FY 11–12 ADULT MEDICAID CLIENT SATISFACTION REPORT

August 2012

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 Medicaid Choice (DHMC), and Rocky Mountain Health Plans (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 2012.

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 DHMC 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 2012 Healthcare Effectiveness Data and Information Set (HEDIS®) Benchmarks and Thresholds for Accreditation.[1-3,1-4,1-5] 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	DHMC	RMHP
★ Rating of Health Plan	★★★ How Well Doctors Communicate	★ Getting Care Quickly	★★★ Rating of All Health Care
★★ Getting Care Quickly	★★★ Rating of Health Plan	★ Getting Needed Care	★★★ Rating of Personal Doctor
★★ Rating of All Health Care	★★★★ Getting Care Quickly	★ Rating of Specialist Seen Most Often	★★★★ How Well Doctors Communicate
★★ Rating of Personal Doctor	★★★★ Getting Needed Care	★★ Rating of All Health Care	★★★★ Rating of Health Plan
★★★ Getting Needed Care	★★★★ Rating of All Health Care	★★★ Rating of Health Plan	★★★★ Rating of Specialist Seen Most Often
★★★ How Well Doctors Communicate	★★★★ Rating of Personal Doctor	★★★ Shared Decision Making	★★★★★ Getting Care Quickly
★★★ Rating of Specialist Seen Most Often	★★★★ Rating of Specialist Seen Most Often	★★★★ How Well Doctors Communicate	★★★★★ Getting Needed Care
★★★ Shared Decision Making	★★★★★ Shared Decision Making	★★★★★ Rating of Personal Doctor	★★★★★ Shared Decision Making
NA Customer Service	NA Customer Service	NA Customer Service	NA Customer Service

★★★★★ 90th Percentile or Above ★★★★ 75th-89th Percentiles ★★★ 50th-74th Percentiles ★★ 25th-49th Percentiles ★ Below 25th Percentile

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).

[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 2012*. Washington, DC: NCQA, January 25, 2012.
[1-5] The star assignments for the Shared Decision Making composite are determined by comparing the plans' three-point mean scores to NCQA's National Distribution of 2011 Adult Medicaid Plan-Level Results. Prepared by NCQA for HSAG on December 16, 2011.

Trend Analysis

In order to evaluate trends in Colorado Medicaid client satisfaction, HSAG performed a stepwise trend analysis. The first step compared the 2012 CAHPS results to the 2011 CAHPS results. If the initial 2012 and 2011 trend analysis did not yield any significant differences, then an additional trend analysis was performed between 2012 and 2010 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	DHMC	RMHP
Global Rating				
Rating of Health Plan	None	None	▲	None
Rating of All Health Care			▲	

▲ *Indicates the 2012 score is significantly higher than the 2011 score*
▼ *Indicates the 2012 score is significantly lower than the 2011 score*
▲ *Indicates the 2012 score is significantly higher than the 2010 score*
▼ *Indicates the 2012 score is significantly lower than the 2010 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.[1-6] 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.[1-7]

Table 1-3
Plan Comparisons Highlights

Colorado Medicaid FFS	Colorado Medicaid PCPP	DHMC	RMHP
↓ Rating of Health Plan	None	↓ Getting Care Quickly	↑ Getting Care Quickly
		↓ Getting Needed Care	↑ Getting Needed Care
			↑ Rating of Health Plan

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

Priority Assignments

Based on the results of the NCQA comparisons and trend analysis, priority assignments were derived for each measure. Measures were assigned into one of four main categories for quality improvement (QI): top, high, moderate, and low priority. 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	DHMC	RMHP
◆ Rating of Health Plan ◆ Rating of All Health Care ◆ Rating of Personal Doctor ◆ Getting Care Quickly ◆ Shared Decision Making	◆ Colorado Medicaid PCPP did not have any Top or High priorities.	◆ Rating of All Health Care ◆ Rating of Specialist Seen Most Often ◆ Getting Needed Care ◆ Getting Care Quickly ◆ Shared Decision Making	◆ RMHP did not have any Top or High priorities.

[1-6] 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.
[1-7] Caution should be exercised when evaluating health plan comparisons, given that population and health plan differences may impact results.

2. 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, DHMC, 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 2011. Adult clients eligible for sampling included those who were 18 years of age or older as of December 31, 2011. DHMC 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 DHMC and RMHP, respectively. The specifications also permit oversampling in increments of 5 percent. A 50 percent oversample was performed on DHMC's adult population. Based on this rate, a total random sample of 2,025 adult clients was selected from this plan. A 5 percent oversample was performed on RMHP's adult population. Based on this rate, a total random sample of 1,418 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 for 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 DHMC 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 cover letter included with the English version of the survey had a Spanish cover letter on the back side informing clients that they could call the toll-free number to request a Spanish version of the CAHPS questionnaire. The cover letter provided with the Spanish version of the CAHPS questionnaire included a text box with a toll-free number that clients could call to request a survey in another language (i.e., English). A second survey mailing was sent to all non-respondents. The second phase, or telephone phase, consisted of Computer Assisted Telephone Interviewing (CATI)

[2-1] National Committee for Quality Assurance. *HEDIS® 2012, Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA Publication, 2011.

for sampled clients who had not mailed in a completed survey. DHMC provided English and Spanish versions of the mail survey and allowed clients the option to complete a CATI survey in English or Spanish. A minimum of three CATI calls was 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.

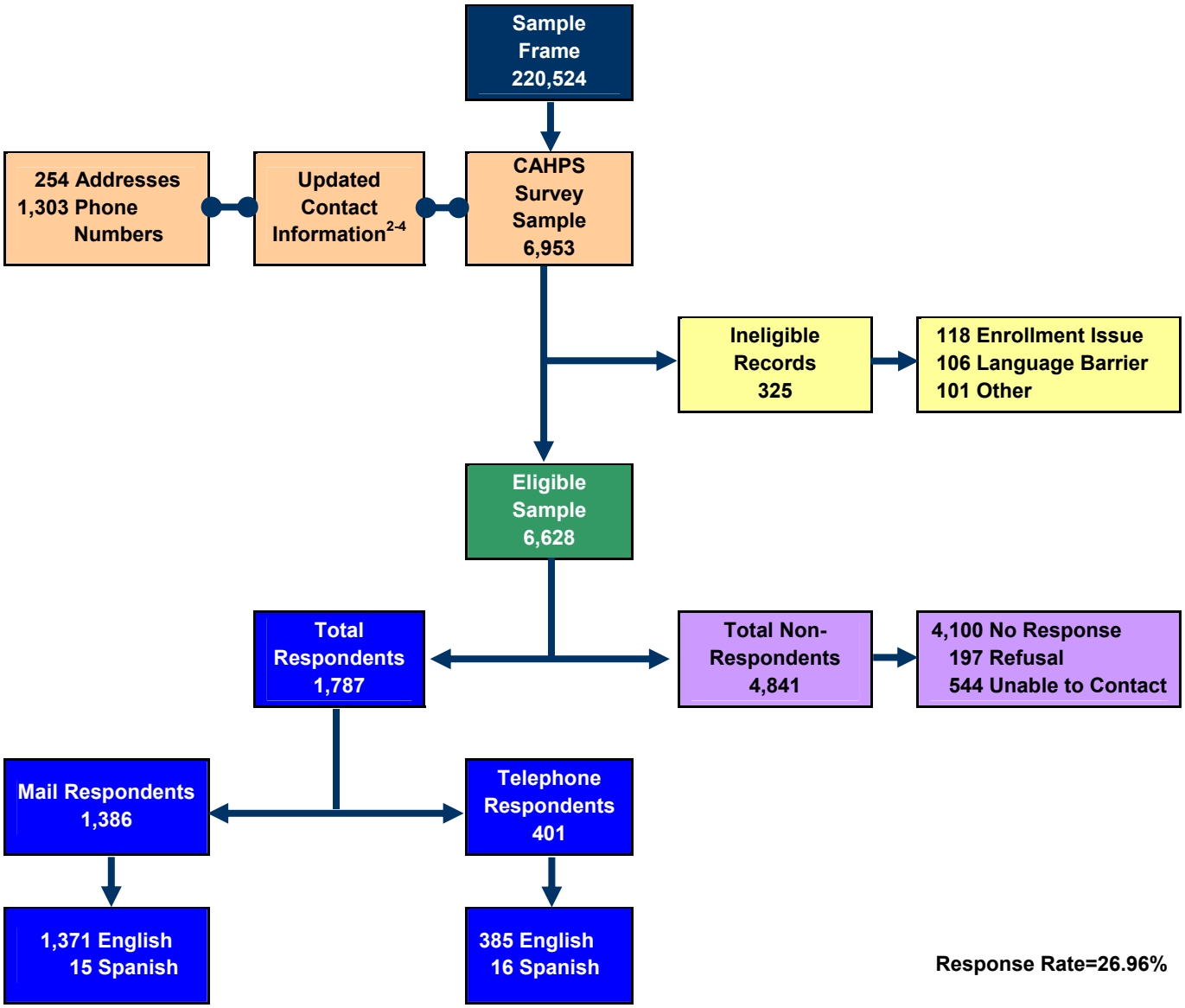
Response Rates

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 1,787 adult clients returned a completed survey, including: 458 FFS, 496 PCPP, 446 DHMC, and 387 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, DHMC, and RMHP, respectively. The 2012 Colorado Medicaid response rate of 26.96 percent was 2.34 percentage points lower than the national adult Medicaid response rate reported by NCQA for 2011, which was 29.3 percent.[2-3]

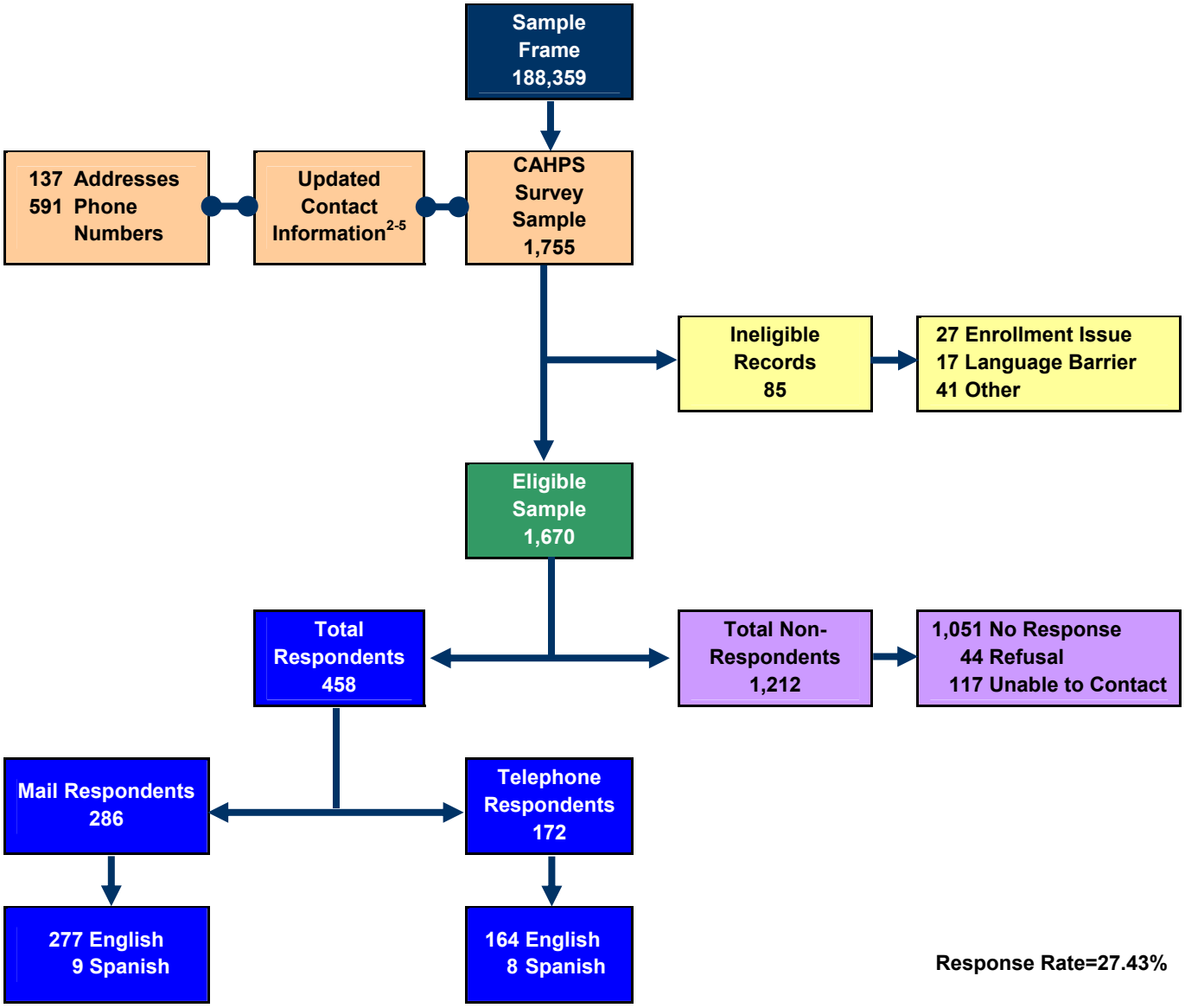
[2-2] National Committee for Quality Assurance. *Quality Assurance Plan for HEDIS 2012 Survey Measures.* Washington, DC: NCQA Publication, 2011.
[2-3] National Committee for Quality Assurance. *HEDIS 2012 Survey Vendor Update Training*. October 20, 2011.

