FY 07–08
ADULT MEDICAID CLIENT SATISFACTION REPORT

August 2008

This report was produced by Health Services Advisory Group, Inc. for the Colorado Department of Health Care Policy & Financing.

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1. Executive Summary

The State of Colorado requires annual administration of client satisfaction surveys to Medicaid clients enrolled as fee-for-service (FFS) or in the Primary Care Physician Program (PCPP). The Colorado Department of Health Care Policy and Financing (the Department) contracts with Health Services Advisory Group, Inc. (HSAG) to administer and report the results of the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Surveys.[1-1] The goal of the CAHPS Health Plan Surveys is to provide performance feedback that is actionable and that will aid in improving overall client satisfaction.

The standardized survey instrument selected was the CAHPS 4.0H Adult Medicaid Health Plan Survey. Adult clients from each plan completed the survey from February to May 2008. Those clients whose primary language was identified as Spanish received a Spanish version of the survey. All other clients received an English version of the survey.

Performance Highlights

The Results Section of this report details the CAHPS results for both the FFS and PCPP populations. The following is a summary of the Adult Medicaid CAHPS performance highlights for each plan. The performance highlights are categorized into each of the three major types of analyses performed on the Colorado CAHPS data:

- National Committee for Quality Assurance (NCQA) Comparisons
- Trend Analysis
- Plan Comparisons

NCQA Comparisons

Overall client satisfaction ratings for four CAHPS global ratings (Rating of Health Plan, Rating of All Health Care, Rating of Personal Doctor, and Rating of Specialist Seen Most Often) and four CAHPS composite measures (Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, and Customer Service) were compared to NCQA's 2008 Healthcare Effectiveness Data and Information Set (HEDIS®) Benchmarks and Thresholds for Accreditation.[1-2,1-3] This comparison resulted in plan ratings of one (★) to five (★★★★★) stars on these CAHPS measures, where one is the lowest possible rating and five is the highest possible rating. The detailed results of this comparative analysis are described in the Results Section beginning on page 2-7. The following are highlights from this comparison:

[1-1] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).
[1-2] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
[1-3] National Committee for Quality Assurance. *HEDIS Benchmarks and Thresholds for Accreditation 2008*. Washington, DC: NCQA, Updated April 14, 2008.

- Colorado Medicaid FFS scored at or above the 75th percentile (i.e., ★★★★ or ★★★★★) on two of the CAHPS measures: Rating of Personal Doctor and Getting Care Quickly.
- Colorado Medicaid PCPP scored between the 50th and 74th percentiles (i.e., ★★★) on four of the CAHPS measures: Rating of Personal Doctor, Rating of Specialist Seen Most Often, Getting Needed Care, and Getting Care Quickly.
- Colorado Medicaid FFS scored below the 50th percentile (i.e., ★ or ★★) on three of the CAHPS measures: Rating of Health Plan, Rating of All Health Care, and Customer Service.
- Colorado Medicaid PCPP scored below the 50th percentile on three of the CAHPS measures: Rating of Health Plan, Rating of All Health Care, and How Well Doctors Communicate.

Trend Analysis

In order to evaluate trends in Colorado Medicaid client satisfaction, the 2008 Colorado Adult Medicaid CAHPS Health Plan Survey results were compared to the 2007 CAHPS results. This year-to-year comparison was performed for each plan on the four global ratings, four composite measures, and two individual question items that were trendable. Changes made to the Customer Service composite make trending of this measure between 2007 and 2008 inappropriate.[1-4] The detailed results of the year-to-year trend analysis are described in the Results Section beginning on page 2-10. The following are highlights of the comparison of the 2008 CAHPS results to the 2007 results:

- Colorado Medicaid (combined FFS and PCPP) exhibited an upward trend on one CAHPS measure, Coordination of Care.
- Colorado Medicaid FFS exhibited an upward trend on six of the CAHPS measures: Rating of All Health Care, Rating of Personal Doctor, Getting Needed Care, Getting Care Quickly, Shared Decision Making, and Coordination of Care.
- Colorado Medicaid PCPP exhibited an upward trend of one CAHPS measure, Health Promotion and Education.
- Colorado Medicaid (combined FFS and PCPP) and Colorado Medicaid FFS did not score significantly higher or lower in 2008 than in 2007 on any of the CAHPS measures.
- Colorado Medicaid PCPP scored significantly lower in 2008 than in 2007 on one CAHPS measure, Getting Needed Care.

[1-4] In 2007, the Customer Service composite consisted of three question items. In 2008, the Customer Service composite was changed to include only two question items.

Plan Comparisons

In order to identify performance differences in client satisfaction between the two Colorado Medicaid plans, the results for FFS and PCPP were compared to one another using standard statistical tests. These comparisons were performed on the four global ratings, five composite measures, and two individual item measures. The detailed results of the plan-to-plan comparative analysis are described in the Results Section beginning on page 2-23. Overall, there were no statistically significant differences between Colorado Medicaid FFS and PCPP on any of the CAHPS measures.[1-5]

Comparison of 2007 to 2008 Plan-Specific Recommendations

The Adult Medicaid CAHPS Health Plan Survey analytic results were used to identify priority areas for quality improvement (QI). The following provides a comparison of the top and high priorities identified for the Colorado Medicaid FFS and PCPP adult Medicaid populations in years 2007 and 2008. This comparison is described in further detail in the Recommendations Section of this report.

Table 1-1—Priority Assignments: Colorado Medicaid FFS

2007 Top and High Priorities	2008 Top and High Priorities
Rating of Health Plan	Rating of Health Plan
Rating of All Health Care	Rating of All Health Care
Getting Needed Care	Customer Service

Table 1-2—Priority Assignments: Colorado Medicaid PCPP

2007 Top and High Priorities	2008 Top and High Priorities
Rating of Health Plan	Rating of Health Plan
Rating of All Health Care	Rating of All Health Care
Getting Needed Care	Getting Needed Care
	How Well Doctors Communicate

[1-5] Caution should be exercised when evaluating health plan comparisons, given that population and health plan differences may impact results.

The Colorado Adult Medicaid CAHPS Health Plan Survey was administered in accordance with all NCQA specifications. Clients eligible for sampling included those who were enrolled in FFS or PCPP at the time the sample was drawn and who were continuously enrolled in FFS or PCPP for at least five of the last six months (July through December) of 2007. Adult clients eligible for sampling included those who were 18 years of age or older as of December 31, 2007.

Survey Administration and Response Rates

Survey Administration

The standard NCQA HEDIS Specifications for Survey Measures require a sample size of 1,350 clients for the Adult Medicaid CAHPS Health Plan Survey.[2-1] The specifications also permit oversampling in increments of 5 percent. For the Colorado Medicaid FFS and PCPP, a 5 percent oversampling was performed on the adult population. Based on this rate, a total random sample of 1,418 adult clients was selected from each participating plan. The oversampling was performed to ensure a greater number of respondents to each CAHPS measure.

The survey administration protocol was designed to achieve a high response rate from clients, thus minimizing the potential effects of non-response bias. The survey process allowed clients two methods by which they could complete the surveys. The first, or mail phase, consisted of a survey being mailed to the sampled clients. For the Colorado Medicaid FFS and PCPP, those clients who were identified as Spanish-speaking through administrative data were mailed a Spanish version of the survey. Clients that were not identified as Spanish-speaking received an English version of the survey. The English and Spanish versions of the survey included a toll-free number that clients could call to request a survey in another language (i.e., English or Spanish). A reminder postcard was sent to all non-respondents, followed by a second survey mailing and reminder postcard. The second phase, or telephone phase, consisted of Computer Assisted Telephone Interviewing (CATI) for sampled clients who had not mailed in a completed survey. Up to six CATI calls were made to each non-respondent.[2-2] Additional information on the survey protocol is included in the Reader's Guide Section beginning on page 4-3.

Response Rates

The Colorado Adult Medicaid CAHPS Health Plan Survey administration was designed to garner the highest possible response rate. The CAHPS Survey response rate is the total number of completed surveys divided by all eligible clients of the sample. A client's survey was assigned a disposition code of "completed" if at least one question was answered. Eligible clients included the

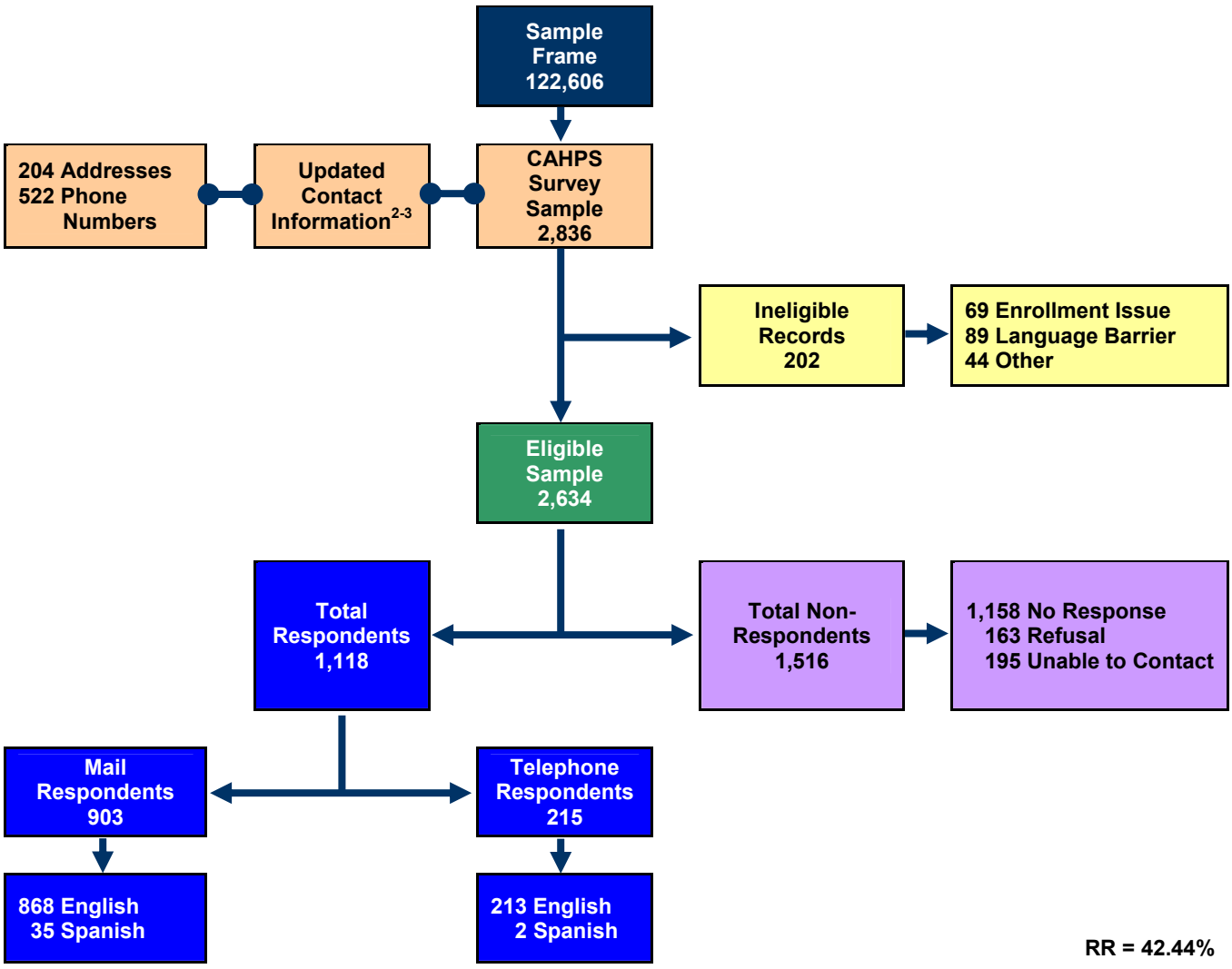
[2-1] National Committee for Quality Assurance. *HEDIS 2008*, *Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA Publication, 2007.

[2-2] National Committee for Quality Assurance. *Quality Assurance Plan for HEDIS 2008 Survey Measures.* Washington, DC: NCQA Publication, 2007.

entire random sample (including any oversample) minus ineligible clients. Ineligible clients met at least one of the following criteria: they were deceased, were invalid (did not meet the eligible population criteria), were mentally or physically unable to complete the survey, or had a language barrier.

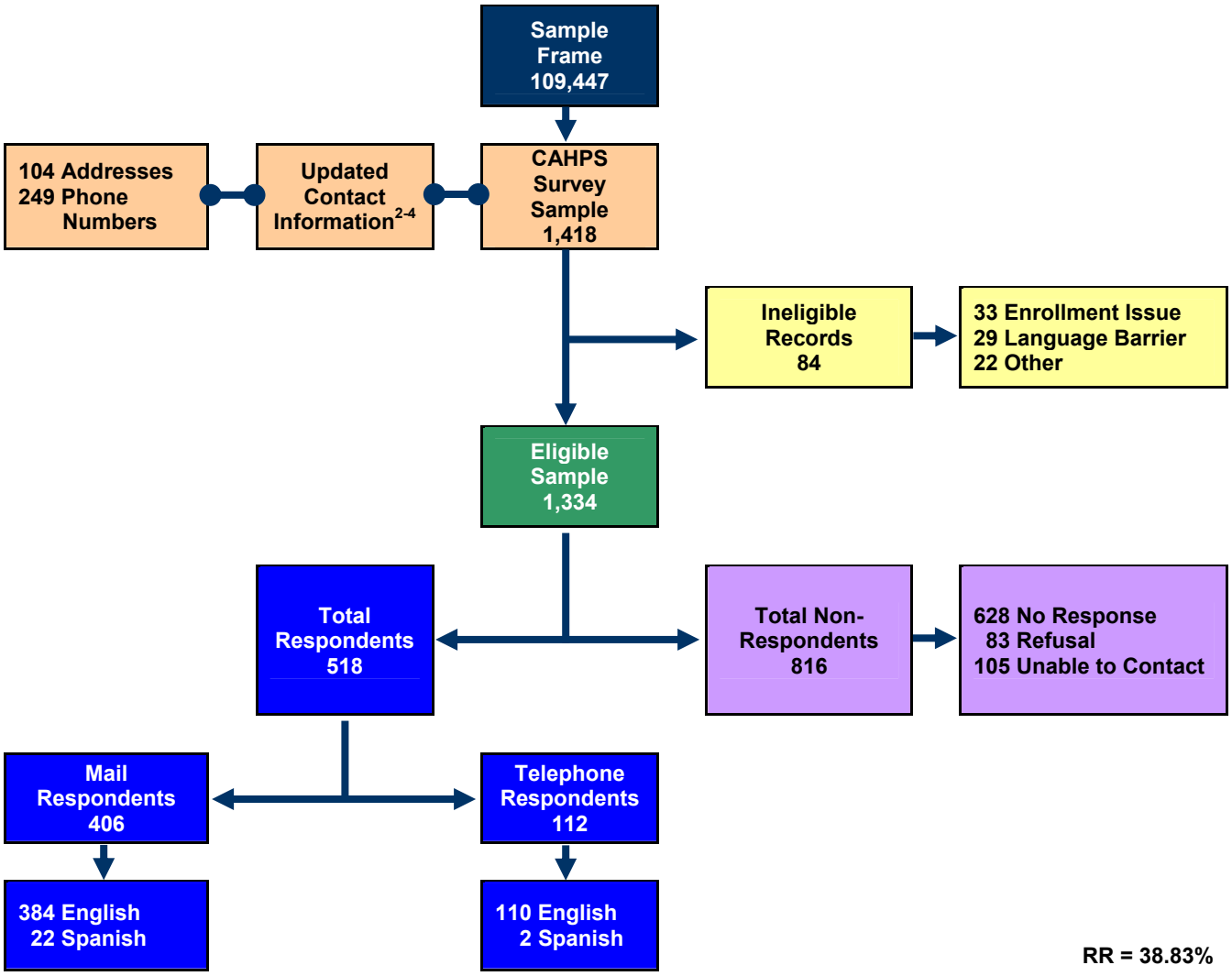
A total of 1,118 adult clients returned a completed survey, including 518 FFS and 600 PCPP clients. Figure 2-1 shows the distribution of survey dispositions and response rate (RR) for Colorado Medicaid FFS and PCPP combined. Figure 2-2 and Figure 2-3, on pages 2-3 and 2-4, show the individual distribution of survey dispositions and response rates for FFS and PCPP, respectively. The Colorado Medicaid 2008 response rate of 42.44 percent was 10.26 percentage points higher than the 2007 response rate.

