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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

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TABLE OF CONTENTS

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.

BACKGROUND AND OBJECTIVES

The Medicare+Choice Program

The Medicare+Choice program and its predecessors were implemented by the Centers for Medicare & Medicaid Services (formerly the Health Care Financing Administration) and by Congress to achieve several objectives, including offering Medicare beneficiaries a choice 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 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, relative to the often-fragmented care provided under original Fee-for-Service Medicare. 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. Since the beginning of the program, CMS has required that MMC plans institute formal quality assurance programs and has monitored plans to ensure that minimum standards of quality of care and services are met.

In the 1990s, quality measurement, performance standards, and quality improvement initiatives increased for MMC plans. Under the Balanced Budget Act of 1997 (BBA-97), Congress mandated that CMS establish quality requirements for health plans enrolling Medicare and Medicaid beneficiaries. The BBA-97 also required that CMS provide Medicare beneficiaries with comparative information on covered benefits, premiums, and quality and performance of managed care plans to assist beneficiaries to make informed choices among plans. In addition, each Medicare plan must participate in at least two Quality Assessment and Performance Improvement projects each year, one chosen by CMS and another that can be selected by the health plan.[1] The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) also directed CMS to develop strategies to assess health plan performance in meeting the needs of racial/ethnic minorities enrolled in Medicare health plans.

The MMC CAHPS® was 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 survey is conducted annually and results are reported and available to beneficiaries, along with information on benefits, premiums, and other quality measures. The MMC CAHPS® includes measures of overall health plan performance and measures of various dimensions of performance, including quality of service, provider relationships, and access to

[1] Lied, Langwell, and McLerran (2001).

care. A related CMS survey collects information on reasons why Medicare beneficiaries disenroll from their MMC plan and makes these results available, along with specific health plan disenrollment rates, to further assist beneficiaries and their advisors to make decisions on health plan enrollment.

While these initiatives provide useful information overall, they do not address the performance of health plans in serving populations with exceptional needs for health care or those who, because of race, ethnicity, and cultural differences, may require special efforts from health plans to assist them to effectively access and use plan services. One component of the MMC CAHPS® project has focused on examining the performance of MMC plans in meeting the needs of those population groups that may require additional attention and efforts from health plans.[2] Results of these special studies suggest that, while health plans are successful in meeting the needs of the typical enrollee, those with exceptional health care needs and members of certain racial/ethnic population groups may encounter greater difficulties in obtaining and using services from their health plans.

Objectives

This report examines the need for and identifies strategies that could be used by CMS to measure performance of MMC plans in serving racial/ethnic minority members and to develop approaches to improving quality of care for these populations.[3] The approach that is 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.

In the next section of this report, we briefly describe the MMC CAHPS® survey and data that are used for the background analysis. Subsequently, evidence on disparities in health care and access to services for racial/ethnic minorities and reasons for these disparities are presented. We then present results from the MMC CAHPS® analyses that highlight differences in health care access to and utilization of services between members of racial/ethnic populations and the White population. Based on these findings, and evidence from previous studies, areas for development of additional targeted performance measures and quality improvement strategies are identified.

[2] See, for instance, Barents Group (2000a, 2000b, 2001a, 2001b, 2001c, 2001d).

[3] A companion report will examine the need for and identify strategies for measuring and improving performance of MMC plans in meeting the needs of Medicare enrollees with exceptional needs for health care.

DATA AND METHODS

Analysis of MMC CAHPS® data provides a foundation for analyzing current performance of MMC plans in serving enrollees who are members of racial/ethnic minority groups. The MMC CAHPS® annual survey sample is sufficiently large to permit analysis of the experiences of African Americans and Hispanics/Latinos enrolled in health plans, relative to the experiences of the majority population. By combining three years of MMC CAHPS® data, excluding multiple responses from sample members included in more than one year, it is possible to also examine the experiences of Asians, American Indians/Alaska Natives, and Native Hawaiians/Pacific Islanders who are members of MMC plans.

Race and Ethnicity

Responses to two multiple-choice questions in the CAHPS® surveys were used to classify individuals by race and ethnicity. The questions and their answer choices were:

What is your race? Please mark one or more.[2]

- ☐ White
- ☐ Black or African American
- ☐ Asian
- ☐ Native Hawaiian or other Pacific Islander
- ☐ American Indian or Alaska Native

Are you of Hispanic or Latino origin or descent?

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

Responses were used to create the six racial/ethnic subgroups described in Table 1.

Table 1. Racial/Ethnic Subgroup Definitions

Subgroup Definition	Descriptor
White, non-Hispanic/Latino	White
Black or African American, non-Hispanic/Latino	African American
Asian, non-Hispanic/Latino	Asian
Native Hawaiian or other Pacific Islander, non-Hispanic/Latino	Native Hawaiian/Pacific Islander
American Indian or Alaska Native, non-Hispanic/Latino	American Indian/Alaska Native
Hispanic/Latino, any race	Hispanic/Latino

Source: MMC CAHPS® Surveys for 1997, 1998, and 1999.

[2] The 1997 survey also included "other" with a write-in box. The relatively few observations for which "other" was the only response for race were deleted for the purposes of this report.

Table 2 provides sample sizes for each of the racial/ethnic groups of interest in the combined MMC CAHPS® data sets for 1997, 1998, and 1999.[3] Clearly, a high majority of MMC enrollees are White and the relative size of each group roughly approximates what it is in the total U.S. population.[4] By combining three years of data, the sample sizes for Asians, Native Hawaiians/Pacific Islanders and American Indians/Alaska Natives are made large enough to permit analyses with a satisfactory degree of statistical significance, even when the groups are disaggregated by gender and other demographic characteristics.

Table 2. Number and Distribution of Unduplicated, Self-Indicated Single-Race and Hispanic/Latino MMC CAHPS® Respondents, 1997-1999

White*	African American*	Asian*	Native Hawaiian/Pacific Islander*	American Indian/Alaska Native*	Hispanic/Latino†
244,030	16,097	5,139	3,951	865	12,098
86.5%	5.7%	1.8%	1.4%	0.3%	4.3%

*Non-Hispanic/Latino. †Hispanic/Latino may be of any race; number shown is for single-race persons only.
Source: MMC CAHPS® Surveys for 1997, 1998, and 1999.
Notes: Numbers exclude persons of unknown Hispanic/Latino ethnicity. Compare with Table 3.

Self-indicated Multiracial Individuals

A classification issue arises because the respondents are allowed to check more than one box for race. Approximately 98 percent of survey respondents checked only one box. However, one percent of respondents checked two boxes and the remaining one percent checked three or more boxes.

Table 3 shows how many indicated one or more boxes. Along the main diagonal, the top figure in each cell is a "minimum," i.e., the number of persons that indicated *only* one race; the bottom figure is "all-inclusive," i.e., it includes the single-race-only persons as well as those who indicated the relevant race *and* one to four other races. For example, 276,055 persons indicated White only and 279,787 indicated White and, possibly, other races as well. Cells above the main diagonal show how many respondents indicated just the two races associated with that particular row and column; e.g., 459 indicated White and African American but no additional races. (The cells below the main diagonal are duplicative of those above and so are left empty.) It is not obvious how to classify the relatively few individuals that indicated three or more races so they

[3] The numbers in Table 2 pertain to single-race individuals of known Hispanic/Latino origin status.
[4] Actually, the proportion of MMC CAHPS respondents that are White is slightly greater than the proportion that is White in the total U.S. population age 65 and over. For the minority racial/ethnic groups, the opposite is true. That is, Whites are slightly over-represented—and minorities are slightly under-represented—in the MMC population compared with the total aged U.S. population.

are excluded from this report. Those respondents who did not choose any race are also excluded.[5]

Table 3. Number of Self-Indicated Single and Biracial MMC CAHPS® Respondents

	White	African American	Asian	Native Hawaiian/ Pacific Islander	American Indian/ Alaska Native
White	276,055 279,787	459	148	145	2362
African American		21,089 22,534	37	9	358
Asian			5,786 6,519	83	9
Native Hawaiian/ Pacific Islander				4,302 4,493	10
American Indian/ Alaska Native					1,289 4,621

Source: MMC CAHPS® Surveys for 1997, 1998, and 1999.
Notes: Numbers for each race include non-Hispanic and Hispanic individuals, as well as persons of unknown Hispanic ethnicity. Compare with Table 2. Along the main diagonal, the top figure in each cell is the "minimum," i.e., the number of persons that indicated *only* one race; the bottom figure is "all-inclusive," i.e., how many indicated the relevant race *and*, possibly, any number and combination of other races. Cells above the main diagonal show how many respondents indicated just the two races associated with that particular row and column. The cells below the main diagonal are duplicative of those above the main diagonal.

