2016 Children's Rehabilitative Services Program Member Satisfaction Report

August 2017

HSAG HEALTH SERVICES ADVISORY GROUP

HSAG HEALTH SERVICES ADVISORY GROUP

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1. Executive Summary

The State of Arizona required the administration of member satisfaction surveys to Medicaid members enrolled in the Arizona Health Care Cost Containment System (AHCCCS) Children's Rehabilitative Services (CRS) 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.[1-1] 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 parents/caretakers' of child members satisfaction with the CRS Program; therefore, caution should be exercised when interpreting these results.

The standardized survey instrument selected was the CAHPS 5.0 Child Medicaid Health Plan Survey with the Healthcare Effectiveness Data and Information Set (HEDIS®) supplemental item set and the Children with Chronic Conditions (CCC) measurement set.[1-2] The parents and caretakers of child members from the CRS Program completed the surveys from February to April 2017.

General Child Performance Highlights

The General Child Results section of this report details the CAHPS results for the CRS Program's general child population. The following is a summary of the general child CAHPS performance highlights for the CRS Program. The performance highlights are categorized into three areas of analysis performed for the general child population:

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

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

NCQA Comparisons

Overall 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 CRS CAHPS survey results were compared to NCQA's 2017 HEDIS Benchmarks and Thresholds for Accreditation.[1-3,1-4] 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.[1-5] The detailed results of this comparative analysis are described in the General Child Results section beginning on page 3-1. Table 1-1 presents the highlights from this comparison.

Table 1-1—NCQA Comparisons Highlights

Measure	Three-Point Mean	Star Rating
Global Rating		
Rating of Health Plan	2.58	★★★
Rating of All Health Care	2.61	★★★★★
Rating of Personal Doctor	2.66	★★★★
Rating of Specialist Seen Most Often	2.65	★★★★
Composite Measure		
Getting Needed Care	2.44	★★
Getting Care Quickly	2.59	★★
How Well Doctors Communicate	2.64	★★
Customer Service	2.49	★
Individual Item Measure		
Coordination of Care	2.26	★
Star Assignments Based on Percentiles: ★Below 25th ★★25th – 49th ★★★50th – 74th ★★★★75th – 89th ★★★★★90th or Above		

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

[1-4] NCQA's benchmarks and thresholds for the child Medicaid population were used to derive the overall member satisfaction ratings; therefore, caution should be exercised when interpreting these results.

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

Rates and Proportions

The question summary rates and global proportions for the CRS Program were compared to 2016 NCQA Child Medicaid Quality Compass® data.[1-6,1-7] 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 General Child Results section beginning on page 3-3. The following are highlights of this comparison:

- The CRS Program scored at or above the national average on five measures: Rating of All Health Care, Rating of Specialist Seen Most Often, Getting Care Quickly, Getting Needed Care, and Health Promotion and Education.

Priority Assignments

Based on the results of the NCQA comparisons, priority assignments were derived for each measure.[1-8] Measures were assigned into one of four main categories for quality improvement (QI): top, high, moderate, and low priority. These priority areas are described in the Recommendations section of this report beginning on page 5-1. The following are the priority areas for the CRS Program:

- Customer Service
- Coordination of Care

[1-6] Quality Compass® is a registered trademark of the National Committee for Quality Assurance (NCQA).

[1-7] NCQA national averages for the child Medicaid population were used for comparative purposes. Given the potential differences in the demographics of these populations (i.e., child Medicaid and CRS), caution should be exercised when interpreting these results.

[1-8] Priority assignments were derived based on the CRS Program's general child population CAHPS results.

Children with Chronic Conditions (CCC) Performance Highlights

The CCC Results section of this report details the CAHPS results for the CRS Program's CCC population. The following is a summary of the CAHPS performance highlights. The detailed results of this analysis are described in the CCC Results section beginning on page 4-2.

Rates and Proportions

The question summary rates and global proportions for the CRS Program's CCC population were compared to 2016 NCQA CCC Medicaid Quality Compass data. These comparisons were performed on the four global ratings, five composite measures, two individual item measures, and five CCC composites and items. The following are highlights of this comparison:

- The CRS Program scored at or above the national average on five measures: Rating of All Health Care, Rating of Specialist Seen Most Often, Health Promotion and Education, Coordination of Care for Children with Chronic Conditions, and Family-Centered Care (FCC): Getting Needed Information.

Survey Administration and Response Rates

Survey Administration

Child members eligible for surveying included those who were enrolled in the CRS Program at the time the sample was drawn and who were continuously enrolled in the CRS Program for at least five of the last six months of the measurement period (October 2015 through March 2016). In addition, child members had to be 21 years of age or younger as of March 31, 2016 to be included in the survey.[2-1]

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

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 CRS 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

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[2-1] For purposes of this report, the age criteria for child members eligible for inclusion in the CAHPS Child Medicaid Health Plan Survey was modified to include members up to 21 years of age or younger as of March 31, 2016. Please note, this deviates from standard NCQA HEDIS specifications, which define eligible child members as 18 years of age or younger as of December 31 of the measurement year.

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

[2-3] Ibid.

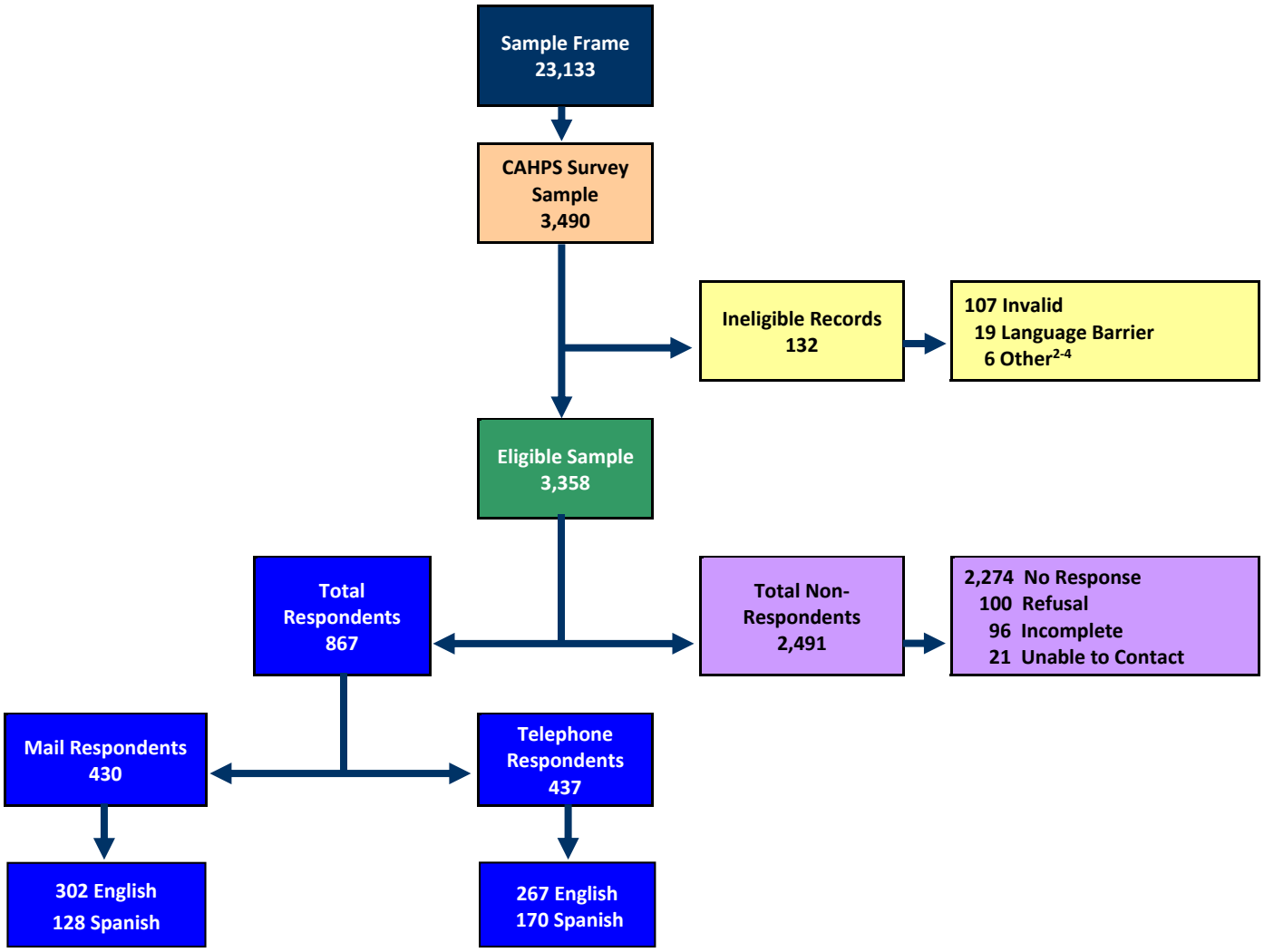
included with the English version of the survey had a Spanish cover letter on the back side informing members that they could call the toll-free number to request a Spanish version of the CAHPS questionnaire. A reminder postcard was sent to all non-respondents, followed by a second survey mailing and 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 6-3.

Response Rates

The 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, 30, 45, 49, and 54. 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), or had a language barrier.

A total of 867 completed surveys were returned on behalf of child members. Figure 2-1, on the following page, shows the distribution of survey dispositions and response rate for the CRS Program. The survey dispositions and response rate are based on the responses of parents/caretakers of children in the general child and Children with Chronic Conditions (CCC) supplemental populations.

Figure 2-1—Distribution of Surveys for CRS Program



Response Rate = 25.82%

The CRS Program's response rate of 25.8 percent was greater than the national child Medicaid response rate reported by NCQA for 2016, which was 23.0 percent.[2-5]

[2-4] The "Other" ineligible records category includes members who were deceased.
[2-5] National Committee for Quality Assurance. *HEDIS 2017 Update Survey Vendor Training*. October 18, 2016.

Child and 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.[2-6] Currently, NCQA does not recommend case-mix adjusting Medicaid CAHPS results to account for these differences.

