Colorado Child Health Plan *Plus* 2017 Client Satisfaction Report

Colorado Department of Health Care Policy & Financing

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HSAG HEALTH SERVICES ADVISORY GROUP

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1. Executive Summary

The State of Colorado was required to administer client satisfaction surveys to clients enrolled in the following Child Health Plan *Plus* (CHP+) plans: Colorado Access, Colorado Choice, Denver Health Medical Plan (DHMP), Kaiser Permanente (Kaiser), 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] The goal of the CAHPS Health Plan Surveys is to provide performance feedback that is actionable and will aid in improving overall client satisfaction.

The standardized survey instrument selected was the CAHPS 5.0 Child Medicaid Health Plan Survey with the Healthcare Effectiveness Data and Information Set (HEDIS®) supplemental item set without the Children with Chronic Conditions (CCC) measurement set.[1-2] The parents or caretakers of child clients from the CHP+ plans completed the surveys from March to May 2017.

Performance Highlights

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

- National Committee for Quality Assurance (NCQA) Comparisons
- Trend Analysis
- Plan Comparisons
- Priority Assignments

[1-1] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).
[1-2] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

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), four composite measures (Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, and Customer Service), and one individual item measure (Coordination of Care) were compared to NCQA's 2017 HEDIS Benchmarks and Thresholds for Accreditation.[1-3,1-4] This comparison resulted in plan ratings of one (★) to five (★★★★★) stars on these CAHPS measures, where one was the lowest possible rating and five was the highest possible rating. The detailed results of this comparative analysis are described in the Results Section beginning on page 2-5. Table 1-1 presents the highlights from this comparison.

Table 1-1—NCQA Comparisons Highlights

Colorado Access	Colorado Choice	DHMP	Kaiser	RMHP
★ Customer Service	★+ Coordination of Care	★+ Coordination of Care	★★+ Rating of Specialist Seen Most Often	★+ Coordination of Care
★★ Coordination of Care	★+ Customer Service	★ Customer Service	★★ Rating of Health Plan	★+ Customer Service
★★ Getting Needed Care	★ Rating of All Health Care	★ Getting Care Quickly	★★★ Customer Service	★ Rating of Health Plan
★★ Rating of Health Plan	★ Rating of Health Plan	★ Getting Needed Care	★★★ Getting Needed Care	★★★ Getting Needed Care
★★★+ Rating of Specialist Seen Most Often	★★+ Rating of Specialist Seen Most Often	★★★ Rating of Health Plan	★★★★ Coordination of Care	★★★★ Getting Care Quickly
★★★ Getting Care Quickly	★★ Getting Needed Care	★★★★ How Well Doctors Communicate	★★★★ Getting Care Quickly	★★★★★+ Rating of Specialist Seen Most Often
★★★★★ How Well Doctors Communicate	★★ Rating of Personal Doctor	★★★★★+ Rating of Specialist Seen Most Often	★★★★★ How Well Doctors Communicate	★★★★★ How Well Doctors Communicate
★★★★★ Rating of All Health Care	★★★ Getting Care Quickly	★★★★★ Rating of All Health Care	★★★★★ Rating of All Health Care	★★★★★ Rating of All Health Care
★★★★★ Rating of Personal Doctor	★★★★ How Well Doctors Communicate	★★★★★ Rating of Personal Doctor	★★★★★ Rating of Personal Doctor	★★★★★ Rating of Personal Doctor

Star Assignments Based on Percentiles: ★★★★★ 90th or Above ★★★★ 75th-89th ★★★ 50th-74th ★★ 25th-49th ★ Below 25th
+ Indicates fewer than 100 responses. Caution should be exercised when evaluating these results.

[1-3] National Committee for Quality Assurance. *HEDIS Benchmarks and Thresholds for Accreditation 2017*. Washington, DC: NCQA, May 4, 2017.

[1-4] NCQA does not publish benchmarks and thresholds for the Shared Decision Making composite measure, and Health Promotion and Education individual item measure; therefore, overall client satisfaction ratings could not be derived for these CAHPS measures.

Trend Analysis

In order to evaluate trends in CHP+ client satisfaction, HSAG performed a stepwise trend analysis, where applicable. The first step compared the 2017 CAHPS results to the 2016 CAHPS results. If the initial 2017 and 2016 trend analysis did not yield any statistically significant differences, then an additional trend analysis was performed between 2017 and 2015 results. The detailed results of the trend analysis are described in the Results Section beginning on page 2-8. Table 1-2 presents the statistically significant results from this analysis.

Table 1-2—Trend Analysis Highlights

Measure Name	Colorado Access	Colorado Choice	DHMP	Kaiser	RMHP
Global Ratings					
Rating of Health Plan	—	—	▲	—	—
Rating of All Health Care	▲	—	—	—	▲
Rating of Personal Doctor	—	—	▲	—	▲
Composite Measures					
How Well Doctors Communicate	▼	—	▲	—	—
Customer Service	—	—+	—	—	▲+

▲ *Indicates the 2017 score is statistically significantly higher than the 2016 score.*
▼ *Indicates the 2017 score is statistically significantly lower than the 2016 score.*
▲ *Indicates the 2017 score is statistically significantly higher than the 2015 score.*
▼ *Indicates the 2017 score is statistically significantly lower than the 2015 score.*
\+ *Indicates fewer than 100 responses. Caution should be exercised when evaluating these results.*
— *Indicates the 2017 score is not statistically significantly different than the 2016 nor the 2015 score.*

Plan Comparisons

In order to identify performance differences in client satisfaction between the Colorado CHP+ plans, the case-mix adjusted results for each plan were compared to one another using standard statistical tests.[1-5] These comparisons were performed on the four global ratings, five composite measures, and two individual item measures. The detailed results of the comparative analysis are described in the Results Section beginning on page 2-22. Table 1-3 presents the statistically significant results from this comparison.[1-6]

Table 1-3—Plan Comparisons Highlights

Colorado Access	Colorado Choice	DHMP	Kaiser	RMHP
—	↓+ Customer Service	↓ Customer Service	—	—
—	↓ Rating of All Health Care	↓ Getting Care Quickly	—	—
—	↓ Rating of Health Plan	↓ Getting Needed Care	—	—
—	↓ Rating of Personal Doctor	—	—	—
—	↑ Getting Care Quickly	—	—	—

↑ *Indicates the plan is statistically significantly higher than the State Average.*
↓ *Indicates the plan is statistically significantly lower than the State Average.*
\+ *Indicates fewer than 100 responses. Caution should be exercised when evaluating these results.*
— *Indicates the plan's score is not statistically significantly different than the State Average.*

[1-5] CAHPS results are known to vary due to differences in respondent age, respondent education level, and client health status. Therefore, results were case-mix adjusted for differences in these demographic variables.

[1-6] Caution should be exercised when evaluating plan comparisons, given that population and 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 quality improvement (QI): top, high, moderate, and low priority. Table 1-4 presents the top and high priorities for each CHP+ plan.

Table 1-4—Top and High Priorities

Colorado Access	Colorado Choice	DHMP	Kaiser	RMHP
• Coordination of Care • Customer Service • Getting Needed Care • Rating of Health Plan	• Coordination of Care+ • Customer Service+ • Getting Needed Care • Rating of Health Plan • Rating of All Health Care • Rating of Personal Doctor • Rating of Specialist Seen Most Often+	• Coordination of Care+ • Customer Service • Getting Care Quickly • Getting Needed Care	• Rating of Health Plan • Rating of Specialist Seen Most Often+	• Coordination of Care+ • Customer Service+ • Rating of Health Plan
+ *Indicates fewer than 100 responses. Caution should be exercised when evaluating these results.*				

2. Results

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.[2-1] Clients eligible for sampling included those who were enrolled in Colorado Access, Colorado Choice, DHMP, Kaiser, and RMHP at the time the sample was drawn, and who were continuously enrolled in the plan for at least five of the last six months (July through December) of 2016. Child clients eligible for sampling included those who were 17 years of age or younger as of December 31, 2016.

Colorado Access, DHMP, Kaiser, and RMHP met the sample size requirements of 1,650. However, Colorado Choice did not meet the minimum sample size criteria. HSAG followed historical NCQA protocol where only one survey can be sent to each household; therefore, after adjusting for duplicate addresses, the actual sample size for Colorado Choice was 1,272. Oversampling was not performed for any of the CHP+ plans.

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 allowed clients two methods by which they could complete the surveys. The first phase, or mail phase, consisted of a survey being mailed to the sampled clients. For CHP+ plans, those clients who were identified as Spanish-speaking through administrative data were mailed a Spanish version of the survey. 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). 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. 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 maximum of six CATI calls was made to each non-respondent. Additional information on the survey protocol is included in the Reader's Guide Section beginning on page 4-3.

[2-1] National Committee for Quality Assurance. *HEDIS® 2017, Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA; 2016.

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 three of the following five questions were answered: 3, 15, 27, 31, and 36. Eligible clients included the entire sample 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.[2-2]

A total of 2,365 completed surveys were returned on behalf of CHP+ clients, including 497 Colorado Access, 353 Colorado Choice, 504 DHMP, 526 Kaiser, and 485 RMHP clients. Table 2-1 depicts the sample distribution and response rates for all participating health plans and the Colorado CHP+ aggregate.

Table 2-1—Colorado CHP+ Sample Distribution and Response Rate

Plan Name	Total Sample	Ineligible Records	Eligible Sample	Total Respondents	Response Rate
Colorado CHP+	**7,872**	**204**	**7,668**	**2,365**	**30.84%**
Colorado Access	1,650	51	1,599	497	31.08%
Colorado Choice	1,272	26	1,246	353	28.33%
DHMP	1,650	49	1,601	504	31.48%
Kaiser	1,650	31	1,619	526	32.49%
RMHP	1,650	47	1,603	485	30.26%

[2-2] National Committee for Quality Assurance. *HEDIS® 2017, Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA; 2016.

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

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

	Colorado CHP+	Colorado Access	Colorado Choice	DHMP	Kaiser	RMHP
Age						
Less than 1	0.5%	0.2%	0.6%	0.4%	0.2%	1.0%
1 to 3	13.1%	13.4%	13.9%	12.6%	11.4%	14.6%
4 to 7	22.3%	24.6%	19.9%	22.4%	22.4%	21.7%
8 to 12	31.9%	29.7%	30.7%	32.5%	32.2%	34.2%
13 to 18	32.2%	32.0%	34.9%	32.1%	33.9%	28.5%
Gender						
Male	50.2%	48.9%	49.3%	50.3%	51.0%	51.5%
Female	49.8%	51.1%	50.7%	49.7%	49.0%	48.5%
Race						
Multi-Racial	9.6%	11.4%	8.1%	9.7%	11.9%	6.2%
White	69.7%	69.9%	82.6%	55.6%	62.3%	80.0%
Black	3.6%	3.6%	0.3%	7.1%	5.8%	0.7%
Asian	5.2%	4.5%	1.2%	6.3%	11.0%	1.6%
Other	12.0%	10.7%	7.8%	21.3%	9.0%	11.6%
Ethnicity						
Hispanic	46.8%	40.2%	39.7%	75.7%	39.2%	37.1%
Non-Hispanic	53.2%	59.8%	60.3%	24.3%	60.8%	62.9%
General Health Status						
Excellent	43.8%	44.1%	47.4%	39.0%	41.7%	48.0%
Very Good	37.2%	35.8%	40.3%	34.1%	41.1%	35.2%
Good	15.9%	16.7%	9.1%	22.8%	15.2%	13.8%
Fair	3.1%	3.5%	3.1%	4.0%	2.1%	2.9%
Poor	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

Please note: Percentages may not total 100.0% due to rounding. Children are eligible for inclusion in CAHPS if they are age 17 or younger as of December 31, 2016. Some children eligible for the CAHPS Survey turned age 18 between January 1, 2017, and the time of survey administration.

[2-3] Agency for Healthcare Research and Quality. *CAHPS Health Plan Survey and Reporting Kit 2008*. Rockville, MD: US Department of Health and Human Services, July 2008.

Table 2-3 shows the self-reported age, gender, level of education, and relationship to the child for the respondents who completed the CAHPS 5.0 Child Medicaid Health Plan Survey.

Table 2-3—Respondent Demographics
Age, Gender, Education, and Relationship to Child

	Colorado CHP+	Colorado Access	Colorado Choice	DHMP	Kaiser	RMHP
Respondent Age						
Under 18	4.0%	3.5%	6.6%	2.3%	3.1%	5.2%
18 to 24	2.1%	1.8%	3.4%	2.3%	1.4%	2.1%
25 to 34	24.8%	29.0%	29.6%	24.3%	17.8%	25.2%
35 to 44	42.4%	42.3%	33.6%	42.8%	45.2%	45.6%
45 to 54	22.6%	19.8%	21.7%	24.9%	27.1%	19.0%
55 to 64	3.4%	2.7%	4.0%	3.1%	4.7%	2.7%
65 or Older	0.6%	0.8%	1.1%	0.4%	0.8%	0.2%
Respondent Gender						
Male	15.2%	16.2%	13.4%	16.3%	15.7%	14.0%
Female	84.8%	83.8%	86.6%	83.7%	84.3%	86.0%
Respondent Education						
8th Grade or Less	9.1%	6.2%	4.0%	23.1%	4.1%	6.7%
Some High School	8.7%	6.2%	2.6%	18.4%	6.8%	8.0%
High School Graduate	24.7%	22.4%	20.0%	31.6%	21.6%	26.7%
Some College	30.1%	33.6%	43.4%	17.4%	31.8%	27.7%
College Graduate	27.5%	31.5%	30.0%	9.5%	35.7%	30.9%
Relationship to Child						
Mother or Father	98.9%	99.0%	98.0%	98.8%	98.8%	99.8%
Grandparent	0.5%	0.4%	0.6%	0.6%	0.6%	0.2%
Legal Guardian	0.2%	0.2%	0.9%	0.0%	0.2%	0.0%
Other[2-4]	0.4%	0.4%	0.6%	0.6%	0.4%	0.0%
Please note: Percentages may not total 100% due to rounding.						

