Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

HMO CUSTOMER SATISFACTION SURVEYS

JUNE GIBBS BROWN
Inspector General

MARCH 1995
OEI-O2-94-00360

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EXECUTIVE SUMMARY

PURPOSE

To assess how Medicare health maintenance organizations (HMOs) are conducting customer satisfaction surveys and how they are utilizing the results of these surveys.

BACKGROUND

In various staff meetings, the Office of Managed Care in the Health Care Financing Administration (HCFA) asked the Office of Inspector General (OIG) to survey how Medicare HMOs are measuring customer satisfaction, particularly of Medicare beneficiaries, and using the resulting data. The HCFA requested this study in order to better ascertain how active its role should be in surveying Medicare HMO enrollees and how the surveys HMOs are conducting can be of use to HCFA in its monitoring efforts.

We selected a stratified random sample of 95 HMO risk and cost contracts out of the universe of 185 such contracts with Medicare beneficiaries enrolled as of February 1, 1995. We sent them a mail questionnaire regarding their customer satisfaction survey procedures and their use of survey results. We also requested copies of their survey instruments, which we analyzed for content and format. We received 72 completed questionnaires and 63 survey instruments.

FINDINGS

Virtually All Risk and Cost HMOs Conduct Customer Satisfaction Surveys

All but one of our respondent HMOs (99 percent) conduct general customer satisfaction surveys.

However, Most HMOs Do Not Target Their Medicare Members

More than half of the HMOs (55 percent) have never conducted a customer satisfaction survey of their Medicare members only. Furthermore, almost all of these (97 percent) also do not include questions specific to Medicare members on their general surveys. More than one-third of all HMOs (39 percent) do not know the satisfaction rate of their Medicare members for their last general survey, and most (65 percent) do not know the Medicare response rate. However, the Medicare specific data which is available shows that Medicare members have high satisfaction rates.

HMO Customer Satisfaction Survey Instruments and Procedures Lack Uniformity

The satisfaction survey instruments used by HMOs vary widely in their format and content; in fact, no two are the same. These instruments differ in their comprehensiveness and in the rating scales and satisfaction questions used. The survey

procedures HMOs use also vary. This lack of uniformity in HMO surveys renders comparisons between HMOs difficult, if not impossible, when assessing Medicare beneficiaries' satisfaction with their plans.

While in Many Ways Basically Sound, Technical Weaknesses in Many HMO Surveys May Mask Problems and Inflate Satisfaction With Managed Care Plans

Many HMOs appear to be following sound survey principles regarding sampling and increasing response rates. Most are also using survey instruments containing clearly worded and focused questions (98 percent) and covering a broad range of satisfaction dimensions (71 percent.) However, many HMO survey instruments do contain weaknesses which may bias, to some degree, survey results. Most significantly, more than half (58 percent) include no questions about problems with or complaints about health plan services, and twenty-nine percent use survey instruments which include an unbalanced five-point rating scale of three positive, one neutral and only one negative response category. Most HMOs are also lacking mail follow-up procedures (21 of 32 which use mail surveys) and are not conducting non-respondent analyses (87 percent.) One-third of HMOs scored adequate on an index of instrument adequacy, and less than half (44 percent) scored adequate on an index of procedure adequacy.

HMOs Use Their Survey Results as Much for Marketing as for Quality Improvement

Nearly three-fourths of HMOs (74 percent) say they use the results of their customer satisfaction surveys to market themselves to potential new members. A similar number (76 percent) report also using their customer satisfaction data to develop quality improvement or corrective action plans. A majority of HMOs share their survey findings with physicians (76 percent) and with plan members (67 percent.)

IMPLICATIONS FOR MEDICARE

We believe the usefulness of customer satisfaction surveys as currently conducted by HMOs is substantially reduced by their lack of uniformity, limited focus on Medicare beneficiaries and technical weaknesses. Therefore, if HCFA seeks data on the satisfaction of Medicare beneficiaries with managed care, we believe it can not rely upon industry surveys as they are now conducted. The HCFA may want to consider alternative approaches to measuring Medicare client satisfaction with managed care, such as conducting its own surveys or requiring HMOs to periodically survey their Medicare members with a standardized instrument and comparable procedures.

The Office of Inspector General is planning further work surveying Medicare beneficiaries about their experiences with HMOs. We will once again conduct a survey of Medicare HMO members similar to one already completed. We are also working on a technical assistance report which will provide HCFA with a more detailed discussion of our methodology for conducting beneficiary surveys and will identify useful survey techniques and methods based on our prior experience.

