

A Paradigm Shift in the Golden Years
The Transition from Federal Medicare to Managed Care Medicare

by

Mary Striegel

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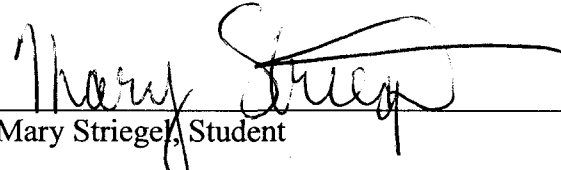
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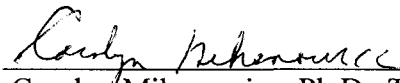
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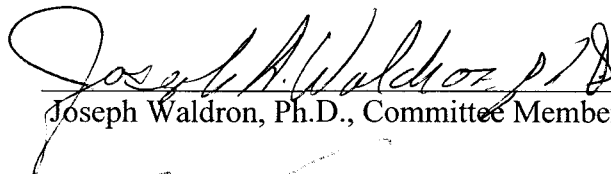

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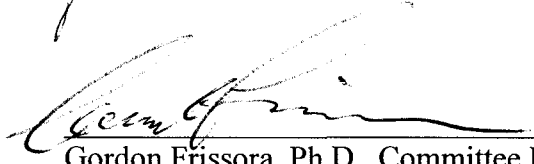
Approvals:


Carolyn Mikanowicz, Ph.D., Thesis Advisor

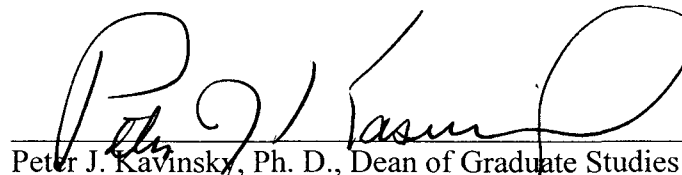
5/25/99
Date


Joseph Waldron, Ph.D., Committee Member

6/1/99
Date


Gordon Frissora, Ph.D., Committee Member

25 May 99
Date


Peter J. Kavinsky, Ph. D., Dean of Graduate Studies

6/2/99
Date

Abstract

Traditional federal Medicare, which provides health insurance coverage for approximately 13% of the national population, spent \$213 billion in 1997. Due to medical advances, escalating healthcare costs and the rising senior population, the existing Medicare program is predicted to be bankrupt by the year 2001. In an attempt to prevent this, the U.S. Department of Health and Human Services enacted legislation to allow commercial insurance plans to offer a managed care Medicare option. Because of low out-of-pocket costs and the extensive use of prevention programs associated with managed care Medicare, senior citizens are rapidly converting to these plans. It is important, then, to examine the quality of healthcare offered by both managed care Medicare and the traditional Medicare plan. This observational study used a descriptive correlational research design composed of a convenience sampling of Allegheny County, PA senior citizens attending community based, congregate senior centers. An adaptation of the Consumer Assessment of Health Plan Survey was used to determine perceptions of quality of care and sociodemographic variables. Using a proportional odds model, it was revealed in the data that the overall quality rating for type of insurance plan was predicted by the rating of physicians' skills, the perception that the plan provided the services needed, the amount of time the physician spent with the subject and education level. The overall plan rating for managed care Medicare was 4.22 (s.d.=0.76) whereas federal Medicare was 2.95 (s.d.=1.39). This data supports the hypothesis that subjects insured by managed care Medicare believe that they are provided with a quality of medical care better than that provided by federal Medicare.

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CHAPTER ONE

Introduction

Preface

Medicare is the primary health insurance provider for American senior citizens, those people aged 65 and older. From national statistics compiled in 1998, it is shown that Medicare covers 38.4 million people, which represents less than 13% of the total population (HCFA, 1998). This relatively small percentage of the population consumed \$213 billion in health care costs, in 1997 (HCFA, 1998). Researchers postulate that if healthcare spending continues at its' current rate for its' current number of participants, the Medicare program will be exhausted by the year 2001 (Schwartz, 1995). Due to the rise in life expectancy coincident with the maturation of the "baby boomers", the senior population will grow to 25% of the total population by 2050 (Vanderlann, 1995). In an attempt to curb Medicare spending, the federal government enacted legislation that enabled Medicare recipients to choose managed care Medicare as an option for their health insurance carrier. To ensure delivery of quality care from these managed care Medicare plans, the Department of Health and Human Services created the Health Care Financing Agency (HCFA). HCFA's primary purpose is the regulation of the entire Medicare program, including traditional Medicare and the managed care Medicare options. (HCFA, 1997).

Problem Statement

Nationally, senior citizens comprise less than 13% of the total population. Comparatively, the senior population of Allegheny County, PA has reached 18.1%, making it the second largest senior citizen population in the United States. In the next ten year period, this geographical area is expected to have a senior population rise to 23%

(Rotstein, 1998). Statistics compiled in 1998 show that 29% of the senior citizens living in Allegheny County, PA have elected managed care Medicare (Rotstein, 1999)). Due to this rapid and voluminous shift from traditional Medicare, it is important to examine the quality of care being offered to these residents. The purpose of this report, then, is to compare the perceptions of quality of care associated with senior citizens who have chosen either traditional Medicare or the managed care Medicare plans.

Hypothesis

Senior Citizens who have chosen managed care Medicare believe that they are provided with a quality of medical care better than that provided by traditional Medicare.

Basic Assumptions

The first basic assumption of this study is that senior citizens who chose managed care Medicare will adhere to the guidelines set forth by that plan and use medical resources as directed by their primary care physician. The second assumption is that study participants will answer survey questions honestly and without fear of retaliation.

Delimitations

There are two delimitations of this study. The first is plan design. Traditional Medicare coverage is available to senior citizens and persons with selected disabilities, regardless of age. However, because of the high percentage of senior citizens living in Allegheny County, PA, this study will be limited to those persons aged 65 and older that are not considered disabled. The second delimitation is geographical composition. Since Allegheny County is an urban area with world-renowned medical systems, the health care in this area may differ from that offered in other metropolitan, suburban or rural areas of the country.

Limitations

The questionnaire was quite lengthy (48 questions) which may have resulted in a lower response rate. The participants may have become distracted prior to the completion of the questionnaire.

This was an observational study that measured perceptions of quality of care. These perceptions can be linked to individual nebulous traits such as attitude, motivation and personality that were not measured by the questionnaire.

While the senior centers and the subjects were chosen in a random manner, the collected data was not randomly distributed. Larger sample sizes may have yielded a more normalized distribution.

Operational Definitions

In this study, the following terms are defined.

Average Adjusted Per Capita Cost (AAPCC)—a complicated formula that is used by the federal government for calculations of payments to managed care programs.

Agency for Health Care Policy and Research (AHCPR)—a federal agency that is charged with supporting and conducting health care research related to insurance plans.

Baby Boomers—those people born between the years of 1946 and 1965.

Consumer Assessment of Health Plans (CAHPS)—a study devised to identify specific quality indicators associated with health insurance plans.

Case Manager—A registered nurse, employed by managed care plans, who coordinates care for the plan members.

Consolidation Omnibus Budget Reconciliation Act (COBRA)—the legislation that allows managed care Medicare beneficiaries to disenroll from the plan every 30 days, if they so choose.

Competitive Medical Plans (CMP)—managed care plans that provide limited access and do not meet federal requirements.

Computerized Needs-Oriented Quality Measurement Evaluation System (CONQUEST)—an online resource that provides managed care Medicare plan information in an easy to read format.

Department of Health and Human Services (DHHS)—a federal agency that has the overall responsibility for administration of the Medicare program.

General Accounting Office (GAO)—the agency responsible for budgeting of the federal programs, including the Medicare program.

Health Care Employer Data Information Set (HEDIS)—a mandatory set of information that managed care plans are required to collect and annually report HCFA.

Health Care Financing Administration (HCFA)—a federal agency that has the responsibility of oversight and regulatory control of the Medicare program.

Health Maintenance Organization (HMO)—managed care plans that are federally qualified, and provide a wide variety of services within a selected network.

Managed Care—health insurance plans that provide a wide variety of services within a select network.

Managed Care Medicare—those managed care plans that have met requirements to provide health insurance coverage for the Medicare population.

Medicare—a federally funded health insurance plan for the aged and disabled.

Medi-gap Policy—supplemental insurance coverage purchased to pay for services not covered by traditional Medicare.

Office of the Inspector General (OIG)—the federal agency responsible for legislative compliance of managed care Medicare plans.

Preferred Provider Organizations (PPO)—managed care plans that, are mainly controlled by physician groups, and provide medical care within a select network.

Peer Review Organization (PRO)—a panel of experts that review medical compliance issues of managed care Medicare plans.

Tax Equity and Fiscal Responsibility Act (TEFRA)—the legislation that allows HCFA to contract with managed care Medicare plans.

Summary

The current Medicare program facing financial insolvency. While both the percentage of the population entitled to federal Medicare and the cost of healthcare continue to rise, the available funds are dwindling. Measures must be adopted to ensure that adequate health insurance coverage continues to exist for the American senior citizen population. Managed care Medicare appears to be a reasonable remedy to the ailing federal Medicare system.

In Chapter Two, a review of the literature is presented.

In Chapter Three, the research methodology, the selected data analysis technique and the survey instrument is discussed.

In Chapter Four, the results of the data analysis are presented with a discussion of the covariates and socioeconomic variables.

In Chapter Five, a summary of the study, the findings, and implications are reviewed. Recommendations for future research are proposed.

CHAPTER TWO

Literature Review

Introduction

If changes are not made to the current federal Medicare program, it is predicted it will be bankrupt by the year 2001, (Schwartz, 1995) leaving virtually no healthcare coverage for American senior citizens. Researchers postulate that managed care Medicare, if regulated properly, is a feasible remedy to this situation. A review of the relevant literature was done and follows in the sections entitled: history of Medicare, insurance benefits of traditional Medicare, expansion of the Medicare program, threats to the traditional Medicare program, Medicare reform, regulation of Medicare, development of a managed care Medicare plan, the managed care Medicare HMO, expansion of managed care Medicare, federal regulation of managed care Medicare, private regulation of managed care Medicare, quality of care associated with managed care Medicare, and a chapter summary.

History of Medicare

The concept of a national health insurance in the United States began in the late 1930's with the congressional assumption that the federal government would be a significant financial contributor. The basic concept and associated details were the subject of 35 years of Congressional debate (HCFA, 1996). Then, on July 30 1965, President Lyndon Johnson delivered this historical speech.

No longer will older Americans be denied the
Healing powers of modern medicine.
No longer will illness crush and destroy
The savings that they so carefully put away
Over a lifetime, so that they might enjoy dignity
In their later years (Kinney, 1995 p.1164).

With this speech, Title XVIII of the Social Security System, entitled “Health Insurance for the Aged and Disabled”, became national law. Title XVIII is also known as Medicare. With the inception of Medicare, the federal government recognized medical care as a basic right—along with food, clothing and shelter (HCFA, 1996). Congress used an 1881 German definition of “elderly” as those people aged 65 years of age and greater (Rotstein, 1998). This age group became targeted for this national health insurance, as they were considered to be a “deserving and privileged population.” (HCFA, 1996). Medicare was designed as “socially unifying legislation” that embraced all social classes, on equal terms, in one age group (HCFA, 1996).

Insurance Benefits of Traditional Medicare

Medicare consists of two distinct parts. At the age of 65, all Americans who have worked a minimum of 16 quarters (or four full time years), are entitled to Part A. Thus, it is considered universal health insurance, covering costs associated with acute care and rehabilitation hospitals, skilled nursing facilities, home care and hospice services. Part A is financed through employer and employee payroll taxes, presently at the rate of 1.45% of gross income (Vladek and King, 1995a).

Part B is a voluntary program covering physician fees, outpatient testing, laboratory services, and durable medical equipment (HCFA, 1997). Part B is financed through monthly premiums, presently at \$43.80, that are paid by the beneficiary, which account for only 25% of the costs. The remaining 75% of the monies are provided by the federal reserve (Callahan, 1996; HCFA, 1997).

Medicare does not cover all medical services and many Medicare recipients also elect supplemental coverage, commonly known as a Medigap policy. Medigap policies

are usually purchased through federally qualified commercial insurance corporations (Callahan, 1996), typically costing between \$500 and \$5,000 per year in premiums (Kinney, 1995). Examples of services not covered by Medicare are preventive health programs, eyeglasses, hearing aids, and prescription drugs (Vladek, 1995a).

Expansion of the Medicare Program

In its' first year, Medicare covered 19.1 million elderly (HCFA, 1996). By the end of 1996, that number rose to 38.4 million (HCFA, 1998). The elderly population is expected to continue to grow at a rapid rate due to advances of modern medicine, better working conditions and a cleaner environment (Rubenstein, 1997). As the American public ages, the incidence of chronic diseases rises (Brown University, 1997). Due to the advances of modern medicine, some chronic diseases are no longer fatal (Vladek, 1995a), creating an older population with more illness and higher associated medical care costs (Brown University, 1997).

Average life expectancy is rising. In 1996, when the national elderly population was 12%, the average life expectancy at birth was 79.7 years for males and 85.6 years for females (Vanderlann, 1995). By the year 2050, it is estimated that this will rise to 85.8 years for males and 89.0 years for females, making the elderly 25% of the total population (Vanderlann, 1995). A large part of this rise can be attributed to the maturation of the "baby boomers", those born between 1946 and 1965. All tolled, the potential number of people eligible for Medicare is expected to reach 80 million by the year 2050 (Blanchette, 1997), representing a 132% rise in the national senior population (HCFA, 1996).

Threats to the Traditional Medicare Program

Medicare is presently the largest payer for healthcare services (Schwartz, 1995). In 1996, Medicare paid \$213 billion for 38.4 million beneficiaries (HCFA, 1998). This payment represented a 10.5% increase from 1995 and accounted for 10% of the federal budget (Vladek, 1995a). Since Medicare's inception, expenditures have risen 3-5% per year beyond general inflation (Callahan, 1996; Pawlson, 1997) and if these costs are not curtailed, the Medicare fund is expected to be depleted by the year 2001 (Schwartz, 1995). The increased number of beneficiaries and the rise in the incidence of chronic illness will result in higher Medicare costs. Managed care Medicare is considered to be a feasible solution to assist with Medicare reform.

