fax #:</td>
<td>218-283-7013</td>
</tr>
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2. County agency contacts:

<table>
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<tr>
<th>Area of Responsibility</th>
<th>Name</th>
<th>Title</th>
<th>Telephone #</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social services</td>
<td>Cindy Ellefson</td>
<td>Supervisor</td>
<td>218-283-7000</td>
</tr>
<tr>
<td>Public health</td>
<td>Susan Congrave</td>
<td>Director</td>
<td>218-283-7070</td>
</tr>
<tr>
<td>Mental health – Adult</td>
<td>Cindy Ellefson</td>
<td>Supervisor</td>
<td>218-283-7000</td>
</tr>
<tr>
<td>Chemical dependency</td>
<td>Cindy Ellefson</td>
<td>Supervisor</td>
<td>218-283-7000</td>
</tr>
<tr>
<td>Transportation</td>
<td>Valerie Long</td>
<td>Supervisor</td>
<td>218-283-7000</td>
</tr>
<tr>
<td>Eligibility - SIS EW and Spousal Impoverishment</td>
<td>Valerie Long</td>
<td>Supervisor</td>
<td>218-283-7000</td>
</tr>
</tbody>
</table>

3. County Geographic and Demographic Characteristics

Describe the county geographic and demographic characteristics

Koochiching County has a large geographical area with sparsely populated areas lacking services. Due to this, transportation is a big issue.

Koochiching County has the highest population decline in the state of Minnesota, which leads to less county resources to serve our outlying areas.

Koochiching County has an aging population.

Koochiching County is working at de-institutionalizing and moving back into our communities, residents of Koochiching County with mental health and developmental disabilities. This is a welcomed opportunity, but at the same time has proven to be a financial burden to the County.
Koochiching County has four medical clinics; one small clinic in Littlefork; a satellite office in Big Falls (of the Big Fork clinic); one in Northome, and a clinic in International Falls with an affiliation to St. Mary’s Medical System/Duluth Clinic. Our county has one hospital, Falls Memorial Hospital. Making a choice in facilities is a non-factor in providing services to our clients. County residents access services throughout Minnesota depending on specialized services needed.

4. County Service Delivery and Access Issues

Describe any specific service delivery and access issues pertaining to the population eligible for MSHO (MA eligible, 65+ years old) in your county

One issue that negatively affects the delivery of services and causes undue hardship on county government is the cost of mailing out MCO’s marketing materials to clients whenever new clients are enrolled, when clients transfer in from another geographic location, or during the open enrollment period. The high cost of these packets is due to the extensive heavy, and expensive marketing materials that each MCO includes; because there is no cost to the MCO’s, there is no incentive for MCO’s to restrict packet size and weight. The County should be reimbursed by the MCO for the cost of mailing out the packets, or assume the function of mailing out the packets.

5. Describe the services provided by the county for the eligible population in the following categories. Be sure to describe the network of providers for each category of service.

A. Mental Health Services - Adult

Koochiching has one local mental health center, Northland Counseling. Their home office is in Grand Rapids. They provide psychiatric assessment, counseling services, ARMHS and pre-petition screenings for the county’s public assistance consumers.

A second provider in Koochiching is Blue Heron Counseling, with the owner being the sole therapist.

Koochiching also utilizes provider, Connie Anderson Aagard, a licensed psychologist from out of the county that comes and serves clients one day a week.

Koochiching has one psychiatrist, Dr. Jeff Hardwig, who is extremely busy with clients waiting up to six months for an appointment to see him.

Early intervention and crisis team services are limited. Preventative care and early assessments are lacking in Koochiching.

Our local MHC faces difficulties in recruiting qualified professional staff. One of the main reasons for this is the inadequate reimbursement for MA clients and the amount of paperwork involved to get reimbursement.

Koochiching does not have a provider of forensic psychology services.

Lack of specialists; psychiatrist is extremely busy requiring approximately a 6 month wait for an appointment; community based services are lacking; crisis bed at hospital is needed; med set-up and management services are needed.

There is no immediate access to a psychiatrist if immediate intervention services are required.

A crisis bed is currently in the process of becoming a reality in Koochiching. There has been no place that will hold a client for stabilization; everyone had to be transported out of the county to a facility in another city (a minimum of 100 miles). Koochiching is hoping to have the crisis bed available sometime in February, 2009.

B. Chemical Dependency Services

The County employs a Rule 25 Assessor who completes the assessment and recommends the appropriate course of treatment. Rational Alternative provides out-patient CD treatment to county residents. Pineview Recovery Center provides detox services and inpatient CD treatment for adults.

For more intense treatment, clients are transferred out of the county where services can be provided.
PMAPs allow very little time for in-patient treatment; the facility then recommends a half-way house to provide additional support. Half-way house services are county funded; this is a good example of cost shifting.

There is no in-patient, out-patient, or after care services for adolescents.

Transportation is an issue.

There is a lack of services for individuals with a dual diagnosis of mental illness and chemical dependency.

Integration with primary care, mental and chemical health services is limited.

C. Elderly Waiver Services, including external case management services (i.e., case management provided by county contracted case management service providers)

24 Hour and 24 Hour + customized living and home care (by private entities) continue to be the services most requested and provided.

In Koochiching, Social Services and Public Health work as a team in completing LTCC’s. From this assessment, an individualized care plan is developed with the client to ensure their care and safety needs are met in a community setting. On-going care coordination is provided to the client with either a social worker or public health nurse acting as the primary care coordinator. Re-assessment of care needs is done at least yearly or if there is a major change in the person’s condition.

It is getting more difficult to offer options because Public Health has been directed to no longer take new referrals in the provision of home care, and private entities are not always providing services as needed or requested.

EW participants in the rural areas of Koochiching face barriers to accessing services such as home-delivered meals, congregate meals, and homemaker services. The private entities that provide homemaking, home health aide, personal care attendants and/or skilled nursing services, will not serve clients in the outlying areas of Koochiching due to the travel distance required to serve these clients.

D. Transportation

Koochiching contracts with AEOA to provide bus service, which is for a limited time period. They recently have extended their run until 7:00 p.m. week-days, but do not run at all on week-ends. It has been difficult for clients to get to appointments or to get home from appointments; there is no transportation in emergencies.

Volunteer drivers are available, but at a greater expense to the county.

Clients access taxi service at county expense when the bus is not available.

Family members provide rides with reimbursement from MA.

Senior Wheels Program

There is no out of county transportation service other than volunteer drivers.

E. Public Health Services

Koochiching County Health Department (KCHD) is located in the same building as Community Services, which enables workers to communicate very effectively on cases. Office hours are Monday – Friday, 8:00 a.m. to 5:00 p.m.

KCHD provides a broad range of services to individuals, families and the public to improve, promote and protect the health of those who live and work in Koochiching.

Programs provided by KCHD include:

Home visiting for maternal/child health
Immunizations
Parenting classes
WIC
Breast feeding – promote
Water testing
Child/Teen check ups
Child/Teen Outreach
Case/Care coordination – EW/CADI waivers
PCA assessments
Foot care
Early Intervention (IEIC)
Jail health – limited
Screenings – PHN clinics

What are the issues?
Transportation
PCA’s – behavioral issues
Speech therapy
Shortage of primary care physicians (increases use of urgent care and emergency rooms at local hospital) Also, does not allow good continuity of care.
Shortage of surgeons
Shortage of specialists
Family Planning – Rx’s
Low population numbers = limit of services and creation of local services/resources
Nursing shortage
Public Health Nursing Recruitment (difficult due to salary not being competitive with hospital or other parts of state)
Training (pca)
Chemical treatment resources
Middle person
FMH – critical access hospital system
Dramatic increase in uncompensated care in local hospital (Charity care and bad debt increasing)
“Frontier” county (difficult for residents outside of a 20 mile radius of International Falls to receive services due to large geographic area – sparsely populated).
Need crisis bed or Hold for mental health
Lack out of home respite
Reimbursement for respite
Inpatient treatment
Lack of adolescent treatment
Need for medication setup/management
People need help accessing services
Denials from existing MCO’s
Advanced life support needed; now have basic (EMS)
Elders need navigation – no family member
Pharmacy access – southern end of Koochiching

6. Identification of Limited or Unavailable Services
Dental access is a problem, especially for MA population
Home Health Care outside of 20 mile radius of International Falls
Radiation treatment related to cancer diagnosis; need to travel 200 mile round trip minimum
Dialysis not available (need to travel 200 miles round trip)

7. Identification of Community Health Care Planning Efforts and Other Local Projects
Local Public Health Department works annually on the six areas of public health responsibility. 2009 will be “accessibility and assurance” to health care services and “environmental” issues. Focus groups are formed and surveys utilized.
8. Identification of Local Public Health Goals
   * Improvement in nutrition of population
   * Increased physical activity
   * Increased number receiving flu vaccine annually
   * Increased number receiving Pneumonia vaccine
   * Decrease in residents smoking/using tobacco products
   * Eliminate children’s exposure of second hand smoke
   * Stabilize the infrastructure of Public Health Department
   * Decrease incidence of Chlamydia in population

9. Other relevant information related to basic health care services for older adults in your county.
   * Access to health services
   * Need for increased understanding of services and health plans, etc
   * Simplification of insurance, Part D, etc.
   * Need for advocates and care coordination of population
LAKE COUNTY

MSHO

COUNTY SERVICE DEVELOPMENT AND ACCESS ISSUES

1. County administration:

<table>
<thead>
<tr>
<th>Agency name:</th>
<th>Agency Name</th>
<th>Lake County Human Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Director's name:</td>
<td>Director’s Name</td>
<td>Dennis R. Henkel</td>
</tr>
<tr>
<td>Address:</td>
<td>Address</td>
<td>616 Third Avenue Two Harbors, MN 55616-1518</td>
</tr>
<tr>
<td>Telephone #:</td>
<td>Telephone Number</td>
<td>218-834-8415</td>
</tr>
<tr>
<td>Fax #:</td>
<td>FAX Number</td>
<td>218-834-8412</td>
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2. County agency contacts:

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<tr>
<th>Area of Responsibility</th>
<th>Name</th>
<th>Title</th>
<th>Telephone #</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social services</td>
<td>Amy Stark</td>
<td>Social Services Supervisor</td>
<td>218/834-8426</td>
</tr>
<tr>
<td></td>
<td>Vickie Thompson</td>
<td>Social Services Supervisor</td>
<td>218/834-8408</td>
</tr>
<tr>
<td>Public health</td>
<td>Mike Duffy</td>
<td>Public Health Supervisor</td>
<td>218-834-8406</td>
</tr>
<tr>
<td>Mental health – Adult</td>
<td>Amy Stark</td>
<td>Social Services Supervisor</td>
<td>218/834-8426</td>
</tr>
<tr>
<td>Chemical dependency</td>
<td>Vickie L. Thompson</td>
<td>Social Services Supervisor</td>
<td>218-834-8408</td>
</tr>
<tr>
<td>Transportation</td>
<td>Kay Larson</td>
<td>Family Services Aide</td>
<td>218-834-8464</td>
</tr>
<tr>
<td>Eligibility: SIS EW and Spousal Impoverishment</td>
<td>Bonnie Swan</td>
<td>Income Maintenance Supervisor</td>
<td>218/834-8407</td>
</tr>
</tbody>
</table>

3. County Geographic and Demographic Characteristics
Lake County is located on the North Shore of Lake Superior and is the fourth-largest county in the state in area but not population. Our population is estimated to be approximately 11,060 year-round residents. The largest city in the county is Two Harbors, the County Seat, with a population of approximately 3,600 persons; the second largest city is Silver Bay with approximately 2,000 persons. New Paragraph: The population of the county is predominately White Persons (98.6%); the remaining 1.4% of the population includes American Indians, Black Persons, Asian Persons and Hispanic Persons. English is the primary language spoken in Lake County. In 2004, the poverty level for children was 11.5%; the poverty for all ages was 7.7% in 2004. New Paragraph: The number of residents age 65 and older living in Lake County is 20.8% and the population under age 18 is 22.9%. The population between the ages of 18 and 64 is
56.3%; females makeup 50.5% of Lake County residents. New Paragraph: The County’s labor force is estimated to be about 6,100 persons. The average median income in 2004 was $45,400.00. The current unemployment rate is 4.1%. New Paragraph: Lake County has, for the most part, a small and widespread population covering a large area. Transportation for medical care (and areas of trade) can be challenging for residents unable to drive because of health and ability issues, those who don’t drive or have unreliable vehicles and those who cannot afford a vehicle.

