

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**Medicaid Managed Care:
The Use of Surveys as a
Beneficiary Protection Tool**



JUNE GIBBS BROWN
Inspector General

MAY 1997
OEI-01-95-00280

OFFICE OF INSPECTOR GENERAL

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EXECUTIVE SUMMARY

PURPOSE:

To assess the usefulness of beneficiary surveys as a beneficiary protection tool for Medicaid managed care.

BACKGROUND

State Medicaid agencies are increasingly enrolling their beneficiaries in full-risk managed care plans. Beneficiary surveys are among the many tools available to them as a beneficiary protection. These surveys can be of value in two basic ways:

To Gain Insights on Plan Performance: State Medicaid agencies rely on health plans to provide the full range of medical services for their enrolled populations. Overseeing the plans' abilities to provide appropriate services is an important agency function. Surveys present an opportunity to give agencies information about plan performance from the perspectives of enrolled beneficiaries.

To Help Beneficiaries Make Informed Enrollment Decisions: Beneficiaries that are informed about their enrollment decisions and the choices they have are likely to be better protected than those who are less informed about their choices. Survey results present an opportunity to help beneficiaries learn from the experiences of others in managed care, thereby helping them to make an informed enrollment choice.

THIS INQUIRY

This inspection seeks a deeper understanding of the usefulness of beneficiary surveys in the two ways described above. It is based on interviews with the Medicaid agency leadership in 11 States, site visits to 4 of those States, and a survey of the managed care plans enrolling Medicaid beneficiaries in all 11 States.

FINDINGS

Surveys of Limited Use as Beneficiary Protection

To date, surveys provided little useful information about plan performance to Medicaid agencies. Agency leadership found their survey results largely confirming what they knew from other sources. They also found them to be of questionable value with regard to the technical quality of care and were reluctant to base corrective actions on survey data.

Surveys have yet to provide beneficiaries with information to help them choose a plan. In one groundbreaking survey, Medicaid beneficiaries found the survey data to be "unwieldy." In general, little is known about what information beneficiaries would like to have when faced with a choice of plans.

Agencies and Plans Face Basic Hurdles in Surveying Medicaid Beneficiaries

The intermittent nature of Medicaid eligibility is such that only about half of the Medicaid beneficiaries eligible in one month will remain eligible 12 months later. Low response rates also create problems for agencies and plans. Two-thirds of the plans in our survey reported response rates of 20 percent or less in their mail surveys. These hurdles make such surveys expensive to conduct in a credible fashion.

Strategic Survey Uses Emerging

Some agencies had some success in using more narrowly focused surveys aimed at answering questions such as: Are enrolled beneficiaries getting the orientation information they need from the health plans? What information do beneficiaries want available to choose a health plan? Others have presented their survey data in such a way as to allow comparisons to average plan scores.

Notwithstanding Limitations, Plans Find Surveys Useful

In fact, plans conduct surveys even where their contract with the Medicaid agency lacks a specific survey requirement. Their survey results have led to a variety of operational improvements and policy changes.

RECOMMENDATIONS

The HCFA should either establish a work group or technical advisory group on Medicaid beneficiary surveys or add surveys to the agenda of an existing group. Either group should provide policy-level guidance on how to make cost-effective use of beneficiary surveys.

This group would provide a forum for more targeted policy-level discussion about the best use of surveys. At a minimum, the group should address the following questions:

- ▶ Given that resources are limited, what level of emphasis should Medicaid agencies give to using surveys for overseeing performance and providing information for beneficiary education and choice?
- ▶ How can beneficiary surveys be used more effectively as a means for overseeing the performance of managed care plans?
- ▶ How can surveys be used more effectively to provide information meaningful to beneficiaries faced with a choice of health plans?
- ▶ How can the agencies' contracts with plans be used to best benefit the agencies' needs for survey information?
- ▶ How can Medicaid agencies best deal with the hurdles inherent in surveying a Medicaid population?

The HCFA should devote greater attention to how the Medicaid agencies are using beneficiary surveys. It should revise its written guides for reviewing and monitoring Medicaid managed care initiatives to call attention to the importance of using beneficiary surveys in more focused, strategic ways.

Toward that end, it should consider adding the questions below to its guides:

- ▶ What does the agency aim to achieve with its beneficiary surveys? To what extent is it related to beneficiary protection?
- ▶ How narrowly has it defined the survey's purpose? Could a more targeted use of a survey enhance its value as a beneficiary protection tool?
- ▶ Will the survey fill a gap in the agency's system for overseeing quality in the health plans? Will it provide information that the agency knows beneficiaries rely upon in choosing a health plan?
- ▶ Does the agency have a cost-effective plan for overcoming the hurdles associated with surveying Medicaid beneficiaries?
- ▶ Has the agency weighed the relative costs of surveying beneficiaries with the relative usefulness of the survey results?

COMMENTS ON THE DRAFT REPORT

We solicited and received comments on the draft report from HCFA and the American Association of Health Plans (AAHP). We include the complete text of their comments in appendix C. Below we summarize the major comments on our recommendations and, in italics, summarize our responses.

The HCFA partially concurred with our recommendation on establishing a group for policy-level guidance on making cost-effective use of beneficiary surveys. It noted its existing Medicaid Managed Care Technical Advisory Group could fulfill this role. It also noted its ongoing collaboration with the Agency for Health Care Policy and Research, which is leading the Consumer Assessment of Health Plans Study. The AAHP supported our recommendation and suggested HCFA include some health plan representatives in the group. *We recognize that HCFA's existing group could be appropriate to provide a forum for policy-level discussion about the use of surveys. We appreciate AAHP's support of our recommendation and urge HCFA to consider including health plan representatives in its group for this discussion.*

Our second recommendation called for HCFA to devote greater attention to how Medicaid agencies are using surveys and to revise its written guides toward that end. The HCFA concurred with points made in our text: that some surveys have multiple objectives and need to be more focused. The HCFA plans to include a special session on surveys in its annual Medicaid Managed Care College and will stress the

importance of surveys in its technical assistance to HCFA regional office and State Medicaid staff. The AAHP supported our recommendation. *We welcome HCFA's plans for survey sessions at its Managed Care College and through its ongoing technical assistance. We urge it to use these venues to stress more strategic and focused uses of surveys. And we reemphasize the need for HCFA to revise its written guides for reviewing Medicaid managed care initiatives. In its comments, HCFA did not indicate that it would revise these guides along the lines we suggested. We appreciate AAHP's support of our recommendation.*

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INTRODUCTION

PURPOSE

To assess the usefulness of beneficiary surveys as a beneficiary protection tool for Medicaid managed care.

