FY 12-13
Adult Medicaid Client Satisfaction Report

August 2013

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

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1. Executive Summary

The State of Colorado requires annual administration of client satisfaction surveys to Medicaid clients enrolled in fee-for-service (FFS) and the Primary Care Physician Program (PCPP). 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] 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 5.0 Adult Medicaid Health Plan Survey with the Healthcare Effectiveness Data and Information Set (HEDIS®) supplemental item set.[1-2] Adult clients from FFS and PCPP completed the surveys from March to May 2013.

Transition from CAHPS 4.0 to 5.0 Survey

In 2012, the Agency for Healthcare Research and Quality (AHRQ) released the CAHPS 5.0 Medicaid Health Plan Surveys. Based on the CAHPS 5.0 versions, the National Committee for Quality Assurance (NCQA) introduced new HEDIS versions of the Adult Health Plan Survey in August 2012, which are referred to as the CAHPS 5.0H Adult Medicaid Health Plan Surveys.[1-3] The following is a summary of the changes resulting from the transition to the CAHPS 5.0 Adult Medicaid Health Plan Survey.[1-4]

Global Ratings

There were no changes made to the four CAHPS global ratings: Rating of Health Plan, Rating of All Health Care, Rating of Personal Doctor, and Rating of Specialist Seen Most Often. The question language, response options, and placement of the global ratings remain the same; therefore, comparisons to national data and trending were performed for all four global ratings.

[1-1] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).
[1-2] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
[1-3] National Committee for Quality Assurance. *HEDIS® 2013, Volume 3: Specifications for Survey Measures*. Washington, DC: NCQA Publication, 2012.
[1-4] National Committee for Quality Assurance. *HEDIS 2013 Survey Vendor Update Training*. October 25, 2012.

Composite Measures

Getting Needed Care

For the Getting Needed Care composite measure, changes were made to the question language and placement of questions included in the composite. One question item that addressed "getting care, tests, or treatment" was moved from the section of the survey titled "Your Health Plan" to the section titled "Your Health Care in the Last 6 Months." While comparisons to national data and trending were performed for this composite measure, the changes to the question language and reordering of questions may impact survey results; therefore, caution should be exercised when interpreting the results of the Getting Needed Care composite measure.

Getting Care Quickly

For questions included in the Getting Care Quickly composite, changes were made to the question language. However, minimal impact is expected due to these changes; therefore, comparisons to national data and trending were performed for this composite measure.

How Well Doctors Communicate

Minor changes were made to the question language for one question included in the How Well Doctors Communicate composite. Negligible impact is expected due to this change in question language; therefore, comparisons to national data and trending were performed for this composite measure.

Customer Service

There were no changes to the question language, response options, or placement of the questions included in the Customer Service composite measure; therefore, comparisons to national data and trending were performed for this composite measure.

Shared Decision Making

Changes were made to the question language, response options, and number of questions for the Shared Decision Making composite measure. All items in the composite measure were reworded to ask about "starting or stopping a prescription medicine," whereas previously the items asked about "choices for your treatment of health care." Response options for these questions were revised from "Definitely yes," "Somewhat yes," "Somewhat no," and "Definitely no" to "Not at all," "A little," "Some," and "A lot" to accommodate the new question language. Also, one question was added to the composite. Due to these changes, comparisons to national data and trending could not be performed for the Shared Decision Making composite measure for 2013.

Individual Items

Coordination of Care

No changes were made to the question language, response options, or placement of the Coordination of Care individual item measure; therefore, comparisons to national data and trending were performed for this measure.

Health Promotion and Education

For the Health Promotion and Education individual item, changes were made to the question language and response options. Response options for this item were revised from "Never," "Sometimes," "Usually," and "Always" to "Yes" and "No." As a result of the change in response options, the Health Promotion and Education individual item measure is not trendable for 2013.

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:

- NCQA Comparisons
- Trend Analysis
- Plan Comparisons
- Priority Assignments

NCQA Comparisons

Overall client satisfaction ratings for four CAHPS global ratings (Rating of Health Plan, Rating of All Health Care, Rating of Personal Doctor, and Rating of Specialist Seen Most Often) and four composite measures (Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, and Customer Service) were compared to NCQA's 2013 HEDIS Benchmarks and Thresholds for Accreditation.[1-5,1-6] This comparison resulted in ratings of one (★) to five (★★★★★) stars on these CAHPS measures, where one was the lowest possible rating and five was the highest possible rating. Table 1-1 presents the results from this comparison.

Table 1-1
NCQA Comparisons Highlights

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

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

[1-5] National Committee for Quality Assurance. *HEDIS Benchmarks and Thresholds for Accreditation 2013*. Washington, DC: NCQA, March 15, 2013.

[1-6] NCQA does not publish benchmarks and thresholds for the Shared Decision Making composite measure, and Coordination of Care and Health Promotion and Education individual item measures; therefore, overall client satisfaction ratings could not be derived for these CAHPS measures.

Trend Analysis

In order to evaluate trends in Colorado Medicaid client satisfaction, HSAG performed a stepwise trend analysis, where applicable. The first step compared the 2013 CAHPS results to the 2012 CAHPS results. If the initial 2013 and 2012 trend analysis did not yield any significant differences, then an additional trend analysis was performed between 2013 and 2011 results. The detailed results of the trend analysis are described in the Results Section beginning on page 2-12. Table 1-2 presents the statistically significant results from this analysis.

Table 1-2
Trend Analysis Highlights

	Colorado Medicaid FFS	Colorado Medicaid PCPP
Global Rating		
Rating of Health Plan	▼ (red)	▼
Rating of Personal Doctor		▼ (red)
Composite Measure		
Customer Service	▲	
Individual Measure		
Coordination of Care		▼

▲ *Indicates the 2013 score is significantly higher than the 2012 score*
▼ *Indicates the 2013 score is significantly lower than the 2012 score*
▲ (red) *Indicates the 2013 score is significantly higher than the 2011 score*
▼ (red) *Indicates the 2013 score is significantly lower than the 2011 score*

Plan Comparisons

In order to identify performance differences in client satisfaction between Colorado Medicaid FFS and PCPP, case-mix adjusted results for each were compared to one another using standard statistical tests.[1-7] 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 2-25. Table 1-3 presents the statistically significant results from this comparison.[1-8]

Table 1-3 Plan Comparisons Highlights	
Colorado Medicaid FFS	**Colorado Medicaid PCPP**
↓ Rating of Health Plan	↑ 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 Colorado Medicaid FFS and PCPP.

Table 1-4 Top and High Priorities	
Colorado Medicaid FFS	**Colorado Medicaid PCPP**
◆ Rating of Health Plan ◆ Rating of All Health Care ◆ Rating of Personal Doctor ◆ Rating of Specialist Seen Most Often ◆ Getting Care Quickly ◆ Customer Service	◆ Rating of Health Plan ◆ Rating of All Health Care ◆ Rating of Personal Doctor ◆ Rating of Specialist Seen Most Often

[1-7] CAHPS results are known to vary due to differences in respondent age, respondent education level, and member health status. Therefore, the results were case-mix adjusted for differences in these demographic variables.

[1-8] Caution should be exercised when evaluating health plan comparisons, given that population and health plan differences may impact results.

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 5.0 Adult Medicaid Health Plan Survey.[2-1] Clients eligible for sampling included those who were enrolled in FFS and PCPP 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 2012. Adult clients eligible for sampling included those who were 18 years of age or older as of December 31, 2012. For Colorado Medicaid FFS and PCPP, a 30 percent oversample of non-dual eligible clients was performed on the adult population. Additionally, for Colorado Medicaid FFS, a 30 percent targeted oversample of adult clients not enrolled in a Regional Care Collaborative Organization (RCCO) was performed. Based on these rates, a total sample of 2,160 and 1,755 adult clients was selected from Colorado Medicaid FFS and PCPP, respectively. 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 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. 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 reminder postcard was sent to all non-respondents, followed by a second survey mailing and reminder postcard. The second phase, or telephone phase, consisted of Computer Assisted Telephone Interviewing (CATI) for sampled clients who had not mailed in a completed survey. A minimum of three CATI calls was made to each non-respondent. Additional information on the survey protocol is included in the Reader's Guide Section beginning on page 4-3.

[2-1] National Committee for Quality Assurance. *HEDIS® 2013, Volume 3: Specifications for Survey Measures*. Washington, DC: NCQA Publication, 2012.

Response Rates

The Colorado CAHPS 5.0 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 1,090 adult clients returned a completed survey, including 563 FFS and 527 PCPP clients. Figure 2-1, on the following page, shows the distribution of survey dispositions and response rate for Colorado Medicaid (i.e., both Colorado FFS and PCPP combined). Figure 2-2 through Figure 2-3 show the individual distribution of survey dispositions and response rates for FFS and PCPP, respectively. The 2013 Colorado Medicaid response rate of 29.68 percent was 3.68 percentage points higher than the national adult Medicaid response rate reported by NCQA for 2012, which was 26.0 percent.[2-2]

[2-2] National Committee for Quality Assurance. *HEDIS 2013 Survey Vendor Update Training*. October 25, 2012.

