CAPITAL AREA BEHAVIORAL HEALTH COLLABORATIVE, INC.
Established October 1999

2014 Provider Satisfaction Survey Report

The 2014 Provider Satisfaction Survey was sent to Providers in the Capital Area provider network to obtain feedback about PerformCare and the HealthChoices program. The survey was sent to 215 Providers via email and regular mail. The survey could be completed using the web-based survey program QuestionPro, or by completing the paper version of the survey and returning it to CABHC. Twelve surveys were returned as undeliverable. Consequently, out of the 203 delivered surveys, we received 66 responses, which is a 33% response rate. This is an increase from the 21% response rate in 2012.

Demographics[1]

Age Group(s) Served by Respondents:

Children/Adolescents	38%
Adults	23%
Both Age Groups	42%

Level(s) of Care Provided by Respondents:

Substance Abuse	18%
Mental Health	68%
Co-Occurring	9%
All Levels of Care	14%

2014 CABHC Provider Satisfaction Survey Results

Providers were asked to respond to survey questions based on their experience with PerformCare within the previous 12 months. Except where noted, the questions used Likert scale ratings. Responses have been given the following numeric values: Very Satisfied = 5, Satisfied = 4, Neutral = 3, Dissatisfied = 2, Very Dissatisfied = 1. "N/A" responses were not included in the scoring. Scoring results from previous surveys is presented for comparison with the results of the 2014 Provider Satisfaction Survey, when applicable.

[1] Percentages include Providers who indicated having both mental health and substance abuse services; and serving both children and adults. This accounts for percentages totaling more than 100%.

Satisfaction

Respondents did not answer every question, so the number of response for each question varies. The column in each table labeled "2014 Percent of Total Respondents" indicates the percentage of all respondents who answered a particular question.

Communication

Written and Electronic Communication	2014 % of Total Respondents	2014 # of Respondents	2014 Mean Response	2012 % of Total Respondents	2012 # of Respondents	2012 Mean Response
Notification and implementation of policy changes affecting Providers	95%	63	3.61	93%	62	3.63
Ease of reaching someone who can answer your questions when calling PerformCare	94%	62	3.56	96%	64	3.67
Ease of calling the Provider Line and reaching the person you are calling	91%	60	3.50	87%	58	3.60
When calling the Provider Line, my calls were returned within 48 hours	83%	55	3.67	81%	54	3.46
Ease in using Provider Portal	85%	56	3.39	87%	58	3.64
Ease of using ProviderConnect	83%	55	3.35	75%	58	3.70
Quality Improvement "Quick Tips" are useful	70%	46	3.36	81%	56	3.72
Provider newsletters are useful	80%	53	3.37	84%	54	3.63
Communication Averages		**56.25**	**3.48**		**58**	**3.63**

Provider Relations

Account Executives	2014 % of Total Respondents	2014 # of Respondents	2014 Mean Response	2012 % of Total Respondents	2012 # of Respondents	2012 Mean Response
When contacting Provider Relations, do you receive satisfactory and timely answers to your questions	91%	60	3.75	88%	59	4.0
How do you find the fairness of Provider Relations/Credentialing site visits	64%	42	3.61	75%	50	4.04
When calling Provider Relations, if you had a problem/issue or concern, the person you spoke with helped to resolve it to your satisfaction	86%	57	3.70	81%	54	4.09
Credentialing and re-credentialing processes	68%	45	3.60	70%	47	3.98
Account Executive Averages		**51**	**3.67**		**52.5**	**4.03**

Provider Manual	2014 Percent of Total Respondents	2014 # of Respondents	Daily	Weekly	Monthly	Yearly	Never
How often did you or your Agency's staff reference the PerformCare Provider Manual?	97%	64	1.6%	4.7%	42.2%	32.8%	18.8%

When you referenced the PerformCare Provider Manual, how beneficial was it?	2014 Percent of Total Respondents	2014 # of Respondents	Very Helpful	Somewhat Helpful	Neutral	A Little Helpful	Not Helpful At All
	97%	64	14.1%	34.4%	15.6%	12.5%	4.7%

