

2001 Michigan Medicaid Consumer Satisfaction Surveys

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RESEARCH OBJECTIVES AND PROCEDURES

Background

To better understand consumer perception of quality, the Michigan Department of Community Health (MDCH) conducts an annual consumer satisfaction survey of Medicaid managed care enrollees. The survey results are an important component of Medicaid program management and oversight. An additional function of the survey results reported here is to provide information to support informed consumer choices of health care services. As stated in the NCQA's 2001 Volume 3 manual, *HEDIS® 2001: Specifications for Survey Measures*: HEDIS is part of an integrated system to establish accountability in managed care.

This is just as true for consumers covered by Medicaid as for those in commercial plans. Data from this study will provide information to various audiences about how managed care plans compare on a variety of quality indicators.

The survey instrument and procedure employed in 2001 to address these objectives is the Consumer Assessment of Health Plans Study questionnaire and protocol (CAHPS® 2.0H). The Michigan Department of Community Health, the state agency in charge of administering the Medicaid program, commissioned Market Facts, a survey research company specializing in consumer satisfaction surveys and NCQA certified vendor, to conduct the survey following standard CAHPS procedures. Survey data collection began in February and ended in May 2001. The adult and child Medicaid CAHPS 2.0H questionnaires used in this study are in Appendix A.

This report presents the consumer satisfaction survey results for Michigan health plans in 2001 (2000 measurement year). Data and analysis from 19 adult plans and 19 child plans are included.

As part of the 2001 Michigan Medicaid CAHPS surveys, each health plan has also been sent: (1) a complete set of cross-tabulation tables showing the entire distribution of responses to each survey question, overall and broken out by demographic and health relevant categories; and (2) electronic data files (member-level data file and summary-level data file), which the plan can use for additional data analysis.

Health Plans Surveyed

The health plans included in the consumer satisfaction research are listed in Table 1. Each plan name has been given a 3-letter abbreviation used in labeling the statistical graphs.

Table 1. Health Plans Surveyed		
Name of Plan	Abbreviation	Primary Office Location
Botsford Health Plan	BOT	Farmington Hills
Cape Health Plan	CAP	Detroit
Care Choices HMO	CAR	Farmington Hills
Community Care Plan	CCP	Grand Rapids
Community Choice Michigan	CCM	Okemos
Great Lakes Health Plan	GLH	Southfield
Health Plan of Michigan	HPM	Southfield
Health Plus of Michigan	PLS	Flint
M-CARE	MCR	Ann Arbor
McLaren Health Plan	MCL	Flint
Midwest Health Plan	MID	Dearborn
Molina Healthcare	MOL	Bloomfield Hills
OmniCare	OCR	Detroit
PHP of Mid-Michigan	PMD	Lansing
PHP of Southwest Michigan	PSW	Kalamazoo
Priority Health	PRI	Grand Rapids
Total Health Care	TOT	Detroit
Upper Peninsula Health Plan	UPP	Marquette
The Wellness Plan	WEL	Detroit

The CAHPS 2.0H Surveys

The adult Medicaid and child Medicaid CAHPS 2.0H surveys are members of a family of surveys that assess patient satisfaction with their experience of care. There are also CAHPS 2.0H surveys for adult commercial and child commercial populations. The surveys were developed under the auspices of the Agency for Healthcare Research and Quality (AHRQ) when the agency was known as the Agency for Health Care Policy and Research (AHCPR). AHRQ is the leading federal agency performing quality of care research, and is responsible for coordinating all federal quality improvement efforts and health services research.

The core of the CAHPS survey is a set of 10 measures that are used to understand satisfaction with the experience with care. These include 5 composites that summarize responses in key areas and 4 ratings questions that reflect overall satisfaction. Using a 0 to 10 scale, the ratings questions ask the respondent to rate their doctor, their specialist, their experience with all care, and their health plan. Results for the rating items are presented in this report as the

percentage that chose the top 3 scores. In other words, all respondents who rated their physician 10, 9, or 8 would be included in this percentage.

Sampling: Eligibility and Selection Procedures

Those eligible to be a respondent in the CAHPS 2.0H adult Medicaid survey had to be 18 years of age or older as of December 31 of the reporting year (2000), and be continuously enrolled in the health plan for at least 5 of the last 6 months of 2000. Those eligible to be a respondent in the child Medicaid survey, had to be the parent or guardian of a child enrolled for at least 5 of the last 6 months of 2000. A child is defined as 12 years and younger as of December 31 of the measurement year. Additionally, the adult or child must be enrolled at the time the survey was completed.

Each health plan was responsible for preparing a database of names, addresses, and phone numbers (when available) of current enrollees meeting these criteria. Market Facts selected survey samples randomly from these lists. In accordance with standard CAHPS protocol, names and addresses of selected enrollees without phone numbers were sent to a telephone matching service to obtain numbers for as many enrollees as possible before the survey began. Additionally, the sample was processed through National Change of Address look-up, to obtain the most up-to-date address for each respondent.

The adult sample for a plan was selected first and those addresses were removed before the child sample for that plan was drawn. This procedure insured that the same household was not selected for both the child and the adult survey.

For the 2001 survey, NCQA required a sample size of 1050 for the Medicaid surveys. This was the same as the 2000 survey, even though this year all plans were required to collect the Advising Smokers to Quit (ASTQ) measure. Even if a health plan collected ASTQ information last year, NCQA required that the health plan collect this information again this year. The ASTQ requirement rotates on a two-year cycle, with the 2000 measurement being a reporting year. Plans were required to over sample if they thought their member databases could not be purged of disenrolled members in time to meet data submission deadlines. This was the case with PHP of Mid-Michigan, which had both adult and child starting sample sizes of 1208. Botsford Health Plan did not have sufficient eligible child members to sample 1050, and therefore had a starting sample size of 757. The duration of the protocol was 76 days. Target response rate was 45 percent.

Contact Protocol

The CAHPS 2.0H survey used to generate the data summarized in this report used a rigorous, multi-stage contact protocol. The protocol featured a mixed-mode approach designed both to maximize response rates, and to give different types of responders a chance to reply to the survey in a way that they find comfortable. For example, telephone responders are more likely to be younger, male, and healthier. Mail responders are more likely to be older, better educated, and less healthy.

To conduct the CAHPS survey, a plan extracted a set of contact information for every eligible member from its database. A certified auditor checked the procedures to make sure that the

sample frame was correctly constructed. The sample frame was sent to Market Facts, where the list was deduplicated so that only one adult from each household remained. Market Facts then drew a random sample of the correct size. The prescribed procedures were followed, as described in the HEDIS® 2001, Volume 3 manual. Table 1 summarizes the NCQA data collection protocol.