[2-6] 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 2-1 shows the demographic characteristics of children for whom a parent or caretaker completed a CAHPS Child Medicaid Health Plan Survey.[2-7]

Table 2-1—CRS Program Child Demographics: Age, Gender, Race, Ethnicity, and General Health Status

Age	
1 to 3	9.2%
4 to 7	18.3%
8 to 12	26.5%
13 to 17	29.8%
18 to 22*	16.3%
Gender	
Male	48.3%
Female	51.7%
Race	
Multi-Racial	8.6%
White	61.7%
Black	7.4%
Asian	1.2%
Native American	2.7%
Other	18.6%
Ethnicity	
Hispanic	66.3%
Non-Hispanic	33.7%
General Health	
Excellent	25.3%
Very Good	27.6%
Good	32.2%
Fair	13.2%
Poor	1.8%

Please note, percentages may not total 100% due to rounding.
** Children were eligible for inclusion in CAHPS if they were 21 years of age or younger as of March 31, 2016. Some children eligible for the CAHPS Survey turned 22 between April 1, 2016 and the time of survey administration.*

[2-7] The child demographic data presented in Table 2-1 are based on the characteristics of the general child population.

Table 2-2 depicts the self-reported age, level of education, gender, and relationship to the child for the respondents who completed the CAHPS Child Medicaid Health Plan Survey.[2-8]

Table 2-2—CRS Program Respondent Demographics: Age, Education, Gender, and Relationship to Child

Respondent Age	
Under 18	5.2%
18 to 24	3.6%
25 to 34	22.2%
35 to 44	39.2%
45 to 54	18.0%
55 to 64	8.0%
65 or Older	3.9%
Respondent Gender	
Male	8.7%
Female	91.3%
Respondent Education	
8th Grade or Less	13.7%
Some High School	16.8%
High School Graduate	30.2%
Some College	30.7%
College Graduate	8.8%
Relationship	
Mother or Father	90.0%
Grandparent	7.1%
Legal Guardian	1.6%
Other[2-9]	1.3%
Please note, percentages may not total 100% due to rounding.	

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

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

[2-9] The "Other" category for respondent demographics response options included aunt or uncle, older brother or sister, other relative, or someone else.

3. General Child Results

The following presents the CAHPS results for the CRS Program's general child population. For the general child population, a total of 405 completed surveys were returned on behalf of child members. These completed surveys were used to calculate the 2016 General Child CAHPS results presented in this section.

NCQA Comparisons

In order to assess the overall performance of the CRS Program, 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.[3-1] The resulting three-point mean scores were compared to NCQA's HEDIS Benchmarks and Thresholds for Accreditation.[3-2] Based on this comparison, 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.[3-3,3-4]

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

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

[3-2] National Committee for Quality Assurance. *HEDIS Benchmarks and Thresholds for Accreditation 2017.* Washington, DC: NCQA, May 4, 2017.

[3-3] 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.

[3-4] NCQA's benchmarks and thresholds for the child Medicaid population were used to derive the overall satisfaction ratings; therefore, caution should be exercised when interpreting these results.

Table 3-1 shows the CRS Program's three-point mean scores and overall member satisfaction ratings on each of the four global ratings, four composite measures, and one individual item measure.

Table 3-1—NCQA Comparisons: Global Ratings

Measure	Three-Point Mean	Star Rating
Global Rating		
Rating of Health Plan	2.58	★★★
Rating of All Health Care	2.61	★★★★★
Rating of Personal Doctor	2.66	★★★★
Rating of Specialist Seen Most Often	2.65	★★★★
Composite Measure		
Getting Needed Care	2.44	★★
Getting Care Quickly	2.59	★★
How Well Doctors Communicate	2.64	★★
Customer Service	2.49	★
Individual Measure		
Coordination of Care	2.26	★
Star Assignments Based on Percentiles: ★Below 25th ★★25th – 49th ★★★50th – 74th ★★★★75th – 89th ★★★★★90th or Above		

Summary of NCQA Comparisons Results

The NCQA comparisons revealed the following summary results:

- The CRS Program scored at or above the 90th percentile on one measure, Rating of All Health Care.
- The CRS Program scored at or between the 75th and 89th percentiles on two measures: Rating of Personal Doctor and Rating of Specialist Seen Most Often.
- The CRS Program scored at or between the 50th and 74th percentiles on one measure, Rating of Health Plan.
- The CRS Program scored at or between the 25th and 49th percentiles on three measures: Getting Needed Care, Getting Care Quickly, and How Well Doctors Communicate.
- The CRS Program scored below the 25th percentile on two measures: Customer Service and Coordination of Care.

Rates and Proportions

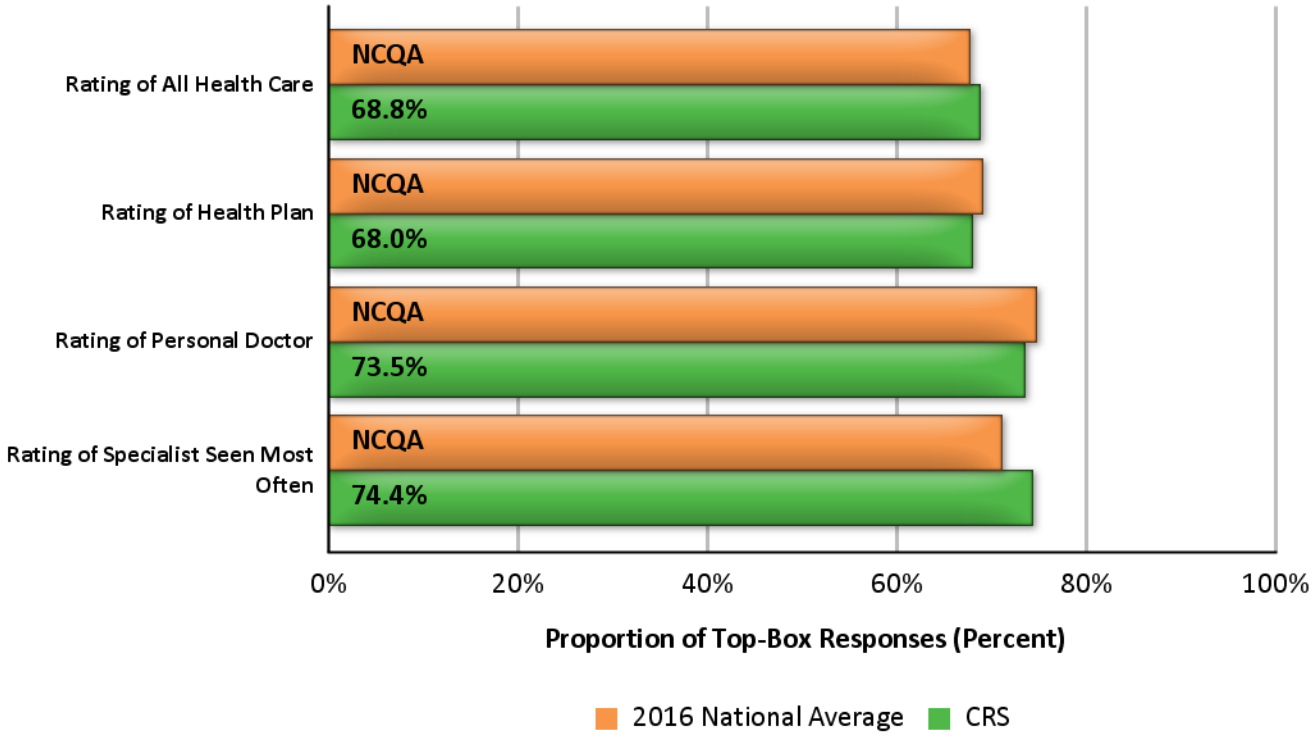
For purposes of calculating the results, question summary rates were calculated for each global rating and individual item measure, and global proportions were calculated for each composite measure. Both the question summary rates and global proportions were calculated in accordance with NCQA HEDIS Specifications for Survey Measures.[3-5] The scoring of the global ratings, composite measures, and individual item measures involved assigning top-level responses a score of one, with all other responses receiving a score of zero. After applying this scoring methodology, the percentage of top-level responses was calculated in order to determine the question summary rates and global proportions. For additional detail, please refer to the *NCQA HEDIS 2017 Specifications for Survey Measures*, *Volume 3*.

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

Global Ratings

Figure 3-1 depicts the top-box question summary rates for each of the global ratings for the CRS Program and the 2016 NCQA National Child Medicaid average using responses of 9 or 10 for top-box scoring.[3-6,3-7]

Figure 3-1—Global Ratings: Question Summary Rates

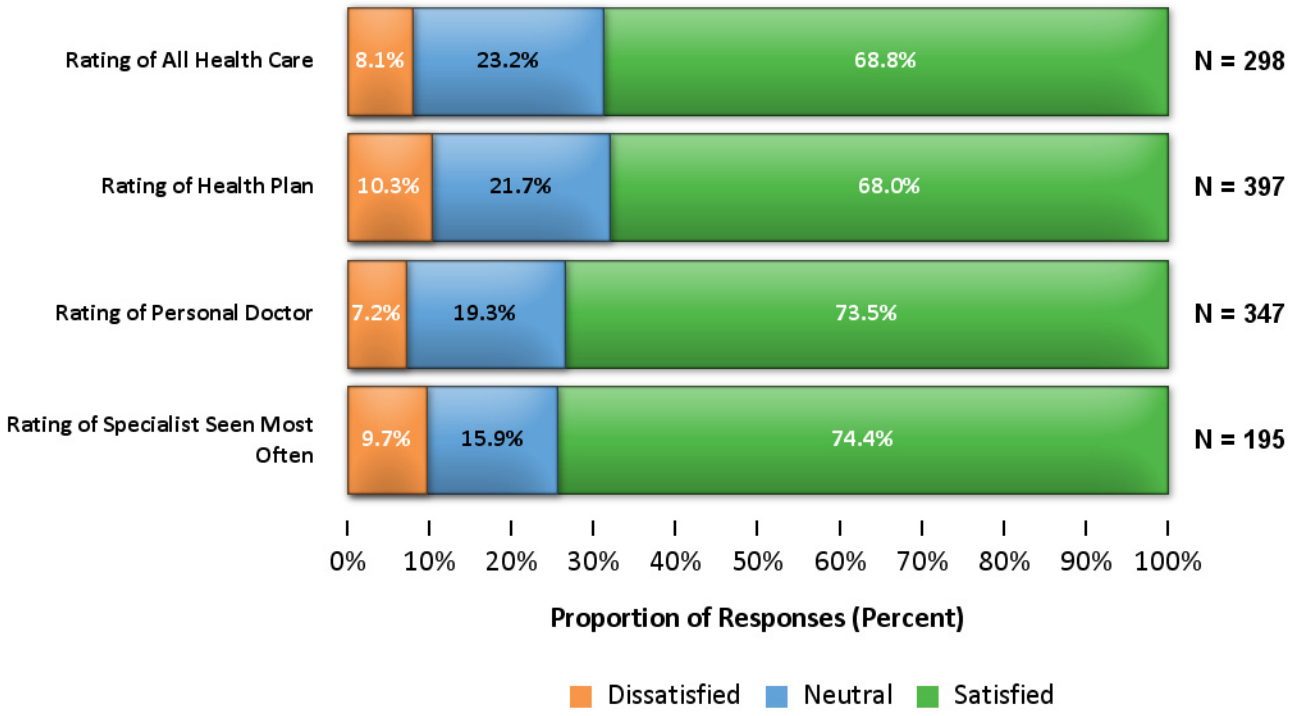


[3-6] For the NCQA national child Medicaid averages, the source for data contained in this publication is Quality Compass® 2016 data and is used with the permission of the National Committee for Quality Assurance (NCQA). Quality Compass 2016 includes certain CAHPS data. Any data display, analysis, interpretation, or conclusion based on these data is solely that of the authors, and NCQA specifically disclaims responsibility for any such display, analysis, interpretation, or conclusion. Quality Compass is a registered trademark of NCQA. CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