Provider Orientation	2014 % of Total Respondents	2014 # of Respondents	2014 Mean Response	2012 % of Total Respondents	2012 # of Respondents	2012 Mean Response
An Account Executive was able to answer all of your questions	9%	6	3.33	4%	3	4.0
The information your Account Executive provides is helpful & valuable	9%	6	3.33	4%	3	4.0
Provider Orientation Averages		**6**	**3.33**		**3**	**4.0**

Provider Meetings & Trainings	2014 % of Total Respondents	2014 # of Respondents	2014 Mean Response	2012 % of Total Respondents	2012 # of Respondents	2012 Mean Response
There is adequate notice to attend any meetings and/or trainings	33%	22	4.0	52%	35	4.14
Availability (dates & locations)	33%	22	3.86	52%	35	4.09
Usefulness of training(s)	30%	20	3.70	52%	35	3.74
Were you satisfied with the accuracy and clarity of the information presented during the meeting as well as with follow-up from the meeting	32%	21	3.52	N/A	N/A	N/A
Provider Meetings & Trainings Average		**21.25**	**3.77**		**35**	**3.99**

Claims Department

Claims Processing	2014 % of Total Respondents	2014 # of Respondents	2014 Mean Response	2012 % of Total Respondents	2012 # of Respondents	2012 Mean Response
Claims payments and/or claims denial letters are received within 45 days	76%	50	3.56	54%	36	3.78
Satisfactory and timely answers to your questions	82%	54	3.63	64%	43	3.70
Consistency in responses to inquiries	79%	52	3.48	63%	42	3.76
Ease of submitting electronic claims	58%	38	3.58	43%	29	3.86
Ease of correcting electronic claims	52%	34	3.26	39%	28	3.32
Ease of correcting paper claims	61%	40	3.18	42%	26	3.38
Please rate your overall experience with claims processing from PerformCare	68%	45	3.53	N/A	N/A	N/A
Claims Processing Averages		**44.7**	**3.46**		**34**	**3.63**

Quality Improvement

Administrative Appeals	2014 % of Total Respondents	2014 # of Respondents	2014 Mean Response	2012 % of Total Respondents	2012 # of Respondents	2012 Mean Response
Adequate explanation of decisions made	32%	21	2.76	31%	21	3.43
Decision regarding your appeal(s) were made within 30 days	32%	21	3.20	31%	21	3.24
There was a fair & reasonable decision outcome	32%	21	2.81	31%	21	3.14
Administrative Appeals Averages		**21**	**2.92**		**21**	**3.27**

Complaints & Grievances	2014 % of Total Respondents	2014 # of Total Respondents	2014 Mean Response	2012 % of Total Respondents	2012 # of Total Respondents	2012 Mean Response
Complaints						
Timeliness of complaint resolution	8%	5	3.40	3%	2	3.50
Proper handling of complaint	8%	5	3.40	3%	2	3.50
A fair and reasonable decision was made	8%	5	3.0	3%	2	3.50
Complaints Averages		**5**	**3.27**		**2**	**3.50**

Grievances						
Timeliness of grievance resolution	15%	10	3.10	7%	5	3.60
Collaborative nature of the grievance meeting	15%	10	3.10	7%	5	3.80
Your involvement in the grievance process	15%	10	3.40	7%	5	4.0
Overall, rate PerformCare's management of the grievance process	15%	10	3.10	7%	5	3.60
Grievances Averages		**10**	**3.18**		**5**	**3.75**

Clinical Department

Care Management	**2014 % of Total Respondents**	**2014 # of Respondents**	**2014 Mean Response**	**2012 % of Total Respondents**	**2012 # of Respondents**	**2012 Mean Response**
Timeliness of authorizations	79%	52	3.88	70%	47	3.87
Accuracy of authorizations	79%	52	3.71	70%	47	3.79
Availability of Clinical Care Managers when needed	77%	51	3.61	67%	45	3.60
Consistency in Care Manager's responses to your inquiries	79%	52	3.50	70%	47	3.72
Consistency in Care Manager's review of child/adolescent treatment plans	55%	36	3.14	51%	34	3.62
Care Managers participation in ISPT meetings (for children/adolescents)	48%	32	3.31	43%	29	3.28
Please rate the overall process by which concurrent reviews are conducted; is it consistent and effective in determining the need for continued treatment	71%	47	3.40	48%	32	3.44
Care Management Averages		**46**	**3.51**		**40.1**	**3.62**

