FY 12-13
CHILD MEDICAID CLIENT SATISFACTION REPORT

August 2013

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

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1. Executive Summary

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

The standardized survey instrument selected was the CAHPS 5.0 Child Medicaid Health Plan Survey with the Healthcare Effectiveness Data and Information Set (HEDIS®) supplemental item set and the Children with Chronic Conditions (CCC) measurement set ("CAHPS 5.0H Child Medicaid Health Plan Survey with CCC").[1-3] The parents or caretakers of child clients from the health plans completed the surveys from March to May 2013.

Transition from CAHPS 4.0 to 5.0 Survey

In 2012, the Agency for Healthcare Research and Quality (AHRQ) released the CAHPS 5.0 Medicaid Health Plan Surveys. Based on the CAHPS 5.0 versions, the National Committee for Quality Assurance (NCQA) introduced new HEDIS versions of the Child Health Plan Surveys in August 2012, which are referred to as the CAHPS 5.0H Child Medicaid Health Plan Surveys.[1-4] The following is a summary of the changes resulting from the transition to the CAHPS 5.0 Child Medicaid Health Plan Survey with CCC measurement set.[1-5]

Global Ratings

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

[1-1] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).
[1-2] The DHMC CAHPS Child Medicaid Survey administration was performed by Morpace. The RMHP CAHPS Child Medicaid Survey administration was performed by the Center for the Study of Services (CSS).
[1-3] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
[1-4] National Committee for Quality Assurance. *HEDIS® 2013, Volume 3: Specifications for Survey Measures*. Washington, DC: NCQA Publication, 2012.
[1-5] National Committee for Quality Assurance. *HEDIS 2013 Survey Vendor Update Training*. October 25, 2012.

Composite Measures

Getting Needed Care

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

Getting Care Quickly

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

How Well Doctors Communicate

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

Customer Service

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

Shared Decision Making

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

Individual Items

Coordination of Care

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

Health Promotion and Education

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

Children with Chronic Conditions (CCC) Composites and Items

There were no changes made to the five measures that comprise the CCC measurement set. The question language, response options, and placement of three CCC composites: Access to Specialized Services, Family Centered Care: Personal Doctor Who Knows Child, and Coordination of Care for Children with Chronic Conditions remain the same. The question language, response options, and placement of the two CCC composite items: Access to Prescription Medicines and Family Centered Care: Getting Needed Information also remained unchanged. Therefore, comparisons to national data were performed for the three CCC composites and two CCC items.

General Child Performance Highlights

The General Child Results Section of this report details the CAHPS results for the general child population for the Colorado Medicaid program in aggregate, FFS, PCPP, DHMC, and RMHP. The following is a summary of the general child CAHPS performance highlights.

NCQA Comparisons

Overall client satisfaction ratings for four CAHPS global ratings (Rating of Health Plan, Rating of All Health Care, Rating of Personal Doctor, and Rating of Specialist Seen Most Often) and four composite measures (Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, and Customer Service) were compared to NCQA's 2013 HEDIS Benchmarks and Thresholds for Accreditation.[1-6,1-7] 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 analysis are described in the General Child Results Section beginning on page on page 3-1. Table 1-1, on the following page, presents the highlights from this comparison.

[1-6] National Committee for Quality Assurance. *HEDIS Benchmarks and Thresholds for Accreditation 2013*. Washington, DC: NCQA, March 15, 2013.

[1-7] NCQA does not publish benchmarks and thresholds for the Shared Decision Making composite measure, and Coordination of Care and Health Promotion and Education individual item measures; therefore, overall client satisfaction ratings could not be derived for these CAHPS measures.

Table 1-1 NCQA Comparisons Highlights			
Colorado Medicaid FFS	**Colorado Medicaid PCPP**	**DHMC**	**RMHP**
★★ Rating of Health Plan	★★* Rating of Specialist Seen Most Often	★ Getting Care Quickly	★★★ Rating of Health Plan
★★★ Getting Care Quickly	★★★ Rating of Health Plan	★★ Customer Service	★★★★* Customer Service
★★★ How Well Doctors Communicate	★★★★ Customer Service	★★ Getting Needed Care	★★★★ Rating of All Health Care
★★★ Rating of All Health Care	★★★★ Getting Needed Care	★★★ How Well Doctors Communicate	★★★★★* Rating of Specialist Seen Most Often
★★★★* Customer Service	★★★★ Rating of Personal Doctor	★★★★ Rating of Health Plan	★★★★★ Getting Care Quickly
★★★★ Rating of Personal Doctor	★★★★★ Getting Care Quickly	★★★★★ Rating of All Health Care	★★★★★ Getting Needed Care
★★★★★* Rating of Specialist Seen Most Often	★★★★★ How Well Doctors Communicate	★★★★★ Rating of Personal Doctor	★★★★★ How Well Doctors Communicate
★★★★★ Getting Needed Care	★★★★★ Rating of All Health Care	★★★★★ Rating of Specialist Seen Most Often	★★★★★ Rating of Personal Doctor

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

Please note: CAHPS scores with fewer than 100 respondents are denoted with an asterisk (*). If there are fewer than 100 respondents for a CAHPS measure, caution should be exercised when interpreting these results.

Trend Analysis

In order to evaluate trends in Colorado Medicaid client satisfaction for the general child population, HSAG performed a stepwise trend analysis, where applicable. The first step compared the 2013 CAHPS results to the 2012 CAHPS results. If the initial 2013 and 2012 trend analysis did not yield any significant differences, then an additional trend analysis was performed between 2013 and 2011 results. The detailed results of the trend analysis are described in the General Child Results Section beginning on page 3-4. Table 1-2 presents the statistically significant results from this analysis.

Table 1-2
Trend Analysis Highlights

	Colorado Medicaid FFS	Colorado Medicaid PCPP	DHMC	RMHP
Global Rating				
Rating of Specialist Seen Most Often			▲ (red)	
Composite Measure				
Getting Needed Care	▲		▲	▲
Getting Care Quickly				▲ (red)
How Well Doctors Communicate			▲	▲
Customer Service	▲*	▲ (red)	▲	

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

Please note: CAHPS scores with fewer than 100 respondents are denoted with an asterisk (*). If there are fewer than 100 respondents for a CAHPS measure, caution should be exercised when interpreting these results.

Plan Comparisons

In order to identify performance differences in client satisfaction between the Colorado Medicaid plans' general child populations, case-mix adjusted results for each plan were compared to one another using standard statistical tests.[1-8] These comparisons were performed on the four global ratings, five composite measures, and two individual item measures. The detailed results of the comparative analysis are described in the General Child Results Section beginning on page 3-17. Table 1-3 presents the statistically significant results from this comparison.[1-9]

Table 1-3
Plan Comparisons Highlights: General Child

Colorado Medicaid FFS	Colorado Medicaid PCPP	DHMC	RMHP
↓ Health Promotion and Education	↑ Getting Care Quickly	↓ Getting Care Quickly	↑ Getting Care Quickly
		↓ Getting Needed Care	↑ Getting Needed Care
			↑ How Well Doctors Communicate

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

Priority Assignments

Based on the results of the NCQA comparisons and trend analysis, priority assignments were derived for each measure.[1-10] Measures were assigned into one of four main categories for quality improvement (QI): top, high, moderate, and low priority. Table 1-4 presents the top and high priorities for each plan.

Table 1-4
Top and High Priorities

Colorado Medicaid FFS	Colorado Medicaid PCPP	DHMC	RMHP
◆ Rating of Health Plan	◆ Rating of Specialist Seen Most Often*	◆ Getting Needed Care ◆ Getting Care Quickly ◆ Customer Service	◆ RMHP did not have any Top or High priorities.

Please note: CAHPS scores with fewer than 100 respondents are denoted with an asterisk (*). If there are fewer than 100 respondents for a CAHPS measure, caution should be exercised when interpreting these results.

[1-8] CAHPS results are known to vary due to differences in respondent age, respondent education level, and member health status. Therefore, the results were case-mix adjusted for differences in these demographic variables.
[1-9] Caution should be exercised when evaluating health plan comparisons, given that population and health plan differences may impact results.
[1-10] Priority assignments were derived for each plan based on their general child population CAHPS results.

Children with Chronic Conditions (CCC) Performance Highlights

The CCC Results Section of this report details the CAHPS results for the FFS, PCPP, DHMC, and RMHP CCC population. The following is a summary of the CAHPS performance highlights. The detailed results of this analysis are described in the CCC Results Section beginning on page 4-1.

Plan Comparisons

In order to identify performance differences in the satisfaction of parents/caretakers of children with chronic conditions between the Colorado Medicaid plans, the CCC population results for each plan were compared to one another. These comparisons were performed on the four global ratings, five composite measures, two individual item measures, and the CCC composites and CCC items. Table 1-5 presents the statistically significant results from this analysis.

Table 1-5
Plan Comparisons Highlights: CCC

Colorado Medicaid FFS	Colorado Medicaid PCPP	DHMC	RMHP
↓ Health Promotion and Education	↑ Getting Care Quickly	↓ Access to Specialized Services	↑ Access to Prescription Medicines
		↓ Getting Care Quickly	↑ Access to Specialized Services
		↑ Health Promotion and Education	↑ Getting Care Quickly
			↑ Getting Needed Care
			↑ Rating of Health Plan

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

The Colorado CAHPS 5.0 Child Medicaid Health Plan Survey with the HEDIS supplemental item set and CCC measurement set was administered in accordance with NCQA specifications.

Survey Administration and Response Rates

Survey Administration

Clients eligible for sampling included those who were enrolled in FFS, PCPP, DHMC, 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 2012. Child clients eligible for sampling included those who were 17 years of age or younger as of December 31, 2012. DHMC and RMHP were responsible for conducting their annual CAHPS surveys. Morpace and the Center for the Study of Services (CSS) administered the CAHPS Surveys for DHMC and RMHP, respectively.

The standard NCQA HEDIS Specifications for Survey Measures require a sample size of 3,490 clients for the CAHPS 5.0 Child Medicaid Health Plan Survey with CCC measurement set.[2-1] A random sample of at least 1,650 child clients was selected from each plan for the CAHPS 5.0 general child sample, which represents the general population of children. Child clients in the CAHPS 5.0 child sample were given a chronic condition prescreen status code of 1 or 2. A prescreen code of 1 indicated that the child client had claims or encounters that did not suggest the client had a greater probability of having a chronic condition. A prescreen code of 2 (also known as a positive prescreen status code) indicated the child client had claims or encounters that suggested the client had a greater probability of having a chronic condition.[2-2] After selecting child clients for the CAHPS 5.0 general child sample, a random sample of up to 1,840 child clients with a prescreen code of 2, which represents the population of children who are more likely to have a chronic condition (i.e., CCC supplemental sample) was selected.

NCQA protocol permits oversampling in increments of 5 percent. Colorado Medicaid FFS and PCPP elected not to conduct an oversample of their child populations. Both DHMC and RMHP elected to conduct an oversample of their general child populations. DHMC conducted a 155 percent oversample and RMHP conducted a 5 percent oversample of their general child population. Colorado Medicaid FFS met the sample size requirement of 3,490 clients (i.e., 1,650 general child and 1,840 CCC clients) for the CAHPS 5.0 Child Medicaid Health Plan Survey with CCC measurement set. However, Colorado Medicaid PCPP, DHMC, and RMHP did not meet the CCC supplemental sample size requirement.

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

[2-2] Ibid.

Table 2-1 depicts the total, general child, and CCC supplemental sample sizes for all participating health plans and the Colorado Medicaid aggregate.

Table 2-1
Child Medicaid
General Child and CCC Supplemental Sample Sizes

Plan Name	Total Sample Size	General Child Sample	CCC Supplemental Sample
Colorado Medicaid	**15,814**	**9,241**	**6,573**
Colorado Medicaid FFS	3,490	1,650	1,840
Colorado Medicaid PCPP	3,313	1,650	1,663
DHMC	5,687	4,208	1,479
RMHP	3,324	1,733	1,591

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 FFS, PCPP, DHMC, and RMHP was a mixed mode methodology which allows clients two methods by which they could complete the surveys. The first phase, or mail phase, consisted of a survey being mailed to the sampled clients. For Colorado Medicaid FFS and PCPP, those clients who were identified as Spanish-speaking through administrative data were mailed a Spanish version of the survey. Clients that were not identified as Spanish-speaking received an English version of the survey. The cover letter included with the English version of the survey had a Spanish cover letter on the back side informing clients that they could call the toll-free number to request a Spanish version of the CAHPS questionnaire. The cover letter provided with the Spanish version of the CAHPS questionnaire included a text box with a toll-free number that clients could call to request a survey in another language (i.e., English). A 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. DHMC provided English and Spanish versions of the mail survey and allowed clients the option to complete a CATI survey in English or Spanish. A minimum of three CATI calls was made to each non-respondent.[2-3] Additional information on the survey protocol is included in the Reader's Guide Section beginning on page 6-3.

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

Response Rates

The Colorado CAHPS 5.0 Child Medicaid Health Plan Survey administration was designed to achieve the highest possible response rate. The CAHPS Survey response rate is the total number of completed surveys divided by all eligible clients of the sample. A client's survey was assigned a disposition code of "completed" if at least one question was answered. Eligible clients included the entire random sample (including any oversample) minus ineligible clients. Ineligible clients met at least one of the following criteria: they were deceased, were invalid (did not meet the eligible population criteria), or had a language barrier.

A total of 4,112 completed surveys were returned on behalf of child clients, including 987 FFS, 950 PCPP, 1,424 DHMC, and 751 RMHP clients. Figure 2-1, on the following page, shows the distribution of survey dispositions and response rate for Colorado Medicaid (i.e., all four health plans combined). Figure 2-2 through Figure 2-5 show the individual distribution of survey dispositions and response rates for FFS, PCPP, DHMC, and RMHP, respectively. The survey dispositions and response rates results are based on the responses of parents/caretakers of children in the general child and CCC supplemental populations.

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

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

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

Sample Frame 285,382

CAHPS Survey Sample 3,490

Updated Contact Information[2-5]

287 Addresses
234 Phone Numbers

Ineligible Records 59

52 Enrollment Issue
6 Language Barrier
1 Other

Eligible Sample 3,431

Total Respondents 987

Total Non-Respondents 2,444

1,856 No Response
86 Refusal
502 Unable to Contact

Mail Respondents 586

454 English
132 Spanish

Telephone Respondents 401

275 English
126 Spanish

Response Rate=28.77%

[2-5] Prior to survey administration, address and phone information is updated for clients of the CAHPS sample using the United States Postal Service's National Change of Address (NCOA) and Telematch databases. The number of updated addresses and telephone numbers are provided for informational purposes only and pertain to FFS and PCPP only.

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

Sample Frame 10,631

CAHPS Survey Sample 3,313

Updated Contact Information[2-6]

271 Addresses
303 Phone Numbers

Ineligible Records 105

86 Enrollment Issue
19 Language Barrier
0 Other

Eligible Sample 3,208

Total Respondents 950

Total Non-Respondents 2,258

1,786 No Response
107 Refusal
365 Unable to Contact

Mail Respondents 670

613 English
57 Spanish

Telephone Respondents 280

246 English
34 Spanish

Response Rate=29.61%

[2-6] Prior to survey administration, address and phone information is updated for clients of the CAHPS sample using the United States Postal Service's National Change of Address (NCOA) and Telematch databases. The number of updated addresses and telephone numbers are provided for informational purposes only and pertain to FFS and PCPP only.

Figure 2-4—Distribution of Surveys for DHMC

Figure 2-5—Distribution of Surveys for RMHP

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

Table 2-2 Child Medicaid Sample Distribution and Response Rate					
Plan Name	Total Sample	Ineligible Records	Eligible Sample	Total Respondents	Response Rate
Colorado Medicaid	**15,814**	**264**	**15,550**	**4,112**	**26.44%**
Colorado Medicaid FFS	3,490	59	3,431	987	28.77%
Colorado Medicaid PCPP	3,313	105	3,208	950	29.61%
DHMC	5,687	13	5,674	1,424	25.10%
RMHP	3,324	87	3,237	751	23.20%

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.[2-7] Table 2-3 shows the demographic characteristics of children for whom a parent/caretaker completed a CAHPS 5.0 Child Medicaid Health Plan Survey.[2-8]

Table 2-3
Child Demographics
Age, Gender, Race/Ethnicity, and General Health Status

	Colorado Medicaid	Colorado Medicaid FFS	Colorado Medicaid PCPP	DHMC	RMHP
Age					
Less than 1	**2.4%**	2.7%	1.0%	2.2%	4.0%
1 to 3	**20.2%**	20.8%	17.3%	22.0%	17.8%
4 to 7	**26.2%**	22.8%	24.0%	27.8%	28.6%
8 to 12	**27.7%**	30.6%	28.8%	27.7%	22.9%
13 to 18	**23.5%**	23.2%	28.8%	20.3%	26.6%
Gender					
Male	**50.8%**	49.7%	52.3%	50.4%	51.5%
Female	**49.2%**	50.3%	47.7%	49.6%	48.5%
Race/Ethnicity					
Multi-Racial	**11.0%**	13.1%	14.9%	8.2%	11.3%
White	**48.1%**	53.0%	52.3%	34.2%	72.8%
Black	**8.1%**	7.4%	10.1%	10.4%	0.9%
Asian	**2.7%**	1.0%	5.4%	3.0%	0.9%
Other	**30.1%**	25.6%	17.3%	44.2%	14.2%
General Health Status					
Excellent	**43.4%**	44.2%	45.6%	42.7%	41.7%
Very Good	**31.6%**	30.2%	29.6%	31.4%	36.4%
Good	**20.4%**	19.2%	20.6%	21.8%	17.9%
Fair	**4.5%**	6.2%	4.3%	4.0%	3.9%
Poor	**0.1%**	0.2%	0.0%	0.1%	0.0%

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, 2012. Some children eligible for the CAHPS Survey turned age 18 between January 1, 2013, and the time of survey administration.