[3-7] NCQA national averages for the child Medicaid population were used for comparative purposes. Given the potential differences in the demographics of these populations (i.e., child Medicaid and CRS), 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 3-2 depicts the proportion of respondents who fell into each response category for each global rating for the CRS Program.

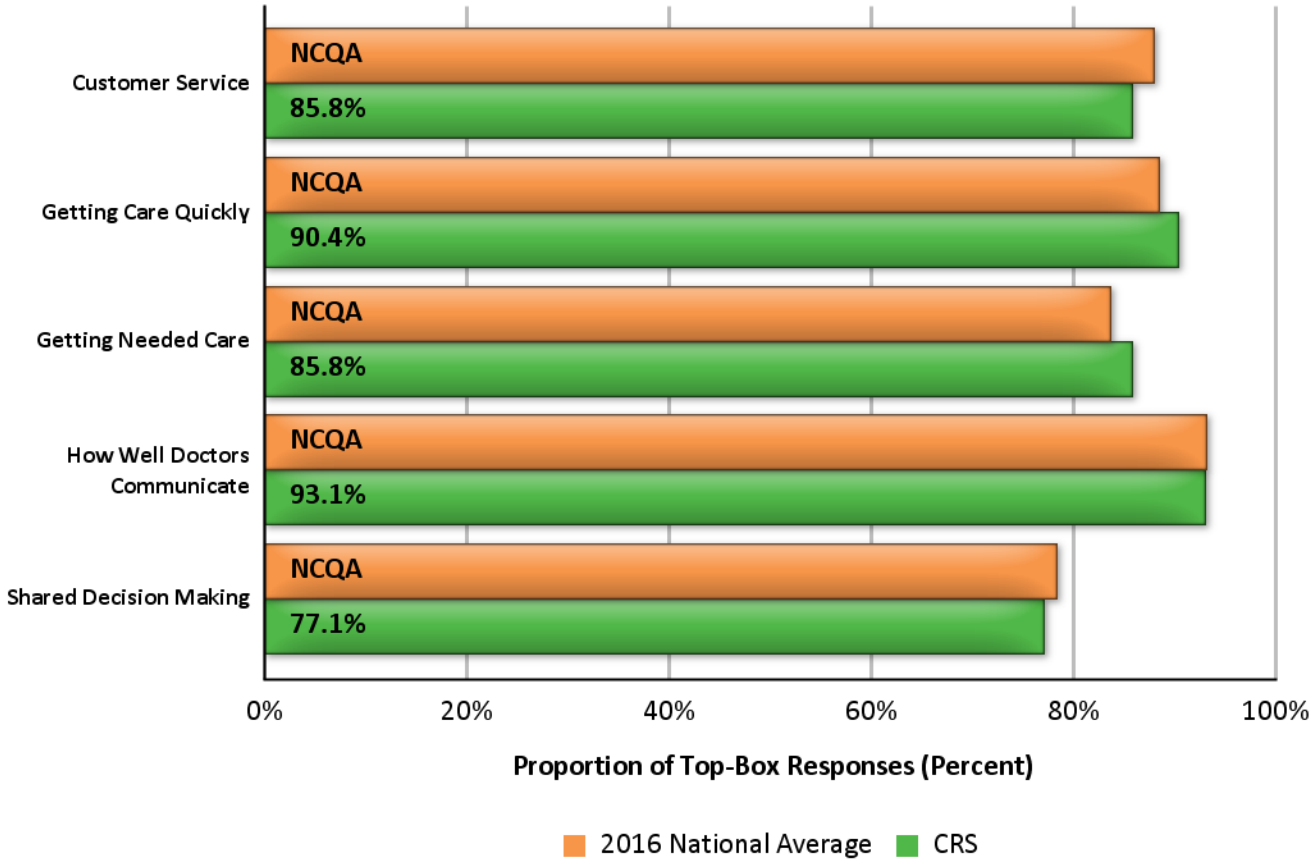
Figure 3-2—Global Ratings: Proportion of Responses



Composite Measures

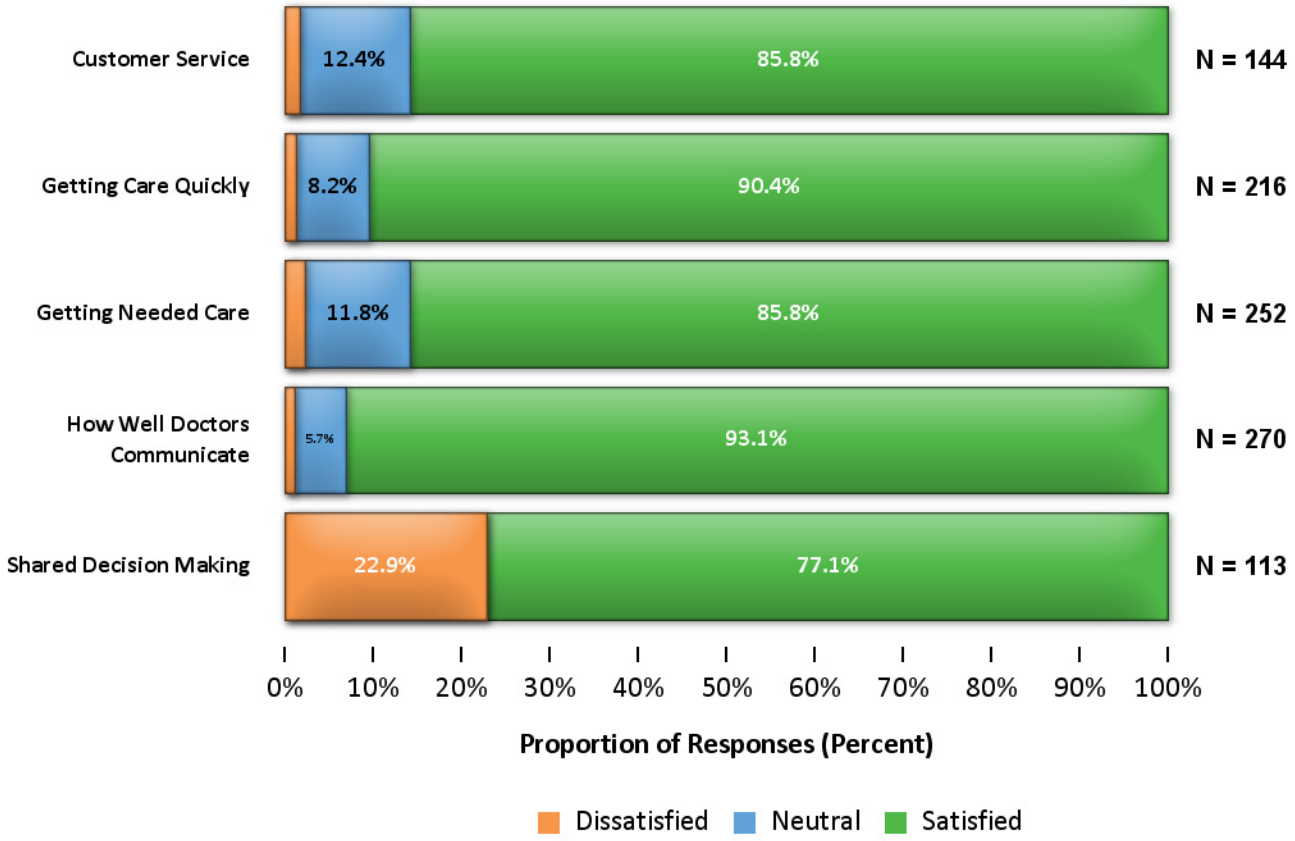
Figure 3-3 depicts the top-box global proportions for the CRS Program and the 2016 NCQA National Child Medicaid average using responses of "Usually" or "Always" for top-box scoring of Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, and Customer Service, and responses of "Yes" for top-box scoring of Shared Decision Making.

Figure 3-3—Composite Measures: Global Proportions



For Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, and Customer Service, responses were classified into one of three response categories as follows: "Never (Dissatisfied)," "Sometimes (Neutral)," and "Usually/Always (Satisfied)." For Shared Decision Making, responses were classified into one of two response categories as follows: "No (Dissatisfied)" and "Yes (Satisfied)." Figure 3-4 depicts the proportion of respondents who fell into each response category for each composite measure for the CRS Program.

