



*Delaware Health  
And Social Services*

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**DIVISION OF MANAGEMENT SERVICES**

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PROCUREMENT

PSC#0704

DATE July 21, 2006

EXTERNAL QUALITY REVIEW ORGANIZATION

FOR

DIVISION OF MEDICAID AND MEDICAL  
ASSISTANCE

Date Due: August 15, 2006  
11:00 AM

ADDENDUM # 2

PLEASE NOTE

THE ATTACHED SHEETS HEREBY BECOME A PART OF THE ABOVE  
MENTIONED BID.

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SANDRA S. SKELLEY, CPPO, CPPB  
PROCUREMENT ADMINISTRATOR  
(302) 255-9291

\_\_\_\_\_  
MARY MARINARI (302) 255-9548

October 17, 2005

Provider Satisfaction Survey  
State of Delaware  
Department of Health and Social Services

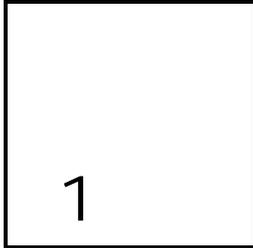
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Government Human Services Consulting

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## Executive Summary

To fulfill an external quality review (EQR) activity, a Provider Satisfaction Survey was completed between July and September 2005. This is the second year of administering a satisfaction survey for PCP's. The purpose of the Provider Satisfaction Survey was to solicit input from primary care providers (PCPs) regarding levels of satisfaction with services provided by two health plans: Diamond State Partners (DSP) and Delaware Physicians Care, Inc. (DPCI), providing care to Delaware Medicaid members. The survey was intended to measure satisfaction with services in the following categories:

- Access to Care;
- Quality of Care; and
- Operational and Administrative Efficiency and Effectiveness.

The survey document was distributed to all participants by mail, using a mailing list provided by the Health Benefits Manager. At the same time the survey was also made available on the Internet and could be completed online. There were 1,600 surveys distributed to PCPs and Advanced Practice Nurses (APNs). Of the surveys distributed, 410 were returned with only 93 surveys completed to a degree that they were usable for analysis. Many were returned with incorrect addresses. The number of viable returned surveys resulted in a response rate of 7 percent. Most responses were received by mail; however, 29 were completed online.

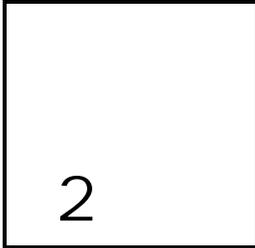
Demographic findings from the Provider Satisfaction Survey indicated that the majority of respondents were in office practices, with over 52 percent in solo office practices and 42 percent in group practice. Only 16 percent have contracts with 1 – 5 health plan networks and 84 percent of the respondents have contracts with 6 or more health plan networks. The fact that physician offices interface with multiple health plans highlights the importance of accessibility, ease of use of services, and timely managed care organization's (MCO) responses.

The majority of responses indicated that access to member information when needed was good to excellent for Delaware Medical Assistance Program (DMAP)/DSP rating a score of 91 percent, the rating for DPCI was 85 percent. The survey identified access to services provided by Behavioral Health (BH) and Substance Abuse (SA) specialists as presenting the most opportunities for improvement. Satisfaction with access to behavioral health and substance abuse providers rated fair to poor by 40 percent of the respondents for both DMAP/DSP and DPCI.

Overall satisfaction was highest with the quality and timeliness of services provided by hospitals, with 95 percent of the respondents rating them good or very good, and emergency departments (EDs), with 87 percent rating them good, very good or excellent. Medical Surgical specialties and ambulatory surgical centers both had 83 percent of the respondents rate them positively. The greatest opportunity for improvement in the areas of quality and timeliness was identified as access to behavioral health specialists with 47 percent rating this as fair to poor in comparison to other health plans.

Survey questions regarding satisfaction levels with operational and administrative effectiveness and efficiency reflect levels of satisfaction with claims processing as satisfied and somewhat satisfied for DMAP/DSP at 67 percent and DPCI at 65 percent. Satisfaction with problem resolution by member services and provider services was rated slightly higher for DMAP/DSP, at 69 and 73 percent than DPCI, rated at 55 and 70 percent.

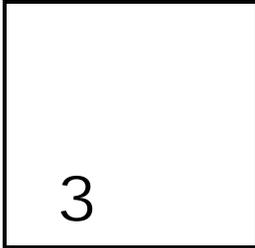
The number of survey respondents was very small and should not be assumed to represent the majority of PCP opinions. It is recommended that further evaluation should occur prior to making major decisions; however, survey results do provide valuable input regarding satisfaction with processes and services provided, from which areas for further assessment can be identified.



## Introduction

On behalf of the State of Delaware (State)/Department of Health and Social Services (DHSS)/Division of Social Services (DSS), Mercer Government Human Services Consulting (Mercer) conducted a Provider Satisfaction Survey as a component of the EQR process. The purpose of the Provider Satisfaction Survey was to acquire feedback from the contracted PCPs, regarding the quality of services provided by Delaware Medicaid programs, DMAP/DSP, the State managed extended fee-for-service (FFS) program, and DPCI, a MCO that had been providing services to the Delaware Medicaid population. The survey was focused on fiscal year (FY) 2004 – 2005 (July 1, 2004 – June 20, 2005).

DMAP/DSP is interested in provider feedback to aid in evaluating and improving processes. The Provider Satisfaction Survey was initiated on July 18, 2005, and was scheduled to be completed by August 22, 2005. The completion date was extended by two weeks to September 6, 2005. The methodology used in the process of implementing and evaluating the Provider Satisfaction Survey was consistent with the DHSS and the Centers for Medicare and Medicaid Services (CMS) protocol. The protocol was titled “*Administering and Validating Surveys.*”



## Methodology

Mercer has access to individuals with expertise in a variety of fields. For this EQR process, Mercer chose a specifically designated team with a variety of specialties and talents applicable to developing, implementing, and analyzing a provider satisfaction survey. Departments or staff participating in the Provider Satisfaction Survey process included: clinical staff, members of the Mercer National Survey Group, analysts, and information technology (IT) staff. The survey design was developed jointly by the clinical and survey group with participation, review, and approval by DSS. Survey review, analysis, reliability, and validity evaluation were completed by the Mercer National Survey Group. Data collection and preparation were managed by IT personnel, and data analysis was completed by the analysts and clinical staff.

This was the second year of administering the Provider Satisfaction Survey. In preparation for this year's survey, an analysis was completed to determine possible reasons for the low participation rate of the prior year's survey. In addition, recommendations from the prior year's survey were considered and discussed with DSS leadership. Adjustments to the process were implemented to increase response rates. In preparing the report for year two of the Provider Satisfaction Survey, a review conducted of current literature provided no substantial updates or information from prior years thus this section of the report was not included. For a copy of the prior literature review and resources used contact Mercer at 602 522 6536. The following steps were completed in preparing for the Provider Satisfaction Survey.

## Survey Purpose

The purpose of the Provider Satisfaction Survey was reaffirmed with DSS. The survey's purpose was to assess PCPs' satisfaction with managed care processes and services in the following categories:

- Access to Care;
- Quality of Care; and
- Operational and Administrative Efficiency and Effectiveness.

Providers were informed that the Provider Satisfaction Survey results would be used to understand and identify improvements to the current processes used by DMAP.

## Unit of Analysis

The unit of analysis refers to the type of entity or entities that the Provider Satisfaction Survey is focused on for the purpose of gathering information. The focus or unit of analysis for the Provider Satisfaction Survey was the State Managed Care Program, specifically DMAP/DSP and DPCI.

