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November 28, 2006

Mary Truhe, RN, BSN
Quality Manager
Landon State Office Building
Kansas Health Policy Authority
900 SW Jackson, Room 900
Topeka, KS 66612

Dear Mary,

Enclosed is KFMC's evaluation of FirstGuard's 2006 CAHPS Survey, which includes the Cross-Program and NCBD Comparison. The evaluation is based on the EQR Protocol for Validating Surveys. The completed Survey Validation Worksheet included in this protocol is also enclosed. Since this is the third year for FirstGuard's assessment to be based on the EQR protocol, full compliance is expected.

After you have an opportunity to review the evaluation report, we can discuss the results during a future KHPA/KFMC contract meeting. In the interim, please contact me if you have any questions regarding this information.

Sincerely,

Stephen Blackwell MBA, CPHQ
Quality Review Coordinator

Enclosures

Xc	Full Report:	Celia Humphreys, Director Quality Management, FirstGuard
	Executive Summary:	Debra Bachmann, Program Manager HWXIX, KHPA Chris English, Program Manager HW XXI, KHPA
	Cover Letter:	John Dixon, Contracts Team Manager, KHPA

Please file this report in the EQRO notebook titled " Surveys," Volume 3 of 4, under the tab labeled *Validation of CAHPS*, HWXIX/HWXXI, 10/01/05-09/30/06.

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WE FACILITATE THE IMPROVEMENT OF HEALTHCARE

FirstGuard CAHPS Validation With NCBD/Cross Program Comparison

Contract Number:	**06385**
Programs:	**HealthConnect Kansas**
	HealthWave 19
	HealthWave 21
Study Year:	**2006**
Submission Date:	**November 28, 2006**

Report Submitted by:

Kansas Foundation for Medical Care, Inc.

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Executive Summary
FirstGuard CAHPS Validation with NCBD/Cross Program Comparison
FirstGuard Health Plan
November 28, 2006

BACKGROUND

As the External Quality Review Organization (EQRO) for the State of Kansas, the Kansas Foundation for Medical Care, Inc. (KFMC) was contractually required to validate FirstGuard's (FG) Consumer Assessment of Healthcare Providers and Systems (CAHPS) conducted in 2006. The objectives were to determine if the survey was administered in a methodologically sound manner and to assess the reliability and validity of its findings. In evaluating the technical methods and results from the FG CAHPS reports, KFMC used, as a guide, the Validating Surveys Protocol provided by The Centers for Medicare and Medicaid Services (CMS). The protocol states the purpose of the survey is to provide information not available through clinical or administrative means and to capture respondent perceptions of access to care and quality of health services. This information is used for the EQRO assessment of the access, quality, and timeliness of health care services provided to Medicaid beneficiaries enrolled in FirstGuard Health Plan.

Activity 7 of the Validating Surveys Protocol includes a step for providing comparative information as directed by the State. KFMC's contract with the State includes a cross-program comparison of FG and HealthConnect Kansas (HCK) CAHPS results, as well as comparison of FG and HCK CAHPS results to the National CAHPS Benchmarking Database (NCBD) CAHPS results. The objectives were to identify any cross-program differences between FG and HCK and to compare each program to NCBD to identify opportunities for improvement. This comparative information provided further data for the EQRO assessment of access, quality, and timeliness of care provided to beneficiaries enrolled in FG.

CONCLUSIONS

FG/TMG Conclusions

Regarding the FG Key Drivers for Rating of Health Plan, plan strengths were identified as the Getting Needed Care composite for HW19 Child and HW21 Child populations and the How Well Doctors Communicate composite for HW21 Child population. The How Well Doctors Communicate composite was noted as an opportunity for improvement regarding the HW19 Adult population. Regarding the FG Key Drivers for Rating of Health Care, three plan strengths were identified. The first involved the Getting Needed Care composite for the HW19 Child and HW21 Child populations. The second involved the Courteous and Helpful Office Staff for the HW21 Child population. The third involved the How Well Doctors Communicate composite for the HW21 Child population. The How Well Doctors Communicate was noted as an opportunity for improvement regarding the HW19 Adult population.

Additional information was requested from FG regarding their level of agreement with the conclusions and recommendations for improvement. FG provided a response indicating a Member Satisfaction Workgroup had been working to develop recommendations and a work-plan to present to their Quality Management Leadership Team (QMLT). This workgroup met with TMG on several occasions to identify opportunities for improvement. The work-plan was approved by the QMLT in October 2006. In addition, FG noted their CLAS (Cultural and Linguistically Appropriate Services) Workgroup reviewed the 2006 CAHPS results. The CLAS Workgroup is responsible for assessment of the CAHPS results pertaining to the profile of survey respondents, segmentation analysis by race and ethnicity and survey question regarding the degree of difficulty in finding a personal doctor who met the member's special cultural and/or spoken language needs. Discussions with FG on November 03, 2006 confirmed the workgroups had developed a work-plan, which was presented to and approved by QMLT.

KFMC conclusions regarding FG CAHPS methodology

Overall, the FG CAHPS methodology was adequate. One area identified in this report, the stratified random sampling process used to select the child populations, appeared to be reflective of inadequate documentation. A second area involving an incorrect disposition code for the child population appeared to be a documentation error. A third area involved lack of assessment of the survey findings and included issues related to sampling error, volume of survey responses to individual questions, non-response bias and interpretation of segmentation analysis.

KFMC conclusions regarding comparisons

Access to Care

Overall, the FG HW19 and HW21 populations were more satisfied than the corresponding HCK populations regarding their access to care. The most pronounced FG strength compared to HCK was noted in the area of delays in care while awaiting plan approval. The HW19 and HW21 Combined Child populations were more satisfied than the NCBD population regarding getting the care, tests and treatments needed.

Quality of Care

There was little difference in the levels of satisfaction between the HW19, HW21 and HCK populations regarding the quality of care they received. There were two differences in satisfaction between the HW19 and HW21 Combined Child populations. The two areas involved providers spending enough time with you and office staff being courteous and respectful. In both instances, the HW21 Combined Child population was more satisfied than the HW19 Combined Child population. All FG populations expressed dissatisfaction with their provider and specialist. All FG populations, except the HW21 General Child population, expressed dissatisfaction with their health care.

Timeliness of Care

The HW19 General and CCC populations were less satisfied than the HCK population with their ability to get appointments when care was not needed right away. HW19 adult,

Combined Child, General Child and CCC populations expressed dissatisfaction with their ability to get appointments when care is needed right away, and when it is not. The HW21 General and CCC populations were more satisfied with their ability to get appointments when care was needed right away than HCK. The HW21 Combined Child population was more satisfied with their ability to get an appointment when care was needed right away than the HW19 Combined Child population. All FG populations expressed dissatisfaction with the attribute related to being taken to the exam room within 15 minutes of their appointment and with their ability to get an appointment when care was not needed right away.

CCC Module

The HW19 CCC population was more satisfied with getting treatment or counseling than the HCK CCC population. The HCK, HW19 CCC and HW21 CCC populations expressed satisfaction with providers understanding how a condition affects the child's day-to-day life. The HCK, HW19 CCC and HW21 CCC populations expressed dissatisfaction with coordination of care among providers or services. The HW19 CCC population was more satisfied than the HCK CCC population with coordination of care among providers or services. The HW21 CCC population was less satisfied than the HCK CCC population with coordination of care among providers or services.

RECOMMENDATIONS

Future surveys

Per KHPA, no recommendations are made due to FirstGuard's transition out of the managed care contract.

Improving access, quality and timeliness of care

Per KHPA, no recommendations are made due to FirstGuard's transition out of the managed care contract.

FirstGuard CAHPS Validation with NCBD/Cross Program Comparison
Kansas Foundation for Medical Care, Inc.
November 2006

Objectives

As the External Quality Review Organization (EQRO) for the State of Kansas, the Kansas Foundation for Medical Care, Inc. (KFMC) was contractually required to validate FirstGuard's (FG) Consumer Assessment of Healthcare Providers and Systems (CAHPS), conducted in 2006. The objectives were to determine if the survey was administered in a methodologically sound manner and to assess the reliability and validity of its findings. In evaluating the technical methods and results from the FG CAHPS reports, KFMC used, as a guide, the Validating Surveys Protocol provided by The Centers for Medicare and Medicaid Services (CMS). The protocol states the purpose of the survey is to provide information not available through clinical or administrative means and to capture respondent perceptions of access to care and quality of health services. This information is used for the EQRO assessment of the access, quality, and timeliness of health care services provided to Medicaid beneficiaries enrolled in FirstGuard Health Plan.

Activity 7 of the Validating Surveys Protocol, includes a step for providing comparative information as directed by the State. KFMC's contract with the State includes a cross program comparison of FG and HealthConnect Kansas (HCK) CAHPS results, as well as comparing FG and HCK CAHPS results to the National CAHPS Benchmarking Database (NCBD) results. The objectives were to identify any cross program differences between FG and HCK and to compare each program to NCBD to identify opportunities for improvement. This comparative information provided further data for the EQRO assessment of access, quality, and timeliness of care provided to beneficiaries enrolled in FG.

Technical Methods of Data Collection and Analysis

The Meyers Group

The Meyers Group (TMG), an NCQA-Certified HEDIS Survey Vendor, was selected by FG to conduct the 2006 CAHPS Survey. As a certified vendor, TMG is required to adhere to the NCQA HEDIS Specifications for Survey Measures. FG has contracted with TMG to administer the CAHPS survey for the past 7 years. The findings were provided in 3 separate reports representing the following 5 population categories: Healthwave 19 Adult; HealthWave 19 General Child and Healthwave 19 Child with Chronic Conditions (HW19 CCC); and Healthwave 21 General Child and HealthWave 21 Child with Chronic Conditions (HW21 CCC). The CCC population was identified using the CAHPS Chronic Conditions Screener as specified by the National Committee for Quality Assurance (NCQA).

FG prepared the database for sampling. The preparation included quality control checks on records to ensure continuous enrollment and eligibility criteria were met. In addition, a sample of the database was reviewed by Ernst and Young, FG's HEDIS Compliance Auditor. FG provided KFMC a copy of the memo from Ernst and Young stating the appropriate audit protocols were

followed and the source code used to produce the files and samples of the output confirmed the required data elements were included. Once the database was deemed appropriate, FG provided it to TMG.

Demographic profiles were provided for each of the five survey populations. Demographic comparisons of survey respondents were made to benchmarks and last year's results based on gender, age, education, duration in plan, health status and race/ethnicity. The Adult and General Child populations were compared to appropriate NCQA benchmarks, while the CCC populations were benchmarked to their respective General Child populations. Statistical significance was calculated for the trend comparisons for all populations. Statistical significance was calculated for benchmark comparisons for the HW19 Adult, HW19 General Child and HW21 General Child populations. Statistical significance was calculated at the 0.05 level of significance. FG's CLAS (Cultural and Linguistically Appropriate Services) Workgroup reviews report results regarding the profile of survey respondents, segmentation analysis by race/ethnicity and the question regarding finding a provider who met their cultural and or spoken language needs. Demographic comparisons of FG survey respondents to FG non-respondents were not completed. This would help identify potential non-response bias.

Four-year trend comparisons of survey results were provided for each of the five survey populations. The trending reflected statistical comparison of the 2006 results to the 2005, 2004 and 2003 results for the composite, composite attribute and rating scores. Statistical significance was calculated at the 0.05 level of significance.

Benchmarking comparisons of survey results were provided for each of the five survey populations. For the HW19 Adult population, comparisons were done using 2005 Quality Compass data as the benchmark for the composite, composite attribute and rating scores. For the HW19 General Child and HW21 General Child populations, comparisons were done using 2005 CAHPS Booklet data as the benchmark for the composite, composite attribute and rating scores. For the HW19 CCC and HW21 CCC populations, comparisons were done using 2005 CAHPS CCC Benchmark data as the benchmark for the composite and rating scores. Composite attribute benchmark data was not available for the CCC populations. The comparisons included testing for statistical significance, which was calculated at the 0.05 level of significance. The HW19 CCC and HW21 CCC populations were also compared to their respective HW19 and HW21 general populations using the composite, composite attribute and rating scores. Statistical significance was not calculated for these comparisons since the general populations and the CCC populations are not mutually exclusive.

The reports provided global proportions for each of the five survey populations. The global proportion tables were reflective of the distribution of responses, by response categories for the composite attribute and rating questions. In addition, the member satisfaction summary portion of the report contained tables providing the distribution of responses for each survey question as well as the results of the statistical significance testing for the trends and benchmarks.

Member satisfaction segmentation analysis tables were provided for each of the five survey populations. These tables stratified the findings of the composite, composite attribute and rating questions by age, respondent education, mode of response (mail or telephone), health status, race

and ethnicity. In addition, the tables provided a range value, which represented the difference in scores between segment groups.

Opportunity analysis was provided for Rating of Health Plan and Rating of Health Care, to identify key drivers of satisfaction for the HW19 Adult, HW19 General Child and the HW21 General Child populations. This process involved use of a multiple linear regression analysis model. The dependent variable was the rating question. The independent variables were the five respondent-level composite variables and indicator variable for the health plan. The composite variables, found to have a significant positive influence (as determined by testing individual beta coefficients with a 0.05 level of significance) on overall satisfaction, were reported as key drivers of overall satisfaction. The composite variables with the highest betas were determined to be key drivers. The higher the beta score, the larger the effect the composite has on overall satisfaction.

Beta correlation coefficients were generated based on comparisons to the 2005 Quality Compass for Adults and the 2005 CAHPS Booklet for the General Child populations. Key drivers of satisfaction were classified into three action categories based on their beta scores. The first category was Plan Strength (market and maintain), which was determined by having a significantly higher score than the comparison (Quality Compass or CAHPS Booklet). The second category was Monitor, which was determined by not being significantly different than the comparison. The third category was Plan Opportunity (investigate and improve), which was determined by having a significantly lower score than the comparison. Key drivers of satisfaction were not calculated for the HW19 CCC and HW21 CCC Child populations. However, beta correlation coefficients were calculated based on comparison to their respective HW 19 and HW21 General Child populations.

Banner tables were provided in the reports to show the detailed results for *each* survey question. Responses were stratified by age, education, duration in health plan, ethnicity, race and whether the responses were gathered by mail or phone. The tables also contain the distribution of responses for each question, the outcome of the individual Z-test for percentages, and the outcome of the statistical significance testing.

Technical notes were included in each report to provide additional information regarding survey administration, question categories and statistical methods.

KFMC's Validation of FirstGuard CAHPS

To ensure a survey produces valid and reliable results, it must be designed and administered in a methodologically sound manner. CAHPS is a survey tool developed to assess consumer satisfaction and member experiences with their health plan. It is a nationally standardized survey tool sponsored by the Agency for Health Care Research and co-developed with NCQA. The tool and survey process has undergone extensive tests for reliability and validity, and subsequent revisions, resulting in detailed technical specifications to be used in conducting the survey. In order to be a dependable source of information, it must be administered according to the CAHPS technical specifications. CAHPS surveys, administered properly, provide information regarding the access, quality and timeliness of health care services provided to Medicaid beneficiaries.

FG provided KFMC with the three CAHPS reports completed by TMG. KFMC evaluated the reports in accordance with the steps outlined in Activities 1 - 7 in the CMS Validating Surveys Protocol to determine the methodological soundness of the surveys. The protocol instructs the administrator, if using the CAHPS survey, to follow the CAHPS Survey and Reporting Kit, which is a step-by-step instruction for sampling, administration, analysis and reporting. Since the MCO/State contract specifies use of the CAHPS survey, the CAHPS technical specifications were referred to throughout the validation process. Overall the CAHPS technical specifications are consistent with the CMS protocol. The findings were documented on the CMS Validating Surveys Worksheet. The direction provided in the protocol assisted in identifying areas of concern involving the validity and reliability of the survey results. KFMC's Health Data Analyst conducted the analysis and evaluation to determine the degree of validity and reliability of the survey results and level of accuracy by which the access, quality and timeliness of health care could be judged.

KFMC stratified composite attribute and rating questions into categories measuring access to care, quality of care and timeliness of care. These categories are noted below.
Attribute questions used to assess access to care were:

- Getting a provider you are happy with.
- Seeing a specialist.
- Getting the care tests or treatments necessary.
- Delays in care while waiting for approval.

Attribute and rating questions used to assess quality of care were:

- Doctors listening carefully.
- Doctors showing respect for what you have to say.
- Doctors spending enough time with you.
- Office staff treating you with courtesy and respect.
- Rating of health care.
- Rating of specialist.
- Rating of personal doctor.

Attribute questions used to assess timeliness of care were:

- Obtaining care right away for an illness, injury or condition.
- Obtaining care when wanted, not when needed.
- Waiting time in doctor's office.

Using findings reported by TMG, strengths and weaknesses were assessed in the areas of access, quality and timeliness of care. (TMG used the NCQA protocol for calculating most positive response which is based on "Usually and Always," "Not a Problem" and "8, 9 and10.") The assessment was based on the most positive response scores to individual survey questions/ratings and involved two comparisons. Strengths were identified as statistically significant increases in most positive response scores respective to both the trend and the benchmark, or a summary score of greater than 90%. Strengths represent higher satisfaction. Weaknesses were identified as statistically significant decreases in most positive response scores respective to both the trend and benchmark, or a summary score of less than 70%. Weaknesses represent lower satisfaction.

Furthermore, the NCBD and cross program comparison data was used to identify strengths and opportunities for improvement. NCBD results for FG and HCK were compared to the NCBD child and adult benchmarks for composite attribute and rating questions. NCBD combines the

General Child and CCC populations for reporting purposes. NCBD results for questions unique to the CCC population (Access to Prescription Medication/Specialized Services and Family Centered Care Module) were not available. Therefore, data from the HCK and TMG reports were used for comparison of questions unique to the CCC population. There are 16 composite attributes, 4 rating questions, and 20 questions unique to the CCC population. In addition, this report provides the results of attribute and rating comparisons between HW19 and HCK Adult populations and HW19, HW21 and HCK Child populations, including stratification of members in the General Child and CCC groups.

FG provided KFMC with their 2006 HW19 and HW21 NCBD Sponsor reports. The findings contained in these reports were compared to those in the 2006 HCK NCBD Sponsor reports. The NCBD reports provided comparison to national, regional, and plan type benchmarks. The Midwest Region, which was used for comparison in this report, is comprised of 12 mid-western states. The NCBD adult Medicaid database consisted of CAHPS survey data from 43,175 survey respondents distributed over 119 health plans. The NCBD child Medicaid database consisted of CAHPS survey data from 50,204 survey respondents distributed over 95 health plans. The NCBD State Children's Health Insurance Program (SCHIP) database consisted of CAHPS survey data from 9,303 survey respondents distributed over 30 health plans. No Primary Care Case Management (PCCM) data was provided in the NCBD adult and child reports. In addition, no Midwest Region data was provided for the HW21 population. Differences were noted in the number of valid responses to individual questions between the NCBD reports, TMG reports and the HCK report. Possible reasons for these differences were NCBD running the survey files through the CAHPS macro, file cleaning and case mix adjustment of the files.

Statistical comparisons of FG's and HCK's results were made to the NCBD results to identify statistically significant differences. All scores represent the most positive responses in each category: "Always," "Not a Problem," or "9 and 10." KFMC stratified the FG CCC data by program (HW19 and HW21) to allow for program comparison. The method of significance testing used by KFMC to compare HCK, HW19 and HW21 response scores was slightly different than the one used by NCBD. NCBD tested the mean of the product means while KFMC tested proportions. An alternative testing method was used by KFMC since the product mean information was not made available. Both methods are statistically valid and yield nearly identical results.

KFMC stratified composite attribute and rating questions into categories measuring access to care, quality of care and timeliness of care using the same categories listed under KFMC's Validation of FG CAHPS on the previous page of this report.

Strengths and weaknesses were assessed based on most positive response scores ("Always," "Not a Problem," or "9 and 10.") to individual survey questions/ratings and involved four comparisons using 2006 CAHPS data. The first involved statistical comparison of FG's composite attribute and rating scores to the NCBD results. The second involved statistical comparison of FG's composite attribute and rating scores to the HCK results. The third involved statistical comparison of FG's attribute and rating scores for their HW19 and HW21 child populations. The fourth involved statistical comparison of HCKs' composite attribute and rating scores to the NCBD results. The NCBD benchmarks included National, Midwest Region and HMO/POS programs. HCK is a Primary Care Case Management (PCCM) program, but the

NCBD data did not contain PCCM program results to compare to the HCK results. FG, being a Health Maintenance Organization, was compared to the NCBD HMO/POS data. FG strengths were identified as those areas with statistically significantly higher results in the most positive response scores. Strengths represent higher satisfaction than compared populations. FG weaknesses were identified as those areas with statistically significantly lower results in the most positive response scores. Weaknesses represent lower satisfaction than compared populations. The comparisons were based on statistically significant differences between FG, NCBD and HCK as well as statistically significant differences between the HW19 and HW21 programs.

