

2010 Provider Satisfaction Survey Summary and Proposed Plan to Improve Satisfaction

The Myers Group (TMG), a National Committee for Quality Assurance (NCQA) Certified Survey Vendor, was selected by University Family Care/Maricopa Health Plan to conduct its 2010 Provider Satisfaction Survey. Information obtained from the survey helps University Physicians Health Plans (UPHP) to measure how well we are meeting providers' expectations and needs. Based on the data collected, this report summarizes the results, assists in identifying plan strengths and opportunities and outlines a proposed plan to improve overall provider satisfaction.

SURVEY TOOL, SAMPLE METHODOLOGY AND COLLECTION PROCESS

UPHP chose to utilize one of TMG's standard survey tool (attached), which contained 6 demographic questions, 32 specific ranking questions, 4 overall satisfaction ranking questions, 3 open-ended questions, and 1 yes/no question. The specific ranking questions had six possible responses, 5 of which could be ranked (from excellent to poor) and the overall satisfaction ranking questions had 4 possible responses (from definitely yes to definitely not).

Ranked questions were categorized as follows:

- Call Center/Members Services Staff (obtaining member information);
- Provider Relations (responsiveness/courtesy/timeliness, quality of information/in-services/education);
- Network (quality of providers in the network, adequacy of network and provider input/recommendations being taken seriously);
- Utilization & Quality Management (including PA/UM staff and processes, case management, consistency and timeliness of decisions, appropriate care/care alternatives, and quality programs);
- Finance Issues (cost control vs. quality of care, reimbursement rates, and claims timeliness/accuracy/inquiry resolution),
- Pharmacy and Drug Benefits (ease and variety of formulary); and
- Overall Satisfaction and Loyalty.

The three open-ended questions asked providers what they like best about the health plans, how the health plans can improve and what immediate actions the health plans could take to improve service to the providers.

A total of 2000 provider office locations were randomly selected from UPHP's provider database. TMG conducted a two-wave mailing and a phone follow-up survey of the selected population. In September, 2010, the initial mailings were sent out to Maricopa Health Plan providers and University Family Care providers. After three weeks a second-wave mailing was re-sent to those who had not responded to the first mailing. After an additional three weeks the project moved to the phone component of data collection and the database was cleaned again. The sample was cleaned by removing duplicate phone numbers from the sample. As a result, a total of 955 records were loaded into the Computer-Assisted Telephone Interview system (CATI). The phone surveys were completed at the end of August. TMG gathered the survey results, analyzed the responses and provided an analysis to UPHP in September 2010.

RESPONSE RATE

Mail

For MHP, 81 valid mail surveys were received and the overall mail response rate was 8.6%. The total mail sample size was 1000 and there were 62 ineligible surveys.

For UFC, 61 valid mail surveys were received and the overall mail response rate was 6.2%. The total mail sample size was 1000 and there were 19 ineligible surveys.

Telephone

For MHP, 176 valid phone surveys were received and the overall phone response rate was 40.93%. The total phone sample size was 543 and there were 113 ineligible surveys: $176 / (543-113) = 40.93\%$.

For UFC, 113 valid phone surveys were received and the overall phone response rate was 40.07%. The total phone sample size was 384 and there were 102 ineligible surveys: $113 / (384-102) = 40.07\%$.

Combined

A total of 431 valid surveys were received and the overall response rate was 16.38%. To calculate the response rate, the total valid surveys received are divided by the total population sample of 2927 providers reduced by 296 ineligible surveys), which results in: $431 / (2927 - 296) = 16.38\%$.

For MHP, 257 valid surveys were received and the overall response rate was 13.39%. The total sample size was 2000 and there were 81 ineligible surveys: $257 / (2000-81) = 13.39\%$.

For UFC, 174 valid surveys were received and the overall response rate was 24.44%. The total sample size was 927 and there were 215 ineligible surveys: $174 / (927-215) = 24.44\%$.