4. County Service Delivery and Access Issues
Lake County covers a wide area with several towns and villages with sparse populations. We are a rural county with sizeable distances between most towns and villages. A portion of the population is low income and many of the residents living in outlying areas of the county, as well as those living in towns and villages receive public assistance, and don’t have or can’t afford their own transportation. We also have those residents who are aged and/or disabled and unable to drive. All of these factors create transportation issues within Lake County. Lake County contracts with AEOA and Northshore Area Partners to provide volunteer drivers and the AEOA bus to provide transportation in certain areas of the county. Case managers set up transportation for clients receiving waivered or alternative care services. New Paragraph: For clients who are members of a Managed Care Organization (MCO), the MCO is expected to provide transportation as part of their client services through their own Care Coordinator and resources and collaborating with our contract providers. MCOs have access to the Lake County provider network and they are encouraged to use those providers as needed such as volunteer drivers and the AEOA bus. Not all MCOs are providing cost effective transportation for clients. Financial Workers arrange volunteer drivers for clients who need transportation to medical appointments and who are not eligible for MCO transportation. New Paragraph: One issue that negatively affects the delivery of services and causes undue hardship on local government is the cost of mailing out thousands of MCO marketing materials to clients whenever new clients are enrolled, when clients transfer in from another geographic location or during the open enrollment period. The high cost of these packets is due to the extensive, heavy and expensive marketing materials that each MCO includes; because there is no cost to MCO(s), there is no incentive for MCO(s) to restrict packet size and weight.

5. Describe the services provided by the county for the eligible population in the following categories. Be sure to describe the network of providers for each category of service.

Mental Health Services – Adult
The Human Development Center is primary provider within Lake County serving adults with mental illness. They have offices in both Two Harbors and Duluth with office hours available at the Lake County Service Center in Silver Bay making it possible for more clients to access services. In addition to HDC, there are three other providers offering Adult Rehabilitative and Mental Health Services (ARMHS) locally – Nystrom Associates, Accend Services and RSI. These services promote psychiatric stability, social competencies, personal and emotional adjustment, independent living and community skills when impaired by symptoms of illness and medication management. Clients are offered a choice of providers and accessing services is not an issue. There are generally not enough mental health professionals to meet the needs of some clients in a timely fashion. Psychiatrists, Advanced Practice Nurses and Psychologists are of limited supply locally and statewide. New Paragraph: Emergency mental health holds have historically been handled primarily by Miller-Dwan Medical Center in Duluth; however, we have occasionally used St. Luke’s Hospital also. New Paragraph: The MCO(s) must describe how they will work with the County, which is the local Mental Health Authority, to provide and coordinate services involving the court system including pre-petition screenings, evaluations, commitment proceedings and other issues including court-ordered treatment. The MCO(s) must indicate how it will work with the county to provide timely response and sharing of necessary information and be present at court hearings if necessary. Lake County, together with HDC staff, provides coordination for adult mental health services. The MCO should describe how current services, including use of county case managers, will allow for continuity of client care in this area.
to maximize community integration/reintegration. New Paragraph: There is a population of adults with serious and persistent mental illness that are not MA eligible but require significant services to keep them stabilized in community care. The MCO(s) is requested to address how assistance with the cost of those services might be addressed, as ultimately having lower cost community services will save MA dollars if hospitalizations are minimized.

**PROVIDERS**

- Human Development Center, Two Harbors, Silver Bay (specific hours only) and Duluth
- Accend Services, Two Harbors (ARMHS only)
- Nystrom Associates, Two Harbors (ARMHS only)

**Chemical Dependency Services**

Chemical Dependency treatment services are available within the county to meet many of the needs of clients seeking chemical dependency treatment. Lake View Memorial Hospital provides detoxification, chemical dependency assessments, Consolidated Chemical Dependency Treatment Fund (CCDTF) outpatient treatment and urinalysis testing services. The Center for Alcohol & Drug, Inc. in Duluth provides detoxification and Rule 25 Assessment services. New Paragraph: Services such as half-way house services after primary CD treatment are not available in Lake County. St. Louis County is the closest and most accessible area for Lake County residents. Depending on availability of space, it is occasionally necessary to send clients to areas more distant than St. Louis County. New Paragraph: Issues that exist in serving this group have been the explosion in the use of methamphetamines. Treatment of meth addicts is said to be lengthier and consequently more expensive. Programs that deal specifically with methamphetamine addiction are not readily accessible. The MCO(s) responding to this RFP will need to work with the county to assure that treatment is appropriate to those adults. New Paragraph: Lake County would like to collaborate with the MCO(s) in the delivery of CD services. The MCO(s) are asked to describe how they will coordinate with the County and current providers to maintain continuity of care and focus on goals of early intervention and community based services. The County requests that the MCO(s) describe how they will work with other community organizations and school districts on the development of the chemical health care delivery system.

**PROVIDERS**

- Rule 25 Assessments, Outpatient Treatment Providers, Detoxification
  - Lake View Memorial Hospital, Two Harbors
  - Center for Alcohol & Drug, Inc., Duluth

- Inpatient Treatment Providers, Extended Care (60 to 90-day program provided by CARE)
  - Miller-Dwan Medical Center, Duluth
  - Community Addiction Recovery Enterprise (CARE), Cloquet, Brainerd, Willmar and St. Peter

- Halfway House:
  - Port Rehab, Duluth

**Elderly Waiver Services**, including external case management services (i.e., case management provided by county contracted case management service providers)

**Nursing Facility Benefit:**

The goal of Lake County is to have persons who are elderly and disabled live in the least restrictive environment that meets the person’s health and safety risks. This means that the nursing facility is the final choice for the care of the individual. There is more focus on the development of customized living and adult foster care options, as these should be less costly and often meet the needs of the person.

**Elderly Waiver Services:**

Lake County Human Services (LCHS) is the contact agency for LTCC and Elderly Waiver; the Public Health Unit is a part of Human Services. Public Health provides the services of a Public Health Nurse.
(PHN) for LTCC screenings and Personal Care Assistant (PCA) assessments. New Paragraph: The waiver case management system is comprised of a social worker and a PHN. The MCO(s) will need to work cooperatively with these case managers. One MCO currently contracts with LCHS to provide care coordination. Other MCOs provide their own care coordination. New Paragraph: LCHS works with a number of other agencies, all of which are MA Certified, including PCA agencies, adult foster care homes, customized living/24-hour customized living, adult day care, home-delivered meals and numerous medical supply companies and pharmacies. New Paragraph: Transportation continues to be an area which needs to be addressed in this county, particularly evenings and weekends. Transportation, other than medical transportation is a need for this group of clients. Northshore Area Partners in Silver Bay and Community Partners in Two Harbors maintain a list of volunteer drivers as well. New Paragraph: Adult Day Care services have proven to be useful not only to the client but also to provide respite to the caregiver. There is only one adult day care provider in the county and that service is offered one day a week. If the family is unable to provide transportation, the MCO is asked to explain how it would provide transportation to adult day care.

PROVIDERS:

Home Care and PCA Agencies:
- SuperiorHealth Community Care, Two Harbors
- Interim Health Care, Duluth
- Heartland PCA, Duluth
- Regency, Duluth
- Center for Independent Living, Duluth
- Life’s Companion, Duluth
- RSI, Duluth
- ARC Northland, Duluth

Supply Companies:
- Lake Superior Medical Supplies, Duluth
- Midwest Medical Supplies, Duluth

Customized Living/Assisted Living, Adult Foster Care and Adult Day Care:
- Barross House
- Sunrise on Superior
- The Cottages (Adult Day Care)
- Nicholson’s Adult Foster Home
- At Home Living

Med Alerts and Emergency Phone Systems
- Lake View Clinic, Two Harbors
- Community Partners (MainStreet Messenger, Two Harbors)
- Northshore Area Partners (MainStreet Messenger, Silver Bay)
- Sheriff’s Office

Transportation
Lake County is served by Arrowhead Economic Opportunity Agency (AEOA), which is a public transit provider. AEOA provides bus transportation to residents of Lake County. Trained volunteer drivers are available through AEOA and Northshore Area Partners to provide medical transportation to EW/AC recipients where necessary, both in and outside of Lake County. Lake County pays for transportation as necessary for open Social Services cases. Special transportation services are available to those who need them through Northern Access in Duluth. New Paragraph: This transportation is usually arranged by a medical provider when ambulance transport is not required but the patient is too ill to travel by car. The cost of this transport is not usually covered by MA. The MCO(s) will need to address how they will coordinate services with AEOA whose transit coordinator currently coordinates MA and social service transportation for the county. New Paragraph: Transportation issues that the MCO(s) need to consider
include reaching folks without phones and support in helping clients make appointments and then keep them. Access to specialist services outside the area for recipients, especially for the disabled population that require regular or multiple trips, has been difficult to arrange for with limited volunteer drivers. New Paragraph: Recently AEOA moved the transportation services coordination offices from Two Harbors to Grand Rapids. This presents some difficulty in coordinating travel for clients in need of volunteer drivers.

Public Health Services

Public Health duties and concerns in Lake County are handled by the in-house Public Health Unit. LCHS further contracts with SuperiorHealth Community Care to ensure additional help is available for Public Health, should it be needed. The County would encourage the MCO to partner with LCHS to address the local public health functions.