[2-7] 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.

[2-8] The child demographic data presented in Table 2-3 are based on the characteristics of the general child population.

Table 2-4 shows the self-reported age, level of education, and relationship to the child for the respondents who completed the CAHPS 5.0 Child Medicaid Health Plan Survey.[2-9]

Table 2-4
Respondent Demographics
Age, Education, and Relationship to Child

	Colorado Medicaid	Colorado Medicaid FFS	Colorado Medicaid PCPP	DHMC	RMHP
Respondent Age					
Under 18	**6.6%**	4.3%	4.0%	7.8%	9.3%
18 to 24	**8.1%**	6.3%	7.4%	10.0%	5.9%
25 to 34	**34.7%**	41.8%	31.4%	31.8%	37.6%
35 to 44	**31.5%**	29.1%	32.6%	34.5%	24.4%
45 to 54	**12.2%**	12.1%	12.1%	11.3%	15.2%
55 to 64	**4.3%**	3.8%	8.1%	3.3%	3.1%
65 or Older	**2.7%**	2.7%	4.3%	1.3%	4.5%
Respondent Education					
8th Grade or Less	**14.1%**	10.2%	4.1%	22.6%	6.5%
Some High School	**20.2%**	17.6%	16.5%	26.3%	11.0%
High School Graduate	**30.3%**	29.6%	29.1%	31.4%	29.5%
Some College	**25.5%**	30.2%	35.4%	14.7%	38.5%
College Graduate	**9.9%**	12.4%	15.0%	5.1%	14.6%
Relationship to Child					
Mother or Father	**92.2%**	93.0%	89.9%	93.8%	89.5%
Grandparent	**5.1%**	5.2%	6.7%	3.8%	6.5%
Legal Guardian	**1.1%**	0.9%	1.7%	0.7%	1.7%
Other	**1.6%**	0.9%	1.7%	1.7%	2.3%

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

[2-9] The respondent demographic data presented in Table 2-4 are based on the characteristics of the general child population.

The following section presents the CAHPS results for the general child population for Colorado Medicaid FFS, PCPP, DHMC, and RMHP.

NCQA Comparisons

In order to assess the overall performance of the Colorado Medicaid plans, the four global ratings and four composite measures were scored on a three-point scale using the scoring methodology detailed in NCQA's HEDIS Specifications for Survey Measures.[3-1] The resulting three-point mean scores were compared to NCQA's HEDIS Benchmarks and Thresholds for Accreditation.[3-2] Based on this comparison, plan ratings of one (★) to five (★★★★★) stars were determined for each CAHPS measure, where one is the lowest possible rating and five is the highest possible rating.

★★★★★	indicates a score at or above the 90th percentile
★★★★	indicates a score at or between the 75th and 89th percentiles
★★★	indicates a score at or between the 50th and 74th percentiles
★★	indicates a score at or between the 25th and 49th percentiles
★	indicates a score below the 25th percentile

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

[3-2] National Committee for Quality Assurance. *HEDIS Benchmarks and Thresholds for Accreditation 2013*. Washington, DC: NCQA, March 15, 2013.

Table 3-1 shows the plans' three-point mean scores and overall client satisfaction ratings on the four global ratings and four composite measures for the general child population.[3-3] NCQA does not provide benchmarks for the Shared Decision Making composite measure, and Coordination of Care and Health Promotion and Education individual measures; therefore, overall client satisfaction ratings could not be determined.

Table 3-1
NCQA Comparisons
Overall Client Satisfaction Ratings

	Colorado Medicaid FFS	Colorado Medicaid PCPP	DHMC	RMHP
Global Rating				
Rating of Health Plan	★★ 2.523	★★★ 2.577	★★★★ 2.621	★★★ 2.590
Rating of All Health Care	★★★ 2.526	★★★★★ 2.597	★★★★★ 2.591	★★★★ 2.582
Rating of Personal Doctor	★★★★ 2.661	★★★★ 2.683	★★★★★ 2.784	★★★★★ 2.710
Rating of Specialist Seen Most Often	★★★★★* 2.662	★★* 2.544	★★★★★ 2.745	★★★★★* 2.675
Composite Measure				
Getting Needed Care	★★★★★ 2.529	★★★★ 2.470	★★ 2.319	★★★★★ 2.625
Getting Care Quickly	★★★ 2.628	★★★★★ 2.710	★ 2.338	★★★★★ 2.699
How Well Doctors Communicate	★★★ 2.712	★★★★★ 2.754	★★★ 2.714	★★★★★ 2.794
Customer Service	★★★★* 2.529	★★★★ 2.529	★★ 2.426	★★★★* 2.536

Please note: CAHPS scores with fewer than 100 respondents are denoted with an asterisk (*). If there are fewer than 100 respondents for a CAHPS measure, caution should be exercised when interpreting these results.

[3-3] Due to the changes to the Getting Needed Care composite measure, caution should be exercised when interpreting the results of the NCQA comparisons and overall client satisfaction ratings for this measure. For detailed information on the changes to the composite measure, please refer to the Executive Summary Section of this report.

Summary of NCQA Comparisons Results

The following table summarizes the NCQA comparisons results for the general child Medicaid population.

Table 3-2
NCQA Comparisons Results

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

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

Please note: CAHPS scores with fewer than 100 respondents are denoted with an asterisk (*). If there are fewer than 100 respondents for a CAHPS measure, caution should be exercised when interpreting these results.

Trend Analysis

In 2011, Colorado Medicaid FFS, PCPP, DHMC, and RMHP had 492, 593, 1,170, and 475 completed general child CAHPS Surveys, respectively. In 2012, Colorado Medicaid FFS, PCPP, DHMC, and RMHP had 553, 533, 901, and 374 completed general child CAHPS Surveys, respectively. In 2013, Colorado Medicaid FFS, PCPP, DHMC, and RMHP had 484, 446, 1,021, and 359 completed general child CAHPS Surveys, respectively. These completed surveys were used to calculate the 2011, 2012, and 2013 CAHPS results presented in this section for trending purposes.[3-4]

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.[3-5] The scoring of the global ratings, composite measures, and individual item measures involved assigning top-level responses a score of one, with all other responses receiving a score of zero. After applying this scoring methodology, the percentage of top-level responses was calculated in order to determine the question summary rates and global proportions. For additional details, please refer to the *NCQA HEDIS 2013 Specifications for Survey Measures*, *Volume 3*.

In order to evaluate trends in Colorado Medicaid client satisfaction, HSAG performed a stepwise three-year trend analysis, where applicable.[3-6] The first step compared the 2013 Colorado Medicaid and plan-level CAHPS scores to the corresponding 2012 scores. If the initial 2013 and 2012 trend analysis did not yield any statistically significant differences, then an additional trend analysis was performed between 2013 and 2011 results. Figure 3-1 through Figure 3-11 show the results of this trend analysis. Statistically significant differences are noted with directional triangles. Scores that were statistically higher in 2013 than in 2012 are noted with black upward (▲) triangles. Scores that were statistically lower in 2013 than in 2012 are noted with black downward (▼) triangles. Scores that were statistically higher in 2013 than in 2011 are noted with red upward (▲) triangles. Scores that were statistically lower in 2013 than in 2011 are noted with red downward (▼) triangles. Scores in 2013 that were not statistically different from scores in 2012 or in 2011 are not noted with triangles.

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

[3-4] Due to changes in the NCQA national averages available for composite measures, the 2011 and 2012 global proportions for each composite measure were recalculated. The 2011 and 2012 CAHPS results for all composite measures presented in this section will not match previous years' Child Medicaid Client Satisfaction Reports.

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

[3-6] Due to the transition from the CAHPS 4.0 to 5.0 Child Medicaid Health Plan Survey, trending could not be performed for the Shared Decision Making composite measure and Health Promotion and Education individual item measure. For detailed information on the changes to these CAHPS measures, please refer to the Executive Summary Section of this report.

Global Ratings

Rating of Health Plan

Colorado Medicaid 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 3-1 shows the 2012 NCQA national average, and the 2011, 2012, and 2013 Rating of Health Plan question summary rates for Colorado Medicaid, FFS, PCPP, DHMC, and RMHP.[3-7,3-8,3-9]

Figure 3-1—Rating of Health Plan

2011 2012 2013

2012 NCQA National Average 67.4

Colorado Medicaid Program 68.1 67.8 68.0

Fee-for-Service 63.3 60.1 65.0

Primary Care Physician Program 64.9 69.0 63.7

Denver Health Medicaid Choice 71.7 71.9 71.5

Rocky Mountain Health Plans 68.3 67.9 67.3

0.0 10.0 20.0 30.0 40.0 50.0 60.0 70.0 80.0 90.0 100.0

Rating of Health Plan

Top Box Response - Percent

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

[3-7] Colorado Medicaid scores in this section are derived from the combined results of the four Colorado Medicaid plans: FFS, PCPP, DHMC, and RMHP.

[3-8] NCQA national averages were not available for 2013 at the time this report was prepared; therefore, 2012 NCQA national data are presented in this section.

[3-9] The source for the NCQA national averages contained in this publication is Quality Compass® 2012 data and is used with the permission of the National Committee for Quality Assurance (NCQA). Quality Compass 2012 includes certain CAHPS data. Any data display, analysis, interpretation, or conclusion based on these data is solely that of the authors, and NCQA specifically disclaims responsibility for any such display, analysis, interpretation, or conclusion. Quality Compass® is a registered trademark of NCQA. CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

Rating of All Health Care

Colorado Medicaid 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 3-2 shows the 2012 NCQA national average, and the 2011, 2012, and 2013 Rating of All Health Care question summary rates for Colorado Medicaid, FFS, PCPP, DHMC, and RMHP.

Figure 3-2—Rating of All Health Care

	2011	2012	2013
2012 NCQA National Average		64.1	
Colorado Medicaid Program	61.8	64.2	65.7 ▲ (red)
Fee-for-Service	60.1	61.9	61.2
Primary Care Physician Program	61.7	67.6	65.7
Denver Health Medicaid Choice	63.4	64.9	68.4
Rocky Mountain Health Plans	60.1	61.7	64.6

0.0 10.0 20.0 30.0 40.0 50.0 60.0 70.0 80.0 90.0 100.0

Rating of All Health Care

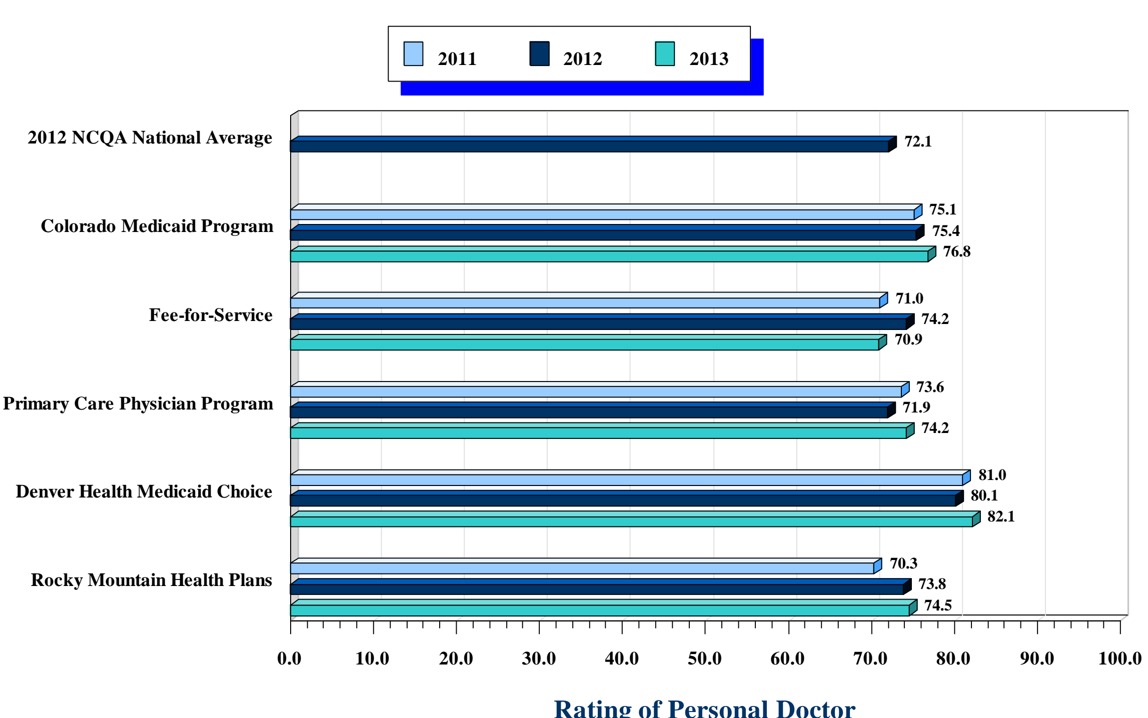
Top Box Response - Percent

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

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 3-3 shows the 2012 NCQA national average, and the 2011, 2012, and 2013 Rating of Personal Doctor question summary rates for Colorado Medicaid, FFS, PCPP, DHMC, and RMHP.

Figure 3-3—Rating of Personal Doctor



Rating of Personal Doctor

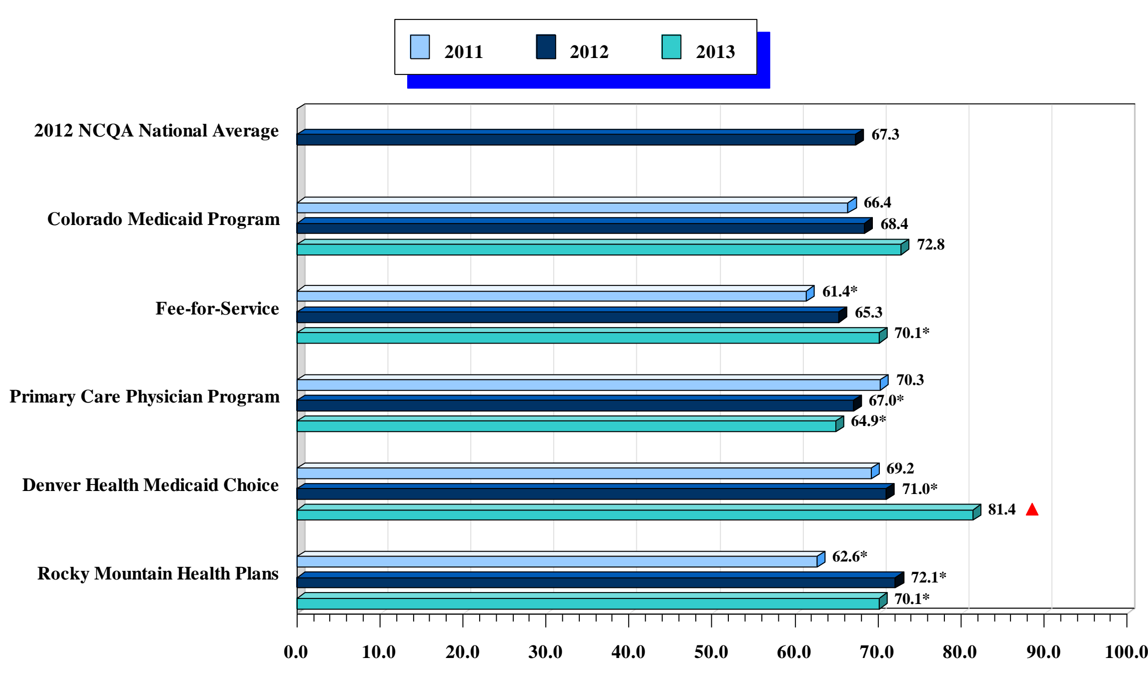
Top Box Response - Percent

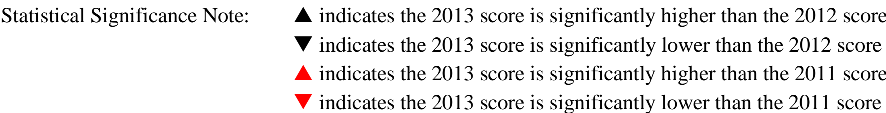
Statistical Significance Note:
▲ indicates the 2013 score is significantly higher than the 2012 score
▼ indicates the 2013 score is significantly lower than the 2012 score
▲ indicates the 2013 score is significantly higher than the 2011 score
▼ indicates the 2013 score is significantly lower than the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

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 3-4 shows the 2012 NCQA national average, and the 2011, 2012, and 2013 Rating of Specialist Seen Most Often question summary rates for Colorado Medicaid, FFS, PCPP, DHMC, and RMHP.