MMC CAHPS® Surveys

Following is a brief description of how the samples were obtained for the MMC CAHPS® Surveys. MMC plans were eligible if they had separate Medicare risk contracts in effect and had been in business for at least two years. Some plans had multiple contracts with CMS. In such cases, each contract unit was treated separately because each contract represents a separate business relationship with CMS. A sample of enrollees who had been enrolled for at least 12 months was drawn for each contract. A random sample of 600 was drawn for most plans, except for a few plans with a small membership for which all eligible enrollees were surveyed.

Beneficiaries were excluded if they disenrolled from the plan after being selected for the sample and before final compilation of the survey data.

[5] The numbers in each cell of Table 3 include Hispanics/Latinos, non-Hispanics/Latinos, and persons of unknown Hispanic/Latino ethnicity. Therefore, the top figure along the main diagonal for a given race is the number of single race persons, who may also be Hispanic/Latino. This is in contrast with Table 2 in which the figure for a given race *excludes* Hispanics/Latinos, who are presented in their own column.

The surveys for 1997, 1998, and 1999 are generally comparable from year to year so the three years of data were aggregated. Some adjustments were required, however. Survey questions that differed across years were handled as described in the following section. A few individuals were surveyed in more than one year; in such cases only records for the latest year were kept. Because the adjusted aggregated data constitute essentially a random sample survey, the unweighted descriptive statistics used in this report do not differ significantly from weighted statistics.

Question Comparability

The content and question wording for the 1997 MMC CAHPS® survey are different from those for the 1998 and 1999 surveys (which are identical) for some questions. The wording of a few questions was modified after 1997. In an attempt to retain as much year-to-year comparability as possible, these differences were addressed question by question—assisted by an examination of response statistics—and a determination was made as to whether or not the difference was material enough to constitute a new question. Table 4 provides a brief description for each case.

Table 4. Resolution of Question Wording Changes in the MMC CAHPS® Surveys

Question # on 1997 Survey	Question # on 1998 and 1999 Surveys	Topic	Problem/Resolution
12	16	Frequency of seeing a specialist	The answers to the 1997 question are qualitative ("Sometimes," "Usually," …), whereas the answers to the 1998/1999 questions are quantitative ("1," "2,"…). The 1997 question was treated as a different question from its equivalent in 1998 and 1999.
19	23	Care for illness or injury	The 1997 question asks if the respondent tried to see a doctor right away to get care for an illness or injury and the one for 1998 and 1999 asks if the respondent had an illness or injury that needed care right away from a doctor. 1997 was treated as a different question from its equivalent in 1998 and 1999.
21	21	Making appointments for regular or routine care	The 1997 question asks if the respondent tried to make an appointment and the one for 1998 and 1999 asks if the respondent made an appointment. 1997 was treated as a different question from its equivalent in 1998 and 1999.
24	25	Times went to emergency room	Multiple-choice answers are different between surveys. The choices for all survey years were recoded to: "None" and "1 or more times."
45	43	Prescriptions	The question in 1997 asks if the respondent obtained any prescription medicine and the one in 1998 and 1999 asks if the respondent obtained any new prescription or refilled a prescription. 1997 was treated as a different question from its equivalent in 1998 and 1999.
77	80	Times advised to quit smoking during specified period	The specified periods differed for the 1997 survey (12 months) and the 1998 and 1999 surveys (6 months). 1997 was treated as a different question from its equivalent in 1998 and 1999.

Source: MMC CAHPS® Surveys for 1997, 1998, and 1999.

PREVIOUS RESEARCH

Racial and ethnic disparities in health status, health insurance coverage, health care utilization, and treatment patterns have become of increasing concern to policymakers. A substantial body of literature has documented racial and ethnic differences in health care access and utilization, as well as disparities in specific treatments.[6]

One recent study, for example, examined hospitalization rates of aged Medicare beneficiaries by racial/ethnic characteristics, including American Indians/Alaska Natives, using enrollment data base indicators of race/ethnicity and Medicare hospital claims data.[7] The study found higher hospitalization rates for African Americans, Hispanics, and American Indians/Alaska Natives than for Whites.

Another study was triggered by a pilot study that suggested that African Americans enrolled in managed care organizations (MCOs) were more likely than Whites to be denied authorization for emergency department (ED) care through gatekeeping.[8] A second, larger study sought to determine the association between ethnicity and denial of authorization at another hospital. It was found that African Americans were more likely to be denied authorization for ED visits by the gatekeepers representing their MCOs even after adjusting for confounders. The study's authors concluded that the questions their findings raise about the equity of gatekeeping indicate a need for additional research in this area.

Most of the literature has focused on African Americans and Hispanics/Latinos in comparison with the White majority, in part because other racial/ethnic minority groups represent a very small proportion of the population and, thus, sufficient data are not available to permit examination of their health care patterns.

Factors Affecting Access and Effective Use of Services by Racial/Ethnic Minorities

Financial difficulty in paying for health care services has been found to be the largest obstacle affecting minorities' access to and use of health care services. Forty-five percent of Hispanic/Latino adults, 41 percent of Asian adults, and 35 percent of African American adults reported difficulty paying for medical care, compared with 28 percent of White adults.[9] However, minority groups often experience cultural- and race-specific barriers. Lack of cultural and linguistic competency among health care providers and institutions, geographic distribution of providers compared with residential patterns of particular racial and ethnic groups, insufficient knowledge of the HMO systems, both intentional and unintentional discrimination in the health care system, cultural unresponsiveness by the health care system,[10] and perceptions of

[6] See, for example, Gaskin and Hoffman (2000), Monheit and Vistnes (2000), Waidmann and Rajan (2000), and Weinick et al. (2000).
[7] Eggers and Greenberg (2000).
[8] Lowe et al. (2001).
[9] BNA Health Care Policy Report (1999).
[10] Robert Wood Johnson Foundation (1998).

discrimination on the part of members of various racial and ethnic groups, are just a few barriers.[11] These and other barriers are discussed in more detail in the following paragraph.

Limited Experience with the Health Care System and with Managed Care Prior to Becoming Eligible for Medicare

Some studies have suggested that African Americans and Hispanics/Latinos were more likely than Whites to lack the experience and skills that are necessary to obtain and effectively use health services.[12] In part, this lack of experience and skills may be due to two factors: 1) minority groups may have less formal education, on average, than the majority population; and 2) a higher proportion of minorities are uninsured, prior to becoming eligible for Medicare, and have limited experience with insurance and with managed care specifically. Those who do not have insurance are less likely to use health care services on a routine basis, and are less likely to have a regular source of care.[13] Irregular and infrequent interactions with the health care system, prior to becoming eligible for Medicare and joining a Medicare health plan, does not provide the experience, knowledge, and skills necessary to overcome managed care barriers to access and effectively use health services. As one example, a recent study found that managed care denials of emergency room claims disproportionately affected African American enrollees of health plans, who were more likely to visit the ER and also more likely to be denied payment for the ER visit.[14]

Geographic Accessibility of Providers

The geographic distribution of providers results in a paucity of providers in minority communities.[17] Many providers have made economic decisions to locate in more affluent areas, which are often primarily White neighborhoods rather than minority neighborhoods. Providers absent in minority communities include physicians, as well as long-term care and home health care providers.[18] As a result, minority members experience problems obtaining care and have fewer choices of providers. These factors may influence the positive or negative perception by a Medicare beneficiary of a health plan's ability to provide satisfactory services.

