

*PROMOTING CHOICE
AND INDEPENDENCE
THROUGH
EMPLOYMENT*

*Demonstration to Maintain
Independence and Employment*

*MaryAlice Mowry
Stay Well, Stay Working*

*The Ticket to Work and Work
Incentives Improvement Act
of 1999
(P.L. 106-170)*

- Legislation seeks to address obstacles that people with disabilities face as they seek sustained employment.
- Demonstrate the value of providing health care benefits and other services to support people in maintaining independence and employment

Demonstration to Maintain Independence and Employment

CMS solicited proposals from States with the goal being to test (demonstrate) the effects on an individuals continued employment and independence by providing medical assistance and other supportive services to people with potentially disabling conditions.

Why Do This Test?

Federal Perspective:

- Each Year over 600,000 workers in the United States leave the labor force and become beneficiaries of the SSDI income assistance program.
- Most federal program direct resources and support to workers who are currently on disability benefit programs (SSI/SSDI, MA-Disabled)
- DMIE does not “supplant” existing state funds that are provided for workers who may have potentially disabling conditions

Why Do This Test?

State Perspective:

- Allows individual states to design a program that utilizes the service delivery and purchasing systems within their states.
- States can direct state resources with federal funds to better serve what is traditionally an un- or underserved population.
- Early Intervention Approach – does it work?
- Good Public Policy - examine how resources can more effectively be used to assist people in maintaining their independence.

The Big Picture

- Minnesota (like many other states) faces a growing workforce shortage
- People want independence and self-sufficiency
- Unemployment of People with Disabilities remains unacceptably high
- Once someone gets on SSA Disability very difficult to work way off
- WIN-WIN-WIN for people/state/federal perspective

“It Takes A Village” You Can’t Do It On Your Own

GOVERNMENTAL

- Legislative

(2003 Laws of MN, 1st Special Session, Chapter 14, Article 6, sec.65)

- State Medicaid Agency

Intra-agency
Collaboration

- Interagency Partners

COMMUNITY

- People who are likely to Enroll

- Advocacy and Stakeholder Groups

- Provider Organizations

Remember – This is a Test

- Continue to keep stakeholders involved
- Let people know what is happening
- Don't jump to conclusion
- Stay true to your model
- This is a Demonstration
- It's lots of work, but worth it!



DMIE
Program Design
A Texas Perspective

Dena Stoner, Senior Policy Advisor
Texas Department of State Health Services

“I defy the tyranny of precedent”

“I have an almost complete disregard for precedent and a faith in the possibility of something better. It irritates me to be told how things have always been done. I go for anything that might improve the past”

---Clara Barton

All Design is Local



- Diverse states require different designs
- Design must consider the environment:
 - Health care financing
 - Delivery and benefit systems
 - Data systems
 - Analytical resources
 - Culture and geography

Texas: The Myth



Houston: The Reality



Texas Design Challenges



- Designing a program which can work and be replicated in a state like Texas, which delegates indigent care to local systems
- Contracting for new and enhanced services outside and within existing networks
- Moving from a public benefit to an insurance paradigm
- Negotiating state and local bureaucracies
- Developing a data system that obtains, contains and tracks individual experience across services and networks
- Changing the culture of provider systems to focus on prevention and integration of individualized services across behavioral and physical medicine disciplines

Texas Health Economics



- Texas ranks near last place in per capita state funding for mental health
- One in four Texans uninsured
- Texas Medicaid is limited (no dental, OP substance abuse, tight eligibility, etc.)
- Public systems of care are severely challenged to meet demand for services



Comparing States

	Minnesota	Kansas	Texas	US
# Uninsured 2005	450,000	290,000	5.5 million	46.5 million
% Uninsured 2005	11%	9%	25%	16%

Source: Kaiser Family Foundation

Houston



- Largest city within Texas
- Fourth largest in the US
- **31.4%** of residents **uninsured** (1.1 million)
- **500,000 underinsured**
- Harris county contributes significant local dollars to care
- Houston public / private agencies provide **\$2 billion** in health care each year to people lacking insurance



