Colorado Child Health Plan *Plus* 2019 Member Experience Report

September 2019

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

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1. Executive Summary

Colorado's Quality Strategy includes the administration of surveys to members enrolled in the following Child Health Plan *Plus* (CHP+) health plans: Colorado Access, Denver Health Medical Plan (DHMP), Friday Health Plans of Colorado (FHP), 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 feedback that is actionable and will aid in improving members' overall experiences.

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 members from the CHP+ health plans completed the surveys from March to May 2019.

Performance Highlights

The Results section of this report details the CAHPS results for the CHP+ health plans. The following is a summary of the CHP+ CAHPS performance highlights for each health 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
- Key Drivers of Low Member Experience Analysis

[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 and Trend Analysis

HSAG compared scores for the CAHPS measures to NCQA's 2018 Quality Compass® Benchmark and Compare Quality Data.[1-3,1-4,1-5] This comparison resulted in overall member experience ratings (i.e., star ratings) of one (★) to five (★★★★★) stars on these CAHPS measures, where one star was the lowest possible rating and five stars was the highest possible rating.[1-6] The detailed results of this comparative analysis are described in the Results section beginning on page 2-5.

In addition, HSAG performed a stepwise trend analysis. First, HSAG compared the 2019 CAHPS results to the 2018 CAHPS results. If the initial 2019 and 2018 trend analysis did not yield any statistically significant differences, then HSAG performed an additional trend analysis between the 2019 and 2017 results. The detailed results of the trend analysis are described in the Results section beginning on page 2-7. Table 1-1, on the following page, presents the highlights from the NCQA Comparisons and Trend Analysis for the Colorado CHP+ Program.

[1-3] National Committee for Quality Assurance. *Quality Compass®: Benchmark and Compare Quality Data 2018.* Washington, DC: NCQA, September 2018.

[1-4] The source for the benchmark and compare quality data used for this comparative analysis is Quality Compass® 2018 data and is used with the permission of the National Committee for Quality Assurance (NCQA). Quality Compass® 2018 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).

[1-5] In 2019, HSAG changed the benchmarking source for the NCQA Comparisons analysis from previous reports; therefore, results may not be comparable to previous years.

[1-6] NCQA's benchmarks for the general child Medicaid population were used to derive the overall member experience ratings; therefore, caution should be exercised when interpreting these results.

Table 1-1—NCQA Comparisons Highlights: Colorado CHP+ Program

Measure	National Comparisons	Trend Analysis
Global Ratings		
Rating of Health Plan	★ 67.1%	▲
Rating of All Health Care	★★ 67.1%	—
Rating of Personal Doctor	★★★ 76.6%	—
Rating of Specialist Seen Most Often	★★★★ 77.9%	—
Composite Measures		
Getting Needed Care	★★★ 87.1%	—
Getting Care Quickly	★★★ 90.5%	—
How Well Doctors Communicate	★★★ 95.4%	—
Customer Service	★ 84.0%	—
Shared Decision Making	★★★ 80.4%	—
Individual Item Measures		
Coordination of Care	★★★ 83.9%	—
Health Promotion and Education	★ 70.0%	—

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

▲ *Indicates the 2019 score is statistically significantly higher than the 2018 score.*

▼ *Indicates the 2019 score is statistically significantly lower than the 2018 score.*

▲ *Indicates the 2019 score is statistically significantly higher than the 2017 score.*

▼ *Indicates the 2019 score is statistically significantly lower than the 2017 score.*

— *Indicates the 2019 score is not statistically significantly different than the 2018 or the 2017 scores.*

The following are highlights of the NCQA Comparisons:

- The Colorado CHP+ Program scored at or between the 75th and 89th percentiles on one measure, Rating of Specialist Seen Most Often.
- The Colorado CHP+ Program scored at or between the 50th and 74th percentiles on six measures: Rating of Personal Doctor, Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, Shared Decision Making, and Coordination of Care.

- The Colorado CHP+ Program scored at or between the 25th and 49th percentiles on one measure, Rating of All Health Care.
- The Colorado CHP+ Program scored below the 25th percentile on three measures: Rating of Health Plan, Customer Service, and Health Promotion and Education.

The following are highlights of the trend analysis:

- The Colorado CHP+ Program scored statistically significantly *higher* in 2019 than 2018 on one measure, Rating of Health Plan.

Plan Comparisons

In order to identify performance differences in members' experiences between the Colorado CHP+ health plans, HSAG compared the case-mix adjusted results for each health plan to one another using standard statistical tests.[1-7] The detailed results of the comparative analysis are described in the Results section beginning on page 2-21. Table 1-2 presents the health plans with statistically significant results from this comparison.[1-8]

Table 1-2—Plan Comparisons Highlights

Colorado Access	DHMP	FHP	Kaiser	RMHP
↑ Rating of Health Plan	—	↓ Rating of All Health Care	↑ How Well Doctors Communicate	↑ How Well Doctors Communicate
—	—	↓ Rating of Health Plan	↑ Rating of Personal Doctor	↑ Rating of Health Plan

↑ *Indicates the plan's score is statistically significantly higher than the State Average.*
↓ *Indicates the plan's score is statistically significantly lower than the State Average.*
— *Indicates the plan's score is not statistically significantly different than the State Average.*

The following are the highlights of the plan comparisons:

- The following plans had two measures that were statistically significantly *higher* than the Colorado CHP+ Program average: Kaiser and RMHP.
- The following plan had one measure that was statistically significantly *higher* than the Colorado CHP+ Program average, Colorado Access.
- The following plan had two measures that were statistically significantly *lower* than the Colorado CHP+ Program average, FHP.

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

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

Key Drivers of Low Member Experience Analysis

In order to determine factors that are contributing to members' low ratings of experience, HSAG focused the key drivers of low member experience analysis on the following three global ratings: Rating of Health Plan, Rating of All Health Care, and Rating of Personal Doctor. The detailed results are described in the Key Drivers of Low Member Experience Analysis section beginning on page 3-1. Table 1-3 shows the "key driver" items (as indicated by a ✓) for each global rating for the Colorado CHP+ Program.

Table 1-3—Key Drivers of Low Member Experience Highlights: Colorado CHP+ Program

Key Drivers	Rating of Health Plan	Rating of All Health Care	Rating of Personal Doctor
Respondents reported that it was not always easy to get the care, tests, or treatment they thought their child needed through their health plan.	✓	✓	✓
Respondents reported that their child's personal doctor did not talk with them about how their child is feeling, growing, or behaving.			✓
Respondents reported that their child's personal doctor did not always seem informed and up-to-date about the care their child received from other doctors or health providers.	✓	✓	✓
Respondents reported that it was often not easy for their child to obtain appointments with specialists.	✓		
Respondents reported that their child's health plan's customer service did not always give them the information or help they needed.	✓	✓	
Respondents reported that forms from their child's health plan were often not easy to fill out.	✓		

2. Results

Survey Administration and Response Rates

Survey Administration

The standard NCQA HEDIS Specifications for Survey Measures require a sample size of 1,650 members for the CAHPS 5.0 Child Medicaid Health Plan Survey.[2-1] Members eligible for sampling included those who were enrolled in Colorado Access, DHMP, FHP, Kaiser, and RMHP at the time the sample was drawn, and who were continuously enrolled in the health plan for at least five of the last six months (July through December) of 2018. Child members eligible for sampling included those who were 17 years of age or younger as of December 31, 2018.

Colorado Access, DHMP, Kaiser, and RMHP met the minimum sample size of 1,650. However, FHP 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 FHP was 1,176. Oversampling was not performed for any of the CHP+ health plans.

The survey administration protocol was designed to achieve a high response rate from members, thus minimizing the potential effects of non-response bias. The survey process allowed for two methods by which surveys could be completed. The first phase, or mail phase, consisted of an English or Spanish survey being mailed to the sampled members. 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 members who had not mailed in a completed survey. Additional information on the survey protocol is included in the Reader's Guide section beginning on page 5-3.

[2-1] National Committee for Quality Assurance. *HEDIS® 2019, Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA; 2018.

Response Rates

The CAHPS survey response rate is the total number of completed surveys divided by all eligible members of the sample. For additional information on the calculation of response rates, please refer to the Reader's Guide section on page 5-4. Table 2-1 depicts the sample distribution and response rates for all participating health plans and the Colorado CHP+ Program.

Table 2-1—Sample Distribution and Response Rate

Plan Name	Total Sample	Ineligible Records	Eligible Sample	Total Respondents	Response Rate
Colorado CHP+ Program	**7,776**	**183**	**7,593**	**1,922**	**25.31%**
Colorado Access	1,650	46	1,604	398	24.81%
DHMP	1,650	49	1,601	366	22.86%
FHP	1,176	24	1,152	240	20.83%
Kaiser	1,650	39	1,611	413	25.64%
RMHP	1,650	25	1,625	505	31.08%

Child and Respondent Demographics

In general, the demographics of a response group influence overall member experience scores. For example, older and healthier respondents tend to report higher levels of member experience; therefore, caution should be exercised when comparing populations that have significantly different demographic properties.[2-2] Table 2-2 shows the demographic characteristics of children for whom a parent/caretaker completed a survey.

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

	Colorado CHP+ Program	Colorado Access	DHMP	FHP	Kaiser	RMHP
Age						
Less than 1	0.3%	0.5%	0.0%	0.8%	0.0%	0.4%
1 to 3	12.1%	10.4%	10.4%	16.5%	11.9%	12.7%
4 to 7	24.8%	27.2%	23.5%	26.7%	21.5%	25.6%
8 to 12	31.0%	29.3%	31.7%	26.7%	30.4%	34.4%
13 to 18*	31.8%	32.6%	34.5%	29.2%	36.1%	27.0%
Gender						
Male	51.3%	51.3%	51.0%	55.3%	50.4%	50.4%
Female	48.7%	48.7%	49.0%	44.7%	49.6%	49.6%
Race						
Multi-Racial	10.9%	11.9%	12.6%	13.5%	10.4%	8.1%
White	66.7%	69.8%	46.9%	75.2%	60.4%	78.0%
Black	4.5%	3.2%	8.5%	0.4%	10.2%	0.2%
Asian	5.3%	5.2%	9.5%	0.9%	9.1%	1.7%
Other**	12.6%	9.9%	22.4%	10.0%	9.9%	12.0%
Ethnicity						
Hispanic	48.6%	51.8%	72.5%	38.5%	40.7%	40.4%
Non-Hispanic	51.4%	48.2%	27.5%	61.5%	59.3%	59.6%
General Health Status						
Excellent	45.9%	43.2%	43.2%	50.2%	46.1%	48.0%
Very Good	35.0%	38.4%	31.5%	35.4%	34.1%	35.5%
Good	15.7%	13.8%	20.9%	12.7%	16.4%	14.3%
Fair	3.3%	4.5%	4.5%	1.3%	3.4%	2.2%
Poor	0.1%	0.0%	0.0%	0.4%	0.0%	0.0%

Please note: Percentages may not total 100% due to rounding.
**Children are eligible for inclusion in CAHPS if they are age 17 or younger as of December 31, 2018. Some children eligible for the CAHPS survey turned age 18 between January 1, 2019, and the time of survey administration.*
***The "Other" category includes responses of Native Hawaiian or Other Pacific Islander, American Indian or Alaska Native, and Other.*

[2-2] 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 survey.

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

	Colorado CHP+ Program	Colorado Access	DHMP	FHP	Kaiser	RMHP
Respondent Age						
Under 18	4.7%	4.0%	4.5%	5.3%	7.0%	3.3%
18 to 24	2.4%	2.4%	1.4%	3.5%	2.5%	2.5%
25 to 34	24.1%	25.4%	22.4%	31.1%	17.2%	26.8%
35 to 44	44.8%	48.4%	47.6%	39.5%	41.6%	44.9%
45 to 54	19.7%	17.2%	20.4%	15.8%	25.2%	18.4%
55 to 64	3.7%	1.6%	3.1%	4.4%	5.7%	3.9%
65 or Older	0.6%	1.1%	0.6%	0.4%	0.7%	0.2%
Respondent Gender						
Male	15.0%	15.4%	17.9%	11.1%	19.5%	10.7%
Female	85.0%	84.6%	82.1%	88.9%	80.5%	89.3%
Respondent Education						
8th Grade or Less	10.1%	10.8%	20.1%	6.0%	5.4%	8.1%
Some High School	9.9%	11.1%	17.2%	3.9%	6.7%	9.1%
High School Graduate	26.0%	24.2%	32.1%	22.4%	26.2%	24.7%
Some College	25.9%	26.8%	18.3%	35.8%	26.5%	25.3%
College Graduate	28.2%	27.1%	12.3%	31.9%	35.1%	32.8%
Relationship to Child						
Mother or Father	99.1%	99.0%	98.9%	97.9%	99.5%	99.6%
Grandparent	0.3%	0.3%	0.3%	0.9%	0.2%	0.0%
Legal Guardian	0.3%	0.3%	0.3%	0.9%	0.2%	0.0%
Other	0.4%	0.5%	0.6%	0.4%	0.0%	0.4%
Please note: Percentages may not total 100% due to rounding.						

