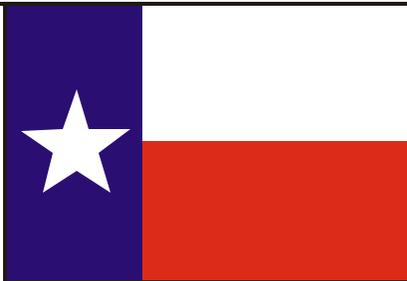


TEXAS

NorthSTAR Program
2001

Provider Satisfaction Survey - Technical Report



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NorthSTAR



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Abstract

In view of the importance of provider satisfaction in determining the extent to which physicians choose to participate in programs, such as Medicaid Managed Care (MMC) (Silverstein, 1997; Silverstein and Kirkman-Liff, 1995), the Texas Department of Mental Health and Mental Retardation (TDMHMR) is measuring provider satisfaction with the NorthSTAR MMC program. NorthSTAR, initiated in Texas on November 1, 1999, provides mental health and substance abuse services to Medicaid clients and indigent individuals based on their need for behavioral health services.

The primary objective of this study is to assess behavioral health providers' perceptions of NorthSTAR's administrative and organizational processes and to examine their levels of satisfaction with the programs coverage of clinical care. Through a mailed survey using a valid, reliable instrument developed by Texas Health Quality Alliance (THQA) for the study of all health providers in Texas, THQA gathered data from the population of 260 behavioral health providers who have received at least one payment for behavioral health services since program inception.

The corrected response rate for this administration was 73.7 percent, and respondents were representative of the population of NorthSTAR behavioral health providers. The majority of respondents were seasoned providers with more than 10 years of experience in their specialty and over a year of experience serving NorthSTAR clients. Over one-half of respondents were in solo practices and were paid on a fee-for-service basis. NorthSTAR clients, in general, comprised less than 25 percent of their clients.

A number of important findings were noted. Approximately 50 percent or more of respondents were very/somewhat satisfied with coverage for treatment/clinical services and the levels of customer service received.

Administratively, the program presents similar challenges to these providers as were noted in the literature. In particular, NorthSTAR providers were dissatisfied with the amount of telephone and paperwork required.

Additionally, it is significant to note that:

- NorthSTAR providers expressed less positive ratings as the proportion of NorthSTAR clients in their caseload increased.
- Higher proportions of Psychiatrists, Psychologists and Licensed Social Workers reported dissatisfaction, compared to other occupational groups.

Introduction and Background

The primary objective of this study is to assess behavioral health providers' perceptions of the NorthSTAR managed care mental health program that was initiated in Texas on November 1, 1999. TDMHMR and the Texas Commission on Alcohol and Drug Abuse jointly administer the program. The goal of the program is to integrate publicly funded behavioral health care (mental health and chemical dependency) so that a cost effective, single system of public behavioral health care is provided to Medicaid clients that will increase the array of services available to them while simplifying their access to these services. Local program administration and authority is provided by the Dallas Area NorthSTAR Authority (DANSA), while Behavioral Health Managed Care Organizations (BHOs)¹ manage the specialty provider networks, including previously existing community mental health centers in the Dallas area.

The program provides mental health and substance abuse services to Medicaid and medically indigent patients based on their need for behavioral health services; most of the non-institutionalized Medicaid population is required to enroll in this program. As of January 1, 2001, the program enrolled approximately 42,300 children, adults, and aged who had either disabilities and were receiving Supplemental Security Income (SSI) or were dually eligible for Medicaid and Medicare Coverage; 116,800 children and adult Temporary Assistance to Needy Families (TANF) clients; and more than 1 million Medicaid eligible women and children. The program's service area includes Dallas and six adjacent counties: Collin, Ellis, Hunt, Kaufman, Navarro, and Rockwall.

This study represents the first external effort to measure provider satisfaction with this behavioral health carve out program established to provide services to Medicaid and medically indigent patients. The survey was conducted in January and February, 2001, a little over one year after program implementation. It is designed to describe providers' overall satisfaction with the NorthSTAR program and to describe that satisfaction within the context of other behavioral health providers and other providers of MMC programs in Texas and nationwide. Provider perception of the impact of NorthSTAR on healthcare delivery and quality is also explored.

This study is organized as follows: The literature section reviews previous studies relevant to the questions of interest to this effort. This review is followed by an outline of the methods used in the design and

¹ Beginning August 1, 2000, only one BHO, Value Options, serves all clients in the program.

execution of the study. The next section presents the results of the analyses while the final section provides a discussion of the findings.

