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Consumer Assessment of Healthcare Providers Systems (CAHPS): Improving Member Experience

Medicare and Medicaid plans are faced with a barrage of regulations, including quality rankings. To improve rankings plans can, and should, work to improve their Consumer Assessment of Healthcare Providers Systems (CAHPS) scores.

The CAHPS annual survey measures member experience with providers and Medicare and Medicaid health insurance plans. It has also become a critical metric used by the Centers for Medicare and Medicaid Services (CMS).

Plans can work to improve CAHPS scores by developing a comprehensive improvement plan involving a holistic year-around approach that involves monitoring the member experience from enrollment through disenrollment. With score improvement comes incentive payments tied to high quality performance.

CAHPS SCORES ARE USED BY:

- The National Committee for Quality Assurance (NCQA) to STAR rate health plans in accreditation scoring
- Potential members to compare plan scores against one another on the NCQA website
- Several state Medicaid programs that require plans to report these surveys and use scores as part of their incentive programs
- CMS, which has increased its STAR rating, CAHPS-related measure from double weighted to quadruple weighted in contract year 2021
- Medicare Advantage Prescription Drug (MAPD) plans, which use CAHPS to calculate 32% of the overall aggregate score

CAHPS COHORTS THAT ARE MEDICARE STAR MEASURES

PART C CAHPS MEASURES (WEIGHTS)	**PART D CAHPS MEASURES** (WEIGHTS)
» Getting needed care (4) » Getting appointment and care quickly (4) » Customer service (4) » Rating of healthcare quality (4) » Rating of health plan (4) » Care coordination (4) » Annual flu vaccine (1)	» Rating of drug plan (4) » Getting needed prescription drugs (4)

ADDITIONAL STAR MEASURES AND ACTIVITIES THAT RELATE TO MEMBER EXPERIENCE

PART C MEASURES (WEIGHTS)	**PART D MEASURES** (WEIGHTS)
» Complaints about the health plan (2) » Member choosing to leave the plan (2) » Plan makes timely appeals decisions (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 the drug plan (2) » Drug plan quality improvement (5)

Health Management Associates' expert colleagues can help plans outline an organizational assessment of member experience and customize interventions and solutions to increase scores.

Our team of quality and accreditation experts can help organizations improve customer service and scores by:

- Establishing a year-around effort
- Using an organizational effort to break down department silos and improve cooperation between departments
- Assessing core functions within the plan and contractors that contribute to member experience including marketing, enrollment, disenrollment, UM, QI, member service, grievances, appeals, etc.
- Identifying and addressing patient frustrations with providers and plans before they become problematic
- Leveraging information technology to make websites more user friendly
- Addressing care and service gaps to ensure member outreach is calibrated and tailored throughout the year
- Recognizing social determinants of health (SDOH) are often overlooked in access to care-related issues, such as lack of transportation or lack of funds for co-payments
- Outlining techniques for obtaining point-of-service feedback to help address potential member experience issues before they arise

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