

# **2016 Acute Care Program Adult Medicaid Member Satisfaction Report**

*August 2017*



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# 1. Executive Summary

The State of Arizona required the administration of member satisfaction surveys to adult Medicaid members enrolled in the Arizona Health Care Cost Containment System (AHCCCS) Acute Care Medicaid managed care program (Acute Care program). AHCCCS contracted 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 Survey.<sup>1-1</sup> The goal of the CAHPS Health Plan Survey is to provide performance feedback that is actionable and that will aid in improving overall member satisfaction. The CAHPS results presented in the report represent a **baseline** assessment of members’ satisfaction with the Acute Care program; therefore, caution should be exercised when interpreting these results.

The standardized survey instruments selected was the CAHPS 5.0 Adult Medicaid Health Plan Survey with the Healthcare Effectiveness Data and Information Set (HEDIS®) supplemental item set.<sup>1-2</sup> Adult members from the Acute Care program completed the surveys from December 2016 to March 2017. Table 1-1 provides a list of the Contractors (i.e., health plans) that participated in the CAHPS Adult Medicaid Health Plan Survey for the Acute Care program.

**Table 1-1—Participating Contractors**

Participating Contractors
Care 1st Health Plan of Arizona
Health Choice Arizona
Health Net Access
Maricopa Health Plan
Mercy Care Plan
Phoenix Health Plan
UnitedHealthcare Community Plan
University Family Care

<sup>1-1</sup> CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

<sup>1-2</sup> HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

## Performance Highlights

The Results section of this report details the CAHPS results for the adult Medicaid population for the Acute Care program in aggregate and each participating Contractor.<sup>1-3</sup> The following is a summary of the adult CAHPS performance highlights. The performance highlights are categorized into three areas of analysis performed for the adult population:

- National Committee for Quality Assurance (NCQA) Comparisons
- Rates and Proportions
- Contractor Comparisons

### NCQA Comparisons

Overall member satisfaction ratings for four CAHPS global ratings (Rating of Health Plan, Rating of All Health Care, Rating of Personal Doctor, and Rating of Specialist Seen Most Often), four CAHPS composite measures (Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, and Customer Service), and one individual item measure (Coordination of Care) from the 2016 CAHPS survey results were compared to NCQA's 2017 HEDIS Benchmarks and Thresholds for Accreditation.<sup>1-4</sup> This comparison resulted in ratings of one (★) to five (★★★★★) stars on these CAHPS measures, where one is the lowest possible rating and five is the highest possible rating.<sup>1-5</sup> The detailed results of this comparative analysis are described in the Results section beginning on page 3-1. Table 1-2, on the following page, presents the highlights from this comparison for the adult Medicaid population for the Acute Care program in aggregate.

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<sup>1-3</sup> The Acute Care program CAHPS results presented in this section for the adult population are derived from the combined results of the eight Contractors that participated in the CAHPS Adult Medicaid Health Plan Surveys.

<sup>1-4</sup> National Committee for Quality Assurance. *HEDIS Benchmarks and Thresholds for Accreditation 2017*. Washington, DC: NCQA, May 4, 2017.

<sup>1-5</sup> NCQA does not publish benchmarks and thresholds for the Shared Decision Making composite measure and Health Promotion and Education individual item measure; therefore, overall member satisfaction ratings could not be derived for these CAHPS measures.

**Table 1-2—NCQA Comparisons Highlights**

Measure	Three-Point Mean	Star Rating
<b>Global Rating</b>		
Rating of Health Plan	2.46	★★★
Rating of All Health Care	2.44	★★★★
Rating of Personal Doctor	2.53	★★★★
Rating of Specialist Seen Most Often	2.54	★★★
<b>Composite Measure</b>		
Getting Needed Care	2.36	★★★
Getting Care Quickly	2.41	★★★
How Well Doctors Communicate	2.59	★★★★
Customer Service	2.55	★★★
<b>Individual Item Measure</b>		
Coordination of Care	2.27	★
Star Assignments Based on Percentiles ★★★★★ 90th or Above   ★★★★★ 75th-89th   ★★★ 50th-74th   ★★ 25th-49th   ★ Below 25th		

The NCQA comparisons revealed the following summary results:

- The Acute Care program did not score at or above the 90th percentile on any of the measures.
- The Acute Care program scored at or between the 75th and 89th percentiles on three measures: Rating of All Health Care, Rating of Personal Doctor, and How Well Doctors Communicate.
- The Acute Care program scored at or between the 50th and 74th percentiles on five measures: Rating of Health Plan, Rating of Specialist Seen Most Often, Getting Needed Care, Getting Care Quickly, and Customer Service.
- The Acute Care program did not score at or between the 25th and 49th percentiles on any of the measures.
- The Acute Care program scored below the 25th percentile on one measure, Coordination of Care.

### Rates and Proportions

The question summary rates and global proportions for the Acute Care program’s adult Medicaid population were compared to 2016 NCQA Adult Medicaid Quality Compass® data.<sup>1-6</sup> These comparisons were performed on the four global ratings, five composite measures, and two individual item measures. The detailed results of these analyses are described in the Results section beginning on page 3-5. The following is a highlight of this comparison:

- The Acute Care program scored at or above the national average on eight measures: Rating of Health Plan, Rating of All Health Care, Rating of Specialist Seen Most Often, Getting Needed Care, Getting Care Quickly, Customer Service, Shared Decision Making, and Health Promotion and Education.

### Contractor Comparisons

In order to identify performance differences in member satisfaction between the eight participating Contractors, the results for each Contractor were compared to the overall Acute Care program average for the adult population using standard statistical testing. These comparisons were performed on the four global ratings, five composite measures, and two individual item measures. The detailed results of the comparative analysis are described in the Results section beginning on page 3-5. Table 1-3 presents the statistically significant results from this comparison.<sup>1-7,1-8</sup>

**Table 1-3—Contractor Comparisons Highlights**

Care 1st Health Plan of Arizona	Health Choice Arizona	Maricopa Health Plan
↓ Rating of All Health Care	↓ Rating of Health Plan	↑ Rating of All Health Care
	↓ Rating of All Health Care	
Mercy Care Plan	UnitedHealthcare Community Plan	
↑ Rating of Health Plan	↑ Rating of Health Plan	
	↑ Rating of All Health Care	
↑ Statistically significantly higher than the Acute Care program average ↓ Statistically significantly lower than the Acute Care program average		

<sup>1-6</sup> Quality Compass® is a registered trademark of the National Committee for Quality Assurance (NCQA).

<sup>1-7</sup> Caution should be exercised when evaluating Contractor comparisons, given that population and Contractor differences may impact results.

<sup>1-8</sup> The Contractor comparative analysis revealed that there were no statistically significant differences between Health Net Access’, Phoenix Health Plan’s, and University Family Care’s results, and the Acute Care program average for the adult population.

### Survey Administration and Response Rates

#### *Survey Administration*

Acute Care members eligible for surveying included those who were enrolled in the Acute Care program at the time the sample was drawn and who were continuously enrolled in Acute Care for at least five of the last six months of the measurement period (October 2015 through March 2016). In addition, adult members had to be 18 years of age or older as of March 31, 2016 to be included in the survey.

The standard NCQA HEDIS Specifications for Survey Measures require a sample size of 1,350 members for the CAHPS 5.0H Adult Medicaid Health Plan Survey. For the Acute Care program's adult Medicaid population, a 20 percent oversample was performed for each participating Contractor. Based on this percentage, a sample of 1,620 adult members was selected from each Contractor for a total sample size of 12,960 adult members. The oversampling was performed to ensure a greater number of respondents to each CAHPS measure.

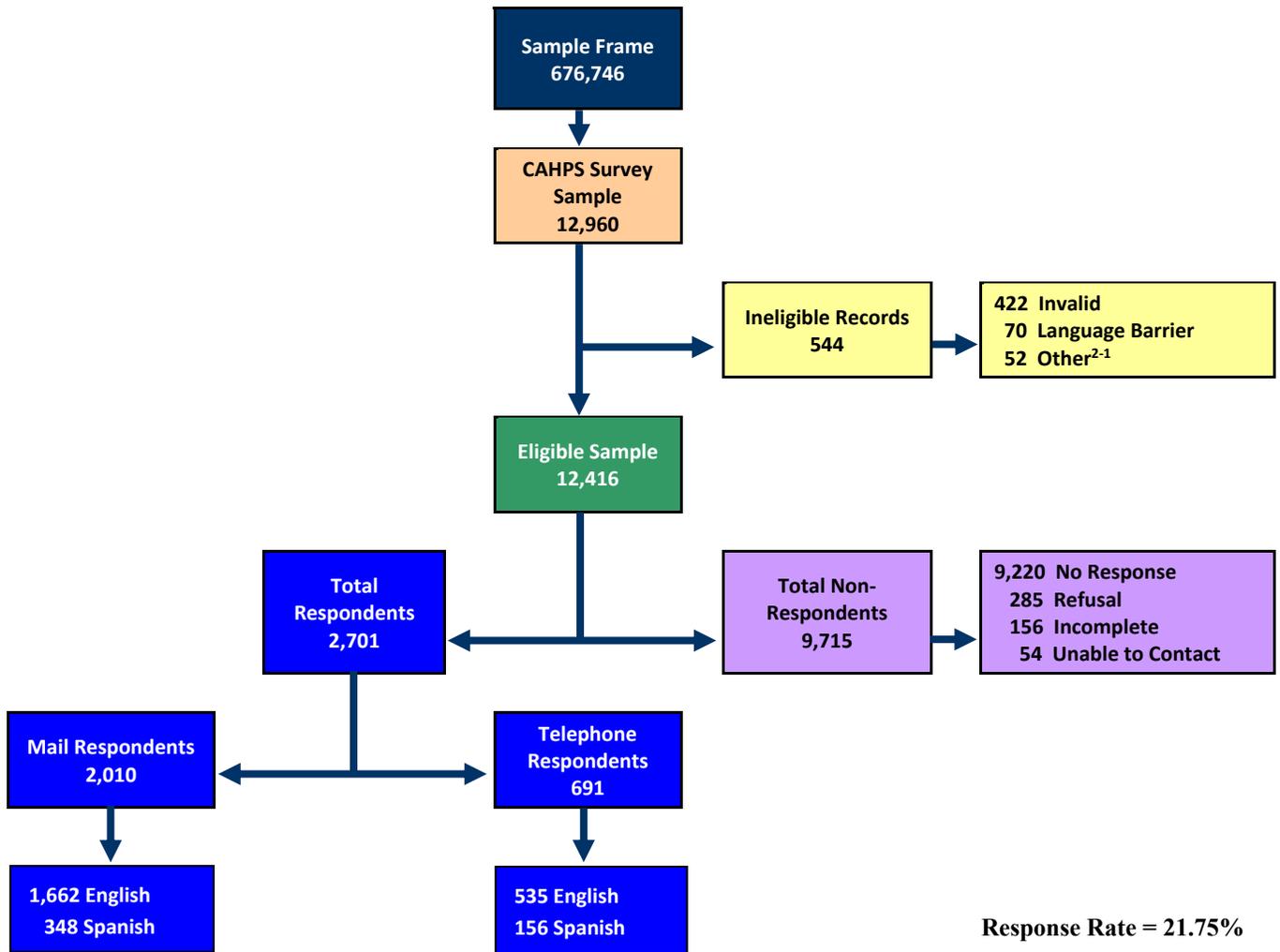
The survey administration protocol was designed to achieve a high response rate from members, thus minimizing the potential effects of non-response bias. The survey process allowed members two methods by which they could complete the surveys. The first, or mail phase, consisted of a survey being mailed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

## **Response Rates**

The Acute Care program CAHPS Survey administration was designed to achieve the highest possible response rate. The CAHPS Survey response rate is the total number of completed surveys divided by all eligible members of the sample. A survey was assigned a disposition code of “completed” if at least three of the following five questions were answered: questions 3, 15, 24, 28, and 35. Eligible members included the entire sample minus ineligible members. Ineligible members met at least one of the following criteria: they were deceased, were invalid (did not meet the eligible population criteria), had a language barrier, or were mentally or physically incapacitated.

A total of 2,701 adult members returned a completed survey. Figure 2-1, on the following page, shows the distribution of survey dispositions and response rates for the Acute Care program’s adult Medicaid population.

**Figure 2-1—Distribution of Surveys for Acute Care Program’s Adult Medicaid Population**



The Acute Care program’s response rate of 21.8 percent for the adult Medicaid population was lower than the national adult Medicaid response rate reported by NCQA for 2016, which was 24.8 percent.<sup>2-2</sup>

<sup>2-1</sup> The “Other” ineligible records category includes members who were deceased or were mentally or physically incapacitated.

<sup>2-2</sup> National Committee for Quality Assurance. *HEDIS 2017 Update Survey Vendor Training*. October 18, 2016.

Table 2-1 depicts the sample distribution and response rates for each participating Contractor and the Acute Care program for the adult Medicaid population.

**Table 2-1—Sample Distribution and Response Rate**

Contractor Name	Total Sample	Ineligible Records	Eligible Sample	Total Respondents	Response Rate
<b>Acute Care Program</b>	<b>12,960</b>	<b>544</b>	<b>12,416</b>	<b>2,701</b>	<b>21.75%</b>
Care 1st Health Plan of Arizona	1,620	69	1,551	290	18.70%
Health Choice Arizona	1,620	66	1,554	348	22.39%
Health Net Access	1,620	65	1,555	319	20.51%
Maricopa Health Plan	1,620	122	1,498	251	16.76%
Mercy Care Plan	1,620	59	1,561	347	22.23%
Phoenix Health Plan	1,620	76	1,544	358	23.19%
UnitedHealthcare Community Plan	1,620	44	1,576	397	25.19%
University Family Care	1,620	43	1,577	391	24.79%

## Respondent Demographics

In general, the demographics of a response group may influence overall member satisfaction scores. For example, older and healthier respondents tend to report higher levels of member satisfaction; therefore, caution should be exercised when comparing populations that have significantly different demographic properties.<sup>2-3</sup> Currently, NCQA does not recommend case-mix adjusting Medicaid CAHPS results to account for these differences.

Table 2-2 through Table 2-7 show respondents’ self-reported age, gender, race, ethnicity, education, and general health status for the adult Medicaid population.

**Table 2-2—Respondent Demographics: Age**

Contractor Name	18 to 24	25 to 34	35 to 44	45 to 54	55 to 64	65 or older
<b>Acute Care Program</b>	<b>8.4%</b>	<b>12.9%</b>	<b>14.9%</b>	<b>19.6%</b>	<b>26.5%</b>	<b>17.7%</b>
Care 1st Health Plan of Arizona	6.0%	18.0%	16.3%	20.1%	27.2%	12.4%
Health Choice Arizona	9.9%	12.8%	15.4%	21.4%	27.0%	13.6%
Health Net Access	8.1%	12.3%	12.6%	20.6%	31.9%	14.5%
Maricopa Health Plan	9.3%	10.5%	9.3%	21.5%	32.0%	17.4%
Mercy Care Plan	7.9%	14.3%	18.8%	17.9%	23.4%	17.6%
Phoenix Health Plan	9.2%	14.1%	16.7%	18.4%	20.4%	21.3%
UnitedHealthcare Community Plan	8.3%	9.6%	14.5%	17.9%	24.4%	25.4%
University Family Care	8.2%	12.4%	14.0%	20.1%	28.3%	16.9%

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

**Table 2-3—Respondent Demographics: Gender**

Contractor Name	Male	Female
<b>Acute Care Program</b>	<b>37.0%</b>	<b>63.0%</b>
Care 1st Health Plan of Arizona	38.4%	61.6%
Health Choice Arizona	37.4%	62.6%
Health Net Access	41.1%	58.9%
Maricopa Health Plan	42.7%	57.3%
Mercy Care Plan	33.0%	67.0%
Phoenix Health Plan	31.7%	68.3%
UnitedHealthcare Community Plan	38.5%	61.5%
University Family Care	35.1%	64.9%

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

<sup>2-3</sup> Agency for Healthcare Research and Quality. *CAHPS Health Plan Survey and Reporting Kit 2008*. Rockville, MD: U.S. Department of Health and Human Services, July 2008.

**Table 2-4—Respondent Demographics: Race**

Contractor Name	Multi-Racial	White	Black	Asian	Native American	Other
<b>Acute Care Program</b>	<b>7.1%</b>	<b>66.2%</b>	<b>6.7%</b>	<b>3.8%</b>	<b>1.8%</b>	<b>14.4%</b>
Care 1st Health Plan of Arizona	4.0%	68.8%	10.3%	3.6%	0.4%	13.0%
Health Choice Arizona	9.5%	67.2%	5.4%	1.9%	4.4%	11.7%
Health Net Access	4.4%	70.6%	4.8%	7.5%	0.7%	11.9%
Maricopa Health Plan	4.1%	67.7%	8.8%	3.2%	0.5%	15.7%
Mercy Care Plan	10.0%	58.1%	9.0%	4.5%	1.7%	16.6%
Phoenix Health Plan	8.6%	60.4%	8.6%	5.3%	1.7%	15.5%
UnitedHealthcare Community Plan	7.3%	66.9%	3.9%	3.4%	2.0%	16.6%
University Family Care	7.4%	70.1%	4.7%	1.5%	2.4%	13.9%

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

**Table 2-5—Respondent Demographics: Ethnicity**

Contractor Name	Hispanic	Non-Hispanic
<b>Acute Care Program</b>	<b>41.5%</b>	<b>58.5%</b>
Care 1st Health Plan of Arizona	40.6%	59.4%
Health Choice Arizona	31.1%	68.9%
Health Net Access	30.1%	69.9%
Maricopa Health Plan	44.9%	55.1%
Mercy Care Plan	40.2%	59.8%
Phoenix Health Plan	46.9%	53.1%
UnitedHealthcare Community Plan	48.1%	51.9%
University Family Care	48.0%	52.0%

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

**Table 2-6—Respondent Demographics: Education**

Contractor Name	8th Grade or Less	Some High School	High School Graduate	Some College	College Graduate
<b>Acute Care Program</b>	<b>12.1%</b>	<b>14.5%</b>	<b>31.8%</b>	<b>30.8%</b>	<b>10.9%</b>
Care 1st Health Plan of Arizona	9.6%	12.9%	31.8%	36.8%	8.9%
Health Choice Arizona	8.5%	14.4%	39.0%	27.9%	10.3%
Health Net Access	7.1%	9.3%	28.6%	37.0%	18.0%
Maricopa Health Plan	14.8%	16.8%	29.5%	25.4%	13.5%
Mercy Care Plan	12.3%	13.8%	30.5%	34.2%	9.2%
Phoenix Health Plan	19.1%	15.9%	30.9%	26.8%	7.4%
UnitedHealthcare Community Plan	12.0%	17.3%	30.1%	28.3%	12.3%
University Family Care	12.9%	15.0%	32.9%	30.8%	8.4%

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

**Table 2-7—Respondent Demographics: General Health Status**

Contractor Name	Excellent	Very Good	Good	Fair	Poor
<b>Acute Care Program</b>	<b>9.9%</b>	<b>21.2%</b>	<b>34.7%</b>	<b>26.2%</b>	<b>8.1%</b>
Care 1st Health Plan of Arizona	8.5%	25.8%	35.7%	24.4%	5.7%
Health Choice Arizona	8.1%	20.9%	30.2%	27.6%	13.1%
Health Net Access	11.5%	23.4%	38.5%	20.2%	6.4%
Maricopa Health Plan	11.7%	20.6%	36.7%	24.6%	6.5%
Mercy Care Plan	9.7%	18.2%	35.9%	29.1%	7.1%
Phoenix Health Plan	7.6%	21.3%	33.6%	27.2%	10.2%
UnitedHealthcare Community Plan	10.6%	20.9%	33.3%	27.6%	7.5%
University Family Care	11.4%	19.4%	35.0%	27.1%	7.2%

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

For additional demographic information, please refer to the cross-tabulations (Tab and Banner Book).

The following presents the CAHPS results for the adult population for the Acute Care program. The CAHPS results presented in this section represent a **baseline** assessment of the adult members' satisfaction with the Acute Care program.

