Experience of Care

# *CAHPS Health Plan Survey 5.0H, Adult Version (CPA)*

Summary of Changes to HEDIS 2013

* Updated the survey questionnaire from version 4.0H to version 5.0H. Revisions include changes to the number, order and wording of survey questions, as well as the following changes to ratings and composites.
* Revised *Rating of Specialist Seen Most Often*; minor wording change is not expected to impact trending.
* Revised *Health Education and Promotion* question wording and response choices; impacts on trending are expected.
* Revised *Getting Needed Care* composite; wording changes not expected to impact trending.
* Revised *Getting Care Quickly* composite; wording changes not expected to impact trending.
* Revised Shared Decision Making composite; added one question and significantly altered the existing questions and response choices. Impacts on trending are expected.
* Added reminder postcards to the data collection protocol.

**Note:** As a result of significant specification changes, NCQA will not publicly report results for Health Education and Promotion or Shared Decision Making in HEDIS 2013.

Description

This survey provides information on the experiences of commercial and Medicaid members with the health plan and gives a general indication of how well the health plan meets members’ expectations. Results summarize member experiences through ratings, composites and question summary rates.

Four global rating questions reflect overall satisfaction:

1. Rating of All Health Care.
2. Rating of Personal Doctor.
3. Rating of Specialist Seen Most Often.
4. Rating of Health Plan.

Seven composite scores summarize responses in key areas:

1. Claims Processing *(commercial only).*
2. Customer Service.
3. Getting Care Quickly.
4. Getting Needed Care.
5. How Well Doctors Communicate.
6. Shared Decision Making.
7. Plan Information on Costs *(commercial only).*

Item-specific question summary rates are reported for the rating questions and each composite question. Question summary rates are also reported individually for two items summarizing the following concepts:

1. Health Promotion and Education.
2. Coordination of Care.

When administered properly in conjunction with the HEDIS protocols for sampling and data collection, the CAHPS Health Plan Survey 5.0H, Adult Version gives a reliable overall assessment of member experience with the health plan. Any alteration to the sampling protocol, the CAHPS 5.0H questionnaire or its administration, other than in conjunction with the HEDIS protocols, may not yield an accurate measurement. Therefore, in order to avoid misleading impressions, **no health plan may represent that it has HEDIS/ CAHPS 5.0H survey results unless it both administers the entire survey without amendment and complies with the instructions for data collection and reporting contained in this volume.**

Eligible Population

|  |  |
| --- | --- |
| Product lines | Commercial, Medicaid (report each product line separately). |
| Ages | 18 years and older as of December 31 of the measurement year. |
| Continuous enrollment | *Commercial:* The measurement year.  *Medicaid:* The last six months of the measurement year. |
| Allowable gap | No more than one gap in enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a Medicaid member for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (the member must be enrolled for 5 of the last 6 months of the measurement year). |
| Current enrollment | Currently enrolled at the time the survey is completed. |

# *CAHPS Health Plan Survey 5.0H, Child Version (CPC)*

Summary of Changes to HEDIS 2013

* Updated the survey questionnaire from version 4.0H to version 5.0H. Revisions include changes to the number, order and wording of survey questions, as well as the following changes to ratings and composites.
* Revised *Rating of Specialist Seen Most Often*; minor wording change is not expected to impact trending.
* Revised *Health Education and Promotion* question wording and response choices; impacts on trending are expected.
* Revised *Getting Needed Care* composite; wording changes not expected to impact trending.
* Revised *Getting Care Quickly* composite; wording changes not expected to impact trending.
* Revised Shared Decision Making composite; added one question and significantly altered the existing questions and response choices. Impacts on trending are expected.
* Added reminder postcards to the data collection protocol.

**Note:** As a result of significant specification changes, NCQA will not publicly report results for Health Education and Promotion or Shared Decision Making in HEDIS 2013.

Description

This measure provides information on parents’ experience with their child’s health plan. Results summarize member experiences through ratings, composites and individual question summary rates.

Four global rating questions reflect overall satisfaction:

1. Rating of All Health Care.
2. Rating of Personal Doctor.
3. Rating of Specialist Seen Most Often.
4. Rating of Health Plan.

Five composite scores summarize responses in key areas:

1. Customer Service.
2. Getting Care Quickly.
3. Getting Needed Care.
4. How Well Doctors Communicate.
5. Shared Decision Making.

