CAPITAL AREA BEHAVIORAL
HEALTH COLLABORATIVE, INC.
Established October 1999

2019 CABHC Provider Satisfaction Survey Report

On an annual basis, CABHC conducts an assessment of the its 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 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 November 2019, the survey was sent via email to 276 providers. Of the 276 surveys, 86 were completed in full resulting in a 31% response rate. In past years, the response rate has been calculated using the number of surveys sent, less the surveys that were returned undeliverable; however, information on the number of surveys that were undeliverable was not available for the 2019 report.

Demographics:

Age Groups Served by Respondents:

Children/Adolescents	19%
Adults	33%
Both Age Groups	48%

Levels of Care Provided by Respondents:

Substance Abuse	16%
Mental Health	53%
Co-Occurring	13%
All Levels of Care	18%

2019 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. For each category,

the results from the previous two years surveys have been presented for comparison. Finally, a year to year comparison of scores from 2014 through 2019 is provided.

Please note that 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.

Communication:

Written and Electronic Communication	2017 Respondents	2017 Mean Score	2018 Respondents	2018 Mean Score	2019 Respondents	2019 Mean Score
Notification and implementation of policy changes affecting Providers	93	3.8	114	3.7	102	3.7
Ease of reaching someone who can answer your questions when calling PerformCare	94	3.9	114	3.8	101	3.9
Ease of calling the Provider Line and reaching the person you are calling	88	3.9	114	3.75	101	3.8
When calling the Provider Line, my calls were returned within 48 hours	77	4.1	112	3.9	99	3.8
Ease in using the website	77	3.6	111	3.6	98	3.7
Ease of using Navinet/JIVA	60	3.2	112	2.9	99	3.7
Communication Average	**82**	**3.8**	**113**	**3.6**	**100**	**3.7**

Communication Comments:
I have no issues getting ahold of our account representative, but I don't always think that things are communicated efficiently. I would suggest that provider reps notify facilities and offices with major updates or changes. Things are missed via the portal messages, or staff turnover.
Overall, we are highly satisfied with the relationship
Have Clinical Care Managers answer their phones.
I don't normally call the communication line. I communicate primary by email. When emailing my rep she responds to me pretty quickly and tries to answer my questions in a timely manner.
It is nice that the AE's send out email communication and reminders when policies are updated. I also like that Webinar Trainings are also sent via email to ensure that providers receive them in a timely manner.
I usually see private insurance but I do see some Medicaid. I probably shouldn't have filled this out
Send communications in a timely manner to avoid mis- communication and potential errors.
Thank you for this opportunity.
Need more communication with the provider reps
Care managers vary in how quickly they return calls.

Provider Relations:

Account Executives	2017 Respondents	2017 Mean Score	2018 Respondents	2018 Mean Score	2019 Respondents	2019 Mean Score
When contacting an Account Executive, do you receive satisfactory and timely answers to your questions	66	4	104	3.9	93	3.8
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	65	3.9	103	3.9	94	3.8
Provider Relations Average	**66**	**4**	**104**	**3.9**	**94**	**3.8**

Provider Relations Comments:
I have no issues communicating with our PR person X. We also have XX, however I believe the history we have with X has us contacting her more frequently even if it's for Franklin County issues. It's a bit confusing to have two PR's.
Overall good
none
I haven't had direct experience with contacting Provider Relations.
AE often ignores questions that may require more in-depth answers. Care connectors and care managers overall are very helpful.
We enjoy our Provider Relations/Account Executive. She is very very helpful.
When you meet with someone directly, and ask a direct question, it would be helpful to receive a clear answer. It is incredibly frustrating when you receive an answer that could mean multiple things, of when you receive one answer one time, and the next time you speak to the same person they provide a different answer about the same item. A clear, concise answer would be appreciated every time.
Again, care managers are great and so helpful!
See prior comment.
When pre-certing/authorizing hospitalizations, we have to be part of three phone calls. One is for the demographics call. Then the clinical coordinator calls back for clinicals. This is the only MA provider that makes you call back with the time they arrive to the unit. This extra call is unnecessary, since this information can be later discovered at the UR review. It wastes the time of Perform Care staff, and the people involved with insurances.
Very helpful with answering questions

Provider Manual	2019 Respondents	Daily	Weekly	Monthly	Yearly	Never
How often did you or your Agency's staff reference the PerformCare Provider Manual?	95	2%	11%	45%	31%	12%

When you referenced the PerformCare Provider Manual, how beneficial was it?	2019 Respondents	Very Helpful	Somewhat Helpful	Neutral	A Little Helpful	Not Helpful at All	N/A or No Experience
	94	12%	48%	14%	10%	2%	15%

Are there topics you believe should be added to the Provider Manual to make it more clear?	2019 Respondents	Yes	No
	88	11%	89%

