CAPITAL AREA BEHAVIORAL HEALTH COLLABORATIVE, INC.
Established October 1999

2016 Provider Satisfaction Survey Report

The 2016 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 282 Providers via email. 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. Surveys were sent to individuals who serve in various positions across our provider agencies. Thirty-six surveys were returned as undeliverable. Consequently, out of the 246 delivered surveys, we received 64 completed surveys, which is a 26% response rate. This is an increase from the 25% completed survey rate in 2015.

Demographics

Age Group(s) Served by Respondents:

Children/Adolescents	11%
Adults	46%
Both Age Groups	42%

Level(s) of Care Provided by Respondents:

Substance Abuse	23%
Mental Health	42%
Co-Occurring	5%
All Levels of Care	25%

2016 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 past Provider Satisfaction Surveys, when applicable.

Respondents did not answer every question, so the number of responses for each question varies. The column in each table labeled "2016 # of Respondents" indicates the number of all respondents who answered a particular question.

Communication

Written and Electronic Communication	2014 # of Respondents	2014 Mean Response	2015 # of Respondents	2015 Mean Response	2016 # of Respondents	2016 Mean Response
Notification and implementation of policy changes affecting Providers	63	3.6	52	3.6	69	3.9
Ease of reaching someone who can answer your questions when calling PerformCare	62	3.6	51	3.9	69	3.9
Ease of calling the Provider Line and reaching the person you are calling	60	3.5	52	3.6	63	3.8
When calling the Provider Line, my calls were returned within 48 hours	55	3.7	50	3.4	60	4.1
Ease in using the website	56	3.4	51	3.7	57	3.7
Ease of using eCura	55	3.4	50	3.5	38	3.6
Quality Improvement "Quick Tips" are useful	46	3.4	49	3.6	N/A	N/A
Provider newsletters are useful	53	3.4	49	3.6	N/A	N/A
	56	**3.5**	**51**	**3.6**	**59**	**3.8**

Communication Comments
I often get the same notification in several different emails - it would be great of communication was streamlined to minimize duplication.
Sometimes the information is not as clear as it could be. That said, I GREATLY appreciate being able to contact my Provider Rep and get a personal response. The ability to talk to 'real live people' really sets PerformCare apart.
No complaints and only positive experiences from our programs.
Member Services often is difficult to navigate and they ask seemingly unnecessary questions when you ask specifically for a person.
Return responses need to be quicker.
Overall, very satisfied. The only concern is related to their assessment process with PerformCare gathering information on individuals prior to making referrals. It may be helpful to gather more in depth information as individuals in the past have shown to require a higher level of care than what we can provide. But overall, it is a great pleasure working with Perform Care.
There's been an issue recently with the internet security certificate for ecura, which I had to contact our IT department and Provider Connect about. Also, ecura times out too quickly and/or without notice. It would be helpful if a timer popped up to let you know how much more time you have before you're kicked out of the program.

PerformCare is one of the easier MA companies as regards communication with whom we interact. At times they do become 'backed up' with calls toward the end of the day; however, in such instances, they are flexible in allowing the review to be completed the following day, so long as the initial call was made the day it was due.
Continue to answer the calls quickly in member services and return calls back in a timely manner.
Little more notice for new policies. Changes occur within a month or less of receiving the notices.
The area rep is hard to reach.
ICMs report they do not use the website, as they feel it is not user friendly and is difficult to navigate.
I have had no problems with PerformCare and have had no need to contact anyone. I have not heard of any complaints from my billing service, either. Payments come in a very timely fashion and there have been no issues. This is a good thing, compared to many other insurance companies.
Call back time for pre-certs has been increasing with lengthy wait times

Provider Relations

Account Executives	2014 # of Respondents	2014 Mean Response	2015 # of Respondents	2015 Mean Response	2016 # of Respondents	2016 Mean Response
When contacting an Account Executive, do you receive satisfactory and timely answers to your questions	60	3.7	45	3.5	52	4.0
When calling an Account Executive, if you had a problem/issue or concern, the person you spoke with helped to resolve it to your satisfaction	57	3.7	45	3.4	52	3.9
	51	**3.7**	**45**	**3.5**	**52**	**4.0**

Provider Relations Comments
Everyone is super helpful! This is a great part of PerformCare!
AE is a great account executive and very easy to work with. She responds quickly and ensures we have answers to our questions in timely manner.
Account manager sometimes takes days or weeks to return calls/emails and then the answer is just the standard PR answer and nothing that is helpful or even acknowledging a problem.
I believe the Account Executive position to be a waste of time, resources and money. I used to meet with my account executive, but do not anymore. When I reach out to her, I rarely get a timely response and always have to follow up with someone else. It's a ridiculous, wasteful position.
AE's are very helpful and responsive when a need arises.
Our agency has had concerns with the professionalism of staff we have dealt with. We have addressed with their manager. Minimal improvement noticed.
Overall, provider relations are very strong.
AE is extremely timely in her responsiveness.
As indicated in an earlier section, PerformCare is one of the more user-friendly companies with whom we interact.
AE is amazing at being responsive and getting answers we need.
Sometimes I've encountered conflicting information from one contact person to the next.
In general do a great job.

