FY 08–09 CHILD MEDICAID CLIENT SATISFACTION REPORT

August 2009

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

1600 East Northern Avenue, Suite 100 ◆ Phoenix, AZ 85020
Phone 602.264.6382 ◆ Fax 602.241.0757

HSAG HEALTH SERVICES ADVISORY GROUP

CONTENTS

1. Executive Summary ... 1-1
Changes to the Child Survey ... 1-1
Composite Measures ... 1-1
Global Ratings ... 1-2
New Content Areas ... 1-3
Performance Highlights ... 1-3
NCQA Comparisons ... 1-4
Trend Analysis ... 1-4
Plan Comparisons ... 1-5

2. Results ... 2-1
Survey Administration and Response Rates ... 2-1
Survey Administration ... 2-1
Response Rates ... 2-2
Child and Respondent Demographics ... 2-8
NCQA Comparisons ... 2-10
Summary of NCQA Comparison Results ... 2-12
Trend Analysis ... 2-13
Global Ratings ... 2-15
Composite Measures ... 2-19
Individual Item Measures ... 2-24
Summary of Trend Analysis Results ... 2-26
Plan Comparisons ... 2-27
Summary of Plan Comparisons Results ... 2-28

3. Recommendations ... 3-1
General Recommendations ... 3-1
Plan-Specific Recommendations ... 3-1
Global Ratings ... 3-3
Composite Measures ... 3-7
Individual Item Measures ... 3-12
Accountability and Improvement of Care ... 3-14

4. Reader's Guide ... 4-1
Survey Administration ... 4-1
Survey Overview ... 4-1
Sampling Procedures ... 4-2
Survey Protocol ... 4-3
Methodology ... 4-5
Response Rates ... 4-5
Child and Respondent Demographics ... 4-5
NCQA Comparisons ... 4-5
Trend Analysis ... 4-7
Plan Comparisons ... 4-7
Limitations and Cautions ... 4-9
Case-Mix Adjustment ... 4-9
Non-response Bias ... 4-9
Causal Inferences ... 4-9
Mode Effects ... 4-9
Survey Vendor Effects ... 4-9

Quality Improvement References 4-10

5. Survey Instrument **5-1**

6. CD-ROM **6-1**

CD Contents 6-1

1. Executive Summary

The State of Colorado requires annual administration of client satisfaction surveys to Medicaid clients enrolled in the following plans: fee-for-service (FFS), Primary Care Physician Program (PCPP), Denver Health Medical Plan (DHMP), and Rocky Mountain Health Plan (RMHP). The Colorado Department of Health Care Policy & Financing (the Department) contracts with Health Services Advisory Group, Inc. (HSAG) to administer and report the results of the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Surveys.[1-1,1-2] The goal of the CAHPS Health Plan Surveys is to provide performance feedback that is actionable and that will aid in improving overall client satisfaction.

The standardized survey instrument selected was the CAHPS 4.0H Child Medicaid Health Plan Survey. The parents or caretakers of child clients from the health plans completed the surveys from February to May 2009.

Changes to the Child Survey

In November 2006, the Agency for Healthcare Research and Quality (AHRQ) released the CAHPS 4.0 Health Plan Surveys. Based on the CAHPS 4.0 versions, the National Committee for Quality Assurance (NCQA) introduced new Healthcare Effectiveness Data and Information Set (HEDIS®) versions of the Child Health Plan Survey in 2009, which are referred to as the CAHPS 4.0H Child Medicaid Health Plan Surveys.[1-3,1-4] The following is a summary of the changes resulting from the transition to the CAHPS 4.0H Child Medicaid Health Plan Survey.[1-5]

Composite Measures

Getting Needed Care

Changes were made to the response choices, question language, and number of questions for the Getting Needed Care composite measure. All response choices were revised from “A Big Problem,” “A Small Problem,” and “Not a Problem” to “Never,” “Sometimes,” “Usually,” and “Always.” Question language was changed in order to accommodate these new responses. Also, three questions were dropped from the composite that addressed two composite items: “Finding a Personal Doctor” and “Getting Plan Approval.” Due to these changes, the composite measure is not trendable for the Child Medicaid population.

[1-1] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).
[1-2] The DHMP CAHPS Child Medicaid Survey administration was performed by Synovate. The RMHP CAHPS Child Medicaid Survey administration was performed by CSS.
[1-3] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
[1-4] National Committee for Quality Assurance. *HEDIS® 2009, Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA Publication, 2008.
[1-5] National Committee for Quality Assurance. *HEDIS 2009 Survey Vendor Update Training*. October 23, 2008.

Getting Care Quickly

For the Getting Care Quickly composite measure, changes were made to the question language and number of questions included in the composite. Two questions were deleted that addressed the following items: "Taken to Exam Room Within 15 Minutes" and "Getting Help by Phone." Due to these changes, the composite measure is not trendable for the Child Medicaid population.

How Well Doctors Communicate

All items in the How Well Doctors Communicate composite were reworded to ask about experiences with "your child's personal doctor," where previously the items had asked about "your child's doctors or other health providers." The rewording is anticipated to have minimal impact on trending; therefore, a trend analysis was performed for the 2009 CAHPS 4.0H Child Medicaid Health Plan Survey.

Courteous and Helpful Office Staff

The Courteous and Helpful Office Staff composite was dropped upon implementation of the CAHPS 4.0H Health Plan Surveys. Due to this change, the composite measure is no longer reported for the Child Medicaid population.

Customer Service

Changes were made to the response choices, question language, and number of questions included in the Customer Service composite measure. All responses were revised from "A Big Problem," "A Small Problem," and "Not a Problem" to "Never," "Sometimes," "Usually," and "Always." Question language was changed in order to accommodate these new responses. One question was removed from the composite; however, an additional question item was added: "Being Treated with Courtesy and Respect." Due to these changes, the composite measure is not trendable for the Child Medicaid population.

Global Ratings

Rating of Health Plan

There were no changes made to the language or the placement of the question. The question is still in the section titled "Your Child's Health Plan." Negligible impact on trending is expected for this global rating; therefore, a trend analysis was performed for the 2009 CAHPS 4.0H Child Medicaid Health Plan Survey.

Rating of All Health Care

There were no changes made to the question language for this global rating; however, the item was moved from the section of the survey after "Your Child's Personal Doctor or Nurse" and "Getting Health Care From a Specialist" to the section titled "Your Child's Health Care in the Last 6 Months." Negligible impact on trending is expected due to this reordering; therefore, a trend analysis was performed for the 2009 CAHPS 4.0H Child Medicaid Health Plan Survey.

Rating of Personal Doctor

Changes were made to the question language for this global rating. Question language was changed to ask respondents to only rate their child's "personal doctor" instead of their child's "personal doctor or nurse." The question is in the section titled "Your Child's Personal Doctor." Minimal impact on trending is expected due to the changes in wording; therefore, a trend analysis was performed for the 2009 CAHPS 4.0H Child Medicaid Health Plan Survey.

Rating of Specialist Seen Most Often

A minor change was made to the question language for this global rating. The wording of the question changed from "the specialist" to "that specialist." The question is in the section titled "Getting Health Care From Specialists." Minimal impact on trending is expected due to the changes in wording; therefore, a trend analysis was performed for the 2009 CAHPS 4.0H Child Medicaid Health Plan Survey.

New Content Areas

One additional composite measure was added to the CAHPS 4.0H Child Medicaid Health Plan Survey: Shared Decision Making. The Shared Decision Making composite includes two questions that have response choices of "Definitely Yes," "Somewhat Yes," "Somewhat No," and "Definitely No."

Furthermore, two individual item measures were added for further analysis: Coordination of Care and Health Promotion and Education. Both items have responses of "Never," "Sometimes," "Usually," and "Always."

Performance Highlights

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

- NCQA Comparisons
- Trend Analysis
- Plan Comparisons

NCQA Comparisons

Overall client satisfaction ratings for four CAHPS global ratings (Rating of Health Plan, Rating of All Health Care, Rating of Personal Doctor, and Rating of Specialist Seen Most Often) and one composite measure (How Well Doctors Communicate) were compared to NCQA's National Distribution of 2008 Child Medicaid CAHPS Plan-level Results (which is referred to as NCQA national results throughout the rest of the document).[1-6,1-7,1-8] 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. The detailed results of this comparative analysis are described in the Results Section beginning on page 2-10. The following are highlights from this comparison:

- Colorado Medicaid FFS scored at or above the 80th percentile (i.e., ★★★★★) on two of the CAHPS measures: Rating of Personal Doctor and Rating of Specialist Seen Most Often.
- Colorado Medicaid PCPP scored at or above the 80th percentile on two of the CAHPS measures: Rating of Personal Doctor and How Well Doctors Communicate.
- RMHP scored at or above the 80th percentile on two of the CAHPS measures: Rating of Personal Doctor and How Well Doctors Communicate.
- Colorado Medicaid FFS scored below the 20th percentile (i.e., ★) on two of the CAHPS measures: Rating of Health Plan and Rating of All Health Care.
- DHMP scored below the 20th percentile on two of the CAHPS measures: Rating of Health Plan and Rating of All Health Care.
- RMHP scored below the 20th percentile on one of the CAHPS measures, Rating of All Health Care.

Trend Analysis

In order to evaluate trends in Colorado Medicaid client satisfaction, HSAG performed a stepwise trend analysis. The first step compared the 2009 CAHPS results to the 2008 CAHPS results. If the initial 2009 and 2008 trend analysis did not yield any significant differences, then an additional trend analysis was performed between 2009 and 2007 results. The detailed results of the trend analysis are described in the Results Section beginning on page 2-13. The following are the statistically significant results from this analysis:

[1-6] *NCQA National Distribution of 2008 Child Medicaid CAHPS Plan-level Results*. Prepared by NCQA for HSAG on November 17, 2008. NCQA does not publish NCQA Benchmarks and Thresholds for the Child Medicaid population. Therefore, star ratings are derived from a custom analysis performed annually by NCQA on behalf of HSAG. This custom analysis provided HSAG with the NCQA national results. This distribution is used to derive the star ratings.
[1-7] NCQA National Child Medicaid data for 2009 were not available at the time this report was prepared.
[1-8] Due to changes made from the CAHPS 3.0H Child Medicaid Health Plan Survey to the CAHPS 4.0H Child Medicaid Health Plan Survey, the Getting Needed Care, Getting Care Quickly, and Customer Service composites are not comparable to NCQA national results. In addition, the Shared Decision Making composite and Coordination of Care and Health Promotion and Education individual measures were added as first-year measures; therefore, national data do not exist.

- Colorado Medicaid scored significantly higher in 2009 than in 2008 on two CAHPS measures: Rating of Personal Doctor and How Well Doctors Communicate. Colorado Medicaid scored significantly lower in 2009 than in 2008 on one CAHPS measure, Rating of All Health Care.
- Colorado Medicaid FFS scored significantly higher in 2009 than in 2008 on two CAHPS measures: Rating of Personal Doctor and How Well Doctors Communicate. FFS scored significantly higher in 2009 than in 2007 on one CAHPS measure, Rating of Health Plan. FFS scored significantly lower in 2009 than in 2008 on one CAHPS measure, Rating of All Health Care.
- Colorado Medicaid PCPP scored significantly higher in 2009 than in 2008 on two CAHPS measures: Rating of Personal Doctor and How Well Doctors Communicate.
- DHMP scored significantly lower in 2009 than in 2007 on one CAHPS measure, Rating of All Health Care.
- RMHP scored significantly higher in 2009 than in 2007 on one CAHPS measure, How Well Doctors Communicate. RMHP scored significantly lower in 2009 than in 2007 on one CAHPS measure, Rating of All Health Care.

Plan Comparisons

In order to identify performance differences in client satisfaction between the Colorado Medicaid plans, the case-mix adjusted results for each plan were compared to one another using standard statistical tests.[1-9] These comparisons were performed on the four global ratings, five composite measures, and two individual item measures. The detailed results of the comparative analysis are described in the Results Section beginning on page 2-27. The following are the statistically significant results from this comparison:[1-10]

- Colorado Medicaid PCPP scored significantly higher than the Colorado Medicaid State average on two of the CAHPS measures: Rating of All Health Care and Getting Care Quickly.
- DHMP scored significantly lower than the Colorado Medicaid State average on two of the CAHPS measures: Rating of All Health Care and Getting Care Quickly.
- RMHP scored significantly higher than the Colorado Medicaid State average on two of the CAHPS measures: Getting Needed Care and Getting Care Quickly.

[1-9] CAHPS results are known to vary due to differences in client and respondent age, education level, and health status. Therefore, results were case-mix adjusted for differences in these demographic variables.

[1-10] Caution should be exercised when evaluating health plan comparisons, given that population and health plan differences may impact results.

2. Results

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

Survey Administration and Response Rates

Survey Administration

The standard NCQA HEDIS Specifications for Survey Measures require a sample size of 1,650 clients for the CAHPS 4.0H Child Medicaid Health Plan Survey.[2-1] Clients eligible for sampling included those who were enrolled in FFS, PCPP, DHMP, and RMHP 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 2008. Child clients eligible for sampling included those who were 17 years of age or younger as of December 31, 2008. DHMP and RMHP were responsible for conducting their annual CAHPS surveys. Synovate and the Center for the Study of Services (CSS) administered the CAHPS 4.0H Child Medicaid Health Plan Surveys for DHMP and RMHP, respectively. The specifications also permit oversampling in increments of 5 percent. No oversampling was performed on DHMP's child population. A total random sample of 1,650 child clients was selected from this plan. A 15 percent oversampling was performed on RMHP's child population. Based on this rate, a total random sample of 1,898 child clients was selected from this plan. For Colorado Medicaid FFS and PCPP, a 30 percent oversampling was performed on the child population. Based on this rate, a total random sample of 2,145 child clients was selected from each participating plan. The oversampling was performed to ensure a greater number of respondents to each CAHPS measure.

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

[2-1] National Committee for Quality Assurance. *HEDIS 2009*, *Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA Publication, 2008.

respondent.[2-2] Additional information on the survey protocol is included in the Reader's Guide Section beginning on page 4-3.