Figure 3-4—Rating of Specialist Seen Most Often





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

Composite Measures[3-10]

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 15 and 46), a top-level response was defined as a response of "Usually" or "Always." Figure 3-5 shows the 2012 NCQA national average, and the 2011, 2012, and 2013 Getting Needed Care global proportions for Colorado Medicaid, FFS, PCPP, DHMC, and RMHP.[3-11]

Figure 3-5—Getting Needed Care

	2011	2012	2013
2012 NCQA National Average		79.3	
Colorado Medicaid Program	77.4	78.7	86.5 ▲
Fee-for-Service	77.9	80.9	88.3 ▲
Primary Care Physician Program	81.5	85.3	86.7
Denver Health Medicaid Choice	69.3	65.9	81.6 ▲
Rocky Mountain Health Plans	84.2	86.5	93.1 ▲

0.0 10.0 20.0 30.0 40.0 50.0 60.0 70.0 80.0 90.0 100.0

Getting Needed Care Composite

Top Box Response - Percent

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

[3-10] As previously noted, the 2011 and 2012 Colorado Medicaid, FFS, PCPP, DHMC, and RMHP CAHPS results for all composite measures were recalculated based on the availability of current NCQA national average data; therefore, the 2011 and 2012 global proportions results presented in this section will not match the 2011 and 2012 CAHPS results in previous years' Child Medicaid Client Satisfaction Reports.

[3-11] Due to the changes to the Getting Needed Care composite measure, caution should be exercised when interpreting the trending results and comparisons to NCQA national averages. For detailed information on the changes to the composite measure, please refer to the Executive Summary Section of this report.

Getting Care Quickly

Colorado Medicaid 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 "Usually" or "Always." Figure 3-6 shows the 2012 NCQA national average, and the 2011, 2012, and 2013 Getting Care Quickly global proportions for Colorado Medicaid, FFS, PCPP, DHMC, and RMHP.

Figure 3-6—Getting Care Quickly

	2011	2012	2013
2012 NCQA National Average		87.3	
Colorado Medicaid Program	84.9	86.3	86.5
Fee-for-Service	87.0	86.3	90.3
Primary Care Physician Program	91.8	92.3	93.7
Denver Health Medicaid Choice	77.0	79.0	77.9
Rocky Mountain Health Plans	88.3	92.3	93.6 ▲ (red)

0.0 10.0 20.0 30.0 40.0 50.0 60.0 70.0 80.0 90.0 100.0

Getting Care Quickly Composite

Top Box Response - Percent

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

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 32, 33, 34, and 37), a top-level response was defined as a response of "Usually" or "Always." Figure 3-7 shows the 2012 NCQA national average, and the 2011, 2012, and 2013 How Well Doctors Communicate global proportions for Colorado Medicaid, FFS, PCPP, DHMC, and RMHP.

Figure 3-7—How Well Doctors Communicate

	2011	2012	2013
2012 NCQA National Average		91.8	
Colorado Medicaid Program	92.8	93.1	95.2
Fee-for-Service	92.6	93.0	94.0
Primary Care Physician Program	94.0	94.9	95.5
Denver Health Medicaid Choice	91.0	91.6	94.7 ▲
Rocky Mountain Health Plans	94.3	93.2	97.3 ▲

0.0 10.0 20.0 30.0 40.0 50.0 60.0 70.0 80.0 90.0 100.0

How Well Doctors Communicate Composite

Top Box Response - Percent

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

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 50 and 51), a top-level response was defined as a response of "Usually" or "Always." Figure 3-8 shows the 2012 NCQA national average, and the 2011, 2012, and 2013 Customer Service global proportions for Colorado Medicaid, FFS, PCPP, DHMC, and RMHP.

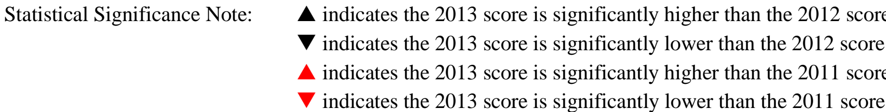
Figure 3-8—Customer Service

	2011	2012	2013
2012 NCQA National Average		83.0	
Colorado Medicaid Program	74.5	79.5	87.5 ▲
Fee-for-Service	64.5*	71.6*	87.9*▲
Primary Care Physician Program	73.8*	86.6*	88.7 ▲ (red)
Denver Health Medicaid Choice	73.4	79.2	86.4 ▲
Rocky Mountain Health Plans	92.3*	83.8*	89.1*

0.0 10.0 20.0 30.0 40.0 50.0 60.0 70.0 80.0 90.0 100.0

Customer Service Composite

Top Box Response - Percent

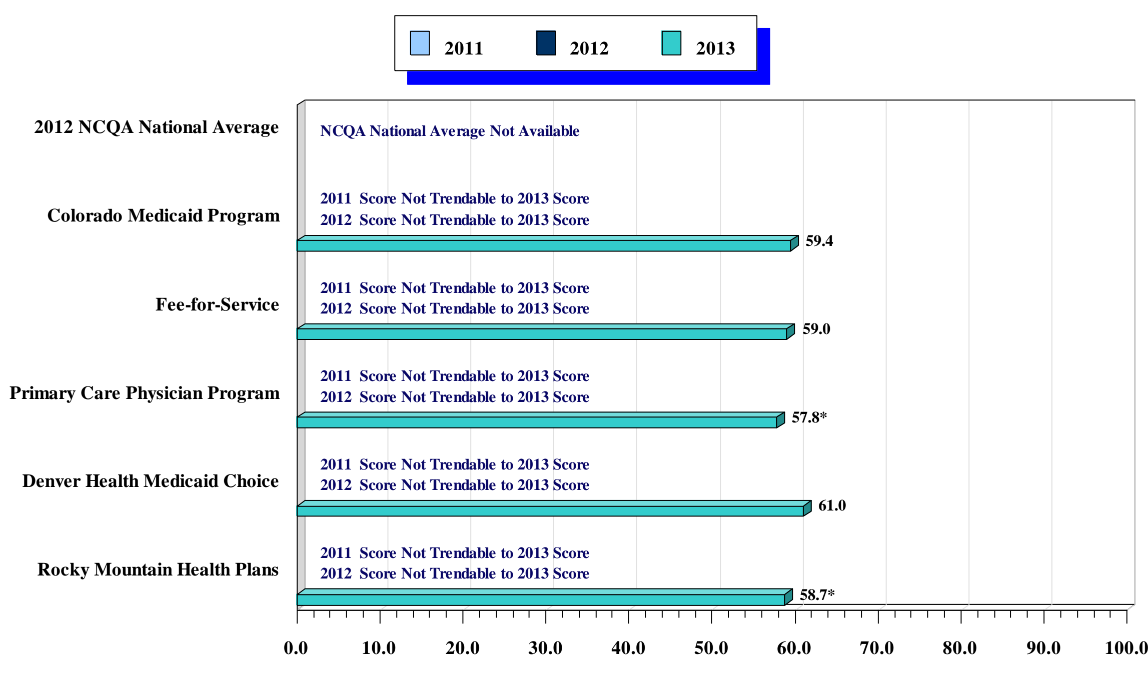

Statistical Significance Note: ▲ indicates the 2013 score is significantly higher than the 2012 score
▼ indicates the 2013 score is significantly lower than the 2012 score
▲ indicates the 2013 score is significantly higher than the 2011 score
▼ indicates the 2013 score is significantly lower than the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

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

Shared Decision Making

Colorado Medicaid parents/caretakers of child clients were asked three questions to assess if their child's doctors discussed starting or stopping a medication with them. For each of these questions (Questions 11, 12, and 13), a top-level response was defined as a response of "A lot" or "Yes." Figure 3-9 shows the 2013 Shared Decision Making global proportions for Colorado Medicaid, FFS, PCPP, DHMC, and RMHP.[3-12]

Figure 3-9—Shared Decision Making



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

[3-12] Due to changes to the Shared Decision Making composite measure, trending and comparisons to NCQA national averages could not be performed for 2013. For detailed information on the changes to the composite measure, please refer to the Executive Summary Section of this report.

Individual Item Measures

Coordination of Care[3-13]

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 40), a top-level response was defined as a response of "Usually" or "Always." Figure 3-10 shows the 2012 NCQA national average, and the 2011, 2012, and 2013 Coordination of Care question summary rates for Colorado Medicaid, FFS, PCPP, DHMC, and RMHP.

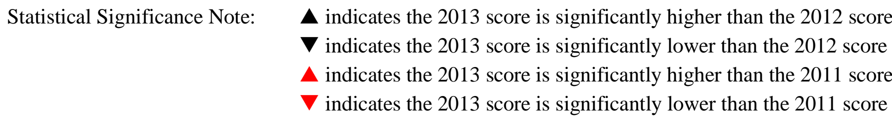
Figure 3-10—Coordination of Care

	2011	2012	2013
2012 NCQA National Average		79.7	
Colorado Medicaid Program	82.0	83.6	82.8
Fee-for-Service	81.3	81.8	80.4
Primary Care Physician Program	79.9	87.3	78.0*
Denver Health Medicaid Choice	83.0	82.6	85.6
Rocky Mountain Health Plans	83.7	82.3	84.3

0.0 10.0 20.0 30.0 40.0 50.0 60.0 70.0 80.0 90.0 100.0

Coordination of Care

Top Box Response - Percent


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

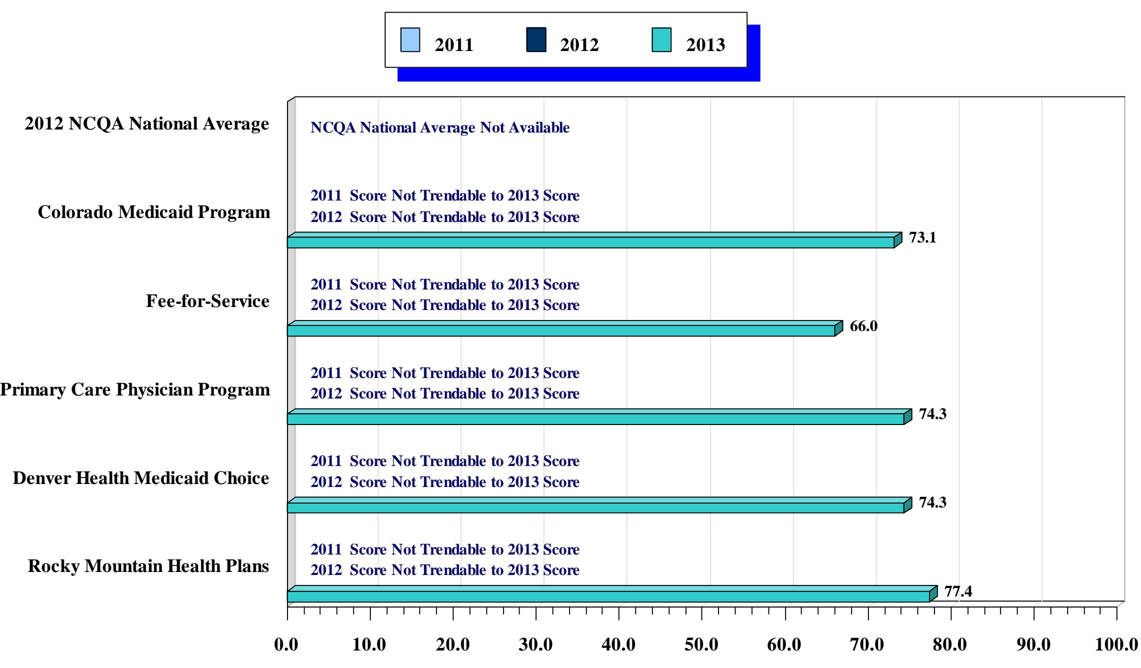
** If the plan had fewer than 100 respondents for a measure, caution should be exercised when interpreting these results.*

[3-13] The 2011 and 2012 CAHPS results for the Coordination of Care individual item were recalculated for Colorado Medicaid, FFS, PCPP, DHMC, and RMHP based on the availability of current NCQA national average data. Therefore, the 2011 and 2012 Coordination of Care question summary rates presented in this section will not match the 2011 and 2012 results in previous years' Child Medicaid Client Satisfaction Reports.

Health Promotion and Education

Colorado Medicaid parents/caretakers of child clients were asked a question to assess if 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 "Yes." Figure 3-11 shows the 2013 Health Promotion and Education question summary rates for Colorado Medicaid, FFS, PCPP, DHMC, and RMHP.[3-14]

Figure 3-11—Health Promotion and Education



[3-14] Due to changes to the Health Promotion and Education individual item measure, trending and comparisons to NCQA national averages could not be performed for 2013. For detailed information on the changes to the individual item measure, please refer to the Executive Summary Section of this report.

Summary of Trend Analysis Results

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

Table 3-3
Trend Analysis Highlights

	Colorado Medicaid FFS	Colorado Medicaid PCPP	DHMC	RMHP
Global Rating				
Rating of Specialist Seen Most Often			▲ (red)	
Composite Measure				
Getting Needed Care	▲		▲	▲
Getting Care Quickly				▲ (red)
How Well Doctors Communicate			▲	▲
Customer Service	▲*	▲ (red)	▲	

▲ *Indicates the 2013 score is significantly higher than the 2012 score*
▼ *Indicates the 2013 score is significantly lower than the 2012 score*
▲ (red) *Indicates the 2013 score is significantly higher than the 2011 score*
▼ (red) *Indicates the 2013 score is significantly lower than the 2011 score*
Please note: CAHPS scores with fewer than 100 respondents are denoted with an asterisk (*). If there are fewer than 100 respondents for a CAHPS measure, caution should be exercised when interpreting these results.

Plan Comparisons

In order to identify performance differences in client satisfaction between the four Colorado Medicaid plans, the results for the FFS, PCPP, DHMC, and RMHP general child population were compared to the State Medicaid average using standard tests for statistical significance.[3-15] 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.[3-16] Given that differences in case-mix can result in differences in ratings between plans that are not due to differences in quality, the data were adjusted to account for disparities in these characteristics. The case-mix adjustment was performed using standard regression techniques (i.e., covariance adjustment).

The scoring of the global ratings, composite measures, and individual item measures involved assigning top-level responses a score of one, with all other responses receiving a score of zero. After applying this scoring methodology, the percentage of top-level responses was calculated in order to determine the question summary rates and global proportions. For additional detail, please refer to the *NCQA HEDIS 2013 Specifications for Survey Measures, Volume 3*.

Statistically significant differences are noted in the tables by arrows. A plan that performed statistically better than the 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.

For purposes of this report, CAHPS scores are reporting for those measures even when NCQA's minimum reporting threshold of 100 respondents was not met; therefore, caution should be exercised when interpreting these results. CAHPS scores with less than 100 respondents are denoted with an asterisk (*).

Table 3-4 shows the results of the plan comparisons analysis. **NOTE: These results may differ from those presented in the trend analysis figures because they have been adjusted for differences in case mix (i.e., the percentages presented have been case-mix adjusted).**

[3-15] Caution should be exercised when evaluating plan comparisons, given that population and plan differences may impact CAHPS results.

[3-16] 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 3-4 Plan Comparisons: General Child				
	Colorado Medicaid FFS	Colorado Medicaid PCPP	DHMC	RMHP
Global Rating				
Rating of Health Plan	65.5% ⇔	65.7% ⇔	67.1% ⇔	69.2% ⇔
Rating of All Health Care	61.3% ⇔	66.4% ⇔	66.0% ⇔	66.2% ⇔
Rating of Personal Doctor	71.3% ⇔	75.1% ⇔	79.5% ⇔	75.9% ⇔
Rating of Specialist Seen Most Often	70.3%* ⇔	65.7%* ⇔	79.9% ⇔	70.6%* ⇔
Composite Measure				
Getting Needed Care	88.7% ⇔	87.2% ⇔	80.1% ↓	93.8% ↑
Getting Care Quickly	90.3% ⇔	93.3% ↑	79.0% ↓	92.9% ↑
How Well Doctors Communicate	94.0% ⇔	95.4% ⇔	94.9% ⇔	97.3% ↑
Customer Service	88.4%* ⇔	89.2% ⇔	85.0% ⇔	89.6%* ⇔
Shared Decision Making	58.5% ⇔	58.8%* ⇔	59.7% ⇔	59.5%* ⇔
Individual Measure				
Coordination of Care	80.3% ⇔	79.0%* ⇔	84.1% ⇔	84.9% ⇔
Health Promotion and Education	66.0% ↓	73.9% ⇔	75.2% ⇔	76.9% ⇔

Please note: CAHPS scores with fewer than 100 respondents are denoted with an asterisk (*). If there are fewer than 100 respondents for a CAHPS measure, caution should be exercised when interpreting these results.