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



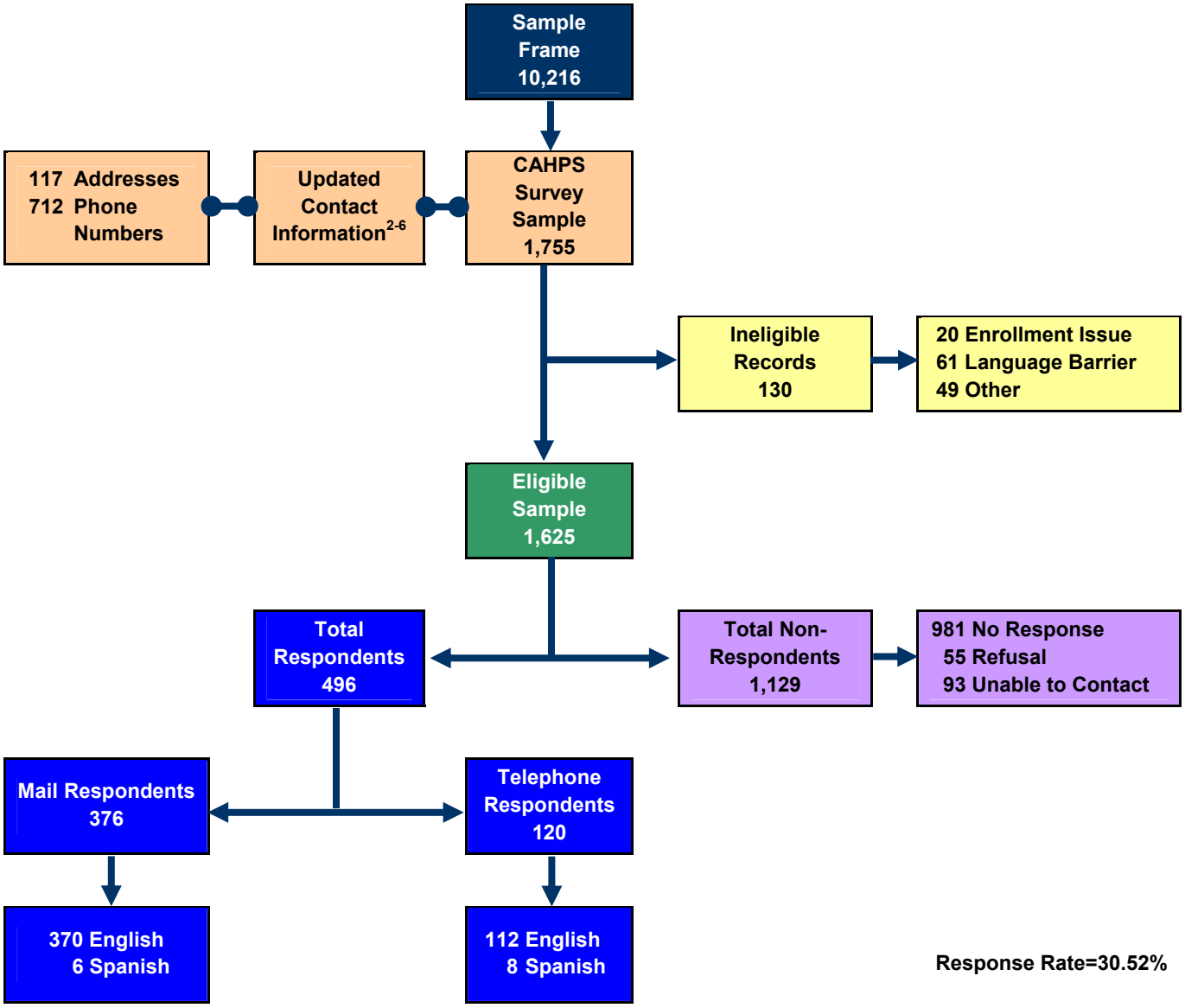
2-4 Prior to survey administration, address and phone information is updated for clients of the CAHPS sample using the United States Postal Service's National Change of Address (NCOA) and Telematch databases. The number of updated addresses and telephone numbers are provided for informational purposes 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 States Postal Service's 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 2-3—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 States Postal Service's 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 2-4—Distribution of Surveys for DHMC

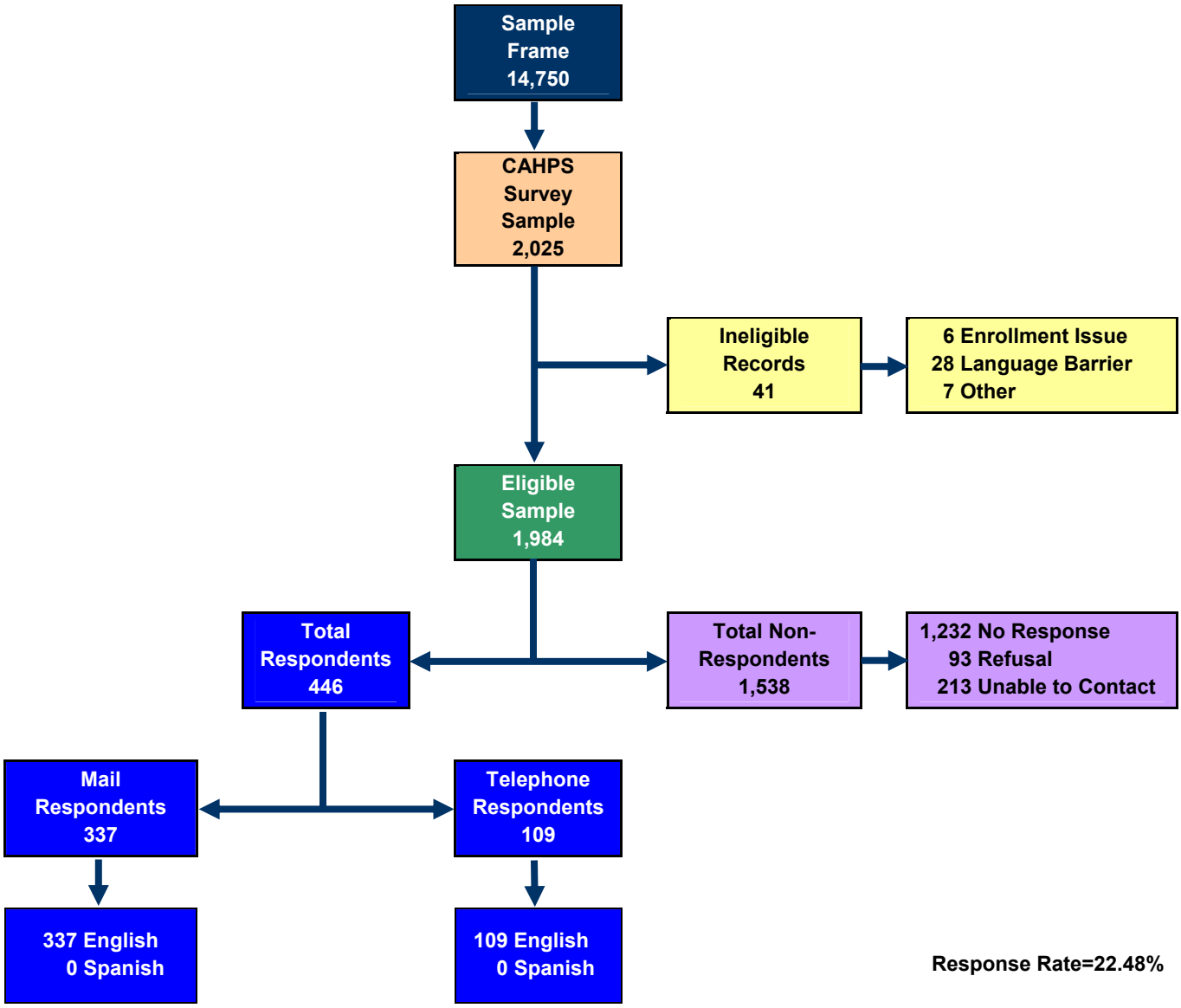
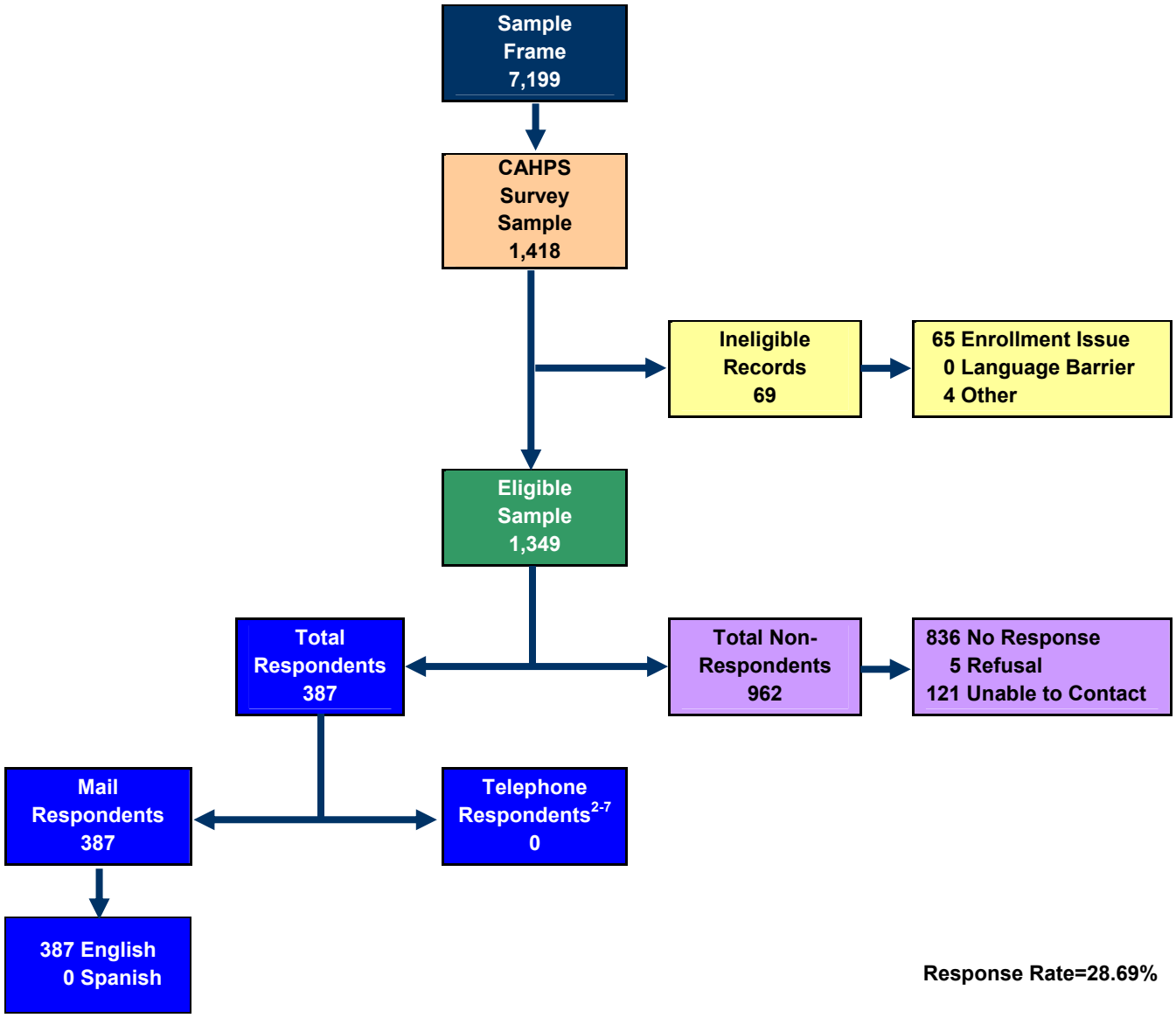