Table 1. Data Collection Protocol	
Survey Task	Timeframe
Send a pre-notification postcard to the member 3 days before the first survey questionnaire mailing.	0 days
Send first questionnaire with cover letter to the member 3 days after the pre-notification postcard.	3 days
Send a postcard reminder to non-respondents 4 to 10 days after mailing the first questionnaire.	7-13 days
Send a second questionnaire with replacement cover letter to non-respondents approximately 30 days after mailing the first questionnaire.	33 days
Send a second postcard reminder to non-respondents 4 to 10 days after mailing the second questionnaire.	37-43 days
Initiate computer-assisted telephone interviews (CATI) for non-respondents approximately 21 days after mailing the second questionnaire.	54 days
Initiate systematic contact for all non-respondents such that at least 6 telephone calls are attempted at different times of day, on different days of the week and in different weeks.	54-76 days
Complete telephone follow-up sequence (completed interviews obtained or maximum calls reached for all non-respondents) approximately 22 days after initiation.	76 days

Response Rates

As directed by NCQA, response rate is calculated by dividing the number of completed surveys by the number in the original sample less ineligible respondents:

$$\frac{\text{completes}}{\text{original sample} - \text{ineligibles}}$$

A complete survey is defined as all critical questions (Adult Medicaid = questions 1 and 21, Child Medicaid = questions 1 and 22) are answered and 80 percent of the total pertinent questions are answered. Questions that are appropriately skipped (item left blank per skip pattern instruction) do not count against the required 80 percent. Additionally, the four Advising Smokers to Quit questions are not included in the calculation of percent complete. Ineligible respondents are defined as respondents who fall into these 5 categories: (1)

deceased; (2) no longer enrolled in the plan; (3) those who could not respond to the survey because of a language barrier; (4) individuals with a bad address AND non-working or unlisted phone number, or a member who is unknown at the dialed phone number, or (5) mentally or physically incapacitated (adult version only).

The overall adult response rate, aggregating across all the samples, is 35.11%; the average response rate (adding up all the response rates and then dividing by 19) is 35.19%. The overall child response rate, aggregating across all the samples, is 31.63%; the average response rate (adding up all the response rates and then dividing by 19) is 31.52%. Table 2 presents the starting sample, sample used to calculate response rate (starting sample minus ineligible), number of completes, and response rate for the adult survey. Table 2A presents the same information for the child survey.

Table 2. Adult Samples and Response Rates				
Plan Name	Starting Sample	Starting Sample minus ineligible	Number of Completes	Response Rate
Botsford Health Plan	1050	1033	211	20.43%
Cape Health Plan	1050	992	276	27.82%
Care Choices HMO	1050	1005	299	29.75%
Community Care Plan	1050	999	440	44.04%
Community Choice Michigan	1050	999	312	31.23%
Great Lakes Health Plan	1050	992	373	37.60%
Health Plan of Michigan	1050	1021	380	37.22%
Health Plus of Michigan	1050	1008	436	43.25%
M-CARE	1050	1003	362	36.09%
McLaren Health Plan	1050	980	423	43.16%
Midwest Health Plan	1050	987	319	32.32%
Molina Healthcare	1050	1010	369	36.53%
OmniCare	1050	1002	261	26.05%
PHP of Mid-Michigan	1208	963	389	40.39%
PHP of Southwest Michigan	1050	966	377	39.03%
Priority Health	1050	1007	419	41.61%
Total Health Care	1050	1017	250	24.58%
Upper Peninsula Health Plan	1050	1032	489	47.38%
The Wellness Plan	1050	957	276	28.84%
			Plan Average (Total / 19)	35.11%

Table 2A. Child Samples and Response Rates				
Plan Name	Starting Sample	Starting Sample minus Ineligibles	Number of Completes	Response Rate
Botsford Health Plan	757	743	126	16.96%
Cape Health Plan	1050	1016	216	21.26%
Care Choices HMO	1050	1013	254	25.07%
Community Care Plan	1050	1006	396	39.36%
Community Choice Michigan	1050	1006	296	29.42%
Great Lakes Health Plan	1050	1019	337	33.07%
Health Plan of Michigan	1050	1031	295	28.61%
Health Plus of Michigan	1050	1003	439	43.77%
M-CARE	1050	984	361	36.69%
McLaren Health Plan	1050	972	401	41.26%
Midwest Health Plan	1050	975	250	25.64%
Molina Healthcare	1050	1025	287	28.00%
OmniCare	1050	1015	200	19.70%
PHP of Mid-Michigan	1208	904	371	41.04%
PHP of Southwest Michigan	1050	942	343	36.41%
Priority Health	1050	992	394	39.72%
Total Health Care	1050	1006	205	20.38%
Upper Peninsula Health Plan	1050	1016	462	45.47%
The Wellness Plan	1050	951	257	27.02%
			Plan Average (Total / 19)	31.52%

Outline of the Report

The remainder of this report is devoted to reporting the survey results.

The first section presents the results for the plans. It begins with an overall assessment that summarizes the plans' performance and highlights their strengths and weaknesses. The next section contains a series of vertical bar graphs. The graphs for the adult sample display scores for each of the 19 managed care plans on each of the survey questions or composites, ordered from high to low. A horizontal line shows the average score of all 19 plans on each item. From these graphs, you can easily determine (1) each plan's performance; (2) how it compares with each of the other plans; and (3) how it compares with the statewide plan average, and (4) how it compares to their performance in the 2000 CAHPS survey.

An Important Note Regarding Statistical Significance

Please be careful to avoid over-interpreting small differences when reading the bar graphs. From the perspective of statistical significance, what is "small" depends on the sample size, the design, and the statistics being compared. Some results, which may appear to be statistically significantly different, are not because they are based on smaller samples than other bars in the graph. On a related point, statistical significance does not necessarily equate to practical significance, which is a matter of judgment. Statistically significant results are reported at the 90% level of statistical confidence.

Interpreting the graphs. To assist you, the plan results that are significantly different from the plan average appear as green numbers in the graphs. Plan results which are significantly different from that plan's results from 2000 appear as a + (plus) or – (minus). The plan average is shown with a horizontal line on each graph.

Interpreting the statistical summary for each plan. Results for each plan are shown in the statistical summary. Results which are significantly different from the plan average appear as a + (plus) or – (minus) on the summary. Results that are significantly different from results in 2000 appear as an H (higher) or L (lower).

A point to keep in mind is that higher (+) than average is not always "better", and lower (-) is not always "poorer" performance. For example, it is preferable for a plan to have a low percentage of members who wait more than seven days for routine care. In this case, the lower the score, the better the plan performs compared to the average plan. Other measures for which this is also true are: the percent of members who wait more than three days to see a doctor for illness or injury; and the percent of members who called or wrote their health plan with a complaint or problem.

Composite Measures

Most of the performance indicators and other measures presented in the report are expressed as the simple percentage of respondents who gave a certain response to a particular survey item. For example, the percent of respondents answering that they saw a medical specialist in the past 6 months, or the percent scoring their health plan with a 10, 9, or 8 on an 11-point quality rating scale. These measures are straightforward and easily understood.