To enhance identification of differences, tables were created to reflect the statistical testing outcome. These tables, labeled "2006 Adult CAHPS Comparison," "2006 Child CAHPS Comparison," and "2006 CCC CAHPS Comparisons," are located in Attachment A. The tables contain the following symbol definitions necessary for interpretation:

- An up arrow represents statistically significantly more favorable results.
- A down arrow represents statistically significantly less favorable results.
- A dash represents no statistically significant differences.
- An asterisk represents no comparisons could be made due to unavailable NCBD PCCM data.

The symbols apply to the first and bolded name in the comparison column. If FG is the first bolded name then the symbol value below applies to FG for that question. The example below provides the following information regarding Question 7 "Not a Problem" response:

- FG exhibited a more favorable rating compared to HCK (.05 level of significance), meaning FG consumers had less of a problem finding a doctor or nurse they were happy with.
- HCK exhibited a less favorable rating compared to MW Reg. and Nat. Avg. (.05 level of significance), meaning HCK consumers had more of a problem finding a doctor or nurse they were happy with. FG ratings were not statistically different than the HMO Avg., the MW Reg. Avg. or the Nat'l Avg.

↑ = more favorable response ↓ = least favorable response — = no statistical significant differences were found between response rates FG = FirstGuard Health Plan HCK = HealthConnect Kansas		Response Measured	**FG** vs HCK	**FG** vs HMO Avg.	**FG** vs MW Region Avg.	**FG** vs Nat'l. Avg.	**HCK** vs MW Region Avg.	**HCK** vs Nat'l Avg.
Getting Needed Care								
Q7	Since you joined your health plan, how much of a problem, if any, was it to get a personal doctor or nurse you are happy with?	Not a problem	↑	—	—	—	↓	↓

The completed Survey Validation Worksheet from the EQR Protocol Tool is provided as Attachment B. Since this is the third year for FG's assessment to be based on the EQR Protocol, full compliance is expected.

Description of Data (Findings)

The Meyers Group Findings

TMG identified strengths and opportunities for improvement by comparing FG's composites and ratings to Quality Compass (Adults) and CAHPS Booklet (General Child) in order to determine their impact upon Rating of Health Care and Rating of Health Plan. TMG reported these findings as key drivers of satisfaction. Regarding Overall Rating of Health Plan, TMG reported the following findings in the three action categories:

Plan Strength (market and maintain).

- Getting Needed Care (HW19 Child and HW21 Child).
- How Well Doctors Communicate (HW21 Child).

Monitor.

- Getting Needed Care (HW19 Adult).
- How Well Doctors Communicate (HW19 Child).
- Customer Service (HW19 Adult, HW19 Child and HW21 Child).

Plan Opportunity (investigate and improve).

- How Well Doctors Communicate (HW19 Adult).

Regarding Overall Rating of Health Care, TMG reported the following findings in the three action categories:

Plan Strength (market and maintain).

- Getting Needed Care (HW19 Child and HW21 Child).
- Courteous and Helpful Office Staff (HW21 Child).
- How Well Doctors Communicate (HW21 Child).

Monitor.

- Getting Needed Care (HW19 Adult).
- How Well Doctors Communicate (HW19 Child).
- Courteous and Helpful Office Staff (HW19 Adult and HW19 Child).

Plan Opportunity (investigate and improve).

- How Well Doctors Communicate (HW19 Adult).

KFMC's Evaluation of FirstGuard CAHPS Methodology

The following assessments are based on the CMS Validating Surveys Worksheet protocol activity categories:

Activity 1: Survey Purpose and Objectives

The purpose of the survey was identified in the four child reports as "assist in identifying member satisfaction strengths and opportunities." The purpose reflected in the adult

report was, "to assist in identifying member satisfaction strengths and opportunities, and aid in assessing NCQA accreditation standings." The reports did not contain specific study objectives. However, upon request, FG provided additional information containing the following six specific study objectives:

- To meet the state's contractual requirements regarding surveys of HealthWave19 and 21 members.
- To assess the degree of loyalty of surveyed members with the addition of the custom question, "Would you recommend FirstGuard to your family or friends?"
- To monitor the awareness level of two FG services, NurseWise and The Guardian Angel Program.
- To determine whether the degree of member satisfaction as assessed in the attributes, composites and ratings changed statistically from 2005 to 2006, from 2004 to 2006 and from 2003 to 2006.
- To determine the areas of health care and health plan service for which members rate FirstGuard significantly different from the national Medicaid average.
- To determine the level of satisfaction of members with the access, quality and/or timeliness of their health care according to the timeframe specified by the HEDIS 2006 technical specifications (a six month period immediately preceding receipt of the survey). Access, quality and/or timeliness of health care are identified through specific attribute questions and rating questions in the CAHPS 3.0H survey tool.

The objectives were clear and measurable.

Activity 2: Survey Audience

The reports implied the survey audience was the health plan. Additional information was provided by FirstGuard which confirmed the entire health plan staff, the physician QM/UM/Credentialing Committee, the Board of Directors, and other Centene Corporation health economics and quality staff were considered the health plan audience. FirstGuard also noted the Kansas Health Policy Authority (KHPA), network providers, and FirstGuard members were considered intended audiences. Based on FG's additional information, all survey audiences appear to have been identified.

Activity 3: Survey Instrument

The CAHPS 3.0H survey tools were used for the 2006 CAHPS survey. The CAHPS 3.0H Adult Medicaid Questionnaire was used for the HW19 Adult population and the CAHPS 3.0H Child Medicaid Questionnaire (with Children with Chronic Conditions [CCC] Measurement Set) was used for the HW19 and HW21 Child populations. These survey tools were also used for the 2005 CAHPS survey. The CAHPS survey instruments and reporting formats have undergone rigorous testing for reliability and validity, including focus group interviewing, cognitive interviewing, and field-testing. As allowed by CAHPS, FG included plan specific questions at the end of the surveys.

Activity 4: Sampling Plan

The study populations were identified in each of the reports; however, no specific sample frame was provided for the HW19 Adult population. The sample frames in each of the child reports included the age range and claims query for probable chronic conditions, but

did not specify the use of enrollment criteria in sample frame development. The age range for the child populations were identified as 0-17 years, but did not specify that 17 year olds needed to be 17 as of December 31st of the measurement year. The sampling strategy (random, stratified random) was noted in each of the reports and sample sizes were consistent with NCQA HEDIS specifications. However details regarding the sample selection process were not provided, such as determination of current enrollment, defining the eligible population, de-duplication to avoid members in the same household being surveyed, and application of the pre-screening algorithm to identify the CCC populations.

Additional information was requested from FG regarding the concerns involving the sampling plan. The additional information verified the sample frames, sampling strategy and the sampling processes were appropriate for all study populations. The additional information also verified the sample selection processes were sound for the HW19 Adult population, but did not contain the level of detail necessary to verify the sample selection processes were sound for the HW19 and HW21 Child populations.

Activity 5: Response Rate

TMG administered the survey using a 5-wave mixed methodology, which included two questionnaire mailings, two reminder postcards, and three telephone follow-ups. The timing of each of these activities was specified in the Technical Notes section of the reports. The surveys were administered according to HEDIS CAHPS protocol.

The reports defined a completed survey as being 80% completed. The reports also defined ineligible members as including those who are deceased, do not meet the eligible population criteria, have a language barrier, or are either mentally or physically incapacitated. This is consistent with the HEDIS protocol for the adult population, but not the child population as defined in *HEDIS 2006 Specifications for Survey Measures*, HEDIS 2006, Volume 3, page 70. This reference states mental or physical incapacitation is not a valid disposition code for the CAHPS 3.0H Child Survey. The HW19 Adult, HW19 General Child and HW21 General Child reports contain tables listing the number of ineligible members in each of the four disposition categories. The HW19 General Child and HW21 General Child ineligible member tables do not identify any members in the mentally or physically incapacitated category.

The reported response rates were HW19 Adult (28.3%), HW19 General Child (41.0%), HW21 General Child (47.4%). The response rates were adjusted and calculated according to the HEDIS CAHPS protocol. Response rates were not calculated for the HW19 CCC and HW21 CCC populations since the general child population data sets and the CCC population data sets do not represent mutually exclusive groups.

According to the NCQA HEDIS specifications, MCOs must achieve a minimum of 411 completed surveys, or 100 responses for each HEDIS survey question to report HEDIS survey results for that question. The target number of completed surveys was not met for the HW19 Adult population (371), but was met for the HW19 Child General population (654) and the HW21 Child General population (734). The reports do not include

discussion regarding the required 100 responses for each HEDIS survey question. Review of the question frequencies for the composite attribute and rating questions reveal at least 100 valid responses per question for the HW19 General Child, HW21 General Child and HW21 CCC populations. The HW19 Adult and CCC populations indicated less than 100 responses for 1 question. This question was the same for both groups and involved their level of understanding of information in the written materials or on the Internet. The reports reflected 98 responses for this question by each population.

TMG included sampling error tables in each of the 5 reports, but did not calculate the sampling error for any of the populations. FG was asked if sampling error was calculated to determine the confidence of the survey findings and degree of generalizeability of the survey results. FG responded stating TMG followed the NCQA protocol for sample selection and data collection, which are designed to achieve responses that are representative of the health plan's population.

No potential sources of non-response bias were identified in the reports. FG was asked if any sources of non-response bias were identified. FG responded by quoting the CMS Validating Survey protocol as follows, "Medicaid beneficiaries have a low survey response rate." FirstGuard also indicated they reviewed the categories of non-response reported by The Meyers Group, "refused to participate" and "maximum attempts made to contact beneficiary without success." FirstGuard noted the category representing the largest number of members was "maximum attempts made to contact beneficiary without success." Regarding this category, Firstguard stated it was difficult to accurately determine the extent of the bias due to the member's unwillingness to communicate with the health plan.

Activity 6: Review of Data Preparation and Analysis

The reports do not contain reference to quality control procedures for the following:

- Survey administration
- Receipt of survey data
- Respondent information and assistance
- Coding, editing and entering data
- Missing data
- Data that fails edits

Additional information was requested and received from FG regarding the quality control procedures noted above. Review of the additional information verified appropriate quality control procedures were in place.

As a NCQA-Certified HEDIS Survey Vendor, TMG was responsible for submitting clean member-level data files to NCQA for calculation of HEDIS survey results, in accordance with the HEDIS survey file layouts. The reports do not contain discussion regarding the data preparation plan. The reports describe various methods used to identify statistical significance and opportunities for improvement including: multi-linear regression analysis, correlation analysis, hypothesis testing, frequency distributions of survey questions, Z-test, mean of means method to evaluate composite scores, segmentation analysis based on respondent demographic information, key and secondary driver

quadrant analysis, and attribute analysis of composites. Additional information was requested and received from FG regarding the data preparation and analysis plans. Review of the additional information verified the existence of data preparation and analysis plans, both of which were methodologically sound.

The reports were based on standard CAHPS reporting format and provided understandable and relevant data to assess satisfaction including demographic analysis, trending, benchmarking, member satisfaction segmentation analysis, and opportunity/key driver analysis for Rating of Health Plan and Rating of Health Care.

Activity 7: Documentation of Validation of Survey

The following represents an assessment of technical methods of validation of survey implementation and analysis:

Strengths

- Use of a 5-wave survey administration protocol.
- Use of a reliable analysis program (NCQA).
- Demographic analysis.
- Trending.
- Benchmarking.
- Key driver analysis for the Adult and two General Child populations.
- Member satisfaction segmentation analysis.

Limitations

Lack of survey methodology documentation doesn't necessarily mean the surveys were done incorrectly. However, if some of these things were indeed not done, or were not done according to the NCQA HEDIS specifications, comparisons to national rates or benchmarks may be invalid. Of particular importance regarding comparability are:

- Lack of detailed documentation regarding the stratified random sampling process used for the child populations.

Generalizability

The ability to draw inferences to the overall HW19 and HW21 populations based on the survey findings may not be valid due to some of the issues previously identified as weaknesses of survey implementation and analysis. Of particular importance regarding generalizability are:

- Lack of documentation of sampling error relating to categories identified in key driver/opportunity analysis.
- Lack of assessment of potential sources on non-response bias.
- Incomplete interpretation of segmentation analysis regarding implications for key driver/opportunity analysis findings.
- Less than 100 valid responses for the HW19 Adult and CCC population regarding the Customer Service composite attribute involving level of understanding of information in the written materials and on the internet.

Comparative Information

The following represents the comparison of FG results to NCQA benchmarks, FG's previous year's results and HCK results. Furthermore, comparisons to NCBD were made

for HW19 Adult, HCK Adult, HW19 Combined Child, HW21 Combined Child and HCK Combined Child populations. In addition, the 2006 HCK CAHPS results were compared to the 2005 HCK CAHPS (noted in report as 2005) results. The table also captures areas where FG and HCK scores were less than 70% or greater than 90%, based on most positive responses of "Not a Problem," "Always" and "9 or 10." The top row of the table identifies the populations and far left column identifies the CAHPS survey questions relating to access, quality and timeliness. The ↑ arrow specifies a statistically significantly higher score than the comparison population. The ↓ arrow specifies a statistically significantly lower score than the comparison population.

	HW19			Combined Child		HW21		HCK			
	Adult	**General Child**	**CCC**	**HW19**	**HW21**	**General Child**	**CCC**	**Adult**	**General Child**	**CCC**	**Combine Child**
ACCESS											
Getting Provider You are Happy With	< 70%				↓NCBD			< 70% ↓NCBD			
Getting a Referral to Specialist	< 70%	↑ NCQA						< 70%	↑ 2005		↑ NCBD
Getting care, tests, treatments as needed		↑ NCQA		↑ NCBD	↑ HCK ↑ NCBD	↑ NCQA					↓HW21
Delays in HealthCare while Waiting Plan Approval	<70% ↑ NCQA	> 90% ↑ HCK ↑ NCQA	> 90% ↑ HCK	<70%	<70%	> 90% ↑ HCK ↑ NCQA	> 90% ↑ HCK	<70%	<70% ↓HW19 ↓HW21	↓HW19 ↓HW21	<70%
Quality of Care											
Providers listening carefully	<70%	↓2005		↓NCBD		↑ NCQA		< 70% ↓NCBD			
Providers showing respect	<70%					↑ NCQA		<70% ↓NCBD	↑ 2005		
Providers spending enough time	<70%	<70% ↓HW21	<70%	<70% ↓HW21	<70% ↑ HCK ↑ NCBD ↑ HW19	<70% ↑ HW19 ↑ NCQA	<70%	<70%	<70%	<70% ↑ 2005	<70% ↓HW21 ↓NCBD
Office staff courteous and respectful				↓NCBD ↓HW21	↑ HCK ↑ NCBD ↑ HW19	↑ HCK		<70% ↓NCBD	↓HW21		↓HW21
Rating of provider	<70%	<70% ↓2005	<70%	<70%	<70%	<70%	<70%	<70%	<70%	<70%	<70%
Rating of specialist	< 70% ↓NCQA	< 70%	< 70%	< 70%	< 70% ↓HCK	< 70%	< 70% ↓HCK	< 70%	< 70%	↑ HW21 ↑ 2005	< 70% ↑ HW21 ↑ NCBD
Rating of health care	< 70%	< 70% ↓HW21	< 70%	< 70%	< 70% ↑ NCBD	↑ HW19 ↑ NCQA	< 70% ↑ NCQA	< 70%	< 70%	< 70%	< 70%

	HW19			Combined Child		HW21		HCK			
	Adult	**General Child**	**CCC**	**HW19**	**HW21**	**General Child**	**CCC**	**Adult**	**General Child**	**CCC**	**Combine Child**
Timeliness of Care											
Getting an appointment when care not needed right away	< 70%	< 70% ↓HCK	< 70% ↓HCK	< 70%	< 70% ↑ NCBD	< 70% ↑ NCQA	< 70%	< 70%	↑ HW19 ↑ 2005	↑ HW19 ↑ 2005	< 70%
Getting an appointment when care needed right away	< 70%	< 70% ↓HW21	< 70%	< 70% ↓HW21	↑ NCBD ↑ HW19	↑ HCK ↑ NCQA ↑ HW19	↑ HCK	< 70% ↓NCBD	< 70% ↓HW21	< 70% ↓HW21	
Taken to exam room within 15 minutes of appointment	< 70% ↓HCK ↓NCBD	< 70% ↑ NCQA	< 70%	< 70%	< 70% ↑ HCK	< 70% ↑ NCQA	< 70% ↑ 2005	< 70% ↑ FG	< 70%	< 70%	< 70% ↓HW21 ↓NCBD
CCC Module											
Getting prescription medicines											
Getting treatment or counseling			↑ HCK							↓HW19	
Provider understands how condition affects child's day to day life			> 90%				> 90%			> 90%	
Coordination of care among providers or services			< 70% ↑ HCK				< 70% ↓HCK			> 70% ↓HW19 ↑ HW21	

Conclusions

FG/TMG Conclusions

Regarding the FG Key Drivers for Rating of Health Plan, plan strengths were identified as the Getting Needed Care composite for HW19 Child and HW21 Child populations and the How Well Doctors Communicate composite for HW21 Child population. The How Well Doctors Communicate composite was noted as an opportunity for improvement regarding the HW19 Adult population. Regarding the FG Key Drivers for Rating of Health Care, three plan strengths were identified. The first involved the Getting Needed Care composite for the HW19 Child and HW21 Child populations. The second involved the Courteous and Helpful Office Staff for the HW21 Child population. The third involved the How Well Doctors Communicate composite for the HW21 Child population.

Additional information was requested from FG regarding their level of agreement with the conclusions and recommendations for improvement. FG provided a response indicating a Member Satisfaction Workgroup had been working to develop recommendations and a work-plan to present to their Quality Management Leadership Team (QMLT). This workgroup met with TMG on several occasions to identify opportunities for improvement. The work-plan was approved by the QMLT in October 2006. In addition, FG noted their CLAS (Cultural and Linguistically Appropriate Services) Workgroup reviewed the 2006 CAHPS results. The CLAS Workgroup is responsible for assessment of the CAHPS results pertaining to the profile of survey respondents, segmentation analysis by race and ethnicity and survey question regarding the degree of difficulty in finding a personal doctor who met the member's special cultural and/or spoken language needs. Discussions with FG on November 03, 2006 confirmed the workgroups had developed a work-plan, which was presented to and approved by QMLT.

KFMC conclusions regarding FG CAHPS methodology

Overall, the FG CAHPS methodology was adequate. One area identified in this report, the stratified random sampling process used to select the child populations, appeared to be reflective of inadequate documentation. A second area involving an incorrect disposition code for the child population appeared to be a documentation error. A third area involved lack of assessment of the survey findings and included issues related to sampling error, volume of survey responses to individual questions, non-response bias and interpretation of segmentation analysis.

KFMC conclusions regarding comparisons

Access to Care

Overall, the FG HW19 and HW21 populations were more satisfied than the corresponding HCK populations regarding their access to care. The most pronounced FG strength compared to HCK was noted in the area of delays in care while awaiting plan approval. The HW19 and HW21 Combined Child populations were more satisfied than the NCBD population regarding getting the care, tests and treatments needed.

Quality of Care

There was little difference in the levels of satisfaction between the HW19, HW21 and HCK populations regarding the quality of care they received. There were two differences in satisfaction between the HW19 and HW21 Combined Child populations. The two areas involved providers spending enough time with you and office staff being courteous and respectful. In both instances, the HW21 Combined Child population was more satisfied than the HW19 Combined Child population. All FG populations expressed dissatisfaction with their provider and specialist. All FG populations, except the HW21 General Child population, expressed dissatisfaction with their health care.

Timeliness of Care

The HW19 General and CCC populations were less satisfied with their ability to get appointments when care was not needed right away than HCK populations. HW19 adult, Combined Child, General Child and CCC populations expressed dissatisfaction with their

ability to get appointments when care is needed right away, and when it is not. The HW21 General and CCC populations were more satisfied than the HCK population with their ability to get appointments when care was needed right away. The HW21 Combined Child population was more satisfied with their ability to get an appointment when care was needed right away than the HW19 Combined Child population. All FG populations expressed dissatisfaction with the attribute related to being taken to the exam room within 15 minutes of their appointment and with their ability to get an appointment when care was not needed right away.

CCC Module

The HW19 CCC population was more satisfied with getting treatment or counseling than the HCK CCC population. The HCK, HW19 CCC and HW21 CCC populations expressed satisfaction with providers understanding how a condition affects the child's day-to-day life. The HCK, HW19 CCC and HW21 CCC populations expressed dissatisfaction with coordination of care among providers or services. The HW19 CCC population was more satisfied than the HCK CCC population with coordination of care among providers or services. The HW21 CCC population was less satisfied than the HCK CCC population with coordination of care among providers or services.

