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Issues and Strategies for Measuring and Improving MMC Plan Performance for Racial/Ethnic Minorities

A Medicare Managed Care CAHPS® Report

Final Report

Contract No. HCFA-500-95-0057/TO#4

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June 15, 2002

EXECUTIVE SUMMARY

Background and Objectives

The Medicare+Choice program and its predecessors were implemented by the Centers for Medicare & Medicaid Services (CMS) and by Congress to achieve several objectives, including offering Medicare beneficiaries choices of insurance arrangements and, potentially, to obtain savings for the Medicare program and its beneficiaries through managed care. While the program has been somewhat volatile in recent years due to health plan withdrawals and changes in supplemental benefit offerings and premiums, more than 5.6 million Medicare beneficiaries are currently enrolled in 175 health plans. Enrollment in Medicare+Choice plans constitutes approximately 90 percent of enrollment in the entire Medicare Managed Care (MMC) program.

MMC plans are structured to coordinate the health care services obtained by Medicare enrollees, usually through a Primary Care Provider responsible for overseeing and authorizing all of the services provided to the Medicare enrollee. This coordination of care has the potential to improve the quality of care and outcomes received by Medicare beneficiaries. However, since the initiation of the program there has been concern that the financial incentives of capitation could lead to “skimping” and inadequate care, particularly for enrollees with high-cost health conditions.

In the 1990s, quality measurement, performance standards, and quality improvement initiatives increased for MMC plans. The MMC CAHPS® surveys were initiated by CMS in 1997 to collect information from Medicare health plan enrollees on their experiences and assessment of the performance of these plans in meeting their needs. The MMC CAHPS® includes health plan performance measures, as well as measures of various dimensions of performance, including quality of service, provider relationships, and access to care. Information is also collected on the health conditions, health status, and health care utilization of the MMC enrollees that responded to the survey.

The purpose of this report is 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 quality of care for these populations. The approach taken for this study relies on analysis of differences in experiences reported by racial/ethnic subgroup populations enrolled in MMC plans to identify potential areas of concern in plan service to these populations. These identified issues are used to develop potential additional performance measures that could be used by CMS to assess health plan service to enrollees who are members of these population groups. Finally, several strategies for encouraging MMC plans to improve quality of care and service for their racial/ethnic minority members are suggested.

Data and Methods

For each survey a random sample of 600 MMC enrollees was drawn (except for a few plans with small enrollment for which all eligible enrollees were surveyed) for most plans that had MMC contracts. Three years (1997, 1998, and 1999) of MMC CAHPS® survey data were combined to increase sample size for some of the smaller racial/ethnic groups. Two questions on the survey permit the identification of six racial/ethnic subgroups:

- White (non-Hispanic/Latino).
- Black or African American (non-Hispanic/Latino).
- Asian (non-Hispanic/Latino).
- Native Hawaiian/Pacific Islander (non-Hispanic/Latino).
- American Indian/Alaska Native (non-Hispanic/Latino).
- Hispanic/Latino, any race.

Persons who indicated that they were of more than one race were excluded. The wording of a few questions was modified after 1997; a determination was made as to whether or not the difference was material enough to constitute a new question.

Previous Research

Several earlier studies focusing on racial/ethnic differences in experiences with MMC plans have also relied on MMC CAHPS® data. One study found that racial/ethnic minority subgroups reported relatively lower ratings for some measures of process of and access to care, compared with other MMC enrollees. African Americans reported higher ratings relative to those of non-Whites in most instances. Compared with the overall enrollee population, however, African Americans' plan ratings were mixed—generally higher for provider measures and lower for access to care measures.

Another MMC CAHPS® study examined the relationship between changes in health status and MMC enrollees' ratings of their health plans for African Americans and persons of Hispanic/Latino ethnicity. The results indicated that a change in health status is indeed an important factor in explaining variations in plan ratings. By controlling for changes in health status in multivariate analyses, other variables intended to proxy a variety of special needs/difficulties indicators, such as demographically defined population subgroups, were shown to be less important in explaining aggregate plan rating differences.

A recent report examined health status, health conditions, and use of services by American Indians enrolled in MMC plans relative to non-Hispanic Whites enrolled in these plans. The findings indicated that American Indian enrollees are less likely to see a primary care doctor, less likely to see a specialist, and more likely to be hospitalized and to use ER services than Whites, overall and by five specific health conditions.