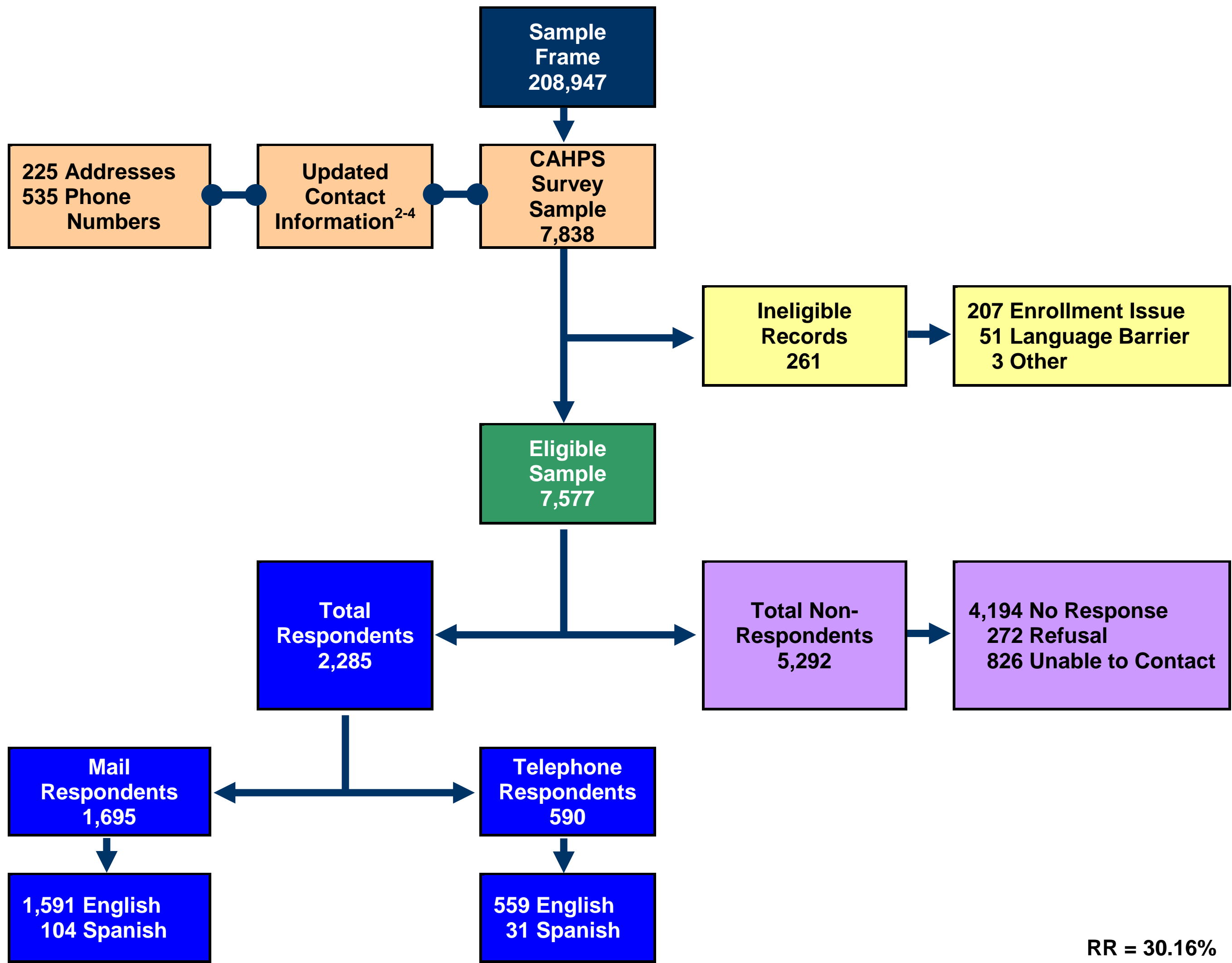
Response Rates

The Colorado CAHPS 4.0H Child Medicaid Health Plan Survey administration was designed to garner the highest possible response rate. The CAHPS Survey response rate is the total number of completed surveys divided by all eligible clients of the sample. A client's survey was assigned a disposition code of "completed" if at least one question was answered. Eligible clients included the 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), or had a language barrier.

A total of 2,285 completed surveys were returned on behalf of child clients, including 694 FFS, 721 PCPP, 335 DHMP, and 535 RMHP clients. Figure 2-1, on the following page, shows the distribution of survey dispositions and response rate (RR) for Colorado Medicaid (i.e., all four health plans combined). Figure 2-2 through Figure 2-5 show the individual distribution of survey dispositions and response rates for FFS, PCPP, DHMP, and RMHP, respectively. The Colorado Medicaid 2009 response rate of 30.16 percent was 4.16 percentage points higher than the national Child Medicaid response rate reported by NCQA for 2008, which was 26.00 percent.[2-3]

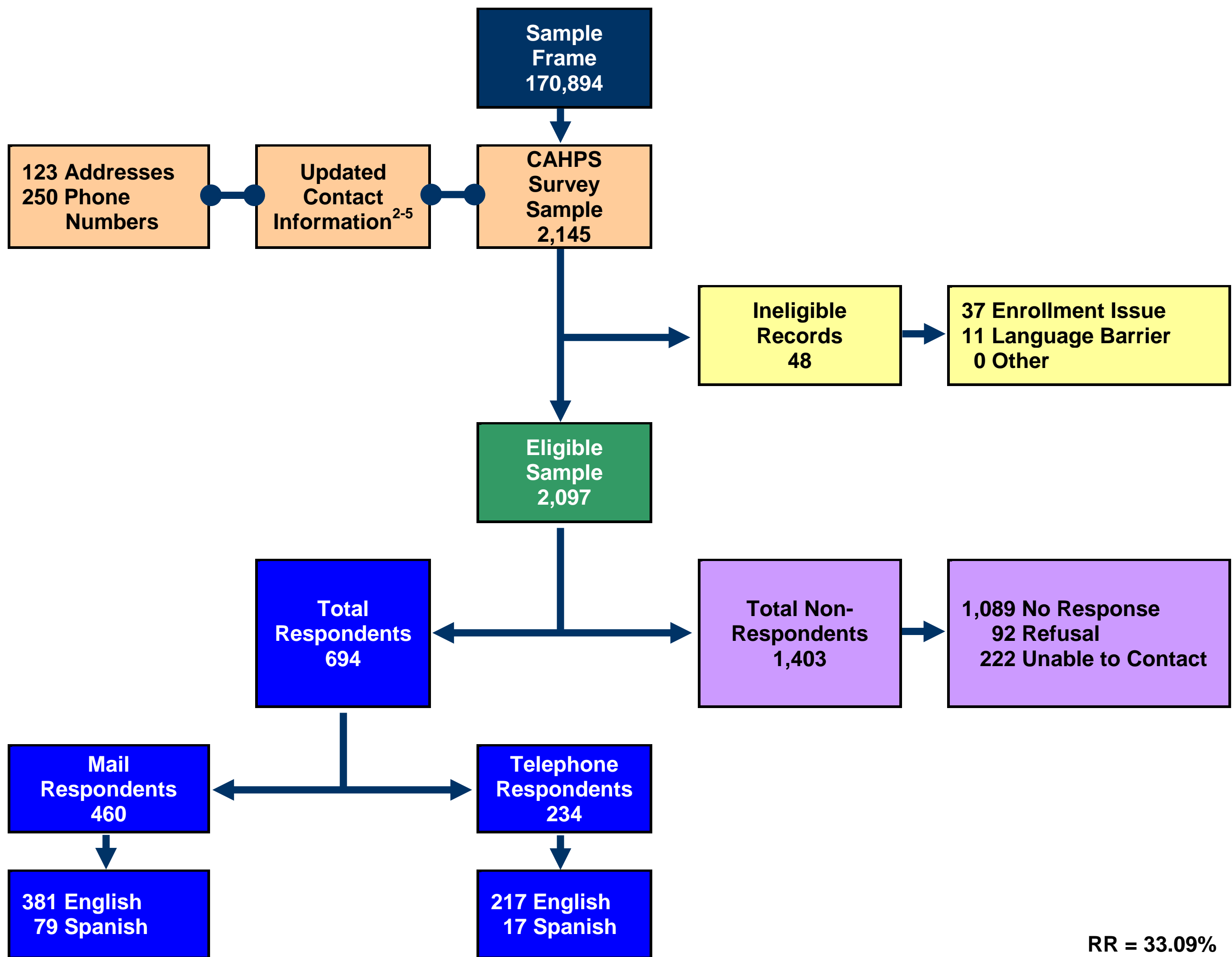
[2-2] National Committee for Quality Assurance. *Quality Assurance Plan for HEDIS 2009 Survey Measures.* Washington, DC: NCQA Publication, 2008.
[2-3] National Committee for Quality Assurance. *HEDIS 2009 Survey Vendor Update Training*. October 23, 2008.

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



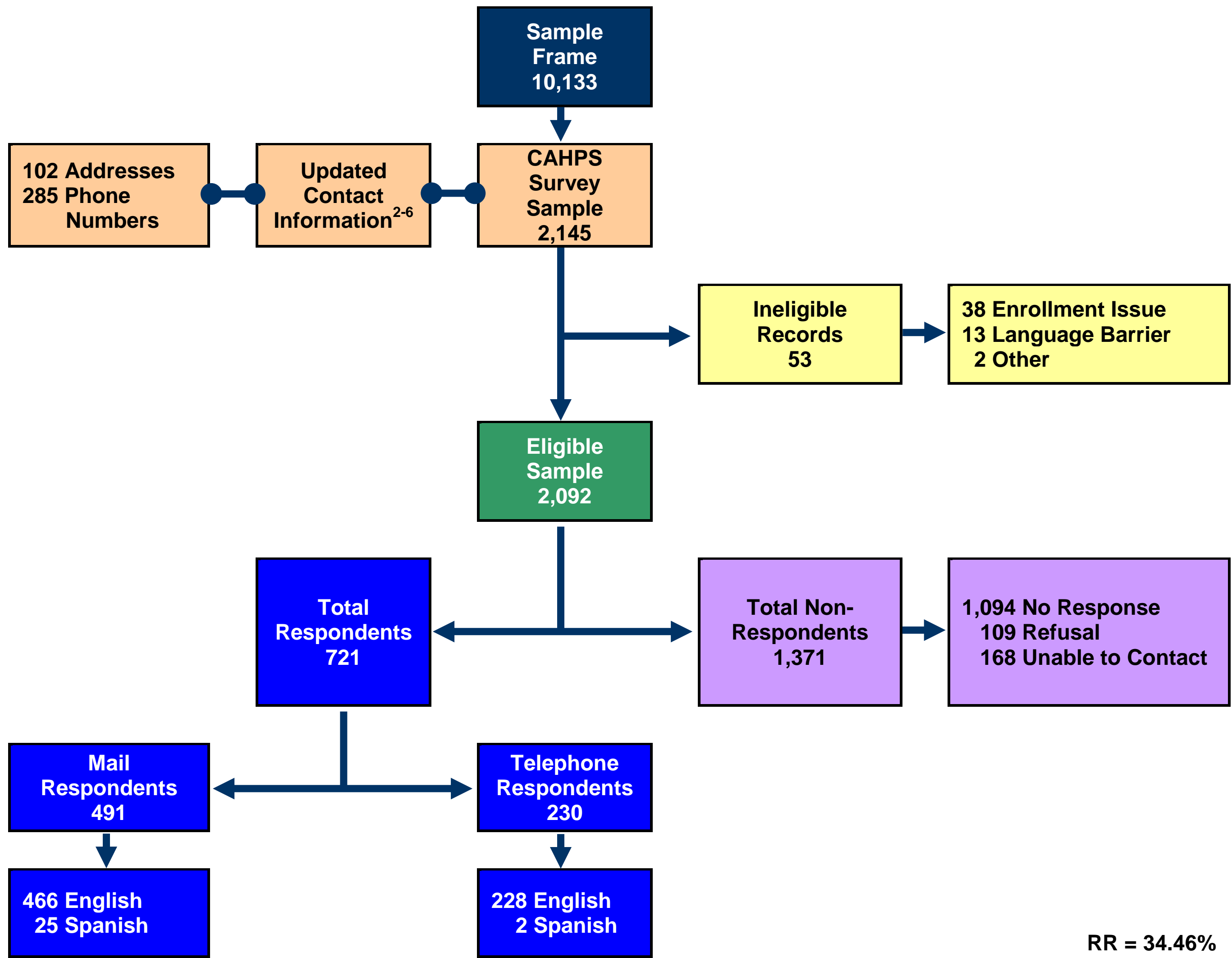
[2-4] Prior to survey administration, address and phone information is updated for clients of the CAHPS sample using the United State Postal Services' National Change of Address (NCOA) and Telematch databases. The number of updated addresses and telephone numbers is provided for informational purposes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

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



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

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



[2-6] Prior to survey administration, address and phone information is updated for clients of the CAHPS sample using the United State Postal Services' NCOA and Telematch databases. The number of updated addresses and telephone numbers is provided for informational purposes only and pertains to FFS and PCPP only. Per NCQA HEDIS Specifications, these clients are retained within the CAHPS Survey sample.

