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**Tracking Performance of
the Medicare+Choice
Program: Results from
the 1998 and 1999
Medicare CAHPS Survey**

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CONTENTS

Chapter	Page
I. INTRODUCTION	1
A. POLICY CONTEXT	1
B. OBJECTIVES OF THIS ANALYSIS.....	2
II. DATA AND METHODS.....	4
A. DESIGN OF THE MEDICARE CAHPS SURVEY.....	4
B. SELECTION OF SURVEY MEASURES.....	5
C. ANALYTICAL APPROACH.....	8
III. RESULTS	15
A. DOES PERFORMANCE VARY BY LOCAL MARKET?	15
B. ARE THERE EARLY TRENDS IN M+C PERFORMANCE?	18
1. Nationwide Trends for All 69 MSAs.....	18
2. Trends by Region and Types of Markets.....	20
IV. DISCUSSION	25
REFERENCES.....	27
APPENDIX A: MEDICARE CAHPS SURVEY INSTRUMENT	
APPENDIX B: 1998 AND 1998 MEDICARE CAHPS RESULTS FOR 69 MSAs	

TABLES

Table		Page
II.1	RESPONSES TO SELECTED MEDICARE CAHPS SURVEY MEASURES FOR A SAMPLE OF 69 MSAS, 1999	7
II.2	1998 AND 1999 MEDICARE CAHPS ENROLLEE SAMPLE SIZES' AND NUMBER OF MCO CONTRACTS REPRESENTED	10
II.3	STANDARD ERRORS OF SELECTED ESTIMATED PROPORTIONS ACCORDING TO DIFFERENT SAMPLE	14
III.1	VARIATION IN MEDICARE CAHPS MEASURES AMONG 69 MSAS, 1998 AND 1999	16
III.2	HIGHER- AND LOWER-PERFORMANCE MSAS ON FIVE MEDICARE CAHPS MEASURES, 1999	17
III.3	OVERALL RATING OF MEDICARE HEALTH PLAN BY HCFA REGION AND SELECTED MARKET CHARACTERISTICS, 1998-1999	21
III.4	PROBLEMS ACCESSING A SPECIALIST BY HCFA REGION AND SELECTED MARKET CHARACTERISTICS, 1998-1999	22

FIGURES

III.1	1998 AND 1999 CAHPS MEASURES IN 69 MSAs	19
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I. INTRODUCTION

A. POLICY CONTEXT

The Medicare+Choice (M+C) program, enacted in the Balanced Budget Act of 1997 (BBA), introduced a substantial set of changes to Medicare managed care. The M+C program is intended to give Medicare beneficiaries a wider set of health plan choices and to help control the growth of Medicare spending. Regulatory changes under the program include expanded eligibility requirements for managed care organizations (MCOs) contracting with Medicare, a new payment system for participating MCOs, and various new administrative, marketing, and quality requirements for MCOs.

Since the BBA was passed, many participating MCOs have reduced their service area or have not renewed their Medicare contracts. At the same time, few new types of plans have joined the program (MedPAC 2000). These changes have potentially important implications for the performance of the M+C program in delivering care to Medicare beneficiaries. In particular, beneficiaries' access to high-quality medical care may be affected as participating MCOs change how they deliver or pay for services in response to regulations or payment changes and as many MCOs exit the Medicare market, potentially disrupting continuity of care. Performance of the M+C program is also likely to vary across local health care markets and over time as new regulations take effect.

As part of the 1997 BBA, Congress mandated efforts to collect data that could be used to assess the performance of M+C in delivering health care services. These efforts, assumed by the Health Care Financing Administration (HCFA), include the Medicare Consumer Assessment of Health Plans Survey (CAHPS), Medicare Health Plan and Employer Data Information Set (HEDIS)®, and the Medicare Health Outcomes Survey (HOS).

In this report, we use data from the 1998 and 1999 Medicare CAHPS surveys to examine how Medicare beneficiaries assess their access to and quality of care they receive from MCOs. The report was prepared by Mathematica Policy Research, Inc. (MPR) under a contract with HCFA to monitor trends in the M+C program. The analysis presented in this report complements other analyses conducted (or currently underway) for this project on such topics as availability of Medicare MCOs, beneficiary enrollment in and disenrollment from Medicare MCOs, MCO benefit offerings, financial status of MCOs, financial arrangements between MCOs and providers, and the actuarial value of MCOs' benefit packages. Also under this contract, we will use 1999 and 2000 Medicare HEDIS data to conduct subsequent analyses of indicators of access and quality. This analysis will be presented in a report submitted to HCFA in spring 2001.

B. OBJECTIVES OF THIS ANALYSIS

The main goal of this analysis is to provide a preliminary and exploratory assessment of variation in Medicare beneficiaries' views of MCO performance in delivering health care services. More specifically, the analysis is intended to:

- Identify measures of key areas of performance in access to and quality of care, including beneficiaries' assessments of (1) the MCO overall, (2) interactions with a primary care doctor in the MCO, (3) access to specialty care in the MCO, (4) MCO performance in providing customer service, and (5) delivery of preventive services by MCO providers
- Examine variation in selected performance measures by market area, region, and type of markets, including the identification of higher and lower performing areas
- Describe changes in performance measures from 1998 through 1999

A second goal of the analysis is to examine some of the methodological issues involved in using CAHPS for assessing MCO performance regarding access to and quality of care in different local markets and for tracking changes in performance over time. In particular, we

describe how the sample design affects the monitoring of performance in the M+C program. We conclude that Medicare CAHPS is not suitable for monitoring the effects of some recent trends in the Medicare market, including non-renewal of MCO contracts and MCO service area reductions. Yet, the data do provide estimates of performance in markets for the part of M+C program that has remained stable. The data cover MCOs that serve M+C enrollees who have been continuously enrolled.

II. DATA AND METHODS

A. DESIGN OF THE MEDICARE CAHPS SURVEY

The Medicare CAHPS survey, which was initiated in its current form in 1998, is administered by HCFA during the fall of each year and is targeted to a sample of 600 Medicare beneficiaries enrolled in each MCO with a Medicare+Choice or a Medicare cost contract.¹ The sample is limited to Medicare beneficiaries who have been continuously enrolled in a Medicare MCO for at least six months. It also covers only MCOs that have had a Medicare contract for more than a year. The survey covers a wide variety of areas, including experiences with a personal doctor, experiences getting care from a specialist, ability to get care by phone, experiences of care provided during the past six months, interactions with the health plan including customer service, and health status and demographic information.

The survey is administered by mail, with telephone follow-up for those not responding by mail. The CAHPS survey instrument was originally developed by a consortium of researchers at Harvard Medical School, RAND, and the Research Triangle Institute (Schnaier et al. 1999). The 1998 Medicare CAHPS survey instrument appears in Appendix A. The same items were asked of Medicare beneficiaries in both 1998 and 1999.

Data from the survey are intended to be used for a variety of purposes, but most prominently, HCFA produces plan-level CAHPS indicators to help Medicare beneficiaries compare the MCOs in their market area as part of the process of choosing a Medicare+Choice plan. MCO-level data on selected CAHPS indicators are maintained on HCFA's Medicare

¹A Medicare CAHPS survey was also fielded in 1997, but the survey instrument was revised in 1998.

Compare database and published on HCFA's Medicare website (www.medicare.gov). So far, the data have not been used for tracking performance over time or for comparing performance in different regions or market areas.

As mentioned, several types of MCOs are not required to participate in CAHPS:

- MCOs that became operational after January 1, 1997 were not required to participate in the 1998 survey. MCOs that became operational after July 1, 1998 were not required to participate in the 1999 survey.
- MCOs that are not renewing their contracts for the upcoming calendar year (i.e., nonrenewals in 1999 for the 1998 CAHPS survey or nonrenewals in 2000 for the 1999 survey) are not required to provide telephone numbers to HCFA for telephone follow-up to nonresponding sample members.

New enrollees (enrolled in the health plan for fewer than six months) and disenrollees from eligible MCOs are also not included in the survey.² In addition, some other types of Medicare beneficiaries also may not be well covered by the survey's sampling approach. In particular, enrollees in MCOs that announced their intent to cancel their contracts or to withdraw from their local service areas in the upcoming calendar year may have an incentive to disenroll before the end of the current year and might have done so by the time the survey is administered.³

B. SELECTION OF SURVEY MEASURES

We chose to examine CAHPS measures of five areas of performance:

²Starting in fall 2000, a Medicare CAHPS disenrollee survey will also be administered by HCFA.