## Audience for Provider Satisfaction Survey Results

The audience for the information resulting from the completion of the Provider Satisfaction Survey is DSS, the DSS Quality Unit, the Quality Improvement Task Force, and providers. The Provider Satisfaction Survey executive summary results may be included in the *Quality Courier*, the DSS bi-annual newsletter.

## Survey Instrument

The survey instrument was developed specifically to assess the performance and processes used by DMAP/DSP and the MCOs providing the services. The Provider Satisfaction Survey questions were reviewed with DSS, and in an effort to shorten the survey, a number of questions were deleted from the document. Each question in the survey tool was assessed for reliability and validity.

Reliability refers to the internal consistency and reproducibility of the questions composing the survey tool. To evaluate the reliability of the Provider Satisfaction Survey questions, each question was assessed against numerous provider satisfaction surveys and balanced with staff expertise to assure internal consistency of each question. Reliability was also assessed in the analysis of survey feedback, again checking reliability in the consistency of responses.

Face validity and content validity assessments were completed on the Provider Satisfaction Survey tool by experienced Mercer National Survey Group members and clinical staff. Face validity indicates that the question generates a common concept or image of what the survey is designed to ask and content validity, which enhances face validity, assures that the questions capture or represent the essence of the concept under study.

## Identification of Provider Satisfaction Survey Participants

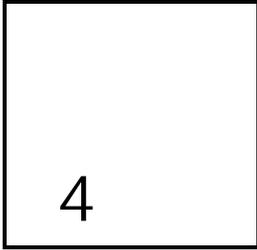
The target recipients for the Provider Satisfaction Survey were PCPs. Practitioners in the Primary Care category included: Internal Medicine (IM), Family Practice (FP), General Practice (GP), Obstetrics/Gynecology (OB/GYN), Pediatricians, Doctors of Osteopathy (DO), APNs, including Nurse Practitioners (NPs) and Nurse Midwives. The Provider Satisfaction Survey was mailed to all PCPs who fit into the identified categories. The participants were identified in each category by codes attached to provider types in the provider network database. The database was provided by the State Benefits Manager, EDS. After applying provider category codes to the database; 1,600 participants were identified.

## Strategy to Maximize Response Rate

Recommendations from the prior year's Provider Satisfaction Survey were discussed with DSS in an effort to maximize the survey response rate. The Provider Satisfaction Survey cover letters, used to introduce the process, were adjusted to request that the survey be distributed to and completed by providers rather than office managers. The cover letter also requested that one survey be completed per provider. Cover letters also assured participants the anonymity and confidentiality of responses, as well as addressed the benefits to the respondent in completing the survey. The provided information would be used to evaluate and improve processes within the Managed Care program. A paper questionnaire, with a return pre-stamped envelope, was mailed to each identified participant and the option of completing the Provider Satisfaction Survey on line was also available. A 24/7 support line was available to assist respondents with any questions or to provide technical support in completing the form via the Internet. For this cycle of the survey, the 2-step Internet access process was changed to a 1-step process. Each provider received their online access with the cover letter. The Provider Satisfaction Survey response rate was monitored each week throughout the process. Halfway into the survey process, each participant who had not yet responded received a personal reminder letter.

## Time Frame

Time frame for participation in the Provider Satisfaction Survey was between July 18, 2005, and August 22, 2005. The time available to respond was extended to September 6, 2005. Provider Satisfaction Surveys were distributed by mail and, simultaneously, made available on line for anyone preferring to complete the tool via the Internet. Until the time of the data analysis, late surveys returned past the deadline date were included in the aggregate survey results. To control data quality, all returned paper Provider Satisfaction Surveys were entered into the same database where online responses were entered. The database assured consistency and accuracy of information in preparation for the analysis.



## Question Summaries

**Question Summaries**

**Delaware Provider Satisfaction Survey**

Demographics						
1.	Demographics — Type of Provider				N <sup>1</sup> = responses	N = 93*
	<u>Physician</u> 86 (92%)	<u>Nurse</u> 2 (2%)	<u>Unknown</u> 5 (5%)			
	<u>Type of Specialist</u>		<u>Type of Specialist</u>			
	Allergy	1 (1%)	Nurse Practitioner	2 (2%)		
	Anesthesiology	2 (2%)	OB/GYN	14 (15%)		
	Behavioral Health	1 (1%)	Ophthalmology	1 (1%)		
	Blank	5 (5%)	Orthopedics	1 (1%)		
	Endocrinology	2 (2%)	Pediatrics	8 (9%)		
	Family Practice	24 (26%)	Phys. Med.& Rehab.	1 (1%)		
	Genetics	1 (1%)	Podiatry	2 (2%)		
	GP	3 (3%)	Psychiatry	1 (1%)		
	GYN Oncology	1 (1%)	Rheumatology	1 (1%)		
	Internal Medicine	21 (23%)	Urology	1 (1%)		
2.	What is your preferred method of providing input to DMAP?					N = 91
	<u>Paper Survey</u> 65 (71%)	<u>Web Based Survey</u> 21 (23%)	<u>Telephone Calls</u> 2 (2%)	<u>Focus Groups</u> 2 (2%)	<u>Other (salaried Federally Qualified Health Center [FQHC])</u> 1 (1%)	
3.	With which of the following health plans have you been contracted? (Please mark all that apply):					N = 93
	<u>Delaware Medical Assistance Program/Diamond State Partners (DMAP/DSP)</u> 83 (89%)		<u>Delaware Physicians Care, Inc (DPCI)</u> 87 (94%)			
4.	Which of the following best describes your primary practice location?					N = 93
	<u>Clinic</u> 7 (8%)	<u>FQHC</u> 4 (4%)	<u>Hospital</u> 4 (4%)	<u>Office</u> 78 (84%)		

<sup>1</sup> N represents the total number of responses to each question.

\* 93 total unique responses.

**Question Summaries**

**Delaware Provider Satisfaction Survey**

<b>Demographics</b>						
5.	Which of the following best describes your primary practice business arrangement?					N = 93
	<u>Self-employed Solo Practice</u>	<u>Self-employed Partnership or Group</u>	<u>Salaried – Physician Office Practice</u>	<u>Salaried – Hospital</u>	<u>Other (please specify below)</u>	
	48 (52%)	27 (29%)	15 (16%)	2 (2%)	1 (1%)	
6.	How many physicians are in your practice group?					N = 93
	<u>Self</u>	<u>2 – 5</u>	<u>6 – 10</u>	<u>≥11</u>		
	48 (52%)	31 (33%)	9 (10%)	5 (5%)		
7.	How many health plan networks (e.g., Aetna, Blue Cross Blue Shield, CIGNA, etc.) are you contracted with?					N = 90
	<u>1 – 5</u>	<u>6 – 10</u>	<u>≥11</u>			
	14 (16%)	36 (40%)	40 (44%)			
8.	What approximate percentage of your patients were enrolled in Delaware Medicaid Programs (DMAP/DSP and DPCI) during FY 2004 (July 1, 2004 – June 30, 2005)?					N = 46
	<u>Percentage of Patients Enrolled</u>					
	0% – 5%	10	(14%)			
	6% – 10%	11	(15%)			
	11% – 20%	17	(24%)			
	21% – 30%	12	(17%)			
	31% – 40%	7	(10%)			
	41% – 50%	8	(11%)			
	51% – 60%	2	(3%)			
	61% – 70%	3	(4%)			
	71% – 80%	2	(3%)			
9.	Are you satisfied with the volume of patients directed to your practice by DMAP/DSP or its contractors?					N = 87
	<u>Extremely Satisfied</u>	<u>Very Satisfied</u>	<u>Somewhat Satisfied</u>	<u>Not Satisfied</u>	<u>Extremely Dissatisfied</u>	
	12 (14%)	44 (51%)	25 (29%)	6 (7%)	0 (0%)	

**Question Summaries**

**Delaware Provider Satisfaction Survey**

**Access to Care**

10. Please rate the following qualities and services provided by DMAP/DSP in comparison to all other managed care plans in which you participate. If you have been contracted with DMAP/DSP, please fill in the first set of boxes. If you have been contracted with DPCI, please fill in the second set of boxes. If you have been contracted with both, please fill in both sets of boxes.