A few measures reported are multi-item composite indexes. These composites are standardized CAHPS quality measures developed by combining responses to several questions. The composites are designed to capture some dimension of quality. Five such composite measures are reported here:

- Getting Needed Care (4 questions)
- Getting Care Quickly (4 questions)
- How Well Doctors Communicate (4 questions)
- Courteous and Helpful Office Staff (2 questions)
- Customer Service (3 questions)

It is possible to present the results of these composite measures as means or as average percentage scores (averaging across each of the questions making up the index). Since attaching a substantive interpretation to mean scores is generally more difficult and potentially confusing, this report presents the average percentages among the questions that make up each composite. A list of questions included in each composite measure and a detailed description of how each composite is calculated is contained in Appendix B.

Market Facts did not administer the CAHPS Medicaid surveys for PHP of Mid-Michigan, and therefore, they are missing from several of the graphs because members of this plan were not asked these supplemental questions:

Adult Table IV-9: Q.50a "In the last 6 months, did you get any new prescription medicine or refill a prescription?"

Adult Table IV-10: Q.50d "Some health plans help with transportation to doctors' offices or clinics. The help can be a shuttle bus, tokens or vouchers for a bus or taxi, or payments for mileage. In the last 6 months did you contact your health plan to get help with transportation?"

Adult Table VIII-5: Q.50b "In the last 6 months, how much of a problem, if any, was it to get your prescription medicine from your health plan?"

Adult Table VIII-6: Q.50c "In the last 6 months, how often did you get the prescription medicine you needed through your health plan?"

Child Table XI-8: Q.60a "In the last 6 months, did your child get any new prescription medicine or refill a prescription?"

Child Table XI-9: Q.60d "Some health plans help with transportation to doctors' offices or clinics. The help can be a shuttle bus, tokens or vouchers for a bus or taxi, or payments for mileage. In the last 6 months did you contact your health plan to get help with transportation for your child?"

Child Table XV-5: Q.60b "In the last 6 months, how much of a problem, if any, was it to get your child's prescription medicine from your health plan?"

Child Table XV-6: Q.60c "In the last 6 months, how often did your child get the prescription medicine he or she needed through your health plan?"

2001 MICHIGAN MEDICAID CONSUMER SATISFACTION SURVEYS: SUMMARY OF PLAN RESULTS

This analysis, prepared for the Michigan Department of Community Health, is an overview of the plan-by-plan findings from the 2001 survey of Medicaid managed care enrollees. Samples of members from each of 19 managed health care plans in Michigan which service Medicaid beneficiaries were surveyed using the Consumer Assessment of Health Plans (CAHPS®) 2.0H instruments and protocols. The reference period for the survey was the 6-month period proceeding the date when the questionnaire or telephone interview was completed. Since the survey was fielded from February through May of 2001, the reference period was August 2000 through May 2001.

Two separate non-overlapping samples from each health plan were surveyed: a sample of adults 18 and older and a sample of children age 12 years and younger. A parent or guardian of the child served as the respondent in the child sample surveys. Data from 19 adult and 19 child samples were reported to the health plans and also constitute the basis for this summary.

This summary addresses plan performance and examines all managed care plans throughout the state that were surveyed. Its purpose is to present estimates and assessments of how plans differ and how well they are performing based on the results of the CAHPS 2.0H consumer satisfaction surveys.

This summary is organized using the same topical subheadings contained in the statistical summaries for the individual plans of both adult and child:

- ❖ Demographic Profile
- ❖ Health Characteristics, Utilization, Plan Tenure
- ❖ Ratings of Medical Providers
- ❖ Getting Medical Care
- ❖ Communications and Interactions with Providers and Office Staff
- ❖ The Health Plan
- ❖ Michigan Enrolls
- ❖ Overall Year to Year Assessment

Adult Survey

Overall Quality Groupings

Viewed across the full range of satisfaction and quality indicators, the following six health plans perform better than average overall in the Adult Sample consumer survey (in alphabetical order):

These six plans are the top performers:

Botsford Health Plan
Care Choices HMO
Health Plus of Michigan
M-CARE
Priority Health
Upper Peninsula Health Plan

These seven plans fall in the middle range:

Community Care Plan
Community Choice Michigan
Great Lakes Health Plan
Health Plan of Michigan
McLaren Health Plan
PHP of Mid-Michigan
PHP of Southwest Michigan

These six plans perform below the average:

Cape Health Plan
Midwest Health Plan
Molina Healthcare
OmniCare
Total Health Care
The Wellness Plan

Demographic Profile

The 19-plan average for **gender** (73% female) shows most plans falling within a fairly modest range of values; that is, the amount of variation on this characteristics is relatively small: from 66% to 77%.

Education (percent of members without high school diploma) shows somewhat greater variation, with plans ranging from 24% to 49% around the 35% plan average.

Variation across plans is sharper on minority group status (percent non-white or Hispanic) and the proportion of members who speak a foreign language at home. These are the demographic variables that tend to distinguish the plans' Medicaid memberships.

Minority group status, defined as self-identification as Hispanic or racially non-white, ranges from a low of 8% for Upper Peninsula Health Plan to a high of 92% for OmniCare, with a plan average of 35%. Other health plans with large minority populations, relative to the statewide plan average, are The Wellness Plan (65%), Botsford Health Plan (64%) and Total Health Care (63%).

With respect to **language**, the average plan has about 7% of members who mainly speak some language other than English at home. However, this average is somewhat misleading because it is being skewed by the 41% of members at Midwest Health Plan whose primary language is something other than English. The other 18 plans fall in the relatively modest range of between 0% and 14%. About one-fifth of adult enrollees in the typical plan (21%) said they sometimes, usually, or always had trouble speaking with or understanding a health care provider because they spoke different languages. "Different languages" may sometimes mean the doctor speaks too technically, in heavily accented English, or simply doesn't use words the respondent understands.

Health-Related Characteristics, Utilization, Plan Tenure

Fifty-seven percent of members in the average health plan rated their **health** as excellent, very good, or good. The variation on this measure ranges from a low of 44% at Molina Healthcare to a high of 68% at M-CARE.

The number of **regular cigarette smokers** in the average plan is 42%, and the range of variation is fairly flat: from 35% at Midwest Health Plan to 49% at Upper Peninsula Health Plan.

The 19 plans differ substantially in the percent of members who report **choosing the plan** rather than being assigned to it. More than any other plan, M-CARE members say they chose their plan (75%); four other plans exhibit member selection rates in the 70% to 73% range. At the other extreme, only 38% of Molina Healthcare members report having chosen the plan themselves. The overall average of member selection is 63%. Since 2000, 12 plans showed significant increases in the percent of members who chose their plans rather than being assigned while two plans showed significant decreases.