Figure 2-1—Distribution of Surveys for Colorado Medicaid (Combined FFS and PCPP)



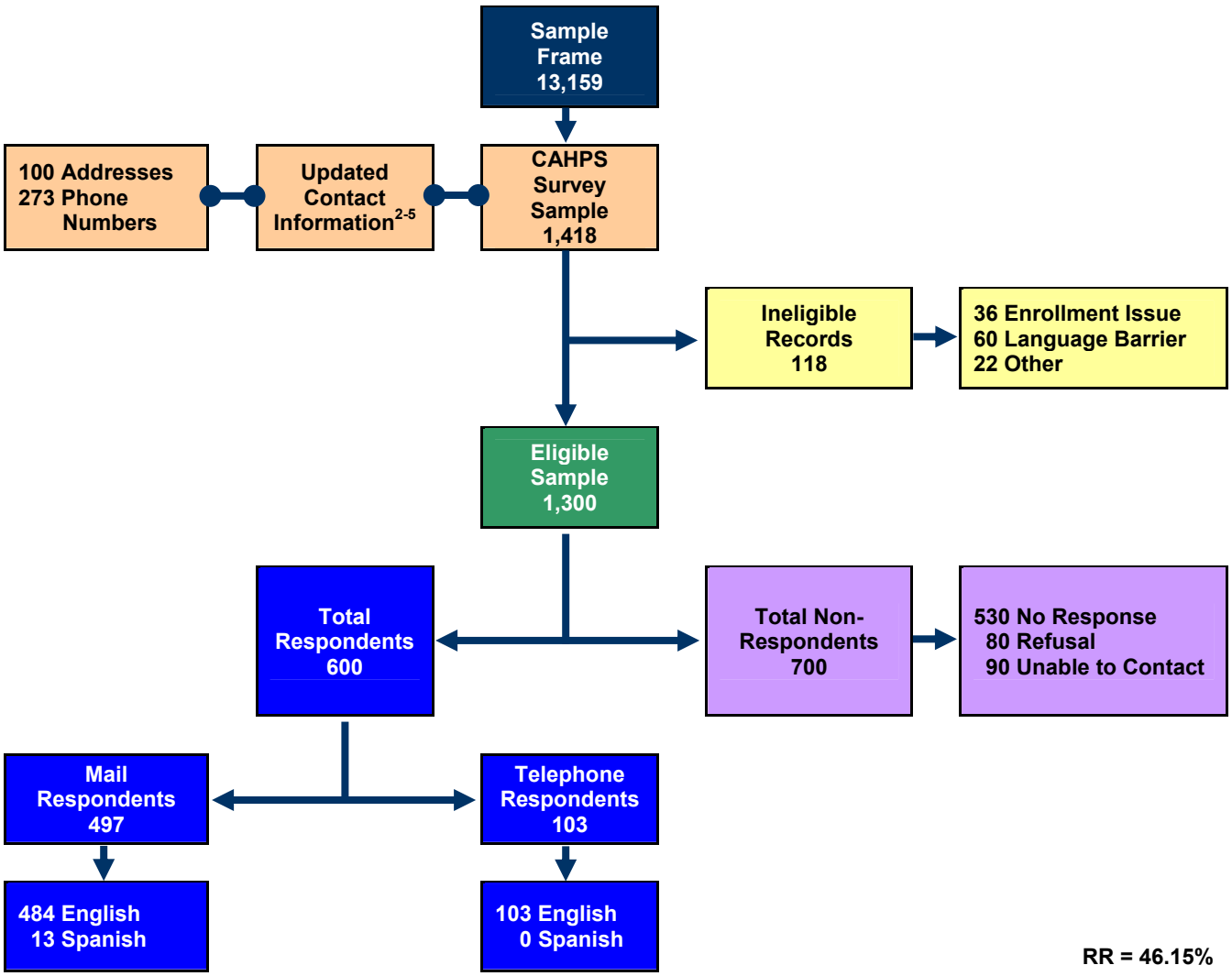
[2-3] Prior to survey administration, address and phone information is updated for clients of the CAHPS sample using the United State Postal Services' National Change of Address (NCOA) and Telematch databases. The number of updated addresses and telephone numbers is provided for informational purposes only. Per NCQA HEDIS Specifications, these clients are retained within the CAHPS Survey sample.

Figure 2-2—Distribution of Surveys for Colorado Medicaid FFS



[2-4] Prior to survey administration, address and phone information is updated for clients of the CAHPS sample using the United State Postal Services' NCOA and Telematch databases. The number of updated addresses and telephone numbers is provided for informational purposes only. Per NCQA HEDIS Specifications, these clients are retained within the CAHPS Survey sample.

Figure 2-3—Distribution of Surveys for Colorado Medicaid PCPP



[2-5] Prior to survey administration, address and phone information is updated for clients of the CAHPS sample using the United State Postal Services' NCOA and Telematch databases. The number of updated addresses and telephone numbers is provided for informational purposes only. Per NCQA HEDIS Specifications, these clients are retained within the CAHPS Survey sample.

Respondent Demographics

In general, the demographics of a response group influence overall client satisfaction scores. For example, older and healthier respondents tend to report higher levels of client satisfaction; therefore, caution should be exercised when comparing populations that have significantly different demographic properties.[2-6] Currently, NCQA does not recommend case-mix adjusting CAHPS results to account for these differences.

Table 2-1 shows Adult Medicaid CAHPS Health Plan Survey respondents' self-reported age, gender, and race/ethnicity.

Table 2-1—Respondent Demographics Age, Gender, and Race/Ethnicity

	Colorado Medicaid (FFS and PCPP Combined)	Colorado Medicaid FFS	Colorado Medicaid PCPP
Age			
18 to 24	9.5%	12.2%	7.1%
25 to 34	15.0%	17.0%	13.3%
35 to 44	14.9%	14.4%	15.4%
45 to 54	16.5%	13.2%	19.3%
55 to 64	14.8%	12.0%	17.3%
65 or older	29.3%	31.2%	27.6%
Gender			
Male	27.6%	23.6%	31.0%
Female	72.4%	76.4%	69.0%
Race/Ethnicity			
Multi-Racial	5.8%	6.6%	5.1%
White	62.8%	64.5%	61.5%
Black	5.7%	4.9%	6.3%
Asian	7.5%	4.7%	9.8%
Other	18.2%	19.3%	17.4%
Please note: Percentages may not total 100% due to rounding.			

[2-6] Agency for Healthcare Research and Quality. *CAHPS Health Plan Survey and Reporting Kit 2007*. Rockville, MD: US Department of Health and Human Services, July 2007.

Table 2-2 depicts Adult Medicaid CAHPS Health Plan Survey respondents' self-reported level of education and general health status.

Table 2-2—Respondent Demographics Education and General Health Status			
	Colorado Medicaid (FFS and PCPP Combined)	**Colorado Medicaid FFS**	**Colorado Medicaid PCPP**
Education			
8th Grade or Less	17.9%	14.9%	20.5%
Some High School	18.4%	17.4%	19.2%
High School Graduate	33.5%	32.7%	34.2%
Some College	24.6%	30.1%	19.8%
College Graduate	5.7%	4.8%	6.4%
General Health Status			
Excellent	6.7%	7.0%	6.4%
Very Good	15.5%	16.6%	14.7%
Good	33.5%	34.5%	32.6%
Fair	29.7%	28.1%	31.0%
Poor	14.6%	13.8%	15.3%
Please note: Percentages may not total 100% due to rounding.			

NCQA Comparisons

In order to assess the overall performance of FFS and PCPP, each CAHPS measure was scored on a three-point scale using the scoring methodology detailed in NCQA's HEDIS Specifications for Survey Measures.[2-7] The resulting three-point mean scores were compared to NCQA's HEDIS Benchmarks and Thresholds for Accreditation.[2-8] Based on this comparison, plan ratings of one (★) to five (★★★★★) stars were determined for each CAHPS measure, where one is the lowest possible rating and five is the highest possible rating.

★★★★★	indicates a score at or above the 90th percentile
★★★★	indicates a score between the 75th and 89th percentiles
★★★	indicates a score between the 50th and 74th percentiles
★★	indicates a score between the 25th and 49th percentiles
★	indicates a score below the 25th percentile
NA	indicates that the plan did not meet the minimum NCQA reporting threshold of 100 respondents
NB	indicates that NCQA did not provide benchmarks for this measure

Table 2-3 shows both plans' three-point mean scores and overall client satisfaction ratings on each of the four global ratings.

Table 2-3—NCQA Comparisons: Overall Client Satisfaction Ratings on the Global Ratings

	Colorado Medicaid FFS		Colorado Medicaid PCPP	
Global Ratings	**Three-Point Mean**	**Star Rating**	**Three-Point Mean**	**Star Rating**
Rating of Health Plan	2.193	★	2.261	★★
Rating of All Health Care	2.212	★★	2.214	★★
Rating of Personal Doctor	2.501	★★★★	2.439	★★★
Rating of Specialist Seen Most Often	2.450	★★★	2.447	★★★

[2-7] National Committee for Quality Assurance. *HEDIS 2008, Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA Publication, 2007.
[2-8] National Committee for Quality Assurance. *HEDIS Benchmarks and Thresholds for Accreditation 2008*. Washington, DC: NCQA, Updated April 14, 2008.

Table 2-4 shows both plans' three-point mean scores and overall client satisfaction ratings on each of the five composite measures.

Table 2-4—NCQA Comparisons: Overall Client Satisfaction Ratings on the Composite Measures

	Colorado Medicaid FFS		Colorado Medicaid PCPP	
Composite Measure	**Three-Point Mean**	**Star Rating**	**Three-Point Mean**	**Star Rating**
Getting Needed Care	2.284	★★★	2.316	★★★
Getting Care Quickly	2.432	★★★★	2.371	★★★
How Well Doctors Communicate	2.549	★★★	2.501	★★
Customer Service	2.180	★★	NA	NA
Shared Decision Making	2.488	NB	2.504	NB

Please note: A minimum of 100 responses to each composite measure is required in order to report the measure as a CAHPS Survey result. Composite measures that do not meet the minimum number of responses are denoted as Not Applicable (NA). Composite measures that NCQA did not provide benchmarks for are denoted as No Benchmark (NB).

Table 2-5 shows both plans' three-point mean scores and overall client satisfaction ratings on each of the two individual item measures.

Table 2-5—NCQA Comparisons: Overall Client Satisfaction Ratings on Individual Item Questions

	Colorado Medicaid FFS		Colorado Medicaid PCPP	
Individual Item	**Three-Point Mean**	**Star Rating**	**Three-Point Mean**	**Star Rating**
Health Promotion and Education	1.856	NB	1.920	NB
Coordination of Care	2.320	NB	2.300	NB

Individual items that NCQA did not provide benchmarks for are denoted as No Benchmark (NB).

Summary of NCQA Comparison Results

The NCQA comparisons revealed the following summary results:

- Colorado Medicaid FFS scored between the 75th and 89th percentiles nationally on two of the CAHPS measures: Rating of Personal Doctor and Getting Care Quickly.
- Colorado Medicaid PCPP did not score at or above the 75th percentile nationally on any of the CAHPS measures.
- Colorado Medicaid FFS scored below the 50th percentile nationally on three of the CAHPS measures: Rating of Health Plan, Rating of All Health Care, and Customer Service. For Rating of Health Plan, FFS scored below the 25th percentile.
- Colorado Medicaid PCPP scored between the 25th and 49th percentiles nationally on three of the CAHPS measures: Rating of Health Plan, Rating of All Health Care, and How Well Doctors Communicate.

Trend Analysis

In 2007, the Colorado Medicaid FFS and PCPP had 383 and 494 completed Adult Medicaid CAHPS Health Plan Surveys, respectively. These completed surveys were used to calculate the 2007 CAHPS results presented in this section for trending purposes.[2-9]

For purposes of the trend analysis, question summary rates were calculated for each global rating and individual item measure, and global proportions were calculated for each composite measure. Both the question summary rates and global proportions were calculated in accordance with NCQA HEDIS Specifications for Survey Measures.[2-10] The scoring of the global ratings, composite measures, and individual item measures involved assigning top-level responses a score of one, with all other responses receiving a score of zero. After applying this scoring methodology, the percentage of top-level responses was calculated in order to determine the question summary rates and global proportions. For additional detail, please refer to the *NCQA HEDIS Specifications for Survey Measures*, *Volume 3*.

