Reporting of CAHPS® Quality Information to Medicare Beneficiaries

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Objectives. To assess which Consumer Assessment of Health Plans (CAHPS®) survey measures Medicare beneficiaries find the most meaningful, how beneficiaries and information intermediaries interpret different formats for presenting CAHPS information, and how beneficiaries have reacted to the CAHPS information included in the annual mailing to beneficiaries called *Medicare & You 2000.*
Data Sources. Fourteen focus groups of beneficiaries and State Health Insurance Assistance Program counselors, more than 200 cognitive interviews, and 122 mall-intercept interviews with beneficiaries were conducted from spring 1998 through winter 2000.
Study Design. In 1998 focus groups and cognitive interviews were conducted with Medicare beneficiaries and State Health Insurance Assistance Program counselors to determine which CAHPS measures to report to Medicare beneficiaries and how to report this information. In 1999 additional focus groups and mall-intercept interviews were conducted to determine which measures to include in *Medicare & You 2000.* To obtain feedback on the CAHPS information in *Medicare & You 2000* additional focus groups were conducted in winter 2000.
Principal Findings. Focus group participants indicated that getting the care they need quickly, having access to specialists, and communicating well with doctors were more important to them than nonmedical characteristics of plans. Most beneficiaries had problems interpreting quality information. Many misinterpreted star charts, and while bar charts appear easier to read, many beneficiaries still had trouble interpreting the information on these charts. Most beneficiaries did not consider quality information important to them and most were unaware of the availability of CAHPS information.
Conclusions. Many challenges lie ahead in making quality information meaningful to Medicare beneficiaries. These challenges include increasing awareness of the existence of this information, educating beneficiaries about how this information can help in choosing a health plan, continuing to simplify reporting formats, assuring beneficiaries that this information comes from a credible source, and providing guidance to beneficiaries about how quality information can help with health care decisions.

Key Words. Alternative reporting formats, CAHPS measures

Presenting "quality information" to Medicare beneficiaries is a mandated requirement of the Balanced Budget Act of 1997. This particular mandate is in part a response to the creation of Medicare+Choice, a program that expands Medicare's original health insurance options. To promote an active and informed selection among Medicare+Choice options by Medicare beneficiaries, the secretary is mandated to disseminate information to current and prospective Medicare beneficiaries about their Medicare+Choice options through three avenues, an annual mailing to all Medicare+Choice eligible individuals, a toll-free number, and an Internet site. A nationally coordinated educational campaign also publicizes the Medicare+Choice options and Medicare program fundamentals to Medicare beneficiaries at the local level. This national campaign is currently coordinated by the Health Care Financing Administration (HCFA). One goal of this National Medicare Education Program (NMEP), referred to as Medicare & You, is to help Medicare beneficiaries make more informed health care decisions through a booklet also called *Medicare & You*. Primary objectives of the education efforts are to ensure that beneficiaries receive accurate, reliable information; have the ability to access information when they need it; understand the information needed to make informed choices; and perceive the NMEP (and the federal government and its partners) as trusted and credible sources of information.

In most of HCFA's dissemination efforts the presentation of quality information has become an important component to help Medicare beneficiaries choose their Medicare+Choice coverage options. For the purposes of this article, quality information is defined as the presentation of selected survey data collected via HCFA's Medicare Consumer Assessment of Health Plans Survey (CAHPS).

Presenting quality information to Medicare beneficiaries is challenging for several reasons. Of 39 million beneficiaries, approximately 22 percent have fewer than nine years of education and 38 percent have fewer than 12 years of education (HCFA 1998). Furthermore, 44 percent of adults aged 65 and over are considered to have limited reading skills (Kirsch et al. 1993). To add to the complexity inherent in presenting quality information,

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38 percent of beneficiaries aged 65 and over report difficulty seeing, even with glasses; 42 percent report difficulty hearing; and 18 percent cannot perform at least one instrumental activity of daily living (HCFA 1998). In addition many beneficiaries are currently uninformed about Medicare and Medicare-related topics. For example, 17 percent of beneficiaries surveyed in six targeted communities as part of HCFA's assessment of the NMEP had never heard of the terms managed care, health maintenance organization, or HMO, although Medicare managed care plans existed in all of these communities (Gaumer and Wilwerding 2000). Also, most beneficiaries do not actively seek out Medicare information; they either seek specific information when a specific need arises or they do not seek information regardless of their health care needs (Barents Group 1998).