Summary of Plan Comparisons Results

The plan comparisons revealed the following statistically significant results.

- Colorado Medicaid FFS scored significantly lower than the Colorado Medicaid State average on one CAHPS measure, Health Promotion and Education.
- Colorado Medicaid PCPP scored significantly higher than the Colorado Medicaid State average on one CAHPS measure, Getting Care Quickly.
- DHMC scored significantly lower than the Colorado Medicaid State average on two CAHPS measures: Getting Needed Care and Getting Care Quickly.
- RMHP scored significantly higher than the Colorado Medicaid State average on three of the CAHPS measures: Getting Needed Care, Getting Care Quickly, and How Well Doctors Communicate.

Supplemental Items

The Department elected to add five supplemental items to the CAHPS Survey for Colorado Medicaid FFS and PCPP. Three of the questions focused on after-hours care (i.e., care during evenings, weekends, or holidays) for their child, and two of the questions focused on their child's doctor's office. DHMC and RMHP used their own survey vendors to administer the CAHPS Survey and did not include these supplemental items in their surveys.

Table 3-5 details the survey language and response options for each of the supplemental items. Table 3-6 through Table 3-10 show the results for each supplemental item. As previously noted, DHMC and RMHP did not include these items in their CAHPS Survey; therefore, supplemental items results are not available and are denoted in the tables with a hyphen (–). For Colorado Medicaid FFS and PCPP, the number and percentage of responses for each item are presented.

Table 3-5
Supplemental Items

Question		Response Options
Q7a.	In the last 6 months, when your child visited a doctor's office or clinic, did someone in the doctor's office or clinic give you information about what to do if your child needed care during evenings, weekends, or holidays?	Yes No
Q7b.	In the last 6 months, did your child need care during evenings, weekends, or holidays?	Yes No
Q7c.	In the last 6 months, how often were you able to get the care your child needed from his or her doctor or other health provider during evenings, weekends, or holidays?	Never Sometimes Usually Always
Q41a.	Some doctor's offices remind patients between visits about tests, treatment or appointments. In the last 6 months, did you get any reminders about your child's care between visits with your child's personal doctor?	Yes No
Q41b.	In the last 6 months, how often did clerks and receptionists at your child's personal doctor's office treat you with courtesy and respect?	Never Sometimes Usually Always

Given Information about After-Hours Care

Parents/caretakers of child clients were asked when their child visited a doctor's office or clinic if someone gave them information about what to do if their child needed care during evenings, weekends, or holidays (Question 7a). Table 3-6 displays the responses for this question.

Table 3-6
Given Information about After-Hours Care

	Yes		No	
	N	%	N	%
Colorado Medicaid FFS	197	62.3%	119	37.7%
Colorado Medicaid PCPP	214	70.4%	90	29.6%
DHMC	—	—	—	—
RMHP	—	—	—	—

Child Needed After-Hours Care

Parents/caretakers of child clients were asked if their child needed care during evenings, weekends, or holidays (Question 7b). Table 3-7 displays the responses for this question.

Table 3-7
Child Needed After-Hours Care

	Yes		No	
	N	%	N	%
Colorado Medicaid FFS	92	29.7%	218	70.3%
Colorado Medicaid PCPP	70	23.1%	233	76.9%
DHMC	—	—	—	—
RMHP	—	—	—	—

Access to After-Hours Care

Parents/caretakers of child clients were asked to assess how often they were able to get the care their child needed from their child's doctor or other health provider during evenings, weekends, or holidays (Question 7c). Table 3-8 displays the responses for this question.

Table 3-8
Access to After-Hours Care

	Never		Sometimes		Usually		Always	
	N	%	N	%	N	%	N	%
Colorado Medicaid FFS	13	14.3%	15	16.5%	17	18.7%	46	50.5%
Colorado Medicaid PCPP	4	5.9%	8	11.8%	16	23.5%	40	58.8%
DHMC	—	—	—	—	—	—	—	—
RMHP	—	—	—	—	—	—	—	—

Patient Reminders

Parents/caretakers of child clients were asked if they received reminders about their child's care (e.g., tests, treatments, or appointments) between visits with their child's personal doctor (Question 41a). Table 3-9 displays the responses for this question.

Table 3-9
Patient Reminders

	Yes		No	
	N	%	N	%
Colorado Medicaid FFS	189	56.6%	145	43.4%
Colorado Medicaid PCPP	189	52.4%	172	47.6%
DHMC	—	—	—	—
RMHP	—	—	—	—

Courtesy of Clerks and Receptionists

Parents/caretakers of child clients were asked to assess how often clerks and receptionists at their child's personal's doctor's office treated them with courtesy and respect (Question 41b). Table 3-10 displays the responses for this question.

Table 3-10
Courtesy of Clerks and Receptionists

	Never		Sometimes		Usually		Always	
	N	%	N	%	N	%	N	%
Colorado Medicaid FFS	4	1.2%	24	7.2%	75	22.6%	229	69.0%
Colorado Medicaid PCPP	15	4.2%	15	4.2%	68	19.0%	259	72.5%
DHMC	—	—	—	—	—	—	—	—
RMHP	—	—	—	—	—	—	—	—

4. CCC Results

A series of questions included in the CAHPS 5.0 Child Medicaid Health Plan Survey with CCC measurement set was used to identify children with chronic conditions (i.e., CCC screener questions). This series contains five sets of survey questions that focus on specific health care needs and conditions. Child clients with affirmative responses to all of the questions in at least one of the following five categories were considered to have a chronic condition:

- Child needed or used prescription medicine.
- Child needed or used more medical care, mental health services, or educational services than other children of the same age need or use.
- Child had limitations in the ability to do what other children of the same age do.
- Child needed or used special therapy.
- Child needed or used mental health treatment or therapy.

The survey responses for child clients in both the general child sample and the CCC supplemental sample were analyzed to determine which child clients had chronic conditions. Therefore, the general population of children (i.e., the general child sample) included children with and without chronic conditions based on the responses to the survey questions.

Based on parents/caretakers responses to the CCC screener questions, Colorado Medicaid FFS, PCPP, DHMC, and RMHP had 363, 412, 284, and 339 completed CAHPS Child Medicaid Health Plan Surveys for the CCC population, respectively. These completed surveys were used to calculate the 2013 CCC CAHPS results presented in this section. It is important to note that 2013 is the first year the CAHPS Child Medicaid Health Plan Survey with the CCC measurement set was administered to the Colorado Medicaid FFS, PCPP, DHMC, and RMHP child population. Therefore, the CAHPS results presented in this section represent a **baseline** assessment of the parents/caretakers of children with chronic conditions satisfaction with the care and services provided by Colorado Medicaid FFS, PCPP, DHMC, and RMHP.

For purposes of calculating the CCC results, 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.[4-1] The scoring of the global ratings, composite measures, individual item measures, and CCC composites and items involved assigning top-level responses a score of one, with all other responses receiving a score of zero. After applying this scoring methodology, the percentage of top-level responses was calculated in order to determine the question summary rates and global proportions. For additional details, please refer to the *NCQA HEDIS 2013 Specifications for Survey Measures, Volume 3*.

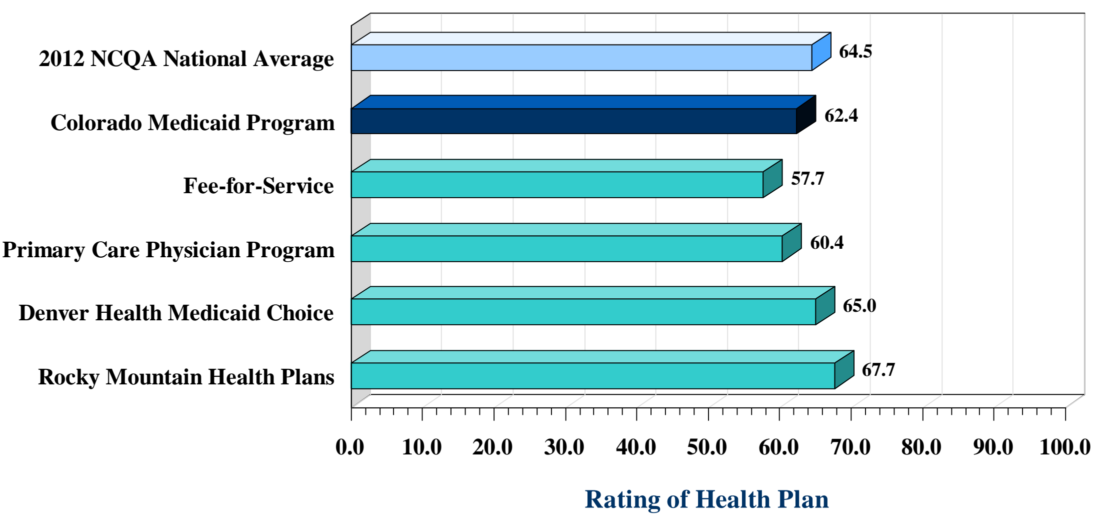
[4-1] National Committee for Quality Assurance. *HEDIS® 2013, Volume 3: Specifications for Survey Measures*. Washington, DC: NCQA Publication, 2012.

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 4-1 shows the 2012 NCQA national average and the 2013 Rating of Health Plan question summary rates for Colorado Medicaid, FFS, PCPP, DHMC, and RMHP.[4-2,4-3]

Figure 4-1—Rating of Health Plan



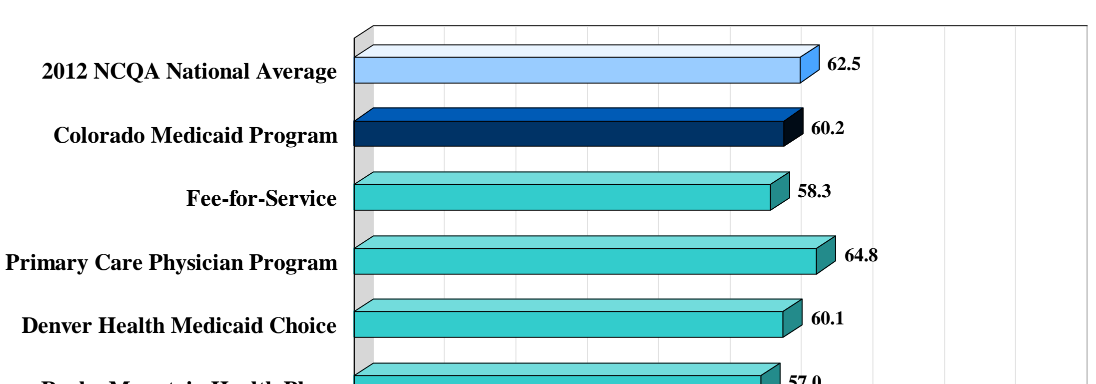
[4-2] Colorado Medicaid scores in this section are derived from the combined CCC population results of the four Colorado Medicaid plans: FFS, PCPP, DHMC, and RMHP.

[4-3] NCQA national averages were not available for 2013 at the time this report was prepared; therefore, 2012 NCQA national averages are presented in this section.

Rating of All Health Care

Colorado Medicaid parents/caretakers of child clients were asked to rate their entire 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 4-2 shows the 2012 NCQA national average and the 2013 Rating of All Health Care question summary rates for Colorado Medicaid, FFS, PCPP, DHMC, and RMHP.

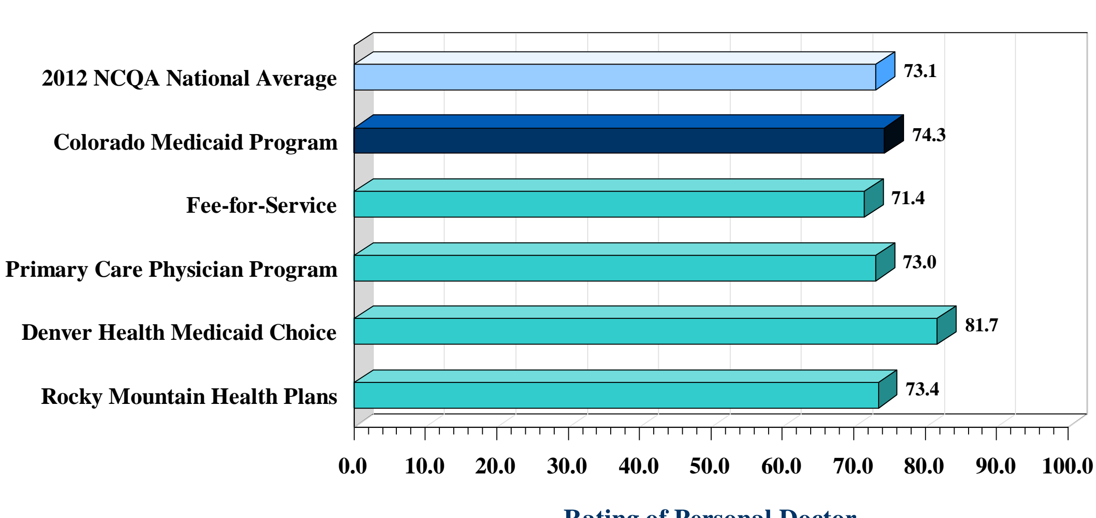
Figure 4-2—Rating of All Health Care



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 4-3 shows the 2012 NCQA national average and the 2013 Rating of Personal Doctor question summary rates for Colorado Medicaid, FFS, PCPP, DHMC, and RMHP.

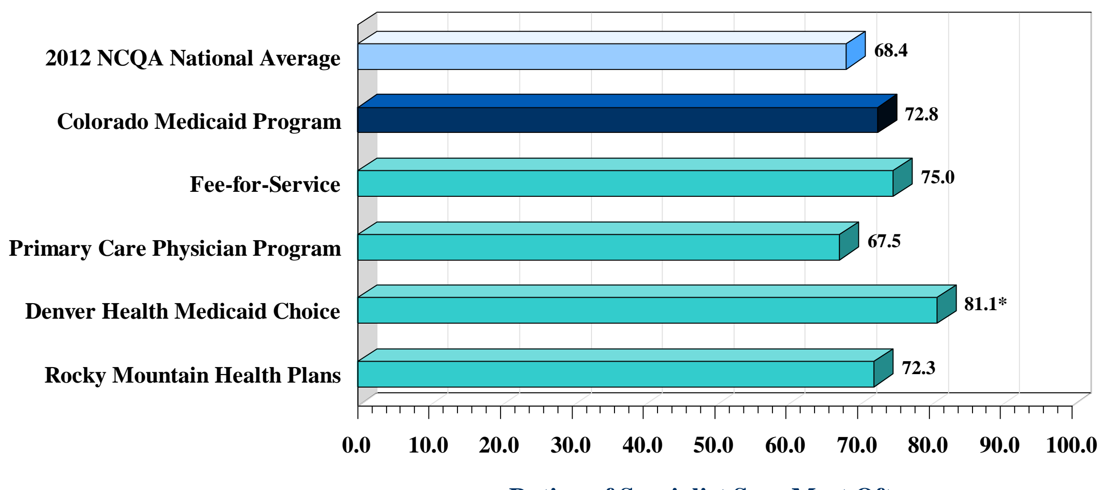
Figure 4-3—Rating of Personal Doctor



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 4-4 shows the 2012 NCQA national average and the 2013 Rating of Specialist Seen Most Often question summary rates for Colorado Medicaid, FFS, PCPP, DHMC, and RMHP.

Figure 4-4—Rating of Specialist Seen Most Often



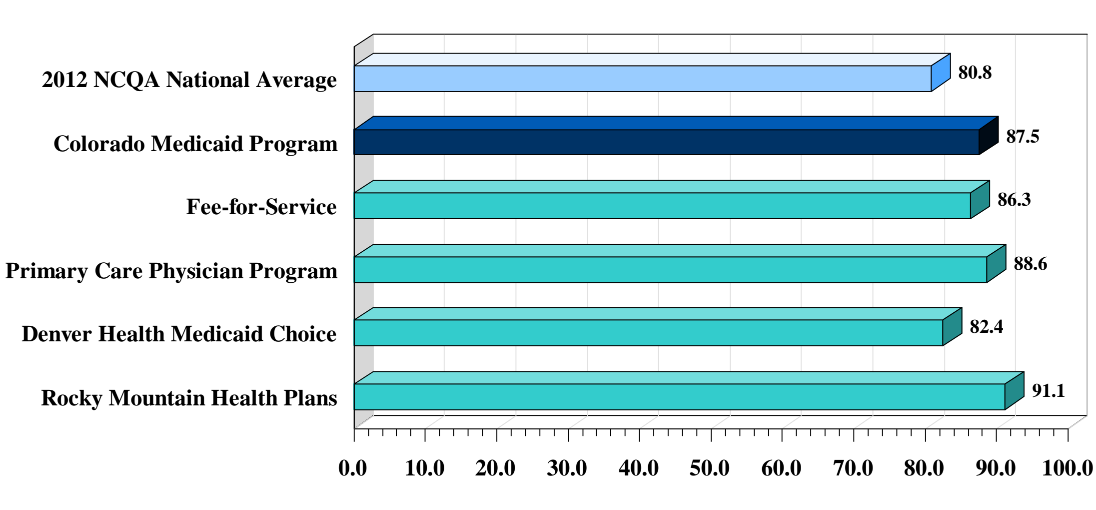
If the plan had fewer than 100 respondents for a measure, caution should be exercised when interpreting these results.