While CAHPS® data can help identify differences in perceptions and satisfaction levels among selected subgroups of the MMC population, the data do not offer explanatory causes of these differences. A Barents Group study for CMS sought to enrich the findings of the CAHPS® data

analyses through qualitative research activities. While African American and Hispanic/Latino MMC enrollees differed significantly across a variety of socio-cultural dimensions, their respective interactions with the managed care delivery system were often very similar because of socioeconomic and cultural factors. A review of the findings 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: enrollee health status, enrollee financial status, and the enrollee's ability to negotiate the barriers inherent in the managed care system.

Racial/Ethnic Minority Enrollees in MMC Plans: Health Status, Plan Ratings, and Use of Services

Differences in Health Status. The original analyses of MMC CAHPS® data presented in this report show that African Americans, Hispanics/Latinos, and American Indians/Alaska Natives were less likely to report that their health is "excellent" or "very good" and were more likely to report their health as "fair" or "poor" than were Whites, Asians, and Native Hawaiians/Pacific Islanders. A different pattern emerged when self-reported changes in health status from the previous year were examined. Whites were least likely to report that their health had improved since the previous year and were more likely than any other group—with the exception of American Indians/Alaska Natives—to report that their health had worsened.

Health Plan Ratings. The ranking of four processes of care measures was the same for every MMC enrollee racial/ethnic group. All gave highest marks to office staff courtesy and respect, followed closely by doctor courtesy and respect and spending enough time with them during visits. There was a significant drop to the lowest-ranked measure—waits in the office exceeding 15 minutes were a significant annoyance to all groups. Whites, African Americans, and Hispanics/Latinos tended to give the highest ratings, but the differences across the various groups were minor. Survey respondents gave good ratings for all access-to-care measures. Respondents indicated that they had least difficulty in getting approvals for payments. On the other hand, respondents had most difficulty in getting home health care. Whites generally gave the highest marks, whereas American Indians/Alaska Natives gave the lowest overall scores. Native Hawaiians/Pacific Islanders were the lowest (or nearly the lowest) of all groups in marks for obtaining specialty referrals, equipment, and therapy, but highest for obtaining home health care, payment approvals, and customer service information. The other racial/ethnic groups ranked more consistently across the six measures.

Utilization of Services. The racial/ethnic minority subgroups had very different patterns of usage, both in comparison with the White majority and across subgroups. For instance, all non-White groups were more likely than Whites to report "No visit to doctor's office." Non-White groups (except for Asians) were more frequent users of emergency rooms compared with Whites. White MMC enrollees were most likely to make doctor and specialist visits and to use prescription medicine. African Americans tended to be above-average utilizers of most services, including hospital services, emergency rooms, and home health care, although they made fewer doctor and specialist visits than Whites did. Asians were the lowest utilizers of all listed health care services. American Indians/Alaska Natives had high rates of use of hospitals, emergency rooms, special medical equipment, special therapy, and home health care. Native Hawaiians/Pacific Islanders did not see doctors or specialists as frequently as other subgroups, but had higher-than-average

use of other health care services. Hispanics/Latinos were a little less likely to use most health care services than were Whites and most other racial/ethnic minority groups. Utilization by enrollees with one (or both) of two health conditions—heart disease and diabetes—was compared with that of all enrollees. As expected, enrollees with either of the two conditions had higher utilization rates for all listed measures than did all enrollees. Just comparing the two conditions, persons with heart disease were higher utilizers than persons with diabetes for a majority of services, although the differences tended to be small.

Issues and Strategies for Measuring Performance of MMC Plans in Meeting the Needs of Racial/Ethnic Minority Enrollees

Designing strategies for performance measurement is not a simple task. There are a number of issues that make this task difficult at the health plan level, including:

- ♦ Small numbers of minority members are enrolled in individual health plans and, as a result, a survey sample is unlikely to include more than a few members of any one minority group at the individual health plan level.
- ♦ Data are incomplete on racial/ethnic identity of individual Medicare beneficiaries in the Medicare Enrollment Data Base (EDB), making it difficult to ensure that broad measurement strategies would capture the universe of specific racial/ethnic group enrollees in health plans; and only limited encounter data are reported by health plans, which would restrict broad measurement strategies to examining hospitalization rates.
- ♦ Costs of a mandated, plan-specific performance measurement strategy would likely be high and—since most MMC plans have only small numbers of racial/ethnic minority group members—would likely produce limited information.

There are a number of feasible strategies that would produce useful information on performance of MMC plans in serving minority enrollees. The relatively small number of enrollees of each racial/ethnic minority group in individual health plans, however, suggests that the most feasible approaches are to: (1) examine performance of individual health plans in serving all minority members, combined, rather than individual racial/ethnic groups; (2) measure aggregate performance of MMC plans in serving minority members in more detail to identify common areas of concern raised by racial/ethnic minority enrollees in MMC plans; and (3) compare performance of MMC plans in serving minorities with performance of the original Medicare program in serving minorities.

