

Minnesota Disability Health Options (MnDHO) Review and Lessons Learned

Submitted by:

Glenda Eoyang, PhD

Lecia Grossman, MA

Human Systems Dynamics Institute

50 East Golden Lake Road

Circle Pines, Minnesota 55014

www.hsdinstitute.org

Date:

June 10, 2013

651-431-4300 or 866-267-7655

Attention. If you need free help interpreting this document, call the above number.

ملاحظة: إذا أردت مساعدة مجانية لترجمة هذه الوثيقة، اتصل على الرقم أعلاه.

កំណត់សំគាល់ ។ បើអ្នកត្រូវការជំនួយក្នុងការបកប្រែឯកសារនេះដោយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទតាមលេខខាងលើ ។

Pažnja. Ako vam treba besplatna pomoć za tumačenje ovog dokumenta, nazovite gore naveden broj.

Thov ua twb zoo nyeem. Yog hais tias koj xav tau kev pab txhais lus rau tsab ntaub ntawv no pub dawb, ces hu rau tus najnpawb xov tooj saum toj no.

ໂປຣດຊາບ. ຖ້າຫາກ ທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປເອກະສານນີ້ຟຣີ, ຈົ່ງໂທໄປທີ່ໝາຍເລກຂ້າງເທິງນີ້.

Hubachiisa. Dokumentiin kun bilisa akka siif hiikamu gargaarsa hoo feete, lakkoobsa gubbatti kenname bibili.

Внимание: если вам нужна бесплатная помощь в устном переводе данного документа, позвоните по указанному выше телефону.

Digniin. Haddii aad u baahantahay caawimaad lacag-la'aan ah ee tarjumaadda qoraalkan, lambarka kore wac.

Atención. Si desea recibir asistencia gratuita para interpretar este documento, llame al número indicado arriba.

Chú ý. Nếu quý vị cần được giúp đỡ dịch tài liệu này miễn phí, xin gọi số bên trên.

LB3-0001 (3-13)

ADA1 (12-12)

This information is available in accessible formats for individuals with disabilities by calling 651-431-4300, toll-free 866-267-7655, or by using your preferred relay service. For other information on disability rights and protections, contact the agency's ADA coordinator.

Contents

Preface.....3

Executive Summary.....4

Introduction.....5

What? (Background)5

 Step 1, Document Review.....6

 Step 2, Key Informant Interviews6

 Step 3, Focus Groups & Survey.....6

 Step 4, Share Findings7

So What? (Lessons learned)7

 Program8

 Successes.....9

 Challenges10

 Enrollment:11

 Successes.....12

 Challenges12

 Execution14

 Successes.....14

 Challenges15

 Outcomes.....16

 Successes.....16

 Challenges17

Now What? (Considerations for Future Action).....18

 Cost/Benefit18

 Shared Understanding.....20

MnDHO Review and Lessons Learned

Decision Making.....	21
Conclusion	22
APPENDIX A: Documentation Reviewed: (listed chronologically).....	23
APPENDIX B: Key Successes & Measures:	24

Preface

The Minnesota Disabilities Health Option (MnDHO) demonstrated an integrated approach to health care and support services for people with disabilities. It was a pioneer for many of the purchasing and service delivery models that are being tested today, and holds valuable lessons for future options. Since MnDHO closed in 2010, there has been a desire on the part of many of those involved to have an opportunity to exchange their perspectives on what they learned, and identify elements from this experience that could shape future approaches to improve services. Toward that end, the DHS Disability Services Division partnered with Special Needs Purchasing to conduct a qualitative assessment of lessons learned from the different perspectives of key stakeholders. We contracted with Human Systems Dynamics to facilitate the process to gain an understanding from those who were invested in MnDHO, such as those from UCare, AXIS, counties, members and DHS staff, of what worked well, the challenges, and how those can inform considerations for future action.

This document summarizes the findings from this assessment. As you read through the report, keep in mind that this represents the perspectives of key stakeholders involved with MnDHO several years after MnDHO ended. There are times when comments appear to contradict each other, and times where comments may not appear to be factually accurate. There was no attempt to reconcile these differences. What was more important for our purposes was to understand the different perspectives, learn from the patterns that emerged from the conversations, and be able to use them as we consider future policy and program changes.

We want to thank the many people who participated in interviews, focus groups, and a debriefing session. The passion, commitment and innovation of these individuals is the reason for the successes of MnDHO. Their feedback has indeed given us insights and ideas that will help us navigate future system change.

Executive Summary

MnDHO broke new ground in many ways. Current and future programs that support people with disabilities, including Special Needs Basic Care (SNBC), benefit from its pioneering spirit. This review looks back at MnDHO, not to judge the past, but to inform the future. It does not point to particular decisions, individuals, organizations, or actions. Instead, the review focuses on systemic patterns of performance and lessons that can inform future programs that focus on systemic change to support individual wellbeing.

Toward this end, we include the following sections in this review:

- What? (Background)
- So What? (Lessons Learned)
- Now What? (Considerations for Future Action)

In a series of interviews, focus groups, surveys and group meetings, information about MnDHO was collected from project partners, (AXIS, UCare, providers, counties and DHS) and MnDHO members. Overall, study participants were in agreement that MnDHO provided marked benefits and outstanding services to its members. The MnDHO program did, however, encounter challenges. The lessons learned in the course of this study fell into four main categories.