New Paragraph: Lake County Human Services, incorporating public health, provides services to eligible county residents to enable them to remain living in the community. Services provided include Long Term Care Consultation (LTCC) by a two-person team consisting of a public health nurse (PHN) and a social worker for home care waiver programs and PCA assessments. PHN determination of appropriate level of care services functions to ensure clients receive optimal and cost effective care delivery to meet their needs. Quality and accessibility initiatives include: Long Term Care Consultation for Elderly Waiver, Alternative Care (and CAC, CADI and TBI)

PROVIDERS:

Home Care and PCA Agencies:
- SuperiorHealth Community Care, Two Harbors
- Interim Health Care, Duluth
- Heartland PCA, Duluth
- Regency, Duluth
- Center for Independent Living, Duluth
- Life’s Companion, Duluth
- RSI, Duluth
- ARC Northland, Duluth

Supply Companies:
- Lake Superior Medical Supplies, Duluth
- Midwest Medical Supplies, Duluth

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Med Alerts and Emergency Phone Systems
- Lake View Clinic, Two Harbors
- Community Partners (MainStreet Messenger, Two Harbors)
- Northshore Area Partners (MainStreet Messenger, Silver Bay)
- Sheriff’s Office

Hospital and Nursing Homes
- Lake View Memorial Hospital, Two Harbors
- Lake View Home, Two Harbors
- Sunrise Home, Two Harbors

6. Identification of Limited or Unavailable Services

Limited:
- Transportation on evenings and weekends
• Contractor availability for home modifications and adaptations
• Chore service for low income
• Memory care
• Adult day care
Unavailable:
• No providers of housing with services in the Silver Bay area

Other Concerns about services that are lacking:
• The lack of available mental health professionals (psychiatrist, advanced practice nurses and psychologists). Public assistance recipients should have unlimited access to mental health sessions.
• The need for case management service for the purpose of making appointments (medical and dental) and following up with clients after appointments to be sure clients understand directives from the health care provider and that they are following through appropriately.
• The lack of client education on how and when to access medical services to reduce the number of emergency room visits.
• The lack of easy access to full dental care – regular, emergency and orthodontia treatments – for public assistance clients.
• The need for arrangements for recipients to access out-of-area specialists when necessary for more complex care needs.
• There is only one adult day care provider in the county and that provider offers adult day care only one day per week.

7. Identification of Community Health Care Planning Efforts and Other Local Projects
Lake County Human Services (LCHS) is the contact agency for LTCC and Elderly Waiver services; the Public Health Unit is a part of Human Services. Public Health provides the services of a Public Health Nurse (PHN) for LTCC screenings and Personal Care Assistant (PCA) assessments. New Paragraph: The waiver case management system is comprised of a social worker and a PHN. The MCO(s) will need to work cooperatively with these case managers. One MCO currently contracts with LCHS to provide care coordination. Other MCOs provide their own care coordination. New Paragraph: LCHS works with a number of other agencies, all of which are MA Certified, including PCA agencies, adult foster care homes, customized living/24-hour customized living, adult day care, home-delivered meals and numerous medical supply companies and pharmacies. New Paragraph: Transportation continues to be an area which needs to be addressed in this county, particularly evenings and weekends. Northshore Area Partners in Silver Bay and Community Partners in Two Harbors maintain a list of volunteer drivers as well.

8. Identification of Local Public Health Goals
Public Health duties and concerns in Lake County are handled by the in-house Public Health Unit. LCHS further contracts with SuperiorHealth Community Care to ensure additional help is available for Public Health, should it be needed. The County would encourage the MCO to partner with LCHS to address the local public health functions. New Paragraph: LCHS, through the Public Health Unit, provides the six Essential Local Public Health Activities as defined by Minnesota Statute. They are:
• Assure an adequate local public health infrastructure
• Prevent the spread of Infectious Disease (immunizations)
• Promote Against Environmental Hazards
- Promote healthy communities and healthy behaviors (WIC/Health Assessment clinics, MCH prenatal education, new mom visits, TANF youth programming)
- Assure the quality and accessibility of health services (Child/Teen outreach)
- Prepare for and respond to disasters and assist communities in recovery

Lake County Human Services, incorporating public health, provides services to eligible county residents to enable them to remain living in the community. Services provided include Long Term Care Consultation (LTCC) by a two-person team consisting of a public health nurse (PHN) and a social worker for home care waiver programs and PCA assessments. PHN determination of appropriate level of care services functions to ensure clients receive optimal and cost effective care delivery to meet their needs.

9. Other relevant information related to basic health care services for older adults in your county. NONE
SAINT LOUIS COUNTY

*No information submitted.*
APPENDIX I: MSHO ASSURANCES

The MCO(s) assures the following by initialing in the space to the left of each statement.

_____ 1. The MCO assures that it will provide the health care services listed in the model contract and the services further negotiated during contract negotiations. Contract language and services may change based on any new legislative or CMS requirements.

_____ 2. The MCO assures that it will limit enrollment to the dual eligible subset of seniors as defined and provided by the State. This includes, as of January 1, 2010, working with the State to no longer enroll Medicaid-only seniors who do not have Medicare Parts A and B.

_____ 3. The MCO assures that it will provide information related to Medicare Advantage Special Need Plan (SNP) applications, additional benefits, contracts, bids, audits and SNP application amendments as described in the model contract.

_____ 4. The MCO assures that it will coordinate Medicare enrollment dates with Department of Human Services (DHS) enrollments according to the methods outlined in the model contract.

_____ 5. The MCO assures that it will submit marketing and member materials to the State and CMS Regional Office for review and approval according to the model contract.

_____ 6. The MCO assures that it will comply with requirements under the 1997 Balanced Budget Act as specified in the contract for serving people with Special Needs. All members enrolled in MSHO plan are considered Special Needs.

_____ 7. The MCO assures that it will coordinate Medicare and Medicaid grievance and appeals procedures as allowed under CMS and State requirements.

_____ 8. The MCO assures that it will report Medicare disenrollment survey information to DHS.

_____ 9. The MCO assures that it is in current compliance with all applicable statutory and regulatory requirements for a licensed HMO under Minnesota Statutes, Chapter 62D, and Minnesota Rules, Parts 4685.0100 to 4685.3400.

_____ 10. The MCO assures that it is has safeguards in place regarding conflicts of interest in purchases involving Medicaid funds, as required by Minnesota Statutes, section 256B.0914.

_____ 11. The MCO assures that the MCO and its providers will not discriminate against any enrollee on the basis of: race, sex, color, religion, health status, age, handicap, national origin, public assistance status, or sexual orientation.

_____ 12. The MCO assures that it will not set any enrollment limits on the number of MSHO enrollees it will serve and the MCO will expand its provider network should full capacity be reached assuming there are providers in the area who have not been extended a contract.

_____ 13. The MCO assures that it will monitor and ensure appropriate access to services where the provider is limited, or where a service is only available through a sole source vendor (e.g. dental or mental health services).
14. The MCO assures that it will provide provider network updates as required by the State, whether there are deletions from or additions to its network, including updates on the MCO’s HCBS provider network.

15. The MCO assures that its provider network has been approved by CMS or that it has an application pending that meets CMS network requirements for Medicare covered services.

16. The MCO assures that it will work collaboratively with the counties’ Public Health Agencies.

17. The MCO assures that it will work with the counties to address the following concerns:
   - Meeting the needs of an aging population;
   - Meeting the needs of Limited English Proficiency (LEP) populations;
   - Maintaining and improving client choice of providers;
   - Improving timely, non-emergency access to providers;
   - Improving prevention and early intervention services.
   - Coordinating American Indian Services with Indian Health Services and Tribal Health Services.
   - Improving the availability of psychiatrists and/or psychologists.

18. The MCO assures that it will participate as cooperative and collaborative members in the health care efforts with the counties.

19. The MCO assures that it will participate in collaborative efforts to design Performance Improvement Projects (PIPs) applicable to seniors, taking into consideration DHS priorities.

20. The MCO assures that it will cooperate with the entity as arranged for by the STATE in an annual independent, external review of the quality of services furnished under the contract.

21. The MCO assures that it will meet the requirements for delegation for any delegated activities related to quality improvement.

22. The MCO assures that it will maintain documentation sufficient to support its care management responsibilities.

23. The MCO assures that it will provide that the STATE, CMS or their agents may evaluate through inspection or other means, the quality, appropriateness, and timeliness of services or administrative procedures performed under the contract.

24. The MCO assures that all incentives must comply with the federal managed care incentive arrangement requirements.

25. The MCO assures that it will take reasonable measures to determine third party reimbursement.

26. The MCO assures that it will have administrative and management arrangements or procedures, including a mandatory compliance plan, that are designed to guard against fraud and abuse.

27. The MCO assures that it will submit Medicare and Medicaid encounter data to DHS including Part D pharmacy data and Elderly Waiver services with appropriate codes and accurate units of service according to the 2009 Model Contract, section 3.5.1.
28. The MCO assures that it will provide for enrollees’ rights as prescribed in the 2009 Model Contract, section 3.1.3.

29. The MCO assures that it will comply with the 2009 Model Contract, section 9.3.10, related annual reviews of care system subcontractors, county coordination systems, and care plan audits.

30. The MCO assures that it will comply with the 2009 Model Contract, section 9.3.22, related to nursing facility subcontracting.

31. The MCO assures that it will comply with the 2009 Model Contract, section 9.3.23, related to Elderly Waiver subcontracting.

By signing this statement, you certify that the information provided is accurate and that you are authorized to sign on behalf of, and legally bind, the Responder.

Authorized Signature: ________________________________________________________

Printed Name:  ______________________________________________________________________

Title:   _______ ___________________

Date:__________________________ Telephone Number:______________________________________
APPENDIX J: PLAN DESIGN FOR MSHO

Exhibits

SERVICE AREA

1. Clearly describe the requested service area in terms of the geographic subdivisions such as counties, cities or townships. Provide a detailed map (with a scale) of the complete service area showing the boundaries, main traffic arteries, and any physical barriers such as rivers.

2. If less than full counties are requested, provide justification for this request of partial counties. If not a full county, zip codes must be provided.

ADMINISTRATIVE AND SERVICE CAPACITY

3. Describe how the MCO will maintain, at a minimum, the current range of providers assuring the current level of enrollee choice. The expectation is that the MCO will have contracted with all or as many county providers to enhance enrollee choice in the service area either directly or through relationships with counties to access existing networks or both.

4. Describe how the MCO will integrate Medicare and Medicaid service delivery to provide a seamless benefit set from the perspective of the enrollee.

5. Explain how the MCO will integrate with the health and county social services agencies to maximize improving the health care of enrollees.

6. Describe any recent changes in the MCO’s current operations affecting the MCO’s ability to provide services under the MSHO program.

7. Describe the MCO’s capacity to implement care management functions, such as screening for special needs (e.g. mental health and/or chemical dependency problems, mental retardation, high risk health problems, difficulty living independently, functional problems, language or comprehension barriers); individual follow-up; monitoring of outcomes; or revision of care plan.

CARE COORDINATION AND SERVICE DELIVERY MODEL:

8. Explain how coordinated care coordination will occur according to the 2009 Model Contract, section 3.5.2.C.

9. Describe how the MCO will provide for comprehensive and coordinated service delivery across provider types with changes in service settings and changes in enrollee condition.

10. Describe the model of how the MCO will provide for comprehensive and coordinated service delivery including a description of MCO’s care coordination system for both enrollees in nursing facilities and in the community including any special provisions for frail community members. Include organizations that will be involved and a brief description of the services provided.
11. Describe how the MCO will give attention to enrollees’ integrated acute care and long-term care needs. Describe how the method of coordinating the medical needs of an enrollee with his/her long-term care or social service needs and how the MCO will work with the local social service agency and other community resources in the community.

12. Describe how the MCO will provide for continuity of care. Include the process for assuring availability and accessibility of services within the MCO’s service area with reasonable promptness and in a manner which assures continuity of care.

13. Describe how the MCO will provide culturally appropriate care to enrollees of different backgrounds. Provide policies for ensuring that services are provided in a culturally competent manner.