As mentioned above, quality information is defined here as beneficiary responses to items on a nationally representative survey. Many of the items on the survey concern beneficiary satisfaction and opinions related to a definition of quality care. To collect enrollee satisfaction[1] information for HCFA's educational efforts, HCFA currently conducts an annual nationwide survey of Medicare beneficiaries enrolled in managed care organizations[2] regarding their experiences with plan performance. This survey, called the Medicare Satisfaction Survey, was developed as part of the Medicare CAHPS initiative. The primary purpose of this survey is to provide information to Medicare beneficiaries to help them make more informed choices among health plans.[3] The survey has more than 50 items that measure beneficiary experiences with their health plan.

WHICH MEASURES ARE IMPORTANT TO MEDICARE BENEFICIARIES?

Because of space limitations in the *Medicare & You* handbook and HCFA's web site, HCFA restricts the number of satisfaction measures presented. To help determine which measures from CAHPS to report to Medicare beneficiaries and how best to display those measures to beneficiaries, HCFA conducted research through focus groups, in-depth interviews, and mall-intercept interviews. This article presents findings from a series of research projects regarding measures beneficiaries find most meaningful, how beneficiaries and information intermediaries interpret different presentation formats, and how beneficiaries react to CAHPS information included in the annual mailing to beneficiaries called *Medicare & You 2000.* The initial test of which measures to report to Medicare beneficiaries from CAHPS consisted of three

focus groups with beneficiaries and three focus groups with State Health Insurance Assistance Program (SHIP)[4] counselors in Maryland, California, and North Carolina in the spring of 1998 as well as 12 cognitive interviews with beneficiaries in Maryland and Massachusetts (Kerwin 1998). Because of the potential confounding in mixing these groups, beneficiaries and SHIP counselors participated in separate sessions. In each of the focus groups with beneficiaries, nine or ten beneficiaries participated. More than half of the participants had attended college, whereas approximately 25 percent had graduated from high school and 13 percent had less than a high school education. Approximately half of the participants were 70 to 74 years of age, whereas the rest were evenly split between younger and older age groups. This first round of testing focused on the Medicare managed care CAHPS information presented on www.medicare.gov as part of *Medicare Health Plan Compare* in January 1999.

Results

As part of the focus group sessions and in-depth interviews, participants rated measures that were most important to them when choosing a health plan. More specifically, participants were given a stack of cards with a different measure listed on each card and were asked to sort the cards in the order of the measures that were the most important to them when choosing a health plan (see appendix A for complete list). The most important measures tended to be

- experiences with getting the care you need;
- experiences with getting the care you need quickly;
- access to specialists; and
- experiences with doctors who communicate well.

The least important measures tended to be

- experiences with the plan's customer service; and
- experiences with courteous and helpful office staff.

Participants indicated that the nonmedical characteristics of plans were less important to them. Some participants also had problems understanding the difference between "getting the care you need" and "getting the care you need quickly." These participants felt that getting care quickly is part of getting needed care.

FORMATS FOR PRESENTING CAHPS INFORMATION

An additional part of this initial testing conducted in spring 1998 concerned gathering feedback about two existing CAHPS reporting formats: bar graphs and star charts (see Appendix B for examples). The bar graphs present the distribution of responses for each plan for a given question or composite.[5] Generally the bar graphs contain three different response options. For example, for the composite about how well doctors communicate[6] there are three response options for reporting purposes: "always," "usually," and "sometimes/never." The star charts present statistically significant differences among plans. The purpose of the stars is to compare one plan against all other plans. Two stars indicate that the plan's rating is not significantly different from all other plans; one star indicates that the plan's rating is significantly lower than all other plans; and three stars indicate that the plan's rating is significantly better than all other plans.

Results

Reaction to the star charts was mixed. Most beneficiaries liked the way the star charts looked; however, there was a great deal of confusion among beneficiaries in terms of what the star charts meant. When focus group participants were asked to find the worst plan, many participants reported the worst plan to be the one with the smallest total number of stars if more than one measure was presented on the same page. It was clear that most participants did not understand the relative nature of the stars. Participants who did understand tended to have advanced degrees or had dealt with statistical issues as part of their occupation. Not surprisingly, most participants equated the stars to the five-star ratings that are generally given to restaurants and hotels. Participants interpreted the stars as absolute ratings as can be seen by questions about why there were no four-star plans.

Participants did understand that more stars are better. However, when asked "If a plan has been given one star for a topic in this chart, what does this mean to you?" the following types of responses were given: "pitiful," "it could kill you," and "it tells me there's a lot of unhappy folk [in that plan]." Participants did not understand that a plan that received one star did not do as well as the other plans against which it was being compared. Among the minority of participants who did understand the relative nature of the stars, some expressed dislike for them. These participants did not think that average is a meaningful measure as revealed by the comment, "It only compares to

the average, and the average of all these could be very low . . . these all could be dogs. And all you're saying is that somebody thinks this is a better dog than another."