[2-4] The "Other" category for Relationship to Child consisted of respondents who selected "Aunt or Uncle," "Older brother or sister," "Other relative," or "Someone else" for Question 46 in the CAHPS 5.0 Child Medicaid Health Plan Survey.

NCQA Comparisons

In order to assess the overall performance of the CHP+ plans, the four CAHPS global ratings (Rating of Health Plan, Rating of All Health Care, Rating of Personal Doctor, and Rating of Specialist Seen Most Often), four CAHPS composite measures (Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, and Customer Service), and one individual item measure (Coordination of Care) were scored on a three-point scale using the scoring methodology detailed in NCQA's HEDIS Specifications for Survey Measures.[2-5] The resulting three-point mean scores were compared to NCQA's HEDIS Benchmarks and Thresholds for Accreditation.[2-6] Based on this comparison, ratings of one (★) to five (★★★★★) stars were determined for each CAHPS measure, where one is the lowest possible rating (i.e., Poor) and five is the highest possible rating (i.e., Excellent) as shown in Table 2-4.[2-7,2-8]

Table 2-4—Star Ratings

Stars	Percentiles
★★★★★ Excellent	At or above the 90th percentile
★★★★ Very Good	At or between the 75th and 89th percentiles
★★★ Good	At or between the 50th and 74th percentiles
★★ Fair	At or between the 25th and 49th percentiles
★ Poor	Below the 25th percentile

2-5 National Committee for Quality Assurance. *HEDIS® 2017, Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA Publication, 2016.

2-6 National Committee for Quality Assurance. *HEDIS Benchmarks and Thresholds for Accreditation 2017*. Washington, DC: NCQA, May 4, 2017.

2-7 NCQA does not publish national benchmarks and thresholds for the Shared Decision Making composite measure, and Health Promotion and Education individual measure; therefore, these CAHPS measures were excluded from the National Comparisons analysis.

2-8 NCQA's benchmarks and thresholds for the child Medicaid population were used to derive the overall satisfaction ratings; therefore, caution should be exercised when interpreting these results.

Table 2-5 shows the plans' three-point mean scores and overall client satisfaction ratings on the four global ratings, four composite measures, and one individual item measure.

Table 2-5—NCQA Comparisons: Overall Client Satisfaction Ratings

	Colorado Access	Colorado Choice	DHMP	Kaiser	RMHP
Global Ratings					
Rating of Health Plan	★★ 2.548	★ 2.274	★★★ 2.589	★★ 2.513	★ 2.503
Rating of All Health Care	★★★★★ 2.608	★ 2.468	★★★★★ 2.620	★★★★★ 2.629	★★★★★ 2.612
Rating of Personal Doctor	★★★★★ 2.688	★★ 2.612	★★★★★ 2.777	★★★★★ 2.692	★★★★★ 2.744
Rating of Specialist Seen Most Often	★★★+ 2.585	★★+ 2.536	★★★★★+ 2.742	★★+ 2.534	★★★★★+ 2.663
Composite Measures					
Getting Needed Care	★★ 2.451	★★ 2.422	★ 2.219	★★★ 2.460	★★★ 2.475
Getting Care Quickly	★★★ 2.651	★★★ 2.655	★ 2.392	★★★★ 2.662	★★★★ 2.677
How Well Doctors Communicate	★★★★★ 2.753	★★★★ 2.737	★★★★ 2.741	★★★★★ 2.791	★★★★★ 2.781
Customer Service	★ 2.450	★+ 2.231	★ 2.384	★★★ 2.526	★+ 2.474
Individual Item Measures					
Coordination of Care	★★ 2.357	★+ 2.305	★+ 2.291	★★★★ 2.508	★+ 2.271
+ Indicates fewer than 100 responses. Caution should be exercised when evaluating these results.					

Summary of NCQA Comparisons Results

The following table summarizes the star ratings from the NCQA comparisons.

Table 2-6—NCQA Comparisons Results

Colorado Access	Colorado Choice	DHMP	Kaiser	RMHP
★ Customer Service	★+ Coordination of Care	★+ Coordination of Care	★★+ Rating of Specialist Seen Most Often	★+ Coordination of Care
★★ Coordination of Care	★+ Customer Service	★ Customer Service	★★ Rating of Health Plan	★+ Customer Service
★★ Getting Needed Care	★ Rating of All Health Care	★ Getting Care Quickly	★★★ Customer Service	★ Rating of Health Plan
★★ Rating of Health Plan	★ Rating of Health Plan	★ Getting Needed Care	★★★ Getting Needed Care	★★★ Getting Needed Care
★★★+ Rating of Specialist Seen Most Often	★★+ Rating of Specialist Seen Most Often	★★★ Rating of Health Plan	★★★★ Coordination of Care	★★★★ Getting Care Quickly
★★★ Getting Care Quickly	★★ Getting Needed Care	★★★★ How Well Doctors Communicate	★★★★ Getting Care Quickly	★★★★★+ Rating of Specialist Seen Most Often
★★★★★ How Well Doctors Communicate	★★ Rating of Personal Doctor	★★★★★+ Rating of Specialist Seen Most Often	★★★★★ How Well Doctors Communicate	★★★★★ How Well Doctors Communicate
★★★★★ Rating of All Health Care	★★★ Getting Care Quickly	★★★★★ Rating of All Health Care	★★★★★ Rating of All Health Care	★★★★★ Rating of All Health Care
★★★★★ Rating of Personal Doctor	★★★★ How Well Doctors Communicate	★★★★★ Rating of Personal Doctor	★★★★★ Rating of Personal Doctor	★★★★★ Rating of Personal Doctor

Star Assignments Based on Percentiles ★★★★★ 90th or Above ★★★★ 75th-89th ★★★ 50th-74th ★★ 25th-49th ★ Below 25th

+ Indicates fewer than 100 responses. Caution should be exercised when evaluating these results.

Trend Analysis

Table 2-7 shows the number of completed surveys in 2015, 2016, and 2017.

Table 2-7—Completed Surveys in 2015, 2016, and 2017

Plan Name	2015	2016	2017
Colorado Access	502	516	497
Colorado Choice	305	312	353
DHMP	430	354	504
Kaiser	514	475	526
RMHP	457	624	485
Total Respondents	**2,208**	**2,281**	**2,365**

These completed surveys were used to calculate the Colorado CHP+ program's and corresponding health plans' 2015, 2016, and 2017 CAHPS results presented in this section for trending purposes. Additionally, the Colorado CHP+ program's 2015, 2016, and 2017 CAHPS results were weighted based on the total eligible population for each plan's CHP+ population.

For purposes of the trend analysis, question summary rates were calculated for each global rating and individual item measure, and global proportions were calculated for each composite measure. Both the question summary rates and global proportions were calculated in accordance with NCQA HEDIS Specifications for Survey Measures.[2-9] 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 2017 Specifications for Survey Measures, Volume 3.

In order to evaluate trends in CHP+ client satisfaction, HSAG performed a stepwise three-year trend analysis, where applicable. The first step compared the 2017 Colorado CHP+ and plan-level CAHPS scores to the corresponding 2016 scores. If the initial 2017 and 2016 trend analysis did not yield any statistically significant differences, then an additional trend analysis was performed between 2017 and 2015 results. Figure 2-1 through Figure 2-11 show the results of this trend analysis. Statistically significant differences are noted with directional triangles. Scores that were statistically significantly higher in 2017 than in 2016 are noted with black upward (▲) triangles. Scores that were statistically significantly lower in 2017 than in 2016 are noted with black downward (▼) triangles. Scores that were statistically significantly higher in 2017 than in 2015 are noted with red upward (▲) triangles. Scores that were statistically significantly lower in 2017 than in 2015 are noted with red downward (▼) triangles.

[2-9] National Committee for Quality Assurance. *HEDIS® 2017, Volume 3: Specifications for Survey Measures*. Washington, DC: NCQA; 2016.

Scores in 2017 that were not statistically significantly different from scores in 2016 or in 2015 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.

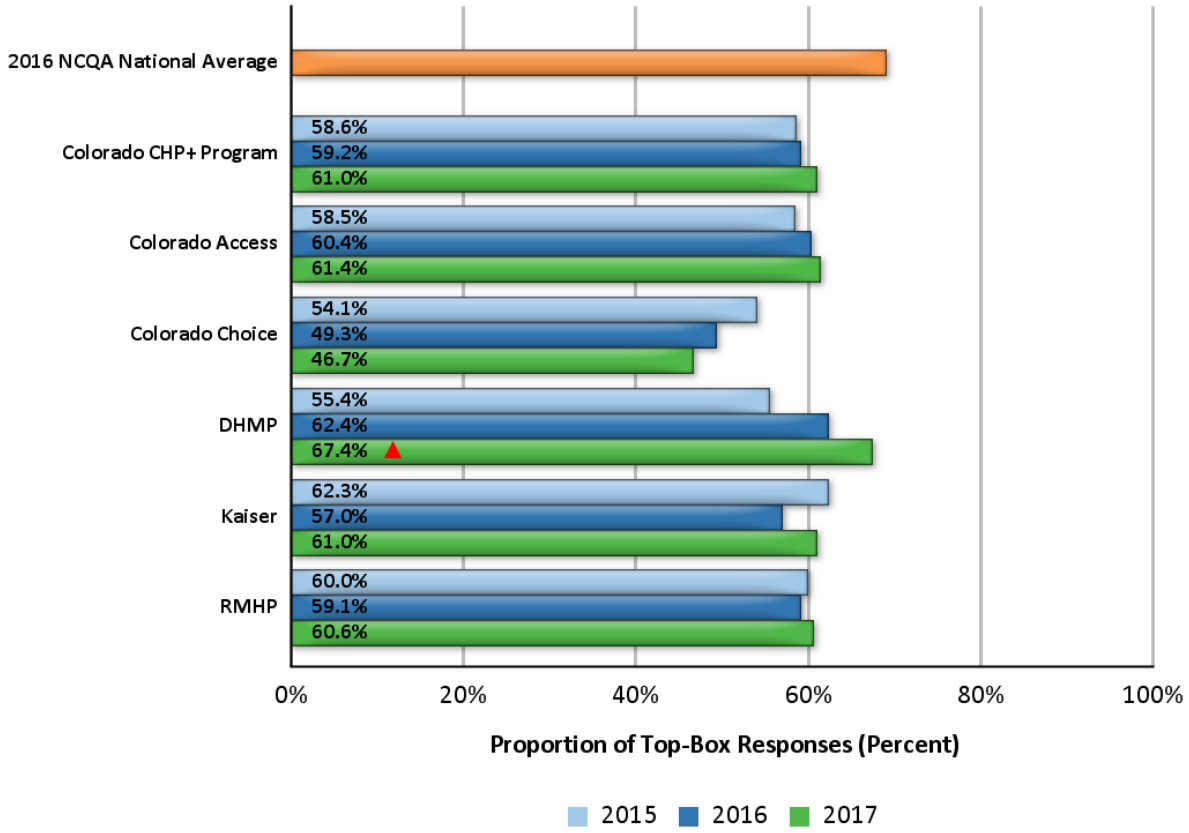
Global Ratings

Rating of Health Plan

Colorado CHP+ parents/caretakers of child clients were asked to rate their child's health plan on a scale of 0 to 10, with 0 being the "worst health plan possible" and 10 being the "best health plan possible." Top-level responses were defined as those responses with a rating of 9 or 10.

Figure 2-1 shows the 2016 NCQA national average and the question summary rates for the Rating of Health Plan global rating.[2-10,2-11,2-12,2-13]

Figure 2-1—Global Ratings: Rating of Health Plan



Statistical Significance Note:
▲ Indicates the 2017 score is statistically significantly higher than the 2016 score.
▼ Indicates the 2017 score is statistically significantly lower than the 2016 score.
▲ Indicates the 2017 score is statistically significantly higher than the 2015 score.
▼ Indicates the 2017 score is statistically significantly lower than the 2015 score.

[2-10] The Colorado CHP+ scores in this section are derived from a weighted average of the five Colorado CHP+ plans: Colorado Access, Colorado Choice, DHMP, Kaiser, and RMHP.

[2-11] NCQA national averages were not available for 2017 at the time this report was prepared; therefore, 2016 NCQA national data are presented in this section.