14. If applicable, describe how the MCO will contract with nonprofit organizations that provide case management.

15. Describe the procedures for coordinating care for American Indian enrollees.

16. If applicable, describe how the MCO will coordinate with Tribal Governments managing Elderly Waiver services.

17. Describe the method for establishing care coordinator to enrollee ratios.

18. Describe the procedures for notification to the enrollee of assigned care coordinator.

19. Describe the MCO’s procedures for providing needs assessment including the collection of ADLs for all community members; diagnostic assessment; the development of an individual care plan; establishment of care plan objectives; follow-up; monitoring of outcomes; and revision of care plan plans as necessary, according to the 2009 Model Contract, section 6.1.3. Describe where the care plan(s) will be located.

20. Describe the method for assessing the health risk status of both institutionalized and community enrollees. If using a tool other than the LTCC, provide copy of the tool used.

21. Describe the procedures for assessing nursing home certifiable status using the long term care consultation (LTCC) process. If using information in addition to the LTCC tool, provide a copy of the tool or information collected.

22. Describe how the MCO will ensure that enrollees and/or authorized representatives are involved in the care planning and consent to recommended interventions and services.

23. Describe the process for coordinating care with counties for enrollees on non-EW waivers.

24. Describe the process of developing and employing protocols to facilitate annual physician visits for primary and preventive care per the 2009 Model Contract, section 6.1.3 (B)(2).

25. Describe the process for care coordinators to communicate with county financial worker using DHS for #5181 per the 2009 Model Contract, section 6.1.3 (B)(7).
26. Describe the process for auditing of the care management system including how audits will be conducted for any subcontract entities as well as for systems administered directly by the MCO.

27. Describe the process for auditing care plans for Elderly Waiver enrollees, according to the 2009 Model Contract, section 7.8.3.

28. Describe the process for conducting the annual reviews of care system subcontractors and county care coordination systems, according to the 2009 Model Contract, section 9.3.10.

**Dental:**

29. Describe how the MCO will work to increase comprehensive oral health services in remote county locations, if proposing in rural areas.

30. Describe how the MCO can encourage and promote the expansion of services by dental providers to include the use of collaborative practice dental hygienists in settings outside of the traditional dental clinic.

31. Describe how the MCO will work to enroll more dental specialists, endodontists and periodontists to enhance their referral network.

32. Describe how the MCO will work to combine appointments for medical and dental services to maximize client time, promote oral disease prevention, provide comprehensive oral health services and improve MCO efficiencies in services.

33. Describe how the MCO will assure local access to dental services. Local services are defined as “within a 60 mile radius of the client’s home”.

**Chemical Dependency:**

34. Describe how the MCO will assure timely access to assessment and chemical dependency treatment services.

35. Describe how the MCO will assure chemical dependency treatment is individualized to meet enrollee's needs.

36. Describe how the MCO will address the needs of enrollees with chronic, relapsing symptoms of chemical dependency.

37. Describe how the MCO will serve new enrollees who are already in a chemical dependency treatment program that was authorized by another placing authority.

38. Describe how the MCO will encourage the screening of enrollees by their primary care clinics. Primary care clinics could make a real difference in their patients’ chemical health if they implemented routine screening for risk of alcohol or other drug use problems. There is a growing body of research supporting screening and brief intervention as effective public health measures and the Substance Abuse and Mental Health Services Administration (SAMHSA). A description of the Screening, Brief Intervention, and Referral to Treatment (SBIRT) model is available on the SAMHSA website at [http://sbirt.samhsa.gov/](http://sbirt.samhsa.gov/).
39. Describe how the MCO will serve chemically dependent clients with histories of previous treatments. Note how services to those with long and severe addiction histories (sometimes called “chronic alcoholics” or long-term addicts”) might differ from other, less experienced treatment repeaters.

40. Describe how the MCO will work with providers of enrollees’ treatment services to resolve MCO billing issues.

41. Providing a mentor has sometimes proven helpful to those clients who are moving between treatment phases or completing treatment. Describe how the MCO support this mentoring concept to support each client’s sobriety.

42. Describe the MCO’s plan for serving clients with co-occurring mental illness and chemical dependency. How will the MCO ensure that persons with these co-occurring disorders have their treatment needs met, including those needing services that are residential and supervised?

43. Describe the MCO’s plan regarding detoxification services. How will the MCO ensure that clients receive all medically necessary detox services?

**Mental Health**

44. Describe the steps and approaches the MCO is taking to assure timely access to psychiatric and psychopharmacologic treatment of person with a mental illness (given the shortage of psychiatrists and other mental health professional prescribers).

45. Describe the MCO’s operational definition of medical necessity for behavioral health (MN statutes 62Q.53) and give a specific example of how this definition is used to provide behavioral health services to enrollees.

46. Describe what specific steps the MCO is taking to better integrate services for enrollees with dual disorders since national research data indicates that approximately 50 percent of persons who have a serious mental illness have a co-occurring substance use/abuse disorder.

47. Describe how the MCO will coordinate the health care (including mental health services) with social services for better client outcomes, since some of the MCO enrollees may need non-health care services which are provided by the county.

48. Describe what role the MCO plays in the event of a court commitment for a mental illness.

49. Describe the steps and approaches the MCO is taking to collaborate with the Adult Mental Health initiatives in service planning, or in developing contractual agreements with community based health providers for persons with mental illness.

50. Describe how the MCO will encourage and support mental health screening by primary care providers and physical health screening by case managers/care coordinators.

51. Describe how the MCO will improve access to psychiatry services.

52. Describe how the MCO will address the monitoring of psychotropic medication and medications prescribed by the client’s primary care physician and the effects of each on the client’s overall health.
HOME HEALTH, PCA, ELDERLY WAIVER, AND NURSING FACILITY SERVICES

53. Describe how the MCO will provide Home Health, PCA, and Elderly Waiver services to the enrollee as listed and described in the 2009 Model Contract, section 6.1.11 and 6.1.14.

54. Describe how the MCO will provide Nursing Facility services to the enrollee as described in the 2009 Model Contract, section 4.21.

55. Describe how the MCO will promote and assure service accessibility of Home Health, PCA, and Elderly Waiver services.

56. Describe how the MCO will promote and assure service accessibility of Nursing Facility services.

57. Describe the procedures and criteria for making referrals to Home Health and PCA providers.

58. Describe the procedures and criteria for making referrals to Elderly Waiver providers.

59. Describe the procedures and criteria for making referrals for Home Health, PCA, and Elderly Waiver services outside of the MCO’s provider network when providers are unavailable or inadequate within the MCO’s provider network to meet an enrollee’s needs.

60. Explain how MCO will transition EW enrollees who are non-English speaking, including the plan for educating and transitioning EW enrollees who are non-English speaking and the plan for monitoring their continued access to culturally appropriate care and services.

61. Describe how the MCO will monitor the Home Health, PCA, or Elderly Waiver provider network for access to culturally appropriate care and services.

62. Describe the MCO’s service authorization and medical necessity requirements as they pertain to Home Health, PCA, and Elderly Waiver and Nursing Facility Services, including:
   a. all services that require service authorization;
   b. how service authorization requests will be submitted;
   c. time-line the MCO will follow;
   d. how the MCO will record all requests and the disposition of each; and
   e. the MCO’s definition of medical necessity and how the MCO will assure that Elderly Waiver services are exempted from that definition.

63. Describe access to and service authorization of nursing facility service under the extended coverage of 180 days.

64. Describe how the MCO(s) will continue to address the needs of nursing home residents under the extended benefit of 180 days of nursing facility coverage.

65. Describe the process to educate Home Health, PCA, and Elderly Waiver providers on MCO billing practices and how to bill the MCO for services.

66. Describe the transitional plan the MCO will follow for providing primary and acute care services, Home Health, PCA, and Elderly Waiver or Nursing Facility services that were prior authorized for an Medical Assistance enrollee under fee-for-service by the STATE or by another MCO prior to the
enrollee's enrollment in the MCO. Explain how special provider care system arrangements with physicians will be maintained for members who were served by those systems under a previous MCO.

67. Describe the process to be used for transitions on and off the Elderly Waiver program and for transitions between the Elderly Waiver program and other waivers (e.g., CAC, CADI, MR/RC, and TBI waiver programs).

68. Explain how the MCO maintains and monitors the network of contracted Home Health and PCA providers and nursing facilities to ensure that adequate access of covered services will meet the needs of the population served.

69. Describe the MCO’s processes related to Elderly Waiver subcontracting as specified in the 2009 Model Contract, section 9.3.23.

70. Describe the MCO’s processes related to Nursing Facility subcontracting as specified in the 2009 Model Contract, section 9.3.24.

**TRANSPORTATION**

71. Describe how the MCO(s) will coordinate services between the County Local Access Plan and the MCO(s) to meet the needs of the individual, especially for out-of-county transportation. Access issues include methods to reach persons without phones, transportation services or support in making/keeping appointments.

72. Describe how the MCO(s) will assure that there is a network of specialized transportation to meet the needs of the recipients within the county. The network needs to include non-emergency medical transportation with wheelchair lift equipped vehicles and emergency transportation.

73. Describe how the MCO(s) could facilitate administration of the transportation services and perhaps provide incentives for special needs and handicap services.

**PUBLIC HEALTH**

74. Describe how the MCO(s) will use Public Health’s expertise in serving the MSHO population.

75. Describe how the MCO(s) will develop a contractual relationship with County Public Health. The contract must clearly delineate the criteria for referral to the public health agency and the specific services the public health agency is authorized to provide.

76. Describe how the MCO(s) will monitor specific health indicators, outcomes, and other specific data needs to be shared between the MCO(s) and public health.

**County Service and Delivery Issues:**

77. Describe how the MCO will provide appropriate, qualified, and accessible interpreters. Describe how the MCO will encourage providers to use MCO’s interpreters. Describe the MCO process to coordinate with county services for interpreters.
78. Describe how the MCO will work with the counties to identify gaps in services. What role will the MCO play in closing those gaps, especially if the need is not medical, but instead a very necessary Social Service?

79. Describe how the MCO will work with the counties and providers to improve communication for access, advocacy, and dispute resolution.

80. Describe how the MCO will provide additional outreach services to the special needs populations to ensure persons have information about services available. These methods should include procedures to reach persons without phones, persons with a need for interpreter services, and persons without transportation services as well as strategies to provide support in making/keeping appointments.

81. Describe how the MCO will assist the county advocates in the resolution of billing and coverage issues? (Issue- advocate calls in through the customer services line and gets someone different each time, so additional time is taken for the representative to review the information and then try to move on with the issue. One contact was available for a short time by an MCO and that worked very well.)

82. Describe how the MCO will enhance current provider enrollee choice by incorporating local (in-county) providers who provide evening hour care after 5:00 p.m. and ample appointment times for clients to ensure timely, sufficient care.

83. Describe how the MCO will address network coverage for clients in need of a large provider network area.

84. Describe how the MCO will assist clients when the client is not enrolled timely in the MCO resulting in a break in services. Examples include; when county healthcare cases are not processed by the time capitation occurs, or, the ‘system’ erroneously enrolls the client in the MCO not of their choosing, or, a break in service occurs when a client moves from one county to another prior to selecting a new clinic.