SURVEYS AS A BENEFICIARY PROTECTION TOOL

Surveys of consumers enrolled in managed care plans are becoming increasingly popular. They can provide important insights to the managed care experience. The surveys' results can be used to market a specific health plan, promote managed care as a delivery system, or simply answer research questions. In fact, the Health Care Financing Administration (HCFA) often requires Medicaid agencies implementing managed care waivers to conduct surveys. And for any of the agencies that are increasingly enrolling their beneficiaries into managed care plans (see appendix A for more background on Medicaid and managed care), surveys can be helpful in another way: beneficiary protection. In that regard they can be of value in two basic ways: to gain insights on plan performance and to help beneficiaries make educated enrollment choices.

To Gain Insights on Plan Performance: State Medicaid agencies rely on health plans to provide the full range of medical services for their enrolled populations. Overseeing the plans' abilities to provide appropriate services is an important agency function. Surveys present an opportunity to give agencies information about plan performance from the perspectives of enrolled beneficiaries.

To Help Beneficiaries Make Informed Enrollment Decisions: Beneficiaries that are informed about their enrollment decisions and the choices they have are likely to be better protected than those who are less informed about their choices. Survey results present an opportunity to help beneficiaries learn from the experiences of others in managed care, thereby helping them to make an informed enrollment choice.

Of course, surveys are not the only tools available to State agencies for beneficiary protection; they are one of many.¹ For example, Medicaid agencies rely on their contracts, plan site visits, complaints, focus groups, and encounter data, among others means, to protect beneficiaries. But surveys, like complaints, are one of the few tools that actually require some direct interactions between the beneficiaries and the agency.

THIS INQUIRY

The HCFA recently issued a guide for States to help them develop customer satisfaction surveys.² It provides some tips on developing surveys, an inventory of recent surveys, and contact people at the agencies for those interested in further information.

This inspection seeks a deeper understanding of the usefulness of surveys as beneficiary protection tools in the two ways described above: plan performance and beneficiary education. Such an understanding is becoming increasingly important as the proportion of Medicaid beneficiaries enrolled in managed care plans continues to mount. Our focus in this inspection is on mail and telephone surveys rather than focus group surveys. We know little now about how effective such mail and telephone surveys have been as a beneficiary protection tool. This inspection also offers some assessment, from the perspective of the Medicaid managed care leadership, of the surveys included in HCFA's recent guide.

METHODOLOGY

In conducting this inspection, we interviewed the Medicaid agency leadership in 11 States that have enrolled significant numbers of Medicaid beneficiaries into full-risk managed care plans.³ All of the 11 States in our study have had experience in surveying, directly or through contractors, their Medicaid populations. Most often, they conducted satisfaction and disenrollment surveys and used a mail or telephone approach. A few agencies also conducted some focus groups. For this inspection, we drew on the 11 agencies' experiences with mail and telephone surveys rather than focus groups. We also conducted our own survey of full-risk managed care plans enrolling Medicaid beneficiaries in those States. (See appendix B for more detailed information on our methodology).

We conducted this inspection in accordance with the *Quality Standards for Inspections* issued by the President's Council on Integrity and Efficiency.

FINDINGS

Surveys, as currently used by the 11 State Medicaid agencies in our sample, are of limited value as a beneficiary protection.

- ▶ Surveys provide little useful information about plan performance to Medicaid agencies.

All of the 11 agencies in our study had experience with surveying beneficiaries over the past 2 to 3 years. Eight of the 11 conducted recent surveys that included goals of assessing plans' performance; 3 of these surveys were still underway at this writing. The bulk of their experience was with satisfaction and disenrollment surveys.

According to the agency leadership, neither satisfaction nor disenrollment surveys provided much in the way of new insights into plan performance. The insights they gained about plan performance from satisfaction surveys were largely limited to enrollee perceptions about customer service issues, such as waiting times. While relevant to a plan's performance, the agency officials pointed out that they were already aware of such concerns through other means, such as complaints and contract compliance visits. Disenrollment surveys were similarly disappointing. Although thousands of beneficiaries disenrolled from plans every month, only a small percent--often 1 percent or less--disenrolled voluntarily; most disenrolled due to a loss of eligibility. So the pool of potential survey respondents from which to gain insight into the performance of any one plan was limited. One agency used over 100 different codes to reflect reasons for disenrollment. With so many codes for so few disenrollees, it is unlikely a pattern would emerge to provide insight into plan performance.

Agency leadership also indicated that surveys had little value with regard to technical quality of care (meaning examinations, follow-through and treatment).⁴ For assessing technical quality of care, they relied more heavily on other indicators of performance, such as encounter data, medical record reviews, contract compliance,

The 1995 Minnesota HDI Survey

In the spring of 1995, the Minnesota Health Data Institute (HDI)--a public-private organization created by the State in 1993 to improve health care for Minnesotans--surveyed 17,591 Minnesotans enrolled in 46 plans, including Medicaid, Medicare, and the privately insured. HDI's goals were to provide "standardized measurement of health plan performance" to consumers, purchasers, and plans.

After the survey, HDI contracted for the project's evaluation. One issue the evaluation explored was whether the survey results helped policymakers monitor and evaluate health system performance. In the evaluation report, policymakers did not identify any ways the survey helped them monitor performance.

(Source: Minnesota Health Data Institute 1995 Consumer Survey Evaluation Report, July 1996)

and complaints.⁵ Surveys are a limited tool to gain insight into so complex a topic as the quality of care. Agency leadership questioned the meaning of satisfaction data: could care that is truly managed lead to lower satisfaction due to restricted access to specialists? They questioned the link between satisfaction and quality. They noted that surveys were not good sources for identifying poor quality-of-care. Indeed, high satisfaction and poor quality can occur simultaneously, as the Massachusetts agency learned when its plans with the highest scores on quality indicators scored lower in satisfaction.⁶ Two officials noted that while the plans' performance matters to the agency, it is the physicians that matter most to the beneficiaries.

What surveys revealed about the plans versus what they revealed about the physicians or group practices complicated their usefulness in certain markets. For example, in the Twin Cities area of Minnesota and certain markets in Missouri, plan networks overlap considerably. This means many of the same physicians and group practices participate in the same plans, so plan-specific interpretations of survey data become questionable.

To date, the agencies have been unable to rely on survey data to make many useful distinctions over time or among plans. For example, the 11 States in our study have yet to conduct the same survey twice, which would allow them to compare results over time.⁷ Also, survey results, such as satisfaction scores, tended to cluster at the high end. Officials from two agencies' leadership noted that their surveys would establish a baseline for future comparisons--in one case a previous survey aimed to do the same but low response rates rendered it unusable.