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 15 and 46), a top-level response was defined as a response of “Usually” or “Always.” Figure 4-5 shows the 2012 NCQA national average and the 2013 Getting Needed Care global proportions for Colorado Medicaid, FFS, PCPP, DHMC, and RMHP.[4-4]

Figure 4-5—Getting Needed Care

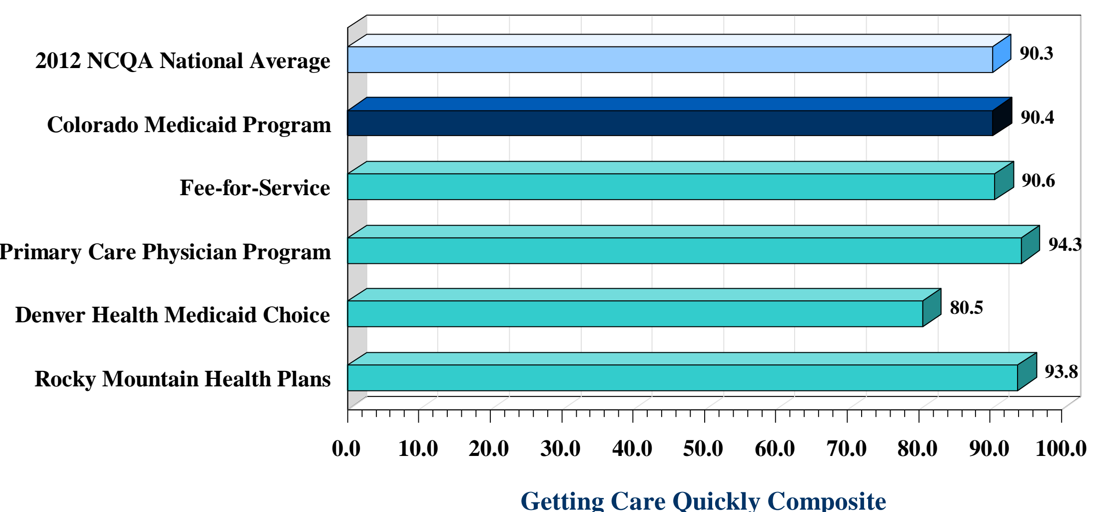


[4-4] Due to the changes to the Getting Needed Care composite measure, caution should be exercised when interpreting the results of the comparisons to NCQA national averages. For detailed information on the changes to the composite measure, please refer to the Executive Summary Section of this report.

Getting Care Quickly

Colorado Medicaid 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 "Usually" or "Always." Figure 4-6 shows the 2012 NCQA national average and the 2013 Getting Care Quickly global proportions for Colorado Medicaid, FFS, PCPP, DHMC, and RMHP.

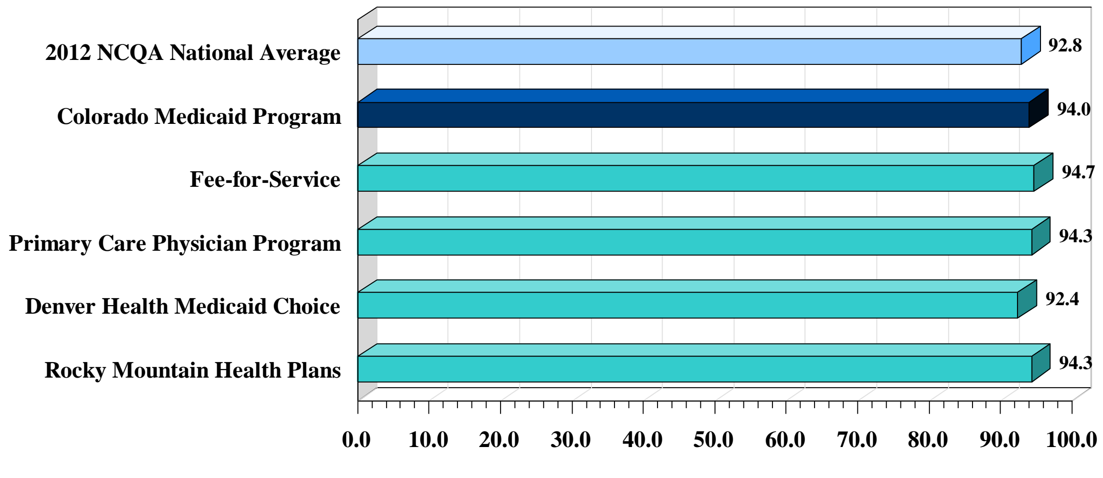
Figure 4-6—Getting Care Quickly



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 32, 33, 34, and 37), a top-level response was defined as a response of "Usually" or "Always." Figure 4-7 shows the 2012 NCQA national average and the 2013 How Well Doctors Communicate global proportions for Colorado Medicaid, FFS, PCPP, DHMC, and RMHP.

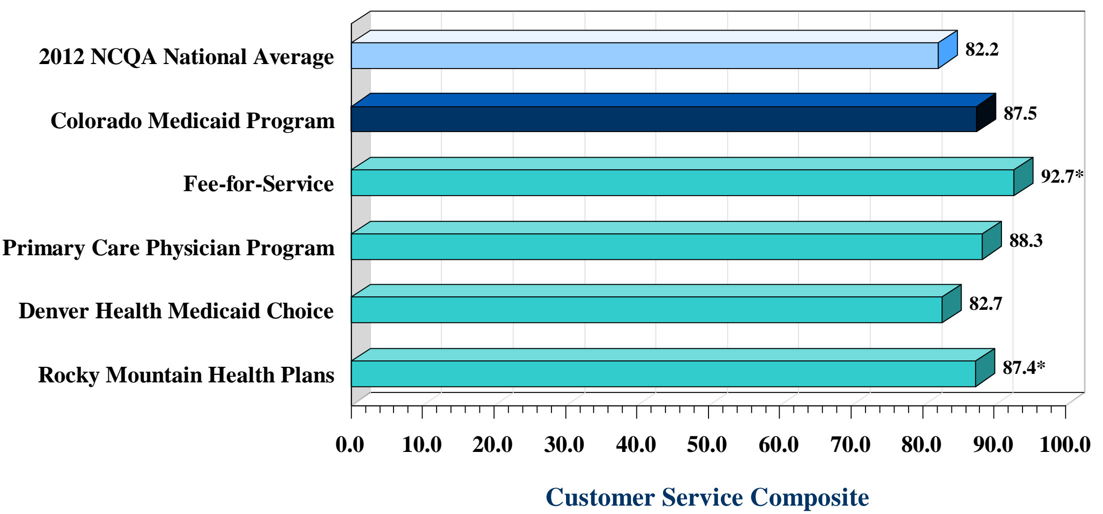
Figure 4-7—How Well Doctors Communicate



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 50 and 51), a top-level response was defined as a response of "Usually" or "Always." Figure 4-8 shows the 2012 NCQA national average and the 2013 Customer Service global proportions for Colorado Medicaid, FFS, PCPP, DHMC, and RMHP.

Figure 4-8—Customer Service

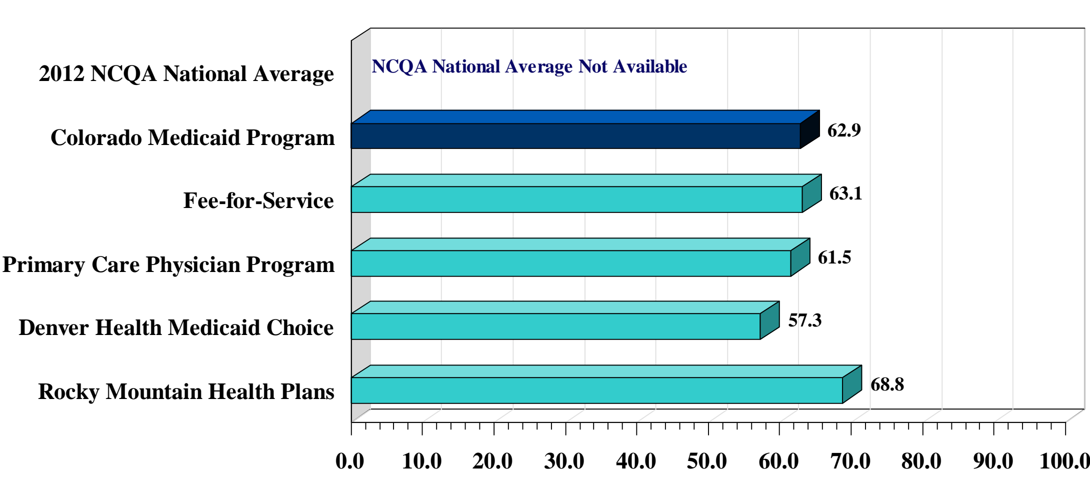


** If the plan had fewer than 100 respondents for a measure, caution should be exercised when interpreting these results.*

Shared Decision Making

Colorado Medicaid parents/caretakers of child clients were asked three questions to assess if their child's doctors discussed starting or stopping medication with them. For each of these questions (Questions 11, 12, and 13), a top-level response was defined as a response of "A lot" or "Yes." Figure 4-9 shows the 2013 Shared Decision Making global proportions for Colorado Medicaid, FFS, PCPP, DHMC, and RMHP.[4-5]

Figure 4-9—Shared Decision Making



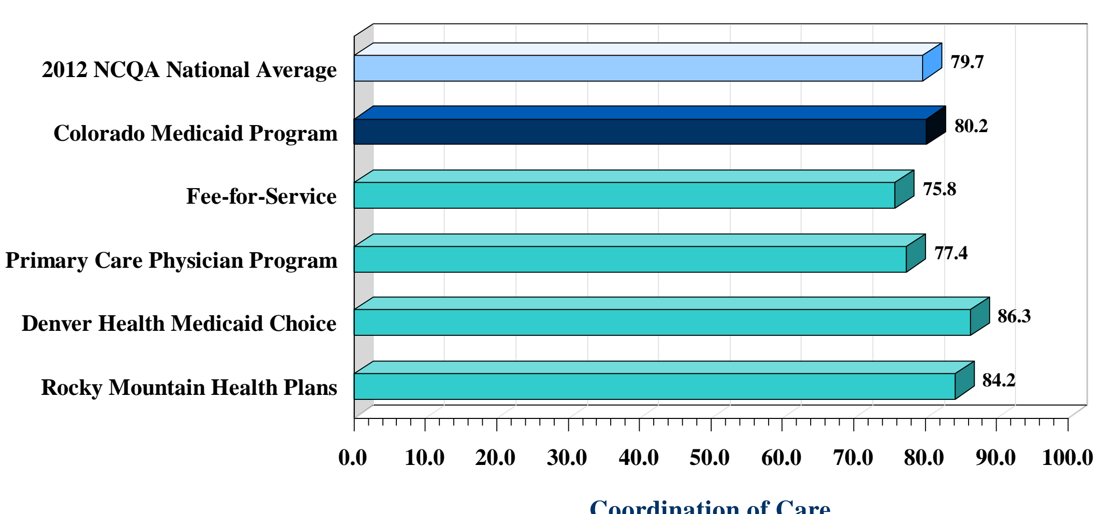
[4-5] Due to changes to the Shared Decision Making composite measure, comparisons to NCQA national averages could not be performed for 2013. For detailed information on the changes to the composite measure, please refer to the Executive Summary Section of this report.

Individual Item Measures

Coordination of Care

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 40), a top-level response was defined as a response of "Usually" or "Always." Figure 4-10 shows the 2012 NCQA national average and 2013 Coordination of Care question summary rates for Colorado Medicaid, FFS, PCPP, DHMC, and RMHP.

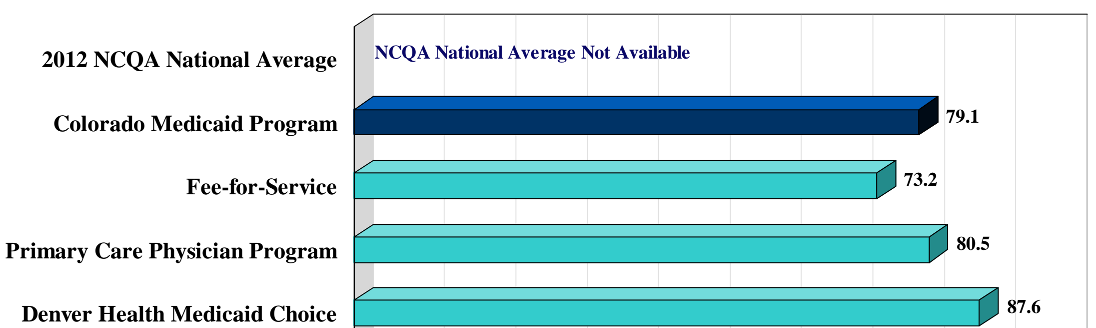
Figure 4-10—Coordination of Care



Health Promotion and Education

Colorado Medicaid parents/caretakers of child clients were asked a question to assess if 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 "Yes." Figure 4-11 shows the 2013 Health Promotion and Education question summary rates for Colorado Medicaid, FFS, PCPP, DHMC, and RMHP.[4-6]

Figure 4-11—Health Promotion and Education



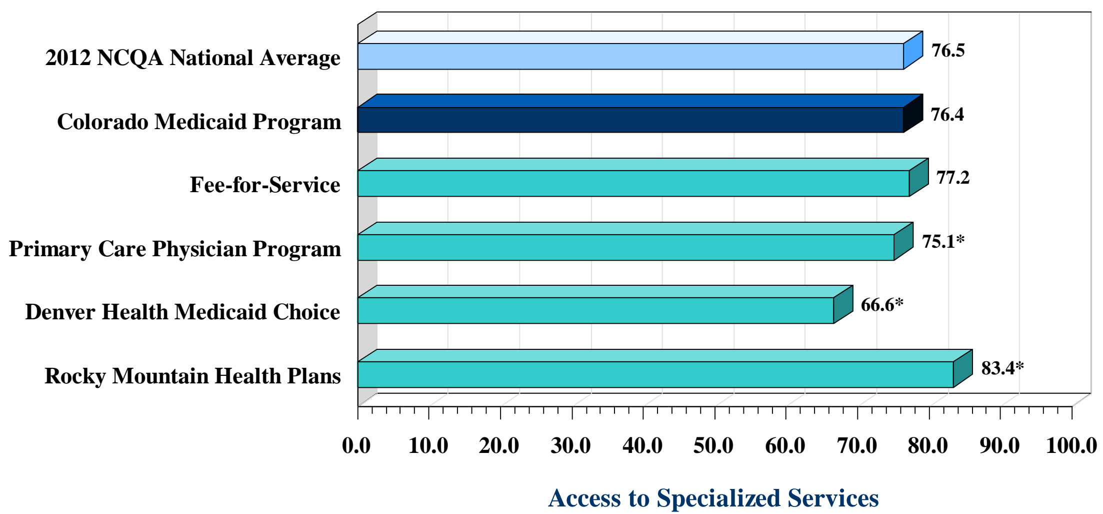
[4-6] Due to changes to the Health Promotion and Education individual item measure, comparisons to NCQA national averages could not be performed for 2013. For detailed information on the changes to the composite measure, please refer to the Executive Summary Section of this report.

CCC Composites and Items

Access to Specialized Services

Colorado Medicaid parents/caretakers of child clients were asked three questions to assess how often it was easy for their child to obtain access to specialized services. For each of these questions (Questions 20, 23, and 26), a top-level response was defined as a response of "Usually" or "Always." Figure 4-12 shows the 2013 Access to Specialized Services global proportions for Colorado Medicaid, FFS, PCPP, DHMC, and RMHP.

