

"Medicare Choices for New Yorkers - Know What Matters!" is a counseling guide designed to provide Medicare intermediaries with the knowledge they need to help seniors make informed choices about their Medicare health coverage.

Medicare Choices for New Yorkers - Know What Matters!

Counseling Guide

**Baruch College School of Public Affairs
and Medicare Rights Center**

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I. Medicare: The need for objective, user-friendly information

The Baruch College School of Public Affairs has developed a set of new booklets entitled *Medicare Choices for New Yorkers - Know What Matters!* The booklets are part of a larger effort to develop and test new and improved ways to provide people on Medicare with objective information to help them choose health plans. Baruch College is now working, in collaboration with the Medicare Rights Center, to provide these booklets to people on Medicare who are considering a change in their health care coverage. Rather than just send booklets out to people who may not be interested in them, or who do not understand how to use them, our strategy is to work with those who are already known and trusted by people on Medicare in New York City. Specifically, we are reaching out to and involving community-based agencies throughout the city who work with seniors and people with disabilities and asking them to participate with us in sharing these new tools with those who really need and want them. In addition to providing the booklets, however, we are providing two additional supports to the agencies with whom we are working. First, we are offering selected agencies training for staff and volunteers who work on the front lines helping people on Medicare to understand the Medicare + Choice program. Second, we are providing this guide to using our materials. Both the training and the guide, together, are designed to provide guidance as you help clients make informed decisions.

This summary guide on the booklets covers:

1. The recent changes in Medicare and how they increase people's need for objective information they can understand and use
2. Background on the Baruch College/Medicare Rights Center Project
3. The information you can find in each of our booklets
4. The critical roles you can play to help people on Medicare make informed decisions about their health plans and the significance of those decisions in the context of quality of care

5. How to use the booklets when counseling people on Medicare to help them decide if an HMO meets their needs and which HMO plan is best for them

The guide was written with a diverse range of counseling staff in mind, including direct service staff, volunteers and paraprofessionals who work with people on Medicare. It is also intended to be a useful resource for counselors and supervisors who may already be familiar with Medicare HMOs in New York City.

Choosing a health plan can be one of the most important decisions made by older Americans and people with disabilities. People on Medicare face greater challenges in choosing their Medicare plan than ever before. Starting in the early 1980's, "risk-contract" HMOs were offered to people on Medicare. Medicare HMOs, as they are called, got off the ground slowly in some parts of the country, and have only become a significant part of the New York scene over the last few years. Most people on Medicare do not understand how HMOs work, how they are different from the traditional Medicare fee for service program, and what those differences mean for them. To add to the confusion, the 1997 Balanced Budget Act (BBA), with its Medicare + Choice strategy, further expanded the types of health insurance options that might be available to people on Medicare. Medicare + Choice lets more private insurance companies offer coverage to people with Medicare. These plans are, nevertheless, part of the Medicare program. While few insurance companies have actually offered these new kinds of plans, changes are taking place in the New York market. For example, in the Year 2000, for the first time, one company will be offering a "Point of Service" (POS) option to its Medicare HMO. And if people on Medicare don't understand the usual HMO, they certainly understand this new option even less!

These changes in Medicare, in combination with intense marketing efforts by Medigap plans and Medicare HMOs and the lack of comprehensive and comprehensible information, leave people on Medicare confused and more likely to make a decision that may not be right for them. Consequently, some people

enroll in a Medicare HMO without realizing what it means about what doctors and hospitals they can and cannot use. Many don't realize they are still in Medicare when they join a Medicare HMO, which means they also don't realize they get the same protections they had under the traditional program. Even worse, some people find out they have unintentionally enrolled in a new plan. Meanwhile, horror stories about HMOs in the press and recent withdrawals by Medicare HMOs in some communities have raised anxieties.

The Medicare + Choice strategy cannot work unless people on Medicare are reasonably well informed about their options. In response, the Medicare program has dramatically increased the attention and resources aimed at improving one's ability to choose the best Medicare health plan that meets their needs. The Health Care Financing Administration (HCFA), which runs Medicare, has sent out printed materials and set up a website, www.medicare.gov. They have also required all Medicare HMOs to participate in efforts to collect information about the real-life experience of their members, so it can be shared with other people on Medicare. Unfortunately, most of this quality information is not easily available. In addition, people on Medicare often find the printed materials that HCFA distributes difficult to understand and use without help. And right now, very few older Americans use the Internet, so they rarely get a chance to see the Website.

Given this state of confusion, it is even more important that people on Medicare gain access to objective information and be given the tools to help them understand what each plan offers and how to decide which plan is best for them.

Why is objective information needed now?

- There are changes in Medicare and more Medicare options
- People on Medicare might not understand the basic Medicare program and are really confused about the new options
- Media stories about HMOs are often frightening and don't give all the facts
- Insurance plans and the HMOs provide information but it usually emphasizes the advantages of their own products, not how they compare with other options
- New information is available on access and quality in Medicare HMOs
- People on Medicare need easy access to this new information, and help in using it, in order to make a decision that is right for them

II. About The Project

The Commonwealth Fund has supported the Baruch College School of Public Affairs to develop independent, user-friendly information on health plans offered to people on Medicare here in New York City. The Commonwealth Fund is a private foundation in New York City that works to improve the health of older Americans. No one who worked on the booklets has anything to gain from a person's decision to join a Medicare HMO. Rather, the intention is to help people on Medicare make a good decision.

The booklets were developed by Dr. Shoshanna Sofaer and her staff, not by Medicare HMOs, insurance companies or even the federal government. Dr. Sofaer is a national expert in health care consumer information and a Professor at Baruch College School of Public Affairs. For over 15 years, Dr. Sofaer has conducted research on how best to inform individual consumers, especially people on Medicare, about the performance of the health care system, so that their

perspective, as well as those of professionals and government officials, influences its direction.