Recommendations

Future surveys

Per KHPA, no recommendations are made due to FirstGuard's transition out of the managed care contract.

Improving access, quality and timeliness of care

Per KHPA, no recommendations are made due to FirstGuard's transition out of the managed care contract.

Degree to Which MCO Addressed Previous Recommendations

Technical reporting

Two of the eight recommendations made during the previous CAHPS Validation report were acted upon. The first implemented recommendation involved use of the CMS protocol as a guide to ensure all documentation elements are provided. The second implemented recommendation involved providing information regarding plans to review the survey findings and identify potential opportunities for improvement. The remaining six recommendations for future surveys reports are recommended again and include the following:

- Document all survey audiences.
- Document all sample selection procedures.
- Verify all disposition codes are correct.
- Document the sampling error relating to categories identified in key driver/opportunity analysis.
- Assess and document potential sources of non-response bias.
- Document the interpretation of segmentation analysis regarding the implications for key driver/opportunity analysis findings.

Improving access, quality and timeliness of care

Two FG recommendations were made during the previous CAHPS Validation report involving assessment of areas identified as representing potential opportunities for improvement. FG reported their Quality Management Leadership Team (QMLT) reviewed the 2005 results and determined the need to establish a workgroup to review the 2006 results and bring recommendations for improvement to QMLT. This workgroup met with TMG on several occasions to identify opportunities for improvement. The workgroup developed a work plan that was reviewed and approved by QMLT in October 2006. FG indicated the work plan would not be implemented due to the status of their managed care contract.

Attachment A

Adult

2006 Adult CAHPS Comparisons

↑ = more favorable response (p value < .05)
↓ = less favorable response (p value < .05)
— = no statistical significant difference between response rates
FG = FirstGuard Health Plan
HCK = HealthConnect Kansas
HW 19 = HealthWave 19

		Response Measured	FG(HW19) vs HCK	FG(HW19) vs HMO Avg.	FG(HW19) vs MW Region Avg.	FG(HW19) vs Nat'l. Avg.	HCK vs MW Region Avg.	HCK vs Nat'l Avg.
Getting Needed Care								
Q7	Since you joined your health plan, how much of a problem, if any, was it to get a personal doctor or nurse you are happy with?	Not a problem	69% (235) — 61% (206)	69% (235) — 71% (24430)	69% (235) — 70% (8917)	69% (235) — 71% (25913)	61% (206) ↓ 70% (8917)	61% (206) ↓ 71% (25913)
Q9	In the last 6 months, how much of a problem, if any, was it to get a referral to a specialist that you needed to see?	Not a problem	66% (131) — 63% (168)	66% (131) — 65% (17111)	66% (131) — 66% (5964)	66% (131) — 65% (18178)	63% (168) — 66% (5964)	63% (168) — 65% (18178)
Q24	In the last 6 months, how much of a problem, if any, was it to get the care, tests or treatment you or a doctor believed necessary?	Not a problem	80% (211) — 72% (208)	80% (211) — 75% (21691)	80% (211) — 78% (8283)	80% (211) — 75% (23074)	72% (208) ↓ 78% (8283)	72% (206) — 75% (23074)
Q26	In the last 6 months, how much of a problem, if any, were delays in the health care while you waited for approval from your health plan?	Not a problem	64% (55) — 53% (92)	64% (55) — 57% (10303)	64% (55) — 58% (3390)	64% (55) — 57% (10852)	53% (92) — 58% (3390)	53% (92) — 57% (10852)
Getting Care Quickly								
Q14	In the last 6 months, when you called during regular office hours, how often did you get the help or advice you needed?	Always	58% (252) — 55% (220)	58% (252) — 57% (21642)	58% (252) — 58% (8286)	58% (252) — 57% (23090)	55% (220) — 58% (8286)	55% (220) — 57% (23090)
Q19	In the last 6 months, not counting the times you needed care right away, how often did you get an appointment for health care as soon as you wanted?	Always	48% (267) — 47% (240)	48% (267) — 48% (25662)	48% (267) — 48% (9828)	48% (267) — 48% (27284)	47% (240) — 48% (9828)	47% (240) — 48% (27284)
Q16	In the last 6 months, when you needed care right away for an illness, injury or condition how often did you get care as soon as you wanted?	Always	56% (207) — 48% (167)	56% (207) — 56% (16690)	56% (207) — 57% (6452)	56% (207) — 56% (17715)	48% (167) ↓ 57% (6452)	48% (167) ↓ 56% (17715)
Q27	In the last 6 months, how often were you taken to the exam room within 15 minutes of your appointment?	Always	14% (288) ↓ 21% (262)	14% 288 ↓ 20% (30031)	14% (288) ↓ 22% (11238)	14% (288) ↓ 20% (31870)	21% (262) — 22% (11238)	21% (262) — 20% (31870)

Statistical significance was calculated using the most positive response and calculations were done with the binomial test.

2006 Adult CAHPS Comparisons

↑ = more favorable response (p value < .05)
↓ = less favorable response (p value < .05)
— = no statistical significant difference between response rates
FG = FirstGuard Health Plan
HCK = HealthConnect Kansas
HW 19 = HealthWave 19

		Response Measured	FG(HW19) vs HCK	FG(HW19) vs HMO Avg.	FG(HW19) vs MW Region Avg.	FG(HW19) vs Nat'l. Avg.	HCK vs MW Region Avg.	HCK vs Nat'l Avg.
How Well Doctors Communicate								
Q30	In the last 6 months, how often did doctors or other health providers listen carefully to you?	Always	59% (299) — 55% (260)	59% (299) ↓ 65% (30282)	59% (299) — 63% (11268)	59% (299) — 64% (32126)	55% (260) ↓ 63% (11268)	55% (260) ↓ 64% (32126)
Q32	In the last 6 months, how often did doctors or other health providers explain things in a way you could understand?	Always	64% (296) — 56% (257)	64% (296) — 64% 30265	64% (296) — 63% (11257)	64% (296) — 63% (32103)	56% (257) ↓ 63% (11257)	56% (257) ↓ 63% (32103)
Q33	In the last 6 months, how often did doctors or other health providers show respect for what you had to say?	Always	64% (295) — 58% (257)	64% (295) — 66% (30232)	64% (295) — 64% (11238)	64% (295) — 66% (32069)	58% (257) ↓ 64% (11238)	58% (257) ↓ 66% (32069)
Q34	In the last 6 months, how often did doctors or other health providers spend enough time with you?	Always	49% (295) — 49% (258)	49% (295) — 54% (30256)	49% (295) — 53% (11259)	49% (295) — 54% (32087)	49% (258) — 53% (11259)	49% (258) — 54% (32087)
Courteous and Helpful Office Staff								
Q28	In the last 6 months, how often did office staff at a doctors office or clinic treat you with courtesy and respect?	Always	74% (299) — 68% (262)	74% (299) — 74% (30323)	74% (299) — 74% (11277)	74% (299) — 74% (32170)	68% (262) ↓ 74% (11277)	68% (262) ↓ 74% (32170)
Q29	In the last 6 months, how often were office staff at a doctors office or clinic as helpful as you thought they should be?	Always	59% (292) — 55% (262)	59% (292) — 61% (30258)	59% (292) — 61% (11267)	59% (292) — 61% (32103)	55% (262) ↓ 61% (11267)	55% (262) ↓ 61% (32103)
Customer Service								
Q43	In the last 6 months, how much of a problem, if any, was it to find or understand information in the written materials or on the Internet?	Not a problem	74% (98) ↑ 56% (68)	74% (98) — 70% (9130)	74% (98) — 69% (3282)	74% (98) — 69% (9545)	56% (68) ↓ 69% (3282)	56% (68) ↓ 69% (9545)
Q45	In the last 6 months, how much of a problem, if any, was it to get the help you needed when you called your health plan's customer service?	Not a problem	68% (156) — 57% (95)	68% (156) — 66% (13754)	68% (156) — 67% (4905)	68% (156) — 65% (14368)	57% (95) ↓ 67% (4905)	57% (95) — 65% (14368)

Statistical significance was calculated using the most positive response and calculations were done with the binomial test.

2006 Adult CAHPS Comparisons

↑ = more favorable response (p value < .05)
↓ = less favorable response (p value < .05)
— = no statistical significant difference between response rates
FG = FirstGuard Health Plan
HCK = HealthConnect Kansas
HW 19 = HealthWave 19

		Response Measured	FG(HW19) vs HCK	FG(HW19) vs HMO Avg.	FG(HW19) vs MW Region Avg.	FG(HW19) vs Nat'l. Avg.	HCK vs MW Region Avg.	HCK vs Nat'l Avg.
Q51	In the last 6 months, how much of a problem, if any, did you have with paperwork for your health plan?	Not a problem	80% (128) ↑ 62% (78)	80% (128) — 73% (8101)	80% (128) ↑ 70% (3043)	80% (128) ↑ 72% (8691)	62% (78) — 70% (3043)	62% (78) — 72% (8691)
Ratings								
Q5	Use any number from 0 to 10, where 0 is the worst personal doctor or nurse possible, and 10 is the best. How would you rate your personal doctor or nurse now?	Rating 9-10	57% (291) — 58% (262)	57% (291) — 59% (31057)	57% (291) — 58% (11536)	57% (291) — 59% (32987)	58% (262) — 58% (11536)	58% (262) — 59% (32987)
Q11	Use any number from 0 to 10, where 0 is the worst specialist possible, and 10 is the best personal specialist possible. How would you rate the specialist?	Rating 9-10	51% (124) — 59% (151)	51% (124) — 59% (15206)	51% (124) — 57% (5336)	51% (124) — 59% (16187)	59% (151) — 57% (5336)	59% (151) — 59% (16187)
Q35	Use any number from 0 to 10, where 0 is the worst health care possible, and 10 is the best health care possible. How would you rate all of your health care?	Rating 9-10	55% (295) — 50% (258)	55% (295) — 55% (30181)	55% (295) — 54% (11215)	55% (295) — 55% (32005)	50% (258) — 54% (11215)	50% (258) — 55% (32005)
Q52	Use any number from 0 to 10, where 0 is the worst health plan possible, and 10 is the best health plan possible. How would you rate your health plan now?	Rating 9-10	57% (361) ↑ 46% (326)	57% (361) — 53% (39740)	57% (361) — 52% (14637)	57% (361) — 53% (42118)	46% (326) ↓ 52% (14637)	46% (326) ↓ 53% (42118)

Statistical significance was calculated using the most positive response and calculations were done with the binomial test.

Child

2006 Child CAHPS Comparisons

↑ = more favorable response (p value < .05)
↓ = less favorable response (p value < .05)
— = no statistical significant difference between response rates
FG = FirstGuard Health Plan (HW 19)
HCK = HealthConnect Kansas
HW 19 = HealthWave 19
HW21 = HealthWave 21

		Response Measured	FG(HW19) vs FG(HW21)	FG(HW19) vs HCK	FG(HW21) vs HCK	FG(HW19) vs HMO Avg.	FG(HW21) vs HMO Avg.	FG(HW19) vs MW Region Avg.	FG(HW19) vs Nat'l. Avg.	FG(HW21) vs Nat'l. Avg.	HCK vs MW Region Avg.	HCK vs Nat'l Avg.	HCK vs FG(HW19)	HCK vs FG(HW21)	FG(HW19) vs. FG(HW21)	HCK vs FG(HW19)	HCK vs FG(HW21)	FG(HW19) vs FG(HW21)
				NCBD									General Child			CCC		
Getting Needed Care																		
Q7	Since your child joined his or her health plan, how much of a problem, if any, was it to get a personal doctor or nurse, for your child, you are happy with?	Not a problem	77% 683 — 77% 707	77% (683) — 77% (325)	77% 707 — 77% 325	77% 683 — 80% 22140	77% 707 ↓ 85% 4039	77% 683 — 78% 4977	77% 683 — 80% 23553	77% 707 ↓ 85% 4039	77% (325) — 78% (4977)	77% (325) — 80% (23553)	80% (159) — 77% (327)	80% (159) — 77% (341)	77% (327) — 77% (341)	74% (166) — 76% (238)	74% (166) — 74% (256)	76% (238) — 74% (256)
Q13	In the last 6 months, how much of a problem, if any, was it to get a referral to a specialist that your child needed to see?	Not a problem	74% 320 — 76% 354	74% (320) — 77% (290)	76% 354 — 77% 290	74% 320 ↑ 68% 12169	76% 354 — 71% 2279	74% 320 — 70% 2856	74% 320 ↑ 68% 13112	76% 354 — 71% 2279	77% (290) ↑ 70% (2856)	77% (290) ↑ 68% (13112)	79% (67) — 75% (128)	79% (67) — 71% (133)	75% (128) — 71% (133)	76% (223) — 72% (196)	76% (223) — 80% (219)	72% (196) — 80% (219)
Q28	In the last 6 months, how much of a problem, if any, was it to get the care, tests or treatment for your child you or a doctor believed necessary?	Not a problem	89% 577 — 90% 689	89% (577) — 85% (399)	90% 689 ↑ 85% 399	89% 577 ↑ 82% 17854	90% 689 ↑ 85% 3214	89% 577 ↑ 86% 4600	89% 577 ↑ 82% 19293	90% 689 ↑ 85% 3214	85% (399) — 86% (4600)	85% (399) — 82% (19293)	86% (138) — 90% (258)	86% (138) — 89% (289)	90% (258) — 89% (289)	85% (267) — 87% (269)	85% (267) — 90% (336)	87% (269) — 90% (336)
Q30	In the last 6 months, how much of a problem, if any, were delays in the health care while you waited for approval from your child's health plan?	Not a problem	60% 96 — 69% 121	60% (96) — 67% (105)	69% 121 — 67% 105	60% 96 — 64% 6433	69% 121 — 70% 1205	60% 96 — 63% 1156	60% 96 — 64% 6860	69% 121 — 70% 1205	67% (105) — 63% (1156)	67% (105) — 64% (6860)	43% (21) ↓ 96% (506)	43% (21) ↓ 98% (513)	96% (506) — 98% (513)	73% (84) ↓ 94% (395)	73% (84) ↓ 94% (491)	94% (395) — 94% (491)
Getting Care Quickly																		
Q18	In the last 6 months, when you called during regular office hours, how often did you get the help or advice you needed for your child?	Always	69% 842 ↓ 75% 897	69% (842) — 70% (517)	75% 897 ↑ 70% 517	69% 842 — 70% 24165	75% 897 — 72% 4437	69% 842 — 72% 6065	69% 842 — 70% 26024	75% 897 — 72% 4437	70% (517) — 72% (6065)	70% (517) — 70% (26024)	71% (205) — 65% (381)	71% (205) — 76% (397)	65% (381) ↓ 76% (397)	67% (293) — 69% (340)	67% (293) — 71% (395)	69% (340) — 71% (395)
Q23	In the last 6 months, not counting the times your child needed care right away, how often did your child get an appointment for health care as soon as you wanted?	Always	63% 837 — 66% 912	63% (837) — 63% (522)	66% 912 — 63% 522	63% 837 — 61% 28016	66% 912 ↑ 60% 5207	63% 837 — 62% 6806	63% 837 — 61% 29998	66% 912 ↑ 60% 5207	63% (522) — 62% (6806)	63% (522) — 61% (29998)	72% (150) ↑ 62% (392)	72% (150) — 66% (397)	62% (392) — 66% (397)	72% (300) ↑ 61% (315)	72% (300) — 65% (393)	61% (315) — 65% (393)
Q20	In the last 6 months, when your child needed care right away for an illness, injury or condition how often did your child get care as soon as you wanted?	Always	69% 559 ↓ 76% 526	69% (559) — 71% (382)	76% 526 — 71% 382	69% 559 — 70% 17108	76% 526 ↑ 71% 2776	69% 559 — 72% 4467	69% 559 — 70% 18462	76% 526 ↑ 71% 2776	71% (382) — 72% (4467)	71% (382) — 70% (18462)	65% (222) — 68% (260)	65% (222) ↓ 78% (231)	68% (260) ↓ 78% (231)	61% (300) — 66% (234)	61% (300) ↓ 72% (238)	66% (234) — 72% (238)
Q31	In the last 6 months, how often was your child taken to the exam room within 15 minutes of his or her appointment?	Always	25% 1091 — 27% 1169	25% (1091) — 22% (627)	27% 1169 ↑ 22% 627	25% 1091 — 27% 34861	27% 1169 — 25% 6479	25% 1091 — 27% 8438	25% 1091 — 27% 37351	27% 1169 — 25% 6479	22% (627) ↓ 27% (8438)	22% (627) ↓ 27% (37351)	22% (281) — 25% (504)	22% (281) — 24% (511)	25% (504) — 24% (511)	21% (346) — 27% (391)	21% (346) — 26% (484)	27% (391) — 26% (484)
How Well Doctors Communicate				NCBD									General Child			CCC		
Q34	In the last 6 months, how often did doctors or other health providers listen carefully to you?	Always	71% 1099 — 74% 1181	71% (1099) — 73% (626)	74% 1181 — 73% 626	71% 1099 ↓ 75% 35600	74% 1181 — 73% 6746	71% 1099 ↓ 74% 8488	71% 1099 ↓ 75% 38103	74% 1181 — 73% 6746	73% (626) — 74% (8488)	73% (626) — 75% (38103)	74% (280) — 70% (511)	74% (280) — 73% (514)	70% (511) — 73% (514)	72% (346) — 70% (397)	72% (346) — 72% (494)	70% (397) — 72% (494)
Q36	In the last 6 months, how often did your child's doctors or other health providers explain things in a way you could understand?	Always	77% 1103 — 79% 1176	77% (1103) — 75% (626)	79% 1176 — 75% 626	77% 1103 — 76% 35570	79% 1176 ↑ 73% 6733	77% 1103 — 76% 8489	77% 1103 — 76% 38075	79% 1176 ↑ 73% 6733	75% (626) — 76% (8489)	75% (626) — 76% (38075)	76% (279) — 77% (512)	76% (279) — 79% (515)	77% (512) — 79% (515)	74% (347) — 80% (397)	74% (347) — 78% (489)	80% (397) — 78% (489)
Q37	In the last 6 months, how often did your child's doctors or other health providers show respect for what you had to say?	Always	76% 1094 — 77% 1178	76% (1094) — 74% (625)	77% 1178 — 74% 625	76% 1094 — 77% 35539	77% 1178 — 76% 6709	76% 1094 — 77% 8476	76% 1094 — 77% 38039	77% 1178 — 76% 6709	74% (625) — 77% (8476)	74% (625) — 77% (38039)	76% (279) — 75% (510)	76% (279) — 77% (517)	75% (510) — 77% (517)	71% (346) — 76% (394)	71% (346) — 75% (492)	76% (394) — 75% (492)
Q40	In the last 6 months, how often did your child's doctors or other health providers explain things in a way your child could understand?	Always	64% 586 — 67% 973	64% (586) — 61% (334)	67% 973 ↑ 61% 334	64% 586 — 67% 22067	67% 973 — 67% 5339	64% 586 — 66% 5355	64% 586 — 67% 23743	67% 973 — 67% 5339	61% (334) — 66% (5355)	61% (334) ↓ 67% (23743)	56% (281) ↓ 65% (266)	56% (281) ↓ 66% (411)	65% (266) — 66% (411)	57% (346) — 64% (275)	57% (346) — 63% (433)	64% (275) — 63% (433)
Q41	In the last 6 months, how often did doctors or other health providers spend enough time with your child?	Always	59% 1099 ↓ 64% 1171	59% (1099) — 56% (627)	64% 1171 ↑ 56% 627	59% 1099 — 61% 35435	64% 1171 ↑ 59% 6684	59% 1099 — 61% 8464	59% 1099 — 61% 37933	64% 1171 ↑ 59% 6684	56% (627) ↓ 61% (8464)	56% (627) ↓ 61% (37933)	61% (124) — 58% (511)	61% (124) — 65% (514)	58% (511) ↓ 65% (514)	62% (210) — 60% (395)	62% (210) — 62% (491)	60% (395) — 62% (491)
Courteous and Helpful Office Staff																		
Q32	In the last 6 months, how often did office staff at your child's doctors office or clinic treat you and your child with courtesy and respect?	Always	77% 1105 ↓ 82% 1182	77% (1105) — 77% (627)	82% 1182 ↑ 77% 627	77% 1105 ↓ 80% 35603	82% 1182 ↑ 79% 6732	77% 1105 ↓ 80% 8487	77% 1105 ↓ 80% 38105	82% 1182 ↑ 79% 6732	77% (627) — 80% (8487)	77% (627) — 80% (38105)	76% (281) — 78% (513)	76% (281) ↓ 82% (518)	78% (513) — 82% (518)	77% (346) — 82% (398)	77% (346) — 80% (494)	82% (398) — 80% (494)
Q33	In the last 6 months, how often were office staff at your child's doctors office or clinic as helpful as you thought they should be?	Always	65% 1106 ↓ 71% 1180	65% (1106) — 66% (625)	71% 1180 ↑ 66% 625	65% 1106 ↓ 68% 35571	71% 1180 ↑ 67% 6736	65% 1106 ↓ 68% 8494	65% 1106 ↓ 68% 38072	71% 1180 ↑ 67% 6736	66% (625) — 68% (8494)	66% (625) — 68% (38072)	69% (279) — 64% (514)	69% (279) — 71% (515)	64% (514) ↓ 71% (515)	65% (346) — 67% (399)	65% (346) — 69% (493)	67% (399) — 69% (493)
Customer Service				NCBD									General Child			CCC		
Q79	In the last 6 months, how much of a problem, if any, was it to find or understand information in the written materials or on the Internet?	Not a problem	74% 271 — 80% 355	74% (271) — 71% (164)	80% 355 ↑ 71% 164	74% 271 — 78% 9152	80% 355 — 81% 2042	74% 271 — 77% 2148	74% 271 — 77% 9714	80% 355 — 81% 2042	71% (164) — 77% (2148)	71% (164) — 77% (9714)	77% (66) — 74% (136)	77% (66) — 81% (172)	74% (136) — 81% (172)	68% (96) — 63% (98)	68% (96) — 75% (146)	63% (98) ↓ 75% (146)