In most cases, agency officials reported they would be reluctant to direct corrective actions to plans based on survey data alone. One agency official referred to the survey data as "too anecdotal" to base any formal corrective actions. An official in another State intended to establish minimum performance levels, or benchmarks, for future surveys. The agency would penalize or direct some action against plans failing to score above the benchmarks. For satisfaction--on which all the plans in the State had scored in the 90s on the most recent survey--the official was considering a benchmark of just 70 percent, thus it is unlikely the benchmarks would be unmet. Most agencies did, however, share their survey results with their plans and expected the data to prompt improvements.

- ▶ The surveys have yet to provide beneficiaries with information to help them choose a plan.

Of the 11 Agencies in our study, 6 had completed or were in the process of completing surveys that included getting information back to beneficiaries as a goal. At the time of this writing, all but one of these surveys were still underway.

The 1995 Minnesota HDI Survey

In October of 1995, 60 newspapers across the State published the results of the survey as an insert to the Sunday edition. The results were also available in libraries.

In Minnesota, county staff educate the Medicaid beneficiaries about their health plan choices. An evaluation of the HDI survey found that while widely disseminated, consumers in general did not find it especially helpful in choosing a health plan.⁸ It also found, through a focus group, that Medicaid beneficiaries found the information to be "unwieldy," a sentiment reflected in the two counties we visited. The staff there responsible for counseling beneficiaries about their plan choices did not use the HDI survey results to help beneficiaries make a choice, saying it contained "too much information to be useful."

Though widely heralded as a groundbreaking survey, the HDI experience raises some important questions about what is really known about what consumers, and particularly Medicaid beneficiaries, want to know when faced with a choice of plans. How important is survey data, such as satisfaction scores or waiting times? The Massachusetts agency has a project underway that aims to measure how useful its report cards are to beneficiaries faced with a choice of plans. The report card includes data from satisfaction surveys, as well as some quality indicators and other information. That agency plans to survey its newly enrolled beneficiaries and assess the report card's impact on their choice of plans. In Oregon, where a consumer scorecard project funded by the Federal government has been underway, officials learned that consumers are "primarily interested in the quality of services offered by their doctors and hospitals, and less interested in data on their health plan itself."⁹ Other researchers have come to different conclusions: "...research by the Picker Institute and others seems to show that patients and consumers don't yet know what measures are actually meaningful to them."¹⁰ Some research has suggested that consumers tend to find satisfaction data suspect and prefer relying on their own family members and friends when choosing a plan.¹¹

Both agencies and plans face basic hurdles in surveying the Medicaid population.

► Intermittent Eligibility

Historically, Medicaid eligibility has been tied to programs that provide temporary assistance such as Aid to Families with Dependent Children. Thus, beneficiaries tend to come in and out of eligibility as their income and family composition changes. The HEDIS Work Group compiled data on the extent to which beneficiaries were continuously enrolled over a 36-month period (see table 1).¹² That data shows a steady decline in continuous enrollment, with just 55 percent enrolled for 1 year, 29 percent for 2 years, and 17 percent for 3 years.

Month	Percent Continuously Enrolled
1	100%
6	74%
12	55%
24	29%
36	17%

*Note: Based on 8 States' experiences
from 10/91 through 12/93
Source: Medicaid HEDIS Draft, July
1995*

The relatively short lengths of time that beneficiaries are enrolled limits the extent of their opportunity to have much contact with or receive care from the plans. Thus the universe from which an agency or plan would draw its survey sample is also limited. In fact, 78 percent of plans responding to our survey identified intermittent eligibility as an obstacle to using surveys. Thirty-eight percent identified it as a major obstacle. The plans identified intermittent eligibility as an obstacle more often than anything else. In the words of some plan officials, members are simply "not enrolled long enough to use services" and "on and off again eligibility...do not lend themselves to a meaningful managed care experience."

► Low Response Rates

Both plans and agencies reported low response rates with their surveys. In fact, according to our survey of plans, 66 percent of the plans that had conducted a mail survey of their Medicaid enrollees had response rates of 20 percent or less. Low response rates were common in the agencies, too. Indeed, in Massachusetts the agency was able to contact just 7 percent of its sample in one survey. The Missouri agency expanded its sample after the response rate to its first mailing was just 8 percent. And early experiences with surveys in Florida, Oregon, and Utah had response rates too low for the survey results to be usable.

Many factors contribute to low response rates within the Medicaid population. Medicaid populations tend to be more transient than other populations, meaning

agencies and plans often contend with outdated addresses and telephone numbers. In Ohio, the agency found about 70 percent of its sample population to be either invalid or with incorrect phone numbers. Differences in language and literacy skills--either on the part of the agency or plan administering the survey or on the part of the beneficiary responding to the survey--also lead to low response rates. Two-thirds of the plans responding to our survey identified literacy problems and half identified language problems as obstacles to using surveys.

► Costs

Conducting credible surveys is costly. It requires well-thought out methodology, and sampling designs, carefully constructed questions, adequate response rates, and careful analysis. Each of those stages can tax a plan or agency's staff, time, and funds. For example, agencies and plans often lack the experience or skills needed to develop a credible questionnaire.¹³ One agency official pointed out that its earlier experience with surveying enrollees failed in large part due to poor survey design. Thirty-two percent of the plans in our survey identified the lack of a suitable off-the-shelf questionnaire as an obstacle to using surveys; 23 percent identified their limited capacity to develop their own questionnaires as an obstacle.

Even if an agency or plan has a suitable questionnaire, actually carrying out the survey can be labor-intensive. It can involve making calls, stuffing and labeling envelopes, tracking responses, targeting follow-up, and analyzing responses, among other tasks--or at a minimum: overseeing the contractor's work. One agency shared the costs of its mail survey by requiring the plans to mail the questionnaire themselves. Forty percent of the responding plans in our survey identified limited capacity to administer surveys and 33 percent identified limited capacity to assess results as obstacles to using them.

Among agencies, costs are also high. For example, to achieve respectable response rates, the Oregon agency used an intensive 5-step process that involved, in multiple languages: an advance letter mailing, an initial survey mailing, a reminder postcard, a second survey mailing, and a second reminder postcard or phone call. The Oregon agency's intensive effort paid off with a 63 percent response rate. Officials there note, however, that "it is too much to do annually."

Other agencies have undertaken similarly intensive survey projects. For example, the Utah agency also undertook a survey that involved agency and field staff--as opposed to a contractor--making calls to a sample of 1,000 enrolled beneficiaries. They completed 579 surveys over a 2-month period, resulting in an adjusted response rate of 73 percent.¹⁴ The Florida agency is also in the midst of its intensive survey effort that involves multiple mailings, similar to the Oregon effort. As of this writing, Florida has a response rate in the low 30s and is extending its surveying by 5 weeks.

Some agencies are beginning to use surveys in strategic ways, with potentially promising results.

► **More Focused Surveys**

Much of agencies' experiences to date has been with large-scale satisfaction surveys that aimed to meet multiple objectives. But some agencies have conducted surveys with a narrower focus and found the results to be quite useful. In the words of one agency leader, "The usefulness of surveys is likely to be closely correlated to how focused they are."

