ValueOptions-KS:

Fiscal Year 2010
Provider Satisfaction Survey

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OBJECTIVES

The survey questionnaire was developed collaboratively between ValueOptions and Fact Finders. A primary objective in designing this questionnaire was to incorporate questions about each aspect of ValueOptions' services that providers may consider when deciding to join or remain in the ValueOptions provider network.

SAMPLE DESIGN

The population surveyed in this research is comprised of ValueOptions-KS providers who were in the Medicaid and/or (SAPT) Block Grant network from July 1, 2009 – June 30, 2010. Providers also had to be active in the network at the time the survey was conducted.

QUESTIONNAIRE DEVELOPMENT

The questionnaire development involves collaboration between Fact Finders, Inc. and the ValueOptions National office. Questions are then customized to the Kansas contract. The question "does your location receive funding through other managed care companies" was added. The question "how would you rate the Medical Director on being professional and courteous" was edited and the words "and courteous" were removed.

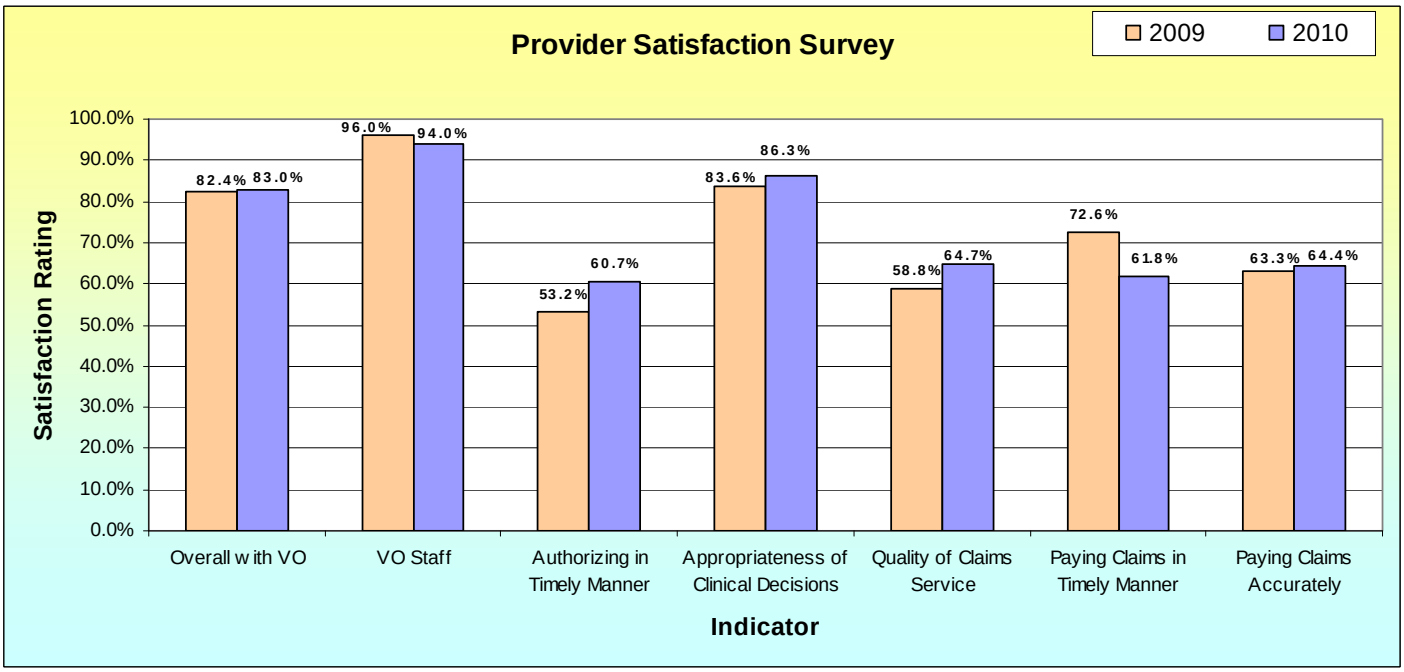
DATA COLLECTION

An online survey tool called SurveyMonkey was utilized to collect the data for this timeframe. An e-mail with the survey link was sent to at least one person in every provider location on June 28, 2010. A reminder e-mail was sent to the same group of providers on July 6, 2010. Similarly to last year, providers had ten calendar days to complete the survey. Ninety five providers responded to the survey during this timeframe (an increase from the eighty five respondents in the previous year). In order to elicit an unbiased response, no provider identifiable information was collected.

