CAPITAL AREA BEHAVIORAL
HEALTH COLLABORATIVE, INC.
Established October 1999

2018 CABHC Provider Satisfaction Survey Report

On an annual basis, CABHC conducts an assessment of the Capital area network of providers through a satisfaction survey. The survey is used to assess the Provider's satisfaction with the BH-MCO, PerformCare, and to obtain feedback about PerformCare and the HealthChoices program. The survey is sent to a variety of individuals who serve in various positions across the provider network of agencies. It can be accessed online using the web-based program, QuestionPro, or by completing a paper version and submitting it to CABHC.

In fall 2018, the survey was sent via email to 310 providers. There were nineteen returned as undeliverable yielding a 94% delivery rate. Of the 291 delivered surveys, 98 were completed in full resulting in a 34% response rate. This is an increase from the 30% response rate in 2017.

Demographics:

Age Groups Served by Respondents:

Children/Adolescents	21%
Adults	42%
Both Age Groups	37%

Levels of Care Provided by Respondents:

Substance Abuse	32%
Mental Health	42%
Co-Occurring	11%
All Levels of Care	15%

2018 Satisfaction Survey Results

Survey recipients were asked to respond to each of the survey questions based on their experiences with PerformCare over the previous twelve months. Except where noted, the questions used a Likert scale rating. Responses were given the following numeric values:
5 = Very Satisfied
4 = Satisfied
3 = Neutral
2 = Dissatisfied
1 = Very Dissatisfied
Responses of N/A, or not applicable, were not included in the scoring calculation; however, individuals responding N/A were included in the number of respondents for each question. Respondents were also given the opportunity to provide any comments they felt were important. All comments received are provided in this report and have been deidentified where applicable.

The survey contained questions on five categories: Communication, Provider Relations, Claims Department, Quality Improvement, and Clinical Department. Results are presented by category and include the number of respondents and a mean score for each question. Results from the previous two years surveys have been presented for comparison. Respondents did not answer every question and there were a number of respondents who initiated the survey on QuestionPro

without completing the survey. Therefore, the number of respondents for each question varies and may be higher than the number of completed surveys reported above. Finally, a year to year comparison of scores is provided.

Communication:

Written and Electronic Communication	2016 # of Respondents	2016 Mean Response	2017 # of Respondents	2017 Mean Response	2018 # of Respondents	2018 Mean Response
Notification and implementation of policy changes affecting Providers	69	3.9	93	3.8	114	3.7
Ease of reaching someone who can answer your questions when calling PerformCare	69	3.9	94	3.9	114	3.8
Ease of calling the Provider Line and reaching the person you are calling	63	3.8	88	3.9	114	3.8
When calling the Provider Line, my calls were returned within 48 hours	60	4.1	77	4.1	112	3.9
Ease in using the website	57	3.7	77	3.6	111	3.6
Ease of using Navinet/JIVA	38	3.6	60	3.2	112	2.9
Communication Average	**59**	**3.8**	**82**	**3.8**	**113**	**3.6**

Communication Comments:
At times, policies will change and providers don't find out until afterwards. There has been no clarification of roles document updated for BHRS in about 4 years and providers are just supposed to interpret vague descriptions only to be told in audits that policies are more concrete; however, they are not written anywhere.
PerformCare does a good job with communication, especially the Care Managers who we have contact with on a regular basis.
Navinet wait time for a response is long at times.
All aspects are good for us
PerformCare continued stay reviews are much longer than any other insurance company. I believe the reviewers have a scripted set of questions that they must ask at each review, even though they got this information previously.
Some customer service staff could use additional training on policy/procedures. Can call and ask one person and receive an almost correct answer and call back with the same question and receive full information from another staff member.
Improve the system in place to make us aware if PerformCare clinical care manager is participating in the ISTP meeting
Utilize the Navient system for all referrals and authorization requests. Improve the ease by which policies can be accessed on the PerformCare website.
When dealing with secondary insurance PerformCare should do a better job investigating as far as verifying accuracy of secondary insurance active. Our facility has a lot of issues billing primary insurance (PerformCare) getting denied because their system reflects secondary when that is not accurate.
This year the service has been outstanding so I actually have no complaints or suggestions
My biggest concern is the lack of consistency between Navinet and the EVS systems... and what other system may be internally used. At times the data on these three systems appear to be in conflict.
Be able to view claim status on website.
N/A

