

2024 Adult Medicaid Health Plan CAHPS® Report

*Michigan Department of Health and
Human Services*

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1. Executive Summary

Introduction

The Michigan Department of Health and Human Services (MDHHS) assesses the perceptions and experiences of members enrolled in the Medicaid health plans (MHPs) and the Fee-for-Service (FFS) population as part of its process for evaluating the quality of health care services provided to adult members in the Michigan Medicaid Program. MDHHS contracted with Health Services Advisory Group, Inc. (HSAG) to administer and report the results of the Consumer Assessment of Healthcare Providers and Systems (CAHPS[®]) Health Plan Survey for the Michigan Medicaid Program.^{1-1,1-2} The goal of the CAHPS Health Plan Survey is to provide performance feedback that is actionable and that will aid in improving members’ overall experiences.

This report presents the 2024 adult Medicaid CAHPS results of members enrolled in an MHP or FFS. A sample of at least 1,350 adult members was selected from the FFS population and each MHP. The surveys were completed from February to May 2024. The standardized survey instrument selected was the CAHPS 5.1 Adult Medicaid Health Plan Survey with the Healthcare Effectiveness Data and Information Set (HEDIS[®]) supplemental item set.^{1-3,1-4} HSAG presents statewide aggregate results and compares them to national Medicaid data and prior years’ results, where appropriate. Throughout this report, two statewide aggregate results are presented for comparative purposes:

- Michigan Medicaid Program: Combined results for FFS and the MHPs.
- Michigan Medicaid Managed Care Program: Combined results for the MHPs.

Table 1-1 provides a list of the MHPs that participated in the survey.

Table 1-1—Participating MHPs

MHP Name	
Aetna Better Health of Michigan	Molina Healthcare of Michigan
Blue Cross Complete of Michigan	Priority Health Choice
HAP CareSource	UnitedHealthcare Community Plan
McLaren Health Plan	Upper Peninsula Health Plan
Meridian Health Plan of Michigan	

¹⁻¹ CAHPS[®] is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

¹⁻² HSAG surveyed the FFS Medicaid population. The MHPs contracted with various survey vendors to administer the CAHPS survey.

¹⁻³ HEDIS[®] is a registered trademark of the National Committee for Quality Assurance (NCQA).

¹⁻⁴ The 2024 CAHPS results were reported to NCQA for the nine MHPs. The 2024 CAHPS survey results for the FFS population were not reported to NCQA.

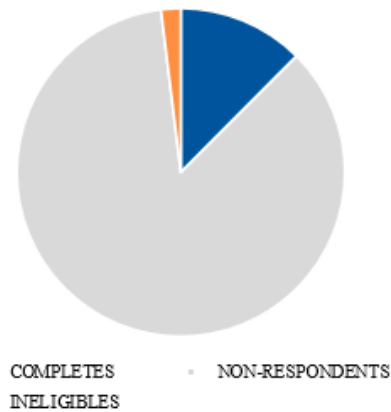
Survey Administration Overview

Figure 1-1 shows the distribution of survey dispositions and response rates for the Michigan Medicaid Program.¹⁻⁵ More detailed results of the distribution of surveys and response rates are found in the Results section beginning on page 3-1.

Figure 1-1—Survey Administration Overview: Michigan Medicaid Program

Survey Administration

Start Survey On:	Finish Survey On:
02.13.24	05.13.24
TOTAL SAMPLE SIZE	21,533
RESPONSE RATE	12.73%



COMPLETES	2,688
NON-RESPONDENTS	18,427
INELIGIBLES	418
UNDELIVERABLES	1,335

DETAILS

	Mail 1	Mail 2	Mail 3	Phone	Web*
Completes	1,062	572	35	596	423
	Incompletes	Refusals	No Response		
Non-Respondents	262	604	17,561		
	Not Enrolled	Deceased	Language Barrier	Incapacitated	
Ineligibles	282	22	62	52	

*Eight (8) surveys were completed in Spanish via web.

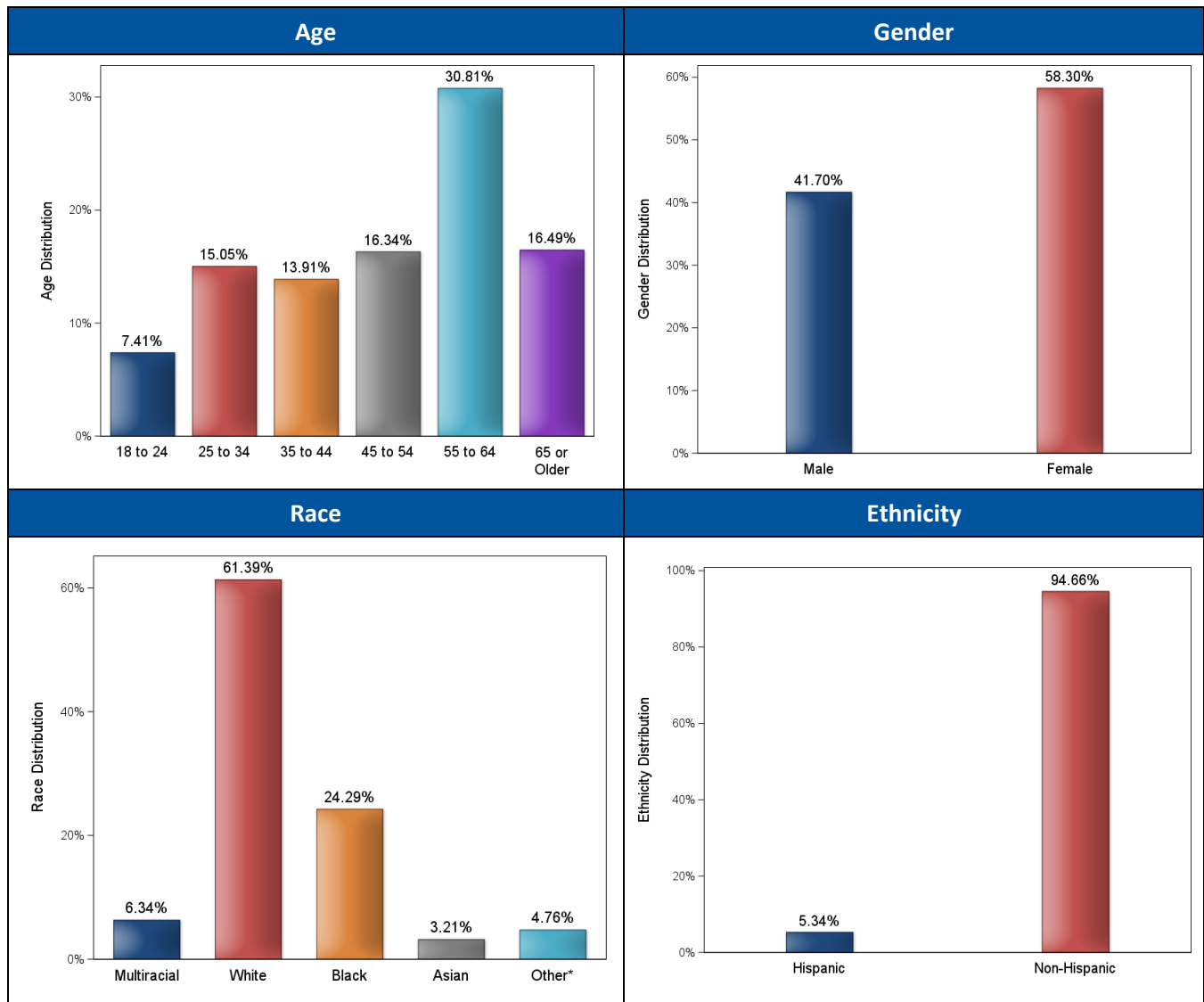
¹⁻⁵ The survey administration protocol employed for FFS was a mixed-mode methodology, which allowed members to complete a survey via mail, telephone, or Internet. The MHPs employed various data collection protocols. The survey administration protocols included mail, telephone, and/or Internet.

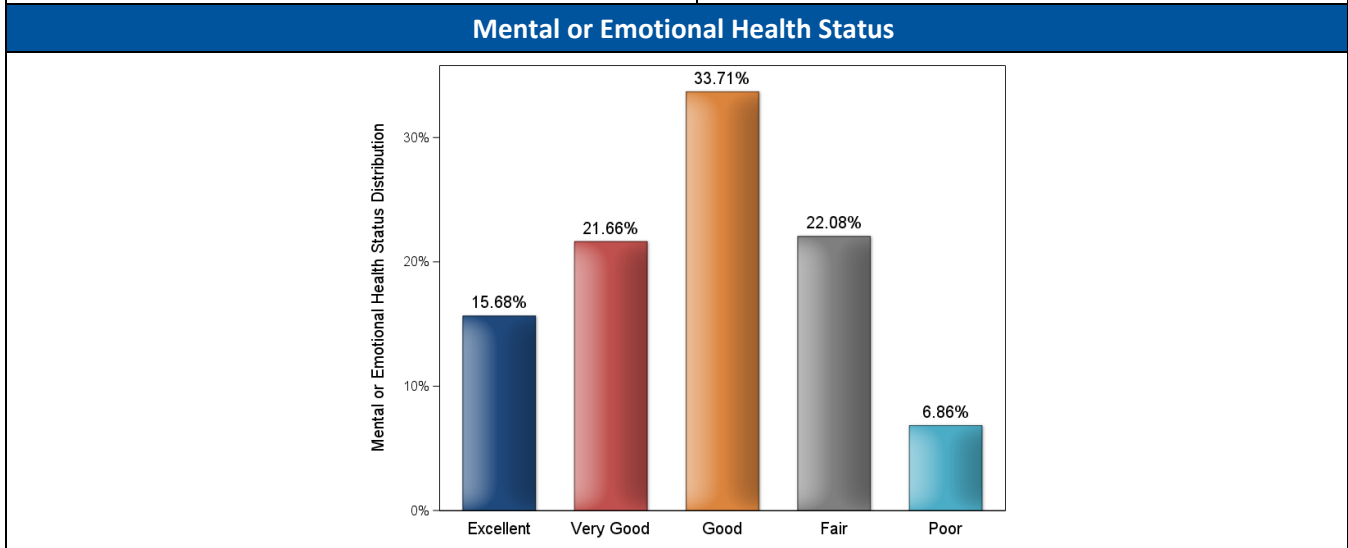
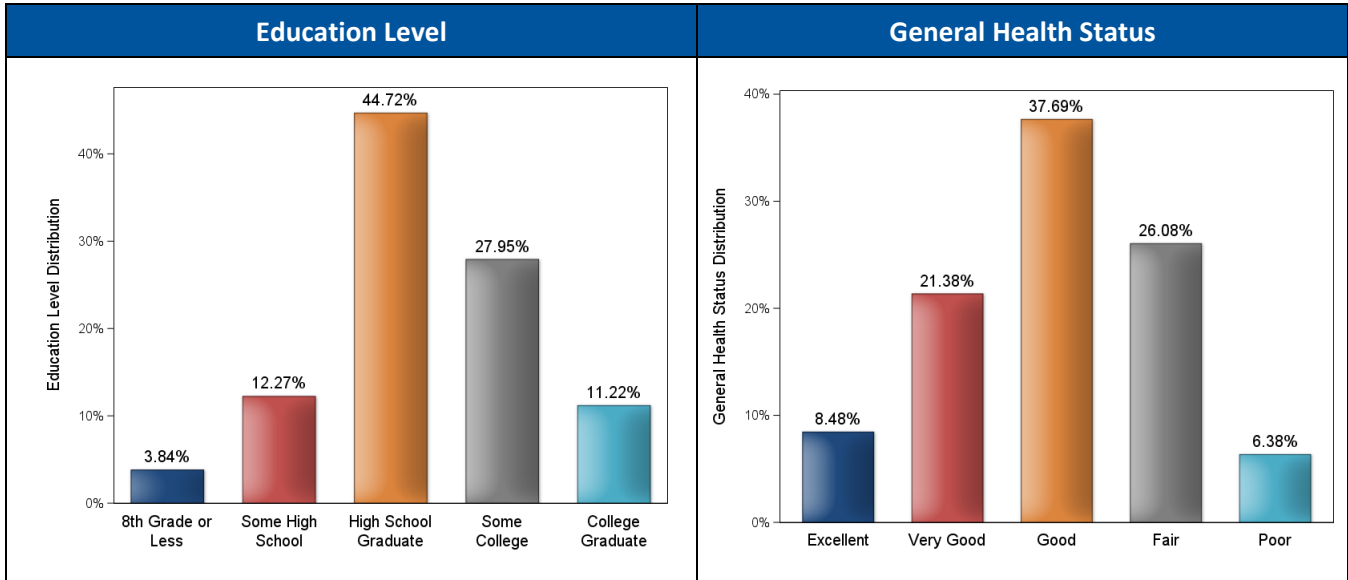
Key Findings

Demographics

Table 1-2 provides an overview of the Michigan Medicaid Program adult member demographics. The detailed results are found in the Results section beginning on page 3-2.

Table 1-2—Member Demographics: Michigan Medicaid Program





* The "Other" race category includes responses of Native Hawaiian or Other Pacific Islander, American Indian or Alaska Native, and Other.
Some percentages may not total 100% due to rounding.

National Comparisons and Trend Analysis

HSAG calculated overall scores for the medical assistance with smoking and tobacco use cessation measure items and top-box scores (i.e., rates of experience) for the other measures. HSAG compared scores for each measure to the National Committee for Quality Assurance’s (NCQA’s) 2023 Quality Compass® Benchmark and Compare Quality Data.^{1-6,1-7,1-8} Based on this comparison, HSAG determined overall member experience ratings (i.e., star ratings) of one (★) to five (★★★★★) stars, where one star is the lowest possible rating (i.e., Poor) and five stars is the highest possible rating (i.e., Excellent). The detailed results of the National Comparisons are found in the Results section beginning on page 3-9. In addition, a trend analysis was performed that compared the 2024 results to the 2023 and 2022 results. The detailed results of this analysis are found in the Trend Analysis section beginning on page 4-1.

Table 1-3 provides highlights of the National Comparisons and Trend Analysis findings for the Michigan Medicaid Program for each measure. The percentages presented below the stars represent the scores, while the stars represent overall member experience ratings when compared to NCQA Quality Compass Benchmark and Compare Quality Data. Only the most recent trend results (i.e., 2024 to 2023) are presented in the table.

Table 1-3—National Comparisons and Trend Analysis: Michigan Medicaid Program

Measure	NCQA Comparisons	Trend Analysis (2024 Compared to 2023)
Global Ratings		
<i>Rating of Health Plan</i>	★★ 61.24%	—
<i>Rating of All Health Care</i>	★★ 55.06%	—
<i>Rating of Personal Doctor</i>	★★ 67.17%	—
<i>Rating of Specialist Seen Most Often</i>	★★★ 67.08%	—
Composite Measures		
<i>Getting Needed Care</i>	★★★ 82.25%	—
<i>Getting Care Quickly</i>	★★★ 83.63%	—

¹⁻⁶ Quality Compass® is a registered trademark of NCQA.

¹⁻⁷ National Committee for Quality Assurance. *Quality Compass®: Benchmark and Compare Quality Data 2023*. Washington, DC: NCQA, September 2023.

¹⁻⁸ Quality Compass 2024 data were not available at the time this report was prepared; therefore, 2023 data were used for comparison.

Measure	NCQA Comparisons	Trend Analysis (2024 Compared to 2023)
<i>How Well Doctors Communicate</i>	★★★ 93.00%	—
<i>Customer Service</i>	★★ 88.65%	—
Individual Item Measure		
<i>Coordination of Care</i>	★★ 83.15%	—
Medical Assistance With Smoking and Tobacco Use Cessation Measure Items		
<i>Advising Smokers and Tobacco Users to Quit</i>	★★★★★ 78.31%	—
<i>Discussing Cessation Medications</i>	★★★★★ 56.88%	—
<i>Discussing Cessation Strategies</i>	★★★ 48.07%	—
Star Assignments Based on Percentiles ★★★★★ 90th or Above ★★★★★ 75th-89th ★★★ 50th-74th ★★ 25th-49th ★ Below 25th ▲ Indicates the 2024 Michigan Medicaid Program's score is statistically significantly higher than 2023. ▼ Indicates the 2024 Michigan Medicaid Program's score is statistically significantly lower than 2023. — Indicates the 2024 Michigan Medicaid Program's score is not statistically significantly different than in 2023.		

Statewide Comparisons

HSAG compared the MHP and FFS results to the Michigan Medicaid Managed Care Program to determine if plan or program results were statistically significantly different than the Michigan Medicaid Managed Care Program. The FFS Program rate for the *Advising Smokers and Tobacco Users to Quit* measure was statistically significantly higher than the Michigan Medicaid Managed Care Program. The detailed results of this analysis are found in the Results section beginning on page 3-13.

Key Drivers of Member Experience Analysis

In order to determine potential items for quality improvement efforts, HSAG conducted a key drivers analysis. HSAG focused the key drivers of member experience analysis on three measures: *Rating of Health Plan*, *Rating of All Health Care*, and *Rating of Personal Doctor*. HSAG refers to the individual items (i.e., questions) for which the odds ratio is statistically significantly greater than 1 as “key drivers” since these items are driving members’ levels of experience with each of the three measures. The detailed results of this analysis are found in the Key Drivers of Member Experience Analysis section beginning on page 5-1. Table 1-4 provides a summary of the survey items identified for each of the three measures as being key drivers of member experience (indicated by a ✓) for the Michigan Medicaid Program.

Table 1-4—Key Drivers of Member Experience: Michigan Medicaid Program

Key Drivers	Response Options	Rating of Health Plan	Rating of All Health Care	Rating of Personal Doctor
Q4. Received care as soon as needed when care was needed right away	Sometimes vs. Always	✓	✓	NS
Q9. Ease of getting the care, tests, or treatment needed	Never vs. Always	✓	✓	NS
	Sometimes vs. Always	✓	✓	NS
	Usually vs. Always	✓	✓	NS
Q12. Personal doctor explained things in an understandable way	Sometimes vs. Always	NS	NS	✓
	Usually vs. Always	NS	NS	✓
Q13. Personal doctor listened carefully	Never vs. Always	NS	NS	✓
	Sometimes vs. Always	NS	NS	✓
	Usually vs. Always	NS	✓	✓
Q14. Personal doctor showed respect for what was said	Sometimes vs. Always	NS	✓	✓
Q15. Personal doctor spent enough time	Never vs. Always	NS	NS	✓
	Sometimes vs. Always	NS	✓	✓
	Usually vs. Always	✓	✓	✓

Key Drivers	Response Options	Rating of Health Plan	Rating of All Health Care	Rating of Personal Doctor
Q24. Health plan's customer service gave the information or help needed	Never vs. Always	✓	NS	NA
	Sometimes vs. Always	✓	NS	NA
	Usually vs. Always	✓	NS	NA
Q25. Treated with courtesy and respect by health plan's customer service staff	Usually vs. Always	✓	NS	NA
Q27. Ease of filling out forms from health plan	Sometimes vs. Always	✓	NS	NA
	Usually vs. Always	✓	NS	NA
<p>NA Indicates that this question was not evaluated for this measure. NS Indicates that the calculated odds ratio estimate is not statistically significantly higher than 1.0; therefore, respondents' answers for those responses do not significantly affect their rating.</p>				

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

Survey Administration

Survey Overview

The survey instrument selected was the CAHPS 5.1 Adult Medicaid Health Plan Survey with the HEDIS supplemental item set. The CAHPS 5.1 Health Plan Surveys are a set of standardized surveys that assess patient perspectives on care. Originally, CAHPS was a five-year collaborative project sponsored by the Agency for Healthcare Research and Quality (AHRQ). The CAHPS questionnaires and consumer reports were developed under cooperative agreements among AHRQ, Harvard Medical School, RAND, and the Research Triangle Institute (RTI). The most recent versions of the surveys (i.e., CAHPS 5.1 Health Plan Surveys) were released by AHRQ in October 2020. Based on the CAHPS 5.1 versions, NCQA introduced new HEDIS versions of the Adult and Child Health Plan Surveys in, which are referred to as the CAHPS 5.1H Health Plan Surveys.²⁻¹

The sampling and data collection procedures for the CAHPS Health Plan Surveys are designed to capture accurate and complete information about consumer-reported experiences with health care. The sampling and data collection procedures promote both the standardized administration of survey instruments and the comparability of results.