Member Services	**2014 % of Total Respondents**	**2014 # of Respondents**	**2014 Mean Response**	**2012 % of Total Respondents**	**2012 # of Respondents**	**2012 Mean Response**
Satisfactory and timely answers to your questions	88%	58	3.71	61%	41	3.88
Consistency in response to inquiries	85%	56	3.66	64%	43	3.65
Directing your call to appropriate department/care manager	89%	59	3.95	61%	41	3.85
Availability of Member Services staff after hours	41%	27	3.59	39%	26	4.19
When calling Member Services, if I had a problem, the person I spoke with helped to resolve it satisfactorily	79%	52	3.71	57%	38	3.89
Member Services Averages		**50.4**	**3.72**		**37.8**	**3.89**

Year to Year Score Comparison

Survey Category	2012 to 2014 Change	2014	2012	2011	2010
Communication	- 4.1%	3.48	3.63	3.86	3.82
Account Executives	- 8.9%	3.67	4.03	4.24	4.13
Provider Orientation	- 16.8%	3.33	4.00	5.00	4.00
Provider Meetings & Trainings	- 5.5%	3.77	3.99	4.13	4.10
Claims Processing	- 4.7%	3.46	3.63	3.85	3.83
Administrative Appeals	- 10.7%	2.92	3.27	3.51	3.71
Complaints	- 6.6%	3.27	3.50	2.25	3.08
Grievances	- 15.2%	3.18	3.75	3.43	3.49
Clinical Care Management	- 3.0%	3.51	3.62	3.49	3.52
Member Services	- 4.4%	3.72	3.89	4.11	4.00
Total Number of Respondents		66	67	74	149
Response Percentage of Total Surveys Sent		33%	21%	19%	24%

Summary

The number of respondents varied greatly from question to question, with Complaints having only 5 respondents, while Communication had 63 respondents. Two new questions were added to the survey this year, one in Claims, and another in Provider Meetings and Trainings.

All ten sections decreased in average score from 2012 to 2014. Provider Meetings and Trainings and Member Services were the two highest scoring sections, scoring 3.77 and 3.72 respectively. Administrative Appeals and Grievances were the lowest scoring sections, scoring 2.92 and 3.18 respectively. It should be noted that these two sections had low numbers of respondents. Administrative Appeals had a total of 21 respondents, while Grievances had a total of 10 respondents. Of the sections which had at least a 75% response rate, which would be 50 respondents, the two highest scoring sections were Member Services, which scored 3.72, and Account Executives, which scored 3.67. The two lowest scoring sections with at least a 75% response rate was Communication, which scored 3.48 and Claims Processing which scored 3.46.

Provider Orientation and Grievances experienced the largest percentage declines in scoring. Provider Orientation fell -16.8% from 2012, and Grievances fell -15.2% from 2012. Again, these sections had low numbers of respondents, which must be taken into consideration when evaluating the scores. The 10 respondents in this years' survey was double the number of respondents in the 2012 survey.

Of the sections which had at least 50 respondents, or a 75% response rate, the largest declines in scoring were seen in Account Executives, which fell -8.9% from 2012, and Claims Processing which fell -4.7% from 2012.

The CABHC Provider Network Committee reviews the results of the survey in order to make recommendations to PerformCare for corrective action in any areas where improvement is needed.

CABHC is grateful for the Providers who participated in this annual Provider Satisfaction Survey. As the HealthChoices monitoring agency for PerformCare Capital Area, we use the survey to provide feedback and recommend changes to PerformCare. We hope that this process will enhance the HealthChoices Behavioral Health program throughout our five county territory.

The following pages contain comments from the survey which we asked the Providers to complete after each section of the survey, especially if they rated a question dissatisfied or extremely dissatisfied. Any names or identifying information has been removed to protect the identity of Providers and PerformCare staff.