During Phase I of our project with The Commonwealth Fund, we actually developed the set of booklets. Working with the Medicare Rights Center, the Baruch project reached out to people on Medicare, and to community-based agencies that serve their health and social service needs, to “reality test” our materials. The Medicare Rights Center (MRC), a national not-for-profit consumer service organization, was established in 1989 to ensure that seniors and people with disabilities receive quality, affordable health care. Through hotline counseling, education and public policy, MRC works to educate the public about Medicare; identify and address systemic problems in the Medicare program; and empower people on Medicare to help themselves and, where necessary, take corrective action on their behalf. As part of our “reality test,” we conducted interviews and focus groups with people on Medicare and with staff and volunteers at several community-based agencies that serve older Americans and people with disabilities. Community-based feedback was used to design clear and unbiased materials that were pleasant and easy to read. Community-based input was also critical to making sure that the booklets addressed the issues that people on Medicare say are most important to them, such as premiums, services covered, providers and health plan quality.

Many people who help older Americans told us they needed simple, accurate and complete materials they could use to help their clients decide whether to join an HMO Medicare health plan. They also said that many older Americans and people with disabilities would need their assistance to fully understand the materials, process them and put them to use in making decisions. In response to these needs, the booklets were written with two audiences in mind - people on Medicare and agency staff, like you, who assist people on Medicare. In Phase II of the project (which is happening now!), we finalized our booklets, selected a group of agencies

to disseminate the booklets to their clients on Medicare, and designed, with the Medicare Rights Center, a training curriculum for their staff and volunteers and this Counseling Guide to support people who participate in the training, especially once they are working with their clients. Training, conducted by Medicare Rights Center staff, began in April, 2000.

Project Overview	
Background	<ul style="list-style-type: none"> → The Commonwealth Foundation funded Baruch College and The Medicare Rights Center to develop the booklets. → The booklets were developed and tested during Phase I of the project. → Phase II of the project involves distributing the booklets to people on Medicare through staff at community agencies.
Objective of the Booklets	<ul style="list-style-type: none"> → Provide the materials and tools needed to help you counsel people on Medicare about their health plan choices → Help people on Medicare make informed decisions about their health plan choices
The Counseling Process	<ul style="list-style-type: none"> → Using the booklets as an aid to counsel people on Medicare. Counseling involves identifying client needs and evaluating which HMO best meets those needs. You should be familiar with the materials and comfortable walking your clients through the process.

III. The Content of the booklets for people on Medicare

These booklets were designed to help older Americans and people with disabilities determine whether it would be a good idea for them to join a Medicare HMO, and if so, to select the HMO that best meets their needs. The booklets not only provide information but they also offer practical advice to help people on Medicare undertake the often daunting task of choosing a health plan. A lot of the information that is needed to compare choices has been gathered in these booklets.

The booklets incorporate three main sources of information about health plans that are not easily available elsewhere. The first source of information, on the premiums, covered services and “ground rules” of each Medicare HMO offered in the Year 2000 in New York City from the HCFA Medicare Compare Website, supplemented by more detailed information disseminated by the plans themselves¹. Researchers at Baruch College, School of Public Affairs clarified any inconsistencies and gaps in the information with plan representatives. This data can be found in the green booklet, *What services are covered and what are their costs?*

The other two sources of data grow out of new HCFA requirements that all Medicare HMOs participate in two important new initiatives to gather objective data on health plan quality. One source of data comes from a survey developed by the Consumer Assessment of Health Plans Study (CAHPS) specifically to get information from Medicare HMO members about their experiences in their plan, and their assessment of their plan’s performance in providing access to quality health care. HCFA mandated the development of this special Medicare Managed Care version of CAHPS and has contracted with an independent group to collect CAHPS survey data from all Medicare HMOs in the country. A second source of

¹ Later this year, when information on premiums and covered services for the Year 2001 become available, we will be updating and reprinting the relevant booklets.

data is information that Medicare HMOs have provided to HCFA on particular quality measures included in the National Committee on Quality Assurance's (NCQA) Health Plan Employer Data and Information Set (HEDIS). These quality measures address whether Medicare HMOs provided their members with specific clinical services that are considered by experts to be critical for preventing illness, catching it early, and treating it appropriately. It is important to note that in addition to requiring Medicare HMOs to provide these HEDIS data, HCFA has also audited the plans to make sure the data they provide are accurate. In fact, when the data have not been found sufficiently accurate, we do not report it. Appendix A has additional detail on the CAHPS and HEDIS measures that are included in the booklet and how the data are collected. Although the CAHPS and HEDIS data was collected in 1998, it represents the most recent information available on the plans. Unfortunately, because large-scale surveys require significant time for data collection and presentation, there is usually a time lag.

Taken together, these three sources of data let people on Medicare compare plans in terms of costs, covered services and access to quality care. In addition, the booklets educate people on Medicare about the range and types of health insurance options now available in New York City and explain the significance of the comparison ratings on the quality of different HMOs.

The CAHPS and HEDIS data are contained in four booklets: *Getting Health Care – Easily*; *Getting a Plan with Good Doctors*; *Prescription Coverage*; and *Staying Healthy and Getting Better*. In each of these booklets, comparative data are presented in easy-to-read charts that highlight the critical differences among plans and important features to consider. Star charts and bar graphs are used to simplify complicated summary information on how well the plans perform on important quality measures. The star charts show how well the scores of each Medicare HMO compare to the average scores for all NYC Medicare HMOs in the survey. Segmented bar charts with legends are used in two booklets, *Getting Health Care –*

- *Easily* and *Getting a Plan with Good Doctors*. These charts provide more detail on the information contained in the star charts, for example on how well doctors communicate with their patients and how easy it is to get health care without long waits. Not all plans provided CAHPS or HEDIS data, primarily because not all Medicare HMOs currently available in NYC were in operation for at least a year when the member survey was conducted in 1998, or have had members on Medicare long enough to collect the HEDIS data. Footnotes explain the reason(s) why not all HMOs are included in every chart. There are also tables and charts in *Thinking about joining an HMO*, which we sometimes call “ the Introductory Booklet,” that compare:

- Original Fee for Service Medicare to Medicare HMOs
- Traditional Medicare HMOs to the Point of Service (POS) Option

Medicare Choices for New Yorkers - Know what matters! consists of six **booklets**. Before reading further, please familiarize yourself with the content of all the booklets as well as the charts. Review the booklets and see how health plans are rated by people who are using each plan, based on the results from independent studies. Each booklet is color-coded in order to make it easier to use:

- Thinking about joining an HMO?:* Blue and red
- What Services are Covered and What are the Costs:* Green
- Prescription Coverage:* Burgundy
- Getting the Health Care You Need – Easily:* Light blue
- Getting a Plan with Good Doctors:* Purple
- Staying Healthy and Getting Better:* Yellow

The chart on the next page gives an overview of what each booklet covers.