The 2008 Colorado Medicaid and plan-level CAHPS scores were compared to the corresponding 2007 scores to determine whether there were statistically significant differences. Figure 2-4 through Figure 2-14 show the results of this trend analysis. Statistically significant differences between scores in 2008 and scores in 2007 for Colorado Medicaid and each plan are noted with directional triangles. Scores that were statistically higher in 2008 than in 2007 are noted with upward (▲) triangles. Scores that were statistically lower in 2008 than in 2007 are noted with downward (▼) triangles. Scores in 2008 that were not statistically different from scores in 2007 are not noted with triangles. Please note, a minimum of 100 responses to each CAHPS measure is required in order to report the measure as a CAHPS Survey result. Measures that do not meet the minimum number of responses are denoted as Not Applicable (NA).

[2-9] For detailed information on the 2007 Colorado Medicaid CAHPS results, please refer to the 2007 Adult Medicaid Client Satisfaction Report.

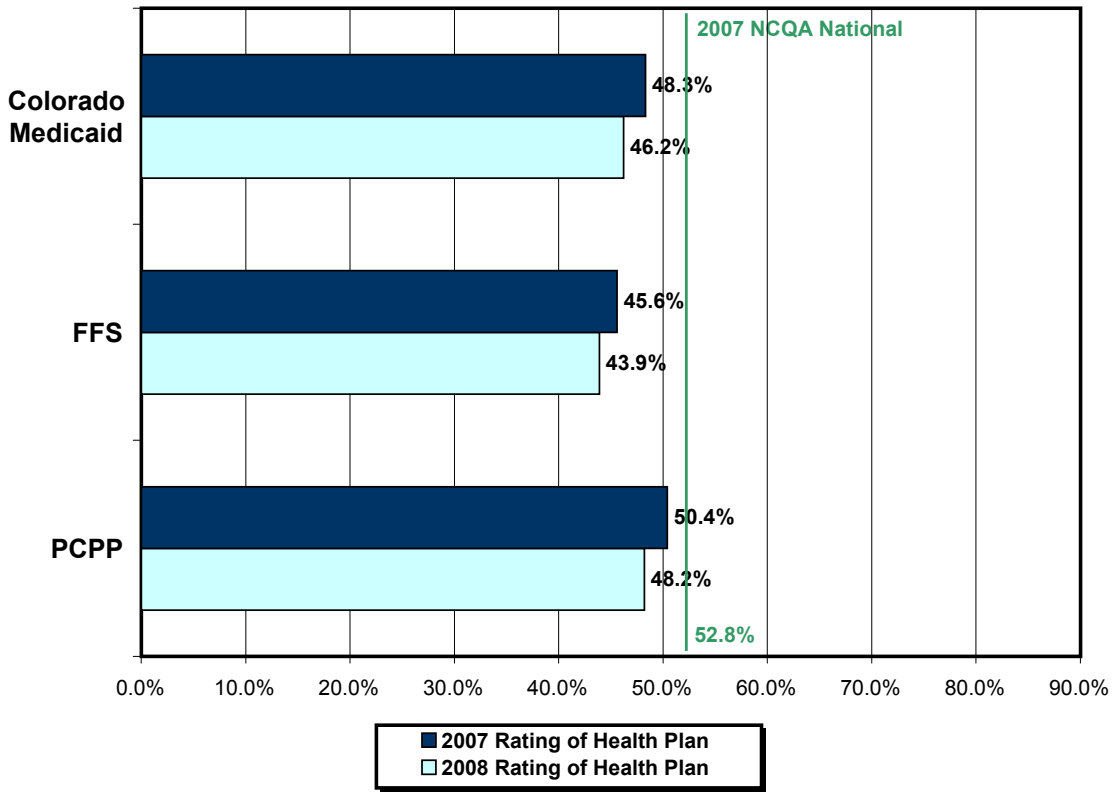
[2-10] National Committee for Quality Assurance. *HEDIS 2008, Volume 3: Specifications for Survey Measures*. Washington, DC: NCQA Publication, 2007.

Global Ratings

Rating of Health Plan

Colorado Medicaid FFS and PCPP adult clients were asked to rate their health plan on a scale of 0 to 10, with 0 being the "worst health plan possible" and 10 being the "best health plan possible." Top-level responses were defined as those responses with a rating of 9 or 10. Figure 2-4 shows the 2007 and 2008 Rating of Health Plan question summary rates for Colorado Medicaid (combined FFS and PCPP), FFS, and PCPP.[2-11]

Figure 2-4—Trend Analysis: Rating of Health Plan

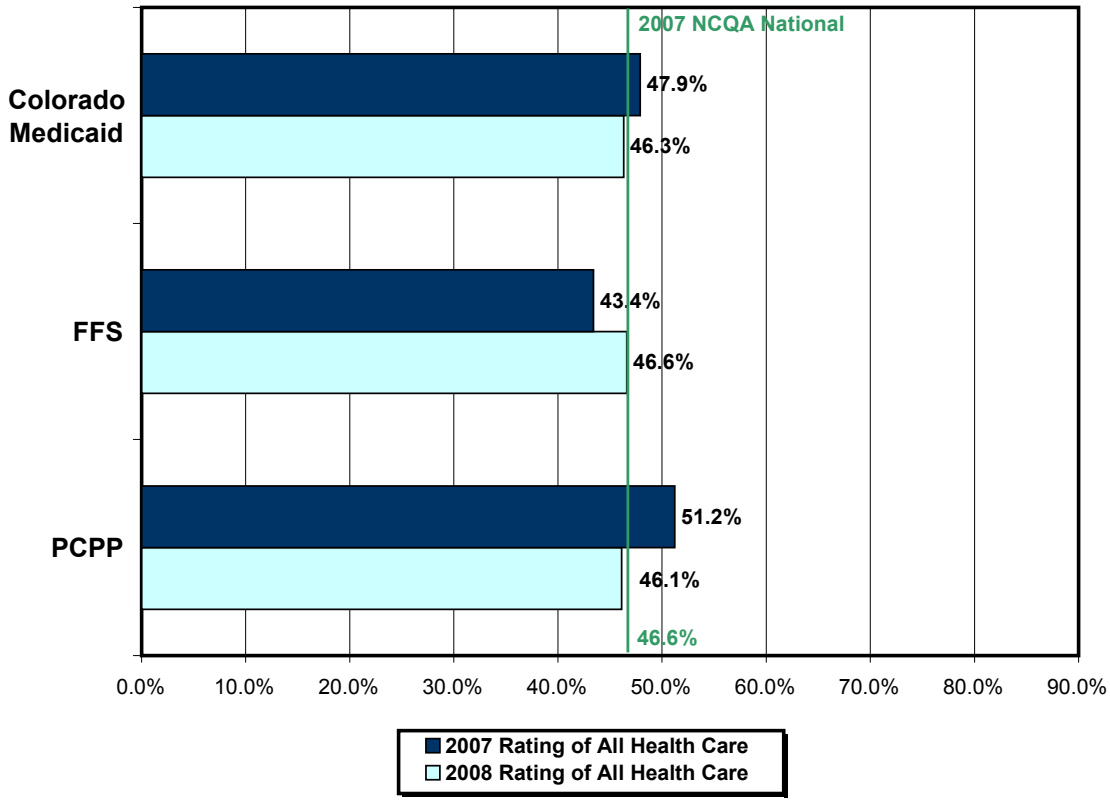


[2-11] Colorado Medicaid scores in this section are limited to the combined results of Colorado Medicaid FFS and PCPP.

Rating of All Health Care

Colorado Medicaid FFS and PCPP adult clients were asked to rate all their health care on a scale of 0 to 10, with 0 being the "worst health care possible" and 10 being the "best health care possible." Top-level responses were defined as those responses with a rating of 9 or 10. Figure 2-5 shows the 2007 and 2008 Rating of All Health Care question summary rates for Colorado Medicaid (combined FFS and PCPP), FFS, and PCPP.

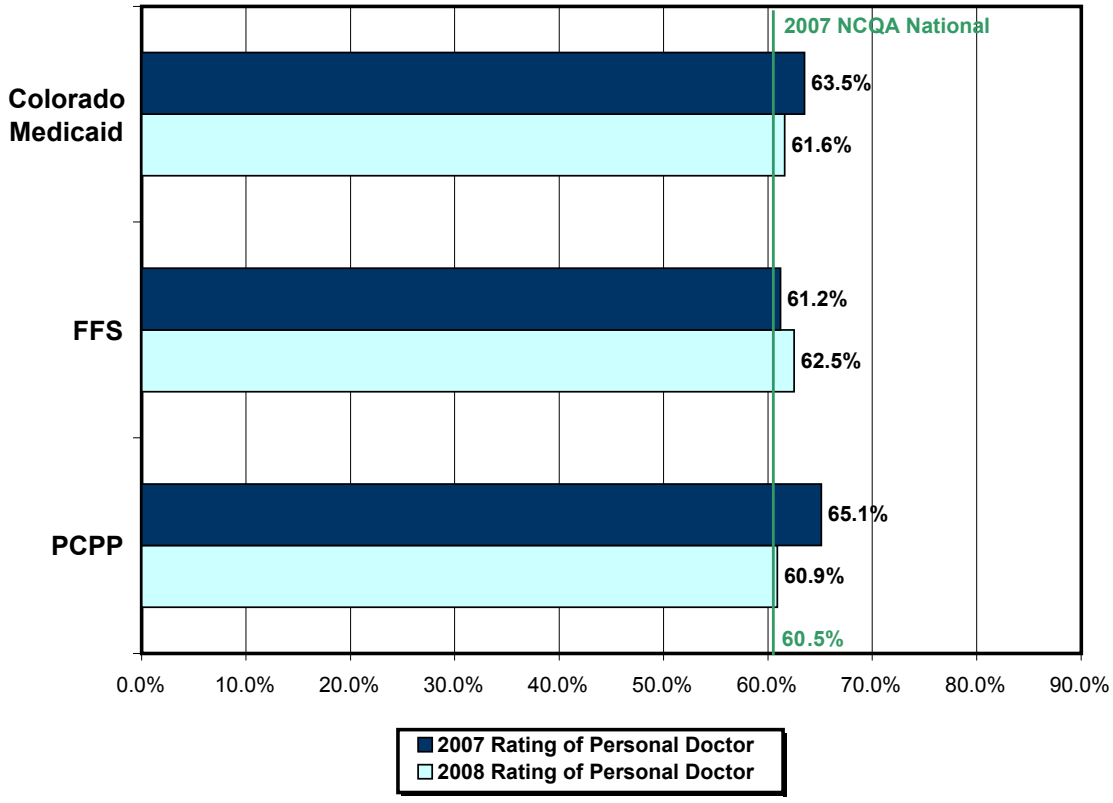
Figure 2-5—Trend Analysis: Rating of All Health Care



Rating of Personal Doctor

Colorado Medicaid FFS and PCPP adult clients were asked to rate their personal doctor on a scale of 0 to 10, with 0 being the "worst personal doctor possible" and 10 being the "best personal doctor possible." Top-level responses were defined as those responses with a rating of 9 or 10. Figure 2-6 shows the 2007 and 2008 Rating of Personal Doctor question summary rates for Colorado Medicaid (combined FFS and PCPP), FFS, and PCPP.

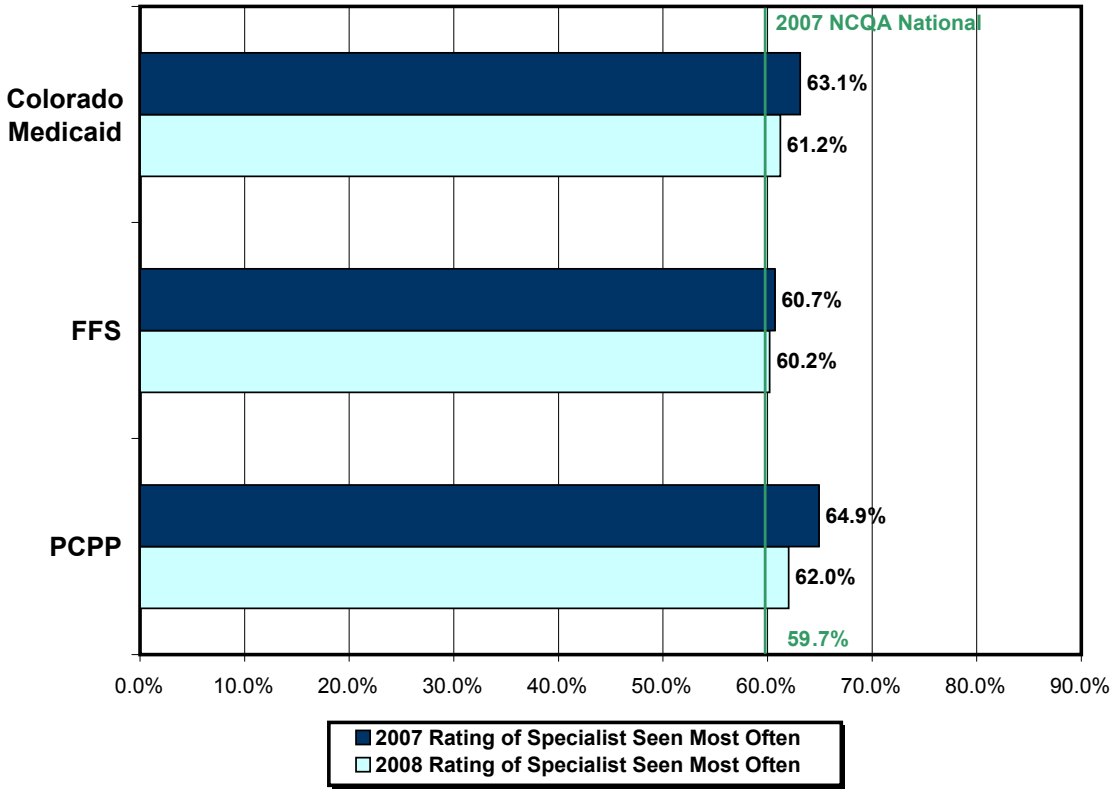
Figure 2-6—Trend Analysis: Rating of Personal Doctor



Rating of Specialist Seen Most Often

Colorado Medicaid FFS and PCPP adult clients were asked to rate the specialist they saw most often on a scale of 0 to 10, with 0 being the "worst specialist possible" and 10 being the "best specialist possible." Top-level responses were defined as those responses with a rating of 9 or 10. Figure 2-7 shows the 2007 and 2008 Rating of Specialist Seen Most Often question summary rates for Colorado Medicaid (combined FFS and PCPP), FFS, and PCPP.