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

[2-3] 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.

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

[2-4] Prior to survey administration, address and phone information is updated for clients of the CAHPS sample using the United 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.

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

Sample Frame 10,832

CAHPS Survey Sample 1,755

Updated Contact Information[2-5]

158 Addresses
257 Phone Numbers

Ineligible Records 127

37 Enrollment Issue
41 Language Barrier
49 Other

Eligible Sample 1,628

Total Respondents 527

Total Non-Respondents 1,101

923 No Response
48 Refusal
130 Unable to Contact

Mail Respondents 428

418 English
10 Spanish

Telephone Respondents 99

93 English
6 Spanish

Response Rate=32.37%

[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.

Table 2-1 depicts the sample distribution and response rates for FFS, PCPP, 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	**3,915**	**243**	**3,672**	**1,090**	**29.68%**
Colorado Medicaid FFS	2,160	116	2,044	563	27.54%
Colorado Medicaid PCPP	1,755	127	1,628	527	32.37%

Respondent Demographics

In general, the demographics of a response group influence overall client satisfaction scores. For example, older and healthier respondents tend to report higher levels of client satisfaction; therefore, caution should be exercised when comparing populations that have significantly different demographic properties.[2-6]

Table 2-2 shows CAHPS 5.0 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
Age			
18 to 24	**7.9%**	9.8%	6.0%
25 to 34	**19.0%**	20.1%	17.9%
35 to 44	**17.8%**	19.2%	16.5%
45 to 54	**17.0%**	15.9%	18.1%
55 to 64	**18.6%**	19.5%	17.7%
65 or Older	**19.7%**	15.5%	24.0%
Gender			
Male	**33.1%**	32.3%	34.0%
Female	**66.9%**	67.7%	66.0%
Race/Ethnicity			
Multi-Racial	**6.6%**	6.0%	7.2%
White	**60.9%**	64.6%	57.1%
Black	**5.9%**	5.0%	6.9%
Asian	**7.6%**	5.0%	10.3%
Other	**19.0%**	19.4%	18.5%

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

[2-6] Agency for Healthcare Research and Quality. *CAHPS Health Plan Survey and Reporting Kit 2008*. Rockville, MD: US Department of Health and Human Services, July 2008.

Table 2-3 shows CAHPS 5.0 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
Education			
8th Grade or Less	**13.2%**	12.0%	14.4%
Some High School	**13.8%**	12.6%	15.0%
High School Graduate	**34.6%**	32.9%	36.3%
Some College	**28.5%**	32.9%	23.8%
College Graduate	**10.0%**	9.6%	10.5%
General Health Status			
Excellent	**8.5%**	8.0%	9.0%
Very Good	**18.5%**	19.5%	17.4%
Good	**30.9%**	31.1%	30.7%
Fair	**29.2%**	28.6%	29.9%
Poor	**13.0%**	12.9%	13.0%

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

NCQA Comparisons

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

★★★★★	indicates a score at or above the 90th percentile
★★★★	indicates a score 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

[2-7] National Committee for Quality Assurance. *HEDIS® 2013, Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA Publication, 2012.

[2-8] National Committee for Quality Assurance. *HEDIS Benchmarks and Thresholds for Accreditation 2013*. Washington, DC: NCQA, March 15, 2013.

Table 2-4 shows the plans' three-point mean scores and overall client satisfaction ratings for the four global ratings and four composite measures.[2-9] NCQA does not provide benchmarks for the Shared Decision Making composite measure, and 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
Global Rating		
Rating of Health Plan	★ 2.182	★ 2.304
Rating of All Health Care	★★ 2.266	★★ 2.284
Rating of Personal Doctor	★★ 2.454	★★★ 2.479
Rating of Specialist Seen Most Often	★★ 2.443	★★ 2.435
Composite Measure		
Getting Needed Care	★★★ 2.336	★★★ 2.340
Getting Care Quickly	★★ 2.350	★★★ 2.401
How Well Doctors Communicate	★★★ 2.553	★★★ 2.555
Customer Service	★ 2.280	★★★ 2.453

[2-9] Due to the changes to the Getting Needed Care composite measure, caution should be exercised when interpreting the results of the NCQA comparisons and overall client satisfaction ratings for this measure. For detailed information on the changes to the composite measure, please refer to the Executive Summary Section of this report.

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	
★	Customer Service	★	Rating of Health Plan
★	Rating of Health Plan	★★	Rating of All Health Care
★★	Getting Care Quickly	★★	Rating of Specialist Seen Most Often
★★	Rating of All Health Care	★★★	Customer Service
★★	Rating of Personal Doctor	★★★	Getting Care Quickly
★★	Rating of Specialist Seen Most Often	★★★	Getting Needed Care
★★★	Getting Needed Care	★★★	How Well Doctors Communicate
★★★	How Well Doctors Communicate	★★★	Rating of Personal Doctor

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

Trend Analysis

In 2011, the Colorado Medicaid FFS and PCPP had 418 and 567 completed CAHPS Adult Medicaid Health Plan Surveys, respectively. In 2012, the Colorado Medicaid FFS and PCPP had 458 and 496 completed CAHPS Adult Medicaid Health Plan Surveys, respectively. These completed surveys were used to calculate the 2012 and 2011 CAHPS results presented in this section for trending purposes.[2-10,2-11]

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.[2-12] 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 2013 Specifications for Survey Measures*, *Volume 3*.

In order to evaluate trends in Colorado Medicaid client satisfaction, HSAG performed a stepwise three-year trend analysis, where applicable.[2-13] The first step compared the 2013 Colorado Medicaid and plan-level CAHPS scores to the corresponding 2012 scores. If the initial 2013 and 2012 trend analysis did not yield any statistically significant differences, then an additional trend analysis was performed between 2013 and 2011 results. Figure 2-4 through Figure 2-14 show the results of this trend analysis. Statistically significant differences are noted with directional triangles. Scores that were statistically higher in 2013 than in 2012 are noted with black upward (▲) triangles. Scores that were statistically lower in 2013 than in 2012 are noted with black downward (▼) triangles. Scores that were statistically higher in 2013 than in 2011 are noted with red upward (▲) triangles. Scores that were statistically lower in 2013 than in 2011 are noted with red downward (▼) triangles. Scores in 2013 that were not statistically different from scores in 2012 or in 2011 are not noted with triangles.

CAHPS scores with fewer than 100 respondents are denoted with an asterisk (*). Caution should be exercised when interpreting results for those measures with fewer than 100 respondents.

[2-10] Due to changes in the NCQA national averages available for composite measures, the 2011 and 2012 global proportions for each composite measure were recalculated. The 2011 and 2012 CAHPS results for all composite measures presented in this section will not match previous years' Adult Medicaid Client Satisfaction Reports.

[2-11] For purposes of the trend analysis, the Colorado Medicaid program's scores for 2011 and 2012 were recalculated to include only Colorado Medicaid FFS and PCPP.

[2-12] National Committee for Quality Assurance. *HEDIS® 2013, Volume 3: Specifications for Survey Measures*. Washington, DC: NCQA Publication, 2012.

[2-13] Due to the transition from the CAHPS 4.0 to 5.0 Adult Medicaid Health Plan Survey, trending could not be performed for the Shared Decision Making composite measure and Health Promotion and Education individual item measure. For detailed information on the changes to these CAHPS measures, please refer to the Executive Summary Section of this report.

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 2-4 shows the 2012 NCQA national average, and the 2011, 2012, and 2013 Rating of Health Plan question summary rates for Colorado Medicaid, FFS, and PCPP.[2-14, 2-15, 2-16]

Figure 2-4—Rating of Health Plan

2011 2012 2013

	2011	2012	2013
2012 NCQA National Average		55.6	
Colorado Medicaid Program	54.5	53.3	47.9 ▼
Fee-for-Service	53.4	47.9	44.8 ▼ (red)
Primary Care Physician Program	55.3	58.2	51.2 ▼

0.0 10.0 20.0 30.0 40.0 50.0 60.0 70.0 80.0 90.0 100.0

Rating of Health Plan

Top Box Response - Percent

Statistical Significance Note:
▲ indicates the 2013 score is significantly higher than the 2012
▼ indicates the 2013 score is significantly lower than the 2012
▲ (red) indicates the 2013 score is significantly higher than the 2011
▼ (red) indicates the 2013 score is significantly lower than the 2011

[2-14] Colorado Medicaid scores in this section are derived from the combined results of the Colorado Medicaid FFS and PCPP plans.

[2-15] NCQA national averages were not available for 2013 at the time this report was prepared; therefore, 2012 NCQA national data are presented in this section.