85. Describe how the MCO will assist clients who are receiving non-formulary prescription drugs when they enroll in the MCO. Some clients report problems when there is no generic equivalent to their prescribed medication.

86. It is becoming increasingly difficult for clients to have vision services covered if there isn’t a dramatic change in their present condition. Describe how the MCO will provide for vision services for clients who may not have a dramatic prescription change but warrant prescription coverage in order to maintain self sufficiency and optical health.
APPENDIX K: SPECIFICATIONS FOR PROVIDER NETWORK INFORMATION FOR MSHO

Before the State can sign a contract with any entity to serve this population, the entity must have MDH approval for its service area.

Submit network information electronically on a CD. Provide a separate listing for each provider type specified below. A sample Excel field format is included on the following page letter. The report requires up-to-date comprehensive provider network information. The State will be mapping this information using geographical software to review the MCO’s network access and capacity. The State may request to see proof of contract status (e.g. contracts, signature pages) for any or all provider types.

Submit the provider network report for Elderly Waiver Services, Personal Care Provider Organizations and Nursing Facility Services under the MSHO program, according to the 2009 Model Contract, section 3.5.2.D. Provider Information:

Report Specifications:

- Use your most current version of Excel.
- Use field names identified in the sample below, you may designate appropriate field length, field order, and report sort that best accommodates your raw data.
- Identify the County where the provider is located.
- Identify the name of the practice, clinic, entity, or use the provider name if a practice name does not exist (for an independent provider).
- Identify the individual provider's last name.
- Identify the individual provider's first name.
- An alpha/numerical street address (physical location) must be used. Use standard abbreviations; Street (St), Avenue (Ave), North East (NE), etc. Do not use PO Box numbers, Room numbers, or Suite numbers.
- Identify the city where the practice is located. Use standard abbreviations.
- Zip codes can be 5 or 9 digits.
- Identify the individual provider service. Covered Elderly Waiver services are listed and described in the 2009 model contract, section 6.1.11.
- To minimize report size, create a zip file.
- Title reports with: MCO’s Name, Program Name (Enrollee Population(s)), County Name and Date.
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<th>Hospital</th>
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For example:

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CARLETON COUNTY

No information submitted.
No information submitted.
KOOCHICHING COUNTY

No information submitted.
LAKE COUNTY

COUNTY SERVICE DEVELOPMENT AND ACCESS ISSUES FOR SNBC
2009

LAKE

1. County administration:

<table>
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<th>Agency name:</th>
<th>Lake County Human Services</th>
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<tbody>
<tr>
<td>Director's name:</td>
<td>Dennis R. Henkel</td>
</tr>
<tr>
<td>Address:</td>
<td>616 Third Avenue</td>
</tr>
<tr>
<td></td>
<td>Two Harbors, MN 55616-1518</td>
</tr>
<tr>
<td>Telephone #:</td>
<td>218-834-8415</td>
</tr>
<tr>
<td>Fax #:</td>
<td>218-834-8412</td>
</tr>
</tbody>
</table>

2. County agency contacts:

<table>
<thead>
<tr>
<th>Area of Responsibility</th>
<th>Name</th>
<th>Title</th>
<th>Telephone #</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Services-</td>
<td>Amy Stark</td>
<td>Social Services Supervisor</td>
<td>218/834-8426</td>
</tr>
<tr>
<td>Disability Services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Area</td>
<td>Mike Duffy</td>
<td>Public Health Supervisor</td>
<td>218-834-8406</td>
</tr>
<tr>
<td>Mental Health – Adult</td>
<td>Amy Stark</td>
<td>Social Services Supervisor</td>
<td>218/834-8426</td>
</tr>
<tr>
<td>Chemical Dependency</td>
<td>Vickie L. Thompson</td>
<td>Social Services Supervisor</td>
<td>218-834-8408</td>
</tr>
<tr>
<td>Transportation</td>
<td>Kay Larson</td>
<td>Family Services Aide</td>
<td>218-834-8464</td>
</tr>
<tr>
<td>Eligibility-MA</td>
<td>Bonnie Swan</td>
<td>Income Maintenance Supervisor</td>
<td>218/834-8407</td>
</tr>
</tbody>
</table>

3. County Geographic and Demographic Characteristics

Lake County is located on the North Shore of Lake Superior and is the fourth-largest county in the state in area but not population. Our population is estimated to be approximately 11,060 year-round residents. The largest city in the county is Two Harbors, the County Seat, with a population of approximately 3,600 persons; the second largest city is Silver Bay with approximately 2,000 persons.

The population of the county is predominately White Persons (98.6%); the remaining 1.4% of the population includes American Indians, Black Persons, Asian Persons and Hispanic Persons. English is the primary language spoken in Lake County. In 2004, the poverty level for children was 11.5%; the poverty for all ages was 7.7% in 2004.

The number of residents age 65 and older living in Lake County is 20.8% and the population under age 18 is 22.9%. The population between the ages of 18 and 64 is 56.3%; females makeup 50.5% of Lake County residents.

The County’s labor force is estimated to be about 6,100 persons. The average median income in 2004 was $45,400.00. The current unemployment rate is 4.1%

Lake County has, for the most part, a small and widespread population covering a large area. Transportation for medical care (and areas of trade) can be challenging for residents unable to drive because of health and ability issues, those who don’t drive or have unreliable vehicles and those who cannot afford a vehicle.

4. County Service Delivery and Access Issues

Lake County covers a wide area with several towns and villages with sparse populations. We are a rural county with sizeable distances between most towns and villages. A portion of the population is low income and many of the residents living in outlying areas of the county, as well as those living in towns and villages receive public assistance, and don’t have or can’t afford their own transportation. We also have those residents who are aged and/or disabled and unable to drive. All of these
factors create transportation issues within Lake County. Lake County contracts with AEOA to provide volunteer drivers and the AEOA bus to provide transportation in certain areas of the county. Our Family Services Aide works with case managers to set up transportation for clients receiving waivered or alternative care services.

For clients who are members of a Managed Care Organization (MCO), the MCO is expected to provide transportation as part of their client services through their own Care Coordinator and resources and collaborating with our contract providers. MCOs have access to the Lake County provider network and they are encouraged to use those providers as needed such as volunteer drivers and the AEOA bus. Not all MCOs are providing cost effective transportation for clients. Financial Workers arrange volunteer drivers for clients who need transportation to medical appointments and who are not eligible for MCO transportation.

One issue that negatively affects the delivery of services and causes undue hardship on local government is the cost of mailing out thousands of MCO marketing materials to clients whenever new clients are enrolled, when clients transfer in from another geographic location or during the open enrollment period. The high cost of these packets is due to the extensive, heavy and expensive marketing materials that each MCO includes; because there is no cost to MCO(s), there is no incentive for MCO(s) to restrict packet size and weight.

a. Primary Care and Primary Care Providers:
   - Lake View Memorial Hospital-Two Harbors
   - Lake View Clinic-Two Harbors
   - Bay Area Health Center-Silver Bay

b. Specialty Networks and providers especially for unusual or low incidence conditions for people with disabilities:
   Home Care and PCA Agencies:
   - SuperiorHealth Community Care-Two Harbors
   - Interim Health Care-Duluth
   - Heartland PCA-Duluth
   - Regency-Duluth
   - Accend Services-Duluth
   - Center for Independent Living Skills-Duluth
   - Life’s Companion-Duluth
   - RSI-Duluth
   - ARC Northland-Duluth

c. Critical Care System:
   - Lake View Memorial Hospital Emergency Room

d. Durable medical equipment (DME) network and home delivery systems:
   Supply Companies:
   - Lake Superior Medical Supplies-Duluth
   - Midwest Medical Supplies-Duluth

e. Pharmacy:
   - SuperiorHealth Pharmacy-Two Harbors
   - SuperiorHealth Pharmacy-Silver Bay

f. Interpreter – Taken from the 2009 Lake County Limited English Proficiency Plan (LEP):

303 Uncommon Languages - There may be circumstances when customers present for services who use a language other than that most commonly used in Lake County. There may be languages such as Russian, Hmong, Vietnamese, Khmer/Cambodian, Lao, Somali as well as sign language need. Receptionist staff will refer all such cases to the Financial Services Supervisor, Social Service Supervisor or Director. This person will be responsible for trying to determine what the customer’s language or country of origin. Once determined, contact will be made with an appropriate interpreter in the customary manner.

304 Affirmative Action - The LCHS employee handling the case will inform either the customer or the interpreter once it has been determined that interpreter services are needed, that there is no charge or fee for the service. This will be communicated in verbal form. At no time in the service delivery process will the customer incur any costs associated with LEP-directed interpreter services.

306 Competency Standards for Interpreters - Any interpreter used for LEP services must be bi-lingual: fluent in English and fluent in the language of the customer needing the service, and be able to convey information in both languages accurately, have had orientation/training that includes the skills and ethics of interpreting, have basic knowledge in both languages of specialized program terms or concepts, and be sensitive to the client’s culture. When using professional interpreter services provided from a recognized agency, such as the Superior Translations and Language Line Services, competency is presumed. When using family, friends or significant others, the intake worker must make a judgment as to the competency of the proposed interpreter. “Certification” as an interpreter is not a pre-requisite.

5. Describe the services provided by the county for the eligible population in the following categories. Be sure to describe the network of providers for each category of service.

a. Mental Health Services – Adult
The Human Development Center is primary provider within Lake County serving adults with mental illness. They have offices in both Two Harbors and Duluth with office hours available at the Lake County Service Center in Silver Bay making it possible for more clients to access services. In addition to HDC, there are three other providers offering Adult Rehabilitative and Mental Health Services (ARMHS) locally – Nystrom Associates, Accend Services and RSI. These
services promote psychiatric stability, social competencies, personal and emotional adjustment, independent living and community skills when impaired by symptoms of illness and medication management. Clients are offered a choice of providers and accessing services is not an issue. There are generally not enough mental health professionals to meet the needs of some clients in a timely fashion. Psychiatrists, Advanced Practice Nurses and Psychologists are of limited supply locally and statewide.

Emergency mental health holds have historically been handled primarily by Miller-Dwan Medical Center in Duluth; however, we have occasionally used St. Luke’s Hospital also. The MCO(s) must describe how they will work with the County, which is the local Mental Health Authority, to provide and coordinate services involving the court system including pre-petition screenings, evaluations, commitment proceedings and other issues including court-ordered treatment. The MCO(s) must indicate how it will work with the county to provide timely response and sharing of necessary information and be present at court hearings if necessary. Lake County, together with HDC staff, provides coordination for adult mental health services. The MCO should describe how current services, including use of county case managers, will allow for continuity of client care in this area to maximize community integration/reintegration.

There is a population of adults with serious and persistent mental illness that are not MA eligible but require significant services to keep them stabilized in community care. The MCO(s) is requested to address how assistance with the cost of those services might be addressed, as ultimately having lower cost community services will save MA dollars if hospitalizations are minimized.

b. Providers
- Human Development Center, Two Harbors, Silver Bay (specific hours only) and Duluth
- Accend Services, Two Harbors (ARMHS only)
- Nystrom Associates, Two Harbors (ARMHS only)

c. Chemical Dependency Services
Chemical Dependency treatment services are available within the county to meet many of the needs of clients seeking chemical dependency treatment. Lake View Memorial Hospital provides detoxification, chemical dependency assessments, Consolidated Chemical Dependency Treatment Fund (CCDTF) outpatient treatment and urinalysis testing services. The Center for Alcohol & Drug, Inc. in Duluth provides detoxification and Rule 25 Assessment services.