Item-specific question summary rates are reported for the rating questions and each composite question. Question summary rates are also reported individually for two items summarizing the following concepts:

1. Health Promotion and Education (Q8).
2. Coordination of Care (Q25, Without CCC version of questionnaire).

When administered properly in conjunction with the protocols for sampling and data collection, the CAHPS Health Plan Survey 5.0H, Child Version gives a reliable overall assessment of member experience with the health plan. Any alteration to the sampling protocol, the CAHPS 5.0H questionnaire or its administration, other than in conjunction with the HEDIS protocols, may not yield an accurate measurement. Therefore, in order to avoid misleading impressions, **no health plan may represent that it has HEDIS/CAHPS 5.0H survey results unless it both administers the entire survey without amendment and complies with the instructions for data collection and reporting contained in this volume.**

Eligible Population

|  |  |
| --- | --- |
| Product lines | Commercial, Medicaid (report each product line separately). |
| Ages | 17 years and younger as of December 31 of the measurement year. |
| Continuous enrollment | *Commercial:* The measurement year.  *Medicaid:* The last six months of the measurement year. |
| Allowable gap | No more than one gap in enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a Medicaid member for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (the member must be enrolled for 5 of the last 6 months of the measurement year). |
| Current enrollment | Currently enrolled at the time the survey is completed. |

# *Protocols for Administering HEDIS/CAHPS Surveys*

NCQA designed the HEDIS sampling and data collection protocols for the CAHPS surveys to capture accurate and complete information about consumer-reported experiences with health care. The sampling and data collection procedures outlined below promote both the standardized administration of the survey instruments by different survey vendors and the comparability of resulting data about health plans. **For results to be considered HEDIS/CAHPS survey results, the health plan must follow one of the standard HEDIS/CAHPS survey protocols or an enhanced protocol preapproved by NCQA.** NCQA provides certified survey vendors with further instruction and training in the protocols and a Quality Assurance Plan (QAP) at HEDIS 2013 Survey Vendor Training.

Sample Frame Data File Generation

Health plans are responsible for generating a complete, accurate and valid sample frame data file that is representative of the entire eligible population. Health plans arrange for an NCQA Certified HEDIS Compliance Auditor to verify the integrity of the sample frame before the survey vendor draws the sample   
and administers the survey.

Health plans have the option of producing a complete sample frame or a reduced sample frame.

* A **complete sample frame** includes the entire eligible population.
* A **reduced sample frame** includes 30,000 members randomly selected from the entire eligible population. The HEDIS Compliance Auditor validates the health plan’s method for selecting the random sample.

A sample frame is produced for each HEDIS/CAHPS survey submission. For example, separate sample frames are produced for commercial and Medicaid, and if the health plan reports results separately by product (HMO, POS, PPO), it must produce sample frames separately by product.

Health plans are *strongly encouraged* to generate sample frames no earlier than January 2013, and *not before* eliminating disenrolled and deceased members and updating membership files with address and telephone number corrections. Health plans may generate the sample frame in December of the measurement year, but must oversample to compensate for members who will disenroll between sample frame generation and administration of the survey. A health plan that generates the sample frame in December of the measurement year must adhere to steps 1–7 of the oversampling process described in the *Sampling Protocol* section below. Health plans must generate a sample frame data file for each product line and product, if applicable, to enable the survey vendor to generate the random sample; must use the standardized layout and format provided for the sample frame data file; and must include all data elements (Tables S-1, S-2).

|  |  |
| --- | --- |
| Standardized format | The standardized format for the sample frame is an ASCII fixed-width text file with defined, fixed column positions for each data element. It contains one record or line for each member who meets the eligible population criteria (one record/member per line; one line per record).  Data elements adhere to the value label characteristics described in Tables S-1 and  S-2 and are placed in the designated columns (field positions). No delimiters are used. All data elements are required. For example, a health plan must assign *Member age as of December 31 of the measurement year* in the adult sample frame even if it does not intend to report the *Aspirin Use and Discussion* measure. |

|  |  |
| --- | --- |
|  | Field contents are aligned to the left, and data start in the first position of each field. If data are not available, field positions are left blank. If applicable, sample frames for different product lines and products may be combined into one data file. Separate layouts are specified for the adult and child surveys; therefore, adult and child data may not be combined into one file.  Additional data elements requested by the survey vendor or provided by the health plan are appended to the end of the data file and are not reviewed during the HEDIS Compliance Audit. |