### NCQA Comparisons

In order to assess the overall performance of the Acute Care program's adult Medicaid population, each of the CAHPS global ratings (Rating of Health Plan, Rating of All Health Care, Rating of Personal Doctor, and Rating of Specialist Seen Most Often), four of the CAHPS composite measures (Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, and Customer Service), and one individual item measure (Coordination of Care) were scored on a three-point scale using the scoring methodology detailed in NCQA's HEDIS Specifications for Survey Measures.<sup>3-1</sup> The resulting three-point mean scores were compared to NCQA's HEDIS Benchmarks and Thresholds for Accreditation.<sup>3-2</sup> Based on this comparison, ratings of one (★) to five (★★★★★) stars were determined for each CAHPS measure, where one is the lowest possible rating and five is the highest possible rating.<sup>3-3</sup>

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

<sup>3-1</sup> National Committee for Quality Assurance. *HEDIS® 2017, Volume 3: Specifications for Survey Measures*. Washington, DC: NCQA Publication, 2016.

<sup>3-2</sup> National Committee for Quality Assurance. *HEDIS Benchmarks and Thresholds for Accreditation 2017*. Washington, DC: NCQA, May 4, 2017.

<sup>3-3</sup> NCQA does not provide benchmarks and thresholds for the Shared Decision Making composite measure and Health Promotion and Education individual item measure; therefore, overall member satisfaction ratings could not be determined for these CAHPS measures.

Table 3-1 shows the Acute Care program’s and participating Contractors’ three-point mean scores and overall adult member satisfaction ratings on each of the four global ratings.

**Table 3-1—NCQA Comparisons: Global Ratings**

Contractor Name	Rating of Health Plan	Rating of All Health Care	Rating of Personal Doctor	Rating of Specialist Seen Most Often
<b>Acute Care Program</b>	★★★ 2.46	★★★★ 2.44	★★★★ 2.53	★★★ 2.54
Care 1st Health Plan of Arizona	★★ 2.40	★★ 2.34	★★★ 2.52	★★★ 2.52
Health Choice Arizona	★ 2.33	★ 2.31	★★ 2.43	★★ 2.48
Health Net Access	★★ 2.36	★★★ 2.38	★★ 2.45	★★★ 2.52
Maricopa Health Plan	★★★★ 2.49	★★★★★ 2.54	★★★ 2.52	★★+ 2.50
Mercy Care Plan	★★★★★ 2.56	★★★★★ 2.46	★★★★★ 2.58	★★★ 2.54
Phoenix Health Plan	★★★★ 2.48	★★★ 2.41	★★★★ 2.54	★ 2.42
UnitedHealthcare Community Plan	★★★★★ 2.54	★★★★★ 2.53	★★★★ 2.54	★★★★★ 2.64
University Family Care	★★★★ 2.48	★★★★★ 2.51	★★★★★ 2.63	★★★★★ 2.62

Star Assignments Based on Percentiles

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

+ indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.

Table 3-2 shows the Acute Care program’s and participating Contractors’ three-point mean scores and overall adult member satisfaction ratings on the four composite measures and one individual item measure.

**Table 3-2—NCQA Comparisons: Composite Measures and Individual Item Measure**

Contractor Name	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service	Coordination of Care
<b>Acute Care Program</b>	★★★ 2.36	★★★ 2.41	★★★★★ 2.59	★★★ 2.55	★ 2.27
Care 1st Health Plan of Arizona	★ 2.26	★★★ 2.42	★★★★★ 2.58	★★★★★ 2.60	★ <sup>+</sup> 2.32
Health Choice Arizona	★ 2.25	★ 2.32	★★ 2.52	★★ 2.53	★ 2.22
Health Net Access	★★ 2.33	★★ 2.36	★★★★★ 2.58	★★★ 2.54	★ 2.14
Maricopa Health Plan	★★★ 2.38	★★★ 2.44	★★★★★ 2.61	★★★ <sup>+</sup> 2.57	★★ <sup>+</sup> 2.36
Mercy Care Plan	★★★★★ 2.42	★★★★★ 2.45	★★★★★ 2.61	★★ <sup>+</sup> 2.50	★ 2.22
Phoenix Health Plan	★★ 2.32	★★★ 2.44	★★★ 2.55	★★ 2.50	★ 2.28
UnitedHealthcare Community Plan	★★★★★ 2.44	★★ 2.38	★★★★★ 2.60	★★★ 2.56	★ 2.26
University Family Care	★★★★★★ 2.45	★★★★★ 2.46	★★★★★★ 2.65	★★★★★ 2.59	★★★ 2.41
Star Assignments Based on Percentiles ★★★★★ 90th or Above   ★★★★★ 75th-89th   ★★★ 50th-74th   ★★ 25th-49th   ★ Below 25th   + indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.					



## Summary of NCQA Comparisons Results

The NCQA comparisons revealed the following summary results for the adult population:

- The Acute Care program scored at or between the 75th and 89th percentiles on three measures: Rating of All Health Care, Rating of Personal Doctor, and How Well Doctors Communicate. The Acute Care program scored below the 25th percentile on one measure, Coordination of Care.
- Care 1st Health Plan of Arizona scored at or between the 75th and 89th percentiles on two measures: How Well Doctors Communicate and Customer Service. Care 1st Health Plan of Arizona scored below the 25th percentile on two measures: Getting Needed Care and Coordination of Care.
- Health Choice Arizona scored at or between the 25th and 49th percentiles on four measures: Rating of Personal Doctor, Rating of Specialist Seen Most Often, How Well Doctors Communicate, and Customer Service. Health Choice Arizona scored below the 25th percentile on five measures: Rating of Health Plan, Rating of All Health Care, Getting Needed Care, Getting Care Quickly, and Coordination of Care.
- Health Net Access scored at or between the 75th and 89th percentiles on one measure, How Well Doctors Communicate. Health Net Access scored below the 25th percentile on one measure, Coordination of Care.
- Maricopa Health Plan scored at or above the 90th percentile on one measure, Rating of All Health Care. Maricopa Health Plan scored between the 25th and 49th percentiles on two measures: Rating of Specialist Seen Most Often and Coordination of Care.
- Mercy Care Plan scored at or above the 90th percentile on three measures: Rating of Health Plan, Rating of All Health Care, and Rating of Personal Doctor. Mercy Care Plan scored below the 25th percentile on one measure, Coordination of Care.
- Phoenix Health Plan scored at or between the 75th and 89th percentiles on two measures: Rating of Health Plan and Rating of Personal Doctor. Phoenix Health Plan scored below the 25th percentile on two measures: Rating of Specialist Seen Most Often and Coordination of Care.
- UnitedHealthcare Community Plan scored at or above the 90th percentile on three measures: Rating of Health Plan, Rating of All Health Care, and Rating of Specialist Seen Most Often. UnitedHealthcare Community Plan scored below the 25th percentile on one measure, Coordination of Care.
- University Family Care scored at or above the 90th percentile on five measures: Rating of All Health Care, Rating of Personal Doctor, Rating of Specialist Seen Most Often, Getting Needed Care, and How Well Doctors Communicate. University Family Care did not score below the 50th percentile on any of the measures.

## Rates and Proportions

For purposes of calculating the results, question summary rates were calculated for each global rating and individual item measure, and global proportions were calculated for each composite measure. Both the question summary rates and global proportions were calculated in accordance with NCQA HEDIS Specifications for Survey Measures.<sup>3-4</sup> The scoring of the global ratings, composite measures, and individual item measures involved assigning top-level responses a score of one, with all other responses receiving a score of zero. After applying this scoring methodology, the percentage of top-level responses was calculated in order to determine the question summary rates and global proportions. For additional detail, please refer to the *NCQA HEDIS 2017 Specifications for Survey Measures, Volume 3*.

## Contractor Comparisons

In order to identify performance differences in member satisfaction between the eight participating Contractors, the 2016 CAHPS results for each Contractor were compared to the overall 2016 Acute Care program average for the adult population to determine if there were any statistically significant differences.<sup>3-5</sup> Statistically significant differences are noted in the figures by arrows. A Contractor that performed statistically significantly higher than the Acute Care program average is denoted with an upward (↑) arrow. Conversely, a Contractor that performed statistically significantly lower than the Acute Care program average is denoted with a downward (↓) arrow. A Contractor's score that is not statistically significantly different than the Acute Care program average is not noted with an arrow.<sup>3-6</sup> In some instances, the mean scores for two Contractors were the same, but one was statistically different from the program average and the other was not. In these instances, it was the difference in the number of respondents between the two Contractors that explains the different statistical results. It is more likely that a statistically significant result will be found in a Contractor with a larger number of respondents. The 2016 NCQA National Adult Medicaid averages are presented for comparison purposes.

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<sup>3-4</sup> National Committee for Quality Assurance. *HEDIS® 2017, Volume 3: Specifications for Survey Measures*. Washington, DC: NCQA Publication, 2016.

<sup>3-5</sup> Caution should be exercised when evaluating Contractor comparisons, given that population and Contractor differences may impact results.

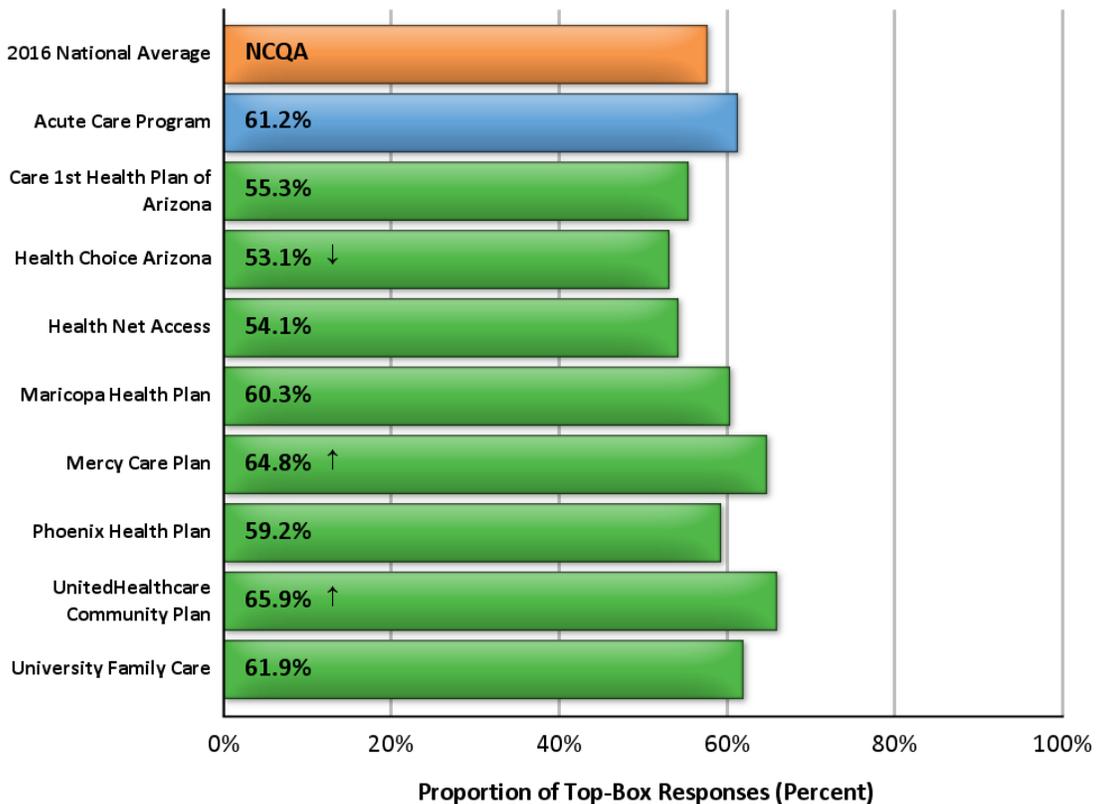
<sup>3-6</sup> A global *F* test was calculated first, which determined whether the difference between Contractors was significant. If the *F* test demonstrated Contractor-level differences, then a *t* test was performed for each Contractor. The *t* test determined whether each Contractor's rate was significantly different from the aggregate rate.

## Global Ratings

### Rating of Health Plan

Adult members were asked to rate their health plan on a scale of 0 to 10, with 0 being the “worst health plan possible” and 10 being the “best health plan possible.” Top-level responses were defined as those responses with a rating of 9 or 10. Figure 3-1 shows the 2016 NCQA National Adult Medicaid average using responses of 9 or 10 for top-box scoring and the 2016 Rating of Health Plan question summary rates for the Acute Care program and the eight participating Contractors.<sup>3-7,3-8</sup>

**Figure 3-1—Rating of Health Plan: Question Summary Rates**



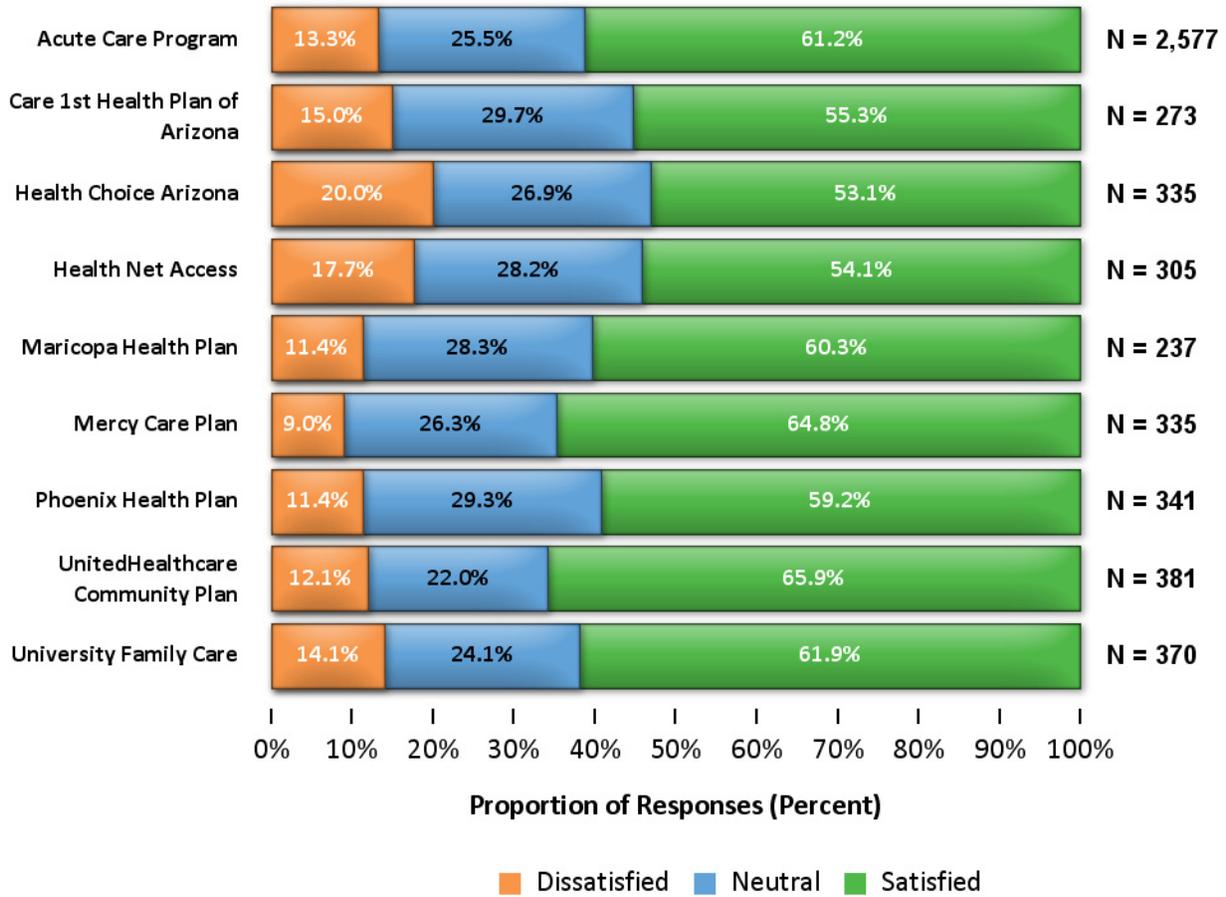
Statistical Significance Note: ↑ indicates the score is statistically significantly higher than the Acute Care Program average  
 ↓ indicates the score is statistically significantly lower than the Acute Care Program average

<sup>3-7</sup> For the NCQA national adult Medicaid averages, the source for data contained in this publication is Quality Compass<sup>®</sup> 2016 data and is used with the permission of the National Committee for Quality Assurance (NCQA). Quality Compass 2016 includes certain CAHPS data. Any data display, analysis, interpretation, or conclusion based on these data is solely that of the authors, and NCQA specifically disclaims responsibility for any such display, analysis, interpretation, or conclusion. Quality Compass is a registered trademark of NCQA. CAHPS<sup>®</sup> is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

<sup>3-8</sup> The AHCCCS Acute Care Program scores presented in this section are derived from the combined results of the eight Contractors that participated in the CAHPS Adult Medicaid Health Plan Survey.

For each global rating question, responses were classified into one of three response categories: “0 to 6 (Dissatisfied),” “7 to 8 (Neutral),” and “9 to 10 (Satisfied).” Figure 3-2 depicts the proportion of respondents who fell into each response category for Rating of Health Plan for the Acute Care program and the eight participating Contractors.

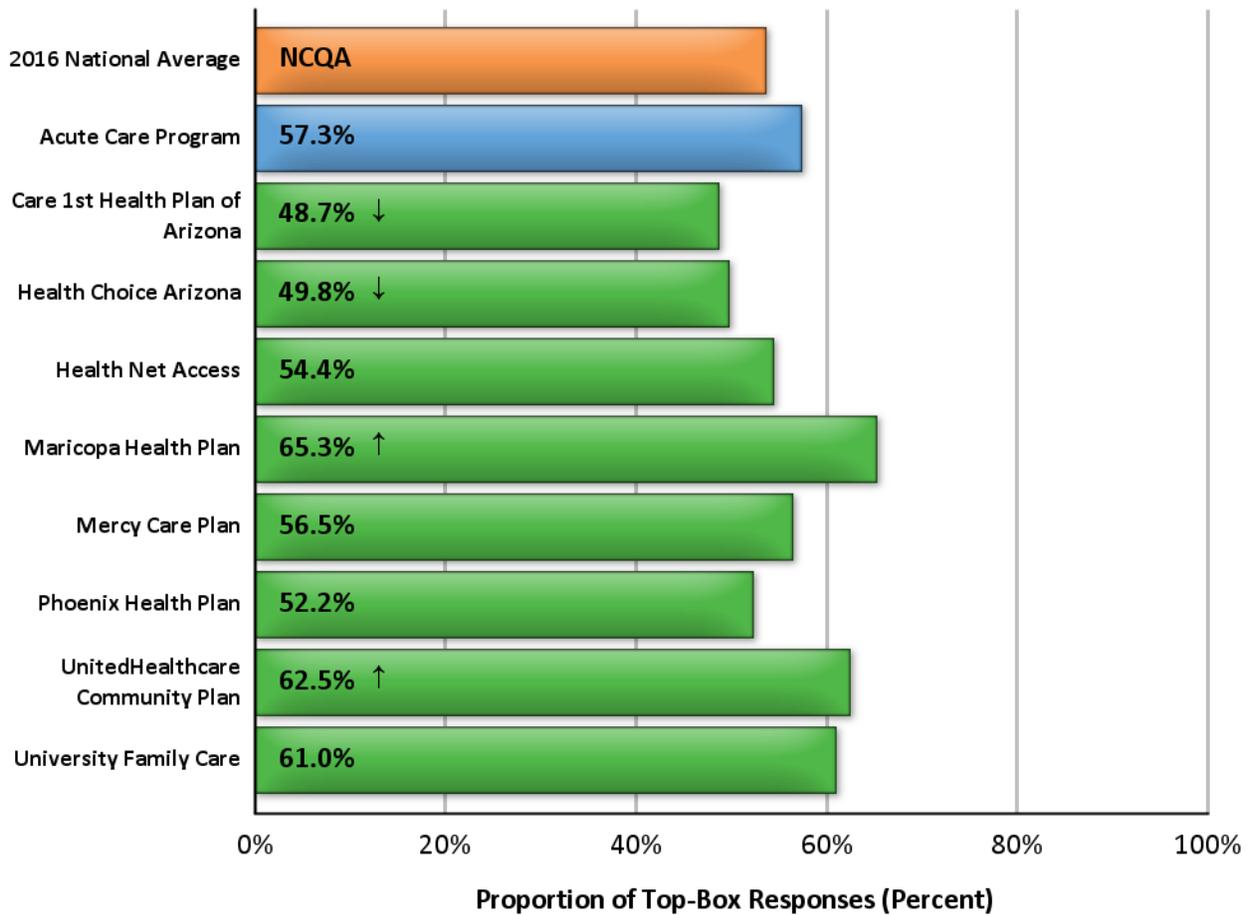
**Figure 3-2—Rating of Health Plan: Proportion of Responses**



### Rating of All Health Care

Adult members were asked to rate all their health care on a scale of 0 to 10, with 0 being the “worst health care possible” and 10 being the “best health care possible.” Top-level responses were defined as those responses with a rating of 9 or 10. Figure 3-3 shows the 2016 NCQA National Adult Medicaid average and the 2016 Rating of All Health Care question summary rates for the Acute Care program and the eight participating Contractors.