Figure 2-7—Trend Analysis: Rating of Specialist Seen Most Often

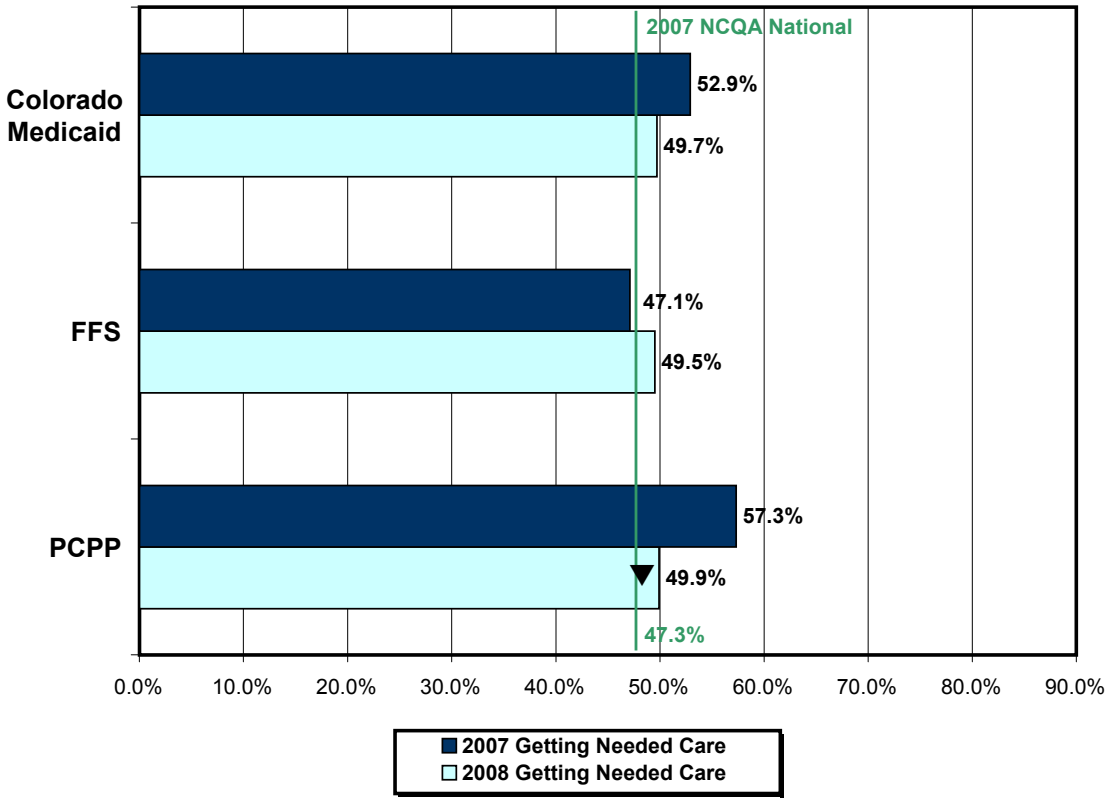


Composite Measures

Getting Needed Care

Colorado Medicaid FFS and PCPP adult clients were asked two questions to assess how often it was easy to get needed care. For each of these questions (Questions 23 and 27), a top-level response was defined as a response of "Always." Figure 2-8 shows the 2007 and 2008 Getting Needed Care global proportions for Colorado Medicaid (combined FFS and PCPP), FFS, and PCPP.

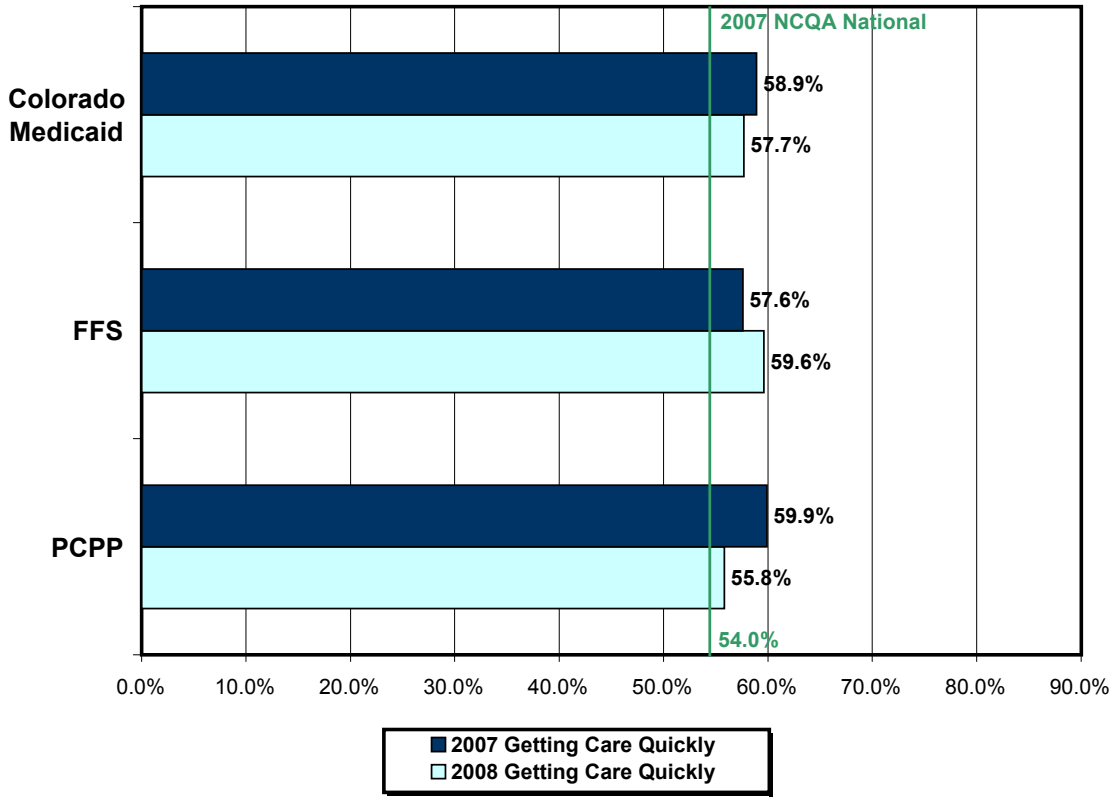
Figure 2-8—Trend Analysis: Getting Needed Care



Getting Care Quickly

Colorado Medicaid FFS and PCPP adult clients were asked two questions to assess how often clients received care quickly. For each of these questions (Questions 4 and 6), a top-level response was defined as a response of "Always." Figure 2-9 shows the 2007 and 2008 Getting Care Quickly global proportions for Colorado Medicaid (combined FFS and PCPP), FFS, and PCPP.

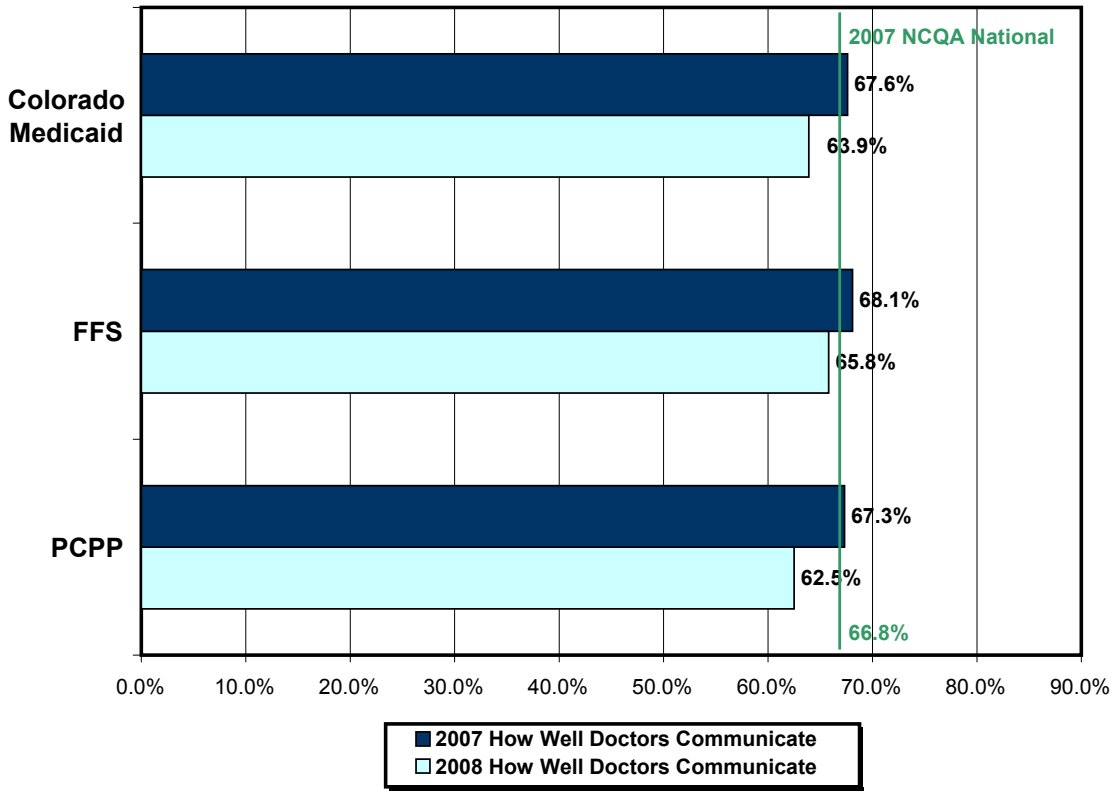
Figure 2-9—Trend Analysis: Getting Care Quickly



How Well Doctors Communicate

Colorado Medicaid FFS and PCPP adult clients were asked four questions to assess how often doctors communicated well. For each of these questions (Questions 15, 16, 17, and 18), a top-level response was defined as a response of "Always." Figure 2-10 shows the 2007 and 2008 How Well Doctors Communicate global proportions for Colorado Medicaid (combined FFS and PCPP), FFS, and PCPP.

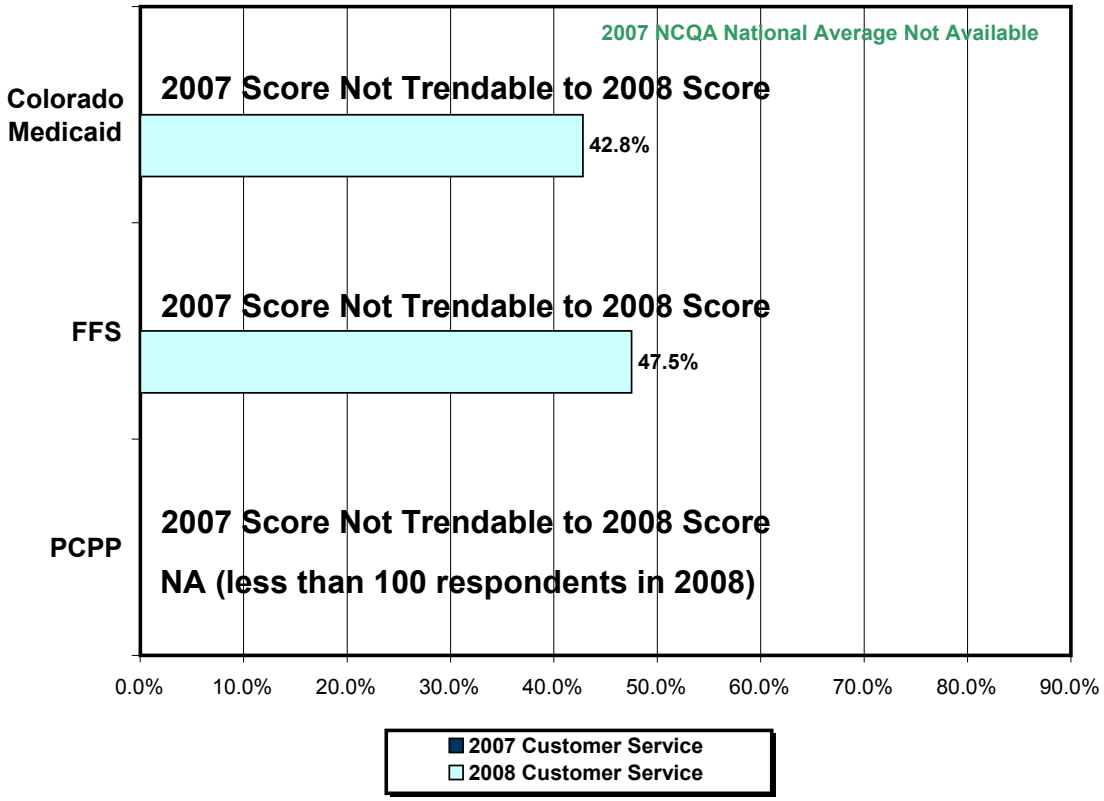
Figure 2-10—Trend Analysis: How Well Doctors Communicate



Customer Service

Colorado Medicaid FFS and PCPP adult clients were asked two questions to assess how often clients obtained needed help/information from customer service. For each of these questions (Questions 31 and 32), a top-level response was defined as a response of "Always." Figure 2-11 shows the 2008 Customer Service global proportions for Colorado Medicaid (combined FFS and PCPP), FFS, and PCPP. Due to changes in the Customer Service composite, results are not trendable from 2007 to 2008, and a 2007 NCQA national average is not available.