2024 CAHPS Performance Measures

The CAHPS 5.1 Adult Medicaid Health Plan Survey with the HEDIS supplemental item set includes 39 core questions that yield 12 measures of experience. These measures include four global rating questions, four composite measures, one individual item measure, and three medical assistance with smoking and tobacco use cessation measure items. The global measures (also referred to as global ratings) reflect overall member experience with the health plan, health care, personal doctors, and specialists. The composite measures are sets of questions grouped together to address different aspects of care (e.g., *Getting Needed Care* or *Getting Care Quickly*). The individual item measure is an individual question that looks at a specific area of care (i.e., *Coordination of Care*). The medical assistance with smoking and tobacco use cessation measure items assess the various aspects of providing medical assistance with smoking and tobacco use cessation. Figure 2-1 lists the measures included in the survey.

²⁻¹ National Committee for Quality Assurance. *HEDIS® Measurement Year 2020, Volume 3: Specifications for Survey Measures*. Washington, DC: NCQA Publication, 2020.

Figure 2-1—CAHPS Measures

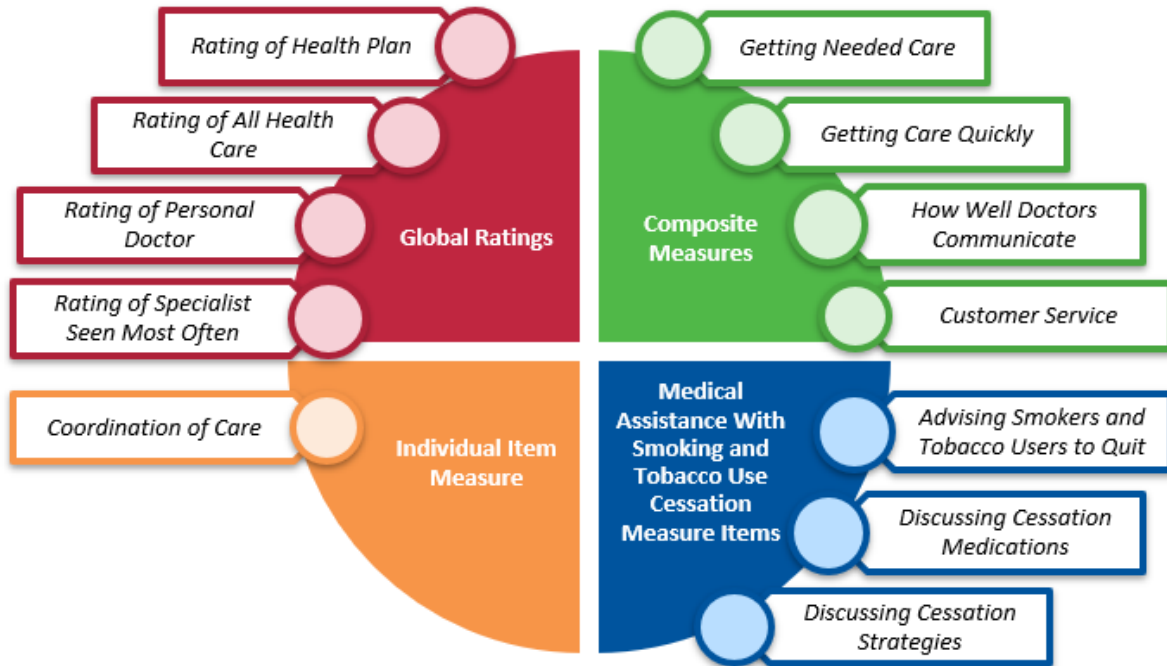


Table 2-1 presents the survey language and response options for each measure.

Table 2-1—Question Language and Response Options

Question Language	Response Options
Global Ratings	
Rating of Health Plan	
28. 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?	0–10 Scale
Rating of All Health Care²⁻¹	
8. 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?	0–10 Scale

²⁻¹ For *Rating of All Health Care*, the gate question asks respondents how many times they received health care in person, by phone, or by video, not counting the times they went to the emergency room in the last six months. If respondents answer “None” to this question, they are directed to skip the question that comprises the *Rating of All Health Care* measure.

Question Language	Response Options
Rating of Personal Doctor²⁻²	
18. 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?	0–10 Scale
Rating of Specialist Seen Most Often²⁻³	
22. We want to know your rating of the specialist you talked to 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?	0–10 Scale
Composite Measures	
Getting Needed Care²⁻⁴	
9. In the last 6 months, how often was it easy to get the care, tests, or treatment you needed?	Never, Sometimes, Usually, Always
20. In the last 6 months, how often did you get an appointment with a specialist as soon as you needed?	Never, Sometimes, Usually, Always
Getting Care Quickly²⁻⁵	
4. In the last 6 months, when you <u>needed care right away</u> , how often did you get care as soon as you needed?	Never, Sometimes, Usually, Always
6. In the last 6 months, how often did you get an appointment for a <u>check-up or routine care</u> as soon as you needed?	Never, Sometimes, Usually, Always
How Well Doctors Communicate²⁻⁶	
12. 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
13. In the last 6 months, how often did your personal doctor listen carefully to you?	Never, Sometimes, Usually, Always

²⁻² For *Rating of Personal Doctor*, the gate question asks respondents if they have a personal doctor. If respondents answer “No” to this question, they are directed to skip the question that comprises the *Rating of Personal Doctor* measure.

²⁻³ For *Rating of Specialist Seen Most Often*, the gate question asks respondents if they made any appointments with a specialist in the last six months. If respondents answer “No” to this question, they are directed to skip the question that comprises the *Rating of Specialist Seen Most Often* measure.

²⁻⁴ For *Getting Need Care*, the gate questions ask respondents how many times they received health care in person, by phone, or by video, not counting the times they went to the emergency room in the last six months and did they make any appointments with a specialist in the last six months. If respondents answer “None” or “No” to these questions, they are directed to skip the questions that collectively comprise the *Getting Needed Care* measure.

²⁻⁵ For *Getting Care Quickly*, the gate questions ask respondents if they had an illness, injury, or condition that needed care right away and did they make any in person, phone, or video appointments for a check-up or routine care. If respondents answer “No” to these questions, they are directed to skip the questions that collectively comprise the *Getting Care Quickly* measure.

²⁻⁶ For *How Well Doctors Communicate*, the gate question asks respondents if they have a personal doctor. If respondents answer “No” to this question, they are directed to skip the questions that collectively comprise the *How Well Doctors Communicate* measure.

Question Language	Response Options
14. In the last 6 months, how often did your personal doctor show respect for what you had to say?	Never, Sometimes, Usually, Always
15. In the last 6 months, how often did your personal doctor spend enough time with you?	Never, Sometimes, Usually, Always
Customer Service²⁻⁷	
24. 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
25. 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
Individual Item Measure	
Coordination of Care²⁻⁸	
17. 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
Medical Assistance With Smoking and Tobacco Use Cessation Measure Items²⁻⁹	
Advising Smokers and Tobacco Users to Quit	
32. 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
Discussing Cessation Medications	
33. 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
Discussing Cessation Strategies	
34. 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

²⁻⁷ For *Customer Service*, the gate question asks respondents if they received information or help from customer service at their health plan in the last six months. If respondents answer “No” to this question, they are directed to skip the questions that collectively comprise the *Customer Service* measure.

²⁻⁸ For *Coordination of Care*, the gate question asks respondents if they have a personal doctor. If respondents answer “No” to this question, they are directed to skip the question that comprises the *Coordination of Care* measure.

²⁻⁹ For the Medical Assistance With Smoking and Tobacco Use Cessation measure items, the gate question asks respondents if they smoke cigarettes or use tobacco every day, some days, or not at all. If respondents answer “Not at all” or “Don’t know” to this question, they are directed to skip the questions that collectively comprise the Medical Assistance With Smoking and Tobacco Use Cessation measure items.

How CAHPS Results Were Collected

Sampling Procedures

For FFS, MDHHS provided HSAG with a list of all eligible members for the sampling frame. HSAG inspected the file records to check for any apparent problems with the file, such as missing address elements. HSAG tried to obtain new addresses for members selected for the sample by processing their addresses through the United States Postal Service's National Change of Address (NCOA) system. The MHPs contracted with separate survey vendors to perform sampling. Following HEDIS requirements, members were sampled who met the following criteria:

- Were 18 years of age or older as of December 31, 2023.
- Were currently enrolled in an MHP or FFS.
- Were continuously enrolled in the plan or program during the last six months of the measurement year (July 1 to December 31, 2023), with no more than one gap in enrollment of up to 45 days (i.e., a member whose coverage lapsed for two months [60 days] was not considered continuously enrolled).
- Had Medicaid as a payer.

A sample of at least 1,350 adult members was selected from the FFS population and each MHP with no more than one member per household being selected.²⁻¹⁰

Survey Protocol

The survey administration protocol employed for FFS was a mixed-mode methodology, which allowed for three methods by which members could complete a survey: 1) mail, 2) Internet, or 3) Computer Assisted Telephone Interviewing (CATI). A cover letter that was mailed to sampled members provided them the option to 1) complete the paper-based survey in English and return it using the pre-addressed, postage-paid return envelope or 2) complete the web-based survey in English or Spanish via a link and username or quick response (QR) code. Non-respondents received a reminder postcard, followed by a second survey mailing and reminder postcard.

CATI was conducted for adult members who did not complete the survey or who requested to complete the survey in Spanish. Up to three CATI calls to each non-respondent were attempted at different times of the day, on different days of the week, and in different weeks.²⁻¹¹ The MHPs employed various data collection protocols. The survey administration protocols included mail, telephone, and/or Internet. In addition, some MHPs had an option for members to complete the survey in Spanish.

²⁻¹⁰ Some MHPs elected to oversample their population.

²⁻¹¹ National Committee for Quality Assurance. *Quality Assurance Plan for HEDIS® Measurement Year 2023 Survey Measures*. Washington, DC: NCQA; 2023.

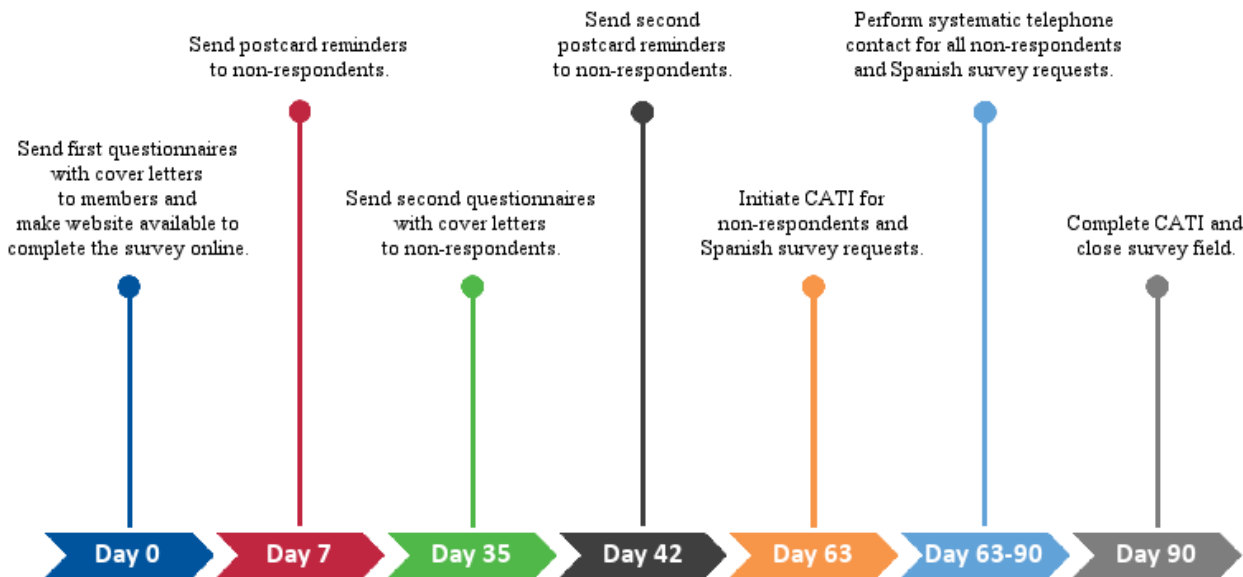
Table 2-2 shows the protocols used by each of the MHPs and FFS, as indicated by a checkmark (✓).

Table 2-2—Data Collection Protocols

	Mail	Telephone	Internet	Spanish
Fee-for-Service Program	✓	✓	✓	✓
Aetna Better Health of Michigan	✓	✓	✓	✓
Blue Cross Complete of Michigan	✓	✓	✓	✓
HAP CareSource	✓	✓	✓	✓
McLaren Health Plan	✓	✓	✓	✓
Meridian Health Plan of Michigan	✓	✓	✓	✓
Molina Healthcare of Michigan	✓	✓	✓	
Priority Health Choice	✓	✓	✓	✓
UnitedHealthcare Community Plan	✓	✓	✓	✓
Upper Peninsula Health Plan	✓	✓	✓	

Figure 2-2 shows the timeline used for the FFS survey administration. Please note, this timeline may not reflect the timelines used by the MHPs.²⁻¹²

Figure 2-2—Survey Timeline



²⁻¹² The survey administration protocol employed for FFS was a mixed-mode methodology, which allowed members to complete a survey via mail, telephone, or Internet. The MHPs employed various data collection protocols. The survey administration protocols included mail, telephone, and/or Internet. The figure shows the timeline used for the FFS survey administration and does not reflect the timelines used by the MHPs.

How CAHPS Results Were Calculated and Displayed

HSAG used the CAHPS scoring approach recommended by NCQA in Volume 3 of HEDIS Specifications for Survey Measures. Based on NCQA's recommendations and HSAG's extensive experience evaluating CAHPS data, HSAG performed a number of analyses to comprehensively assess member experience. In addition to individual plan results, HSAG combined results from FFS and the MHPs to calculate a Michigan Medicaid Program score. Also, HSAG combined results from the MHPs to calculate a Michigan Medicaid Managed Care Program score. This section provides an overview of each analysis.

Who Responded to the Survey

NCQA defines the response rate as the total number of completed surveys divided by all eligible members of the sample.²⁻¹³ HSAG considered a survey completed if members answered at least three of the following five questions: 3, 10, 19, 23, and 28.²⁻¹⁴ Eligible members included the entire sample minus ineligible members. Ineligible members met at least one of the following criteria: they were deceased, did not meet the eligible criteria on page 2-5, were mentally or physically incapacitated, or had a language barrier (the survey was made available in both English and Spanish).

$$\text{Response Rate} = \frac{\text{Number of Completed Surveys}}{\text{Sample Size} - \text{Number of Ineligible Members}}$$

Demographics of Adult Members

The demographic analysis evaluated demographic information of adult members based on responses to the survey. The demographic characteristics included age, gender, race, ethnicity, education level, general health status, and mental or emotional health status.

Scoring Calculations

For purposes of the National Comparisons, Statewide Comparisons, and Trend Analysis, HSAG calculated top-box scores for each measure following NCQA HEDIS Specifications for Survey Measures.²⁻¹⁵ Although NCQA requires a minimum of at least 100 respondents on each item in order to obtain a reportable survey result, HSAG presented results with fewer than 100 respondents. Therefore,

²⁻¹³ National Committee for Quality Assurance. *HEDIS® Measurement Year 2023, Volume 3: Specifications for Survey Measures*. Washington, DC: NCQA; 2023.

²⁻¹⁴ Please refer to Section 6 of the report ("Survey Instrument") for a copy of the survey instrument to see the survey question language.

²⁻¹⁵ National Committee for Quality Assurance. *HEDIS® Measurement Year 2023, Volume 3: Specifications for Survey Measures*. Washington, DC: NCQA; 2023.

caution should be exercised when evaluating measures' results with fewer than 100 respondents, which are denoted with a cross (+).

Global Ratings, Composite Measures, and Individual Item Measure

HSAG calculated top-box scores by assigning top-box responses a score of one, with all other responses receiving a score of zero. A "top-box" response was defined as follows:

- "9" or "10" for the global ratings.
- "Usually" or "Always" for the composite and individual item measures.

For the global ratings and individual item, top-box scores were defined as the proportion of responses with a score value of one over all responses. For the composite measures, first a separate top-box score was calculated for each question within the composite measure. The final composite measure score was determined by calculating the average score across all questions within the composite measure (i.e., mean of the composite items' top-box scores).

Medical Assistance With Smoking and Tobacco Use Cessation Measure Items

HSAG calculated three scores that assess different facets of providing medical assistance with smoking and tobacco use cessation:

- *Advising Smokers and Tobacco Users to Quit*
- *Discussing Cessation Medications*
- *Discussing Cessation Strategies*

These scores assess the percentage of smokers or tobacco users who were advised to quit, were recommended cessation medications, and were provided cessation methods or strategies, respectively. Responses of "Sometimes," "Usually," and "Always" were used to determine if the member qualified for inclusion in the numerator. The scores presented follow NCQA's methodology of calculating a rolling average using the current and prior years' results. Please exercise caution when reviewing the trend analysis results for the medical assistance with smoking and tobacco use cessation measure items, as the 2024 results contain members who responded to the survey in 2023 or 2024 and indicated that they were current smokers or tobacco users. The 2023 results contain members who responded to the survey in 2022 or 2023 and indicated that they were current smokers or tobacco users. The 2022 results contain members who responded to the survey in 2021 or 2022 and indicated that they were current smokers or tobacco users.

Weighting

HSAG calculated both a weighted Michigan Medicaid Program score and a weighted Michigan Medicaid Managed Care Program score based on the total eligible population for each plan's or program's adult population. The Michigan Medicaid Program includes results from both the MHPs and

the FFS population. The Michigan Medicaid Managed Care Program is limited to the results of the MHPs (i.e., the FFS program is not included).

National Comparisons

HSAG compared the scores to NCQA's 2023 Quality Compass Benchmark and Compare Quality Data to derive the overall member experience ratings (i.e., star ratings).²⁻¹⁶ Ratings of one (★) to five (★★★★★) stars were determined for each measure using the percentile distributions shown in Table 2-3.

Table 2-3—Star Rating Percentile Distributions

Stars	Percentiles
★★★★★ Excellent	At or above the 90th percentile
★★★★ Very Good	At or between the 75th and 89th percentiles
★★★ Good	At or between the 50th and 74th percentiles
★★ Fair	At or between the 25th and 49th percentiles
★ Poor	Below the 25th percentile

Statewide Comparisons

The results of the MHPs and FFS program were compared to the Michigan Medicaid Managed Care Program to determine if the results were statistically significantly different. Colors in the figures note statistically significant differences. Green indicates a score that was statistically significantly higher than the Michigan Medicaid Managed Care Program. Conversely, red indicates a score that was statistically significantly lower than the Michigan Medicaid Managed Care Program. Blue represents scores that were not statistically significantly different from the Michigan Medicaid Managed Care Program. Also, the NCQA adult Medicaid national averages are presented in the figures for comparison.²⁻¹⁷

²⁻¹⁶ National Committee for Quality Assurance. *Quality Compass®: Benchmark and Compare Quality Data 2023*. Washington, DC: NCQA, September 2023.

²⁻¹⁷ The source for the national data contained in this publication is Quality Compass® 2023 and is used with the permission of NCQA. Quality Compass 2023 includes certain CAHPS data. Any data display, analysis, interpretation, or conclusion based on these data is solely that of the authors, and NCQA specifically disclaims responsibility for any such display, analysis, interpretation, or conclusion. Quality Compass is a registered trademark of NCQA. CAHPS® is a registered trademark of AHRQ.

MHP Comparisons

The results of the MHPs were compared to the Michigan Medicaid Managed Care Program. Two types of hypothesis tests were applied to these results. First, a global F test was calculated, which determined whether the difference between MHP scores was significant. If the F test demonstrated MHP-level differences (i.e., p value < 0.05), then a t test was performed for each MHP. The t test determined whether each MHP's score was statistically significantly different from the Michigan Medicaid Managed Care Program. This analytic approach follows AHRQ's recommended methodology for identifying significant plan-level performance differences.

Fee-for-Service Program Comparisons

The results of the FFS program were compared to the Michigan Medicaid Managed Care Program. One type of hypothesis test was applied to these results. A t test was performed to determine whether the results of the FFS program were statistically significantly different (i.e., p value < 0.05) from the Michigan Medicaid Managed Care Program results.

Trend Analysis

HSAG performed a t test to determine whether results in 2024 were statistically significantly different from results in 2023 and 2022. A difference was considered statistically significant if the two-sided p value of the t test was less than 0.05. The two-sided p value of the t test is the probability of observing by chance a test statistic as extreme as or more extreme than the value actually observed by chance under the assumption of no difference between years.

Scores that were statistically significantly higher in 2024 than in 2023 or 2022 are noted with upward triangles (▲). Scores that were statistically significantly lower in 2024 than in 2023 or 2022 are noted with downward triangles (▼). Scores in 2024 that were not statistically significantly different from scores in 2023 or 2022 are noted with a dash (—).