COMMENTS

We received favorable comments from HCFA on the draft report, expressing their appreciation for the timeliness and significance of our study. In particular, HCFA states that this report will be a major factor in influencing its decision to develop its own beneficiary satisfaction survey capability. The actual comments received are included in Appendix C.

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INTRODUCTION

PURPOSE

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BACKGROUND

In various staff meetings, the Office of Managed Care in the Health Care Financing Administration (HCFA) asked the Office of Inspector General (OIG) to survey how Medicare HMOs are measuring customer satisfaction and using the resulting data. The OIG was asked to pay particular attention to what the managed care industry is doing to measure the satisfaction of its Medicare members. The HCFA requested this study in order to better ascertain how active its role should be in surveying Medicare HMO enrollees and how the surveys HMOs are conducting can be of use to HCFA in its monitoring efforts.

This report follows earlier OIG reports on Medicare managed care. These included one entitled "Beneficiary Perspectives of Medicare Risk HMOs" which surveyed beneficiaries about their experiences with HMOs. This report found that while risk HMOs provide adequate service access for most of their Medicare enrollees, some serious problems remained with enrollment procedures and service access and disenrollees were more likely than enrollees to have experienced problems with HMO services. A further report on "Medicare Risk HMOs: Beneficiary Enrollment and Service Access Problems" looked more closely at HMO-level data to identify the distribution of these problems and found that they existed in varying degrees of intensity among HMOs and more frequently with disenrollees than with enrollees. Another report, entitled "Medicare Risk HMO Performance Indicators," found that HMO disenrollment rates, along with customer satisfaction surveys, appear to be useful managed care performance indicators.

The Industry

Health maintenance organizations are a form of managed care in which a patient selects a primary care physician from a group of approved plan providers to act as the patient's first point of contact within the health care system. This physician must authorize any specialist, hospital or other type of care the patient receives. According to industry estimates, approximately 50 million individuals in the United States are enrolled in one of the 550 HMOs across the country.

An HMO can pay its physicians in different ways. A primary care physician or specialist can be paid on a capitation basis, in which he or she is paid one monthly amount per each patient regardless of how much care that patient receives. Physicians can also be paid on a fee-for-service basis. Some HMOs use a combination of these different payment methods.

Medicare HMOs

Medicare beneficiaries have the option of receiving their health care from an HMO approved by HCFA. Once approved, the HMO generally applies for a risk or cost Medicare contract. In a risk contract, the HMO provides the full Medicare benefit package and is paid on a prospective per capita basis, in which it is required to absorb any financial losses but is permitted to retain any financial savings. Under such a contract, payment is made on a prepaid capitation basis with no retroactive adjustment. The HCFA encourages HMOs to apply for risk contracts. In a cost contract, the HMO also provides the full Medicare benefit package but is paid on a reasonable cost basis. An HMO can also serve Medicare patients through a health care prepayment plan agreement or as a demonstration project.

The number of Medicare risk and cost contracts continues to grow. As of February 1, 1995, 157 plans had risk contracts and 30 had cost contracts with HCFA, with a total enrollment of approximately 2.5 Medicare million beneficiaries. This is an increase from July of last year, when there were 136 risk HMOs and 27 cost HMOs. In February 1993, only 87 HMOs had risk contracts to serve Medicare beneficiaries.

While only about seven percent of the Medicare population nationwide is enrolled in HMOs, the geographical distribution of this enrollment varies widely. The distribution of Medicare HMO enrollees is concentrated in four States: California, New York, Florida, and Arizona. A few States have no Medicare beneficiaries enrolled in managed care programs.

Section 42 CFR 417.107(h) of the regulations require federally qualified HMOs with Medicare enrollees to implement ongoing quality assurance programs. These programs must have the following basic components: a quality assurance methodology, a peer review process, systematic data collection of performance and patient results, and remedial action procedures.

As part of the systematic data collection requirement listed above, HMOs are required to share their data collection results with their providers of care and institute any needed changes based on these results. Data can be collected from any of several different sources, including member satisfaction surveys. These surveys, however, are not required by law.

Customer Satisfaction Initiatives

Several efforts have been under way in the managed care industry to develop methodologies and instruments for measuring and reporting performance ratings, including customer satisfaction, in managed health care. These initiatives have primarily been motivated by an interest in the industry and among health care consumers in establishing standard measures by both individuals and employers can compare and contrast different health plans. Few of these initiatives, however, are specifically aimed at the Medicare population.