Services such as half-way house services after primary CD treatment are not available in Lake County. St. Louis County is the closest and most accessible area for Lake County residents. Depending on availability of space, it is occasionally necessary to send clients to areas more distant than St. Louis County.

Issues that exist in serving this group have been the explosion in the use of methamphetamines. Treatment of meth addicts is said to be lengthier and consequently more expensive. Programs that deal specifically with methamphetamine addiction are not readily accessible. The MCO(s) responding to this RFP will need to work with the county to assure that treatment is appropriate to those adults.

Lake County would like to collaborate with the MCO(s) in the delivery of CD services. The MCO(s) are asked to describe how they will coordinate with the County and current providers to maintain continuity of care and focus on goals of early intervention and community based services. The County requests that the MCO(s) describe how they will work with other community organizations and school districts on the development of the chemical health care delivery system.

d. Providers
  Rule 25 Assessments, Outpatient Treatment Providers and Detoxification
  - Lake View Memorial Hospital, Two Harbors
  - Center for Alcohol & Drug, Inc., Duluth

  Inpatient Treatment Providers, Extended Care (60 to 90-day program provided by CARE)
  - Miller-Dwan Medical Center, Duluth
  - Community Addition Recovery Enterprise (CARE), Cloquet, Brainerd, Willmar and St. Peter

  Halfway House:
  - Port Rehab, Duluth

  Adult Foster Care, Adult Day Care and DT&H
  - The Cottages (Adult Day Care)
  - Nicholson’s Adult Foster Home
  - At Home Living
  - DRCC
  - My House in Two Harbors
  - South Harbor
  - Lake County DAC (DT&H)

e. Nursing Facility Benefit:
The goal of Lake County is to have persons who are elderly and disabled live in the least restrictive environment that meets the person’s health and safety risks. This means that the nursing facility is the final choice for the care of the individual. There is more focus on the development of customized living and adult foster care options, as these should be less costly and often meet the needs of the person.

f. **Transportation**

Lake County is served by Arrowhead Economic Opportunity Agency (AEOA), which is a public transit provider. AEOA provides bus transportation to residents of Lake County. Trained volunteer drivers are available through AEOA to provide MA recipients with medical transportation where necessary, both in and outside of Lake County. Lake County pays for transportation as necessary for open Social Services cases. Special transportation services are available to those who need them through Northern Access in Duluth. This transportation is usually arranged by a medical provider when ambulance transport is not required but the patient is too ill to travel by car. The cost of this transport is not usually covered by MA. The MCO(s) will need to address how they will coordinate services with AEOA whose transit coordinator currently coordinates MA and social service transportation for the county.

Transportation issues that the MCO(s) need to consider include reaching folks without phones and support in helping clients make appointments and then keep them. Access to specialist services outside the area for recipients, especially for the disabled population that require regular or multiple trips, has been difficult to arrange for with limited volunteer drivers.

Recently AEOA moved the transportation services coordination offices from Two Harbors to Grand Rapids. This presents some difficulty in coordinating travel for clients in need of volunteer drivers.

g. **Public Health Services**

Public Health duties and concerns in Lake County are handled by the in-house Public Health Unit. LCHS further contracts with SuperiorHealth Community Care to ensure additional help is available for Public Health, should it be needed. The County would encourage the MCO to partner with LCHS to address the local public health functions.

LCHS, through the Public Health Unit, provides these three Essential Local Public Health Activities as defined by Minnesota Statute. They are:

- Assure an adequate local public health infrastructure
- Promote Against Environmental Hazards
- Prepare for and respond to disasters and assist communities in recovery

Lake County Human Services, incorporating public health, provides services to county residents, the disabled of all ages, and the elderly over age 65 who are on Medical Assistance and have medical, mental health, or behavioral health needs to enable them to remain living in the community if they so choose. Services provided include Long Term Care Consultation (LTCC) by a two-person team consisting of a public health nurse (PHN) and a social worker for home care waiver programs and PCA assessments. PHN determination of appropriate level of care services functions to ensure clients receive optimal and cost effective care delivery to meet their needs. Quality and accessibility initiatives include: Long Term Care Consultation for Elderly Waiver, Alternative Care (and CAC, CADI and TBI).

h. **Home Health Agency Services**

- SuperiorHealth Community Care

i. **Identification of Local Public Health Goals**

Public Health duties and concerns in Lake County are handled by the in-house Public Health Unit. LCHS further contracts with SuperiorHealth Community Care to ensure additional help is available for Public Health, should it be needed. The County would encourage the MCO to partner with LCHS to address the local public health functions.

LCHS, through the Public Health Unit, provides the six Essential Local Public Health Activities as defined by Minnesota Statute. They are:

- Assure an adequate local public health infrastructure
- Prevent the spread of Infectious Disease (immunizations)
- Promote Against Environmental Hazards
- Promote healthy communities and healthy behaviors (WIC/Health Assessment clinics, MCH prenatal education, new mom visits, TANF youth programming)
- Assure the quality and accessibility of health services (Child/Teen outreach)
- Prepare for and respond to disasters and assist communities in recovery

Lake County Human Services, incorporating public health, provides services to eligible county residents to enable them to remain living in the community. Services provided include Long Term Care Consultation (LTCC) by a two-person team consisting of a public health nurse (PHN) and a social worker for home care waiver programs and PCA assessments. PHN determination of appropriate level of care services functions to ensure clients receive optimal and cost effective care delivery to meet their needs.
10. Other relevant information related to basic health care services for older adults in your county.  NONE
ST. LOUIS COUNTY

No information submitted.
APPENDIX M: SNBC ASSURANCES

The MCO(s) assures the following by initialing in the space to the left of each statement.

1. The MCO assures that they will provide the health care services listed in the model contract and the services further negotiated during contract negotiations. Contract language and services may change based on any new legislative or CMS requirements.

2. The MCO assures that it will limit enrollment to the dual eligible subset of people with disabilities as defined and provided by the State.

3. The MCO assures that it will provide information related to Medicare Advantage Special Need Plan (SNP) applications, additional benefits, contracts, bids, audits and SNP application amendments as described in the model contract.

4. The MCO assures that it will coordinate Medicare enrollment dates with Department of Human Services (DHS) enrollments according to the methods outlined in the model contract.

5. The MCO assures that it will submit marketing and member materials to the State and Regional Office for review and approval according to the model contract.

6. The MCO assures that it will comply with requirements under the 1997 Balanced Budget Act as specified in the contract for serving people with Special Needs. All members enrolled in SNBC plan are considered Special Needs.

7. The MCO assures that it will coordinate Medicare and Medicaid grievance and appeals procedures as allowed under CMS and State requirements.

8. The MCO assures that it will report Medicare disenrollment survey information to DHS.

9. The MCO assures that it is in current compliance with all applicable statutory and regulatory requirements for a licensed HMO under Minnesota Statutes, Chapter 62D, and Minnesota Rules, Parts 4685.0100 to 4685.3400.

10. The MCO assures that it has safeguards in place regarding conflicts of interest in purchases involving Medicaid funds, as required by Minnesota Statutes, section 256B.0914.

11. The MCO assures that the MCO and its providers will not discriminate against any enrollee on the basis of: race, sex, color, religion, health status, age, handicap, national origin, public assistance status, or sexual orientation.

12. The MCO assures that it will not set any enrollment limits on the number of SNBC enrollees it will serve and will expand its provider network should full capacity be reached.

13. The MCO assures that it will monitor and ensure appropriate access to services where the provider is limited, or where a service is only available through a sole source vendor (e.g. dental or mental health services).

14. The MCO assures that it will provide provider network updates as required by the State, whether there are deletions from or additions to its network.
15. The MCO assures that its provider network has been approved by CMS or that it has an application pending that meets CMS network requirements for Medicare covered services.

16. The MCO assures that it work collaboratively with the counties’ Public Health Agencies.

17. The MCO assures that it will work with the counties to address the following concerns:
   • Meeting the needs of people with disabilities;
   • Meeting the needs of Limited English Proficiency (LEP) populations;
   • Maintaining and improving client choice of providers;
   • Improving timely, non-emergency access to providers;
   • Improving prevention and early intervention services;
   • Coordinating American Indian Services with Indian Health Services and Tribal Health Services;
   • Improving the availability of psychiatrists and/or psychologists.

18. The MCO assures that it will participate as cooperative and collaborative members in the health care efforts with the counties.

19. The MCO assures that it will provide copies of CMS Health Plan Employer Data and Information Set (HEDIS) submissions and Consumer Assessment of Healthcare Providers and Systems (CAHPS) reports applicable to enrollees of the SNBC program.

20. The MCO assures that it will participate in collaborative efforts to design Performance Improvement Projects (PIPs) applicable to people with disabilities, taking into consideration DHS priorities.

21. The MCO assures that it will cooperate with the entity as arranged for by the STATE in an annual independent, external review of the quality of services furnished under the contract.

22. The MCO assures that it will meet the requirements for delegation for any delegated activities related to quality improvement.

23. The MCO assures that it will maintain documentation sufficient to support its care management responsibilities.

24. The MCO assures that it will provide that the STATE, CMS or their agents may evaluate through inspection or other means, the quality, appropriateness, and timeliness of services or administrative procedures performed under the contract.

25. The MCO assures that all incentives must comply with the federal managed care incentive arrangement requirements.

26. The MCO assures that it will take reasonable measures to determine third party reimbursement.

27. The MCO assures that it will have administrative and management arrangements or procedures, including a mandatory compliance plan, that are designed to guard against fraud and abuse.

28. The MCO assures that it will provide for enrollees’ rights as prescribed in the 2009 Model Contract.
29. The MCO assures that it will submit Medicare and Medicaid encounter data to DHS including Part D pharmacy data as outlined in the model contract.

30. The MCO assures that it will report mental health measures developed by the mental health outcomes measures workgroup as defined in the model contract.

31. The MCO assures that it will work with DHS workgroups to develop specialized utilization tracking and outcome measures appropriate to people with disabilities including those with mental illness, developmental disabilities and physical disabilities.

32. The MCO assures that it will ensure that SNP Part D formularies are appropriate to the needs of people with disabilities.

33. The MCO assures that it will submit Medication Therapy Management (MTM) descriptions, as required by the model contract.

34. The MCO assures that it will coordinate health plan services with public health and social services and participate on appropriate committees and subcommittees and through other appropriate means.

35. The MCO assures that it will develop effective way to communicate with the county staff and providers.

36. The MCO assures that it will support local case management systems and coordinate health plan services with this system.

37. The MCO assures that it will share data with counties as appropriate to support access to local services and health plan services.

38. The MCO assures that it will foster collaboration between the local provider community, MCO and county public health and social services.

39. The MCO assures that it will provide the consumers with timely (prior) notice regarding upcoming changes to their benefit sets, co pay amounts, prior authorization requirements, etc.

40. The MCO assures that it will be considerate and responsive to persons needing formulary drugs, versus generic. In particular, the MCO must describe how consumers can be assured that consideration will be given for new and or improved prescription medication (such as blood thinners) which their medical provider recommends as being more effective in treating their condition.