³Nelson et al. (2000) provide data indicating that MCO enrollment levels declined substantially in the latter half of a calendar year (i.e., July to December) in some markets in which withdrawals or service area reductions were announced for the next calendar year. In these markets, enrollment then increased early in the next year as many disenrolled beneficiaries apparently enrolled in new MCOs, after several months in the Medicare fee-for-service environment.

1. Rating of overall health plan performance
2. Doctor's listening ability during visits in the past six months
3. Problems with accessing specialists in the MCO during the past six months
4. Helpfulness of customer service during the past six months
5. Delivery of flu shot by the health plan or personal doctor last winter

We selected these areas of performance with several considerations in mind. First, we wanted to track a small, manageable number of indicators that cover a fairly broad range of performance areas. Second, we wanted to reflect distinct dimensions of performance that have been identified in prior conceptual and empirical work using Medicare CAHPS data. Dimensions identified by Zaslavsky et al. (2000) include overall assessments (including rating of overall health plan), interactions with personal doctor (including a doctor's listening ability), access to medical services (including problems accessing a specialist), and customer service (including helpfulness of customer service). In addition, we wanted to examine delivery of flu shots as an important measure of the delivery of preventive services.

As shown in Table II.1, most Medicare respondents in the 69 metropolitan statistical areas (MSAs) included in our M+C program monitoring system gave highly favorable assessments of Medicare MCO performance as measured by the five indicators. We decided to construct measures that reflect the percentage of respondents giving favorable responses, such as high overall ratings of the health plan. This approach is consistent with a goal of examining the ability of the M+C program to achieve a high standard of performance. (Further details on the sampling methods for this analysis are discussed in the next section.) The measures used in this analysis are:

- Percentage who gave a health plan rating of 8 or more (on a scale 0 to 10)
- Percentage who said that their personal doctor usually or always listened carefully, among those who visited a doctor in the past six months

TABLE II .1
RESPONSES TO SELECTED MEDICARE CAHPS SURVEY MEASURES
FOR A SAMPLE OF 69 MSAS, 1999

	Percentage of Medicare Enrollees
Overall rating of health plan	
Less than 5	4.2
5-7	16.1
8	15.4
9	19.0
10	45.3
Sample size	86,342
In last 6 months, doctor listened carefully ^a	
Never	0.8
Sometimes	5.3
Usually	21.7
Always	72.1
Sample size	66,378
In last six months, problems accessing a specialist ^b	
Big problem	6.7
Small problem	12.1
No problem	81.2
Sample size	44,026
In last six months, customer service is helpful ^c	
Never	3.6
Sometimes	12.0
Usually	25.7
Always	58.6
Sample size	27,050
Received a flu shot from health plan or personal doctor last	
No	37.2
Yes	62.8
Sample size	86,151

SOURCE: 1999 Medicare CAHPS data.

^a Among enrollees with a doctor visit in past six months.

^b Among enrollees who said they needed a specialist in past six months.

^c Among enrollees who called their plan's customer service department in past six months.

- Percentage with no problems accessing a specialist, among those who needed a specialist during the past six months
- Percentage who said that customer service was usually or always helpful, among those who contacted customer service during the past six months
- Percentage who received a flu shot from the health plan or personal doctor last winter

In general, the results shown in Table II.1 appear to be consistent with results derived from other sources. For example, the annual delivery of flu shots nationwide for those age 65 and older increased from 58 percent to 65 percent between 1995 and 1997, according to the Behavioral Risk Factor Surveillance System (BRFSS) administered by the Centers for Disease Control (*MMWR* 1998, *MMWR* 1997). Other recent survey data also show that most Medicare MCO enrollees have a generally favorable opinion of access to care in their health plans (Nelson et al. 1997).

C. ANALYTICAL APPROACH

This report focuses on Medicare CAHPS data collected in 1998 and 1999. The primary units of analysis are the 69 MSAs nationwide in the M+C monitoring system. These are all MSAs with a population of at least 1.5 million people and all other MSAs with a Medicare MCO penetration rate of at least 30 percent.⁴ This definition of MSAs was designed to yield a set of markets that are important in terms of monitoring the implementation of the M+C program. However, the results from these 69 MSAs are not necessarily representative of all MSAs nationwide.

⁴See Chapter II in Nelson et al. (2000) for a more detailed discussion of the methods used to define these 69 MSAs as units of analysis and the rationale for these criteria.

We restricted our analysis to Medicare CAHPS respondents living in these 69 MSAs and assigned each respondent to one of the 69 MSAs based on their county of residence in July of the current survey year (that is, as of July 1998 for analysis of the 1998 CAHPS data). This allowed us to generate MSA-level estimates for 1998 and 1999. By also assigning MSAs to their associated HCFA region, we were able to generate estimates for all 10 HCFA regions.⁵ In addition, we classified MSAs according to the following market characteristics:

- Number of Medicare MCO enrollees in the MSA in 1998 or 1999
- Medicare MCO penetration in the MSA in 1998 or 1999
- Change in Medicare MCO penetration from 1997 to 1999
- Number of Medicare MCOs operating in the market in 1998 or 1999
- Change in the number of Medicare MCOs from 1997 to 2000
- Medicare+Choice payment rates in the MSA as a percentage of average U.S. payments

As shown in Table II.2, MSA sample sizes ranged from 110 to 3,548, but the majority of MSAs had more than 600 respondents.⁶ A total of 81,449 Medicare beneficiaries responded to the survey in 1998, and 86,342 beneficiaries responded in 1999 across the 69 MSAs. These sample sizes are based on the number of persons responding to the survey question about overall health plan rating, which was targeted to all respondents. Sample sizes were smaller for other survey questions targeted to subgroups of beneficiaries.

⁵Estimates at the regional level represent the largest MSAs (or smaller, high Medicare MCO penetration MSAs) in those regions and are not necessarily representative of all geographic areas in a given region.

⁶Medicare MCO contracts often cover multiple MSAs, so even though 600 respondents were targeted for each Medicare MCO contract, several MSAs have fewer than 600 respondents.

TABLE II.2

1998 AND 1999 MEDICARE CAHPS ENROLLEE SAMPLE SIZES
AND NUMBER OF MCO CONTRACTS REPRESENTED^a

MSA	1998		1999	
	Enrollee Sample Size in MSA ^a	Number of Medicare MCO Contracts Represented ^b	Enrollee Sample Size in MSA ^a	Number of Medicare MCO Contracts Represented ^b
Albuquerque, NM	1,682	4	1,241	3
Atlanta, GA	1,890	4	3,024	7
Bakersfield, CA	941	2	639	3
Baltimore, MD	1,603	5	1,028	4
Baton Rouge, LA	535	4	422	3
Boston, MA	2,097	7	1,392	5
Boulder, CO	128	3	189	4
Chicago, IL	2,202	6	1,878	5
Cincinnati, OH	1,216	4	1,566	6
Cleveland, OH	2,068	7	2,967	10
Colorado Springs, CO	313	2	427	2
Dallas, TX	1,270	5	1,834	8
Daytona Beach, FL	828	2	551	3
Denver, CO	2,546	6	2,421	6
Detroit, MI	720	2	1,907	6
Dubuque, IA	119	1	211	1
Eugene, OR	529	2	561	3
Fort Lauderdale, FL	1,187	8	1,290	10
Fort Worth, TX	755	5	963	7
Grand Junction, CO	283	1	271	1
Honolulu, HI	582	2	1,046	3
Houma, LA	310	3	195	2
Houston, TX	1,876	8	1,899	8
Jacksonville, FL	2,166	6	1,623	4
Kansas City, MO	2,260	5	3,147	7
Killeen, TX	237	1	208	1

MSA	1998	1999
	Enrollee Sample Size in MSA ^a	Enrollee Sample Size in MSA ^a
	Number of Medicare MCO Contracts Represented ^b	Number of Medicare MCO Contracts Represented ^b
Las Vegas, NV	1,821	5
Los Angeles, CA	2,766	13
Medford, OR	499	2
Miami, FL	962	8
Minneapolis, MN	1,485	3
Modesto, CA	398	2
Nassau, NY	2,072	10
New Haven, CT	909	3
New York, NY	2,893	10
Newark, NJ	542	5
Norfolk, VA	507	1
Oakland, CA	1,238	8
Olympia, WA	193	5
Orange County, CA	832	9
Philadelphia, PA	3,322	11
Phoenix, AZ	2,515	8
Pittsburgh, PA	1,294	3
Portland, OR	3,233	10
Pueblo, CO	172	1
Riverside, CA	1,290	10
Rochester, NY	977	2
Sacramento, CA	1,258	6
St. Louis, MO	1,413	3
Salem, OR	702	6
San Antonio, TX	1,275	4
San Diego, CA	1,504	5
San Francisco, CA	1,354	8

MSA	1998		1999	
	Enrollee Sample Size in MSA ^a	Number of Medicare MCO Contracts Represented ^b	Enrollee Sample Size in MSA ^a	Number of Medicare MCO Contracts Represented ^b
San Jose, CA	932	8	622	7
San Luis Obispo, CA	687	4	230	2
Santa Barbara, CA	350	4	379	3
Santa Rosa, CA	559	2	577	2
Seattle, WA	2,016	7	1,885	6
Spokane, WA	2,140	6	1,499	4
State College, PA	158	2	156	2
Stockton, CA	215	3	272	4
Tampa, FL	2,902	8	2,650	9
Tucson, AZ	1,212	4	1,194	6
Vallejo, CA	123	3	110	3
Ventura, CA	136	7	152	7
Washington, DC	902	6	1,116	5
West Palm Beach, FL	815	8	936	6
Williamsport, PA	416	1	422	1
Yolo, CA	117	2	117	1

SOURCE: 1998 and 1999 Medicare CAHPS data.

