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December 1, 2006

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

Dear Mary,

Enclosed is KFMC's validation report of FirstGuard's Provider Satisfaction Survey. After you have an opportunity to review the report, we can discuss the results during a future KHPA/KFMC contract meeting.

Please contact me if you have any questions regarding the report.

Sincerely,

Laura Sanchez, RN

Laura Sanchez, RN
Project Manager, Medicaid Quality Improvement

Enclosures

CC Electronic Report:	Celia Humphreys, Quality Management Director, FG
Report Summary:	Debra Bachmann, HW19 & Pace Program Manager, KHPA
	Chris English, HW21 & Healthy Families Program Manager, KHPA
Cover Letter:	John Dixon, Contract Manager, KHPA

Please file this report in the EQRO notebook titled " Surveys," Volume 4 of 4, under the tab labeled *MCO Validation of Provider Surveys*, HWXIX/HWXXI, 10/01/05-09/30/2006.

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WE FACILITATE THE IMPROVEMENT OF HEALTHCARE

Validation of FirstGuard's Provider Satisfaction Survey

Contract Number:	**06385**
Program(s) Reviewed:	**HealthWave 19**
	HealthWave 21
Survey Year:	**2006**
Submission Date:	**December 1, 2006**

Report Submitted by:

Kansas Foundation for Medical Care, Inc.
2947 S.W. Wanamaker Drive
Topeka, Kansas 66614-4193
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Kansas Foundation for Medical Care, Inc.
Validation of FirstGuard's Provider Satisfaction Survey
December 2006

OBJECTIVES

The Kansas Foundation for Medical Care, Inc. (KFMC) validated FirstGuard's (FG's) Provider Satisfaction Survey that was conducted in 2006. The objective was to determine if the survey was administered in a methodologically sound manner. The design and administration of a survey must be carried out in accordance with generally accepted principles in order for the survey to produce valid and reliable information. In evaluating the technical methods and results from FG's final report, KFMC used as a guide, the Validating Surveys Protocol provided by the Centers for Medicare and Medicaid Services (CMS).

TECHNICAL METHODS

To validate FG's Provider Satisfaction Survey, KFMC completed the seven activities outlined in the Validating Surveys Protocol. The narrative from the protocol was used as a guide in answering the questions. The activities included: 1) Review Survey Purpose(s) and Objectives, 2) Review Intended Survey Audience, 3) Assess Reliability and Validity of Survey Instrument, 4) Review Sampling Plan, 5) Review Adequacy of Response Rate, 6) Review Data Preparation and Analysis, and 7) Document Evaluation of Survey. Each activity is comprised of one or more survey elements. KFMC's evaluation of the activities is discussed below.

Activity 1: Survey Purpose and Objectives
FG has contracted with The Myers Group (TMG) to administer their Provider Satisfaction Survey and prepare the final report since 2000. TMG is a National Committee for Quality Assurance (NCQA) certified Health Plan Employer Data and Information Set (HEDIS) survey vendor. TMG administered the survey to Primary Care Physicians (PCPs) and Obstetric/ Gynecology (OB/GYN) providers who were contracted participants in the FG network for Medicaid HealthWave (HW) 19 and/or HW21. Most of the providers were affiliated with both product lines. The survey was designed to collect accurate and reliable feedback from the network providers about the quality of services FG has provided. The survey domains included: Customer Service, Provider Relations, the FG Network, Utilization Management, Quality Management, Finance Issues, Pharmacy and Drug Benefits, Newsletters, and Overall Satisfaction. In the survey, providers also compared their satisfaction with FG Health Plan to other health plans in which they participated. FG submitted the following reported survey objectives that were explicit and measurable:

- To satisfy Kansas contractual requirements.
- To evaluate any statistically significant change in provider rating with each survey statement in the various categories. The three categories included: change in provider rating of FG versus all other health plans for 2006; change in provider ratings from 2006 to 2005; and change in provider ratings from 2006 to 2004.
- To maintain at least a 30% response rate.

Activity 2: Survey Audience
FG identified the entities listed below as the survey audience. The entities with an asterisk are accountable for the quality and scope of FG's services.

- *FirstGuard Quality Management Leadership Team
- *Kansas Quality Management/Credentialing Committee
- *Senior FirstGuard leadership
- *FirstGuard staff
- *Board of Directors
- Kansas Health Policy Authority (KHPA)
- HealthWave 19 and HealthWave 21 memberships
- Network providers
- Centene Corporate leadership.

Activity 3: Survey Instrument
FG submitted a copy of the 2006 survey instrument with their final report. No changes were made from the 2005 survey. TMG provided documentation (page 2-4 of the 2006 report) establishing the reliability of the Provider Satisfaction Survey. Cronbach's alpha was used as a measure of the survey's reliability. The values for each composite (questions with similar content grouped together) were tested on the 2005 Medicaid Book of Business benchmark data. TMG collected this Provider Satisfaction Survey data from 11 plans and 3,020 respondents. The degree of consistency (positive correlations $r > 0.7$) was noted for all six of the composite values tested. However, TMG stated that three of the five composites tested to measure the survey's reliability (Network, Quality Management, and Finance Issues), could not be evaluated for significant differences between the TMG Medicaid Book of Business data and FG's data due to survey tool differences. See TMG's comments on page 1-5 of their report. Because the differences in these questions could have also affected the survey reliability results, TMG should have evaluated the degree of internal consistency only using composites that were comparable, or tested the composite values on FG's survey data from two different years.

Activity 4: Sampling Plan
FG submitted their sample frame statistics with their Final Report. Eligible providers were participants with FG as of January 1, 2006, and still active as of July 1, 2006. The sample frame consisted of 1642 eligible providers who contracted with both HW19 and HW21; 21 were only participants with HW19; and 56 exclusively contracted with HW21. TMG stratified the sample by FG's three product lines (2 Kansas HW products and Missouri MC+). Each HW product line represented 33% (333) of the total sample. Because there were only 493 eligible providers from Missouri MC+, TMG first selected providers (334) from this product. TMG then selected the remaining providers (333 from each HW product line) from a randomized list of providers not already selected. FG has providers who participate in all three product lines. Of those providers selected in the HW19 and HW21 samples, 76 were also providers participating in Missouri MC+. FG recognized the sampling methodology had an overlap and provided rationale. However, the overlap was not addressed as a sampling bias or limitation. Because the study objectives included comparing provider ratings from 2006 to 2004 and 2005, it was appropriate to use the same sampling method.

