2016 CAHPS Medicaid Managed Care Survey Summary Report

Managed Care Quality and Monitoring Division
California Department of Health Care Services

January 2018

2016 Medicaid Managed Care CAHPS Survey
Summary Report
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Commonly Used Abbreviations and Acronyms

Following is a list of abbreviations and acronyms used throughout this report.

- **AHRQ**—Agency for Healthcare Research and Quality.
- **CAHPS®**—Consumer Assessment of Healthcare Providers and Systems.[i]
- **CATI**—Computer Assisted Telephone Interviewing.
- **CFR**—Code of Federal Regulations.
- **CMS**—Centers for Medicare & Medicaid Services.
- **COHS**—County Organized Health System.
- **CP**—commercial plan.
- **DHCS**—California Department of Health Care Services.
- **EQR—**external quality review.
- **EQRO**—external quality review organization.
- **FFS**—fee-for-service.
- **GMC**—Geographic Managed Care.
- **HEDIS®**—Healthcare Effectiveness Data and Information Set.[ii]
- **HSAG**—Health Services Advisory Group, Inc.
- **IOM**—Institute of Medicine.
- **LI**—Local Initiative.
- **MCMC**—Medi-Cal Managed Care.
- **MCP**—Medi-Cal managed care health plan.
- **NCOA**—National Change of Address.
- **NCQA**—National Committee for Quality Assurance.
- **Non-SPD**—Non-Seniors and Persons with Disabilities.
- **QI**—quality improvement.
- **SCAN**—Senior Care Action Network.
- **SPD**—Seniors and Persons with Disabilities.
- **TPM**—Two-Plan Model.

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

1. Executive Summary

The Centers for Medicare & Medicaid Services (CMS) requires that states, through their contracts with managed care plans, measure and report on performance to assess the quality and appropriateness of care and services provided to beneficiaries. The California Department of Health Care Services (DHCS) periodically assesses the perceptions and experiences of Medi-Cal Managed Care (MCMC) beneficiaries as part of its process for evaluating the quality of health care services provided by Medi-Cal managed care health plans (MCPs) to MCMC beneficiaries.

DHCS contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to administer and report the results of the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey.[1-1] The administration of the CAHPS Survey is an optional Medicaid external quality review (EQR) activity to assess managed care beneficiaries' satisfaction with their health care services. The goal of the CAHPS Health Plan Survey is to provide performance feedback that is actionable and will aid in improving overall beneficiary satisfaction. DHCS required that CAHPS Surveys are administered to both adult beneficiaries and parents or caretakers of child beneficiaries.

This report presents the 2016 CAHPS results from adult beneficiaries and parents or caretakers of child beneficiaries enrolled in an MCP who completed surveys from February to May 2016, which represent beneficiaries' experiences with care and services over the prior six months. The standardized survey instruments selected were the CAHPS 5.0H Adult and Child Medicaid Health Plan Surveys with the Healthcare Effectiveness Data and Information Set (HEDIS®) supplemental item set.[1-2] Table 1-1, on the following page, provides a list of MCPs that participated in the survey. DHCS contracted with 22 MCPs to provide health care services in all 58 counties throughout California.[1-3]

[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).
[1-3] HSAG refers to Kaiser NorCal and Kaiser SoCal as two separate MCPs in this report; however, DHCS only holds one contract with Kaiser (KP Cal, LLC).

Table 1-1—Participating MCPs

MCP Names	
Alameda Alliance for Health (AAH)	Health Plan of San Joaquin (HPSJ)
Anthem Blue Cross Partnership Plan (Anthem)	Health Plan of San Mateo (HPSM)
California Health & Wellness Plan (CHW)	Inland Empire Health Plan (IEHP)
CalOptima	KP Cal, LLC Kaiser NorCal (Kaiser NorCal)
CalViva Health (CalViva)	KP Cal, LLC Kaiser SoCal (Kaiser SoCal)
Care1st Partner Plan (Care1st)	Kern Family Health Care (KFHC)
CenCal Health (CenCal)	L.A. Care Health Plan (L.A. Care)
Central California Alliance for Health (CCAH)	Molina Healthcare of California Partner Plan, Inc. (Molina)
Community Health Group Partnership Plan (CHG)	Partnership HealthPlan of California (Partnership)
Contra Costa Health Plan (CCHP)	San Francisco Health Plan (SFHP)
Gold Coast Health Plan (Gold Coast)	Santa Clara Family Health Plan (SCFHP)
Health Net Community Solutions, Inc. (Health Net)	

Performance Highlights

Sample sizes for the 2016 CAHPS Survey were established with the following goals:

1. Obtain 411 completed surveys at the MCP level.
2. Obtain 100 completed surveys at the reporting-unit level.

While the sample sizes were determined based on the goals, a number of measures at the reporting-unit level had fewer than 100 responses. According to NCQA HEDIS Specifications for Survey Measures, if a measure has fewer than 100 responses, the measure is not reportable; therefore, caution should be taken when interpreting the results.[1-4] NCQA HEDIS Specifications for Survey Measures recommends targeting 411 completed surveys to meet the following statistical parameters: 1) confidence intervals with a margin of error under 5 percent at the 95 percent confidence level, and 2) statistical power of at least 80 percent in detecting differences of 10 percentage points.[1-5] Based on the sample sizes, it would be expected that a number of reporting units would not have reached 411 completed surveys; therefore, caution should be taken when interpreting the results.

For purposes of National Comparisons, HSAG compared the 2016 CAHPS results to NCQA's 2016 HEDIS Benchmarks and Thresholds for Accreditation, to determine star ratings for each CAHPS

[1-4] National Committee for Quality Assurance. *HEDIS® 2016, Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA Publication, 2015.
[1-5] Ibid.

measure, where applicable.[1-6,1-7,1-8] HSAG also conducted State Comparisons analyses to facilitate comparisons of the MCPs' performance, provide model type comparisons, and comparisons of the Seniors and Persons with Disabilities (SPD) and non-SPD populations. For the model type and subpopulation analyses, since population weights were not included, the rates may not be representative of the plan types and subpopulations (i.e., County Organized Health System [COHS] model, Geographic Managed Care [GMC] model, Imperial model, Regional model, San Benito model, Two-Plan Model [TPM], SPD population, and non-SPD population). Caution should be taken when interpreting these results. HSAG conducted the National Comparisons and State Comparisons analyses separately for the adult and child Medicaid populations.

Overall, the gaps between the national 25th and 90th percentiles were on average 7.4 percentage points for the adult population and 7.5 percentage points for the child population, indicating that the distributions of national performance were close together. The differences between the MCMC weighted averages and the National Medicaid averages ranged from 1.3 percentage points to 8.3 percentage points, with an average of 4.8 percentage points for the adult population and from -1.1 to 8.6 percentage points, with an average of 4.7 percentage points for the child population. Differences in rates should be evaluated from a clinical perspective. While the MCMC weighted average results may be higher or lower than the national average, differences in rates may not be important from a clinical point of view.

For the star ratings analysis, HSAG found that results from the MCP reporting units showed generally *Poor* or *Fair* performance across the global ratings and composite measures for both the adult and child populations when compared to national Medicaid percentiles. The **Rating of Personal Doctor** and **Rating of Specialist Seen Most Often** global ratings for the child Medicaid survey were the exception and showed *Very Good* performance when compared to national data. Additionally, the **How Well Doctors Communicate** and **Rating of Specialist Seen Most Often** global ratings for the adult Medicaid survey showed *Good* performance when compared to national data.

Kaiser NorCal - KP North was the only MCP to demonstrate significantly higher performance than the MCMC average for six of the nine CAHPS measures, for both adult and child populations. In addition, when compared to national data, Kaiser NorCal's adult and child populations showed *Excellent* or *Very Good* star rating performance for six measures. Kaiser SoCal - San Diego County received significantly higher scores than the MCMC average for four of the nine measures.

Molina - Sacramento County showed the greatest opportunity for improvement, demonstrating significantly lower performance than the MCMC average for two measures for the adult population and four measures for the child population.

In assessing the MCPs' strengths and weaknesses across the CAHPS global ratings and composite measures, **Getting Care Quickly** and **Getting Needed Care** had the highest number of MCP reporting

[1-6] National Committee for Quality Assurance. *HEDIS Benchmarks and Thresholds for Accreditation 2016.* Washington, DC: NCQA, January 21, 2016.

[1-7] NCQA does not publish benchmarks and thresholds for the Shared Decision Making composite measure; therefore, overall member satisfaction ratings could not be derived for this CAHPS measure.

[1-8] Refer to the Reader's Guide section for information regarding the assignment of star ratings and methodology used for this analysis.

units that demonstrated *Poor* star rating performance for the adult and child populations. Forty-eight out of 53 MCP reporting units demonstrated *Poor* performance for **Getting Care Quickly**, and 47 MCPs demonstrated *Poor* performance for **Getting Needed Care** for the adult population**.** Forty-eight MCP reporting units demonstrated *Poor* performance for **Getting Care Quickly**, and 42 MCP reporting units demonstrated *Poor* performance for **Getting Needed Care** for the child population. These measures have the greatest opportunity for improvement.

When comparing the model types' CAHPS results to national data for the adult population, the Imperial model outperformed the other model types for two out of eight measures. Additionally, the COHS model, GMC model, and San Benito model outperformed the other model type for one out of eight measures for the adult population. For the State Comparisons analysis, the GMC model type scored significantly higher than the MCMC average for five measures. The COHS model type scored significantly higher than the MCMC average for one measure. The Regional model type scored significantly lower than the MCMC average for two out of nine measures. In addition, the TPM scored significantly lower than the MCMC average for one measure.

When comparing the model types' CAHPS results to national data for the child population, the GMC model type MCPs outperformed the other model types on three of the eight measures. For the State Comparisons analysis, the GMC model type scored significantly higher than the MCMC average for three out of nine measures. The COHS model type scored significantly higher than the MCMC average for two out of nine measures. In addition, the TPM scored significantly higher than the MCMC average for one measure. The Regional and San Benito model types scored significantly lower than the MCMC average for one measure.

When comparing the SPD and non-SPD populations' CAHPS results to national data, the SPD population outperformed the non-SPD population for all eight measures for the adult population. For the child population, the SPD population outperformed the non-SPD population for seven of the eight measures; however, star rating performance did not differ between the populations on four out of eight measures. For the State Comparisons analysis, the adult SPD population scored significantly higher than the non-SPD population for two out of nine measures. For the child population, there were no statistically, significant differences between the SPD and non-SPD populations' rates.

DHCS demonstrates a commitment to monitor and improve beneficiaries' satisfaction through the administration of the CAHPS Survey. The CAHPS Survey plays an important role as a quality improvement (QI) tool for MCPs. The standardized data and results can be used to identify relative strengths and weaknesses in performance, identify areas for improvement, and trend progress over time.

Based on 2016 CAHPS performance, MCPs have opportunities to improve beneficiaries' satisfaction with care and services. Most measures received *Poor* or *Fair* star ratings when compared to national Medicaid data.

MCPs have the greatest opportunities for improvement on the **Getting Care Quickly** and **Getting Needed Care** measures. Low performance in these areas may point to issues with access to and timeliness of care.

General Recommendations

Based on the 2016 CAHPS results, HSAG provides the following global recommendations for improvement:

- DHCS should consider conducting a barrier analysis or focus groups to identify appropriate interventions to implement.
- DHCS should consider selecting a beneficiary satisfaction measure(s) as a formal QI project as a strategy for improving results.

MCPs that demonstrated above average performance should share initiatives and strategies that have been successful in meeting and exceeding beneficiaries' expectations.

2. Introduction

Sampling Procedures

Beneficiaries eligible for sampling included those who were MCP beneficiaries at the time the sample was drawn and who were continuously enrolled in the MCP for at least five of the last six months (July through December) of 2015 with no more than a 45-day gap in enrollment. Adult beneficiaries eligible for sampling included those who were 18 years of age or older (as of December 31, 2015). Child beneficiaries eligible for sampling included those who were 17 years of age or younger (as of December 31, 2015).

For the adult and child Medicaid managed care populations, HSAG selected a systematic sample of Medicaid beneficiaries from each of the MCPs at the parent-unit level for surveying. A minimum of 1,350 adult Medicaid beneficiaries and 1,650 child Medicaid beneficiaries were selected from each of the participating MCPs at the MCP parent-unit level (i.e., plan-level). Additionally, HSAG conducted a targeted oversample of the adult and child Medicaid populations, where appropriate, to accommodate reporting-unit level (i.e., county/region-level) reporting. Based on this sampling approach, for the 2016 CAHPS survey administration, HSAG administered the CAHPS Surveys to 40,676 adult beneficiaries and 42,780 parents or caretakers of child beneficiaries.

Survey Administration

HSAG designed the survey administration protocol to achieve a high response rate from beneficiaries, thus minimizing the potential effects of non-response bias. The survey process allowed beneficiaries two methods by which they could complete the surveys. The first, or mail phase, consisted of a survey being mailed to the sampled beneficiaries. Beneficiaries who were identified as Spanish-speaking through administrative data were mailed a Spanish version of the survey. Beneficiaries who 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 beneficiaries that they could call the toll-free number to request a Spanish version of the CAHPS questionnaire. The cover letter provided with the Spanish version of the CAHPS questionnaire had an English cover letter on the back side informing beneficiaries that they could call the toll-free number to request an English version of the CAHPS questionnaire. All non-respondents received a reminder postcard, followed by a second survey mailing and reminder postcard. The second phase, or telephone phase, consisted of conducting Computer Assisted Telephone Interviewing (CATI) of sampled beneficiaries who had not mailed in a

completed survey. A series of at least three CATI calls was made to each non-respondent.[2-1] Additional information on the survey protocol is included in the Reader's Guide section beginning on page 4-1.

CAHPS Results

CAHPS satisfaction measures are derived from individual questions that ask for a general rating, as well as groups of questions that form composite measures. Results presented in this report include four global ratings: Rating of Health Plan, Rating of All Health Care, Rating of Personal Doctor, and Rating of Specialist Seen Most Often. Five composite measures are also reported: Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, Customer Service, and Shared Decision Making.

HSAG presented MCP reporting unit-level and aggregate MCMC results and compared them to available national adult and child Medicaid data; displayed MCP reporting-unit level results to facilitate comparisons; provided comparisons among MCMC COHS model, GMC model, Imperial model, Regional model, San Benito model, and TPM; and provided comparisons amongst the SPD and non-SPD populations.

[2-1] National Committee for Quality Assurance. *Quality Assurance Plan for HEDIS 2016 Survey Measures*. Washington, DC: NCQA Publication, 2015.

3. Background

Medi-Cal Managed Care Overview

DHCS administers Medi-Cal, California's Medicaid program through its fee-for-service (FFS) and managed care delivery systems. MCMC serves about 80 percent of the Medi-Cal population, with 20 percent enrolled in FFS Medi-Cal.[3-1] During the review period, DHCS contracted with 22 full-scope MCPs and three specialty health plans (SHPs).[3-2] As of March 2016, MCMC provided services to an estimated 10.3 million beneficiaries statewide.[3-3]

Medi-Cal Managed Care Delivery System

DHCS administers MCMC through a service delivery system that encompasses six different MCP model types: COHS, GMC, TPM, Regional, Imperial, and San Benito. DHCS monitors MCP performance across model types. Table 3-1 shows the participating MCPs by model type.

County-Organized Health System

A COHS is a nonprofit, independent public agency that contracts with DHCS to administer Medi-Cal benefits through a wide network of managed care providers. Each COHS MCP is sanctioned by the County Board of Supervisors and governed by an independent commission. DHCS has contracts with six COHS MCPs operating in 22 counties.

Geographic Managed Care

Under the GMC model, DHCS allows MCMC beneficiaries to select from several commercial plans (CPs) within a specified geographic area. DHCS has contracts with five GMC MCPs in San Diego County and four GMC MCPs in Sacramento County.

Two-Plan Model

Under TPM, beneficiaries may choose from two MCPs; typically, an MCP is a local initiative (LI) and the other a CP. DHCS contracts with both plans. The LI is established under authority of the local

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3-1 *Medi-Cal Managed Care Program Fact Sheet – Managed Care Models*, November 2014. Available at: http://www.dhcs.ca.gov/provgovpart/Documents/MMCDModelFactSheet.pdf. Accessed on: July 15, 2016.

3-2 HSAG refers to Kaiser NorCal and Kaiser SoCal as two separate MCPs in this report; however, DHCS only holds one contract with Kaiser (KP Cal, LLC).

3-3 *Medi-Cal Managed Care Enrollment Report*, March 2016. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Documents/MMCD_Enrollment_Reports/MMCEnrollRptMar2016.pdf. Accessed on: May 2, 2016.

government with input from State and federal agencies, local community groups, and health care providers to meet the needs and concerns of the community. The CP is a private insurance plan that also provides care for Medi-Cal beneficiaries. DHCS has contracts with 12 TPM MCPs in 14 counties.

Regional

The Regional model consists of three CPs that provide services to beneficiaries in the rural counties of the State, primarily in northern and eastern California. DHCS has contracts with three Regional MCPs in 18 counties.

Imperial

This model operates in Imperial County with two CPs. DHCS has contracts with two Imperial MCPs in Imperial County.

San Benito

This model operates in San Benito County and provides services to MCMC beneficiaries through a CP and FFS Medi-Cal. DHCS has contracts with one San Benito MCP in San Benito County.

Table 3-1 lists the MCPs, their respective model types, and the counties they serve.

Table 3-1—Medi-Cal Managed Care Health Plans by Model Type as of March 31, 2016

Model Type		MCP Name	Counties
Two-Plan	Commercial	Anthem	Alameda, Contra Costa, Fresno, Kings, Madera, San Francisco, Santa Clara
		Health Net	Kern, Los Angeles, San Joaquin, Stanislaus, Tulare
		Molina	Riverside, San Bernardino
	Local Initiative	Alameda	Alameda
		Anthem	Tulare
		CalViva	Fresno, Kings, Madera
		CCHP	Contra Costa
		HPSJ	San Joaquin, Stanislaus
		IEHP	Riverside, San Bernardino
		KFHC	Kern
		L.A. Care	Los Angeles
		SFHP	San Francisco
		SCFHP	Santa Clara

Model Type	MCP Name	Counties
Geographic Managed Care	Anthem	Sacramento
	Health Net	
	Kaiser NorCal*	
	Molina	
	Care1st	San Diego
	CHG	
	Health Net	
	Kaiser SoCal	
	Molina	
County-Organized Health System	CalOptima	Orange
	CenCal	San Luis Obispo, Santa Barbara
	CCAH	Merced, Monterey, Santa Cruz
	Gold Coast	Ventura
	HPSM	San Mateo
	Partnership	Del Norte, Humboldt, Lake, Lassen, Marin, Mendocino, Modoc, Napa, Shasta, Siskiyou, Solano, Sonoma, Trinity, Yolo
Imperial	Molina	Imperial
	CHW	
San Benito	Anthem	San Benito
Regional	Anthem	Butte, Colusa, Glenn, Plumas, Sierra, Sutter, Tehama (MCPs will report a single, multi-county rate for these counties, which are collectively referred to as Region 1.)
	CHW	
	Anthem	Alpine, Amador, Calaveras, El Dorado, Inyo, Mariposa, Mono, Nevada, Placer, Tuolumne, Yuba (MCPs will report a single, multi-county rate for these counties, which are collectively referred to as Region 2.)
	CHW	
	Kaiser NorCal*	Amador, El Dorado, Placer

* Kaiser NorCal provides Medi-Cal services in Sacramento County as a GMC model type and in Amador, El Dorado, and Placer counties as a Regional model type; however, the MCP reports performance measure rates for all counties combined. DHCS's decision to have Kaiser NorCal report the combined rates ensures that the MCP has a sufficient sample size to compute accurate performance measure rates that represent the availability and quality of care provided for the population in the region and assists Kaiser NorCal with maximizing operational and financial efficiencies by reducing the number of encounter data validation, improvement plans, PIPs, and Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey activities. HSAG categorized Kaiser NorCal as a GMC model type for purposes of the model type comparisons analysis in section 5.

DHCS also contracted with three SHPs—AIDS Healthcare Foundation, Family Mosaic Project, and SCAN Health Plan. DHCS requires that SHPs conduct their own consumer satisfaction surveys on an annual basis due to the unique services provided and membership size; therefore, SHPs were not included in the 2016 CAHPS Survey administration.

Seniors and Persons with Disabilities

The 1115 "Bridge to Reform" Waiver allowed the transition of the SPD population from FFS into Medi-Cal Managed Care. This transition allowed DHCS to achieve care coordination, better manage chronic conditions, and improve health outcomes for the SPD population. In June 2011, DHCS began to enroll the SPD population according to their birth months into MCPs in 16 counties. The transition of the SPD population was completed in May 2012 and approximately 240,000 beneficiaries were enrolled. In December 2014, DHCS began mandatory enrollment for SPD beneficiaries into MCPs in 19 counties.

How DHCS Uses Beneficiary Satisfaction Results

The overall goal of DHCS is to preserve and improve the health status of all Californians. MCMC provides services to a large population of low-income children, families, and adults, as well as an expanding population of SPD beneficiaries. Since MCMC serves some of California's most vulnerable populations, the need to evaluate and monitor the quality of and access to health care, including beneficiary satisfaction, has remained a key objective for DHCS in meeting its overarching goal.

One strategy established to evaluate and monitor the quality of health care is administration of the CAHPS Surveys. This strategy is consistent with the *Medi-Cal Managed Care Quality Strategy—November 2015* objective to establish formal systematic monitoring and evaluation of the quality of care and services provided to all enrolled MCMC beneficiaries including individuals with chronic conditions and special health care needs. DHCS used the results from the CAHPS surveys to inform quality improvement efforts.

DHCS shares MCP-specific and aggregate CAHPS results with MCPs and publically releases the *CAHPS Summary Report* so that MCMC beneficiaries and other stakeholders can use the information to make informed decisions. DHCS also incorporates CAHPS results into its consumer guides for new enrollees and uses the data as part of its annual performance assessment of MCPs and MCMC as a whole.

4. Reader's Guide

CAHPS Performance Measures

Table 4-1 lists the global ratings and composite measures included in the CAHPS 5.0H Adult Medicaid and Child Medicaid Health Plan Surveys.

Table 4-1—CAHPS Measures

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

How CAHPS Results Were Collected

Sampling Procedures

The beneficiaries eligible for sampling included those who were MCMC beneficiaries at the time HSAG drew the sample and who were continuously enrolled in the same MCP for at least five of the last six months (July through December) of 2015 with no more than a 45-day gap in enrollment. The adult beneficiaries eligible for sampling included those who were 18 years of age or older, and the child beneficiaries eligible for sampling included those who were 17 years of age or younger (as of December 31, 2015). DHCS provided HSAG with a CAHPS sample frame for each MCP from which HSAG selected the adult and child samples. Additionally, in order to accommodate county/region-level reporting, HSAG conducted a county- or region-level oversample, where appropriate.

HSAG selected a systematic sample of eligible beneficiaries for inclusion in the surveys. HSAG selected a systematic sample of at least 1,350 adult beneficiaries and at least 1,650 child beneficiaries from each participating MCP.

Survey Protocol

The survey administration process allowed for two methods by which beneficiaries could complete a survey. The first, or mail phase, consisted of sampled beneficiaries receiving a survey via mail. Beneficiaries who were identified as Spanish-speaking through administrative data were mailed a Spanish version of the survey. Beneficiaries who 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 beneficiaries that they could call the toll-free number to

request a Spanish version of the CAHPS questionnaire. The cover letter provided with the Spanish version of the CAHPS questionnaire had an English cover letter on the back side informing beneficiaries that they could call the toll-free number to request an English version of the CAHPS questionnaire. All non-respondents received a reminder postcard, followed by a second survey mailing and reminder postcard. The second phase, or telephone phase, consisted of conducting CATI of sampled beneficiaries who had not mailed in a completed survey. HSAG attempted up to three CATI calls to each non-respondent. 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 an MCP's population.[4-1]

DHCS provided HSAG with a list of all eligible beneficiaries for the sampling frames. HSAG sampled beneficiaries who met the following criteria:

- Were 18 years of age or older as of December 31, 2015 for the adult population.
- Were 17 years of age or younger as of December 31, 2015 for the child population.
- Were currently enrolled in MCMC.
- Had been continuously enrolled in the MCP for at least five of the last six months of 2015.
- Had Medicaid as a payer.

HSAG inspected a sample of the file records from the sampling frame to check for any apparent problems with the files, such as missing address elements. HSAG obtained new addresses for beneficiaries selected for the sample by processing sampled beneficiaries' addresses through the United States Postal Service's National Change of Address (NCOA) system, as available. Prior to initiating CATI, HSAG employed the Telematch telephone number verification service to locate and/or update telephone numbers for all non-respondents.

The specifications also require that the name of the MCP appear in the questionnaires, letters, and postcards; that the letters and cards bear the signature of a high-ranking MCP 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.

[4-1] 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.

Table 4-2 shows the CAHPS timeline used in the administration of the CAHPS 5.0H Adult and Child Medicaid Health Plan Surveys.

Table 4-2—CAHPS 5.0H Survey Timeline

Task	Timeline
Send first questionnaire with cover letter to the beneficiary or parent/caretaker of the child beneficiary.	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 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

How CAHPS Results Were Calculated and Displayed

HSAG used the CAHPS scoring approach recommended by NCQA in HEDIS 2016, Volume 3: Specifications for Survey Measures. Based on NCQA's recommendations and HSAG's extensive experience evaluating CAHPS data, HSAG performed a number of analyses to comprehensively assess beneficiary satisfaction. This section provides an overview of each analysis. As applicable, MCPs' county/region-level results presented in this report are based on the general sample and county/region-level oversample of beneficiaries selected for surveying.

Who Responded to the Survey

The administration of the CAHPS 5.0H Adult and Child Medicaid Health Plan Surveys is comprehensive and is designed to garner the highest possible response rate. The CAHPS Survey response rate is the total number of completed surveys divided by all eligible beneficiaries of the sample.[4-2] HSAG considered a survey completed if beneficiaries, or parents or caretakers of sampled child beneficiaries answered at least three of the following five questions: questions 3, 15, 24, 28, and 35 for adult Medicaid and questions 3, 15, 27, 31, and 36 for child Medicaid, as specified by NCQA. Eligible beneficiaries included the entire sample minus ineligible beneficiaries. Ineligible beneficiaries met at least one of the following criteria: they were deceased, were invalid (did not meet the eligible population criteria), were mentally or physically incapacitated (adult population only), were removed from sample during deduplication, or had a language barrier.

[4-2] National Committee for Quality Assurance. *HEDIS® 2016, Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA Publication, 2015.

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

Beneficiary and Respondent Demographics

The demographic analysis evaluated self-reported and child demographic information from survey respondents. Given that the demographics of a response group may influence overall beneficiary satisfaction scores, it is important to evaluate all CAHPS results in the context of the actual respondent population. Caution should be exercised when extrapolating the CAHPS results to the entire population if the respondent population differs significantly from the actual population of the MCP.

Respondent Analysis

The respondent analysis compared the demographic characteristics of adult and child beneficiaries to the demographic characteristics of adult and child beneficiaries in the sampling frames. The demographic characteristics evaluated as part of the respondent analysis included adult and child beneficiary age, gender, and language.

National Comparisons

HSAG calculated three-point mean scores for the adult and child populations separately and compared them to NCQA's HEDIS Benchmarks and Thresholds for Accreditation, except for the Shared Decision Making composite measure.[4-3,4-4] Based on this comparison, HSAG determined ratings of one (★) to five (★★★★★) stars for each CAHPS measure where one is the lowest possible rating (i.e., *Poor*) and five is the highest possible rating (i.e., *Excellent*). NCQA requires a minimum of 100 responses on each item in order to report the item as a valid CAHPS Survey result. However, for purposes of this report, HSAG reported CAHPS results for a measure even when the minimum reporting of 100 respondents was not met. Therefore, caution should be exercised when evaluating measures' results with fewer than 100 responses, which are denoted with a cross (+).

[4-3] National Committee for Quality Assurance. *HEDIS Benchmarks and Thresholds for Accreditation 2016*. Washington, DC: NCQA, January 21, 2016.

[4-4] NCQA does not publish benchmarks and thresholds for the Shared Decision Making composite measure; therefore, overall beneficiary satisfaction ratings could not be derived for this CAHPS measure.

Table 4-3 shows the percentiles that HSAG used to determine star ratings for each CAHPS measure. Refer to Appendix A for additional information regarding the methodology HSAG used to produce the star rating assignments.

Table 4-3—Star Ratings Crosswalk

Stars	Adult and Child Percentiles
★★★★★	At or above the 90th percentile
★★★★	At or above the 75th and below the 90th percentiles
★★★	At or above the 50th and below the 75th percentiles
★★	At or above the 25th and below the 50th percentiles
★	Below the 25th percentile

State Comparisons

For purposes of the State Comparisons analysis, HSAG presented the adult and child population results separately for each global rating and composite measure. HSAG calculated question summary rates for each global rating and global proportions for each composite measure.[4-5] For the global ratings, HSAG considered a top-box response a value of 9 or 10. For the composite measures, responses of "Usually," "Always," or "Yes" were considered top-box responses.

Results for the MCMC average were weighted based on the eligible population for each MCP reporting unit and population (i.e., adult or child). This use of a weighted average, based on each MCP reporting unit's eligible population size, provides the most representative overall MCMC rate. HSAG based the eligible population size of each MCP reporting unit on the total number of beneficiaries included in the MCP's sample frame for that population (i.e., eligible populations at the time HSAG drew the CAHPS sample).

Results were also case-mix adjusted. Case-mix refers to the characteristics of the respondents used in adjusting the results for comparability among MCPs. Given that differences in case-mix can result in differences in ratings between MCPs that are not due to differences in quality, the data were adjusted to account for disparities in these characteristics. Results were case-mix adjusted for reported beneficiary general health status, respondent educational level, respondent age, and beneficiary race/ethnicity.

Two types of hypothesis tests were then applied to these results. First, HSAG calculated a global *F* test, which determined whether the difference between reporting-unit level means was significant. If the *F* test demonstrated reporting-unit-level differences (i.e., $p < 0.05$), then HSAG performed a *t* test for each reporting unit. The *t* test determined whether each reporting-unit's mean was significantly different from the overall program aggregate. This analytic approach follows the Agency for Healthcare Research and Quality's (AHRQ's) recommended methodology for identifying statistically significant performance

[4-5] National Committee for Quality Assurance. *HEDIS® 2016, Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA Publication, 2015.

differences. HSAG suppressed MCPs results with fewer than 11 cases in the numerator to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standards.

Model Type Comparisons

For each model type, HSAG performed National and State Comparisons using a similar methodology as discussed above. Please refer to Table 3-1, beginning on page 3-2, for a list of MCPs and their respective model type. Please note, HSAG categorized Kaiser NorCal as a GMC model type for purposes of the model type comparisons analysis.

SPD Comparisons

For purposes of the SPD comparisons, HSAG calculated National and State Comparisons results stratified by SPD enrollment status (i.e., non-SPD and SPD populations) using a methodology similar to the model type comparisons.

Key Drivers of Satisfaction

In order to determine potential items for QI efforts, HSAG performed a key drivers of satisfaction analysis for the adult and child populations at the MCMC level (i.e., statewide level). The purpose of the key drivers of satisfaction analysis is to help decision makers identify specific aspects of care that will most benefit from QI activities. The analysis provides information on:

- How ***well*** the population is performing on the survey item.
- How ***important*** that item is to overall satisfaction.

A problem score at or above the median problem score is considered to be "high." A correlation at or above the median correlation is considered to be "high." Key drivers are those items for which the problem score and correlation are both at or above their respective medians. The median, rather than the mean, is used to ensure that extreme problem scores and correlations do not have disproportionate influence in prioritizing individual questions.

Correlation

HSAG used the Pearson product moment correlation to calculate the relationship between the problem score of a question and priority items. This conversion modifies the distributions of both variables so that they conform to the standard normal distribution and can be compared.

The correlation can range from -1 to 1, with negative values indicating a negative relationship between overall satisfaction and a particular survey item. However, the correlation analysis conducted is not focused on the direction of the correlation, but rather on the degree of correlation. Therefore, the absolute value of r is used in the analysis, and the range for r is 0 to 1. An r of zero indicates no relationship between the response to a question and satisfaction. As r increases, the importance of the question to the respondent's satisfaction increases.

Limitations and Cautions

The findings presented in this CAHPS report are subject to some limitations in the survey design, analysis, and interpretation. Sample sizes for the 2016 CAHPS Survey were established with the following goals:

1. Obtain 411 completed surveys at the MCP level.
2. Obtain 100 completed surveys at the reporting-unit level.

While the sample sizes were determined based on the goals, a number of measures at the reporting-unit level had fewer than 100 responses. According to NCQA HEDIS Specifications for Survey Measures, if a measure has fewer than 100 responses, the measure is not reportable; therefore, caution should be taken when interpreting the results.[4-6] NCQA HEDIS Specifications for Survey Measures recommends targeting 411 completed surveys to meet the following statistical parameters: 1) confidence intervals with a margin of error under 5 percent at the 95 percent confidence level, and 2) statistical power of at least 80 percent in detecting differences of 10 percentage points.[4-7] Based on the sample sizes, it would be expected that a number of reporting units would not have reached 411 completed surveys; therefore, caution should be taken when interpreting the results. For the model type and subpopulation analyses, since population weights were not included, the rates may not be representative of the plan types and subpopulations (i.e., COHS model, GMC model, Imperial model, Regional model, San Benito model, TPM, SPD population, and non-SPD population). Caution should be taken when interpreting these results. DHCS should consider these limitations when interpreting or generalizing the findings.