There is less variation in the number who **needed immediate care** in the past six months for illness or injury: the plan average is 45% and the range is from 36% (Midwest Health Plan) to 52% (Health Plan of Michigan). A similar finding holds true for **emergency room visits**, with a plan average of 30% making one or more trips in the past six months, and a range from 22% (Midwest Health Plan) to 35% (Community Choice Michigan).

The average proportion of members who made **three or more trips to a doctor's office** for care is 48%, with plans falling within a moderate band of 44% to 54%. An average 39% of members made **visits to specialists**, with the highest at Care Choices HMO (44%) and the lowest at Cape Health Plan (28%).

Six of the health plans have a larger than average proportion of **new enrollees** – those who say they have been with their plan for less than 12 consecutive months: Molina Healthcare (43%), Cape Health Plan (38%), McLaren Health Plan (35%), Botsford Health Plan (34%), OmniCare (34%), and Midwest Health Plan (30%). Two plans lie at the opposite extreme, having few new members: Care Choices HMO (10%), and PHP of Mid-Michigan (11%). The statewide plan average is 25%. Since 2000, seven plans had significant decreases in the percent of members who were enrolled for less than 12 months, while four plans had increases in the percentage of members who are new.

Almost four-fifths of members (79%) got at least one **prescription filled** in the last 6 months; the range of variation is 72% to 84%.

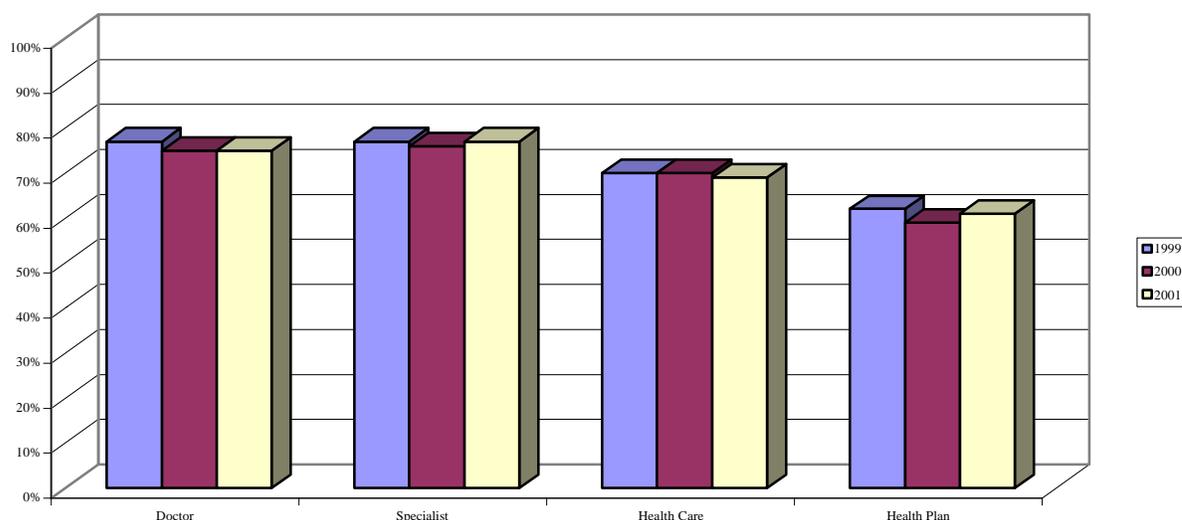
At 17%, Cape Health Plan and Botsford Health Plan have the highest percentage of members who called to get transportation help. The plan average is 9%.

Ratings of Medical Providers

A majority of members in all plans feel they have a **“personal doctor or nurse.”** The overall plan average is 77%. However, some plans score more positively on this key indicator than others, as the value ranges from 64% at Total Health Care to 89% at Upper Peninsula Health Plan. Since 2000, only one plan has shown improvement on this measure (Health Plus of Michigan) while three plans posted declines: Community Care Plan, Health Plan of Michigan, and PHP of Southwest Michigan.

- ❖ Ratings of medical providers differ by 19 percentage points among the 19 health plans. On the 0-10 scaled rating of one’s **“personal doctor or nurse”** (asked only of respondents who said they had one), 75% gave a rating of 10, 9, or 8. This measure is virtually unchanged across the state since 2000, with only two health plans receiving lower ratings for their personal providers (Community Care Plan and Great Lakes Health Plan) and one plan receiving higher ratings (Health Plan of Michigan).
- ❖ Similarly for ratings of members’ medical **specialists** (asked of enrollees who had seen a specialist in the last 6 months), 77% gave a rating of 10, 9, or 8. Community Care Plan showed lower ratings than 2000 on this measure, while Health Plan of Michigan and Total Health Care showed higher ratings. This satisfaction measure exhibited a 16-point spread (69% - 85%).
- ❖ On the third scaled healthcare provider quality item, (ratings of **“all doctors and other health providers”**), 69% gave the top-3-category rating. Three plans showed significant decreases on this measure since 2000: Community Care Plan, Priority Health, and The Wellness Plan. There is a 21-point range in scores: 60% - 81%. Botsford Health Plan is at the top of the list on this important indicator, followed by Upper Peninsula Health Plan (77%) and M-CARE (76%).

Percent that Rate Providers 8, 9, or 10
Adult



There has been very little change over the last three years for the four ratings questions. The ratings for Doctors and Specialists have remained consistently high, with all scores falling above the 70% mark. Although Doctors and Specialists are rating above 70%, the rating for all health care has fallen just below 70%. The rating of the health plan has the most room for improvement, with scores consistently falling below the 60% mark.

Getting Medical Care

The multi-item **Getting Needed Care** composite measure represents a blend of finding a suitable personal doctor or nurse, getting referrals to specialists, getting care believed to be necessary, and receiving prompt approvals from the health plan. On average, 7 of 10 members (71%) report that getting care is not a problem. The highest scoring plan, based on this composite, is Botsford Health Plan (83%), followed closely by Upper Peninsula Health Plan (82%). The only changes since 2000 were improved performance by McLaren Health Plan and a decline in performance by Health Plus of Michigan and the Wellness Plan.

The multi-item **Getting Care Quickly** composite measure is a combination of getting prompt assistance from the doctor's office, getting appointments promptly, getting prompt care for illness or injury, and waiting time at the doctor's office. On average, 77% of enrollees had no problems obtaining care quickly. One plan, Community Care Plan declined on this measure. . On average, 24% of members report waiting more than 7 days to get an **appointment for routine care**. Performance varies, however, from 14% at Health Plan of Michigan to 35% at the Wellness Plan. Four plans improved their performance on this measure since last year's survey: OmniCare, Total Health Care, Cape Health Plan, and Health Plus of Michigan.

Getting an **appointment for illness or injury**, measured as the percent of members who wait more than 3 days, ranges from a low of 16% at Upper Peninsula Health Plan to a high of 31% at OmniCare with a statewide average of 23%. This was an area of improvement for two plans since last year: Total Health Care and Health Plus of Michigan. Care Choices HMO experienced a decline in this measure.