1. **Program** - Not only was the program complex, but it was also different in many ways from programs that were more familiar to study participants.
2. **Enrollment** - Innovative processes and procedures for enrollment were intentionally designed to improve services for members, which they did.
3. **Execution** - MnDHO program provided important support for members, but it changed existing processes for everyone, including providers, members and others involved in administration. The evolution of the program and processes led to different understandings of how the program was to be executed.
4. **Outcomes** - The purpose of MnDHO was to improve health and quality of life outcomes for members, but the inconsistent measurement and reporting of outcomes added yet another layer of complexity to the MnDHO experience.

Considerations for future action fall into three categories:

1. **Cost/Benefit:** Establish policies and procedures that capture and report information to support transparent and frequent financial and outcomes analysis.
2. **Shared Understanding.** Ensure that everyone across the system is able to receive and share information relevant to member outcomes as well as program design, execution and enrollment.
3. **Decision Making:** Define decision making authority and accountability early and review it often. Put procedures in place to assure shared and data-informed decision making at all levels.

Introduction

Change is always challenging, even in simple systems. Minnesota Disabilities Health Options (MnDHO) introduced a vision of change that was complex at many levels. Individuals, communities, organizations, and the systems that support them changed relationships, policies, procedures and practices as a result of MnDHO. Of course, such a change presented many complex challenges for everyone. In fact, these challenges could have been overwhelming, without the good intentions and heart-felt commitment of everyone who was involved in the effort. As a program, MnDHO succeeded in many ways; effects of the program are still evident across the system. Members reported better health and quality of life and project partners involved in MnDHO expressed lessons learned. In facing the challenges of these changes, study participants learned a great deal from MnDHO and each other. The purpose of this report is to share MnDHO transformations; new program, program and process designs; and individual and organizational lessons to help inform future programs.

MnDHO broke new ground in many ways. Current and future programs that support people with disabilities will benefit from its pioneering spirit. This review looks back at MnDHO, not to judge the past, but to inform the future. It does not point to particular decisions, individuals, organizations, or actions. Instead, the review focuses on systemic patterns of performance and lessons that can inform future programs that focus on systemic change to support individual wellbeing.

Toward this end, we include the following sections in this review:

- What? (Background)
- So What? (Lessons Learned)
- Now What? (Considerations for Future Action)

What? (Background)

In 2001, the Minnesota Department of Human Services (DHS) launched the Minnesota Disabilities Health Options (MnDHO) program as a voluntary managed care program for persons with disabilities. MnDHO has been nationally recognized as an innovative managed care program, and it received high satisfaction ratings from its members. MnDHO ended in December 2010. The program implemented diverse and innovative features, services and delivery procedures. While the program had its challenges, the process was immensely informative. Lessons learned from MnDHO will be invaluable for future program design and implementation. As Minnesota moves into 2013 and beyond, DHS will launch a variety of programs designed to optimize choice, quality and cost for home and community-based services for people with disabilities. Each of these programs will benefit from the lessons learned from MnDHO. To help the project partners make the most of the MnDHO experience, the Human Systems Dynamics team collected lessons learned from project partners and MnDHO members and compiled them into this

report. Human Systems Dynamics used the following process to collect and process information from various stakeholders.

Step 1, Document Review

The Human Systems Dynamics team reviewed documents from various points in MnDHO's evolution. (See [Appendix A](#) for a listing of documents reviewed.)

Step 2, Key Informant Interviews

Human Systems Dynamics interviewed nine MnDHO stakeholders identified by Alex Bartolic, DHS Disability Services Division Director, and Pamela Parker, DHS Manager, Special Needs Purchasing. The interviews revolved around the following questions:

- What did you see as MnDHO's greatest asset?
 - For those who received services
 - For those who delivered and funded services
- What might have made MnDHO more successful? Why?
- What did you and the collection of project partners learn from being a part of MnDHO that would be beneficial for future programs?
- How was MnDHO the same as program(s) recipients were utilizing prior to joining MnDHO? What are the important similarities you believe should inform future programs?
- How was MnDHO different from the previous program options (or current)? What are the important differences you believe should inform future programs?

Step 3, Focus Groups & Survey

From January 23 to February 25, 2013, Human Systems Dynamics conducted five focus groups with the following groups:

- AXIS (14 participants)
- UCare (five participants)
- Members/advocates (seven participants)
- Providers (five participants) and
- DHS/counties (10 participants).

MnDHO members were also given the opportunity to contribute through phone or electronic survey which resulted in two telephone and two electronic surveys.

DHS invited individuals who were extensively involved with MnDHO to participate and asked them to extend the invitation to others who might have valuable input. MnDHO members were informed of the focus group and survey option through Access Press, Minnesota Consortium for Citizens with Disabilities (MN-CCD), DHS web site announcement and AXIS coordinators who were currently serving ex-MnDHO members.