Literature

Satisfaction is a key factor in determining the extent to which physicians choose to participate in programs, such as MMC (Silverstein, 1997; Silverstein and Kirkman-Liff, 1995). Therefore, policy analysts at all levels are concerned that if great numbers of physicians choose not to participate in special programs, then patients who enroll in them will have decreased access to care (The MedStat Quality Catalyst[®] Program, 1998). Surveys of physicians have highlighted several major areas of concern. There is a general low opinion of MMC programs among primary care physicians, such as internal medicine providers (Feldman, Novack, and Gracely, 1998). They are particularly concerned that their patients may not have access to needed medications and that practitioners in their specialty may receive inadequate reimbursement. These practitioners also believe that managed care may negatively impact quality of care in other areas, such as the amount of time patients are allowed to remain hospitalized, the availability of diagnostic testing, the frequency of visits to specialists, and the choice of specialists (Feldman, Novack, and Gracely, 1998). Physicians also fear that managed care may decrease their autonomy in making clinical decisions while increasing “unnecessary” administrative reviews, such as service utilization and satisfaction studies. Physicians dislike the possibility that the costs of care may be considered in making clinical decisions (The MedStat Quality Catalyst[®] Program, 1998). The authors of this study interpreted these results as sending a strong message about the gap between physicians’ and health plans’ goals and objectives.

Behavioral health providers have experienced differences in access and utilization of inpatient care as compared to outpatient care while serving special populations in managed care programs. Behavioral health providers in managed care programs, in comparison to these providers in fee-for-service programs, report significantly lower levels of access to high-intensity inpatient services, such as inpatient care for psychiatric conditions and supervised residential treatment (Fried, et al., 2000). In contrast, these providers report managed care has increased outpatient treatment options in terms of the use of partial hospitalization programs and the implementation of various levels of care of varying intensity (Cunningham, 1997). While providers in these situations are expected to produce results with fewer visits, one study has noted that outpatient treatment is just as likely to end based on the decisions of patient and providers as on utilization review decisions (Cuffel, et al., 2000).

An area of concern in managed care studies is the relationship between administrative aspects of managed care and provider satisfaction. Studies of MMC providers in the STAR program in Texas have found that respondents in general were more dissatisfied than satisfied with

the administration and paperwork of MMC programs (THQA, 1999, 2000). Other studies have found that high denial rate of claims (as reported by physicians), longer turnaround time for reimbursement (Kerr, et al., 2000) and inadequate reimbursement (Silverstein and Kirkman-Liff, 1995; Silverstein, 1997) were significantly associated with decreased managed care satisfaction. Long turnaround times and denial rates were mitigated for physicians who reported that their plans did a good job of providing guidelines for claims submission. Additionally, as the percentage of managed care patients increased, satisfaction with managed care reimbursement systems increased (Kerr, et al., 1997). The table in Appendix A lists the provider satisfaction surveys cited in this literature review along with several other works that were reviewed, their method of data collection, and whether or not they included questions directly pertaining to provider satisfaction.

The NorthSTAR waiver represents a significant attempt to increase access to care and to integrate care for all persons with serious mental illness and chemical dependency in the Dallas area. A major focus of the waiver is to increase access by increasing the number of providers and to reduce confusion about reimbursement. This report presents the first external evaluation of the impact these changes have had on provider perceptions and provider satisfaction.

Methods

This baseline study assesses behavioral health provider satisfaction with the NorthSTAR program in the Dallas Service Delivery Area (SDA).

Sample Selection

The population consisted of 260 behavioral health providers who had received at least one payment for behavioral health services since program inception.

Data Collection

The instrument. This study used a slightly modified version of the Texas MMC Provider Satisfaction Survey administered by THQA in previous studies of provider satisfaction (THQA, 1998, 1999). Many of the items on this survey have already been found reliable and valid for behavioral health providers during the earlier survey administrations. The Texas MMC Provider Satisfaction instrument has a Cronbach's alpha of 0.9711. A factor analysis yielded a one factor solution and item to total score correlation above 0.50. A detailed discussion of the development process and piloting of the items for the instrument is included in Appendix B, as well as a copy of the survey instrument used.

The instrument is designed to gather information on two NorthSTAR program domains – coverage of clinical care and administrative and organizational processes. Section I of the NorthSTAR survey instrument addressed issues concerning clinical care. If the individual completing the survey was not the actual clinician who provided the care, the respondent was instructed to proceed directly to Section II, which addressed administrative and organizational issues associated with the NorthSTAR program. Section III asked the individual about his/her overall satisfaction and perceptions of NorthSTAR in such areas as access, quality of care, and continuity of care. A Demographic Information Section included several questions about the provider's practice including practice type, length of involvement in NorthSTAR, and percentage of his/her patients enrolled in the NorthSTAR program.