Figure 2-4—Distribution of Surveys for DHMP

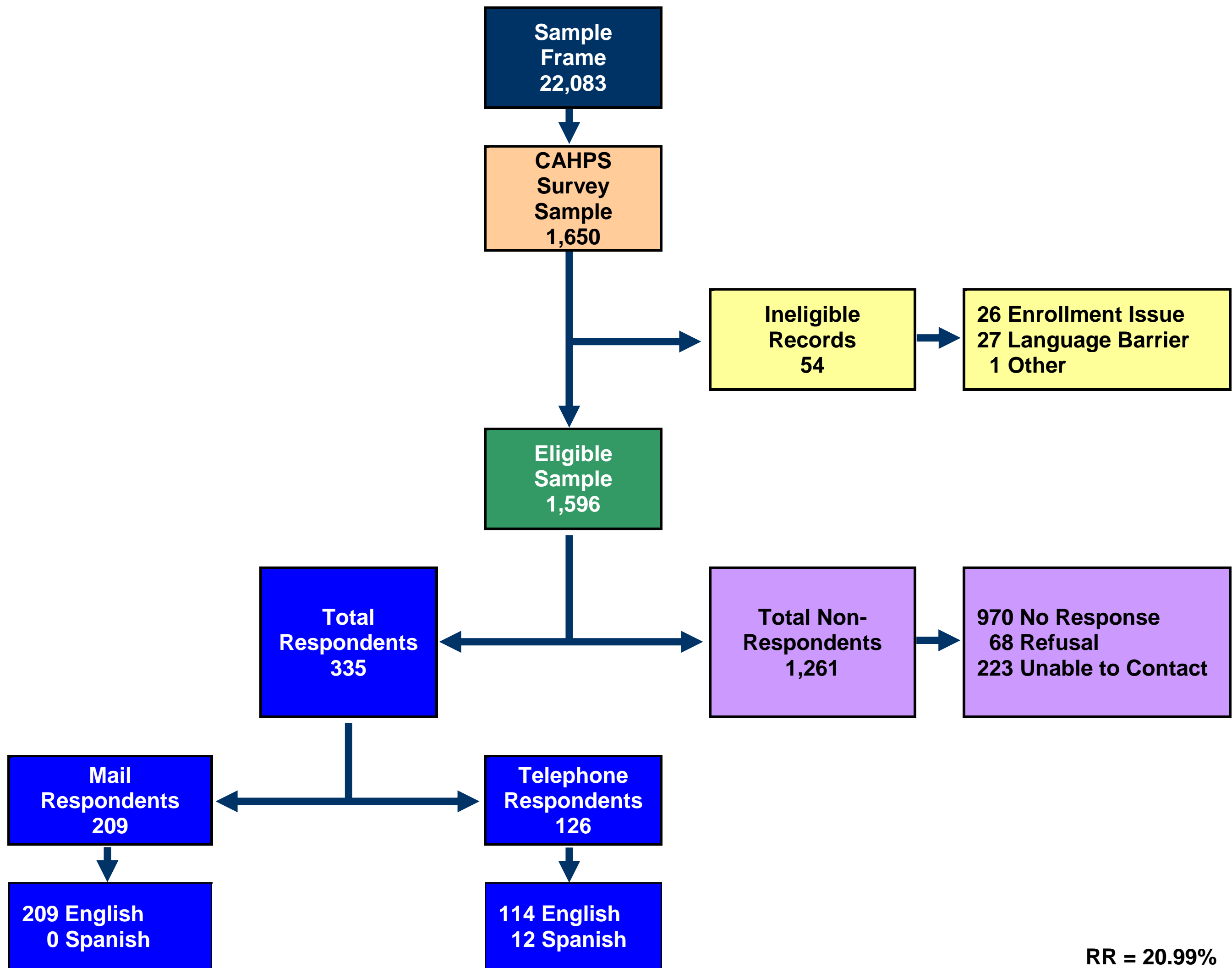
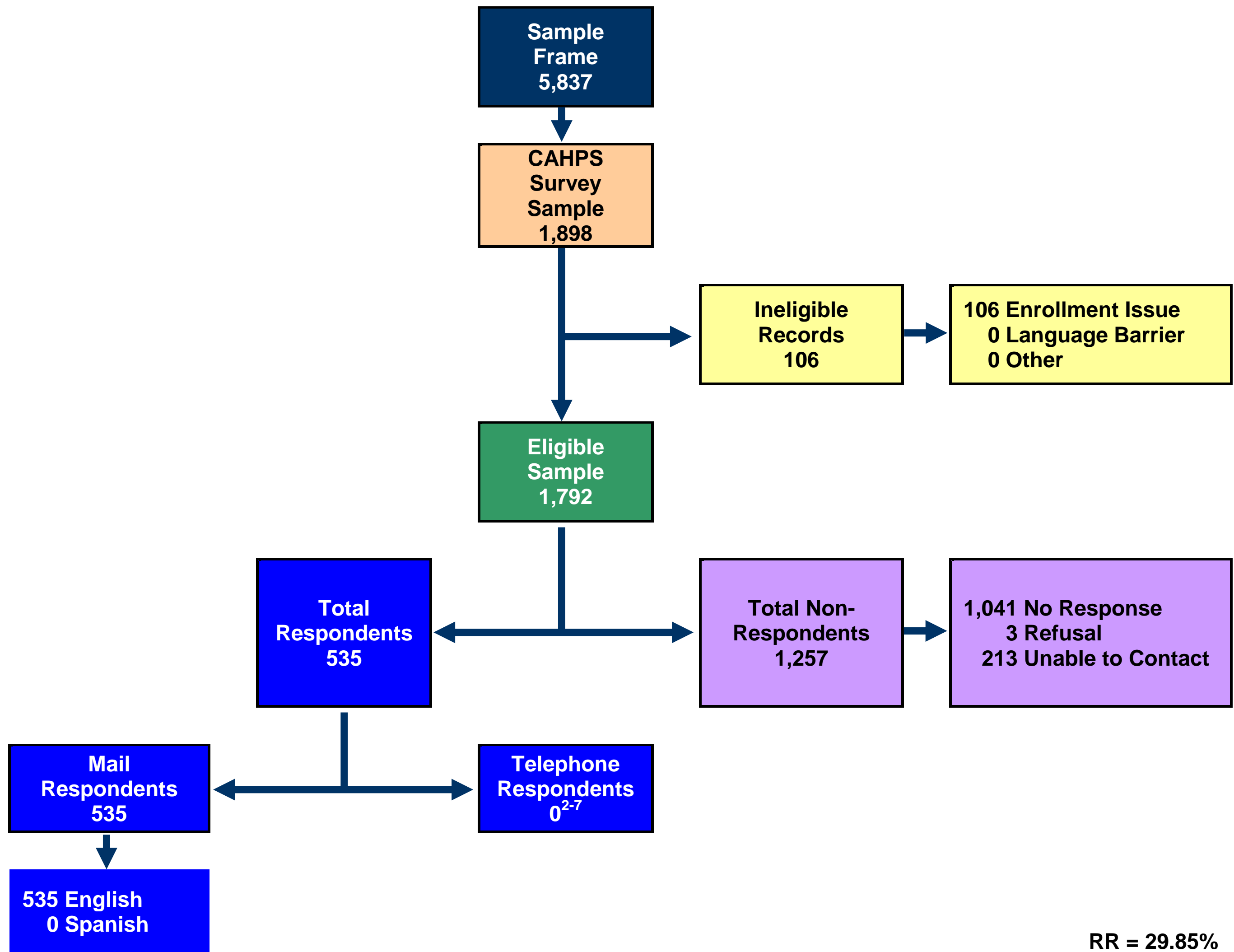


Figure 2-5—Distribution of Surveys for RMHP



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

Child and Respondent Demographics

In general, the demographics of a response group influence overall client satisfaction scores. For example, older and healthier respondents tend to report higher levels of client satisfaction; therefore, caution should be exercised when comparing populations that have significantly different demographic properties.[2-8]

Table 2-1 shows the demographic characteristics of children for whom a parent/caretaker completed a CAHPS 4.0H Child Medicaid Health Plan Survey.

Table 2-1
Child Demographics
Age, Gender, Race/Ethnicity, and General Health Status

	Colorado Medicaid[2-9]	Colorado Medicaid FFS	Colorado Medicaid PCPP	DHMP	RMHP
Age					
Less than 1	**3.6%**	7.1%	0.7%	2.9%	3.7%
1 to 3	**24.3%**	29.4%	16.5%	25.6%	27.7%
4 to 7	**23.2%**	24.8%	21.7%	19.9%	25.3%
8 to 12	**25.6%**	20.2%	33.8%	24.4%	22.2%
13 to 18	**23.2%**	18.5%	27.4%	27.2%	21.1%
Gender					
Male	**52.3%**	50.4%	53.6%	48.6%	55.2%
Female	**47.7%**	49.6%	46.4%	51.4%	44.8%
Race/Ethnicity					
Multi-Racial	**12.6%**	16.2%	15.1%	9.6%	6.7%
White	**50.7%**	53.0%	45.3%	19.2%	72.6%
Black	**7.0%**	5.2%	9.7%	14.9%	1.2%
Asian	**3.2%**	2.9%	4.8%	4.3%	0.8%
Other	**26.5%**	22.6%	25.2%	52.0%	18.7%
General Health Status					
Excellent	**36.1%**	38.5%	34.1%	37.5%	35.0%
Very Good	**38.1%**	39.2%	36.5%	29.0%	44.4%
Good	**20.3%**	17.4%	21.2%	30.3%	16.6%
Fair	**4.9%**	4.8%	6.7%	3.2%	3.8%
Poor	**0.5%**	0.1%	1.4%	0.0%	0.2%

Please note: Percentages may not total 100% due to rounding. Children are eligible for inclusion in CAHPS if they are age 17 or younger as of December 31, 2008. Some children eligible for the CAHPS Survey turned age 18 between January 1, 2009, and the time of survey administration.

[2-8] Agency for Healthcare Research and Quality. *CAHPS Health Plan Survey and Reporting Kit 2008*. Rockville, MD: US Department of Health and Human Services, July 2008.
[2-9] Colorado Medicaid includes the combined demographics of FFS, PCPP, DHMP, and RMHP.

Table 2-2 shows the self-reported age, level of education, and relationship to the child for the respondents who completed the CAHPS 4.0H Child Medicaid Health Plan Survey.

Table 2-2
Respondent Demographics
Age, Education, and Relationship to Child

	Colorado Medicaid	Colorado Medicaid FFS	Colorado Medicaid PCPP	DHMP	RMHP
Respondent Age					
Under 18	**11.8%**	9.1%	10.7%	18.2%	12.7%
18 to 24	**7.6%**	7.9%	5.0%	6.0%	11.6%
25 to 34	**25.7%**	27.8%	21.8%	17.9%	33.1%
35 to 44	**25.2%**	26.9%	25.8%	29.0%	19.8%
45 to 54	**16.1%**	15.0%	17.9%	19.4%	13.1%
55 to 64	**8.6%**	8.2%	11.2%	6.9%	6.5%
65 or Older	**5.1%**	5.0%	7.6%	2.7%	3.2%
Respondent Education					
8th Grade or Less	**7.1%**	4.8%	5.2%	17.2%	6.7%
Some High School	**16.3%**	16.1%	16.8%	25.7%	10.4%
High School Graduate	**31.3%**	28.8%	29.8%	28.1%	38.4%
Some College	**33.2%**	35.1%	37.6%	20.5%	32.4%
College Graduate	**12.1%**	15.1%	10.7%	8.6%	12.1%
Relationship to Child					
Mother or Father	**85.2%**	85.6%	80.9%	87.9%	88.9%
Grandparent	**10.0%**	8.6%	14.1%	8.3%	7.4%
Legal Guardian	**3.2%**	4.5%	3.3%	2.5%	2.0%
Other	**1.5%**	1.4%	1.7%	1.3%	1.8%

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

NCQA Comparisons

In order to assess the overall performance of the Colorado Medicaid plans, each CAHPS measure was scored on a three-point scale using the scoring methodology detailed in NCQA's HEDIS Specifications for Survey Measures.[2-10] The resulting three-point mean scores were compared to 2008 NCQA national results.[2-11,2-12] Based on this comparison, plan ratings of one (★) to five (★★★★★) stars were determined for each CAHPS measure, where one is the lowest possible rating and five is the highest possible rating.

★★★★★	indicates a score at or above the 80th percentile
★★★★	indicates a score between the 60th and 79th percentiles
★★★	indicates a score between the 40th and 59th percentiles
★★	indicates a score between the 20th and 39th percentiles
★	indicates a score below the 20th percentile
NA	indicates that the health plan did not meet the minimum NCQA reporting threshold of 100 respondents

[2-10] National Committee for Quality Assurance. *HEDIS® 2009*, *Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA Publication, 2008.
[2-11] *NCQA National Distribution of 2008 Child Medicaid CAHPS Plan-level Results*. Prepared by NCQA for HSAG on November 17, 2008. NCQA does not publish NCQA Benchmarks and Thresholds for the Child Medicaid population. Therefore, star ratings are derived from a custom analysis performed annually by NCQA on behalf of HSAG. This custom analysis provided HSAG with the NCQA national results. This distribution is used to derive the star ratings.
[2-12] NCQA National Child Medicaid data for 2009 were not available at the time this report was prepared.

Table 2-3 shows the plans' three-point mean scores and overall client satisfaction ratings on each of the four global ratings and one composite measure. Due to changes made from the CAHPS 3.0H Child Medicaid Health Plan Survey to the CAHPS 4.0H Child Medicaid Health Plan Survey, the Getting Needed Care, Getting Care Quickly, and Customer Service composites are not comparable to NCQA national results. In addition, the Shared Decision Making composite and Coordination of Care and Health Promotion and Education individual measures were added as first-year measures; therefore, national data do not exist.

Table 2-3
NCQA Comparisons
Overall Client Satisfaction Ratings

	Colorado Medicaid FFS	Colorado Medicaid PCPP	DHMP	RMHP
Global Rating				
Rating of Personal Doctor	★★★★★ 2.599	★★★★★ 2.643	★★ 2.521	★★★★★ 2.620
Rating of Specialist Seen Most Often	★★★★★ 2.587	★★★ 2.529	NA NA	NA NA
Rating of All Health Care	★ 2.435	★★★ 2.560	★ 2.294	★ 2.480
Rating of Health Plan	★ 2.436	★★★ 2.499	★ 2.406	★★★★ 2.559
Composite Measure				
How Well Doctors Communicate	★★★★ 2.628	★★★★★ 2.694	★★ 2.551	★★★★★ 2.709

Please note: A minimum of 100 responses to each measure is required in order to report the measure as a CAHPS Survey Result. Measures that do not meet the minimum number of responses are denoted as Not Applicable (NA).

Summary of NCQA Comparison Results

The NCQA comparisons revealed the following summary results:

- Colorado Medicaid FFS scored at or above the 80th percentile nationally on two of the CAHPS measures: Rating of Personal Doctor and Rating of Specialist Seen Most Often. For How Well Doctors Communicate, FFS scored between the 60th and 79th percentiles.
- Colorado Medicaid PCPP scored at or above the 80th percentile nationally on two of the CAHPS measures: Rating of Personal Doctor and How Well Doctors Communicate.
- RMHP scored at or above the 80th percentile nationally on two of the CAHPS measures: Rating of Personal Doctor and How Well Doctors Communicate. For Rating of Health Plan, RMHP scored between the 60th and 79th percentiles.
- Colorado Medicaid FFS scored below the 20th percentile nationally on two of the CAHPS measures: Rating of Health Plan and Rating of All Health Care.
- DHMP scored between the 20th and 39th percentiles nationally on two of the CAHPS measures: Rating of Personal Doctor and How Well Doctors Communicate. In addition, DHMP scored below the 20th percentile on two of the CAHPS measures: Rating of Health Plan and Rating of All Health Care.
- RMHP scored below the 20th percentile nationally on one CAHPS measure, Rating of All Health Care.

