
Minnesota Senior Health Options

**Provider Survey Report:
Summary of 2000 Survey of
MSHO Care Coordinators,
Nurse Practitioners, and
Physicians**

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MSHO Demonstration Background

Minnesota has approximately 570,000 seniors in Medicare, of whom 46,000 are eligible for both Medicare and Medicaid. About 26,200 seniors are enrolled in Minnesota's prepaid managed care system for Medicaid beneficiaries—otherwise known as the Prepaid Medical Assistance Program, or PMAP. The PMAP program began in 1985. Medicaid costs in Minnesota are about \$3 billion per year, of which more than \$1 billion is spent on services for seniors. Medicaid spends about \$850 million per year on nursing home care—about 28,000 seniors on Medicaid live in Minnesota nursing homes.

Description of MSHO

In 1997 the Minnesota Department of Human Services (DHS) implemented a five-year demonstration called Minnesota Senior Health Options (MSHO) that combines Medicare and Medicaid financing and brings together primary care, acute care, long-term care, and community-based services. The demonstration serves people over age 65 who are dually eligible for both Medicare and Medicaid. These seniors may reside in either the community or a nursing facility in the seven-county metropolitan area in and around Minneapolis and St. Paul.

The goals of the MSHO demonstration are to:

- Align fiscal incentives to support sound clinical practice
- Provide a seamless point of access for both acute and long-term care benefits for the older consumer
- Move toward a single point of accountability for care for this population
- Reduce cost shifting between Medicare and Medicaid

DHS obtained federal waivers that allow the state to choose contractors capable of providing a full range of integrated medical and social services on a capitated risk basis. The State manages a combined Medicare and Medicaid contract with health plans that, in turn, subcontract with providers to offer this complete set of services. This includes services traditionally covered under PMAP, as well as Medicare deductibles and coinsurance, medical supplies and equipment, dental care, therapies, prescription drugs, medical transportation, and home care services. It also covers services included under Part A and Part B of Medicare, such as hospitalization and physician office visits. In addition, health plans are able to provide extended home care services to frail elderly people who are at risk for nursing home care (called "Elderly Waiver" services). MSHO requires the health plan to be responsible for the first 180 days of care in a nursing facility for those who enroll in MSHO while residing in the community but end up requiring nursing facility care.

MSHO is offered as a voluntary option to the standard PMAP plan, in which most Medicaid-eligible seniors, including those dually eligible, are required to enroll. A single enrollment process is used for both Medicare and Medicaid, with MSHO enrollment being processed at the state level. Plans may market to their current enrollees and participate in the enrollment process for current members. Enrollees may disenroll on a monthly basis, but will stay in the same plan's PMAP program if they do so, until the next PMAP open enrollment period.

Health plans participating in MSHO have been encouraged to develop new partnerships with primary, acute, and long-term care providers and with county public health departments in order to better serve seniors. One expectation for MSHO is that it would encourage a more integrated service delivery system. A unique feature of MSHO is the care coordination that is expected to occur across settings.

Health Plans and Care Systems

Two health plans began MSHO enrollment in March of 1997—a third plan began participating in MSHO in September of that year. The three health plans and corresponding care systems (provider networks) participating in MSHO differ from each other in organizational structure and approach. They also differ by financial arrangements with their subcontracted care systems. All three health plans have had previous experience in the Medicaid managed care program (PMAP), although two plans had no previous experience with Medicare. The third health plan had previously offered a dually eligible product in the Twin Cities for clients in a nursing home setting who chose to enroll in the plan's Medicare risk product.

The networks of all three health plans overlap to some extent; that is, the same provider could be in all three health plans' care systems. Care system networks also differ in many ways, for example, by number and location of hospitals, clinics, and nursing homes and by care coordination models. For example, some care coordination models rely heavily on geriatric nurse practitioners (G.N.P.s) who work extensively in the nursing home setting, while others use social workers or R.N.s who primarily work in clinic and community settings. The care coordination models and the use of care coordinators differ from health plan to health plan and from care system to care system. The MSHO demonstration did not dictate one model or method for these functions. This allows maximum provider flexibility. It also creates variability that can sometimes lead to confusion or duplication of effort. This issue is alluded to in some of the comments provided by survey respondents.

The three health plans participating in MSHO serve both community enrollees and MSHO enrollees residing in a nursing facility; however, the proportion of enrollees living in nursing homes versus the community differs by plan.