Two industry groups are particularly active in managed care quality and customer satisfaction issues. The National Committee for Quality Assurance (NCQA) is a voluntary private accreditation agency active in setting and enforcing HMO quality standards. In November 1993, it developed the Health Plan Employer Data and Information Set (HEDIS), which defines performance measures to evaluate, among other things, a plan's quality of care, member access to care, and member satisfaction. The NCQA publishes the results of its accreditation reviews nationwide. Also, the Group Health Association of America (GHAA), a managed care industry group to which most HMOs belong, has developed a model consumer satisfaction questionnaire which is available to its members.

METHODOLOGY

In conducting this inspection, we selected a stratified random sample out of the universe of 185 HMO risk and cost contracts with Medicare beneficiaries enrolled as of February 1, 1995 (nine additional HMO risk and cost contracts were dropped from the universe because they had no Medicare enrollees at the time the sample was drawn.) These HMO contracts were stratified into three groups of high, medium and low Medicare enrollment, based on the number of Medicare beneficiaries in each. The HMOs in the high stratum have Medicare enrollments of larger than 42,550, while those in the medium and low strata have between 42,500 and 1000 and less than 1000 Medicare members respectively. We purposely contacted all of the contracts in the high stratum. See Appendix A for a more detailed explanation of strata selection.

We selected 95 HMO risk and cost contracts for the final sample: all 13 from the first stratum, 70 from the second stratum, and 12 from the third stratum. Medicare enrollment in the 13 high stratum contracts accounts for 51 percent of all Medicare enrollment nationwide in managed care. Forty-seven different HMOs across the country hold these 95 contracts. Eighty-two of the 95 are risk contracts, and the remaining 13 are cost contracts.

We sent all 95 a mail questionnaire which requested information about their customer satisfaction survey procedures and their use of survey results. We also requested copies of the HMOs' survey instruments. After allowing six weeks for data collection, during which time we conducted a second mailing to non-respondents, we achieved an overall response rate of 76 percent for the questionnaires. We also achieved a 66 percent overall response rate for the survey instruments after making a minimum of two follow-up telephone calls to HMOs who did not initially send us their instruments. For the mail questionnaires, we achieved response rates of 100 percent for the high stratum, 77 percent for the medium stratum, and 42 percent for the low stratum. For the survey instruments, we achieved response rates of 100, 64 and 42 percent for each of the three strata respectively. All differences reported between strata are statistically significant at the 95 percent confidence level.

Differing response rates among strata suggest the possibility of non-response bias. While we did use Chi-square to test for such bias, due to our relatively small sample size and

resulting small cell sizes in the two-variable tables, it was not a valid test. Therefore, we acknowledge the possibility of non-response bias but are not able to quantify it.

To assess HMO customer satisfaction survey procedures, we reviewed the returned mail questionnaires to determine, among other things, their sampling methods, follow-up procedures, and their means of determining response and satisfaction rates. Our findings on survey procedures are based on the HMOs' answers to these questionnaires. See Appendix A for confidence intervals of fifteen key questions.

To assess HMO survey instruments, we developed a detailed review sheet which we used to systematically evaluate each instrument for both form and content. This review sheet included assessments of each instrument's length, dimensions of satisfaction measured, scales and format used, clarity of instructions and questions, and user friendliness.

We also constructed two indexes of survey adequacy - one for instruments and the other for procedures. We used data from the instrument review sheets discussed above to construct the index of instrument adequacy. This index was based on three key variables: comprehensiveness of satisfaction dimensions, balanced response categories, and problem specific questions. The index of procedure adequacy was based on four variables: level of confidence sought, frequency of follow-up efforts, conducting a non-respondent analysis, and use of balanced criteria for determining overall satisfaction. For these four variables, we used indicators from the questionnaires returned by HMOs. In each of the two indexes, we gave the variables a subscore, which were then combined to give total scores for instrument adequacy and procedure adequacy respectively. The indexes of survey adequacy are explained in greater detail in Appendix B.

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

FINDINGS

VIRTUALLY ALL RISK AND COST HMOs CONDUCT CUSTOMER SATISFACTION SURVEYS

General Membership Satisfaction Surveys

All but one of the respondent HMOs (99 percent) conduct general customer satisfaction surveys. Almost all (95 percent) consider these general surveys to be very or somewhat useful. A majority of HMOs (60 percent) conduct their surveys at least once a year, while thirteen percent survey their members twice a year. Most of the remaining 28 percent conduct satisfaction surveys on an ongoing basis.

Nearly three-fourths of HMOs occasionally (24 percent) or always (49 percent) use a professional research agency to conduct their customer satisfaction surveys, with a total of 37 different research firms cited by the responding HMOs. All of the HMOs with high Medicare enrollment hire professional research firms, as compared to 70 percent of HMOs with medium and low Medicare enrollments.