This sampling strategy had the potential to over-represent providers who participated in multiple product lines and were located in the Kansas City metro area. This appeared to be evident by the proportion of city and rural providers in the sample frame compared to the proportion selected in the sample. FG's sample statistics are displayed in the **table below**.

Setting	Sample Frame	Percent	Sample Count	Percent
Rural	921	43.30%	273	27.30%
City	1204	56.70%	727	72.60%

Activity 5: Response Rate
TMG administered the provider survey from August through October 2006, employing a two-wave mail and phone follow-up methodology. The survey and customized cover letter were mailed followed by a replacement survey and cover letter to all nonrespondents (approximately three weeks later). About two weeks after the second mailing, telephone calls were made to office managers of non-respondent practices. For HW19 practices, 217 office managers were contacted; since the majority of HW19 and HW21 providers are contracted with both product lines, the number for HW21 was comparable (216).

TMG reported the total number of surveys completed by mail and phone. However, specifications for calculating raw and adjusted response rates were given separately for the mail and phone components of the survey, and an *overall response rate* was not calculated. Using the provided data, KFMC calculated the HW19 and HW21 *overall* adjusted response rates, noted in the table below. The denominators were adjusted for the one deceased provider and those with bad addresses and no forwarding information.

Providers	Distributed	Completed Mail	Completed Phone	Ineligible	Adjusted Rate
HW19	653	108	63	25	27.2%
HW21	652	108	64	23	27.3%

Activity 6: Data Preparation and Analysis
The eligible provider population file was sent to TMG in their requested file format, with specific definitions for each field. FG audited the database to ensure the data integrity of the required content. Completed surveys were scanned into TMG's Survey Management System (SMS) for data entry of results. TMG had processes in place to handle bad addresses, refusals, and ineligible providers. For surveys completed by telephone, silent monitoring equipment was used and TMG's supervisory staff observed 50% of the interviewing team each shift. TMG followed the NCQA decision rule process for handling the data since they are a NCQA certified CAHPS vendor.

Although separate survey reports were provided for HW19 and HW21, the data was comparable between the two reports since most providers were affiliated with both product lines. The final reports provided clear and pertinent data to assess the providers' satisfaction with FG. Respondents were asked to rate the service areas (attributes) provided by FG in comparison to "all other managed care plans in which they participated." This comparison data was also included in the report. Twenty-seven of the survey questions were categorized into the following eight composites:

- Customer Service (2)
- Provider Relations (5)
- Network (3)
- Utilization Management (4)
- Quality Management (4)
- Finance Issues (4)
- Pharmacy and Drug Benefits (2)
- Overall Satisfaction and Loyalty (3)

In addition to the composite questions, the survey had three questions about FG's newsletter, one question on the use of clinical practice guidelines, two open-ended questions (What do you like best about FirstGuard Health Plan? and How can we improve FirstGuard Health Plan?), and one question on who completed the survey. There were also seven questions regarding the respondents' practice characteristics (demographics).

Summary Rate Scores (in prior surveys referred to as Top Box Scores) were provided for the eight composites, and also for each of the 27 individual survey questions within the composites. The Summary Rate Scores were the sum of favorable responses such as "excellent" and "very good;" "very satisfied" and "somewhat satisfied;" and "definitely yes" and "probably yes." Although separate reports were provided for HW19 and HW21, the data was comparable between the two reports since most providers were affiliated with both products. TMG expanded the Executive Summary to include a description of the composites and also noted changes in this year's analysis. The report described the following methods used to analyze the survey data: Trending Analysis, Benchmark Comparison, Mean Score Analysis, Gap Analysis, Segmentation Analysis, Correlation and Opportunity Analysis, Loyalty Analysis, and testing for statistically significant differences (Z-test). These methods were appropriate for analyzing FG's survey data.

In the trend analysis, TMG explored whether provider satisfaction has changed over time among the composites by comparing the Summary Rate Scores between the 2006 and 2005 surveys and the 2006 and 2004 surveys. For the benchmark analysis, TMG compared the FG 2006 results to the 2005 TMG Medicaid Book of Business data. Testing for statistical significant differences was performed with a 0.05 level of significance.

The loyalty analysis stratified provider respondents into three zones. Loyal providers were defined as those who were "very satisfied" with the plan (question 31), and would recommend the plan to other physicians and patients (questions 29 & 30). Providers who were in the "defection zone" were very dissatisfied and not likely to recommend the plan to other patients and physicians. In the "indifferent zone" providers were mixed as to whether they were satisfied or whether they were willing to recommend the plan to other patients and physicians.

TMG listed the respondents' practice demographics and reply to the overall satisfaction question (31) with their response to the open-ended questions (32 and 33). KFMC noted that the comments included in the HW19 and HW21 reports were identical. While visiting with the SQI Project Manager (11/17/06), KFMC was informed that the HW19 and HW21 comments also included comments from respondents who were only contracted with Missouri MC+. However,

the SQI Project Manager said the number of these comments was small and generally the comments are similar among all three products.

DESCRIPTION OF DATA (FINDINGS)

Activity 7: Document Evaluation of Survey
For both the HW19 and HW21 survey responses, there was a statistically significant improvement (0.05 level of significance) in the Summary Rate Score for "accuracy of claims processing" between the 2006 and 2005 rates; the 2006 and 2004 rates; and for the 2006 FG Health Plan rate compared to the rate for "all other managed care plans in which they participated."

The attributes (service areas) listed below had statistically significant improvements, for both the HW19 and HW21 responses, between the 2006 and 2004 Summary Rate Scores. There has also been an upward trend in the rates since 2004. All of the following service areas *except* "reimbursement rates for services you provide," also had a statistically significant higher 2006 FG Summary Rate Score, for both HW19 and HW21, compared to the score for "all other managed care plans in which they participated."

