FY 09–10 ADULT MEDICAID CLIENT SATISFACTION REPORT

August 2010

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

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HSAG HEALTH SERVICES ADVISORY GROUP

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1. Executive Summary

The State of Colorado requires annual administration of client satisfaction surveys to Medicaid clients enrolled in the following plans: fee-for-service (FFS), Primary Care Physician Program (PCPP), Denver Health Medical Plan (DHMP), and Rocky Mountain Health Plan (RMHP). The Colorado Department of Health Care Policy & 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.[1-1,1-2] The goal of the CAHPS Health Plan Surveys is to provide performance feedback that is actionable and 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 2010.

Performance Highlights

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

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

[1-1] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).
[1-2] The DHMP CAHPS Adult Medicaid Survey administration was performed by Morpace. The RMHP CAHPS Adult Medicaid Survey administration was performed by the Center for the Study of Services (CSS).

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 five CAHPS composite measures (Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, Customer Service, and Shared Decision Making) were compared to NCQA's 2010 Healthcare Effectiveness Data and Information Set (HEDIS®) Benchmarks and Thresholds for Accreditation.[1-3,1-4,1-5,1-6,1-7] 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 2-11. Table 1-1 presents the highlights from this comparison.

Table 1-1
NCQA Comparisons Highlights

Colorado Medicaid FFS	Colorado Medicaid PCPP	DHMP	RMHP
★ Rating of Health Plan	★★ Rating of Health Plan	★ Getting Needed Care	★★★ Rating of Specialist Seen Most Often
★ Rating of All Health Care	★★★ Rating of All Health Care	★ Getting Care Quickly	★★★★ Rating of Health Plan
★★ Getting Care Quickly	★★★ Rating of Specialist Seen Most Often	★ Rating of All Health Care	★★★★ Rating of Personal Doctor
★★★ Getting Needed Care	★★★★ Getting Needed Care	★ Rating of Health Plan	★★★★ How Well Doctors Communicate
★★★ Rating of Personal Doctor	★★★★ Getting Care Quickly	★ Shared Decision Making	★★★★★ Rating of All Health Care
★★★ How Well Doctors Communicate	★★★★ Rating of Personal Doctor	★★ Rating of Specialist Seen Most Often	★★★★★ Getting Needed Care
★★★★ Rating of Specialist Seen Most Often	★★★★ How Well Doctors Communicate	★★★ How Well Doctors Communicate	★★★★★ Getting Care Quickly
★★★★ Shared Decision Making	★★★★★ Shared Decision Making	★★★★ Rating of Personal Doctor	★★★★★ Customer Service
NA Customer Service	NA Customer Service	NA Customer Service	★★★★★ Shared Decision Making

★★★★★ 90th Percentile or Above ★★★★ 75th – 89th Percentiles ★★★ 50th – 74th Percentiles ★★ 25th – 49th Percentiles ★ Below 25th Percentile NA Not Applicable

[1-3] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
[1-4] National Committee for Quality Assurance. *HEDIS Benchmarks and Thresholds for Accreditation 2010*. Washington, DC: NCQA, Updated February 4, 2010.
[1-5] NCQA National Distribution of 2009 Adult Medicaid Plan-Level Results. Prepared by NCQA for HSAG on December 9, 2009.
[1-6] The star assignments for the Shared Decision Making composite are determined by comparing the plans' three-point mean scores to the distribution of NCQA's 2009 National Adult Medicaid data.
[1-7] National data do not exist for Coordination of Care and Health Promotion and Education individual measures.

Trend Analysis

In order to evaluate trends in Colorado Medicaid client satisfaction, HSAG performed a stepwise trend analysis. The first step compared the 2010 CAHPS results to the 2009 CAHPS results. If the initial 2010 and 2009 trend analysis did not yield any significant differences, then an additional trend analysis was performed between 2010 and 2008 results. The detailed results of the trend analysis are described in the Results Section beginning on page 2-14. Table 1-2 presents the statistically significant results from this analysis.

Table 1-2
Trend Analysis Highlights

	Colorado Medicaid FFS	Colorado Medicaid PCPP	DHMP	RMHP
Global Ratings				
Rating of Health Plan		▲	▼	
Rating of All Health Care			▼	
Composite Measures				
Getting Needed Care			▼	
Getting Care Quickly	▼		▼	
How Well Doctors Communicate		▲		
Individual Item Measures				
Coordination of Care				▼

▲ *indicates the 2010 score is significantly higher than the 2009 score*
▼ *indicates the 2010 score is significantly lower than the 2009 score*
▲ *indicates the 2010 score is significantly higher than the 2008 score*
▼ *indicates the 2010 score is significantly lower than the 2008 score*

Plan Comparisons

In order to identify performance differences in client satisfaction between the Colorado Medicaid plans, the case-mix adjusted results for each plan were compared to one another using standard statistical tests.[1-8] These comparisons were performed on the four global ratings, five composite measures, and two individual item measures. The detailed results of the comparative analysis are described in the Results Section beginning on page 2-27. Table 1-3 presents the statistically significant results from this comparison:[1-9]

Table 1-3
Plan Comparisons Highlights

Colorado Medicaid FFS	Colorado Medicaid PCPP	DHMP	RMHP
↓ Rating of Health Plan	↑ Getting Care Quickly	↓ Rating of All Health Care	↑ Rating of Health Plan
		↓ Getting Needed Care	↑ Rating of All Health Care
		↓ Getting Care Quickly	↑ Getting Needed Care
			↑ Getting Care Quickly
			↑ Customer Service

↑Statistically better than the State average
↓Statistically worse than the State average

Priority Assignments

Table 1-4 presents the top and high priorities for each plan.

Table 1-4
Top and High Priorities

Colorado Medicaid FFS	Colorado Medicaid PCPP	DHMP	RMHP
◆ Rating of Health Plan ◆ Rating of All Health Care ◆ Getting Care Quickly	◆ Rating of Health Plan	◆ Rating of Health Plan ◆ Rating of All Health Care ◆ Getting Needed Care ◆ Getting Care Quickly ◆ Shared Decision Making ◆ Rating of Specialist Seen Most Often	◆ Rocky Mountain Health Plan did not have any Top or High priorities.

[1-8] CAHPS results are known to vary due to differences in client age, education level, and health status. Therefore, results were case-mix adjusted for differences in these demographic variables.
[1-9] Caution should be exercised when evaluating health plan comparisons, given that population and health plan differences may impact results.

The Colorado CAHPS 4.0H Adult Medicaid Health Plan Survey was administered in accordance with all NCQA specifications.

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 CAHPS 4.0H Adult Medicaid Health Plan Survey.[2-1] Clients eligible for sampling included those who were enrolled in FFS, PCPP, DHMP, or RMHP at the time the sample was drawn and who were continuously enrolled in one of these plans for at least five of the last six months (July through December) of 2009. Adult clients eligible for sampling included those who were 18 years of age or older as of December 31, 2009. DHMP and RMHP were responsible for conducting their annual CAHPS surveys. Morpace and the Center for the Study of Services (CSS) administered the CAHPS 4.0H Adult Medicaid Health Plan Surveys for DHMP and RMHP, respectively. The specifications also permit oversampling in increments of 5 percent. No oversampling was performed on DHMP's adult population. A total random sample of 1,350 adult clients was selected from this plan. A 15 percent oversample was performed on RMHP's adult population. Based on this rate, a total random sample of 1,553 adult clients was selected from this plan. The health plans forwarded the survey results to HSAG for analysis. For Colorado Medicaid FFS and PCPP, a 30 percent oversample was performed on the adult population. Based on this rate, a total random sample of 1,755 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 employed by RMHP was a mail-only methodology, which consisted of a survey only being mailed to sampled clients. The survey process employed by FFS, PCPP, and DHMP allowed clients two methods by which they could complete the surveys. The first phase, or mail phase, consisted of a survey being mailed to the sampled clients. For 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. While DHMP did not provide Spanish versions of the mail surveys, clients had the option to complete a CATI survey in Spanish. Up to six CATI

[2-1] National Committee for Quality Assurance. *HEDIS 2010, Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA Publication, 2009.

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.

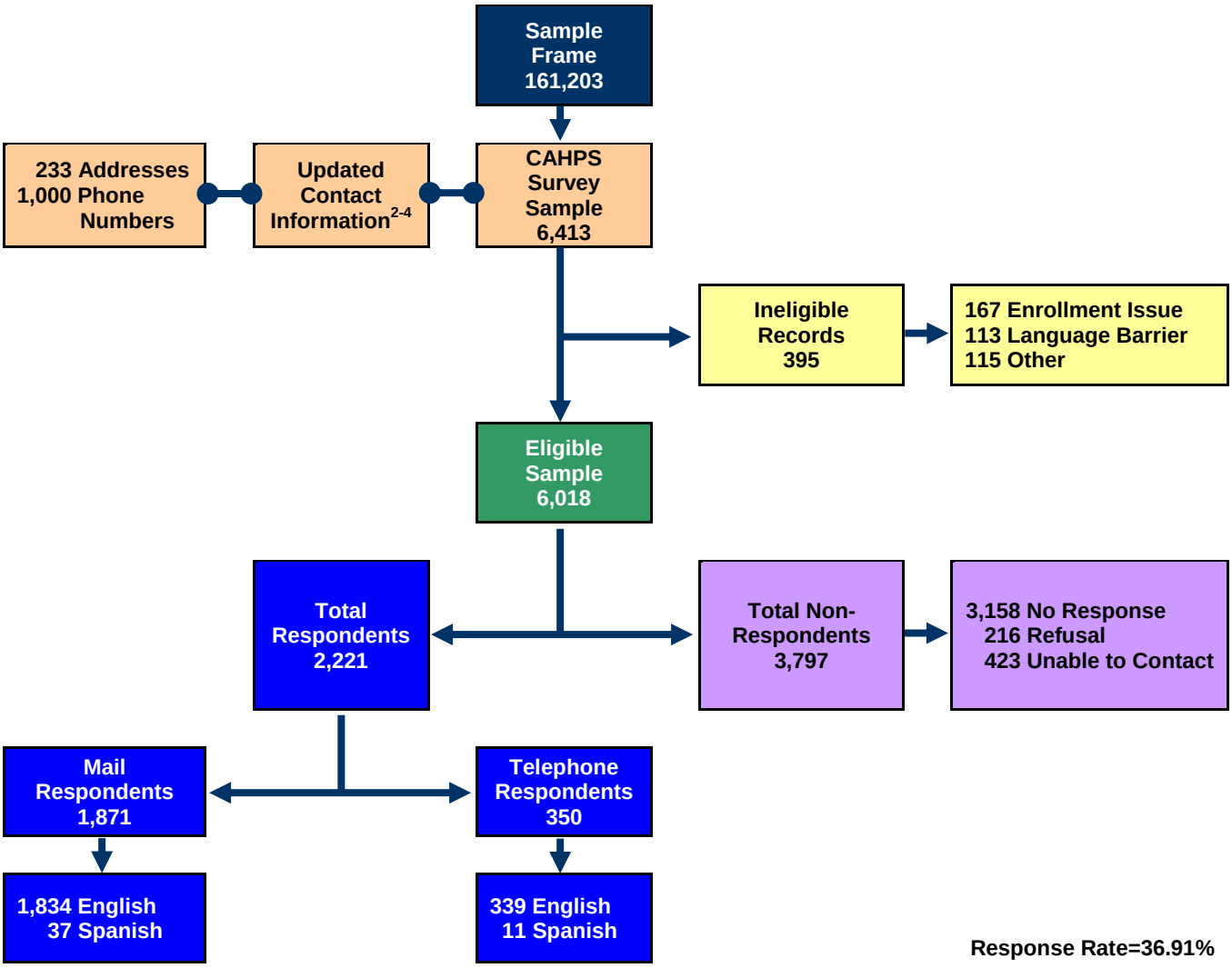
Response Rates

The Colorado CAHPS 4.0H Adult Medicaid Health Plan Survey administration was designed to achieve 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 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 2,221 adult clients returned a completed survey, including: 577 FFS, 674 PCPP, 414 DHMP, and 556 RMHP clients. Figure 2-1, on the following page, shows the distribution of survey dispositions and response rate for Colorado Medicaid (i.e., all four Colorado plans combined). Figure 2-2 through Figure 2-5 show the individual distribution of survey dispositions and response rates for FFS, PCPP, DHMP, and RMHP, respectively. The 2010 Colorado Medicaid response rate of 36.91 percent was 6.31 percentage points higher than the national adult Medicaid response rate reported by NCQA for 2009, which was 30.60 percent.[2-3]