NCQA Comparisons

In order to assess the overall performance of the CHP+ health plans, HSAG compared the scores for each measure to NCQA's 2018 Quality Compass Benchmark and Compare Quality Data.[2-3,2-4,2-5] Based on this comparison, HSAG determined overall member experience ratings (i.e., star ratings) of one (★) to five (★★★★★) stars for each CAHPS measure, where one star is the lowest possible rating (i.e., Poor) and five stars is the highest possible rating (i.e., Excellent) as shown in Table 2-4.[2-6] For details on the calculation of this comparative analysis, please refer to the Reader's Guide section beginning on page 5-5.

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

2-3 National Committee for Quality Assurance. *Quality Compass®: Benchmark and Compare Quality Data 2018.* Washington, DC: NCQA, September 2018.

2-4 Quality Compass® data were not available for 2019 at the time this report was prepared; therefore, 2018 data were used for this comparative analysis.

2-5 In 2019, HSAG changed the benchmarking source for the NCQA Comparisons analysis from previous reports; therefore, results may not be comparable to previous years.

2-6 NCQA's benchmarks and thresholds for the general child Medicaid population were used to derive the overall member experience ratings; therefore, caution should be exercised when interpreting these results.

Table 2-5 shows the health plans' scores and overall member experience ratings for each measure.

Table 2-5—NCQA Comparisons: Overall Member Experience Ratings

	Colorado CHP+ Program	Colorado Access	DHMP	FHP	Kaiser	RMHP
Global Ratings						
Rating of Health Plan	★ 67.1%	★★ 69.3%	★ 65.4%	★ 55.2%	★ 60.9%	★ 68.3%
Rating of All Health Care	★★ 67.1%	★★ 67.7%	★★ 69.2%	★ 50.6%	★★ 67.2%	★★ 67.7%
Rating of Personal Doctor	★★★ 76.6%	★★★ 78.0%	★★ 75.7%	★ 71.0%	★★★ 78.1%	★ 71.2%
Rating of Specialist Seen Most Often	★★★★ 77.9%	★★★★+ 77.1%	★★★★★+ 85.3%	★★+ 71.1%	★★+ 73.3%	★★★★★+ 82.9%
Composite Measures						
Getting Needed Care	★★★ 87.1%	★★★ 87.7%	★ 79.7%	★★★★+ 90.1%	★★★ 85.5%	★★★★ 90.1%
Getting Care Quickly	★★★ 90.5%	★★★ 90.5%	★ 85.0%	★★★+ 91.0%	★★★ 90.8%	★★★★ 93.3%
How Well Doctors Communicate	★★★ 95.4%	★★★ 94.8%	★★★ 94.4%	★★ 92.9%	★★★★★ 97.8%	★★★★★ 97.1%
Customer Service	★ 84.0%	★ 81.9%	★★ 87.8%	★+ 84.0%	★ 86.5%	★★ 87.9%
Shared Decision Making	★★★ 80.4%	★★★+ 79.6%	★+ 72.8%	★★★+ 80.4%	★★★★★+ 84.9%	★★★★★+ 84.8%
Individual Item Measures						
Coordination of Care	★★★ 83.9%	★★★+ 83.8%	★★★+ 83.1%	★+ 79.7%	★★★★ 88.2%	★★ 81.7%
Health Promotion and Education	★ 70.0%	★ 68.7%	★★ 71.7%	★★ 71.2%	★★★ 73.8%	★★ 70.8%
+ Indicates fewer than 100 responses. Caution should be exercised when evaluating these results.						

Trend Analysis

Table 2-6 shows the number of completed surveys in 2017, 2018, and 2019.[2-7]

Table 2-6—Completed Surveys in 2017, 2018, and 2019

Plan Name	2017	2018	2019
Colorado Access	497	412	398
DHMP	504	355	366
FHP	353	274	240
Kaiser	526	340	413
RMHP	485	533	505
Total Respondents	**2,365**	**1,914**	**1,922**

HSAG used the completed surveys and corresponding health plans' 2017, 2018, and 2019 CAHPS results presented in this section for trending purposes. Additionally, the Colorado CHP+ Program's 2017, 2018, and 2019 CAHPS results were weighted based on the total eligible population of each health plan's CHP+ population.

Scoring involved assigning top-box responses a score of one, with all other responses receiving a score of zero.[2-8] After applying this scoring methodology, HSAG calculated the percentage of top-box responses in order to determine the top-box scores. For additional details, please refer to the Reader's Guide section beginning on page 5-6. NCQA national averages for the child Medicaid population and CAHPS Database benchmarks for the Children's Health Insurance Program (CHIP) population are presented for comparative purposes, where available.[2-9,2-10,2-11,2-12] For additional details, please refer to the *NCQA HEDIS 2019 Specifications for Survey Measures, Volume 3*.

2-7 FHP was referred to as Colorado Choice in 2017. Colorado Choice was acquired by FHP in November 2017.

2-8 National Committee for Quality Assurance. *HEDIS® 2019, Volume 3: Specifications for Survey Measures*. Washington, DC: NCQA; 2018.

2-9 The source for the NCQA national averages contained in this publication is Quality Compass® 2018 data and is used with the permission of the National Committee for Quality Assurance (NCQA). NCQA Quality Compass national averages for the child Medicaid population are used for comparative purposes, since NCQA does not publish separate benchmarking data for the CHIP population. Quality Compass® 2018 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).

2-10 The CAHPS Database is the repository for data from selected CAHPS surveys, which is collected through participating organizations. The CAHPS Health Plan Survey Database does not produce benchmarks for the Shared Decision Making composite measure, and the Coordination of Care and Health Promotion and Education individual item measures; therefore, CAHPS Database benchmarks are not presented for these measures. These benchmarks are displayed with "2018 CAHPS Database Benchmark Not Available" in the bars of the figures.

2-11 Agency for Healthcare Research and Quality. Aggregated Data: Health Plans. Available at: https://cahpsdatabase.ahrq.gov/CAHPSIDB/HP/about.aspx. Accessed on: August 1, 2019.

2-12 CAHPS Database benchmarks and NCQA national averages were not available for 2019 at the time this report was prepared; therefore, 2018 benchmarks and national data are presented in this section.

In order to evaluate trends in CHP+ member experience, HSAG performed a stepwise three-year trend analysis. First, HSAG compared the 2019 Colorado CHP+ and plan-level CAHPS scores to the corresponding 2018 scores. If the initial 2019 and 2018 trend analysis did not yield any statistically significant differences, then HSAG performed an additional trend analysis between the 2019 and 2017 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 2019 than in 2018 are noted with black upward (▲) triangles. Scores that were statistically significantly lower in 2019 than in 2018 are noted with black downward (▼) triangles. Scores that were statistically significantly higher in 2019 than in 2017 are noted with red upward (▲) triangles. Scores that were statistically significantly lower in 2019 than in 2017 are noted with red downward (▼) triangles. Scores in 2019 that were not statistically significantly different from scores in 2018 or in 2017 are not noted with triangles.

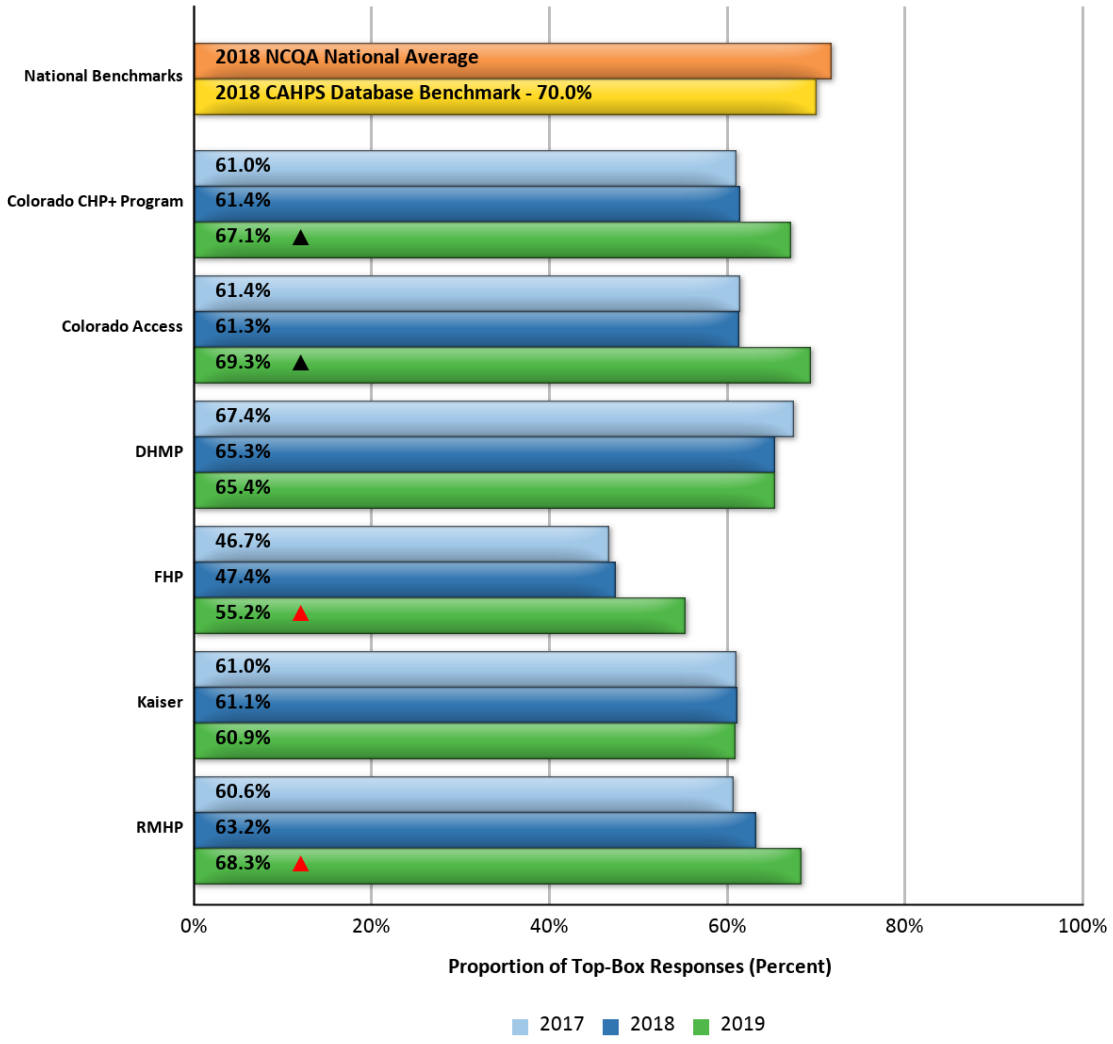
CAHPS scores with fewer than 100 respondents are denoted with a cross (+). Caution should be exercised when interpreting results for those measures with fewer than 100 respondents.

Global Ratings

Rating of Health Plan

Colorado CHP+ parents/caretakers of child members 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-box responses were defined as those responses with a rating of "9" or "10." Figure 2-1 shows the 2018 NCQA national average, the 2018 CAHPS Database Benchmark, and the top-box scores for the Rating of Health Plan global rating.