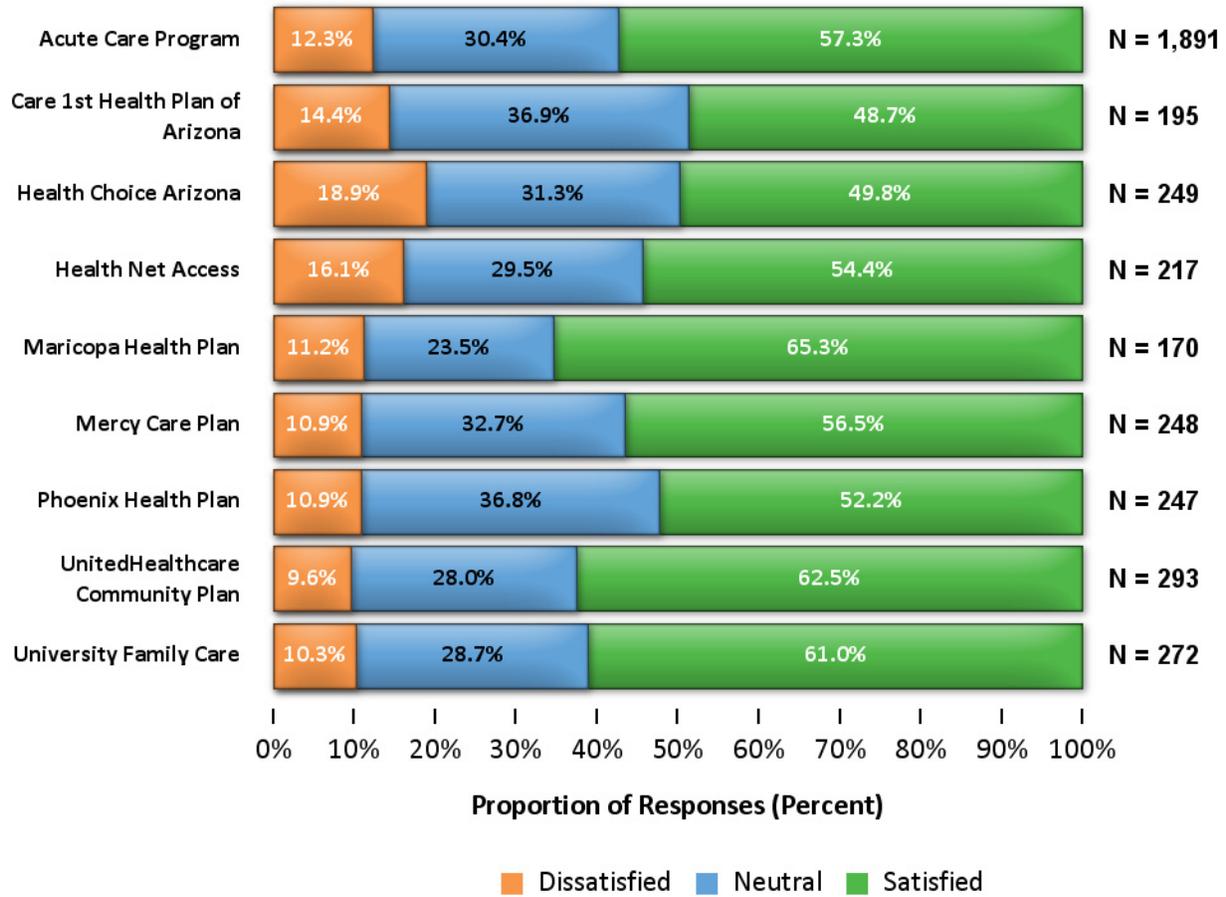
**Figure 3-3—Rating of All Health Care: Question Summary Rates**



Statistical Significance Note: ↑ indicates the score is statistically significantly higher than the Acute Care Program average  
 ↓ indicates the score is statistically significantly lower than the Acute Care Program average

For each global rating question, responses were classified into one of three response categories: “0 to 6 (Dissatisfied),” “7 to 8 (Neutral),” and “9 to 10 (Satisfied).” Figure 3-4 depicts the proportion of respondents who fell into each response category for Rating of All Health Care for the Acute Care program and the eight participating Contractors.

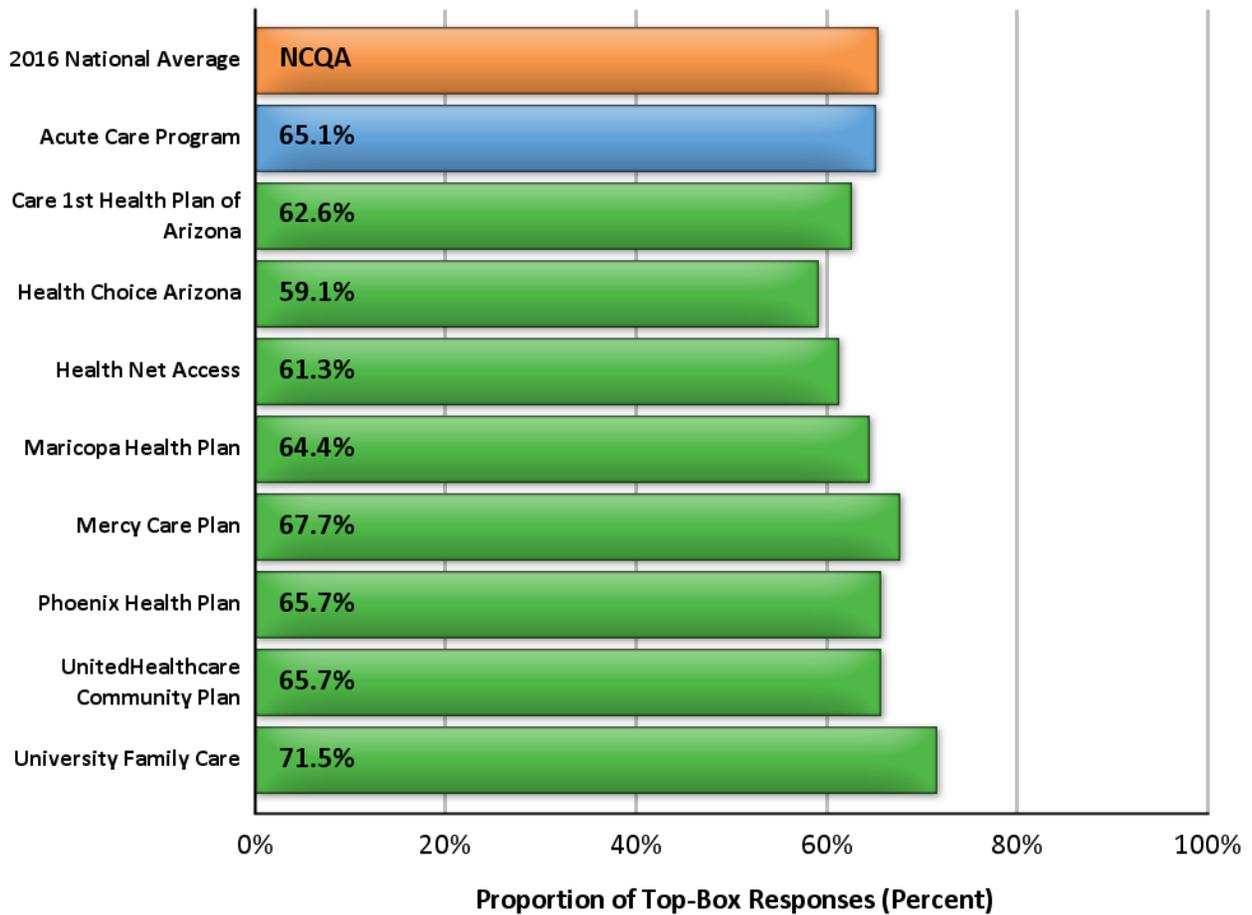
**Figure 3-4—Rating of All Health Care: Proportion of Responses**



### Rating of Personal Doctor

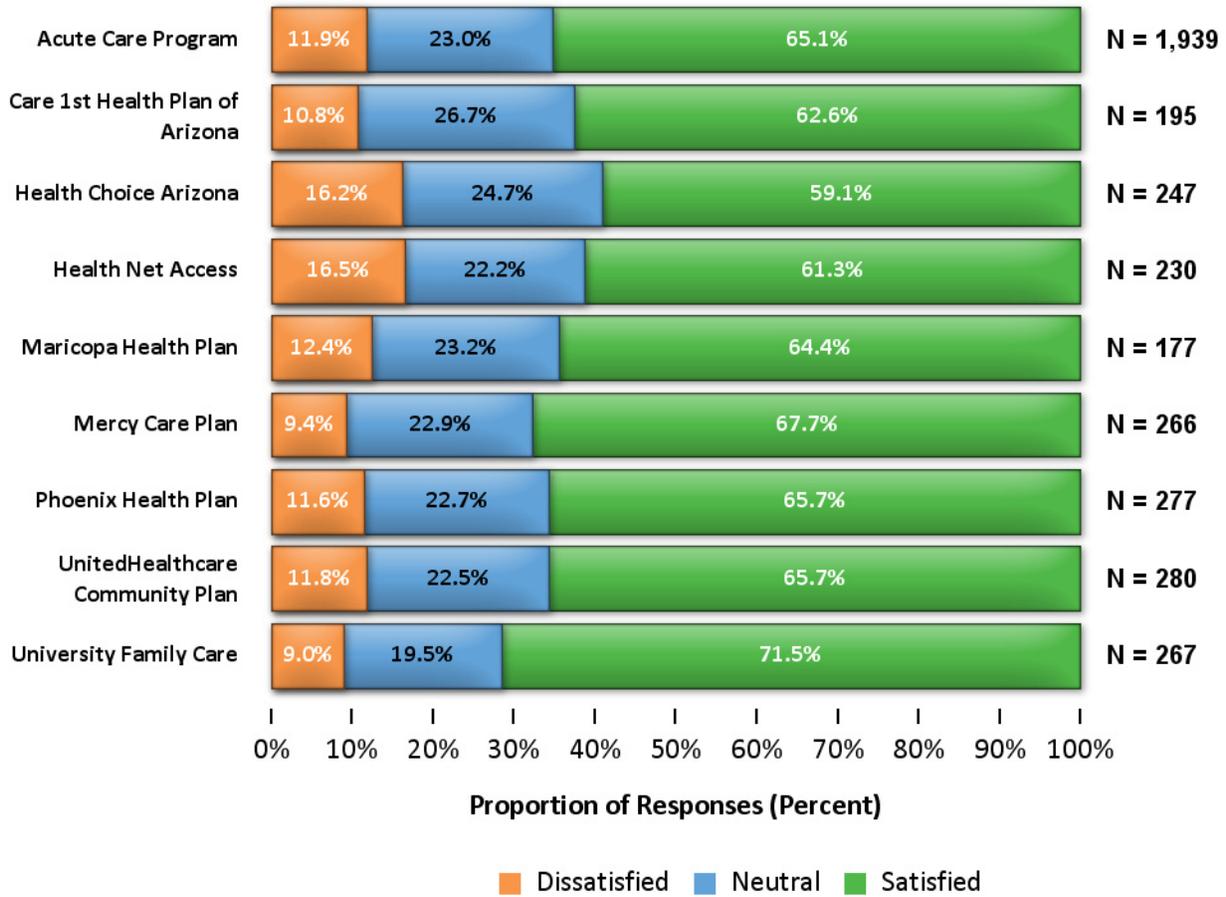
Adult members were asked to rate their personal doctor on a scale of 0 to 10, with 0 being the “worst personal doctor possible” and 10 being the “best personal doctor possible.” Top-level responses were defined as those responses with a rating of 9 or 10. Figure 3-5 shows the 2016 NCQA National Adult Medicaid average and the 2016 Rating of Personal Doctor question summary rates for the Acute Care program and the eight participating Contractors.

**Figure 3-5—Rating of Personal Doctor: Question Summary Rates**



For each global rating question, responses were classified into one of three response categories: “0 to 6 (Dissatisfied),” “7 to 8 (Neutral),” and “9 to 10 (Satisfied).” Figure 3-6 depicts the proportion of respondents who fell into each response category for Rating of Personal Doctor for the Acute Care program and the eight participating Contractors.

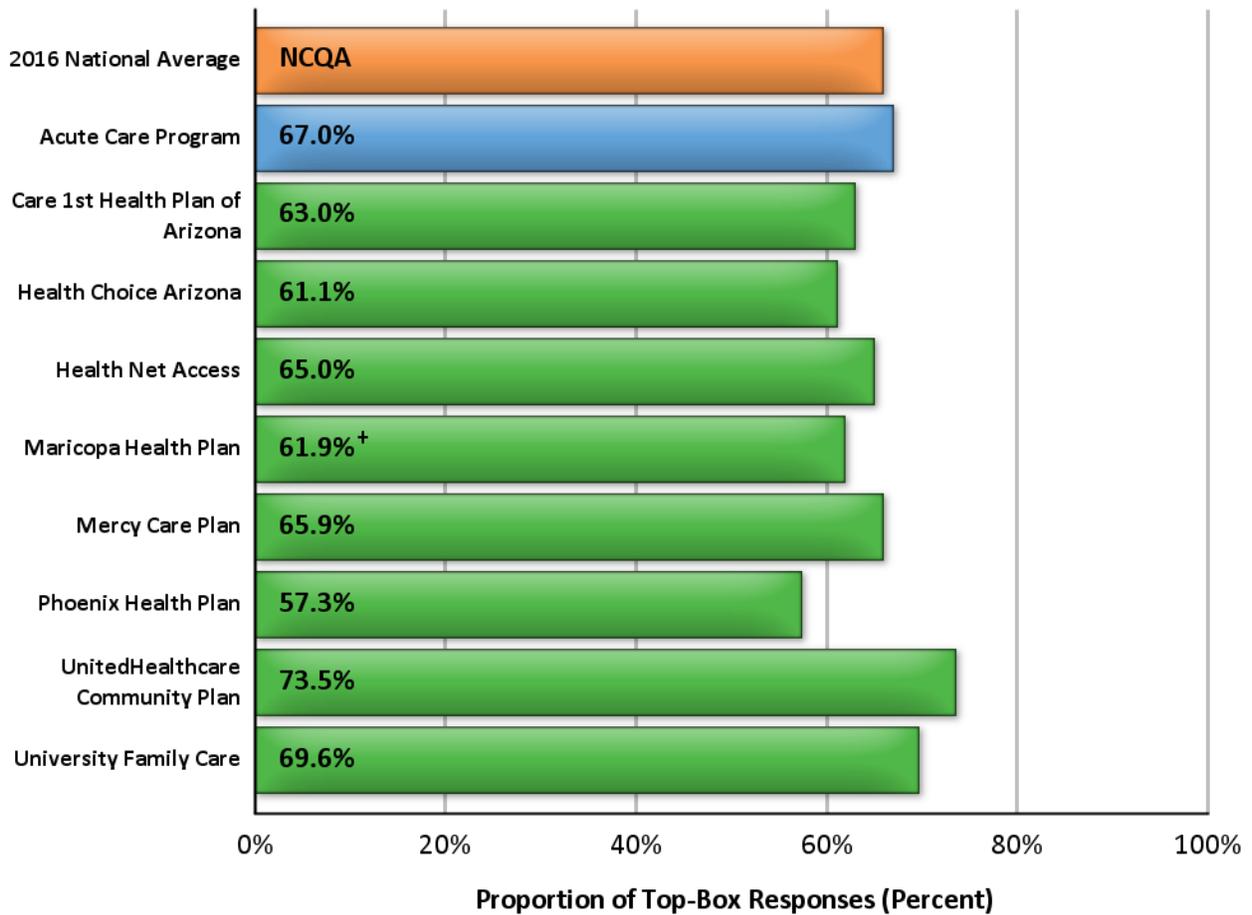
**Figure 3-6—Rating of Personal Doctor: Proportion of Responses**



### Rating of Specialist Seen Most Often

Adult members were asked to rate the specialist they saw most often on a scale of 0 to 10, with 0 being the “worst specialist possible” and 10 being the “best specialist possible.” Top-level responses were defined as those responses with a rating of 9 or 10. Figure 3-7 shows the 2016 NCQA National Adult Medicaid average and the 2016 Rating of Specialists Seen Most Often question summary rates for the Acute Care program and the eight participating Contractors.

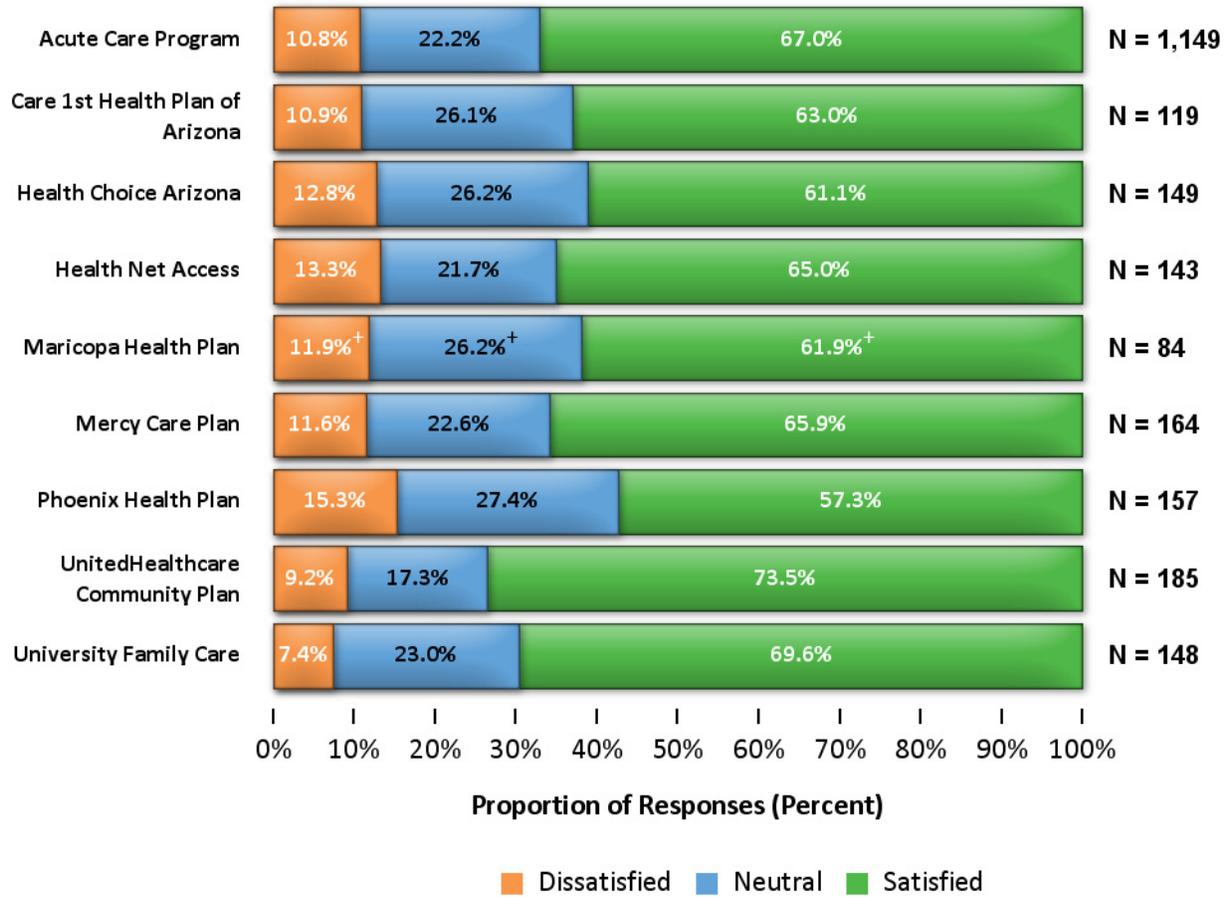
**Figure 3-7—Rating of Specialist Seen Most Often: Question Summary Rates**



*+ Indicates fewer than 100 respondents. Caution should be exercised when interpreting these results.*

For each global rating question, responses were classified into one of three response categories: “0 to 6 (Dissatisfied),” “7 to 8 (Neutral),” and “9 to 10 (Satisfied).” Figure 3-8 depicts the proportion of respondents who fell into each response category for Rating of Specialist Seen Most Often for the Acute Care program and the eight participating Contractors.

