Implementation of the Medicare Managed Care CAHPS®: Strategies for Reducing Barriers to Access and Increasing Effective Use of Services by Vulnerable Medicare Populations Enrolled in Health Plans

Purpose: This report presents the findings from the Medicare Managed Care Qualitative Subgroup Analysis, the second facet (Round 2) of the Centers for Medicare and Medicaid Services' (CMS) effort to assess the experiences and needs of four subgroups of the Medicare managed care population: disabled enrollees under the age of 65; seniors over age 65 who are in frail health; African-American enrollees; and Hispanic enrollees.

By way of background, the Medicare Managed Care (MMC) Consumer Assessment of Health Plans Study (CAHPS®) surveys were created to obtain information from enrollees in Medicare managed care plans. Respondents are asked questions concerning their assessment of the performance of their plans and providers, their overall health status, health conditions, and health system utilization**.** Results from the surveys provide CMS with information that can be used to monitor the quality of care and relative performance of Medicare managed care plans. The results are also used to examine the need for and to identify strategies that could be used by CMS to measure performance of MMC plans in serving racial/ethnic minority members and develop approaches to improving the quality of care for these populations. Finally, the results provide information to health plans on their own performance that may help them identify problems and improve the quality of care and services they provide to both general Medicare populations and Medicare populations with special needs (e.g., racial/ethnic minority members, people with disabilities).

The MMC CAHPS Subgroup Analysis represents CMS' effort to make an initial assessment of the experiences for various subgroups of the Medicare managed care population. The first facet (Round 1) of this project involved a quantitative assessment of MMC CAHPS survey results. Key findings from Round 1 included the following:

1) Enrollees who are eligible for Medicare due to disability of care, rather than age, have lower ratings of HMO performance across all dimensions of performance than other HMO enrollees.

2) Aged enrollees who are in self-reported fair/poor health and who have limited independence also have lower ratings than other enrollees on most dimensions of HMO performance.

3) Ethnic minority beneficiaries are more satisfied with their health plans overall when compared to other M+C enrollees; however they are less

satisfied specifically with the process of care and their ability to access needed services.

While there are numerous possible explanations for the results obtained in the Round 1 analysis, this facet of the study was limited in its ability to explain the quantitative findings. Thus, the purpose of Round 2 of the MMC Subgroup Analysis was to determine the "why" behind some of those findings. Specifically, the purpose of Round 2 (the qualitative subgroup analysis) was to determine the basis for the three key findings discovered in Round 1. The study team conducted literature reviews, site visits to eleven Medicare managed care plans, two rounds of Technical Expert Panel discussions, and numerous focus groups with subgroup beneficiaries in an effort to answer the following questions:

1) What are the specific characteristics of each of these subgroups that may impact enrollees' satisfaction with their health services under a managed care arrangement?

2) How do beneficiaries in these four subgroups experience their care and access to services under a Medicare managed care plan?

3) What can be done to improve enrollees' levels of satisfaction and the quality of care that they receive?

Results: A careful review of the findings from all four of the study methods suggests that, regardless of the individual's age, race, or disability status, MMC beneficiaries viewed their plan experiences positively or negatively along three critical dimensions: 1) enrollee health status; 2) enrollee financial status; and 3) the enrollee's ability to negotiate the barriers inherent in the managed care system. Specifically, enrollees expected that when they had a health condition requiring medical treatment, the managed care plan would cover the cost of the necessary services. When those services were denied by the plan, individuals often required assistance either to negotiate the intricacies of the plan's bureaucracy (and get the decision overturned) or to locate an alternative, affordable source of treatment. It was this issue of assistance *qua* advocacy that emerged as most difficult for many of the focus group participants, but that also suggested the most possible solutions.

Suggestions were made for solutions to come from the plans themselves, as well as from individuals outside the managed care structure, as follows:

1) Given that the MMC CAHPS plan data evinced a direct correlation between plan satisfaction and enrollees' health status, one might anticipate that improvements in beneficiaries' health care would lead *indirectly* to an increase in plan satisfaction. While both case management (strategies to ensure that each enrollee receives preventive and maintenance service) and disease management (strategies to

ameliorate chronic disease conditions) are utilized by MMC plans with an eye toward balancing quality care and financial sustainability, these programs should also maintain or improve enrollees' health and, by extension, their satisfaction with their plans.

2) Plan benefits information should not only be written or presented in a culturally appropriate way (e.g., in a person's native language, using types of media preferred by the subgroup), but in ways that can be accessed and understood by enrollees with any number of characteristics or challenges (e.g., visual impairments, cognitive challenges). Information should be in a format that is clear, simple, and easy to understand.

3) Plans should simplify their automated telephone customer service option menus, and also make it easier for callers to access a "live" person in a reasonable amount of time. In addition, stricter monitoring of help lines, or even stricter requirements for responding to incoming calls, may help alleviate long wait times and other difficulties encountered by callers.

    - Individuals with various cognitive impairments have significant difficulties trying to negotiate the telephone options maze, which requires a level of patience and attention to detail and sequencing that many beneficiaries do not have.

4) Plans should support regular get-togethers that provide enrollees a forum to share their ideas, experiences, and approaches to solving a common health care problem.

    - The focus groups provided the research team with numerous opportunities to observe the benefits that naturally accrue to individuals who participate in these interactions. Focus group participants, themselves, widely noted the power of the group process.

    - Sometimes it was a simple dynamic, whereby individuals shared their experiences and respective approaches to solving a common problem.

    - Just as often, though, empowered members of the group took up "the cause" of their less-empowered colleagues, sharing names of physicians who were particularly well-liked, offering ideas about where enrollees could go for possible financial assistance, and even suggesting where individuals might be able to receive affordable treatment when they needed services not covered by the HMO.

5) Because of cognitive or other challenges, many MMC plan enrollees need additional support or advocacy from outside the plan, in order to receive the medical care they need.

    - Given the competing interests of the beneficiaries and the plans (i.e., both parties are looking to the other to absorb the cost of health services), the advocate should be somebody *not* directly linked to the plan itself.

    - One example was found on one site visit, where plan enrollees had access to an ombudsperson whose job was to report not to the plan, but to the county health department.