[2-16] The source for the NCQA national averages contained in this publication is Quality Compass® 2012 data and is used with the permission of the National Committee for Quality Assurance (NCQA). Quality Compass 2012 includes certain CAHPS data. Any data display, analysis, interpretation, or conclusion based on these data is solely that of the authors, and NCQA specifically disclaims responsibility for any such display, analysis, interpretation, or conclusion. Quality Compass® is a registered trademark of NCQA. CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

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 2-5 shows the 2012 NCQA national average, and the 2011, 2012, and 2013 Rating of All Health Care question summary rates for Colorado Medicaid, FFS, and PCPP.

Figure 2-5—Rating of All Health Care

Statistical Significance Note:
- ▲ indicates the 2013 score is significantly higher than the 2012
- ▼ indicates the 2013 score is significantly lower than the 2012
- ▲ indicates the 2013 score is significantly higher than the 2011
- ▼ indicates the 2013 score is significantly lower than the 2011

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 2-6 shows the 2012 NCQA national average, and the 2011, 2012, and 2013 Rating of Personal Doctor question summary rates for Colorado Medicaid, FFS, and PCPP.

Figure 2-6—Rating of Personal Doctor

	2011	2012	2013
2012 NCQA National Average		61.9	
Colorado Medicaid Program	67.6	64.7	61.1▼
Fee-for-Service	63.6	61.6	60.0
Primary Care Physician Program	70.2	67.1	62.0▼

Rating of Personal Doctor

Top Box Response - Percent

Statistical Significance Note:
▲ indicates the 2013 score is significantly higher than the 2012
▼ indicates the 2013 score is significantly lower than the 2012
▲ (red) indicates the 2013 score is significantly higher than the 2011
▼ (red) indicates the 2013 score is significantly lower than the 2011

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 2-7 shows the 2012 NCQA national average, and the 2011, 2012, and 2013 Rating of Specialist Seen Most Often question summary rates for Colorado Medicaid, FFS, and PCPP.

Figure 2-7—Rating of Specialist Seen Most Often

	2011	2012	2013
2012 NCQA National Average		62.1	
Colorado Medicaid Program	65.0	63.8	59.1
Fee-for-Service	64.2	64.2	60.0
Primary Care Physician Program	65.6	63.4	58.1

0.0 10.0 20.0 30.0 40.0 50.0 60.0 70.0 80.0 90.0 100.0

Rating of Specialist Seen Most Often

Top Box Response - Percent

Statistical Significance Note:
▲ indicates the 2013 score is significantly higher than the 2012
▼ indicates the 2013 score is significantly lower than the 2012
▲ indicates the 2013 score is significantly higher than the 2011
▼ indicates the 2013 score is significantly lower than the 2011

Composite Measures[2-17]

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 14 and 25), a top-level response was defined as a response of "Usually" or "Always." Figure 2-8 shows the 2012 NCQA national average, and the 2011, 2012, and 2013 Getting Needed Care global proportions for Colorado Medicaid, FFS, and PCPP.[2-18]

Figure 2-8—Getting Needed Care

Statistical Significance Note: ▲ indicates the 2013 score is significantly higher than the 2012
▼ indicates the 2013 score is significantly lower than the 2012
▲ indicates the 2013 score is significantly higher than the 2011
▼ indicates the 2013 score is significantly lower than the 2011

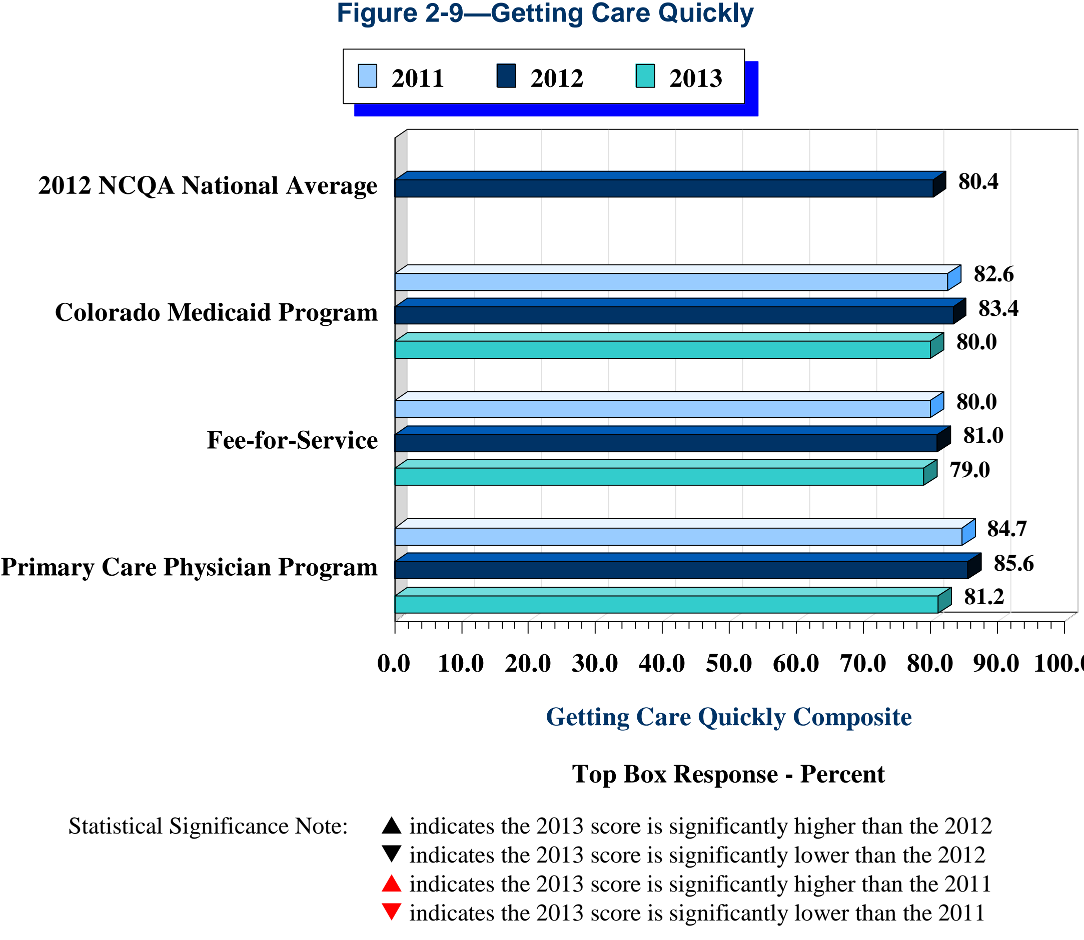
[2-17] As previously noted, the 2011 and 2012 Colorado Medicaid, FFS, and PCPP CAHPS results for all composite measures were recalculated based on the availability of current NCQA national average data; therefore, the 2011 and 2012 global proportions results presented in this section will not match the 2011 and 2012 CAHPS results in previous years' Adult Medicaid Client Satisfaction Reports.

[2-18] Due to changes to the Getting Needed Care composite measure, caution should be exercised when interpreting the trending results and comparisons to NCQA national averages. For detailed information on the changes to the composite measure, please refer to the Executive Summary Section of this report.

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 "Usually" or "Always." Figure 2-9 shows the 2012 NCQA national average, and the 2011, 2012, and 2013 Getting Care Quickly global proportions for Colorado Medicaid, FFS, and PCPP.

Figure 2-9—Getting Care Quickly



Statistical Significance Note: ▲ indicates the 2013 score is significantly higher than the 2012
▼ indicates the 2013 score is significantly lower than the 2012
▲ indicates the 2013 score is significantly higher than the 2011
▼ indicates the 2013 score is significantly lower than the 2011

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 17, 18, 19, and 20), a top-level response was defined as a response of "Usually" or "Always." Figure 2-10 shows the 2012 NCQA national average, and the 2011, 2012, and 2013 How Well Doctors Communicate global proportions for Colorado Medicaid, FFS, and PCPP.

Figure 2-10—How Well Doctors Communicate

2011 2012 2013

2012 NCQA National Average 87.8

Colorado Medicaid Program 89.3 89.0 87.8

Fee-for-Service 86.7 87.7 88.3

Primary Care Physician Program 91.0 90.0 87.4

0.0 10.0 20.0 30.0 40.0 50.0 60.0 70.0 80.0 90.0 100.0

How Well Doctors Communicate Composite

Top Box Response - Percent

Statistical Significance Note:
▲ indicates the 2013 score is significantly higher than the 2012
▼ indicates the 2013 score is significantly lower than the 2012
▲ indicates the 2013 score is significantly higher than the 2011
▼ indicates the 2013 score is significantly lower than the 2011

Customer Service

Colorado Medicaid adult clients were asked two questions to assess how they 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 "Usually" or "Always." Figure 2-11 shows the 2012 NCQA national average, and the 2011, 2012, and 2013 Customer Service global proportions for Colorado Medicaid, FFS, and PCPP.