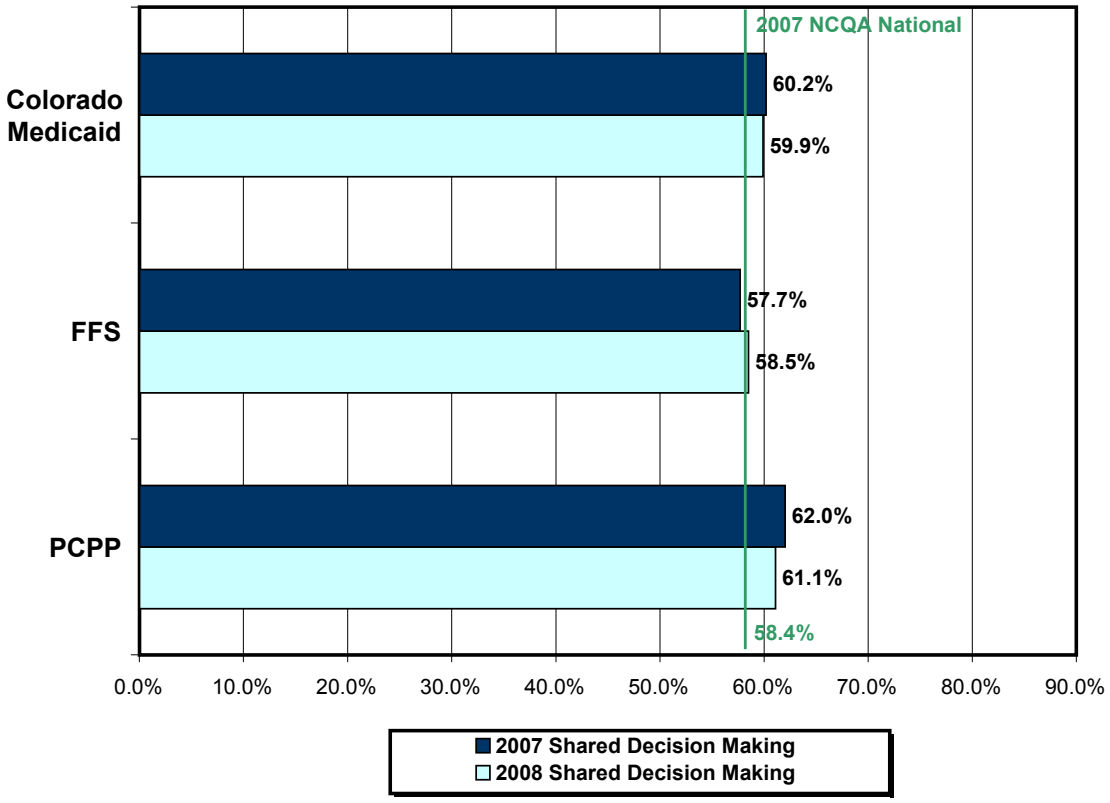
Figure 2-11—Trend Analysis: Customer Service



Shared Decision Making

Colorado Medicaid FFS and PCPP adult clients were asked two questions to assess if doctors discussed treatment choices with them. For each of these questions (Questions 10 and 11), a top-level response was defined as a response of "Definitely Yes." Figure 2-12 shows the 2007 and 2008 Shared Decision Making global proportions for Colorado Medicaid (combined FFS and PCPP), FFS, and PCPP.

Figure 2-12—Trend Analysis: Shared Decision Making

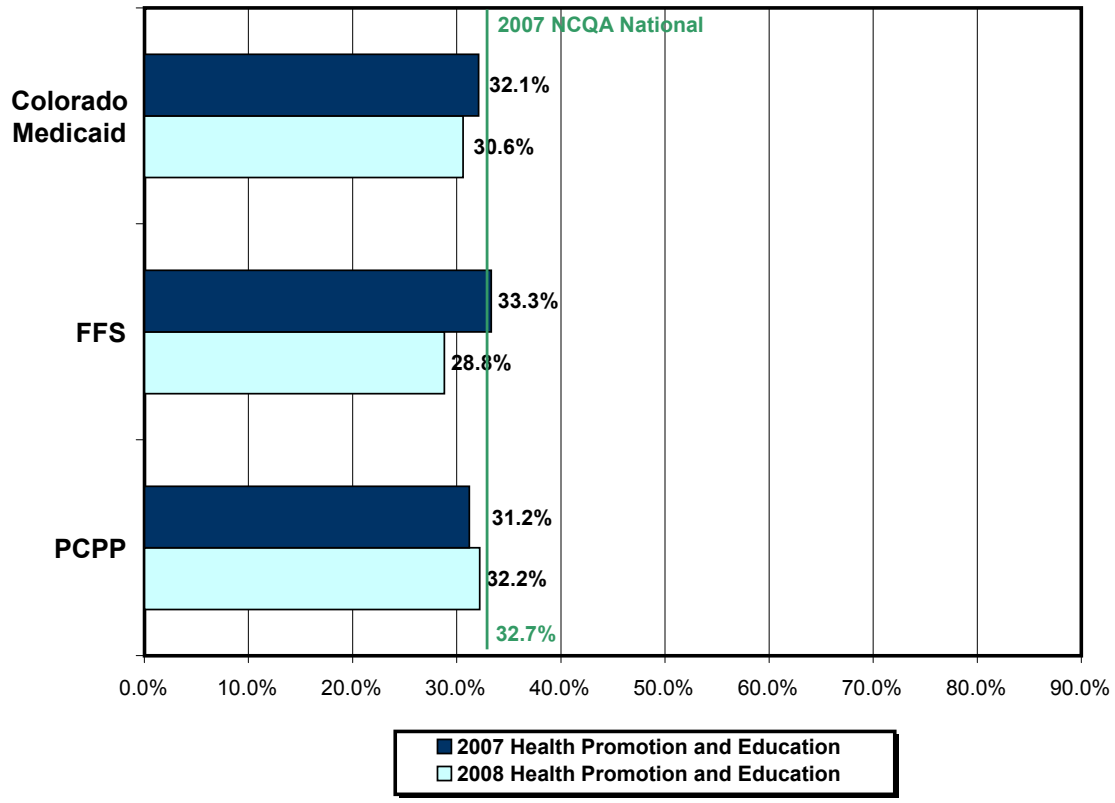


Individual Item Measures

Health Promotion and Education

Colorado Medicaid FFS and PCPP adult clients were asked a question to assess how often their doctor talked with them about specific things they could do to prevent illness. For this question (Question 8), a top-level response was defined as a response of "Always." Figure 2-13 shows the 2007 and 2008 Health Promotion and Education question summary rates for Colorado Medicaid (combined FFS and PCPP), FFS, and PCPP.

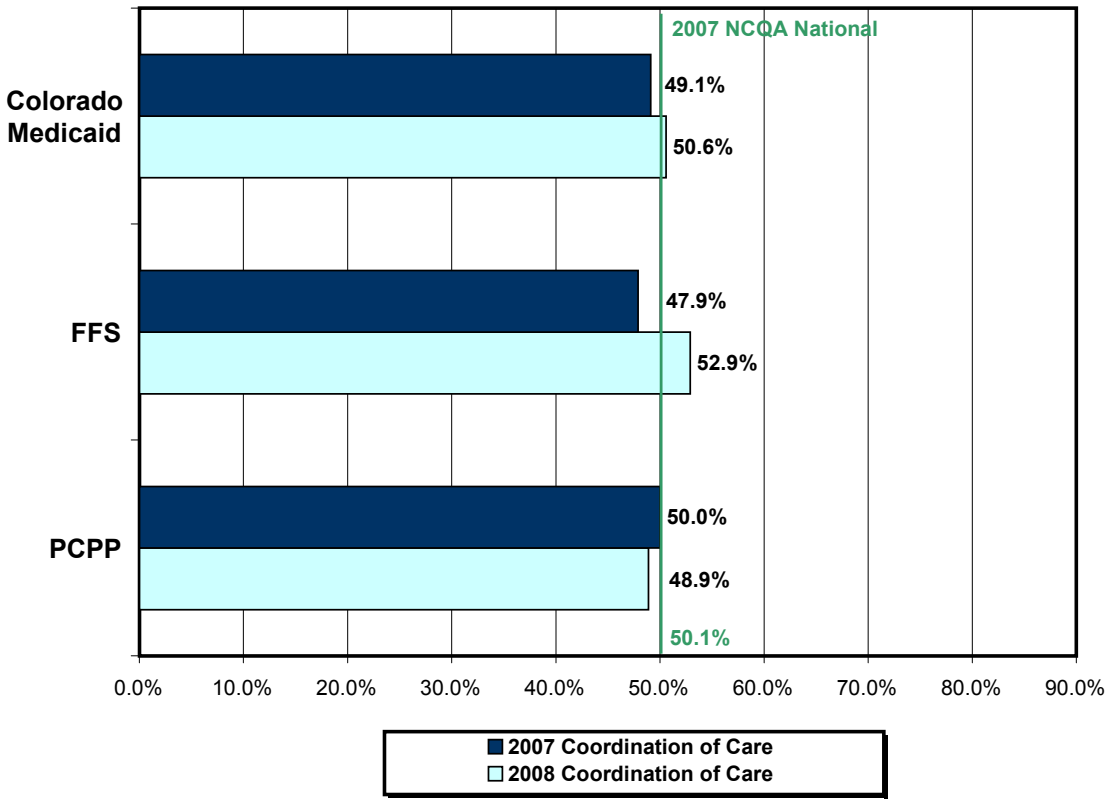
Figure 2-13—Trend Analysis: Health Promotion and Education



Coordination of Care

Colorado Medicaid FFS and PCPP adult clients were asked a question to assess how often their personal doctor seemed informed and up-to-date about care they had received from another doctor. For this question (Question 20), a top-level response was defined as a response of "Always." Figure 2-14 shows the 2007 and 2008 Coordination of Care question summary rates for Colorado Medicaid (combined FFS and PCPP), FFS, and PCPP.

Figure 2-14—Trend Analysis: Coordination of Care



Summary of Trend Analysis Results

The 2007 to 2008 trend analysis revealed the following summary results. The references to significant differences below refer to statistically significant differences between the 2007 and 2008 CAHPS results.

- The 2008 Customer Service CAHPS composite measure was not trendable between 2007 and 2008 due to changes in the composite measure.
- Colorado Medicaid (combined FFS and PCPP) exhibited an upward trend on one CAHPS measure, Coordination of Care.
- Colorado Medicaid FFS exhibited an upward trend on six of the CAHPS measures: Rating of All Health Care, Rating of Personal Doctor, Getting Needed Care, Getting Care Quickly, Shared Decision Making, and Coordination of Care.
- Colorado Medicaid PCPP exhibited an upward trend of one CAHPS measure, Health Promotion and Education.
- For Colorado Medicaid (FFS and PCPP combined) and Colorado Medicaid FFS, the 2007 to 2008 trend analysis revealed there were no statistically significant differences.
- For Colorado Medicaid PCPP, the 2007 to 2008 trend analysis revealed there was one statistically significant difference. PCPP scored significantly lower in 2008 than in 2007 on the Getting Needed Care measure.

Plan Comparisons

In order to identify performance differences in client satisfaction between the two Colorado Medicaid plans, the results for FFS and PCPP were compared to one another using standard tests for statistical significance.

Note: Caution should be exercised when evaluating plan comparisons, given that population and plan differences may impact CAHPS results.

For purposes of the plan comparisons, question summary rates and global proportions were calculated using the methodology described in the trend analysis section. In short, the scoring of the global ratings, composite measures, and individual item measures involved assigning top-level responses a score of one, with all other responses receiving a score of zero. After applying this scoring methodology, the percentage of top-level responses was calculated in order to determine the question summary rates and global proportions. For additional detail, please refer to the *NCQA HEDIS Specifications for Survey Measures, Volume 3*.

Statistically significant differences between the two plans are noted in the tables by arrows. When a statistically significant difference exists between the plans' scores, the higher performing plan's score is denoted with an upward (↑) arrow. Conversely, the lower performing plan's score is denoted with a downward (↓) arrow. If the differences are not statistically significant, then both plans' scores are denoted with a horizontal (↔) arrow. If either plan does not meet NCQA's requirement of 100 respondents, then comparisons are not performed, and the question summary rate or global proportion is denoted as Not Applicable (NA). For 2008, there were no statistically significant differences in performance between plans on any of the measures.

Table 2-6 shows both plans' question summary rates and plan comparisons on each of the four global ratings.

Table 2-6—Plan Comparisons: Global Ratings

	Colorado Medicaid FFS	Colorado Medicaid PCPP
Global Ratings	**Question Summary Rate**	**Question Summary Rate**
Rating of Health Plan	43.9% ↔	48.2% ↔
Rating of All Health Care	46.6% ↔	46.1% ↔
Rating of Personal Doctor	62.5% ↔	60.9% ↔
Rating of Specialist Seen Most Often	60.2% ↔	62.0% ↔

Table 2-7 shows both plans' global proportions and plan comparisons on each of the five composite measures.

Table 2-7—Plan Comparisons: Composite Measures		
	Colorado Medicaid FFS	Colorado Medicaid PCPP
Composite Measure	**Global Proportion**	**Global Proportion**
Getting Needed Care	49.5% ↔	49.9% ↔
Getting Care Quickly	59.6% ↔	55.8% ↔
How Well Doctors Communicate	65.8% ↔	62.5% ↔
Customer Service	47.5% NA	NA
Shared Decision Making	58.5% ↔	61.1% ↔
Please note: A minimum of 100 responses to each composite measure is required in order to report the measure as a CAHPS Survey result. Composite measures that do not meet the minimum number of responses are denoted as Not Applicable (NA).		

Table 2-8 shows both plans' question summary rates and plan comparisons on each of the two individual item measures.

Table 2-8—Plan Comparisons: Individual Item Measures		
	Colorado Medicaid FFS	Colorado Medicaid PCPP
Individual Items	**Question Summary Rate**	**Question Summary Rate**
Health Promotion and Education	28.8% ↔	32.2% ↔
Coordination of Care	52.9% ↔	48.9% ↔

Summary of Plan Comparison Results

The plan comparisons revealed the following summary results.

- Colorado Medicaid FFS scored higher than Colorado Medicaid PCPP on five of the CAHPS measures: Rating of All Health Care, Rating of Personal Doctor, Getting Care Quickly, How Well Doctors Communicate, and Coordination of Care.
- Colorado Medicaid PCPP scored higher than Colorado Medicaid FFS on five of the CAHPS measures: Rating of Health Plan, Rating of Specialist Seen Most Often, Getting Needed Care, Shared Decision Making, and Health Promotion and Education.
- There were no statistically significant differences between Colorado Medicaid FFS and PCPP on any of the CAHPS measures.
- The Customer Service composite was not evaluated because Colorado Medicaid PCPP did not meet the NCQA minimum threshold of 100 responses for this composite measure.

3. Recommendations

General Recommendations

HSAG recommends the continued administration of the CAHPS 4.0H Adult Medicaid survey in fiscal year (FY) 2008-2009. This will allow HSAG to perform complete benchmarking and trend evaluation on the adult data. HSAG also recommends the continued use of administrative data in identifying the Spanish-speaking population. Significantly more surveys were completed in Spanish during the FY 2007-2008 survey administration than last year's survey administration due to the identification of these clients prior to the start of the survey.

Plan-Specific Recommendations

This section presents Adult Medicaid CAHPS recommendations for Colorado Medicaid FFS and PCPP. The recommendations are grouped into four main categories for QI: top, high, moderate, and low priority. The priority of the recommendations is based on the combined results of the NCQA comparisons and trend analysis.