Booklet	Area of Interest
<p>Thinking about joining an HMO?</p> <p>The Blue and Red booklet</p>	<p>This introductory booklet gives background information comparing original Medicare to Medicare HMOs. It describes the differences between a basic HMO plan and a new Point of Service, or POS, option. In addition, it identifies several things to consider when choosing a new plan and lists nine steps that are critical to making an informed decision. Information available in the other booklets is previewed. A worksheet is provided to help people examine and compare the different plans. It also covers consumer rights, grievance procedures and important sources for information or assistance.</p>
<p>What Services are Covered and What are the Costs</p> <p>The Green Booklet</p>	<p>This booklet shows you what NYC Medicare HMOs have in common, and how they differ, in terms of their premiums, the services they cover, and what it costs when a person visits the doctor, uses an emergency room, fills prescriptions, goes to a skilled nursing facility, stays in a mental hospital or gets outpatient mental health care.</p>
<p>Prescriptions and Premiums</p> <p>The Burgundy Booklet</p>	<p>This booklet provides greater detail on prescription drugs. There is also a chart on prescription coverage that includes the costs for premiums. Another chart gives information from the CAHPS survey about how easy members said it was to get prescriptions through the HMO plan. These charts are particularly helpful for people on a limited budget.</p>
<p>Getting the Health Care You Need – Easily</p> <p>The Light Blue Booklet</p>	<p>This important booklet on access provides data from CAHPS on the real-life experience of Medicare HMO members. The data describes how easy it was to get a referral, to get the care they needed and to get service without long waits. The information also describes whether customer service was efficient and helpful and how often getting approvals was hassle-free. Overall ratings on each Medicare HMO are also provided.</p>
<p>Getting a Plan with Good Doctors</p> <p>The Purple booklet</p>	<p>This booklet provides information from CAHPS surveys about how well doctors in different plans communicate with their patients and whether they spend enough time with them. It also compares member ratings of the health care in each Medicare HMO and reports on the HEDIS measure that shows the percentage of specialists in each plan that are board certified.</p>
<p>Staying Healthy and Getting Better</p> <p>The Yellow Booklet</p>	<p>This booklet reports on HEDIS measures and CAHPS survey questions that show how well different plans do at (1) helping members to stay healthy and (2) taking care of them when they are sick. This includes measures of important preventive care, such as breast screens and flu shots and measures showing how often plans prescribe the right drugs to prevent more heart attacks and how often people with diabetes receive eye exams.</p>

by familiarizing yourself with the booklets, you will be better prepared to answer questions and locate the most relevant information for a particular client. When people on Medicare, for example, come to you for help because they can no longer afford their prescription coverage, you will then know where to find critical information comparing the prescription costs and coverage for each HMO plan. If a HMO plan has denied someone an important service recommended by their primary care doctor, you will know that the booklet *Thinking about joining an HMO?* (the blue and red booklet) provides information about individual rights and grievance procedures. It also provides phone numbers of organization that can help resolve such problems. But the booklets also go beyond the basic facts. They inform the reader about how features of individual HMO plans can affect access to care and the quality of care received.

IV. How to Use the Booklets

The Role of Counseling

We think the booklets do a good job of providing information. But we also know that for most people on Medicare, the booklets alone won't do the trick. They need help from a trusted person in understanding the value of the booklets, thinking through what information they want and where to find it, understanding the information, and using it to make a decision. That's where you come in -- **YOUR ROLE IS CRITICAL!** Helping people on Medicare to make a good decision can make a difference to people's financial circumstances, to whether they have access to high quality health care, and to whether they are satisfied with the choice they have made. Many people on Medicare may not be able to find their way through the maze of complexity represented by the Medicare+Choice options. Yet with your help people on Medicare can make informed decisions that may make a difference to their lives.

While people on Medicare need objective information, so do the people that help them make decisions -- their friends, families, or the staff at the agencies they visit. You are in a unique position to assist people on Medicare. First and foremost, this is because you are trusted by the people you serve. You are often the first person that seniors and people with disabilities turn to for help with all kinds of problems. You can also help legitimate a source of information, which people on Medicare rightly question given the degree to which they are subject to advertising and marketing onslaughts from "interested" rather than "disinterested" sources. The chart on page 14 identifies the many roles that you may have in helping people on Medicare make a health care coverage decision.

Perhaps most important, you are in a position to help explain things that people do not immediately understand. You can help them interpret information and use it to make their decisions. As a counselor, you know that you have to respond to the immediate concerns that people bring to you. Similarly, you know that you often

need to bring people's attention to other important issues they may not yet have thought about. For example, most people on Medicare are used to thinking about how much a health plan will cost, or how well they cover a particular service, like prescription medications. These are important issues; that's why our booklets provide information on them. But many people on Medicare don't realize that when they join a Medicare HMO, they are also choosing the people from whom they will get their health care and the rules they will have to follow in getting health care. So in addition to providing information on cost and coverage, we also have booklets on topics like getting access to care or getting the right kind of care when you are sick. These issues can directly affect the quality of care the HMO plan provides. You can also better inform people on Medicare to be conscientious consumers and advocates.

You are in a better position to play these roles if: (1) you have user-friendly materials to assist them, materials that are attractive, relevant, engaging and easy to understand; and (2) you have acquired the knowledge and skills necessary to use the materials in interacting with people on Medicare.