Figure 2-11—Customer Service

2011 2012 2013

2012 NCQA National Average 80.4

Colorado Medicaid Program 76.7 73.7 81.9 ▲

Fee-for-Service 69.6* 66.7* 79.6 ▲

Primary Care Physician Program 81.8* 80.5* 84.4

0.0 10.0 20.0 30.0 40.0 50.0 60.0 70.0 80.0 90.0 100.0

Customer Service Composite

Top Box Response - Percent

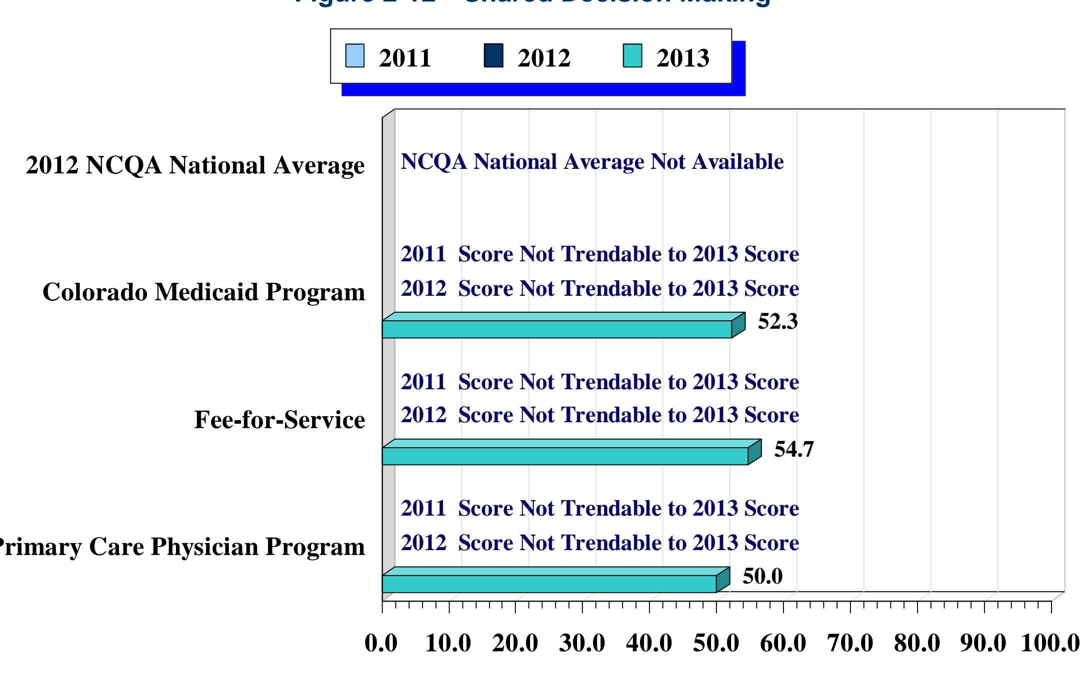
Statistical Significance Note:
▲ indicates the 2013 score is significantly higher than the 2012
▼ indicates the 2013 score is significantly lower than the 2012
▲ indicates the 2013 score is significantly higher than the 2011
▼ indicates the 2013 score is significantly lower than the 2011

* *If the plan had fewer than 100 respondents for a measure, caution should be exercised when interpreting these results.*

Shared Decision Making

Colorado Medicaid adult clients were asked three questions to assess if doctors discussed starting or stopping medication with them. For each of these questions (Questions 10, 11, and 12), a top-level response was defined as a response of "A lot" or "Yes." Figure 2-12 shows the 2013 Shared Decision Making global proportions for Colorado Medicaid, FFS, and PCPP.[2-19]

Figure 2-12—Shared Decision Making



[2-19] Due to changes to the Shared Decision Making composite measure, trending and comparisons to NCQA national averages could not be performed for 2013. For detailed information on the changes to the composite measure, please refer to the Executive Summary Section of this report.

Individual Item Measures

Coordination of Care[2-20]

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 22), a top-level response was defined as a response of "Usually" or "Always." Figure 2-13 shows the 2012 NCQA national average, and the 2011, 2012, and 2013 Coordination of Care question summary rates for Colorado Medicaid, FFS, and PCPP.

Figure 2-13—Coordination of Care

	2011	2012	2013
2012 NCQA National Average		77.5	
Colorado Medicaid Program	81.5	82.0	77.8
Fee-for-Service	77.3	75.9	77.2
Primary Care Physician Program	84.4	87.4	78.3▼

Coordination of Care

Top Box Response - Percent

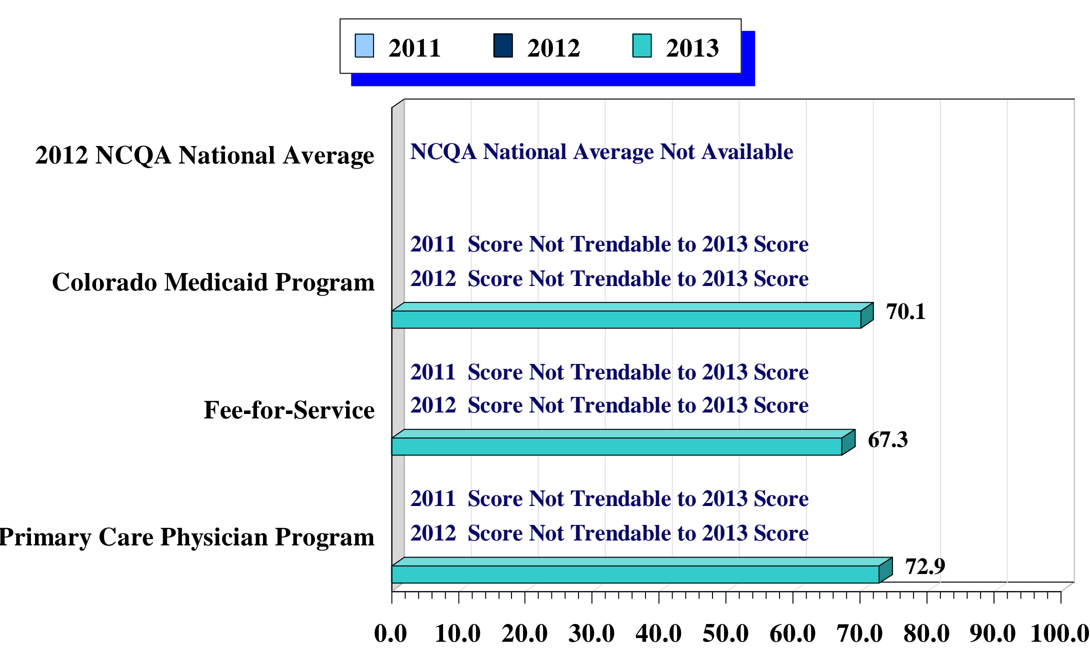
Statistical Significance Note: ▲ indicates the 2013 score is significantly higher than the 2012
▼ indicates the 2013 score is significantly lower than the 2012
▲ indicates the 2013 score is significantly higher than the 2011
▼ indicates the 2013 score is significantly lower than the 2011

[2-20] The 2011 and 2012 CAHPS results for the Coordination of Care individual item were recalculated for Colorado Medicaid, FFS, and PCPP based on the availability of current NCQA national average data. Therefore, the 2011 and 2012 Coordination of Care question summary rates presented in this section will not match the 2011 and 2012 results in previous years' Adult Medicaid Client Satisfaction Reports.

Health Promotion and Education

Colorado Medicaid adult clients were asked a question to assess if 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 "Yes." Figure 2-14 shows the 2013 Health Promotion and Education question summary rates for Colorado Medicaid, FFS, and PCPP.[2-21]

Figure 2-14—Health Promotion and Education



[2-21] Due to changes to the Health Promotion and Education individual item measure, trending and comparisons to NCQA national averages could not be performed for 2013. For detailed information on the changes to the individual item measure, please refer to the Executive Summary Section of this report.

Summary of Trend Analysis Results

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

Table 2-6
Trend Analysis Highlights

	Colorado Medicaid FFS	Colorado Medicaid PCPP
Global Rating		
Rating of Health Plan	▼ (red)	▼
Rating of Personal Doctor		▼ (red)
Composite Measure		
Customer Service	▲	
Individual Measure		
Coordination of Care		▼

▲ *Indicates the 2013 score is significantly higher than the 2012 score*
▼ *Indicates the 2013 score is significantly lower than the 2012 score*
▲ (red) *Indicates the 2013 score is significantly higher than the 2011 score*
▼ (red) *Indicates the 2013 score is significantly lower than the 2011 score*

Plan Comparisons

In order to identify performance differences in client satisfaction between the two Colorado Medicaid plans, the results for FFS and PCPP were compared to one another using standard tests for statistical significance.[2-22] 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 Colorado Medicaid FFS and PCPP were case-mix adjusted for general health status, educational level, and age of the respondent.[2-23] 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 2013 Specifications for Survey Measures, Volume 3*.

Statistically significant differences are noted in the tables by arrows. A plan that performed statistically better than the comparative plan is denoted with an upward (↑) arrow. Conversely, a plan that performed statistically worse than the comparative plan is denoted with a downward (↓) arrow. If a plan's score is not statistically different than the comparative plan, the plan's score is denoted with a horizontal (⇔) arrow.