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

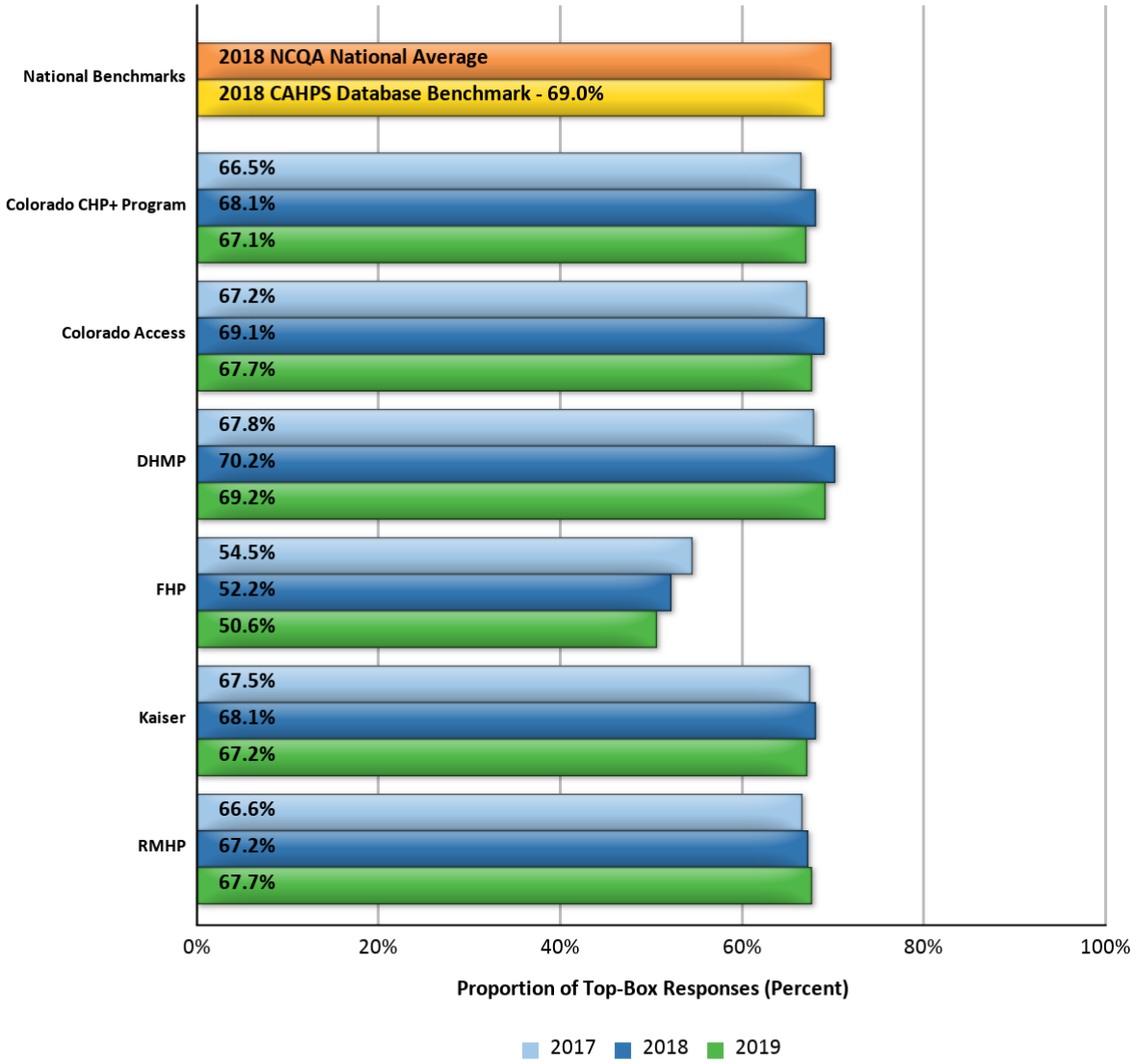


Statistical Significance Note: ▲ Indicates the 2019 score is statistically significantly higher than the 2018 score.
▼ Indicates the 2019 score is statistically significantly lower than the 2018 score.
▲ Indicates the 2019 score is statistically significantly higher than the 2017 score.
▼ Indicates the 2019 score is statistically significantly lower than the 2017 score.
If no statistically significant differences were found, no indicators (▲,▼ or ▲,▼) appear on the figure.

Rating of All Health Care

Colorado CHP+ parents/caretakers of child members 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-box responses were defined as those responses with a rating of "9" or "10." Figure 2-2 shows the 2018 NCQA national average, the 2018 CAHPS Database Benchmark, and the top-box scores for the Rating of All Health Care global rating.

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

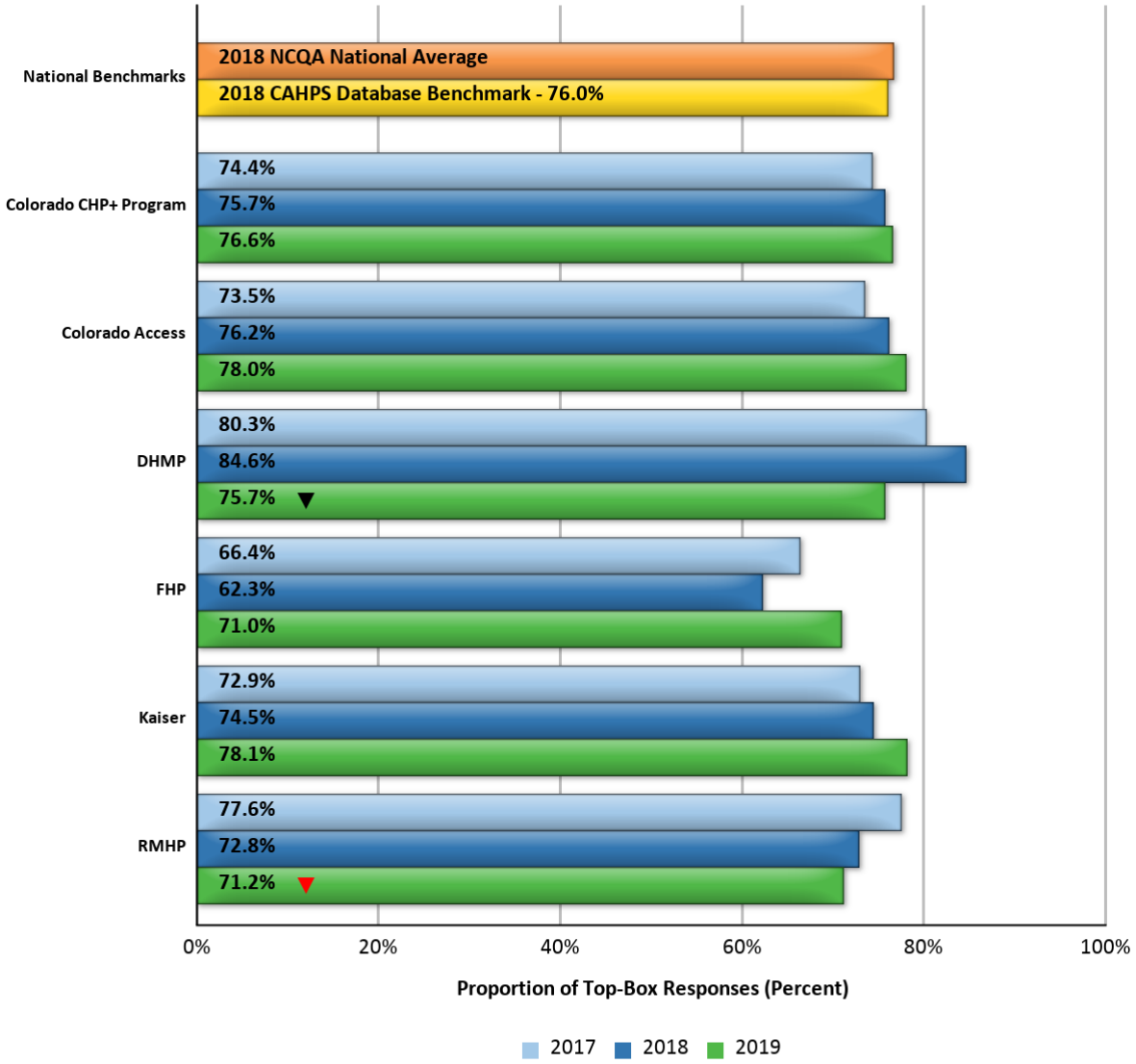


Statistical Significance Note: ▲ Indicates the 2019 score is statistically significantly higher than the 2018 score.
▼ Indicates the 2019 score is statistically significantly lower than the 2018 score.
▲ Indicates the 2019 score is statistically significantly higher than the 2017 score.
▼ Indicates the 2019 score is statistically significantly lower than the 2017 score.
If no statistically significant differences were found, no indicators (▲,▼ or ▲,▼) appear on the figure.

Rating of Personal Doctor

Colorado CHP+ parents/caretakers of child members 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-box responses were defined as those responses with a rating of "9" or "10." Figure 2-3 shows the 2018 NCQA national average, the 2018 CAHPS Database Benchmark, and the top-box scores for the Rating of Personal Doctor global rating.

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



Statistical Significance Note:
▲ Indicates the 2019 score is statistically significantly higher than the 2018 score.
▼ Indicates the 2019 score is statistically significantly lower than the 2018 score.
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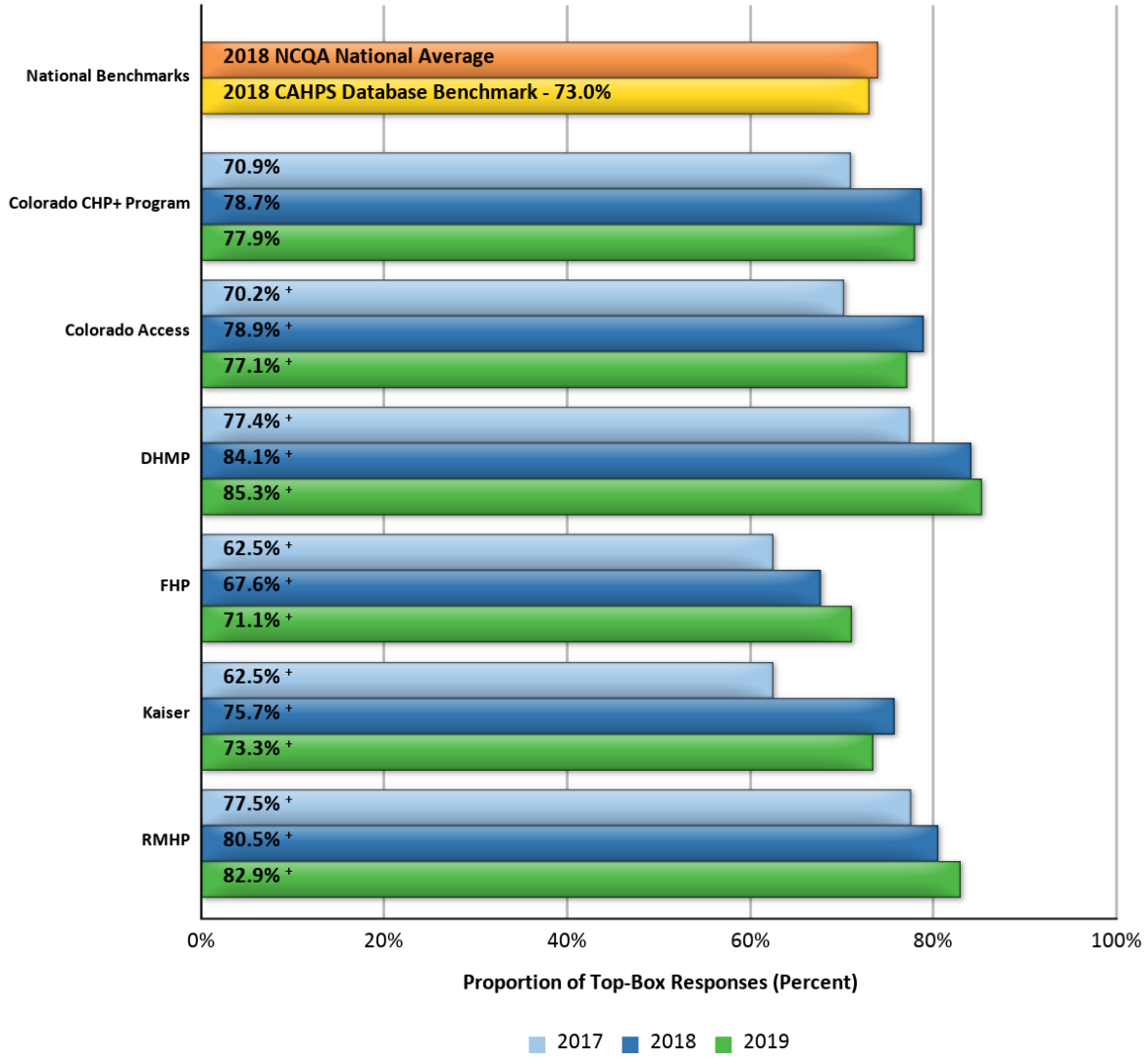
If no statistically significant differences were found, no indicators (▲,▼ or ▲,▼) appear on the figure.

Rating of Specialist Seen Most Often

Colorado CHP+ parents/caretakers of child members 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-box responses were defined as those responses with a rating of "9" or "10." Figure 2-4 shows the 2018 NCQA national average, the 2018 CAHPS Database Benchmark, and the top-box scores for the Rating of Specialist Seen Most Often global rating.