Case-Mix Adjustment

While HSAG risk adjusted the State Comparisons data to account for differences in reported beneficiary general health status, respondent age, respondent education, and beneficiary race/ethnicity, it was not possible to adjust for differences in beneficiary or respondent characteristics not measured in the survey instrument. These characteristics include income, employment, or any other characteristics that may not be under the MCP's control.

Non-Response Bias

The experiences of the survey respondent population may be different than those of non-respondents with respect to their health care services and may vary by MCP or MCP reporting unit. Therefore, DHCS should consider the potential for non-response bias when interpreting CAHPS results.

[4-6] National Committee for Quality Assurance. *HEDIS® 2016, Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA Publication, 2015.
[4-7] Ibid.

Causal Inferences

Although this report examines whether beneficiaries report differences in satisfaction with various aspects of their health care experiences, these differences may not be completely attributable to the MCP. These analyses identify whether beneficiaries give different ratings of satisfaction with their MCP. The survey by itself does not necessarily reveal the exact cause of these differences.

Survey Instrument

The surveys were only administered in two languages, English and Spanish, as CAHPS 5.0H Health Plan Surveys in alternative languages were not approved by NCQA at the time of survey administration. Therefore, caution should be exercised when interpreting CAHPS results, given that MCMC beneficiaries may not have been able to complete a survey due to language barriers.

5. Results

Who Responded to the Survey

HSAG mailed a total of 40,676 adult surveys and 42,780 child surveys to the sample of beneficiaries selected for surveying. Of these, a total of 9,492 adult surveys and 11,349 child surveys were completed. HSAG used these completed surveys to calculate the MCMC CAHPS results presented in this section.

The CAHPS Survey response rate is the total number of completed surveys divided by all eligible beneficiaries of the sample. If a beneficiary answered at least three of five questions on the survey, HSAG counted the survey as complete.[5-1] Eligible beneficiaries included the entire sample minus ineligible beneficiaries. Ineligible beneficiaries met at least one of the following criteria: they were deceased, were invalid (did not meet the eligible population criteria), were mentally or physically incapacitated (adult population only), were removed from sample during deduplication, or had a language barrier.

Table 5-1 presents the total number of beneficiaries sampled, the number of ineligible beneficiaries, the number of surveys completed, and the response rate for the adult and child beneficiaries selected for surveying.

Table 5-1—Total Number of Respondents and Response Rates

	Total Adult	Total Child
Sample Size	40,676	42,780
Ineligible Beneficiaries	1,692	971
Eligible Sample	38,984	41,809
Number of Surveys Completed	9,492	11,349
Response Rate	24.35%	27.14%

Response rate is calculated as Number of Surveys Completed/Eligible Sample.

Beneficiary and Respondent Demographics[5-2]

In general, the demographics of a response group may influence overall beneficiary satisfaction scores. For example, older and healthier respondents tend to report higher levels of beneficiary satisfaction; therefore, exercise caution when comparing populations that have significantly different demographic properties.

[5-1] A survey was considered a complete and valid survey for the CAHPS Adult Medicaid Survey when three of the following five questions were appropriately answered: 3, 15, 24, 28, and 35. A survey was considered a complete and valid survey for the CAHPS Child Medicaid Survey when three of the following five questions were appropriately answered: 3, 15, 27, 31, and 36.

[5-2] HSAG did not perform any weighting on the beneficiary and respondent demographics.

Figures 5-1 through 5-5 depict the adult statewide respondent demographics.

Figure 5-1—Statewide Adult Respondent Demographics – Age

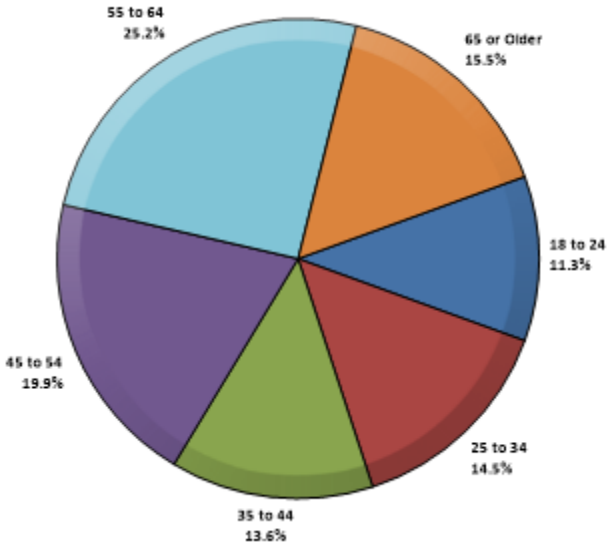


Figure 5-2—Statewide Adult Respondent Demographics – Gender

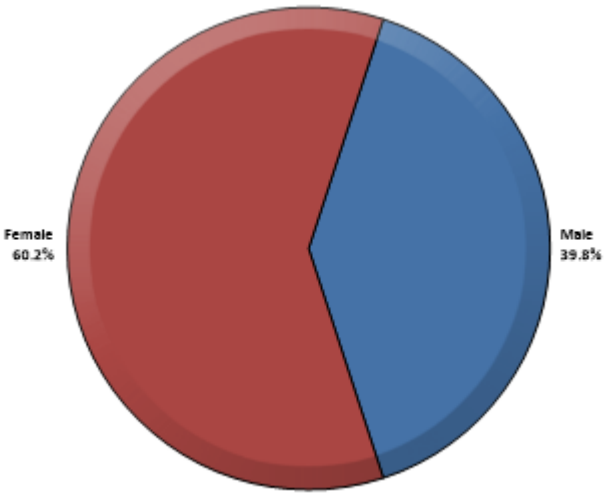


Figure 5-3—Statewide Adult Respondent Demographics – Race/Ethnicity

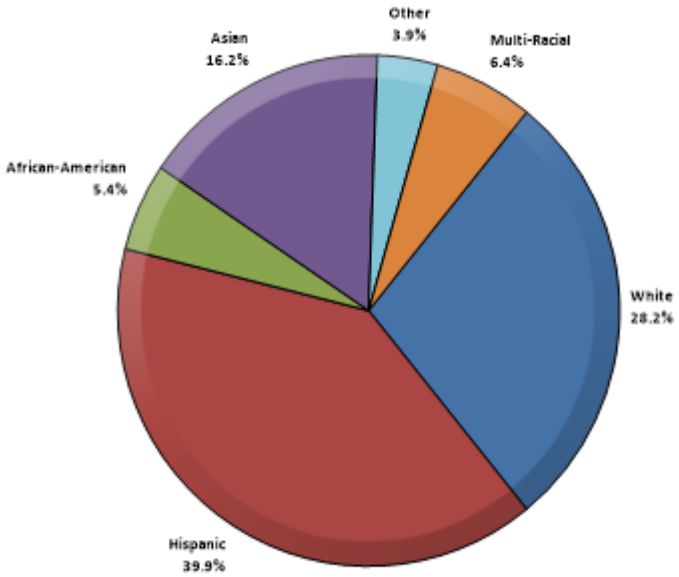


Figure 5-4—Statewide Adult Respondent Demographics – Education

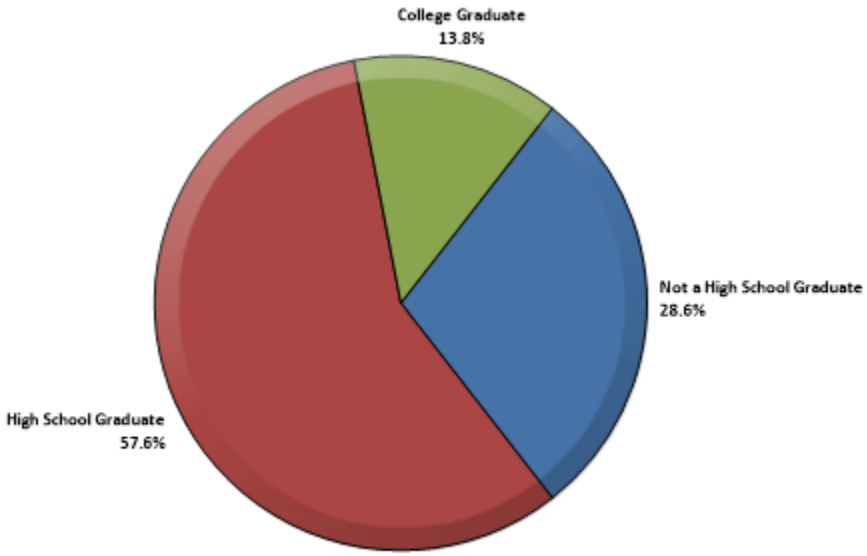
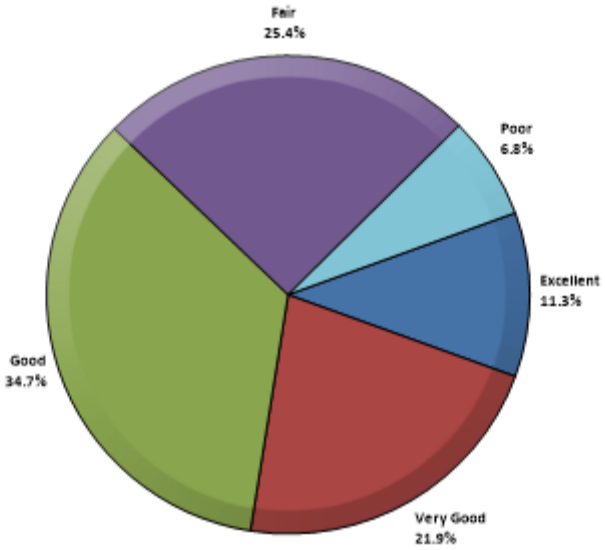
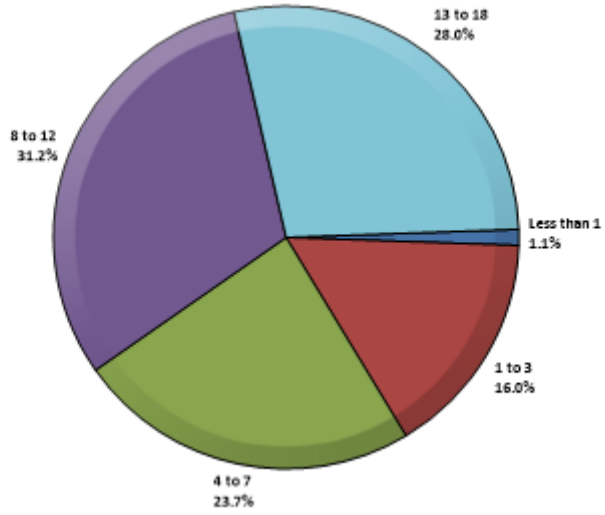


Figure 5-5—Statewide Adult Respondent Demographics – General Health Status



Figures 5-6 through 5-9 depict the statewide demographic characteristics of children for whom a parent or caretaker completed a survey.

Figure 5-6—Statewide Child Demographics – Age[5-3]



[5-3] Children were eligible for inclusion in CAHPS if they were 17 years of age or younger as of December 31, 2015. Some children eligible for the CAHPS Survey turned 18 between January 1, 2016 and the time of survey administration.

Figure 5-7—Statewide Child Demographics – Gender

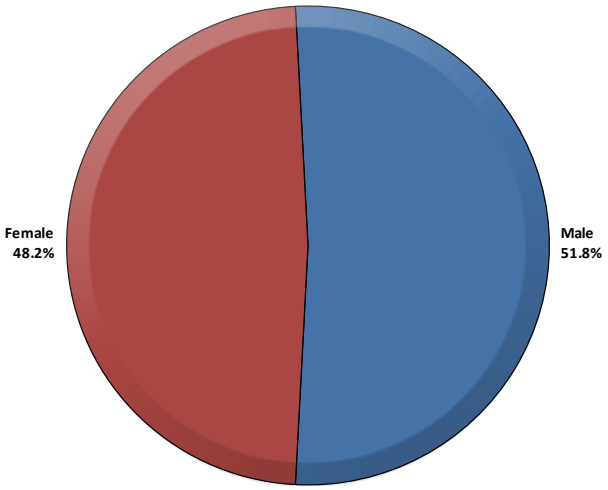


Figure 5-8—Statewide Child Demographics – Race/Ethnicity

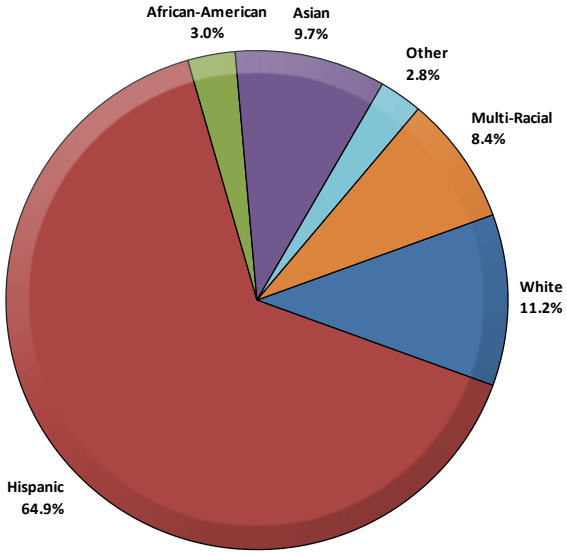
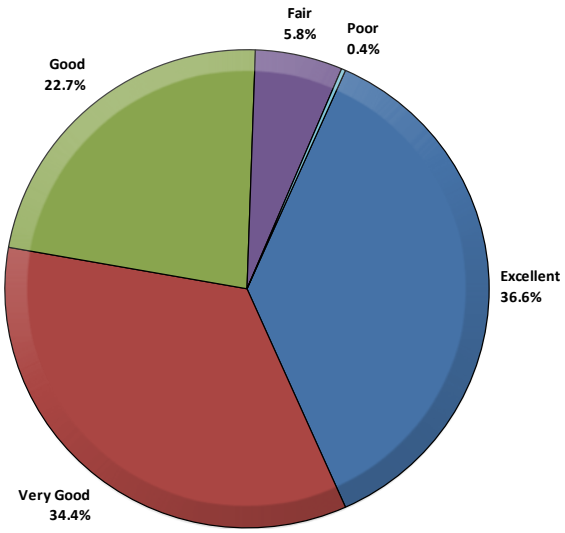


Figure 5-9—Statewide Child Demographics – General Health Status



Figures 5-10 through 5-13 depict the statewide demographic characteristics of the parents or caretakers who completed a survey on behalf of the child beneficiary.

Figure 5-10—Statewide Child Respondent Demographics – Age

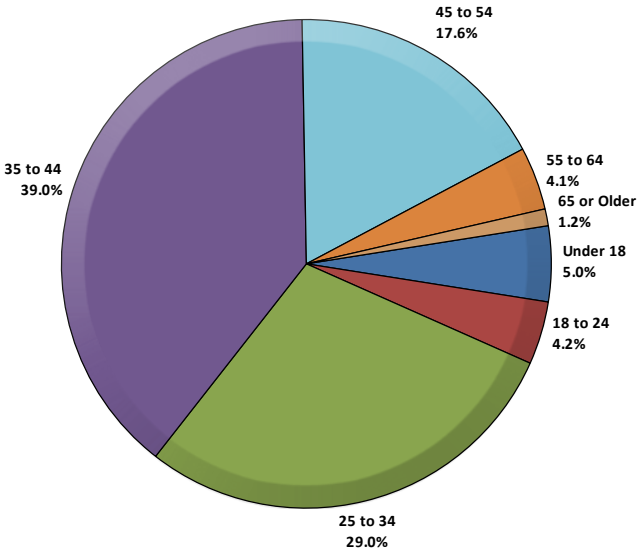


Figure 5-11—Statewide Child Respondent Demographics – Gender

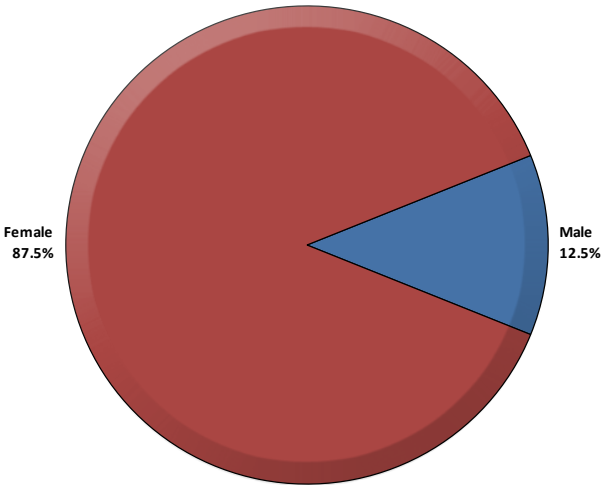


Figure 5-12—Statewide Child Respondent Demographics – Education

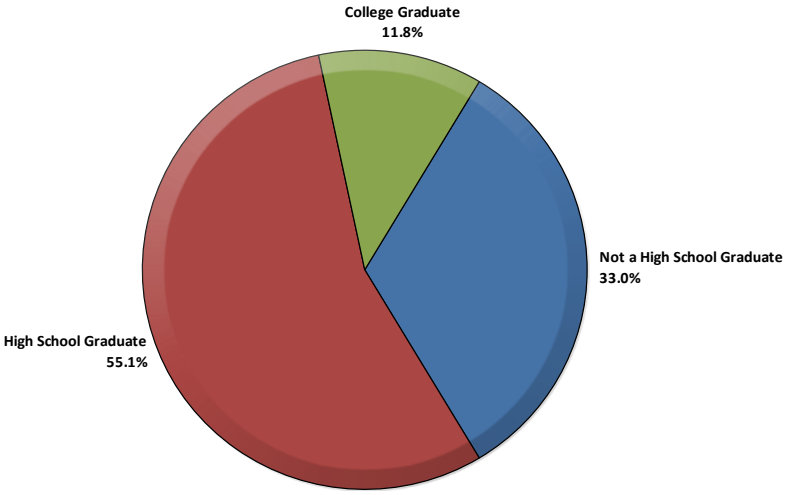
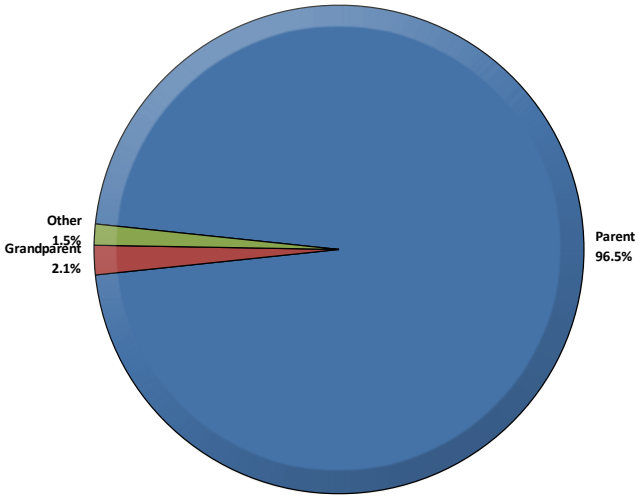


Figure 5-13—Statewide Child Respondent Demographics – Relationship to Child



Respondent Analysis

HSAG compared the demographic characteristics (i.e., age, gender, and language) of adult and child beneficiary survey respondents to the demographic characteristics of beneficiaries in the sampling frame at the statewide level. For purposes of this analysis, the adult and child populations' results are presented separately. Table 5-2 and Table 5-3 present the results of the respondent analysis for the adult and child populations, respectively.[5-4] Please note that variables from the sample frame were used for this analysis. Therefore, demographic results in this section may be different than those presented in the demographic analysis, which used actual responses from the survey instrument.

Table 5-2—Statewide Adult Respondent Analysis Results

	Adult Respondents	Adult Sampling Frame
Age		
18 to 24	12.4%	19.4%
25 to 34	14.6%	21.7%
35 to 44	13.5%	14.4%
45 to 54	20.3%	16.0%
55 to 64	24.7%	15.8%
65 or older	14.5%	12.6%
Gender		
Male	40.1%	43.6%
Female	59.9%	56.4%

[5-4] HSAG did not weight the demographic results for the adult and child beneficiary survey respondents.

	Adult Respondents	Adult Sampling Frame
Language		
Spanish	24.3%	19.1%
Non-Spanish	75.7%	80.9%

Please note, percentages for each demographic category may not total 100% due to rounding.

Table 5-3—Statewide Child Respondent Analysis Results

	Child Respondents	Child Sampling Frame
Age		
Less than 1	1.9%	1.7%
1 to 3	17.0%	17.2%
4 to 7	23.9%	24.7%
8 to 12	30.7%	30.2%
13 to 17	26.4%	26.2%
Gender		
Male	51.6%	51.1%
Female	48.4%	48.9%
Language		
Spanish	52.3%	36.3%
Non-Spanish	47.7%	63.7%

Please note, percentages for each demographic category may not total 100% due to rounding.

Rating of Health Plan

Measure Definition

MCMC beneficiaries were asked to rate their MCP on a scale of 0 to 10, with 0 being the "worst health plan possible" and 10 being the "best health plan possible."

National Comparisons

Table 5-4 and Table 5-5 show the adult and child three-point means and star ratings for Rating of Health Plan, respectively.

Table 5-4—Adult National Comparisons – Rating of Health Plan

Reporting Unit Name	Three-Point Mean	Star Rating
Kaiser SoCal - San Diego	2.61	★★★★★
Kaiser NorCal - KP North	2.56	★★★★★
CHW - Imperial	2.49	★★★★
Health Net - Tulare	2.44	★★★
HPSM - San Mateo	2.43	★★★
Anthem - Madera	2.39	★★+
CenCal - Santa Barbara	2.39	★★
CalViva - Madera	2.38	★★
Gold Coast - Ventura	2.38	★★
CalViva - Kings	2.37	★★
Anthem - Kings	2.36	★+
IEHP - Riverside, San Bernardino	2.36	★
Molina - Imperial	2.36	★
Partnership - Southeast	2.36	★
CCAH - Monterey, Santa Cruz	2.35	★
CHG - San Diego	2.34	★
CCHP - Contra Costa	2.34	★
Health Net - Los Angeles	2.34	★
SCFHP - Santa Clara	2.34	★
Health Net - San Diego	2.32	★
HPSJ - San Joaquin	2.32	★
L.A. Care - Los Angeles	2.32	★
Partnership - Southwest	2.32	★
MCMC	**2.31**	★
Molina - Riverside, San Bernardino	2.31	★+
CCAH - Merced	2.30	★
CalViva - Fresno	2.30	★
KFHC - Kern	2.30	★
Molina - San Diego	2.30	★
CalOptima - Orange	2.28	★
Anthem - Tulare	2.27	★
Care1st - San Diego	2.27	★
AAH - Alameda	2.25	★
SFHP - San Francisco	2.25	★
Anthem - Santa Clara	2.23	★
HPSJ - Stanislaus	2.22	★
Anthem - San Benito	2.21	★+
CHW - Region 1	2.20	★
Anthem - San Francisco	2.19	★+
CenCal - San Luis Obispo	2.19	★
Health Net - Kern	2.15	★+
Partnership - Northeast	2.14	★
Health Net - San Joaquin	2.13	★+
Anthem - Region 1	2.11	★+
Anthem - Fresno	2.08	★+

Reporting Unit Name	Three-Point Mean	Star Rating
Partnership - Northwest	2.07	★
Health Net - Stanislaus	2.04	★+
Molina - Sacramento	2.04	★+
Anthem - Alameda	2.02	★+
Anthem - Contra Costa	2.02	★+
Anthem - Region 2	1.99	★
Anthem - Sacramento	1.96	★+
CHW - Region 2	1.94	★
Health Net - Sacramento	1.92	★+

+ If the MCP had fewer than 100 respondents for a measure, caution should be exercised when evaluating the results.

Table 5-5—Child National Comparisons – Rating of Health Plan

Reporting Unit Name	Three-Point Mean	Star Rating
Kaiser NorCal - KP North	2.73	★★★★★
Kaiser SoCal - San Diego	2.71	★★★★★
Molina - San Diego	2.66	★★★★
Health Net - Tulare	2.65	★★★★+
CalOptima - Orange	2.64	★★★★
CHW - Imperial	2.64	★★★★
SCFHP - Santa Clara	2.62	★★★★
Partnership - Southeast	2.61	★★★
CCAH - Monterey, Santa Cruz	2.60	★★★
HPSM - San Mateo	2.60	★★★
CHG - San Diego	2.59	★★★
Anthem - Alameda	2.58	★★★+
IEHP - Riverside, San Bernardino	2.58	★★★
Partnership - Southwest	2.58	★★★
AAH - Alameda	2.57	★★★
Anthem - Contra Costa	2.57	★★★+
CenCal - Santa Barbara	2.57	★★★
HPSJ - San Joaquin	2.57	★★★
CalViva - Fresno	2.56	★★
Health Net - Los Angeles	2.56	★★
SFHP - San Francisco	2.56	★★
MCMC	**2.55**	★★
Gold Coast - Ventura	2.55	★★
L.A. Care - Los Angeles	2.55	★★
KFHC - Kern	2.54	★★
Anthem - Tulare	2.53	★★
Anthem - Kings	2.52	★★+
CenCal - San Luis Obispo	2.52	★★
CCHP - Contra Costa	2.52	★★
CalViva - Madera	2.52	★★+
Anthem - Fresno	2.51	★★+
CalViva - Kings	2.49	★+

Reporting Unit Name	Three-Point Mean	Star Rating
Anthem - Madera	2.48	★+
Anthem - Santa Clara	2.47	★+
Care1st - San Diego	2.46	★
Molina - Imperial	2.44	★+
Molina - Riverside, San Bernardino	2.43	★
HPSJ - Stanislaus	2.41	★
CHW - Region 2	2.40	★+
Anthem - Sacramento	2.38	★+
CHW - Region 1	2.38	★
Health Net - San Diego	2.38	★+
CCAH - Merced	2.37	★
Anthem - Region 1	2.35	★+
Health Net - Stanislaus	2.35	★+
Health Net - Sacramento	2.34	★+
Anthem - San Francisco	2.32	★+
Health Net - San Joaquin	2.31	★+
Anthem - Region 2	2.28	★+
Health Net - Kern	2.28	★+
Anthem - San Benito	2.27	★
Partnership - Northwest	2.27	★+
Molina - Sacramento	2.11	★+
Partnership - Northeast	2.08	★+

+If the MCP had fewer than 100 respondents for a measure, caution should be exercised when evaluating the results.

State Comparisons

Figure 5-14 and Figure 5-15 show the adult and child State Comparisons for Rating of Health Plan, respectively.

Figure 5-14—Rating of Health Plan – Adult Top-Box Rates

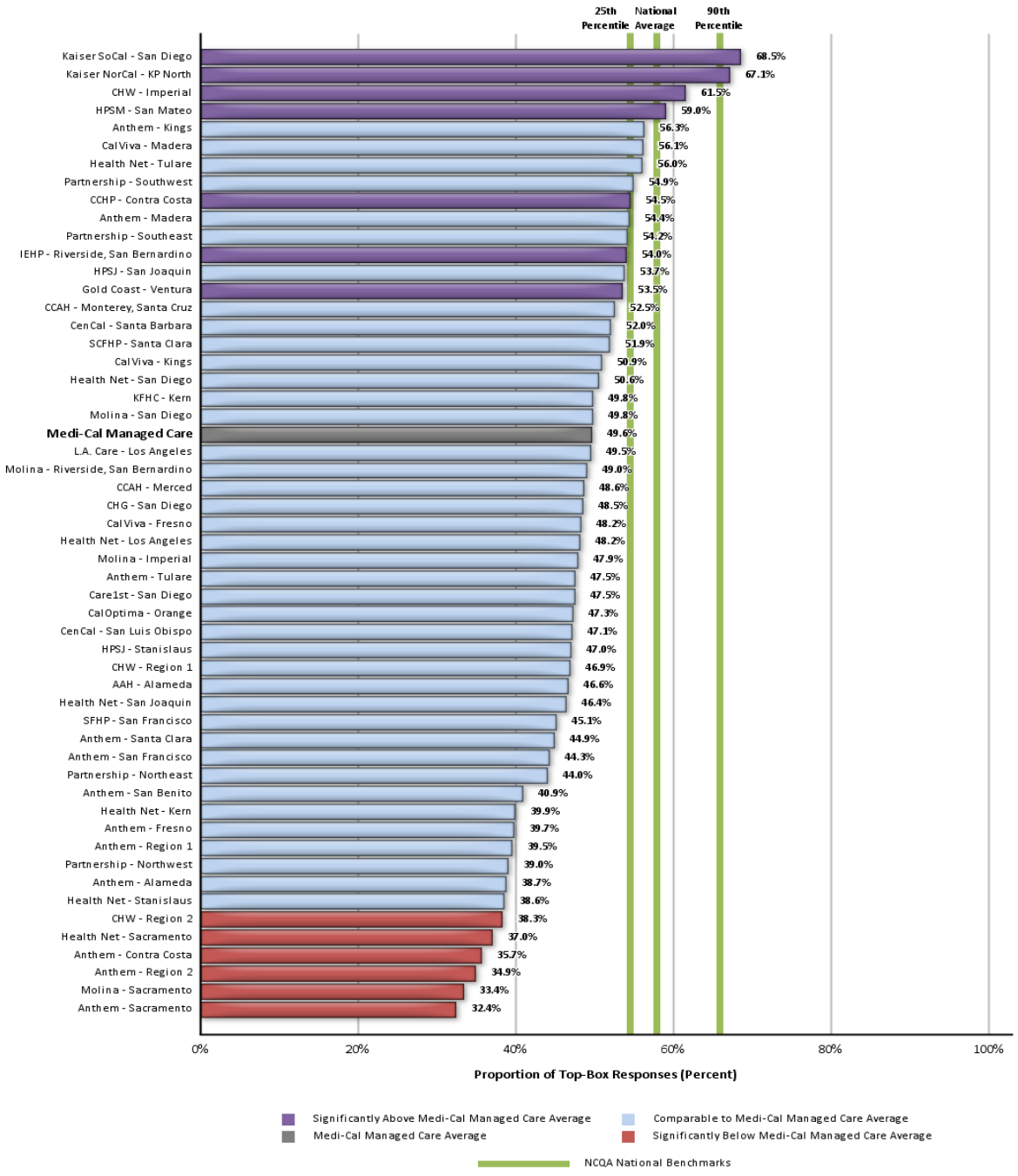
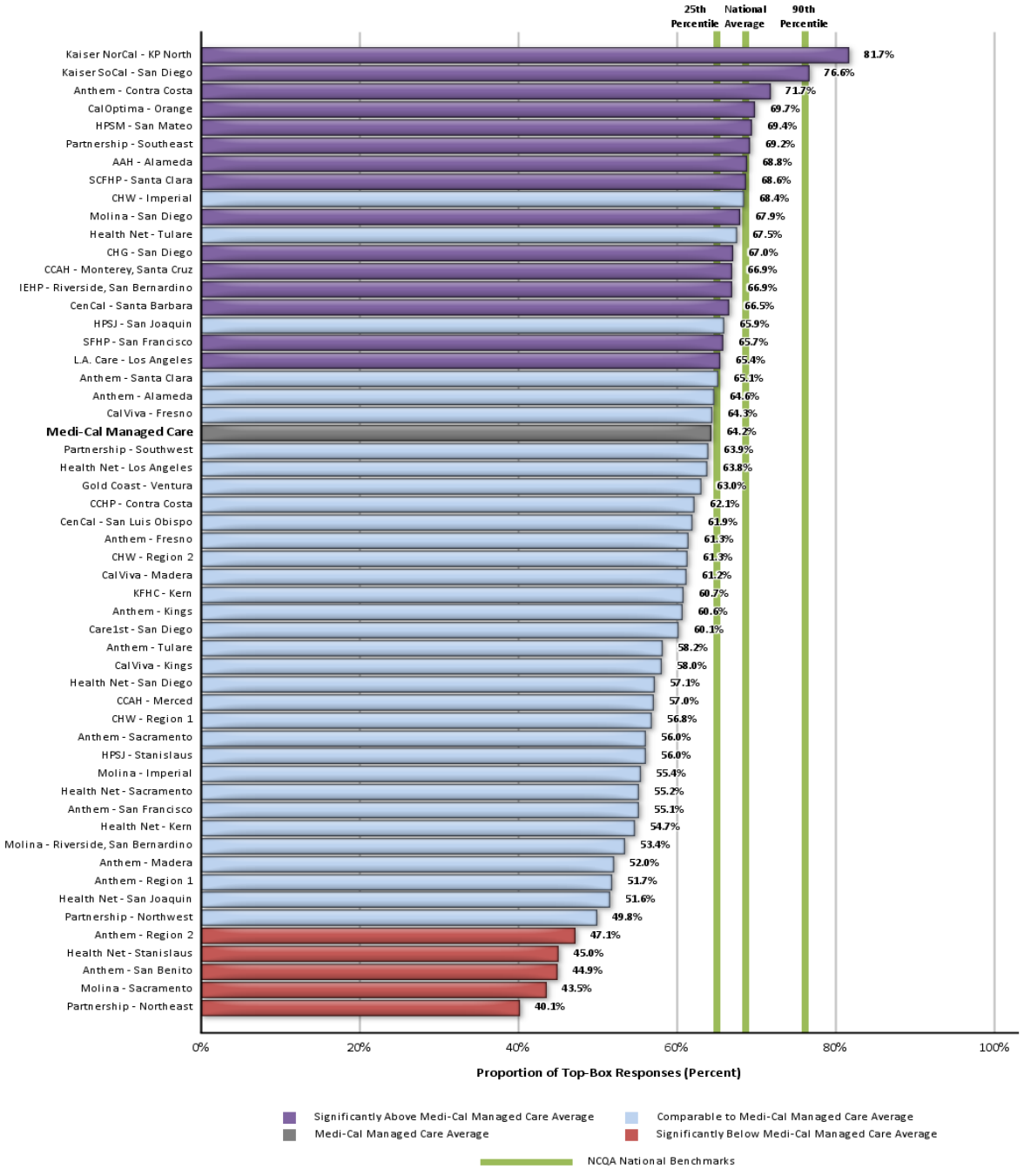


Figure 5-15—Rating of Health Plan – Child Top-Box Rates



Summary of Results

Caution: The majority of the reporting units had fewer than 100 respondents for **Rating of Health Plan**. According to NCQA's specifications, rates with fewer than 100 respondents are not reportable.