Figure 4-12—Access to Specialized Services

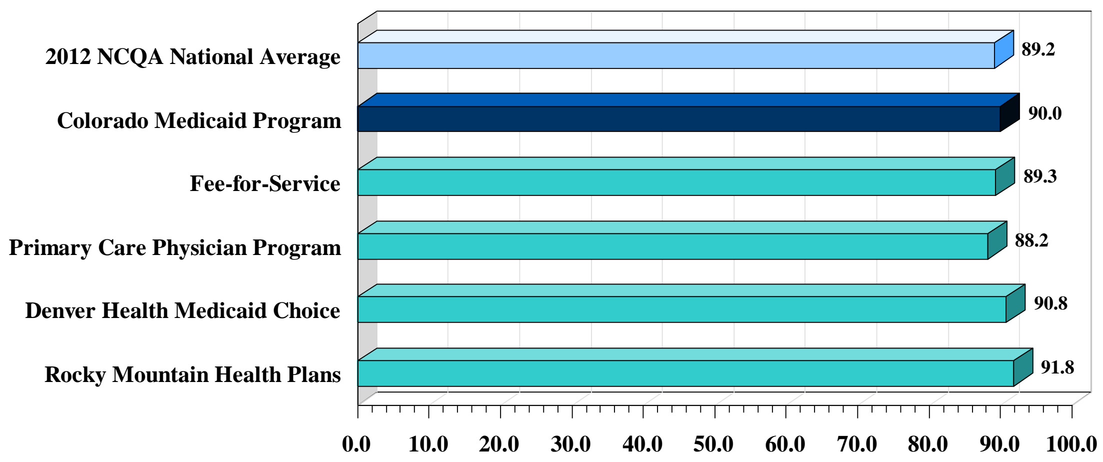


** If the plan had fewer than 100 respondents for a measure, caution should be exercised when interpreting these results.*

Family-Centered Care (FCC): Personal Doctor Who Knows Child

Colorado Medicaid parents/caretakers of child clients were asked three questions to assess whether their child had a personal doctor who knew them. For each of these questions (Questions 38, 43, and 44), a top-level response was defined as a response of "Yes." Figure 4-13 shows the 2013 FCC: Personal Doctor Who Knows Child global proportions for Colorado Medicaid, FFS, PCPP, DHMC, and RMHP.

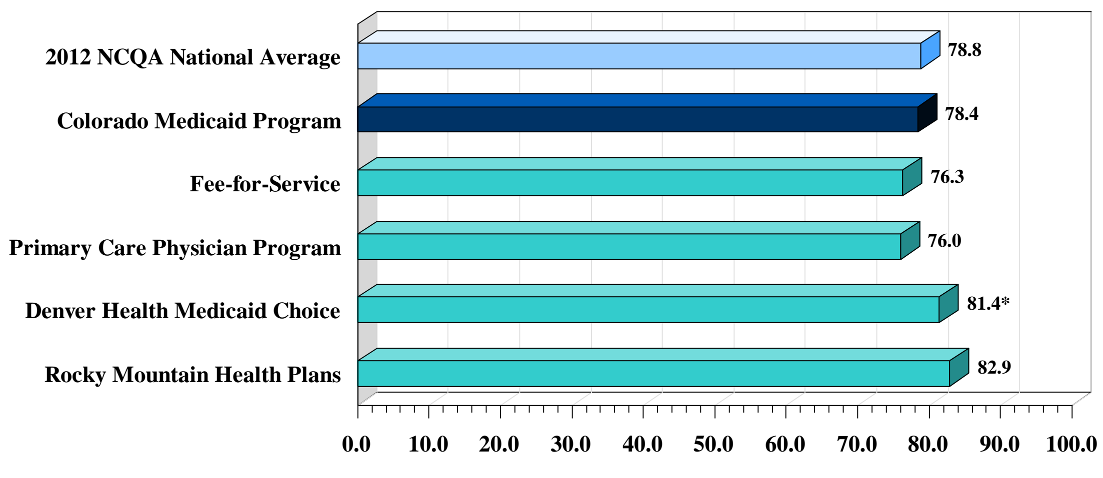
Figure 4-13—FCC: Personal Doctor Who Knows Child



Coordination of Care for Children with Chronic Conditions

Colorado Medicaid parents/caretakers of child clients were asked two questions to assess whether they received help in coordinating their child's care. For each of these questions (Questions 18 and 29), a top-level response was defined as a response of "Yes." Figure 4-14 shows the 2013 Coordination of Care for Children with Chronic Conditions global proportions for Colorado Medicaid, FFS, PCPP, DHMC, and RMHP.

Figure 4-14—Coordination of Care for Children with Chronic Conditions

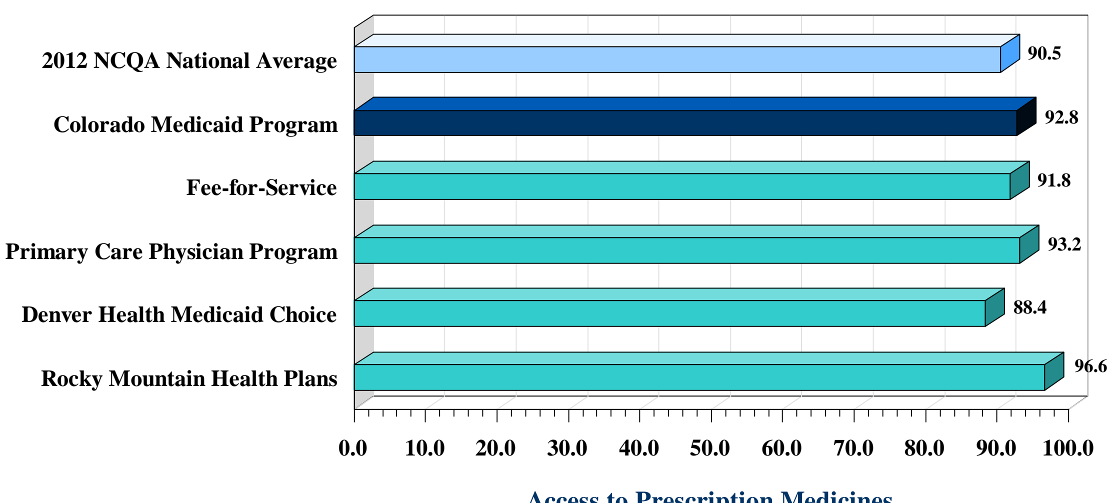


** If the plan had fewer than 100 respondents for a measure, caution should be exercised when interpreting these results.*

Access to Prescription Medicines

Colorado Medicaid parents/caretakers of child clients were asked a question to assess how often it was easy to obtain prescription medicines for their child through their health plan. For this question (Question 56), a top-level response was defined as a response of "Usually" or "Always." Figure 4-15 shows the 2013 Access to Prescription Medicines question summary rates for Colorado Medicaid, FFS, PCPP, DHMC, and RMHP.

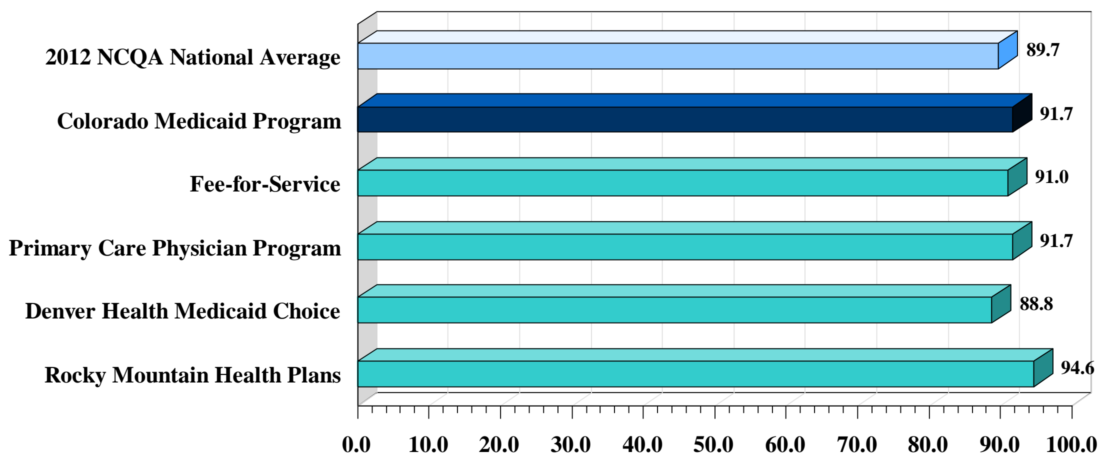
Figure 4-15—Access to Prescription Medicines



FCC: Getting Needed Information

Colorado Medicaid parents/caretakers of child clients were asked a question to assess how often their questions were answered by doctors or other health providers. For this question (Question 9), a top-level response was defined as a response of "Usually" or "Always." Figure 4-16 shows the 2013 FCC: Getting Needed Information question summary rates for Colorado Medicaid, FFS, PCPP, DHMC, and RMHP.

Figure 4-16—FCC: Getting Needed Information



CCC Comparisons

In order to identify performance differences in client satisfaction between the four Colorado Medicaid plans, the CCC CAHPS results for FFS, PCPP, DHMC, and RMHP were compared to the Colorado Medicaid State average using standard tests for statistical significance. 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. The CCC results for the Colorado Medicaid plans were case-mix adjusted for client general health status, respondent educational level, and respondent age.[4-7] 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, individual item measures, and CCC composites and items involved assigning top-level responses a score of one, with all other responses receiving a score of zero. After applying this scoring methodology, the percentage of top-level responses was calculated in order to determine the question summary rates and global proportions. For additional details, please refer to the *NCQA HEDIS 2013 Specifications for Survey Measures, Volume 3*.

Statistically significant differences between the plans' CCC scores and the Colorado Medicaid State CCC average are noted in the tables with arrows. A plan that performed statistically better than the CCC State average is denoted with an upward (↑) arrow. Conversely, a plan that performed statistically worse than the CCC State average is denoted with a downward (↓) arrow. If a plan's score is not statistically different than the CCC State average, the plan's score is denoted with a horizontal (↔) arrow.

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

Table 4-1 shows the results of the plan comparisons analysis. **NOTE: These results may differ from those presented in the CCC figures because they have been adjusted for differences in case mix (i.e., the percentages presented have been case-mix adjusted).**

[4-7] 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 4-1 Plan Comparisons: CCC				
	Colorado Medicaid FFS	Colorado Medicaid PCPP	DHMC	RMHP
Global Rating				
Rating of Health Plan	59.4% ⇔	61.4% ⇔	60.9% ⇔	69.0% ↑
Rating of All Health Care	59.5% ⇔	64.9% ⇔	58.2% ⇔	57.7% ⇔
Rating of Personal Doctor	72.5% ⇔	73.8% ⇔	79.1% ⇔	74.1% ⇔
Rating of Specialist Seen Most Often	75.0% ⇔	67.8% ⇔	81.0%* ⇔	72.1% ⇔
Composite Measure				
Getting Needed Care	86.4% ⇔	88.4% ⇔	82.5% ⇔	91.1% ↑
Getting Care Quickly	90.2% ⇔	93.8% ↑	81.8% ↓	93.4% ↑
How Well Doctors Communicate	94.6% ⇔	93.8% ⇔	93.1% ⇔	94.2% ⇔
Customer Service	92.6%* ⇔	88.7% ⇔	82.2% ⇔	87.7%* ⇔
Shared Decision Making	62.9% ⇔	60.4% ⇔	59.4% ⇔	68.0% ⇔
Individual Measure				
Coordination of Care	76.7% ⇔	77.9% ⇔	84.2% ⇔	84.9% ⇔
Health Promotion and Education	73.1% ↓	80.6% ⇔	87.7% ↑	77.2% ⇔
CCC Composite and Items				
Access to Specialized Services	78.5% ⇔	76.1%* ⇔	63.2%* ↓	84.4%* ↑
FCC: Personal Doctor Who Knows Child	89.4% ⇔	88.4% ⇔	90.8% ⇔	91.7% ⇔
Coordination of Care for CCC	76.9% ⇔	76.6% ⇔	80.2%* ⇔	82.9% ⇔
Access to Prescription Medicines	91.9% ⇔	93.0% ⇔	88.6% ⇔	96.5% ↑
FCC: Getting Needed Information	90.9% ⇔	91.5% ⇔	89.3% ⇔	94.4% ⇔

Please note: CAHPS scores with fewer than 100 respondents are denoted with an asterisk (*). If there are fewer than 100 respondents for a CAHPS measure, caution should be exercised when interpreting these results.

Summary of CCC Comparisons Results

The CCC comparisons revealed the following statistically significant results.

- Colorado Medicaid FFS scored significantly lower than the CCC Colorado Medicaid State average on one CAHPS measure, Health Promotion and Education.
- Colorado Medicaid PCPP scored significantly higher than the CCC Colorado Medicaid State average on one CAHPS measures, Getting Care Quickly.
- DHMC scored significantly higher than the CCC Colorado Medicaid State average on one CAHPS measure, Health Promotion and Education. Additionally, DHMC scored significantly lower than the CCC Colorado Medicaid State average on two CAHPS measures: Getting Care Quickly and Access to Specialized Services.
- RMHP scored significantly higher than the CCC Colorado Medicaid State average on five of the CAHPS measures: Rating of Health Plan, Getting Needed Care, Getting Care Quickly, Access to Specialized Services, and Access to Prescription Medicines.

General Recommendations

HSAG recommends the continued administration of the CAHPS 5.0 Child Medicaid Health Plan Survey with the HEDIS supplemental item set and CCC measurement in fiscal year (FY) 2013-2014. HSAG will continue performing 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 for the FY 2011-2012 survey administration is comparable to the completed surveys in Spanish for the FY 2012-2013 survey administration due to the identification of these clients prior to the start of the survey.

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 QI: top, high, moderate, and low priority. The priority of the recommendations is based on the combined results of the general child NCQA comparisons and trend analysis.[5-1,5-2]

The priorities presented in this section should be viewed as potential suggestions for QI. Additional sources of QI information, such as other HEDIS results, should be incorporated into a comprehensive QI plan. A number of resources are available to assist state Medicaid agencies and plans with the implementation of CAHPS-based QI initiatives. A comprehensive list of these resources is included in the Reader's Guide Section, beginning on page 6-11.

[5-1] Due to the transition from the CAHPS 4.0 to 5.0 Child Medicaid Health Plan Survey, comparisons to national data and trending could not be performed for the Shared Decision Making composite measure and Health Promotion and Education individual item measure; therefore, priority assignments cannot be derived for these measures.

[5-2] NCQA does not provide benchmarks for the Coordination of Care individual item measure; therefore, priority assignments cannot be derived for this measure.

Table 5-1 shows how the priority assignments are determined for each plan on each CAHPS measure.

Table 5-1—Derivation of Priority Assignments on each CAHPS Measure		
NCQA Comparisons (Star Ratings)	**Trend Analysis**	**Priority Assignment**
★	▼	Top
★	—	Top
★	▲	Top
★★	▼	Top
★★	—	High
★★	▲	High
★★★	▼	High
★★★	—	Moderate
★★★	▲	Moderate
★★★★	▼	Moderate
★★★★	—	Moderate
★★★★★	▼	Moderate
★★★★	▲	Low
★★★★★	—	Low
★★★★★	▲	Low
Please note: Trend analysis results reflect those between either the 2013 and 2012 results or the 2013 and 2011 results.[5-3] *If statistically significant differences were not identified during the trend analysis, this lack of statistical significance is denoted with a hyphen (—) in the table above.*		

[5-3] For more detailed information on the trend analysis results, please see the General Child Results Section of this report.

Global Ratings

Rating of Health Plan

Table 5-2 shows the priority assignments for the overall Rating of Health Plan measure.

Table 5-2
Priority Assignments
Rating of Health Plan

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

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

Alternatives to One-on-One Visits

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

Health Plan Operations

It is important for health plans to view their organization as a collection of microsystems (such as providers, administrators, and other staff that provide services to members) that provide the health plan's health care "products." Health care microsystems include: a team of health providers, patient/population to whom care is provided, environment that provides information to providers and patients, support staff, equipment, and office environment. The goal of the microsystems approach is to focus on small, replicable, functional service systems that enable health plan staff to provide high-quality, patient-centered care. The first step to this approach is to define a measurable

collection of activities. Once the microsystems are identified, new processes that improve care should be tested and implemented. Effective processes can then be rolled out throughout the health plan.

Online Patient Portal

A secure online patient portal allows members easy access to a wide array of health plan and health care information and services that are particular to their needs and interests. To help increase members' satisfaction with their health plan, health plans should consider establishing an online patient portal or integrating online tools and services into their current Web-based systems that focus on patient-centered care. Online health information and services that can be made available to members include: health plan benefits and coverage forms, online medical records, electronic communication with providers, and educational health information and resources on various medical conditions. Access to online interactive tools, such as health discussion boards allow questions to be answered by trained clinicians. Online health risk assessments can provide members instant feedback and education on the medical condition(s) specific to their health care needs. In addition, an online patient portal can be an effective means of promoting health awareness and education. Health plans should periodically review health information content for accuracy and request member and/or physician feedback to ensure relevancy of online services and tools provided.

Promote Quality Improvement Initiatives

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

Specific QI initiatives aimed at engaging employees can include quarterly employee forums, an annual all-staff assembly, topic-specific improvement teams, leadership development courses, and employee awards. As an example, improvement teams can be implemented to focus on specific topics such as service quality; rewards and recognition; and patient, physician, and employee satisfaction.

Rating of All Health Care

Table 5-3 shows the priority assignments for the Rating of All Health Care measure.