- Frequency and effectiveness of provider representative visits
- Degree of improvement plan has made to reduce/eliminate the "hassle factor" of getting patients the services they need
- Accuracy of claims processing
- Timeliness of claims processing
- Reimbursement rates for services you provide

In the comparison of the 2006 FG rates, to the 2005 TMG Medicaid Book of Business rates and percentiles, the following service areas had statistically significant higher rates and were at or above the 75th percentile (percentage of distribution).
<u>HW19</u>:

- Degree of improvement plan has made to reduce/eliminate the "hassle factor" of getting patients the services they need
- Accuracy of claims processing
- Timeliness of claims processing

<u>HW21</u>:

- Degree of improvement plan has made to reduce/eliminate the "hassle factor" of getting patients the services they need
- Accuracy of claims processing

Based on the loyalty analysis, 23% of the HW19 respondents and 22% of the HW21 respondents were determined to be "loyal" ("very satisfied" with the plan and would recommend the plan to other physicians and patients). The percentage of "loyal" respondents was down from the 2005 Provider Survey, (30% for both HW19 and HW21).

The bivariate Pearson correlation test identified which service areas influenced the providers' "overall satisfaction" (question 31). The service areas listed below were the key drivers of "overall satisfaction" for both HW19 and HW21 respondents. Results from the Opportunity

Analysis (comparison of the 2006 FG Summary Rate Scores to the 2005 TMG Medicaid Book of Business percentile scores) identified that two of the service areas were "strengths" (FG rate above the 75th percentile) and one service area was an "opportunity" to investigate and improve (FG rate below the 25th percentile). These results are also noted below.

- Timeliness of claims processing (strength)
- Accuracy of claims processing (strength)
- Volume of health plan patients directed to your practice (opportunity to investigate and improve)

TMG did a trend comparison on the profile of survey respondents (who completed survey). There has been a statistically significant increase (0.05 level of significance) in the rate of office manager respondents between the 2006 and 2004 survey. Most likely the increase of office manager respondents, in both 2006 and 2005 compared to 2004, is due to FG adding phone follow-up (with office managers) for nonrespondents to the survey methodology (in 2005 and 2006).

In the "segmentation analysis," TMG compared the Summary Rate Scores across the respondents' practice demographics, response to "who completed the survey," and setting of the respondents (rural versus city). Although TMG did not test the rates for statistically significant differences, there were large differences in some of the segmentation analyses. In assessing the results, caution should be used when the "Valid n" (number of respondents giving a valid response) is small.

As previously mentioned on page 2, due to the over-sampling of the providers who also contracted with Missouri MC+, the sample strategy had the potential to include a higher percent of city providers than rural providers. The "segmentation analysis" of rural versus city respondents, as displayed on chart 6H of TMG's report, helps show where this bias may be the greatest. KFMC performed a chi-square test and determined that the following three service areas had statistically significant lower ($p<0.05$) Summary Rate Scores for providers located in the city than rural providers:

- Quality of provider orientation process
- Quality of written communication, policy bulletins, and manuals
- Ease of using formulary

<u>Assessment of Technical Methods of Survey Implementation and Analysis</u>

Strengths

- Clearly defined the random sample process (logic, deduplication etc.) Sample frame statistics were provided, e.g. the number of total providers selected, number of providers contracted with both HW19 and HW21, number of providers exclusively with HW19, and how many only contracted with HW21.
- Executive Summary expanded to include descriptions of the composites and to explain changes to this year's analyses.
- TMG compared FG's practice demographics between the present survey respondents and prior survey respondents, in addition to the comparison with the TMG Medicaid Book of Business.

- Survey results were analyzed using various analytic methods to assist in identifying opportunities for improvement.
- Report was thorough, was well organized, and provided a good interpretation of the analytic tests.

Weaknesses

- Three of the five composites TMG used in establishing the survey's reliability (Cronbach's alpha analysis) were not comparable between the TMG Medicaid Book of Business and FG due to differences in the survey questions.
- 2006 survey response rate decreased eight percentage points (8.3% HW19, 8.6% HW21) from the 2005 survey. One of the 2006 survey objectives was "to maintain at least a 30% response rate." This year's adjusted survey response was 27 percent (27.2% HW19, 27.3% HW21).
- *Overall response rate* was not calculated; only provided raw and adjusted response rates separately for the mail and phone components of the survey.
- On some of TMG's data charts (e.g. 3A) the number of total respondents was shown instead of the valid "Ns," or including a footnote stating that the percentages were based on the number of respondents who answered the questions.
- Included comments from the open-ended questions from respondents who were only contracted with Missouri MC+. (However, the number of these comments was small.)

Limitations/Generalizeability

Due to the over-sampling of the providers who were also contracted with Missouri MC+, the sampling strategy had the potential to over-represent providers who participated in multiple product lines and were located in the Kansas City metro area. As previously stated, this appeared to be evident by the proportion of city and rural providers in the sample frame compared to the proportion selected in the sample. Depending on the practice demographics of the over-sample, differences in practices, location, and experiences with other Managed Care Plans, the results may have been swayed. The phone follow-up method also created another source of potential non-response bias. Selecting a single provider to represent non-respondent practices may cause larger practices to be underrepresented in the results.

FG did not achieve 200 returned surveys this year; therefore, there is some potential for a non-response bias. This would decrease the level of confidence one can place on the generalizeability of their survey findings. Since the practice demographics provided by the respondents are not available for the nonrespondents, it is unknown how individuals who did not respond may have differed from those who responded.

CONCLUSIONS

(Regarding Strengths and Weaknesses with Respect to Access, Quality, and/or Timeliness)

None of FG's survey questions directly assessed the quality, access, and or timeliness of healthcare provided to beneficiaries. However, several of the survey questions assessed the FG/provider relationship in respect to these areas, and have the potential to impact the healthcare that is provided to beneficiaries. The attributes (service areas) that were determined to be strengths or weaknesses are listed below. In making this determination, KFMC assessed the

following: 1) statistically significant differences (higher or lower) in the 2006 FG Summary Rate Score compared to the score for "all other managed care plans;" and 2) percentage of positive responses, ("excellent," "very good," and "good") in 2006.

Access
Based on the low percentage of positive responses, the following two service areas were identified as access weaknesses: 1) Process of obtaining pre-certifications/referral/authorization information (74% HW19 and 72% HW21) and 2) Variety of drugs available in formulary (49% HW19 and 48% HW21). FG already has a process in place to address the formulary. See additional comments in the last paragraph on page 9. No service areas were identified as strengths (*enhancements*) related to access.

Quality
The service area "Quality of written communication, policy bulletins, and manuals" was determined to be a strength for HW19 and HW21 due to the statistically significant higher 2006 FG Summary Rate Score compared to the score for "all other managed care plans." Based on the low percentage of positive responses, the following two service areas were identified as quality weaknesses: 1) Quality of provider orientation process (68% HW19 and 67% HW21) and 2) Quality of health plan's specialists (73% HW21).