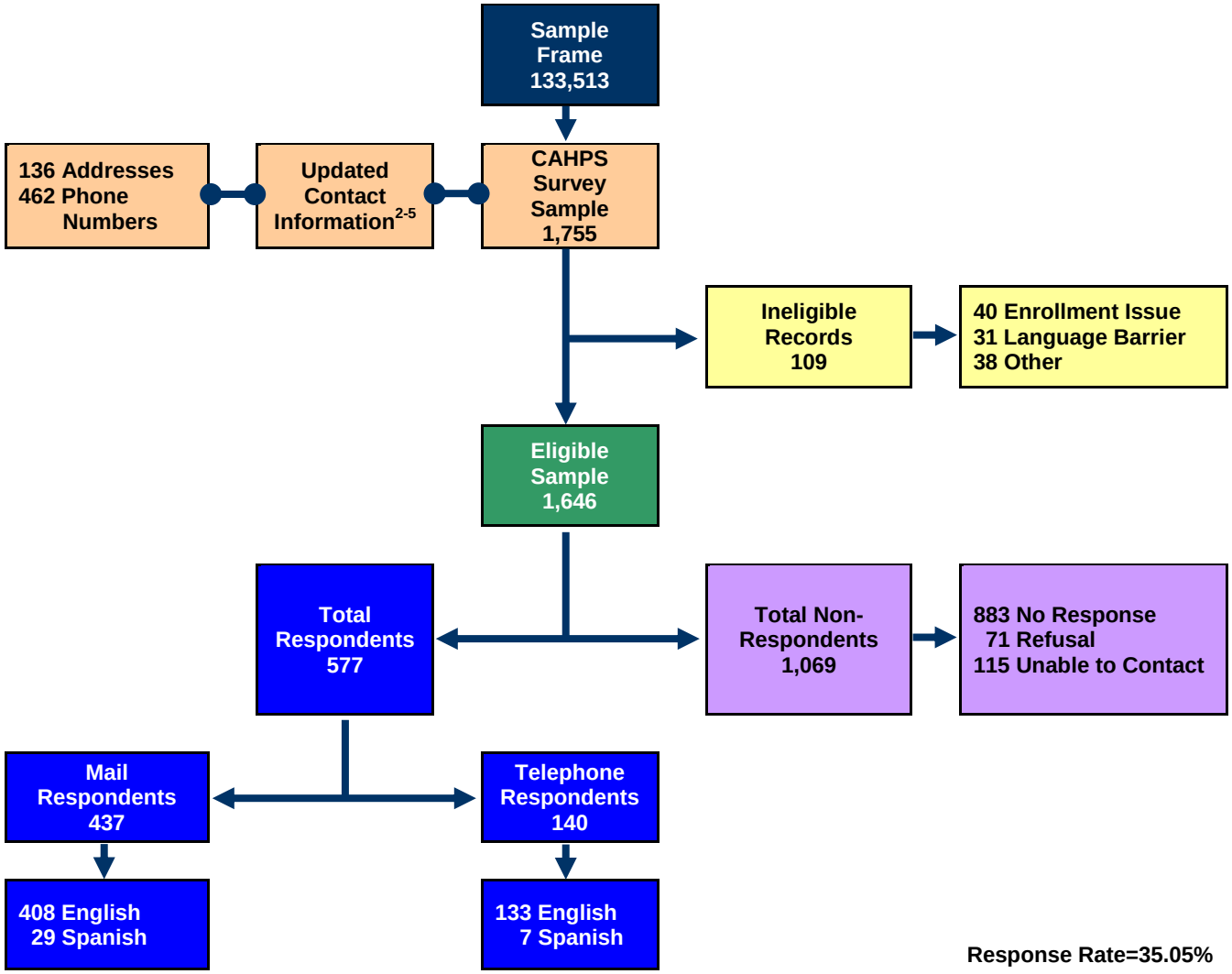
[2-2] National Committee for Quality Assurance. *Quality Assurance Plan for HEDIS 2010 Survey Measures.* Washington, DC: NCQA Publication, 2009.
[2-3] National Committee for Quality Assurance. *HEDIS 2010 Survey Vendor Update Training*. October 22, 2009.

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



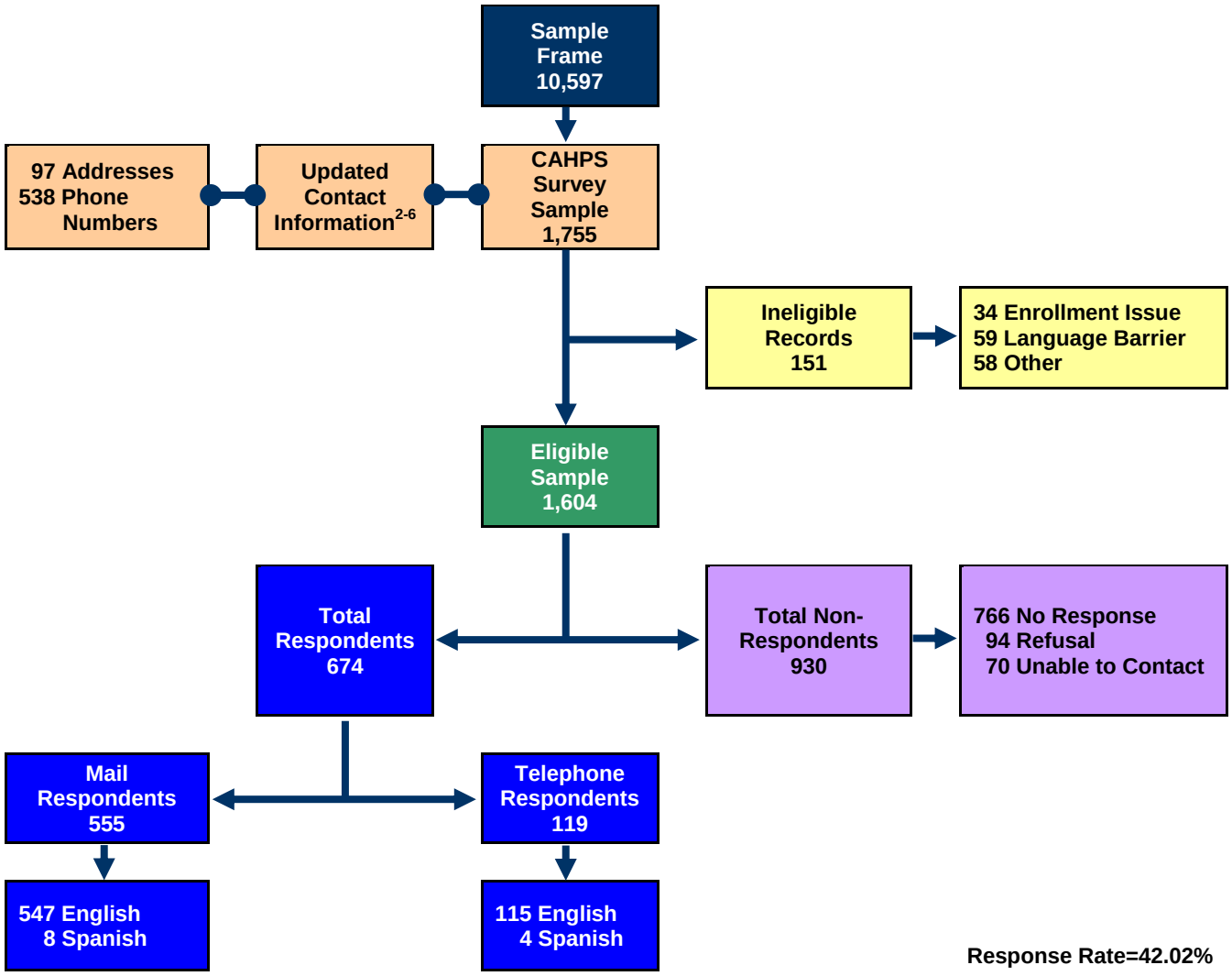
[2-4] Prior to survey administration, address and phone information is updated for clients of the CAHPS sample using the United State Postal Services' National Change of Address (NCOA) and Telematch databases. The number of updated addresses and telephone numbers are provided for informational purposes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

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



[2-5] 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 are 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



[2-6] 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 are provided for informational purposes only. Per NCQA HEDIS Specifications, these clients are retained within the CAHPS Survey sample.

Figure 2-4—Distribution of Surveys for DHMP

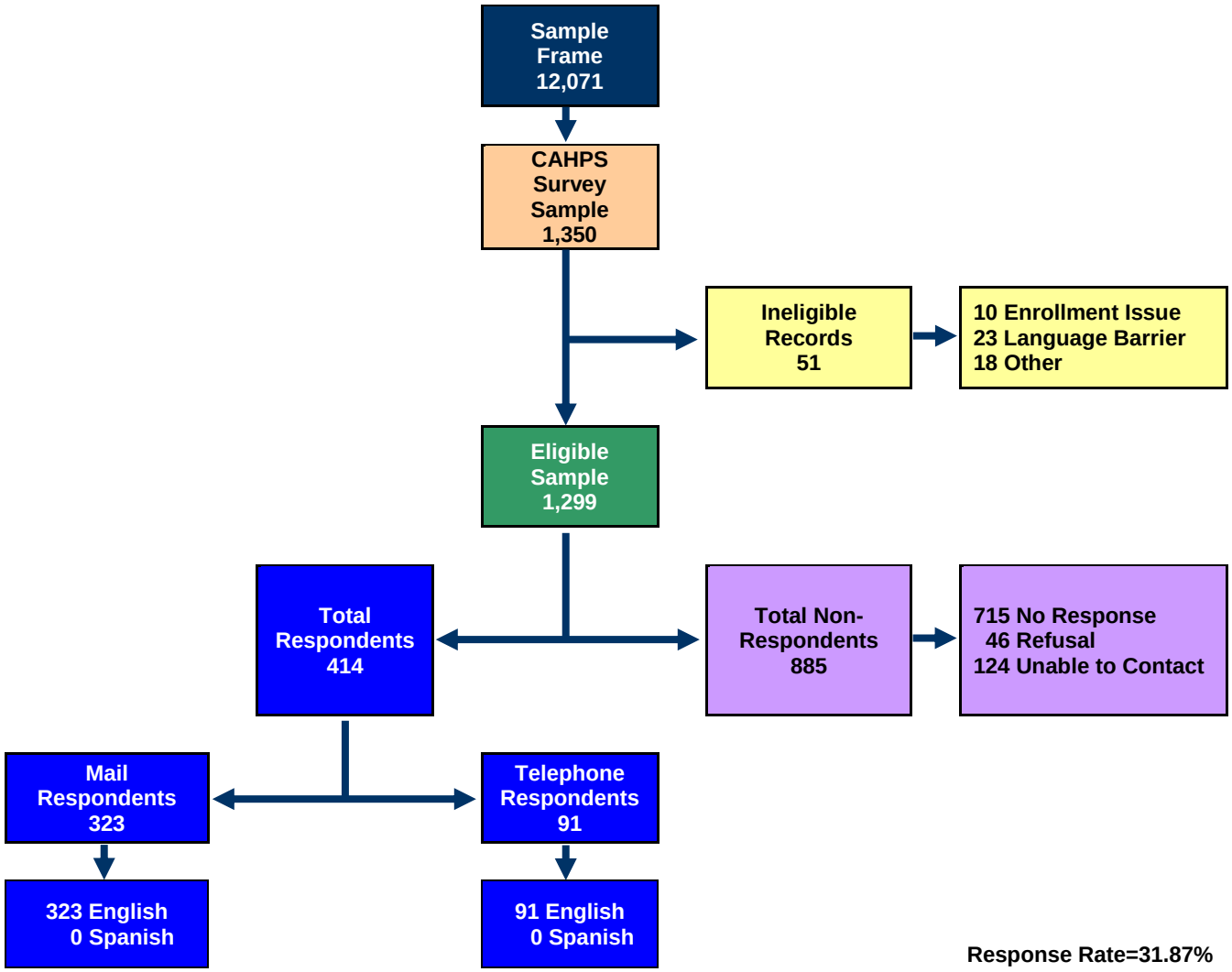
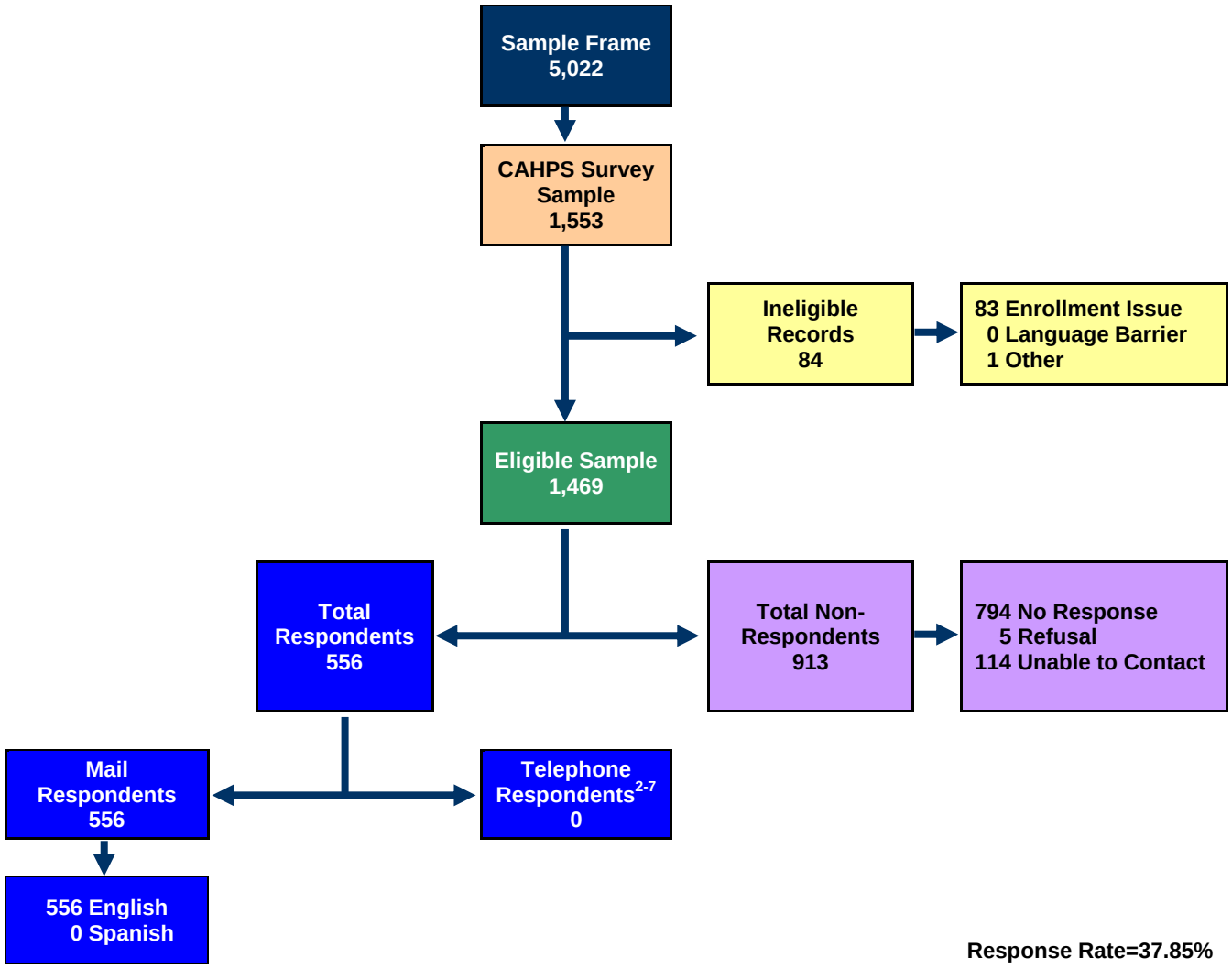


Figure 2-5—Distribution of Surveys for RMHP



[2-7] RMHP did not perform a telephone phase during the survey administration. RMHP employed a mail-only methodology.

Table 2-1 depicts the sample distribution and response rates for all participating health plans and the Colorado Medicaid aggregate.