Key Drivers of Member Experience Analysis

HSAG performed a key drivers of member experience analysis for the following three global ratings: *Rating of Health Plan*, *Rating of All Health Care*, and *Rating of Personal Doctor*. The purpose of the key drivers of member experience analysis is to help decision makers identify specific aspects of care that will most benefit from quality improvement activities.

Table 2-4 depicts the survey items (i.e., questions) that were analyzed for each measure in the key drivers of member experience analysis as indicated by a checkmark (✓), as well as each survey item's baseline response that was used in the statistical calculation.

Table 2-4—Correlation Matrix

Question Number	Rating of Health Plan	Rating of All Health Care	Rating of Personal Doctor	Baseline Response
Q4. Received care as soon as needed when care was needed right away	✓	✓	✓	Always
Q6. Received appointment for a checkup or routine care as soon as needed	✓	✓	✓	Always
Q9. Ease of getting the care, tests, or treatment needed	✓	✓	✓	Always
Q12. Personal doctor explained things in an understandable way	✓	✓	✓	Always
Q13. Personal doctor listened carefully	✓	✓	✓	Always
Q14. Personal doctor showed respect for what was said	✓	✓	✓	Always
Q15. Personal doctor spent enough time	✓	✓	✓	Always
Q17. Personal doctor seemed informed and up-to-date about care from other doctors or health providers	✓	✓	✓	Always
Q20. Received appointment with a specialist as soon as needed	✓	✓		Always
Q24. Health plan's customer service gave the information or help needed	✓	✓		Always
Q25. Treated with courtesy and respect by health plan's customer service staff	✓	✓		Always
Q27. Ease of filling out forms from health plan	✓	✓		Always

HSAG measured each global rating's performance by assigning the responses into a three-point scale as follows:

- 0 to 6 = 1 (Dissatisfied)
- 7 to 8 = 2 (Neutral)
- 9 to 10 = 3 (Satisfied)

For each item evaluated, HSAG calculated the relationship between the item's response and performance on each of the three measures using a polychoric correlation, which is used to estimate the correlation between two theorized normally distributed continuous latent variables, from two observed ordinal variables. HSAG then prioritized items based on their correlation to each measure.

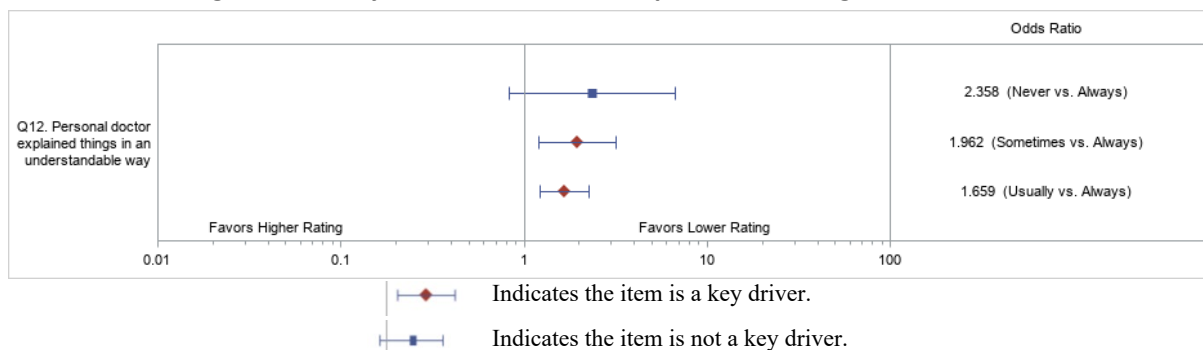
The correlation can range from -1 to 1, with negative values indicating an inverse relationship between overall member experience and a particular survey item. However, the correlation analysis conducted is not focused on the direction of the correlation, but rather on the degree of correlation. Therefore, the absolute value of the correlation is used in the analysis, and the range is 0 to 1. A zero indicates no

relationship between the response to a question and the member's experience. As the value of correlation increases, the importance of the question to the respondent's overall experience increases.

After prioritizing items based on their correlation to each measure, HSAG estimated the odds ratio, which is used to quantify respondents' tendency to choose a lower rating over a higher rating based on their responses to the evaluated items. The odds ratio can range from 0 to infinity. Key drivers are those items for which the odds ratio is statistically significantly greater than 1. If a response to an item has an odds ratio value that is statistically significantly greater than 1, then a respondent who provides a response other than the baseline is more likely to provide a lower rating on the measure than respondents who provide the baseline response. As the odds ratio value increases, the tendency for a respondent who provided a non-baseline response to choose a lower rating increases.

In Figure 2-3, the results indicate that respondents who answered "Never," "Sometimes," or "Usually" to question 12 are 2.358, 1.962, and 1.659 times, respectively, more likely to provide a lower rating for their health plan than respondents who answered "Always." The items identified as key drivers are indicated with a red diamond.

Figure 2-3—Key Drivers of Member Experience: Rating of Health Plan



Limitations and Cautions

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

Case-Mix Adjustment

The demographics of a response group may impact member experience. Therefore, differences in the demographics of the response group may impact CAHPS results. NCQA does not recommend case-mix adjusting Medicaid CAHPS results to account for these differences; therefore, no case-mix adjusting was performed on these results.

Causal Inferences

Although this report examines experiences with various aspects of health care by plan and program, any identified difference may not be completely attributable to an MHP or the FFS program. These analyses identify whether respondents give different ratings of experience with their plan or program. The survey by itself does not necessarily reveal the exact cause of these differences.

Survey Vendor Effects

The CAHPS survey was administered by multiple survey vendors. NCQA developed its Survey Vendor Certification Program to ensure standardization of data collection and the comparability of results across health plans. However, due to the different processes employed by the survey vendors (e.g., mode of survey administration, population oversampling, etc.), there is still the small potential for vendor effects. Therefore, survey vendor effects should be considered when interpreting the CAHPS results.

Non-Response Bias

The experiences of the survey respondent population may be different than that of non-respondents with respect to their health care services and may vary by plan or program. According to research, late respondents (i.e., respondents who submitted a survey later than the first mailing/round) could potentially be non-respondents if the survey had ended earlier.²⁻¹⁸ To identify potential non-response bias, HSAG compared the top-box scores from late respondents to early respondents (i.e., respondents who submitted a survey during the first round) for each measure. Results indicate that early respondents are statistically significantly more likely to provide a higher top-box response for the *Getting Needed Care*, *Rating of Specialist Seen Most Often*, and *Advising Smokers and Tobacco Users to Quit* measures. MDHHS should consider that potential non-response bias may exist when interpreting CAHPS results for these measures.

²⁻¹⁸ Korkeila, K., et al. "Non-response and related factors in a nation-wide health survey." *European Journal of Epidemiology* 17.11 (2001): 991-999.

Who Responded to the Survey

Table 3-1 shows the total number of members sampled, the number of surveys completed, the number of ineligible members, and the response rates. For additional information on the calculation of response rates, please refer to page 2-7 of the Reader’s Guide section.

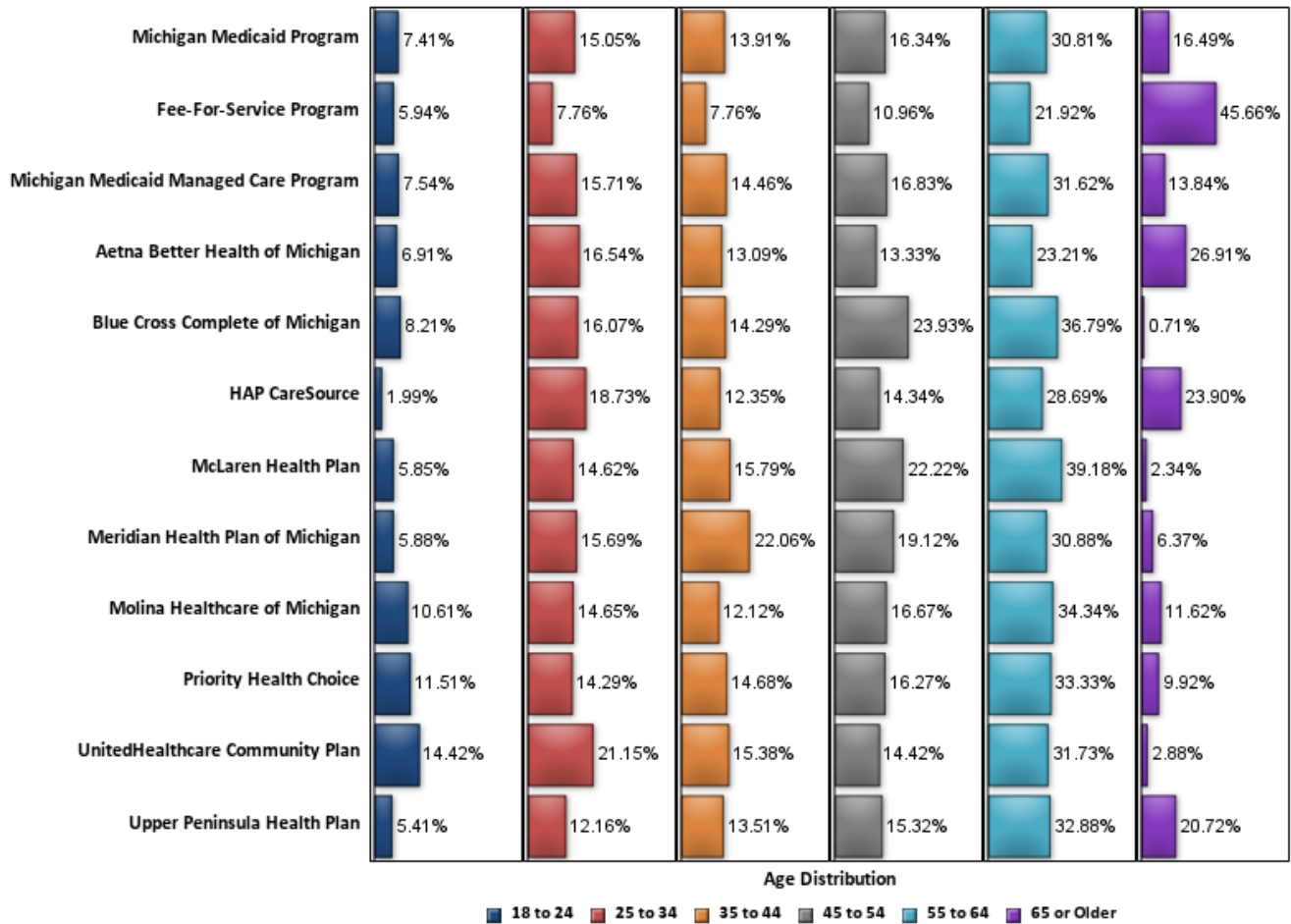
Table 3-1—Distribution of Surveys and Response Rates

Program/MHP Name	Sample Size	Completes	Ineligibles	Response Rate
Michigan Medicaid Program	21,533	2,688	418	12.73%
Fee-For-Service Program	1,350	222	84	17.54%
Michigan Medicaid Managed Care Program	20,183	2,466	334	12.42%
Aetna Better Health of Michigan	2,268	413	66	18.76%
Blue Cross Complete of Michigan	2,295	286	36	12.66%
HAP CareSource	2,700	259	46	9.76%
McLaren Health Plan	2,160	176	24	8.24%
Meridian Health Plan of Michigan	2,160	210	34	9.88%
Molina Healthcare of Michigan	2,295	204	36	9.03%
Priority Health Choice	2,255	254	32	11.43%
UnitedHealthcare Community Plan	1,890	212	24	11.36%
Upper Peninsula Health Plan	2,160	452	36	21.28%

Demographics of Adult Members

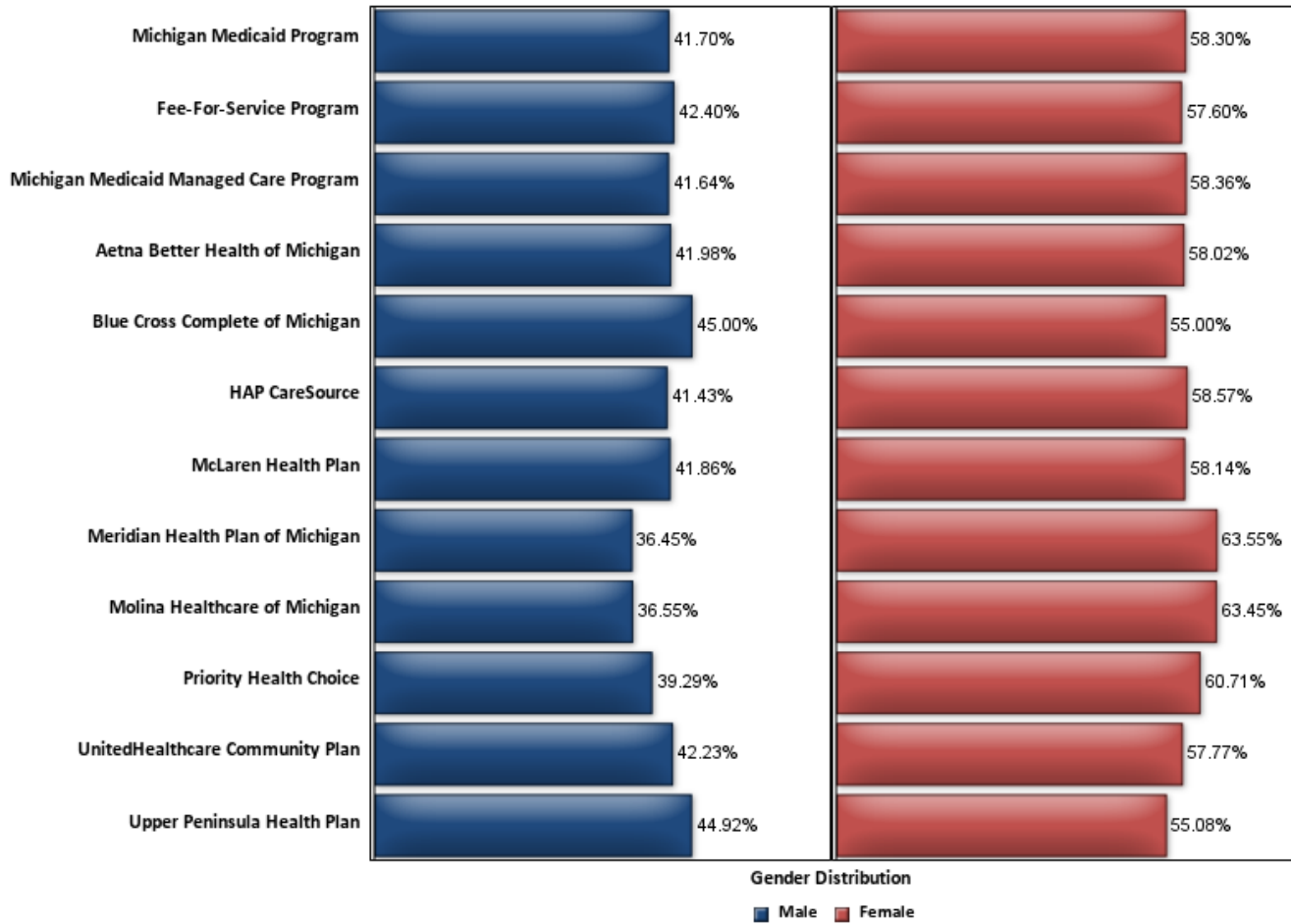
Figure 3-1 through Figure 3-7 depict the demographics of members who completed a survey.

Figure 3-1—Adult Member Demographics: Age



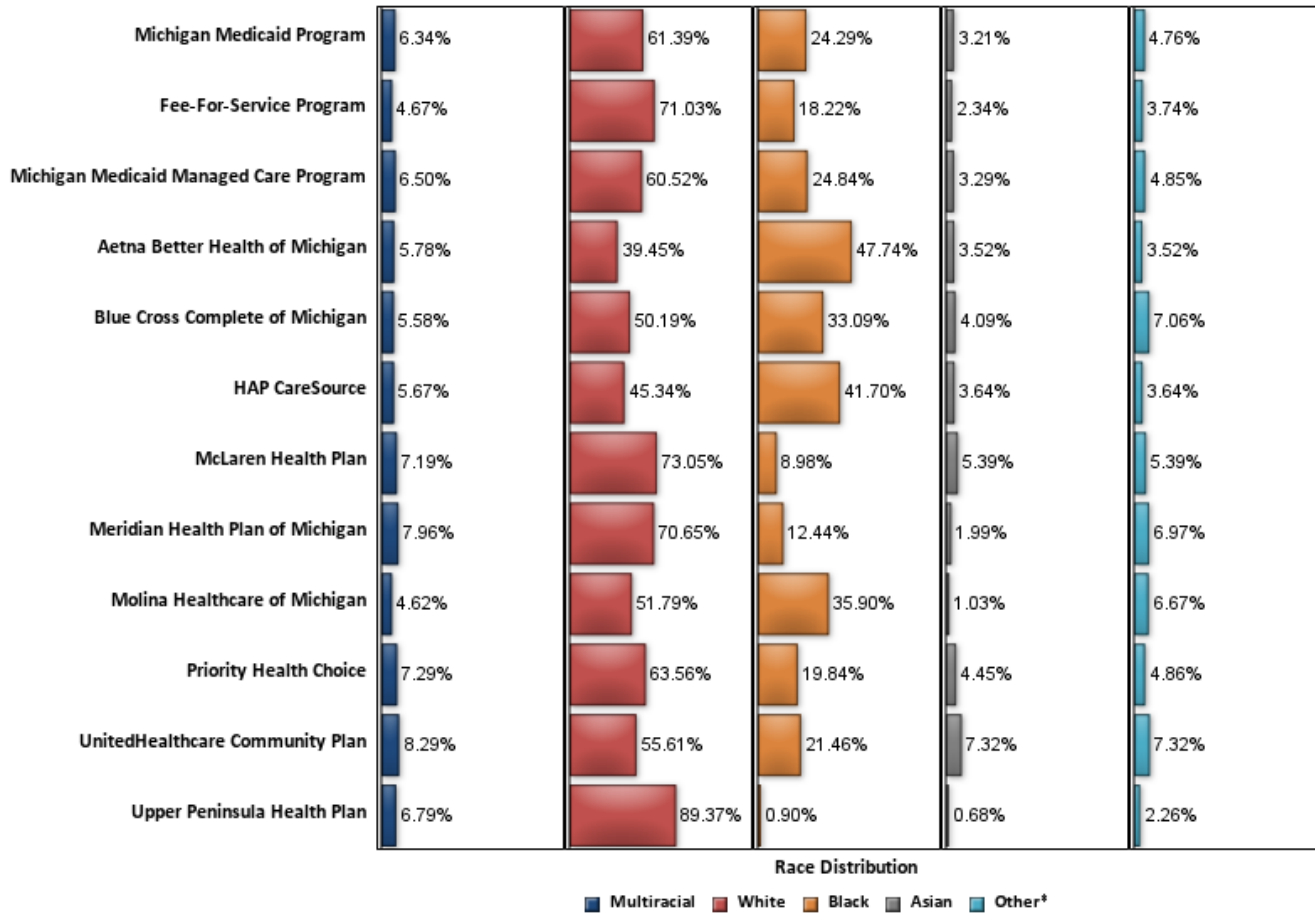
Some percentages may not total 100% due to rounding.

Figure 3-2—Adult Member Demographics: Gender



Some percentages may not total 100% due to rounding.