Trend Analysis

In 2007, the Colorado Medicaid FFS, PCPP, DHMP, and RMHP had 354, 432, 287, and 479 completed CAHPS Child Medicaid Health Plan Surveys, respectively. In 2008, the Colorado Medicaid FFS, PCPP, and DHMP had 548, 521, and 308 completed CAHPS Child Medicaid Health Plan Surveys, respectively. These completed surveys were used to calculate the 2008 and 2007 CAHPS results presented in this section for trending purposes.[2-13] RMHP did not conduct a CAHPS 3.0H Child Medicaid Health Plan Survey in 2008; therefore, trending could not be performed for RMHP's scores between 2009 and 2008.

For purposes of the trend analysis, question summary rates were calculated for each global rating and individual item measure, and global proportions were calculated for each composite measure. Both the question summary rates and global proportions were calculated in accordance with NCQA HEDIS Specifications for Survey Measures.[2-14] The scoring of the global ratings, composite measures, and individual item measures involved assigning top-level responses a score of one, with all other responses receiving a score of zero. After applying this scoring methodology, the percentage of top-level responses was calculated in order to determine the question summary rates and global proportions. For additional detail, please refer to the *NCQA HEDIS Specifications for Survey Measures*, *Volume 3*.

In order to evaluate trends in Colorado Medicaid client satisfaction, HSAG performed a stepwise three-year trend analysis. The first step compared the 2009 Colorado Medicaid and plan-level CAHPS scores to the corresponding 2008 scores. If the initial 2009 and 2008 trend analysis did not yield any statistically significant differences, then an additional trend analysis was performed between 2009 and 2007 results. Figure 2-6 through Figure 2-16 show the results of this trend analysis. Statistically significant differences are noted with directional triangles. Scores that were statistically higher in 2009 than in 2008 are noted with black upward (▲) triangles. Scores that were statistically lower in 2009 than in 2008 are noted with black downward (▼) triangles. Scores that were statistically higher in 2009 than in 2007 are noted with red upward (▲) triangles. Scores that were statistically lower in 2009 than in 2007 are noted with red downward (▼) triangles. Scores in 2009 that were not statistically different from scores in 2008 or in 2007 are not noted with triangles. Please note, a minimum of 100 responses to each CAHPS measure is required in order to report the measure as a CAHPS Survey result. Measures that do not meet the minimum number of responses are denoted as Not Applicable (NA).

[2-13] For detailed information on the 2007 and 2008 FFS and PCPP CAHPS results, please refer to the 2007 and 2008 Child Medicaid Client Satisfaction Reports.

[2-14] National Committee for Quality Assurance. *HEDIS 2009, Volume 3: Specifications for Survey Measures*. Washington, DC: NCQA Publication, 2008.

Due to the changes made from the CAHPS 3.0H Child Medicaid Health Plan Survey to the CAHPS 4.0H Child Medicaid Health Plan Survey, the following composites were not trendable:

- Getting Needed Care
- Getting Care Quickly
- Customer Service

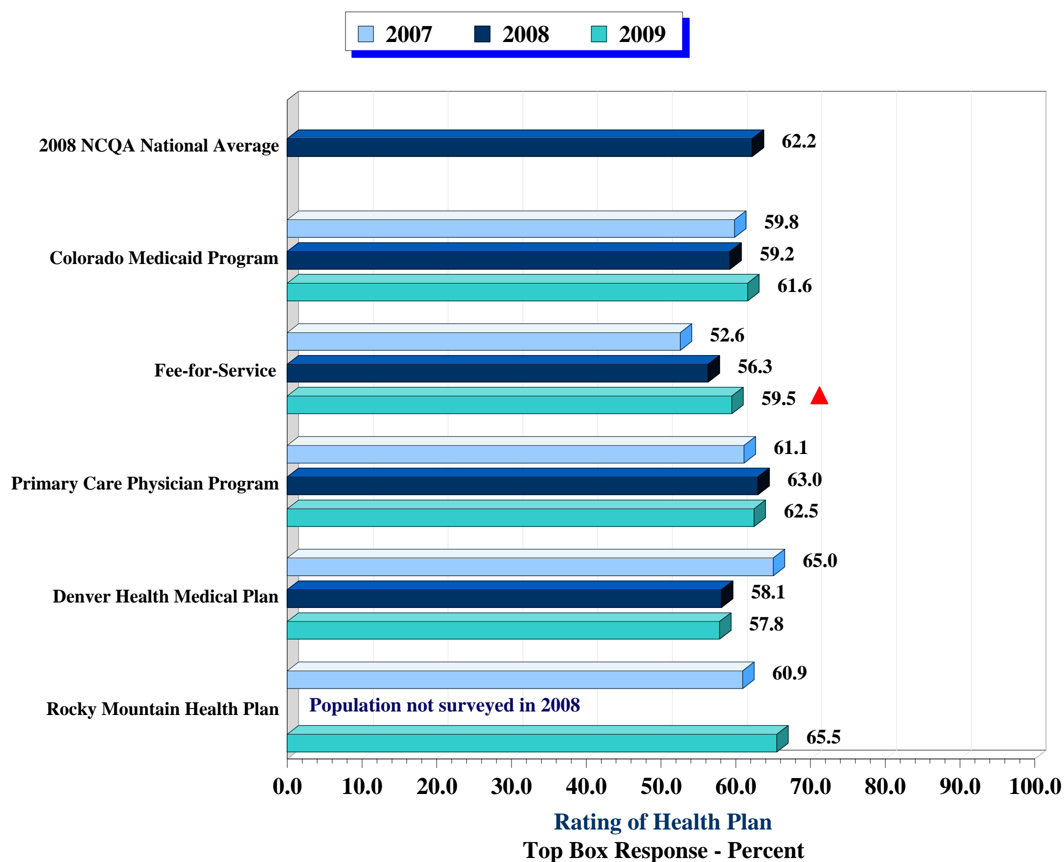
In addition, Shared Decision Making, Coordination of Care, and Health Promotion and Education are first-year measures for the CAHPS 4.0H Child Medicaid Health Plan Survey; therefore, these measures were also not trendable.

Global Ratings

Rating of Health Plan

Colorado Medicaid parents/caretakers of child clients were asked to rate their child's health plan on a scale of 0 to 10, with 0 being the "worst health plan possible" and 10 being the "best health plan possible." Top-level responses were defined as those responses with a rating of 9 or 10. Figure 2-6 shows the 2007, 2008, and 2009 Rating of Health Plan question summary rates for Colorado Medicaid, FFS, PCPP, DHMP, and RMHP.[2-15,2-16,2-17]

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



Statistical Significance Note:
- ▲ indicates the 2009 score is significantly higher than 2008
- ▼ indicates the 2009 score is significantly lower than 2008
- ▲ (red) indicates the 2009 score is significantly higher than 2007
- ▼ (red) indicates the 2009 score is significantly lower than 2007

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

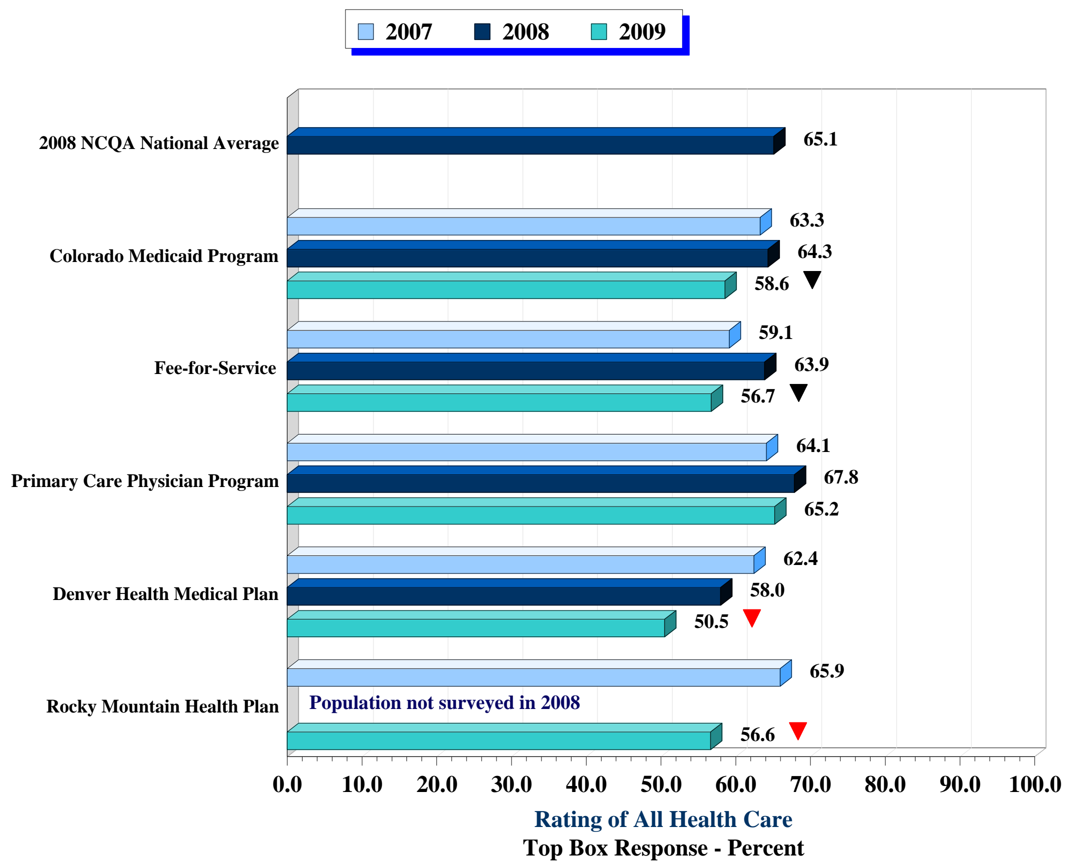
[2-16] RMHP did not administer the Child Medicaid Survey in 2008; therefore, 2008 results for RMHP are not presented.

[2-17] NCQA national averages were not available for 2009 at the time this report was prepared; therefore, 2008 NCQA national averages are presented in this section.

Rating of All Health Care

Colorado Medicaid parents/caretakers of child clients were asked to rate all their child's health care on a scale of 0 to 10, with 0 being the "worst health care possible" and 10 being the "best health care possible." Top-level responses were defined as those responses with a rating of 9 or 10. Figure 2-7 shows the 2007, 2008, and 2009 Rating of All Health Care question summary rates for Colorado Medicaid, FFS, PCPP, DHMP, and RMHP.

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

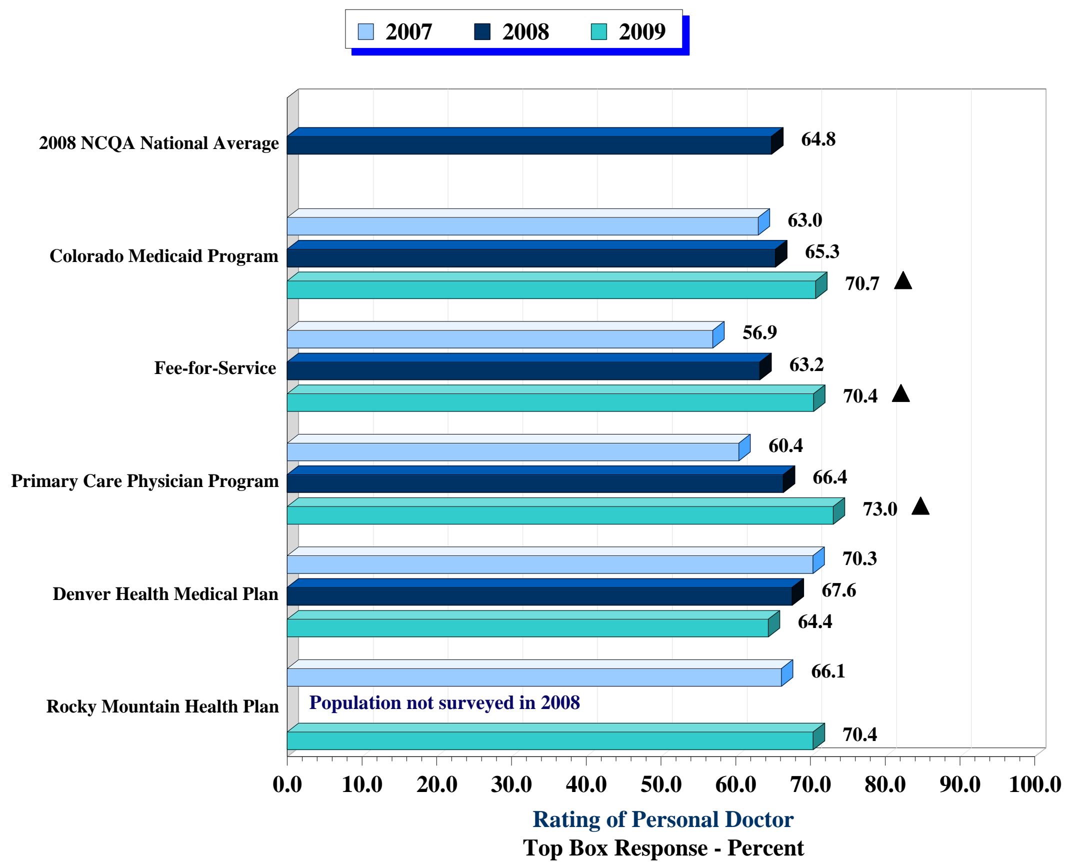


Statistical Significance Note:
▲ indicates the 2009 score is significantly higher than 2008
▼ indicates the 2009 score is significantly lower than 2008
▲ indicates the 2009 score is significantly higher than 2007
▼ indicates the 2009 score is significantly lower than 2007

Rating of Personal Doctor

Colorado Medicaid parents/caretakers of child clients were asked to rate their child's personal doctor on a scale of 0 to 10, with 0 being the "worst personal doctor possible" and 10 being the "best personal doctor possible." Top-level responses were defined as those responses with a rating of 9 or 10. Figure 2-8 shows the 2007, 2008, and 2009 Rating of Personal Doctor question summary rates for Colorado Medicaid, FFS, PCPP, DHMP, and RMHP.