Table 2-1
Adult Medicaid
Sample Distribution and Response Rate

Plan Name	Total Sample	Ineligible Records	Eligible Sample	Total Respondents	Response Rate
Colorado Medicaid	6,413	395	6,018	2,221	36.91%
Colorado Medicaid FFS	1,755	109	1,646	577	35.05%
Colorado Medicaid PCPP	1,755	151	1,604	674	42.02%
DHMP	1,350	51	1,299	414	31.87%
RMHP	1,553	84	1,469	556	37.85%

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.[2-8]

Table 2-2 shows CAHPS 4.0H Adult Medicaid Health Plan Survey respondents' self-reported age, gender, and race/ethnicity.

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

	Colorado Medicaid	Colorado Medicaid FFS	Colorado Medicaid PCPP	DHMP	RMHP
Age					
18 to 24	**10.2%**	10.3%	7.3%	10.4%	13.5%
25 to 34	**15.5%**	21.4%	12.2%	12.7%	15.5%
35 to 44	**13.0%**	13.9%	12.1%	15.0%	11.8%
45 to 54	**15.7%**	11.6%	17.7%	17.8%	15.8%
55 to 64	**16.8%**	13.4%	19.7%	21.4%	13.5%
65 or Older	**28.8%**	29.4%	31.0%	22.6%	30.0%
Gender					
Male	**29.5%**	27.5%	36.3%	31.7%	22.0%
Female	**70.5%**	72.5%	63.7%	68.3%	78.0%
Race/Ethnicity					
Multi-Racial	**6.3%**	10.3%	6.1%	3.4%	4.5%
White	**64.2%**	65.1%	61.2%	35.8%	85.8%
Black	**8.7%**	5.5%	6.5%	29.0%	0.6%
Asian	**5.6%**	4.0%	12.3%	4.2%	0.6%
Other	**15.2%**	15.1%	13.9%	27.6%	8.5%

Please note: Percentages may not total 100% due to rounding.

[2-8] Agency for Healthcare Research and Quality. *CAHPS Health Plan Survey and Reporting Kit 2008.* Rockville, MD: US Department of Health and Human Services, July 2008.

Table 2-3 shows CAHPS 4.0H Adult Medicaid Health Plan Survey respondents' self-reported level of education and general health status.

Table 2-3
Respondent Demographics
Education and General Health Status

	Colorado Medicaid	Colorado Medicaid FFS	Colorado Medicaid PCPP	DHMP	RMHP
Education					
8th Grade or Less	**15.2%**	14.1%	16.8%	18.7%	11.6%
Some High School	**18.2%**	15.6%	16.7%	25.3%	17.5%
High School Graduate	**35.7%**	31.9%	38.8%	30.6%	39.7%
Some College	**23.6%**	28.8%	20.9%	18.7%	25.2%
College Graduate	**7.3%**	9.6%	6.7%	6.6%	6.0%
General Health Status					
Excellent	**6.4%**	7.8%	4.3%	8.3%	6.2%
Very Good	**19.1%**	18.7%	18.1%	18.1%	21.3%
Good	**31.8%**	32.4%	30.9%	29.3%	34.2%
Fair	**29.2%**	26.9%	31.2%	33.4%	26.0%
Poor	**13.6%**	14.2%	15.5%	10.9%	12.3%

Please note: Percentages may not total 100% due to rounding.

NCQA Comparisons

In order to assess the overall performance of the Colorado Medicaid plans, each CAHPS measure was scored on a three-point scale using the scoring methodology detailed in NCQA's HEDIS Specifications for Survey Measures.[2-9] The resulting three-point mean scores were compared to NCQA's HEDIS Benchmarks and Thresholds for Accreditation, except for the Shared Decision Making composite.[2-10] NCQA does not publish benchmarks and thresholds for the Shared Decision Making composite; therefore, the Shared Decision Making star ratings were based on NCQA's 2009 National Adult Medicaid data.[2-11,2-12] 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 at or between the 75th and 89th percentiles
★★★	indicates a score at or between the 50th and 74th percentiles
★★	indicates a score at or 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 and thresholds for this measure

[2-9] National Committee for Quality Assurance. *HEDIS 2010, Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA Publication, 2009.
[2-10] National Committee for Quality Assurance. *HEDIS Benchmarks and Thresholds for Accreditation 2010*. Washington, DC: NCQA, Updated February 4, 2010.
[2-11] NCQA National Distribution of 2009 Adult Medicaid Plan-Level Results. Prepared by NCQA for HSAG on December 9, 2009.
[2-12] The star assignments for the Shared Decision Making composite are determined by comparing the plans' three-point mean scores to the distribution of NCQA's 2009 National Adult Medicaid data.

Table 2-4 shows the plans' three-point mean scores and overall client satisfaction ratings on each of the four global ratings and five composite measures. NCQA does not provide benchmarks for the Coordination of Care and Health Promotion and Education individual measures; therefore, overall client satisfaction ratings could not be determined.

Table 2-4
NCQA Comparisons
Overall Client Satisfaction Ratings

	Colorado Medicaid FFS	Colorado Medicaid PCPP	DHMP	RMHP
Global Rating				
Rating of Health Plan	★ 2.192	★★ 2.362	★ 2.228	★★★★ 2.471
Rating of All Health Care	★ 2.211	★★★ 2.315	★ 2.072	★★★★★ 2.405
Rating of Personal Doctor	★★★ 2.462	★★★★ 2.520	★★★★ 2.513	★★★★ 2.512
Rating of Specialist Seen Most Often	★★★★ 2.521	★★★ 2.477	★★ 2.412	★★★ 2.481
Composite Measure				
Getting Needed Care	★★★ 2.271	★★★★ 2.367	★ 1.941	★★★★★ 2.455
Getting Care Quickly	★★ 2.347	★★★★ 2.432	★ 2.044	★★★★★ 2.481
How Well Doctors Communicate	★★★ 2.547	★★★★ 2.581	★★★ 2.547	★★★★ 2.580
Customer Service	**NA** NA	**NA** NA	**NA** NA	★★★★★ 2.558
Shared Decision Making	★★★★ 2.536	★★★★★ 2.558	★ 2.430	★★★★★ 2.595
Individual Measure				
Coordination of Care	**NB** 2.316	**NB** 2.397	**NB** 2.202	**NB** 2.339
Health Promotion and Education	**NB** 1.870	**NB** 1.974	**NB** 1.932	**NB** 1.950

Please note: A minimum of 100 responses to each 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). Measures that NCQA did not provide benchmarks for are denoted as No Benchmark (NB).

Summary of NCQA Comparison Results

The following table summarizes the NCQA comparison results.

Table 2-5
NCQA Comparisons Results

Colorado Medicaid FFS	Colorado Medicaid PCPP	DHMP	RMHP
★ Rating of Health Plan	★★ Rating of Health Plan	★ Getting Needed Care	★★★ Rating of Specialist Seen Most Often
★ Rating of All Health Care	★★★ Rating of All Health Care	★ Getting Care Quickly	★★★★ Rating of Health Plan
★★ Getting Care Quickly	★★★ Rating of Specialist Seen Most Often	★ Rating of All Health Care	★★★★ Rating of Personal Doctor
★★★ Getting Needed Care	★★★★ Getting Needed Care	★ Rating of Health Plan	★★★★ How Well Doctors Communicate
★★★ Rating of Personal Doctor	★★★★ Getting Care Quickly	★ Shared Decision Making	★★★★★ Rating of All Health Care
★★★ How Well Doctors Communicate	★★★★ Rating of Personal Doctor	★★ Rating of Specialist Seen Most Often	★★★★★ Getting Needed Care
★★★★ Rating of Specialist Seen Most Often	★★★★ How Well Doctors Communicate	★★★ How Well Doctors Communicate	★★★★★ Getting Care Quickly
★★★★ Shared Decision Making	★★★★★ Shared Decision Making	★★★★ Rating of Personal Doctor	★★★★★ Customer Service
NA Customer Service	NA Customer Service	NA Customer Service	★★★★★ Shared Decision Making

★★★★★ 90th Percentile or Above ★★★★ 75th – 89th Percentiles ★★★ 50th – 74th Percentiles ★★ 25th – 49th Percentiles ★ Below 25th Percentile NA Not Applicable

Trend Analysis

In 2008, the Colorado Medicaid FFS, PCPP, DHMP, and RMHP had 518, 600, 373, and 574 completed CAHPS 4.0H Adult Medicaid Health Plan Surveys, respectively. In 2009, the Colorado Medicaid FFS, PCPP, DHMP, and RMHP had 600, 712, 392, and 570 completed CAHPS 4.0H Adult Medicaid Health Plan Surveys, respectively. These completed surveys were used to calculate the 2009 and 2008 CAHPS results presented in this section for trending purposes.[2-13]

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.[2-14] 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 details, please refer to the *NCQA HEDIS Specifications for Survey Measures, Volume 3*.

In order to evaluate trends in Colorado Medicaid client satisfaction, HSAG performed a stepwise three-year trend analysis. The first step compared the 2010 Colorado Medicaid and plan-level CAHPS scores to the corresponding 2009 scores. If the initial 2010 and 2009 trend analysis did not yield any statistically significant differences, then an additional trend analysis was performed between 2010 and 2008 results. Figure 2-6 through Figure 2-16 show the results of this trend analysis. Statistically significant differences are noted with directional triangles. Scores that were statistically higher in 2010 than in 2009 are noted with black upward (▲) triangles. Scores that were statistically lower in 2010 than in 2009 are noted with black downward (▼) triangles. Scores that were statistically higher in 2010 than in 2008 are noted with red upward (▲) triangles. Scores that were statistically lower in 2010 than in 2008 are noted with red downward (▼) triangles. Scores in 2010 that were not statistically different from scores in 2009 or in 2008 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).

[2-13] For detailed information on the 2008 FFS and PCPP CAHPS results, please refer to the 2008 Adult Medicaid Client Satisfaction Report. For detailed information on the 2009 FFS, PCPP, DHMP, and RMHP results, please refer to the 2009 Adult Medicaid Client Satisfaction Report.

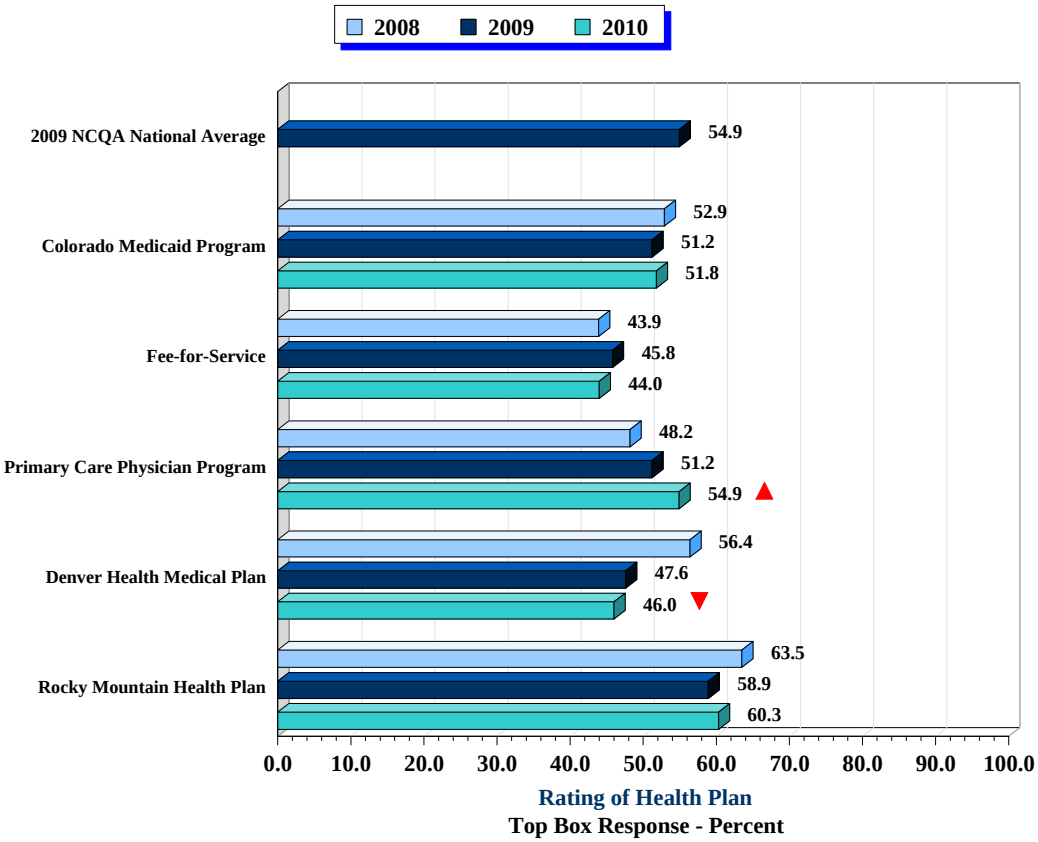
[2-14] National Committee for Quality Assurance. *HEDIS 2010, Volume 3: Specifications for Survey Measures*. Washington, DC: NCQA Publication, 2009.