^aNumber of sample members responding to the CAHPS survey item asking for an overall rating of their health plan.

^bIncludes only contracts covering at least 50 enrollees surveyed in the MSA, or at least 5 percent of all enrollees surveyed in the MSA. Includes Medicare+Choice/risk and cost contracts.

The overall response rates nationwide were 79.1 percent for 1998 and 80.4 percent in 1999 (data not shown). Item nonresponse (when a respondent did not know or refused to answer a question) was relatively rare at usually less than 5 percent of all respondents.

After we constructed the MSA-level indicators, we proceeded with the analysis in three steps. First, we analyzed variation among the 69 MSAs for the five selected CAHPS measures. Second, we assessed whether there were early national trends in any of the five measures of M+C performance between 1998 and 1999. Third, we examined trends by HCFA region and MSAs classified by selected market characteristics.

As shown in Table II.3, the statistical precision of estimates typically generated in this analysis is fairly high for most MSAs. Standard errors are plus or minus one or two percentage points around estimated percentages ranging from 60 to 90 percent for MSAs with 500 respondents. Estimates for MSAs with smaller samples are less precise, particularly when measures are focused on a subset of the population, as mentioned above. Thus, in the table, we flagged MSAs with fewer than 100 sample members for specific measures, indicating the need to view the precision of the estimates cautiously.

To test for the statistical significance of differences between estimates for individual MSAs, we conducted t-tests for differences in proportions between each MSA and the median MSA for that year. We also tested the significance of differences between 1998 and 1999 estimates for each MSA. Significance levels were defined at the conventional $p < 0.05$ level. A similar approach was used for testing differences among categories of MSAs. We generally chose the first category of MSAs for each attribute as a reference category (rather than a median). When comparing 10 HCFA regions, however, we chose region 9 (California, Arizona, Hawaii, and Nevada) as the reference category, because it had the largest M+C enrollment.

TABLE II.3
STANDARD ERRORS OF SELECTED ESTIMATED PROPORTIONS
ACCORDING TO DIFFERENT SAMPLE SIZES

MSA Sample Size	Estimated Proportion			
	0.60	0.70	0.80	0.90
30	0.09	0.08	0.07	0.05
50	0.07	0.06	0.06	0.04
100	0.05	0.05	0.04	0.03
300	0.03	0.03	0.02	0.02
500	0.02	0.02	0.02	0.01
1,000	0.02	0.01	0.01	0.01

NOTE: The standard error of a proportion is estimated as $[(p * (1-p))/n]^{0.5}$, where p equals the estimated proportion and n equals the sample size.

III. RESULTS

A. DOES PERFORMANCE VARY BY LOCAL MARKET?

Overall, we found a small amount of MSA-level variation in most performance measures. For example, the percentage giving a health plan rating of 8 or more varies by only about 5 percentage points for the middle half of the distribution (25th to 75th percentile), although variation is somewhat higher at the extremes (Table III.1). MCO performance on the other measures generally varied to a similar extent across MSAs, although variation in the prevalence of flu shots delivered by the health plan was somewhat higher, at about nine percentage points for the middle half of the distribution.

Given the low level of variation among MSAs, the sampling error associated with MSA-level estimates, as well as survey measurement error, we decided not to rank MSAs according to their performance on individual indicators. The rankings were judged to be too sensitive to these sources of error for this type of analysis. Instead, we identified groups of MSAs that ranked consistently high or low on all five measures. We defined consistently high (or low) performance as being in the top (or bottom) half of the distribution on all five measures. In Table III.2, we show the two groups of MSAs that consistently scored in the top and bottom half of the distribution for all five measures in 1999. Of the 69 MSAs, 11 were identified as consistently higher performers, and 9 were identified as consistently lower performers.⁷

⁷When we developed higher cutoff points (for example, 25th and 75th percentile of MSAs for all five measures), a much smaller number of MSAs exceeded or fell below these cutoffs. Given the sampling error associated with estimates, we decided not to single out these markets as particularly high or low performers.

TABLE III.1

VARIATION IN MEDICARE CAHPS MEASURES AMONG 69 MSAS, 1998 AND 1999

CAHPS Measures ^a	Percentage of Medicare MCO Enrollees	
	1998	1999
Overall rating of health plan is 8 or more (scale 0 to 10)		
Highest ranking MSA	94.1	94.2
90th percentile	87.5	86.3
75th percentile	83.9	82.9
Median MSA	81.8	80.8
25th percentile	79.4	78.2
10th percentile	77.5	75.7
Lowest ranking MSA	70.5	68.2
In Past Six Months, Doctor Usually Or Always Listened Carefully		
Highest ranking MSA	99.1	98.2
90th percentile	96.9	96.4
75th percentile	96.2	95.5
Median MSA	94.5	93.8
25th percentile	93.2	92.8
10th percentile	92.0	91.7
Lowest ranking MSA	89.0	87.5
In Past Six Months, No Problems Accessing A Specialist		
Highest ranking MSA	94.6	94.3
90th percentile	88.8	88.1
75th percentile	86.0	85.8
Median MSA	82.5	81.7
25th percentile	79.5	77.7
10th percentile	76.5	75.0
Lowest ranking MSA	59.0	69.1
In Past Six Months, Customer Service Was Usually Or Always Helpful		
Highest ranking MSA	100.0	100.0
90th percentile	92.4	92.7
75th percentile	90.8	89.3
Median MSA	86.6	85.4
25th percentile	83.7	82.1
10th percentile	82.1	79.3
Lowest ranking MSA	78.0	75.9
Received Flu Shot From Health Plan Or Personal Doctor During The Previous Winter		
Highest ranking MSA	83.3	79.9
90th percentile	71.9	74.1
75th percentile	68.0	69.0
Median MSA	62.2	63.0
25th percentile	58.5	60.0
10th percentile	56.2	55.9
Lowest ranking MSA	49.1	46.4

SOURCE: 1998 and 1999 Medicare CAHPS data.

^aPercentiles for each measure are based on separate MSA rankings for 1998 and 1999.

TABLE III.2

HIGHER- AND LOWER-PERFORMING MSAS ON FIVE MEDICARE CAHPS MEASURES, 1999

	Percentage of Medicare MCO Enrollees				
	Overall Health Plan Rating of 8 or More	Doctor Usually or Always Listens	No Problems Accessing a Specialist	Customer Service Usually or Always Helpful	Received Flu Shot from Plan Last Winter
ALL 69 MSAS	79.7	94.3	81.2	84.4	62.8
Higher-Performing MSAs^a					
Killeen, TX ^b	94.2	98.2	92.7 ^c	97.0 ^c	78.1
State College, PA	89.1	97.5	88.2 ^c	95.0 ^c	75.2
Baton Rouge, LA	87.0	96.4	83.7	86.2	63.9
Medford, OR ^c	86.4	97.1	88.7	91.0	64.0
Dubuque, IA ^b	86.3	98.1	93.8 ^d	100.0 ^e	79.0
Williamsport, PA	84.6	97.8	94.3	92.7 ^d	70.7
Portland, OR	83.2	94.7	83.8	92.3	72.8
Minneapolis, MN	82.7	95.6	87.0	91.0	78.7
St. Louis, MO	82.7	95.0	84.6	91.9	63.7
Eugene, OR ^c	82.4	95.7	86.6	93.5	66.8
Spokane, WA	82.2	95.9	86.7	87.8	69.8
Lower-Performing MSAs^f					
Sacramento, CA	79.1	93.3	78.7	81.8	62.8
Los Angeles, CA	79.0	92.6	75.0	82.7	62.9
Houston, TX	78.8	91.5	75.6	81.4	55.9
Fort Worth, TX	78.5	92.7	75.5	84.4	56.7
Dallas, TX	78.3	92.8	77.2	81.7	63.0
Phoenix, AZ	78.1	91.9	78.9	83.9	62.4
San Jose, CA	76.2	92.8	77.9	82.6	62.0
Chicago, IL	76.2	91.4	79.7	80.1	56.4
New York, NY	73.0	93.1	78.0	78.3	56.1
Las Vegas, NV	71.3	88.9	70.4	75.9	51.6

SOURCE: 1999 Medicare CAHPS data.