MSHO enrollment began in March of 1997. Enrollment figures for October 2000 were 3,727. The total number of people served since the inception of the demonstration is 6,985. The difference between the total number served and current enrollment is due largely to the death rate, given the frailty of this population. Original projections for MSHO over the life of this demonstration (five years) put the total number of people to be served at 4,000—the demonstration met that goal in less than four years. About 75 percent of current enrollees reside in the nursing home, and about 25 percent live in the community.

MSHO Enrollment by Plan, October 2000

Health Plan A

2,340 enrollees

2,156 enrollees, or 92 percent nursing home residents

184 enrollees, or 8 percent community residents

Health Plan B

379 enrollees

173 enrollees, or 46 percent nursing home residents

206 enrollees, or 54 percent community residents

Health Plan C

1,008 enrollees

476 enrollees, or 47 percent nursing home residents

532 enrollees, or 53 percent community residents

Survey Background and Methodology

Background on Performance Measurement

The MSHO demonstration rests on the premise that elderly enrollees will benefit from greater care coordination efforts and a more integrated care management process across organizations. There is an implicit assumption that by integrating the comprehensive benefit package that extends from primary, preventive, and acute care into long-term and community-based care and that by aligning financial incentives through the payment system offered to the health plans, there will be an improvement in continuity of care. As noted, there is variability in care management methods, provider networks, use of county services, physician involvement, and other aspects of the program from one health plan to another. Therefore, some variability in experience from one care coordinator to another, one nurse practitioner to another, or one physician to another is expected. Nevertheless, it is important to document their experiences in a way that will lead to understanding of common issues or themes regarding MSHO.

Current performance measurement tools used in the healthcare field are not designed to measure the integration of care across settings. They do not directly examine communication or coordination of care across multiple provider settings, nor do they track longitudinal outcomes. Similarly, satisfaction surveys are usually focused on only one setting or patient experience at one point in time.

The MSHO demonstration has employed several methods for evaluating the progress toward more integrated systems of care and the effects of MSHO on the client, the provider networks, and the health plans. For example, the Consumer Assessment of Health Plans Survey (CAHPS) instrument was used to obtain information about MSHO clients' satisfaction with care. Also, DHS funded two focus groups—one examining changes in health plans' and care systems' practices due to MSHO and the other asking beneficiaries and families of beneficiaries about their experiences with MSHO. These focus groups provided rich qualitative information about changes in process and structure of care due to MSHO, as well as benefits perceived by clients themselves.

Purpose

As discussed, information from the MSHO beneficiaries themselves and from administrative personnel at both the health plans and care systems (provider networks) on the impact of MSHO had been collected through satisfaction surveys and focus groups. In the focus groups MSHO beneficiaries had identified the care coordination aspect of MSHO as central to the improvements in the care they received. For this reason and because information from the direct professional caregivers had not been collected in a formal way, the MSHO staff at DHS was interested in hearing directly from care coordinators, nurse practitioners, and physicians who see, serve, and treat MSHO beneficiaries directly. The perspectives of these key "players" are important in understanding whether and how the MSHO demonstration has had an impact in serving these beneficiaries.

Survey Design and Process

State of Minnesota MSHO staff requested that we survey three groups: care coordinators who have MSHO clients in their caseloads, nurse practitioners (NPs) who are serving MSHO clients, and physicians who had at least six MSHO beneficiaries in their practices. Three separate sets of questions were developed. The questions for the care coordinator and nurse practitioner surveys were similar, and the format for the survey was a mail-out questionnaire. The questions for the physicians were significantly different from the other two, and the format for the survey was to be a telephone interview. We asked the physicians fewer questions in order to encourage participation. After trying unsuccessfully to set up interviews by telephone with the physicians, we redesigned the physician survey as a mail-out survey.

A set of potential questions was developed by research staff at the National Chronic Care Consortium (NCCC) in June 2000 for each of the three surveys. These questions were reviewed and modified by staff at the Minnesota Department of Human Services. The modified set of questions was then presented to health plan representatives at a meeting in mid-July, and comments or suggested changes were recommended by early August. The three sets of questions (in the form of a draft questionnaire for the nurse practitioners and care coordinators and in the form of an interview protocol for the physicians), were provided to a group of thirteen physicians for their comment. These physicians are the medical directors for the three MSHO health plans and primary participating care systems.

The survey questionnaires and interview protocol were finalized in mid-August, and questionnaires were mailed out with a return requested by mid-September. A stamped, addressed envelope was provided with the nurse practitioner and care coordinator survey questionnaires. Samples of the care coordinator and nurse practitioner surveys and request letters are provided in the Appendix of this report.