Other Types of Surveys

A majority of HMOs are also conducting other types of surveys. These include surveys of disenrollees (92 percent), on the functional or health status of their members (58 percent), and of the working aged (53 percent.) Fifty-nine percent of HMOs also survey the physicians who work for them about their satisfaction.

HOWEVER, MOST HMOs DO NOT TARGET THEIR MEDICARE MEMBERS

Medicare Satisfaction Surveys

While HMOs conduct satisfaction surveys of their general memberships, they pay less specific attention to their Medicare members. More than half of the HMOs (54 percent) have never conducted a customer satisfaction survey of their Medicare members only; in fact, eight percent of these survey only their commercial, non-Medicare, members on satisfaction. Seven of the HMOs who have not yet conducted a Medicare only survey did volunteer, however, that they are planning to do so within the next year. Almost all of the HMOs (97 percent) which do not conduct Medicare only surveys also do not include questions specific to Medicare members on their general surveys; the few who do ask only a limited number of Medicare questions.

While most HMOs have the potential to identify Medicare members in their general surveys by identifying the respondent's age, for the most part they are not extracting Medicare specific data. More than one-third of all HMOs (39 percent) do not know the satisfaction rate of their Medicare members for their last general survey, and most (65 percent) do not know the Medicare response rate. Nevertheless, whether or not they

survey Medicare enrollees, more than half of the HMOs (58 percent) believe it is easier to survey Medicare members than it is to survey non-Medicare members, primarily because the former are more responsive, have more time, and are easier to reach.

The Medicare data which is available shows that Medicare HMO members have high satisfaction rates. All of the HMOs with Medicare data report overall satisfaction rates of 75 percent or higher for their Medicare members. Similarly, virtually all (99 percent) report the same 75 percent or higher satisfaction rate for all members.

HMO CUSTOMER SATISFACTION SURVEY INSTRUMENTS AND PROCEDURES LACK UNIFORMITY

The lack of uniformity in HMO survey instruments and procedures renders comparisons between HMOs difficult, if not impossible, when assessing Medicare beneficiaries' satisfaction with their plans.

Satisfaction Survey Instruments

The survey instruments used by HMOs vary widely in their format and content. No two risk and cost HMOs use the same instrument. Of our sample survey instruments, none use an exact duplication of the GHAA satisfaction survey instrument, although almost half (48 percent) use some exact or similar headings, questions and rating scales from that survey. The HMO instruments differ significantly in their length, ranging in size from 1 to 45 pages and including from between 9 to 159 different questions.

Rating scales and overall satisfaction questions on survey instruments are also inconsistent across HMOs. Our review of HMOs' instruments identified 26 different scales used for responses, ranging from a simple two-point scale of yes or no, to a ten-point scale covering a range of satisfaction levels. Fourteen different types of questions are used to measure overall satisfaction, including questions which ask about satisfaction with medical care, most recent visit, quality of service, health plan and a particular medical center. Three-fourths of HMOs, however, use a question about satisfaction with their plan to measure overall satisfaction.

Satisfaction Survey Procedures

Sampling procedures also differ. Fourteen percent of HMOs survey their entire membership. Of the 86 percent who survey a sample of their membership, sample sizes vary from 100 to over 5000. The size and type of sample used varies according to the purpose of each HMO's survey. While most (51 percent) use a simple random sample, another 41 percent use a stratified random sample, and eight percent a purposive sample. Forty-nine percent of the HMOs select their sample from a universe of one particular subgroup, as defined, for example, by a minimum length of membership, while most of the remaining sample from the universe of their entire membership.

Furthermore, other survey procedures used by HMOs vary. Forty-four percent administer their customer satisfaction survey by telephone only, 16 percent administer it by telephone and mail, and 37 percent by mail only. The remaining generally use an in-office self-administered questionnaire in combination with mail or telephone. Excluding those which conduct ongoing surveys, sixty-two percent of HMOs stop data collection after ten weeks and the remaining third continue collecting data for longer than ten weeks.

WHILE IN MANY WAYS BASICALLY SOUND, TECHNICAL WEAKNESSES IN MANY HMO SURVEYS MAY MASK PROBLEMS AND INFLATE SATISFACTION WITH MANAGED CARE PLANS

HMO Survey Strengths

Many HMOs appear to be following sound survey principles regarding sampling, efforts to increase response rates by telephone, and instrumentation. A majority (71 percent) were seeking confidence intervals of 95 percent or higher in designing their sample size. Close to half (44 percent) used sample sizes of over 1000 members, which, in combination with their generally high response rates, should have ensured a good level of precision in their surveys. Additionally, most HMOs who use telephone surveys make a strong effort to maximize their response rates. Almost all of these (94 percent) try to contact members at least three times before considering them to be non-respondents.