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



Statistical Significance Note: ▲ Indicates the 2019 score is statistically significantly higher than the 2018 score.
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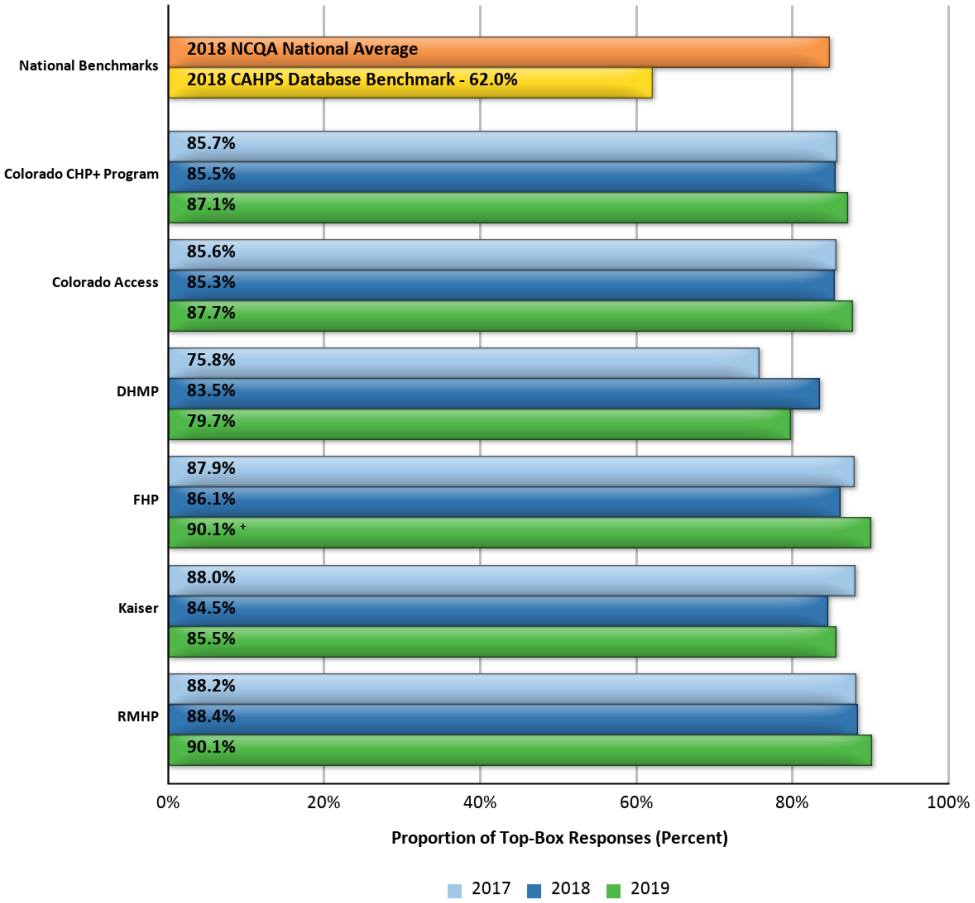
+ Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.

Composite Measures

Getting Needed Care

Colorado CHP+ parents/caretakers of child members 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-box response was defined as a response of "Usually" or "Always."[2-13] Figure 2-5 shows the 2018 NCQA national average, the 2018 CAHPS Database Benchmark, and the top-box scores for the Getting Needed Care composite measure.

Figure 2-5—Composite Measure: Getting Needed Care



Statistical Significance Note: ▲ Indicates the 2019 score is statistically significantly higher than the 2018 score.
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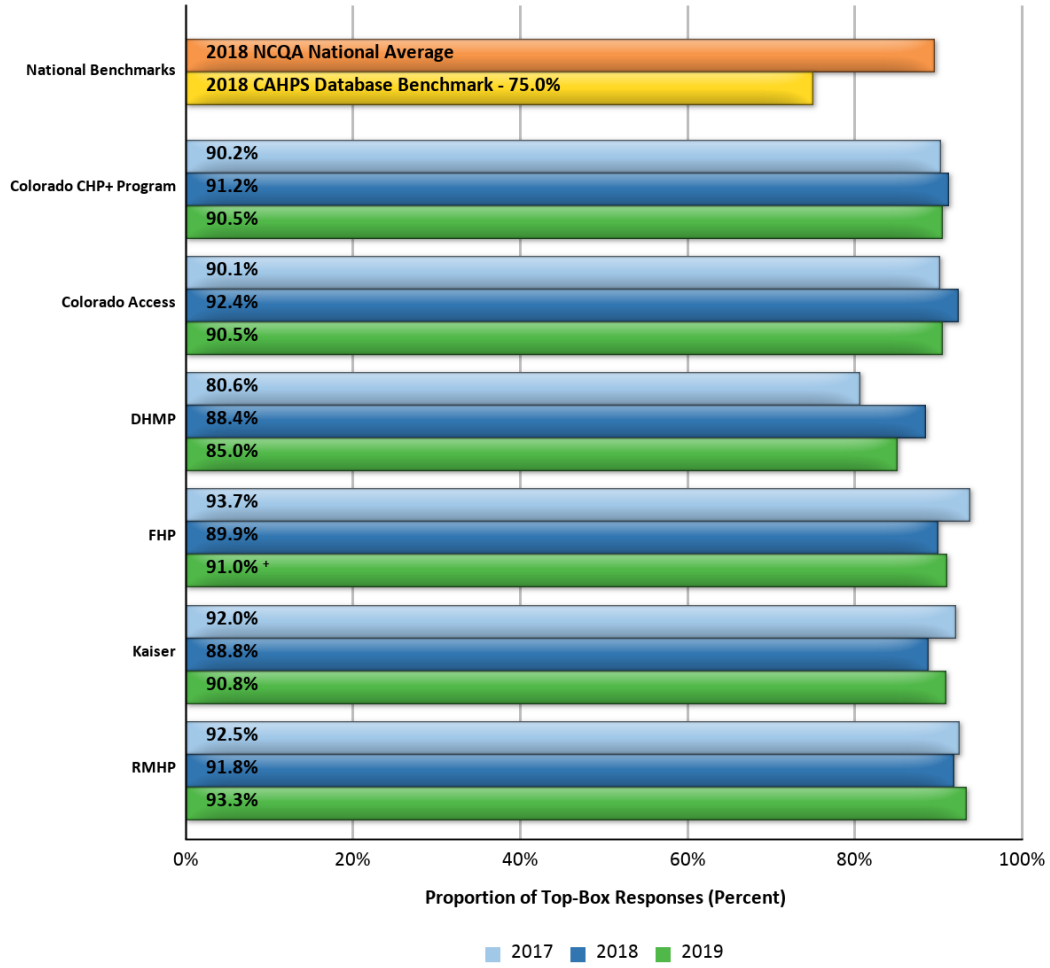
[2-13] The CAHPS Health Plan Survey Database defines a top-box response as "Always;" therefore, caution should be exercised when comparing the top-box scores to the 2018 CAHPS Database Benchmark for this measure.

Getting Care Quickly

Colorado CHP+ parents/caretakers of child members were asked two questions to assess how often their child received care quickly. For each of these questions (Questions 4 and 6), a top-box response was defined as a response of "Usually" or "Always."[2-14] Figure 2-6 shows the 2018 NCQA national average, the 2018 CAHPS Database Benchmark, and the top-box scores for the Getting Care Quickly composite measure.

Figure 2-6—Composite Measure: Getting Care Quickly



Statistical Significance Note: ▲ Indicates the 2019 score is statistically significantly higher than the 2018 score.
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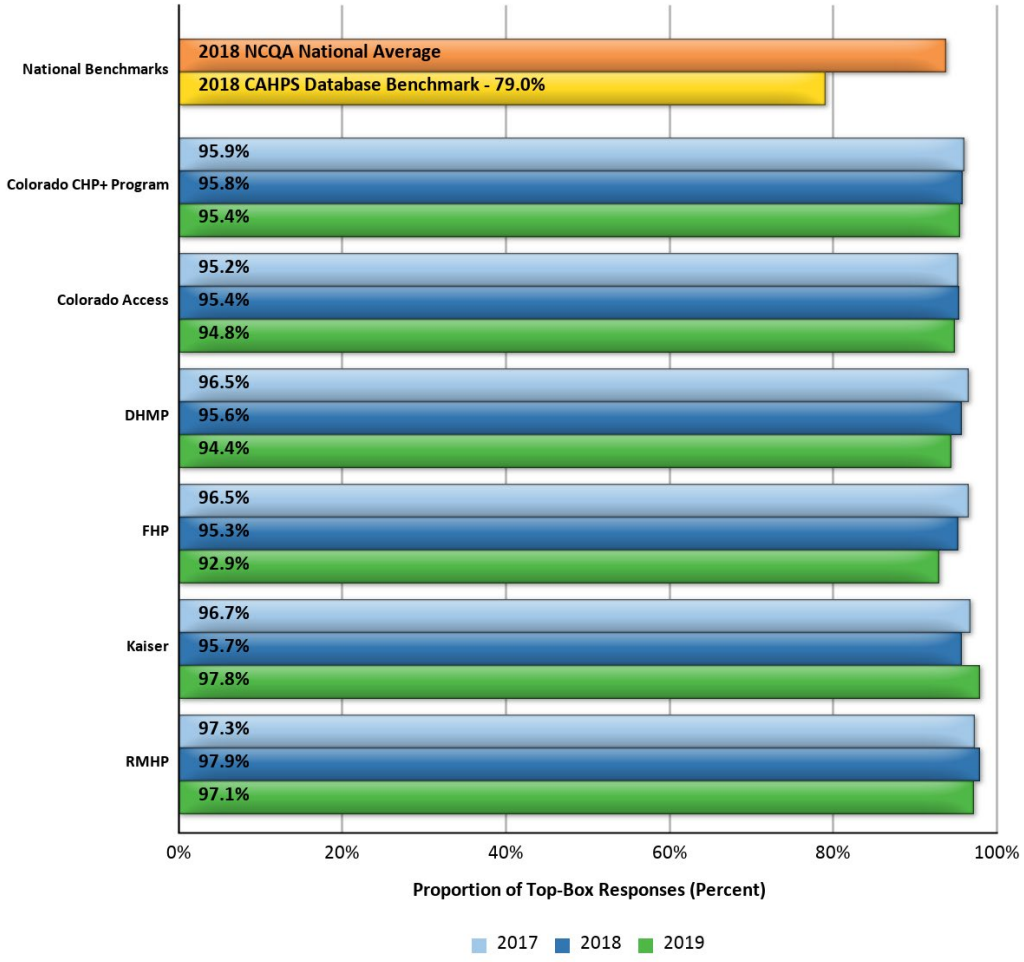
[2-14] The CAHPS Health Plan Survey Database defines a top-box response as "Always;" therefore, caution should be exercised when comparing the top-box scores to the 2018 CAHPS Database Benchmark for this measure.

How Well Doctors Communicate

Colorado CHP+ parents/caretakers of child members 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-box response was defined as a response of "Usually" or "Always."[2-15] Figure 2-7 shows the 2018 NCQA national average, the 2018 CAHPS Database Benchmark, and the top-box scores for the How Well Doctors Communicate composite measure.

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



Statistical Significance Note: ▲ Indicates the 2019 score is statistically significantly higher than the 2018 score.
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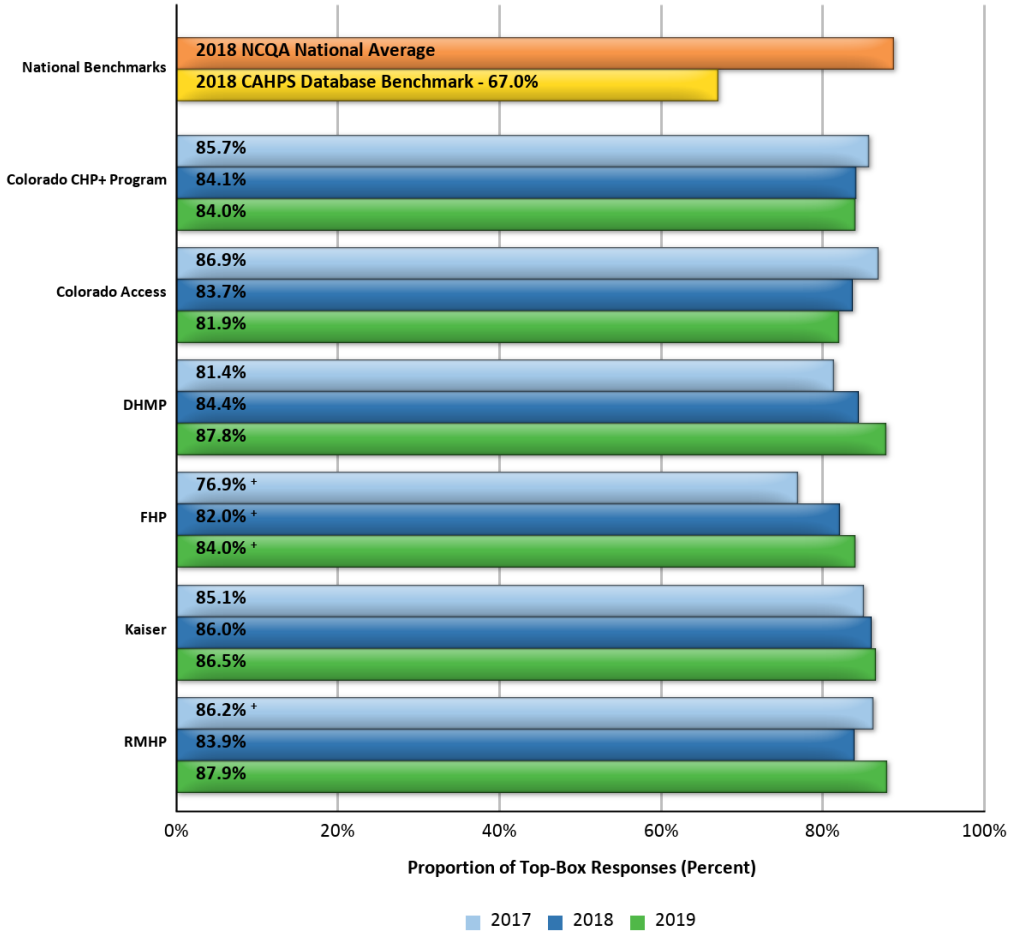
[2-15] The CAHPS Health Plan Survey Database defines a top-box response as "Always;" therefore, caution should be exercised when comparing the top-box scores to the 2018 CAHPS Database Benchmark for this measure.

