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Excelling on CAHPS: Lessons from Top-Performing Medicaid and CHIP Health Plans

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Speakers

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Moderator

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Dale Shaller

Shaller (opening), Slide 1

Well, good afternoon and good morning to those on the West Coast, and Happy St. Patrick's Day. Welcome to our Webcast on "Excelling on CAHPS: Lessons from Top-Performing Medicaid and CHIP Health Plans." My name is Dale Shaller, and I'll be the moderator for today's Webcast.

Shaller (opening), Slide 2

Our event today is one in a series of Webcasts on CAHPS, which stands for Consumer Assessment of Healthcare Providers and Systems, and it's produced by the CAHPS User Network. Many of you I know are familiar with the CAHPS surveys and program, but just a few words of background.

Primarily funded by the Agency for Healthcare Research and Quality, or AHRQ, the CAHPS program develops standardizes surveys for assessing patients' experiences with their care, produces a number of products and services to support their use, such as the National CAHPS Database. CAHPS surveys have been developed to assess patient experience in both ambulatory and facility-based health care settings.

Shaller (opening), Slide 3

The CAHPS family of surveys has expanded rapidly over the past two decades. As shown here, facility surveys include HCAHPS, or Hospital CAHPS, for hospitals, as well as CAHPS for dialysis centers and nursing homes. The CAHPS suite of ambulatory care surveys has expanded to include not just the original Health Plan Survey, circled here in red because it is the focus of our Webinar today, but we also have CAHPS surveys for medical groups and individual clinicians, known as the CAHPS Clinician & Group Survey, or CG-CAHPS, and other surveys that are designed for surgical care, behavioral health, home health and special populations.

Shaller (opening), Slide 4

The focus of our Webcast today is on the use of the CAHPS Health Plan Survey, and it's intended to highlight success stories from two health plans, one serving the adult Medicaid population and one serving enrollees in the Children's Health Insurance Program, or CHIP, all with the aim of trying to answer this question: “What does it take to achieve scores above the 80th percentile on all of the CAHPS Health Plan Survey core composites and rating measures?” And, given the large number of respondents to our Webcast today -- we have

over 500 registrations -- we know this is an important topic of interest to a large number of health plans and other stakeholder groups around the country.

Shaller (opening), Slide 5

To help explore our topic today we're pleased to feature speakers from two public health plan programs in different parts of the country. Stacia Cohen is Vice President of the Medicare Stars Center of Excellence and former Director of Medicare and Medicaid Program Management at Blue Cross and Blue Shield of Minnesota, based in Eagan, Minnesota. And Christopher Sellers is Director of Data and Evaluation for the ALL Kids Children's Health Insurance Program with the Alabama Department of Public Health in Montgomery, Alabama.

And, again, my name is Dale Shaller. I'm a member of the National CAHPS Consortium, Managing Director of the CAHPS Database, and I'll be moderating today's discussion about how these two health plans were able to achieve and sustain their exceptional results on their respective CAHPS Health Plan Surveys and also what lessons their experience can offer other health plans, particularly those serving Medicaid and CHIP enrollees.

Shaller (opening), Slide 6

Just a few quick housekeeping details; if you need help at any time during the Webcast you can use the Q&A icon. And you can also join us by phone at any time by dialing the number on your screen, 855-442-5743, and entering the Conference ID number listed.

Another problem that you sometimes have is if your computer freezes during the presentations, and if that does happen you can simply hit your F5 button on your keyboard to refresh your screen. But what you might be just experiencing is in terms of lag time and slide advancing is related to your Internet connection speed. So you can also try logging out and logging back in to the Webcast.

Shaller (opening), Slide 7

Given the large number of participants on today's event, we're going to be taking questions submitted online only. And to ask a question you simply click the Q&A icon to get that box to appear, and then you just type in your question in the text box and you select Submit, and then we will be reviewing your questions and fielding them during the Q&A sessions. There are two of them in today's Webcast. But I'd encourage you to send in your questions as soon as you can so that we can make sure to tee up as many as possible.

Shaller (opening), Slide 8

Today's slides are also available for downloading by clicking on the icon at the bottom of your screen that says Download Slides. And that's going to generate a PDF version of the presentation that you can download and save.

Shaller (opening), Slide 9

And we also have some additional resources available that you can access under the Resources icon, and here you'll find links to the CAHPS Improvement Guide and other resources for improvement. We have several case studies and links to the CAHPS site as well as the CAHPS Database site, and also links to both the BluePlus of Minnesota and the ALL Kids program sites.

Shaller (opening), Slide 10

I know many of you are familiar with the CAHPS Health Plan Survey and what it measures, but just quickly, for those who aren't, the survey consists of a set of core questions that address four domains of care that we know are important to health plan enrollees. Two of them have to do with access issues -- getting needed care and

getting care quickly. One has to do with communication with doctors and another has to do with getting information and customer service from the health plan itself.

There are four questions that ask survey respondents to rate their personal doctor, a specialist if they've seen one in the past 12 months, their overall health care and the health plan overall itself. And all of these rating questions are on a scale of 0 to 10.