PerformCare Department or Subject	Comments
Claims	I work on the direct care side of the process with PerformCare and thus do not directly submit claims myself. I know our agency submits claims electronically, but I am unable to respond to the majority of claims in this section. I can say that when I am drawn into the claims process to check on an authorization issue with our care manager related to a claims issue I feel my calls are responded to in a timely manner and the staff are very helpful in answering my questions.
Claims	The system of mailing TPL claims to Kentucky is a true joke. The papers get "lost" and/or never received.
Claims	Why can't TPL's be sent via Emdeon?
Claims	The only problem I see with claims is that when submitting a corrected claim the lag time on the website to see if claim is being reprocessed. Right now lag time is between 1 ½ to 2 months from corrected claim submission date.
Claims	Filing claims on provider connect takes a lot of time billing for each day instead of monthly.
Claims	Our company uses a third party billing agency. We upload the services to their system and they submit the claims. I'm vaguely aware of the process, but I do know that there have not been many complaints.
Claims	During this period, our agency has wished to bill electronically, but the response from PerformCare has not been forthcoming.
Claims	Corrected claims and secondary claims take MONTHS to process. VERY DISSATISFIED with claims processing. Incorrect denials, claims that "disappear", then because claims processing takes so long, until you find out it's gone you guys deny for timely. We should have as much time to file as you do to process.
Claims	I do not actually submit claims but they are submitted by others at my agency.
Claims	Would prefer electronic but cannot accommodate on either computer.
Claims	Corrected claims were taking 4-6 months to be paid, this has improved. In order to get improved processing time on the corrected claims, our billing department had to begin sending certified mail.
Claims	When compared with other MCO's that we deal with, the ProviderConnect system for submitting claims is very much NOT user friendly. The user interface causes eye strain and often requires more than one invoice for a month of service (when more than one authorization is required to cover a full month). In addition, corrected claims cannot be submitted through ProviderConnect and require a paper re-submission through the London, KY processing center.
Claims	We have chosen not to bill electronically bill because of having to deal with a clearing house and the related house.
Claims	Would like to get denial when claim has incorrect state ID #.
Claims	Secondary claims are paid in a VERY untimely basis. Sometimes 9 months.
Clinical & Care Management	Our CCM is great to work with and timely in her responses to us. She is easy to establish a rapport with and this makes the authorization/review process so much easier to get through! Thanks!!!
Clinical & Care Management	Poor management from the top down. One care manager is a bully to agencies and attempts to dictate treatment instead of manage the treatment. We have attempted to resolve issues with managers and nothing is ever done to address the concerns.
Clinical & Care Management	There has been a decline in in the approval for Family Based services and BHRS in general. Many families are struggling because of this. There are no equivalent services for families to be utilizing as there are in the Philadelphia and Pittsburgh geographies.
Clinical & Care Management	Is there a Clinical Director? People are usually nice and helpful, but there does lack consistence form CM to CM. One CM is very difficult to work with. Again, most are very nice and helpful.
Clinical & Care Management	Consistent answer not always given.
Clinical & Care Management	There are certain CCM's that get back to you in a timely manner and some that don't. There are certain CCM's that give correct information and some that don't (or you feel like you can't trust the information given).
Clinical & Care Management	There is not consistency given with authorizations – i.e. a call is not always made to inform you that services have been authorized.
Clinical & Care Management	This section was completed mostly with experience related to OON agreements. It has been difficult at times to reach a care manager to assist with this. This was only related to one county specifically.