Harris County Hospital District



- Largest Texas hospital district
- Fourth largest in the US
- Extensive and complex delivery system (hospitals, clinics, contracted providers)
- 500,000 per year served
- HCHD programs ensure access to care (Gold Card)
- Members contribute, based on income
- HCHD is integrating community behavioral health with physical medicine
- Delivery system has some limits / gaps in services and access (e.g. substance abuse)



Data Issues



- State / local data systems are siloed
- State data systems in transition
- HCHD traditionally was a provider of health care, not an insurer – data systems geared to billing, not payment or analysis
- HCHD is implementing an electronic medical record system

State/Local Partnership



HCHD

Develop/ operate
DMIE benefits
system

Provide **match**
for Medicaid-
like services

DSHS

(State MHSA Authority)
Oversee
Manage Project

UT Austin

(Addiction Research
Institute)

Operate DMIE
data system

Conduct
independent
evaluation

Texas DMIE Project



- Service Area: Harris County
- Evaluates effects of access to health care coverage on working individuals with potentially disabling behavioral health (mental health or substance abuse) conditions
- \$21.1 million federal, \$4.9 million HCHD match

Texas DMIE Design



- Randomized controlled trial
- 800 in intervention group, 625 control
- Intervention and control groups drawn from HCHD GoldCard program
- Intervention group receives enhanced medical, behavioral, dental, case management and vocational services

Inclusion Criteria



- HCHD Goldcard member
- Received HCHD services in the last 12 months
- Employed 40 hours a month or an average of 40 hours for the past three months, or an average of 40 hours for the past 6 months
- 21 – 60 years of age
- Not receiving or seeking assistance, such as SSI or SSDI
- Diagnoses:
 - schizophrenia, bi-polar disorder, major depression;
or
 - behavioral health diagnoses co-occurring with a physical diagnosis which would reasonably be expected to increase the likelihood of eligibility for SSI or SSDI.

Candidate Pool



- Over 15,000 HCHD GoldCard members have a BH condition and are working part or full-time
- Over 7,000 members meet criteria for inclusion in the DMIE study, per HCHD administrative data

Intervention Services



- Chemical dependency treatment services including:
 - Outpatient Detox
 - Intensive Outpatient
 - Partial Hospitalization
 - Residential Treatment
- Prescriptions above the 3 per month Medicaid limit
- Expanded Durable Medical Equipment
- Preventative and restorative dental treatment
- Enhanced psych and neuropsych assessments
- Improved access to outpatient mental health services (expedited office or outpatient visits)

Case Management



- Individual planning addressing life and health issues
- Advocacy, direct services, motivational interviewing, coordination and intervention
- Assistance in connecting to other community resources

Vocational Services



Employment/Vocational supports including:

- Vocational Assessment/Evaluation
- Collaboration with an Employer
- Vocational Support Groups
- Collaboration with Family/Friends
- Vocational Treatment Planning/Career Development
- Vocational Counseling
- Coordination with and referral to resources including the Gulf Coast Workforce Board, Texas Workforce Commission, the WorkSource and vocational rehabilitation

Integration



- Co-location of behavioral health and physical medicine
- DMIE medical director function includes primary care and behavioral health staff
- Case management integrated with vocational interventions

Evaluation Measures



- HPQ: The World Health Organization's Work Performance Questionnaire (HPQ) - baseline / annually
- ADL and IADL scales - baseline / annually
- SF12v2 - annually
- **Basis-24 health status survey - at least annually**
- HCHD administrative data (demographics)
- State unemployment data - annually
- HCHD customer healthcare cost and utilization data - at least annually
- Focus group and individual interview - at least annually

Diverse Issues / Strategies

- Texas
 - working adults with behavioral health conditions in the hospital district's benefits program for low-income people
 - enhanced health services, vocational services and case management
- Kansas
 - working adults, in high risk pool insurance program
 - premium support, enhanced health services, case management
- Minnesota -
 - working adults with severe mental illness
 - Medicaid services, employment supports and a "navigator"

Questions for Panelists



- Describe the greatest challenge you faced in designing your project and how you addressed this challenge.
- What design advice would you give to a state considering a DMIE-like project?