In addition to the core measures, there are a large number of supplemental questions that can be added to the core to meet specific needs, such as chronic conditions questions, behavioral health, interpreter services, questions related to mobility, impaired populations and other topics. And so we also have adult and child versions of the Health Plan Survey provided in both English and Spanish.

Shaller (opening), Slide 11

Now, the CAHPS scores that were used to compare against the scores of the two health plans that are a part of our Webcast came from the National CAHPS Database, which is a free service supported by AHRQ. It's open to all Medicaid and CHIP users of the Health Plan Survey as well as a component devoted to the CG-CAHPS Survey.

Both BluePlus of Minnesota and the ALL Kids program voluntarily submitted or authorized that their data be submitted on their behalf to the CAHPS Database, and then was combined with hundreds of other health plan data to contribute to this national database and thereby enable their results to be compared to a large number of health plans as reference points. And that's also how we were able to identify these two plans as high performers.

And so the CAHPS Database provides comparative results through several platforms that include an Online Reporting System, we do annual chartbooks that summarize key findings, and we make available research data files that are available on request. And I'll say a bit more about the CAHPS Database and what's available and how to participate at the end of our Webcast.

Shaller (opening), Slide 12

So without any further delay, I'm pleased to turn things over to our first speaker, Stacia Cohen, who, like Chris, will address these topics in presenting their success story: a bit about the organization; a snapshot of their CAHPS scores; how CAHPS is used; factors contributing to their performance; and then thoughts about their barriers or sustainability and lessons for other Medicaid and CHIP plans.

So, Stacia, take it away.

Stacia Cohen

Cohen, Slide 13

Well, thank you. I appreciate the opportunity to speak to everyone today. I'm just making sure the slide advances. Everybody can see that, I assume?

So a little bit about BluePlus's performance. First of all, I want to clarify that BluePlus is the HMO arm of Blue Cross and Blue Shield of Minnesota.

Cohen, Slide 14

It is a requirement in the state of Minnesota to participate in managed Medicaid that you either be an HMO or you be one of a group of counties that have come together pursuant to a joint powers agreement to contract for Medicaid and bear full risk. So, all of the health plans in Minnesota are actually HMOs.

The history of the BluePlus Medicaid plans, Medical Assistance in Minnesota is actually quite old now. People have been participating in managed care, this is the 30th year and there has been mandatory enrollment for Medicaid-eligible recipients for over 20 years in Minnesota. There is also a program for the -- it's typically thought of as the program for the working poor, which is publicly subsidized, called MinnesotaCare.

In 2016 our MinnesotaCare program is converting to the basic health plan but will stay in the suite of products offered through the state contract. It will not be offered as a QHP on the Exchange. So I think that's a little bit different than many states in the country and thought that was an important thing for people to understand.

The reason that Minnesota went to managed care all those years ago was to improve access to services for Medicaid recipients.

Cohen, Slide 15

And, as you will see as we move to the top box scores that has really over time played out to be a very effective mechanism. You'll note that the scores, that five of these eight scores have a statistically relevant improvement over the national percentile in terms of getting access to needed care; getting it quickly; their doctor communications; doctor ratings and overall health care ratings. Statistically we perform better than the rest of the country, and I think that's the long and rich history of managed care here.

Cohen, Slide 16

When we think about how we use CAHPS data internally here at Blue Cross, there's a couple of really relevant points. First of all, Blue Cross does accredit our Medicaid program specifically through NCQA. So we have a very formal system in place to conduct quality improvement, oversight and monitoring activity. And because the member experience of care is part of that quality system, we actually have a fairly robust process in place.

So we use data in a number of ways, and we actually monitor data across a number of points, including not only in our CAHPS surveys but complaints, grievances, appeals, our customer service, timeliness and friendliness, claims monitoring, and then member satisfaction with our utilization management activities. Many of those we do as part of our NCQA accreditation, so it keeps at a minimum a quarterly review of data points and opportunities for us to right the ship, if you will, when we see data that are not where we would like them to be.

In addition, so that we don't have any surprises with an annual CAHPS survey, we do ongoing surveys of member satisfaction, particularly with our customer service area. And we do surveys through the Blue Cross association of things like First Call Resolution and how quickly we were able to -- and accurately were able to resolve their question.

Cohen, Slide 17

This next slide is really to take that information about sort of the formal process and give you a picture of how we embed that into our overall quality improvement program oversight. So, as you will see, one of the three key pillars of work that we do is our Member Experience Workgroup. And that really supports our overall enterprise-level consumer experience strategic pillar. So we have really formal reporting in there.

That Member Experience Workgroup meets regularly. It does report up to the Quality Council. As you will note our Quality Council is a VP-level committee, and it is intended to both drive execution and create shared accountability for outcomes across the enterprise. Outcomes related to our Medicaid business are not just owned in government programs. They are really reflective of the work of the enterprise.

Cohen, Slide 18

When we think about what are those elements that really impact our CAHPS scores, we have a couple that we, frankly, benefit from but really don't influence. In particular, the Medicaid benefit package in Minnesota has an actuarial value of somewhere around 98 percent. It is a very generous benefit package. So we don't have a lot of people dissatisfied with their benefits.