Communication and Interaction with Providers and Office Staff

How Well Doctors Communicate is a composite measure consisting of listening carefully, explaining things clearly, showing respect for the patient's views, and spending enough time with the patient. A high percentage of health plan members, an average of 84%, say their doctors always or usually communicate well. The range of scores across the 19 plans is a small 14 percentage points.

The **Courteous and Helpful Office Staff** composite measure is a combination of displaying courtesy and respect, and the perception that office staff is as "helpful as you thought they should be." A large majority of each plan's members, averaging 87%, say office staff is usually or always courteous and helpful, with a 17-percentage point variation among plans. Priority Health, Community Care Plan, PHP of Southwest Michigan, Community Choice Michigan, and Total Health Care received lower ratings than last year on this measure.

The Health Plan

The **customer service** composite represents three areas: finding or understanding information in written materials, getting help when customer service was called, and required paperwork. Customer service ratings vary considerably across the plans, from a low of 51% who said they had no problems with customer service at Molina Healthcare to a high of 79% at Botsford Health Plan. The average is 63%. Customer service is one dimension where there seems to be room for improvement nearly everywhere. Only one plan, McLaren Health Plan, improved significantly since last year.

Fifty-three percent of plan members report that the **information they received before joining the plan** was correct. The highest score is 62% at Upper Peninsula Health Plan. The Wellness Plan declined this year on this measure, and two plans improved their scores: Upper Peninsula Health Plan and Care Choices HMO.

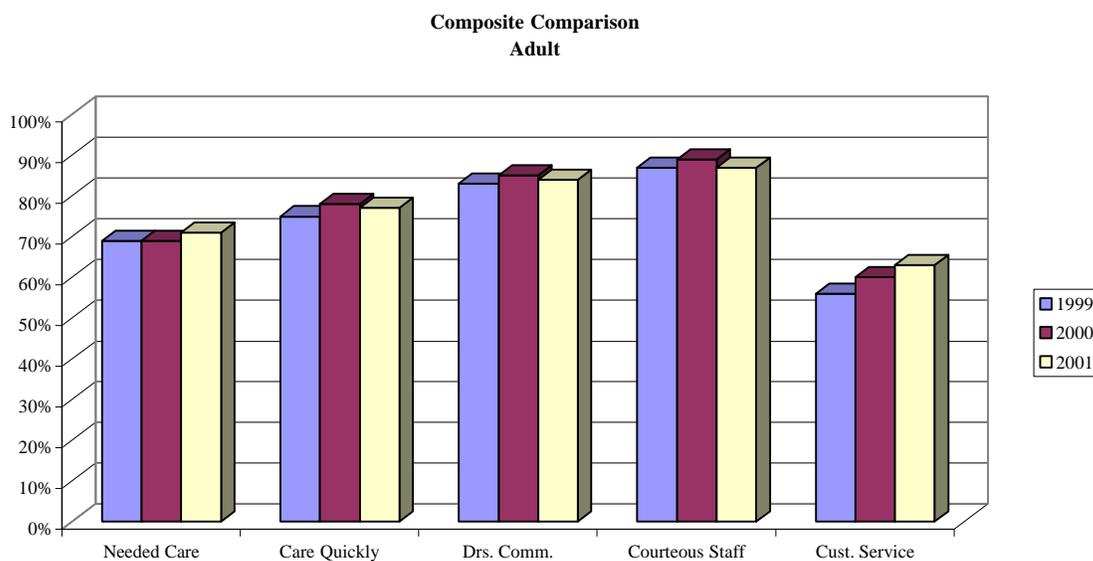
On average 12% of members **contacted their health plan with a complaint** or problem in the last six months. Members of Molina Healthcare were the most likely to contact their health plan (19%). Members of M-CARE and Midwest Health Plan reported the lowest likelihood of complaints or problems (9%). Three plans had a smaller percentage of members who voiced complaints about their plan this year: Health Plan of Michigan, Great Lakes Health Plan, and Care Choices HMO. Only PHP of Southwest Michigan had a higher percentage of members with complaints this year.

Of those who had obtained prescriptions, 74% percent of the members had **no problem getting the prescription filled** through their plan. Molina Healthcare (55%) has the lowest score on this indicator, but four other plans are also below the plan average: Great Lakes Health Plan (68%), Botsford Health Plan (68%), McLaren Health Plan (65%), and Cape Health Plan (64%). Health Plan of Michigan at 73% and McLaren Health Plan at 65% improved their performance on this measure since last year while HealthPlus of Michigan and Community Care Plan decreased.

Of the smokers who saw a doctor in the last 6 months, on average 65% were **advised to quit smoking**. Priority Health (75%) and Community Care Plan (74%) are doing the best job on this measure, while Botsford Health Plan (54%) has the lowest percentage of members reporting being advised to quit. Community Care Plan was also the only plan to improve since last year, and McLaren Health Plan was the only plan to decline.

When asked to rate **"all their experiences with your health plan,"** 61%, on average across the 19 plans, gave a rating of 10, 9, or 8 on the 11-point rating scale (0-10, where 0 is worst health plan possible and 10 is best health plan possible). Plan ratings ranged from a low of 46% at Molina Healthcare to 71% at PHP of Mid-Michigan and Botsford Health Plan. *This "overall" rating may be the single most important performance indicator in the survey.* It seems to correlate positively with many of the CAHPS scores and ratings. So it is encouraging that the trend was upward for three plans this year: PHP of Mid-Michigan, McLaren Health Plan, and Health Plan of Michigan. Only The Wellness Plan received lower overall ratings than last year.

Composite Scores:



The State average for the five composite scores has remained almost constant during the last three years. The chart above illustrates State averages for the composite measures since 1999. The Customer Satisfaction composite score has shown the most change, going from 56% in 1999, to 60% in 2000, and increasing again to 61% in 2001. Although this measure has risen, there is still room for improvement, as it also consistently falls short of the other measures.

Michigan Enrolls

The survey of Michigan Medicaid managed care providers included a series of questions about the member's experience with Michigan Enrolls, the enrollment broker contracted by Medicaid to assist beneficiaries enrolling in health plans. A little over half (58%) of adult Medicaid managed care enrollees report receiving information from Michigan Enrolls before signing up with their current health plan. Of these adults, 85% report receiving an information packet in the mail; 96% found the information somewhat or very helpful.

Over three-fourths (78%) of members knew about the Michigan Enrolls toll-free telephone number, and of these, 62% called the number for assistance in making their choice. The Michigan Enrolls toll-free line provided 96% of callers with some or all the advice they needed. On rating all experiences with Michigan Enrolls, 61% of enrollees who used this service gave it a top-3 score of 10, 9, or 8 on an 11-point scale.

Overall Assessment of Year-to-Year Changes in Plan Performance

Are plans as a whole doing better or worse than last year in delivering health care to their members? Looking at performance across plans, few measures registered net changes – that is, more plans moving in the positive than in the negative direction, or vice versa -- since the survey was last conducted in 2000. No areas appear to have significant shifts upward or downward.