Customer Service

Colorado CHP+ parents/caretakers of child members 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-box response was defined as a response of "Usually" or "Always."[2-16] Figure 2-8 shows the 2018 NCQA national average, the 2018 CAHPS Database Benchmark, and the top-box scores for the Customer Service composite measure.

Figure 2-8—Composite Measure: Customer Service



Statistical Significance Note: ▲ Indicates the 2019 score is statistically significantly higher than the 2018 score.
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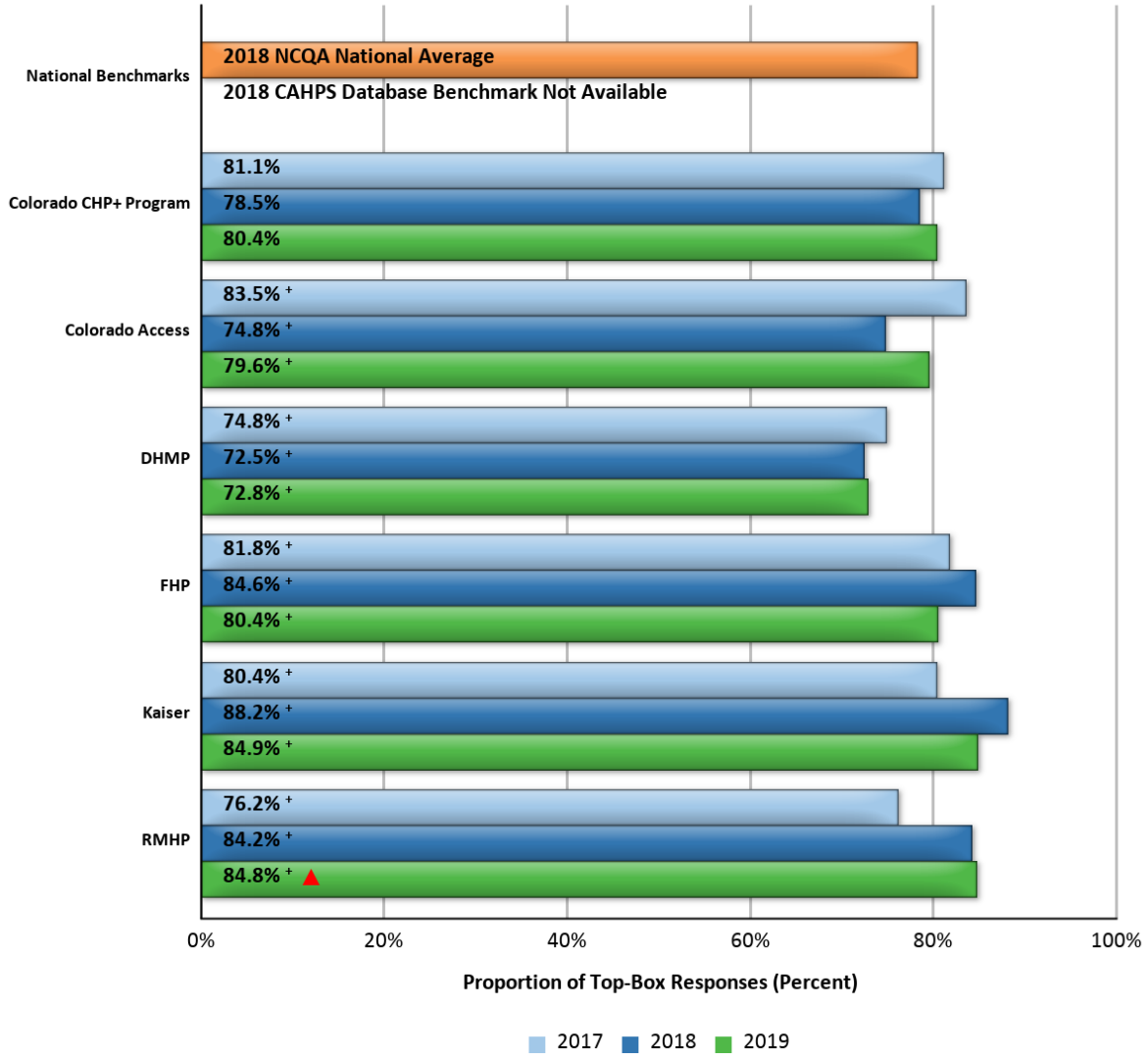
[2-16] The CAHPS Health Plan Survey Database defines a top-box response as "Always;" therefore, caution should be exercised when comparing the top-box scores to the 2018 CAHPS Database Benchmark for this measure.

Shared Decision Making

Colorado CHP+ parents/caretakers of child members 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-box response was defined as a response of "Yes." Figure 2-9 shows the 2018 NCQA national average and the top-box scores for the Shared Decision Making composite measure.

Figure 2-9—Composite Measure: Shared Decision Making



Statistical Significance Note: ▲ Indicates the 2019 score is statistically significantly higher than the 2018 score.
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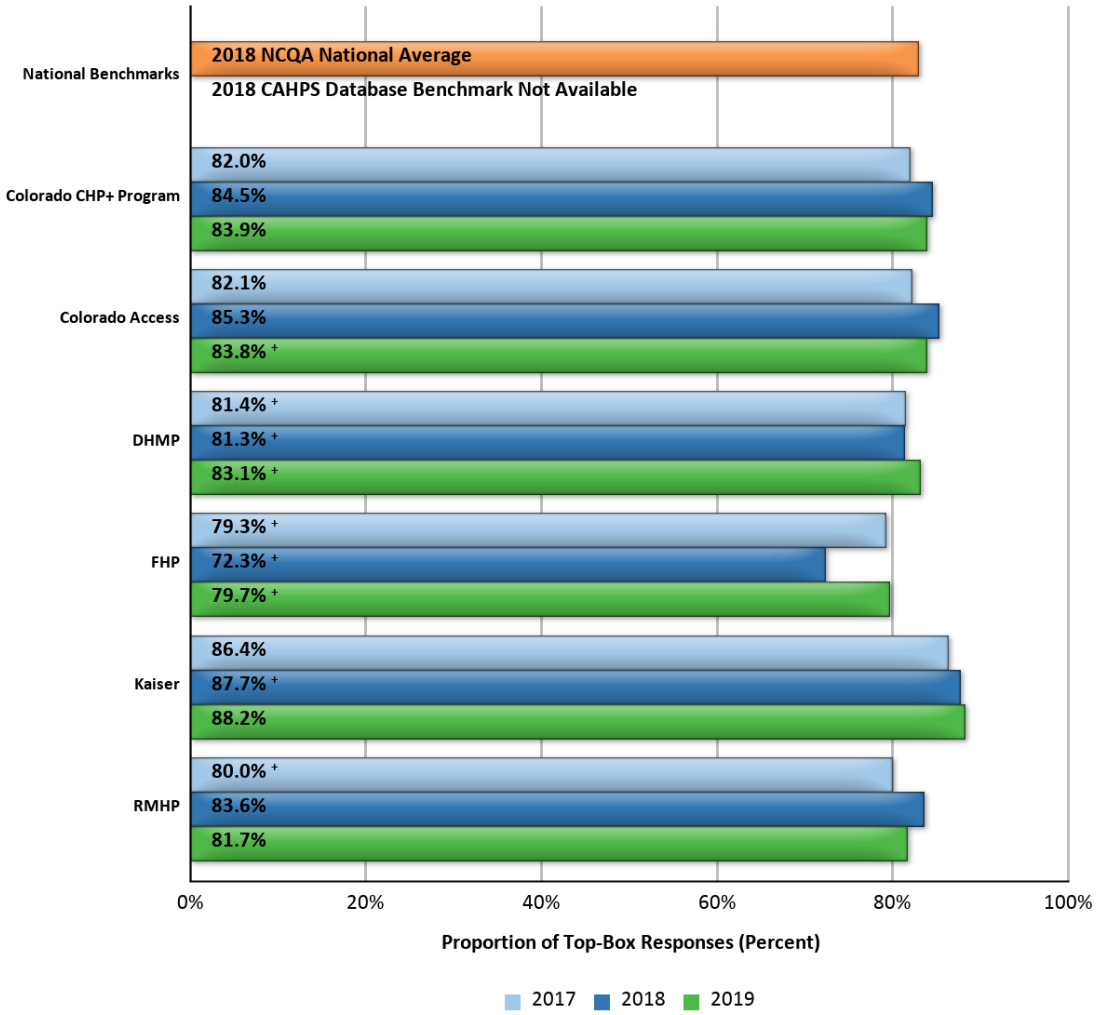
Individual Item Measures

Coordination of Care

Colorado CHP+ parents/caretakers of child members 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-box response was defined as a response of "Usually" or "Always." Figure 2-10 shows the 2018 NCQA national average and the top-box scores for the Coordination of Care individual item measure.

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



Statistical Significance Note: ▲ Indicates the 2019 score is statistically significantly higher than the 2018 score.
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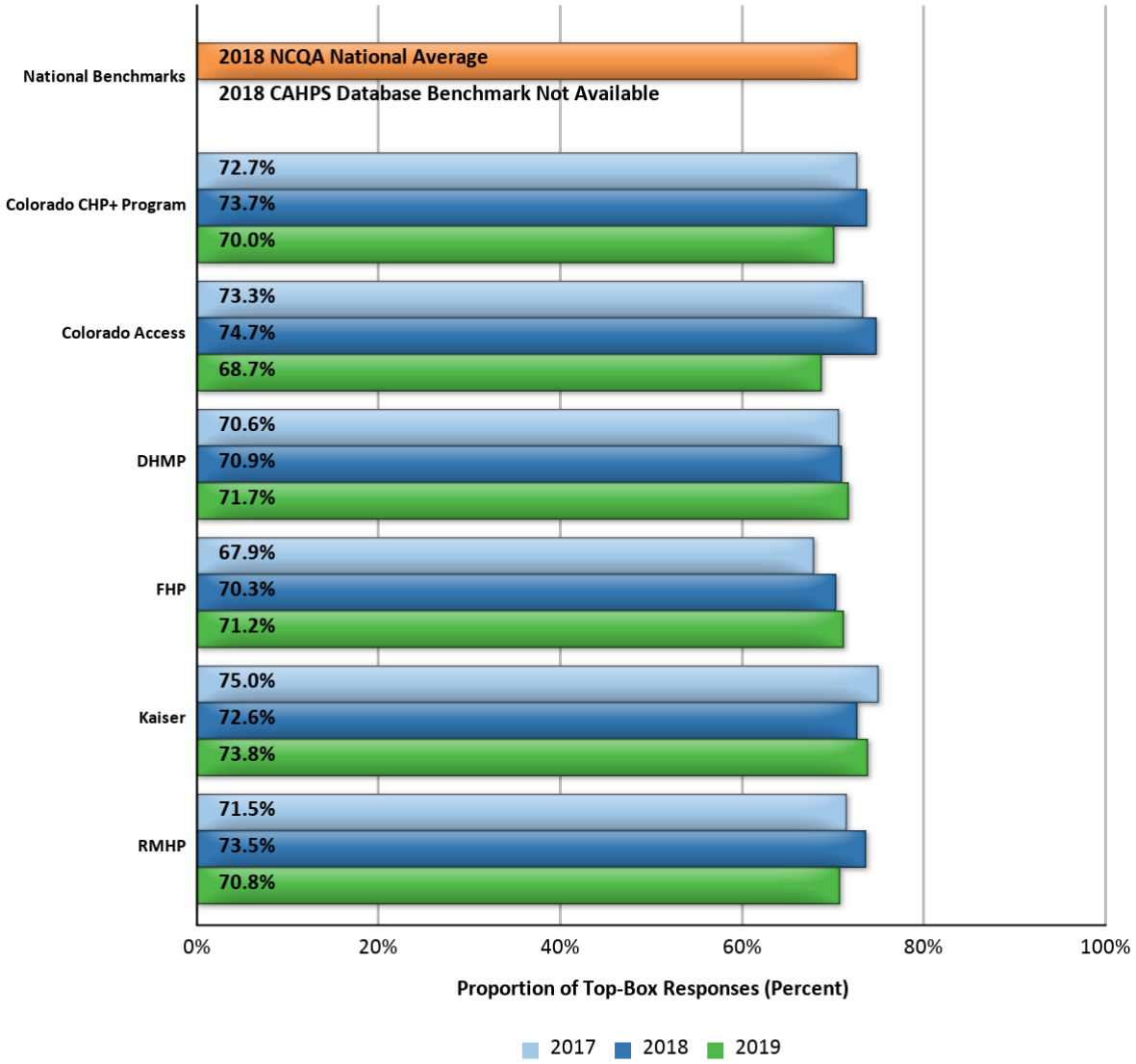
Health Promotion and Education

Colorado CHP+ parents/caretakers of child members 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-box response was defined as a response of "Yes." Figure 2-11 shows the 2018 NCQA national average and the top-box scores for the Health Promotion and Education individual item measure.