Agency staff and volunteers have important roles. You can:

Connect with those who need help

Identify people who may need to make a change in their health care coverage or who could benefit from this type of information
Let them know that new and useful information and support is available to help them make a good choice

Assess the needs of people on Medicare

Help people understand what is important to them in choosing a health care plan
Help people figure out whether it makes sense for them to consider a Medicare HMO, and to identify HMOs available in their area
Help connect people to the information on the issues that are most important to them, in our booklets and from other sources

Help people understand how Medicare HMOs work

In person-to-person interactions, go through the background information we provide on Medicare HMOs and make sure people “get it”
Help people understand the comparative information on topics of concern
Point out additional topics they might want to consider

Gather and Distribute information

Provide information on issues most important to them, from our booklets and other sources
Legitimate the trustworthiness and usefulness of the information

Help people use the information to make a good decision

Help people apply information to their individual circumstances and find out which HMOs do a good job in areas that are important to them
Help people use the worksheet to make their decisions

Empowering clients to be self advocates

Review consumer rights and responsibilities

V. Assessment and Counseling

The process of counseling someone to make an informed decision is not always easy and may require employing many of the roles identified in the previous chart. You can view the counseling process in stages that parallel the roles described in the previous chart.

Stage 1: Connecting with the person who may need help

In many cases, people on Medicare will be approaching you with an existing concern or set of concerns. These people include:

- Those who have expressed interest in considering an HMO
- Those who are currently in an HMO but want to know what other HMOs have to offer
- Those who have a problem or concern that might be rectified by switching to another HMO

In many situations, people may need information but may not be aware that information is available. You need to be sensitive to subtle signs that indicate that someone may need more information, though they may not yet realize it. Such signs or events act as “triggers” that signal a need for information or help. By recognizing such triggers, you can identify issues of concern that may need to be immediately addressed. The screen on page 18 can be used to identify such triggers. By becoming familiar with the triggers, you can help others to resolve emerging problems before a small problem reaches crisis proportions. The screening tool will help you to identify trigger events that may indicate that someone is either interested in or in need of information or counseling.

There are many different types of triggers; they may vary in terms of the scope and severity of the issue involved. Some triggers relate to an individual's general confusion and need for clear information, and others occur during significant life changes. Also, when people on Medicare are generally dissatisfied with their health plan, their physician or the services covered, they may need help finding a more appropriate plan.

During the Medicare open enrollment period in early fall, for example, many people will receive the *Medicare & You* handbook from the government. This may cause people on Medicare to become confused about Medicare or to have new concerns that need to be addressed. They may believe that their Medicare coverage has changed or they simply may not understand some of the information contained in the handbook. These individuals should look at the introductory booklet, *Thinking about Joining a Medicare HMO?* the blue and red booklet. This booklet explains Medicare changes and options in plain English. Also, many older Americans are bombarded by information from insurance companies, including Medicare HMOs. During a breakfast meeting sponsored by a commercial plan, older Americans are often persuaded to join a plan that they do not fully understand or later regret joining. During these times you need to let people on Medicare know that new and useful information and support is available to clarify their concerns and help them make a good choice.

People tend to have more questions about their health plans when significant life changes occur. Significant life changes include turning 65 years old and becoming eligible for Medicare. Another significant life event is when people on Medicare are informed that their physician, who they have seen for many years, is planning to retire. General dissatisfaction with their current health care coverage can also trigger an interest in information. People may find the green booklet on prescription coverage useful if, for example, the cost of their Medigap premium has become exorbitant or they have no coverage for regularly prescribed medicine. Many people experience disappointment when they feel that their doctor does not communicate well or is not being responsive to their concerns. These individuals should look at the purple booklet *Getting a Plan with Good Doctors*. Sometimes, people's financial circumstances may change, making it more difficult to keep their current health care coverage or pay out of pocket expenses. Since Medicare HMOs are often a less costly option, many people turn to them at this time. You

can help them understand more about the choice, and make sure that if they join an HMO, they pick one which provides better than average health care, as indicated in the data in our booklets.

Perhaps most important, events that cause people to seek information can be viewed as “teachable moments” when people will pay more attention to new information or ideas than they might at other times.

Screening tool: Identifying Triggers

General Confusion and lack of information

- News stories about changes in Medicare and new options
- The *Medicare & You* booklet sent out by HCFA (in the fall)
- Promotional materials received from Medicare HMOs or Medigap plans
- An experience that causes confusion about their current policy (see Health Systems)

Life changes

- About to turn 65 or retire and need Medicare
- Qualified for Medicare after 3 months on SSDI
- Loss of partner or caregiver or other changes in one's support system
- A recent move to a new neighborhood
- Traveling or going out-of-state for an extended period
- Physician retirement or death
- Changes in financial situation
- Changes in health status

Dissatisfaction with Health Systems

- Poor quality current care, excessive paper work, long waiting times
- High cost of premiums, out-of-pocket costs, prescriptions
- Poor customer service: denial of care or long waiting time for an approval to a recommended service
- Sudden changes in plan: cost, physician list, services

Dissatisfaction with How One is Treated by Physician or Plan

- Poor communication skills
- Concern with physician knowledge of medical history or specific health issues
- Problems with referral and service coordination
- Health care provider has left a health plan

Dissatisfied with Type of Services Received

- Provision or lack of provision of preventive services, tests, and referrals
- Limited access to specialists, mental health professionals, other health professionals

Stage 2: Assessing health care needs

During your initial counseling session, assess the individual's experience and needs in order to (1) determine how appropriate the booklets are for that individual and (2) whether it is even appropriate for the person to consider joining an HMO.

During the initial assessment you can learn many things about people that will help you to identify their priorities as well as unmet needs. First you need to know whether the person is eligible for Medicare or whether the person has Medicare.

You should also find out if the person has both Medicare and Medicaid or any other types of health care coverage e.g. retiree insurance. Ask the following questions:

Initial questions to be asked
→ How old are you?
→ Are you eligible for Medicare?
→ Do you have Medicaid?
→ Do you have any other insurance? → Retiree benefits?
→ Are you comfortable reading in English?
→ Are you happy with your current health plan? → If not, why not?
→ Does your monthly income cover your monthly expenses?