Figure 2-5—Distribution of Surveys for RMHP



[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	**6,953**	**325**	**6,628**	**1,787**	**26.96%**
Colorado Medicaid FFS	1,755	85	1,670	458	27.43%
Colorado Medicaid PCPP	1,755	130	1,625	496	30.52%
DHMC	2,025	41	1,984	446	22.48%
RMHP	1,418	69	1,349	387	28.69%

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	DHMC	RMHP
Age					
18 to 24	**8.3%**	11.8%	4.4%	7.4%	10.3%
25 to 34	**16.0%**	19.1%	11.6%	16.0%	18.2%
35 to 44	**13.5%**	16.6%	13.1%	13.1%	11.1%
45 to 54	**16.9%**	15.9%	15.2%	21.0%	15.8%
55 to 64	**18.0%**	12.9%	20.4%	19.6%	18.9%
65 or Older	**27.2%**	23.7%	35.4%	22.9%	25.8%
Gender					
Male	**29.9%**	26.2%	34.1%	32.7%	25.8%
Female	**70.1%**	73.8%	65.9%	67.3%	74.2%
Race/Ethnicity					
Multi-Racial	**5.8%**	8.6%	6.0%	4.1%	4.3%
White	**62.4%**	68.9%	61.5%	35.9%	83.8%
Black	**9.8%**	5.6%	6.9%	26.4%	0.8%
Asian	**6.1%**	3.9%	13.1%	4.4%	1.6%
Other	**15.9%**	13.0%	12.6%	29.2%	9.4%

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	DHMC	RMHP
Education					
8th Grade or Less	**15.1%**	9.5%	19.3%	20.5%	10.2%
Some High School	**15.6%**	12.3%	13.6%	24.3%	12.4%
High School Graduate	**34.0%**	35.3%	35.2%	27.2%	38.7%
Some College	**26.5%**	31.6%	23.1%	21.7%	30.4%
College Graduate	**8.7%**	11.2%	8.9%	6.3%	8.3%
General Health Status					
Excellent	**8.2%**	8.7%	6.9%	10.2%	7.1%
Very Good	**18.5%**	21.7%	14.2%	17.3%	21.6%
Good	**29.9%**	27.9%	30.3%	29.3%	32.4%
Fair	**29.7%**	29.9%	32.2%	32.5%	23.2%
Poor	**13.7%**	11.9%	16.3%	10.7%	15.8%

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 2011 National Adult Medicaid data.[2-11] 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

[2-9] National Committee for Quality Assurance. *HEDIS® 2012, Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA Publication, 2011.
[2-10] National Committee for Quality Assurance. *HEDIS Benchmarks and Thresholds for Accreditation 2012*. Washington, DC: NCQA, January 25, 2012.
[2-11] The star assignments for the Shared Decision Making composite are determined by comparing the plans' three-point mean scores to NCQA's National Distribution of 2011 Adult Medicaid Plan-Level Results. Prepared by NCQA for HSAG on December 16, 2011.

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	DHMC	RMHP
Global Rating				
Rating of Health Plan	★ 2.256	★★★ 2.458	★★★ 2.384	★★★★ 2.524
Rating of All Health Care	★★ 2.277	★★★★ 2.364	★★ 2.289	★★★ 2.322
Rating of Personal Doctor	★★ 2.449	★★★★★ 2.560	★★★★★ 2.573	★★★ 2.492
Rating of Specialist Seen Most Often	★★★ 2.473	★★★★ 2.513	★ 2.342	★★★★ 2.507
Composite Measure				
Getting Needed Care	★★★ 2.294	★★★★ 2.381	★ 2.036	★★★★★ 2.494
Getting Care Quickly	★★ 2.338	★★★★ 2.441	★ 2.107	★★★★★ 2.480
How Well Doctors Communicate	★★★ 2.547	★★★ 2.565	★★★★ 2.589	★★★★ 2.589
Customer Service	**NA** NA	**NA** NA	**NA** NA	**NA** NA
Shared Decision Making	★★ 2.497	★★★★ 2.554	★★ 2.481	★★★★ 2.554

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).

Summary of NCQA Comparisons Results

The following table summarizes the NCQA comparisons results.

Table 2-5
NCQA Comparisons Results

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

★★★★★ 90th Percentile or Above ★★★★ 75th-89th Percentiles ★★★ 50th-74th Percentiles ★★ 25th-49th Percentiles ★ Below 25th Percentile

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).

Trend Analysis

In 2010, the Colorado Medicaid FFS, PCPP, DHMC, and RMHP had 577, 674, 414, and 556 completed CAHPS 4.0H Adult Medicaid Health Plan Surveys, respectively. In 2011, the Colorado Medicaid FFS, PCPP, DHMC, and RMHP had 418, 567, 468, and 510 completed CAHPS 4.0H Adult Medicaid Health Plan Surveys, respectively. These completed surveys were used to calculate the 2011 and 2010 CAHPS results presented in this section for trending purposes.[2-12]

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.[2-13] 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 2012 Colorado Medicaid and plan-level CAHPS scores to the corresponding 2011 scores. If the initial 2012 and 2011 trend analysis did not yield any statistically significant differences, then an additional trend analysis was performed between 2012 and 2010 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 2012 than in 2011 are noted with black upward (▲) triangles. Scores that were statistically lower in 2012 than in 2011 are noted with black downward (▼) triangles. Scores that were statistically higher in 2012 than in 2010 are noted with red upward (▲) triangles. Scores that were statistically lower in 2012 than in 2010 are noted with red downward (▼) triangles. Scores in 2012 that were not statistically different from scores in 2011 or in 2010 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).

[2-12] For detailed information on the 2010 FFS, PCPP, DHMC, and RMHP CAHPS results, please refer to the 2010 Adult Medicaid Client Satisfaction Report. For detailed information on the 2011 FFS, PCPP, DHMC, and RMHP results, please refer to the 2011 Adult Medicaid Client Satisfaction Report.

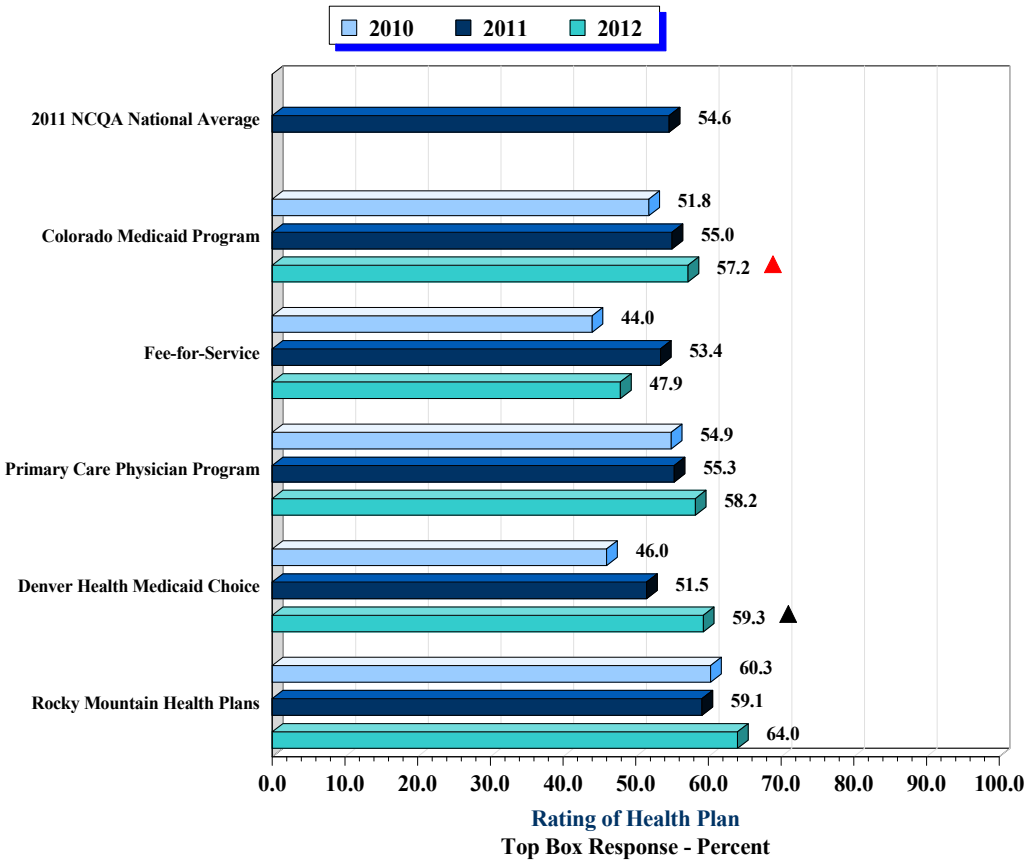
[2-13] National Committee for Quality Assurance. *HEDIS® 2012, Volume 3: Specifications for Survey Measures*. Washington, DC: NCQA Publication, 2011.

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 2011 NCQA national average, and the 2010, 2011, and 2012 Rating of Health Plan question summary rates for Colorado Medicaid, FFS, PCPP, DHMC, and RMHP.[2-14,2-15]

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



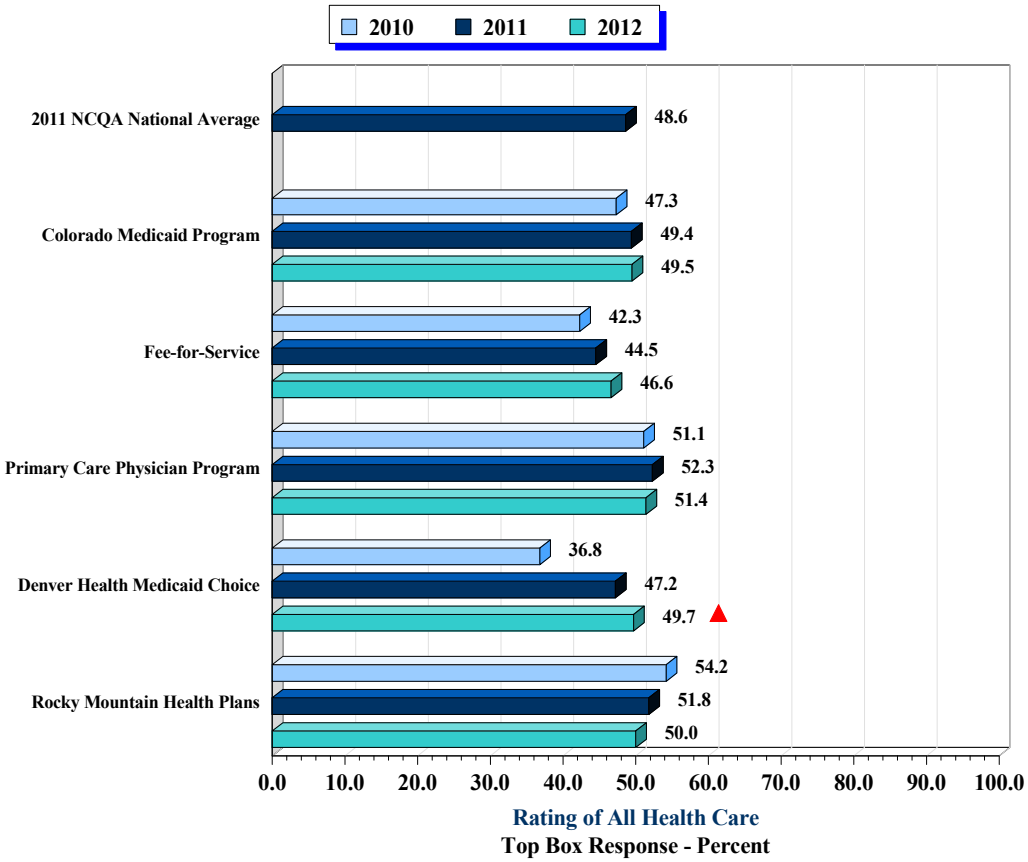
Statistical Significance Note:
▲ indicates the 2012 score is significantly higher than the 2011 score
▼ indicates the 2012 score is significantly lower than the 2011 score
▲ indicates the 2012 score is significantly higher than the 2010 score
▼ indicates the 2012 score is significantly lower than the 2010 score

[2-14] Colorado Medicaid scores in this section are derived from the combined results of the four Colorado Medicaid plans: FFS, PCPP, DHMC, and RMHP. This includes results from plans with fewer than 100 respondents.
[2-15] NCQA national averages were not available for 2012 at the time this report was prepared; therefore, 2011 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 2011 NCQA national average, and the 2010, 2011, and 2012 Rating of All Health Care question summary rates for Colorado Medicaid, FFS, PCPP, DHMC, and RMHP.