2006 Child CAHPS Comparisons

↑ = more favorable response (p value < .05)
↓ = less favorable response (p value < .05)
— = no statistical significant difference between response rates
FG = FirstGuard Health Plan (HW 19)
HCK = HealthConnect Kansas
HW 19 = HealthWave 19
HW21 = HealthWave 21

		Response Measured	FG(HW19) vs FG(HW21)	FG(HW19) vs HCK	FG(HW21) vs HCK	FG(HW19) vs HMO Avg.	FG(HW21) vs HMO Avg.	FG(HW19) vs MW Region Avg.	FG(HW19) vs Nat'l. Avg.	FG(HW21) vs Nat'l. Avg.	HCK vs MW Region Avg.	HCK vs Nat'l Avg.	HCK vs FG(HW19)	HCK vs FG(HW21)	FG(HW19) vs. FG(HW21)	HCK vs FG(HW19)	HCK vs FG(HW21)	FG(HW19) vs FG(HW21)
				NCBD									General Child			CCC		
Q81	In the last 6 months, how much of a problem, if any, was it to get the help you needed when you called your child's health plan's customer service?	Not a problem	71% 314 — 68% 380	71% (314) — 70% (151)	68% 380 — 70% 151	71% 314 — 69% 10273	68% 380 — 71% 2717	71% 314 — 74% 2558	71% 314 — 69% 10843	68% 380 — 71% 2717	70% (151) — 74% (2558)	70% (151) — 69% (10843)	73% (59) — 72% (144)	73% (59) — 66% (172)	72% (144) — 66% (172)	69% (92) — 69% (129)	69% (92) — 62% (150)	69% (129) — 62% (150)
Q87	In the last 6 months, how much of a problem, if any, did you have with paperwork for your child's health plan?	Not a problem	82% 415 — 83% 463	82% (415) — 83% (246)	83% 463 — 83% 246	82% 415 — 79% 8810	83% 463 — 80% 3669	82% 415 — 81% 2220	82% 415 — 78% 9684	83% 463 — 80% 3669	83% (246) — 81% (2220)	83% (246) — 78% (9684)	91% (111) ↓ 96% (649)	91% (111) — 95% (719)	96% (649) — 95% (719)	82% (120) ↓ 94% (475)	82% (120) ↓ 95% (583)	94% (475) — 95% (583)
Ratings																		
Q5	Use any number from 0 to 10, where 0 is the worst personal doctor or nurse possible, and 10 is the best. How would you rate your child's personal doctor or nurse now?	Rating 9-10	63% 1244 — 62% 1386	63% (1244) — 65% (681)	62% 1386 — 65% 681	63% 1244 ↓ 66% 38952	62% 1386 — 64% 7568	63% 1244 — 64% 9403	63% 1244 ↓ 66% 41718	62% 1386 — 64% 7568	65% (681) — 64% (9403)	65% (681) — 66% (41718)	63% (327) — 59% (583)	63% (327) — 62% (626)	59% (583) — 62% (626)	66% (354) — 65% (444)	66% (354) — 63% (545)	65% (444) — 63% (545)
Q15	Use any number from 0 to 10, where 0 is the worst specialist possible, and 10 is the best personal specialist possible. How would you rate your child's specialist?	Rating 9-10	65% 286 — 58% 330	65% (286) — 69% (301)	58% 330 ↓ 69% 301	65% 286 — 63% 10972	58% 330 — 60% 2116	65% 286 — 62% 2635	65% 286 — 63% 11873	58% 330 — 60% 2116	69% (301) ↑ 62% (2635)	69% (301) ↑ 63% (11873)	63% (65) — 62% (116)	63% (65) — 62% (120)	62% (116) — 62% (120)	71% (236) — 65% (183)	71% (236) ↑ 58% (208)	65% (183) — 58% (208)
Q51	Use any number from 0 to 10, where 0 is the worst health care possible, and 10 is the best health care possible. How would you rate all of your child's health care?	Rating 9-10	66% 1099 — 69% 1175	66% (1099) — 67% (625)	69% 1175 — 67% 625	66% 1099 — 66% 35481	69% 1175 ↑ 66% 6749	66% 1099 — 66% 8479	66% 1099 — 66% 37972	69% 1175 ↑ 66% 6749	67% (625) — 66% (8479)	67% (625) — 66% (37972)	68% (281) — 64% (512)	68% (281) — 70% (513)	64% (512) ↓ 70% (513)	67% (344) — 65% (394)	67% (344) — 69% (490)	65% (394) — 69% (490)
Q88	Use any number from 0 to 10, where 0 is the worst health plan possible, and 10 is the best health plan possible. How would you rate your child's health plan now?	Rating 9-10	70% 1382 — 70% 1578	70% (1382) ↑ 65% (756)	70% 1578 ↑ 65% 756	70% 1382 ↑ 61% 46203	70% 1578 ↑ 64% 9175	70% 1382 ↑ 62% 10812	70% 1382 ↑ 62% 49438	70% 1578 ↑ 64% 9175	65% (756) — 62% (10812)	65% (756) — 62% (49438)	71% (374) — 70% (648)	71% (374) — 70% (723)	70% (648) — 70% (723)	60% (382) ↓ 70% (471)	60% (382) ↓ 68% (586)	70% (471) — 68% (586)

CCC Child

2006 CCC CAHPS Comparisons

↑ = more favorable response (p value < .05)
↓ = less favorable response (p value < .05)
— = no statistical significant difference between response rates
N/A = sample size proportions are too small to test for statistically significant difference
FG = FirstGuard Health Plan
HCK = HealthConnect Kansas
HW 19 = HealthWave 19
HW21 = HealthWave 21

		Response Measured	HCK vs FG(HW19)	HCK vs FG(HW21)	FG(HW19) vs FG(HW21)
Access to Prescription Medicine			**CCC**		
Q90	Of those respondents who got a prescription for medicine or refilled a prescription for their child: "In the last 6 months, how much of a problem, if any, was it to get your child's prescription medicine?"	Not a problem	84% (354) — 87% (422)	84% (354) — 88% (535)	87% (422) — 88% (535)
Q91	Of those respondents who reported having a problem getting prescription medicine for their child: "Did anyone from your child's health plan, doctor's office or clinic help you with this problem?"	Yes	67% (57) — 52% (54)	67% (57) — 68% (65)	52% (54) — 68% (65)
Access to Specialized Services					
Q64	Of those respondents who tried to get special medical equipment for their child: "In the last 6 months, how much of a problem, if any, was it to get special medical equipment for your child?"	Not a problem	70% (88) — 83% (66)	70% (88) — 74% (49)	83% (66) — 74% (49)
Q65	Of those respondents who reported having a problem getting medical equipment: "Did anyone from your child's health plan, doctor's office or clinic help you with this problem?"	Yes	60% (25) — 64% (11)	60% (25) — 50% (12)	64% (11) #N/A 50% (12)
Q67	Of those respondents who tried to get special therapy for their child: "In the last 6 months, how much of a problem, if any, was it to get special therapy for your child?"	Not a problem	78% (96) — 75% (57)	78% (96) ↑ 61% (36)	75% (57) — 61% (36)
Q68	Of those respondents who reported having a problem getting special therapy: "Did anyone from your child's health plan, doctor's office or clinic help you with this problem?"	Yes	29% (21) — 57% (14)	29% (21) — 42% (12)	57% (14) — 42% (12)
Q70	Of those respondents who tried to get treatment or counseling for an emotional, developmental or behavioral problem for their child: "In the last 6 months, how much of a problem, if any, was it to get this treatment or counseling for your child?"	Not a problem	71% (127) ↓ 82% (125)	71% (127) — 77% (150)	82% (125) — 77% (150)
Q71	Of those respondents who reported having a problem getting treatment or counseling: "Did anyone from your child's health plan, doctor's office or clinic help you with this problem?"	Yes	33% (36) — 30% (23)	33% (36) — 36% (33)	30% (23) — 36% (33)

Statistical significance was calculated using the most positive response and calculations were done with the binomial test.

2006 CCC CAHPS Comparisons

↑ = more favorable response (p value < .05)
↓ = less favorable response (p value < .05)
— = no statistical significant difference between response rates
N/A = sample size proportions are too small to test for statistically significant difference
FG = FirstGuard Health Plan
HCK = HealthConnect Kansas
HW 19 = HealthWave 19
HW21 = HealthWave 21

		Response Measured	HCK vs FG(HW19)	HCK vs FG(HW21)	FG(HW19) vs FG(HW21)
Personal Doctor or Nurse Who Knows Child and Supports Parents			**CCC**		
Q8	In the last 6 months, did your child's personal doctor or nurse talk with you about how your child is feeling, growing, or behaving?	Yes	79% (386) — 74% (472)	79% (386) ↑ 73% (586)	74% (472) — 73% (586)
Q10	Of those respondents whose child has a medical, behavioral or other health condition: "Does your child's personal doctor or nurse understand how these medical, behavioral or other health conditions affect your child's day-to-day life?"	Yes	93% (319) — 95% (345)	93% (319) — 95% (415)	95% (345) — 95% (415)
Q11	Of those respondents whose child has a medical, behavioral or other health condition: "Does your child's personal doctor or nurse understand how your child's medical, behavioral or other health conditions affect your family's day-to-day life?"	Yes	90% (316) — 89% (341)	90% (316) — 91% (415)	89% (341) — 91% (415)
Shared Decision Making					
Q47	Of those respondents who made decisions about their child's health care: "When decisions were made in the last 6 months, how often did your child's doctors or other health providers offer you choices about your child's health care?"	Always	57% (220) — 57% (205)	57% (220) — 58% (253)	57% (205) — 58% (253)
Q48	Of those respondents who made decisions about their child's health care: "How often did your child's doctors or other health providers discuss with you the good and bad things about each of the different choices for your child's health care?"	Always	68% (219) — 67% (206)	68% (219) — 67% (252)	67% (206) — 67% (252)
Q49	Of those respondents who made decisions about their child's health care: "When decisions were made in the last 6 months, how often did your child's doctors or other health providers ask you to tell them what choices you prefer?"	Always	56% (220) — 55% (202)	56% (220) — 50% (251)	55% (202) — 50% (251)
Q50	Of those respondents who made decisions about their child's health care: "When decisions were made in the last 6 months, how often did your child's doctors or other health providers involve you as much as you wanted?"	Always	73% (219) — 68% (204)	73% (219) — 73% (253)	68% (204) — 73% (253)

Statistical significance was calculated using the most positive response and calculations were done with the binomial test.

2006 CCC CAHPS Comparisons

↑ = more favorable response (p value < .05)
↓ = less favorable response (p value < .05)
— = no statistical significant difference between response rates
N/A = sample size proportions are too small to test for statistically significant difference
FG = FirstGuard Health Plan
HCK = HealthConnect Kansas
HW 19 = HealthWave 19
HW21 = HealthWave 21

		Response Measured	HCK vs FG(HW19)	HCK vs FG(HW21)	FG(HW19) vs FG(HW21)
Getting Needed Information			**CCC**		
Q43	Of those respondents who had questions or concerns about their child's health or health care: "In the last 6 months, how often did your child's doctors or other health providers make it easy for you to discuss your questions or concerns?"	Always	64% (207) — 63% (185)	64% (207) — 69% (206)	63% (185) — 69% (206)
Q44	Of those respondents who had questions or concerns about their child's health or health care: "In the last 6 months, how often did you get the specific information you needed from your child's doctors and other health providers?"	Always	59% (207) — 58% (184)	59% (207) — 62% (206)	58% (184) — 62% (206)
Q45	Of those respondents who had questions or concerns about their child's health or health care: "In the last 6 months, how often did you have your questions answered by your child's doctors or other health providers?"	Always	64% (206) — 66% (183)	64% (206) — 71% (206)	66% (183) — 71% (206)
Coordination of Care					
Q54	In the last 6 months, did you get the help you needed from your child's doctors or other health providers in contacting our child's school or daycare?	Yes	96% (92) #N/A 97% (57)	96% (92) #N/A 89% (72)	97% (57) #N/A 89% (72)
Q72	In the last 6 months, did your child get care from more than one kind of health care provider or use more than one kind of health care service?	Yes	53% 384 ↑ 38% 467	53% 384 ↑ 35% 579	38% 467 — 35% 579
Q73	Of respondents whose child had more than one kind of health care provider: "In the last 6 months, did anyone from your child's health plan, doctor's office or clinic help coordinate your child's care among these different providers or services?"	Yes	65% 203 ↓ 67% 175	65% 203 ↑ 61% 196	67% 175 — 61% 196

Statistical significance was calculated using the most positive response and calculations were done with the binomial test.

Attachment B

ATTACHMENT B

SURVEY VALIDATION WORKSHEET
2006 FirstGuard CAHPS

SURVEY ELEMENT	DOCUMENTATION
Activity 1: Survey Purposes(s) and Objective(s)	
• **There is a written statement of survey purpose(s) that addresses access, timeliness, and/or quality of care.**	The Meyers Group (TMG), an NCQA-Certified HEDIS Survey Vendor, was selected by FirstGuard to conduct the 2006 CAHPS Survey. The results were reported in the following categories; Healthwave 19 Adult, HealthWave 19 General Child, HealthWave 19 Child with Chronic Conditions (HW19 CCC), Healthwave 21 General Child, and HealthWave 21 Child with Chronic Conditions (HW21 CCC). The purpose of the survey was identified in the four child reports as to, "assist in identifying member satisfaction strengths and opportunities." The purpose reflected in the adult survey was to, " assist in identifying member satisfaction strengths and opportunities and aids in assessing NCQA accreditation standings."
• **Unit(s) of analysis is clearly stated and includes individual MCOs.**	The unit(s) of analysis was child beneficiaries in the HealthWave 19 (HW19) and HealthWave 21 (HW21) programs, and adult beneficiaries in the HW 19 program.
• **Study objectives are clear, measurable, and in writing.**	The study objectives were not listed in the reports, but were implied in various report areas that were measurable such as trending, benchmarking, and opportunity analysis. Additional information was provided by FirstGuard which contained the following study objectives: • To meet the state's contractual requirements regarding surveys of HealthWave19 and 21 members. • To assess the degree of loyalty of surveyed members with the addition of the custom question, "Would you recommend FirstGuard to your family or friends?" • To monitor the awareness level of two FirstGuard services, NurseWise and The Guardian Angel Program. • To determine whether the degree of member satisfaction as assessed in the attributes, composites and ratings changed statistically from 2006 to 2005, from 2006 to 2004 and 2006 to 2003. • To determine the areas of health care and health plan service for which members rate FirstGuard significantly different from the National Medicaid average. • To determine the level of satisfaction of members with the access, quality and/or timeliness of their health care according to the timeframe specified by the HEDIS 2006 technical specifications (a six month period immediately preceding receipt of the survey). Access, quality and/or timeliness of health care are identified through specific attribute questions and rating questions in the CAHPS 3.0H survey tool. These objectives are clear and measurable.

SURVEY VALIDATION WORKSHEET
2006 FirstGuard CAHPS

SURVEY ELEMENT	DOCUMENTATION
Activity 2: Survey Audience(s)	
• **Audiences for survey findings are identified.**	The report documentation implied the survey audience was the health plan. Additional information provided by FirstGuard confirmed the entire health plan staff, the physician QM/UM/Credentialing Committee, the Board of Directors, and other Centene Corporation health economics and quality staff were considered the health plan audience. FirstGuard also noted the Kansas Health Policy Authority (KHPA), network providers, and FirstGuard members were considered intended audiences. Based on FG's additional information, all survey audiences appear to have been identified.
Activity 3: Survey Instrument	
• **If an existing survey instrument was used, there is evidence of its reliability.**	The CAHPS (Consumer Assessment of Healthcare Providers and Systems) 3.0H survey tools were used for the survey. The CAHPS 3.0H Adult Medicaid Questionnaire was used for the HW19 adult population and the CAHPS 3.0H Child Medicaid Questionnaire (with Children with Chronic Conditions [CCC] Measurement Set) was used for the HW19 and HW21 Child populations. CAHPS is a set of survey tools developed to assess consumer satisfaction, and experiences with their health plan. It is a nationally standardized survey tool sponsored by the Agency for Healthcare Research (AHRQ) and co-developed with the National Committee for Quality Assurance (NCQA). The CAHPS survey instruments and reporting formats have undergone rigorous testing for reliability and validity, including focus group interviewing, cognitive interviewing, and field-testing. There were no changes in the CAHPS 3.0H Adult and Child Member Satisfaction Surveys from the previous year. FirstGuard included the following plan specific questions at the end of the questionnaires for all HealthWave populations: • How would you rate your understanding of the benefits FirstGuard Health Plan offers you/your child? • What Customer Service areas do you like best about FirstGuard? • With the choices your health plan gave you, how much of a problem, if any, was it to get a personal doctor who met your/your child's special cultural and/or spoken language needs? • Do you know who to call to find out about HealthWave eligibility, benefit termination, obtaining a new identification card, benefit application status, health care benefits and premium payment (child survey only)? • Did you receive the Winter 2005 edition of Heart and Soul Newsletter in January? • Does the information in the Heart and Soul Newsletter help you understand your/your child's health care benefits? • Would you recommend your health plan to your family or friends? • Are you aware that FirstGuard Health Plan has support for pregnant members called the

SURVEY VALIDATION WORKSHEET
2006 FirstGuard CAHPS

SURVEY ELEMENT	DOCUMENTATION
	Guardian Angel Program? • Are you aware of FirstGuard Health Plan's nurse advice line that is available 24 hours per day?
• **If an existing survey instrument was used, there is evidence of its validity.**	The CAHPS survey instruments and reporting formats have undergone rigorous testing for reliability and validity, including focus group interviewing, cognitive interviewing, and field-testing.
• **If a newly developed survey was used, there is evidence of reliability testing.**	Not applicable.
• **If a newly developed survey was used, there is evidence of validity testing.**	Not applicable.
• **If using an adapted survey: there is evidence of reliability testing.**	Not applicable.
• **If using an adapted survey, there is evidence of validity.**	Not applicable.
Activity 4: Sampling Plan	
• **Population to be studied was clearly identified.**	The study populations were clearly identified in each of the reports. The study populations are HW19 adults, HW19 children, and HW21 children who meet the CAHPS eligibility criteria.
• **Sample frame was clearly defined and appropriate.**	No specific sample frame was provided in the report for the HW19 Adult CAHPS survey administration. Children ages 0 – 17 from the HW19 membership database were used as the general population sample

SURVEY VALIDATION WORKSHEET
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	for the HW19 Child CAHPS survey. An additional group of child members, ages 0 – 17, with a claim status indicating a probable chronic condition, as defined by NCQA, were randomly selected from the eligible population. There was no discussion in the report of the use of enrollment criteria in determining the sample frame. Children ages 0 – 17 from the HW21 membership database were used as the general population sample for the HW21 Child CAHPS survey. An additional group of child members, ages 0 – 17, with a claim status indicating a probable chronic condition, as defined by NCQA, were randomly selected from the eligible population. There was no discussion in the report of the use of enrollment criteria in determining the sample frame. There was no mention in the reports whether the sampling process eliminated the possibility of one household receiving more than one survey. The following are the criteria/guidelines, based on HEDIS 2006, Volume 3: S*pecifications for Survey Measures:* 1. Currently enrolled at the time the survey is completed. 2. Enrolled 5 of the last 6 months of the measurement year (2005) and have no more than a one gap in enrollment during any time from July through December. 3. The child population should consist of members 17 years of age and younger as of December 31 of the measurement year. 4. The adult population should consist of members 18 years of age and older as of December 31 of the measurement year. 5. The sample should not include more than one person (adult or child) per household. Additional information provided by FirstGuard confirmed the sample frame was appropriate and no households received more than one survey. The additional information indicated FirstGuard prepared the database for sampling. The preparation included quality control checks on records to ensure continuous enrollment and eligibility criteria were met. In addition, a sample of the database was reviewed by Ernst & Young, FirstGuard's HEDIS Compliance Auditor. FirstGuard provided a copy of a memo from Ernst & Young stating the appropriate audit protocols were followed and the source code used to produce the files and samples of the output confirmed the required data elements were included. Once the database was deemed appropriate, FirstGuard provided it to The Myers Group. The additional information provided by FirstGuard verified the sample frame was appropriate.