Step 4, Share Findings

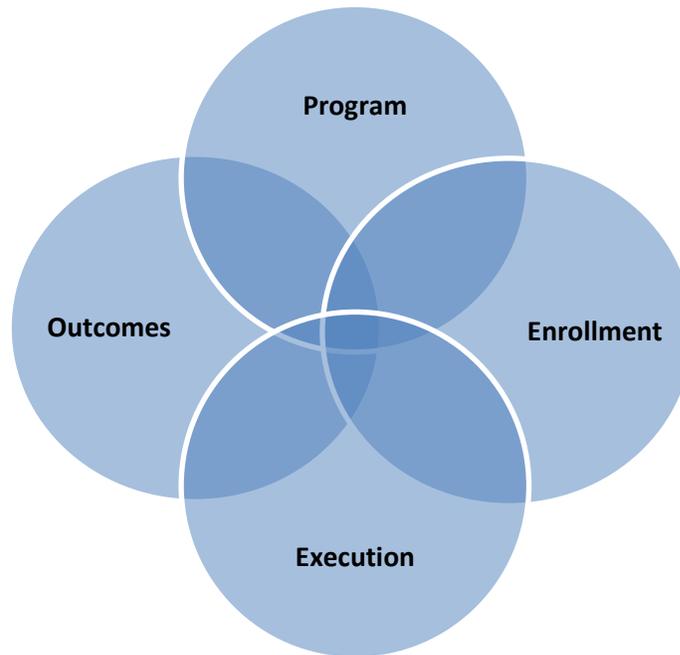
Human Systems Dynamics presented and discussed patterns and themes from the interviews, focus groups and surveys. A cross-section of stakeholders (approximately 40 participants in person and 23 registered for virtual connection) participated in this two-hour public meeting, which was also accessible as a webinar. The purpose of this meeting was to validate lessons gathered during focus groups and discuss how to use the information for future managed healthcare programs for persons with disabilities.

So What? (Lessons learned)

Four categories of patterns surfaced during the information gathering process. These categories are represented in Figure 1, summarized below and explored in more detail in the rest of the report.

1. **Program** - MnDHO's contract included details about services that were offered and requirements for eligibility and service delivery. Not only was the program complex, but it was also different in many ways from programs that were more familiar to study participants. Complexity and uniqueness of the program made it difficult for individuals and organizations to manage and deliver consistently across the system.
2. **Enrollment** - Enrollment processes, procedures and requirements were also somewhat complicated and different from those for more familiar programs. The innovative processes were intentionally designed to improve service to members. In spite of the care taken by DHS to explain and simplify enrollment, study participants observed that individuals and organizations misunderstood or implemented the program differently.
3. **Execution** - The implementation and execution processes for MnDHO included a variety of innovations as well. On the one hand, the new processes provided important support for members. On the other hand, they introduced new procedures and changed existing processes for everyone, including providers, members and others involved in administering. Differences among project partners' cultures, expectations, management structures and areas of professional expertise added other challenges to execution of MnDHO across the system. In addition, internal issues within project partners contributed to challenges in execution of the program.
4. **Outcomes** - The purpose of MnDHO was to improve health and quality of life outcomes for members, but measurement and reporting of outcomes added yet another layer of complexity to the MnDHO experience. The absence of reliable baseline measures, accepted indicators, consistent data collection and reporting, insufficient staff and incompatible data systems made it impossible to systematically track MnDHO's effect on outcomes.

Figure 1. Four aspects of MnDHO and their complex interdependencies



Each of these four aspects of the MnDHO program was extremely complex on its own. Implementing MnDHO was further complicated by the fact that they all influenced each other.

Program details were complicated by shifts in the roles and responsibilities in the enrollment process, which were *executed* by different groups in different organizations. Those changes, in turn, made it difficult to measure and report *outcomes*. These complex interdependencies caused problems. The interdependencies also complicated processes for resolving problems when they arose. Decision making and implementation processes were decentralized, so it was difficult to resolve issues, even when they were recognized and correctly diagnosed.

In the pages that follow, each of these program aspects is explored, including overall patterns, successes and challenges.

Program

Lessons from the document review, interviews and focus groups focused on:

- a) Features of the program
- b) How the risk adjustment system worked or impacted the program
- c) Program goals and
- d) Levels of funding and services delivered. There was general satisfaction with the features and benefits of the program, as well as the changes to the program that

occurred over time. The challenges stemmed from lack of understanding and consistency, which resulted from the challenges in program, enrollment, execution and outcomes described above.

Successes

MnDHO was successful because it led to creative solutions to member's concerns, ease for members and support that allowed members to live more independently. Particular successes included the following:

- **Integrated funding.** The integration of Medicare/Medicaid funding streams in support of people with disabilities increased the quality of life and ease for members. Members had just one card and a single set of materials to understand the program. The integration gave more flexibility in finding solutions to meet members' short and long-term care needs. The integration of funding and one card reduced confusion and complexity for members.
- **Service flexibility.** The Medicare/Medicaid integrated funding and service allowed creative ways to serve the members' needs, both short-term and long-term. The creative solutions increased independent-living, reduced need for crisis services and provided restorative and preventative services. Most important, the services under MnDHO were tailored to fit the members' unique needs.
- **Care coordination.** Care coordination was a key element in program success and person-centeredness. Interviewees and participants in focus groups described care coordination as most successful when coordinators had both medical and case management skills. Understanding the members' needs and looking at their health holistically offered a gateway for many other program successes, including attention to preventive care, education and member engagement in healthcare planning, medical care follow-up and handling medical issues before they escalated to a crisis. The care team structure and the relationship-based care were seen as assets for members and their caregivers.
- **New relationships across organizations.** MnDHO provided an opportunity for project partners to work together in new ways around an innovative program. The extensive collaboration needed across organizations resulted in new personal and organizational relationships as well as more collaborative policies and procedures.
- **Systems and processes defined.** As MnDHO evolved, new systems and processes were defined for working within project partners as well as across project partners. Changes over time made the processes more effective, but individuals and groups found it difficult to absorb some changes as they occurred.
- **Improved understanding.** MnDHO members and professionals in a variety of roles developed greater understanding of and appreciation for the challenges of others involved in the system. As the process of implementing MnDHO progressed, an improved understanding developed about what managed care was, and what it could be, for persons with disabilities. This understanding provided new ideas for

handling the challenges and special needs, especially for persons with complex long-term needs.