The MCMC's star ratings for **Rating of Health Plan** were *Poor* for the adult population and *Fair* for the child population. For the National Comparisons, 43 out of 53 MCP reporting units for the adult population and 23 out of 53 MCP reporting units for the child population demonstrated *Poor* performance for this measure. There were three MCP reporting units for the adult population and seven MCP reporting units for the child population that had star ratings of *Excellent* or *Very Good* for **Rating of Health Plan**.

There were two MCP reporting units that received *Excellent* star ratings for both the adult and child populations when compared to national data and also scored significantly higher than the MCMC weighted average for the State Comparisons analysis:

- Kaiser NorCal – KP North
- Kaiser SoCal – San Diego

There were six MCP reporting units that received *Poor* star ratings for the adult population when compared to national data and also scored significantly lower than the MCMC weighted average for the State Comparisons analysis:

- Anthem – Contra Costa
- Anthem – Region 2
- Anthem – Sacramento
- CHW – Region 2
- Health Net – Sacramento
- Molina – Sacramento

There were five MCP reporting units that received *Poor* star ratings for the child population when compared to national data and also scored significantly lower than the MCMC weighted average for the State Comparisons analysis:

- Anthem – Region 2
- Anthem – San Benito
- Health Net – Stanislaus
- Molina – Sacramento
- Partnership – Northeast

Improvement Strategies

Alternatives to One-on-One Visits

MCPs should engage in efforts that assist providers in examining and improving their systems' abilities to manage beneficiary demand. As an example, MCPs 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 primary care provider availability. Additionally, for beneficiaries who need a follow-up appointment, a system could be developed and tested where a nurse or primary care provider assistant contacts the beneficiary by phone two weeks prior to when the follow-up visit would have occurred to determine whether the beneficiary'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, MCPs can assist in improving primary care provider availability and ensuring beneficiaries receive immediate medical care and services.

MCP Operations

It is important for MCPs to view their organization as a collection of microsystems (such as providers, administrators, and other staff who provide services to beneficiaries) that provide the MCP's health care "products." Health care microsystems include: a team of health providers, beneficiary/population to whom care is provided, environment that provides information to providers and beneficiaries, support staff, equipment, and office environment. The goal of the microsystems approach is to focus on small, replicable, functional service systems that enable MCP staff to provide high-quality, beneficiary-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 MCP.

Online Beneficiary Portals

To help increase beneficiaries' satisfaction with their MCPs, MCPs should consider enhancing their current online beneficiary portal or Web-based systems to integrate online tools and services that focus on beneficiary-centered care. In addition to MCP benefits and coverage forms, online health information and services that can be made available to beneficiaries include: online medical records, electronic communication with providers, and educational health information and resources on various medical conditions. Access to online interactive tools, such as health discussion boards, allow questions to be answered by trained clinicians. Online health risk assessments can provide beneficiaries instant feedback and education on the medical condition(s) specific to their health care needs. In addition, an online beneficiary portal can be an effective means of promoting health awareness and education. MCPs should periodically review health information content for accuracy and request beneficiary and/or primary care provider feedback to ensure relevancy of online services and tools provided.

Promote QI Initiatives

Implementation of organization-wide QI initiatives are most successful when MCP 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 MCP organization, establishing MCP-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, MCPs can assess whether QI initiatives have been effective in improving the quality of care delivered to beneficiaries.

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 beneficiary, primary care provider, and employee satisfaction.

Rating of All Health Care

Measure Definition

MCMC beneficiaries 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."

National Comparisons

Table 5-6 and Table 5-7 show the adult and child three-point means and star ratings for Rating of All Health Care, respectively.

Table 5-6—Adult National Comparisons – Rating of All Health Care

Reporting Unit Name	Three-Point Mean	Star Rating
Health Net - San Diego	2.63	★★★★★+
Kaiser SoCal - San Diego	2.58	★★★★★
Kaiser NorCal - KP North	2.47	★★★★★
HPSJ - San Joaquin	2.38	★★★
Health Net - Tulare	2.37	★★★+
CCAH - Merced	2.36	★★★+
CHW - Imperial	2.36	★★★+
Gold Coast - Ventura	2.36	★★★
HPSM - San Mateo	2.35	★★
Molina - Riverside, San Bernardino	2.35	★★+
SCFHP - Santa Clara	2.35	★★
CalOptima - Orange	2.34	★★
CCHP - Contra Costa	2.34	★★
CCAH - Monterey, Santa Cruz	2.33	★★
IEHP - Riverside, San Bernardino	2.33	★★
Molina - Imperial	2.33	★★+
Anthem - Madera	2.32	★★+
Molina - San Diego	2.32	★★
SFHP - San Francisco	2.32	★★
Anthem - Kings	2.30	★+
CHG - San Diego	2.30	★
MCMC	**2.29**	★
Care1st - San Diego	2.29	★
CalViva - Fresno	2.29	★
CalViva - Madera	2.29	★+
L.A. Care - Los Angeles	2.29	★
CenCal - Santa Barbara	2.28	★
CalViva - Kings	2.26	★+
Health Net - Los Angeles	2.25	★
AAH - Alameda	2.22	★
HPSJ - Stanislaus	2.21	★+
Molina - Sacramento	2.21	★+
Anthem - San Benito	2.19	★+
Anthem - Tulare	2.18	★+
CenCal - San Luis Obispo	2.18	★
KFHC - Kern	2.18	★
Partnership - Southwest	2.18	★+
Partnership - Northwest	2.16	★+
Partnership - Southeast	2.16	★+
Anthem - Region 1	2.15	★+
Anthem - San Francisco	2.15	★+
CHW - Region 2	2.13	★+
Partnership - Northeast	2.12	★+
Anthem - Santa Clara	2.10	★+
Health Net - Stanislaus	2.09	★+

Reporting Unit Name	Three-Point Mean	Star Rating
Anthem - Region 2	2.08	★+
Anthem - Sacramento	2.08	★+
CHW - Region 1	2.06	★+
Anthem - Contra Costa	2.02	★+
Anthem - Fresno	2.02	★+
Health Net - Kern	2.02	★+
Anthem - Alameda	1.97	★+
Health Net - San Joaquin	1.97	★+
Health Net - Sacramento	1.94	★+

+If the MCP had fewer than 100 respondents for a measure, caution should be exercised when evaluating the results.

Table 5-7—Child National Comparisons – Rating of All Health Care

Reporting Unit Name	Three-Point Mean	Star Rating
Kaiser NorCal - KP North	2.73	★★★★★
Health Net - San Diego	2.70	★★★★★+
Kaiser SoCal - San Diego	2.69	★★★★★
Anthem - Contra Costa	2.63	★★★★★+
Molina - San Diego	2.62	★★★★★
CalOptima - Orange	2.61	★★★★★
Anthem - Alameda	2.60	★★★★★+
HPSM - San Mateo	2.60	★★★★★
CHG - San Diego	2.58	★★★★
CalViva - Kings	2.58	★★★★+
SCFHP - Santa Clara	2.57	★★★★
AAH - Alameda	2.55	★★★
Molina - Riverside, San Bernardino	2.55	★★★+
SFHP - San Francisco	2.55	★★★
Partnership - Southeast	2.54	★★★
CenCal - San Luis Obispo	2.53	★★★+
Health Net - Tulare	2.53	★★★+
Anthem - Sacramento	2.52	★★★+
Anthem - San Francisco	2.52	★★★+
Anthem - Tulare	2.52	★★★+
CCHP - Contra Costa	2.52	★★★
MCMC	**2.51**	★★
Care1st - San Diego	2.51	★★
Anthem - Fresno	2.50	★★+
CHW - Imperial	2.49	★★+
L.A. Care - Los Angeles	2.49	★★
Gold Coast - Ventura	2.48	★
Health Net - Los Angeles	2.48	★
KFHC - Kern	2.47	★
Partnership - Southwest	2.47	★
CCAH - Monterey, Santa Cruz	2.46	★
CenCal - Santa Barbara	2.45	★

Reporting Unit Name	Three-Point Mean	Star Rating
CalViva - Madera	2.45	★+
Anthem - Kings	2.44	★+
Anthem - Region 2	2.44	★+
CHW - Region 2	2.43	★+
CalViva - Fresno	2.43	★
Anthem - Madera	2.41	★+
CHW - Region 1	2.41	★+
Anthem - Region 1	2.40	★+
Anthem - San Benito	2.40	★+
IEHP - Riverside, San Bernardino	2.40	★
Anthem - Santa Clara	2.39	★+
HPSJ - Stanislaus	2.39	★+
HPSJ - San Joaquin	2.38	★
Partnership - Northwest	2.35	★+
Health Net - Sacramento	2.33	★+
Health Net - Kern	2.29	★+
Health Net - San Joaquin	2.29	★+
Molina - Imperial	2.26	★+
CCAH - Merced	2.22	★+
Health Net - Stanislaus	2.21	★+
Partnership - Northeast	2.12	★+
Molina - Sacramento	2.10	★+

+If the MCP had fewer than 100 respondents for a measure, caution should be exercised when evaluating the results.

State Comparisons

Figure 5-16 and Figure 5-17 show the adult and child State Comparisons for Rating of All Health Care, respectively.

Figure 5-16—Rating of All Health Care – Adult Top-Box Rates

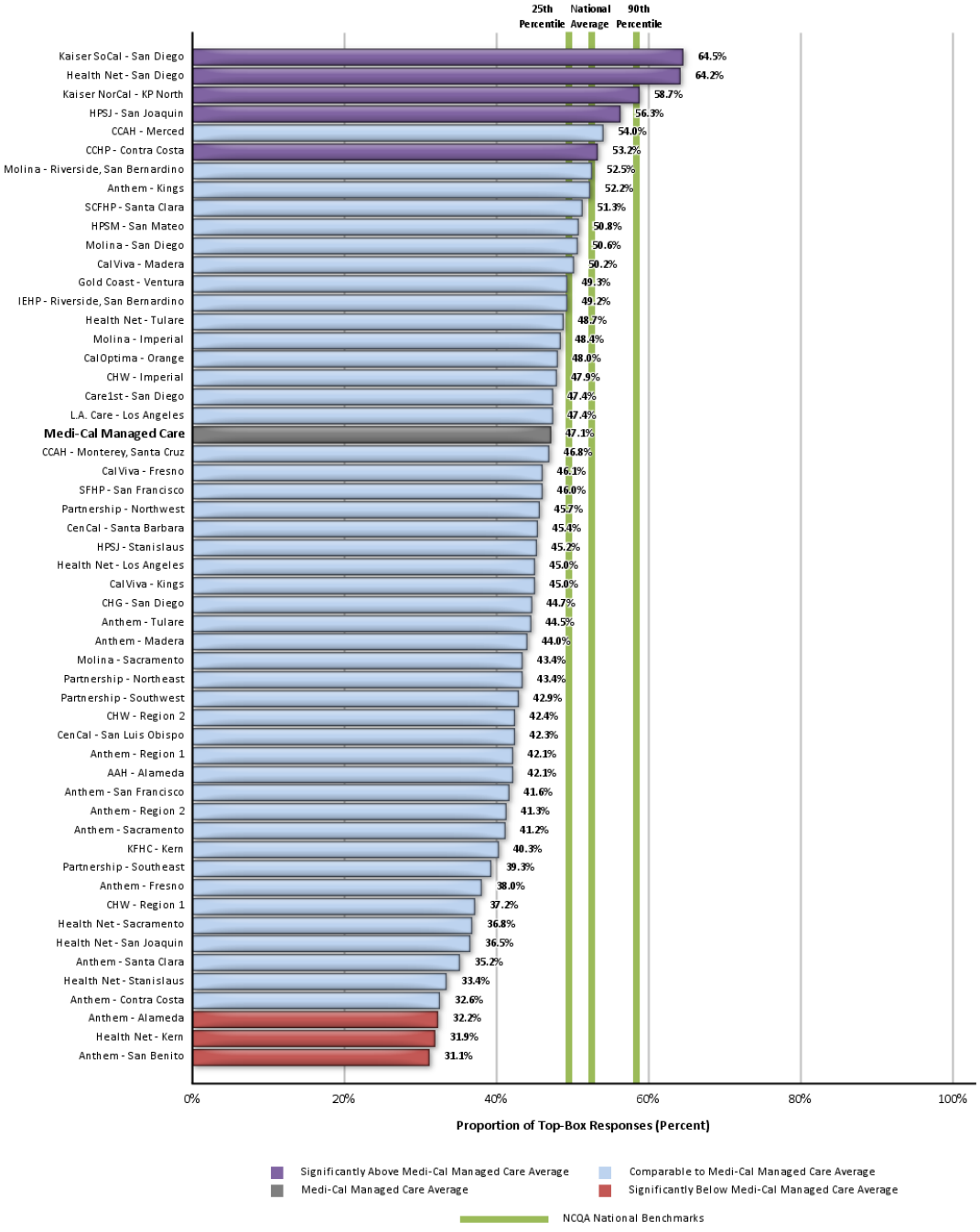
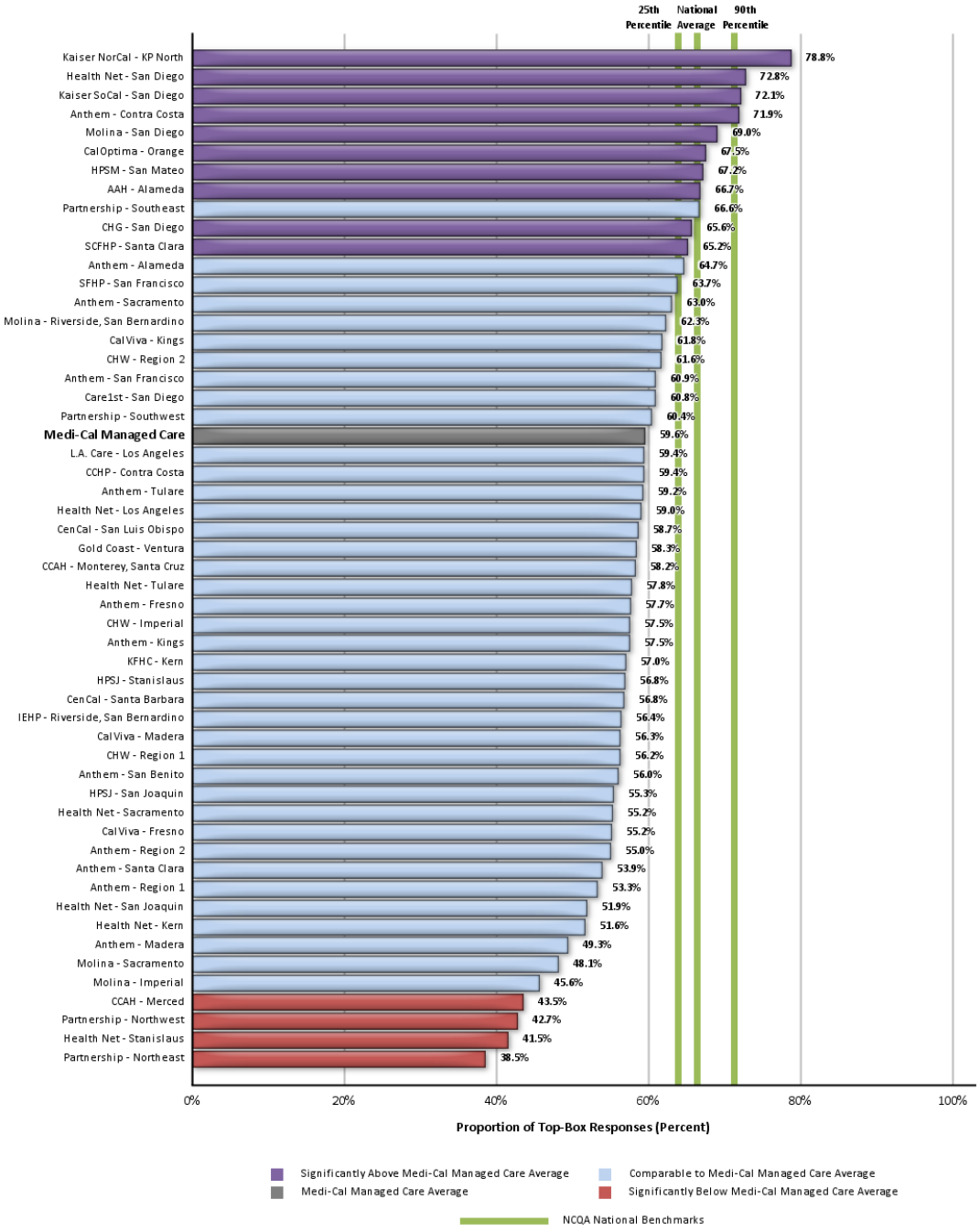


Figure 5-17—Rating of All Health Care – Child Top-Box Rates



Summary of Results

Caution: The majority of the reporting units had fewer than 100 respondents for **Rating of All Health Care**. According to NCQA's specifications, rates with fewer than 100 respondents are not reportable.

The MCMC's star ratings for **Rating of All Health Care** were *Poor* for the adult population and *Fair* for the child population. For the National Comparisons, 33 out of 53 MCP reporting units for the adult population and 28 out of 53 MCP reporting units for the child population demonstrated *Poor* star rating performance for this measure. There were three MCP reporting units for the adult population and 11 MCP reporting units for the child population that had star ratings of *Excellent* or *Very Good* for **Rating of All Health Care**.

There were three MCP reporting units that received *Excellent* star ratings for the adult population when compared to national data and also scored significantly higher than the MCMC weighted average for the State Comparisons analysis:

- Health Net – San Diego
- Kaiser NorCal – KP North
- Kaiser SoCal – San Diego

There were seven MCP reporting units that received *Excellent* star ratings for the child population when compared to national data and also scored significantly higher than the MCMC weighted average for the State Comparisons analysis:

- Anthem – Contra Costa
- CalOptima – Orange
- Health Net – San Diego
- Health Net – San Mateo
- Kaiser NorCal – KP North
- Kaiser SoCal – San Diego
- Molina – San Diego

There were three MCP reporting units that received *Poor* star ratings for the adult population when compared to the national data and also scored significantly lower than the MCMC weighted average for the State Comparisons analysis:

- Anthem – Alameda
- Anthem – San Benito
- Health Net – Kern

There were four MCP reporting units that received *Poor* star ratings for the child population when compared to the national data and also scored significantly lower than the MCMC weighted average for the State Comparisons analysis:

- CCAH – Merced
- Health Net – Stanislaus
- Partnership – Northeast
- Partnership – Northwest

Improvement Strategies

Access to Care

MCPs should identify potential barriers for beneficiaries receiving appropriate access to care. Access to care issues include obtaining the care that the beneficiary and/or primary care provider deemed necessary, obtaining timely urgent care, locating a personal doctor, or receiving adequate assistance when calling a primary care provider office. MCPs should attempt to reduce any hindrances a beneficiary 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, MCPs can develop standardized protocols and scripts for common occurrences within the primary care provider office setting, such as late beneficiaries. With proactive policies and scripts in place, the late beneficiary can be notified the primary care provider has moved on to the next beneficiary and will work the late beneficiary into the rotation as time permits. This type of structure allows the late beneficiary to still receive care without causing delay in the appointments of other beneficiaries. 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.

Beneficiary and Family Engagement Advisory Councils

Since both beneficiaries and families have direct experience with an illness or health care system, their perspectives can provide significant insight when performing an evaluation of health care processes. Therefore, MCPs should consider creating opportunities and functional roles that include the beneficiaries and families who represent the populations they serve. Beneficiaries and family members could serve as advisory council members providing new perspectives and serving as a resource to health care processes. Beneficiary interviews on services received and family inclusion in care planning can be an effective strategy for involving beneficiaries 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 MCP and its beneficiaries. The councils' roles within an MCP 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-beneficiary relationship.

Rating of Personal Doctor

Measure Definition

MCMC beneficiaries 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."

National Comparisons

Table 5-8 and Table 5-9 show the adult and child three-point means and star ratings for Rating of Personal Doctor, respectively.

Table 5-8—Adult National Comparisons – Rating of Personal Doctor

Reporting Unit Name	Three-Point Mean	Star Rating
Anthem - San Benito	2.69	★★★★★+
Molina - Imperial	2.65	★★★★★+
Kaiser SoCal - San Diego	2.64	★★★★★
Gold Coast - Ventura	2.62	★★★★★
Health Net - Tulare	2.62	★★★★★+
Partnership - Southwest	2.60	★★★★★+
CalViva - Kings	2.59	★★★★★+
Health Net - San Diego	2.59	★★★★★+
CCHP - Contra Costa	2.58	★★★★★
Anthem - Region 1	2.56	★★★★+
HPSM - San Mateo	2.56	★★★★
Anthem - Kings	2.53	★★★★+
CHW - Imperial	2.53	★★★★+
CHG - San Diego	2.53	★★★★
Partnership - Southeast	2.53	★★★★+
CalOptima - Orange	2.51	★★★
CalViva - Madera	2.51	★★★+
Care1st - San Diego	2.49	★★
CCAH - Merced	2.49	★★+
CCAH - Monterey, Santa Cruz	2.49	★★
CenCal - Santa Barbara	2.48	★★
Kaiser NorCal - KP North	2.48	★★
L.A. Care - Los Angeles	2.48	★★
MCMC	**2.47**	★★
KFHC - Kern	2.47	★★
Partnership - Northwest	2.47	★★+
HPSJ - Stanislaus	2.46	★★+
AAH - Alameda	2.45	★★
Anthem - San Francisco	2.45	★★+
SFHP - San Francisco	2.45	★★
Health Net - Stanislaus	2.43	★★+

Reporting Unit Name	Three-Point Mean	Star Rating
SCFHP - Santa Clara	2.43	★★
Anthem - Tulare	2.42	★+
CenCal - San Luis Obispo	2.42	★+
Molina - San Diego	2.42	★
CalViva - Fresno	2.41	★
HPSJ - San Joaquin	2.41	★
Molina - Riverside, San Bernardino	2.40	★+
Anthem - Region 2	2.39	★+
IEHP - Riverside, San Bernardino	2.39	★
Partnership - Northeast	2.39	★+
Anthem - Contra Costa	2.38	★+
Anthem - Alameda	2.37	★+
Health Net - Los Angeles	2.37	★
Molina - Sacramento	2.35	★+
Anthem - Madera	2.33	★+
CHW - Region 2	2.33	★+
Anthem - Santa Clara	2.23	★+
CHW - Region 1	2.23	★+
Health Net - Sacramento	2.22	★+
Health Net - San Joaquin	2.22	★+
Anthem - Sacramento	2.21	★+
Health Net - Kern	2.17	★+
Anthem - Fresno	2.16	★+

+If the MCP had fewer than 100 respondents for a measure, caution should be exercised when evaluating the results.

Table 5-9—Child National Comparisons – Rating of Personal Doctor

Reporting Unit Name	Three-Point Mean	Star Rating
Kaiser NorCal - KP North	2.82	★★★★★
Anthem - Contra Costa	2.80	★★★★★+
CenCal - San Luis Obispo	2.79	★★★★★
Molina - San Diego	2.79	★★★★★
CHW - Imperial	2.78	★★★★★+
Health Net - Tulare	2.76	★★★★★+
Kaiser SoCal - San Diego	2.76	★★★★★
AAH - Alameda	2.73	★★★★★
CHG - San Diego	2.73	★★★★★
Partnership - Southwest	2.72	★★★★★
HPSM - San Mateo	2.70	★★★★★
SCFHP - Santa Clara	2.70	★★★★★
CalOptima - Orange	2.69	★★★★★
Partnership - Southeast	2.69	★★★★★
CCAH - Monterey, Santa Cruz	2.68	★★★★
Gold Coast - Ventura	2.68	★★★★
SFHP - San Francisco	2.68	★★★★
Anthem - Alameda	2.67	★★★★+
CCHP - Contra Costa	2.67	★★★★

Reporting Unit Name	Three-Point Mean	Star Rating
MCMC	**2.65**	★★★★
Anthem - Fresno	2.64	★★★+
CHW - Region 2	2.64	★★★+
Health Net - San Diego	2.64	★★★+
CenCal - Santa Barbara	2.63	★★★
Anthem - Tulare	2.62	★★★+
Anthem - Region 1	2.61	★★+
Care1st - San Diego	2.61	★★
Health Net - Los Angeles	2.60	★★
HPSJ - San Joaquin	2.60	★★
KFHC - Kern	2.60	★★
L.A. Care - Los Angeles	2.59	★★
Partnership - Northwest	2.58	★★+
Anthem - Region 2	2.57	★+
Anthem - San Francisco	2.57	★+
Anthem - Madera	2.55	★+
CalViva - Kings	2.55	★+
Health Net - Stanislaus	2.55	★+
CCAH - Merced	2.54	★+
CalViva - Madera	2.54	★+
Molina - Imperial	2.54	★+
CHW - Region 1	2.53	★+
Health Net - San Joaquin	2.53	★+
HPSJ - Stanislaus	2.51	★+
CalViva - Fresno	2.50	★
IEHP - Riverside, San Bernardino	2.50	★
Molina - Riverside, San Bernardino	2.50	★
Anthem - Kings	2.49	★+
Anthem - Santa Clara	2.49	★+
Anthem - San Benito	2.49	★+
Health Net - Sacramento	2.47	★+
Anthem - Sacramento	2.45	★+
Health Net - Kern	2.43	★+
Partnership - Northeast	2.33	★+
Molina - Sacramento	2.23	★+

+If the MCP had fewer than 100 respondents for a measure, caution should be exercised when evaluating the results.

State Comparisons

Figure 5-18 and Figure 5-19 show the adult and child State Comparisons for Rating of Personal Doctor, respectively.

Figure 5-18—Rating of Personal Doctor – Adult Top-Box Rates

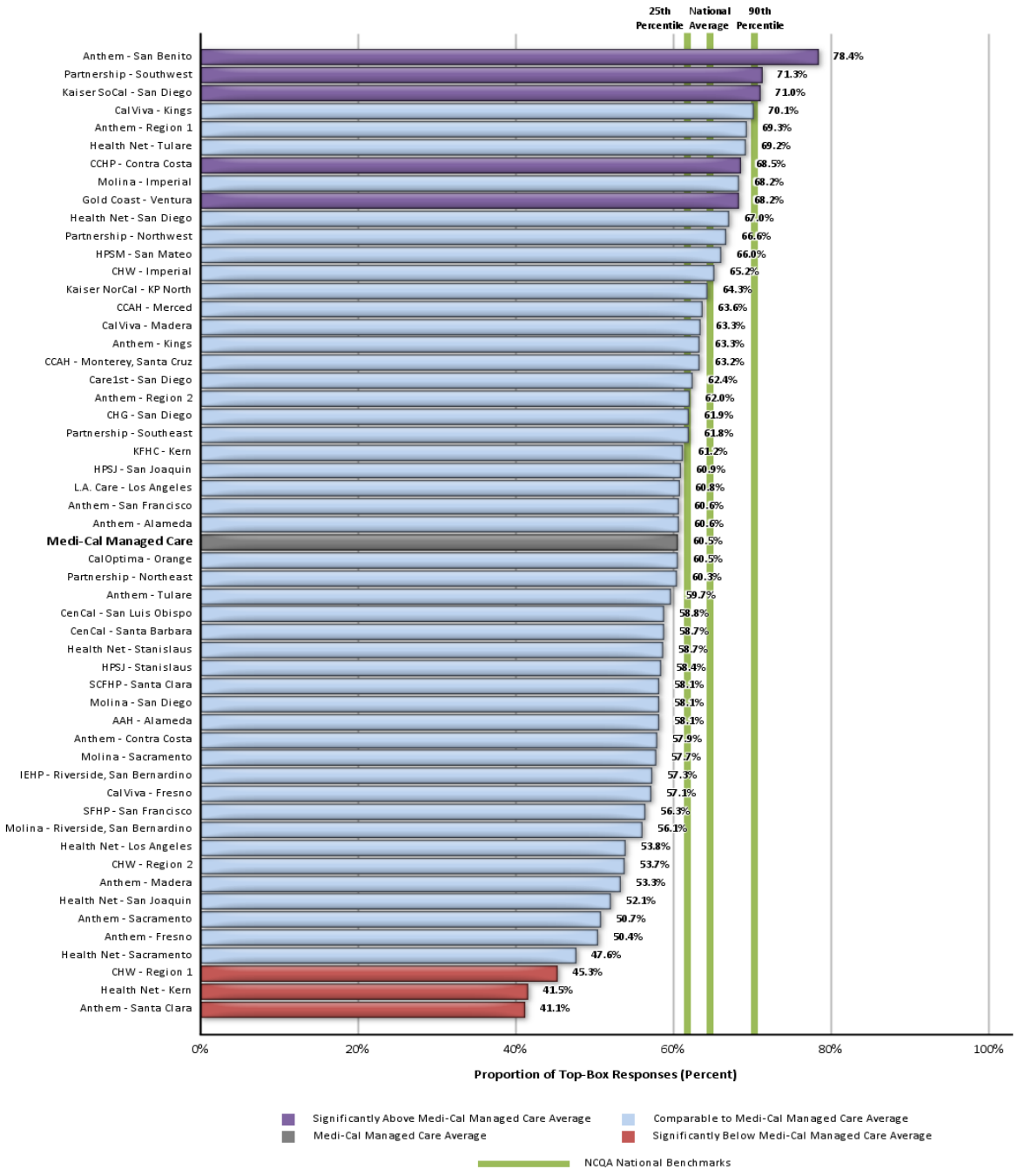
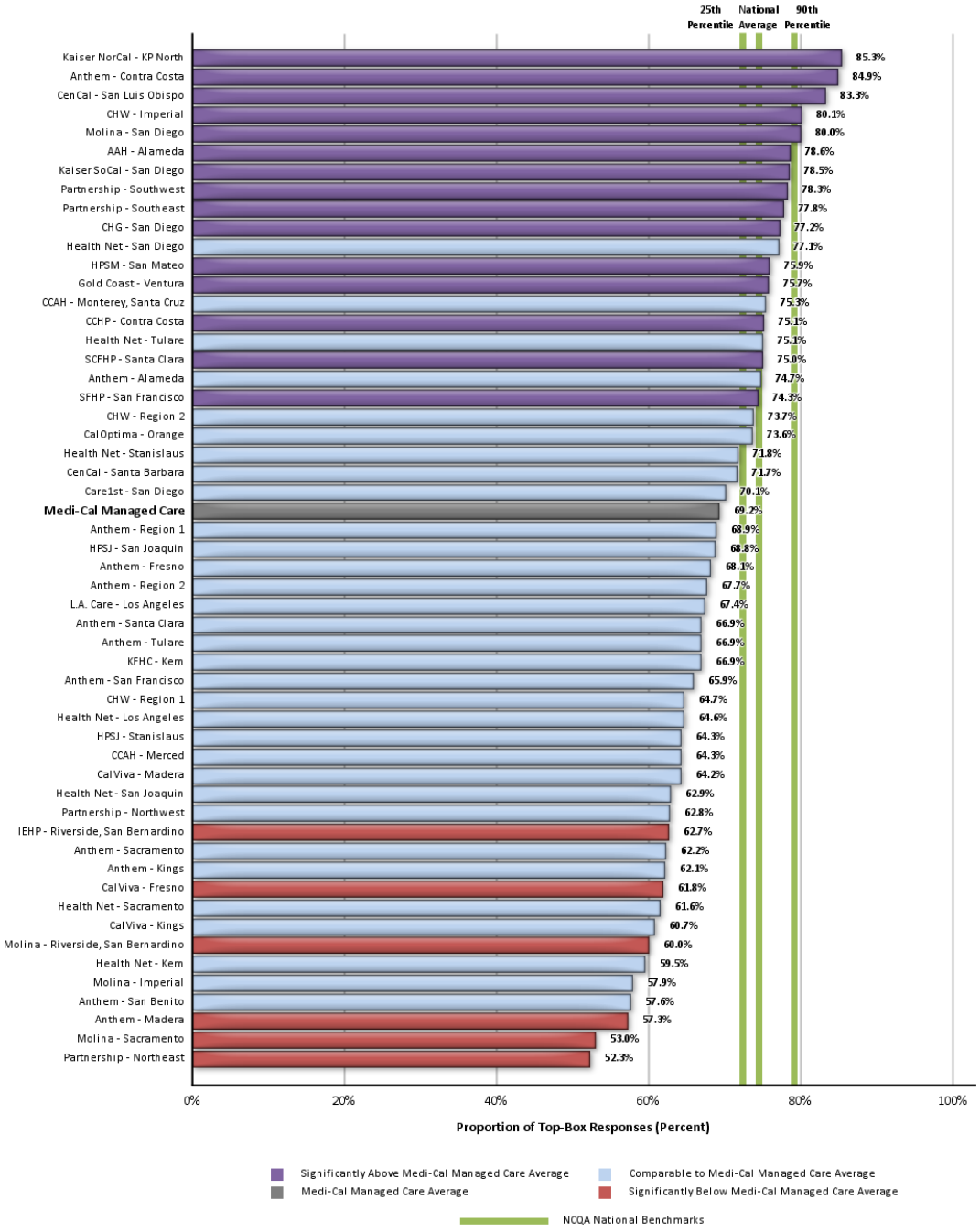


Figure 5-19—Rating of Personal Doctor – Child Top-Box Rates



Summary of Results

Caution: The majority of the reporting units had fewer than 100 respondents for **Rating of Personal Doctor**. According to NCQA's specifications, rates with fewer than 100 respondents are not reportable.