### Table S-1: Standardized Layout for Sample Frame Data File (Adult Survey)

| Required Data Element | Field Positions | | | Value Labels |
| --- | --- | --- | --- | --- |
| Length | Start | End |
| Health care organization name | 60 | 1 | 60 |  |
| Member product line\* | 1 | 61 | 61 | 1 = Commercial 2 = Medicaid |
| Member product\* | 1 | 62 | 62 | 1 = HMO 2 = POS 3 = PPO |
| Subscriber or family ID number | 25 | 63 | 87 |  |
| Member-unique ID | 25 | 88 | 112 | This ID differentiates between individuals when family members share the subscriber ID |
| Member first name | 25 | 113 | 137 |  |
| Member middle initial | 1 | 138 | 138 |  |
| Member last name | 25 | 139 | 163 |  |
| Member gender\* | 1 | 164 | 164 | 1 = Male 2 = Female 9 = Missing/not available |
| Member date of birth | 8 | 165 | 172 | MMDDYYYY |
| Member mailing address 1 | 50 | 173 | 222 | Street address or post office box |
| Member mailing address 2 | 50 | 223 | 272 | Mailing address 2nd line (if needed) |
| Member city | 30 | 273 | 302 |  |
| Member state | 2 | 303 | 304 | 2-character state abbreviation |
| Member zip code | 5 | 305 | 309 | 5-digit number |
| Member telephone number | 10 | 310 | 319 | 3-digit area code plus 7-digit phone number;  no separators or delimiters |
| Flu Shots for Adults Ages 50–64  Eligibility Flag\* | 1 | 320 | 320 | 1 = Eligible  2 = Ineligible  0 = Member is in the Medicaid product line for which the measure *is not* reported |
| Member age as of December 31 of the measurement year\* | 2 | 321 | 322 | Numeric, 2-digit variable.  For members age 80 years and older, code as 80. For example, a member who is 89 years of age as of December 31 of the measurement year will be coded 80. |

\*A valid value is required for every member in the record.

### Table S-2: Standardized Layout for Sample Frame Data File (Child Survey Without CCC)

| Required Data Element | Field Positions | | | Value Labels |
| --- | --- | --- | --- | --- |
| Length | Start | End |
| Health care organization name | 60 | 1 | 60 |  |
| Product line\* | 1 | 61 | 61 | 1 = Commercial 2 = Medicaid |
| Product\* | 1 | 62 | 62 | 1 = HMO 2 = POS 3 = PPO |
| Subscriber or family ID number | 25 | 63 | 87 |  |
| Member-unique ID | 25 | 88 | 112 | This ID differentiates between individuals when family members share the subscriber ID |
| Member first name | 25 | 113 | 137 |  |
| Member middle initial | 1 | 138 | 138 |  |
| Member last name | 25 | 139 | 163 |  |
| Member gender\* | 1 | 164 | 164 | 1 = Male 2 = Female 9 = Missing/not available |
| Member date of birth | 8 | 165 | 172 | MMDDYYYY |
| Member mailing address 1 | 50 | 173 | 222 | Street address or post office box |
| Member mailing address 2 | 50 | 223 | 272 | Mailing address 2nd line (if needed) |
| Member city | 30 | 273 | 302 |  |
| Member state | 2 | 303 | 304 | 2-character state abbreviation |
| Member zip code | 5 | 305 | 309 | 5-digit number |
| Member telephone number | 10 | 310 | 319 | 3-digit area code plus 7-digit phone number; no separators or delimiters |
| Parent/caretaker first name | 25 | 320 | 344 | Required only if mailing materials are to be addressed to the parent or caretaker |
| Parent/caretaker middle initial | 1 | 345 | 345 | Required only if mailing materials are to be addressed to the parent or caretaker |
| Parent/caretaker last name | 25 | 346 | 370 | Required only if mailing materials are to be addressed to the parent or caretaker |

\*A valid value is required for every member in the record.

*Note*

* *For the CAHPS 5.0H Child Survey, the health plan selects one of the following options for personalizing correspondence and, based on this determination, provides either the parent/caretaker’s mailing address or child member’s mailing address information in field positions 173–309:*
* *Parent/caretaker’s name and child’s name are used in all cover letters, postcards and envelopes.   
  Parent/caretaker’s address is used for addressing all mailing pieces.*
* *Child surveys are addressed “To the parent/caretaker of [child member’s name].” Child member’s address is used for addressing all mailing pieces.*

CAHPS Sample Frame Validation Process

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| --- | --- |
| ***Step 1*** | In the Healthcare Organization Questionnaire (HOQ), the health plan enters information on the number of HEDIS/CAHPS survey submissions it intends to report. This is the number of sample frames the health plan must produce. |
| ***Step 2*** | The health plan generates the sample frame data files according to the HEDIS specifications. |
| ***Step 3*** | The health plan delivers the sample frame data files to the HEDIS Compliance Auditor. |
| ***Step 4*** | The auditor validates the sample frame data files and notifies the health plan of the results. If needed, the health plan makes corrections to the sample frame until it achieves the desired audit result. |
| ***Step 5*** | The auditor enters the result of the sample frame validation into the HOQ. |
| ***Step 6*** | The health plan forwards the sample frame data files and documentation of sample frame validation results to the NCQA Certified HEDIS Survey Vendor. |
| ***Step 7*** | The survey vendor administers the CAHPS survey according to HEDIS specifications. |

Sampling Protocol

Prior to sampling, the survey vendor confirms with the health plan that an NCQA Certified HEDIS Compliance Auditor has verified the integrity of the sample frame.

For each HEDIS/CAHPS survey administered, the survey vendor draws a random sample of members, employing the required sample size as indicated in Table S-3. In a health plan with fewer eligible members than the required sample size, the sample includes the health plan’s entire eligible population.