Provider Manual	2016 # of Respondents	Daily	Weekly	Monthly	Yearly	Never
How often did you or your Agency's staff reference the PerformCare Provider Manual?	70	0%	6%	38%	40%	16%

When you referenced the PerformCare Provider Manual, how beneficial was it?	2016 # of Respondents	Very Helpful	Somewhat Helpful	Neutral	A Little Helpful	N/A or No Experience
	68	14%	40%	18%	8%	20%

Provider Meetings & Trainings	2014 # of Respondents	2014 Mean Response	2015 # of Respondents	2015 Mean Response	2016 # of Respondents	2016 Mean Response
There is adequate notice to attend any meetings and/or trainings	22	4.0	14	4.5	29	3.9
Availability (dates & locations)	22	3.9	14	4.7	28	3.9
Usefulness of training(s)	20	3.7	14	4.7	28	3.6
Were you satisfied with the accuracy and clarity of the information presented during the meeting as well as with follow-up from the meeting	21	3.5	14	4.3	29	3.6
Provider Meetings & Trainings Average	**21**	**3.8**	**14**	**4.5**	**29**	**3.8**

Meetings and Trainings Comments
Sometimes I feel like the trainings don't have enough detailed information.
When questions arise at provider meetings I can assured that many of the responses will be 'we will have to get back to you on that' and there is rarely even follow up.
I appreciate the follow up, but I don't always feel that the clarity is present between Perform Care staff. We continue- at times- to be told one thing by one person/department, yet something different at the provider meetings from a different person/department.
For webinar trainings most of the time presenters just read the power point slides. There wasn't much additional info added. I can print out the power point info, read over myself and not have to sit through the webinar.
Requests for the meetings need to be sent out at least 4 weeks in advance if not more. It is difficult to be able to schedule meetings within a short time period.
Webinars consist of staff reading the Power Point slides, little elaboration is given.
Please be more detailed if SA OP/SA IOP is not required for specific roll outs of new programs etc.
It would be helpful to have people that could make decisions actually at the trainings.

Claims Department

Claims Processing	2014 # of Respondents	2014 Mean Response	2015 # of Respondents	2015 Mean Response	2016 # of Respondents	2016 Mean Response
Claims payments and/or claims denial letters are received within 45 days	50	3.6	42	3.8	41	4.0
Satisfactory and timely answers to your questions	54	3.6	42	3.9	47	3.9
Consistency in responses to inquiries	52	3.5	42	3.9	46	3.9
Ease of submitting electronic claims	38	3.6	42	4.1	34	4.00
Ease of correcting electronic claims	34	3.3	42	3.8	33	3.8
Ease of correcting paper claims	40	3.2	40	3.8	28	3.6
Please rate your overall experience with claims processing from PerformCare	45	3.5	42	4.0	40	3.9
Claims Processing Averages	**45**	**3.5**	**42**	**3.9**	**38**	**3.9**

Claims Comments
I just submitted my first claims about a week ago, so I can't say much about this yet. However, I submitted claims using my practice management system and have noticed that PerformCare is slower than other companies to indicate the claim has been accepted. With the other two panels I am on, my claims are typically marked as accepted within a day or two and paid within 2 weeks. The PerformCare claims I submitted 8 days ago still show as 'received' (not yet as 'accepted'), so that process seems slower.
I have called Claim many times over the years regarding denials. All the claims reps have been very helpful.
Claims process entirely too slow. We should have as long to correct a claim as you have to process a corrected claim. It often takes months to hear anything back. Often there is no response to submitted claims and due to how long claims take to process we are often told our claims are timely when the fault lies with the slow pace of processing.
Claims have been submitted with ease, and staff was always helpful and professional.
Our normal submission is by paper claim; fiscal department is made to feel this is not an acceptable long term submission procedure. We feel we are penalized for using the paper claim.
Billing service handles all of my claims. I have not had any negative comments from them regarding PerformCare.
When there are errors correction of claims is time consuming and arduous.
PerformCare takes longer to pay claims than any other HealthChoices provider with whom we do business.