41. The MCO assures that it will submit to DHS all practice Guidelines adopted by the MCO upon DHS request.

42. The MCO assures that it will include specific strategies relevant to people with disabilities in Centers for Medicare & Medicaid Services (CMS) and State Quality Assurance plans and reports.
By signing this statement, you certify that the information provided is accurate and that you are authorized to sign on behalf of, and legally bind, the Responder.

Authorized Signature: ____________________________________________

Printed Name: ________________________________________________

Title: _________________________________________________________

Date: ___________________________ Telephone Number: ________________
APPENDIX N: PLAN DESIGN FOR SNBC

SERVICE AREA:

1. Clearly describe the requested service area in terms of the geographic subdivisions such as counties, cities or townships. Provide a detailed map (with a scale) of the complete service area showing the boundaries, main traffic arteries, and any physical barriers such as rivers.

2. If less than full counties are requested, provide justification for this request of partial counties. If not a full county, zip codes must be provided.

3. Submit a complete copy of the CMS SNP application on CD, including the approved or proposed network, description of clinical programs and other program description information required by CMS and any additional amendments to the application including additional information provided per the most recent version of the CMS Call Letter for 2010.

ADMINISTRATION:

4. Describe how the MCO(s) will enhance its customer/member services function to accommodate people with disabilities including:
   - Train staff to accommodate special needs of people with disabilities, including the ability to effectively communicate with individuals with mental health needs.
   - Assigning designated trained staff and back up staff to customer service calls from people with disabilities enrolled in this product.
   - How the MCO(s) staff will be trained on referring people to services covered by state agencies/counties and information on services not covered by the MCO, including carved out services.

5. Describe how the MCO(s) will establish stakeholder committees including people with disabilities and consumer advocates and include them in ongoing meaningful participation in MCO decision-making and advisory processes with the development of SNBC.

6. Describe how the MCO(s) will help ensure that the transition to managed care and the selection of primary care provider occurs smoothly.

7. Describe what mechanisms the MCO(s) will implement to identify and respond to people who need alternative communication approaches.

MARKETING

8. Describe the MCO’s marketing strategy for enrolling people with disabilities into SNBC.

9. Provide a copy of the MCO’s marketing plan as provided to CMS, with additions as needed for the Medicaid only population.

NETWORKS:
6. Describe how the MCO will provide access to primary care physicians and specialists with capacity to serve people with disabilities.

7. Describe how the MCO will educate enrollees on how to obtain prescription drugs and access benefits beyond the COC.

12. Describe how the MCO will promote and assure service accessibility. This includes services that are to be provided inside or outside the requested service area as long as health care services are accessible and available to enrollees.

13. Describe how the MCO(s) identifies and recruits providers. Explain how the MCO maintains and monitors the network of contracted providers (i.e. primary care physicians, specialists, hospitals, nursing homes, home health agencies, etc.) to ensure that adequate access of covered services will meet the needs of the population served.

14. Describe how the MCO(s) will assure a range of providers to allow for enrollee choice. The expectation is that the MCO(s) will have contracted with all or as many providers as possible to enhance enrollee choice in the service area.

15. Describe any recent changes in the MCO’s current operations affecting the MCO’s ability to provide services under the program.

16. Describe whether the MCO is using a primary care clinic or physician model, care system model, medical home model or other similar gate keeper mechanisms to coordinate primary and specialty care.

17. Explain the role of primary care physicians, how often members can change primary care clinics or care systems and what role specialists can play in these models.

18. Explain if all contracted providers are available to the enrollee on normal referral from the primary care physician or by self-referral or if there are sub-networks (e.g. based on the member’s selection or a primary care physician or care system) and consequently different procedures for accessing care within the sub-networks. Also, if a gatekeeper model is used; all services for which the member may self-refer should be clearly identified.

19. Describe how the MCO will update provider subcontracts to inform clinics and physicians about the special needs of people with disabilities served under SNBC.

20. Describe how the MCO will survey provider clinics for physical accessibility including availability of equipment and processes needed to provide examinations, preventive care and testing to people with disabilities. Explain how this survey information will be available to prospective members.

21. Describe how the MCO will provide training and orientation on SNBC and special needs of people with disabilities to be served for participating clinics.

22. Describe how the MCO has expanded its network to provide adequate specialty access for unusual or low incidence conditions.

23. Describe how the MCO has expanded its network to assure access to an array of DME providers commonly used by people with disabilities providing a broad array of specialty items.
24. Describe how the MCO will assure expedited determinations and home delivery options for wheelchair batteries, oxygen and respiratory equipment and other similar essential equipment for members who require them.

25. Describe how the MCO will assure that there is a network of specialized transportation providers to meet the needs of people with disabilities. The network needs to include non-emergency medical transportation with wheelchair lift equipped vehicles and emergency transportation.

26. Describe how the MCO will provide protocols for timely access to a variety of modes of transportation adequate to serve the needs of people with a wide range of disabilities.

27. Describe how the MCO will coordinate services between the County Local Access Plan and the MCO(s) to meet the needs of the individual, especially for out-of-county transportation. Access issues include methods to reach persons without phones, transportation services or support in making/keeping appointments.

28. Describe how the MCO contracts for home health care services and how adequate access to certified home health agencies with experience in serving people with disabilities will be achieved and maintained.

29. Describe provider contracting arrangements and access procedures for members who require nursing home and skilled nursing facility stays.

30. Describe how the MCO will identify the needs of members and communicate that information to providers in a timely manner.

**Dental:**

31. Describe how the MCO will work to increase comprehensive oral health services in remote county locations, if proposing in rural areas.

32. Describe how the MCO can encourage and promote the expansion of services by dental providers to include the use of collaborative practice dental hygienists in settings outside of the traditional dental clinic.

33. Describe how the MCO will work to enroll more dental specialists, endodontists and periodontists to enhance their referral network.

34. Describe how the MCO will work to combine appointments for medical and dental services to maximize client time, promote oral disease prevention, provide comprehensive oral health services and improve MCO efficiencies in services.

35. Describe how the MCO will assure local access to dental services. Local services are defined as “within a 60 mile radius of the client’s home”.

**Chemical Dependency:**

36. Describe how the MCO will assure timely access to assessment and chemical dependency treatment services.
37. Describe how the MCO will assure chemical dependency treatment is individualized to meet enrollee's needs.

38. Describe how the MCO will address the needs of enrollees with chronic, relapsing symptoms of chemical dependency.

39. Describe how the MCO will serve new enrollees who are already in a chemical dependency treatment program that was authorized by another placing authority.

40. Describe how the MCO will encourage the screening of enrollees by their primary care clinics. Primary care clinics could make a real difference in their patients’ chemical health if they implemented routine screening for risk of alcohol or other drug use problems. There is a growing body of research supporting screening and brief intervention as effective public health measures and the Substance Abuse and Mental Health Services Administration (SAMHSA). A description of the Screening, Brief Intervention, and Referral to Treatment (SBIRT) model is available on the SAMHSA website at [http://sbirt.samhsa.gov/](http://sbirt.samhsa.gov/).

41. Describe how the MCO will serve chemically dependent clients with histories of previous treatments. Note how services to those with long and severe addiction histories (sometimes called “chronic alcoholics” or long-term addicts”) might differ from other, less experienced treatment repeaters.

42. Describe how the MCO will work with providers of enrollees’ treatment services to resolve MCO billing issues.

43. Since most often the “chronic population” does not have primary care providers, describe how the MCO plans to address this population and obtain accurate information from the user in order to determine the most effective treatment of care.

44. Providing a mentor has sometimes proven helpful to those clients who are moving between treatment phases or completing treatment. Describe how the MCO support this mentoring concept to support each client’s sobriety.

45. Describe the MCO’s plan for serving clients with co-occurring mental illness and chemical dependency. How will the MCO ensure that persons with these co-occurring disorders have their treatment needs met, including those needing services that are residential and supervised?

46. Describe the MCO’s plan regarding detoxification services. How will the MCO ensure that clients receive all medically necessary detox services?

**Mental Health**

47. Describe the steps and approaches the MCO is taking to assure timely access to psychiatric and psychopharmacologic treatment of person with a mental illness (given the shortage of psychiatrists and other mental health professional prescribers).
48. Describe the MCO’s operational definition of medical necessity for behavioral health (MN statutes 62Q.53) and give a specific example of how this definition is used to provide behavioral health services to enrollees.

49. Describe what specific steps the MCO is taking to better integrate services for enrollees with dual disorders since national research data indicates that approximately 50 percent of persons who have a serious mental illness have a co-occurring substance use/abuse disorder.

50. Describe how the MCO will coordinate the health care (including mental health services) with social services for better client outcomes, since some of the MCO enrollees may need non-health care services which are provided by the county.

51. Describe what role the MCO plays in the event of a court commitment for a mental illness.

52. Describe the steps and approaches the MCO is taking to collaborate with the Adult Mental Health initiatives in service planning, or in developing contractual agreements with community based health providers for persons with mental illness.

53. Describe how the MCO will encourage and support mental health screening by primary care providers and physical health screening by case managers/care coordinators.

54. Describe how the MCO will improve access to psychiatry services.

55. Describe how the MCO will address the monitoring of psychotropic medication and medications prescribed by the client’s primary care physician and the effects of each on the client’s overall health.

**Care management and service delivery model**

56. Describe how the MCO will provide and arrange to provide the benefits described in the 2009 SNBC Model Contract to people with disabilities including how the MCO will manage and provide for special medical needs for people with disabilities.

57. Describe the MCO’s process for triggers, scheduling and follow up mechanisms to facilitate annual physician visits for all SNBC members.

58. Describe the MCO process for risk screening within 30 days of enrollment. Include copies of proposed tools, method of collecting information (eg. phone, email, mail, in person contacts), how the MCO will incorporate standardized elements to be required by the State, how mental health and chemical health issues will be identified, and how referrals for additional assessment, intervention or care management will be made based on screening information. Describe how the MCO(s) will periodically update enrollees health risk screening to identify changing health, functional, communication and to collect relevant member health information.

59. Describe the MCO’s procedures for follow up such as providing needs assessment; diagnostic assessment; the development of an individual treatment plan; establishment of treatment objectives; treatment follow-up; monitoring of outcomes; and revision of treatment plans as necessary.
60. Describe special arrangements in place to serve, and promote and assure service accessibility to all types of people with mental illness, people with developmental disabilities and people with physical disabilities including each group’s special needs.

61. Describe the MCO’s prior authorization and medical necessity requirements including:
   a. all services that require prior authorization;
   b. how prior authorization requests will be submitted;
   c. a timeline the MCO will follow;
   d. how the MCO will record all requests and disposition of each; and
   e. how the DHS definition of medical necessity will be applied.

62. Describe the transitional plan the MCO will follow for providing services that were prior authorized for an enrollee under fee-for-service by the State prior to the person’s enrollment in the MCO.

63. Describe how the MCO will provide for continuity of care. Include the process for assuring availability and accessibility of services within the MCO’s service area with reasonable promptness and in a manner which assures continuity of care.

64. Describe how the MCO will provide culturally appropriate care to enrollees of different backgrounds.

65. Describe how the MCO will provide for American Sign Language (ASL) and other communication alternatives for members who need these services during medical visits and to facilitate communication with the MCO.

