2003 INNOVATIONS AWARDS PROGRAM
Application Form

1. Program Name

   Minnesota Disability Health Options

2. Administering Agency

   Minnesota Department of Human Services

3. Contact Person (Name & Title)

   Pamela J. Parker

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8. Please provide a two-sentence description of the program.

   Minnesota Disability Health Options (MnDHO) is a unique managed health care program, operating under agreements between the State and Federal government and through a partnership between a provider care management organization and a sponsoring health plan, that integrates Medicaid and Medicare financing and primary, acute and long-term care for people with physical disabilities, aged 18-64, living in either institutional or community settings. All MnDHO enrollees are assigned an R.N. health coordinator, who helps enrollees navigate the complex health care system, live more independently, and maintain their health.

9. How long has this program been operational (month and year)?

   MnDHO has been operational for one year, seven months, since implementation in September 2001. Medicare was integrated into MnDHO beginning in November 2001.

10. Why was the program created? (What problem[s] or issue[s] was it designed to address?)

    Medicaid-eligible people with physical disabilities typically have multiple chronic conditions that require care from a large number of providers including specialty and primary care physicians and clinics, durable medical equipment suppliers, and long-term care providers. Although Minnesota's Medicaid benefits are relatively comprehensive offering free choice among many providers, people with disabilities face the challenges of coping with a complex and fragmented medical system on top of the many difficulties inherent in living day to day with severe physical disabilities. Many are dually eligible for both Medicaid and Medicare. Neither Medicaid nor Medicare offers them assistance in navigating a complex health care system that requires managing the many financial and coverage interactions between the two payors as well as the logistics of multiple relationships and appointments with multiple providers.

    Furthermore, primary care providers often lack experience and expertise with disabilities and many people with disabilities do not receive regular primary care for basic health maintenance. Lack of flexibility in the Medicare and Medicaid benefits also means that people with physical disabilities often lack access to simple and basic non-medical services and equipment that could help them remain independent and living in the community, for example, nutritional supplements, massage therapy, stair glides, and others. The result is fragmented, haphazard health care and inadequate preventive care for people with physical disabilities, too often resulting in nursing home placement and further deterioration of health. Focus groups of people with disabilities have underscored the need for assistance in navigating, coordinating and accessing this complex healthcare system and for better management of primary, acute and long-term care services.

    Although Minnesota has offered some case management services for people with disabilities, few people with physical disabilities qualify for or access them. Additionally, while various programs manage some long-term care services for clients, none also manages clients' medical care.

    Minnesota has had success with a managed care program for seniors age 65 and over, Minnesota Senior Health Options (MSHO), which combines Medicaid and Medicare financing to provide a comprehensive range of health and support services under an unusual agreement with the federal Centers for Medicare and Medicaid Services (CMS). Enrollment in MSHO is voluntary. MSHO also includes coordination of all aspects of individuals' health care – primary and acute medical care as well as long-

term care services. Implemented in 1997, MSHO has an enrollment of about 5,000 individuals, more than 25% of the market share of dually-eligible seniors in the Minneapolis-St. Paul metropolitan area.

While commercial managed care is often controversial for people with disabilities, many in the disability community also recognized that prepaid Medicaid and Medicare can be a tool to improve care coordination and service delivery to people with disabilities, allowing more coverage flexibility, streamlining access to services and reducing cost shifting while controlling costs. Such programs can provide health plans the flexibility and incentive to fund preventive and other care to reduce costly hospital and nursing home stays, thus potentially generating efficiencies as well as more desirable outcomes for enrollees.

11. Describe the specific activities and operations of the program in chronological order.

The project was initiated in 1998 by AXIS Healthcare, which approached the State in partnership with a health plan, UCare Minnesota, with interest in establishing a program similar to MSHO for people with disabilities. AXIS Healthcare is a joint venture of Courage Center, a facility specializing in rehabilitation of people with physical disabilities, and Sister Kenny Institute, a rehabilitation hospital unit. UCare Minnesota is a Minnesota-based non profit HMO specializing in public programs including MSHO, Medicare+Choice, and the State's Prepaid Medical Assistance Program (PMAP) for families, children and seniors.