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

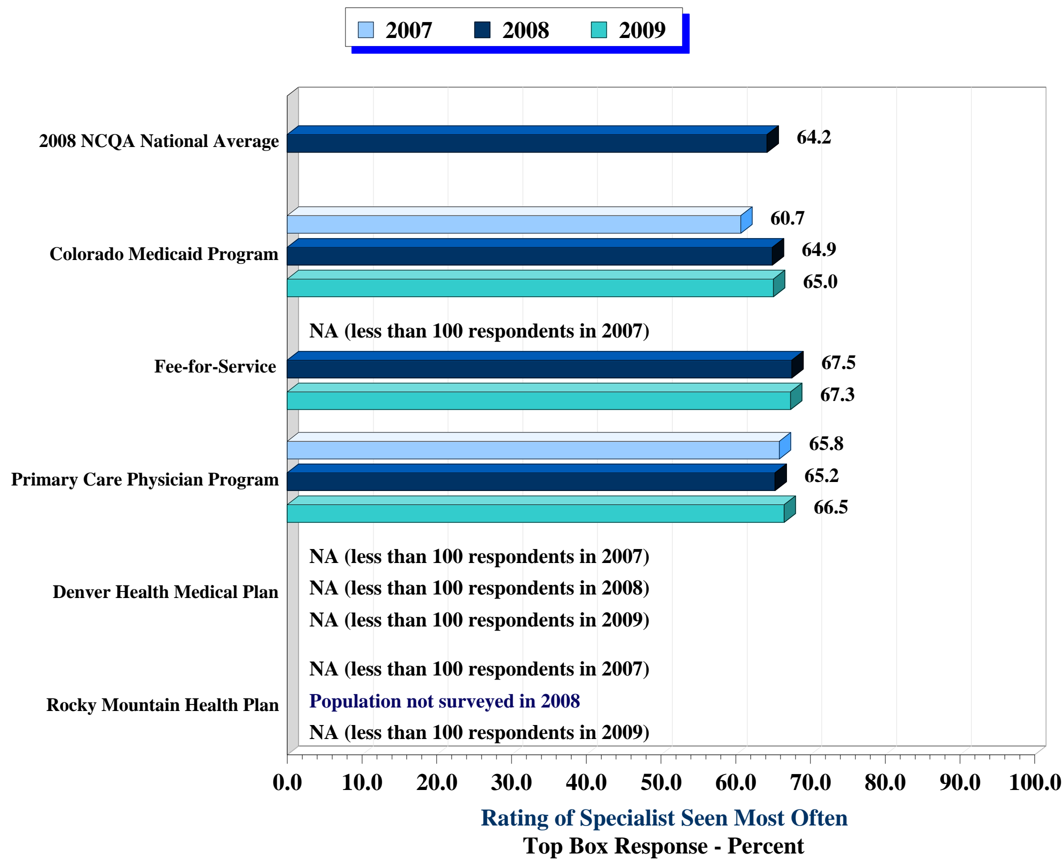


Statistical Significance Note: ▲ indicates the 2009 score is significantly higher than 2008
▼ indicates the 2009 score is significantly lower than 2008
▲ indicates the 2009 score is significantly higher than 2007
▼ indicates the 2009 score is significantly lower than 2007

Rating of Specialist Seen Most Often

Colorado Medicaid parents/caretakers of child clients were asked to rate the specialist their child saw most often on a scale of 0 to 10, with 0 being the "worst specialist possible" and 10 being the "best specialist possible." Top-level responses were defined as those responses with a rating of 9 or 10. Figure 2-9 shows the 2007, 2008, and 2009 Rating of Specialist Seen Most Often question summary rates for Colorado Medicaid, FFS, PCPP, DHMP, and RMHP.

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



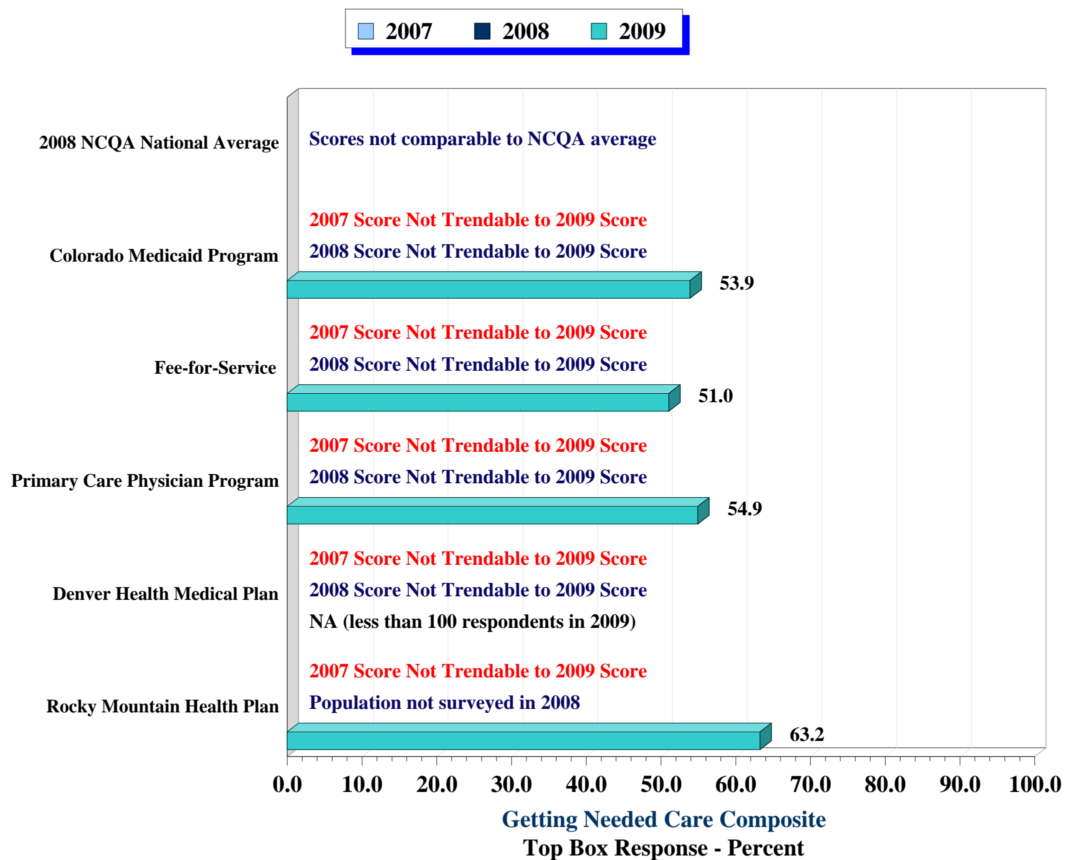
Statistical Significance Note:
▲ indicates the 2009 score is significantly higher than 2008
▼ indicates the 2009 score is significantly lower than 2008
▲ indicates the 2009 score is significantly higher than 2007
▼ indicates the 2009 score is significantly lower than 2007

Composite Measures

Getting Needed Care

Colorado Medicaid parents/caretakers of child clients were asked two questions to assess how often it was easy to get needed care for their child. For each of these questions (Questions 26 and 30), a top-level response was defined as a response of "Always." Figure 2-10 shows the 2009 Getting Needed Care global proportions for Colorado Medicaid, FFS, PCPP, DHMP, and RMHP.

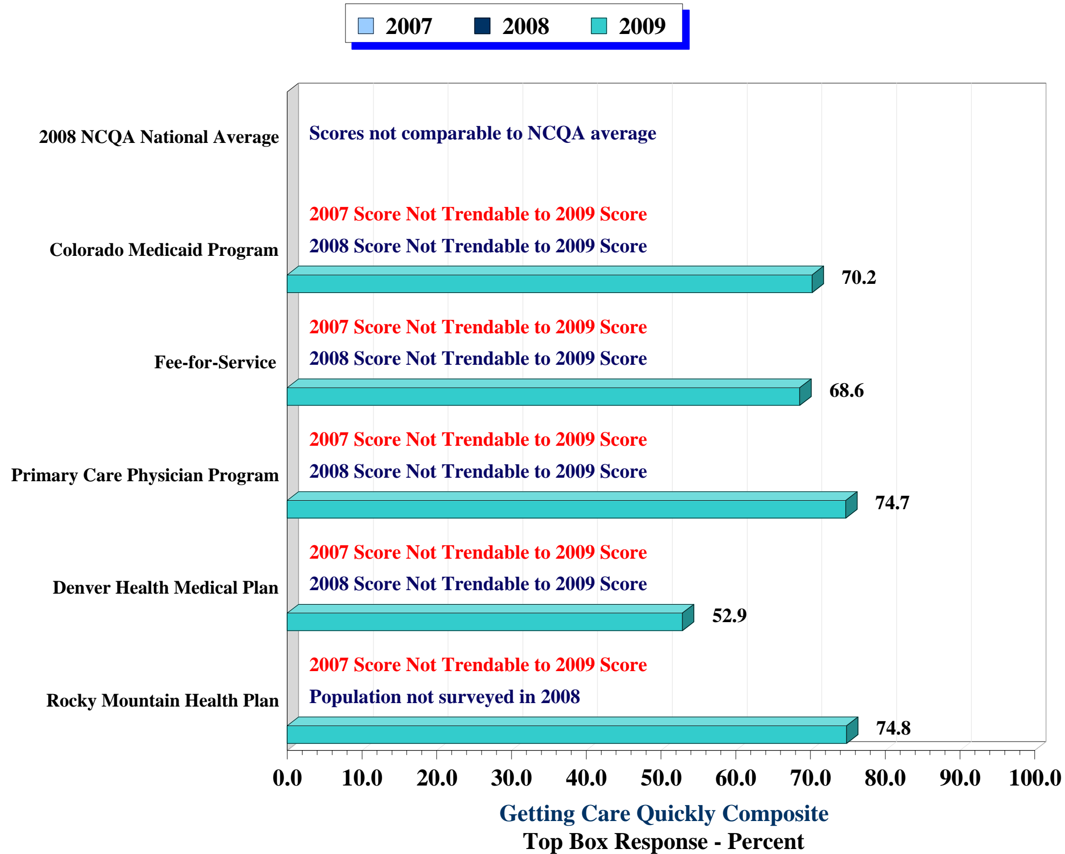
Figure 2-10—Trend Analysis: Getting Needed Care



Getting Care Quickly

Colorado Medicaid parents/caretakers of child clients were asked two questions to assess how often their child received care quickly. For each of these questions (Questions 4 and 6), a top-level response was defined as a response of "Always." Figure 2-11 shows the 2009 Getting Care Quickly global proportions for Colorado Medicaid, FFS, PCPP, DHMP, and RMHP.

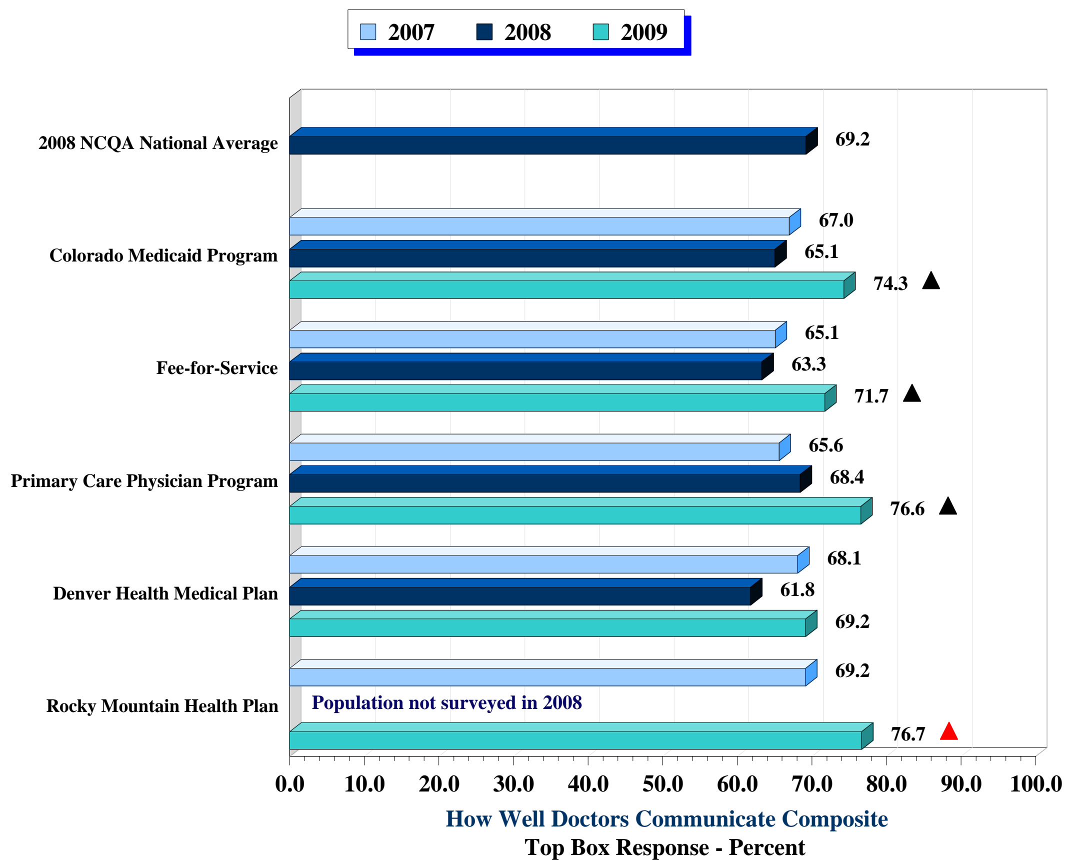
Figure 2-11—Trend Analysis: Getting Care Quickly



How Well Doctors Communicate

Colorado Medicaid parents/caretakers of child clients were asked four questions to assess how often their child's doctors communicated well. For each of these questions (Questions 15, 16, 17, and 20), a top-level response was defined as a response of "Always." Figure 2-12 shows the 2007, 2008, and 2009 How Well Doctors Communicate global proportions for Colorado Medicaid, FFS, PCPP, DHMP, and RMHP.

