



Minnesota Department of **Human Services**

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*A Medicaid Managed Care Plan for Adults With Physical Disabilities*

Project Summary

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## *Project Description*

*Minnesota Disability Health Options (MnDHO)* is a managed care product that will be offered to Medicaid-eligible adults aged 18 to 65 with physical disabilities. MnDHO is a new product under *Minnesota Senior Health Options (MSHO)*, which is offered only to persons age 65 and over who are eligible for both Medicare and Medicaid. MSHO integrates the financing and service delivery for Medicare/Medicaid beneficiaries in a comprehensive managed care delivery system. While MSHO enrollees must be dually eligible, MnDHO will be offered to both dual eligible and those who have Medicaid eligibility only. MnDHO will be a voluntary option for Medicaid eligible adults with a certified disability, who have a primary physical disability and who reside in Hennepin, Ramsey, Anoka or Dakota counties.

The State expects to contract with one health plan for mid-2001 implementation and possibly with a second health plan for implementation in later 2001. Health plans will receive a Medicaid capitation for both the acute and long term care Medicaid covered services, including home and community-based waiver services. For the 25% of the population who also have Medicare eligibility, the health plan will also receive the applicable AAPCC Medicare capitation. For persons who are nursing home certifiable in the community, the Medicare rate will be adjusted by the PACE adjuster to accommodate increased service needs for this population. MnDHO will utilize most of the administrative systems utilized in MSHO, but as a new product MnDHO will have it's own set of rates and unique requirements to meet the needs of people with disabilities.

## *History*

Minnesota's managed care programs have historically excluded people with disabilities under age 65. While Minnesota's Medicaid managed care population has continued to grow over the past 15 years, this group has remained under the fee- for-service system. However, DHS did undergo an early experiment with serving people with disabilities under managed care. When PMAP was implemented in 1985, people with disabilities under age 65 were enrolled in the original demonstration project counties, Hennepin, Dakota and Itasca. They remained enrolled for one year, until a major contractor dropped out of the project. This contractor, Blue Cross/Blue Shield of Minnesota had enrolled the majority of the population. The State did not wish to further disrupt care by requiring enrollment in a new health plan. Therefore, the entire population was disenrolled. An additional reason for this decision lay in the inability to enroll a subset of the population with disabilities, people with developmental disabilities. This group was never enrolled because the State and the counties had not yet resolved anticipated coordination problems between health plans and counties. Counties are responsible for case management and for delivery and payment of many services to people with developmental disabilities. Furthermore, the State believed that people with disabilities should not be "mainstreamed" into an HMO delivery system, but needed a managed system geared to their unique needs.

In 1994 the State began planning to develop specially designed disability delivery systems. These ideas were incorporated into the planning and design of the *Demonstration Project for People*

*with Disabilities* (DPPD). This proposed demonstration was to be implemented in Olmsted, Blue Earth, Sibley and Freeborn Counties in Spring, 2000. In late 1999 Olmsted County dropped out of the project, followed by Blue Earth County in March 2000, leaving the future of DPPD uncertain. As originally designed, DPPD was to include all disabilities in a mandatory county-based managed care system. The State hopes to issue a Request for Interest (RFI) to ascertain if other counties are interested in pursuing this initiative.

UCare Minnesota, an MSHO contractor, in partnership with AXIS Healthcare submitted a proposal to the Department in 1998 to serve younger people with disabilities in a managed care delivery system. Since that time, department staff have been working with UCare/AXIS to design a disability option under the MSHO project, using existing state authority and expanding the federal waiver authority to include this new population. MnDHO will offer an alternative to the fee-for-service system for people with disabilities in four metropolitan counties.

### ***Potential Contractors***

The MnDHO RFP was issued on November 24, 1999, with proposals due by December 30, 1999. Appropriate requirements focusing on people with physical disabilities from the DPPD Contracting Specifications were included in the RFP. Current MSHO contracts will be amended to reflect the additional population and concomitant requirements. Contract negotiations should occur in Fall 2000.