**Figure 3-8—Rating of Specialist Seen Most Often: Proportion of Responses**



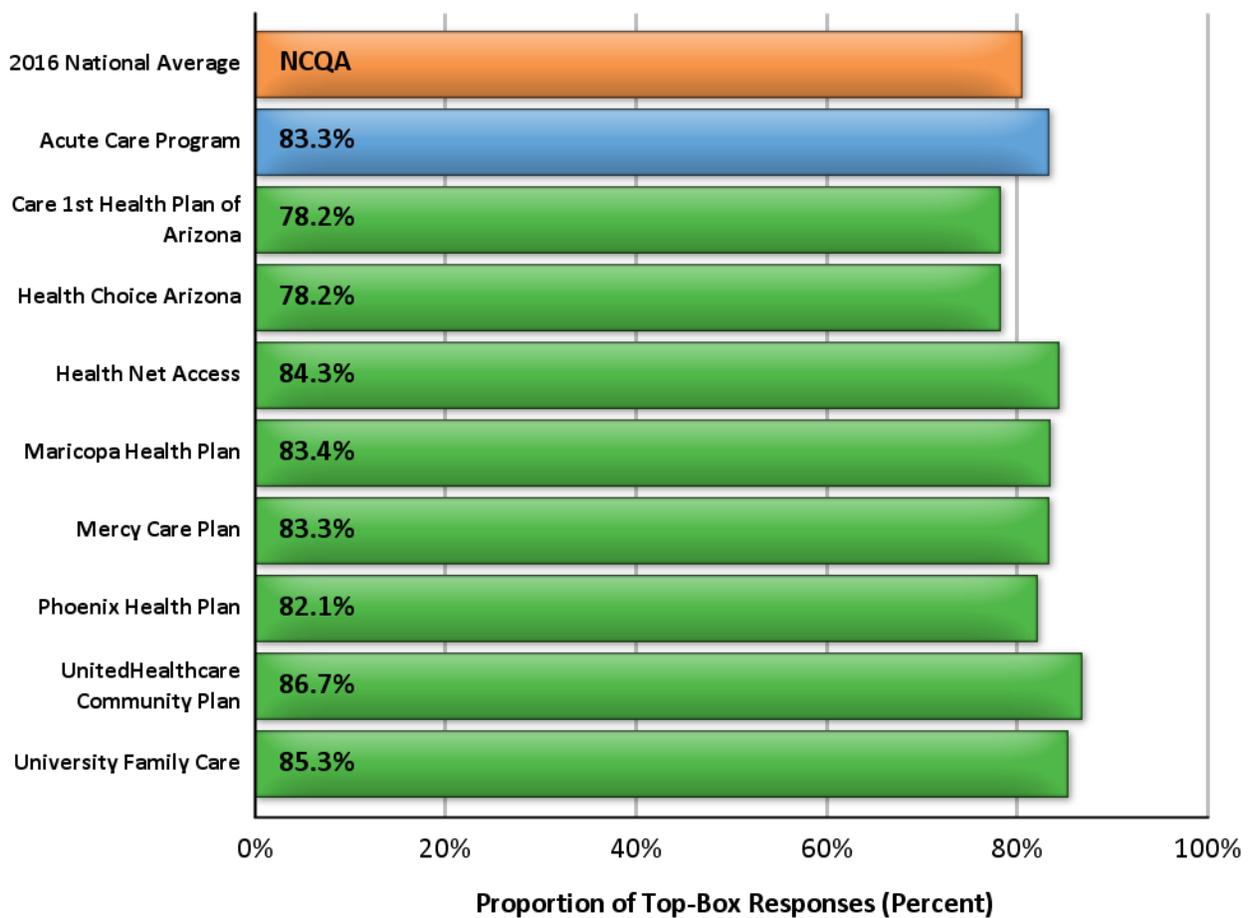
*+ Indicates fewer than 100 respondents. Caution should be exercised when interpreting these results.*

## Composite Measures

### Getting Needed Care

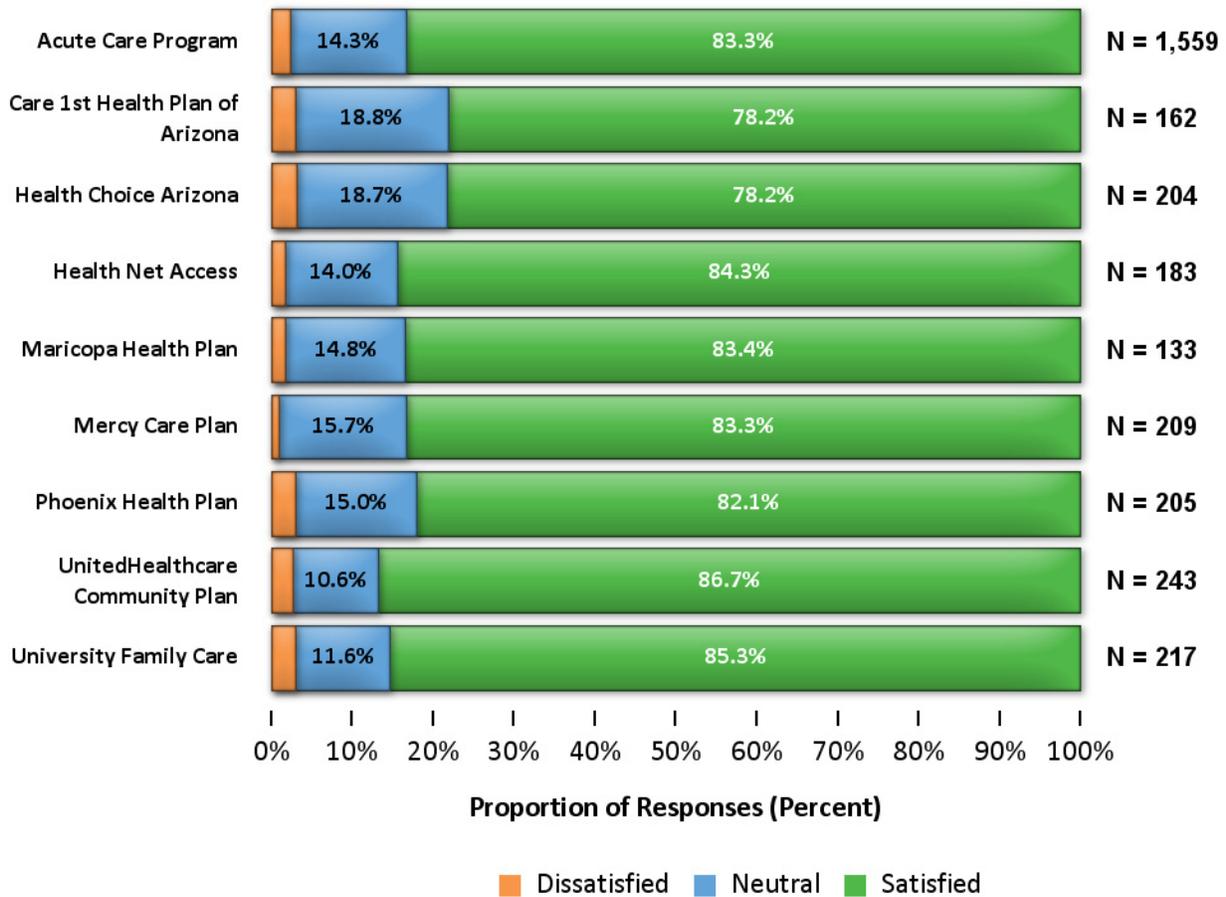
Adult members were asked two questions to assess how often it was easy to get needed care. For each of these questions (Questions 14 and 25), a top-level response was defined as a response of “Usually” or “Always.” Figure 3-9 shows the 2016 NCQA National Adult Medicaid average and the 2016 Getting Needed Care global proportions for the Acute Care program and the eight participating Contractors.

**Figure 3-9—Getting Needed Care: Global Proportions**



For the Getting Needed Care composite measure questions, responses were classified into one of three response categories as follows: “Never (Dissatisfied),” “Sometimes (Neutral),” and “Usually/Always (Satisfied).” Figure 3-10 depicts the proportion of respondents who fell into each response category for Getting Needed Care for the Acute Care program and the eight participating Contractors.

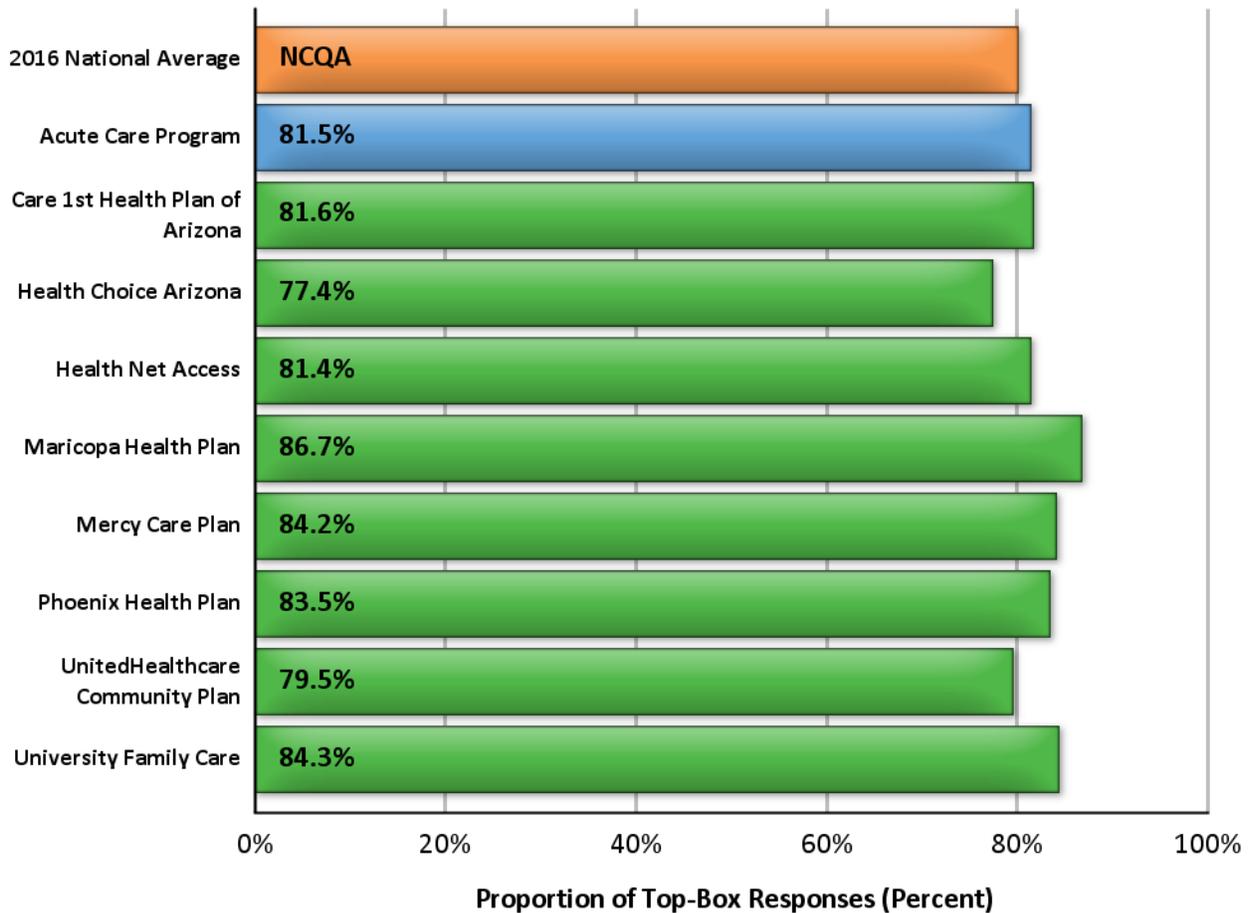
**Figure 3-10—Getting Needed Care: Proportion of Responses**



### Getting Care Quickly

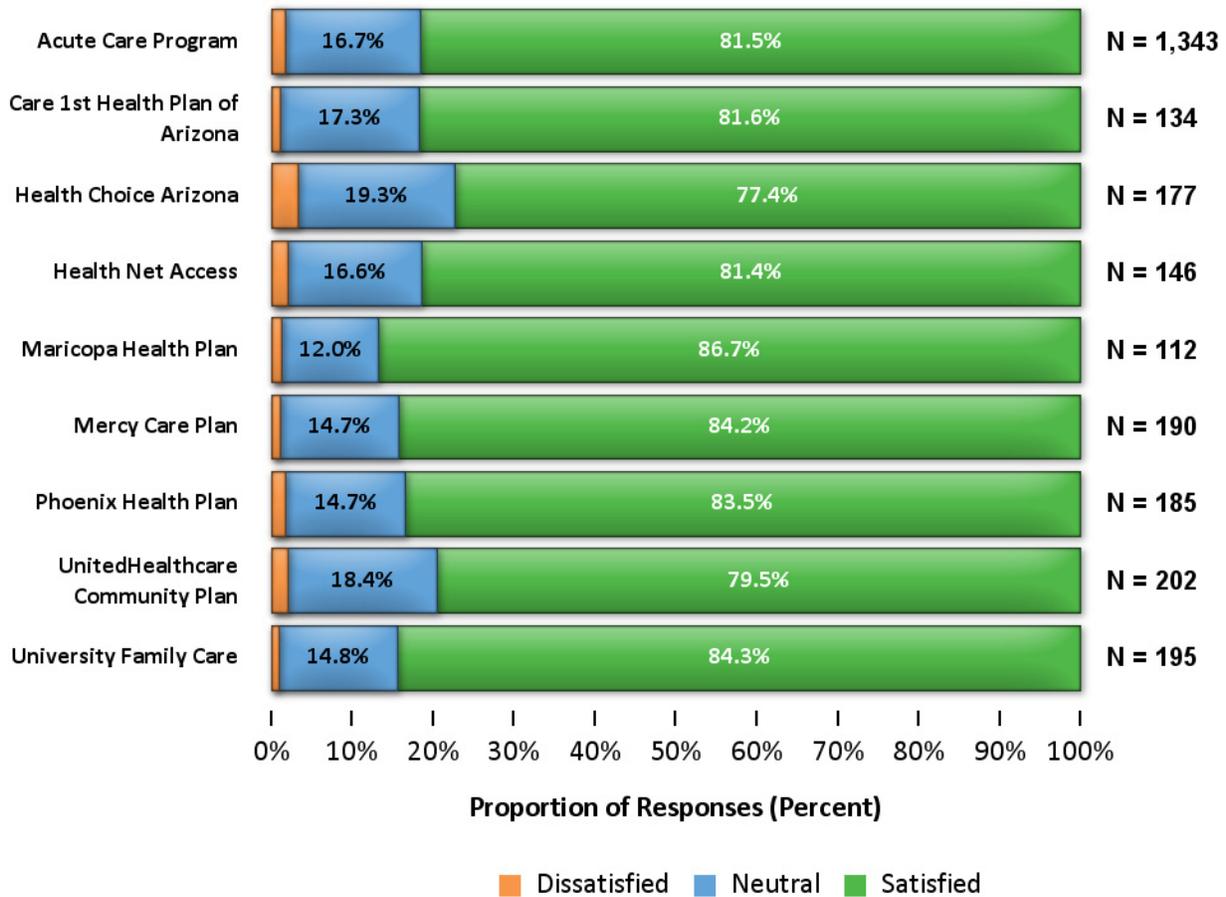
Adult members were asked two questions to assess how often they received care quickly. For each of these questions (Questions 4 and 6), a top-level response was defined as a response of “Usually” or “Always.” Figure 3-11 shows the 2016 NCQA National Adult Medicaid average and the 2016 Getting Care Quickly global proportions for the Acute Care program and the eight participating Contractors.

**Figure 3-11—Getting Care Quickly: Global Proportions**



For the Getting Care Quickly composite measure questions, responses were classified into one of three response categories as follows: “Never (Dissatisfied),” “Sometimes (Neutral),” and “Usually/Always (Satisfied).” Figure 3-12 depicts the proportion of respondents who fell into each response category for Getting Care Quickly for the Acute Care program and the eight participating Contractors.

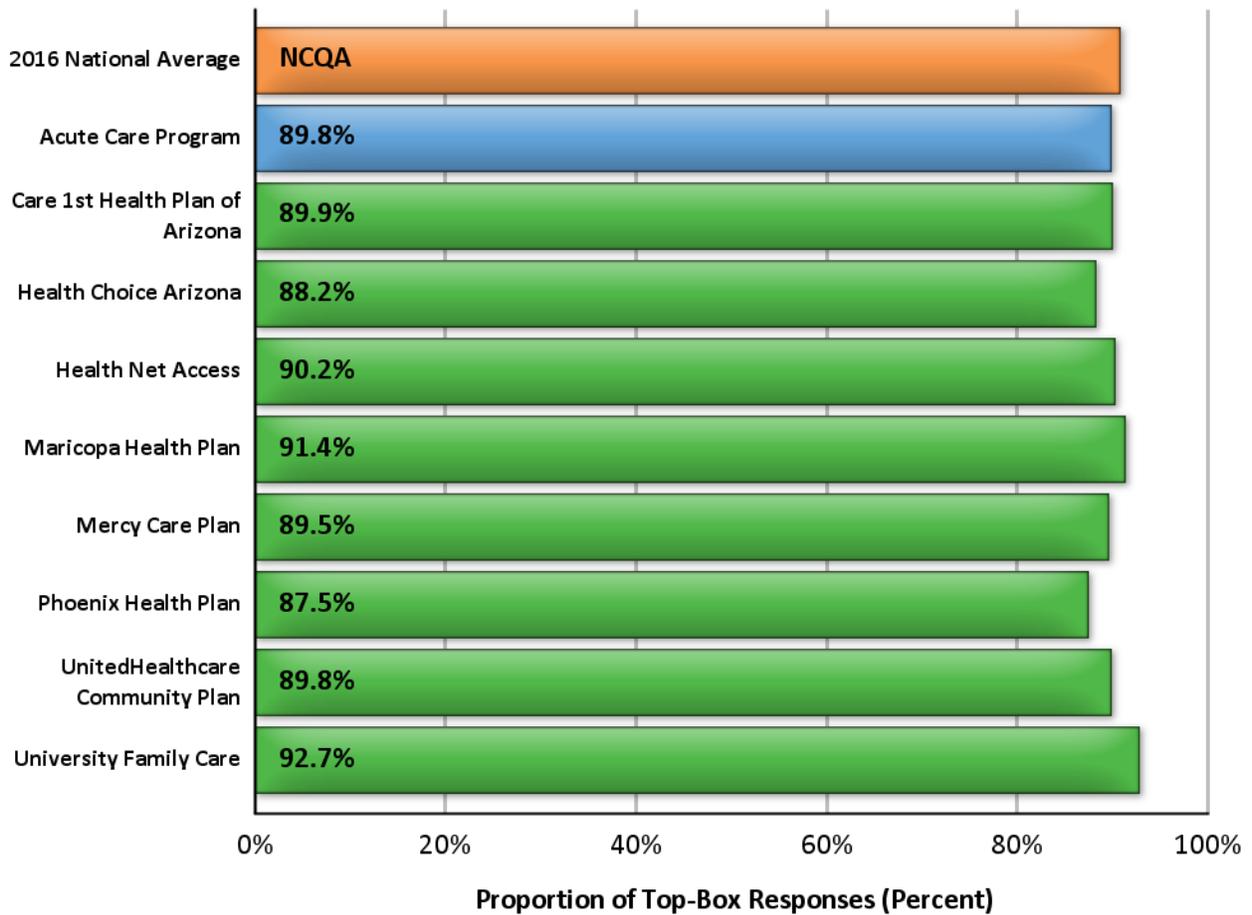
**Figure 3-12—Getting Care Quickly: Proportion of Responses**