Recruitment

Kansas Demonstration to Maintain
Independence and Employment

Jean Hall

Associate Research Professor

University of Kansas

Brief Overview of the Kansas Project

- Target population is participants in the state high risk insurance pool—people who are uninsurable in the private market
- Individuals with high out-of-pocket medical costs and a variety of potentially disabling physical and mental conditions
- Demographically diverse, with wide ranges in earnings and types of employment
- 71% are self-employed, creating unique problems with tracking earnings and hours worked

The Intervention

- State Medicaid Plan Services as wraparound to high risk coverage
- Premium subsidies and greatly reduced copays
- Additional medical and related services including
 - Patient education/case management
 - Weight loss programs
 - Dental and vision coverage
 - Assistive technology
 - Disease management

Recruitment

- Difficult to predict actual eligible sample because no employment data are collected from participants
- In Kansas, a captive audience
- Issues:
 - Extreme skepticism
 - Distrust due to past experiences
 - Too good to be true
 - Balancing intervention benefits with control group: **Disappointment Factor**
- Helped somewhat to use the program administrator for second round recruitment

National Evaluation of the DMIE:

Purpose and Design

Henry T. Ireys

Gilbert Gimm

Bob Weathers

CMS New Freedom Initiative Conference

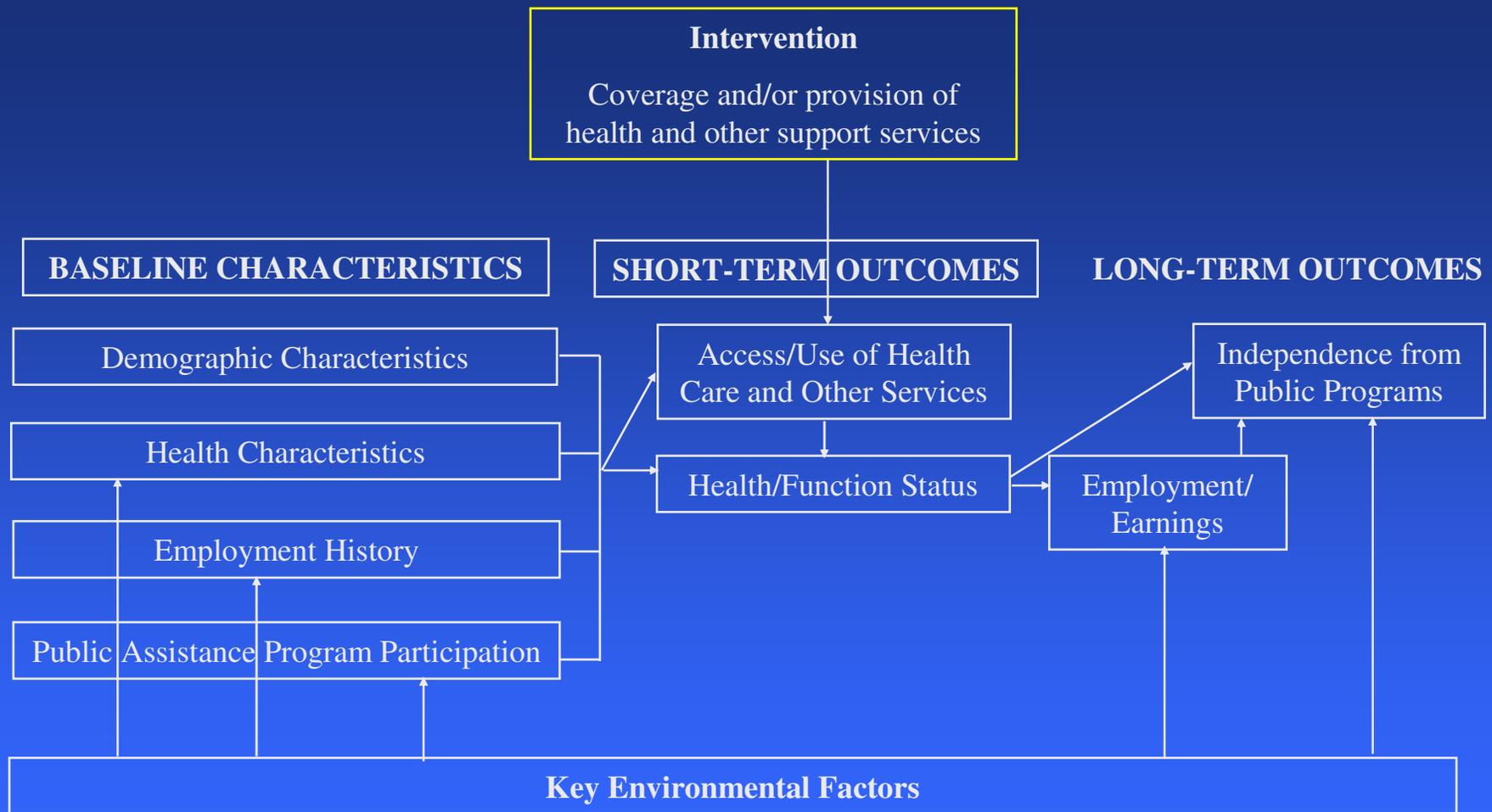
Baltimore, Maryland

March 2007

National DMIE Evaluation Goals

- Assist in addressing primary question:
 - Can a program of medical assistance and other supports forestall or prevent the loss of employment and independence due to a potentially disabling physical or mental impairment?
- Build on individual state evaluations
- Synthesize “lessons learned” from cross-state comparisons, to extent possible

A Logic Model for the Evaluation



Evaluation Design

- All DMIE projects
 - Two-group randomized design
 - Sufficient sample size to detect modest effects
- These features add credibility to evaluation findings

Data Collection

- Uniform data set (UDS) from states, based on
 - State administrative databases
 - State-supported surveys of DMIE participants
 - UI wage records
- UDS includes standard set of variables
 - SSI, SSDI enrollment
 - Employment, earnings
 - Health, functional status
 - Use of health care
 - Demographic characteristics

Data Collection (continued)

- Data from federal sources, including
 - SSA program records from the Ticket Research Files (TRF)
 - SSA Master Earnings File (MEF)
- MPR develops individual-level data files for analysis by state

