Ipsos Public Affairs
The Social Research and Corporate Reputation Specialists

October 10, 2013

Ms. Roberta Wagner
DEPARTMENT OF ADMINISTRATION, PURCHASING DIVISION
2019 WASHINGTON STREET EAST
CHARLESTON, WEST VIRGINIA 25305-0130

Re: RFQ #BMS14056

Dear Ms. Wagner:

Ipsos is pleased to submit the enclosed quotation to conduct 2014 Adult Medicaid CAHPS for the State of West Virginia. Ipsos understands the requirements for this project as noted in the Request for Quotation (RFQ) #BMS14056. The project team for this project has extensive experience in healthcare research. The team includes members with whom we have successfully completed CAHPS work, past and present, and have earned NCQA's highest level of certification.

As a global full service market research firm, Ipsos has developed dozens of core competencies that allow us to provide efficient, cost effective, and innovative data collection, analysis, and consulting services to our clients. The primary core competencies we believe are most central to the State of West Virginia's data collection needs, most directly support our proposal to conduct this work, and will provide superior value and service to the State of West Virginia are:

- Extensive experience and expertise in execution of NCQA protocol
- Application of different techniques to maximize response rates
- Advanced security systems, sample management and data management protocols
- Industry leadership in measuring and analyzing customer experience performance
- Proven track record conducting methodologically rigorous, large-scale surveys

We welcome the opportunity to work with the State of West Virginia on this important program. I am authorized to negotiate with the State of West Virginia on both the scope and price of this proposed project. The price proposal we have submitted for this project is valid for a period of one-hundred-eighty (180) days. After that we reserve the right to reconsider pricing structures.

Please feel free to contact me with any questions concerning this submission.

Sincerely,

J F Hodes

Jan F. Hodes
Senior Vice President
Ipsos' Healthcare Policy Institute

10/15/13 04:22:10 PM
West Virginia Purchasing Division

CERTIFICATION AND SIGNATURE PAGE

By signing below, I certify that I have reviewed this Solicitation in its entirety; understand the requirements, terms and conditions, and other information contained herein; that I am submitting this bid or proposal for review and consideration; that I am authorized by the bidder to execute this bid or any documents related thereto on bidder's behalf; that I am authorized to bind the bidder in a contractual relationship; and that to the best of my knowledge, the bidder has properly registered with any State agency that may require registration.

Ipsos Public Affairs, Inc.

(Company)

(Authorized Signature)

Clifford Young, Managing Director

(Representative Name, Title)

202-463-7300	202-688-2793
(Phone Number)	(Fax Number)

October 10, 2013

(Date)

ADDENDUM ACKNOWLEDGEMENT FORM
SOLICITATION NO.: BMS14056

Instructions: Please acknowledge receipt of all addenda issued with this solicitation by completing this addendum acknowledgment form. Check the box next to each addendum received and sign below. Failure to acknowledge addenda may result in bid disqualification.

Acknowledgment: I hereby acknowledge receipt of the following addenda and have made the necessary revisions to my proposal, plans and/or specification, etc.

Addendum Numbers Received:
(Check the box next to each addendum received)

[X]	Addendum No. 1	[ ]	Addendum No. 6
[ ]	Addendum No. 2	[ ]	Addendum No. 7
[ ]	Addendum No. 3	[ ]	Addendum No. 8
[ ]	Addendum No. 4	[ ]	Addendum No. 9
[ ]	Addendum No. 5	[ ]	Addendum No. 10

I understand that failure to confirm the receipt of addenda may be cause for rejection of this bid. I further understand that any verbal representation made or assumed to be made during any oral discussion held between Vendor's representatives and any state personnel is not binding. Only the information issued in writing and added to the specifications by an official addendum is binding.

Ipsos Public Affairs
Company

[signature]
Authorized Signature

10/10/13
Date

NOTE: This addendum acknowledgement should be submitted with the bid to expedite document processing.

Revised 6/8/2012

10. VENDOR DEFAULT:

10.1. The following shall be considered a vendor default under this Contract.

10.1.1. Failure to perform Contract Services in accordance with the requirements contained herein.

10.1.2.Failure to comply with other specifications and requirements contained herein.

10.1.3. Failure to comply with any laws, rules, and ordinances applicable to the Contract Services provided under this Contract.

10.1.4. Failure to remedy deficient performance upon request.

10.2. The following remedies shall be available to Agency upon default.

10.2.1. Cancellation of the Contract.

10.2.2. Cancellation of one or more release orders issued under this Contract.

10.2.3. Any other remedies available in law or equity.

11. MISCELLANEOUS:

11.1. Contract Manager: During its performance of this Contract, Vendor must designate and maintain a primary contract manager responsible for overseeing Vendor's responsibilities under this Contract. The Contract manager must be available during normal business hours to address any customer service or other issues related to this Contract. Vendor should list its Contract manager and his or her contact information below.

Contract Manager: **Jan Hodes**
Telephone Number: **(678) 896-3729**
Fax Number: **(202) 688-2793**
Email Address: **Jan.Hodes@Ipsos.com**

REQUEST FOR QUOTATION
BMS14056
National Committee for Quality Assurance ("NCQA") Certified
Healthcare Effectiveness Data and Information Set ("HEDIS") Survey Vendor

Exhibit A: Pricing Page

All inclusive price for each survey conducted using the Mail Only Methodology:

				Total Cost for Survey 1
Total Cost Survey 1 for Calendar Year December 2012 – November 2013				(A) $17,800

Renewal Periods:

				Total Cost for Survey 2
Total Cost Survey 2 for Calendar Year December 2013 – November 2014				(B) $18,208

Grand Total (Cost A + B Surveys)

$ 36,008

Notes
1. The Vendors Grand Total will include all general and administrative staffing (secretarial, clerical, etc.), travel, supplies and other resource costs necessary to perform all services within the scope of this procurement.
2. The Contract will be awarded to the Vendor with the lowest Grand Total meeting specifications.

Ipsos Public Affairs, Inc.
(Company)

Jacob Gessel, Compliance Officer
(Representative Name, Title)

202-420-2013 // 202-688-2793
(Contact Phone/Fax Number)

10/10/2013
(Date)

WV STATE GOVERNMENT

HIPAA BUSINESS ASSOCIATE ADDENDUM

This Health Insurance Portability and Accountability Act of 1996 (hereafter, HIPAA) Business Associate Addendum ("Addendum") is made a part of the Agreement ("Agreement") by and between the State of West Virginia ("Agency"), and Business Associate ("Associate"), and is effective as of the date of execution of the Addendum.

The Associate performs certain services on behalf of or for the Agency pursuant to the underlying Agreement that requires the exchange of information including protected health information protected by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), as amended by the American Recovery and Reinvestment Act of 2009 (Pub. L. No. 111-5) (the "HITECH Act"), any associated regulations and the federal regulations published at 45 CFR parts 160 and 164 (sometimes collectively referred to as "HIPAA"). The Agency is a "Covered Entity" as that term is defined in HIPAA, and the parties to the underlying Agreement are entering into this Addendum to establish the responsibilities of both parties regarding HIPAA-covered information and to bring the underlying Agreement into compliance with HIPAA.

Whereas it is desirable, in order to further the continued efficient operations of Agency to disclose to its Associate certain information which may contain confidential individually identifiable health information (hereafter, Protected Health Information or PHI); and

Whereas, it is the desire of both parties that the confidentiality of the PHI disclosed hereunder be maintained and treated in accordance with all applicable laws relating to confidentiality, including the Privacy and Security Rules, the HITECH Act and its associated regulations, and the parties do agree to at all times treat the PHI and interpret this Addendum consistent with that desire.

NOW THEREFORE: the parties agree that in consideration of the mutual promises herein, in the Agreement, and of the exchange of PHI hereunder that:

1. **Definitions.** Terms used, but not otherwise defined, in this Addendum shall have the same meaning as those terms in the Privacy, Security, Breach Notification, and Enforcement Rules at 45 CFR Part 160 and Part 164.

   a. **Agency Procurement Officer** shall mean the appropriate Agency individual listed at: http://www.state.wv.us/admin/purchase/vrc/agencyli.html.

   b. **Agent** shall mean those person(s) who are agent(s) of the Business Associate, in accordance with the Federal common law of agency, as referenced in 45 CFR § 160.402(c).

   c. **Breach** shall mean the acquisition, access, use or disclosure of protected health information which compromises the security or privacy of such information, except as excluded in the definition of Breach in 45 CFR § 164.402.

   d. **Business Associate** shall have the meaning given to such term in 45 CFR § 160.103.

   e. **HITECH Act** shall mean the Health Information Technology for Economic and Clinical Health Act. Public Law No. 111-05. 111th Congress (2009).

f. **Privacy Rule** means the Standards for Privacy of Individually Identifiable Health Information found at 45 CFR Parts 160 and 164.

g. **Protected Health Information or PHI** shall have the meaning given to such term in 45 CFR § 160.103, limited to the information created or received by Associate from or on behalf of Agency.

h. **Security Incident** means any known successful or unsuccessful attempt by an authorized or unauthorized individual to inappropriately use, disclose, modify, access, or destroy any information or interference with system operations in an information system.

i. **Security Rule** means the Security Standards for the Protection of Electronic Protected Health Information found at 45 CFR Parts 160 and 164.

j. **Subcontractor** means a person to whom a business associate delegates a function, activity, or service, other than in the capacity of a member of the workforce of such business associate.

2. **Permitted Uses and Disclosures.**

a. **PHI Described.** This means PHI created, received, maintained or transmitted on behalf of the Agency by the Associate. This PHI is governed by this Addendum and is limited to the minimum necessary, to complete the tasks or to provide the services associated with the terms of the original Agreement, and is described in Appendix A.

b. **Purposes.** Except as otherwise limited in this Addendum, Associate may use or disclose the PHI on behalf of, or to provide services to, Agency for the purposes necessary to complete the tasks, or provide the services, associated with, and required by the terms of the original Agreement, or as required by law, if such use or disclosure of the PHI would not violate the Privacy or Security Rules or applicable state law if done by Agency or Associate, or violate the minimum necessary and related Privacy and Security policies and procedures of the Agency. The Associate is directly liable under HIPAA for impermissible uses and disclosures of the PHI it handles on behalf of Agency.

c. **Further Uses and Disclosures.** Except as otherwise limited in this Addendum, the Associate may disclose PHI to third parties for the purpose of its own proper management and administration, or as required by law, provided that (i) the disclosure is required by law, or (ii) the Associate has obtained from the third party reasonable assurances that the PHI will be held confidentially and used or further disclosed only as required by law or for the purpose for which it was disclosed to the third party by the Associate; and, (iii) an agreement to notify the Associate and Agency of any instances of which it (the third party) is aware in which the confidentiality of the information has been breached. To the extent practical, the information should be in a limited data set or the minimum necessary information pursuant to 45 CFR § 164.502, or take other measures as necessary to satisfy the Agency's obligations under 45 CFR § 164.502.

3. **Obligations of Associate.**

   a. **Stated Purposes Only.** The PHI may not be used by the Associate for any purpose other than as stated in this Addendum or as required or permitted by law.

   b. **Limited Disclosure.** The PHI is confidential and will not be disclosed by the Associate other than as stated in this Addendum or as required or permitted by law. Associate is prohibited from directly or indirectly receiving any remuneration in exchange for an individual's PHI unless Agency gives written approval and the individual provides a valid authorization. Associate will refrain from marketing activities that would violate HIPAA, including specifically Section 13406 of the HITECH Act. Associate will report to Agency any use or disclosure of the PHI, including any Security Incident not provided for by this Agreement of which it becomes aware.

   c. **Safeguards.** The Associate will use appropriate safeguards, and comply with Subpart C of 45 CFR Part 164 with respect to electronic protected health information, to prevent use or disclosure of the PHI, except as provided for in this Addendum. This shall include, but not be limited to:

      i. Limitation of the groups of its workforce and agents, to whom the PHI is disclosed to those reasonably required to accomplish the purposes stated in this Addendum, and the use and disclosure of the minimum PHI necessary or a Limited Data Set;

      ii. Appropriate notification and training of its workforce and agents in order to protect the PHI from unauthorized use and disclosure;

      iii. Maintenance of a comprehensive, reasonable and appropriate written PHI privacy and security program that includes administrative, technical and physical safeguards appropriate to the size, nature, scope and complexity of the Associate's operations, in compliance with the Security Rule;

      iv. In accordance with 45 CFR §§ 164.502(e)(1)(ii) and 164.308(b)(2), if applicable, ensure that any subcontractors that create, receive, maintain, or transmit protected health information on behalf of the business associate agree to the same restrictions, conditions, and requirements that apply to the business associate with respect to such information.

   d. **Compliance With Law.** The Associate will not use or disclose the PHI in a manner in violation of existing law and specifically not in violation of laws relating to confidentiality of PHI, including but not limited to, the Privacy and Security Rules.

   e. **Mitigation.** Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Associate of a use or disclosure of the PHI by Associate in violation of the requirements of this Addendum, and report its mitigation activity back to the Agency.

f. **Support of Individual Rights.**

i. **Access to PHI.** Associate shall make the PHI maintained by Associate or its agents or subcontractors in Designated Record Sets available to Agency for inspection and copying, and in electronic format, if requested, within ten (10) days of a request by Agency to enable Agency to fulfill its obligations under the Privacy Rule, including, but not limited to, 45 CFR § 164.524 and consistent with Section 13405 of the HITECH Act.

ii. **Amendment of PHI.** Within ten (10) days of receipt of a request from Agency for an amendment of the PHI or a record about an individual contained in a Designated Record Set, Associate or its agents or subcontractors shall make such PHI available to Agency for amendment and incorporate any such amendment to enable Agency to fulfill its obligations under the Privacy Rule, including, but not limited to, 45 CFR § 164.526.

iii. **Accounting Rights.** Within ten (10) days of notice of a request for an accounting of disclosures of the PHI, Associate and its agents or subcontractors shall make available to Agency the documentation required to provide an accounting of disclosures to enable Agency to fulfill its obligations under the Privacy Rule, including, but not limited to, 45 CFR §164.528 and consistent with Section 13405 of the HITECH Act. Associate agrees to document disclosures of the PHI and information related to such disclosures as would be required for Agency to respond to a request by an individual for an accounting of disclosures of PHI in accordance with 45 CFR § 164.528. This should include a process that allows for an accounting to be collected and maintained by Associate and its agents or subcontractors for at least six (6) years from the date of disclosure, or longer if required by state law. At a minimum, such documentation shall include:

- the date of disclosure;
- the name of the entity or person who received the PHI, and if known, the address of the entity or person;
- a brief description of the PHI disclosed; and
- a brief statement of purposes of the disclosure that reasonably informs the individual of the basis for the disclosure, or a copy of the individual's authorization, or a copy of the written request for disclosure.

iv. **Request for Restriction.** Under the direction of the Agency, abide by any individual's request to restrict the disclosure of PHI, consistent with the requirements of Section 13405 of the HITECH Act and 45 CFR § 164.522, when the Agency determines to do so (except as required by law) and if the disclosure is to a health plan for payment or health care operations and it pertains to a health care item or service for which the health care provider was paid in full "out-of-pocket."

v. **Immediate Discontinuance of Use or Disclosure.** The Associate will immediately discontinue use or disclosure of Agency PHI pertaining to any individual when so requested by Agency. This includes, but is not limited to, cases in which an individual has withdrawn or modified an authorization to use or disclose PHI.

g. **Retention of PHI.** Notwithstanding section 4.a. of this Addendum, Associate and its subcontractors or agents shall retain all PHI pursuant to state and federal law and shall continue to maintain the PHI required under Section 3.f. of this Addendum for a period of six (6) years after termination of the Agreement, or longer if required under state law.

h. **Agent's, Subcontractor's Compliance.** The Associate shall notify the Agency of all subcontracts and agreements relating to the Agreement, where the subcontractor or agent receives PHI as described in section 2.a. of this Addendum. Such notification shall occur within 30 (thirty) calendar days of the execution of the subcontract and shall be delivered to the Agency Procurement Officer. The Associate will ensure that any of its subcontractors, to whom it provides any of the PHI it receives hereunder, or to whom it provides any PHI which the Associate creates or receives on behalf of the Agency, agree to the restrictions and conditions which apply to the Associate hereunder. The Agency may request copies of downstream subcontracts and agreements to determine whether all restrictions, terms and conditions have been flowed down. Failure to ensure that downstream contracts, subcontracts and agreements contain the required restrictions, terms and conditions may result in termination of the Agreement.

j. **Federal and Agency Access.** The Associate shall make its internal practices, books, and records relating to the use and disclosure of PHI, as well as the PHI, received from, or created or received by the Associate on behalf of the Agency available to the U.S. Secretary of Health and Human Services consistent with 45 CFR § 164.504. The Associate shall also make these records available to Agency, or Agency's contractor, for periodic audit of Associate's compliance with the Privacy and Security Rules. Upon Agency's request, the Associate shall provide proof of compliance with HIPAA and HITECH data privacy/protection guidelines, certification of a secure network and other assurance relative to compliance with the Privacy and Security Rules. This section shall also apply to Associate's subcontractors, if any.

k. **Security.** The Associate shall take all steps necessary to ensure the continuous security of all PHI and data systems containing PHI. In addition, compliance with 74 FR 19006 Guidance Specifying the Technologies and Methodologies That Render PHI Unusable, Unreadable, or Indecipherable to Unauthorized Individuals for Purposes of the Breach Notification Requirements under Section 13402 of Title XIII is required, to the extent practicable. If Associate chooses not to adopt such methodologies as defined in 74 FR 19006 to secure the PHI governed by this Addendum, it must submit such written rationale, including its Security Risk Analysis, to the Agency Procurement Officer for review prior to the execution of the Addendum. This review may take up to ten (10) days.

l. **Notification of Breach.** During the term of this Addendum, the Associate shall notify the Agency and, unless otherwise directed by the Agency in writing, the WV Office of Technology immediately by e-mail or web form upon the discovery of any Breach of unsecured PHI; or within 24 hours by e-mail or web form of any suspected Security Incident, intrusion or unauthorized use or disclosure of PHI in violation of this Agreement and this Addendum, or potential loss of confidential data affecting this Agreement. Notification shall be provided to the Agency Procurement Officer at www.state.wv.us/admin/purchase/vrc/agencyli.htm and,

unless otherwise directed by the Agency in writing, the Office of Technology at incident@wv.gov or https://apps.wv.gov/ot/ir/Default.aspx.

The Associate shall immediately investigate such Security Incident, Breach, or unauthorized use or disclosure of PHI or confidential data. Within 72 hours of the discovery, the Associate shall notify the Agency Procurement Officer, and, unless otherwise directed by the Agency in writing, the Office of Technology of: (a) Date of discovery; (b) What data elements were involved and the extent of the data involved in the Breach; (c) A description of the unauthorized persons known or reasonably believed to have improperly used or disclosed PHI or confidential data; (d) A description of where the PHI or confidential data is believed to have been improperly transmitted, sent, or utilized; (e) A description of the probable causes of the improper use or disclosure; and (f) Whether any federal or state laws requiring individual notifications of Breaches are triggered.

Agency will coordinate with Associate to determine additional specific actions that will be required of the Associate for mitigation of the Breach, which may include notification to the individual or other authorities.

All associated costs shall be borne by the Associate. This may include, but not be limited to costs associated with notifying affected individuals.

If the Associate enters into a subcontract relating to the Agreement where the subcontractor or agent receives PHI as described in section 2.a. of this Addendum, all such subcontracts or downstream agreements shall contain the same incident notification requirements as contained herein, with reporting directly to the Agency Procurement Officer. Failure to include such requirement in any subcontract or agreement may result in the Agency's termination of the Agreement.

m. **Assistance in Litigation or Administrative Proceedings.** The Associate shall make itself and any subcontractors, workforce or agents assisting Associate in the performance of its obligations under this Agreement, available to the Agency at no cost to the Agency to testify as witnesses, or otherwise, in the event of litigation or administrative proceedings being commenced against the Agency, its officers or employees based upon claimed violations of HIPAA, the HIPAA regulations or other laws relating to security and privacy, which involves inaction or actions by the Associate, except where Associate or its subcontractor, workforce or agent is a named as an adverse party.

4. **Addendum Administration.**

a. **Term.** This Addendum shall terminate on termination of the underlying Agreement or on the date the Agency terminates for cause as authorized in paragraph (c) of this Section, whichever is sooner.

b. **Duties at Termination.** Upon any termination of the underlying Agreement, the Associate shall return or destroy, at the Agency's option, all PHI received from, or created or received by the Associate on behalf of the Agency that the Associate still maintains in any form and retain no copies of such PHI or, if such return or destruction is not feasible, the Associate shall extend the protections of this Addendum to the PHI and limit further uses and disclosures to the purposes that make the return or destruction of the PHI infeasible. This shall also apply to all agents and subcontractors of Associate. The duty of the Associate and its agents

and subcontractors to assist the Agency with any HIPAA required accounting of disclosures survives the termination of the underlying Agreement.

c. **Termination for Cause.** Associate authorizes termination of this Agreement by Agency, if Agency determines Associate has violated a material term of the Agreement. Agency may, at its sole discretion, allow Associate a reasonable period of time to cure the material breach before termination.

d. **Judicial or Administrative Proceedings.** The Agency may terminate this Agreement if the Associate is found guilty of a criminal violation of HIPAA. The Agency may terminate this Agreement if a finding or stipulation that the Associate has violated any standard or requirement of HIPAA/HITECH, or other security or privacy laws is made in any administrative or civil proceeding in which the Associate is a party or has been joined. Associate shall be subject to prosecution by the Department of Justice for violations of HIPAA/HITECH and shall be responsible for any and all costs associated with prosecution.

e. **Survival.** The respective rights and obligations of Associate under this Addendum shall survive the termination of the underlying Agreement.

5. **General Provisions/Ownership of PHI.**

a. **Retention of Ownership.** Ownership of the PHI resides with the Agency and is to be returned on demand or destroyed at the Agency's option, at any time, and subject to the restrictions found within section 4.b. above.

b. **Secondary PHI.** Any data or PHI generated from the PHI disclosed hereunder which would permit identification of an individual must be held confidential and is also the property of Agency.

c. **Electronic Transmission.** Except as permitted by law or this Addendum, the PHI or any data generated from the PHI which would permit identification of an individual must not be transmitted to another party by electronic or other means for additional uses or disclosures not authorized by this Addendum or to another contractor, or allied agency, or affiliate without prior written approval of Agency.

d. **No Sales.** Reports or data containing the PHI may not be sold without Agency's or the affected individual's written consent.

e. **No Third-Party Beneficiaries.** Nothing express or implied in this Addendum is intended to confer, nor shall anything herein confer, upon any person other than Agency, Associate and their respective successors or assigns, any rights, remedies, obligations or liabilities whatsoever.

f. **Interpretation.** The provisions of this Addendum shall prevail over any provisions in the Agreement that may conflict or appear inconsistent with any provisions in this Addendum. The interpretation of this Addendum shall be made under the laws of the state of West Virginia.

g. **Amendment.** The parties agree that to the extent necessary to comply with applicable law they will agree to further amend this Addendum.

h. **Additional Terms and Conditions.** Additional discretionary terms may be included in the release order or change order process.