### How Well Doctors Communicate

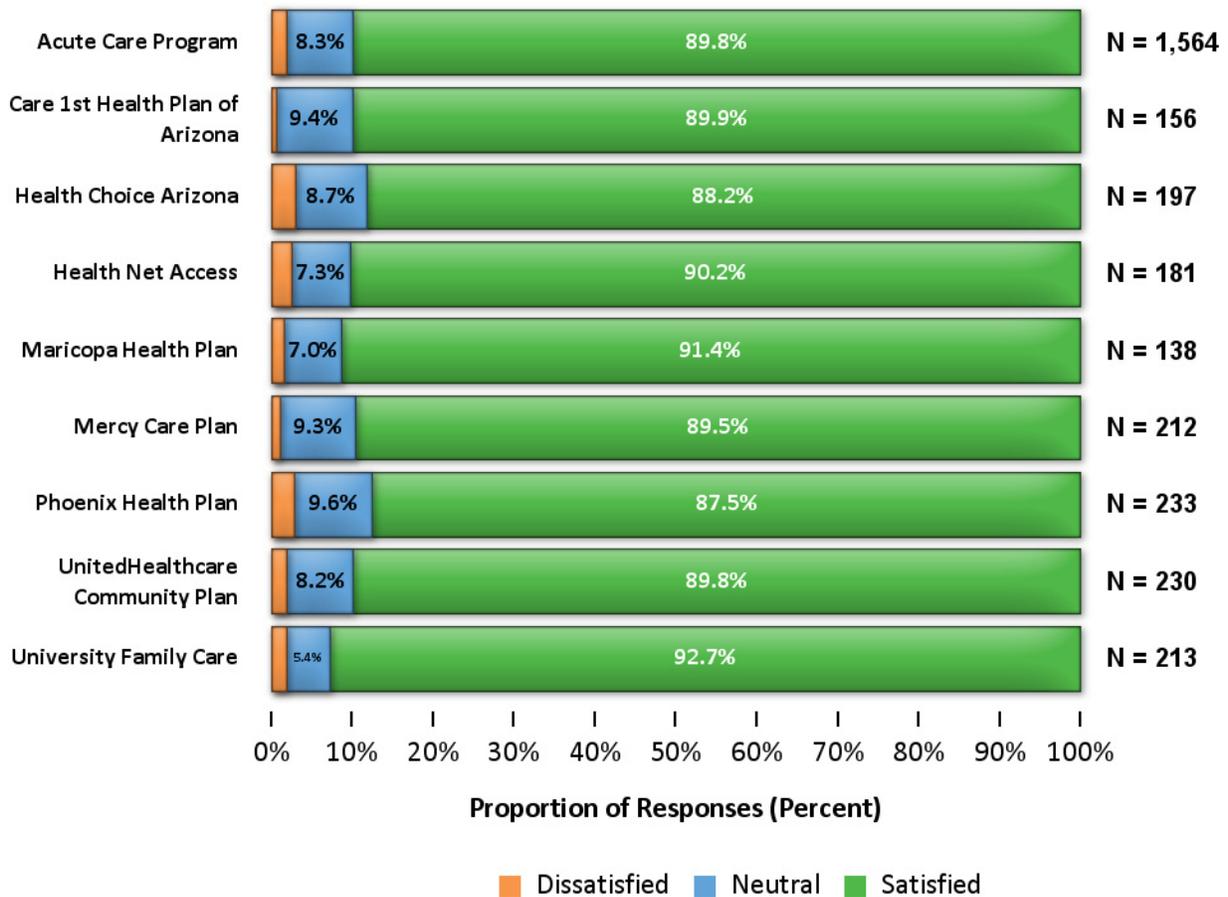
Adult members were asked four questions to assess how often doctors communicated well. For each of these questions (Questions 17, 18, 19, and 20), a top-level response was defined as a response of “Usually” or “Always.” Figure 3-13 shows the 2016 NCQA National Adult Medicaid average and the 2016 How Well Doctors Communicate global proportions for the Acute Care program and the eight participating Contractors.

**Figure 3-13—How Well Doctors Communicate: Global Proportions**



For the How Well Doctors Communicate composite measure questions, responses were classified into one of three response categories as follows: “Never (Dissatisfied),” “Sometimes (Neutral),” and “Usually/Always (Satisfied).” Figure 3-14 depicts the proportion of respondents who fell into each response category for How Well Doctors Communicate for the Acute Care program and the eight participating Contractors.

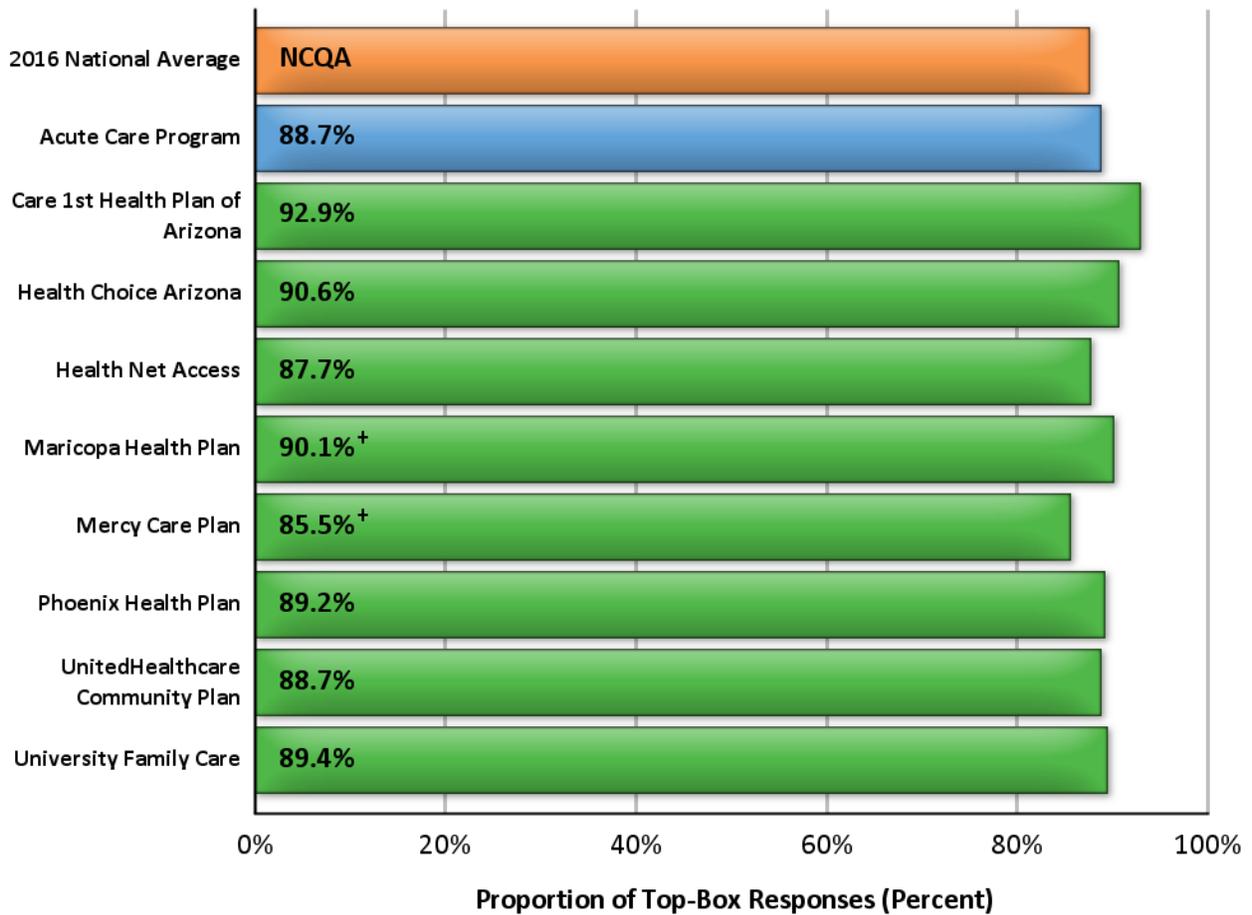
**Figure 3-14—How Well Doctors Communicate: Proportion of Responses**



### Customer Service

Adult members were asked two questions to assess how they obtained needed help/information from customer service. For each of these questions (Questions 31 and 32), a top-level response was defined as a response of “Usually” or “Always.” Figure 3-15 shows the 2016 NCQA National Adult Medicaid average and the 2016 Customer Service global proportions for the Acute Care program and the eight participating Contractors.

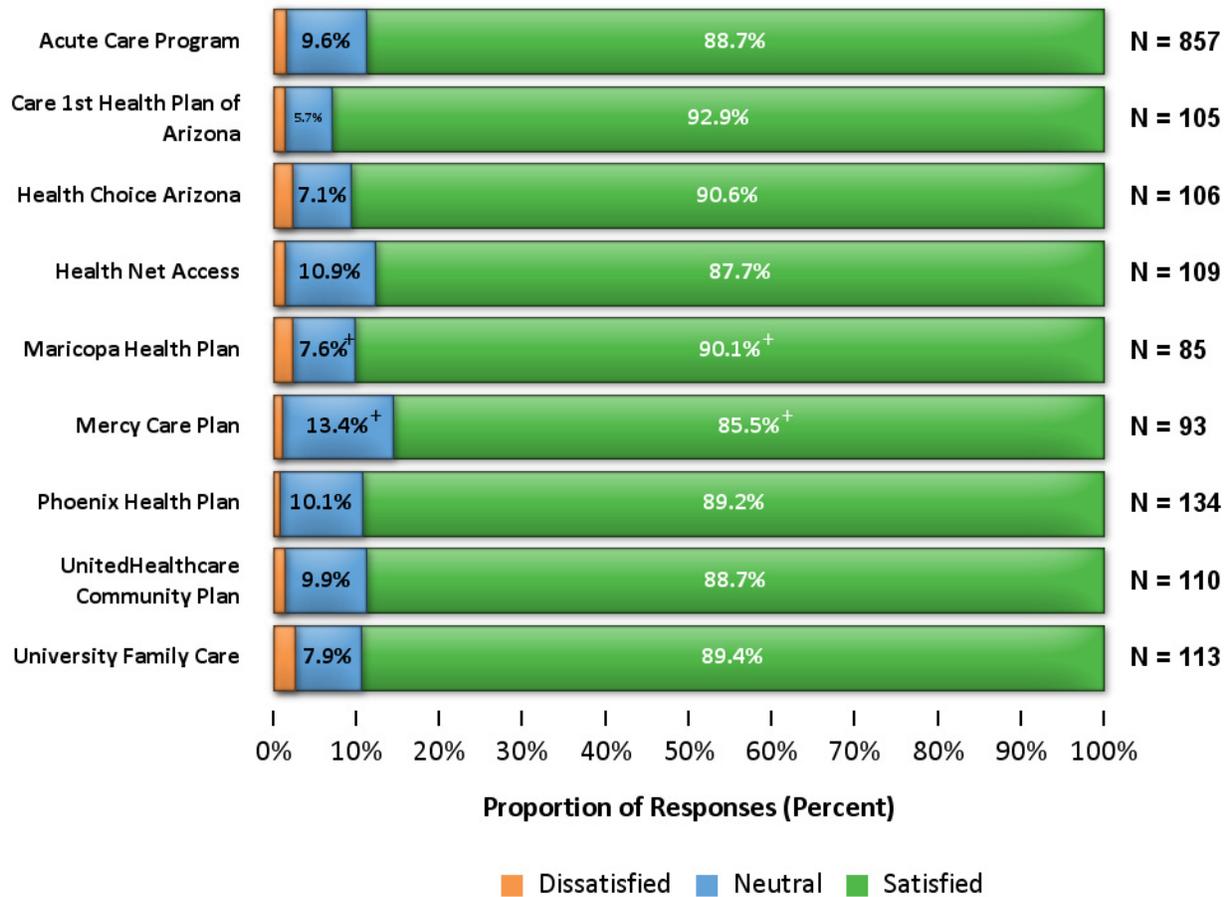
**Figure 3-15—Customer Service: Global Proportions**



*+ Indicates fewer than 100 respondents. Caution should be exercised when interpreting these results.*

For the Customer Service composite measure questions, responses were classified into one of three response categories as follows: “Never (Dissatisfied),” “Sometimes (Neutral),” and “Usually/Always (Satisfied).” Figure 3-16 depicts the proportion of respondents who fell into each response category for Customer Service for the Acute Care program and the eight participating Contractors.

**Figure 3-16—Customer Service: Proportion of Responses**

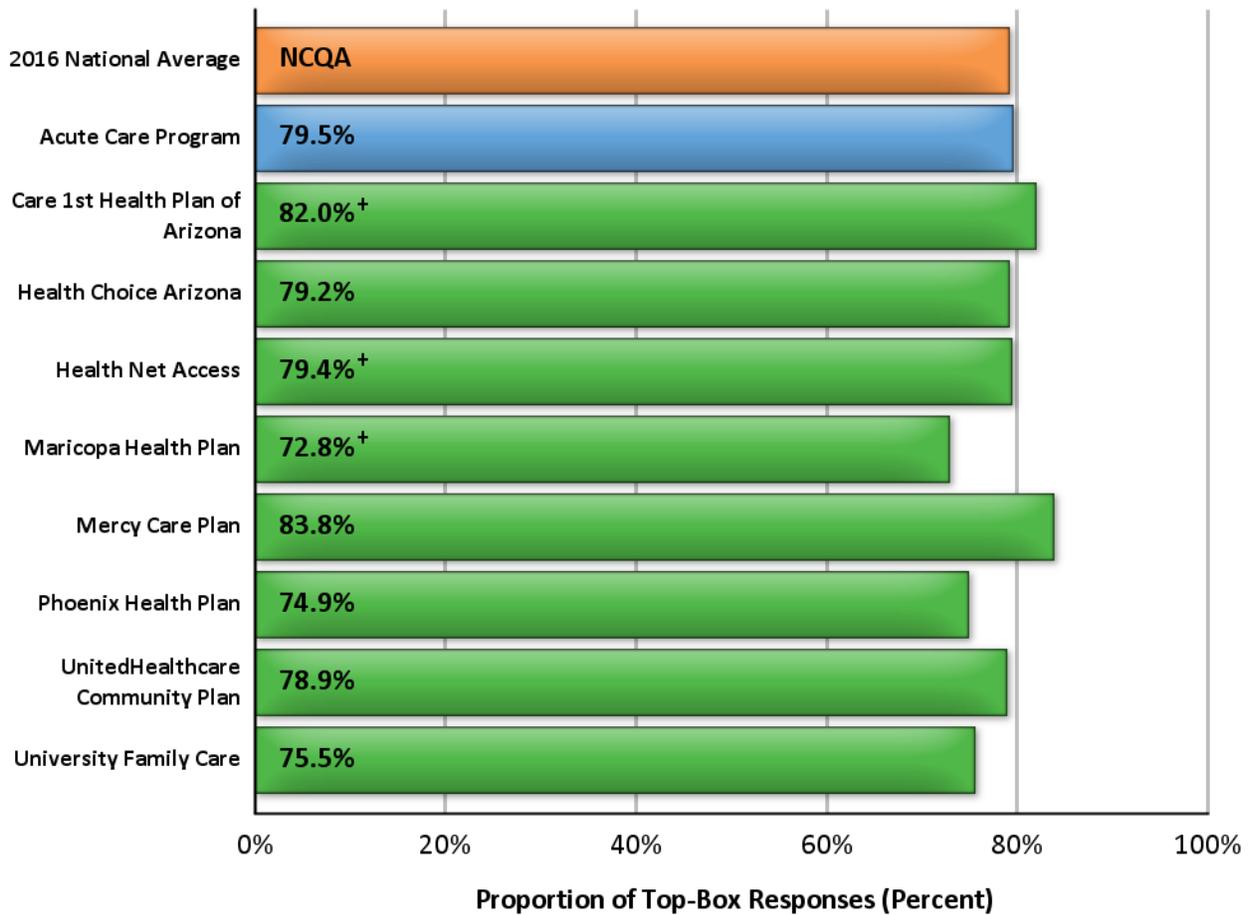


*+ Indicates fewer than 100 respondents. Caution should be exercised when interpreting these results.*

### Shared Decision Making

Adult members were asked three questions to assess if doctors or other health providers discussed starting or stopping a prescription medicine with them. For each of these questions (Questions 10, 11, and 12), a top-level response was defined as a response of “Yes.” Figure 3-17 shows the 2016 NCQA National Adult Medicaid average and the 2016 Shared Decision Making global proportions for the Acute Care program and the eight participating Contractors.

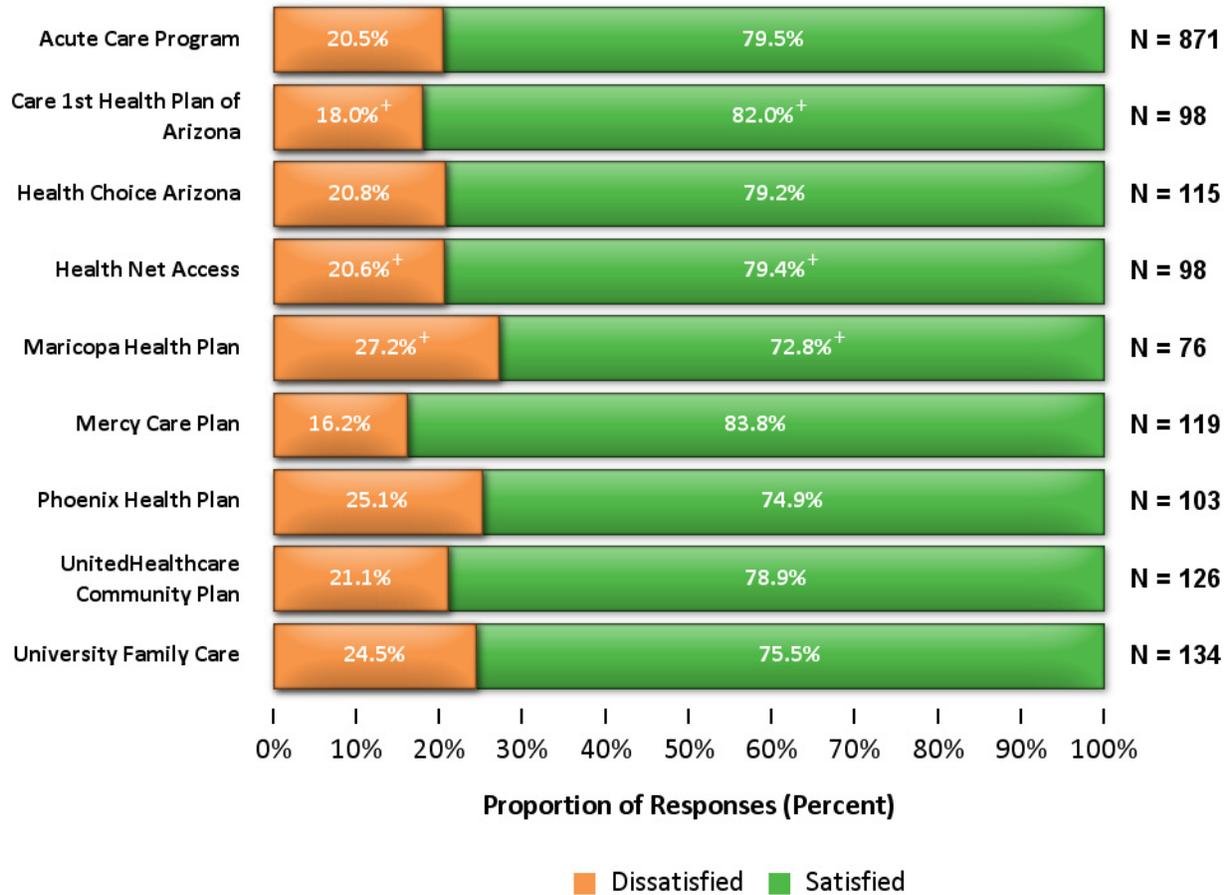
**Figure 3-17—Shared Decision Making: Global Proportions**



*+ Indicates fewer than 100 respondents. Caution should be exercised when interpreting these results.*

For the Shared Decision Making composite measure questions, responses were classified into one of two response categories: “Yes (Satisfied)” or “No (Dissatisfied).” Figure 3-18 depicts the proportion of respondents who fell into each response category for Shared Decision Making for the Acute Care program and the eight participating Contractors.