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



Statistical Significance Note: ▲ Indicates the 2019 score is statistically significantly higher than the 2018 score.
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▼ Indicates the 2019 score is statistically significantly lower than the 2017 score.
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Summary of Trend Analysis Results

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

Table 2-7—Trend Analysis Highlights

Measure Name	Colorado CHP+ Program	Colorado Access	DHMP	FHP	Kaiser	RMHP
Global Ratings						
Rating of Health Plan	▲	▲	—	▲	—	▲
Rating of Personal Doctor	—	—	▼	—	—	▼
Composite Measures						
Shared Decision Making	—	—+	—+	—+	—+	▲+

▲ *Indicates the 2019 score is statistically significantly higher than the 2018 score.*
▼ *Indicates the 2019 score is statistically significantly lower than the 2018 score.*
▲ *Indicates the 2019 score is statistically significantly higher than the 2017 score.*
▼ *Indicates the 2019 score is statistically significantly lower than the 2017 score.*
— *Indicates the 2019 score is not statistically significantly different than the 2018 or the 2017 scores.*
\+ *Indicates fewer than 100 responses. Caution should be exercised when evaluating these results.*

Plan Comparisons

In order to identify performance differences in members' experiences between the five Colorado CHP+ health plans, HSAG compared the results for Colorado Access, DHMP, FHP, Kaiser, and RMHP to the Colorado CHP+ Program average using standard tests for statistical significance.[2-17] For purposes of this comparison, results were case-mix adjusted; therefore, these results may differ from those presented in the trend analysis figures. Additional information is included in the Reader's Guide section beginning on page 5-7.

Statistically significant differences are noted in Table 2-8 by arrows. A health plan that performed statistically significantly higher than the Colorado CHP+ Program average is denoted with an upward (↑) arrow. Conversely, a health plan that performed statistically significantly lower than the Colorado CHP+ Program average is denoted with a downward (↓) arrow. A health plan that did not perform 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 all measures even when NCQA's minimum reporting threshold of 100 respondents was not met; therefore, caution should be exercised when interpreting results based on less than 100 respondents. CAHPS scores with less than 100 respondents are denoted with a cross (+). Table 2-8, on the following page, shows the results of the plan comparisons analysis.

[2-17] Caution should be exercised when evaluating plan comparisons, given that population and plan differences may impact CAHPS results.

Table 2-8—Plan Comparisons

	Colorado Access	DHMP	FHP	Kaiser	RMHP
Global Ratings					
Rating of Health Plan	69.4% ↑	62.5% ↔	56.1% ↓	62.5% ↔	68.5% ↑
Rating of All Health Care	67.9% ↔	67.4% ↔	51.2% ↓	68.5% ↔	67.4% ↔
Rating of Personal Doctor	78.1% ↔	74.2% ↔	71.2% ↔	79.5% ↑	71.1% ↔
Rating of Specialist Seen Most Often	77.7%+ ↔	84.2%+ ↔	70.9%+ ↔	73.9%+ ↔	82.9%+ ↔
Composite Measures					
Getting Needed Care	87.7% ↔	80.7% ↔	89.5%+ ↔	85.3% ↔	89.9% ↔
Getting Care Quickly	90.4% ↔	87.0% ↔	90.4%+ ↔	89.6% ↔	93.3% ↔
How Well Doctors Communicate	94.9% ↔	94.9% ↔	92.8% ↔	97.4% ↑	97.0% ↑
Customer Service	82.0% ↔	87.6% ↔	84.2%+ ↔	86.7% ↔	87.9% ↔
Shared Decision Making	79.4%+ ↔	74.2%+ ↔	80.0%+ ↔	84.7%+ ↔	84.2%+ ↔
Individual Item Measures					
Coordination of Care	84.1%+ ↔	82.1%+ ↔	80.1%+ ↔	88.5% ↔	81.7% ↔
Health Promotion and Education	68.9% ↔	73.5% ↔	70.5% ↔	72.8% ↔	70.4% ↔

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

Summary of Plan Comparisons Results

The plan comparisons revealed the following statistically significant results.

- Colorado Access scored statistically significantly higher than the Colorado CHP+ Program average on one measure, Rating of Health Plan.
- FHP scored statistically significantly lower than the Colorado CHP+ Program average on two measures: Rating of Health Plan and Rating of All Health Care.
- Kaiser scored statistically significantly higher than the Colorado CHP+ Program average on two measures: Rating of Personal Doctor and How Well Doctors Communicate.
- RMHP scored statistically significantly higher than the Colorado CHP+ Program average on two measures: Rating of Health Plan and How Well Doctors Communicate.

Supplemental Items

The Department elected to add five supplemental items to the standard CAHPS 5.0 Child Medicaid Health Plan Survey for the Colorado CHP+ health plans. Table 2-9 details the survey language and response options for each of the supplemental items. Table 2-10 through Table 2-14 show the results for each supplemental item. For all Colorado CHP+ health plans, the number and percentage of responses for each item are presented.[2-18]

Table 2-9—Supplemental Items

Question		Response Options
Q48a.	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
Q48b.	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
Q48c.	In the last 6 months, did your child's doctor's office or health 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, 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

[2-18] Respondents who answered, "My child did not see a doctor or other health provider in the last 6 months" or "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" were excluded from the analysis.

Talked About Child's Behavior

Parents/caretakers of child members 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 48a). Table 2-10 displays the responses for this question.

Table 2-10—Talked About Child's Behavior

Plan Name	Yes		No	
	N	%	N	%
Colorado CHP+ Program	**773**	**58.4%**	**551**	**41.6%**
Colorado Access	165	57.7%	121	42.3%
DHMP	127	52.3%	116	47.7%
FHP	91	56.2%	71	43.8%
Kaiser	166	58.7%	117	41.3%
RMHP	224	64.0%	126	36.0%
Please note: Percentages may not total 100.0% due to rounding.				

Talked About Household Problems That Might Affect Child

Parents/caretakers of child members 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 48b). Table 2-11 displays the responses for this question.

Table 2-11—Talked About Household Problems That Might Affect Child

Plan Name	Yes		No	
	N	%	N	%
Colorado CHP+ Program	**410**	**31.7%**	**883**	**68.3%**
Colorado Access	82	29.5%	196	70.5%
DHMP	78	32.8%	160	67.2%
FHP	47	29.4%	113	70.6%
Kaiser	90	32.8%	184	67.2%
RMHP	113	32.9%	230	67.1%
Please note: Percentages may not total 100.0% due to rounding.				

Received Information About After-Hours Care

Parents/caretakers of child members were asked if their child's doctor's office or health provider's office gave them information about what to do if their child needed care during evenings, weekends, or holidays (Question 48c). Table 2-12 displays the responses for this question.

Table 2-12—Received Information About After-Hours Care

Plan Name	Yes		No	
	N	%	N	%
Colorado CHP+ Program	**574**	**44.6%**	**714**	**55.4%**
Colorado Access	120	42.7%	161	57.3%
DHMP	100	42.9%	133	57.1%
FHP	66	41.3%	94	58.8%
Kaiser	120	43.8%	154	56.2%
RMHP	168	49.4%	172	50.6%
Please note: Percentages may not total 100.0% due to rounding.				

Access to After-Hours Care

Parents/caretakers of child members 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 2-13 displays the responses for this question.

Table 2-13—Access to After-Hours Care

Plan Name	Never		Sometimes		Usually		Always	
	N	%	N	%	N	%	N	%
Colorado CHP+ Program	**137**	**23.7%**	**75**	**13.0%**	**141**	**24.4%**	**224**	**38.8%**
Colorado Access	33	23.2%	18	12.7%	39	27.5%	52	36.6%
DHMP	37	34.9%	13	12.3%	20	18.9%	36	34.0%
FHP	8	12.1%	9	13.6%	23	34.8%	26	39.4%
Kaiser	31	24.4%	17	13.4%	27	21.3%	52	40.9%
RMHP	28	20.6%	18	13.2%	32	23.5%	58	42.6%
Please note: Percentages may not total 100.0% due to rounding.								

Number of Days Waiting to See Health Provider

Parents/caretakers of child members were asked, not counting the times their child needed health care right away, how many days they usually had to wait between making an appointment and their child actually seeing a health provider (Question 48e). Table 2-14 and Table 2-15 display the responses for this question.

Table 2-14—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	
	N	%	N	%	N	%	N	%	N	%
Colorado CHP+ Program	**372**	**30.5%**	**222**	**18.2%**	**265**	**21.8%**	**175**	**14.4%**	**101**	**8.3%**
Colorado Access	83	31.6%	47	17.9%	55	20.9%	39	14.8%	22	8.4%
DHMP	50	24.0%	26	12.5%	44	21.2%	30	14.4%	24	11.5%
FHP	53	33.8%	28	17.8%	38	24.2%	17	10.8%	12	7.6%
Kaiser	77	28.8%	63	23.6%	54	20.2%	45	16.9%	17	6.4%
RMHP	109	33.7%	58	18.0%	74	22.9%	44	13.6%	26	8.0%

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

Table 2-15—Number of Days Waiting to See Health Provider (Continued)

Plan Name	15 to 30 days		31 to 60 days		61 to 90 days		91 days or longer	
	N	%	N	%	N	%	N	%
Colorado CHP+ Program	**53**	**4.4%**	**23**	**1.9%**	**5**	**0.4%**	**2**	**0.2%**
Colorado Access	9	3.4%	6	2.3%	1	0.4%	1	0.4%
DHMP	23	11.1%	9	4.3%	1	0.5%	1	0.5%
FHP	7	4.5%	2	1.3%	0	0.0%	0	0.0%
Kaiser	6	2.2%	3	1.1%	2	0.7%	0	0.0%
RMHP	8	2.5%	3	0.9%	1	0.3%	0	0.0%

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

Key Drivers of Low Member Experience Analysis

HSAG performed an analysis of key drivers of low member experience for the following three global ratings:

- Rating of Health Plan
- Rating of All Health Care
- Rating of Personal Doctor

Key drivers of low member experience are defined as those items that (1) have a problem score that is greater than or equal to the program's/CHP+ health plan's median problem score for all items examined, and (2) have a correlation that is greater than or equal to the program's/CHP+ health plan's median correlation for all items examined.[3-1] For additional information on the key drivers of low member experience analysis, please refer to the Reader's Guide section on page 5-8. Table 3-1 through Table 3-3 depict those survey items identified for each of the three measures as being key drivers of low member experience for the Colorado CHP+ Program and each CHP+ health plan (as indicated by a ✓).

Table 3-1—Key Drivers Analysis: Rating of Health Plan Summary Table

Key Drivers	Colorado CHP+ Program	Colorado Access	DHMP	FHP	Kaiser	RMHP
Respondents reported that when their child needed care right away, they did not receive care as soon as they needed it.				✓		
Respondents reported that a doctor or other health provider did not talk about the reasons they might not want their child to take a medicine.				✓		
Respondents reported that when they talked about their child starting or stopping a prescription medicine, a doctor or other health provider did not ask what they thought was best for their child.				✓		
Respondents reported that it was not always easy to get the care, tests, or treatment they thought their child needed through their health plan.	✓		✓	✓	✓	

[3-1] A problem score is the score associated with a response in which the member identified a negative experience and was assigned a "1." A positive experience with care (i.e., non-negative) was assigned a "0."