Furthermore, our review of HMO survey instruments revealed several positive features. A great majority of the instruments generally include questions which are specific (92 percent), clearly worded (98 percent) and focused on only one thought at a time (98 percent.) The instruments also cover a broad range of satisfaction dimensions. The most common include ability to provide prompt service (96 percent), overall satisfaction with services (87 percent), staff courtesy (84 percent), access to services (82 percent), physician communication (81 percent), and physician competence (77 percent.) Of the seventeen possible dimensions of satisfaction we looked for in the HMOs' instruments, a majority (71 percent) include at least ten.

HMO Survey Instrument Weaknesses

However, our instrument review also revealed some weaknesses in the survey instruments which may bias, to some degree, survey results. More than half of the instruments (58 percent) include no questions about problems with or complaints about health plan services. Of the 42 percent which do include these topics, most ask only one or two questions. For the most part, the questionnaires ask only if a member has ever had a problem with or complaint about their care, and how satisfied he or she was with its resolution. The OIG report referenced earlier on beneficiary perspectives of risk HMOs included several questions in its beneficiary survey specific to problems with HMO services. These questions were important in understanding, among other things, reasons for dissatisfaction and disenrollment with HMOs. Half of the instruments (51 percent) do not ask respondents for their suggestions for improving the HMO.

Other deficiencies noted in the HMOs' instruments may compromise their objectivity. Forty-six percent use at least one unbalanced rating scale. The most common of these, a five-point rating scale of three positive, one neutral and only one negative response category, is used by twenty-nine percent of the HMOs. Furthermore, of the quarter which use agree or disagree statements, almost all include only positive statements for respondents to respond to. While this has the advantage of ensuring greater ease for the respondent, it also has the disadvantage of possibly resulting in more positive ratings. Other weaknesses noted include few or unclear interviewer instructions on telephone survey instruments (24 percent), confusing or unclear questionnaire formats (20 percent), and inconsistent rating scales (20 percent) and repetitive questions within an instrument (15 percent.)

We also rated each survey instrument to determine its level of user friendliness. In doing this, we looked for several qualities, including clarity of format, simplicity of directions and questions, and overall attractiveness. While most surveys (73 percent) were rated user friendly, only eleven percent were rated very user friendly and 16 percent were deemed not user friendly. A majority (80 percent) of those rated user friendly are mail surveys, while most (70 percent) rated not user friendly for either the respondent or the interviewer are telephone surveys.

HMO Survey Procedure Weaknesses

Most HMOs are also lacking certain survey procedures which, if used, may increase survey accuracy. Twenty-nine of 32 sample HMOs which use mail surveys do not try to contact members who do not return their original questionnaires; just one-third send non-respondents a second copy. Additionally, a large majority (87 percent) have never conducted a non-respondent analysis, which would enable them to know if non-respondents differed in any way from respondents, thus alerting them to possible bias in the survey findings. Finally, less than half of the HMOs (43 percent) have ever conducted a bilingual survey. All of these HMOs have conducted surveys in Spanish, and many are based in States with a large Spanish-speaking population. The lack of a bilingual survey may be a survey weakness in those geographical areas with large numbers of non-English speaking clients; without them, the experiences and satisfaction of these clients can not be fully comprehended.

Indexes of Survey Adequacy

As described in our methodology and explained in Appendix B, we constructed two indexes of survey adequacy - one for instruments and the other for procedures. One-third of the HMOs' instruments (32 percent) scored adequate on our survey instrument index, while another 28 percent scored somewhat adequate. Of the remaining instruments, 24 percent scored somewhat inadequate and 16 percent inadequate.

The HMOs were also scored on the adequacy of their survey procedures. On this index, less than one-half (44 percent) scored adequate, and thirty-one percent scored somewhat

adequate. Another ten percent of the HMOs scored somewhat inadequate, while 15 percent scored inadequate.