The survey described at the right is an example of a focused survey designed to meet specific information needs of the agency. We also learned of another focused survey in Utah, where agency staff spent some late nights in hospital emergency rooms interviewing Medicaid beneficiaries. That survey gave the agency new insights into inappropriate emergency room usage and led to changes in its policies on emergency room copayments and reimbursement.

The Utah New Medicaid HMO Enrollee Survey

In early 1996, the Utah agency designed a beneficiary survey to determine whether new Medicaid enrollees had received orientation information from their health plans. The agency limited its sample to newly enrolled beneficiaries. The agency and field staff conducted the interviews--which consisted of just 10 questions--by telephone. On average, each call lasted less than 5 minutes.

Other agencies have had similar success with narrowly focused surveys. For example, the Rhode Island agency conducted two surveys: one to determine what factors beneficiaries relied upon to select their health plans and one to determine what factors they relied upon to choose a primary care physician. The Massachusetts enrollment broker reduced its field staff from 45 to 10 based in part on information learned through a focused survey.

► **Better Presentation of Survey Data**

As we have seen, to date the agencies in our study have not repeated the same survey, thereby precluding them from presenting survey results over time. Nonetheless, some agencies have presented their survey data in such a way as to maximize its utility. For example, the Oregon agency divided its presentation of survey results between plans in urban and rural areas. It included the average scores for plans in each area, and used colors to indicate which plan's scores were above or below average. Of course, whether the average score was good or bad is unknown. Nevertheless, presenting the data with an average provided some context in understanding one plan's performance relative to the average.

Notwithstanding the limitations of beneficiary surveys, health plans still find them to be of some use in identifying and responding to enrollee concerns.

► **Plans Conduct Surveys Even Without Contractual Requirements**

Eight of the 11 agencies in our sample required that the plans they contract with conduct surveys. According to our survey, the majority of plans responding from all 11 States had surveyed Medicaid beneficiaries in the past 2 years.¹⁵ Yet even plans without the contractual requirement conducted surveys. In fact, the majority of responding plans (85 percent) from those 3 States conducted surveys anyway. On average, the plans responding from those States conducted about 4 surveys over the past 2 years. Overall, 83 percent of the responding plans surveyed their memberships, including Medicaid, an average of about 5 times over the past 2 years.

The actual contract requirements regarding surveys varied from agency to agency, but overall, the contract language regarding surveys was quite limited. Seven of the eight contracts required the plans to conduct the surveys annually and to report results to the agencies, but none specified methodologies for the plans to use. Two contracts specified that the survey must cover "perceived problems in quality, availability, and accessibility" of health care services, but the others lacked specific requirements for the surveys' contents.

The lack of many specific contractual requirements allows plans great latitude in surveying beneficiaries, and we found great variation among the plans' approaches to surveying.¹⁶ For example, for their most recent survey, 64 percent of plans conducted a mail survey, 24 percent telephone, and about 4 percent each self-administered, in-person, and focus group. Plans also often surveyed their whole membership, rather than just Medicaid beneficiaries. In fact, 44 percent of responding plans reported that their most recent survey included non-Medicaid enrollees. Targeting certain Medicaid enrollees for recent surveys was also common among responding plans. Of the 80 percent that targeted in some way, 51 percent targeted Medicaid disenrollees; 45 percent, Medicaid enrollees in certain geographic areas; 44 percent, users of certain Medicaid services; 33 percent, users of certain physicians; and 26 percent, Medicaid enrollees with certain diagnoses.

Institutionalizing the Survey Process

One Medicaid-only plan we visited had institutionalized its surveys so that each quarter, it sent out satisfaction surveys to a 25 percent random sample of members who had been continuously enrolled for 6 months. Each month, it sent out disenrollment surveys to 100 percent of voluntary disenrollees. Both surveys are in English and Spanish. Response rates hovered around 10 percent for these surveys, and the plan considered the results a rolling source of feedback to share with its providers.

► Plan Surveys Lead to Improvements

Even though plans face the same hurdles--such as low response rates--as agencies in surveying their Medicaid enrollees, the plans in our own survey routinely surveyed their memberships. Their surveys gave them some cues about what mattered to their memberships, thereby guiding their improvements and helping them compete.¹⁷

The operational focus of plans' surveys is evident by the variety of changes they prompted within the plans. Indeed, 56 percent of the responding plans explained their surveys' usefulness in terms of the improvements to which they led. This reflects national trends in health plans using surveys: in 1995, virtually all plans--99 percent--reported using of surveys for quality improvement, provider feedback, and marketing.¹⁸

According to our survey, plans made both operational and policy changes based on insights they gained from surveying their Medicaid enrollees. For example, they expanded their provider networks, translated written materials, revised prescription drug policies, added toll-free telephone lines, changed referral policies, and increased hours of operation, among others. A few plans also noted that they used surveys to give feedback to their physicians, and in some cases, had established incentives for physicians who scored high on surveys.

Percent of Plans Rating Surveys as Useful for Identifying Medicaid Enrollee Concerns About:

Quality of Care 75%
(interpersonal communication, listening, responsiveness, manner, courtesy)

Quality of Customer Service 73%
(responsiveness to questions, concerns, and complaints)

Waiting Times 65%
(for appointments, and in waiting and exam rooms)

Access 55%
(to specialty care such as mental health, prenatal, substance abuse, and to emergency rooms)

Technical Quality of Care 36%
(examinations, follow-through, and treatment)

*Note: Categories adapted from the Draft Medicaid HEDIS document, July 1995. N=69-79.
Source: 1996 OIG Survey.*

RECOMMENDATIONS

This report raises some questions about the usefulness and cost-effectiveness of surveys in protecting beneficiaries from the vulnerabilities associated with full-risk managed care plans. There are two basic ways in which surveys can serve as a beneficiary protection tool: (1) to provide Medicaid agencies with information on the performance of the plans enrolling Medicaid beneficiaries, and (2) to provide the beneficiaries facing a choice of health plans information to help them choose. Given the partnership nature of the Medicaid program, the Federal and State governments should work cooperatively to identify ways in which surveys can best be used as a cost-effective beneficiary protection tool. Toward that end, we direct the following recommendations to the Health Care Financing Administration:

The HCFA should either establish a work group or technical advisory group on Medicaid beneficiary surveys or add surveys to the agenda of an existing group. Either group should provide policy-level guidance on how to make cost-effective use of beneficiary surveys.

Such a group would provide a forum for more targeted policy-level discussion amongst State Medicaid leadership on how to best use surveys as a beneficiary protection. Medicaid policymakers need to figure out how surveys can best fit in with the array of beneficiary protection tools, such as encounter data and HEDIS and contracts, at their disposal. The involvement of officials at the policy level is key, because without direction from that level, the danger exists that the group will become consumed with the methodological minutiae of conducting surveys rather than the information needs they can fill.