Table 2-7, on the following page, shows the 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).**

[2-22] Caution should be exercised when evaluating plan comparisons, given that population and plan differences may impact CAHPS results.

[2-23] 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
Global Rating		
Rating of Health Plan	45.4% ↓	50.6% ↑
Rating of All Health Care	46.1% ⇔	48.3% ⇔
Rating of Personal Doctor	60.6% ⇔	61.4% ⇔
Rating of Specialist Seen Most Often	60.1% ⇔	58.1% ⇔
Composite Measure		
Getting Needed Care	81.9% ⇔	81.8% ⇔
Getting Care Quickly	79.2% ⇔	81.0% ⇔
How Well Doctors Communicate	88.5% ⇔	87.3% ⇔
Customer Service	79.6% ⇔	84.3% ⇔
Shared Decision Making	54.7% ⇔	50.0% ⇔
Individual Measure		
Coordination of Care	77.8% ⇔	77.7% ⇔
Health Promotion and Education	67.4% ⇔	72.7% ⇔

Summary of Plan Comparisons Results

The plan comparisons revealed the following statistically significant results.

- Colorado Medicaid FFS scored significantly lower than Colorado Medicaid PCPP on one CAHPS measure, Rating of Health Plan.
- Colorado Medicaid PCPP scored significantly higher than Colorado Medicaid FFS on one CAHPS measure, Rating of Health Plan.

Supplemental Items

The Department elected to add 10 supplemental items to the standard CAHPS 5.0 Adult Medicaid Health Plan Survey. Table 2-8 details the survey language and response options for each of the supplemental items. Table 2-9 through Table 2-18 show the results for each supplemental item. For these supplemental items, the number and percentage of responses for each item are presented.

Table 2-8
Supplemental Items

Question		Response Options
Q14a.	In the last 6 months, when a doctor or other health provider ordered a blood test, x-ray, or other test for you, how often did someone follow up to give you those results?	Never Sometimes Usually Always
Q14b.	In the last 6 months, did a doctor or other health provider talk with you about specific goals for your health?	Yes No
Q14c.	In the last 6 months, did a doctor or other health provider ask you if there are things that make it hard for you to take care of your health?	Yes No
Q14d.	In the last 6 months, did a doctor or other health provider ask you if there was a period of time when you felt sad, empty or depressed?	Yes No
Q14e.	In the last 6 months, did you and a doctor or other health provider talk about things in your life that worry you or cause you stress?	Yes No
Q14f.	In the last 6 months, did you and a doctor or other health provider talk about a personal problem, family problem, alcohol use, drug use, or a mental or emotional illness?	Yes No
Q20a.	Thinking back about the care you received in the last 6 months, how often do you think your personal doctor understood the things that really matter to you about your health care?	Never Sometimes Usually Always
Q20b.	In the past 6 months, did you ever leave your personal doctor's office confused about what to do next to manage your health?	Yes No
Q23a.	In the last 6 months, did your personal doctor or other health provider talk to you about resources in your neighborhood to support you in managing your health?	Yes No
Q36a.	Have you had a flu shot since September 1, 2012?	Yes No Don't know

Follow Up on Blood Test, X-ray, or Other Test Results

Colorado Medicaid adult clients were asked to assess how often someone followed up with them to give them the results of their blood test, x-ray, or other test ordered by a doctor or other health provider (Question 14a). Table 2-9 displays the responses for this question.

Table 2-9
Follow Up on Blood Test, X-ray, or Other Test Results

	Never		Sometimes		Usually		Always	
	N	%	N	%	N	%	N	%
Colorado Medicaid FFS	29	7.7%	54	14.4%	83	22.1%	210	55.9%
Colorado Medicaid PCPP	19	4.8%	47	11.8%	86	21.7%	245	61.7%

Specific Goals for Health

Colorado Medicaid adult clients were asked if a doctor or other health provider talked with them about specific goals for their health (Question 14b). Table 2-10 displays the responses for this question.

Table 2-10
Specific Goals for Health

	Yes		No	
	N	%	N	%
Colorado Medicaid FFS	242	63.9%	137	36.1%
Colorado Medicaid PCPP	270	68.0%	127	32.0%

Difficulty with Taking Care of Health

Colorado Medicaid adult clients were asked if a doctor or other health provider asked them if there were things that made it hard for them to take care of their health (Question 14c). Table 2-11 displays the responses for this question.

Table 2-11
Difficulty with Taking Care of Health

	Yes		No	
	N	%	N	%
Colorado Medicaid FFS	173	45.6%	206	54.4%
Colorado Medicaid PCPP	168	42.9%	224	57.1%

Asked about Emotional Health

Colorado Medicaid adult clients were asked if a doctor or other health provider asked them if there was a period of time when they felt sad, empty or depressed (Question 14d). Table 2-12 displays the responses for this question.

Table 2-12
Asked about Emotional Health

	Yes		No	
	N	%	N	%
Colorado Medicaid FFS	190	49.5%	194	50.5%
Colorado Medicaid PCPP	185	47.1%	208	52.9%

Talked about Things that Worry or Cause Stress

Colorado Medicaid adult clients were asked if they and a doctor or other health provider talked about things in their life that worry them or cause them stress (Question 14e). Table 2-13 displays the responses for this question.

Table 2-13
Talked about Things that Worry or Cause Stress

	Yes		No	
	N	%	N	%
Colorado Medicaid FFS	182	48.0%	197	52.0%
Colorado Medicaid PCPP	172	43.4%	224	56.6%

Talked about Problems, Substance Use, or Other Illness

Colorado Medicaid adult clients were asked if they talked to a doctor or other health provider about a personal or family problem, alcohol or drug use, or a mental or emotional illness (Question 14f). Table 2-14 displays the responses for this question.

Table 2-14
Talked about Problems, Substance Use, or Other Illness

	Yes		No	
	N	%	N	%
Colorado Medicaid FFS	144	37.8%	237	62.2%
Colorado Medicaid PCPP	144	36.5%	251	63.5%

Personal Doctor Understood Clients' Health Care Matters

Colorado Medicaid adult clients were asked to assess how often their personal doctor understood the things that really matter to them about their health care (Question 20a). Table 2-15 displays the responses for this question.

Table 2-15
Personal Doctor Understood Clients' Health Care Matters

	Never		Sometimes		Usually		Always	
	N	%	N	%	N	%	N	%
Colorado Medicaid FFS	11	3.7%	36	12.1%	86	28.9%	165	55.4%
Colorado Medicaid PCPP	12	3.4%	44	12.5%	97	27.5%	200	56.7%

Confused about Next Steps for Management of Own Health

Colorado Medicaid adult clients were asked if they ever left their personal doctor's office confused about what to do next to manage their health (Question 20b). Table 2-16 displays the responses for this question.

Table 2-16
Confused about Next Steps for Management of Own Health

	Yes		No	
	N	%	N	%
Colorado Medicaid FFS	48	16.4%	245	83.6%
Colorado Medicaid PCPP	55	15.6%	298	84.4%

Neighborhood Resources to Support Health Management

Colorado Medicaid adult clients were asked if their personal doctor or other health provider talked to them about neighborhood resources to support them in managing their own health (Question 23a). Table 2-17 displays the responses for this question.

Table 2-17
Neighborhood Resources to Support Health Management

	Yes		No	
	N	%	N	%
Colorado Medicaid FFS	127	35.0%	236	65.0%
Colorado Medicaid PCPP	130	30.8%	292	69.2%

Flu Shots

Colorado Medicaid adult clients were asked if they had a flu shot since September 1, 2012 (Question 36a). Table 2-18 displays the responses for this question.

Table 2-18
Flu Shots

	Yes		No		Don't Know	
	N	%	N	%	N	%
Colorado Medicaid FFS	263	49.6%	258	48.7%	9	1.7%
Colorado Medicaid PCPP	321	64.1%	172	34.3%	8	1.6%

General Recommendations

HSAG recommends the continued administration of the CAHPS 5.0 Adult Medicaid Health Plan Survey in fiscal year (FY) 2013-2014. 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 for the FY 2011-2012 survey administration is comparable to the completed surveys in Spanish for the FY 2012-2013 survey administration due to the identification of these clients prior to the start of the survey.

In FY 2012-2013, the sampling methodology used for the Colorado CAHPS Adult Medicaid Health Plan Survey was modified from previous years in an effort to decrease the percentage of respondents 65 years of age and older, given that this respondent population is eligible for health care coverage under both Medicaid and Medicare (i.e., dual eligible) and may potentially bias the Colorado Adult Medicaid CAHPS Survey results. In FY 2012-2013, a 30 percent targeted oversample of non-dual eligible clients (i.e., adult clients younger than 65 years of age) was conducted for Colorado Medicaid FFS and PCPP. A comparison of the FY 2012-2013 survey demographics results to FY 2011-2012 reveal a decrease in the proportion of the respondent population for both Colorado Medicaid FFS and PCPP that were 65 years of age and older. In FY 2011-2012, the percentage of respondents 65 years of age or older was 23.7 percent for Colorado Medicaid FFS and 35.4 percent for PCPP. In FY 2012-2013, this respondent population decreased to 15.5 percent for Colorado Medicaid FFS and 24.0 percent for PCPP representing a decrease of 8.2 percent and 11.4 percent, respectively. Based on these findings, HSAG recommends the continued implementation of a modified sampling methodology for the adult Medicaid population if the State wishes to minimize the impact of this respondent population on the Adult Medicaid CAHPS Survey results.

