HEALTH MANAGEMENT ASSOCIATES

CAHPS® Digging Deeper into the Member Experience

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David Wedemeyer, BSN
Principal Consultant

CAHPS® is Critical for Health Plan Growth and Ratings

- NCQA uses CAHPS surveys to STAR rate Health Plan in Accreditation scoring and on their web site.
- Several Medicaid programs include CAHPS results as part of their Incentive Programs and have Plan required reporting.
- With these changes Members are becoming more informed and will use this data to make better decisions on which plans will serve their needs best.
- In the end, an improved patient experience can impact improved patient outcomes and can result in happier and more healthy membership.

Type	NCQA Accreditation	Consumer Satisfaction	Prevention	Treatment
HMO	Yes	3.5	5.0	4.5
PPO	Yes	3.5	3.5	3.5
HMO/POS	No	3.5	4.5	4.0
PPO	Yes	4.0	4.5	3.5
HMO	Yes	3.0	3.0	3.5

CAHPS® is Critical to the Medicare STAR Rating Calculations

- CMS has increased CAHPS related measures from 1.5 STAR to 2 STARs already.
- CAHPS measures are increasing from double weighted to quadruple weighted in contract year 2021 (which will be 2023 STAR rating).
- This represents 32% of the of the aggregate score for MAPD

Part C CAHPS Measures	Part D CAHPS Measures
➢ Getting Needed Care ➢ Getting Appointments and Care Quickly ➢ Customer Service ➢ Rating of Health Care Quality ➢ Rating of Health Plan ➢ Care Coordination ➢ Annual Flu Vaccine (1)	➢ Rating of Drug Plan ➢ Getting Needed Prescription Drugs

- The average STAR rating among the 9 CAHPS measures for MAPD **DSNP** Plans in 2019 was **3.23** (159 plans)
- The average STAR rating among the 9 CAHPS measures for MAPD **non-DSNP** plans in 2019 was **3.42** (212 plans)

Improving CAHPS® for Medicare STAR Rating is Deeper than the Survey

- Several other measures are also "Patient Experience" related.

Part C Measures	Part D Measures
➢ Complaints about the Health Plan (2) ➢ Members Choosing to Leave the Plan (2) ➢ Plan Makes Timely Decisions about Appeals (2) ➢ Reviewing Appeal Decisions (2) ➢ Call Center- Language Interpreter and TTY Availability (2) ➢ Health Plan Quality Improvement (5)	➢ Call Center- Language Interpreter and TTY Availability (2) ➢ Appeals Auto Forwarded (2) ➢ Appeals Upheld (2) ➢ Complaints about the Drug Plan (2) ➢ Member Choosing to Leave Plan (2) ➢ Drug Plan Quality Improvement (5)

- Additional measures in Part C are patient survey related.

Part C HOS Measures
➢ Improving or Maintaining Physical Health (3) ➢ Improving or Maintaining Mental Health (3) ➢ Monitoring Physical Activity (1) ➢ Reducing Risk of Falling (1) ➢ Improving Bladder Control (1)

Selection and Production of CAHPS® Sample Frame

- NCQA requires Medicaid Plan to select Child or Adult CAHPS to be used for Health Plan ratings.
  - This decision is based on which would be expected to perform better and should be compared to the previous year
  - Analytics to understand which would be the better opportunity for the Plan is recommended before selecting
  - Each year we need to check and make sure this remains the NCQA selection process
- CMS will produce the sample frame for Medicare Plans. It's the plans responsibility to contract the CAHPS vendor and notify CMS of who the vendor is. Medicare plans will get want to send the vendor updated contact information, member language to help the vendor in their efforts.
- Commercial plans utilize the Adult survey
- Some Certified HEDIS systems where you're managing the data import and running your own measures could have a selection to survey members who are currently active as of the sample pull. It's critical to make sure the sample is based on currently eligible members.

What are Some Barriers to Customer Service Improvement?