Clinical & Care Management	Don't understand why some things approved, others are not.
Clinical & Care Management	One CM seems to be the only one who consistently answers the phone.
Clinical & Care Management	Reviewer can be short, nasty, rude and angry.
Clinical & Care Management	There are some CCM's that are easier to get a hold of and respond to you than others.
Clinical & Care Management	Inconsistency is the word that comes to mind when thinking of the care management team. Some care management staff are flat out rude and so no respect for the staff that are actually working directly with the members. Care managers are to use their skills to help the team, not make it worse!
Clinical & Care Management	The way services are approved/denied makes no sense. Inconsistent.
Clinical & Care Management	CM's rarely get back to us within 48 hours.
Clinical & Care Management	There are some CM's that stand out among the rest. For example, there are two CM's that are extremely active and involved in cases and participate in meetings in person quite frequently (when needed due to the high profile nature of the case). However, there was a situation recently where there was a case that specifically required an in-person meeting with the family and the CM had let a us know (although the meeting was scheduled within 10 miles of the PerformCare office for the CM's convenience) that she couldn't leave the office for meetings because she had too many cases assigned to her. We had specifically requested the CM to be present in person, and under the current administration have never requested an in-person meeting attendance from a CM. Despite the presentation of the rationale behind the need for an in-person, the CM yet again declined to participate in person. Due to this, the meeting did not occur due to the family's belief it was not an important matter. I was very dissatisfied with this interaction and the inconsistency when support was specifically requested.
Clinical & Care Management	The pre-cert and concurrent reviews consistently take 20-30 minutes to complete per case. This is more time consuming that the other PA Medicaid reviews which typically take 15 minutes.
Clinical & Care Management	Overall this year my experience with CCM's has been positive. Helpful and easy to work with.
Clinical & Care Management	I find the CM's that we communicate with regularly regarding partial hospital services to be very helpful and easy to speak with.
Clinical & Care Management	Most CM's do not answer the phone.
Clinical & Care Management	CCM's do not return calls within 48 hours. Sometimes it is days.
Clinical & Care Management	Care managers give the impression that they do not have the time to be available or to spend on phone conferences.
Clinical & Care Management	I placed a call and emphasized the importance of a timely response and the care manager not only failed to return the call within two days, but seemed very apathetic in response to learning that her lack of timeliness impacted a member's well-being at many levels.
Communication	I appreciate the open lines of communication we have established and the clarity of expectations.
Communication	I hate the current secure email system. Maybe it is just me.
Communication	Poor communication set up when providers need to talk to complaints and grievances.
Communication	Convoluted. No voice mail access.
Communication	Calls are not always returned within the 48 hour timeframe and we have been told that it is our fault for not following up if a call is not returned.
Communication	It is very annoying to be quizzed about who you are calling for, for what reason, etc.
Communication	It feels as though calls are being screened and when sent to voicemail I feel as though the person is not interested in speaking to me.
Communication	I am unaware of a newsletter….

Communication	The provider line is not effective at resolving claim concerns or errors with professionalism or courtesy. Several times errors have been made to be the result of a provider, when in fact it is not. We frequently receive error messages such as 165, detailing the claim not payable due to it having been submitted past the 30 day period. When in fact the claim is within just days of the service. This is often a PerformCare error and has been explained to me that if I did not include the secondary insurance on the claim it would not occur. When in fact PerformCare requires the provider to list primary insurance as a good faith attempt at billing the claim properly. The refusal to accept mistakes on PerformCare's behalf is a huge issue when calling the provider line.
Communication	Just continued notification for trainings.
Communication	Frustrating when calling care connectors and get the hunt group, often have to wait 1-2 days for call back.
Communication	Claims personnel are very helpful. Normally when dealing with children Provider Relations are excellent.
Communication	Could not utilize your online billing. Staff was extremely available and helpful….but in the end everyone just said "do paper billing". I have office 8.0. The resignation to impossibility is short sighted as while 8.0 will improve more people will be using it. If it was solved with my computer, then the next one who has it will benefit, etc. How many failures until someone figures it out?
Communication	Overall, and otherwise, I am happy to provide services to the Medicaid population.
Communication	The portal is difficult to navigate and locate items you are looking for. I haven't received any quick tips for quite some time.
Communication	The QA staff are responsive and communicative. The AE staff are responsive, though the information requested is often not accessible to them, either. The special investigations unit staff and those in positions to facilitate meetings or respond to program and policy questions are often evasive. The ecura access experiences problems too often.
Communication	In general, communication with PerformCare staff leaves staff feeling judged, evaluated, and as if they have done something wrong. This is a real barrier to working together for the client/family. The communication relationship with PerformCare is weak and often results in punitive consequences if disagreement occurs. This type of "bullying" oversite is unhelpful and disrespectful.
Communication	There has been a dramatic decline in overall knowledge of provider issues in the last year or so.
Communication	Would like to speak to a real person and not use email. Many challenges when trying to change information of provider in Ecura.
Communication	Reaching person you are calling has improved.
Communication	ProviderConnect is not use friendly and is often inaccessible.
Communication	Be able to log in on a consistent basis and have it function properly when logging in.
General	Your system is very rigid and prevents clients from accessing good services. Clients do not understand the complexity of the provider needing to be in network with primary in order for PerformCare to be accessed. Although you believe there are enough providers, there are not. In particular, young children (under 6) with trauma or attachment or anxiety are underserved with your provider list.
General	I feel PerformCare is improving from the CBHNP days. It is still difficult to get a unified answer and understand who is actually in charge. However, it is better than it used to be.
General	We've had so many issues with claims – most of our providers now refuse to take MA clients.
General	Weekly HIPPA violations occur in which I receive medical information that does not pertain to me. Calls are made to PerformCare, however the issue continues.
Grievances	Grievances are scary for families. Often times responses seem "cookie cutter".
Meetings & Trainings	Provider meetings stopped – this is very unfortunate.
Meetings & Trainings	Clarity is often missing, and assumptions or expectations are inaccurate or unrealistic.
Member Services	The member services representatives at PerformCare have been polite, professional and helpful when I have placed calls to the agency for authorization and inquiry purposes.
Member Services	They used to answer more questions; now they always seem to transfer elsewhere (care connectors mostly).
Member Services	Often times I feel as though I am being quizzed about why I'm calling.
Member Services	We call in to coordinate care for members….member service staff will not tell us which agency a member is receiving services from? Will give us all of the other info, dates, units, etc., but not the name of the actual agency???

