

Medicare Fee-for-Service
National Implementation Subgroup Analysis—
Final Report for Year 2

Purpose: CMS currently conducts three Consumer Assessment of Health Plan Surveys (CAHPS®) of the Medicare population: 1) the Medicare CAHPS Fee-for-Service (MFFS) Survey; 2) the Medicare CAHPS Managed Care (MMC) Survey; and 3) the Medicare CAHPS Managed Care Disenrollment Assessment Survey. The surveys collect information on an annual basis to fulfill a requirement of Congress (under the Balanced Budget Act of 1997) to provide information to Medicare beneficiaries on the quality of health services provided through the Original Medicare Plan (also known as MFFS) and to compare this information to similar information collected from beneficiaries enrolled in MMC health plans. Comparative information from all three surveys is reported to Medicare beneficiaries on the Medicare Health Plan Compare web site so they can make more informed decisions when choosing a Medicare health plan.

The purpose of the subject study was to gain a better understanding of the differences in health services experience and satisfaction among subgroups of Medicare beneficiaries including geographic levels (national, regional, and state levels), sociodemographics, health plan options, and health status. This report highlights variations in ratings and composites across geographic levels, among subgroups of beneficiaries within the MFFS plan at the regional and individual levels, and among beneficiaries enrolled in MFFS and MMC by plan option and health status.

Results: The analyses performed in this study examined differences across selected data aggregation options for the most-positive CAHPS ratings and responses (i.e., “10,” “Always,” “Not a Problem,” or “Yes”). This required the construction of CAHPS ratings and composites that can be compared across managed care plans and between managed care and fee-for-service options.

The first part of this study focused on the MFFS plan. Three types of analyses were performed:

1. Descriptive Analysis — This consisted of frequency distributions and cross-tabulations by sociodemographics, health status, insurance, and other variables (e.g., MMC penetration rates, urban/rural and having a personal doctor).
2. Multivariate Analysis — This examined differences among subgroups of Medicare beneficiaries at the individual level to understand differences in health services experience and satisfaction by characteristics of subgroups within the MFFS population.

3. Geographic Variation in Ratings and Composites by Subgroups of MFFS Beneficiaries — This analysis looked at variations in performance indicators aggregated to different geographic levels and stratified by a number of beneficiary subgroups including self-reported health status, insurance, and demographic characteristics.

A total of nine performance indicators (five composite indicators and four rating indicators) were used from the *2001 CAHPS Medicare Satisfaction Survey* to conduct these three analyses:

- ▶ *Needed Care Composite*
- ▶ *Good Communication Composite*
- ▶ *Care Quickly Composite*
- ▶ *Respectful Treatment Composite*
- ▶ *Medicare Customer Service Composite*
- ▶ *Rate Personal Doctor*
- ▶ *Rate Specialist*
- ▶ *Rate Health Care*
- ▶ *Rate Medicare*

Key findings from each of the three types of analyses are as follows:

1. Descriptive Analysis:

- There are differences in satisfaction and experience associated with sociodemographic characteristics, health status, and insurance type.
- In general, beneficiaries who gave a higher percentage of most-positive responses were older, female, with less education.
- However, there was an inconsistent pattern of responses by race and ethnicity.

2. Multivariate Analysis:

- In general, beneficiaries who were more satisfied and reported better experiences were older, healthier, less educated, black, Hispanic, or female.
- The association between insurance and ratings and composites was inconsistent. While we would expect that beneficiaries with insurance in addition to Medicare—particularly those with prescription drug coverage—would report higher ratings for obtaining needed care or obtaining care quickly, this was not always the case.

- Beneficiaries living in areas with up to 25% MMC penetration were more satisfied and reported better experiences than those living in areas with greater than 25% MMC penetration.
- Beneficiaries living in urban areas were less satisfied and reported worse experiences with their health care than those living in rural areas.
- Beneficiaries with no personal doctor or nurse were less satisfied and reported worse experiences than those who reported having a personal doctor or nurse.
- Overall, the findings related to age, education, gender, health status, having a personal doctor or nurse, and living in an urban versus rural area are consistent with results from the *2000 CAHPS Medicare Satisfaction Survey*.
 - However, the findings related to MMC penetration are not consistent with results from the *2000 Survey* which found that beneficiaries living in areas with lower MMC (< 25%) were less satisfied, reported more problems, and assigned lower ratings than beneficiaries living in areas with higher MMC penetration.
- Similar to the *2000 Survey*, there are statistically significant differences in satisfaction and experience by type of insurance. Some of the findings are consistent across both years, but others are not.