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

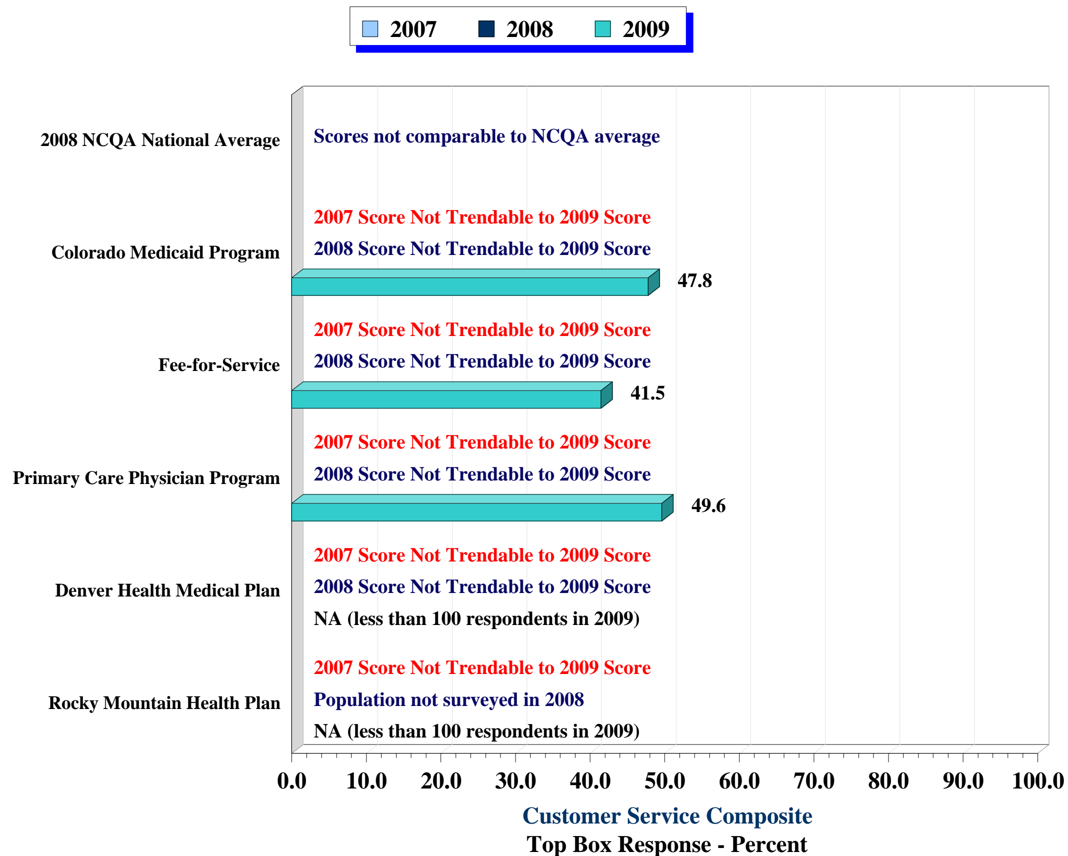


Statistical Significance Note: ▲ indicates the 2009 score is significantly higher than 2008
▼ indicates the 2009 score is significantly lower than 2008
▲ (red) indicates the 2009 score is significantly higher than 2007
▼ (red) indicates the 2009 score is significantly lower than 2007

Customer Service

Colorado Medicaid parents/caretakers of child clients were asked two questions to assess how often they obtained needed help/information from customer service. For each of these questions (Questions 32 and 33), a top-level response was defined as a response of "Always." Figure 2-13 shows the 2009 Customer Service global proportions for Colorado Medicaid, FFS, PCPP, DHMP, and RMHP.

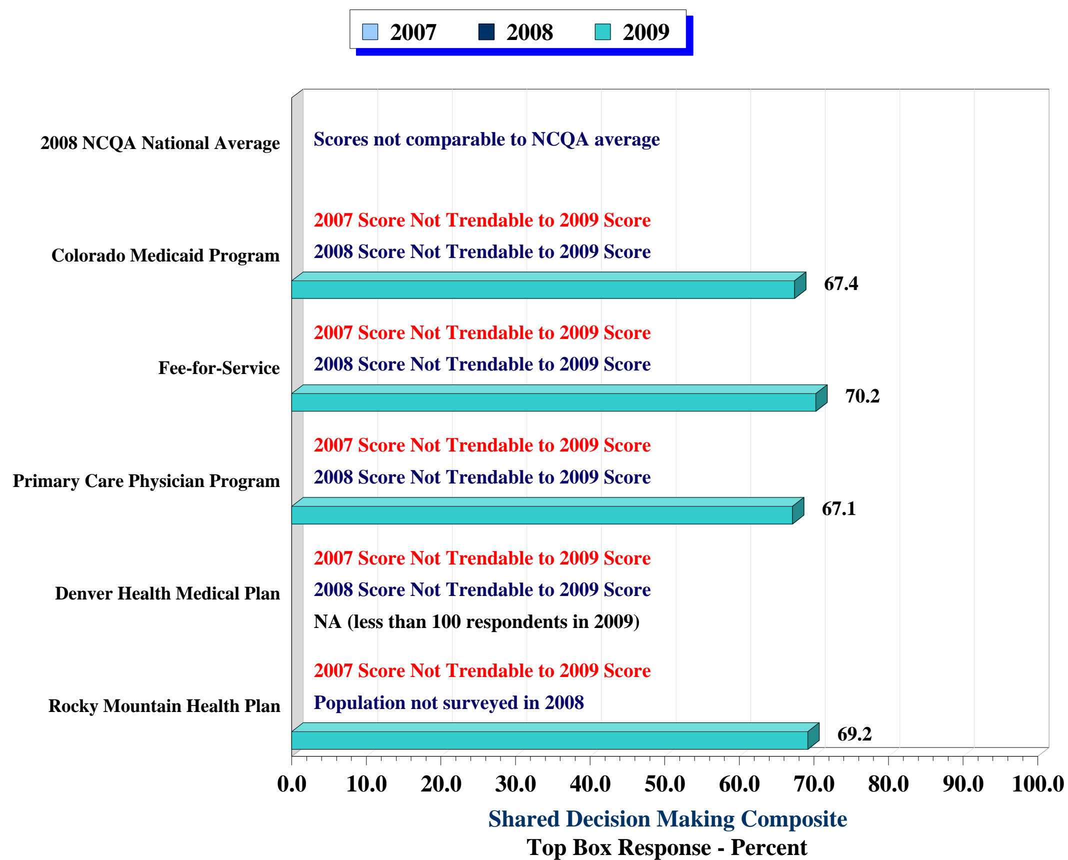
Figure 2-13—Trend Analysis: Customer Service



Shared Decision Making

Colorado Medicaid parents/caretakers of child clients were asked two questions to assess if their child's doctors discussed treatment choices with them. For each of these questions (Questions 10 and 11), a top-level response was defined as a response of "Definitely Yes." Figure 2-14 shows the 2009 Shared Decision Making global proportions for Colorado Medicaid, FFS, PCPP, DHMP, and RMHP.

Figure 2-14—Trend Analysis: Shared Decision Making

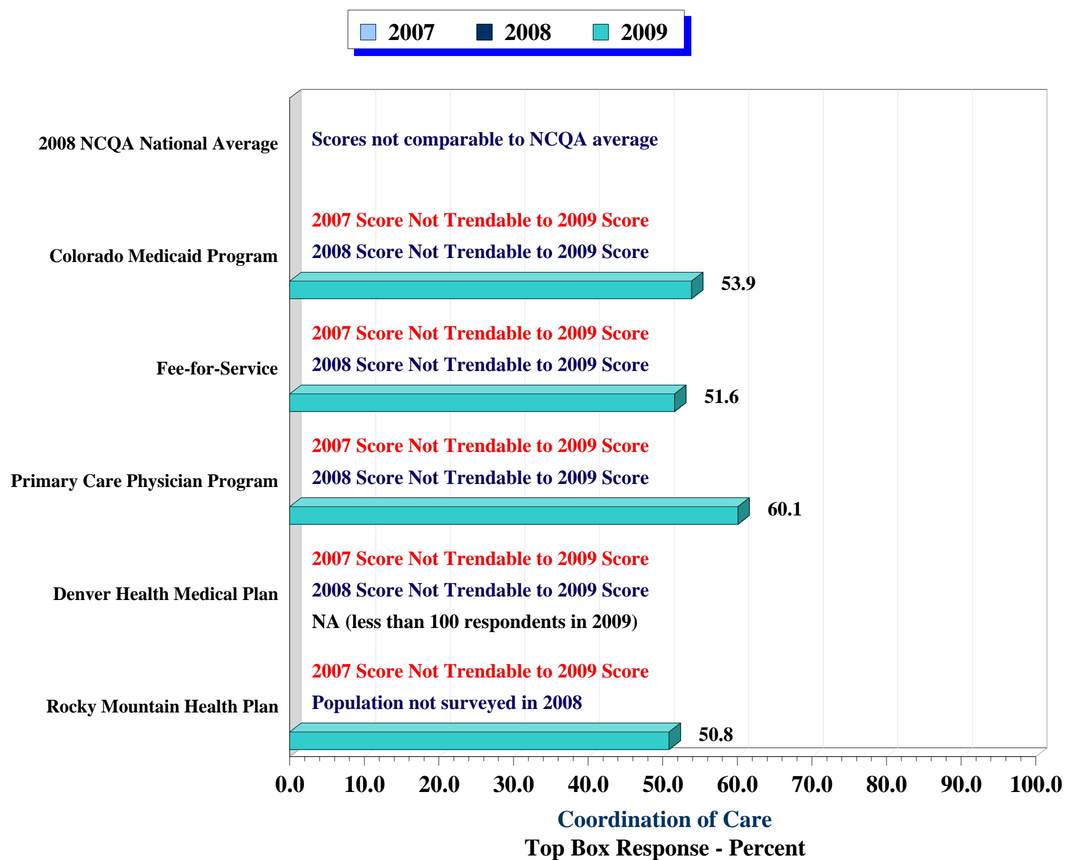


Individual Item Measures

Coordination of Care

Colorado Medicaid parents/caretakers of child clients were asked a question to assess how often their child's personal doctor seemed informed and up-to-date about care their child had received from another doctor. For this question (Question 23), a top-level response was defined as a response of "Always." Figure 2-15 shows the 2009 Coordination of Care question summary rates for Colorado Medicaid, FFS, PCPP, DHMP, and RMHP.

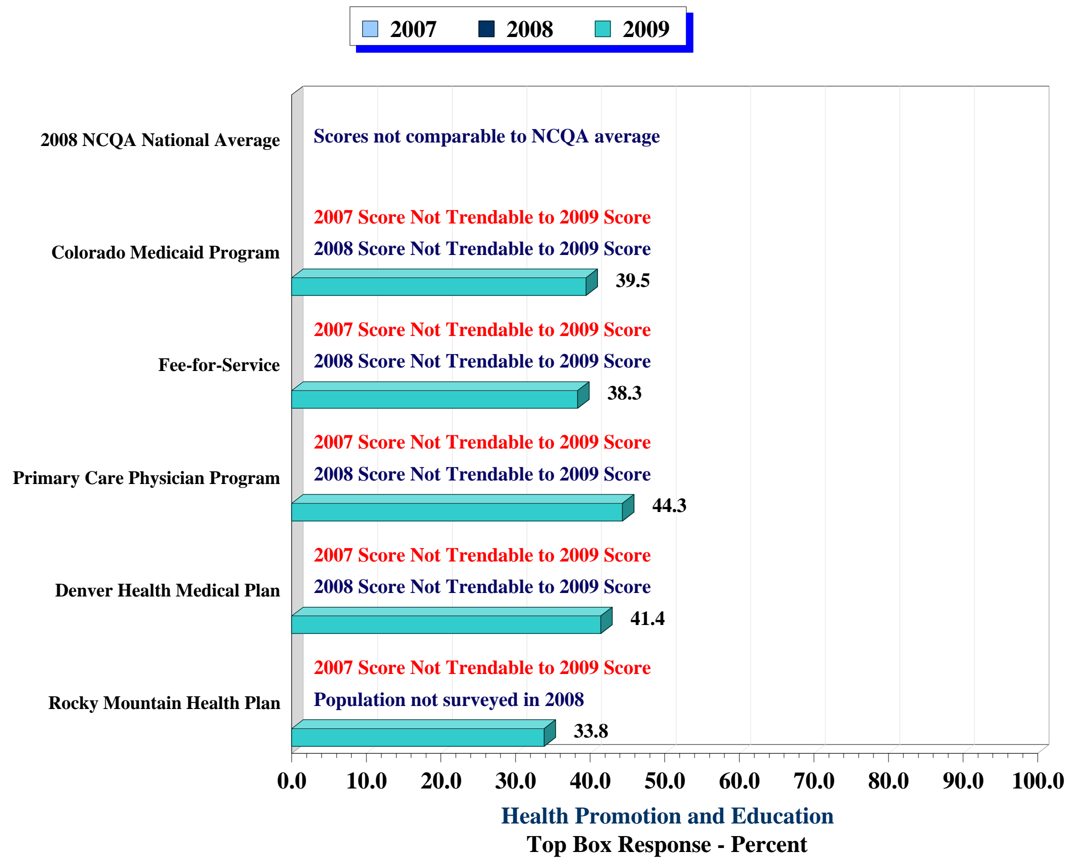
Figure 2-15—Trend Analysis: Coordination of Care



Health Promotion and Education

Colorado Medicaid parents/caretakers of child clients were asked a question to assess how often their child's doctor talked with them about specific things they could do to prevent illness in their child. For this question (Question 8), a top-level response was defined as a response of "Always." Figure 2-16 shows the 2009 Health Promotion and Education question summary rates for Colorado Medicaid, FFS, PCPP, DHMP, and RMHP.

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



Summary of Trend Analysis Results

The trend analysis revealed the following summary results. The references to significant differences below refer to statistically significant differences between either: 1) 2009 and 2008 CAHPS results or 2) 2009 and 2007 CAHPS results.