Four potential strategies for measuring performance of MMC plans in serving minority enrollees that rely on Medicare CAHPS® data are:

1. Develop individual health plan measures of performance, using MMC CAHPS® data, stratified by White and Other Racial/Ethnic Groups.

2. Augment the MMC CAHPS® to obtain additional information from racial/ethnic minority enrollees.

3. Conduct analyses of the Disenrollment CAHPS® survey data to assess differences between minority disenrollees and majority disenrollees on ratings of specific dimensions of performance.

4. Conduct analyses comparing MMC CAHPS® responses and ratings with Fee-for-Service CAHPS® responses and ratings.

CMS is continuing to improve the racial/ethnic identifiers on the Medicare EDB. Eventually, these identifiers can be expected to be complete and accurate for most beneficiaries and will facilitate the use of the EDB as a tool for measuring performance of MMC health plans in serving minority enrollees. Even if the EDB does not have complete data for all racial/ethnic groups, it could be used to examine some dimensions of performance for those groups for which the identifiers are relatively complete. Strategies relying on the EDB that might be considered include:

1. Examining enrollment rates of minority Medicare beneficiaries in each health plan, relative to the minority population in the health plan's market area; and

2. Examining voluntary disenrollment rates of minority enrollees, relative to voluntary disenrollment rates of majority enrollees.

CMS might also conduct studies using a "mystery shopper" approach to test whether providers are as likely to refer minority patients for specialist appointments and other services.

Issues and Strategies for Improving Performance of MMC Plans in Serving Racial and Ethnic Minorities

Issues

A broad strategy for mandating or encouraging MMC plans to undertake programs that would improve the service to racial and ethnic minorities enrolled in these plans could be designed. However, there would be significant costs to MMC plans if it were mandated that they meet extensive new requirements to improve performance in serving minority enrollees. The recent history of the MMC program has been one of substantial numbers of plans withdrawing from participation in the program. Imposing new requirements and costs would likely result in some MMC plans withdrawing from Medicare participation, even though their minority members are generally satisfied with most aspects of the care they receive from their plans.

The strategies developed to improve performance of MMC plans in serving their minority members should focus on development of tools that could be voluntarily adopted by MMC plans, on feedback to health plans of performance measures that provide information on how minority members fare in specific health plans, and on incentives to encourage health plans to improve aspects of process and access that would result in increased use of services and better outcomes for their minority members.

Strategies to Improve Performance of MMC Plans

CMS could develop tools that could be adopted voluntarily by MMC plans that want to address specific areas of performance that are most relevant for minority members. Examples of the type of tools that might be developed by CMS include:

- Cultural competency training programs for health plan providers and staff.
- Outreach/education programs targeted at informing minority members about the importance of routine visits to PCPs and preventive care.
- "Best practices" programs for addressing specific health conditions that disproportionately affect minorities.

CMS could provide to those health plans with at least 10 percent minority enrollment selected MMC CAHPS® measures and data, with national and regional comparisons of these data broken out by (combined) minority enrollees and non-minority enrollees. Examples of this type of feedback include ratings of doctor spending enough time with their patients and patient difficulty in accessing specific services; and the proportion of enrollees who do not have a personal physician, did not see a doctor in the last six months, and who used ER services.

CMS could offer incentives and rewards, such as financial bonuses, to MMC plans that develop and/or implement specific practices and programs to improve performance in serving racial/ethnic minorities. Alternatively, health plans demonstrating improved performance in serving minority enrollees could be exempted from some types of regulatory/reporting requirements.

Conclusion

MMC plans, in general, are meeting the needs of their racial/ethnic minority members. Overall, most minority enrollees give their health plans good ratings that are not significantly different than the ratings given by non-minority members. Futhermore, minority enrollees are more likely than non-minority enrollees to report that their health has improved in the past year.

Based on the MMC CAHPS® data, however, it appears that, compared with non-minority enrollees:

- Minority enrollees have more difficulty in obtaining access to some services.
- Minority enrollees, even when accounting for health conditions, are less likely to have visited their regular provider.
- Minority enrollees are less likely to visit a specialty physician.
- Minority enrollees are more likely to be hospitalized and to use ER services.
- Minority enrollees are more likely to report "fair" or "poor" health status.

CMS could undertake additional monitoring of MMC plan performance in serving minorities and, with these data in hand, could develop a variety of programs and incentives that could reduce disparities and improve the health of minority Medicare beneficiaries. The strategies discussed in this report represent some potential avenues for CMS to consider in achieving those objectives.