- Realizing this is not a seasonal effort, but rather a continual year-round focus that needs to be established.
- This is an organizational effort that transcends multiple departments throughout the organization, such as Pharmacy, Utilizations Management, Case Management, Member Services, Population Health Management, Quality Improvement and much more
- A frustrated Provider could equal a frustrated Member or more
- IT Departments that work to make website more user friendly or works to provide accurate information to key department and providers
- HEDIS and Adherence measures can cause different departments, vendors, and providers to do outreach to members attempting to address care and service gaps. These efforts could feel to a member as poor customer service if these outreaches are not calibrated, consistent in messaging, or tailored throughout the year.
- Social Determinants of Health (SDoH) are often overlooked access to care related issues, such as lack of transportation, lack of funds for co-payments or other supporting needs not covered, health literacy, an inability to navigate the plans, or State or federal Governments administrative barriers.

What Can You Do to Improve CAHPS® Scores?

- Customer Service should start with enrollment:
  - Establishing and maintaining a good connection to the member at the beginning of enrollment can go a long way.
  - New member customer service calls help a member get established better and is an opportunity to answer questions they may have.
    - Are they struggling to understand the benefits, State or Federal requirements, or how to see their PCP
  - It can be used to ensure they can access the web site and the member handbook, they have a PCP, and understand how to use the plan services.
  - It's an opportunity to leave them with resources and who to contact to get issues resolved in the future.
  - It shows this is a caring plan that is interested in serving their needs from the start

Tracking and Understanding Why a Member Disenrolled

Understanding the member experience is an end-to-end function so disenrollment surveys are a great way to understand potential issues the plan can correct and improve upon.

- Disenrollment surveys are a best practice and although many plans might do them the data is critical to be sharing internally for quality of care and service improvement.
  - They should be compared with complaints, grievances, and customer service data and a trending analysis done.
  - Access issues relate to member dissatisfaction, so trending disenrollment, grievances, and access to care studies, including geographical mapping is critical to gain a **full** picture
- These can identify specific providers or groups that are not performing well that might be behavioral issues to identify and address.
- Not all members file complaint or grievances when they are dissatisfied with care or services, many will leave a plan over filing a complaint.
- Some issues may not be easily resolvable, but a plan can change practices to minimize the impacts of the issue identified. (i.e. a remote area does not have coverage, free transportation or travel providers to cover gap, and the plan can openly communicate these issues with potential members).

Breakdown Organizational Silos

- Break down organizational silos, while at the same time thinking about everywhere the member touches the system, they gain consistency in their reminders.
  - Feeding gap information to customer service screens for when a member calls in for another reason
  - Does not matter the department that delivers the message so look to consolidate outreach efforts and time them for impact
  - Multiple media (letters, e-mails, text messages, outreach calls, etc.) gives the plan greater options to deliver the message but these messages must be consistent.
- Orient the member with messaging around what the plan can do when known barriers are identified
  - The plan might have a referral process barriers, look for better coordination and identification of situations where you can reduce this barrier.

Custom Questions to Drive Deeper Analytics

With the CAHPS sample frame a Plan can add custom questions, and a few specific data points to help drive deeper analytical understanding (may need approval)

- Plans can add custom questions, that can gain more specific timelines (days) it took to gain appointments, or authorization processes.
- Plans can add Group Identifiers to sample frame, to perform groups rates and breakdowns
- Plans can ask specific questions about their Disease Management, Case Management, or Population Management Programs
- Geographical markers can help Plans look for trends in specific geographical areas but might need additional survey methods in conjunction.
- Provider breakdowns can give more detail for provider specific rates and can be utilized with incentive or P4P programs. Often the CAHPS sample frames are not large enough for provider breakdowns but coupled with proactive surveys they can be utilized.
- What outreach media does the member prefer

Mid-Year (Off-Season) CAHPS® Efforts:

Who are the Plan's most likely to be dissatisfied members?