**Figure 3-18—Shared Decision Making: Proportion of Responses**



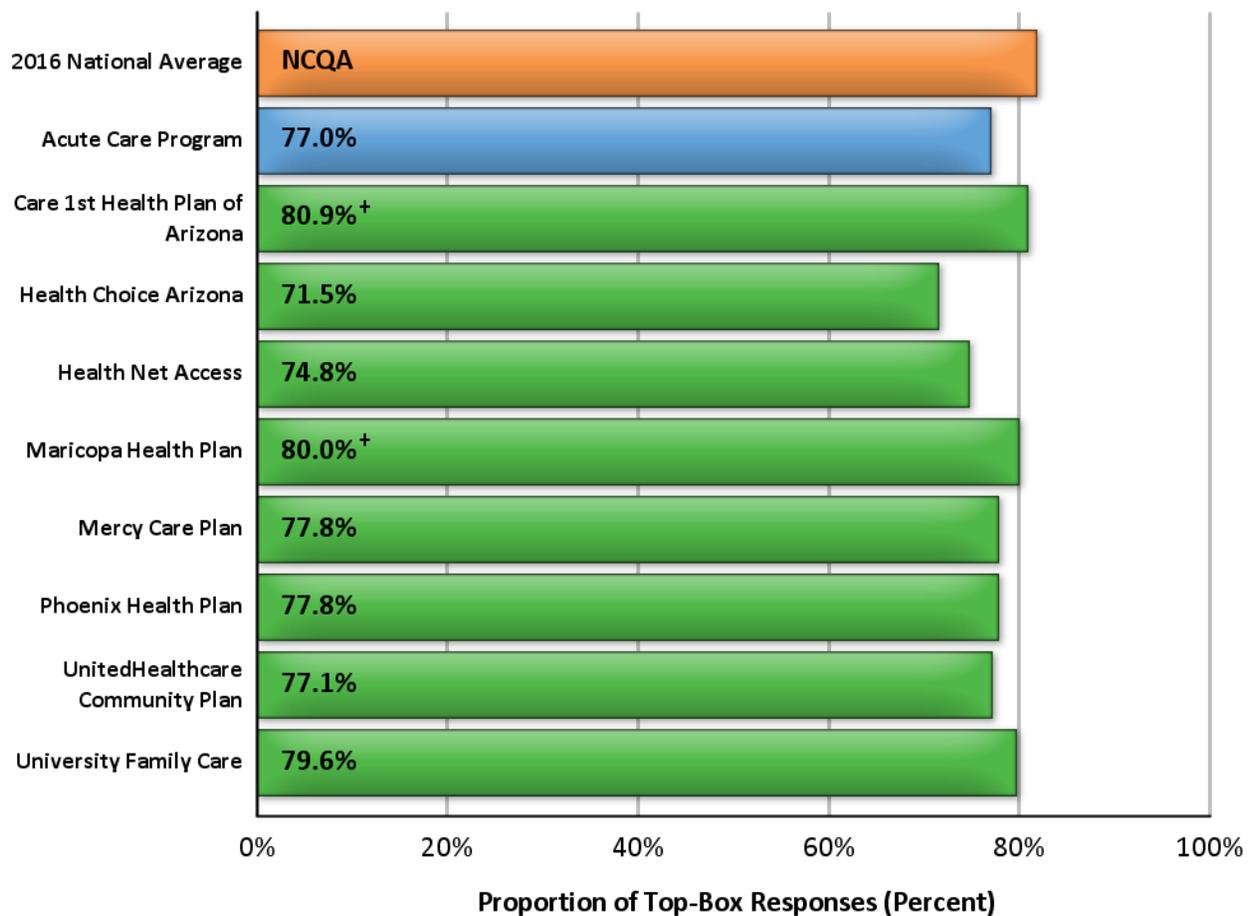
*+ Indicates fewer than 100 respondents. Caution should be exercised when interpreting these results.*

## Individual Item Measures

### Coordination of Care

Adult members were asked a question to assess how often their personal doctor seemed informed and up-to-date about care they had received from another doctor. For this question (Question 22), a top-level response was defined as a response of “Usually” or “Always.” Figure 3-19 shows the 2016 NCQA National Adult Medicaid average and the 2016 Coordination of Care question summary rates for the Acute Care program and the eight participating Contractors.

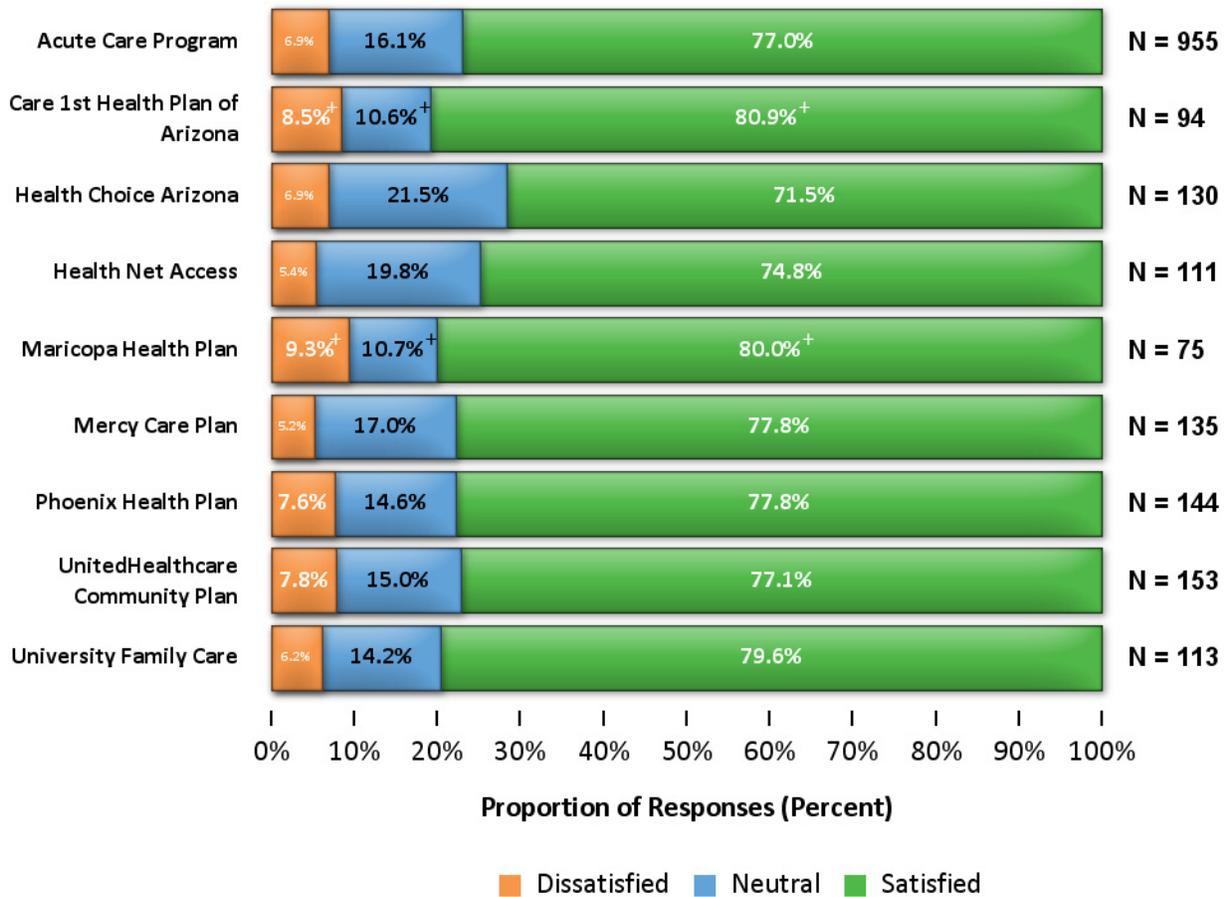
**Figure 3-19—Coordination of Care: Question Summary Rates**



*+ Indicates fewer than 100 respondents. Caution should be exercised when interpreting these results.*

For the Coordination of Care individual item measure question, responses were classified into one of three response categories: “Never (Dissatisfied),” “Sometimes (Neutral),” and “Usually/Always (Satisfied).” Figure 3-20 depicts the proportion of respondents who fell into each response category for Coordination of Care for the Acute Care program and the eight participating Contractors.

**Figure 3-20—Coordination of Care: Proportion of Responses**

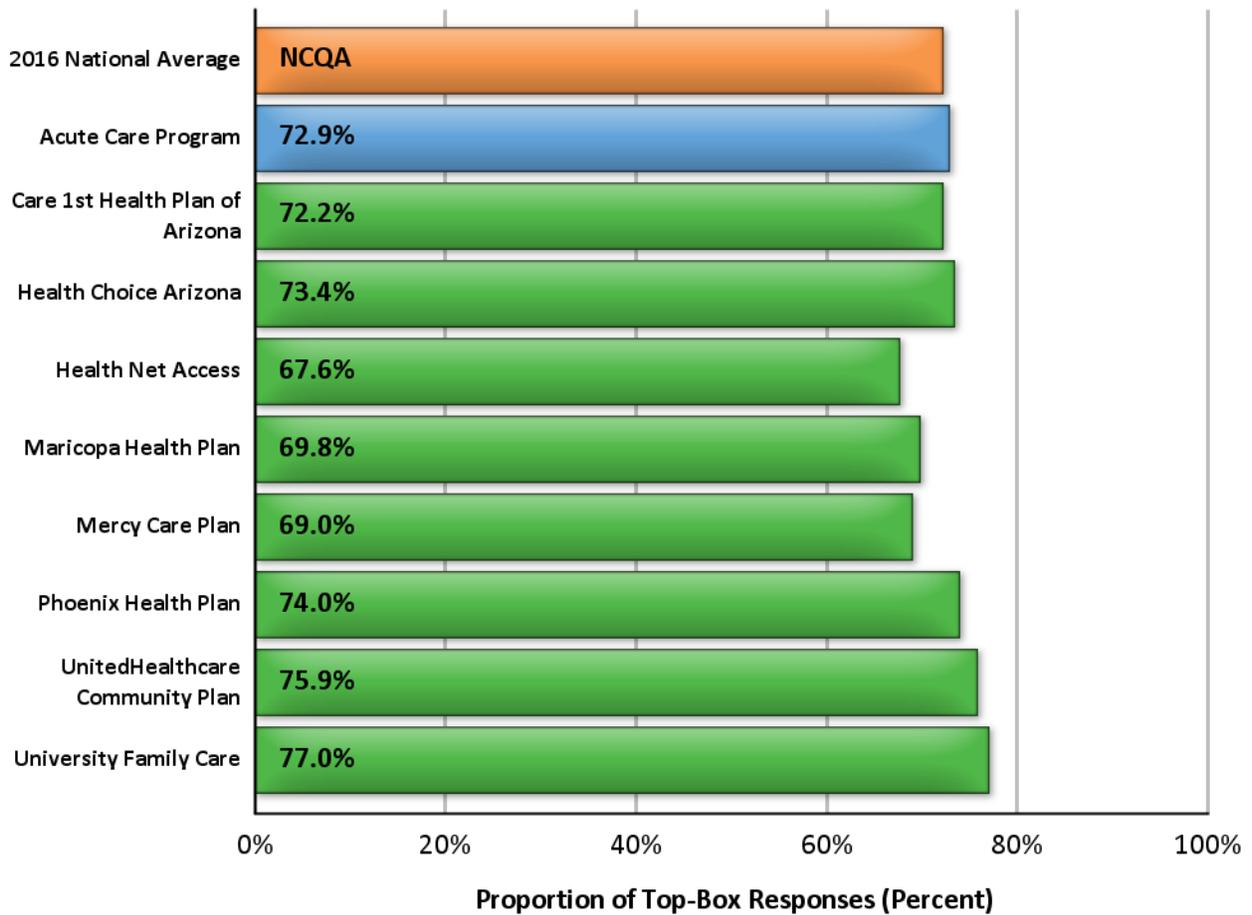


*+ Indicates fewer than 100 respondents. Caution should be exercised when interpreting these results.*

**Health Promotion and Education**

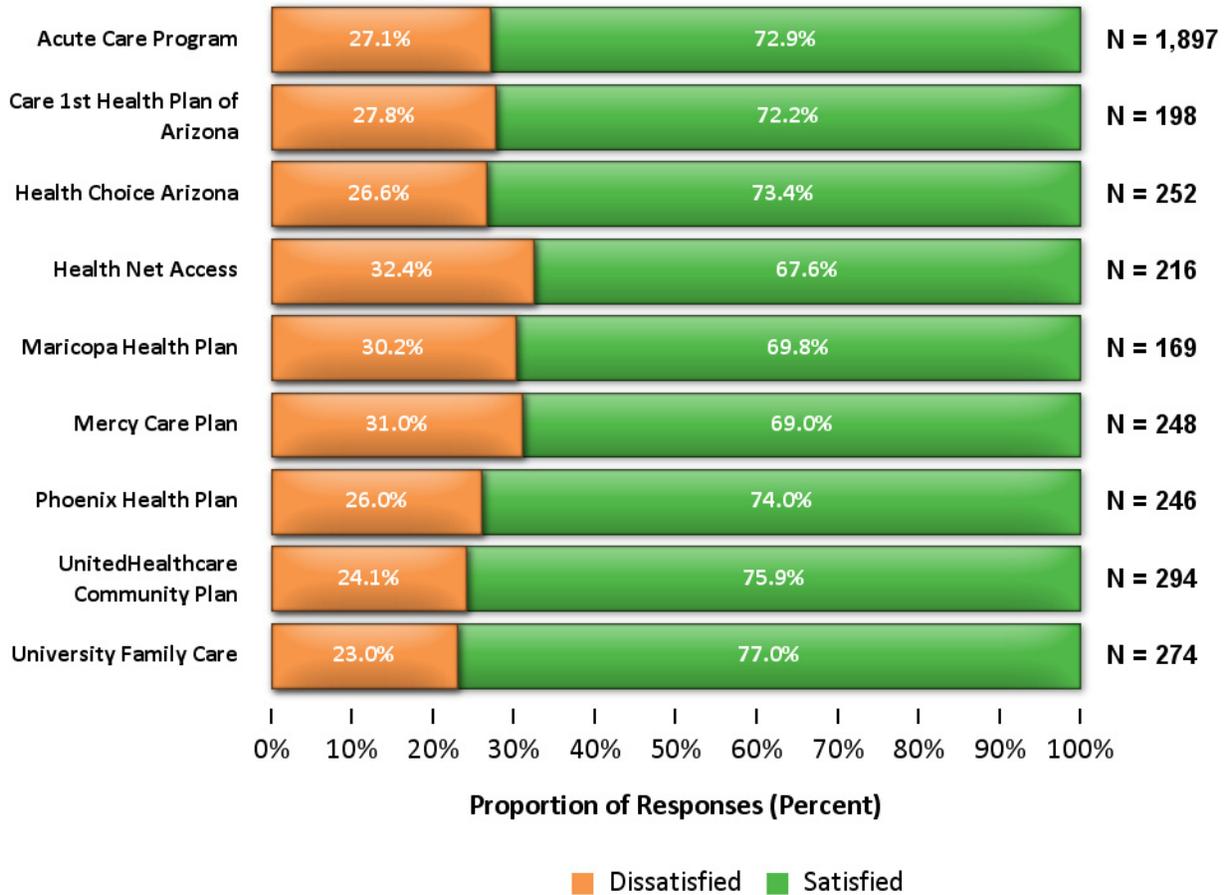
Adult members were asked a question to assess if their doctor talked with them about specific things they could do to prevent illness. For this question (Question 8), a top-level response was defined as a response of “Yes.” Figure 3-21 shows the 2016 NCQA National Adult Medicaid average and the 2016 Health Promotion and Education question summary rates for the Acute Care program and the eight participating Contractors.

**Figure 3-21—Health Promotion and Education: Question Summary Rates**



For the Health Promotion and Education individual item measure question, responses were classified into one of two response categories: “Yes (Satisfied)” or “No (Dissatisfied).” Figure 3-22 depicts the proportion of respondents who fell into each response category for Health Promotion and Education for the Acute Care program and the eight participating Contractors.

**Figure 3-22—Health Promotion and Education: Proportion of Responses**





## Summary of Rates and Proportions

Evaluation of Rates and Proportions for the Acute Care adult population revealed the following summary results.

- The Acute Care program scored at or above the national average on eight measures: Rating of Health Plan, Rating of All Health Care, Rating of Specialist Seen Most Often, Getting Needed Care, Getting Care Quickly, Customer Service, Shared Decision Making, and Health Promotion and Education. The Acute Care program scored below the national average on three measures: Rating of Personal Doctor, How Well Doctors Communicate, and Coordination of Care.
- Care 1st Health Plan of Arizona scored at or above the national average on four measures: Getting Care Quickly, Customer Service, Shared Decision Making, and Health Promotion and Education. Care 1st Health Plan of Arizona scored below the national average on seven measures: Rating of Health Plan, Rating of All Health Care, Rating of Personal Doctor, Rating of Specialist Seen Most Often, Getting Needed Care, How Well Doctors Communicate, and Coordination of Care.
- Health Choice Arizona scored at or above the national average on three measures: Customer Service, Coordination of Care, and Health Promotion and Education. Health Choice Arizona scored below the national average on eight measures: Rating of Health Plan, Rating of All Health Care, Rating of Personal Doctor, Rating of Specialist Seen Most Often, Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, and Shared Decision Making.
- Health Net Access scored at or above the national average on five measures: Rating of All Health Care, Getting Needed Care, Getting Care Quickly, Customer Service, and Shared Decision Making. Health Net Access scored below the national average on six measures: Rating of Health Plan, Rating of Personal Doctor, Rating of Specialist Seen Most Often, How Well Doctors Communicate, Coordination of Care, and Health Promotion and Education.
- Maricopa Health Plan scored at or above the national average on six measures: Rating of Health Plan, Rating of All Health Care, Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, and Customer Service. Maricopa Health Plan scored below the national average on five measures: Rating of Personal Doctor, Rating of Specialist Seen Most Often, Shared Decision Making, Coordination of Care, and Health Promotion and Education.
- Mercy Care Plan scored at or above the national average on six measures: Rating of Health Plan, Rating of All Health Care, Rating of Personal Doctor, Getting Needed Care, Getting Care Quickly, and Shared Decision Making. Mercy Care Plan scored below the national average on five measures: Rating of Specialist Seen Most Often, How Well Doctors Communicate, Customer Service, Coordination of Care, and Health Promotion and Education.
- Phoenix Health Plan scored at or above the national average on six measures: Rating of Health Plan, Rating of Personal Doctor, Getting Needed Care, Getting Care Quickly, Customer Service, and Health Promotion and Education. Phoenix Health Plan scored below the national average on five measures: Rating of All Health Care, Rating of Specialist Seen Most Often, How Well Doctors Communicate, Shared Decision Making, and Coordination of Care.



- UnitedHealthcare Community Plan scored at or above the national average on seven measures: Rating of Health Plan, Rating of All Health Care, Rating of Personal Doctor, Rating of Specialist Seen Most Often, Getting Needed Care, Customer Service, and Health Promotion and Education. UnitedHealthcare Community Plan scored below the national average on four measures: Getting Care Quickly, How Well Doctors Communicate, Shared Decision Making, and Coordination of Care.
- University Family Care scored at or above the national average on nine measures: Rating of Health Plan, Rating of All Health Care, Rating of Personal Doctor, Rating of Specialist Seen Most Often, Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, Customer Service, and Health Promotion and Education. University Family Care scored below the national average on two measures: Shared Decision Making and Coordination of Care.

### ***Summary of Contractor Comparisons Results***

The contractor comparisons for the Acute Care adult population revealed the following summary results.

- Care 1st Health Plan of Arizona performed statistically significantly lower than the Acute Care program average on one measure, Rating of All Health Care.
- Health Choice Arizona performed statistically significantly lower than the Acute Care program average on two measures: Rating of Health Plan and Rating of All Health Care.
- Health Net Access did not perform statistically significantly higher or lower than the Acute Care program average on any of the measures.
- Maricopa Health Plan performed statistically significantly higher than the Acute Care program average on one measure, Rating of All Health Care.
- Mercy Care Plan performed statistically significantly higher than the Acute Care program average on one measure, Rating of Health Plan.
- Phoenix Health Plan did not perform statistically significantly higher or lower than the Acute Care program average on any of the measures.
- UnitedHealthcare Community Plan performed statistically significantly higher than the Acute Care program average on two measures: Rating of Health Plan and Rating of All Health Care.
- University Family Care did not perform statistically significantly higher or lower than the Acute Care program average on any of the measures.

## 4. Recommendations

This section presents Adult Medicaid CAHPS recommendations for the Acute Care program. The recommendations presented in this section should be viewed as potential suggestions for quality improvement (QI). Additional sources of QI information, such as other HEDIS results, should be incorporated into a comprehensive QI plan. A number of resources are available to assist state Medicaid agencies and programs with the implementation of CAHPS-based QI initiatives. A comprehensive list of these resources is included on page 4-25.

### Priority Assignments

This section defines QI priority assignments for each global rating, composite measure, and individual item measure. The priority assignments are grouped into four main categories for QI: top, high, moderate, and low priority. The priority assignments are based on the results of the NCQA comparisons.<sup>4-1</sup>

Table 4-1 shows how the priority assignments are determined for Acute Care on each CAHPS measure.