Provider-Patient Interaction

African American and Hispanic/Latino patients may prefer race/ethnic compatibility when seeking care. African American patients considered the race of the physician as a preference factor in their decision, and not necessarily geographic convenience alone.[19] Gray and Stoddard found that African Americans were more likely to select a minority physician when available.[20] According to Cooper-Patrick and colleagues, higher levels of patient satisfaction, more patient

[11] BNA Health Care Policy Report (2000).
[12] Robert Wood Johnson Foundation (1998).
[13] Kaiser Commission on Medicaid and the Uninsured (2000).
[14] Lowe et al. (2001).
[15] Robert Wood Johnson Foundation (1998).
[16] Kaiser Commission on Medicaid and the Uninsured (2000).
[17] Watson (1997).
[18] Watson (2000).
[19] Somnath et al. (2000).
[20] Gray and Stoddard (1997).

involvement in care, and better health outcomes often resulted through improved cross-cultural communication and interaction between primary care physicians and patients.[21] Several studies have analyzed the consequences of race-concordant physician-patient relationships. In a recent study by La Veist and his colleagues at the Johns Hopkins Bloomberg School of Public Health, patients were less likely to perceive discrimination when the patient-provider relationship was race-concordant.[22] In non-concordant relationships, differences may be reflected in the nature of physician-patient interactions during the discussion of treatment options.[23] For example, African American patients who saw African American physicians experienced a greater degree of participation in their treatment and in the decision-making process.[24]

By ensuring patient access to minority physicians, health plans could increase the likelihood of effective communication and interaction between patients and providers. In turn, this could lead to increased use of services by minority enrollees and improved outcomes.

Provider Biases

Treatment decisions may reflect subconscious biases on the part of providers. Physicians' predispositions for more aggressively treating patients who are wealthier, more productively employed, and more assertive have been documented.[26] Similarly, the race and sex of a patient may independently influence how physicians manage chest pain, regardless of clinical symptoms.[27] Racial and ethnic biases and stereotyping may be unintentionally incorporated into a provider's interpretation of patient symptoms, assumptions regarding patient behavior, and medical decision-making.[28] Sheifer, Escarce, and Schulman corroborate the premise that physician biases may impact treatment decisions, thus furthering racial disparities.[29]

Research also has shown that physicians were more likely to include patients in health care decisions when the patient was of the same ethnic group as the provider.[30] In addition, patient satisfaction reportedly varied with the degree that the patient was included in a participatory medical decision-making process. African Americans were more likely than Whites to say they were not included in the decision-making process and rated their visits as significantly less participatory after adjusting for age, gender, education, marital status, health status, and the length of the patient-physician relationship.[31]

[21] Cooper-Patrick et al. (1999).
[22] La Veist et al. (2000).
[23] Horner et al. (1995).
[24] Cooper-Patrick et al. (1999).
[25] Gray and Stoddard (1997).
[26] Council on Ethical and Judicial Affairs of the American Medical Association (1990).
[27] Schulman et al. (1999).
[28] Cooper-Patrick et al. (1999).
[29] Sheifer et al. (2000).
[30] Cooper-Patrick et al. (1999).
[31] Cooper-Patrick et al. (1999).

English Language Proficiency

Among the barriers encountered in the health care system by the Hispanic/Latino population, language and communication difficulties are among the most prevalent. The U.S. Census Bureau reports that in 1997, approximately 44 percent of the Hispanic/Latino population was foreign-born.[33] Spanish is the first language for a significant portion of this group. Due to a lack of Hispanic/Latino providers, many of these patients may encounter communication barriers with their health care providers.[34] Although many non-Hispanic/Latino providers may speak Spanish as a second language, they are less likely to be able to converse in Spanish to a degree that would facilitate the comprehensive exchange of medical information and adequate outreach efforts. The inability of a health care provider to solicit patient impressions about his or her illness, due to language difficulties, poses a significant problem to the delivery of effective health care to individuals of Hispanic/Latino origin, in addition to frustration on the part of a Hispanic/Latino patient. Often, Hispanic/Latino patients report that providers fail to listen to them and fail to consistently ask about other treatment regimens being used, and the patient leaves the encounter without being assured that they will get needed care.[35]

Thus, for Hispanic/Latino patients the degree of racial concordance is even more important due to the extensive language and cultural differences that can exist between patient and provider. In a study to assess the literacy of patients at two large urban public hospitals, 61 percent of Spanish-speaking patients were found to have inadequate or marginal functional health literacy.[36] By comparing these patients to functionally literate patients, researchers discovered that inadequate health literacy has a negative impact on patient management of both diabetes and hypertension.

Evidence from the MMC CAHPS®

As part of the five-year MMC CAHPS® project, a specific research agenda was developed to examine differences among subgroups of the MMC population in their experiences and ratings of overall and dimensions of health plan performance. One component of this research agenda focuses on racial/ethnic minorities, including African Americans, Hispanics/Latinos, and other Racial/Ethnic Minorities.

Analyses of differences by race and ethnicity in ratings of MMC plans have been conducted on an ongoing basis, as each year of the MMC CAHPS® data become available. Results indicated that, while health plans were viewed favorably overall by African Americans and Hispanics/Latinos, these groups rate some dimensions of process of care and of access to care

[32] Reschovsky (1999/2000).
[33] U.S. Department of Commerce (1993).
[34] Hispanics/Latinos only represent approximately five percent of all U.S. physicians. Furthermore, Hispanic-Latinos represent only about three percent of mid-level providers such as registered nurses, pharmacists, and physical therapists. Some of these providers may not speak Spanish, which means that although cultural barriers may be avoided, a language barrier may exist that interferes with a provider's ability to take an accurate medical history and/or interpret a patient's overall symptoms and/or condition. See Ginzberg (1991).
[35] Barents (1999a, 1999b, 2001c).
[36] Bass and McKaughan (1996).

lower than did the majority population.[37] While the differences in ratings were small, the fact that they were persistent across years suggests that some minority enrollees might have had greater difficulty understanding and navigating the managed care system than did majority enrollees.

Additional analyses that focused on the relationships between changes in health status and ratings of health plans, however, demonstrated that those enrollees who experienced a decline in health status were more likely to give lower ratings to their health plans. Multivariate analysis determined that a portion of the racial/ethnic differences in ratings of process of care and access to care could be explained by changes in health status, when that variable was included in the estimation.[38]

The MMC CAHPS® data also permit examination of patterns of use of health services by enrollees. Two studies suggest that minority enrollees in Medicare health plans were less likely to visit their primary care provider and were less likely to visit specialty physicians. In turn, minorities were more likely, on average, to be hospitalized and to use emergency rooms. These patterns also were observed for enrollees with several self-reported serious health conditions (i.e., minorities who reported that they had a heart condition were less likely to have visited a primary care provider and less likely to have visited a specialty physician than were majority enrollees with a self-reported heart condition).[39, 40]

Another report presents the findings from the MMC Qualitative Subgroup Analysis, the second facet of the CMS effort to assess the experiences and needs of four subgroups of the MMC population. Among these subgroups are African- American enrollees and Hispanic enrollees. The goal of the qualitative subgroup analysis was to determine the basis for the findings of the quantitative MMC CAHPS® studies. The study team conducted literature reviews, site visits to eleven MMC plans, two rounds of Technical Expert Panel discussions, and numerous focus groups with subgroup beneficiaries in an effort to answer the following questions:

- What are the specific characteristics of each of these subgroups that may impact enrollees' satisfaction with their health services under a managed care arrangement?
- How do beneficiaries in these four subgroups experience their care and access to services under a MMC plan?
- What can be done to improve enrollees' levels of satisfaction and the quality of care that they receive?

[37] Barents (2000a and 2000b)
[38] Barents (2001b)
[39] Barents (2001a).
[40] Barents (2001d).

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, M+C beneficiaries viewed their plan experiences positively or negatively along three critical dimensions:

- Enrollee health status.
- Enrollee financial status.
- 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 a plan's bureaucracy (and get the decision overturned) or to locate an alternative, affordable source of treatment.[41]

Discussion

The research findings discussed briefly above suggest that racial/ethnic minority members of Medicare health plans may have greater difficulty obtaining access to needed services and/or effectively using those services. The barriers to care may include lack of experience and skills to understand and deal effectively with managed care utilization management systems, fragmented use of services prior to becoming Medicare-eligible that established patterns of low use and reliance on emergency room services, limited facility with English, and cultural differences that may result in poor communication and ineffective interactions with health plan providers and staff. The patterns of lower use of primary care and specialty physician services and higher rates of hospitalization and ER use by racial/ethnic minority enrollees in Medicare health plans suggest that some or all of these factors may be present in Medicare health plans and, if addressed, could have a positive impact on health care use and health outcomes for these health plan members.

[41] Barents (2001c).

RACIAL/ETHNIC MINORITY ENROLLEES IN MMC PLANS: HEALTH STATUS, PLAN RATINGS, AND USE OF SERVICES

This section presents data from the MMC CAHPS® surveys that describe respondents' health status, health conditions, ratings of plans on process of care and access to care, and utilization of several types of health care services. These data, which are disaggregated by racial/ethnic group, provide a backdrop for discussing measurement and performance improvement issues for minority groups that are addressed in subsequent sections.