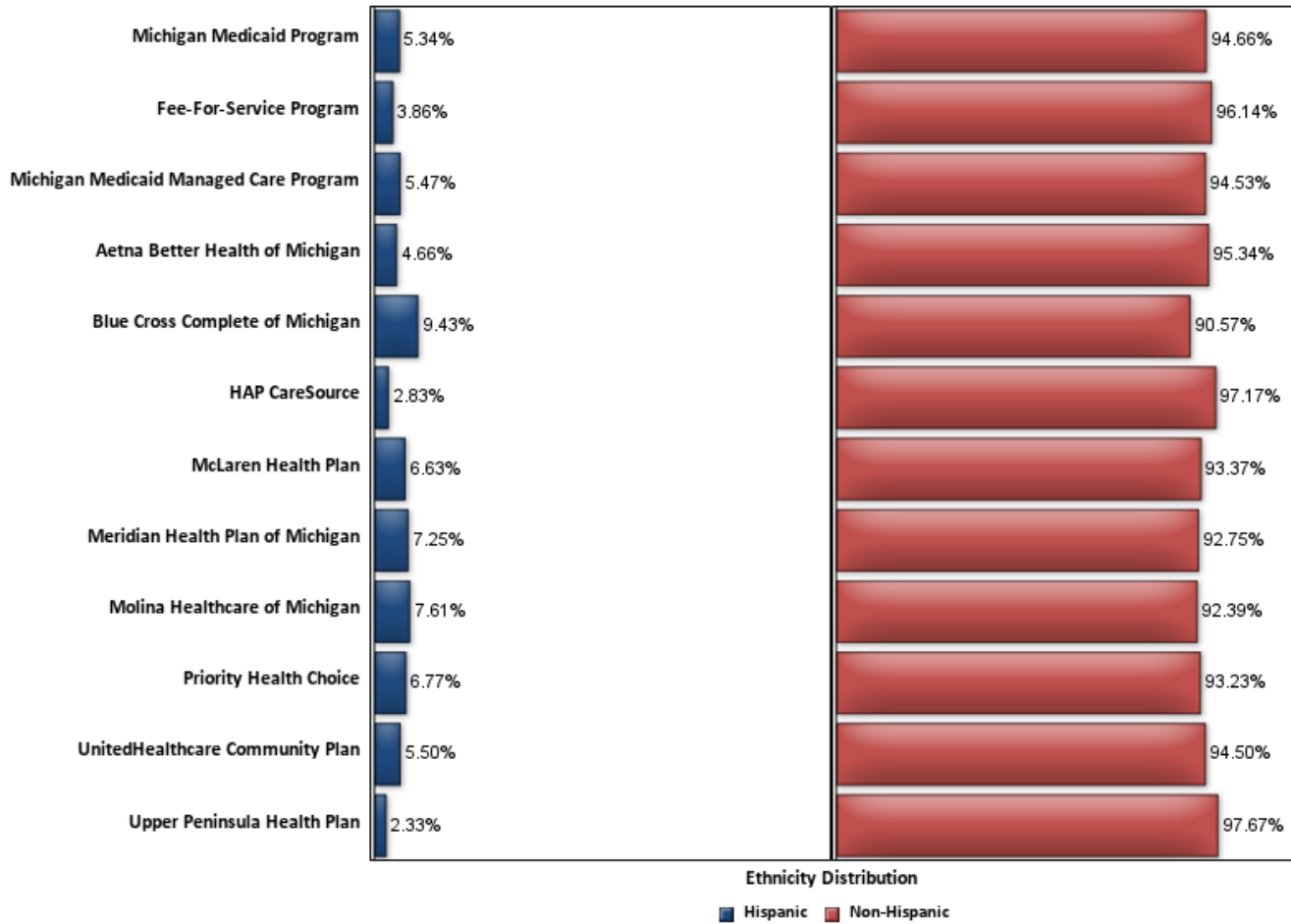
Figure 3-3—Adult Member Demographics: Race



Some percentages may not total 100% due to rounding.

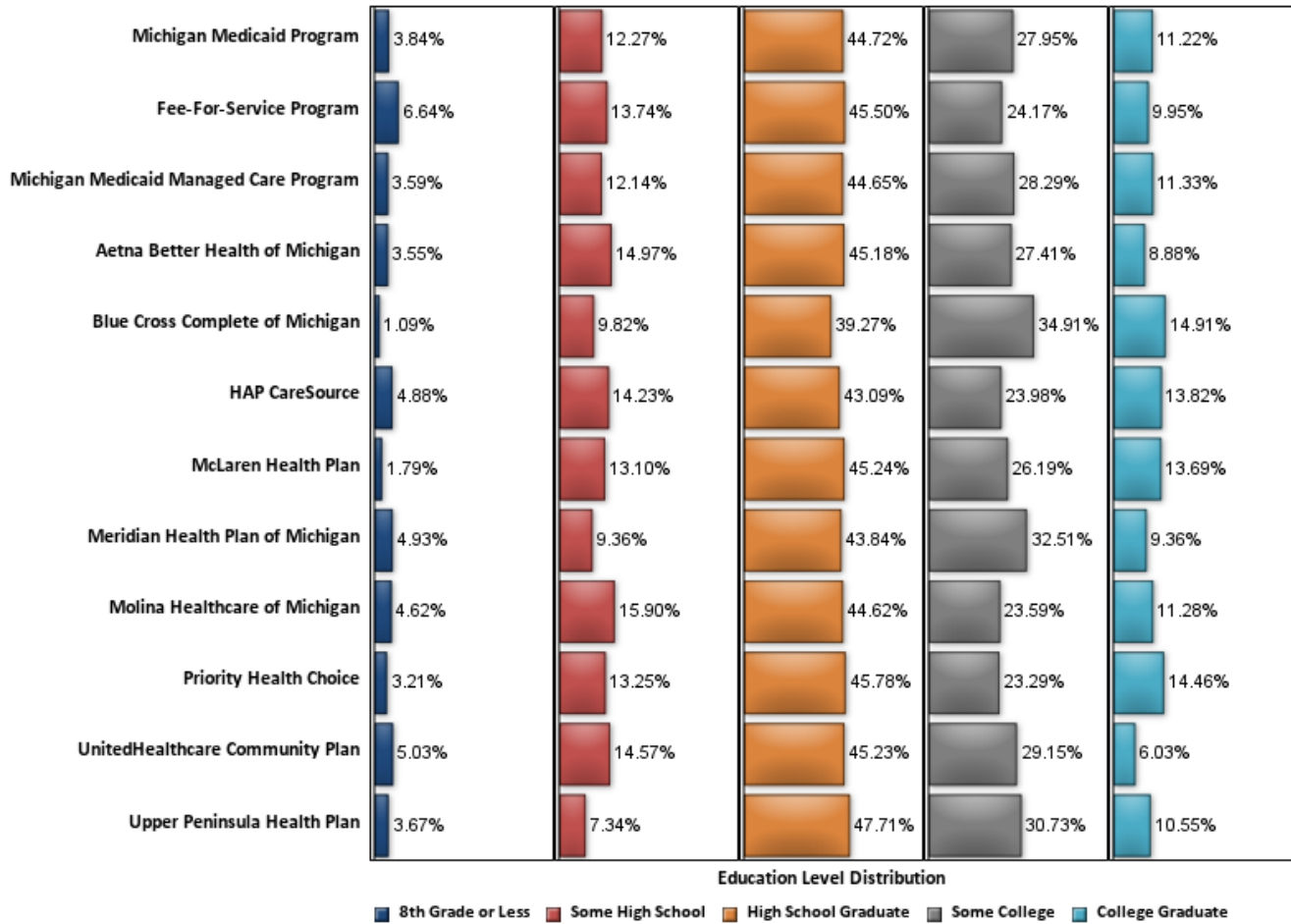
**The "Other" race category includes responses of Native Hawaiian or Other Pacific Islander, American Indian or Alaska Native, and Other.*

Figure 3-4—Adult Member Demographics: Ethnicity



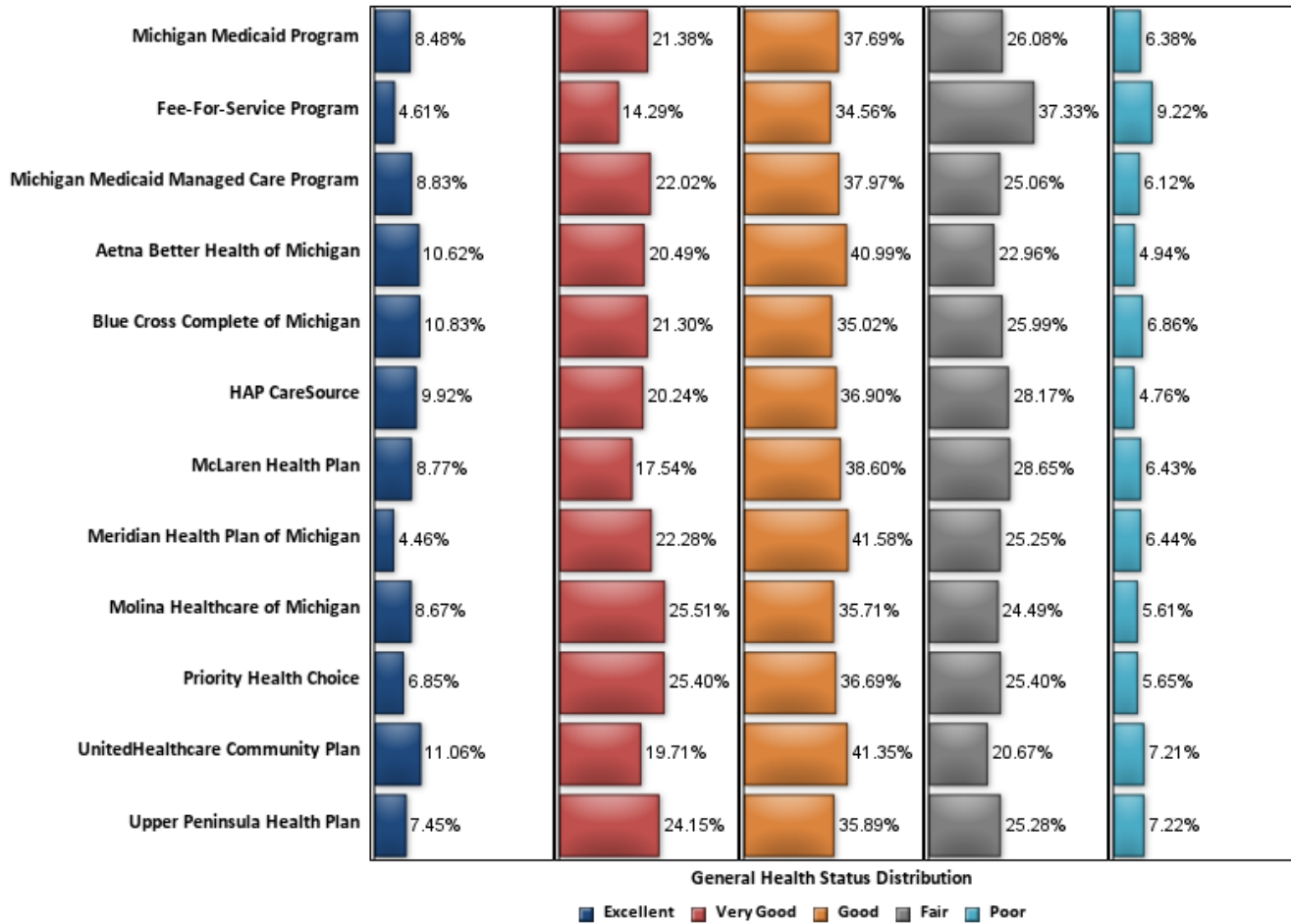
Some percentages may not total 100% due to rounding.

Figure 3-5—Adult Member Demographics: Education Level



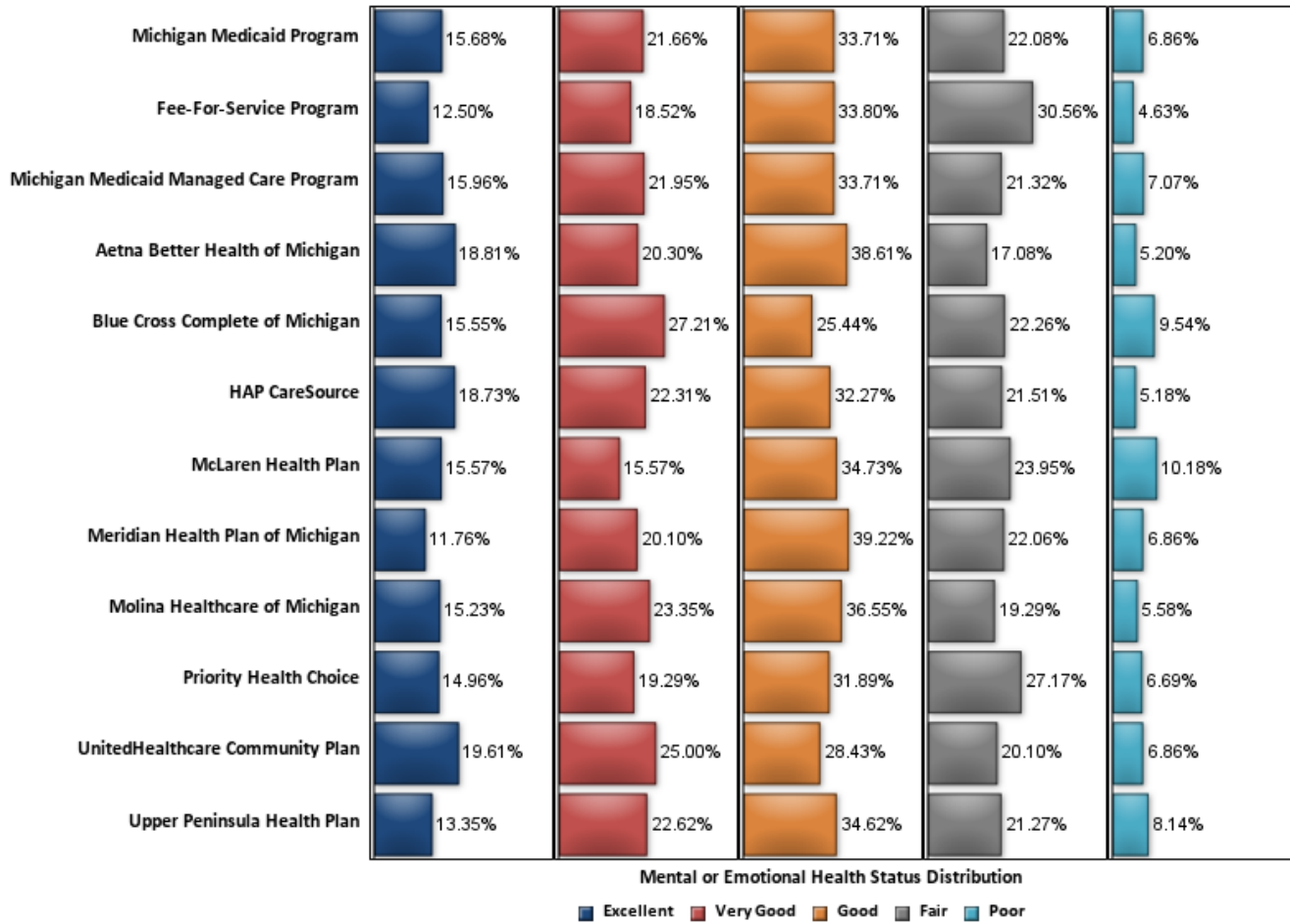
Some percentages may not total 100% due to rounding.

Figure 3-6—Adult Member Demographics: General Health Status



Some percentages may not total 100% due to rounding.

Figure 3-7—Adult Member Demographics: Mental or Emotional Health Status



Some percentages may not total 100% due to rounding.

National Comparisons

In order to assess the overall performance, HSAG compared scores for the measures to NCQA’s 2023 Quality Compass Benchmark and Compare Quality Data.^{3-1,3-2} Based on this comparison, ratings of one (★) to five (★★★★★) stars were determined for each measure, where one is the lowest possible rating (i.e., Poor) and five is the highest possible rating (i.e., Excellent), as shown in Table 3-2.

Table 3-2— Star Rating Percentile Distributions

Stars	Percentiles
★★★★★ Excellent	At or above the 90th percentile
★★★★ Very Good	At or between the 75th and 89th percentiles
★★★ Good	At or between the 50th and 74th percentiles
★★ Fair	At or between the 25th and 49th percentiles
★ Poor	Below the 25th percentile

The percentages presented in the following three tables represent the scores, while the stars represent overall member experience ratings when the scores were compared to NCQA Quality Compass Benchmark and Compare Quality Data.

³⁻¹ National Committee for Quality Assurance. *Quality Compass®: Benchmark and Compare Quality Data 2023*. Washington, DC: NCQA, September 2023.

³⁻² Quality Compass 2024 data were not available at the time this report was prepared; therefore, 2023 data were used for comparison.

Table 3-3 shows the scores and overall member experience ratings on the four global ratings.

Table 3-3—National Comparisons: Global Ratings

Program/MHP Name	Rating of Health Plan	Rating of All Health Care	Rating of Personal Doctor	Rating of Specialist Seen Most Often
Michigan Medicaid Program	★★ 61.24%	★★ 55.06%	★★ 67.17%	★★★ 67.08%
Fee-For-Service Program	★ 56.80%	★★ 53.85%	★★ 66.12%	★ 61.48%
Michigan Medicaid Managed Care Program	★★★ 62.72%	★★ 55.46%	★★ 67.52%	★★★★ 68.93%
Aetna Better Health of Michigan	★★★ 62.12%	★★ 55.97%	★★★ 68.34%	★★ 65.63%
Blue Cross Complete of Michigan	★★★ 63.67%	★★★ 57.84%	★★ 65.78%	★★★ 68.75%
HAP CareSource	★★ 59.84%	★★★★★ 64.60%	★★★★ 72.14%	★★★★ 70.00%
McLaren Health Plan	★★ 61.45%	★★ 54.78%	★ 60.87%	★★★★★ 74.70% ⁺
Meridian Health Plan of Michigan	★★ 60.10%	★ 49.62%	★★★ 70.22%	★★ 63.44% ⁺
Molina Healthcare of Michigan	★★★ 64.29%	★★★★★ 59.70%	★★ 68.05%	★★★★★ 77.91% ⁺
Priority Health Choice	★★★★ 66.94%	★★ 55.28%	★★ 66.36%	★★ 66.04%
UnitedHealthcare Community Plan	★★ 61.50%	★★★ 56.35%	★★★ 68.99%	★★ 66.27% ⁺
Upper Peninsula Health Plan	★★★★★ 69.05%	★★★★★ 61.13%	★★★★ 72.75%	★★★ 66.67%

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

Table 3-4 shows the scores and overall member experience ratings on the four composite measures.

Table 3-4—National Comparisons: Composite Measures

Program/MHP Name	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service
Michigan Medicaid Program	★★★ 82.25%	★★★ 83.63%	★★★ 93.00%	★★ 88.65%
Fee-For-Service Program	★★★★ 85.20%	★★★★ 85.78%	★★ 92.65%	★★ 88.57% ⁺
Michigan Medicaid Managed Care Program	★★ 81.27%	★★★ 82.92%	★★★ 93.11%	★★ 88.68%
Aetna Better Health of Michigan	★★★ 83.26%	★★ 80.76%	★ 91.01%	★★★ 89.99%
Blue Cross Complete of Michigan	★★★ 83.36%	★★★ 83.76%	★★★ 93.83%	★★ 89.10%
HAP CareSource	★★★ 83.64%	★★★ 82.98%	★★ 92.05%	★★★★★ 92.07%
McLaren Health Plan	★★ 81.04%	★★★ 81.87% ⁺	★★ 92.22%	★★ 88.87% ⁺
Meridian Health Plan of Michigan	★★ 77.97%	★★★ 81.67%	★★★★★ 95.35%	★ 85.22% ⁺
Molina Healthcare of Michigan	★★ 80.48%	★★★ 82.85% ⁺	★★ 92.02%	★★★ 89.96% ⁺
Priority Health Choice	★★★★ 84.74%	★★★ 84.49%	★★ 91.82%	★★ 88.85% ⁺
UnitedHealthcare Community Plan	★★ 81.43%	★★★ 83.70% ⁺	★★ 91.61%	★★★ 90.76% ⁺
Upper Peninsula Health Plan	★★★★ 86.48%	★★★★★ 86.94%	★★★★★ 95.03%	★★★★★ 94.15%

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

Table 3-5 shows the scores and overall member experience ratings on the one individual item measure and three medical assistance with smoking and tobacco use cessation measure items.