In addition, there are no carve-outs in Minnesota, and we think that that has been important. The health plans have worked with the state for a long time to preserve that so that sometimes the sources of dissatisfaction that plans are experiencing are when you have one benefit manager doing mental health or substance abuse, you have another one doing medical care, you may have a whole other carve-out for dental services and/or transportation. And that has -- we frequently hear that as a source of angst in some other parts of the state. We don't really influence that other than continuing to stress the importance of that both with the state and with our legislators.

The other factor we also don't have a lot of control over is the consolidation of the care system. Minnesota is a highly consolidated market. There are about eight care systems in the state that cover the vast majority of medical services rendered here.

However, there are a number of things that we do feel directly we do that influence positively our CAHPS scores. So some of those that I think are worth highlighting are that we do not use a gatekeeper model here. Most of the health plans in Minnesota do not. I think some of that has to do with how long we've had managed care here in Minnesota. Some of that is, frankly, as soon as one plan does a gatekeeper model, or doesn't do a gatekeeper model, all the other plans end up needing to follow suit or they're at a competitive disadvantage.

The other things we do specifically here at Blue Cross are our Medicaid and government programs; customer service is done in a dedicated unit. It is purpose built, and it is really focused exclusively on our government programs business. Consequently, we don't have a lot of confusion about how to respond to benefit questions and inquiries. We are able to train our staff to push information to people at a much lower reading level and generally speaking have had extremely high scores in our customer service area. In addition, all of the non-emergency transportation is also coordinated in the same unit with our customer service so that we don't have to pass beneficiaries around to a number of different locations to service their needs.

Cohen, Slide 19

As I think about some of the other environmental impacts on CAHPS, another thing that I thought was important to share with you, because this is something that all of the plans and providers came together a number of years ago in Minnesota and did, and we support them, we fund them, both in the startup and in ongoing funding. We have two quality improvement organizations in Minnesota. One is called Minnesota Community Measurement. The other is the Institute for Clinical Systems Improvement. And that has really baked the concept of quality improvement and measurement into the way health care is both delivered and paid for in Minnesota.

And those two organizations publish a number of statewide results that the plan and provider groups use to inform program changes. So, for example, just hot off the press is a new health equity report about what does -- what are the disparate outcomes by some of our ethnic and cultural groups on specific health outcomes in Minnesota.

Cohen, Slide 20

When we look at how do we overcome barriers, I'm sure that many of you noted on the map that BluePlus's footprint in Minnesota is predominantly rural. We are the largest rural health plan in Minnesota. And as a result we frequently have distance barriers. We have populations that are very geographically dispersed. Being the "Land of 10,000 Lakes," in some of our counties we have great big bodies of water and people have to travel all the way around the body of water to get to health care. So that does create some interesting challenges.

We've had to get quite creative about how do we meet people's health care needs in terms of using things like telemedicine, online care. There's a robust program in Minnesota for paying for physician extenders. In the population here in Minnesota, the Medicaid population, over 80 percent of our counties are considered rural and so for BluePlus that has a pretty significant impact.

I think the other thing I would highlight is that county provider and advocacy groups have a strong influence on member satisfaction, both from a positive perspective when they are happy with health plan performance. I think they speak very positively about health plans, and I think that drives improvement in CAHPS scores. When they are unhappy, I would say that the exact opposite happens. So that's a constituency we pay really close attention to, because we believe it has a direct impact on our scores. So we staff intentionally to provide good service and relationship management with county and provider staff.

Additionally, like most states all health care is local, all politics is local, and we've had to come up with very region-specific member options.

Finally, one of the other things that we do here in Minnesota, and virtually all the health plans do, because if you don't it's a dissatisfier, is member incentives for things like seeking appropriate preventive care.

Cohen, Slide 21

To sustain the gains, as I mentioned, we here have a very clearly baked atmosphere of continuous improvement. That's part of the culture here at Blue Cross, but it's very deliberate, and it needs some care and feeding. That does not happen by accident. It's something that we have to be really purposeful about.

We also have both a Member and a Senior Advisory Council who inform program changes, and those are comprised of a lot of stakeholders that serve the Medicaid population. That's one of the ways we give voice to the advocacy groups, because we recognize that they have a pretty powerful voice.

Cohen, Slide 22

Finally, some key takeaways. For any new plans entering this space, one of the really most important takeaways is that you cannot build your Medicaid delivery system on your commercial chassis. That is just a recipe for disaster. The population needs very different things. They need very different case management. They need very different customer service. Most case management models are built off catastrophic care. That's not this population. Not that there aren't ever any cases in there. There certainly are. But that might be one or two percent of the population. But the needs for case management and care navigation are much broader than that.

Finally, I would also say your network design needs fine-tuning. That's one of the things we've learned, frankly, in some ways the hard way is that as health plans we tend to focus on hospital and physician providers, because that's where a lot of the care and a lot of the spend is. In the Medicaid space, public health and behavioral health providers are critical -- a critical part of the network and need some very purposeful build to ensure that you're meeting the needs of the beneficiaries.

Cohen, Slide 23
And I think that comes to the end of my time here. So I thank you for the opportunity to speak, and I will open it up for questions.