AGREED:

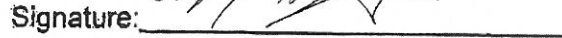
Name of Agency:______________________

Signature:__________________________

Title:______________________________

Date:_______________________________

Name of Associate: Ipsos Public Affairs, Inc.

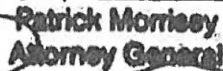
Signature: 

Clifford Young

Title: Managing Director

Date: October 10, 2013

Form - WVBAA-012004
Amended 06.26.2013

APPROVED AS TO FORM THIS 26th
DAY OF ______ 20 13
Patrick Morrisey
Attorney General

BY ______________________

Appendix A

(To be completed by the Agency's Procurement Officer prior to the execution of the Addendum, and shall be made a part of the Addendum. PHI not identified prior to execution of the Addendum may only be added by amending Appendix A and the Addendum, via Change Order.)

Name of Associate: Ipsos Public Affairs, Inc.

Name of Agency: Bureau for Medical Services

Describe the PHI (do not include any actual PHI). If not applicable, please indicate the same.

Plan/Program Name
Sex
Race

Ipsos Public Affairs

Ipsos Public Affairs

The Social Research and Corporate Reputation Specialists

2013 Medicare CAHPS® Report
(MA, MA-PD)
Health Plan

Prepared for:

Prepared by: Ipsos-Reid Public Affairs

Date: June 2013

Plan logo

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The concepts and ideas submitted to you herein are the intellectual property of Ipsos. They are strictly of confidential nature and are submitted to you under the understanding that they are to be considered by you in the strictest confidence and that no use shall be made of the said concepts and ideas. Ipsos does not, in providing this report, accept or assume responsibility for any other purpose or to any other person to whom this report is shown or in to whose hands it may come save where expressly agreed by our prior consent in writing.

Company Name
Title

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Executive Summary

Improving and Maintaining Quality

Ipsos conducted attributable effects analysis to determine what attributes drive overall rating of the health plan. This analysis identifies 2 types of drivers. Potential drivers are attributes where the greatest benefit can be realized through improvements in quality. Maintenance drivers are those that would result in the greatest loss of overall health plan rating if quality declined in these attributes.

Plan customer service attributes appear amongst the strongest Maintenance and Potential Drivers for the health plan. Improving forms, reducing wait time to resolve complaints, reducing wait time for answers to after-hours medical questions are likely to improve the health plan's overall rating. The health plan should focus on maintaining the ability to handle complaints to satisfaction, maintaining the courtesy and respect of customer service agents, and the ability to provide information about prescription drugs in order to maintain its current rating.

Top 3 Potential Drivers	Top 3 Maintenance Drivers
How long did it take for your health plan to settle you complaint? (52%)	Thinking about the complaint process, regardless of whether you agree or disagree with the final outcome, how satisfied are you with how your health plan handled your complaint? (63%)
In the last 6 months, when you phoned a doctor's office or clinic after regular office hours, how often did you get an answer to your medical question as soon as you needed? (50%)	In the last 6 months, how often did your health plan's customer service staff treat you with courtesy and respect? (62%)
In the last 6 months, how often were the forms from your health plan easy to fill out? (43%)	In the last 6 months, how often did your prescription drug plan's customer service give you the information or help you needed about prescription drugs? (50%)

The Medicare CAHPS questionnaire contains questions associated with six composite scores. Composite scores are higher in 4 of 6 composite measures compared to 2012. More detailed item per item comparisons will be provided later in the report.

Composite Measures	2013**	2012**	2011**
Getting Needed Care	66.40%	66.40%	66.40%
Getting Care Quickly	66.40%	66.40%	66.40%
Doctor Communication	66.40%	66.40%	66.40%
Customer Service	66.40%	66.40%	66.40%
Getting Needed Rx Drugs	66.40%	66.40%	66.40%
Getting Info on Rx Drug Cost & Coverage	66.40%	66.40%	66.40%

**Percent endorsing "Always or Usually"

Introduction and Background

The Centers for Medicare & Medicaid Services (CMS) collects information about Medicare beneficiaries' experience with and ratings of Medicare Advantage (MA), Medicare Advantage Prescription Drug (MA-PD), Medicare Advantage Preferred Provider Organization (MA PPO), and stand-alone Medicare Prescription Drug Plan (PDP) plans through the Medicare CAHPS survey. The Medicare CAHPS® survey is a part of the Consumer Assessment of Healthcare Providers and Systems (CAHPS® initiative, a family of surveys developed by a consortium of researchers from the American Institutes for Research (AIR), Harvard Medical School, RAND Corporation, and RTI International under a cooperative agreement by CMS and the Agency for Healthcare Research and Quality (AHRQ). The Medicare CAHPS survey is comprised of four questionnaires: MA, MA-PD, MA PPO, and PDP. The Medicare CAHPS survey is administered at the contract level to members who have been enrolled in their plans for six months or longer.

In 2012, CMS required Medicare Advantage plans with more than 600 members to contract with a vendor to administer the Medicare CAHPS® survey. Ipsos became a CMS certified Medicare CAHPS® vendor in 2010, the first year CMS certified vendors to conduct the Medicare CAHPS® survey on behalf of Medicare plans. _______ contracted with Ipsos to conduct the Medicare CAHPS® survey.

Methodology

Consistent with the CMS-defined protocol, CMS drew a random sample of 800 members of __________. Ipsos administered the Medicare CAHPS survey using a mixed mail and telephone methodology. A total of 470 valid completes were received from the sample, yielding a response rate of 60.65%. A survey is classified as a valid completion if the plan member answers at least one reportable measure and greater than or equal to 50 percent of the applicable-to-all (ATA) questions. For further details of the sample dispositions, see Appendix A: Response Rates and Survey Protocol.

The timeline for the 2013 Medicare CAHPS survey is shown below.

Task	Date
Mail Pre-notification letters	February 21, 2013
Customer Support Telephone Center opens	February 22, 2013
Mail first questionnaire with cover letter	February 28, 2013
Mail second questionnaire with cover letter to non-respondents	March 27, 2013
Initiate telephone follow-up for non-respondents	April 16 – 22, 2013
Conduct additional telephone attempts for non-respondents	April 23 – May 29, 2013
Submit interim files to CMS (RAND)	May 10, 2013
Data collection ends (cut-off date for mail questionnaires, telephone interviewing ends, Customer Support center closes	May 29, 2013
Submit final data files to CMS	June 12, 2013

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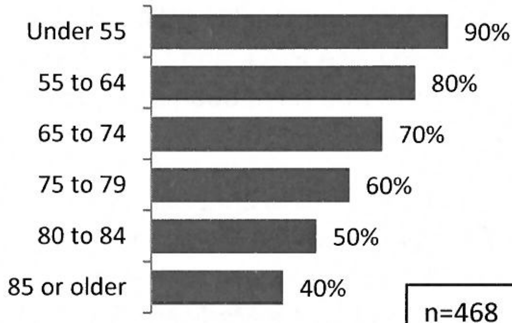
Survey Participants

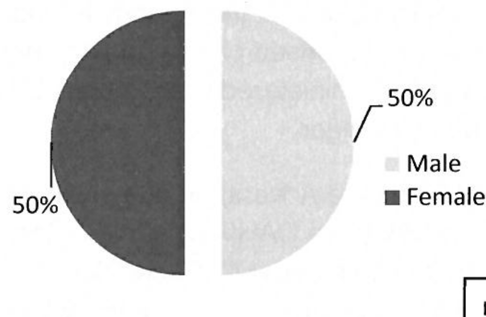
The valid survey completions for ________'s Medicare CAHPS survey totaled 470, yielding a response rate of 60.65%.

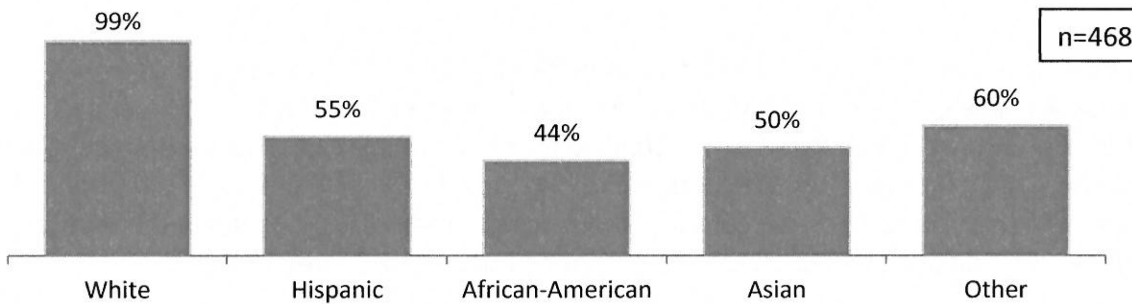
The following charts summarize the demographic makeup of the sample.

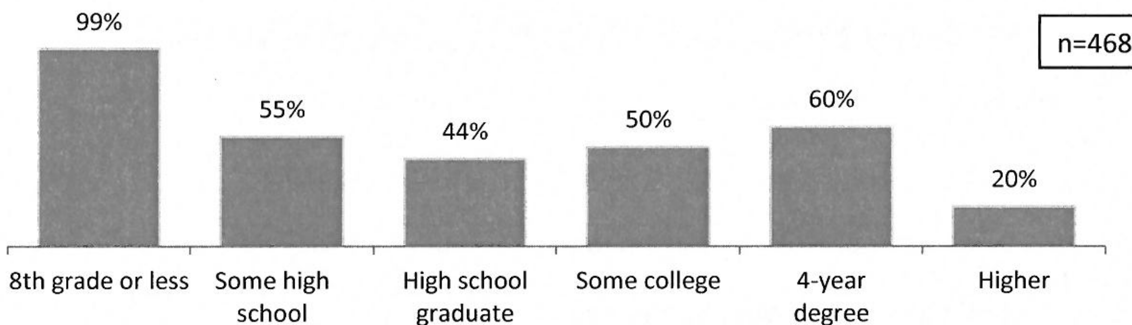
EXHIBIT 1: DEMOGRAPHIC BREAKDOWN OF RESPONDENT POPULATION

Demographic Breakdown of Respondent Population (2013)









Key Driver Analysis

What is Attributable Effects Analysis?

Attributable Effects is a probability-based analysis that partitions the impact of each possible driver into two components: Potential and Loss. Briefly, potential estimates the degree to which improvement in a particular driver would increase the patients' overall rating of the health plan (outcome). Loss estimates the degree to which a decrease in the driver would reduce the overall rating among affected patients.

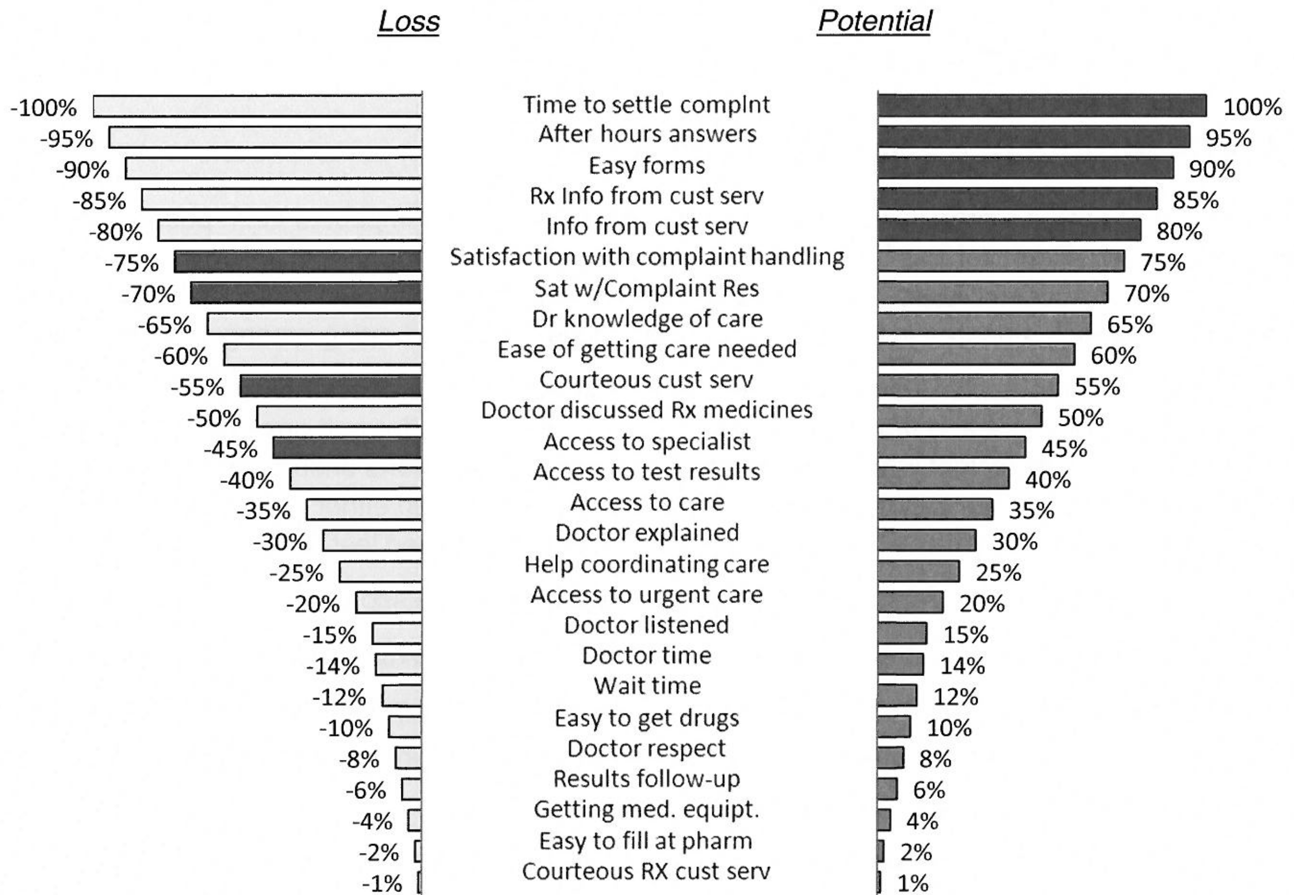
The strength of Attributable Effects Analysis is that it focuses on differences between those who are highly satisfied with care and those who are not. This analysis is performed one survey question at a time, and can provide insight into where quality improvement (QI) efforts should be focused. It identifies attributes of care that can have an impact on the outcome in either direction: potential improvement areas as well as where current effort must be maintained lest scores deteriorate.

Attributable effects analysis rates each attribute with two percentage scores:

- **Loss** is the percentage of those rating their health plan favorably who are at risk of changing their opinion if the associated product characteristic were perceived poorly. Attributes with high loss scores are referred to as maintenance drivers where performance must be maintained to retain current levels of overall rating.
- **Potential** is the percentage of those currently not rating their health plan favorably that would change their rating favorably if the associated characteristics were perceived positively. Attributes with high potential scores are referred to as potential drivers where quality improvement has the greatest potential for improving overall outcome.

A positive or favorable experience can be defined differently depending on the questions being asked. For CAHPS surveys most attributes use the scale "Never", "Sometimes", "Usually", and "Always". In these cases a positive or favorable experience is defined as a respondent indicating that the event "always" occurs. For the dependent variable (overall rating of health plan), a positive or favorable outcome is defined as a respondent rating their health plan a 9 or 10 on a scale from 0 to 10.

EXHIBIT 2: ATTRIBUTABLE EFFECTS ANALYSIS – DRIVERS OF OVERALL RATING OF HEALTH PLAN



Potential

The three features with highest potential to improve overall ratings of this health plan include:

- Reducing time for complaint resolution (52%)
- Getting answer to after-hours medical question (50%)
- Having easy to complete forms (43%)

This indicates that one can effectively improve member rating of their health plan by improving their satisfaction in these domains.

Maintenance

The three features with highest importance for maintaining overall rating of this health plan include:

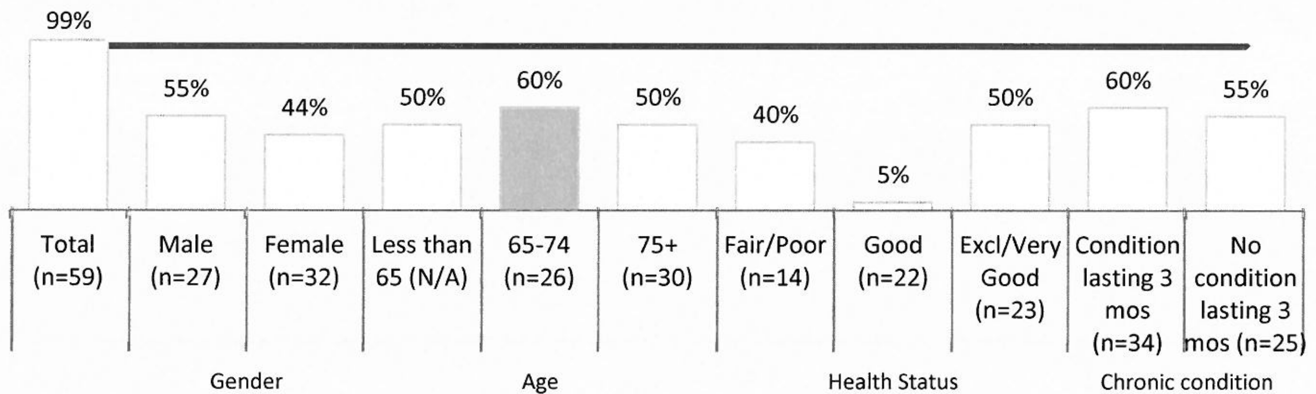
- Being satisfied with handling of complaint (63%)
- Having courteous and respectful customer service (62%)
- Getting information about prescription drugs (50%)

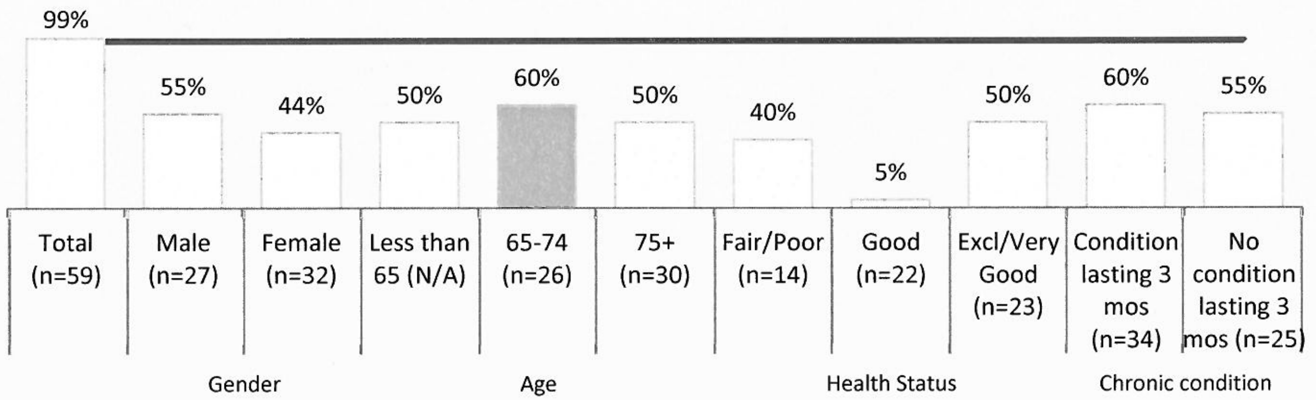
This indicates that one should focus on maintaining current levels of member satisfaction with these attributes, because a decline would have likely have a negative effect on overall rating of the health plan

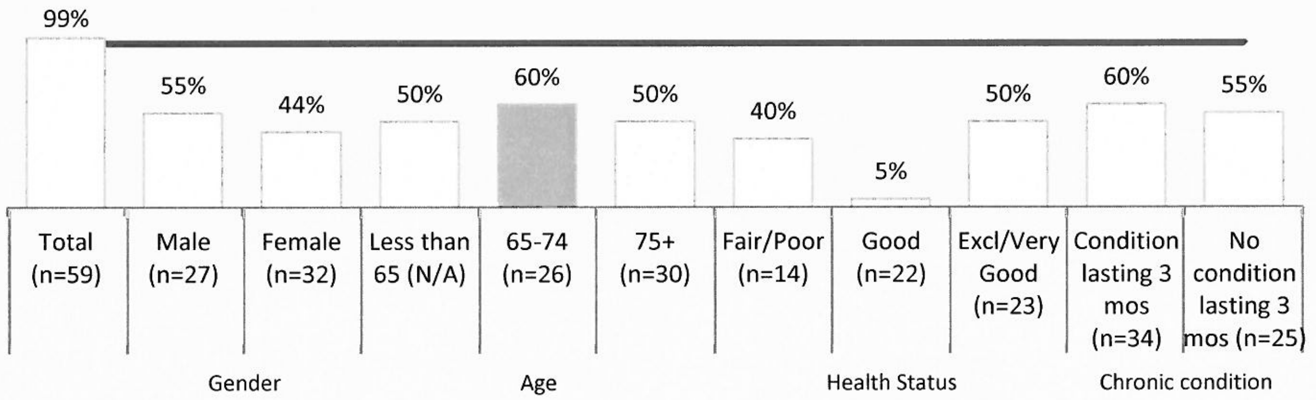
Member Retention Model

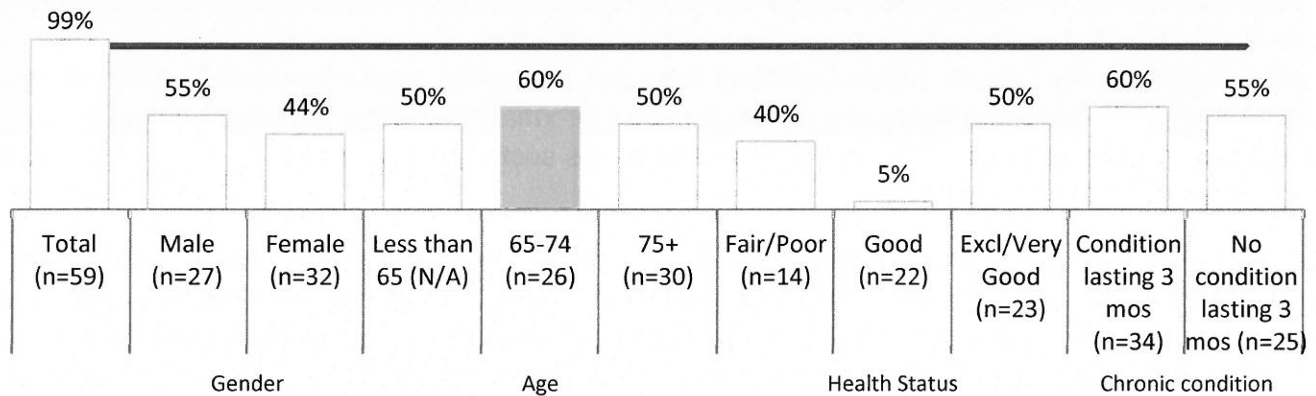
The Member Retention Model is designed to identify those members with the greatest potential to become "likers" on the attributes with the greatest potential to drive overall rating of the health plan. ___ should focus on groups with the greatest potential increase in satisfaction with the attribute.