<u><b>DMAP/DSP</b></u>	<u><b>Excellent</b></u>	<u><b>Very Good</b></u>	<u><b>Good</b></u>	<u><b>Fair</b></u>	<u><b>Poor</b></u>	
Ability to access member information when needed	16 (18%)	37 (43%)	26 (30%)	6 (7%)	2 (2%)	N= 87
Ability to access behavioral health provider for member when needed	5 (7%)	14 (21%)	21 (31%)	10 (15%)	17 (25%)	N= 67
Ability to access substance abuse provider for member when needed	4 (6%)	13 (20%)	21 (33%)	13 (20%)	13 (20%)	N= 64
Ability to access care/disease management information for member when needed	4 (6%)	21 (30%)	25 (36%)	12 (17%)	7 (10%)	N= 69
<u><b>DPCI</b></u>	<u><b>Excellent</b></u>	<u><b>Very Good</b></u>	<u><b>Good</b></u>	<u><b>Fair</b></u>	<u><b>Poor</b></u>	
Ability to access member information when needed	19 (21%)	34 (38%)	23 (26%)	10 (11%)	3 (3%)	N= 89
Ability to access behavioral health provider for member when needed	7 (11%)	15 (23%)	18 (27%)	13 (20%)	13 (20%)	N= 66
Ability to access substance abuse provider for member when needed	6 (10%)	12 (20%)	18 (30%)	15 (25%)	9 (15%)	N= 60
Ability to access care/disease management information for member when needed	6 (9%)	22 (32%)	24 (35%)	11 (16%)	6 (9%)	N= 69

**Question Summaries**

**Delaware Provider Satisfaction Survey**

**Quality of Care**

<p>11. The following relates to the Delaware Medicaid quality newsletter, the <i>Quality Courier</i>.</p> <p>An article focusing on obesity in childhood and adolescence was published in the <i>Quality Courier</i> during 2004. The content of the article was:</p> <table border="0"> <tr> <td><u>Excellent</u></td> <td><u>Very Good</u></td> <td><u>Good</u></td> <td><u>Fair</u></td> <td><u>Poor</u></td> </tr> <tr> <td>1 (1%)</td> <td>14 (17%)</td> <td>15 (19%)</td> <td>2 (2%)</td> <td>0 (0%)</td> </tr> </table> <p>An article focusing on Hypertension Guidelines was published in the <i>Quality Courier</i> during 2004. The content of the article was:</p> <table border="0"> <tr> <td><u>Excellent</u></td> <td><u>Very Good</u></td> <td><u>Good</u></td> <td><u>Fair</u></td> <td><u>Poor</u></td> </tr> <tr> <td>1 (1%)</td> <td>17 (21%)</td> <td>14 (17%)</td> <td>4 (5%)</td> <td>0 (0%)</td> </tr> </table> <p>An article focusing on the Smart Start Program was published in the <i>Quality Courier</i> in 2005. The article was:</p> <table border="0"> <tr> <td><u>Excellent</u></td> <td><u>Very Good</u></td> <td><u>Good</u></td> <td><u>Fair</u></td> <td><u>Poor</u></td> </tr> <tr> <td>1 (1%)</td> <td>11 (14%)</td> <td>13 (16%)</td> <td>4 (5%)</td> <td>0 (0%)</td> </tr> </table> <p>Did the Smart Start Program article encourage you to refer more members to the program?</p> <table border="0"> <tr> <td><u>Yes</u></td> <td><u>No</u></td> </tr> <tr> <td>18 (38%)</td> <td>30 (63%)</td> </tr> </table>	<u>Excellent</u>	<u>Very Good</u>	<u>Good</u>	<u>Fair</u>	<u>Poor</u>	1 (1%)	14 (17%)	15 (19%)	2 (2%)	0 (0%)	<u>Excellent</u>	<u>Very Good</u>	<u>Good</u>	<u>Fair</u>	<u>Poor</u>	1 (1%)	17 (21%)	14 (17%)	4 (5%)	0 (0%)	<u>Excellent</u>	<u>Very Good</u>	<u>Good</u>	<u>Fair</u>	<u>Poor</u>	1 (1%)	11 (14%)	13 (16%)	4 (5%)	0 (0%)	<u>Yes</u>	<u>No</u>	18 (38%)	30 (63%)	<p>N= 81</p> <p>N= 82</p> <p>N= 81</p>
<u>Excellent</u>	<u>Very Good</u>	<u>Good</u>	<u>Fair</u>	<u>Poor</u>																															
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18 (38%)	30 (63%)																																		
<p>I am interested in reading articles in the <i>Quality Courier</i> about the following topics:</p> <ul style="list-style-type: none"> <li>▪ Adult obesity</li> <li>▪ Available specialists patients can be referred</li> <li>▪ Cardiology topics/cardiac health</li> <li>▪ Diabetes mellitus</li> <li>▪ Different programs offered by Medicaid providers</li> <li>▪ Disease management</li> <li>▪ Hypertension</li> <li>▪ Prenatal care and delivery</li> <li>▪ Reasons for reducing reimbursement for Evaluation &amp; Management (E&amp;M)</li> </ul>																																			

**Question Summaries**

**Delaware Provider Satisfaction Survey**

<b>Quality of Care</b>							
12.	Please rate the following qualities and services provided by Medicaid in comparison to all other managed care plans in which you participate.						
	<b><u>All Delaware Medicaid Plans</u></b>	<b><u>Excellent</u></b>	<b><u>Very Good</u></b>	<b><u>Good</u></b>	<b><u>Fair</u></b>	<b><u>Poor</u></b>	
	Medical/Surgical Specialists	3 (4%)	27 (32%)	40 (47%)	11 (13%)	4 (5%)	N= 85
	Behavioral Health Specialists	0 (0%)	12 (17%)	25 (36%)	15 (22%)	17 (25%)	N= 69
	Hospitals	0 (0%)	8 (40%)	11 (55%)	0 (0%)	1 (5%)	N= 20
	Emergency Departments	3 (4%)	33 (43%)	35 (46%)	4 (5%)	1 (1%)	N= 76
	Urgent Care Facilities	2 (3%)	24 (33%)	29 (40%)	13 (18%)	4 (6%)	N= 72
	Skilled Nursing Facilities	1 (1%)	19 (28%)	35 (51%)	10 (14%)	4 (6%)	N= 69
	Ambulatory Surgery Centers	3 (4%)	21 (31%)	32 (48%)	9 (13%)	2 (3%)	N= 67
	Plan-specific qualities and services:						
	<b><u>DMAP/DSP</u></b>	<b><u>Excellent</u></b>	<b><u>Very Good</u></b>	<b><u>Good</u></b>	<b><u>Fair</u></b>	<b><u>Poor</u></b>	
	Encouragement of Preventive Care	2 (3%)	16 (22%)	41 (56%)	10 (14%)	4 (5%)	N= 73
	Facilitation of Clinical Care	3 (4%)	17 (24%)	33 (46%)	11 (15%)	8 (11%)	N= 72
	Commitment to Disease Management Programs	1 (1%)	18 (26%)	35 (50%)	10 (14%)	6 (9%)	N= 70
	<b><u>DPCI</u></b>	<b><u>Excellent</u></b>	<b><u>Very Good</u></b>	<b><u>Good</u></b>	<b><u>Fair</u></b>	<b><u>Poor</u></b>	
	Encouragement of Preventive Care	6 (7%)	21 (25%)	38 (46%)	13 (16%)	5 (6%)	N= 83
	Facilitation of Clinical Care	4 (5%)	23 (28%)	33 (40%)	15 (18%)	7 (9%)	N= 82
	Commitment to Disease Management Programs	5 (6%)	15 (19%)	35 (45%)	16 (21%)	7 (9%)	N= 78