Survey Administration. The data collection method employed for this project was a mark-sense paper-and-pencil survey distributed by mail. Every survey was labeled with a tracking identification number to allow THQA to maintain the confidentiality of responses and to retrieve valuable demographic information on providers. In addition, the tracking number helped to ensure that providers who had completed a survey were not re-contacted.

Each survey packet mailed to providers contained a cover letter describing the purpose of the study and provided assurance of confidentiality of responses. The letter also encouraged providers to

complete the survey and return it in the enclosed postage-paid business-reply envelope.

The first set of surveys was mailed on 2/15/01. For providers who did not respond to the mailed survey within 2 weeks of the initial mailing, a second survey was mailed on 3/2/01 with a follow-up letter. Individuals who did not respond to either survey attempt received three telephone calls in an attempt to complete the survey process. Telephone follow-up by THQA staff began on 3/12/01 and continued through the end of the data collection period.

Every contact with a provider, by mail or telephone, was recorded in a limited-access database maintained at THQA. Each contact was also assigned a result code to indicate whether or not an interview had been completed, rescheduled, or refused at the time of contact. This database was updated daily to minimize incomplete and duplicate entries. At the conclusion of the data collection phase, each respondent was assigned a final result code indicating the survey was either (1) completed by mail or (2) not completed. In the event a survey was not completed, an explanation was included in the database. Typical reasons for incomplete surveys were refusal to participate in the survey, no longer participating in Medicaid, and lack of accurate contact information.

Data from all surveys were double keyed, and the resulting data were saved to a file. The data were then cleaned, and quality checks were performed to assure consistency of responses. The final data were imported into SAS for analysis.

Statistical Analyses

All analyses in this report are based on unweighted data, and all analyses were performed using SAS Version 8.1. The following definitions and formulae guide the analyses.

Calculating and Reporting Response Rate. A response rate is calculated separately for each survey using the following formula:

$$\frac{\text{Number of completed returned questionnaire}}{\text{Total number of respondents selected - (deceased + ineligible + bad contacts)}}$$

The final distribution of the responses for the survey in terms of completion status is described. Respondents and non-respondents are further categorized by their licensure type, and an overview of the distribution of the two groups are examined.

Characteristics of Respondents. The sample is stratified by the various surveys demographic and practice characteristics (e.g., type of patient care, primary billing type), and percentage of respondents in select categories is described.

Quantifying and Reporting Satisfaction. For each area of two program domains – clinical care and administration/organization – satisfaction is measured on a five point Likert Scale using the following definitions: The positive endpoint, “very satisfied,” was defined as “I would not make major changes to NorthSTAR on the issue in question.” The negative endpoint, “very dissatisfied,” was defined as “I have considered dropping out of NorthSTAR based on the issue in question.” These definitions were provided to respondents in order to reduce the variability in interpretation and maximize the internal consistency of responses.

A satisfaction score is calculated for each respondent based on questions 4, 5, 6, 8, 9, 11, and 12 on the survey instrument. To be included in the analysis, the respondent had to answer at least five of the seven questions. Responses were coded on a scale of 1 to 5, using 5 to represent “Very Satisfied” and 1 to represent “Very Dissatisfied”. Responses of “Not Applicable” were not used to compute satisfaction. To arrive at a single indicator of satisfaction for each respondent, responses were averaged using a standard equation:

$$\frac{\text{Sum of Valid Responses}}{\text{Total Number of Valid Responses}}$$

The computation of this average allowed for the comparison of respondents who did not answer every question with those who did answer every question (a minimum criteria of five complete questions was set for inclusion in the analyses). An overall satisfaction score was calculated as well, by averaging respondents’ scores.

Satisfaction is presented by a number of important provider and practice characteristics. Frequencies are first presented for satisfaction with the two program domains – clinical care and administration/organization – addressed in the questionnaire. In this analysis, each question in the two domains is examined, and the five categories of responses for satisfaction are collapsed into three categories: satisfied, neutral, and dissatisfied.

Next frequencies are presented for the three individual questions of the domains with the highest proportion of respondents indicating they were **very satisfied** and then for the three individual questions of the domains with the highest proportion of respondents indicating they were **very dissatisfied**.

Satisfaction also is described in terms of provider type. Respondents are stratified by occupation, and their level of satisfaction (all categories provided) is displayed in tabular format. This analysis includes only respondents with calculable satisfaction scores (at least five of the seven items).