Challenges

MnDHO challenges included:

- Inconsistent execution of program and
- Inconsistent understanding of goals and measures by different groups at various times in the evolution of the program.

Refer to [Appendix B](#) for successes and potential measures identified by participants in focus groups.) The following program challenges were the ones most often mentioned by participants in this study:

- **Voluntary program.** Most study participants saw the voluntary aspect of MnDHO as a success for members. However, there was disagreement about whether this was beneficial for the program overall. Questions about the value of a voluntary program related to impact on the number of enrollees and the financial viability of the program. These two valid, though contradictory, views of voluntary status constituted a challenge for the program implementation.
- **Similarity and differences in waiver usage.** There was confusion among study participants (except for DHS) as to how home and community-based services (HCBS) waiver programs were to be used and how MnDHO was the same as and different from other programs, including fee for service programs. CMS also imposed restrictions that complicated and reduced flexibility necessary to completely implement the goals of the program. While the MnDHO design and documentation may have been clear on all points of distinction with HCBS waiver programs, the variety of project partner responsibilities and experience, the constraints of CMS waivers and inconsistent understandings created particular challenges.
- **Eligibility criteria.** Even though MnDHO eligibility criteria were documented, they were complex and depended on information from a variety of sources. Different levels of understanding across study participants and challenges with diagnostic information contained in MMIS made it difficult to implement eligibility criteria consistently across the system.
- **Unclear goals and measures.** Participating organizations were not aligned in the overall goals and measures of success for MnDHO. This led to confusion regarding:
 - Where to focus efforts
 - What to train and emphasize with staff
 - What to track and
 - How to hold people and organizations accountable.

There were program evaluation criteria proposed in 2001, but they were not formally accepted, implemented, or supported through the duration of the program.

- **Unclear or overly restrictive boundaries for allowable benefits.** The boundaries and authorization for how money could be used in MnDHO were not executed consistently, by all project partners. Sometimes the reason was misunderstanding; sometimes it was differing expectations for MnDHO process and outcomes. In addition, CMS restrictions were not always flexible enough to allow the program to meet the needs of individual members. This lack of understanding, or difference in expectations, between MnDHO project partners and CMS, resulted in inconsistent utilization of home and community-based services (HCBS) benefits and the perception that some care coordinators authorized members' "wants versus needs." This could have increased costs, and it certainly increased misunderstandings about how the program was to be executed.
- **Medicare risk adjustment system.** The Medicare Hierarchical Condition Categories (HCC) risk adjustment payment method used to pay UCare for MnDHO did not adequately account for the severity and complexity in the dual eligible-population. The system was not adequate, timely, transparent, or adjusted for persons with disabilities.
- **Information and tracking systems not compatible across project partner organizations.** Project partners had different information technology systems and methods for tracking information and results. In the view of some focus group participants, this resulted in misaligned information for monitoring the program and difficulties in tracking and transferring member information from one project partner to another.
- **Finding the right benefits set.** As the program progressed, DHS added new benefits, such as mental health targeted case management, crisis services, assertive community treatment (ACT) services, intensive residential treatment services (IRTS) etc. Participating organizations found it challenging to select and access the right benefit set to keep the program person-centered and financially viable. The misaligned information and information systems added to the difficulty of monitoring and/or adjusting benefits and benefit sets over time.

Enrollment: The comments of focus group members, interviewees and survey respondents focused on several issues with enrollment, including:

- a) Pool of potential members for the program
- b) Options for marketing to this population
- c) Application process and
- d) Assessment process.

Successes

Enrollment success patterns and themes from the interviews, focus groups and surveys primarily focused on ease-of-use for enrollees and the ability to serve those with complex needs.

- **Easy for members to enroll.** There was much program education and information to help members choose whether to enroll in the program. UCare added staff to provide additional support as the program evolved.
- **Reached hard-to-reach population.** This was due to the ability for applicants to apply by phone and to complete assessments at the location of the members' choice
- **Assessment location chosen by the member.** Applicants could request the assessment location, making access to the process easy for members. .
- **Served those with complex needs.** Due to the integrated funding and services, those with complex needs were attracted to and served by the program.

Challenges

The challenges cited were primarily linked to causes for low enrollment. The reasons given were various, including: member perception, county support, complexity of the program and the challenges of marketing to this population.

- **Fewer members than expected.** Because fewer members enrolled than were expected, the program did not reach economies of scale, and it was difficult to get an adequate, generalizable picture of program results. Some respondents expressed an opinion that the financials, execution and outcomes would have been more positive with a larger pool or one with a wider variety of member need levels. Three reasons mentioned for lower enrollment than expected were that it was a voluntary program, the marketing restrictions and the limited geography the program encompassed.
- **Voluntary program.** The voluntary aspect of the program created a smaller member pool than a non-voluntary program would have. Many study participants thought that if the program had been mandatory with an opt-out option, the program would have drawn more members. As a result, it would have been more financially stable and sustainable. Others believed the small size and slow growth made it easier to find and work out execution details. Persons with disabilities are not accustomed to deciding between multiple choices for health plans or for home- and community-based services, which may have reduced enrollment in a program that was voluntary.
- **Ability to market.** The complexity of the program and the restrictions placed on marketing to this population based on Medicaid Law were perceived as contributing factors in low enrollment. The observation was also made by focus group members that word of mouth, more than traditional consumer marketing approaches, was more effective for MnDHO.