3. Geographic Variation in Ratings and Composites by Subgroups:

- Compared with other indicators, fewer Medicare beneficiaries give the highest rating to their overall Medicare experience (Rate Medicare indicator) and there is substantial variation across state and regional geographic areas for this indicator.
 - Across all geographic levels, the Needed Care composite constantly garnered the highest percentage of most-positive responses, and the Rate Medicare indicator had the lowest percentages of most-positive responses. These findings are consistent with those of 2000.
- Notable differences across states (including the District of Columbia and Puerto Rico) and regions also exist for personal doctor ratings, specialist rating, and the Medicare Customer Service composite.

These findings are consistent with those resulting from the descriptive and multivariate analyses discussed previously.

- The following subgroups reported lower levels of satisfaction: younger beneficiaries (especially those under 46 years), beneficiaries with more than a high school education, men, those who are less healthy (fair/poor self-reported health, chronically ill, hospitalized overnight in the last year), and those without a personal doctor.
 - When education data are aggregated to the CMS region and the national level, it is apparent that MFFS beneficiaries with less than high school education or general equivalency diploma report more positive perceptions of their health care than those with more education.
 - Generally, a lower percentage of chronically ill beneficiaries responded most positively to all of the indicators compared with beneficiaries who are not chronically ill.
- On the national level, a similar percentage of Medicare beneficiaries indicated that they always receive needed care in 2001 than in 2000 (89% vs. 87%). The percentage of beneficiaries assigning a “10” for Rate Medicare (46%), Rate Health Care (49%), Rate Specialist (485), and Rate Personal Doctor (50%) were all within 1 to 2 percentage points of what they were in 2000.
- Findings were mixed for some of the other subgroups, with members reporting positive experiences and high levels of satisfaction for some of the indicators but negative experiences and dissatisfaction for other indicators.
 - A higher proportion of Hispanic beneficiaries than non-Hispanics gave a rating of “10” across the indicators. Hispanics reported worse experiences than non-Hispanics on the Needed Care, Care Quickly, and Respectful Treatment composites. However, non-Hispanics were less satisfied than Hispanics as they gave a lower percentage of “10s” for all four ratings.
 - Findings were also mixed for race with black beneficiaries reporting worse experiences than blacks on six of the nine indicators.
 - There are also mixed findings for those with different types of supplemental insurance. For example, beneficiaries who

have additional insurance without prescription drug coverage provided a lower percentage of most-positive responses for the Good Communication and Respectful Treatment composites and all four ratings. On the other hand, dually eligible beneficiaries provided the lowest percentage of most-positive responses for the Needed Care and Care Quickly composites.

The second part of this study focused on analyzing comparisons between MFFS and MMC. The ratings and composites listed below were used in this analysis:

- ▶ *Needed Care Composite*
- ▶ *Good Communication Composite*
- ▶ *Care Quickly Composite*
- ▶ *Rate Health Care*
- ▶ *Rate Medicare*
- ▶ *Flu Shot Indicator*

Key findings from each of this analysis are as follows:

- On the national level, the percentage of beneficiaries providing the most-positive response decreased slightly from 2000 to 2001.
- At least half of the states that were ranked in the top 10 or bottom 10 by the percentage of most-positive responses in 2000 remained in the top or bottom 10 in 2001. However, there appears to be more movement in and out of the top and bottom 10 in MFFS compared to MMC.
- On the national level, MMC performed better than MFFS on four of the six indicators in 2001 compared with three of the six indicators in 2000.
- On the national level in 2001, MFFS beneficiaries gave significantly higher percentages of the most-positive response for the Needed Care composite, Rate Medicare Plan a 10, and Rate Health Care a 10. In 2000, MFFS beneficiaries gave a higher percentage of most-positive responses for Needed Care, Rate Medicare Plan a 10, and slightly higher for Care Quickly.
- A consistent finding that emerged from the analysis of the 2000 and 2001 pooled survey data across MFFS and MMC is that a lower percentage of beneficiaries in fair/poor health responded most positively compared with beneficiaries in excellent/very good health for the Needed Care, Good Communications, and Care Quickly composites, and the Health Care rating. However, the opposite pattern occurs for the Flu Shot indicator, with a higher percentage of beneficiaries in fair/poor health receiving a flu shot.

- Possible reasons for this include: 1) beneficiaries in fair/poor health often have more doctor office visits and probably received their flu shot during one of these visits; 2) physicians are more aggressive at recommending the flu shot for those in poorer health; and 3) beneficiaries in fair/poor health elect to receive a flu shot more often than those in excellent/very good health because they feel more vulnerable to catching the flu.
- Among beneficiaries in excellent/very good health, a higher percentage of MMC beneficiaries responded most positively for all but the Needed Care composite, compared to MFFS beneficiaries. State differences tended to be consistent with national results.
- Among beneficiaries in poor/fair health, a higher percentage of MMC beneficiaries responded most positively for four of six indicators (Good Communication, Care Quickly, Rate Health Care, and Flu Shot), compared to MFFS beneficiaries. State differences tended to be consistent with national results.