The priorities presented in this section should be viewed as potential suggestions for QI. Additional sources of QI information, such as other HEDIS results, should be incorporated into a comprehensive QI plan. A number of resources are available to assist state Medicaid agencies and plans with the implementation of CAHPS-based QI initiatives. A comprehensive list of these resources is included in the Reader's Guide Section, beginning on page 4-9.

Table 3-1 shows how the priority assignments are determined for each plan on each CAHPS measure.

Table 3-1—Derivation of Priority Assignments on each CAHPS Measure		
NCQA Comparisons (Star Ratings)	**Trend Analysis**	**Priority Assignment**
★	▼	Top
★	—/NT	Top
★	▲	Top
★★	▼	Top
★★	—/NT	High
★★	▲	High
★★★	▼	High
★★★	—/NT	Moderate
★★★	▲	Moderate
NA/NB	NA/NT/—	Moderate
★★★★	▼	Moderate
★★★★	—/NT	Moderate
★★★★★	▼	Moderate
★★★★	▲	Low
★★★★★	—/NT	Low
★★★★★	▲	Low

Please note:
If statistically significant differences were not identified during the trend analysis, this lack of statistical significance is denoted with a hyphen (—) in the table above.
If a trend analysis was not completed due to changes in a measure, this is denoted as Not Trendable (NT) in the table above.

Global Ratings

Rating of Health Plan

Table 3-2 shows the priority assignments for the overall Rating of Health Plan measure.

Table 3-2—Priority Assignments: Rating of Health Plan			
Plan	NCQA Comparisons (Star Ratings)	Trend Analysis	Priority Assignment
FFS	★	—	Top
PCPP	★★	—	High

At the client level, the overall Rating of Health Plan measure is driven principally by client perception of both plan and physician office operations.

Plan operations include those services provided by the plan directly:

- Distribution of information about the plan.
- Customer service.
- Identification of a provider.

Physician office operations cover all activities that take place in physician offices:

- Scheduling of routine appointments.
- Obtaining interpreters.
- Client satisfaction with their physicians.

In order to improve the overall Rating of Health Plan, QI activities should target both plan and physician office operations.

Rating of All Health Care

Table 3-3 shows the priority assignments for the Rating of All Health Care measure.

Table 3-3—Priority Assignments: Rating of All Health Care			
Plan	NCQA Comparisons (Star Ratings)	Trend Analysis	Priority Assignment
FFS	★★	—	High
PCPP	★★	—	High

At the client level, rating of physicians, perception of access to care, experience with care, and experience with the health plan principally drive the overall Rating of All Health Care measure. The rating of physicians includes the overall satisfaction with both personal doctors and specialists.

Access to care issues include:

- Problems obtaining the care that the client and/or physician thought was necessary.
- Problems obtaining urgent care in a timely fashion.
- Problems finding a personal doctor.
- Difficulty receiving assistance when calling physician offices.

Experience with care issues include:

- Receiving ample time with the physician.
- Having questions and concerns addressed by the physician.
- Receiving understandable and useful information from the physician.
- Being provided care in a timely fashion.

Experience with health plan issues include:

- Receiving accurate and understandable information from the plan.
- Receiving adequate customer service.
- Avoiding problems with health plan paperwork.

In order to improve the overall Rating of All Health Care measure, QI activities should target client satisfaction with physicians, client perception of access to care, experience with care, and experience with the health plan.

Rating of Personal Doctor

Table 3-4 shows the priority assignments for the Rating of Personal Doctor measure.

Table 3-4—Priority Assignments: Rating of Personal Doctor			
Plan	NCQA Comparisons (Star Ratings)	Trend Analysis	Priority Assignment
FFS	★★★★	—	Moderate
PCPP	★★★	—	Moderate

At the client level, communication and waiting time issues principally drive this rating.

Communication issues include:

- Being treated with courtesy and respect.
- Being listened to carefully.
- Receiving clear explanations.

Waiting time issues include:

- Problems receiving needed care when desired.
- Issues acquiring care quickly.

In order to improve the Rating of Personal Doctor, QI activities should target these communication and waiting-time issues.

Rating of Specialist Seen Most Often

Table 3-5 shows the priority assignments for the Rating of Specialist Seen Most Often measure.

Table 3-5—Priority Assignments: Rating of Specialist Seen Most Often			
Plan	NCQA Comparisons (Star Ratings)	Trend Analysis	Priority Assignment
FFS	★★★	—	Moderate
PCPP	★★★	—	Moderate

At the client level, "red tape" issues principally drive the overall Rating of Specialist Seen Most Often measure and include:

- Ease of obtaining health plan approval for the specialist visit.
- Ease of obtaining a referral to see the specialist.
- Availability to see the specialist in a timely fashion.

In order to improve the overall performance on the Rating of Specialist Seen Most Often global rating, QI activities should target the ease of obtaining a referral and health plan approval for a specialist visit. Additionally, the timeliness of specialist visits should be addressed if clients report dissatisfaction with lengthy wait times.

Composite Measures

Getting Needed Care

Table 3-6 shows the priority assignments for the Getting Needed Care measure.

Table 3-6—Priority Assignments: Getting Needed Care			
Plan	NCQA Comparisons (Star Ratings)	Trend Analysis	Priority Assignment
FFS	★★★	–	Moderate
PCPP	★★★	▼	High

At the client level, access-to-care issues principally drive this measure. Access-to-care issues include:

- Obtaining the care a doctor believed to be necessary.
- Helpfulness of office staff.

Some potential sources of access to care issues are resource and technical limitations, which include telephone systems and service expectations. In order to improve clients' satisfaction under the Getting Needed Care measure, QI activities should target obtaining the care a doctor believes to be necessary and helpfulness of office staff. Other potential actions could include producing a flow chart of the process from the client's view from beginning to end, identifying barriers or unnecessary steps, and creating new avenues of information.

Getting Care Quickly

Table 3-7 shows the priority assignments for the Getting Care Quickly measure.

Table 3-7—Priority Assignments: Getting Care Quickly			
Plan	NCQA Comparisons (Star Ratings)	Trend Analysis	Priority Assignment
FFS	★★★★	—	Moderate
PCPP	★★★	—	Moderate

At the client level, waiting time issues principally drive this measure. Waiting time issues include:

- Waiting for an appointment for routine care.
- Waiting more than 15 minutes beyond the start of an appointment to be seen in the doctor's office.

In order to improve clients' satisfaction under the Getting Care Quickly measure, QI activities should target these wait time issues.

How Well Doctors Communicate

Table 3-8 shows the priority assignments for the How Well Doctors Communicate measure.

Table 3-8—Priority Assignments: How Well Doctors Communicate			
Plan	NCQA Comparisons (Star Ratings)	Trend Analysis	Priority Assignment
FFS	★★★	—	Moderate
PCPP	★★	—	High

At the client level, issues involving providing information to and receiving information from the provider principally drive this measure. These issues include:

- Careful listening by the providers.
- Clear explanations in response to questions.
- Spending a sufficient amount of time during the exchange of information.

Other possible sources of provider communication issues are time constraints, perceptions of the clients, and differences in experience, education, culture, and expectations. In order to improve clients' satisfaction under the How Well Doctors Communicate measure, QI activities should target careful listening by the providers, clear explanations in response to questions, and spending a sufficient amount of time during the exchange of information. Other potential actions could include staff training, mentoring or coaching, direct client feedback, and reviewing performance expectations and guidelines.

Customer Service

Table 3-9 shows the priority assignments for the Customer Service measure.

Table 3-9—Priority Assignments: Customer Service			
Plan	NCQA Comparisons (Star Ratings)	Trend Analysis	Priority Assignment
FFS	★★	NT	High
PCPP	NA	NT	Moderate

At the client level, issues that involve both obtaining and understanding information from the plan are the key drivers of the Customer Service composite score. These issues include:

- Difficulty getting help when calling customer service.
- Difficulty finding or understanding information about the plan.

In order to improve clients' satisfaction under the Customer Service measure, QI activities should target perceptions of the accessibility and usefulness of the information provided. Other potential actions could include customer service training; allowing clients to voice concerns and questions via a technical support line; and updating information to account for differences in experience, education, culture, and expectations.

Shared Decision Making

Table 3-10 shows the priority assignments for the Shared Decision Making measure.

Table 3-10—Priority Assignments: Shared Decision Making			
Plan	NCQA Comparisons (Star Ratings)	Trend Analysis	Priority Assignment
FFS	NB	—	Moderate
PCPP	NB	—	Moderate

At the client level, a doctor's willingness to educate clients about multiple treatment options and the pros and cons of each treatment option principally drive this measure. In order to improve client satisfaction scores under the Shared Decision Making measure, client QI activities should focus on:

- Encouragement of client participation in decision making by physicians/health providers.
- Assuring that an adequate amount of time is spent with clients to allow for client education.[3-1]
- Providing provider education on the importance of shared decision making for client autonomy and improved client satisfaction.[3-2]

[3-1] Fraenkel L and McGraw S. "What are the Essential Elements to Enable Patient Participation in Medical Decision Making?" *Journal of General Internal Medicine*. May 2007. 22(5): 614-9

[3-2] McGuire A, McCullough L, et al. "Missed Expectations? Physicians' Views of Patients' Participation in Medical Decision Making." *Medical Care*. May 2005. 43(5): 466-70.

Individual Item Measures

Health Promotion and Education

Table 3-11 shows the priority assignments for the Health Promotion and Education measure.

Table 3-11—Priority Assignments: Health Promotion and Education			
Plan	NCQA Comparisons (Star Ratings)	Trend Analysis	Priority Assignment
FFS	NB	—	Moderate
PCPP	NB	—	Moderate

At the client level, this measure is driven by the physician discussing health promotion and disease prevention with the patient. Health promotion includes enabling the patient to take control over their health. Health education is a component of health promotion that involves increasing patients' knowledge about their own health and well-being.[3-3] In addition to one-on-one modes of health promotion and education, other communication efforts can include: lectures, group/panel discussions, and presentations. However, demographics such as age, physical barriers, and race/ethnicity need to be considered in order to determine the most effective method of health promotion and education for a particular patient or patient group.[3-4]

[3-3] UNESCO Institute for Education. *Health Promotion and Health Education for Adults*. 1999. Hamburg, Germany.
[3-4] Saha A, Poddar E, and Mankad M. "Effectiveness of Different Methods of Health Education: A Comparative Assessment in a Scientific Conference." *BMC Public Health.* 2005; 5:88.

Coordination of Care

Table 3-12 shows the priority assignments for the Coordination of Care measure.

Table 3-12—Priority Assignments: Coordination of Care			
Plan	NCQA Comparisons (Star Ratings)	Trend Analysis	Priority Assignment
FFS	NB	—	Moderate
PCPP	NB	—	Moderate

At the client level, a personal doctor's knowledge of additional care received by other doctors and health providers principally drives this measure. Barriers to coordination of care include:

- Lack of coordinated follow-up between specialists and personal doctors.
- Lack of easy access to medical records or insufficient detail included in the records.
- Absence of a defined care plan maintained by the personal doctor.

Studies have demonstrated that effective coordination of care tends to lead to fewer complaints reported by clients.[3-5] Further, coordination of care among physicians in primary care practices tends to yield better client outcomes.[3-6]

[3-5] Parchman M, Noel P, Lee S. "Primary Care Attributes, Health Care System Hassles, and Chronic Illness." *Medical Care*. Nov 2005. 43(11): 1123-9.
[3-6] Parkerton P, Smith D, Straley H. "Primary Care Practice Coordination Versus Physician Continuity." *Family Medicine*. Jan 2004. 36(1): 15-21.

Comparison of 2007 to 2008 Plan-Specific Recommendations

The following tables present a comparison of the top and high priorities identified for the Colorado Medicaid FFS and PCPP adult Medicaid populations in years 2007 and 2008.

Table 3-13—Priority Assignments: Colorado Medicaid FFS

2007 Top and High Priorities	2008 Top and High Priorities
Rating of Health Plan	Rating of Health Plan
Rating of All Health Care	Rating of All Health Care
Getting Needed Care	Customer Service

For Colorado Medicaid FFS, two measures, Rating of Health Plan and Rating of All Health Care, were identified in both 2007 and 2008 as top or high priorities. While Getting Needed Care was identified in 2007 as a top priority, in 2008 the measure was identified as only a moderate priority. On the other hand, the Customer Service composite was identified as a moderate priority in 2007 but was identified as a top or high priority in 2008.

Table 3-14—Priority Assignments: Colorado Medicaid PCPP

2007 Top and High Priorities	2008 Top and High Priorities
Rating of Health Plan	Rating of Health Plan
Rating of All Health Care	Rating of All Health Care
Getting Needed Care	Getting Needed Care
	How Well Doctors Communicate

For Colorado Medicaid PCPP, all three measures, Rating of Health Plan, Rating of All Health Care, and Getting Needed Care, identified in 2007 as top or high priorities were also identified in 2008 as top or high priorities. Furthermore, How Well Doctors Communicate was also identified in 2008 as a top or high priority, where it was identified as a low priority in 2007.

Although the administration of the CAHPS survey takes place at the health plan level, the accountability for the performance lies at both the plan and provider network level. Table 3-15 provides a summary of the responsible parties for various aspects of care.[2-7]

Table 3-15—Accountability for Areas of Care

Domain	Composite	Who Is Accountable?	
		Health Plan	Provider Network
Access	Getting Needed Care	✓	✓
	Getting Care Quickly		✓
Interpersonal Care	How Well Doctors Communicate		✓
	Shared Decision Making		✓
Plan Administrative Services	Customer Service	✓	
Personal Doctor			✓
Specialist			✓
All Health Care		✓	✓
Health Plan		✓	

Although performance on some of the global ratings and composite measures may be driven by the actions of the provider network, the plan can still play a major role in influencing the performance of provider groups through intervention and incentive programs.

Those measures identified for FFS and PCPP that exhibited continued low performance between 2007 and 2008 suggest that additional analysis may be required to identify what is truly causing low performance in these areas. Methods that could be used include:

- Conducting a correlation analysis to assess if specific issues are related to overall ratings (i.e., those question items or composites that are predictors of rating scores).
- Drawing on the analysis of population sub-groups (e.g., health status, race, age) to determine if there are client groups that tend to have lower levels of satisfaction (see Tab and Banner Book).
- Using other indicators to supplement CAHPS data such as client complaints/grievances, feedback from staff, and other survey data.
- Conducting focus groups and interviews to determine what specific issues are causing low satisfaction ratings.

After identification of the specific problem(s), then necessary QI activities could be developed. However, the methodology for QI activity development should follow a cyclical process (e.g., Plan-Do-Study-Act [PDSA]) that allows for testing and analysis of interventions in order to assure that the desired results are achieved.