Table 3-5—National Comparisons: Individual Item and Medical Assistance With Smoking and Tobacco Use Cessation Measure Items

Program/MHP Name	Coordination of Care	Advising Smokers and Tobacco Users to Quit	Discussing Cessation Medications	Discussing Cessation Strategies
Michigan Medicaid Program	★★ 83.15%	★★★★★ 78.31%	★★★★★ 56.88%	★★★ 48.07%
Fee-For-Service Program	★ 81.25% ⁺	★★★★★ 84.96%	★★★★★ 60.71%	★★★ 48.21%
Michigan Medicaid Managed Care Program	★★ 83.78%	★★★ 76.11%	★★★★★ 55.61%	★★★ 48.02%
Aetna Better Health of Michigan	★ 76.87%	★★★ 73.28%	★★★★★ 55.46%	★★ 46.19%
Blue Cross Complete of Michigan	★★★★★ 87.37% ⁺	★★★ 76.65%	★★★ 52.98%	★★ 45.83%
HAP CareSource	★ 79.17% ⁺	★ 63.81%	★★ 47.52%	★★ 45.10%
McLaren Health Plan	★★ 84.48% ⁺	★★ 71.43%	★★ 48.65%	★★ 43.12%
Meridian Health Plan of Michigan	★ 80.00% ⁺	★★★★★ 80.45%	★★★★★ 60.77%	★★★★★ 54.96%
Molina Healthcare of Michigan	★★★ 86.49% ⁺	★★★ 74.82%	★★★ 53.15%	★★★ 48.20%
Priority Health Choice	★★ 84.55%	★★★ 75.83%	★★★ 54.62%	★★ 41.67%
UnitedHealthcare Community Plan	★★ 83.33% ⁺	★★★★★ 77.14%	★★★★★ 61.32%	★★★ 49.04%
Upper Peninsula Health Plan	★★★★★ 89.25%	★★ 72.34%	★★★ 53.79%	★★ 43.93%

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

Statewide Comparisons

For purposes of the Statewide Comparisons analysis, HSAG calculated overall scores for the medical assistance with smoking and tobacco use cessation measure items and top-box scores for the other measures.³⁻³ For information on the survey language and response options for the measures, please refer to the Reader's Guide beginning on page 2-2. For more detailed information regarding the calculation of these measures, please refer to the Reader's Guide section beginning on page 2-7.

The Michigan Medicaid Program and Michigan Medicaid Managed Care Program results were weighted based on the eligible population for each adult population (i.e., FFS and/or MHPs). HSAG compared the MHP and FFS results to the Michigan Medicaid Managed Care Program to determine if the results were statistically significantly different than the Michigan Medicaid Managed Care Program. Colors in the figures note statistically significant differences. MHP/program scores with fewer than 100 respondents are denoted with a cross (+). Caution should be used when evaluating scores derived from fewer than 100 respondents. Also, the NCQA adult Medicaid national averages are presented for comparison.³⁻⁴

In some instances, the scores presented for two MHPs were similar, but one was statistically different from the Michigan Medicaid Managed Care Program and the other was not. In these instances, it was the difference in the number of respondents between the two MHPs that explains the different statistical results. It is more likely that a statistically significant result will be found in an MHP with a larger number of respondents.

³⁻³ HSAG followed *HEDIS® Measurement Year 2023, Volume 3: Specifications for Survey Measures* for calculating top-box responses.

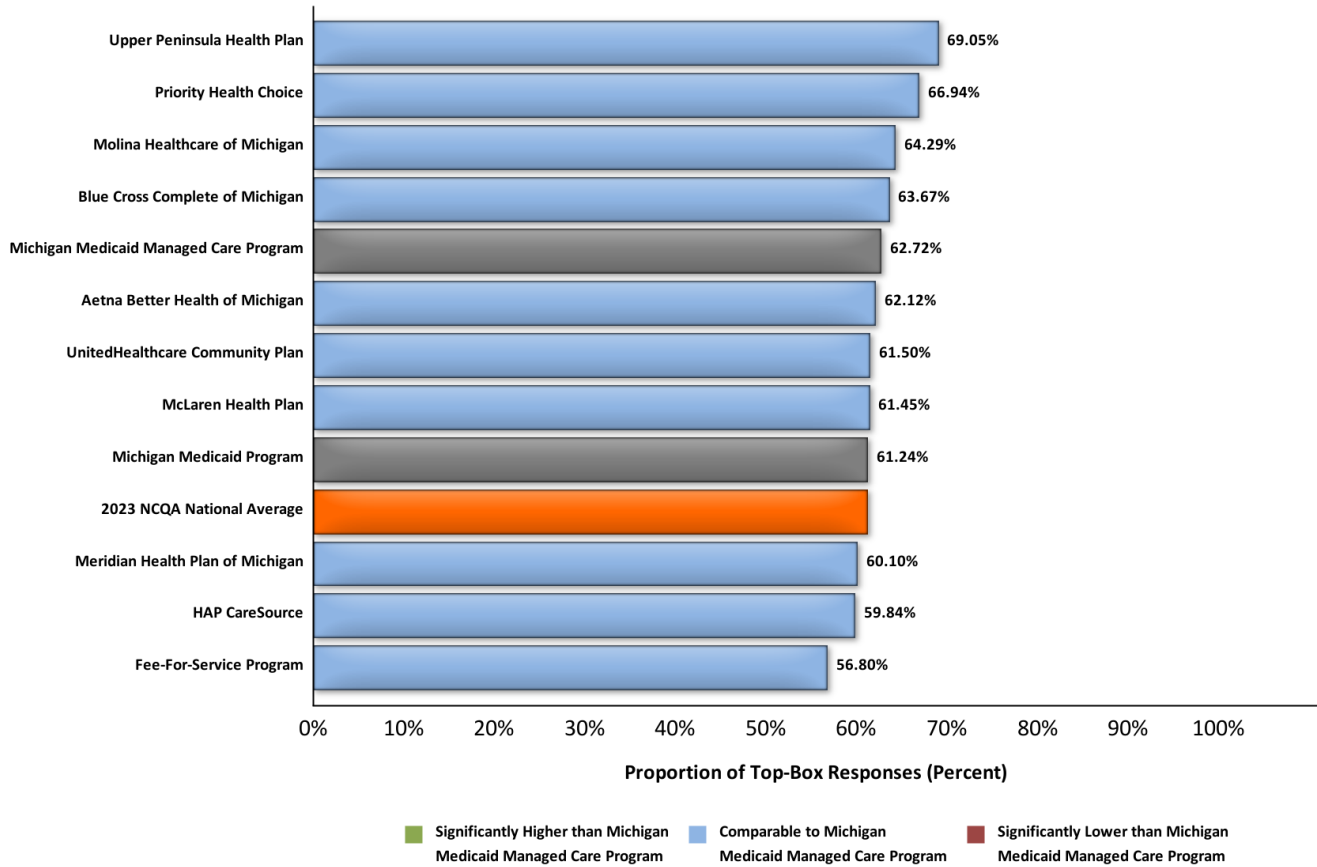
³⁻⁴ The source for the national data contained in this publication is Quality Compass 2023 and is used with the permission of NCQA. Quality Compass 2023 includes certain CAHPS data. Any data display, analysis, interpretation, or conclusion based on these data is solely that of the authors, and NCQA specifically disclaims responsibility for any such display, analysis, interpretation, or conclusion. Quality Compass is a registered trademark of NCQA. CAHPS® is a registered trademark of AHRQ.

Global Ratings

Rating of Health Plan

Figure 3-8 shows the *Rating of Health Plan* top-box scores.

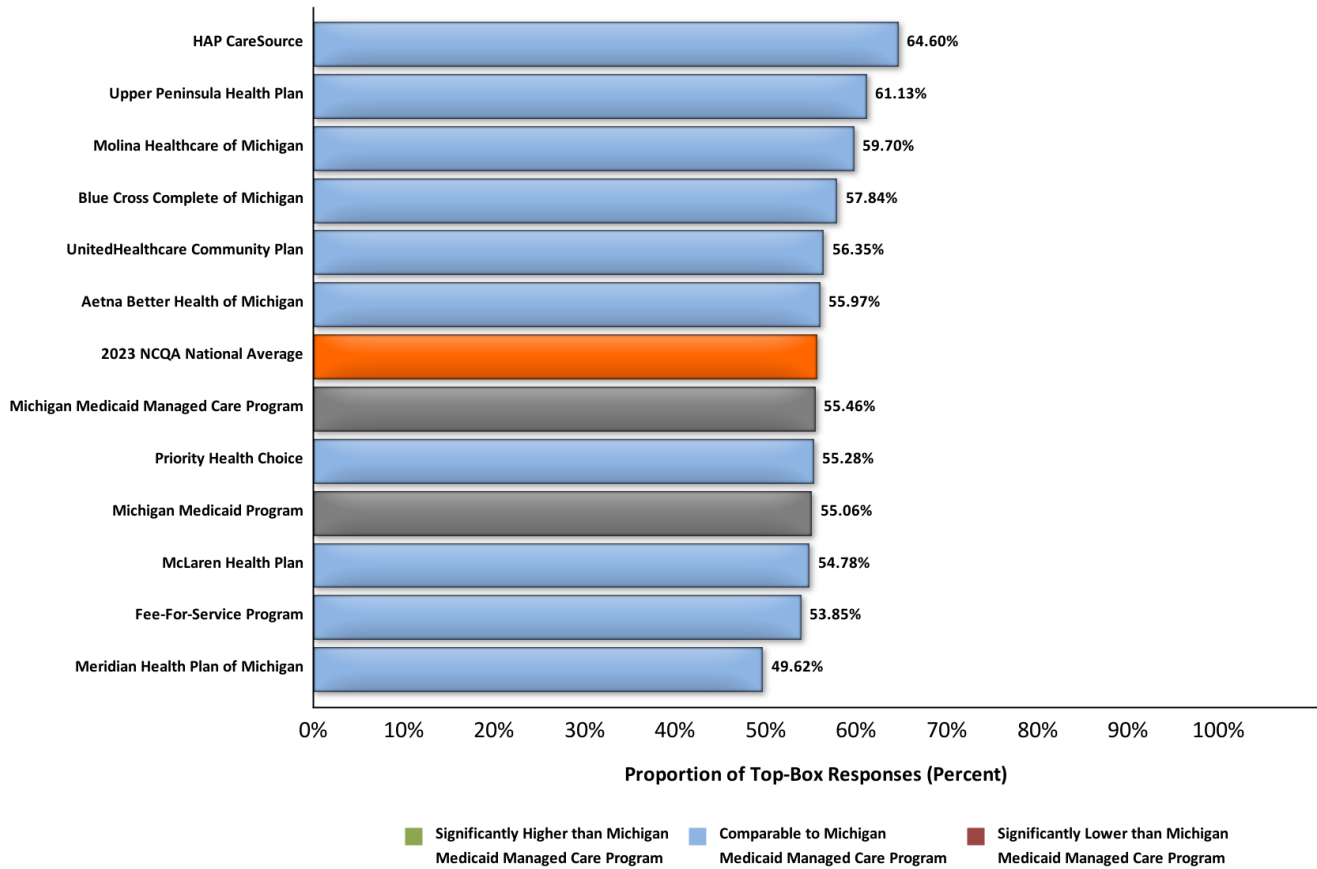
Figure 3-8—Top-Box Scores: Rating of Health Plan



Rating of All Health Care

Figure 3-9 shows the *Rating of All Health Care* top-box scores.

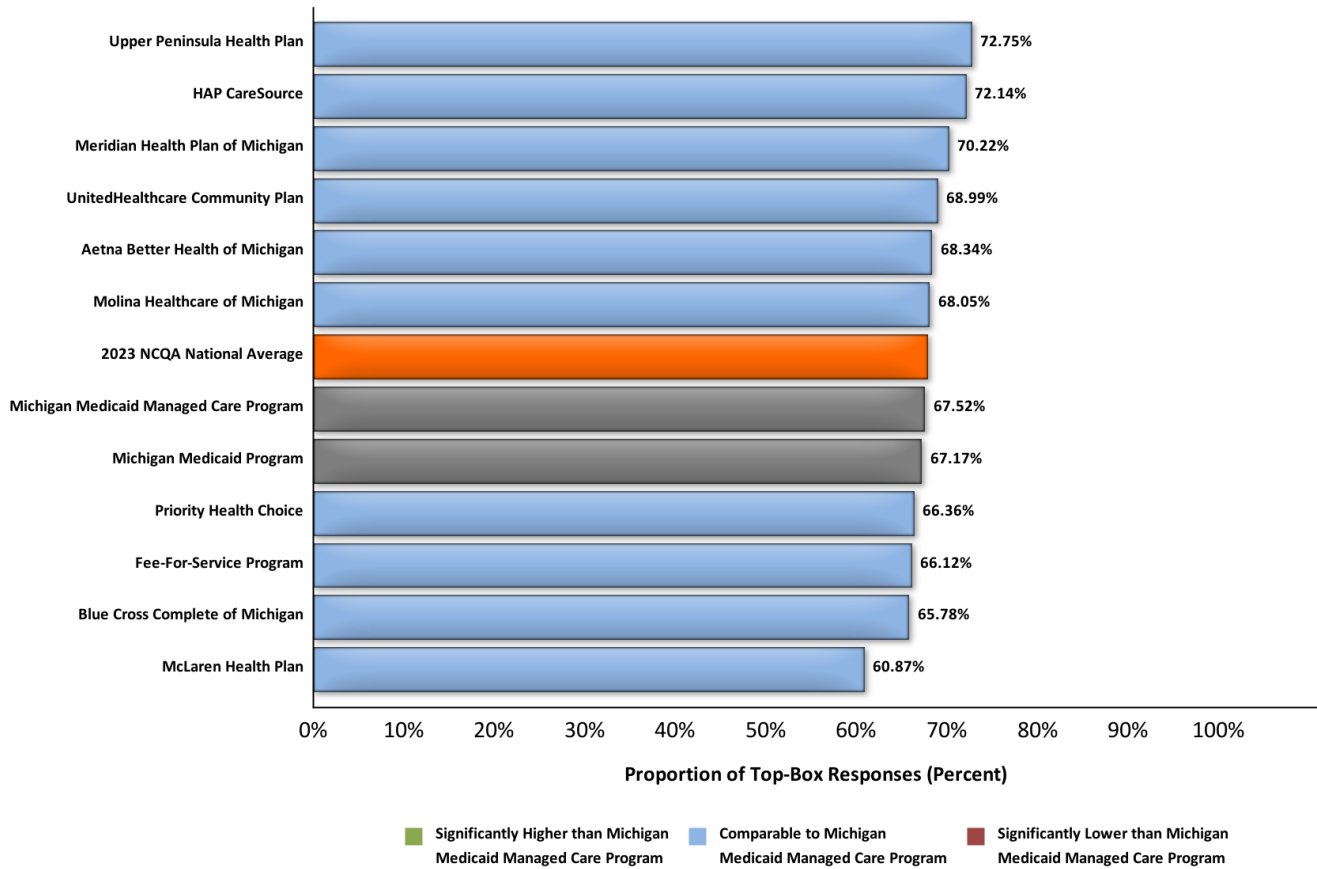
Figure 3-9—Top-Box Scores: Rating of All Health Care



Rating of Personal Doctor

Figure 3-10 shows the *Rating of Personal Doctor* top-box scores.

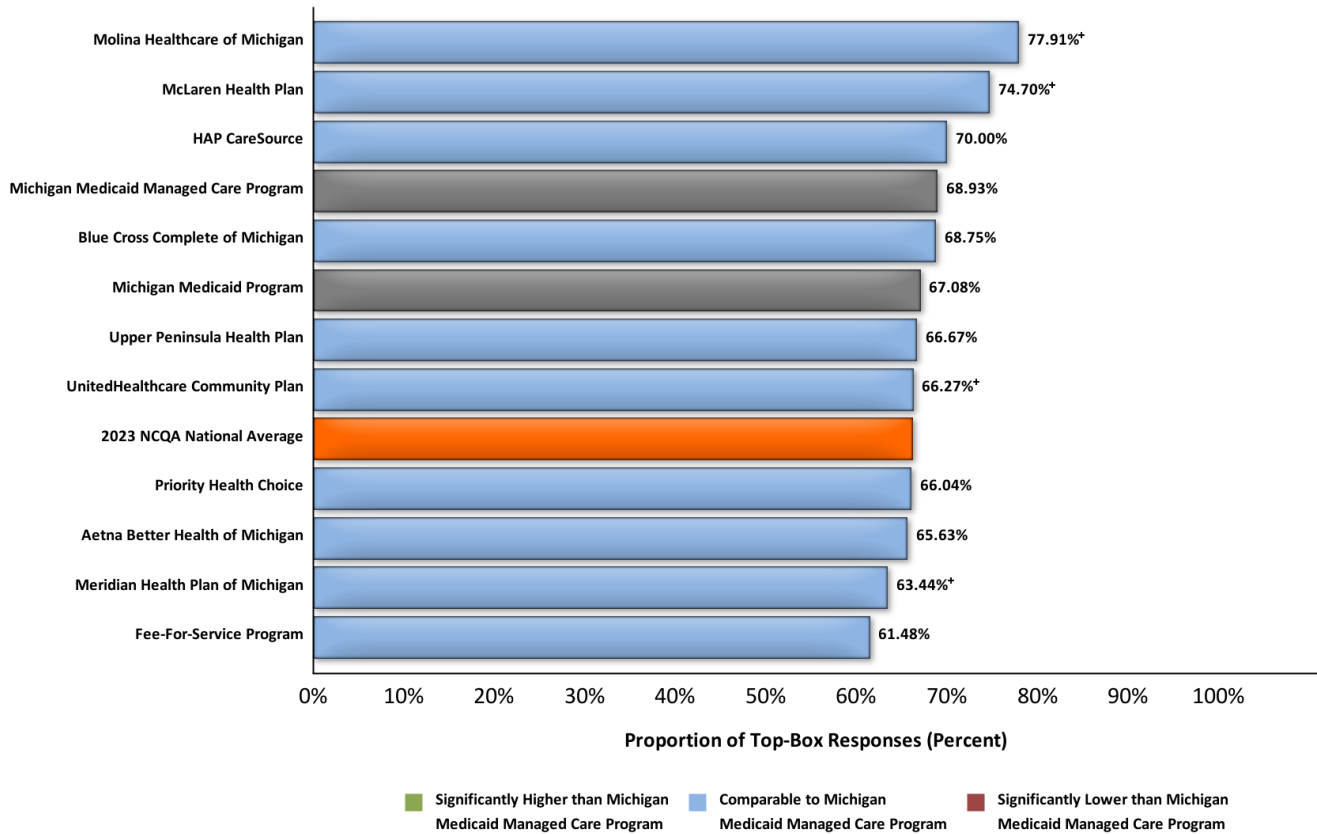
Figure 3-10—Top-Box Scores: Rating of Personal Doctor



Rating of Specialist Seen Most Often

Figure 3-11 shows the *Rating of Specialist Seen Most Often* top-box scores.

Figure 3-11—Top-Box Scores: Rating of Specialist Seen Most Often



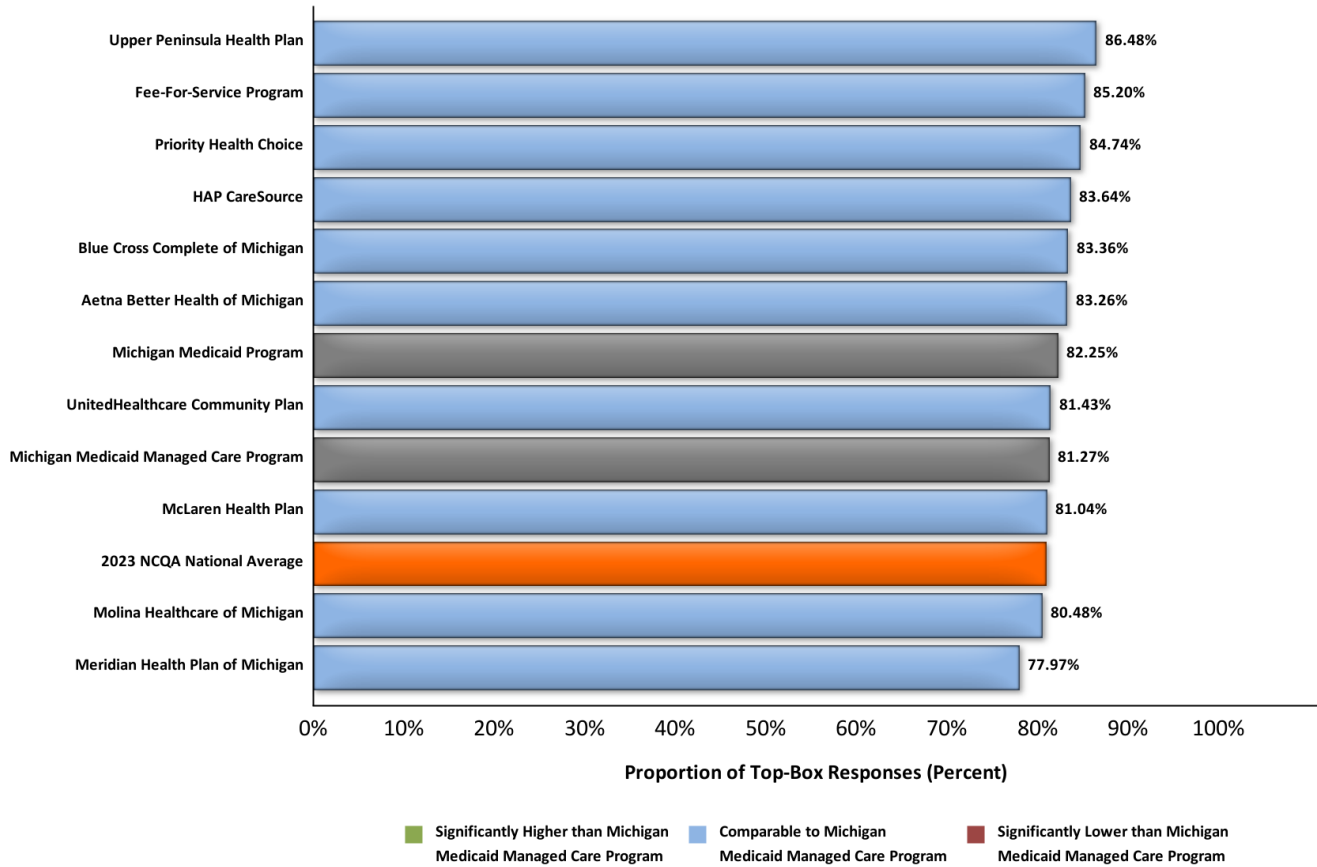
+ Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.