Quality Improvement

Credentialing & Re-credentialing	2014 # of Respondents	2014 Mean Response	2015 # of Respondents	2015 Mean Response	2016 # of Respondents	2016 Mean Response
Credentialing and re-credentialing processes	45	3.60	45	2.8	64	3.7

Administrative Appeals	2014 # of Respondents	2014 Mean Response	2015 # of Respondents	2015 Mean Response	2016 # of Respondents	2016 Mean Response
Adequate explanation of decisions made	21	2.8	12	3.8	22	3.7
Decision regarding your appeal(s) were made within 30 days	21	3.2	12	3.9	22	4.0
There was a fair & reasonable decision outcome	21	2.8	12	3.7	22	3.7
Administrative Appeals Averages	**21**	**2.9**	**12**	**3.8**	**22**	**3.8**

Grievances	2014 # of Respondents	2014 Mean Response	2015 # of Respondents	2015 Mean Response	2016 # of Respondents	2016 Mean Response
Timeliness of grievance resolution	10	3.1	9	4.1	5	3.8
Collaborative nature of the grievance meeting	10	3.0	8	4.1	5	3.6
Your involvement in the grievance process	10	3.4	9	4.3	5	3.6
Overall, rate PerformCare's management of the grievance process	10	3.1	10	4.3	5	3.6
Grievances Averages	**10**	**3.2**	**9**	**4.2**	**5**	**3.7**

Treatment Record Reviews	2014 # of Respondents	2014 Mean Response	2015 # of Respondents	2015 Mean Response	2016 # of Respondents	2016 Mean Response
Do you understand the expectations of the questions in the Treatment Record Review	N/A	N/A	N/A	N/A	5	3.6
Do you feel the process was fair	N/A	N/A	N/A	N/A	5	3.6
Do you feel the Treatment Record Review process was helpful	N/A	N/A	N/A	N/A	5	3.6
Were you satisfied with any assistance provided by the Quality Improvement Department	N/A	N/A	N/A	N/A	5	3.6
Treatment Record Review Average	**N/A**	**N/A**	**N/A**	**N/A**	**5**	**3.6**

Clinical Department

Care Management	2014 # of Respondents	2014 Mean Response	2015 # of Respondents	2015 Mean Response	2016 # of Respondents	2016 Mean Response
Timeliness of authorizations	52	3.9	39	3.4	52	3.8
Accuracy of authorizations	52	3.7	41	3.2	53	4.0
Availability of Clinical Care Managers when needed	51	3.6	40	2.8	52	3.7
Consistency in Care Manager's responses to your inquiries	52	3.5	40	3.0	52	4.0
Consistency in Care Manager's review of child/adolescent treatment plans	36	3.1	39	3.0	22	3.8
Care Managers participation in ISPT meetings (for children/adolescents)	32	3.3	37	3.3	16	3.4
Please rate the overall process by which concurrent reviews are conducted; is it consistent and effective in determining the need for continued treatment	47	3.4	40	3.4	47	3.8
Care Management Averages	**46**	**3.5**	**39**	**3.2**	**42**	**3.8**

Care Management Comments
Timeliness of authorizations has gone down-hill in the past few months. It has taken days to get some authorizations for inpatient substance abuse and can take 6 or more hours for inpatient mental health.
Care managers completing continued stay reviews will often delay reviews, particularly discharge reviews for days if they are unscheduled due to reported care managers having too many reviews scheduled for the day.
Care managers also provide a lot of personal feedback on the patients and thoughts for discharge planning. Some care managers do not follow PCPC criteria for substance abuse authorizations and base authorization on the number of days in treatment.
The reviewer continues to add questions to reviews and ask many requests of the treatment teams. She is also rude and disrespectful.
Some care managers are much more pleasant to work with than others. My teams, families and I have felt judged by the tone of her voice and comments made during reviews and when I have called for clarification regarding different 'issues' with cases.
Care managers are willing to discuss clients within the parameters of appropriate confidentiality constrains and are in general most helpful.
Too much information is requested outside of confidentiality regulations.
The 24 hour time period in submitting an IOP authorization is difficult as it truly is not a 24 hour period. You must submit by the next day at noon I believe. 48 hours is more realistic from the time of the evaluation not the start of the business day.
Detox level of care requires more timely authorization numbers to pre-cert for aftercare placements prior to member completion of treatment.
The policy to require IOP authorizations for substance use outpatient treatment did add on additional workload to multiple domains in our work flow. Going back to a no authorization process would be appreciated, if it were possible.
I have had to reach out to a care management supervisor because of a particular care manager's inefficient manner in which she is conducting continued stay reviews and discharge reviews. Continued stays take a half an hour or more and discharge reviews take at least 15 minutes and the care manager is asking questions over and over that we have already answered and then is asking questions that only she or I could speculate - such as 'Why do you think the member would want to engage in that sort of behavior' - which is not useful in determining patient progress towards treatment goals. I initially reached out to