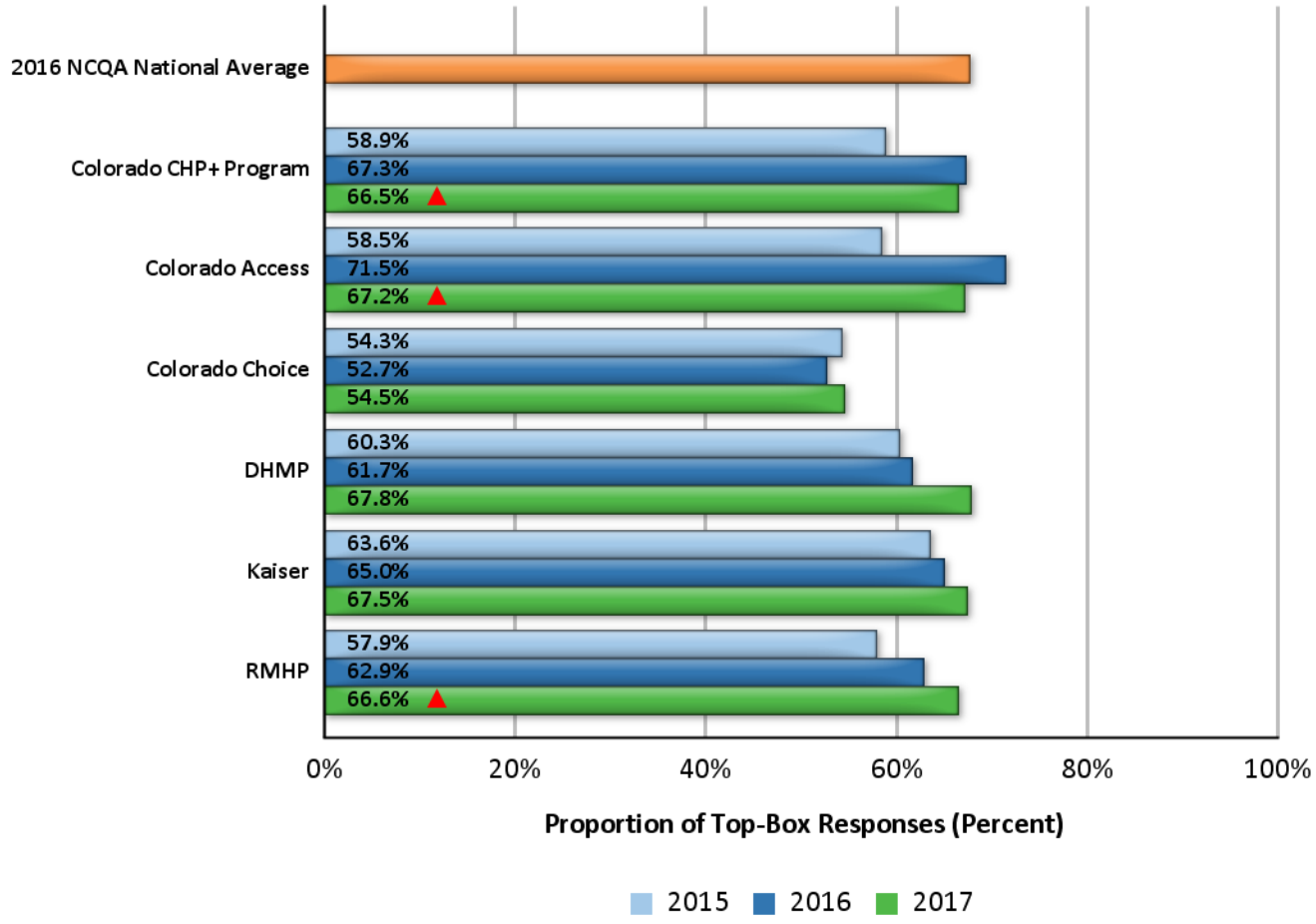
[2-12] The source for the NCQA national averages contained in this publication is Quality Compass® 2016 data and is used with the permission of the National Committee for Quality Assurance (NCQA). Quality Compass 2016 includes certain CAHPS data. Any data display, analysis, interpretation, or conclusion 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).

[2-13] NCQA national averages for the child Medicaid population are used for comparative purposes, since NCQA does not provide separate benchmarking data for the CHP+ population.

Rating of All Health Care

Colorado CHP+ parents/caretakers of child clients were asked to rate 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 2-2 shows the 2016 NCQA national average and the question summary rates for the Rating of All Health Care global rating.

Figure 2-2—Global Ratings: Rating of All Health Care

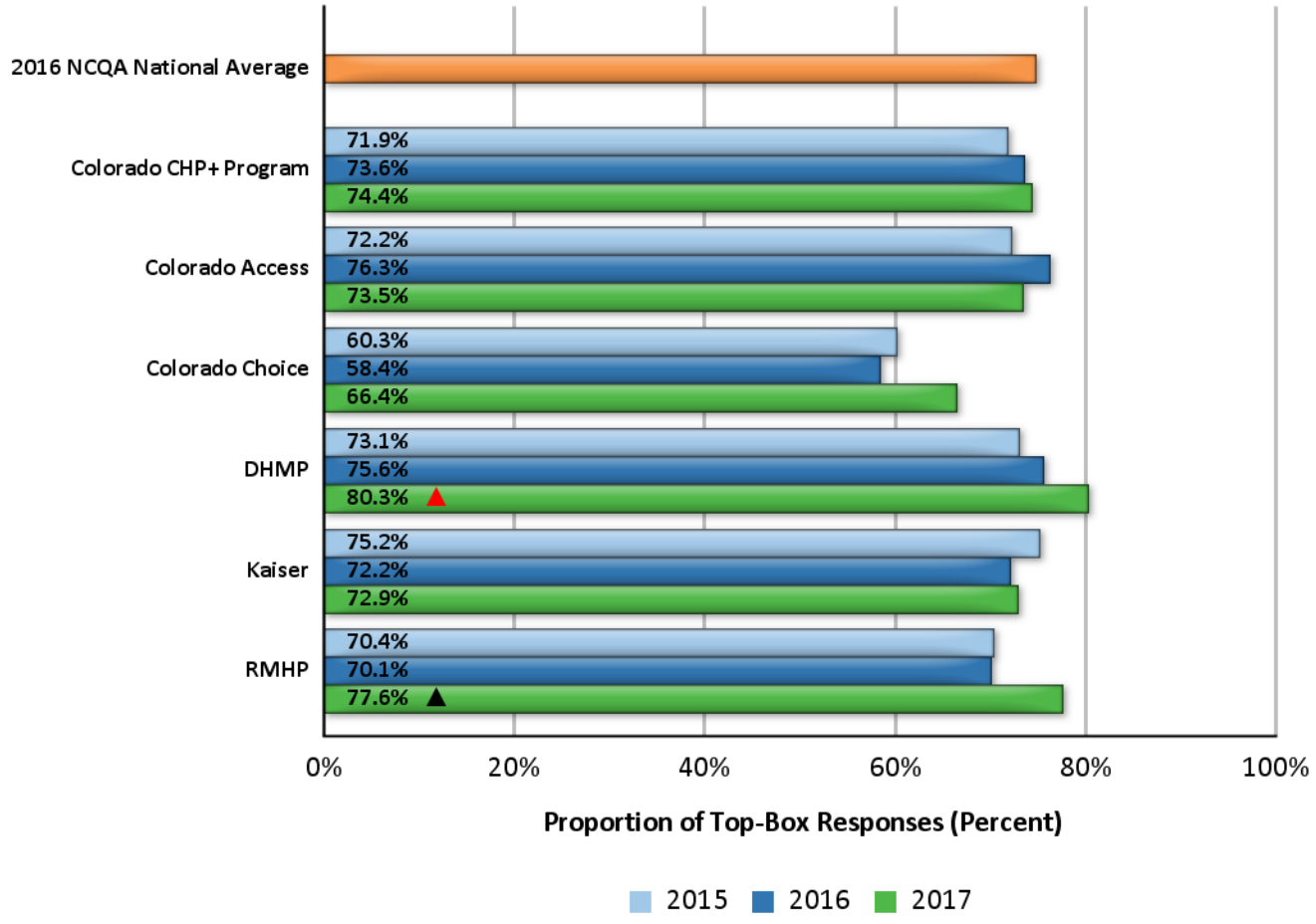


Statistical Significance Note:
▲ Indicates the 2017 score is statistically significantly higher than the 2016 score.
▼ Indicates the 2017 score is statistically significantly lower than the 2016 score.
▲ Indicates the 2017 score is statistically significantly higher than the 2015 score.
▼ Indicates the 2017 score is statistically significantly lower than the 2015 score.

Rating of Personal Doctor

Colorado CHP+ 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 2-3 shows the 2016 NCQA national average and the question summary rates for the Rating of Personal Doctor global rating.

Figure 2-3—Global Ratings: Rating of Personal Doctor

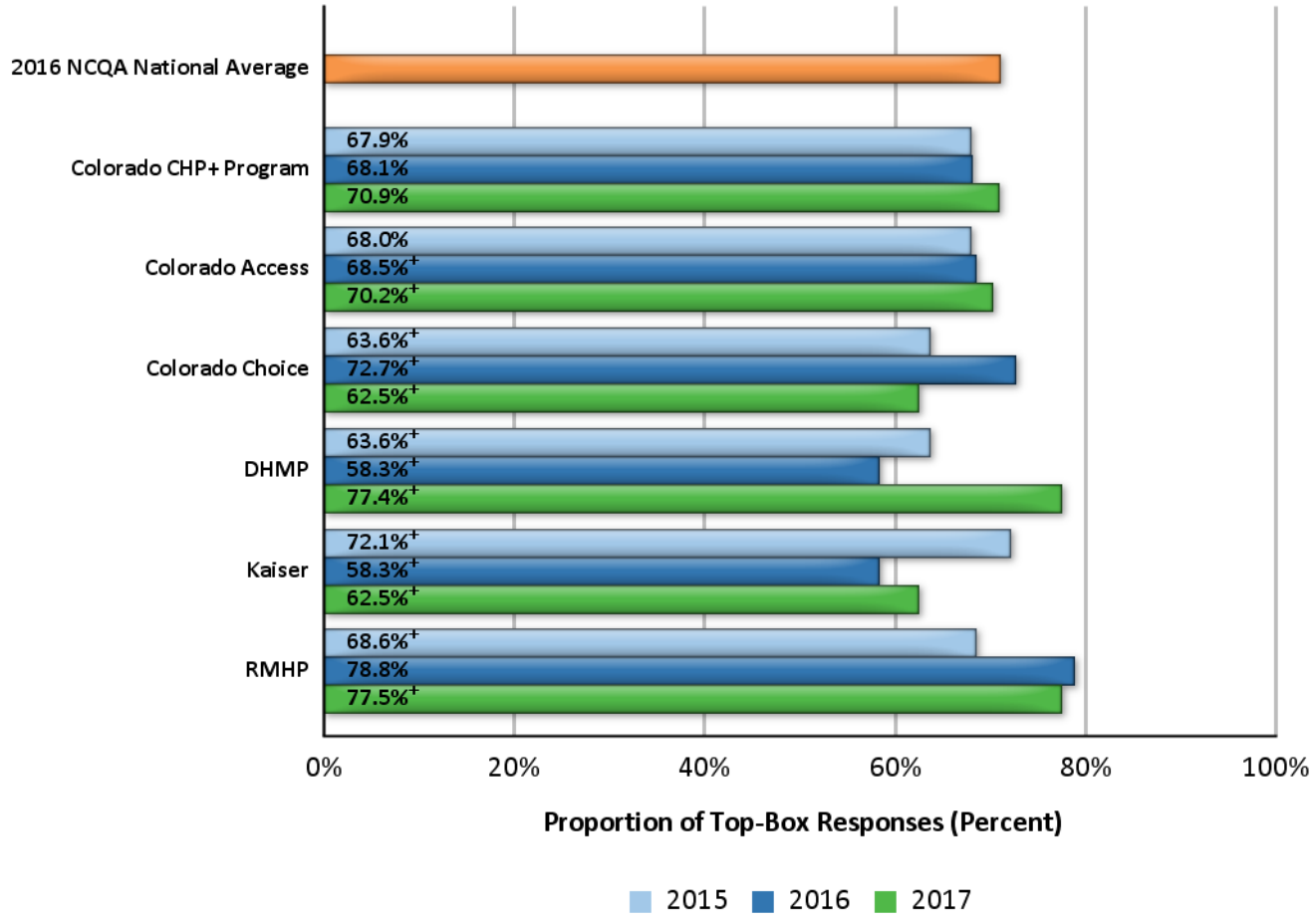


Statistical Significance Note:
▲ Indicates the 2017 score is statistically significantly higher than the 2016 score.
▼ Indicates the 2017 score is statistically significantly lower than the 2016 score.
▲ Indicates the 2017 score is statistically significantly higher than the 2015 score.
▼ Indicates the 2017 score is statistically significantly lower than the 2015 score.

Rating of Specialist Seen Most Often

Colorado CHP+ 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 2-4 shows the 2016 NCQA national average and the question summary rates for the Rating of Specialist Seen Most Often global rating.