The booklets will help many people on Medicare. However, be aware that the booklets are not appropriate for everyone. The booklets, for example, are written only in English. They were also primarily written for people who just have

Medicare, not those who also receive Medicaid. People who are dual eligible have different options, as do people with retiree insurance (a supplement from their own or their spouse's former employer). The options available to people who receive both Medicare and Medicaid are not fully addressed in these booklets. People with retiree health benefits also have distinct needs. They may not be able to return to their employer sponsored plan once they leave it; they need to talk with their own or their spouse's former employer before making any change. The chart below summarizes the relevance of the booklets for several groups of people.

When The Booklets Are, and Are Not Appropriate		
<i>When the booklets are not appropriate</i>	<i>Who the booklets can help</i>	<i>Special issues to keep in mind re HMOs</i>
Language: other than English only	People who will soon be eligible for Medicare	Travel frequently and need health care when away from home
People on Medicare and Medicaid	People interested in a Medicare HMO option	Unique disability
People with other insurance i.e, retiree health insurance	People on limited budgets	Want the freedom to use any doctor
	People who have trouble paying for prescription drugs or premiums	Need to see a lot of specialists
	People with current problems with their health plans (financial, personal, change in physician etc)	Unique relationship with a physician

People with special issues may or may not find a Medicare HMO to be a good match. Someone who travels frequently, for example, may want the flexibility of

seeing any doctor, even when traveling; most Medicare HMOs cover only emergency care when a member is away from the service area of their network of providers. People who travel a lot or live in another part of the country during part of the year may want to consider a Point of Service option HMO, if they can afford the extra cost. An HMO may not be a good option for people who have a strong attachment to a physician who does not participate in Medicare HMO plans. On the other hand, some people who have a strong attachment to their doctor still find Medicare HMOs to be a compelling option because there are fewer out-of-pocket costs. People with disabilities who regularly visit one or more specialists should make sure that they are part of the plan. Many people with disabilities have been seeing the same specialist as their primary source of care for their entire life and they may not be willing to go to another primary care physician, even if the plan includes their physician as a specialist.

The initial process of identifying an individual's primary concerns may entail helping the person think through what is of greatest interest to them, and then later providing booklets on these topics. Several other issues need to be considered when assessing people's needs and interest in the materials. First, do they want general or specific information or do they even know what they want?

Consider the specific needs of people on Medicare:
→ What do they want from a Medicare plan?
→ What are their priorities: costs? providers? quality? all of these?
→ Do they have financial constraints?
→ Do they want one specific question answered or a broader understanding of Medicare?
→ Are there specific features or services that are very important to them?

Stage 3: Understanding how Medicare HMOs work

While the booklets can be very useful, they need to be introduced in a way that will help people on Medicare understand why this particular information is relevant to them and how it can help them in deciding which health plan to join or evaluating how well their plan compares to others. Because people on Medicare are not use to getting significant levels of objective comparative information about their health care coverage options, they need to be told that such information is available from credible sources. They need to have key messages reinforced about the meaning of quality care and they need good navigational assistance about how and where to find important information. Many people will need help in understanding how the health care system is changing and how to use new comparative quality data to make real life choices. You can help identify information that is relevant to the issues that are most important to them, in our booklets and from other sources. The person may need additional help to understand the comparative information we provide on topics of interest.

Once it is clear that a Medicare HMO may be a viable option, you will need to assess the person's knowledge of HMOs versus traditional Medicare. There are clear advantages to HMOs but they also have their own rules and conditions that can limit individual choice. When counseling people on Medicare about their choices, use the chart on Page 3 of the blue and red booklet, *Thinking about Joining an HMO?* to make sure that the person on Medicare understands the differences between original Medicare and a Medicare HMO. Make sure the person fully understands the implications of his/her decision before joining a new plan. This will entail reviewing the differences between the original Medicare fee-for-service program and a Medicare HMO. It also requires that the person understand that there is a new option now available, the POS. Many issues need to be considered before joining an HMO. This is not to say that there are not lots of

people for whom a Medicare HMO is a good choice – it is to say that people will be more satisfied with their HMO, and their choice in general, if they make it “with eyes open.”

This process may require that you help clients understand basic facts about Medicare or the health care delivery system. You may also need to clarify misconceptions, explain the features of individual plans and the terminology used by health insurance companies. Everyone should know what is at stake when they choose a Medicare HMO.

HMOs also use a lot terminology that may not be familiar to people on original Medicare. In order to help you explain the terminology, Appendix B in this guide provides definitions of the jargon commonly used by health plans.

Several other issues need to be considered when assessing people’s understanding of the materials. How familiar are they with Medicare + Choice? How much new information can they handle at one time?. See the chart below for questions for you to answer regarding a person's understanding of the materials.

Consider how well people on Medicare understand the materials:
→ How much do they already know and how familiar with Medicare are they?
→ Could they make a decision without help but want to get more data to review?
→ Are they asking for practical advice in making an immediate decision or are they looking for general information to be used later on?
→ Do they need help reviewing all the materials or only certain booklets?

The next section addresses the context in which the booklets can be distributed and how to distribute the booklets, without overwhelming people on Medicare.

Stage 4: Gather and distribute information

As already mentioned, you should learn why the person is seeking help and what the person cares about before providing a lot of information. In general, you should begin with the introductory blue and red booklet, *Thinking about Joining an HMO?* Depending on the person's interest, the other booklets can be referred to as a whole for background information or individual booklets can be used to answer specific questions or concerns. Find the information on the features of the plan that are most important to your client, such as whether you can see a specialist, get appointments without long delays, whether the doctor spends enough time with you. These issues are all covered in the light blue booklet, *Getting the Health Care You Need – Easily*. You can put all the information together to find the plan that best meets that person's needs and priorities. If someone wants to remain with his/her existing provider, for example, then you could begin with the *Getting a Plan with Good Doctors* booklet, the purple booklet. This booklet addresses that issue but also broadens the issues to include other information associated with the quality of care doctors provide in different HMO plans.