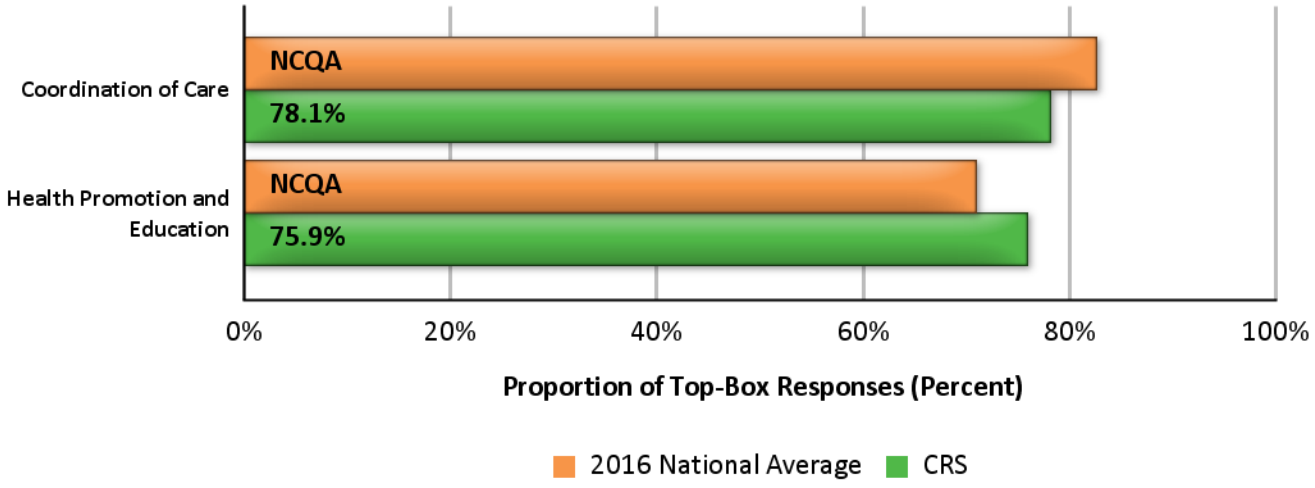
Figure 3-4—Composite Measures: Proportion of Responses



Individual Item Measures

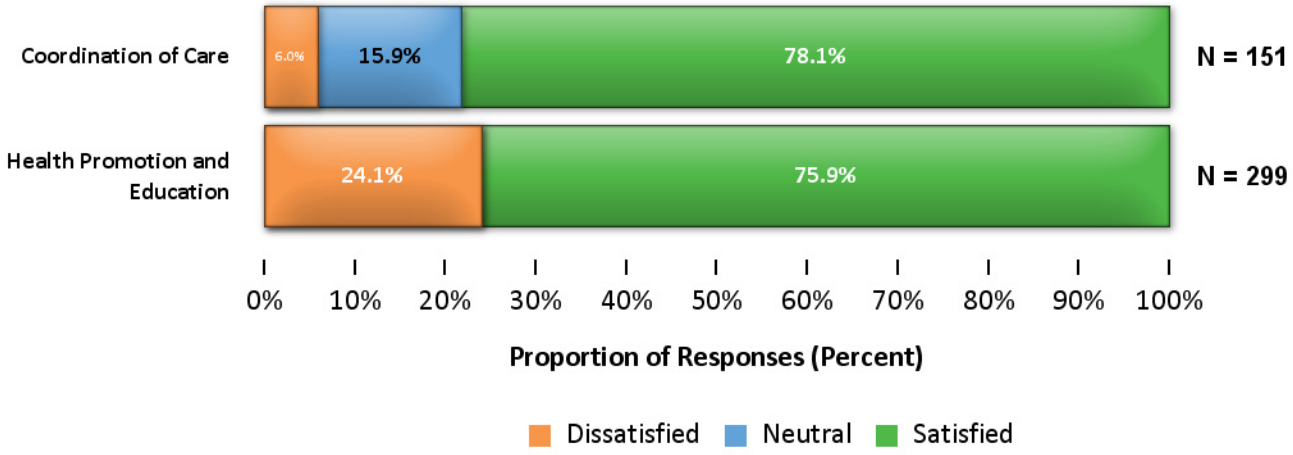
Figure 3-5 depicts the top-box question summary rates for the CRS Program and the 2016 NCQA National Child Medicaid average using responses of "Usually" or "Always" for top-box scoring of Coordination of Care, and responses of "Yes" for top-box scoring of Health Promotion and Education.

Figure 3-5—Individual Item Measures: Global Proportions



For Coordination of Care, responses were classified into one of three response categories: "Never (Dissatisfied)," "Sometimes (Neutral)," and "Usually/Always (Satisfied)." For Health Promotion and Education, responses were classified into one of two response categories: "No (Dissatisfied)" or "Yes (Satisfied)." Figure 3-6 depicts the proportion of respondents who fell into each response category for each individual item measure for the CRS Program.

Figure 3-6—Individual Item Measures: Proportion of Responses



Summary of Rates and Proportions

Evaluation of the CRS Program's Rates and Proportions for the general child population revealed the following summary results.

- The CRS Program scored at or above the national average on five measures: Rating of All Health Care, Rating of Specialist Seen Most Often, Getting Care Quickly, Getting Needed Care, and Health Promotion and Education.
- The CRS Program scored below the national average on six measures: Rating of Health Plan, Rating of Personal Doctor, Customer Service, How Well Doctors Communicate, Shared Decision Making, and Coordination of Care.

4. Children with Chronic Conditions Results

Chronic Conditions Classification

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

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

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

Based on parents/caretakers' responses to the CCC screener questions, the CRS Program had 574 completed CAHPS Child Medicaid Health Plan Surveys for the CCC population. These completed surveys were used to calculate the 2016 CCC CAHPS results presented in this section. The CAHPS results presented in this section represent a **baseline** assessment of the parents/caretakers' satisfaction with the care and services provided by the CRS Program.

Rates and Proportions

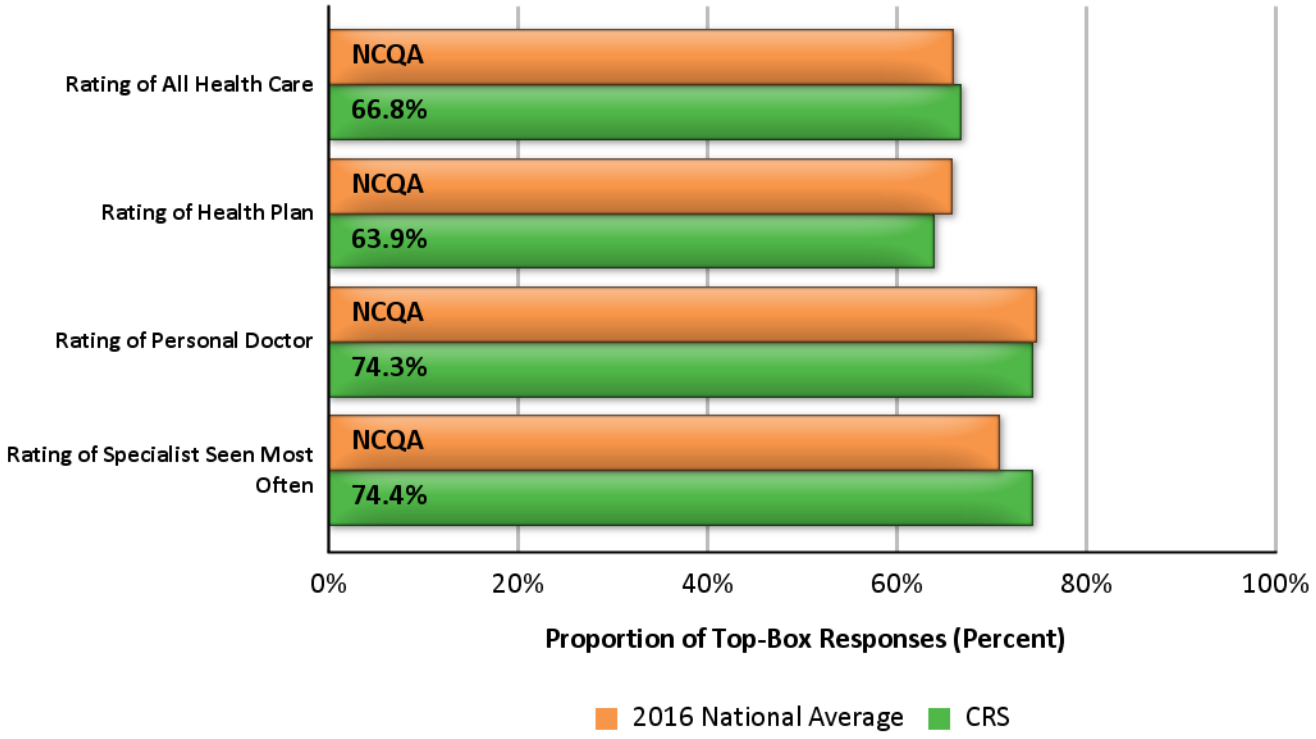
For purposes of calculating the Children with Chronic Conditions (CCC) results, question summary rates were calculated for each global rating and individual item measure, and global proportions were calculated for each composite measure. Both the question summary rates and global proportions were calculated in accordance with NCQA HEDIS Specifications for Survey Measures.[4-1] The scoring of the global ratings, composite measures, individual item measures, and CCC composites and items involved assigning top-level responses a score of one, with all other responses receiving a score of zero. After applying this scoring methodology, the percentage of top-level responses was calculated in order to determine the question summary rates and global proportions. For additional details, please refer to the *NCQA HEDIS 2017 Specifications for Survey Measures*, *Volume 3*.

[4-1] National Committee for Quality Assurance. *HEDIS® 2017, Volume 3: Specifications for Survey Measures*. Washington, DC: NCQA Publication, 2016.