With input from people with physical disabilities, AXIS had developed and implemented a successful care coordination pilot project for individuals receiving Medicaid on a fee-for-service basis and was interested in implementing this model under integrated Medicare and Medicaid capitation arrangements.

The State issued an RFI for special projects in 1998, receiving a response proposal from AXIS Healthcare and UCare Minnesota. After discussion with CMS confirming the feasibility of adding people with disabilities to its MSHO Medicare demonstration, the State issued an RFP for potential MnDHO contractors in November 1999. UCare Minnesota responded in partnership with AXIS Healthcare. The State began contract negotiations with UCare and also began negotiations with CMS to obtain the necessary and complex waivers of Medicaid and Medicare regulations. CMS approved the Medicaid waivers in March 2001 and the Medicare waivers in October 2001. Marketing of the MnDHO product began in July 2001, with enrollment beginning in August 2001 and services to enrollees beginning in September 2001.

UCare and AXIS are partners, with UCare managing the network and AXIS providing the care management. The partners share financial risk. The program relies on a primary care model with extensive access to specialty providers. Working closely with AXIS, UCare established a primary care provider network of five clinics with special expertise or willing to learn about and accept patients with physical

disabilities. A broad network of specialty care providers, medical equipment suppliers, home health and personal care agencies with expertise in serving this population are also included in the network.

Care management and day-to-day member support is provided by expert staff at AXIS. Each member is provided an RN health coordinator. Members are given a comprehensive assessment to determine their need for health care and support services. Enrollees work in partnership with the health coordinator to develop their own plan of care, with an emphasis on consumer direction and preventive care measures, and stay in close contact with health coordinators. Building a trust relationship between the health coordinator and the member is a key goal, important to improving health outcomes. Health coordinators authorize most health and support services that enrollees need, with some oversight by the health plan. The health plan conducts most of the administrative activities necessary for managed health care plans. State, health plan, and AXIS staff remain in close collaboration, with almost daily communication to resolve issues and concerns as they arise.

12. Why is the program a new and creative approach or method?

MnDHO is the only managed health care program in the country that enrolls people with physical disabilities at all levels of severity, regardless of residential setting, and that integrates both Medicaid and Medicare financing. Other programs enroll only those with very specific diagnoses or extreme levels of severity, or those living in nursing homes or only those living in the community. Few programs integrate financing for both Medicaid and Medicare, and few have CMS approval for a specialized risk adjustor to accommodate the higher costs of focusing on people with severe disabilities. Additionally, each MnDHO enrollee is assigned an R.N. health coordinator, who works with enrollees to develop a plan of care, get necessary services, and navigate a confusing health care system. While this may sound like a logical service, it is rarely available in either the fee for service or managed care health care environment.

MnDHO is also the only program serving people with disabilities that is sponsored by a health plan in partnership with an expert provider-based care management organization. This partnership could serve as a model for development of other specialized health plans in the country.

Additionally, this program is unique for the close collaboration among the parties – the State, health plan, care management organization, the federal government (CMS) and the enrollees. The State, UCare Minnesota, and AXIS Healthcare worked closely to develop this program and continue to meet regularly to iron out issues and concerns about the program. CMS provided assistance and guidance on how to include people with physical disabilities under the demonstration and remains involved on a day-to-day basis, providing oversight and assistance in transitioning the program to a new Medicare risk adjustment model now being implemented. People

with physical disabilities helped design the program and continue to be consulted regularly on all aspects of the program.

Also, see the MnDHO website at http://www.dhs.state.mn.us/healthcare/MSHO-MNDHO/default.htm for more information.

13. What were the program's start-up costs? (Provide detail about specific purchases for this program, staffing needs and other financial expenditures, as well as existing materials, technology and staff already in place.)

    The program's start-up costs are difficult to establish since existing staff, at the state, provider and the health plan level, did much of the work. We estimate that direct start-up costs at the state level were approximately $750,000 over a two-year period. About $250,000 of this cost was for approximately two additional full-time equivalents. About $500,000 was spent in contracts for actuarial, consulting and evaluation services and marketing and educational materials. Much of this was funded through a grant from the Center for Health Care Strategies, associated with the Robert Wood Johnson Foundation. The state funding and the RWJF funding included a 50% match of federal dollars.