Plan-Specific Recommendations

This section presents Adult Medicaid CAHPS recommendations for the two 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.[3-1,3-2]

The priorities presented in this section should be viewed as potential suggestions for QI. Additional sources of QI information, such as other HEDIS results, should be incorporated into a comprehensive QI plan. A number of resources are available to assist state Medicaid agencies and plans with the implementation of CAHPS-based QI initiatives. A comprehensive list of these resources is included in the Reader's Guide Section, beginning on page 4-10.

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
★★★★	▼	Moderate
★★★★	—	Moderate
★★★★★	▼	Moderate
★★★★	▲	Low
★★★★★	—	Low
★★★★★	▲	Low

Please note: Trend analysis results reflect those between either the 2013 and 2012 results or the 2013 and 2011 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.

[3-1] Due to the transition from the CAHPS 4.0 to 5.0 Adult Medicaid Health Plan Survey, comparisons to national data and trending could not be performed for the Shared Decision Making composite measure and Health Promotion and Education individual item measure; therefore, priority assignments cannot be derived for these measures.

[3-2] NCQA does not provide benchmarks for the Coordination of Care individual item measure; therefore, priority assignments cannot be derived for this measure.

[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	★	▼	Top

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

Alternatives to One-on-One Visits

To achieve improved quality, timeliness, and access to care, health plans should engage in efforts that assist providers in examining and improving their systems' abilities' to manage patient demand. As an example, health plans can test alternatives to traditional one-on-one visits, such as telephone consultations, telemedicine, or group visits for certain types of health care services and appointments to increase physician availability. Additionally, for patients who need a follow-up appointment, a system could be developed and tested where a nurse or physician assistant contacts the patient by phone two weeks prior to when the follow-up visit would have occurred to determine whether the patient's current status and condition warrants an in-person visit, and if so, schedule the appointment at that time. Otherwise, an additional status follow-up contact could be made by phone in lieu of an in-person office visit. By finding alternatives to traditional one-on-one, in-office visits, health plans can assist in improving physician availability and ensuring patients receive immediate medical care and services.

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 engaging employees can include quarterly employee forums, an annual all-staff assembly, topic-specific improvement teams, 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.

Rating of All Health Care

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

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

In order to improve the Rating of All Health Care measure, QI activities should target client perception of access to care and patient and family engagement 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. Standard practices and established protocols can assist in this process by ensuring access to care issues are handled consistently across all practices. For example, health plans can develop standardized protocols and scripts for common occurrences within the provider office setting, such as late patients. With proactive polices and scripts in place, the late patient can be notified the provider has moved onto the next patient and will work the late patient into the rotation as time permits. This type of structure allows the late patient to still receive care without causing delay in the appointments of other patients. Additionally, having a well-written script prepared in the event of an uncommon but expected situation allows staff to work quickly in providing timely access to care while following protocol.

Patient and Family Engagement Advisory Councils

Since both patients and families have the direct experience of an illness or health care system, their perspectives can provide significant insight when performing an evaluation of health care processes. Therefore, health plans should consider creating opportunities and functional roles that include the patients and families who represent the populations they serve. Patient and family members could serve as advisory council members providing new perspectives and serving as a resource to health care processes. Patient interviews on services received and family inclusion in care planning 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, involvement in advisory 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	★★★	▼	High

In order to improve the Rating of Personal Doctor measure, QI activities should target maintaining truth in scheduling, patient-direct feedback, physician-patient communication, and improving shared decision making.

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 type of monitoring 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. Additionally, by measuring the amount of time it takes to provide care, both health plans and physician offices' can identify where streamlining opportunities exist. If providers are finding bottlenecks within their patient flow processes, they may consider implementing daily staff huddles to improve communication or working in teams with cross-functionalities to increase staff responsibility and availability.

Patient-Direct Feedback

Health plans can explore additional methods for obtaining direct patient 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). Comment card questions may also prompt feedback

regarding other topics, such as providers' listening skills, wait time to obtaining an appointment, customer service, and other items of interest. Research suggests the addition of the question, "Would you recommend this physician's office to a friend?" greatly predicts overall patient satisfaction. 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.

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, collaborative communication which involves allowing the patient to discuss and share in the decision making process, as well as 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.

Improving Shared Decision Making

Health plans should encourage skills training in shared decision making for all physicians. Implementing an environment of shared decision making and physician-patient collaboration 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 physicians with the skills necessary to facilitate the shared decision making process; ensuring that physicians understand the importance of taking each patient's values into consideration; and understanding patients' preferences and needs. Effective and efficient training methods include seminars and workshops.

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	★★	—	**High**
PCPP	★★	—	**High**

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

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 reminder system could be implemented to ensure that these patients are receiving the appropriate attention at the appropriate time. This triggering system could be used by staff to prompt general follow-up contact or specific interaction with patients to ensure they have necessary tests completed before an appointment or various other prescribed reasons. For example, after a planned visit, follow-up contact with patients could be scheduled within the reminder system to ensure patients understood all information provided to them and/or to address any questions they may have.

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. According to a 2009 review of more than 100 studies published in the journal *Medical Care*, patients' adherence to recommended treatments and management of chronic conditions is 12 percent higher when providers receive training in communication skills. By establishing skills training for specialists, health plans can not only improve the quality of care delivered to its members but also their potential health outcomes.

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. Furthermore, the local provider is more involved in the consultation process and more informed about the care the patient is receiving.

Composite Measures

Getting Needed Care

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

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

In order to improve clients' satisfaction under the Getting Needed Care measure, QI activities should target appropriate health care providers, providing interactive workshops, "max-packing," language concordance programs, and streamlining the referral process.

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. Health plans should actively attempt to match patients with appropriate health care providers and engage providers in their efforts to ensure appointments are scheduled for patients to receive care in a timely manner. These efforts can lead to improvements in quality, timeliness, and patients' overall access to care.

Interactive Workshops

Health plans should engage in promoting health education, health literacy, and preventive health care amongst their membership. Increasing patients' health literacy and general understanding of their health care needs can result in improved health. Health plans can develop community-based interactive workshops and educational materials to provide information on general health or specific needs. Free workshops can vary by topic (e.g., women's health, specific chronic conditions) to address and inform the needs of different populations. Access to free health assessments also can assist health plans in promoting patient health awareness and preventive health care efforts.

"Max-Packing"

Health plans can assist providers in implementing strategies within their system that allow for as many of the patient's needs to be met during one office visit when feasible; a process called "max-packing." "Max-packing" is a model designed to maximize each patient's office visit, which in many cases eliminates the need for extra appointments. Max-packing strategies could include using

a checklist of preventive care services to anticipate the patient's future medical needs and guide the process of taking care of those needs a scheduled visit, whenever possible. Processes could also be implemented wherein staff review the current day's appointment schedule for any future appointments a patient may have. For example, if a patient is scheduled for their annual physical in the fall and a subsequent appointment for a flu vaccination, the current office visit could be used to accomplish both eliminating the need for a future appointment. Health plans should encourage the care of a patient's future needs during a visit and determine if, and when, future follow-up is necessary.

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.

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.

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**

In order to improve clients' satisfaction under the Getting Care Quickly measure, QI activities should target decreasing no-show appointments, electronic communication, nurse advice help lines, open access scheduling, and patient flow.

Decrease No-Show Appointments

Studies have indicated that reducing the demand for unnecessary appointments and increasing availability of physicians can result in decreased no-shows and improve members' perceptions of timely access to care. Health plans can assist providers in examining patterns related to no-show appointments in order to determine the factors contributing to patient no-shows. For example, it might be determined that only a small percentage of the physicians' patient population accounts for no-shows. Thus, further analysis could be conducted on this targeted patient population to determine if there are specific contributing factors (e.g., lack of transportation). Additionally, an analysis of the specific types of appointments that are resulting in no-shows could be conducted. Some findings have shown that follow-up visits account for a large percentage of no-shows. Thus, the health plan can assist providers in re-examining their return visit patterns and eliminate unnecessary follow-up appointments or find alternative methods to conduct follow-up care (e.g., telephone and/or e-mail follow-up). Additionally, follow-up appointments could be conducted by another health care professional such as nurse practitioners or physician assistants.

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.

Nurse Advice Help Line

Health plans can establish a nurse advice help line to direct 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 care quickly by providing quick, easy access to the resources and expertise of clinical staff.

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.

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**

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 necessary tools to effectively communicate with 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. 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.

Language Barriers

Health plans can consider hiring interpreters that serve as full-time time staff members at provider offices with a high volume of non-English speaking patients to ensure accurate communication amongst patients and physicians. Offering an in-office, 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.