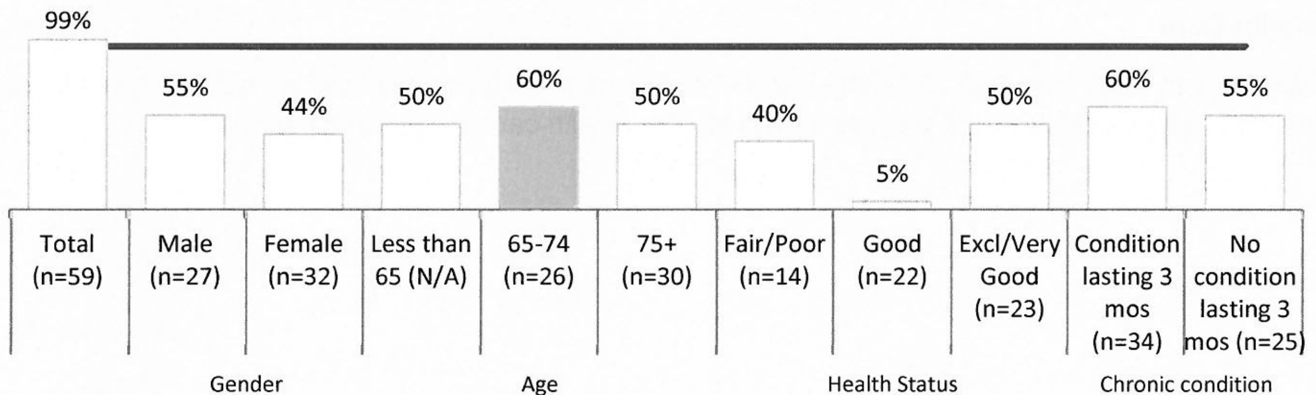
EXHIBIT 3: MEMBER RETENTION MODEL




99%
55%
44%
50%
60%
50%
40%
5%
50%
60%
55%
Total (n=59)
Male (n=27)
Female (n=32)
Less than 65 (N/A)
65-74 (n=26)
75+ (n=30)
Fair/Poor (n=14)
Good (n=22)
Excl/Very Good (n=23)
Condition lasting 3 mos (n=34)
No condition lasting 3 mos (n=25)
Gender
Age
Health Status
Chronic condition


99%
55%
44%
50%
60%
50%
40%
5%
50%
60%
55%
Total (n=59)
Male (n=27)
Female (n=32)
Less than 65 (N/A)
65-74 (n=26)
75+ (n=30)
Fair/Poor (n=14)
Good (n=22)
Excl/Very Good (n=23)
Condition lasting 3 mos (n=34)
No condition lasting 3 mos (n=25)
Gender
Age
Health Status
Chronic condition





The results of the MRM suggest which demographic groups to focus on to increase satisfaction with key attributes:

- Time taken to resolve complaint – focus on members 65-74 years of age
- Getting answer to after hours medical question – focus on members in good health and with chronic conditions

- Having easy to complete forms – focus on members in very good or excellent health and members with chronic conditions
- Customer service giving information/help needed – focus on members in poor or fair health and members with chronic conditions

Overall Ratings

At the core of 2012 Medicare CAHPS® questionnaire are five Overall Ratings rating patient satisfaction with overall health care, personal doctors, specialists, health plan, and prescription drug plan. This section of the Survey Results covers *summary rates* and *three point means* for these Overall Ratings (see Appendix B: Summary Rates and Means for more information). Higher numbers on both these measures reflect greater satisfaction. For comparison, this section also includes ________'s 2012 and 2011 Medicare CAHPS results.

On all Overall Ratings questions, respondents rate their health/prescription drug plan on an 11-point scale with 0 representing the worst rating and 10 the best rating. CMS separates the ratings scale into three categories: 0-6, 7-8, and 9-10. For the purposes of these proportions, ratings of 9 or 10 are coded as “satisfied”; ratings of 7 or 8 are coded as “neutral”; and ratings of 0 through 6 are coded as “dissatisfied.” Exhibits 4-8 show the distributions of dissatisfied, neutral, and satisfied respondents for the Medicare CAHPS® 2013 Overall Ratings questions.

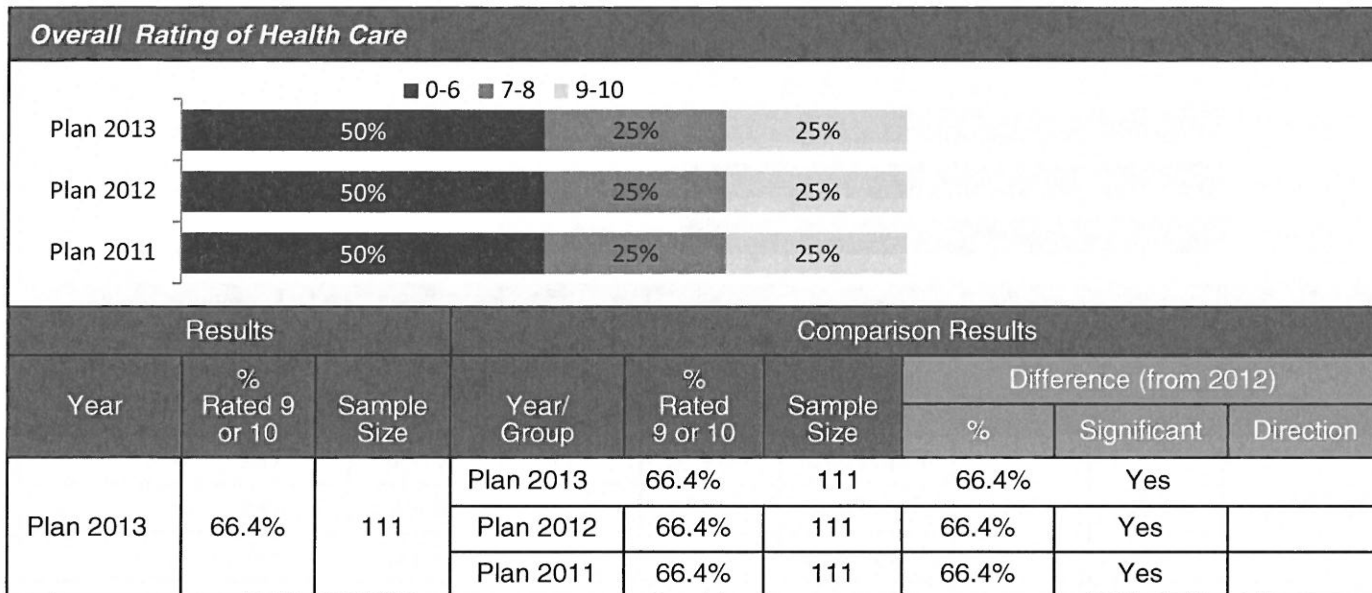
Overall Ratings: Summary Rates Using Responses of 9 or 10

The charts and tables below present _______________‘s Overall Ratings Top Scores (rating of 9 or 10) for 2013 compared _______’s 2012 and 2011 ratings.

Health Care

Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your health care in the last 6 months?

EXHIBIT 4: OVERALL RATING OF HEALTH CARE

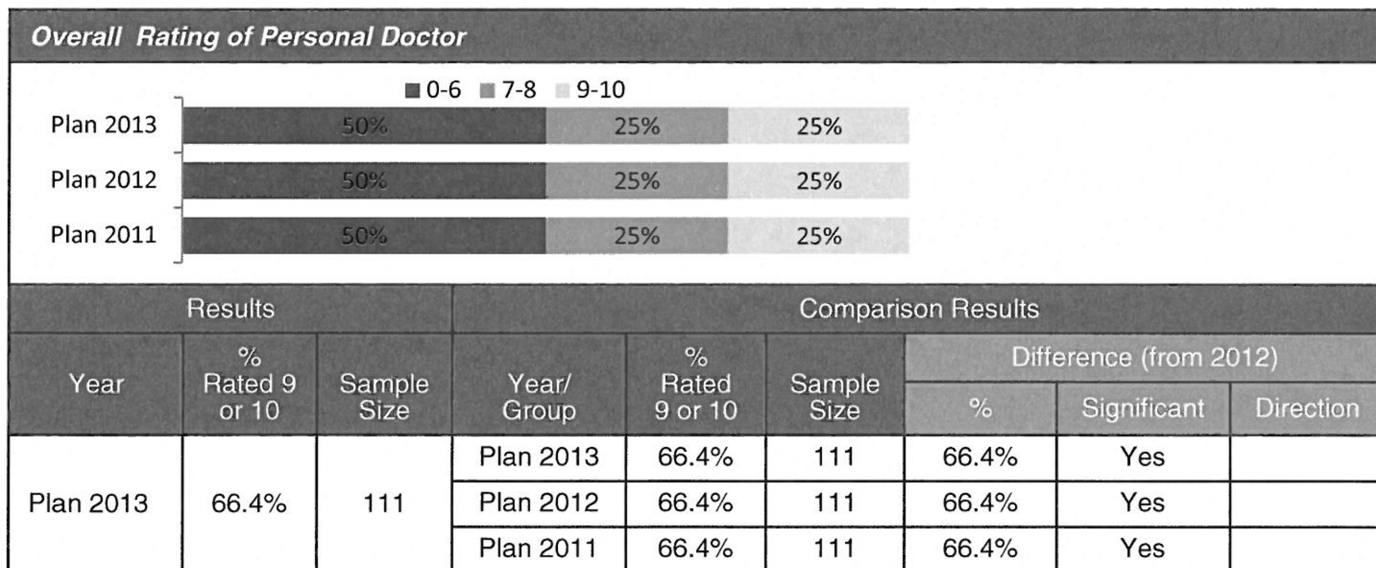


Results			Comparison Results					
						Difference (from 2012)		
Year	% Rated 9 or 10	Sample Size	Year/ Group	% Rated 9 or 10	Sample Size	%	Significant	Direction
Plan 2013	66.4%	111	Plan 2013	66.4%	111	66.4%	Yes	
			Plan 2012	66.4%	111	66.4%	Yes	
			Plan 2011	66.4%	111	66.4%	Yes	

Personal Doctor

Using any number from 0 to 10, where 0 is the worst personal doctor possible and 10 is the best personal doctor possible, what number would you use to rate your personal doctor?

EXHIBIT 5: OVERALL RATING OF PERSONAL DOCTOR



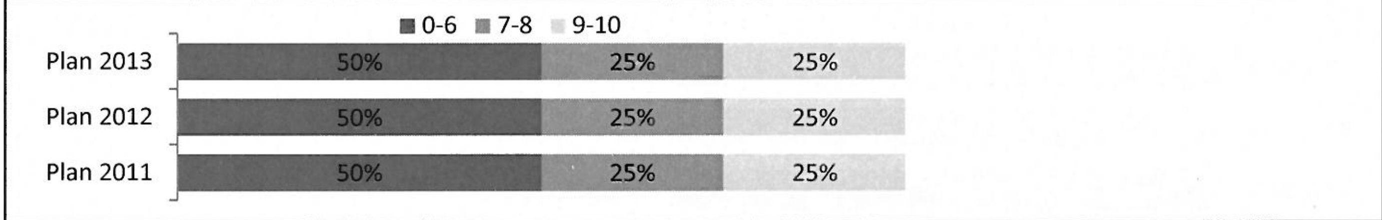
Results			Comparison Results					
						Difference (from 2012)		
Year	% Rated 9 or 10	Sample Size	Year/ Group	% Rated 9 or 10	Sample Size	%	Significant	Direction
Plan 2013	66.4%	111	Plan 2013	66.4%	111	66.4%	Yes	
			Plan 2012	66.4%	111	66.4%	Yes	
			Plan 2011	66.4%	111	66.4%	Yes	

Specialist

We want to know your rating of the specialist you saw most often in the last 6 months. Using any number from 0 to 10, where 0 is the worst specialist possible and 10 is the best specialist possible, what number would you use to rate that specialist?

EXHIBIT 6: OVERALL RATING OF SPECIALIST

Overall Rating of Specialist

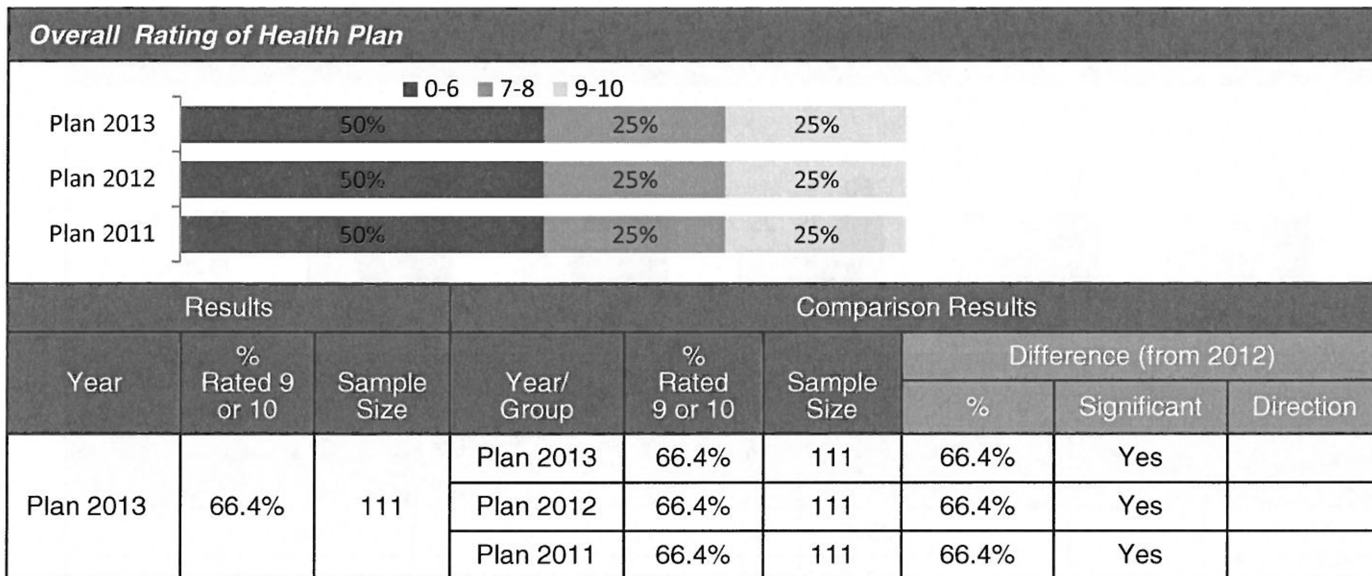


Results			Comparison Results					
						Difference (from 2012)		
Year	% Rated 9 or 10	Sample Size	Year/ Group	% Rated 9 or 10	Sample Size	%	Significant	Direction
Plan 2013	66.4%	111	Plan 2013	66.4%	111	66.4%	Yes	
			Plan 2012	66.4%	111	66.4%	Yes	
			Plan 2011	66.4%	111	66.4%	Yes	

Health Plan

Using any number from 0 to 10, where 0 is the worst health plan possible and 10 is the best health plan possible, what number would you use to rate your health plan?

EXHIBIT 7: OVERALL RATING OF HEALTH PLAN

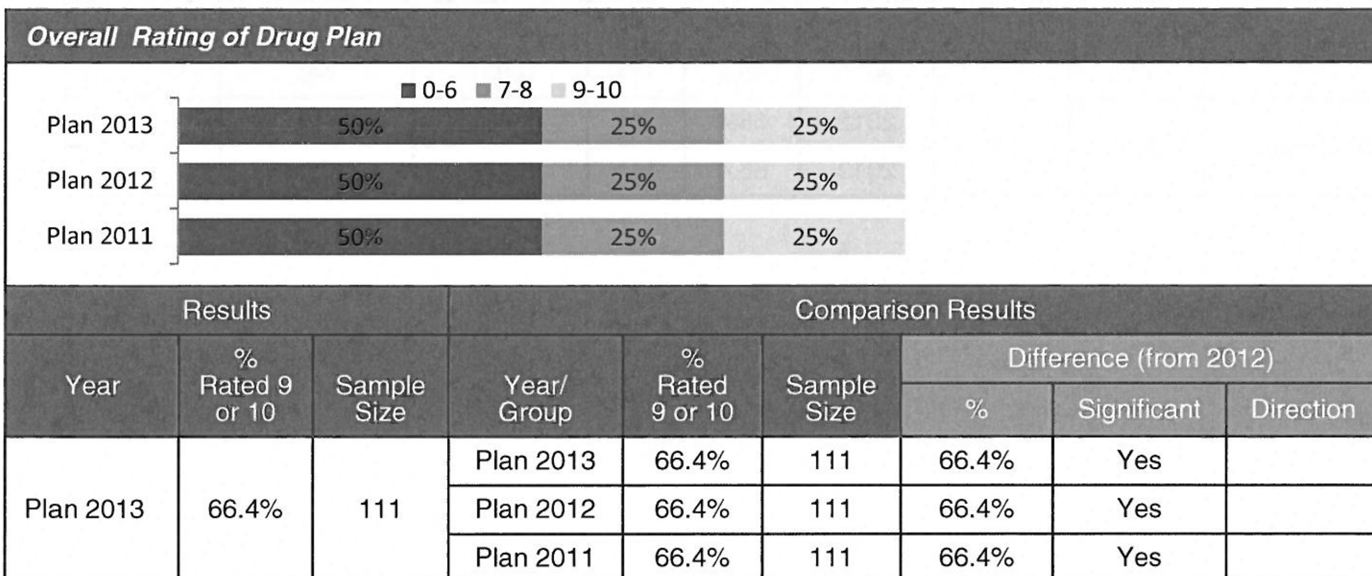


Results			Comparison Results					
						Difference (from 2012)		
Year	% Rated 9 or 10	Sample Size	Year/ Group	% Rated 9 or 10	Sample Size	%	Significant	Direction
Plan 2013	66.4%	111	Plan 2013	66.4%	111	66.4%	Yes	
			Plan 2012	66.4%	111	66.4%	Yes	
			Plan 2011	66.4%	111	66.4%	Yes	

Prescription Drug Plan

Using any number from 0 to 10, where 0 is the worst prescription drug plan possible and 10 is the best prescription drug plan possible, what number would you use to rate your prescription drug plan?

EXHIBIT 8: OVERALL RATING OF PRESCRIPTION DRUG PLAN

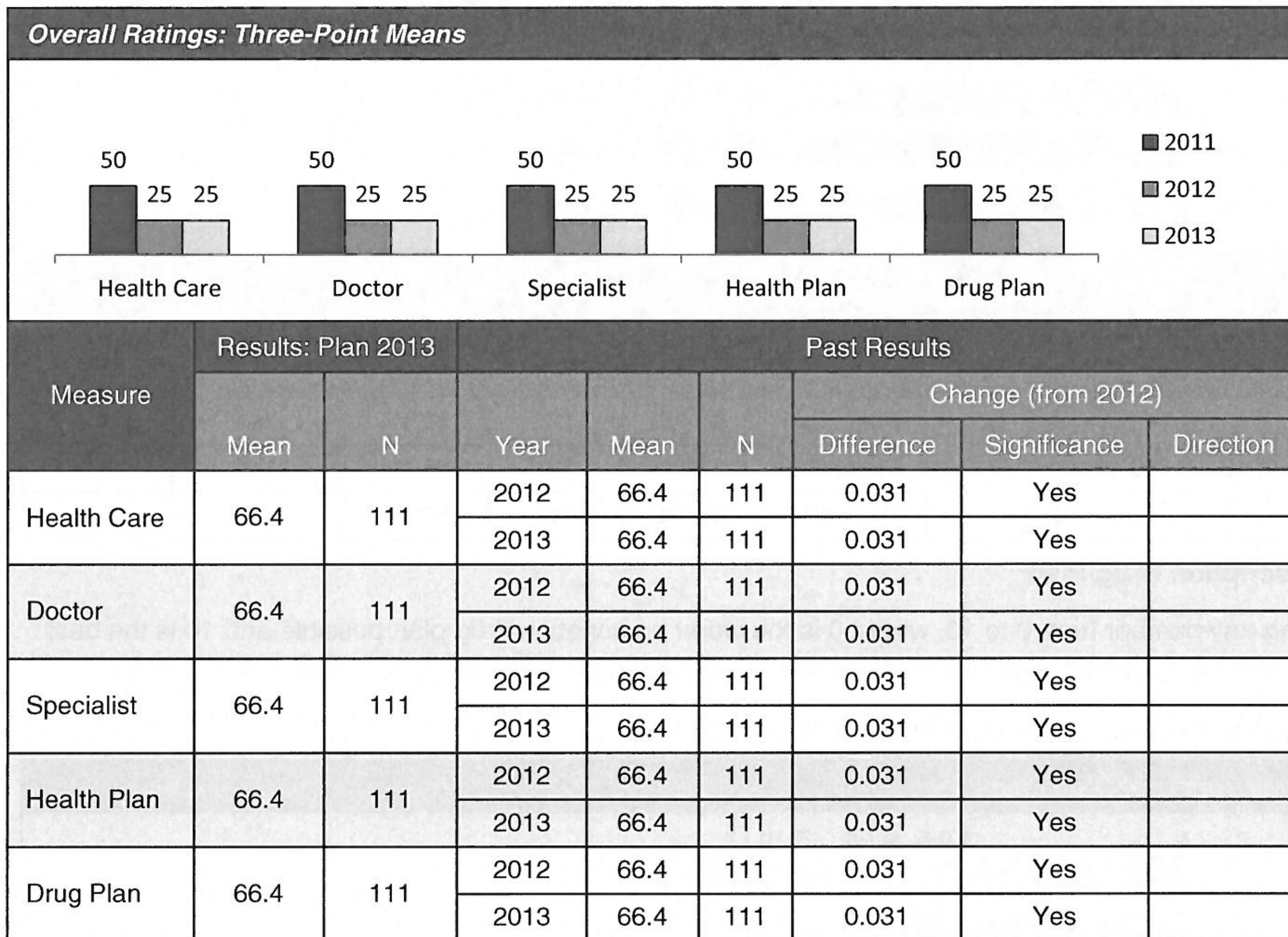


Results			Comparison Results					
						Difference (from 2012)		
Year	% Rated 9 or 10	Sample Size	Year/ Group	% Rated 9 or 10	Sample Size	%	Significant	Direction
Plan 2013	66.4%	111	Plan 2013	66.4%	111	66.4%	Yes	
			Plan 2012	66.4%	111	66.4%	Yes	
			Plan 2011	66.4%	111	66.4%	Yes	

Overall Ratings: Three Point Means

The following table shows _________'s three point means from this year and the past two years.