Differences in Health Status

Table 5 presents MMC CAHPS® statistics on health status, change in health status, and the presence of a serious health condition, by racial/ethnic group.

Table 5. Health Status and Health Conditions for MMC CAHPS® Enrollees, By Racial/Ethnic Group

Survey Question	White	African American	Asian	Native Hawaiian/ Pacific Islander	American Indian/ Alaska Native	Hispanic/ Latino
Current Health Status	**%**	**%**	**%**	**%**	**%**	**%**
Excellent or Very Good	34.4	25.1	34.8	38.5	31.7	31.7
Good	38.5	35.2	39.6	33.6	30.3	30.3
Fair or Poor	27.1	39.8	25.6	27.9	38.0	38.0
Health Status Compared with 1 Year Ago	**%**	**%**	**%**	**%**	**%**	**%**
Improved	18.8	31.3	23.0	37.0	26.4	28.6
Same	64.5	53.2	63.5	49.5	52.1	55.7
Worse	16.8	15.4	13.5	13.5	21.5	15.7
Current Health Status	**%**	**%**	**%**	**%**	**%**	**%**
Heart Disease	25.0	21.4	16.8	22.4	27.0	22.2
Cancer	15.8	10.7	8.6	13.4	12.2	9.9
Stroke	8.1	10.7	7.7	9.8	12.9	8.6
COPD	5.8	4.1	2.9	4.8	8.5	3.9
Diabetes	14.0	27.0	18.2	15.0	25.0	22.8

Source: MMC CAHPS® surveys for 1997, 1998, and 1999.

African Americans, Hispanics/Latinos, and American Indians/Alaska Natives were less likely to report that their health was "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.

When specific self-reported health conditions were examined, American Indians/Alaska Natives more frequently reported having been told by a doctor that they had heart disease, stroke, and

COPD than any other racial/ethnic group. All other racial/ethnic groups were more likely to report having diabetes than Whites, with African Americans most likely to report diabetes. Whites were more likely to report having cancer than any of the other groups and more likely to report heart disease than any other group except American Indians/Alaska Natives. Overall, Asians were least likely to have one of these serious health conditions, reporting the lowest proportions among all the groups for all conditions except diabetes.

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 since the previous year. Since changes in health status may reflect the quality or quantity of health plan services and outcomes, the fact that all racial/ethnic minorities reported higher rates of improvement in health status and (with the exception of American Indians/Alaska Natives) lower rates of worsened health than Whites may indicate that MMC plans are providing good service to racial/ethnic minorities, in general.

Conclusions about racial/ethnic differences in health status and need for services are difficult to draw based on these data. American Indians/Alaska Natives are the only group that appears to have consistently greater needs for health care, citing poorer health status, worse health than in the previous year, and more serious health conditions than any other group. Asians, on the other hand, appear to be in overall better health than other groups, being least likely to report "fair or poor" health, least likely to report that their health had worsened, and reporting the lowest proportions of serious health conditions. Relative to White enrollees however, racial/ethnic minority enrollees in MMC plans have substantially higher rates of diabetes, suggesting that health plans need to have strong diabetes identification and management programs to meet the needs of these population groups.

Health Plan Ratings

To explore further the experiences of members of racial/ethnic minority groups enrolled in MMC plans, we conducted analyses of their ratings of "process of care" and "access to care" measures, using the MMC CAHPS® data. The objective of these analyses was to assess whether any differences in experiences or use of services between members of these groups and Whites would suggest systematic disparities in the delivery of service and/or health care.

Process of Care

Table 6 presents MMC enrollees' ratings for several process-of-care metrics. The ranking of the 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. Although the differences were quite small, all racial/ethnic groups rated office staff courtesy and respect somewhat lower than did Whites. It was interesting, also, that Asians, Native Hawaiian/Pacific Islanders, and American Indian/Alaska Natives consistently rated their plans lower on all process of care measures than did White enrollees. There was a significant drop off 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.

Table 6. Means of Process of Care Ratings by MMC CAHPS® Enrollees, By Racial/Ethnic Group

Survey Question	White	African American	Asian	Native Hawaiian/ Pacific Islander	American Indian/ Alaska Native	Hispanic/ Latino
Office staff courtesy and respect (1-4)	3.86	3.83	3.69	3.82	3.79	3.81
Doctor courtesy and respect (1-4)	3.68	3.70	3.62	3.63	3.52	3.72
Spend enough time (1-4)	3.54	3.56	3.46	3.49	3.43	3.54
Wait more than 15 minutes (1-4)*	2.09	2.00	1.96	2.05	1.99	1.90

Source: MMC CAHPS® surveys for 1997, 1998, and 1999.

Note: Numbers in parentheses indicate the range of multiple-choice answers. A higher number indicates a more favorable rating.

*Scale inverted from survey question: 1=Always to 4=Never.

Access to Care

Table 7 compares racial/ethnic groups' ratings for several access-to-care measures. They generally gave good ratings for all measures, with the lowest score being 2.44 on a scale for which 3 is best. Respondents indicated that they had least difficulty in obtaining approvals for payments; in fact, this question elicited considerably higher ratings than any other question and was rated highest by all racial/ethnic groups. On the other hand, respondents had most difficulty in obtaining home health care. Obtaining information from customer service also received below-average marks. These findings point to areas in MMC plans are already doing a good job and those to which they could devote more resources to improve enrollee satisfaction.

Whites generally gave the highest marks, whereas American Indians/Alaska Natives gave the lowest overall scores. Again, although the differences are small, members of minority groups ranked their plans lower than did White enrollees on level of difficulty in getting referrals to specialists, equipment, and therapy. Interestingly, Native Hawaiians/Pacific Islanders were the lowest (or nearly the lowest) of all groups in marks for getting specialty referrals, equipment, and therapy, but highest for getting home health care, payment approvals, and customer service information. American Indian enrollees ranked their plans lowest, among all the groups, on difficulty in obtaining referrals to specialists, difficulty in obtaining home health care, difficulty in obtaining approvals for payments, and difficulty in obtaining information from customer service.

Table 7. Means of Access to Care Ratings by MMC CAHPS® Enrollees, By Racial/Ethnic Group

Survey Question	White	African American	Asian	Native Hawaiian /Pacific Islander	American Indian/ Alaska Native	Hispanic/ Latino
Level of difficulty in getting referral to specialist (1-3)	2.79	2.72	2.64	2.67	2.63	2.69
Level of difficulty in getting equipment (1-3)	2.74	2.63	2.71	2.52	2.64	2.61
Level of difficulty in getting therapy (1-3)	2.70	2.61	2.63	2.50	2.63	2.64
Level of difficulty in getting HH care (1-3)	2.60	2.48	2.56	2.64	2.46	2.48
Level of difficulty in getting approvals for payments (1-3)	2.87	2.82	2.88	2.88	2.75	2.81
Level of difficulty in getting information from customer service (1-3)	2.61	2.56	2.58	2.71	2.44	2.56

Source: MMC CAHPS® surveys for 1998, and 1999. Data for the 1997 MMC CAHPS® survey are not comparable.
Note: Numbers in parentheses indicate the range of multiple-choice answers. A higher number indicates a lower level of difficulty.

Utilization of Services

All Enrollees

The percentage of MMC enrollees in each racial/ethnic group that utilizes various types of health care services is shown in Table 8. The racial/ethnic minority subgroups had very different patterns of usage, both in comparison with the White majority and across subgroups.

- All other racial/ethnic groups were more likely than Whites to report "No visit to doctor's office."
- All other racial/ethnic 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, 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 less likely to use most health care services than were Whites and most other racial/ethnic minority groups.