Analyses

- Quantitative
 - Assessment of randomization
 - Descriptive, bivariate analyses of group differences
 - Multivariate modeling
- Qualitative
 - Key informant interviews in all states regarding program, evaluation
 - Implementation challenges, environmental context, sentinel events

Final Report

- Did the projects work?
- Were there differential benefits?
- What helped and what got in the way?
- To what extent did the state's own evaluation project influence the DMIE program?
- What are the lessons for CMS and other states?

Process Evaluation and Project Status Discussion

Jean Hall

Associate Research Professor

University of Kansas

Process Evaluation

- Process evaluation is necessary to differentiate between failings in the actual program and failings in how the program was implemented and operated. Process evaluation also informs future replication efforts.
- Early process problems identified in the Kansas program center mostly on billing, claims processing, and reimbursement mechanisms. We also had lower than expected enrollment.
- Pros and cons to wrapping around an existing program

Process Issue

“Sometimes it is confusing as to who you are supposed to call before using any benefits and also you have to wait awhile for reimbursement. This made you not schedule things you would like to do because you would have to pay up front not knowing when you would get reimbursed.”

Project Status and Early Successes

- Recruitment and enrollment complete: 197 intervention and 180 control group members; attrition of control group members
- Process issues with claims processing
- A great deal of pent up need for basic and diagnostic services and pharmacy
- Unanticipated outcome: the high risk pool is absorbing much of the cost instead of the project

Successes

“I’m part of your study on KHIA insurance, and I just got a letter and I’m in shock. I mean, if this is real, this almost saved my life. If all the things that are said there are real I guess I’m kind of doing a “somebody better wake me up” sort of thing because literally I work to pay my insurance. And wow! I mean, I’m going to continue working, but maybe I could get something else. Anyway if this is true I thank you very much, and I realize it’s not just you responsible for it, but it’s pretty dramatic change and thank you.”

Successes

“This program was a godsend. If it wasn't for this program I don't know how I would make it. Something needs to be done with our health care system for those with chronic illnesses [who] can't be insured except through the high risk pool. Between the high premiums and deductibles it is tough.”

Panel Discussion Questions and Answers