HMOs USE THEIR SURVEY RESULTS AS MUCH FOR MARKETING AS FOR QUALITY IMPROVEMENT

Marketing

A majority of HMOs are using their satisfaction surveys in their marketing plans. Nearly three-fourths (74 percent) say they use the results of their customer satisfaction surveys to attract potential new members. Most of this marketing consists of reporting survey data in speeches or other oral presentations, and in pamphlets or brochures. Seventeen percent use their survey findings for advertising purposes. The HMOs which use their survey results for marketing have higher overall satisfaction rates than those which do not market their survey results; 46 percent of the former report overall satisfaction rates of 75 percent or more, while 20 percent of the latter report the same overall satisfaction rates.

Quality Improvement

A similar number of HMOs utilize survey results for quality improvement purposes. Three-fourths (76 percent) report using their customer satisfaction data to develop improvement or corrective action plans. One-third (34 percent) use the results for tracking performance and developing strategic goals. Almost all (97 percent) include their satisfaction surveys in their Medicare quality assurance programs.

Most HMOs also share their survey results with employees and members. A majority distribute their survey findings to physicians (76 percent) and to plan customers (67 percent.) In fact, more than one-third (36 percent) use these results to determine all or part of their physician reimbursement. Of those HMOs who conduct satisfaction surveys of their physicians, a few (16 percent) compare these results to those of their member satisfaction survey results.

Differences Between HMOs

The HMOs use their survey results somewhat differently depending on the size of their Medicare enrollment. Almost all of the HMOs with high Medicare enrollment (92 percent) use their survey data for quality improvement purposes, compared to 75 percent of HMOs with medium and low Medicare enrollments. Marketing of survey results is conducted by 58 percent of high enrollment HMOs, in contrast to 75 percent of medium and low enrollment HMOs. A comparison of the instruments used by high Medicare enrollment HMOs with those used by medium and low Medicare enrollment HMOs reveals some important differences in this regard. For example, more than half of the former (69 percent) have questions which ask members about problems or complaints with their health plans, as compared to just forty percent of the latter. Also, HMOs with a large number of Medicare enrollees are more likely to ask for suggestions for improvement on their questionnaires than are HMOs with fewer Medicare enrollees.

IMPLICATIONS FOR MEDICARE

We believe the usefulness of customer satisfaction surveys as currently conducted by HMOs is substantially reduced by their lack of uniformity, limited focus on Medicare beneficiaries and technical weaknesses. Therefore, if HCFA seeks data on the satisfaction of Medicare beneficiaries with managed care, we believe it can not rely upon industry surveys as they are now conducted. The HCFA may want to consider alternative approaches to measuring Medicare client satisfaction with managed care, such as conducting its own surveys or requiring HMOs to periodically survey their Medicare members with a standardized instrument and comparable procedures.

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APPENDIX A

STATISTICAL PROCEDURES

I. SAMPLE SELECTION

Our original universe of HMO Medicare contracts consisted of 193 risk and cost contracts which had been awarded as of February 1, 1995. However, we eliminated eight of these contracts which had no Medicare enrollees at the time our sample was drawn. This left us with a universe of 185 risk and cost contracts.

We stratified these 185 contracts into three groups - large, medium, and small - based on the number of Medicare enrollees in each HMO contract. Just 13 large HMO contracts accounted for 51 percent of all Medicare managed care enrollment. We sampled these 13 at a rate of 100 percent. We sampled the medium stratum HMOs at a rate of 54 percent and the low stratum HMOs at a rate of 28 percent.

The sample size of 95 was based on the assumption of a 75 percent response rate. The 95 were stratified as follows:

STRATA	# OF MEDICARE ENROLLEES	UNIVERSE	SAMPLE
1 (large)	> 42500	13	13
2 (medium)	1000 - 42500	130	70
3 (low)	<1000	42	12
TOTAL		185	95

II. CONFIDENCE INTERVALS FOR 15 KEY QUESTIONS

We calculated confidence intervals for fifteen key questions. The response estimate and 95% confidence interval is given for each of the following:

From the mail questionnaire

1. Have you ever conducted a customer satisfaction survey of any kind?
   "Yes" response estimate: 99%
   Lower interval: 97%
   Upper interval: 100%

2. Have you ever conducted a customer satisfaction survey of your Medicare enrollees only?
   "No" response estimate: 55%
   Lower interval: 44%
   Upper interval: 66%

3. How many times did you try to contact members who did not return the mail questionnaire before finally considering them to be non-respondents?
   "No contact" estimate: 65%
   Lower interval: 49%
   Upper interval: 80%

4. How many times did you try to reach members by telephone before finally considering them to be non-respondents?
   3 or more times estimate: 94%
   Lower interval: 89%
   Upper interval: 98%

5. Did your survey instrument include any questions which were asked only of Medicare enrollees?
   "No" estimate: 97%
   Lower interval: 93%
   Upper interval: 100%