Global Ratings

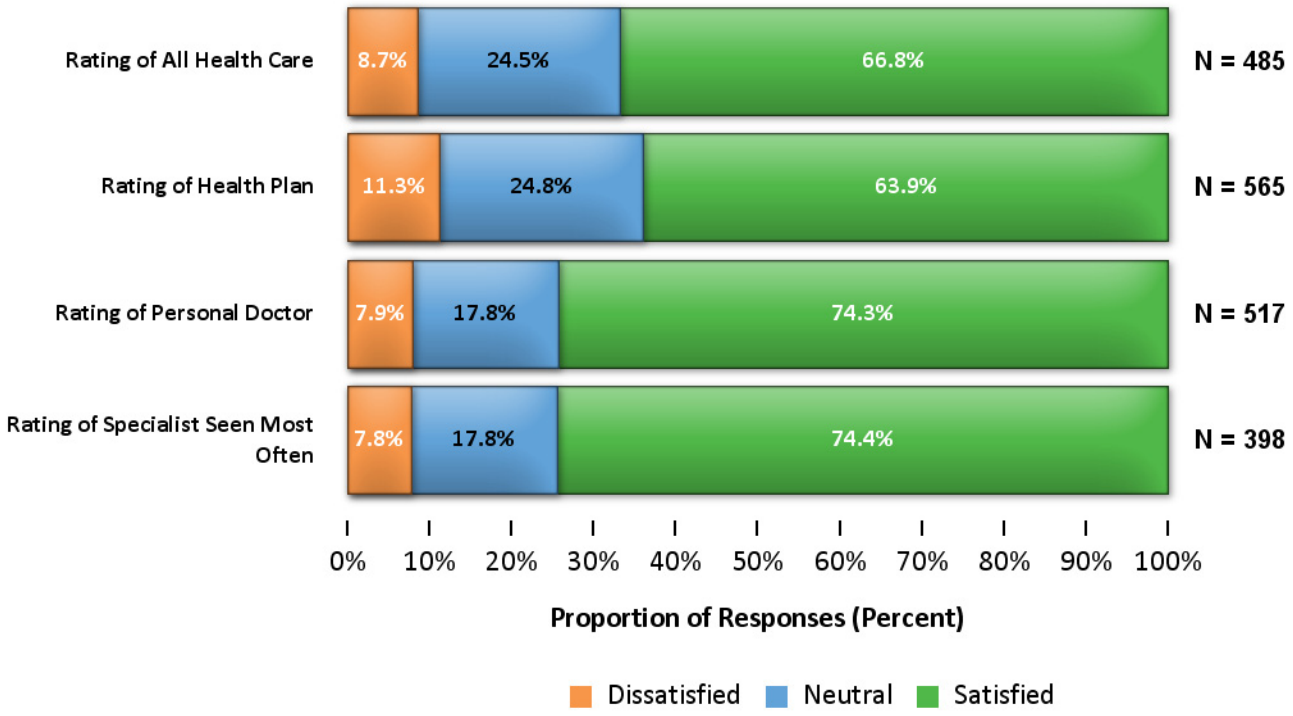
Figure 4-1 depicts the top-box question summary rates for each of the global ratings for the CRS Program and the 2016 NCQA National CCC Medicaid average using responses of 9 or 10 for top-box scoring.

Figure 4-1—Global Ratings: 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 4-2 depicts the proportion of respondents who fell into each response category for each global rating for the CRS Program.

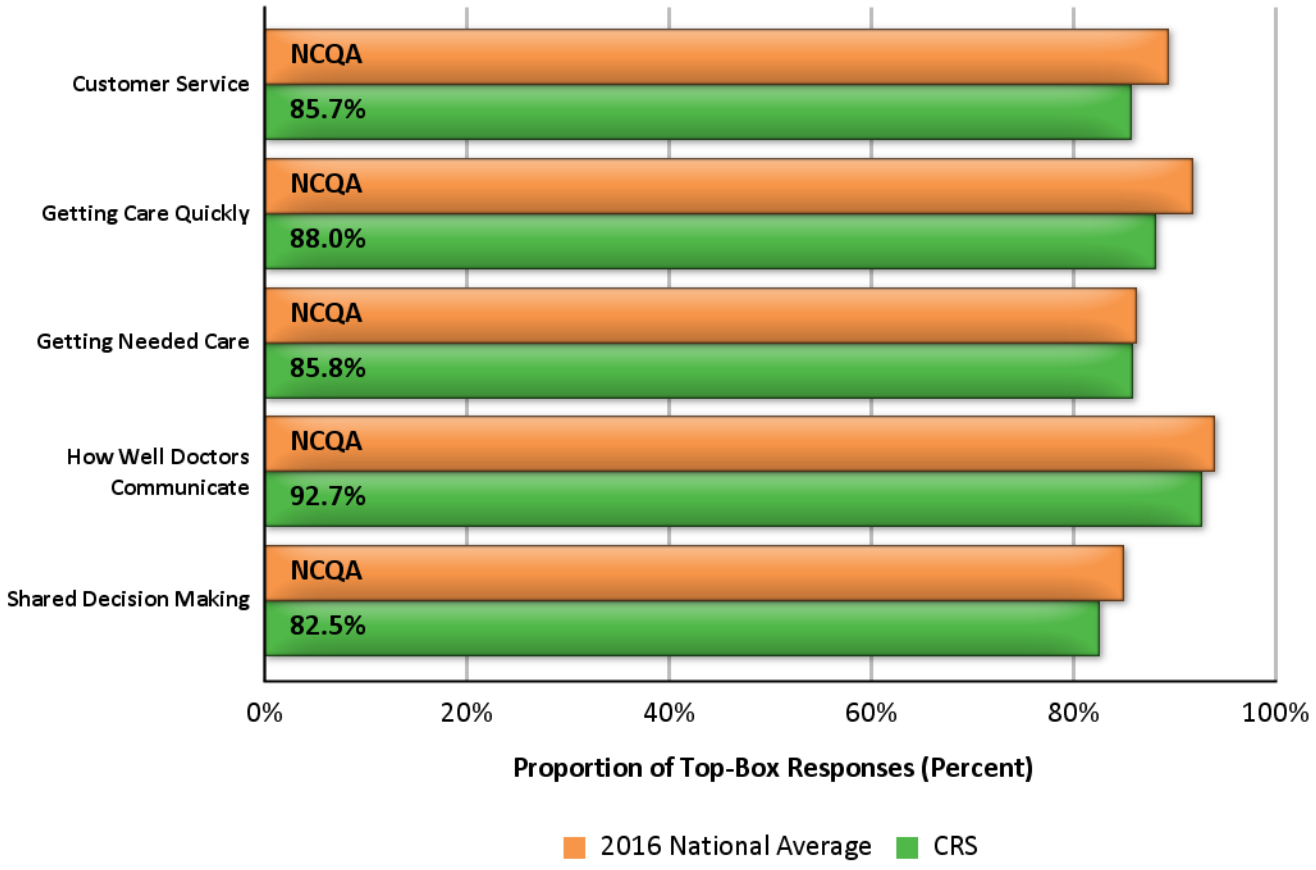
Figure 4-2—Global Ratings: Proportion of Responses



Composite Measures

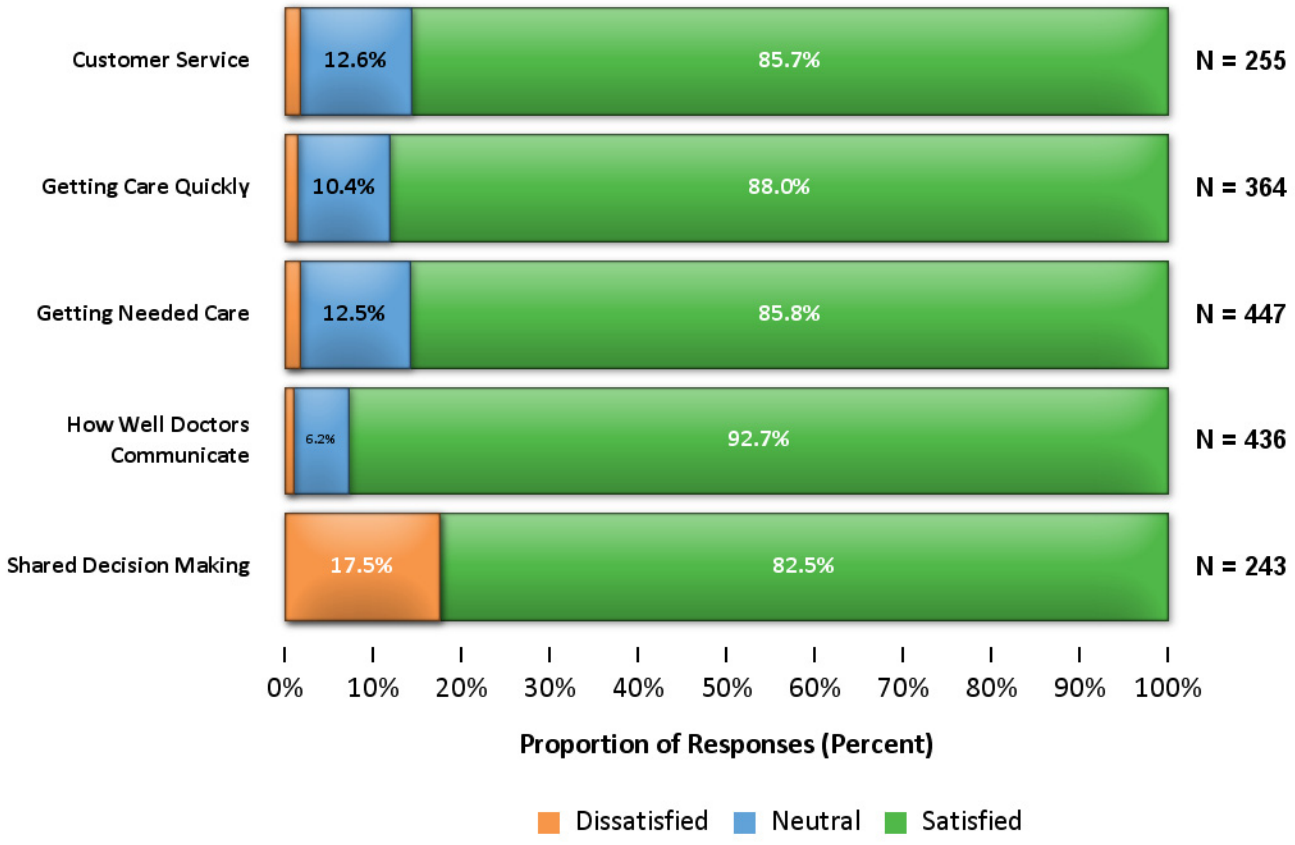
Figure 4-3 depicts the top-box global proportions for the CRS Program and the 2016 NCQA National CCC Medicaid average using responses of "Usually" or "Always" for top-box scoring of Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, and Customer Service, and responses of "Yes" for top-box scoring of Shared Decision Making.

Figure 4-3—Composite Measures: Global Proportions



For Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, and Customer Service, responses were classified into one of three response categories as follows: "Never (Dissatisfied)," "Sometimes (Neutral)," and "Usually/Always (Satisfied)." For Shared Decision Making, responses were classified into one of two response categories as follows: "No (Dissatisfied)" and "Yes (Satisfied)." Figure 4-4 depicts the proportion of respondents who fell into each response category for each composite measure for the CRS Program.

