CAPITAL AREA BEHAVIORAL HEALTH COLLABORATIVE, INC.
Established October 1999

PROVIDER SATISFACTION SURVEY REPORT

2012

The 2012 Provider Satisfaction survey was sent to all Providers listed in the CBHNP Capital Area provider network to obtain feedback about CBHNP and the HealthChoices program. The survey was sent to 345 Providers via email to be completed using the web-based survey program QuestionPro. Twenty-six surveys were returned as undeliverable. Consequently, out of the 319 delivered surveys, we received 67 responses, which is a 21% response rate. This is a slight decrease from the 23.9% response rate the prior year.

Demographics[1]

Age group(s) served by Respondents:

Children	40%
Adolescents	40%
Adults	19%
All age groups	49%

Level(s) of Care provided by Respondents:

Substance Abuse	16%
Mental Health	97%
Co-Occurring	22%

2012 CABHC Provider Satisfaction Survey Results

Providers were asked to respond to survey items based on their experiences with CBHNP in the prior 12 months. Except where noted, the questions used Likert scale ratings. Responses have been given numeric values as follows: Very Satisfied = 5, Satisfied = 4, Neutral = 3, Dissatisfied = 2, Very Dissatisfied = 1. Answers marked "N/A" were not calculated into the scores. Data from past surveys is presented alongside the response data for the 2012 Provider Satisfaction Survey when applicable.

Satisfaction

All respondents did not answer every question. Therefore, the number of respondents counted in rating each question varies. The number of respondents not answering a particular question or giving an answer of "N/A" was not included in the totals. The column in each table labeled "2012 Percent of Total Respondents" indicates the percentage of all respondents who answered a particular question.

[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%.

Communication

Communication	2012 Percent of Total Respondents	2012 Mean Response	2011 Mean Response	2010 Mean Response
General				
Notification and implementation of policy changes affecting Providers	93%	3.63	3.90	3.81
Ease of reaching someone who can answer your questions when calling CBHNP.	96%	3.67	4.02	3.80
Ease of calling the Provider Line and reaching the person you are calling	87%	3.60	3.78	3.96
When calling the Provider Line, my calls were returned within 24 hours	81%	3.46	3.68	3.65
Ease in using Provider Portal	87%	3.64	3.96	3.79
Ease in using ProviderConnect	75%	3.70	3.84	3.88
Newsletters				
Clear and Useful	84%	3.63	3.92	3.79
QI Quick Tips				
Clear and Useful	81%	3.72	3.78	3.84
Communication Averages		3.63	3.86	3.82

Provider Relations

Provider Manual						
Frequency in which you or your staff's agency reference the CBHNP Provider Manual	**2012 Percent of Total Respondents**	**Daily**	**Weekly**	**Monthly**	**Yearly**	**Never**
	87%	3.5%	6.9%	51.7%	32.8%	5.2%
How beneficial was the Provider Manual when you referenced it?	**2012 Percent of Total Respondents**	**Very Helpful**	**Somewhat Helpful**	**Neutral**	**A little Helpful**	**Not Helpful At All**
	81%	11.1%	59.3%	20.4%	7.4%	1.9%

Providers were also asked about for suggestions of additions or clarifications to the Provider Manual. These suggestions are in the Comments section.

Provider Orientation	**2012 % of Total Respondents**	**2012 Mean Response**	**2011 Mean Response**	**2010 Mean Response**
Answered all of your questions	4%	4.0	5.0	4.0
Helpful/valuable information received	4%	4.0	5.0	4.0
Provider Orientation Averages		4.0	5.0	4.0

Account Executives **(formerly Provider Relations Representatives)**	**2012 % of Total Respondents**	**2012 Mean Response**	**2011 Mean Response**	**2010 Mean Response**
Answering Questions in a Satisfactory and Timely Manner	88%	4.0	4.09	4.0
Fairness of Provider Relations site visit(s)	75%	4.04	4.26	4.13
When calling Provider Relations, if I had a problem, the person I spoke with helped to resolve it	81%	4.09	4.43	4.27
(Re)Credentialing Process	70%	3.98	4.19	4.10
Account Executive Averages		4.03	4.24	4.13