**Question Summaries**

**Delaware Provider Satisfaction Survey**

**Operational and Administrative Efficiency and Effectiveness**

13. What was the average turnaround time for prior approval requests for the Medicaid plans?							DMAP/ DSP N = 58  DPCI N = 74				
<b><u>Days</u></b>	<b><u>DMAP/DSP</u></b>		<b><u>DPCI</u></b>		<b><u>Days</u></b>	<b><u>DMAP/DSP</u></b>		<b><u>DPCI</u></b>			
0 days	5	(9%)	3	(4%)	15 days	3		(5%)	2	(3%)	
1 days	3	(5%)	6	(8%)	21 days	0		(0%)	2	(3%)	
2 days	20	(34%)	20	(27%)	23 days	1		(2%)	1	(1%)	
3 days	12	(21%)	8	(11%)	28 days	0		(0%)	1	(1%)	
4 days	1	(2%)	5	(7%)	30 days	0		(0%)	3	(4%)	
5 days	3	(5%)	7	(9%)	32 days	0		(0%)	1	(1%)	
6 days	0	(0%)	1	(1%)	40 days	0		(0%)	1	(1%)	
7 days	5	(9%)	5	(7%)	45 days	1		(2%)	0	(0%)	
10 days	1	(2%)	2	(3%)	90 days	1		(2%)	1	(1%)	
14 days	2	(3%)	5	(7%)							
14. What has been the turnaround time (from point of submission in mail, electronically, facsimile to reimbursement) for processing a claim?								DMAP/ DSP N = 66  DPCI N = 73			
<b><u>Days</u></b>	<b><u>DMAP/DSP</u></b>		<b><u>DPCI</u></b>		<b><u>Days</u></b>	<b><u>DMAP/DSP</u></b>			<b><u>DPCI</u></b>		
0 days	1	(2%)	1	(1%)	23 days	1			(2%)	2	(3%)
1 days	1	(2%)	1	(1%)	25 days	1	(2%)		2	(3%)	
3 days	1	(2%)	0	(0%)	28 days	1	(2%)		1	(1%)	
4 days	0	(0%)	1	(1%)	30 days	26	(39%)		19	(26%)	
5 days	2	(3%)	1	(1%)	35 days	1	(2%)		1	(1%)	
7 days	1	(2%)	0	(0%)	40 days	1	(2%)		1	(1%)	
10 days	3	(5%)	4	(5%)	45 days	3	(5%)		3	(4%)	
13 days	0	(0%)	1	(1%)	50 days	0	(0%)		1	(1%)	
14 days	10	(15%)	13	(18%)	55 days	1	(2%)		0	(0%)	
15 days	1	(2%)	4	(5%)	60 days	4	(6%)		3	(4%)	
20 days	3	(5%)	6	(8%)	90 days	0	(0%)		2	(3%)	
21 days	4	(6%)	5	(7%)	180 days	0	(0%)		1	(1%)	

**Question Summaries**

**Delaware Provider Satisfaction Survey**

**Operational and Administrative Efficiency and Effectiveness**

15. Please rate how satisfied you have been with the responsiveness and accuracy of services provided by Medicaid managed care plan in comparison to all other managed care plans in which you participate.

	<u>Satisfied</u>	<u>Somewhat Satisfied</u>	<u>Neutral</u>	<u>Somewhat Dissatisfied</u>	<u>Dissatisfied</u>	<u>Did Not Utilize</u>	
<b><u>DMAP/DSP</u></b>							
Claims processing	23 (27%)	34 (40%)	7 (8%)	8 (9%)	10 (12%)	3 (4%)	N= 85
Claims reimbursement	19 (23%)	27 (32%)	14 (17%)	7 (8%)	14 (17%)	3 (4%)	N= 84
Problem resolution by provider relations representatives	21 (24%)	29 (34%)	13 (15%)	9 (10%)	10 (12%)	4 (5%)	N= 86
Problem resolution by member services representatives	20 (24%)	25 (30%)	13 (15%)	10 (12%)	10 (12%)	6 (7%)	N= 84
Problem resolution requiring Medical Director intervention	10 (13%)	14 (18%)	13 (16%)	0 (0%)	9 (11%)	33 (42%)	N= 79
<b><u>DPCI</u></b>							
Claims processing	29 (34%)	26 (31%)	8 (9%)	9 (11%)	10 (12%)	3 (4%)	N= 85
Claims reimbursement	29 (34%)	27 (32%)	9 (11%)	10 (12%)	7 (8%)	3 (4%)	N= 85
Problem resolution by provider relations representatives	22 (26%)	25 (29%)	13 (15%)	10 (12%)	13 (15%)	3 (3%)	N= 86
Problem resolution by member services representatives	19 (23%)	23 (28%)	12 (14%)	10 (12%)	14 (17%)	5 (6%)	N= 83
Problem resolution requiring Medical Director intervention	12 (15%)	10 (12%)	17 (21%)	2 (2%)	15 (18%)	26 (32%)	N= 82

**Question Summaries**

**Delaware Provider Satisfaction Survey**

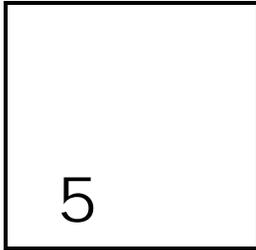
**Operational and Administrative Efficiency and Effectiveness**

16. Please rate how satisfied you have been with the responsiveness and accuracy of services provided by Medicaid managed care plan in comparison to all other managed care plans in which you participate.							
<b><u>DMAP/DSP</u></b>	<b><u>Satisfied</u></b>	<b><u>Somewhat Satisfied</u></b>	<b><u>Neutral</u></b>	<b><u>Somewhat Dissatisfied</u></b>	<b><u>Dissatisfied</u></b>	<b><u>Did Not Utilize</u></b>	
Quality of written communications (newsletters)	24 (29%)	25 (30%)	25 (30%)	2 (2%)	2 (2%)	6 (7%)	N= 84
Effectiveness of provider relations representative call/visits	15 (18%)	22 (26%)	20 (24%)	8 (10%)	7 (8%)	12 (14%)	N= 84
Follow up on unresolved billing/claims issues by provider relations	9 (11%)	24 (29%)	18 (21%)	20 (24%)	7 (8%)	6 (7%)	N= 84
<b><u>DPCI</u></b>	<b><u>Satisfied</u></b>	<b><u>Somewhat Satisfied</u></b>	<b><u>Neutral</u></b>	<b><u>Somewhat Dissatisfied</u></b>	<b><u>Dissatisfied</u></b>	<b><u>Did Not Utilize</u></b>	
Quality of written communications (newsletters)	22 (26%)	13 (15%)	34 (40%)	1 (1%)	8 (9%)	8 (9%)	N= 86
Effectiveness of provider relations representative call/visits	18 (22%)	14 (17%)	19 (23%)	10 (12%)	13 (16%)	9 (11%)	N= 83
Follow up on unresolved billing/claims issues by provider relations	16 (19%)	17 (20%)	19 (22%)	13 (15%)	15 (17%)	6 (7%)	N= 86