Dale Shaller
Great, Stacia. Thank you so much. That was a very, very helpful overview of your program at BluePlus in the context of the Minnesota market.

We do have several questions. I'm going to start with one that asks about the generous benefits that you provide without carve-outs. The question is, is this cost-effective? In other words, do you have any helpful facts about generous benefits leading to better medical care that offset the cost of generous benefits?

Stacia Cohen
Well, I would say that the benefits, that is dictated by the state here in Minnesota, so, frankly, what the plans think about it is a little bit irrelevant.

Cohen, Slide 24
However, we certainly have seen some improved health outcomes across a number of domains. When we look at the performance, for example, on HEDIS, we fairly consistently perform above the 90th percentile in a lot of measures that you don't see as typically in Medicaid programs. And so I think that that has to do in part with the benefit set.

That nonemergency transportation is a covered Medicaid benefit, so you don't have people who don't seek appropriate preventive services because they can't get there. We don't have cost-prohibitive copayments on a number of services.

I would say that one of the areas that we have the most stark opportunity would be that there really is essentially no cost-sharing on emergency services, and so there continues to be an inordinately high amount of emergency room utilization. That, however, is one of the quality metrics the state bakes into the managed care contract. There are -- there is something they call a withhold, and they hold 5 percent of our premium back and set some withhold targets across cost and quality, and if we achieve those we get that additional premium.

Dale Shaller
Okay, great. So there are a number of other questions. Let me get to them. We have about six of them. So, but first one up is what kind of incentives does Minnesota offer for member use of preventive services? Could you give a few examples?

Stacia Cohen
Sure. We have a Member Rewards program. They're gift cards in the amount of ranging from 25 dollars to 75 dollars dependent on the frequency of service that's required. So, for example, 2-year-olds who are fully immunized and have had all six visits prior to 15 months that we do a 75-dollar gift card for that. We also do them for women who have appropriate prenatal care in the first trimester and appropriate postpartum care during the days -- during the HEDIS window postpartum.

Dale Shaller
Okay. So there's a couple of questions here that relate to how you relate to your provider network. One is asking about any specific incentives that you give to your providers, your provider network, based on CAHPS results. And then I have another one for you.

Stacia Cohen
Sure. We do a couple of different things with our provider network. We have something called the Aligned Incentive Program that attaches pay for quality across a number of measurements. They actually don't use HEDIS. They use Minnesota Community Measurement Standards, which are slightly different.

We also on the Medicaid side have our revenue and expense models, so we have moved into total cost of care arrangements and we use quality metrics as the gateway. So the more of our quality targets that they hit, the more -- the higher percentage of their gain-sharing they're eligible for.

Dale Shaller
Are there ways -- Stacia, this other question relates to ways that you engage those providers directly in the CAHPS scores. So do you collect any provider-specific CAHPS, and do you -- how do you relate back your CAHPS Health Plan scores to their performance?

Stacia Cohen
Sure. So CG-CAHPS is part of our Aligned Incentive agreement, and so we use -- so in our pay for quality program CG-CAHPS is used as one of the quality metrics.

Dale Shaller
Would you -- this is another question related to the provider network, and the question is to describe what you mean by a robust primary care network that's different than what you would use for commercial and Medicare. Is that what you mean? You actually have a -- do you have a separate network for that?

Stacia Cohen
No. No, I was saying that the network you need to pay attention to outside of primary care is public health and behavioral health providers, because hospital and clinic utilization isn't sort of -- it's not the key priority at the state level. It's also not the key place that beneficiaries access. They use a lot of public health services, and they use a lot of behavioral health services. And so when you're thinking about how you deal with your provider network, if you don't have good access to those two kinds of programs, that will drive increased complaints and decrease member satisfaction.

Dale Shaller
Okay. One other question, and we have just a couple more minutes before we'll turn to Chris. Can you describe what you mean by public health providers? Again, kind of a provider network question.

Stacia Cohen
Sure. That is services rendered by the public health department. So here in Minnesota many of our counties, if not most of them, have a robust public health home visiting program, for example, so services actually rendered by the public health department.

Dale Shaller
There are a number of questions that I think we'll try to get back to during the next Q&A session, but let me just pose one more, because I think it's a tough one that I think many plans can relate to serving this population. The question comes from Nevada, where there's something like 69 percent of invalid phone numbers and poor tracking of valid addresses among their members. How do you connect with a population that is that difficult to reach? Or do you have that problem?

Stacia Cohen
We share that pain. I would say that we get -- about 40 percent of our mail gets returned for bad addresses, and we have bad phone numbers on roughly the same percentage. We are starting to get more and more email

addresses, and people are starting to be more comfortable providing their cell phone numbers because they would rather get pushed text messages than get phone calls.

One of the things we learned, and we didn't really know, is that even things like our medical management programs, most Medicaid beneficiaries, at least in Minnesota, do have cell phone coverage. However, they do not want us burning up their minutes. They're happy to receive information, and they're happy to exchange text messaging, but they do not want us using their phone minutes. So we are also -- yes, that's a pain shared by everybody. I think everybody's trying to figure out how to have a multichannel approach.