Timeliness
KFMC determined the "Timeliness of claims processing" service area to be a strength for HW19 and HW21 due to the statistically significant higher 2006 FG Summary Rate Score compared to the score for "all other managed care plans." TMG's bivariate Pearson correlation test also identified this service area as a key driver of "overall satisfaction." In addition, the Opportunity Analysis (comparison of the 2006 FG Summary Rate Scores to the 2005 TMG Medicaid Book of Business percentile scores) identified this service area as a "strength" (FG rate above the 75th percentile). Based on the low percentage of positive responses, the following two service areas were identified as timeliness weaknesses: 1) Timeliness of consultation reports from specialists (73% HW19 and 71% HW21) and 2) Timeliness of resolution requiring Medical Director intervention (69% for both HW19 and HW21).

RECOMMENDATIONS

Future Surveys

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

Improving Access, Quality and Timeliness of Care

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

DEGREE TO WHICH MCO ADDRESSED PREVIOUS RECOMMENDATIONS

FG has addressed two of the three recommendations made in the 2005 Provider Survey Validation Report. TMG determined in the 2005 Correlation analysis that "timeliness of claims

processing" was a key driver of "overall satisfaction," and KFMC identified this service area as a weakness (based on low percentage of positive responses in 2005). KFMC had recommended FG might want to perform a small audit of claim payments to explore if there were opportunities for improving the timeliness of the process. However, FG was already in the process of getting a weekly report on claims when the recommendation was made. "Timeliness of claims processing" was identified in this year's survey as a strength. See comments on previous page under "Timeliness."

KFMC identified "variety of drugs in formulary" as an access weakness due to the very low percentage (50%) of positive responses in 2005. A recommendation was made to provide more education to the providers regarding the drugs that are available in the formulary. However, KFMC was informed during a meeting (2/10/06) with FG and KHPA that the issue is not related to education of what drugs are available, or the prior authorization process. KHPA also stated FG is in compliance with their contractual obligation in regard to the drug formulary and they have a process in place to address this issue.

PROVIDER SURVEY VALIDATION WORKSHEET
FirstGuard Health Plan

SURVEY ELEMENT	DOCUMENTATION
Activity 1: Survey Purposes(s) and Objective(s)	
• **There is a written statement of survey purpose(s) that addresses access, timeliness, and/or quality of care.**	The Myers Group (TMG), contracted to administer the survey and prepare a final report, stated the "purpose of the annual provider satisfaction survey was to collect accurate and reliable feedback from network providers about the quality of the services provided by FirstGuard Health Plan." The survey domains included: Customer Service, Provider Relations, the FirstGuard Network, Utilization Management, Quality Management, Finance Issues, Pharmacy and Drug Benefits, Newsletters, and Overall Satisfaction. The survey questions addressed access, timeliness, and quality of health care in regard to the FirstGuard/provider relationship. In the survey, providers also compared their satisfaction with FirstGuard Health Plan to other health plans in which they participated.
• **Unit(s) of analysis is clearly stated and includes individual MCO.**	The unit of analysis was individual Primary Care Physicians (PCPs) and Obstetric/Gynecology (OB/GYN) providers who were active in the FirstGuard (FG) network.
• **Study objectives are clear, measurable, and in writing.**	In response to KFMC's recommendations, included in the 2006 Provider Survey Methodology feedback, FG changed the time periods in the second objective to reflect this year's survey. The following reported survey objectives were explicit and measurable: • To satisfy Kansas contractual requirements. • To evaluate any statistically significant change in provider rating with each survey statement in the various categories. The three categories include: change in provider rating of FG versus all other health plans for 2006; change in provider ratings from 2006 to 2005; and change in provider ratings from 2006 to 2004. • To maintain at least a 30% response rate.
Activity 2: Survey Audience(s)	
• **Audiences for survey findings are identified.**	FG identified the entities listed below as the survey audience. The entities with an asterisk are accountable for the quality and scope of FG's services. • *FirstGuard Quality Management Leadership Team • *Kansas Quality Management/Credentialing Committee • *Senior FirstGuard leadership • *FirstGuard staff • *Board of Directors • Kansas Health Policy Authority (KHPA) • HealthWave 19 and HealthWave 21 memberships • Network providers • Centene Corporate leadership.

PROVIDER SURVEY VALIDATION WORKSHEET
FirstGuard Health Plan

<table>
<tr><th>SURVEY ELEMENT</th><th>DOCUMENTATION</th></tr>
<tr><td colspan="2">Activity 3: Survey Instrument</td></tr>
<tr><td>• If an existing survey instrument was used, there is evidence of its reliability.</td><td>FG submitted a copy of the 2006 survey instrument with their final report. No changes were made from the 2005 survey. TMG provided documentation (page 2-4 of the 2006 report) establishing the reliability of the Provider Satisfaction Survey. Cronbach's alpha was used as a measure of the survey's reliability. The values for each composite (questions with similar content grouped together) were tested on the 2005 Medicaid Book of Business benchmark data. TMG collected this Provider Satisfaction Survey data from 11 plans and 3,020 respondents. The degree of consistency (positive correlations r > 0.7) between the composite values is noted below.
<table>
<tr><th>Composite</th><th>Cronbach's Alpha</th></tr>
<tr><td>Providers Relations</td><td>0.913</td></tr>
<tr><td>Network</td><td>0.871</td></tr>
<tr><td>Quality Management</td><td>0.962</td></tr>
<tr><td>Finance Issues</td><td>0.886</td></tr>
<tr><td>Pharmacy and Drug Benefits</td><td>0.865</td></tr>
<tr><td>Overall Satisfaction</td><td>0.925</td></tr>
</table>
TMG stated that three of the five composites tested to measure the survey's reliability (Network, Quality Management, and Finance Issues), could not be evaluated for significant differences between the TMG Medicaid Book of Business data and FG's data due to survey tool differences. See TMG's comments on page 1-5 of their report. Because the differences in these questions could have also affected the survey reliability results, TMG should have evaluated the degree of internal consistency only using composites that were comparable, or tested the composite values on FG's survey data from two different years.</td></tr>
<tr><td>• If an existing survey instrument was used, there is evidence of its validity.</td><td>TMG provided the following documentation: "the 2006 Provider Satisfaction Survey was developed utilizing input from several health plans and health industry professionals. Over the past six years the survey has been used for over 150 projects and has been consistently updated with provider feedback. Currently there is no publicly reported benchmark available for comparison to the TMG Provider Satisfaction Survey."</td></tr>
<tr><td>• If a newly developed survey was used, there is evidence of reliability testing.</td><td>Not applicable.</td></tr>
<tr><td>• If a newly developed survey was used, there is evidence of validity testing.</td><td>Not applicable.</td></tr>
</table>