The MCMC's star ratings for **Rating of Personal Doctor** were *Fair* for the adult population and *Very Good* for the child population. For the National Comparisons, there were 22 out of 53 MCP reporting units for both the adult and child populations that demonstrated *Poor* performance for this measure. There were 15 MCP reporting units for the adult population and 19 MCP reporting units for the child population that had *Excellent* or *Very Good* star ratings for **Rating of Personal Doctor**.

There were five MCP reporting units that received *Excellent* star ratings for the adult population when compared to national data and also scored significantly higher than the MCMC weighted average for the State Comparisons analysis:

- Anthem – San Benito
- CCHP – Contra Costa
- Gold Coast – Ventura
- Kaiser SoCal – San Diego
- Partnership – Southwest

There were 12 MCP reporting units that received *Excellent* star ratings for the child population when compared to national data and also scored significantly higher than the MCMC weighted average for the State Comparisons analysis:

- AAH – Alameda
- Anthem – Contra Costa
- CenCal – San Luis Obispo
- CHG – San Diego
- CHW – Imperial
- HPSM – San Mateo
- Kaiser NorCal – KP North
- Kaiser SoCal – San Diego
- Molina – San Diego
- Partnership – Southeast
- Partnership – Southwest
- SCFHP – Santa Clara

There were three MCP reporting units that received *Poor* star ratings for the adult population when compared to the national data and also scored significantly lower than the MCMC weighted average for the State Comparisons analysis:

- Anthem – Santa Clara
- CHW – Region 1
- Health Net – Kern

There were six MCP reporting units that received *Poor* star ratings for the child population when compared to the national data and also scored significantly lower than the MCMC weighted average for the State Comparisons analysis:

- Anthem – Madera
- CalViva – Fresno
- IEHP – Riverside and San Bernardino
- Molina – Riverside and San Bernardino
- Molina – Sacramento
- Partnership – Northeast

Improvement Strategies

Direct Beneficiary Feedback

MCPs can explore additional methods for obtaining direct beneficiary feedback to improve beneficiary satisfaction, such as comment cards. Comment cards have been utilized and found to be a simple method for engaging beneficiaries and obtaining rapid feedback on their recent primary care provider office visit experiences. MCPs can assist in this process by developing comment cards that primary care provider office staff can provide to beneficiaries following their visit. Comment cards can be provided to beneficiaries with their office visit discharge paperwork, via postal mail, or via email. Asking beneficiaries 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 primary care provider's office to a friend?" greatly predicts overall beneficiary 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.

Primary Care Provider-Beneficiary Communication

MCPs should encourage primary care provider-beneficiary communication to improve beneficiary satisfaction and outcomes. Indicators of good primary care provider-beneficiary communication include providing clear explanations, listening carefully, and being understanding of beneficiaries' perspectives. MCPs can also create specialized workshops focused on enhancing primary care providers' communication skills, relationship building, and the importance of primary care provider-beneficiary communication. Training sessions can include topics such as improving listening techniques, beneficiary-centered interviewing skills, collaborative communication which involves allowing the beneficiary 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 primary care provider-beneficiary communication. Examples of effective tools include visual medication schedules and the "Teach Back" method, which has beneficiaries communicate back the information the primary care provider has provided.

Improving Shared Decision Making

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

Rating of Specialist Seen Most Often

Measure Definition

MCMC beneficiaries were asked to rate the specialist seen most often on a scale of 0 to 10, with 0 being the "worst specialist possible" and 10 being the "best specialist possible."

National Comparisons

Table 5-10 and Table 5-11 show the adult and child star ratings for Rating of Specialist Seen Most Often, respectively.

Table 5-10—Adult National Comparisons – Rating of Specialist Seen Most Often

Reporting Unit Name	Three-Point Mean	Star Rating
Health Net - San Diego	2.80	★★★★★+
CCAH - Merced	2.71	★★★★★+
Kaiser SoCal - San Diego	2.71	★★★★★
CenCal - San Luis Obispo	2.69	★★★★★+
HPSM - San Mateo	2.66	★★★★★+
Kaiser NorCal - KP North	2.66	★★★★★
CHW - Imperial	2.62	★★★★★+
CenCal - Santa Barbara	2.58	★★★★+
HPSJ - San Joaquin	2.58	★★★★+
CCHP - Contra Costa	2.57	★★★★+
Health Net - San Joaquin	2.57	★★★★+
SCFHP - Santa Clara	2.57	★★★★
Gold Coast - Ventura	2.54	★★★
Care1st - San Diego	2.53	★★★
Molina - Imperial	2.53	★★★+
Partnership - Northeast	2.53	★★★+
Health Net - Stanislaus	2.52	★★★+
Health Net - Tulare	2.52	★★★+
MCMC	**2.51**	**★★★**
CalViva - Kings	2.51	★★★+
Health Net - Los Angeles	2.51	★★★+
IEHP - Riverside, San Bernardino	2.51	★★★
CalOptima - Orange	2.50	★★
CCAH - Monterey, Santa Cruz	2.49	★★+
CHG - San Diego	2.49	★★
KFHC - Kern	2.49	★★+
CalViva - Madera	2.48	★★+
AAH - Alameda	2.47	★
Anthem - Kings	2.47	★+
Molina - Riverside, San Bernardino	2.47	★+
Anthem - Santa Clara	2.46	★+

Reporting Unit Name	Three-Point Mean	Star Rating
Molina - San Diego	2.46	★+
Anthem - Madera	2.45	★+
Health Net - Kern	2.45	★+
Partnership - Southeast	2.45	★+
Anthem - Region 1	2.43	★+
Anthem - Contra Costa	2.42	★+
L.A. Care - Los Angeles	2.42	★+
SFHP - San Francisco	2.42	★+
Anthem - Region 2	2.41	★+
CalViva - Fresno	2.39	★+
Health Net - Sacramento	2.39	★+
Anthem - Sacramento	2.38	★+
CHW - Region 2	2.37	★+
HPSJ - Stanislaus	2.36	★+
Partnership - Northwest	2.36	★+
Anthem - San Benito	2.35	★+
Anthem - Fresno	2.32	★+
Partnership - Southwest	2.32	★+
CHW - Region 1	2.31	★+
Anthem - San Francisco	2.27	★+
Anthem - Alameda	2.23	★+
Anthem - Tulare	2.22	★+
Molina - Sacramento	2.22	★+

+If the MCP had fewer than 100 respondents for a measure, caution should be exercised when evaluating the results.

Table 5-11—Child National Comparisons – Rating of Specialist Seen Most Often

Reporting Unit Name	Three-Point Mean	Star Rating
HPSJ - Stanislaus	2.92	★★★★★+
CalViva - Kings	2.82	★★★★★+
CCAH - Monterey, Santa Cruz	2.81	★★★★★+
Kaiser NorCal - KP North	2.79	★★★★★+
Anthem - Alameda	2.77	★★★★★+
Anthem - Contra Costa	2.77	★★★★★+
Anthem - Sacramento	2.77	★★★★★+
Partnership - Northwest	2.75	★★★★★+
Partnership - Southwest	2.75	★★★★★+
CCHP - Contra Costa	2.72	★★★★★+
Kaiser SoCal - San Diego	2.72	★★★★★+
AAH - Alameda	2.70	★★★★★+
Care1st - San Diego	2.69	★★★★★+
CHW - Imperial	2.68	★★★★★+
Partnership - Southeast	2.68	★★★★★+
Anthem - San Benito	2.67	★★★★★+
CenCal - San Luis Obispo	2.67	★★★★★+
KFHC - Kern	2.67	★★★★★+

Reporting Unit Name	Three-Point Mean	Star Rating
SFHP - San Francisco	2.66	★★★★★+
MCMC	**2.65**	**★★★★**
CHG - San Diego	2.65	★★★★+
HPSM - San Mateo	2.64	★★★★+
Molina - Riverside, San Bernardino	2.64	★★★★+
SCFHP - Santa Clara	2.64	★★★★+
Gold Coast - Ventura	2.63	★★★★+
L.A. Care - Los Angeles	2.63	★★★★+
IEHP - Riverside, San Bernardino	2.61	★★★+
Anthem - Region 2	2.60	★★★+
CalOptima - Orange	2.59	★★★+
Molina - San Diego	2.58	★★+
Anthem - Santa Clara	2.57	★★+
CHW - Region 1	2.56	★★+
CCAH - Merced	2.55	★★+
Health Net - Los Angeles	2.55	★★+
Anthem - Region 1	2.54	★★+
CHW - Region 2	2.53	★★+
CalViva - Fresno	2.53	★★+
Health Net - San Diego	2.53	★★+
CenCal - Santa Barbara	2.51	★+
Anthem - Tulare	2.50	★+
Health Net - Kern	2.50	★+
CalViva - Madera	2.36	★+
HPSJ - San Joaquin	2.32	★+
Anthem - Fresno	S	S
Anthem - Kings	S	S
Anthem - Madera	S	S
Anthem - San Francisco	S	S
Health Net - Sacramento	S	S
Health Net - San Joaquin	S	S
Health Net - Stanislaus	S	S
Health Net - Tulare	S	S
Molina - Imperial	S	S
Molina - Sacramento	S	S
Partnership - Northeast	S	S

+If the MCP had fewer than 100 respondents for a measure, caution should be exercised when evaluating the results.
S = Indicates the MCP had fewer than 11 cases in the numerator for this measure; therefore, DHCS suppressed displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

State Comparisons

Figure 5-20 and Figure 5-21 show the adult and child State Comparisons for Rating of Specialist Seen Most Often, respectively.

Figure 5-20—Rating of Specialist Seen Most Often – Adult Top-Box Rates

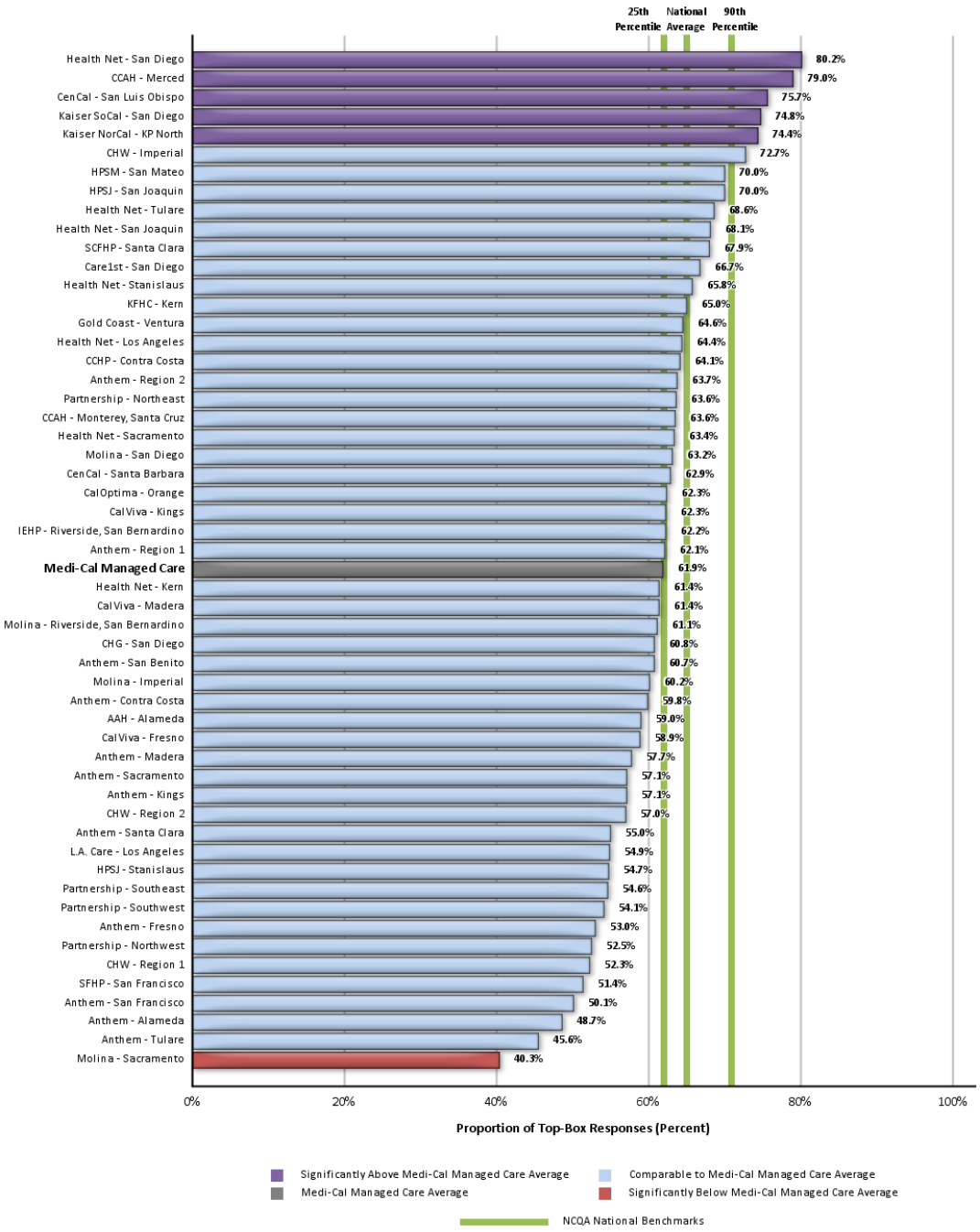
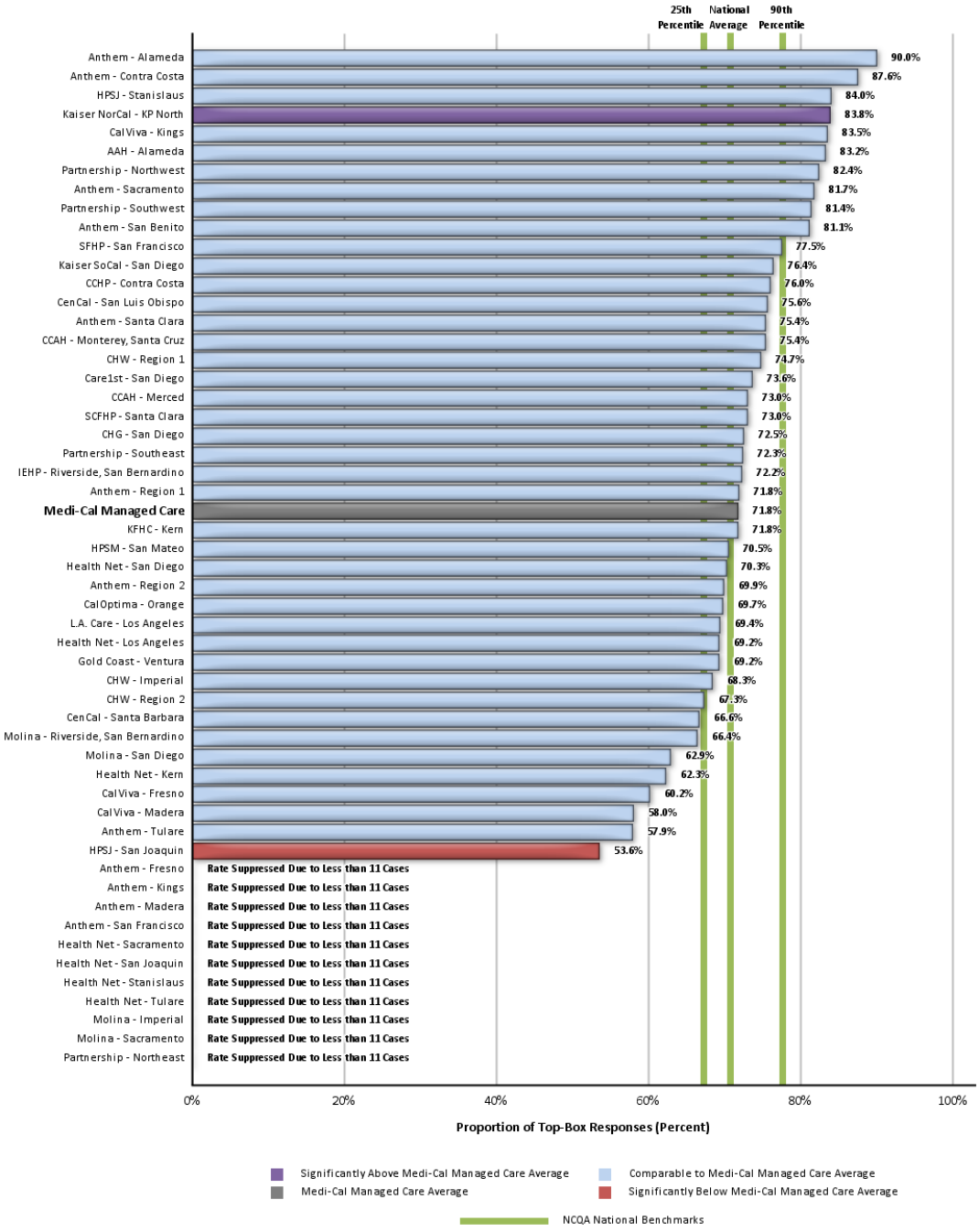


Figure 5-21—Rating of Specialist Seen Most Often – Child Top-Box Rates



Summary of Results

Caution: The majority of the reporting units had fewer than 100 respondents for **Rating of Specialist Seen Most Often**. According to NCQA's specifications, rates with fewer than 100 respondents are not reportable.

The MCMC's star rating for **Rating of Specialist Seen Most Often** was *Good* for the adult population and *Very Good* for the child population. For the National Comparisons, 27 out of 53 MCP reporting units for the adult population and five out of 42 MCP reporting units for the child population demonstrated *Poor* performance for this measure. There were 12 MCP reporting units for the adult population and 25 MCP reporting units for the child population that had star ratings of *Excellent* or *Very Good* for **Rating of Specialist Seen Most Often**.

There were five MCP reporting units that received *Excellent* star ratings for the adult population when compared to national data and also scored significantly higher than the MCMC weighted average for the State Comparisons analysis:

- CCAH – Merced
- CenCal – San Luis Obispo
- Health Net – San Diego
- Kaiser NorCal – KP North
- Kaiser SoCal – San Diego

There was one MCP reporting unit that received an *Excellent* star rating for the child population when compared to national data and also scored significantly higher than the MCMC weighted average for the State Comparisons analysis:

- Kaiser NorCal – KP North

There was one MCP reporting unit that received a *Poor* star rating for the adult population when compared to the national data and also scored significantly lower than the MCMC weighted average for the State Comparisons analysis:

- Molina – Sacramento

There was one MCP reporting unit that received a *Poor* star rating for the child population when compared to the national data and also scored significantly lower than the MCMC weighted average for the State Comparisons analysis:

- HPSJ – San Joaquin

Improvement Strategies

Planned Visit Management

MCPs should work with providers to encourage the implementation of systems that enhance the efficiency and effectiveness of specialist care. For example, by identifying beneficiaries with chronic conditions who have routine appointments, a reminder system could be implemented to ensure that these beneficiaries are receiving the appropriate attention at the appropriate time. This triggering system could be used by staff to prompt general follow-up contacts or specific interactions with beneficiaries 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 beneficiaries could be scheduled within the reminder system to ensure beneficiaries understood all information provided to them and/or to address any questions they may have.

Skills Training for Specialists

MCPs can create specialized workshops or seminars that focus on training specialists in the skills they need to effectively communicate with beneficiaries to improve provider-beneficiary communication. Training seminars can include sessions for improving communication skills with different cultures and handling challenging beneficiary encounters. In addition, workshops can use case studies to illustrate the importance of communicating with beneficiaries and offer insight into specialists' roles as both managers of care and educators of beneficiaries. By establishing skills training for specialists, MCPs can not only improve the quality of care delivered to its beneficiaries but also their potential health outcomes.

Telemedicine

MCPs 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 beneficiaries in varying locations. Telemedicine, such as live interactive videoconferencing, allows providers to offer care from a remote location. Specialists located in urban settings can diagnose and treat beneficiaries in communities where there is a shortage of specialists. Telemedicine consultation models allow for the local provider to both present the beneficiary 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 beneficiary is receiving.

Getting Needed Care

Measure Definition

Two questions (Questions 14 and 25 in the CAHPS Adult Medicaid Health Plan Survey and Questions 14 and 28 in the CAHPS Child Medicaid Health Plan Survey) were asked to assess how often it was easy to get needed care.

Survey Questions

Adult Survey

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

- Never
- Sometimes
- Usually
- Always

Question 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

Child Survey

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

- Never
- Sometimes
- Usually
- Always

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

- Never
- Sometimes
- Usually
- Always

National Comparisons

Table 5-12 and Table 5-13 show the adult and child three-point means and star ratings for Getting Needed Care, respectively.

Table 5-12—Adult National Comparisons – Getting Needed Care

Reporting Unit Name	Three-Point Mean	Star Rating
Kaiser NorCal - KP North	2.51	★★★★★
Kaiser SoCal - San Diego	2.46	★★★★★
Health Net - San Diego	2.45	★★★★★+
Health Net - Tulare	2.38	★★★+
CHW - Imperial	2.32	★★+
CenCal - Santa Barbara	2.31	★★
Partnership - Northeast	2.29	★+
CalOptima - Orange	2.26	★
CenCal - San Luis Obispo	2.26	★+
CCAH - Monterey, Santa Cruz	2.25	★+
Gold Coast - Ventura	2.25	★
IEHP - Riverside, San Bernardino	2.24	★
L.A. Care - Los Angeles	2.24	★
Anthem - Kings	2.23	★+
HPSM - San Mateo	2.23	★
Partnership - Southeast	2.23	★+
CCAH - Merced	2.22	★+
HPSJ - San Joaquin	2.22	★
KFHC - Kern	2.22	★
Molina - Imperial	2.22	★+
MCMC	**2.21**	★
Anthem - Madera	2.21	★+
CalViva - Fresno	2.21	★
Molina - San Diego	2.21	★+
Anthem - Tulare	2.20	★+
CHW - Region 2	2.20	★+
CalViva - Kings	2.20	★+
CHG - San Diego	2.19	★
CCHP - Contra Costa	2.19	★
Partnership - Northwest	2.19	★+

Reporting Unit Name	Three-Point Mean	Star Rating
Care1st - San Diego	2.18	★
Anthem - Region 1	2.17	★+
Health Net - Kern	2.17	★+
Anthem - San Francisco	2.16	★+
CalViva - Madera	2.15	★+
Molina - Riverside, San Bernardino	2.15	★+
Anthem - Region 2	2.13	★+
AAH - Alameda	2.12	★
Partnership - Southwest	2.10	★+
Health Net - Los Angeles	2.09	★+
SCFHP - Santa Clara	2.09	★
CHW - Region 1	2.08	★+
Health Net - Stanislaus	2.08	★+
SFHP - San Francisco	2.07	★
HPSJ - Stanislaus	2.03	★+
Anthem - Contra Costa	2.02	★+
Molina - Sacramento	2.02	★+
Anthem - San Benito	1.99	★+
Anthem - Sacramento	1.97	★+
Anthem - Fresno	1.95	★+
Health Net - Sacramento	1.95	★+
Health Net - San Joaquin	1.92	★+
Anthem - Alameda	1.91	★+
Anthem - Santa Clara	1.76	★+

+If the MCP had fewer than 100 respondents for a measure, caution should be exercised when evaluating the results.

Table 5-13—Child National Comparisons – Getting Needed Care

Reporting Unit Name	Three-Point Mean	Star Rating
Kaiser NorCal - KP North	2.66	★★★★★
Health Net - San Joaquin	2.65	★★★★★+
Anthem - Fresno	2.51	★★★+
CalViva - Kings	2.50	★★★+
Health Net - Tulare	2.50	★★★+
Kaiser SoCal - San Diego	2.49	★★★
Partnership - Southwest	2.46	★★+
Anthem - San Francisco	2.45	★★+
CCHP - Contra Costa	2.40	★★
Anthem - Alameda	2.39	★★+
Anthem - Madera	2.39	★★+
CHW - Imperial	2.37	★+
SCFHP - Santa Clara	2.36	★
Anthem - Kings	2.34	★+
HPSJ - Stanislaus	2.34	★+
Partnership - Southeast	2.34	★+
Anthem - San Benito	2.32	★+
Molina - San Diego	2.31	★+

Reporting Unit Name	Three-Point Mean	Star Rating
CenCal - San Luis Obispo	2.30	★+
Partnership - Northwest	2.30	★+
MCMC	**2.29**	★
AAH - Alameda	2.29	★
Anthem - Contra Costa	2.29	★+
Anthem - Santa Clara	2.29	★+
CenCal - Santa Barbara	2.29	★
CHW - Region 2	2.29	★+
CHW - Region 1	2.28	★+
CHG - San Diego	2.28	★
HPSM - San Mateo	2.28	★
Molina - Riverside, San Bernardino	2.28	★+
CalViva - Fresno	2.26	★
CalOptima - Orange	2.25	★
IEHP - Riverside, San Bernardino	2.25	★
SFHP - San Francisco	2.25	★
Health Net - San Diego	2.24	★+
KFHC - Kern	2.24	★
CCAH - Monterey, Santa Cruz	2.23	★
Health Net - Kern	2.23	★+
Anthem - Region 2	2.22	★+
Anthem - Tulare	2.22	★+
Care1st - San Diego	2.22	★
Anthem - Region 1	2.21	★+
HPSJ - San Joaquin	2.21	★
L.A. Care - Los Angeles	2.21	★
Gold Coast - Ventura	2.20	★
Molina - Imperial	2.18	★+
Health Net - Los Angeles	2.15	★
Health Net - Stanislaus	2.14	★+
CalViva - Madera	2.10	★+
Partnership - Northeast	2.08	★+
CCAH - Merced	2.05	★+
Anthem - Sacramento	1.98	★+
Health Net - Sacramento	1.95	★+
Molina - Sacramento	1.93	★+

+If the MCP had fewer than 100 respondents for a measure, caution should be exercised when evaluating the results.

State Comparisons

Figure 5-22 and Figure 5-23 show the adult and child State Comparisons for Getting Needed Care, respectively.

Figure 5-22—Getting Needed Care – Adult Top-Box Rates

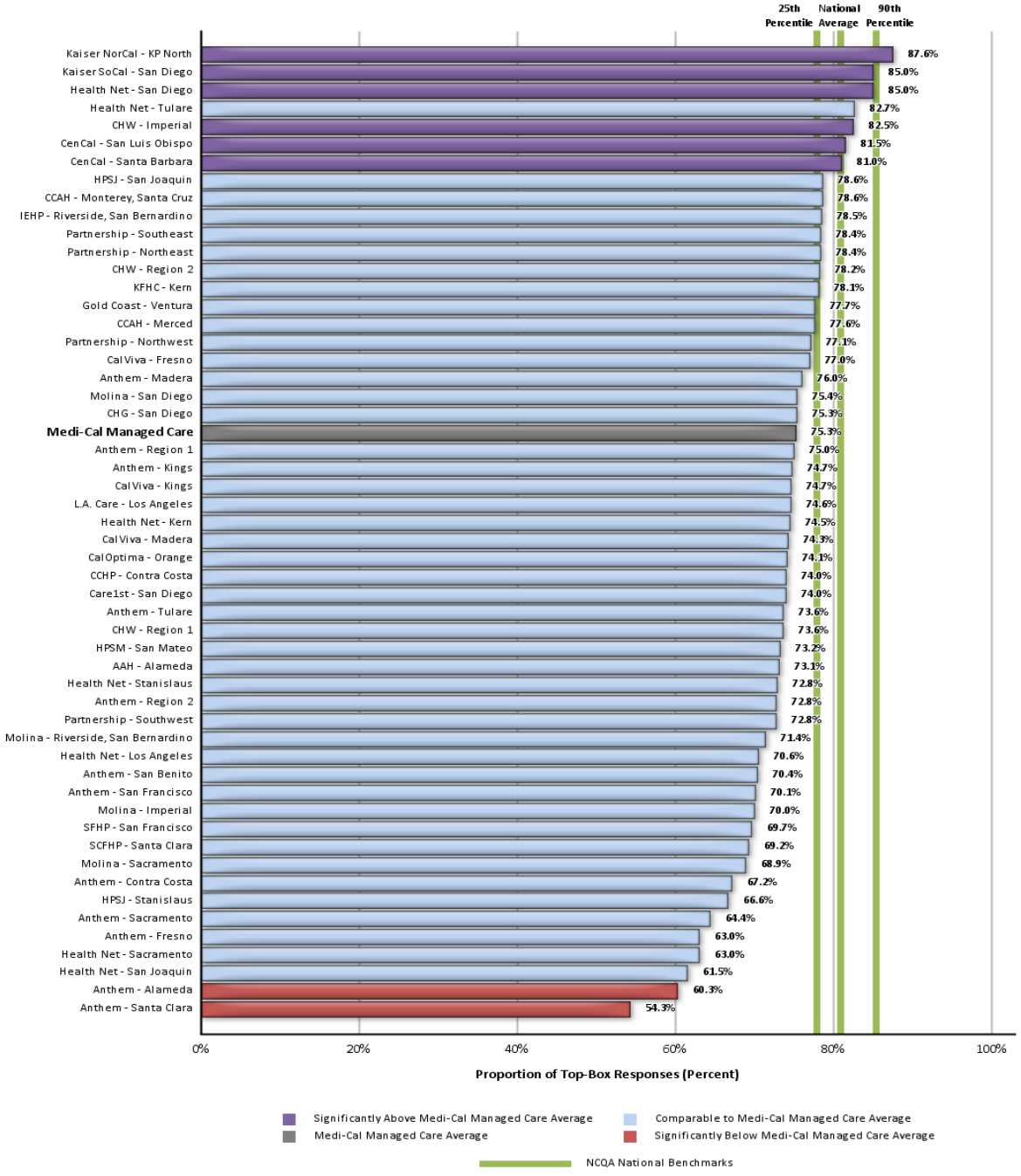
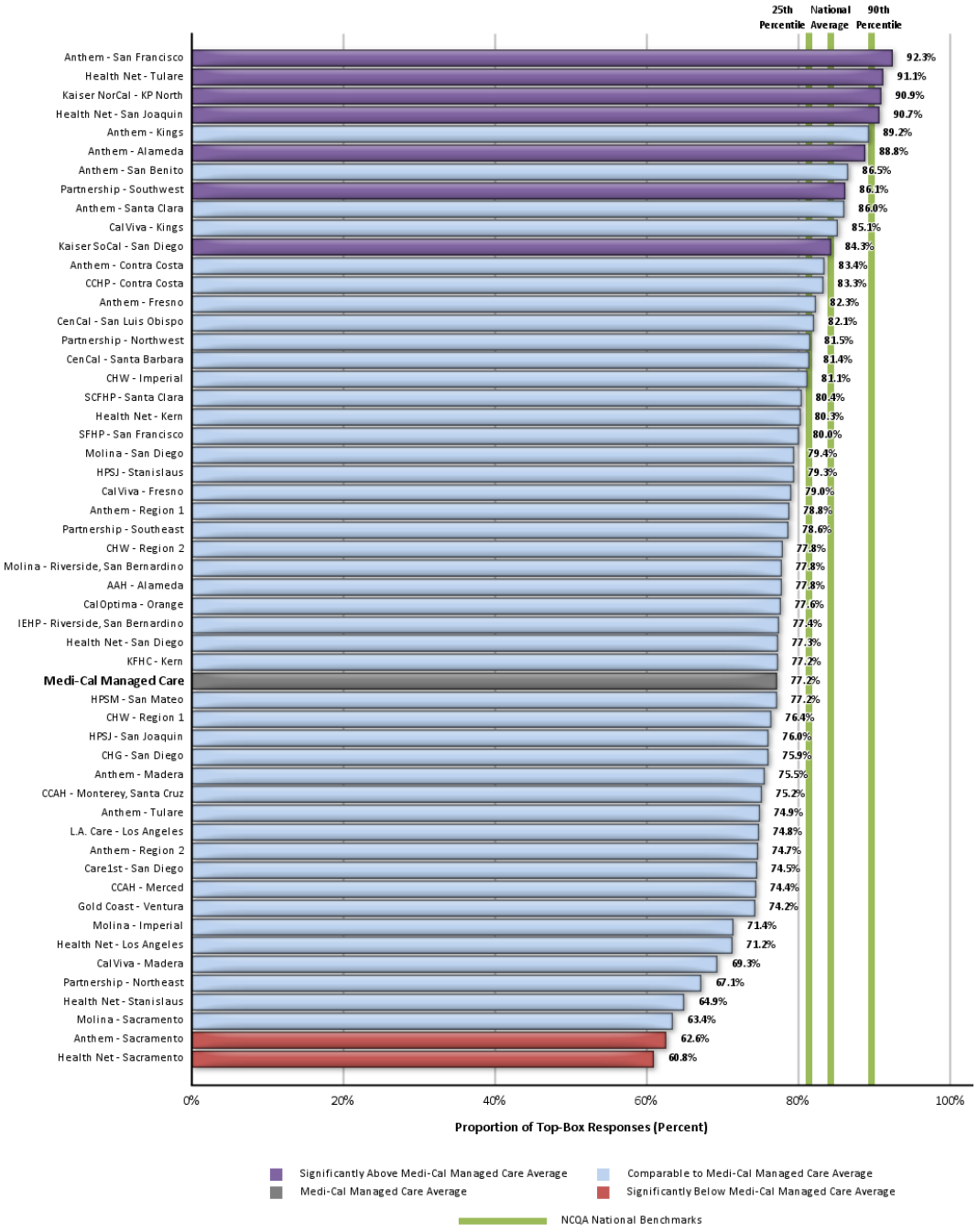


Figure 5-23—Getting Needed Care – Child Top-Box Rates



Summary of Results

Caution: The majority of the reporting units had fewer than 100 respondents for **Getting Needed Care**. According to NCQA's specifications, rates with fewer than 100 respondents are not reportable.