It would be helpful if we could get a care connector on the first try. Usually, you need something / information right away. While they do call back pretty quickly, there is the inevitable phone tag that goes on.
That Navinet sends emails to providers when PerformCare is going to attend or not attend a meeting.
None at this time.
Things are good
Email Providers directly when announcing a policy change OR fax them with the changes
The program is not difficult to use, but it is time consuming as client information has to be entered for every submission i.e. client name, diagnosis, demographics

Provider Relations:

Account Executives	2016 # of Respondents	2016 Mean Response	2017 # of Respondents	2017 Mean Response	2018 # of Respondents	2018 Mean Response
When contacting an Account Executive, do you receive satisfactory and timely answers to your questions	52	4	66	4	104	3.9
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	52	3.9	65	3.9	103	3.9
Provider Relations Average	**52**	**4**	**66**	**4**	**104**	**3.9**

Provider Relations Comments:
Since our AE left, I am unsure who our account rep is.
From an administrative viewpoint, we have been dissatisfied with our Account Executive. She has been difficult to get responses from in a timely manner. She has often times canceled scheduled meetings at the last minute, or not communicated changes to scheduled meetings well. She has not been satisfactory with regards to follow up on requested items, in a timely manner.
Depending on who you speak with, that person may not understand billing rules.
Our Account Executive is awesome!
I usually contact by email if any questions
Our provider rep is always there to assist us with our questions or issues. Her response times are amazing along with her follow up
Generally, they are very helpful
Our county reps are very helpful
Concerning the relations of the providers, some of them are not personable at all! They are condescending and speak down to us about our clients and say before the assessment is done that, they will not get funded but that they guess they will continue just to say that it completed. Certain providers are very unpleasant and could use some manners.
I love working with our AE; she gets back to me in a decent time and answers my questions.

Provider Manual	2018 # of Respondents	Daily	Weekly	Monthly	Yearly	Never
How often did you or your Agency's staff reference the PerformCare Provider Manual?	104	0%	6%	38%	42%	13%

When you referenced the PerformCare Provider Manual, how beneficial was it?	2018 # of Respondents	Very Helpful	Somewhat Helpful	Neutral	A Little Helpful	N/A or No Experience
	102	14%	38%	21%	10%	18%

Provider Manual Comments:
Links to endorsed evidence-based practices and/or a list of providers who offer recommended evidence base practices. An example is SBIRT. We are attempting to implement this and I've attempted to get a contact at another provider in the network in order to consult with or get guidance and I have been unsuccessful.
More clear guidelines for clarification of roles
A more concise, clear way to change tax ID.
See very few PerformCare clients so not much use of manual
More information on opioid coverage specific to methadone services and Medicare exclusions covered by PerformCare
List what documents are needed for a continued care packet for CRR HH
More information regarding billing parameters and the utilization of the incident management reporting system. It would be helpful to offer clear expectations for what should be reported as an "incident" and how this information must be communicated.
The occasional strange thing comes up I cannot solve however, sending an email works and the regular problems are in the manual
More info on quality reviews
Credentialing processes are confusing. We are not a large agency and often stumble upon questions that have been difficult and lost valuable time. Also, the process of credentialing takes on average 6 months from beginning to end... frustrating if not a clinic.
Best practices and guidelines for ABA
Manual should include list of relevant memos related to billing, policy, etc. so that providers are aware of what exists
Clarity on hours during which clinical funding calls will be accepted.
Our AE is amazing
Since we are in the mist of changing our Tax ID it would be helpful to have an outlined definitions and actions that need to be taken to do so. As I am finding out there are many different things that have to happen and its very confusing!