- **Limited geography.** The small geographical region of the program, especially at the beginning, made for a smaller pool of potential members.
- **Complexity of the program.** Due to the complexity of the program, study participants shared that a more hands-on approach was needed to help educate and enroll members. After additional staff was hired to assist members in understanding the program, enrollment increased. Staff who assisted with enrollment were better able to answer questions from potential members when they had higher levels of experience with and understanding of the questions, needs and challenges of people with disabilities.
- **Variations among Lead Agencies.** Lead agencies (including counties, tribes and managed care organizations) had varying levels of understanding of and commitment to MnDHO; so they had varying levels of support for the program. This program was unfamiliar, untested and possibly seen as risky or competitive for the lead agencies. When members turned to the local agencies (counties and tribes) for guidance (their normal source of information), the lead agencies often did not have the information or understanding to encourage members to enroll in MnDHO.
- **Small provider network.** Some study participants saw the small provider network as an advantage because it made execution and education easier. But the smaller network limited the number of enrollees. Potential members chose to stay with their providers who were not in the network, rather than joining MnDHO. Finding providers with the needed disability expertise was also difficult. It took additional education for providers to understand the program, to contract with UCare, and to provide services adapted to the needs of people with disabilities. The small pool of providers also meant that individual providers were occasionally stretched beyond capacity to provide services to all MnDHO members.
- **Inconsistent practices and procedures.** While there was an established and documented process for enrollment, the understanding about enrollment process and eligibility were not always consistent across project partners. Over time, procedures within organizations and across the system changed for a variety of reasons, and project partners were not always prepared to adjust to those changes efficiently. Also, professionals involved in the various roles of the program did not have equal understanding of the needs of people with disabilities. In addition, transitions in and out of MnDHO were more or less easy or reliable, depending on the lead agency's internal policies and processes.
- **Mental health needs and impact on eligibility.** At the beginning of the program, the impact of mental health needs for those with complex physical disabilities was not well understood. Over time it became clear that a person's mental health needs could overshadow physical needs and, as a result, a potential member would be judged ineligible because the claims in the system reflected the presence of mental health diagnosis with no diagnoses supporting the individual having physical disability.

Execution

Comments about execution of the program focused on the following issues:

- a) Processes
- b) Decision-making and authority
- c) Roles and responsibilities
- d) Training and
- e) Evolution over time.

The evolution over time takes into account what happened as the program was adapted for new information and for changing circumstances, as well as how those changes affected different project partners.

MnDHO was a new and innovative program that involved multiple stakeholders and significant changes over time. While the contract with the managed care organization specified laws, rights, duties and benefits and processes were documented by organizations, they were not always implemented consistently or with fidelity. Despite the numerous challenges, the project partners remained very committed to the success of the program and the health of its members, resulting in very satisfied members overall.

Successes

In general, execution from a member's viewpoint was very successful. There was agreement among all study participants that the program was person-centered and innovative in meeting members' needs.

- **Integrated services.** With services integrated, members received more holistic, person-centered care. The care coordination considered the medical, mental, dental, preventative and community-based services to create a holistic plan.
- **Care coordination.** Care coordination was essential to this program for the many reasons mentioned in this report. Members found great value in MnDHO's "care coordination" and identified it as different and beyond "case management." The care was coordinated by a care coordinator and supported by a team comprised of resource, benefit and health coordinators. Members voiced great appreciation for this team approach and its ability to provide creative solutions.
- **Member education.** As the recurring health needs of the member population were acknowledged, education pieces were developed (on UTIs, skin and wound care). These resources helped educate the members and reduce the number and severity of crisis situations.
- **Project partners committed to working with people with disabilities.** In the view of study participants, MnDHO project partners were very committed to the population they served. This dedication showed in members' satisfaction with the care they received in the program.

- **Right service, right person, right time.** The combination of the care coordinators role, expertise, medical background and the flexibility of care solutions resulted in extraordinary service, which gained MnDHO national recognition.
- **Member advisory group.** DHS established a member advisory group during the planning phases of MnDHO and continued throughout its duration. This advisory group had a direct impact on the program design and its evolutionary changes. Program planning, program expansion, consumer protection, quality assurance measures, and many other approaches were made based on their recommendations.
- **Regular meetings and discussions.** There were many meetings and communications among the project partners. In spite of multiple meetings and communication venues as well as thorough initial documentation of the program and protocols, miscommunications and lack of clarity persisted. More transparency in expectations, clear roles and responsibilities for decision making, timely identification and resolution of issues and lines of accountability could alleviate this situation in future programs.

Challenges

The primary challenges in execution were with lack of clarity and inconsistencies within and across project partners. Tensions existed between the CMS restrictions and the desire of some care coordinators to provide particular services to their members. These challenges compounded and caused confusion, eroded trust across organizations and, in the long run, may have affected outcomes.