66. Describe how the MCO will integrate Medicare and Medicaid service delivery to provide a seamless benefit set for from the perspective of the enrollee.

67. Describe the MCOs care management system including the following:
   • Describe the activities and responsibilities that are part of the care management process including:
   • Access to RN call line, 24/7/365.
   • Protocols for access to individual intermittent telephonic case management.
   • Protocols for access to ongoing intensive care management including face to face assistance.
   • The methods for identifying people for care management.
   • Triage criteria for access to various case management levels
   • The qualifications for case managers
   • Contracts or staffing mechanisms for case management (eg by plan, care system or contracts with counties)
   • How the care management system will coordinate both Medicare and Medicaid service
   • How the care management system facilitates communication between physicians, case managers, mental health providers and other medical services provided by the plan
   • How the care management system will communicate with social and other services provided outside of the plan.
   • How care management functions will meet the special needs of people with mental illness, people with developmental disabilities, and people with physical disabilities

68. Describe how care management functions may differ for people in nursing homes, group residential housing or ICFs-MR, people receiving home and community based services.
69. Describe how staff involved in care management and health plan staff will communicate with staff of home care agencies, nursing homes, group homes, residential housing settings and ICFs-MR on an ongoing basis to accommodate the needs of members living in those settings and served by those providers.

70. Describe how the MCO will make available and provide self management materials and information designed to assist people with disabilities to manage their chronic conditions.

71. Describe how the MCO will design intervention strategies for people with key medical conditions common among people with disabilities that often lead to hospitalizations or deteriorating medical conditions such as skin breakdown, urinary tract infections and the need for prescription drugs, especially those for mental health diagnoses.

72. Describe how the MCO will utilize and incorporate strategies for prevention of hospitalizations and functional deterioration into care provision and care management.

73. Describe the process for obtaining member input on satisfaction with individual care manager services.

74. Describe the process for the care management staff to obtain information on recommendations made by nurses staffing after-hours advice lines.

75. Describe the strategies for providing disease management for members with multiple chronic illnesses or conditions.

76. Describe the MCO’s capacity and process for implementing other related care management functions, such as screening for special needs (e.g. mental health and/or chemical dependency problems, mental retardation, high risk health problems, difficulty living independently, functional problems, language or comprehension barriers, need for rehabilitation); individual treatment follow-up; monitoring of outcomes; or revision of treatment plans.

77. Describe how disease management protocols will be chosen, developed or adapted to be applicable to the special needs of people with disabilities.

78. Describe the procedures and criteria for making referrals to providers including specialists.

79. Describe the procedures and criteria for making referrals for services outside of the MCO’s provider network when providers are unavailable or inadequate within the MCO’s provider network to meet an enrollee’s needs.

80. Describe how the MCO will ensure that enrollees and/or authorized representatives are involved in the treatment planning and consent to medical treatment.

81. Describe how the MCO will work with the health care recipients and providers to ensure that patients are accessing emergency care (emergency rooms) appropriately. MCO should describe how they will educate enrollees on the appropriate use of emergency rooms for services, utilization of urgent care, and when it is appropriate to access emergency services.
82. Describe the method of coordinating the medical needs of an enrollee with his/her social service needs and how the MCO will work with the local social service agency and other community resources in the community.

83. Describe how the MCO will establish HIPPA safe electronic communication protocols with county and social service providers designed to coordinate medical care with other services.

84. Describe how the MCO will communicate to the county waiver case manager the home care services that have been authorized by the MCO.

85. Describe how the MCO will communicate to counties a contact person the county case manager can contact to get information regarding the MCO’s authorization for home care services.

86. Describe access to and service authorization procedures for skilled and custodial nursing facility services under the 100 day coverage for Medicare and Medicaid.

87. Describe the procedures for coordinating care for American Indian enrollees.

88. Describe the procedures for coordinating with IEP/IFSP services and supports.

89. Describe the MCO’s contractual relationship with County Public Health. The contract must clearly delineate the criteria for referral to the public health agency and the specific services the public health agency is authorized to provide.

**County provided specific questions**

90. Given the need for providers who have the knowledge, skills and values to provide basic health care benefits for adults with a mental illness, developmental disability or physical disability – how will the MCO ensure that the MCO’s network meets this need? How will clients and county case managers be provided information about the approved providers?

91. How will the MCO arrange their system so that clients and their county case managers are able to obtain timely access to health care needs so that they do not have to jump through difficult “hoops”?

92. What will the MCO incorporate in their system so that the necessary coordination occurs between the health care service system and the county social services, particularly case management services?

93. How will the MCO address the problems of insufficient access for these populations to:
   - dental
   - psychiatric
   - podiatry

94. How will the MCO provide a fast resolution dispute system?

95. How will the MCO address the issues of racial disparities for clients of color? How will the MCO address limited English proficiency for clients?

96. How will the MCO assure a culturally responsive health system?

97. Will the formulary restrict what psychiatric medications a person can access? Will there be co-pays
County Service and Delivery Issues

98. Describe how the MCO will provide appropriate, qualified, and accessible interpreters. Describe how the MCO will encourage providers to use MCO’s interpreters. Describe the MCO process to coordinate with county services for interpreters.

99. Describe how the MCO will work with the counties to identify gaps in services. What role will the MCO play in closing those gaps, especially if the need is not medical, but instead a very necessary Social Service?

100. Describe how the MCO will work with the counties and providers to improve communication for access, advocacy, and dispute resolution.

101. Describe how the MCO will provide additional outreach services to the special needs populations to ensure persons have information about services available. These methods should include procedures to reach persons without phones, persons with a need for interpreter services, and persons without transportation services as well as strategies to provide support in making/keeping appointments.

102. Describe how the MCO will assist the county advocates in the resolution of billing and coverage issues? (Issue- advocate calls in through the customer services line and gets someone different each time, so additional time is taken for the representative to review the information and then try to move on with the issue. One contact was available for a short time by an MCO and that worked very well.)

103. Describe how the MCO will enhance current provider enrollee choice by incorporating local (in-county) providers who provide evening hour care after 5:00 p.m. and ample appointment times for clients to ensure timely, sufficient care.

104. Describe how the MCO will address network coverage for clients in need of a large provider network area.

105. Describe how the MCO will assist clients who are receiving non-formulary prescription drugs when they enroll in the MCO. Some clients report problems when there is no generic equivalent to their prescribed medication.

106. It is becoming increasingly difficult for clients to have vision services covered if there isn’t a dramatic change in their present condition. Describe how the MCO will provide for vision services for clients who may not have a dramatic prescription change but warrant prescription coverage in order to maintain self sufficiency and optical health.
APPENDIX O  GUIDING PRINCIPLES

Please describe in detail with appropriate examples, how the MCO practices will be consistent with the following principles for serving people with disabilities.

TO DESIGN, IMPLEMENT, EVALUATE AND IMPROVE SERVICES FOR PERSONS WITH DISABILITIES

RELATIONSHIP
   Relationships are promoted, nurtured and honored so that people with disabilities are able to plan with and be supported by those who know and care about them.

COORDINATION
   Primary and acute healthcare and community supports are provided seamlessly so that the quality of life for people with disabilities is maintained and enhanced.

AUTHORITY AND RESPONSIBILITY
   People with disabilities have control over and accept the consequences of their decisions regarding their support and services so that choice and risk are balanced within their lives.

EQUITY
   A common method is used for assessing needs and assigning resources so that people with disabilities with similar needs have access to comparable resources.

HEALTH AND SAFETY
   Health and safety protections are established to balance each person’s vulnerabilities, right to accept reasonable risk, and responsibility to society.

FLEXIBILITY
   System design and funding are flexible so people can develop support in ways that best meet their needs.

CULTURAL DIVERSITY
   Information, communication, support and services are developed and delivered in a culturally relevant context.

TRANSPARENCY
   Service options, outcomes, regulations and funding are understandable so people with disabilities can make informed decisions and the public can evaluate the system.

HEALTHCARE
   Health care is delivered by clinicians with experience serving people with disabilities and the care provided is based on early intervention, prevention and management of chronic conditions.
APPENDIX P: SPECIFICATIONS FOR PROVIDER NETWORK INFORMATION FOR SNBC

Submit network information electronically on a CD. Provide a separate listing for each provider type specified below. A sample Excel field format is included on the following page letter. The report requires up-to-date comprehensive provider network information. The State will be mapping this information using geographical software to review the MCO’s network access and capacity. The State may request to see proof of contract status (e.g. contracts, signature pages) for any or all provider types.

If you have separate provider networks for specific enrollee populations, send a separate provider network report for each population.

Report Requirements:

- Use your most current version of Excel.
- Use field names identified in the sample below, you may designate appropriate field length, field order, and report sort that best accommodates your raw data.
- Identify the County where the provider is located.
- Identify the name of the practice, clinic, entity, or use the provider name if a practice name does not exist (for an independent provider).
- Identify the individual provider's last name.
- Identify the individual provider's first name.
- An alpha/numerical street address (physical location) must be used. Use standard abbreviations; Street (St), Avenue (Ave), North East (NE), etc. Do not use PO Box numbers, Room numbers, or Suite numbers.
- Identify the city where the practice is located. Use standard abbreviations.
- Zip codes can be 5 or 9 digits.
- Identify the individual provider or practice specialty (be as specific as possible). Your report can also include pharmacies, transportation, and interpreter providers even though these providers were excluded in contract language.
### Specialty Practice Name

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<th>Specialty</th>
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<th>Provider Last Name</th>
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<th>Street Address</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
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<td>Nutrition</td>
<td>Psychiatry (MD)</td>
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<td>Speech therapy</td>
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<td>Orthopaedic</td>
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- To minimize report size, create a zip file.

Title reports with:
MCO’s Name, Program Name (Enrollee Population(s)), County Name and Date

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<tr>
<th>State</th>
<th>County</th>
<th>Specialty</th>
<th>Practice Name</th>
<th>Provider Last Name</th>
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<th>State</th>
<th>Zip Code</th>
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APPENDIX Q: QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAM

To be completed for both MSHO and SNBC

1. Describe recent change(s) in the MCO's Quality Assessment and Performance Improvement Program that has resulted in real and sustained improvements in the care and services provided to enrollees with special needs.

2. What action has the MCO taken in response to findings (recommendations, mandatory improvement and deficiencies) indicated in the most recent MDH QA Examination? In addition, describe the changes in your quality improvement processes as a result of the recommendations made in the most recent Annual Technical Report by the External Quality Review Organization.

3. How has the MCO within the last year acted upon consumer feedback from grievances and appeals, or consumer/provider satisfactions surveys?

4. Describe how issues identified by County Public Health and Social Services organizations and the Long Term Care Gaps Analysis, conducted by the Department’s Continuing Care Administration, are integrated into the MCO's Quality Assessment and Performance Improvement Program for MSHO and/or SNBC.
Number of Medicaid fee - for - service beneficiaries eligible for SNBC, by county, as of February 27, 2009

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Number of Medicaid fee - for - service beneficiaries eligible for SNBC, by county, as of February 27, 2009

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Number of Medicaid fee-for-service beneficiaries eligible for SNBC, by county, as of February 27, 2009

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Number of Medicaid fee-for-service beneficiaries eligible for SNBC, by county, as of February 27, 2009

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Total 78,009