- ❖ One area of increased performance compared to 2000 is the rating members gave their health plan based on "all experiences with the plan". Three plans received higher ratings this year: PHP of Mid-Michigan improved from 62% in 2000 to 71% in 2001, McLaren Health Plan improved from 51% in 2000 to 57% in 2001, and Health Plan of Michigan improved from 50% in 2000 to 57% in 2001. The Wellness Plan was the only plan that showed a decrease in the percentage of members who gave their health plan a rating of 8, 9, or 10 on an 11-point scale. Their rate declined from 61% in 2000 to 52% in 2001.
- ❖ Three of the plans were lower than last year for the rating members gave all doctors and other health providers: Community Care Plan dropped from 79% in 2000 to 72% in 2001, Priority Health dropped from 77% in 2000 to 70% in 2001, and The Wellness Plan dropped from 70% in 2000 to 63% to 2001. No plan improved its performance on this measure.
- ❖ The plans showed a slight decline in the number of members indicating they had a personal doctor or nurse. The three plans who showed the greatest decrease were: Community Care Plan which dropped from 85% in 2000 to 81% in 2001, Health Plan of Michigan

dropped from 85% to 81%, and PHP of Southwest Michigan dropped from 82% to 75%. Community Care Plan and Health Plan of Michigan remain above average on this measure.

- ❖ Another area for plans to focus on is providing fast access to care. Four of the 19 plans saw increases in the percent of members who had to wait more than 7 days to see a doctor for regular or routine care: OmniCare, Total Health Care, Cape Health Plan, and Health Plus of Michigan, although only OmniCare and Total Health Care are above the plan average on this measure. Plans fared slightly better in providing urgent care, with only two plans having an increase in the percentage of members who had to wait more than 3 days to see a doctor for illness or injury: Total Health Care and Health Plus of Michigan. Only Care Choices HMO did better than last year in providing prompt urgent care.
- ❖ Customer service is improving, although there remains room for improvement. Three plans had a smaller percentage of members who voiced complaints about their plan this year: Health Plan of Michigan, Great Lakes Health Plan, and Care Choices HMO. With regard to members reporting problems with customer service, only McLaren Health Plan worsened this year; Care Choices HMO and The Wellness Plan improved. On a related topic, staff courtesy ratings, although still fairly high, were lower this year in five plans: Priority Health, Community Care Plan, PHP of Southwest Michigan, Community Choice Michigan, and Total Health Care.

Child Survey

The child survey sampled children 12 years and younger. A parent or guardian of the child served as the respondent. Data from 19 child samples were reported and constitute the basis for this summary.

Overall Quality Groupings

Viewed across the full range of satisfaction and quality indicators, the following five health plans perform better than average overall in the Child Sample consumer survey (in alphabetical order):

These five plans are the top performers:

Botsford Health Plan
Care Choices HMO
Community Care Plan
M-CARE
Upper Peninsula Health Plan

These eleven plans fall in the middle range:

Cape Health Plan
Great Lakes Health Plan
Health Plan of Michigan
Health Plus of Michigan
McLaren Health Plan
Midwest Health Plan
OmniCare
PHP of Mid-Michigan
PHP of Southwest Michigan
Priority Health
The Wellness Plan

These three plans perform below the average:

Community Choice Michigan
Molina Healthcare
Total Health Care

Demographic Profile

The child samples tend to differ substantially on most demographic variables.

The percentage of child enrollees who are **non-white or Hispanic** averages 41% across the 19 health plans, but this figure disguises impressive variation, as the plans range from a low of 8% (Molina Healthcare) to a high of 95% (OmniCare).

In the average plan, 21% of the parents have not finished **high school**. One plan stands out as having a large proportion of parents in this category: Midwest Health Plan (41%). Upper Peninsula Health Plan lies at the opposite end of the education spectrum, with only 5% of non-high school diploma/non-GED parents.

The same health plan has a large numbers of children whose **primary language** at home is not English: Midwest Health Plan (41%). In most other plans, this percentage is much smaller, ranging from 0-17%. Nevertheless, 23% of the children, on average, are reported to sometimes, usually, or always have difficulty speaking with or understanding doctors because they “speak different languages.” The 19-plan range is 9% to 36%. The range is the about the same for parents who reported language barriers in communicating with providers: 11% to 36%.

Health Characteristics, Utilization, and Tenure

In all of the plans, child enrollees are reported as being in **good health**: 94% were rated by parents as having “excellent,” “very good,” or “good” health.

The plans vary greatly in the proportion of parents who say they **chose the plan** vs. being assigned to it. In four plans, 80% or more of members chose the plan for their child: M-CARE (90%), Health Plus of Michigan (84%), OmniCare (83%), and The Wellness Plan (80%). At the other extreme, a little over half of Molina Healthcare parents (53%) say they chose the health plan for their child.

The percentage of children **needing urgent care** for an illness or injury in the last 6 months is fairly well spread out around the 41% plan average with a range from 30% at OmniCare to 56% at Health Plan of Michigan.

Incidence of **emergency room visits** in the last 6 months averages 22% across the plans. Variation on this measure is lower than on most others (18-30%).

The incidence of **visits for routine care** ranges from 26% at OmniCare to 46% at Midwest Health Plan. The plan average is 33%.

Cape Health Plan stands out from the other plans by having 49% of **new child enrollees** (defined as in the plan less than 12 months). At the other extreme, Care Choices HMO enrollees are least likely to be enrolled less than one year (9%). The plan average is 26%.

Parents of OmniCare children are least likely to report that their child visited a **specialist** doctor in the past 6 months (9%). Health Plan of Michigan child enrollees have the highest utilization of specialist visits, with 24% compared with the plan average of 15%.

On average, 57% of child members got at least **one prescription filled** in the last 6 months; the range of variation is 45% to 72%.

Ratings of Medical Providers

The plans vary in the proportions of parents who perceive that their child has a “**personal doctor or nurse**,” from a strong 89% and 88% respectively at Health Plan of Michigan and Upper Peninsula Health Plan to 61% at Midwest Health Plan. The plan average is 78%.