Composite Measures

Getting Needed Care

Figure 3-12 shows the *Getting Needed Care* top-box scores.

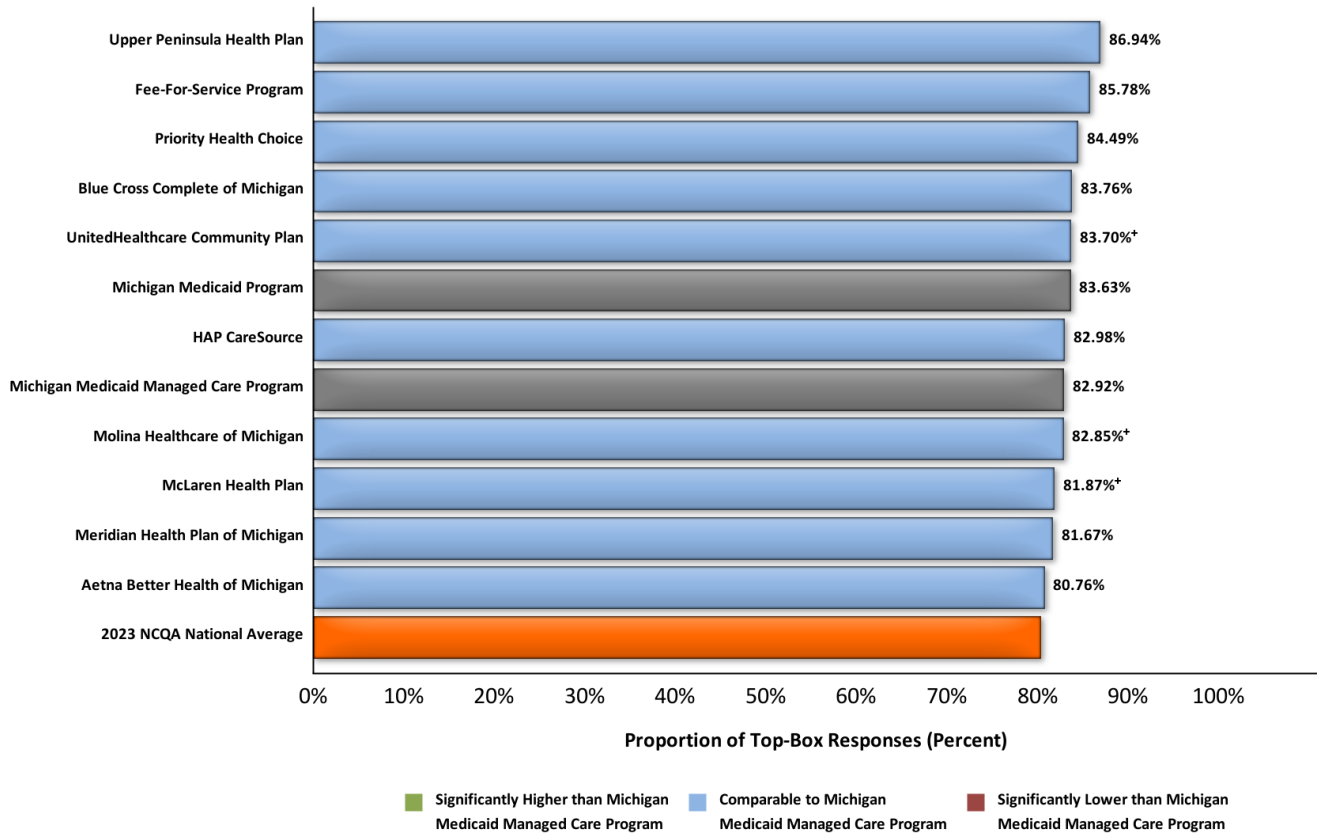
Figure 3-12—Top-Box Scores: Getting Needed Care



Getting Care Quickly

Figure 3-13 shows the *Getting Care Quickly* top-box scores.

Figure 3-13—Top-Box Scores: Getting Care Quickly

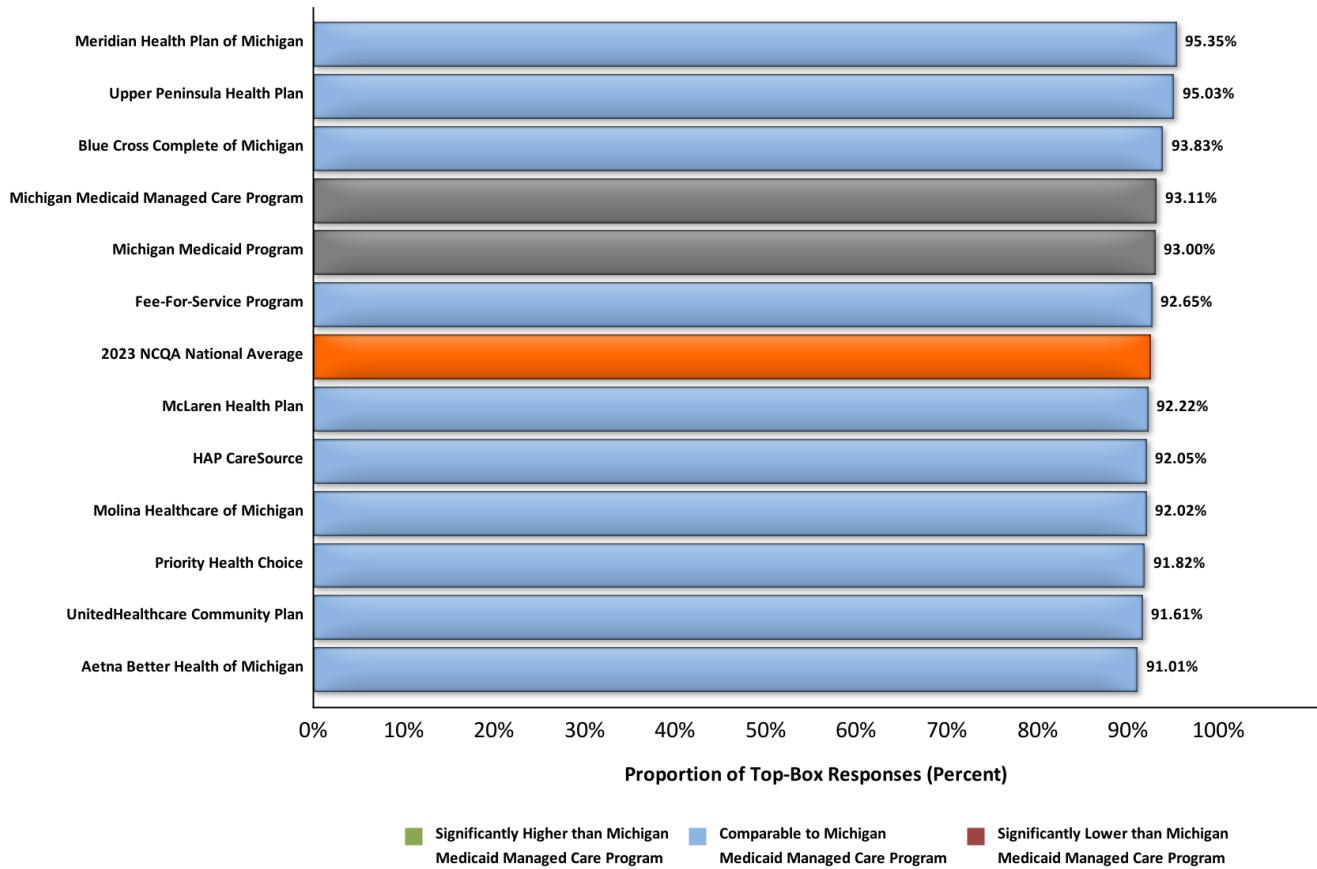


⁺ Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.

How Well Doctors Communicate

Figure 3-14 shows the *How Well Doctors Communicate* top-box scores.

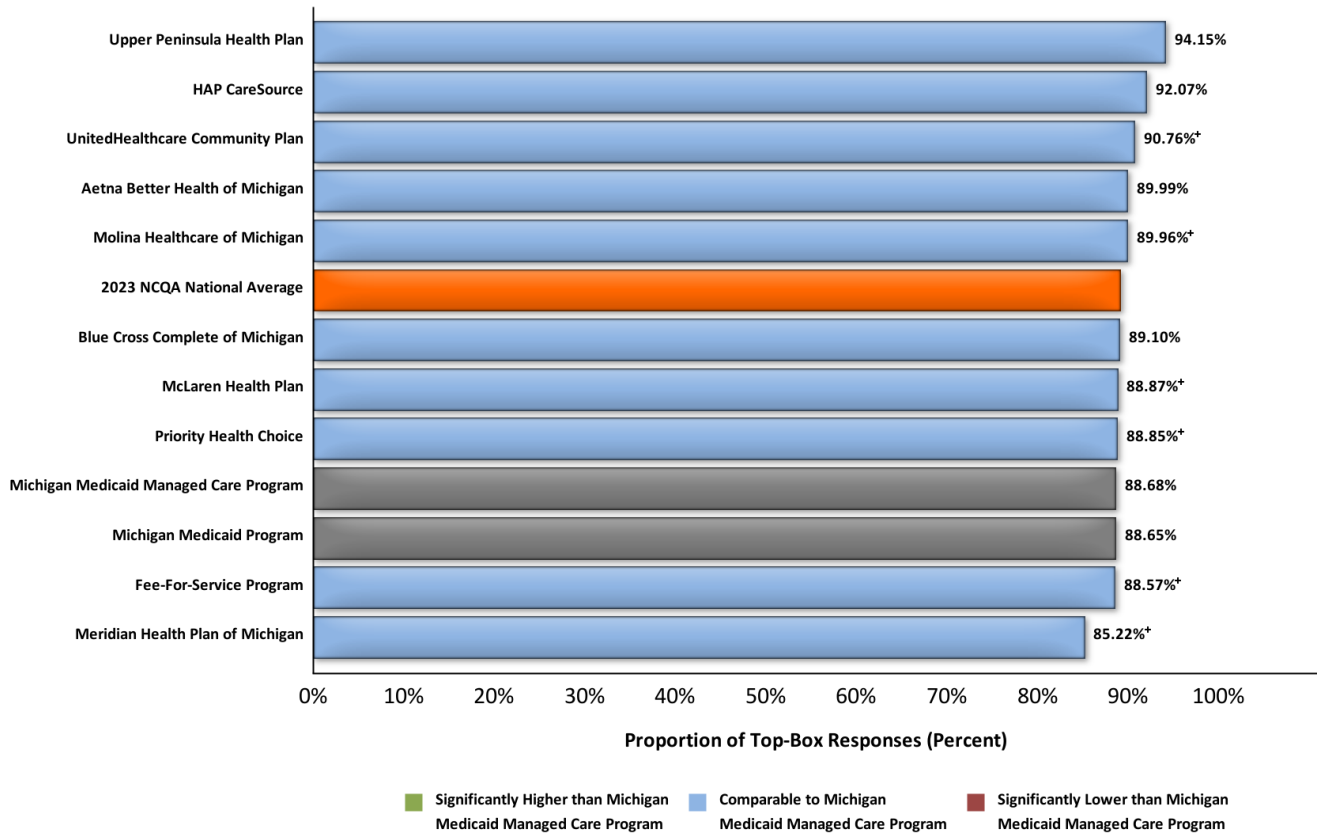
Figure 3-14—Top-Box Scores: How Well Doctors Communicate



Customer Service

Figure 3-15 shows the *Customer Service* top-box scores.

Figure 3-15—Top-Box Scores: Customer Service



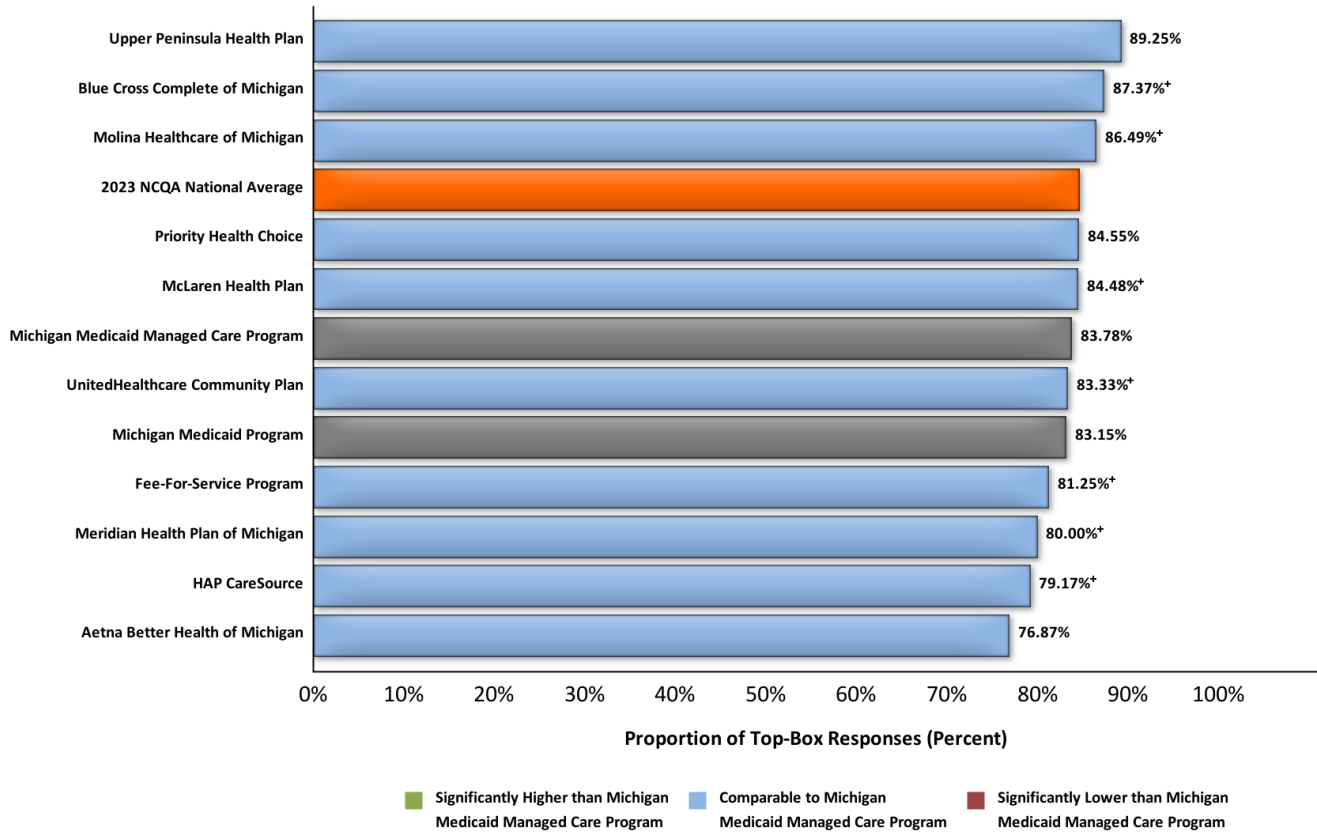
+ Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.

Individual Item Measure

Coordination of Care

Figure 3-16 shows the *Coordination of Care* top-box scores.

Figure 3-16—Top-Box Scores: Coordination of Care

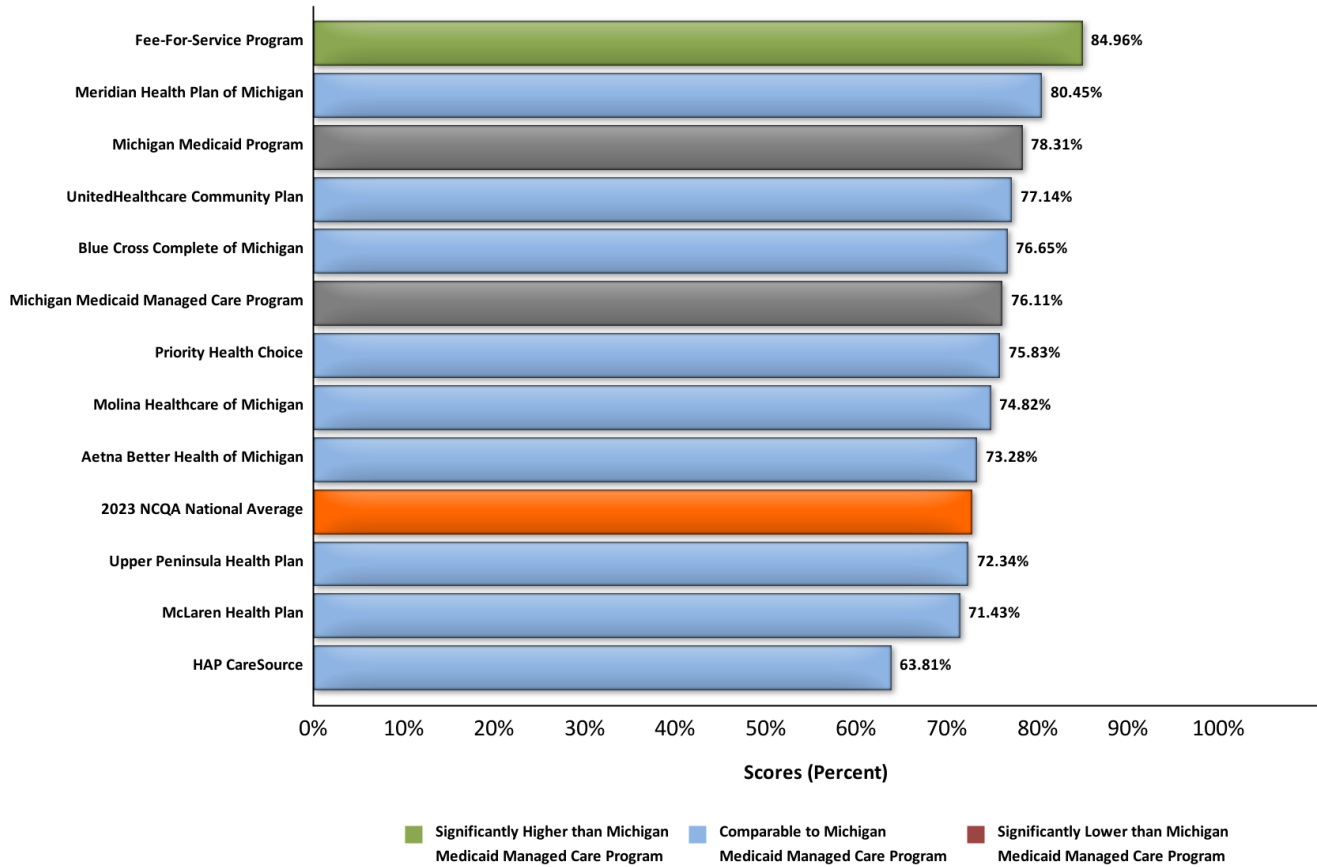


Medical Assistance With Smoking and Tobacco Use Cessation Measure Items

Advising Smokers and Tobacco Users to Quit

Figure 3-17 shows the *Advising Smokers and Tobacco Users to Quit* scores.