Figure 2-4—Global Ratings: Rating of Specialist Seen Most Often



Statistical Significance Note:

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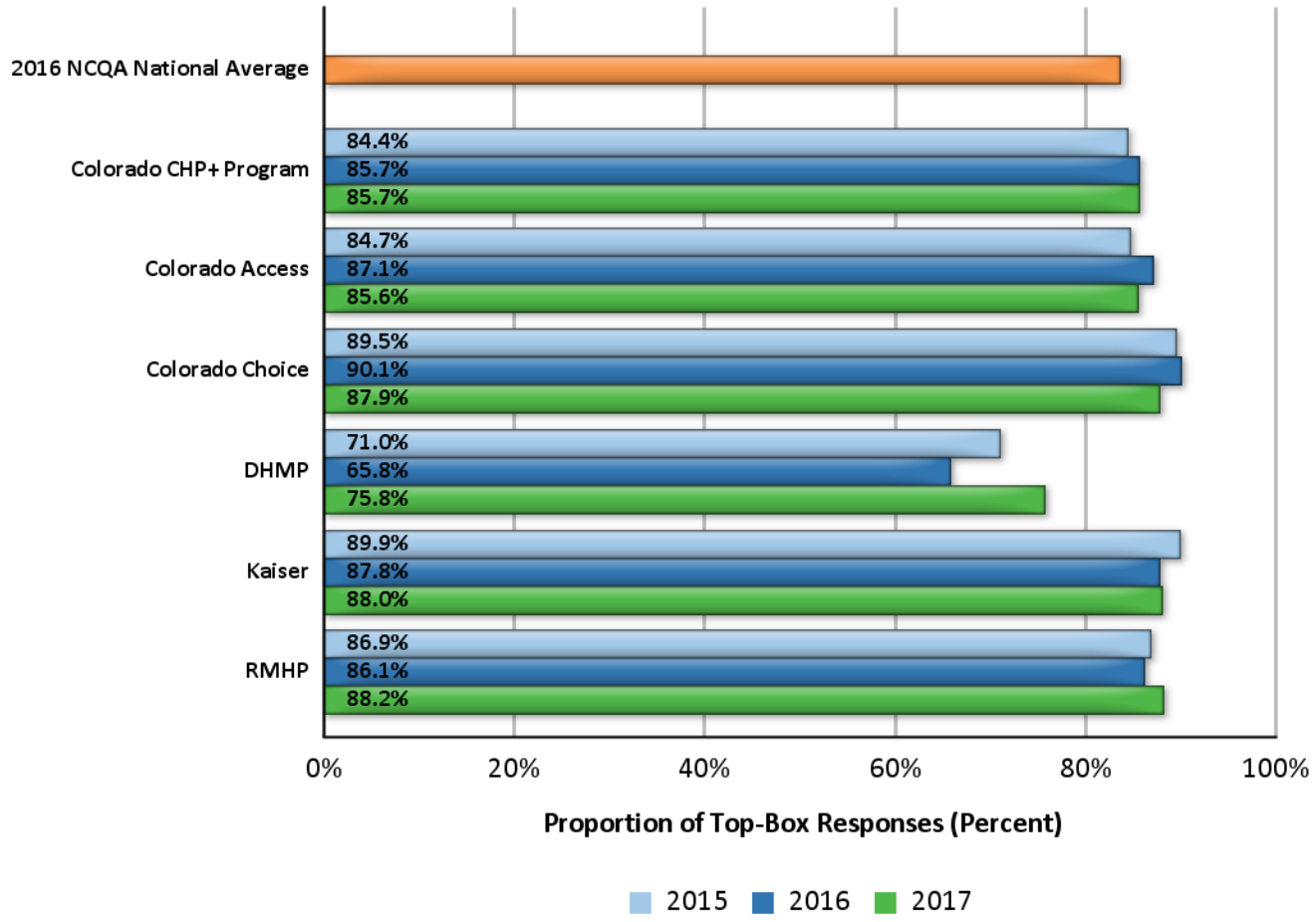
▼ Indicates the 2017 score is statistically significantly lower than the 2016 score.
▲ Indicates the 2017 score is statistically significantly higher than the 2015 score.
▼ Indicates the 2017 score is statistically significantly lower than the 2015 score.
+ Indicates fewer than 100 responses. Caution should be exercised when evaluating these results.

Composite Measures

Getting Needed Care

Colorado CHP+ 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 2-5 shows the 2016 NCQA national average and the global proportions for the Getting Needed Care composite measure.

Figure 2-5—Composite Measures: Getting Needed Care



Statistical Significance Note:
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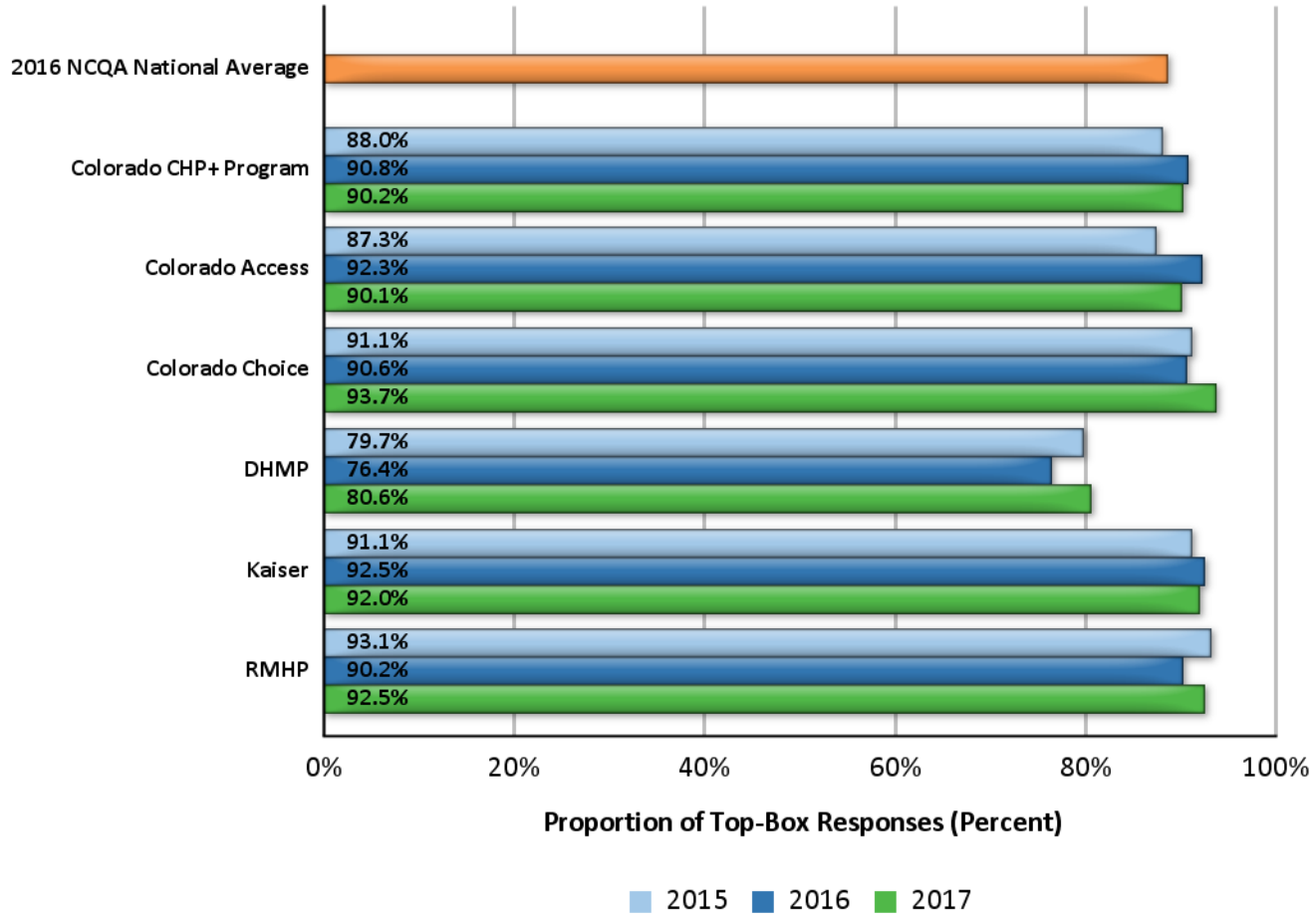
▼ Indicates the 2017 score is statistically significantly lower than the 2016 score.
▲ Indicates the 2017 score is statistically significantly higher than the 2015 score.
▼ Indicates the 2017 score is statistically significantly lower than the 2015 score.

Getting Care Quickly

Colorado CHP+ 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 2-6 shows the 2016 NCQA national average and the global proportions for the Getting Care Quickly composite measure.

Figure 2-6—Composite Measures: Getting Care Quickly

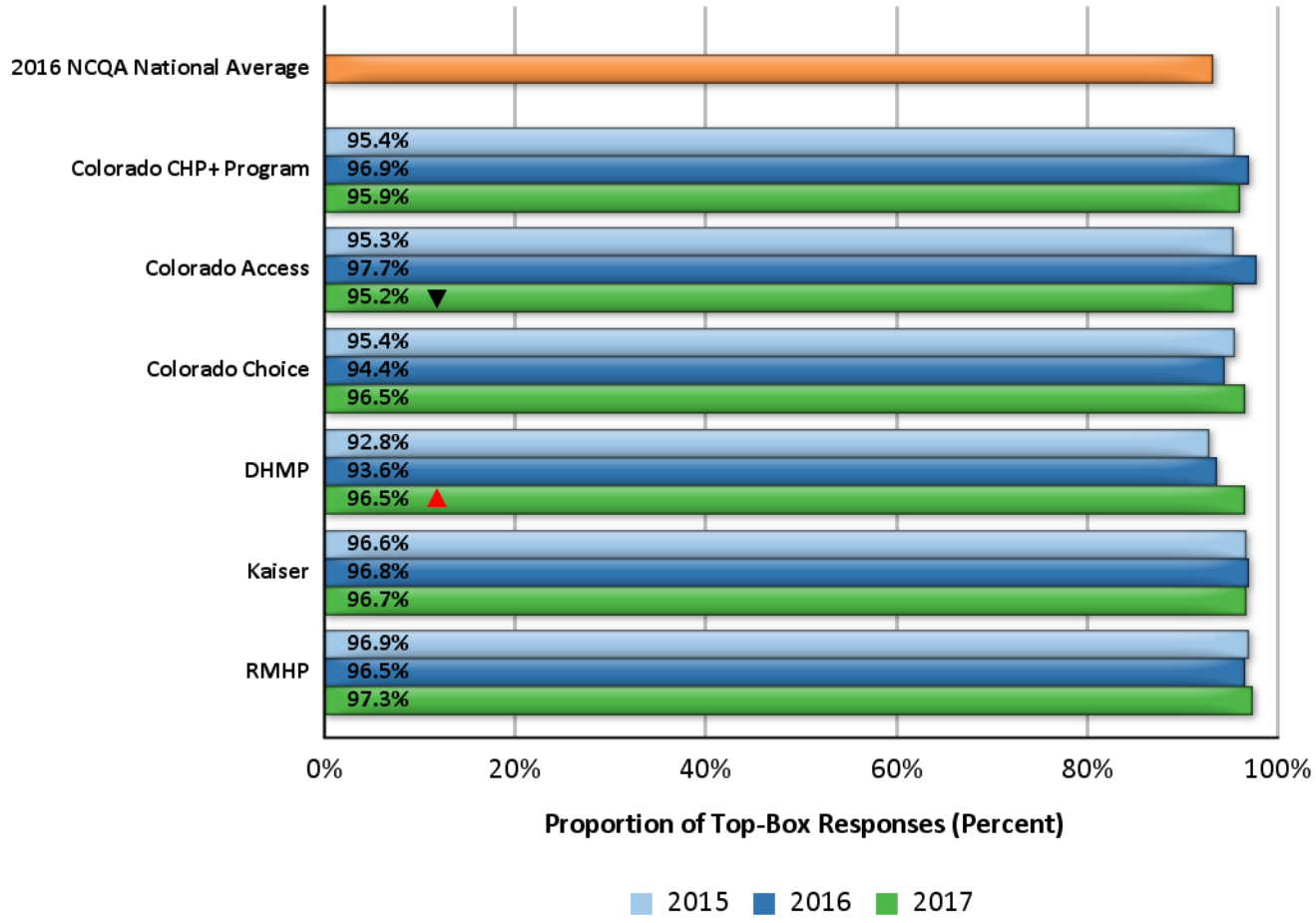


Statistical Significance Note:
▲ Indicates the 2017 score is statistically significantly higher than the 2016 score.
▼ Indicates the 2017 score is statistically significantly lower than the 2016 score.
▲ Indicates the 2017 score is statistically significantly higher than the 2015 score.
▼ Indicates the 2017 score is statistically significantly lower than the 2015 score.

How Well Doctors Communicate

Colorado CHP+ 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 2-7 shows the 2016 NCQA national average and the global proportions for the How Well Doctors Communicate composite measure.

Figure 2-7—Composite Measures: How Well Doctors Communicate

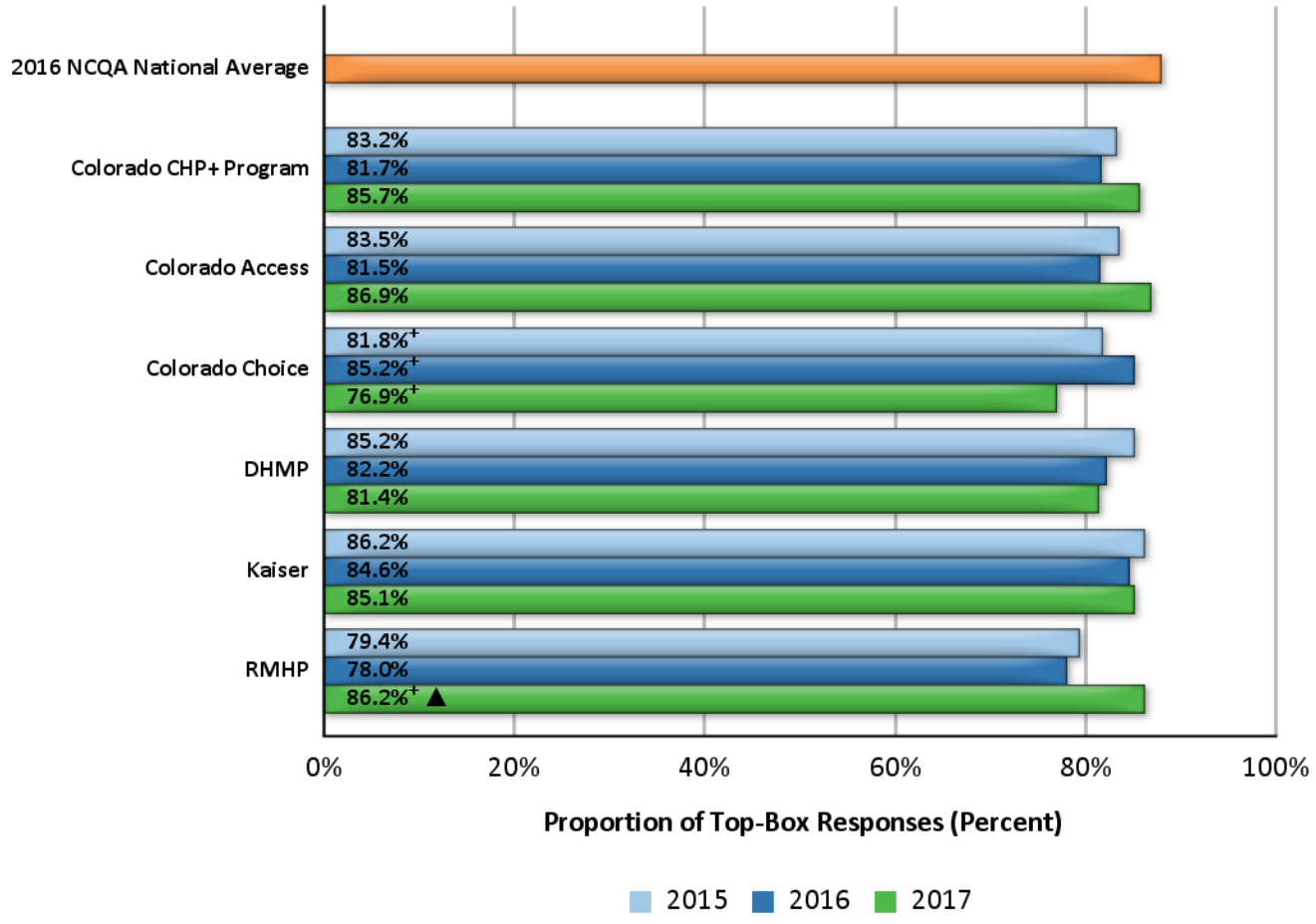


Statistical Significance Note:
▲ Indicates the 2017 score is statistically significantly higher than the 2016 score.
▼ Indicates the 2017 score is statistically significantly lower than the 2016 score.
▲ Indicates the 2017 score is statistically significantly higher than the 2015 score.
▼ Indicates the 2017 score is statistically significantly lower than the 2015 score.