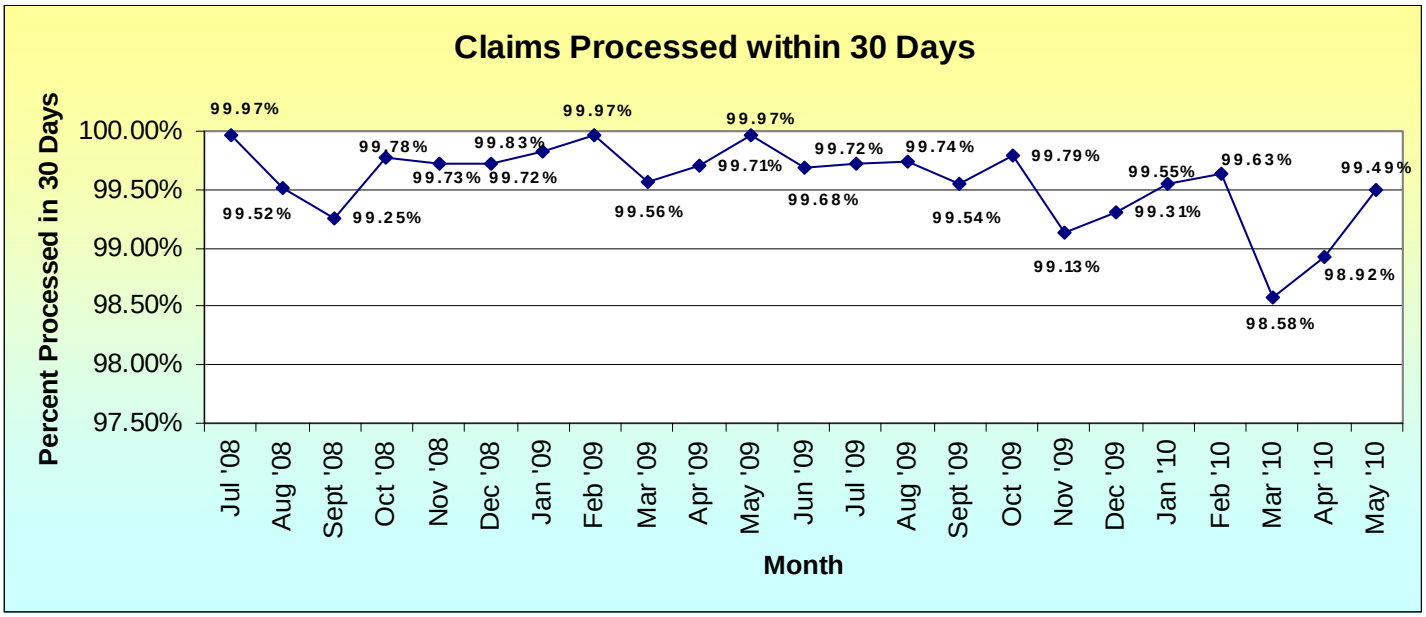
ANALYSIS

This is the third annual provider satisfaction survey conducted for the ValueOptions-KS network. Other than where noted in the questionnaire development section above, data collection procedures and survey tool were consistent for the past two years. Overall, 83.0% of providers surveyed were satisfied with ValueOptions. 78.8% of providers responded that ValueOptions had gotten much better or gotten better. However, one provider commented that there needed to be a "stayed the same" option added. This option was included in the first fiscal year measurement but was removed in order to be compliant with the recommendations from an independent audit of the survey tool.