### Table S-3: Survey Sample Sizes

|  |  |
| --- | --- |
| Survey Type | Required Sample Size |
| Adult Commercial | 1,100 |
| Adult Medicaid | 1,350 |
| Child Commercial | 900 |
| Child Medicaid | 1,650 |

|  |  |
| --- | --- |
| Deduplication | To reduce respondent burden, the survey vendor deduplicates samples so that only one adult member per household is included in the adult sample and only one child member per household is included in the child sample. The survey vendor selects the adult sample first and then deduplicates the population, using the subscriber ID number, so that no children of the selected adult households are in the child survey sample. If the health plan does not use a subscriber ID, the sample is deduplicated by address.  If a HEDIS survey is being collected and reported more than once for a given sample frame (e.g., if a state is sponsoring a survey for a health plan and the health plan is also conducting its own survey), survey vendors may collaborate to deduplicate samples. |

|  |  |  |
| --- | --- | --- |
|  | | With the health plan’s approval:   * One survey vendor may draw two deduplicated random samples and provide another survey vendor with one sample. * One survey vendor may share the list of sampled members with another survey vendor. The second survey vendor excludes these members (as well as all members of the household) from the sample frame prior to drawing the second random sample. |
| Small numbers | | A health plan with very small numbers of eligible members (where denominators of less than 100 are expected) should contact NCQA to determine specific HEDIS survey reporting requirements. The health plan can submit concerns through the NCQA PCS system at www.ncqa.org/pcs or fax to the attention of Policy at 202-955-3599. |
| Oversampling | | A health plan must oversample if it cannot eliminate disenrolled members from membership files; correct addresses and, when appropriate, telephone numbers; and provide updated, accurate sample frames to the survey vendor by the required date. For example, a health plan that receives December membership updates from purchasers in January may need additional time to enter updates into its membership files. Similarly, a health plan that does not receive December membership updates from purchasers until late February may be unable to update membership files before generating the sample frame.  Health plans must oversample enough to guarantee that sufficient eligible members are surveyed to meet the required sample size. A health plan that oversamples due to anticipated disenrollment arranges for the survey vendor to complete steps 1–7 of the oversampling process, below.  Health plans may also oversample to obtain a greater number of completed surveys at the end of the survey administration. For example, the health plan may oversample if it has a prior history of low survey response rates; if it anticipates that a significant number of the telephone numbers in the membership files are inaccurate; or, if after reviewing the information in *Appendix 7: General Recommendations for Oversampling for Survey Measures,* it does not expect to achieve a denominator of 100 for most survey calculations. If the health plan oversamples for these reasons, the survey vendor adheres to the oversampling process below but *does not* perform step 1 or steps 4–6. |
| Oversampling rates | Health plans may oversample using rates in increments of 5 percent (e.g., 5, 10, 15). Final sample sizes (FSS) for oversampling rates of 5 percent–30 percent are provided in Table S-4. The survey vendor calculates the final sample size for oversampling rates greater than 30 percent using the following formula.  FSS = Required Sample Size (RSS) x Oversampling Rate (round up) |
| Oversampling process |  |
| *Step 1* | The health plan provides the survey vendor with the validated sample frame before eliminating disenrolled members, and estimates the percentage of anticipated disenrolled members. Based on the estimated percentage of disenrolled members, the health plan and the survey vendor determine the oversampling rate necessary to obtain the RSS of currently enrolled members. |
| *Step 2* | The survey vendor selects the FSS from Table S-4 using the predetermined oversampling rate and based on the following formula.  FSS = RSS + (RSS × oversampling rate), round up to the next whole number |