- **Lack of clarity and consistency between and within project partners.** There were multiple levels and execution points where a lack of consistency and misunderstandings caused confusion. One study participant said, “Everyone would call everyone” and not necessarily get the same answers.
 - **Roles.** There was confusion about where certain responsibilities fell between the project partners. The ambiguity created confusion not only for those executing the program but also for members. For example, members were often confused about which organization to contact for benefit information and questions. Based on the information we collected, many providers didn’t understand the different project partners’ roles, so sometimes they would request information from the wrong organization. Project partners and members would be confused and frustrated when they received different information from different project partners.
 - **Decision-making rights and accountability.** There was confusion and variability on the level of service authorization by care coordinators. Even though Disability Services Division created an on-line manual, responsibility and accountability for certain decisions were sometimes unclear to project partners. One participant gave the example that they might contact DHS and the county to resolve an issue and get two different

answers. It is interesting to note that even this observation indicates confusion about lead agency, DHS, AXIS and UCare roles and responsibilities for decision-making and action.

- **Processes.** Study participants reported inconsistencies between and within their organizations. In some cases, communication within organizations was more difficult than communication between organizations.
- **Evolution.** There was no consistent plan for how changes would be monitored, documented, accommodated and communicated. Sometimes changes or decisions would be made by one project partner (DHS, AXIS, or UCare), but communication would not reach other project partners, providers or members.
- **Knowledge and skills not consistent.** There were varying levels of knowledge and skills, especially in HCBS waiver policy and disability expertise.
- **Inconsistencies in provider payments.** Many different variables determined the payment for providers. It appeared to some of the focus group participants that providers were paid inconsistently for services provided. This may have been because the payment policies and processes were complex and not well understood by all. Because the managed care payment process was different from the customary processes at the local agencies (counties and tribes), providers were frequently confused and frustrated.

Outcomes

While medical outcome information was not systematically tracked throughout the program, respondents acknowledged many outcomes of the program, including:

- a) Member health and quality of life
- b) Member satisfaction and
- c) Service delivery.

Members commented on how these factors translated to outcomes.

Successes

Overall, members were very satisfied with MnDHO and their care.

- **Better proactive and timely care.** Most members who participated in this study agreed that they received proactive and timely care facilitated by the care coordinator through in-home visits and medical professional coordination. They also noted longer physician appointments, care coordinator attendance at appointments and follow-up to appointments as helping with health results. This timely and proactive care often kept members from utilizing more expensive and disruptive crisis care.
- **Members engaged in their health planning.** Members were more educated about their health and engaged in their planning. Care coordinators facilitated this

engagement and helped members make informed choices. As a voluntary plan, members felt more engaged because of choice and the “bargaining power” the voluntary program provided them.

- **Members had ownership in the program.** Through engagement in their healthcare planning and through the Member Advisory Board, members felt more empowered and had more stake in MnDHO than in other plans. Some focus group participants reported hearing members talk about “My MnDHO.” This factor was a bit complicated because some MnDHO members were not clear about the different roles and identities for DHS, MnDHO, lead agencies, AXIS, or UCare. Nevertheless, they felt personally connected and invested.
- **Members relocated into community.** Members were relocated out of nursing facilities and into the community. Some focus group and survey participants judged the relocation process to be smoother during MnDHO than before it. Preventative care also helped keep members from entering nursing facilities unnecessarily.
- **Members very satisfied with their care.** Surveys and anecdotal reports collected throughout life of the program, along with the member focus group and surveys for this report, showed an overwhelming satisfaction with MnDHO.
- **Each project partner learned from participating in MnDHO.** While the path was not always smooth, the program encouraged adaptation and innovation for individuals, processes, organizations and systems.

Challenges

The major challenge for outcomes was the relatively low number of enrollees, which made it difficult to generalize findings about outcomes for members. Concerns included having clear and consistent measures, data collection and reporting processes, common information systems and sufficient personnel to analyze and report on outcomes across the program. Between 2001 and 2005, various efforts were made by DHS and other project partners to evaluate the program, but findings were not sufficiently integrated into program decision making, policies, procedures, or practices. Due to lack of funding of the evaluation activities DHS was unable to sustain evaluation of the program.

- **Lower participation than anticipated.** Participation was lower than expected (for reasons mentioned in the enrollment section of this report). Lower participation made it more difficult to establish baselines and track outcomes reliably.
- **Unclear and inconsistent evaluation of processes and outcomes.** Many activities, processes, project partners and outcomes contributed to MnDHO’s success. The absence of an overarching and consistently implemented evaluation design and structured engagement of players in data collection, analysis and subsequent decision making made it difficult to assess the program over time. Some project partners indicated that they and their organizations were unclear of the measures for success. As a result, accountability, reliable tracking and evidence-based decision making were difficult to establish and sustain.

- **Difficult to compare/contrast outcomes with other programs.** Tracking and information systems within and among project partners were not aligned for a variety of reasons, including limitations of existing information systems, lack of resources to obtain or develop new tools and lack of personnel to manage data. For all these reasons it was difficult to obtain consistent or complete information to support comparison of MnDHO outcomes with those of other programs.
- **MnDHO population was not comparable to other populations.** There were varying perspectives among study participants about whether the MnDHO population was different from fee-for-service populations. Some respondents believed that persons with very complex long-term disability health issues gravitated to MnDHO to receive the flexibility of services and care coordination to meet their needs. Because of the complexity of the program, number of project partners and lack of resources, it was difficult to test this assumption or to compare results with other programs.
- **Unclear/inconsistent understanding and commitment to goals and expectations.** The goals and expectations for the program were documented, but individuals and organizations across the system understood and implemented them differently, leading to inconsistent execution.
- **Medicaid risk adjustment system implemented late in the program.** Without implementation of a reliable risk adjustment system and a match controlled group, it was impossible to assess or understand the financial impacts of choices made during the first seven years of the program. As a result, project partners were unable to make necessary adjustments to the program or its processes in a timely way.