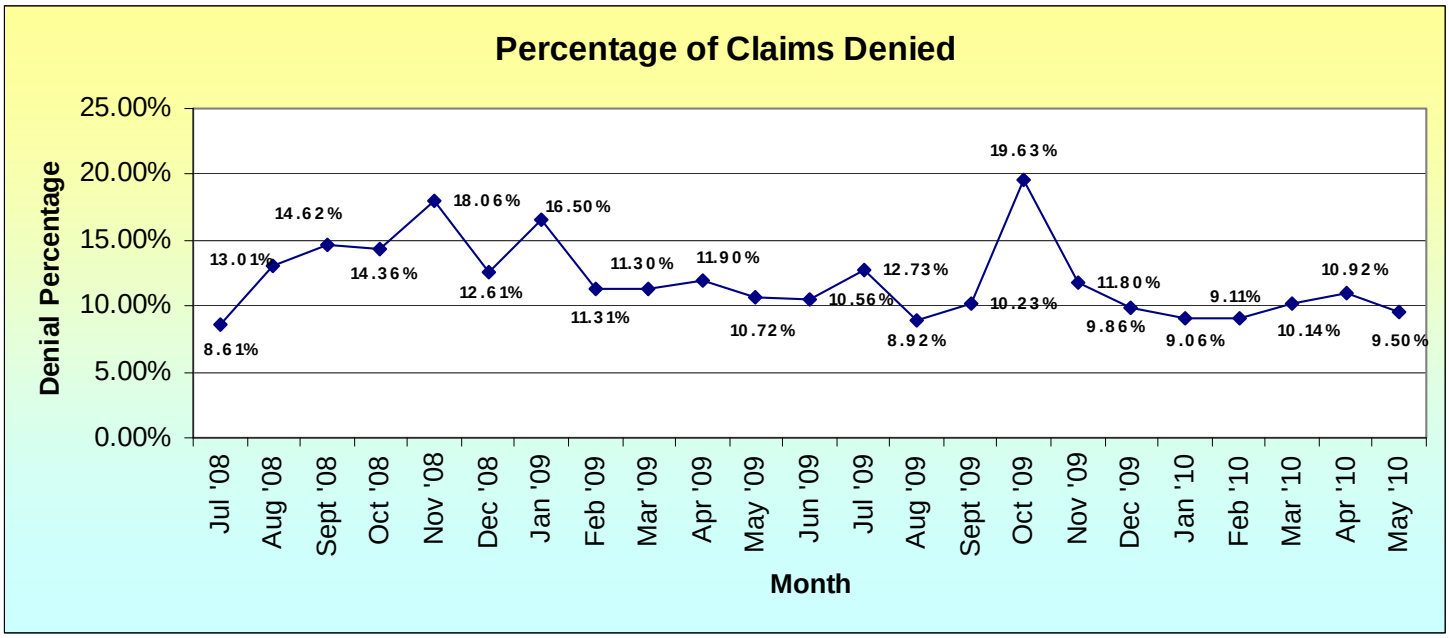
Satisfaction scores for every indicator related to authorizations were higher than in the previous year. The scores most improved were related to ease of initial authorization and authorizing care in a timely manner.



Scores related to the satisfaction claims processes were low this year in comparison to other questions. The most notable difference in scores came from a question related to the timeliness of claims payment. 61.8% of providers rated ValueOptions very good or good, compared to 72.6% one year ago.



ValueOptions is contractually obligated to process claims within 90 days of receipt. Per the chart above, this standard is exceeded by processing over 99% of claims within 30 days. Issues related to members with Medicaid spenddown has resulted in 233 claim lines processing outside of the 90 day requirement (.07% of the claim lines processed in FY '10). ValueOptions continues to work with the fiscal vendor to resolve these issues. Denial rates were also analyzed to see if there was a relationship between claims payment and timeliness. Per the chart below, claims denial rates are consistently lower than in previous years. In order to address the perception of untimely claims payment, the National Director of Claims Payment will be in Kansas for a face to face meeting with providers in July. She will hold a workshop to explain ValueOptions claims submission and payment procedures as well as answer individual provider questions.



Several open-ended questions were asked of providers. Twenty-eight providers had suggestions for improving the authorization procedures. The improvement suggested the most often was clinical staff being more flexible in the interpretation of ASAM placement criteria. Improvements to the KCPC and ease of the authorization procedures were also listed as opportunities for improvement. In order to address provider concerns in a more timely manner, the Director of Clinical Operations now attends Regional Quality Improvement Committee meetings.

When asked what evidence-based practices were used at their facility, a majority of providers responded that cognitive behavioral therapy (CBT) was used. This is similar to the results from the previous year and may be because other funding streams at provider locations require CBT for their clients.

Providers were also asked to make suggestions to improve services as well as to list ValueOptions services they were most satisfied with over the last fiscal year. The top three categories where improvements were suggested were clinical processes, billing/claims processes and communication. Some providers also perceived clinical denials as a way for ValueOptions to save money. ValueOptions staff will review the provider suggestions and develop interventions, including education, whenever possible.

When asked about the area of services they are most satisfied with, the answer given the most by providers was the helpfulness and friendliness of the ValueOptions of Kansas staff. This is consistent with the responses given for the same question in previous years.