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**Minnesota has a strong tradition of advocacy for people with disabilities of all ages.** For the past 20 years, the Minnesota Consortium for Citizens with Disabilities (MN-CCD) and its earlier iterations has worked for positive policy change at primarily the state level. Advocates and their allies have lobbied hard to establish programs and benefits that will maximize the independence of individuals with disabilities. Examples of success include personal care attendant services as a Medicaid state plan entitlement, increased consumer-directed service options, a strong community-based – rather than institutional – living bias, and improved housing and transportation options. Our Medicaid buy-in program now enrolls about 7,000 individuals who are working at least part-time.

We have worked hard to unite all parts of our community, those with physical, developmental, and mental health conditions, to speak as one voice to affect positive change. While there is much yet to be accomplished, particularly given current budget pressures at the state and federal level, we are proud of the current support system and the partnerships that have been forged with county, state, and elected officials to maintain its success.

A strong menu of public health program options, many with a care coordination component, is also now available in Minnesota. These are all voluntary in nature, as Pam has mentioned. The non-elderly population of individuals with disabilities remains the only constituency not mandated by state law to enroll in a managed care program.

**Health care is not enough. Health care reform is not enough.** A great deal of the local energy expended to improve current disability policies and programs focuses on the Medicaid program. Primarily, this is because the program has expanded here in Minnesota to encompass a broad array of social supports, not just medical services. Our Medicaid waived service options here are strong. The relative risk for Medicaid recipients in times of fiscal austerity is large. Medicaid touches all types of disabilities and all ages. Preserving the hard-fought gains won by our statewide advocacy community is in the best interest of all Minnesotans with disabilities and those who support them.

For many who are part of the disability community, their stability and independence relies on many factors. Health care services, or traditional *medical* services may be a necessary component to maintain ideal health, but it often is not the *only* determinant of an individual's health status. Yet much of the reform debate that happened here in Minnesota in 2007 and 2008 and the current focus in Congress is on creating access to health care services for the uninsured and underinsured. While this is important, we cannot ignore the long-term care and

social support needs that are not medical in nature. Many people with disabilities are not by definition 'sick' and in need of medical care, but a wide body of research does suggest we have a 'thinner margin of health,' meaning the potential decline in health is more accelerated once it begins when compared to those without disabilities. It is often non-*medical* services, such as home health aides, access to care coordination, and other traditional social supports that are equally important to sustaining the health and independence of those who use the health system most often.

Increasingly we are talking to policy makers about what we can do to sustain overall health, recognizing the multitude of social and economic determinants that must be considered to achieve this – not just medical or acute care services. We know this philosophy is embodied in the CLASS Act that we hope will remain an integral part of the health reform dialogue at the national level.

**What is the value added of MnDHO?** The Minnesota Disability Health Options (MnDHO) program Pam Parker discussed embodies this integrated view of overall health. It does not artificially divide, through either care coordination roles and responsibilities or through program financing, medical services from non-medical services. Since its inception in 2001, the monthly per member capitation has included Medicaid and Medicare dollars across the continuum of care. (Approximately 54 percent of the MnDHO population is comprised of dual eligibles.) The authorization for services often rests with the care coordination organization, Axis Healthcare, which is independent of the health plan, UCare. At times, for large expenditures, this is a negotiated authorization between Axis and UCare. The commitment of the health plan to this product can't be understated. UCare is the only health plan in Minnesota that has no commercial lines of business. Its entire book of business is comprised of individuals enrolled in government funded health programs.

The financing of this program has changed over time, as Pam has mentioned, and is now risk-adjusted for both medical and non-medical services. This means that mathematical algorithms have been developed to better match the anticipated cost of program enrollees with the monthly amount that should be reimbursed for the services they actually utilize. There are significant challenges to doing this, many of them due to the dynamic nature of a population with a diverse set of medical conditions and disabilities. The relatively small size of the MnDHO population is also challenging, as are true comparisons to those who are not enrolled in managed care programs. This is especially problematic when exploring the utilization of Medicaid waived services. No study has yet been completed to look – over a time horizon of at least three years – at MnDHO enrollees and those in the Medicaid fee-for-service system to compare not just costs but health outcomes. Ultimately this is a question of value-added for the MnDHO program. When compared against a similarly complex population of those who have chosen not to enroll in MnDHO, how do the two service delivery options compare? While we would welcome such an analysis, at a time of scarce resources and competing priorities no such study has yet been completed.

(In 2007, NIDRR made the study of care coordination options a top priority, and in 2008 the University of Minnesota's Institute on Community Integration was awarded a \$1.5 million grant to explore our current programs here in Minnesota. We look forward to their results, which we hope will help identify and define what successful care coordination should like.)

What we do know, and what the peer-reviewed MnDHO research has shown, is that providing care coordination services increases access to service. This phenomena of latent demand is not surprising and is reflected elsewhere in the health services literature. Assisting an individual – who may never before have had an informed choice in the fee-for-service system where no care coordination options exist – in identifying their health and social needs results in greater access to services. This is a good thing, as long as it is contributing to overall health in a way that is cost-effective.

So how does MnDHO work for the consumer? One care team comprised of a nurse and social worker works with the individual MnDHO enrollee to establish a care plan that bridges the entire health continuum. Often, it includes preventive health services that are not paid for as a part of the traditional fee-for-service Medicaid benefit set. A great example is a fitness club membership at a fully-accessible facility where trained staff can assist with transferring and equipment setup for those with significant physical limitations. Research funded by the Milbank foundation and the locally based UCare Minnesota Foundation indicates participation in this fitness regimen actually decreases the number of chronic or secondary conditions for most enrollees. (Currently, we are attempting to establish a correlation between program participation and declining health expenses.)