If an individual answered 'yes' to this item, they were prompted to please add suggestions or comments. The following comments were received:

Provider Manual Comments:
I don't need to access the provider manual in my current position.
none
Perhaps list benefits or regulatory exclusions of FQHC's?
It is difficult to find the information I need in there
authorizations for different level of care. information about claim differences.
Performance Standards
List who can bill what codes and what modifiers can be used for the providers
Much of the issue I run into is with 'interpretation' of the laws/definitions and it seems no one is typically willing to expressly define what the State is defining and so it leaves it up to some shades of gray that are not always easy to navigate. So, generally, having clarity is always appreciated. I would also appreciate more information on testing and assessment guidelines, particularly how PC is taking hour long and 30 minute unites and combining them in a way that makes understanding what is being covered and paid for very clear for the evaluator.
It can be difficult to find things in the provider manual
Long hold times
Denial of service, grievance and continuation rights process.
I expect some changes now with IBHS
Sometimes the bed search isn't completed and crisis staff have to do this on their own. They also do not call at shift changes and periods of time with updates. It would help if X would be more personable and patient. It would also help if XX would show more motivation

Provider Orientation	2018 Respondents	2018 Mean Score	2019 Respondents	2019 Mean Score
An Account Executive was able to answer all of your questions	6	3.5	1	4
The information your account Executive provides is helpful and valuable	6	3.5	1	4
Provider Orientation Average	**6**	**3.5**	**1**	**4**

Provider Meetings & Trainings	2017 Respondents	2017 Mean Score	2018 Respondents	2018 Mean Score	2019 Respondents	2019 Mean Score
There is adequate notice to attend any meetings and/or trainings	37	4.2	30	3.9	44	4.0
Availability (dates & locations)	37	4	30	3.8	44	4.0
Usefulness of training(s)	37	3.6	30	3.5	44	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	38	3.7	30	3.6	43	3.6
Provider Meetings & Trainings Average	**37**	**3.9**	**30**	**3.7**	**44**	**3.8**

Meeting and Training Comments:
inefficient use of time
The data that is delivered and reviewed during AE Meetings is different from the data that we specifically collect and report on as a provider, so it is useless. I am not sure how the data is pulled, but it doesn't match and, therefore, we do not use it.
Individuals running provider meetings seem to be uninformed on many topics.
Would be helpful that PerformCare staff that make the decisions attend the provider meetings. Many questions cannot be answered during the meetings.
Unfortunately; it is tough for PerformCare to give answer, when they still dont have the answer from the state.
It would be better to have more variety in times so that at least one person from each agency is able to attend.
minimal info about IBHS

Claims Department:

Claims Processing	2017 Respondents	2017 Mean Score	2018 Respondents	2018 Mean Response	2019 Respondents	2019 Mean Score
Claims payments and/or claims denial letters are received within 45 days	56	3.6	99	3.9	92	3.8
Satisfactory and timely answers to your questions	66	3.7	100	3.8	92	3.7
Consistency in responses to inquiries	67	3.6	99	3.7	90	3.7
Ease of submitting electronic claims	45	3.8	100	4.1	92	3.9
Ease of correcting electronic claims	45	3.5	100	3.7	92	3.7
Ease of correcting paper claims	44	3.5	98	3.6	90	3.4
Please rate your overall experience with claims processing from PerformCare	57	3.6	98	3.8	92	3.6
Claims Processing Average	**54**	**3.6**	**99**	**3.8**	**91**	**3.7**

Claims Processing Comments:
I have no experience with the claims process
Submission process for TPL claims is extremely time consuming Can't this be electronic?
none
I could not access the Change Healthcare site and could not get them to respond to inquiries from me
I think it is unfair to begin timely filing at the beginning of a date range. the clock for timely filing should start at the end, for monthly claims (which is how I've been instructed to bill inpatient), issues are already 30 days behind when they are filed.
I do not have any direct experience submitting claims to PerformCARE.
The process of submitted COB's claims is very time consuming.
We receive far too many erroneous denials. Claims submitted since the July 1 rate increase have been an absolute nightmare, as rates were not updated and now we are receiving overpayments due to incorrect allowable amounts. This is causing an incredible amount of extra work for our small office.
I've had issues with correcting claims. There is a reference number located on the letter that I get back when something is denied and I need to submit. If I use that reference number it gets denied again. It is unclear on the letter that it needs to be the original claim number
submitted through centralized business office so I have no clue
In the past 12 months, how have you submitted your claims? Electronic and Paper
Submitting claims electronically is a breeze. Adjusting denied claims is simple as well, if you know what you're doing. The one negative aspect I have found is trying to get answers from your representatives on how to adjust claims, or how to receive a denied claims report. When your representative was asked how do we know what is denied, I was told, 'you need to view the ACK Report, but I can't tell you how or where to go to review that.' That is incredibly frustrating. Your representatives should be trained to know exactly where to tell me to go to view the report or how to gain access to it.
Nonstandard location code forces manual adjustments to electronic claims. Medicare code is@2, PerformCare is 11, requires clumsy work around n my EHR. I am forced to st paper CMS150 to PerformCare when Highmark is primary and PerformCare is secondary