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• **Sampling strategy (simple random, stratified random, non-probability) was appropriate to study question.**	A random sample was used to select participants for the HW19 Adult CAHPS survey. A stratified random sample was used to select participants for the HW19 and HW21 Child CAHPS surveys. Child members were randomly selected from the eligible, general population. An additional group of eligible, child members with a claim status of probable chronic condition, as defined by NCQA, was also randomly selected. The sampling strategy used by the survey administrator was consistent with NCQA protocol and appropriate.
• **If random sampling is used, sampling process was valid.**	Details regarding the random sample selection process for the HW19 Adult CAHPS survey were not provided in the report. However, additional information from The Meyers Group outlined the following random sampling procedure: • The raw database of (8,961) records for HealthWave 19 is loaded in our programmer's tool. • First de-duplication by household takes place. This process will obviously reduce the available database records to some lesser number. • Next, using a random number generator software tool, the entire set of numbers in the de-duped database is loaded and a smaller subset of randomly generated numbers (approximately 5,000) is pulled into a spreadsheet, then we assign random numbers to the file. • Next this random sample is sent through a telephone and address append process to improve the number of valid addresses and phone numbers. • After the telephone and address append, a final de-duplication is provided which may further reduce the valid number within the random sample. • The process is completed when the required sample number of "1,350" is pulled from the random sample. This sample is audited then used for the survey. Based on the additional information, the random sampling process was valid.
• **If stratified random sampling is used, sampling process was valid.**	An overview of the sampling process used for the HW19 and HW21 Child populations was provided in the reports. However, details regarding the stratified random sample selection process for HW19 and HW21 Child CAHPS surveys were not provided in the reports. Additional information was requested, but not provided regarding the stratified random sampling process as was provided for the random sampling process noted for the assessment element immediately above. KFMC was unable to confirm the stratified random sampling process used to select the HW19 and HW21 Child populations was valid.

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• **If non-probability sampling is used, there is clear and strong evidence why random sampling was not feasible.**	Not applicable.
• **Sample size was determined using reasonable statistical parameters, as appropriate to survey purpose and objectives.**	NCQA protocols specify the following sample sizes for the Medicaid CAHPS survey: Adult = 1,350; Child (with CCC measurement set) = 3,490 (1,650 general population + 1,840 children with probable chronic conditions based on claims data). The reports indicated the sample sizes, based on NCQA protocols, were appropriate for the HW19 Adult, HW19 Child, and HW21 Child populations.
• **Sample selection processes were sound.**	FirstGuard prepared the database for sampling. The preparation included quality control checks on records to ensure continuous enrollment and eligibility criteria were met. In addition, a sample of the database was reviewed by Ernst and Young, FirstGuard's HEDIS Compliance Auditor. FirstGuard provided a memo from Ernst and Young stating the appropriate audit protocols were followed and the source code used to produce the files and samples of the output confirmed the required data elements were included. Once the database was deemed appropriate, FirstGuard provided it to The Meyers Group. Details regarding the random sample selection process for the HW19 Adult survey were not provided in the report. However, additional information from FirstGuard verified the sample selection processes used for the HW19 Adult survey were sound. Generally, the technical sampling specifications were followed for the child populations. Additional detail regarding the sample selection processes was requested for all three populations. FG responded by providing detailed information for the adult population. Detailed sampling specifications were not provided for the child populations.
Activity 5: Response rate	
• **Specify if mail, phone, face-to-face, or combination strategy was used to contact targeted survey respondents.**	CAHPS protocol allows plans to select from two survey administration options, a five-wave mail only methodology or a mixed methodology (mail and telephone), which includes two questionnaire mailings, two reminder postcards, and a telephone follow-up. The reports indicated the CAHPS surveys were administered to the HW19 and HW21 populations using the mixed methodology and following the NCQA protocol.

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• **Specifications for calculating raw and adjusted response rates are clear and appropriate.**	The HEDIS protocol for administration of CAHPS 3.0 surveys define the calculation of response rates as follows: Completed Mail and Telephone Surveys Sample Size – Ineligible Surveys The reports defined a completed survey as those that are 80% completed. The reports also defined ineligible members as including those who are deceased, do not meet the eligible population criteria, have a language barrier, or are either mentally or physically incapacitated. This is consistent with the HEDIS protocol for the adult population, but not the child population as defined in *HEDIS 2006 Specifications for Survey Measures*, HEDIS 2006, Volume 3, page 70. This reference states mental or physical incapacitation is not a valid disposition code for the CAHPS 3.0H Child Survey. All of the reports contain tables listing the number of ineligible members in each of the four disposition categories. While the HW19 and HW21 Child reports contained "mental/physically incapacitated" as a category, no cases were reported in this area. The reports identified the following response rates: HW19 Adult – 28.3% (371 responses from a sample of 1,350 minus 38 ineligibles). HW19 Child General Population – 41.0% (654 responses from a sample of 1,650 minus 54 ineligibles). HW21 Child General Population – 47.4% (734 responses from a sample of 1,650 minus 100 ineligibles). HW19 CCC Population – The survey administrator did not calculate the response rate for the sample of children with probable chronic conditions based on claims. HW21 CCC Population – The survey administrator did not calculate the response rate for the sample of children with probable chronic conditions based on claims. The specifications for calculating raw and adjusted response rates were clear and appropriate for the HW19 Adult population and were mostly clear for the HW19 and HW21 Child populations with the exception of including mental/physically incapacitated as a disposition category for the child population.
• **The response rate, potential sources of non-response and bias, and implications of the response rate for the generalizeability of survey findings are assessed.**	According to the HEDIS CAHPS protocols, MCOs must achieve a minimum of 411 completed surveys, or 100 responses for each HEDIS survey question to report HEDIS survey results for that question. If the number of responses to any question is less than 100, HEDIS results calculated using that question receive a measure result of Not Applicable (NA). Each of the reports stated the target number of completed survey responses for the HW19 Adult, HW19 Child General Population and HW21 Child General Population was 411**,** but did not include discussion regarding the 100 responses for each HEDIS survey question. The target for completed number of surveys was not met for the HW19 Adult Population (371), but was met for the HW19 Child General Population (654) and the

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	HW21 Child General Population (734). FirstGuard stated they were considering over-sampling the HW19 Adult population in 2007 in order to achieve the NCQA target of 411 completed surveys. Review of the question frequencies for the composite attribute and rating questions revealed at least 100 valid responses for the HW19 Child General, HW21 Child General and HW21 CCC populations. The HW19 Adult and CCC population reports indicated less than 100 responses for one question. This question was the same for both groups and involved their level of understanding of information in the written materials or on the internet. The reports reflected 98 responses for this question by each population. The reports for all survey populations stated, "The characteristics of respondents surveyed should be representative of your member population." TMG included a sampling error table in the reports for each of the HW19 and HW21 populations, but did not calculate the sampling error. The sampling error is defined as the extent to which survey results may differ from what would be obtained if every eligible member in the sample had been surveyed. The size of the error depends on the percentage distributions and the number of members surveyed. The more disproportionate the percentage distributions or the larger the sample size, the smaller the error. The 95% confidence interval reflects on average, in 95 out of 100 samples, the true unknown population percentage. FirstGuard was asked if the sampling error was calculated to assess the confidence of the survey findings and the degree of generalizeability of the survey results. FirstGuard responded that The Meyers Group followed the NCQA protocol for sample selection and data collection and this protocol was specifically designed to achieve responses that are representative of the health plan's population. No potential sources of non-response bias were identified in the reports. FirstGuard was asked if any sources of non-response bias were identified. Firstguard responded by quoting the CMS Validating Survey Protocol as follows, "Medicaid beneficiaries have a low survey response rate." FirstGuard also indicated they reviewed the categories of non-response reported by The Meyers Group; "refused to participate" and "maximum attempts made to contact beneficiary without success." FirstGuard noted the category representing the largest number of members was "maximum attempts made to contact beneficiary without success." Regarding this category, Firstguard stated it was difficult to accurately determine the extent of the bias due to the member's unwillingness to communicate with the health plan. FirstGuard did not assess the potential sources of non-response bias or the implications of the response rates for the generalizeability of the survey findings.

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Activity 6: Review of Data Preparation and Analysis	
• **Quality control procedures were in place for: administration of the survey; receipt of survey data; respondent information and assistance; coding, editing and entering data; and procedures for missing data and data that fails edits.**	The HEDIS 2006 Specifications for Survey Measures suggest the following: • Use of a confidential tracking identification number, which is used to record member responses so follow-up mailings of questionnaires are only sent to nonrespondents. • Review each questionnaire for legibility and completeness. If member responses are ambiguous, a coding specialist employs decision rules documented in the Quality Assurance Plan. • To ensure data quality, two separate data entry specialists must independently enter answers for each questionnaire. Comparison of the separate entries identifies data entry errors that need adjudication. • Develop a written protocol of personnel training and quality control processes. The reports stated a survey was included as valid if the member appropriately responds to Question 1 and answers at least 80% of the standard survey questions. If a respondent did not respond to a particular question, the response is considered “missing.” If a respondent answered a question by marking more than one response, the response is considered a “multiple mark.” Missing or multiple mark responses are not considered valid and are not used in the analysis. The report does not contain reference to a tracking number system, coding decision rules, data entry inter-rater reliability, personnel training, or a written quality control process. Additional information was requested from FirstGuard regarding the quality control procedures that were in place involving survey administration and data management. Regarding quality control procedures used for respondent information and assistance, FirstGuard provided the following response: “All interviewers are trained on the standard responses provided by NCQA "Frequently Asked Questions". A copy of the FAQ's and Responses is at each Interviewer workstation. Many FAQ responses are also embedded in the CATI program itself. In addition, TMG uses silent monitoring equipment. Our supervisory staff observes 50% of the interviewing team each shift at which time the Interviewers are rated on their performance and coached on how to improve. Any Interviewer needing remedial assistance is assigned to a special "Mini-training" session to review those areas in need of correction. Additional information was requested from FirstGuard regarding quality control procedures used for survey administration, such as training programs for and monitoring of personnel in the telephone phase of data collection, address standardization, monitoring printing and mailing processes etc.

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	FirstGuard provided the following response to the request for additional information, “TMG uses several quality control standards for the production/mailing of materials and sampling criteria. During the printing phase of the project, all materials are typeset by in-house TMG typesetting staff. TMG uses commercial print industry standard software packages to produce these materials such as Quark Xpress, Adobe Illustrator, and Adobe Photoshop. Once materials are typeset, they are sent to the Project Manager for review. The Project Manager thoroughly reviews all material proofs prior to sending to the client. If the materials are acceptable, they are forwarded to the client for review and approval. TMG requires that clients sign off on all materials prior to print production. Once materials are approved and ordered, they are delivered to TMG by our Commercial Print Vendors. All materials are then reviewed by the Print Manager and the Project Manager one last time to ensure proper production and print quality. After the Print Manager and Project Manager have reviewed these materials, they are required to sign off on them. Once all materials have been approved and survey administration begins, TMG's on-sight mail fulfillment department begins processing the materials. During each phase of production, the Mail Fulfillment Department checks every 15th to 25th piece to ensure proper printing, insertion into envelope, and to ensure that all materials match for the project. After a survey project has completed printing and insertion, one last audit is performed by randomly selecting 25 envelopes from the project to open and verify that the materials inside are correct. Once this is completed, the project is banded and trayed according to USPS specifications and CASS Zip+4 standards. Prior to delivery to the post office, the Mailroom Supervisor audits the project to ensure it has been put together to USPS specifications and that all paperwork has been completed properly. For sampling, all samples are put through a National Change of Address process that updates and standardizes addresses. TMG uses multiple vendors for this process who get their address information directly from the USPS national database. The NCOA process updates the address with the most current address on record for a member as well as formats the address in an acceptable format according to USPS regulations. Please see the attached Survey Administration "Work Breakdown Schedule" Flow Chart. This document is designed to identify all process steps and audit procedures in The Myers Group survey administration. This is a confidential document.” Additional information was requested from FirstGuard regarding quality control procedures used for coding, editing and entering data. FirstGuard provided the following response to the request for additional information, “TMG uses Verity's Teleform Scanning software to process mail surveys. This software is a smart software program that allows us to program decision rules and coding specifications for surveys according to client or CAHPS standards. For CAHPS Surveys, TMG follows the coding conventions as outlined by NCQA and programs them into our scanning scripts. Part of Verity's Teleform software is also a OCR and OMR recognition engine that takes scanned surveys and applies confidence levels to member marks. If a mark is within an acceptable range, it is accepted. However, if

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	a mark is outside an acceptable range, has multiple marks, or a decision process cannot be determined it is then transferred to a Verification Operator to review on the screen and make the decision as to what the mark and coding should be. All Scanning and Verification Operators are trained on the NCQA data decision rules so that when on-screen verification is needed the appropriate coding can be made. TMG also has the ability to "force" verification of key fields so that they are reviewed each time regardless of the mark a member has made. Data is also spot-checked by the Survey Administration Manager. The Survey Administration Manager randomly pulls hardcopies of scanned surveys and compares them to verified data. Decision rules and coding are checked to ensure that data has been collected properly." Based on the additional information provided by FirstGuard, the appropriate quality control procedures were in place.
• **Methodologically appropriate data preparation and analysis procedures were used.**	As a NCQA-Certified HEDIS Survey Vendor, TMG is responsible for submitting clean member-level data files to NCQA for calculation of HEDIS survey results, in accordance with the HEDIS survey file layouts. The reports do not contain discussion regarding the data preparation plan. The reports described various methods used to identify statistical significance and opportunities for improvement including: multi-linear regression analysis, correlation analysis, hypothesis testing, frequency distributions of survey questions, Z-test, mean of means method to evaluate composite scores, segmentation analysis based on respondent demographic information, key driver analysis, and attribute analysis of composites. Additional information was requested from FirstGuard regarding the data preparation and analysis procedures used for the surveys. FirstGuard provided the following response to the request for additional information, "TMG follows the NCQA decision rules for handling of CAHPS data. The NCQA decision rule process is a structured set of criteria that we are required to follow as an NCQA Certified CAHPS Vendor. This process allows for us to process surveys to determine 80% completion rules; process final dispositions such as ineligibles, language barriers, refusals, deceased, and mentally/physically incapacitated; as well as recode data based skip patterns or missing information." Based on the additional information provided by FirstGuard, the data preparation and analysis plan were methodologically sound, since it was attested to the NCQA decision rules were followed.

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• **Final report provided understandable and relevant data.**	The reports were understandable, relevant and based on standard CAHPS reporting format which included the following: Composites The CAHPS core survey included five composite categories, which were found in both the Adult and Child surveys. Each composite category represented an overall aspect of plan quality and was composed of related questions. The related questions or composite attributes were shown individually. Six additional composites were calculated for the CAHPS 3.0H Child Survey (with CCC measurement set), which was referred to as the CCC measurement set composites. Summary rates were calculated for all composites and composite attributes and represent the most positive response option of "Usually" and "Always" and "Not a Problem." The summary rates were used when statistical comparisons were made. Ratings The core survey included 4 questions where respondents are asked to assign a numeric value ranging from 0-10. Responses were divided into three segments (0-3, 4-7 and 8-10). Summary rates were calculated for each of the four questions and represent the most positive response option of 8, 9 or 10. The summary rates were used when statistical comparisons were made. Plan Specific Questions Plan specific supplemental questions were added to the CAHPS 3.0H survey for all survey populations. These questions were designed to measure level of understanding of health plan benefits, level of satisfaction with member newsletter, level of satisfaction with Customer Service, degree of awareness of the Guardian Angel and Nurse Advice programs, degree of difficulty in obtaining a personal doctor or nurse who met the members cultural and/or spoken language needs and level of understanding regarding who to call to obtain answers to eligibility and benefits questions. The reports were organized in an understandable manner consisting of 11distinct sections. These sections included: 1. Executive Summary. 2. Project Overview. 3. Trend comparisons to previous years for composites, attributes, and ratings. 4. Benchmark comparison to appropriate 2005 CAHPS data. 5. Member satisfaction summary for all questions. 6. Member satisfaction segmentation for composites, attributes, and ratings. 7. Opportunity analysis for Rating of Health Plan. 8. Key driver for Rating of Health Care. 9. Technical notes. 10. Banner tables of individual question results. 11. Glossary of Terms.

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	The reports contained relevant information to assess satisfaction and identify areas requiring improvement.
	Trending and Benchmarking Trending and benchmarking, which provides important insight into member satisfaction over time, was done for all five populations. Trending involved statistical comparison between 2006 and the previous three years of results for composites, composite attributes and ratings. Benchmarking involved statistical comparison between the 2006 results and appropriate 2005 data for composites, composite attributes and ratings. Benchmarking comparisons were made between the 2006 FirstGuard HW19 Adult results and the 2005 Quality Compass. Benchmarking comparisons were made between the 2006 FirstGuard HW19 and HW21 General Child results and the 2005 CAHPS Booklet (Medicaid Child). The source for this benchmark is a collection of CAHPS 3.0 mean survey ratings for 36 Medicaid Child (Non CCC) samples that submitted data to NCQA in 2005. For the HW19 CCC and HW21 CCC populations benchmarking comparisons were made with the respective HW19 and HW21 General Child populations and between the 2005 CAHPS Medicaid CCC benchmark. This benchmark represents the mean score of approximately 18 Medicaid Child CCC samples submitted to NCQA in 2005. Member Satisfaction Summary The member satisfaction summary section of the report contained limited benchmark and trend comparisons, as noted above, for *all* survey questions. The trend data was only reflective of comparisons between the 2006 and 2005 results and the CCC population results did not reflect the comparison to the 2005 CAHPS Medicaid CCC benchmark. Member Satisfaction Segmentation Segmentation analysis provided insight into member satisfaction based on age, education, duration in plan, ethnicity, race and data collection mode for the Adult Survey and on child's age, respondents level of level of education, and rating of child's health status, race and ethnicity for the child survey. The report stated that TMG has noted, over time, higher levels of satisfaction among respondents who were less educated, were older, have been with the plan longer, and report better health status. A profile of survey respondents by demographics reported statistical demographic comparisons between the 2006 CAHPS and 2005 CAHPS results as well as the 2006 CAHPS results and the 2005 Quality Compass for the HW19 Adult population. A profile of survey respondents by demographics reported statistical demographic comparisons between the 2006 CAHPS and 2005 CAHPS results as well as the 2006 CAHPS results and the 2005 CAHPS Booklet (Medicaid Child) for the HW19 General Child, and the HW21 General Child populations. A profile of HW19 and HW21 CCC survey respondents by demographics reported statistical demographic comparisons between the 2006 CAHPS and 2005 CAHPS results as well as the 2006 CAHPS results to the 2006 HW19 and HW21 General Child

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	populations. The reports do not contain a detailed interpretation of the segmentation analysis effect on survey generalizeability. Opportunity analysis for rating of Health Plan (Adult Question 52, Child Question 88) A multiple linear regression was run on TMG's Book of Business (2005) for Medicaid Child and Adult plans. The dependent variable was the health plan rating question. The independent variables were the five respondent-level composite variables and indicator variables for the health plan. Those composite variables found to have a significant positive influence (as found by testing individual beta coefficients with a 0.05 level of significance) on overall satisfaction were reported as a Key Drivers of overall satisfaction. The higher the beta score, the larger the effect the composite has on overall satisfaction, with all other composites held constant. Those composite variables with the highest betas were determined to be Key Drivers. The opportunity analysis section of the report identified key drivers of health plan satisfaction. Key drivers were defined as composite areas found to have the most positive impact on overall rating of the health plan as determined by the regression analysis. Key drivers were stratified into three categories based on plan summary rate scores and comparison to NCQA benchmarks. The first category was "Plan Opportunities" where composites below the 50th percentile are grouped. The second category, "Monitor," contained composites ranking between the 50th and 75th percentile. The third category was "Plan Strength" where composite rankings at the 75th percentile or higher are listed. Key driver analysis for Rating of Health Care (Adult Question 35, Child Question 51) TMG used regression analysis to determine the key drivers of health care rating.
Activity 7: Documentation of Validation of Survey. The EQRO documents its findings regarding its:	
• **Assessment of the technical methods of survey implementation and analysis, and the survey's technical strengths and weaknesses.**	The strengths of the survey implementation and analysis include: • Use of a 5-wave survey administration protocol, including two survey mailings, two reminder postcards, and one reminder telephone call. • Use of a reliable analysis program (NCQA). • Comparison to Quality Compass data for the Adult population, 2005 CAHPS Booklet for general child population and 2005 CAHPS Medicaid CCC Benchmark for CCC population (Benchmarking). • Comparison to previous years data (Trending). • Key and secondary driver analysis. • Segmentation analysis.