Table 5-3
Priority Assignments
Rating of All Health Care

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

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

Access to Care

Health plans should identify potential barriers for patients receiving appropriate access to care. Access to care issues include obtaining the care that the patient and/or physician deemed necessary, obtaining timely urgent care, locating a personal doctor, or receiving adequate assistance when calling a physician office. The health plan should attempt to reduce any hindrances a patient might encounter while seeking care. Standard practices and established protocols can assist in this process by ensuring access to care issues are handled consistently across all practices. For example, health plans can develop standardized protocols and scripts for common occurrences within the provider office setting, such as late patients. With proactive polices and scripts in place, the late patient can be notified the provider has moved onto the next patient and will work the late patient into the rotation as time permits. This type of structure allows the late patient to still receive care without causing delay in the appointments of other patients. Additionally, having a well-written script prepared in the event of an uncommon but expected situation allows staff to work quickly in providing timely access to care while following protocol.

Patient and Family Engagement Advisory Councils

Since both patients and families have the direct experience of an illness or health care system, their perspectives can provide significant insight when performing an evaluation of health care processes. Therefore, health plans should consider creating opportunities and functional roles that include the patients and families who represent the populations they serve. Patient and family members could serve as advisory council members providing new perspectives and serving as a resource to health care processes. Patient interviews on services received and family inclusion in care planning can be an effective strategy for involving members in the design of care and obtaining their input and feedback on how to improve the delivery of care. Further, involvement in advisory councils can provide a structure and process for ongoing dialogue and creative problem-solving between the

health plan and its members. The councils' roles within a health plan organization can vary and responsibilities may include input into or involvement in: program development, implementation, and evaluation; marketing of health care services; and design of new materials or tools that support the provider-patient relationship.

Rating of Personal Doctor

Table 5-4 shows the priority assignments for the Rating of Personal Doctor measure.

Table 5-4
Priority Assignments
Rating of Personal Doctor

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

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

Maintain Truth in Scheduling

Health plans can request that all providers monitor appointment scheduling to ensure that scheduling templates accurately reflect the amount of time it takes to provide patient care during a scheduled office visit. Health plans could provide assistance or instructions to those physicians unfamiliar with this type of assessment. Patient dissatisfaction can often be the result of prolonged wait times and delays in receiving care at the scheduled appointment time. One method for evaluating appropriate scheduling of various appointment types is to measure the amount of time it takes to complete the scheduled visit. This type of monitoring will allow providers to identify if adequate time is being scheduled for each appointment type and if appropriate changes can be made to scheduling templates to ensure patients are receiving prompt, adequate care. Patient wait times for routine appointments should also be recorded and monitored to ensure that scheduling can be optimized to minimize these wait times. Additionally, by measuring the amount of time it takes to provide care, both health plans and physician offices' can identify where streamlining opportunities exist. If providers are finding bottlenecks within their patient flow processes, they may consider implementing daily staff huddles to improve communication or working in teams with cross-functionalities to increase staff responsibility and availability.

Patient-Direct Feedback

Health plans can explore additional methods for obtaining direct patient feedback to improve patient satisfaction, such as comment cards. Comment cards have been utilized and found to be a simple method for engaging patients and obtaining rapid feedback on their recent physician office visit experiences. Health plans can assist in this process by developing comment cards that physician office staff can provide to patients following their visit. Comment cards can be provided to patients with their office visit discharge paperwork or via postal mail or e-mail. Asking patients to describe

what they liked most about the care they received during their recent office visit, what they liked least, and one thing they would like to see changed can be an effective means for gathering feedback (both positive and negative). Comment card questions may also prompt feedback regarding other topics, such as providers' listening skills, wait time to obtaining an appointment, customer service, and other items of interest. Research suggests the addition of the question, "Would you recommend this physician's office to a friend?" greatly predicts overall patient satisfaction. This direct feedback can be helpful in gaining a better understanding of the specific areas that are working well and areas which can be targeted for improvement.

Physician-Patient Communication

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

Improving Shared Decision Making

Health plans should encourage skills training in shared decision making for all physicians. Implementing an environment of shared decision making and physician-patient collaboration requires physician recognition that patients have the ability to make choices that affect their health care. Therefore, one key to a successful shared decision making model is ensuring that physicians are properly trained. Training should focus on providing physicians with the skills necessary to facilitate the shared decision making process; ensuring that physicians understand the importance of taking each patient's values into consideration; and understanding patients' preferences and needs. Effective and efficient training methods include seminars and workshops.

Rating of Specialist Seen Most Often

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

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

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

Please note: CAHPS scores with fewer than 100 respondents are denoted with an asterisk (*). If there are fewer than 100 respondents for a CAHPS measure, caution should be exercised when interpreting these results.

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

Planned Visit Management

Health plans should work with providers to encourage the implementation of systems that enhance the efficiency and effectiveness of specialist care. For example, by identifying patients with chronic conditions that have routine appointments, a reminder system could be implemented to ensure that these patients are receiving the appropriate attention at the appropriate time. This triggering system could be used by staff to prompt general follow-up contact or specific interaction with patients to ensure they have necessary tests completed before an appointment or various other prescribed reasons. For example, after a planned visit, follow-up contact with patients could be scheduled within the reminder system to ensure patients understood all information provided to them and/or to address any questions they may have.

Skills Training for Specialists

Health plans can create specialized workshops or seminars that focus on training specialists in the skills they need to effectively communicate with patients to improve physician-patient communication. Training seminars can include sessions for improving communication skills with different cultures and handling challenging patient encounters. In addition, workshops can use case studies to illustrate the importance of communicating with patients and offer insight into specialists' roles as both managers of care and educators of patients. According to a 2009 review of more than 100 studies published in the journal *Medical Care*, patients' adherence to recommended treatments and management of chronic conditions is 12 percent higher when providers receive training in communication skills. By establishing skills training for specialists, health plans can not only improve the quality of care delivered to its members but also their potential health outcomes.

Telemedicine

Health plans may want to explore the option of telemedicine with their provider networks to address issues with provider access in certain geographic areas. Telemedicine models allow for the use of electronic communication and information technologies to provide specialty services to patients in varying locations. Telemedicine such as live, interactive videoconferencing allows providers to offer care from a remote location. Physician specialists located in urban settings can diagnose and treat patients in communities where there is a shortage of specialists. Telemedicine consultation models allow for the local provider to both present the patient at the beginning of the consult and to participate in a case conference with the specialist at the end of the teleconference visit. Furthermore, the local provider is more involved in the consultation process and more informed about the care the patient is receiving.

Composite Measures

Getting Needed Care

Table 5-6 shows the priority assignments for the Getting Needed Care measure.

Table 5-6 Priority Assignments Getting Needed Care Composite			
Plan	**NCQA Comparisons (Star Ratings)**	**Trend Analysis**	**Priority Assignment**
FFS	★★★★★	▲	**Low**
PCPP	★★★★	—	**Moderate**
DHMC	★★	▲	**High**
RMHP	★★★★★	▲	**Low**

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

Appropriate Health Care Providers

Health plans should ensure that patients are receiving care from physicians most appropriate to treat their condition. Tracking patients to ascertain they are receiving effective, necessary care from those appropriate health care providers is imperative to assessing quality of care. Health plans should actively attempt to match patients with appropriate health care providers and engage providers in their efforts to ensure appointments are scheduled for patients to receive care in a timely manner. These efforts can lead to improvements in quality, timeliness, and patients' overall access to care.

Interactive Workshops

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

"Max-Packing"

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

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

Language Concordance Programs

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

Referral Process

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

Getting Care Quickly

Table 5-7 shows the priority assignments for the Getting Care Quickly measure.

Table 5-7 Priority Assignments Getting Care Quickly Composite			
Plan	NCQA Comparisons (Star Ratings)	Trend Analysis	Priority Assignment
FFS	★★★	—	Moderate
PCPP	★★★★★	—	Low
DHMC	★	—	Top
RMHP	★★★★★	▲	Low

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

Decrease No-Show Appointments

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

Electronic Communication

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

noted that Health Insurance Portability and Accountability Act (HIPAA) regulations must be carefully reviewed when implementing this form of communication.

Nurse Advice Help Line

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

Open Access Scheduling

Health plans should encourage providers to explore open access scheduling. An open access scheduling model can be used to match the demand for appointments with physician supply. This type of scheduling model allows for appointment flexibility and for patients to receive same-day appointments. Instead of booking appointments weeks or months in advance, an open access scheduling model includes leaving part of a physician's schedule open for same-day appointments. Open access scheduling has been shown to have the following benefits: 1) reduces delays in patient care; 2) increases continuity of care; and 3) decreases wait times and number of no-shows resulting in cost savings.

Patient Flow Analysis

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

How Well Doctors Communicate

Table 5-8 shows the priority assignments for the How Well Doctors Communicate measure.

Table 5-8
Priority Assignments
How Well Doctors Communicate Composite

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

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

Communication Tools for Patients

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

Improve Health Literacy

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

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

Language Barriers

Health plans can consider hiring interpreters that serve as full-time time staff members at provider offices with a high volume of non-English speaking patients to ensure accurate communication amongst patients and physicians. Offering an in-office, interpretation service promotes the development of relationships between the patient and family members with their physician. With an interpreter present to translate, the physician will have a more clear understanding of how to best address the appropriate health issues and the patient will feel more at ease. Having an interpreter on site is also more time efficient for both the patient and physician, allowing the physician to stay on schedule.

Customer Service

Table 5-9 shows the priority assignments for the Customer Service measure.

Table 5-9
Priority Assignments
Customer Service Composite

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

Please note: CAHPS scores with fewer than 100 respondents are denoted with an asterisk (*). If there are fewer than 100 respondents for a CAHPS measure, caution should be exercised when interpreting these results.

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

Call Centers

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

Creating an Effective Customer Service Training Program

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

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

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

Customer Service Performance Measures

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

Accountability and Improvement of Care

Although the administration of the CAHPS survey takes place at the health plan level, the accountability for the performance lies at both the plan and provider network level. Table 5-10 provides a summary of the responsible parties for various aspects of care.[5-4]

Table 5-10—Accountability for Areas of Care

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

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

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

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

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

[5-4] Edgman-Levitan S, Shaller D, McInnes K, et al. *The CAHPS® Improvement Guide: Practical Strategies for Improving the Patient Care Experience.* Department of Health Care Policy Harvard Medical School, October 2003.

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

Survey Administration

Survey Overview

The survey instrument selected was the CAHPS 5.0 Child Medicaid Health Plan Survey with the HEDIS supplemental item set and CCC measurement set. The CAHPS 5.0 Health Plan Surveys are a set of standardized surveys that assess patient perspectives on care. Originally, CAHPS was a five-year collaborative project sponsored by AHRQ. The CAHPS questionnaires and consumer reports were developed under cooperative agreements among AHRQ, Harvard Medical School, RAND, and the Research Triangle Institute (RTI). In 1997, NCQA, in conjunction with AHRQ, created the CAHPS 2.0H Survey measure as part of NCQA's HEDIS.[6-1] 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.[6-2] The result of this re-evaluation and update process was the development of the CAHPS 3.0H Health Plan Surveys. The goal of the CAHPS 3.0H Health Plan Surveys was to effectively and efficiently obtain information from the person receiving care. In 2006, AHRQ released the CAHPS 4.0 Health Plan Surveys. Based on the CAHPS 4.0 versions, NCQA introduced new HEDIS versions of the Adult Health Plan Survey in 2007 and the Child Health Plan Survey in 2009, which are referred to as the CAHPS 4.0H Health Plan Surveys.[6-3,6-4] In 2012, AHRQ released the CAHPS 5.0 Health Plan Surveys. Based on the CAHPS 5.0 versions, NCQA introduced new HEDIS versions of the Adult and Child Health Plan Surveys in August 2012, which are referred to as the CAHPS 5.0H Health Plan Surveys.[6-5]

The HEDIS sampling and data collection procedures for the CAHPS 5.0 Health Plan Survey were designed to capture accurate and complete information about consumer-reported experiences with health care. The sampling and data collection procedures promote both the standardized administration of survey instruments and the comparability of the resulting health plan data.

[6-1] National Committee for Quality Assurance. *HEDIS® 2002*, *Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA Publication, 2001.
[6-2] National Committee for Quality Assurance. *HEDIS® 2003*, *Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA Publication, 2002.
[6-3] National Committee for Quality Assurance. *HEDIS® 2007*, *Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA Publication, 2006.
[6-4] National Committee for Quality Assurance. *HEDIS® 2009*, *Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA Publication, 2008.
[6-5] National Committee for Quality Assurance. *HEDIS® 2013*, *Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA Publication, 2012.

The CAHPS 5.0H Child Medicaid Health Plan Survey with CCC measurement set includes 83 core questions that yield 16 measures of satisfaction. These measures include four global rating questions, five composite measures, two individual item measures, and five CCC composite measures/items. 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 6-1 lists the global ratings, composite measures, individual item measures, and CCC composites/items included in the CAHPS 5.0H Child Medicaid Health Plan Survey with CCC measurement set.

Table 6-1—CAHPS Measures

Global Ratings	Composite Measures	Individual Item Measures	CCC Composites/Items
Rating of Health Plan	Getting Needed Care	Coordination of Care	Access to Prescription Medicines
Rating of All Health Care	Getting Care Quickly	Health Promotion and Education	Access to Specialized Services
Rating of Personal Doctor	How Well Doctors Communicate		Family Centered-Care (FCC): Personal Doctor Who Knows Child
Rating of Specialist Seen Most Often	Customer Service		FCC: Getting Needed Information
	Shared Decision Making		Coordination of Care for Children with Chronic Conditions

Sampling Procedures

The clients eligible for sampling included those who were FFS, PCPP, DHMC, or RMHP clients at the time the sample was drawn and who were continuously enrolled for at least five of the last six months (July through December) of 2012. The clients eligible for sampling included those who were age 17 or younger (as of December 31, 2012).

The standard NCQA specifications for survey measures require a sample size of 1,650 for the general child population and 1,840 for the CCC supplemental population (for a total 3,490 child clients) for the CAHPS 5.0 Child Medicaid Health Plan Survey with CCC measurement set. The NCQA protocol also permits oversampling in 5 percent increments. For FFS and PCPP, no oversample was performed on the child population. However, DHMC and RMHP both conducted an oversample of their general child population. For DHMC, a 155 percent oversample was performed on the general child population. For RMHP, a 5 percent oversample was performed on the general child population. This oversampling was performed to ensure a greater number of respondents to each CAHPS measure. Colorado Medicaid FFS met the CCC supplemental sample

size requirement; however, Colorado Medicaid PCPP, DHMC, and RMHP did not. Table 6-2 provides a summary of the total, general child, and CCC supplemental sample sizes for Colorado Medicaid FFS, PCPP, DHMC, and RMHP, respectively.[6-6]

Table 6-2— General Child and CCC Supplemental Sample Sizes			
Plan Name	**Total Sample Size**	**General Child Sample**	**CCC Supplemental Sample**
Colorado Medicaid FFS	3,490	1,650	1,840
Colorado Medicaid PCPP	3,313	1,650	1,663
DHMC	5,687	4,208	1,479
RMHP	3,324	1,733	1,591

Survey Protocol

Table 6-3 shows the standard mixed mode (i.e., mail followed by telephone follow-up) CAHPS timeline used in the administration of the Colorado CAHPS 5.0 Child Medicaid Health Plan Surveys. The timeline is based on NCQA HEDIS Specifications for Survey Measures.[6-7]

Table 6-3—CAHPS 5.0 Mixed-Mode Methodology Survey Timeline	
Task	**Timeline**
Send first questionnaire with cover letter to the parent/caretaker of child member.	0 days
Send a postcard reminder to non-respondents four to 10 days after mailing the first questionnaire.	4 – 10 days
Send a second questionnaire (and letter) to non-respondents approximately 35 days after mailing the first questionnaire.	35 days
Send a second postcard reminder to non-respondents four to 10 days after mailing the second questionnaire.	39 – 45 days
Initiate CATI interviews for non-respondents approximately 21 days after mailing the second questionnaire.	56 days
Initiate systematic contact for all non-respondents such that at least three telephone calls are attempted at different times of the day, on different days of the week, and in different weeks.	56 – 70 days
Telephone follow-up sequence completed (i.e., completed interviews obtained or maximum calls reached for all non-respondents) approximately 14 days after initiation.	70 days

[6-6] The sampling for DHMC and RMHP was performed by Morpace and CSS, respectively.
[6-7] National Committee for Quality Assurance. *HEDIS® 2013, Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA Publication, 2012.

The survey administration for DHMC and RMHP was performed by Morpace and CSS, respectively. The CAHPS 5.0 Health Plan Survey process employed by FFS, PCPP, DHMC, and RMHP allowed clients two methods by which they could complete a survey. The first phase, or mail phase, consisted of a survey being mailed to all sampled clients. For Colorado Medicaid FFS and PCPP, those clients who were identified as Spanish-speaking through administrative data were mailed a Spanish version of the survey. Clients that were not identified as Spanish-speaking received an English version of the survey. The English and Spanish versions of the survey included a toll-free number that clients could call to request a survey in another language (i.e., English or Spanish). A reminder postcard was sent to all non-respondents, followed by a second survey mailing and reminder postcard. The second phase, or telephone phase, consisted of CATI of sampled clients who had not mailed in a completed survey. DHMC provided English and Spanish versions of the mail survey and allowed clients the option to complete a CATI survey in English or Spanish. A series of at least three CATI calls was made to each non-respondent.[6-8] 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.[6-9]

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

- Were age 17 or younger as of December 31, 2012.
- Were currently enrolled in FFS, PCPP, DHMC, or RMHP.
- Had been continuously enrolled for at least five of the last six months of 2012.
- Had Medicaid as a payer.