Finally, satisfaction is described in terms of the intensity of the providers' involvement with NorthSTAR. Respondents were first stratified by the amount of time they had worked with the NorthSTAR program and then by the percentage of their patients who were NorthSTAR clients. Levels of satisfaction are displayed in tabular format for the two stratifications.

The last analysis examines the perception of providers of the program's impact on health care quality and service delivery in terms of access, continuity, and administrative costs. The results are displayed in tabular format.

Results

This section presents the results of the analyses described earlier in the methods' section. Response level frequencies of raw data items are presented in Appendix C.

Study Response

The survey was mailed to 260 NorthSTAR behavioral health providers. The corrected response rate for this administration was 73.7 percent and was distributed as detailed in Table 1. In summary, a total of 187 responses were received by THQA. Of these responses, 164 surveys (63.1%) were considered complete enough to include in the analysis. The balance of the collected responses consisted of duplicates that were discovered using the tracking information to match responses to providers. This duplication occurred during the follow-up period between when providers mailed their completed surveys and when they were received by THQA. If a provider completed the survey, but it had not been received, then the provider was still eligible to receive a follow-up survey or telephone call. Of responses not collected by THQA, one in five represented behavioral health providers who did not respond (n=54; 20.8% of surveys administered). The next two largest categories represented practitioners who do not participate in the NorthSTAR program (n=19; 7.3% of surveys administered) and incorrect contact information (n=17; 6.5% of surveys administered).

Table 1. Final Distribution of NorthSTAR Provider Responses

Distribution of Responses	Population (n=260)
Completed survey	164 (63.1%)
Refused	5 (1.9%)
Incorrect contact information – address or phone number	17 (6.5%)
Wrong person	1 (0.4%)
Practitioner does not participate in NorthSTAR	19 (7.3%)
Did not respond	54 (20.8%)

Respondents and nonrespondents were examined in terms of the licensure information provided on the 260 members of the population. The information in Table 2 indicates that the distribution of the sample of respondents was similar to the distribution of non-respondents in terms of this important characteristic. Among behavioral health providers where the licensure type was provided, the largest category of respondents and nonrespondents was composed of licensed professional counselors (34.1% and 27.1%, respectively) followed by psychologists (20.1% and 18.8%, respectively) and licensed social workers (21.9% and 12.5% respectively).

Table 2. Comparison of Licensure Characteristics of the Target Population, Respondents and Non-respondents

Licensure Type	Target Population n=260	Respondents n=164	Non Respondents n=96
Psychiatrist	24 (9.2%)	12 (7.3%)	12 (12.5%)
Psychologist	51 (19.6%)	33 (20.1%)	18 (18.8%)
Licensed Professional Counselor (LPC)	82 (85.4%)	56 (34.1%)	26 (27.1%)
Licensed Social worker - Advance Clinical Practitioner (LSW-ACP) or Licensed Master Social Worker (LMSW)	33 (12.7%)	21 (21.9%)	12 (12.5%)
Licensed Marriage Family Therapist (LMFT)	10 (3.8%)	7 (4.3%)	3 (3.1%)
Licensed Chemical Dependency Counselor (LCDC)	1 (0.4%)	0 (0.0%)	1 (1.0%)
Other	59 (22.7%)	35 (21.3%)	24 (25.0%)

Characteristics of Respondents

Table 3 presents selected demographic and practice characteristics for the NorthSTAR survey responders^{2,3}. In summary:

- The majority of behavioral health providers were in a solo practice (58.5%) and were established providers of behavioral health care, with almost 70 percent indicating they were in practice for more than 10 years.
- A little more than one-half of the practitioners (50.6%) indicated they provided only mental health care; ten providers (6.1%) indicated they provided chemical dependency care only.
- The vast majority (80.5%) indicated they were paid on a fee-for-service basis.
- Three out of four providers (78.7%) had worked with the NorthSTAR program for more than 1 year. NorthSTAR provided less than 25 percent of patients for almost 60 percent of the providers surveyed.

Table 3. Demographic and Practice Characteristics of Respondents

Characteristic	Number	Percent
Practice Type		
Group	21	12.80%
Residential Facility	6	3.66%
Solo	96	58.54%
Inpatient Facility	8	4.88%
Specialty Provider Network	8	4.88%
Primary Outpatient Facility	21	12.80%
Provider Type of the Person Completing the Survey		
Psychiatrist	12	7.32%
Psychologist	32	19.51%
Nurse	3	1.83%
Nurse Practitioner	1	0.61%
Physician Assistant	0	0.00%
Licensed Counselor	70	42.68%
Licensed Social Worker – Advanced Clinical Practitioner	19	11.59%
Licensed Marriage Family Therapist	23	14.02%
Licensed Master Social Worker	5	3.05%
Licensed Chemical Dependency Counselor	16	9.76%
Office Staff	15	9.15%
Other	13	7.93%

² Numbers may not add up to 164 for each item, as some individuals gave more than one answer to a question, and others skipped questions.