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	★	▲	**Top**
PCPP	★★★	—	**Moderate**

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

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.

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 toward 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. 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.

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.

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 3-10 provides a summary of the responsible parties for various aspects of care.[3-4]

Table 3-10—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 and PCPP 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.

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 5.0 Adult Medicaid Health Plan Survey with the HEDIS supplemental item set. The CAHPS 5.0 Health Plan Surveys are a set of standardized surveys that assess patient perspectives on care. Originally, CAHPS was a five-year collaborative project sponsored by AHRQ. 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. 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 Health Plan Survey in 2009, which are referred to as the CAHPS 4.0H Health Plan Surveys.[4-3,4-4] In 2012, AHRQ released the CAHPS 5.0 Health Plan Surveys. Based on the CAHPS 5.0 versions, NCQA introduced new HEDIS versions of the Adult and Child Health Plan Surveys in August 2012, which are referred to as the CAHPS 5.0H Health Plan Surveys.[4-5]

The sampling and data collection procedures for the CAHPS 5.0 Health Plan Survey were 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.

[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.

[4-5] National Committee for Quality Assurance. *HEDIS® 2013*, *Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA Publication, 2012.

The CAHPS 5.0 Adult Medicaid Health Plan Survey with the HEDIS supplemental item set includes 57 core questions that yield 11 measures of satisfaction. These measures include four global rating questions, five composite measures, and two individual item measures. The global measures (also referred to as global ratings) reflect overall satisfaction with the health plan, health care, personal doctors, and specialists. The composite measures are sets of questions grouped together to address different aspects of care (e.g., "Getting Needed Care" or "Getting Care Quickly"). The individual item measures are individual questions that look at a specific area of care (i.e., "Health Promotion and Education" and "Coordination of Care").

Table 4-1 lists the global ratings, composite measures, and individual item measures included in the CAHPS 5.0 Adult Medicaid Health Plan Survey with the HEDIS supplemental item set.

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 or PCPP clients at the time the sample was drawn and who were continuously enrolled for at least five of the last six months (July through December) of 2012. The clients eligible for sampling included those who were age 18 or older (as of December 31, 2012).

The standard NCQA specifications for survey measures require a sample size of 1,350 clients for the CAHPS 5.0 Adult Medicaid Health Plan Survey. For FFS, a 60 percent oversample was performed on the adult population, which included a 30 percent oversample of non-dual eligible clients and a 30 percent targeted oversample of adult clients not enrolled in a RCCO. For PCPP, a 30 percent oversample of non-dual eligible clients was performed on the adult population. Based on these rates, a total sample of 2,160 and 1,755 adult clients was selected from Colorado Medicaid FFS and PCPP, 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 5.0 Adult Medicaid Health Plan Surveys.

Table 4-2—CAHPS 5.0 Mixed-Mode Methodology Survey Timeline

Task	Timeline
Send first questionnaire with cover letter to the member.	0 days
Send a postcard reminder to non-respondents four to 10 days after mailing the first questionnaire.	4 – 10 days
Send a second questionnaire (and letter) to non-respondents approximately 35 days after mailing the first questionnaire.	35 days
Send a second postcard reminder to non-respondents four to 10 days after mailing the second questionnaire.	39 – 45 days
Initiate CATI interviews for non-respondents approximately 21 days after mailing the second questionnaire.	56 days
Initiate systematic contact for all non-respondents such that at least three 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 CAHPS 5.0 Health Plan Survey process 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. Clients who were identified as Spanish-speaking through administrative data were mailed a Spanish version of the survey. Clients that were not identified as Spanish-speaking received an English version of the survey. The English and Spanish versions of the survey included a toll-free number that clients could call to request a survey in another language (i.e., English or Spanish). A reminder postcard was sent to all non-respondents, followed by a second survey mailing and reminder postcard. The second phase, or telephone phase, consisted of CATI of sampled clients who had not mailed in a completed survey. A series of at least three CATI calls was made to each non-respondent. It has been shown that the addition of the telephone phase aids in the reduction of non-response bias by increasing the number of respondents who are more demographically representative of a plan's population.[4-6]

[4-6] Fowler FJ Jr., Gallagher PM, Stringfellow VL, et al. "Using Telephone Interviews to Reduce Nonresponse Bias to Mail Surveys of Health Plan Members." *Medical Care*. 2002; 40(3): 190-200.

All eligible clients were provided for sampling. Sampling clients included those who met the following criteria:

- Were age 18 or older as of December 31, 2012.
- Were currently enrolled in FFS or PCPP.
- Had been continuously enrolled for at least five of the last six months of 2012.
- Had Medicaid as a payer.

HSAG inspected a sample of the file records to check for any apparent problems with the files, such as missing address elements. The 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. The survey samples were samples with no more than one client being selected per household.

The name of the plan appeared in the questionnaires and cover letters; the letters beared the signature of a high-ranking plan or state official; and the questionnaire packages included a postage-paid reply envelope addressed to the organization conducting the surveys.

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 5.0 Adult Medicaid Health Plan Survey is comprehensive and is designed to achieve the highest possible response rate. The response rate is defined as the total number of completed surveys divided by all eligible clients of the sample.[4-7] A client's survey was assigned a disposition code of "completed" if at least one question was answered within the survey. Eligible clients include the entire random sample (including any oversample) minus ineligible clients. Ineligible clients of the sample met one or more of the following criteria: were deceased, were invalid (did not meet criteria described on page 4-4), were mentally or physically unable to complete the survey, or had a language barrier.

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

Respondent Demographics

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

[4-7] National Committee for Quality Assurance. *HEDIS® 2013, Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA Publication, 2012.

NCQA Comparisons

An analysis of the Colorado CAHPS 5.0 Adult Medicaid Health Plan Survey results was conducted using NCQA HEDIS Specifications for Survey Measures.[4-8] 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. For purposes of this report, plans' results are reported for a CAHPS measure even when the NCQA minimum reporting threshold of 100 respondents was not met.

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 for Accreditation to derive the overall client satisfaction ratings (i.e., star ratings) for each CAHPS measure, except for the Shared Decision Making composite measure and Coordination of Care and Health Promotion and Education individual item measures. NCQA does not publish benchmarks and thresholds for these measures; therefore, star ratings could not be assigned. For detailed information on the derivation of three-point mean scores, please refer to *NCQA HEDIS 2013 Specifications for Survey Measures, Volume 3*.

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

[4-8] National Committee for Quality Assurance. *HEDIS® 2013, Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA Publication, 2012.

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

Table 4-3—Overall Adult Medicaid Client Satisfaction Ratings Crosswalk				
Measure	**90th Percentile**	**75th Percentile**	**50th Percentile**	**25th Percentile**
Rating of Health Plan	2.54	2.46	2.40	2.32
Rating of All Health Care	2.41	2.37	2.31	2.25
Rating of Personal Doctor	2.57	2.51	2.46	2.42
Rating of Specialist Seen Most Often	2.56	2.52	2.47	2.43
Getting Needed Care	2.43	2.35	2.28	2.18
Getting Care Quickly	2.48	2.44	2.40	2.33
How Well Doctors Communicate	2.64	2.58	2.54	2.48
Customer Service	2.55	2.47	2.42	2.34

[4-9] National Committee for Quality Assurance. *HEDIS Benchmarks and Thresholds for Accreditation 2013*. Washington, DC: NCQA, March 15, 2013.

Trend Analysis

In order to evaluate trends in Colorado Medicaid client satisfaction, HSAG performed a stepwise three-year trend analysis, where applicable. The first step compared the 2013 CAHPS results to the 2012 CAHPS results. If the initial 2013 and 2012 trend analysis did not yield any significant differences, then an additional trend analysis was performed between 2013 and 2011 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, where appropriate. Both the question summary rates and global proportions were calculated in accordance with NCQA HEDIS Specifications for Survey Measures.[4-10] The scoring of the global ratings, composite measures, and individual item measures involved assigning top-level responses a score of one, with all other responses receiving a score of zero. After applying this scoring methodology, the percentage of top-level responses was calculated in order to determine the question summary rates and global proportions. For additional details, please refer to the *NCQA HEDIS 2013 Specifications for Survey Measures, Volume 3*.

The 2013 Colorado Medicaid and plan-level CAHPS scores were compared to the corresponding 2012 scores to determine whether there were statistically significant differences. If there were no statistically significant differences from 2013 to 2012, then 2013 scores were compared to 2011 scores. A difference was considered significant if the two-sided p-value of the t-test was less than 0.05. Scores that were statistically higher in 2013 than in 2012 are noted with black upward (▲) triangles. Scores that were statistically lower in 2013 than in 2012 are noted with black downward (▼) triangles. Scores that were statistically higher in 2013 than in 2011 are noted with red upward (▲) triangles. Scores that were statistically lower in 2013 than in 2011 are noted with red downward (▼) triangles. Scores in 2013 that were not statistically different from scores in 2012 or in 2011 are not noted with triangles.