Quality Improvement Department:

Credentialing & Re-credentialing	2017 Respondents	2017 Mean Score	2018 Respondents	2018 Mean Score	2019 Respondents	2019 Mean Score
Fairness of Credentialing and Re-credentialing process	80	3.6	94	3.5	86	3.8

Administrative Appeals	2017 Respondents	2017 Mean Score	2018 Respondents	2018 Mean Score	2019 Respondents	2019 Mean Score
Adequate explanation of decisions made	17	3.7	30	3.2	24	3.4
Decision regarding your appeal(s) were made within 30 days	17	3.4	30	3.7	24	3.6
There was a fair & reasonable decision outcome	15	3.6	30	3.2	23	3.4
Administrative Appeals Average	**16**	**3.6**	**30**	**3.4**	**24**	**3.5**

Complaints	2018 Respondents	2018 Mean Score	2019 Respondents	2019 Mean Score
Timeliness of complaint resolution:	7	3.6	2	4
Proper handling of complaint:	7	3.8	2	4
A fair and reasonable decision was made:	7	3.6	2	4
Complaints Average	**7**	**3.7**	**2**	**4.0**

Grievances	2017 Respondents	2017 Mean Score	2018 Respondents	2018 Mean Score	2019 Respondents	2019 Mean Score
Timeliness of grievance resolution	14	4.1	12	3.6	10	4.1
Collaborative nature of the grievance meeting	14	3.9	12	3.3	10	4
Your involvement in the grievance process	14	3.9	12	3.7	10	3.9
Overall, rate PerformCare's management of the grievance process	14	3.9	12	3.3	10	4
Grievances Average	**14**	**3.9**	**12**	**3.5**	**10**	**4**

Treatment Record Reviews	2017 Respondents	2017 Mean Score	2018 Respondents	2018 Mean Score	2019 Respondents	2019 Mean Score
Do you understand the expectations of the questions in the Treatment Record Review	15	3.2	14	3.9	11	4.1
Do you feel the process was fair	15	3.3	14	3.8	11	4.2
Do you feel the Treatment Record Review process was helpful	15	3.5	14	3.5	11	4.1
Were you satisfied with any assistance provided by the Quality Improvement Department	14	3.8	14	3.8	10	4.1
Treatment Record Review Average	**15**	**3.4**	**14**	**3.8**	**11**	**4.1**

Clinical Department:

Care Management	2017 Respondents	2017 Mean Score	2018 Respondents	2018 Mean Score	2019 Respondents	2019 Mean Score
Timeliness of authorizations	68	4.2	98	4.1	87	4.0
Accuracy of authorizations	68	4.2	97	4.0	87	3.9
Availability of Clinical Care Managers when needed	68	4.1	97	3.9	86	3.7
Consistency in Care Manager's responses to your inquiries	63	4.2	97	3.9	84	3.9
Consistency in Care Manager's review of child/adolescent treatment plans	39	3.9	96	3.9	86	3.8
Care Managers participation in ISPT meetings (for children/adolescents)	34	3.8	95	3.8	86	3.6
Please rate the overall process by which concurrent reviews are conducted; is it consistent and effective in determining the need for continued treatment	55	3.9	96	4.0	85	3.9
Care Management Averages	**56**	**4**	**97**	**3.9**	**86**	**3.8**

Care Management Comments:
I have no UR experience with PC.
Do away with 35-page treatment plans for BHRS Completely unnecessary
TCM authorization notices are not coming to our office with any regularity. we have to constantly call member services to get authorization codes start dates etc.
It would be good for us to be notified ahead of time if our ongoing reviewer will be changing for any reason. Overall, we have had good interaction with reviewers. We have no complaints about the care managers.
when attempting to address the needs of adult patients, it is difficult to connect with a care manager and/or supervisor.
I do not have direct experience with this, but I am hearing that these reviews can be very lengthy which takes more resources on the program end.
Care managers vary in their response time to questions.
Some care managers are very helpful and consistent while others cause unnecessary follow up. There seems to be different expectations depending on what care manager you are dealing with. Some are too involved and cause conflict with members though are unwilling/unavailable to step in then when needed.
Hoping the massive BHRS packets and 50-page treatment plans are a thing of the past with IBHS coming
care managers are very helpful
On a few occasions' authorizations were approved for different codes than what was requested, and after speaking to care manager they admitted it was an error. Many care managers take more than 48hrs to return calls

