FY 13-14 CHILD MEDICAID CLIENT SATISFACTION REPORT

September 2014

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

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CONTENTS

1. Executive Summary 1-1
FFS and PCPP Performance Highlights 1-2
NCQA Comparisons 1-3
RCCO Comparisons 1-4
Priority Assignments 1-4
DHMC and RMHP Performance Highlights 1-6
NCQA Comparisons 1-7
Trend Analysis 1-8
Plan Comparisons 1-9
Priority Assignments 1-10

2. FFS and PCPP Results 2-1
Survey Administration and Response Rates 2-1
Survey Administration 2-1
Response Rates 2-2
Child and Respondent Demographics 2-14
NCQA Comparisons 2-19
Summary of NCQA Comparisons Results 2-22
Rates and Proportions 2-23
Global Ratings 2-24
Composite Measures 2-27
Individual Item Measures 2-31
RCCO Comparisons 2-33
Summary of RCCO Comparisons Results 2-35
Supplemental Items 2-36

3. DHMC and RMHP Results 3-1
Survey Administration and Response Rates 3-1
Survey Administration 3-1
Response Rates 3-2
Child and Respondent Demographics 3-7
NCQA Comparisons 3-9
Summary of NCQA Comparisons Results 3-11
Trend Analysis 3-12
Global Ratings 3-13
Composite Measures 3-17
Individual Item Measures 3-22
Plan Comparisons 3-24
Summary of Plan Comparisons Results 3-25

4. Recommendations 4-1
General Recommendations 4-1
Plan-Specific Recommendations 4-1
Priority Assignments 4-2
Global Ratings 4-3
Composite Measures 4-12
Accountability and Improvement of Care 4-21

5. Reader's Guide 5-1
Survey Administration 5-1

Survey Overview 5-1
Sampling Procedures 5-2
Survey Protocol 5-3
Methodology 5-5
Response Rates 5-5
Child and Respondent Demographics 5-5
NCQA Comparisons 5-6
Trend Analysis 5-7
RCCO Comparisons 5-8
Plan Comparisons 5-9
Limitations and Cautions 5-10
Case-Mix Adjustment 5-10
Non-Response Bias 5-10
Causal Inferences 5-10
Survey Vendor Effects 5-10
Sampling Effects 5-10
Baseline FFS, RCCO, and PCPP Results 5-11
Quality Improvement References 5-12

6. Survey Instrument 6-1

7. CD 7-1
CD Contents 7-1

1. Executive Summary

The State of Colorado requires annual administration of client satisfaction surveys to Medicaid clients enrolled in fee-for-service (FFS), the 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.

It is important to note that in state fiscal year (SFY) 2013-2014, the survey instrument selected for FFS and PCPP clients was a modified version of the CAHPS 5.0 Child Medicaid Health Plan Survey with the Healthcare Effectiveness Data and Information Set (HEDIS®) supplemental item set and survey questions from the Child Clinician and Group CAHPS surveys with Patient-Centered Medical Home™ (PCMH™) items ("Child CAHPS PCMH Survey").[1-3,1-4,1-5] Additionally, SFY 2013-2014 represents the first year, parents/caretakers of FFS clients enrolled in one of the seven participating Regional Care Collaborative Organizations (RCCOs) were included in the annual administration of client satisfaction surveys. The 2014 FFS and PCPP CAHPS results presented in this report represent a **baseline** assessment of parents'/caretakers' satisfaction with Colorado Medicaid FFS, participating RCCOs, and PCPP; therefore, caution should be exercised when interpreting these results. For DHMC and RMHP, the standardized survey instrument selected was the CAHPS 5.0 Child Medicaid Health Plan Survey with the HEDIS supplemental item set. Child clients enrolled in FFS, participating RCCOs, PCPP, DHMC, and RMHP completed the surveys from March to May 2014.

[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] Patient-Centered Medical Home™ (PCMH™) is a trademark of the National Committee for Quality Assurance (NCQA).

[1-5] It is important to note that for the FFS and PCPP CAHPS survey administration, the Department elected to modify the CAHPS 5.0 Child Medicaid Health Plan Survey and remove the Rating of Health Plan global rating question and Customer Service composite measure survey questions; therefore, CAHPS survey results for FFS and PCPP are limited to the three global ratings (Rating of All Heath Care, Rating of Personal Doctor, and Rating of Specialist Seen Most Often), four composite measures (Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, and Shared Decision Making), and two individual item measures (Coordination of Care and Health Promotion and Education).

FFS and PCPP Performance Highlights

The FFS and PCPP Results Section of this report details the CAHPS results for Colorado Medicaid FFS, FFS clients enrolled in one of the seven participating RCCOs, the RCCO program in aggregate (i.e., seven participating RCCOs combined), and PCPP. Table 1-1 lists the RCCOs for each region.

Table 1-1
Participating Colorado RCCOs

Region 1: Rocky Mountain Health Plans
Region 2: Colorado Access
Region 3: Colorado Access
Region 4: Integrated Community Health Partners
Region 5: Colorado Access
Region 6: Colorado Community Health Alliance
Region 7: Community Care of Central Colorado

The following is a summary of the Child Medicaid CAHPS performance highlights for Colorado Medicaid FFS, the seven participating RCCOs, and PCPP. The performance highlights are categorized into three major types of analyses performed on the CAHPS data:

- National Committee for Quality Assurance (NCQA) Comparisons
- RCCO Comparisons
- Priority Assignments

NCQA Comparisons

Overall client satisfaction ratings for three CAHPS global ratings (Rating of All Health Care, Rating of Personal Doctor, and Rating of Specialist Seen Most Often) and three composite measures (Getting Needed Care, Getting Care Quickly, and How Well Doctors Communicate) were compared to NCQA's 2014 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 FFS and PCPP Results Section beginning on page 2-19. Table 1-2 presents the highlights from this comparison.

Table 1-2
NCQA Comparisons Highlights

Plan Name	Rating of All Health Care	Rating of Personal Doctor	Rating of Specialist Seen Most Often	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate
Colorado Medicaid FFS	★★	★★	★★+	★	★★	★★★
Colorado RCCO Program	★	★★	★★	★	★★	★★
Region 1: Rocky Mountain Health Plans	★★	★	★★+	★	★★	★
Region 2: Colorado Access	★★★★	★★★★	★★★★★+	★★+	★★	★★
Region 3: Colorado Access	★	★	★★+	★★	★	★★★
Region 4: Integrated Community Health Partners	★	★	★+	★★★+	★	★★
Region 5: Colorado Access	★★	★★★	★★★★+	★	★	★
Region 6: Colorado Community Health Alliance	★★★	★★	★★★+	★+	★★	★★
Region 7: Community Care of Central Colorado	★	★	★+	★	★★	★
Colorado Medicaid PCPP	★★★★	★★★★	★★+	★★★★	★★★★★	★★★

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

[1-6] National Committee for Quality Assurance. *HEDIS Benchmarks and Thresholds for Accreditation 2014*. Washington, DC: NCQA, January 30, 2014.

[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.

RCCO Comparisons

In order to identify performance differences in client satisfaction between the seven participating Colorado RCCOs, case-mix adjusted results for each were compared to one another using standard statistical tests.[1-8] These comparisons were performed on the three global ratings, four composite measures, and two individual item measures. The detailed results of the comparative analysis are described in the FFS and PCPP Results Section beginning on page 2-33.[1-9]

Priority Assignments

Based on the results of the NCQA comparisons, priority assignments were derived for each measure. Measures were assigned into one of four main categories for quality improvement (QI): top, high, moderate, and low priority. Table 1-3 presents the top and high priorities for Colorado Medicaid FFS and PCPP.

Table 1-3
Top and High Priorities

Colorado Medicaid FFS	Colorado Medicaid PCPP
◆ Rating of All Health Care ◆ Rating of Personal Doctor ◆ Rating of Specialist Seen Most Often ◆ Getting Needed Care ◆ Getting Care Quickly	◆ Rating of Specialist Seen Most Often

[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 RCCO comparisons, given that population and RCCO differences may impact results.

Table 1-4 presents the top and high priorities for each of the seven participating RCCOs.

Table 1-4
Top and High Priorities

Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7
◆ Rating of All Health Care	◆ Getting Needed Care+	◆ Rating of All Health Care	◆ Rating of All Health Care	◆ Rating of All Health Care	◆ Rating of Personal Doctor	◆ Rating of All Health Care
◆ Rating of Personal Doctor	◆ Getting Care Quickly	◆ Rating of Personal Doctor	◆ Rating of Personal Doctor	◆ Getting Needed Care	◆ Getting Needed Care+	◆ Rating of Personal Doctor
◆ Rating of Specialist Seen Most Often+	◆ How Well Doctors Communicate	◆ Rating of Specialist Seen Most Often+	◆ Rating of Specialist Seen Most Often+	◆ Getting Care Quickly	◆ Getting Care Quickly	◆ Rating of Specialist Seen Most Often+
◆ Getting Needed Care		◆ Getting Needed Care	◆ Getting Care Quickly	◆ How Well Doctors Communicate	◆ How Well Doctors Communicate	◆ Getting Needed Care
◆ Getting Care Quickly		◆ Getting Care Quickly	◆ How Well Doctors Communicate			◆ Getting Care Quickly
◆ How Well Doctors Communicate						◆ How Well Doctors Communicate

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

DHMC and RMHP Performance Highlights

The DHMC and RMHP Results Section of this report details the CAHPS results for DHMC, RMHP, and the Colorado Medicaid plans in aggregate (i.e., DHMC and RMHP combined). The following is a summary of the Child Medicaid CAHPS performance highlights for the Colorado Medicaid aggregate, DHMC, and RMHP. The performance highlights are categorized into four major types of analyses performed on the CAHPS data:

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

NCQA Comparisons

Overall client satisfaction ratings for four CAHPS global ratings (Rating of Health Plan, Rating of All Health Care, Rating of Personal Doctor, and Rating of Specialist Seen Most Often) and four composite measures (Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, and Customer Service) were compared to NCQA's 2014 HEDIS Benchmarks and Thresholds for Accreditation.[1-10,1-11] 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 DHMC and RMHP Results Section beginning on page 3-9. Table 1-5 presents the highlights from this comparison.

Table 1-5
NCQA Comparisons Highlights

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

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

[1-10] National Committee for Quality Assurance. *HEDIS Benchmarks and Thresholds for Accreditation 2014*. Washington, DC: NCQA, January 30, 2014.

[1-11] NCQA does not publish benchmarks and thresholds for the Shared Decision Making composite measure, and Coordination of Care and Health Promotion and Education individual item measures; therefore, overall client satisfaction ratings could not be derived for these CAHPS measures.

Trend Analysis

In order to evaluate trends in Colorado Medicaid client satisfaction with the Colorado Medicaid plans, HSAG performed a stepwise trend analysis, where applicable. The first step compared the 2014 CAHPS results to the 2013 CAHPS results.[1-12] If the initial 2014 and 2013 trend analysis did not yield any significant differences, then an additional trend analysis was performed between 2014 and 2012 results. The detailed results of the trend analysis are described in the DHMC and RMHP Results Section beginning on page 3-12. Table 1-6 presents the statistically significant results from this analysis.

Table 1-6
Trend Analysis Highlights

	Colorado Medicaid	DHMC	RMHP
Global Rating			
Rating of Personal Doctor	▼	▼	
Composite Measure			
Getting Needed Care	▲	▼	
Getting Care Quickly	▲	▲	
How Well Doctors Communicate	▲		

▲ *Indicates the 2014 score is significantly higher than the 2013 score*
▼ *Indicates the 2014 score is significantly lower than the 2013 score*
▲ *Indicates the 2014 score is significantly higher than the 2012 score*
▼ *Indicates the 2014 score is significantly lower than the 2012 score*

[1-12] The 2013 CAHPS results for DHMC's and RMHP's general child population were used for purposes of the trend analysis (i.e., 2013 general child CAHPS results).

Plan Comparisons

In order to identify performance differences in client satisfaction between DHMC and RMHP, case-mix adjusted results for each were compared to one another using standard statistical tests.[1-13] These comparisons were performed on the four global ratings, five composite measures, and two individual item measures. The detailed results of this comparative analysis are described in the DHMC and RMHP Results Section beginning on page 3-24. Table 1-7 presents the statistically significant results from this comparison.[1-14]

Table 1-7
Plan Comparisons Highlights

DHMC		RMHP	
↓	Getting Needed Care	↑	Getting Needed Care
↓	Getting Care Quickly	↑	Getting Care Quickly

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

[1-13] 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.

[1-14] Caution should be exercised when evaluating health plan comparisons, given that population and health plan differences may impact results.

Priority Assignments

Based on the results of the NCQA comparisons and trend analysis, priority assignments were derived for each measure. Measures were assigned into one of four main categories for QI: top, high, moderate, and low priority. Table 1-8 presents the top and high priorities for DHMC and RMHP.

Table 1-8
Top and High Priorities

DHMC	RMHP
◆ Getting Needed Care ◆ Getting Care Quickly ◆ How Well Doctors Communicate ◆ Customer Service	◆ Rating of All Health Care ◆ Customer Service+

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

2. FFS and PCPP Results

The following section presents the CAHPS results for Colorado Medicaid FFS, RCCO program in aggregate (i.e., seven participating RCCOs combined), participating RCCOs, and PCPP.

Survey Administration and Response Rates

Survey Administration

For the FFS and PCPP CAHPS survey administration, clients eligible for sampling included those who were enrolled in FFS, FFS clients enrolled in participating RCCOs, and PCPP at the time the sample was drawn and who were continuously enrolled for at least five of the last six months (July through December) of 2013. Child clients eligible for sampling included those who were 17 years of age or younger as of December 31, 2013.

The standard NCQA HEDIS Specifications for Survey Measures require a sample size of 1,650 clients for the CAHPS 5.0 Child Medicaid Health Plan Survey.[2-1] For Colorado Medicaid FFS and PCPP, a random sample of at least 1,650 child clients was selected from each plan. Additionally, to accommodate RCCO-level reporting for Colorado Medicaid FFS, a RCCO-level oversample was conducted, such that a random sample of 800 child FFS clients enrolled in RCCO (i.e., sample of 800 RCCO child clients) was selected from each of the seven participating RCCOs. The oversampling was performed to ensure a greater number of respondents for each CAHPS measure.

The survey administration protocol was designed to achieve a high response rate from clients, thus minimizing the potential effects of non-response bias. The survey process employed by FFS and PCPP allowed clients two methods by which they could complete the surveys. The first phase, or mail phase, consisted of a survey being mailed to the sampled clients. Clients who were identified as Spanish-speaking through administrative data were mailed a Spanish version of the survey. Clients that were not identified as Spanish-speaking received an English version of the survey. The cover letter included with the English version of the survey had a Spanish cover letter on the back side informing clients that they could call the toll-free number to request a Spanish version of the CAHPS questionnaire. The cover letter provided with the Spanish version of the CAHPS questionnaire included a text box with a toll-free number that clients could call to request a survey in another language (i.e., English). A reminder postcard was sent to all non-respondents, followed by a second survey mailing and reminder postcard. The second phase, or telephone phase, consisted of Computer Assisted Telephone Interviewing (CATI) for sampled clients who had not mailed in a completed survey. A minimum of three CATI calls was made to each non-respondent.[2-2] Additional information on the survey protocol is included in the Reader's Guide Section beginning on page 5-3.

[2-1] National Committee for Quality Assurance. *HEDIS® 2014, Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA Publication, 2013.

[2-2] National Committee for Quality Assurance. *Quality Assurance Plan for HEDIS 2014 Survey Measures*. Washington, DC: NCQA Publication, 2013.

Response Rates

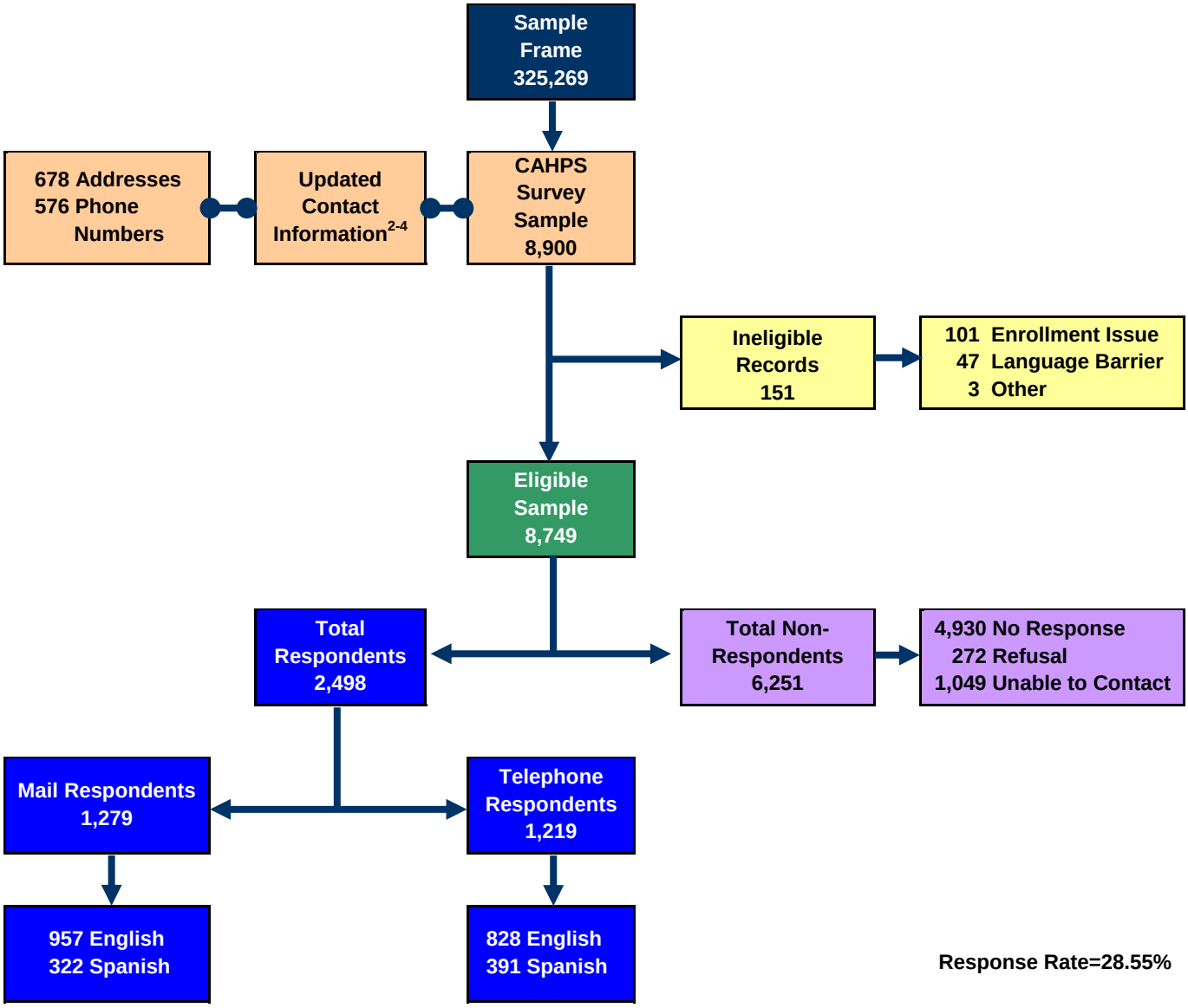
The Colorado CAHPS 5.0 Child Medicaid Health Plan Survey administration was designed to achieve the highest possible response rate. The CAHPS Survey response rate is the total number of completed surveys divided by all eligible clients of the sample. A client's survey was assigned a disposition code 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 2,498 completed surveys were returned on behalf of child clients, including 422 FFS, 1,604 RCCOs, and 472 PCPP clients. Figure 2-1, on the following page, shows the distribution of survey dispositions and response rate based on the total completed surveys returned on behalf of child clients (i.e., Colorado Medicaid FFS, seven participating RCCOs, and PCPP combined). Figure 2-2 shows the distribution of survey dispositions and response rate for Colorado Medicaid FFS. Figure 2-3 through Figure 2-9 show the individual distribution of survey dispositions and response rates for each of the seven participating RCCOs. Figure 2-10 shows the distribution of survey dispositions and response rates for PCPP. The survey disposition and response rates are based on the responses of parents/caretakers of children selected as part of the FFS general sample, RCCO-level oversamples, and PCPP.

The 2014 Colorado child Medicaid total response rate of 28.6 percent was 0.1 percentage points lower than the national child Medicaid response rate reported by NCQA for 2013, which was 28.7 percent.[2-3]

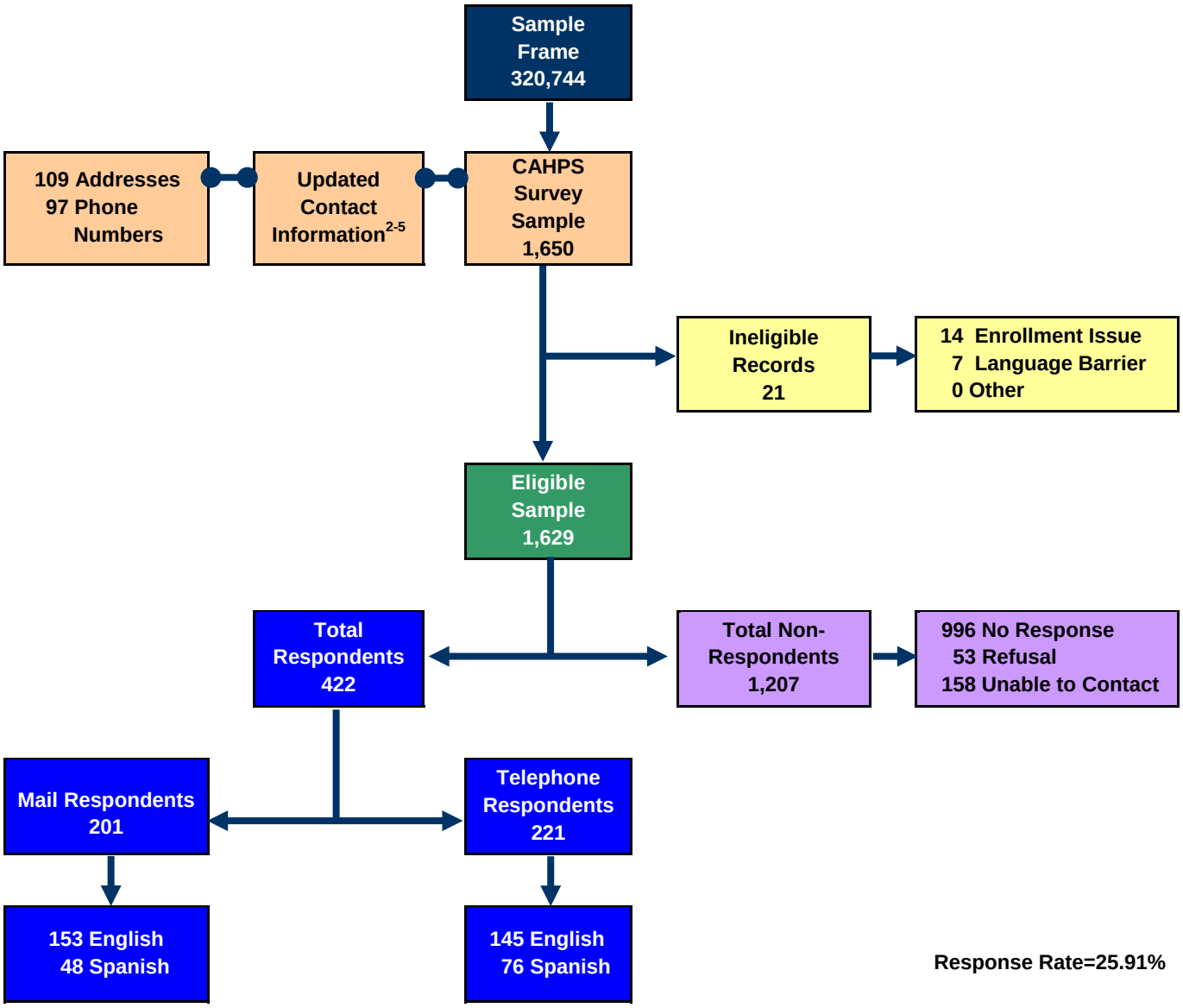
[2-3] National Committee for Quality Assurance. *HEDIS 2014 Survey Vendor Update Training*. October 24, 2013.