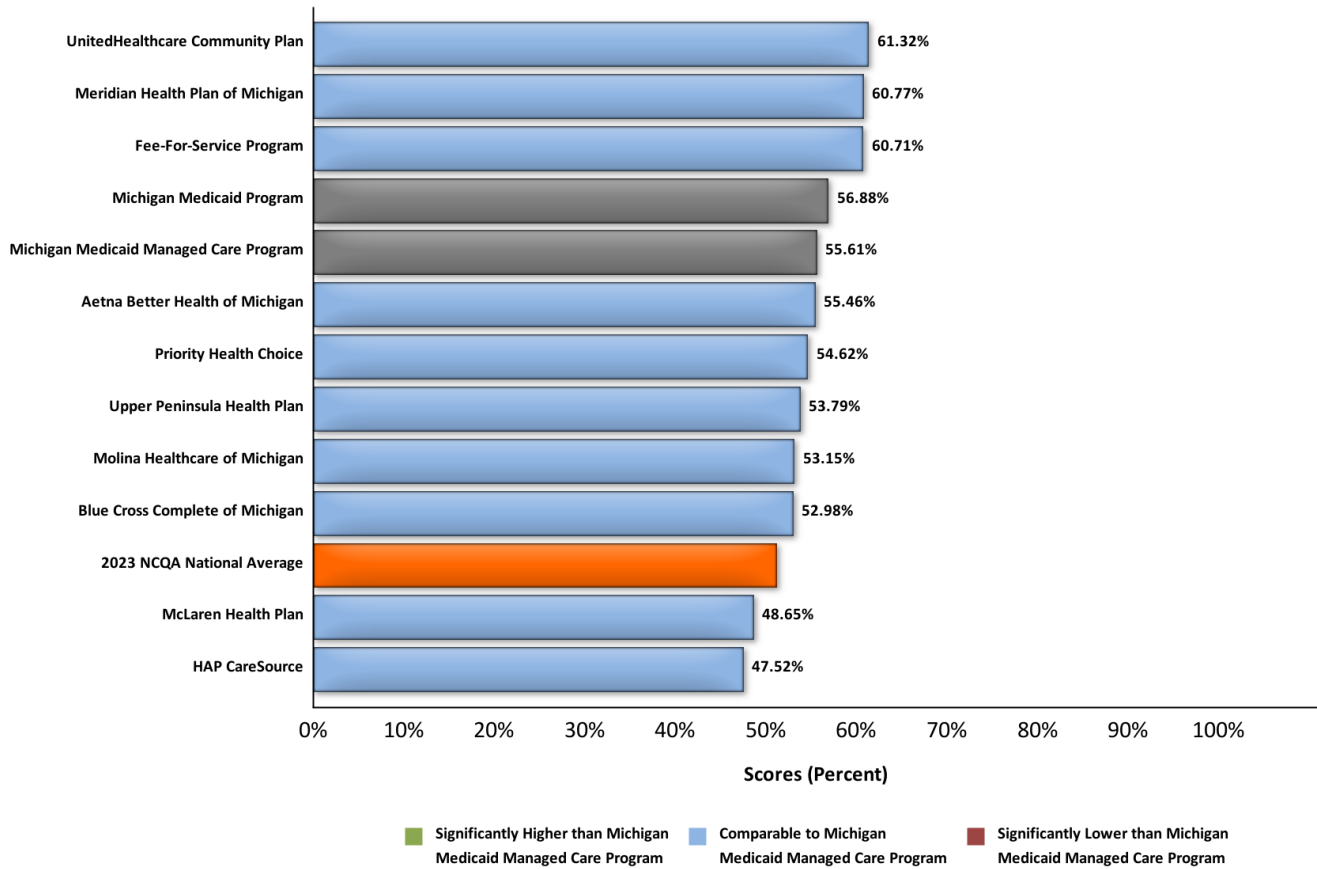
Figure 3-17—Overall Scores: Advising Smokers and Tobacco Users to Quit Scores



Discussing Cessation Medications

Figure 3-18 shows the *Discussing Cessation Medications* scores.

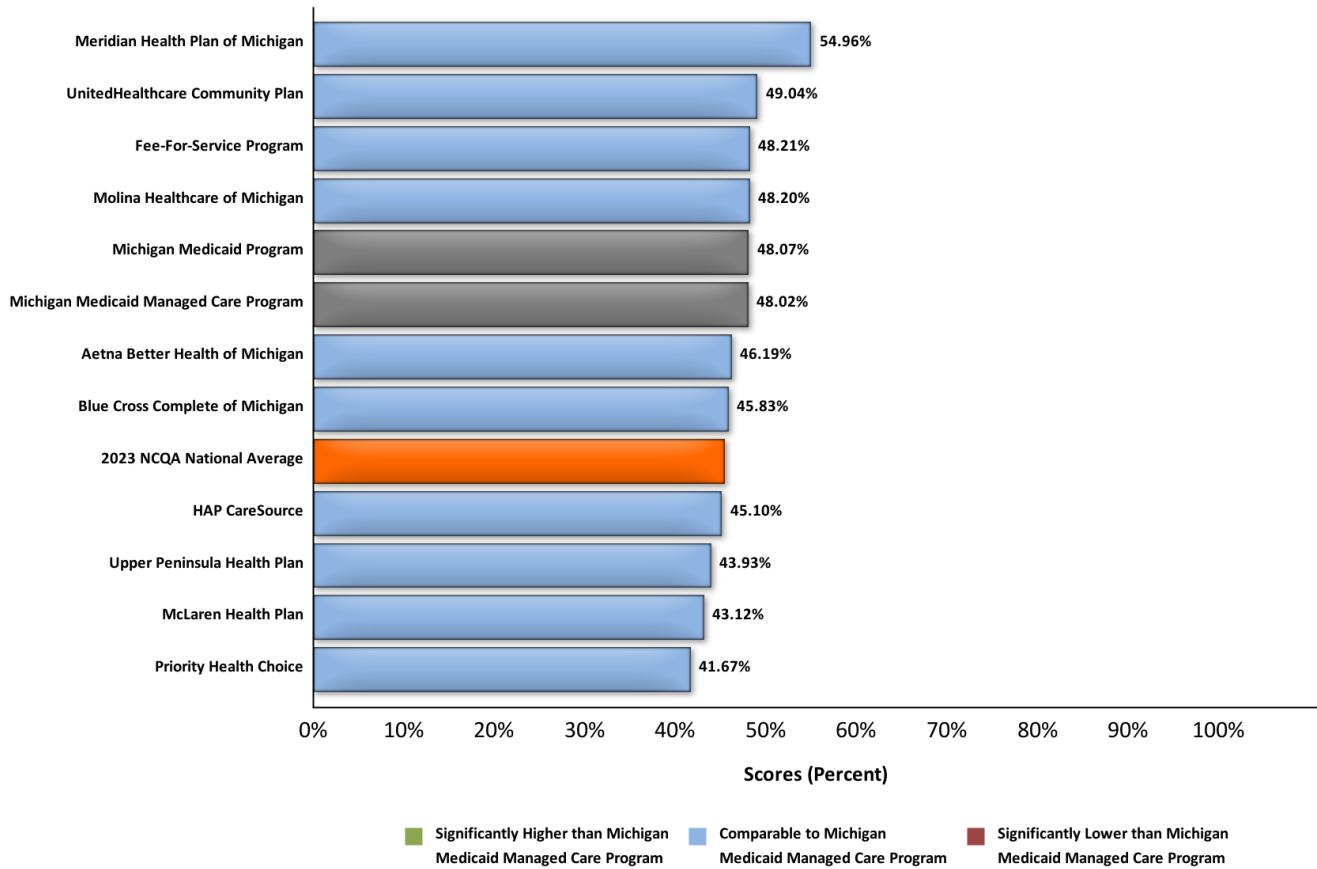
Figure 3-18—Overall Scores: Discussing Cessation Medications Scores



Discussing Cessation Strategies

Figure 3-19 shows the *Discussing Cessation Strategies* scores.

Figure 3-19—Overall Scores: Discussing Cessation Strategies Scores



4. Trend Analysis

The results from the 2022, 2023, and 2024 completed CAHPS surveys were used to perform the trend analysis presented in this section.⁴⁻¹ The 2024 scores were compared to the 2023 and 2022 scores to determine whether there were statistically significant differences.⁴⁻² Statistically significant results are noted with triangles. Measures that did not meet the minimum number of 100 respondents required by NCQA are denoted with a cross (+). Caution should be used when evaluating scores derived from fewer than 100 respondents. For more detailed information regarding this analysis, please refer to the Reader's Guide section beginning on page 2-10.

⁴⁻¹ Following NCQA's methodology of calculating a rolling average for the medical assistance with smoking and tobacco use cessation measure items, the 2024 scores contain members who responded to the 2024 or 2023 surveys and indicated that they were current smokers or tobacco users. The 2023 scores contain members who responded to the 2023 or 2022 surveys and indicated that they were current smokers or tobacco users. The 2022 scores contain members who responded to the 2022 or 2021 surveys and indicated that they were current smokers or tobacco users.

⁴⁻² Total Health Care was acquired by Priority Health Choice effective October 1, 2021, and was not included in the 2022 and 2023 survey administrations.

Global Ratings

Rating of Health Plan

Table 4-1 shows the 2022, 2023, and 2024 top-box scores and trend results for *Rating of Health Plan*.

Table 4-1—Trend Analysis: Rating of Health Plan

Program/MHP Name	2022	2023	2024	Trend Results (2024 Compared to 2023)	Trend Results (2024 Compared to 2022)
Michigan Medicaid Program	63.88%	62.62%	61.24%	—	—
Fee-For-Service Program	64.37%	60.18%	56.80%	—	—
Michigan Medicaid Managed Care Program	63.74%	63.43%	62.72%	—	—
Aetna Better Health of Michigan	65.31%	57.89%	62.12%	—	—
Blue Cross Complete of Michigan	69.14%	63.23%	63.67%	—	—
HAP CareSource	64.22%	63.89%	59.84%	—	—
McLaren Health Plan	59.57%	63.35%	61.45%	—	—
Meridian Health Plan of Michigan	61.67%	63.76%	60.10%	—	—
Molina Healthcare of Michigan	61.98%	65.67%	64.29%	—	—
Priority Health Choice	66.67%	61.72%	66.94%	—	—
UnitedHealthcare Community Plan	63.30%	62.64%	61.50%	—	—
Upper Peninsula Health Plan	71.12%	64.44%	69.05%	—	—
<p>▲ Indicates the 2024 score is statistically significantly higher than the trend year. ▼ Indicates the 2024 score is statistically significantly lower than the trend year. — Indicates the 2024 score is not statistically significantly different than the trend year.</p>					

Rating of All Health Care

Table 4-2 shows the 2022, 2023, and 2024 top-box scores and trend results for *Rating of All Health Care*.

Table 4-2—Trend Analysis: Rating of All Health Care

Program/MHP Name	2022	2023	2024	Trend Results (2024 Compared to 2023)	Trend Results (2024 Compared to 2022)
Michigan Medicaid Program	56.94%	57.25%	55.06%	—	—
Fee-For-Service Program	59.39%	54.97%	53.85%	—	—
Michigan Medicaid Managed Care Program	56.22%	58.01%	55.46%	—	—
Aetna Better Health of Michigan	51.61%	54.19%	55.97%	—	—
Blue Cross Complete of Michigan	59.20%	58.74%	57.84%	—	—
HAP CareSource	59.29%	57.14%	64.60%	—	—
McLaren Health Plan	58.06%	57.14%	54.78%	—	—
Meridian Health Plan of Michigan	49.59%	56.58%	49.62%	—	—
Molina Healthcare of Michigan	55.75%	62.50%	59.70%	—	—
Priority Health Choice	61.84%	52.00%	55.28%	—	—
UnitedHealthcare Community Plan	60.87%	62.18%	56.35%	—	—
Upper Peninsula Health Plan	56.13%	52.81%	61.13%	▲	—
▲ Indicates the 2024 score is statistically significantly higher than the trend year. ▼ Indicates the 2024 score is statistically significantly lower than the trend year. — Indicates the 2024 score is not statistically significantly different than the trend year.					

Rating of Personal Doctor

Table 4-3 shows the 2022, 2023, and 2024 top-box scores and trend results for *Rating of Personal Doctor*.

Table 4-3—Trend Analysis: Rating of Personal Doctor

Program/MHP Name	2022	2023	2024	Trend Results (2024 Compared to 2023)	Trend Results (2024 Compared to 2022)
Michigan Medicaid Program	66.69%	66.53%	67.17%	—	—
Fee-For-Service Program	67.27%	71.98%	66.12%	—	—
Michigan Medicaid Managed Care Program	66.52%	64.71%	67.52%	—	—
Aetna Better Health of Michigan	67.74%	68.00%	68.34%	—	—
Blue Cross Complete of Michigan	65.57%	62.14%	65.78%	—	—
HAP CareSource	72.68%	71.03%	72.14%	—	—
McLaren Health Plan	69.50%	65.41%	60.87%	—	—
Meridian Health Plan of Michigan	63.16%	65.22%	70.22%	—	—
Molina Healthcare of Michigan	64.71%	65.67%	68.05%	—	—
Priority Health Choice	65.52%	64.80%	66.36%	—	—
UnitedHealthcare Community Plan	72.30%	62.33%	68.99%	—	—
Upper Peninsula Health Plan	71.87%	67.48%	72.75%	—	—
<p>▲ Indicates the 2024 score is statistically significantly higher than the trend year. ▼ Indicates the 2024 score is statistically significantly lower than the trend year. — Indicates the 2024 score is not statistically significantly different than the trend year.</p>					

Rating of Specialist Seen Most Often

Table 4-4 shows the 2022, 2023, and 2024 top-box scores and trend results for *Rating of Specialist Seen Most Often*.

Table 4-4—Trend Analysis: Rating of Specialist Seen Most Often

Program/MHP Name	2022	2023	2024	Trend Results (2024 Compared to 2023)	Trend Results (2024 Compared to 2022)
Michigan Medicaid Program	68.82%	65.27%	67.08%	—	—
Fee-For-Service Program	76.69%	68.91%	61.48%	—	▼
Michigan Medicaid Managed Care Program	66.50%	64.05%	68.93%	—	—
Aetna Better Health of Michigan	66.25% ⁺	64.66%	65.63%	—	—
Blue Cross Complete of Michigan	74.07%	63.36%	68.75%	—	—
HAP CareSource	67.78% ⁺	63.10% ⁺	70.00%	—	—
McLaren Health Plan	62.22% ⁺	56.04% ⁺	74.70% ⁺	▲	—
Meridian Health Plan of Michigan	61.64% ⁺	64.65% ⁺	63.44% ⁺	—	—
Molina Healthcare of Michigan	67.00%	68.00%	77.91% ⁺	—	—
Priority Health Choice	75.47%	60.20% ⁺	66.04%	—	—
UnitedHealthcare Community Plan	64.00% ⁺	69.41% ⁺	66.27% ⁺	—	—
Upper Peninsula Health Plan	62.84%	64.61%	66.67%	—	—

⁺ Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.
 ▲ Indicates the 2024 score is statistically significantly higher than the trend year.
 ▼ Indicates the 2024 score is statistically significantly lower than the trend year.
 — Indicates the 2024 score is not statistically significantly different than the trend year.

Composite Measures

Getting Needed Care

Table 4-5 shows the 2022, 2023, and 2024 top-box scores and trend results for the *Getting Needed Care* composite measure.

Table 4-5—Trend Analysis: Getting Needed Care

Program/MHP Name	2022	2023	2024	Trend Results (2024 Compared to 2023)	Trend Results (2024 Compared to 2022)
Michigan Medicaid Program	83.66%	83.38%	82.25%	—	—
Fee-For-Service Program	86.44%	83.11%	85.20%	—	—
Michigan Medicaid Managed Care Program	82.85%	83.46%	81.27%	—	—
Aetna Better Health of Michigan	83.36%	83.11%	83.26%	—	—
Blue Cross Complete of Michigan	83.50%	84.50%	83.36%	—	—
HAP CareSource	80.93%	80.54%	83.64%	—	—
McLaren Health Plan	85.28%	87.78%	81.04%	—	—
Meridian Health Plan of Michigan	79.21% ⁺	81.81%	77.97%	—	—
Molina Healthcare of Michigan	87.01%	82.10%	80.48%	—	—
Priority Health Choice	84.78%	83.70%	84.74%	—	—
UnitedHealthcare Community Plan	79.79% ⁺	83.65%	81.43%	—	—
Upper Peninsula Health Plan	84.35%	83.19%	86.48%	—	—

⁺ Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.
[▲] Indicates the 2024 score is statistically significantly higher than the trend year.
[▼] Indicates the 2024 score is statistically significantly lower than the trend year.
 — Indicates the 2024 score is not statistically significantly different than the trend year.

Getting Care Quickly

Table 4-6 shows the 2022, 2023, and 2024 top-box scores and trend results for the *Getting Care Quickly* composite measure.

Table 4-6—Trend Analysis: Getting Care Quickly

Program/MHP Name	2022	2023	2024	Trend Results (2024 Compared to 2023)	Trend Results (2024 Compared to 2022)
Michigan Medicaid Program	82.40%	82.88%	83.63%	—	—
Fee-For-Service Program	83.68%	81.89%	85.78%	—	—
Michigan Medicaid Managed Care Program	82.02%	83.21%	82.92%	—	—
Aetna Better Health of Michigan	84.43% ⁺	77.26%	80.76%	—	—
Blue Cross Complete of Michigan	80.31%	82.90%	83.76%	—	—
HAP CareSource	85.21% ⁺	78.70% ⁺	82.98%	—	—
McLaren Health Plan	85.43%	87.87%	81.87% ⁺	—	—
Meridian Health Plan of Michigan	78.82% ⁺	82.68%	81.67%	—	—
Molina Healthcare of Michigan	83.84%	79.94%	82.85% ⁺	—	—
Priority Health Choice	85.81%	90.11% ⁺	84.49%	—	—
UnitedHealthcare Community Plan	79.54% ⁺	80.29% ⁺	83.70% ⁺	—	—
Upper Peninsula Health Plan	87.09%	85.88%	86.94%	—	—

⁺ Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.
[▲] Indicates the 2024 score is statistically significantly higher than the trend year.
[▼] Indicates the 2024 score is statistically significantly lower than the trend year.
 — Indicates the 2024 score is not statistically significantly different than the trend year.

How Well Doctors Communicate

Table 4-7 shows the 2022, 2023, and 2024 top-box scores and trend results for the *How Well Doctors Communicate* composite measure.

Table 4-7—Trend Analysis: How Well Doctors Communicate

Program/MHP Name	2022	2023	2024	Trend Results (2024 Compared to 2023)	Trend Results (2024 Compared to 2022)
Michigan Medicaid Program	92.14%	92.33%	93.00%	—	—
Fee-For-Service Program	94.73%	93.77%	92.65%	—	—
Michigan Medicaid Managed Care Program	91.38%	91.85%	93.11%	—	—
Aetna Better Health of Michigan	92.74%	91.04%	91.01%	—	—
Blue Cross Complete of Michigan	92.11%	92.10%	93.83%	—	—
HAP CareSource	95.35%	93.32%	92.05%	—	—
McLaren Health Plan	94.15%	92.11%	92.22%	—	—
Meridian Health Plan of Michigan	89.04%	91.44%	95.35%	—	▲
Molina Healthcare of Michigan	88.63%	90.47%	92.02%	—	—
Priority Health Choice	92.93%	93.49%	91.82%	—	—
UnitedHealthcare Community Plan	93.10%	91.76%	91.61%	—	—
Upper Peninsula Health Plan	95.42%	95.44%	95.03%	—	—
▲ Indicates the 2024 score is statistically significantly higher than the trend year. ▼ Indicates the 2024 score is statistically significantly lower than the trend year. — Indicates the 2024 score is not statistically significantly different than the trend year.					

Customer Service

Table 4-8 shows the 2022, 2023, and 2024 top-box scores and trend results for the *Customer Service* composite measure.

Table 4-8—Trend Analysis: Customer Service

Program/MHP Name	2022	2023	2024	Trend Results (2024 Compared to 2023)	Trend Results (2024 Compared to 2022)
Michigan Medicaid Program	91.28%	89.64%	88.65%	—	—
Fee-For-Service Program	90.71% ⁺	92.88% ⁺	88.57% ⁺	—	—
Michigan Medicaid Managed Care Program	91.45%	88.56%	88.68%	—	—
Aetna Better Health of Michigan	89.86% ⁺	89.65%	89.99%	—	—
Blue Cross Complete of Michigan	92.68% ⁺	91.65%	89.10%	—	—
HAP CareSource	91.64%	90.26% ⁺	92.07%	—	—
McLaren Health Plan	87.13% ⁺	88.34% ⁺	88.87% ⁺	—	—
Meridian Health Plan of Michigan	90.60% ⁺	90.55% ⁺	85.22% ⁺	—	—
Molina Healthcare of Michigan	94.88% ⁺	83.68%	89.96% ⁺	—	—
Priority Health Choice	90.40% ⁺	92.35% ⁺	88.85% ⁺	—	—
UnitedHealthcare Community Plan	91.71% ⁺	82.84% ⁺	90.76% ⁺	—	—
Upper Peninsula Health Plan	94.81%	92.77%	94.15%	—	—
⁺ Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results. [▲] Indicates the 2024 score is statistically significantly higher than the trend year. [▼] Indicates the 2024 score is statistically significantly lower than the trend year. [—] Indicates the 2024 score is not statistically significantly different than the trend year.					