The survey group should aim to build on the existing "Customer Satisfaction Surveys for Medicaid Beneficiaries: A State Guide" recently issued by HCFA. At a minimum, the group should address the following questions with an eye toward maximizing surveys' potential as a beneficiary protection tool:

- ▶ Given that resources are limited, what level of emphasis should Medicaid agencies give to using surveys for overseeing performance and providing information for beneficiary education and choice?

Medicaid agencies need to maximize the potential of surveys as a beneficiary protection tool, and this will involve tough choices. Using a single survey to serve multiple objectives can limit its effectiveness in meeting any one objective. Conducting a survey and having credible data takes an intensive effort. Medicaid agencies need to consider the strengths and weaknesses of their existing beneficiary protection systems and weigh the relative merit of using a survey for oversight or educational purposes.

- ▶ How can beneficiary surveys be used more effectively as a means for overseeing the performance of health plans?

Medicaid agencies rely on a variety of data and information to assess the performance of managed care plans. Surveys could serve to provide information about topics which other oversight tools fail to address or address insufficiently. For example, surveys could be used to gain a better understanding of the experiences of the chronically ill or of those enrolled in managed care but not receiving services (do they consider themselves healthy? do they know they are enrolled? do they know how to access services?).

- ▶ How can surveys be used more effectively to provide information meaningful to beneficiaries faced with a choice of health plans?

The Agency for Health Care Policy and Research (AHCPR) is engaged in a 5-year Consumer Assessment of Health Plan Survey project aimed at using surveys to develop report cards for consumers facing a choice of plans.¹⁹ What can Medicaid agencies learn from this project? What is known about what types of information Medicaid beneficiaries need when making a choice?

- ▶ How can the agencies' contracts with managed care plans best benefit the agencies' needs for survey information?

Medicaid agencies have an opportunity with their contracts to call for the plans to conduct specific surveys and even to stipulate the sampling design, the question phrasing, and the survey methodology. How should agencies best take advantage of that opportunity? Should they aim to have all their plans conduct uniform surveys according to contract specifications?

- ▶ How can Medicaid agencies best deal with the hurdles inherent in surveying a Medicaid population?

Conducting a credible survey always requires careful consideration to a variety of methodological issues, such as sampling and approach (telephone, mail, or in-person, for example). But surveying a Medicaid population presents unique hurdles, such as short and discontinuous eligibility.

The HCFA should devote greater attention to how the Medicaid agencies are using beneficiary surveys. It should revise its written guides for reviewing and monitoring Medicaid managed care initiatives to call attention to the importance of using beneficiary surveys in more focused, strategic ways.

The HCFA already identifies surveys and their uses as a point of review in its guides for reviewing and monitoring Medicaid managed care initiatives.²⁰ It could, however, enhance the attention it gives to surveys by incorporating greater discussion, inquiry, and assessment of agencies' use of surveys at each point for formal review or monitoring. Toward that end, it should consider adding the questions below to its guides:

- ▶ What does the agency aim to achieve with its beneficiary surveys? To what extent is it related to beneficiary protection?
- ▶ How narrowly has it defined the survey's purpose? Could a more targeted use of a survey enhance its value as a beneficiary protection tool?
- ▶ Will the survey fill a gap in the agency's system for overseeing quality in the health plans? Will it provide information that the agency knows beneficiaries rely upon in choosing a health plan?
- ▶ Does the agency have a cost-effective plan for overcoming the hurdles associated with surveying Medicaid beneficiaries?
- ▶ Has the agency weighed the relative costs of surveying beneficiaries with the relative usefulness of the survey results?

COMMENTS ON THE DRAFT REPORT

We solicited and received comments on the draft report from the Health Care Financing Administration (HCFA) and the American Association of Health Plans (AAHP). We include the complete text of the detailed comments in appendix C. Below, we summarize HCFA's and AAHP's major comments on the recommendations and then, in italics, offer our responses.

RECOMMENDATIONS FROM THE DRAFT REPORT

The HCFA should either establish a work group or technical advisory group on Medicaid beneficiary surveys or add surveys to the agenda of an existing group. Either group should provide policy-level guidance on how to make cost-effective uses of beneficiary surveys.

The HCFA partially concurred with this recommendation. It pointed out that its existing Medicaid Managed Care Technical Advisory Group has a work group currently working on consumer information and surveys. The HCFA agreed with our assessment that agencies often conduct surveys for multiple purposes but disagreed with our assessment that these were often of limited value. The HCFA pointed out that it is not feasible for States to develop single-purpose surveys. It further noted that it believes States have obtained some meaningful information from surveys, even where that information was not what the State intended to acquire. And it noted its ongoing collaboration with the Agency for Health Care Policy and Research, which is leading the Consumer Assessment of Health Plans Study.

The AAHP supported this recommendation and suggested that HCFA include some health plans in this work group. It reinforced the importance of weighing the relative costs of surveys with the relative usefulness of the survey results for not only State agencies but also health plans.

We recognize that HCFA's Technical Advisory Group could be an appropriate group to provide policy-level guidance on the cost-effective use of beneficiary surveys and we urge it to continue collaborating on the Consumer Assessment project. We maintain, however, that based on this inquiry, narrowly focused surveys have been more useful to State agencies as a beneficiary protection tool.

We appreciate AAHP's support for our recommendation and urge HCFA to consider including health plan representatives in its Technical Advisory Group to discuss the cost-effective use of surveys.

The HCFA should devote greater attention to how the Medicaid agencies are using beneficiary surveys. It should revise its written guides for reviewing and monitoring Medicaid managed care initiatives to call attention to the importance of using beneficiary surveys in more focused, strategic ways.

The HCFA concurred with points raised in our findings and text: that some surveys have multiple objectives and need to be more focused. It pointed out that surveys are a very important part of State agencies' requirements under the Quality Assurance Reform Initiative, which is being replaced with a system of standards for both Medicare and Medicaid. It anticipates that surveys will be an important component of that new system. The HCFA plans to include a special session on survey development and use of survey data in its annual Managed Care College and will stress the importance of surveys in its technical assistance to HCFA regional office and State Medicaid staff.

The AAHP supported this recommendation.

We welcome HCFA's plans for survey sessions at its Managed Care College and through its ongoing technical assistance and urge it to use these venues to stress more focused and strategic uses of surveys. And we reemphasize the need for HCFA to revise its written guides for reviewing and monitoring Medicaid managed care initiatives. In its comments, HCFA did not indicate that it would revise these guides along the lines we suggested.

We appreciate AAHP's support of our recommendation.