Dale Shaller

Very good, Stacia. Thanks again so much for that very helpful presentation. And to those of you sending in questions, thank you for those, and we'll get to as many unanswered questions as possible.

But first we will turn now to Chris Sellers. Chris, take it away on All Kids.

Christopher Sellers

Sellers, Slide 25

Thank you, Dale. It's good to be here today and to share our history as a CHIP assessing consumer experience. My name is Chris Sellers, and I'm Director of Data and Evaluation for ALL Kids, which is Alabama's Children's Health Insurance Program.

Sellers, Slide 26

Just to give you a little background on who we are, Alabama has the distinction of having the first approved CHIP plan in the nation. We are administered by the Alabama Department of Public Health. That is a separate agency from the state Medicaid agency. As such, we are a standalone program. We are a separate CHIP.

We deliver our health care through a private fee-for-service delivery model. While we are separate from Medicaid, we have extensive collaboration with Medicaid, of course. We always have had a joint paper application with Medicaid. When we began our online application it, too, was a joint application with Medicaid. We are currently in the process of merging our eligibility and enrollment systems. This was partly in an effort to be more compliant with Affordable Care Act provisions.

We also collaborate extensively with Medicaid when it comes to grant projects. We have projects we work with Medicaid on funded by Southern Institute. Most recently, we were a recipient of the Maximum Enrollment Grant funded by Robert Wood Johnson Foundation.

Sellers, Slide 27

Our experience with CAHPS began in 2011 as a result of the CHIP Reauthorization Act. When we began to use CAHPS formally, we started with the core set and we added the supplements for chronic conditions as well as dental, access to specialist care and the care coordination. In our earlier years we actually added a supplement of -- a customized supplement for outreach assessment. We had a lot of outreach with our families through different media channels, and we were trying to assess which channel was most effective in reaching our families.

As far as how we deliver our survey out, we have an approach of using a mixed mail/telephone mode, meaning we do the mail first and if we need to then we kick in the telephone mode. Our response rate has been unusually high. This past year it was 38 percent. In years prior it's been as high as 43 percent. And in every year so far that we've done CAHPS we've had enough response through mail only in the short term to not have to go into the second phase of doing the telephone mode. And our vendor has told us several times that that's a sign that -- the fact that they are so willing to respond is usually a good sign that they are satisfied with the program.

Sellers, Slide 28

On this next slide I want to show you some of our data. We're looking here at the core composites and some of the health -- some of the ratings from CAHPS, comparing in 2013 our results against the 2013 national benchmark of 80 percent, and in 2014 looking at our results compared against the national benchmark of 90 percent. And, as you can see, for most measures we just barely meet or we exceed the benchmark that year.

Most importantly, I like to look at the lowest -- at the bottom row, health plan rating. We consistently every year score much higher than the benchmark. So that's a source of pride for us, of course, and we're glad that our families find us in a favorable light.

But we do dig beneath the surface on this. We don't just look at the overall average of the composites. Those composites are built off of smaller items. We look at those, as well. And, for instance, on Doctor Communication, for a few years we found that even though the average was above benchmark, there were some pieces to that that were performing what we thought was rather low.

As a response, we went back to the CAHPS library, pulled out the communication subset and felt we'll add this supplement in the following year just to kind of get a deeper look and to see what's going on. So this is a good panel to start with. It tells you kind of where you are in a dashboard sense. But it also gives you an opportunity to dig a little deeper. And you can even come up with custom questions as you need to if that's what helps you in your circumstance.

Sellers, Slide 29

This next slide is another way that we can look at our families' value with our program. This is a Key Driver Analysis. In this situation we're looking at a Pearson's Correlation Coefficient. Ideally if something's fully correlated the value is 1.0. We don't achieve anything that high, but what we can look at is particular questions on our survey that are -- that satisfaction with that item relates most often with satisfaction with the overall health plan.

For instance, easy to get prescriptions, that has been a top contender among our most highly correlated items that correlate the best with overall satisfaction. Even though it's at 0.3, you can see that it's higher than, say, the other elements. Over the years we see that there's a certain number that always maintain a high correlation, or higher correlation with respect to others. That gives you an idea of, in our situation, any changes to our pharmacy benefit may affect overall satisfaction with the program. It's good to have this information available.

Can we look at the next slide real quick? I also wanted to mention that the -- I do need to back up for a second, sorry. Another thing that we do with our data is not just looking at even these correlations at the top box level. We go back and we look at our items using both the top and the second top. So, if the values are “Sometimes,” “Always” and “Never” and “Usually,” are we looking at “Always” only, or can we look at “Always” and “Usually?” And sometimes you can see that there's much more satisfaction when you include the “Usually.”

And you can see the undercurrents. Are people shifting from “Always” to “Usually?” Are they shifting from “Usually” to “Always?” There's just more than one way of looking at the data, and we kind of recommend getting in there and seeing it both ways and tracking those things over time and seeing if indeed you're seeing what you expect or if you see a trend that you think should be addressed.

Sellers, Slide 30

And looking to why do we think we're doing well, I kind of agree with what Stacia was saying. A lot of is an artifact of the way the program has been designed and developed. In part, of course, it's about the health care, but in other parts it may be more about the infrastructure. Our program was founded on two principles of being family friendly and being administratively simple. We could talk about that for years.