[2-7] Edgman-Levitan S, et al. *The CAHPS Improvement Guide: Practical Strategies for Improving the Patient Care Experience.* Department of Health Care Policy Harvard Medical School, October 2003.

This section provides a comprehensive overview of CAHPS, including the CAHPS Survey administration protocol and analytic methodology. It is designed to provide supplemental information to the reader that may aid in the interpretation and use of the CAHPS results presented in this report.

Survey Administration

Survey Overview

The survey instrument selected was the CAHPS 4.0H Adult Medicaid Health Plan Survey. The CAHPS 4.0H Health Plan Surveys are a set of standardized surveys that assess patient perspectives on care. Originally, CAHPS was a five-year collaborative project sponsored by AHRQ, formerly known as the Agency for Health Care Policy and Research (AHCPR). The CAHPS questionnaires and consumer reports were developed under cooperative agreements among AHRQ, Harvard Medical School, RAND, and the Research Triangle Institute (RTI). In 1997, NCQA, in conjunction with AHRQ, created the CAHPS 2.0H Survey measure as part of NCQA's HEDIS.[4-1] In 2002, AHRQ convened the CAHPS Instrument Panel to re-evaluate and update the CAHPS Health Plan Surveys and to improve the state-of-the-art methods for assessing clients' experiences with care.[4-2] The result of this re-evaluation and update process was the development of the CAHPS 3.0H Health Plan Surveys. The goal of the CAHPS 3.0H Health Plan Surveys was to effectively and efficiently obtain information from the person receiving care. NCQA also includes CAHPS results as part of the scoring algorithm in its accreditation program for managed care organizations. In 2006, AHRQ released the CAHPS 4.0 Health Plan Surveys. Based on the CAHPS 4.0 versions, NCQA introduced new HEDIS versions of the Adult Health Plan Survey in 2007, which are referred to as the CAHPS 4.0H Health Plan Surveys.[4-3] It is anticipated that NCQA will release the CAHPS 4.0H Child Health Plan Survey in 2009.[4-4]

The HEDIS sampling and data collection procedures for the CAHPS 4.0H Health Plan Survey is designed to capture accurate and complete information about consumer-reported experiences with health care. The sampling and data collection procedures promote both the standardized administration of survey instruments and the comparability of the resulting health plan data. HSAG's administration of the surveys was completed with strict adherence to required specifications.

[4-1] National Committee for Quality Assurance. *HEDIS 2002*, *Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA Publication, 2001.
[4-2] National Committee for Quality Assurance. *HEDIS 2003*, *Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA Publication, 2002.
[4-3] National Committee for Quality Assurance. *HEDIS 2007*, *Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA Publication, 2006.
[4-4] National Committee for Quality Assurance. *HEDIS Survey Vendor Update*. April 9, 2007.

The CAHPS 4.0H Adult Medicaid Health Plan Survey includes 51 core questions that yield 11 measures of satisfaction. These measures include four global rating questions, five composite measures, and two individual item measures. The global measures (also referred to as global ratings) reflect overall satisfaction with the health plan, health care, personal doctors, and specialists. The composite measures are sets of questions grouped together to address different aspects of care (e.g., "Getting Needed Care" or "Getting Care Quickly"). The individual item measures are individual questions that look at a specific area of care (i.e., "Health Promotion and Education" and "Coordination of Care").

Table 4-1 lists the global ratings, composite measures, and individual item measures included in the CAHPS 4.0H Adult Medicaid Health Plan Survey.

Table 4-1—CAHPS Measures

Global Ratings	Composite Measures	Individual Item Measures
Rating of Health Plan	Getting Needed Care	Health Promotion and Education
Rating of All Health Care	Getting Care Quickly	Coordination of Care
Rating of Personal Doctor	How Well Doctors Communicate	
Rating of Specialist Seen Most Often	Customer Service	
	Shared Decision Making	

Sampling Procedures

The clients eligible for sampling included those who were FFS or PCPP clients at the time the sample was drawn and who were continuously enrolled for at least five of the last six months (July through December) of 2007. The clients eligible for sampling included those who were age 18 or older (as of December 31, 2007).

A random sample of 1,418 adult clients was selected from each participating plan, and a total of 2,836 adult surveys were mailed out for the FFS and PCPP Colorado Medicaid plans. The NCQA protocol permits oversampling in 5 percent increments. For the FFS and PCPP, a 5 percent oversampling was performed on the adult population. This oversampling was performed to ensure a greater number of respondents to each CAHPS measure.

Survey Protocol

The CAHPS 4.0H Health Plan Survey process allowed for two methods by which clients could complete a survey. The first, or mail phase, consisted of a survey being mailed to all sampled clients. For the Colorado Medicaid FFS and PCPP, those clients who were identified as Spanish-speaking through administrative data were mailed a Spanish version of the survey. Clients that were not identified as Spanish-speaking received an English version of the survey. The English and Spanish versions of the survey included a toll-free number that clients could call to request a survey in another language (i.e., English or Spanish). A reminder postcard was sent to all non-respondents, followed by a second survey mailing and reminder postcard. The second phase, or telephone phase, consisted of CATI of sampled clients who had not mailed in a completed survey. A series of up to six CATI calls was made to each non-respondent.[4-5] It has been shown that the addition of the telephone phase aids in the reduction of non-response bias by increasing the number of respondents who are more demographically representative of a plan's population.[4-6]

HEDIS specifications require that HSAG be provided a list of all eligible clients for the sampling frame. Following HEDIS requirements, HSAG sampled clients who met the following criteria:

- Were age 18 or older as of December 31, 2007.
- Were currently enrolled in FFS or PCPP.
- Had been continuously enrolled for at least five of the last six months of 2007.
- Had Medicaid as the primary payer.

HSAG inspected a sample of the file records to check for any apparent problems with the files, such as missing address elements. A random sample of records from each population was passed through the United States Postal Service's National Change of Address (NCOA) system to obtain new addresses for clients who had moved (if they had given the Postal Service a new address). Following NCQA requirements, the survey samples were random samples with no more than one client being selected per household.

The HEDIS specifications require that the name of the plan appear in the questionnaires, letters, and postcards; that the letters and cards bear the signature of a high-ranking plan or state official; and that the questionnaire packages include a postage-paid reply envelope addressed to the organization conducting the surveys. HSAG complied with these specifications.

[4-5] National Committee for Quality Assurance. *Quality Assurance Plan for HEDIS 2008 Survey Measures.* Washington, DC: NCQA Publication, 2007.
[4-6] Fowler FJ Jr., Gallagher PM, Stringfellow VL, et al. "Using Telephone Interviews to Reduce Nonresponse Bias to Mail Surveys of Health Plan Members." *Medical Care*. 2002; 40(3): 190-200.

Table 4-2 shows the CAHPS timeline used in the administration of the Colorado Adult Medicaid CAHPS Health Plan Surveys. The timeline is based on NCQA HEDIS Specifications for Survey Measures.[4-7]

Table 4-2—CAHPS 4.0H Survey Timeline	
Task	**Timeline**
Send first questionnaire with cover letter to the respondent.	0 days
Send a postcard reminder to non-respondents four to 10 days after mailing the first questionnaire.	4 – 10 days
Send a second questionnaire (and letter) to non-respondents approximately 35 days after mailing the first questionnaire.	35 days
Send a second postcard reminder to non-respondents four to 10 days after mailing the second questionnaire.	39 – 45 days
Initiate CATI interviews for non-respondents approximately 21 days after mailing the second questionnaire.	56 days
Initiate systematic contact for all non-respondents such that at least six telephone calls are attempted at different times of the day, on different days of the week, and in different weeks.	56 – 70 days
Telephone follow-up sequence completed (i.e., completed interviews obtained or maximum calls reached for all nonrespondents) approximately 14 days after initiation.	70 days

[4-7] National Committee for Quality Assurance. *HEDIS 2008*, *Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA Publication, 2007.

Methodology

HSAG used the CAHPS scoring approach recommended by NCQA in Volume 3 of HEDIS Specifications for Survey Measures. Based on NCQA's recommendations and HSAG's extensive experience evaluating CAHPS data, a number of analyses were performed to comprehensively assess client satisfaction with the Colorado Medicaid FFS and PCPP. This section provides an overview of each analysis.

Response Rates

The administration of the Adult Medicaid CAHPS 4.0H Health Plan Survey is comprehensive and is designed to garner the highest possible response rate. NCQA defines the response rate as the total number of completed surveys divided by all eligible clients of the sample.[4-8] A client's survey was assigned a disposition code of "completed" if at least one question was answered within the survey. Eligible clients include the entire random sample (including any oversample) minus ineligible clients. Ineligible clients of the sample met one or more of the following criteria: were deceased, were invalid (did not meet criteria described on page 4-3), were mentally or physically incapacitated, or had a language barrier.

$$\textit{Response Rate} = \frac{\textit{Number of Completed Surveys}}{\textit{Random Sample - Ineligibles}}$$

Respondent Demographics

The demographic analysis evaluated self-reported demographic information from survey respondents. Given that the demographics of a response group influence overall client satisfaction scores, it is important to evaluate all CAHPS results in the context of the actual respondent population. If the respondent population differs significantly from the actual population of the plan, then caution must be exercised when extrapolating the CAHPS results to the entire population.

NCQA Comparisons

An analysis of the Colorado Adult Medicaid CAHPS Health Plan Survey results was conducted using NCQA HEDIS Specifications for Survey Measures. Per these specifications, results for the adult and child Medicaid populations are reported separately, and no weighting or case-mix adjustment is performed on the results. NCQA also requires a minimum of 100 responses on each item in order to report the item as a valid CAHPS Survey result.

In order to perform the NCQA comparisons, a three-point mean score was determined for each CAHPS measure. The resulting three-point mean scores were compared to published NCQA

[4-8] National Committee for Quality Assurance. *HEDIS 2008*, *Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA Publication, 2007.

Benchmarks and Thresholds to derive the overall client satisfaction ratings (i.e., star ratings) for each CAHPS measure. For detailed information on the derivation of three-point mean scores, please refer to *NCQA HEDIS 2008 Specifications for Survey Measures, Volume 3*.

Plan ratings of one (★) to five (★★★★★) stars were determined for each CAHPS measure using the following percentile distributions:

★★★★★	indicates a score at or above the 90th percentile
★★★★	indicates a score between the 75th and 89th percentiles
★★★	indicates a score between the 50th and 74th percentiles
★★	indicates a score between the 25th and 49th percentiles
★	indicates a score below the 25th percentile
NA	indicates that the plan did not meet the minimum NCQA reporting threshold of 100 respondents
NB	indicates that NCQA did not provide benchmarks for this measure

Table 4-3 shows the benchmarks and thresholds used to derive the overall client satisfaction ratings on each CAHPS measure.[4-9]

Table 4-3—Overall Adult Medicaid Client Satisfaction Ratings Crosswalk

Measure	90th Percentile	75th Percentile	50th Percentile	25th Percentile
Rating of Health Plan	2.49	2.41	2.32	2.24
Rating of All Health Care	2.36	2.30	2.23	2.17
Rating of Personal Doctor	2.54	2.48	2.42	2.38
Rating of Specialist Seen Most Often	2.53	2.49	2.44	2.39
Getting Needed Care	2.40	2.32	2.24	2.10
Getting Care Quickly	2.46	2.41	2.35	2.26
How Well Doctors Communicate	2.64	2.58	2.54	2.48
Customer Service	2.39	2.30	2.25	2.18
Shared Decision Making	NB	NB	NB	NB
Health Promotion and Education	NB	NB	NB	NB
Coordination of Care	NB	NB	NB	NB

[4-9] National Committee for Quality Assurance. *HEDIS Benchmarks and Thresholds for Accreditation 2008*. Washington, DC: NCQA, Updated April 14, 2008.

Trend Analysis

A trend analysis was performed to determine if significant changes in client satisfaction occurred between 2007 and 2008. For purposes of this analysis, question summary rates were calculated for each global rating and individual item measure, and global proportions were calculated for each composite measure. Both the question summary rates and global proportions were calculated in accordance with NCQA HEDIS Specifications for Survey Measures.[4-10] The scoring of the global ratings, composite measures, and individual item measures involved assigning top-level responses a score of one, with all other responses receiving a score of zero. After applying this scoring methodology, the percentage of top-level responses was calculated in order to determine the question summary rates and global proportions. For additional detail, please refer to the *NCQA HEDIS 2008 Specifications for Survey Measures, Volume 3*.

The 2008 Colorado Medicaid and plan-level CAHPS scores were compared to the corresponding 2007 scores to determine whether there were statistically significant differences. The difference in performance from 2007 to 2008 is considered significant if the two-sided *p* value of the *t* test is less than 0.05. Scores that were statistically higher in 2008 than in 2007 are noted with upward (▲) triangles. Scores that were statistically lower in 2008 than in 2007 are noted with downward (▼) triangles. Scores in 2008 that were not statistically different from scores in 2007 are not noted with triangles. Also, measures that did not meet the minimum number of 100 responses required by NCQA are denoted as NA.

Plan Comparisons

Plan comparisons were performed to identify client satisfaction performance differences between the FFS and PCPP Colorado Medicaid plans. For purposes of the plan comparisons, question summary rates and global proportions were calculated using the methodology described in the trend analysis section. The difference in performance between the two plans is considered significant if the two-sided *p* value of the *t* test is less than 0.05. Statistically significant differences between the two plans are noted by arrows in the results section tables. When a statistically significant difference exists between the plans' scores, the higher-performing plan will be denoted by an upward (↑) arrow. Conversely, the lower-performing plan will be denoted with a downward (↓) arrow. If the differences are not statistically significant, then both plans' scores are denoted with a horizontal (↔) arrow. If either plan does not meet NCQA's requirement of 100 respondents, then comparisons are not performed, and the measure's question summary rate or global proportion is denoted as NA.

[4-10] National Committee for Quality Assurance. *HEDIS 2008*, *Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA Publication, 2007.

Limitations and Cautions

The findings presented in the 2008 Colorado CAHPS reports are subject to some limitations in the survey design, analysis, and interpretation. These limitations should be considered carefully when interpreting or generalizing the findings. These limitations are discussed below.

Case-Mix Adjustment

As described in the respondent demographics subsection, the demographics of a response group may impact client satisfaction. Therefore, differences in the demographics of the response group may impact CAHPS results. NCQA does not recommend case-mix adjusting CAHPS results to account for these differences.[4-11]

Non-response Bias

The experiences of the survey respondent population may be different than that of non-respondents with respect to their health care services and may vary by plan. Therefore, the potential for non-response bias should be considered when interpreting CAHPS results.