Global Ratings

Rating of Health Plan

Colorado Medicaid 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 2-6 shows the 2008, 2009, and 2010 Rating of Health Plan question summary rates for Colorado Medicaid, FFS, PCPP, DHMP, and RMHP.[2-15,2-16]

Figure 2-6—Trend Analysis: Rating of Health Plan



Statistical Significance Note:
▲ indicates the 2010 score is significantly higher than the 2009 score
▼ indicates the 2010 score is significantly lower than the 2009 score
▲ indicates the 2010 score is significantly higher than the 2008 score
▼ indicates the 2010 score is significantly lower than the 2008 score

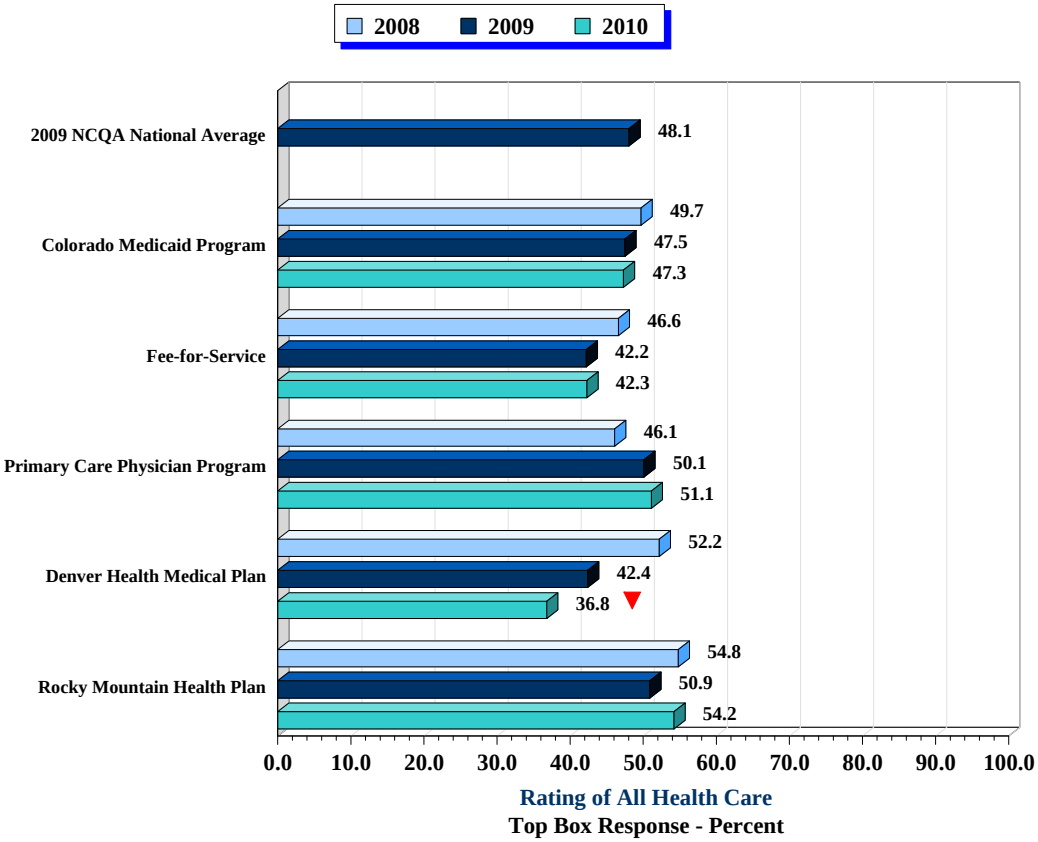
[2-15] Colorado Medicaid scores in this section include the combined results of the four Colorado Medicaid plans: FFS, PCPP, DHMP, and RMHP.

[2-16] NCQA national averages were not available for 2010 at the time this report was prepared; therefore, 2009 NCQA national averages are presented in this section.

Rating of All Health Care

Colorado Medicaid 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 2-7 shows the 2008, 2009, and 2010 Rating of All Health Care question summary rates for Colorado Medicaid, FFS, PCPP, DHMP, and RMHP.

Figure 2-7—Trend Analysis: Rating of All Health Care

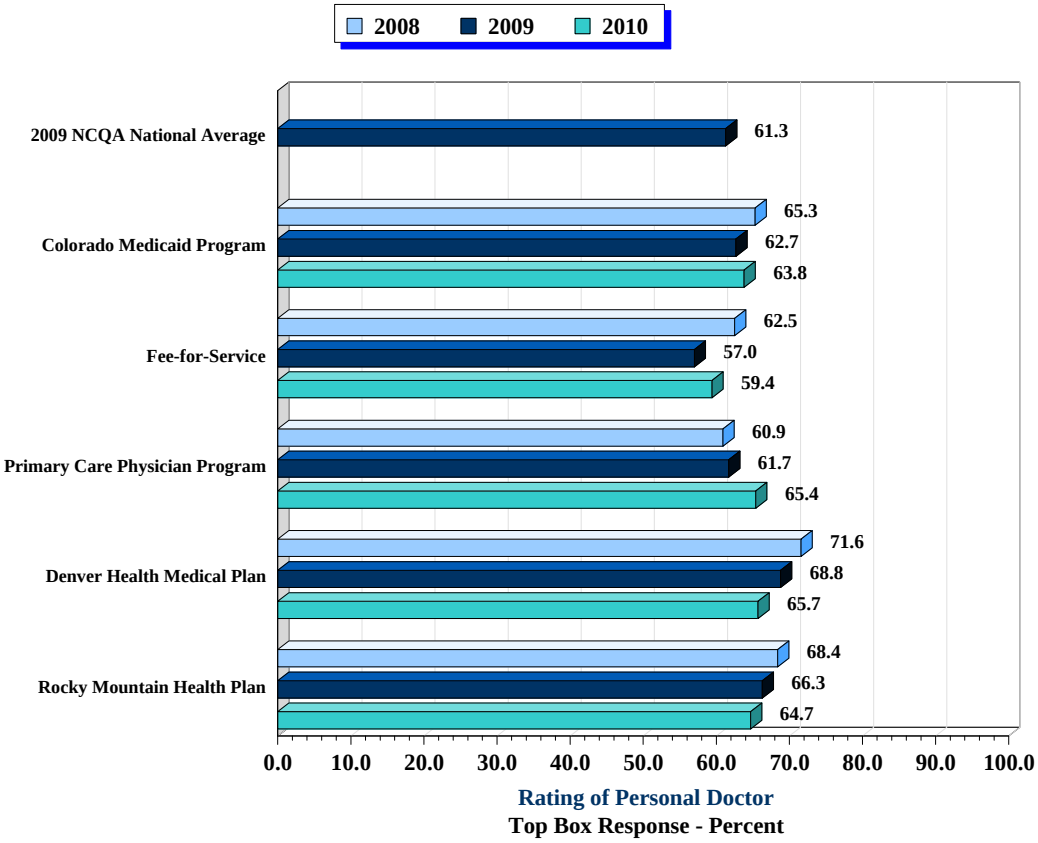


Statistical Significance Note:
▲ indicates the 2010 score is significantly higher than the 2009 score
▼ indicates the 2010 score is significantly lower than the 2009 score
▲ indicates the 2010 score is significantly higher than the 2008 score
▼ indicates the 2010 score is significantly lower than the 2008 score

Rating of Personal Doctor

Colorado Medicaid 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 2-8 shows the 2008, 2009, and 2010 Rating of Personal Doctor question summary rates for Colorado Medicaid, FFS, PCPP, DHMP, and RMHP.

Figure 2-8—Trend Analysis: Rating of Personal Doctor

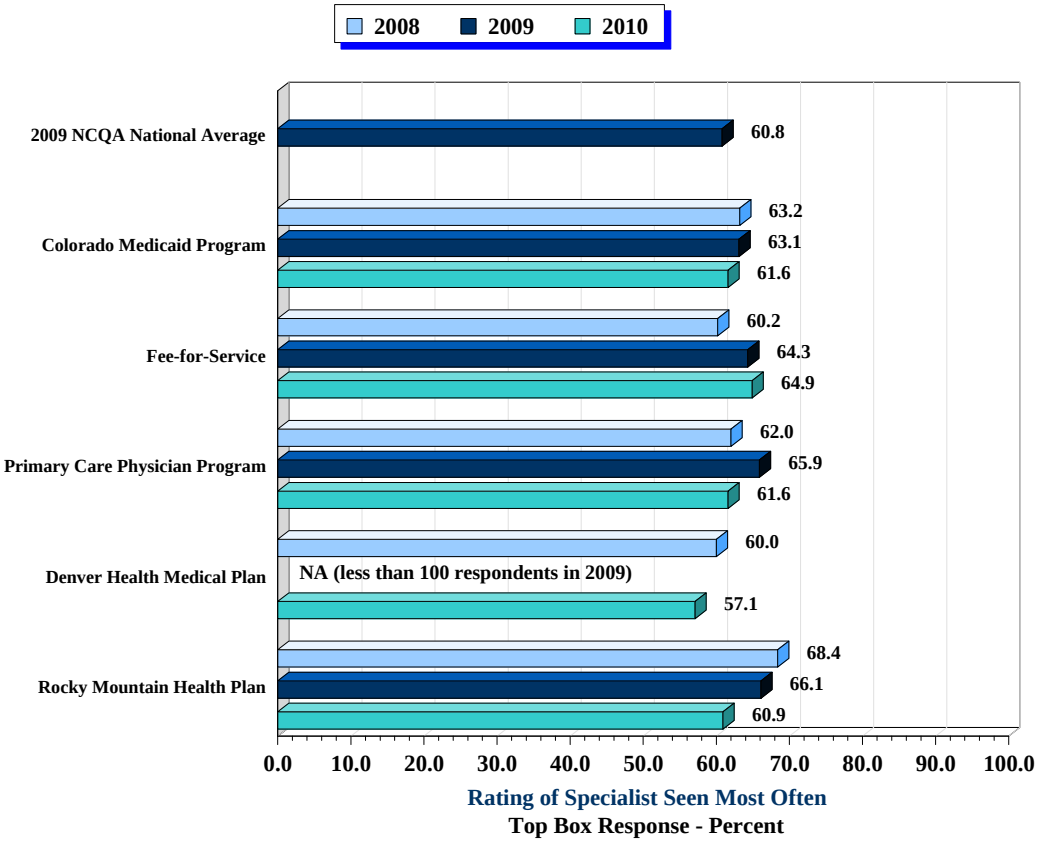


Statistical Significance Note:
▲ indicates the 2010 score is significantly higher than the 2009 score
▼ indicates the 2010 score is significantly lower than the 2009 score
▲ indicates the 2010 score is significantly higher than the 2008 score
▼ indicates the 2010 score is significantly lower than the 2008 score

Rating of Specialist Seen Most Often

Colorado Medicaid 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 2-9 shows the 2008, 2009, and 2010 Rating of Specialist Seen Most Often question summary rates for Colorado Medicaid, FFS, PCPP, DHMP, and RMHP.

Figure 2-9—Trend Analysis: Rating of Specialist Seen Most Often



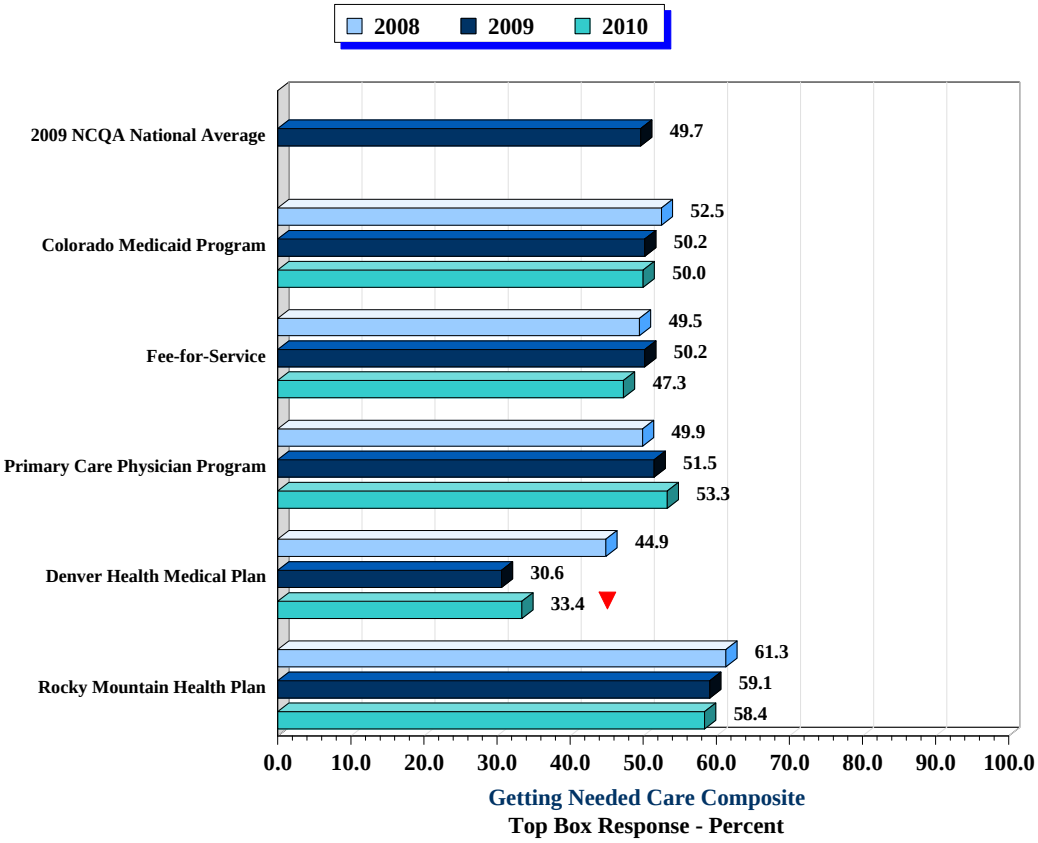
Statistical Significance Note:
▲ indicates the 2010 score is significantly higher than the 2009 score
▼ indicates the 2010 score is significantly lower than the 2009 score
▲ indicates the 2010 score is significantly higher than the 2008 score
▼ indicates the 2010 score is significantly lower than the 2008 score

Composite Measures

Getting Needed Care

Colorado Medicaid 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 2-10 shows the 2008, 2009, and 2010 Getting Needed Care global proportions for Colorado Medicaid, FFS, PCPP, DHMP, and RMHP.