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	The weaknesses of the survey implementation and analysis include. Activity 4: Sampling Plan • Lack of detailed documentation necessary to confirm the validity of the stratified random sampling process used for the HW19 and HW21 Child populations. Activity 5: Response rate • Inclusion of incorrect disposition code ("mentally/physically incapacitated") for the child populations. • Less than 100 responses for the HW19 Adult and CCC population regarding the Customer Service composite attribute involving level of understanding of information in the written materials and on the internet. • Lack of documentation of percentage implications of sampling error. • Lack of assessment of potential sources of non-response bias. • Lack of assessment of implications of response rate for generalizeability of survey findings. Activity 6: Review of data preparation and analysis • Incomplete interpretation of the segmentation analysis effect on survey generalizeability. • Key and secondary drivers are exclusively based on their relationship to the benchmarks. (Opportunities for improvement may not be highlighted if the benchmark scores are also low.)
• **The limitations /generalizeability of survey findings.**	**Limitation** Lack of detailed survey methodology documentation as noted in the above section under "Weaknesses of survey implementation and analysis" doesn't necessarily mean the survey was done incorrectly. However, if some of these things were indeed not done, or were not done according to the NCQA HEDIS specifications, comparisons to national rates or benchmarks may be invalid. Of particular importance regarding comparability are: • Lack of detailed documentation regarding the stratified random sampling process used for the child populations, such as de-duplication and the address append process. **Generalizability** The ability to draw inferences to the overall HW19 and HW21 populations based on the survey findings may not be valid due to some of the issues identified in the above section under "Weaknesses of survey implementation and analysis." Of particular importance regarding generalizability are: • Less than 100 valid responses for the HW19 Adult and CCC population regarding the Customer Service composite attribute involving level of understanding of information in the written materials and on the internet. • Lack of documentation of percentage implications of sampling error. • Lack of assessment of potential sources of non-response bias. • Incomplete interpretation of segmentation analysis.

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• **Conclusions drawn from the survey data.**	**Results** *HW19 Adult* Demographic comparison to Benchmark (2005 Quality Compass) Statistically significant differences were noted in demographic comparisons between the 2006 FG CAHPS Adult respondents and the Adult respondents represented in the 2005 Quality Compass data. These differences were noted in Gender, Age, Race, Education, Duration with Plan and Health Status. The report did not specify how these demographic differences were correlated with satisfaction. Demographic comparison to Trend (FG 2006-2004) No statistically significant differences were noted in demographic comparisons between Adults who responded in 2006 compared to those who responded in 2005. However, three statistically significant differences were noted in the demographic comparisons of adult respondents between 2006 and 2004. The differences involved age, race/ethnicity and duration in plan. The report did not specify how these demographic differences were correlated with satisfaction Trend comparisons: 2006-2003 (Composites, Ratings and Composite Attributes) There were no statistically significant differences in composite or rating score comparisons during the 4-year period. There were two statistically significant differences in composite attribute score comparisons during the 4-year period. The first involved a statistically significant decrease in satisfaction in 2006 compared to 2004 for the composite attribute, “Obtaining care when wanted, not when needed right away.” The second involved a statistically significant increase in satisfaction in 2006 compared to 2003 for the composite attribute, “Getting help when calling customer service.” Benchmark comparison (Composites, Ratings and Composite Attributes) There were no statistically significant differences between the 2006 FG composite scores and the composite score represented by the 2005 Quality Compass (All Plans). There was a statistically significant decrease in the 2006 FG Rating of Specialist score compared to the Rating of Specialist score represented by the 2005 Quality Compass (All Plans). A statistically significant increase in satisfaction was noted in one of FG’s composite attribute question scores compared to the scores represented by the 2005 Quality Compass (All Plans). The question involved “Delays in care while waiting for approval”. There were no composite attribute questions where FG showed as statistically significant decrease in satisfaction compared to the 2005 Quality Compass (All Plans). Member satisfaction segmentation Stratification of summary rates for composites, composite attributes and ratings by respondent age, education, ethnicity, race and data collection mode were captured for the Adult population. An interpretation of the segmentation was not provided.

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	Opportunity analysis for Rating of Health Plan (Question 52) The report included an Opportunity Analysis section, which contained Key Drivers of satisfaction as well as beta attribute correlations with plan rating (Question 52). Three composites were identified as key drivers based on regression analysis. These were "How Well Doctors Communicate," "Customer Service," and "Getting Needed Care." The summary rate composite score for "How well Doctors Communicate" was at the 38th percentile and identified as an opportunity to investigate and improve. The question in the "How Well Doctors Communicate" composite that demonstrated the lowest level of satisfaction was Question 34, which involved doctors spending enough time with the patient. The summary rate composite score for "Customer Service" was at the 63rd percentile and was identified as an area to continue to monitor. The question in the "Customer Service" composite that demonstrated the lowest level of satisfaction was Question 45, which involved getting help when calling the plans customer service. The summary rate composite score for "Getting Needed Care" was at the 62nd percentile and was identified as an area to continue to monitor. The question in the "Getting Needed Care" composite that demonstrated the lowest level of satisfaction was Question 9, which involved seeing a specialist. No questions ranked above the 75th percentile, which was defined as a plan strength. Attribute and rating correlations with Rating of Health Plan identified one question that reflected statistically significant increased levels of satisfaction compared to the 2005 Quality Compass. The question involved delays in care while awaiting plan approval. Attribute and rating correlations with Rating of Health Plan identified one question that reflected statistically significant decreased levels of satisfaction compared to the 2005 Quality Compass. The question involved rating of specialist. Key Driver analysis for Rating of Health Care (Question 35) Using the same regression analysis model as described above to identify Key Drivers Health Plan Rating, TMG identified the Key Drivers of satisfaction related to Rating of Health Care. The three composites identified as Key Drivers of satisfaction were, "How Well Doctors Communicate," "Getting Needed Care" and "Courteous and Helpful Office Staff". The summary rate composite score for "How well Doctors Communicate" was at the 38th percentile and identified as an opportunity to investigate and improve. The question in the "How Well Doctors Communicate" composite that demonstrated the lowest level of satisfaction was Question 34, which involved doctors spending enough time with the patient. The summary rate composite score for "Getting Needed Care" was at the 62nd percentile and identified as an area to continue to monitor. The question in the "Getting Needed Care" composite that demonstrated the lowest level of satisfaction was Question 9, which involved seeing a specialist. The summary rate composite score for "Courteous and Helpful Office Staff" was at the 69th percentile and was identified as an area to continue to monitor. The question in the "Courteous and Helpful Office Staff" composite that demonstrated the lowest level of satisfaction was Question 29, which involved the helpfulness of office staff. No questions ranked above the 75th percentile, which

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	was defined as a plan strength. Attribute and rating correlations with Rating of Health Care identified one question that reflected statistically significant increased levels of satisfaction compare to the 2005 Quality Compass. The question involved delays in care while awaiting plan approval. Attribute and rating correlations with Rating of Health Care identified one question that reflected statistically significant decreased levels of satisfaction compare to the 2005 Quality Compass. The question involved rating of specialist. *HW19 General Child* Demographic Comparisons to Benchmark (2005 CAHPS Booklet) Statistically significant differences were noted in demographic comparisons between the 2006 FG CAHPS HW 19 General Child respondents and the General Child respondents represented in the 2005 CAHPS Booklet. These differences were noted in respondent's gender, respondent's age, respondent's education, child's duration in plan, child's health status, child's gender, child's age and child's race/ethnicity. The report did not specify how the demographic differences were correlated with satisfaction. Demographic comparison to Trend (FG 2006-2004) A statistically significant difference was noted in demographic comparisons between 2006 HW 19 Child population data compared to the 2005 data. This difference involved the child's age. Three statistically significant differences were noted in the demographic comparisons of HW19 respondents between 2006 and 2004. The differences involved respondent's education, child's duration in plan and child's age. The report did not specify how any of the demographic differences were correlated with satisfaction. Trend comparisons: 2006-2003 (Composites, Ratings and Composite Attributes) There were no statistically significant differences in composite score comparisons during the 4-year period. One statistically significant difference in rating score comparisons was noted during the 4-year period. The difference involved "Rating of Personal Doctor" which reflected a statistically significant decrease in satisfaction in 2006 compared to 2005. There were six statistically significant differences in composite attribute score comparisons during the 4-year period. Four of the differences represented statistically significant increases in satisfaction and two represented statistically significant decreases in satisfaction. Two of the statistically significant increases in satisfaction involved "Getting help when calling customer service," and were reflected in the comparisons of the 2006 to 2005 and 2006 to 2004 results. The remaining two statistically significant increases in satisfaction involved "Waiting time in

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	the doctors office," and were reflected in the comparisons of the 2006 to 2005 and 2006 to 2004 results. The first statistically significant decrease in satisfaction involved "Doctors listening carefully," and was noted in the comparison of the 2006 to 2005 results. The second statistically significant decrease in satisfaction involved "Finding and understanding information," and was noted in the comparison of the 2006 to 2005 results. <u>Benchmark comparison (Composites, Ratings and Composite Attributes)</u> There was a statistically significant increase in satisfaction in the 2006 FG composite score for "Getting Needed Care," compared to the composite scores represented by the 2005 CAHPS Booklet. There was a statistically significant increase in satisfaction in the 2006 FG scores for "Rating of Health Plan," compared to the corresponding rating scores represented by the 2005 CAHPS Booklet. Statistically significant increases in satisfaction were noted in five FG composite attribute question scores compared to the scores represented by the 2005 CAHPS Booklet. Eleven attribute question score comparisons did not reveal any statistically significant differences. No composite attribute score comparisons represented decreased satisfaction. <u>Member satisfaction segmentation</u> Stratification of summary rates for composites, composite attributes and ratings by child's age, respondent education, child's health status, child's race and child's ethnicity was provided for the HW19 General Child population. An interpretation of the segmentation was not provided. <u>Opportunity analysis for Rating of Health Plan (Question 88)</u> The report included an Opportunity Analysis section, which contained Key Drivers of satisfaction as well as beta attribute correlations with plan rating (Question 88). Three composites were identified as key drivers based on regression analysis. These were "Getting Needed Care," "Customer Service" and "How Well Doctors Communicate." The summary rate composite score for "Getting Needed Care" was "significantly higher" than the 2005 CAHPS Booklet mean summary rate and was identified as an area of plan strength to market and maintain. The question in the "Getting Needed Care" composite that demonstrated the highest level of satisfaction was Question 30, which involved delays in the child's care while waiting for approval. The summary rate composite scores for "Customer Service" and "How Well Doctors Communicate" were "not significantly different" than the 2005 CAHPS Booklet mean summary rate and were identified as areas to continue to monitor. The question in the "Customer Service" composite that demonstrated the lowest level of satisfaction was Question 81, which involved getting help when calling customer service. The question in the "How Well Doctors Communicate" composite that demonstrated the lowest level of satisfaction was Question 41, which involved doctors spending enough time with the child. Attribute and rating correlations with Rating of Health Plan identified five questions that reflected statistically significant increased levels of satisfaction compare to the 2005 CAHPS Booklet. These

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	questions are summarized below: • Getting a referral to a specialist for the child • Getting care, tests or treatments necessary for your child • Delays in your child's care while awaiting plan approval • Wait time in the doctors office • Child's doctor explaining things in an understandable way Attribute and rating correlations with Rating of Health Plan identified no questions that reflected statistically significant decreased levels of satisfaction compared to the 2005 CAHPS Booklet. <u>Key Driver analysis for Rating of Health Care (Question 51)</u> Using the same regression analysis model as described above to identify Key Drivers Health Plan Rating, TMG identified the Key Drivers of satisfaction related to Rating of Health Care. The three composites identified as Key Drivers of satisfaction were, "Getting Needed Care," How Well Doctors Communicate," and "Courteous and Helpful Office Staff". The summary rate composite score for "Getting Needed Care" was "significantly higher" than the 2005 CAHPS Booklet and identified as a plan strength to market and maintain. The question in the "Getting Needed Care" composite that demonstrated the highest level of satisfaction was Question 30, which involved delays in care while awaiting plan approval. The summary rate composite score for "How Well Doctors Communicate" was "not statistically different" than the 2005 CAHPS Booklet and was identified as an area to continue to monitor. The question in the "How Well Doctors Communicate" composite that demonstrated the lowest level of satisfaction was Question 41, which involved doctors spending enough time with the child. The summary rate composite score for "Courteous and Helpful Office Staff" was "not statistically different" than the 2005 CAHPS Booklet and was identified as an area to monitor. The question in the "Courteous and Helpful Office Staff" composite that demonstrated the lowest level of satisfaction was Question 33, which involved office staff being as helpful as it was thought they should be. Attribute and rating correlations with Rating of Health Care identified six questions that reflected statistically significant increased levels of satisfaction compare to the 2005 CAHPS Booklet. These questions are summarized below: • Getting a referral to a specialist for your child • Getting care, tests or treatments necessary for your child • Delays in your child's care while awaiting plan approval • Wait time in the doctors office • Child's doctor explaining things in an understandable way • How would you rate your health plan

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	Attribute and rating correlations with Rating of Health Care identified no questions that reflected statistically significant decreased level of satisfaction compared to the 2005 CAHPS Booklet. *HW19 CCC* <u>Demographic Comparisons to Benchmark (HW19 General Population)</u> Demographic comparisons were made between the HW19 CCC population and the HW19 General Child population. These comparisons reflected differences in respondent's gender, respondent's age, respondent's education, child's duration in plan, child's health status, child's gender, child's age and child's race/ethnicity. The report notes statistical significance testing was not appropriate for these two groups since they are not mutually exclusive. The report did not specify how the demographic differences were correlated with satisfaction. <u>Demographic comparison to Trend (FG 2006, 2005 and 2004)</u> Statistically significant differences were noted in demographic comparisons between 2006 and 2005 HW 19 CCC population data. The differences involved the child's duration in plan and the child's race/ethnicity. Additional statistically significant differences were noted in the demographic comparisons between the 2006 and 2004 data. These differences involved respondent's relation to child, respondent's education, child's duration in plan and child's race/ethnicity. The report did not specify how any of the demographic differences were correlated with satisfaction. <u>Trend comparisons (Composites, Ratings and Composite Attributes)</u> Four-year trending results (2006-2003) were provided for the core composite, rating and core composite attribute scores. There were no statistically significant differences in HW19 CCC composite or rating scores during the 4-year period. There were four statistically significant differences in composite attribute scores during the 4-year period. Two of the differences represented statistically significant increases in satisfaction and two represented statistically significant decreases in satisfaction. The first statistically significant increase in satisfaction involved "Waiting time in the doctors office" and was reflected in the comparison of the 2006 to the 2004 results. The second statistically significant increase in satisfaction involved "Doctors showing respect for what you had to say" and was noted in the comparison of the 2006 to 2003 results. The two statistically significant decreases in satisfaction involved "Finding/understanding information" and were noted in the comparisons of the 2006 to 2005 results and the 2006 to 2003 results. Three-year trending results (2006-2004) were provided for the six additional composites unique to children with chronic conditions. These additional CCC composites include Access to Prescription Medicines, Access to Specialized Services, Personal Doctor or Nurse Who Knows the Child, Shared Decision Making, Getting Needed Information and Coordination of Care. There were two statistically

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	significant differences in CCC composite scores during the 3-year period. Both differences were noted with the Access to Prescription Medicines composite and both represented statistically significant increases in satisfaction. The first was reflected in the comparison of the 2006 to 2005 results and the second was noted in the comparison of the 2006 to 2004 results. There were five statistically significant differences in CCC composite attribute scores during the 3-year period. Four of the differences represented statistically significant increases in satisfaction and one represented a statistically significant decrease in satisfaction. Two of the statistically significant increases in satisfaction involved, getting the child's prescription medicine and were reflected in the comparisons of the 2006 to 2005 and 2006 to 2004 results. The third statistically significant increase in satisfaction involved getting special medical equipment and was noted in the comparison of the 2006 to 2005 results. The fourth statistically significant increase in satisfaction involved the doctor or nurse understanding of how the child's medical, behavioral or other health conditions affects the child's day-to-day life and was noted in the comparison of the 2006 to 2004 results. The one statistically significant decrease in satisfaction involved the doctor or nurse talking with the parent about how the child was feeling, growing or behaving and was noted in the comparison of the 2006 to 2005 results. <u>Benchmark comparison (Composites, Ratings and Composite Attributes)</u> Comparisons were made between the 2006 HW19 CCC composite, rating and composite attribute scores and the 2006 HW19 General Child composite, rating and composite attribute scores. The report noted that statistical testing was not appropriate for these two groups since they are not mutually exclusive. Three of the five composite scores for the CCC population were higher than the General Child population composite scores. In addition, two of the four rating scores were higher for the CCC population. Comparisons were also made between the 2006 HW19 CCC composite and rating scores and the 2005 CAHPS CCC benchmark. The benchmark represented the mean score of approximately 18 Medicaid CCC samples submitted to NCQA in 2005. (Benchmark data was not available for the composite attributes.) Statistically significant differences were noted for two composite scores and one rating score. The "Getting Care Quickly" composite score represented an increase in satisfaction compared to the benchmark while the "Customer Service" composite score represented a decrease in satisfaction compared to the benchmark. The "Rating of Health Plan" score represented a decrease in satisfaction compared to the benchmark. The TMG report also contained benchmark comparisons for the 6 additional composites unique to the CCC population. The 2005 CAHPS CCC benchmark was used for these comparisons. Benchmark data was not available for the composite attributes. The additional CCC composites include Access to Prescription Medicines, Access to Specialized Services, Personal Doctor or Nurse Who Knows the Child, Shared Decision Making, Getting Needed Information and Coordination of Care. The comparisons identified no statistically significant differences.