Health plans interested in offering this new product must also contract for seniors under the Minnesota Senior Health Options. DHS received two responses to the RFP. A complete proposal was submitted by UCare Minnesota in partnership with AXIS Healthcare, a specialized disability delivery system. AXIS Healthcare is a partnership among Courage Center and Sister Kenny Institute, two organizations with extensive experience in serving people with disabilities. In addition, Hennepin County in partnership with Metropolitan Health Plan submitted a placeholder letter, with a full proposal due in October 2000. They requested and were granted additional time to respond to the RFP. Thus, the State anticipates a two stage implementation in Hennepin County, with UCare/AXIS to begin enrollment six months prior to the start of enrollment in MHP.

The RFP was reissued in August 2000 and MHP/Hennepin County submitted a response. DHS will review their proposal and respond to them by November 2000.

### ***Profile of People With Physical Disabilities***

The population of people with disabilities under age 65 is very diverse, no less so the subpopulation of people with physical disabilities. ***People with physical disabilities*** comprise about 40 percent of the statewide population of people with disabilities, ***about 18,400 adults in the seven county metropolitan area*** and 29,400 adults statewide. About *twenty percent of*

*adults with physical disabilities in the metropolitan area also have a diagnosis of developmental disability or mental illness.*

Most people with physical disabilities are served in community settings. Only about 5 percent of People with disabilities, 1800 people statewide, are served in nursing facilities. Fifty-six percent of NF residents under age 65 reside in Hennepin and Ramsey counties. Sixty seven percent of NF residents under age 65 are between the ages of 46 and 65.

Although many people with disabilities are served in the community, several challenges remain. Two of the biggest challenges are lack of accessible/affordable housing and lack of adequate personnel capacity for community-based supports, due to the historically low salaries for these positions and competing employment opportunities available in a booming Minnesota job market.

Although Minnesota's home and community based waiver programs have been successful in keeping people in community settings, less than 10% of people with physical disabilities under age 65 are served by these programs. An additional 19 percent are served through the MA home care program, which does not include case management services.

### *Why Managed Care for People With Disabilities?*

As noted, people with disabilities are currently excluded from participation in Minnesota Medicaid managed care programs. The *Demonstration Project for People With Disabilities* (DPPD) was originally designed to include all disabilities in a mandatory county-based managed care system. When DPPD failed to implement this comprehensive approach, it evolved into the testing of smaller focused models. MnDHO is now the only proposed Minnesota model implementing approaches to serve adults with physical disabilities. MnDHO provides people with physical disabilities with a voluntary option to enroll in a managed care system geared to meet their diverse needs. Access to integrated Medicare funding as part of the system is needed for the portion of the population which is dually eligible.

People with disabilities have a multiplicity of diagnoses, a range of functional abilities and varying support systems to help them meet their health care and independent lifestyle needs. The vast majority of people with physical disabilities do not have access to service coordination and alternative services to support them in the community. As noted, less than 10% of people with physical disabilities are served by home and community based waiver programs, in which their long term care needs are provided and managed in a more integrated manner. However, even those on the waiver programs do not have access to comprehensive coordination of acute medical services.

Consumers with physical disabilities report dissatisfaction with the current fee-for-service system under which they now receive care. Consumers who participated in the DPPD planning process, as well as those who participated in the AXIS Healthcare consumer advisory group, reported

that, although they have access to a complete range of services and individual providers provide good care, their care is not coordinated across services and providers. Providers often lack experience and expertise in disabilities, resulting in a lack of understanding of the consumer's individual needs. This lack of expertise and service coordination often results in the haphazard provision of care and inflexibility in the way services are delivered. A managed care delivery system specifically geared to the needs of people with physical disabilities can resolve some of these problems by providing a care system which is focused on individual needs, with ongoing service coordination, consumer control of appropriate services, a flexible benefit package and access to a complete array of specialty services. Consumers can become partners in the care system to assure that their needs are met both efficiently and appropriately. This type of system can best be accomplished under a capitated model, which allows the health plan to integrate funding and services into a single plan.