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



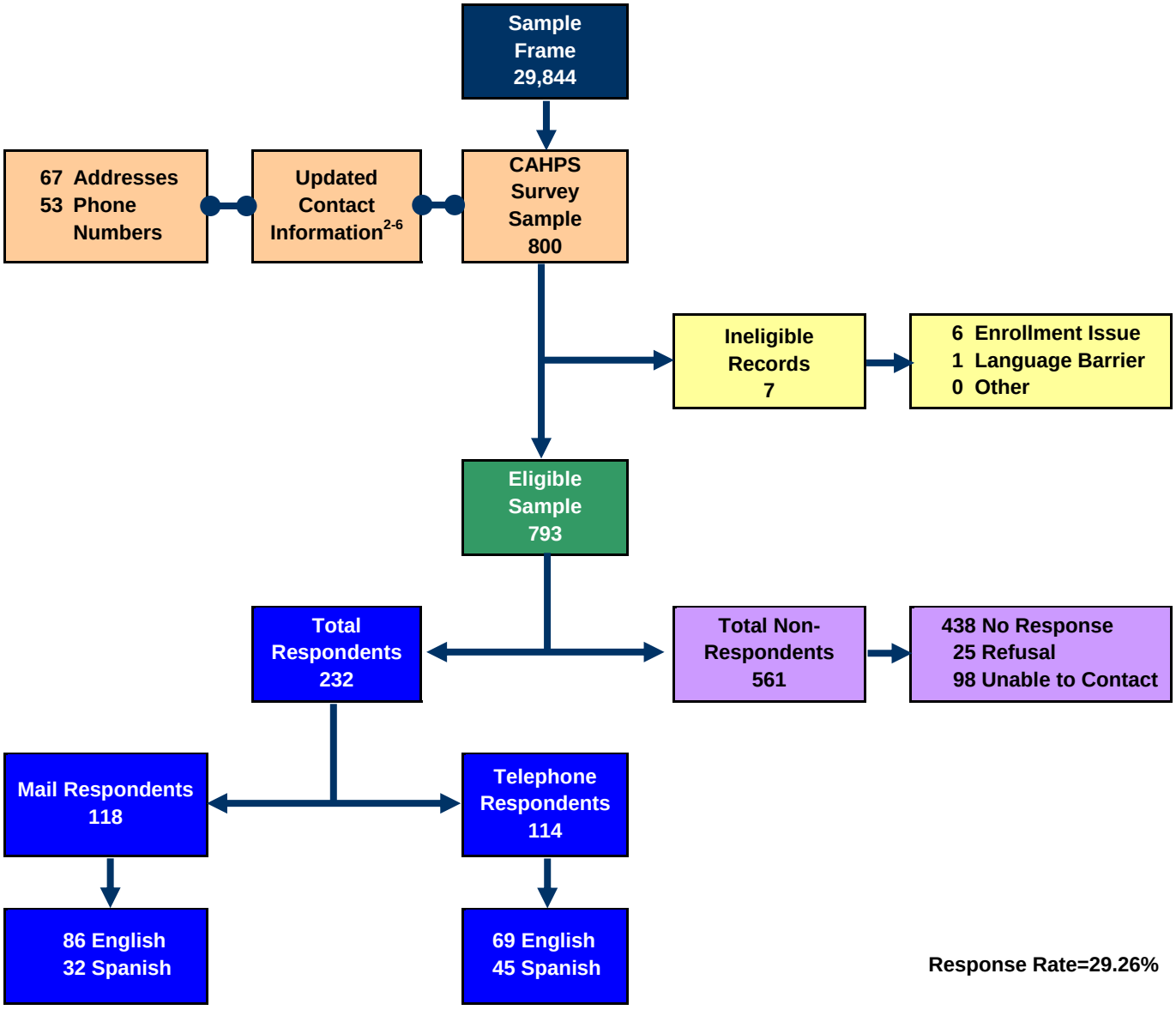
2-4 Prior to survey administration, address and phone information is updated for clients of the CAHPS sample using the United States Postal Service's National Change of Address (NCOA) and Telematch databases. The number of updated addresses and telephone numbers are provided for informational purposes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

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



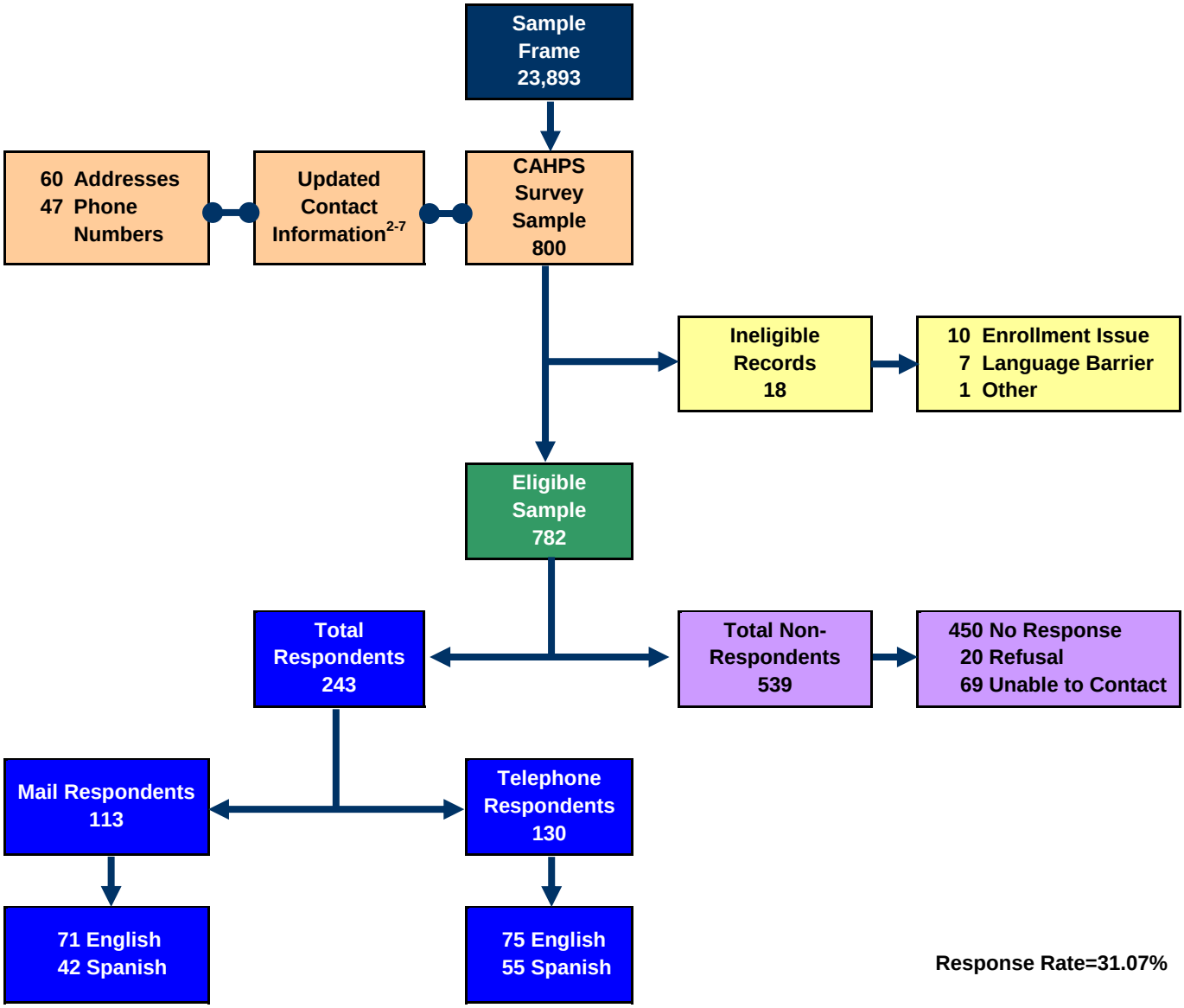
[2-5] Prior to survey administration, address and phone information is updated for clients of the CAHPS sample using the United States Postal Service's National Change of Address (NCOA) and Telematch databases. The number of updated addresses and telephone numbers are provided for informational purposes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

Figure 2-3—Distribution of Surveys for Region 1: Rocky Mountain Health Plans



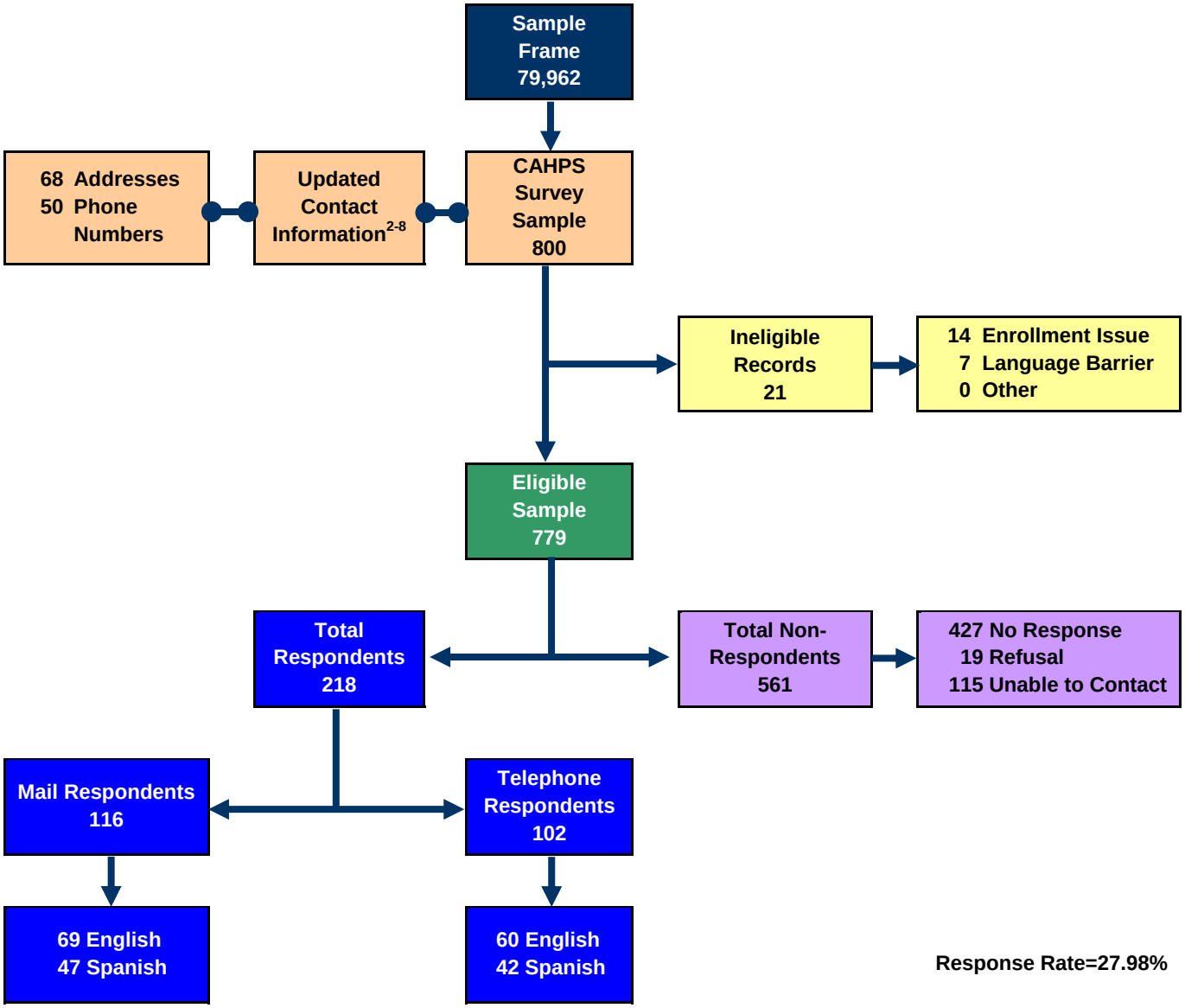
2-6 Prior to survey administration, address and phone information is updated for clients of the CAHPS sample using the United States Postal Service's National Change of Address (NCOA) and Telematch databases. The number of updated addresses and telephone numbers are provided for informational purposes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

Figure 2-4—Distribution of Surveys for Region 2: Colorado Access



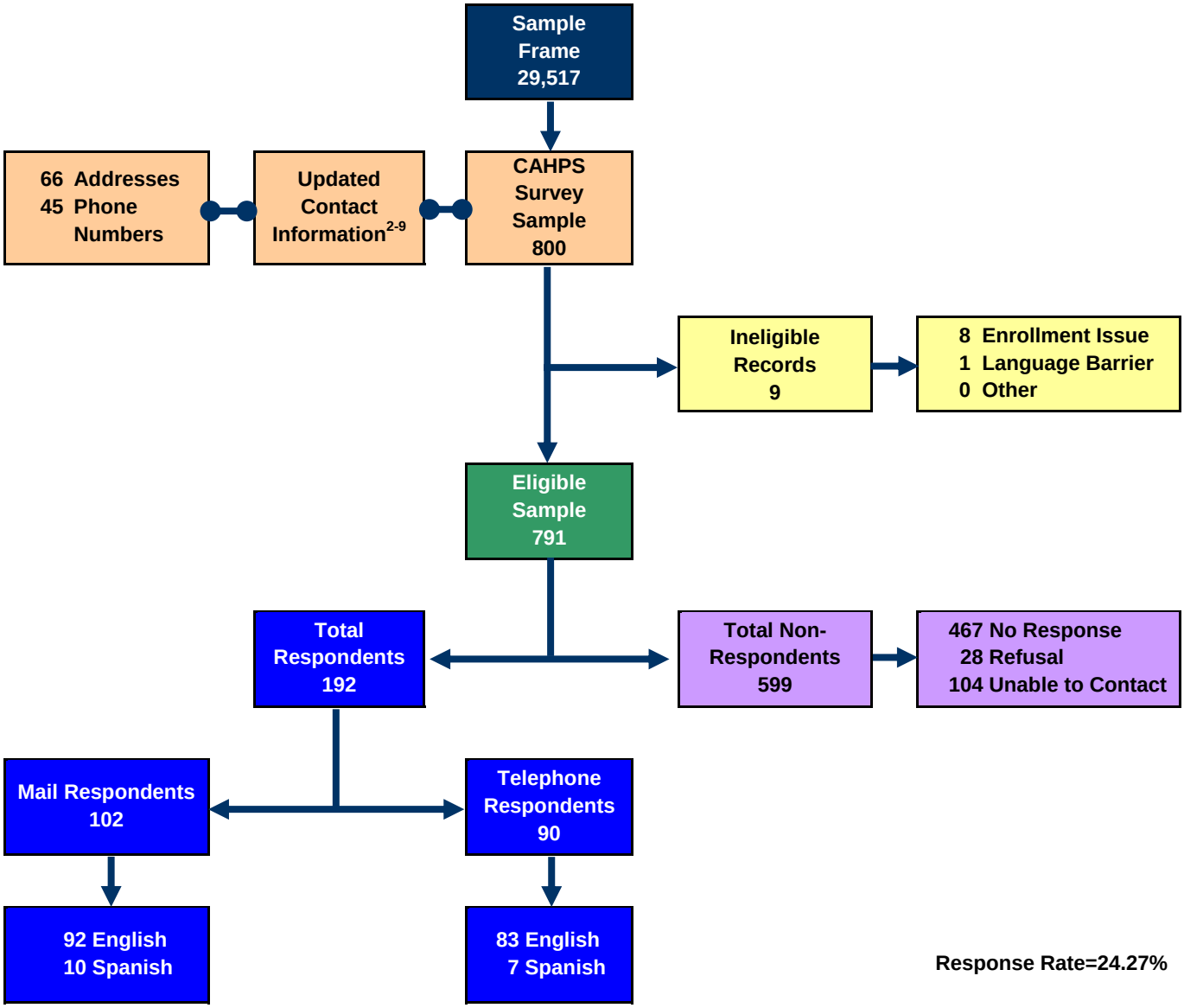
2-7 Prior to survey administration, address and phone information is updated for clients of the CAHPS sample using the United States Postal Service's National Change of Address (NCOA) and Telematch databases. The number of updated addresses and telephone numbers are provided for informational purposes only.

Figure 2-5—Distribution of Surveys for Region 3: Colorado Access



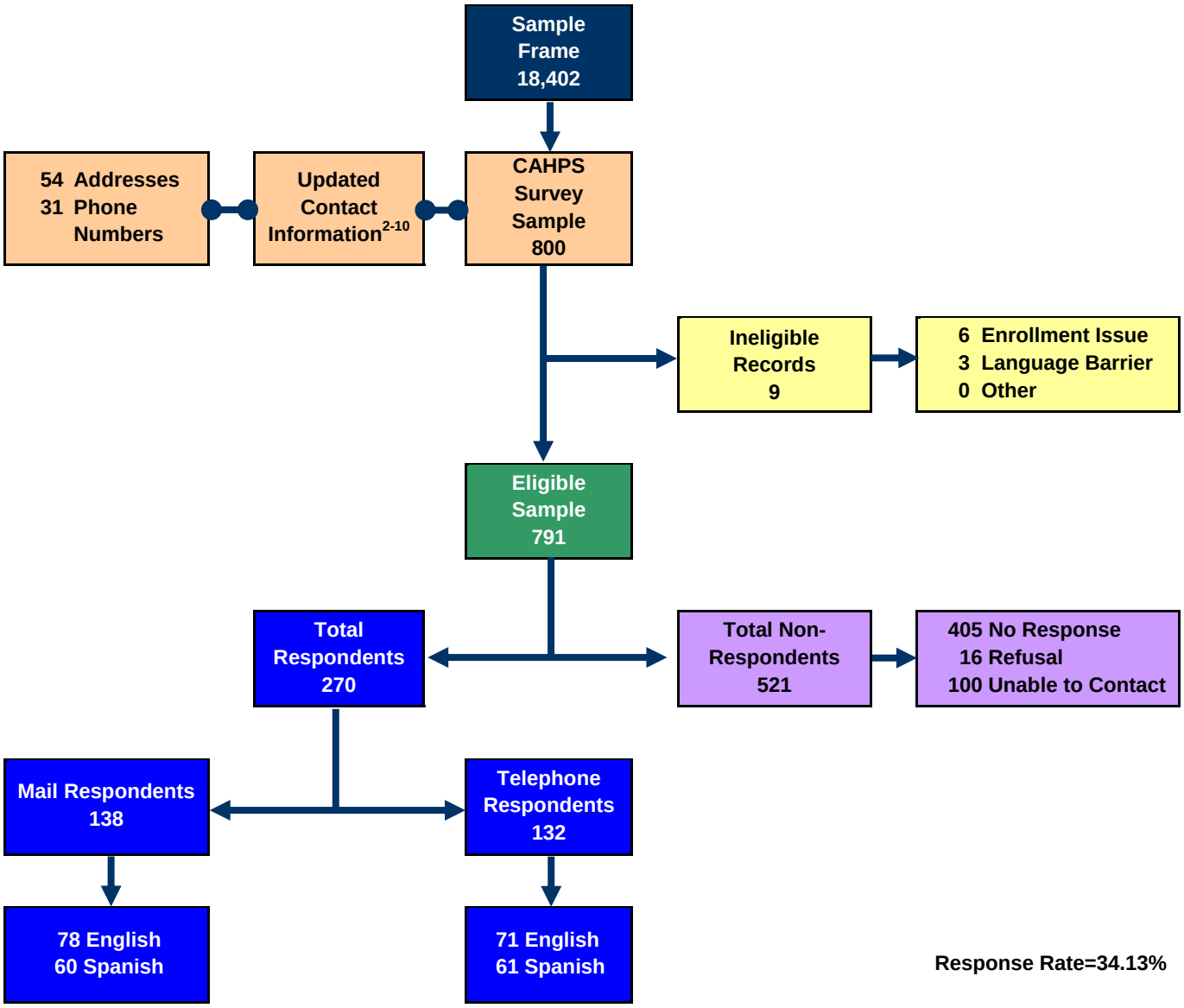
2-8 Prior to survey administration, address and phone information is updated for clients of the CAHPS sample using the United States Postal Service's National Change of Address (NCOA) and Telematch databases. The number of updated addresses and telephone numbers are provided for informational purposes only.

Figure 2-6—Distribution of Surveys for Region 4: Integrated Community Health Partners



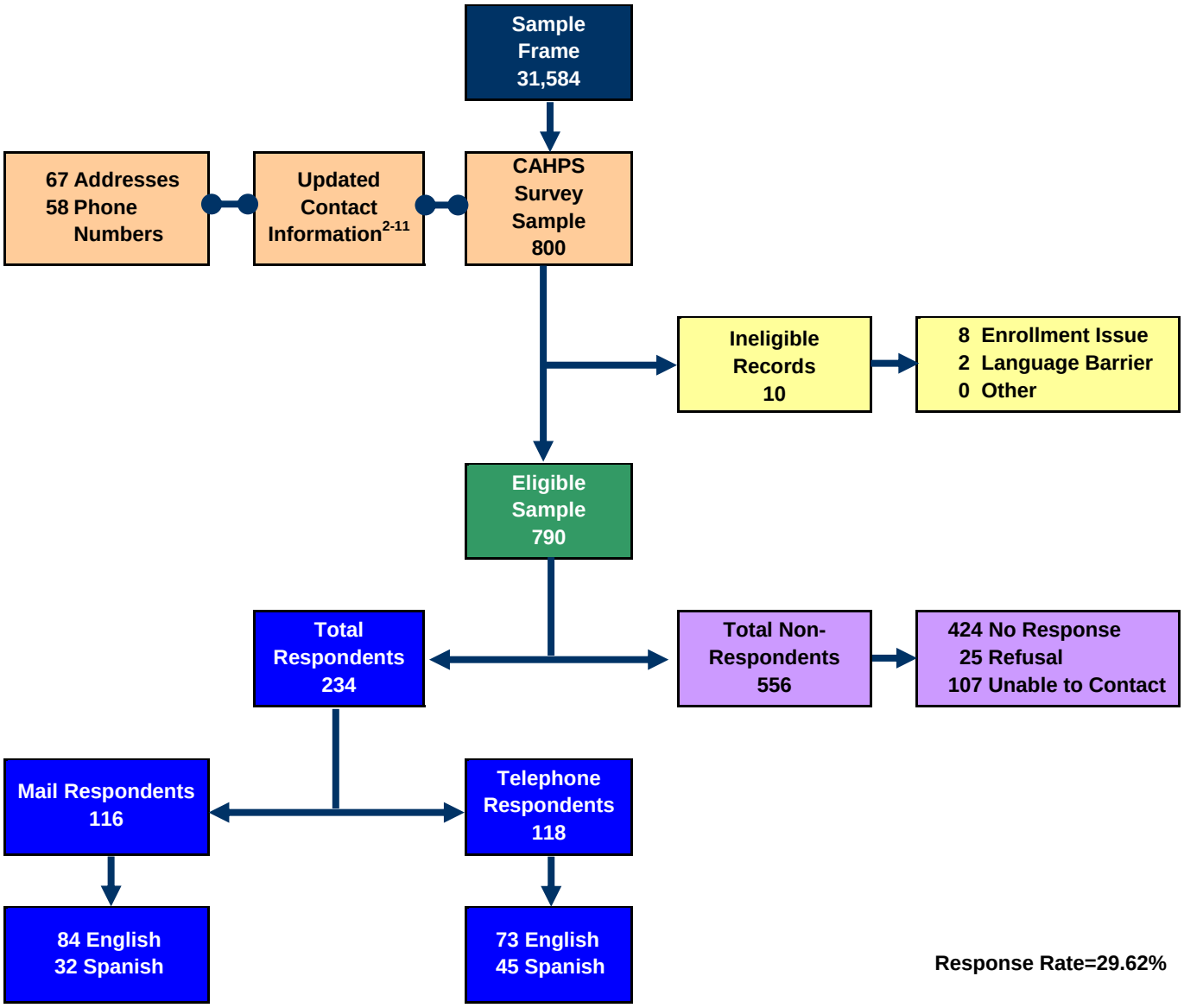
2-9 Prior to survey administration, address and phone information is updated for clients of the CAHPS sample using the United States Postal Service's National Change of Address (NCOA) and Telematch databases. The number of updated addresses and telephone numbers are provided for informational purposes only.

Figure 2-7—Distribution of Surveys for Region 5: Colorado Access



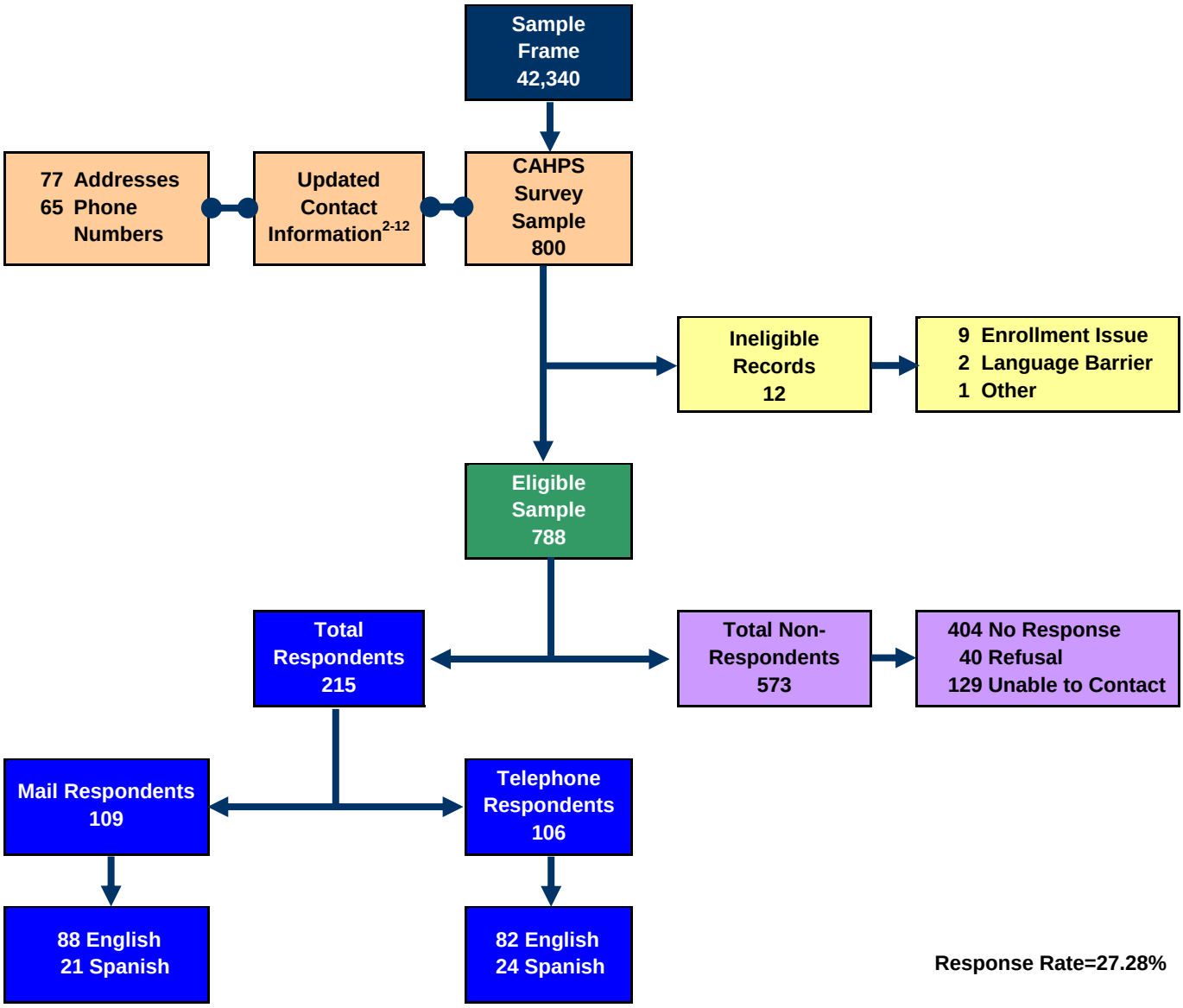
[2-10] Prior to survey administration, address and phone information is updated for clients of the CAHPS sample using the United States Postal Service's National Change of Address (NCOA) and Telematch databases. The number of updated addresses and telephone numbers are provided for informational purposes only.