Table 8. Health Care Utilization for MMC CAHPS® Enrollees, By Racial/Ethnic Group

Survey Question	White	African American	Asian	Native Hawaiian/ Pacific Islander	American Indian/ Alaska Native	Hispanic/ Latino
Health Care Use in Last 6 Months	**%**	**%**	**%**	**%**	**%**	**%**
No Visit to Doctor's Office	20.8	23.3	29.8	30.1	26.3	25.4
One Visit to Doctor's Office	21.4	16.9	20.6	22.7	17.3	17.6
Two to Four Visits to Doctor's Office	43.1	44.1	39.6	35.0	39.0	42.2
Five or More Visits to Doctor's Office	14.7	15.8	10.1	12.3	17.4	14.8
Any Visit to a Specialist	56.0	49.7	45.3	44.2	48.3	53.4
Any Hospital Inpatient Use	18.2	19.7	12.9	19.0	24.9	18.1
Any Emergency Room Use	13.1	18.1	11.8	18.6	19.5	14.0
Any Prescription Medicine Use	82.2	77.7	70.0	76.3	73.1	77.3
Any Special Medical Equipment Use	11.0	14.7	7.8	15.5	17.7	10.3
Any Special Therapy Use	9.9	10.5	7.6	10.3	11.8	10.1
Any Home Health Care Use	4.9	8.5	3.1	7.7	8.6	5.1

Source: MMC CAHPS® surveys for 1997, 1998, and 1999.

There clearly were differences across MMC CAHPS® survey groups in the utilization of various types of health care services, which might indicate where MMC plans need to do more on behalf of racial/ethnic minorities—for instance, in getting more of them into doctors' offices. On a deeper level, these disparities raise the question of what portion of these differences is due to differences in the needs of the various groups and what portion is related to other factors, such as availability of services, cultural differences in the propensity of MMC plan enrollees to avail themselves of available services, and possible bias in the provision of service.

Some of the differences in use of services shown in Table 8 could be explained by differences in health status or health conditions. To further examine use patterns, enrollees who reported that they had heart conditions or diabetes were analyzed separately. Tables 9 and 10 present utilization data on each of these two diseases.

Enrollees with Heart Disease

Table 9 presents health care utilization information for MMC enrollees with heart disease. Top-line findings for each racial/ethnic group are as follows:

- All racial/ethnic minority group enrollees with heart conditions were less likely to visit a doctor than were White enrollees.
- Whites with heart disease are more likely to have doctor's office and specialist visits and to use prescription medicine than other groups, but used fewer services of other types.
- African Americans with heart disease made the most frequent use of emergency rooms.
- Asian MMC enrollees with heart disease were the least intensive users of many health care services.
- Native Hawaiians/Pacific Islanders with heart disease tended to see specialists more and visit a doctor's office less, compared with other groups with heart disease; they were also above-average users of hospitals, emergency rooms, and other types of health care services.
- American Indians/Alaska Natives with heart disease were hospitalized more frequently and made more frequent use of emergency rooms and special medical equipment.
- Hispanics/Latinos with heart disease were somewhat more frequent users of health care services than Whites were, except for doctors, specialists, and prescription drugs.

Enrollees with Diabetes

The health care utilization patterns for MMC enrollees with a history of diabetes are presented in Table 10. Following are summary results by racial/ethnic group.

- All racial/ethnic minority members with diabetes were less likely to see their doctor than were White members.
- Use of emergency rooms also showed considerable variation across groups. American Indians/Alaska Natives, African Americans, and Native Hawaiians/Pacific Islanders with diabetes had the highest rates of such visits, whereas Asians and Whites had much lower rates.
- White MMC enrollees with diabetes made relatively frequent visits to doctor's offices and specialists and were more likely to use prescription medicine; otherwise, they were moderate to below average compared with other groups.
- African Americans with diabetes ranked above average in use of emergency rooms and home health care, but were about average with respect to the other types of health care.
- Asian MMC enrollees with diabetes were low users of most categories of health care, compared with Whites and other racial/ethnic minority groups.
- Native Hawaiians/Pacific Islanders with diabetes tended to be relatively high utilizers of many types of health care, except for doctor and specialist visits.

- American Indians/Alaska Natives with diabetes were at or near the top in use of nearly every category of health service.
- Hispanic/Latino MMC enrollees with diabetes were about average in use of nearly all health care services.

Table 9. Health Care Utilization for MMC CAHPS® Enrollees with Heart Disease, By Racial/Ethnic Group

Survey Question	White	African American	Asian	Native Hawaiian/ Pacific Islander	American Indian/ Alaska Native	Hispanic/ Latino
Health Care Use in Last 6 Months	**%**	**%**	**%**	**%**	**%**	**%**
No Visit to Doctor's Office	12.7	14.7	19.0	19.8	17.0	15.9
One Visit to Doctor's Office	17.4	12.7	16.2	19.1	13.9	15.0
Two to Four Visits to Doctor's Office	48.9	49.7	47.7	41.6	44.0	47.5
Five or More Visits to Doctor's Office	21.0	22.9	17.1	19.5	25.1	21.7
Any Visit to a Specialist	68.9	63.7	62.6	69.6	65.7	69.5
Any Hospital Inpatient Use	31.1	36.1	27.3	32.8	40.5	33.6
Any Emergency Room Use	20.2	28.3	20.4	26.2	27.4	22.6
Any Prescription Medicine Use	92.3	87.3	87.4	85.3	86.3	88.0
Any Special Medical Equipment Use	16.5	23.5	14.6	21.5	24.9	17.1
Any Special Therapy Use	12.8	15.3	12.3	14.1	12.7	14.0
Any Home Health Care Use	7.9	14.6	6.2	12.8	10.3	9.8

Source: MMC CAHPS® surveys for 1997, 1998, and 1999.

Table 10. Health Care Utilization for MMC CAHPS® Enrollees with Diabetes, By Racial/Ethnic Group

Survey Question	White	African American	Asian	Native Hawaiian/ Pacific Islander	American Indian/ Alaska Native	Hispanic/ Latino
Health Care Use in Last 6 Months	**%**	**%**	**%**	**%**	**%**	**%**
No Visit to Doctor's Office	12.1	15.4	18.6	20.6	14.8	18.0
One Visit to Doctor's Office	16.4	13.2	18.6	19.6	12.9	14.5
Two to Four Visits to Doctor's Office	50.3	49.3	48.1	42.6	48.3	47.5
Five or More Visits to Doctor's Office	21.3	22.1	14.7	17.2	23.9	20.0
Any Visit to a Specialist	65.5	58.8	53.8	48.7	60.4	60.8
Any Hospital Inpatient Use	26.1	25.9	21.4	28.0	31.9	24.7
Any Emergency Room Use	17.9	23.0	16.1	22.4	24.4	18.5
Any Prescription Medicine Use	92.6	86.6	82.7	92.1	87.3	86.9
Any Special Medical Equipment Use	17.6	20.4	10.9	21.8	23.4	15.1
Any Special Therapy Use	12.6	13.0	11.3	14.5	11.1	12.9
Any Home Health Care Use	8.1	12.8	4.2	10.7	9.8	7.7

Source: MMC CAHPS® surveys for 1997, 1998, and 1999.

Discussion

The evidence on health status of MMC enrollees suggests that there was no clear pattern of greater or lesser need for health care by racial/ethnic group. While several minority groups were more likely to report that their health was fair or poor than were Whites, these groups were also somewhat more likely to report that their health had improved and less likely to report that their health had deteriorated. When health conditions were examined, Whites were equally or more likely to report that they had most conditions, with the exception of diabetes.

Racial/ethnic minority groups also gave positive ratings to their health plans on process and access measures, and these ratings were similar to the ratings that Whites gave to their health plans. Overall, however, there was a pattern of slightly lower ratings on most dimensions of process and access, particularly for Asians, American Indians/Alaska Natives, and Hawaiians/Pacific Islanders.

These data suggest that health plans are doing a good job of serving their racial/ethnic minority members. Minorities were more likely to report improvements in health than were Whites, and gave their health plans high ratings.

On the less positive side, however, patterns of utilization provide evidence that minorities were less likely to visit their primary care physician and less likely to be referred to and/or to visit a specialty physician, even when serious health conditions were present. The primary care physician was the entry point to all other health services, including referral physicians, in most health plans and was also responsible for managing the overall health care of the member. The fact that most minority enrollees were more likely to be hospitalized and to have emergency room visits may, in part, be due to their lower frequency of contact with physicians in the plan. These different patterns of utilization of services may be due to a number of factors, including lesser experience with the health care system, cultural or language barriers to effective use of services, discomfort with physicians and other health care providers who were not of the same racial/ethnic group, geographic distribution of physician network that was not as easily accessible for minority enrollees, and other factors.

To better understand the factors that may influence lower utilization of services by racial/ethnic minorities in health plans, it is necessary first to be able to measure performance on specific dimensions that are most likely to be associated with health care use for these populations. If specific dimensions of performance can be measured and can provide insight into the aspects of health plan organization and management that are important to achieving better outcomes for minority enrollees, then it would be possible to develop strategies and incentives to encourage health plans to address the identified issues.