**Question Summaries**

**Delaware Provider Satisfaction Survey**

Operational and Administrative Efficiency and Effectiveness								
17.	Please rate the quality and effectiveness of the following administrative communications of the Medicaid plans in comparison to all other managed care plans in which you participate.							
	<b><u>DMAP/DSP</u></b>	<b><u>Satisfied</u></b>	<b><u>Somewhat Satisfied</u></b>	<b><u>Neutral</u></b>	<b><u>Somewhat Dissatisfied</u></b>	<b><u>Dissatisfied</u></b>	<b><u>Did Not Utilize</u></b>	
	Benefit changes and plan information	20 (24%)	23 (27%)	21 (25%)	9 (11%)	9 (11%)	3 (4%)	N= 85
	Policy updates	24 (28%)	23 (27%)	20 (24%)	8 (9%)	7 (8%)	3 (4%)	N= 85
	<b><u>DPCI</u></b>	<b><u>Satisfied</u></b>	<b><u>Somewhat Satisfied</u></b>	<b><u>Neutral</u></b>	<b><u>Somewhat Dissatisfied</u></b>	<b><u>Dissatisfied</u></b>	<b><u>Did Not Utilize</u></b>	
	Benefit changes and plan information	23 (27%)	16 (19%)	21 (24%)	11 (13%)	13 (15%)	2 (2%)	N= 86
	Policy updates	25 (29%)	17 (20%)	21 (24%)	7 (8%)	13 (15%)	3 (3%)	N= 86

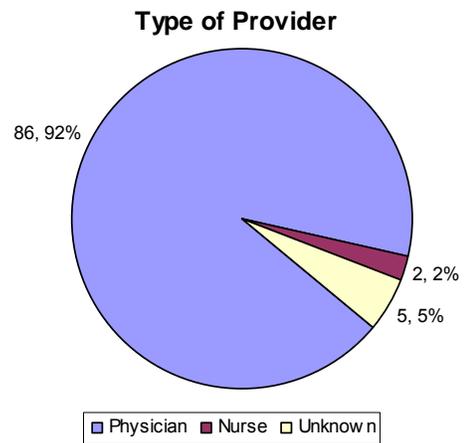


## Analysis

For this section of the analysis, charts are included to visually represent responses and, in some cases, relationships. For questions with responses that include ranking on a scale, the associated charts reflect the ratings of “good,” “very good,” and “excellent.” Other questions will include all response choices.

## Demographics

The demographic section of the Provider Satisfaction Survey provides information about respondents, and creates a context within which to understand and relate subsequent question responses. A total of 99 Provider Satisfaction Surveys were returned. Out of this number, 93 were completed enough to be considered for this report. The following chart provides a high-level breakdown of the respondents to the survey. The target participants for the Provider Satisfaction Survey were PCPs and APNs. Ninety-two percent of the respondents were physicians and 2.2 percent were APNs with 5.5 percent of participants unknown. Physician Assistants and Specialty Providers were not identified as planned participants in this survey process.

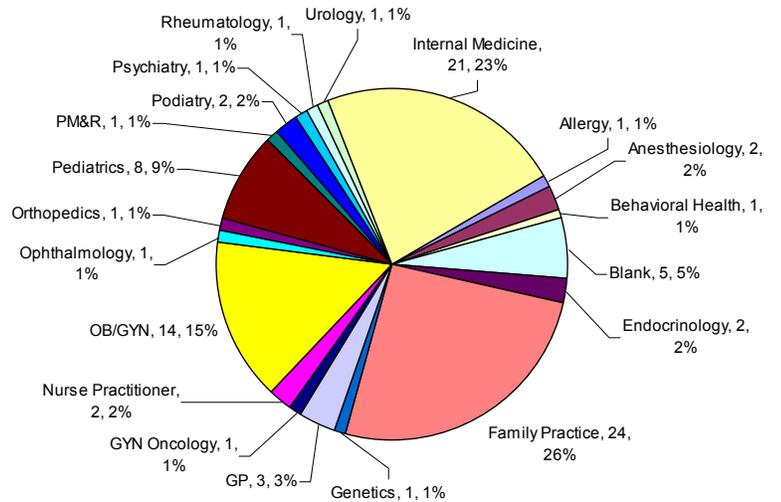


The chart below further breaks down the composition of the physician respondents. It is of note that the breakdown includes specialists or non-PCPs not targeted for this survey.

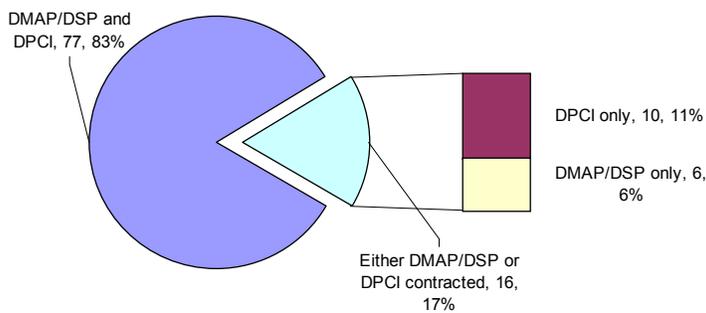
The number of non-targeted/non-primary care respondents was 16 (17 percent). The Provider Satisfaction Surveys may have been received in error, or the surveys which were received by a group practice may have been shared within the group.

At least two Provider Satisfaction Surveys were completed on behalf of all members of a group; thus, the actual respondent number may be greater than the 99 surveys returned.

**Provider Specialty**



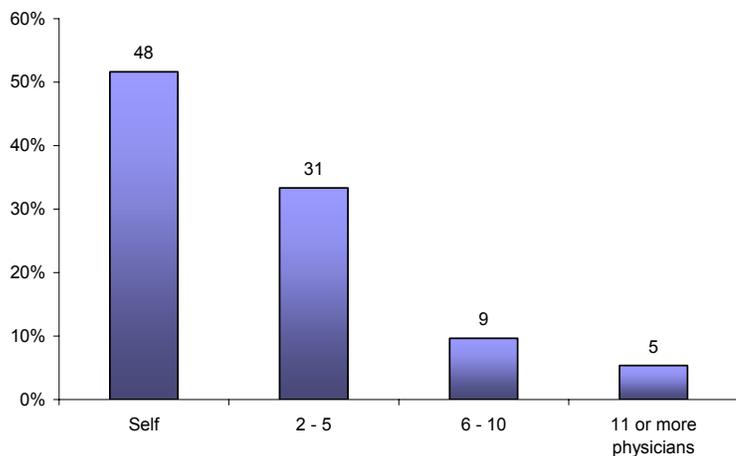
**Health Plans Contracted**



When asked which health plans respondents were contracted with, 77 respondents indicated they are contracted with both DMAP/DSP and DPCI. The remaining 16 are contracted with either DMAP/DSP or DPCI. A further breakdown indicated that of these, 10 are contracted with DPCI but not with DMAP/DSP, and 6 are contracted with DMAP/DSP but not with DPCI.