EXHIBIT 9: OVERALL RATINGS THREE POINT MEANS



Measure	Results: Plan 2013		Past Results					
						Change (from 2012)		
	Mean	N	Year	Mean	N	Difference	Significance	Direction
Health Care	66.4	111	2012	66.4	111	0.031	Yes	
			2013	66.4	111	0.031	Yes	
Doctor	66.4	111	2012	66.4	111	0.031	Yes	
			2013	66.4	111	0.031	Yes	
Specialist	66.4	111	2012	66.4	111	0.031	Yes	
			2013	66.4	111	0.031	Yes	
Health Plan	66.4	111	2012	66.4	111	0.031	Yes	
			2013	66.4	111	0.031	Yes	
Drug Plan	66.4	111	2012	66.4	111	0.031	Yes	
			2013	66.4	111	0.031	Yes	

Composite Measures

CMS creates composite measures by combining responses for sets of related questions (see Appendix C: Technical Notes for more information). Each of the questions included in these composite scores is associated with the response scales: "Never," "Sometimes," "Usually," "Always." To form composite scores, ratings are divided into three categories: dissatisfied ("Sometimes," or "Never"), neutral ("Usually"), and satisfied ("Always").

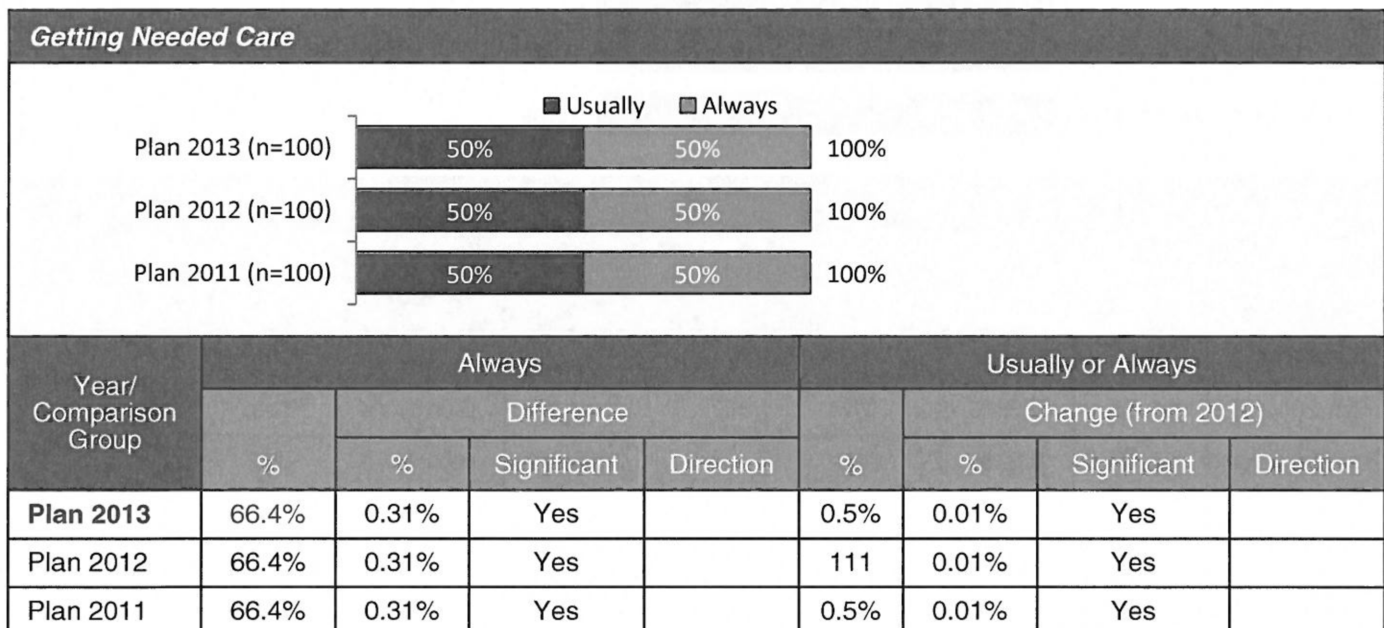
_______________'s composite summary rates for 2013 are presented below and compared to the results from the 2012 and 2011 ___________ Medicare CAHPS survey. In all cases, higher numbers reflect more respondent satisfaction. Z-tests for proportions with a confidence interval of .95 are used to test for significant differences.

Getting Needed Care

The Getting Needed Care composite reflects members' satisfaction with access to specialists and necessary care. The following questions are included in the composite score:

- *In the last 6 months, how often was it easy to get appointments with specialists?*
- *In the last 6 months, how often was it easy to get the care, tests, or treatment you thought you needed through your health plan?*

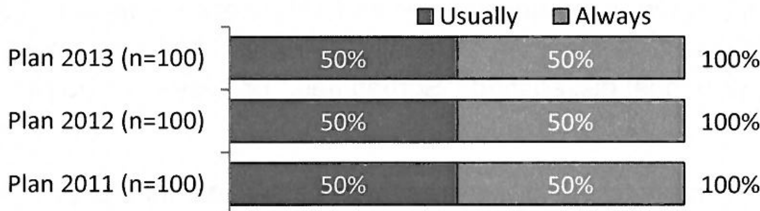
EXHIBIT 10: COMPOSITE SCORE: GETTING NEEDED CARE



Year/ Comparison Group	Always				Usually or Always			
		Difference				Change (from 2012)		
	%	%	Significant	Direction	%	%	Significant	Direction
Plan 2013	66.4%	0.31%	Yes		0.5%	0.01%	Yes	
Plan 2012	66.4%	0.31%	Yes		111	0.01%	Yes	
Plan 2011	66.4%	0.31%	Yes		0.5%	0.01%	Yes	

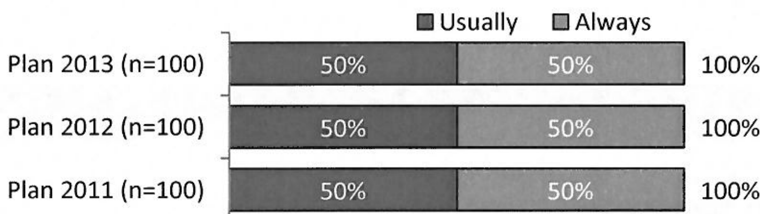
EXHIBIT 11: DETAILED ANALYSIS: GETTING NEEDED CARE

Easy To Get Appointment With Specialists



Year/ Comparison Group	Always				Usually or Always			
		Difference				Difference		
	%	%	Significant	Direction	%	%	Significant	Direction
Plan 2013	66.4%	0.31%	Yes		0.5%	0.01%	Yes	
Plan 2012	66.4%	0.31%	Yes		111	0.01%	Yes	
Plan 2011	66.4%	0.31%	Yes		0.5%	0.01%	Yes	

Easy To Get The Care, Tests, Or Treatment Needed



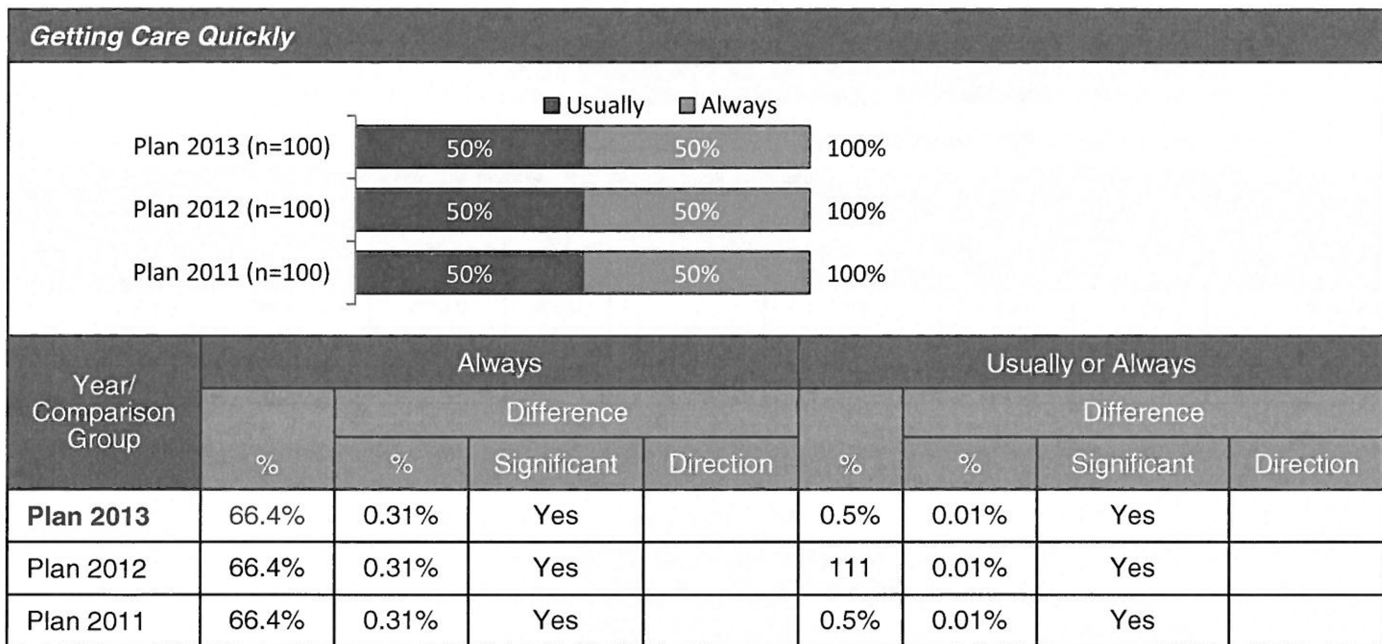
Year/ Comparison Group	Always				Usually or Always			
		Difference				Difference		
	%	%	Significant	Direction	%	%	Significant	Direction
Plan 2013	66.4%	0.31%	Yes		0.5%	0.01%	Yes	
Plan 2012	66.4%	0.31%	Yes		111	0.01%	Yes	
Plan 2011	66.4%	0.31%	Yes		0.5%	0.01%	Yes	

Getting Care Quickly

The Getting Care Quickly composite measures member satisfaction with access to urgent and routine care. It includes the following questions.

- *In the last 6 months, when you needed care right away, how often did you get care as soon as you thought you needed?*
- *In the last 6 months, not counting the times you needed care right away, how often did you get an appointment for your health care at a doctor's office or clinic as soon as you thought you needed?*
- *Wait time includes time spent in the waiting room and exam room. In the last 6 months, how often did you see the person you came to see within 15 minutes of your appointment time?*

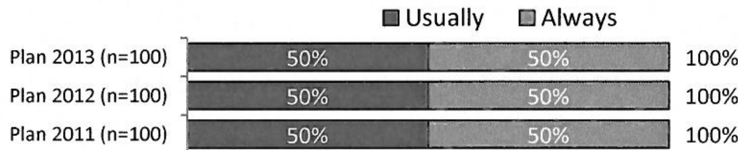
EXHIBIT 12: COMPOSITE SCORE: GETTING CARE QUICKLY



Year/ Comparison Group	Always				Usually or Always			
		Difference				Difference		
	%	%	Significant	Direction	%	%	Significant	Direction
Plan 2013	66.4%	0.31%	Yes		0.5%	0.01%	Yes	
Plan 2012	66.4%	0.31%	Yes		111	0.01%	Yes	
Plan 2011	66.4%	0.31%	Yes		0.5%	0.01%	Yes	

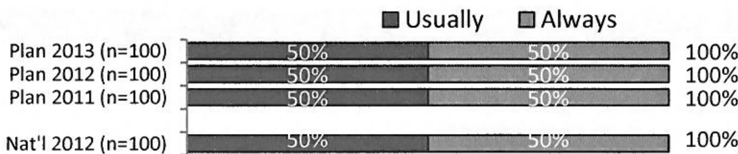
EXHIBIT 13: DETAILED ANALYSIS: GETTING CARE QUICKLY

Get Care As Soon As You Thought You Needed



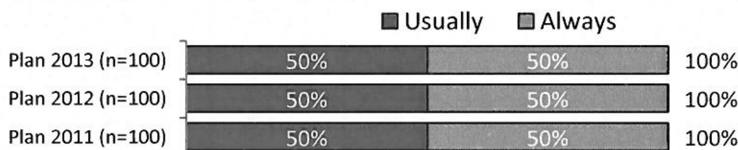
Year/ Comparison Group	Always				Usually or Always			
		Difference				Difference		
	%	%	Significant	Direction	%	%	Significant	Direction
Plan 2013	66.4%	0.31%	Yes		0.5%	0.01%	Yes	
Plan 2012	66.4%	0.31%	Yes		111	0.01%	Yes	
Plan 2011	66.4%	0.31%	Yes		0.5%	0.01%	Yes	

Get Appointment As Soon As You Thought You Needed



Year/ Comparison Group	Always				Usually or Always			
		Difference				Difference		
	%	%	Significant	Direction	%	%	Significant	Direction
Plan 2013	66.4%	0.31%	Yes		0.5%	0.01%	Yes	
Plan 2012	66.4%	0.31%	Yes		111	0.01%	Yes	
Plan 2011	66.4%	0.31%	Yes		0.5%	0.01%	Yes	

Seen Within 15 Minutes Of Appointment Time



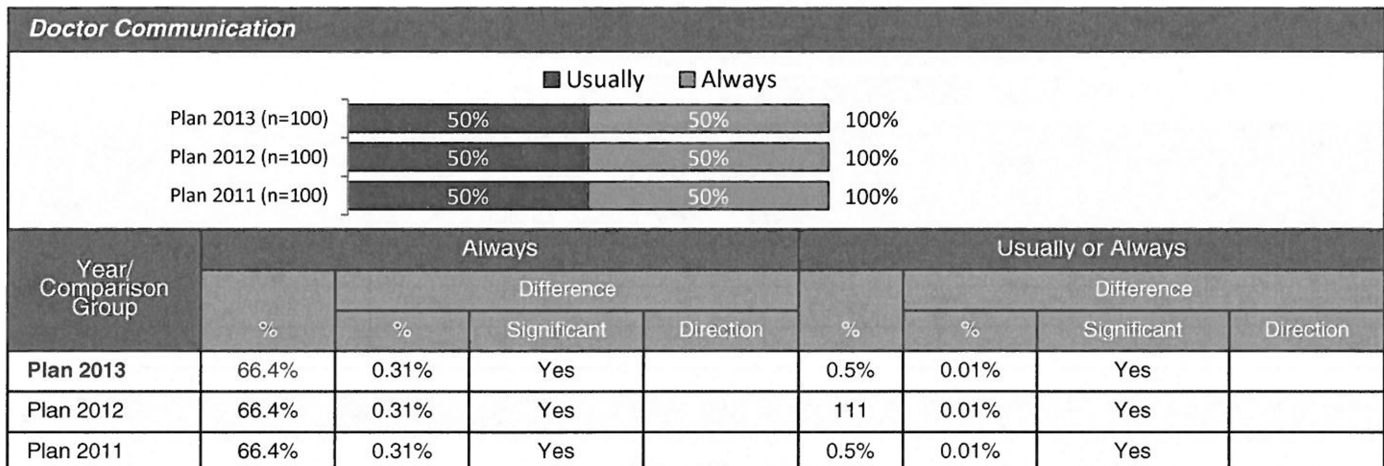
Year/ Comparison Group	Always				Usually or Always			
		Difference				Difference		
	%	%	Significant	Direction	%	%	Significant	Direction
Plan 2013	66.4%	0.31%	Yes		0.5%	0.01%	Yes	
Plan 2012	66.4%	0.31%	Yes		111	0.01%	Yes	
Plan 2011	66.4%	0.31%	Yes		0.5%	0.01%	Yes	

Doctors Who Communicate Well

The Doctors Who Communicate Well composite measures satisfaction with how well providers listen, explain care issues, show respect, and spend time with members. It includes the following questions:

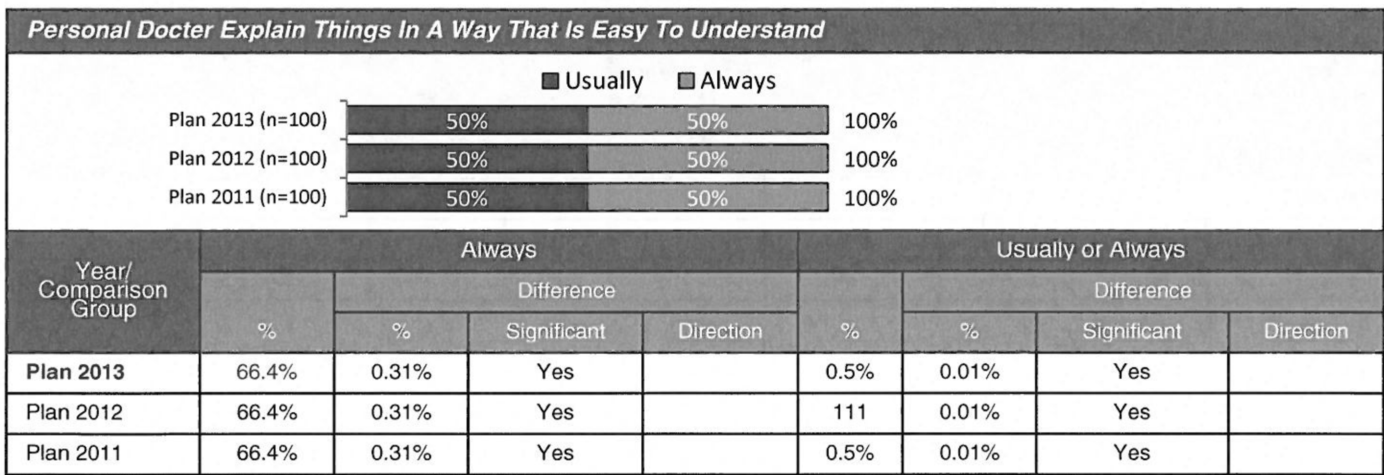
- *In the last 6 months, how often did your personal doctor explain things in a way that was easy to understand?*
- *In the last 6 months, how often did your personal doctor listen carefully to you?*
- *In the last 6 months, how often did your personal doctor show respect for what you had to say?*
- *In the last 6 months, how often did your personal doctor spend enough time with you?*

EXHIBIT 14: COMPOSITE SCORE: DOCTORS WHO COMMUNICATE WELL



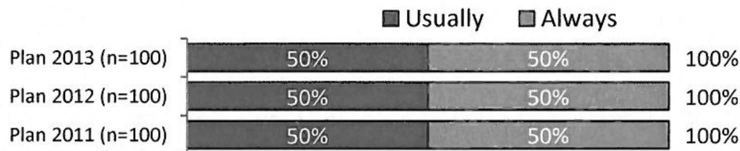
Year/ Comparison Group	Always				Usually or Always			
		Difference				Difference		
	%	%	Significant	Direction	%	%	Significant	Direction
Plan 2013	66.4%	0.31%	Yes		0.5%	0.01%	Yes	
Plan 2012	66.4%	0.31%	Yes		111	0.01%	Yes	
Plan 2011	66.4%	0.31%	Yes		0.5%	0.01%	Yes	

EXHIBIT 15: DETAILED ANALYSIS: DOCTORS WHO COMMUNICATE WELL



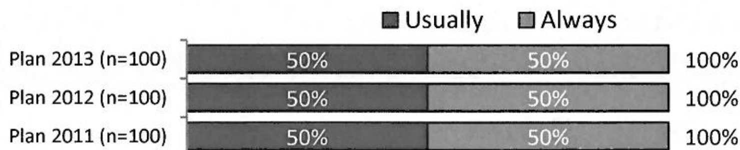
Year/ Comparison Group	Always				Usually or Always			
		Difference				Difference		
	%	%	Significant	Direction	%	%	Significant	Direction
Plan 2013	66.4%	0.31%	Yes		0.5%	0.01%	Yes	
Plan 2012	66.4%	0.31%	Yes		111	0.01%	Yes	
Plan 2011	66.4%	0.31%	Yes		0.5%	0.01%	Yes	

Personal Docter Listens Carefully



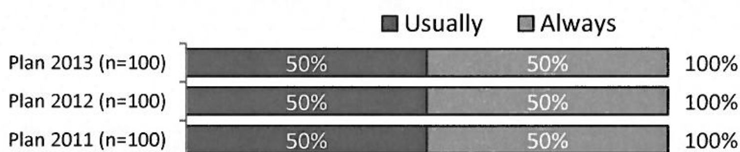
Year/ Comparison Group	Always				Usually or Always			
		Difference				Difference		
	%	%	Significant	Direction	%	%	Significant	Direction
Plan 2013	66.4%	0.31%	Yes		0.5%	0.01%	Yes	
Plan 2012	66.4%	0.31%	Yes		111	0.01%	Yes	
Plan 2011	66.4%	0.31%	Yes		0.5%	0.01%	Yes	

Personal Docter Shows Respect For What Patient Has To Say



Year/ Comparison Group	Always				Usually or Always			
		Difference				Difference		
	%	%	Significant	Direction	%	%	Significant	Direction
Plan 2013	66.4%	0.31%	Yes		0.5%	0.01%	Yes	
Plan 2012	66.4%	0.31%	Yes		111	0.01%	Yes	
Plan 2011	66.4%	0.31%	Yes		0.5%	0.01%	Yes	

Personal Docter Spend Enough Time With Patient



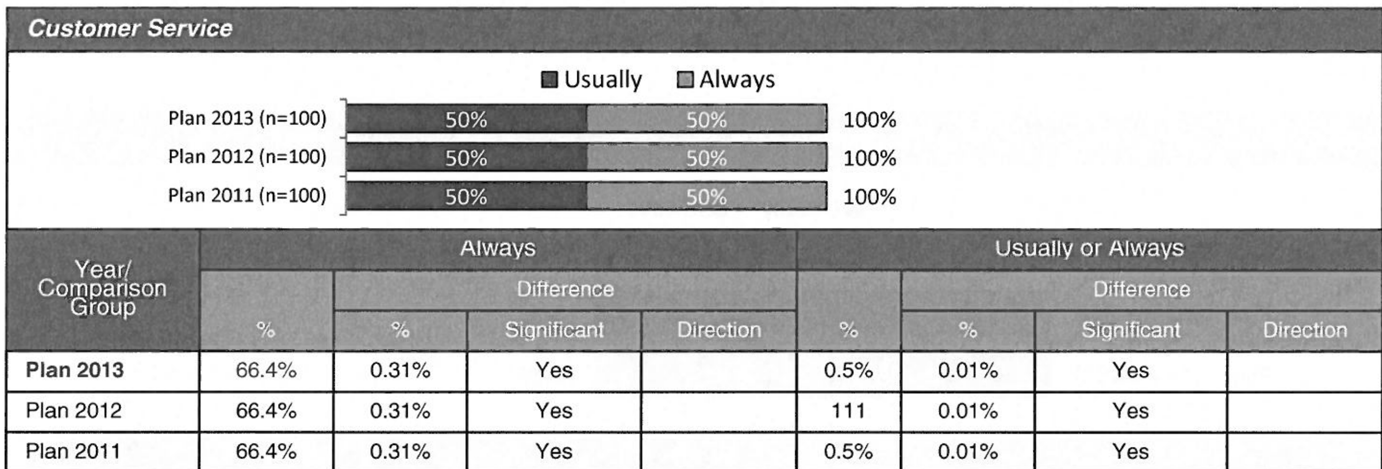
Year/ Comparison Group	Always				Usually or Always			
		Difference				Difference		
	%	%	Significant	Direction	%	%	Significant	Direction
Plan 2013	66.4%	0.31%	Yes		0.5%	0.01%	Yes	
Plan 2012	66.4%	0.31%	Yes		111	0.01%	Yes	
Plan 2011	66.4%	0.31%	Yes		0.5%	0.01%	Yes	