APPENDIX A

BACKGROUND ON MEDICAID MANAGED CARE

Medicaid Expansion into Managed Care Programs

Over the past 15 years, States have increasingly used managed care to provide medical services for Medicaid beneficiaries. This trend has accelerated in the past few years: in 1991, 2.7 million Medicaid beneficiaries were enrolled in managed care, by 1993, that number grew to 4.8 million, and in 1996, 13 million. As of June 1996, 39 percent of all Medicaid beneficiaries were enrolled in some kind of managed care arrangement.

To date, States have primarily enrolled adults and children in low-income families into managed care, whereas aged or disabled beneficiaries remain under fee-for-service systems. By 1996, over 500 managed care organizations were providing services to 13 million Medicaid beneficiaries.

The movement to enroll Medicaid beneficiaries in managed care began in earnest in the early 1980s, as States experienced significant fiscal pressures due to rising Medicaid costs. While States viewed managed care as a way to contain Medicaid costs, they were constrained by Federal standards required for Medicaid enrollment in managed care.

In response to mounting concerns, Congress allowed States greater flexibility to deviate from those standards through amendments to the 1981 Omnibus Budget Reconciliation Act.²¹ For example, the amendments allow States to pursue freedom-of-choice waivers (under section 1915 of the Social Security Act) that release them from certain Federal provisions, such as the free-choice-of-provider provision. To date, 42 States have freedom-of-choice waivers.

States also can receive research and demonstration waivers under section 1115 of the Social Security Act. Since 1992, many States have aggressively pursued such waivers. States implementing or pursuing 1115 waivers often extend, as a part of their demonstration, insurance benefits to those not otherwise eligible for Medicaid, such as the working poor and their families. As of this writing, HCFA has approved 18 research and demonstration waivers. Of those, 12 States have implemented their programs, 5 are pending implementation, and one has no plans to implement.²² The HCFA is currently reviewing nine States' applications.²³

Defining Managed Care

Although managed care organizations vary, they generally feature a focus on primary, preventive health care and care coordination. That focus is believed to improve care and access for enrollees. It is also thought to promote cost containment, thus slowing the rate of increase in health care spending.

The managed care organizations enrolling Medicaid beneficiaries can generally be defined as fitting into one of two basic types: health maintenance organizations and fee-for-service primary care case management (PCCM) programs. Both types feature coordinated care. But each carries a different level of financial risk. Health maintenance organizations (hereafter referred to as health plans or plans) are full-risk plans that contract with Medicaid for a fixed fee per person and provide comprehensive services.²⁴ PCCM programs comprise providers, usually primary care physicians, willing to serve as gatekeepers and take responsibility for approving and coordinating enrollees' care. Medicaid pays PCCM providers on a fee-for-service basis, but they receive a case management fee to cover their added responsibilities. Thus PCCM providers are at no financial risk.

Some agencies also contract with plans separately for certain aspects of care, such as mental health, substance abuse, and dental care. The arrangements for these "carve-outs" vary in terms of the services included and the level of financial risk the plan assumes.

APPENDIX B

METHODOLOGY

We drew on three major sources of data for this study: (1) interviews with the Medicaid managed care leadership in 11 States, (2) a survey of the full-risk managed care plans enrolling beneficiaries in those 11 States, and (3) the model contracts used by the Medicaid agencies in contracting with the managed care plans.

11 Participating State Medicaid Agencies

At the outset of our study, we chose the 13 State Medicaid programs that had made a significant commitment to enrolling their beneficiaries in full-risk managed care plans, represented different geographic areas of the country, and with waivers in various stages of approval or implementation. Medicaid agencies in 11 of these States participated: Arizona, California, Florida, Massachusetts, Minnesota, Missouri, New York, Ohio, Oregon, Rhode Island, and Utah. Two State agencies declined to participate. Of the participating 11 States, 6 had approved and implemented 1115 waivers (Arizona, California, Minnesota, Ohio, Oregon, and Rhode Island), 2 had approved waivers pending implementation (Florida and Massachusetts), and 3 had pending waivers (Missouri, New York, and Utah). Together, the 11 States represent about 37 percent of all Medicaid beneficiaries in the country. The results of our study are not generalizable to other State Medicaid agencies.

Interviews and Site Visits

We conducted structured telephone interviews with the Medicaid managed care leadership in eight of the State Medicaid agencies. We visited the Medicaid agencies in five of the States on one or more occasions to conduct the interviews in person and meet with additional agency staff, advocates, and representatives of the State's legislature and managed care plans. We conducted site visits in California, Massachusetts, Minnesota, Rhode Island, and Utah. During both the telephone interviews and site visits we collected any relevant documents such as survey reports, contracts, and evaluations.

Contract Review

We reviewed the model contracts in use at the time of our interviews for requirements related to surveys.

Survey of Full-Risk Managed Care Plans in 11 States

We received lists of full-risk managed care plans enrolling Medicaid beneficiaries from each of the 11 agencies in our sample. We then sent, via facsimile, a questionnaire asking about the plan's recent survey activity. We sent a second survey to nonresponding plans after about 3 weeks, and then followed up by telephone

with remaining nonresponding plans after about 6-8 weeks. The universe for this survey included 162 plans in 11 States. Eight of the 162 plans were invalid because they no longer enrolled Medicaid beneficiaries, therefore our adjusted universe included 154 plans. We received 105 completed questionnaires in time to be included in our analysis. Our adjusted response rate was 68 percent.

We attempted to conduct a non-respondent analysis to determine how nonresponding plans differ from responding plans, if they do at all. Because we lacked certain data elements, such as tax status and size of enrolled population for some plans, we were unable to complete the analysis. The results of our health plan survey are not generalizable to all plans.

APPENDIX C

COMMENTS ON THE DRAFT REPORT

In this appendix, we present in full the comments from the Health Care Financing Administration and the American Association of Health Plans.



The Administrator
Washington, D.C. 20201

DATE: APR 23 1997

TO: June Gibbs Brown
Inspector General

FROM: Bruce C. Vladeck
Administrator

A handwritten signature in black ink, appearing to read "B. Vladeck", written over the printed name of the sender.

SUBJECT: Office of Inspector General (OIG) Draft Report: "Medicaid Managed Care:
The Use of Surveys as a Beneficiary Protection Tool," (OEI-01-95-00280)

We reviewed the above-referenced report that finds surveys have been of limited use as a beneficiary protection tool.

Our detailed comments on the report recommendations are attached for your consideration. Thank you for the opportunity to review and comment on this report.

Attachment

Comments of the Health Care Financing Administration (HCFA)
on Office of Inspector General (OIG) Draft Report:
“Medicaid Managed Care: The Use of Surveys as a Beneficiary Protection Tool,”
(OEI-01-95-00280)

OIG Recommendation

HCFA should either establish a work group or technical advisory group on Medicaid beneficiary surveys or add surveys to the agenda of an existing group. Either group should provide policy-level guidance on how to make cost-effective use of beneficiary surveys.