Provider Orientation	2018 # of Respondents	2018 Mean Response
An Account Executive was able to answer all of your questions	6	3.5
The information your account Executive provides is helpful and valuable	6	3.5
Provider Orientation Average	**6**	**3.5**

Provider Meetings & Trainings	2016 # of Respondents	2016 Mean Response	2017 # of Respondents	2017 Mean Response	2018 # of Respondents	2018 Mean Response
There is adequate notice to attend any meetings and/or trainings	29	3.9	37	4.2	30	3.9
Availability (dates & locations)	28	3.9	37	4	30	3.8
Usefulness of training(s)	28	3.6	37	3.6	30	3.5
Were you satisfied with the accuracy and clarity of the information presented during the meeting as well as with follow-up from the meeting	29	3.6	38	3.7	30	3.6
Provider Meetings & Trainings Average	**29**	**3.8**	**37**	**3.9**	**30**	**3.7**

Meeting and Trainings Comments:
The Account Executive has requested a meeting with case management staff. The Case Management staff has offered numerous dates/ times for this meeting, but due to late response from AE it became difficult to reserve the room for the meeting and reserve time in case management schedules. Meeting were finally scheduled, only to be cancelled by the AE due to staffing availability issues at PerformCare. Unfortunately, by cancelling just before the meeting, this causes an issue with Case management staff trying to fill that gap of time with consumers to meet productivity.
I would like to see PerformCare offer more clinical trainings such as DBT, Play Therapy, Mindfulness, etc. that would also allow for certifications in certain areas. As a provider, we continue to be asked about specialties of our clinicians but specialized training and certification is extremely expensive and also hard to arrange. It would be helpful if PC would provide this at no cost to providers.
It's hard to hear everyone in those big conference rooms
There are never staff present that can answer providers questions. Always given the answer "we will take it back" and then we never hear back. We have been speaking about the same concerns for 10+ years, with no resolution.

Claims Department:

Claims Processing	2016 # of Respondents	2016 Mean Response	2017 # of Respondents	2017 Mean Response	2018 # of Respondents	2018 Mean Response
Claims payments and/or claims denial letters are received within 45 days	41	4	56	3.6	99	3.9
Satisfactory and timely answers to your questions	47	3.9	66	3.7	100	3.8
Consistency in responses to inquiries	46	3.9	67	3.6	99	3.7
Ease of submitting electronic claims	34	4	45	3.8	100	4.1
Ease of correcting electronic claims	33	3.8	45	3.5	100	3.7
Ease of correcting paper claims	28	3.6	44	3.5	98	3.6
Please rate your overall experience with claims processing from PerformCare	40	3.9	57	3.6	98	3.8
Claims Processing Average	**38**	**3.9**	**54**	**3.6**	**99**	**3.8**

Claims Processing Comments:
Please excuse my answer for "in the past 12 months, how have you submitted your claims" We have not submitted claims in the past 12 months
We are required to submit our claims via paper and it would be very helpful if we could submit them electronically.
I do not have direct experience with this as our Central Business office has a billing dept that submits claims
PerformCare should consider reducing the use of multiple clearinghouse activity to receive claims. Most of our claims go directly to the payer from our clearinghouse or through one additional clearinghouse with claims arriving to the payer within 24-48 hours of submission. PerformCare takes too long and this process may make claims timely.
Submitting secondary claims has been extremely frustrating. Because we use our EHR to submit primary claims, we aren't able to use Change/Emdeon to submit secondary claims and must mail them in. We have received denials that take weeks upon weeks to resolve (e.g., lack of clarity regarding reason for denial). We are grateful for our Account Exec's assistance with these situations, because over the past year or so the Claims Department has become increasing less helpful (e.g., doesn't have answers to questions, whereas two years ago they were very knowledgeable and I could easily get answers/resolution). And the whole process for submitting paper claims is very frustrating, as things that would not be an issue on electronic claims are suddenly "unacceptable" on paper claims.
Emdeon was a total disaster! (on their side). had to go back to paper claims. Navinet still seems to be limited in scope for claims.