^aIncludes MSAs who consistently ranked in the top half of all 69 MSAs on each of the five measures shown. MSAs are sorted according to percentage of enrollees who gave an overall health plan ranking of 8 or more.

^bAll enrollees are in Medicare cost contracts in this MSA.

^cMore than 25 percent of enrollees are in cost contracts in this MSA.

^dEstimate is based on a sample size of fewer than 100 enrollees.

^eEstimate is based on a sample size of fewer than 50 enrollees.

^fIncludes MSAs that consistently ranked in the bottom half of all 69 MSAs on each of the five measures shown. MSAs are sorted according to percentage of enrollees who gave an overall health plan ranking of 8 or more.

The performance of these two groups of MSAs is clearly different, yet not dramatically so. It would be difficult to argue, for example, that the lower-performing MSAs are poor performers in an absolute sense. In fact, the data do not offer a clear picture of what an appropriate standard of performance should be. The majority of enrollees gave favorable assessments even in the very lowest performing MSAs.

The higher-performing markets appear to represent a range of geographic regions, although several are in the Pacific Northwest (Oregon and Washington). At the same time, many of the markets (including two in Oregon) have a high percentage of enrollees in Medicare cost contracts. Given that there is less of an incentive to contain medical costs in Medicare cost contracts, highly favorable consumer assessments may not be particularly surprising in these markets.

The lower-performing markets, on the other hand, are heavily concentrated in California, Texas, Arizona, and Nevada, with some in other areas of the country. Some of these western and southwestern states are highly penetrated by MCOs, with some large national and regional health plans having a strong presence.

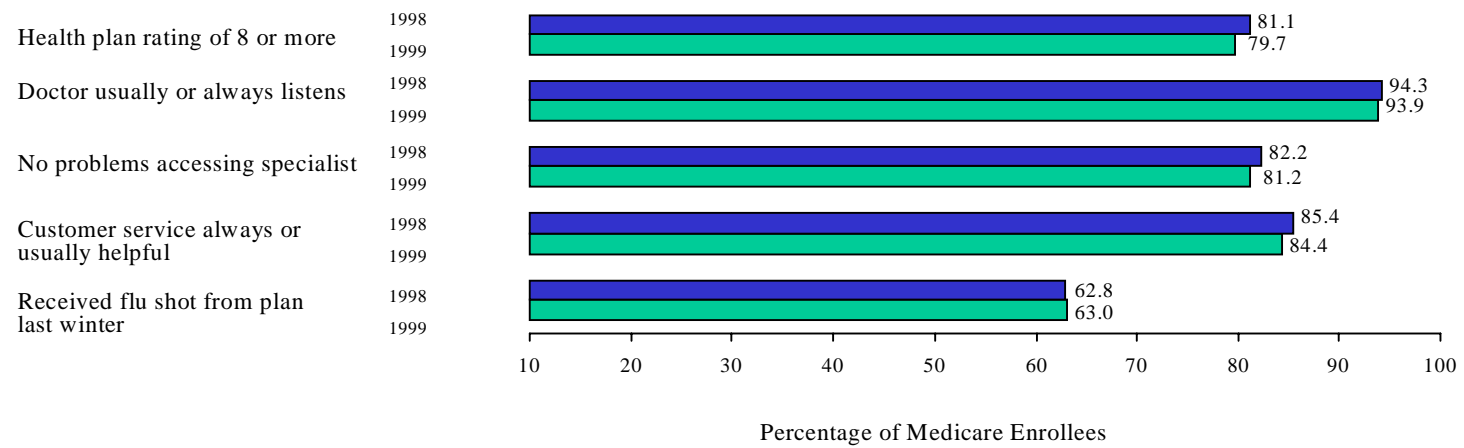
A complete list of estimates for all 69 MSAs for each of the five measures is presented in Appendix B (Tables B.1-B.5). Markets with a sample size of under 100 and under 50 enrollees are flagged, indicating that the estimates for these markets are less precise than for markets with a larger sample size.

B. ARE THERE EARLY TRENDS IN M+C PERFORMANCE?

1. Nationwide Trends for All 69 MSAs

We found small decreases in the percentage giving favorable assessments of performance between 1998 and 1999 for the 69 MSAs combined, ranging from one to three percentage points (Figure III.1). Though small, these early differences are consistent across all five measures.

FIGURE V.1
1998 AND 1999 CAHPS MEASURES IN 69 MSAs



Source: 1998 and 1999 Medicare CAHPS data

These results are also consistent with recent events in the M+C program, such as withdrawals by MCOs in local service areas, which may be viewed unfavorably by respondents even if the withdrawals did not directly affect them. A one-year change of this magnitude does not appear to have significant policy implications. Nonetheless, consistently recurring decreases of this size over several years would be more cause for concern about the performance the Medicare+Choice program.⁸

2. Trends by Region and Types of Markets

a. HCFA Region

When we examined trends in performance measures for individual HCFA regions, we also found little cross-sectional variation across regions and few strong trends from 1998 to 1999. Our regional analysis focuses on two measures--overall health plan rating and problems accessing a specialist--but the limited degree of regional variation is similar across all five measures, including the three not shown (Tables III.3 and III.4). For example, the percentage of respondents giving an overall health plan rating of eight or more ranged between 78 and 83 percent across the 10 HCFA regions in 1999.

Region 1 is the one exception to these general findings. Compared with other regions, the percentage giving a favorable health plan rating in Region 1 in 1998 was relatively high, but it

⁸The absence of any real change in flu shot delivery by Medicare MCOs was somewhat unexpected, given the substantial growth in the rate of flu shot delivery for the elderly nationwide in the mid-1990s, as discussed earlier (*MMWR* 1997, *MMWR* 1998). It is unclear whether this general trend has continued in the last couple of years. However, this indicator is only intended to measure the extent to which Medicare MCOs are delivering flu shots, so it may not reflect the gains achieved in other sectors of the delivery system for Medicare beneficiaries.

TABLE III.3
OVERALL RATING OF MEDICARE HEALTH PLAN
BY HCFA REGION AND SELECTED MARKET CHARACTERISTICS, 1998-1999

	Percentage of Medicare Enrollees with a Health Plan Rating of 8 or More		
	1998	1999	1998-1999 Difference
ALL 69 MSAs	81.1	79.7	-1.4 ^b
HCFA Region			
Region 1	86.0 ^a	79.7	-6.3 ^b
Region 2	81.8 ^a	77.5 ^a	-4.3 ^b
Region 3	80.3 ^a	79.8	-0.5
Region 4	81.8 ^a	80.3 ^a	-1.5 ^b
Region 5	81.1 ^a	79.5	-1.6 ^b
Region 6	82.1 ^a	80.7 ^a	-1.4 ^b
Region 7	81.9 ^a	79.7	-2.2 ^b
Region 8	79.4	77.5 ^a	-1.9 ^b
Region 9 (reference)	79.0	79.2	0.2
Region 10	82.6 ^a	82.7 ^a	0.1
Medicare risk enrollment in MSA^c			
Less than 50,000 enrollees (reference)	82.0	81.2	-0.8 ^b
50,000-99,999 enrollees	79.9 ^a	78.3 ^a	-1.6 ^b
100,000-149,999 enrollees	82.4	81.2	-1.2 ^b
150,000 or more enrollees	80.4 ^a	79.3 ^a	-1.1 ^b
Medicare risk penetration in MSA^c			
Less than 25 percent (reference)	81.6	78.8	-2.8 ^b
25 to 40 percent	80.9 ^a	80.5 ^a	-0.4
Greater than 40 percent	80.6 ^a	80.4 ^a	-0.2
Change In Risk Penetration, 1997-1999			
Decrease in penetration (reference)	78.4	80.3	1.9 ^b
0 to 5 percent increase	81.1 ^a	79.7	-1.4 ^b
Greater than 5 percent increase	82.6 ^a	79.5	-3.1 ^b
Number of Medicare risk contracts in MSA^c			
One (reference)	88.7	87.7	-1.0
Two	83.3 ^a	83.8 ^a	0.5
Three to four	83.6 ^a	80.6 ^a	-3.0 ^b
Five or more	80.5 ^a	79.0 ^a	-1.5 ^b
Change in number of risk contracts, 1997-2000			
Decrease of 4 or more (reference)	78.3	79.0	0.7
Decrease of 1 to 3	81.1 ^a	79.3	-1.8 ^b
No change	81.7 ^a	79.1	-2.6 ^b
Increase of 1	81.3 ^a	80.3 ^a	-1.0 ^b
Increase of 2 or more	82.5 ^a	81.4 ^a	-1.1
Ratio of Medicare payment rate in MSA to national average^c			
Less than 1.00 (reference)	83.3	83.2	-0.1
1.00 to 1.15	79.8 ^a	79.8 ^a	0.0
Greater than 1.15	80.8 ^a	78.6 ^a	-2.2 ^b

SOURCE: 1998 and 1999 Medicare CAHPS data.