By being family friendly we mean we want to be approachable, easy to communicate with. By doing that we hear more from our families and we can be more responsive to their needs. We also strive to be administratively simple, trying to reduce barriers to enrollment, trying to reduce other administrative barriers, trying to make our program as open as possible to help these families find health care for their children.

Other plan features that we have, we have very low cost-sharing. That's always something that satisfies the families. We also have very comprehensive benefits. In fact, we had dental benefits long before it was required of the CHIP program, and our goal has always been to provide the most robust package of benefits possible for our children.

Another design feature we have is the private delivery model. This helps remove the Medicaid stigma. So a lot of our families, they don't identify us with Medicaid, the providers don't identify us with Medicaid. Our children have private insurance cards. And so removing that stigma is satisfying for our families.

There's also a level of self-perception. Our families have cost-sharing. It is low cost-sharing comparatively speaking, but these parents do not feel like they're getting a handout. They feel like they're finding a way of having affordable health care. So these families are working families and they're contributing to their children's health care, and they find a great deal of satisfaction in that, as well.

Sellers, Slide 31

So how do we address the barriers that we find? Well, the main thing is open communication. We try to keep open communication with our families and with our partners. When it comes to open communication with our families, we have an in-house call center staffed by customer service representatives here locally. We also have a staff of master-level social workers who also receive phone calls, and those get triaged to them as needed. Of course, that keeps our ears wide open for what's going on with our families.

Prior to using CAHPS in 2011, we actually had a 10-year suite of surveys that we conducted with the University of Alabama at Birmingham School of Public Health using CAHPS-like surveys. So we were really familiar with a lot of the CAHPS questions already. We used these to do a suite of surveys over 10 years looking at our new enrollees, looking at children with special health care needs, groups looking at adolescent health, looking at disenrollees. So it's important for us not to just simply use CAHPS officially as one survey and that's your way of finding out what's going on with your family. We also look at are there subgroups you need to look at? Can you look at them over time, as well? Can you customize these surveys to look at particular questions that you have?

We provide feedback opportunities through our applications. We have our online and our paper applications at different times of our history have had surveys attached to them where we could more passively get families to provide us with feedback.

We've also conducted focus groups on occasion. That's not a regular activity that we have, but when the occasion arises where we need to and there's the opportunity for it, we'll do focus groups in different areas of the state, often looking at specific subgroups, say those who disenrolled, or those who did not renew, or may be new enrollees.

In addition to keeping the direct line with our families open, we keep open communication with our partners, as well. And often the partners work closely with families, so they often can pass information to us. We meet monthly with our health plan vendors. We collaborate with many partners statewide, including state agencies, Department of Mental Health, Medicaid, of course, our Children's Rehab Services.

We're also involved in a lot of quality measures, and this kind of gets back to the health care piece. But there's many quality alliances, especially with our larger hospitals and our universities, and we're always partnering

with them, as well. So I think most of our partners and our families realize that we are looking out for their interest, trying ways to always improve the care that we provide for them.

Sellers, Slide 32

So where are we going from here? Well, we always look to see what's coming up next. We have not yet done CAHPS for our Medicaid child expansion. This is a group of 6- to 18-year-olds. In our state they run from 100 percent to 146 percent FPL. These children will be CHIP funded, but they're administered by the Alabama Medicaid agency. So we haven't really worked out the difference on how we need to assess their consumer assessment, keeping in mind they're not having care delivered by the same delivery model that we provide through ALL Kids. This will be provided through Medicaid. So we're interested in knowing what their experiences are.

We've always tried to do a lot of work with Medicaid looking at the churning issue. So as children transition back and forth between the Medicaid program and our CHIP program, are we able to maintain quality care for them, and what's their -- as a consumer, what's their experience as they try and shift between the two different modes of delivery?

Another thing we're looking forward to is the child hospital CAHPS. That's just now coming together, and so we're looking forward to CMS's guidance on that, and can we use this, and how will we be using this.

Sellers, Slide 33

So what did we learn and what are our take-home points? Basically keeping our eyes and ears open to what our families need, if it's through the families directly or if it's even through our collaborations with our partners if they can relay information to us. So I always recommend that we just keep our eyes and our ears open. In our situation we use -- our call center's very helpful.

Deep and broad collaborations with all your partners. Assessing consumer experience, not just always doing it, but to do it in various ways, I think that's been a real key for us. We don't rely on one instrument or one time of the year to ask questions. We have multiple modes of families to reach us, different channels for them to come to us and to give us information that we need so we can see our program through their eyes.

And that's all I have for you.

Dale Shaller

Shaller (closing), Slide 34

Okay, Chris. Thank you so much. That was terrific. Really appreciate the fine presentation on what you're doing down in Alabama with your ALL Kids program.

There are a number of questions that have queued up. I'm going to take two right off the top, because they're really sort of technical questions that relate to this survey administration. One has to do with the standard regarding number of CAHPS surveys that health plans should attempt to hit in order to get results that are "valid." They're actually -- we would refer to that as reliable across different plans in terms of the number of respondents. We have a target of 300 completed surveys at the plan level, which we have shown through experience is adequate for plan-to-plan comparisons.