DEMOGRAPHICS OF SURVEY RESPONDENTS

Of the 257 MHP providers that responded to the survey, 79 were dentist offices, and 177 were either primary care or specialty offices. The respondents included a mixture of physicians/providers (7.8%), office managers (68.0%) and nurses/other (24.2%). 50.9% of the respondents were solo practitioners, 36.8% in practices with 2-5 providers and 12.3% over 5 providers respectively. The break-down of years in practice among the respondents is: less than 5 years (24.0%); 5-15 years (38.6%); and 16 or more years (37.4%). 68.8% of providers indicated that UFC/MHP represented 0-10% of their office's total managed care volume with the remaining provider's breakdown as follows: 11-20% of total managed care volume (21.9%); 21-100% of total managed care volume (9.4%). The top four AHCCCS health plan's that providers indicated they were also participants in were: Mercy Care (91.1%), APIPA (96.2%), Phoenix Health Plan (84.7%), and Health Choice 77.1%.

Of the 174 UFC providers that responded to the survey, 47 were dentist offices, and 127 were either primary care or specialty offices. The respondents included a mixture of physicians/providers (24.5%), office managers (53.8%) and nurses/other (21.7%). 33.6% of

the respondents were solo practitioners, 42.6% in practices with 2-5 providers and 23.8% over 5 providers respectively. The break-down of years in practice among the respondents is: less than 5 years (17.1%); 5-15 years (30.1%); and 16 or more years (52.8%). 46.6% of providers indicated that UFC/MHP represented 0-10% of their office's total managed care volume with the remaining provider's breakdown as follows: 11-20% of total managed care volume (24.6%); 21-100% of total managed care volume (28.8%). The top four AHCCCS health plan's that providers indicated they were also participants in were: Mercy Care (82.2%), AIPA (78.2%), Phoenix Health Plan (66.3%), and Health Choice (66.3%).

BENCHMARKING AND COMPARISONS TO OTHER AHCCCS PLANS

As a national survey vendor, TMG conducts surveys on behalf of multiple health plans, including commercial and Medicaid plans. TMG's 2009 Medicaid book of business included 34 Medicaid plans encompassing 9,901 respondents. The 2009 TMG Medicaid Book of Business is a benchmark containing data from all eligible Provider Satisfaction Surveys for which TMG collected data in 2009 and is comprised of primary care and specialty providers. This benchmark is calculated on the plan level, meaning the summary rate from the 34 plans is averaged to calculate the benchmark. Where available, comparisons of UFC/MHP summary rates were shown alongside the 2009 TMG Medicaid Book of Business (BoB) summary rates and summary rate percentiles. TMG did not have dentist benchmark data. Therefore, benchmark comparisons only consisted of PCP and specialty providers.

For each ranked survey question, respondents ranked UFC/MHP as well as "all other health plans" with which the provider participates. TMG created summary rates/percentiles for both UFC/MHP and "all other health plans." TMG then compared the provider's scores on UFC/MHP to the "all other health plan" summary rates/percentiles.

SUMMARY RESULTS

TMG's summary rates contained in the following table are the proportion of respondents who selected the most positive response options (excellent or very good; definitely or probably yes; and very or somewhat satisfied) for the specific attribute/composites. For the combined UFC/MHP scores of total respondents, those highlighted in green scored significantly higher than the "all other plan" summary score, the TMG Medicaid BoB 2009 summary score, or both. Those not highlighted were not significantly higher or lower from the other comparative scores and those highlighted in red scored significantly lower.