### ***Target Population***

MnDHO will serve people with a primary physical disability, without a primary mental illness (MI) or developmental disability (DD). MnDHO enrollment criteria use receipt of services targeted to MI or DD primary diagnostic groups as a proxy for primary diagnosis. Persons with a DD screening document on MMIS or persons receiving Rule 79 case management or county MH community support services (CSS) will be ineligible to enroll. Enrollment parameters are the following:

- Enrollment is voluntary.
- The health plan will enroll both Medicaid only eligibles and people with dual Medicaid/Medicare eligibility.  
Eligible health plans must demonstrate the ability to serve all types of potential enrollees from the target population.
- Enrollment is limited to adults aged 18 through 64.
- People on the CAC, EW and MR/RC waivers will be excluded from participation. CADI and TBI waiver recipients may enroll.  
People with a medical spenddown will be allowed to enroll, but will be required to pay their spend down to the state and to meet this monthly obligation in order to retain enrollment.
- Enrollees must have a certified disability through the State Medical Review Team (SMRT) or social security disability.
- People with a "working disabled" basis of eligibility (MA DP, MA DI, 15 or 16) will be eligible to enroll. Spenddown may be waived for this group.
- People with a "blind" basis of eligibility (Bx) will be eligible to enroll.  
People with disabilities who have an TANF basis of eligibility will be eligible to enroll, if they have received SMRT or SSI certification of their disability.
- Consistent with current waiver program policy, people who turn 65 after enrollment in MnDHO, will have the option of remaining in the product. Those who choose to disenroll will have to enroll in PMAP, or may optionally enroll in MSHO.
- Health plans will be permitted to specify a maximum enrollment for the first year.

## *Philosophy of Care*

MnDHO has a consumer-centered vision of service delivery, which embodies the following principles:

- **Holistic Focus.** The managed care system has a holistic focus, meaning it consistently focuses on the person being served within the context of his/her living situation and disability diagnosis. It includes and coordinates all health, both acute and long term care, as well as mental health and social support services within the scope of the contract and coordinates with providers of services outside of the scope of the contract.
- **Enrollee Self-Determination.** The managed care system strives to include a maximum level of enrollee choice and self-determination, in accord with the following principles:
  - Freedom ~ The ability for individuals, with freely chosen people, to plan and live a life with necessary support.
  - Support ~ The arranging of resources, both formal and informal, that will assist an individual to live a life he or she chooses.
  - Authority ~ Individuals will control resources, both formal and informal, that will assist them to live a life they choose.
  - Responsibility ~ Individual's acceptance of benefits and risks of choices made, and accountability for spending public money in ways that assure health and safety and that are life enhancing.
- **Disability Competence.** The managed care system ensures that individual providers possess disability expertise and experience and the provider network as a whole is capable of facilitating the service access needs particular to people with physical disabilities.
- **ADA Accessibility.** Each provider and the provider network as a whole accommodates the access needs of people with physical disabilities, including: (a) the number of appropriately trained staff to meet enrollee's needs during the service session; (b) the physical plant of the service site; and (c) the availability and use of equipment and durable medical equipment needed by the enrollee to gain access to the service site. If indicated by clinical need, appropriate services may be provided in the enrollee's normal home, work, and community settings,
- **Integrated Service Coordination.** The health plan service coordinator works with the enrollee as partner in planning service needs. The service coordinator has the authority, within his/her scope of practice, to authorize necessary services and is capable of working with families, other providers and external case managers to meet each enrollee's individual access needs.