- Members who have filed a Grievance, Complaint, or Appeal should have a "Just Checking In" call about a week after the resolution to check if the plan resolved all issues to their satisfaction.
- Running a off season CAHPS gives the Plan an opportunity to identify members who are dissatisfied and gives an opportunity to resolve their issues.
- The plan can make sure they have enough per provider to use these as results for incentive or for P4P programs.
- Recommend this survey go out to members in the third quarter and make sure you survey all members who filed a grievance, appeal, had a denial or are in pain management to ensure they have received a survey.
- Send them a proactive CAHPS survey to ID if they have any current dissatisfaction and perform a follow-up for those that answer negatively to assist them. This gives the Plan an opportunity to resolve any dissatisfaction with member who experienced a dissatisfying event. It also gives the member an opportunity to vent their frustrations, and if the plan responds its more likely they will answer in a more positive way on future surveys, if their issues were addressed.

Focused Surveys:

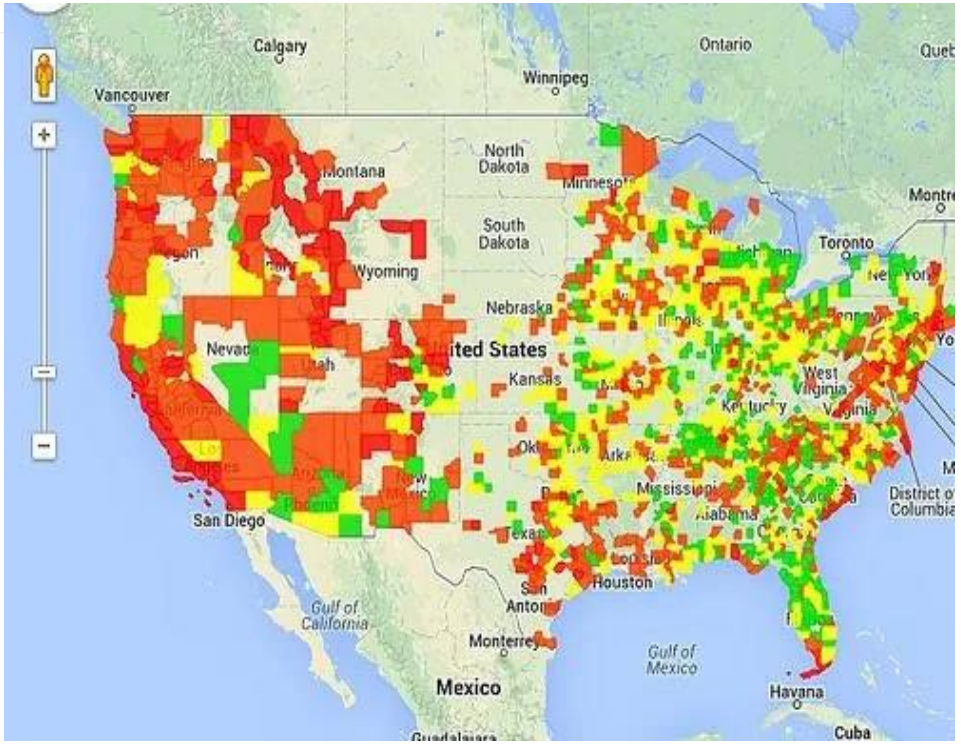
Why these are critical to drive sustainable behavior change?

- It's critical that members have a voice and feel they are listened to. The focused surveys can be done during the NCQA blackout period, so this is important to understand. We recommend at least a PCP and specialty one:
  - The PCP focused survey would ID all members who were seen by their PCP in prior month and send random survey to a **sample (like 200 controls cost)**, specifically asking how that visit went.
  - The PCPs tend to change their behavior knowing their patient will be surveyed each time, so behavior changes needed do occur with this over time.
  - Members who are upset need to ventilate and express these issues, and this gives them an avenue to resolve these issues. On an actual CAHPS survey we would not know who answered negatively and would not be able to resolve their issues.
- It gives the opportunity for the plan to plant seeds in the mind of the member. "What improvements would we need to make to earn a rating of 9-10 out of a scale of 1-10?"