Access to assistive technology is also available through MnDHO. At times, this includes inexpensive over the counter purchases – not just medical devices or supplies purchased through a traditional medical equipment supplier. The goal is to maximize health and independence, and these ‘benefit exception’ purchases are designed with this in mind.

MnDHO has also excelled at getting a majority of new enrollees in to see a primary care doctor within a month or two after enrollment, establishing a clinical link that often has not previously existed. (Every enrollee must select a primary care doctor.) Members have access to a 24/7 triage line to address their concerns or needs, even on weekends. Additionally, the care coordination agency also employs a full-time Medicaid eligibility specialist who partners with the state (DHS), counties, and the health plan (UCare) to prevent the on-again, off-again churning of the MnDHO population that a recent study of California’s MediCal population found significantly increased ER and hospitalization costs in the fee-for-service population.

Studies of the MnDHO program by the National Rehabilitation Hospital Center for Health and Disability Research and George Mason University Center for the Study of Chronic Illness & Disability have indicated that enrollees are more likely than those in the fee-for-service system to receive needed care and are highly satisfied with the care they have received after they enrolled in the MnDHO program. The percentage of participants who reported having received needed care also increased in the year following MnDHO enrollment, especially in accessing their primary care doctor and getting needed medical equipment. Significant improvement was also found in areas such as health care coordination, quality of interaction with health care providers, and promptness of care.

**MnDHO is a voluntary choice among many care coordination options.**

Choice matters. The MnDHO program was founded primarily for those with physical disabilities and is now only available in the seven-county metropolitan area. I believe – and my organization believes – it is the best program model that combines the aligned financial incentives and funding flexibility to optimize consumer health. Enrollees can disenroll at any time, but they choose to do so in very low numbers.

But we recognize that other models of care can and do exist and people with disabilities should have choices. Pam has mentioned the Special Needs Plan Basic option that excludes personal care attendant services and other long-term support services from the financial control of the health plan. Some in our local advocacy community strongly believe these long-term supports should not be bundled with medical services in a managed care plan. Again, choice matters, and today in Minnesota we are fortunate that many choices exist.

We are on the cusp of implementing health care homes here in Minnesota, a care coordination concept born in the pediatric population that is now being applied to adults with complex health needs as well. This will pay a monthly care coordination payment to those medical clinics who have met the state's certification standards. An extensive public and transparent process has taken place over the last several months that has included multiple stakeholders, including those with disabilities and their families, to design a patient-centered, health care home system. The next step of our state health reform will reward providers who achieve quality outcomes on behalf of their patients and consumers. This first step of designating a health care home will only examine if care coordination has in fact occurred.

There is a state expectation that for those with complex conditions a comprehensive care plan will be developed. How clinics will operationalize the linkages to other non-medical providers, or coordinate with existing support plans that may rest within the county or educational system has yet to be seen. While there was some debate at the State Capitol in 2009 if health care homes should be mandatory for all people with disabilities, no such requirement was passed. Health care homes will, however, be widely available in the commercial managed care product world as well. The Minnesota Health Care Reform Act of 2008 stated they must be a part of health plan program offerings beginning in 2011.

Another state care coordination program has shown promising outcomes for individuals who have significant mental health needs but do not formally meet the Medicaid definition of disabled under state or Social Security Administration definitions. The Demonstration to Maintain Independence in Employment now operating in Minnesota uses a care navigator to assist individuals in designing health, behavioral health and employment support services. A rigorous evaluation of the three-year project designed by the Lewin Group has shown improved mental health and functional status of enrollees, increased use of preventive care and a finding that enrollees are less likely to apply for Social Security benefits. DHS has recently announced that this CMS funded program, also called Stay Well, Stay Working, will be extended for another year.

**What role do consumers play in defining policy?** Pam has mentioned the Managed Care Stakeholder Advisory Group that the Department of Human Services convened in 2005 after partnering with disability advocates at the

Capitol that session to authorize the state to wrap Medicaid services around the Medicare benefits for those enrolling in Special Needs plans. A part of that law said that any time significant changes in policy are proposed that would affect managed care programs in Minnesota, a stakeholder's group must be consulted. Now at the same table are representatives of state government, counties, health plans, medical and long-term care providers, clinicians, and advocates. While we may not always agree with our colleagues in state government, we all agree that formal infrastructures must exist to bring together interested parties to negotiate solutions to complex policy problems.

Similarly, our coalition of disability organizations, MN-CCD, now co-chaired by Steve Larson of the Arc of Minnesota and Jeff Nachbar of the Brain Injury Association of Minnesota, has an open and transparent process that informs the establishment of our priorities as well as our stakeholder education and lobbying strategies. Some of the most exciting work now occurring within MN-CCD is our increasing efforts to partner with the aging community, recognizing that our common policy and consumer interests far outweigh our differences.

In conclusion, I hope I have provided you not just with a basic understanding of the MnDHO program, as was my charge, but with an overall sense that here in Minnesota we all take our commitment to maximize the health and independence of people with disabilities very seriously. We have an active, diverse and successful advocacy community that partners closely with legislators and state and county officials, and not just on health and Medicaid issues. The outcome of this hard work is a strong system of supports for individuals and their families, and multiple service options when it comes to the provision of health and long-term support services. Thank you for continued interest in our efforts, and we hope our learnings might successfully be duplicated elsewhere.