Category Summary (Total Respondents):

Attributes/ Composites	Summary Rate Definition	UFC 2010 Summary Rate (Include	MHP 2010 Summary Rate (Include	All Other Plans 2010	TMG Medicaid BoB 2009
Call Center/Member Services Staff (obtaining member information)	Excellent or Very	49.5%	51.3%	39.25%	51.2%
Provider Relations (responsiveness/ courtesy/ timeliness, quality of information/ in-services/ education)	Excellent or Very Good	34.1%	33.5%	25.55%	41.5%

Network (quality of providers/ adequacy of network/ provider input taken seriously)	Excellent or Very Good	29.8%	28.8%	28.75%	35.3%
Utilization & Quality Management (PA/ UM staff/processes, case management; consistent/ timely decisions, quality programs)	Excellent or Very Good	29.4%	25.6%	20.75%	NA
Finance Issues (cost control vs. quality of care, reimbursement rates, claims timeliness/ accuracy/ inquiry)	Excellent or Very Good	25.5%	26.7%	20.45%	NA
Pharmacy & Drug Benefits (easy & variety of formulary)	Excellent or Very Good	16.5%	19.0%	16.5%	22.6%
Recommend to Other Physicians	Definitely or Probably	78.6%	87.1%	NA	83.8%
Recommend to Other Patients	Definitely or Probably	72.7%	81.0%	NA	83.8%
Overall Satisfaction with UFC/MHP	Very or Somewhat	69.9%	75.0%	81.5%	75.2%
Overall Satisfaction with all other health plans	Very or Somewhat	76.2%	86.8%	NA	81.1%

For total respondents, these summary scores showed that both the Call Center/Member Services and Provider Relations were scored significantly higher than the scores given to all other health plans. Overall satisfaction with UFC/MHP scored significantly lower than the “all other health plans” score, but was not significantly lower than the TMG Medicaid 2009 BoB summary score.

Ranked Survey Question Results

TMG’s analysis also provided comparisons to ranked survey questions within each category. Total respondents scored the following questions higher or lower than all other health plans or than the TMG 2009 BoB summary scores:

All Respondents:

Attributes/ Composites	Summary Rate Definition	UFC 2010 Summary Rate (Include	MHP 2010 Summary Rate (Include	All Other Plans 2010	TMG Medicaid BoB 2009
Q1. Process of obtaining member information (eligibility, benefit coverage, co-pay amounts)	Excellent or Very Good	49.5%	51.3%	36.6%	51.2%
Q2. Responsiveness and courtesy of the health plan's provider relations representative	Excellent or Very Good	39.6%	42.2%	30.0%	51.7%

Q3. Timeliness to answer questions and/or resolve problems.	Excellent or Very Good	35.8%	35.1%	24.5%	41.3%
Q4. Quality of provider orientation process.	Excellent or Very Good	31.5%	29.2%	17.9%	38.5%
Q6. Quality of written communication, policy bulletins, and manuals.	Excellent or Very Good	33.7%	34.4%	25.0%	41.7%
Q10. Behavioral health network has an adequate number of high quality practitioners to whom I can refer my patients.	Excellent or Very Good	17.8%	21.7%	21.4%	24.3%
Q14. Phone access to UM staff.	Excellent or Very Good	28.7%	34.7%	21.6%	40.8%
Q33. Ease of using formulary.	Excellent or Very Good	20.5%	23.6%	16.9%	24.9%
Q35. Would you recommend University/Maricopa Health Plan to other physicians' practices?	Definitely Yes or Probably	78.6%	87.1%	NA	83.8%

Questions 1, 2, 3, 4 and 6 are included in and reflective of the Call Center/Member Services and Provider Relations summary categories above. The remaining questions are included in the following categories: Q10-Network; Q14-Utilization & Quality Management; Q33-Pharmacy & Drug Benefits; and Q35-Overall Satisfaction. These responses identify potential areas of satisfaction or opportunities for improvement.

Correlation Analysis to Overall Satisfaction

The provider's overall satisfaction with the plan is an important measure of how well UFC/MHP is meeting the needs and expectations of the provider network. The collection and review of data related to the provider's rating of UFC/MHP could provide the fundamental information needed to help maintain or even improve the overall caliber of the plans. Not all plan services impact providers' overall rating of the plan to the same degree. TMG ran a correlation analysis to determine which attributes have the strongest relationship with overall rating of the plan. The correlation analysis produced the Pearson Correlation Coefficient, which illustrates the strength of the relationship between each attribute and overall satisfaction. A correlation coefficient of 1 represents the strongest correlation (a perfect positive correlation), while a coefficient of 0 represents the weakest correlation (no correlation). As the correlation coefficient increases, so does the strength of the relationship. The attributes considered highly correlated with overall satisfaction are noted below. Attributes are listed in descending order of correlation coefficient.