6. What confidence level were you seeking?
   95% or higher estimate: 71%
   Lower interval: 57%

Upper interval: 85%

7. For your Medicare enrollees only, what response rate did you achieve in your last customer satisfaction survey?
"Don't Know" estimate: 65%
Lower interval: 54%
Upper interval: 76%

8. What percentage of your Medicare members only did you find to be satisfied overall?
"Don't Know" estimate: 39%
Lower interval: 30%
Upper interval: 49%

9. Did you use the results of your customer satisfaction survey to develop a quality improvement or corrective action plan?
"Yes" estimate: 76%
Lower interval: 67%
Upper interval: 86%

10. Did you share the results of your customer satisfaction survey with your members?
"Yes" estimate: 67%
Lower interval: 57%
Upper interval: 77%

11. Did you share the results of your customer satisfaction survey with the physicians who work for your HMO?
"Yes" estimate: 76%
Lower interval: 66%
Upper interval: 87%

12. Did you use the results of your customer satisfaction survey to market the HMO to potential new members?
"Yes" estimate: 73%
Lower interval: 65%
Upper interval: 83%

<u>From the survey instrument review sheet</u>

13. Generally, are [instrument] questions worded clearly and focused on one thought?
"Yes" estimate: 98%
Lower interval: 96%
Upper interval: 100%

14. Did the instrument use a rating scale of poor, fair, good, very good, and excellent?
"Yes" estimate: 29%

Lower interval:	19%
Upper interval:	39%

15. How many questions, including subquestions, ask about problems with or complaints about health plan services?

"No questions" estimate	58%
Lower interval:	45%
Upper interval:	71%

APPENDIX B

INDEXES OF SURVEY ADEQUACY

I. INDEX OF INSTRUMENT ADEQUACY

This index of instrument adequacy is based on the sum of scores achieved by each HMO on three separate variables:

(1) comprehensiveness of satisfaction dimensions
(2) balance of response categories
(3) problem-specific questions

Scores on each variable could range from +2 to -2 according to the criteria for each discussed below.

(1) Comprehensiveness of Satisfaction Dimensions

The following ten dimensions of satisfaction were selected from a longer list of such dimensions which we looked for in the HMOs' survey instruments: patient access to general or specialty care; physician or staff courtesy; cost of care; coordination or continuity of care; physician competence; choice of providers; communication with physicians or staff; office waiting time; suggestions for improving HMOs; and, plans to stay with the plan.

Based on the number of these dimensions included in each HMO's survey instrument, the following scores were used:

No. of dimensions	Score
0-4	-2
5	-1
6-7	+1
8-10	+2

(2) Balance of Response Categories

Balance of response categories refers to whether or not a rating scale includes an even number of positive and negative responses. For example, a scale with one positive, one neutral, and one negative response - good, fair, poor - is balanced, while a scale with two positive, one neutral, and one negative response - very good, good, fair, poor - is unbalanced. Scores for this variable were based on two items: 1) whether response categories for overall satisfaction questions were balanced or not; and 2) whether response categories for all other questions were all balanced, almost all balanced, only some balanced, or all unbalanced. Based on the extent to which HMOs used balanced categories, the following scores were used:

	OVERALL SATISFACTION RESPONSE CATEGORIES		
	All Balanced	Not All Balanced	No Overall Question
ALL OTHER RESPONSE CATEGORIES			
All Balanced	+2	-1	+2
Almost All Balanced	+1	-1	-1
Only Some Balanced	-1	-2	-2
None Balanced	-2	-2	-2

(3) Problem-Specific Questions

Based on the number of questions about potential problems or complaints included in the HMOs' survey instruments, the following scores were used:

# of Questions	Score
0	-2
1-4	+1
5+	+2

After scoring the HMOs on each of the three variables, we added the three scores together to give a total instrument adequacy score for each HMO. Scores ranged from +6 to -6, with a midpoint of +1.65. The mean score is 1.1.

The 63 HMO instruments were grouped into the following four levels of adequacy based on their index scores:

Level of Adequacy	#HMOs	%	Score
Adequate	20	32%	(+4 to +6)
Somewhat adequate	13	28%	(+1 to +3)
Somewhat inadequate	20	24%	(0 to -2)
Inadequate	10	32%	(-3 to -6)

II. INDEX OF SURVEY PROCEDURE ADEQUACY

This index of procedure adequacy is based on the sum of scores achieved by each HMO on four separate variables:

(1) level of confidence sought
(2) frequency of follow-up efforts
(3) conducting a non-respondent analysis
(4) use of balanced criteria for determining overall satisfaction

Scores on each variable could range from +2 to -1 according to the criteria for each discussed below.