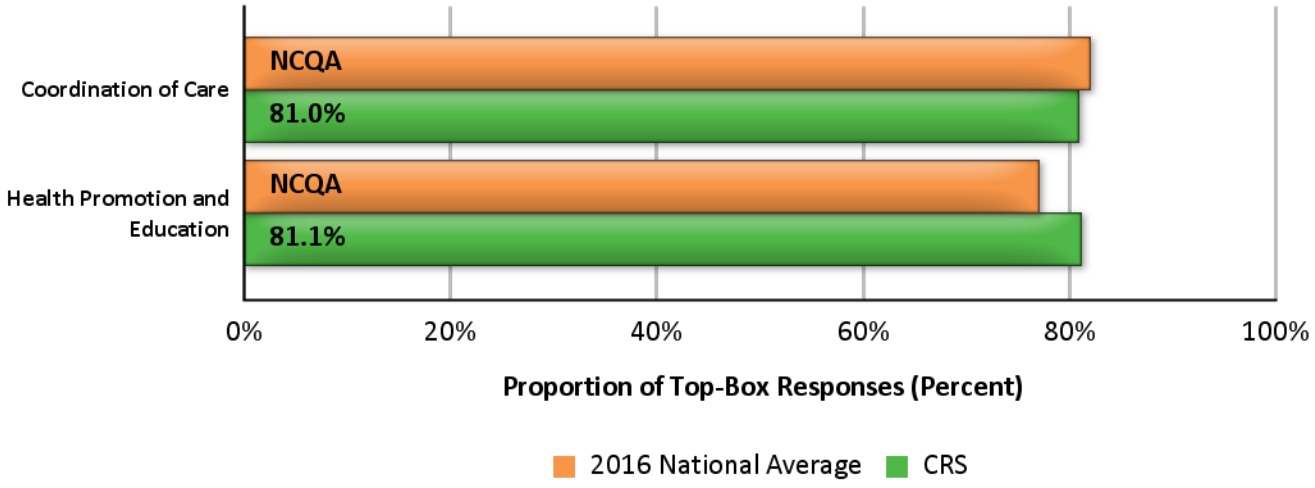
Figure 4-4—Composite Measures: Proportion of Responses



Individual Item Measures

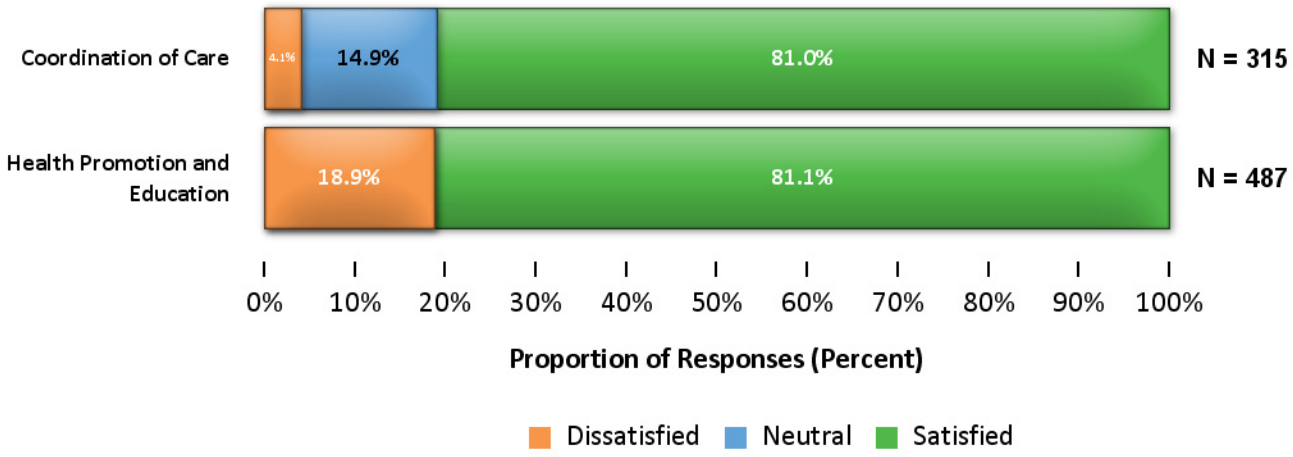
Figure 4-5 depicts the top-box question summary rates for the CRS Program and the 2016 NCQA National CCC Medicaid average using responses of "Usually" or "Always" for top-box scoring of Coordination of Care, and responses of "Yes" for top-box scoring of Health Promotion and Education.

Figure 4-5—Individual Item Measures: Question Summary Rates



For Coordination of Care, responses were classified into one of three response categories: "Never (Dissatisfied)," "Sometimes (Neutral)," and "Usually/Always (Satisfied)." For Health Promotion and Education, responses were classified into one of two response categories: "No (Dissatisfied)" or "Yes (Satisfied)." Figure 4-6 depicts the proportion of respondents who fell into each response category for each individual item measure for the CRS Program.

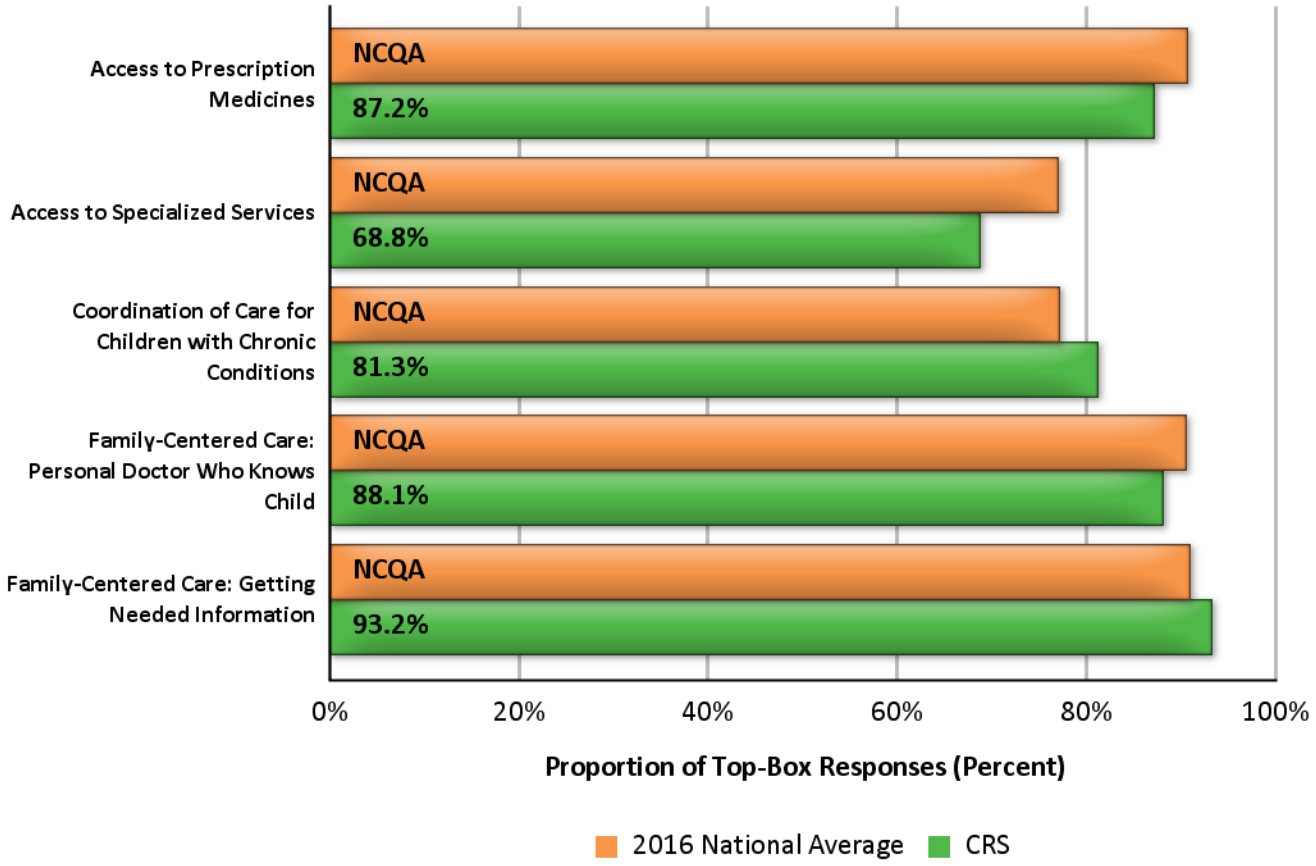
Figure 4-6—Individual Item Measures: Proportion of Responses