Medicare Reform

A primary goal of Medicare reform is to move federal Medicare beneficiaries to managed care Medicare (Meng, Jatulis, McDonald and Legorreta, 1997; Roller and Allman, 1996) with an expected decrease in overall Medicare spending. (Aston, 1997; Besdine, 1997; Miller and Luft, 1997). The concept of managed care Medicare is not new. In fact, a managed care Medicare option was offered in 1965, with the initial presentation of the traditional Medicare platform (Kinney, 1995). However, due to the initial low reimbursement rates to qualified insurance companies, there was no inherent incentive to market this insurance option. This lack of action led to public naiveté and consequent low enrollment rates (Boult, Pacala and Boult, 1995). By 1982, the rising elderly population and their associated medical costs provided the impetus for Medicare to improve reimbursement rates to qualified health insurance plans, thereby increasing public awareness of this Medicare option (Wagner, 1996; Vanderlann, 1995).

Regulation of Medicare

The Department of Health and Human Services (DHHS) has the overall responsibility for the administration of the Medicare program. DHHS created the Health Care Financing Administration (HCFA) to ensure provision of quality care in the Medicare system (HCFA, 1997). HCFA's responsibilities are the formation of policy and procedures, contract oversight, operations and general financing (HCFA, 1997). As the managed care Medicare market was developed, HCFA's role was expanded to assume its' regulatory and administrative controls (HCFA, 1997).

Development of a Managed Care Medicare Plan

In an effort to shift some of its beneficiaries to managed care, HCFA examined three types of managed care plans: Competitive Medical Plans (CMP), Preferred Provider Organizations (PPO) and Health Maintenance Organizations (HMO). Competitive Medical Plans are plans that do not meet federal requirements and provide limited service. Most CMP's are located in rural areas. HCFA chose not to use these plans due to potential regulation problems and limited access (DeMichelle and Gottlich, 1996). Preferred Provider Organizations are plans that employ select physicians and contract with specific hospitals. Participants of this plan receive low cost care if they stay within the PPO network. If they chose to go outside the network, they must pay a significant portion of the medical costs. In a three year (1992-1995) HFCA sponsored study, researchers found that the PPO programs were of high cost with many administrative flaws (McIlrath, 1995). Health Maintenance Organizations are federally qualified plans that provide a select network of physicians and hospitals, yet provide a full range of services. HMOs are largely rooted in wellness programs and preventive medicine

(Aliberti and Deroulin, 1995). Of the three potential plans, HCFA chose HMO for managed care Medicare due to its extensive services and large coverage area. HCFA found that plans other than HMO's are controversial and may actually increase costs to the federal government, rather than generate savings. Other plans are also subject to fewer consumer protections and have more complex payment schedules (Feder and Moon, 1998). The Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982 authorized HCFA to contract with federally qualified HMOs (Kinney, 1995).

To be federally qualified, a Medicare HMO must meet stringent criteria.

1. HMOs must meet federal statutory, regulatory and contract requirements.
2. HMOs must serve at least 5000 people.
3. HMOs must offer at least all services provided by federal Medicare.
4. HMOs must have member grievance and appeal procedures (Kinney, 1995 p. 1178).

The Managed Care Medicare HMO

Medicare HMO plans are commonly known as managed care Medicare (MCM), and will be herein referenced as such.

To provide all services offered by federal Medicare, MCM bundles Part A and B into one benefit package. This creates low out-of-pocket costs, eliminates the need for a Medigap policy, and provides additional health benefits (DeMichelle, 1996). MCM are not permitted to retain savings through plan efficiencies, thereby enhancing benefits for the enrollees (White, 1997). MCM is required to collect information on its members and most plans use this as a data base to develop epidemiology based programs (Besdine, 1997). This allows MCM to offer preventive programs such as routine mammography,

prostate and colorectal screening and routine immunizations (Group Health Foundation, 1995; Vanderlann, 1995).

HCFA pays MCM 95% of the amount that HCFA would have paid to care for that beneficiary under traditional Medicare (Buntin, 1998; Kinney, 1995). This amount is calculated using a complicated formula known as the adjusted average per capita cost (AAPCC) that is primarily based on age, sex, welfare status, institutionalization and geographic area. AAPCC is published annually in the federal register (Fox, 1996).

Expansion of Managed Care Medicare

MCM plans are growing as rapidly as the individual number of beneficiaries. As of September 1997, there were 303 registered Medicare HMO plans, an increase of 56% from the preceding 10 month period (Sherman and Colenda, 1998).

In 1985, there were 300,000 MCM beneficiaries. In 1995, the number rose to 3.1 million (DeMichelle, 1996) and another 1 million enrolled in MCM in 1996 (Fisher, 1996; Lamphere, 1997). With a total of 5 million members, MCM experienced an unprecedented growth rate of 38% in a 15-month period between 1995-1996 (Brown University, 1997). The American Association of Health Plans (AAHP) report that 100,000 seniors continue to enroll in MCM each month (American Association of Health Plans, 1998). Researchers forecast that this trend will continue (Landers, 1999).

Federal Regulation of Managed Care Medicare

Because of this explosive growth, the General Accounting Office (GAO) is questioning the ability of HCFA to monitor this adaptation of the Medicare program (DeMichelle, 1996; Martin, 1998). To provide oversight, HCFA has employed a variety of measures to regulate MCM. A panel of experts, referred to as a Peer Review

Organization (PRO), assists HCFA with review of hospital medical records. This allows HCFA to target specific hospitals and physicians whose practice patterns differ from the norm. The PRO will then contact these providers and perform targeted compliance audits (Docteur, Colby and Gold 1996; Inglehart, 1992). HCFA requires MCM to collect their own statistics (Eli Research, 1996; Lohr, 1988). For internal validity and consistency, HCFA has developed a mandatory set of items known as the Health Care Data Information Set (HEDIS) (Docteur, 1996, Kang, 1997; George and Bearon, 1980). HEDIS requires plans to provide data on mammography, diabetic eye exams, smoking cessation programs, immunizations and a senior health survey (Kang, 1997).

This senior health survey is a measure of the functioning and well being of the enrollees. By HCFA mandate, it must be administered on a voluntary basis, only after the person has submitted an application for plan enrollment. This mandate is designed to prevent plans from prohibiting enrollment to those who have chronic and severe health conditions (Kang, 1997; Stewart and Ware, 1992), and is to be used for screening purposes only (Besdine, 1997; Vladek, 1995b).

Case mangers that are employed by the MCM use this screening information. (Wagner, 1996). The role of the case managers is dictated by the MCM (Group Health Foundation, 1995; Pacala, Boulton, Hepburn, Kane, Kane, and Malone, 1997), but typically provide oversight for high-risk members (Pacala, 1997; Roggin, 1997; Rubenstein, 1997). The case manger can coordinate the members' care and direct them to appropriate use of MCM resources (Martin, 1998; Roller and Allman, 1996; Williams, Elder, Seidman and Mayer 1997). Case managers can also promote continuity of care through solicitation of appropriate community agencies (Boulton, 1995; Pawlson, 1997; Reidel and Long, 1996).

HCFA also monitors MCM educational materials, application forms and marketing efforts. MCM must submit all proposed written materials for HCFA approval before they are issued to the public (Grimaldi, 1997; Neuman, Maibach, Dusenbury, Kitchman and Zupp, 1998). Further, in dealing with individual members with questionable mental status, MCM representatives must involve significant others or issue a mentation test before accepting any signed enrollment applications (Kinney, 1995).

Because MCM plans can differ dramatically, (Butler, 1995), HCFA has imposed legislation, noted as the Consolidation Omnibus Budget Reconciliation Act (COBRA), stating that members can disenroll from a plan for any reason and as often as every 30 days (Kinney, 1995; Pretzer, 1998). MCM disenrollment rates are considered to be an objective measure of quality of care (Riley, Ingber and Tudor, 1997). In 1997, the GAO found that disenrollment rates vary from 14.6% to 40%, depending on the MCM plan (Cleary and McNeil, 1998). In 1997, Riley, Ingber and Tudor studied disenrollment rates of MCM and found that disenrollment was higher in the first three months and was mainly associated with members who switched from one plan to another. This suggests that members frequently shop around for best pricing and coverage.

An important finding by Riley et al. (1997) was that people with chronic illness disenroll sooner, returning to the traditional Medicare plan. This implies that the chronically ill are a vulnerable population in the scope of MCM (Archer, 1998; Besdine, 1997; Morgan, Virnig, DeVito and Perisly, 1997.). An article by Kane (1996), supported by Friedland and Feder (1998), suggests that there are higher disenrollment rates among African Americans, the severely ill and the very old, suggesting that there is decreased access to care for these subgroups (Kane, 1996). This information highlights the need for

longitudinal and population based studies focusing on the availability of providers, the appropriateness of the medical care being provided and the outcome of these services (Morgan, 1997; Wholey, Burns and Lavizzo-Mourey, 1998).

Private Regulation of Managed Care Medicare

For any healthcare plan to succeed it must involve physicians. The GAO states that 77% of practicing physicians accept Medicare and managed care insurance plans (Besdine, 1997; Terry, 1997). The American Medical Association (AMA) is involved with HCFA to monitor physician involvement in the overall Medicare program. The AMA states that physicians have a moral and ethical responsibility to treat their patients appropriately and encourages physicians to identify and aggressively manage frail patients using prevention strategies and medical management regardless of the type of health care coverage (Kavesh, 1996; Sherman and Colenda, 1998). Further, the AMA states that physicians should encourage patients to utilize prevention programs and medical care routinely available in MCM plans (Watcher, Katz, Showstack, Bindman and Goldman , 1998).

Quality of Care Associated with Managed Care Medicare

The Journal of the American Medical Association reports that quality problems exist throughout the entire U.S. healthcare system, regardless of the type of insurance coverage. Work needs to be done to achieve uniform quality throughout the entire healthcare system, focusing on quality assessment and quality improvement (Brook, 1997).

Because it is a relatively new concept, managed care Medicare has been suspected of providing inferior care. This is an area of concern for consumers, providers and the

care plans, as compared to other forms of health care coverage. To monitor this situation, HCFA instituted the Agency for Health Care Policy and Research (AHCPR). This is the lead federal agency charged with supporting and conducting health service research (AHCPR, 1997). The AHCPR sponsored a five year study, the Consumer Assessment of Health Plans (CAHPS) (CAHPS, 1996), to identify health insurance plans that consistently offer high quality care for MCM (CAHPS, 1996) and to provide this information to the general public (Kang, 1997). CAHPS preliminary findings show that consumers desire to remain under the care of their current physician and to have minimal out-of-pocket costs (AHCPR, 1997; Sofacer, 1998; Watcher, 1998). To improve availability of this information, AHCPR developed a Computerized Needs-Oriented Quality Measurement Evaluation System (CONQUEST), an on-line resource that provides information on accessible, effective and safe means of care for the elderly population (CONQUEST, 1998).

Research findings by the American Association of Health Plans (AAHP) show that MCM plans “provide care comparable to or better than care provided by traditional Medicare” (AAHP, 1998). In 1997, Miller and Luft, found that quality of care provided in MCM was approximately equal to that in traditional Medicare, with similar prescribed treatment plans for patients with congestive heart failure, colorectal cancer, diabetes, hypertension and ambulatory care. The Center for Disease Control (CDC) concurs with Miller and Luft and state that for these diseases MCM provides equivalent or superior care than federal Medicare. The CDC elaborates that the coordinated and comprehensive nature of MCM services is superior to the episodic and fragmented care offered by traditional Medicare (AAHP, 1998). In 1997, Meng et. al. conducted a study that showed

traditional Medicare (AAHP, 1998). In 1997, Meng et. al. conducted a study that showed that MCM enrollees highly rated plan satisfaction, quality of care provided and physician skills. Further, a study conducted by Mathematica Policy Research for the Physician Payment Review Commission showed that 96% of the MCM beneficiaries rate their care as very good or excellent (AAHP, 1997). Additionally, this study compared MCM with traditional Medicare in four vulnerable areas: overall healthcare, physician's exam, physician availability and office accessibility. More than 90% provided good to excellent ratings while 2% were dissatisfied (AAHP, 1997). The need for this type of research will continue as the senior population continues to rise and the American healthcare system continues to change.

Summary

In conclusion, the MCM program is showing expansive growth. While HCFA is encouraging senior citizens to enroll in MCM, they are monitoring access and quality of care provided. Many studies have been done to investigate quality of care associated with this new phase of Medicare (Gourley and Duncan, 1998; Sherman, 1998). An article by Butler (1995), supported by Meng et. al. (1997), finds MCM are reporting high ratings for satisfaction, as well as, physician skills and prescribed plans of care (Cleary, and McNeil, 1988; Meng, 1997). Data collection and interpretation are important to ensure provision of necessary care and the quality associated with that care (Oberlander, 1997; Sherman, 1998). This research supports the assumption that MCM is a viable, feasible option for providing quality care for America's elderly population; and is the basis to investigate the hypothesis that similar findings will exist in the senior population living in Allegheny County, PA.

Chapter Three provides an outline of the methodologies used in the study. An explanation of the design, the sample population and measurement tool is discussed.

Chapter Four illustrates the descriptive data and relevant findings from the collected questionnaires. The significance of these findings are reported and discussed.

Chapter Five presents the conclusions and implications of the study. Recommendations for future research are proposed.

CHAPTER THREE

Methodology

Introduction

Chapter three provides an outline of the research methodologies used in the study to compare the perceptions of quality of care in a convenience sample of senior citizens living in Allegheny County, PA. It investigated the quality of care comparisons between a selected senior citizen population insured by managed care Medicare (MCM) and those participants enrolled in a federal Medicare (FM) plan. It also investigated the relationships between perceptions of quality of care and selected variables that are significant correlations of these perceptions. An explanation of the design, sample, measurement tool and the statistical methods used are discussed.

Research Design

A descriptive correlation research design was used in this study. A self-administered survey was conducted to determine the perceptions of quality of care compared to MCM and the federal Medicare plan.