The MCMC's star ratings for **Getting Needed Care** were *Poor* for both the adult and child populations. For the National Comparisons, 47 out of 53 MCP reporting units for the adult population and 42 out of 53 MCP reporting units for the child population demonstrated *Poor* performance for this measure. There were three MCP reporting units for the adult population and two MCP reporting units for the child population that had star ratings of *Excellent* for **Getting Needed Care**.

There were three MCP reporting units that demonstrated *Excellent* performance for the adult population when compared to national data and also scored significantly higher than the MCMC weighted average for the State Comparisons analysis:

- Health Net – San Diego
- Kaiser NorCal – KP North
- Kaiser SoCal – San Diego

There were two MCP reporting units that demonstrated *Excellent* performance for the child population when compared to national data and also scored significantly higher than the MCMC weighted average for the State Comparisons analysis:

- Health Net – San Joaquin
- Kaiser NorCal – KP North

There were two MCP reporting units that had star ratings indicating *Poor* performance for the adult population when compared to the national data and also scored significantly lower than the MCMC weighted average for the State Comparisons analysis:

- Anthem – Alameda
- Anthem – Santa Clara

There were two MCP reporting units that had star ratings indicating *Poor* performance for the child population when compared to the national data and also scored significantly lower than the MCMC weighted average for the State Comparisons analysis:

- Anthem – Sacramento
- Health Net – Sacramento

Improvement Strategies

Appropriate Health Care Providers

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

Interactive Workshops

MCPs should engage in promoting health education, health literacy, and preventive health care amongst their membership. Increasing beneficiaries' health literacy and general understanding of their health care needs can result in improved health. MCPs 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 MCPs in promoting beneficiary health awareness and preventive health care efforts.

Language Concordance Programs

MCPs should make an effort to match beneficiaries with providers who speak their preferred languages. Recruiting bilingual providers is important since such providers typically are not readily available. Matching beneficiaries to providers who speak their languages can significantly improve the health care experience and quality of care for beneficiaries. Beneficiaries who can communicate with their provider 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 providers, beneficiaries with limited English proficiency can schedule more frequent visits with their providers and are better able to manage health conditions.

Getting Care Quickly

Measure Definition

Two questions (Questions 4 and 6 in the CAHPS Adult and Child Medicaid Health Plan Surveys) were asked to assess how often beneficiaries received care quickly.

Survey Questions

Adult Survey

Question 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

Question 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

Child Survey

Question 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

Question 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

National Comparisons

Table 5-14 and Table 5-15 show the adult and child three-point means and star ratings for Getting Care Quickly, respectively.

Table 5-14—Adult National Comparisons – Getting Care Quickly

Reporting Unit Name	Three-Point Mean	Star Rating
Kaiser NorCal - KP North	2.51	★★★★★
Kaiser SoCal - San Diego	2.45	★★★
Health Net - San Diego	2.41	★★+
Molina - Imperial	2.38	★★+
Anthem - Madera	2.37	★★+
Care1st - San Diego	2.34	★
Anthem - Region 1	2.32	★+
Partnership - Northwest	2.30	★+
CalViva - Fresno	2.28	★
CHW - Imperial	2.27	★+
CCHP - Contra Costa	2.26	★
Anthem - Region 2	2.25	★+
Gold Coast - Ventura	2.25	★
Partnership - Northeast	2.25	★+
Anthem - Tulare	2.24	★+
IEHP - Riverside, San Bernardino	2.24	★
Molina - San Diego	2.24	★+
CalViva - Madera	2.23	★+
CenCal - Santa Barbara	2.22	★
Health Net - Tulare	2.22	★+
Partnership - Southwest	2.22	★+
MCMC	**2.21**	★
AAH - Alameda	2.21	★
CHW - Region 1	2.21	★+
CHW - Region 2	2.21	★+
HPSJ - Stanislaus	2.21	★+
L.A. Care - Los Angeles	2.21	★
KFHC - Kern	2.20	★
Molina - Riverside, San Bernardino	2.20	★+
CCAH - Monterey, Santa Cruz	2.19	★+
HPSJ - San Joaquin	2.19	★
Molina - Sacramento	2.19	★+
Partnership - Southeast	2.18	★+
CalViva - Kings	2.17	★+
Health Net - Stanislaus	2.17	★+
CHG - San Diego	2.16	★
Anthem - Kings	2.15	★+
HPSM - San Mateo	2.14	★
Anthem - Alameda	2.13	★+
CenCal - San Luis Obispo	2.13	★+

Reporting Unit Name	Three-Point Mean	Star Rating
CalOptima - Orange	2.12	★
CCAH - Merced	2.11	★+
Anthem - Sacramento	2.09	★+
SFHP - San Francisco	2.08	★
Anthem - San Benito	2.07	★+
SCFHP - Santa Clara	2.04	★
Health Net - Kern	2.03	★+
Anthem - Fresno	2.02	★+
Anthem - San Francisco	2.01	★+
Health Net - Los Angeles	2.01	★+
Anthem - Contra Costa	1.95	★+
Health Net - San Joaquin	1.94	★+
Health Net - Sacramento	1.93	★+
Anthem - Santa Clara	1.92	★+

+If the MCP had fewer than 100 respondents for a measure, caution should be exercised when evaluating the results.

Table 5-15—Child National Comparisons – Getting Care Quickly

Reporting Unit Name	Three-Point Mean	Star Rating
Kaiser NorCal - KP North	2.75	★★★★★
Anthem - Fresno	2.71	★★★★★+
Health Net - San Diego	2.70	★★★★★+
Kaiser SoCal - San Diego	2.60	★★
Health Net - Tulare	2.57	★★+
Anthem - Region 2	2.53	★+
Partnership - Northwest	2.53	★+
Anthem - Alameda	2.52	★+
Anthem - Tulare	2.50	★+
CHW - Region 2	2.50	★+
Health Net - San Joaquin	2.50	★+
CenCal - San Luis Obispo	2.49	★+
CalViva - Fresno	2.49	★
Partnership - Southwest	2.49	★+
CHW - Region 1	2.48	★+
Molina - Riverside, San Bernardino	2.48	★+
CalOptima - Orange	2.45	★
SCFHP - Santa Clara	2.45	★
Molina - San Diego	2.43	★+
Anthem - Kings	2.40	★+
L.A. Care - Los Angeles	2.40	★
Partnership - Southeast	2.40	★+
MCMC	**2.39**	★
CHW - Imperial	2.39	★+
Anthem - Madera	2.38	★+
Molina - Imperial	2.38	★+
AAH - Alameda	2.37	★

Reporting Unit Name	Three-Point Mean	Star Rating
Anthem - San Francisco	2.37	★+
CCHP - Contra Costa	2.37	★
KFHC - Kern	2.37	★
Anthem - Contra Costa	2.35	★+
CalViva - Madera	2.35	★+
HPSM - San Mateo	2.35	★
IEHP - Riverside, San Bernardino	2.34	★
Anthem - Santa Clara	2.33	★+
CHG - San Diego	2.33	★
CalViva - Kings	2.33	★+
Anthem - San Benito	2.32	★+
Care1st - San Diego	2.32	★
CenCal - Santa Barbara	2.32	★
HPSJ - San Joaquin	2.31	★
Anthem - Region 1	2.28	★+
CCAH - Monterey, Santa Cruz	2.28	★
HPSJ - Stanislaus	2.28	★+
Partnership - Northeast	2.28	★+
SFHP - San Francisco	2.27	★
Health Net - Los Angeles	2.26	★
Gold Coast - Ventura	2.25	★
Health Net - Kern	2.25	★+
CCAH - Merced	2.24	★+
Health Net - Sacramento	2.20	★+
Anthem - Sacramento	2.16	★+
Health Net - Stanislaus	2.01	★+
Molina - Sacramento	1.75	★+

+If the MCP had fewer than 100 respondents for a measure, caution should be exercised when evaluating the results.

State Comparisons

Figure 5-24 and Figure 5-25 show the adult and child State Comparisons for Getting Care Quickly, respectively.

Figure 5-24—Getting Care Quickly – Adult Top-Box Rates

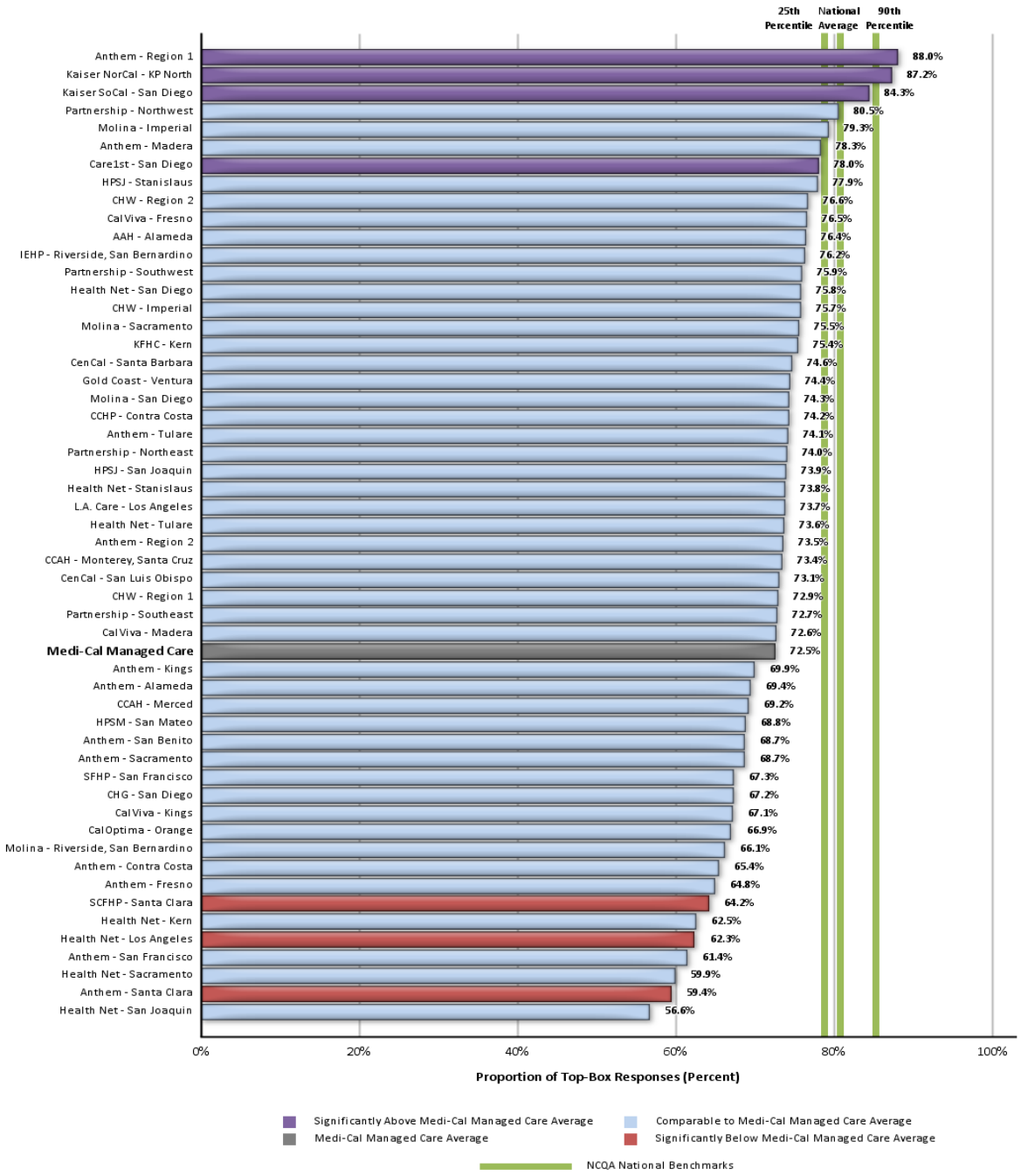
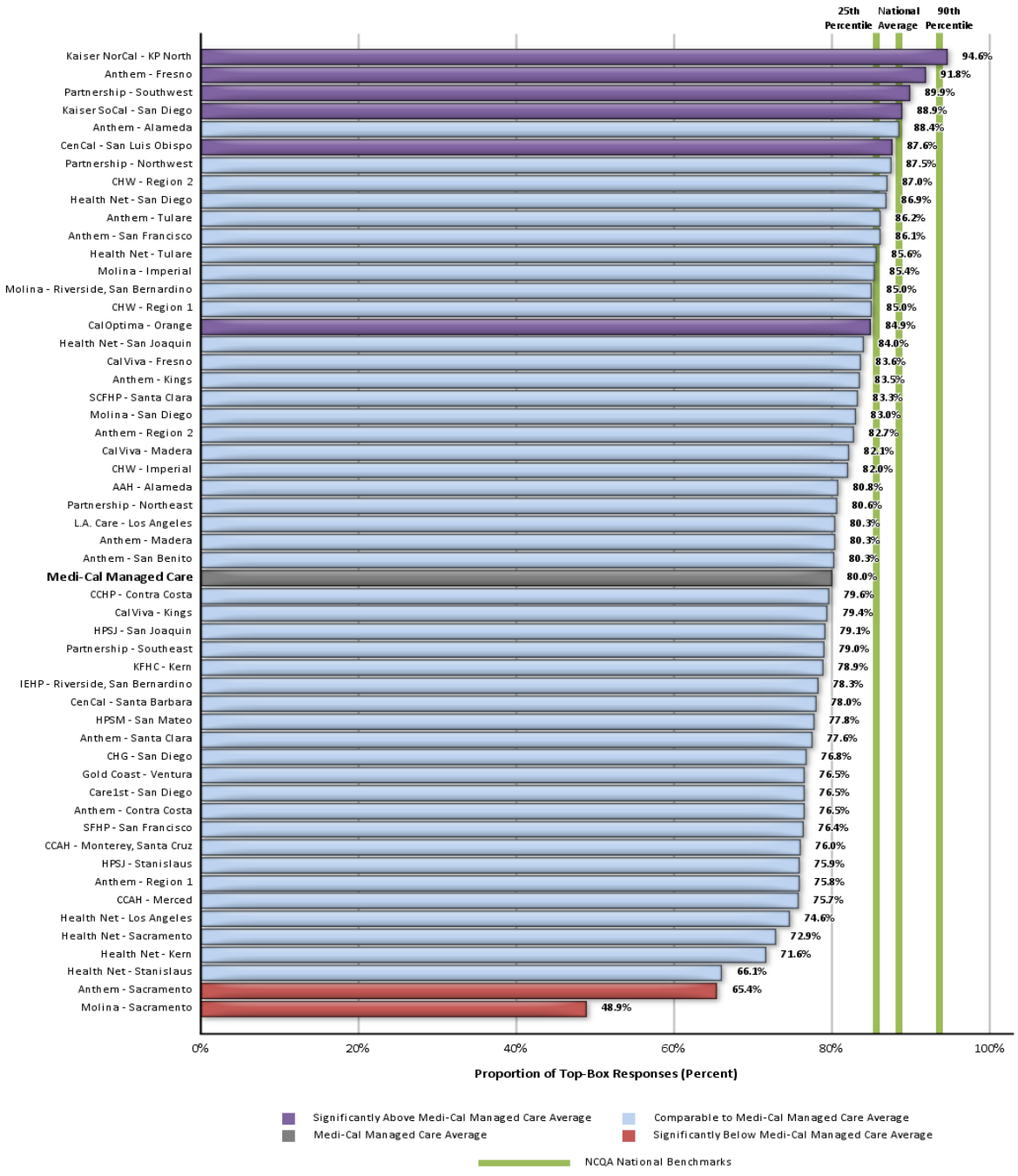


Figure 5-25—Getting Care Quickly – Child Top-Box Rates



Summary of Results

Caution: The majority of the reporting units had fewer than 100 respondents for **Getting Care Quickly**. According to NCQA's specifications, rates with fewer than 100 respondents are not reportable.

The MCMC's star ratings for **Getting Care Quickly** were *Poor* for both the adult and child populations. For the National Comparisons, 48 out of 53 MCP reporting units demonstrated *Poor* performance for both the adult and child populations for this measure. There was one MCP reporting unit for the adult population and three MCP reporting units for the child population that had star ratings of *Excellent* for **Getting Care Quickly**.

There was one MCP reporting unit that had a star rating that indicated *Excellent* performance for the adult population when compared to national data and also scored significantly higher than the MCMC weighted average for the State Comparisons analysis:

- Kaiser NorCal – KP North

There were two MCP reporting units that had star ratings that indicated *Excellent* performance for the child population when compared to national data and also scored significantly higher than the MCMC weighted average for the State Comparisons analysis:

- Anthem – Fresno
- Kaiser NorCal – KP North

There were three MCP reporting units that had star ratings that indicated *Poor* performance for the adult population when compared to the national data and also scored significantly lower than the MCMC weighted average for the State Comparisons analysis:

- Anthem – Santa Clara
- Health Net – Los Angeles
- SCFHP – Santa Clara

There were two MCP reporting units that had star ratings that indicated *Poor* performance for the child population when compared to the national data and also scored significantly lower than the MCMC weighted average for the State Comparisons analysis:

- Anthem – Sacramento
- Molina – Sacramento

Improvement Strategies

Decrease No-Show Appointments

Studies have indicated that reducing the demand for unnecessary appointments and increasing availability of primary care providers can result in decreased no-shows and improve beneficiaries' perceptions of timely access to care. MCPs can assist providers in examining patterns related to no-show appointments in order to determine the factors contributing to beneficiary no-shows. For example, it might be determined that only a small percentage of the primary care provider's beneficiary population accounts for no-shows. Thus, further analysis could be conducted on this targeted beneficiary 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 MCP 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 email follow-up). Additionally, follow-up appointments could be conducted by another health care professional such as nurse practitioners or physician.

Electronic Communication

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

Beneficiary Flow Analysis

MCPs should request that all providers monitor beneficiary flow. The MCPs could provide instructions and/or assistance to those providers who are unfamiliar with this type of evaluation. Dissatisfaction with timely care is often a result of bottlenecks and redundancies in the administrative and clinical beneficiary 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 beneficiary flow analysis. A beneficiary flow analysis involves tracking a beneficiary's experience throughout a visit or clinical service (i.e., the time it takes to complete various parts of the visit/service). Examples of steps that are tracked include wait time at check-in, time to complete check-in, wait time in waiting room, wait time in exam room, and time with provider. This type of analysis can help providers identify "problem" areas, including steps that can be eliminated or steps that can be performed more efficiently.

How Well Doctors Communicate

Measure Definition

Four questions (Questions 17, 18, 19, and 20 in the CAHPS Adult Medicaid Health Plan Survey and Questions 17, 18, 19, and 22 in the CAHPS Child Medicaid Health Plan Survey) were asked to assess how often doctors communicated well.

Survey Questions

Adult Survey

Question 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

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

- Never
- Sometimes
- Usually
- Always

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

- Never
- Sometimes
- Usually
- Always

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

- Never
- Sometimes
- Usually
- Always

Child Survey

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

- Never
- Sometimes
- Usually
- Always

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

- Never
- Sometimes
- Usually
- Always

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

- Never
- Sometimes
- Usually
- Always

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

- Never
- Sometimes
- Usually
- Always

National Comparisons

Table 5-16 and Table 5-17 show the adult and child three-point means and star ratings for How Well Doctors Communicate, respectively.

Table 5-16—Adult National Comparisons – How Well Doctors Communicate

Reporting Unit Name	Three-Point Mean	Star Rating
Kaiser SoCal - San Diego	2.72	★★★★★
Partnership - Southwest	2.67	★★★★★+
CCHP - Contra Costa	2.64	★★★★★
Kaiser NorCal - KP North	2.64	★★★★★
SFHP - San Francisco	2.64	★★★★★
CalOptima - Orange	2.63	★★★★
Gold Coast - Ventura	2.63	★★★★
Health Net - San Diego	2.62	★★★★+
Anthem - Tulare	2.61	★★★★+
CalViva - Madera	2.61	★★★★+
Health Net - Tulare	2.60	★★★★+
Molina - Sacramento	2.60	★★★★+
Care1st - San Diego	2.59	★★★★
CHG - San Diego	2.59	★★★★
Partnership - Northeast	2.59	★★★★+
HPSM - San Mateo	2.58	★★★★
Partnership - Northwest	2.58	★★★★+
Anthem - San Francisco	2.57	★★★+
CenCal - Santa Barbara	2.57	★★★
CalViva - Kings	2.57	★★★+
Molina - San Diego	2.57	★★★+
Partnership - Southeast	2.57	★★★+
MCMC	**2.55**	**★★★**
Anthem - Region 1	2.55	★★★+
CCAH - Monterey, Santa Cruz	2.55	★★★+
CHW - Region 2	2.55	★★★+
CalViva - Fresno	2.55	★★★
HPSJ - Stanislaus	2.54	★★★+
L.A. Care - Los Angeles	2.54	★★★
Anthem - Contra Costa	2.53	★★+
Anthem - Kings	2.53	★★+
CCAH - Merced	2.53	★★+
IEHP - Riverside, San Bernardino	2.53	★★
SCFHP - Santa Clara	2.51	★★
AAH - Alameda	2.50	★★
Anthem - Region 2	2.50	★★+
Anthem - San Benito	2.50	★★+
CenCal - San Luis Obispo	2.50	★★+
Molina - Imperial	2.50	★★+
Anthem - Sacramento	2.49	★★+

Reporting Unit Name	Three-Point Mean	Star Rating
Health Net - Stanislaus	2.49	★★+
KFHC - Kern	2.48	★★
Molina - Riverside, San Bernardino	2.47	★+
Anthem - Alameda	2.46	★+
Health Net - San Joaquin	2.44	★+
Health Net - Kern	2.43	★+
Health Net - Los Angeles	2.43	★+
Anthem - Madera	2.42	★+
HPSJ - San Joaquin	2.42	★
Health Net - Sacramento	2.39	★+
CHW - Imperial	2.38	★+
CHW - Region 1	2.36	★+
Anthem - Fresno	2.31	★+
Anthem - Santa Clara	2.31	★+

+If the MCP had fewer than 100 respondents for a measure, caution should be exercised when evaluating the results.

Table 5-17—Child National Comparisons – How Well Doctors Communicate

Reporting Unit Name	Three-Point Mean	Star Rating
Kaiser NorCal - KP North	2.80	★★★★★
Kaiser SoCal - San Diego	2.80	★★★★★
Anthem - Contra Costa	2.77	★★★★★+
Anthem - Fresno	2.77	★★★★★+
CenCal - San Luis Obispo	2.70	★★★+
CCHP - Contra Costa	2.70	★★★
Health Net - San Diego	2.70	★★★+
Partnership - Northwest	2.70	★★★+
CCAH - Monterey, Santa Cruz	2.69	★★★
CHW - Imperial	2.69	★★★+
CHW - Region 2	2.69	★★★+
HPSM - San Mateo	2.68	★★★
Molina - San Diego	2.68	★★★
Anthem - Alameda	2.66	★★+
CHG - San Diego	2.66	★★
AAH - Alameda	2.65	★★
SCFHP - Santa Clara	2.65	★★
Partnership - Northeast	2.64	★★+
SFHP - San Francisco	2.64	★★
Partnership - Southeast	2.63	★★+
Health Net - Tulare	2.62	★+
MCMC	**2.61**	★
CalOptima - Orange	2.61	★
CHW - Region 1	2.61	★+
Anthem - Sacramento	2.60	★+
Anthem - San Francisco	2.60	★+
Health Net - San Joaquin	2.60	★+

Reporting Unit Name	Three-Point Mean	Star Rating
Anthem - Region 2	2.59	★+
Gold Coast - Ventura	2.58	★
Partnership - Southwest	2.58	★+
Care1st - San Diego	2.57	★
CalViva - Kings	2.57	★+
Anthem - Tulare	2.55	★+
Health Net - Stanislaus	2.55	★+
Anthem - Kings	2.54	★+
Anthem - Region 1	2.54	★+
CenCal - Santa Barbara	2.54	★
IEHP - Riverside, San Bernardino	2.54	★
KFHC - Kern	2.54	★
L.A. Care - Los Angeles	2.54	★
Molina - Imperial	2.53	★+
HPSJ - San Joaquin	2.52	★
Anthem - San Benito	2.51	★+
HPSJ - Stanislaus	2.50	★+
Molina - Riverside, San Bernardino	2.50	★+
CCAH - Merced	2.48	★+
Health Net - Los Angeles	2.48	★
CalViva - Fresno	2.47	★
Anthem - Madera	2.46	★+
Anthem - Santa Clara	2.46	★+
Health Net - Kern	2.46	★+
Health Net - Sacramento	2.39	★+
CalViva - Madera	2.33	★+
Molina - Sacramento	2.07	★+

+If the MCP had fewer than 100 respondents for a measure, caution should be exercised when evaluating the results.

State Comparisons

Figure 5-26 and Figure 5-27 show the adult and child State Comparisons for How Well Doctors Communicate, respectively.

Figure 5-26—How Well Doctors Communicate – Adult Top-Box Rates

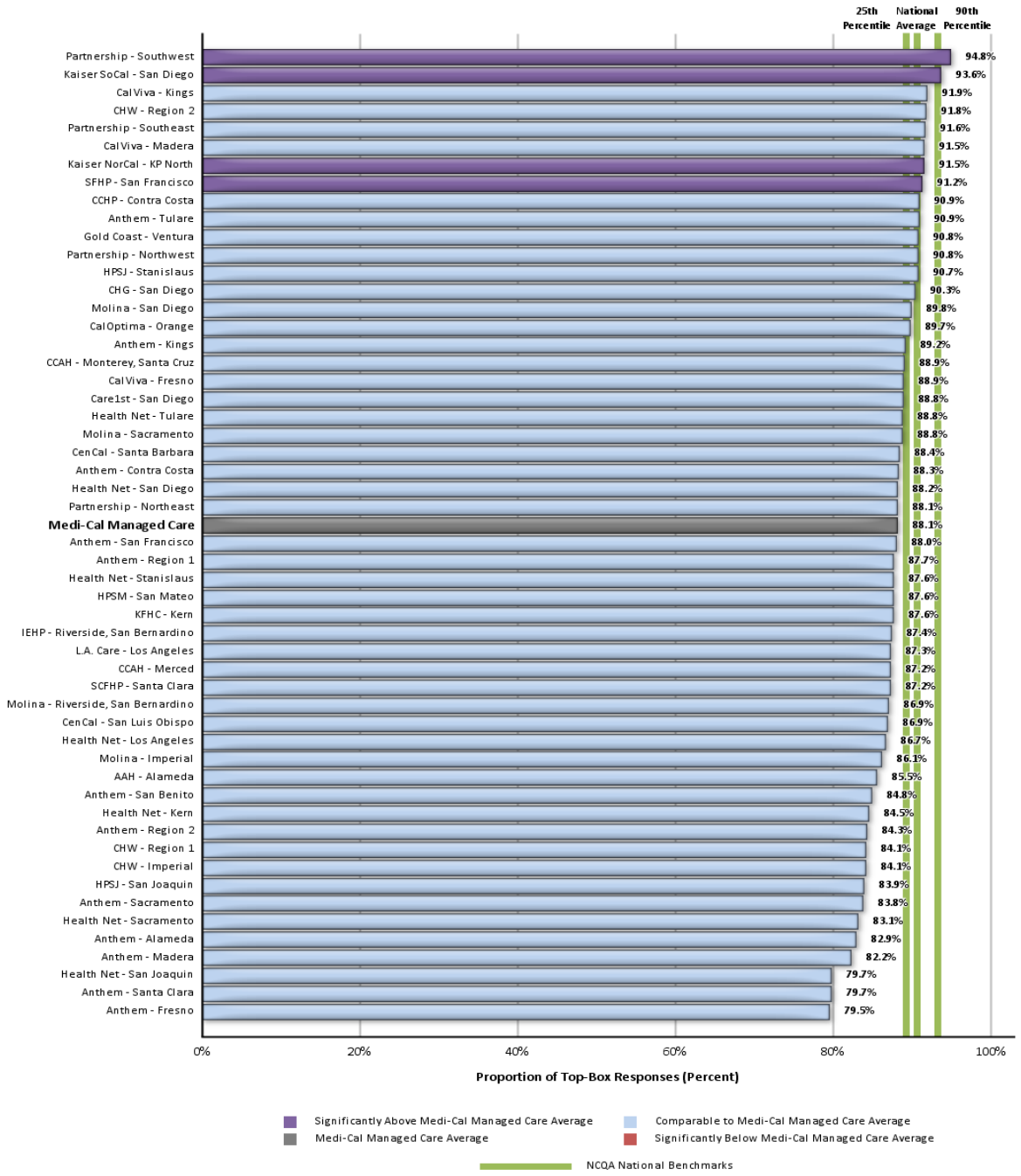
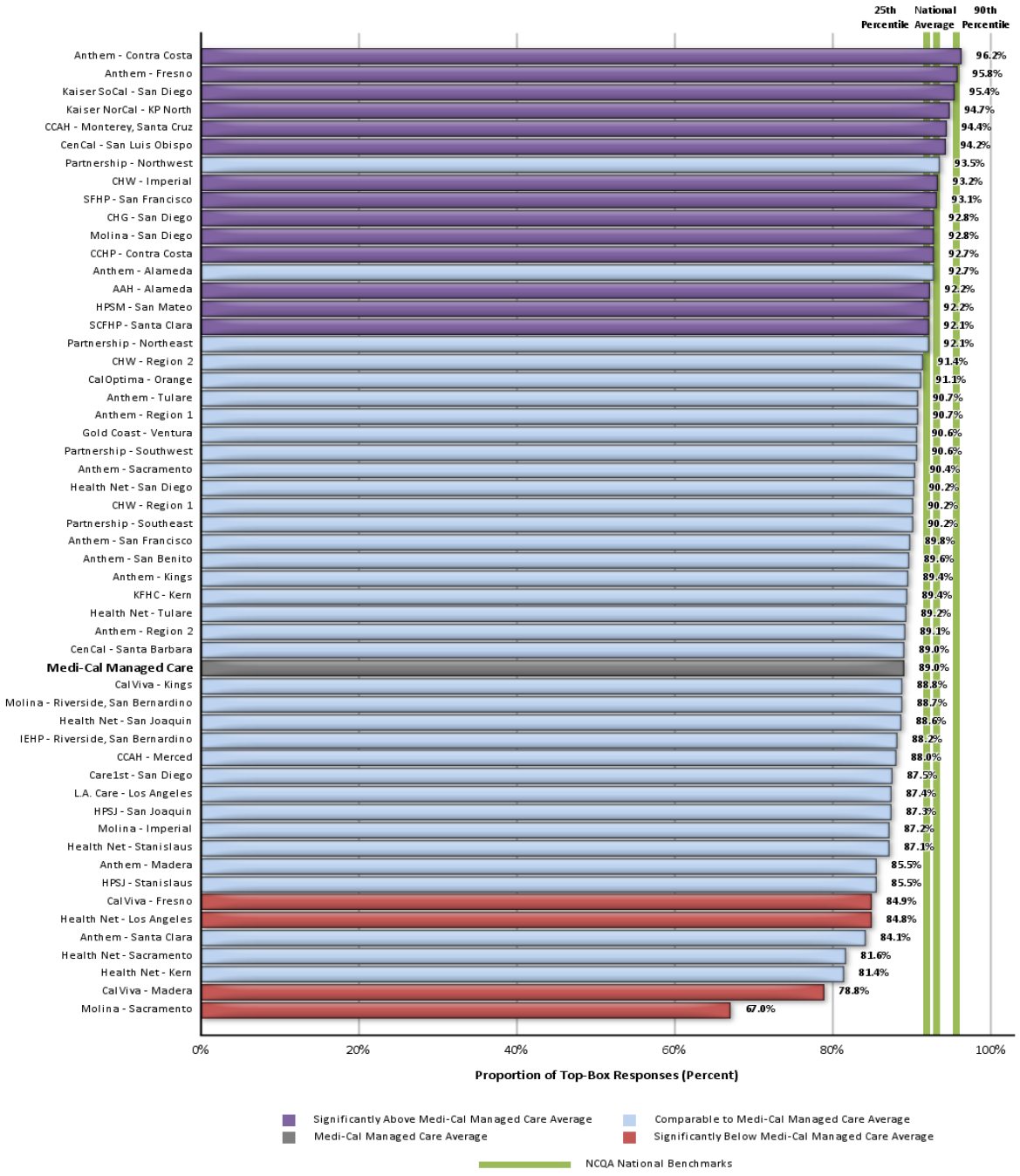


Figure 5-27—How Well Doctors Communicate – Child Top-Box Rates



Summary of Results

Caution: The majority of the reporting units had fewer than 100 respondents for **How Well Doctors Communicate**. According to NCQA's specifications, rates with fewer than 100 respondents are not reportable.