^a Estimate is statistically significantly different than the reference category for that year (p<0.05).

^b Estimated 1998-1999 percentage point difference is statistically significant (p<0.05).

^c Market characteristics were classified separately, using 1998 and 1999 attributes, for the 1998 and 1999 CAHPS results.

TABLE III.4
PROBLEMS ACCESSING A SPECIALIST BY
HCFA REGION AND SELECTED MARKET CHARACTERISTICS, 1998-1999

	Percentage of Medicare Enrollees with No Problems Accessing a Specialist		
	1998	1999	1998-1999 Difference
ALL 69 MSAs	82.2	81.2	-1.0 ^b
HCFA region			
Region 1	88.4 ^a	86.6 ^a	-1.8
Region 2	85.5 ^a	83.2 ^a	-2.3 ^b
Region 3	84.1 ^a	82.3 ^a	-1.8
Region 4	82.7 ^a	82.0 ^a	-0.7
Region 5	82.5 ^a	81.6 ^a	-0.9
Region 6	80.8 ^a	78.9 ^a	-1.9 ^b
Region 7	87.1 ^a	87.2 ^a	0.1
Region 8	81.2 ^a	78.1	-3.1 ^b
Region 9 (reference)	77.8	77.4	-0.4
Region 10	84.7 ^a	84.6 ^a	-0.1
Medicare risk enrollment in MSA^c			
Less than 50,000 enrollees (reference)	83.3	82.2	-1.1 ^b
50,000-99,999 enrollees	81.5 ^a	80.5 ^a	-1.0 ^b
100,000-149,999 enrollees	82.3	80.7 ^a	-1.6 ^b
150,000 or more enrollees	81.3 ^a	81.1	-0.2
Medicare risk penetration in MSA^c			
Less than 25 percent (reference)	83.7	81.8	-1.9 ^b
25 to 40 percent	81.9 ^a	81.4	-0.5
Greater than 40 percent	79.7 ^a	79.6 ^a	-0.1
Change in risk penetration, 1997-1999			
Decrease in penetration (reference)	79.2	79.9	0.7
0 to 5 percent	82.0 ^a	80.9	-1.1 ^b
Greater than 5 percent	84.4 ^a	82.7 ^a	-1.7 ^b
Number of Medicare risk contracts in MSA^c			
One (reference)	88.1	89.4	1.3
Two	82.6 ^a	84.1 ^a	1.5
Three to four	85.5 ^a	81.9 ^a	-3.6 ^b
Five or more	81.5 ^a	80.7 ^a	-0.8 ^b
Change in number of risk contracts, 1997-2000			
Decrease of 4 or more (reference)	78.7	77.8	-0.9
Decrease of 1 to 3	82.0 ^a	80.8 ^a	-1.2 ^b
No change	82.7 ^a	80.6 ^a	-2.1 ^b
Increase of 1	82.3 ^a	81.9 ^a	-0.4
Increase of 2 or more	85.1 ^a	84.9 ^a	-0.2
Ratio of Medicare payment rate in MSA to national average^c			
Less than 1.00 (reference)	85.2	84.7	-0.5
1.00 to 1.15	81.2 ^a	81.0 ^a	-0.2
Greater than 1.15	81.3 ^a	80.2 ^a	-1.1 ^b

SOURCE: 1998 and 1999 Medicare CAHPS data.

^aEstimate is statistically significantly different than reference category for that year (p<0.05).

^bEstimated 1998-1999 percentage point difference is statistically significant (p<0.05).

^cMarket characteristics were classified separately, using 1998 and 1999 data, for the 1998 and 1999 CAHPS results.

declined in 1999 by six percentage points.⁹ Region 2 experienced a smaller, but still significant decline of four percentage points. In general, most regions experienced small declines consistent with trends for the 69 MSAs as a whole. Performance did not substantially increase in any region (that is, more than a one percentage point increase). Nor were any of the increases statistically significant.

b. Market Characteristics

We also found little variation according to Medicare market characteristics. However, small differences were often statistically significant because of large sample sizes. One exception is that Medicare MCO enrollees in MSAs with one MCO contract tended to rate their plans significantly more favorably and were less likely to have problems accessing specialists. For example, in MSAs with only one Medicare MCO contract, 89 percent of enrollees gave a rating of eight or more to their health plan in 1999, compared with 81 percent in MSAs with five or more Medicare MCOs. This disparity actually increased slightly from 1998 to 1999, as the prevalence of favorable assessments decreased the most in MSAs with larger numbers of Medicare MCO contracts. Surprisingly, we did not observe a similar relationship between health plan ratings and Medicare MCO penetration levels, which we had expected, given the likely correlation between the number of Medicare MCO contracts and Medicare MCO penetration levels.

This finding could indicate that increased competition between MCOs is associated with reduced enrollee satisfaction. However, the number of MCOs is likely to be confounded by

⁹Region 1 includes the states Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont.

population size, geographic scope, or perhaps other MSA characteristics. Further investigation would be necessary to draw firm conclusions about this somewhat unexpected finding.

We also see a significant (though modest) difference in assessments according to M+C payment rates. Both the overall ratings of the health plan and assessments of access to specialists were more favorable in MSAs where M+C payment rates are lower. This is also somewhat surprising given that one would expect lower rates to strengthen the incentive for MCOs to aggressively manage care and limit access to medical services. Yet, this MSA characteristic may also be correlated with other market features that led to these differences in assessments.

Beyond these cross-sectional differences, we observed few strong associations between MSA characteristics and performance trends for 1998 and 1999. Consistent with trends for the nationwide group of 69 MSAs, most specific categories of MSAs experienced small declines in the prevalence of favorable assessments. However, one exception is that we found that MSAs that experienced a decline in penetration also experienced an increase in favorable assessments. For example, overall health plan ratings increased by 1.9 percentage points in markets with a decline in MCO penetration, while markets with an increase in MCO penetration experienced a 1.4 to 3.1 percentage point decrease in health plan ratings.

IV. DISCUSSION

As discussed in Chapter II, CAHPS was designed to measure enrollees' assessments of the care they receive in their health plan. However, in an environment in which a significant percentage of Medicare enrollees are forced to leave their MCOs because of contract non-renewals and service area reductions, the CAHPS design may not address important differences when making market level comparisons, or tracking changes over time. In particular, the survey does not cover those beneficiaries in the local market who disenrolled voluntarily or who disenrolled because MCO service area reductions or contract non-renewals. One would expect that many of those who disenrolled for either reason would tend to give less favorable assessments because of the resulting discontinuity of care or gap in supplemental coverage. HCFA is currently initiating efforts to routinely survey beneficiaries who voluntarily disenroll, as well as survey, on an as needed basis, beneficiaries who disenrolled because of service area reductions or contract non-renewals.

Nonetheless, the CAHPS data are useful for tracking MSA-level performance as long as it is recognized that the measures focus on the "stable" part of each MSA's local M+C market, that is, MCOs that continue to participate in M+C and serve beneficiaries who have remained continuously enrolled in these plans. These MCOs and their enrollees still represent a large part of the M+C market nationwide. For example, about five percent of Medicare M+C enrollees were affected by contract nonrenewals and service area reductions in 2000.¹⁰

¹⁰However, this number is predicted to increase nearly three-fold in 2001 (Gold and Justh 2000).

Viewed from this perspective, the results of this analysis do not indicate major problems in how beneficiaries assess performance for the “stable” part of the M+C market. Most enrollees gave their MCOs a generally favorable assessment, and variation among MSAs is not exceptionally high, especially when considering the sampling error associated with some MSA-level estimates. It is also important that the variation observed may be due to differences in traditional practice patterns or in prevailing attitudes in these communities, rather than differences in MCO behavior, *per se*.¹¹ Medicare fee-for-service CAHPS may offer a benchmark for comparison with M+C performance in individual market areas.