Now What? (Considerations for Future Action)

The interviews, focus groups, surveys and large group presentations generated the following considerations for programs that will be developed in the future for persons with disabilities. The considerations fall into three categories: a) those that will affect cost/benefit of the program, b) those that will result in a shared understanding and alignment, c) and those that affect clear accountability and decision-making.

Cost/Benefit

In general, the considerations for cost/benefit are those actions that affect the business case for the program and help monitor the costs to make informed financial decisions.

- Identify a few key measures to continually and consistently measure and report on throughout the program. Ensure project partners monitor against the same yardstick for cost analysis and success measures to monitor sustainability and efficacy of the program.

- Establish a plan for attracting a sufficient number of members for cost efficiencies. Make restrictions explicit when marketing plans are determined by Balanced Budget Act of 1997 (BBA), Medicaid and Medicare. This could include a pre-determined marketing plan, beginning with a larger geographical area and/or ensuring that lead agency personnel understand and support program enrollment. Another option, currently in practice for SNBC, is to make membership the default option and require members who do not want it to opt out of the program.
- Create a tiered system of care coordination based on the complexity of members' needs. A tiered system can assist in assigning the appropriate number of members per coordinator and still reach member satisfaction, health outcomes and cost efficiencies. This could also reduce care coordinator burnout and turnover.
- Implement a risk adjustment system at the beginning of program that accurately reflects the population enrolled in the plan. A well-designed risk adjustment system:
 - Aligns incentives
 - Limits gaming and
 - Protects risk-bearing entities.

If a reliable risk adjustment system cannot be implemented:

- Begin with an approximation
- Incorporate a gain/loss risk sharing mechanism and
- Adjust frequently with a transparent process.

Frequent and transparent analysis and adjustment allows for better shared decision making.

- Incorporate medical and quality of life measures, both short-term and long-term, into ongoing success measures.
- Establish integrated (or at least compatible) tracking system across project partners to ensure consistent reporting and the ability to track and manage costs. Provide sufficient resources for personnel and systems to support such a system-wide evaluation effort.
- Share financial information and benefit costs with all project partners so they are apprised of viability of the program and can engage with ideas and changes that might be required to sustain the program. Also establish and audit procedures for information collection and reporting to ensure fidelity and consistency across project partners and through time.
- Consider the cost/benefit impacts of the size of the provider pool and the number of payers and other players to meet member needs while leveraging competition in the marketplace to control costs. Use simulation modeling or scenario planning to support transparent and shared decision making.

Shared Understanding

A key theme across the lessons learned was the confusion and misalignment among and within those included in this study (UCare, AXIS, counties, DHS, providers, members) regarding program features, goals, processes, actions and decision-making authority. Home and community-based services and mental health services proved particularly challenging, as they involved changes over time. Following are considerations to provide clarity and alignment to project partners' shared understanding.

- Ensure clarity and alignment of purpose and goals throughout program and with all appropriate staff in participating organizations. Some questions to answer and provide ongoing education about:
 - What are the services and benefits?
 - What are the key measures of success?
 - What is the anticipated member pool?
 - How is the program similar to and different from other waiver programs?
- Effective training is difficult because of high levels of turnover among program personnel, variable commitment (of individuals and organizations) to the program, program and process complexities and changes in the program over time. To respond to these issues, training should be:
 - Delivered by experts in content and process, rather than ones who only have preparation of “train-the-trainers”
 - Delivered repeatedly structured to support questions/answers as well as case studies and practice
 - Supported with easy to use reference materials
- Ensure that all parties involved in enrollment (or in regular contact with members) have the correct information about eligibility, enrollment processes, marketing and similarities to and differences from other waiver programs.
- Ensure that communication and processes are:
 - Explicit about how they conform to Medicare/Medicaid law and
 - Consistent across all project partners and functions
 - Reviewed and approved by all relevant project partners.
- Ensure that marketing materials are structured so that they are easy for members to access and understand.
- Inform Lead Agencies (including counties, tribes and managed care organizations) with more program information, success measures and member stories and engage them in dialog to help understand the benefits. Consider different training modalities to engage them in the learning. Traditionally persons with disabilities rely on the county to provide them information on their choices in home- and community-based services. So, when a new program is established, a strong alliance between DHS and the lead agencies is needed. By providing more and more consistent training to the lead agencies, they can be even stronger allies in helping persons with disabilities choose wisely.