Causal Inferences

Although this report examines whether clients of various plans report differences in satisfaction with various aspects of their health care experiences, these differences may not be completely attributable to the Medicaid plan. These analyses identify whether clients in various types of plans give different ratings of satisfaction with their Medicaid plan. The survey by itself does not necessarily reveal the exact cause of these differences.

[4-11] Agency for Healthcare Research and Quality. *CAHPS Health Plan Survey and Reporting Kit 2007*. Rockville, MD: US Department of Health and Human Services, July 2007.

Quality Improvement References

The CAHPS surveys were originally developed to meet the need for usable, relevant information on quality of care from the patient's perspective. However, the surveys also play an important role as a QI tool for health care organizations, which can use the standardized data and results to identify relative strengths and weaknesses in their performance, determine where they need to improve, and track their progress over time.[4-12] The following references offer guidance on possible approaches to CAHPS-related QI activities.

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[4-12] AHRQ Website. *CAHPS User Resources: Quality Improvement Resources.* Available at: https://www.cahps.ahrq.gov/content/resources/QI/RES_QI_Intro.asp?p=103&s=31. Accessed on: July 18, 2008.

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5. Survey Instrument

The survey instrument selected for the 2008 Colorado Adult Medicaid Client Satisfaction Survey was the CAHPS 4.0H Adult Medicaid Health Plan Survey. This section provides a copy of the survey instrument.

CAHPS® 4.0H Adult Questionnaire (Medicaid)

SURVEY INSTRUCTIONS

- Answer <u>all</u> the questions by checking the box to the left of your answer.
- You are sometimes told to skip over some questions in this survey. When this happens you will see an arrow with a note that tells you what question to answer next, like this:

  ☑ Yes ➔**Go to Question 1**

  ☐ No

All information that would let someone identify you or your family will be kept private.* Synovate *will not share your personal information with anyone without your OK. You may choose to answer this survey or not. If you choose not to, this will not affect the benefits you get.

You may notice a number on the cover of this survey. This number is ONLY used to let us know if you returned your survey so we don't have to send you reminders.

***If you want to know more about this study, please call* 1-800-914-2283.**

1. Our records show that you are now in {INSERT HEALTH PLAN NAME/STATE MEDICAID PROGRAM NAME}. Is that right?

[1] ☐ Yes ➔**If Yes, go to Question 3**

[2] ☐ No

2. What is the name of your health plan? (Please print)

_____

YOUR HEALTH CARE IN THE LAST 6 MONTHS

These questions ask about your own health care. Do <u>not</u> include care you got when you stayed overnight in a hospital. Do <u>not</u> include the times you went for dental care visits.

3. In the last 6 months, did you have an illness, injury, or condition that <u>needed care right away</u> in a clinic, emergency room, or doctor's office?

[1] ☐ Yes

[2] ☐ No ➔**If No, go to Question 5**

4. In the last 6 months, when you <u>needed care right away</u>, how often did you get care as soon as you thought you needed?

[1] ☐ Never

[2] ☐ Sometimes

[3] ☐ Usually

[4] ☐ Always

5. In the last 6 months, <u>not</u> counting the times you needed care right away, did you make any appointments for your health care at a doctor's office or clinic?

[1] ☐ Yes

[2] ☐ No ➔**If No, go to Question 7**

6. **In the last 6 months, <u>not</u> counting the times you needed care right away, how often did you get an appointment for your health care at a doctor's office or clinic as soon as you thought you needed?**

   [1]☐ Never
   [2]☐ Sometimes
   [3]☐ Usually
   [2]☐ Always

7. **In the last 6 months, <u>not</u> counting the times you went to an emergency room, how many times did you go to a doctor's office or clinic to get health care for yourself?**

   [0]☐ None ➔**If None, Go to Question 13**
   [1]☐ 1
   [2]☐ 2
   [3]☐ 3
   [4]☐ 4
   [5]☐ 5 to 9
   [6]☐ 10 or more

8. **In the last 6 months, how often did you and a doctor or other health provider talk about specific things you could do to prevent illness?**

   [1]☐ Never
   [2]☐ Sometimes
   [3]☐ Usually
   [4]☐ Always

9. **Choices for your treatment or health care can include choices about medicine, surgery, or other treatment. In the last 6 months, did a doctor or other health provider tell you there was more than one choice for your treatment or health care?**

   [1]☐ Yes
   [2]☐ No ➔**If No, Go to Question 12**

10. **In the last 6 months, did a doctor or other health provider talk with you about the pros and cons of each choice for your treatment or health care?**

    [1]☐ Definitely yes
    [2]☐ Somewhat yes
    [3]☐ Somewhat no
    [4]☐ Definitely no

11. **In the last 6 months, when there was more than one choice for your treatment or health care, did a doctor or other health provider ask which choice was best for you?**

    [1]☐ Definitely yes
    [2]☐ Somewhat yes
    [3]☐ Somewhat no
    [4]☐ Definitely no

12. Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your health care in the last 6 months?

- 00☐ 0 Worst health care possible
- 01☐ 1
- 02☐ 2
- 03☐ 3
- 04☐ 4
- 05☐ 5
- 06☐ 6
- 07☐ 7
- 08☐ 8
- 09☐ 9
- 10☐ 10 Best health care possible

YOUR PERSONAL DOCTOR

13. A personal doctor is the one you would see if you need a check-up, want advice about a health problem, or get sick or hurt. Do you have a personal doctor?

- 1☐ Yes
- 2☐ No ➔**If No, Go to Question 22**

14. In the last 6 months, how many times did you visit your personal doctor to get care for yourself?

- 0☐ None ➔**If None, Go to Question 21**
- 1☐ 1
- 2☐ 2
- 3☐ 3
- 4☐ 4
- 5☐ 5 to 9
- 6☐ 10 or more

15. In the last 6 months, how often did your personal doctor explain things in a way that was easy to understand?

- 1☐ Never
- 2☐ Sometimes
- 3☐ Usually
- 4☐ Always

16. In the last 6 months, how often did your personal doctor listen carefully to you?

- 1☐ Never
- 2☐ Sometimes
- 3☐ Usually
- 4☐ Always

17. In the last 6 months, how often did your personal doctor show respect for what you had to say?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

18. In the last 6 months, how often did your personal doctor spend enough time with you?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

19. In the last 6 months, did you get care from a doctor or other health provider besides your personal doctor?

1 ☐ Yes
2 ☐ No **➔If No, Go to Question 21**

20. In the last 6 months, how often did your personal doctor seem informed and up-to-date about the care you got from these doctors or other health providers?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

21. Using any number from 0 to 10, where 0 is the worst personal doctor possible and 10 is the best personal doctor possible, what number would you use to rate your personal doctor?

00 ☐ 0 Worst personal doctor possible
01 ☐ 1
02 ☐ 2
03 ☐ 3
04 ☐ 4
05 ☐ 5
06 ☐ 6
07 ☐ 7
08 ☐ 8
09 ☐ 9
10 ☐ 10 Best personal doctor possible

GETTING HEALTH CARE FROM SPECIALISTS

When you answer the next questions, do <u>not</u> include dental visits or care you got when you stayed overnight in a hospital.

22. Specialists are doctors like surgeons, heart doctors, allergy doctors, skin doctors, and other doctors who specialize in one area of health care. In the last 6 months, did you try to make any appointments to see a specialist?

[1] ☐ Yes
[2] ☐ No **➔If No, Go to Question 26**

23. In the last 6 months, how often was it easy to get appointments with specialists?

[1] ☐ Never
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always

24. How many specialists have you seen in the last 6 months?

[0] ☐ None **➔If None, Go to Question 26**
[1] ☐ 1 specialist
[2] ☐ 2
[3] ☐ 3
[4] ☐ 4
[5] ☐ 5 or more specialists

25. We want to know your rating of the specialist you saw most often in the last 6 months. Using any number from 0 to 10, where 0 is the worst specialist possible and 10 is the best specialist possible, what number would you use to rate that specialist?

[00] ☐ 0 Worst specialist possible
[01] ☐ 1
[02] ☐ 2
[03] ☐ 3
[04] ☐ 4
[05] ☐ 5
[06] ☐ 6
[07] ☐ 7
[08] ☐ 8
[09] ☐ 9
[10] ☐ 10 Best specialist possible

YOUR HEALTH PLAN

The next questions ask about your experience with your health plan.

26. In the last 6 months, did you try to get any kind of care, tests, or treatment through your health plan?

[1] ☐ Yes
[2] ☐ No ➔**If No, Go to Question 28**

27. In the last 6 months, how often was it easy to get the care, tests, or treatment you thought you needed through your health plan?

[1] ☐ Never
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always

28. In the last 6 months, did you look for any information in written materials or on the Internet about how your health plan works?

[1] ☐ Yes
[2] ☐ No ➔**If No, Go to Question 30**

29. In the last 6 months, how often did the written materials or the Internet provide the information you needed about how your health plan works?

[1] ☐ Never
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always

30. In the last 6 months, did you try to get information or help from your health plan's customer service?

[1] ☐ Yes
[2] ☐ No ➔**If No, Go to Question 33**

31. In the last 6 months, how often did your health plan's customer service give you the information or help you needed?

[1] ☐ Never
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always

32. In the last 6 months, how often did your health plan's customer service staff treat you with courtesy and respect?

[1] ☐ Never
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always

33. In the last 6 months, did your health plan give you any forms to fill out?

[1] ☐ Yes
[2] ☐ No ➔**If No, Go to Question 35**

34. In the last 6 months, how often were the forms from your health plan easy to fill out?

[1] ☐ Never
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always

35. Using any number from 0 to 10, where 0 is the worst health plan possible and 10 is the best health plan possible, what number would you use to rate your health plan?

00☐ 0 Worst health plan possible
01☐ 1
02☐ 2
03☐ 3
04☐ 4
05☐ 5
06☐ 6
07☐ 7
08☐ 8
09☐ 9
10☐ 10 Best health plan possible

ABOUT YOU

36. In general, how would you rate your overall health?

1☐ Excellent
2☐ Very good
3☐ Good
4☐ Fair
5☐ Poor

37. Do you now smoke cigarettes every day, some days, or not at all?

1☐ Every day
2☐ Some days
3☐ Not at all ➔**If Not at all, Go to Question 41**
4☐ Don't know ➔**If Don't know, Go to Question 41**

38. In the last 6 months, on how many visits were you advised to quit smoking by a doctor or other health provider in your plan?

0☐ None
1☐ 1 visit
2☐ 2 to 4 visits
3☐ 5 to 9 visits
4☐ 10 or more visits
5☐ I had no visits in the last 6 months

39. On how many visits was medication recommended or discussed to assist you with quitting smoking (for example: nicotine gum, patch, nasal spray, inhaler, prescription medication)?

- [0] ☐ None
- [1] ☐ 1 visit
- [2] ☐ 2 to 4 visits
- [3] ☐ 5 to 9 visits
- [4] ☐ 10 or more visits
- [5] ☐ I had no visits in the last 6 months

40. On how many visits did your doctor or health provider recommend or discuss methods and strategies (other than medication) to assist you with quitting smoking?

- [0] ☐ None
- [1] ☐ 1 visit
- [2] ☐ 2 to 4 visits
- [3] ☐ 5 to 9 visits
- [4] ☐ 10 or more visits
- [5] ☐ I had no visits in the last 6 months

41. In the last 6 months, have you seen a doctor or other health provider 3 or more times for the same condition or problem?

- [1] ☐ Yes
- [2] ☐ No **➔If No, Go to Question 43**

42. Is this a condition or problem that has lasted for at least 3 months? Do <u>not</u> include pregnancy or menopause.

- [1] ☐ Yes
- [2] ☐ No

43. Do you now need or take medicine prescribed by a doctor? Do <u>not</u> include birth control.

- [1] ☐ Yes
- [2] ☐ No **➔If No, Go to Question 45**

44. Is this to treat a condition that has lasted for at least 3 months? Do <u>not</u> include pregnancy or menopause.

- [1] ☐ Yes
- [2] ☐ No

45. What is your age?

- [1] ☐ 18 to 24
- [2] ☐ 25 to 34
- [3] ☐ 35 to 44
- [4] ☐ 45 to 54
- [5] ☐ 55 to 64
- [6] ☐ 65 to 74
- [7] ☐ 75 or older

46. Are you male or female?

- [1] ☐ Male
- [2] ☐ Female

47. What is the highest grade or level of school that you have completed?

- [1] ☐ 8th grade or less
- [2] ☐ Some high school, but did not graduate
- [3] ☐ High school graduate or GED
- [4] ☐ Some college or 2-year degree
- [5] ☐ 4-year college graduate
- [6] ☐ More than 4-year college degree

48. Are you of Hispanic or Latino origin or descent?

[1]☐ Yes, Hispanic or Latino

[2]☐ No, Not Hispanic or Latino

49. What is your race? Please mark one or more.

[a]☐ White

[b]☐ Black or African-American

[c]☐ Asian

[d]☐ Native Hawaiian or other Pacific Islander

[e]☐ American Indian or Alaska Native

[f]☐ Other

50. Did someone help you complete this survey?

[1]☐ Yes **➔If Yes, Go to Question 51**

[2]☐ No **➔Thank you. Please return the completed survey in the postage-paid envelope.**

51. How did that person help you? Check all that apply.

[a]☐ Read the questions to me

[b]☐ Wrote down the answers I gave

[c]☐ Answered the questions for me

[d]☐ Translated the questions into my language

[e]☐ Helped in some other way

THANK YOU

Please return the completed survey in the postage-paid envelope.

6. CD-ROM

The accompanying CD includes all of the information from the Executive Summary, Results, Recommendations, Reader's Guide, and Survey Instrument sections of this report. The CD also contains electronic copies of comprehensive cross-tabulations (Tab and Banner books) on each survey question for both FFS and PCPP.

CD Contents

- Colorado Adult Medicaid CAHPS Report
- Overall Colorado Adult Medicaid Cross-tabulations (Tab and Banner Book)
- FFS Adult Medicaid Cross-tabulations (Tab and Banner Book)
- PCPP Adult Medicaid Cross-tabulations (Tab and Banner Book)

Please note, the CD contents are in the form of an Adobe Acrobat portable document format (PDF) file. Internal PDF bookmarks can be used to navigate from section to section within the PDF file.

A free Adobe Acrobat Reader can be downloaded from Adobe's Web site at:
http://www.adobe.com/products/acrobat/readstep2.htm