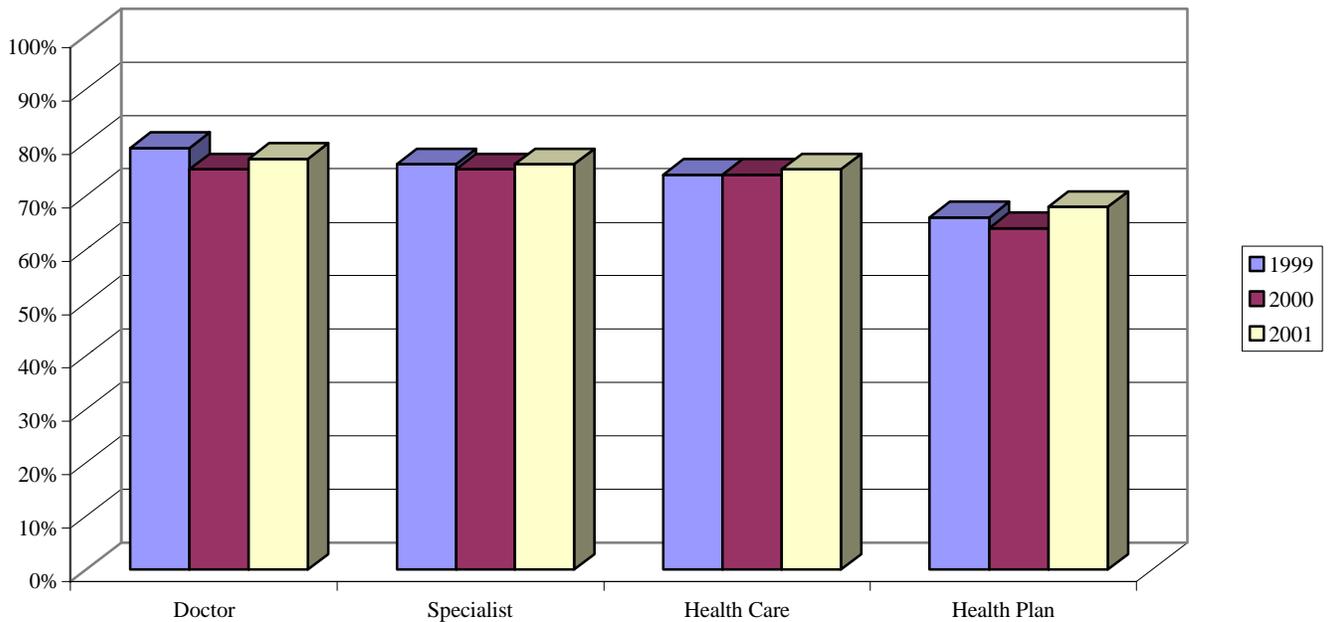
Four out of every five parents (81%), on average across the plans, say that during office visits, their child’s doctor or nurse usually or always **discusses how the child is “feeling, growing, and behaving.”** Two plans performed lower than the norm: Cape Health Plan (74%) and Midwest Health Plan (77%).

Parents were asked to rate their child’s doctors and other health providers on an 11-point (0-10) scale, where 10 is the “best personal doctor or nurse possible” and 0 is worst. There were three separate ratings: the personal doctor or nurse (if any), the medical specialist seen most often (if any), and “all doctors and other health providers.” Scores are reported based on the percent giving a rating of 10, 9, or 8 (the three highest ratings).

- ❖ Top-3 ratings of children’s **personal doctor or nurse** average 77% across the plans – representing a fairly high level of satisfaction. (As in the Adult sample survey, this question is asked only of those whose child is perceived to have such a provider.) The small range of variation runs from a low of 71% at Great Lakes Health Plan to a high of 84% at M-CARE.
- ❖ Ratings of children’s **specialists** show a little more variation, ranging from a low of 63% at Priority Health to 88% at OmniCare. The statewide average is 76%. Three plans improved since last year: OmniCare, Care Choices HMO, and M-CARE.
- ❖ Ratings of “**all doctors and other health providers**” average 75%. Total Health Care (67%), Cape Health Plan (69%), and Community Choice Michigan (70%) are below the average, while M-CARE and Community Care Plan top the list at 84% and 83%, respectively. Only OmniCare improved since last year.

While there is some correlation in these three sets of provider ratings, plans that score well on one measure do not always score well on the others.

**Percent that Rate Child's Provider an 8, 9, or 10
Child**



As the chart above indicates, for the past three years, parents have consistently rated medical providers very highly. The 2001 overall rating of the health plan shows improvement from both 1999 and 2000. This rating is the State's lowest, but is moving in a positive direction. The ratings for doctor, specialist, and health care are all very good, remaining above the 70% mark.

Getting Medical Care

The plan average on the multi-item **Getting Needed Care** composite is 79%; that is, almost four-fifths of parents in the typical plan report that getting care was not a problem. There are no sharply extreme scores on this measure: three plans scored below average, with the lowest score at 71% from Molina Healthcare. Six plans share above average standing with scores that range from 83% to 86%. Care Choices HMO was the only plan showing improved performance since 2000.

Seven plans received above average status for the **Getting Care Quickly** composite, which averaged 81% across the plans: more than 4 out of 5 parents say their child usually or always received care quickly in the typical plan. Five plans received below average ratings on this indicator.

On average, 17% of parents in the typical Medicaid health plan report that their child usually had to wait more than a week to get an **appointment for routine care**. The range of variation on this measure is wide: 7% (Great Lakes Health Plan) to 31% (OmniCare). This year only one plan had fewer children than last year waiting more than 7 days for routine care: Cape Health Plan.

Overall, 6% of parents say their child usually had to wait more than 3 days to get an **appointment for illness or injury**. Only two plans performed worse than average: OmniCare (14%) and Community Choice Michigan (11%). Great Lakes Health Plan, HealthPlan of Michigan, and Upper Peninsula Health Plan have the best record among the plans in this regard, with only 3% of children waiting more than 3 days for an appointment to treat illness or injury.

Once again, the agreement between the two measures is less than many would expect, as some who do well providing quick appointments for routine care do less well at providing rapid appointments for those in need of immediate care, and vice versa.

Midwest Health Plan (59%) scored considerably below the plan average of 69% and Molina Healthcare improved its performance in **reminding parents of children under age 2 about child immunization**.

Communication and Interaction with Providers and Office Staff

In general, the plans perform positively on the **How Well Doctors Communicate** composite measure: 88%, on average across the plans, indicate that the child's doctors and other health care providers always or usually communicate well. The range of variation is relatively narrow: 83% to 92%.

Parents differ more among the plans on the question of whether doctors and other providers usually or always **"explained things in a way their child could understand."** Eighty-one percent answer affirmatively, on average. Total Health Care scored lower than last year on this measure and at 61% is well below the plan average. However, McLaren Health Plan did better than in 2000.

For the **Courteous and Helpful Office Staff** composite measure, parents in most of the plans feel office staff is always or usually courteous and helpful: Ninety percent, on average, give this answer. As with the provider communication composite, the range is narrow: 85% to 93%.

The Health Plan

The plans are quite different in terms of customer service ratings. According to the 3-item **customer service composite**, the range varies from a high of 84% of parents with Botsford Health Plan reporting no problems with customer service from their child's plan to a low of 55% at Molina Healthcare, although this score is an improvement over last year. The other improved plan is Great Lakes Health Plan. The overall average is 70%.