The MCMC's star ratings for **How Well Doctors Communicate** were *Good* for the adult population and *Poor* for the child population. For the National Comparisons, 12 out of 53 MCPs for the adult population and 33 out of 53 MCP reporting units for the child population had *Poor* star rating performance for this measure. There were 17 MCP reporting units for the adult population and four MCP reporting units for the child population that demonstrated *Excellent* or *Very Good* performance for **How Well Doctors Communicate**.

There were two MCP reporting units that demonstrated *Excellent* performance for both the adult and child populations when compared to the national data and also scored significantly higher than the MCMC weighted average for the State Comparisons analysis:

- Kaiser NorCal – KP North
- Kaiser SoCal – San Diego

There were no MCP reporting units that demonstrated *Poor* performance for the adult population and also scored significantly lower than the MCMC weighted average for the State Comparisons analysis.

There were four MCP reporting units that demonstrated *Poor* performance for the child population when compared to the national data and also scored significantly lower than the MCMC weighted average for the State Comparisons analysis:

- CalViva – Fresno
- CalViva – Madera
- Health Net – Los Angeles
- Molina – Sacramento

Improvement Strategies

Communication Tools for Beneficiaries

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

Improve Health Literacy

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

Additionally, health literacy coaching can be implemented to ease the inclusion of health literacy into practice. MCPs can offer a full-day workshop where providers have the opportunity to participate in simulation training resembling the clinical setting. Workshops also provide an opportunity for MCPs to introduce providers to the *AHRQ Health Literacy Universal Precautions Toolkit*, which can serve as a reference for devising health literacy plans. Ultimately, by redefining health literacy as not only an individual's ability to understand basic health information, but also the responsibility of the health system to inform beneficiaries of appropriate services, the quality of beneficiary care can be greatly improved.

Language Barriers

MCPs can consider hiring interpreters that serve as full-time staff members at provider offices with a high volume of non-English speaking beneficiaries to ensure accurate communication amongst beneficiaries and providers. Offering an in-office, interpretation service promotes the development of relationships between the beneficiary and family members with their provider. With an interpreter present to translate, the provider will have a clearer understanding of how to best address the appropriate health issues and the beneficiary will feel more at ease. Having an interpreter on site is also more time efficient for both the beneficiary and provider, allowing the provider to stay on schedule. MCPs that make the effort to accommodate those beneficiaries who do not speak English helps them to feel valued and comfortable, thus increasing overall beneficiary satisfaction.

Customer Service

Measure Definition

Two questions (Questions 31 and 32 in the CAHPS Adult Medicaid Health Plan Survey and Questions 32 and 33 in the CAHPS Child Medicaid Health Plan Survey) were asked to assess how often beneficiaries were satisfied with customer service.

Survey Questions

Adult Survey

Question 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

Question 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

Child Survey

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

- Never
- Sometimes
- Usually
- Always

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

- Never
- Sometimes
- Usually
- Always

National Comparisons

Table 5-18 and Table 5-19 show the adult and child three-point means and star ratings for Customer Service, respectively.

Table 5-18—Adult National Comparisons – Customer Service

Reporting Unit Name	Three-Point Mean	Star Rating
Partnership - Northwest	2.81	★★★★★+
Anthem - Region 1	2.73	★★★★★+
CHW - Imperial	2.71	★★★★★+
CCAH - Monterey, Santa Cruz	2.63	★★★★★+
Partnership - Southeast	2.62	★★★★★+
Health Net - San Joaquin	2.58	★★★★+
Kaiser SoCal - San Diego	2.58	★★★★
Kaiser NorCal - KP North	2.56	★★★
Molina - Imperial	2.56	★★★+
Molina - Riverside, San Bernardino	2.56	★★★+
Partnership - Southwest	2.56	★★★+
HPSM - San Mateo	2.54	★★★+
Health Net - Tulare	2.53	★★+
CCHP - Contra Costa	2.51	★★+
Partnership - Northeast	2.51	★★+
CalViva - Kings	2.50	★★+
CalViva - Madera	2.50	★★+
Care1st - San Diego	2.48	★★
CenCal - San Luis Obispo	2.48	★★+
CHW - Region 2	2.47	★+
Gold Coast - Ventura	2.46	★+
Anthem - San Benito	2.45	★+
MCMC	**2.44**	★
CenCal - Santa Barbara	2.44	★+
IEHP - Riverside, San Bernardino	2.43	★+
Anthem - Sacramento	2.42	★+
KFHC - Kern	2.42	★+
Anthem - Madera	2.41	★+
CHG - San Diego	2.41	★+
HPSJ - Stanislaus	2.41	★+

Reporting Unit Name	Three-Point Mean	Star Rating
Molina - Sacramento	2.41	★+
Anthem - Region 2	2.40	★+
CCAH - Merced	2.40	★+
Health Net - Los Angeles	2.39	★+
L.A. Care - Los Angeles	2.39	★+
SFHP - San Francisco	2.39	★+
Anthem - Alameda	2.38	★+
Anthem - Tulare	2.38	★+
Health Net - Stanislaus	2.38	★+
CalViva - Fresno	2.36	★+
HPSJ - San Joaquin	2.36	★+
CHW - Region 1	2.35	★+
Molina - San Diego	2.35	★+
Health Net - Kern	2.34	★+
Anthem - San Francisco	2.31	★+
Health Net - San Diego	2.31	★+
Anthem - Kings	2.30	★+
SCFHP - Santa Clara	2.30	★+
Anthem - Contra Costa	2.26	★+
AAH - Alameda	2.24	★+
CalOptima - Orange	2.24	★+
Anthem - Fresno	2.23	★+
Health Net - Sacramento	2.18	★+
Anthem - Santa Clara	2.04	★+

+If the MCP had fewer than 100 respondents for a measure, caution should be exercised when evaluating the results.

Table 5-19—Child National Comparisons – Customer Service

Reporting Unit Name	Three-Point Mean	Star Rating
CalViva - Kings	2.70	★★★★★+
Health Net - Kern	2.68	★★★★★+
Health Net - Stanislaus	2.67	★★★★★+
Health Net - San Diego	2.65	★★★★★+
Kaiser NorCal - KP North	2.64	★★★★★
Anthem - Kings	2.63	★★★★★+
IEHP - Riverside, San Bernardino	2.63	★★★★★+
Kaiser SoCal - San Diego	2.61	★★★★
KFHC - Kern	2.57	★★★+
Anthem - Sacramento	2.56	★★★+
CCAH - Merced	2.56	★★★+
Anthem - Fresno	2.55	★★★+
HPSJ - Stanislaus	2.55	★★★+
Molina - San Diego	2.55	★★★+
CCAH - Monterey, Santa Cruz	2.54	★★★+
Partnership - Northeast	2.54	★★★+
Molina - Riverside, San Bernardino	2.53	★★★+

Reporting Unit Name	Three-Point Mean	Star Rating
CHW - Imperial	2.52	★★+
CCHP - Contra Costa	2.51	★★
Partnership - Southeast	2.51	★★+
AAH - Alameda	2.50	★★
Anthem - Region 2	2.50	★★+
CHG - San Diego	2.50	★★
CalViva - Madera	2.50	★★+
CalViva - Fresno	2.49	★
HPSM - San Mateo	2.49	★
MCMC	**2.48**	★
CalOptima - Orange	2.48	★
CHW - Region 2	2.48	★+
HPSJ - San Joaquin	2.47	★+
SFHP - San Francisco	2.46	★
Anthem - Alameda	2.45	★+
SCFHP - Santa Clara	2.45	★
Partnership - Southwest	2.44	★+
CenCal - San Luis Obispo	2.43	★+
Care1st - San Diego	2.41	★
CenCal - Santa Barbara	2.41	★
Health Net - Los Angeles	2.41	★+
Health Net - Sacramento	2.40	★+
Health Net - Tulare	2.40	★+
Anthem - Madera	2.38	★+
CHW - Region 1	2.38	★+
L.A. Care - Los Angeles	2.38	★
Molina - Imperial	2.38	★+
Anthem - San Benito	2.37	★+
Gold Coast - Ventura	2.36	★+
Anthem - San Francisco	2.33	★+
Molina - Sacramento	2.33	★+
Anthem - Region 1	2.31	★+
Anthem - Contra Costa	2.30	★+
Anthem - Tulare	2.30	★+
Anthem - Santa Clara	2.29	★+
Health Net - San Joaquin	S	S
Partnership - Northwest	S	S

+If the MCP had fewer than 100 respondents for a measure, caution should be exercised when evaluating the results.
S = Indicates the MCP had fewer than 11 cases in the numerator for this measure; therefore, DHCS suppressed displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

State Comparisons

Figure 5-28 and Figure 5-29 show the adult and child State Comparisons for Customer Service, respectively.

Figure 5-28—Customer Service – Adult Top-Box Rates

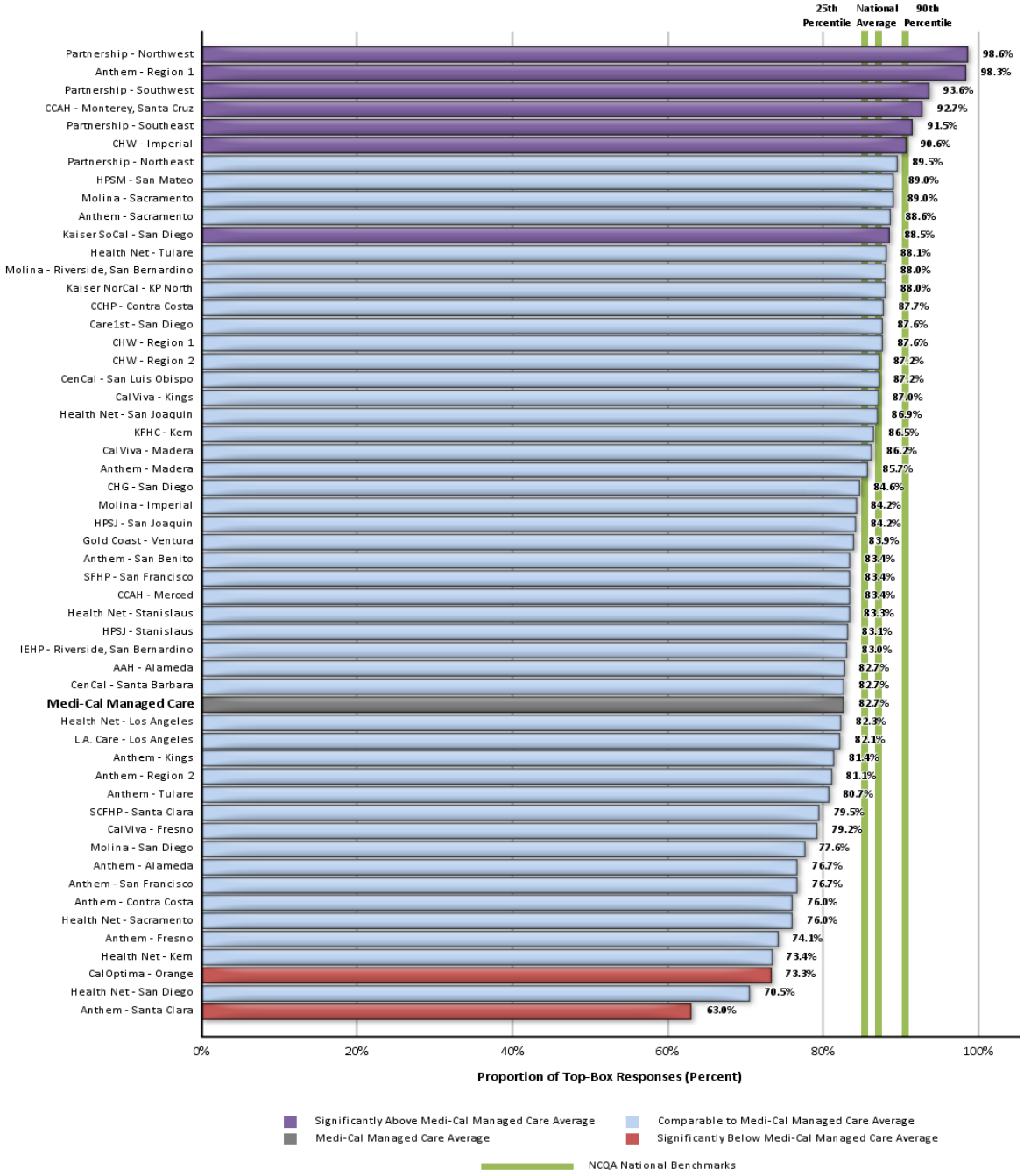
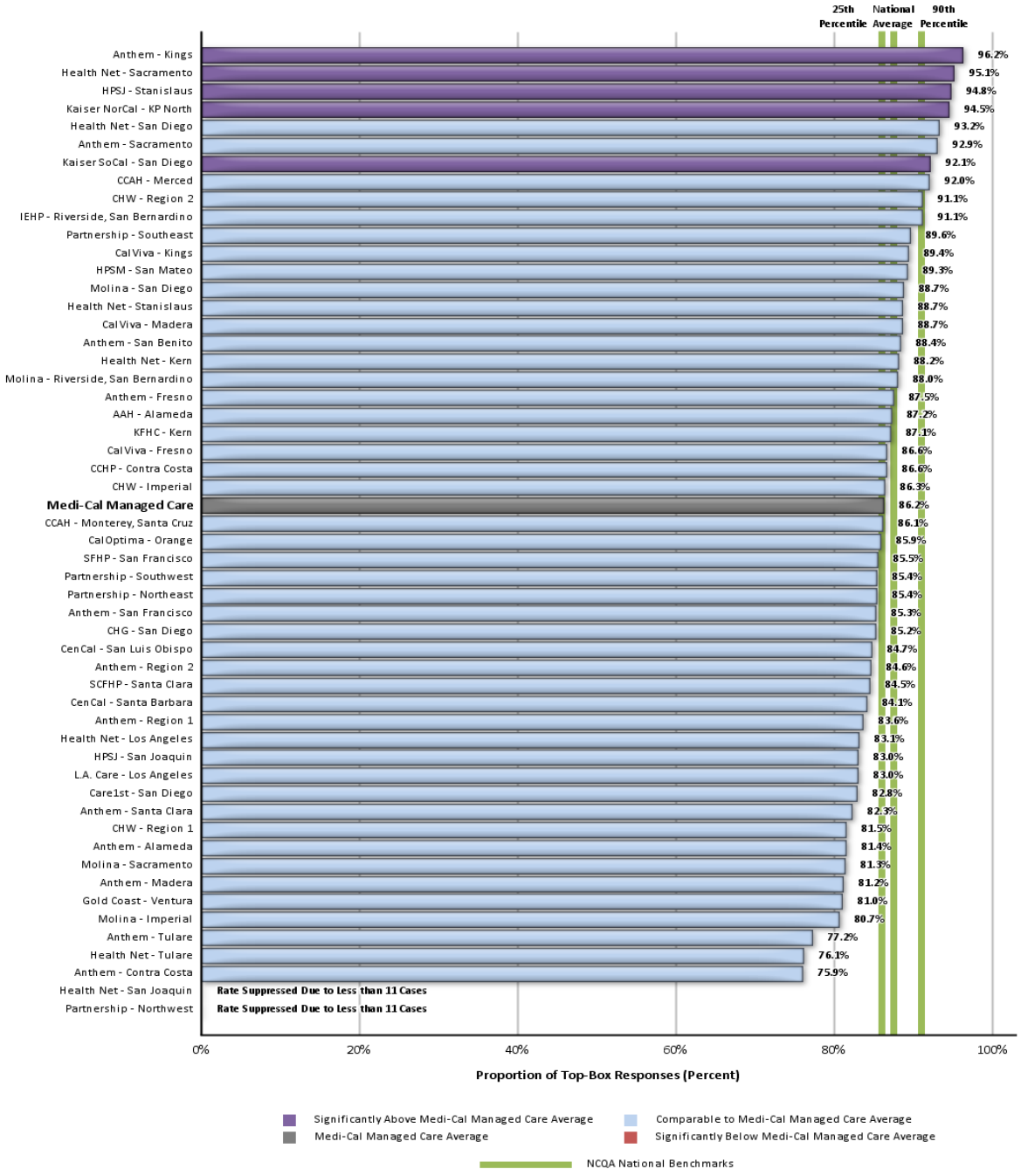


Figure 5-29—Customer Service – Child Top-Box Rates



Summary of Results

Caution: The majority of the reporting units had fewer than 100 respondents for **Customer Service**. According to NCQA's specifications, rates with fewer than 100 respondents are not reportable.

The MCMC's star ratings for **Customer Service** were *Poor* for both the adult and child populations. For the National Comparisons, 34 out of 53 MCP reporting units for the adult population and 27 out of 51 MCP reporting units for the child population had a *Poor* star rating for this measure. There were seven MCP reporting units for the adult population and eight MCP reporting units for the child population that had star ratings of *Excellent* or *Very Good* for **Customer Service**.

There were five MCP reporting units that received *Excellent* star ratings for the adult population when compared to national data and also scored significantly higher than the MCMC weighted average for the State Comparisons analysis:

- Anthem – Region 1
- CCAH – Monterey and Santa Cruz
- CHW – Imperial
- Partnership – Northwest
- Partnership – Southeast

There were three MCP reporting units that received *Excellent* star ratings for the child population when compared to the national data and also scored significantly higher than the MCMC weighted average for the State Comparisons analysis:

- Anthem – Kings
- Health Net – Stanislaus
- Kaiser NorCal – KP North

There were two MCP reporting units that received *Poor* star ratings for the adult population when compared to the national data and also scored significantly lower than the MCMC weighted average for the State Comparisons analysis:

- Anthem – Santa Clara
- CalOptima – Orange

There were no MCP reporting units that demonstrated Poor performance for the child population and also scored significantly lower than the MCMC weighted average for the State Comparisons analysis.

Improvement Strategies

Call Centers

An evaluation of current MCP call center hours and practices can be conducted to determine if the hours and resources meet beneficiaries' needs. If it is determined that the call center is not meeting beneficiaries' needs, an after-hours customer service center can be implemented to assist beneficiaries after normal business hours and/or on weekends. Additionally, asking beneficiaries to complete a short survey at the end of each call can assist in determining if beneficiaries are getting the help they need and identify potential areas for customer service improvement.

Creating an Effective Customer Service Training Program

MCP efforts to improve customer service should include implementing a training program to meet the needs of their unique work environment. Direct beneficiary 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 beneficiary 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. MCPs 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 MCP-level customer service standards can assist in addressing areas of concern and serve as domains for which MCPs 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 beneficiary's inquiry about prior authorizations, and the number of beneficiary 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.

Shared Decision Making

Measure Definition

Three questions (Questions 10, 11, and 12 in the CAHPS Adult and Child Medicaid Health Plan Surveys) were asked regarding the involvement of a beneficiary in taking or not taking a prescription medicine and starting or stopping a prescription medicine.[5-5]

Survey Questions

Adult Survey

Question 10. Did you and a doctor or other health provider talk about the reasons you might want to take a medicine?

- Yes
- No

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

- Yes
- No

Question 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

Child Survey

Question 10. Did you and a doctor or other health provider talk about the reasons you might want your child to take a medicine?

- Yes
- No

[5-5] NCQA does not publish benchmarks and thresholds for the Shared Decision Making composite measure; therefore, comparisons to national data (i.e., National Comparisons analysis) could not be performed and star ratings could not be determined for this CAHPS measure.

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

- Yes
- No

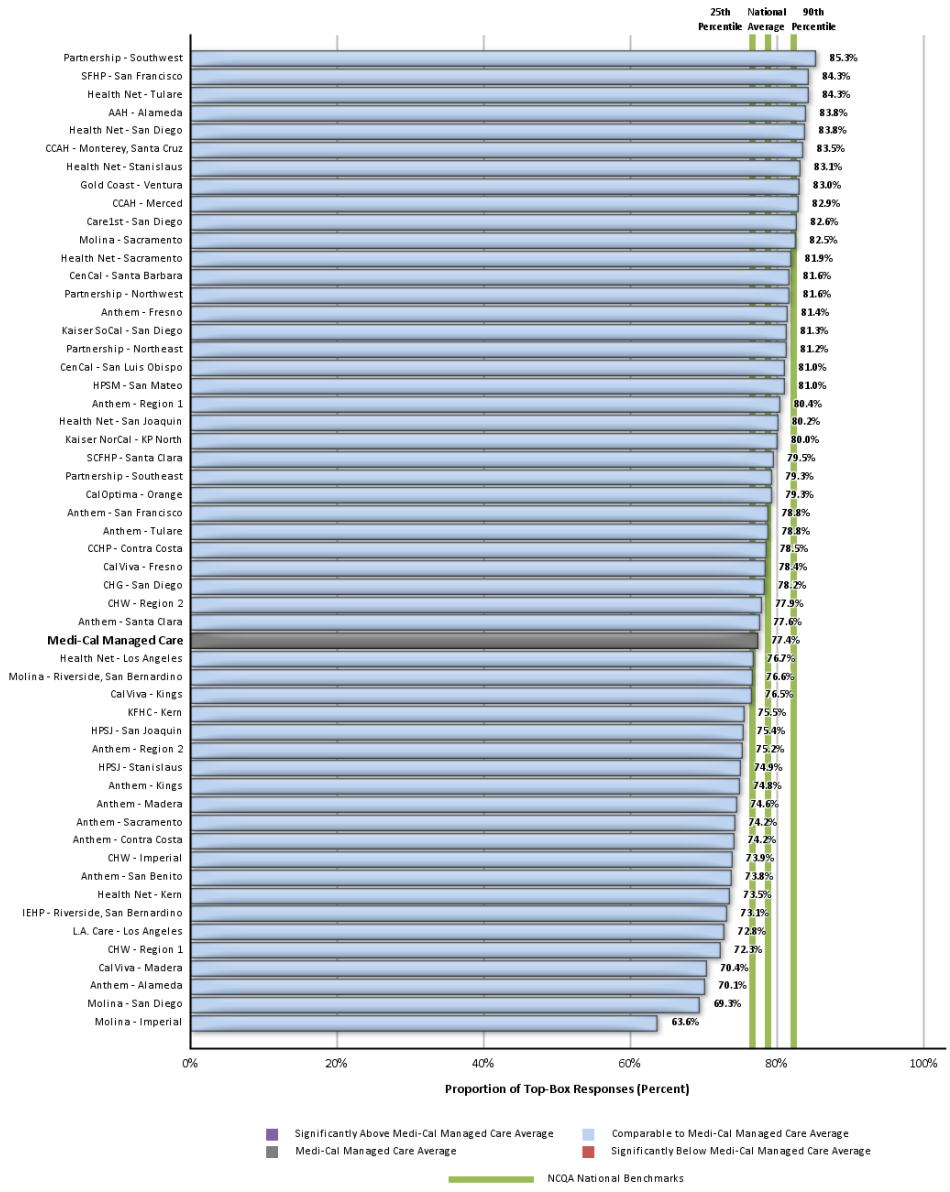
Question 12. When you talked about your child starting or stopping a prescription medicine, did a doctor or other health provider ask you what you thought was best for your child?

- Yes
- No

State Comparisons

Figure 5-30 and Figure 5-31 show the adult and child State Comparisons for Shared Decision Making, respectively.[5-6,5-7]

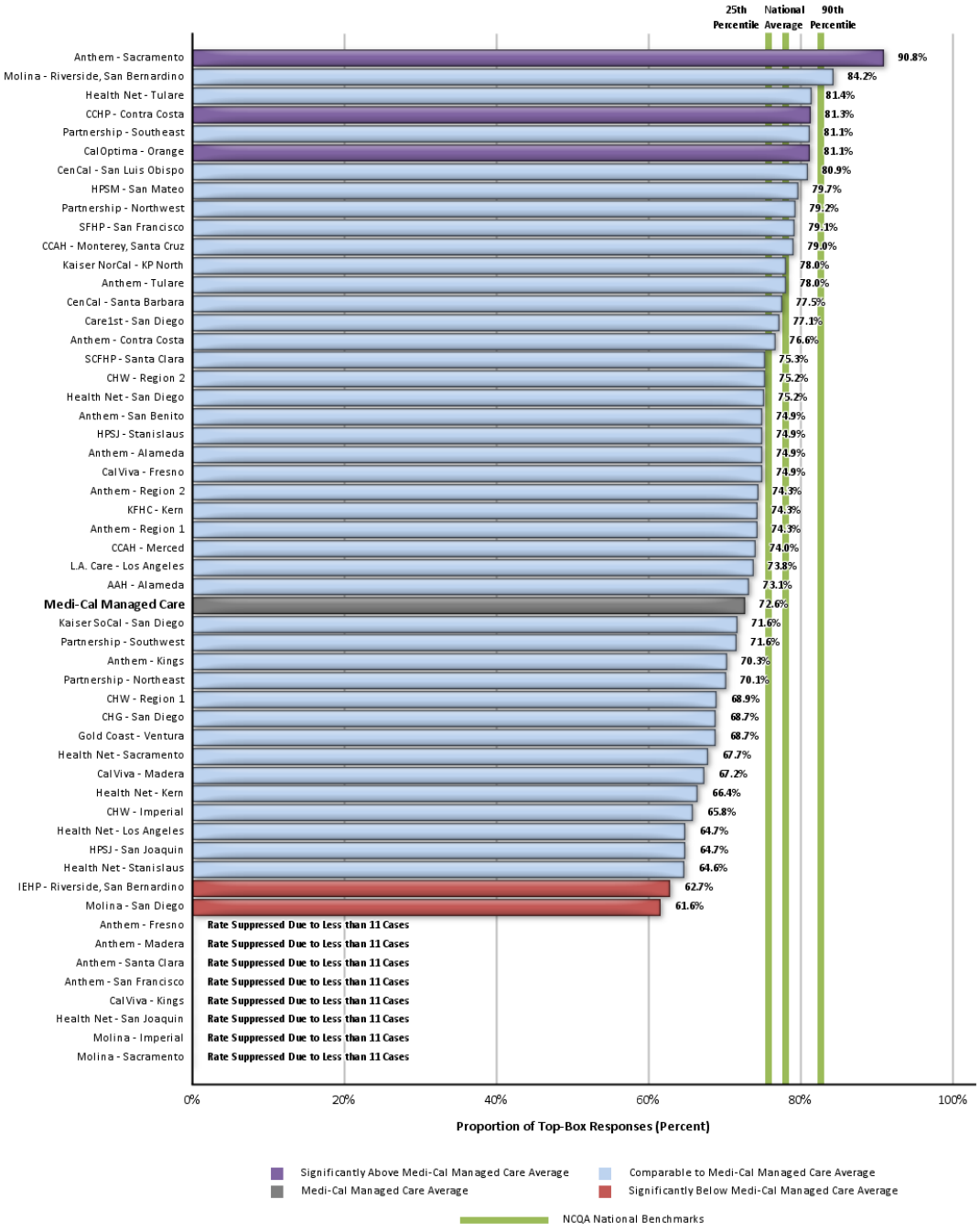
Figure 5-30—Shared Decision Making – Adult Top-Box Rates



5-6 The following reporting units had greater than 100 responses for this measure for the adult population: Care1st-San Diego, CHG-San Diego, Gold Cost-Ventura, HPSM-San Mateo, IEHP-Riverside and San Bernardino, Kaiser NorCal-KP North, Kaiser SoCal-San Diego, SCFHP-Santa Clara.

5-7 All reporting units had fewer than 100 responses for this measure for the child population.

Figure 5-31—Shared Decision Making – Child Top-Box Rates



Summary of Results

There were no MCP reporting units in the adult population that scored significantly higher or lower than the MCMC weighted average for Shared Decision Making.

There were three MCP reporting units in the child population that scored significantly higher than the MCMC weighted average for Shared Decision Making:

- Anthem – Sacramento
- CCHP – Contra Costa
- CalOptima – Orange

There were two MCP reporting units in the child population that scored significantly lower than the MCMC weighted average for the State Comparisons analysis for Shared Decision Making:

- IEHP – Riverside and San Bernardino
- Molina – San Diego

Improvement Strategies

Shared Decision Making Materials

Beneficiaries may become more involved in the management of their health care if providers promote shared decision making. Providers will be able to better encourage their beneficiaries to participate if the MCP provides the providers with literature that conveys the importance of the shared decision making model. In addition, materials such as health care goal-setting handouts and forms can assist providers in facilitating the shared decision making process with their beneficiaries. MCPs can also provide beneficiaries with pre-structured question lists to assist them in asking all the necessary questions so the appointment is as efficient and effective as possible.

Beneficiary Education

Beneficiaries who are educated about their medical condition(s) are more likely to play an active role in the management of their own health. MCPs can provide beneficiaries with educational literature and information. Items such as brochures on a specific medical condition and a copy of the assessment and plan, and portions of the provider's progress notes together with a glossary of terms can empower beneficiaries with the information they need to ask informed questions and express personal values and opinions about their condition and treatment options. Access to this information can also improve beneficiaries' understanding of their medical condition(s) and treatment plan, as well as facilitate discussion about their health care.

Model Type Comparisons

National Comparisons

Table 5-20 and Table 5-21 present the model type star results for the global ratings and composite measures, respectively.