Figure 2-8—Distribution of Surveys for Region 6: Colorado Community Health Alliance



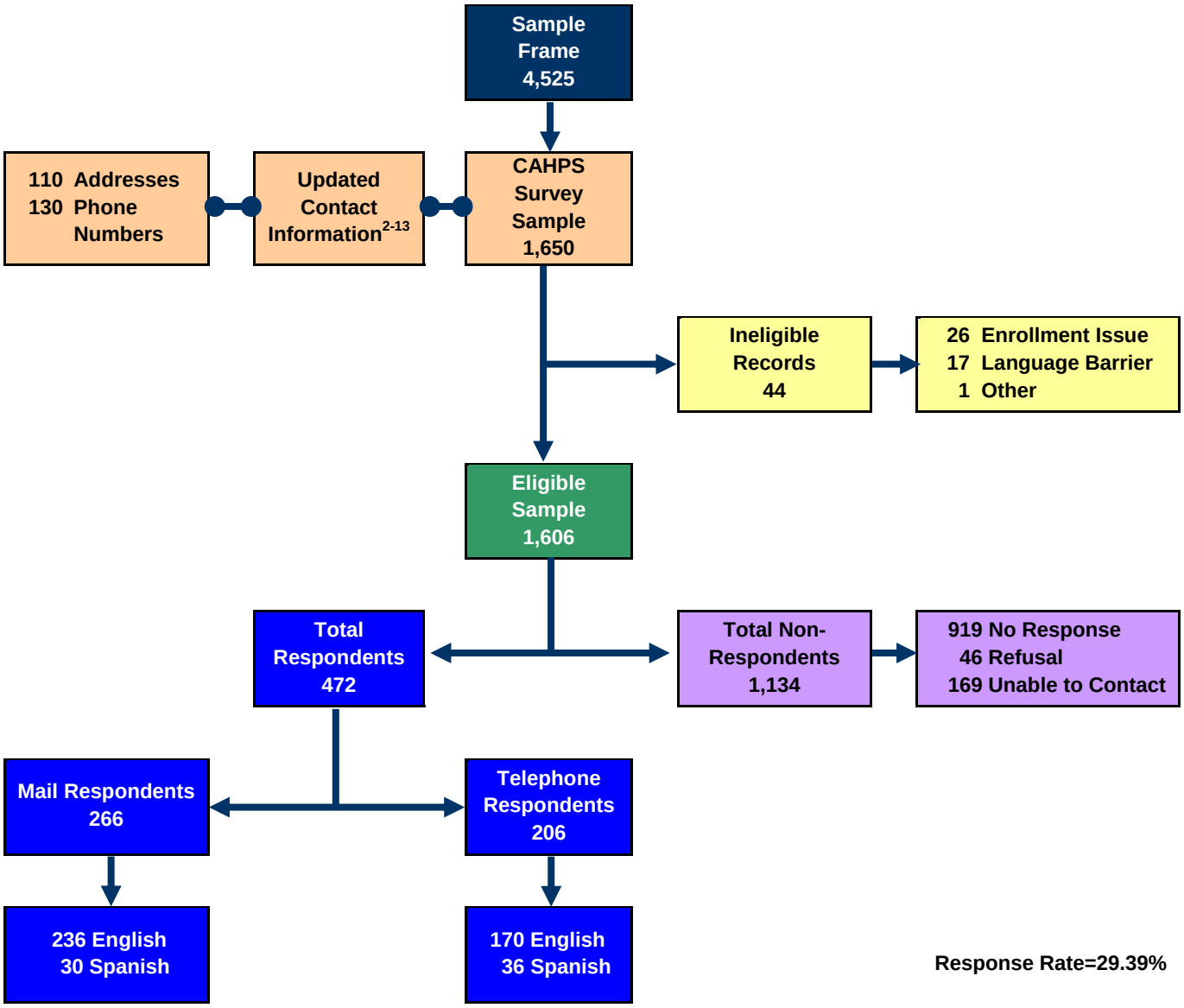
2-11 Prior to survey administration, address and phone information is updated for clients of the CAHPS sample using the United States Postal Service's National Change of Address (NCOA) and Telematch databases. The number of updated addresses and telephone numbers are provided for informational purposes only.

Figure 2-9—Distribution of Surveys for Region 7: Community Care of Central Colorado



[2-12] Prior to survey administration, address and phone information is updated for clients of the CAHPS sample using the United States Postal Service's National Change of Address (NCOA) and Telematch databases. The number of updated addresses and telephone numbers are provided for informational purposes only.

Figure 2-10—Distribution of Surveys for Colorado Medicaid PCPP



[2-13] Prior to survey administration, address and phone information is updated for clients of the CAHPS sample using the United States Postal Service's National Change of Address (NCOA) and Telematch databases. The number of updated addresses and telephone numbers are provided for informational purposes only.

Table 2-1 depicts the sample distribution and response rates for Colorado Medicaid FFS, the seven participating RCCOs, and PCPP, and overall total.

Table 2-1
Colorado Child Medicaid
Sample Distribution and Response Rate

Plan Name	Total Sample	Ineligible Records	Eligible Sample	Total Respondents	Response Rate
Colorado Child Medicaid Total	**8,900**	**151**	**8,749**	**2,498**	**28.55%**
Colorado Medicaid FFS	1,650	21	1,629	422	25.91%
Region 1: Rocky Mountain Health Plans	800	7	793	232	29.26%
Region 2: Colorado Access	800	18	782	243	31.07%
Region 3: Colorado Access	800	21	779	218	27.98%
Region 4: Integrated Community Health Partners	800	9	791	192	24.27%
Region 5: Colorado Access	800	9	791	270	34.13%
Region 6: Colorado Community Health Alliance	800	10	790	234	29.62%
Region 7: Community Care of Central Colorado	800	12	788	215	27.28%
Colorado Medicaid PCPP	1,650	44	1,606	472	29.39%

As previously noted, the Colorado Medicaid FFS sample included both child FFS clients enrolled in a RCCO (i.e., RCCO child clients) and child clients not enrolled in a RCCO (i.e., non-RCCO child clients). Therefore, the completed surveys returned on behalf of RCCO child clients included children in both the Colorado Medicaid FFS sample and RCCO-level oversamples. Based on administrative data, the following table shows the number of completed CAHPS surveys for the seven participating RCCOs and the Colorado RCCO program in aggregate (i.e., seven RCCOs combined). These completed surveys were used to derive the 2014 Colorado RCCO Program and RCCO-level results presented in the FFS and PCPP Results section of the report.

Table 2-2
Colorado RCCO Clients
Completed CAHPS Surveys

RCCO Name	Total Respondents
Colorado RCCO Program	**1,864**
Region 1: Rocky Mountain Health Plans	261
Region 2: Colorado Access	275
Region 3: Colorado Access	305
Region 4: Integrated Community Health Partners	209
Region 5: Colorado Access	288
Region 6: Colorado Community Health Alliance	265
Region 7: Community Care of Central Colorado	261

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.[2-14]

Table 2-3 through Table 2-6 show the demographic characteristics of children for whom a parent/caretaker completed a CAHPS 5.0 Child Medicaid Health Plan Survey for age, gender, race/ethnicity, and general health status, respectively.

Table 2-3
Child Demographics
Age

Plan Name	Less than 1	1 to 3	4 to 7	8 to 12	13 to 18
Colorado Medicaid FFS	**1.1%**	**20.3%**	**25.0%**	**28.4%**	**25.3%**
Colorado RCCO Program	**1.1%**	**16.7%**	**27.7%**	**29.6%**	**24.9%**
Region 1: Rocky Mountain Health Plans	0.9%	17.7%	31.2%	29.4%	20.8%
Region 2: Colorado Access	1.2%	19.3%	26.4%	28.3%	24.8%
Region 3: Colorado Access	1.5%	17.4%	26.3%	31.5%	23.3%
Region 4: Integrated Community Health Partners	0.5%	14.3%	24.3%	30.7%	30.2%
Region 5: Colorado Access	1.5%	17.1%	29.4%	32.7%	19.3%
Region 6: Colorado Community Health Alliance	1.6%	13.1%	25.5%	31.1%	28.7%
Region 7: Community Care of Central Colorado	0.4%	17.1%	30.4%	22.9%	29.2%
Colorado Medicaid PCPP	**0.5%**	**9.1%**	**21.4%**	**32.0%**	**37.0%**

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, 2013. Some children eligible for the CAHPS Survey turned age 18 between January 1, 2014 and the time of survey administration.

[2-14] Agency for Healthcare Research and Quality. *CAHPS Health Plan Survey and Reporting Kit 2008*. Rockville, MD: US Department of Health and Human Services, July 2008.

Table 2-4 Child Demographics Gender		
Plan Name	**Male**	**Female**
Colorado Medicaid FFS	**52.0%**	**48.0%**
Colorado RCCO Program	**49.6%**	**50.4%**
Region 1: Rocky Mountain Health Plans	48.9%	51.1%
Region 2: Colorado Access	51.0%	49.0%
Region 3: Colorado Access	52.8%	47.2%
Region 4: Integrated Community Health Partners	47.9%	52.1%
Region 5: Colorado Access	48.1%	51.9%
Region 6: Colorado Community Health Alliance	47.4%	52.6%
Region 7: Community Care of Central Colorado	50.6%	49.4%
Colorado Medicaid PCPP	**53.7%**	**46.3%**
Please note: Percentages may not total 100% due to rounding.		

Table 2-5 Child Demographics Race/Ethnicity					
Plan Name	**Multi-Racial**	**White**	**Black**	**Asian**	**Other**
Colorado Medicaid FFS	**13.6%**	**59.5%**	**7.1%**	**3.6%**	**16.3%**
Colorado RCCO Program	**15.1%**	**55.6%**	**5.6%**	**2.1%**	**21.6%**
Region 1: Rocky Mountain Health Plans	14.6%	65.7%	0.5%	0.9%	18.3%
Region 2: Colorado Access	13.9%	58.2%	1.0%	2.4%	24.5%
Region 3: Colorado Access	13.7%	50.6%	6.9%	4.3%	24.5%
Region 4: Integrated Community Health Partners	17.3%	56.6%	1.2%	0.0%	24.9%
Region 5: Colorado Access	14.2%	43.4%	15.1%	1.8%	25.6%
Region 6: Colorado Community Health Alliance	12.1%	64.5%	3.7%	2.3%	17.3%
Region 7: Community Care of Central Colorado	20.6%	50.9%	9.8%	2.3%	16.4%
Colorado Medicaid PCPP	**14.1%**	**52.0%**	**12.9%**	**5.4%**	**15.6%**
Please note: Percentages may not total 100% due to rounding.					

Table 2-6 Child Demographics General Health Status					
Plan Name	**Excellent**	**Very Good**	**Good**	**Fair**	**Poor**
Colorado Medicaid FFS	**36.7%**	**36.2%**	**22.6%**	**4.2%**	**0.3%**
Colorado RCCO Program	**38.6%**	**35.1%**	**21.1%**	**4.9%**	**0.2%**
Region 1: Rocky Mountain Health Plans	41.5%	35.8%	18.3%	4.4%	0.0%
Region 2: Colorado Access	40.4%	31.6%	22.4%	5.6%	0.0%
Region 3: Colorado Access	32.7%	36.8%	24.3%	6.3%	0.0%
Region 4: Integrated Community Health Partners	36.1%	41.4%	16.8%	5.8%	0.0%
Region 5: Colorado Access	38.1%	33.3%	23.0%	5.2%	0.4%
Region 6: Colorado Community Health Alliance	39.9%	31.9%	23.4%	4.4%	0.4%
Region 7: Community Care of Central Colorado	42.0%	36.6%	18.1%	2.9%	0.4%
Colorado Medicaid PCPP	**35.5%**	**38.0%**	**21.0%**	**4.5%**	**0.9%**
Please note: Percentages may not total 100% due to rounding.					

Table 2-7 through Table 2-9 show 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.

Table 2-7
Respondent Demographics
Respondent Age

Plan Name	Under 18	18 to 24	25 to 34	35 to 44	45 to 54	55 and Older
Colorado Medicaid FFS	**2.6%**	**9.0%**	**33.2%**	**36.4%**	**11.9%**	**6.9%**
Colorado RCCO Program	**3.6%**	**6.5%**	**35.3%**	**36.8%**	**11.7%**	**6.1%**
Region 1: Rocky Mountain Health Plans	3.0%	9.1%	34.1%	37.9%	12.5%	3.4%
Region 2: Colorado Access	2.0%	8.4%	37.6%	34.4%	11.6%	6.0%
Region 3: Colorado Access	2.3%	5.3%	38.3%	37.5%	12.9%	3.8%
Region 4: Integrated Community Health Partners	4.7%	8.4%	33.7%	30.5%	10.0%	12.6%
Region 5: Colorado Access	4.6%	4.2%	36.6%	38.9%	11.8%	3.8%
Region 6: Colorado Community Health Alliance	4.5%	4.9%	31.6%	39.3%	12.3%	7.4%
Region 7: Community Care of Central Colorado	4.1%	6.2%	34.7%	37.6%	10.3%	7.0%
Colorado Medicaid PCPP	**6.4%**	**5.3%**	**24.0%**	**32.6%**	**14.6%**	**17.1%**

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

Table 2-8
Respondent Demographics
Respondent Education

Plan Name	8th Grade or Less	Some High School	High School Graduate	Some College	College Graduate
Colorado Medicaid FFS	**11.3%**	**13.2%**	**28.0%**	**32.7%**	**14.8%**
Colorado RCCO Program	**12.6%**	**13.7%**	**30.9%**	**31.8%**	**11.1%**
Region 1: Rocky Mountain Health Plans	7.8%	12.6%	32.0%	32.0%	15.6%
Region 2: Colorado Access	21.8%	11.7%	34.7%	26.2%	5.6%
Region 3: Colorado Access	11.1%	13.7%	33.2%	29.0%	13.0%
Region 4: Integrated Community Health Partners	6.3%	14.7%	29.5%	42.6%	6.8%
Region 5: Colorado Access	16.1%	19.5%	30.7%	21.8%	11.9%
Region 6: Colorado Community Health Alliance	16.0%	11.5%	28.8%	30.9%	12.8%
Region 7: Community Care of Central Colorado	7.0%	11.6%	26.9%	43.4%	11.2%
Colorado Medicaid PCPP	**6.0%**	**14.9%**	**30.6%**	**33.6%**	**14.9%**

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

Table 2-9 Respondent Demographics Relationship to Child				
Plan Name	**Mother or Father**	**Grandparent**	**Legal Guardian**	**Other**
Colorado Medicaid FFS	**92.0%**	**5.3%**	**1.3%**	**1.3%**
Colorado RCCO Program	**92.4%**	**4.9%**	**1.3%**	**1.4%**
Region 1: Rocky Mountain Health Plans	96.6%	1.7%	0.4%	1.3%
Region 2: Colorado Access	91.6%	6.4%	0.8%	1.2%
Region 3: Colorado Access	95.5%	3.0%	0.8%	0.8%
Region 4: Integrated Community Health Partners	83.7%	12.0%	1.1%	3.3%
Region 5: Colorado Access	95.0%	2.3%	1.1%	1.5%
Region 6: Colorado Community Health Alliance	91.3%	5.4%	2.5%	0.8%
Region 7: Community Care of Central Colorado	90.8%	5.4%	2.1%	1.7%
Colorado Medicaid PCPP	**83.1%**	**12.2%**	**3.1%**	**1.6%**
Please note: Percentages may not total 100% due to rounding.				

NCQA Comparisons

In order to assess the overall performance of Colorado Medicaid FFS, Colorado RCCO Program, participating RCCOs, and PCPP, the three CAHPS global ratings and three CAHPS composite measures were scored on a three-point scale using the scoring methodology detailed in NCQA's HEDIS Specifications for Survey Measures.[2-15,2-16] The resulting three-point mean scores were compared to NCQA's HEDIS Benchmarks and Thresholds for Accreditation.[2-17] Based on this comparison, plan ratings of one (★) to five (★★★★★) stars were determined for each CAHPS measure, where one is the lowest possible rating and five is the highest possible rating.

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

[2-15] National Committee for Quality Assurance. *HEDIS® 2014, Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA Publication, 2013.

[2-16] As previously noted, the Colorado Medicaid FFS sample included child FFS clients enrolled in a RCCO (i.e., RCCO clients) and clients not enrolled in a RCCO (i.e., non-RCCO clients); therefore, the Colorado Medicaid FFS results presented in this section are based on parents'/caretakers' responses of RCCO and non-RCCO child clients. The Colorado RCCO Program and individual RCCOs' results presented in this section are based on the responses of parents/caretakers of RCCO child clients included in the RCCO-level oversamples and Colorado Medicaid FFS sample. Therefore, the respondent populations included in the Colorado Medicaid FFS analysis and the RCCO program and individual RCCO-level analysis may overlap.

[2-17] National Committee for Quality Assurance. *HEDIS Benchmarks and Thresholds for Accreditation 2014.* Washington, DC: NCQA, January 30, 2014.

Table 2-10 shows the three-point mean scores and overall client satisfaction ratings for the three global ratings for Colorado Medicaid FFS, Colorado RCCO Program, the seven participating RCCOs, and PCPP.

Table 2-10
NCQA Comparisons
Overall Client Satisfaction Ratings for Global Ratings

Plan Name	Rating of All Health Care	Rating of Personal Doctor	Rating of Specialist Seen Most Often
Colorado Medicaid FFS	★★ **2.494**	★★ **2.610**	★★+ **2.580**
Colorado RCCO Program	★ **2.488**	★★ **2.596**	★★ **2.567**
Region 1: Rocky Mountain Health Plans	★★ 2.497	★ 2.566	★★+ 2.548
Region 2: Colorado Access	★★★★ 2.578	★★★★ 2.683	★★★★★+ 2.719
Region 3: Colorado Access	★ 2.484	★ 2.567	★★+ 2.550
Region 4: Integrated Community Health Partners	★ 2.428	★ 2.525	★+ 2.500
Region 5: Colorado Access	★★ 2.491	★★★ 2.649	★★★★+ 2.659
Region 6: Colorado Community Health Alliance	★★★ 2.547	★★ 2.617	★★★+ 2.613
Region 7: Community Care of Central Colorado	★ 2.393	★ 2.558	★+ 2.422
Colorado Medicaid PCPP	★★★★ **2.583**	★★★★ **2.654**	★★+ **2.581**

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

Table 2-11 shows the three-point mean scores and overall client satisfaction ratings for the three composite measures for Colorado Medicaid FFS, Colorado RCCO Program, the seven participating RCCOs, and PCPP. NCQA does not provide benchmarks 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 determined.

Table 2-11
NCQA Comparisons
Overall Client Satisfaction Ratings for Composite Measures

Plan Name	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate
Colorado Medicaid FFS	★ **2.366**	★★ **2.542**	★★★ **2.683**
Colorado RCCO Program	★ **2.367**	★★ **2.556**	★★ **2.639**
Region 1: Rocky Mountain Health Plans	★ 2.336	★★ 2.557	★ 2.621
Region 2: Colorado Access	★★+ 2.426	★★ 2.589	★★ 2.671
Region 3: Colorado Access	★★ 2.459	★ 2.539	★★★ 2.685
Region 4: Integrated Community Health Partners	★★★+ 2.486	★ 2.521	★★ 2.660
Region 5: Colorado Access	★ 2.300	★ 2.497	★ 2.596
Region 6: Colorado Community Health Alliance	★+ 2.280	★★ 2.579	★★ 2.651
Region 7: Community Care of Central Colorado	★ 2.309	★★ 2.605	★ 2.603
Colorado Medicaid PCPP	★★★★ **2.522**	★★★★★ **2.703**	★★★ **2.707**

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

Summary of NCQA Comparisons Results

The following tables summarize the NCQA comparisons results for the global ratings and composite measures, respectively.

Table 2-12
NCQA Comparisons Results
Global Ratings

Plan Name	Rating of All Health Care	Rating of Personal Doctor	Rating of Specialist Seen Most Often
Colorado Medicaid FFS	★★	★★	★★+
Colorado RCCO Program	★	★★	★★
Region 1: Rocky Mountain Health Plans	★★	★	★★+
Region 2: Colorado Access	★★★★	★★★★	★★★★★+
Region 3: Colorado Access	★	★	★★+
Region 4: Integrated Community Health Partners	★	★	★+
Region 5: Colorado Access	★★	★★★	★★★★+
Region 6: Colorado Community Health Alliance	★★★	★★	★★★+
Region 7: Community Care of Central Colorado	★	★	★+
Colorado Medicaid PCPP	★★★★	★★★★	★★+

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

Table 2-13
NCQA Comparisons Results
Composite Measures

Plan Name	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate
Colorado Medicaid FFS	★	★★	★★★
Colorado RCCO Program	★	★★	★★
Region 1: Rocky Mountain Health Plans	★	★★	★
Region 2: Colorado Access	★★+	★★	★★
Region 3: Colorado Access	★★	★	★★★
Region 4: Integrated Community Health Partners	★★★+	★	★★
Region 5: Colorado Access	★	★	★
Region 6: Colorado Community Health Alliance	★+	★★	★★
Region 7: Community Care of Central Colorado	★	★★	★
Colorado Medicaid PCPP	★★★★	★★★★★	★★★

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

Rates and Proportions

For purposes of calculating the 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.[2-18] 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 2014 Specifications for Survey Measures*, *Volume 3*.

CAHPS scores with fewer than 100 respondents are denoted with a cross (+). Caution should be exercised when interpreting results for those measures with fewer than 100 respondents.

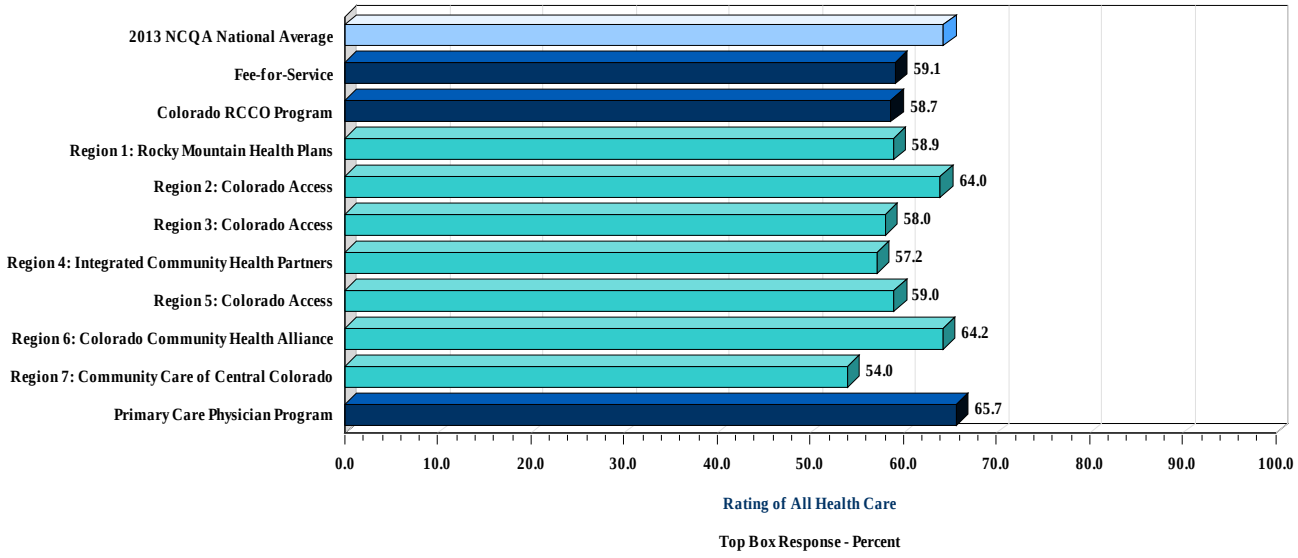
[2-18] National Committee for Quality Assurance. *HEDIS® 2014, Volume 3: Specifications for Survey Measures*. Washington, DC: NCQA Publication, 2013.