Setting

This study was conducted at four congregate senior centers in Allegheny County, PA. A random sampling was done to select two urban centers within the city limits of Pittsburgh, PA and two rural centers located on the outer perimeters of Allegheny County, PA (The 1998 Bell Atlantic Telephone Directory). The participating rural centers were located in New Kensington, PA (the northeast corner of Allegheny County) and Penn Hills, PA (the eastern border of Allegheny County). Appendix A includes identification of the senior centers, their addresses and the directors' names.

Subjects

To obtain a reasonable estimate of population parameters, 200 participants, aged 65 and older, were selected from a convenience sampling. Four groups, chosen from community based congregate senior centers, comprised the sampling. The participants were divided into three age categories, as described by Rotstein, (1998), the “young old” aged 65-74, the “middle old” aged 75- 84, and the “old old” aged 85 and older.

Sampling Plan

Because the method of obtaining subjects for the study was a convenience sampling, the ability to detect significant relationships and differences would have increased as the sample size increased. To comply with requirements set forth by the authors of the commercial survey, a p value of .05 was used to determine statistical significance in this study (U.S. Department of Health and Human Services, 1997).

The four groups were divided into an equal sampling to give better variance estimates and were grouped as follows: 50 urban based participants with traditional Medicare, 50 urban based participants with MCM, 50 rural based participants with traditional Medicare and 50 rural based participants with MCM.

Ethical considerations and human subjects protection has been addressed during this research. Appendix B lists the precautions taken to ensure fair and just treatment of the participants and authorization from the Human Subjects committee.

Instrumentation

To obtain a suitable commercial instrument for this study, the U.S. Department of Health and Human Services was contacted. Because of its' relationship to quality of care, the Consumer Assessment of Health Plan Survey (CAHPS) was chosen. Since the CAHPS survey is a publication of the U.S. Department of Health and Human Services, it is not subject to copyright protections. A standard cover letter by John Eisenberg, M.D. is enclosed in Appendix C.

In exchange for permission to use the CAHPS survey instrument, the CAHPS committee requests a copy of the final research project (U.S. Department of Health and Human Services, 1997).

The original version of the CAHPS survey consisted of 88 questions. To emphasize the collection of responses related to quality of care, the survey was modified according to the specific guidelines listed in Appendix H of the CAHPS Reporting Kit (U.S. Department of Health and Human Services, 1997). The modified version, used in this study, consisted of 48 questions with an anticipated completion time of 20 minutes. Appendix D contains this survey instrument and the scoring legend.

Questions were structured to fit three specific categories. Seven items (numbered 1,2,26,27,28,29,48) described the health plan. Twenty-four items (numbered 7,11,13,14,21,22,23,24,25,32,33,34,35,36,37,38,39,41,42,43,44,45,46,47) characterized the subject. Seventeen items (numbered 3,4,5,6,8,9,10,12,15,16,17,18,19,20,30,31,40) depicted quality. Each question was asked in a multiple choice format with 13 questions rated on an informal Likert scale with the lowest response, "a", equal to 1 and the highest response, "f", equal to 5.

Procedure

The directors of four community based, congregate senior centers were contacted to obtain written consent to survey its' attendees. Using the random sampling method described above, the four centers were chosen.

In a telephone conversation, the directors provided information on the hours of operation, characteristics of the population served and peak hours of attendance. All centers operated on a Monday through Friday daytime, business-hour schedule. Specific days and times, over a one-week period, were arranged to administer the survey instrument. The data collection was scheduled to coincide with planned center activities, when requested by the administrative director. A detailed cover letter was provided to explain the purpose and nature of the study and the credentials of the researcher. The directors of each center provided individual written consent. These are enclosed in Appendix A.

While in the center, the researcher observed each attendee. The attendees were approached individually and questioned about age, insurance type and interest in voluntary participation in the study. The senior attendees who consented to participate in the survey were escorted to a quiet area of the center and were given individual, written questionnaires and pens. They were told to keep the pen in appreciation for their participation.

While written instructions are listed on the survey instrument, the following verbal instructions were also given.

This is a study to examine if you believe that your insurance plan provides quality of care. This is an anonymous, confidential, voluntary survey. If you choose not to finish it, you may leave and take your survey form with you. Please do not put your name on

the survey. If anyone needs help with any of the question or has trouble seeing the print, please raise your hand and you will be assisted by this researcher. This survey will take approximately 20 minutes to complete. When you are finished, please place it in the box on this table. No one will know your answers. Thank you for participating in this research project.

When they were completed, the participants placed the surveys in a sealed, slotted box that was placed on a table in the front of the room. The researcher remained in the room until all surveys were collected. Before leaving, all research materials were gathered and the participants and staff were verbally thanked. A follow up thank you letter was sent to the director of each participating center. (Appendix A).

A total of 200 (N=200) surveys were distributed. One hundred seventy seven surveys were successfully completed, for a return rate of 88%. All surveys were administered and retrieved by the researcher at the time of data collection.

Data Analysis

The data sets were analyzed using the Statistical Analysis Systems (SAS) for Windows program. Variables were assigned. Across all testing, the dependent variable was perception of quality of care (UQC and RQC). The independent sociodemographic variables were identified to be education level (ED1, ED2), race (AA, W), marital status (M, NM), age (AGE1, AGE2, AGE3) and sex (M, F). All variables were analyzed for relationships and differences using descriptive statistics, logistical regression and a proportional odds model developed using the SAS computer package. All equations and SAS commands are listed in Appendix E. Descriptive statistics were collected for survey question 48, where comments were solicited.

Summary

In this chapter, research methodologies were used to compare the perceptions of quality of care associated with MCM and federal Medicare (FM) and its' relationships to the selected variables. Data obtained from this study provided a baseline for the insured, ambulatory, senior citizen population of Allegheny County, PA.

Chapter Four provides the statistical analysis and relevant findings of the collected data. The significance of these findings are reported and discussed.

Chapter Five presents the conclusions and implications of the study. Recommendations for future research are proposed.

CHAPTER FOUR

Analysis of Data

Introduction

Information from the completed senior health plan survey was used to determine perceptions of quality of care associated with managed care Medicare and federal Medicare. The objective of this analysis is to determine the relationships among type of insurance plan, perceptions of quality associated with that plan and covariates.

Demographic Profile of the Subjects

A total of 200 (N=200) questionnaires were distributed to a convenience sampling of senior citizens attending four congregate senior citizen centers in Allegheny County, PA. One hundred seventy seven questionnaires were completed, for a response rate of 88%. The socioeconomic data collected are summarized in Table 1 that follows.

Table 1: The socioeconomic data for managed care Medicare (MCM) and federal Medicare (FM) by number, percentage and significance.

Variable	Number MCM	Percentage of MCM sample	Number FM	Percentage of FM sample	Percentage of total sample	Model significance
<u>Age</u>						
65-74 years	44	45	34	43	44	NS*
75-84 years	47	47	32	42	45	NS*
85+ years	8	8	12	15	11	NS*
<u>Sex</u>						
Male/M	40	41	41	52	46	NS*
Female/F	59	59	37	47	54	NS*
<u>Race</u>						
AA	18	18	22	28	23	NS*
Caucasian	81	82	56	72	77	NS*
<u>Marital Status</u>						
Married	42	42	31	40	41	NS*
Not Married	57	58	47	60	59	NS*
<u>Income Class</u>						
20-29K	17	17	20	26	21	NS*
30-39K	36	36	30	38	37	NS*
40-49K	20	20	23	30	24	NS*
50-59K	10	10	11	14	12	NS*
<u>Education Level</u>						
High School	74	75	65	83	78	Y**
College	25	25	13	16	21	Y**

*NS= not significant by proportional odds model.

**Y= significant by proportional odds model.

Descriptive Statistics Analysis

The socioeconomic data reflected that 44% of the total subject population were in age range 1 (65-74 years), 45% were in age range 2 (75-84 years) and 11% were in age range 3 (85 years and above). The ratio of men to women was 46% male to 54% female. Only two racial classes were identified in the sample population—23% of the respondents were African American and 77% of the respondents were Caucasian. Marital status was classified as either married (41%) or not married (59%). Four income classes were identified where 82% of the respondents reported highest yearly lifetime earnings to be between \$20-49,000 per year. Seventy eight percent of the respondents reported an 8th to 12th grade education and 21% reported at least “some” college education.

Rotstein (1999) reports that MCM accounts for 29% of the senior citizen population in Allegheny County, PA. The composition of this sample was 56% MCM and 44% FM. This is significantly higher than the senior population of Allegheny County, PA, reported as a whole.

Throughout the literature, there are perceived concerns that the transition to managed care Medicare requires changing existing physician relationships and reducing the access to specialty care. (AHCPR, 1997; Miller and Luft, 1997, Sofacer, 1998; Watcher, 1998.) These concerns are not reflected in this study sample. Ninety three percent of the sample stated that they were able to maintain the services of their current physician and 95% readily reported access to specialty care.

The Proportional Odds Model Analysis

The response variable (RATEPLAN) is the reported experience with health insurance plan measured on a scale from one (worst) to five (best). A histogram, and follow up two sample t-testing, of this response was done and showed that the assumptions of normality were not met; thus usual regression methods (including ANOVA) are not appropriate statistical testing for these responses. Since the response is categorical and ordered, a proportional odds model could be used to analyze this data. Using SAS, a potential proportional odds model was identified. This model assumes a linear model for the log odds of observing a response $\geq j$ given covariates x_1 through x_k ,

$$\log\left(\frac{P(Y \geq j | x_1, K, x_k)}{1 - P(Y \geq j | x_1, K, x_k)}\right) = \alpha_j + \beta_1 x_1 + K + \beta_k x_k .$$

The interpretation is that the odds of observing response $\geq j$ are $\exp(\beta_1(x_{12} - x_{11}) + K + \beta_k(x_{k2} - x_{k1}))$ times higher at (x_{12}, \dots, x_{k2}) than at (x_{11}, \dots, x_{k1}) .

Using nuisance parameters, alpha1-4, in this model, a goodness of fit test showed adequate fit (p=0.08) of the assumption of the proportional odds model. Table 2, below, shows the results from fitting the proportional odds model using forward stepwise variable selection. Appendix E contains the SAS commands for this model.

Table 2: Results from fitting the proportional odds model using forward stepwise variable selection.

Parameter	Estimate	Standard Error	P-value
Alpha1	-10.13	1.06	0.0001
Alpha2	-7.99	0.96	0.0001
Alpha3	-6.28	0.87	0.0001
Alpha4	-4.19	0.80	0.0001
HPSERV	1.70	0.52	0.0011
RATEMD	0.72	0.17	0.0001
MDTIME	1.07	0.21	0.0001
EDUC	0.43	0.18	0.0162

The insurance plan quality rating (RATEPLAN) is predicted by the subjects rating of the care provided by their doctor (RATEMD), whether the plan provided help, equipment and services needed (HPSERV), the perception that the doctor spent sufficient time with the patient (MDTIME), and the education level (EDUC). Since the covariate coefficients are all positive, the odds of observing favorable service rating, higher doctor rating, higher rating of time spent with the doctor and higher levels of education yield a higher rating of plan (RATEPLAN). The average plan rating for MCM was 4.22 (s.d.=0.76) while the average rating for FM was 2.95 (s.d=1.39). Histograms of this are shown in Figure 1 and Figure 1A.

Figure 1: Histograms showing the distribution of plan rating by plan type where one is the worst possible plan and five is the best possible plan. Those covered by managed care Medicare appear to rate their plan more highly than those under federal Medicare.