Figure 2-10—Trend Analysis: Getting Needed Care

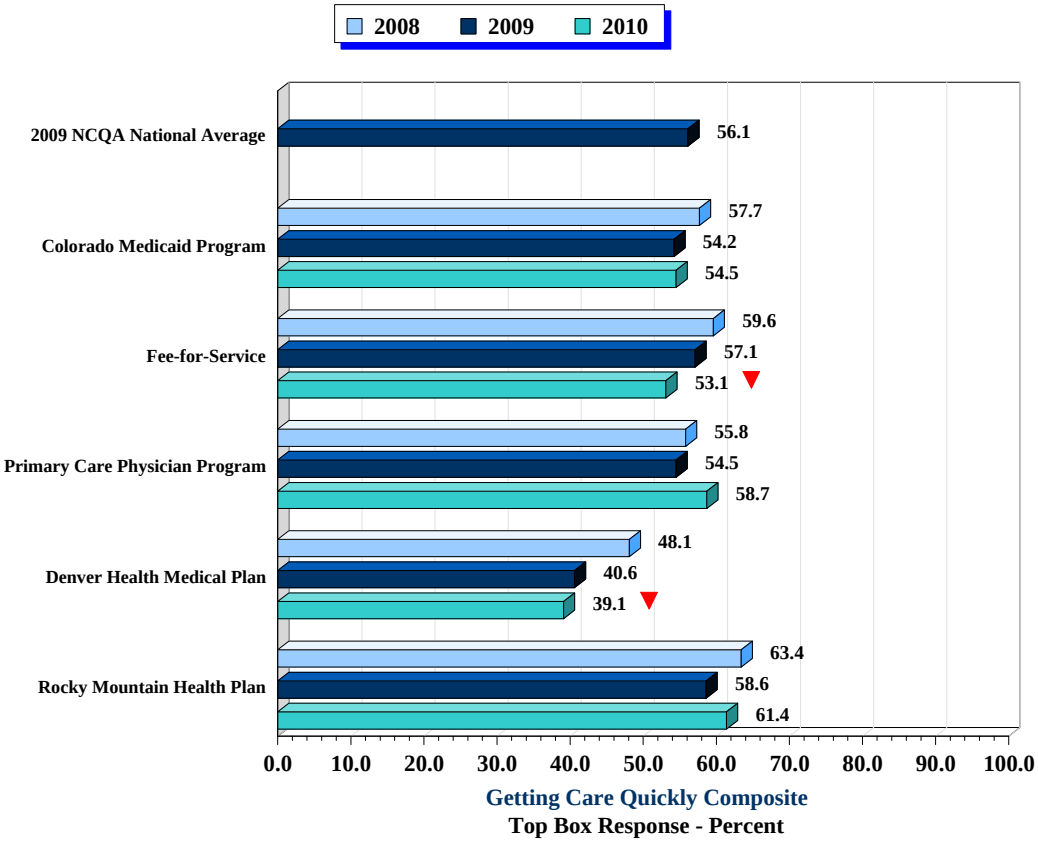


Statistical Significance Note:
▲ indicates the 2010 score is significantly higher than the 2009 score
▼ indicates the 2010 score is significantly lower than the 2009 score
▲ indicates the 2010 score is significantly higher than the 2008 score
▼ indicates the 2010 score is significantly lower than the 2008 score

Getting Care Quickly

Colorado Medicaid 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 2-11 shows the 2008, 2009, and 2010 Getting Care Quickly global proportions for Colorado Medicaid, FFS, PCPP, DHMP, and RMHP.

Figure 2-11—Trend Analysis: Getting Care Quickly

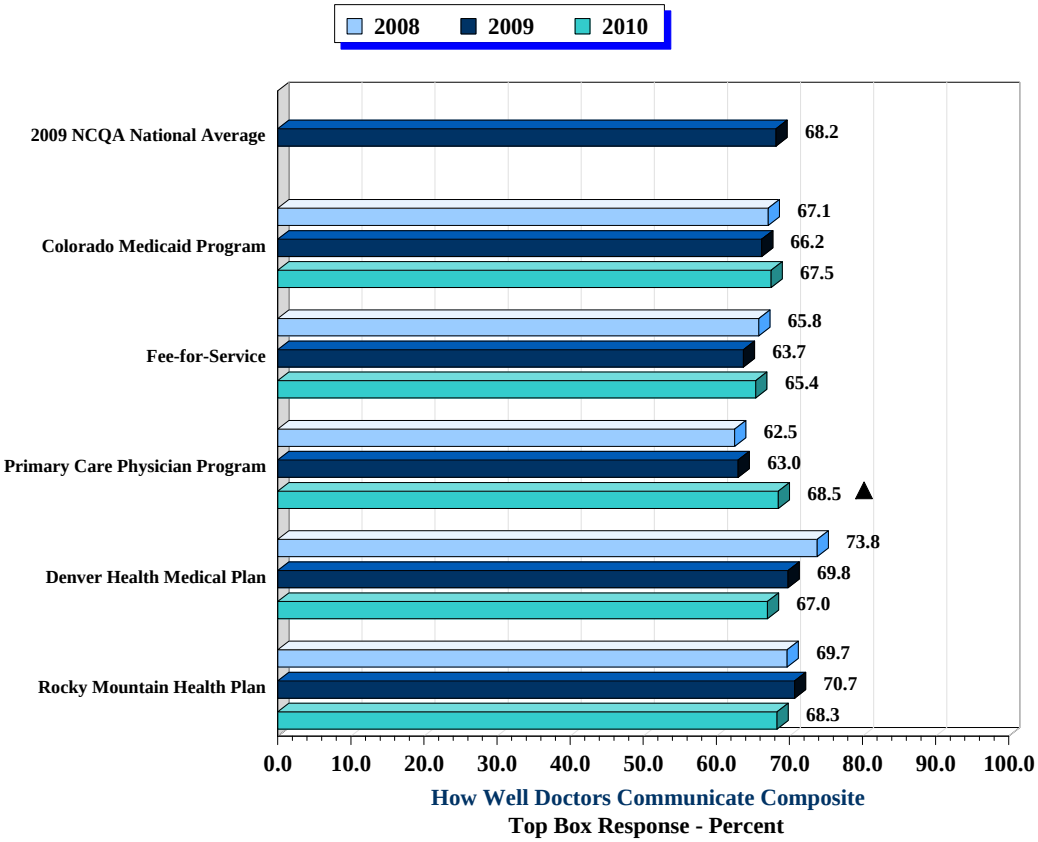


Statistical Significance Note:
▲ indicates the 2010 score is significantly higher than the 2009 score
▼ indicates the 2010 score is significantly lower than the 2009 score
▲ indicates the 2010 score is significantly higher than the 2008 score
▼ indicates the 2010 score is significantly lower than the 2008 score

How Well Doctors Communicate

Colorado Medicaid 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 2-12 shows the 2008, 2009, and 2010 How Well Doctors Communicate global proportions for Colorado Medicaid, FFS, PCPP, DHMP, and RMHP.

Figure 2-12—Trend Analysis: How Well Doctors Communicate

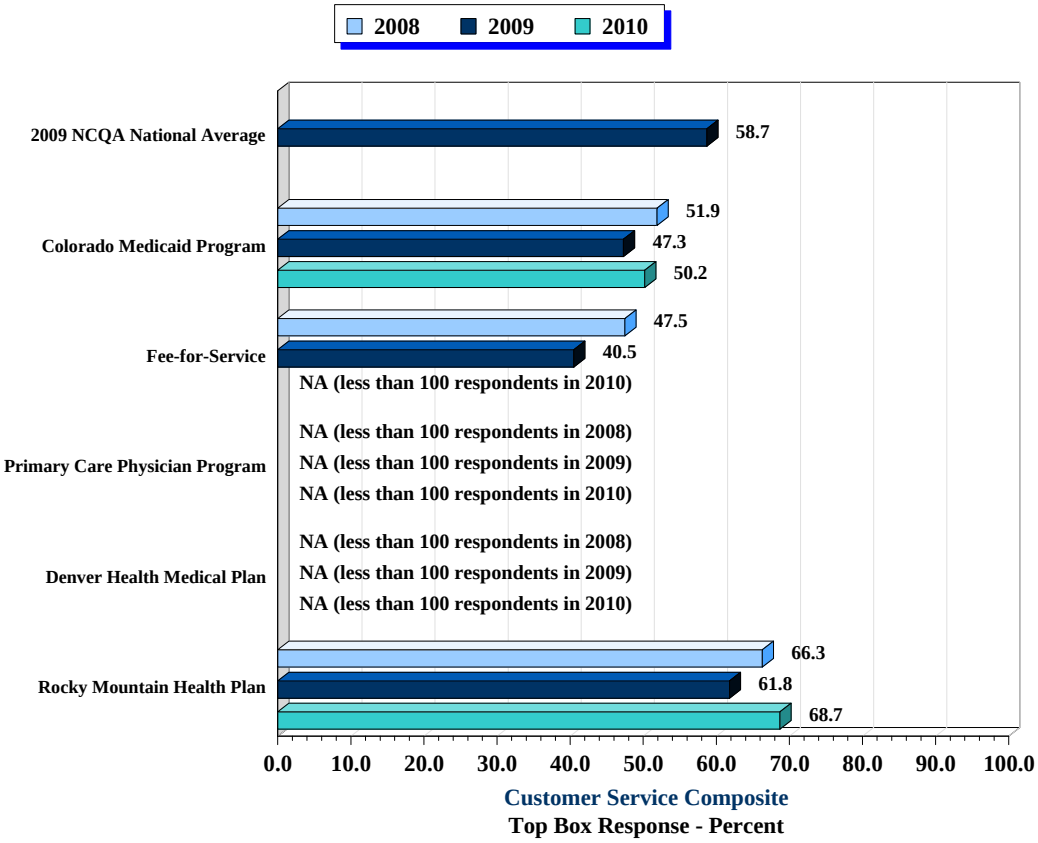


Statistical Significance Note:
▲ indicates the 2010 score is significantly higher than the 2009 score
▼ indicates the 2010 score is significantly lower than the 2009 score
▲ indicates the 2010 score is significantly higher than the 2008 score
▼ indicates the 2010 score is significantly lower than the 2008 score

Customer Service

Colorado Medicaid 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 2-13 shows the 2008, 2009, and 2010 Customer Service global proportions for Colorado Medicaid, FFS, PCPP, DHMP, and RMHP.

Figure 2-13—Trend Analysis: Customer Service

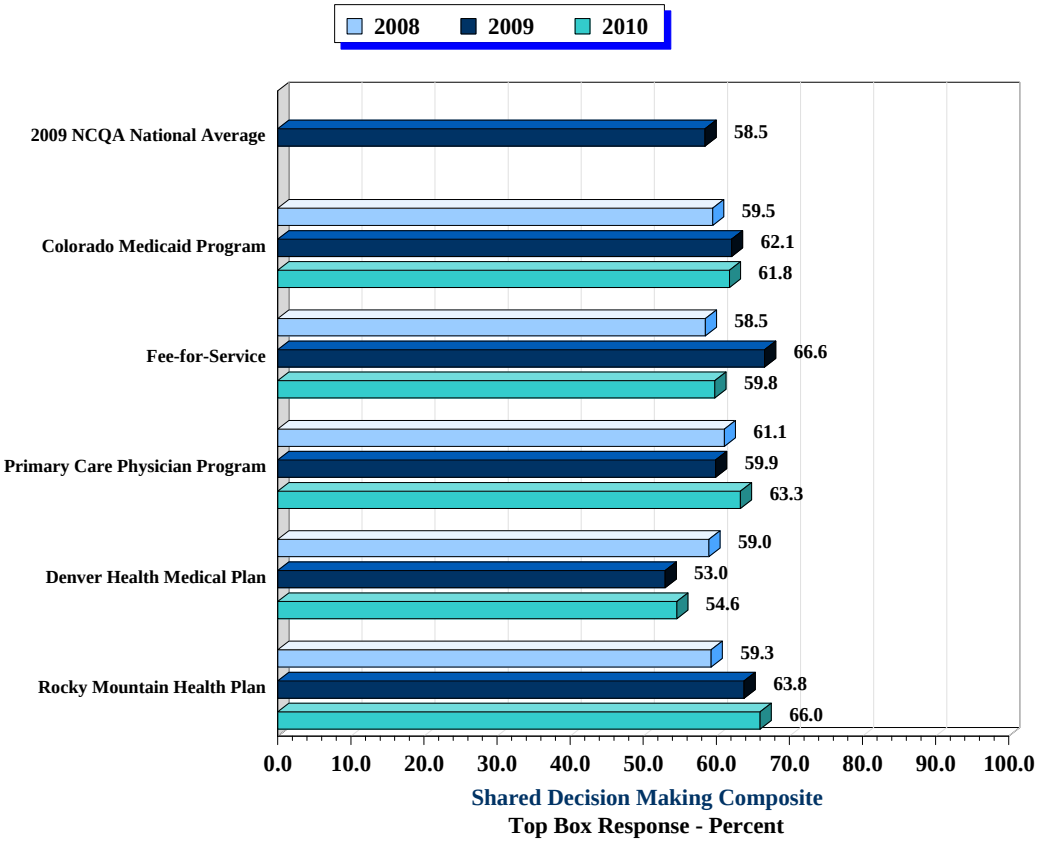


Statistical Significance Note:
▲ indicates the 2010 score is significantly higher than the 2009 score
▼ indicates the 2010 score is significantly lower than the 2009 score
▲ indicates the 2010 score is significantly higher than the 2008 score
▼ indicates the 2010 score is significantly lower than the 2008 score

Shared Decision Making

Colorado Medicaid 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 2-14 shows the 2008, 2009, and 2010 Shared Decision Making global proportions for Colorado Medicaid, FFS, PCPP, DHMP, and RMHP.