Global Ratings

Rating of All Health Care

Colorado Medicaid parents/caretakers of child clients were asked to rate all their child's health care on a scale of 0 to 10, with 0 being the "worst health care possible" and 10 being the "best health care possible." Top-level responses were defined as those responses with a rating of 9 or 10. Figure 2-11 shows the 2013 NCQA national average and 2014 Rating of All Health Care question summary rates for FFS, Colorado RCCO Program, the seven participating RCCOs, and PCPP.[2-19, 2-20,2-21,2-22]

Figure 2-11—Rating of All Health Care



2-19 As previously noted, the Colorado Medicaid FFS sample included child FFS clients enrolled in a RCCO (i.e., RCCO clients) and clients not enrolled in a RCCO (i.e., non-RCCO clients); therefore, the Colorado Medicaid FFS results presented in this section are based on parents'/caretakers' responses of RCCO and non-RCCO child clients. The Colorado RCCO Program and individual RCCOs' results presented in this section are based on the responses of parents/caretakers of RCCO child clients included in the RCCO-level oversamples and Colorado Medicaid FFS sample. Therefore, the respondent populations included in the Colorado Medicaid FFS analysis and the RCCO program and individual RCCO-level analysis may overlap.

2-20 Colorado RCCO Program scores presented in this section are derived from the combined results of the seven participating RCCOs.

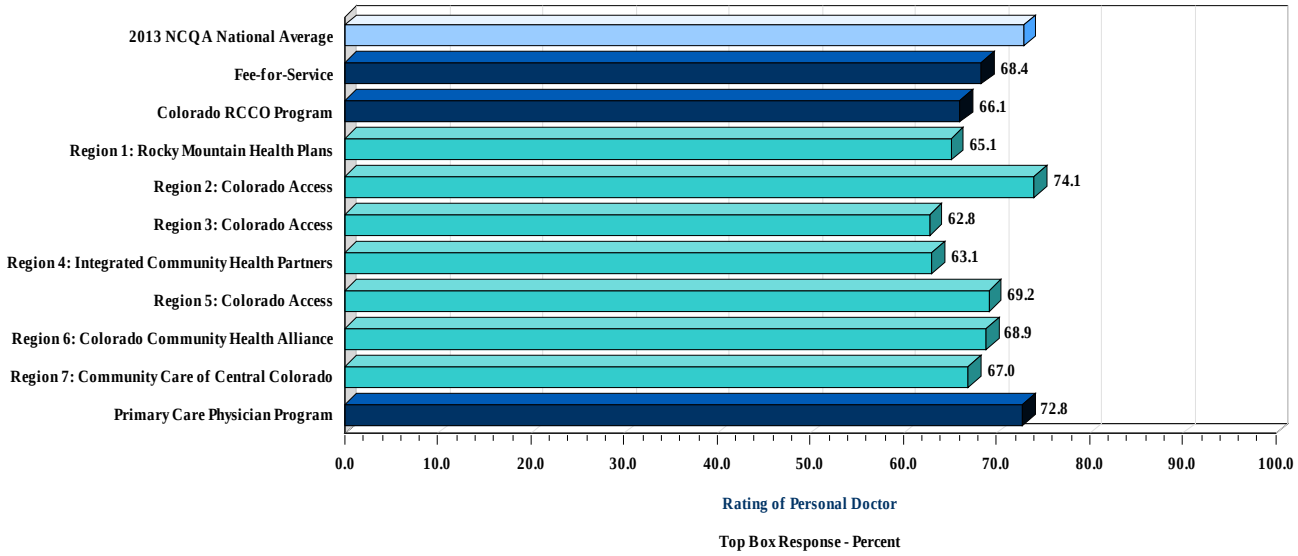
2-21 NCQA national averages were not available for 2014 at the time this report was prepared; therefore, 2013 NCQA national data are presented in this section.

2-22 The source for the NCQA national averages contained in this publication is Quality Compass® 2013 data and is used with the permission of the National Committee for Quality Assurance (NCQA). Quality Compass 2013 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 Personal Doctor

Colorado Medicaid parents/caretakers of child clients were asked to rate their child's personal doctor on a scale of 0 to 10, with 0 being the "worst personal doctor possible" and 10 being the "best personal doctor possible." Top-level responses were defined as those responses with a rating of 9 or 10. Figure 2-12 shows the 2013 NCQA national average and 2014 Rating of Personal Doctor question summary rates for FFS, Colorado RCCO Program, the seven participating RCCOs, and PCPP.

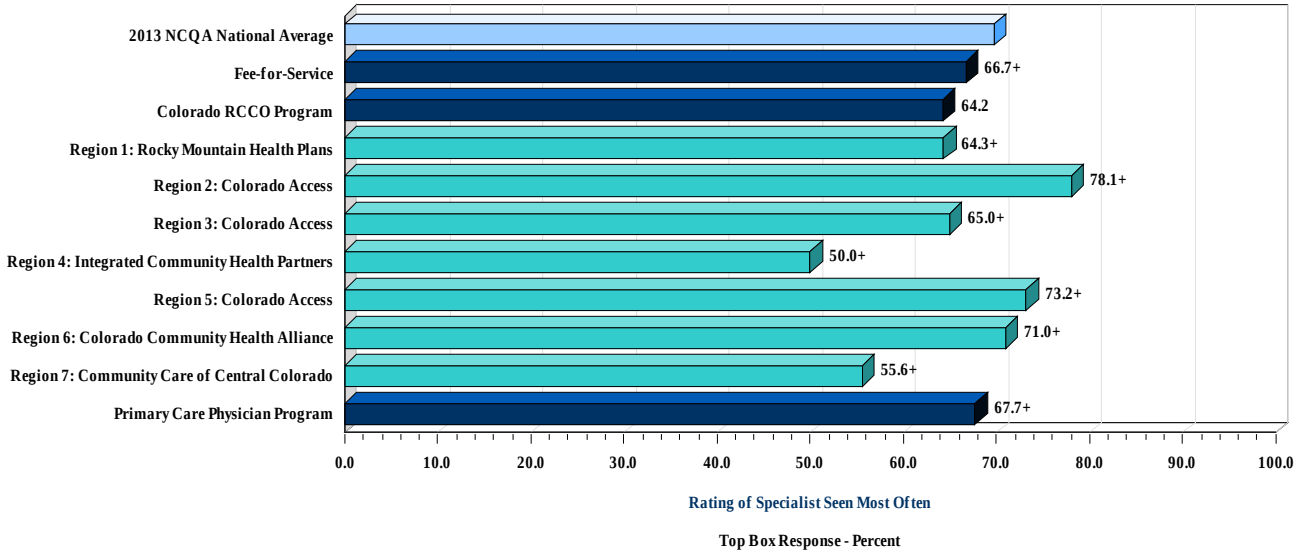
Figure 2-12—Rating of Personal Doctor



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 2-13 shows the 2013 NCQA national average and 2014 Rating of Specialist Seen Most Often question summary rates for FFS, Colorado RCCO Program, the seven participating RCCOs, and PCPP.

Figure 2-13—Rating of Specialist Seen Most Often



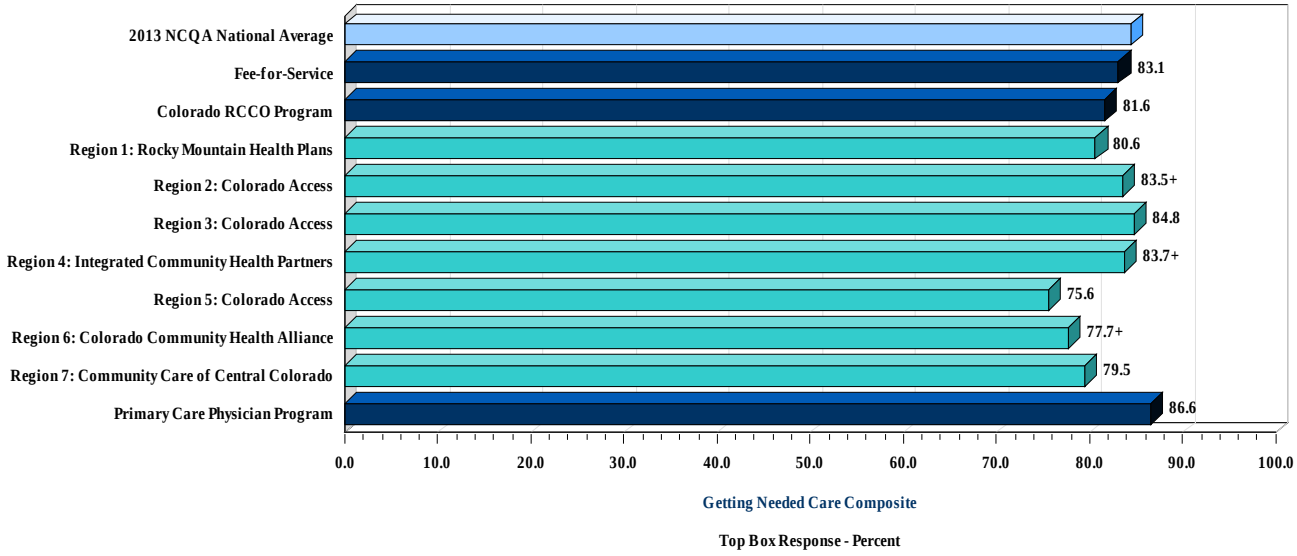
+ If the plan had fewer than 100 respondents for a measure, caution should be exercised when interpreting these results.

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 13 and 44), a top-level response was defined as a response of "Usually" or "Always." Figure 2-14 shows the 2013 NCQA national average and 2014 Getting Needed Care global proportions for FFS, Colorado RCCO Program, the seven participating RCCOs, and PCPP.

Figure 2-14—Getting Needed Care

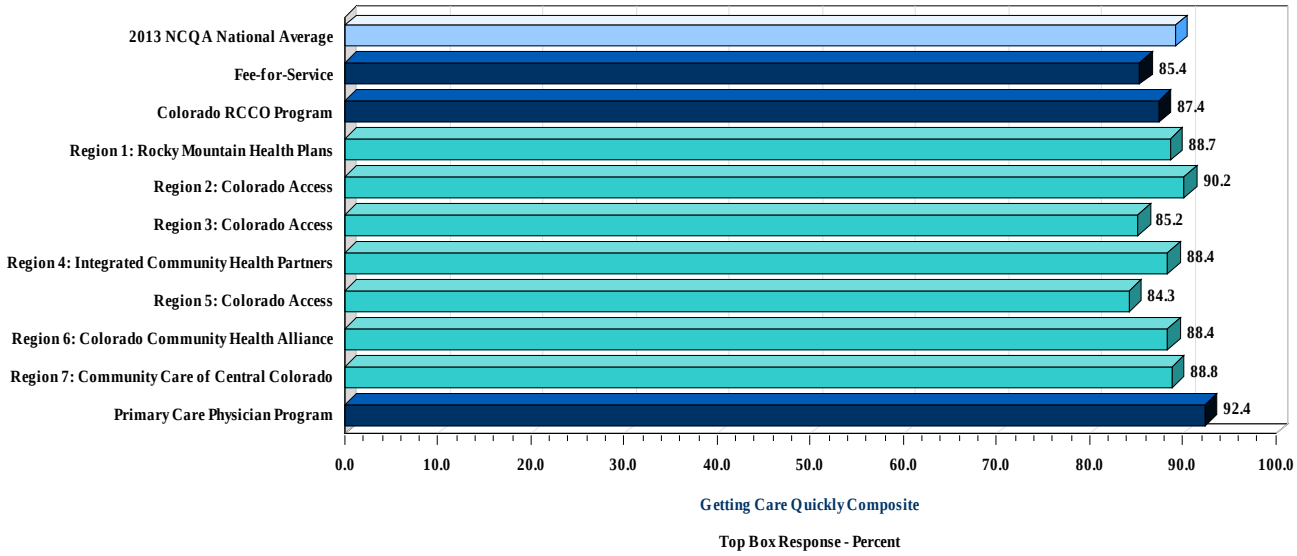


+ If the plan had fewer than 100 respondents for a measure, caution should be exercised when interpreting these results.

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 2-15 shows the 2013 NCQA national average and 2014 Getting Care Quickly global proportions for FFS, Colorado RCCO Program, the seven participating RCCOs, and PCPP.

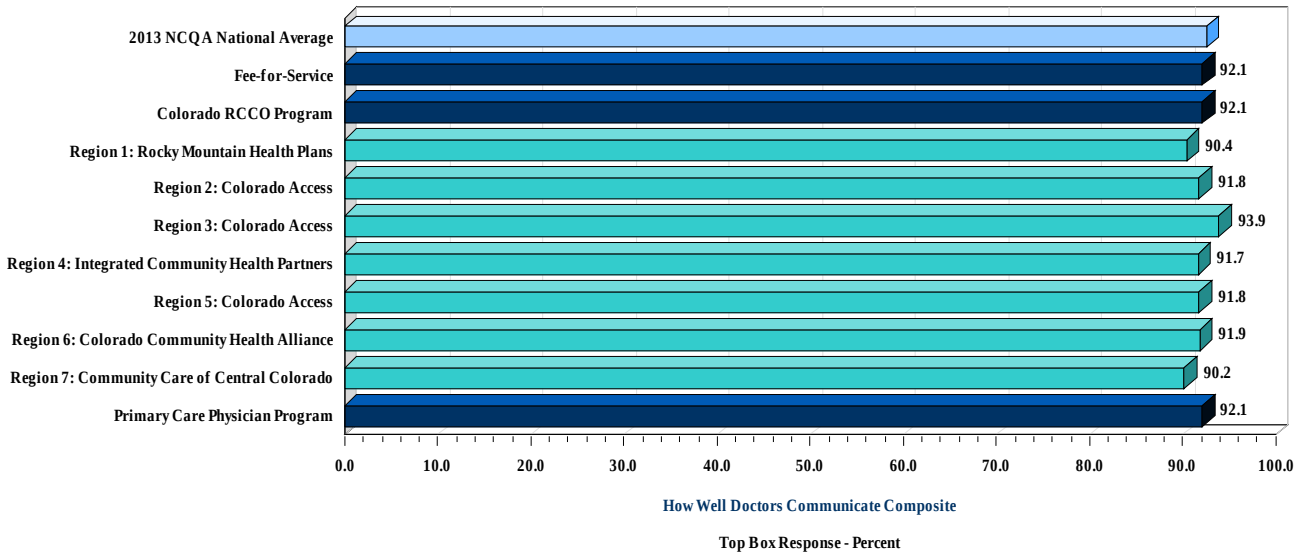
Figure 2-15—Getting Care Quickly



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 24, 25, 26, and 29), a top-level response was defined as a response of "Usually" or "Always." Figure 2-16 shows the 2013 NCQA national average and 2014 How Well Doctors Communicate global proportions for FFS, Colorado RCCO Program, the seven participating RCCOs, and PCPP.

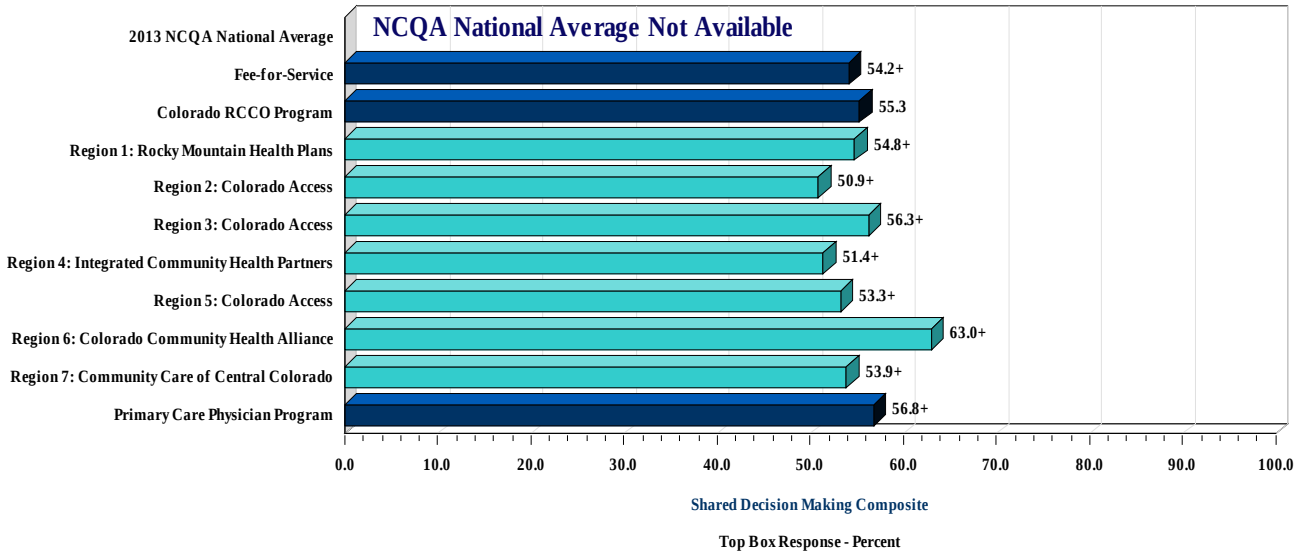
Figure 2-16—How Well Doctors Communicate



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 10, 11, and 12), a top-level response was defined as a response of "A lot" or "Yes." Figure 2-17 shows the 2014 Shared Decision Making global proportions for FFS, Colorado RCCO Program, the seven participating RCCOs, and PCPP.[2-23]

Figure 2-17—Shared Decision Making



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

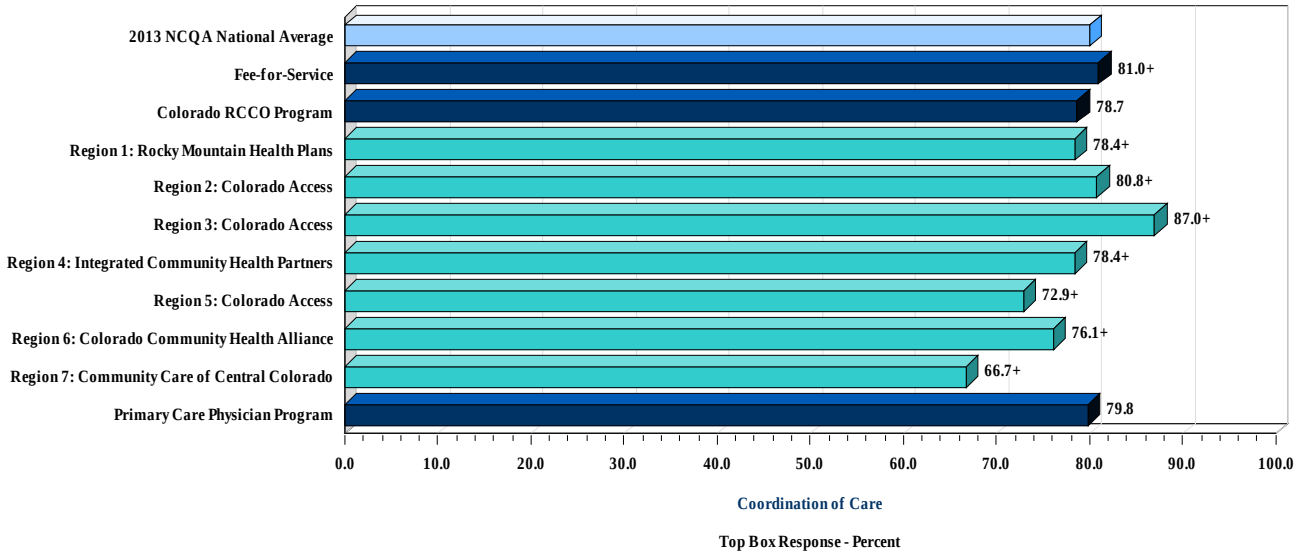
[2-23] With the transition to the CAHPS 5.0 Child Medicaid Health Plan Survey and changes to the Shared Decision Making composite measure, 2013 NCQA national averages are not available for this CAHPS measure.

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 34), a top-level response was defined as a response of "Usually" or "Always." Figure 2-18 shows the 2013 NCQA national average and the 2014 Coordination of Care question summary rates for FFS, Colorado RCCO Program, the seven participating RCCOs, and PCPP.

Figure 2-18—Coordination of Care

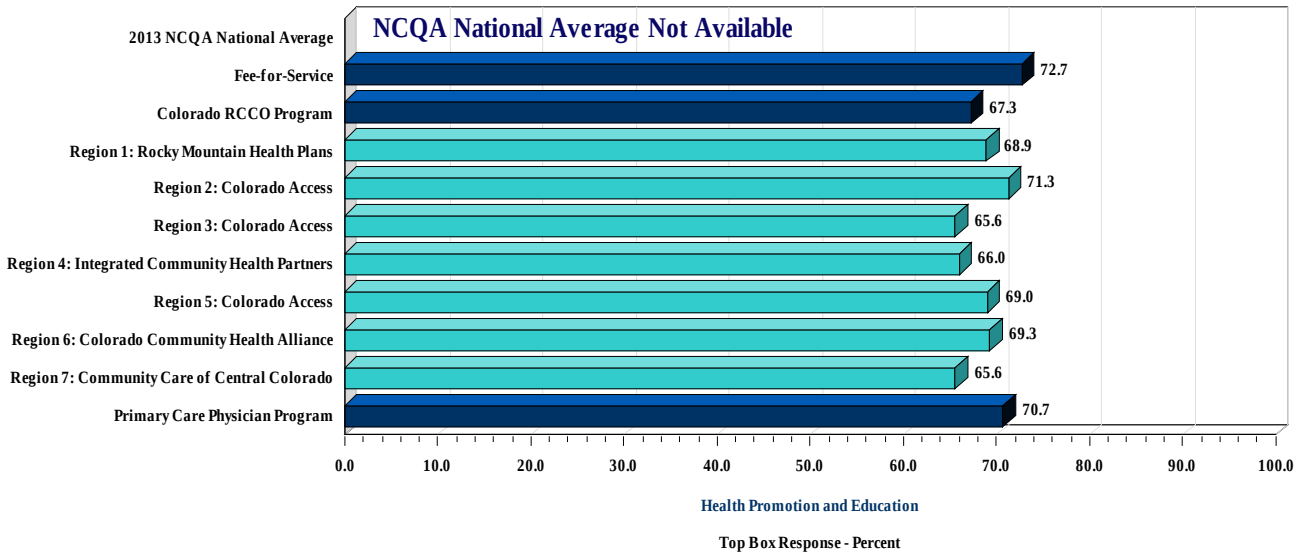


+ If the plan had fewer than 100 respondents for a measure, caution should be exercised when interpreting these results.

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 2-19 shows the 2014 Health Promotion and Education question summary rates for FFS, Colorado RCCO Program, the seven participating RCCOs, and PCPP. [2-24]

Figure 2-19—Health Promotion and Education



[2-24] With the transition to the CAHPS 5.0 Child Medicaid Health Plan Survey and changes to the Health Promotion and Education individual item measure, 2013 NCQA national averages are not available for this CAHPS measure.

RCCO Comparisons

In order to identify performance differences in client satisfaction between the seven Colorado RCCOs, the results of each were compared to one another using standard tests for statistical significance.[2-25] 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 were case-mix adjusted for general health status, respondent educational level, and age of the respondent.[2-26] Given that differences in case-mix can result in differences in ratings between RCCOs 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 2014 Specifications for Survey Measures, Volume 3*.

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

Table 2-14 through Table 2-16, on the following pages show the results of the RCCO comparisons analysis for the global ratings, composite measures, and individual items measures, respectively. **NOTE: These results may differ from those presented in the rates and proportions figures because they have been adjusted for differences in case mix (i.e., the percentages presented have been case-mix adjusted).**

[2-25] Caution should be exercised when evaluating RCCO comparisons, given that population and RCCO differences may impact CAHPS results.

[2-26] Agency for Healthcare Research and Quality. *CAHPS Health Plan Survey and Reporting Kit 2008*. Rockville, MD: US Department of Health and Human Services, July 2008.

Table 2-14 RCCO Comparisons Global Ratings			
Plan Name	**Rating of All Health Care**	**Rating of Personal Doctor**	**Rating of Specialist Seen Most Often**
Region 1: Rocky Mountain Health Plans	59.1% ↔	65.5% ↔	64.9%+ ↔
Region 2: Colorado Access	63.7% ↔	72.9% ↔	77.6%+ ↔
Region 3: Colorado Access	58.7% ↔	63.7% ↔	65.1%+ ↔
Region 4: Integrated Community Health Partners	57.6% ↔	63.5% ↔	48.2%+ ↔
Region 5: Colorado Access	58.9% ↔	69.1% ↔	73.3%+ ↔
Region 6: Colorado Community Health Alliance	63.8% ↔	68.3% ↔	71.5%+ ↔
Region 7: Community Care of Central Colorado	53.5% ↔	67.1% ↔	56.5%+ ↔
Please note: CAHPS scores with fewer than 100 respondents are denoted with a cross (+). If there are fewer than 100 respondents for a CAHPS measure, caution should be exercised when interpreting these results.			

Table 2-15 Plan Comparisons Composite Measures			
Plan Name	**Getting Needed Care**	**Getting Care Quickly**	**How Well Doctors Communicate**
Region 1: Rocky Mountain Health Plans	79.5% ↔	88.0% ↔	89.7% ↔
Region 2: Colorado Access	84.4%+ ↔	90.9% ↔	92.5% ↔
Region 3: Colorado Access	84.7% ↔	85.5% ↔	94.2% ↔
Region 4: Integrated Community Health Partners	83.1%+ ↔	88.3% ↔	91.5% ↔
Region 5: Colorado Access	76.4% ↔	84.9% ↔	92.9% ↔
Region 6: Colorado Community Health Alliance	78.4%+ ↔	88.3% ↔	91.4% ↔
Region 7: Community Care of Central Colorado	78.9% ↔	88.0% ↔	89.7% ↔
Please note: CAHPS scores with fewer than 100 respondents are denoted with a cross (+). If there are fewer than 100 respondents for a CAHPS measure, caution should be exercised when interpreting these results.			