ISSSUES AND STRATEGIES FOR MEASURING PERFORMANCE OF MMC PLANS IN MEETING THE NEEDS OF RACIAL/ETHNIC MINORITIES

Issues for Measuring Performance

While it would be desirable to measure performance of MMC plans in serving racial/ethnic minorities, 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.
- Incomplete data 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 limited encounter data 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.

Each of these issues is discussed below. We then discuss a number of performance measurement strategies that might be feasible and produce useful information.

Small Numbers of Minority Enrollees in Most Health Plans

A few MMC plans have high enrollment of racial/ethnic minorities (e.g. the Chinese Community Health Plan in California and a few health plans, primarily in Florida, that enroll high proportions of Hispanics/Latinos). Most MMC plans, however, have small numbers of enrollees from any one racial/ethnic minority group. This report relies on data from the three-year combined MMC CAHPS® files. Since the sample selection methodology randomly chooses 600 enrollees from each health plan (or all enrollees for health plans with less than 600 members), the maximum number of enrollees surveyed over three years for each health plan would be 1800. The minimum, maximum, and mean number of MMC CAHPS® survey respondents at the health plan level over a three-year period, by racial/ethnic group, is shown below (Table 13).[42]

For each racial/ethnic group (including Whites), there is at least one health plan that does not have any enrollees who were members of that group (Row 1). On the other hand, some health plans enroll significant numbers of minority members, particularly of African Americans and Hispanics/Latinos (Row 2). The mean number of enrollees in health plans, by racial/ethnic group, is most useful to examine for developing strategies to measure performance in serving

[42] For Table 13, the data on individual survey respondents were collapsed to produce a dataset containing the number of individuals, by race, in each plan. From this, the minimum, maximum, and average number of individuals, by race, was calculated for each plan.

minority enrollees at the individual health plan level. Nearly 87 percent of the average MMC plan's enrollment is White and 13 percent are members of any minority group. African American and Hispanics/Latinos make up 10 percent of the average enrollment and Asians, Hawaiians/Pacific Islanders, and American Indians, combined, make up 3 percent of the average enrollment.

Table 13. Distribution of MMC CAHPS® Survey Respondents Across Health Plans, By Racial/Ethnic Group

	White	African American	Asian	Native Hawaiian/ Pacific Islander	American Indian/ Alaska Native	Hispanic/ Latino
Minimum	0	0	0	0	0	0
Maximum	1214	394	536	95	16	370
Mean	590.9	39.0	12.4	9.6	2.1	29.3

Source: MMC CAHPS® surveys for 1997, 1998, and 1999.
Note: Data on individual survey respondents were collapsed to produce a dataset containing the number of individuals, by race, in each plan. From this, the minimum, maximum, and average number of individuals, by race, was calculated for each plan.

To put this into perspective, if the annual MMC CAHPS® sample were tripled—from 600 per plan to 1800 per plan—the average number of African American respondents per plan would be 39, while the average number of American Indian respondents per plan would be 2. If the performance measurement strategy focused on all enrollees who were members of a racial/ethnic minority group, combined, then the average number of minority members per plan would be 92. However, even if the annual MMC CAHPS® sample were tripled, there would be a significant number of MMC plans with such small numbers of minority enrollees that it would not be possible to measure their performance specific to these enrollees. And, tripling or quadrupling the MMC CAHPS® sample—or the sample size of other surveys that might be considered—would be very costly.

Table 14. Distribution of Minority Enrollment Across MMC Plans (Percentage of total plan enrollment)

Zero percent	1 to 5 percent	6 to 10 percent	11 to 20 percent	21 percent or more
0.0	26.4	24.2	32.0	17.4

Source: MMC CAHPS® surveys for 1997, 1998, and 1999.
Note: Data on individual survey respondents were collapsed to produce a dataset containing the number of individuals, by race, in each plan. Next, the percentage of "minority" (i.e., non-White) respondents was calculated for each plan. This was used to calculate the percentage distribution of minorities in the selected categories.

Table 14 presents the distribution of minority enrollment across MMC plans. Not one MMC plan had no minority enrollees; in other words, every plan had at least one minority enrollee. Nearly half of the MMC plans, however, had a minority enrollment of 10 percent or less. Minorities represented more than 20 percent of total enrollment for only 17 percent of plans.

Inadequate Data for Designing and Implementing a Broad Performance Measurement Strategy

If a survey methodology to collect plan-level data on performance specific to minority enrollees is not feasible and very costly, a broad strategy might be developed to use routinely collected data to examine some dimensions of performance. For example, CMS could use racial/ethnic identifiers on the Enrollment Data Base (EDB) to examine the number of members of racial/ethnic groups that are enrolled in each health plan, relative to the distribution of Medicare beneficiaries by race and ethnicity in the health plan's market area. While there may be self-selection, by race and ethnicity, into health plans, plans that enroll disproportionately few members of minority groups might warrant examination to determine whether their choice of provider network or other factors might discourage minorities from enrolling. The feasibility of implementing this strategy, however, is dependent on the completeness and accuracy of the race and ethnicity indicators on the Medicare Enrollment Data Base. While CMS has made significant progress in this area—including conducting a one-time survey to ask Medicare beneficiaries to provide race and ethnicity information—completeness and accuracy is still uncertain and has been estimated to differ by racial/ethnic group.[43]

Another broad strategy to measure performance of the individual health plan in serving minority groups—which would also depend on the EDB—would be to use encounter data that are reported by health plans. At present, only hospital encounter data are reported, with physician encounter data to be reported (possibly) in the near future. If both hospital and physician encounter data were available, and the EDB race and ethnicity indicators were complete and accurate, then it would be possible to examine hospitalization rates and physician encounter rates, by race and ethnicity, for individual health plans. It is uncertain, however, how complete and accurate the reported hospital encounter data are and, once physician encounter data are reported, it may take many years to ensure that complete and accurate data are available.

Costs of a Targeted Performance Measurement System

Any health plan-specific approach to measuring performance of health plans in serving racial/ethnic minority members is likely to be relatively costly. Given the current state of the MMC program and the substantial numbers of health plans that have withdrawn from participation over the last five years, any strategy that imposed new costs or reporting burden on MMC plans would probably be perceived as undesirable. The extent to which CMS would be willing (and able) to incur substantial additional costs to conduct targeted performance measurement is also a consideration. For example, it would be possible to survey the universe of MMC plan enrollees to obtain precise estimates of performance for each health plan, but the costs and the feasibility of this strategy would be prohibitive. The performance measurement strategies discussed in the next section are those that have been considered feasible, useful, and that would not impose significant costs on health plans and relatively moderate costs for CMS.

Strategies for Measuring Performance

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

[43] Eggers and Greenberg (2000).

racial/ethnic minority group in individual health plans, however, suggests that the most feasible approaches are: 1) examining performance of individual health plans in serving all minority members, combined, rather than individual racial/ethnic groups; 2) measuring aggregate performance of MMC plans in serving minority members, in more detail, in order to identify common areas of concern raised by racial/ethnic minority enrollees in MMC plans; and 3) comparing performance of MMC plans in serving minorities with performance of the original Medicare program in serving minorities. Each of these three strategies relies primarily on Medicare CAHPS® data, with some modifications. Additional strategies that rely on other data sources are also discussed below.

Strategies to Measure Performance Using Medicare CAHPS® Data

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

1. *Develop individual health plan measures of performance, using MMC CAHPS® data, stratified by White and Other Racial/Ethnic Groups.* This strategy is based on an assumption that there are common issues for racial/ethnic minority groups and that health plan organization and management approaches affect all racial/ethnic minority groups in a similar manner. If all respondents who are members of any minority group are combined, there may be sufficient sample size from the MMC CAHPS® to permit comparison of ratings of the plan by minority members and Whites. On average, 13 percent of MMC health plan enrollment is Non-White and Non-Hispanic. Annual MMC CAHPS® sample size per plan is 600, with an average 80 percent response rate. The average plan, then, would have 62 respondents who are members of a minority group. The issue of the appropriate sample size to produce reliable estimates would need to be addressed by a statistician; however, it is likely that a substantial majority of MMC plans would have sufficient sample size to produce estimates of ratings of specific performance measures for minority enrollees. These ratings could then be compared with ratings given by Whites to determine the extent to which the plan is serving its minority members comparably or whether there may be specific areas that indicate that there may be problems.