Most participants felt that the bar charts provided more information than the star charts and were easier to read. For example, one participant remarked, "I think it's better than the stars because it gives you more detail, a more precise measure of satisfaction and dissatisfaction, than the stars." Yet others found them confusing to read. Another participant stated, "I think this is a lot . . . it's confusing, especially for older adults. I'd have to sit down and look into this to work it out fair." Still others found the bars difficult to read because they did not have a good understanding of the term "percentage."

Based in part on these findings, HCFA decided to not present the star charts to beneficiaries on the Internet site or in the *Medicare & You* handbook. It was quite possible that presenting the stars would do more harm than good in helping beneficiaries choose among plans. Consequently, while the bar graphs are not a perfect reporting format, both the Internet and *Medicare & You* information contains only bar graphs.

Because there was some confusion about the bars as a way of presenting quality information, additional testing of the bar charts occurred in May 1999. The bar chart testing was a subset of the overall testing of the handbook in which 190 cognitive interviews were conducted in Chicago, New Jersey, Los Angeles, and Tampa. Five percent of the participants in this round of testing had less than a high school education, 33 percent had a high school degree, and the remaining participants had attended some college or had graduated from college. Sixty-one percent were under 70 years of age, 26 percent were between 70 and 74 years of age, and 13 percent were 75 years of age or over. In the cognitive interviews beneficiaries were given a mock-up version of the *Medicare & You* handbook. Initially HCFA planned on including in the bar graph the percentage of beneficiaries in a plan who said their doctors never or sometimes communicate well, usually communicate well, and always communicate well. In the cognitive interviews it was clear that beneficiaries found these bar graphs confusing. Fifty-one percent of participants were not able to pick which plan's doctors communicated the worst when shown a series of bar graphs for this measure. Based on this confusion and a general concern about the complexity of the bar charts, HCFA decided to include a single bar in the handbook to represent the percentage of beneficiaries who said their doctors always communicate well. (A copy of the CAHPS presentation in *Medicare & You 2000* is contained in Appendix C.)

ADDITIONAL TESTING

After the above research was completed, HCFA leadership decided to present only one CAHPS measure in the *Medicare & You 2000* handbook. Although this was considered an inadequate amount of information to allow beneficiaries to make informed decisions, the goal was to use this limited measure to entice beneficiaries to call 1-800-MEDICARE to request a document[7] showing additional quality measures. To help HCFA decide which measure to include in the handbook, HCFA conducted mall-intercept interviews to obtain beneficiary preferences for this measure. Participants were asked to choose between two highly regarded measures based on feedback from prior focus groups and the variability of beneficiary ratings for the CAHPS measures across plans. In New York, Tallahassee, Chicago, Denver, and Los Angeles 122 mall-intercept interviews were conducted. Fifteen percent of the participants in the mall-intercept interviews had less than a high school education, 43 percent had graduated from high school, and the rest had attended college. Additionally, 36 percent were 70 to 74 years of age, 37 percent were 65 to 69 years of age, and the rest were aged 75 and over. Respondents were asked which of the following two measures would better help them choose a health plan: (1) doctors who communicate well or (2) getting care quickly. Seventy-one beneficiaries preferred doctors who communicate well; this information helped HCFA leadership choose this measure for inclusion in the *Medicare & You 2000* handbook.

BENEFICIARY REACTION TO THE CAHPS INFORMATION IN *MEDICARE & YOU 2000*

Because HCFA provided beneficiaries with CAHPS information for the first time in the *Medicare & You 2000* handbook, HCFA wanted to receive feedback from beneficiaries on the quality section of the handbook that contained both the CAHPS and Health Plan Employer Data Set (HEDIS) information. Four focus groups were conducted in February 2000 in Springfield, Massachussetts, Tucson, Arizona, and Dayton, Ohio to obtain feedback from beneficiaries on the local information pages in the handbook (Hatt, Joseph, Hassol, et al. 2000). Three of the focus groups were made up of Medicare beneficiaries in managed care, whereas the fourth group contained both beneficiaries in managed care and original Medicare as well as beneficiaries who were recently dropped from a managed care plan. Forty-five percent of participants

were 65 to 69 years of age, 31 percent were 70 to 74 years of age, and the remaining 24 percent were aged 75 or older. Almost all beneficiaries in these focus groups remembered receiving a copy of *Medicare & You* in the fall. The majority reported skimming through the handbook and filing it away for future reference. Only a handful of beneficiaries, however, noticed the quality pages in the handbook. In fact, of all focus groups for the NMEP assessment, five of 89 participants noticed the quality section when they received the handbook. None of the focus group participants, even those who made health plan changes, had used the quality information in the handbook to make decisions about their health insurance. Preliminary information from the Medicare Current Beneficiary Survey[8] indicates that approximately 16 percent of beneficiaries had noticed the quality information in the handbook.