- The following CAHPS measures were not trendable: Getting Needed Care, Getting Care Quickly, Customer Service, Shared Decision Making, Coordination of Care, and Health Promotion and Education.
- Colorado Medicaid scored significantly higher in 2009 than in 2008 on two CAHPS measures: Rating of Personal Doctor and How Well Doctors Communicate. Colorado Medicaid scored significantly lower in 2009 than in 2008 on one CAHPS measure, Rating of All Health Care.
- Colorado Medicaid FFS scored significantly higher in 2009 than in 2008 on two CAHPS measures: Rating of Personal Doctor and How Well Doctors Communicate. FFS scored significantly higher in 2009 than in 2007 on one CAHPS measure, Rating of Health Plan. FFS scored significantly lower in 2009 than in 2008 on one CAHPS measure, Rating of All Health Care.
- Colorado Medicaid PCPP scored significantly higher in 2009 than in 2008 on two CAHPS measures: Rating of Personal Doctor and How Well Doctors Communicate.
- DHMP scored significantly lower in 2009 than in 2007 on one CAHPS measure, Rating of All Health Care.
- RMHP scored significantly higher in 2009 than in 2007 on one CAHPS measure, How Well Doctors Communicate. RMHP scored significantly lower in 2009 than in 2007 on one CAHPS measure, Rating of All Health Care.

Plan Comparisons

In order to identify performance differences in client satisfaction between the four Colorado Medicaid plans, the results for FFS, PCPP, DHMP, and RMHP were compared to the State Medicaid average using standard tests for statistical significance.[2-18] For purposes of this comparison, results were case-mix adjusted. Case-mix refers to the characteristics of respondents used in adjusting the results for comparability among health plans. Results for the Colorado Medicaid plans were case-mix adjusted for client general health status, respondent educational level, and respondent age.[2-19] Given that differences in case-mix can result in differences in ratings between plans that are not due to differences in quality, the data were adjusted to account for disparities in these characteristics. The case-mix adjustment was performed using standard regression techniques (i.e., covariance adjustment).

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

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

Table 2-4 shows the question summary rates and global proportions results of the plan comparisons analysis. **NOTE: These results (i.e., the percentages presented) will differ from those presented in the trend analysis figures because they have been adjusted for differences in case mix.**

[2-18] Caution should be exercised when evaluating plan comparisons, given that population and plan differences may impact CAHPS results.

[2-19] 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 2-4
Plan Comparisons

	Colorado Medicaid FFS	Colorado Medicaid PCPP	DHMP	RMHP
Global Rating				
Rating of Health Plan	60.3% ⇔	63.7% ⇔	55.6% ⇔	65.8% ⇔
Rating of All Health Care	56.8% ⇔	66.1% ↑	49.5% ↓	56.7% ⇔
Rating of Personal Doctor	70.0% ⇔	73.7% ⇔	64.2% ⇔	70.2% ⇔
Rating of Specialist Seen Most Often	68.8% ⇔	68.2% ⇔	NA	NA
Composite Measure				
Getting Needed Care	50.9% ⇔	56.0% ⇔	NA	63.1% ↑
Getting Care Quickly	67.4% ⇔	74.7% ↑	53.6% ↓	75.3% ↑
How Well Doctors Communicate	71.0% ⇔	77.0% ⇔	69.2% ⇔	76.9% ⇔
Customer Service	41.0% ⇔	51.5% ⇔	NA	NA
Shared Decision Making	69.9% ⇔	67.4% ⇔	NA	69.1% ⇔
Individual Measure				
Coordination of Care	52.0% ⇔	60.0% ⇔	NA	51.6% ⇔
Health Promotion and Education	38.5% ⇔	44.6% ⇔	40.5% ⇔	34.3% ⇔

Please note: A minimum of 100 responses to each measure is required in order to report the measure as a CAHPS Survey Result. Measures that do not meet the minimum number of responses are denoted as Not Applicable (NA).

Summary of Plan Comparisons Results

The plan comparisons revealed the following statistically significant results.

- Colorado Medicaid PCPP scored significantly higher than the Colorado Medicaid State average on two of the CAHPS measures: Rating of All Health Care and Getting Care Quickly.
- DHMP scored significantly lower than the Colorado Medicaid State average on two of the CAHPS measures: Rating of All Health Care and Getting Care Quickly.
- RMHP scored significantly higher than the Colorado Medicaid State average on two of the CAHPS measures: Getting Needed Care and Getting Care Quickly.

General Recommendations

HSAG recommends the continued administration of the CAHPS 4.0H Child Medicaid Health Plan Survey in fiscal year (FY) 2009-2010. This will allow HSAG to perform complete benchmarking and trend evaluation on the child data. HSAG also recommends the continued use of administrative data in identifying the Spanish-speaking population. The number of completed surveys in Spanish during the FY 2007-2008 survey administration is very comparable to the completed surveys in Spanish for the FY 2008-2009 survey administration.

Plan-Specific Recommendations

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

The priorities presented in this section should be viewed as potential suggestions for QI. Additional sources of QI information, such as other HEDIS results, should be incorporated into a comprehensive QI plan. A number of resources are available to assist state Medicaid agencies and plans with the implementation of CAHPS-based QI initiatives. 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
NA	NA/—	Moderate
★★★★	▼	Moderate
★★★★	—	Moderate
★★★★★	▼	Moderate
★★★★	▲	Low
★★★★★	—	Low
★★★★★	▲	Low

Please note:
Trend analysis results reflect those between either the 2009 and 2008 results or the 2009 and 2007 results.[3-1]
If statistically significant differences were not identified during the trend analysis, this lack of statistical significance is denoted with a hyphen (—) in the table above.
Global ratings or composite measures that do not meet the minimum number of responses are denoted as Not Applicable (NA).

[3-1] For more detailed information on the trend analysis results, please see the Results section of this report.

Global Ratings

Rating of Health Plan

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

Table 3-2
Priority Assignments
Rating of Health Plan

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

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

Plan operations include those services provided by the plan directly:

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

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

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

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

Rating of All Health Care

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

Table 3-3
Priority Assignments
Rating of All Health Care

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

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

Access to care issues include:

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

Experience with care issues include:

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

Experience with health plan issues include:

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

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

Rating of Personal Doctor

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

Table 3-4
Priority Assignments
Rating of Personal Doctor

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

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

Communication issues include:

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

Waiting time issues include:

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

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

Rating of Specialist Seen Most Often

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

Table 3-5
Priority Assignments
Rating of Specialist Seen Most Often

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

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

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

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

Composite Measures

Getting Needed Care

Since this measure was modified with the implementation of the CAHPS 4.0H Child Medicaid Health Plan Survey, the results were not trendable and were not comparable to NCQA national data. Therefore, priority assignments could not be made.

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

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

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

Getting Care Quickly

Since this measure was modified with the implementation of the CAHPS 4.0H Child Medicaid Health Plan Survey, the results were not trendable and were not comparable to NCQA national data. Therefore, priority assignments could not be made.

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

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

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

How Well Doctors Communicate

Table 3-6 shows the priority assignments for the How Well Doctors Communicate measure.

Table 3-6
Priority Assignments
How Well Doctors Communicate Composite

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

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

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

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

Customer Service

Since this measure was modified with the implementation of the CAHPS 4.0H Child Medicaid Health Plan Survey, the results were not trendable and were not comparable to NCQA national data. Therefore, priority assignments could not be made.

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

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

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

Shared Decision Making

Since this measure is new with the implementation of the CAHPS 4.0H Child Medicaid Health Plan Survey, the results were not trendable and NCQA national data were not available. Therefore, priority assignments could not be made.

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

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

[3-2] Fraenkel L and McGraw S. "What are the Essential Elements to Enable Patient Participation in Medical Decision Making?" *Journal of General Internal Medicine*. May 2007. 22(5): 614-9

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

Individual Item Measures

Coordination of Care

Since this measure is new with the implementation of the CAHPS 4.0H Child Medicaid Health Plan Survey, the results were not trendable and NCQA national data were not available. Therefore, priority assignments could not be made.

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

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

Studies have demonstrated that effective coordination of care tends to lead to fewer complaints reported by clients.[3-4] Further, coordination of care among physicians in primary care practices tends to yield better client outcomes.[3-5]

[3-4] Parchman M, Noel P, Lee S. "Primary Care Attributes, Health Care System Hassles, and Chronic Illness." *Medical Care*. Nov 2005. 43(11): 1123-9.

[3-5] Parkerton P, Smith D, Straley H. "Primary Care Practice Coordination Versus Physician Continuity." *Family Medicine*. Jan 2004. 36(1): 15-21.

Health Promotion and Education

Since this measure is new with the implementation of the CAHPS 4.0H Child Medicaid Health Plan Survey, the results were not trendable and NCQA national data were not available. Therefore, priority assignments could not be made.

At the client level, this measure is driven by the physician discussing health promotion and disease prevention with the patient. Health promotion includes enabling the patient to take control over their health. Health education is a component of health promotion that involves increasing patients' knowledge about their own health and well-being.[3-6] In addition to one-on-one modes of health promotion and education, other communication efforts can include: lectures, group/panel discussions, and presentations. However, demographics such as age, physical barriers, and race/ethnicity need to be considered in order to determine the most effective method of health promotion and education for a particular patient or patient group.[3-7]

[3-6] UNESCO Institute for Education. *Health Promotion and Health Education for Childs*. 1999. Hamburg, Germany.
[3-7] Saha A, Poddar E, and Mankad M. "Effectiveness of Different Methods of Health Education: A Comparative Assessment in a Scientific Conference." *BMC Public Health.* 2005; 5:88.

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 3-7 provides a summary of the responsible parties for various aspects of care.[3-8]

Table 3-7—Accountability for Areas of Care			
Domain	Composite	Who Is Accountable?	
		Health Plan	Provider Network
Access	Getting Needed Care	✓	✓
	Getting Care Quickly		✓
Interpersonal Care	How Well Doctors Communicate		✓
	Shared Decision Making		✓
Plan Administrative Services	Customer Service	✓	
Personal Doctor			✓
Specialist			✓
All Health Care		✓	✓
Health Plan		✓	

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

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

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

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

[3-8] Edgman-Levitan S, et al. *The CAHPS® Improvement Guide: Practical Strategies for Improving the Patient Care Experience.* Department of Health Care Policy Harvard Medical School, October 2003.

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

Survey Administration

Survey Overview

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

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

[4-1] National Committee for Quality Assurance. *HEDIS® 2002*, *Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA Publication, 2001.
[4-2] National Committee for Quality Assurance. *HEDIS® 2003*, *Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA Publication, 2002.
[4-3] National Committee for Quality Assurance. *HEDIS® 2007*, *Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA Publication, 2006.
[4-4] National Committee for Quality Assurance. *HEDIS® 2009*, *Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA Publication, 2008.

The CAHPS 4.0H Child Medicaid Health Plan Survey includes 47 core questions that yield 11 measures of satisfaction. These measures include four global rating questions, five composite measures, and two individual item measures. The global measures (also referred to as global ratings) reflect overall satisfaction with the health plan, health care, personal doctors, and specialists. The composite measures are sets of questions grouped together to address different aspects of care (e.g., "Getting Needed Care" or "Getting Care Quickly"). The individual item measures are individual questions that look at a specific area of care (i.e., "Health Promotion and Education" and "Coordination of Care").

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

Table 4-1—CAHPS Measures

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

Sampling Procedures

The clients eligible for sampling included those who were FFS, PCPP, DHMP, or RMHP clients at the time the sample was drawn and who were continuously enrolled for at least five of the last six months (July through December) of 2008. The clients eligible for sampling included those who were age 17 or younger (as of December 31, 2008).

The standard NCQA HEDIS specifications for survey measures require a sample size of 1,650 clients for the CAHPS 4.0H Child Medicaid Health Plan Survey. The NCQA protocol permits oversampling in 5 percent increments. For DHMP, no oversampling was performed on the child population. For FFS and PCPP, a 30 percent oversampling was performed on the child population. For RMHP, a 15 percent oversampling was performed on the child population. This oversampling was performed to ensure a greater number of respondents to each CAHPS measure. For FFS and PCPP, a random sample of 2,145 child clients was selected from each participating plan. A random sample of 1,650 and 1,898 child clients was selected from DHMP and RMHP, respectively.[4-5]

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

Survey Protocol

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

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

The survey administration for DHMP and RMHP was performed by Synovate and CSS, respectively. The CAHPS 4.0H Health Plan Survey process employed by RMHP was a mail-only methodology, which consisted of a survey only being mailed to sampled clients. The CAHPS 4.0H Health Plan Survey process employed by FFS, PCPP, and DHMP allowed clients two methods by which they could complete a survey. The first, or mail phase, consisted of a survey being mailed to all sampled clients. For Colorado Medicaid FFS and PCPP, those clients who were identified as Spanish-speaking through administrative data were mailed a Spanish version of the survey. Clients that were not identified as Spanish-speaking received an English version of the survey. The English and Spanish versions of the survey included a toll-free number that clients could call to request a survey in another language (i.e., English or Spanish). A reminder postcard was sent to all non-respondents, followed by a second survey mailing and reminder postcard. The second phase, or telephone phase, consisted of CATI of sampled clients who had not mailed in a completed survey. A series of up to six CATI calls was made to each non-respondent.[4-8] It has been shown that the addition of the telephone phase aids in the reduction of non-response bias by increasing the number of respondents who are more demographically representative of a plan's population.[4-9]

[4-6] Please note, the timeline used by RMHP will vary due to the mail-only protocol employed.
[4-7] National Committee for Quality Assurance. *HEDIS 2009*, *Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA Publication, 2008.
[4-8] National Committee for Quality Assurance. *Quality Assurance Plan for HEDIS 2009 Survey Measures.* Washington, DC: NCQA Publication, 2008.
[4-9] Fowler FJ Jr., Gallagher PM, Stringfellow VL, et al. "Using Telephone Interviews to Reduce Nonresponse Bias to Mail Surveys of Health Plan Members." *Medical Care*. 2002; 40(3): 190-200.

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

- Were age 17 or younger as of December 31, 2008.
- Were currently enrolled in FFS or PCPP.
- Had been continuously enrolled for at least five of the last six months of 2008.
- Had Medicaid as the primary payer.