Plan Comparisons

Plan comparisons were performed to identify client satisfaction differences that were statistically different between the two plans. 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 clients and 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, education level, and age of the respondent.

One type of hypothesis test was applied to the adult CAHPS comparative results. The t-test determined whether there were statistically significant differences between the two plans.

[4-10] National Committee for Quality Assurance. *HEDIS® 2013, Volume 3: Specifications for Survey Measures*. Washington, DC: NCQA Publication, 2012.

Limitations and Cautions

The findings presented in the 2013 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 the 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.

Sampling Effects

The sampling approach employed for Colorado Medicaid FFS and PCPP populations differed; while results of the plan comparisons were case-mix adjusted for differences in general health status, education level, and age of respondent, the sample of clients selected for inclusion in the CAHPS surveys varied between the two plans. Due to these differences, there is still the small potential for sampling effects. Therefore, sampling effects should be considered when interpreting the CAHPS results.

Quality Improvement References

The CAHPS surveys were originally developed to meet the need of consumers for usable, relevant information on quality of care from the members' perspective. However, they 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. The following references offer guidance on possible approaches to CAHPS-related QI activities.

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5. Survey Instrument

The survey instrument selected for the 2013 Colorado Adult Medicaid Client Satisfaction Survey was the CAHPS 5.0 Adult Medicaid Health Plan Survey with the HEDIS supplemental item set. This section provides a copy of the survey instrument.

Your privacy is protected. All information that would let someone identify you or your family will be kept private. The research staff 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 the survey so we don't have to send you reminders.

If you want to know more about this study, please call 1-877-455-3391.

SURVEY INSTRUCTIONS

- **Please be sure to fill the response circle completely. Use only black or blue ink or dark pencil to complete the survey.**

Correct Mark ● **Incorrect Marks**

- **You are sometimes told to skip over some questions in the survey. When this happens you will see an arrow with a note that tells you what question to answer next, like this:**

● **Yes ➔ *Go to Question 1***
○ **No**

↓ START HERE ↓

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

○ Yes ➔ ***Go to Question 3***
○ No

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

____

YOUR HEALTH CARE IN THE LAST 6 MONTHS

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

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

   ○ Yes
   ○ No ➔ ***Go to Question 5***

4. **In the last 6 months, when you needed care right away, how often did you get care as soon as you needed?**

   ○ Never
   ○ Sometimes
   ○ Usually
   ○ Always

5. **In the last 6 months, did you make any appointments for a check-up or routine care at a doctor's office or clinic?**

   ○ Yes
   ○ No ➔ ***Go to Question 7***

6. **In the last 6 months, how often did you get an appointment for a check-up or routine care at a doctor's office or clinic as soon as you needed?**

   ○ Never
   ○ Sometimes
   ○ Usually
   ○ Always

7. **In the last 6 months, not 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?**

   ○ None ➔ ***Go to Question 15***
   ○ 1 time
   ○ 2
   ○ 3
   ○ 4
   ○ 5 to 9
   ○ 10 or more times

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

   ○ Yes
   ○ No

9. **In the last 6 months, did you and a doctor or other health provider talk about starting or stopping a prescription medicine?**

   ○ Yes
   ○ No ➔ ***Go to Question 13***

10. **When you talked about starting or stopping a prescription medicine, how much did a doctor or other health provider talk about the reasons you might want to take a medicine?**

    ○ Not at all
    ○ A little
    ○ Some
    ○ A lot

11. **When you talked about starting or stopping a prescription medicine, how much did a doctor or other health provider talk about the reasons you might not want to take a medicine?**

    ○ Not at all
    ○ A little
    ○ Some
    ○ A lot

12. **When you talked about starting or stopping a prescription medicine, did a doctor or other health provider ask you what you thought was best for you?**

    ○ Yes
    ○ No

13. **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

14. **In the last 6 months, how often was it easy to get the care, tests, or treatment you needed?**

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ Always

14a. **In the last 6 months, when a doctor or other health provider ordered a blood test, x-ray, or other test for you, how often did someone follow up to give you those results?**

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ Always

14b. **In the last 6 months, did a doctor or other health provider talk with you about specific goals for your health?**

- ○ Yes
- ○ No

14c. **In the last 6 months, did a doctor or other health provider ask you if there are things that make it hard for you to take care of your health?**

- ○ Yes
- ○ No

14d. **In the last 6 months, did a doctor or other health provider ask you if there was a period of time when you felt sad, empty or depressed?**

- ○ Yes
- ○ No

14e. **In the last 6 months, did you and a doctor or other health provider talk about things in your life that worry you or cause you stress?**

- ○ Yes
- ○ No

14f. **In the last 6 months, did you and a doctor or other health provider talk about a personal problem, family problem, alcohol use, drug use, or a mental or emotional illness?**

- ○ Yes
- ○ No

YOUR PERSONAL DOCTOR

15. **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?**

- ○ Yes
- ○ No ➔ ***Go to Question 24***

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

- ○ None ➔ ***Go to Question 23***
- ○ 1 time
- ○ 2
- ○ 3
- ○ 4
- ○ 5 to 9
- ○ 10 or more times

17. **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

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

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ Always

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

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ Always

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

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ Always

20a. Thinking back about the care you received in the last 6 months, how often do you think your personal doctor understood the things that really matter to you about your health care?

- Never
- Sometimes
- Usually
- Always

20b. In the past 6 months, did you ever leave your personal doctor's office confused about what to do next to manage your health?

- Yes
- No

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

- Yes
- No ➔ ***Go to Question 23***

22. 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

23. 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

23a. In the last 6 months, did your personal doctor or other health provider talk to you about resources in your neighborhood to support you in managing your health?

- Yes
- No

GETTING HEALTH CARE FROM SPECIALISTS

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

24. 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 make any appointments to see a specialist?

- Yes
- No ➔ ***Go to Question 28***

25. In the last 6 months, how often did you get an appointment to see a specialist as soon as you needed?

- Never
- Sometimes
- Usually
- Always

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

- None ➔ ***Go to Question 28***
- 1 specialist
- 2
- 3
- 4
- 5 or more specialists

27. 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.

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?

- ○ Yes
- ○ 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

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

- ○ Yes
- ○ 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?

- ○ Yes
- ○ 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?

- ○ Excellent
- ○ Very Good
- ○ Good
- ○ Fair
- ○ Poor

36a. Have you had a flu shot since September 1, 2012?

- ○ Yes
- ○ No
- ○ Don't know

37. In general, how would you rate your overall mental or emotional health?

- ○ Excellent
- ○ Very Good
- ○ Good
- ○ Fair
- ○ Poor

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

- ○ Every day
- ○ Some days
- ○ Not at all ➔ ***Go to Question 42***
- ○ Don't know ➔ ***Go to Question 42***

39. 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

40. 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

41. 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

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

- ○ Yes
- ○ No
- ○ Don't know

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

- ○ Yes
- ○ No
- ○ Don't know

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

- ○ Yes
- ○ No

45. Are you aware that you have any of the following conditions? Mark one or more.

- ○ High cholesterol
- ○ High blood pressure
- ○ Parent or sibling with heart attack before the age of 60

46. Has a doctor ever told you that you have any of the following conditions? Mark one or more.

- ○ A heart attack
- ○ Angina or coronary heart disease
- ○ A stroke
- ○ Any kind of diabetes or high blood sugar

47. In the last 6 months, did you get health care 3 or more times for the same condition or problem?

- ○ Yes
- ○ No ➔ ***Go to Question 49***

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

- ○ Yes
- ○ No

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

- ○ Yes
- ○ No ➔ ***Go to Question 51***

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

- ○ Yes
- ○ No

51. What is your age?

- ○ 18 to 24
- ○ 25 to 34
- ○ 35 to 44
- ○ 45 to 54
- ○ 55 to 64
- ○ 65 to 74
- ○ 75 or older

52. Are you male or female?

- ○ Male
- ○ Female

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

- ○ 8th grade or less
- ○ Some high school, but did not graduate
- ○ High school graduate or GED
- ○ Some college or 2-year degree
- ○ 4-year college graduate
- ○ More than 4-year college degree

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

- ○ Yes, Hispanic or Latino
- ○ No, Not Hispanic or Latino

55. What is your race? Mark one or more.

- ○ White
- ○ Black or African-American
- ○ Asian
- ○ Native Hawaiian or other Pacific Islander
- ○ American Indian or Alaska Native
- ○ Other

56. Did someone help you complete this survey?

- ○ Yes ➔ ***Go to Question 57***
- ○ No ➔ ***Thank you. Please return the completed survey in the postage-paid envelope.***

57. How did that person help you? Mark one or more.

- ○ Read the questions to me
- ○ Wrote down the answers I gave
- ○ Answered the questions for me
- ○ Translated the questions into my language
- ○ Helped in some other way

Thanks again for taking the time to complete this survey! Your answers are greatly appreciated.

When you are done, please use the enclosed prepaid envelope to mail the survey to:

DataStat, 3975 Research Park Drive, Ann Arbor, MI 48108

6. CD

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 and PCPP.

CD Contents

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

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