A second question real quickly related to what we've been talking about in terms of the top box scores relates to the most positive response available on a given question. There's a scale, usually “Never” to “Always,” for most of the CAHPS questions, or the ratings of 0 to 10, and when we refer to top box as has been done by both Stacia and Chris we're talking about the percentage of respondents that are selecting the most positive response.

So, Chris, directly to you now, there are a number of questions. One has to do with how does Alabama ensure high participation among practitioners? Are payment rates comparable to Medicare?

Christopher Sellers
So, we contract -- at this point we don't have a carve-out in our state any more, either. At times we have had carve-outs by both area of service or geography. So as it stands today we use Blue Cross and Blue Shield Alabama. That is the largest insurance group in the state. They have the largest provider network. So in our agreement with Blue Cross, if that provider is with Blue Cross and they are accepting new patients, then they can accept -- then they must accept ALL Kids. ALL Kids is not treated separately from the other plans offered by Blue Cross. So that's one way that we address provider network, and that's one of the values we get from working with Blue Cross is that we have -- it's the largest provider network in the state.

Dale Shaller
Okay. And what are the primary ethnic groups that your program serves in Alabama?

Christopher Sellers
We're basically two-thirds white and one-third black, and then there's a smattering of other races and combinations in between.

Dale Shaller
Can you say a little more, Chris, about the kind of feedback you get at the application level? What do you mean when you refer to that?

Christopher Sellers
Well, it's meant different things at different times. So there for a number of years we asked kind of, I'll say, almost kind of a health screening question just to get a sense of what kind of conditions do children have as they come into the program. That really wasn't as helpful for us as we kind of imagined in the earlier days, but it is something that we collected for years, in addition to getting more demographics about the family themselves -- education level, income level, just things about the family, things that they might need. Those surveys kind of changed over time, though. If we found a question was no longer informing us with something we would tweak it and go a different route.

Dale Shaller
Okay. So another question has to do with the families with children in Alabama, do they all have cost-sharing benefits, or are there any exceptions? Is there, for example, a sliding scale?

Christopher Sellers
We have three cost-sharing groups. There's basically what we -- we have a no-fee category, and that's mainly for Native Americans and for those who have exceeded their annual max. That doesn't happen very often, so we have a small number of Native Americans in the program. They have no cost-sharing. Then we have what we would call a low-fee and a fee group. Comparatively speaking, they're all rather minimal.

Dale Shaller
Chris, do you use any questions from the Chronic Child Survey, that supplemental set?

Christopher Sellers
Yes, that supplement is in our -- we use the core set that includes the Chronic Child supplement.

Dale Shaller
I see. And do you see any differences in the kind of responses you get from that set versus the core set? They're basically different questions, so you really wouldn't be able to compare differences.

Christopher Sellers
And we don't stratify in our -- we've not asked that feature to be done yet. I mean, we know that that's possible, but we have not stratified a chronically ill child versus a non-chronically ill.

Dale Shaller
You also -- I just want to -- you gave a great example earlier in your presentation about looking underneath the composite scores to individual questions and actually drawing from the supplemental item set, which you were able to do to dig deeper on some of the scores; I thought that was very helpful. So one other question, I think, and I have a couple more then to field back to you, Stacia. But, Chris, would you describe some of the channels that you use to reach consumers?

Christopher Sellers
Well, a number of them. To start out we used to have a -- the whole health fair presence and working with providers at the local level. That was one method of reaching out to families. Another one has been to use billboards. When it gets to bigger media, we've done a little bit of television. We started using billboards at one point. We started using even a -- and I forget what the term for it is, but when you're in a movie theater and before the show starts, that slide deck that pops up, we had a presence there, as well. We called that just movie theater. We also had a large sports outreach, so we were affiliated with marketing with our football, college-level football and basketball and other college sports, which in Alabama is a real winner. Popular way of reaching people.

Dale Shaller
Football is big there.

Christopher Sellers
And that would've been multimedia, both television and radio and the actual presence in the stadium.

Dale Shaller
Okay. Great. So, Stacia, I want to bring you back in, too. You had talked a little bit about the CG-CAHPS Survey, and a couple of questions had come in that I wasn't able to field earlier. One has to do with how do you go about conducting those surveys, and how often is the CG-CAHPS Survey fielded? Can you address how that fits into your CAHPS Health Plan Survey data?

Stacia Cohen
Sure. We don't actually conduct the CG-CAHPS Survey. Our provider network does. And certainly not all providers do it, but certainly all of the large care systems and people who are reporting in to Minnesota Community Measurements do CG-CAHPS. It's baked into most pay-for-performance programs between the health plans and providers in the state. We're pretty consistently using the same measurement methodology. So the providers actually contract and do that themselves.

Dale Shaller
And those data, as you mentioned, in terms of the Minnesota environment are collected and published through Minnesota Health Scores by Minnesota Community Measurement.

Stacia Cohen
That's correct.

Dale Shaller
This is a question related to the comparability or confidence that we can have in the CAHPS data that are collected by the individual organizations themselves. Do you ever have any concerns about the comparability of these results across health plans, since you're all kind of using your own vendors?