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

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

Methodology

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

Response Rates

The administration of the CAHPS 4.0H Child Medicaid Health Plan Survey is comprehensive and is designed to garner the highest possible response rate. NCQA defines the response rate as the total number of completed surveys divided by all eligible clients of the sample.[4-10] A client's survey was assigned a disposition code of "completed" if at least one question was answered within the survey. Eligible clients include the entire random sample (including any oversample) minus ineligible clients. Ineligible clients of the sample met one or more of the following criteria: were deceased, were invalid (did not meet criteria described on page 4-4), or had a language barrier.

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

Child and Respondent Demographics

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

NCQA Comparisons

An analysis of the Colorado CAHPS 4.0H Child Medicaid Health Plan Survey results was conducted using NCQA HEDIS Specifications for Survey Measures. Per these specifications, results for the adult and child Medicaid populations are reported separately, and no weighting or case-mix adjustment is performed on the results. NCQA also requires a minimum of 100 responses on each item in order to report the item as a valid CAHPS Survey result.

[4-10] National Committee for Quality Assurance. *HEDIS 2009*, *Volume 3: Specifications for Survey Measures*. Washington, DC: NCQA Publication, 2008.

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 national results to derive the overall client satisfaction ratings (i.e., star ratings) for each CAHPS measure. For detailed information on the derivation of three-point mean scores, please refer to *NCQA HEDIS 2009 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 80th percentile
★★★★	indicates a score between the 60th and 79th percentiles
★★★	indicates a score between the 40th and 59th percentiles
★★	indicates a score between the 20th and 39th percentiles
★	indicates a score below the 20th percentile
NA	indicates that the health plan did not meet the minimum NCQA reporting threshold of 100 respondents

Table 4-3 shows the NCQA national distributions used to derive the overall client satisfaction ratings on comparable CAHPS measures.[4-11]

Table 4-3
Overall Child Medicaid Client Satisfaction Ratings Crosswalk

Measure	80th Percentile	60th Percentile	40th Percentile	20th Percentile
Rating of Health Plan	2.590	2.544	2.494	2.441
Rating of All Health Care	2.603	2.566	2.543	2.494
Rating of Personal Doctor	2.590	2.561	2.539	2.508
Rating of Specialist Seen Most Often	2.566	2.533	2.508	2.476
How Well Doctors Communicate	2.656	2.626	2.596	2.547

[4-11] *NCQA National Distribution of 2008 Child Medicaid CAHPS Plan-level Results*. Prepared by NCQA for HSAG on November 17, 2008. NCQA does not publish NCQA Benchmarks and Thresholds for the Child Medicaid population. Therefore, star ratings are derived from a custom analysis performed annually by NCQA on behalf of HSAG. This custom analysis provided HSAG with the NCQA national results. This distribution is used to derive the star ratings.

Trend Analysis

In order to evaluate trends in Colorado Medicaid client satisfaction, HSAG performed a stepwise three-year trend analysis. The first step compared the 2009 CAHPS results to the 2008 CAHPS results. If the initial 2009 and 2008 trend analysis did not yield any significant differences, then an additional trend analysis was performed between 2009 and 2007 results. For purposes of this analysis, question summary rates were calculated for each global rating and individual item measure, and global proportions were calculated for each composite measure. Both the question summary rates and global proportions were calculated in accordance with NCQA HEDIS Specifications for Survey Measures.[4-12] 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 detail, please refer to the *NCQA HEDIS 2009 Specifications for Survey Measures, Volume 3*.

The 2009 Colorado Medicaid and plan-level CAHPS scores were compared to the corresponding 2008 scores to determine whether there were statistically significant differences. If there were no statistically significant differences from 2009 to 2008, then 2009 scores were compared to 2007 scores. A difference is considered significant if the two-sided *p* value of the *t* test is less than 0.05. Scores that were statistically higher in 2009 than in 2008 are noted with black upward (▲) triangles. Scores that were statistically lower in 2009 than in 2008 are noted with black downward (▼) triangles. Scores that were statistically higher in 2009 than in 2007 are noted with red upward (▲) triangles. Scores that were statistically lower in 2009 than in 2007 are noted with red downward (▼) triangles. Scores in 2009 that were not statistically different from scores in 2008 or in 2007 are not noted with triangles. Per NCQA specifications, measures that did not meet the minimum number of 100 responses required by NCQA are denoted as NA.

Plan Comparisons

Plan comparisons were performed to identify client satisfaction differences that were statistically different than the State average. Given that differences in case-mix can result in differences in ratings between plans that are not due to differences in quality, the data were adjusted to account for disparities in these characteristics. Case-mix refers to the characteristics of clients and respondents used in adjusting the results for comparability among health plans. Results for the Colorado Medicaid plans were case-mix adjusted for client general health status, respondent education level, and respondent age.

[4-12] National Committee for Quality Assurance. HEDIS 2009, Volume 3: Specifications for Survey Measures. Washington, DC: NCQA Publication, 2008.

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

The weighted score was:

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

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

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

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

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

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

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

The variance of Δ_p was:

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

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

Limitations and Cautions

The findings presented in the 2009 Colorado Child 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 client and 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 the parents or caretakers of clients of various plans report differences in satisfaction with various aspects of their child's health care experiences, these differences may not be completely attributable to the Medicaid plan. These analyses identify whether parents or caretakers of clients in various types of plans give different ratings of satisfaction with their child's Medicaid plan. The survey by itself does not necessarily reveal the exact cause of these differences.

Mode Effects

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

Survey Vendor Effects

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

Quality Improvement References

The CAHPS surveys were originally developed to meet the need for usable, relevant information on quality of care from the patient's perspective. However, the surveys also play an important role as a QI tool for health care organizations, which can use the standardized data and results to identify relative strengths and weaknesses in their performance, determine where they need to improve, and track their progress over time.[4-13] The following references offer guidance on possible approaches to CAHPS-related QI activities.

Backer LA. Strategies for better patient flow and cycle time. *Family Practice Management*. 2002; 9(6): 45-50. Available at: http://www.aafp.org/fpm/20020600/45stra.html. Accessed on: July 23, 2009.

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

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

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

Edgman-Levitan S, Shaller D, McInnes K, Joyce R, Coltin K, Cleary P. *The CAHPS® Improvement Guide: Practical Strategies for Improving the Patient Care Experience*. Department of Health Care Policy, Harvard Medical School; 2003. Available at: http://www.cahps-sun.org/Whatsnew/QI%20guide.pdf. Accessed on: July 23, 2009.

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

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

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

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

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

[4-13] AHRQ Website. *CAHPS User Resources: Quality Improvement Resources.* Available at: https://www.cahps.ahrq.gov/content/resources/QI/RES_QI_Intro.asp?p=103&s=31. Accessed on: July 23, 2009.

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

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

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

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

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

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

Murray M. Reducing waits and delays in the referral process. *Family Practice Management*. 2002; 9(3): 39-42. Available at: http://www.aafp.org/fpm/20020300/39redu.html. Accessed on: July 23, 2009.

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

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

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

Wasson JM, Godfrey M, Nelson E, et al. Microsystems in health care: Part 4. Planning patient-centered care. *Joint Commission Journal on Quality and Safety*. 2003; 29(5): 227-237. Available at: http://howsyourhealth.com/html/CARE.pdf. Accessed on: July 23, 2009.

5. Survey Instrument

The survey instrument selected for the 2009 Colorado Child Medicaid Client Satisfaction Survey was the CAHPS 4.0H Child Medicaid Health Plan Survey. This section provides a copy of the survey instrument.

CAHPS® 4.0H, Child Questionnaire (Without CCC Measure)

SURVEY INSTRUCTIONS

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

☑ Yes ➔**If Yes, Go to Question 1**

☐ No

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

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

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

Please answer the questions for the child listed on the envelope. Please do not answer for any other children.

1. **Our records show that your child is now in {Health Plan Name}. Is that right?**
   [1]☐ Yes ➔ **If Yes, Go to Question 3**
   [2]☐ No

2. **What is the name of your child's health plan? (please print)**

   ____

YOUR CHILD'S HEALTH CARE IN THE LAST 6 MONTHS

These questions ask about your child's health care. Do not include care your child got when he or she stayed overnight in a hospital. Do not include the times your child went for dental care visits.

3. **In the last 6 months, did your child have an illness, injury, or condition that needed care right away in a clinic, emergency room, or doctor's office?**
   [1]☐ Yes
   [2]☐ No ➔ **If No, Go to Question 5**

4. **In the last 6 months, when your child needed care right away, how often did your child get care as soon as you thought he or she needed?**
   [1]☐ Never
   [2]☐ Sometimes
   [3]☐ Usually
   [4]☐ Always

5. **In the last 6 months, not counting the times your child needed care right away, did you make any appointments for your child's health care at a doctor's office or clinic?**
   [1]☐ Yes
   [2]☐ No ➔ **If No, Go to Question 7**

6. **In the last 6 months, <u>not</u> counting the times your child needed care right away, how often did you get an appointment for health care at a doctor's office or clinic as soon as you thought your child needed?**
   - [1] ☐ Never
   - [2] ☐ Sometimes
   - [3] ☐ Usually
   - [4] ☐ Always

7. **In the last 6 months, <u>not</u> counting the times your child went to an emergency room, how many times did he or she go to a doctor's office or clinic to get health care?**
   - [0] ☐ None ➔ **If None, Go to Question 13**
   - [1] ☐ 1
   - [2] ☐ 2
   - [3] ☐ 3
   - [4] ☐ 4
   - [5] ☐ 5 to 9
   - [6] ☐ 10 or more

8. **In the last 6 months, how often did you and your child's doctor or other health provider talk about specific things you could do to prevent illness in your child?**
   - [1] ☐ Never
   - [2] ☐ Sometimes
   - [3] ☐ Usually
   - [4] ☐ Always

9. **Choices for your child's treatment or health care can include choices about medicine, surgery, or other treatment. In the last 6 months, did your child's doctor or other health provider tell you there was more than one choice for your child's treatment or health care?**
   - [1] ☐ Yes
   - [2] ☐ No ➔ **If No, Go to Question 12**

10. **In the last 6 months, did your child's doctor or other health provider talk with you about the pros and cons of each choice for your child's treatment or health care?**
    - [1] ☐ Definitely yes
    - [2] ☐ Somewhat yes
    - [3] ☐ Somewhat no
    - [4] ☐ Definitely no

11. **In the last 6 months, when there was more than one choice for your child's treatment or health care, did your child's doctor or other health provider ask you which choice you thought was best for your child?**
    - [1] ☐ Definitely yes
    - [2] ☐ Somewhat yes
    - [3] ☐ Somewhat no
    - [4] ☐ Definitely no

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

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

YOUR CHILD'S PERSONAL DOCTOR

13. **A personal doctor is the one your child would see if he or she needs a checkup or gets sick or hurt. Does your child have a personal doctor?**

[1] ☐ Yes
[2] ☐ No ➔ **If No, Go to Question 25**

14. **In the last 6 months, how many times did your child visit his or her personal doctor for care?**

[0] ☐ None ➔ **If None, Go to Question 24**
[1] ☐ 1
[2] ☐ 2
[3] ☐ 3
[4] ☐ 4
[5] ☐ 5 to 9
[6] ☐ 10 or more

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

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

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

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

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

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

18. Is your child able to talk with doctors about his or her health care?

[1] ☐ Yes
[2] ☐ No ➔ **If No, Go to Question 20**

19. In the last 6 months, how often did your child's personal doctor explain things in a way that was easy for <u>your child</u> to understand?

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

20. In the last 6 months, how often did your child's personal doctor spend enough time with your child?

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

21. In the last 6 months, did your child's personal doctor talk with you about how your child is feeling, growing, or behaving?

[1] ☐ Yes
[2] ☐ No

22. In the last 6 months, did your child get care from a doctor or other health provider besides his or her personal doctor?

[1] ☐ Yes
[2] ☐ No ➔ **If No, Go to Question 24**

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

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

24. 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 child's personal doctor?

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

GETTING HEALTH CARE FROM SPECIALISTS

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

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

[1] ☐ Yes
[2] ☐ No ➔ **If No, Go to Question 29**

26. In the last 6 months, how often was it easy to get appointments for your child with specialists?

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

27. How many specialists has your child seen in the last 6 months?

[0] ☐ None ➔ **If None, Go to Question 29**
[1] ☐ 1 specialist
[2] ☐ 2
[3] ☐ 3
[4] ☐ 4
[5] ☐ 5 or more specialists

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

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

YOUR CHILD'S HEALTH PLAN

The next questions ask about your experience with your child's health plan.

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

[1] ☐ Yes
[2] ☐ No ➔ **If No, Go to Question 31**

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

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

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

[1] ☐ Yes
[2] ☐ No ➔ **If No, Go to Question 34**

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

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

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

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

34. In the last 6 months, did your child's health plan give you any forms to fill out?

[1] ☐ Yes
[2] ☐ No ➔ **If No, Go to Question 36**

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

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

36. 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 child's health plan?

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

ABOUT YOUR CHILD AND YOU

37. In general, how would you rate your child's overall health?

[1] ☐ Excellent
[2] ☐ Very Good
[3] ☐ Good
[4] ☐ Fair
[5] ☐ Poor

38. What is your child's age?

[00] ☐ Less than 1 year old
______ YEARS OLD *(write in)*

39. Is your child male or female?

[1] ☐ Male
[2] ☐ Female

40. Is your child of Hispanic or Latino origin or descent?

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

41. What is your child's race? Please mark one or more.

[a] ☐ White
[b] ☐ Black or African-American
[c] ☐ Asian
[d] ☐ Native Hawaiian or other Pacific Islander
[e] ☐ American Indian or Alaska Native
[f] ☐ Other

42. What is your age?

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

43. Are you male or female?

[1] ☐ Male
[2] ☐ Female

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

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

45. How are you related to the child?

[1] ☐ Mother or father
[2] ☐ Grandparent
[3] ☐ Aunt or uncle
[4] ☐ Older sibling
[5] ☐ Other relative
[6] ☐ Legal guardian

46. Did someone help you complete this survey?

[1] ☐ Yes ➔ **If Yes, Go to Question 47**
[2] ☐ No ➔ **Thank you. Please return the completed survey in the postage-paid envelope.**

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

[a] ☐ Read the questions to me
[b] ☐ Wrote down the answers I gave
[c] ☐ Answered the questions for me
[d] ☐ Translated the questions into my language
[e] ☐ Helped in some other way

THANK YOU

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

6. CD-ROM

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

CD Contents

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

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

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