    In addition to direct costs, the project relied on existing Department of Human Services (DHS) staff for consultation and support in areas such as contract management, systems modifications, payment policy, disability policy, rate-setting mechanisms, and secretarial support.

    The provider care system, AXIS, incurred significant start-up costs, mostly in hiring staff and renting and furnishing a facility – which were mostly absorbed by its founders, Sister Kenny Institute and the Courage Center. AXIS Healthcare also received a grant from the Center for Health Care Strategies to assist with evaluation and setting up a care management system. The health plan, UCare Minnesota, also incurred start-up costs, but generally relied on existing staff for start-up activities.

14. What are the program's annual operational costs?

    The State's annual operational costs for this program are currently estimated to be about $250,000.

15. How is the program funded?

    Services under the program include all Medicare and Medicaid services. Medicaid capitations are provided to the health plan by the State. CMS provides the Medicare capitation to the health plan. Medicare capitations are similar to those provided to other M+C plans, except that the Medicare demonstration status allows an additional risk adjustor for people in the community who meet nursing home levels of care. UCare pays AXIS for care management services and the two partners share risk for program costs. State staff and administrative costs are covered through state

Medicaid administrative funds which are matched by CMS. While some care management funds are included in the capitations, other administrative costs incurred by UCare and AXIS must be covered by the overall program payment.

16. Did this program require the passage of legislation, executive order or regulations? If YES, please indicate the citation number.

    The program was developed under existing authority, Minnesota Statutes, section 256B.69, subdivision 23. This statute required a minor amendment to allow for implementation of this program.

17. What equipment, technology and software are used to operate and administer this program?

    At both the state and health plan level, existing systems are used to operate and administer this program. Some modification of the state's Medicaid system was necessary to accommodate the MnDHO program. AXIS Healthcare has developed its own system for managing its assessment and medical data. The State is in the process of implementing a new risk adjustment system for Medicaid costs for MnDHO using the Chronic Disability Payment System developed by Rick Kronick. In addition, CMS is applying its new Medicare risk adjustment system to the project.

18. To the best of your knowledge, did this program originate in your state? If YES, please indicate the innovator's name, present address and telephone number.

    Yes, the MnDHO program began in Minnesota. Innovators are Pamela Parker, at the address and telephone number given above, and Chris Duff, AXIS Healthcare, at 2356 University Ave. W., Suite 401, St. Paul, MN 55114. Phone: (651) 556-0863.

19. Are you aware of similar programs in other states? If YES, which ones and how does this program differ?

    We are aware of two similar – but significantly different – programs in other states: Community Medical Alliance(CMA) of Boston and Wisconsin Partnership.

    The Wisconsin Partnership program serves elders and people with physical disabilities who meet criteria for nursing home level of care. Like MnDHO, it includes both Medicaid and Medicare capitations, has a Medicare risk adjustment and offers the full range of medical and long-term care services. Unlike MnDHO, individuals in the Wisconsin Partnership must meet a nursing home level of care to qualify for the program while MnDHO enrolls individuals regardless of the severity level. Also, the Partnership program does not involve a health plan and is sponsored by small local providers.

CMA is a Medicaid managed care program sponsored by a health plan which offers enrollees a broad range of services including clinical and hospital care, as well as care coordination and other support services. However unlike MnDHO, CMA does not include Medicare funding. MnDHO capitates both Medicaid and Medicare funds, thereby reducing the potential for cost-shifting between these funding sources and granting greater flexibility to the health plan to provide the best possible services to its enrollees. In addition, CMA serves a narrower range of people with physical disabilities – those with end-stage AIDS or those with severe physical disabilities such as permanent triplegia or quadriplegia. Unlike CMA, MnDHO program serves people with any kind of physical disability and of all varying levels of severity.