Customer Service

Colorado CHP+ parents/caretakers of child clients were asked two questions to assess how often they obtained needed help/information from the health plan's 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 2-8 shows the 2016 NCQA national average and the global proportions for the Customer Service composite measure.

Figure 2-8—Composite Measures: Customer Service



Statistical Significance Note:

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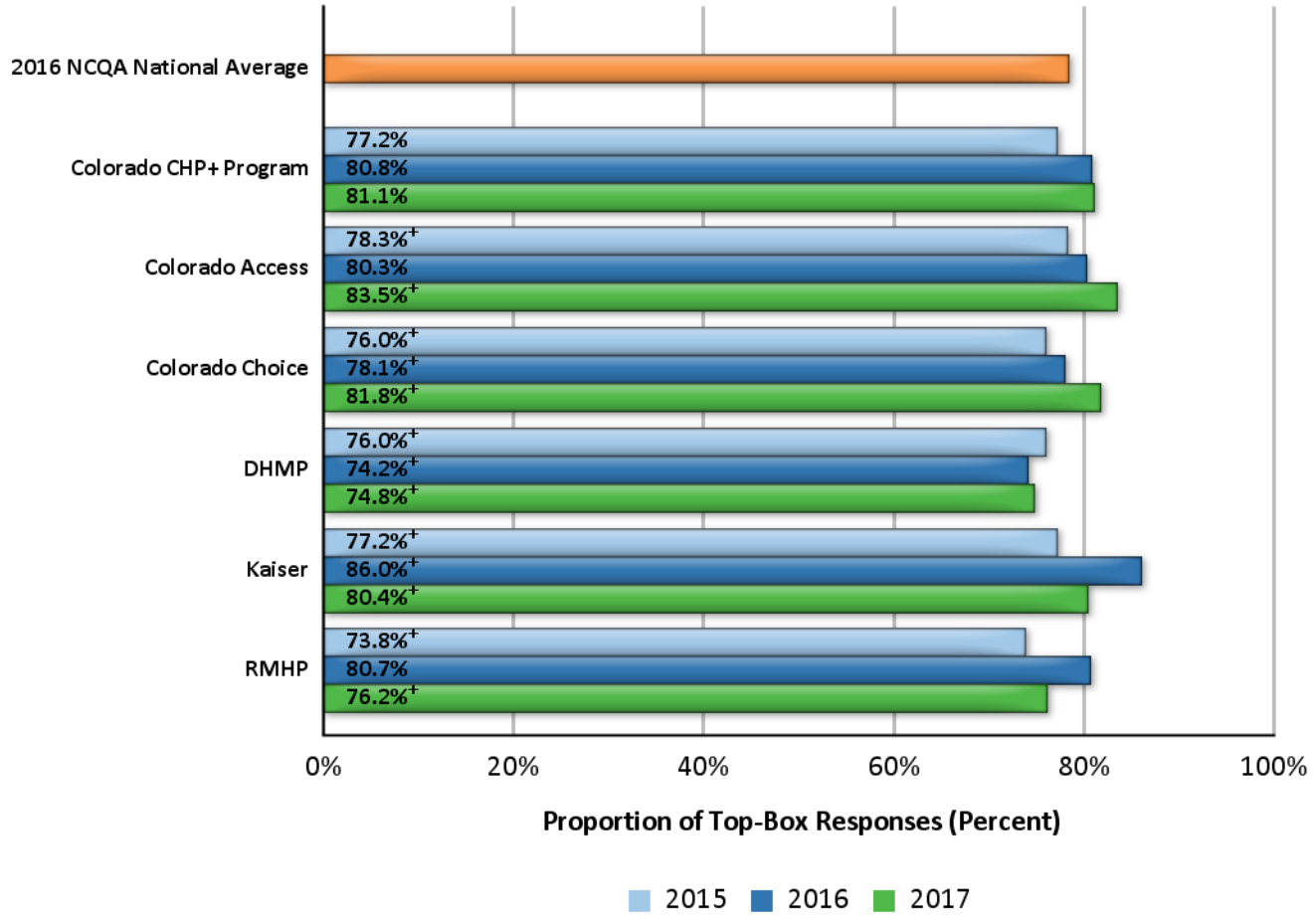
▼ Indicates the 2017 score is statistically significantly lower than the 2016 score.
▲ Indicates the 2017 score is statistically significantly higher than the 2015 score.
▼ Indicates the 2017 score is statistically significantly lower than the 2015 score.
+ Indicates fewer than 100 responses. Caution should be exercised when evaluating these results.

Shared Decision Making

Colorado CHP+ parents/caretakers of child clients were asked three questions to assess if their child's doctors discussed starting or stopping a prescription medicine with them. For each of these questions (Questions 10, 11, and 12), a top-level response was defined as a response of "Yes." Figure 2-9 shows the 2016 NCQA national average and the global proportions for the Shared Decision Making composite measure.

Figure 2-9—Composite Measures: Shared Decision Making



Statistical Significance Note:

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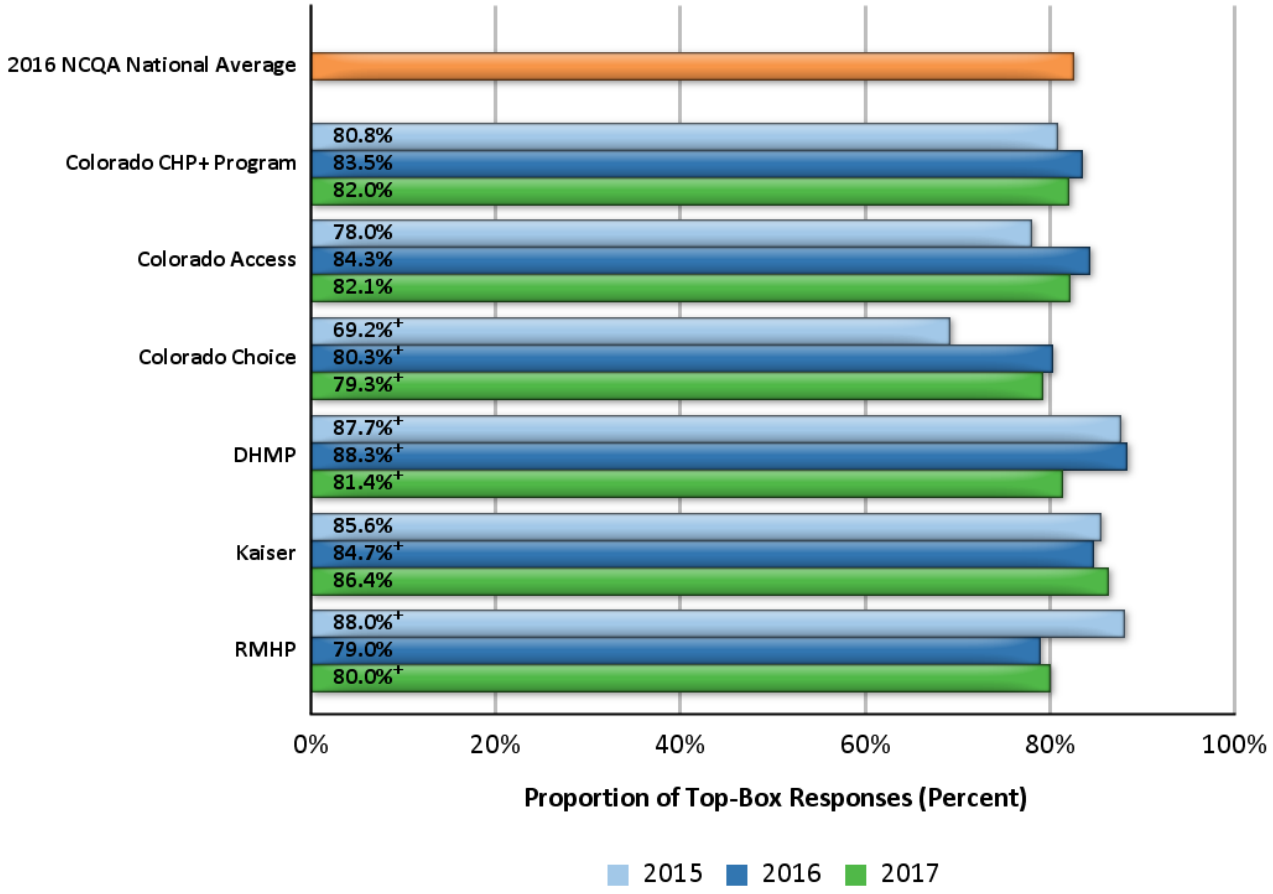
▼ Indicates the 2017 score is statistically significantly lower than the 2016 score.
▲ Indicates the 2017 score is statistically significantly higher than the 2015 score.
▼ Indicates the 2017 score is statistically significantly lower than the 2015 score.
\+ Indicates fewer than 100 responses. Caution should be exercised when evaluating these results.

Individual Item Measures

Coordination of Care

Colorado CHP+ 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 2-10 shows the 2016 NCQA national average and the question summary rates for the Coordination of Care individual item measure.

Figure 2-10—Individual Item Measures: Coordination of Care



Statistical Significance Note:

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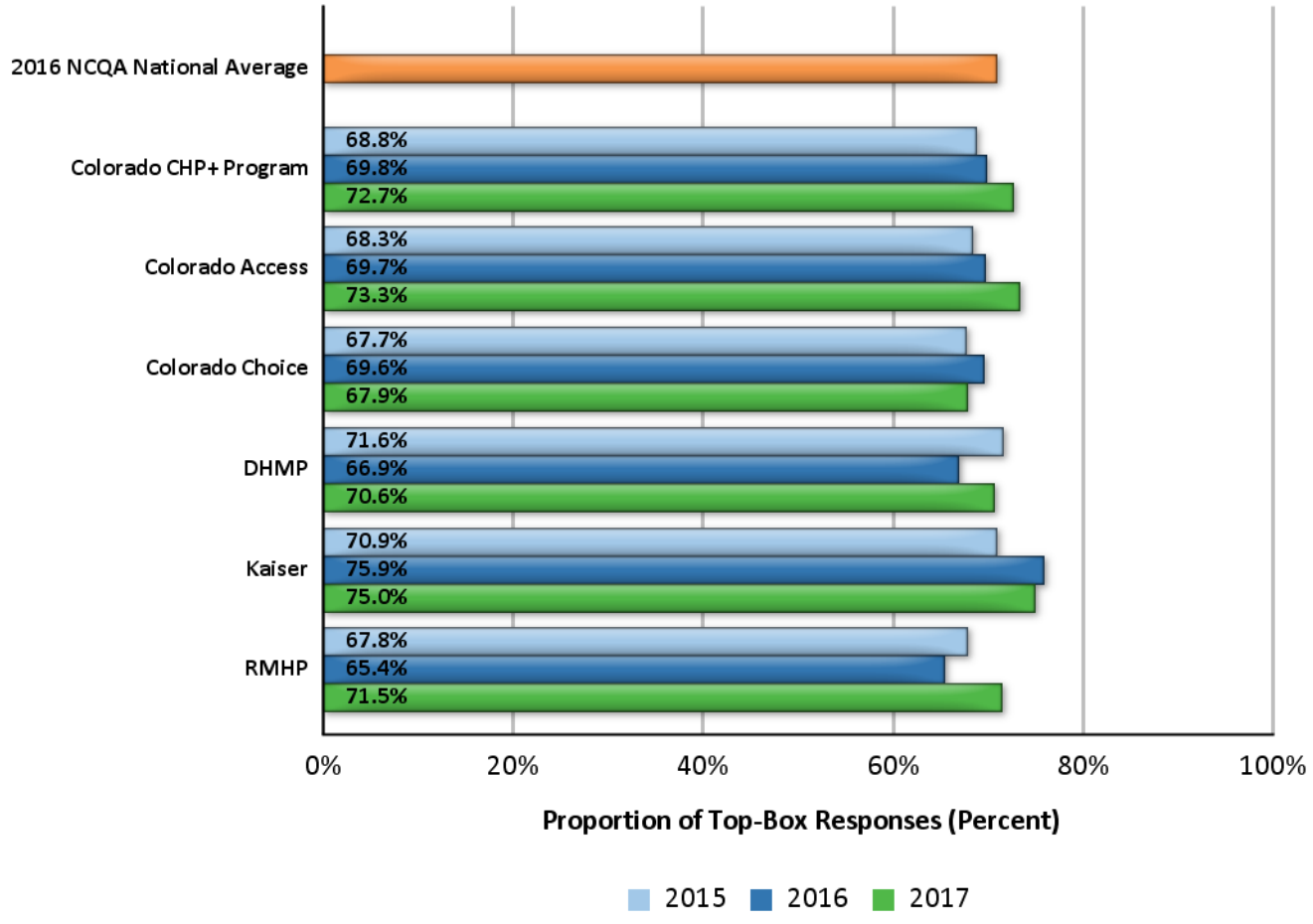
▼ Indicates the 2017 score is statistically significantly lower than the 2016 score.
▲ Indicates the 2017 score is statistically significantly higher than the 2015 score.
▼ Indicates the 2017 score is statistically significantly lower than the 2015 score.
+ Indicates fewer than 100 responses. Caution should be exercised when evaluating these results.