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

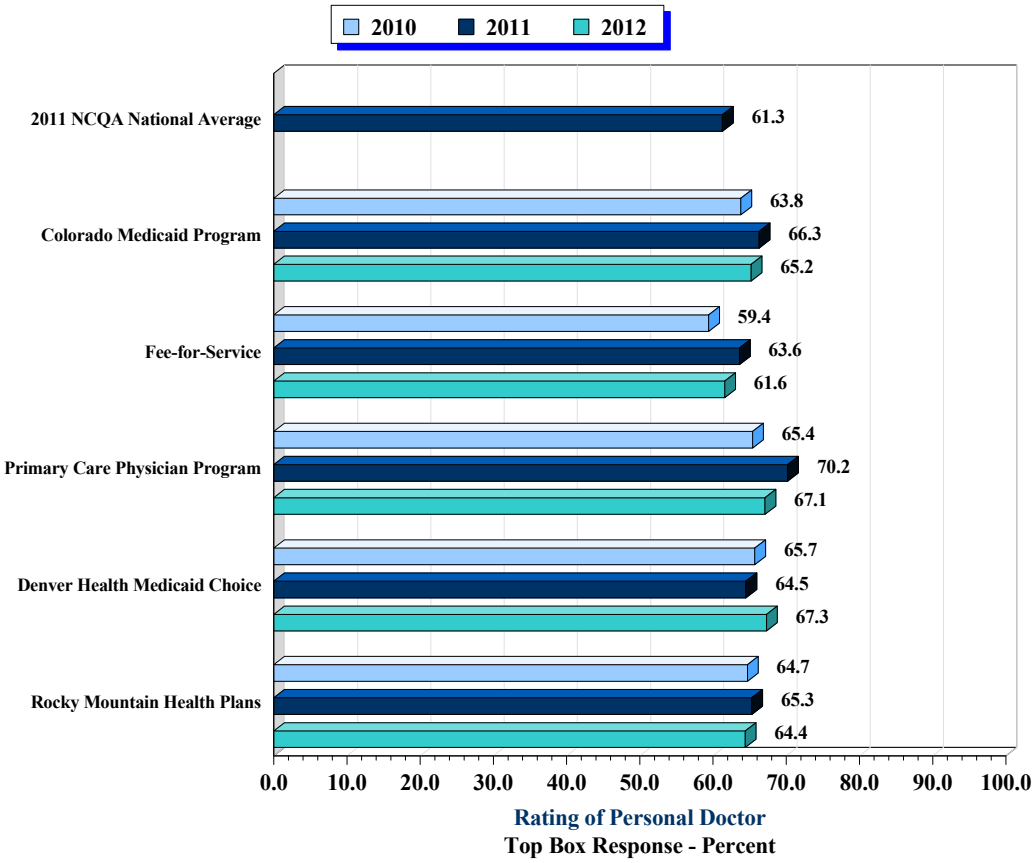


Statistical Significance Note:
▲ indicates the 2012 score is significantly higher than the 2011 score
▼ indicates the 2012 score is significantly lower than the 2011 score
▲ indicates the 2012 score is significantly higher than the 2010 score
▼ indicates the 2012 score is significantly lower than the 2010 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 2011 NCQA national average, and the 2010, 2011, and 2012 Rating of Personal Doctor question summary rates for Colorado Medicaid, FFS, PCPP, DHMC, and RMHP.

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

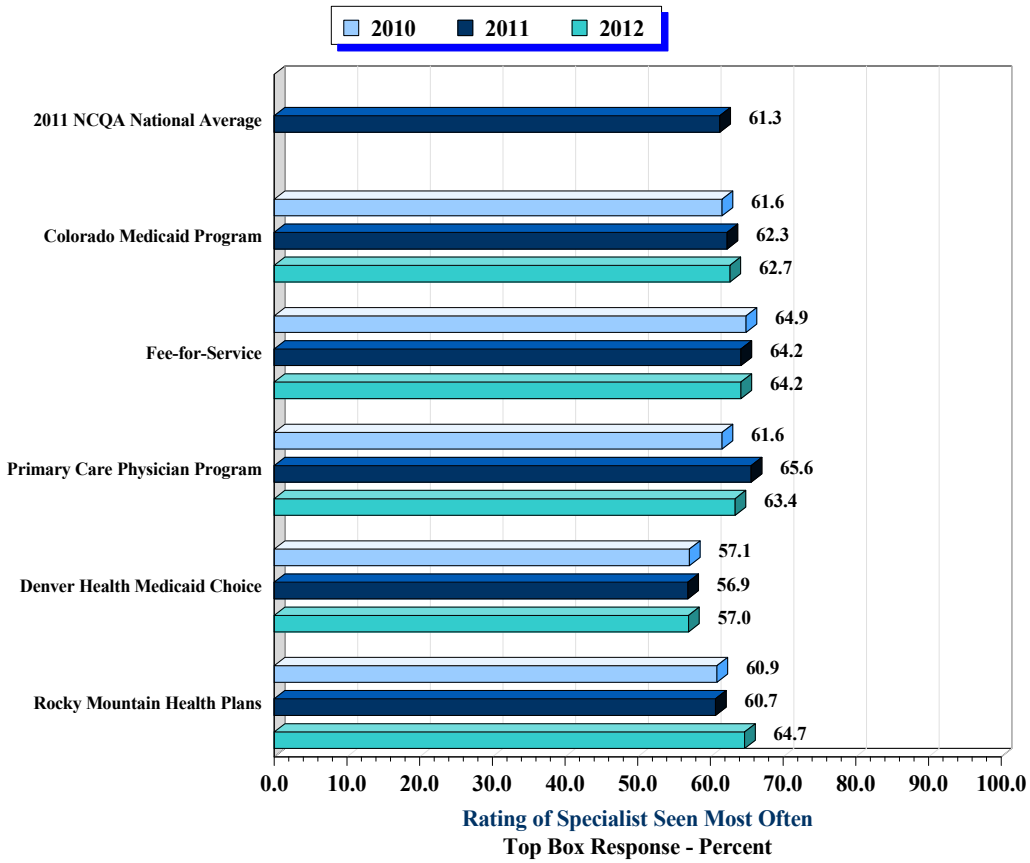


Statistical Significance Note:
▲ indicates the 2012 score is significantly higher than the 2011 score
▼ indicates the 2012 score is significantly lower than the 2011 score
▲ indicates the 2012 score is significantly higher than the 2010 score
▼ indicates the 2012 score is significantly lower than the 2010 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 2011 NCQA national average, and the 2010, 2011, and 2012 Rating of Specialist Seen Most Often question summary rates for Colorado Medicaid, FFS, PCPP, DHMC, and RMHP.

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



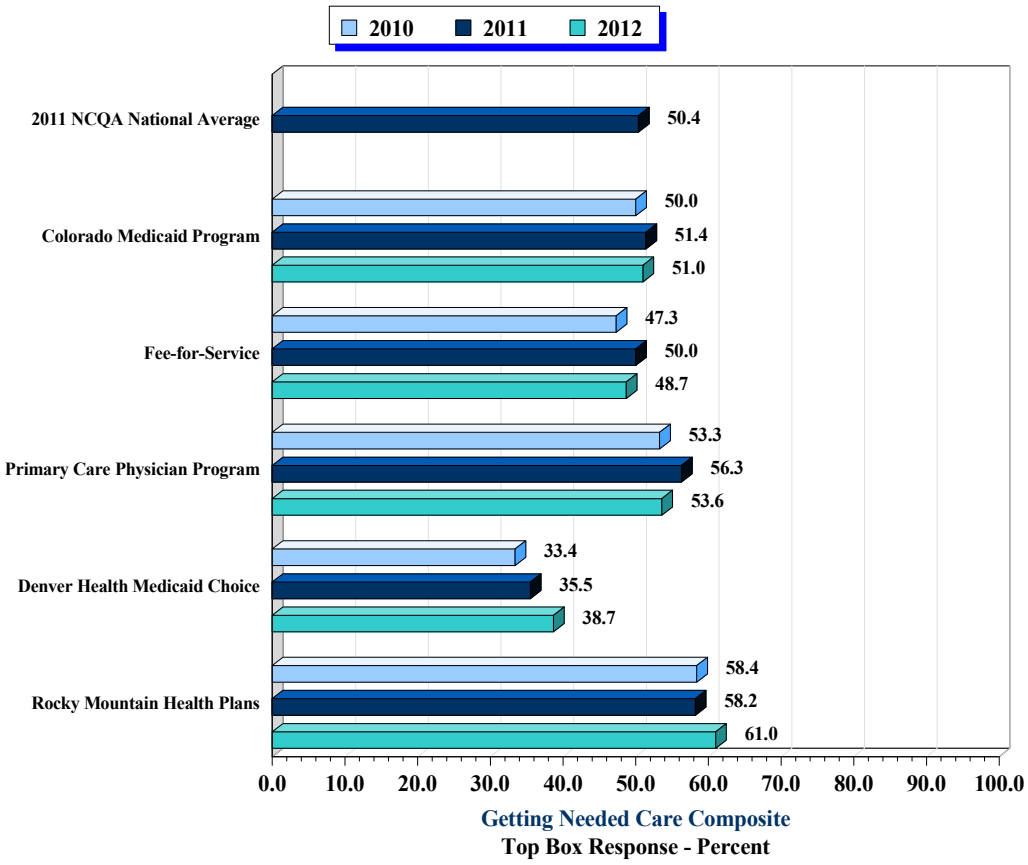
Statistical Significance Note:
▲ indicates the 2012 score is significantly higher than the 2011 score
▼ indicates the 2012 score is significantly lower than the 2011 score
▲ indicates the 2012 score is significantly higher than the 2010 score
▼ indicates the 2012 score is significantly lower than the 2010 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 2011 NCQA national average, and the 2010, 2011, and 2012 Getting Needed Care global proportions for Colorado Medicaid, FFS, PCPP, DHMC, and RMHP.

Figure 2-10—Trend Analysis: Getting Needed Care

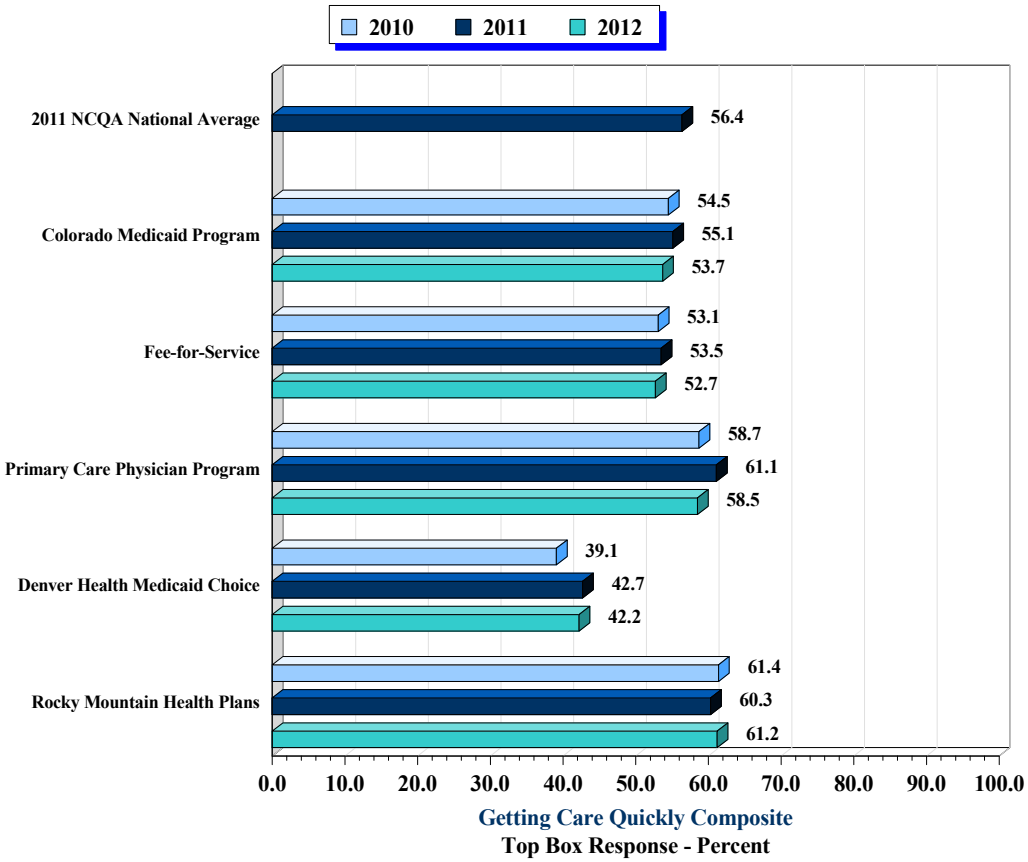


Statistical Significance Note:
▲ indicates the 2012 score is significantly higher than the 2011 score
▼ indicates the 2012 score is significantly lower than the 2011 score
▲ indicates the 2012 score is significantly higher than the 2010 score
▼ indicates the 2012 score is significantly lower than the 2010 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 2011 NCQA national average, and the 2010, 2011, and 2012 Getting Care Quickly global proportions for Colorado Medicaid, FFS, PCPP, DHMC, and RMHP.