Member Services	2017 Respondents	2017 Mean Score	2018 Respondents	2018 Mean Score	2019 Respondents	2019 Mean Score
Satisfactory and timely answers to your questions	65	3.9	97	3.9	87	3.8
Consistency in response to inquiries	65	3.8	96	3.8	86	3.9
Directing your call to appropriate department/care manager	65	4	98	4.0	87	3.9
Availability of Member Services staff after hours	32	3.9	96	3.7	86	3.8
When calling Member Services, if I had a problem, the person I spoke with helped to resolve it satisfactorily	55	3.2	97	3.9	87	3.8
Member Services Averages	**56**	**3.8**	**97**	**3.9**	**87**	**3.8**

Member Services Comments:
I have no experience working with member services.
we have only had minor difficulties with one member services person otherwise they are fast, friendly, knowledgeable and very fun to work with.
X is not always the most pleasant sounding on the phone
I do not have direct experience with contacting Member Services.

Other Additional Comments:
Love PC staff. Have not personally had any notable issues related to PC. I will pass this survey to others in the facility who could be of more assistance in answering some of these questions. Thank you!
The time needed for timely filing for primary and secondary claims needs extended. There also needs to be some exceptions for timely filing of secondary claims when the member doesn't notify the provider in a timely manner that they have MA as a secondary insurance causing the claims to be denied for timely filing when it was the member who never notified the provider.
When calling for authorization for IP, the process requires 3 calls/touch points and is time consuming. It would a good goal to reduce wait time and number of calls for authorizations. Staff are always friendly and helpful during the process.

Year to Year Comparison:

Survey Category	2014	2015	2016	2017	2018	2019
Communication	3.5	3.6	3.8	3.8	3.6	3.7
Provider Relations	3.7	3.2	4	4	3.9	3.8
Provider Orientation	3.3	N/A	N/A	N/A	3.5	4
Provider Meetings & Trainings	3.8	4.5	3.8	3.9	3.7	3.8
Claims Processing	3.5	3.9	3.9	3.6	3.8	3.7
Administrative Appeals	2.9	3.8	3.8	3.6	3.4	3.5
Credentialing & Re-credentialing	3.6	2.8	3.7	3.6	3.5	3.8
Complaints	3.3	N/A	N/A	N/A	3.6	4
Grievances	3.2	4.2	3.7	3.9	3.5	4
Treatment Record Reviews	N/A	N/A	3.6	3.4	3.8	4.1
Clinical Care Management	3.5	3.2	3.8	4	3.9	3.8
Member Services	3.7	3.9	3.8	3.8	3.9	3.8
Average Total Score	**3.4**	**3.8**	**3.8**	**3.8**	**3.7**	**3.8**
Total Number of Respondents	66	60	64	82	98	86
Response Percentage of Total Surveys Sent	33%	25%	26%	30%	34%	31%*

* In past years, the response rate has been calculated using the number of surveys sent, less the surveys that were returned undeliverable. Information on undelivered surveys was not available for the 2019 report.

Summary:

The 2019 CABHC Provider Satisfaction Survey yielded a response rate of 31% and had a total average score of 3.8 out of a possible 5. This is a slight improvement from 2018. 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 100. 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 increased slightly from the previous year. The item with the biggest increase in score was: “Ease of using Navinet/JIVA” which scored a 3.7 compared to 2.9 in 2018. The comments for this section were mainly positive.

The Provider Relations section covered Account Executives, the Provider Manual, Provider Orientation, and Provider Meetings and Trainings. Overall, the scores for this section had little change compared to the previous year. The comments concerning the Account Executives were mainly positive, however, there were some comments related to not getting clear answers from 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. All comments received related to Provider Meetings and Training were negative.

The Claims Department section of the survey showed a decrease in the total average score, with five of the seven items scoring lower than in 2018. The items with the biggest decrease were “Ease of submitting electronic claims”, “Ease of correcting paper claims”, and “Rate your overall experience with claims processing from PerformCare”. The comments in this section were mainly frustrations with various aspects of the claims process.

The Quality Improvement Department section of the survey covered Credentialing and Re-credentialing, Administrative Appeals, Complaints, Grievances, and Treatment Record Reviews. The overall scores in all five areas went up in 2019 with the most improvement seen in Grievances. There were no comments for this section.

The Clinical Department section of the survey covered Care Management and Member Services. In comparing the results of the 2019 survey to the previous year, the Care Management section scores decreased slightly for six of the seven questions. The most notable decreases were observed for the items “Availability of Care Managers when needed” and “Care Managers participation in ISPT meetings”. The comments for this section were varied and included positive feedback and frustrations. For the Member Services section of the survey, the scores decreased slightly on all five items. There were no concerning comments for this section.

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.