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	Member satisfaction segmentation Stratification of summary rates for composites, composite attributes and ratings by Child's Age, Respondent Education, Child's Health Status, Child's Race and Child's Ethnicity was provided for the HW19 CCC population. An interpretation of the segmentation was not provided. Opportunity analysis for Rating of Health Plan (Question 88) The report did not include an Opportunity Analysis section for the HW19 CCC population to identify Key Drivers of satisfaction, but did include beta attribute and rating correlations with plan rating (Question 88) based on comparisons to the HW19 General Child population. Statistical testing was not done to identify statistically significant differences. Key Driver analysis for Rating of Health Care (Question 51) The report did not include an Opportunity Analysis section for the HW19 CCC population to identify Key Drivers of satisfaction, but did include beta attribute and rating correlations with health care rating (Question 51) based on comparisons to the HW19 General Child population. Statistical testing was not done to identify statistically significant differences. *HW21 General Child* Demographic Comparisons to Benchmark (2005 CAHPS Booklet) Statistically significant differences were noted in demographic comparisons between the 2006 FG CAHPS HW 21 General Child respondents and the General Child respondents represented in the 2005 CAHPS Booklet data. These differences were noted in respondent's age, respondent's relation to child, respondent's education, child's duration in plan, child's health status, child's age and child's race/ethnicity. The report did not specify how these demographic differences were correlated with satisfaction. Demographic comparison to Trend (FG 2006-2004) Statistically significant differences were noted in demographic comparisons between 2006 HW 21 General Child population data compared to the 2005 HW21 General Child population data. The differences involved the child's duration in plan and the child's age. Additional statistically significant differences were noted in the demographic comparisons between the 2006 and 2004 data. These differences involved respondent's gender, respondent's age, child's duration in plan and child's race/ethnicity. The report did not specify how any of the demographic differences were correlated with satisfaction. Trend comparisons: 2006-2003 (Composites, Ratings and Composite Attributes) There were no statistically significant differences in composite score comparison during the 4-year

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	period. One statistically significant difference in rating score comparisons was noted between 2006 CAHPS and 2003 CAHPS. The difference involved "Rating of Health Plan" and represented a statistically significant increase in satisfaction in 2006 compared to 2003. There were three statistically significant differences in composite attribute score comparisons during the 4-year period. The first two differences involved "Getting the help/advice you need" which reflected a statistically significant increase in satisfaction in 2006 compared to 2005 and in 2006 compared to 2004. The third difference involved "Finding/understanding information" which reflected a statistically significant increase in satisfaction in 2006 compared to 2004. <u>Benchmark comparison (Composites, Ratings and Composite Attributes)</u> There were statistically significant increases in satisfaction in the 2006 FG composite score for "Getting Needed Care," "Getting Care Quickly," "How Well Doctors Communicate," and "Courteous and Helpful Office Staff" compared to the composite scores represented by the 2005 CAHPS Booklet. There were statistically significant increases in satisfaction in the 2006 FG scores for "Rating of Health Care," and Rating of Health Plan" compared to the corresponding rating scores represented by the 2005 CAHPS Booklet. The scores for "Rating of Person Doctor" and "Rating of Specialist" revealed not statistical differences compared to the 2005 CAHPS Booklet. Statistically significant increases in satisfaction were noted in 11 FG composite attribute question scores compared to the scores represented by the 2005 CAHPS Booklet. Five attribute question score comparisons did not reveal any statistically significant differences. <u>Member satisfaction segmentation</u> Stratification of summary rates for composites, composite attributes and ratings by child's age, respondent education, child's health status, child's race and child's ethnicity was provided for the HW21 General Child population. An interpretation of the segmentation was not provided. <u>Opportunity analysis for Rating of Health Plan (Question 88)</u> The report included an Opportunity Analysis section, which contained Key Drivers of satisfaction as well as beta attribute correlations with plan rating (Question 88). Three composites were identified as key drivers based on regression analysis. These were "How Well Doctors Communicate," "Getting Needed Care" and "Customer Service." The summary rate composite scores for "How Well Doctors Communicate" and "Getting Needed Care" were rated "significantly higher" than the 2005 CAHPS Booklet mean summary rate. Both of these summary rate composite scores were identified as plan strengths to market and maintain. The question in the "How Well Doctors Communicate" composite that demonstrated the highest level of satisfaction was Question 37, which involved doctors showing respect for what you had to say. The question in the "Getting Needed Care" composite that demonstrated the highest level of satisfaction was Question 30, which involved delays in the child's care while waiting for approval. The summary rate composite score for "Customer Service" was rated

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	"not significantly different" than the 2005 CAHPS Booklet mean summary rate and was identified as an area to continue to monitor. The question in the "Customer Service" composite that demonstrated the lowest level of satisfaction was Question 81, which involved getting help when calling customer service. No composite was identified as an opportunity for improvement. Attribute and rating correlations with Rating of Health Plan identified 12 questions that reflected statistically significant increased levels of satisfaction compare to the 2005 CAHPS Booklet mean score. These questions are summarized below: • Getting care, tests or treatments necessary for your child • Delays in your child's care while awaiting plan approval • Getting the help/advice you need for your child • Obtaining care right away for an illness, injury or condition • Obtaining care when wanted, not when needed right away • Waiting time in your child's doctors office • Child's doctor listening carefully to you • Child's doctor explaining things in an understandable way • Child's doctor showing respect for what you had to say • Doctors spending enough time with child • Helpful office staff • How would you rate your health care No attribute or rating correlations with Rating of Health Plan were identified that reflected statistically significant decreased levels of satisfaction compared to the 2005 CAHPS Booklet mean score. <u>Key Driver analysis for Rating of Health Care (Question 51)</u> Using the same regression analysis model as described above to identify Key Drivers Health Plan Rating, TMG identified the Key Drivers of satisfaction related to Rating of Health Care. The three composites identified as Key Drivers of satisfaction were, "Getting Needed Care," How Well Doctors Communicate," and "Courteous and Helpful Office Staff". The summary rate composite scores for these three composites were rated "significantly higher" than the 2005 CAHPS Booklet mean summary rate and represented plan strengths to market and maintain. The question in the "Getting Needed Care" composite that demonstrated the highest level of satisfaction was Question 30, which involved delays in care while awaiting plan approval. The question in the "How Well Doctors Communicate" composite that demonstrated the highest level of satisfaction was Question 37, which involved doctors showing respect for what you had to say. The question in the "Courteous and Helpful Office Staff" composite that demonstrated the highest level of satisfaction was Question 32, which involved office staff treating you with courtesy and respect.

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	Attribute and rating correlations with Rating of Health Care identified 12 questions that reflected statistically significant increased levels of satisfaction compare to the 2005 CAHPS Booklet. These questions are summarized below: • Getting care, tests or treatments necessary for your child • Delays in your child's care while awaiting plan approval • Getting the help/advice you need for your child • Obtaining care right away for an illness, injury or condition • Obtaining care when wanted, not when needed right away • Waiting time in your child's doctors office • Child's doctor listening carefully • Child's doctor explaining things in an understandable way • Child's doctor showing respect for what you had to say • Doctors spending enough time with child • Office staff as helpful as you thought they should be • Rating of health plan No attribute or rating correlations with Rating of Health Care were identified that reflected statistically significant decreased levels of satisfaction compared to the 2005 CAHPS Booklet. *HW21 CCC* <u>Demographic Comparisons to Benchmark (HW21 General Population)</u> Demographic comparisons were made between the HW21 CCC population and the HW21 General Child population. These comparisons reflected differences in respondent's gender, respondent's age, respondent's education, child's duration in plan, child's health status, child's gender, child's age and child's race/ethnicity. The report notes statistical significance testing was not appropriate for these two groups since they are not mutually exclusive. The report did not specify how any demographic differences were correlated with satisfaction. <u>Demographic comparison to Trend (FG 2006-2004)</u> Statistically significant differences were noted in demographic comparisons between 2006 and 2005 HW 21 CCC population data. The difference involved the child's duration in plan, child's health status and child's race/ethnicity. Additional statistically significant differences were noted in the demographic comparisons between the 2006 and 2004 data. These differences involved respondent's age, child's duration in plan and child's age. The report did not specify how any of the demographic differences were correlated with satisfaction.

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	Trend comparisons (Composites, Ratings and Composite Attributes) Four-year trending results (2006-2003) were provided for the core composite, rating and core composite attribute scores. There was one statistically significant difference in composite scores during the 4-year period. The difference was noted in the comparison between the 2006 and 2004 CAHPS results. This difference involved the composite "Courteous and Helpful Office Staff" and represented a statistically significant increase in satisfaction in 2006 compare to 2004. There were two statistically significant differences between rating scores during the 4-year period. The differences involved "Rating of Health Care" and Rating of Health Plan" and were noted in the comparisons of the 2006 to 2004 CAHPS results. In both instances, these ratings represented statistically significant increases in satisfaction in 2006 compared to 2004. There were five statistically significant differences in composite attribute scores during the 4-year period. In all five instances, the 2006 CAHPS results represented statistically significant increases in satisfaction compared to the preceding three years. The first two differences involved "Waiting time in the doctors office" which was identified in the 2006 to 2005 and 2006 to 2003 CAHPS result comparisons. The third difference involved "Doctors listening carefully to you" which was identified in the 2006 to 2004 CAHPS result comparisons. The fourth difference involved "Office staff treating you with courtesy and respect" which was identified in the 2006 to 2004 CAHPS result comparisons. The final difference involved "Office staff as helpful as you thought they should be" which was identified in the 2006 to 2004 CAHPS result comparisons. Three-year trending results (2006-2004) were provided for the six additional composites unique to children with chronic conditions. These additional CCC composites include Access to Prescription Medicines, Access to Specialized Services, Personal Doctor or Nurse Who Knows the Child, Shared Decision Making, Getting Needed Information and Coordination of Care. There were two statistically significant differences in CCC composite scores during the 3-year period. Both differences were noted with the Access to Prescription Medicines composite and both represented statistically significant increases in satisfaction. The first was reflected in the comparison of the 2006 to 2005 results and the second was noted in the comparison of the 2006 to 2004 results. There were six statistically significant differences in CCC composite attribute scores during the 3-year period. All differences represented statistically significant increases in satisfaction in 2006 compared to the trended year. The first two differences involved getting the child's prescription medicine, which were noted in the 2006 to 2005 and 2006 to 2004 comparisons. The third difference involved getting treatment or counseling for the child and was noted in the 2006 to 2005 comparison. The fourth difference involved the doctor or nurse understanding of how the child's conditions affect the child's day-to-day life and was noted in the 2006 to 2004 comparison. The fifth difference involved the doctor or nurse understanding of how the child's conditions affect the family's day-to-day life and was noted in the 2006 to 2004 comparison. The final difference involved getting specific information from the child's doctor or health provider and was noted in the 2006 to 2004 comparison.

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	Benchmark comparison (Composites, Ratings and Composite Attributes) Comparisons were made between the 2006 HW21 CCC composite, rating and composite attribute scores and the 2006 HW21 General Child composite, rating and composite attribute scores. The report noted that statistical testing was not appropriate for these two groups since they are not mutually exclusive. Three composite scores for the General Child population were higher and one was lower than the composite scores for the CCC population. In addition, three of the four rating scores were higher for the General Child population. The one rating score that was lower was "Rating of Personal Doctor." Comparisons were also made between the 2006 HW19 CCC composite and rating scores and the 2005 CAHPS CCC benchmark. The benchmark represented the mean score of approximately 18 Medicaid CCC samples submitted to NCQA in 2005. (Benchmark data was not available for the composite attributes.) Statistically significant differences were noted for four composite scores and two rating scores. The four composites where differences were noted were "Getting Needed Care," "Getting Care Quickly," "How Well Doctors Communicate" and "Courteous and Helpful Office Staff." All 2006 composite scores represented statistically significant increases in satisfaction compared to the benchmark. In addition, "Rating of Health Care" and "Rating of Health Plan" represented statistically significant increases in satisfaction compared to the benchmark. The TMG report also contained benchmark comparisons for the six additional composites unique to the CCC population. The 2005 CAHPS CCC benchmark was used for these comparisons. The additional CCC composites include Access to Prescription Medicines, Access to Specialized Services, Personal Doctor or Nurse Who Knows the Child, Shared Decision Making, Getting Needed Information and Coordination of Care. The composite comparisons identified two statistically significant differences. The first involved "Access to Prescription Medicines" and the second involved "Getting Needed Information." Both differences represented statistically significant increases in satisfaction in 2006 compared to the benchmark. Benchmark data was not available for the composite attributes. Member satisfaction segmentation Stratification of summary rates for composites, composite attributes and ratings by child's age, respondent's education, child's health status, child's race and child's ethnicity was provided for the HW21 CCC population. An interpretation of the segmentation was not provided. Opportunity analysis for Rating of Health Plan (Question 88) The report did not include an Opportunity Analysis section for the HW21 CCC population to identify Key Drivers of satisfaction, but did include beta attribute and rating correlations with plan rating (Question 88) based on comparisons to the HW21 General Child population. Statistical testing was not done to identify statistically significant differences.

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	Key Driver analysis for Rating of Health Care (Question 51) The report did not include an Opportunity Analysis section for the HW21 CCC population to identify Key Drivers of satisfaction, but did include beta attribute and rating correlations with health care rating (Question 51) based on comparisons to the HW21 General Child population. Statistical testing was not done to identify statistically significant differences. **Conclusions** TMG's conclusions were noted in the reports. FG provided no documentation regarding their level agreement with the conclusions or recommendations for improvement in the TMG reports. The FG cover letter dated July 20, 2006 that was attached to the TMG reports noted the following; "The final reports have not been reviewed internally by the Quality Management Leadership Team (QMLT) or any other FirstGuard Committee. Therefore, there is no assessment or recommendation to accompany the reports at this time." FG indicated in a February 10, 2006 meeting with KHPA and KFMC that an addendum report would be submitted in September of each year providing information on their review and interpretation of the survey findings and plans for subsequent actions. FG noted in their September 12, 2006 response to KFMC's request for additional information regarding CAHPS survey methodology that a Member Satisfaction Workgroup had been working to develop recommendations and a work-plan to present to the QMLT. This workgroup met with TMG on several occasions to identify opportunities for improvement. The work-plan was to be presented with final approval by the QMLT in October 2006. In addition, FG noted their CLAS (Cultural and Linguistically Appropriate Services) Workgroup was scheduled to receive the 2006 CAHPS results on September 13, 2006. The CLAS Workgroup is responsible for assessment of the CAHPS results pertaining to the profile of survey respondents, segmentation analysis by race and ethnicity and survey question regarding the degree of difficulty in finding a personal doctor who met the member's special cultural and/or spoken language needs. Discussions with FG on November 03, 2006 confirmed the workgroups had developed a work-plan, which was presented to and approved by QMLT. FG indicated the work-plan would not be implemented.
• **A detailed assessment of each MCO's strengths and weaknesses with respect to (as appropriate) access, quality, and/or timeliness of health care furnished to Medicaid enrollees.**	The following is an assessment of strengths and weaknesses in the areas of access, quality and timeliness of care. The assessment is based on most positive response scores ("Usually" and "Always," "Not a Problem," or "8, 9 and 10.") to individual survey questions/ratings and involves two comparisons. The first involves statistical comparison of composite attribute and rating scores to the 2005 CAHPS scores and the 2005 benchmark scores (Quality Compass for adults and CAHPS Booklet for children.) The second involves the 2006 composite attribute and rating summary scores. Strengths were identified as a statistically significant increase in most positive response scores respective to both the trend and the benchmark or a summary score of greater than 90%. Strengths represent increased satisfaction. Weaknesses were identified as a statistically significant decrease in most positive response scores respective to both the trend and benchmark or a summary score of less than 70%. Weaknesses

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	represent decreased satisfaction. General composite attribute and rating questions were grouped into the following three categories: • Access to Care • Quality of Care • Timeliness of Care <u>Access to Care</u> The attribute questions used to measure access to care were: • Getting a provider you are happy with • Seeing a specialist • Getting the care, tests or treatments necessary • Delays in care while waiting for approval <u>Quality of Care</u> The attribute/rating questions used to measure quality of care were: • Doctors listening carefully • Doctors showing respect for what you had to say • Doctors spending enough time with you • Office staff treating you with courtesy and respect • Rating of health care • Rating of specialist • Rating of personal doctor <u>Timeliness of Care</u> The attribute questions used to measure timeliness of care were: • Obtaining care right away for an illness/injury/condition • Obtaining care when wanted, not when needed right away • Waiting time in doctor's office *HW19 Adult* <u>Access to Care Strengths</u> There were no instances where FG's 2006 CAHPS attribute scores related to access to care were statistically significantly greater than both the FG 2005 CAHPS attribute scores and the 2005 Quality Compass attribute scores. However, the 2006 FG attribute score for delays in care while waiting for approval was 93.1% and was considered a FG strength.

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	Access to Care Weaknesses There were no instances where FG's 2006 CAHPS attribute scores related to access to care were statistically significantly lower than both the FG 2005 CAHPS attribute scores and the 2005 Quality Compass attribute scores. However, the 2006 FG attribute scores for getting a provider you are happy with seeing a specialist were 68.5% and 65.6% respectively. Both of these areas are considered FG weaknesses. Quality of Care Strengths There were no instances where FG's 2006 CAHPS attribute scores related to quality of care were statistically significantly higher than both the FG 2005 CAHPS attribute scores and the 2005 Quality Compass attribute scores. However, the 2006 FG attribute score for office staff treating you with courtesy and respect was 93.6% and was considered a FG strength. Quality of Care Weakness There were no instances where FG's 2006 CAHPS attribute scores related to quality of care were statistically significantly lower than both the FG 2005 CAHPS attribute scores and the 2005 Quality Compass attribute scores. However, the 2006 FG attribute score for rating of specialist was 63.7% and was considered a FG weakness. Timeliness of Care Strength There were no instances where FG's 2006 CAHPS attribute scores related to timeliness of care were statistically significantly higher than both the FG 2005 CAHPS attribute scores and the 2005 Quality Compass attribute scores. In addition, there were no 2006 FG attribute scores greater than 90%. No FG strengths were identified involving timeliness of care. Timeliness of Care Weakness There were no instances where FG's 2006 CAHPS attribute scores related to timeliness of care were statistically significantly lower than both the FG 2005 CAHPS attribute scores and the 2005 Quality Compass attribute scores. However, the 2006 FG attribute score for waiting time in the doctor's office was 49.7% and was considered a FG weakness. *HW19 General Child* Access to Care Strengths There were no instances where FG's 2006 CAHPS attribute scores related to access to care were statistically significantly greater than both the FG 2005 CAHPS attribute scores and the 2005 CAHPS

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	Booklet attribute scores. The 2006 FG attribute score involving delays in care while waiting for approval was 96.4% and was considered a FG strength. Access to Care Weaknesses There were no instances where FG's 2006 CAHPS attribute scores related to access to care were statistically significantly lower than both the FG 2005 CAHPS attribute scores and the 2005 CAHPS Booklet attribute scores. In addition, there were no 2006 FG attribute scores related to access to care lower than 70%. No FG weaknesses were identified involving access to care. Quality of Care Strengths There were no instances where FG's 2006 CAHPS attribute scores related to quality of care were statistically significantly higher than both the FG 2005 CAHPS attribute scores and the 2005 CAHPS Booklet attribute scores. There were three instances where 2006 FG attribute scores related to quality of care were greater than 90%. These areas involved doctors listening carefully (91.8%), doctors showing respect for what you had to say (93.3%) and office staff treating you with courtesy and respect (93.6%). These three areas are considered FG strengths. Quality of Care Weakness There were no instances where FG's 2006 CAHPS attribute scores related to quality of care were statistically significantly lower than both the FG 2005 CAHPS attribute scores and the 2005 CAHPS Booklet attribute scores. In addition there were no 2006 FG attribute scores or ratings that were lower than 70%. No FG weaknesses were identified involving quality of care. Timeliness of Care Strength There were no instances where FG's 2006 CAHPS attribute scores related to timeliness of care were statistically significantly higher than both the FG 2005 CAHPS attribute scores and the 2005 CAHPS Booklet attribute scores. However, the 2006 FG attribute score for obtaining care right away for an illness, injury or condition was 90.8% and was considered a FG strength. Timeliness of Care Weakness There were no instances where FG's 2006 CAHPS attribute scores related to timeliness of care were statistically significantly lower than both the FG 2005 CAHPS attribute scores and the 2005 CAHPS Booklet attribute scores. However, the 2006 FG attribute score for waiting time in the doctor's office was 58.3% and was considered a FG weakness.

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	HW19 CCC Access to Care Strengths Benchmarking to the 2005 CAHPS CCC benchmark was not done for attribute questions relating to access to care. The 2006 FG attribute score involving delays in care while waiting for approval was 93.9% and was considered a FG strength. Access to Care Weaknesses Benchmarking to the 2005 CAHPS CCC benchmark was not done for attribute questions relating to access to care. There were no 2006 FG attribute scores lower than 70%. No FG weaknesses were identified involving quality of care. Quality of Care Strengths Benchmarking to the 2005 CAHPS CCC benchmark was only done for the rating questions related to quality of care. There were no instances where FG's 2006 CAHPS rating scores related to quality of care were statistically significantly higher than both the FG 2005 CAHPS rating scores and the 2005 CAHPS CCC benchmark rating scores. There were three instances where the 2006 FG attribute scores were greater than 90%. The first involved doctors listening carefully to you (93.7%). The second involved doctors showing respect for what you had to say (94.9%). The third involved office staff treating you with courtesy and respect (94.2%). These three areas are considered FG strengths. Quality of Care Weakness Benchmarking to the 2005 CAHPS CCC benchmark was only done for the rating questions related to quality of care. There were no instances where FG's 2006 CAHPS rating scores related to quality of care were statistically significantly lower than both the FG 2005 CAHPS rating scores and the 2005 CAHPS Booklet rating scores. There were no instances where FG's 2006 CAHPS attribute or rating scores related to quality of care were lower than 70%. No FG weaknesses were identified involving quality of care. Timeliness of Care Strength Benchmarking to the 2005 CAHPS CCC benchmark was not done for attribute questions relating to timeliness of care. There were two instances where FG's 2006 attribute scores related to timeliness of care was greater than 90%. The first involved obtaining care right away for an illness, injury or condition (91.5%). The second involved obtaining care when wanted, not when needed right away (90.2%). These two areas are considered FG strengths.