Figure 2-14—Trend Analysis: Shared Decision Making



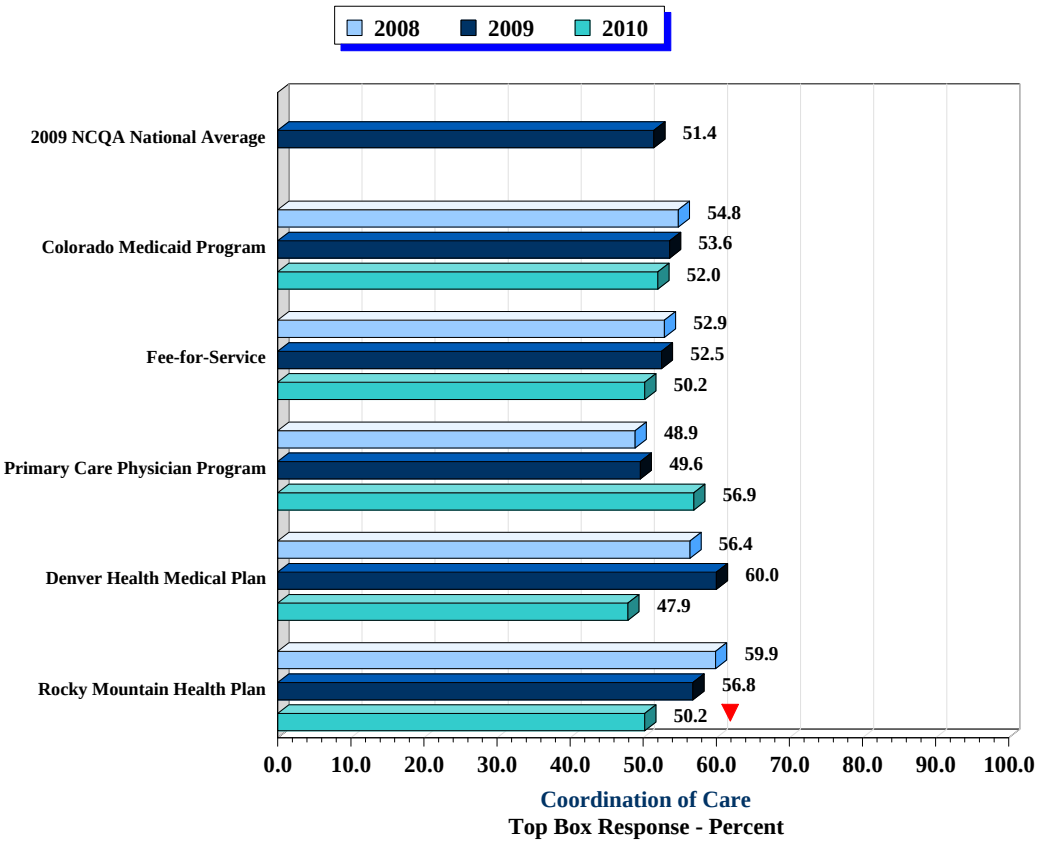
Statistical Significance Note:
▲ indicates the 2010 score is significantly higher than the 2009 score
▼ indicates the 2010 score is significantly lower than the 2009 score
▲ indicates the 2010 score is significantly higher than the 2008 score
▼ indicates the 2010 score is significantly lower than the 2008 score

Individual Item Measures

Coordination of Care

Colorado Medicaid 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 2-15 shows the 2008, 2009, and 2010 Coordination of Care question summary rates for Colorado Medicaid, FFS, PCPP, DHMP, and RMHP.

Figure 2-15—Trend Analysis: Coordination of Care

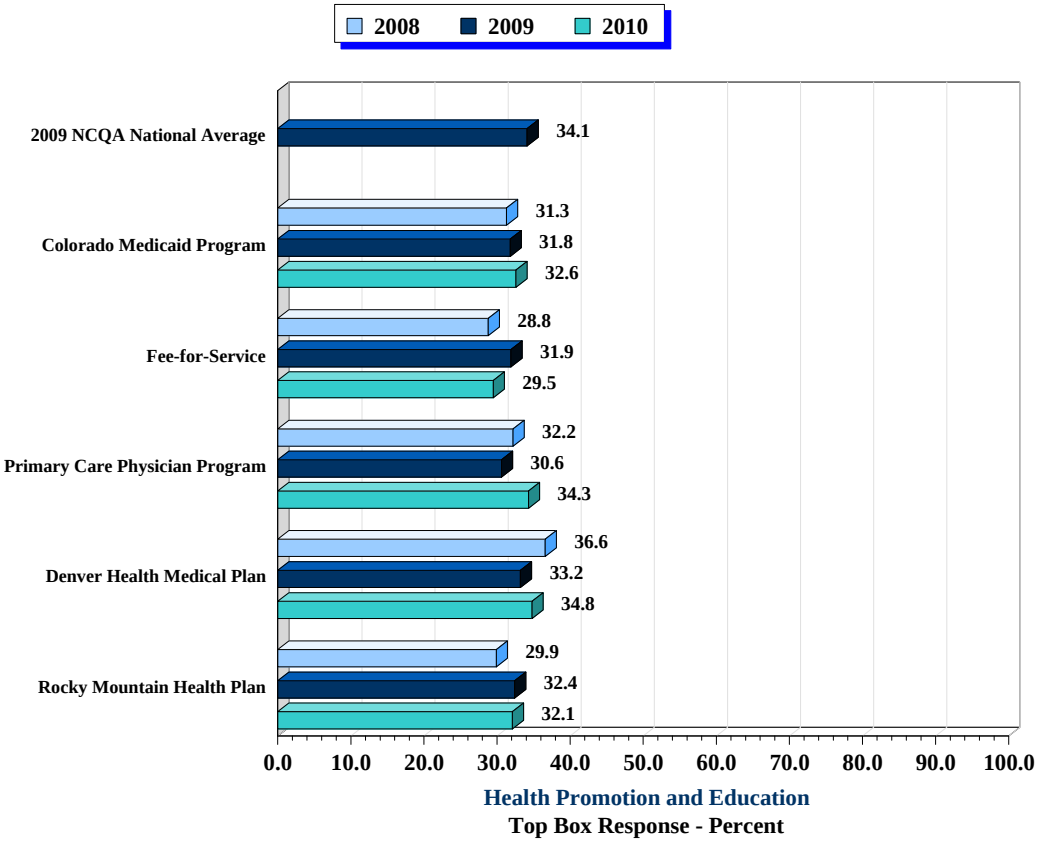


Statistical Significance Note:
▲ indicates the 2010 score is significantly higher than the 2009 score
▼ indicates the 2010 score is significantly lower than the 2009 score
▲ indicates the 2010 score is significantly higher than the 2008 score
▼ indicates the 2010 score is significantly lower than the 2008 score

Health Promotion and Education

Colorado Medicaid 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 2-16 shows the 2008, 2009, and 2010 Health Promotion and Education question summary rates for Colorado Medicaid, FFS, PCPP, DHMP, and RMHP.

Figure 2-16—Trend Analysis: Health Promotion and Education



Statistical Significance Note:
▲ indicates the 2010 score is significantly higher than the 2009 score
▼ indicates the 2010 score is significantly lower than the 2009 score
▲ indicates the 2010 score is significantly higher than the 2008 score
▼ indicates the 2010 score is significantly lower than the 2008 score

Summary of Trend Analysis Results

The following table summarizes the statistically significant differences from the trend analysis.

Table 2-6
Trend Analysis Results

	Colorado Medicaid FFS	Colorado Medicaid PCPP	DHMP	RMHP
Global Ratings				
Rating of Health Plan		▲	▼	
Rating of All Health Care			▼	
Composite Measures				
Getting Needed Care			▼	
Getting Care Quickly	▼		▼	
How Well Doctors Communicate		▲		
Individual Item Measures				
Coordination of Care				▼

▲ *indicates the 2010 score is significantly higher than the 2009 score*
▼ *indicates the 2010 score is significantly lower than the 2009 score*
▲ *indicates the 2010 score is significantly higher than the 2008 score*
▼ *indicates the 2010 score is significantly lower than the 2008 score*

Plan Comparisons

In order to identify performance differences in client satisfaction between the four Colorado Medicaid plans, the results for FFS, PCPP, DHMP, and RMHP were compared to the State Medicaid average using standard tests for statistical significance.[2-17] For purposes of this comparison, results were case-mix adjusted. Case-mix refers to the characteristics of respondents used in adjusting the results for comparability among health plans. Results for the Colorado Medicaid plans were case-mix adjusted for general health status, educational level, and age of the respondent.[2-18] Given that differences in case-mix can result in differences in ratings between plans that are not due to differences in quality, the data were adjusted to account for disparities in these characteristics. The case-mix adjustment was performed using standard regression techniques (i.e., covariance adjustment).

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 are noted in the tables by arrows. A plan that performed statistically better than the State average is denoted with an upward (↑) arrow. Conversely, a plan that performed statistically worse than the State average is denoted with a downward (↓) arrow. A plan that did not perform statistically different than the State average is denoted with a horizontal (↔) arrow. If a plan does not meet NCQA's requirement of 100 respondents, the plan's question summary rate or global proportion for that measure is denoted as Not Applicable (NA).

Table 2-7 presents the question summary rates and global proportions results of the plan comparisons analysis. **NOTE: These results may differ from those presented in the trend analysis figures because they have been adjusted for differences in case mix (i.e., the percentages presented have been case-mix adjusted).**

[2-17] Caution should be exercised when evaluating plan comparisons, given that population and plan differences may impact CAHPS results.

[2-18] Agency for Healthcare Research and Quality. *CAHPS Health Plan Survey and Reporting Kit 2008*. Rockville, MD: US Department of Health and Human Services, July 2008.

Table 2-7 Plan Comparisons				
	Colorado Medicaid FFS	**Colorado Medicaid PCPP**	**DHMP**	**RMHP**
Global Rating				
Rating of Health Plan	44.5% ↓	54.4% ↔	45.9% ↔	60.4% ↑
Rating of All Health Care	42.4% ↔	50.8% ↔	37.0% ↓	54.1% ↑
Rating of Personal Doctor	59.8% ↔	65.1% ↔	65.4% ↔	64.8% ↔
Rating of Specialist Seen Most Often	65.4% ↔	61.9% ↔	56.5% ↔	60.9% ↔
Composite Measure				
Getting Needed Care	48.2% ↔	53.1% ↔	32.8% ↓	58.3% ↑
Getting Care Quickly	53.1% ↔	58.5% ↑	39.3% ↓	61.4% ↑
How Well Doctors Communicate	65.4% ↔	68.6% ↔	67.0% ↔	68.2% ↔
Customer Service	NA	NA	NA	69.3% ↑
Shared Decision Making	59.2% ↔	63.5% ↔	55.2% ↔	65.9% ↔
Individual Measure				
Coordination of Care	50.3% ↔	56.6% ↔	47.9% ↔	50.4% ↔
Health Promotion and Education	29.6% ↔	34.0% ↔	35.0% ↔	32.1% ↔

Please note: A minimum of 100 responses to each 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). All plans' results, including results from plans with fewer than 100 respondents, are included in the derivation of the state average.

Summary of Plan Comparisons Results

The plan comparisons revealed the following statistically significant results.

- Colorado Medicaid FFS scored significantly lower than the Colorado Medicaid State average on one CAHPS measure, Rating of Health Plan.
- Colorado Medicaid PCPP scored significantly higher than the Colorado Medicaid State average on one CAHPS measure, Getting Care Quickly.
- DHMP scored significantly lower than the Colorado Medicaid State average on three CAHPS measures: Rating of All Health Care, Getting Needed Care, and Getting Care Quickly.
- RMHP scored significantly higher than the Colorado Medicaid State average on five CAHPS measures: Rating of Health Plan, Rating of All Health Care, Getting Needed Care, Getting Care Quickly, and Customer Service.

General Recommendations

HSAG recommends the continued administration of the CAHPS 4.0H Adult Medicaid Health Plan Survey in fiscal year (FY) 2010-2011. HSAG will continue performing complete benchmarking and trend evaluation on the adult data. HSAG also recommends the continued use of administrative data in identifying the Spanish-speaking population. The number of completed surveys in Spanish during the FY 2008-2009 survey administration is comparable to the completed surveys in Spanish for the FY 2009-2010 survey administration due to the identification of these clients prior to the start of the survey.

NCQA recommends oversampling if a health plan has a prior history of low survey response rates or if it does not expect to achieve a denominator of 100 for most survey calculations. In FY 2007-2008, FY 2008-2009, and FY 2009-2010, DHMP elected not to oversample their population. In FY 2007-2008 and FY 2008-2009, DHMP did not reach the NCQA target of 411 survey respondents. In FY 2009-2010, DHMP only exceeded the NCQA target by three respondents. HSAG recommends that DHMP oversample the adult population in FY 2010-2011 to achieve a higher number of respondents.

Plan-Specific Recommendations

This section presents Adult Medicaid CAHPS recommendations for the four Colorado Medicaid plans. The recommendations are grouped into four main categories for quality improvement (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.[3-1] A comprehensive list of these resources is included in the Reader's Guide Section, beginning on page 4-10.

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

[3-1] AHRQ Web site. The CAHPS Improvement Guide. Available at: http://www.cahps.ahrq.gov/qiguide/default.aspx. Accessed on: July 1, 2010.

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

Please note:
Trend analysis results reflect those between either the 2010 and 2009 results or the 2010 and 2008 results.[3-2]
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.
Global ratings, composite measures, or individual item measures that do not meet the minimum number of responses are denoted as Not Applicable (NA).
Measures that NCQA did not provide benchmarks for are denoted as No Benchmark (NB).

[3-2] For more detailed information on the trend analysis results, please see the Results section of this report.

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
DHMP	★	▼	Top
RMHP	★★★★	—	Moderate

In order to improve the overall Rating of Health Plan, QI activities should target health plan operations and health plan experiences.

Health Plan Operations

It is important for health plans to view their organization as a collection of microsystems, such as providers, administrators, and other staff that provide services to clients, that provide the health plan's health care "products." Health care microsystems include: a team of providers, patient/population to whom care is provided, environment that provides information to providers and patients, support staff, equipment, and office environment. The goal of the microsystems approach is to focus on small, replicable, function service systems that enable health plan staff to provide high-quality, patient-centered care. The first step to this approach is to define a measureable collection of activities. Once the microsystems are identified, new processes that improve care should be tested and implemented. Effective processes can then be rolled out throughout the health plan.

Health Plan Experiences

Quality initiative efforts should focus on the overall experience a client has with the health plan. This includes effectively managing paperwork to ensure a complete and timely process. It is also important for health plans to monitor the relevance and comprehensiveness of information that is distributed to its clients. Furthermore, providing high-quality customer service can help improve clients' perceptions of their health plan.

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	★	—	Top
PCPP	★★★	—	Moderate
DHMP	★	▼	Top
RMHP	★★★★★	—	Low

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

Access to Care

Health plans should identify potential barriers that prevent patients from receiving appropriate access to care. Access to care issues include obtaining the care that the patient and/or physician deem necessary, obtaining timely urgent care, locating a personal doctor, or receiving adequate assistance when calling a physician office. It is important to reduce any hindrances a patient might encounter while seeking care.

Health Care Experiences

To improve patients' health care experience, health plans should eliminate any unnecessary challenges a patient might encounter when receiving health care and to ensure that patients receive adequate time with a clinician so that questions and concerns may be appropriately addressed. This includes providing patients with ample information that is easy to understand. In addition, providing care in a timely fashion will help increase patients' satisfaction with their health care experience.

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
DHMP	★★★★	—	Moderate
RMHP	★★★★	—	Moderate

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

Physician and Patient Communication

Increased communication levels between physicians and patients are important. Indicators of good communication include providing clear explanations, listening carefully, and treating patients with courtesy and respect.