Table 2-16 RCCO Comparisons Individual Item Measures		
Plan Name	**Coordination of Care**	**Health Promotion and Education**
Region 1: Rocky Mountain Health Plans	77.8%+ ↔	68.0% ↔
Region 2: Colorado Access	81.7%+ ↔	72.1% ↔
Region 3: Colorado Access	87.0%+ ↔	65.2% ↔
Region 4: Integrated Community Health Partners	78.5%+ ↔	65.7% ↔
Region 5: Colorado Access	73.6%+ ↔	69.7% ↔
Region 6: Colorado Community Health Alliance	75.3%+ ↔	69.6% ↔
Region 7: Community Care of Central Colorado	66.4%+ ↔	65.4% ↔
Please note: CAHPS scores with fewer than 100 respondents are denoted with a cross (+). If there are fewer than 100 respondents for a CAHPS measure, caution should be exercised when interpreting these results.		

Summary of RCCO Comparisons Results

The RCCO comparisons revealed that there were no statistically significant differences between the RCCOs' results when evaluating performance differences.

Supplemental Items

The Department elected to add 16 supplemental items to the standard CAHPS 5.0 Child Medicaid Health Plan Survey. Table 2-17 details the survey language and response options for each of the supplemental items. Table 2-18 through Table 2-33 show the results for each supplemental item. For these supplemental items, the number and percentage of responses for each item are presented.

Table 2-17
Supplemental Items

Question		Response Options
Q14.	In the last 6 months, did you child's doctor or other health provider order a blood test, x-ray, or other test for your child?	Yes No
Q15.	In the last 6 months, when your child's doctor or other health provider ordered a blood test, x-ray, or other test for your child, how often did someone follow up to give you those results?	Never Sometimes Usually Always
Q16.	In the last 6 months, did your child's doctor or other health provider talk with you about specific goals for your child's health?	Yes No
Q17.	In the last 6 months, did your child's doctor or other health provider ask you if there are things that make it hard for you to take care of your child's health?	Yes No
Q18.	In the last 6 months, did you and your child's doctor or other health provider talk about your child's learning ability?	Yes No
Q19.	In the last 6 months, did you and your child's doctor or other health provider talk about the kinds of behaviors that are normal for your child at this age?	Yes No
Q20.	In the last 6 months, did you and your child's doctor or other health provider talk about your child's moods and emotions?	Yes No
Q31.	Thinking about the care your child received in the last 6 months, how often do you think your child's personal doctor understood the things that really matter to you about your child's health care?	Never Sometimes Usually Always
Q32.	In the past 6 months, did you ever leave your child's personal doctor's office confused about what to do next to manage your child's health?	Yes No

Table 2-17 Supplemental Items		
Question		**Response Options**
Q35.	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
Q36.	In the last 6 months, did your child take any prescription medicine?	Yes No
Q37.	In the last 6 months, did you and your child's personal doctor talk at each visit about all the prescription medicines your child was taking?	Yes No
Q38.	In the last 6 months, did your child's personal doctor's office give you information about what to do if your child needed care during evenings, weekends, or holidays?	Yes No
Q39.	In the last 6 months, did your child need care from his or her personal doctor during evenings, weekends, or holidays?	Yes No
Q40.	In the last 6 months, how often were you able to get the care your child needed from his or her personal doctor during evenings, weekends, or holidays?	Never Sometimes Usually Always
Q42.	In the last 6 months, did your child's personal doctor or other health provider talk to you about resources in your neighborhood to support you in managing your child's health?	Yes No

Test and X-rays

Parents/caretakers of child clients were asked if their child's doctor or other health provider ordered a blood test, x-ray, or other test for their child (Question 14). Table 2-18 displays the responses for this question.

Table 2-18
Doctor Ordered Blood Test, X-ray, or Other Tests

Plan/RCCO	Yes		No	
	N	%	N	%
Colorado Medicaid FFS	85	32.3%	178	67.7%
Region 1: Rocky Mountain Health Plans	41	25.0%	123	75.0%
Region 2: Colorado Access	33	19.9%	133	80.1%
Region 3: Colorado Access	52	26.9%	141	73.1%
Region 4: Integrated Community Health Partners	41	28.7%	102	71.3%
Region 5: Colorado Access	45	25.7%	130	74.3%
Region 6: Colorado Community Health Alliance	41	27.3%	109	72.7%
Region 7: Community Care of Central Colorado	52	31.5%	113	68.5%
Colorado Medicaid PCPP	113	35.3%	207	64.7%

Parents/caretakers of child clients were asked to assess how often someone followed up with them to give them the results of their child's blood test, x-ray, or other test ordered by a doctor or other health provider (Question 15). Table 2-19 displays the responses for this question.

Table 2-19
Follow Up on Blood Test, X-ray, or Other Test Results

Plan/RCCO	Never		Sometimes		Usually		Always	
	N	%	N	%	N	%	N	%
Colorado Medicaid FFS	5	6.0%	12	14.3%	16	19.0%	51	60.7%
Region 1: Rocky Mountain Health Plans	1	2.4%	3	7.3%	6	14.6%	31	75.6%
Region 2: Colorado Access	2	6.3%	2	6.3%	5	15.6%	23	71.9%
Region 3: Colorado Access	3	5.9%	6	11.8%	8	15.7%	34	66.7%
Region 4: Integrated Community Health Partners	6	15.0%	4	10.0%	5	12.5%	25	62.5%
Region 5: Colorado Access	3	6.7%	8	17.8%	9	20.0%	25	55.6%
Region 6: Colorado Community Health Alliance	6	14.6%	3	7.3%	7	17.1%	25	61.0%
Region 7: Community Care of Central Colorado	5	9.8%	5	9.8%	10	19.6%	31	60.8%
Colorado Medicaid PCPP	4	3.6%	8	7.2%	9	8.1%	90	81.1%

Specific Goals for Health

Parents/caretakers of child clients were asked if a doctor or other health provider talked with them about specific goals for their child's health (Question 16). Table 2-20 displays the responses for this question.

Table 2-20
Specific Goals for Health

Plan/RCCO	Yes		No	
	N	%	N	%
Colorado Medicaid FFS	140	53.8%	120	46.2%
Region 1: Rocky Mountain Health Plans	81	49.1%	84	50.9%
Region 2: Colorado Access	84	51.9%	78	48.1%
Region 3: Colorado Access	105	54.7%	87	45.3%
Region 4: Integrated Community Health Partners	78	53.4%	68	46.6%
Region 5: Colorado Access	90	51.1%	86	48.9%
Region 6: Colorado Community Health Alliance	77	50.7%	75	49.3%
Region 7: Community Care of Central Colorado	71	43.0%	94	57.0%
Colorado Medicaid PCPP	183	57.7%	134	42.3%

Difficulty with Taking Care of Child's Health

Parents/caretakers of child clients were asked if their child's doctor or other health provider asked them if there are things that made it hard for the parent/caretaker to take care of their child's health (Question 17). Table 2-21 displays the responses for this question.

Table 2-21
Difficulty with Taking Care of Child's Health

Plan/RCCO	Yes		No	
	N	%	N	%
Colorado Medicaid FFS	65	24.9%	196	75.1%
Region 1: Rocky Mountain Health Plans	41	24.8%	124	75.2%
Region 2: Colorado Access	42	25.9%	120	74.1%
Region 3: Colorado Access	45	23.7%	145	76.3%
Region 4: Integrated Community Health Partners	24	16.6%	121	83.4%
Region 5: Colorado Access	45	25.7%	130	74.3%
Region 6: Colorado Community Health Alliance	30	19.6%	123	80.4%
Region 7: Community Care of Central Colorado	36	21.8%	129	78.2%
Colorado Medicaid PCPP	55	17.1%	266	82.9%

Talked About Learning Ability

Parents/caretakers of child clients were asked if they and their child's doctor or other health provider talked about their child's learning ability (Question 18). Table 2-22 displays the responses for this question.

Table 2-22
Talked About Learning Ability

Plan/RCCO	Yes		No	
	N	%	N	%
Colorado Medicaid FFS	120	45.6%	143	54.4%
Region 1: Rocky Mountain Health Plans	69	41.8%	96	58.2%
Region 2: Colorado Access	57	35.0%	106	65.0%
Region 3: Colorado Access	72	37.5%	120	62.5%
Region 4: Integrated Community Health Partners	38	26.6%	105	73.4%
Region 5: Colorado Access	83	47.2%	93	52.8%
Region 6: Colorado Community Health Alliance	61	40.4%	90	59.6%
Region 7: Community Care of Central Colorado	64	38.8%	101	61.2%
Colorado Medicaid PCPP	107	33.6%	211	66.4%

Talked about Child's Behavior

Parents/caretakers of child clients were asked if they and their child's doctor or other health provider talked about the kinds of behaviors that are normal for their child's age (Question 19). Table 2-23 displays the responses for this question.

Table 2-23
Talked About Child's Behavior

Plan/RCCO	Yes		No	
	N	%	N	%
Colorado Medicaid FFS	146	56.4%	113	43.6%
Region 1: Rocky Mountain Health Plans	92	55.8%	73	44.2%
Region 2: Colorado Access	92	57.1%	69	42.9%
Region 3: Colorado Access	105	54.7%	87	45.3%
Region 4: Integrated Community Health Partners	69	47.9%	75	52.1%
Region 5: Colorado Access	95	54.3%	80	45.7%
Region 6: Colorado Community Health Alliance	98	64.5%	54	35.5%
Region 7: Community Care of Central Colorado	84	51.2%	80	48.8%
Colorado Medicaid PCPP	157	49.2%	162	50.8%

Talked about Child's Moods and Emotions

Parents/caretakers of child clients were asked if they and their child's doctor or other health provider talked about their child's moods and emotions (Question 20). Table 2-24 displays the responses for this question.

Table 2-24
Talked About Child's Moods and Emotions

Plan/RCCO	Yes		No	
	N	%	N	%
Colorado Medicaid FFS	120	46.5%	138	53.5%
Region 1: Rocky Mountain Health Plans	80	49.1%	83	50.9%
Region 2: Colorado Access	68	41.7%	95	58.3%
Region 3: Colorado Access	72	38.3%	116	61.7%
Region 4: Integrated Community Health Partners	53	36.3%	93	63.7%
Region 5: Colorado Access	73	42.2%	100	57.8%
Region 6: Colorado Community Health Alliance	75	49.3%	77	50.7%
Region 7: Community Care of Central Colorado	65	39.6%	99	60.4%
Colorado Medicaid PCPP	142	44.2%	179	55.8%

Personal Doctor Understood Child's Health Care Matters

Parents/caretakers of child clients were asked to assess how often their child's personal doctor understood the things that really matter to the parent/caretaker about their child's health care (Question 31). Table 2-25 displays the responses for this question.

Table 2-25
Personal Doctor Understood Child's Health Care Matters

Plan/RCCO	Never		Sometimes		Usually		Always	
	N	%	N	%	N	%	N	%
Colorado Medicaid FFS	3	1.5%	17	8.6%	54	27.3%	124	62.6%
Region 1: Rocky Mountain Health Plans	4	3.1%	9	6.9%	36	27.7%	81	62.3%
Region 2: Colorado Access	0	0.0%	11	8.1%	30	22.1%	95	69.9%
Region 3: Colorado Access	3	2.2%	8	5.9%	34	25.2%	90	66.7%
Region 4: Integrated Community Health Partners	3	2.6%	8	6.8%	26	22.2%	80	68.4%
Region 5: Colorado Access	0	0.0%	12	8.6%	41	29.3%	87	62.1%
Region 6: Colorado Community Health Alliance	1	0.8%	8	6.6%	30	24.6%	83	68.0%
Region 7: Community Care of Central Colorado	4	2.5%	15	9.5%	42	26.6%	97	61.4%
Colorado Medicaid PCPP	3	1.1%	17	6.2%	60	21.8%	195	70.9%

Confused about Next Steps for Management of Child's Health

Parents/caretakers of child clients were asked if they ever left their child's personal doctor's office confused about what to do next to manage their child's health (Question 32). Table 2-26 displays the responses for this question.

Table 2-26
Confused about Next Steps for Management of Child's Health

Plan/RCCO	Yes		No	
	N	%	N	%
Colorado Medicaid FFS	14	7.1%	183	92.9%
Region 1: Rocky Mountain Health Plans	9	7.0%	120	93.0%
Region 2: Colorado Access	7	5.1%	130	94.9%
Region 3: Colorado Access	9	6.7%	126	93.3%
Region 4: Integrated Community Health Partners	12	10.3%	105	89.7%
Region 5: Colorado Access	16	11.4%	124	88.6%
Region 6: Colorado Community Health Alliance	8	6.6%	114	93.4%
Region 7: Community Care of Central Colorado	16	10.1%	142	89.9%
Colorado Medicaid PCPP	17	6.2%	259	93.8%

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 35). Table 2-27 displays the responses for this question.

Table 2-27
Patient Reminders

Plan/RCCO	Yes		No	
	N	%	N	%
Colorado Medicaid FFS	117	59.4%	80	40.6%
Region 1: Rocky Mountain Health Plans	83	64.3%	46	35.7%
Region 2: Colorado Access	74	54.0%	63	46.0%
Region 3: Colorado Access	81	60.9%	52	39.1%
Region 4: Integrated Community Health Partners	75	65.8%	39	34.2%
Region 5: Colorado Access	88	63.8%	50	36.2%
Region 6: Colorado Community Health Alliance	72	59.0%	50	41.0%
Region 7: Community Care of Central Colorado	89	57.1%	67	42.9%
Colorado Medicaid PCPP	170	61.8%	105	38.2%

Prescription Medicine

Parents/caretakers of child clients were asked if their child took prescription medicine in the last 6 months (Question 36). Table 2-28 displays the responses for this question.

Table 2-28
Prescription Medicine

Plan/RCCO	Yes		No	
	N	%	N	%
Colorado Medicaid FFS	110	55.8%	87	44.2%
Region 1: Rocky Mountain Health Plans	60	46.5%	69	53.5%
Region 2: Colorado Access	62	46.3%	72	53.7%
Region 3: Colorado Access	71	53.4%	62	46.6%
Region 4: Integrated Community Health Partners	66	56.9%	50	43.1%
Region 5: Colorado Access	61	43.9%	78	56.1%
Region 6: Colorado Community Health Alliance	55	45.1%	67	54.9%
Region 7: Community Care of Central Colorado	79	50.3%	78	49.7%
Colorado Medicaid PCPP	157	57.7%	115	42.3%

Parents/caretakers of child clients were asked if they and their child's personal doctor talked at each visit about all the prescription medicines that their child was taking (Question 37). Table 2-29 displays the responses for this question.

Table 2-29
Talked about Child's Prescription Medicines

Plan/RCCO	Yes		No	
	N	%	N	%
Colorado Medicaid FFS	100	90.9%	10	9.1%
Region 1: Rocky Mountain Health Plans	52	86.7%	8	13.3%
Region 2: Colorado Access	55	88.7%	7	11.3%
Region 3: Colorado Access	58	81.7%	13	18.3%
Region 4: Integrated Community Health Partners	57	86.4%	9	13.6%
Region 5: Colorado Access	52	85.2%	9	14.8%
Region 6: Colorado Community Health Alliance	46	85.2%	8	14.8%
Region 7: Community Care of Central Colorado	71	91.0%	7	9.0%
Colorado Medicaid PCPP	139	88.5%	18	11.5%

After-Hours Care

Parents/caretakers of child clients were asked when they visited their child's personal doctor's office if someone gave them information about what to do if their child needed care during evenings, weekends, or holidays (Question 38). Table 2-30 displays the responses for this question.

Table 2-30
Given Information about After-Hours Care

Plan/RCCO	Yes		No	
	N	%	N	%
Colorado Medicaid FFS	138	70.8%	57	29.2%
Region 1: Rocky Mountain Health Plans	86	67.2%	42	32.8%
Region 2: Colorado Access	86	63.7%	49	36.3%
Region 3: Colorado Access	82	62.1%	50	37.9%
Region 4: Integrated Community Health Partners	82	70.7%	34	29.3%
Region 5: Colorado Access	97	70.3%	41	29.7%
Region 6: Colorado Community Health Alliance	73	60.3%	48	39.7%
Region 7: Community Care of Central Colorado	96	61.1%	61	38.9%
Colorado Medicaid PCPP	190	69.6%	83	30.4%

Parents/caretakers of child clients were asked if their child needed care during evenings, weekends, or holidays (Question 39). Table 2-31 displays the responses for this question.

Table 2-31
Child Needed After-Hours Care

Plan/RCCO	Yes		No	
	N	%	N	%
Colorado Medicaid FFS	41	20.9%	155	79.1%
Region 1: Rocky Mountain Health Plans	21	16.4%	107	83.6%
Region 2: Colorado Access	22	16.4%	112	83.6%
Region 3: Colorado Access	27	20.8%	103	79.2%
Region 4: Integrated Community Health Partners	16	13.9%	99	86.1%
Region 5: Colorado Access	25	18.1%	113	81.9%
Region 6: Colorado Community Health Alliance	17	14.0%	104	86.0%
Region 7: Community Care of Central Colorado	27	17.3%	129	82.7%
Colorado Medicaid PCPP	48	17.7%	223	82.3%

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 40). Table 2-32 displays the responses for this question.

Table 2-32
Access to After-Hours Care

Plan/RCCO	Never		Sometimes		Usually		Always	
	N	%	N	%	N	%	N	%
Colorado Medicaid FFS	10	24.4%	10	24.4%	8	19.5%	13	31.7%
Region 1: Rocky Mountain Health Plans	7	35.0%	3	15.0%	2	10.0%	8	40.0%
Region 2: Colorado Access	6	28.6%	3	14.3%	5	23.8%	7	33.3%
Region 3: Colorado Access	7	25.9%	6	22.2%	7	25.9%	7	25.9%
Region 4: Integrated Community Health Partners	4	25.0%	3	18.8%	3	18.8%	6	37.5%
Region 5: Colorado Access	5	20.0%	5	20.0%	3	12.0%	12	48.0%
Region 6: Colorado Community Health Alliance	4	25.0%	1	6.3%	2	12.5%	9	56.3%
Region 7: Community Care of Central Colorado	11	40.7%	5	18.5%	5	18.5%	6	22.2%
Colorado Medicaid PCPP	11	25.0%	7	15.9%	5	11.4%	21	47.7%

Neighborhood Resources to Support Health Management

Parents/caretakers of child clients were asked if their child's personal doctor or other health provider talked to them about neighborhood resources to support the parent/caretaker in managing their child's health (Question 42). Table 2-33 displays the responses for this question.

Table 2-33
Neighborhood Resources to Support Health Management

Plan/RCCO	Yes		No	
	N	%	N	%
Colorado Medicaid FFS	81	30.6%	184	69.4%
Region 1: Rocky Mountain Health Plans	72	40.9%	104	59.1%
Region 2: Colorado Access	65	34.6%	123	65.4%
Region 3: Colorado Access	61	33.5%	121	66.5%
Region 4: Integrated Community Health Partners	49	31.2%	108	68.8%
Region 5: Colorado Access	55	29.3%	133	70.7%
Region 6: Colorado Community Health Alliance	54	29.5%	129	70.5%
Region 7: Community Care of Central Colorado	53	25.6%	154	74.4%
Colorado Medicaid PCPP	125	32.9%	255	67.1%

3. DHMC and RMHP Results

The following section presents the CAHPS results for the Colorado Medicaid plans in aggregate (i.e., DHMC and RMHP combined), DHMC, and RMHP.

Survey Administration and Response Rates

Survey Administration

The standard NCQA HEDIS Specifications for Survey Measures require a sample size of 1,650 clients for the CAHPS 5.0 Child Medicaid Health Plan Survey.[3-1] Clients eligible for sampling included those who were enrolled in 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 2013. Child clients eligible for sampling included those who were 17 years of age or younger as of December 31, 2013. DHMC and RMHP were responsible for conducting their annual CAHPS surveys. Morpace and the Center for the Study of Services (CSS) administered the CAHPS Child Medicaid Health Plan Surveys for DHMC and RMHP, respectively. For DHMC, a 25 percent oversample was performed. For the RMHP, oversampling was not performed. Based on these rates, a total sample of 2,063 and 1,650 child clients was selected from DHMC and RMHP, respectively. The oversampling was performed to ensure a greater of respondents for each CAHPS measure.

The survey administration protocol was designed to achieve a high response rate from clients, thus minimizing the potential effects of non-response bias. The survey process employed by RMHP was a mail-only methodology, which consisted of a survey only being mailed to sampled clients. The survey process employed by DHMC allowed clients two methods by which they could complete the surveys. The first phase, or mail phase, consisted of a survey being mailed to the sampled clients. 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. Both DHMC and RMHP provided English and Spanish versions of the mail survey. DHMC also 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.[3-2] Additional information on the survey protocol is included in the Reader's Guide Section beginning on page 5-3.

[3-1] National Committee for Quality Assurance. *HEDIS® 2014, Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA Publication, 2013.

[3-2] National Committee for Quality Assurance. *Quality Assurance Plan for HEDIS 2014 Survey Measures*. Washington, DC: NCQA Publication, 2013.

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 722 completed surveys were returned on behalf of child clients, including 412 DHMC and 310 RMHP clients. Figure 3-1, on the following page, shows the distribution of survey dispositions and response rate for the Colorado Medicaid aggregate (i.e., DHMC and RMHP combined). Figure 3-2 and Figure 3-3 show the distribution of survey dispositions and response rate for DHMC and RMHP, respectively. The 2014 Colorado Child Medicaid aggregate response rate of 19.62 percent was 9.08 percentage points lower than the national child Medicaid response rate reported by NCQA for 2013, which was 28.7 percent.[3-3]

[3-3] National Committee for Quality Assurance. *HEDIS 2013 Survey Vendor Update Training*. October 24, 2013.