HCFA Response

We partially concur with the intent of the recommendation to provide policy-level guidance on how to make cost-effective use of beneficiary surveys.

HCFA already has a Medicaid Managed Care Technical Advisory Group (MMCTAG) that works in conjunction with the Medicaid Managed Care Team (MMCT) in the Office of Managed Care (OMC). The MMCTAG is comprised of state Medicaid agency staff, the American Public Welfare Association, and the MMCT staff. The MMCTAG provides valuable input essential for the accuracy and completion of many HCFA projects. As part of its fiscal year 1996 agenda, the MMCTAG formed six work groups to address issues they consider to be the most urgent in the rapid transition from fee-for-service to managed care. One of these groups is working on consumer information, which has as one of its goals the development of a document on survey instruments tested and validated.

The report states beneficiary surveys developed by state Medicaid agencies are developed for different purposes and to meet various objectives. We agree with that assessment. However, due to limited state resources, it is not feasible for states to develop surveys for a single purpose. When they are developed and used for a single purpose, they are only one part of the overall assessment. The purposes of Medicaid surveys range from internal assessment of a plan's performance, to assessing how satisfied beneficiaries are with a plan and its services, to identifying areas for potential improvement, etc. The purpose of the survey dictates how it should be constructed, what should be included, to whom and when it should be administered, and most importantly, how the results can and should be compiled and utilized. Because of the variation among states' administration and coverage, it is very difficult to come up with one method or instrument that will satisfy everyone's needs. Although states are currently experimenting with different instruments and formats, we believe they have obtained some meaningful information about beneficiaries (maybe not what they started out to acquire, but nonetheless, useful).

We concur with the need for additional policy-level guidance on survey use. HCFA is already collaborating with the Agency for Health Care Policy and Research on the development of its Consumer Assessment of Health Plans Survey (CHAPS). This survey includes questions for the Medicaid population, as well as commercial and Medicare populations. In addition, HCFA recently prepared and distributed copies of "Customer Satisfaction Surveys for Medicaid Beneficiaries: A State Guide" to Medicaid Associate Regional Administrators for release to their respective states for input. This document, containing information on specific survey instruments developed by states and national organizations, will assist states in developing or improving existing customer satisfaction surveys for the Medicaid population. Although we are making progress, there still needs to be more work done in this area, particularly on the use of beneficiary survey results.

OIG Recommendation

HCFA should devote greater attention to how the Medicaid agencies are using beneficiary surveys. It should revise its written guides for reviewing and monitoring Medicaid managed care initiatives to call attention to the importance of using beneficiary surveys in more focused, strategic ways.

HCFA Response

We concur that some state surveys are very general, attempt to address too many issues at once, and need to be more focused. Surveys are a very important part of states' requirements under the Quality Assurance Reform Initiative (QARI). As states become more experienced in survey design, analysis, and use, we expect the surveys to be more focused in what questions they are trying to answer and the purposes they are used for. We have, however, made some progress in this area and are working to improve it even further. The existing MMCTAG established a work group on consumer information, whose goal is to collect information on what Medicaid recipients want to know about health plans and providers and how beneficiaries think information should be presented. The MMCTAG also plans to work with Harvard Medical School and/or Rand in the piloting of the CHAPS Medicaid survey. In addition, the QARI is being replaced with a system that will contain quality standards for both Medicaid and Medicare. We anticipate additional focus on the importance of surveys and baseline data to measure demonstrable improvement in beneficiary care and outcomes. OMC also sponsors a Managed Care College each year. We plan to include a special session on survey development and use of survey data. Finally, as part of our continuing technical assistance to regional office and state Medicaid staff, we will emphasize the importance of surveys and how they can be used to monitor managed care initiatives.



American Association of
HEALTH PLANS

April 11, 1997

June Gibbs Brown
Inspector General
Office of Inspector General
Department of Health and Human Services
330 Independence Avenue, SW
Washington, DC 20201

Dear Ms. Brown:

On behalf of the American Association of Health Plans (AAHP), thank you for the opportunity to review and provide comments on the Office of Inspector General's (OIG's) draft inspection report, "Medicaid Managed Care: Use of Surveys as a Beneficiary Protection Tool." AAHP represents approximately 1000 health plans serving over 100 million Americans nationwide. Many of AAHP's members provide services to Medicaid beneficiaries.

AAHP agrees with the basic findings and recommendations of the report. AAHP fully supports initiation of new efforts designed to improve information to beneficiaries about their enrollment options to help them make better informed choices. We also recognize that, for a number of reasons, State mandated surveys may be of limited value as a beneficiary protection tool and may not provide useful information to beneficiaries.

AAHP specifically supports the recommendation that HCFA form a work group or technical advisory group to provide policy-level guidance on how to make cost-effective use of beneficiary surveys. We also appreciate and agree with the recommendation that HCFA should consider the relative costs of surveying beneficiaries with the relative usefulness of the survey results. Consideration of this issue is equally relevant whether the survey costs are incurred by the State Medicaid Agency directly or by the health plan.

Our suggestions and comments are relatively minor. We suggest several refinements to the Executive Summary to clarify a few issues and to give greater prominence to some important points made in the body of the report. The following are suggested revisions to the Executive Summary:

- At the end of the second paragraph of the Background section of the Executive Summary, we suggest that the OIG add a sentence or two noting that there are also many other methods to measure plan performance, including HEDIS and the evaluation of other utilization data. Also, we suggest that the text note that to obtain a beneficiary perspective on health plans, surveys are rarely used alone and complement other types of performance measurement data.
- In the next paragraph of the Executive Summary, we suggest that the narrative note that

June Gibbs Brown
April 11, 1997
Page 2

other tools, such as descriptions of benefits, access requirements, and the delivery system, may assist the consumer in making informed enrollment decisions.


- We suggest that the Executive Summary note that there are two types of surveys. The first type, which is the focus of the report, is State mandated surveys (either conducted by the State Medicaid Agency or the health plan on its behalf). The second type of survey is one conducted voluntarily by health plans. We suggest that the Executive Summary note briefly that health plans frequently conduct their own surveys and that these surveys may lead to improvements by the plans. (This point is noted on page 10 of the draft report).

AAHP also recommends that the OIG suggest that HCFA obtain the participation of health plans in its work group activities.

Further, we suggest that the OIG identify as an issue for consideration the possibility of giving health plans the discretion to decide, subject to State approval, the survey's focus. The draft report suggests that survey needs may vary among health plans. If so, it would be desirable to give health plans the flexibility to decide how best to meet those needs. This suggestion could be incorporated in the fourth bullet on page 12 of the draft report.