PROVIDER SURVEY VALIDATION WORKSHEET
FirstGuard Health Plan

SURVEY ELEMENT	DOCUMENTATION
• **If using an adapted survey: there is evidence of reliability testing.**	Not applicable.
• **If using an adapted survey, there is evidence of validity.**	Not applicable.
Activity 4: Sampling Plan	
• **Population to be studied was clearly identified.**	The survey population included all individual PCPs and OB/GYN providers who were contracted participants in the FG network for HealthWave (HW) 19 and/or HW21.
• **Sample frame was clearly defined and appropriate.**	FG submitted their sample frame statistics with their Final Report. Eligible providers were participants with FG as of January 1, 2006, and still active as of July 1, 2006. The sample frame consisted of 1642 eligible providers who contracted with both HW19 and HW21; 21 were only participants with HW19; and 56 exclusively contracted with HW21.
• **Sampling strategy (simple random, stratified random, non-probability) was appropriate to study question.**	FG stated in their 2006 Provider Satisfaction Survey Methodology that TMG would perform a *random sampling* from the provider file using a random number generator software tool. However, TMG's comments, also included in the methodology, indicated the sample would be *stratified by specialty* (PCP and OBGYN) as well as FG's three product lines (2 Kansas HW products and Missouri MC+). In FG's response, to KFMC's methodology recommendations, they clarified that TMG did not stratify by specialty, only by product line. However, another sentence in their response appeared to contradict this statement. "FirstGuard providers were stratified with regard to specialty type: OB/GYN and PCP." The Project Manager Strategic Quality Improvement at FG clarified via E-mail (11/20/06) "the intent of the sentence was to say that the pool of eligible providers for the survey were OB/GYN and PCP physicians." Each HW product line represented 33% (333) of the total sample. However, because most HW providers were contracted with both product lines, there was overlap. For additional details on the sampling limitations, see Survey Element "sample selection processes were sound" on the next page.
• **If random sampling is used, sampling process was valid.**	Not applicable.
• **If stratified random sampling is used, sampling process was valid.**	The provider survey sample was selected using a random number generator software tool. With their Final Report, FG submitted a copy of the sample statistics that included the sample frame (eligible providers) and the final sample counts. For additional comments regarding sampling , see Survey Element "sample selection processes were sound."
• **If non-probability sampling is used, there is clear and strong evidence why random sampling was not feasible.**	Not applicable.
• **Sample size was determined using**	FG reported that the sample size (1000) was determined based on allowable budget, the 2005 provider

<table>
<tr><th>SURVEY ELEMENT</th><th>DOCUMENTATION</th></tr>
<tr><td>reasonable statistical parameters, as appropriate to survey purpose and objectives.</td><td>survey response rate, and the 2005 successful methodology of mixed mail and phone.</td></tr>
<tr><td>• Sample selection processes were sound.</td><td>The sample selection processes used to generate the sample had the potential to introduce a sampling bias. Providers who contracted with more than one product line had a higher probability of being surveyed. Because there were only 493 eligible providers from Missouri MC+, TMG first selected providers (334) from this product. TMG then selected the remaining providers (333 from each HW product line) from a randomized list of providers not already selected. FG has providers who participate in all three product lines. Of those providers selected in the HW19 and HW21 samples, 76 were also providers participating in Missouri MC+. FG recognized the sampling methodology had an overlap and provided rationale. However, the overlap was not addressed as a sampling bias or limitation. Because the study objectives included comparing provider ratings from 2006 to 2004 and 2005, it was appropriate to use the same sampling method.

The sampling strategy had the potential to over-represent providers who participated in multiple product lines and were located in the Kansas City metro area. This appeared to be evident by the proportion of city and rural providers in the sample frame compared to the proportion selected in the sample. FG’s sample statistics are displayed in the table below.
<table>
<tr><th>Setting</th><th>Sample Frame</th><th>Percent</th><th>Sample Count</th><th>Percent</th></tr>
<tr><td>Rural</td><td>921</td><td>43.30%</td><td>273</td><td>27.30%</td></tr>
<tr><td>City</td><td>1204</td><td>56.70%</td><td>727</td><td>72.60%</td></tr>
</table></td></tr>
<tr><td colspan="2">Activity 5: Response Rate</td></tr>
<tr><td>• Specify if mail, phone, face-to-face, or combination strategy was used to contact targeted survey respondents.</td><td>TMG administered the provider survey from August through October 2006, employing a two-wave mail and phone follow-up methodology. The survey and customized cover letter were mailed followed by a replacement survey and cover letter to all nonrespondents (approximately three weeks later). About two weeks after the second mailing, telephone calls were made to office managers of non-respondent practices. For HW19 practices, 217 office managers were contacted; since the majority of HW19 and HW21 providers were contracted with both product lines, the number for HW21 was comparable (216). To obtain more information regarding TMG’s phone methodology, KFMC contacted the Strategic Quality Improvement (SQI) Project Manager at FG by telephone (11/17/06). FG’s Project Manager explained that the list of non-respondents prepared for the phone follow-up was randomized, and when there was a duplicate phone number the provider was not loaded. The office manager who responded was linked to the randomly chosen provider, and the survey would have been counted for HW19 and HW21, if the provider contracted with both product lines. For the telephone interviewing data collection</td></tr>
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<tr><th>SURVEY ELEMENT</th><th>DOCUMENTATION</th></tr>
<tr><td></td><td>process, the database was exported from TMG's Survey Management System (SMS) into their Computer-Assisted Telephone Interview (CATI) network.</td></tr>
<tr><td>• Specifications for calculating raw and adjusted response rates are clear and appropriate.</td><td>TMG reported the total number of surveys completed by mail and phone. However, specifications for calculating raw and adjusted response rates were given separately for the mail and phone components of the survey, and an overall response rate was not calculated. Ineligible dispositions such as phone number not in service and wrong number, identified during the phone calls, should not be used to adjust the overall response rate since providers had an opportunity to respond by mail. However, one provider was identified as deceased and should be included with the ineligibles for the overall response rate. Using the provided data, KFMC calculated the HW19 and HW21 overall adjusted response rates, noted in the table below. The denominators were adjusted for the one deceased provider and those with bad addresses and no forwarding information.
<table>
<tr><th>Providers</th><th>Distributed</th><th>Completed Mail</th><th>Completed Phone</th><th>Ineligible</th><th>Adjusted Rate</th></tr>
<tr><td>HW19</td><td>653</td><td>108</td><td>63</td><td>25</td><td>27.2%</td></tr>
<tr><td>HW21</td><td>652</td><td>108</td><td>64</td><td>23</td><td>27.3%</td></tr>
</table></td></tr>
<tr><td>• The response rate, potential sources of non-response and bias, and implications of the response rate for the generalizeability of survey findings are assessed.</td><td>The adjusted response rate for HW19 providers was 27.2% (171/628) and for HW21 providers the adjusted response rate was 27.3% (172/629). One of FG's survey objectives was to perform a statistical analysis to evaluate for any significant changes in the provider ratings between the 2005 and 2006 surveys. In order for FG to have comparable statistical power to the 2005 survey, they needed to have a similar number of respondents for the 2006 survey. In 2005 the response rates for HW19 and HW21 were 35.5% (256/722) and 35.9% (257/715) respectively. Because FG received fewer than 200 returned surveys, some non-response bias may have been introduced. This would lessen the confidence one could place on the generalizeability of the survey findings, and FG should consider the margin of sampling error and level of certainty (confidence interval) when interpreting the results. A sampling error table was included in TMG's report, but none of examples were specific to FG's survey response rate. Regarding the overall satisfaction of FG Health Plan (question 31), 75% of the HW19 respondents indicated they were "very satisfied" or "somewhat satisfied." Using this data, KFMC calculated the following percents: sampling error 3.36%; margin of error 6.59%; and 95% confidence interval 68.56%-81.75%. Not all of the respondents answered this question (124/165).