Wait Times

Physicians should attempt to decrease the time between the point that care is needed and when it is received by eliminating barriers that may prohibit patients from receiving prompt, adequate care. This can be achieved by identifying and resolving bottlenecks and redundancies in the patient flow process. Collaborating with other departments can also improve patient flow. Furthermore, physicians can identify areas in the process where physician workload can be redistributed to eliminate excess wait times.

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
DHMP	★★	—	High
RMHP	★★★	—	Moderate

In order to improve the overall performance on the Rating of Specialist Seen Most Often global rating, QI activities should target specialist availability, referral process, and telemedicine.

Specialist Availability

Increasing the availability of specialists will allow patients to receive timely care. One method that can be used to improve the perceived ability to access care is to develop a scheduling model that allows for appointment-flexibility for those patients who need to see a specialist.

Referral Process

Streamlining the referral process allows clients to more readily obtain the care they need. The first step to a streamlined referral process is having effective communication mechanisms between primary care physicians (PCPs) and specialists to determine which clinical conditions require a referral. Furthermore, by involving the patient in the referral process, he/she is made more aware of the necessary information needed for the provider or upcoming appointment. Next, it is helpful for providers to have access to a standardized referral form to ensure that all necessary information is being collected from the parties involved (e.g., plans, patients, and providers).

Telemedicine

Telemedicine models allows for the use of electronic communication and information technologies to provide specialty services to patients in varying locations. Telemedicine such as live, interactive video conferencing allows providers to offer care from a remote location. Physician specialists located in urban settings can diagnose and treat patients in communities where there is a shortage of specialists. Telemedicine consultation models allow for the local provider to both present the patient at the beginning of the consult and to participate in a case conference with the specialist at the end of the teleconference visit. This allows for the local provider to be more involved in the consultation process and more informed about the care the patient is receiving.

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 Composite

Plan	NCQA Comparisons (Star Ratings)	Trend Analysis	Priority Assignment
FFS	★★★	—	Moderate
PCPP	★★★★	—	Moderate
DHMP	★	▼	Top
RMHP	★★★★★	—	Low

In order to improve clients' satisfaction under the Getting Needed Care measure, QI activities should target provider directories, appropriate health care providers, and referral experts.

Provider Directories

Enhancing provider directories will allow patients to effectively choose a physician that will meet their needs. Frequent production of provider directories is essential to ensure that the most current provider information is available. The utility of the provider directory can further be enhanced by identifying those providers who are currently accepting new patients. This simplifies patients' options when choosing a new physician. In addition to listing those providers that are accepting new patients, it is helpful to include expanded information on each physician. For example, providing information training, board certification(s), background information, specialty, and language(s) spoken will allow patients to choose a physician that best meets their needs. Furthermore, developing and publishing physician-level performance measures would give patients the ability to compare providers and make decisions accordingly.

Appropriate Health Care Providers

Health plans should ensure that patients are receiving care from physicians most appropriate to treat their condition. Tracking patients to ascertain they are receiving effective, necessary care from those physicians is imperative to assessing the quality of care they are getting.

Referral Expert

A referral expert can be either a person and/or computer that is responsible for tracking and managing each health plan's referral requirements. Referral experts can decrease the time and energy lost from getting referral approvals. Reducing, or eliminating, delays for referrals, tests, and procedures can increase patient satisfaction. Also, referral experts can save costs associated with phone and paper-based approval processes, and costs that result from grievances and complaints.

Getting Care Quickly

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

Table 3-7
Priority Assignments
Getting Care Quickly Composite

Plan	NCQA Comparisons (Star Ratings)	Trend Analysis	Priority Assignment
FFS	★★	▼	Top
PCPP	★★★★	—	Moderate
DHMP	★	▼	Top
RMHP	★★★★★	—	Low

In order to improve clients' satisfaction under the Getting Care Quickly measure, QI activities should target open access scheduling, patient flow, and electronic communication.

Open Access Scheduling

A scheduling model that allows appointment-flexibility for those patients making same-day appointments is one method that can be used to improve the perceived ability to access care. Instead of booking appointments weeks or months in advance, an open access scheduling model including leaving part of a physician's schedule open for same-day appointments. Open access scheduling has been shown to have the following benefits: 1) reduces delays in patient care; 2) increases continuity of care; and 3) decreases wait times and number of no-shows resulting in cost savings.

Patient Flow

It is important to simplify patient flow in order to decrease wait times. Identifying and resolving bottlenecks and redundancies in this process is one method that may be used to achieve these results. Patient flow can also be streamlined by identifying areas in the process where physician workloads can be redistributed to other staff (e.g., collection of patient's health history can be assigned to a physician assistant).

Electronic Communication

Electronic forms of communication between patient and provider can help alleviate the demand for in-person visits. Electronic communication can provide prompt care to patients that may not require a physician's appointment and can provide physicians with more availability to see patients that require an in-person assessment. This form of communication can also be used when scheduling appointments, providing prescription refills, answering patient questions, educating patients on health topics, and disseminating lab results. It should be noted that the Health Insurance Portability and Accountability Act (HIPAA) regulations must be carefully reviewed when implementing this form of communication.

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 Composite

Plan	NCQA Comparisons (Star Ratings)	Trend Analysis	Priority Assignment
FFS	★★★	—	Moderate
PCPP	★★★★	▲	Low
DHMP	★★★	—	Moderate
RMHP	★★★★	—	Moderate

In order to improve clients' satisfaction under the How Well Doctors Communicate measure, QI activities should focus on skills training, communication tools, and educational materials.

Skills Training for Clinicians and Physicians

Specialized workshops for clinicians and physicians can enhance their communication skills with patients. The seminars can include sessions for communicating with various cultures and challenging patients. In addition, the training can provide methods to effectively communicate a patient's history, how to be empathetic, and how to effectively communicate various treatment options to a patient.

Communication Tools for Patients

Providing patients with a pre-structured question list will help them to ask all pertinent questions when they speak with their provider. Administering surveys after the patient visit can also be a useful tool to ensure that their next visit meets all expectations. Furthermore, providing patients with a copy of their medical record can improve communication between patients and providers.

Educational Materials

Physicians may provide educational literature to patients before, during, and after a visit. Patients will be able to educate themselves on a medical condition specific to their needs. An automatic program could be used to send patients information relative to their appointment.

Customer Service

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

Table 3-9 Priority Assignments Customer Service Composite			
Plan	NCQA Comparisons (Star Ratings)	Trend Analysis	Priority Assignment
FFS	NA	NA	Moderate
PCPP	NA	NA	Moderate
DHMP	NA	NA	Moderate
RMHP	★★★★★	—	Low

In order to improve clients' satisfaction under the Customer Service measure, QI activities should focus on creating tools to identify challenges, service recovery, performance measures, and employee training and empowerment.

Tools to Further Identify Challenges

Health plans can create an individualized survey based on key areas that are noted for improvement and develop questions that will identify specific customer service challenges that need to be addressed. Furthermore, a focus group can provide insight into additional problems not able to be captured through a survey. One method that could be used is to appoint a staff member to conduct a walkthrough of the process a client would go through in contacting customer service. This will assist in identifying potential areas for QI.

Service Recovery

Service recovery can range from a wide range of events from listening to a patient who is upset to handing out incentives to patients who have had to wait longer than a specified time for a doctor's visit. Service recovery can also include events such as making amends for issues that were patient created.

Customer Service Performance Measures

Health plans should evaluate and modify internal customer service performance measures. New measures should be communicated with staff members. By tracking and reporting progress internally and modifying measures as needed, customer service performance may be improved.

Employee Training and Empowerment

It is important to ensure customer service staff have adequate training on all pertinent business processes; furthermore, staff members should feel empowered to resolve any issues a client might have. This will eliminate transferring members to various employees and will help to resolve a complaint in a timely manner.

Shared Decision Making

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

Table 3-10
Priority Assignments
Shared Decision Making Composite

Plan	NCQA Comparisons (Star Ratings)	Trend Analysis	Priority Assignment
FFS	★★★★	—	Moderate
PCPP	★★★★★	—	Low
DHMP	★	—	Top
RMHP	★★★★★	—	Low

In order to improve client satisfaction scores under the Shared Decision Making measure, QI activities should focus on skills training for physicians, promoting shared decision making, and ensuring patients spend enough time with their physician.

Skills Training for Physicians

Implementing a shared decision making model requires physician recognition that patients have the ability to make choices that affect their health care. Therefore, a key to a successful shared decision making model is ensuring that physicians are properly trained. Training should focus on providing skills to facilitate the shared decision making process; ensuring that physicians understand the importance of taking into consideration each patient's values, preferences, and needs; and improving communication skills. Effective and efficient training methods include seminars and workshops.

Physician Encouragement of Shared Decision Making

Patients may become more involved in the management of their health care if physicians promote shared decision making. Physicians will be able to better encourage their patients to participate if the health plan provides physicians with literature that conveys the importance of the shared decision making model.

Adequate Time Spent With Physicians

Shared decision making is more likely to occur when a physician has enough time scheduled for an appointment. It is important that neither the physician nor the patient feel rushed during an appointment. Pre-structured question lists may be provided to patients in order to assist them in asking all necessary questions so the appointment is as efficient and effective as possible.

Individual Item Measures

Coordination of Care

Table 3-11 shows the priority assignments for the Coordination of Care measure.

Table 3-11
Priority Assignments
Coordination of Care

Plan	NCQA Comparisons (Star Ratings)	Trend Analysis	Priority Assignment
FFS	NB	—	Moderate
PCPP	NB	—	Moderate
DHMP	NB	—	Moderate
RMHP	NB	▼	Moderate

In order to improve client satisfaction scores under the Coordination of Care measure, QI activities should focus on communication tools, planned visits, and coordination between physicians.

Communication Tools for Patients

Providing patients with a copy of their medical record can improve communication between patients and providers. Administering surveys after the patient visit can also be a useful tool to ensure that their next visit meets all expectations. Patients can complete a questionnaire that asks about their perceptions of care received to date, functional and clinical health status, and health risk status. Providers can use this information to deliver a treatment plan that is appropriate for each patient.

Planned Visit Management

By identifying patients with chronic conditions that have routine appointments, a system could be implemented to ensure that these patients have the necessary tests done before an appointment.

Coordination Between Physicians

A referral agreement can improve the flow of information among the PCP, specialist, and patient. PCPs and specialists should develop guidelines to identify which clinical conditions the PCPs should manage and which should be referred to specialists.

Health Promotion and Education

Table 3-12 shows the priority assignments for the Health Promotion and Education measure.

Table 3-12
Priority Assignments
Health Promotion and Education

Plan	NCQA Comparisons (Star Ratings)	Trend Analysis	Priority Assignment
FFS	NB	—	Moderate
PCPP	NB	—	Moderate
DHMP	NB	—	Moderate
RMHP	NB	—	Moderate

In order to improve client satisfaction scores under the Health Promotion and Education measure, QI activities should focus on group visits, support groups, and educational materials.

Group Visits

Where appropriate, group visits are an efficient way for patients to have face-to-face contact with their physician, get educational content, and learn from experiences of other patients. Additionally, this method does not interrupt a physician's time throughout the day. These groups provide social and psychological support for participants to help motivate them to follow their treatment plan and take more responsibility for their own health. Benefits of this method include reduced health care costs, greater patient and physician satisfaction, patient empowerment, and greater patient compliance.

Support Groups

Trained professionals can moderate support groups and educate patients in self-care training. An ample amount of literature and guidebooks are available that can serve as a text for self-care programs. The guidebooks can also be used as a relevant source for support group meetings.

Educational Materials

Physicians can facilitate patient education by providing patients access to pertinent and specific information, either via the Internet or in print. There are several products available where patients can independently research information about their own health care.

Accountability and Improvement of Care

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 3-13 provides a summary of the responsible parties for various aspects of care.[3-3]

Table 3-13—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 health plan can still play a major role in influencing the performance of provider groups through intervention and incentive programs.

Those measures identified for FFS, PCPP, DHMP, and RMHP that exhibited low performance 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.

[3-3] 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 the Agency for Healthcare Research and Quality (AHRQ). 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] NCQA released the CAHPS 4.0H Child Medicaid 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 2009, Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA Publication, 2008.

The CAHPS 4.0H Adult Medicaid Health Plan Survey includes 56 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., "Coordination of Care" and "Health Promotion and Education").

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	Coordination of Care
Rating of All Health Care	Getting Care Quickly	Health Promotion and Education
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, PCPP, DHMP, or RMHP 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 2009. The clients eligible for sampling included those who were age 18 or older (as of December 31, 2009).

The standard NCQA HEDIS specifications for survey measures require a sample size of 1,350 clients for the CAHPS 4.0H Adult Medicaid Health Plan Survey. The NCQA protocol permits oversampling in 5 percent increments. For DHMP, no oversampling was performed on the adult population. For FFS and PCPP, a 30 percent oversample was performed on the adult population. For RMHP, a 15 percent oversample was performed on the adult population. This oversampling was performed to ensure a greater number of respondents to each CAHPS measure. For FFS and PCPP, a random sample of 1,755 adult clients was selected from each participating plan. A random sample of 1,350 and 1,533 adult clients was selected for DHMP and RMHP, respectively.[4-5]

[4-5] The sampling for DHMP and RMHP was performed by Morpace and CSS, respectively.

Survey Protocol

Table 4-2 shows the standard mixed mode (i.e., mail followed by telephone follow-up) CAHPS timeline used in the administration of the Colorado CAHPS 4.0H Adult Medicaid Health Plan Surveys.[4-6] The timeline is based on NCQA HEDIS Specifications for Survey Measures.[4-7]

Table 4-2—CAHPS 4.0H Mixed Mode Methodology 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 non-respondents) approximately 14 days after initiation.	70 days

The survey administration for DHMP and RMHP was performed by Morpace and CSS, respectively. The CAHPS 4.0H Health Plan Survey process employed by RMHP was a mail-only methodology, which consisted of a survey only being mailed to sampled clients. The CAHPS 4.0H Health Plan Survey process employed by FFS, PCPP, and DHMP allowed clients two methods by which they could complete a survey. The first phase, or mail phase, consisted of a survey being mailed to all sampled clients. For 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. DHMP did not provide Spanish versions of the mail survey; however, clients had the option to complete a CATI survey in Spanish. A series of up to six CATI calls was made to each non-respondent.[4-8] It has been shown that the addition of the telephone phase aids in the reduction

[4-6] Please note, the timeline used by RMHP will vary due to the mail-only protocol employed.
[4-7] National Committee for Quality Assurance. *HEDIS 2010, Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA Publication, 2009.
[4-8] National Committee for Quality Assurance. *Quality Assurance Plan for HEDIS 2010 Survey Measures.* Washington, DC: NCQA Publication, 2009.

of non-response bias by increasing the number of respondents who are more demographically representative of a plan's population.[4-9]

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, 2009.
- Were currently enrolled in FFS, PCPP, DHMP, or RMHP.
- Had been continuously enrolled for at least five of the last six months of 2009.
- 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.