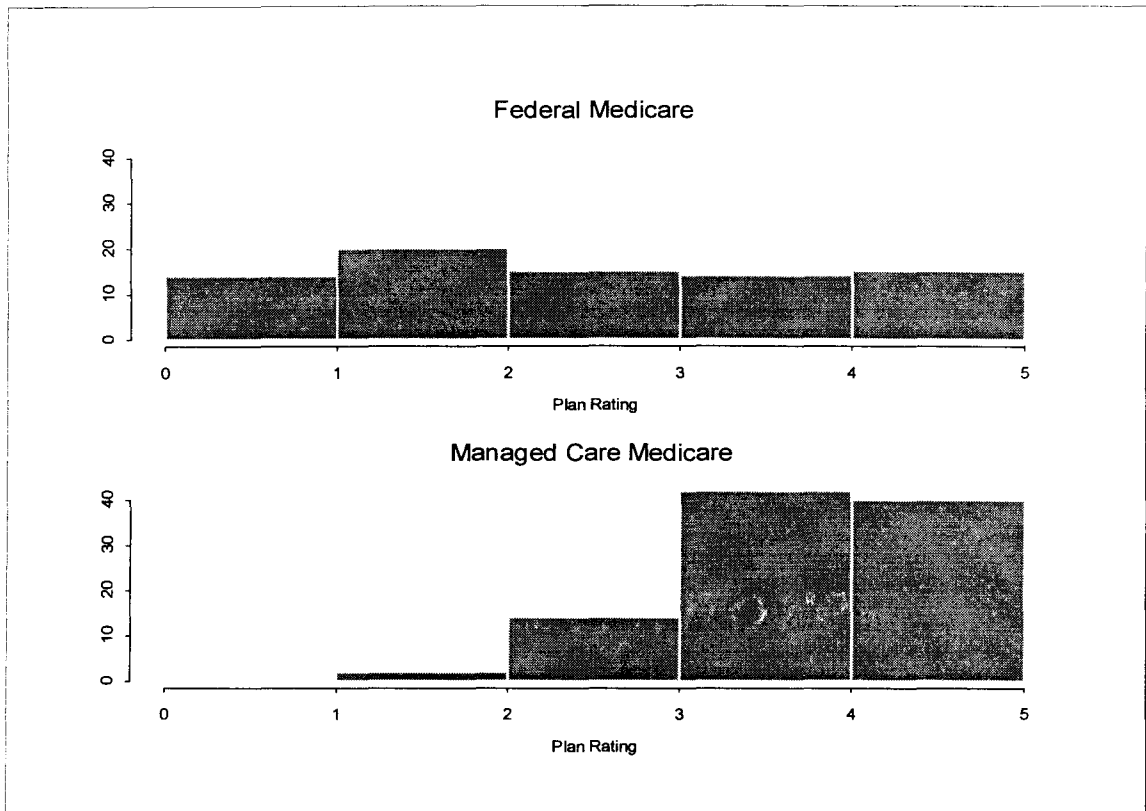
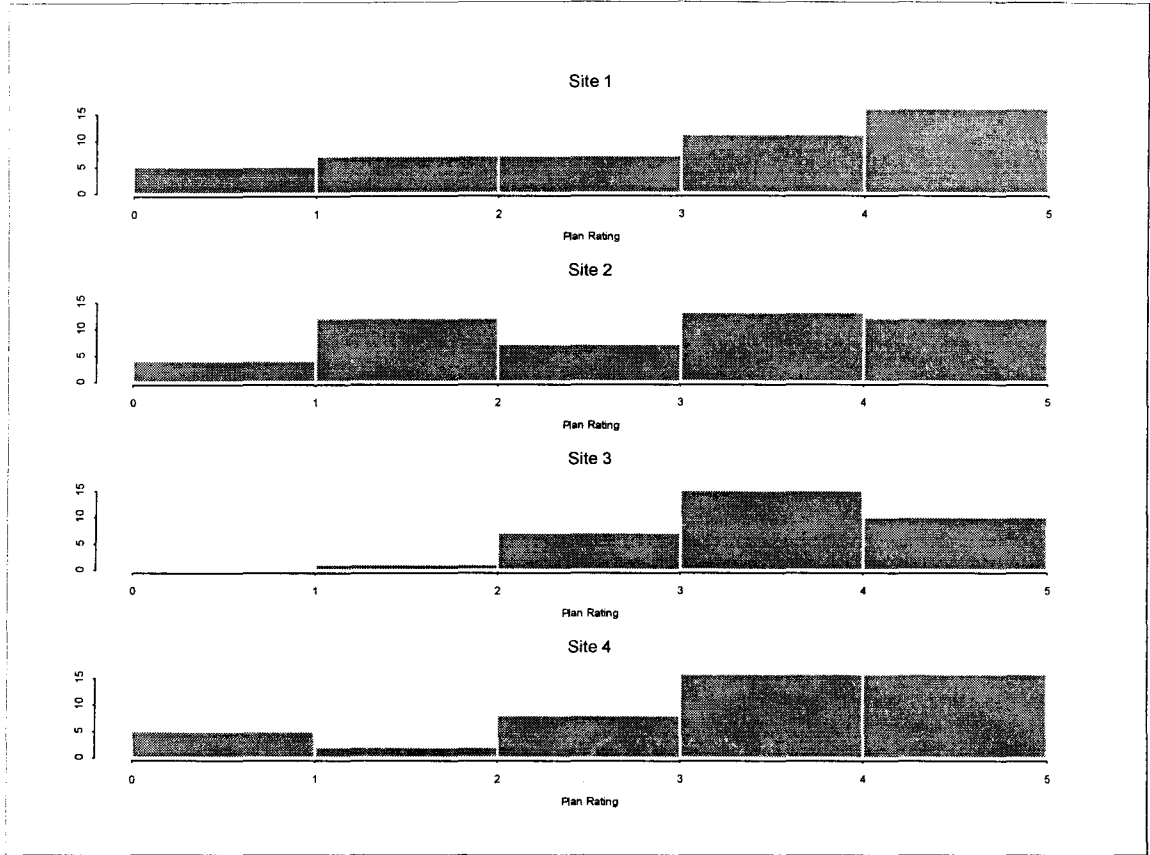
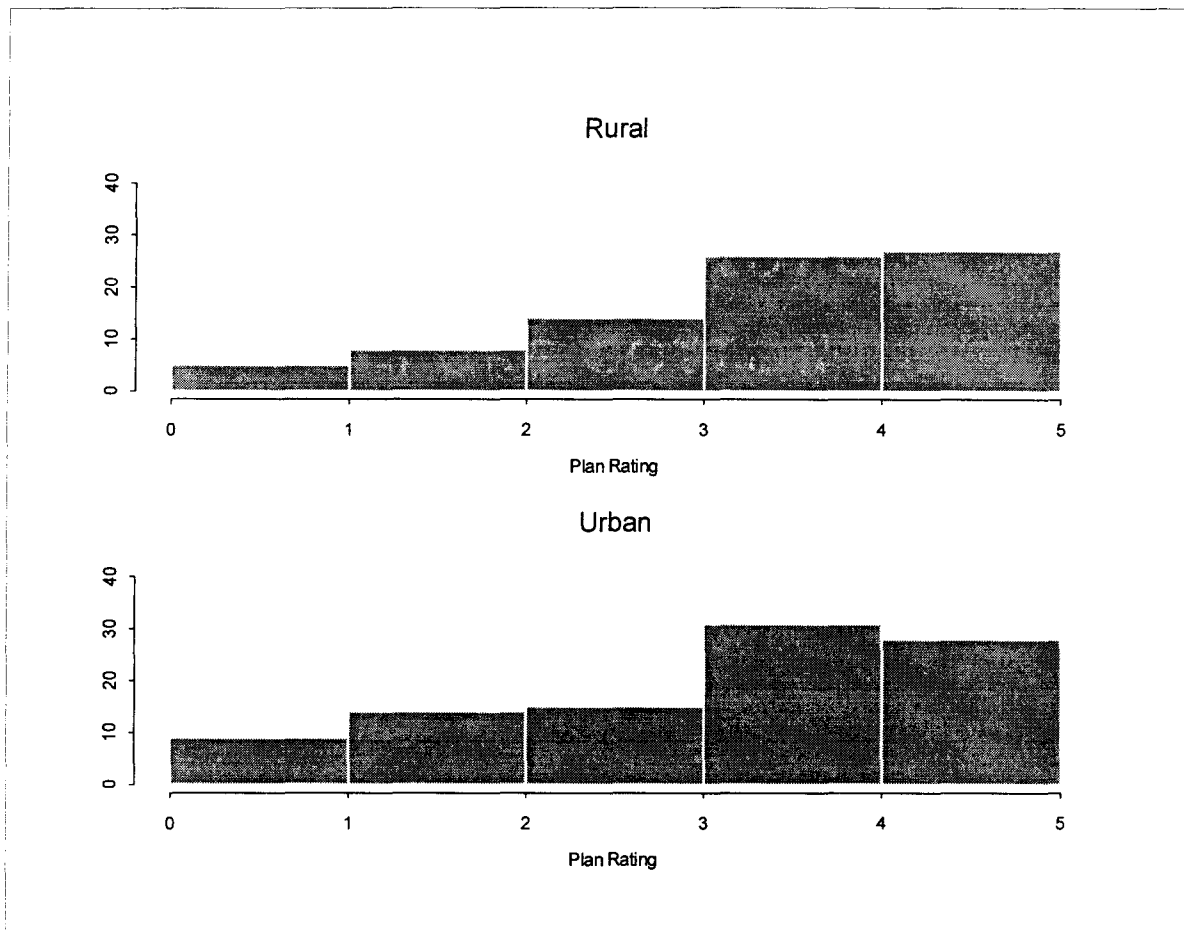


Figure 1A: Histogram showing the cumulative distribution of plan rating by site where one is the worst possible plan and five in the best possible plan. Site 1 and Site 3 are rural. Site 2 and Site 4 are urban.



To determine if geographical differences affect perceptions of quality of care, two urban and two rural sites were analyzed. Fifty six percent of the urban subjects elected MCM while 44% remained with FM. Forty five percent of the rural subjects elected MCM while 55% remained with FM. Using the proportional odds model of analysis, there is no significant difference in the perceived quality of care among these geographical areas, thus Urban Quality of Care (UQC)=Rural Quality of Care (RQC). A representation of this is listed in Figure 2.

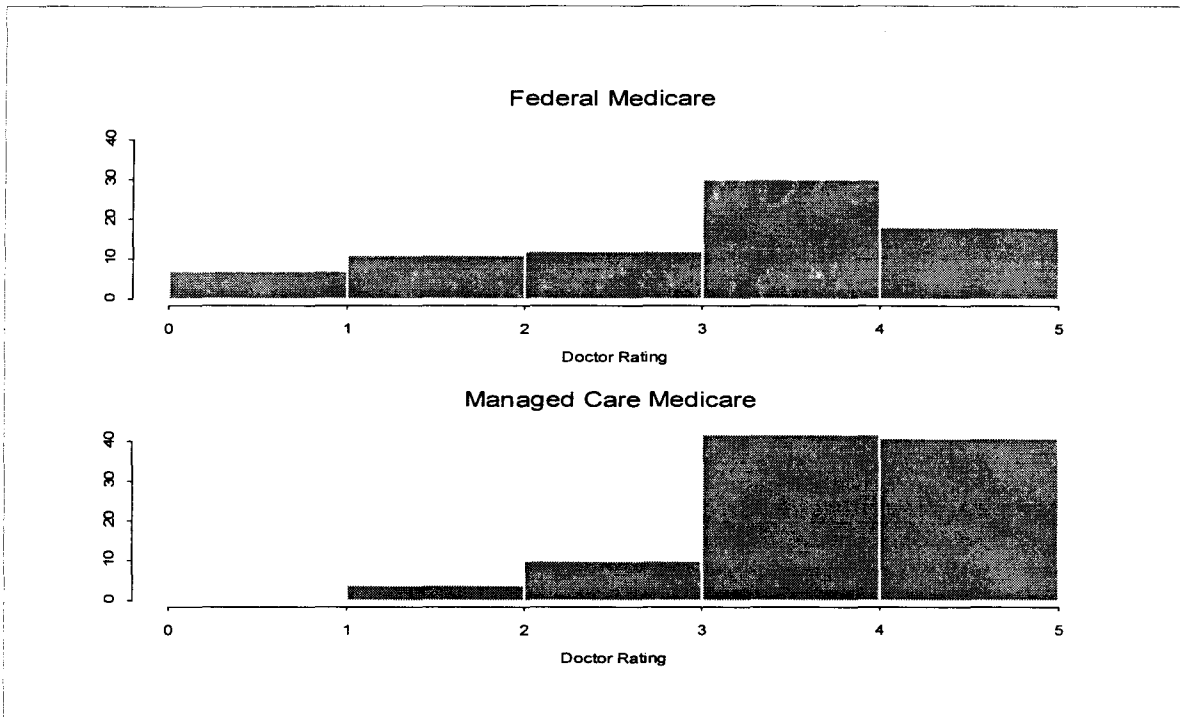
Figure 2: Histograms showing the distribution of plan rating, where one is the worst possible plan and five is the best possible plan, for rural vs. urban locations supporting the conclusion of no significant effect of rural vs. urban setting.



To examine perceptions of quality of medical care provided by their physicians, subjects were asked to rate the skills of their physician on a Likert scale with the lowest response being one and the highest response being five. Eighty seven percent of the respondents rated their physician skills as good to excellent. Those subjects with MCM reported higher skill levels than those with FM. The proportional odds model showed that the effect of plan type had a significant effect on the odds of reporting a favorable doctor rating. Estimate 0.72, $X^2(1, N=177)=17.5$, $p=.0001$.

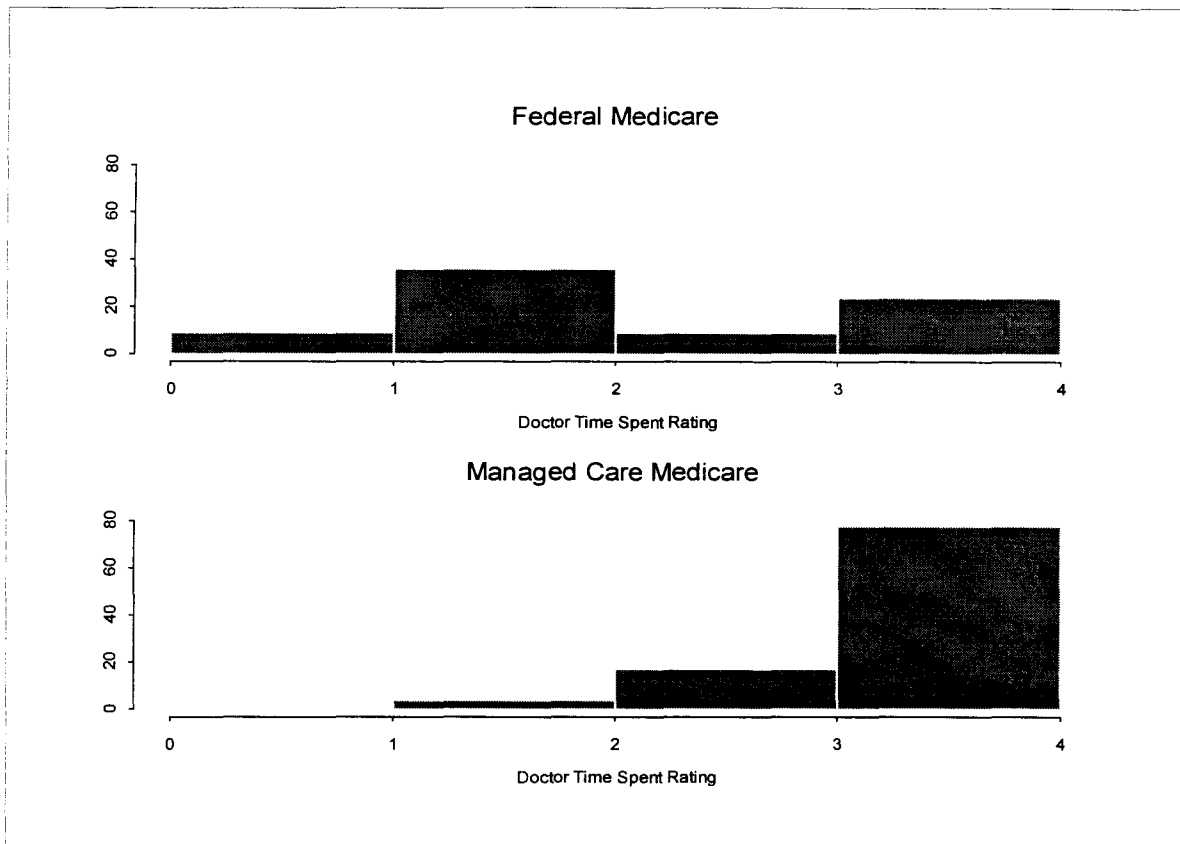
Figure 3 demonstrates this in histogram form.