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	Timeliness of Care Weakness Benchmarking to the 2005 CAHPS CCC benchmark was not done for attribute questions relating to timeliness of care. The 2006 FG attribute score for waiting time in the doctor's office was 61.9% and was considered a FG weakness. *HW21 General Child* Access to Care Strengths There were no instances where FG's 2006 CAHPS attribute scores related to access to care were statistically significantly greater than both the FG 2005 CAHPS attribute scores and the 2005 CAHPS Booklet attribute scores. The 2006 FG attribute score involving delays in care while waiting for approval was 97.5% and was considered a FG strength. Access to Care Weaknesses There were no instances where FG's 2006 CAHPS attribute scores related to access to care were statistically significantly lower than both the FG 2005 CAHPS attribute scores and the 2005 CAHPS Booklet attribute scores. In addition, there were no 2006 FG attribute score related to access to care lower than 70%. No FG weaknesses were identified involving access to care. Quality of Care Strengths There were no instances where FG's 2006 CAHPS attribute scores related to quality of care were statistically significantly higher than both the FG 2005 CAHPS attribute scores and the 2005 CAHPS Booklet attribute scores. There were four instances where FG attribute scores were greater than 90%. The first involved doctors listening carefully (94.9%). The second involved doctors showing respect for what you had to say (95.6%). The third involved doctors spending enough time with your child (90.9%). The fourth involved office staff treating you with courtesy and respect (94.4%). These four areas are considered FG strengths. Quality of Care Weakness There were no instances where FG's 2006 CAHPS attribute scores related to quality of care were statistically significantly lower than both the FG 2005 CAHPS attribute scores and the 2005 CAHPS Booklet attribute scores. In addition there were no 2006 FG attribute or rating scores that were lower than 70%. No FG weaknesses were identified involving quality of care. Timeliness of Care Strength There were no instances where FG's 2006 CAHPS attribute scores related to timeliness of care were

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	statistically significantly higher than both the FG 2005 CAHPS attribute scores and the 2005 CAHPS Booklet attribute scores. There were two instances where FG's 2006 attribute score were greater than 90%. The first involved obtaining care right away for an illness, injury or condition (93.5%). The second involved obtaining care when wanted, not when needed right away (92.4%). These two areas are considered FG strengths. <u>Timeliness of Care Weakness</u> There were no instances where FG's 2006 CAHPS attribute scores related to timeliness of care were statistically significantly lower than both the FG 2005 CAHPS attribute scores and the 2005 CAHPS Booklet attribute scores. However, the 2006 FG attribute score for waiting time in the doctor's office was 59.7% and was considered a FG weakness. *HW21 CCC* <u>Access to Care Strengths</u> Benchmarking to the 2005 CAHPS CCC benchmark was not done for the attribute questions relating to access to care. The 2006 FG attribute score involving delays in care while waiting for approval was 94.1% and was considered a FG strength. <u>Access to Care Weaknesses</u> Benchmarking to the 2005 CAHPS CCC benchmark was not done for the attribute questions relating to access to care. There were no 2006 FG attribute scores lower than 70%. No FG weaknesses were identified involving access to care. <u>Quality of Care Strengths</u> Benchmarking to the 2005 CAHPS CCC benchmark was only done for the rating questions related to quality of care. There were no instances where FG's 2006 CAHPS rating scores related to quality of care were statistically significantly higher than both the FG 2005 CAHPS rating scores and the 2005 CAHPS CCC benchmark. There were four instances where 2006 FG attribute scores were greater than 90%. The first involved doctors listening carefully to you (94.1%). The second involved doctors showing respect for what you had to say (95.3%). The third involved doctors spending enough time with you (91.0%). The fourth involved office staff treating you with courtesy and respect (96.0%). These four areas were considered FG strengths.

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	Quality of Care Weakness Benchmarking to the 2005 CAHPS CCC benchmark was only done for the rating questions related to quality of care. There were no instances where FG's 2006 CAHPS rating scores related to quality of care were statistically significantly lower than both the FG 2005 CAHPS rating scores and the 2005 CAHPS CCC benchmark. There were no instances where FG's 2006 CAHPS attribute or rating scores related to quality of care were lower than 70%. No FG weaknesses were identified involving quality of care. Timeliness of Care Strength Benchmarking to the 2005 CAHPS CCC benchmark was not done for attribute questions relating to timeliness of care. There were two instances where FG's 2006 attribute scores related to timeliness of care was greater than 90%. The first involved obtaining care right away for an illness, injury or condition (93.3%). The second involved obtaining care when wanted, not when needed right away (92.6%). These two areas were considered FG strengths. Timeliness of Care Weakness Benchmarking to the 2005 CAHPS CCC benchmark was not done for attribute questions relating to timeliness of care. The 2006 FG attribute score for waiting time in the doctor's office was 65.9% and was considered a FG weakness.
• **Comparative information about all MCOs (as directed by the State).**	The following is an assessment of strengths and weaknesses in the areas of access, quality and timeliness of care. The assessment is based on most positive response scores ("Always," "Not a Problem," or "9 and 10.") to individual survey questions/ratings and involves four comparisons using 2006 CAHPS data. The first involves statistical comparison of FirstGuard's composite attribute and rating scores to the National CAHPS Benchmarking Database (NCBD) results. The second involves statistical comparison of FirstGuard's composite attribute and rating scores to the HealthConnect Kansas results. The third involves statistical comparison of FirstGuard's attribute and rating scores for their HW19 and HW21 Child populations. The fourth involves statistical comparison of HealthConnect Kansas' composite attribute and rating scores to the NCBD results. The NCBD benchmarks include National, Midwest Region and HMO/POS programs. The NCBD HW21 report did not contain data for the Midwest Region. HCK is a Primary Care Case Management (PCCM) program, but the NCBD data did not contain PCCM program results to compare to the HCK results. FirstGuard, being an Health Maintenance Organization, was compared to the NCBD HMO/POS data. Strengths were identified as statistically significant increases in most positive response rate scores between FirstGuard and all NCBD benchmarks, FirstGuard and HCK, FirstGuard's HW19 and HW21 Child population and HCK and all NCBD benchmarks. Strengths represent increased satisfaction. Weaknesses were identified as statistically significant decrease in most positive response rate scores between FirstGuard and all

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	NCBD benchmarks, FirstGuard and HCK, FirstGuard's HW19 and HW21 Child populations and HCK and all NCBD benchmarks. Weaknesses represent decreased satisfaction. The comparisons listed below were based on statistically significant differences between FirstGuard, NCBD and HCK as well as statistically significant differences between the HW19 and HW21 programs. Access to Care The attribute questions used to measure access to care were: • Getting a provider you are happy with • Seeing a specialist • Getting the care, tests or treatments necessary • Delays in care while waiting for approval Quality of Care The attribute/rating questions used to measure quality of care were: • Doctors listening carefully • Doctors showing respect for what you had to say • Doctors spending enough time with you • Office staff treating you with courtesy and respect • Rating of health care • Rating of specialist • Rating of personal doctor Timeliness of Care The attribute questions used to measure timeliness of care were: • Obtaining care right away for an illness/injury/condition • Obtaining care when wanted, not when needed right away • Waiting time in doctor's office *FirstGuard to NCBD –* Access to Care Strengths There were no instances where FirstGuard's HW19 adult population attribute scores relating to access to care were statistically significantly higher than all NCBD benchmark scores. Based on NCBD comparison, no FirstGuard strengths were identified involving the HW19 adult population.

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	There was one instance where FirstGuard's HW19 Combined Child population attribute scores relating to access to care were statistically significantly higher than all NCBD benchmark scores. There was one instance where FirstGuard's HW21 Combined Child population attribute scores relating to access to care were statistically significantly higher than all NCBD benchmark scores. In both cases, the difference involved getting the care, tests or treatments necessary. Based on NCBD comparison, this area is considered a FirstGuard strength involving both the HW19 and HW21 Combined Child populations. Access to Care Weaknesses There were no instances where FirstGuard's HW19 adult population attribute scores relating to access to care were statistically significantly lower than all NCBD benchmark scores. There were no instances where FirstGuard's HW19 Combined Child population attribute scores relating to access to care were statistically significantly lower than all NCBD benchmark scores. Based on the NCBD comparisons, no FirstGuard weaknesses were identified involving the HW19 adult and HW19 Combined Child populations. There was one instance where FirstGuard's HW21 Combined Child population attribute scores relating to access to care were statistically significantly lower than all NCBD benchmark scores. The difference involved getting a provider you are happy with. Based on NCBD comparisons, this area is considered a FirstGuard weakness involving the HW21 Combined Child population. Quality of Care Strengths There were no instances where FirstGuard's HW19 adult population attribute/rating scores relating to quality of care were statistically significantly higher than all NCBD benchmark scores. There were no instances where FirstGuard's HW19 Combined Child population attribute/rating scores relating to quality of care were statistically significantly higher than all NCBD benchmark scores. Based on NCBD comparisons, no FirstGuard strengths were identified involving the HW19 adult and HW19 Combined Child populations. There were three instances where FirstGuard's HW21 Combined Child population attribute/rating scores relating to quality of care were statistically significantly higher than all NCBD benchmark scores. The first involved doctors spending enough time with you. The second involved office staff treating you with courtesy and respect. The third involved rating of health care. Based on NCBD comparisons, these three areas involving the HW21 Combined Child population were considered FirstGuard strengths. Quality of Care Weaknesses There were no instances where FirstGuard's HW19 adult population attribute/rating scores relating to quality of care were statistically significantly lower than all NCBD benchmark scores.

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	There were no instances where FirstGuard's HW21 Combined Child population attribute/rating scores relating to quality of care were statistically significantly lower than all NCBD benchmark scores. Based on NCBD comparisons, no FirstGuard weaknesses were identified involving the HW19 adult and HW21 Combined Child populations. There were two instances where FirstGuard's HW19 Combined Child population attribute/rating scores relating to quality of care were statistically significantly lower than all NCBD benchmark scores. The first involved doctors listening carefully and the second involved office staff treating you with courtesy and respect. Based on NCBD comparisons, these two areas involving the HW19 Combined Child population were considered FirstGuard weaknesses. Timeliness of Care Strengths There were no instances where FirstGuard's HW19 adult population attribute scores relating to timeliness of care were statistically significantly higher than all NCBD benchmark scores. There were no instances where FirstGuard's HW19 Combined Child population attribute scores relating to timeliness of care were statistically significantly higher than all NCBD benchmark scores. Based on NCBD comparison, no FirstGuard strengths were identified involving the HW19 adult and HW19 Combined Child populations. There were two instances where FirstGuard's HW21 Combined Child population attribute scores relating to timeliness of care were statistically significantly higher than all NCBD benchmark scores. The first area involved obtaining care right away for an illness, injury or condition and the second involved obtaining care when wanted, not when needed right away. Based on NCBD comparison, these two areas involving the HW21 Combined Child population were considered FirstGuard strengths. Timeliness of Care Weaknesses There was one instance where FirstGuard's HW19 adult population attribute scores relating to timeliness of care were statistically significantly lower than all NCBD benchmark scores. The difference involved waiting time in the doctor's office. Based on NCBD comparison, this area involving the HW19 adult population is considered a FirstGuard weakness. There were no instances where FirstGuard's HW19 Combined Child population attribute scores relating to timeliness of care were statistically significantly lower than all NCBD benchmark scores. There were no instances where FirstGuard's HW21 Combined Child population attribute scores relating to timeliness of care were statistically significantly lower than all NCBD benchmark scores. Based on NCBD comparison, no FirstGuard weaknesses were identified involving either the HW19 or HW21 Combined Child populations.

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	FirstGuard to HCK Access to Care Strengths There were no instances where FirstGuard's HW19 adult population attribute scores relating to access to care were statistically significantly higher than HCK's adult population scores. Based on comparison with HCK, no FirstGuard strengths were identified involving the HW19 adult population. There was one instance where FirstGuard's HW19 and HW21 General Child population's attribute scores relating to access to care were statistically significantly higher than HCK's General Child population scores. The difference involved delays in care while waiting for approval. Based on comparison with HCK, this area represents a FirstGuard strength involving the HW19 and HW21 General Child populations. There was one instance where FirstGuard's HW19 and HW21 CCC population's attribute scores relating to access to care were statistically significantly higher than HCK's CCC population scores. The difference involved delays in care while waiting for approval. Based on comparison with HCK, this area represents a FirstGuard strength involving the HW19 and HW21 CCC populations. Access to Care Weaknesses There were no instances where FirstGuard's HW19 adult population attribute scores relating to access to care were statistically significantly lower than HCK's adult population scores. Based on comparison with HCK, no FirstGuard weaknesses were identified involving the HW19 adult population. There were no instances where FirstGuard's HW19 and HW21 General Child population's attribute scores relating to access to care were statistically significantly lower than HCK's General Child population scores. Based on comparison with HCK, no FirstGuard weaknesses were identified involving the HW19 and HW21 General Child populations. There were no instances where FirstGuard's HW19 and HW21 CCC population's attribute scores relating to access to care were statistically significantly lower than HCK's CCC population scores. Based on comparison with HCK, no FirstGuard weaknesses were identified involving the HW19 and HW21 CCC populations. Quality of Care Strengths There were no instances where FirstGuard's HW19 adult population attribute/rating scores relating to quality of care were statistically significantly higher than HCK's adult population scores. Based on comparison with HCK, no FirstGuard strengths were identified involving the

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	HW19 adult population. There were no instances where FirstGuard's HW19 General Child population's attribute scores relating to quality of care were statistically significantly higher than HCK's General Child population scores. Based on comparisons to HCK, no strengths involving the HW19 General Child population were identified. There was one instance where FirstGuard's HW21 General Child population attribute scores relating to access to care were statistically significantly higher than HCK's General Child population scores. The differences involved office staff treating you with courtesy and respect. Based on comparison with HCK, this area represents a FirstGuard strength involving the HW21 General Child population. There were no instances where FirstGuard's HW19 and HW21 CCC population's attribute scores relating to access to care were statistically significantly higher than HCK's CCC population scores. Based on comparison with HCK, no FirstGuard strengths were identified involving the HW19 and HW21 CCC populations. Quality of Care Weaknesses There were no instances where FirstGuard's HW19 adult population attribute/rating scores relating to quality of care were statistically significantly lower than HCK's adult population scores. Based on comparison with HCK, no FirstGuard weaknesses were identified involving the HW19 adult population. There were no instances where FirstGuard's HW19 and HW21 general population attribute/rating scores relating to quality of care were statistically significantly lower than HCK's General Child population scores. Based on comparison with HCK, no FirstGuard weaknesses were identified involving the HW19 and HW21 General Child populations. There were no instances where FirstGuard's HW19 CCC population attribute/rating scores relating to quality of care were statistically significantly lower than HCK's CCC population scores. Based on comparison with HCK, no FirstGuard weaknesses were identified involving the HW19 CCC populations. There was one instance where FirstGuard's HW21 CCC population attribute/rating scores relating to quality of care were statistically significantly lower than HCK's CCC population scores. The difference involved rating of specialist. Based on comparison with HCK, this area represents a FirstGuard weakness involving the HW21 CCC population. Timeliness of Care Strengths There were no instances where FirstGuard's HW19 adult population attribute scores relating to timeliness of care were statistically significantly higher than HCK's adult population scores. Based on comparison with HCK, no FirstGuard strengths were identified involving the HW19

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	adult population. There were no instances where FirstGuard's HW19 General Child population's attribute scores relating to timeliness of care were statistically significantly higher than HCK's General Child population scores. Based on comparison with HCK, no strengths were identified involving the HW19 General Child population. There was one instance where FirstGuard's HW21 General Child population's attribute scores relating to timeliness of care were statistically significantly higher than HCK's General Child population scores. This difference involved obtaining care right away for an illness, injury or condition. Based on comparison to HCK, this area represents a FirstGuard strength involving the HW21 General Child population. There were no instances where FirstGuard's HW19 CCC population's attribute scores relating to timeliness of care were statistically significantly higher than HCK's CCC population scores. Based on comparison with HCK, no FirstGuard strengths were identified involving the HW19 CCC population. There was one instance where FirstGuard's HW21 CCC population's attribute scores relating to timeliness of care were statistically significantly higher than HCK's CCC population scores. This difference involved obtaining care right away for an illness, injury or condition. Based on comparison to HCK, this area represents a FirstGuard strength involving the HW21 CCC population. Timeliness of Care Weaknesses There was one instance where FirstGuard's HW19 adult population attribute scores relating to timeliness of care were statistically significantly lower than HCK's adult population scores. This difference involved waiting time in the doctor's office. Based on comparison with HCK, this area represents a FirstGuard weakness involving the HW19 adult population. There were no instances where FirstGuard's HW21 General Child population's attribute scores relating to timeliness of care were statistically significantly lower than HCK's General Child population scores. Based on comparison with HCK, no FirstGuard weaknesses were identified involving the HW21 General Child population. There was one instance where FirstGuard's HW19 General Child population's attribute scores relating to timeliness of care were statistically lower than HCK's General Child population scores. This difference involved obtaining care when wanted, not when needed right away. Based on comparison with HCK, this area represents a FirstGuard weakness involving the HW19 General Child population. There were no instances where FirstGuard's HW21 CCC population's attribute scores relating to timeliness of care were statistically significantly lower than HCK's CCC population scores. Based on comparison with HCK, no FirstGuard weaknesses were identified involving the HW21 CCC populations. There was one instance where FirstGuard's HW19 CCC population attribute scores

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	relating to timeliness of care were statistically significantly lower than HCK's CCC population scores. This difference involved obtaining care when wanted, not when needed right away. Based on comparison with HCK, this area represents a FirstGuard weakness involving the HW19 CCC population. *HW19 to HW21* There were two areas involving quality of care where statistically significant differences were noted between the HW19 and HW21 General Child population's attribute/rating scores. The first difference involved doctors spending enough time with you and the second involved rating of health care. In both instances the HW21 General Child population's scores were statistically significantly higher than those of the HW19 General Child population. There was one area involving timeliness of care where statistically significant differences were noted between the HW19 and HW21 General Child population's attribute/rating scores. The difference involved obtaining care right away for an illness, injury or condition. In this instance, the HW21 General Child population scores were statistically significantly higher than those of the HW19 General Child population. No statistically significant differences were noted between the HW19 and HW21 CCC populations involving access, quality or timeliness. *HCK to NCBD* Access to Care Strengths There were no instances where the HCK's adult population attribute scores relating to access to care were statistically significantly higher than all NCBD benchmarks scores. Based on NCBD comparison, no HCK strengths were identified involving the adult population. There was one instance where the HCK's Combined Child population attribute scores relating to access to care were statistically significantly higher than all NCBD benchmarks scores. This difference involved seeing a specialist. Based on NCBD comparison, this area represents an HCK strength involving the HCK Combined Child population. Access to Care Weaknesses There was one instance where HCK's adult population attribute scores relating to access to care were statistically significantly lower than all NCBD benchmark scores. This difference involved getting a provider you are happy with. Based on NCBD comparison, this area represents an HCK weakness involving the HCK adult population. There were no instances where HCK's Combined Child population attribute scores relating to access to care were statistically significantly lower than all NCBD benchmark scores. Based on NCBD comparison, no HCK weaknesses were identified involving the Combined Child

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	population. Quality of Care Strengths There were no instances where HCK's adult population attribute/rating scores relating to quality of care were statistically significantly higher than all NCBD benchmarks scores. Based on NCBD comparison, no HCK strengths were identified involving the adult population. There was one instance where HCK's Combined Child population attribute/rating scores relating to quality of care were statistically significantly higher than all NCBD benchmarks scores. The difference involved rating of specialist. Based on NCBD comparison, this area represents an HCK strength involving the Combined Child population. Quality of Care Weaknesses There were three instances where HCK's adult population attribute/rating scores relating to quality of care were statistically significantly lower than all NCBD benchmark scores. These differences involved doctors listening carefully, doctors showing respect for what you had to say and office staff treating you with courtesy and respect. Based on NCBD comparison, these three areas involving the adult population represent HCK weaknesses. There was one instance where HCK's Combined Child population attribute/rating scores relating to quality of care were statistically significantly lower than all NCBD benchmark scores. This difference involved doctors spending enough time with you. Based on NCBD comparison, this area involving the Combined Child population represents an HCK weakness. Timeliness of Care Strengths There were no instances where HCK's adult population attribute scores relating to timeliness of care were statistically significantly higher than all NCBD benchmarks scores. There were no instances where HCK's Combined Child population attribute scores relating to timeliness of care were statistically significantly higher than all NCBD benchmarks scores. Based on NCBD comparison, no HCK strengths were identified involving the adult and Combined Child populations. Timeliness of Care Weaknesses There was one instance where HCK's adult population attribute scores relating to timeliness of care were statistically significantly lower than all NCBD benchmarks scores. The difference involved obtaining care right away for an illness, injury or condition. Based on NCBD comparison, this area involving the HCK adult population represents an HCK weakness.

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	There was one instance where HCK's Combined Child population attribute scores relating to timeliness of care were statistically significantly lower than all NCBD benchmarks. The difference involved waiting time in the doctor's office. Based on NCBD comparison, this area represents an HCK weakness involving the Combined Child population. *Cross Program Comparison of CCC Module Questions* The following represents comparison of the most positive response scores to the CCC Module questions by the HW19, HW21 and HCK populations. These questions are unique to the CCC population and are not included in the above assessment of access, quality and timeliness. The comparisons identified below reflect statistically significant differences between the HCK, HW19 and HW21 CCC population responses. • The HW19 response score regarding the ability to obtain treatment or counseling for a child's emotional, developmental or behavioral problems was statistically significantly higher than the response score for HCK. • The HW19 response score regarding coordination of care among providers or services was statistically significantly higher than the response score from HCK. • The HW21 response score regarding coordination of care among providers or services was statistically significantly lower than the response score from HCK.