2. *Augment the MMC CAHPS® to obtain additional information from racial/ethnic minority enrollees.* Analysis of the MMC CAHPS® data, presented earlier in this report, indicates that racial/ethnic minority enrollees are slightly more likely to give lower ratings on process and access dimensions of plan performance and are less likely to have contact with primary care physicians and with specialists, compared with White enrollees. More information on the reasons for these differences in ratings and utilization of services compared with White enrollees would be useful and could provide guidance for developing strategies for performance improvement. The MMC CAHPS® survey instrument could be augmented with a few questions that could provide useful information. For example, if survey respondents reported that they had not visited their primary physician during the previous three months, they could be asked, “Why didn’t you visit your primary physician?” with possible responses of “Doctor didn’t tell me to make an appointment,” “Tried to make an appointment, but couldn’t get in,” “Too hard to get to the doctor’s office,” etc. Similarly, if the survey respondents replied that they had visited the emergency room, they could be asked “Did your

health plan pay for the ER visit or did you have to pay?" and "What is the reason that you went to the ER?" with possible responses including "Doctor or other health plan representative told me to," "Couldn't reach my doctor," etc. Additional questions could also be developed to elicit information on whether the enrollees speak English as their primary language and, if not, whether they are able to see a doctor who speaks their language. Analyses of the responses to these additional questions, by racial/ethnic group could provide valuable insights on issues that may pose barriers to effective use of services by minority enrollees of health plans.

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.* The Disenrollment CAHPS® data offer the possibility of identifying differences among disenrollees, by race and ethnicity, in their ratings of their health plan and in the reasons why they chose to leave the health plan. While the survey samples for the Disenrollment CAHPS® and Disenrollment "Reasons" survey are not large enough to permit health plan-specific estimates, by race and ethnicity, the aggregate analysis could provide measures of differences in health plan performance by race and ethnicity. In turn, this performance measurement could yield information for developing strategies to improve performance of health plans in serving minority enrollees.

4. *Conduct analyses comparing MMC CAHPS® responses and ratings with Fee-for-Service CAHPS® responses and ratings.* Whether MMC plans are serving minority enrollees as effectively as they serve majority enrollees and whether there are differences among MMC plans in meeting the needs of minority enrollees are both important issues. Of equal importance, however, is whether minority enrollees in health plans are better served than minority Medicare beneficiaries who choose to remain in original fee-for-service Medicare. With the FFS CAHPS® survey now being fielded annually, on the same schedule as the MMC CAHPS®, it would be feasible to conduct analyses that would answer the question: "Are minority Medicare beneficiaries better served in MMC plans or in original Medicare?" These comparisons could focus on ratings of overall, process, and access dimensions of performance. In addition, comparisons could be made to determine whether minority beneficiaries are more likely to visit a doctor in original Medicare or MMC plans or to have "no visit," and other utilization measures that are captured in both surveys. It would also be informative to compare the likelihood of improvement or deterioration in health status for minority beneficiaries in original Medicare and in health plans. Measurement of the performance of MMC plans in meeting the needs of minority enrollees, relative to the performance of original Medicare in meeting those needs, would provide context for interpreting and understanding the performance of all health plans and across-plan differences.

Strategies to Measure Performance Using Other Data Sources

To the extent that the Medicare Enrollment Data Base has been determined to have reliable and complete data on race and ethnicity of Medicare beneficiaries, it could be a tool for measuring performance of MMC health plans in serving minority enrollees. CMS is continuing to improve the racial/ethnic identifiers on the EDB and, eventually, these identifiers can be expected to be

complete and accurate for most beneficiaries. 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 that might be considered, that rely on the EDB, include:

1. *Examine enrollment rates of minority Medicare beneficiaries in each health plan, relative to the minority population in the health plan's market area.* A health plan in an area with a significant minority population that has few or no minority enrollees may warrant examination by CMS to assess the reasons for the low enrollment. The health plan provider network, for example, may be geographically distributed in areas that are not convenient for minority beneficiaries to access. Customer service representatives and providers may be homogeneous and not reflective of the minority population's culture and language. Or, marketing strategies of the health plan may be developed to attract the majority population and not to attract minority enrollees (e.g., holding health fairs in majority population areas and not in minority population areas).

2. *Examine voluntary disenrollment rates of minority enrollees, relative to voluntary disenrollment rates of majority enrollees.* The EDB could also be used to examine whether minority enrollees in health plans are more or less likely than majority enrollees to voluntarily disenroll from their health plan, and whether there are differences in disenrollment rates during the initial three months after enrollment and after longer time periods. Aggregate data could provide information, depending on the findings, that would suggest strategies for improving performance of health plans for minority enrollees. For example, if minority enrollees were more likely than majority enrollees to disenroll in the initial three months, this could indicate that some changes in marketing and information on the health plan could be important to ensure that minority beneficiaries better understand the health plan and implications of enrollment.

Other strategies might be considered for measuring performance of health plans in serving minority enrollees, if and when reliable hospital and physician encounter data are available from health plans on an enrollee-specific basis. Given that patterns of use for minority members indicate lower use of primary care and specialty physician services and, generally, higher rates of hospitalization, the hospital and physician encounter data could be used to identify health plans that have higher rates of minority member visits to physicians. In addition, analyses could be conducted to assess whether minority enrollees who see plan physicians more frequently are less likely to be hospitalized. However, it is unlikely that reliable hospital and physician encounter data will be available in the near future for use in performance measurement.

CMS also could consider developing some targeted "special studies" that would provide additional information on health plan performance and underlying reasons for any differences in performance that are observed for minority enrollees. For example, if CMS wanted to better understand the extent and reasons that minority enrollees with serious health conditions are less likely to report visiting a specialist, a study could be designed to provide information on this issue.

One approach would use a "mystery shopper" design to test whether providers are as likely to refer minority patients for specialist appointments and other services. For example, a White patient with heart disease and African American patient with heart disease both visit the same PCP with the same symptoms to see if they get the same advice/referrals. This would allow CMS to determine whether the PCP is consistent in his/her referral advice. If differences in referral patterns were identified, CMS could consider developing strategies to improve performance that include education program requirements for PCPs that increase the PCP's awareness of the potential for bias in treatment patterns by race and ethnicity.

These types of studies have been conducted in both fee-for-service and health plan settings in the past—although not specifically targeted to Medicare health plan enrollees or to specific patterns of differential use of services by minority enrollees in Medicare health plans. However, the results would not produce performance measures at the individual health plan level—or if they did, the special study would be prohibitively costly.

Still, CMS may identify specific issues that are ambiguous or that suggest that further investigation of factors that may underlie differences in performance are necessary. Special targeted studies would supplement and provide greater ability to interpret performance measures that suggest that there are disparities in treatment and in effective use of health plan services by minorities.

ISSUES AND STRATEGIES FOR IMPROVING PERFORMANCE OF MMC PLANS IN SERVING RACIAL AND ETHNIC MINORITIES

Issues For Improving Performance

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. Many States, for example, require Medicaid managed care plans to recruit providers and customer service staff that are reflective of the racial/ethnic mix of their enrollees, to make all materials available in all languages spoken by a minimum of 5% of enrollees, to develop tracking systems and outreach plans to ensure that all members have initial appointments with their PCPs, and to provide cultural competency training to providers and staff.[44]

Medicaid managed care plans, however, enroll a disproportionate number of racial/ethnic minorities, relative to the proportion of minorities who are enrolled in MMC plans. Fewer than 50 percent of MMC plans have more than 10 percent enrollment of racial/ethnic minorities. Given this, a broad strategy that mandates MMC plans to undertake significant new programs would probably not be warranted.

In addition, there would be significant costs to MMC plans if CMS were to mandate that all MMC plans meet extensive new requirements to improve performance in serving minority enrollees. Imposing new requirements and costs would likely result in some MMC plans withdrawing from Medicare participation. This consequence would not be beneficial, nor justified, since minority enrollees in Medicare plans are generally satisfied with most aspects of the care that they receive from their plans. And, research has demonstrated that minority enrollees may be disproportionately affected by withdrawal of MMC plans.[45]

With these considerations in mind, the development of strategies to improve performance of MMC plans in serving their racial/ethnic minority members should focus on development of tools, by CMS, that could be voluntarily adopted by MMC plans, on feedback to health plans of performance measures that provide information on how minority members are "faring" 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 For Improving Performance

<u>Development of "Tools" to Improve Performance</u>

CMS could develop, or support the development, of "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:

[44] See, for example, the Commonwealth of Pennsylvania requirements for Medicaid Health Choices plans and State of Texas requirements for Medicaid managed care plans in Houston, TX.
[45] Laschober et al. (1999).