Health Plan Customer Service

The Health Plan Customer Service composite measures member satisfaction with their ability to understand the plan's written materials and paperwork and to get help when they call. The composite includes the following questions:

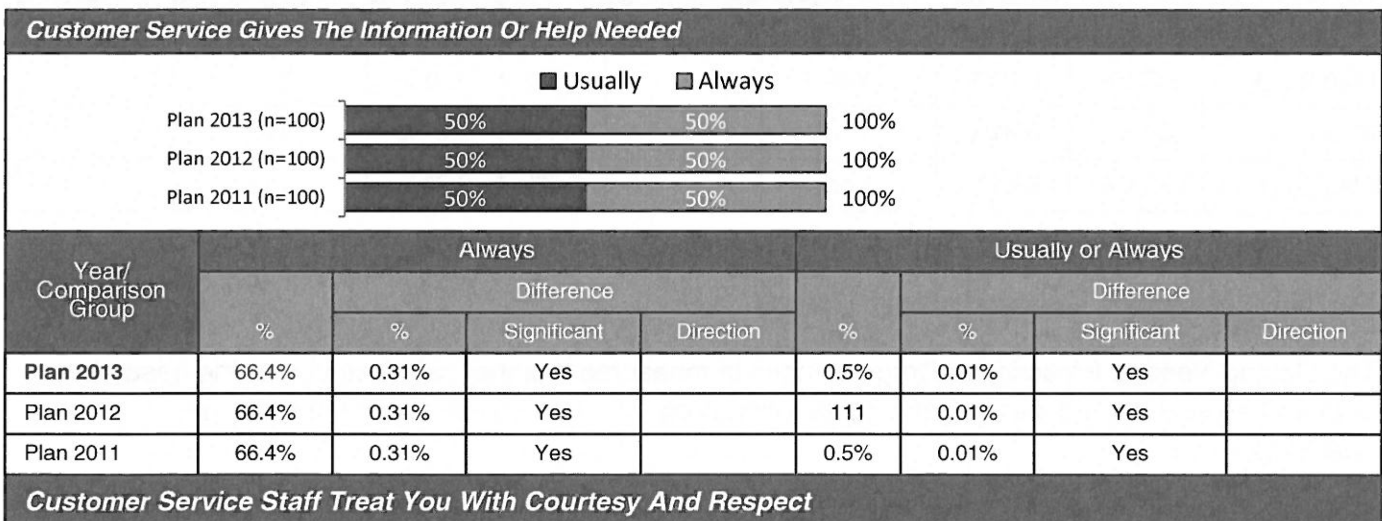
- *In the last 6 months, how often did your health plan's customer service give you the information or help you needed?*
- *In the last 6 months, how often did your health plan's customer service staff treat you with courtesy and respect?*
- *In the last 6 months, how often were the forms from your health plan easy to fill out?*

EXHIBIT 16: COMPOSITE SCORE: HEALTH PLAN CUSTOMER SERVICE



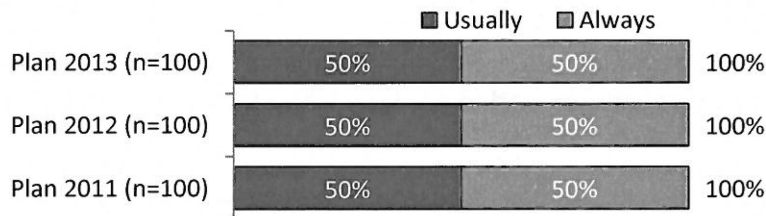
Year/ Comparison Group	Always				Usually or Always			
		Difference				Difference		
	%	%	Significant	Direction	%	%	Significant	Direction
Plan 2013	66.4%	0.31%	Yes		0.5%	0.01%	Yes	
Plan 2012	66.4%	0.31%	Yes		111	0.01%	Yes	
Plan 2011	66.4%	0.31%	Yes		0.5%	0.01%	Yes	

EXHIBIT 17: DETAILED ANALYSIS: HEALTH PLAN CUSTOMER SERVICE



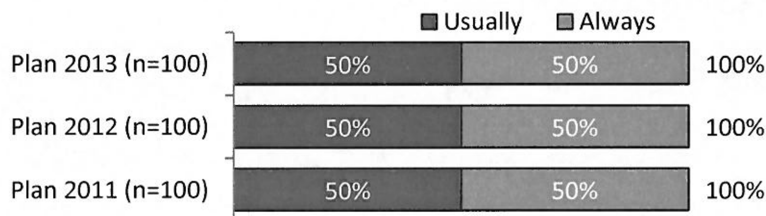
Year/ Comparison Group	Always				Usually or Always			
		Difference				Difference		
	%	%	Significant	Direction	%	%	Significant	Direction
Plan 2013	66.4%	0.31%	Yes		0.5%	0.01%	Yes	
Plan 2012	66.4%	0.31%	Yes		111	0.01%	Yes	
Plan 2011	66.4%	0.31%	Yes		0.5%	0.01%	Yes	

Customer Service Staff Treat You With Courtesy And Respect



Year/ Comparison Group	Always				Usually or Always			
	%	Difference			%	Difference		
		%	Significant	Direction		%	Significant	Direction
Plan 2013	66.4%	0.31%	Yes		0.5%	0.01%	Yes	
Plan 2012	66.4%	0.31%	Yes		111	0.01%	Yes	
Plan 2011	66.4%	0.31%	Yes		0.5%	0.01%	Yes	

The Forms From Your Health Plan Easy To Fill Out



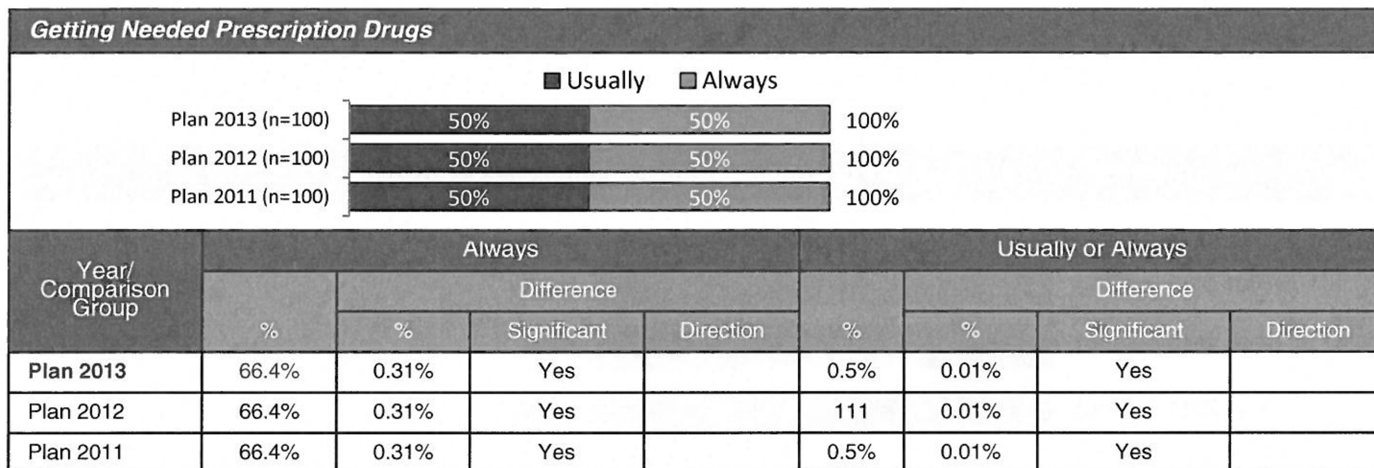
Year/ Comparison Group	Always				Usually or Always			
	%	Difference			%	Difference		
		%	Significant	Direction		%	Significant	Direction
Plan 2013	66.4%	0.31%	Yes		0.5%	0.01%	Yes	
Plan 2012	66.4%	0.31%	Yes		111	0.01%	Yes	
Plan 2011	66.4%	0.31%	Yes		0.5%	0.01%	Yes	

Getting Needed Prescription Drugs

The Getting Needed Prescription Drugs composite measures member satisfaction with the ease of use of their prescription drug plan to get a prescription filled. The composite includes the following questions:

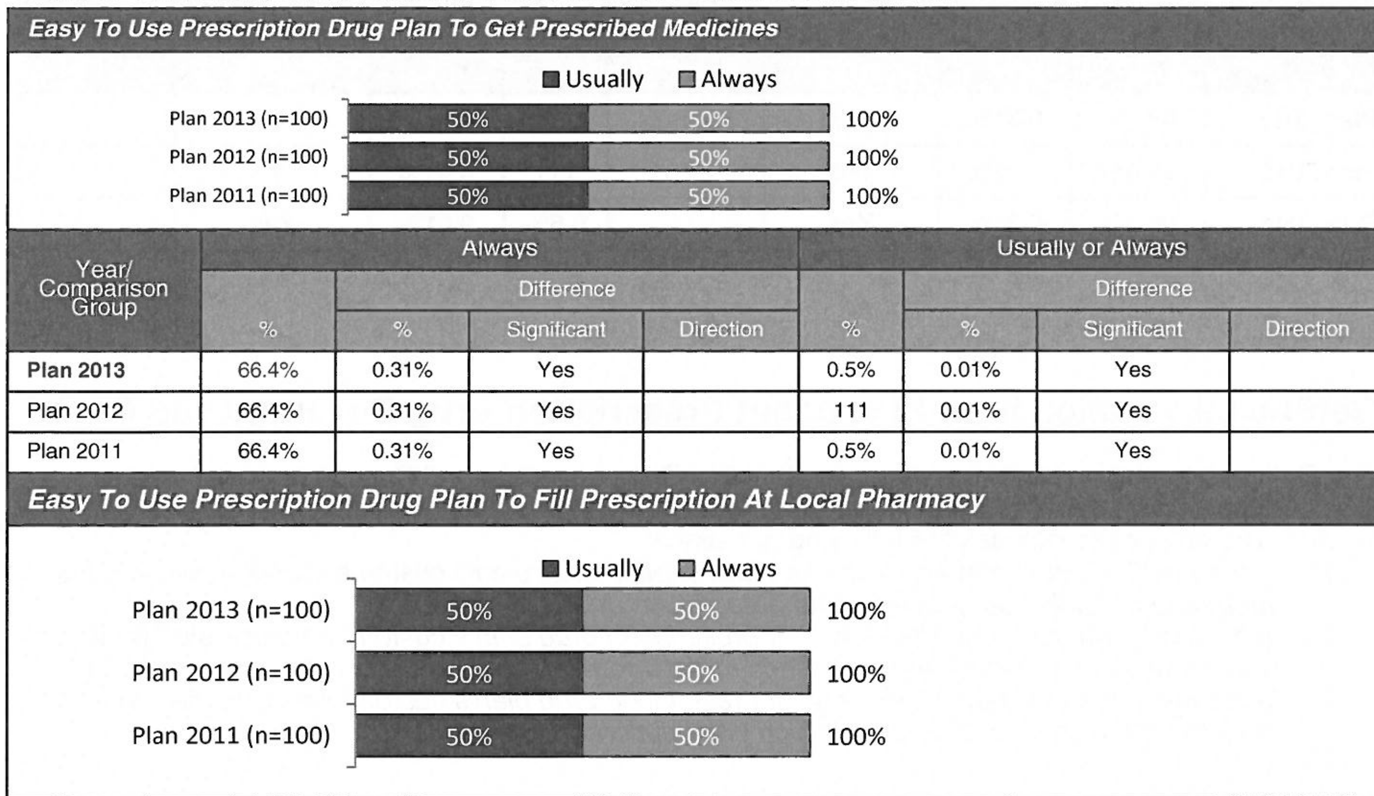
- *In the last 6 months, how often was it easy to use your prescription drug plan to get the medicines your doctor prescribed?*
- *In the last 6 months, how often was it easy to use your prescription drug plan to fill a prescription at your local pharmacy?*
- *In the last 6 months, how often was it easy to use your prescription drug plan to fill a prescription by mail?*

EXHIBIT 18: COMPOSITE SCORE: GETTING NEEDED PRESCRIPTION DRUGS



Year/ Comparison Group	Always				Usually or Always			
		Difference				Difference		
	%	%	Significant	Direction	%	%	Significant	Direction
Plan 2013	66.4%	0.31%	Yes		0.5%	0.01%	Yes	
Plan 2012	66.4%	0.31%	Yes		111	0.01%	Yes	
Plan 2011	66.4%	0.31%	Yes		0.5%	0.01%	Yes	

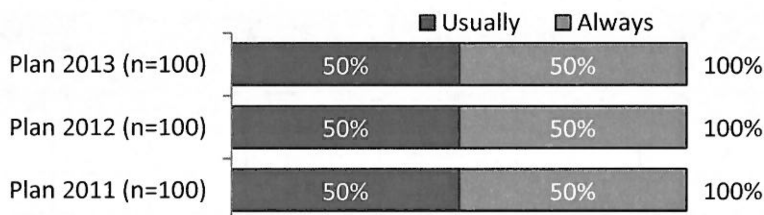
EXHIBIT 19: DETAILED ANALYSIS: GETTING NEEDED PRESCRIPTION DRUGS



Year/ Comparison Group	Always				Usually or Always			
		Difference				Difference		
	%	%	Significant	Direction	%	%	Significant	Direction
Plan 2013	66.4%	0.31%	Yes		0.5%	0.01%	Yes	
Plan 2012	66.4%	0.31%	Yes		111	0.01%	Yes	
Plan 2011	66.4%	0.31%	Yes		0.5%	0.01%	Yes	

Year/ Comparison Group	Always				Usually or Always			
		Difference				Difference		
	%	%	Significant	Direction	%	%	Significant	Direction
Plan 2013	66.4%	0.31%	Yes		0.5%	0.01%	Yes	
Plan 2012	66.4%	0.31%	Yes		111	0.01%	Yes	
Plan 2011	66.4%	0.31%	Yes		0.5%	0.01%	Yes	

Easy To Use Prescription Drug Plan To Fill Prescription By Mail



Year/ Comparison Group	Always				Usually or Always			
		Difference				Difference		
	%	%	Significant	Direction	%	%	Significant	Direction
Plan 2013	66.4%	0.31%	Yes		0.5%	0.01%	Yes	
Plan 2012	66.4%	0.31%	Yes		111	0.01%	Yes	
Plan 2011	66.4%	0.31%	Yes		0.5%	0.01%	Yes	

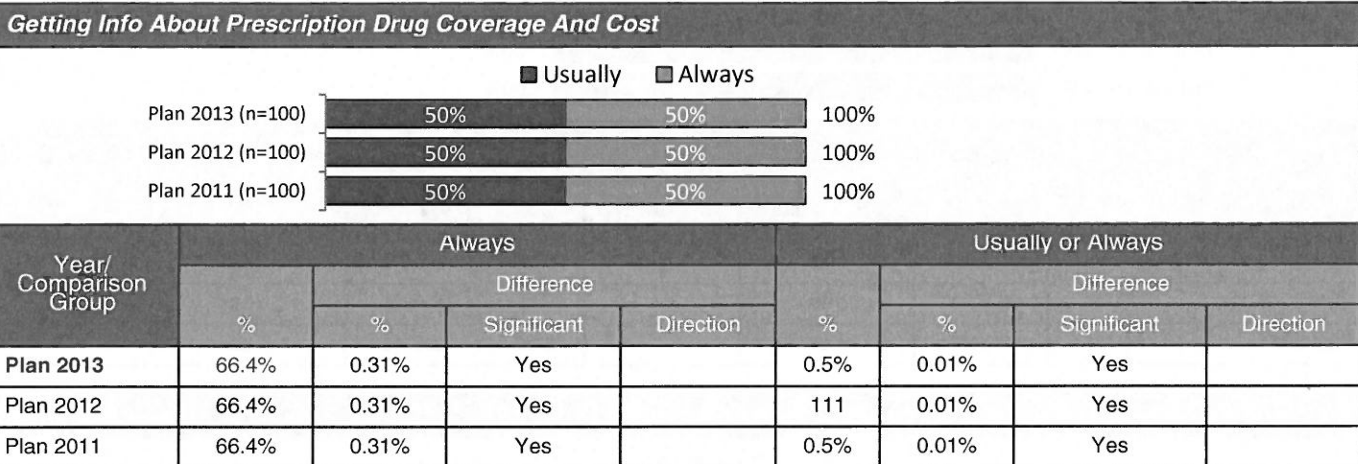
Getting Information from Plan about Prescription Drug Coverage and Cost

The Getting Information from Plan about Prescription Drug Coverage and Cost composite measures member satisfaction with the ability to get information about their prescription drug plan from customer service. The composite includes the following questions:

- *In the last 6 months, how often did your prescription drug plan's customer service give you the information or help you needed about prescription drugs?*
- *In the last 6 months, how often did your prescription drug plan's customer service staff treat you with courtesy and respect when you tried to get information or help about prescription drugs?*
- *In the last 6 months, how often did your prescription drug plan's customer service give you all the information you needed about which prescription medicines were covered?*

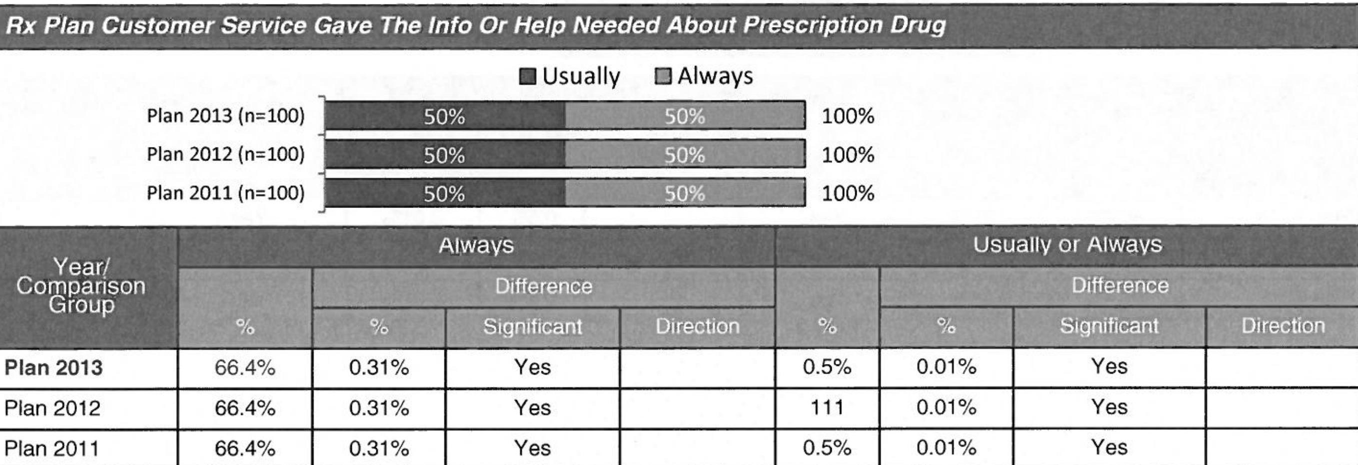
- *In the last 6 months, how often did your prescription drug plan's customer service give you all the information you needed about how much you would have to pay for your prescription medication?*

EXHIBIT 20: COMPOSITE SCORE: GETTING INFO ABOUT PRESCRIPTION DRUG COVERAGE AND COST

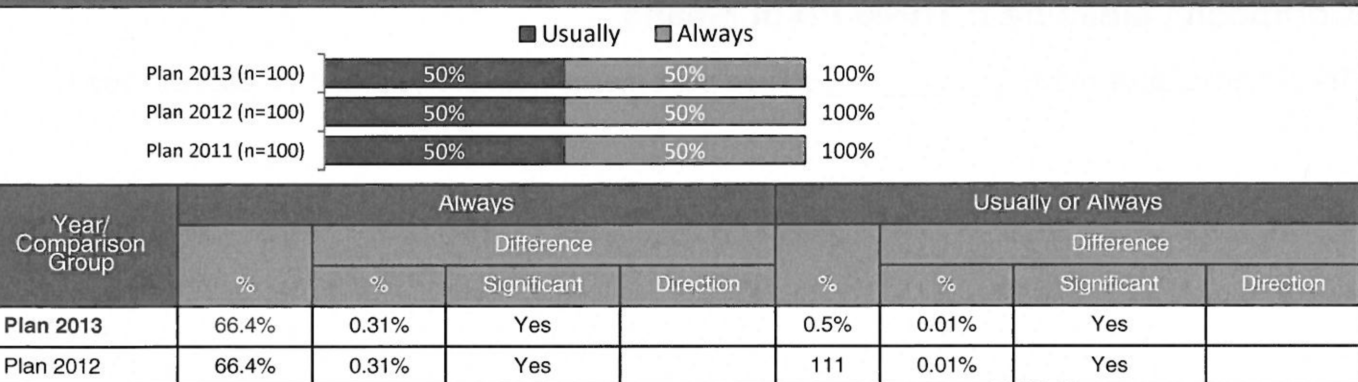


Year/ Comparison Group	Always				Usually or Always			
		Difference				Difference		
	%	%	Significant	Direction	%	%	Significant	Direction
Plan 2013	66.4%	0.31%	Yes		0.5%	0.01%	Yes	
Plan 2012	66.4%	0.31%	Yes		111	0.01%	Yes	
Plan 2011	66.4%	0.31%	Yes		0.5%	0.01%	Yes	

EXHIBIT 21: DETAILED ANALYSIS: GETTING INFO ABOUT PRESCRIPTION DRUG COVERAGE AND COST



Year/ Comparison Group	Always				Usually or Always			
		Difference				Difference		
	%	%	Significant	Direction	%	%	Significant	Direction
Plan 2013	66.4%	0.31%	Yes		0.5%	0.01%	Yes	
Plan 2012	66.4%	0.31%	Yes		111	0.01%	Yes	
Plan 2011	66.4%	0.31%	Yes		0.5%	0.01%	Yes	



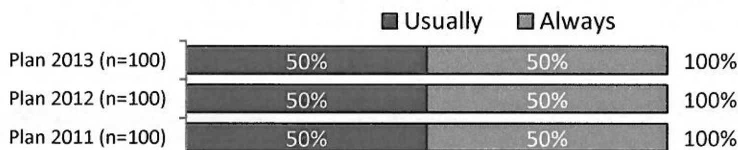
Year/ Comparison Group	Always				Usually or Always			
		Difference				Difference		
	%	%	Significant	Direction	%	%	Significant	Direction
Plan 2013	66.4%	0.31%	Yes		0.5%	0.01%	Yes	
Plan 2012	66.4%	0.31%	Yes		111	0.01%	Yes	

Plan 2011	66.4%	0.31%	Yes		0.5%	0.01%	Yes	

Prescription Drug Plan Gave Information On Which Prescription Drug Covered

Year/ Comparison Group	Always				Usually or Always			
		Difference				Difference		
	%	%	Significant	Direction	%	%	Significant	Direction
Plan 2013	66.4%	0.31%	Yes		0.5%	0.01%	Yes	
Plan 2012	66.4%	0.31%	Yes		111	0.01%	Yes	
Plan 2011	66.4%	0.31%	Yes		0.5%	0.01%	Yes	

Prescription Drug Plan Gave Information On Cost Of Prescription Drug



Year/ Comparison Group	Always				Usually or Always			
		Difference				Difference		
	%	%	Significant	Direction	%	%	Significant	Direction
Plan 2013	66.4%	0.31%	Yes		0.5%	0.01%	Yes	
Plan 2012	66.4%	0.31%	Yes		111	0.01%	Yes	
Plan 2011	66.4%	0.31%	Yes		0.5%	0.01%	Yes	

Composite Measures: Three Point Means

The following table shows ___________'s three point means from this year and the past two years.