Figure 2-11—Trend Analysis: Getting Care Quickly

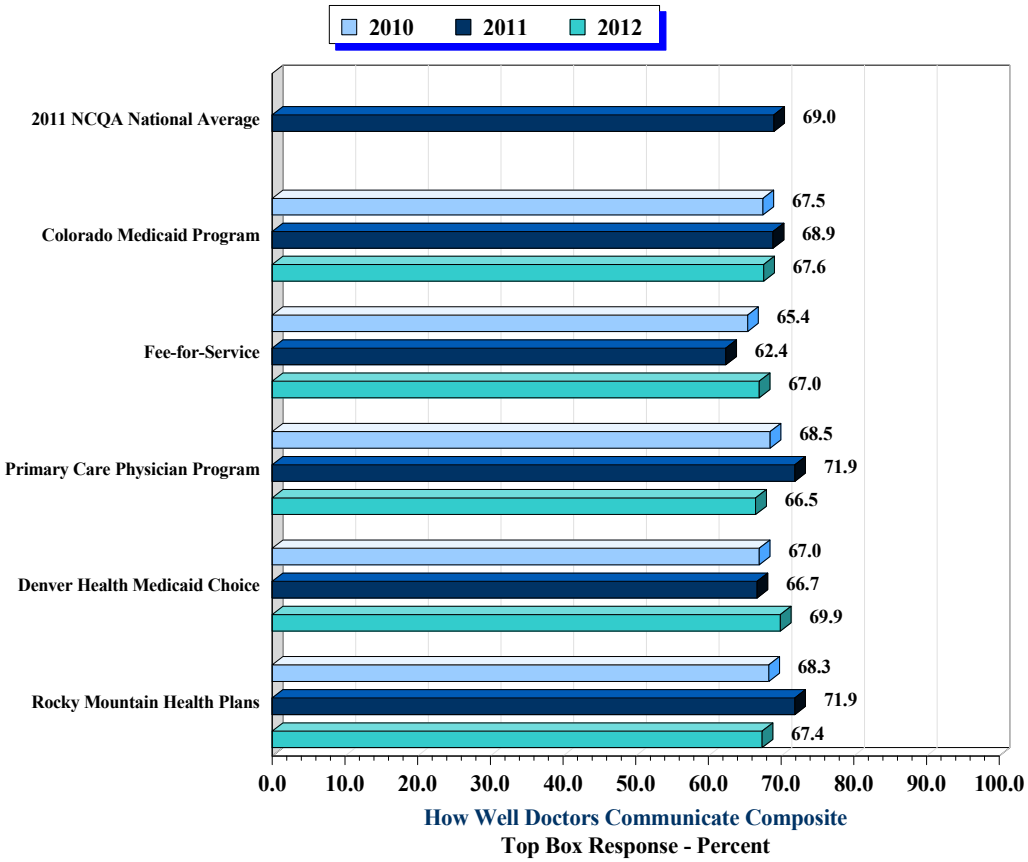


Statistical Significance Note:
▲ indicates the 2012 score is significantly higher than the 2011 score
▼ indicates the 2012 score is significantly lower than the 2011 score
▲ indicates the 2012 score is significantly higher than the 2010 score
▼ indicates the 2012 score is significantly lower than the 2010 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 2011 NCQA national average, and the 2010, 2011, and 2012 How Well Doctors Communicate global proportions for Colorado Medicaid, FFS, PCPP, DHMC, and RMHP.

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

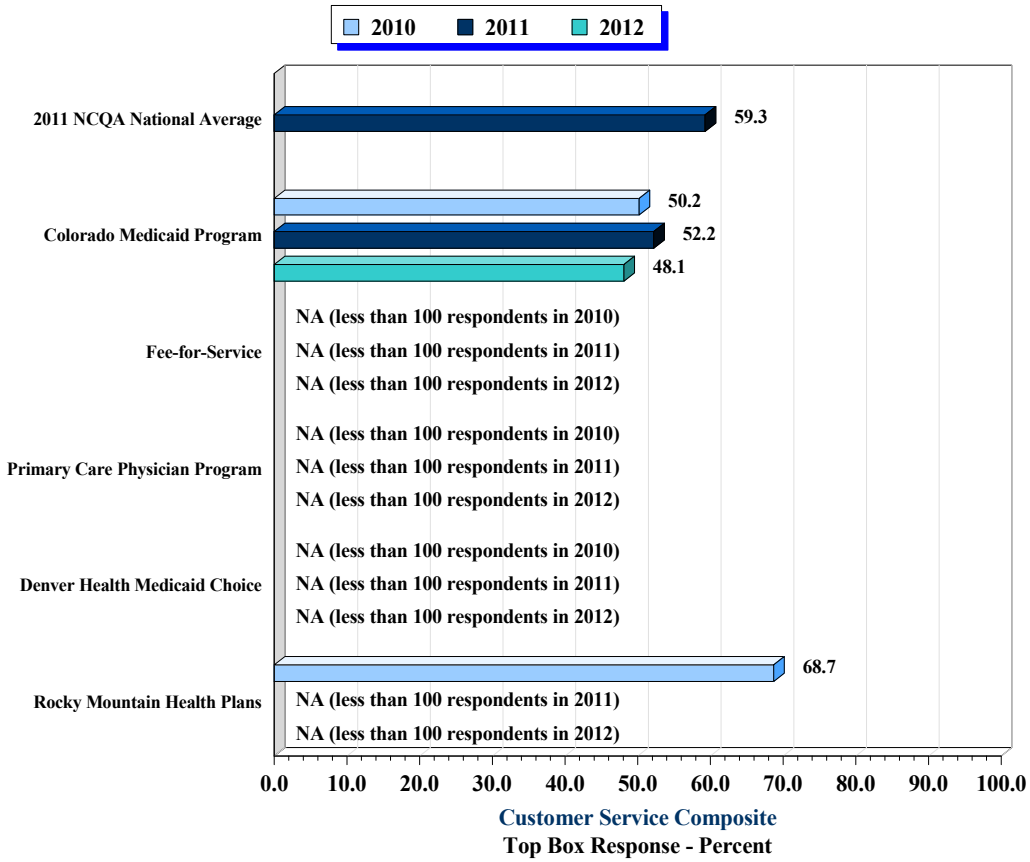


Statistical Significance Note:
▲ indicates the 2012 score is significantly higher than the 2011 score
▼ indicates the 2012 score is significantly lower than the 2011 score
▲ indicates the 2012 score is significantly higher than the 2010 score
▼ indicates the 2012 score is significantly lower than the 2010 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 2011 NCQA national average, and the 2010, 2011, and 2012 Customer Service global proportions for Colorado Medicaid, FFS, PCPP, DHMC, and RMHP.

Figure 2-13—Trend Analysis: Customer Service

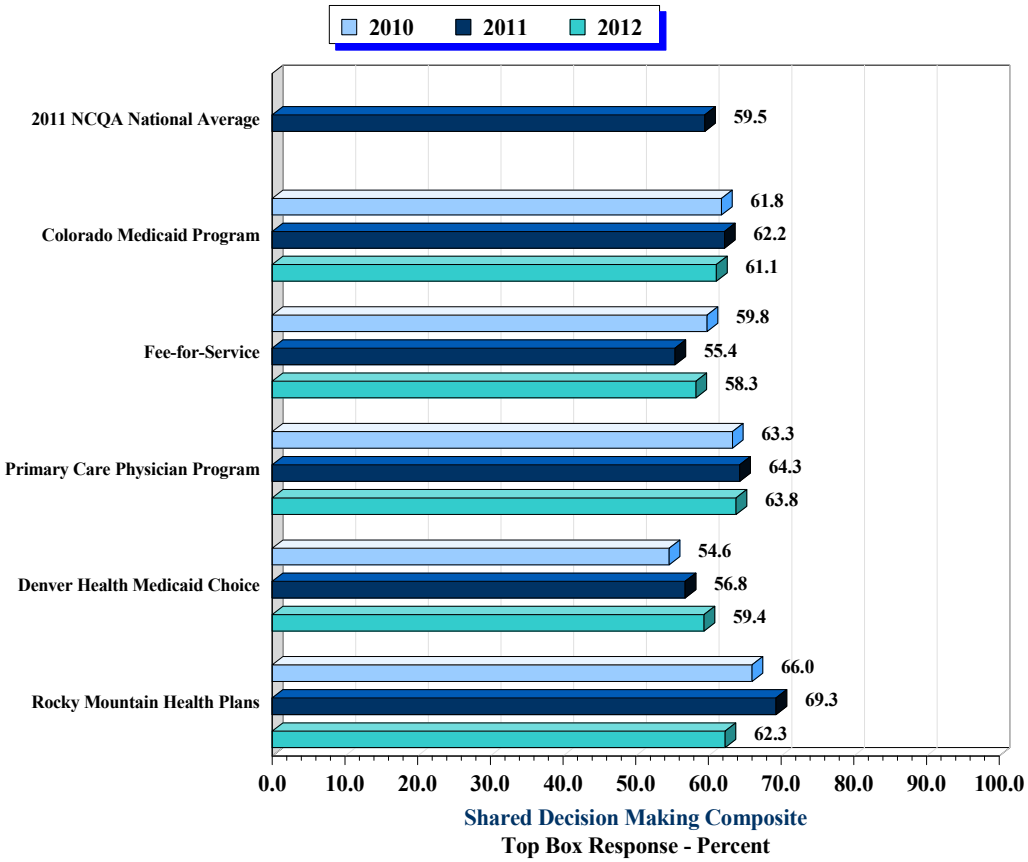


Statistical Significance Note:
▲ indicates the 2012 score is significantly higher than the 2011 score
▼ indicates the 2012 score is significantly lower than the 2011 score
▲ indicates the 2012 score is significantly higher than the 2010 score
▼ indicates the 2012 score is significantly lower than the 2010 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 2011 NCQA national average, and the 2010, 2011, and 2012 Shared Decision Making global proportions for Colorado Medicaid, FFS, PCPP, DHMC, and RMHP.

Figure 2-14—Trend Analysis: Shared Decision Making



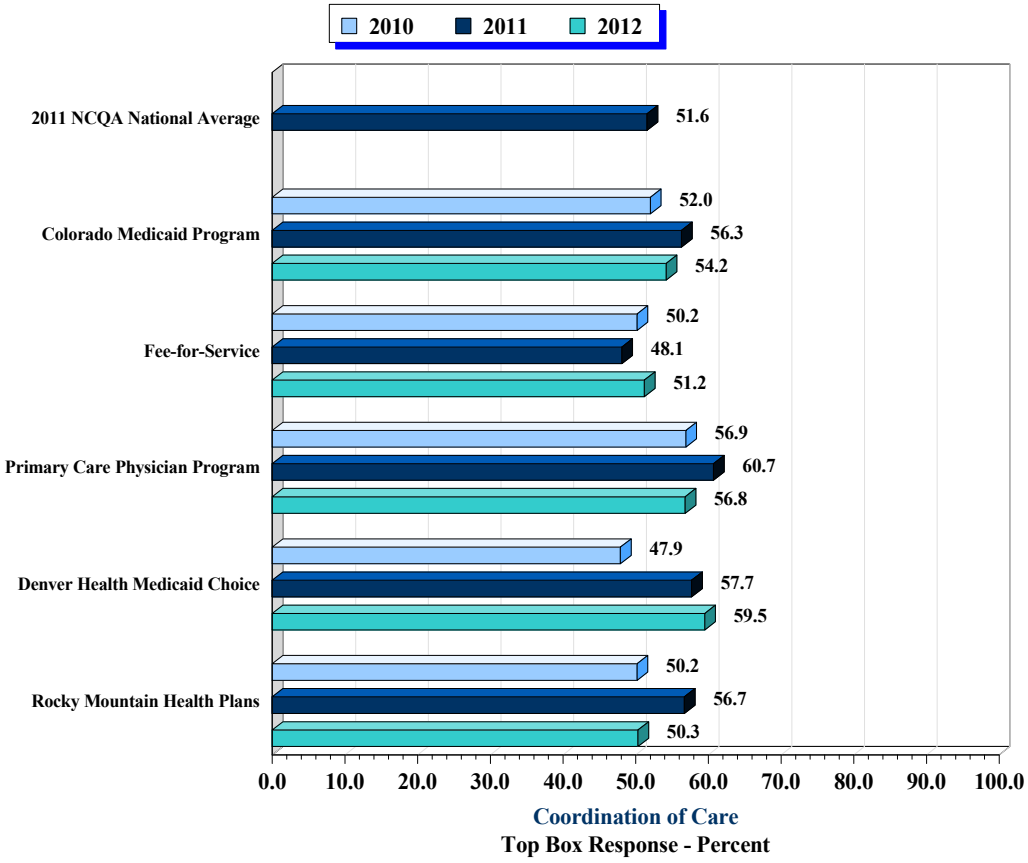
Statistical Significance Note:
▲ indicates the 2012 score is significantly higher than the 2011 score
▼ indicates the 2012 score is significantly lower than the 2011 score
▲ indicates the 2012 score is significantly higher than the 2010 score
▼ indicates the 2012 score is significantly lower than the 2010 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 2011 NCQA national average, and the 2010, 2011, and 2012 Coordination of Care question summary rates for Colorado Medicaid, FFS, PCPP, DHMC, and RMHP.