Figure 3-1—Distribution of Surveys for Colorado Medicaid Program (DHMC and RMHP combined)

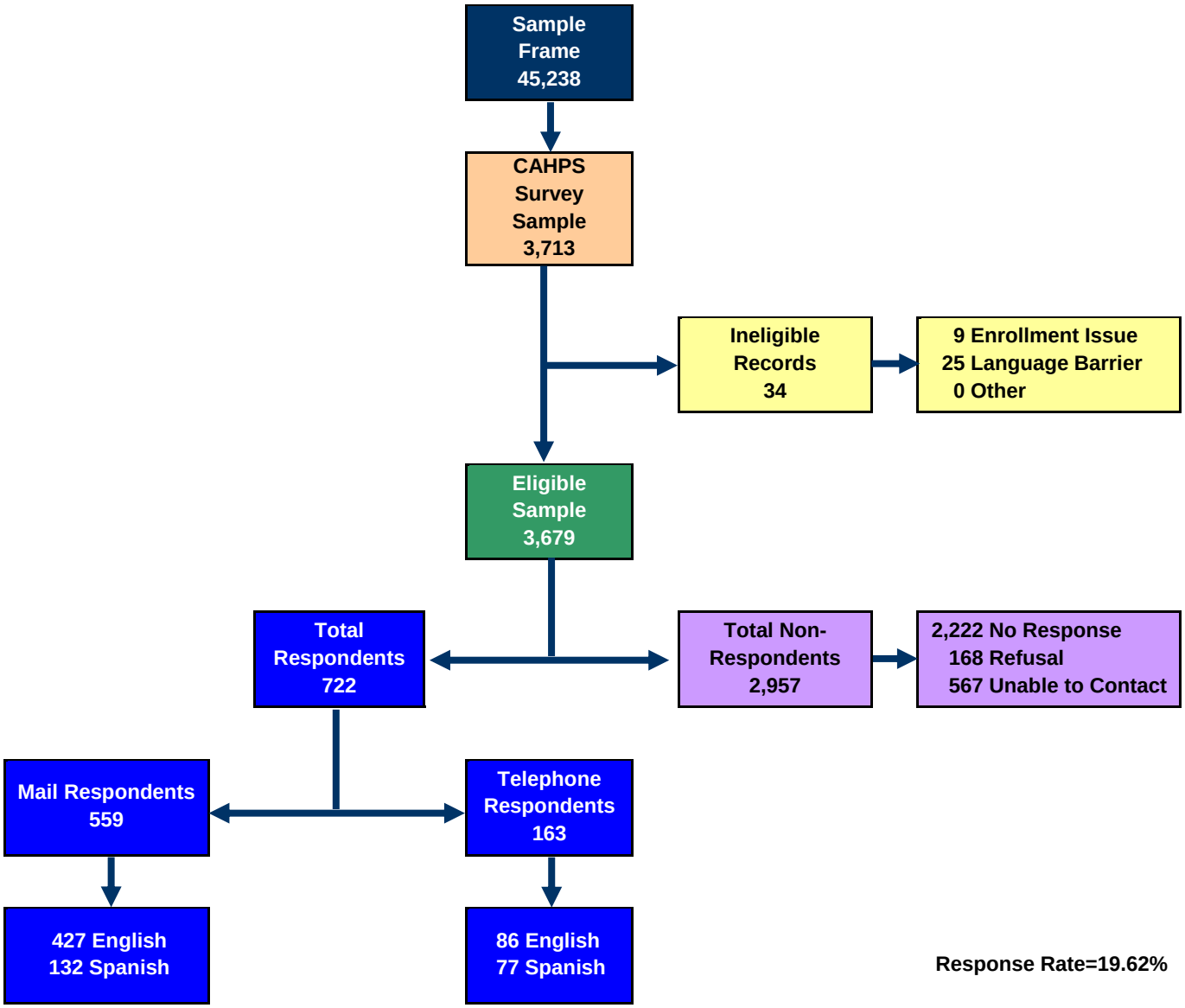


Figure 3-2—Distribution of Surveys for DHMC

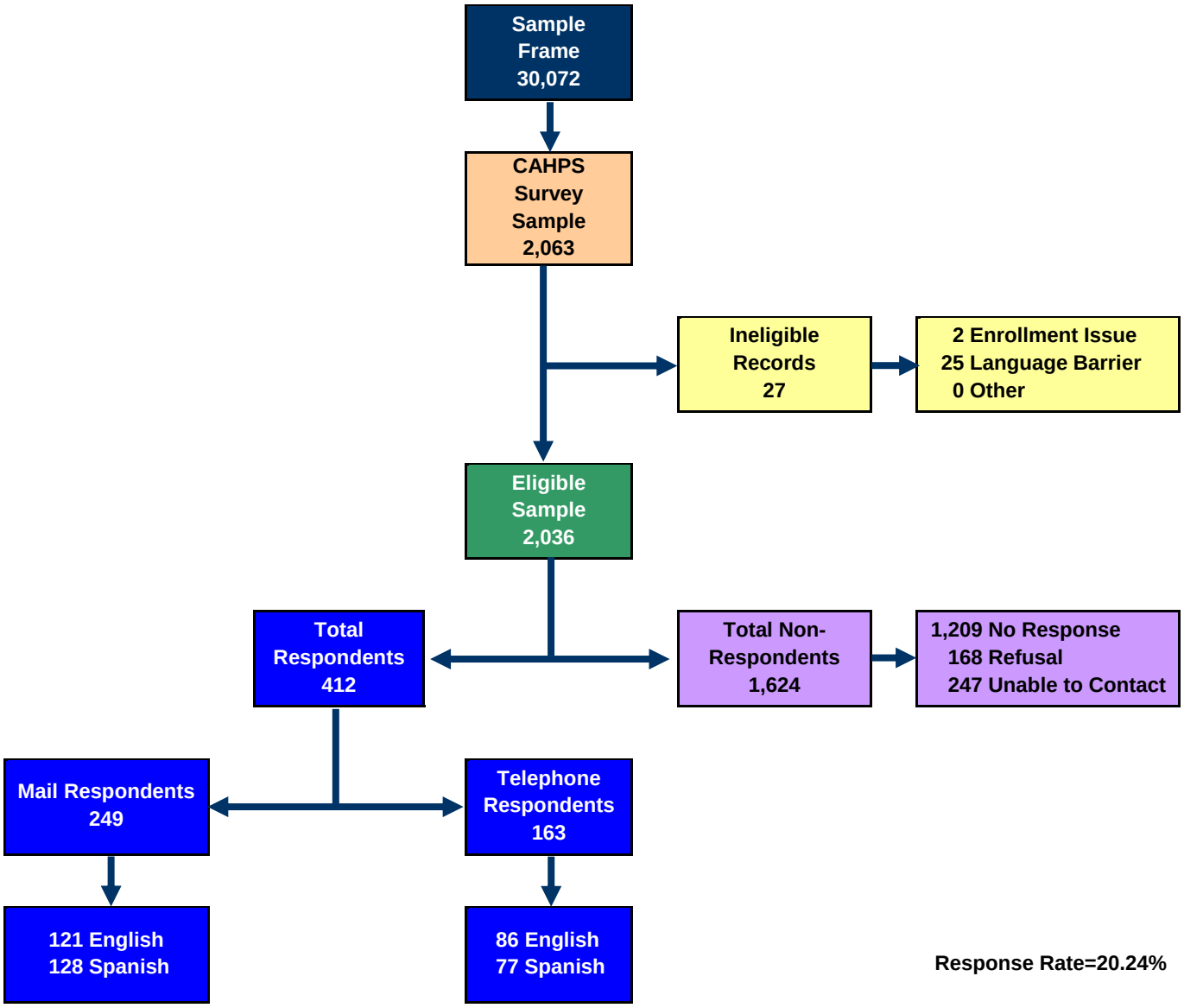


Figure 3-3—Distribution of Surveys for RMHP

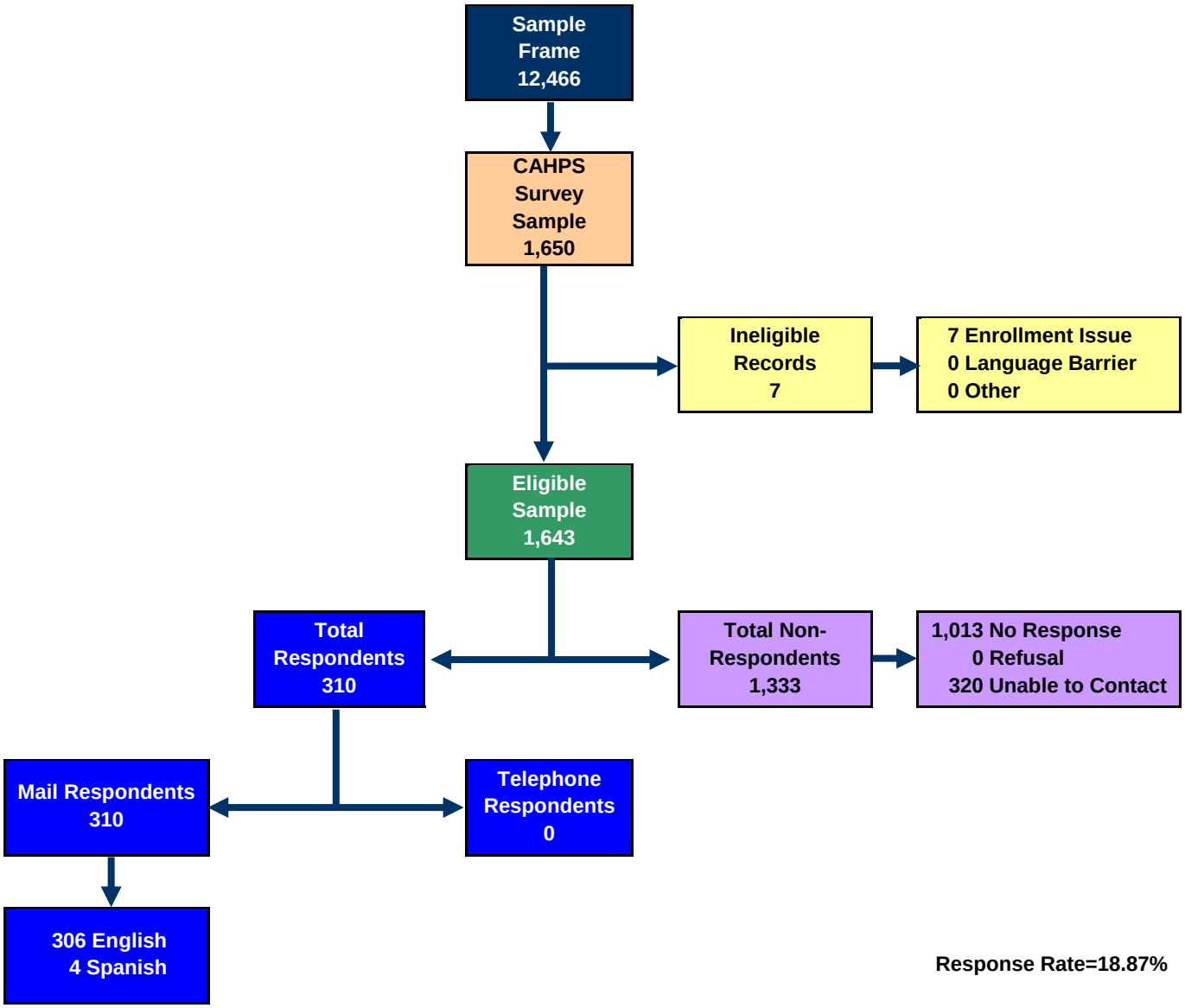


Table 3-1 depicts the sample distribution and response rates for DHMC, RMHP, and the Colorado Medicaid aggregate (i.e., DHMC and RMHP combined).

Table 3-1
Colorado Medicaid Aggregate
Sample Distribution and Response Rate

Plan Name	Total Sample	Ineligible Records	Eligible Sample	Total Respondents	Response Rate
Colorado Medicaid Aggregate	**3,713**	**34**	**3,679**	**722**	**19.62%**
DHMC	2,063	27	2,036	412	20.24%
RMHP	1,650	7	1,643	310	18.87%

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.[3-4]

Table 3-2 shows the demographic characteristics of children for whom a parent/caretaker completed a CAHPS 5.0 Child Medicaid Health Plan Survey for age, gender, race/ethnicity, and general health status.

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

	Colorado Medicaid Aggregate	DHMC	RMHP
Age			
Less than 1	**1.4%**	1.5%	1.3%
1 to 3	**17.3%**	16.7%	18.2%
4 to 7	**26.7%**	24.6%	29.5%
8 to 12	**27.4%**	31.1%	22.5%
13 to 18	**27.1%**	26.1%	28.5%
Gender			
Male	**52.2%**	53.8%	50.2%
Female	**47.8%**	46.2%	49.8%
Race/Ethnicity			
Multi-Racial	**6.8%**	7.7%	5.7%
White	**53.8%**	36.3%	74.7%
Black	**5.7%**	10.1%	0.4%
Asian	**2.9%**	5.1%	0.4%
Other	**30.8%**	40.8%	18.9%
General Health Status			
Excellent	**41.1%**	41.8%	40.3%
Very Good	**34.1%**	29.7%	39.9%
Good	**20.3%**	23.1%	16.5%
Fair	**3.8%**	4.9%	2.3%
Poor	**0.7%**	0.5%	1.0%

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, 2013. Some children eligible for the CAHPS Survey turned age 18 between January 1, 2014 and the time of survey administration.

[3-4] 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 3-3 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.

Table 3-3
Respondent Demographics
Age, Education, and Relationship to Child

	Colorado Medicaid Aggregate	DHMC	RMHP
Respondent Age			
Under 18	**8.4%**	6.9%	10.6%
18 to 24	**6.2%**	7.1%	5.0%
25 to 34	**30.9%**	29.4%	33.0%
35 to 44	**33.5%**	36.5%	29.4%
45 to 54	**13.6%**	14.2%	12.9%
55 or Older	**7.3%**	5.9%	9.2%
Respondent Education			
8th Grade or Less	**17.2%**	22.7%	9.7%
Some High School	**18.4%**	24.2%	10.7%
High School Graduate	**30.8%**	33.1%	27.7%
Some College	**23.4%**	13.8%	36.3%
College Graduate	**10.2%**	6.2%	15.7%
Relationship to Child			
Mother or Father	**92.0%**	92.6%	91.3%
Grandparent	**5.7%**	5.0%	6.7%
Legal Guardian	**1.3%**	1.5%	1.0%
Other	**1.0%**	1.0%	1.0%

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

NCQA Comparisons

In order to assess the overall performance of the Colorado Medicaid plans, the four CAHPS global ratings and four CAHPS composite measures were scored on a three-point scale using the scoring methodology detailed in NCQA's HEDIS Specifications for Survey Measures.[3-5] The resulting three-point mean scores were compared to NCQA's HEDIS Benchmarks and Thresholds for Accreditation.[3-6] 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

[3-5] National Committee for Quality Assurance. *HEDIS® 2014, Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA Publication, 2013.

[3-6] National Committee for Quality Assurance. *HEDIS Benchmarks and Thresholds for Accreditation 2014.* Washington, DC: NCQA, January 30, 2014.

Table 3-4 shows the plans' three-point mean scores and overall client satisfaction ratings on the four global ratings and four composite measures. NCQA does not provide benchmarks for the Shared Decision Making composite measure, and the Coordination of Care and Health Promotion and Education individual item measures; therefore, overall client satisfaction ratings could not be determined.

Table 3-4
NCQA Comparisons
Overall Client Satisfaction Ratings

	Colorado Medicaid Aggregate	DHMC	RMHP
Global Rating			
Rating of Health Plan	★★★ 2.603	★★★ 2.595	★★★ 2.613
Rating of All Health Care	★★★ 2.539	★★★ 2.557	★★ 2.517
Rating of Personal Doctor	★★★★ 2.657	★★★★ 2.673	★★★ 2.640
Rating of Specialist Seen Most Often	★★★★★ 2.664	★★★★★+ 2.689	★★★★+ 2.635
Composite Measure			
Getting Needed Care	★ 2.346	★ 2.185	★★★★ 2.544
Getting Care Quickly	★★ 2.555	★ 2.499	★★★ 2.623
How Well Doctors Communicate	★★★ 2.683	★★ 2.673	★★★ 2.694
Customer Service	★ 2.465	★ 2.482	★+ 2.431

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

Summary of NCQA Comparisons Results

The following table summarizes the NCQA comparisons results.

Table 3-5
NCQA Comparisons Results

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

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

Trend Analysis

In 2012, DHMC and RMHP had 901 and 374 completed CAHPS Child Medicaid Health Plan Surveys, respectively. In 2013, DHMC and RMHP had 1,021 and 359 completed CAHPS Child Medicaid Health Plan Surveys for the general child population, respectively. In 2014, DHMC and RMHP had 412 and 310 completed CAHPS Child Medicaid Health Plan Surveys, respectively. These completed surveys were used to calculate the 2012, 2013, and 2014 CAHPS results presented in this section for trending purposes.[3-7,3-8]

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.[3-9] 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 2014 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.[3-10] The first step compared the 2014 Colorado Medicaid program and plan-level CAHPS scores to the corresponding 2013 general child scores. If the initial 2014 and 2013 trend analysis did not yield any statistically significant differences, then an additional trend analysis was performed between 2014 and 2012 results. Figure 3-4 through Figure 2-19 show the results of this trend analysis. Statistically significant differences are noted with directional triangles. Scores that were statistically higher in 2014 than in 2013 are noted with black upward (▲) triangles. Scores that were statistically lower in 2014 than in 2013 are noted with black downward (▼) triangles. Scores that were statistically higher in 2014 than in 2012 are noted with red upward (▲) triangles. Scores that were statistically lower in 2014 than in 2012 are noted with red downward (▼) triangles. Scores in 2014 that were not statistically different from scores in 2013 or in 2013 are not noted with triangles.

CAHPS scores with fewer than 100 respondents are denoted with a cross (+). Caution should be exercised when interpreting results for those measures with fewer than 100 respondents.

3-7 The 2013 CAHPS results presented in this section for the Colorado Medicaid Program, DHMC, and RMHP are derived from DHMC's and RMHP's 2013 general child CAHPS results (i.e., 2013 CAHPS survey results for DHMC's and RMHP's child population only).

3-8 For purposes of the trend analysis, the Colorado Medicaid program's scores for 2012 and 2013 were recalculated to include only DHMC and RMHP.

3-9 National Committee for Quality Assurance. *HEDIS® 2014, Volume 3: Specifications for Survey Measures*. Washington, DC: NCQA Publication, 2013.

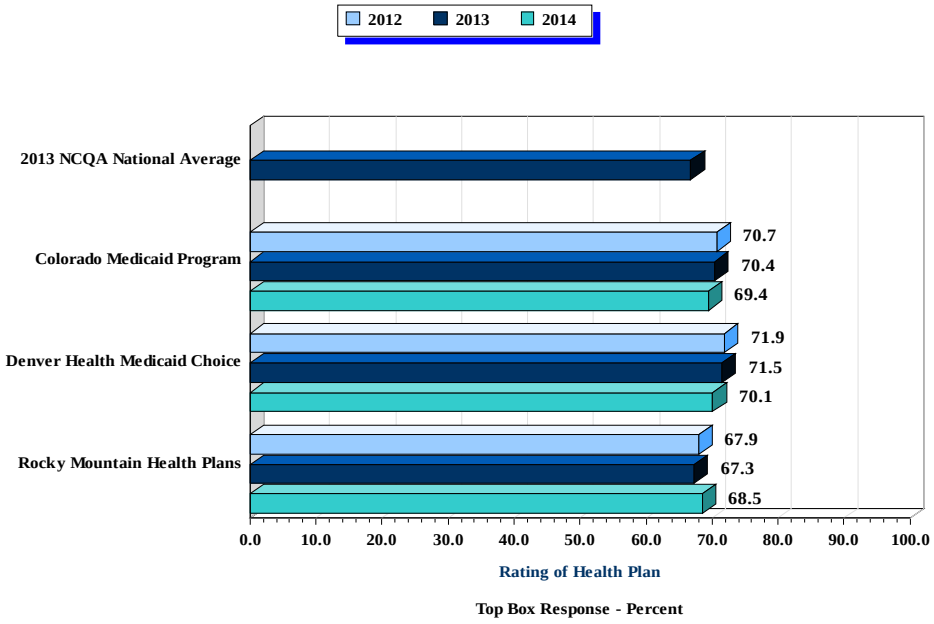
3-10 For the Shared Decision Making composite measure and Health Promotion and Education individual item measure, a trend analysis of 2014 scores to 2012 scores could not be performed given the changes to these measures with the transition from the CAHPS 4.0 to 5.0 Child Medicaid Health Plan Survey. For these CAHPS measures, the trend analysis was limited to a comparison of 2014 to 2013 CAHPS scores.

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 3-4 shows the 2013 NCQA national average, and the 2012, 2013, and 2014 Rating of Health Plan question summary rates for the Colorado Medicaid Program, DHMC, and RMHP. [3-11,3-12]

Figure 3-4—Rating of Health Plan



Statistical Significance Note:
▲ indicates the 2014 score is significantly higher than the 2013 score
▼ indicates the 2014 score is significantly lower than the 2013 score
▲ indicates the 2014 score is significantly higher than the 2012 score
▼ indicates the 2014 score is significantly lower than the 2012 score

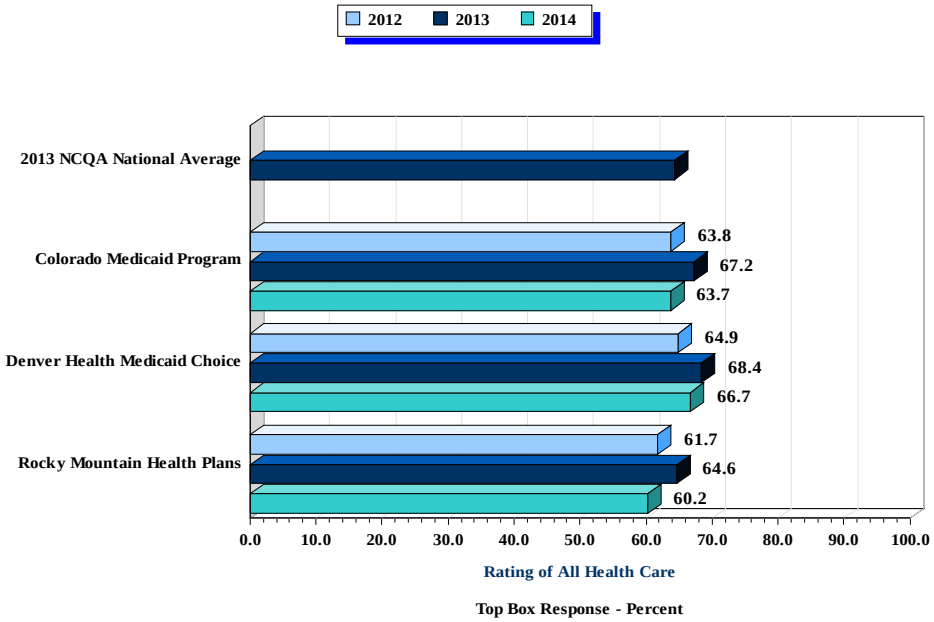
[3-11] Colorado Medicaid scores in this section are derived from the combined results of the two Colorado Medicaid plans: DHMC and RMHP.

[3-12] NCQA national averages were not available for 2014 at the time this report was prepared; therefore, 2013 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 3-5 shows the 2013 NCQA national average, and the 2012, 2013, and 2014 Rating of All Health Care question summary rates for the Colorado Medicaid Program, DHMC, and RMHP.

Figure 3-5—Rating of All Health Care



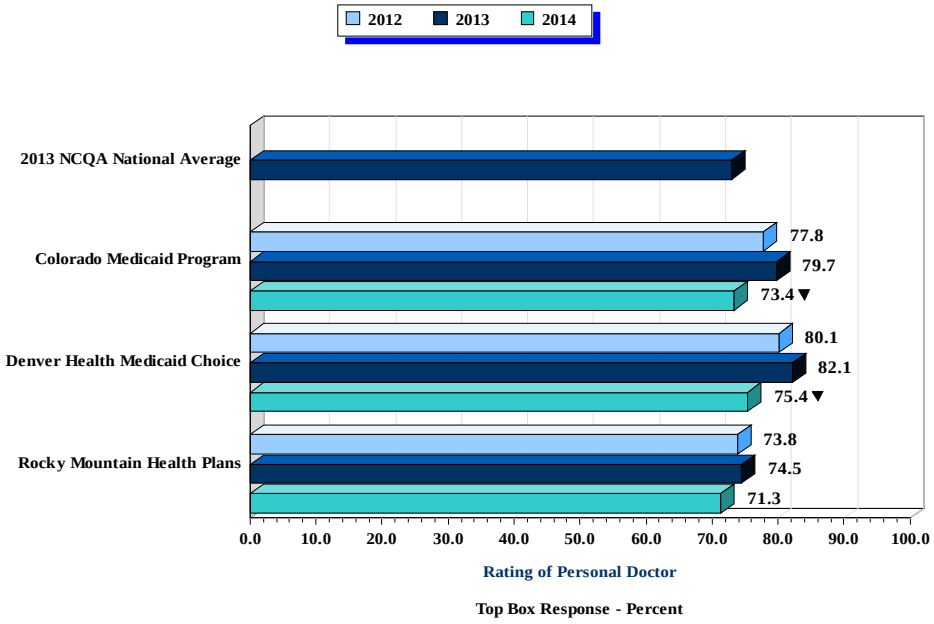
Statistical Significance Note:

▲ indicates the 2014 score is significantly higher than the 2013 score
▼ indicates the 2014 score is significantly lower than the 2013 score
▲ indicates the 2014 score is significantly higher than the 2012 score
▼ indicates the 2014 score is significantly lower than the 2012 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 3-6 shows the 2013 NCQA national average, and the 2012, 2013, and 2014 Rating of Personal Doctor question summary rates for the Colorado Medicaid Program, DHMC, and RMHP.

Figure 3-6—Rating of Personal Doctor



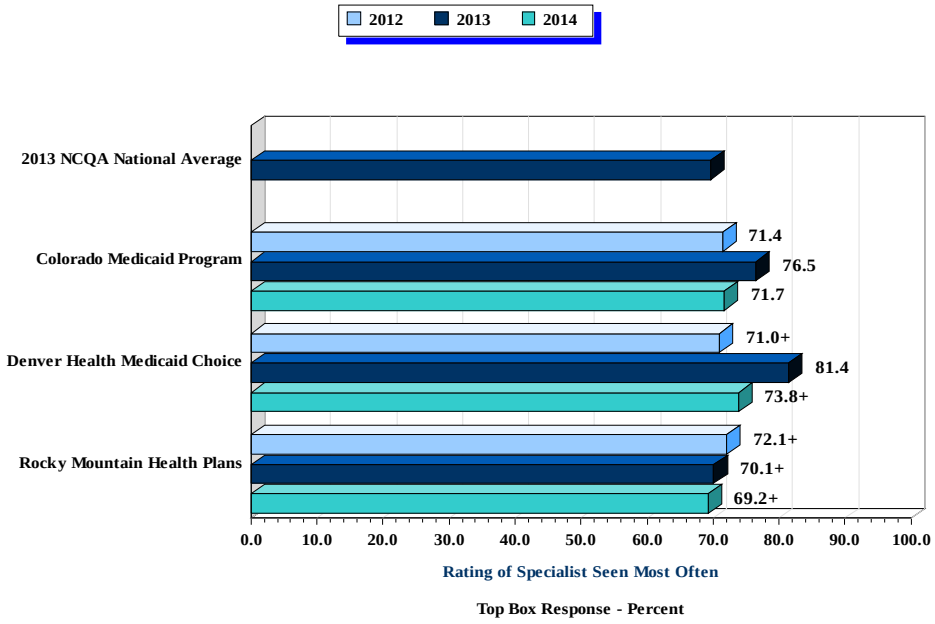
Statistical Significance Note:

▲ indicates the 2014 score is significantly higher than the 2013 score
▼ indicates the 2014 score is significantly lower than the 2013 score
▲ indicates the 2014 score is significantly higher than the 2012 score
▼ indicates the 2014 score is significantly lower than the 2012 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 3-7 shows the 2013 NCQA national average, and the 2012, 2013, and 2014 Rating of Specialist Seen Most Often question summary rates for the Colorado Medicaid Program, DHMC, and RMHP.