### Table S-4: Oversampling Rates and Final Sample Sizes

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Survey Type | | RSS | Oversampling Rate and FSS | | | | | |
| 5% | 10% | 15% | 20% | 25% | 30% |
| Adult Commercial | | 1,100 | 1,155 | 1,210 | 1,265 | 1,320 | 1,375 | 1,430 |
| Adult Medicaid | | 1,350 | 1,418 | 1,485 | 1,553 | 1,620 | 1,688 | 1,755 |
| Child Commercial | | 900 | 945 | 990 | 1,035 | 1,080 | 1,125 | 1,170 |
| Child Medicaid | | 1,650 | 1,733 | 1,815 | 1,898 | 1,980 | 2,063 | 2,145 |
| *Step 3* | | The survey vendor randomly samples the FSS and administers the survey to all members of the FSS, in accordance with the HEDIS protocol. | | | | | | | |
| *Step 4* | | The survey vendor and health plan select one of the following options, which allows the health plan to provide the vendor with updated membership information while protecting member confidentiality and minimizing the burden on the health plan and the vendor. For all of the options, and when appropriate, the health plan returns the updated membership information to the survey vendor *before* the telephone phase of the protocol so the vendor can update sampled members’ telephone numbers before telephone interviewing. | | | | | | | |
| Option 1 | | After the survey vendor draws the FSS, it creates a reduced membership file three times the FSS. Members selected for the FSS constitute one-third of the reduced membership file; the remaining two-thirds of the file consists of nonsampled health plan members. This blinds the health plan to the sampled members and protects member confidentiality. The survey vendor forwards the reduced membership file to the health plan.  The health plan updates the reduced membership file with disenrolled members, the dates of disenrollment and, when appropriate, members with updated telephone numbers and the new number, and forwards the updated reduced membership file to the survey vendor. | | | | | | | |
| Option 2 | | The health plan starts with the original sample frame and updates the file with disenrolled members, the dates of disenrollment and, when appropriate, members with updated telephone numbers and the new number, and forwards the updated sample frame to the survey vendor. | | | | | | | |
| Option 3 | | The health plan generates a new file containing all disenrolled members, the dates of disenrollment and, when appropriate, members with updated phone numbers and the new number, and forwards the new file to the survey vendor. | | | | | | | |
| *Step 5* | | After receiving the updated sample frame, the survey vendor identifies disenrolled members in the FSS and assigns all disenrolled members a final disposition code of “Ineligible: Does not meet *Eligible Population* criteria.” Members are considered disenrolled when their disenrollment date is on or before the date on which the survey vendor fielded the survey (the date of the first questionnaire mailing).  For example, if the survey vendor fields a survey on February 20, members who disenrolled on or before February 20 are considered disenrolled. Members who disenrolled on or after February 21 are not considered disenrolled. | | | | | | | |
| *Step 6* | | The survey vendor continues to administer the survey to all remaining eligible members in the FSS. | | | | | | | |
| *Step 7* | | The survey vendor includes all members of the FSSin the member-level data file that it submits to NCQA for calculation of HEDIS survey results. | | | | | | | |

Oversampling Example

A health plan contracts with an NCQA Certified survey vendor to collect CAHPS adult survey results for its commercial product line. The health plan cannot update the membership file with disenrolled members by the time it delivers the sample frame to the survey vendor, so it contracts with the survey vendor to oversample.

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| --- | --- |
| *Step 1* | The health plan provides the sample frame to the survey vendor. Based on experience with this product line, the health plan believes that 10 percent of members in the sample frame are disenrolled. The health plan, in conjunction with the survey vendor, selects an oversampling rate of 10 percent. |
| *Step 2* | The RSS is 1,100 and the oversampling rate is 10 percent. The FSS (from Table S-4) is 1,210. |
| *Step 3* | The survey vendor randomly samples 1,210 members from the sample frame and administers the survey to all 1,210 members of the FSS, in accordance with the HEDIS protocols for administering the CAHPS survey. |
| *Step 4* | The survey vendor returns a reduced membership file containing 3,630 (3 × 1,210) members to the health plan. The 1,210 sampled members are embedded in the reduced membership file. The health plan indicates members in the reduced membership file who have disenrolled and returns it to the survey vendor. |
| *Step 5* | The survey vendor identifies that 50 members of the FSS are disenrolled. The survey vendor assigns the 50 disenrolled members a final disposition code of “Ineligible: Does not meet Eligible Population criteria.” |
| *Step 6* | The survey vendor continues with the HEDIS protocol for administering the CAHPS adult survey for the remaining 1,160 eligible members. |
| *Step 7* | The member-level data file that the survey vendor submits to NCQA for calculation of survey results includes all 1,210 members of the FSS. |

Data Collection Protocol

The health plan and survey vendor select one of two standard options for administering HEDIS/CAHPS surveys:

1. The **mail-only methodology,** a five-wave mail protocol with three questionnaire mailings and two reminder postcards.

2. The **mixed methodology,** a four-wave mail protocol (two questionnaires and two reminder postcards) with telephone follow-up of at least three telephone attempts.

The basic tasks and time frames for the two protocol options are detailed in the following tables.

The survey vendor is expected to maximize the final survey response rate and to pursue contacts with potential respondents until the selected data collection protocol is completed. Achieving 411 completed surveys does not justify cessation of the survey protocol.

NCQA does not allow the health plan or survey vendor to use incentives of any kind. Proxy responses are not permitted for the adult survey; the sampled member must complete his or her own survey. Either parent or a caretaker who is familiar with the child’s health care may complete the child survey.

The survey vendor is expected to maintain the confidentiality of randomly sampled members. Neither NCQA nor the health plan has access to the names of members selected for the survey.