The phone follow-up method created another source of potential non-response bias not mentioned in the report. Selecting a single provider to represent non-respondent practices may cause larger practices to be underrepresented in the results.</td></tr>
<tr><td colspan="2">Activity 6: Review of Data Preparation and Analysis</td></tr>
<tr><td>• Quality control procedures were in</td><td>The eligible provider population file was sent to TMG in their requested file format, with specific definitions for each field. FG audited the database to ensure the data integrity of the required content. To</td></tr>
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place for: administration of the survey; receipt of survey data; respondent information and assistance; coding, editing and entering data; and procedures for missing data and data that fails edits.	ensure that the most accurate mailing information was obtained and the response rate maximized, TMG updated and appended the database using NCOA (National Change of Address) and CASS Zip+4 software. The survey tool and all cover letters had TMG's toll-free number listed, to allow providers to call if they had any questions about the survey and its purpose. TMG did not attempt to answer any questions specific to the health plan and their services. TMG's staff referred these types of calls to FG's provider hotline. Processes were in place to handle bad addresses, refusals, and ineligible providers. TMG assigned codes to each answer option on the survey. Beside each answer option, a code was placed next to the check box. Completed surveys were scanned into TMG's Survey Management System for data entry of the paper survey results using Verity's Teleform software. TMG provided the following description, of the two-step process used with the Teleform software: 1) paper surveys were scanned to capture data points based on the thresholds set in the system parameters; and 2) manual user-verification was performed for any marks on the survey that fell outside of the parameters, as well as key questions for validation. Prior to active production scanning, a TMG operator completed 10 test surveys and processed the surveys through the scanning system. After they confirmed from the test data output that all values were processed correctly, the production scanning began. The Survey Flow Chart indicated the typed comments to the open-ended questions would be proofread by the comment processor. For surveys completed by telephone, TMG used silent monitoring equipment and their supervisory staff observed 50% of the interviewing team each shift. The interviewers were rated on their performance and coached on how to improve.
• **Methodologically appropriate data preparation and analysis procedures were used.**	TMG followed the National Committee for Quality Assurance (NCQA) decision rule process for handling the data since they are a NCQA certified Consumer Assessment of Healthcare Providers and Systems (CAHPS) vendor. TMG uses similar coding conventions to the CAHPS Surveys for all of their survey tools.
• **Final report provided understandable and relevant data.**	The final report provided clear and pertinent data to assess the providers' satisfaction with FG. Respondents were asked to rate the service areas (attributes) provided by FG in comparison to "all other managed care plans in which they participated." This comparison data was also included in the report. Twenty-seven of the survey questions were categorized into the following eight composites: • Customer Service (2) • Provider Relations (5) • Network (3) • Utilization Management (4) • Quality Management (4) • Finance Issues (4) • Pharmacy and Drug Benefits (2) • Overall Satisfaction and Loyalty (3)

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	In addition to the composite questions, the survey had three questions about FG's newsletter, one question on the use of clinical practice guidelines, two open-ended questions (What do you like best about FirstGuard Health Plan? and How can we improve FirstGuard Health Plan?), and one question on who completed the survey. There were also seven questions regarding the respondents' practice characteristics (demographics). Summary Rate Scores (in prior surveys referred to as Top Box Scores) were provided for the eight composites, and also for each of the 27 individual survey questions within the composites. The Summary Rate Scores were the sum of favorable responses such as "excellent" and "very good;" "very satisfied" and "somewhat satisfied;" and "definitely yes" and "probably yes." Although separate reports were provided for HW19 and HW21, the data was comparable between the two reports since most providers were affiliated with both product lines. The sample sizes and number of respondents were almost the same between the two groups of providers, HW19 (171/653) and HW21 (172/652), and the frequencies of the question responses were quite similar. Each of the survey reports consisted of an Executive Summary and the following main sections: 1. Project Overview (background, response rate, sampling error, reliability, and provider profile) 2. Comparison Summaries (FG with "all other plans," trending data; 2004-2006, TMG 2005 Medicaid Book of Business, and TMG 2005 Medicaid Book of Business Percentiles) 3. Question Summaries (question response percents; included summary rate scores and mean scores) 4. Analyses for Mean Score and Gap Score (difference in mean scores) 5. Segmentation Analysis (by practice demographics) 6. Statistical Analysis (correlation analysis and opportunity analysis) 7. Loyalty Analysis (satisfaction with the plan, and willingness to recommend the plan to other physicians and patients) 8. Technical Notes (explanations for analyses) 9. FirstGuard Survey Tool 10. Comments (responses to open-ended questions) 11. Glossary of Terms 12. Banner Tables (results of each survey question stratified by practice characteristics) TMG expanded the Executive Summary to include a description of the composites and also noted changes in this year's analysis. However, two of the items in the "New in 2006" list, "Trend Comparisons" and "Question Summaries," did not appear to have changed since the 2005 Survey. TMG's 2006 modifications to the analyses are noted below (italic print) with the corresponding analysis description. <u>Practice Demographics</u> TMG performed a trend analysis for the seven questions regarding the respondents' practice characteristics (demographics) and the question "who completed the survey." They provided data for