Figure 3-7—Rating of Specialist Seen Most Often



Statistical Significance Note:
- ▲ indicates the 2014 score is significantly higher than the 2013 score
- ▼ indicates the 2014 score is significantly lower than the 2013 score
- ▲ indicates the 2014 score is significantly higher than the 2012 score
- ▼ indicates the 2014 score is significantly lower than the 2012 score

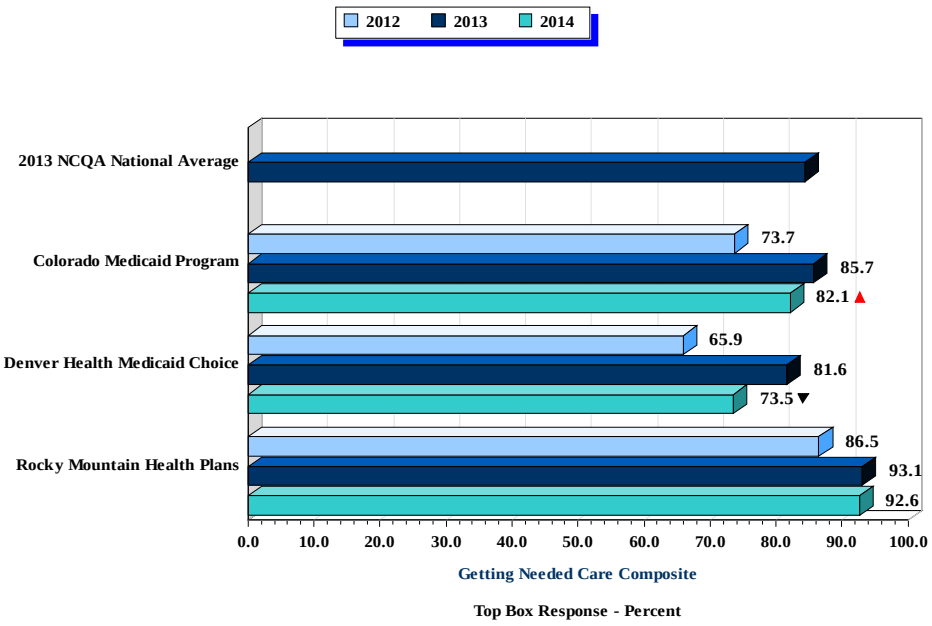
+ If the plan had fewer than 100 respondents for a measure, caution should be exercised when interpreting these results.

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 14 and 28), a top-level response was defined as a response of "Usually" or "Always." Figure 3-8 shows the 2013 NCQA national average, and the 2012, 2013, and 2014 Getting Needed Care global proportions for the Colorado Medicaid Program, DHMC, and RMHP.

Figure 3-8—Getting Needed Care

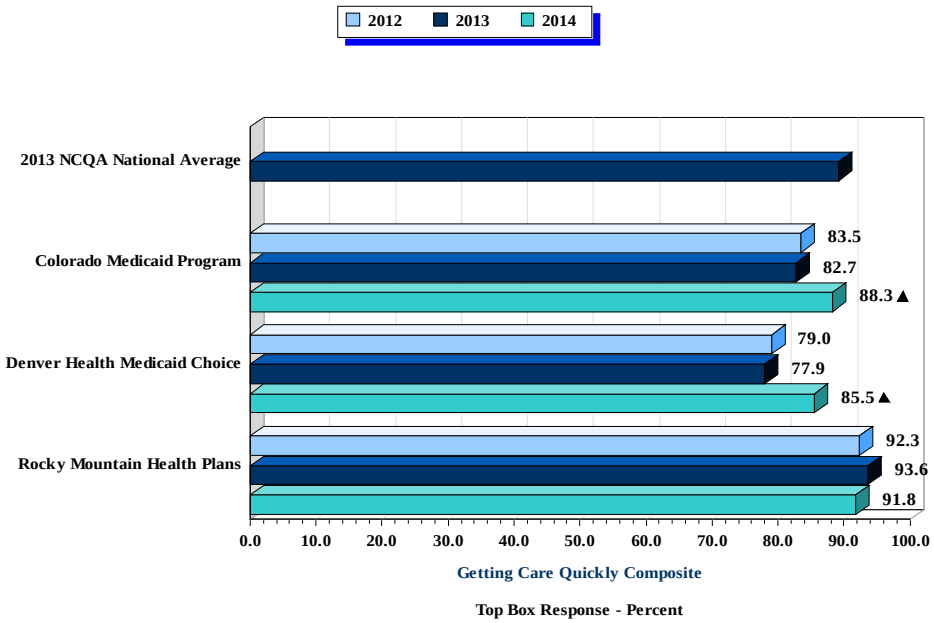


Statistical Significance Note:
▲ indicates the 2014 score is significantly higher than the 2013 score
▼ indicates the 2014 score is significantly lower than the 2013 score
▲ indicates the 2014 score is significantly higher than the 2012 score
▼ indicates the 2014 score is significantly lower than the 2012 score

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 3-9 shows the 2013 NCQA national average, and the 2012, 2013, and 2014 Getting Care Quickly global proportions for the Colorado Medicaid Program, DHMC, and RMHP.

Figure 3-9—Getting Care Quickly



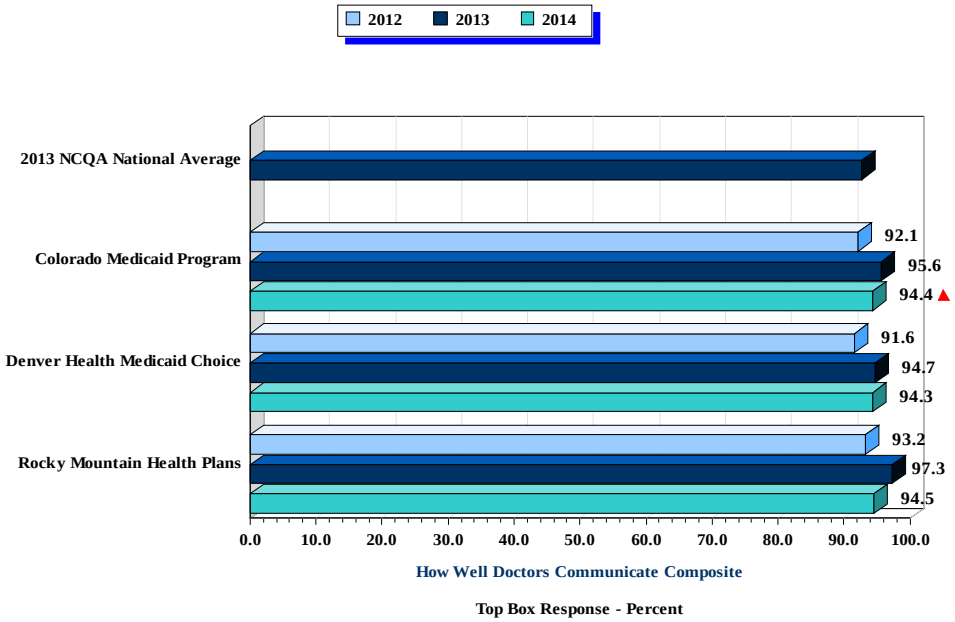
Statistical Significance Note:

▲ indicates the 2014 score is significantly higher than the 2013 score
▼ indicates the 2014 score is significantly lower than the 2013 score
▲ indicates the 2014 score is significantly higher than the 2012 score
▼ indicates the 2014 score is significantly lower than the 2012 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 17, 18, 19, and 22), a top-level response was defined as a response of "Usually" or "Always." Figure 3-10 shows the 2013 NCQA national average, and the 2012, 2013, and 2014 How Well Doctors Communicate global proportions for the Colorado Medicaid Program, DHMC, and RMHP.

Figure 3-10—How Well Doctors Communicate

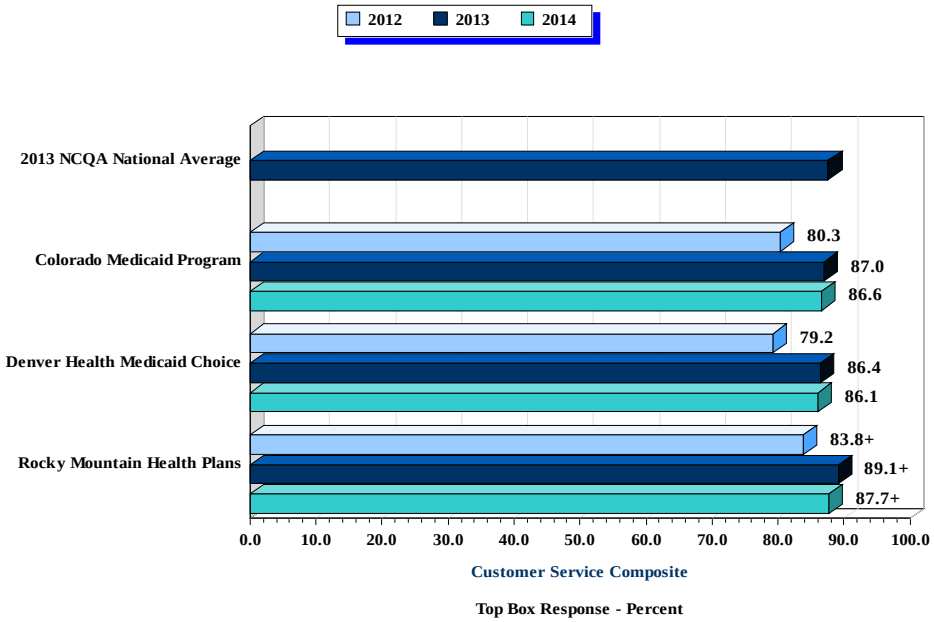


Statistical Significance Note:
▲ indicates the 2014 score is significantly higher than the 2013 score
▼ indicates the 2014 score is significantly lower than the 2013 score
▲ indicates the 2014 score is significantly higher than the 2012 score
▼ indicates the 2014 score is significantly lower than the 2012 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 32 and 33), a top-level response was defined as a response of "Usually" or "Always." Figure 3-11 shows the 2013 NCQA national average, and the 2012, 2013, and 2014 Customer Service global proportions for the Colorado Medicaid Program, DHMC, and RMHP.

Figure 3-11—Customer Service



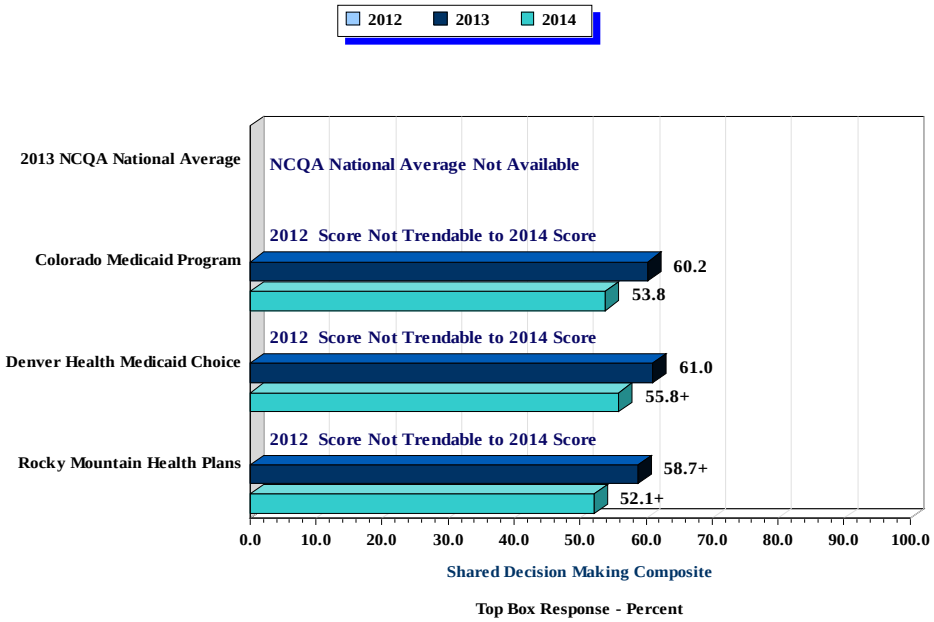
Statistical Significance Note:
▲ indicates the 2014 score is significantly higher than the 2013 score
▼ indicates the 2014 score is significantly lower than the 2013 score
▲ indicates the 2014 score is significantly higher than the 2012 score
▼ indicates the 2014 score is significantly lower than the 2012 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 prescription medication with them. For each of these questions (Questions 10, 11, and 12), a top-level response was defined as a response of "A lot" or "Yes." Figure 3-12 shows the 2013 and 2014 Shared Decision Making global proportions for the Colorado Medicaid Program, DHMC, and RMHP.[3-13]

Figure 3-12—Shared Decision Making



Statistical Significance Note: ▲ indicates the 2014 score is significantly higher than the 2013 score
▼ indicates the 2014 score is significantly lower than the 2013 score

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

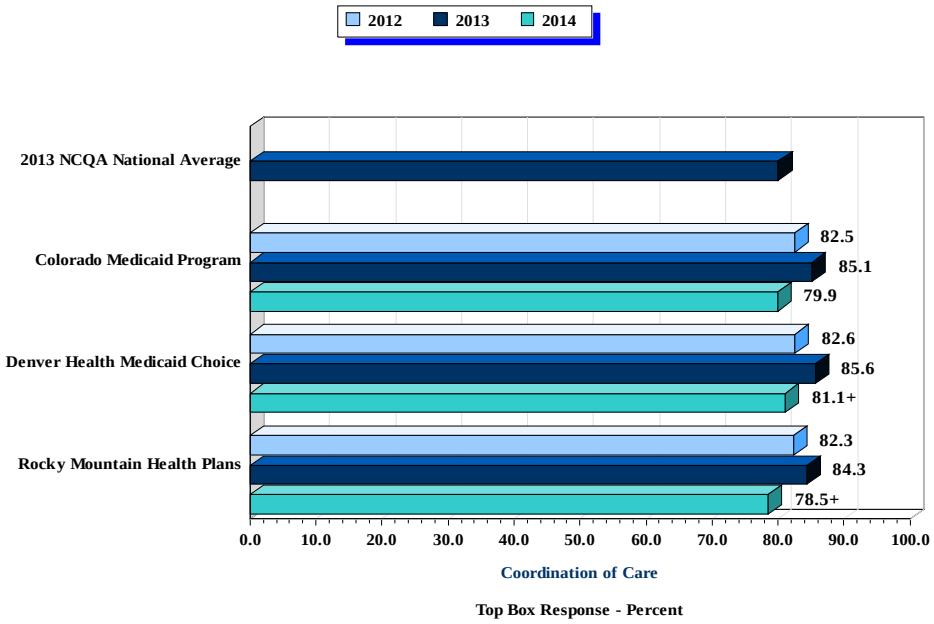
[3-13] With the transition to the CAHPS 5.0 Child Medicaid Health Plan Survey and changes to the Shared Decision Making composite measure, 2013 NCQA national averages are not available for this CAHPS measure and trending of 2014 scores to 2012 scores could not be performed.

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 25), a top-level response was defined as a response of "Usually" or "Always." Figure 3-14 shows the 2013 NCQA national average, and the 2012, 2013, and 2014 Coordination of Care question summary rates for the Colorado Medicaid Program, DHMC, and RMHP.

Figure 3-13—Coordination of Care



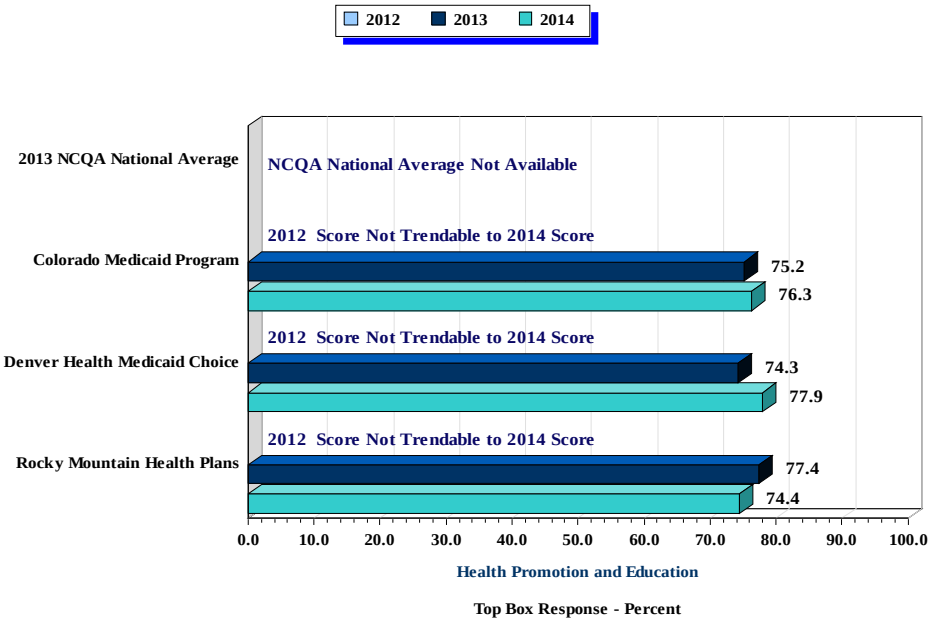
Statistical Significance Note:
- ▲ indicates the 2014 score is significantly higher than the 2013 score
- ▼ indicates the 2014 score is significantly lower than the 2013 score
- ▲ indicates the 2014 score is significantly higher than the 2012 score
- ▼ indicates the 2014 score is significantly lower than the 2012 score

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

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 3-14 shows the 2013 and 2014 Health Promotion and Education question summary rates for the Colorado Medicaid Program, DHMC, and RMHP.[3-14]

Figure 3-14—Health Promotion and Education



Statistical Significance Note: ▲ indicates the 2014 score is significantly higher than the 2013 score
▼ indicates the 2014 score is significantly lower than the 2013 score

[3-14] With the transition to the CAHPS 5.0 Child Medicaid Health Plan Survey and changes to the Health Promotion and Education individual item measure, 2013 NCQA national averages are not available for this CAHPS measure and trending of 2014 scores to 2012 scores could not be performed.

Plan Comparisons

In order to identify performance differences in client satisfaction between the Colorado Medicaid plans', the results for DHMC and RMHP were compared to one another 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. Results for DHMC and RMHP were case-mix adjusted for client general health status, respondent educational level, and age of the respondent.[3-15] 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 2014 Specifications for Survey Measures, Volume 3*.

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

Table 3-6, on the following page, shows the results of the plan comparisons analysis. **NOTE: These results may differ from those presented in the trend analysis figures because they have been adjusted for differences in case mix (i.e., the percentages presented have been case-mix adjusted).**

[3-15] 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 3-6 Plan Comparisons Results		
	DHMC	**RMHP**
Global Rating		
Rating of Health Plan	67.5% ⇔	71.1% ⇔
Rating of All Health Care	65.3% ⇔	61.6% ⇔
Rating of Personal Doctor	73.2% ⇔	73.5% ⇔
Rating of Specialist Seen Most Often	72.2%+ ⇔	70.8%+ ⇔
Composite Measure		
Getting Needed Care	73.8% ↓	92.3% ↑
Getting Care Quickly	85.5% ↓	91.8% ↑
How Well Doctors Communicate	94.8% ⇔	94.1% ⇔
Customer Service	85.4% ⇔	88.5%+ ⇔
Shared Decision Making	57.5%+ ⇔	50.4%+ ⇔
Individual Item Measure		
Coordination of Care	82.9%+ ⇔	76.7%+ ⇔
Health Promotion and Education	79.6% ⇔	72.7% ⇔
Please note: CAHPS scores with fewer than 100 respondents are denoted with a cross (+). 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.

- DHMC scored significantly lower than RMHP on two CAHPS measures: Getting Needed Care and Getting Care Quickly.
- RMHP scored significantly higher than DHMC on two CAHPS measures: Getting Needed Care and Getting Care Quickly.

4. Recommendations

General Recommendations

HSAG recommends the continued administration of the CAHPS 5.0 Child Medicaid Health Plan Survey with the HEDIS supplemental item set in fiscal year (FY) 2014-2015. HSAG will continue performing complete benchmarking and trend evaluation on the child data, where applicable. 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 2012-2013 survey administration is comparable to the completed surveys in Spanish for the FY 2013-2014 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.[4-1,4-2]

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 5-12.

[4-1] 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.

[4-2] NCQA does not provide benchmarks for the Coordination of Care individual item measure; therefore, priority assignments cannot be derived for this measure.

Priority Assignments

The priority assignments for Colorado Medicaid FFS, the seven participating RCCOs, and PCPP are based on the results of the NCQA comparisons.[4-3] Table 4-1 shows how the priority assignments are determined for FFS, RCCOs, and PCPP on each CAHPS measure.

Table 4-1— FFS and PCPP Derivation of Priority Assignments on each CAHPS Measure

NCQA Comparisons (Star Ratings)	Priority Assignment
★	Top
★★	High
★★★	Moderate
★★★★	Low
★★★★★	Low

The priority assignments for DHMC and RMHP are based on the results of the NCQA comparisons and the trend analysis. Table 4-2 shows how the priority assignments are determined for DHMC and RMHP on each CAHPS measure.

Table 4-2—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[4-4]
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.

[4-3] For Colorado Medicaid FFS, the seven participating RCCOs, and PCPP, priority assignments were based on the results of the NCQA comparisons since trending results were not available.
[4-4] For more detailed information on the trend analysis results, please see Results Section of this report.

Global Ratings

Rating of Health Plan

Table 4-3 shows the priority assignments for the overall Rating of Health Plan measure for DHMC and RMHP.[4-5]

Table 4-3
Priority Assignments
Rating of Health Plan

Plan	NCQA Comparisons (Star Ratings)	Trend Analysis	Priority Assignment
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

[4-5] Priority assignments for the overall Rating of Health Plan measure could not be derived for Colorado Medicaid FFS, the seven participating RCCOs, and PCPP, given that the CAHPS measure was not included in the modified CAHPS Child Medicaid Health Plan Survey administered to these populations; thus, results for this CAHPS measure are not available.

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 4-4 shows the priority assignments for the Rating of All Health Care measure for Colorado Medicaid FFS, the seven participating RCCOs, and PCPP.

Table 4-4
Priority Assignments
Rating of All Health Care

Plan	NCQA Comparisons (Star Ratings)	Priority Assignment
Colorado Medicaid FFS	★★	High
Region 1: Rocky Mountain Health Plans	★★	High
Region 2: Colorado Access	★★★★	Low
Region 3: Colorado Access	★	Top
Region 4: Integrated Community Health Partners	★	Top
Region 5: Colorado Access	★★	High
Region 6: Colorado Community Health Alliance	★★★	Moderate
Region 7: Community Care of Central Colorado	★	Top
Colorado Medicaid PCPP	★★★★	Low

Table 4-5 shows the priority assignments for the Rating of All Health Care measure for DHMC and RMHP.

Table 4-5
Priority Assignments
Rating of All Health Care

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

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

Access to Care

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

Patient and Family Engagement Advisory Councils

Since both patients and families have the direct experience of an illness or health care system, their perspectives can provide significant insight when performing an evaluation of health care processes. Therefore, health plans should consider creating opportunities and functional roles that include the patients and families who represent the populations they serve. Patient and family members could serve as advisory council members providing new perspectives and serving as a resource to health care processes. Patient interviews on services received and family inclusion in care planning can be an effective strategy for involving members in the design of care and obtaining their input and feedback on how to improve the delivery of care. Further, involvement in advisory councils can provide a structure and process for ongoing dialogue and creative problem-solving between the health plan and its members. The councils' roles within a health plan organization can vary and responsibilities may include input into or involvement in: program development, implementation, and evaluation; marketing of health care services; and design of new materials or tools that support the provider-patient relationship.

Rating of Personal Doctor

Table 4-6 shows the priority assignments for the Rating of Personal Doctor measure for Colorado Medicaid FFS, the seven participating RCCOs, and PCPP.

Table 4-6
Priority Assignments
Rating of Personal Doctor

Plan	NCQA Comparisons (Star Ratings)	Priority Assignment
Colorado Medicaid FFS	★★	High
Region 1: Rocky Mountain Health Plans	★	Top
Region 2: Colorado Access	★★★★	Low
Region 3: Colorado Access	★	Top
Region 4: Integrated Community Health Partners	★	Top
Region 5: Colorado Access	★★★	Moderate
Region 6: Colorado Community Health Alliance	★★	High
Region 7: Community Care of Central Colorado	★	Top
Colorado Medicaid PCPP	★★★★	Low

Table 4-7 shows the priority assignments for the Rating of Personal Doctor measure for DHMC and RMHP.

Table 4-7
Priority Assignments
Rating of Personal Doctor

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

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 4-8 shows the priority assignments for the Rating of Specialist Seen Most Often measure for Colorado Medicaid FFS, the seven participating RCCOs, and PCPP.

Table 4-8
Priority Assignments
Rating of Specialist Seen Most Often

Plan	NCQA Comparisons (Star Ratings)	Priority Assignment
Colorado Medicaid FFS	★★+	**High+**
Region 1: Rocky Mountain Health Plans	★★+	**High+**
Region 2: Colorado Access	★★★★★+	**Low+**
Region 3: Colorado Access	★★+	**High+**
Region 4: Integrated Community Health Partners	★+	**Top+**
Region 5: Colorado Access	★★★★+	**Low+**
Region 6: Colorado Community Health Alliance	★★★+	**Moderate+**
Region 7: Community Care of Central Colorado	★+	**Top+**
Colorado Medicaid PCPP	★★+	**High+**

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

Table 4-9 shows the priority assignments for the Rating of Specialist Seen Most Often measure for DHMC and RMHP.

Table 4-9
Priority Assignments
Rating of Specialist Seen Most Often

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

*Please note: CAHPS scores with fewer than 100 respondents are denoted with a cross (+). 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 4-10 shows the priority assignments for the Getting Needed Care measure for Colorado Medicaid FFS, the seven participating RCCOs, and PCPP.

Table 4-10
Priority Assignments
Getting Needed Care

Plan	NCQA Comparisons (Star Ratings)	Priority Assignment
Colorado Medicaid FFS	★	Top
Region 1: Rocky Mountain Health Plans	★	Top
Region 2: Colorado Access	★★+	High+
Region 3: Colorado Access	★★	High
Region 4: Integrated Community Health Partners	★★★+	Moderate+
Region 5: Colorado Access	★	Top
Region 6: Colorado Community Health Alliance	★+	Top+
Region 7: Community Care of Central Colorado	★	Top
Colorado Medicaid PCPP	★★★★	Low

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

Table 4-11 shows the priority assignments for the Getting Needed Care measure for DHMC and RMHP.