- Create and follow a more deliberate plan for sharing program information and ongoing changes. A communication plan gives all parties a shared understanding of what information will be shared, when and by whom. In such a complex environment, an effective communication plan does not just include what information is shared with whom, it must also account for formal methods to collect information from project partners and to support dialogue and shared decision making. Effective communication in dialogue (sometimes supported by an external facilitator) will help surface and resolve issues when they arise, rather than letting them grow and become more intractable over time.
- Create and update a workflow process diagram so that all project partners see how processes take place and who is responsible. This also provides a working document as the program evolves so that when changes are made everyone has the same reference point for understanding changes and their impact.
- Provide consistent and repeated training, in multiple training methods, on processes, decision-making, roles/responsibilities and evolutionary changes. Providing information and training in multiple methods (instructor led, action-based learning, virtual, e-learning, etc.) provides easier access for the multiple project partners and an e-learning format provides a repository for ongoing learning as changes are made, re-learning is needed and staff turnover.
- Create a “playbook” that contains information on the program, key outcomes and measures, workflow processes and how to execute to attain the key success measures. This is the “go-to” document for all those who work in the program. This document should:
 - Be developed in collaboration with all project partners
 - Include principles and guidelines from the contract
 - Highlight key regulatory and legal restrictions (the complete list is found in the contract)
 - Be integrated into training programs
 - Be updated frequently
 - Include images and document design that make it easy to access, understand and remember

Decision Making

Based on the responses from interviewees and focus group attendees, throughout the program, there were multiple points of confusion on which individual or organization was responsible to make certain decisions. The considerations below are those that would help alleviate misinformation, misunderstanding and result in greater alignment and efficiencies for data-informed and collaborative decisions.

- Create a shared understanding and process for transparency in decision-making authority and processes. Sharing decisions and processes with all relevant project

partners as the program evolves will provide more clarity and understanding. Specifically be clear on level and limits for authorizing services.

- Establish clear and function-specific roles/responsibilities determined by business process, not by organization or title. This practice will support communication and process efficiencies across project partners.
- Establish an adaptive process for change management and communication to provide fast cycle time for discovering, understanding, reporting and adjusting to changes at any point in the system. Document, implement, utilize and continuously communicate changes and critical measure outcomes so that all parties can adapt accordingly and meet goals.
- Establish stronger, more explicit goals and measures, consistently report on them throughout the program, and provide resources to support evaluation processes. Areas to consider measuring: member satisfaction, member health outcomes (short- and long-term), service expectations and delivery, capacity and preparation of service providers to work effectively with people with disabilities, and expectations for project partners. Evaluation designs and reports from early in the MnDHO program can provide other insights into appropriate indicators and evaluation processes.

Conclusion

Many programmatic and systemic changes have taken place since the close of MnDHO. Those changes, particularly the design and implementation of SNBC, have been informed by the lessons learned from MnDHO, including those documented here. Over the coming months and years, Minnesota will continue to explore ways to effectively and efficiently meet the needs and support the opportunities for people with disabilities and their caregivers. One thing is certain, however, individuals and organizations will continue to adapt as needs and opportunities emerge. We hope that this review and its report will support that on-going adaptation process.

Respectfully submitted,
May 1, 2013
Glenda H. Eoyang, PhD
Lecia Grossman, MA
Human Systems Dynamics Institute

APPENDIX A:
Documentation Reviewed: (listed chronologically)

- MnDHO Communication Plan (no date)
- AXIS Healthcare Member Stories (no date)
- MnDHO Project Summary (September, 2001)
- MnDHO Protocol (September, 2001)
- MnDHO draft evaluation design (November 26, 2001)
- MnDHO Speaking Points Document (January 18, 2002)
- UCare and Minnesota DHS Meeting - Clinical Recommendations (August 19, 2002)
- Lessons Learned from the Start-up of UCare Complete: A Managed Care Program for Adults with Disabilities (November 25, 2002)
- National Rehabilitation Hospital Center for Health & Disability Research – Longitudinal Survey on MnDHO (December, 2002)
- MnDHO Training Guide by Sue Bulger, AXIS Healthcare (February 06, 2004)
- Letter to Pamela Parker from Dr. Rhode supporting MnDHO (July 23, 2004)
- Model Comparisons (June 6, 2005)
- Evaluation of the Minnesota Disability Health Options (MnDHO) Program, Start-Up Phase, September 2001-August 2004, Susan E. Palsbo, PhD and Pei-Shu Ho, PhD (July, 2005)
- MDH Audit memo from UCare to AXIS (December 15, 2005)
- UCare Minnesota's Improvement Plan for AXIS Healthcare (January 1, 2006)
- MnDHO Service Plan 2004/2005 Compliance Review Report (April 6, 2006)
- Consumer Evaluation of a Disability Care Coordination Organization, Susan E. Palsbo, PhD and Pei-Shu Ho, PhD (Journal of Healthcare for the Poor and Underserved, 2007, p.887-901)
- AXIS Newsletter – Leg Fact Sheet and Member Stories (January, 2007)
- Innovations award letter to Cara Bailey from the Ash Institute for democratic governance and innovation (February 27, 2007)
- UCare Response to MPRO MnDHO Audit Report (March, 4 2009)
- 2010 MnDHO Contract UCare Minnesota (December 10, 2009)
- MnDHO Closure FAQ (August 3, 2010)
- UCare Complete MnDHO presentation (August 18, 2010)

**APPENDIX B:
Key Successes & Measures:**

Member Health	<p>Member retention over time % receiving preventative services Member health/health plan understanding Reduction of crisis interventions (hospital days per 1000 days of program) Fewer complications (pressure ulcers, wounds) Relocations into the community Quality of care</p>
Disability Expertise	<p>Member rating of providers and expertise Providers have X number of years of experience or training working with PWD Member advisory board established Disability best practices demonstrated</p>
Member Satisfaction	<p>Efficient and easy enrollment process Level of health plan understanding, support & service Quality of life (mobility, socialization, ease of transportation, ability to work or volunteer) Satisfaction with care coordination Level of autonomy and choice Minimal paperwork Satisfaction with provider network choices Satisfaction with response time for equipment orders</p>