Similar to prior findings, participants in these focus groups were confused about how to read and interpret the information presented in the quality section of the handbook. Some beneficiaries found the bar charts difficult to read. Others did not understand that the CAHPS information came from a survey, in particular a survey of people in the plans who were similar to them. Furthermore, others found it difficult to find the CAHPS information that matched their particular plan.

Overall these groups had mixed reactions to the CAHPS measure included in the handbook. Some beneficiaries thought the "doctors who communicate well" measure was very important to them. Others did not find this measure as meaningful. These later focus group participants said that it did not matter to them if their doctor was "grouchy" as long as the doctor provided appropriate care. Others said that the "bedside manner" of the doctor is not that important. As a result of this feedback *Medicare & You 2001* includes a different CAHPS measure. HCFA includes the overall rating of health care from all doctors and other health professionals as the CAHPS measure in *Medicare & You 2001.*

CONCLUSIONS AND FUTURE CHALLENGES

The work to date indicates that there are many challenges to overcome in terms of presenting quality information to Medicare beneficiaries to help them choose their health plans. The first hurdle is making beneficiaries aware of the existence of quality information about their health care coverage options. Most beneficiaries currently are not aware that such information exists. Once

Medicare beneficiaries are aware of its existence it will be important to help them understand how quality information can help them make or confirm a health plan choice. Of particular interest will be beneficiaries who are choosing a health plan, such as people turning 65 or beneficiaries who need to choose a new plan because of health plan termination or changes in the benefits offered by their current plan. Our current research suggests that the latter element will be HCFA's greatest challenge. In a recent survey of beneficiaries in the NMEP case study sites, only 25 percent of beneficiaries said they had reviewed their health insurance coverage in the past year, including looking at other types of insurance (Gaumer and Wilwerding 2000). It is debatable whether beneficiaries' review included any attention to quality information. Indeed, most focus group beneficiaries said they would not read the quality information if they were happy with their current plan.

The difficulty associated with educating beneficiaries regarding quality information cannot be understated. Testing indicates that some beneficiaries will not be willing or able to interpret or understand the presentations of the quality information. One participant in the focus groups stated, "It makes work" to read through all of this material. Another beneficiary, referring to the quality pages, noted, "It's like getting a kid to do homework. This is homework for us." Thus, while it is important to continue to work toward simplifying the presentation of quality information, it is clear that a portion of beneficiaries will have trouble interpreting quality information no matter how simple it is. It is therefore critical to develop alternative avenues of assistance. For example, HCFA should work closely with information intermediaries such as SHIP counselors and family members who can help Medicare beneficiaries use this information. HCFA is aware that the presentation of quality information is generating increased interest both inside and outside the government. A likely result will be the need to present more quality information to consumers. Our current work points out the many challenges in making quality information more meaningful to Medicare beneficiaries. It is likely that written material will be an inadequate solution to making quality information a useful tool for all beneficiaries.

APPENDIX A

Complete list of Medicare CAHPS information sorted through by beneficiaries. The items below represent individual items on the CAHPS survey or composites of several items.

1. Experiences with getting the care you need
2. Experiences with doctors who communicate well
3. Rating of the care from all doctors and other health care providers in the plan
4. Rating of the health plan
5. Experiences in getting referrals to specialists
6. Experiences with the plan's customer service, information, and paperwork
7. Experiences with getting the care you need quickly
8. Experiences with courteous and helpful office staff

APPENDIX B

Getting Care that is Needed

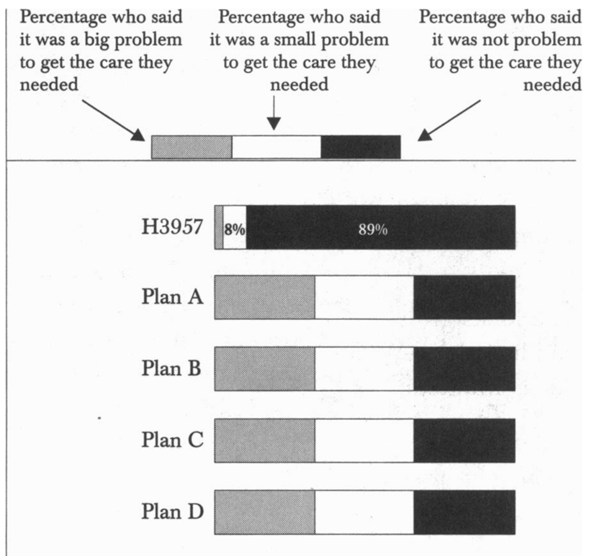
The bar graphs show answers to survey questions that asked Medicare managed care plan members how much of a problem it was to:

• Find a personal doctor or nurse

• Get a referral to a specialist that they wanted to see

• Get the care they or their doctor believed necessary

• Get care approved by the health plan without delays



Survey Year: 1999

Plan Number: H3957

Percentages may not add to 100% due to rounding.