Table 5-20—Model Type Global Ratings

Model Type	Rating of Health Plan	Rating of All Health Care	Rating of Personal Doctor	Rating of Specialist Seen Most Often
Adult Medicaid				
COHS	★ 2.32	★ 2.28	★★★ 2.52	★★★ 2.54
GMC	★★ 2.38	★★★ 2.39	★★★ 2.51	★★★★ 2.58
Imperial	★★ 2.42	★★ 2.35	★★★★★ 2.59	★★★★+ 2.58
Regional	★ 2.06	★ 2.10	★ 2.37	★ 2.38
San Benito	★+ 2.21	★+ 2.19	★★★★★+ 2.69	★+ 2.35
TPM	★ 2.29	★ 2.26	★★ 2.43	★ 2.47
Child Medicaid				
COHS	★★ 2.56	★★ 2.50	★★★★ 2.67	★★★★ 2.64
GMC	★★★ 2.59	★★★★★ 2.61	★★★★★ 2.71	★★★★★ 2.68
Imperial	★★★ 2.58	★ 2.43	★★★★★ 2.72	★★★★★+ 2.69
Regional	★ 2.36	★ 2.42	★★ 2.58	★★+ 2.56
San Benito	★ 2.27	★+ 2.40	★+ 2.49	★★★★★+ 2.67
TPM	★★ 2.54	★★ 2.49	★★★ 2.62	★★★★ 2.64

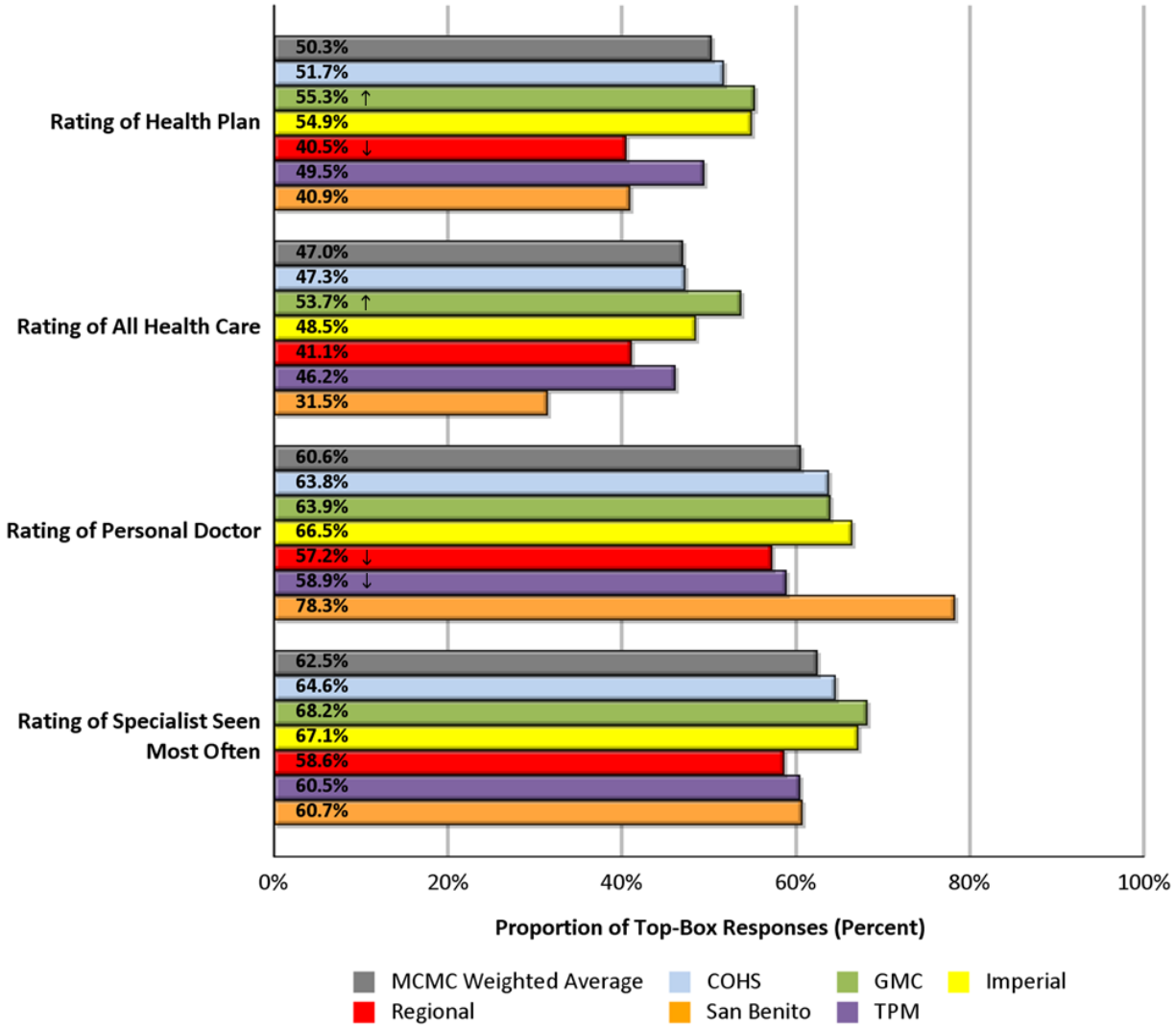
Table 5-21—Model Type Composite Measures

Model Type	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service
Adult Medicaid				
COHS	★ 2.25	★ 2.19	★★★★ 2.59	★★ 2.48
GMC	★ 2.30	★ 2.33	★★★★ 2.62	★ 2.47
Imperial	★ 2.28	★ 2.32	★ 2.43	★★★★★+ 2.64
Regional	★ 2.15	★ 2.25	★★ 2.48	★+ 2.46
San Benito	★+ 1.99	★+ 2.07	★★+ 2.50	★+ 2.45
TPM	★ 2.15	★ 2.16	★★ 2.52	★ 2.38
Child Medicaid				
COHS	★ 2.26	★ 2.36	★ 2.62	★ 2.46
GMC	★ 2.36	★ 2.47	★★★ 2.69	★★★ 2.54
Imperial	★+ 2.31	★+ 2.38	★★+ 2.66	★+ 2.48
Regional	★ 2.26	★ 2.45	★ 2.60	★ 2.41
San Benito	★+ 2.32	★+ 2.32	★+ 2.51	★+ 2.37
TPM	★ 2.29	★ 2.38	★ 2.58	★ 2.48

State Comparisons

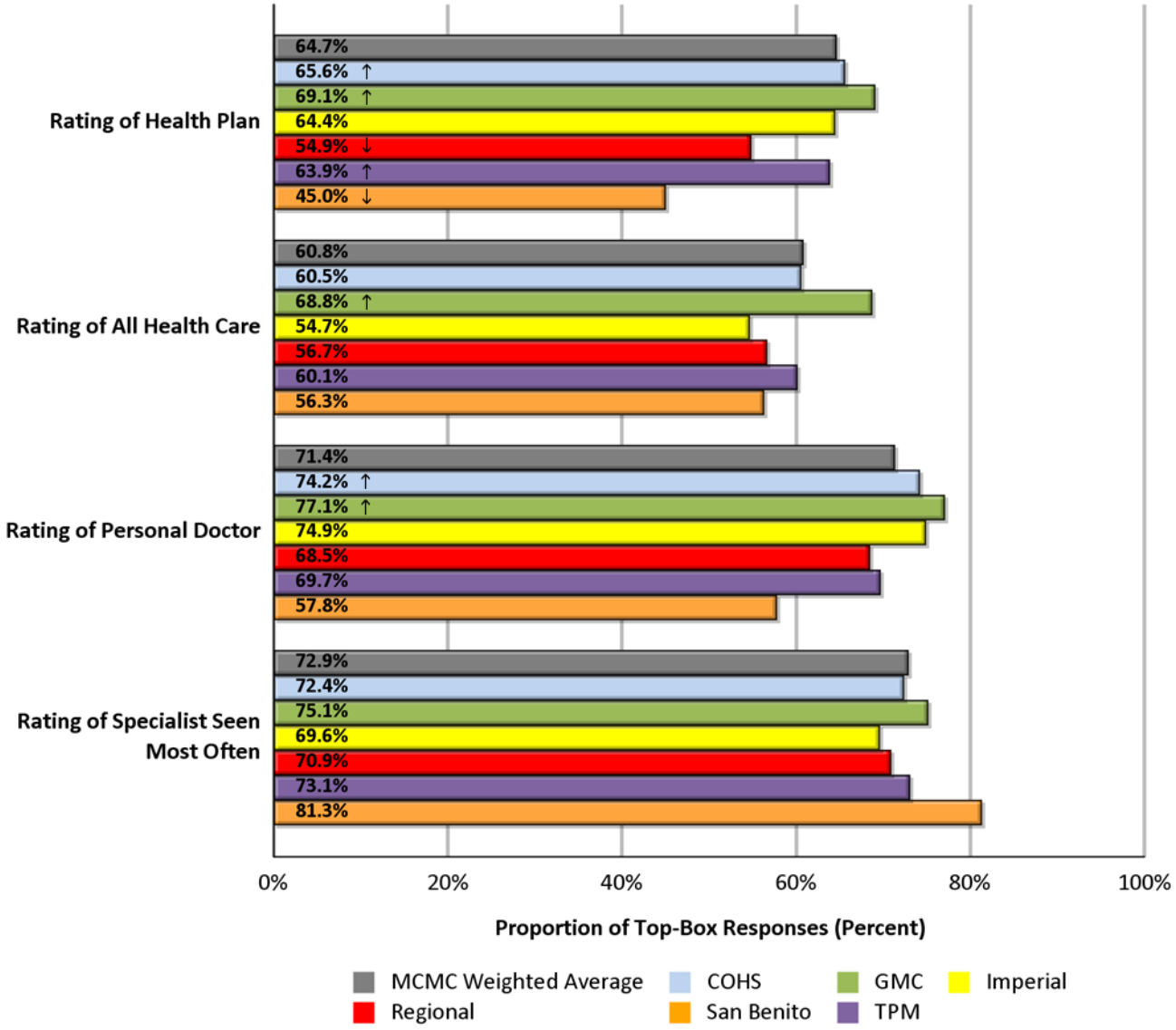
Figure 5-32 and Figure 5-33 present the adult and child model type State Comparisons results for the global ratings, respectively.

Figure 5-32—Adult State Comparisons – Global Ratings



Statistical Significance Note: ↑ indicates the model type's rate is significantly higher than the MCMC weighted average
↓ indicates the model type's rate is significantly lower than the MCMC weighted average

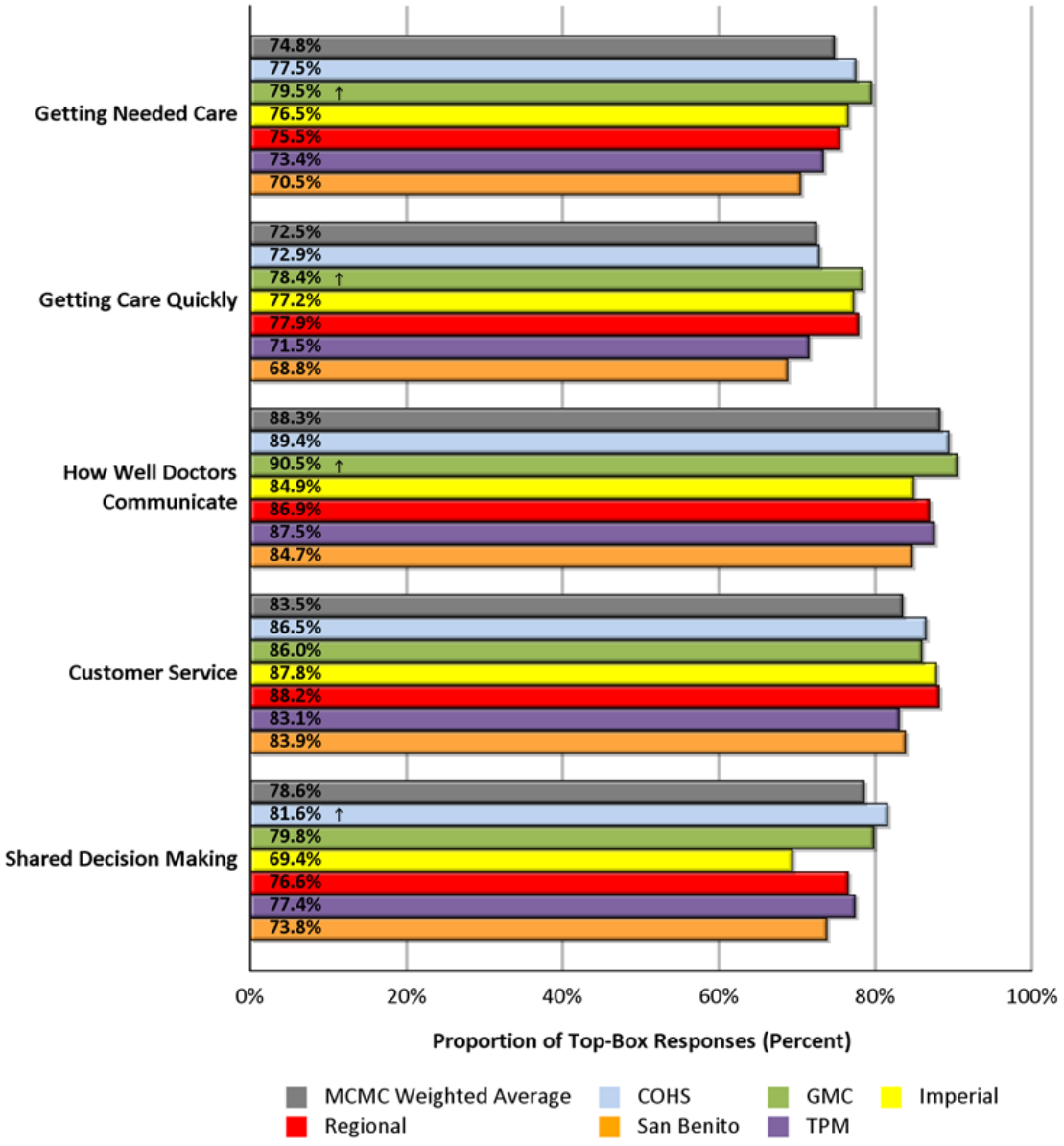
Figure 5-33—Child State Comparisons – Global Ratings



Statistical Significance Note: ↑ indicates the model type's rate is significantly higher than the MCMC weighted average
↓ indicates the model type's rate is significantly lower than the MCMC weighted average

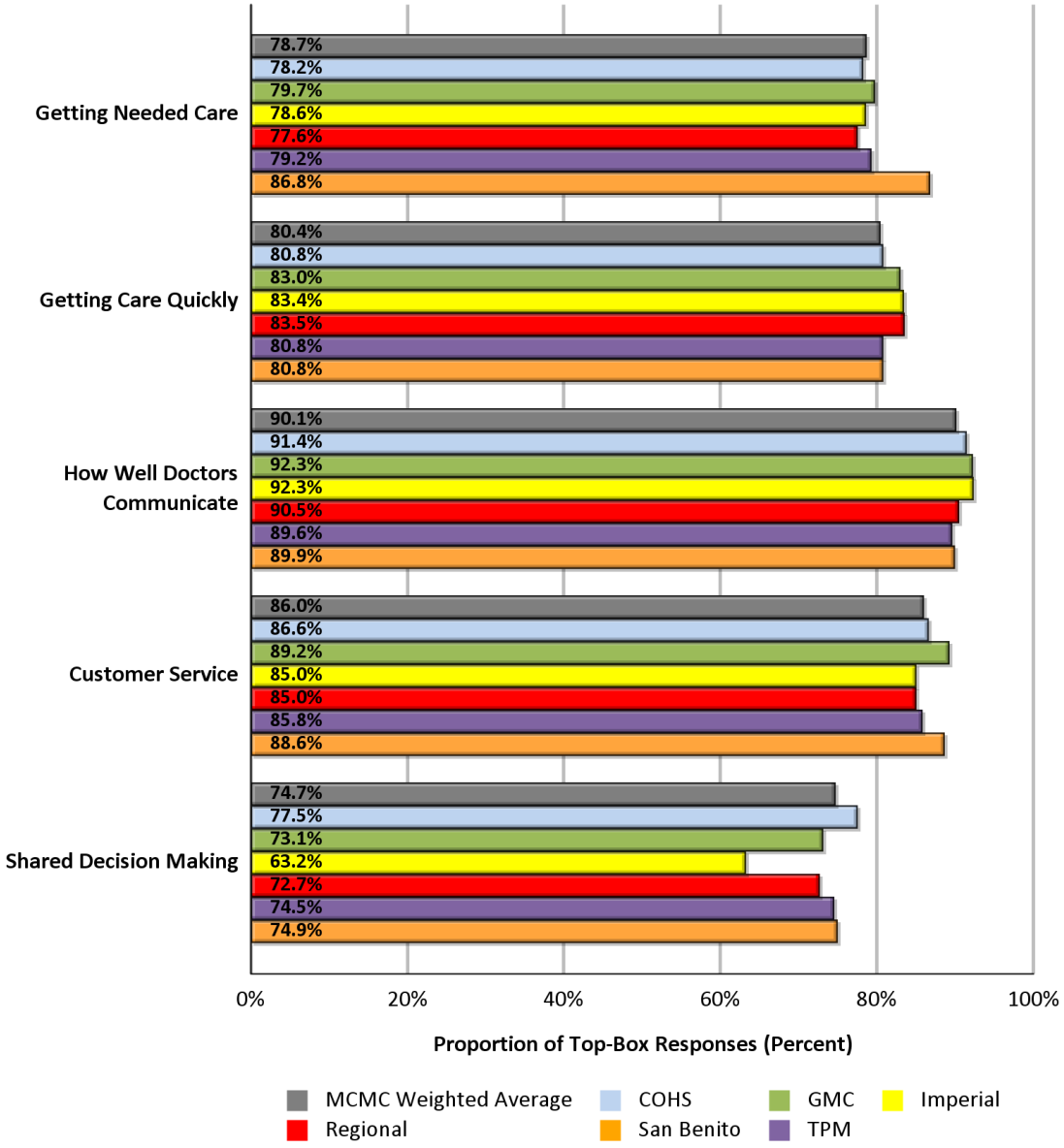
Figure 5-34 and Figure 5-35 present the adult and child model type State Comparisons results for the composite measures, respectively.

Figure 5-34—Adult State Comparisons – Model Type Composite Measures



Statistical Significance Note: ↑ indicates the model type's rate is significantly higher than the MCMC weighted average
↓ indicates the model type's rate is significantly lower than the MCMC weighted average

Figure 5-35—Child State Comparisons – Model Type Composite Measures



Summary of Results

Caution: the rates presented for the COHS model, GMC model, Regional model, and TPM are not weighted by eligible population; therefore, the results may not truly represent the rates of the populations within the COHS model, GMC model, Regional model, and TPM.

In comparing the CAHPS results to national data for the adult population:

- The Imperial model outperformed the other model types for two out of eight measures.
- The COHS model, GMC model, and San Benito model outperformed the other model types for one out of eight measures for the adult population.

For the State Comparisons analysis for the adult population:

- The GMC model type scored significantly higher than the MCMC average for five out of nine measures.
- The COHS model type scored significantly higher than the MCMC average for one measure.
- The Regional model type scored significantly lower than the MCMC average for two out of nine measures.
- The TPM scored significantly lower than the MCMC average for one measure.

In comparing the CAHPS results to national data for the child population:

- The GMC model type outperformed the other model types on three of the eight measures.

For the State Comparisons for the child population:

- The GMC model type scored significantly higher than the MCMC average for three out of nine measures.
- The COHS model type scored significantly higher than the MCMC average for two out of nine measures.
- The TPM scored significantly higher than the MCMC average for one measure.
- The Regional and San Benito model types scored significantly lower than the MCMC average for one measure.

SPD Comparisons

National Comparisons

Table 5-22 and Table 5-23 present the non-SPD and SPD populations' star results for the global ratings and composite measures, respectively.

Table 5-22—Non-SPD and SPD Global Ratings

Population	Rating of Health Plan	Rating of All Health Care	Rating of Personal Doctor	Rating of Specialist Seen Most Often
Adult Medicaid				
Non-SPD	★ 2.28	★ 2.27	★★ 2.43	★ 2.47
SPD	★★ 2.37	★★ 2.33	★★★★ 2.55	★★★★ 2.58
Child Medicaid				
Non-SPD	★★ 2.55	★★ 2.51	★★★★ 2.65	★★★★ 2.65
SPD	★ 2.49	★★ 2.51	★★★★★ 2.69	★★★★★ 2.67

Table 5-23—Non-SPD and SPD Composite Measures

Population	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service
Adult Medicaid				
Non-SPD	★ 2.16	★ 2.16	★★ 2.53	★ 2.44
SPD	★★ 2.31	★ 2.33	★★★★ 2.60	★ 2.42
Child Medicaid				
Non-SPD	★ 2.29	★ 2.39	★ 2.61	★ 2.48
SPD	★ 2.36	★ 2.46	★★ 2.67	★ 2.48

State Comparisons

Figure 5-36 and Figure 5-37 present the adult and child non-SPD and SPD populations' State Comparisons results for the global ratings, respectively.

Figure 5-36—Adult State Comparisons – Non-SPD and SPD Global Ratings

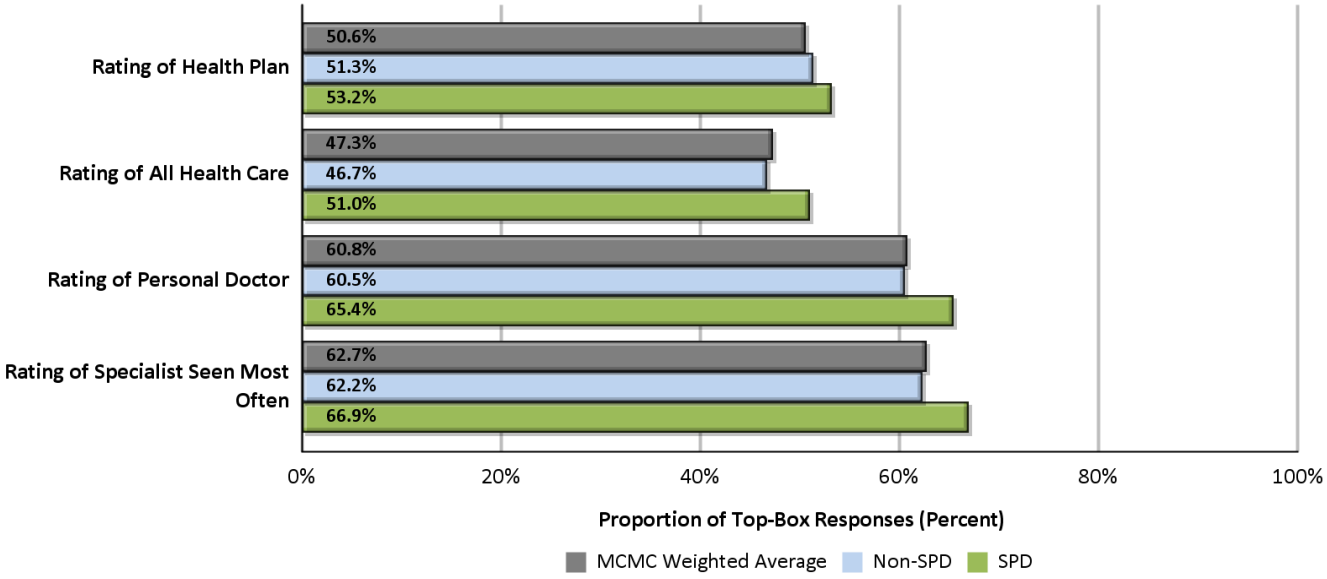


Figure 5-37—Child State Comparisons – Non-SPD and SPD Global Ratings

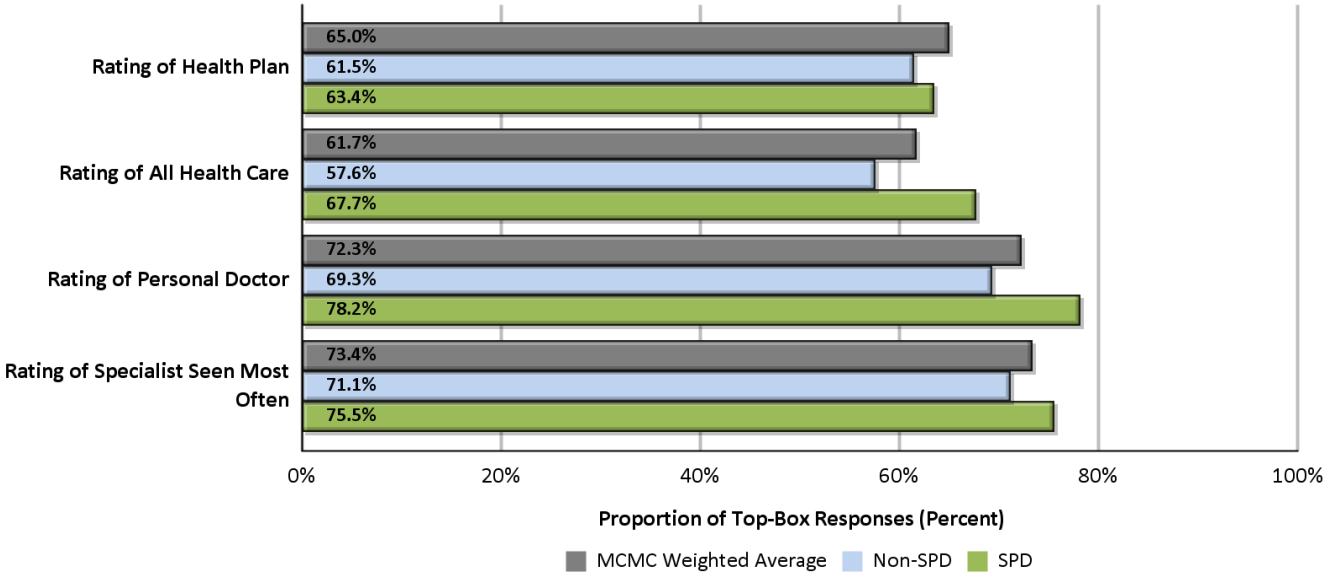
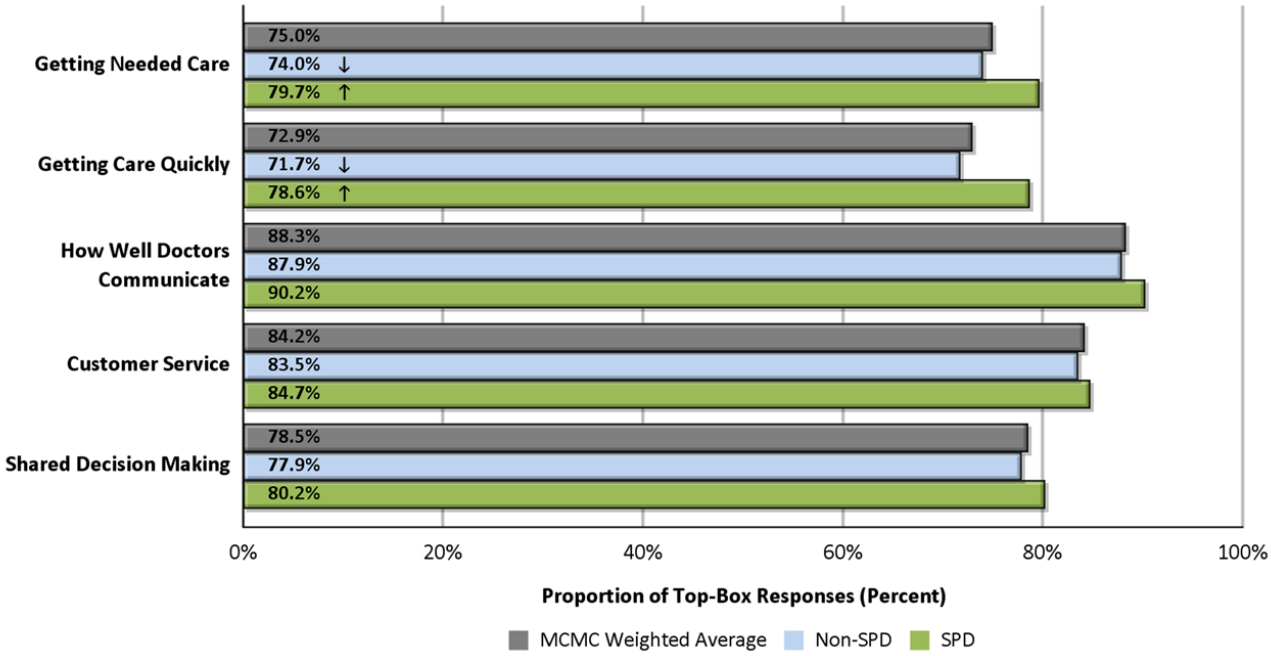


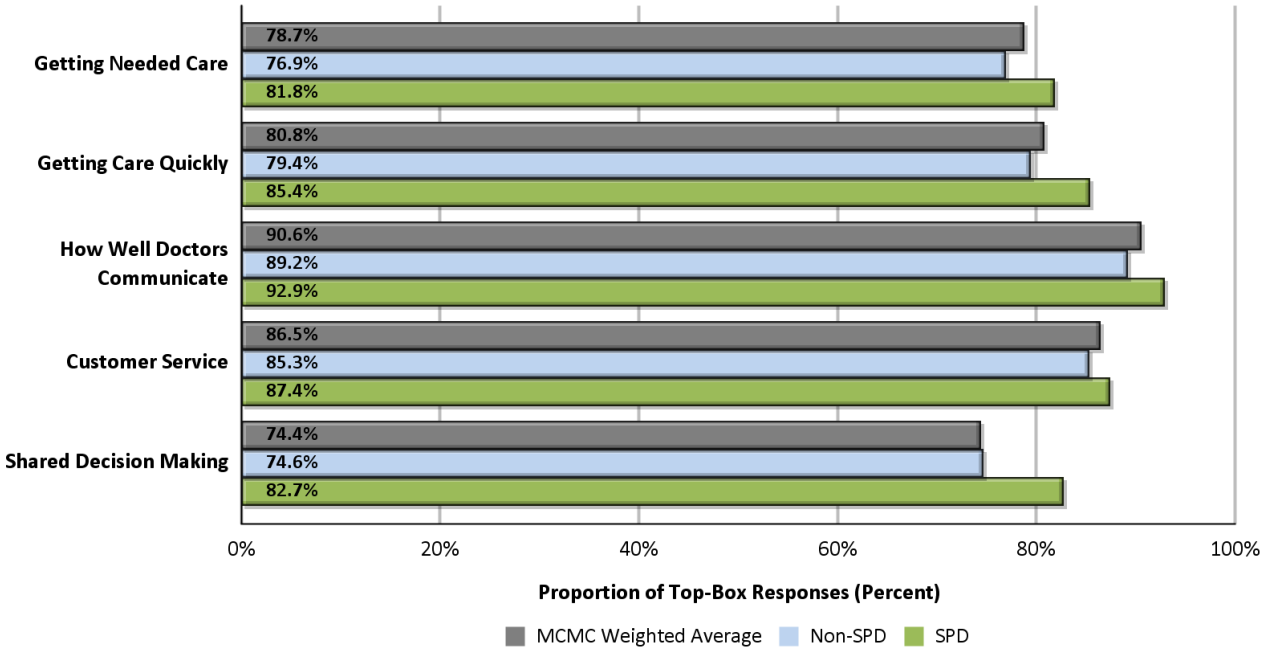
Figure 5-38 and Figure 5-39 present the adult and child non-SPD and SPD populations' State Comparisons results for the composite measures, respectively.

Figure 5-38—Adult State Comparisons – Non-SPD and SPD Composite Measures



Statistical Significance Note: ↑ indicates the population's rate is significantly higher than the MCMC weighted average
↓ indicates the population's rate is significantly lower than the MCMC weighted average

Figure 5-39—Child State Comparisons – Non-SPD and SPD Composite Measures



Summary of Results

Caution: the rates presented for the SPD and non-SPD populations are not weighted by eligible population; therefore, the results may not truly represent the rates of the SPD and non-SDP populations.

In comparing the SPD and non-SPD populations' CAHPS results to national data, the SPD population outperformed the non-SPD population for all eight measures for the adult population. For the State Comparisons analysis, the adult SPD population scored significantly higher than the non-SPD population for two out of nine measures.

In comparing the SPD and non-SPD populations' CAHPS results to national data, the star rating performance did not differ between the SPD and non-SPD populations on four out of eight measures. For the State Comparisons analysis, the SPD population outperformed the non-SPD population for all nine measures for the child population. For the child population, there were no statistically, significant differences between the SPD and non-SPD populations' rates.

Additional Areas of Evaluation[5-8]

Caution: the following evaluations are based on rates that are not weighted by eligible population; therefore, the results may not truly represent the rates of the adult and/or child Medi-Cal populations.

Medical Assistance with Smoking and Tobacco Use Cessation

The survey instrument included a series of questions to adult beneficiaries regarding medical assistance with smoking and tobacco use cessation. Three smoking and tobacco use cessation measures were calculated based on responses to this series of questions. HSAG included only adult beneficiaries who reported smoking or using tobacco some days or every day in these measures results. Table 5-24 presents the Medical Assistance with Smoking and Tobacco Use Cessation results.[5-9]

Table 5-24—Medical Assistance with Smoking and Tobacco Use Cessation Measure Results

Measure	Rate
Advising Smokers and Tobacco Users to Quit	65.43%
Discussing Cessation Medications	38.32%
Discussing Cessation Strategies	35.08%

Question 39 in the CAHPS Adult Medicaid Health Plan Survey asked beneficiaries how often they smoke cigarettes or use tobacco.[5-10] Table 5-25 presents the frequency distribution of the responses to this survey item

Table 5-25—Frequency of Cigarette or Tobacco Use

Every Day	Some Days	Not at All	Don't Know
10.36%	6.96%	81.67%	1.01%

Questions 40 through 42 in the CAHPS Adult Medicaid Health Plan Survey asked beneficiaries how often doctors or other health providers advised them to quit smoking or using tobacco and how frequently cessation strategies or medications were discussed.[5-11] Table 5-26 presents the frequency distribution of the responses to these survey items.

[5-8] Please note, the results presented in this section were not population weighted; therefore, the rates do not present statewide rates.
[5-9] The rates presented are based on a single year of data and do not follow NCQA's methodology of calculating a rolling average.
[5-10] Refer to the Survey Instrument section of this report beginning on page 8-1 for the actual question language.
[5-11] Ibid.

Table 5-26—Smoking and Tobacco Use Cessation Advice from Doctor or Health Provider

Item	Response Distributions			
	Never	Sometimes	Usually	Always
How often beneficiary was advised to quit smoking or using tobacco by a doctor or other health provider	34.57%	19.04%	15.72%	30.67%
How often medication was recommended or discussed by a doctor or health provider to assist beneficiary with quitting smoking or using tobacco	61.68%	17.85%	8.83%	11.64%
How often methods and strategies were discussed with or provided by a doctor or health provider to assist beneficiary with quitting smoking or using tobacco	64.92%	15.59%	7.99%	11.50%

Aspirin Use and Discussion

The survey instrument included a series of questions regarding aspirin and medication utilization among adult beneficiaries. HSAG calculated two aspirin measures based on responses to this series of questions. Table 5-27 presents the results of the Aspirin Use and Discussion measures.[5-12]

Table 5-27—Aspirin Use and Discussion Measure Results

Measure	Rate
Aspirin Use	30.63%
Discussing Aspirin Risks and Benefits	33.30%

Questions 46 and 47 in the CAHPS Adult Medicaid Health Plan Survey asked beneficiaries to identify if they are aware of having, or if a doctor has ever told them they have, certain conditions.[5-13] Table 5-28 presents the frequency distribution of the responses to these survey items. Responses of beneficiaries who selected multiple conditions were combined into a single category.