**Table 4-1—Derivation of Priority Assignments on Each CAHPS Measure**

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

<sup>4-1</sup> NCQA does not publish Benchmarks and Thresholds for Accreditation for the Shared Decision Making composite measure, and Health Promotion and Education individual item measure; therefore, overall member satisfaction ratings could not be derived for these CAHPS measures.

Table 4-2 shows the priority assignments for the Acute Care program adult population.

**Table 4-2—Priority Assignments**

Measure	NCQA Comparisons (Star Ratings)	Priority Assignment
Coordination of Care	★	Top
Getting Needed Care	★★★	Moderate
Getting Care Quickly	★★★	Moderate
Rating of Health Plan	★★★	Moderate
Rating of Specialist Seen Most Often	★★★	Moderate
Customer Service	★★★	Moderate
Rating of All Health Care	★★★★★	Low
Rating of Personal Doctor	★★★★★	Low
How Well Doctors Communicate	★★★★★	Low

## Global Ratings

### Rating of Health Plan

Table 4-3 shows the priority assignments for the overall Rating of Health Plan measure for the adult population.

**Table 4-3—Rating of Health Plan: Priority Assignments**

Contractor Name	NCQA Comparisons (Star Ratings)	Priority Assignments
Care 1st Health Plan of Arizona	★★	High
Health Choice Arizona	★	Top
Health Net Access	★★	High
Maricopa Health Plan	★★★★★	Low
Mercy Care Plan	★★★★★	Low
Phoenix Health Plan	★★★★★	Low
UnitedHealthcare Community Plan	★★★★★	Low
University Family Care	★★★★★	Low

### Rating of All Health Care

Table 4-4 shows the priority assignments for the Rating of All Health Care measure for the adult population.

**Table 4-4—Rating of All Health Care: Priority Assignments**

Contractor Name	NCQA Comparisons (Star Ratings)	Priority Assignments
Care 1st Health Plan of Arizona	★★	High
Health Choice Arizona	★	Top
Health Net Access	★★★	Moderate
Maricopa Health Plan	★★★★★	Low
Mercy Care Plan	★★★★★	Low
Phoenix Health Plan	★★★	Moderate
UnitedHealthcare Community Plan	★★★★★	Low
University Family Care	★★★★★	Low

### Rating of Personal Doctor

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

**Table 4-5—Rating of Personal Doctor: Priority Assignments**

Contractor Name	NCQA Comparisons (Star Ratings)	Priority Assignments
Care 1st Health Plan of Arizona	★★★	Moderate
Health Choice Arizona	★★	High
Health Net Access	★★	High
Maricopa Health Plan	★★★	Moderate
Mercy Care Plan	★★★★★	Low
Phoenix Health Plan	★★★★	Low
UnitedHealthcare Community Plan	★★★★	Low
University Family Care	★★★★★	Low

### Rating of Specialist Seen Most Often

Table 4-6 shows the priority assignments for the Rating of Specialist Seen Most Often measure for the adult population.

**Table 4-6—Rating of Specialist Seen Most Often: Priority Assignments**

Contractor Name	NCQA Comparisons (Star Ratings)	Priority Assignments
Care 1st Health Plan of Arizona	★★★	Moderate
Health Choice Arizona	★★	High
Health Net Access	★★★	Moderate
Maricopa Health Plan	★★	High
Mercy Care Plan	★★★	Moderate
Phoenix Health Plan	★	Top
UnitedHealthcare Community Plan	★★★★★	Low
University Family Care	★★★★★	Low

### Composite Measures

#### Getting Needed Care

Table 4-7 shows the priority assignments for the Getting Needed Care measure for the adult populations.

**Table 4-7—Getting Needed Care: Priority Assignments**

Contractor Name	NCQA Comparisons (Star Ratings)	Priority Assignments
Care 1st Health Plan of Arizona	★	Top
Health Choice Arizona	★	Top
Health Net Access	★★	High
Maricopa Health Plan	★★★	Moderate
Mercy Care Plan	★★★★	Low
Phoenix Health Plan	★★	High
UnitedHealthcare Community Plan	★★★★	Low
University Family Care	★★★★★	Low

### Getting Care Quickly

Table 4-8 shows the priority assignments for the Getting Care Quickly measure for the adult populations.

**Table 4-8—Getting Care Quickly: Priority Assignments**

Contractor Name	NCQA Comparisons (Star Ratings)	Priority Assignments
Care 1st Health Plan of Arizona	★★★	Moderate
Health Choice Arizona	★	Top
Health Net Access	★★	High
Maricopa Health Plan	★★★	Moderate
Mercy Care Plan	★★★★	Low
Phoenix Health Plan	★★★	Moderate
UnitedHealthcare Community Plan	★★	High
University Family Care	★★★★	Low

### How Well Doctors Communicate

Table 4-9 shows the priority assignments for the How Well Doctors Communicate measure for the adult population.

**Table 4-9—How Well Doctors Communicate: Priority Assignments**

Contractor Name	NCQA Comparisons (Star Ratings)	Priority Assignments
Care 1st Health Plan of Arizona	★★★★	Low
Health Choice Arizona	★★	High
Health Net Access	★★★★	Low
Maricopa Health Plan	★★★★	Low
Mercy Care Plan	★★★★	Low
Phoenix Health Plan	★★★	Moderate
UnitedHealthcare Community Plan	★★★★	Low
University Family Care	★★★★★	Low

**Customer Service**

Table 4-10 shows the priority assignments for the Customer Service measure for the adult population.

**Table 4-10—Customer Service: Priority Assignments**

Contractor Name	NCQA Comparisons (Star Ratings)	Priority Assignments
Care 1st Health Plan of Arizona	★★★★	Low
Health Choice Arizona	★★	High
Health Net Access	★★★	Moderate
Maricopa Health Plan	★★★	Moderate
Mercy Care Plan	★★	High
Phoenix Health Plan	★★	High
UnitedHealthcare Community Plan	★★★	Moderate
University Family Care	★★★★	Low

**Individual Item Measure**

**Coordination of Care**

Table 4-11 shows the priority assignments for the Coordination of Care measure for the adult populations.

**Table 4-11—Coordination of Care: Priority Assignments**

Contractor Name	NCQA Comparisons (Star Ratings)	Priority Assignments
Care 1st Health Plan of Arizona	★	Top
Health Choice Arizona	★	Top
Health Net Access	★	Top
Maricopa Health Plan	★★	High
Mercy Care Plan	★	Top
Phoenix Health Plan	★	Top
UnitedHealthcare Community Plan	★	Top
University Family Care	★★★	Moderate

## Recommendations for Quality Improvement

HSAG presented QI recommendations for each global rating, composite measure, and individual item measure.

### *Global Ratings*

#### **Rating of Health Plan**

In order to improve the overall Rating of Health Plan, QI activities should target alternatives to one-on-one visits, Contractor operations, and promoting QI initiatives. The following are recommendations of best practices and other proven strategies that may be used or adapted by the Contractor to target improvement in each of these areas.

#### ***Alternatives to One-on-One Visits***

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

#### ***Contractor Operations***

It is important for Contractors to view their organization as a collection of microsystems (such as providers, administrators, and other staff that provide services to members) that provide the Contractor's health care "products." Health care microsystems include: a team of health providers, patient/population to whom care is provided, environment that provides information to providers and patients, support staff, equipment, and office environment. The goal of the microsystems approach is to focus on small, replicable, functional service systems that enable Contractor staff to provide high-quality, patient-centered care. The first step to this approach is to define a measurable collection of activities. Once the microsystems are identified, new processes that improve care should be tested and implemented. Effective processes can then be rolled out throughout the Contractor.

### ***Promote Quality Improvement Initiatives***

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

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

## Rating of All Health Care

In order to improve the Rating of All Health Care measure, QI activities should target client perception of access to care, making patient-centered care a core value, patient and family engagement advisory councils, reducing barriers, and telehealth tools. The following are recommendations of best practices and other proven strategies that may be used or adapted by the Contractor to target improvement in each of these areas.

### ***Access to Care***

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

### ***Making Patient-Centered Care a Core Value***

Focusing on the needs of individual patients rather than overall populations/programs provides an opportunity for Contractors to improve performance. When patients are listened to, informed, and respected, these actions strengthen the patient-clinician relationship, promote communication, help patients know and understand more about their health, and facilitate involvement in their own care. The Contractors should consider capturing aspects of what counts as patient-centered care and how it can be implemented/improved by developing measures from the perspectives of stakeholders including patients, their families, clinicians, and health systems. Other valuable information on patient experience can be taken directly from continuous samples of patient feedback. This actionable feedback can be gathered through detailed surveys, standardized patient assessments, or direct observation. These results can be widely communicated through the delivery of reports at the site, department, and individual provider levels for the continual awareness of performance improvement areas.

### ***Patient and Family Engagement Advisory Councils***

Since both patients and families have the direct experience of an illness or health care system, their perspectives can provide significant insight when performing an evaluation of health care processes. Therefore, Contractors should consider creating opportunities and functional roles that include the patients and families who represent the populations they serve. Patient and family members could serve as advisory council members providing new perspectives and serving as a resource to health care

processes. Patient interviews on services received and family inclusion in care planning can be an effective strategy for involving members in the design of care and obtaining their input and feedback on how to improve the delivery of care. Further, involvement in advisory councils can provide a structure and process for ongoing dialogue and creative problem-solving between the Contractor and its members. The councils' roles within a Contractor organization can vary and responsibilities may include input into or involvement in: program development, implementation, and evaluation; marketing of health care services; and design of new materials or tools that support the provider-patient relationship.

### ***Reducing Barriers to Integration of Social Services with Medical Services***

Social, behavioral, and environmental factors are important factors of health when prescribing treatments for patients; therefore, Contractors should use an integration model that emphasizes a team-based clinical care approach, which connects patients to care with community resources and supports. Integrated arrangement, financing, and delivery of non-medical social services, such as food, housing, transportation, and income assistance, with medical services is important to improve outcomes, achieve cost savings, and enhance equity. Contractors can implement models for health and social services integration, so that Medicaid managed care plans can coordinate with social and community interventions that have proven to be effective in improving outcomes and reducing costs.

### ***Telehealth Tools***

Contractors should promote the use of effective telehealth tools. Telehealth technologies, such as the use of the Internet, telephone, and other methods, can help increase patient access to medical care, especially in remote, rural, or underserved areas. Some helpful telehealth tools include services that enable doctors and patients to conference over video and communicate on a secure platform through in-app text and call features. Other apps such as instructional videos, frequently asked questions (FAQs), and troubleshooting guides provide patients with a source of confidence through readily available information that allows them to solve problems without needing to contact their doctor. These tools not only limit the amount of in-office appointments, but also provide patients with crucial information outside regular office hours. Also, with the assistance of apps that allow patients the opportunity to regularly rate their satisfaction on medical equipment they have received, such as hearing aids, doctors can use the results, even between appointments, to actively intervene to their concerns in a timely manner.

## Rating of Personal Doctor

In order to improve the Rating of Personal Doctor measure, QI activities should target maintaining truth in scheduling, patient-direct feedback, physician-patient communication, and shared decision making. The following are recommendations of best practices and other proven strategies that may be used or adapted by the Contractor to target improvement in each of these areas.

### ***Maintain Truth in Scheduling***

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

### ***Direct Patient Feedback***

Contractors can explore additional methods for obtaining direct patient feedback to improve patient satisfaction, such as comment cards. Comment cards have been utilized and found to be a simple method for engaging patients and obtaining rapid feedback on their recent physician office visit experiences. Contractors can assist in this process by developing comment cards that physician office staff can provide to patients following their visit. Comment cards can be provided to patients with their office visit discharge paperwork or via postal mail or email. Asking patients to describe what they liked most about the care they received during their recent office visit, what they liked least, and one thing they would like to see changed can be an effective means for gathering feedback (both positive and negative). Comment card questions may also prompt feedback regarding other topics, such as providers' listening skills, wait time to obtaining an appointment, customer service, and other items of interest. Research suggests the addition of the question, "Would you recommend this physician's office to a friend?" greatly predicts overall patient satisfaction. This direct feedback can be helpful in gaining a better understanding of the specific areas that are working well and areas which can be targeted for improvement.

### ***Physician-Patient Communication***

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

### ***Improving Shared Decision Making***

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

## Rating of Specialist Seen Most Often

In order to improve the overall performance on the Rating of Specialist Seen Most Often global rating, QI activities should target planned visit management, skills training, and telemedicine. The following are recommendations of best practices and other proven strategies that may be used or adapted by the Contractor to target improvement in each of these areas.

### ***Planned Visit Management***

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

### ***Skills Training for Specialists***

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

### ***Telemedicine***

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

## **Composite Measures**

### **Getting Needed Care**

In order to improve members' satisfaction under the Getting Needed Care measure, QI activities should target appropriate health care providers, providing interactive workshops, "max-packing," language concordance programs, streamlining the referral process, and utilizing health information technology. The following are recommendations of best practices and other proven strategies that may be used or adapted by the Contractor to target improvement in each of these areas.

#### ***Appropriate Health Care Providers***

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

#### ***Interactive Workshops***

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

#### ***"Max-Packing"***

Contractors can assist providers in implementing strategies within their system that allow for as many of the patient's needs to be met during one office visit when feasible; a process call "max packing." "Max-packing" is a model designed to maximize each patient's office visit, which in many cases eliminates the need for extra appointments. "Max-packing" strategies could include using a checklist of preventive care services to anticipate the patient's future medical needs and guide the process of taking care of those needs during a scheduled visit, whenever possible. Processes also could be implemented wherein staff review the current day's appointment schedule for any future appointments a patient may have. For example, if a patient is scheduled for their annual physical in the fall and a subsequent appointment for a flu vaccination, the current office visit could be used to accomplish both eliminating the need for a future appointment. Contractors should encourage the care of a patient's future needs during a visit and determine if, and when, future follow-up is necessary.

### ***Language Concordance Programs***

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

### ***Referral Process***

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

### ***Utilize Health Information Technology***

MCPs that use health information technology to its fullest have stronger patient-tracking capabilities and coordinated care. Health information technology allows MCPs access to real-time data (e.g., the outcomes of face-to-face visits with members) and can better facilitate documentation, communication, decision support, and automated reminders, thus ensuring members are receiving the care that they need. Furthermore, utilizing health information technology may help increase the number of members who receive a copy of their care plan.

## Getting Care Quickly

In order to improve members' satisfaction under the Getting Care Quickly measure, QI activities should target decreasing no-show appointments, electronic communication, patient flow, and Internet access. The following are recommendations of best practices and other proven strategies that may be used or adapted by the Contractor to target improvement in each of these areas.

### ***Decrease No-Show Appointments***

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

### ***Electronic Communication***

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

### ***Patient Flow Analysis***

Contractors should request that all providers monitor patient flow. The Contractors could provide instructions and/or assistance to those providers that are unfamiliar with this type of evaluation. Dissatisfaction with timely care is often a result of bottlenecks and redundancies in the administrative and clinical patient flow processes (e.g., diagnostic tests, test results, treatments, hospital admission, and specialty services). To address these problems, it is necessary to identify these issues and determine the optimal resolution. One method that can be used to identify these problems is to conduct a patient flow analysis. A patient flow analysis involves tracking a patient's experience throughout a visit or clinical

service (i.e., the time it takes to complete various parts of the visit/service). Examples of steps that are tracked include wait time at check-in, time to complete check-in, wait time in waiting room, wait time in exam room, and time with provider. This type of analysis can help providers identify “problem” areas, including steps that can be eliminated or steps that can be performed more efficiently.

### ***Internet Access for Health Information and Advice***

In order to supplement clinician information in a more accessible, convenient, and immediate manner for patients, Contractors can provide useful and reliable sources on the Internet. This can be accomplished by including relevant health information and tools on their website or directing patients to specific external sites during office visits, in printed materials, or in emails. It is also helpful to inform members and patients on specific places to obtain this information or to provide Internet-based resources directly in the clinic in case they lack access to the Internet.

## How Well Doctors Communicate

In order to improve members' satisfaction under the How Well Doctors Communicate measure, QI activities should focus on communication tools, physician communications skills, and improving health literacy. The following are recommendations of best practices and other proven strategies that may be used or adapted by the Contractor to target improvement in each of these areas.

### ***Communication Tools for Patients***

Contractors can encourage patients to take a more active role in the management of their health care by providing them with the necessary tools to effectively communicate with physicians. This can include items such as "visit preparation" handouts, sample symptom logs, and health care goals and action planning forms that facilitate physician-patient communication. Furthermore, educational literature and information on medical conditions specific to their needs can encourage patients to communicate with their physicians on any questions, concerns, or expectations they may have regarding their health care and/or treatment options. Also, patients can be encouraged to bring in lists of questions to their visits that are prompted by cards or an electronic form that lists topics including symptoms and medications. Having a written record of questions about their medical conditions or the reason for their visit provides doctors with an effective way to generate communication with patients. The list also gives patients the ability to record what is discussed and what is agreed upon between the doctor and patient during the visit for future reference.

### ***Developing Physician Communication Skills for Patient-Centered Care***

Communication skills are an important component of the patient-centered care approach. Patient-centered communication can have a positive impact on patient satisfaction, adherence to treatments, and self-management of conditions. Indicators of good physician communication skills include providing clear explanations, listening carefully, checking for understanding, and being considerate of members' perspectives. Physicians should ask questions about members' concerns, priorities, and values and listen to their answers. Also, physician should check for understanding by allowing members to repeat back what they understand about their conditions and the actions they will take to monitor/manage their conditions while reinforcing key messages.

Contractors can provide specialized training for staff in this area that impart effective communication skills and strategies, focus on relationship building, and stress the importance of physician-member communication. Training can also include the following fundamental functions of physician-patient communication: fostering healing relationships, exchanging information, responding to patients' emotions, managing uncertainty, making informed decisions, enabling patient self-management, and written communication. Training physicians in the communication skills they need can be done through in-house programs or through communications programs offered by outside organizations including workshops and seminars.

### ***Improve Health Literacy***

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

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

## Customer Service

In order to improve members' satisfaction under the Customer Service measure, QI activities should focus on customer service training programs, performance measures, recognizing and rewarding success, studying patient and staff experiences, and tracking and trending member and provider issues. The following are recommendations of best practices and other proven strategies that may be used or adapted by the Contractor to target improvement in each of these areas.

### ***Creating an Effective Customer Service Training Program***

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

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

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

### ***Customer Service Performance Measures***

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

### ***Recognizing and Rewarding Success***

To ensure successful customer service, it is important to invest in staff who have an aptitude for service. In particular, Contractors should maintain an internal rewards and recognition system, which can lead to the pursuit of, and ultimately, the achievement of performance improvement. An excellent way to

cultivate this culture of improvement within an organization is by educating new employees during orientation on how the internal reward and recognition system is linked to its philosophy of care. This develops an attitude of confidence in and enhances the relationship between the employee and the organization, which in turn creates a sense of belonging and self-worth and sparks a desire to succeed.

Contractors can implement rewards that support the entire organization and not just an individual. Such rewards include publically posting thank-you letters from patients and families, holding routine meetings with employees and senior management to improve communication and trust, and ensuring employees have the proper training and resources to perform their job well.

### ***Studying Patient and Staff Experiences***

When patients and members are assured that they are being listened to, they are more likely to have a positive health care experience. Instead of assuming that the solution to a problem is already known, it can be a great benefit to try to understand the underlying issue from the perspective of the patient. Although this can be accomplished in a number of ways, reviewing patient letters of complaints and compliments or CAHPS survey responses can often identify the proper approach to take.

One such approach is focus groups where staff and patients are led by a moderator to discuss specific information about a problem and ideal strategies for improvement. Videotaping these discussions, which often hold a lot of emotion toward the kind of service received, can have a great impact on altering the attitudes and beliefs of staff members. Another way to provide staff with the ability to realize the emotional and physical experiences a patient might have is by performing a walkthrough. This gives staff members the ability to do everything patients and families are asked to do. Similarly, with his or her permission, a staff member can accompany a patient through his or her visit. Notes taken from these experiences can be shared with leadership to help develop improvement plans.

### ***Tracking and Trending Member and Provider Issues***

The Contractor should continue tracking and trending member and provider issues such as the investigation and analysis of quality of care issues. This would include the continuation of a resolution process that must include follow-up with the member to assist in ensuring his or her immediate health care needs are met, a letter of closure that provides sufficient detail to ensure that the member has an understanding of the resolution of their issue as well as a Contractor contact name and telephone number to call for assistance or to express any unresolved concerns, and analysis of the effectiveness of the interventions taken.

## **Individual Item Measure**

### **Coordination of Care**

In order to improve members' satisfaction under the Coordination of Care measure, QI activities should focus on evaluating care based on the individual's goals and data sharing. The following are recommendations of best practices and other proven strategies that may be used or adapted by the Contractor to target improvement in each of these areas.