[4-9] 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.

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 plans. This section provides an overview of each analysis.

Response Rates

The administration of the CAHPS 4.0H Adult Medicaid Health Plan Survey is comprehensive and is designed to achieve 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.[4-10] 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 4-4), were mentally or physically unable to complete the survey, or had a language barrier.

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

Respondent Demographics

The demographic analysis evaluated self-reported demographic information from survey respondents. Given that the demographics of a response group can 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 CAHPS 4.0H Adult Medicaid 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.

[4-10] National Committee for Quality Assurance. *HEDIS 2010, Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA Publication, 2009.

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 Benchmarks and Thresholds to derive the overall client satisfaction ratings (i.e., star ratings) for each CAHPS measure, except for the Shared Decision Making composite. NCQA does not publish benchmarks and thresholds for the Shared Decision Making composite; therefore, the Shared Decision Making star ratings were based on NCQA's 2009 National Adult Medicaid data. For detailed information on the derivation of three-point mean scores, please refer to *NCQA HEDIS 2010 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 at or between the 75th and 89th percentiles
★★★	indicates a score at or between the 50th and 74th percentiles
★★	indicates a score at or 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 and thresholds for this measure

Table 4-3 shows the benchmarks and thresholds used to derive the overall client satisfaction ratings on each CAHPS measure.[4-11,4-12,4-13]

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

Measure	90th Percentile	75th Percentile	50th Percentile	25th Percentile
Rating of Health Plan	2.54	2.46	2.38	2.31
Rating of All Health Care	2.39	2.33	2.27	2.23
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	2.53	2.47	2.40	2.31
Shared Decision Making	2.55	2.52	2.49	2.44

[4-11] National Committee for Quality Assurance. *HEDIS Benchmarks and Thresholds for Accreditation 2010*. Washington, DC: NCQA, Updated February 4, 2010.
[4-12] NCQA National Distribution of 2009 Adult Medicaid Plan-Level Results. Prepared by NCQA for HSAG on December 9, 2009.
[4-13] The star assignments for the Shared Decision Making composite are determined by comparing the plans' three-point mean scores to the distribution of NCQA's 2009 National Adult Medicaid data.

Trend Analysis

In order to evaluate trends in Colorado Medicaid client satisfaction, HSAG performed a stepwise three-year trend analysis. The first step compared the 2010 CAHPS results to the 2009 CAHPS results. If statistically significant differences were found, no additional analysis was performed. If no statistically significant differences were found between the 2010 and 2009 results, a second analysis was performed which compared 2010 to 2008 CAHPS results. 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.[4-14] 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 2010 Specifications for Survey Measures, Volume 3*.

The 2010 Colorado Medicaid and plan-level CAHPS scores were compared to the corresponding 2009 scores to determine whether there were statistically significant differences. If there were no statistically significant differences from 2010 to 2009, then 2010 scores were compared to 2008 scores. A difference is considered significant if the two-sided *p* value of the *t* test is less than 0.05. Scores that were statistically higher in 2010 than in 2009 are noted with black upward (▲) triangles. Scores that were statistically lower in 2010 than in 2009 are noted with black downward (▼) triangles. Scores that were statistically higher in 2010 than in 2008 are noted with red upward (▲) triangles. Scores that were statistically lower in 2010 than in 2008 are noted with red downward (▼) triangles. Scores in 2010 that were not statistically different from scores in 2009 or in 2008 are not noted with triangles. Per NCQA specifications, 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 differences that were statistically different than the State average. Given that differences in case-mix can result in differences in ratings between plans that are not due to differences in quality, the data were adjusted to account for disparities in these characteristics. Case-mix refers to the characteristics of respondents used in adjusting the results for comparability among health plans. Results for the Colorado Medicaid plans were case-mix adjusted for general health status, educational level, and age of the respondent.

[4-14] National Committee for Quality Assurance. *HEDIS 2010, Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA Publication, 2009.

Two types of hypothesis tests were applied to the adult CAHPS comparative results. First, a global *F* test was calculated, which determined whether the difference between the health plans' scores was significant.

The weighted score was:

$$\hat{\mu} = \left(\sum_p \hat{\mu}_p / \hat{V}_p\right) / \left(\sum_p 1/\hat{V}_p\right)$$

The *F* statistic was determined using the formula below:

$$F = (1/(P-1))\sum_p \left(\hat{\mu}_p - \hat{\mu}\right)^2 / \hat{V}_p$$

The *F* statistic, as calculated above, had an *F* distribution with ($P-1$, q) degrees of freedom, where q was equal to n/P (i.e., the average number of respondents in a plan). Due to these qualities, this *F* test produced *p* values that were slightly larger than they should have been; therefore, finding significant differences between health plans was less likely. An alpha-level of 0.05 was used. If the *F* test demonstrated health plan-level differences (i.e., $p < 0.05$), then a *t* test was performed for each health plan.

The *t* test determined whether each health plan's score was significantly different from the results of the other Colorado Medicaid health plans. The equation for the differences was as follows:

$$\Delta_p = \hat{\mu}_p - (1/P)\sum_{p'} \hat{\mu}_{p'} = ((P-1)/P)\hat{\mu}_p - \sum\nolimits^*_{p'} (1/P)\hat{\mu}_{p'}$$

In this equation, $\sum^*$ was the sum of all health plans except health plan *p*.

The variance of Δ_p was:

$$\hat{V}\left(\Delta_p\right) = \left[(P-1)/P\right]^2 \hat{V}_p + 1/P^2 \sum_{p'} \hat{V}_p$$

The *t* statistic was $\Delta_p / \hat{V}\left(\Delta_p\right)^{1/2}$ and had a *t* distribution with $(n_p - 1)$ degrees of freedom. This statistic also produced *p* values that were slightly larger than they should have been; therefore, finding significant differences between a health plan *p* and the combined results of all Colorado Medicaid health plans was less likely.

Limitations and Cautions

The findings presented in the 2010 Colorado Adult Medicaid CAHPS report 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

While data for the plan comparisons have been adjusted for differences in survey-reported general health status, age, and education, it was not possible to adjust for differences in respondent characteristics that were not measured. These characteristics include income, employment, or any other characteristics that may not be under the plans' control.

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.

Mode Effects

The CAHPS survey was administered via mixed-mode (all plans except RMHP) and mail-only mode (RMHP) methodologies. The mode in which a survey is administered may have an impact on respondents' assessments of their health care experiences. Therefore, mode effects should be considered when interpreting the CAHPS results.

Survey Vendor Effects

The CAHPS 4.0H Adult Medicaid Health Plan Survey was administered by multiple survey vendors. NCQA developed its Survey Vendor Certification Program to ensure standardization of data collection and the comparability of results across health plans. However, due to the different processes employed by the survey vendors, there is still the small potential for vendor effects. Therefore, survey vendor effects should be considered when interpreting the CAHPS results.

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.[4-15] The following references offer guidance on possible approaches to CAHPS-related QI activities.

AHRQ Web site. The CAHPS Improvement Guide. Available at: http://www.cahps.ahrq.gov/qiguide/default.aspx. Accessed on: July 1, 2010.

Backer LA. Strategies for better patient flow and cycle time. *Family Practice Management*. 2002; 9(6): 45-50. Available at: http://www.aafp.org/fpm/20020600/45stra.html. Accessed on: July 1, 2010.

Berwick DM. A user's manual for the IOM's 'Quality Chasm' report. *Health Affairs*. 2002; 21(3): 80-90.

Bonomi AE, Wagner EH, Glasgow RE, et al. Assessment of chronic illness care (ACIC): a practical tool to measure quality improvement. *Health Services Research*. 2002; 37(3): 791-820.

Camp R, Tweet AG. Benchmarking applied to health care. *Joint Commission Journal on Quality Improvement*. 1994; 20: 229-238.

Edgman-Levitan S, Shaller D, McInnes K, Joyce R, Coltin K, Cleary P. *The CAHPS® Improvement Guide: Practical Strategies for Improving the Patient Care Experience*. Department of Health Care Policy, Harvard Medical School; 2003. Available at: http://www.cahps.ahrq.gov/qiguide/default.aspx?print=1. Accessed on: July 1, 2010.

Garwick AW, Kohrman C, Wolman C, et al. Families' recommendations for improving services for children with chronic conditions. *Archives of Pediatric and Adolescent Medicine*. 1998; 152(5): 440-8.

Gerteis M, Edgman-Levitan S, Daley J. *Through the Patient's Eyes: Understanding and Promoting Patient-Centered Care*. San Francisco, CA: Jossey-Bass; 1993.

Grumbach K, Selby JV, Damberg C, et al. Resolving the gatekeeper conundrum: what patients value in primary care and referrals to specialists. *Journal of the American Medical Association*. 1999; 282(3): 261-6.

Institute of Medicine. *Crossing the Quality Chasm: A New Health System for the 21st Century*. Washington, DC: National Academy Press; 2001.

[4-15] AHRQ Web site. *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 1, 2010.

Keating NL, Green DC, Kao AC, et al. How are patients' specific ambulatory care experiences related to trust, satisfaction, and considering changing physicians? *Journal of General Internal Medicine*. 2002; 17(1): 29-39.

Korsch BM, Harding C. *The Intelligent Patient's Guide to the Doctor-Patient Relationship: Learning How to Talk So Your Doctor Will Listen*. New York, NY: Oxford University Press; 1998.

Langley GJ, Nolan KM, Norman CL, Provost LP, Nolan TW. *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance*. San Francisco, CA: Jossey-Bass; 1996.

Leebov W, Scott G. *Service Quality Improvement: The Customer Satisfaction Strategy for Health Care*. Chicago, IL: American Hospital Publishing, Inc.; 1994.

Leebov W, Scott G, Olson L. *Achieving Impressive Customer Service: 7 Strategies for the Health Care Manager*. San Francisco, CA: Jossey-Bass; 1998.

Maly RC, Bourque LB, Engelhardt RF. A randomized controlled trial of facilitating information given to patients with chronic medical conditions: Effects on outcomes of care. *Journal of Family Practice*. 1999; 48(5): 356-63.

Molnar C. Addressing challenges, creating opportunities: fostering consumer participation in Medicaid and Children's Health Insurance managed care programs. *Journal of Ambulatory Care Management*. 2001; 24(3): 61-7.

Murray M. Reducing waits and delays in the referral process. *Family Practice Management*. 2002; 9(3): 39-42. Available at: http://www.aafp.org/fpm/20020300/39redu.html. Accessed on: July 1, 2010.

Murray M, Berwick DM. Advanced access: reducing waiting and delays in primary care. *Journal of the American Medical Association.* 2003; 289(8): 1035-40.

Nelson AM, Brown SW. *Improving Patient Satisfaction Now: How to Earn Patient and Payer Loyalty*. New York, NY: Aspen Publishers, Inc.; 1997.

Spicer J. Making patient care easier under multiple managed care plans. *Family Practice Management*. 1998; 5(2): 38-42, 45-8, 53.

Wasson JM, Godfrey M, Nelson E, et al. Microsystems in health care: Part 4. Planning patient-centered care. *Joint Commission Journal on Quality and Safety*. 2003; 29(5): 227-237. Available at: http://howsyourhealth.com/html/CARE.pdf. Accessed on: July 1, 2010.

5. Survey Instrument

The survey instrument selected for the 2010 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 ➔**If 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 not include care you got when you stayed overnight in a hospital. Do not include the times you went for dental care visits.

3. In the last 6 months, did you have an illness, injury, or condition that needed care right away 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 needed care right away, 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, not 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
   4☐ 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 you thought 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 or use tobacco 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, how often were you advised to quit smoking or using tobacco by a doctor or other health provider in your plan?

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

39. In the last 6 months, how often was medication recommended or discussed by a doctor or health provider to assist you with quitting smoking or using tobacco? Examples of medication are: nicotine gum, patch, nasal spray, inhaler, or prescription medication.

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

40. In the last 6 months, how often did your doctor or health provider discuss or provide methods and strategies other than medication to assist you with quitting smoking or using tobacco? Examples of methods and strategies are: telephone helpline, individual or group counseling, or cessation program.

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

41. Do you take aspirin daily or every other day?

1☐ Yes
2☐ No
3☐ Don't know

42. Do you have a health problem or take medication that makes taking aspirin unsafe for you?

1☐ Yes
2☐ No
3☐ Don't know

43. Has a doctor or health provider ever discussed with you the risks and benefits of aspirin to prevent heart attack or stroke?

1☐ Yes
2☐ No

44. Are you aware that you have any of the following conditions? Check all that apply.

a☐ High cholesterol
b☐ High blood pressure
c☐ Parent or sibling with heart attack before the age of 60

45. Has a doctor ever told you that you have any of the following conditions? Check all that apply.

a☐ A heart attack
b☐ Angina or coronary heart disease
c☐ A stroke
d☐ Any kind of diabetes or high blood sugar

46. 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 48**

47. 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

48. Do you now need or take medicine prescribed by a doctor? Do not include birth control.

[1] ☐ Yes
[2] ☐ No ➔**If No, Go to Question 50**

49. Is this to treat a condition that has lasted for at least 3 months? Do not include pregnancy or menopause.

[1] ☐ Yes
[2] ☐ No

50. 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

51. Are you male or female?

[1] ☐ Male
[2] ☐ Female

52. 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

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

[1] ☐ Yes, Hispanic or Latino
[2] ☐ No, Not Hispanic or Latino

54. 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

55. Did someone help you complete this survey?

[1] ☐ Yes ➔**If Yes, Go to Question 56**
[2] ☐ No ➔**Thank you. Please return the completed survey in the postage-paid envelope.**

56. 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.

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 FFS, PCPP, DHMP, and RMHP.

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)
- DHMP Adult Medicaid Cross-tabulations (Tab and Banner Book)
- RMHP 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.