Provider Meetings and Trainings	2012 % of Total Respondents	2012 Mean Response	2011 Mean Response	2010 Mean Response
Adequate notice to attend	52%	4.14	4.41	4.37
Availability (dates and locations)	52%	4.09	4.08	4.11
Usefulness/Appropriate to your level of care	52%	3.74	3.89	3.81
Provider Meetings and Trainings Averages		3.99	4.13	4.10

Quality Improvement

Administrative Appeals	2012 % of Total Respondents	2012 Mean Response	2011 Mean Response	2010 Mean Response
Adequate explanation of decision	31%	3.43	3.33	3.61
Decision was made within the stated 30 days	31%	3.24	3.90	3.92
Fair decision outcome	31%	3.14	3.30	3.59
Administrative Appeals Averages		3.27	3.51	3.71

Complaints and Grievances	2012 % of Total Respondents	2012 Mean Response	2011 Mean Response	2010 Mean Response
Complaints				
Timeliness of complaint resolution	3%	3.50	2.0	3.0
Proper handling of complaint	3%	3.50	2.0	3.0
Fair decision outcome	3%	3.50	2.0	3.0
Overall HealthChoices complaint process	3%	3.50	3.0	3.33
Grievances				
Timeliness of grievance resolution	7%	3.60	3.46	3.51
Collaborative nature of grievance meeting	7%	3.80	3.29	3.46
Your involvement in grievance process	7%	4.00	3.33	3.39
Overall HealthChoices grievance process	7%	3.60	3.63	3.59
Complaints and Grievances Averages		3.63	3.43	3.49

Clinical Department

Care Management	2012 % of Total Respondents	2012 Mean Response	2011 Mean Response	2010 Mean Response
Timeliness of authorizations	70%	3.87	3.81	3.76
Accuracy of authorizations	70%	3.79	3.98	3.92
Availability of Clinical Care Managers	67%	3.60	3.41	3.51
Consistency in response inquiries	70%	3.72	3.57	3.62
Consistency in review of child/adolescent treatment plans	51%	3.62	3.06	3.15
Participation in ISPT meetings *(for children/adolescents)*	43%	3.28	3.07	3.15
The process by which concurrent reviews are conducted is consistent and effective in determining the need for continued treatment	48%	3.44	3.54	3.53
Care Management Averages		3.62	3.49	3.52

Member Services	2012 % of Total Respondents	2012 Mean Response	2011 Mean Response	2010 Mean Response
Satisfactory answers to your questions	61%	3.88	4.17	4.05
Consistency in response inquiries	64%	3.65	3.96	3.85
Directing your call to appropriate department/care manager	61%	3.85	4.20	4.10
Availability of Member Services Staff after hours	39%	4.19	4.03	3.98
When calling Member Services, if I had a problem, the person I spoke with helped to resolve it	57%	3.89	4.17	4.02
Member Services Averages		3.89	4.11	4.00

Claims Department

Claims Processing	2012 % of Total Respondents	2012 Mean Response	2011 Mean Response	2010 Mean Response
Claims payments and/or denial letters received within the stated 45 days	54%	3.78	3.91	3.86
Satisfactory and timely answers to your questions	64%	3.70	3.92	3.95
Consistency in response inquiries	63%	3.76	3.73	3.70
Ease of submitting electronic claims	43%	3.86	4.04	4.02
Ease of correcting *paper* claims	42%	3.32	3.76	3.65
Ease of correcting *electronic* claims	39%	3.38	3.70	3.77
Claims Processing Averages		3.63	3.85	3.83

Additionally, 12% of respondents indicated that they submitted electronic claims, 28% submitted paper claims, and 27% submitted both.

Summary

The number of respondents varied widely from question to question, with Provider Orientation having the least at 3 respondents, and the Communications section having 62 respondents. Thus changes in scores from the previous year should be noted as being relative to the number of respondents in both surveys.

The section regarding satisfaction with *Account Executives* scored the highest at 4.03 out of 5 points, followed by *Member Services* at 3.89. These are both slight decreases from last year by 0.21 and 0.22 respectively. With the exception of *Clinical Care Management*, each section decreased in score from 2011 to 2012. The greatest decrease was for *Administrative Appeals*, specifically in the timeliness of decisions made. The overall *Administrative Appeals* score decreased by 7% from 3.51 to 3.27. It should be noted that 28% of respondents indicated having experience with Administrative Appeals.