- Cultural competency training programs for health plan providers and staff.
- Outreach/education programs targeted to 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.

Develop Effective Cultural Competency Training Programs and Make the Programs and Materials Available to MMC Plans

The importance of culture in health care has received increased attention in the last two decades. Its importance is particularly relevant for racial/ethnic minority patients who receive health care from systems that are largely organized and staffed with majority group members. Examples of negative health consequences that could result from a lack of cultural awareness among provider staff include missed opportunities for screening due to unfamiliarity with the prevalence of conditions among certain minority groups; failure to take into account differing responses to medication; lack of knowledge about traditional remedies, leading to harmful drug interactions; and diagnostic errors resulting from miscommunication.

There is, however, an inadequate base of knowledge on effective training mechanisms to increase cultural competency, and on the impact of cultural competency training on behaviors and outcomes for minorities. A recent article reviews and synthesizes the literature on cultural competency objectives and strategies and considers the potential impact of cultural competency programs on racial and ethnic health disparities.[46] The authors developed a conceptual model of the potential for cultural competency to reduce disparities, using the research literature both to develop the model and to analyze whether the evidence supported it. They concluded that, theoretically, cultural competency training should result in improved outcomes. However, they pointed out that there is inadequate evidence on the type of cultural competency training that is effective and on the actual impacts of cultural competency training on outcomes.

There are a number of unanswered questions related to cultural competency training programs that would need to be addressed in designing an effective program. These include:

1. What are the important elements of a cultural competency training program that would result in increased awareness and sensitivity of health care providers and staff to cultural differences that affect health care use, compliance, and outcomes?

2. Is a single training program sufficient, or do separate programs need to be developed for health plan staff and for providers?

3. Do separate cultural competency training programs need to be developed for each racial and ethnic group (and for subgroups—e.g. Mexican-Americans and Cuban-Americans), or can a

[46] Brach and Fraser (2000).

generic cultural competency training program be adequate to increase staff and provider awareness and knowledge?

4. Is there an impact of cultural competency training on health care use, compliance, and health outcomes of racial and ethnic minorities?

CMS could undertake or support a research agenda to address these outstanding questions and implement pilot projects that would test the effectiveness of different strategies for increasing cultural competency within health plans. Results of this research and evaluation of the effectiveness of the pilot programs could then be used to develop cultural competency training programs, and associated materials. Then, CMS could disseminate broad information about the importance of cultural competency, its impacts on health outcomes of minorities, and make these program and training materials available to all MMC plans and encourage their use.

Design and Disseminate Outreach/Educational Strategies and Materials to Increase Use of Routine and Preventive Care by Minorities

Evidence presented earlier in this report indicates that racial/ethnic minorities are less likely to visit their PCP and more likely to report that their health status is "fair" or "poor." Routine visits to PCPs and preventive care could increase early detection of disease. Early detection could, in turn, reduce deterioration of health and improve health outcomes and health status over time. An effective strategy for outreach and education of minority members of health plans could result in increased routine visits to PCPs, with associated improvements in health.

CMS has undertaken considerable research on effective outreach and educational strategies to communicate important health insurance and public health information to racial/ethnic minorities enrolled in Medicare, Medicaid, and SCHIP.[47] Synthesis of this research, and other related research, could be conducted by CMS, focusing particularly on evidence of effective strategies for communicating health information to specific populations. Once evidence on effective strategies and "best practices" is assembled, CMS could use this evidence to design "messages," outreach strategies, and materials for a comprehensive program to communicate the importance of routine and preventive care to minority members of MMC plans. CMS could then disseminate data from the MMC CAHPS® on the lower PCP visit rates of minority enrollees, on health status disparities between minorities and the majority population, and on the potential for health plans to reduce costs through prevention and early detection, and announce the availability to MMC plans of outreach strategies and materials designed to increase routine visits and preventive care by minorities.

Develop and Disseminate "Best Practices" Guidelines for Detecting and Managing Health Conditions that Disproportionately Affect Minorities

CMS, either directly or through the PROs, could initiate a project to review and summarize research on specific health conditions that disproportionately affect minorities and on health conditions for which outcomes of the health condition have been determined to be worse for minorities. The objectives of this research review would include:

[47] Barents Group LLC (1998a, 1998b, 1999a, 1999b).

1. Identifying those health conditions for which minorities are at greater risk.
2. Identifying health conditions for which minorities exhibit worse outcomes.
3. Identifying underlying factors that contribute to higher prevalence and/or worse outcomes.
4. Summarizing evidence of differential treatment patterns by providers that may contribute to differential outcomes.
5. Determining effective strategies for encouraging minorities to seek early detection of specific conditions.
6. Determining whether different strategies are needed for effective management of specific health conditions for minorities.

If the review of existing research provided a solid foundation for developing guidelines for "best practices" to improve early detection, effective management, and outcomes for minorities, then CMS could develop a series of "best practices" guidelines and informational "white papers" to disseminate to health plans (and to original Medicare providers).

If the review of research did not provide strong evidence, then CMS could consider undertaking specific research and pilot programs that would build a foundation for developing "best practices" guidelines. These research and pilot programs could be targeted to a limited number of health conditions that have been identified as having the greatest negative impact on health status, morbidity, and mortality of minority Medicare beneficiaries.

Provide "Feedback" to MMC Plans on Performance in Serving Racial/Ethnic Minorities

While a number of MMC plans have few minority members, a majority (53 percent) has 10 percent or more (combined) minority enrollment. CMS could provide to those health plans with at least 10 percent minority enrollment some selected MMC CAHPS® measures and data, with national and regional comparisons of these data, broken out by (combined) minority enrollees and non-minority enrollees. For example, CMS might consider providing:

- ratings of courtesy and respect
- ratings of doctor spending enough time
- ratings of difficulty in access to specific services
- proportion reporting that they have a personal physician
- proportion who did not have a physician visit in past six months
- proportion who did not see a specialty physician
- proportion who used ER services

This information could be included in each MMC plan's annual health plan report, with national or regional comparisons. While the numbers of respondents in each plan who are racial/ethnic minorities may be small, for some plans the number of respondents may be sufficiently large to provide reliable estimates of differences in perceptions and experiences of minority enrollees relative to non-minorities. Narrative in the plan report section and table footnotes could distinguish for plans the reliability of the estimates.

This information, if provided to health plans, might highlight areas for improvement for some health plans. In addition, it could provide CMS Central Office and Regional Office staff with data that could be used to encourage health plans to address disparities in performance, perceptions, and access/use of services.

Provide Incentives to MMC Plans to Adopt Practices and Initiatives to Improve Performance in Serving Racial/Ethnic Minorities

CMS could consider offering incentives to MMC plans to develop and/or implement specific practices and programs to improve performance in serving racial/ethnic minorities. These incentives could be financial (e.g., paying a "bonus" to health plans that demonstrated a higher proportion of minority members visiting a doctor this year compared with last year; providing materials and technical assistance for implementing cultural competency programs). Alternatively, health plans demonstrating improved performance or implementing strategies to improve performance in serving minority enrollees could be relieved from some types of regulatory/reporting requirements.

CMS could work with the managed care industry and MMC plans to develop appropriate (and feasible) incentives that would be effective in encouraging MMC plans to develop and participate in initiatives that could lead to better service and improved outcomes for minority members.

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. When the Fee-for-Service CAHPS® data are available and analyzed, findings will provide additional evidence on the extent to which racial/ethnic minorities in MMC plans have better or worse experiences with process of care and access to care than their counterparts who are not in managed care. 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 visit 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.

On the positive side, minority enrollees are more likely than non-minority enrollees to report that their health has improved in the past year—suggesting that MMC plans are providing beneficial care to their minority members. And, it is possible that the analysis of Fee-For-Service CAHPS® data could produce findings that indicate that minority Medicare beneficiaries in managed care plans are receiving care that is more accessible and of greater quantity than minority Medicare beneficiaries in original Medicare.

Reducing racial/ethnic disparities in access to and use of health services and in health status and health outcomes is an important goal for CMS. Even if MMC plans are serving their minority members well, disparities in use of services and in health status remain. 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 that CMS could consider to achieve those objectives.

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