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	2004 through 2006. *This is the first year TMG has trended this data*. Statistically significant differences were noted between 2006 and 2005 and 2006 and 2004. Trend and Benchmark Analyses TMG analyzed whether provider satisfaction has changed over time among the composites by comparing the Summary Rate Scores between the 2006 and 2005 surveys and the 2006 and 2004 surveys. In the benchmark analysis, TMG compared the FG 2006 results to the 2005 TMG Medicaid Book of Business data. Testing for statistical significant differences was performed with a 0.05 level of significance. Mean Score Analysis In the Mean Score Analysis TMG calculated (for 24 questions) the overall mean (average) score for FG Health Plan and for "all other plans" the providers participated in; and for the 2005 TMG Medicaid Book of Business Sponsor plans (average of plans sponsoring survey) and for "all other plans" they participated in. The Plan Gap, the difference between mean scores was then calculated for FG and for "all other plans" the providers participated in, and for the TMG Medicaid Book of Business Sponsor plans and "all other plans" they participated in. In addition, TMG calculated the Gap Difference between the FG Gap Score and the Sponsor Gap Score. Gap Analysis In the 2006 Gap Analysis, TMG reported the overall mean (average) score for FG Health Plan, compared to the 2005 TMG Medicaid Book of Business Gap Score and percentiles (percentage of a distribution [25th, 50th, 75th etc.]) The analysis was performed on 24 of the survey questions. In part of TMG's explanation of the analysis, they referenced FG's "overall satisfaction gap score" (question 31). However, in the illustration of the analysis, question 1 (Process of obtaining member information) was displayed. The example is provided in TMG's report on page 5-2. Segmentation Analysis TMG segmented the provider responses (for 27 questions) by the demographic questions (primary care vs. specialty etc.); by survey respondent (physician, office manager etc.); and by rural versus city. Percentages were given for the Summary Rate Scores. Correlation and Opportunity Analyses To assist FG in their efforts to improve provider satisfaction, TMG ran a bivariate Pearson correlation to test which service areas influenced the providers' overall satisfaction (question 31) with FG. The analysis also determined the strength of the correlation coefficient. The "key drivers" were those attributes (service areas) that had the highest correlation. Last year TMG compared the FG Summary Rate Score to the TMG Medicaid Book of Business Rate. *For 2006, TMG analyzed the FG Summary Rate Score to the TMG Medicaid Book of Business Rates for the 25th and 75th Percentiles*. In the

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	Opportunity Analysis, TMG compared the 2006 Summary Rate Scores for FG to the 2005 TMG Medicaid Book of Business percentile scores. Those attributes scoring at or above the 75th percentile were considered "strengths" and attributes scoring below the 25th percentile were considered "opportunities." <u>Loyalty Analysis</u> The loyalty analysis stratified provider respondents into three zones. Loyal providers were defined as those who were "very satisfied" with the plan (question 31), and would recommend the plan to other physicians and patients (questions 29 & 30). Providers who were in the "defection zone" were very dissatisfied and not likely to recommend the plan to other patients and physicians. In the "indifferent zone" providers were mixed as to whether they were satisfied or whether they were willing to recommend the plan to other patients and physicians. *In 2006 TMG added a trend comparison between, 2006 and 2005 and 2006 and 2004.* <u>Open-ended Questions</u> TMG listed the respondents' practice demographics and reply to the overall satisfaction question (31) with their response to the open-ended questions (32 and 33). The comments included in the HW19 and HW21 reports were identical. While visiting with the SQI Project Manager (11/17/06), KFMC was informed that the HW19 and HW21 comments also included comments from respondents who were only contracted with Missouri MC+. However, the SQI Project Manager said the number of these comments was small and generally the comments are similar among all three products. While TMG's approach to analyzing the survey data appeared appropriate and the report sections were understandable, it would have been helpful to add the valid "N" on charts where the information was not noted. For example, the HW19 Provider Profile Charts 2A and 2B showed the number of total respondents as 171. However, the shown percentages were calculated from the total number of respondents who answered the questions, which is not necessarily the total number of surveys received. Instead of showing the valid "Ns," TMG could state in a footnote that the percentages were based on the number of respondents who answered the questions. These notations were also needed on charts 2A-2D, 3A-3D, 5A and 5B, and 7A. Survey answers marked "N/A" by the respondents were removed from each of the question denominators in all of the analyses. Although this was apparent when verifying the data in the Banner Tables, providing this information in a footnote or adding an explanation on the Banner Tables would strengthen the report.

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Activity 7: Document Evaluation of Survey. The EQRO documents its findings regarding its:	
• **Assessment of the technical methods of survey implementation and analysis, and the survey's technical strengths and weaknesses.**	Strengths of the survey implementation and analysis include: • Clearly defined the random sample process (logic, deduplication etc.) Sample frame statistics were provided, e.g. the number of total providers selected, number of providers contracted with both HW19 and HW21, number of providers exclusively with HW19, and how many only contracted with HW21. • Executive Summary expanded to include descriptions of the composites and to explain changes to this year's analyses. • TMG compared FG's practice demographics between the present survey respondents and prior survey respondents, in addition to the comparison with the TMG Medicaid Book of Business. • Survey results were analyzed using various analytic methods to assist in identifying opportunities for improvement. • Report was thorough, was well organized, and provided a good interpretation of the analytic tests. Weaknesses of the survey implementation and analysis include**:** • Three of the five composites TMG used in establishing the survey's reliability (Cronbach's alpha analysis) were not comparable between the TMG Medicaid Book of Business and FG due to differences in the survey questions. • 2006 survey response rate decreased eight percentage points (8.3% HW19, 8.6% HW21) from the 2005 survey. One of the 2006 survey objectives was "to maintain at least a 30% response rate." This year's adjusted survey response was 27 percent (27.2% HW19, 27.3% HW21). • *Overall response rate* was not calculated; only provided raw and adjusted response rates separately for the mail and phone components of the survey. • On some of TMG's data charts (e.g. 3A) the number of total respondents was shown instead of the valid "Ns," or including a footnote stating that the percentages were based on the number of respondents who answered the questions. • Included comments from the open-ended questions from respondents who were only contracted with MC+. (However, the number of these comments was small.)
• **The limitations/generalizeability of survey findings**	Due to the over-sampling of the providers who were also contracted with Missouri MC+, the sampling strategy had the potential to over-represent providers who participated in multiple product lines and were located in the Kansas City metro area. As previously stated, this appeared to be evident by the proportion of city and rural providers in the sample frame compared to the proportion selected in the sample. Depending on the practice demographics of the over-sample, differences in practices, location, and experiences with other Managed Care Plans, the results may have been swayed. The phone follow-up method also created another source of potential non-response bias. Selecting a single provider to