the care manager supervisor on 11/22/16 and was told it would be looked into. I left her a VM then again on 11/30/16 after I've found that no changed are noted in efficiency of reviews with the care manager.
The clinical care managers take hours to get back to us about initial authorizations and continued stay reviews. Some rehab and detox patients have waited more than 6 hours for precertification resulting in them deciding against treatment or in rare cases safety issues. The care managers are excellent when they do call back and precertification can be completed quickly in most cases but the wait is difficult for the facility and the patient.
It would be helpful to be able to do concurrent reviews after hours due to working in an OP setting when we still see clients who need a higher level of care ASAP.
During our review process, staff from PerformCare have always been helpful, understanding and professional.
Because admission to detox is not pre-cert, authorizations for detox are often incorrect and inputted as 3a when they should be 4a. We are a hospital and have the ability to treat both 3a and 4a LOC but more often than not the authorization is issued for 3a despite the request for 4a.
Authorizations are in increments that are too small for our level of care. For example, we operate a 2B halfway house and often receive authorizations in increments of 15 days when we have a strong track record of members in our care for up to 90 days. The authorization codes are specific to the 15 day increments, and it would be helpful if the authorization code remained the same for each client-member, and if the authorization would be for a longer duration of time.

Member Services	2014 # of Respondents	2014 Mean Response	2015 # of Respondents	2015 Mean Response	2016 # of Respondents	2016 Mean Response
Satisfactory and timely answers to your questions	58	3.7	41	4.0	56	4.0
Consistency in response to inquiries	56	3.7	40	3.9	56	3.8
Directing your call to appropriate department/care manager	59	4.0	39	4.0	56	4.0
Availability of Member Services staff after hours	27	3.6	41	3.8	32	3.5
When calling Member Services, if I had a problem, the person I spoke with helped to resolve it satisfactorily	52	3.7	40	3.9	48	3.8
Member Services Averages	**50**	**3.7**	**40**	**3.9**	**50**	**3.8**

Member Services Comments
During the past year, my satisfaction with member services has decreased. We have had multiple difficulties in getting authorization numbers for members upon arrival and member services seem to forget to call us back and we have always had to continue to reach out and member services reps seem to not be able to give rationale as to the problem. Answers do not seem consistent among member service rep.
It would be nice if they didn't drill you about the purpose of your call.... it sometimes feels intrusive and when the CCM doesn't pick up it feels as though you are being avoided.
I am glad to work with a dedicated person assigned to my agency rather than just getting whoever was available at the time of my call. There was never a problem with member service care managers, but I like dealing with one person vs. many.
PerformCare personnel are consistently courteous and provide satisfactory responses.
Member services employees are always friendly and as helpful as they can be. It's a pleasure working with them every day.
I have had no reason to contact PerformCare in the past 12 months.
Many recent issues with un-timeliness of responses, especially around pre-certs.

Year to Year Score Comparison

Survey Category	2011	2012	2014	2015	2016
Communication	3.9	3.6	3.5	3.6	3.8
Provider Relations	4.2	4.0	3.7	3.2	4.0
Provider Orientation	5.0	4.0	3.3	N/A	N/A
Provider Meetings & Trainings	4.1	4.0	3.8	4.5	3.8
Claims Processing	3.9	3.6	3.5	3.9	3.9
Administrative Appeals	3.5	3.3	2.9	3.8	3.8
Credentialing & Re-credentialing	N/A	N/A	3.6	2.8	3.7
Complaints	2.3	3.5	3.3	N/A	N/A
Grievances	3.4	3.8	3.2	4.2	3.7
Treatment Record Reviews	N/A	N/A	N/A	N/A	3.6
Clinical Care Management	3.5	3.6	3.5	3.2	3.8
Member Services	4.1	3.9	3.7	3.9	3.8
Average Total Score	**3.8**	**3.7**	**3.4**	**3.8**	**3.8**
Total Number of Respondents	74	67	66	60	64
Response Percentage of Total Surveys Sent	19%	21%	33%	25%	26%

Summary

The number of respondents varied greatly from question to question, with Grievances and Treatment Record Reviews having only 5 respondents, while Credentialing and Re-credentialing had 64 respondents.

Four sections decreased in scoring from 2015 to 2016, Claims Processing, Grievances, Member Services, and Provider Meetings and Trainings. The two lowest scoring sections were Grievances and Treatment Record Reviews, scoring 3.65 and 3.60 respectively. Provider Relations and Claims Processing were the two highest scoring sections, scoring 3.99 and 3.90 respectively. Of the sections which had at least a 75% response rate, which would be 48 respondents, the highest scoring section was Provider Relations, which scored 3.99. Overall, the Average Total Score stayed the same which was 3.80 in 2015 and 2016.

Several comments in the Care Management section are focused on Substance Abuse services. Providers expressed concern with their experiences with Care Managers regarding authorizations, continued stay reviews, wait times for pre-certifications, and overall professionalism of Care Managers.

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

CABHC is grateful for the Providers who participated in this annual Provider Satisfaction Survey. 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 Counties.