### Mail-Only Methodology

|  |  |
| --- | --- |
| Survey Vendor Tasks | Time Frame |
| Send first questionnaire and cover letter to the member | 0 days |
| Send a postcard reminder to nonrespondents 4-10 days after mailing the first questionnaire | 4-10 days |
| Send a second questionnaire and second cover letter to nonrespondents approximately 35 days after mailing the first questionnaire | 35 days |
| Send a second postcard reminder to nonrespondents 4-10 days after mailing the second questionnaire | 39-45 days |
| Send a third questionnaire and third cover letter to nonrespondents approximately 25 days after mailing the second questionnaire | 60 days |
| Allow at least 21 days for the third questionnaire to be returned by the member | 81 days |

### Mixed Methodology

|  |  |
| --- | --- |
| Survey Vendor Tasks | Time Frame |
| Send first questionnaire and cover letter to the member | 0 days |
| Send a postcard reminder to nonrespondents 4-10 days after mailing the first questionnaire | 4-10 days |
| Send a second questionnaire and second cover letter to nonrespondents approximately 35 days after mailing the first questionnaire | 35 days |
| Send a second postcard reminder to nonrespondents 4-10 days after mailing the second questionnaire | 39-45 days |
| Initiate computer-assisted telephone interviews (CATI) for nonrespondents approximately 21 days after mailing the second questionnaire | 56 days |
| Initiate systematic contact for all nonrespondents so that at least 3 telephone calls are attempted at different times of day, on different days of the week and in different weeks | 56–70 days |
| Complete telephone follow-up sequence (completed interviews obtained or maximum calls reached for all nonrespondents) approximately 14 days after initiation | 70 days |

Mail Phase of the Protocol

The mailing component of the protocol uses standardized questionnaires, cover letters and reminder postcards provided by NCQA and included as appendices in this volume. The survey vendor is responsible for reproducing a sufficient number of all questionnaires, cover letters and reminder postcards for survey administration.

|  |  |
| --- | --- |
| Approval of printed materials | The survey vendor forwards all materials to NCQA for approval prior to printing. NCQA reviews printed materials and responds to the survey vendor within five working days. |
| Questionnaire | To ensure the comparability of survey results, the health plan and survey vendor may not change the wording of the survey questions, the response categories or the order of the questions.  The survey vendor may modify the format and layout of the questionnaire, adhering to formatting parameters specified in the QAP. The survey vendor must customize select questions in the survey with the health plan name (for commercial surveys) or the state Medicaid program name (for Medicaid surveys).  To ensure confidentiality, member names and addresses are not printed on the survey questionnaire. Questionnaires are labeled with a confidential tracking identification number, which is used to record each member’s response status so that follow-up mailings of the questionnaire are sent only to nonrespondents. |

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| --- | --- |
| Cover letters  and reminder postcards | Cover letters and reminder postcards may be modified only with prior NCQA approval. Correspondence is personalized as follows.   * The member’s full name is used in all cover letters and envelopes. * The *Letter for First Questionnaire* and *Letter for Second and Third Questionnaires* include the health plan name and signature of a health plan executive. The health plan can opt to include the name and signature on the *Reminder Postcards*, but this is not required. * The survey firm’s toll-free customer support telephone number is listed on the *Letter for First Ques*t*ionnaire, Letter for Second and Third Questionnaires and Reminder Postcards* for members with questions. The telephone line must be staffed from 9:00 a.m. to 8:00 p.m. (survey vendor local time). |
| Personalizing child mail materials | The health plan selects one of the following two options for personalizing the child survey correspondence.   1. Parent/caretaker’s name and child’s name are used in all cover letters, postcards and envelopes. The parent/caretaker’s address is used for addressing all mailing pieces. 2. Child surveys are addressed “To the parent/caretaker of [child member name].” The child member’s address is used for addressing all mailing pieces. |
| Return envelopes | Questionnaire mailings include stamped return envelopes or business reply mail envelopes addressed to the survey vendor. |
| First-class postage | First-class postage and postal bar codes are used on all mailing pieces. |
| Address standardization | To increase the deliverability of the mail survey, all addresses must be complete and accurate. The survey vendor employs address standardization techniques to ensure that address information is current and formatted to enhance deliverability. Minimum standardization techniques are described in the QAP. |
| First mailing | The first mailing includes a questionnaire, the *Letter for First Questionnaire* and a stamped return envelope or business reply mail envelope addressed to the survey vendor. |
| Second and third mailings | The second and (if applicable) third mailings contain a questionnaire, the *Letter for Second and Third Questionnaire* and a stamped return envelope or business reply mail envelope addressed to the survey vendor. |
| Data entry | The survey vendor reviews each returned mail questionnaire for legibility and completeness. If member responses are ambiguous, a coding specialist employs decision rules documented in the QAP. After coding is complete, data are uploaded to the vendor’s survey management system.  Questionnaires can be keyed or optically scanned. To ensure quality for key-entered data, two separate data entry specialists must independently key-enter answers for each questionnaire. A comparison of the separate entries identifies data entry errors needing adjudication. |
| Quality control | The survey vendor establishes training programs for all personnel involved in the mail phase of the protocol. It also establishes quality control procedures and monitors staff performance and subcontractors, if applicable, to ensure integrity of the printing and mailing processes. The survey vendor provides NCQA with written documentation of personnel training and quality control processes. |

Telephone Phase of the Protocol

The telephone component of the protocol uses standardized, computer-assisted telephone interviewing (CATI) scripts and design specifications provided by NCQA. The survey vendor is responsible for programming the scripts and specifications into its existing CATI software. The survey vendor establishes enough operating CATI stations to ensure that interviewers are able to complete the telephone phase of the protocol within the protocol timeline.