Trends in assessments of performance also appear to be fairly stable during the first two years for which data are available. However, the small declines from 1998 to 1999 should be re-examined to determine whether they signal more significant trends for M+C enrollees in future years.

¹¹ This point was made by a member of our technical advisory panel, Eric Schneider, Harvard School of Public Health, during the development of a design memorandum submitted to HCFA in July 2000.

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APPENDICES

APPENDIX B

1998 AND 1999 MEDICARE CAHPS RESULTS FOR 69 MSAS

TABLE B.1

OVERALL HEALTH PLAN RATINGS IN 69 MSAS FOR 1998 AND 1999

	Percentage of Medicare Enrollees with Overall Health Plan Rating of 8 or More		
	1998	1999	1998-1999 Difference
69 MSAs	81.1	79.7	-1.4 ^b
Albuquerque, NM	81.9	81.5	-0.4
Atlanta, GA	80.3	80.0	-0.3
Bakersfield, CA (1999 median)	80.0	80.8	0.8
Baltimore, MD	78.7 ^a	76.1 ^a	-2.6
Baton Rouge, LA	87.1 ^a	87.0 ^a	-0.1
Boston, MA	88.2 ^a	85.0 ^a	-3.2 ^b
Boulder, CO	80.4	75.7	-4.7
Chicago, IL	79.4	76.2 ^a	-3.2 ^b
Cincinnati, OH (1998 median)	81.8	80.3	-1.5
Cleveland, OH	81.2	76.7 ^a	-4.5 ^b
Colorado Springs, CO	79.9	75.4 ^a	-4.5
Dallas, TX	82.0	78.3	-3.7 ^b
Daytona Beach, FL	82.2	82.9	0.7
Denver, CO	78.1 ^a	76.9 ^a	-1.2
Detroit, MI	83.3	80.6	-2.7
Dubuque, IA	86.6	86.3	-0.3
Eugene, OR	81.1	82.4	1.3
Fort Lauderdale, FL	78.6 ^a	81.4	2.8 ^b
Fort Worth, TX	82.9	78.5	-4.4
Grand Junction, CO	88.3 ^a	91.5 ^a	3.2
Honolulu, HI	87.3 ^a	86.8 ^a	-0.5
Houma, LA	85.8	82.1	-3.7
Houston, TX	79.4	78.8	-0.6
Jacksonville, FL	83.2	81.5	-1.7
Kansas City, MO	81.6	79.3	-2.3 ^b
Killeen, TX	94.1 ^a	94.2 ^a	0.1
Las Vegas, NV	70.5 ^a	71.3 ^a	0.8
Los Angeles, CA	78.4 ^a	79.0	0.6
Medford, OR	85.2	86.4 ^a	1.2
Miami, FL	83.8	82.2	-1.6
Minneapolis, MN	80.7	82.7	2.0
Modesto, CA	83.9	85.3	1.4
Nassau, NY	80.6	74.3 ^a	-6.3 ^b
New Haven, CT	80.9	76.0 ^a	-4.9 ^b
New York, NY	78.8 ^a	73.0 ^a	-5.8 ^b
Newark, NJ	75.2 ^a	68.2 ^a	-7.0 ^b
Norfolk, VA	88.6 ^a	83.4	-5.2 ^b
Oakland, CA	80.2	80.6	0.4
Olympia, WA	78.8	85.0	6.2
Orange County, CA	77.9 ^a	81.3	3.4

Percentage of Medicare Enrollees with Overall Health Plan Rating of 8 or More			
	1998	1999	1998-1999 Difference
Philadelphia, PA	83.8	82.7	-1.1
Phoenix, AZ	77.3 ^a	78.1	0.8
Pittsburgh, PA	84.7	82.7	-2.0
Portland, OR	82.9	83.2	0.3
Pueblo, CO	82.0	75.5 ^a	-6.5
Riverside, CA	79.5	81.6	2.1
Rochester, NY	90.1 ^a	89.7 ^a	-0.4
Sacramento, CA	82.4	79.1	-3.3 ^b
St. Louis, MO	82.7	82.7	0.0
Salem, OR	83.4	3.1	-0.3
San Antonio, TX	81.0	3.8	2.8
San Diego, CA	82.4	1.8	-0.6
San Francisco, CA	76.3 ^a	7.6 ^a	-2.7
San Jose, CA	77.5 ^a	7.2 ^a	-1.3
San Luis Obispo, CA	79.2	7.3	-0.9
Santa Barbara, CA	80.6	8.5	0.9
Santa Rosa, CA	83.5	86.3 ^a	2.8
Seattle, WA	79.4	80.3	0.9
Spokane, WA	85.0 ^a	82.2	-2.8 ^b
State College, PA	87.3	89.1 ^a	1.8
Stockton, CA	85.1	80.9	-4.2
Tampa, FL	82.2	78.7	-3.5 ^b
Tucson, AZ	79.9	78.4	-1.5
Vallejo, CA	89.4 ^a	78.2	-11.2 ^b
Ventura, CA	75.7	79.6	3.9
Washington, DC	71.6 ^a	75.7 ^a	4.1 ^b
West Palm Beach, FL	77.1 ^a	76.2 ^a	-0.9
Williamsport, PA	88.9 ^a	84.6	-4.3
Yolo, CA	85.5	79.5	-6.0

SOURCE: 1998 and 1999 Medicare CAHPS data.

^aEstimate is statistically significantly different than median MSA for that year ($p < 0.05$).

^bEstimated 1998-1999 percentage point change is statistically significant ($p < 0.05$).

TABLE B.2

ASSESSMENT OF DOCTOR LISTENING SKILLS IN 69 MSAS, 1998 AND 1999

	Percentage of Medicare Enrollees Who Said Doctor Usually or Always Listens Carefully		
	1998	1999	1998-1999 Difference
All 69 MSAS	94.3	93.9	-0.4 ^b
Albuquerque, NM	93.0	94.4	1.4
Atlanta, GA	94.4	94.4	0.0
Bakersfield, CA	91.7 ^a	90.3	-1.4
Baltimore, MD	95.2	94.2	-1.0
Baton Rouge, LA	96.7 ^a	96.4	-0.3
Boston, MA	96.7	96.2	-0.5
Boulder, CA ^c	97.0	96.7	-0.3
Chicago, IL	93.9	91.4	-2.5 ^b
Cincinnati, OH	96.2	94.4	-1.8 ^b
Cleveland, OH	94.2	94.3	0.1
Colorado Springs, CO	91.5	94.6	3.1
Dallas, TX	93.5	92.8	-0.7
Daytona Beach, FL	93.8	93.6	-0.2
Denver, CO	94.6	94.2	-0.4
Detroit, MI	94.2	93.5	-0.7
Dubuque, IA ^c	99.0 ^a	98.1 ^a	-0.9
Eugene, OR	95.7	95.7	0.0
Fort Lauderdale, FL	90.9 ^a	91.7	0.8
Fort Worth, TX	94.2	92.7	-1.5
Grand Junction, CO	97.6 ^a	92.9	-4.7 ^b
Honolulu, HI	97.6 ^a	95.3	-2.3 ^b
Houma, LA	94.9	95.4	0.5
Houston, TX	92.4 ^a	91.5	-0.9
Jacksonville, FL	93.1	93.8	0.7
Kansas City, MO	94.9	94.6	-0.3
Killeen, TX	96.6	98.2 ^a	1.6
Las Vegas, NV	89.0 ^a	88.9 ^a	-0.1
Los Angeles, CA	92.8	92.6	-0.2
Medford, OR	95.7	97.1 ^a	1.4
Miami, FL	92.9	94.8	1.9
Minneapolis, MN	95.2	95.6	0.4
Modesto, CA (1999 median)	92.0	94.0	2.0
Nassau, NY	96.1	93.4	-2.7 ^b
New Haven, CT	96.2	95.5	-0.7
New York, NY	93.6	93.1	-0.5
Newark, NJ	94.3	92.6	-1.7
Norfolk, VA	96.9 ^a	94.0	-2.9
Oakland, CA	93.8	92.9	-0.9