Figure 3: Histograms showing the distribution of doctor rating by plan type where one is the worst possible medical care and five is the best possible medical care. Doctors appear to be more highly rated by subjects in managed care Medicare.



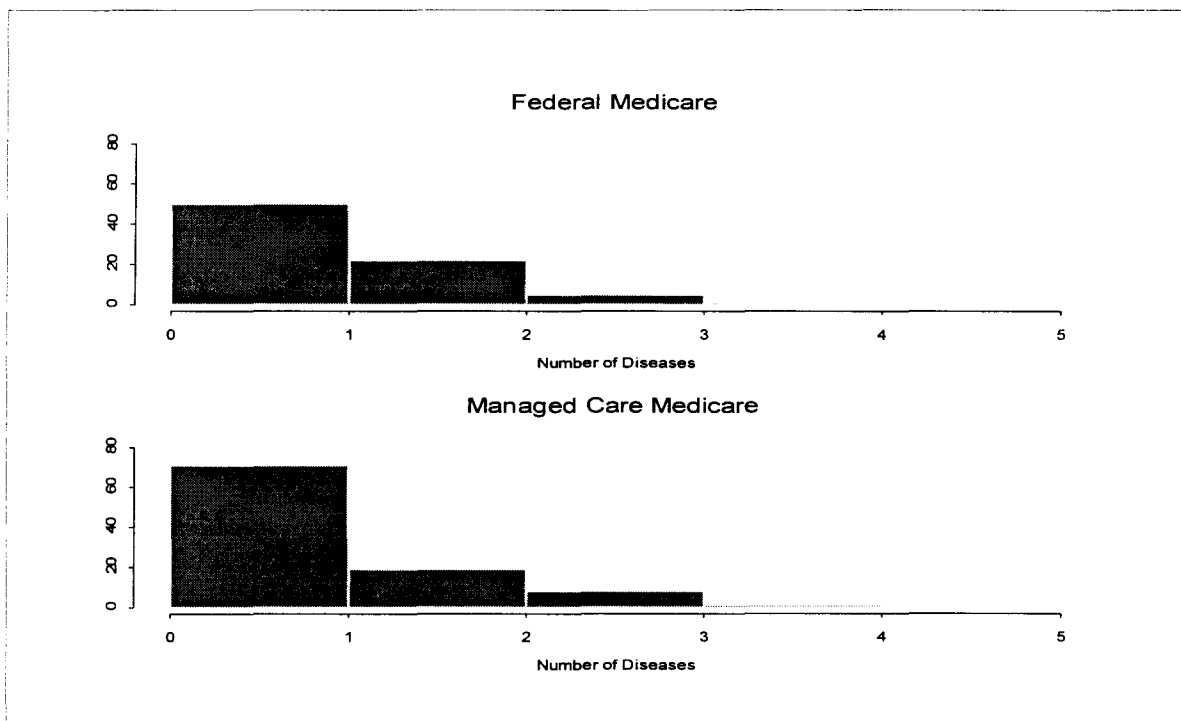
An indicator, of perceived quality of care referenced throughout the literature, is the amount of time a physician spent with the patient while in the physician office. (Miller and Luft, 1998; Watcher, 1998.) This indicator was rated on a Likert scale with the lowest response being one and the highest response being four. Ninety six percent of MCM stated that their physician “usually or always” spends enough time with them, while 42% of FM stated the same response. The proportional odds model showed that the effect of plan type had a significant effect on the odds of reporting an adequate amount of time spent with their physician. Estimate 1.07, $X^2(1, N=177)=24.8, p=0.0001$. This histogram is described in Figure 4.

Figure 4: Histograms showing the relationship between plan type and rating of doctor time spent where one is the least amount of time spent and five is the most amount of time spent. Those in managed care Medicare show higher ratings of time spent with the doctor.



One of the criticisms of MCM, listed in the literature, is that senior citizens who are chronically ill do not elect MCM coverage (Kane, 1996). To examine this possibility, five chronic diseases were chosen for analysis (U.S. Department of Health and Human Services, 1997). Each subject was asked if a series of questions to indicate the following: heart disease (HRHD), cancer (HRCA), stroke (HRCVA), lung disease (HRLD) and/or diabetes mellitus (HRDM). Responses were rated as "no" or "yes" and scored zero and one respectively. These variables were summed and each of the subjects was scored from 0/5, the most healthy, to 5/5, the most sick. The resultant histogram (Figure 5) showed that there is no statistical significance between plan type and the summed number of existing chronic illnesses.

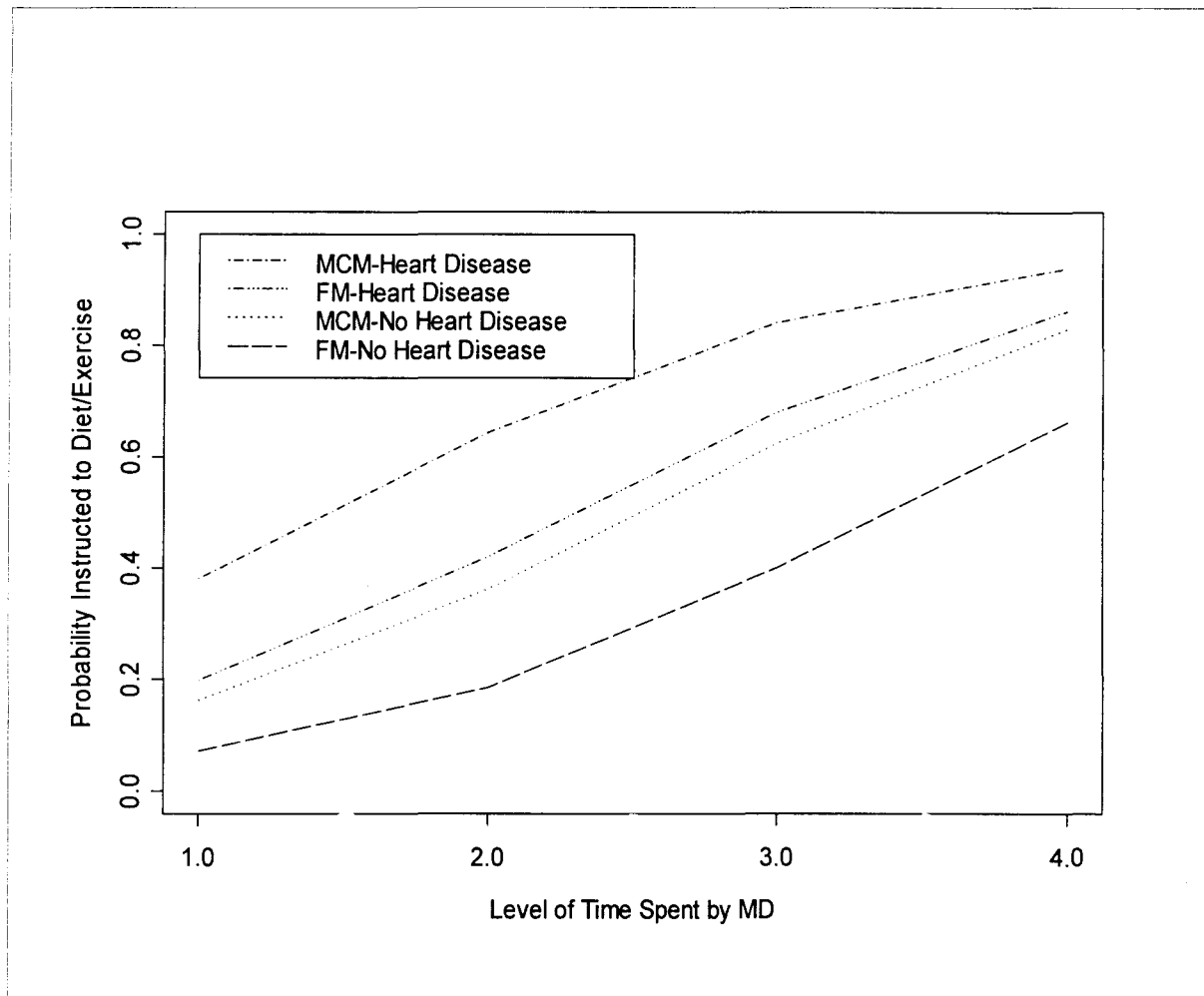
Figure 5: Histogram showing the relationship between number of members with chronic diseases and plan type. There appears to be no significant difference between the two plans.



Logistic Regression

Managed care Medicare is highly rated due to its' support of prevention programs (AAHP, 1998). Three preventive education parameters (diet, exercise and smoking cessation) were chosen for analysis (U.S. Department of Health and Human Services, 1997). Diet and exercise education was compared to plan type and heart disease. A logistic regression was calculated, yielding results that are statistically significant and demonstrate that subjects with MCM with known heart disease spend more time with their physician and receive more diet and exercise education than the FM counterparts. Estimate 1.15, $X^2(1, N=177)=7.03, p=0.0080$.

Figure 6: Probability plot of diet and exercise education versus time spent by physician in respondents with and without heart disease. Those with MCM received more diet and exercise education than those with FM.



While smoking cessation advice/education was included as a potential indicator of perceived quality of care, it was not identified as a significant variable in the proportional odds model. Representing a small percentage of the subjects, smokers (N=38), comprised only 21% of the total population, thus indicating no measurable significance.

Fifteen percent of the respondents listed positive and negative comments. Positive comments were listed as MCM: good care (7%), low cost (3%), eyeglass coverage (2%), good doctors (2%), pharmacy plan (2%) and convenience (1%); FM: universal acceptance (3%), convenience (2%) and good doctors (2%). Negative comments were listed as: MCM: use of formulary (2%), referrals (1%); FM: high cost of coinsurance (6%), limited equipment coverage (1%), no pharmacy plan (1%).

Summary

A total of 200 questionnaires were distributed to a convenience sampling of senior citizens attending urban and rural based congregate senior citizen centers in Allegheny County, PA. One hundred seventy seven were returned for a response rate of 88%. Site location did not appear to have a significant influence on perceived quality of care. An analysis of the data show that the results were not normally distributed, thus traditional statistical analysis could not be done. A proportional odds model was used to evaluate the data. This analysis showed that four variables (HPSERV, RATEMD, MDTIME, and EDUC) predicted plan rating. A graphic model showing these relationships is shown in Figure 7.

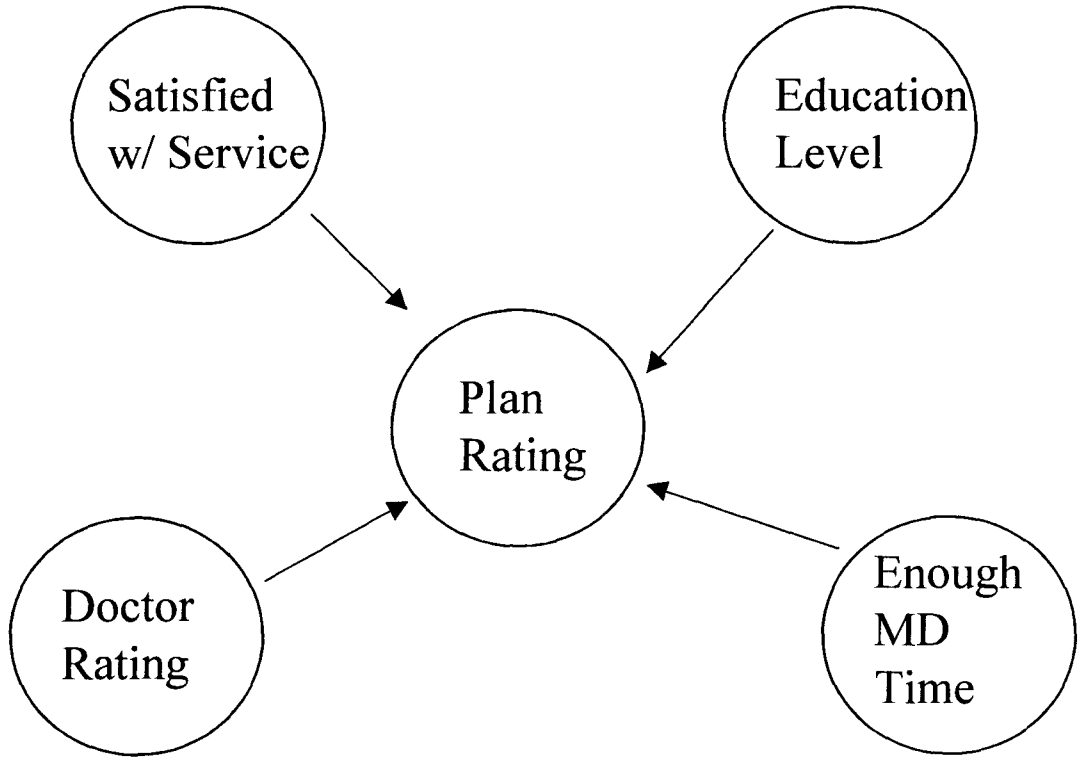
MCM shows consistently high ratings based on the descriptive statistics. Ninety three percent of the population was able to retain the services of their selected physician. Ninety five percent received appropriate specialty care. When rating physician skills as

good to excellent, those subjects with MCM scored 87%, whereas 60% FM reported this same response. Ninety six percent of MCM respondents reported that their physician “usually or always” spent enough time with them while only 42% of FM responded the same way. MCM members consistently reported more diet and exercise education.

These data analyses revealed that the respondents with MCM had overall positive responses and supports the hypothesis that those with MCM believe that they are provided with a quality of medical care better than that provided by FM.

This study is further summarized in Chapter Five.

Figure 7: Graphical depiction showing relationships among the variables impacting plan rating.