While all the booklets can be selectively used during the previous stages, by the end of Stage 3 it should be clear which booklets are most relevant to the needs and interests of your client. By this point, the client should know that the booklets are for them to take home to read or to refer at a later point. People should also be encouraged to come back or call to get other booklets of interest or to have issues further clarified.

You do not want to give people more information than they can handle. Otherwise you may just add to their confusion and anxiety. You may need to reassess whether the person is ready for more information that broadens the discussion to

include different aspects about quality of care. The complete set of concepts, messages, and information that people may, therefore, need to be disaggregated into less daunting “ chunks” and delivered over time. That’s why we created a set of booklets rather than one single booklet!

Stage 5: Making the decision

Another very useful tool is the worksheet contained in the introductory booklet. You can use the worksheet when counseling people on Medicare. In order to use the worksheet in *Thinking about Joining an HMO?* the blue and red booklet the person will first need to:

- a) Know which HMOs are available where the person lives
- b) Find out which Medicare HMOs their doctor is in
- c) Decide what’s most important to them in a health plan
- d) Use the booklets to find out which HMOs do a good job in areas that are important to them

Once the worksheet is completed it should be easier to make a choice among plans. The booklet takes them step-by-step through the decision making process. It is organized into questions to narrow choices by identifying which health plan did well on topics that are of high importance to the individual. It identifies things to think about as you review the information about benefits, coverage, costs, doctors, and quality of care. This process can help people on Medicare organize information to clarify the pros and cons of each plan. The “ summary chart” allow people, at times with your assistance, to check off the plans that did well on the topics that match their needs and concerns. It can also help you focus your interactions with people on Medicare from the outset or after other concerns have been addressed.

There are several important distinctions to be made between assisting someone and making explicit recommendations that may bias the information. Exploring health plan options takes time and involves having the person thoughtfully consider what is important to them. While you can help them to get important information and

weigh their option, you need to remain neutral. Neutrality involves being forthright in pointing out **both** the positive **and** negative interpretations of comparative performance data. This is true both for a specific piece of information and for an entire set of information on different topics.

Helping someone to make an informed decision is not easy. There are no right answers and it would be unusual for a plan to perfectly match someone's particular needs. There are, however, plans that may be a better match than others. In the end, the Medicare plan that is likely to work best for an individual is the one that matches the person's own needs and values. If a person on Medicare highly values preventive care, for example, it would be important to ensure that these types of services are covered. On the other hand, if financial cost and preventive care represent a daily concern, then plans that provide excellent preventive services but high premiums may not be appropriate.

Step 6: Empowering clients to be self advocates

An important step in helping your clients become their own advocates is reviewing their consumer rights. In an effort to better educate and inform people on Medicare as consumers, the last section of the introductory booklet contains a list of names and numbers to call for further information and reviews the rights and responsibilities of people on Medicare. People in a Medicare HMO are, for example, entitled to all services covered by original Medicare. They will not, however, be covered for care that they get from doctors not in the network, unless there is an emergency. Once enrolled in a Medicare HMO, people have the right to leave the HMO or switch to another HMO or return to original Medicare. Medicare HMOs also have appeals procedures for those who feel that they have been wrongly denied services or coverage. Under the standard appeals process, the HMO must review your case within 30 days. If you think your health could be seriously harmed by waiting for a decision about the appeal, you can request a fast decision to be made and they must answer you within 72 hours.

An informed public can help to improve the overall quality of our health care system by encouraging a health care market place that rewards coverage options that provide real value. Individual consumers, as well as communities, can play a significant role in shaping the health care system to be more responsive to individual needs and the overall quality of care.

Appendix A

Health Care Quality Data Available On Medicare HMOs: An Overview

In response to the growing demand for information regarding the quality of health care in general, and Medicare HMOs in particular, HCFA has mandated that all Medicare HMOs participate in two important quality information initiatives, known familiarly as CAHPS (for Consumer Assessment of Health Plans Study) and HEDIS (for Health Plan Employer Data and Information Set). In the following paragraphs, we describe the background on each of these initiatives, so that you can be confident that the data in the booklets are meaningful and come from objective sources. In the next section, we will specify, booklet by booklet, details about each of the quality measures included, and how the data are presented.

CAHPS

CAHPS is a multi-year effort initiated in 1995 by the Agency for Health Care Policy and Research (AHCPR), which is now known as the Agency for Health Care Research and Quality (AHRQ). The goal of CAHPS is (1) to develop surveys of people in various health insurance plans to get feedback from them on important aspects of their experience and (2) to develop ways of sharing that feedback with people like them who are trying to make a health care coverage decision. The topics included on the CAHPS survey were chosen based on research with consumers that (1) identified the issues consumers cared about and (2) identified the issues they wanted to hear about from other consumers.

Consumers are smart: they know other consumers can't tell them much about the outcomes of their surgeries, but that they would be the real "experts" on issues like access to care and the quality of their communications with doctors, medical office staff and health plan customer relations departments.

Shortly after CAHPS began, HCFA decided that it needed a way to assess how people on Medicare were responding to *their* health care experiences, especially those enrolled in Medicare HMOs. They therefore supported the development of a CAHPS survey designed specifically for people on Medicare enrolled in HMOs²; they also contracted with a major survey research firm to actually conduct the survey. The booklets report information from the second administration of the CAHPS surveys across the United States. HCFA has included a *very limited* number of CAHPS items on its website and in its publication *Medicare & You*. Our booklets include all the CAHPS items on which there were enough responses from consumers to ensure that the results are reliable. We also follow the model of reporting used by the CAHPS project nationally, which is, in most cases, to combine questions on a particular topic into a “composite” score. This reduces the number of “data points” that anyone has to look at, which helps keep people on Medicare (and you!) from being overwhelmed. However, in the chart below, we will give you the details about the specific questions included in each composite, so that you can provide more information to your clients if they are interested.