Quality Improvement Department:

Credentialing & Re-credentialing	2016 # of Respondents	2016 Mean Response	2017 # of Respondents	2017 Mean Response	2018 # of Respondents	2018 Mean Respons e
Fairness of Credentialing and Re-credentialing process	64	3.7	80	3.6	94	3.5

Administrative Appeals	2016 # of Respondents	2016 Mean Response	2017 # of Respondents	2017 Mean Response	2018 # of Respondents	2018 Mean Response
Adequate explanation of decisions made	22	3.7	17	3.7	30	3.2
Decision regarding your appeal(s) were made within 30 days	22	4	17	3.4	30	3.7
There was a fair & reasonable decision outcome	22	3.7	15	3.6	30	3.2
Administrative Appeals Average	**22**	**3.8**	**16**	**3.6**	**30**	**3.4**

Complaints	2018 # of Respondents	2018 Mean Response
Timeliness of complaint resolution:	7	3.6
Proper handling of complaint:	7	3.8
A fair and reasonable decision was made:	7	3.6
Complaints Average	**7**	**3.7**

Grievances	2016 # of Respondents	2016 Mean Response	2017 # of Respondents	2017 Mean Response	2018 # of Respondents	2018 Mean Response
Timeliness of grievance resolution	5	3.8	14	4.1	12	3.6
Collaborative nature of the grievance meeting	5	3.6	14	3.9	12	3.3
Your involvement in the grievance process	5	3.6	14	3.9	12	3.7
Overall, rate PerformCare's management of the grievance process	5	3.6	14	3.9	12	3.3
Grievances Average	**5**	**3.7**	**14**	**3.9**	**12**	**3.5**

Treatment Record Reviews	2016 # of Respondents	2016 Mean Response	2017 # of Respondents	2017 Mean Response	2018 # of Respondents	2018 Mean Response
Do you understand the expectations of the questions in the Treatment Record Review	5	3.6	15	3.2	14	3.9
Do you feel the process was fair	5	3.6	15	3.3	14	3.8
Do you feel the Treatment Record Review process was helpful	5	3.6	15	3.5	14	3.5
Were you satisfied with any assistance provided by the Quality Improvement Department	5	3.6	14	3.8	14	3.8
Treatment Record Review Average	**5**	**3.6**	**15**	**3.4**	**14**	**3.8**

Quality Improvement Comments:
Administrative Appeals are unfair. When PerformCare makes a mistake, which results in them denying payment, it should not be left on the provider to have to do the work to submit an admin appeal to request payment. This is additional work on the provider for errors that they did not make. PerformCare should be fixing the errors on their end and taking the responsibility off the Provider. If the error was the Provider's fault, that is a different story. At that point, I don't even spend the time completing the appeal, because they always get denied if the fault is with the provider. Again, not really fair because sometimes people do make mistakes.

Clinical Department:

Care Management	2016 # of Respondents	2016 Mean Response	2017 # of Respondents	2017 Mean Response	2018 # of Respondents	2018 Mean Response
Timeliness of authorizations	52	3.8	68	4.2	98	4.1
Accuracy of authorizations	53	4	68	4.2	97	4.0
Availability of Clinical Care Managers when needed	52	3.7	68	4.1	97	3.9
Consistency in Care Manager's responses to your inquiries	52	4	63	4.2	97	3.9
Consistency in Care Manager's review of child/adolescent treatment plans	22	3.8	39	3.9	96	3.9
Care Managers participation in ISPT meetings (for children/adolescents)	16	3.4	34	3.8	95	3.8
Please rate the overall process by which concurrent reviews are conducted; is it consistent and effective in determining the need for continued treatment	47	3.8	55	3.9	96	4.0
Care Management Averages	**42**	**3.8**	**56**	**4**	**97**	**3.9**