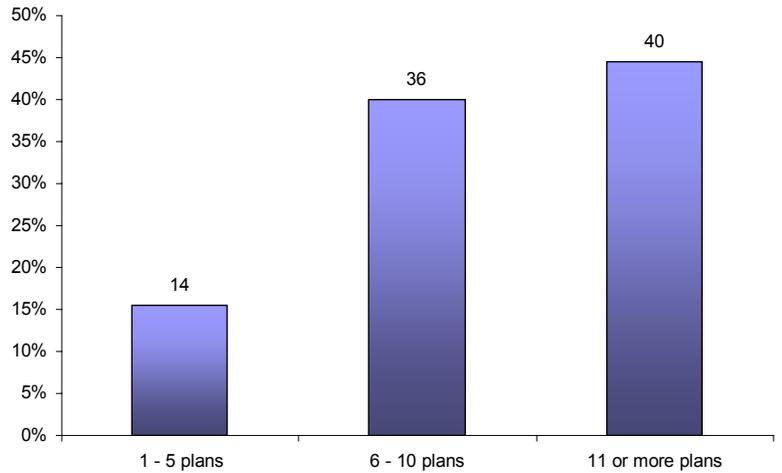
A total of 78 (84 percent) respondents indicated that their primary work location was the office. A total of 52 percent indicated that they were in solo practice, with 33 percent indicating that they were in small group practices of 2 – 5.

**Number of Physicians in Practice Group**

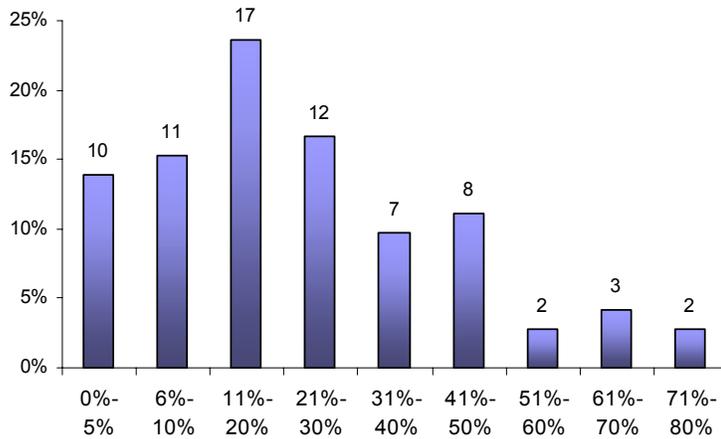


The majority of solo or small group practices are contracted with multiple health plans. Over 40 percent of all respondents are contracted with 6 – 10 plans and 44 percent are contracted with 11 or more. The large number of contracted health plans reflects a degree of complexity for the practitioner in interfacing with various services and the processes required to access those services.

**Number of Health Plan Networks Contracted**

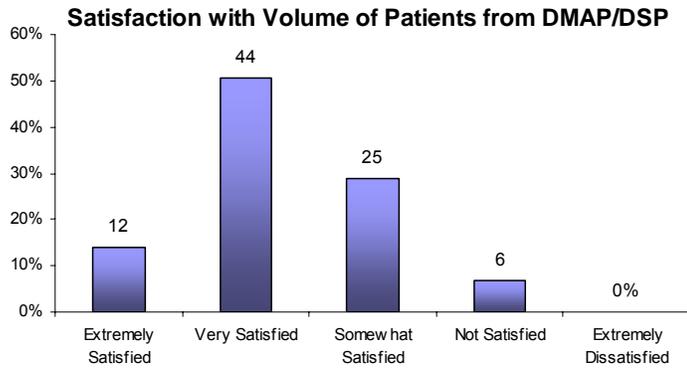


**Percent of Patients Enrolled in Delaware Medicaid Programs During FY 2004/2005**



The graph to the left represents responses reflecting the percentage of a provider's patients enrolled in the Delaware Medicaid Program. The X axis indicates the percentage of respondents' panels that are DMAP/DSP or DPCI patients. The number at the top of each column indicates the number of respondents per each percentage range.

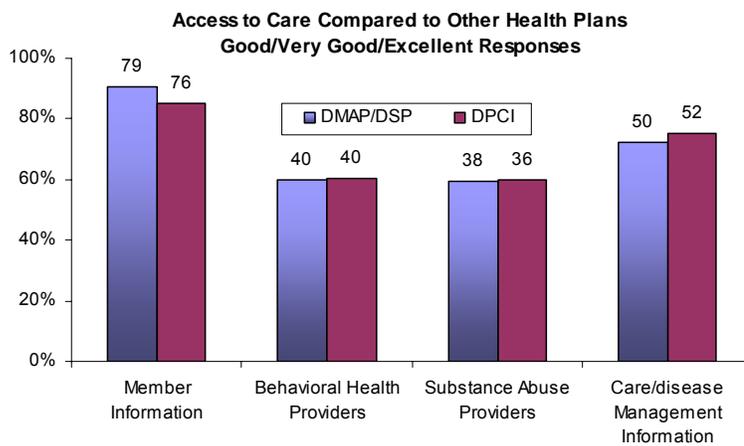
For example, the first bar tells us that 10 PCPs have 0 – 5 percent of their panels composed of Medicaid members. This information helps to understand the comparison of panel composition with the satisfaction level for the volume of Medicaid patients that are directed into a providers practice.



Most respondents indicate a strong satisfaction with the volume of patients directed to their practice. What this does not tell us is the actual panel size. Panel size would allow an assessment of the actual Medicaid members enrolled within each practice and the availability of provider selection options.

### Access to Care and Services

This section provides insight into the ease of access to specified services as perceived by survey respondents. The ease of access to service that providers experience is important in facilitating needed care to members. Easy access also impacts provider’s satisfaction and the ability to practice efficiently.

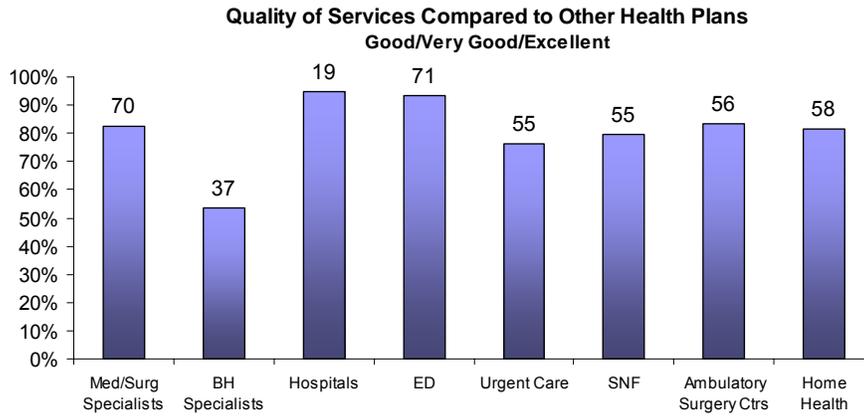


The chart to the left reflects satisfaction with access to services provided by DMAP/DSP and DPCI, as compared to access for those same services across all other health plans with whom the respondent is contracted. Satisfaction levels reflect ratings of “good,” “very good,” and “excellent.” Responses represent areas of opportunity for access issues

related to BH and SA. Responses appear relatively consistent for both health plans. The most satisfaction is related to the ability to access member information for DMAP/DSP and DPCI.

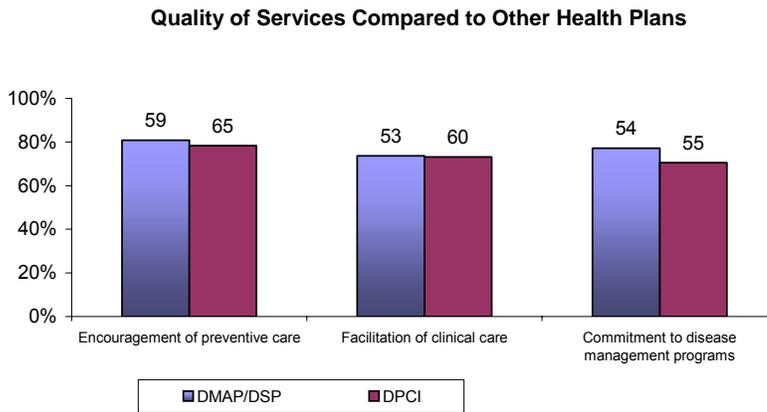
## Quality Services

This section of the Provider Satisfaction Survey addresses quality-related services and processes. Quality services addressed in the survey include feedback related to the quality of specialty providers accessed for referrals, facilities, and services, as well as plan-specific qualities and services.