HSAG inspected a sample of the file records to check for any apparent problems with the files, such as missing address elements. A random sample of records from each population was passed through the United States Postal Service's National Change of Address (NCOA) system to obtain new addresses for clients who had moved (if they had given the Postal Service a new address). Prior to initiating CATI, HSAG employed the Telematch telephone number verification service to locate and/or update telephone numbers for all non-respondents. Following NCQA requirements, the survey samples were random samples with no more than one client being selected per household.

The specifications also require that the name of the plan appear in the questionnaires and cover letters; that the letters bear the signature of a high-ranking plan or state official; and that the questionnaire packages include a postage-paid reply envelope addressed to the organization conducting the surveys. HSAG followed these specifications.[6-10]

[6-8] National Committee for Quality Assurance. *Quality Assurance Plan for HEDIS 2013 Survey Measures.* Washington, DC: NCQA Publication, 2012.

[6-9] 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.

[6-10] Please note, HSAG performed the CAHPS survey administration for Colorado Medicaid FFS and PCPP only. The survey administration for DHMC and RMHP was performed by Morpace and CSS, respectively.

Methodology

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

Response Rates

The administration of the CAHPS 5.0 Child Medicaid Health Plan Survey is comprehensive and is designed to achieve the highest possible response rate. NCQA defines the response rate as the total number of completed surveys divided by all eligible clients of the sample.[6-11] A client's survey was assigned a disposition code of "completed" if at least one question was answered within the survey. Eligible clients include the entire random sample (including any oversample) minus ineligible clients. Ineligible clients of the sample met one or more of the following criteria: were deceased, were invalid (did not meet criteria described on page 6-4), 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.

[6-11] National Committee for Quality Assurance. *HEDIS® 2013, Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA Publication, 2012.

NCQA Comparisons

An analysis of the CAHPS Survey results was conducted using NCQA HEDIS Specifications for Survey Measures.[6-12] 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. However, for purposes of this report, plans' results are reported for a CAHPS measure even when the NCQA minimum reporting threshold of 100 respondents was not met. Therefore, caution should be exercised when interpreting results for those measures with fewer than 100 respondents.

In order to perform the NCQA comparisons, a three-point mean score was determined for the four CAHPS global ratings and four CAHPS composite measures. The resulting three-point mean scores were compared to published NCQA Benchmarks and Thresholds for Accreditation to derive the overall client satisfaction ratings (i.e., star ratings). NCQA does not publish benchmarks and thresholds for the Shared Decision Making composite measure, and Coordination of Care and Health Promotion and Education individual item measures; therefore, star ratings could not be assigned for these measures. For detailed information on the derivation of three-point mean scores, please refer to *NCQA HEDIS 2013 Specifications for Survey Measures, Volume 3*.

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

★★★★★	indicates a score at or above the 90th percentile
★★★★	indicates a score at or between the 75th and 89th percentiles
★★★	indicates a score at or between the 50th and 74th percentiles
★★	indicates a score at or between the 25th and 49th percentiles
★	indicates a score below the 25th percentile

[6-12] National Committee for Quality Assurance. *HEDIS® 2013*, *Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA Publication, 2012.

Table 6-4 shows the benchmarks and thresholds used to derive the overall client satisfaction ratings on each CAHPS measure.[6-13]

Table 6-4—Overall Child Medicaid Client Satisfaction Ratings Crosswalk

Measure	90th Percentile	75th Percentile	50th Percentile	25th Percentile
Rating of Health Plan	2.67	2.62	2.57	2.51
Rating of All Health Care	2.59	2.57	2.52	2.49
Rating of Personal Doctor	2.69	2.65	2.62	2.58
Rating of Specialist Seen Most Often	2.66	2.62	2.59	2.53
Getting Needed Care	2.50	2.45	2.36	2.29
Getting Care Quickly	2.69	2.66	2.61	2.54
How Well Doctors Communicate	2.75	2.72	2.68	2.63
Customer Service	2.58	2.51	2.46	2.40

Trend Analysis

In order to evaluate trends in Colorado Medicaid client satisfaction, HSAG performed a stepwise three-year trend analysis.[6-14] The first step compared the 2013 CAHPS results to the 2012 CAHPS results. If the initial 2013 and 2012 trend analysis did not yield any significant differences, then an additional trend analysis was performed between 2013 and 2011 results. For purposes of this analysis, question summary rates were calculated for each global rating and individual item measure, and global proportions were calculated for each composite measure. Both the question summary rates and global proportions were calculated in accordance with NCQA HEDIS Specifications for Survey Measures.[6-15] The scoring of the global ratings, composite measures, and individual item measures involved assigning top-level responses a score of one, with all other responses receiving a score of zero. After applying this scoring methodology, the percentage of top-level responses was calculated in order to determine the question summary rates and global proportions. For additional details, please refer to the *NCQA HEDIS 2013 Specifications for Survey Measures, Volume 3*.

[6-13] National Committee for Quality Assurance. *HEDIS Benchmarks and Thresholds for Accreditation 2013*. Washington, DC: NCQA, March 15, 2013.
[6-14] 2013 represented the first year the CAHPS 5.0 Child Medicaid Health Plans Survey with the CCC measurement set was administered to child clients enrolled in FFS, PCPP, DHMC, and RMHP; therefore, trending could not be performed for the CCC CAHPS results.
[6-15] National Committee for Quality Assurance. *HEDIS® 2013, Volume 3: Specifications for Survey Measures*. Washington, DC: NCQA Publication, 2012.

The 2013 Colorado Medicaid and plan-level CAHPS scores were compared to the corresponding 2012 scores to determine whether there were statistically significant differences. If there were no statistically significant differences from 2013 to 2012, then 2013 scores were compared to 2011 scores. A difference is considered significant if the two-sided *p*-value of the *t*-test is less than 0.05. Scores that were statistically higher in 2013 than in 2012 are noted with black upward (▲) triangles. Scores that were statistically lower in 2013 than in 2012 are noted with black downward (▼) triangles. Scores that were statistically higher in 2013 than in 2011 are noted with red upward (▲) triangles. Scores that were statistically lower in 2013 than in 2011 are noted with red downward (▼) triangles. Scores in 2013 that were not statistically different from scores in 2012 or in 2011 are not noted with triangles. For purposes of this report, plans' results are reported for a CAHPS measure even when the NCQA minimum reporting threshold of 100 respondents was not met. Therefore, caution should be exercised when interpreting results for those measures with fewer than 100 respondents.

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. These comparisons were performed for both the general child population and the CCC population.

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:

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

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:

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

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

The variance of Δ_p was:

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

The t statistic was $\Delta_p / \hat{V}(\Delta_p)^{1/2}$ 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 2013 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.

Survey Vendor Effects

The CAHPS 5.0 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.

Baseline CCC Results

It is important to note that in SFY 2012-2013 the CAHPS 5.0 Child Medicaid Health Plan Survey with CCC measurement was administered to child Medicaid clients enrolled in FFS, PCPP, DHMC, and RMHP for the first time. The 2013 CAHPS results for the CCC population presented in the report represent a **baseline** assessment for the CCC population. Therefore, caution should be exercised when interpreting these results.

Quality Improvement References

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

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7. Survey Instrument

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

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

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

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

SURVEY INSTRUCTIONS

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

  Correct Mark ● **Incorrect Marks**

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

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

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/STATE MEDICAID PROGRAM NAME]. Is that right?**

   ○ Yes ➔ ***Go to Question 3***
   ○ 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?

- ○ Yes
- ○ 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 he or she needed?

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

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

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

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

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

7. In the last 6 months, not 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?

- ○ None ➔ ***Go to Question 16***
- ○ 1 time
- ○ 2
- ○ 3
- ○ 4
- ○ 5 to 9
- ○ 10 or more times

7a. In the last 6 months, when your child visited a doctor's office or clinic, did someone in the doctor's office or clinic give you information about what to do if your child needed care during evenings, weekends, or holidays?

- ○ Yes
- ○ No

7b. In the last 6 months, did your child need care during evenings, weekends, or holidays?

- ○ Yes
- ○ No ➔ ***Go to Question 8***

7c. In the last 6 months, how often were you able to get the care your child needed from his or her doctor or other health provider during evenings, weekends, or holidays?

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

8. In the last 6 months, did you and your child's doctor or other health provider talk about specific things you could do to prevent illness in your child?

- ○ Yes
- ○ No

9. In the last 6 months, how often did you have your questions answered by your child's doctors or other health providers?

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

10. In the last 6 months, did you and your child's doctor or other health provider talk about starting or stopping a prescription medicine for your child?

- ○ Yes
- ○ No ➔ ***Go to Question 14***

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

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

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

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

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

- ○ Yes
- ○ No

14. **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?**

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

Worst Health Care Possible — Best Health Care Possible

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

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

16. **Is your child now enrolled in any kind of school or daycare?**

- ○ Yes
- ○ No ➔ ***Go to Question 19***

17. **In the last 6 months, did you need your child's doctors or other health providers to contact a school or daycare center about your child's health or health care?**

- ○ Yes
- ○ No ➔ ***Go to Question 19***

18. **In the last 6 months, did you get the help you needed from your child's doctors or other health providers in contacting your child's school or daycare?**

- ○ Yes
- ○ No

SPECIALIZED SERVICES

19. **Special medical equipment or devices include a walker, wheelchair, nebulizer, feeding tubes, or oxygen equipment. In the last 6 months, did you get or try to get any special medical equipment or devices for your child?**

- ○ Yes
- ○ No ➔ ***Go to Question 22***

20. **In the last 6 months, how often was it easy to get special medical equipment or devices for your child?**

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

21. **Did anyone from your child's health plan, doctor's office, or clinic help you get special medical equipment or devices for your child?**

- ○ Yes
- ○ No

22. **In the last 6 months, did you get or try to get special therapy such as physical, occupational, or speech therapy for your child?**

- ○ Yes
- ○ No ➔ ***Go to Question 25***

23. **In the last 6 months, how often was it easy to get this therapy for your child?**

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

24. **Did anyone from your child's health plan, doctor's office, or clinic help you get this therapy for your child?**

- ○ Yes
- ○ No

25. **In the last 6 months, did you get or try to get treatment or counseling for your child for an emotional, developmental, or behavioral problem?**

- ○ Yes
- ○ No ➔ ***Go to Question 28***

26. **In the last 6 months, how often was it easy to get this treatment or counseling for your child?**

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

27. **Did anyone from your child's health plan, doctor's office, or clinic help you get this treatment or counseling for your child?**

- ○ Yes
- ○ No

28. **In the last 6 months, did your child get care from more than one kind of health care provider or use more than one kind of health care service?**

- ○ Yes
- ○ No ➔ ***Go to Question 30***

29. **In the last 6 months, did anyone from your child's health plan, doctor's office, or clinic help coordinate your child's care among these different providers or services?**

- ○ Yes
- ○ No

YOUR CHILD'S PERSONAL DOCTOR

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

- ○ Yes
- ○ No ➔ ***Go to Question 45***

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

- ○ None ➔ ***Go to Question 41***
- ○ 1 time
- ○ 2
- ○ 3
- ○ 4
- ○ 5 to 9
- ○ 10 or more times

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

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

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

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

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

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

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

- ○ Yes
- ○ No ➔ ***Go to Question 37***

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

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

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

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

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

- ○ Yes
- ○ No

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

- ○ Yes
- ○ No ➔ ***Go to Question 41***

40. 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?

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

41. 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?

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

Worst Personal Doctor Possible — Best Personal Doctor Possible

41a. Some doctor's offices remind patients between visits about tests, treatment or appointments. In the last 6 months, did you get any reminders about your child's care between visits with your child's personal doctor?

- ○ Yes
- ○ No

41b. In the last 6 months, how often did clerks and receptionists at your child's personal doctor's office treat you with courtesy and respect?

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

42. Does your child have any medical, behavioral, or other health conditions that have lasted for more than 3 months?

- ○ Yes
- ○ No ➔ ***Go to Question 45***

43. Does your child's personal doctor understand how these medical, behavioral, or other health conditions affect your child's day-to-day life?

- ○ Yes
- ○ No

44. Does your child's personal doctor understand how your child's medical, behavioral, or other health conditions affect your family's day-to-day life?

- ○ Yes
- ○ No

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.

45. Specialists are doctors like surgeons, heart doctors, allergy doctors, skin doctors, and other doctors who specialize in one area of health care.

In the last 6 months, did you make any appointments for your child to see a specialist?

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

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

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

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

- ○ None ➔ ***Go to Question 49***
- ○ 1 specialist
- ○ 2
- ○ 3
- ○ 4
- ○ 5 or more specialists

48. 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?

○	○	○	○	○	○	○	○	○	○	○
0	1	2	3	4	5	6	7	8	9	10
Worst Specialist Possible										Best Specialist Possible

YOUR CHILD'S HEALTH PLAN

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

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

- ○ Yes
- ○ No ➔ ***Go to Question 52***

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

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

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

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

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

- ○ Yes
- ○ No ➔ ***Go to Question 54***

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

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

54. 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?

○	○	○	○	○	○	○	○	○	○	○
0	1	2	3	4	5	6	7	8	9	10
Worst Health Plan Possible										Best Health Plan Possible

PRESCRIPTION MEDICINES

55. **In the last 6 months, did you get or refill any prescription medicines for your child?**

   - ○ Yes
   - ○ No ➔ ***Go to Question 58***

56. **In the last 6 months, how often was it easy to get prescription medicines for your child through his or her health plan?**

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

57. **Did anyone from your child's health plan, doctor's office, or clinic help you get your child's prescription medicines?**

   - ○ Yes
   - ○ No

ABOUT YOUR CHILD AND YOU

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

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

59. **In general, how would you rate your child's overall mental or emotional health?**

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

60. **Does your child currently need or use medicine prescribed by a doctor (other than vitamins)?**

   - ○ Yes
   - ○ No ➔ ***Go to Question 63***

61. **Is this because of any medical, behavioral, or other health condition?**

   - ○ Yes
   - ○ No ➔ ***Go to Question 63***

62. **Is this a condition that has lasted or is expected to last for at least 12 months?**

   - ○ Yes
   - ○ No

63. **Does your child need or use more medical care, more mental health services, or more educational services than is usual for most children of the same age?**

   - ○ Yes
   - ○ No ➔ ***Go to Question 66***

64. **Is this because of any medical, behavioral, or other health condition?**

   - ○ Yes
   - ○ No ➔ ***Go to Question 66***

65. **Is this a condition that has lasted or is expected to last for at least 12 months?**

   - ○ Yes
   - ○ No

66. **Is your child limited or prevented in any way in his or her ability to do the things most children of the same age can do?**

   - ○ Yes
   - ○ No ➔ ***Go to Question 69***

67. **Is this because of any medical, behavioral, or other health condition?**

   - ○ Yes
   - ○ No ➔ ***Go to Question 69***

68. **Is this a condition that has lasted or is expected to last for at least 12 months?**

   - ○ Yes
   - ○ No

69. **Does your child need or get special therapy such as physical, occupational, or speech therapy?**

   - ○ Yes
   - ○ No ➔ ***Go to Question 72***

70. **Is this because of any medical, behavioral, or other health condition?**

   - ○ Yes
   - ○ No ➔ ***Go to Question 72***

71. **Is this a condition that has lasted or is expected to last for at least 12 months?**

- ○ Yes
- ○ No

72. **Does your child have any kind of emotional, developmental, or behavioral problem for which he or she needs or gets treatment or counseling?**

- ○ Yes
- ○ No ➔ ***Go to Question 74***

73. **Has this problem lasted or is it expected to last for at least 12 months?**

- ○ Yes
- ○ No

74. **What is your child's age?**

- ○ Less than 1 year old
- ☐☐ YEARS OLD (write in)

75. **Is your child male or female?**

- ○ Male
- ○ Female

76. **Is your child of Hispanic or Latino origin or descent?**

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

77. **What is your child's race? Mark one or more.**

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

78. **What is your age?**

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

79. **Are you male or female?**

- ○ Male
- ○ Female

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

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

81. **How are you related to the child?**

- ○ Mother or father
- ○ Grandparent
- ○ Aunt or uncle
- ○ Older brother or sister
- ○ Other relative
- ○ Legal guardian
- ○ Someone else

82. **Did someone help you complete this survey?**

- ○ Yes ➔ ***Go to Question 83***
- ○ No ➔ ***Thank you. Please return the completed survey in the postage-paid envelope.***

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

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

THANK YOU

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

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

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

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

CD Contents

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