For the physician survey, a cover letter describing the survey was included with the survey instrument and was mailed out in August. The physicians were informed that the NCCC was compiling the information and that the research associate from the NCCC would be conducting the telephone interviews. One week later NCCC administrative support personnel began contacting each physician's office to set up the telephone interviews sometime over the next month (that is, by the end of September). It proved difficult to get through the physicians' schedulers in order to set up these interviews. Most schedulers stated that the physicians were not interested in participating. After these attempts were made, NCCC research staff worked with DHS to redesign the survey as a one-page mailout. In addition, the medical directors of all three participating health plans were asked to co-sign the cover letter describing the survey and its purpose, and they did so willingly.

This second mailout to the physicians was conducted in early October, with a request for response by early November. A stamped, addressed envelope was provided with the survey questionnaire. A sample physician survey and request letter are provided in the Appendix.

Participant Selection and Response

Care coordinators working with beneficiaries who were enrolled in MSHO as of June 2000 were identified through the health plans and several care system providers. Names, phone numbers, and mailing addresses for 25 care coordinators were collected. These 25 care coordinators received mailed surveys; 15 responded initially. Telephone calls to the nonresponders generated another 6 returned surveys. In all, 21 of the care coordinators responded for a response rate of 84 percent. Out of these 21 responses, 4 of the care coordinators had just started their jobs and had only one client and therefore did not complete the survey. Another coordinator had just changed jobs and declined to answer the questions. Ultimately, there were 16 completed questionnaires to review. The final response rate was 16 out of 25 coordinators, or 64 percent.

Nurse practitioners working with beneficiaries who were enrolled in MSHO as of June 2000 were identified through the health plans and several care system providers. Names, phone numbers, and mailing addresses for 34 NPs were collected. These 34 NPs received mailed surveys; 17 responded initially. Telephone calls to the nonresponders generated another 7 returned surveys. In all, 24 of the NPs responded for a response rate of 71 percent. Out of these 24 responses, 4 of the NPs had just started their jobs and could complete only a small portion of the survey. Ultimately, there were 20 completed questionnaires to review. The final response rate was 20 out of 34 NPs, or 59 percent.

Physicians working with beneficiaries who were enrolled in MSHO as of June 2000 were identified through the health plans and several care system providers. Names, phone numbers, and mailing addresses were collected for 26 physicians who had at least six patients—several of them had over 100 MSHO beneficiaries in their practices (mostly nursing home residents). These 26 physicians received the mailed survey; 5 responded initially. Telephone calls to the nonresponders generated another 6 returned surveys. In all, 11 out of 26 physicians responded for a response rate of 42 percent.

Survey Summary and Highlights

Care Coordinators

Overall, the care coordinators' responses to this survey were very positive about MSHO. A sizeable majority of the care coordinators reported that there are real advantages with MSHO over other existing structures for healthcare delivery and payment for their dually eligible clients. Strength areas included greater flexibility in service benefits and in how these care coordinators provided care management services, better communication with other providers, and fewer administrative barriers to service. Areas of difficulty included the need for greater awareness of and support about MSHO in the marketplace—particularly among the county representatives who often have the role of describing this program to seniors and helping them enroll. There was strong interest in having MSHO continue and in increasing the number of MSHO-only or MSHO-predominate clinics or other settings, since it was believed that through higher MSHO client penetration in a given clinic and greater MSHO visibility overall, greater practice change would occur.

Nurse Practitioners

Overall, the NPs responding to this survey were largely positive about MSHO. Most said that MSHO had provided several advantages, particularly around access to benefits and streamlining billing and administration. The MSHO demonstration had not noticeably changed the interaction with physicians or the level of personal involvement these NPs had with their clients or patients. The nurse practitioners indicated that this was positive, since the level of interaction was already high. Nearly all of the MSHO beneficiaries served by these NPs were living in a nursing home—and many of these nursing homes were already part of clinical models that were in place prior to MSHO (for example, the EverCare and Fairview Partners models, which rely heavily on proactive clinical management by an NP). As a positive comment, many of these NPs—those practicing the EverCare model of clinical management—stated that the MSHO demonstration has allowed flexibility in benefits but has not altered their clinical care practices for their patients. This also was seen as a positive, since the NPs view the EverCare model as an effective method of providing care to nursing home residents. MSHO provides the integrated funding that allows these clinical models to continue and grow.

Physicians

The sample size of respondents from the physician group is small; less than half of the targeted physicians responded to the survey. Therefore, it is not possible to make conclusions about the general physician sentiment regarding MSHO, even among this group of physicians who have a higher number of MSHO beneficiaries than many other participating physicians.