Assessing Geographical Mapped Results

Understanding deeper the barriers to care and services

- Identifies geographical areas of concern that can be caused by access issues
- Appointment availability can be tied into this to provide a clear picture of the member experience when trying to make an appointment
- If a geographical area has lower CAHPS rates, further breakdown should be done assessing other factors contributing, such as availability of specific providers or services, distance to services, appropriate number of services for volume of members.
- If the Plan contracts with several different networks this can be looked at by network to understand the true member experience. The Plan that has multiple networks can consider a safety net that helps solidify all their network contracts.



Member 12-Month Touch Point Mapping

Understanding the members journey through the Health Plan and process to find a balanced approach

- Mapping out the one-year experience (all touch points) to drive balance in the member engagement approach.
  - Should includes every aspect (Enrollment, new member outreach, quality, Case Management, Disease Management, routine mailings, routine contact calls, pharmacy interventions, annual, quarterly or monthly newsletters or reminders.
- This can balance the approach by looking at the entire organizations touch points. For example, a Medicare member might be heavily hit with outreach during open enrollment and much less in the 2nd quarter and maybe some balance can ensure the messages are received.
- A stronger elevation of messaging can be done, where one outreach can help to prepare for the next
- Consolidation of efforts can be considered where two efforts can be consolidated into one saving cost and abrasion to members (such as Risk Adjustment and HEDIS intervention)
- Think about ways to sustain the message by selecting activities members can do to learn the message and retain the message

Assessing Ways to Improve Flu Vaccination Responses

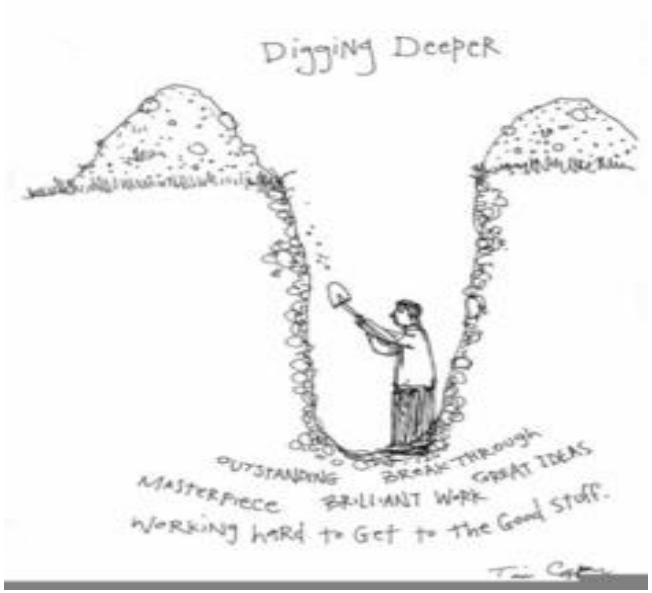
Ensuring member received Flu shot

- This is a survey measure done through CAHPS, members are responding if they had the flu shot or not. Thank You messaging to those who have had the shot that send them a refrigerator magnet or button that states; “I’ve got my FLU Shot this year” helps remind them before the survey.
- Typically, the timeframe to start the flu shot reminder to members would be in the 3rd quarter when the flu shot antigen is about to be released.
- Remember this is a survey measure, meaning the member is answering on the CAHPS survey if they received this from July 1, 202X to present. A Thank You postcard for getting their flu shot reminds them prior to the survey they received it. This measure is collected by survey and is done during CAHPS in March and April.

Assessing Additional Barriers to Care and Services

Understanding deeper the barriers to care and services

- If the Plan is requiring a prior authorization process for a mammogram, should consider making this a direct auth process so these is no approval barriers
- Study has found a relation to how many days it takes to gain an appointment to dissatisfaction of CAHPS survey
  - About 6 days for a routine visit the entire survey tends to go negative.
- If an initial consultation is rarely denied, consider direct authorization to eliminate the process causing barriers that frustrate members and providers



Questions?

Contact Information

David Wedemeyer
Principal, Los Angeles
DWedemeyer@healthmanagement.com