	Percentage of Medicare Enrollees Who Said Doctor Usually or Always Listens Carefully		
	1998	1999	1998-1999 Difference
Olympia, WA	96.3	96.3	0.0
Orange County, CA	93.7	92.4	-1.3
Philadelphia, PA	96.4 ^a	95.5	-0.9
Phoenix, AZ	91.8 ^a	91.9	0.1
Pittsburgh, PA	95.3	95.6	0.3
Portland, OR	95.3	94.7	-0.6
Pueblo, CO	98.1 ^a	95.9	-2.2
Riverside, CA	92.0	92.3	0.3
Rochester, NY	96.5	93.6	-2.9
Sacramento, CA	93.2	93.3	0.1
St. Louis, MO	94.1	95.1	1.0
Salem, OR	93.4	92.9	-0.5
San Antonio, TX	92.9	93.3	0.4
San Diego, CA	94.9	93.8	-1.1
San Francisco, CA (1998 median)	94.5	93.4	-1.1
San Jose, CA	96.5 ^a	92.8	-3.7 ^b
San Luis Obispo, CA	93.1	93.8	0.7
Santa Barbara, CA	92.0	95.6	3.6
Santa Rosa, CA	96.6	96.4	-0.2
Seattle, WA	96.1	95.6	-0.5
Spokane, WA	97.1 ^a	95.9	-1.2
State College, PA	99.1 ^a	97.5	-1.6
Stockton, CA	94.8	92.5	-2.3
Tampa, FL	94.0	93.4	-0.6
Tucson, AZ	93.1	92.4	-0.7
Vallejo, CA ^c	96.6	89.6	-7.0
Ventura, CA	96.1	93.5	-2.6
Washington, DC	94.4	93.2	-1.2
West Palm Beach, FL	90.8 ^a	90.5 ^a	-0.3
Williamsport, PA	95.7	97.8 ^a	2.1
Yolo, CA ^c	94.4	87.5	-6.9

SOURCE: 1998 and 1999 Medicare CAHPS data.

^aEstimate is statistically significantly different than median MSA for that year (p<0.05).

^bEstimated 1998-1999 percentage point change is statistically significant (p<0.05).

^cSample size in MSA is smaller than 100 enrollees.

TABLE B.3

PROBLEMS ACCESSING A SPECIALIST IN 69 MSAS, 1998 AND 1999

	Percentage of Medicare Enrollees Who Had No Problems Accessing a Specialist		
	1998	1999	1998-1999 Difference
All 69 MSAS	82.2	81.2	-1.0 ^b
Albuquerque, NM	84.3	80.9	-3.4
Atlanta, GA (1999 median)	82.3	81.7	-0.6
Bakersfield, CA	86.0 ^a	74.0 ^a	-12.0
Baltimore, MD	83.8	80.8	-3.0
Baton Rouge, LA	85.2	83.7	-1.5
Boston, MA	91.1 ^a	87.9 ^a	-3.2
Boulder, CO ^c	82.5	76.2	-6.3
Chicago, IL	79.2	79.7	0.5
Cincinnati, OH	85.1	83.1	-2.1
Cleveland, OH (1998 median)	82.4	80.8	-1.6
Colorado Springs, CO	79.6	82.0	2.4
Dallas, TX	79.4	77.2 ^a	-2.2
Daytona Beach, FL	84.7	79.3	-5.4
Denver, CO	79.8	75.0 ^a	-4.8 ^b
Detroit, MI	82.3	76.9 ^a	-5.4 ^b
Dubuque, IA ^d	89.8	93.8 ^a	4.0
Eugene, OR	82.8	86.6 ^a	3.8
Fort Lauderdale, FL	84.8	81.7	-3.1
Fort Worth, TX	81.4	75.5 ^a	-5.9 ^b
Grand Junction, CO	86.9	90.8 ^a	3.9
Honolulu, HI	85.8	80.4	-5.4
Houma, LA ^c	89.2 ^a	87.2	-2.0
Houston, TX	75.6	75.6 ^a	0.0
Jacksonville, FL	80.3	81.7	1.4
Kansas City, MO	87.0 ^a	86.8 ^a	-0.2
Killeen, TX ^c	88.8 ^a	92.7 ^a	3.9
Las Vegas, NV	73.1 ^a	70.4 ^a	-2.7
Los Angeles, CA	76.7 ^a	75.0 ^a	-1.7
Medford, OR	84.1	88.7 ^a	4.6
Miami, FL	74.0 ^a	77.3 ^a	3.3
Minneapolis, MN	86.9 ^a	87.0 ^a	0.1
Modesto, CA	84.7	85.8	1.1
Nassau, NY	84.6	81.9	-2.7
New Haven, CT	89.2 ^a	85.8 ^a	-3.4
New York, NY	81.7	78.0 ^a	-3.7 ^b
Newark, NJ	86.9	83.0	-3.9
Norfolk, VA	90.1 ^a	86.0	-4.1
Oakland, CA	81.9	79.8	-2.1
Olympia, WA ^c	81.3	78.2	-3.1

Percentage of Medicare Enrollees Who Had No Problems Accessing a Specialist			
	1998	1999	1998-1999 Difference
Orange County, CA	71.9 ^a	75.0 ^a	3.1
Philadelphia, PA	87.4 ^a	87.8 ^a	0.4
Phoenix, AZ	76.0 ^a	78.9	2.9
Pittsburgh, PA	86.3 ^a	82.3	-4.0 ^b
Portland, OR	83.9	83.8	-0.1
Pueblo, CO ^c	94.6 ^a	82.1	-
Riverside, CA	77.8 ^a	77.7 ^a	-0.1
Rochester, NY	91.3 ^a	88.1 ^a	-3.2
Sacramento, CA	79.5	78.7	-0.8
St. Louis, MO	83.5	84.6	1.1
Salem, OR	84.6	84.5	-0.1
San Antonio, TX	79.9	82.7	2.8
San Diego, CA	78.5 ^a	82.2	3.7
San Francisco, CA	80.7	75.6 ^a	-5.1 ^b
San Jose, CA	79.2	77.9	-1.3
San Luis Obispo, CA	79.3	75.0	-4.3
Santa Barbara, CA	78.4	77.0	-1.4
Santa Rosa, CA	79.7	78.1	-1.6
Seattle, WA	82.8	82.2	-0.6
Spokane, WA	88.5 ^a	86.7 ^a	-1.8
State College, PA ^c	87.2	88.2	1.0
Stockton, CA ^c	80.8	75.7	-5.1
Tampa, FL	85.4	84.4 ^a	-1.0
Tucson, AZ	79.0	77.9 ^a	-1.1
Vallejo, CA ^d	81.3	73.3	-8.0
Ventura, CA ^c	59.0 ^a	69.1 ^a	10.1
Washington, DC	79.6	79.1	-0.5
West Palm Beach, FL	78.2	81.7	3.5
Williamsport, PA	88.2 ^a	94.3 ^a	6.1 ^b
Yolo, CA ^c	75.0	89.1	14.1

SOURCE: 1998 and 1999 Medicare Consumer Assessment of Health Plans Survey data.

^aEstimate is statistically significantly different than median MSA for that year ($p < 0.05$).

^bEstimated 1998-1999 percentage point change is statistically significant ($p < 0.05$).

^cSample size in MSA is smaller than 100 enrollees.

^dSample size in MSA is smaller than 50 enrollees.

TABLE B.4

ASSESSMENT OF PLANS' CUSTOMER SERVICE IN 69 MSAS, 1998 AND 1999

	Percentage of Medicare Enrollees Who Said Customer Service Was Usually or Always Helpful		
	1998	1999	1998-1999 Difference
All 69 MSAS	85.4	84.4	-1.0 ^b
Albuquerque, NM	83.7	85.1	1.4
Atlanta, GA	85.1	84.1	-1.0
Bakersfield, CA	86.0	91.4 ^a	5.4
Baltimore, MD	82.6	76.8 ^a	-5.8 ^b
Baton Rouge, LA	85.2	86.2	1.0
Boston, MA	91.1	91.2 ^a	0.1
Boulder, CO ^b	80.6	85.3	4.7
Chicago, IL	81.0 ^a	80.1 ^a	-0.9
Cincinnati, OH (1999 median)	85.5	85.4	-0.1
Cleveland, OH	84.4	80.8	-3.6
Colorado Springs, CO	86.0	87.5	1.5
Dallas, TX	83.2	81.7	-1.5
Daytona Beach, FL	87.8	82.1	-5.7
Denver, CO	86.7	87.3	0.6
Detroit, MI	92.1 ^a	87.4	-4.7 ^b
Dubuque, IA ^d	100.0	100.0	0.0
Eugene, OR ^c	94.5 ^a	93.5 ^a	-1.0
Fort Lauderdale, FL	83.4	84.0	0.6
Fort Worth, TX	87.3	84.4	-2.9
Grand Junction, CO ^c	96.2 ^a	88.9	-7.3
Honolulu, HI ^a	82.7	87.0	4.3
Houma, LA ^d	90.9	80.9	-10.0
Houston, TX	78.7 ^a	81.4	2.7
Jacksonville, FL	85.9	83.2	-2.7
Kansas City, MO	90.8	84.3	-6.5 ^b
Killeen, TX ^d	93.9	97.0 ^a	3.1
Las Vegas, NV	78.1 ^a	75.9 ^a	-2.2
Los Angeles, CA	81.9	82.7	0.8
Medford, OR ^c	94.8 ^a	91.0 ^a	-3.8
Miami, FL	84.5	79.7 ^a	-4.8
Minneapolis, MN	87.1	91.0 ^a	3.9
Modesto, CA ^c	88.8	91.2	2.4
Nassau, NY	86.8	78.7 ^a	-8.1 ^b
New Haven, CT	87.0	84.1	-2.9
New York, NY	83.0	78.3 ^a	-4.7 ^b
Newark, NJ	84.5	78.0 ^a	-6.5 ^b