Table 5-28—Self-Reported Conditions

Item	Response Distributions
Beneficiary Aware of Having Condition	
High cholesterol	18.98%
High blood pressure	31.47%
Parent or sibling with heart attack before the age of 60	11.76%
Multiple conditions	37.79%
Condition Diagnosed by Doctor	

5-12 The rates presented are based on a single year of data and do not follow NCQA's methodology of calculating a rolling average.

5-13 Refer to the Survey Instrument section of this report beginning on page 8-1 for the actual language of these questions.

Item	Response Distributions
Heart attack	14.67%
Angina or coronary heart disease	5.14%
Stroke	4.53%
Any kind of diabetes or high blood sugar	6.32%
Multiple conditions	69.33%

Medication Utilization

The survey instrument included a series of questions to adult beneficiaries regarding aspirin and other medication use.[5-14] Table 5-29 displays the results for these survey items.

Table 5-29—Medication Utilization

Item	Response Distributions		
	Yes	No	Don't Know
Aspirin			
Beneficiary takes aspirin daily or every other day	21.73%	77.27%	1.00%
Beneficiary has health problems or takes medication that makes taking aspirin unsafe	7.35%	82.88%	9.77%
Doctor or other health provider has discussed with the beneficiary the risk and benefits of aspirin to prevent heart attack or stroke	32.56%	67.44%	N/A
Other Medications			
Beneficiary has seen a doctor or other health provider at least 3 times in the last 6 months for the same condition or problem	27.24%	72.76%	N/A
For those beneficiaries who have been seen at least 3 times in the last 6 months for the same condition, the condition lasted for at least 3 months	80.54%	19.46%	N/A
Beneficiary needs or takes medicine prescribed by a doctor	56.84%	43.16%	N/A
For those beneficiaries taking prescription medications, the medications are used to treat a condition that has lasted for at least 3 months	89.94%	10.06%	N/A

5-14 Refer to the Survey Instrument section of this report beginning on page 8-1 for the actual language of these questions.

Flu Vaccination

Question 38 in the CAHPS Adult Medicaid Health Plan Survey asked beneficiaries if they had a flu shot or flu spray since July 1, 2015.[5-15] Table 5-30 displays the responses to this survey item.

Table 5-30—Flu Vaccination Measure Results

Response	Adult Medicaid
Yes	42.45%
No	57.55%

After-Hours Care Information

One question asked if adult and child beneficiaries, when visiting a doctor's office or clinic, were given information about what to do if the beneficiary needed care during evening, weekends, or holidays in the last 6 months (Question 59 in the CAHPS Adult Medicaid Health Plan Survey and Question 49 in the CAHPS Child Medicaid Health Plan Survey).[5-16] Table 5-31 displays the responses for this question.

Table 5-31—After-Hours Care Information in the Past 6 Months

Response	Response Distributions	
	Adult Medicaid	Child Medicaid
Yes	30.99%	43.96%
No	53.04%	39.55%
Did not see a doctor or provider in last 6 months	15.98%	16.49%

[5-15] Refer to the Survey Instrument section of this report beginning on page 8-1 for the actual question language.
[5-16] Ibid.

Difficulty with Taking Care of Beneficiary's Health

One question asked if adult and child beneficiaries had been asked by a doctor or other health provider if there are things that make it hard to take care of the beneficiary's health (Question 60 in the CAHPS Adult Medicaid Health Plan Survey and Question 51 in the CAHPS Child Medicaid Health Plan Survey).[5-17] Table 5-32 displays the responses for this question.

Table 5-32—Difficulty with Taking Care of Beneficiary's Health

Response	Response Distributions	
	Adult Medicaid	Child Medicaid
Yes	21.37%	23.81%
No	62.93%	60.65%
Did not see a doctor or provider in last 6 months	15.71%	15.54%

Discussed Food Nutrition

One question asked parents or caretakers of child beneficiaries if they had discussed with the child beneficiary's doctor or other health care provider how much or what kind of food the child beneficiary eats (Question 50 in the CAHPS Child Medicaid Health Plan Survey).[5-18] Table 5-33 displays the responses for this question.

Table 5-33—Discussed Food Nutrition

Response	Child Medicaid
Yes	51.08%
No	33.97%
My child did not see their doctor or other health provider in the last 6 months	14.95%

[5-17] Refer to the Survey Instrument section of this report beginning on page 8-1 for the actual question language.
[5-18] Ibid.

Mental or Emotional Assistance

One question asked adult beneficiaries if they talked with a doctor or other health provider about a personal problem, family problem, alcohol use, drug use, or a mental or emotional illness (Question 61 in the CAHPS Adult Medicaid Health Plan Survey).[5-19] Table 5-34 displays the responses for this question.

Table 5-34—Mental or Emotional Assistance

Response	Adult Medicaid
Yes	20.76%
No	63.85%
I did not visit a doctor's office or clinic in the last 6 months	15.39%

[5-19] Refer to the Survey Instrument section of this report beginning on page 8-1 for the actual question language.

6. Conclusions and Recommendations

Medi-Cal Managed Care Performance

In order to assess the overall performance of MCMC, HSAG aggregated results for the four CAHPS global ratings and four composite measures and compared them to NCQA's HEDIS Benchmarks and Thresholds for Accreditation.[6-1,6-2,6-3] Based on this comparison, HSAG determined ratings of one (★) to five (★★★★★) stars for each of these CAHPS measures, where one is the lowest possible rating (i.e., *Poor*) and five is the highest possible rating (i.e., *Excellent*).

Table 6-1 shows the MCMC's star ratings for each global rating and the four composite measures.

Table 6-1—Medi-Cal Managed Care 2016 CAHPS National Comparisons Results

Measure	Adult Medicaid	Child Medicaid
Global Ratings		
Rating of Health Plan	★	★★
Rating of All Health Care	★	★★
Rating of Personal Doctor	★★	★★★★
Rating of Specialist Seen Most Often	★★★	★★★★
Composite Measures		
Getting Needed Care	★	★
Getting Care Quickly	★	★
How Well Doctors Communicate	★★★	★
Customer Service	★	★

The MCMC results showed generally *Poor* or *Fair* star rating performance across the global ratings and composite measures for both the adult and child populations when compared to national Medicaid data. The Rating of Specialist Seen Most Often and How Well Doctors Communicate measures were the exceptions, where both showed *Good* performance when compared to national results for the adult Medicaid survey. The child Medicaid survey had two exceptions, as well with Rating of Personal Doctor and Rating of Specialist Seen Most Often measures, which both showed *Very Good* performance when compared to national results.

6-1 National Committee for Quality Assurance. *HEDIS Benchmarks and Thresholds for Accreditation 2016.* Washington, DC: NCQA, January 21, 2016.
6-2 NCQA does not publish benchmarks and thresholds for the Shared Decision Making composite measure; therefore, overall beneficiary satisfaction ratings could not be derived for this CAHPS measure.
6-3 Refer to Appendix A for additional details regarding the methodology used for this analysis.

Priority Assignments

This section defines QI priority assignments for each global rating and composite measure. The priority assignments are grouped into four main categories for QI: top, high, moderate, and low priority. The priority assignments for the MCMC are based on the results of the National Comparisons for the adult and child populations.[6-4]

Table 6-2 shows how the priority assignments are determined on each CAHPS measure.

Table 6-2—Derivation of Priority Assignments on Each CAHPS Measure

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

Table 6-3 shows the statewide MCMC priority assignments for the adult population.

Table 6-3—Adult Priority Assignments

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

[6-4] NCQA does not publish national benchmarks and thresholds for the Shared Decision Making composite measure; therefore, a priority assignment cannot be derived for this measure.

Table 6-4 shows the statewide MCMC priority assignments for the child population.

Table 6-4—Child Priority Assignments

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

Key Drivers of Satisfaction

For the statewide MCMC adult and child populations, HSAG performed a key drivers of satisfaction analysis. The purpose of the key drivers of satisfaction analysis is to help decision makers identify specific aspects of care that are most likely to benefit from QI activities. The analysis provides information on: (1) how well the program is performing on the survey item (question), and (2) how important that item is to overall satisfaction. The key drivers of satisfaction analysis focuses on all of the top priorities.

HSAG measured performance on a survey item by calculating a problem score, in which HSAG defined a negative experience with care as a problem and assigned a "1," and a positive experience (i.e., non-negative) was assigned a "0." The higher the problem score, the lower the beneficiary satisfaction with the aspect of service measured by that question. The problem score can range from 0 to 1.

For each item evaluated, HSAG used a Pearson product moment correlation to calculate the relationship between the item's problem score and performance on the priority area. HSAG then prioritized items based on their overall problem score and their correlation to the priority area. Key drivers of satisfaction were defined as those items that (1) have a problem score that is greater than or equal to the program's median problem score for all items examined, and (2) have a correlation that is greater than or equal to the program's median correlation for all items examined.

Table 6-5 and Table 6-6 depicts the MCMC's key drivers of satisfaction for the statewide adult and child populations, respectively.

Table 6-5—Adult Key Drivers of Satisfaction

Key Drivers of Satisfaction
Rating of Health Plan
Respondents reported that their personal doctor did not always seem informed and up-to-date about the care they received from other doctors or health providers.
Respondents reported that it was often not easy for them to obtain appointments with specialists.
Respondents reported that their health plan's customer service did not always give them the information or help they needed.
Respondents reported that when they needed care right away, they did not receive care as soon as they needed it.
Rating of All Health Care
Respondents reported that it was not always easy to get the care, tests, or treatment they thought they needed through their health plan.
Respondents reported that their personal doctor did not always seem informed and up-to-date about the care they received from other doctors or health providers.
Respondents reported that it was often not easy for them to obtain appointments with specialists.
Respondents reported that when they needed care right away, they did not receive care as soon as they needed it.
Respondents reported that when they did not need care right away, they did not obtain an appointment for health care as soon as they thought they needed.
Customer Service
Respondents reported that their health plan's customer service did not always give them the information or help they needed.
Getting Needed Care
Respondents reported that it was often not easy for them to obtain appointments with specialists.
Respondents reported that when they did not need care right away, they did not obtain an appointment for health care as soon as they thought they needed.
Getting Care Quickly
Respondents reported that when they did not need care right away, they did not obtain an appointment for health care as soon as they thought they needed.

Table 6-6—Child Key Drivers of Satisfaction

Key Drivers of Satisfaction
Customer Service
Respondents reported that their child's health plan's customer service did not always give them the information or help they needed.
Getting Needed Care
Respondents reported that it was often not easy for their child to obtain appointments with specialists.
Respondents reported that when their child did not need care right away, they did not obtain an appointment for health care as soon as they thought they needed.
Getting Care Quickly
Respondents reported that when their child did not need care right away, they did not obtain an appointment for health care as soon as they thought they needed.
How Well Doctors Communicate
Respondents reported that their child's personal doctor did not always spend enough time with them.
Respondents reported that their child's personal doctor did not always seem informed and up-to-date about the care their child received from other doctors or health providers.

Recommendations

HSAG recommends that DHCS focus on the areas identified as key drivers of satisfaction for MCMC. Please refer to the *Improvement Strategies* listed for each measure in section 5 for general recommendations based on the most up-to-date information in the CAHPS literature.[6-5] DHCS should evaluate these general recommendations in the context of its own operational and QI activities. For additional information, please refer to the QI references in section 7.

[6-5] AHRQ Website. *CAHPS Improvement Guide.* Available at: http://www.ahrq.gov/cahps/quality-improvement/improvement-guide/improvement-guide.html. Accessed on: July 11, 2016.

7. Quality Improvement References

AHRQ originally developed the CAHPS surveys to meet the need of consumers for usable, relevant information on quality of care from the beneficiaries' perspectives. However, they also play an important role as a QI tool for health care organizations, which can use the standardized data and results to identify relative strengths and weaknesses in their performance, determine where they need to improve, and track their progress over time.[7-1] The following references offer guidance on possible approaches to CAHPS-related QI activities.

AHRQ Health Care Innovations Exchange Website. *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: July 11, 2016.

AHRQ Health Care Innovations Exchange Website. *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: July 11, 2016.

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Flores G. Language barriers to health care in the United States. The New England Journal of Medicine. 2006; 355(3): 229-31.

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8. Survey Instruments

HSAG selected the following survey instruments: CAHPS 5.0H Adult Medicaid and CAHPS 5.0H Child Medicaid Health Plan Surveys. This section provides copies of the survey instruments.

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 1-888-248-5294.

SURVEY INSTRUCTIONS

- **Please be sure to fill the response circle <u>completely</u>. Use only <u>black or blue ink</u> or <u>dark pencil</u> to complete the survey.**

  Correct Mark ● **Incorrect Marks** 

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

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

START HERE

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										Best Health Care Possible

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

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

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?

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

GETTING HEALTH CARE FROM SPECIALISTS

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

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

Worst Health Plan Possible — Best Health Plan 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 <u>mental or emotional</u> health?

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

38. Have you had either a flu shot or flu spray in the nose since July 1, 2015?

- ○ 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 <u>not</u> include pregnancy or menopause.

- ○ Yes
- ○ No

50. Do you now need or take medicine prescribed by a doctor? Do <u>not</u> 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 <u>not</u> 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
- ○ No ➔ ***Go to Question 59***

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

ADDITIONAL QUESTIONS

59. In the last 6 months, when you visited a doctor's office or clinic, did someone in the doctor's office or clinic give you information about what to do if you needed care during evenings, weekends, or holidays?

- ○ Yes
- ○ No
- ○ I did not visit a doctor's office or clinic in the last 6 months

60. 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
- ○ I did not see a doctor or other health provider in the last 6 months

61. In the last 6 months, did you and a doctor or other health provider talk about a personal problem, family problem, alcohol use, drug use, or a mental or emotional illness?

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

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

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

DataStat, 3975 Research Park Drive
Ann Arbor, MI 48108

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 1-888-248-5294.

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 15***
- ○ 1 time
- ○ 2
- ○ 3
- ○ 4
- ○ 5 to 9
- ○ 10 or more times

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

- ○ Yes
- ○ No

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

- ○ Yes
- ○ No ➔ ***Go to Question 13***

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

- ○ Yes
- ○ No

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

- ○ Yes
- ○ No

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

- ○ Yes
- ○ No

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

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

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

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

YOUR CHILD'S PERSONAL DOCTOR

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

- ○ Yes
- ○ No ➔ ***Go to Question 27***

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

- ○ None ➔ ***Go to Question 26***
- ○ 1 time
- ○ 2
- ○ 3
- ○ 4
- ○ 5 to 9
- ○ 10 or more times

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

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

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

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

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

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

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

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

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

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

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

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

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

- ○ Yes
- ○ No

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

- ○ Yes
- ○ No ➔ ***Go to Question 26***

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

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

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

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

Worst Personal Doctor Possible — Best Personal Doctor Possible

GETTING HEALTH CARE FROM SPECIALISTS

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

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

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

- ○ Yes
- ○ No ➔ ***Go to Question 31***

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

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

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

- ○ None ➔ ***Go to Question 31***
- ○ 1 specialist
- ○ 2
- ○ 3
- ○ 4
- ○ 5 or more specialists

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

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

YOUR CHILD'S HEALTH PLAN

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

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

- ○ Yes
- ○ No ➔ ***Go to Question 34***

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

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

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

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

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

- ○ Yes
- ○ No ➔ ***Go to Question 36***

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

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

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

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

ABOUT YOUR CHILD AND YOU

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

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

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

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

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

- ○ Less than 1 year old

☐☐ YEARS OLD (write in)

40. Is your child male or female?

- ○ Male
- ○ Female

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

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

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

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

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

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

44. Are you male or female?

- ○ Male
- ○ Female

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

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

46. How are you related to the child?

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

47. Did someone help you complete this survey?

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

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

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

ADDITIONAL QUESTIONS

49. In the last 6 months, when your child visited a doctor's office or clinic did someone in the doctor's office or clinic give you information about what to do if your child needed care during evenings, weekends, or holidays?

- ○ Yes
- ○ No
- ○ My child did not visit a doctor's office or clinic in the last 6 months

50. In the last 6 months, did you and your child's doctor or other health care provider talk about how much or what kind of food your child eats?

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

51. 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
- ○ My child did not see their doctor or other health provider in the last 6 months

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

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

DataStat, 3975 Research Park Drive
Ann Arbor, MI 48108

Appendix A: Methodology

Sampling Methodology

Sampling Assumptions

Following NCQA's specifications, HSAG used a systematic sampling method to select the samples for the adult Medicaid and child Medicaid samples. HSAG selected the sample sizes based on the goal of achieving 411 complete and valid surveys at the MCP level. To determine the established sample sizes, the following components were evaluated:

1. Previous years' response rates.
2. Percentage of ineligible beneficiaries in the sample.
3. Percentage of beneficiaries who were unable to be contacted due to bad address and phone number.
4. Percentage of beneficiaries that refused to participate.

Based on historical CAHPS disposition information for the California Medicaid population, oversampling of the general population was not required for the child Medicaid general sample. NCQA's recommended minimum required sample sizes provided sufficient responses. For the adult Medicaid general samples, based on historical CAHPS disposition information for the California adult Medicaid population, oversampling of the general sample was only required for three MCPs: CalOptima, IEHP, and Kaiser NorCal.

Given NCQA's changes to the sampling methodology, beneficiaries in the same MCP from duplicate households were not removed from the sample. While only the first beneficiary from a household received a survey, duplicate beneficiaries in a household were still submitted to NCQA with an assigned disposition code that they were deduplicated from the sample. If the sample fell below the minimum required sample size after deduplication, HSAG identified an appropriate oversample rate to ensure the minimum required sample size was met per NCQA specifications.

General Adult Sample

Table A-1 provides an example of the assumptions made in preparing the estimated sample sizes for the general adult population.[A-1]

Table A-1—Assumptions Applied in Deriving General Adult Sampling Plan and Corresponding Sample Sizes

Assumption	Anticipated Impact
1) At least 3 percent of beneficiaries will have incorrect contact (address and phone) information.	1) ~3% of the sample
2) At least 4 percent of beneficiaries will refuse to complete the survey.	2) ~4% of the sample
3) At least 7 percent of the beneficiaries, upon contact, will be categorized as ineligible for the survey (e.g., not enrolled, incapacitated, language barrier, deceased).	3) ~7% of the sample
4) At least 38 percent of the remaining eligible beneficiaries sampled will be respondents to the survey.	4) ~ 38% response[A-2]
5) Response rates may be differential across MCPs.	5) Unknown

Based on the assumptions presented directly above, Table A-2 depicts the estimated general adult sample size and corresponding anticipated number of respondents.

Table A-2—General Adult Respondent Sample Size Determination

	MCP Starting Sample Size	MCP Remaining Sample Size
Starting Sample Size	1,350	1,350
Inaccurate Contact Information	1,350	1,310
Refusal	1,310	1,256
Ineligible	1,256	1,161
Respondents	1,161	**441**
Please note, numbers may not tie out due to rounding.		

[A-1] Assumptions based on statewide average adult Medicaid dispositions from the 2013 California Medicaid CAHPS Survey.
[A-2] The percentage of responses is different than the response rate.

General Child Sample

Table A-3 provides an example of the assumptions made in preparing the estimated sample sizes for the general child population.[A-3]

Table A-3—Assumptions Applied in Deriving General Child Sampling Plan and Corresponding Sample Sizes

Assumption	Anticipated Impact
1) At least 3 percent of beneficiaries will have incorrect contact (address and phone) information.	1) ~3% of the sample
2) At least 3 percent of parents/caretakers of beneficiaries will refuse to complete the survey.	2) ~3% of the sample
3) At least 3 percent of beneficiaries, upon contact, will be categorized as ineligible for the survey (e.g., not enrolled, language barrier, deceased).	3) ~3% of the sample
4) At least 42 percent of the remaining eligible beneficiaries sampled will be respondents to the survey.	4) ~ 42% response[A-4]
5) Response rates may be differential across MCPs.	5) Unknown

Based on the assumptions presented directly above, Table A-4 depicts the estimated general child sample size and corresponding anticipated number of respondents.

Table A-4—General Child Respondent Sample Size Determination

	MCP Starting Sample Size	MCP Remaining Sample Size
Starting Sample Size	1,650	1,650
Inaccurate Contact Information	1,650	1,601
Refusal	1,601	1,551
Ineligible	1,551	1,502
Respondents	1,502	**630**
Please note, numbers may not tie out due to rounding.		

[A-3] Assumptions based on statewide average child Medicaid dispositions from the 2013 California Medicaid CAHPS Survey.
[A-4] The percentage of responses is different than the response rate.

County-Level Oversample

For the county-level oversample for the adult and child Medicaid populations, HSAG took the following steps to derive the necessary county-level oversample:

1. Estimated the respondent population size for each reporting unit from the general sample.
2. Determined the additional respondents required to reach the target of 100 completed surveys per reporting level.
3. Using the assumptions above, calculated the additional oversample required for each reporting unit to reach a target of 100 completed surveys per reporting unit.

Adult and Child Medicaid Managed Care Sampling

For the adult and child Medicaid managed care populations, HSAG conducted a systematic sample of Medicaid beneficiaries for each of the 23 MCPs at the parent-unit level. To accommodate county/region-level reporting, HSAG conducted a targeted oversample of the adult and child Medicaid populations, where appropriate. The following describes how this sampling approach was employed for the Medicaid managed care population.

General Sample

The first step of the sampling strategy was to select a stratified sample of adult and child Medicaid beneficiaries for each MCP at the parent-unit level. HSAG conducted sampling in accordance with NCQA's recommended error rate of ±5 percent at a 95 percent confidence level. The NCQA sampling methodology is designed to yield 411 completed surveys per MCP. The projected number of 411 completed surveys is designed by NCQA to yield at least 100 responses per survey question, which is the minimum reporting threshold required by NCQA. Based on the NCQA minimum recommended sample size for the CAHPS Adult Medicaid Health Plan Survey, HSAG selected a minimum of 1,350 adult Medicaid beneficiaries from each of the 23 participating MCPs at the MCP parent-unit level. Based on the NCQA minimum recommended sample size for the CAHPS Child Medicaid Health Plan Survey, HSAG selected a minimum of 1,650 child Medicaid beneficiaries from each of the 23 participating MCPs at the MCP parent-unit level.

County-Level Oversampling

For purposes of county-level reporting, HSAG refined the NCQA sampling methodology, such that a targeted oversample was conducted, where appropriate, with the goal of achieving 100 completed surveys per MCP reporting unit (i.e., contract/county/region). In the context of NCQA's recommended sample size for the CAHPS Adult Medicaid and Child Medicaid Health Plan Surveys and DHCS's surveying and reporting needs, Table A-5 and Table A-6, on the following pages, depict the final sample

sizes for the adult Medicaid and child Medicaid populations, respectively, for each MCP including any oversampling.[A-5]

Table A-5—Adult Medicaid Managed Care Sample Sizes for Each MCP

MCP	General Sample Size	County Oversample Size	Total Sample Size
AAH	1,356	—	1,356
Anthem	1,350	4,233	5,583
CHW	1,354	156	1,510
CalOptima	1,418	—	1,418
CalViva	1,351	745	2,096
Care1st	1,350	—	1,350
CenCal	1,352	48	1,400
CCAH	1,350	—	1,350
CHG	1,350	—	1,350
CCHP	1,350	—	1,355
Gold Coast	1,351	—	1,351
Health Net	1,355	2,361	3,716
HPSJ	1,352	25	1,377
HPSM	1,353	—	1,353
IEHP	1,620	—	1,620
Kaiser NorCal	1,689	—	1,689
Kaiser SoCal	1,350	—	1,350
KFHC	1,354	—	1,354
L.A. Care	1,352	—	1,352
Molina	1,351	670	2,021
Partnership	1,351	655	2,006
SFHP	1,366	—	1,366
SCFHP	1,353	—	1,353
Total Sample	**31,783**	**8,893**	**40,676**

[A-5] The numbers displayed in Table A-5 include surveyed members only.

Table A-6—Child Medicaid Managed Care Sample Sizes for Each MCP

MCP	General Sample Size	County Oversample Size	Total Sample Size
AAH	1,656	—	1,656
Anthem	1,655	2,427	4,082
CHW	1,653	—	1,653
CalOptima	1,650	—	1,650
CalViva	1,655	420	2,075
Care1st	1,656	—	1,656
CenCal	1,650	—	1,650
CCAH	1,651	—	1,651
CHG	1,652	—	1,652
CCHP	1,658	—	1,658
Gold Coast	1,653	—	1,653
Health Net	1,650	1,310	2,960
HPSJ	1,651	—	1,651
HPSM	1,655	—	1,655
IEHP	1,650	—	1,650
Kaiser NorCal	1,650	—	1,654
Kaiser SoCal	1,653	—	1,653
KFHC	1,655	—	1,655
L.A. Care	1,651	—	1,651
Molina	1,652	390	2,042
Partnership	1,654	205	1,859
SFHP	1,656	—	1,656
SCFHP	1,658	—	1,658
Total Sample	**38,028**	**4,752**	**42,780**

National Comparisons

HSAG conducted an analysis of the CAHPS Survey results using NCQA HEDIS Specifications for Survey Measures.[A-6] NCQA requires a minimum of 100 responses on each item in order to report the item as a valid CAHPS Survey result. Therefore, caution should be exercised when evaluating measures' results with fewer than 100 responses, which are denoted with a cross (+). HSAG used the following methodology to perform the National Comparisons analysis.

Three-Point Mean Calculations

In order to perform the National Comparisons, HSAG determined a three-point mean score for each CAHPS measure. For the global ratings, HSAG scored the response values as follows:

- Response values of 9 and 10 were given a score of 3.
- Response values of 7 and 8 were given a score of 2.
- Response values of 0 through 6 were given a score of 1.

The three-point global rating mean was the sum of the response scores (1, 2, or 3) divided by the total number of responses to the global rating question.

For composite measures, response values were scored as follows:

- Responses of "Always" were given a score of 3.
- Response of "Usually" were given a score of 2.
- All other responses were given a score of 1.

The three-point composite mean was the average of the mean score of each question included in the composite.

[A-6] National Committee for Quality Assurance. *HEDIS® 2016, Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA Publication, 2015.

Star Rating Assignments

To derive the overall beneficiary satisfaction ratings for each CAHPS measure, HSAG compared the resulting adult and child Medicaid three-point mean scores to NCQA's Benchmarks and Thresholds for Accreditation, except the Shared Decision Making composite.[A-7] NCQA does not publish benchmarks and thresholds for the Shared Decision Making composite; therefore, star ratings could not be assigned for this CAHPS measure. The National Comparisons analysis scored each measure using a one (★) to five (★★★★★) star rating system, where one is the lowest possible rating and five is the highest possible rating.

Table A-7 shows the adult and child percentiles used to determine star ratings for each CAHPS measure.

Table A-7—Star Ratings

Stars	Adult and Child Percentiles
★★★★★ *Excellent*	At or above the 90th percentile
★★★★ *Very Good*	At or above the 75th and below the 90th percentiles
★★★ *Good*	At or above the 50th and below the 75th percentiles
★★ *Fair*	At or above the 25th and below the 50th percentiles
★ *Poor*	Below the 25th percentile

Table A-8 and Table A-9 show the benchmarks and thresholds used to derive the overall adult Medicaid and child Medicaid beneficiary satisfaction ratings on each CAHPS measure, respectively.[A-8]

Table A-8—Overall Adult Medicaid Beneficiary Satisfaction Ratings Crosswalk

Measure	90th Percentile	75th Percentile	50th Percentile	25th Percentile
Rating of Health Plan	2.55	2.49	2.43	2.37
Rating of All Health Care	2.45	2.42	2.36	2.31
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	2.42	2.37	2.31
Getting Care Quickly	2.49	2.46	2.42	2.36
How Well Doctors Communicate	2.64	2.58	2.54	2.48
Customer Service	2.61	2.58	2.54	2.48

[A-7] National Committee for Quality Assurance. *HEDIS Benchmarks and Thresholds for Accreditation 2016*. Washington, DC: NCQA, January 21, 2016.

[A-8] Ibid.

Table A-9—Overall Child Medicaid Beneficiary 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	2.58	2.53	2.47	2.39
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

State Comparisons

HSAG calculated case-mix adjusted top-box rates for each global rating and composite measure. Top-box rates were calculated in accordance with NCQA HEDIS Specifications for Survey Measures. The scoring of the global ratings and composite measures involved assigning top-level responses a score of one, with all other responses receiving a score of zero. After applying this scoring methodology, HSAG calculated the percentage of top-level responses in order to determine the top-box rates. For additional detail, please refer to the *NCQA HEDIS 2016 Specifications for Survey Measures, Volume 3*.

For purposes of the State Comparisons, HSAG applied two types of hypothesis tests to the results. First, HSAG calculated a global *F* test, which determined whether the difference between the MCP scores was significant. If the *F* test demonstrated MCP-level differences (i.e., $p \leq 0.05$), then HSAG performed a *t* test for each MCP. The *t* test determined whether each MCP's score was significantly different from the overall MCMC Program aggregate. The graphs also include vertical lines indicating the 2015 Quality Compass 25th percentile, national average, and 90th percentile for comparison purposes.[A-9] HSAG suppressed MCPs results with fewer than 11 cases in the numerator to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standards.

Key Drivers of Satisfaction

In order to determine potential items for QI efforts, HSAG performed a key drivers of satisfaction analysis at the statewide level for the adult and child populations separately. The purpose of the key drivers of satisfaction analysis is to help decision makers identify specific aspects of care that will most benefit from quality improvement activities. The analysis provides information on:

- How well the population is performing on the survey item.
- How important that item is to overall satisfaction.

[A-9] 2015 Quality Compass data reflects measurement year 2014 rates.

Table A-10 depicts the CAHPS 5.0H Adult Medicaid and Child Medicaid Health Plan Surveys items that were analyzed for each global rating and composite measure in the program-level key drivers of satisfaction analysis.[A-10]

Table A-10—Correlation Matrix

Question Number	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
Q4	✓	✓	✓	✓	✓	✓		
Q6	✓	✓	✓	✓	✓	✓		
Q8	✓	✓	✓	✓			✓	
Q9	✓	✓	✓	✓	✓		✓	
Q10	✓	✓	✓	✓	✓		✓	
Q11	✓	✓	✓	✓			✓	
Q12	✓	✓	✓	✓	✓		✓	
Q14	✓	✓	✓	✓	✓	✓		✓
Q17	✓	✓	✓				✓	
Q18	✓	✓	✓				✓	
Q19	✓	✓	✓				✓	
Q21*	✓	✓	✓				✓	
Q22 (CM)/Q20 (AM)	✓	✓	✓		✓		✓	
Q23*	✓	✓	✓					
Q25 (CM)/Q22 (AM)	✓	✓	✓				✓	
Q28 (CM)/Q25 (AM)	✓	✓		✓	✓	✓		
Q32 (CM)/Q31 (AM)	✓	✓						✓
Q33 (CM)/Q32 (AM)	✓	✓						✓
Q35 (CM)/Q34 (AM)	✓	✓						✓

A checkmark (✓) indicates that the question was used in the key drivers of satisfaction analysis for the specified global rating or composite measure.

* Please note: Questions 21 and 23 correspond to the CAHPS Child Medicaid Health Plan Survey only; therefore, these survey items were not evaluated as part of the key drivers of satisfaction analysis for the adult population.
CM indicates the question number corresponds to the CAHPS Child Medicaid Health Plan Survey.
AM indicates the question number corresponds to the CAHPS Adult Medicaid Health Plan Survey.

[A-10] The question numbers listed for each survey item evaluated correspond with the CAHPS 5.0H Adult and Child Medicaid Health Plan Surveys.

Perceived performance on a survey question was measured by calculating a *problem score*, in which a negative experience with care was defined as a problem and assigned a "1," and a positive experience was assigned a "0." The higher the problem score, the lower the beneficiary satisfaction with the aspect of service measured by that question. The problem score could range from 0 to 1.

Table A-11 depicts the problem score assignments for the different response categories.

Table A-11—Assignment of Problem Scores

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

A problem score at or above the median problem score was considered to be "high." A correlation at or above the median correlation was considered to be "high." Key drivers were those items for which the problem score and correlation were both at or above their respective medians. The median, rather than the mean, was used to ensure that extreme problem scores and correlations do not have disproportionate influence in prioritizing individual questions.

Correlation

Using the Pearson product moment correlation, HSAG calculated the relationship between the problem score of a question and priority items. This conversion modifies the distributions of both variables so that they conform to the standard normal distribution and can be compared.

The correlation could range from -1 to 1, with negative values indicating a negative relationship between overall satisfaction and a particular survey item. However, the correlation analysis conducted was not focused on the direction of the correlation, but rather on the degree of correlation. Therefore, the absolute value of r was used in the analysis, and the range for r was 0 to 1. An r of zero indicated no relationship between the response to a question and satisfaction. As r increased, the importance of the question to the respondent's satisfaction increased.