MHP

Attribute Correlation	Coefficient
Q2. Responsiveness and courtesy of the health plan's Provider Relations representatives.	0.576
Q3. Timeliness to answer questions and/or resolve problems.	0.651
Q12. Process of obtaining pre-certification / referral /	0.533

authorization information	
Q13. Timeliness of UM's pre-certification process.	0.559
Q16. Consistency of review decisions.	0.552
Q19. Degree of improvement plan has made to reduce/eliminate the "hassle factor" of getting patients the service they need.	0.618
Q30. Accuracy of claims processing.	0.580
Q32. Resolution of claims payment problems or disputes.	0.563

UFC

Attribute Correlation	Coefficient
Q3. Timeliness to answer questions and/or resolve problems.	0.651
Q4. Quality of provider orientation process.	0.660
Q19. Degree of improvement plan has made to reduce/eliminate the "hassle factor" of getting patients the service they need.	0.685
Q21. The health plan's facilitation/support of appropriate clinical care for patients.	0.730
Q23. Alternative care and community resource options offered by the Care/Care Manager to my patients.	0.666
Q24. The health plan's commitment to chronic disease management programs.	0.740
Q28. Extent to which the plan controls costs while maintaining a high quality of care.	0.688

The remaining questions were identified as areas to monitor and no questions were identified as opportunities that should be investigated and improved.

Loyalty Analysis

TMG's loyalty analysis was completed to determine overall provider loyalty to UFC/MHP. Provider loyalty develops when the health plan consistently meets or exceeds the expectations of its providers. A loyal provider is very satisfied with the plan and willing to recommend the plan to other physicians and patients. Provider loyalty is based upon responses to Question 37, ("Overall Satisfaction with University Family Care/Maricopa Health Plan?"), Question 35, ("Would you recommend University Family Care/Maricopa Health Plan to other physicians' practices?"), and Question 36, ("Would you recommend University Family Care/Maricopa Health Plan to other patients?").

The different zones within the loyalty analysis are defined as follows:

- *Loyal Zone*: Providers are very satisfied and likely to recommend the plan to other patients and physicians.
- *Defection Zone*: Providers are very dissatisfied and not likely to recommend the plan to other patients and physicians.
- *Indifferent Zone*: Providers are mixed as to whether they are satisfied or whether they would be willing to recommend the plan to other patients and physicians.

Zone	MHP 2010 Valid n	Percent	2009 TMG BoB
Loyal	45	31.3%	31.0%
Indifferent	97	67.4%	65.2%

Defection	2	1.4%	3.8%
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Zone	UFC 2010 Valid n	Percent	2009 TMG BoB
Loyal	24	24.5%	31.0%
Indifferent	67	68.4%	65.2%
Defection	7	7.1%	3.8%

TMG’s analysis determined that UFC/MHP provider loyalty was not significantly higher or lower than the TMG 2009 BoB.

Individual Responses Analysis

The analysis provided by TMG provided great insight and some direction, but the picture seemed somewhat incomplete. In an effort to identify additional information to help explain the overall satisfaction score and drill down into specific categories, UPHP completed an analysis of the individual responses to the open-ended questions: What do you like best about UFC/MHP?, How can we improve UFC/MHP?, and What immediate actions would you like UFC/MHP to take to improve services provided to network physicians?