Health Promotion and Education

Colorado CHP+ 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 2-11 shows the 2016 NCQA national average and the question summary rates for the Health Promotion and Education individual item measure.

Figure 2-11—Individual Item Measures: Health Promotion and Education



Statistical Significance Note:
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▼ Indicates the 2017 score is statistically significantly lower than the 2016 score.
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▼ Indicates the 2017 score is statistically significantly lower than the 2015 score.

Summary of Trend Analysis Results

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

Table 2-8—Trend Analysis Highlights

Measure Name	Colorado Access	Colorado Choice	DHMP	Kaiser	RMHP
Global Ratings					
Rating of Health Plan	—	—	▲	—	—
Rating of All Health Care	▲	—	—	—	▲
Rating of Personal Doctor	—	—	▲	—	▲
Composite Measures					
How Well Doctors Communicate	▼	—	▲	—	—
Customer Service	—	—+	—	—	▲+

▲ *Indicates the 2017 score is statistically significantly higher than the 2016 score.*
▼ *Indicates the 2017 score is statistically significantly lower than the 2016 score.*
▲ *Indicates the 2017 score is statistically significantly higher than the 2015 score.*
▼ *Indicates the 2017 score is statistically significantly lower than the 2015 score.*
\+ *Indicates fewer than 100 responses. Caution should be exercised when evaluating these results.*
— *Indicates the 2017 score is not statistically significantly different than the 2016 nor the 2015 score.*

Plan Comparisons

In order to identify performance differences in client satisfaction between the five Colorado CHP+ plans, the results for Colorado Access, Colorado Choice, DHMP, Kaiser, and RMHP were compared to the Colorado CHP+ program average using standard tests for statistical significance.[2-14] For purposes of this comparison, results were case-mix adjusted. Case-mix refers to the characteristics of respondents used in adjusting the results for comparability among health plans. Results for the CHP+ plans were case-mix adjusted for client general health status, respondent educational level, and respondent age.[2-15] 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 2017 Specifications for Survey Measures, Volume 3.

Statistically significant differences are noted in the tables by arrows. A plan that performed statistically significantly higher than the Colorado CHP+ program average is denoted with an upward (↑) arrow. Conversely, a plan that performed statistically significantly lower than the Colorado CHP+ program average is denoted with a downward (↓) arrow. A plan that is not statistically significantly different than the Colorado CHP+ program average is denoted with a horizontal (↔) arrow.

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

Table 2-9, on the following page, shows the results of the plan comparisons analysis. Please note, these results may differ from those presented in the trend analysis figures because they have been adjusted for differences in case mix (i.e., the percentages presented have been case-mix adjusted).

[2-14] Caution should be exercised when evaluating plan comparisons, given that population and plan differences may impact CAHPS results.

[2-15] 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 2-9—Plan Comparisons

	Colorado Access	Colorado Choice	DHMP	Kaiser	RMHP
Global Ratings					
Rating of Health Plan	62.7% ⇔	48.0% ↓	63.0% ⇔	62.5% ⇔	61.0% ⇔
Rating of All Health Care	67.8% ⇔	55.2% ↓	65.4% ⇔	68.6% ⇔	66.6% ⇔
Rating of Personal Doctor	74.2% ⇔	66.7% ↓	77.9% ⇔	74.3% ⇔	77.7% ⇔
Rating of Specialist Seen Most Often	72.8%+ ⇔	64.9%+ ⇔	68.9%+ ⇔	64.7%+ ⇔	78.8%+ ⇔
Composite Measures					
Getting Needed Care	86.1% ⇔	88.4% ⇔	74.3% ↓	88.1% ⇔	88.5% ⇔
Getting Care Quickly	89.7% ⇔	93.1% ↑	82.5% ↓	91.4% ⇔	92.2% ⇔
How Well Doctors Communicate	95.1% ⇔	96.4% ⇔	97.5% ⇔	96.3% ⇔	97.1% ⇔
Customer Service	87.5% ⇔	77.6%+ ↓	79.0% ↓	85.6% ⇔	86.8%+ ⇔
Shared Decision Making	83.3%+ ⇔	80.2%+ ⇔	78.1%+ ⇔	79.5%+ ⇔	75.6%+ ⇔
Individual Item Measures					
Coordination of Care	82.0% ⇔	80.1%+ ⇔	80.6%+ ⇔	86.1% ⇔	80.3%+ ⇔
Health Promotion and Education	72.3% ⇔	66.5% ⇔	75.1% ⇔	73.1% ⇔	71.1% ⇔

\+ *Indicates fewer than 100 responses. Caution should be exercised when evaluating these results.*
— *Indicates the plan's score is not statistically significantly different than the State Average.*

Summary of Plan Comparisons Results

The plan comparisons revealed the following statistically significant results.

- Colorado Choice scored statistically significantly higher than the Colorado CHP+ program average on one CAHPS measure, Getting Care Quickly. Additionally, Colorado Choice scored statistically significantly lower than the Colorado CHP+ program average on four CAHPS measures: Rating of Health Plan, Rating of All Health Care, Rating of Personal Doctor, and Customer Service.
- DHMP scored statistically significantly lower than the Colorado CHP+ program average on three CAHPS measures: Getting Needed Care, Getting Care Quickly, and Customer Service.

Supplemental Items

The Department elected to add six supplemental items to the standard CAHPS 5.0 Child Medicaid Health Plan Survey for the Colorado CHP+ plans. Table 2-10 details the survey language and response options for each of the supplemental items. Table 2-11 through Table 2-16 show the results for each supplemental item. For all Colorado CHP+ plans, the number and percentage of responses for each item are presented.

Table 2-10—Supplemental Items

Question		Response Options
Q48a.	In the last 6 months, not counting the times your child needed health care right away, how many days did you usually have to wait between making an appointment and your child actually seeing a health provider?	Same day 1 day 2 to 3 days 4 to 7 days 8 to 14 days 15 to 30 days 31 to 60 days 61 to 90 days 91 days or longer My child did not see a health provider in the last 6 months
Q48b.	In the last 6 months, how often was it easy to get appointments for your child with specialists?	Never Sometimes Usually Always My child did not see a specialist in the last 6 months
Q48c.	Did this provider's office give you information about what to do if your child needed care during evenings, weekends, or holidays?	Yes No
Q48d.	In the last 6 months, how often were you able to get the care your child needed from his or her doctor or other health provider during evenings, weekends, or holidays?	Never Sometimes Usually Always My child did not need care from his or her doctor or other health provider during evenings, weekends, or holidays in the last 6 months
Q48e.	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 My child did not see a doctor or other health provider in the last 6 months
Q48f.	In the last 6 months, did you and your child's doctor or other health provider talk about whether there are any problems in your household that might affect your child?	Yes No My child did not see a doctor or other health provider in the last 6 months

Number of Days Waiting to See Health Provider

Parents/caretakers of child clients were asked how many days were between making an appointment and their child actually seeing a health provider (Question 48a). Table 2-11 displays the responses for this question.

Table 2-11—Number of Days Waiting to See Health Provider

Plan Name	Same day		1 day		2 to 3 days		4 to 7 days		8 to 14 days		15 to 30 days		31 to 60 days		61 to 90 days		91 days or longer	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Colorado Access	114	30.9%	60	16.3%	60	16.3%	53	14.4%	40	10.8%	30	8.1%	7	1.9%	2	0.5%	3	0.8%
Colorado Choice	82	31.5%	48	18.5%	62	23.8%	30	11.5%	17	6.5%	13	5.0%	4	1.5%	2	0.8%	2	0.8%
DHMP	62	21.2%	39	13.3%	72	24.6%	53	18.1%	37	12.6%	22	7.5%	3	1.0%	3	1.0%	2	0.7%
Kaiser	100	26.5%	74	19.6%	92	24.3%	55	14.6%	32	8.5%	18	4.8%	4	1.1%	1	0.3%	2	0.5%
RMHP	112	32.2%	72	20.7%	61	17.5%	51	14.7%	19	5.5%	17	4.9%	10	2.9%	3	0.9%	3	0.9%

Please note: Percentages may not total 100.0% due to rounding.

Appointments with Specialists

Parents/caretakers of child clients were asked to assess how often it was easy to get appointments for their child with specialists (Question 48b). Table 2-12 displays the responses for this question.

Table 2-12—Appointments with Specialists

Plan Name	Never		Sometimes		Usually		Always	
	N	%	N	%	N	%	N	%
Colorado Access	24	15.1%	24	15.1%	49	30.8%	62	39.0%
Colorado Choice	15	15.2%	13	13.1%	37	37.4%	34	34.3%
DHMP	29	17.6%	35	21.2%	43	26.1%	58	35.2%
Kaiser	24	14.0%	26	15.2%	58	33.9%	63	36.8%
RMHP	16	10.4%	22	14.3%	48	31.2%	68	44.2%

Please note: Percentages may not total 100.0% due to rounding.

Received Information About After-Hours Care

Parents/caretakers of child clients were asked if their child's provider's office gave them information about what to do if their child needed care during evenings, weekends, or holidays (Question 48c). Table 2-13 displays the responses for this question.

Table 2-13—Received Information About After-Hours Care

Plan Name	Yes		No	
	N	%	N	%
Colorado Access	335	73.8%	119	26.2%
Colorado Choice	199	63.4%	115	36.6%
DHMP	270	59.0%	188	41.0%
Kaiser	337	69.3%	149	30.7%
RMHP	290	67.6%	139	32.4%
Please note: Percentages may not total 100.0% due to rounding.				

Access to After-Hours Care

Parents/caretakers of child clients were asked to assess how often they were able to get the care their child needed from their child's doctor or other health provider during evenings, weekends, or holidays (Question 48d). Table 2-14 displays the responses for this question.

Table 2-14—Access to After-Hours Care

Plan Name	Never		Sometimes		Usually		Always	
	N	%	N	%	N	%	N	%
Colorado Access	38	25.5%	13	8.7%	32	21.5%	66	44.3%
Colorado Choice	25	21.9%	19	16.7%	29	25.4%	41	36.0%
DHMP	49	32.5%	38	25.2%	18	11.9%	46	30.5%
Kaiser	39	26.0%	13	8.7%	27	18.0%	71	47.3%
RMHP	20	16.5%	16	13.2%	30	24.8%	55	45.5%
Please note: Percentages may not total 100.0% due to rounding.								

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 48e). Table 2-15 displays the responses for this question.

Table 2-15—Talked About Child's Behavior

Plan Name	Yes		No	
	N	%	N	%
Colorado Access	269	71.5%	107	28.5%
Colorado Choice	145	59.9%	97	40.1%
DHMP	183	52.9%	163	47.1%
Kaiser	237	61.7%	147	38.3%
RMHP	213	62.6%	127	37.4%
Please note: Percentages may not total 100.0% due to rounding.				

Talked About Household Problems That Might Affect Child

Parents/caretakers of child clients were asked if they and their child's doctor or other health provider talked about any problems in their household that might affect their child (Question 48f). Table 2-16 displays the responses for this question.

Table 2-16—Talked About Household Problems That Might Affect Child

Plan Name	Yes		No	
	N	%	N	%
Colorado Access	148	40.1%	221	59.9%
Colorado Choice	80	33.6%	158	66.4%
DHMP	101	30.7%	228	69.3%
Kaiser	120	32.3%	252	67.7%
RMHP	115	35.4%	210	64.6%
Please note: Percentages may not total 100.0% due to rounding.				

3. Recommendations

General Recommendations

HSAG recommends the continued administration of the CAHPS 5.0 Child Medicaid Health Plan Survey in FY 2017-2018. HSAG will continue performing complete benchmarking and trend evaluation on the child data. Additionally, HSAG recommends the continued use of administrative data in identifying the Spanish-speaking population. There were 568 completed surveys in Spanish for the FY 2016-2017 survey administration which is greater than the 331 completed surveys in Spanish for the FY 2015-2016 survey administration.

Plan-Specific Priority Assignments

This section presents the results of the priority assignments for the five Colorado CHP+ plans. The priority assignments are grouped into four main categories for QI: top, high, moderate, and low priority. The priority of the CAHPS measure is based on the results of the NCQA comparisons and trend analysis.[3-1] This section also presents general best practices and recommendations based on the information available in the CAHPS literature.