Clinical Care Management increased in score by 3.7% from 3.49 to 3.62. This was mostly attributable to Provider satisfaction in the consistency of review of child and adolescent treatment plans which had an increase in score of 18% from 3.06 to 3.62.

As the HealthChoices monitoring agency for CBHNP Capital Area, we use the survey to provide feedback and recommend changes to CBHNP. The CABHC Provider Network Committee reviews the results of the survey in order to make recommendations to CBHNP for corrective action in any areas where improvement is needed. We hope that this process will enhance the HealthChoices Behavioral Health program throughout our five-county territory.

CABHC would like to thank Providers for participating in this annual Provider satisfaction survey. If you have any questions or comments, please feel free to contact me at ddaddario@cabhc.org or 717.671.7190 ext 105.

CBHNP Department or subject (if any)	Comments
Administrative Appeals	We have been given verbal approval from a claims director only to have her later deny them. Sometimes we don't get an answer for 45+ days.
Claims	Would appreciate it if CBHNP develops capacity to accept secondary claims electronically.
Claims	We would love to be able to send them electronically but it is too time intensive. If the claims were as easy to submit electronically as they are with Highmark via Navi Net we would send them that way.
Claims	We were not overly happy that we had to incur costs to submit claims electronically through CBHNP. Of further concern was that if you were a high volume provider you did not have to use the clearinghouse and the process remained the same --- not new process, no incurred expense. But for the 'little guys' you both had to go through a process that was not easy with Emdeon (not real attentive to the project) and further expense to the provider. Claims staff have always been helpful and we are glad to know that they are still with your organization since the new process began. Length of time for claims to pay is longer than most and correcting claims is very lengthy.
Claims	My claims are submitted by my billing service, so I have no experience with this, personally.
Claims	It is frustrating that when CBHNP makes the error, the burden is on the program to do the admin appeal to amend the issue.
Claims	I do not do the billing, but I know we submit claims electronically.
Claims	Electronic is great.
Claims	Billing is done at different location and that person is not available.
Claims	The processing time is too long since claims processing moved to Kentucky. It takes more than 45 days to be processed at times.
Clinical and Care Management	There seems to have been an increased inaccuracy with authorizations - more auths seem to have been 'missed' by the care managers when they receive the packet or the auth is issued for the incorrect service. It hasn't been overly problematic, but we've noticed it seems to be occurring more recently than in the past.
Clinical and Care Management	Review protocol is too lengthy.
Clinical and Care Management	Please consider extension of hours for concurrent reviews, including electronic submission of materials.
Clinical and Care Management	Often staff from CBHNP is not available for the ISPT in person or by phone, and their input is valuable. It would be good if we knew meetings scheduled at set times could be staffed.
Clinical and Care Management	In regards to authorizations. It is difficult for providers now that the HY modifier is not included on the authorizations. I understand that providers should and do know how to bill. However, sometimes the information that providers have is correct and CBHNP is incorrect resulting in mispayment. To correct payments you then have to have authorizations correct which from my experience the provider representative must become involved. Overall a lengthy process and once that could be avoided with the HY modifier being included on the authorization.
Clinical and Care Management	Ease of contacting Care Managers varies widely depending on the care manager. Some are extremely easy to get a hold of, while others seem to rarely return calls.
Communication	Your MCO is one of the best that we work with.