The MnDHO program's inclusion of disabilities at all levels of severity is an important policy difference from both the CMA and Wisconsin Partnership programs. In MnDHO, if individuals are classified as having a physical disability, they are eligible to enroll even if the disability is currently fairly stable and not very debilitating. Preventive care benefits these individuals by stabilizing their health and slowing down the rate of deterioration from their disabilities. The individual remains healthier and more independent, and therefore costs to the health care system are also reduced.

MnDHO is also unique in its organizational structure. MnDHO is the only program serving people with disabilities we are aware of that is based on a partnership between a health plan and an expert provider-sponsored care management organization.

20. Has the program been fully implemented? If NO, what actions remain to be taken?

    The program was fully implemented by November 2001, after the state had received federal approval to integrate Medicare funding into this program.

21. Briefly evaluate (pro and con) the program's effectiveness in addressing the defined problem[s] or issue[s]. Provide tangible examples.

    Preliminary results from studies of the MnDHO program by an independent evaluator and by a consultant hired by the State to monitor the program's start up show that MnDHO is succeeding in addressing the problems of people with physical disabilities who complain of fragmented, uncoordinated health care and general dissatisfaction with health care. (see attachment).

    A longitudinal study of MnDHO enrollees and focus group studies of MnDHO enrollees and comparable individuals in Medicaid fee-for-service reveal high levels of satisfaction with MnDHO, with care coordination as a core strength of the program. Approximately 85 percent of MnDHO enrollees in one study said they had never had coordination of services before MnDHO; 90 percent indicated greater satisfaction with MnDHO than with their previous Medicaid fee-for-service experience.

Initial findings from the longitudinal study of 20 enrollees indicated greater satisfaction after MnDHO enrollment in the areas of getting health care services, the primary doctor, care management, planning for treatment and services, communicating with providers, and helpfulness of health coordination staff.

MnDHO enrollees praised AXIS staff's involvement of enrollees in their own health care decision making and their positive relationships with doctors. They also expressed the same level of dissatisfaction with personal care attendants as those in the control group.

Increased preventive care has been another important success of the MnDHO program. For many people with physical disabilities, health care too often consists of dealing with one crisis after another, leading to deterioration of the individual's health and to increased health care costs. Prevention is an important part of the MnDHO program. The MnDHO program's focus on preventive care includes: (1) assigning a primary care doctor to enrollees (many people with physical disabilities see specialists and don't have a primary care doctor); (2) development of a preventive care checklist; (3) 24-hour, seven-day-a-week access to the health coordinator; and (4) review of hospitalization and other utilization data. This focus on preventive care means that enrollees stay healthier and are more likely to stay out of hospitals and nursing homes. AXIS staff intervene at the earliest signs of problems that could potentially develop into complications lasting months.

Enrollees also encounter the unavailability of affordable housing. The Twin Cities metropolitan area has low apartment vacancy rates and high-cost housing, making affordable housing a problem for many, but even more so for people with disabilities who often have low incomes and require accessible housing. UCare and AXIS have worked hard to help institutionalized enrollees find housing in the community. Through their efforts, 28 institutionalized individuals have left institutions and resumed living in the community. AXIS and UCare worked with providers, recruiting them to develop and provide housing for these individuals. AXIS has also helped enrollees move out of substandard housing and into more suitable and comfortable homes. The ultimate solution to the housing shortage for people with disabilities, however, cannot be solved entirely by the efforts of AXIS and UCare and will require additional resources and partnerships.

In addition, the partners have been reviewing data on hospital and nursing home admissions and length of stay. This data shows that MnDHO may be succeeding in reducing enrollees' hospital length of stay, nursing facility admissions, and nursing facility length of stay. However, we are awaiting additional data and analysis to confirm these preliminary findings.

22. How has the program grown and/or changed since its inception?

The program has not changed significantly in design since implementation although it continues to grow and change in other ways. A year and half into implementation,

MnDHO enrollment is at 177 as of April 1, 2003, and continues to grow steadily, as projected. We anticipate continued interest in this program and continued enrollment growth. Although the overall design of the program has not changed, some modifications have been made to eligibility criteria to assure that anyone who has a physical disability, even though they may also have severe mental health needs, has the chance to enroll in MnDHO. AXIS staff have developed expertise on mental health as they discovered the extent of mental health issues in the MnDHO population – more than half of the enrollees were found to have secondary diagnoses of depression. AXIS hired a mental health consultant and also provided additional mental health training for its health coordinators.