The priorities presented in this section should be viewed as potential suggestions for QI. Additional sources of QI information, such as other HEDIS results, should be incorporated into a comprehensive QI plan. A number of resources are available to assist state Medicaid agencies and plans with the implementation of CAHPS-based QI initiatives. A comprehensive list of these resources is included in the Reader's Guide Section, beginning on page 4-11.

[3-1] NCQA does not provide benchmarks for the Shared Decision Making composite measure and Health Promotion and Education individual item measure; therefore, priority assignments cannot be derived for these measures.

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

Table 3-1—Derivation of Priority Assignments on Each CAHPS Measure

NCQA Comparisons (Star Ratings)	Trend Analysis	Priority Assignment
★	▼/▼	Top
★	—	Top
★	▲/▲	Top
★★	▼/▼	Top
★★	—	High
★★	▲/▲	High
★★★	▼/▼	High
★★★	—	Moderate
★★★	▲/▲	Moderate
★★★★	▼/▼	Moderate
★★★★	—	Moderate
★★★★★	▼/▼	Moderate
★★★★	▲/▲	Low
★★★★★	—	Low
★★★★★	▲/▲	Low

Please note: Trend analysis results reflect those between either the 2017 and 2016 results or the 2017 and 2015 results.[3-2] *If statistically significant differences were not identified during the trend analysis, this lack of statistical significance is denoted with a hyphen (—) in the table above.*

[3-2] For more detailed information on the trend analysis results, please see the Results Section of this report.

Global Ratings

Table 3-2 through Table 3-10 display the priority assignments for the global ratings, composite measures, and individual item measure. Table 3-2 shows the priority assignments for the overall Rating of Health Plan measure.

Table 3-2—Priority Assignments: Rating of Health Plan

Plan Name	NCQA Comparisons (Star Ratings)	Trend Analysis	Priority Assignment
Colorado Access	★★	—	High
Colorado Choice	★	—	Top
DHMP	★★★	▲	Moderate
Kaiser	★★	—	High
RMHP	★	—	Top
+ Indicates fewer than 100 responses. Caution should be exercised when evaluating these results.			

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

Table 3-3—Priority Assignments: Rating of All Health Care

Plan Name	NCQA Comparisons (Star Ratings)	Trend Analysis	Priority Assignment
Colorado Access	★★★★★	▲	Low
Colorado Choice	★	—	Top
DHMP	★★★★★	—	Low
Kaiser	★★★★★	—	Low
RMHP	★★★★★	▲	Low
+ Indicates fewer than 100 responses. Caution should be exercised when evaluating these results.			

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

Table 3-4—Priority Assignments: Rating of Personal Doctor

Plan Name	NCQA Comparisons (Star Ratings)	Trend Analysis	Priority Assignment
Colorado Access	★★★★★	—	Low
Colorado Choice	★★	—	High
DHMP	★★★★★	▲	Low
Kaiser	★★★★★	—	Low
RMHP	★★★★★	▲	Low
+ Indicates fewer than 100 responses. Caution should be exercised when evaluating these results.			

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

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

Plan Name	NCQA Comparisons (Star Ratings)	Trend Analysis	Priority Assignment
Colorado Access	★★★+	—	Moderate+
Colorado Choice	★★+	—	High+
DHMP	★★★★★+	—	Low+
Kaiser	★★+	—	High+
RMHP	★★★★★+	—	Low+
+ Indicates fewer than 100 responses. Caution should be exercised when evaluating these results.			

Composite Measures

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

Table 3-6—Priority Assignments: Getting Needed Care Composite

Plan Name	NCQA Comparisons (Star Ratings)	Trend Analysis	Priority Assignment
Colorado Access	★★	—	High
Colorado Choice	★★	—	High
DHMP	★	—	Top
Kaiser	★★★	—	Moderate
RMHP	★★★	—	Moderate
+ Indicates fewer than 100 responses. Caution should be exercised when evaluating these results.			

Table 3-7 shows the priority assignments for the Getting Care Quickly measure.

Table 3-7—Priority Assignments: Getting Care Quickly Composite

Plan Name	NCQA Comparisons (Star Ratings)	Trend Analysis	Priority Assignment
Colorado Access	★★★	—	Moderate
Colorado Choice	★★★	—	Moderate
DHMP	★	—	Top
Kaiser	★★★★	—	Moderate
RMHP	★★★★	—	Moderate
+ Indicates fewer than 100 responses. Caution should be exercised when evaluating these results.			

Table 3-8 shows the priority assignments for the How Well Doctors Communicate measure.

Table 3-8—Priority Assignments: How Well Doctors Communicate Composite

Plan Name	NCQA Comparisons (Star Ratings)	Trend Analysis	Priority Assignment
Colorado Access	★★★★★	▼	Moderate
Colorado Choice	★★★★	—	Moderate
DHMP	★★★★	▲	Low
Kaiser	★★★★★	—	Low
RMHP	★★★★★	—	Low
+ Indicates fewer than 100 responses. Caution should be exercised when evaluating these results.			

Table 3-9 shows the priority assignments for the Customer Service measure.

Table 3-9—Priority Assignments: Customer Service Composite

Plan Name	NCQA Comparisons (Star Ratings)	Trend Analysis	Priority Assignment
Colorado Access	★	—	Top
Colorado Choice	★+	—	Top+
DHMP	★	—	Top
Kaiser	★★★	—	Moderate
RMHP	★+	▲	Top+
+ Indicates fewer than 100 responses. Caution should be exercised when evaluating these results.			

Individual Item Measure

Table 3-10 shows the priority assignments for the Coordination of Care measure.

Table 3-10—Priority Assignments: Coordination of Care

Plan Name	NCQA Comparisons (Star Ratings)	Trend Analysis	Priority Assignment
Colorado Access	★★	—	High
Colorado Choice	★+	—	Top+
DHMP	★+	—	Top+
Kaiser	★★★★	—	Moderate
RMHP	★+	—	Top+
+ Indicates fewer than 100 responses. Caution should be exercised when evaluating these results.			

Quality Improvement Recommendations

In order to improve the overall priority assignment ratings, CHP+ plans could explore the following QI activities:

Perform Root Cause Analyses

The health plans could conduct root cause analyses of study indicators that have been identified as areas of low performance. This type of analysis is typically conducted to investigate process deficiencies and unexplained outcomes to identify causes and devise potential improvement strategies. If used to study deficiencies in care or services provided to members, root cause analyses would enable the health plans to better understand the nature and scope of problems, identify causes and their interrelationships, identify specific populations for targeted interventions, and establish potential performance improvement strategies and solutions. Methods commonly used to conduct root cause analyses include process flow mapping, which is used to define and analyze processes and identify opportunities for process improvement, and the four-stage Plan-Do-Study-Act (PDSA) problem-solving model used for continuous process improvement.[3-3]

Conduct Frequent Assessments of Targeted Interventions

Continuous quality improvement (CQI) is a cyclical, data-driven process in which small-scale, incremental changes are identified, implemented, and measured to improve a process or system, similar to the PDSA problem-solving model. Changes that demonstrate improvement can then be standardized and implemented on a broader scale. To support continuous, cyclical improvement, the health plans should frequently measure and monitor targeted interventions. Key data should be collected and reviewed regularly to provide timely, ongoing feedback regarding the effectiveness of interventions in achieving desired results. A variety of methods can be used for CQI data collection and analysis, including surveys, interviews, focus groups, "round table" sessions, document reviews, and benchmarking.

Facilitate Coordinated Care

Health plans should assist in facilitating the process of coordinated care between providers and care coordinators to ensure child clients are receiving the care and services most appropriate for their health care needs. Coordinated care is most effective when care coordinators and providers organize their efforts to deliver the same message to parents or caretakers of child clients. Parents or caretakers are more likely to play an active role in the management of their child's health care and benefit from care coordination efforts if they are receiving the same information from both care coordinator and providers. Improving the system-level coordination between providers and care coordinators will enhance the service and care received by parents or caretakers of child clients. Additionally, providing patient registries or clinical information systems that allow providers and care coordinators to enter information

[3-3] Plan-Do-Study-Act (PDSA) Worksheet. *Institute for Healthcare Improvement.* Available at: http://www.ihi.org/knowledge/Pages/Tools/PlanDoStudyActWorksheet.aspx. Accessed on: June 20, 2017.

on patients (e.g., notes from a telephone call with a parent or caretaker or a child's physician visit) can help reduce duplication of services and facilitate care coordination.

Access to Care

Health plans should identify potential barriers for parents or caretakers of child clients receiving appropriate access to care. Access to care issues include obtaining the care that the child and/or physician deemed necessary, obtaining timely urgent care, or locating a personal doctor for a child. The health plan should attempt to reduce any hindrances a parent or caretaker might encounter while seeking care for their child. 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 parent or caretaker of a child client 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.

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 parents' or caretakers' 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 parent or caretaker 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 parents or caretakers of child clients communicate back the information the physician has provided.

Accountability and Improvement of Care

Although the administration of the CAHPS survey takes place at the health plan level, the accountability for the performance lies at both the plan and provider network level. Table 3-11 provides a summary of the responsible parties for various aspects of care.[3-4]

Table 3-11—Accountability for Areas of Care

Domain	Composite Measures	Individual Item Measures	Who is Accountable?	
			Health Plan	Provider Network
Access	Getting Needed Care		✓	✓
	Getting Care Quickly			✓
Interpersonal Care	How Well Doctors Communicate	Coordination of Care		✓
	Shared Decision Making			✓
Plan Administrative Services	Customer Service	Health Promotion and Education	✓	✓
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 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.

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

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., PDSA) that allows for testing and analysis of interventions in order to assure that the desired results are achieved.

4. Reader's Guide

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

Survey Administration

Survey Overview

The survey instrument selected was the CAHPS 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 the Agency for Healthcare Research and Quality (AHRQ). The CAHPS questionnaires and consumer reports were developed under cooperative agreements among AHRQ, Harvard Medical School, RAND, and the Research Triangle Institute (RTI). In 1997, NCQA, in conjunction with AHRQ, created the CAHPS 2.0H Survey measure as part of NCQA's HEDIS.[4-1] In 2002, AHRQ convened the CAHPS Instrument Panel to re-evaluate and update the CAHPS Health Plan Surveys and to improve the state-of-the-art methods for assessing clients' experiences with care.[4-2] The result of this re-evaluation and update process was the development of the CAHPS 3.0H Health Plan Surveys. The goal of the CAHPS 3.0H Health Plan Surveys was to effectively and efficiently obtain information from the person receiving care. In 2006, AHRQ released the CAHPS 4.0 Health Plan Surveys. Based on the CAHPS 4.0 versions, NCQA introduced new HEDIS versions of the Adult Health Plan Survey in 2007 and the Child Health Plan Survey in 2009, which are referred to as the CAHPS 4.0H Health Plan Surveys.[4-3,4-4] In 2012, AHRQ released the CAHPS 5.0 Health Plan Surveys. Based on the CAHPS 5.0 versions, NCQA introduced new HEDIS versions of the Adult and Child Health Plan Surveys in August 2012, which are referred to as the CAHPS 5.0 Health Plan Surveys.[4-5]

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

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

The CAHPS 5.0 Child Medicaid Health Plan Survey 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., "Coordination of Care" and "Health Promotion and Education").

Table 4-1 lists the global ratings, composite measures, and individual item measures included in the CAHPS 5.0 Child Medicaid Health Plan Survey.

Table 4-1—CAHPS Measures

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

Sampling Procedures

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

- Were age 17 or younger as of December 31, 2016.
- Were currently enrolled in Colorado Access, Colorado Choice, DHMP, Kaiser, or RMHP.
- Had been continuously enrolled for at least five of the last six months of 2016.
- Had Medicaid as a payer.

Additionally, NCQA specifications require a sample size of 1,650 clients for the CAHPS 5.0 Child Medicaid Health Plan Survey. For Colorado Access, DHMP, Kaiser, and RMHP, a total random sample of 1,650 child clients was selected from these plans. Colorado Choice did not meet the minimum sample size criteria; therefore, 1,272 child clients were selected from Colorado Choice's eligible population. The selected survey samples were random samples with no more than one client being selected per household.

Survey Protocol

Table 4-2 shows the standard mixed mode (i.e., mail followed by telephone follow-up) CAHPS timeline used in the administration of the Colorado CAHPS 5.0 Child Medicaid Health Plan Surveys. The timeline is based on NCQA HEDIS Specifications for Survey Measures.[4-6]

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

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

The CAHPS 5.0 Health Plan Survey process allowed clients two methods by which they could complete a survey. The first phase, or mail phase, consisted of a survey being mailed to all sampled clients. For CHP+ plans, those clients who were identified as Spanish-speaking through administrative data were mailed a Spanish version of the survey. Clients that were not identified as Spanish-speaking received an English version of the survey. The English and Spanish versions of the survey included a toll-free number that clients could call to request a survey in another language (i.e., English or Spanish). A reminder postcard was sent to all non-respondents, followed by a second survey mailing and reminder postcard. The second phase, or telephone phase, consisted of CATI of sampled clients who had not mailed in a completed survey. A series of up to six CATI calls was made to each non-respondent. It has

[4-6] National Committee for Quality Assurance. *HEDIS® 2017, Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA Publication, 2016.

been shown that the addition of the telephone phase aids in the reduction of non-response bias by increasing the number of respondents who are more demographically representative of a plan's population.[4-7]

HSAG inspected a sample of the file records to check for any apparent problems with the files, such as missing address elements. The entire 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 specifications also require that the name of the plan appear in the questionnaires and cover letters; that the letters bear the signature of a high-ranking plan or state official; and that the questionnaire packages include a postage-paid reply envelope addressed to the organization conducting the surveys. HSAG followed these specifications.