#### ***Coordinate Care Based on the Individual's Goals***

When providers share an understanding of a patient's goals, they are able to communicate and coordinate care in a way that directly impacts the outcomes and experience of the person receiving it. Coordinating goal-based care is established by creating a plan that places the individual at the center and seamlessly works with the entire care team who supports the individual, including family and friend caregivers and medical providers. During goal planning discussions, the patient should be provided a judgment-free, respectful, and supportive environment that acknowledges them as an expert in their own life so they can articulate what is important to them, be fully informed about their options, and be a priority in the creation of shared goals. Also, forming a safe place for expression of ideas and solutions to the individual's current status and care plan within this collaboration results in an understanding of alternative perspectives from each team member's unique role, which leads to a better outcome that could not be achieved alone. Also, engaging all appropriate parties in these discussions on a consistent basis and quickly when urgent needs arise avoids gaps in care and provides each person with a clear understanding of their specific roles and responsibilities related to the care the individual should receive.

#### ***Data Sharing***

Interoperable health information technology and electronic medical record systems are one key to successful Contractors. Hospitals operating within each organization should have effective communication processes in place to ensure information is shared on a timely basis. Systems should be designed to enable effective and efficient coordination of care and reporting on various aspects of quality improvement.

Contractors can enable providers to share data electronically on each client and store data in a central data warehouse so all entities can easily access information. Contractors could organize clients' health and utilization information into summary reports that track clients' interventions and outstanding needs. Contractors should pursue joint activities that facilitate coordinated, effective care, such as an urgent care option in the emergency department and combining medical and behavioral health services in primary care clinics.

## Accountability and Improvement of Care

Although the administration of the CAHPS survey takes place at the Contractor level, the accountability for the performance lies at both the Contractor and provider network levels. Table 4-12 provides a summary of the responsible parties for various aspects of care.<sup>4-2</sup>

**Table 4-12—Accountability for Areas of Care**

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

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

Those measures identified for the Contractors that exhibited low performance suggest that additional analysis may be required to identify what is truly causing low performance in these areas. Methods that could be used include:

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

<sup>4-2</sup> 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.

- Conducting focus groups and interviews to determine what specific issues are causing low satisfaction ratings.

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

## Quality Improvement References

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

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

### Survey Administration

#### Survey Overview

The survey instrument selected was the CAHPS 5.0 Adult Medicaid Health Plan Survey with the HEDIS supplemental item set. The CAHPS Health Plan Surveys are a set of standardized surveys that assess patient perspectives on care. Originally, CAHPS was a five-year collaborative project sponsored by AHRQ. The CAHPS questionnaires and consumer reports were developed under cooperative agreements among AHRQ, Harvard Medical School, RAND, and the Research Triangle Institute (RTI). In 1997, NCQA, in conjunction with AHRQ, created the CAHPS 2.0H Survey measure as part of NCQA's HEDIS.<sup>5-1</sup> 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.<sup>5-2</sup> 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.<sup>5-3,5-4</sup> In 2012, AHRQ released the CAHPS 5.0 Health Plan Surveys. Based on the CAHPS 5.0 versions, NCQA introduced new HEDIS versions of the Adult and Child Health Plan Surveys in August 2012, which are referred to as the CAHPS 5.0H Health Plan Surveys.<sup>5-5</sup>

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<sup>5-1</sup> National Committee for Quality Assurance. *HEDIS® 2002, Volume 3: Specifications for Survey Measures*. Washington, DC: NCQA Publication, 2001.

<sup>5-2</sup> National Committee for Quality Assurance. *HEDIS® 2003, Volume 3: Specifications for Survey Measures*. Washington, DC: NCQA Publication, 2002.

<sup>5-3</sup> National Committee for Quality Assurance. *HEDIS® 2007, Volume 3: Specifications for Survey Measures*. Washington, DC: NCQA Publication, 2006.

<sup>5-4</sup> National Committee for Quality Assurance. *HEDIS® 2009, Volume 3: Specifications for Survey Measures*. Washington, DC: NCQA Publication, 2008.

<sup>5-5</sup> 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 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 data.

The CAHPS 5.0 Adult Medicaid Health Plan Survey with the HEDIS supplemental item set includes 58 core questions that yield 11 measures of satisfaction. These measures include four global rating questions, five composite measures, and two individual item measures. The global measures (also referred to as global ratings) reflect overall satisfaction with the Contractor, 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 Adult Medicaid Health Plan Survey with the HEDIS supplemental item set.

**Table 5-1—CAHPS Measures**

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

## Sampling Procedures

The members eligible for sampling included those who were Acute Care members at the time the sample was drawn and who were continuously enrolled for at least five of the of the last six months of the measurement period (October 2015 through March 2016). The adult members eligible for sampling included those who were 18 years of age or older (as of March 31, 2016).

For the CAHPS Adult Medicaid Health Plan Survey, the standard NCQA specifications for survey measures require a sample size of 1,350 members. For the Acute Care adult Medicaid population, a 20 percent oversample was performed, and a sample of 1,620 adult members was selected from each participating Contractor's eligible adult Medicaid population.

## Survey Protocol

The CAHPS Health Plan Survey process allows for two methods by which members can complete a survey. The first, or mail phase, consisted of a survey being mailed to all sampled members. For the Acute Care program, those members who were identified as Spanish-speaking through administrative data were mailed a Spanish version of the survey. The cover letter provided with the Spanish version of the CAHPS questionnaire included a text box with a toll-free number that members could call to request a survey in another language (i.e., English). Members that were not identified as Spanish-speaking received an English version of the survey. The cover letter included with the English version of the survey had a Spanish cover letter on the back side informing members that they could call the toll-free number to request a Spanish version of the CAHPS questionnaire. A reminder postcard was sent to all non-respondents, followed by a second survey mailing and reminder postcard. The second phase, or telephone phase, consisted of 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 program's population.<sup>5-6</sup>

HSAG was provided a list of all eligible members for the sampling frame. HSAG sampled members who met the following criteria:

- Adult members who were 18 or older as of March 31, 2016.
- Were currently enrolled in the Acute Care program.
- Had been continuously enrolled for at least five of the six months of the measurement period (i.e., October 1, 2015 to March 31, 2016).
- Had Medicaid as a payer.

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<sup>5-6</sup> 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.

HSAG inspected a sample of the file records to check for any apparent problems with the files, such as missing address elements. After the sample was selected, records from each population were passed through the United States Postal Service's National Change of Address (NCOA) system to obtain new addresses for 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 survey samples were systematic samples with no more than one member being selected per household.

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

Table 5-2 shows the CAHPS timeline used in the administration of the Acute Care program's CAHPS 5.0H Adult Medicaid Health Plan Survey. The timeline is based on NCQA HEDIS Specifications for Survey Measures.<sup>5-7</sup>

**Table 5-2—CAHPS 5.0 Survey Timeline**

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

<sup>5-7</sup> National Committee for Quality Assurance. *HEDIS® 2017, Volume 3: Specifications for Survey Measures*. Washington, DC: NCQA Publication, 2016.

## 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 satisfaction with Acute Care. This section provides an overview of each analysis.

### *Response Rates*

The administration of the CAHPS Adult Medicaid Health Plan Survey is comprehensive and 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.<sup>5-8</sup> A survey is assigned a disposition code of "completed" if at least three of the following five questions were answered: questions 3, 15, 24, 28, and 35. Eligible members include the entire sample (including any oversample) 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 5-3), had a language barrier, or were mentally or physically incapacitated.

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

### *Member and Respondent Demographics*

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

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<sup>5-8</sup> National Committee for Quality Assurance. *HEDIS® 2017, Volume 3: Specifications for Survey Measures*. Washington, DC: NCQA Publication, 2016.

## NCQA Comparisons

An analysis of the Acute Care program's CAHPS 5.0 Adult Medicaid Health Plan Survey results was conducted using NCQA HEDIS Specifications for Survey Measures.<sup>5-9</sup> Per these specifications, no weighting or case-mix adjustment is performed on the results. Although NCQA requires a minimum of at least 100 responses on each item in order to obtain a reportable CAHPS Survey result, HSAG presented results with less than 100 responses. Therefore, caution should be exercised when interpreting results for those measures with fewer than 100 respondents. CAHPS scores with fewer than 100 respondents are denoted with a cross (+).

In order to perform the NCQA comparisons, a three-point mean score was determined for each CAHPS measure. The resulting three-point mean scores were compared to published NCQA Benchmarks and Thresholds to derive the overall member satisfaction ratings (i.e., star ratings) for each CAHPS measure, except for the Shared Decision Making composite measure and Health Promotion and Education individual item measure. NCQA does not publish benchmarks and thresholds for these measures; therefore, star ratings could not be assigned. For detailed information on the derivation of three-point mean scores, please refer to *NCQA HEDIS 2017 Specifications for Survey Measures, Volume 3*.

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

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

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<sup>5-9</sup> National Committee for Quality Assurance. *HEDIS® 2017, Volume 3: Specifications for Survey Measures*. Washington, DC: NCQA Publication, 2016.

Table 5-3 shows the benchmarks and thresholds used to derive the overall member satisfaction ratings on each CAHPS measure.<sup>5-10</sup>

**Table 5-3—Overall Adult Medicaid Member Satisfaction Ratings Crosswalk**

Measure	90th Percentile	75th Percentile	50th Percentile	25th Percentile
Rating of Health Plan	2.53	2.48	2.43	2.35
Rating of All Health Care	2.46	2.43	2.38	2.32
Rating of Personal Doctor	2.57	2.53	2.50	2.43
Rating of Specialist Seen Most Often	2.59	2.56	2.51	2.48
Getting Needed Care	2.45	2.41	2.35	2.28
Getting Care Quickly	2.49	2.45	2.40	2.33
How Well Doctors Communicate	2.64	2.58	2.54	2.48
Customer Service	2.61	2.58	2.54	2.48
Coordination of Care	2.50	2.44	2.39	2.34

### Rates and Proportions

Rates and Proportions were presented that compared member satisfaction performance between the Acute Care program and the 2016 NCQA Adult Medicaid average. For purposes of this analysis, question summary rates were calculated for each global rating and individual item measure, and global proportions were calculated for each composite measure. Both the question summary rates and global proportions were calculated in accordance with NCQA HEDIS Specifications for Survey Measures.<sup>5-11</sup> The scoring of the global ratings, composite measures, and individual item measures involved assigning top-level responses a score of one, with all other responses receiving a score of zero. After applying this scoring methodology, the percentage of top-level responses was calculated in order to determine the question summary rates and global proportions. For additional detail, please refer to the *NCQA HEDIS 2017 Specifications for Survey Measures, Volume 3*.

<sup>5-10</sup> National Committee for Quality Assurance. *HEDIS Benchmarks and Thresholds for Accreditation 2017*. Washington, DC: NCQA, May 4, 2017.

<sup>5-11</sup> National Committee for Quality Assurance. *HEDIS® 2017, Volume 3: Specifications for Survey Measures*. Washington, DC: NCQA Publication, 2016.

## Contractor Comparisons

Comparisons were performed to identify member satisfaction differences that were statistically significantly different between the Acute Care Contractors. Two types of hypothesis tests were applied to the Acute Care comparative results. First, a global  $F$  test was calculated, which determined whether the differences between the Contractors' scores were significant.

The weighted score was:

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

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

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

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

The  $t$  test determined whether each Contractor's score was significantly different from the overall results of the other participating Contractors. The equation for the differences was as follows:

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

In this equation,  $\Sigma^*$  was the sum of all Contractors except Contractor  $p$ .

The variance of  $\Delta_p$  was:

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

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

## Limitations and Cautions

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

### *Case-Mix Adjustment*

As described in the demographics subsection, the demographics of a response group may impact member satisfaction. Therefore, differences in the demographics of the response group may impact CAHPS results. NCQA does not recommend case-mix adjusting Medicaid CAHPS results to account for these differences.<sup>5-12</sup>

### *Non-Response Bias*

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

### *Causal Inferences*

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

### *Baseline Results*

The 2016 CAHPS results presented in the report represent a **baseline** assessment of members' satisfaction with the Acute Care program Contractors; therefore, caution should be exercised when interpreting results.

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<sup>5-12</sup> Agency for Healthcare Research and Quality. *CAHPS Health Plan Survey and Reporting Kit 2008*. Rockville, MD: U.S. Department of Health and Human Services, July 2008.

## 6. Survey Instrument

The survey instrument selected for the 2016 Acute Care Adult Medicaid Member Satisfaction Survey was the CAHPS 5.0 Adult Medicaid Health Plan Survey with the HEDIS supplemental item set. This section provides a copy of the survey instrument.

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

If you want to know more about this study, please call 1-877-455-9242.

**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** ↓

1. Our records show that you are now in [HEALTH PLAN NAME]. Is that right?

Yes → *Go to Question 3*  
 No

2. What is the name of your health plan? (Please print)

\_\_\_\_\_

## YOUR HEALTH CARE IN THE LAST 6 MONTHS

These questions ask about your own health care. Do not include care you got when you stayed overnight in a hospital. Do not include the times you went for dental care visits.

3. In the last 6 months, did you 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 you needed care right away, how often did you get care as soon as you needed?
- Never  
 Sometimes  
 Usually  
 Always
5. In the last 6 months, did you make any appointments for a check-up or routine care at a doctor's office or clinic?
- Yes  
 No → *Go to Question 7*
6. In the last 6 months, how often did you get an appointment for a check-up or routine care at a doctor's office or clinic as soon as you needed?
- Never  
 Sometimes  
 Usually  
 Always

7. In the last 6 months, not counting the times you went to an emergency room, how many times did you go to a doctor's office or clinic to get health care for yourself?
- 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 a doctor or other health provider talk about specific things you could do to prevent illness?
- Yes  
 No
9. In the last 6 months, did you and a doctor or other health provider talk about starting or stopping a prescription medicine?
- Yes  
 No → *Go to Question 13*
10. Did you and a doctor or other health provider talk about the reasons you might want to take a medicine?
- Yes  
 No
11. Did you and a doctor or other health provider talk about the reasons you might not want to take a medicine?
- Yes  
 No

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

- 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 health care in the last 6 months?

- 
- 0 1 2 3 4 5 6 7 8 9 10
- Worst Health Care Possible Health Care Possible Best

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

- Never
- Sometimes
- Usually
- Always

14a. In the last 6 months, when a doctor or other health provider ordered a blood test, x-ray, or other test for you, how often did someone follow up to give you those results?

- Never
- Sometimes
- Usually
- Always
- I did not have a blood test, x-ray or other test ordered in the last 6 months.

14b. In the last 6 months, did a doctor or other health provider talk with you about specific goals for your health?

- Yes
- No

14c. In the last 6 months, did a doctor or other health provider ask you if there are things that make it hard for you to take care of your health?

- Yes
- No

14d. In the last 6 months, did a doctor or other health provider ask you if there was a period of time when you felt sad, empty or depressed?

- Yes
- No

### YOUR PERSONAL DOCTOR

15. A personal doctor is the one you would see if you need a check-up, want advice about a health problem, or get sick or hurt. Do you have a personal doctor?

- Yes
- No → *Go to Question 24*

16. In the last 6 months, how many times did you visit your personal doctor to get care for yourself?

- None → *Go to Question 23*
- 1 time
- 2
- 3
- 4
- 5 to 9
- 10 or more times



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

- Never
- Sometimes
- Usually
- Always

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

- Never
- Sometimes
- Usually
- Always

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

- Never
- Sometimes
- Usually
- Always

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

- Never
- Sometimes
- Usually
- Always

21. In the last 6 months, did you get care from a doctor or other health provider besides your personal doctor?

- Yes
- No → **Go to Question 23**

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

- Never
- Sometimes
- Usually
- Always

23. 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 personal doctor?

- |                       |                       |                       |                       |                       |                       |                       |                       |                       |                       |                       |
|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| <input type="radio"/> |
| 0                     | 1                     | 2                     | 3                     | 4                     | 5                     | 6                     | 7                     | 8                     | 9                     | 10                    |
| Worst                 |                       |                       |                       |                       |                       | Best                  |                       |                       |                       |                       |
| Personal Doctor       |                       |                       |                       |                       |                       | Personal Doctor       |                       |                       |                       |                       |
| Possible              |                       |                       |                       |                       |                       | Possible              |                       |                       |                       |                       |

**GETTING HEALTH CARE FROM SPECIALISTS**

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

24. 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 to see a specialist?

- Yes
- No → **Go to Question 28**



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

- Never
- Sometimes
- Usually
- Always

26. How many specialists have you seen in the last 6 months?

- None → **Go to Question 28**
- 1 specialist
- 2
- 3
- 4
- 5 or more specialists

27. We want to know your rating of the specialist you 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 HEALTH PLAN

The next questions ask about your experience with your health plan.

28. In the last 6 months, did you look for any information in written materials or on the Internet about how your health plan works?

- Yes
- No → **Go to Question 30**

29. In the last 6 months, how often did the written materials or the Internet provide the information you needed about how your health plan works?

- Never
- Sometimes
- Usually
- Always

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

- Yes
- No → **Go to Question 33**

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

- Never
- Sometimes
- Usually
- Always

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

- Never
- Sometimes
- Usually
- Always

33. In the last 6 months, did your health plan give you any forms to fill out?

- Yes
- No → **Go to Question 35**

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

- Never
- Sometimes
- Usually
- Always

35. 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 health plan?

- |                       |                       |                       |                       |                       |                       |                       |                       |                       |                       |                       |
|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| <input type="radio"/> |
| 0                     | 1                     | 2                     | 3                     | 4                     | 5                     | 6                     | 7                     | 8                     | 9                     | 10                    |
| Worst                 |                       |                       |                       |                       | Best                  |                       |                       |                       |                       |                       |
| Health Plan           |                       |                       |                       |                       | Health Plan           |                       |                       |                       |                       |                       |
| Possible              |                       |                       |                       |                       | Possible              |                       |                       |                       |                       |                       |

### ABOUT YOU

36. In general, how would you rate your overall health?

- Excellent
- Very Good
- Good
- Fair
- Poor

37. In general, how would you rate your overall mental or emotional health?

- Excellent
- Very Good
- Good
- Fair
- Poor

38. Have you had either a flu shot or flu spray in the nose since July 1, 2016?

- Yes
- No
- Don't know

39. Do you now smoke cigarettes or use tobacco every day, some days, or not at all?

- Every day
- Some days
- Not at all → *Go to Question 43*
- Don't know → *Go to Question 43*

40. In the last 6 months, how often were you advised to quit smoking or using tobacco by a doctor or other health provider in your plan?

- Never
- Sometimes
- Usually
- Always

41. In the last 6 months, how often was medication recommended or discussed by a doctor or health provider to assist you with quitting smoking or using tobacco? Examples of medication are: nicotine gum, patch, nasal spray, inhaler, or prescription medication.

- Never
- Sometimes
- Usually
- Always

42. In the last 6 months, how often did your doctor or health provider discuss or provide methods and strategies other than medication to assist you with quitting smoking or using tobacco? Examples of methods and strategies are: telephone helpline, individual or group counseling, or cessation program.

- Never
- Sometimes
- Usually
- Always

◆

43. Do you take aspirin daily or every other day?

- Yes
- No
- Don't know

44. Do you have a health problem or take medication that makes taking aspirin unsafe for you?

- Yes
- No
- Don't know

45. Has a doctor or health provider ever discussed with you the risks and benefits of aspirin to prevent heart attack or stroke?

- Yes
- No

46. Are you aware that you have any of the following conditions? Mark one or more.

- High cholesterol
- High blood pressure
- Parent or sibling with heart attack before the age of 60

47. Has a doctor ever told you that you have any of the following conditions? Mark one or more.

- A heart attack
- Angina or coronary heart disease
- A stroke
- Any kind of diabetes or high blood sugar

48. In the last 6 months, did you get health care 3 or more times for the same condition or problem?

- Yes
- No → **Go to Question 50**

◆

49. Is this a condition or problem that has lasted for at least 3 months? Do not include pregnancy or menopause.

- Yes
- No

50. Do you now need or take medicine prescribed by a doctor? Do not include birth control.

- Yes
- No → **Go to Question 52**

51. Is this medicine to treat a condition that has lasted for at least 3 months? Do not include pregnancy or menopause.

- Yes
- No

52. What is your age?

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

53. Are you male or female?

- Male
- Female

54. 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

◆ **55. Are you of Hispanic or Latino origin or descent?**

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

**56. What is your race? Mark one or more.**

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

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

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

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

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

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

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

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