Percentages less than 8% are not displayed in the bars due to space limitations.

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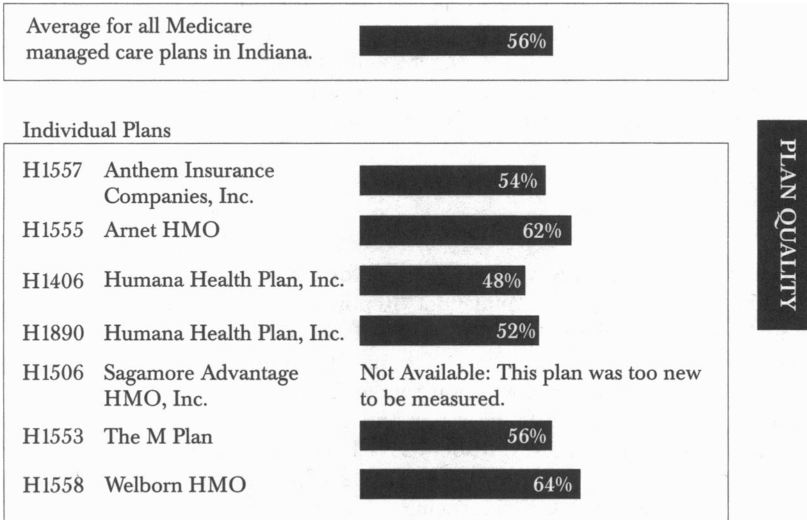
APPENDIX C

Section 3: Medicare Health Plans

Indiana Managed Care Plans
The Percentage Who Rated Their Own Care as the Best Possible Care (a rating of 10)



Source: 1999 Medicare satisfaction survey of people like you; www.medicare.gov.

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NOTES

1. Enrollee satisfaction information is one type of quality measure that is currently available to Medicare beneficiaries; measures from HEDIS are also available.
2. Approximately 17 percent of Medicare beneficiaries are enrolled in a Medicare managed care organization.
3. This survey is also being used by health plans for their quality-improvement activities and by HCFA for plan monitoring and the Government Performance and Results Act requirements.

4. SHIP counselors provide in-person and telephone counseling to Medicare beneficiaries about a variety of Medicare-related topics including health plan choice.
5. For composites, similar items on the survey are grouped together for reporting purposes.
6. This composite combines four questions on the survey that ask Medicare managed care plan members how often in the last six months their doctors and other health care providers listened carefully, explained things in a way they could understand, showed respect for what they had to say, and spent enough time with them.
7. This document also includes cost, benefit, and additional HEDIS information.
8. The Medicare Current Beneficiary Survey is a longitudinal panel survey of a representative sample of Medicare beneficiaries.

REFERENCES

Barents Group. 1998. "HCFA Market Research for Beneficiaries: Summary Report on the General Medicare Population." Reported to the Health Care Financing Administration under contract No. 500-95-0057/TO#2.

Gaumer, G., and J. Wilwerding. 2000. "National Medicare Education Program Assessment: Utilization of Information Sources by Beneficiaries." Reported to the Health Care Financing Administration under contract No. 500-95-0062/TO#2.

Hatt, L., C. Joseph, A. Hassol, K. Carlson, K. Nash, and A. Piacitelli. 2000. "National Medicare Education Program Assessment: *Medicare & You 2000* Handbook." Reported to the Health Care Financing Administration under contract No. 500-95-0062/TO #2.

Health Care Financing Administration. 1998. Medicare Current Beneficiary Survey.

Kerwin, J. 1998. "CAHPS Managed Care Reporting Project: Report on Findings." Reported to the Health Care Financing Administration under contract No. 500-95-0057/TO#4.

Kirsch, I., A. Jungebult, L. Jenkins, and A. Kolstad. 1993. *Adult Literacy in America: A First Look at the Findings of the National Adult Literacy Survey.* Washington, DC: National Center for Education Statistics, U.S. Department of Education.