Methodology

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

Response Rates

The administration of the CAHPS 5.0 Child Medicaid Health Plan Survey is comprehensive and is designed to achieve the highest possible response rate. NCQA defines the response rate as the total number of completed surveys divided by all eligible clients of the sample.[4-8] A client's survey was assigned a disposition code of "completed" if at least three of the following five questions were answered: 3, 15, 27, 31, and 36. Eligible clients include the entire sample minus ineligible clients. Ineligible clients of the sample met one or more of the following criteria: were deceased, were invalid (did not meet criteria described on page 4-2), or had a language barrier.

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

[4-7] 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.

[4-8] National Committee for Quality Assurance. *HEDIS® 2017, Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA Publication, 2016.

Child and Respondent Demographics

The demographic analysis evaluated child and self-reported demographic information from survey respondents.

Table 4-3 shows the survey question numbers that are associated with the respective demographic categories that were analyzed.

Table 4-3—Child and Respondent Demographic Items Analyzed

Demographic Category	Survey Question Number
Table 2-2—Child Demographic	
Age	39
Gender	40
Race	42
Ethnicity	41
General Health Status	36
Table 2-3—Respondent Demographic	
Respondent Age	43
Respondent Gender	44
Respondent Education	45
Relationship to Child	46

NCQA Comparisons

An analysis of the CAHPS Survey results was conducted using NCQA HEDIS Specifications for Survey Measures.[4-9] Per these specifications, no weighting or case-mix adjustment is performed on the results. NCQA requires a minimum of at least 100 responses on each item in order to obtain a reportable CAHPS Survey result. However, for purposes of this report, plans' results are reported for a CAHPS measure even when the NCQA minimum reporting threshold of 100 respondents was not met. Therefore, caution should be exercised when interpreting results for those measures with fewer than 100 respondents.

In order to perform the NCQA comparisons, a three-point mean score was determined for the four global ratings, four composite measures, and one individual item 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

[4-9] National Committee for Quality Assurance. *HEDIS® 2017, Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA Publication, 2016.

thresholds for the Shared Decision Making composite, and Health Promotion and Education individual item measure; 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 2017 Specifications for Survey Measures, Volume 3.

Table 4-4 shows the percentiles that were used to determine star ratings for each CAHPS measure.

Table 4-4—Star Ratings

Stars	Percentiles
★★★★★ Excellent	At or above the 90th percentile
★★★★ Very Good	At or between the 75th and 89th percentiles
★★★ Good	At or between the 50th and 74th percentiles
★★ Fair	At or between the 25th and 49th percentiles
★ Poor	Below the 25th percentile

Table 4-5 shows the benchmarks and thresholds used to derive the overall client satisfaction ratings on each CAHPS measure.[4-10]

Table 4-5—Overall Child Medicaid Client Satisfaction Ratings Crosswalk[4-11]

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	2.56	2.51	2.46	2.37
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	2.63	2.58	2.53	2.50
Coordination of Care	2.52	2.48	2.42	2.36

[4-10] National Committee for Quality Assurance. *HEDIS Benchmarks and Thresholds for Accreditation 2017*. Washington, DC: NCQA, May 4, 2017.

[4-11] NCQA's benchmarks and thresholds for the child Medicaid population were used to derive the overall satisfaction ratings; therefore, caution should be exercised when interpreting these results.

Trend Analysis

In order to evaluate trends in Colorado CHP+ client satisfaction, HSAG performed a stepwise three-year trend analysis. The first step compared the 2017 CAHPS results to the 2016 CAHPS results. If the initial 2017 and 2016 trend analysis did not yield any significant differences, then an additional trend analysis was performed between 2017 and 2015 results. For purposes of this analysis, question summary rates were calculated for each global rating and individual item measure, and global proportions were calculated for each composite measure. Both the question summary rates and global proportions were calculated in accordance with NCQA HEDIS Specifications for Survey Measures.[4-12] The scoring of the global ratings, composite measures, and individual item measures involved assigning top-level responses a score of one, with all other responses receiving a score of zero. After applying this scoring methodology, the percentage of top-level responses was calculated in order to determine the question summary rates and global proportions. For additional details, please refer to the NCQA HEDIS 2017 Specifications for Survey Measures, Volume 3.

A difference is considered statistically significant if the two-sided *p* value of the *t* test is less than 0.05. Scores that were statistically significantly higher in 2017 than in 2016 are noted with black upward (▲) triangles. Scores that were statistically significantly lower in 2017 than in 2016 are noted with black downward (▼) triangles. Scores that were statistically significantly higher in 2017 than in 2015 are noted with red upward (▲) triangles. Scores that were statistically significantly lower in 2017 than in 2015 are noted with red downward (▼) triangles. Scores in 2017 that were not statistically significantly different from scores in 2016 or in 2015 are not noted with triangles.

For purposes of this report, plans' results are reported for a CAHPS measure even when the NCQA minimum reporting threshold of 100 respondents was not met. Therefore, caution should be exercised when interpreting results for those measures with fewer than 100 respondents.

Weighting

For purposes of the trend analysis, HSAG calculated a weighted score for the Colorado CHP+ program. The 2015, 2016, and 2017 CAHPS scores for Colorado CHP+ were weighted based on each of the plan's total eligible CHP+ population for the corresponding year.

The weighted score was:

$$\mu = \sum_p w_p \mu_p$$

Where w_p is the weight for plan p.

[4-12] National Committee for Quality Assurance. *HEDIS® 2017, Volume 3: Specifications for Survey Measures*. Washington, DC: NCQA Publication, 2016.

Plan Comparisons

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

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

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

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

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

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

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

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

The variance of Δ_p was:

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

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

For the plan comparisons, no threshold number of responses was required for the results to be reported. Measures with less than 100 responses are denoted with a cross (+). Caution should be used when evaluating rates derived from fewer than 100 respondents.

Limitations and Cautions

The findings presented in this CAHPS report are subject to some limitations in the survey design, analysis, and interpretation. These limitations should be considered carefully when interpreting or generalizing the findings. These limitations are discussed below.

Case-Mix Adjustment

While data for the plan comparisons have been adjusted for differences in survey-reported general health status, age, and education, it was not possible to adjust for differences in member and respondent characteristics that were not measured. These characteristics include income, employment, or any other characteristics that may not be under the plans' control.

Non-Response Bias

The experiences of the survey respondent population may be different than that of non-respondents with respect to their health care services. Therefore, the potential for non-response bias should be considered when interpreting CAHPS results.

Causal Inferences

Although this report examines whether clients report differences in satisfaction with various aspects of their health care experiences, these differences may not be completely attributable to the CHP+ plan. The survey by itself does not necessarily reveal the exact cause of these differences.

Quality Improvement References

The CAHPS surveys were originally developed to meet the needs of consumers for usable, relevant information on quality of care from the clients' 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.[4-13]

AHRQ Health Care Innovations Exchange Web site. *Addressing Language Access Issues in Your Practice: A Toolkit for Physicians and Their Staff Members.* Available at: https://innovations.ahrq.gov/qualitytools/addressing-language-access-issues-your-practice-toolkit-physicians-and-their-staff. Accessed on: August 15, 2017.

AHRQ Health Care Innovations Exchange Web site. *Better Communication, Better Care: Provider Tools to Care for Diverse Populations.* Available at: https://innovations.ahrq.gov/qualitytools/better-communication-better-care-provider-tools-care-diverse-populations. Accessed on: August 15, 2017.

AHRQ Health Care Innovations Exchange Web site. *Expanding Interpreter Role to Include Advocacy and Care Coordination Improves Efficiency and Leads to High Patient and Provider Satisfaction*. Available at: https://innovations.ahrq.gov/profiles/expanding-interpreter-role-include-advocacy-and-care-coordination-improves-efficiency-and. Accessed on: August 15, 2017.

AHRQ Health Care Innovations Exchange Web site. *Improving Cultural Competency in Children's Health Care: Expanding Perspectives.* Available at: https://innovations.ahrq.gov/qualitytools/improving-cultural-competency-childrens-health-care-expanding-perspectives. Accessed on: August 15, 2017.

AHRQ Health Care Innovations Exchange Web site. *Improving Quality and Achieving Equity: A Guide for Hospital Leaders.* Available at: https://innovations.ahrq.gov/qualitytools/improving-quality-and-achieving-equity-guide-hospital-leaders. Accessed on: August 15, 2017.

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: https://innovations.ahrq.gov/profiles/interactive-workshops-enhance-access-health-education-and-screenings-improve-outcomes-low. Accessed on: August 15, 2017.

AHRQ Health Care Innovations Exchange Web site. *Online Tools and Services Activate Plan Enrollees and Engage Them in Their Care, Enhance Efficiency, and Improve Satisfaction and Retention*. Available at: https://innovations.ahrq.gov/profiles/online-tools-and-services-activate-plan-enrollees-and-engage-them-their-care-enhance. Accessed on: August 15, 2017.

[4-13] Agency for Healthcare Research and Quality. *Improving Patient Experience*. Available at: http://www.ahrq.gov/cahps/quality-improvement/index.html. Accessed on: August 15, 2017.

AHRQ Health Care Innovations Exchange Web site. *Health Plan's Comprehensive Strategy Involving Physician Incentives and Targeted Recruitment Enhances Patient Access to Language-Concordant Physicians.* Available at: https://innovations.ahrq.gov/profiles/health-plans-comprehensive-strategy-involving-physician-incentives-and-targeted-recruitment. Accessed on: August 15, 2017.

American Academy of Pediatrics Web site. *Open Access Scheduling*. Available at: https://www.aap.org/en-us/professional-resources/practice-transformation/managing-practice/Pages/open-access-scheduling.aspx. Accessed on: August 15, 2017.

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5. Survey Instrument

The survey instrument selected for the 2017 Colorado CHP+ Client Satisfaction Survey was the CAHPS 5.0 Child Medicaid Health Plan Survey with the HEDIS supplemental item set without CCC measurement set. This section provides a copy of the survey instrument.

COLORADO
Department of Health Care Policy & Financing

DataStat

Your privacy is protected. The research staff will not share your personal information with anyone without your OK. Personally identifiable information will not be made public and will only be released in accordance with federal laws and regulations.

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

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

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 in [HEALTH PLAN NAME/STATE MEDICAID PROGRAM NAME]. Is that right?**

○ Yes ➔ ***Go to Question 3***
○ No

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

_____

YOUR CHILD'S HEALTH CARE IN THE LAST 6 MONTHS

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

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

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

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

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

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

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

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

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

7. In the last 6 months, not counting the times your child went to an emergency room, how many times did he or she go to a doctor's office or clinic to get health care?

- ○ None ➔ ***Go to Question 15***
- ○ 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. Did you and a doctor or other health provider talk about the reasons you might want your child to take a medicine?

- ○ Yes
- ○ No

11. Did you and a doctor or other health provider talk about the reasons you might not want your child to take a medicine?

- ○ Yes
- ○ No

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. 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

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

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ 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?

- ○ Yes
- ○ 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?

- ○ None ➔ ***Go to Question 26***
- ○ 1 time
- ○ 2
- ○ 3
- ○ 4
- ○ 5 to 9
- ○ 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?

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

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

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

19. 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

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

- ○ Yes
- ○ 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?

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

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

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ 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?

- ○ Yes
- ○ 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?

- ○ Yes
- ○ 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?

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ 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?

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

Worst Personal Doctor Possible — Best Personal Doctor Possible

GETTING HEALTH CARE FROM SPECIALISTS

When you answer the next questions, do <u>not</u> include dental visits or care 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?

- ○ Yes
- ○ 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?

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

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

- ○ None ➔ ***Go to Question 31***
- ○ 1 specialist
- ○ 2
- ○ 3
- ○ 4
- ○ 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?

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

YOUR CHILD'S HEALTH PLAN

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

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

- ○ Yes
- ○ No ➔ ***Go to Question 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?

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ 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?

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

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

- ○ Yes
- ○ 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?

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ 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?

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

ABOUT YOUR CHILD AND YOU

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

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

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

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

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

- ○ Less than 1 year old

☐☐ YEARS OLD (write in)

40. Is your child male or female?

- ○ Male
- ○ Female

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

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

42. 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

43. 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

44. Are you male or female?

- ○ Male
- ○ Female

45. 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

46. How are you related to the child?

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

47. Did someone help you complete this survey?

- ○ Yes ➔ ***Go to Question 48***
- ○ No ➔ ***Go to Question 48a***

48. 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

ADDITIONAL QUESTIONS

48a. In the last 6 months, <u>not</u> counting the times your child needed health care right away, how many days did you usually have to wait between making an appointment and your child actually seeing a health provider?

- ○ Same day
- ○ 1 day
- ○ 2 to 3 days
- ○ 4 to 7 days
- ○ 8 to 14 days
- ○ 15 to 30 days
- ○ 31 to 60 days
- ○ 61 to 90 days
- ○ 91 days or longer
- ○ My child did not see a health provider in the last 6 months

48b. In the last 6 months, how often was it easy to get appointments for your child with specialists?

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ Always
- ○ My child did not see a specialist in the last 6 months

48c. Did this provider's office give you information about what to do if your child needed care during evenings, weekends, or holidays?

- ○ Yes
- ○ No

48d. In the last 6 months, how often were you able to get the care your child needed from his or her doctor or other health provider during evenings, weekends, or holidays?

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ Always
- ○ My child did not need care from his or her doctor or other health provider during evenings, weekends, or holidays in the last 6 months

48e. 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
- ○ My child did not see a doctor or other health provider in the last 6 months ➔ ***Thank you. Please return the completed survey in the postage-paid envelope.***

48f. In the last 6 months, did you and your child's doctor or other health provider talk about whether there are any problems in your household that might affect your child?

- ○ Yes
- ○ No
- ○ My child did not see a doctor or other health provider in the last 6 months

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

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

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