Children with Chronic Conditions (CCC) Composites and Items

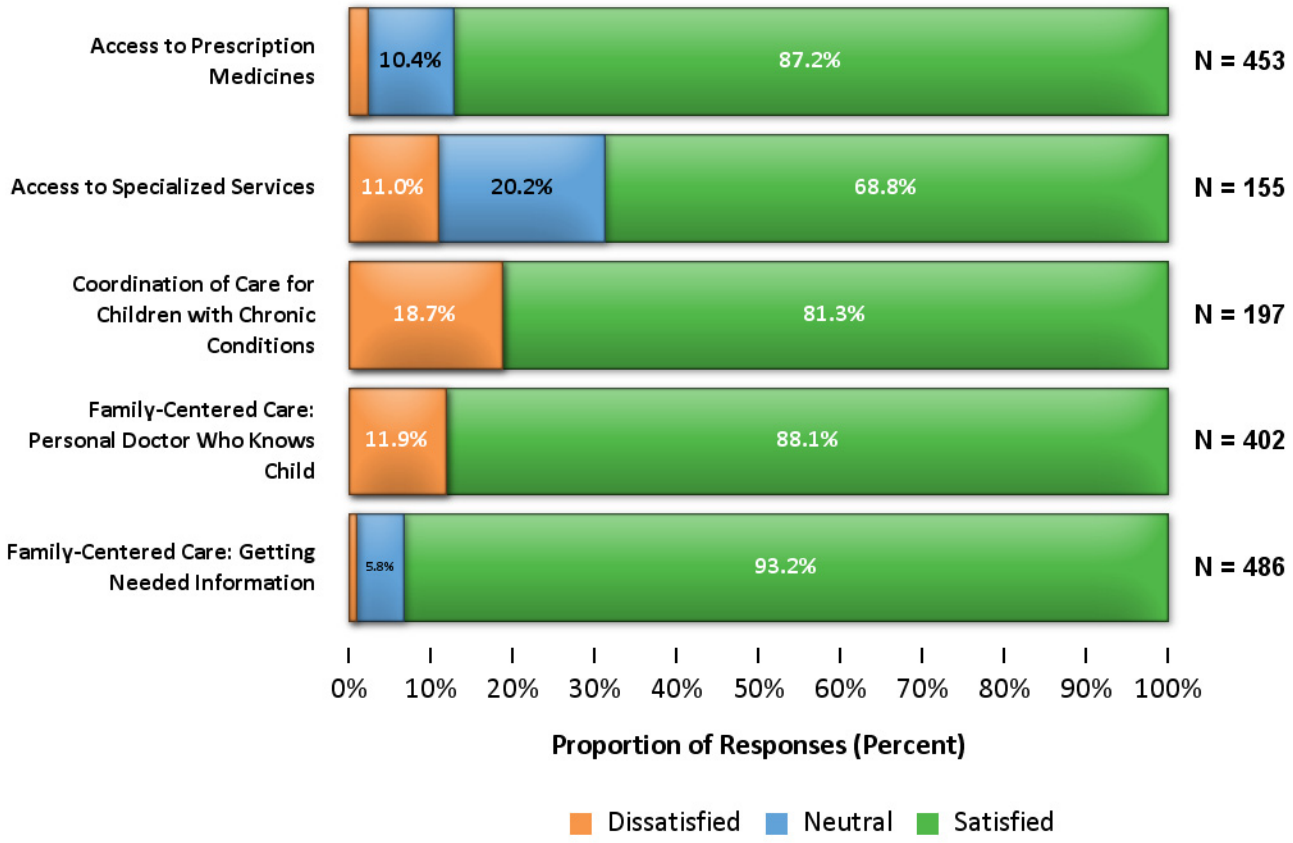
Figure 4-7 depicts the top-box question summary rates for the CRS Program and the 2016 NCQA National CCC Medicaid average using responses of "Usually" or "Always" for top-box scoring of Access to Specialized Services, Access to Prescription Medicines, and Family-Centered Care (FCC): Getting Needed Information, and responses of "Yes" for top-box scoring of FCC: Personal Doctor Who Knows Child and Coordination of Care for Children with Chronic Conditions.

Figure 4-7—CCC Composites and Items: Global Proportions/Question Summary Rates



For Access to Specialized Services, Access to Prescription Medicines, and FCC: Getting Needed Information, responses were classified into one of three response categories as follows: "Never (Dissatisfied)," "Sometimes (Neutral)," and "Usually/Always (Satisfied)." For FCC: Personal Doctor Who Knows Child and Coordination of Care for Children with Chronic Conditions, responses were classified into one of two response categories: "No (Dissatisfied)" and "Yes (Satisfied)." Figure 4-8 depicts the proportion of respondents who fell into each response category for each individual item measure for the CRS Program.

Figure 4-8—CCC Composites and Items: Proportion of Responses



Summary of Children with Chronic Conditions (CCC) Rates and Proportions

Evaluation of the CRS Program's rates and proportions for the CCC population revealed the following summary results.

- The CRS Program scored at or above the national average on five measures: Rating of All Health Care, Rating of Specialist Seen Most Often, Health Promotion and Education, Coordination of Care for Children with Chronic Conditions, and FCC: Getting Needed Information.
- The CRS Program scored below the national average on 11 measures: Rating of Health Plan, Rating of Personal Doctor, Customer Service, Getting Care Quickly, Getting Needed Care, How Well Doctors Communicate, Shared Decision Making, Coordination of Care, Access to Prescription Medicines, Access to Specialized Services, and FCC: Personal Doctor Who Knows Child.

5. Recommendations

This section presents Child Medicaid CAHPS recommendations for the CRS Program for each CAHPS measure. 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 5-7.

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.[5-1,5-2]

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

Table 5-1—Derivation of Priority Assignments on Each CAHPS Measure

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

[5-1] NCQA does not publish Benchmarks and Thresholds for Accreditation for the children with chronic conditions population; therefore, the NCQA Comparisons analysis was limited to the general child population (i.e., NCQA comparisons could not be performed for the population of children with chronic conditions).

[5-2] 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 5-2 shows the priority assignments for the CRS Program.

Table 5-2—Priority Assignments

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

Recommendations for Quality Improvement

HSAG presented QI recommendations for top priority assignments only.

Composite Measure

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, and studying member and staff experiences. 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 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 interactions with parents/caretakers of child members 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 publicly posting thank-you letters from parents/caretakers of child members, 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 Member and Staff Experiences

When parents/caretakers of child 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 parent or caretaker. Although this can be accomplished in a number of ways, reviewing 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 parents/caretakers of child members 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 towards 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 parent/caretaker of the child member might have is by performing a walkthrough. This gives staff members the ability to do everything the parents/caretakers and families are asked to do. Similarly, with their permission, a staff member can accompany a parent/caretaker and their child member through their visit. Notes taken from these experiences can be shared with leadership to help develop improvement plans.

Individual Item Measure

Coordination of Care

In order to improve members' satisfaction under the Coordination of Care measure, QI activities should focus on evaluating child member'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 Child Member's Goals

When providers share an understanding of a child member's goals, they are able to communicate and coordinate care in a way that directly impacts the outcomes and experience of the child receiving it. Coordinating goal-based care is established by creating a plan that places the child member at the center and seamlessly works with the entire care team who supports the child, including parents/caregivers and medical providers. During goal planning discussions, the parents/caretakers of child members should be provided a judgment-free, respectful, and supportive environment that acknowledges them as an expert in their child's 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 child member'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 child member should receive.

Data Sharing

Interoperable health information technology and electronic medical record systems are one key to successful Contractors. Pediatricians and 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 child members' health and utilization information into summary reports that track child members' interventions and outstanding needs. Contractors should pursue joint activities that facility 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 program level, the accountability for the performance lies at both the program and provider network level. Table 5-3 provides a summary of the responsible parties for various aspects of care.[5-3]

Table 5-3—Accountability for Areas of Care

Domain	General Child Composites	Individual Item Measures	CCC Composites and Items	Who Is Accountable?	
				Contractor	Provider Network
Access	Getting Needed Care		Access to Specialized Services	✓	✓
	Getting Care Quickly		Access to Prescription Medicines	✓	✓
Interpersonal Care	How Well Doctors Communicate	Coordination of Care	Coordination of Care for Children with Chronic Conditions		✓
	Shared Decision Making				✓
Plan Administrative Services	Customer Service	Health Promotion and Education	FCC: Getting Needed Information	✓	✓
Personal Doctor			FCC: Personal Doctor Who Knows Child	✓	✓
Specialist					✓
All Health Care				✓	✓
Health Plan				✓	

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

[5-3] Edgman-Levitan S, Shaller D, McInnes K, et al. *The CAHPS® Improvement Guide: Practical Strategies for Improving the Patient Care Experience.* Department of Health Care Policy Harvard Medical School, October 2003.

Those measures identified for the CRS Program 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 member 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.
- 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.

AHRQ Health Care Innovations Exchange Web site. *Expanding Interpreter Role to Include Advocacy and Care Coordination Improves Efficiency and Leads to High Patient and Provider Satisfaction*. Available at: https://innovations.ahrq.gov/profiles/expanding-interpreter-role-include-advocacy-and-care-coordination-improves-efficiency-and. Accessed on: June 27, 2017.

AHRQ Health Care Innovations Exchange Web site. *Interactive Workshops Enhance Access to Health Education and Screenings, Improve Outcomes for Low-Income and Minority Women*. Available at: https://innovations.ahrq.gov/profiles/interactive-workshops-enhance-access-health-education-and-screenings-improve-outcomes-low. Accessed on: June 27, 2017.

AHRQ Health Care Innovations Exchange Web site. *Online Tools and Services Activate Plan Enrollees and Engage Them in Their Care, Enhance Efficiency, and Improve Satisfaction and Retention*. Available at: https://innovations.ahrq.gov/profiles/online-tools-and-services-activate-plan-enrollees-and-engage-them-their-care-enhance. Accessed on: June 27, 2017.

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AHRQ Health Care Innovations Exchange Web site. *Program to Engage Employees in Quality Improvements Increases Patient and Employee Satisfaction and Reduces Staff Turnover.* Available at: https://innovations.ahrq.gov/profiles/program-engage-employees-quality-improvements-increases-patient-and-employee-satisfaction. Accessed on: June 27, 2017.

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6. Reader's Guide

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

Survey Administration

Survey Overview

The survey instrument selected was the CAHPS 5.0 Child Medicaid Health Plan Survey with the HEDIS supplemental item set and CCC measurement set. The CAHPS 5.0H Health Plan Surveys are a set of standardized surveys that assess patient perspectives on care. Originally, CAHPS was a five-year collaborative project sponsored by AHRQ. The CAHPS questionnaires and consumer reports were developed under cooperative agreements among AHRQ, Harvard Medical School, RAND, and the Research Triangle Institute (RTI). In 1997, NCQA, in conjunction with AHRQ, created the CAHPS 2.0H Survey measure as part of NCQA's HEDIS.[6-1] In 2002, AHRQ convened the CAHPS Instrument Panel to re-evaluate and update the CAHPS Health Plan Surveys and to improve the state-of-the-art methods for assessing clients' experiences with care.[6-2] The result of this re-evaluation and update process was the development of the CAHPS 3.0H Health Plan Surveys. The goal of the CAHPS 3.0H Health Plan Surveys was to effectively and efficiently obtain information from the person receiving care. In 2006, AHRQ released the CAHPS 4.0 Health Plan Surveys. Based on the CAHPS 4.0 versions, NCQA introduced new HEDIS versions of the Adult Health Plan Survey in 2007 and the Child Health Plan Survey in 2009, which are referred to as the CAHPS 4.0H Health Plan Surveys.[6-3,6-4] In 2012, AHRQ released the CAHPS 5.0 Health Plan Surveys. Based on the CAHPS 5.0 versions, NCQA introduced new HEDIS versions of the Adult and Child Health Plan Surveys in August 2012, which are referred to as the CAHPS 5.0H Health Plan Surveys.[6-5]

The 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

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

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

The CAHPS 5.0 Child Medicaid Health Plan Survey with the HEDIS supplemental item set and Children with Chronic Conditions (CCC) measurement set includes 83 core questions that yield 16 measures of satisfaction. These measures include four global rating questions, five composite measures, two individual item measures, and five CCC composite measures/items. The global measures (also referred to as global ratings) reflect overall satisfaction with the 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"). The CCC composite measures/items are a set of questions focused on specific health care needs and domains (e.g., "Access to Prescription Medicines" or "Coordination of Care for Children with Chronic Conditions").