The number of people surveyed in each Medicare HMO, and how the sample is drawn for the survey, are specified and consistent across all Medicare HMOs; the sample is large enough to make sure the results are reliable and representative of Medicare plan members as a whole. Statisticians associated with CAHPS have spelled out these details and they are rigorously followed in implementing the survey. In addition, the survey results have been adjusted to account for differences that exist in the mix of people in each Medicare HMO. Thus, for example, some HMOs avoid enrolling really sick people while others do not.

² HCFA has, more recently, supported the development of a CAHPS survey for people on Medicare who remain in the fee-for service system. The data from these surveys would, of course, be very helpful to people trying to decide whether an HMO is a good idea for them at all. Unfortunately, however, it will be a couple of years before data from this survey will be available for all communities across the country.

Since it is often the case that sicker people are less satisfied with their health care, no matter where they get it, the CAHPS results are adjusted so that plans that actually enroll sick people are not penalized and those who put up barriers to sick people are not rewarded.

HEDIS

The other main source of comparative data on individual health plans in New York City is based on the work of the National Committee for Quality Assurance (NCQA), which has developed a set of measures of the performance of HMOs called the Health plan Employer Data and Information Set (HEDIS). Initially, HEDIS measures were not designed to address people on Medicare. In 1995, however, when the last major revision of this measurement set was undertaken, NCQA decided to expand the scope of HEDIS to include items of particular interest to older Americans. HCFA staff were active participants in the effort to pick measures of this kind; Dr. Sofaer also tested measures NCQA was considering to make sure they were of interest, and meaningful, to people on Medicare. One component of HEDIS are measures of clinical effectiveness. HCFA has selected several measures from this group that they believe will be of greatest interest to people on Medicare (as well as to themselves in their role of monitor of HMO performance); they have mandated that all Medicare HMOs submit data on these measures annually. The data for these measures are typically drawn from the administrative or clinical records of HMOs. The way these data are collected, and how the measures are calculated, have been carefully specified by NCQA. In addition, HCFA has “audited” the HMOs to make sure they have actually submitted accurate data. We have selected, from among the measures on which data are mandated, those that we believe, based on our testing with consumers, are of greatest relevance and interest, and those on which there is confidence that the HMO data are reliable.

Our experience indicates that while consumers generally understand the meaning and importance of CAHPS data, they need more help in understanding the meaning and importance of HEDIS information. The booklets therefore provide, for each HEDIS measure, a “plain English” version of the measure, a brief statement of why it is important and another brief statement of what it shows you about a Medicare HMO. Note that people often don’t realize that a health plan (rather than their doctor) can have a big impact on the quality of care. These statements help them to understand how the health plan can have such an impact.

If you have questions about the data in the booklets, or if a client asks a question you can’t answer, please do not hesitate to call the staff of the project at Baruch to get an answer. You can call Tracey Dewart at 802-5979 or Shoshanna Sofaer at 802-5980.

Data Contained in Each Booklet

Introduction: Thinking about joining an HMO, the blue and red booklet

There are no CAHPS or HEDIS data in this booklet.

What services are covered and what are the costs? The green booklet

There are no CAHPS or HEDIS data in this booklet. All the information comes from the Medicare Compare Website, from Medicare HMO brochures, and from follow-up research on ambiguous or confusing items.

Prescription Coverage, the burgundy booklet

There are two kinds of information in this booklet. One kind is traditional data on prescription coverage and premiums in each of the Medicare HMOs in New York City; it is the same as the data in the general booklet on premiums and services covered. In addition, however, this booklet includes information from CAHPS, in the form of a star rating that compares what members of each HMO say about getting prescriptions through their Medicare HMO. We report a composite measure consisting of two questions:

- “In the last 6 months, how much of a problem, if any, was it to get your prescription medicine from your HMO?” with the response options: 1. A big problem 2. A small problem 3. Not a problem.
- “In the last 6 months, how often did you get the prescription medicine you needed through your HMO” with the response options: 1. Never 2. Sometimes 3. Usually 4. Always.

The data was recoded to have the response options 'Never and Sometimes', 'Usually' and 'Always'.

Getting a Plan with Good Doctors, the purple booklet

This booklet contains both CAHPS and HEDIS data. The first three charts report CAHPS data; the last chart reports one HEDIS item.

Chart 1 presents Star ratings from information on different CAHPS items, as described below:

- **Was it easy to find a doctor you like**, represents responses to a single CAHPS item “With the choices the HMO plan gave you, how much of a problem, if any, was it to get a personal doctor or nurse you are happy with?” with the response options: 1. A big problem. 2. A small problem 3. Not a problem.
- **How well do HMO doctors communicate** represents a composite of four questions, asking how often the person’s doctor or health care provider:
 - Listen carefully to them?
 - Explain things to them in a way they could understand?
 - Showed respect for what they had to say?
 - Spent enough time with them?

All these questions have the same response options: 1. Never 2. Sometimes 3. Usually 4. Always.

- **Rating of the HMO Health Care providers** represents a single question: “ We want to know your rating of your personal doctor or nurse. Use any number from 0-10 where 0 is the worst personal doctor or nurse possible and 10 is the best personal doctor or nurse possible. How would you rate your personal doctor or nurse now?”

Chart 2

Was it easy to find a doctor you like, represents a bar chart of the responses to a single item “ With the choices the HMO plan gave you, how much of a problem, if any, was it to get a personal doctor or nurse you are happy with?” with the response options: 1. A big problem. 2. A small problem. 3. Not a problem.

Chart 3

How well do HMO doctors communicate represents a bar chart with legends of the composite data in the 2nd column of chart 1 on whether HMO doctors communicate well.

The legends include: 'Never and Sometimes', 'Usually' and 'Always'.

Chart 4

Board certification reflects the data collected by HEDIS. It asks “ The percentage of board-certified primary care doctors in each Medicare managed care plan.”

Getting the Health Care You Need - Easily, the light blue booklet

Chart 1 presents star ratings from information on different CAHPS items, as described below:

- **Was it easy to get referrals to specialists**, represents responses to a single item “ In the last 6 months, how much of a problem, if any, was it to get a referral to see a specialist? with the response options: 1. A big problem 2. A small problem 3. Not a problem.
- **Was it easy to get other care needed** represents a composite of three questions, asking:
 - How much of a problem was it to get a referral to a specialist you needed to see?
 - How much of a problem was it to get care you or a doctor believed necessary?
 - When you called during regular office hours, how often did you get help or advice you needed?