Key Drivers	Colorado CHP+ Program	Colorado Access	DHMP	FHP	Kaiser	RMHP
Respondents reported that their child's personal doctor did not talk with them about how their child is feeling, growing, or behaving.						✓
Respondents reported that their child's personal doctor did not always seem informed and up-to-date about the care their child received from other doctors or health providers.	✓		✓	✓	✓	✓
Respondents reported that it was often not easy for their child to obtain appointments with specialists.	✓	✓			✓	
Respondents reported that their child's health plan's customer service did not always give them the information or help they needed.	✓	✓		✓	✓	✓
Respondents reported that their child's health plan's customer service staff did not always treat them with courtesy and respect.		✓				
Respondents reported that forms from their child's health plan were often not easy to fill out.	✓	✓	✓	✓	✓	✓

Table 3-2—Key Drivers Analysis: Rating of All Health Care Summary Table

Key Drivers	Colorado CHP+ Program	Colorado Access	DHMP	FHP	Kaiser	RMHP
Respondents reported that when their child needed care right away, they did not receive care as soon as they needed it.					✓	
Respondents reported that when their child did not need care right away, they did not obtain an appointment for health care as soon as they thought they needed.						✓
Respondents reported that a doctor or other health provider did not always talk to them about specific things they could do to prevent illness in their child.		✓				
Respondents reported that when they talked about their child starting or stopping a prescription medicine, a doctor or other health provider did not ask what they thought was best for their child.						✓
Respondents reported that it was not always easy to get the care, tests, or treatment they thought their child needed through their health plan.	✓		✓	✓	✓	
Respondents reported that their child's personal doctor did not talk with them about how their child is feeling, growing, or behaving.		✓				✓
Respondents reported that their child's personal doctor did not always seem informed and up-to-date about the care their child received from other doctors or health providers.	✓	✓	✓	✓	✓	✓
Respondents reported that it was often not easy for their child to obtain appointments with specialists.					✓	
Respondents reported that their child's health plan's customer service did not always give them the information or help they needed.	✓					
Respondents reported that their child's health plan's customer service staff did not always treat them with courtesy and respect.				✓		
Respondents reported that forms from their child's health plan were often not easy to fill out.		✓			✓	

Table 3-3—Key Drivers Analysis: Rating of Personal Doctor Summary Table

Key Drivers	Colorado CHP+ Program	Colorado Access	DHMP	FHP	Kaiser	RMHP
Respondents reported that when their child needed care right away, they did not receive care as soon as they needed it.				✓		
Respondents reported that a doctor or other health provider did not talk about the reasons they might want their child to take a medicine.		✓				✓
Respondents reported that it was not always easy to get the care, tests, or treatment they thought their child needed through their health plan.	✓		✓	✓		
Respondents reported that their child's personal doctor did not talk with them about how their child is feeling, growing, or behaving.	✓	✓			✓	
Respondents reported that their child's personal doctor did not always seem informed and up-to-date about the care their child received from other doctors or health providers.	✓	✓	✓	✓	✓	✓

The following key drivers were identified for all three global ratings for the Colorado CHP+ Program average:

- Parents or caretakers reported that it was not always easy getting the care, tests, or treatment they thought their child needed through their health plan.
- Parents or caretakers reported that their child's personal doctor did not always seem informed and up-to-date about the care their child received from other doctors or health providers.

The following key driver was identified for both the Rating of Health Plan and Rating of All Health Care global ratings for the Colorado CHP+ Program average:

- Parents or caretakers reported that their child's health plan's customer service did not always give them the information or help they needed.

4. Conclusions and Recommendations

HSAG drew conclusions and identified quality improvement (QI) recommendations based on the following analyses: national comparisons, trend analysis, and key drivers of low member experience analysis. HSAG used the results from these analyses to determine areas of low and high performance to create conclusions and recommendations for the CHP+ health plans' consideration.

Conclusions

The majority of parents or caretakers of child members reported being satisfied with their specialists, timeliness of care, and their children's doctors' communication about starting or stopping a prescription medicine. Conversely, the majority of parents or caretakers of child members reported being dissatisfied with their child's health plan, overall health care, health plan's customer service, coordination of care, and doctors' communication about preventing illness in their child.

The NCQA comparisons revealed the following:

- The Colorado CHP+ Program did not score at or above the 90th percentile on any measure.
- The Colorado CHP+ Program scored below the 25th percentile on the following three measures: Rating of Health Plan, Customer Service, and Health Promotion and Education.

A comparison of the Colorado CHP+ Program's top-box scores to the 2018 NCQA national averages revealed the following:

- The Colorado CHP+ Program's 2019 scores were above the 2018 NCQA child Medicaid national averages for the following six measures:
  - Rating of Specialist Seen Most Often
  - Getting Needed Care
  - Getting Care Quickly
  - How Well Doctors Communicate
  - Shared Decision Making
  - Coordination of Care
- The Colorado CHP+ Program's 2019 scores were below the 2018 NCQA child Medicaid national averages for the following five measures:
  - Rating of Health Plan
  - Rating of All Health Care
  - Rating of Personal Doctor
  - Customer Service
  - Health Promotion and Education

The trend analysis revealed the following:

- The Colorado CHP+ Program's and Colorado Access' 2019 scores were statistically significantly higher than the 2018 scores for the Rating of Health Plan global rating.
- DHMP's 2019 score was statistically significantly lower than the 2018 score for the Rating of Personal Doctor global rating.

Although the Colorado CHP+ Program scored statistically significantly higher in 2019 than in 2018 for the Rating of Health Plan global rating, comparisons to the NCQA child Medicaid national average and key drivers analysis results identified opportunities for improvement for this global rating, as well as the Rating of All Health Care and Rating of Personal Doctor global ratings. HSAG identified the following "key driver" items for these three global ratings, which may indicate specific areas for improvement in access to care, coordination of care, communication, and customer service:

- Rating of Health Plan, Rating of Health Care, and Rating of Personal Doctor: Parents or caretakers reported that it was not always easy to get the care, tests, or treatment they thought their child needed through their health plan. Also, parents or caretakers reported that their child's personal doctor did not always seem informed and up-to-date about the care their child received from other doctors or health providers.
- Rating of Health Plan and Rating of All Health Care: Parents or caretakers reported that they did not always get the information or help they needed from their child's health plan's customer service.
- Rating of Health Plan: Parents or caretakers reported that appointments with specialists were not easily obtained for their child. In addition, parents or caretakers reported that forms from their child's health plan were not easy to fill out.
- Rating of Personal Doctor: Parents or caretakers reported that their child's personal doctor did not talk with them about how their child is feeling, growing, or behaving.

General Recommendations

Colorado could benefit from continuing to:

- Use benchmarking and trend analysis on standardized performance measures from any CAHPS or other surveys to:
  - Set clear goals for health plans and assist the health plans in designing related QI activities.
  - Use the longitudinal trends to assist with barrier analysis and goal setting.
- Use administrative data in identifying the Spanish-speaking population when conducting surveys. There were 546 completed surveys in Spanish for the FY 2018-2019 survey administration, which accounted for approximately 28 percent of the total number of responses.
- Encourage health plans with statistically significantly higher ratings to share "best practices" among the other health plans.

Quality Improvement Recommendations

The following QI recommendations are based on the results of the four analyses performed for the five Colorado CHP+ health plans. Each health plan should evaluate these recommendations in the context of its own operational and QI activities. The following includes best practices and other proven strategies that may be used or adapted by the CHP+ health plans to target improvement.

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.[4-1]

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.

[4-1] Plan-Do-Study-Act (PDSA) Worksheet. *Institute for Healthcare Improvement.* Available at: http://www.ihi.org/knowledge/Pages/Tools/PlanDoStudyActWorksheet.aspx. Accessed on: August 1, 2019.

Facilitate Coordinated Care

Health plans should assist in facilitating the process of coordinated care to ensure child members are receiving the care and services most appropriate for their health care needs. This effort should extend beyond typical care coordination between a primary care provider and another health care provider to include cross-system coordination. This ensures that coordination occurs between primary care providers and home health services, schools, mental health systems, or other institutional systems. Cross systems collaboration finds solutions to community problems, streamlines access to and expedites service delivery, and promises to impact social determinants of health. It addresses the multi-faceted needs of various populations that individual programs are not designed to address, specifically for children from at-risk families and youth involved with the child welfare system. Coordinated care is most effective when care coordinators and providers organize their efforts to deliver the same message to parents or caretakers of child members, who are more likely to play an active role in the management of their child's health care. Additionally, providing patient registries or clinical information systems that allow providers and care coordinators to enter and view information 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.

Customer Service

Health plans should keep their members engaged through regular communications about programs and services available. Also, they should educate members about the health plan's programs that meet their individualized cost and care needs and guide them through the application and enrollment process. Health plans should ensure that their websites are informative and easy to navigate, especially for new members. Also, health plans should implement self-service options, which ensures that data are shared consistently across systems (e.g., mobile, web, interactive voice response [IVR], etc.) and that members have easy access to help through web virtual health assistants and chat features. This helps decrease the amount of inbound calls and contact resolution, provides a seamless experience for members to get their questions answered, and provides clinical advice to assess members' conditions along with the appropriate follow-up. Proactive engagement, including text, email, and automated voice notifications, helps inform members of appointments and further actions required and lets members know the status of claims and when preventive services, such as flu shots, are available.

Access to Care

Health plans should identify potential barriers for parents or caretakers of child members receiving appropriate access to care. Access to care issues include obtaining the care that the parent and/or physician deemed necessary, obtaining timely urgent care, or locating a personal doctor for a child. Establishing standard practices and protocols, including scripts for common occurrences within the provider office setting could ensure that access to care issues are handled consistently across all health plans. Also, health plans should continue efforts to expand the availability of evening and weekend hours by adopting alternative schedules. For instance, 24/7 coverage could be attained through a fast rotation shift pattern of four teams and a combination of three eight-hour shifts on weekdays and two 12-hour shifts on weekends.[4-2] Additionally, health plans should encourage or incentivize provider practices to collaborate for providing extended hours of operation if the individual provider is solely unable to do so.

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 4-1, on the following page, provides a summary of the responsible parties for various aspects of care.[4-3]

[4-2] Business Management Systems. Employee Scheduling with Snap Schedule. Available at: https://www.bmscentral.com/learn-employee-scheduling/tag/8-hour-shift/. Accessed on: August 1, 2019.

[4-3] 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. Available at: http://www.improvingchroniccare.org/downloads/advanced_topics_cahps_improvement_guide.pdf. Accessed on: August 1, 2019.

Table 4-1—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 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:

- Drawing on the analysis of population sub-groups (e.g., health status, race, age) to determine if there are member groups that tend to have lower levels of member experience (see Tab and Banner Book).
- Using other indicators to supplement CAHPS data such as member complaints/grievances, feedback from staff, and other survey data.
- Conducting focus groups and interviews to determine what specific issues are causing low member experience ratings.

After identification of the specific problem(s), 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.

5. Reader's Guide

This section provides a comprehensive overview of CAHPS, including the 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.[5-1] In 2002, AHRQ convened the CAHPS Instrument Panel to re-evaluate and update the CAHPS Health Plan Surveys and to improve the state-of-the-art methods for assessing members' experiences with care.[5-2] The result of this re-evaluation and update process was the development of the CAHPS 3.0H Health Plan Surveys. The goal of the CAHPS 3.0H Health Plan Surveys was to effectively and efficiently obtain information from the person receiving care. In 2006, AHRQ released the CAHPS 4.0 Health Plan Surveys. Based on the CAHPS 4.0 versions, NCQA introduced new HEDIS versions of the Adult Health Plan Survey in 2007 and the Child Health Plan Survey in 2009, which are referred to as the CAHPS 4.0H Health Plan Surveys.[5-3,5-4] In 2012, AHRQ released the CAHPS 5.0 Health Plan Surveys. Based on the CAHPS 5.0 versions, NCQA introduced new HEDIS versions of the Adult and Child Health Plan Surveys in August 2012, which are referred to as the CAHPS 5.0 Health Plan Surveys.[5-5]

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

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. 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 member experience 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 5-1 lists the global ratings, composite measures, and individual item measures included in the CAHPS 5.0 Child Medicaid Health Plan Survey.

Table 5-1—CAHPS Measures

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

Sampling Procedures

Sampled members included those who met the following criteria:

- Were age 17 or younger as of December 31, 2018.
- Were currently enrolled in Colorado Access, DHMP, FHP, Kaiser, or RMHP.
- Had been continuously enrolled for at least five of the last six months of 2018.
- Had Medicaid as a payer.