EXHIBIT 22: COMPOSITE MEASURES THREE POINT MEANS

Composite Measures: Three-Point Means

Measure	Results: Plan 2013		Past Results					
						Change (from 2012)		
	Mean	N	Year	Mean	N	Difference	Significance	Direction
Getting Needed Care	**66.4**	**111**	2012	66.4	111	0.031	Yes	
			2013	66.4	111	0.031	Yes	
Getting Care Quickly	**66.4**	**111**	2012	66.4	111	0.031	Yes	
			2013	66.4	111	0.031	Yes	
Doctor Communication	**66.4**	**111**	2012	66.4	111	0.031	Yes	
			2013	66.4	111	0.031	Yes	
Customer Service	**66.4**	**111**	2012	66.4	111	0.031	Yes	
			2013	66.4	111	0.031	Yes	
Getting Needed Rx Drugs	**66.4**	**111**	2012	66.4	111	0.031	Yes	
			2013	66.4	111	0.031	Yes	
Getting info on Drug Coverage & Cost	**66.4**	**111**	2012	66.4	111	0.031	Yes	
			2013	66.4	111	0.031	Yes	

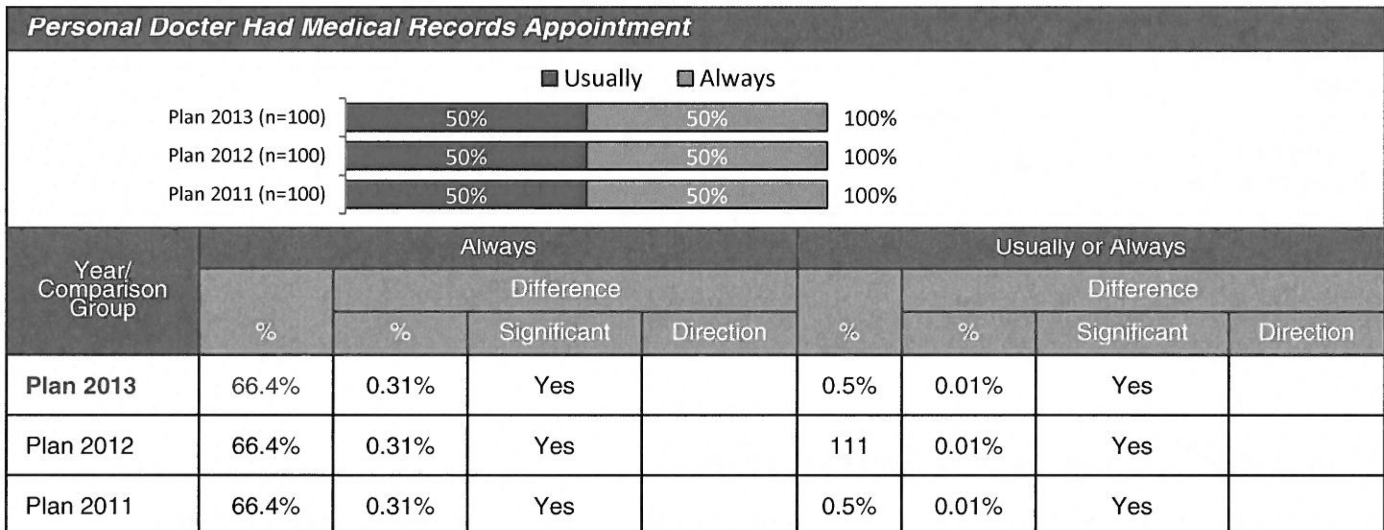
Coordination of Care Questions

In 2012, CMS added a set of questions regarding coordination of care to the Medicare CAHPS questionnaire. The coordination of care items represents a potential reporting composite.

The Coordination of Care composite includes the following questions:

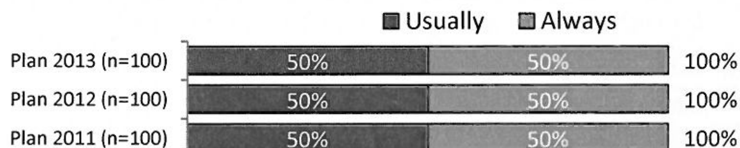
- *In the last 6 months, when you visited your personal doctor for a scheduled appointment, how often did he or she have your medical records or other information about your care?*
- *In the last 6 months, when your personal doctor ordered a blood test, x-ray or other test for you, how often did someone from your personal doctor's office follow up to give you those results?*
- *In the last 6 months, when your personal doctor ordered a blood test, x-ray or other test for you, how often did you get those results as soon as you needed them?*
- *How often did you and your personal doctor talk about all the prescription medications you were taking?*
- *In the last 6 months, did you get the help you needed from your personal doctor's office to manage your care among these different providers and services?*
- *In the last 6 months, how often did your personal doctor seem informed and up-to-date about the care you got from specialists?*

EXHIBIT 23: DETAILED ANALYSIS: COORDINATION OF CARE



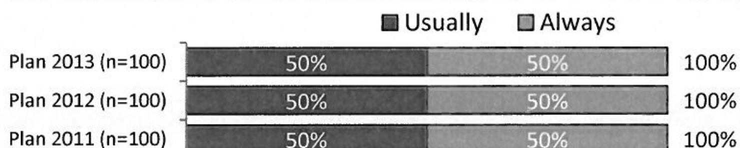
Year/ Comparison Group	Always				Usually or Always			
	%	Difference			%	Difference		
		%	Significant	Direction		%	Significant	Direction
Plan 2013	66.4%	0.31%	Yes		0.5%	0.01%	Yes	
Plan 2012	66.4%	0.31%	Yes		111	0.01%	Yes	
Plan 2011	66.4%	0.31%	Yes		0.5%	0.01%	Yes	

Docter Office Followed Up On Test Results



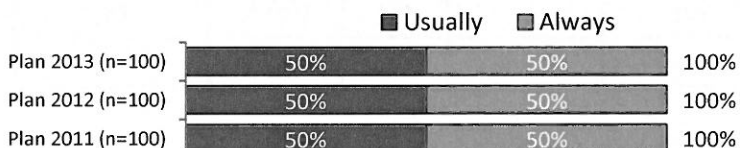
Year/ Comparison Group	Always				Usually or Always			
	%	Difference			%	Difference		
		%	Significant	Direction		%	Significant	Direction
Plan 2013	66.4%	0.31%	Yes		0.5%	0.01%	Yes	
Plan 2012	66.4%	0.31%	Yes		111	0.01%	Yes	
Plan 2011	66.4%	0.31%	Yes		0.5%	0.01%	Yes	

Access To Test Result



Year/ Comparison Group	Always				Usually or Always			
	%	Difference			%	Difference		
		%	Significant	Direction		%	Significant	Direction
Plan 2013	66.4%	0.31%	Yes		0.5%	0.01%	Yes	
Plan 2012	66.4%	0.31%	Yes		111	0.01%	Yes	
Plan 2011	66.4%	0.31%	Yes		0.5%	0.01%	Yes	

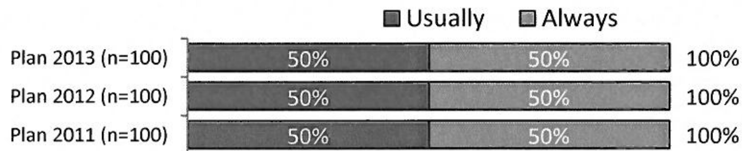
Personal Docter Discussed Prescription Medicines



Year/ Comparison Group	Always				Usually or Always			
	%	Difference			%	Difference		
		%	Significant	Direction		%	Significant	Direction
Plan 2013	66.4%	0.31%	Yes		0.5%	0.01%	Yes	
Plan 2012	66.4%	0.31%	Yes		111	0.01%	Yes	
Plan 2011	66.4%	0.31%	Yes		0.5%	0.01%	Yes	

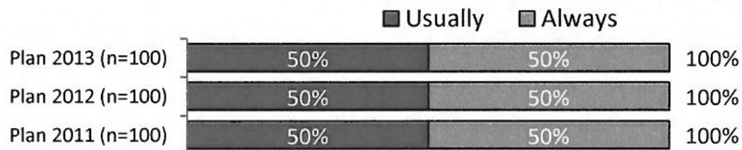
Ipsos Public Affairs

Got Help Needed To Manage Care



Year/ Comparison Group	Always				Usually or Always			
		Difference				Difference		
	%	%	Significant	Direction	%	%	Significant	Direction
Plan 2013	66.4%	0.31%	Yes		0.5%	0.01%	Yes	
Plan 2012	66.4%	0.31%	Yes		111	0.01%	Yes	
Plan 2011	66.4%	0.31%	Yes		0.5%	0.01%	Yes	

Personal Docter Up-To-Date About Care From Specialists



Year/ Comparison Group	Always				Usually or Always			
		Difference				Difference		
	%	%	Significant	Direction	%	%	Significant	Direction
Plan 2013	66.4%	0.31%	Yes		0.5%	0.01%	Yes	
Plan 2012	66.4%	0.31%	Yes		111	0.01%	Yes	
Plan 2011	66.4%	0.31%	Yes		0.5%	0.01%	Yes	

Additional CAHPS Questions

The Medicare CAHPS survey includes nine additional questions for which summary rates are reported:

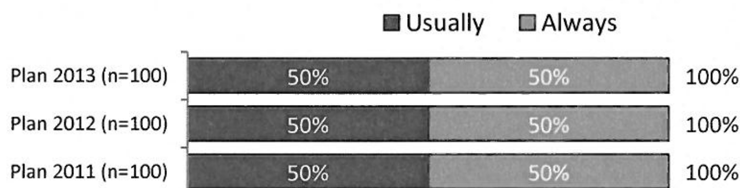
- *After Hours Answer to Medical Question*
- *Getting Needed Medical Equipment*
- *Satisfaction With Help Received To Coordinate Care*
- *Visit Notes*
- *Easy To Get Prescription Drugs*
- *Willingness To Recommend Plan For Drug Coverage*
- *Satisfaction with Health Plan's Handling of Complaint*
- *Influenza Vaccination*
- *Pneumonia Shot*

The After Hours Answer to Medical Question question is:

In the last 6 months, when you phoned a doctor's office or clinic after regular office hours, how often did you get an answer to your medical question as soon as you needed?

EXHIBIT 24: GETTING ANSWER TO AFTER HOURS MEDICAL QUESTION

Get Answer To After Hours Medical Question As Soon As You Thought You Needed

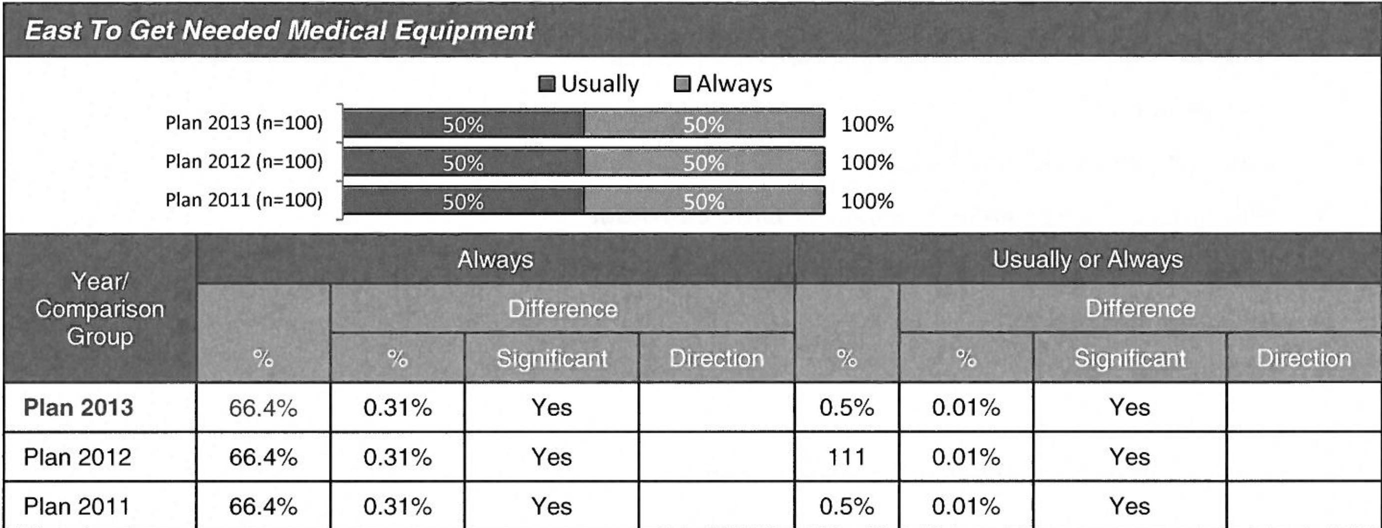


Year/ Comparison Group	Always				Usually or Always			
		Difference				Difference		
	%	%	Significant	Direction	%	%	Significant	Direction
Plan 2013	66.4%	0.31%	Yes		0.5%	0.01%	Yes	
Plan 2012	66.4%	0.31%	Yes		111	0.01%	Yes	
Plan 2011	66.4%	0.31%	Yes		0.5%	0.01%	Yes	

The Getting Needed Medical Equipment question is:

In the last 6 months, how often was it easy to get the medical equipment you needed through your health plan?

EXHIBIT 25: EASY TO GET NEEDED MEDICAL EQUIPMENT



Year/ Comparison Group	Always				Usually or Always			
		Difference				Difference		
	%	%	Significant	Direction	%	%	Significant	Direction
Plan 2013	66.4%	0.31%	Yes		0.5%	0.01%	Yes	
Plan 2012	66.4%	0.31%	Yes		111	0.01%	Yes	
Plan 2011	66.4%	0.31%	Yes		0.5%	0.01%	Yes	

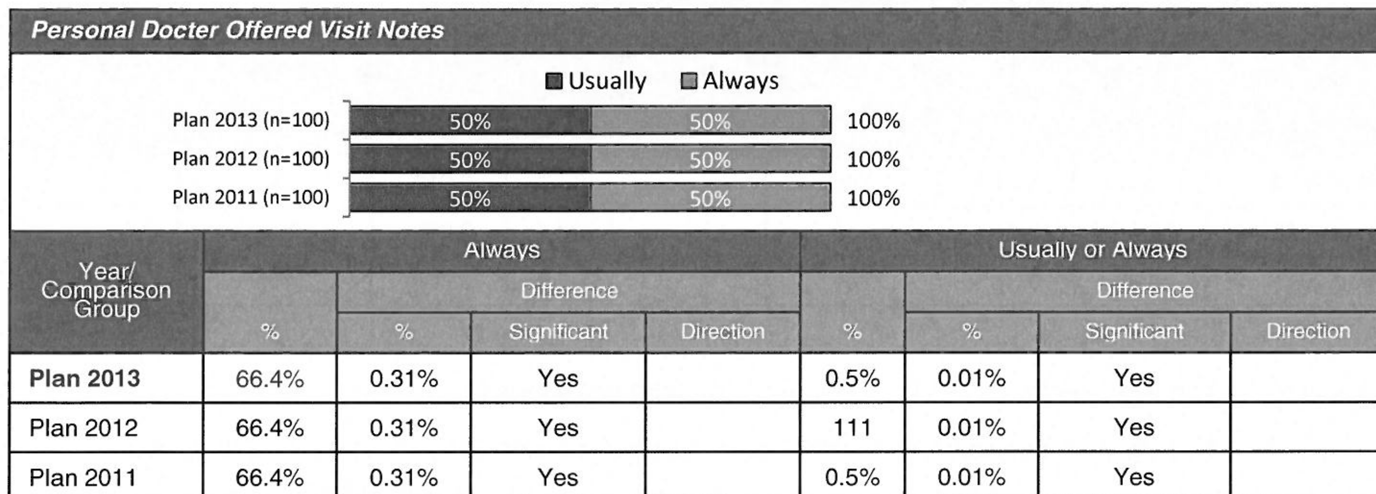
The Satisfaction with Help Received to Coordinate Care question is:

How satisfied are you with the help you received to coordinate your care in the last 6 months?

The Visit Notes question is:

Visit notes sum up what was talked about on a visit to a doctor's office. Visit notes may be available on paper, on a website or by e-mail. In the last 6 months, did anyone in your personal doctor's office offer you visit notes?

EXHIBIT 27: VISIT NOTES

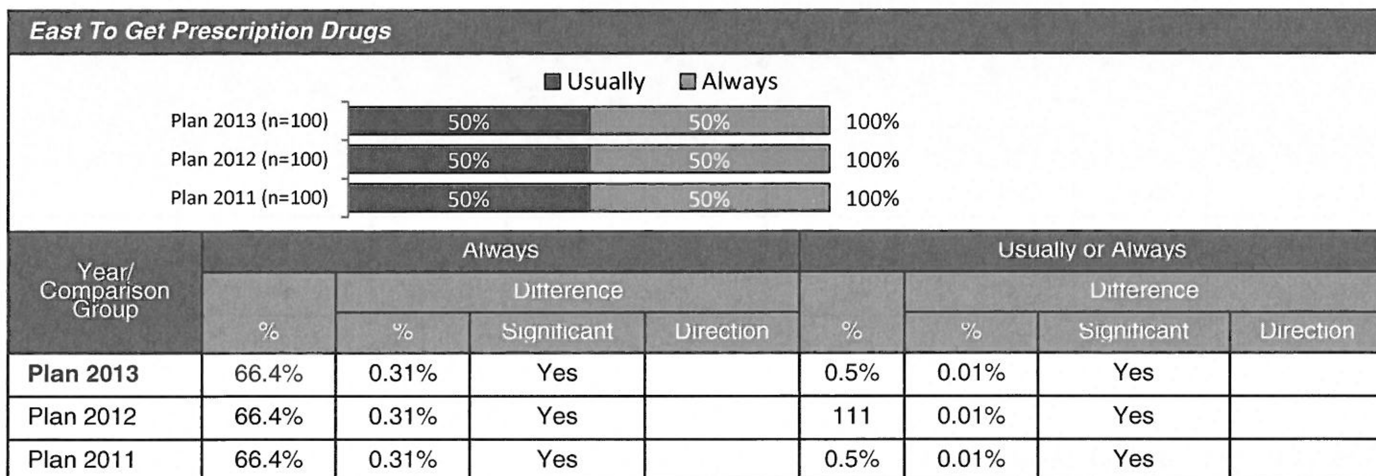


Year/ Comparison Group	Always				Usually or Always			
		Difference				Difference		
	%	%	Significant	Direction	%	%	Significant	Direction
Plan 2013	66.4%	0.31%	Yes		0.5%	0.01%	Yes	
Plan 2012	66.4%	0.31%	Yes		111	0.01%	Yes	
Plan 2011	66.4%	0.31%	Yes		0.5%	0.01%	Yes	

The Easy to Get Prescription Drugs question is:

[MA Only] In the last 6 months, how often was it easy to get the medicines your doctor prescribed?

EXHIBIT 28: EASY TO GET PRESCRIPTION DRUGS

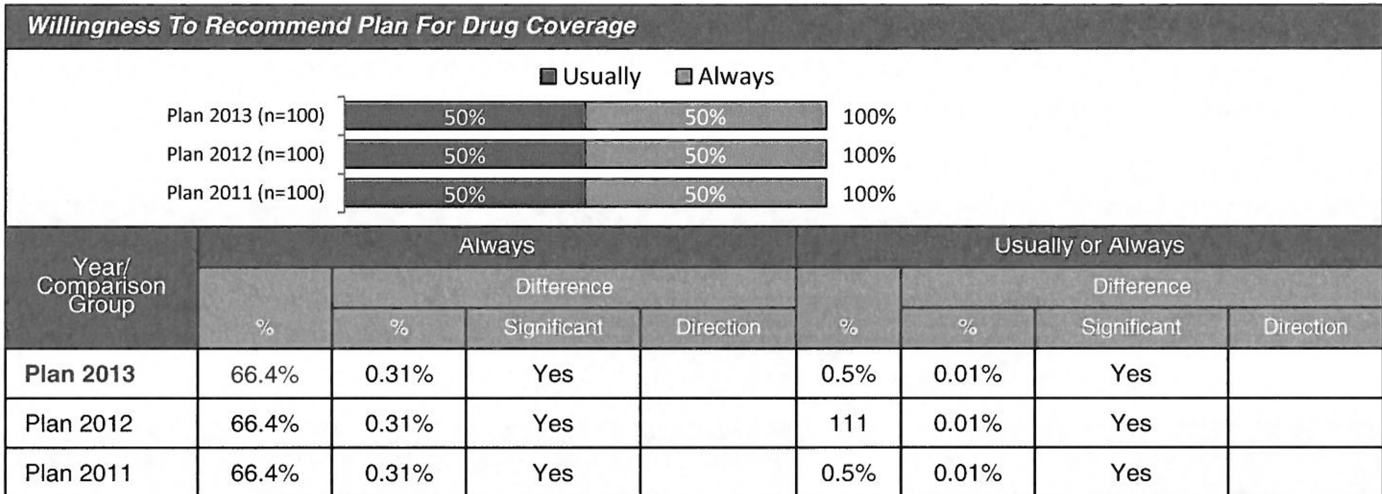


Year/ Comparison Group	Always				Usually or Always			
		Difference				Difference		
	%	%	Significant	Direction	%	%	Significant	Direction
Plan 2013	66.4%	0.31%	Yes		0.5%	0.01%	Yes	
Plan 2012	66.4%	0.31%	Yes		111	0.01%	Yes	
Plan 2011	66.4%	0.31%	Yes		0.5%	0.01%	Yes	

The Willingness to Recommend Plan for Drug Coverage is:

Would you recommend your prescription drug plan for coverage of prescription drugs to other people like yourself?