Care Management Comments:
As an FQHC, the services we provider are mostly medical - primary care and dental; however, with an integrated behavioral health program and a suboxone program on site, we are equipped to assist patients with both medical and behavioral health issues. the lack of availability of care management resources for the adult population makes it challenging to manage patients with higher behavioral health needs. attempts to contact the clinical department have typically failed.
Some Care Managers are really great with support and participation when requested. Some are not in the loop at all and difficult to get a hold of.
The PerformCare managers are very involved in the client's meetings - great collaboration with many if not all!
Reviews could be more tailored to the program's availability due to the enormity of work clinicians are already required to do.
Some care managers are better at participating in treatment team meetings than others.
I only rarely do BHRS evals for Perform Care members. My only complaint is that you mandate a certain form be done that you have to be certified to do, but it doesn't make sense for me to take all this training and get certified regularly if I only see about one of your clients (if that) for an eval each year. I have been able to get exempt from this but it takes numerous phone calls to do this. It would be nice if this exemption could automatically be tied to providers like me.
I work mainly with Clinical Care Manager. She is knowledgeable, helpful, timely, accommodating, and often provides clinical feedback in thinking outside of the box to fit the needs of the child in treatment. She goes above and beyond. We appreciate her hard work.
Great team of individuals who are always very helpful, responsive and polite when interacting with members and professionals.
We just started needing authorizations for one of our services and it has been going as well as I can expect.
CCM continues to be an accommodating reviewer, we enjoy working with her.

Excellent investment in the clients.
It is difficult to box clinical staff in to a particular day or time frame when doing reviews due to working with people who often have crises or other demands within the program.
It would be nice for authorizations to be electronic instead of still being in paper form. I oversee Franklin and Fulton and York and Adams Counties which use CCBH and they have switched over to electronic authorizations which make a world of difference!
We do not receive denial letter in a timely manner or at all.

Member Services	2016 # of Respondents	2016 Mean Response	2017 # of Respondents	2017 Mean Response	2018 # of Respondents	2018 Mean Response
Satisfactory and timely answers to your questions	56	4	65	3.9	97	3.9
Consistency in response to inquiries	56	3.8	65	3.8	96	3.8
Directing your call to appropriate department/care manager	56	4	65	4	98	4.0
Availability of Member Services staff after hours	32	3.5	32	3.9	96	3.7
When calling Member Services, if I had a problem, the person I spoke with helped to resolve it satisfactorily	48	3.8	55	3.2	97	3.9
Member Services Averages	**50**	**3.8**	**56**	**3.8**	**97**	**3.9**

Member Services Comments:
Helpful; Knowledgeable staff
Care Managers are not always consistent with information that they provide. This can be very frustrating.
As previously mentioned, some staff could use additional training
There was one member services staff member who was rude every time we called, however we have not spoken to her for several months, she may no longer be there.
Member services have really known most of the clients that I have shared and were very invested in trying to help the members.
The people who answer the phones are very helpful and polite.

Other Additional Comments:
PerformCare is always very helpful with re-credentialing process.
As a provider, PerformCare is responsible for identifying a CRRHH when this recommendation is made from our level of care. It is not felt that there is adequate communication from PC to us, as the provider, on the progress being made during this search.
Generally, our experience with PerformCare has been excellent. Customer service, especially from two AE's has been exceptional.