Figure 2-15—Trend Analysis: Coordination of Care

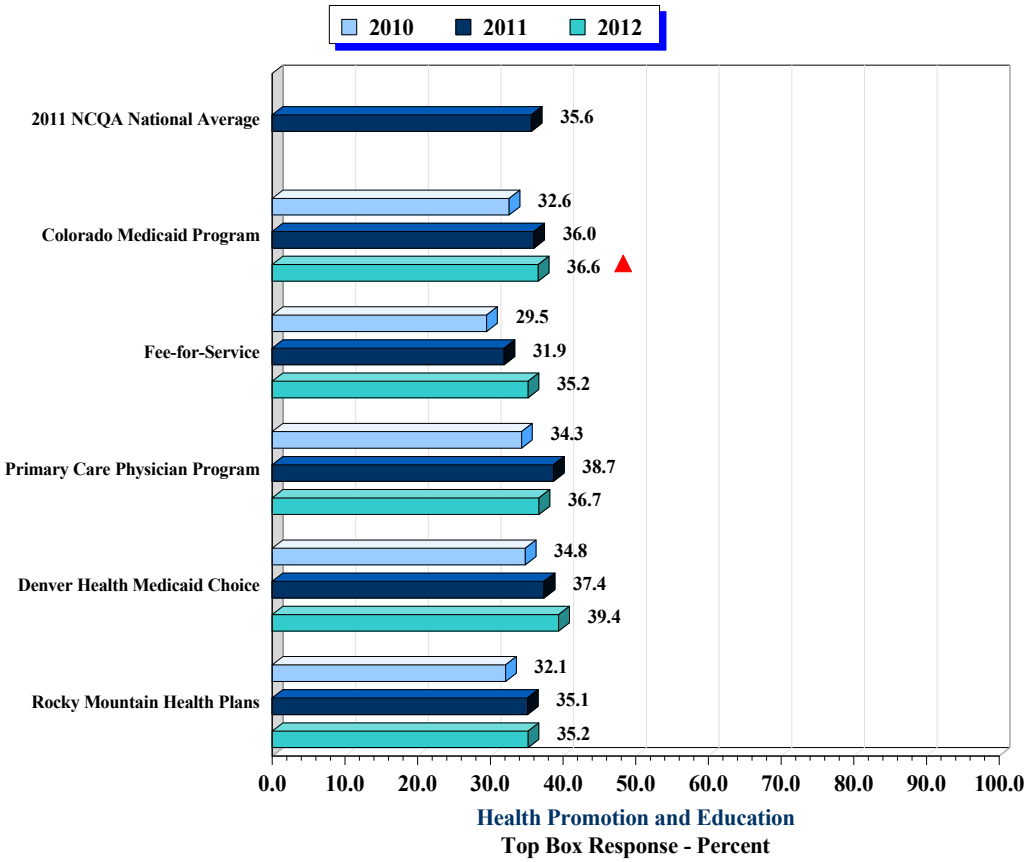


Statistical Significance Note:
▲ indicates the 2012 score is significantly higher than the 2011 score
▼ indicates the 2012 score is significantly lower than the 2011 score
▲ indicates the 2012 score is significantly higher than the 2010 score
▼ indicates the 2012 score is significantly lower than the 2010 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 2011 NCQA national average, and the 2010, 2011, and 2012 Health Promotion and Education question summary rates for Colorado Medicaid, FFS, PCPP, DHMC, and RMHP.

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



Statistical Significance Note:
▲ indicates the 2012 score is significantly higher than the 2011 score
▼ indicates the 2012 score is significantly lower than the 2011 score
▲ indicates the 2012 score is significantly higher than the 2010 score
▼ indicates the 2012 score is significantly lower than the 2010 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	DHMC	RMHP
Global Rating				
Rating of Health Plan	None	None	▲	None
Rating of All Health Care			▲	

▲ *Indicates the 2012 score is significantly higher than the 2011 score*
▼ *Indicates the 2012 score is significantly lower than the 2011 score*
▲ *Indicates the 2012 score is significantly higher than the 2010 score*
▼ *Indicates the 2012 score is significantly lower than the 2010 score*

Plan Comparisons

In order to identify performance differences in client satisfaction between the four Colorado Medicaid plans, the results for FFS, PCPP, DHMC, and RMHP were compared to the State Medicaid average using standard tests for statistical significance.[2-16] 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.[2-17] 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 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).**

[2-16] Caution should be exercised when evaluating plan comparisons, given that population and plan differences may impact CAHPS results.

[2-17] 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**	**DHMC**	**RMHP**
Global Rating				
Rating of Health Plan	49.4% ↓	57.3% ↔	58.2% ↔	64.5% ↑
Rating of All Health Care	47.1% ↔	51.2% ↔	49.5% ↔	49.9% ↔
Rating of Personal Doctor	62.2% ↔	66.9% ↔	66.8% ↔	64.5% ↔
Rating of Specialist Seen Most Often	64.8% ↔	63.2% ↔	56.4% ↔	64.9% ↔
Composite Measure				
Getting Needed Care	49.5% ↔	53.2% ↔	38.2% ↓	61.1% ↑
Getting Care Quickly	53.1% ↔	58.4% ↔	41.6% ↓	61.5% ↑
How Well Doctors Communicate	66.7% ↔	67.2% ↔	69.8% ↔	67.2% ↔
Customer Service	NA	NA	NA	NA
Shared Decision Making	58.0% ↔	64.6% ↔	59.5% ↔	61.7% ↔
Individual Measure				
Coordination of Care	51.5% ↔	56.3% ↔	60.0% ↔	50.0% ↔
Health Promotion and Education	35.3% ↔	36.5% ↔	39.3% ↔	35.3% ↔

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).

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 did not score significantly higher or lower than the Colorado Medicaid State average on any of the CAHPS measures.
- DHMC scored significantly lower than the Colorado Medicaid State average on two CAHPS measures: Getting Needed Care and Getting Care Quickly.
- RMHP scored significantly higher than the Colorado Medicaid State average on three CAHPS measures: Rating of Health Plan, Getting Needed Care, and Getting Care Quickly.

Supplemental Items

The Department elected to add three supplemental items to the standard CAHPS 4.0H Adult Medicaid Health Plan Survey for Colorado Medicaid FFS and PCPP. All three questions focused on their health plan's Internet site. DHMC and RMHP used their own survey vendors to administer the CAHPS 4.0H Adult Medicaid Survey and did not to include these supplemental items in their surveys.

Table 2-8 details the survey language and response options for each of the supplemental items. Table 2-9 through Table 2-11 show the results for each supplemental item. As previously noted, DHMC and RMHP did not include these items in their CAHPS Survey; therefore, supplemental item results are not available and are denoted in the tables with a hyphen (□). For Colorado Medicaid FFS and PCPP, the number and percentage of responses for each item are presented.

Health Plan's Internet Site

Table 2-8
Supplemental Items

Question		Response Options
Q29a.	When you looked for information in the last 6 months, did you go to your health plan's Internet site?	Yes No
Q29b.	How useful was the information you found on your health plan's Internet site?	Not at all useful Not very useful Somewhat useful Very useful Extremely useful
Q29c.	In the last 6 months, did you use information on your health plan's Internet site to choose a doctor, specialist, or group of health providers for your child?	Yes No

Went to Health Plan's Internet Site

Clients were asked if they went to their health plan's Internet site when looking for information on how their health plan works (Question 29a). Table 2-9 displays the responses for this question.

Table 2-9
Went to Health Plan's Internet Site

	Yes		No	
	N	%	N	%
Colorado Medicaid FFS	38	50.7%	37	49.3%
Colorado Medicaid PCPP	32	58.2%	23	41.8%
DHMC	—	—	—	—
RMHP	—	—	—	—

Usefulness of Information Found on Health Plan's Internet Site

Clients were asked to assess the usefulness of the information found on their health plan's Internet site (Question 29b). Table 2-10 displays the responses for this question.

Table 2-10
Usefulness of Information Found on Health Plan's Internet Site

	Not at all useful		Not very useful		Somewhat useful		Very useful		Extremely useful	
	N	%	N	%	N	%	N	%	N	%
Colorado Medicaid FFS	4	10.5%	3	7.9%	15	39.5%	12	31.6%	4	10.5%
Colorado Medicaid PCPP	2	6.3%	5	15.6%	11	34.4%	13	40.6%	1	3.1%
DHMC	—	—	—	—	—	—	—	—	—	—
RMHP	—	—	—	—	—	—	—	—	—	—

Used Information on Health Plan's Internet Site to Choose a Provider

Clients were asked if they used information found on their health plan's Internet site to choose a doctor, specialist, or group of health providers (Question 29c). Table 2-11 displays the responses for this question.

Table 2-11
Used Information on Health Plan's Internet Site to Choose a Provider

	Yes		No	
	N	%	N	%
Colorado Medicaid FFS	11	29.7%	26	70.3%
Colorado Medicaid PCPP	9	28.1%	23	71.9%
DHMC	—	—	—	—
RMHP	—	—	—	—

3. Recommendations

General Recommendations

HSAG recommends the continued administration of the CAHPS 4.0H Adult Medicaid Health Plan Survey in fiscal year (FY) 2012-2013. 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 2010-2011 survey administration is comparable to the completed surveys in Spanish for the FY 2011-2012 survey administration due to the identification of these clients prior to the start of the survey.

In FY 2011-2012, response rates for RMHP were lower than in previous years. In FY 2011-2012, response rates for RMHP decreased 5.61 percent from FY 2010-2011, and 9.16 percent from FY 2009-2010. Additionally, in FY 2011-2012, RMHP did not reach the NCQA target of 411 survey respondents. A review of the percentage of oversampling performed by RMHP for their adult population revealed that oversampling was decreased from 15 percent in FY 2009-2010 and FY 2010-2011 to 5 percent in FY 2011-2012. This decrease in the percentage of oversampling for RMHP's adult population could have contributed to the decrease in response rates observed for FY 2011-2012. HSAG recommends that RMHP increase their percentage of oversampling in FY 2012-2013 to achieve a higher number of respondents comparable to previous years.

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 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.[3-1]

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.[3-2] A comprehensive list of these resources is included in the Reader's Guide Section, beginning on page 4-10.

[3-1] NCQA does not provide benchmarks for the Coordination of Care and Health Promotion and Education individual measures; therefore, priority assignments cannot be derived.

[3-2] Agency for Healthcare Research and Quality. *The CAHPS Improvement Guide*. Available at: http://www.cahps.ahrq.gov/qiguide/default.aspx. Accessed on: June 1, 2012.

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

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

Please note: Trend analysis results reflect those between either the 2012 and 2011 results or the 2012 and 2010 results.[3-3]
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 or composite measures that do not meet the minimum number of responses are denoted as Not Applicable (NA).

[3-3] 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	★★★	—	Moderate
DHMC	★★★	▲	Moderate
RMHP	★★★★	—	Moderate

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).

In order to improve the overall Rating of Health Plan, QI activities should target health plan operations, online patient portals, and promoting QI initiatives.

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 members) that provide the health plan's health care "products." Health care microsystems include: a team of health 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, functional service systems that enable health plan staff to provide high-quality, patient-centered care. The first step to this approach is to define a measurable 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.

Online Patient Portal

A secure online patient portal allows members easy access to a wide array of health plan and health care information and services that are particular to their needs and interests. To help increase members' satisfaction with their health plan, health plans should consider establishing an online patient portal or integrating online tools and services into their current Web-based systems that focus on patient-centered care. Online health information and services that can be made available to members include: health plan benefits and coverage forms, online medical records, electronic communication with providers, and educational health information and resources on various medical conditions. Access to online interactive tools, such as health discussion boards allow

questions to be answered by trained clinicians. Online health risk assessments can provide members instant feedback and education on the medical condition(s) specific to their health care needs. In addition, an online patient portal can be an effective means of promoting health awareness and education. Health plans should periodically review health information content for accuracy and request member and/or physician feedback to ensure relevancy of online services and tools provided.