As in the Adult sample survey, providing **correct information** to parents before they enroll their child in the plan is one area where most of the plans could improve performance. Only 58%, on average, say that all of the information provided before sign-up was correct. M-CARE does best among the 19 plans on this measure (65%) and is the only plan to improve since last year. Total Health Care (49%) scores the lowest.

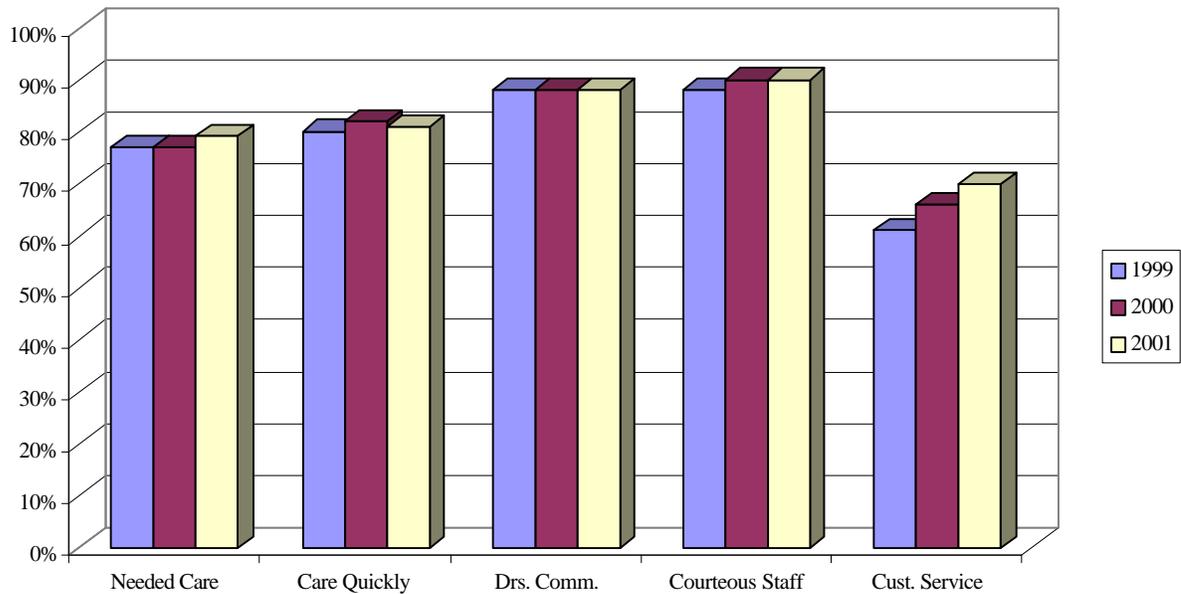
On average, 6% of parents say they **contacted the plan with a complaint or problem** related to their child's care in the last 6 months. Molina Healthcare parents were much more likely than those with children in other plans to lodge a complaint (11%). Molina Healthcare, Care Choices HMO, and Community Choice Michigan improved since last year; all had decreases in the percent of parents who contacted their plan with a problem or complaint.

In the typical plan, 83% did not have a problem **getting their child's prescription medicine through the health plan**. Although the overall average is fairly high, there is some variation on this measure: from a low of 65% at Molina Healthcare to a high of 94% at Care Choices HMO. Community Choice Michigan improved on its performance this year, while Community Care Plan and Total Health Care had decrements in performance. On average, 74% of parents report always getting their child's prescription through the health plan.

Over two-thirds of parents in the average plan (68%) give a 10, 9, or 8 rating on the 0-10 scale intended to reflect "**all your experience with your child's health plan.**" Seven plans were above average and three below, with Molina Healthcare being the lowest at 50%. Six plans improved their ratings since 2000: Care Choices HMO, PHP of Mid-Michigan, Midwest Health Plan, PHP of Southwest Michigan, Cape Health Plan, and Community Choice Michigan.

Composite Scores

**Composite Comparisons
Child**



The State average for the five composite scores has remained almost constant during the last three years. The chart above illustrates State averages for the composite measures since 1999. The Customer Satisfaction composite score has shown the most change, going from 61% in 1999, to 66% in 2000, and increasing again to 70% in 2001. As with adult, this is the lowest composite score for the State, and therefore has the most room for improvement. The continued increase is a positive indicator.

Michigan Enrolls

The survey of Michigan Medicaid managed care providers included a series of questions about the parent’s experience with Michigan Enrolls, the enrollment broker contracted by Medicaid to assist beneficiaries enrolling in health plans. Sixty-seven percent of parents report receiving information from Michigan Enrolls before enrolling their child in his or her current health plan. Of these parents, 81% received an information packet in the mail and 26% called the toll-free information line. The information from Michigan Enrolls was somewhat or very helpful to 96% of parents in choosing their child’s health plan.

Four-fifths (81%) of the parents knew of the Michigan Enrolls toll-free number, and of these, 66% called the number for assistance in making their choice. Of the parents who used the toll-free line to obtain information, 96% got all or some of the advice they needed. On rating all experiences with Michigan Enrolls, 68% of parents who used this service gave it a top-3 score of 10, 9, or 8 on an 11-point scale.

Overall Assessment of Year-to-Year Changes in Plan Performance

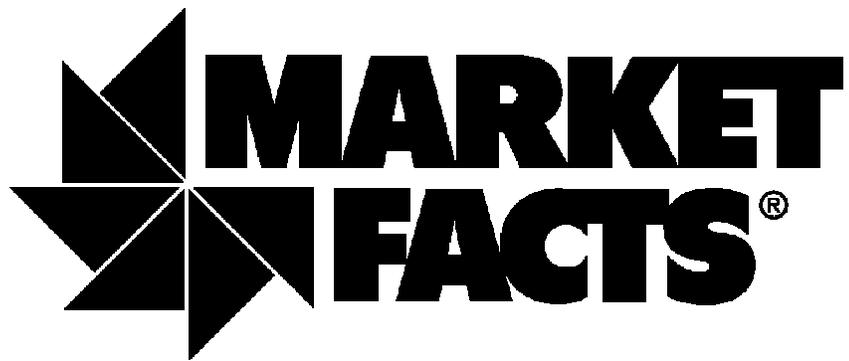
Most of the measures for the child survey had no change in performance in 2001 from 2000. Looking at performance across plans, there are two measures that registered improvement in plan performance since the previous survey, conducted in 2000:

- ❖ Six plans received higher overall ratings from parents this year:

	<u>2000 Score</u>	<u>2001 Score</u>
Care Choices HMO	67%	74%,
PHP of Mid-Michigan	67%	74%,
Midwest Health Plan	65%	74%,
PHP of Southwest Michigan	62%	71%,
Cape Health Plan	53%	64%, and
Community Choice Michigan	56%	63%.

No plans showed a decrease since last year.

- ❖ The percent of parents who chose their child's health plan rather than being assigned increased in nearly half the plans. This year, 11 of the 19 plans had an increased proportion of parents who chose their child's health plan rather than being assigned.



Summary and Individual Plan Results