23. What limitations or obstacles might other states expect to encounter if they attempt to adopt this program?

    There are a number of limitations or obstacles other states might expect to encounter in adopting a program like MnDHO, including: federal approval for waivers and for integrated Medicaid and Medicare financing, adequate financing, and development of unique partnerships between a health plan, the state, providers and consumer advocates. However, that said, we do believe the model is replicable if care and attention is paid to key elements as described below.

    The importance of strong public/private partnerships in developing a MnDHO-type program cannot be overemphasized. As mentioned earlier, MnDHO's partnership of State, Federal, health plan, and provider organization appears to be unique. Programs like MnDHO require the involvement of the State, with its expertise in Medicaid and CMS, which grants waivers and pays Medicare capitations. Health plan involvement is crucial because of their experience with managed care. It is also important to have the involvement of providers who are experts in disability issues, and, even more important, the involvement of consumers, who are the true experts in knowing the needs of people with disabilities. In the MnDHO model, the state worked in close partnership with UCare, an HMO with large numbers of Medicaid and Medicare enrollees and with AXIS Healthcare, a care management organization experienced in working with people with physical disabilities. The MnDHO partners developed a relationship of close collaboration and frequent, almost daily communication, and continue to maintain this relationship well into implementation of the MnDHO program. Furthermore, consumers have been very involved in development and implementation of the MnDHO program through two consumer advisory groups, one run by AXIS and the other by the State.

    Other states may also face obstacles or limitations when negotiating with CMS for waivers for these programs. Negotiations can take a year or longer and even then approval is not guaranteed as CMS has granted approval to only a few integrated Medicaid/Medicare programs. There is still no clear policy from CMS on such waivers, with policies differing from one administration to another, although currently there seems to be more support from CMS for managed care approaches. Minnesota was fortunate in already having an existing Medicaid/Medicare

demonstration to build on and even so, negotiations lasted about a year. For other states it may be more of an uphill battle to start from scratch in developing an integrated Medicaid/Medicare product.

Another important potential limitation is financing. Enrollment of the high-risk population of people with disabilities requires that financing be sufficient to cover services and adequately compensate health plans that choose to take on the risk of serving this population. In addition, since 25% or more of the disability population is eligible for both Medicaid and Medicare ("dual eligible"), a truly integrated program will capitate both fund sources. The MnDHO program incorporates both Medicaid and Medicare funds, with the state paying the health plan a Medicaid capitation and CMS paying a Medicare capitation. Capitating Medicare gives health plans the funds up front for enhancing preventive and other care to keep enrollees out of hospitals and nursing homes. The state successfully negotiated a risk adjustment for Medicare rates from CMS for enrollees at risk of institutionalization, thus providing better funding for services to keep high-risk enrollees out of institutions.

Additionally, it is crucial to have a rate-setting methodology that health plans trust to fairly compensate them for a high-risk population. The sophistication of Minnesota's rate-setting model for MnDHO played an important role in easing health plan concerns about MnDHO's viability. The state's Medicaid rate-setting model of 20 rate cells is fairly complex, factoring in residence in a nursing facility, nursing home certifiable status, participation in home and community based and home care programs, historical Medicaid fee-for-service experience, eligibility for Medicare, and other factors. Changes to the enrollees' capitation rates can be made within a month or two to reflect changes in the enrollees' health conditions.

The sophistication and sensitivity of this model to immediate changes in the mix of enrollees gave some assurance to the health plan that it would receive adequate payments for a risky population. The State also promised to implement the Chronic Illness and Disability Payment System (CDPS) for Medicaid acute costs in the MnDHO program by October 2003. CDPS shows promise of even greater accuracy in rate-setting than our current model.

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DEADLINE: All original applications must be postmarked or e-mailed by April 11, 2003, to be considered for an Innovations Award for 2003.