(1) Level of Confidence Sought

Based on the level of confidence HMOs were seeking when selecting their survey samples, the following scores were used:

Confidence Interval	Score
90% or higher	+1
under 90%	-1
Does not apply (did not use sample)	0

(2) Frequency of Follow-up Efforts

The extent to which HMOs employed follow-up procedures with non-respondents was scored for each of three survey modes: mail, telephone and in-office. The following scores were used:

A. Mail:

# times non-respondents are contacted:	Score
2 or more times	+2
1 time	+1
No contact made	-1
Does not apply (no mail survey)	0

B. Telephone:

# times non-respondents are contacted:	Score
3 or more times	+2
1 or 2 times	+1
No contact made	-1
Does not apply (no phone survey)	0

C. In-office survey:

Follow-up procedures	Score
Follow-up with refusals	+2
No follow-up with refusals	-1
Does not apply (no in-office survey)	0

None of the HMOs used all three modes. However, those which used both mail and telephone to administer their survey were given one combined score for follow-up of frequency efforts. These HMOs could not achieve a score greater than +2; in this way, they were not given extra credit for using two survey modes. If they achieved a negative score for one of the two modes, it was subtracted from any positive scores to give a total score.

(3) Conducting a Non-respondent Analysis

Based on whether an HMO conducted a non-respondent analysis, the following scores were used:

Non-respondent analysis?	Score
Yes	+1
No	-1

(4) Use of Balanced Criteria for Determining Overall Satisfaction

On the mail questionnaires, we asked HMOs how they derived an overall satisfaction rating for their members. If they determined this rating by taking only the positive responses from a scale which itself is balanced, they used balanced criteria to derive overall satisfaction. Based on whether an HMO used balanced criteria in determining an overall satisfaction rate, the following scores were used:

Balanced Criteria?	Score
Yes	+1
No	-1

As with the index of instrument adequacy, we added an HMO's scores on these four variables together to give a total procedure adequacy score for each HMO. Scores ranged from +5 to -5, with a midpoint of 2. The mean score is 1.4.

The 72 HMO questionnaires on survey procedures were grouped into the following four levels of adequacy based on their index scores:

Level of Adequacy	#HMOs	%	Score
Adequate	32	44%	(+5 to +3)
Somewhat adequate	22	31%	(+2 to +1)
Somewhat inadequate	7	10%	(0 to -1)
Inadequate	11	15%	(-2 to -5)

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administrat

The Administrator
Washington, D.C. 20201

DATE: FEB 14 1996

TO: June Gibbs Brown
Inspector General

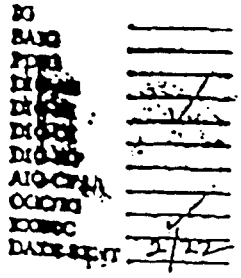
FROM: Bruce C. Vladeck
Administrator

SUBJECT: Office of Inspector General Draft Report: "Health Maintenance Organizations (HMOs) Customer Satisfaction Surveys," (OEI-02-94-00360)

We reviewed the above-referenced draft report which assesses how HMOs are conducting customer satisfaction surveys and how they are utilizing the results of these surveys. The study was conducted in cooperation with HCFA's managed care operations and has provided major insights into the need for an independent Office of Managed Care beneficiary survey capability. Our detailed comments are attached.

Thank you for the opportunity to review and comment on this draft report.

Attachment



Health Care Financing Administration (HCFA) Comments on Office of Inspector General (OIG) Draft Report: Health Maintenance Organizations (HMOs) Customer Satisfaction Surveys (OEI-02-94-00360)

HCFA Comments

The OIG study has provided major insights into the need for an independent Office of Managed Care beneficiary survey capability and on the type of issues/survey questions our program should include.

The study is methodologically sound and the sample size/response rate large enough to assure statistical significance. The conclusions are based on, and supported by, the study data. Findings of particular interest to us include:

1. While most HMOs conduct member satisfaction surveys, most do not include Medicare members in the surveys.

2. HMO survey instruments lack uniformity of approach and design.

3. Technical weaknesses give an over-inflated sense of member satisfaction and may mask problems.

4. Survey data are used as much for marketing purposes as for quality improvement purposes.

This study will be a major factor in influencing our decision to develop an independent beneficiary satisfaction survey capability. We would like to express our appreciation to the OIG for addressing our operational needs in such a timely manner. We hope the future will include similar joint interagency cooperation.