Additionally, NCQA specifications require a sample size of 1,650 members for the CAHPS 5.0 Child Medicaid Health Plan Survey. For Colorado Access, DHMP, Kaiser, and RMHP, a total sample of 1,650 child members was selected from these health plans. FHP did not meet the minimum sample size criteria; therefore, 1,176 child members were selected from FHP's eligible population. The selected survey samples were random samples with no more than one member being selected per household.

Survey Protocol

Table 5-2 shows the standard mixed mode (i.e., mail followed by telephone follow-up) timeline used in the administration of the Colorado CAHPS 5.0 Child Medicaid Health Plan Surveys. The timeline is based on NCQA HEDIS Specifications for Survey Measures.[5-6]

Table 5-2—CAHPS 5.0 Mixed-Mode Survey Timeline

Task	Timeline
Send first questionnaire with cover letter to the parent/caretaker of child member.	0 days
Send a postcard reminder to non-respondents seven days after mailing the first questionnaire.	7 days
Send a second questionnaire (and letter) to non-respondents 28 days after mailing the first questionnaire.	28 days
Send a second postcard reminder to non-respondents seven days after mailing the second questionnaire.	35 days
Initiate CATI interviews for non-respondents 28 days after mailing the second questionnaire.	56 days
Initiate systematic contact for all non-respondents such that up to six telephone calls are attempted at different times of the day, on different days of the week, and in different weeks.	56 – 77 days
Telephone follow-up sequence completed (i.e., completed interviews obtained or maximum calls reached for all non-respondents) 21 days after initiation.	77 days

The CAHPS 5.0 Health Plan Survey process allowed for two methods by which surveys could be completed. The first phase, or mail phase, consisted of a survey being mailed to all sampled members. For CHP+ health plans, those members who were identified as Spanish-speaking through administrative data were mailed a Spanish version of the survey. Members 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 members 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 members who had not mailed in a completed survey. A series of up to six CATI calls was made to each non-respondent. It has been shown that the addition of the telephone phase aids in the reduction of non-response bias by increasing the number of respondents who are more demographically representative of a health plan's population.[5-7]

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

[5-6] National Committee for Quality Assurance. *HEDIS® 2019, Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA Publication, 2018.

[5-7] 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.

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

Methodology

HSAG used the CAHPS scoring approach recommended by NCQA in Volume 3 of HEDIS Specifications for Survey Measures. Based on NCQA's recommendations and HSAG's extensive experience evaluating CAHPS data, a number of analyses were performed to comprehensively assess member experience with the CHP+ health 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 members of the sample.[5-8] A member'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 members include the entire sample minus ineligible members. Ineligible members of the sample met one or more of the following criteria: were deceased, were invalid (did not meet criteria described on page 5-2), or had a language barrier.

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

Child and Respondent Demographics

The demographic analysis evaluated child and self-reported demographic information from survey respondents. Table 5-3, on the following page, shows the survey question numbers that are associated with the respective demographic categories that were analyzed.

[5-8] National Committee for Quality Assurance. *HEDIS® 2019, Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA Publication, 2018.

Table 5-3—Child and Respondent Demographic Items Analyzed

Demographic Category	Survey Question Number
Table 2-2—Child Demographics	
Age	39
Gender	40
Race	42
Ethnicity	41
General Health Status	37
Table 2-3—Respondent Demographics	
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's 2018 Quality Compass Benchmark and Compare Quality Data.[5-9,5-10] 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, the health 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, HSAG calculated results in accordance with NCQA HEDIS Specifications for Survey Measures.[5-11] The scoring of the measures involved assigning top-box responses a score of one, with all other responses receiving a score of zero. After applying this scoring methodology, HSAG calculated the percentage of top-box responses in order to determine the top-box scores. For additional details, please refer to the *NCQA HEDIS 2019 Specifications for Survey Measures, Volume 3*. HSAG compared the resulting top-box scores to published NCQA Quality Compass Benchmark and Compare Quality Data to derive the overall member experience ratings (i.e., star ratings).

Table 5-4 shows the percentiles that were used to determine star ratings.

5-9 National Committee for Quality Assurance. *Quality Compass®: Benchmark and Compare Quality Data 2018.* Washington, DC: NCQA, September 2018.

5-10 In 2019, HSAG changed the benchmarking source for the NCQA Comparisons analysis from previous reports; therefore, results may not be comparable to previous years.

5-11 National Committee for Quality Assurance. *HEDIS® 2019, Volume 3: Specifications for Survey Measures*. Washington, DC: NCQA Publication, 2018.

Table 5-4—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

Trend Analysis

In order to evaluate trends in Colorado CHP+ member experience, HSAG performed a stepwise three-year trend analysis. First, HSAG compared the 2019 CAHPS top-box scores to the 2018 CAHPS top-box scores. If the initial 2019 and 2018 trend analysis did not yield any significant differences, then HSAG performed an additional trend analysis between the 2019 and 2017 results.

A difference was 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 2019 than in 2018 are noted with black upward (▲) triangles. Scores that were statistically significantly lower in 2019 than in 2018 are noted with black downward (▼) triangles. Scores that were statistically significantly higher in 2019 than in 2017 are noted with red upward (▲) triangles. Scores that were statistically significantly lower in 2019 than in 2017 are noted with red downward (▼) triangles. Scores in 2019 that were not statistically significantly different from scores in 2018 or in 2017 are not noted with triangles.

For purposes of this report, health 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 2017, 2018, and 2019 CAHPS scores for Colorado CHP+ were weighted based on each health 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 health plan p and μ_p is the score for health plan p.

Plan Comparisons

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

HSAG applied two types of hypothesis tests to the child CAHPS comparative results. First, HSAG calculated a global *F* test, which determined whether the difference between the health plans' scores was significant. The *F* statistic was determined using the formula below:

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

The *F* statistic, as calculated above, had an *F* distribution with ($P - 1$, q) degrees of freedom, where q was equal to $n - P -$ (*number of case-mix adjusters*). 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 HSAG performed a *t* test 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:

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

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

The variance of Δ_p was:

$$\hat{V}(\Delta_p) = \left(1 - \frac{1}{P}\right)^2 \hat{V}_p + \frac{\sum_{p'}^{*} \hat{V}_{p'}}{P^2}$$

The *t* statistic was $\frac{\Delta_p}{\sqrt{\hat{V}(\Delta_p)}}$ and had a *t* distribution with *n* – *P* – (*number of case-mix adjusters*) 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.

Key Drivers of Low Member Experience

In order to determine factors that are contributing to members' low ratings of member experience, HSAG performed a key drivers of low member experience analysis for the following three global ratings: Rating of Health Plan, Rating of All Health Care, and Rating of Personal Doctor. The purpose of the key drivers of low member experience analysis is to help decision makers identify specific aspects of care that will most benefit from QI activities. The analysis provides information on:

- How ***well*** the health plan/program is performing on the survey item.
- How ***important*** that item is to overall member experience.

Table 5-5 depicts the survey items that were analyzed in the key drivers of low member experience analysis (as indicated by a ✓).

Table 5-5—Correlation Matrix

Question Number	Rating of Health Plan	Rating of All Health Care	Rating of Personal Doctor
Q4. Child got care as soon as needed	✓	✓	✓
Q6. Got an appointment at a doctor's office or clinic as soon as child needed	✓	✓	✓
Q8. Talked about preventing illness in child	✓	✓	✓
Q9. Talked about starting or stopping a prescription medicine for your child	✓	✓	✓
Q10. Talked about reasons for child to take medicine	✓	✓	✓

Question Number	Rating of Health Plan	Rating of All Health Care	Rating of Personal Doctor
Q11. Talked about reasons for not wanting child to take a medicine	✓	✓	✓
Q12. Asked about thoughts for child starting or stopping a prescription medicine	✓	✓	✓
Q14. Ease of getting care, tests, or treatment child needed	✓	✓	✓
Q17. Child's personal doctor explained things understandably	✓	✓	✓
Q18. Child's personal doctor listened carefully	✓	✓	✓
Q19. Child's personal doctor showed respect for what you had to say	✓	✓	✓
Q21. Child's personal doctor explained things in an understandable way to child	✓	✓	✓
Q22. Child's personal doctor spent enough time with child	✓	✓	✓
Q23. Child's personal doctor talked about how child is feeling, growing, or behaving	✓	✓	✓
Q25. Child's personal doctor seemed informed and up-to-date about care from other doctors or health providers	✓	✓	✓
Q28. Got appointment for child to see a specialist as soon as needed	✓	✓	
Q32. Got information or help needed by customer service	✓	✓	
Q33. Treated with courtesy and respect by customer service staff	✓	✓	
Q35. Ease of filling out forms	✓	✓	

HSAG evaluated these global ratings to determine if particular CAHPS items (i.e., questions) have a high problem score (i.e., poor performance) and are strongly correlated with one or more of these measures. These individual CAHPS items, which HSAG refers to as "key drivers," have the greatest potential to affect change in the member's overall experience with the global ratings, and therefore are areas of focus for possible QI efforts.

HSAG measured each survey item's performance by calculating a problem score. A problem score is the score associated with a response in which the member identified a negative experience and was assigned a "1." A positive experience with care (i.e., non-negative) was assigned a "0." The higher the problem score, the lower the member's experience with the aspect of service measured by that question. The problem score could range from 0 to 1.

Table 5-6 depicts the problem score assignments for the different response categories.

Table 5-6—Problem Score Assignment

Never/Sometimes/Usually/Always Format		
Response Category	**Classification**	**Code**
Never	Problem	1
Sometimes	Problem	1
Usually	Not a Problem	0
Always	Not a Problem	0
No Answer	Not classified	Missing
No/Yes Format		
Response Category	**Classification**	**Code**
No	Problem	1
Yes	Not a Problem	0
No Answer	Not classified	Missing

For each item evaluated, HSAG calculated the relationship between the item's problem score and performance on each of the three measures using a Polychoric correlation, which is used to estimate the correlation between two theorized normally distributed continuous latent variables, from two observed ordinal variables. HSAG then prioritized items based on their overall problem score and their correlation to each measure. The correlation can range from -1 to 1, with negative values indicating a negative relationship between the member's overall experience and a particular survey item. However, the correlation analysis conducted is not focused on the direction of the correlation, but rather on the degree of correlation. Therefore, the absolute value of r is used in the analysis, and the range for r is 0 to 1. An r of zero indicates no relationship between the response to a question and member experience. As r increases, the importance of the question to the respondent's overall member experience increases.

The median, rather than the mean, is used to ensure that extreme problem scores and correlations do not have disproportionate influence in prioritizing individual questions. Key drivers of low member experience are defined as those items that:

- Have a problem score that is greater than or equal to the median problem score for all items examined.
- Have a correlation that is greater than or equal to the median correlation for all items examined.

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.

CAHPS Database Benchmarks

A total of 14 states submitted 2018 data to the CAHPS Health Plan Survey Database for the CHIP population with a combined total of 13,933 respondents; furthermore, 1,953 of these respondents were from Colorado.[5-12] The CAHPS Health Plan Survey Database does not produce benchmarks for the Shared Decision Making composite measure, and the Coordination of Care and Health Promotion and Education individual item measures; therefore, CAHPS Database benchmarks are not presented for these measures. Additionally, 2019 CAHPS Database benchmarks produced from the CAHPS 5.0 Child Medicaid Health Plan Survey were not available at the time this report was prepared. Also, the CAHPS Health Plan Survey Database defines a top-box response as "Always" rather than "Usually" and "Always" for the composite measures. Caution should be exercised when comparing the 2018 CAHPS Database benchmarks to the 2019 Colorado CHP+ Survey results.

Case-Mix Adjustment

While data for the plan comparisons have been adjusted for differences in survey-reported general health status, respondent age, and respondent 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 health plans' control.

Causal Inferences

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

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.

[5-12] Agency for Healthcare Research and Quality. 2018 CAHPS Health Plan Survey Database: 2018 Chartbook: What Consumers Say About Their Experiences With Their Health Plans and Medical Care. Available at: https://cahpsdatabase.ahrq.gov/files/2018CAHPSHealthPlanChartbook.pdf. Accessed on: August 1, 2019.

6. Survey Instrument

The survey instrument selected for the 2019 Colorado CHP+ Member Experience Survey was the CAHPS 5.0 Child Medicaid Health Plan Survey with the HEDIS supplemental item set without the 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 completely. Use only black or blue ink or dark pencil to complete the survey.**

Correct Mark ● **Incorrect Marks** 

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

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

⬇ START HERE ⬇

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 Child Health Plan *Plus* - [HEALTH PLAN 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
- ○ 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, 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.***

48b. 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

48c. In the last 6 months, did your child's doctor's office or health 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 during evenings, weekends, or holidays in the last 6 months

48e. 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

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