Member Services	Member Services personnel answering phones are ALWAYS polite and will whatever they can to help.
Member Services	The pre-cert process for detox transfers to rehab it not timely. You are expected to call in the day before discharge from detox then the CM has 2 days to call back to complete the review. We had two cases recently of patients with high recidivism who were denied rehab at the time of pre-cert which makes aftercare planning difficult at the last minute. We also risk having unauthorized days.
Provider Manual	How to manage the financial stuff better.
Provider Manual	When to do addendums.
Provider Manual	Appeal process for getting coverage for days missed when person switched insurances, from county to PerformCare. I did this and was told that I couldn't do it yet because bill had not yet been denied, but I couldn't find anything about waiting for bill to be denied before making the appeal. Only that the appeal had to me made in so many days or it would be denied.
Provider Manual	Bulletins easier to find.
Provider Manual	Clarification on types of services that can be held on the same day and claim information should be clearer and easier to find.
Provider Manual	Not everything can possibly be captured in the manual, and the information is pretty good considering the task.
Provider Relations	I was not in need of contacting provider relations this year, but in the past I have found them to be very helpful when an issue has arisen. Likewise, I do not handle the credentialing/recredentialing process as this is completed by staff in our home office thus I cannot speak to the ease of this process.
Provider Relations	Provider relations is more interested in finding fault, exercising authority and holding interminable discussions that have absolutely nothing to do with improving client care.
Provider Relations	It is clear that their expressed purpose is to reduce the number of providers through a series of meaningless, self-centered, condescending meetings.
Provider Relations	Our AE is awesome. Wasn't the name changed to account executives?
Provider Relations	Visits that include "findings" annoying in that visitor refused to look at anything that would clarify "finding" even if it clearly pointed to something that was in error.
Provider Relations	Having to defend things that are clearly within the rules is a waste of time.
Provider Relations	I haven't enjoyed the move to AE's. It feels very impersonal; however, I'm glad I have a new AE that actually follows up with questions/concerns/etc. and doesn't blame her blackberry for issues.
Provider Relations	It's a shame PerformCare has done away with quarterly provider meetings in which Providers could get together and express concerns and ask questions. It makes providers feel alone and disjointed.
Provider Relations	Our AE has been great to work with. She's always helpful in explaining and resolving issues related to services to providers and potential changes in services. Sometimes things can be very confusing in managed care, but she has been able to bridge the language to better suit the providers.
Provider Relations	Our provider relations rep is excellent. She has been very helpful and keeps us informed quite well.
Provider Relations	We love our provider rep! She works her butt off and is always responsive to our many questions!
Provider Relations	Credentialing visits are communicated and executed well. Some of the feedback from the site visits reflects a subjective perception and a lack of understanding of the program delivery and treatment. Our program should have an avenue to be able to respond to those critical comments that seem subjective and which impact our overall scores in the credentialing process. Much of the feedback in credentialing and on site audits has improved the quality of our program and aided in treatment delivery. For this, we are grateful.