Category Mapping:

While categorizing written responses can be highly subjective, some common themes were identified. Each response was analyzed and many could be categorized. For example, a response to the question “what do you like best” was: *“I like the ease of prior authorizations”* and a response to the question “how can we improve”: was: *Authorizations to go through when we need them ASAP! Other plans can cover things over the phone*. Both of these responses could be included in the category of “Prior Authorizations/Referrals”. Some responses fit into more than one category, such as: *“The good response for provider relations, and good payment reimbursement timelines”* which could be mapped to both provider relations and claims processing. In some cases a response did not fit in a specific category or was too general such as: *“Nothing that I can think of”*. Non-responses or over-generalizations were included in the category “no comment”.

Core Value Mapping:

In an effort to provide a more complete picture, each response was also compared to UPHP’s core values: to be the most effective, most efficient and easiest health plan to work with. For two of the responses above, *“I like the ease of prior authorization”* and *“authorizations to go through when we need them ASAP! Other plans can cover things over the phone”* were mapped to ease and efficiency respectively. In some cases, more than one value was identified. The response to the question “how can we improve: *“To make it faster and easier in regards to requesting authorizations”* was correlated to prior authorizations/referrals for both ease and efficiency. Other responses had different categories, such as provider relations and claims processing but shared the same value, such as this response: *“The good response for provider relations, and good payment reimbursement timelines”* which was mapped to effectiveness.

OBSERVATIONS TOWARD IMPROVEMENT

The analyses completed by both TMG and UPHP above provide an in-depth look at the

complex relationships UFC/MHP currently realize with their network providers. In some service categories, we have implemented philosophies and processes that can be used to build a bridge toward provider “loyalty”. Some processes and interfaces valued by the majority of providers include our focus on customer service, our value to be the “easiest” health plan to work with, and some specific faces & voices within the plan (Member Services, Provider Relations, and Claims Customer Service) have been able to successfully connect with the providers or staff in the provider offices. That said, the survey results do indicate that our customer service philosophy is not reaching all intended recipients. While the combined respondents and office manager respondents scored UFC/MHP well in most customer service areas, the physicians were less impressed with our commitment to “Ultimate Care.” UPHP needs to do a better job penetrating the front and back office staff and to create situations where UPHP staff can directly demonstrate our customer service/Ultimate Care commitment to our network providers.

While the survey identified some positives, in most of the plan categories, the results indicate that we are providing services and interactions that aren’t significantly dissatisfying, but they aren’t significantly satisfying either. This may be resulting in greater provider indifference toward the plan which can influence a provider’s overall satisfaction with UPHP. That said; several of these categories may have been greater areas of dissatisfaction this year due to UFC/MHP’s expansion and explosive growth. Indeed, plans for improvement are already underway in several categories, including the two most often cited as potential opportunities for improvement—claims resolution, accuracy and efficiency and prior authorization ease, access and understanding. UPHP needs to utilize one of its greatest strengths—taking provider input and recommendations seriously—to let providers know they’ve been heard and to point out the operational improvements that are being implemented as a direct result of their feedback. Further, while we might do a good job listening to our providers, we need to do a better and more consistent job communicating the outcomes of all that input. We also need to consider the three facets of UPHP’s value statement when implementing a process improvement—effectiveness, efficiency and ease. Operational changes may make it easier on our providers, but we may be missing an opportunity to also positively affect their perception of efficiency and effectiveness. Through the combination of implementing process improvement and effectively communicating these enhancements to our network providers, UPHP may be able to positively influence providers and move some of our providers from indifference to loyalty.

Of course, the health plan must also consider whether it actually wants to influence some elements that may have not scored particularly well. As an AHCCCS plan, there are those components that some providers will continually identify as a nuisance or will find distasteful despite UPHP’s best efforts. Some providers will continue to rail against the notion of prior authorization and utilization management—arguing that it is of no value and should be eliminated altogether. Some provider offices will continue to refuse to invest in training their staff on billing practices and will remain frustrated when payment is reduced, denied or otherwise challenged. Providers will continue to identify the AHCCCS fee schedule as too little reimbursement for so much care. In those instances, UPHP needs to let providers know what it has done and continues to do to mitigate and minimize any negative impact these factors may have on provider satisfaction.