Year to Year Comparison:

Survey Category	2012	2014	2015	2016	2017	2018
Communication	3.6	3.5	3.6	3.8	3.8	3.6
Provider Relations	4	3.7	3.2	4	4	3.9
Provider Orientation	4	3.3	N/A	N/A	N/A	3.5
Provider Meetings & Trainings	4	3.8	4.5	3.8	3.9	3.7
Claims Processing	3.6	3.5	3.9	3.9	3.6	3.8
Administrative Appeals	3.3	2.9	3.8	3.8	3.6	3.4
Credentialing & Re-credentialing	N/A	3.6	2.8	3.7	3.6	3.5
Complaints	3.5	3.3	N/A	N/A	N/A	3.6
Grievances	3.8	3.2	4.2	3.7	3.9	3.5
Treatment Record Reviews	N/A	N/A	N/A	3.6	3.4	3.8
Clinical Care Management	3.6	3.5	3.2	3.8	4	3.9
Member Services	3.9	3.7	3.9	3.8	3.8	3.9
Average Total Score	**3.7**	**3.4**	**3.8**	**3.8**	**3.8**	**3.7**
Total Number of Respondents	67	66	60	64	82	98
Response Percentage of Total Surveys Sent	21%	33%	25%	26%	30%	34%

Summary:

The 2018 CABHC Provider Satisfaction Survey yielded the highest response rate, 34%, and the highest number of respondents, 98, since beginning the survey in 2012. The survey contained questions on five categories: Communication, Provider Relations, Claims Department, Quality Improvement Department, and Clinical Department. The Survey's Communication category had the highest number of respondents with 113. Subsections of the Quality Improvement Department category had the lowest number of respondents, this was noted for Complaints, Grievances, and Treatment Record Reviews. These are continuing trends from the previous year.

For the Communications section, the overall score decreased slightly from the previous year. The two items with the biggest decrease in score were: "Ease of using Navinet/JIVA" which fell below a score of 3 and "When calling the Provider line, my calls are returned within 48 hours". The comments for this section touched on Navinet/JIVA as being easy to use, but that it takes too long and can be slow. There were also a few comments pertaining to providers wanting notification on whether a CCM was attending a meeting.

The Provider Relations section covered Account Executives, the Provider Manual, Provider Orientation, and Provider Meetings and Trainings. Overall the scores for this section decrease slightly from the previous year with the most notable decreases seen in the Provider Meetings and Trainings section. The comments concerning the Account Executives were mainly positive, however, there were some comments related to difficulties with scheduling meetings with AE's. The comments relating to the Provider Manual contained many suggestions on items that Providers would like to see added to the manual to better assist them.

The Claims Department section of the survey had nearly double the number of respondents in 2018 than in 2017 and scored higher on all seven questions in the survey. The comments in this section dealt mainly with paper versus electronic claims and some frustrations with having to use paper claims.

The Quality Improvement Department section of the survey covered Credentialing and Re-credentialing, Administrative Appeals, Complaints, Grievances, and Treatment Record Reviews. The overall scores went down for Credentialing and Re-credentialing, Administrative Appeals, and Grievances. The most notable decrease was seen in the Grievances section with decreases in all four questions for this section. The Treatment Record Reviews section showed increases in the score when compared to last year. There was only one comment for this piece of the survey and it was related to the "unfairness" of Administrative Appeals.

The Clinical Department section of the survey covered Care Management and Member Services. In comparing the results of the 2018 survey to the previous year, the Care Management section scores stayed the same for two questions and decreased slightly for four of the questions. The most notable decrease was observed for the item "Consistency in Care Managers responses to your inquires". The comments for this section were mainly positive, stating that the Care Managers are helpful, knowledgeable, responsive, and accommodating. One comment noted a lack of Care Management resources for the adult population. For the Member Services section of the survey, the overall score on this segment increased with the most notable increase seen in the item "When calling Member Services, if I had a problem, the person I spoke with helped resolve it satisfactorily". Again, the comments for this section were mainly positive.

CABHC is grateful for the Providers who participated in this annual Provider Satisfaction Survey. Our Provider Relations Committee reviews the results of the survey to provide feedback and recommend changes to PerformCare as needed. We hope that this process will enhance the HealthChoices Behavioral Health program throughout Cumberland, Dauphin, Lancaster, Lebanon, and Perry Counties.