CHAPTER FIVE

Summary, Conclusions and Recommendations

Summary

In providing healthcare for approximately 13% of the national population, federal Medicare spent \$213 billion in 1997 (HCFA, 1998). As both the elderly population and the cost of healthcare continue to rise, the available funds continue to dwindle. Experts predict that the existing Medicare program will be bankrupt by the year 2001—leaving virtually no healthcare coverage for American senior citizens (Schwartz, 1995). In an attempt to curb Medicare spending, the U.S Department of Health and Human Services enacted legislation to allow commercial insurance plans to offer a managed care Medicare option (HCFA, 1997). Because of low out-of-pocket costs associated with MCM, senior citizens are rapidly converting to these plans.

The purpose of this study was to identify the perceptions of quality of care in a convenience sample of 200 senior citizens living in Allegheny County, PA. Selected sociodemographic variables: age, gender, race, income, marital status and education level were investigated to show if linear relationships existed between those factors. A survey instrument created by the U.S. Department of Health and Human Services, known as the Consumer Assessment of Health Plan Survey, was adapted for this research. Information from the 177 completed surveys was used to determine perceptions of quality of care associated with MCM and FM. The survey included an intrinsic variable for rating of quality of health plan. Data analysis of this variable showed that the data were not normally distributed, thus usual regression methods were not appropriate. A proportional odds model of analysis showed that perceived

rating of quality of health plan was predicted by the ratings of the physicians' skills, whether the plan provided the services needed, the amount of time spent with the physician and the subjects' education level.

Conclusions

Information obtained from the completed Senior Health Plan Surveys revealed the following:

- Ninety three percent of the respondents were able to retain the services of their physician.
- Ninety five percent readily reported access to specialty care.
- The overall plan quality rating is predicted by: the subjects' rating of their physicians' skills, whether the plan provided the services needed, the amount of time the physician spent with them and the subjects' education level. (See graphical model in Figure 7.)
- MCM members tend to rate their plans higher than those covered by FM.
(See histogram in Figure 1.)
- Geographical area held no significance in plan rating. (See histogram in Figure 2.)
- MCM members rate their physicians' skills more highly than those covered by FM.
(See histogram in Figure 3.)
- Physicians are rated as spending more time with their MCM patients than their FM patients.
(See histogram in Figure 4.)
- There is no significant difference in number of chronic illnesses between the two plan types.
(See histogram in Figure 5.)
- MCM members receive more diet and exercise education than those covered by FM.
(See histogram in Figure 6.)

Implications

The respondents in this study, who have been able to retain the services of their original physician, have shown an overall positive response toward the quality of care provided by MCM. This is consistent with the literature findings and suggests that MCM is a feasible alternative to FM within the limitations of this study.

Research Recommendations

Similar studies to determine perceptions of quality of care associated with MCM and FM need to be conducted in Allegheny County, PA. It is not known whether the perceptions of this sample are reflective of the cross section of all of the senior citizens of Allegheny County, PA. The subjects, in this sample were generally ambulatory, social beings with some enthusiasm for life, and these traits may have influenced their survey responses. This type of study needs to be extended to the homebound and/or institutionalized population of Allegheny County, PA, as well.

While this study can serve to increase the awareness that MCM is a feasible option for the senior citizen population of Allegheny County, PA, additional research needs to be conducted to determine if these findings are representative of this population as a whole.

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Appendix A

Center Identification and Permission

Center Identification

Site 1

Alle-Kiski Valley Senior Citizen Center
1039 Third Ave
New Kensington, PA 15068
Director: Carrie Murray

Site 2

Elder Ado Senior Citizen Center
320 Brownsville Road
Pittsburgh, PA 15210
Director: Rose Trautvatter

Site 3

Penn Hills Senior Community Center
147 Jefferson Road
Pittsburgh, PA 15235
Director: Corinne Puszko

Site 4

National Steelworkers Old Timers Fund
500 Market Street
McKeesport, PA 15132
Director: Kevin Duffy

RECEIVED

MAR 05 1999

March 3, 1999

Dear Ms. Murray,

My name is Mary Striegel and I am a graduate student at the Youngstown State University majoring in Health and Human Services. As a partial requirement for a Master's degree, I am conducting a survey to determine the senior citizen's perception of quality of care in both managed care Medicare and traditional Medicare. This study will enable me to complete thesis requirements, and more importantly, identify information that may have a significant impact on the health insurance offered in Allegheny County, PA.

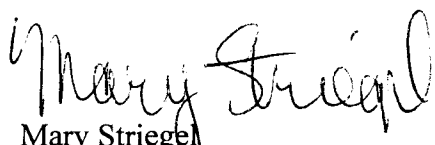
I am asking for your permission to enter your senior center and administer questionnaires to your senior citizen attendees. The questionnaire consists of 48 questions and will take approximately 20 minutes to complete. Your decision to allow me to collect this information is completely voluntary.

This study is for research purposes only and all responses will be held strictly confidential. No one will be asked to identify him or herself in any way. The findings will be reported in aggregate form only, no individual responses will be used.

A summary of the results of the study will be available upon request. You may obtain a copy by contacting me at the phone number listed below. If you have any questions about this study, please contact me or my faculty advisor at the phone numbers listed below.

If you agree to allow me to conduct this survey at this senior citizen center, please sign one copy of this letter and return to me in the self addressed, stamped envelope. Thank you, in advance, for your time and cooperation in this research study.

Sincerely,

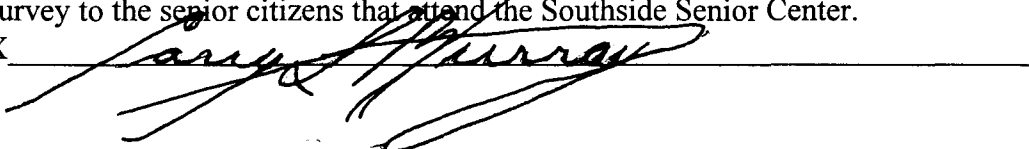


Mary Striegel
404 East Main Street
Evans City, PA 16033
(724) 538-4232

Carolyn Mikanowicz, Ph.D.
Faculty Advisor
The Youngstown State University
One University Plaza
Youngstown, Ohio 44555
(330) 742-3658

I give my permission for Mary Striegel to administer an anonymous, confidential, voluntary survey to the senior citizens that attend the Southside Senior Center.

X



**Alle-Kiski Valley
Senior Citizens Center, Inc.**

1039 THIRD AVENUE — NEW KENSINGTON, PA 15068

PHONE: 335-8597



TO: TO WHOM IT MAY CONCERN

FROM: FRAN MIKOLAS, DIRECTOR *FM*

RE: SURVEY

DATE: APRIL, 1999

MARY STRIEGEL HAD PERMISSION TO COME TO THE ALLE-KISKI VALLEY SENIOR CITIZENS CENTER, INC. TO DO AN ANONYMOUS SURVEY IN APRIL, 1999.

Fran Mikolas

FM/gc

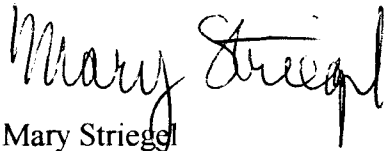
cc: file

404 East Main Street
Evans City, PA 16033
(724) 538-4232
May 5, 1999

Ms. Carrie Murray
Alle-Kiski Senior Citizen Center
1039 Third Avenue
New Kensington, PA 15068

Dear Ms. Murray,

I want to take this opportunity to thank you for allowing me to enter this senior citizen center and survey your participants. I not only learned a great deal, but I met some wonderful people. It is my hope that the information that I collected will be of valuable importance as the face of modern healthcare changes. If my research article is accepted for publication, I will share the information with your center. If there is any additional information that you made need, in the future, please do not hesitate to call me. Thank You.

A handwritten signature in cursive script that reads "Mary Striegel". The signature is written in black ink and is positioned above the printed name.

Mary Striegel

March 12, 1999

Dear Ms. Trautvatter,

My name is Mary Striegel and I am a graduate student at the Youngstown State University majoring in Health and Human Services. As a partial requirement for a Master's degree, I am conducting a survey to determine the senior citizen's perception of quality of care in both managed care Medicare and traditional Medicare. This study will enable me to complete thesis requirements, and more importantly, identify information that may have a significant impact on the health insurance offered in the western Pennsylvania area.

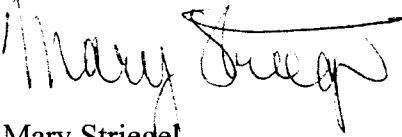
I am asking for your permission to enter your senior center, perform a free blood pressure screening and administer a general questionnaire to your senior citizen attendees. The questionnaire will take approximately 15 minutes to complete. Your decision to allow me to collect this information is completely voluntary.

This study is for research purposes only and all responses will be held strictly confidential. No one will be asked to identify him or herself in any way. The findings will be reported in aggregate form only, no individual responses will be used.

A summary of the results of the study will be available upon request. You may obtain a copy by contacting me at the phone number listed below. If you have any questions about this study, please contact me or my faculty advisor at the phone numbers listed below.

If you agree to allow me to conduct this survey at this senior citizen center, please sign one copy of this letter and return to me in the self addressed stamped envelope. Thank you, in advance, for you time and cooperation in this research study.

Sincerely,



Mary Striegel
404 East Main Street
Evans City, PA 16033
(724) 538-4232

Carolyn Mikanowicz, Ph.D.
Faculty Advisor
The Youngstown State University
One University Plaza
Youngstown, Ohio 44555
(330) 742-3658

I give my permission for Mary Striegel to administer an anonymous, confidential, voluntary survey to the senior citizens who attend this senior center.

X Rose Trautvatter

Elder Ado Senior Citizen Center

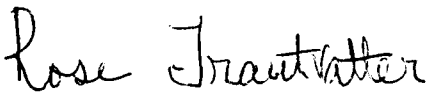
320 Brownsville Road Pittsburgh PA 15210

April 1999

To Whom It May Concern:

I give permission for Mary Striegel to enter this senior center and administer an anonymous and confidential survey to the senior citizens participating in planned center activities.

Sincerely,

A handwritten signature in cursive script that reads "Rose Trautvatter".

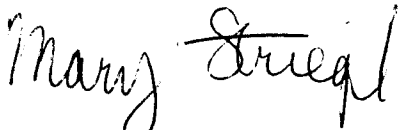
Rose Trautvatter
Program Director

404 East Main Street
Evans City, PA 16033
(724) 538-4232
May 5, 1999

Ms. Rose Trautvatter
Elder-Ado Senior Citizen Center
320 Brownsville Road
Pittsburgh, PA 15210

Dear Ms. Trautvatter,

I want to take this opportunity to thank you for allowing me to enter this senior citizen center and survey your participants. I not only learned a great deal, but I met some wonderful people. It is my hope that the information that I collected will be of valuable importance as the face of modern healthcare changes. If my research article is accepted for publication, I will share the information with your center. If there is any additional information that you made need, in the future, please do not hesitate to call me. Thank You.

A handwritten signature in cursive script that reads "Mary Striegel". The signature is written in black ink and is positioned above the printed name.

Mary Striegel

March 12, 1999

Dear Corinne,

My name is Mary Striegel and I am a graduate student at the Youngstown State University majoring in Health and Human Services. As a partial requirement for a Master's degree, I am conducting a survey to determine the senior citizen's perception of quality of care in both managed care Medicare and traditional Medicare. This study will enable me to complete thesis requirements, and more importantly, identify information that may have a significant impact on the health insurance offered in the western Pennsylvania area.

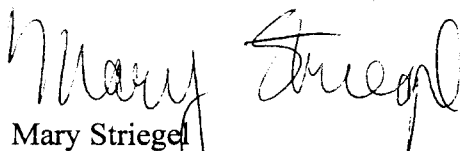
I am asking for your permission to enter your senior center, perform a free blood pressure screening and administer a general questionnaire to your senior citizen attendees. The questionnaire will take approximately 15 minutes to complete. Your decision to allow me to collect this information is completely voluntary.

This study is for research purposes only and all responses will be held strictly confidential. No one will be asked to identify him or herself in any way. The findings will be reported in aggregate form only, no individual responses will be used.

A summary of the results of the study will be available upon request. You may obtain a copy by contacting me at the phone number listed below. If you have any questions about this study, please contact me or my faculty advisor at the phone numbers listed below.

If you agree to allow me to conduct this survey at this senior citizen center, please sign one copy of this letter and return to me in the self addressed stamped envelope. Thank you, in advance, for you time and cooperation in this research study.

Sincerely,



Mary Striegel
404 East Main Street
Evans City, PA 16033
(724) 538-4232

Carolyn Mikanowicz, Ph.D.
Faculty Advisor
The Youngstown State University
One University Plaza
Youngstown, Ohio 44555
(330) 742-3658

I give my permission for Mary Striegel to administer an anonymous, confidential, voluntary survey to the senior citizens who attend this senior center.

X Corinne Fungo



Municipality of PENN HILLS

A HOME RULE COMMUNITY

MUNICIPAL BUILDING

12245 FRANKSTOWN ROAD • PENN HILLS, PA 15235-3494

April, 1999

I give Mary Striegel permission to enter the Penn Hills Senior Service Center to administer an anonymous, confidential survey.

Sincerely,

Corinne Puszko
Penn Hills Senior Service Center
147 Jefferson Road
Pittsburgh, PA 15235
(412) 244-3405

404 East Main Street
Evans City, PA 16033
(724) 538-4232
May 5, 1999

Ms. Corrine Puszko
Penn Hills Senior Citizen Center
147 Jefferson Road
Pittsburgh, PA 15235

Dear Ms. Puszko,

I want to take this opportunity to thank you for allowing me to enter this senior citizen center and survey your participants. I not only learned a great deal, but I met some wonderful people. It is my hope that the information that I collected will be of valuable importance as the face of modern healthcare changes. If my research article is accepted for publication, I will share the information with your center. If there is any additional information that you made need, in the future, please do not hesitate to call me. Thank You.



Mary Striegel

March 24, 1999

Dear Mr. Duffy,

My name is Mary Striegel and I am a graduate student at the Youngstown State University majoring in Health and Human Services. As a partial requirement for a Master's degree, I am conducting a survey to determine the senior citizen's perception of quality of care in both managed care Medicare and traditional Medicare. This study will enable me to complete thesis requirements, and more importantly, identify information that may have a significant impact on the health insurance offered in the western Pennsylvania area.