To ensure the comparability of survey results, survey vendors may not change the wording of the survey questions, the response categories or the question order. The CATI script and design specifications may be modified only with prior NCQA approval.

|  |  |
| --- | --- |
| Telephone number standardization | The survey vendor employs telephone number standardization techniques to ensure the accuracy of telephone numbers. Minimum standards for validating telephone numbers are described in the QAP. |
| Telephone attempts | The survey vendor attempts to contact nonrespondents by telephone so that at least three telephone calls are attempted at different times of day, on different days of the week and in different weeks. |
| Reminder call | The survey vendor may perform a reminder telephone call to encourage members to complete and return the questionnaires they received in the mail. The reminder call does not satisfy one of the three required telephone attempts. |
| Quality control | The survey vendor establishes training programs for all personnel involved in the telephone phase of the protocol. The vendor also establishes quality control procedures and monitors staff and subcontractor performance (if applicable) to ensure the integrity of the telephone interviewing process. The survey vendor provides NCQA with written documentation of personnel training and quality control processes. |

Protocol Enhancement Options

A health plan and survey vendor must submit a written proposal to NCQA if they collect HEDIS/CAHPS survey results using a methodology that differs from the standard HEDIS protocols. The proposal must meet the following criteria:

* Describes the proposed methodology.
* Explicitly describes differences between the proposed methodology and the standard HEDIS methodology.
* Provides rationale for the proposed methodology (e.g., using translations, improved response rates, cost effectiveness, demographics of health plan membership).
* Allows five working days for a written response from NCQA.

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| Enhanced methodology | This is an optional methodology in which enhancements are made without significantly altering the standard methodology. The health plan is not required to achieve a minimum response rate. |
| Standardized Internet data collection protocol enhancement | NCQA provides a standardized Internet data collection protocol enhancement  for optional use by health plans and survey vendors. Specifications for the standardized HEDIS/CAHPS Internet enhancement are included as Appendix 8 of this volume. |

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| Spanish translations | Standardized Spanish HEDIS translations of mail materials are available for use during survey administration. Spanish CATI scripts are not available, but the survey vendor may produce them for use during telephone interviewing.  Annually, in consultation with the health plan, the survey vendor decides how the Spanish questionnaires will be incorporated into the data collection protocol and submits the proposed methodology to NCQA in writing. After it approves the methodology, NCQA forwards the standardized HEDIS translations to the vendor. |

Supplemental Questions Option

Health plans may add supplemental questions with prior NCQA approval. NCQA requires prior approval and imposes a 20-question limit on supplemental questions:

* To minimize burden on the respondent.
* To prevent the possibility that the member’s responses to the CAHPS questions are affected by the supplemental questions.
* To prevent a high nonresponse rate to the survey due to the presence of supplemental questions.
* To maintain a level of standardization necessary for results to be considered HEDIS/CAHPS survey results and appropriate for plan-to-plan comparison.

Survey vendors are not permitted to renumber the core CAHPS survey questions. If the health plan intends to add a supplemental question, for example, after Q12 of the adult commercial survey, the supplemental question is numbered “12a.”

A health plan that uses the mixed methodology protocol may limit supplemental questions to one mode of data collection. For example, the plan may opt to ask supplemental questions on the mail questionnaire and not during CATI interviewing (or vice versa). Data collected through supplemental questions are excluded from the member-level data file that the survey vendor submits to NCQA.

Supplemental Question Review Process

Supplemental questions must be approved by NCQA prior to survey administration. The health plan or survey vendor must submit supplemental questions not previously approved by NCQA in writing to NCQA for approval. Approved questions do not require reapproval in subsequent years. NCQA reviews *new* supplemental questions and responds to health plans or survey vendors within five working days. NCQA evaluates each supplemental question against the following criteria.

**Is the supplemental question consistent with the *key principles* of CAHPS survey questions?**

* Questions are as specific as possible.
* Questions minimize wordiness, complexity and technical jargon.
* Response options match the question wording in a way that reflects respondent experiences.
* Questions are neutral and do not lead the respondent to a particular response choice.
* Questions do not rely on grids or matrices (several questions with the same introduction listed vertically with the introduction to the question, or stem, used only once), since respondents frequently forget the question’s stem and reference period after the first few items.

**Is the question worded as consistently as possible with CAHPS survey questions?** For example, does the question begin “In the last 12 months,” as opposed to “Over the last 12 months” or “In the past 12 months”?