Table 4-11
Priority Assignments
Getting Needed Care

Plan	NCQA Comparisons (Star Ratings)	Trend Analysis	Priority Assignment
DHMC	★	▼	Top
RMHP	★★★★	—	Moderate

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

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.

Getting Care Quickly

Table 4-12 shows the priority assignments for the Getting Care Quickly measure for Colorado Medicaid FFS, the seven participating RCCOs, and PCPP.

Table 4-12 Priority Assignments Getting Care Quickly		
Plan	NCQA Comparisons (Star Ratings)	Priority Assignment
Colorado Medicaid FFS	★★	High
Region 1: Rocky Mountain Health Plans	★★	High
Region 2: Colorado Access	★★	High
Region 3: Colorado Access	★	Top
Region 4: Integrated Community Health Partners	★	Top
Region 5: Colorado Access	★	Top
Region 6: Colorado Community Health Alliance	★★	High
Region 7: Community Care of Central Colorado	★★	High
Colorado Medicaid PCPP	★★★★★	Low

Table 4-13 shows the priority assignments for the Getting Care Quickly measure for DHMC and RMHP.

Table 5-12 Priority Assignments Getting Care Quickly			
Plan	NCQA Comparisons (Star Ratings)	Trend Analysis	Priority Assignment
DHMC	★	▲	Top
RMHP	★★★	—	Moderate

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

Decrease No-Show Appointments

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

Electronic Communication

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

Nurse Advice Help Line

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

Open Access Scheduling

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

Patient Flow Analysis

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

How Well Doctors Communicate

Table 4-14 shows the priority assignments for the How Well Doctors Communicate measure.

Table 4-14 Priority Assignments How Well Doctors Communicate		
Plan	**NCQA Comparisons (Star Ratings)**	**Priority Assignment**
Colorado Medicaid FFS	★★★	**Moderate**
Region 1: Rocky Mountain Health Plans	★	**Top**
Region 2: Colorado Access	★★	**High**
Region 3: Colorado Access	★★★	**Moderate**
Region 4: Integrated Community Health Partners	★★	**High**
Region 5: Colorado Access	★	**Top**
Region 6: Colorado Community Health Alliance	★★	**High**
Region 7: Community Care of Central Colorado	★	**Top**
Colorado Medicaid PCPP	★★★	**Moderate**

Table 4-15 shows the priority assignments for the How Well Doctors Communicate measure for DHMC and RMHP.

Table 4-15 Priority Assignments How Well Doctors Communicate			
Plan	**NCQA Comparisons (Star Ratings)**	**Trend Analysis**	**Priority Assignment**
DHMC	★★	—	**High**
RMHP	★★★	—	**Moderate**

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

Communication Tools for Patients

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

Improve Health Literacy

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

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

Language Barriers

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

Customer Service

Table 4-16 shows the priority assignments for the Customer Service measure.

Table 4-16
Priority Assignments
Customer Service

Plan	NCQA Comparisons (Star Ratings)	Trend Analysis	Priority Assignment
DHMC	★	—	Top
RMHP	★+	—	Top+

Please note: CAHPS scores with fewer than 100 respondents are denoted with a cross (+). 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/RCCO and provider network level. Table 4-17 provides a summary of the responsible parties for various aspects of care.[4-6]

Table 4-17—Accountability for Areas of Care

Domain	Composite	Who Is Accountable?	
		Plan/RCCO	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, RCCOs, 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.

[4-6] 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.

5. Reader's Guide

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

Survey Administration

Survey Overview

For the FFS and PCPP population, the survey instrument selected was a modified version of the CAHPS 5.0 Child Medicaid Health Plan Survey with the HEDIS supplemental item set. For DHMC and RMHP, the survey instrument selected was the standard CAHPS 5.0 Child Medicaid Health Plan Survey with the HEDIS supplemental item set. The CAHPS 5.0 Health Plan Surveys are a set of standardized surveys that assess patient perspectives on care. Originally, CAHPS was a five-year collaborative project sponsored by AHRQ. The CAHPS questionnaires and consumer reports were developed under cooperative agreements among AHRQ, Harvard Medical School, RAND, and the Research Triangle Institute (RTI). In 1997, NCQA, in conjunction with AHRQ, created the CAHPS 2.0H Survey measure as part of NCQA's HEDIS.[5-1] 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.[5-2] 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.[5-3,5-4] 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.[5-5]

The sampling and data collection procedures for the CAHPS 5.0 Health Plan Survey were designed to capture accurate and complete information about consumer-reported experiences with health

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

care. The sampling and data collection procedures promote both the standardized administration of survey instruments and the comparability of the resulting health plan data.

The CAHPS 5.0 Child Medicaid Health Plan Survey with the HEDIS supplemental item set includes 48 core questions that yield 11 measures of satisfaction. These measures include four global rating questions, five composite measures, and two individual item measures. The global measures (also referred to as global ratings) reflect overall satisfaction with the health plan, health care, personal doctors, and specialists. The composite measures are sets of questions grouped together to address different aspects of care (e.g., "Getting Needed Care" or "Getting Care Quickly"). The individual item measures are individual questions that look at a specific area of care (i.e., "Health Promotion and Education" and "Coordination of Care").

As previously noted, for Colorado Medicaid FFS and PCPP, the Department elected to modify the CAHPS 5.0 Child Medicaid Health Survey and removed the Rating of Health Plan global rating question and Customer Service composite measure set of questions. However, the survey instrument selected for DHMC and RMHP was the standard CAHPS 5.0 Child Medicaid Health Plan Survey. Table 5-1 lists the global ratings, composite measures, and individual item measures included in the CAHPS 5.0 Child Medicaid Health Plan Survey with the HEDIS supplemental item set.

Table 5-1—CAHPS Measures

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

Sampling Procedures

The clients eligible for sampling included those who were FFS, PCPP, DHMC, or RMHP clients at the time the sample was drawn and who were continuously enrolled for at least five of the last six months (July through December) of 2013. The clients eligible for sampling included those who were age 17 or younger (as of December 31, 2013).

The standard NCQA HEDIS Specifications for Survey Measures require a sample size of 1,650 clients for the CAHPS 5.0 Child Medicaid Health Plan Survey.[2-6] For Colorado Medicaid FFS and PCPP, a random sample of 1,650 child clients was selected from each plan. Additionally, for Colorado Medicaid FFS, a targeted RCCO-level oversample was conducted, such that a sample of 800 child clients was selected from each of the seven participating RCCOs. Following final sample

[2-6] National Committee for Quality Assurance. *HEDIS® 2014, Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA Publication, 2013.

selection, the total sample sizes for Colorado Medicaid FFS and PCPP were 7,250 and 1,650 child clients, respectively. RMHP elected not to perform an oversample of its child population; therefore, a total sample size of 1,650 child clients was selected from this plan. DHMC performed a 25 percent oversample on the child population. Based on this rate, a total sample of 2,063 child clients was selected from DHMC.[5-7]

Survey Protocol

Table 5-2 shows the standard mixed mode (i.e., mail followed by telephone follow-up) CAHPS timeline used in the administration of the Colorado CAHPS 5.0 Child Medicaid Health Plan Surveys. The timeline is based on NCQA HEDIS Specifications for Survey Measures.[5-8]

Table 5-2—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

The survey administration for DHMC and RMHP was performed by Morpace and CSS, respectively. The survey process employed by RMHP was a mail-only methodology, which consisted of a survey only being mailed to sampled clients. RMHP provided English and Spanish versions of the mail survey. The survey process employed by FFS, PCPP, and DHMC allowed clients two methods by which they could complete a survey. The first phase, or mail phase, consisted of a survey being mailed to all sampled clients. For FFS and PCPP, 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

[5-7] The sampling for DHMC and RMHP was performed by Morpace and CSS, respectively.
[5-8] National Committee for Quality Assurance. *HEDIS® 2014, Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA Publication, 2013.

completed survey. FFS, PCPP, and DHMC all 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.[5-9] 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.[5-10]

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

- Were age 17 or younger as of December 31, 2013.
- Were currently enrolled in FFS, PCPP, DHMC, or RMHP.
- Had been continuously enrolled for at least five of the last six months of 2013.
- 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. The survey samples were 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; the letters bear the signature of a high-ranking plan or state official; and the questionnaire packages include a postage-paid reply envelope addressed to the organization conducting the surveys. HSAG followed these specifications.[5-11]

[5-9] National Committee for Quality Assurance. *Quality Assurance Plan for HEDIS 2014 Survey Measures.* Washington, DC: NCQA Publication, 2013.

[5-10] 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.

[5-11] Please note, HSAG performed the CAHPS survey administration for Colorado Medicaid FFS, the seven participating RCCOs, 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. 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.[5-12] 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 5-4), 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 or RCCO, then caution must be exercised when extrapolating the CAHPS results to the entire population.

[5-12] National Committee for Quality Assurance. *HEDIS® 2014, Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA Publication, 2013.

NCQA Comparisons

An analysis of the CAHPS Survey results was conducted using NCQA HEDIS Specifications for Survey Measures.[5-13] 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, 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 each CAHPS measure. The resulting three-point mean scores were compared to published NCQA Benchmarks and Thresholds for Accreditation to derive the overall client satisfaction ratings (i.e., star ratings). 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 2014 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

[5-13] National Committee for Quality Assurance. *HEDIS® 2014, Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA Publication, 2013.

Table 5-3 shows the benchmarks and thresholds used to derive the overall client satisfaction ratings on each CAHPS measure.[5-14]

Table 5-3—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 client satisfaction, HSAG performed a stepwise three-year trend analysis for DHMC and RMHP, where applicable.[5-15] The first step compared the 2014 CAHPS results to the 2013 CAHPS results. If the initial 2014 and 2013 trend analysis did not yield any significant differences, then an additional trend analysis was performed between 2014 and 2012 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.[6-16] 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 2014 Specifications for Survey Measures, Volume 3*.

[5-14] National Committee for Quality Assurance. *HEDIS Benchmarks and Thresholds for Accreditation 2014*. Washington, DC: NCQA, January 30, 2014.

[6-15] 2014 represented the first year a modified version of the CAHPS 5.0 Child Medicaid Health Plan Survey was administered to child clients enrolled in FFS, participating RCCOs, and PCPP as part of the annual CAHPS survey administration; therefore, trending could not be performed for these populations.

[6-16] National Committee for Quality Assurance. *HEDIS® 2014, Volume 3: Specifications for Survey Measures*. Washington, DC: NCQA Publication, 2013.

The 2014 Colorado Medicaid program and plan-level CAHPS scores were compared to the corresponding 2013 scores to determine whether there were statistically significant differences. If there were no statistically significant differences from 2014 to 2013, then 2014 scores were compared to 2012 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 2014 than in 2013 are noted with black upward (▲) triangles. Scores that were statistically lower in 2014 than in 2013 are noted with black downward (▼) triangles. Scores that were statistically higher in 2014 than in 2012 are noted with red upward (▲) triangles. Scores that were statistically lower in 2014 than in 2012 are noted with red downward (▼) triangles. Scores in 2014 that were not statistically different from scores in 2013 or in 2012 are not noted with triangles.

RCCO Comparisons

RCCO comparisons were performed to identify client satisfaction differences that were statistically different between the seven RCCOs. Given that differences in case-mix can result in differences in ratings between RCCOs 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 RCCOs. Results for the Colorado Medicaid RCCOs were case-mix adjusted for client general health status, respondent education level, and respondent age.

Two types of hypothesis tests were applied to the RCCO comparative results. First, a global *F* test was calculated, which determined whether the difference between the RCCOs' 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 RCCO). Due to these qualities, this *F* test produced *p*-values that were slightly larger than they should have been; therefore, finding significant differences between RCCOs was less likely. An alpha-level of 0.05 was used. If the *F* test demonstrated RCCO-level differences (i.e., $p < 0.05$), then a *t*-test was performed for each RCCO.

The *t*-test determined whether each RCCO's score was significantly different from the overall results of the other RCCOs. The equation for the differences was as follows:

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

In this equation, Σ^{*} was the sum of all RCCOs except RCCO *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 RCCO *p* and the results of all other Colorado RCCOs was less likely.

Plan Comparisons

Plan comparisons were performed to identify client satisfaction differences that were statistically different between the DHMC and RMHP. 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.

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

Limitations and Cautions

The findings presented in the 2014 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 RCCO 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 RCCOs' or 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 RCCO/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 RCCOs or plans report differences in satisfaction with various aspects of their child's health care experiences, these differences may not be completely attributable to the RCCO/Medicaid plan. These analyses identify whether parents or caretakers of clients in various types of RCCOs/plans give different ratings of satisfaction with their child's RCCO/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.

Sampling Effects

The sampling approach employed for Colorado Medicaid FFS, participating RCCOs, and PCPP populations differed. Due to these differences, there is still the small potential for sampling effects. Therefore, sampling effects should be considered and caution should be exercised when interpreting the CAHPS results.

Baseline FFS, RCCO, and PCPP Results

It is important to note that in SFY 2013-2014, the modified version of the CAHPS 5.0 Child Medicaid Health Plan Survey was administered to child FFS, RCCO, and PCPP clients for the first time. The 2014 CAHPS results for FFS, the seven participating RCCOs, and PCPP presented in the report represent a **baseline** assessment of parents'/caretakers' satisfaction. 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' perspectives. 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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AHRQ Health Care Innovations Exchange Web site. *Interactive Workshops Enhance Access to Health Education and Screenings, Improve Outcomes for Low-Income and Minority Women*. Available at: http://www.innovations.ahrq.gov/content.aspx?id=2605. Accessed on: July 1, 2014.

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6. Survey Instrument

The survey instruments selected for the 2014 Colorado Child Medicaid Client Satisfaction Survey administration differed between the FFS and PCPP populations and the DHMC and RMHP plans. The survey instrument selected for FFS and PCPP was a modified version of the CAHPS 5.0 Child Medicaid Health Plan Survey with the HEDIS supplemental item set. For DHMC and RMHP, the survey instrument selected was the standard CAHPS 5.0 Child Medicaid Health Plan Survey with the HEDIS supplemental item set. This section provides a copy of each 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 <u>completely</u>. Use only <u>black or blue ink</u> or <u>dark pencil</u> to complete the survey.**

Correct Mark ● **Incorrect Marks** 

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

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

START HERE

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 enrolled in [Colorado Medicaid/Medicaid's Primary Care Physician Program]. 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 22***
- ○ 1 time
- ○ 2
- ○ 3
- ○ 4
- ○ 5 to 9
- ○ 10 or more times

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, 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 13***

10. 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

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 not 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, did a doctor or other health provider ask you what you thought was best for your child?

- ○ Yes
- ○ No

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

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

14. In the last 6 months, did your child's doctor or other health provider order a blood test, x-ray, or other test for your child?

- ○ Yes
- ○ No ➔ ***Go to Question 16***

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

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

16. In the last 6 months, did your child's doctor or other health provider talk with you about specific goals for your child's health?

- ○ Yes
- ○ No

17. In the last 6 months, did your child's doctor or other health provider ask you if there are things that make it hard for you to take care of your child's health?

- ○ Yes
- ○ No

18. In the last 6 months, did you and your child's doctor or other health provider talk about your child's learning ability?

- ○ Yes
- ○ No

19. In the last 6 months, did you and your child's doctor or other health provider talk about the kinds of behaviors that are normal for your child at this age?

- ○ Yes
- ○ No

20. In the last 6 months, did you and your child's doctor or other health provider talk about your child's moods and emotions?

- ○ Yes
- ○ No

21. 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

YOUR CHILD'S PERSONAL DOCTOR

22. A personal doctor is the one your child would see if he or she needs a check-up, has a health problem, or gets sick or hurt. Does your child have a personal doctor?

- ○ Yes
- ○ No ➔ ***Go to Question 43***

23. 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

24. 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

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

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

26. 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

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

- ○ Yes
- ○ No ➔ ***Go to Question 29***

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

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

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

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

30. 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

31. Thinking about the care your child received in the last 6 months, how often do you think your child's personal doctor understood the things that really matter to you about your child's health care?

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

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

- ○ Yes
- ○ No

33. 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 35***

34. 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

35. 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

36. In the last 6 months, did your child take any prescription medicine?

- ○ Yes
- ○ No ➔ ***Go to Question 38***

37. In the last 6 months, did you and your child's personal doctor talk at each visit about all the prescription medicines your child was taking?

- ○ Yes
- ○ No

38. In the last 6 months, did your child's personal doctor's office give you information about what to do if your child needed care during evenings, weekends, or holidays?

- ○ Yes
- ○ No

39. In the last 6 months, did your child need care from his or her personal doctor during evenings, weekends, or holidays?

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

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

- ○ 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

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

- ○ Yes
- ○ No

GETTING HEALTH CARE FROM SPECIALISTS

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

43. 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 47***

44. 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

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

- ○ None ➔ ***Go to Question 47***
- ○ 1 specialist
- ○ 2
- ○ 3
- ○ 4
- ○ 5 or more specialists

46. 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

ABOUT YOU AND YOUR CHILD

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

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

48. In general, how would you rate your child's overall <u>mental or emotional</u> health?

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

49. What is <u>your child's</u> age?

- ○ Less than 1 year old

☐☐ YEARS OLD (write in)

50. Is your child male or female?

- ○ Male
- ○ Female

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

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

52. 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

53. What is <u>your</u> age?

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

54. Are you male or female?

- ○ Male
- ○ Female

55. 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

56. How are you related to the child?

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

57. Did someone help you complete this survey?

- ○ Yes ➔ ***Go to Question 58***
- ○ No ➔ ***Thank you. Please return the completed survey in the postage-paid envelope.***

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

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

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

When you are done, please use the enclosed postage-paid envelope to mail the survey to:

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

CAHPS® 5.0H Child Questionnaire (Without CCC Measure)

SURVEY INSTRUCTIONS

Note: *The questionnaire is worded for the Medicaid product line. If administering to a commercial product line, replace "6" with "12" in all references of "last 6 months."*

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

☑ Yes ➔**If Yes, Go to Question 1**

☐ No

{This box should be placed on the Cover Page}

Your privacy is protected. All information that would let someone identify you or your family will be kept private. **{SURVEY VENDOR NAME}** ***will not share your personal information with anyone without your OK.***

You may choose to answer this survey or not. If you choose not to, this will not affect the benefits you get. You may notice a number on the cover of this survey. This number is ONLY used to let us know if you returned your survey so we don't have to send you reminders.

If you want to know more about this study, please call
{SURVEY VENDOR TOLL-FREE TELEPHONE NUMBER}.

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 {INSERT HEALTH PLAN NAME}. Is that right?

[1] ☐ Yes ➔**If Yes, Go to Question 3**

[2] ☐ No

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

_____

YOUR CHILD'S HEALTH CARE IN THE LAST 6 MONTHS

These questions ask about your child's health care. Do <u>not</u> include care your child got when he or she stayed overnight in a hospital. Do <u>not</u> 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 <u>needed care right away</u> in a clinic, emergency room, or doctor's office?

[1] ☐ Yes

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

4. In the last 6 months, when your child <u>needed care right away</u>, how often did your child get care as soon as he or she needed?

[1] ☐ Never

[2] ☐ Sometimes

[3] ☐ Usually

[4] ☐ Always

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

[1] ☐ Yes

[2] ☐ No ➔**If No, Go to Question 7**

6. **In the last 6 months, when you made an appointment for a <u>check-up or routine care</u> for your child at a doctor's office or clinic, how often did you get an appointment as soon as your child needed?**
   - [1] ☐ Never
   - [2] ☐ Sometimes
   - [3] ☐ Usually
   - [4] ☐ Always

7. **In the last 6 months, <u>not</u> counting the times your child went to an emergency room, how many times did he or she go to a doctor's office or clinic to get health care?**
   - [0] ☐ None ➔**If None, Go to Question 15**
   - [1] ☐ 1 time
   - [2] ☐ 2
   - [3] ☐ 3
   - [4] ☐ 4
   - [5] ☐ 5 to 9
   - [6] ☐ 10 or more times

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?**
   - [1] ☐ Yes
   - [2] ☐ No

9. **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?**
   - [1] ☐ Yes
   - [2] ☐ No ➔**If No, Go to Question 13**

10. **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?**
    - [1] ☐ Not at all
    - [2] ☐ A little
    - [3] ☐ Some
    - [4] ☐ A lot

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 <u>not</u> want your child to take a medicine?**
    - [1] ☐ Not at all
    - [2] ☐ A little
    - [3] ☐ Some
    - [4] ☐ A lot

12. **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?**
    - [1] ☐ Yes
    - [2] ☐ No

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

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

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

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

YOUR CHILD'S PERSONAL DOCTOR

15. 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?

- 1 ☐ Yes
- 2 ☐ No ➔ **If No, Go to Question 27**

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

- 0 ☐ None ➔ **If None, Go to Question 26**
- 1 ☐ 1 time
- 2 ☐ 2
- 3 ☐ 3
- 4 ☐ 4
- 5 ☐ 5 to 9
- 6 ☐ 10 or more times

17. 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?

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

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

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

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

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

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

1☐ Yes
2☐ No ➔**If No, Go to Question 22**

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

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

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

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

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

1☐ Yes
2☐ No

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

1☐ Yes
2☐ No ➔ **If No, Go to Question 26**

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

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

26. Using any number from 0 to 10, where 0 is the worst personal doctor possible and 10 is the best personal doctor possible, what number would you use to rate your child's personal doctor?

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

GETTING HEALTH CARE FROM SPECIALISTS

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

27. 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?

1☐ Yes

2☐ No ➔**If No, Go to Question 31**

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

1☐ Never

2☐ Sometimes

3☐ Usually

4☐ Always

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

0☐ None ➔**If None, Go to Question 31**

1☐ 1 specialist

2☐ 2

3☐ 3

4☐ 4

5☐ 5 or more specialists

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

00☐ 0 Worst specialist possible

01☐ 1

02☐ 2

03☐ 3

04☐ 4

05☐ 5

06☐ 6

07☐ 7

08☐ 8

09☐ 9

10☐ 10 Best specialist possible

YOUR CHILD'S HEALTH PLAN

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

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

[1] ☐ Yes

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

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

[1] ☐ Never

[2] ☐ Sometimes

[3] ☐ Usually

[4] ☐ Always

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

[1] ☐ Never

[2] ☐ Sometimes

[3] ☐ Usually

[4] ☐ Always

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

[1] ☐ Yes

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

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

[1] ☐ Never

[2] ☐ Sometimes

[3] ☐ Usually

[4] ☐ Always

36. Using any number from 0 to 10, where 0 is the worst health plan possible and 10 is the best health plan possible, what number would you use to rate your child's health plan?

[00] ☐ 0 Worst health plan possible

[01] ☐ 1

[02] ☐ 2

[03] ☐ 3

[04] ☐ 4

[05] ☐ 5

[06] ☐ 6

[07] ☐ 7

[08] ☐ 8

[09] ☐ 9

[10] ☐ 10 Best health plan possible

ABOUT YOUR CHILD AND YOU

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

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

38. In general, how would you rate your child's overall <u>mental or emotional</u> health?

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

39. What is <u>your child's</u> age?

00 ☐ Less than 1 year old
_____ YEARS OLD *(write in)*

40. Is your child male or female?

1 ☐ Male
2 ☐ Female

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

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

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

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

43. What is <u>your</u> age?

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

44. Are you male or female?

1 ☐ Male
2 ☐ Female

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

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

46. How are you related to the child?

[1] ☐ Mother or father
[2] ☐ Grandparent
[3] ☐ Aunt or uncle
[4] ☐ Older brother or sister
[5] ☐ Other relative
[6] ☐ Legal guardian
[7] ☐ Someone else

47. Did someone help you complete this survey?

[1] ☐ Yes ➔**If Yes, Go to Question 48**
[2] ☐ No ➔**Thank you. Please return the completed survey in the postage-paid envelope.**

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

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

THANK YOU

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

7. CD

The accompanying CD includes all of the information from the Executive Summary, FFS and PCPP Results, DHMC and RMHP 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, seven participating RCCOs, RCCO program (i.e., seven participating RCCOs combined), PCPP, DHMC, RMHP, and Colorado Medicaid program (i.e., DHMC and RMHP combined).

CD Contents

- Colorado Child Medicaid CAHPS Report
- FFS Child Medicaid Cross-tabulations (Tab and Banner Book)
- Overall Colorado RCCO Child Medicaid Cross-tabulations (Tab and Banner Book)
- Region 1: Rocky Mountain Health Plans Cross-tabulations (Tab and Banner Book)
- Region 2: Colorado Access Cross-tabulations (Tab and Banner Book)
- Region 3: Colorado Access Cross-tabulations (Tab and Banner Book)
- Region 4: Integrated Community Health Partners Cross-tabulations (Tab and Banner Book)
- Region 5: Colorado Access Cross-tabulations (Tab and Banner Book)
- Region 6: Colorado Community Health Alliance Cross-tabulations (Tab and Banner Book)
- Region 7: Community Care of Central Colorado Cross-tabulations (Tab and Banner Book)
- PCPP Child Medicaid Cross-tabulations (Tab and Banner Book)
- Overall Colorado Child Medicaid Cross-tabulations (Tab and Banner Book)
- DHMC Child Medicaid Cross-tabulations (Tab and Banner Book)
- RMHP Child Medicaid Cross-tabulations (Tab and Banner Book)

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