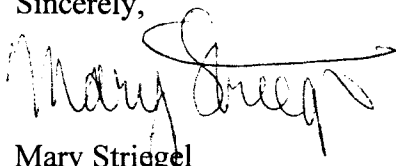
I am asking for your permission to enter your senior center, perform a free blood pressure screening and administer a general questionnaire to your senior citizen attendees. The questionnaire will take approximately 15 minutes to complete. Your decision to allow me to collect this information is completely voluntary.

This study is for research purposes only and all responses will be held strictly confidential. No one will be asked to identify him or herself in any way. The findings will be reported in aggregate form only, no individual responses will be used.

A summary of the results of the study will be available upon request. You may obtain a copy by contacting me at the phone number listed below. If you have any questions about this study, please contact me or my faculty advisor at the phone numbers listed below.

If you agree to allow me to conduct this survey at this senior citizen center, please sign one copy of this letter and return to me in the self addressed stamped envelope. Thank you, in advance, for your time and cooperation in this research study.

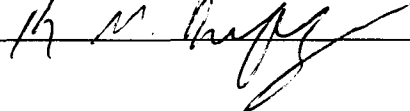
Sincerely,



Mary Striegel
404 East Main Street
Evans City, PA 16033
(724) 538-4232

Carolyn Mikanowicz, Ph.D.
Faculty Advisor
The Youngstown State University
One University Plaza
Youngstown, Ohio 44555
(330) 742-3658

I give my permission for Mary Striegel to administer an anonymous, confidential, voluntary survey to the senior citizens who attend this senior center.

X  _____

National Steelworkers Oldtimers Foundation

500 Market Street
McKeesport, Pennsylvania 15132

Phone 412-678-0159
Fax 412-678-2684

April, 1999

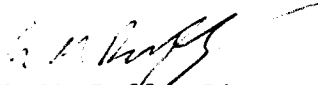
To whom it may concern:

This letter is to acknowledge that Mary Striegel has permission to perform blood pressure screenings and conduct a survey of National Steelworkers Oldtimers Foundation consumers concerning health care issues.

The consumers will participate voluntarily and remain anonymous.

Allegheny County Area Agency on Aging is aware of this agreement.

Sincerely,

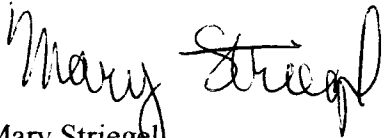

K. M. Duffy, Director
Mon Yough Project

404 East Main Street
Evans City, PA 16033
(724) 538-4232
May 5, 1999

Mr. Kevin Duffy
National Steelworkers Old-timers Fund
500Market Street
McKeesport, PA 15132

Dear Mr. Duffy,

I want to take this opportunity to thank you for allowing me to enter this senior citizen center and survey your participants. I not only learned a great deal, but I met some wonderful people. It is my hope that the information that I collected will be of valuable importance as the face of modern healthcare changes. If my research article is accepted for publication, I will share the information with your center. If there is any additional information that you made need, in the future, please do not hesitate to call me. Thank You.


Mary Striegel

Appendix B

Ethical Consideration and Human Subjects' Protections and Consent Form

Ethical Considerations

To ensure that adequate safeguards were included and respected in this study, the following principles were applied to all participants.

1. Subjects legal rights were respected; their right to privacy, dignity and comfort were maintained during the investigation through the protection of confidentiality. All participants were instructed not to place their names or any identifying marks on the questionnaire.
2. Participation in this investigation was voluntary and the right to withdraw at any time, without penalty, was permitted.
3. The results of this research study was made available upon request.
4. Instructions and disclosure, given to the directors of the senior centers, are listed in Appendix A.



Youngstown State University / One University Plaza / Youngstown, Ohio 44555-0001

April 20, 1999

Dr. Carolyn Mikanowicz, Associate Professor, for
Ms. Mary Striegel, Student
Department of Health Professions
CAMPUS

Dear Dr. Mikanowicz and Ms. Striegel:

The Human Subjects Research Committee has reviewed your protocol, HSRC#55-99, "A Paradigm Shift in the Golden Years. The Transition from Federal Medicare to Managed Medicare," and determined that it is exempt from review based on a DHHS Category 2 exemption.

Any changes in your research activity should be promptly reported to the Human Subjects Research Committee and may not be initiated without HSRC approval except where necessary to eliminate hazard to human subjects. Any unanticipated problems involving risks to subjects should also be promptly reported to the Human Subjects Research Committee.

Best wishes in the conduct of your study.

Sincerely,

A handwritten signature in black ink, appearing to read 'Eric Lewandowski'.

Eric Lewandowski
Administrative Co-chair
Human Subjects Research Committee

c: Mr. Joseph Mistovich, Chair
Department of Health Professions

Celebrating
YSU
30 Years
as a State University

Exempt Protocol Submission Form

Date Submitted: 4 / 5 / 99

File Number _____ (completed by HSC)

Title of Research: A Paradigm Shift in the Golden Years. The transition from Federal Medicare to managed care Medicare.

Principal Investigator(s): Mary Striegel

Advisor (if appropriate): Carolyn Mikanowicz, Ph.D

Department(s): The College of Health and Human Services

Anticipated Funding Source: self funded

Projected Duration of Research: 2 to 4 weeks months Projected Starting Date: 4 / 15 / 99

Other organizations and/or agencies, if any, involved in the study: none

Exempt under code (see definitions above - circle one): 1 (2) 3 4 5 6

Summary Abstract (BRIEF description of participants, measures, procedures used in the proposed research - 250 words or less, attach copy of [] Consent Form and [] measures)

Traditional Medicare, which provides health insurance coverage for approximately 13% of the national population, spent \$203 billion dollars in associated health care costs in 1996. Due to the advances of modern medicine and the maturation of the "baby boomers", the senior population is predicted to swell to 25% in the next 50 years. If current spending continues, the present Medicare program will be bankrupt by the year 2001—leaving virtually no health care coverage for American senior citizens. In an attempt to curb Medicare spending, the U.S. Department of Health and Human Services enacted legislation to allow commercial insurance plans to offer a managed care Medicare option. Because of the low out-of-pocket costs and the extensive use of prevention programs associated with managed care Medicare, senior citizens are rapidly converting to these managed care plans. It is important, then, to examine to quality of care offered by both managed care Medicare and the traditional Medicare plan. This study will use a descriptive correlational research design composed of convenience sampling of Allegheny County, PA senior citizens to compare perceptions of quality of care in both types of insurance plans. The, 200 subject, sample will be obtained from urban and rural based senior citizens attending community based, aggregate senior centers. A survey instrument created by the U.S. Department of Health and Human Services, known as the Consumer Assessment of Health Plan Survey, will be adapted for this research. Participants will be asked to provide socioeconomic data to compare perceptions of quality of care associated with these variables. Data will be analyzed using analysis of variance testing (ANOVA), independent t-tests and descriptive statistics.

Investigator's Signature: Mary Striegel Date: 4-5-99

Advisor's Signature (if appropriate): Carolyn Mikanowicz Date: 4-5-99

Approved [] Approved with Conditions [] Full Committee Review []

HSC Committee Chair _____ Date: 1/1

Received
To be completed by Human Subjects Secretary)

Protocol #
To be completed by Human Subjects Secretary)

**YOUNGSTOWN STATE UNIVERSITY
Human Subjects Protocol Review Form**

Principal Investigator* Carolyn Mikanowicz, Ph.D The College of Health and Human Services
student investigators, Typed Name & Title Department Name & Telephone # 742-3658
(advisor's name first)

Investigator* Mary Striegel student 724-538-4232
Typed Name & Title Department Name & Telephone #

Investigator* _____
Typed Name & Title Department Name & Telephone #

Please Note: Do not list collaborators from other institutions here unless they hold approved joint appointment(s) at YSU

Title of Study A Paradigm Shift in the Golden Years. The transition from Federal Medicare
to managed care Medicare.

External Funding Involved?
(Please check appropriate box) NO YES

Source(s), Type in Name of Funding Agency/Program _____

Activity Start Date _____ **End Date** _____ **Anticipated Funding Date** _____

Collaborating Institutions Involved?
(Please check appropriate box) NO YES

Source(s), Type in the Following _____
Institution Name Name & Title of Chief Collaborator

Institution Name Name & Title of Chief Collaborator

Is Study Subject to Other Institutional Human Subjects Review?
NO YES

Source(s), Type in the Following _____
Institution Name Protocol Review Date/Determination

Institution with Primary Review Responsibility
YSU OTHER _____ (Please Identify)

INSTRUCTIONS TO INVESTIGATORS

*The purpose of an institutional human subjects review is to foster academic inquiry through the study of human processes and behavior, while protecting subject rights and interests. The following questions are intended to promote both of these ends. Please answer each question below accurately, completely and in language comprehensible to an informed layperson. Attach additional pages as necessary. Requests for further information or clarification of issues or questions related to human subjects research or this protocol may be directed to the current co-chairs of the YSU Human Subjects Committee via the Office of Grants and Sponsored Programs (Telephone 742-2377). **Please type all responses on this form and any attachments.***

1. Briefly describe the nature of the activity you are proposing to conduct involving human subjects.

Please try to limit your response to the space provided, and be sure to address the following: (A) the purpose of the research and the hypotheses to be tested; (B) short references to the pertinent scientific literature; (C) an overview of the research design, method and mode of analysis; (D) an appraisal of the anticipated value of the research to the investigator(s), the human subjects, YSU, the scientific community, and society-at-large; (E) the specific site(s) of the research; and (F) investigator access to them.

Traditional Medicare, which provides health insurance coverage for approximately 13% of the national population, spent \$203 billion dollars in associated health care costs in 1996 (Health Care Financing Administration, 1997). Due to the advances of modern medicine and the maturation of the "baby boomers", the senior population is expected to rise to 25% of the total population in the next 10 years (Vanderlann, 1995). If current spending continues, the current Medicare program will be bankrupt by the year 2001, leaving the elderly population with no form of health insurance coverage (Schwartz, 1995). In an attempt to curb Medicare spending, the U.S. Department of Health and Human Services enacted legislation to allow commercial insurance plans to offer a managed care Medicare option. Because of the low out-of-pocket costs and the extensive use of wellness programs associated with managed care Medicare, senior citizens are rapidly converting to these plans.

The purpose of this research is to examine perceptions of quality of care of those senior citizens who have health insurance coverage by either traditional Medicare or the managed care Medicare options.

This research will test the hypothesis that senior citizens who have chosen managed care Medicare believe they are provided with a quality of medical care better than that provided by traditional Medicare.

This study will use a descriptive correlational research design composed of a convenience sampling of senior citizens to compare perceptions of quality of care in both types of insurance plans. The 200 subject, sample will be obtained from senior citizens who participate in community based, congregate senior centers. A survey instrument created by the U.S. Department of Health and Human Services, known as the Consumer Assessment of Health Plans Survey, was adapted for this research. Participants will be asked to provide socioeconomic data to compare perceptions of quality of care associated with these variables. Data will be analyzed using analysis of variance testing (ANOVA), independent t-tests and descriptive statistics.

This study will provide beneficial baseline data on the individual perceptions of quality of care for a select population of senior citizens. This data can be used by the local health departments, local departments of aging, governmental agencies, such as the U.S. Department of Health and Human Services, and the individual managed care Medicare plans offered in this geographical area. By conducting this type of research, the Youngstown State University will be seen as a leader in this field as this type of insurance is presently becoming available to the senior citizen population of Mahoning and Trumbull Counties.

Nationally, senior citizens comprise less than 13% of the total population. Comparatively, the senior citizen population of Allegheny County, PA has reached 18.1%, making it the second largest senior citizen population in the United States. In the next ten years, this geographical area is expected to have a senior population rise to 23% (Allegheny County Health Department, 1997). Because of the large percentage of senior citizens living in Allegheny County, Pennsylvania, it has been chosen as a site for this study. The administrators of four community based, congregate senior citizen centers will be contacted to obtain written permission to survey its' attendees. To compare data across geographical regions, two urban based and two rural based areas within Allegheny County, Pennsylvania will be chosen for participation.

Mary Striegel, graduate student, will do all research. The faculty advisor for this study is Carolyn Mikanowicz, Ph.D. Others on the thesis panel include Joseph Waldron, Ph.D. and Gordon Frissora, Ph.D. No other persons will have access to the specific search data. All data will be reported in aggregate form. Once completed, the research will be provided, by the researcher, upon request as outlined by the school of graduate studies.

2. Please describe the target population in specific terms. Be sure to provide detail about numbers of subjects, age, gender, physical condition or any other information that establishes the parameters of the population of your study.

A total of 200 subjects will be surveyed. The subjects must be aged 65 or older and be insured by either traditional Medicare or managed care Medicare. The participant must be able to answer basic questions about their health status and their insurance plans. The researcher will assist, as individually requested, those willing participants whom are observed to have low literacy levels or cognitive impairments.

3. Briefly describe each of the different conditions or manipulations to be conducted in the study.

A self-administered survey will be conducted. See specifics listed in question 5.

i. Briefly describe the nature of the measures or observations that will be taken in the study.

To determine individual perceptions of quality of care associated with traditional Medicare and managed care Medicare, a voluntary, anonymous and confidential survey will be administered. Participants will be asked to provide socioeconomic variables to assess variance in perceptions of quality of care associated with both types of insurance plans.

ii. If any questionnaires, tests, or other instruments are to be used, please provide a brief description and either a copy or an indication of when a copy will be submitted to the Committee for review.

The survey instrument was modified according to guidelines listed in Appendix H of the Consumer Assessment of Health Plans Survey Reporting Kit that was developed by the U.S. Department of Health and Human Services. This modified version consists of 48 questions and will take approximately 15 to 20 minutes to complete. Please see the attached survey instrument.

Questions were instructed to fit three specific categories. Seven items (numbered 1,2,26,27,28,29,48) describe the health plan. Twenty-four items (numbered 7,11,13,14,21,22,23,24,25,32,33,34,35,36,37,38,39,41,42,43,44,45,46,47) characterize the subject. Seventeen items (numbered 3,4,5,6,8,9,10,12,15,16,17,18,19,20,30,31,40) depict quality. Each question is asked in a multiple-choice format rated on an informal Likert scale with the lowest response, "a", equal to one and increasing accordingly by one point.