The data was recoded to have the response options 'Never and Sometimes', 'Usually' and 'Always'.

- **Was easy to get care without long waits** represents a composite of four questions, asking:
 - How often did you get an appointment for regular or routine health care as soon as you wanted?
 - When you needed care right away for an illness or injury, how often did you get care as soon as you wanted?
 - How much of a problem were delays in health care while you waited for approval from your health plan?

- How often did you wait in doctor’s office more than 15 minutes past your appointment time to see the person you went to see?

The data was recoded to have the response options 'Never and Sometimes', 'Usually' and 'Always'.

Chart 2 presents star ratings from information on different CAHPS items, as described below:

- **Rating of HMO customer service** represents a single question: “ How much of a problem, if any, was it to get the help you needed when you called the HMO's customer service?” with the response options: 1. A big problem 2. A small problem 3. Not a problem
- **HMO Paper work and approvals** represents responses from people who had experience with paper work from the health plan to the question "how much of a problem, if any, did you have with paperwork with health plan? with the response options: 1. A big problem 2. A small problem 3. Not a problem.
- **Health Plan Rating** represents a single question: “ We want to know your rating of all your experience with your health plan. Use any number from 0-10 where 0 is the worst health plan possible and 10 is the best health care possible. How would you rate your health plan now?”

Chart 3 presents information from the first column in Chart 1 on:

- **Was it easy to get referrals to specialists?** It represents a bar chart of the single item “ In the last 6 months, how much of a problem, if any, was it to get a referral to see a specialist? The bars represent the percentage of respondents who indicated that it was not a problem with the response options: 1. A big problem 2. A small problem 3. Not a problem.

Chart 4 presents information from the 2nd column in Chart 1 on:

Was it easy to get other care needed? It represents a bar chart with the legends 'Never and Sometimes', 'Usually' and 'Always'.

Chart 5 presents information from the 3rd column from Chart 1 on:

How easy it was to get care without long waits It represents a bar chart with the legends 'Never and Sometimes', 'Usually' and 'Always'.

Staying Healthy and Getting Better, the yellow booklet

Chart 1

Percent of women who got tested for breast cancer is a HEDIS measure. It shows the “percentage of women in each HMO between the ages of 52 and 69 who got an x-ray to check for breast cancer (called a mammogram) in the past 2 years.”

Chart 2

Percent of members who got a flu shot last year represents CAHPS data. The CAHPS question asks "did you get a flu shot last year from September-December 1997?"

Chart 3

Eye exams for people with diabetes is a HEDIS measure. It shows the “percentage of plan members with diabetes mellitus in each Medicare HMO plan who got an eye exam to make sure their eyes were healthy.”

Chart 4

Prescribing the right drugs to prevent more heart attacks is a HEDIS measure. It shows the "percent of members in each HMO Who Got Beta blocker after a hospital stay for a heart attack".

Appendix B

Definitions of Terms

Accreditation: The process under which health plans are reviewed and judged for quality by an outside organization, such as the National Committee for Quality Assurance

Capitation: A method of payment for health care services in which providers are paid a fixed monthly rate for each plan member they have as a patient regardless of the amount of care the member receives.

Co-payment: A small set fee you pay for a service (e.g. \$5 co-payment for a visit to a doctor). Members typically pay a co-payment ranging from \$5 -\$15 every time they visit the doctor, have test done, or have a prescription filled.

Deductible: The amount per year you must pay for services before insurance begins to cover costs. This feature is more common with traditional insurance.

Disenrollment: The procedure you must follow to cancel your membership in a plan.

Exclusion: Health services that are not covered by your health plan or specific circumstances under which your plan will not pay for services.

Experimental procedures or services: Services that are not recognized under generally accepted medical standards as and effective for treating a particular condition. In some instances, health insurers may differ on their determination of what is “ experimental “ and what is not.

Fee-for-service: The traditional method of paying for medical services where doctors and hospitals are paid for each service they provide.

Formulary: A list of approved drugs under a health plan’s prescription drug benefits.

HMO: Health plans that provide comprehensive health care services to members for a fixed fee. Members are generally limited to using doctors and hospitals designated by the HMO.

Medical group: A professional organization of physicians that contract with a health plan to deliver both primary – or basic – and specialty care to plan members.

Medically necessary: A term used by insurance companies and health plans to describe care that is appropriate and provided according to general standards of medical care.

Network: The doctors, clinics, hospitals and other medical providers that a health plan contracts with to provide health care to its members.

Out-of –Pocket: Your out-of-pocket costs are the amount you pay for you health care. The costs depend on the health plan you choose, how often you need care, the type of care you need and the extra benefits covered by the plan.

Point of service: An option provided by some HMOs that allows members to go outside the plan’s physician and hospital network for care, but requires that they pay higher costs for sharing than they would for network providers.

Premium: Yearly cost for the insurance. Supplemental insurance usually has a premium but HMOs usually have no premium.

Primary care physician (PCP): Primary care physicians are trained to give basic care. In an HMO, they often coordinate and give you most of your care. In order to see a specialist, you will have to see your primary care physician to get a referral, unless you are in a Point of Service plan (POS). When you join an HMO, you select your primary care physician from a list of doctors who are participating in the Plan. If you already have a doctor you want to continue to see, make sure that s/he is in the plan and is accepting new patients under that plan.

Referral: Authorization for a member of a managed care plan to receive care from a specialist of hospital. The member's primary care physician is responsible for making the referral.

Specialist: A physician with training or expertise in an area of medicine. HMO members usually need approval for their primary care physician to see a specialist.

Utilization review: A process used by health plans and medical groups to reduce what they deem to be unnecessary and ineffective care and to hold down medical costs. It's also used to prevent unnecessary hospital admissions and reduce lengths of hospital stay.