Further, some categories may be easy to influence but the resultant change may negatively impact the plan’s ability to succeed. Thus, any change considered needs to be carefully measured to ensure UPHP can continue to fulfill its obligations to both the state and its provider partners. An example of this is the size and composition of the provider network. While there were indications that the quality of physicians in the networks is not satisfactory

and the number of specialists available is not adequate, if we add every provider's personal referral choice, those loyal network providers and provider partners may realize a loss in referrals and revenue—which can negatively impact their future loyalty to the plan and UPHP. However, our network providers may not be aware of all of the network additions and enhancements that have been implemented. We need to do a better job letting providers know when we have added specialists and other service enhancements to the network. We also need to create value for our current provider partners--UPH and MIHS. We need to identify our provider partner's strengths and promote those strengths and enhancements to the rest of the network. While steps have certainly been taken to minimize the negative stereotypes of UPH Hospital and MIHS as "County" facilities, perceptions do remain and UPHP needs to find ways that demonstrate a shift in philosophy from government-run facilities to facilities that are building on their strengths as well as re-shaping and improving their weaknesses. If MMC has the best trauma center in the State, UPHP needs to get that message out. When UPH and MIHS take steps to enhance the patient's experience, communicating those improvements to the provider community-at-large will help create more comfort for "county-run" or "county-branded" operations.

Another category that was not highly rated was formulary and drug benefits. While it is imperative that UFC/MHP tightly manage the formulary and all of its associated costs, providers may not fully understand the need for a restricted formulary. Since perceptions are largely based on personal experience, it is sometimes difficult for a provider (and especially their staff) to grasp the need for restrictions. Providers who practice conservatively do not always realize the extent of over-utilization that is taking place. UPHP needs to develop tools to better educate providers on utilization practices and to show them why restrictions are needed. UFC/MHP also need to research those specific requests identified in the survey to determine whether there are other options available to providers that they might not be aware of. For example, one comment was that UFC/MHP needed a pocket formulary. Both plans already have a pocket formulary and pocket formularies are given out to each provider office when they are in-serviced and throughout the year. Yet, these tools are not getting to everyone who needs them. We need to ensure that providers have the tools they need in order to successfully care for our members. Finally, in those instances where we are unable to make changes, we need to be honest with our network providers and help them understand why changes can't be made. They may not always like the rules, but they will appreciate our honesty.

PLAN FOR IMPROVEMENT

As summarized above, there are steps that need to be taken to enhance network provider's overall satisfaction with the health plan. While UFC/MHP's overall satisfaction score was not significantly lower than TMG's BoB, it was significantly lower than the score providers gave to "all other health plans." This plan will primarily focus on remedies that will improve provider's perception of our plan—by continuing to do those things we already do well, by promoting/marketing our strengths and by implementing process improvements that will result in improved provider satisfaction.

1. Overall Satisfaction and Loyalty

- Continued focus on improving overall satisfaction with Health Plan

Intervention -

- Create permanent Provider/Member Satisfaction Work Group composed of representatives from all Health Plan Department's that directly impact provider's

and member's satisfaction with MHP's performance to develop and implement PDSA to address every area of dissatisfaction.

- Develop formalized, Health Plan-wide provider escalation process to better review and address provider satisfaction concerns.
- The Operations Management Team will review progress of Provider Satisfaction Work Group on a monthly basis to ensure consistent progress is being made and ensure Health Plan-wide buy-in on all provider satisfaction efforts.

2. Provider Relations:

- Responsiveness and courtesy of the Health Plan's Provider Relations Representatives
- Quality of provider orientation process

Intervention -

- Continued quarterly all staff Network Development Department meetings with topics / training on Customer Service and Ultimate Care. Training will include scenarios, role playing and guest speakers to educate staff on the importance of service.
- Yearly, off-site, all day retreat geared toward improving the Health Plan's service model, training and sharing best practices.
- Continued mandatory Provider Relations Representative attendance at the Plan's "Ultimate Care" training series.
- Development of incentive programs for staff to encourage stellar service.
- Creation of a Provider Relations Representative subcommittee to regularly review Provider Relations Representative approach, provider packets, materials, websites, in-services, and large group provider education sessions to ensure presentations and materials are up-to-date, appropriate and relevant.
- Increase the amount of time visiting providers and provider's office staff to improve perception and communication between the plan and providers.
- Added Senior Provider Relations Representative. This position is a seasoned lead who is available to all Provider Relations staff to troubleshoot and assist with complicated service issues.