There is general satisfaction with the quality of services provided. The lowest satisfaction was with BH providers, which is consistent with the responses to access to BH providers. Hospitals and EDs have the highest

overall satisfaction, which includes “good,” “very good,” and “excellent” responses, at 95 percent and 93 percent.



Participants were asked to respond with levels of satisfaction regarding services provided by DMAP/DSP and DPCI. While significant differences exist between DMAP/DSP and DPCI programs, processes and resources focused on preventive care, care facilitation

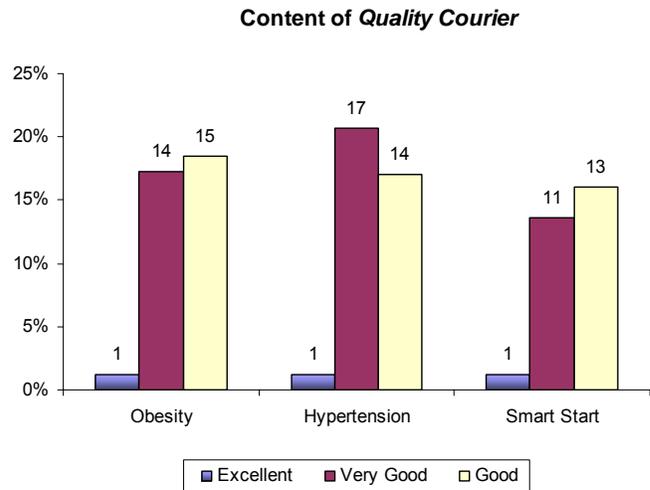
and disease management; responses reflect very limited difference in satisfaction levels. Also providers who responded to this question were more likely to rate services in this area as “good” rather than “very good” or “excellent.”

## Quality Courier

An important means of communicating quality news and information to all providers in the DMAP/DSP network is the *Quality Courier*: a bi-annual newsletter focusing on QIs and dissemination of information. Of the 93 surveys, most provided feedback related to the *Quality Courier*.

The survey intended to determine if providers receiving the *Quality Courier* reviewed clinical articles appearing in the newsletter. Clinical articles addressing pertinent issues are focused in each *Quality Courier* issue. Over half of the respondents did not reply to this question.

For those who did respond specifically to this question, the articles were considered “very good” or “good.”



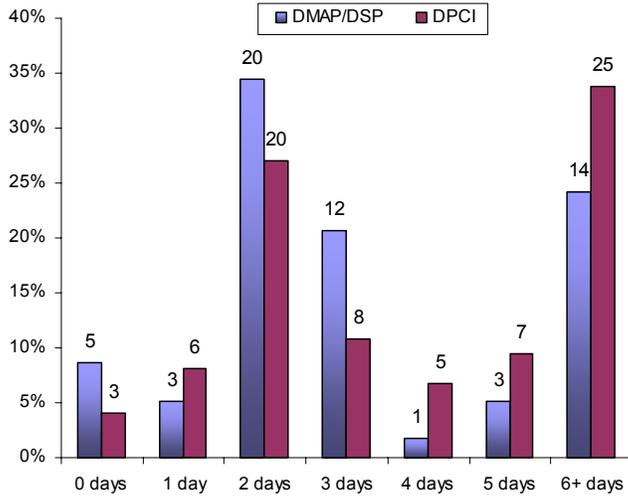
The survey also attempted to determine if the featured articles influenced behavioral change. One question particularly focused on the Smart Start Program and asked if after reading the article they would refer more pregnant members to the Smart Start Program. The majority of respondents (63 percent) said that the Smart Start Program article did not encourage them to refer more members. It is unclear whether these providers are already Smart Start Program users, if their panel members require Smart Start referrals, or if the provider is not a program supporter. When broken down by the 14 OB/GYNs who responded, 7 responded that they reviewed the article and rated it as “good” or “very good.” Of these 7, 71 percent (5) responded that the article did encourage them to refer their patients to the Smart Start Program. It is unclear whether the 2 who answered that the article did not encourage them to refer their patients to the Smart Start Program were already referring to Smart Start or that the article had no effect on their referring pattern. The overall numbers of OB/GYNs who responded to the Smart Start Program questions are small, but it is encouraging that the article had impact among those most likely to see pregnant women.

In regard to future *Quality Courier* topics, respondents mentioned adult obesity, cardiology topics, diabetes mellitus, prenatal care and delivery, disease management, and hypertension. Each of these topics was mentioned by one respondent apiece. Interest was also expressed in subjects related to reasons for reducing reimbursement for Evaluation & Management (E&M) and available specialists to whom patients can be referred.

## Availability of Support Services

The ability to access health plan support services and receive a timely response is important to providers and often impacts the ability and efficiency of care coordination and timeliness. The chart to the left represents the average perceived turnaround times for prior authorization requests. Most requests are processed within three days or less, with

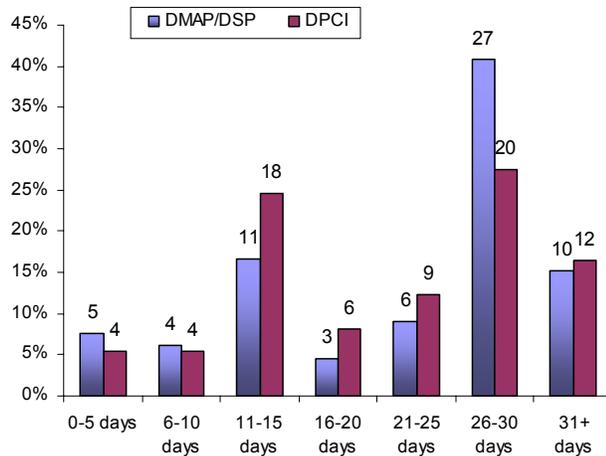
**Average Turnaround Time for Prior Approval Requests**



the majority of responses occurring around day two. The volume of responses identifying turnaround times for preauthorization decision greater than five days spikes. This may be related to the type of case submitted for review. Additional information may be required to assess the types of cases involved to accurately assess longer turnaround times.

Turnaround times for claims were also explored. The most frequent response to the question about the turnaround time for processing a claim hovered around 14 days and 30 days. Thirty days is the targeted time frame for processing of clean claims, so it is interesting that the perception is that a fair number of claims are processed after the 30-day limit. The question, however, does not differentiate between a clean claim and a claim that requires correction or adjustments prior to being paid.