Promote Quality Improvement Initiatives

Implementation of organization-wide QI initiatives are most successful when health plan staff at every level are involved; therefore, creating an environment that promotes QI in all aspects of care can encourage organization-wide participation in QI efforts. Methods for achieving this can include aligning QI goals to the mission and goals of the health plan organization, establishing plan-level performance measures, clearly defining and communicating collected measures to providers and staff, and offering provider-level support and assistance in implementing QI initiatives. Furthermore, by monitoring and reporting the progress of QI efforts internally, health plans can assess whether QI initiatives have been effective in improving the quality of care delivered to members.

Specific QI initiatives aimed at improving patient care and service and engaging employees can include quarterly employee forums, an annual all-staff assembly, topic-specific improvement team, leadership development courses, and employee awards. As an example, improvement teams can be implemented to focus on specific topics such as service quality, rewards and recognition, and patient, physician, and employee satisfaction and how the organization can improve in these areas. Evidence has shown that QI initiatives that engage employees in improvement efforts can lead to improved patient satisfaction, as well consumer's perception of the quality of care and services provided.

Rating of All Health Care

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

Table 3-3
Priority Assignments
Rating of All Health Care

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

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).

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

Access to Care

Health plans should identify potential barriers for patients receiving appropriate access to care. Access to care issues include obtaining the care that the patient and/or physician deemed necessary, obtaining timely urgent care, locating a personal doctor, or receiving adequate assistance when calling a physician office. The health plan should attempt to reduce any hindrances a patient might encounter while seeking care.

Health Care Experiences

To improve patients' health care experience, health plans should identify and eliminate patient challenges when receiving health care. This includes ensuring that patients receive adequate time with a physician so that questions and concerns may be appropriately addressed and providing patients with ample information that is understandable. Furthermore, ensuring that patients receive quality care in a timely manner can help improve patients' perceptions of their health care.

Patient and Family Advisory Councils

Since both patients and families have the direct experience with an illness or the health care system, their perspectives can provide significant insight when performing an evaluation of health care processes. Therefore, health plans should consider creating patient and family advisory councils, composed of the patients and families who represent the population(s) they serve. These councils can be an effective strategy for involving members in the design of care and obtaining their input and feedback on how to improve the delivery of care. Further, these councils can provide a structure and process for ongoing dialogue and creative problem-solving between the health plan and its members. The councils' roles within a health plan organization can vary and responsibilities may

include input into or involvement in: program development, implementation, and evaluation; marketing of health care services; and design of new materials or tools that support the provider-patient relationship.

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	★★	—	High
PCPP	★★★★★	—	Low
DHMC	★★★★★	—	Low
RMHP	★★★	—	Moderate

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).

In order to improve the Rating of Personal Doctor, QI activities should target physician-patient communication, appointment scheduling, and patient-direct feedback.

Physician-Patient Communication

Health plans should encourage physician-patient communication to improve patient satisfaction and outcomes. Indicators of good physician-patient communication include providing clear explanations, listening carefully, and being understanding of patients' perspectives. Health plans can also create specialized workshops focused on enhancing physicians' communication skills, relationship building, and the importance of physician-patient communication. Training sessions can include topics such as improving listening techniques, patient-centered interviewing skills, and effectively communicating expectations and goals of health care treatment. In addition, workshops can include training on the use of tools that improve physician-patient communication. Examples of effective tools include visual medication schedules and the "Teach Back" method, which has patients communicate back the information the physician has provided.

Maintain Truth in Scheduling

Health plans can request that all providers monitor appointment scheduling to ensure that scheduling templates accurately reflect the amount of time it takes to provide patient care during a scheduled office visit. Health plans could provide assistance or instructions to those physicians unfamiliar with this type of assessment. Patient dissatisfaction can often be the result of prolonged wait times and delays in receiving care at the scheduled appointment time. One method for evaluating appropriate scheduling of various appointment types is to measure the amount of time it takes to complete the scheduled visit. This will allow providers to identify if adequate time is being scheduled for each appointment type and if appropriate changes can be made to scheduling templates to ensure patients are receiving prompt, adequate care. Patient wait times for routine

appointments should also be recorded and monitored to ensure that scheduling can be optimized to minimize these wait times.

Patient-Direct Feedback

Health plans can explore additional methods for obtaining patient-direct feedback to improve patient satisfaction, such as comment cards. Comment cards have been utilized and found to be a simple method for engaging patients and obtaining rapid feedback on their recent physician office visit experiences. Health plans can assist in this process by developing comment cards that physician office staff can provide to patients following their visit. Comment cards can be provided to patients with their office visit discharge paperwork or via postal mail or e-mail. Asking patients to describe what they liked most about the care they received during their recent office visit, what they liked least, and one thing they would like to see changed can be an effective means for gathering feedback (both positive and negative). This direct feedback can be helpful in gaining a better understanding of the specific areas that are working well and areas which can be targeted for improvement.

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
DHMC	★	—	Top
RMHP	★★★★	—	Moderate

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).

In order to improve the overall performance on the Rating of Specialist Seen Most Often global rating, QI activities should target telemedicine, skills training, planned visit management, and the referral process.

Telemedicine

Health plans may want to explore the option of telemedicine with their provider networks to address issues with provider access in certain geographic areas. Telemedicine models allow for the use of electronic communication and information technologies to provide specialty services to patients in varying locations. Telemedicine, such as live, interactive videoconferencing, 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.

Skills Training for Specialists

Health plans can create specialized workshops or seminars that focus on training specialists in the skills they need to effectively communicate with patients to improve physician-patient communication. Training seminars can include sessions for improving communication skills with different cultures and handling challenging patient encounters. In addition, workshops can use case studies to illustrate the importance of communicating with patients and offer insight into specialists' roles as both managers of care and educators of patients.

Planned Visit Management

Health plans should work with providers to encourage the implementation of systems that enhance the efficiency and effectiveness of specialist care. For example, by identifying patients with chronic conditions that have routine appointments, a system could be implemented to ensure that these patients have necessary tests completed before an appointment. Furthermore, follow-up with patients should be carried out to ensure that they understand all information provided to them during their visit.

Referral Process

Streamlining the referral process, allows health plan members to more readily obtain the care they need. A referral expert can assist with this process and expedite the time from physician referral to the patient receiving needed care. A referral expert can be either a person and/or electronic system that is responsible for tracking and managing each health plan's referral requirements. An electronic referral system, such as a Web-based system, can improve the communication mechanisms between primary care physicians (PCPs) and specialists to determine which clinical conditions require a referral. This may be determined by referral frequency. An electronic referral process also allows providers to have access to a standardized referral form to ensure that all necessary information is collected from the parties involved (e.g., plans, patients, and providers) in a timely manner.

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
DHMC	★	—	Top
RMHP	★★★★★	—	Low

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).

In order to improve clients' satisfaction under the Getting Needed Care measure, QI activities should target provider directories, appropriate health care providers, and 24-hour nurse lines.

Enhanced 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 information is available. The utility of the provider directory can be enhanced by highlighting/emphasizing 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 on 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 appropriate health care providers is imperative to assessing quality of care.

24-Hour Bilingual Nurse Line

Health plans should consider implementing a 24-hour bilingual nurse line to provide medical advice to Spanish-speaking patients. Offering this service will dissolve any racial disparities resulting from an English language barrier. Having a bilingual nurse advice line will ensure that the needs of its

Spanish-speaking patients are being met. Spanish-speaking patients who are able to directly communicate with nurses will be more inclined to be proactive about their health, gain clarity about treatment options, and make more informed decisions resulting in less frequent visits to the emergency department (ED) and a significant reduction in costs. In addition, phone calls from the advice line should be made to follow up on patients' visits to the hospital or ED, overseeing that appropriate referrals have been made and any issues resolved. Overall patient satisfaction amongst non-English speaking populations can improve when provided with nurse advice help lines that provide them with quality health care that is accessible and accommodating.

Additionally, nurse advice help lines can be beneficial in directing members to the most appropriate level of care for their health problem. Members unsure if their health problem requires immediate care or a physician visit, can be directed to the help line, where nurses can assess their situation and provide advice for receiving care and/or offer steps they can take to manage symptoms of minor conditions. Additionally, a 24-hour help line can improve members' perceptions of getting needed care quickly by providing quick, easy access to the resources and expertise of clinical staff.

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	★★	—	High
PCPP	★★★★	—	Moderate
DHMC	★	—	Top
RMHP	★★★★★	—	Low

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).

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

Open Access Scheduling

Health plans should encourage providers to explore open access scheduling. An open access scheduling model can be used to match the demand for appointments with physician supply. This type of scheduling model allows for appointment flexibility and for patients to receive same-day appointments. Instead of booking appointments weeks or months in advance, an open access scheduling model includes 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 Analysis

Health plans should request that all providers monitor patient flow. The health plans could provide instructions and/or assistance to those providers that are unfamiliar with this type of evaluation. Dissatisfaction with timely care is often a result of bottlenecks and redundancies in the administrative and clinical patient flow processes (e.g., diagnostic tests, test results, treatments, hospital admission, and specialty services). To address these problems, it is necessary to identify these issues and determine the optimal resolution. One method that can be used to identify these problems is to conduct a patient flow analysis. A patient flow analysis involves tracking a patient's experience throughout a visit or clinical service (i.e., the time it takes to complete various parts of the visit/service). Examples of steps that are tracked include wait time at check-in, time to complete check-in, wait time in waiting room, wait time in exam room, and time with provider. This type of analysis can help providers identify "problem" areas, including steps that can be eliminated or steps that can be performed more efficiently.

A patient flow analysis should include measuring the amount of time it takes to complete a scheduled visit for various appointment types. By creating a schedule template that accurately reflects patient flow, providers can reduce patient dissatisfaction with prolonged wait times and office staff time spent explaining appointment delays.

Electronic Communication

Health plans should encourage the use of electronic communication where appropriate. Electronic forms of communication between patients and providers can help alleviate the demand for in-person visits and provide prompt care to patients that may not require an appointment with a physician. Electronic communication can also be used when scheduling appointments, requesting referrals, providing prescription refills, answering patient questions, educating patients on health topics, and disseminating lab results. An online patient portal can aid in the use of electronic communication and provide a safe, secure location where patients and providers can communicate. It should be noted that Health Insurance Portability and Accountability Act (HIPAA) regulations must be carefully reviewed when implementing this form of communication.

Internet Access for Health Information and Advice

Health plans should create Web sites that can assist consumers seeking information about symptoms, drugs, conditions and diseases, fitness, and nutrition. The Internet is a useful research tool for consumers to access an abundance of information quickly and easily. According to a 2007 poll by Harris Interactive, 160 million Americans were using the Internet to find health information, which showed a 37 percent increase since 2005. Harris Interactive estimates that 84 percent of all online adults have researched health information online. The implementation of Web sites for health plans can result in improved quality of care, timeliness, and efficiency for consumers.

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	★★★	—	Moderate
DHMC	★★★★	—	Moderate
RMHP	★★★★	—	Moderate

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).

In order to improve clients' satisfaction under the How Well Doctors Communicate measure, QI activities should focus on communication tools, improving health literacy, and language barriers.

Communication Tools for Patients

Health plans can encourage patients to take a more active role in the management of their health care by providing them with the tools necessary to effectively communicate with their physicians. This can include items such as "visit preparation" handouts, sample symptom logs, and health care goals and action planning forms that facilitate physician-patient communication. Furthermore, educational literature and information on medical conditions specific to their needs can encourage patients to communicate with their physicians any questions, concerns, or expectations they may have regarding their health care and/or treatment options.

Improve Health Literacy

Often health information is presented to patients in a manner that is too complex and technical, which can result in patient inadherence and poor health outcomes. To address this issue, health plans should consider revising existing and creating new print materials that are easy-to-understand based on patients' needs and preferences. Materials such as patient consent forms and disease education materials on various conditions can be revised and developed in new formats to aid patients' understanding of the health information that is being presented to them. Further, providing training for health care workers on how to use these materials with their patients and ask questions to gauge patient understanding can help improve patients' level of satisfaction with provider communication.

Additionally, health literacy coaching can be implemented to ease the inclusion of health literacy into physician practice. Health plans can offer a full day workshop where physicians have the opportunity to participate in simulation training resembling the clinical setting. Workshops also provide an opportunity for health plans to introduce physicians to the *AHRQ Health Literacy*

Universal Precautions Toolkit which can serve as a reference for devising health literacy plans. Ultimately, by redefining health literacy as not only an individual's ability to understand basic health information, but also the responsibilities of the health system to inform patients of appropriate services, the quality of patient care can be greatly improved.