Based on these 11 physicians' responses, however, feelings are either neutral or slightly positive, with one or two physicians feeling very positive about the impact of MSHO. The physicians' written comments reveal that, where they have had a chance to work with MSHO NPs and coordinators, they see them as a valuable asset. Unfortunately, many of these physicians have not worked with the NPs or coordinators. In addition, many physicians did not seem to have much information about MSHO or their MSHO patients as a group—in fact 6 out of the 11 responding physicians are not even aware when they are treating an MSHO patient. Some physicians expressed pride in the fact that they do not know when they are treating an MSHO patient: "Irregardless of insurance, we treat all our patients the same." This would, understandably, make it difficult to evaluate any impact of the demonstration. The relatively small percentage of MSHO patients in these physicians' practices also appears to serve as a barrier to more profound delivery system change or program evaluation.

Survey Highlights

Area of Inquiry	Care Coordinators n=16	Nurse Practitioners n=20	Physicians n=11
Client profile	Split fairly evenly between clients in nursing homes and in community.	Almost all (19 out of 20) had exclusively nursing home residents.	Question not asked.
Client learns about role of care coordinator or nurse practitioner	Through initial marketing/ enrollment process or through personal visit or call by coordinator.	Through initial marketing/ enrollment process or through nursing home staff or personal visit at nursing home.	Question not asked.
Interaction with other providers	Most (88%) have direct interaction with clients' other medical providers, and most said MSHO facilitated this interaction.	All have direct interaction with clients' physicians. Most (14 out of 18) said that MSHO has not affected this interaction. (Note: Many EverCare or Fairview Partners NPs work under a previously established model of team care.)	6 physicians said they had worked with NPs or care coordinators; 4 said they had not.
Transitions in care	All care coordinators who work with clients in the community said transitions were better with MSHO; care coordinators who work with nursing home residents were also largely positive about MSHO's effects on care transitions.	7 NPs said MSHO had positively affected transitions; 6 said there was no effect, and 7 other NPs did not know of any effect on transitions in care due to MSHO.	Though they were not asked directly about transitions, physicians were asked about follow-up in care. Almost half (5) said they were seeing improved follow-up and monitoring under MSHO for their patients. Another 5 said they did not know if the follow-up was better.
Changes as a result of MSHO	11 out of 16 (69%) of the care coordinators said that MSHO has allowed them to do things differently.	15 out of 19 of the NPs (79% of responders) said that MSHO has allowed them to do things differently.	Question not asked.

Survey Highlights

Area of Inquiry	Care Coordinators n=16	Nurse Practitioners n=20	Physicians n=11
Simplification by MSHO	11 (69%) of the care coordinators said that MSHO has made things simpler for them compared to previous work with similar clients.	8 out of 19 NPs responding (42%) said that MSHO has made things simpler for them.	3 physicians said MSHO provided simplified access to acute and long-term care benefits; another 3 said MSHO did this "somewhat."
Advantages of MSHO	13 (81%) of the care coordinators said there are advantages from MSHO that were not there before.	14 (70%) of the NPs said there were advantages from MSHO.	About half (5) of the physicians said there were advantages from MSHO.
Disadvantages of MSHO	5 (31%) of the care coordinators said that some things were harder for them because of MSHO, though some of the comments were related to aspects of the health plans or counties, not issues that MSHO could influence or impact.	3 (15%) of the NPs said that some things were harder for them because of MSHO, primarily regarding paperwork or eligibility issues.	Only 2 physicians said that there were disadvantages—although their comments referred to the need for greater volume (more patients) in the program in order to make a bigger impact.
Administrative hassles	12 (75%) of the care coordinators said that MSHO had reduced administrative hassles for them, especially in obtaining approval for services.	10 (50%) of the NPs said that MSHO had reduced administrative hassles for them.	2 physicians said that MSHO had reduced administrative conflicts; another 5 did not know, and 3 said that MSHO had not reduced hassles.
Flexibility of benefits	13 (81%) of the care coordinators said that there was greater flexibility of benefits under MSHO.	16 (80%) of the NPs said that there was greater flexibility of benefits under MSHO.	3 physicians said that MSHO provided simplified access to acute and long-term care benefits.
Measuring outcomes	Care coordinators and NPs suggested that outcomes such as hospitalizations, emergency room visits, nursing home admissions and physician office visits be tracked in order to measure the results of MSHO. They also suggested moving away from only looking at healthcare utilization as a measure of success and wanted to see more emphasis on evaluating the quality of the interventions provided, the disability prevention and wellness achieved, and the customer and family satisfaction. NPs were very interested in quality of life measures and provision of comfort care.		The 3 physicians who responded were interested in a variety of measures: healthcare utilization, quality of life, rate of fractures, patient / family satisfaction, and the management of patients across settings.