Table 6-1 lists the global ratings, composite measures, individual item measures, and CCC composites/items included in the CAHPS 5.0 Child Medicaid Health Plan Survey with the HEDIS supplemental item set and CCC measurement set.

Table 6-1—CAHPS Measures

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

Sampling Procedures

The members eligible for sampling included those who were CRS Program members at the time the sample was drawn and who were continuously enrolled for at least five of the last six months of the measurement period (October 2015 through March 2016). The members eligible for sampling included those who were 21 years of age or younger (as of March 31, 2016).[6-6]

The standard NCQA specifications for survey measures require a sample size of 1,650 for the general population and 1,840 for the Children with Chronic Conditions (CCC) supplemental population (for a total 3,490 child members) for the CAHPS Child Medicaid Health Plan Survey with CCC measurement set. For the CRS Program, a sample of 1,650 child members was selected for the CAHPS 5.0 general child sample, which represents the general population of children. After selecting child members for the CAHPS 5.0 general child sample, a sample of up to 1,840 child members with a prescreen code of 2, which represents the population of children who are more likely to have a chronic condition (i.e., CCC supplemental sample) was selected. For the CRS Program, a total of 3,490 child members (i.e., 1,650 general child and 1,840 CCC members) was selected.

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 CRS 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.[6-7]

[6-6] For purposes of this report, the age criteria for child members eligible for inclusion in the CAHPS Child Medicaid Health Plan Survey was modified to include members up to 21 years of age or younger as of March 31, 2016. Please note, this deviates from standard NCQA HEDIS specifications, which define eligible child members as 18 years of age or younger as of December 31 of the measurement year.

[6-7] Fowler FJ Jr., Gallagher PM, Stringfellow VL, et al. "Using Telephone Interviews to Reduce Nonresponse Bias to Mail Surveys of Health Plan Members." *Medical Care*. 2002; 40(3): 190-200.

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

- Were 21 years of age or younger as of March 31, 2016.
- Were currently enrolled in the CRS Program.
- Had been continuously enrolled for at least five of the six months from October 1, 2015 to March 31, 2016.
- Had Medicaid as a payer.

HSAG inspected a sample of the file records to check for any apparent problems with the files, such as missing address elements. After the sample was selected, the records 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 program 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 6-2 shows the CAHPS timeline used in the administration of the CRS Program's CAHPS 5.0 Child Medicaid Health Plan Surveys. The timeline is based on NCQA HEDIS Specifications for Survey Measures.[6-8]

Table 6-2—CAHPS 5.0 Survey Timeline

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

[6-8] 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 the CRS Program. This section provides an overview of each analysis.

Response Rates

The administration of the CAHPS Child Medicaid Health Plan Survey is comprehensive and is designed to achieve the highest possible response rate. NCQA defines the response rate as the total number of completed surveys divided by all eligible members of the sample.[6-9] A survey is assigned a disposition code of "completed" if at least three of the following five questions were answered: questions 3, 30, 45, 49, and 54. 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 6-4), or had a language barrier.

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

Child and Respondent Demographics

The demographic analysis evaluated child and self-reported demographic information from survey respondents. 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 population differs significantly from the actual population of the program, then caution must be exercised when extrapolating the CAHPS results to the entire population.

[6-9] National Committee for Quality Assurance. *HEDIS® 2017*, *Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA Publication, 2016.

NCQA Comparisons

An analysis of the CRS Program's CAHPS 5.0 Child Medicaid Health Plan Survey results was conducted using NCQA HEDIS Specifications for Survey Measures.[6-10] Per these specifications, no case-mix adjustment is performed on the results. NCQA also requires a minimum of 100 responses on each item in order to obtain a reportable CAHPS Survey result.

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.[6-11] 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

[6-10] National Committee for Quality Assurance. *HEDIS® 2017*, *Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA Publication, 2016.

[6-11] As previously noted, NCQA's benchmarks and thresholds for the child Medicaid population were used to derive the overall member satisfaction ratings; therefore, caution should be exercised when interpreting these results.

Table 6-3 shows the benchmarks and thresholds used to derive the overall member satisfaction ratings on each CAHPS measure.[6-12]

Table 6-3—Overall Child Medicaid Member Satisfaction Ratings Crosswalk

Measure	90th Percentile	75th Percentile	50th Percentile	25th Percentile
Rating of Health Plan	2.67	2.62	2.57	2.51
Rating of All Health Care	2.59	2.57	2.52	2.49
Rating of Personal Doctor	2.69	2.65	2.62	2.58
Rating of Specialist Seen Most Often	2.66	2.62	2.59	2.53
Getting Needed Care	2.56	2.51	2.46	2.37
Getting Care Quickly	2.69	2.66	2.61	2.54
How Well Doctors Communicate	2.75	2.72	2.68	2.63
Customer Service	2.63	2.58	2.53	2.50
Coordination of Care	2.52	2.48	2.42	2.36

Rates and Proportions

Rates and proportions were presented that compared member satisfaction performance between the CRS Program and the 2016 NCQA National Child Medicaid average for the general child population or the 2016 NCQA National Children with Chronic Conditions (CCC) Medicaid average for the CCC population. For purposes of this analysis, question summary rates were calculated for each global rating and individual item measure, and global proportions were calculated for each composite measure. Both the question summary rates and global proportions were calculated in accordance with NCQA HEDIS Specifications for Survey Measures.[6-13] The scoring of the global ratings, composite measures, individual item measures, and CCC composites and items involved assigning top-level responses a score of one, with all other responses receiving a score of zero. After applying this scoring methodology, the percentage of top-level responses was calculated in order to determine the question summary rates and global proportions. For additional detail, please refer to the *NCQA HEDIS 2017 Specifications for Survey Measures, Volume 3*.

[6-12] National Committee for Quality Assurance. *HEDIS Benchmarks and Thresholds for Accreditation 2017.* Washington, DC: NCQA, May 4, 2017.

[6-13] National Committee for Quality Assurance. *HEDIS® 2017, Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA Publication, 2016.

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 respondent 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.[6-14]

Non-Response Bias

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

Causal Inferences

Although this report examines whether members report differences in satisfaction with various aspects of their health care experiences, these differences may not be completely attributable to the CRS Program. The survey by itself does not necessarily reveal the exact cause of these differences. As such, caution should be exercised when interpreting these results.

Baseline Results

The 2016 CAHPS results presented in the report represent a **baseline** assessment of parents'/caretakers' satisfaction with the CRS Program; therefore, caution should be exercised when interpreting results.

[6-14] 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.

7. Survey Instrument

The survey instrument selected for the 2016 CRS Program Child Medicaid Member Satisfaction Survey was the CAHPS 5.0 Child Medicaid Health Plan Survey with HEDIS supplemental item set and Children with Chronic Conditions (CCC) measurement set. This section provides a copy of the survey instrument.

AHCCCS
Arizona Health Care Cost Containment System

DataStat

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

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

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

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

Please answer the questions for the child listed on the envelope. Please do not answer for any other children.

1. **Our records show that your child is now in [HEALTH PLAN NAME/STATE MEDICAID PROGRAM NAME]. Is that right?**

   ○ Yes ➔ ***Go to Question 3***
   ○ No

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

   _____

YOUR CHILD'S HEALTH CARE IN THE LAST 6 MONTHS

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

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

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

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

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

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

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

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

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

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

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

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

- ○ Yes
- ○ No

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

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

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

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

11. Did you and a doctor or other health provider talk about the reasons you might want your child to take a medicine?

- ○ Yes
- ○ No

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

- ○ Yes
- ○ No

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

- ○ Yes
- ○ No

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

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

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

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

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

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

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

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

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

- ○ Yes
- ○ No

SPECIALIZED SERVICES

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

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

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

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

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

- ○ Yes
- ○ No

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

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

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

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

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

- ○ Yes
- ○ No

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

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

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

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

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

- ○ Yes
- ○ No

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

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

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

- ○ Yes
- ○ No

29a. How satisfied are you with the help you got to coordinate your child's care in the last 6 months?

- ○ Very dissatisfied
- ○ Dissatisfied
- ○ Neither dissatisfied nor satisfied
- ○ Satisfied
- ○ Very satisfied

YOUR CHILD'S PERSONAL DOCTOR

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- ○ Yes
- ○ No

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

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

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

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

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

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

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

- ○ Yes
- ○ No

41b. In the last 6 months, did your child's doctor or other health provider ask you if there are things that make it hard for you to take care of your child's health?

- ○ Yes
- ○ No

41c. In the last 6 months, did a doctor or other health provider talk with you about specific goals for your child's health?

- ○ Yes
- ○ No

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

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

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

- ○ Yes
- ○ No

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

- ○ Yes
- ○ No

GETTING HEALTH CARE FROM SPECIALISTS

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

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

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

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

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

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

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

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

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

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

YOUR CHILD'S HEALTH PLAN

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

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

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

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

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

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

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

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

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

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

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

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

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

PRESCRIPTION MEDICINES

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

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

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

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

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

- ○ Yes
- ○ No

ABOUT YOUR CHILD AND YOU

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

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

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

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

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

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

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

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

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

- ○ Yes
- ○ No

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

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

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

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

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

- ○ Yes
- ○ No

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

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

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

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

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

- ○ Yes
- ○ No

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

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

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

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

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

- ○ Yes
- ○ No

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

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

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

- ○ Yes
- ○ No

74. What is your child's age?

- ○ Less than 1 year old

☐☐ YEARS OLD (write in)

75. Is your child male or female?

- ○ Male
- ○ Female

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

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

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

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

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

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

79. Are you male or female?

- ○ Male
- ○ Female

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

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

81. How are you related to the child?

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

82. Did someone help you complete this survey?

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

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

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

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