EXHIBIT 29: WILLINGNESS TO RECOMMEND PLAN FOR DRUG COVERAGE

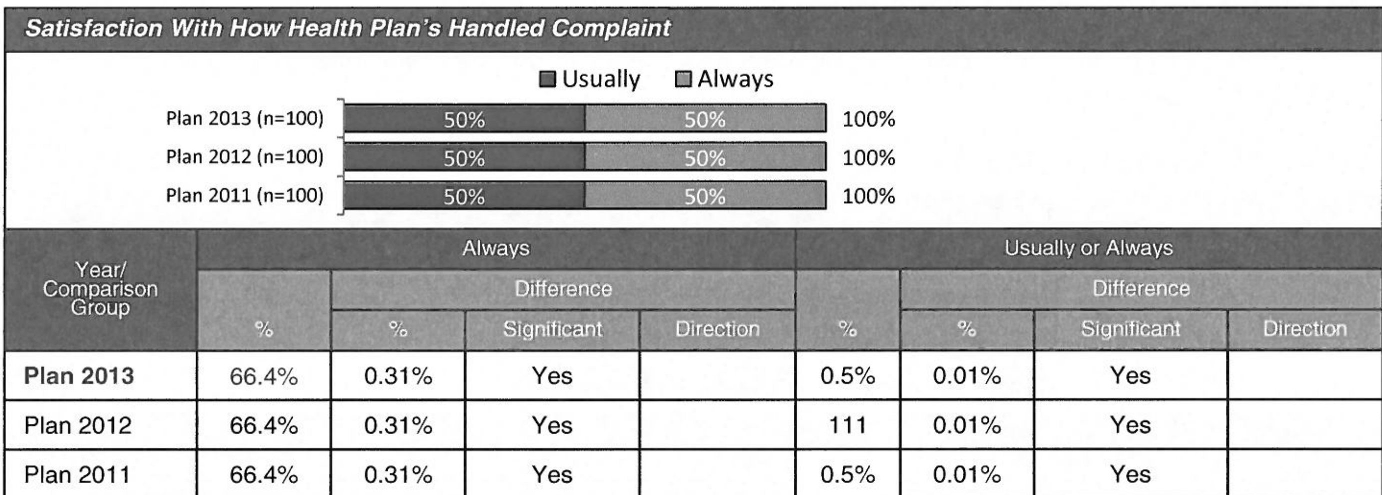


Year/ Comparison Group	Always				Usually or Always			
		Difference				Difference		
	%	%	Significant	Direction	%	%	Significant	Direction
Plan 2013	66.4%	0.31%	Yes		0.5%	0.01%	Yes	
Plan 2012	66.4%	0.31%	Yes		111	0.01%	Yes	
Plan 2011	66.4%	0.31%	Yes		0.5%	0.01%	Yes	

The Satisfaction with Health Plan's Handling of Complaint questions is:

- *Thinking about the complaint process, regardless of whether you agree or disagree with the final outcome, how satisfied are you with how your health plan handled your complaint?*

EXHIBIT 30: SATISFACTION WITH HEALTH PLAN'S HANDLING OF COMPLAINT

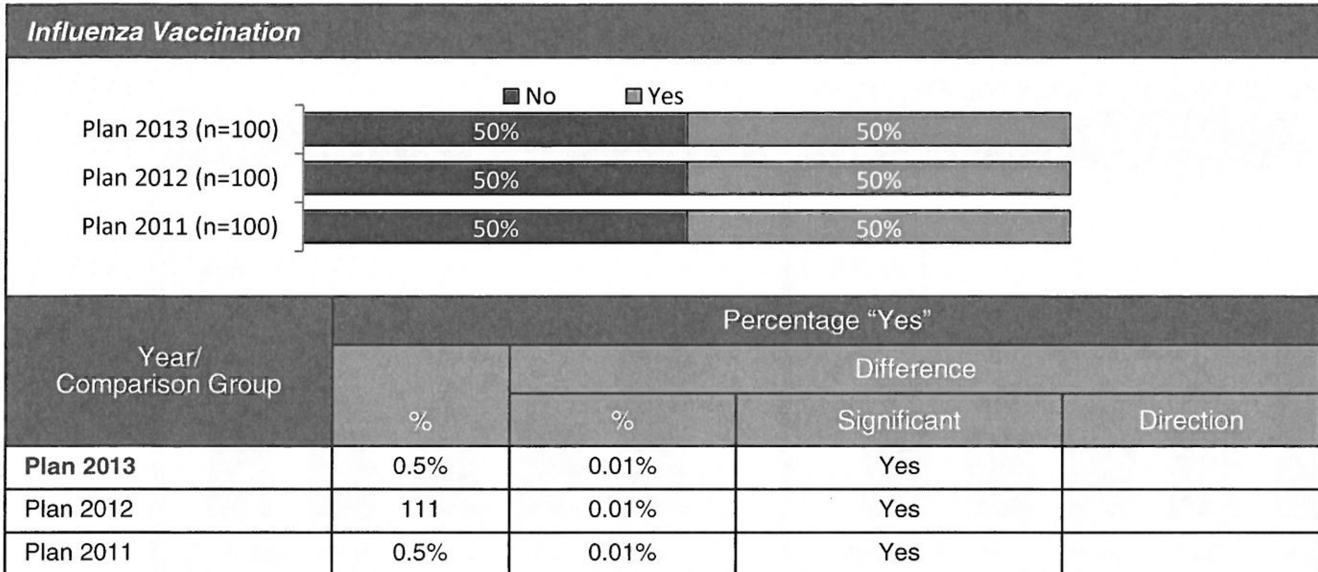


Year/ Comparison Group	Always				Usually or Always			
		Difference				Difference		
	%	%	Significant	Direction	%	%	Significant	Direction
Plan 2013	66.4%	0.31%	Yes		0.5%	0.01%	Yes	
Plan 2012	66.4%	0.31%	Yes		111	0.01%	Yes	
Plan 2011	66.4%	0.31%	Yes		0.5%	0.01%	Yes	

The Influenza Vaccination question is:

- *Have you had a flu shot since September 1, 2012?*

EXHIBIT 31: INFLUENZA VACCINATION

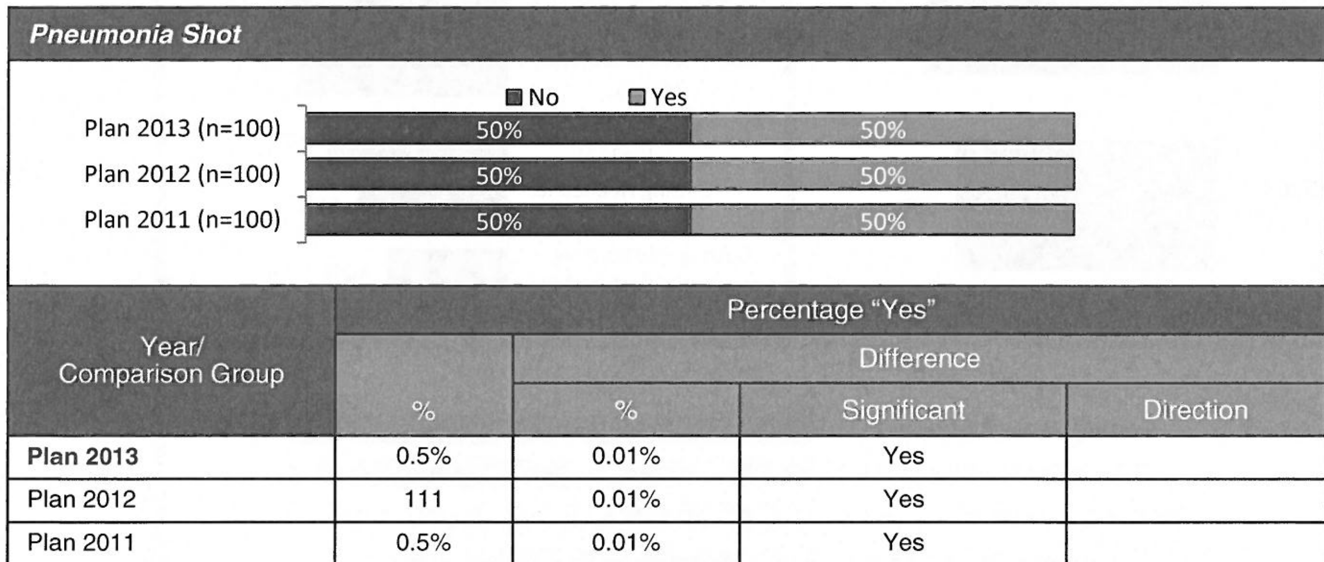


Year/ Comparison Group	Percentage "Yes"			
		Difference		
	%	%	Significant	Direction
Plan 2013	0.5%	0.01%	Yes	
Plan 2012	111	0.01%	Yes	
Plan 2011	0.5%	0.01%	Yes	

The Pneumonia Shot question is:

- *Have you ever had a pneumonia shot? This shot is usually given only once or twice in a person's lifetime and is different from a flu shot. It is also called the pneumococcal vaccine.*

EXHIBIT 32: PNEUMONIA SHOT



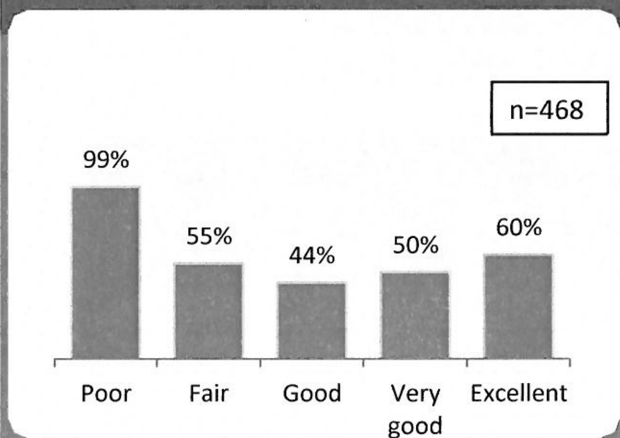
Year/ Comparison Group	Percentage "Yes"			
		Difference		
	%	%	Significant	Direction
Plan 2013	0.5%	0.01%	Yes	
Plan 2012	111	0.01%	Yes	
Plan 2011	0.5%	0.01%	Yes	

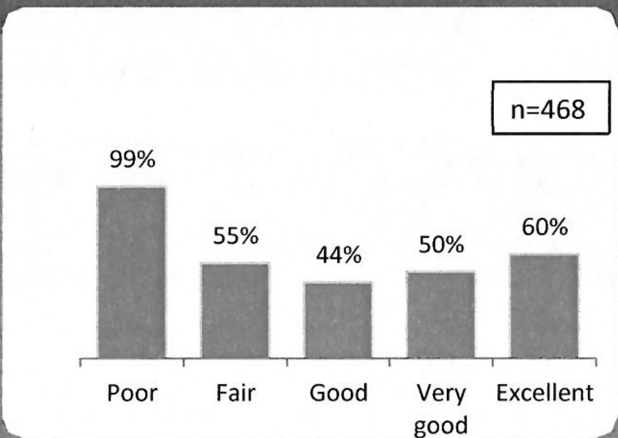
Ipsos Public Affairs

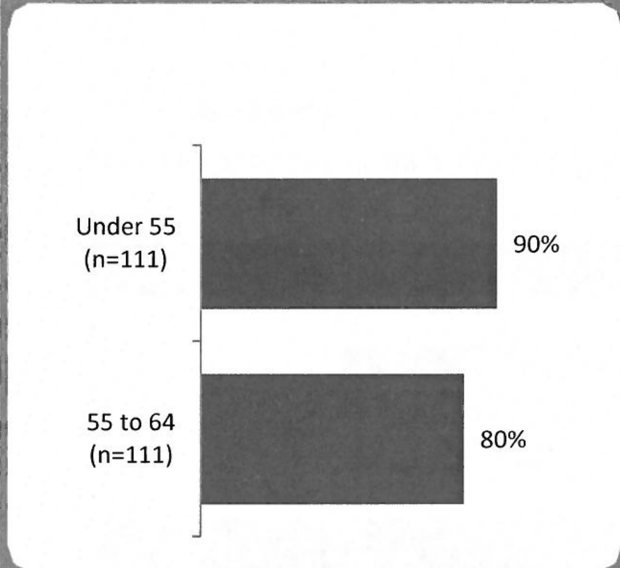
Health Demographics

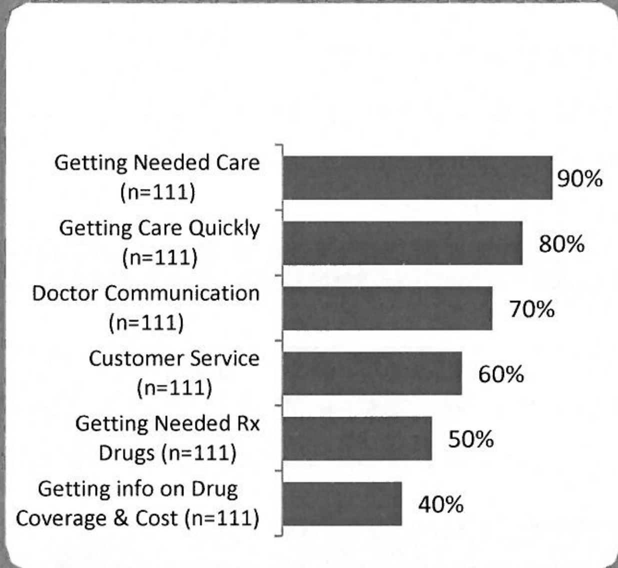
EXHIBIT 33: HEALTH STATUS AND PRACTICE

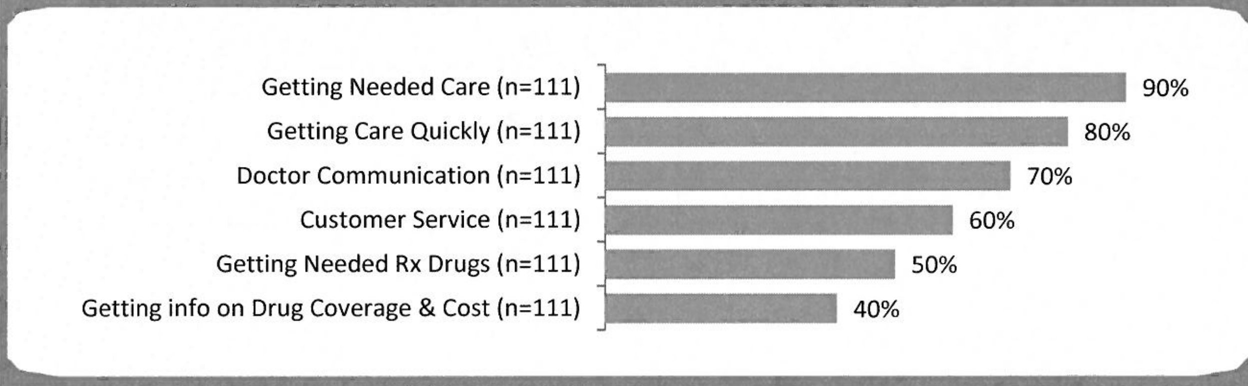
Health







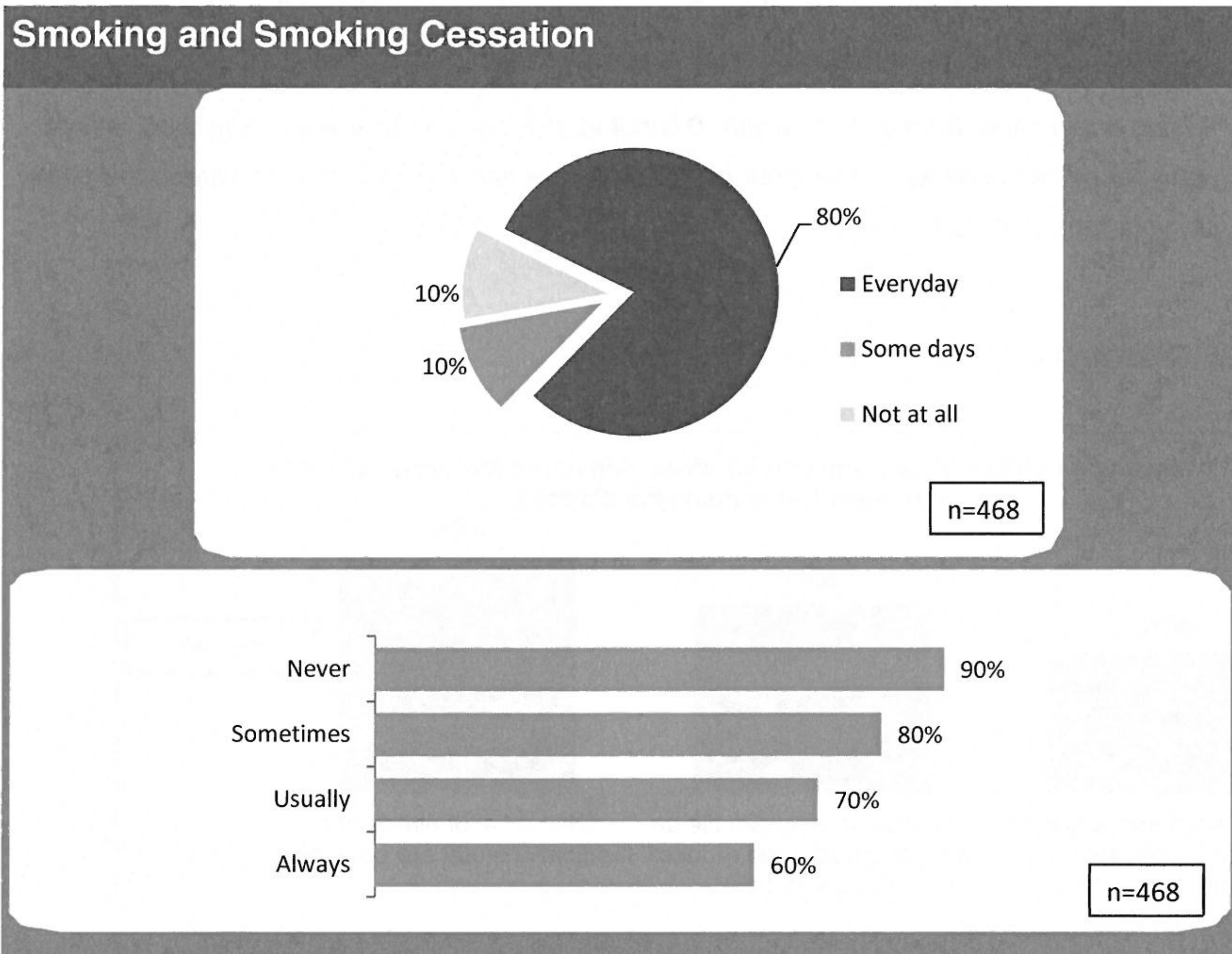




Smoking and Smoking Cessation

The Advising Smokers to Quit rate represents the percentage of members 18 and older who were continuously enrolled during the measurement year, who were smokers who were seen by a ________ provider during the measurement year, and for whom smoking cessation was recommended in the last 6 months.

EXHIBIT 34: SMOKING AND SMOKING CESSATION

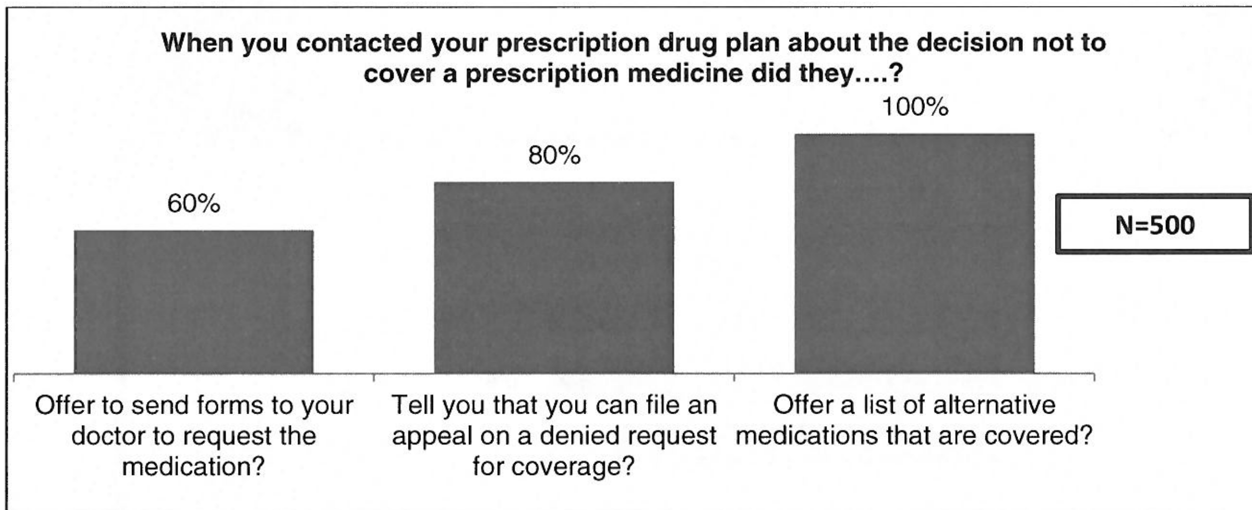


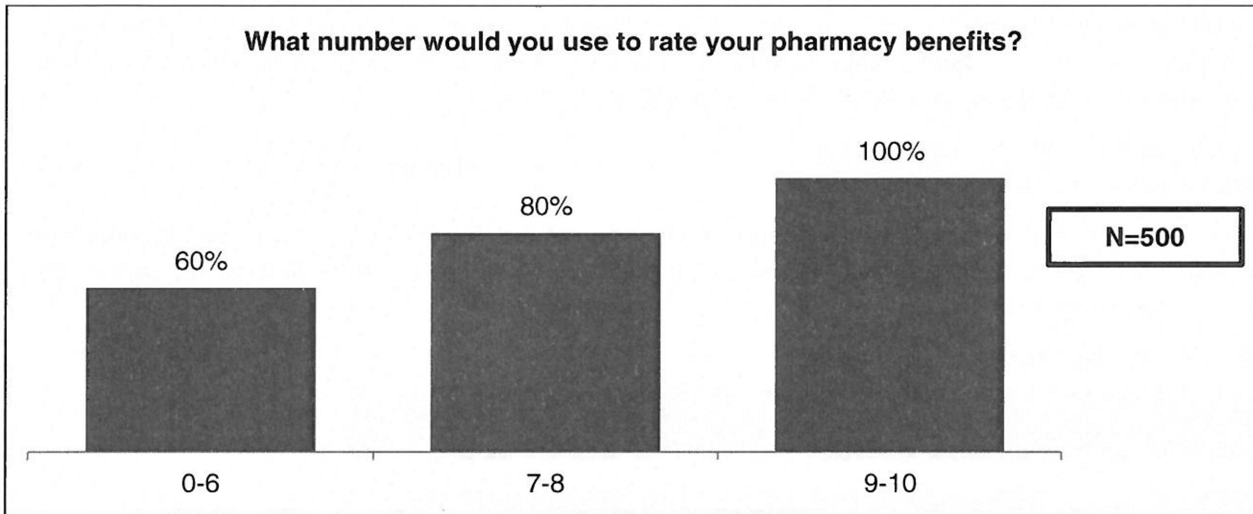
Supplemental Questions

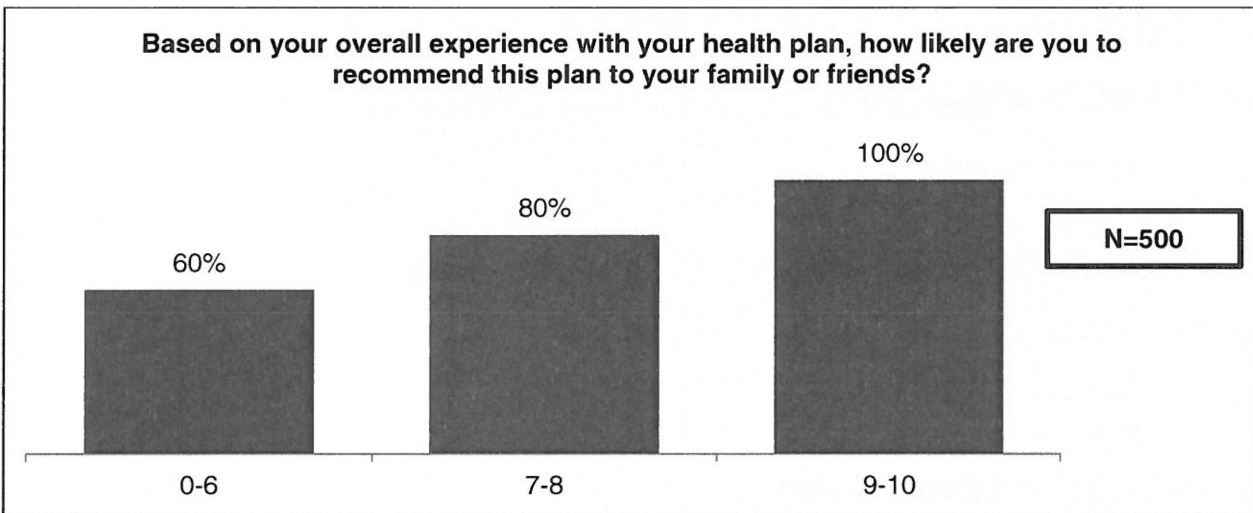
In 2012, __________ added three additional questions to the survey. These custom questions read:

- *When you contacted your prescription drug plan about the decision not to cover a prescription medicine did they…(Please mark one or more)*
    a. *Offer to send forms to your doctor to request the medication*
    b. *Tell you that you can file an appeal on a denied request for coverage*
    c. *Offer a list of alternative medications that are covered*
- *Using any number from 0 to 10, where 0 is extremely dissatisfied and 10 is extremely satisfied, what number would you use to rate your pharmacy benefits?*
- *Using any number from 0 to 10, where 0 is not at all likely and 10 is extremely likely, based on your overall experience with your health plan, how likely are you to recommend this plan to your family or friends?*

EXHIBIT 35: CUSTOM QUESTIONS




What number would you use to rate your pharmacy benefits?
60%
80%
100%
N=500
0-6
7-8
9-10


Based on your overall experience with your health plan, how likely are you to recommend this plan to your family or friends?
60%
80%
100%
N=500
0-6
7-8
9-10

Appendix A: Response Rates and Survey Protocol

Response Rates

The response rate was calculated by dividing the number of completed surveys by the number in the original sample minus the ineligible respondents. Ineligible respondents are those who are deceased, who do not meet *Eligible Population* criteria, who cannot respond to the survey in the language in which the survey is administered, who are mentally or physically incapacitated, or who are institutionalized.

$$\frac{\text{Completed mail and telephone surveys}}{\text{Sample size} - \text{(Ineligible surveys)}} = \text{Response rate}$$

Non-response includes: partial complete, bad address/telephone, refusal, blank returned, and non-response after maximum attempts. The table below shows the total number of members in your sample that fell into each of the various disposition categories.

EXHIBIT 36: RESPONSE RATES

Responses Rates and Dispositions		
	Year 2013	Year 2012
Responses Rate	99.99%	99.99%
Sample Size	800	800
Total Completes	470	470
Total Ineligibles	470	470
Deceased	4	4
Language Barrier	4	4
Mentally/Physically Incapacitated	4	4
Institutionalized	4	4
Total Non-response	330	330
Partially completed survey	4	4
Bad Address/Phone, Unknown at Address	4	4
Refusal	4	4
Blank Returned	4	4
Maximum Attempts	4	4

Survey Methods and Procedures

Sampling: Eligibility and Selection Procedures

To be eligible for participation in the ___________ Medicare CAHPS® survey, plan members had to be 18 years of age or older at the time of the sample draw and have been continuously enrolled in the plan for at least 6 months. In addition, beneficiaries known to be deceased, institutionalized, under 18 years of age, or included in another contract's sample were excluded.

Appendix B: Summary Rates and Means

Overall Ratings

Summary Rates and Three Point Means

The summary rate categories represent respondents answering "9" or "10" for the global measure questions. Three point rating scores are assigned to the rating questions as follows: 0-6 = 1, 7-8 = 2, and 9-10 = 3.

Summary Rate / Three point Mean Scoring

Global Measure Question Scoring		
Survey rating	Top Score	Three Point Mean Score
0 (Worst)		1
1		1
2		1
3		1
4		1
5		1
6		1
7		2
8		2
9	Top Score	3
10 (Best)	Top Score	3

Composite Measures

CMS has six pre-defined composite measures:

- Getting needed care
- Getting care quickly
- Doctors who communicate well
- Health plan customer service
- Getting needed prescription drugs
- Getting information from plan about prescription drug coverage and cost

Composite Mean Scores (Three Point Means)

Three point scoring assigns a value of 1, 2, or 3 to each question response category and then computes a numerical average based on valid responses to the question or questions. The three point values are assigned to question answer categories as follows:

Response	Score		Response	Score
Definitely No	1		Never	1
Somewhat No	1		Sometimes	1
Somewhat Yes	2		Usually	2
Definitely Yes	3		Always	3
Definitely Yes	3		Always	3

The table below lists all the questions included in the Medicare CAHPS composite scores and their corresponding values on the three-point scale. The "mean of means" method is used in computing the three point composite score. Each question is weighted equally in a composite regardless of the number of valid responses.

Summary Rates

A *Summary Rate* is the percentage of respondents providing the most positive response on a given question. The following table lists the questions included in the composite scores and the responses included in the summary rate for each.

Composite	Question	Never	Sometimes	Usually	Always
Getting Needed Care	Q29. In the last 6 months, how often was it easy to get appointments with specialists?	1	1	2	3
	Q35. In the last 6 months, how often was it easy to get the care, tests, or treatment you thought you needed through your health plan?	1	1	2	3
Getting Care Quickly	Q4. In the last 6 months, when you needed care right away, how often did you get care as soon as you thought you needed?	1	1	2	3
	Q6. In the last 6 months, not counting the times you needed care right away, how often did you get an appointment for your health care at a doctor's office or clinic as soon as you thought you needed?	1	1	2	3
	Q8. Wait time includes time spent in the waiting room and exam room. In the last 6 months, how often did you see the person you came to see within 15 minutes of your appointment time?	1	1	2	3
		Never	Sometimes	Usually	Always
Doctors Who Communicate Well	Q17. In the last 6 months, how often did your personal doctor explain things in a way that was easy to understand?	1	1	2	3

Composite	Question	Never	Sometimes	Usually	Always
	Q18. In the last 6 months, how often did your personal doctor listen carefully to you?	1	1	2	3
	Q19. In the last 6 months, how often did your personal doctor show respect for what you had to say?	1	1	2	3
	Q20. In the last 6 months, how often did your personal doctor spend enough time with you?	1	1	2	3
		Never	Sometimes	Usually	Always
Health Plan Customer Service	Q37. In the last 6 months, how often did your health plan's customer service give you the information or help you needed?	1	1	2	3
Health Plan Customer Service	Q38. In the last 6 months, how often did your health plan's customer service staff treat you with courtesy and respect?	1	1	2	3
Health Plan Customer Service	Q40. In the last 6 months, how often were the forms from your health plan easy to fill out?	1	1	2	3
Getting Needed Prescription Drugs	Q59. In the last 6 months, how often was it easy to use your prescription drug plan to get the medicines your doctor prescribed?	1	1	2	3
Getting Needed Prescription Drugs	Q61. In the last 6 months, how often was it easy to use your prescription drug plan to fill a prescription at your local pharmacy?	1	1	2	3
Getting Needed Prescription Drugs	Q63. In the last 6 months, how often was it easy to use your prescription drug plan to fill a prescription by mail?	1	1	2	3
		Never	Sometimes	Usually	Always
Getting Plan Information about Prescription Drug Coverage & Cost	Q49. In the last 6 months, how often did you prescription drug plan's customer service give you the information or help you needed about prescription drugs?	1	1	2	3
Getting Plan Information about Prescription Drug Coverage & Cost	Q50. In the last 6 months, how often did you prescription drug plan's customer service staff treat you with courtesy and respect when you tried to get information or help about prescription drugs?	1	1	2	3
Getting Plan Information about Prescription Drug Coverage & Cost	Q52. In the last 6 months, how often did your prescription drug plan's customer service give you all the information you needed about which prescription medicines were covered?	1	1	2	3
Getting Plan Information about Prescription Drug Coverage & Cost	Q54. In the last 6 months, how often did your prescription drug plan's customer service give you all the information you needed about how much you would have to pay for your prescription medication?	1	1	2	3

Appendix C: Technical Notes

Overall Ratings Categories

There are five overall rating questions that ask the respondent to rate his/her experience with: 1) all health care, 2) health plan, 3) personal doctor or nurse, 4) specialist seen most often, and 5) prescription drug plan. For each rating question, respondents were asked to provide ratings using an 11-point scale with "0" representing the worst rating and "10" the best rating.

Sampling Error

Sampling error measures the extent to which survey results differ from what would be obtained if every eligible member in the sample had been surveyed. The size of the error depends largely on the response distributions (i.e., the number of respondents selecting each answer category) and the number of members surveyed. The more disproportionate the percentage distributions or the larger the sample size, the smaller the error will be. The following table may be used in estimating sampling error. The percentages indicate the range (plus or minus the figure shown) within which the results could be expected to occur 95 times out of 100 for each sample size.

Sampling Error

Valid Responses	Percentage Distribution 50/50	60/40	70/30	80/20	90/10
300	5.7	5.5	5.2	4.5	3.4
500	4.4	4.3	4	3.5	2.6
750	3.6	3.5	3.3	2.9	2.1
1000	3.1	3	2.8	2.5	1.9
1500	2.5	2.5	2.3	2	1.5

* .05 confidence level

The sampling error table is used in the following manner. Assume that "overall rating of the health plan" received a Top Score percentage of seventy percent (70.0%) from a sample of 500 valid responses. Look at the table where the sample size of 500 intersects the percentage distribution of 70/30. The margin of error for this sample size is four percentage points (4.0%). Therefore, 95 times out of 100, the percent of respondents rating "overall rating of the health plan" between 9 and 10 (Top Score) would be between 66.0% and 74.0%, with the most likely result being the 70.0% obtained.

Assigning Disposition Codes

Using a confidential tracking number, Ipsos assigns each member in the sample a disposition code that is used to track and report whether they have returned a questionnaire or need a repeat mailing or telephone follow-up. After data collection is completed, Ipsos assigns each member of the sample one of the following final disposition codes to report to CMS:

- Complete Survey
- Ineligible: Institutionalized
- Ineligible: Deceased

Ineligible: Language barrier
Ineligible: Mentally or physically incapacitated
Ineligible: Does not meet Eligible Population criteria
Non-response: Maximum number of attempts
Non-response: Partially completed survey
Non-response: Refusal
Non-response: Blank returned
Non-response: Bad address and non-working/unlisted phone number or member is unknown at the dialed number

Total Survey Response Rates

Ipsos calculates and reports a total survey response rate for each sample. The response rate is the total number of completed surveys divided by all eligible members of the sample. Eligible members include the entire random sample minus members assigned a disposition code of ineligible.
The total survey response rate is calculated as follows:

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

Previous Years' Data for Comparisons

Unweighted data from 2012 and 2011 were used to make meaningful comparisons to 2013 data. Composites were computed by assigning equal weight to each item of the composite measure.

Statistical Testing

Ipsos uses the most appropriate statistical methods to test for differences in member satisfaction scores. Conclusions about differences in satisfaction scores are made using statistical hypothesis testing. For example, we test for differences between ___________'s 2013 and 2012 scores.
A statistical hypothesis testing involves stating a hypothesis that the satisfaction scores for the populations under comparison are equal. When this hypothesis is proved to be statistically unsupportable (often referred to as being rejected), the conclusion is made that the results are statistically different or statistically significant. The equal-scores hypothesis is rejected if the absolute value of the test statistic exceeds a value corresponding to a level of significance. The test statistic utilized depends on the characteristics of the populations under comparison.

Statistical Test for Differences in Proportions or Percentages: Z-test

Tests comparing scores between two population groups that are percentages or proportions use the Z-statistic. The test statistic, Z, is computed as follows:

$$Z = \frac{p_1 - p_2}{\sqrt{p\,q\left(\frac{1}{n_1} + \frac{1}{n_2}\right)}}$$

where, p_1 = score for the 1st population

p_2 = score for the 2nd population
n_1 = sample size of the 1st population
n_2 = sample size of the 2nd population
p = pooled score
$p = (p_1n_1 + p_2n_2) / (n_1 + n_2)$
$q = 1 - p$

With large sample sizes (generally n >30), the z-statistic has a standard normal distribution. Thus, the hypothesis that the populations under comparison have equal satisfaction scores is rejected at a 0.05 level of confidence when the absolute value of the z-statistic exceeds 1.96 (obtained from the cumulative standard normal distribution table).

Statistical Test for Differences for Means: T-test

Tests comparing the composite scores for two population groups use the T-statistic. The test statistic, T, is as follows:

$$T = {(C_1 - C_2)}/{S_{C_1 - C_2}}$$

Here, C_1 and C_2 are the scores for population 1 and population 2, respectively. The score is either a mean or a composite score. The standard error for the difference between two scores depends on whether the scores are means or composites.
The sampling variance (square of the standard error) of the difference between two means with a relatively large sample size for each sample (above 30 for each) is:

$$S^2_{C_1 - C_2} = S^2_{C_1} + S^2_{C_2}$$

Here Sc1 and Sc2 are the standard errors for C1 and C2.
The formula for a composite is:

$$S_c^2 = \frac{N}{N-1} \sum_{i=1}^{N} \left(\sum_{j=1}^{m} \frac{1}{m} * \frac{x_{ij} - \bar{x}_j}{n_i} \right)^2$$

Let:

i = 1, ..., m questions in a composite
j = 1, ..., n_i members responding to question i
x_{ij} = score of member j on question i (either 1, 2 or 3)
$\bar{x}_i$ = average score for question i
N = number of members responding to at least one question in the composite

The formula for a composite is much simpler with:

$$S_c^2 = \frac{1}{n(n-1)} \sum_{i=1}^{N} (x_i - \bar{x})^2$$

With large sample sizes, the T-statistic has a standard normal distribution. Thus, the hypothesis that the populations under comparison have equal satisfaction scores is rejected at a 0.05 level of confidence when the absolute value of the z-statistic exceeds 1.96 (obtained from the cumulative standard normal distribution table).

Statistical Significance

Statistical significance is the likelihood that conclusions resulting from a sample also hold true for the population from which the sample was taken. A level of significance refers to the degree to which the conclusion is significant.

An observed effect that is significant at the .10 level means that we can feel 90% confident (1-.10) that the observed sample is not derived by chance from the population. In other words, the sample is a true effect that resulted from the population. For example, if the difference between a plan's overall satisfaction scores for 2013 and 2012 is statistically significant at the .10 level, you can be 90% confident that the difference between the two scores would also be observed if all members were surveyed for both years.

Rev. 07/12

State of West Virginia

VENDOR PREFERENCE CERTIFICATE

Certification and application* is hereby made for Preference in accordance with *West Virginia Code*, §5A-3-37. (Does not apply to construction contracts). *West Virginia Code*, §5A-3-37, provides an opportunity for qualifying vendors to request (at the time of bid) preference for their residency status. Such preference is an evaluation method only and will be applied only to the cost bid in accordance with the *West Virginia Code*. This certificate for application is to be used to request such preference. The Purchasing Division will make the determination of the Resident Vendor Preference, if applicable.

1. **Application is made for 2.5% resident vendor preference for the reason checked:**

____ Bidder is an individual resident vendor and has resided continuously in West Virginia for four (4) years immediately preceding the date of this certification; **or,**

____ Bidder is a partnership, association or corporation resident vendor and has maintained its headquarters or principal place of business continuously in West Virginia for four (4) years immediately preceding the date of this certification; or 80% of the ownership interest of Bidder is held by another individual, partnership, association or corporation resident vendor who has maintained its headquarters or principal place of business continuously in West Virginia for four (4) years immediately preceding the date of this certification; **or,**

____ Bidder is a nonresident vendor which has an affiliate or subsidiary which employs a minimum of one hundred state residents and which has maintained its headquarters or principal place of business within West Virginia continuously for the four (4) years immediately preceding the date of this certification; **or,**

2. **Application is made for 2.5% resident vendor preference for the reason checked:**

____ Bidder is a resident vendor who certifies that, during the life of the contract, on average at least 75% of the employees working on the project being bid are residents of West Virginia who have resided in the state continuously for the two years immediately preceding submission of this bid; **or,**

3. **Application is made for 2.5% resident vendor preference for the reason checked:**

____ Bidder is a nonresident vendor employing a minimum of one hundred state residents or is a nonresident vendor with an affiliate or subsidiary which maintains its headquarters or principal place of business within West Virginia employing a minimum of one hundred state residents who certifies that, during the life of the contract, on average at least 75% of the employees or Bidder's affiliate's or subsidiary's employees are residents of West Virginia who have resided in the state continuously for the two years immediately preceding submission of this bid; **or,**

4. **Application is made for 5% resident vendor preference for the reason checked:**

____ Bidder meets either the requirement of both subdivisions (1) and (2) or subdivision (1) and (3) as stated above; **or,**

5. **Application is made for 3.5% resident vendor preference who is a veteran for the reason checked:**

____ Bidder is an individual resident vendor who is a veteran of the United States armed forces, the reserves or the National Guard and has resided in West Virginia continuously for the four years immediately preceding the date on which the bid is submitted; **or,**

6. **Application is made for 3.5% resident vendor preference who is a veteran for the reason checked:**

____ Bidder is a resident vendor who is a veteran of the United States armed forces, the reserves or the National Guard, if, for purposes of producing or distributing the commodities or completing the project which is the subject of the vendor's bid and continuously over the entire term of the project, on average at least seventy-five percent of the vendor's employees are residents of West Virginia who have resided in the state continuously for the two immediately preceding years.

7. **Application is made for preference as a non-resident small, women- and minority-owned business, in accordance with *West Virginia Code* §5A-3-59 and *West Virginia Code of State Rules*.**

____ Bidder has been or expects to be approved prior to contract award by the Purchasing Division as a certified small, women- and minority-owned business.

Bidder understands if the Secretary of Revenue determines that a Bidder receiving preference has failed to continue to meet the requirements for such preference, the Secretary may order the Director of Purchasing to: (a) reject the bid; or (b) assess a penalty against such Bidder in an amount not to exceed 5% of the bid amount and that such penalty will be paid to the contracting agency or deducted from any unpaid balance on the contract or purchase order.

By submission of this certificate, Bidder agrees to disclose any reasonably requested information to the Purchasing Division and authorizes the Department of Revenue to disclose to the Director of Purchasing appropriate information verifying that Bidder has paid the required business taxes, provided that such information does not contain the amounts of taxes paid nor any other information deemed by the Tax Commissioner to be confidential.

Under penalty of law for false swearing (West Virginia Code, §61-5-3), Bidder hereby certifies that this certificate is true and accurate in all respects; and that if a contract is issued to Bidder and if anything contained within this certificate changes during the term of the contract, Bidder will notify the Purchasing Division in writing immediately.

Bidder: Ipsos Public Affairs, Inc. Signed: [signature]

Date: 10/14/13 Title: Compliance and Contracts Officer

RFQ No. BMS14056

STATE OF WEST VIRGINIA
Purchasing Division

PURCHASING AFFIDAVIT

MANDATE: Under W. Va. Code §5A-3-10a, no contract or renewal of any contract may be awarded by the state or any of its political subdivisions to any vendor or prospective vendor when the vendor or prospective vendor or a related party to the vendor or prospective vendor is a debtor and: (1) the debt owed is an amount greater than one thousand dollars in the aggregate; or (2) the debtor is in employer default.

EXCEPTION: The prohibition listed above does not apply where a vendor has contested any tax administered pursuant to chapter eleven of the W. Va. Code, workers' compensation premium, permit fee or environmental fee or assessment and the matter has not become final or where the vendor has entered into a payment plan or agreement and the vendor is not in default of any of the provisions of such plan or agreement.

DEFINITIONS:

"Debt" means any assessment, premium, penalty, fine, tax or other amount of money owed to the state or any of its political subdivisions because of a judgment, fine, permit violation, license assessment, defaulted workers' compensation premium, penalty or other assessment presently delinquent or due and required to be paid to the state or any of its political subdivisions, including any interest or additional penalties accrued thereon.

"Employer default" means having an outstanding balance or liability to the old fund or to the uninsured employers' fund or being in policy default, as defined in W. Va. Code § 23-2c-2, failure to maintain mandatory workers' compensation coverage, or failure to fully meet its obligations as a workers' compensation self-insured employer. An employer is not in employer default if it has entered into a repayment agreement with the Insurance Commissioner and remains in compliance with the obligations under the repayment agreement.

"Related party" means a party, whether an individual, corporation, partnership, association, limited liability company or any other form or business association or other entity whatsoever, related to any vendor by blood, marriage, ownership or contract through which the party has a relationship of ownership or other interest with the vendor so that the party will actually or by effect receive or control a portion of the benefit, profit or other consideration from performance of a vendor contract with the party receiving an amount that meets or exceed five percent of the total contract amount.

AFFIRMATION: By signing this form, the vendor's authorized signer affirms and acknowledges under penalty of law for false swearing (*W. Va. Code* §61-5-3) that neither vendor nor any related party owe a debt as defined above and that neither vendor nor any related party are in employer default as defined above, unless the debt or employer default is permitted under the exception above.

WITNESS THE FOLLOWING SIGNATURE:

Vendor's Name: Ipsos Public Affairs, Inc.

Authorized Signature: [signature] Date: 11 October 2013

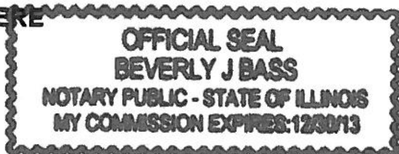
State of Illinois

County of Will, to-wit:

Taken, subscribed, and sworn to before me this 11th day of October, 2013.

My Commission expires December 30, 2013.

AFFIX SEAL HERE



NOTARY PUBLIC Beverly J. Bass