. Will the subjects encounter the possibility of psychological, social, physical or legal risk, that is, the probability of harm or injury occurring as a result of participation in this research study?

Yes No If so, please describe.

. Will the study involve any stress, that is, any physical, chemical or emotional factors that may cause bodily or mental tension and may be a factor in causing disease? Yes No
If so, please describe.

. Will the subjects be deceived or misled in any way? Yes No
If so, please describe and include a statement regarding the nature of their debriefing.

9. Will there be any probing for information that an individual might consider to be personal or sensitive? Yes No If so, please describe.
10. Will subjects be presented with materials that they might regard to be offensive, threatening, or degrading? Yes No If so, please describe.

11. Approximately how much time will be required of each subject?

The survey will take approximately 15 to 20 minutes to complete.

12. How will subjects for this study be solicited or contacted?

The administrators of four community based, congregate senior citizen centers will be contacted to obtain written permission to survey its' attendees. In a telephone conversation, the administrators will be asked to provide information on the hours of operation, characteristics of the population served and the peak hours of attendance. A written, detailed cover letter will be sent to the administrators asking for permission to conduct this survey. While in the center, the researcher will visually observe the senior citizens. Each will be individually asked questions related to age, insurance type and willingness to participate in a voluntary, anonymous and confidential survey. Those willing to participate will be escorted to a quiet area of the senior center where the survey will be self-administered. The researcher will remain in the room at all times for observation, questions and required assistance.

13. What steps will be taken to insure that subjects' participation is voluntary? What inducements will be offered to subjects for their participation? What is the source of those inducements?

Voluntary participation will be stressed to the senior center administrators as well as to the individual subjects. Verbal and written directions will be given stating that this is a voluntary survey, that the subject may refuse to participate and opt to withdraw from the survey process at any time, without any penalty. All survey forms are to be placed in a slotted, sealed box by the participant.

In appreciation for participating, the subjects will be offered a complimentary pen that will be provided by the researcher.

4. It is important that subjects be informed regarding the general nature of the proposed human subject activity, especially including a description of anything they may consider unpleasant or risky. Please provide a statement regarding the nature of the information, which will be stated orally or otherwise made available to potential subjects prior to their volunteering.

This is a survey to determine if you believe that your insurance plan provides quality of care. This study is specifically designed to compare traditional Medicare to managed care Medicare. If you are aged 65 or older and are insured by either of these plans and are willing to participate in a voluntary, anonymous and confidential survey, please follow me to this corner of the lunchroom. If you choose not to finish the survey, you may leave and take your survey with you. This is anonymous. Please do not put your name or any identifying marks on the survey form. If anyone needs help with any of the questions or has trouble seeing the print, please raise your hand and I will assist you. This survey will take approximately 15 to 20 minutes to complete. When you are finished, please place it in the box on the table. No one will know your answers. Please keep the pens in thanks of your participation. Thank you for participating in this research project.

5. What steps are being taken to insure that subjects give their consent prior to participating? Will a written consent form be used? Yes No If so, please attach it to this form. If not, state why not. If subjects are minors, how will parental/guardian consent be obtained?

The written consent of the senior citizen center administrators will be collected. Each subject will be asked individually and collectively for verbal consent to participate. Each subject will be permitted to stop participating at any point, if they so chose, without any form of penalty. Completion of the written survey instrument indicates consent.

6. Will any aspect of the data be made part of a permanent record that can be identified, directly or indirectly, with a subject? Yes No

17. Will the fact that a subject did or did not participate in a specific experiment or study be made part of any permanent record available to a supervisor, teacher or employer? Yes No
18. What steps will be taken to insure the anonymity of subjects' identities or the confidentiality of the data they provide?

The subjects will be instructed, in written and verbal direction, to refrain from putting their names or any identifying marks on the survey instrument. The individual participants will place all completed survey forms in a sealed, slotted box. The researcher will only open the box after leaving the premises. All data will be reported in aggregate form so no individual responses can be identified.

19. Will any data from files or other archival data be used? Yes No
20. If there are any risks involved in the study, please describe any offsetting benefits that may accrue to the subject or to society.

There are no risks involved in this study.

INVESTIGATOR STATEMENT OF ASSURANCES

- A. I/we hereby state that I/we will follow and conform to all applicable laws, regulations and policies affecting human subjects in research established by Youngstown State University and/or other cognizant oversight authorities, including but not limited to those cited in the handbook, *Human Subjects Research: Regulations and Procedures*.
- B. I/we hereby recognize the right of legally-authorized access by members or representatives of the Youngstown State University Human Subjects Committee to any pertinent records associated with the above study, and further agree to provide the Committee, upon request, with documentation of any and all procedures undertaken as part of this study.
- C. I/we hereby agree to notify the Committee in advance of any changes in project scope that would materially affect the conduct of the study, or any aspect of the study, relative to human subjects activity or involvement.
- D. I/we affirm that the project as described above is a true, accurate, and complete representation of the study to be conducted under Youngstown State University auspices and with Youngstown State University approval.
- E. I/we affirm that all individuals associated with the conceptualization, organization and conduct of the study described above possess the requisite qualifications to undertake it. (All student investigators must attach a copy of their curriculum vitae and/or a letter from their approved academic advisor attesting to the students' qualifications to conduct faculty-supervised research).
- F. (For studies conducted off-campus) I/we affirm that all appropriate authorizations, clearances and approvals have been obtained to allow the above activity to occur at the above designated site(s), and that documentation to this effect is, or is being, provided to the Human Subjects Committee in support of this protocol.

Carolyn Mikanowicz
Principal Investigator Signature
Carolyn Mikanowicz, Ph.D

4/5/99
Date

Mary Striegel
Co-Investigator Signature
Mary Striegel, graduate student

4/5/99
Date

Co-Investigator Signature

Date

Co-Investigator Signature

Date

this form supercedes any previous Human Subjects protocol forms, which may not be used for Human Subjects Committee review.

Appendix C

Written Permission to Administer Survey

Foreword to the CAHPS™ 1.0 Survey and Reporting Kit

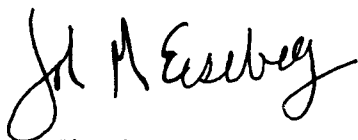
In today's competitive health care market, consumers want dependable information that will help them make better choices about their health care. As a CAHPS project sponsor, you understand this and can use the CAHPS™ 1.0 Survey and Reporting Kit to collect and present information about plan members' assessment of the quality of care and services they have received. This information will help your employees, plan members, program participants, or residents of your area make choices among health plans.

The Kit is also designed to help purchasers and health plans. It provides information on how to collect reliable and valid data from consumers on their assessment of their health plans and includes tested formats for reporting this information to other consumers choosing a health plan. CAHPS can help purchasers as they decide which plans to offer consumers and can also assist health plans as they strive to improve the care and services they provide.

CAHPS is a collaborative effort between the Agency for Health Care Policy and Research (AHCPR) and Harvard Medical School, RAND, Research Triangle Institute, and Westat. It builds on an extensive history of publicly and privately funded research, including work by the Health Care Financing Administration (HCFA) and the National Committee for Quality Assurance (NCQA). From this foundation, CAHPS advances the field of health care consumer assessment and reporting.

The CAHPS products have been thoroughly tested by the CAHPS development team using the latest psychometric and cognitive testing techniques. Further, each product has been reviewed by survey and reporting experts and by potential sponsors. These products are currently being used by our demonstration sites and other sponsors.

There is no charge and no copyright protections for the CAHPS™ 1.0 Survey and Reporting Kit. We ask only that you help us to advance our work by collaborating with other sponsors and sharing your results with us. We welcome you as a partner in this process of learning from consumers as we assist them in their expanding role as health care decision makers.



John Eisenberg, M.D.

Administrator
Agency for Health Care Policy and Research
Rockville, MD

Appendix D
Survey Questionnaire

Senior Citizen

Health Insurance Plan Survey

This survey is anonymous. Please do not put your name on it.

All answers are to be used for a research project comparing insurance plans offered to the elderly, and will be held strictly confidential. Please circle the best answer for each question listed below.

1. My health insurance plan is:

- a. Federal Medicare
- b. Managed Care Medicare

2. How many months or years, in a row, have you been covered by this insurance plan?

- a. less than 1 year
- b. 1 to 2 years
- c. 3 to 5 years
- d. more than 5 years

3. Since you joined this health insurance plan, have you selected one medical doctor that manages most of your care?

- a. yes
- b. no

4. If you selected one specific medical doctor, was it easy to find one that accepts this insurance plan?

- a. yes
- b. no

5. If you changed insurance plans, were you able to keep your own doctor as your primary care giver?

- a. yes
- b. no

6. Where 0 is the worst and 5 is the best, how would you rate the care provided by your medical doctor?

- a. 1
- b. 2
- c. 3
- d. 4
- e. 5

7. Specialists are doctors like surgeons, heart doctors and skin doctors. In the past 6 months, have you thought that you needed to see a specialist?

- a. yes
- b. no

8. In the past 6 months, how often did you see a specialist when you thought that you needed one?

- a. never
- b. sometimes
- c. usually
- d. always

9. At the times when you thought you needed to see a specialist, was your medical doctor willing to send you?

- a. yes
- b. no

10. On a scale of 0 to 5, where 0 is the worst and 5 is the best, rate the care you received by this specialist.

- a. 1
- b. 2
- c. 3
- d. 4
- e. 5

11. In the past 6 months, did you try to see your medical doctor for an illness or injury?

- a. yes
- b. no

12. In the past 6 months, when you tried to be seen for an illness or injury, how often did you see your doctor as soon as you wanted?

- a. never
- b. sometimes
- c. usually
- d. always

- 13. In the past 6 months, how many times have you gone to an emergency room?**
- a. none.
 - b. 1 to 2 times
 - c. 3 to 4 times
 - d. 5 to 6 times
 - e. more than 7 times
- 14. In the past 6 months, how many times have you been admitted to the hospital overnight or longer?**
- a. none
 - b. 1 to 2 times
 - c. 3 to 4 times
 - d. 5 to 6 times
 - e. more than 7 times
- 15. In the past 6 months, has your medical doctor talked to you about a healthy diet?**
- a. yes
 - b. no
- 16. In the past 6 months, has your medical doctor talked to you about an exercise program?**
- a. yes
 - b. no
- 17. When you visit your medical doctor, does he/she explain things in a way that you can understand?**
- a. never
 - b. sometimes
 - c. usually
 - d. always
- 18. When you visit your medical doctor, does he/she spend enough time with you?**
- a. never
 - b. sometimes
 - c. usually
 - d. always
- 19. Does your medical doctor know what you think they should about your medical history?**
- a. yes
 - b. no

20. When your doctor makes decisions about your health care, are you involved as much as you think that you should be?

- a. never
- b. sometimes
- c. usually
- d. always

21. In the past 6 months, how often did you get the medical tests that you thought that you needed?

- a. never
- b. sometimes
- c. usually
- d. always

22. In the past 6 months, have you needed home equipment, like a cane, wheelchair or oxygen?

- a. yes
- b. no

23. In the past 6 months, have you had any health problems for which you needed physical, occupational or speech therapies?

- a. yes
- b. no

24. In the past 6 months, have you had any health problems for which you needed home care nursing?

- a. yes
- b. no

25. In the past 6 months, have you had to take any prescription medications?

- a. yes
- b. no

26. Does your health plan have medication coverage?

- a. yes
- b. no

27. In the past 6 months, did you call your health insurance plans' customer service center for information?

- a. yes
- b. no

28. In the past 6 months, have you called or written your health insurance plan with a complaint or problem?

- a. yes
- b. no

29. If you called your health insurance plan with a problem, was it settled to your satisfaction?

- a. yes
- b. no
- c. waiting for it to be settled

30. In the past 6 months, did your health insurance plan provide all of the help, equipment and services you thought you needed?

- a. yes
- b. no

31. On a scale of 0 to 5, with 0 being the worst and 5 being the best, rate your experience with your health insurance plan.

- a. 1
- b. 2
- c. 3
- d. 4
- e. 5
- f. 5

32. Has your doctor ever told you that you have heart disease?

- a. yes
- b. no

33. Has your doctor ever told you that you had cancer?

- a. yes
- b. no

34. Has your doctor ever told you that you had a stroke?

- a. yes
- b. no

35. Has your doctor ever told you that you have lung disease?

- a. yes
- b. no

- 36. Has your doctor ever told you that you had diabetes?**
a. yes
b. no
- 37. In the past 12 months, have you had a flu shot?**
a. yes
b. no
- 38. Did your insurance plan pay for that flu shot?**
a. yes
b. no
- 39. Do you now smoke?**
a. every day
b. some days
c. not at all
- 40. On how many visits to the doctor did he/she advise you to stop smoking?**
a. I don't smoke
b. none
b. 1 to 3 visits
c. 4 to 6 visits
d. 9 or more visits
- 41. In general, how would you rate your overall health?**
a. poor
b. fair
c. good
d. very good
e. excellent
- 42. What is your age now?**
a. 65 to 75
b. 76 to 84
c. 85 or older
- 43. What is your gender?**
a. male
b. female

44. What is the highest grade level that you completed?

- a. 8th grade or less
- b. some high school
- c. high school graduate
- d. some college
- e. college graduate
- f. more than a 4 year college degree

45. How would you describe your race?

- a. Asian or Pacific Islander
- b. Black or African American
- c. Spanish American
- d. White
- e. Other race _____

46. When you were last working, what was your income before taxes?

- a. less than \$10,000
- b. \$20,000 to 29,999
- c. \$30,000 to 39,999
- d. \$40,000 to 49,999
- e. \$50,000 to 59,999
- f. \$60,000 to 69,999
- g. \$70,000 to 79,999
- h. \$80,000 or more

47. Which of the following best describes your current marital status?

- a. never married
- b. married
- c. separated
- d. divorced
- e. widowed

48. Name the best and/or worst parts of your current health plan.

Best: _____

Worst: _____