Language Barriers

Health plans can consider hiring an interpreter as a full time staff member to ensure accurate communication amongst patients and physicians with an English language barrier. Offering an interpretation service promotes the development of relationships between the patient and family members with their physician. With an interpreter present to translate, the physician will have a more clear understanding of how to best address the appropriate health issues and the patient will feel more at ease. Having an interpreter on site is also more time efficient for both the patient and physician, allowing the physician to stay on schedule. Health plans that make the effort to accommodate those patients who do not speak English helps them to feel valued and comfortable, thus increasing overall patient satisfaction.

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
DHMC	NA	NA	Moderate
RMHP	NA	NA	Moderate

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).

In order to improve clients' satisfaction under the Customer Service measure, QI activities should focus on service recovery, performance measures, employee training and empowerment, a customer service training program, and evaluating call centers.

Service Recovery

A health plan can implement a service recovery program to ensure members are provided appropriate assistance for their problems. Service recovery can include listening to a patient who is upset, handing out incentives to patients who have had to wait longer than a specified time for a doctor visit, and assessing events to identify the source of the problem. Some issues arise from experiences with a specific staff person in the service process, which can reflect a training problem, while others may be the result of system problems that require an entirely different process to resolve. Service recovery programs that include implementing a process for tracking problems and complaints can help ensure correct improvement processes are put into place.

Customer Service Performance Measures

Setting plan-level customer service standards can assist in addressing areas of concern and serve as domains for which health plans can evaluate and modify internal customer service performance measures, such as call center representatives' call abandonment rates (i.e., average rate of disconnects), the amount of time it takes to resolve a member's inquiry about prior authorizations, and the number of member complaints. Collected measures should be communicated with providers and staff members. Additionally, by tracking and reporting progress internally and modifying measures as needed, customer service performance is more likely to improve.

Employee Training and Empowerment

Employees who have the necessary skills and tools to appropriately communicate with members and answer their questions and/or complete their requests are more likely to provide exceptional customer service. Therefore, it is important for health plans and providers to ensure that staff have

adequate training on all pertinent business processes. Furthermore, staff members should feel empowered to resolve most issues a member might have. This will eliminate transferring members to multiple employees and will help to resolve a complaint in a more timely manner.

Creating an Effective Customer Service Training Program

Health plan efforts to improve customer service should include implementing a training program to meet the needs of their unique work environment. Direct patient feedback should be disclosed to employees to emphasize why certain changes need to be made. Additional recommendations from employees, managers, and business administrators should be provided to serve as guidance when constructing the training program. It is important that employees receive direction and feel comfortable putting new skills to use before applying them within the work place.

The customer service training should be geared towards teaching the fundamentals of effective communication. By reiterating basic communication techniques, employees will have the skills to communicate in a professional and friendly manner. How to appropriately deal with difficult patient interactions is another crucial concern to address. Employees should feel competent in resolving conflicts and service recovery.

The key to ensuring that employees carry out the skills they learned in training is to not only provide motivation, but implement a support structure when they are back on the job so that they are held responsible to apply it. It is advised that all employees sign a commitment statement to affirm the course of action agreed upon. Health plans should ensure leadership is involved in the training process to help establish camaraderie between managers and employees and to help employees realize the impact of their role in making change.

Call Centers

An evaluation of current health plan call center hours and practices can be conducted to determine if the hours and resources meet members' needs. If it is determined that the call center is not meeting members' needs, an after-hours customer service center can be implemented to assist members after normal business hours and/or on weekends. Additionally, asking members to complete a short survey at the end of each call can assist in determining if members are getting the help they need and identify potential areas for customer service improvement.

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	★★	—	High
PCPP	★★★★	—	Moderate
DHMC	★★	—	High
RMHP	★★★★	—	Moderate

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).

In order to improve client satisfaction scores under the Shared Decision Making measure, QI activities should focus on skills training for physicians, shared decision making materials, patient education, and language concordance programs.

Skills Training for Physicians

Health plans should encourage skills training for all physicians. Implementing a shared decision making model requires physician recognition that patients have the ability to make choices that affect their health care. Therefore, one 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 each patient's values into consideration; understanding patients' preferences and needs; and improving communication skills. Effective and efficient training methods include seminars and workshops.

Shared Decision Making Materials

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 the physicians with literature that conveys the importance of the shared decision making model. In addition, materials such as health care goal-setting handouts and forms can assist physicians in facilitating the shared decision making process with their patients. Health plans can also provide members with pre-structured question lists to assist them in asking all the necessary questions so the appointment is as efficient and effective as possible.

Patient Education

Patients who are educated about their medical condition(s) are more likely to play an active role in the management of their own health. Health plans can provide members with educational literature and information. Items such as brochures on a specific medical condition and a copy of the assessment and plan portions of the physician's progress notes together with a glossary of terms can

empower patients with the information they need to ask informed questions and express personal values and opinions about their condition and treatment options. Access to this information can also improve members' understanding of their medical condition(s) and treatment plan, as well as facilitate discussion about their health care.

Language Concordance Programs

Health plans should make an effort to match patients with physicians who speak their preferred language. Offering incentives for physicians to become fluent in another language, in addition to recruiting bilingual physicians, is important because typically such physicians are not readily available. Matching patients to physicians who speak their language can significantly improve the health care experience and quality of care for patients. Patients who can communicate with their physician are more informed about their health issues and are able to make deliberate choices about an appropriate course of action. By increasing the availability of language-concordant physicians, patients with limited English proficiency can schedule more frequent visits with their physicians and are better able to manage health conditions.

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 3-11 provides a summary of the responsible parties for various aspects of care.[3-4]

Table 3-11—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, DHMC, 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.

[3-4] Edgman-Levitan S, Shaller D, McInnes K, et al. *The CAHPS® Improvement Guide: Practical Strategies for Improving the Patient Care Experience.* Department of Health Care Policy Harvard Medical School, October 2003.

4. Reader's Guide

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 and the Child Medicaid Health Plan Survey in 2009, which are referred to as the CAHPS 4.0H Health Plan Surveys.[4-3,4-4]

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. Administration of the surveys was completed with strict adherence to required specifications.

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

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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.

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, DHMC, 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 2011. The clients eligible for sampling included those who were age 18 or older (as of December 31, 2011).

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 FFS and PCPP, a 30 percent oversample was performed on the adult population. For DHMC, a 50 percent oversample was performed on the adult population. For RMHP, a 5 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 2,025 and 1,418 adult clients was selected for DHMC and RMHP, respectively.[4-5]

[4-5] The sampling for DHMC 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 member.	0 days
Send a second questionnaire (and cover letter) to non-respondents approximately 35 days after mailing the first questionnaire.	35 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 DHMC 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 DHMC 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 second survey mailing was sent to all non-respondents. The second phase, or telephone phase, consisted of CATI of sampled clients who had not mailed in a completed survey. DHMC provided English and Spanish versions of the mail survey and allowed clients the option to complete a CATI survey in English or Spanish. A series of at least three 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 of non-response bias by increasing the number of respondents who are more demographically representative of a plan's population.[4-9]

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® 2012, Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA Publication, 2011.

4-8 National Committee for Quality Assurance. *Quality Assurance Plan for HEDIS 2012 Survey Measures.* Washington, DC: NCQA Publication, 2011.

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.

HEDIS specifications require that plans provide a list of all eligible clients for the sampling frame. Following HEDIS requirements, sampled clients included those who met the following criteria:

- Were age 18 or older as of December 31, 2011.
- Were currently enrolled in FFS, PCPP, DHMC, or RMHP.
- Had been continuously enrolled for at least five of the last six months of 2011.
- 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). Prior to initiating CATI, HSAG employed the Telematch telephone number verification service to locate and/or update telephone numbers for all non-respondents. 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 and cover letters; that the cover letters 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.[4-10]

[4-10] Please note, HSAG performed the CAHPS survey administration for Colorado Medicaid FFS and PCPP only. The survey administration for DHMC and RMHP was performed by Morpace and CSS, respectively.

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.[4-11] 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.

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

Respondent Demographics

The demographic analysis evaluated self-reported demographic information from survey respondents. Given that the demographics of a response group 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.

[4-11] National Committee for Quality Assurance. *HEDIS® 2012, Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA Publication, 2011.

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 2011 National Adult Medicaid data. For detailed information on the derivation of three-point mean scores, please refer to *NCQA HEDIS 2012 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

Table 4-3 shows the benchmarks and thresholds used to derive the overall client satisfaction ratings on each CAHPS measure.[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	2.35	2.29	2.23
Rating of Personal Doctor	2.56	2.51	2.45	2.40
Rating of Specialist Seen Most Often	2.56	2.50	2.46	2.41
Getting Needed Care	2.42	2.35	2.28	2.18
Getting Care Quickly	2.47	2.43	2.39	2.32
How Well Doctors Communicate	2.64	2.58	2.54	2.48
Customer Service	2.53	2.47	2.40	2.32
Shared Decision Making	2.57	2.53	2.50	2.44

[4-12] National Committee for Quality Assurance. *HEDIS Benchmarks and Thresholds for Accreditation 2012*. Washington, DC: NCQA, January 25, 2012.

[4-13] The star assignments for the Shared Decision Making composite are determined by comparing the plans' three-point mean scores to NCQA's National Distribution of 2011 Adult Medicaid Plan-Level Results. Prepared by NCQA for HSAG on December 16, 2011.

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 2012 CAHPS results to the 2011 CAHPS results. If statistically significant differences were found, no additional analysis was performed. If no statistically significant differences were found between the 2012 and 2011 results, a second analysis was performed which compared 2012 to 2010 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 2012 Specifications for Survey Measures, Volume 3*.

The 2012 Colorado Medicaid and plan-level CAHPS scores were compared to the corresponding 2011 scores to determine whether there were statistically significant differences. If there were no statistically significant differences from 2012 to 2011, then 2012 scores were compared to 2010 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 2012 than in 2011 are noted with black upward (▲) triangles. Scores that were statistically lower in 2012 than in 2011 are noted with black downward (▼) triangles. Scores that were statistically higher in 2012 than in 2010 are noted with red upward (▲) triangles. Scores that were statistically lower in 2012 than in 2010 are noted with red downward (▼) triangles. Scores in 2012 that were not statistically different from scores in 2011 or in 2010 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® 2012, Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA Publication, 2011.

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:

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

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:

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

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 2012 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 (i.e., 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.

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[4-15] Agency for Healthcare Research and Quality. *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: June 1, 2012.

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5. Survey Instrument

The survey instrument selected for the 2012 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.

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 [HEALTH PLAN NAME]
Is that right?

[1]☐ Yes ➔**If Yes, Go to Question 3**
[2]☐ No

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

_____

YOUR HEALTH CARE IN THE LAST 6 MONTHS

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

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

[1]☐ Yes
[2]☐ No ➔**If No, Go to Question 5**

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

Never ☐ Sometimes ☐ Usually ☐ Always ☐

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

[1]☐ Yes
[2]☐ No ➔**If No, Go to Question 7**

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

Never ☐ Sometimes ☐ Usually ☐ 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?

Never ☐ Sometimes ☐ Usually ☐ 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?

0 1 2 3 4 5 6 7 8 9 10

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Worst health care possible — 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?

Never ☐ Sometimes ☐ Usually ☐ Always ☐

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

Never ☐ Sometimes ☐ Usually ☐ Always ☐

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

Never ☐ Sometimes ☐ Usually ☐ Always ☐

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

Never ☐ Sometimes ☐ Usually ☐ 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?

Never ☐ Sometimes ☐ Usually ☐ 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?

0 1 2 3 4 5 6 7 8 9 10

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Worst personal doctor possible — 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?

Never ☐ Sometimes ☐ Usually ☐ 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?

0 1 2 3 4 5 6 7 8 9 10

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Worst specialist possible — 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?

Never ☐ Sometimes ☐ Usually ☐ 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?

Never ☐ Sometimes ☐ Usually ☐ Always ☐

29a. When you looked for information in the last 6 months, did you go to your health plan's Internet site?

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

29b. How useful was the information you found on your plan's Internet site?

[1] ☐ Not at all useful
[2] ☐ Not very useful
[3] ☐ Somewhat useful
[4] ☐ Very useful
[5] ☐ Extremely useful

29c. In the last 6 months, did you use information on your health plan's Internet site to choose a doctor, specialist, or group of health providers?

[1] ☐ Yes
[2] ☐ No

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?

Never ☐ Sometimes ☐ Usually ☐ Always ☐

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

Never ☐ Sometimes ☐ Usually ☐ 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?

Never ☐ Sometimes ☐ Usually ☐ 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?

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

Worst health plan possible — 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?

Never ☐ Sometimes ☐ Usually ☐ 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.

Never ☐ Sometimes ☐ Usually ☐ 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.

Never ☐ Sometimes ☐ Usually ☐ 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 <u>not</u> 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 <u>not</u> 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, DHMC, 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)
- DHMC 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.