Individual Item Measure

Coordination of Care

Table 4-9 shows the 2022, 2023, and 2024 top-box scores and trend results for the *Coordination of Care* individual item measure.

Table 4-9—Trend Analysis: Coordination of Care

Program/MHP Name	2022	2023	2024	Trend Results (2024 Compared to 2023)	Trend Results (2024 Compared to 2022)
Michigan Medicaid Program	83.83%	86.55%	83.15%	—	—
Fee-For-Service Program	84.91%	88.30% ⁺	81.25% ⁺	—	—
Michigan Medicaid Managed Care Program	83.51%	85.97%	83.78%	—	—
Aetna Better Health of Michigan	79.71% ⁺	84.43%	76.87%	—	—
Blue Cross Complete of Michigan	90.80% ⁺	85.22%	87.37% ⁺	—	—
HAP CareSource	84.93% ⁺	86.67% ⁺	79.17% ⁺	—	—
McLaren Health Plan	85.06% ⁺	83.95% ⁺	84.48% ⁺	—	—
Meridian Health Plan of Michigan	72.73% ⁺	87.37% ⁺	80.00% ⁺	—	—
Molina Healthcare of Michigan	83.84% ⁺	87.18%	86.49% ⁺	—	—
Priority Health Choice	92.13% ⁺	91.78% ⁺	84.55%	—	—
UnitedHealthcare Community Plan	88.06% ⁺	79.31% ⁺	83.33% ⁺	—	—
Upper Peninsula Health Plan	83.72%	87.65%	89.25%	—	—
<p>+ Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results. ▲ Indicates the 2024 score is statistically significantly higher than the trend year. ▼ Indicates the 2024 score is statistically significantly lower than the trend year. — Indicates the 2024 score is not statistically significantly different than the trend year.</p>					

Medical Assistance With Smoking and Tobacco Use Cessation

Advising Smokers and Tobacco Users to Quit

Table 4-10 shows the 2022, 2023, and 2024 scores and trend results for the *Advising Smokers and Tobacco Users to Quit* measure.

Table 4-10—Trend Analysis: Advising Smokers and Tobacco Users to Quit

Program/MHP Name	2022	2023	2024	Trend Results (2024 Compared to 2023)	Trend Results (2024 Compared to 2022)
Michigan Medicaid Program	76.78%	77.76%	78.31%	—	—
Fee-For-Service Program	81.20%	80.62%	84.96%	—	—
Michigan Medicaid Managed Care Program	75.48%	76.80%	76.11%	—	—
Aetna Better Health of Michigan	72.37%	70.86%	73.28%	—	—
Blue Cross Complete of Michigan	74.48%	75.48%	76.65%	—	—
HAP CareSource	70.73%	65.69%	63.81%	—	—
McLaren Health Plan	70.72%	72.05%	71.43%	—	—
Meridian Health Plan of Michigan	74.10%	78.13%	80.45%	—	—
Molina Healthcare of Michigan	79.05%	82.45%	74.82%	—	—
Priority Health Choice	76.92%	74.80%	75.83%	—	—
UnitedHealthcare Community Plan	79.19%	78.57%	77.14%	—	—
Upper Peninsula Health Plan	76.40%	73.44%	72.34%	—	—
<p>▲ Indicates the 2024 score is statistically significantly higher than the trend year. ▼ Indicates the 2024 score is statistically significantly lower than the trend year. — Indicates the 2024 score is not statistically significantly different than the trend year.</p>					

Discussing Cessation Medications

Table 4-11 shows the 2022, 2023, and 2024 scores and trend results for the *Discussing Cessation Medications* measure.

Table 4-11—Trend Analysis: Discussing Cessation Medications

Program/MHP Name	2022	2023	2024	Trend Results (2024 Compared to 2023)	Trend Results (2024 Compared to 2022)
Michigan Medicaid Program	56.81%	57.62%	56.88%	—	—
Fee-For-Service Program	63.64%	63.28%	60.71%	—	—
Michigan Medicaid Managed Care Program	54.80%	55.74%	55.61%	—	—
Aetna Better Health of Michigan	57.89%	54.34%	55.46%	—	—
Blue Cross Complete of Michigan	51.56%	54.49%	52.98%	—	—
HAP CareSource	51.61%	46.08%	47.52%	—	—
McLaren Health Plan	50.00%	50.31%	48.65%	—	—
Meridian Health Plan of Michigan	54.94%	55.20%	60.77%	—	—
Molina Healthcare of Michigan	61.84%	62.11%	53.15%	—	—
Priority Health Choice	49.42%	51.56%	54.62%	—	—
UnitedHealthcare Community Plan	56.76%	61.26%	61.32%	—	—
Upper Peninsula Health Plan	58.87%	53.18%	53.79%	—	—
<p>▲ Indicates the 2024 score is statistically significantly higher than the trend year. ▼ Indicates the 2024 score is statistically significantly lower than the trend year. — Indicates the 2024 score is not statistically significantly different than the trend year.</p>					

Discussing Cessation Strategies

Table 4-12 shows the 2022, 2023, and 2024 scores and trend results for the *Discussing Cessation Strategies* measure.

Table 4-12—Trend Analysis: Discussing Cessation Strategies

Program/MHP Name	2022	2023	2024	Trend Results (2024 Compared to 2023)	Trend Results (2024 Compared to 2022)
Michigan Medicaid Program	49.37%	50.26%	48.07%	—	—
Fee-For-Service Program	56.49%	53.54%	48.21%	—	—
Michigan Medicaid Managed Care Program	47.28%	49.16%	48.02%	—	—
Aetna Better Health of Michigan	50.34%	51.20%	46.19%	—	—
Blue Cross Complete of Michigan	43.98%	47.40%	45.83%	—	—
HAP CareSource	44.35%	38.83%	45.10%	—	—
McLaren Health Plan	43.89%	46.54%	43.12%	—	—
Meridian Health Plan of Michigan	45.96%	50.39%	54.96%	—	—
Molina Healthcare of Michigan	54.81%	55.38%	48.20%	—	—
Priority Health Choice	44.71%	40.77%	41.67%	—	—
UnitedHealthcare Community Plan	47.62%	51.85%	49.04%	—	—
Upper Peninsula Health Plan	52.69%	48.10%	43.93%	—	▼
<p>▲ Indicates the 2024 score is statistically significantly higher than the trend year. ▼ Indicates the 2024 score is statistically significantly lower than the trend year. — Indicates the 2024 score is not statistically significantly different than the trend year.</p>					

5. Key Drivers of Member Experience Analysis

HSAG performed an analysis of key drivers of member experience for the following measures: *Rating of Health Plan*, *Rating of All Health Care*, and *Rating of Personal Doctor*. Key drivers of member experience are defined as those items for which the odds ratio is statistically significantly greater than 1. For additional information on the statistical calculation, please refer to the Reader’s Guide section on page 2-10.

Figure 5-1 through Figure 5-3 depict the results of the analysis for the Michigan Medicaid Program. The items identified as key drivers are indicated with a red diamond.

Figure 5-1—Key Drivers of Member Experience: Rating of Health Plan—Michigan Medicaid Program

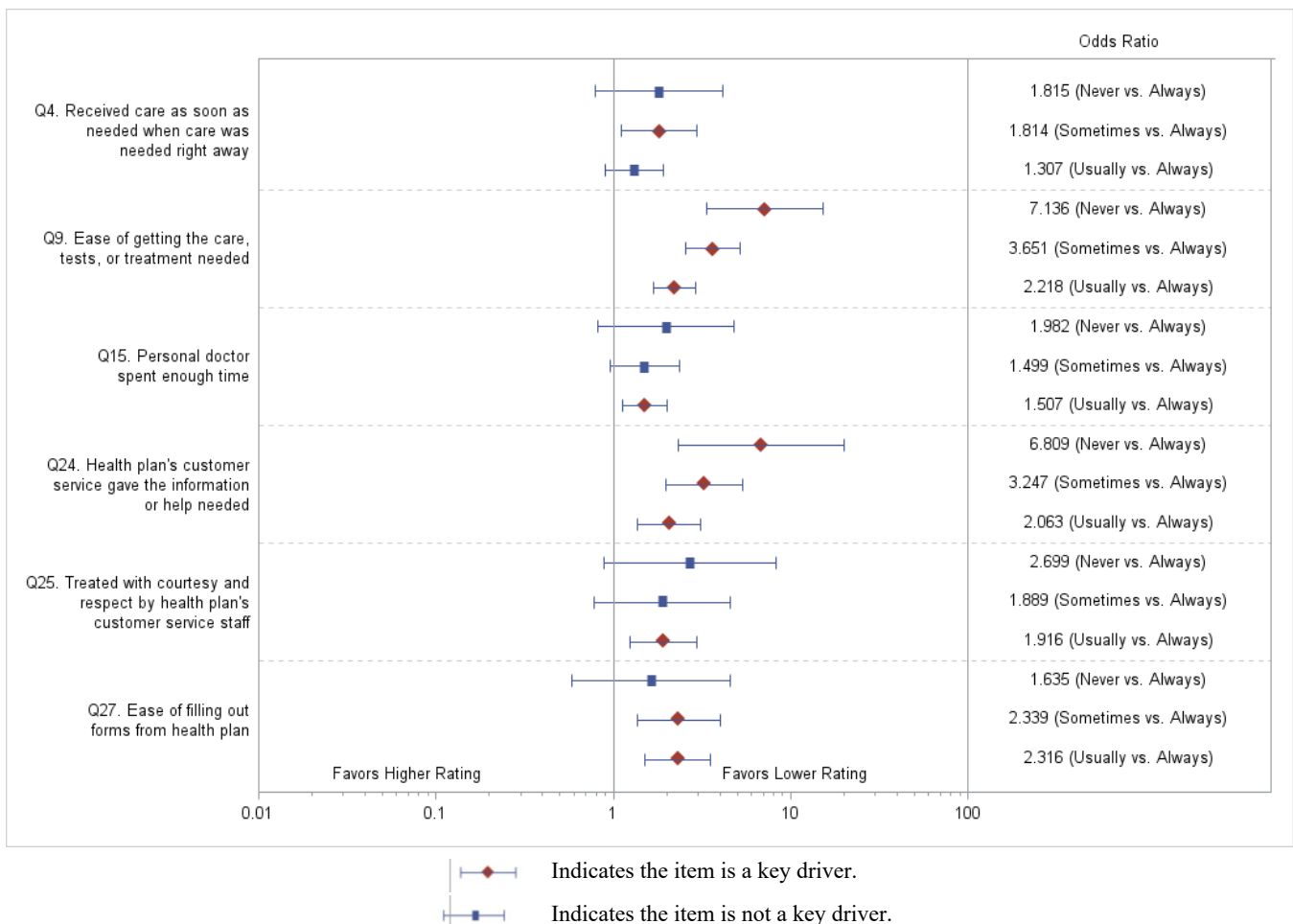


Figure 5-2—Key Drivers of Member Experience: Rating of All Health Care—Michigan Medicaid Program

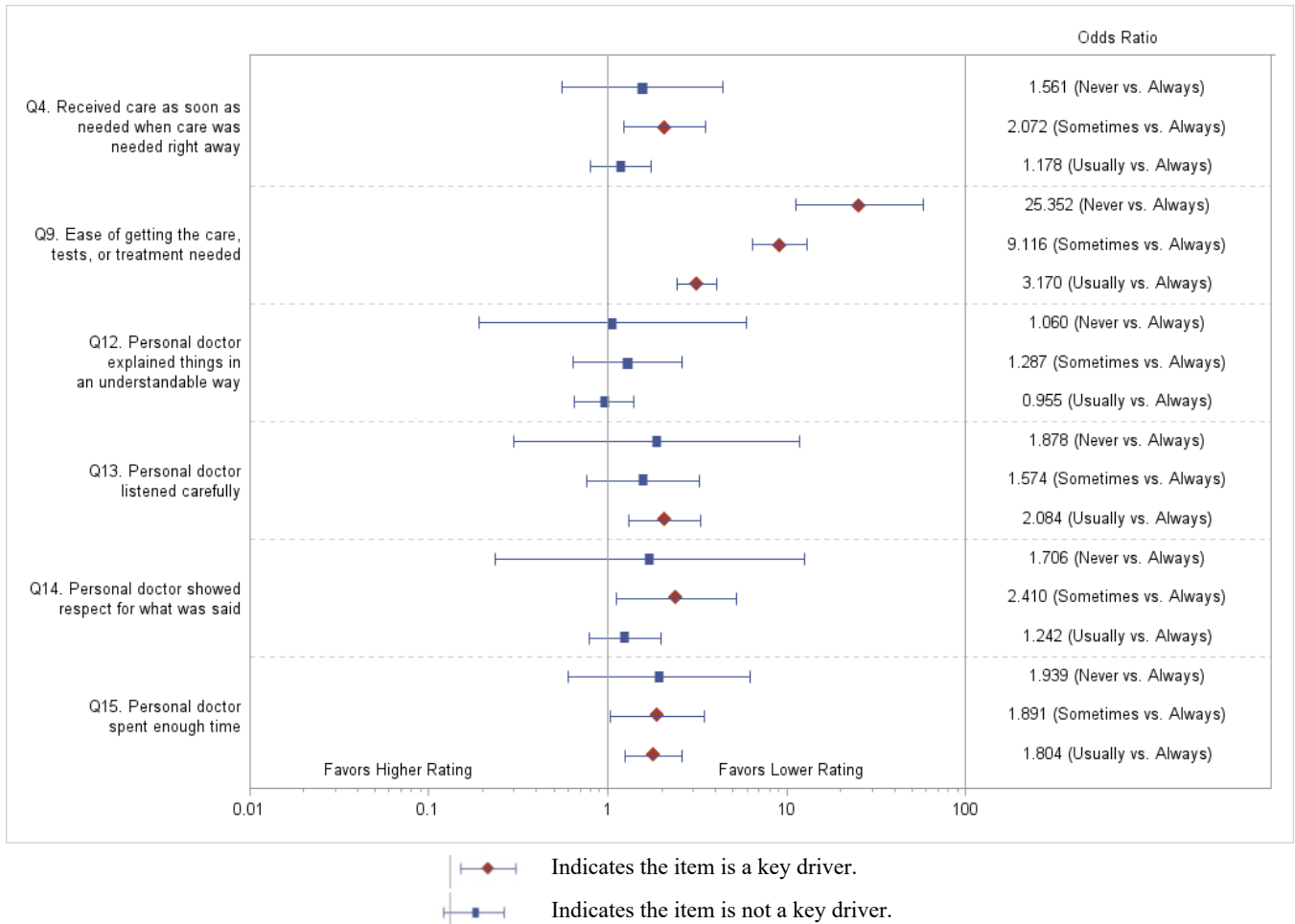
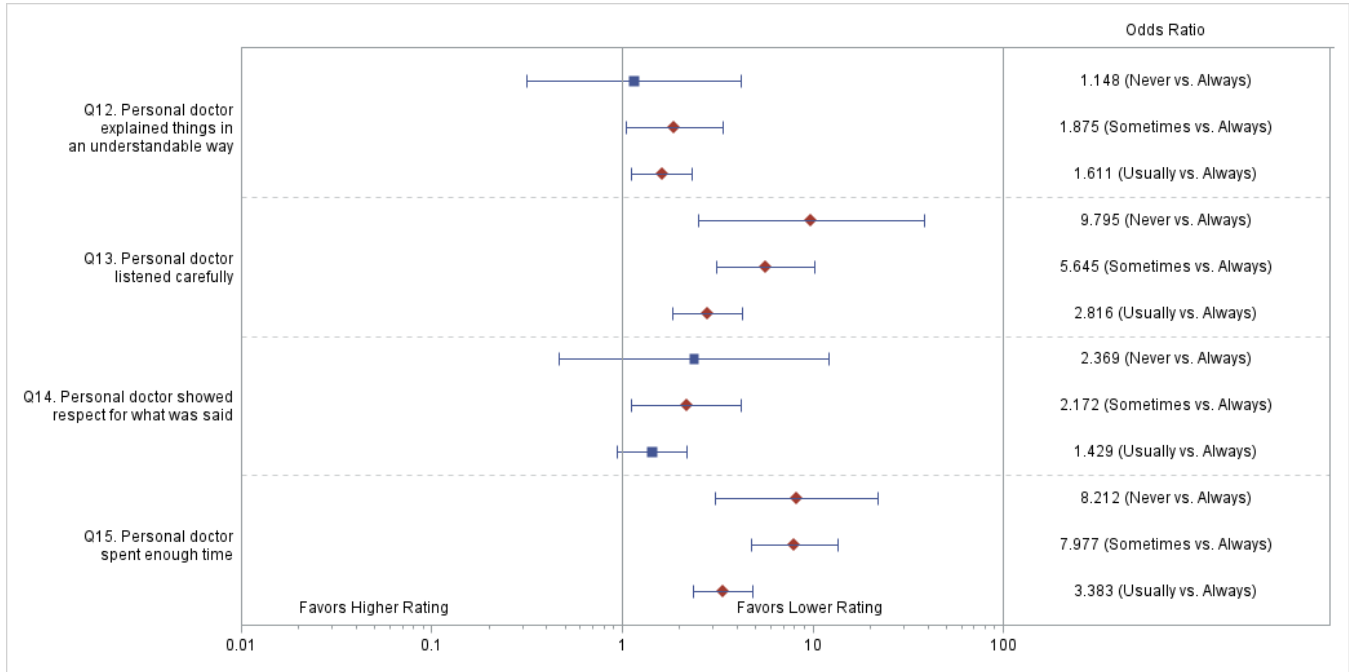




Figure 5-3—Key Drivers of Member Experience: Rating of Personal Doctor—Michigan Medicaid Program



 Indicates the item is a key driver.
 Indicates the item is not a key driver.

6. Survey Instrument

The survey instrument selected was the CAHPS 5.1 Adult Medicaid Health Plan Survey with HEDIS supplemental item set. HSAG administered the CAHPS survey to the FFS population. The MHPs contracted with various survey vendors to administer the CAHPS survey. This section provides a copy of the survey instrument administered by HSAG.

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 1-888-506-5134.

SURVEY INSTRUCTIONS

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



- 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:



↓ **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 from a clinic, emergency room, or doctor's office. This includes care you got in person, by phone, or by video. 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?

- 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 in person, phone, or video appointments for a check-up or routine care?

- 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 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 get health care for yourself in person, by phone, or by video?

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

8. 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 Best
Health Care Health Care
Possible Possible

9. 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

10. A personal doctor is the one you would talk to 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 19*

11. In the last 6 months, how many times did you have an in person, phone, or video visit with your personal doctor about your health?

- None → Go to Question 18
- 1 time
- 2
- 3
- 4
- 5 to 9
- 10 or more times

12. 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

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

- Never
- Sometimes
- Usually
- Always

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

- Never
- Sometimes
- Usually
- Always

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

- Never
- Sometimes
- Usually
- Always

16. 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 18

17. 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

18. 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 Best
- Personal Doctor Personal Doctor
- Possible Possible



GETTING HEALTH CARE FROM SPECIALISTS

When you answer the next questions, include the care you got in person, by phone, or by video. Do not include dental visits or care you got when you stayed overnight in a hospital.

19. 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 with a specialist?

- Yes
- No → *Go to Question 23*

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

- Never
- Sometimes
- Usually
- Always

21. How many specialists have you talked to in the last 6 months?

- None → *Go to Question 23*
- 1 specialist
- 2
- 3
- 4
- 5 or more specialists

22. We want to know your rating of the specialist you talked to 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.

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

- Yes
- No → *Go to Question 26*

24. 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

25. 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

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

- Yes
- No → **Go to Question 28**

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

- Never
- Sometimes
- Usually
- Always

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

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

ABOUT YOU

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

- Excellent
- Very Good
- Good
- Fair
- Poor

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

- Excellent
- Very Good
- Good
- Fair
- Poor

31. 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 35**
- Don't know → **Go to Question 35**

32. 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

33. 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

34. 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



35. 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

36. Are you male or female?

- Male
- Female

37. 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

38. Are you of Hispanic or Latino origin or descent?

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

39. 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

40. Some health plans help with transportation to doctors' offices or clinics. This 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 phone your health plan to get help with transportation?

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

41. In the last 6 months, when you phoned to get help with transportation from your health plan, how often did you get it?

- Never → *Thank you. Please return the completed survey in the postage-paid envelope.*
- Sometimes
- Usually
- Always

42. In the last 6 months, how often did the help with transportation meet your needs?

- Never
- Sometimes
- Usually
- Always

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**