CBHNP Department or subject (if any)	Comments
Communication	Within the last 12 months there were more than 6 times when clinical error on your part denied auths for us and I was required to reissue the request or complete an appeal. Hopefully this is solved with no auths.
Communication	Wish we could obtain claim status on line with Provider Connect.
Communication	When you call the 1 888-700-7370 phone number all you get is from one recording to another, and they don't return your phone calls, you have to call repeatedly. I called the other day and I had to call 5 times to get someone to help me.
Communication	When calling the provider line, it is frustrating that the provider services person questions who/why you are calling. I often feel that my calls for some reason are being screened especially since 99% of the time I must leave a message and am unable to speak to the person I called.
Communication	They send out so many emails that all start by saying the same thing you're never quite sure what it is announcing. You have to pick through it to figure it out. Their call system is also incredibly confusing and you never get a person. If I get a direct call from someone to call them back, they should give me their direct line in return. It's a loop around of voice mails. I just want to talk to my rep.
Communication	There is a lot of communication and sometimes it doesn't apply as it is with many insurance companies. I am satisfied
Communication	The Provider Connect is beneficial in theory, but doesn't allow a lot of practical use for clinical staff. We used to be able to submit critical incident reports through Provider Connect, but that has been discontinued and we have gone back to paper submissions because CBHNP staff either didn't know how to find our submissions or were not able to access them. I think there could be a lot more functionality with the Provider Connect program, and am hopeful that it will eventually evolve into something more useful. It has been beneficial for verifying authorizations, member info, etc...
Communication	The communication comes through fine. The amount is the problem. There are non-stop changes that make it nearly impossible to keep up with and remember as it impacts the programs. As soon as you adjust to one change, there is another. Each seeming to require more time and/or documentation.
Communication	Since I get automatic updates from the portal, it is the easiest way for me to access other things, but it is hard to find the forms, which is what I try to get to most.
Communication	Not sure how quick tips relates or replaces or sets policy and procedure.
Communication	It would be great if the ProviderConnect issue with submitting notes with incident reports could be resolved. That creates more work for us.
Communication	I would like to see the ability to enter claims on line become simpler and more user friendly.
Communication	I have never had any trouble connecting with someone. When I call with questions. The people are always nice and set a good example of teamwork and customer service.
Communication	Frequent changes in staff and their responsibilities is confusing at times
General	The only standing issue we have had recently with CBHNP was not get full reimbursement for services do to MA eligibility issues with one of our long term clients from Lancaster Co. - he lost his MA & we were only able to get partial payment for services at our RTF. We had no control over the loss it was an issue with parents & county.

CBHNP Department or subject (if any)	Comments
General	The authorizations have not been entered into ECura in a very timely manner and there have been a few errors in recent weeks/ month or two
General	Except for the claims problem last year, I have had a great experience with CBHNP and would rather deal with them than with almost any other insurance company with which I'm credentialed.
Provider Portal	Often unable to access because system is down.
Provider Relations	Would hope that CBHNP considers moving from paper secondary and corrected claims to an electronic process.
Provider Relations	We have only made a few calls since I have been supervisor - provider relations call back in a timely manner, but some issues which we had no control over were not rectified. Ongoing MA Eligibility issues -
Provider Relations	Sometimes I think my questions must be off the wall, nobody seems able to answer them, and they get forwarded on and on.
Provider Relations	responsive, knowledgeable
Provider Relations	Provider relations/account execs are helpful and quick...at least ours is. Does not really assist with the amount of change that comes through.
Provider Relations	Make it easier to find things with a better way to search topics
Provider Relations	Excellent
Provider Relations	Kelly Lauer is great to work with and very knowledgeable & helpful.
Provider Relations Manual	Re-credentialing process is not very clear at this time.
Provider Relations Manual	Paper Billing requirements
Provider Relations Manual	Issues surrounding grievances - clearer timeframes & resolution of fiscal issues
Provider Relations Manual	I cannot answer this, I don't usually use it.
Provider Relations Manual	Billable and non-billable activities
QI	MA issue was never completely rectified - only partially
QI	It feels like Corporate Compliance is driving Clinical decisions. It was appalling that a recent meeting that was set up to talk about and clarify the roles in BHRS was led by corporate compliance and not by clinical department
QI	I had a significant problem in the latter part of 2011 with claims, but it appears that I wasn't the only one. A major glitch seemed to happen when billing started going through EMDEON. I am pleased that this was finally straightened out after months of no payments and everyone I dealt with at CBHNP was very nice and helpful. I was signed up for electronic payments, but I am still getting my paper checks. I also discovered last week that only 5 claims can be handled at a time, per info given my billing service. I think the change-over at the end of 2011 was a fiasco and I'm not so sure that it's straightened out yet. I don't mind paper checks and EOBs, but I understood the electronic claims process would be much faster.