Percentage of Medicare Enrollees Who Said Customer Service Was Usually or Always Helpful			
	1998	1999	1998-1999 Difference
Norfolk, VA	91.8	89.3	-2.5
Oakland, CA	85.0	82.6	-2.4
Olympia, WA ^d	89.6	81.4	-8.2
Orange County, CA	84.2	90.3 ^a	6.1 ^b
Philadelphia, PA	85.4	85.6	0.2
Phoenix, AZ	82.5	83.9	1.4
Pittsburgh, PA	90.7	87.5	-3.2
Portland, OR	91.1 ^a	92.3 ^a	1.2
Pueblo, CO ^d	90.9	79.4	-11.5 ^b
Riverside, CA	83.5	85.5	2.0
Rochester, NY	92.2	93.6 ^a	1.4
Sacramento, CA	84.5	81.8	-2.7
St. Louis, MO	90.4	91.9 ^a	1.5
Salem, OR	88.3	94.2 ^a	5.9
San Antonio, TX	78.0 ^a	82.7	4.7
San Diego, CA	85.0	86.4	1.4
San Francisco, CA	83.1	87.9	4.8
San Jose, CA (1998 median)	86.6	82.6	-4.0
San Luis Obispo, CA ^c	91.3	86.6	-4.7
Santa Barbara, CA ^c	88.9	87.0	-1.9
Santa Rosa, CA	89.8	90.9	1.1
Seattle, WA	85.6	87.1	1.5
Spokane, WA	91.4 ^a	87.8	-3.6
State College, PA ^d	93.3	95.0 ^a	1.7
Stockton, CA ^d	88.4	77.8	-10.6
Tampa, FL	82.9	81.2 ^a	-1.7
Tucson, AZ	84.7	83.1	-1.6
Vallejo, CA ^d	93.1	92.8	-0.3
Ventura, CA ^c	89.7	87.5	-2.2
Washington, DC	78.1 ^a	83.8	5.7
West Palm Beach, FL	82.1	76.3 ^a	-5.8
Williamsport, PA ^c	90.8	92.7 ^a	1.9
Yolo, CA ^d	91.3	85.2	-6.1

SOURCE: 1998 and 1999 MCAHP Survey data.

^aEstimate is statistically significantly different than median MSA for that year (p<0.05).

^bEstimated 1998-1999 percentage point change is statistically significant (p<0.05).

^cSample size in MSA is smaller than 100 enrollees.

^dSample size in MSA is smaller than 50 enrollees.

TABLE B.5

PLANS' DELIVERY OF FLU SHOTS IN 69 MSAS, 1998 AND 1999

	Percentage of Medicare Enrollees Who Received a Flu Shot from Their Health Plan Last Winter		
	1998	1999	1998-1999 Difference
All 69 MSAS	63.0	62.8	-0.2
Albuquerque, NM	70.2 ^a	67.1 ^a	-3.1
Atlanta, GA	58.5 ^a	55.5 ^a	-3.0 ^b
Bakersfield, CA	67.0 ^a	66.1	-0.9
Baltimore, MD	61.1	57.3 ^a	-3.8
Baton Rouge, LA	58.7	63.9	5.2
Boston, MA	57.5 ^a	57.2 ^a	-0.3
Boulder, CO	68.2	66.5	-1.7
Chicago, IL	56.2 ^a	56.4 ^a	0.2
Cincinnati, OH	60.0	61.1	1.1
Cleveland, OH (1998 median)	62.2	62.0	-0.2
Colorado Springs, CO	54.7 ^a	60.6	5.9
Dallas, TX (1999 median)	57.4 ^a	63.0	5.6 ^b
Daytona Beach, FL	65.6	68.6 ^a	3.0
Denver, CO	69.2 ^a	70.8 ^a	1.6
Detroit, MI	56.9 ^a	52.8 ^a	-4.1
Dubuque, IA	58.4	79.0 ^a	20.6 ^b
Eugene, OR	66.5	66.8	0.3
Fort Lauderdale, FL	60.3	60.3	0.0
Fort Worth, TX	60.5	56.7 ^a	-3.8
Grand Junction, CO	80.3 ^a	79.9 ^a	-0.4
Honolulu, HI	79.8 ^a	77.2 ^a	-2.6
Houma, LA	51.8 ^a	55.9	4.1
Houston, TX	56.9 ^a	55.9 ^a	-1.0
Jacksonville, FL	60.0	61.7	1.7
Kansas City, MO	65.9 ^a	62.6	-3.3 ^b
Killeen, TX	83.3 ^a	78.1 ^a	-5.2
Las Vegas, NV	50.0 ^a	51.6 ^a	1.6
Los Angeles, CA	57.7 ^a	62.9	5.2 ^b
Medford, OR	70.6 ^a	64.0	-6.6 ^b
Miami, FL	51.5 ^a	51.4 ^a	-0.1
Minneapolis, MN	77.8 ^a	78.7 ^a	0.9
Modesto, CA	61.1	59.2	-1.9
Nassau, NY	62.8	61.1	-1.7
New Haven, CT	58.3 ^a	60.0	1.7
New York, NY	57.8 ^a	56.1 ^a	-1.7
Newark, NJ	49.1 ^a	46.4 ^a	-2.7
Norfolk, VA	61.6	60.1	-1.5

Percentage of Medicare Enrollees Who Received a Flu Shot from Their Health Plan Last Winter			
	1998	1999	1998-1999 Difference
Oakland, CA	63.9	70.9 ^a	7.0 ^b
Olympia, WA	67.5	72.1 ^a	4.6
Orange County, CA	54.8 ^a	58.9	4.1
Philadelphia, PA	62.1	61.6	-0.5
Phoenix, AZ	65.3 ^a	62.4	-2.9 ^b
Pittsburgh, PA	60.1	53.4 ^a	-6.7 ^b
Portland, OR	73.3 ^a	72.8 ^a	-0.5
Pueblo, CO	68.4	66.3	-2.1
Riverside, CA	59.6	59.8	0.2
Rochester, NY	74.8 ^a	74.1 ^a	-0.7
Sacramento, CA	62.8	62.8	0.0
St. Louis, MO	66.6 ^a	63.7	-2.9
Salem, OR	71.9 ^a	69.4 ^a	-2.5
San Antonio, TX	66.1 ^a	67.0 ^a	0.9
San Diego, CA	72.1 ^a	69.4 ^a	-2.7
San Francisco, CA	61.9	66.3	4.4 ^b
San Jose, CA	58.3 ^a	62.0	3.7
San Luis Obispo, CA	63.4	61.3	-2.1
Santa Barbara, CA	59.5	62.1	2.6
Santa Rosa, CA	71.5 ^a	68.0 ^a	-3.5
Seattle, WA	65.1	67.5 ^a	2.4
Spokane, WA	70.2 ^a	69.8 ^a	-0.4
State College, PA	68.0	75.2 ^a	7.2
Stockton, CA	60.8	63.7	2.9
Tampa, FL	61.9	62.5	0.6
Tucson, AZ	65.6	67.1 ^a	1.5
Vallejo, CA ^c	66.4	72.2 ^a	5.8
Ventura, CA	59.4	59.6	0.2
Washington, DC	56.2 ^a	63.7	7.5 ^b
West Palm Beach, FL	66.3 ^a	69.0 ^a	2.7
Williamsport, PA	69.3 ^a	70.7 ^a	1.4
Yolo, CA ^a	71.3 ^a	74.1 ^a	2.8

SOURCE: 1998 and 1999 Medicare Consumer Assessment of Health Plans Survey data

^aEstimate is statistically significantly different than median MSA for that year ($p < 0.05$).

^bEstimated 1998-1999 percentage point change is statistically significant ($p < 0.05$).

^cSample size in MSA is smaller than 100 enrollees.