- **Independent Living.** The managed care system is designed to support individuals to live independently in the community with necessary clinical and social supports.
- **Choice and Flexibility in Home Care Services.** Since home care services are so crucial to maintaining independent living, enrollees should have the maximum control over these services and flexibility in how they are delivered. While it is understood that every consumer request will not be granted, the managed care system in accordance with the vision set forth in this section should allow enrollees to direct their own care to the extent that they are capable of doing so. Capability to direct one's own care is defined in Minnesota Rules 9505.0335, subp.1 A, 1-4. The principle above of enrollee responsibility should put some natural controls on these services. For example, since a personal care assistant is part of the enrollee's day-to-day life, it is important for the individual to choose who provides this crucial care.

### *Rate-Setting*

The rate setting methodology is adjusted for historical risk, using the same rate cells as MSHO uses, so that it fits with the current MSHO Medicare reimbursement model. Rate cells include geographical (Hennepin and other metro) and Medicare coverage adjustments. In addition, "experience/service need adjusted" rate cells are designated. The initial rates are based on the MSHO rating scheme, with broad rate cells for:

- Nursing facility residents
- Conversions: people served in the community, previously served in the NF
- Nursing home certifiable (NHC)-community: people receiving waiver or home care services
- Community people, who are not NHC

The "conversion" and "nursing home certifiable- community" categories are further subdivided into experience-based rate cells, reflecting waiver or home care eligibility. High, medium and low cost categories, based on long term care costs are designated for the CADI/ home care rate cell. Acute care costs for all rate cells are averaged. There are a total of 14 rate cell categories, which are then adjusted for Medicare eligibility and county of residence (Hennepin or other metro).

Rates were calculated based on the calendar year 1996 & 1997 fee-for-service experience. All rate cells are discounted, except for the value of the 180 NF liability. Health plans may purchase stop-loss reinsurance on total per person costs exceeding designated thresholds within a contract year. The cost of this reinsurance coverage will be deducted from the rates for health plans who choose to purchase this coverage. In addition, the State is offering risk-sharing up to the value of 1.5% of the capitation, based on the health plan's actual enrollment mix.

In order to account for variable risk on acute care expenses, the state will utilize the *Disability Payment System (DPS)* to calculate an aggregate plan-specific risk adjustment for acute care costs only. Like PMAP, the rates will not be risk adjusted prospectively. Instead, the plan will

receive a health plan risk adjustment each quarter based on the plan's previous twelve month claims experience.

### ***Federal Waiver Authority***

MSHO has completed the transition from 1115 (demonstration) waivers to a 1915 (a) and (c) option. The State submitted a the 1917 (c), CADI and TBI Waiver requests to include MnDHO in summer 2000. The CADI waiver request has been approved and the TBI authority is expected in the near future. In early October, 2000, the State submitted to HCFA the 1915 (a) (managed care state plan option) and Medicare (402) waiver request to include MnDHO in the MSHO waiver authority.

### ***Implementation Timelines***

Enrollment into UCare Minnesota is targeted to begin in mid-2001. If MHP/Hennepin County meets all of the RFP requirements, enrollment may begin as early as July 2001. Enrollment functions will be carried out by the health plans. Prior to the initiation of consumer education, DHS will hold training sessions to educate county staff about this product.

# MDHO Rating Scheme

	Nursing facility resident	Nursing home certifiable-conversions	Nursing home certifiable-community (diversions)	Other community										
Medicare	Inst. AAPCC	2.39 X AAPCC (PACE adjuster)	2.39 X AAPCC (PACE adjuster)	non-inst. AAPCC										
Medicaid acute	Average rate	TBI NF	TBI NB	HC Hi-vent	CADI/HC Average acute	Average rate								
							hi	med	low					
Medicaid LTC	ffs- before enrollment	TBI NF	TBI NB	HC Hi-vent	CADI/HC Average acute	Average rate								
	180 days- after enrollment						hi	med	low					
DHS Rate Cell Category	N	M	L	K	J	I	H	G	F	E	D	C	B	A