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	represent non-respondent practices may cause larger practices to be underrepresented in the results. FG did not achieve 200 returned surveys this year; therefore, there is some potential for a non-response bias. This would decrease the level of confidence one can place on the generalizeability of their survey findings. Since the practice demographics provided by the respondents are not available for the nonrespondents, it is unknown how individuals who did not respond may have differed from those who responded.
• **Conclusions drawn from the data.**	For both the HW19 and HW21 survey responses, there was a statistically significant improvement (0.05 level of significance) in the Summary Rate Score for "accuracy of claims processing" between the 2006 and 2005 rates; the 2006 and 2004 rates; and for the 2006 FG Health Plan rate compared to the rate for "all other managed care plans in which they participated." The attributes (service areas) listed below had statistically significant improvements, for both the HW19 and HW21 responses, between the 2006 and 2004 Summary Rate Scores. There has also been an upward trend in the rates since 2004. All of the following service areas *except* "reimbursement rates for services you provide," also had a statistically significant higher 2006 FG Summary Rate Score, for both HW19 and HW21, compared to the score for "all other managed care plans in which they participated." • Frequency and effectiveness of provider representative visits • Degree of improvement plan has made to reduce/eliminate the "hassle factor" of getting patients the services they need • Accuracy of claims processing • Timeliness of claims processing • Reimbursement rates for services you provide In the comparison of the 2006 FG rates, to the 2005 TMG Medicaid Book of Business rates and percentiles, the following service areas had statistically significant higher rates and were at or above the 75th percentile. HW19: • Degree of improvement plan has made to reduce/eliminate the "hassle factor" of getting patients the services they need • Accuracy of claims processing • Timeliness of claims processing HW21: • Degree of improvement plan has made to reduce/eliminate the "hassle factor" of getting patients the services they need • Accuracy of claims processing

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	Based on the loyalty analysis, 23% of the HW19 respondents and 22% of the HW21 respondents were determined to be "loyal" ("very satisfied" with the plan and would recommend the plan to other physicians and patients). The percentage of "loyal" respondents was down from the 2005 Provider Survey, (30% for both HW19 and HW21). The bivariate Pearson correlation test identified the service areas listed below as key drivers of "overall satisfaction" for both HW19 and HW21 respondents. Results from the Opportunity Analysis (comparison of the 2006 FG Summary Rate Scores to the 2005 TMG Medicaid Book of Business percentile scores) identified that two of the service areas were "strengths" (FG rate above the 75th percentile) and one service area was an "opportunity" to investigate and improve (FG rate below the 25th percentile). These results are also noted below. • Timeliness of claims processing (strength) • Accuracy of claims processing (strength) • Volume of health plan patients directed to your practice (opportunity to investigate and improve) TMG did a trend comparison on the profile of survey respondents (who completed survey). There has been a statistically significant increase (0.05 level of significance) in the rate of office manager respondents between the 2006 and 2004 survey. Most likely the increase of office manager respondents, in both 2006 and 2005 compared to 2004, is due to FG adding phone follow-up (with office managers) for nonrespondents to the survey methodology (in 2005 and 2006). In the "segmentation analysis," TMG compared the Summary Rate Scores across the respondents' practice demographics, response to "who completed the survey," and setting of the respondents (rural versus city). Although TMG did not test the rates for statistically significant differences, there were large differences in some of the segmentation analyses. In assessing the results, caution should be used when the "Valid n" (number of respondents giving a valid response) is small. As previously mentioned under Survey Element "sample selection processes were sound" (page 4), due to the over-sampling of the providers who also contracted with Missouri MC+, the sample strategy had the potential to include a higher percent of city providers than rural providers. The "segmentation analysis" of rural versus city respondents, as displayed on chart 6H of TMG's report, helps show where this bias may be the greatest. KFMC performed a chi-square test and determined that the following three service areas had statistically significant lower ($p<0.05$) Summary Rate Scores for providers located in the city than rural providers: • Quality of provider orientation process • Quality of written communication, policy bulletins, and manuals • Ease of using formulary

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• **A detailed assessment of the MCO's strengths and weaknesses with respect to (as appropriate) access, quality, and/or timeliness of health care furnished to clients.**	None of FG's survey questions directly assessed the quality, access, and or timeliness of healthcare provided to beneficiaries. However, several of the survey questions assessed the FG/provider relationship in respect to these areas, and have the potential to impact the healthcare that is provided to beneficiaries. The attributes (service areas) that were determined to be strengths or weaknesses are listed below. In making this determination, KFMC assessed the following: 1) statistically significant differences (higher or lower) in the 2006 FG Summary Rate Score compared to the score for "all other managed care plans;" and 2) percentage of positive responses, ("excellent," "very good," and "good") in 2006. <u>Access Strengths</u> None identified. <u>Access Weakness</u> Process of obtaining pre-certifications/referral/authorization information. Variety of drugs available in formulary. (FG has a process in place to address this service area.) <u>Quality Strength</u> Quality of written communication, policy bulletins, and manuals. <u>Quality Weakness</u> Quality of provider orientation process. Quality of health plan's specialists. <u>Timeliness Strength</u> Timeliness of claims processing. <u>Timeliness Weakness</u> Timeliness of consultation reports from specialists. Timeliness of resolution requiring Medical Director intervention.
• **Comparative information about all MCOs (as directed by the State).**	Not applicable.