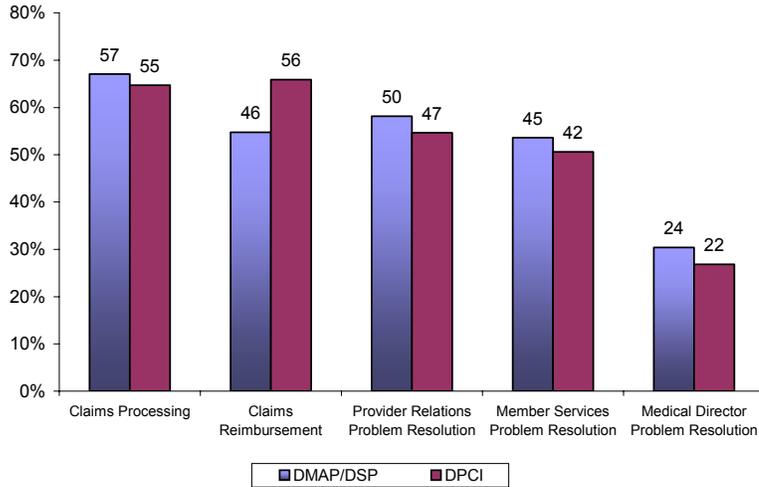
**Average Turnaround Time for Processing a Claim**



## Operational and Administrative Efficiency and Effectiveness

As the survey indicated, the majority of providers are contracted with multiple health plans. Having multiple managed care contracts can result in provider inefficiencies,

**Satisfaction with Responsiveness and Accuracy of Services Compared to Other Medicaid Managed Care Plans**  
Satisfied/Somewhat Satisfied Responses

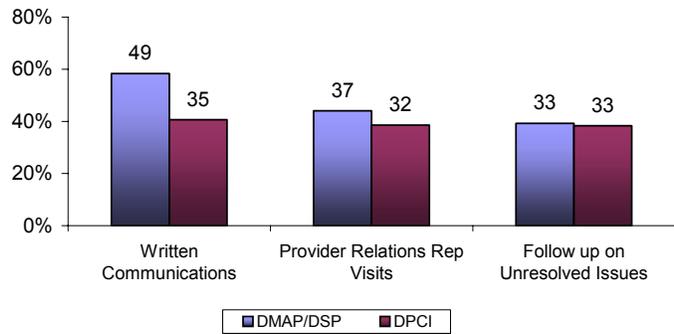


unless the administrative processes required to interface with the health plan are clear and the health plan is timely in providing responses. The chart to the right reflects areas of strong satisfaction with various aspects of administrative services. Between 79 and 86 respondents addressed various parts of this question with 7 – 17 responses remaining neutral. In response to

satisfaction with the Medical Director for problem resolution, almost one-third of participants indicated they did not attempt to use the Medical Director. Of those who had accessed the Medical Director, most were satisfied.

The chart to the right addresses the efficiency and effectiveness of identified health plan functions and asks respondents to rate the quality of each. The number of respondents to this question ranged from 83 – 86. The strongest levels of satisfaction were related to DMAP/DSP’s quality of written communications, such as newsletters, at 58 percent as compared with

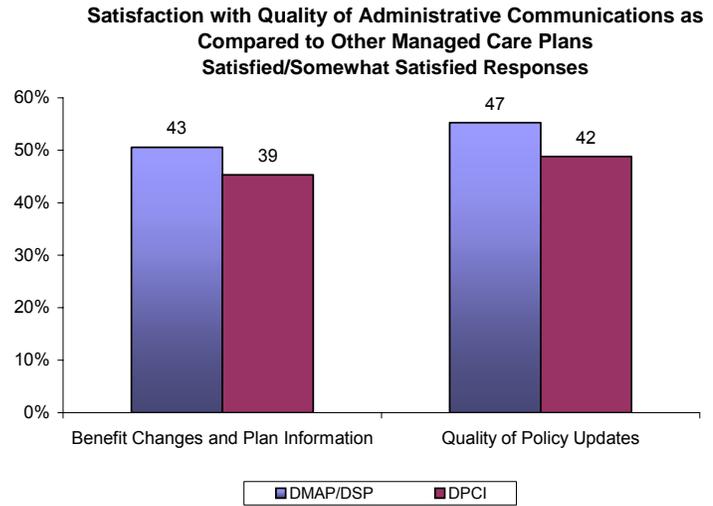
**Satisfaction with Quality of Services Compared to Other Managed Care Plans**  
Satisfied/Somewhat Satisfied Responses

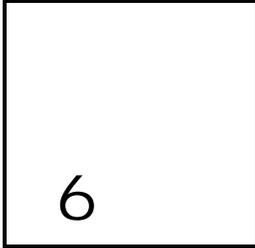


DPCI’s quality of written communications of 41 percent. Again, the number of respondents should be considered in making decisions based upon responses.

The chart to the right demonstrates levels of satisfaction with communication of policy and benefit updates and changes by the health plan. Eighty-five – eighty-six respondents addressed this question.

Responses reflect equal levels of satisfaction between health plans. Responses are slightly variant related to quality of policy updates as compared to communication of benefit and plan information.





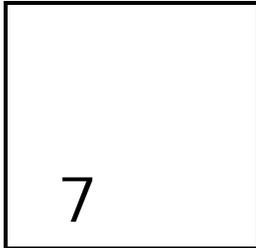
## Strategies to Increase Provider Participation

### Participation Rate

As in the prior year's survey process, the information provided by the Health Benefit Manager was inaccurate. The inaccuracies impacted the ability to correctly identify providers for participation in the survey process, as well as the ability to deliver surveys correctly. To identify participants in the Provider Satisfaction Survey a data download was received. This data was run against a listing of provider taxonomies, identifying providers by type. Using this technique, PCPs fitting the inclusion criteria, as determined by the State, were identified for participation in this survey. Results of this process identified 1,600 participants. The intent was to identify individual PCPs versus multispecialty groups or subspecialists. Based upon this information, in early July 2005, surveys were mailed to PCPs in the DMAP/DSP and DPCI networks. Of the surveys disseminated, 93 surveys were completed and 317 were returned unopened. The survey response rate to this survey was 7 percent, as calculated with a denominator of 1,283 (total minus those returned) and a numerator of 93. For future surveys to be successful an accurate listing of providers is essential. Efforts should be made to improve the accuracy of the provider list.

An additional influence, which may have impacted the response rate for the provider survey was the timing of the DPCI Provider Satisfaction Survey. DPCI, the second MCO included in the survey, had completed their own provider satisfaction survey two weeks prior to the distribution of the DSS survey. The proximity in time of both surveys may have negatively impacted the providers' willingness to complete two surveys so close together. For future surveys, either rotating the timing of the survey cycle with the DPCI should be initiated or consideration should be given to the use of focus groups for accessing provider feedback.

As a component of the strategy to maximize survey response rate, halfway through the survey cycle a targeted reminder mailing occurred. Reminders were sent to providers who had not yet responded to the survey.



### Recommendations to Maximize Survey Response Rate

Issues	Resolution
Low Response Rate	<ul style="list-style-type: none"> <li>▪ Explore alternative methods of accessing providers for input and feedback, such as:                             <ul style="list-style-type: none"> <li>– focus groups;</li> <li>– participation in meetings;</li> <li>– incentives;</li> <li>– develop announcements of upcoming Provider Satisfaction Survey to be included in provider newsletters and placed on EDS provider website to ensure providers are aware;</li> <li>– explore communications regarding survey for presentation at provider network meetings;</li> <li>– avoid survey distribution near DPCI provider survey cycle; and</li> <li>– implement a more aggressive reminder process including phone outreach.</li> </ul> </li> </ul>
Use of Online Survey	<ul style="list-style-type: none"> <li>▪ Consider adding a Provider Survey link to the DSS or EDS web site to facilitate provider access and visual presentation.                             <ul style="list-style-type: none"> <li>– Maintain online provider survey managed by Mercer as well as link from DSS or EDS web site.</li> <li>– Explore availability of an email list serve from Health Benefits Manager.</li> </ul> </li> </ul>
Accuracy of Providers Database	<ul style="list-style-type: none"> <li>▪ Work with DSS to develop a strategy to access more accurate database information.</li> </ul>

**MERCER**  
Government Human Services Consulting

Mercer Government Human Services Consulting, Inc.  
3131 E. Camelback Road, Suite 300  
Phoenix, AZ 85016-4536  
602 522 6500