**Are the response options as consistent as possible with CAHPS response choices?** For example, are response options written in the first-person voice? Are response options in the same order as the CAHPS response choices?

**Does the question have the potential to offend a member, resulting in termination of the survey?** For example, does the question address overly sensitive material, or is it worded in an offensive or negative manner?

**Does the question collect information that would jeopardize the member’s confidentiality?** For example, does the question ask for the member’s zip code or e-mail address? Does the question ask members to name their provider?

**Does the question focus on marketing?** For example, does the question ask members to list names of the health plan’s competitors?

In general, NCQA approves any question from the HEDIS 3.0 1998 Member Satisfaction Survey, from previous versions of the CAHPS survey or from the CAHPS supplemental question sets. If a proposed supplemental question fails to meet one or more criteria listed above, NCQA may not approve the question or may require the health plan or survey vendor to place the question at the end of the CAHPS survey. NCQA works with the health plan or survey vendor to modify supplemental questions to meet the criteria listed above.

***Note:*** *The health plan and survey vendor determine question placement, but NCQA may approve supplemental questions contingent on placement at the end of the CAHPS survey.*

Data Coding and Disposition Codes

Using the confidential tracking number, the survey vendor assigns each member in the sample a disposition code used to track and report whether the member has returned a questionnaire or needs a repeat mailing or telephone follow-up. Typically, disposition codes are either interim (to indicate the status of each member in the sample during the data collection period) or final (to document the outcome of each member’s response at the end of data collection).

Maintaining up-to-date disposition codes is especially important because the codes allow the survey vendor to calculate and report the response rate and project the number of completed questionnaires at any time during the data collection period. After data collection is completed, the survey vendor assigns each member one of the following final disposition codes to report to NCQA:

* Complete and Valid Survey.
* Ineligible: Deceased.
* Ineligible: Does not meet eligible population criteria.
* Ineligible: Language barrier.
* Ineligible: Mentally or physically incapacitated.
* Nonresponse: Refusal.
* Nonresponse: After maximum attempts.
* Nonresponse: Bad address.
* Nonresponse: Bad address *and* nonworking/unlisted phone number or member is unknown at the dialed phone number.

**Note:** The disposition code Ineligible: Mentally or physically incapacitated is only valid for adult surveys; it is not valid for child surveys.

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| Complete and Valid Survey | The survey vendor assigns a member a disposition code of Complete and Valid Survey when the following conditions are met:   * At least one survey question is answered. * Responses indicate that the member meets the eligible population criteria. |

To maximize the amount of survey data collected, the health plan may arrange for the survey vendor to recontact members with missing responses.

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| Total survey response rates | The survey vendor calculates and reports a total survey response rate for each sample. The **response rate** is the total number of completed surveys divided by all eligible members of the sample. **Eligible members** are the entire random sample (including any oversample) minus members assigned a disposition code of “Ineligible.” The total survey response rate is calculated as follows. |

Complete and Valid Surveys

Entire random sample –[Ineligible: Deceased + Ineligible: Does not meet *Eligible* *Population* criteria  
+ Ineligible: Language barrier + Ineligible: Mentally or physically incapacitated]

**Note:** The disposition code Ineligible: Mentally or physically incapacitated is not valid for the CAHPS 5.0H Child Survey; thus, the total survey response rate formula for the child survey does not include it.

Data Elements for Reporting

A health plan and survey vendor that submits HEDIS survey data to NCQA must provide the following data elements.

### Table S-5: Data Elements for HEDIS/CAHPS Surveys

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| Header Record |
| Measurement year |
| Data file type (adult member, child member) |
| Health care organization ID |
| Health care organization name |
| Product line (commercial, Medicaid) |
| Product (HMO, POS, PPO, or combined products) |
| Submission ID |
| Survey protocol (mail-only methodology, mixed methodology, other) |
| Sample frame size |
| Eligible population size (members who meet all criteria) |
| Survey vendor organization name and contact information |
| Oversampling information (Did the health plan oversample? Oversampling rationale.) |
| Oversampling rate |
| Final sample size |
| Final sample size discrepancy flag (valid, not valid/rationale) |
| Total response rate |
| Flu Shots for Adults Ages 50–64 results included? (adult commercial only) |
| Medical Assistance With Smoking and Tobacco Use Cessation results included? (adult only) |
| Aspirin Use and Discussion results included? (adult only) |
| Was the sample frame validated by a HEDIS Compliance Auditor? |
| Number supplemental questions |
| Member-Level Record |
| Record ID |
| Disposition of survey |
| Survey round |
| Survey language |
| Member gender |
| Member year of birth |
| City of member |
| State of member |
| Flu Shots for Adults Ages 50–64 Eligibility Flag (commercial only) |
| Member age as of December 31 of the measurement year (adult only) |
| Item-by-item responses to each question in the survey |