Stacia Cohen
For our Medicaid contract I do not, because it's actually conducted by the state of Minnesota.

Dale Shaller
Right. And so that is something that is kind of a nuance in this state, but -- go ahead.

Stacia Cohen
Well, we also conduct our own CAHPS survey annually, because we do that for our NCQA accreditation. And then we're able to compare the state results to ours. Because one would assume that with a population size as large as ours we're not hitting up the same people, and we should be seeing comparable results. And we have seen consistency between the state-gathered results and our own survey vendor.

Dale Shaller
Great. That's good to know. Here's a question for both of you. Chris, we'll start with you. The question has to do with best practices that you might be able to relate in terms of achieving your high scores on members' experience with customer service. I mean, do you have some examples on how health plans can go about pushing those scores up?

Stacia Cohen
This is Stacia. I'd be glad to speak to that.

Dale Shaller
Go ahead.

Stacia Cohen
We have quality measures for our customer service reps that are actually measured on a monthly basis, and it's part of their corporate incentives plan, so they have to meet certain targets to be eligible for their pay incentive. In addition, we do random surveys that are conducted. It's a six-question survey. The member has to, obviously, volunteer to participate in it. But it's offered randomly after interactions with our customer service team, but frequently enough that we have a large enough body of data to get -- to be able to score it at an individual customer service representative level.

Dale Shaller
Okay. Here's a question for either of you, Chris or Stacia. All health plans use a survey vendor of some kind. How active is your vendor in actually assisting you in achieving improvements in your scores? Chris?

Christopher Sellers
Well, our vendor has a -- is willing to go deeper if we need to. They've always helped us kind of, again, look deeper into the data. That was really -- when we first got into CAHPS officially, the data was in a format we didn't really understand, and it wasn't quite the way we had done it when we did our 10 years prior using CAHPS-like questions. So the vendor was instrumental in helping us analyze the data and digging a little deeper. And it's with them that we were identifying different supplements, if we wanted to add them to dig deeper, as well as looking between top box and the top two box.

Dale Shaller
So they've been an active partner. Stacia, could you say the same for your vendor?

Stacia Cohen
The state's vendor does not interact with the health plan.

Dale Shaller
But you on your side do have your own vendor.

Stacia Cohen
We do have our own vendor. And years ago they certainly did, much like Chris said, some education about how we read that, but we actually have our own research team here at Blue Cross, so they do that data crunching for us.

Dale Shaller
Okay. We got to many questions, not all of them. I really appreciate all of the questions that were sent to us and apologize for not getting to all of them. We only have a few minutes left, and I just want to move on, then, into the closing segment of our Webcast today.

Shaller (closing), Slide 35
We've talked a lot about the CAHPS Database as a source of data. This is a screenshot that shows the URL address of the CAHPS Database Online Reporting System. Currently we have comparison data for 2014 that relates to the adult and child Medicaid populations, the CHIP data that had been submitted. We also have data from Medicare managed care enrollees. So that can be viewed in a variety of ways, by tables and bar charts and percentiles, and users can build their own reports.

Shaller (closing), Slide 36
We also, for those who don't like to use online systems for looking up results, we put together a chartbook that kind of summarizes key findings, and we make that available every year, as well.

Shaller (closing), Slide 37
With respect to our time frame, this year our schedule for receiving health plan submissions to add to the database and thereby do comparisons will begin on June 1, and we have a two-week period ending June 12, and then we report results generally in October of that same year, October of 2015 this year. I also want to mention that we're right in the middle of our Clinician & Group Database submission period. It will end on the 27th of March. And we'll be reporting results on our CG-CAHPS Survey data in the early part of June.

Shaller (closing), Slide 38
So this image is one of our submission sites which has its own URL. You can get to this site, if you look on the left -- if you're anywhere on the CAHPS Database site there's a legend on the left that allows you to go wherever you need to, whether you want to look at comparative data or go to the submission site. That's what the red circle is highlighting, how you get to the Health Plan submission page.

Shaller (closing), Slide 39
Now, finally, I just want to make sure that everyone knows that if you're interested in receiving email updates, which we send out on a periodic basis, regarding CAHPS information and upcoming events, you can be on the listserv for these emails by going to the CAHPS site shown here. There's a little icon up on the upper right which gets you to the AHRQ Web site where you can select email updates, and that allows you to enroll to get periodic email updates. And so you will learn about these kinds of events as they are scheduled throughout the

year, and you'll receive email messages regarding both the Health Plan as well as the CG-CAHPS Survey databases.

So we have reached the top of the hour.

Shaller (closing), Slide 40

We want to thank Chris and Stacia for your contributions, your very, very helpful, informative presentations today. I want to thank all of our participants for attending and for the questions that came in. And I want to ask each of you to complete an evaluation survey when we end the Webcast in just a few seconds. You will get a popup in another window. Please complete the survey. It helps us a lot. And click on Submit the Survey when you're done. And just so you know, you can contact us at any time through our email or our phone addresses and visit us on our Web site as indicated here.

So, again, thanks to Chris, thanks to Stacia, thank you all, and have a great St. Patty's Day