3. Network:

- Quality of health plan's primary care providers
- Quality of health plan's specialists
- Specialist network has an adequate number of high-quality specialists to whom I can refer my patients.

Intervention –

- MHP will continue to review network adequacy on a quarterly basis to ensure a sufficient amount of primary care providers (PCP's) and specialists are available in all areas and the plan remains in compliance with contractual obligations. The plan will also continue to review and present all letters of interest received from PCP's and Specialists with the Contract Strategy committee.
- UFC will continue to review network adequacy on a quarterly basis to ensure a sufficient amount of primary care providers (PCP's) are available in all areas and the plan remains in compliance with contractual obligations. The plan will also continue to review and present all letters of interest received from PCP's with the Contract Strategy committee.
- To further ensure MHP/UFC meets provider's needs in this area MHP will conduct a focused survey of respondents geared toward creating an open dialogue to discover what changes/revisions in provider network may positively impact satisfaction rates.

4. Utilization and Quality Management:

- Timeliness of resolution requiring Medical Director intervention
- Timeliness of UM's pre-certification process
- Phone access to UM staff
- Timeliness of Credentialing

Intervention –

- Medical Director Team to review response approach to determine whether additional efficiencies can be achieved.
- Medical Director Team is now fully staffed with a Chief Medical Director, Senior Medical Director, and Medical Director and the Team has already implemented an approach to ensure optimal coverage and response rates. It is believed this improved approach will have a positive impact on provider satisfaction.
- MHP/UFC will review its credentialing processes to identify efficiencies and will work to reduce credentialing turnaround times.
- UFC will include representation from Utilization Management and Quality Management Departments on the Provider/Member Satisfaction Work Group to identify ways to improve provider's perception of our timeliness and availability in relation to PA calls.

5. Finance Issues:

- Timeliness of claims processing

Intervention –

- MHP/UFC has focused on the conversion of providers from paper to electronic submission / payment to ensure more expedient processing and payment to providers. MHP will continue to pursue electronic claims processing for all MHP/UFC providers.
- MHP/UFC has also created cross functional work groups between the Claims Department, Network Development, and Information Services to review claims service requests, discuss provider perception of timeliness, address elevated concerns and correct any payment issues.
- MHP/UFC will develop a process to improve Claims Department responsiveness to claims resubmissions, re-work, and special projects.

6. Pharmacy and Drug Benefits:

- Limitation of drugs on formulary

Intervention –

- MHP/UFC works with Express Scripts to ensure the most comprehensive medication list is available to our members and providers while ensuring MHP/UFC's financial stability.
- To further ensure MHP/UFC meets provider's needs in this area, MHP/UFC will conduct an additional survey of respondents geared toward creating an open dialogue to discover what providers feel would increase their satisfaction rates.

7. Call Center/Customer Care:

- Timeliness to resolve live call
- Claims Customer Service turnaround time

Intervention –

- UPHP has recently hired a full-time Customer Care Center Trainer who works directly with Customer Care Center staff to improve working knowledge on provider-specific service concerns. UPHP will continue with focused training of Customer Care Representatives on all aspects of provider service.

- UPHP to identify ways to improve the speed a provider call into the Customer Care Center can be completed.

ANTICIPATED OUTCOME

Through the implementation of the above named interventions MHP strives to improve our trending satisfaction rates by 5% over the course of 2011 survey year.

Through the implementation of the above named interventions UFC strives to improve overall satisfaction rates by 7% over the course of 2011 survey year.