Thank you again for the opportunity to comment on this draft report. If your staff would like to discuss further our comments, please call me at (202) 778-3209 or Michelle Fried, Counsel for Federal Programs, at (202) 778-8484.

Sincerely,


Candace K. Schaller
Executive Director, Regulatory Affairs

APPENDIX D

ENDNOTES

1. The Federal government requires Medicaid agencies enrolling their beneficiaries into managed care to meet certain quality assurance requirements. Among these requirements are those that call for each managed care plan to have an internal quality assurance plan, grievance procedure, and total enrollment comprised of not more than 75 percent Medicaid and/or Medicare beneficiaries. Federal regulations also require the plans to allow disenrollment on demand within 1 month of requesting it, although this can be waived for a 6-month lock-in period. Statutory requirements limit the manner in which plans can pay their physicians, generally referred to as the physician incentive program. Agencies must conduct periodic medical audits to ensure quality and access of services and provide data on reasons for beneficiary disenrollment. Agencies must also ensure that an independent, external review of the quality of services be conducted annually for each managed care plan. The agencies, of course, can build upon these Federal requirements, and the Health Care Financing Administration can waive certain requirements through the different waiver programs.

2. C. Baldwin, "Customer Satisfaction Surveys for Medicaid Beneficiaries: A State Guide," (Baltimore, MD: Office of State Health Reform Demonstrations, HCFA) November 1996.

3. The 11 States are: Arizona, California, Florida, Massachusetts, Minnesota, Missouri, New York, Ohio, Oregon, Rhode Island, and Utah.

4. By technical quality of care we mean treatment, examinations, follow-through, and preventive care as opposed to interpersonal communications and courtesy. We base this distinction on categories presented in the Draft Medicaid HEDIS document published in July of 1995.

5. The agencies in our sample were all in various stages of the process of getting and using encounter data to help them assess plan performance. For the most part, as of this writing, agencies lack validated encounter data. They also were in various stages of requiring their plans to report HEDIS indicators.

6. R. H. Brook, C. J. Kamberg, and E. A. McGlynn, "Health System Reform and Quality," *Journal of the American Medical Association* 276(6) (August 14, 1996): 478 and Massachusetts Healthcare Purchaser Group, "Cost/Quality Challenge," March 1996.

7. In Oregon, the State agency conducted a baseline survey in 1994, then conducted another survey in 1996. The agency revised the second survey, thereby affecting the direct comparability of results between the two surveys. (*The Oregon Health Plan*

Medicaid Demonstration Project: 1994 and 1996 Comparative Client Satisfaction Data, Preliminary Aggregate Report.)

8. Minnesota Health Data Institute, "Evaluation Report of the Minnesota Health Data Institute 1995 Consumer Survey," (July 1996)

9. Joseph Mangano, Ed., "Oregon Consumers Favor Doctor Data" *Quality Management Update* 6(18) (September 18, 1996).

10. Robert Cunningham, Ed., "Consumers Gaining Leverage in Quality Assurance Arena," *Medicine & Health* (June 17, 1996). See also Harold S. Luft, "Modifying managed Competition to Address Cost and Quality," *Health Affairs* (Spring 1996): 23-28 and Frederick Schneider Research, "Medicaid and Managed Care: Focus Group Studies of Low Income Medicaid Beneficiaries in Five States," (Washington DC: May 1996).

11. Henry J. Kaiser Family Foundation, "Americans as Health Care Consumers: The Role of Quality Information," (October 1996) and Robert Cunningham, Ed., "Consumers Gaining Leverage in Quality Assessment Arena."

12. The Medicaid HEDIS (Health Plan Employer Data and Information Set) Work Group comprises individuals and organizations that worked together to develop measures for monitoring the performance of managed care plans serving the Medicaid population. The National Committee for Quality Assurance sponsored the Work Group in association with HCFA and the American Public Welfare Association.

13. The Agency for Health Care Policy and Research (AHCPR) is currently funding a 5-year project aimed, in part, at developing and testing questionnaires to assess plans. This project, called the Consumer Assessment of Health Plans Study (CAHPS), is at year 3 and beginning to field test its questionnaires. The CAHPS encompasses all types of health plans as well as the privately and publicly (Medicare and Medicaid) insured. The Health Care Financing Administration has called for managed care plans enrolling Medicare beneficiaries to use the CAHPS questionnaire. Eventually the AHCPR expects that its CAHPS questionnaires will be available to interested parties without charge.

14. The response rate was calculated after deducting 204 beneficiaries identified as ineligible for reasons such as disconnected phones, moved out of the area, and deceased.

15. Of the 17 respondents that indicated they had not conducted any surveys that included Medicaid beneficiaries in the past 2 years, 14 had plans to conduct such surveys within the next year.

16. In another recent survey of health plans (with Medicare risk and cost contracts), the Office of Inspector General also found great variety in plan approaches to surveys (Office of Inspector General, *HMO Customer Satisfaction Surveys*, March 1996).

17. In another recent survey of health plans (with Medicare risk and cost contracts), the Office of Inspector General found that plans used their survey results as much for marketing as for improvements. (Office of Inspector General, *HMO Customer Satisfaction Surveys*, March 1996)

18. American Association of Health Plans, "1995 AAHP HMO PPO Trends Report."

19. The CAHPS aims to help consumers choose the best-suited health plan for their needs by developing and testing questionnaires to assess plans, reporting the survey information to consumers, and evaluating their usefulness. This ambitious project encompasses the privately insured as well as the Medicaid and Medicare populations. As of this writing, the CAHPS project is at year 3 and beginning to field test its surveys.

20. HCFA, "Monitoring Guide for Medicaid Managed Care Initiatives," Working Draft (September 1996) and "Medicaid Pre-Implementation Review Guide for Section 1115 Demonstration Waivers," Working Draft, (August 1995).

21. The 1981 amendments also allow States to enroll Medicaid beneficiaries in limited-risk managed care organizations (i.e., no risk for inpatient care) that fail to meet Federal qualifications.

22. The following States have implemented their 1115 waivers: Alabama, Arizona, California, Delaware, Hawaii, Minnesota, Ohio, Oklahoma, Oregon, Rhode Island, Tennessee, and Vermont. The following States have approved 1115 waivers that are pending implementation: Florida, Illinois, Kentucky, Maryland, and Massachusetts. South Carolina has an approved waiver but no plans for implementation.

23. States with 1115 waivers under review are: Georgia, Kansas, Louisiana, Missouri, New Hampshire, New York, Texas, Utah, and Washington.

24. Federal regulations define comprehensive services as either inpatient hospital services and one other mandatory service or three or more mandatory services (42 CFR 434.21). Mandatory services are defined in statute as inpatient and outpatient care, physicians' services, and laboratory and diagnostic services, among others (42 USC §1396d(a)).