³ Information on provider type is representative of the actual respondent.

Table 3. Demographic and Practice Characteristics of Respondents (continued)

Characteristic	Number	Percent
Type of Patient Care		
Chemical Dependency (CD)	10	6.10%
Mental Health (MH)	83	50.61%
Both MH and CD	70	42.68%
Adult	36	21.95%
Child	5	3.05%
Both	108	65.85%
Primary Billing Type		
Fee-for-Service	132	80.49%
Capitation	3	1.83%
Case Rate	12	7.32%
Combination	8	4.88%
Other	2	1.22%
Time Involved with NorthSTAR		
Less than 6 Months	4	2.44%
6 Months – 1 Year	26	15.85%
Greater than 1 Year	129	78.66%
Percentage of Patients Enrolled in NorthSTAR		
Less than 25%	98	59.76%
25-49%	30	18.29%
50-74%	17	10.37%
75-100%	14	8.54%
Years in Practice		
Under 1 Year	0	0.00%
1-3 Years	3	1.83%
4-6 Years	26	15.85%
7-9 Years	23	14.02%
10 Years or More	112	68.29%
NorthSTAR Plan		
Magellan	16	9.76%
Value Options	141	85.98%

Satisfaction by Program Domains

Table 4 presents the analysis of satisfaction with the two program domains – coverage of clinical care and administrative/organizational processes – that were addressed in the questionnaire. In summary:

- Among the areas of the coverage of clinical care domain, 53.50 percent of behavioral health providers were satisfied/very satisfied with NorthSTAR's provision of appropriate coverage for treatment/clinical services according to nationally recognized standards of care.
- Among the areas of the administrative/organizational processes domain, 51.55 percent of providers were very/somewhat satisfied with the customer service provided by the health plan.
- More than 60 percent of providers expressed dissatisfaction with two areas of the administrative/organizational processes domain – Amount of paperwork associated with the program (74.03%) followed by the adequacy of the reimbursement (67.95%).
- It should be noted that more than 30 percent of providers indicated 'don't know' as a response to satisfaction in the areas of: Coverage of prescription drug benefits; Appeals process; and Ability to impact quality management and/or quality assurance activities.

Table 4. Satisfaction Level by Program Domain

Program Domain	Level of Satisfaction			
	Satisfied n (%)	Neutral n (%)	Dissatisfied n (%)	Don't Know n (%)
Clinical Care				
Appropriate coverage of treatment or clinical services according to nationally recognized standards of care	84 (53.50%)	17 (10.83%)	53 (33.76%)	3 (1.91%)
Coverage of prescription drug benefits for patients	23 (17.83%)	18 (13.95%)	49 (37.98%)	39 (30.23%)
Administrative and Organizational Processes				
Amount of paperwork required	29 (18.83%)	10 (6.49%)	114 (74.03%)	1 (0.65%)
Amount of phone work required	53 (34.19%)	18 (11.61%)	82 (52.90%)	2 (1.29%)
Customer service provided	83 (51.55%)	11 (6.83%)	64 (39.75%)	3 (1.86%)
Timeliness/accuracy of claims/capitation payments	78 (48.45%)	14 (8.70%)	67 (41.61%)	2 (1.24%)
Adequate reimbursement	44 (28.21%)	6 (3.85%)	106 (67.95%)	0 (0.00%)
Ease of obtaining authorizations/precertifications	72 (44.17%)	17 (10.43%)	71 (43.56%)	3 (1.84%)
Timeliness/accuracy of obtaining authorizations/precertifications	69 (42.33%)	17 (10.43%)	72 (44.17%)	5 (3.07%)
Provider education opportunities	46 (30.07%)	44 (28.76%)	36 (23.53%)	27 (17.65%)
Appeals process	15 (11.72%)	19 (14.84%)	40 (31.25%)	54 (42.19%)
Ability to impact quality management and/or quality assurance activities	26 (18.06%)	27 (18.75%)	45 (31.25%)	46 (31.94%)

Areas of Highest Satisfaction

Figure 1 presents the three individual questions from the two NorthSTAR program domains with the highest proportion of respondents indicating they were **very satisfied**. All three areas were in the administrative and organizational processes domain and included the timeliness/accuracy of NorthSTAR's claims/capitation payments followed by the timeliness/accuracy of authorizations/pre-certifications and customer service.

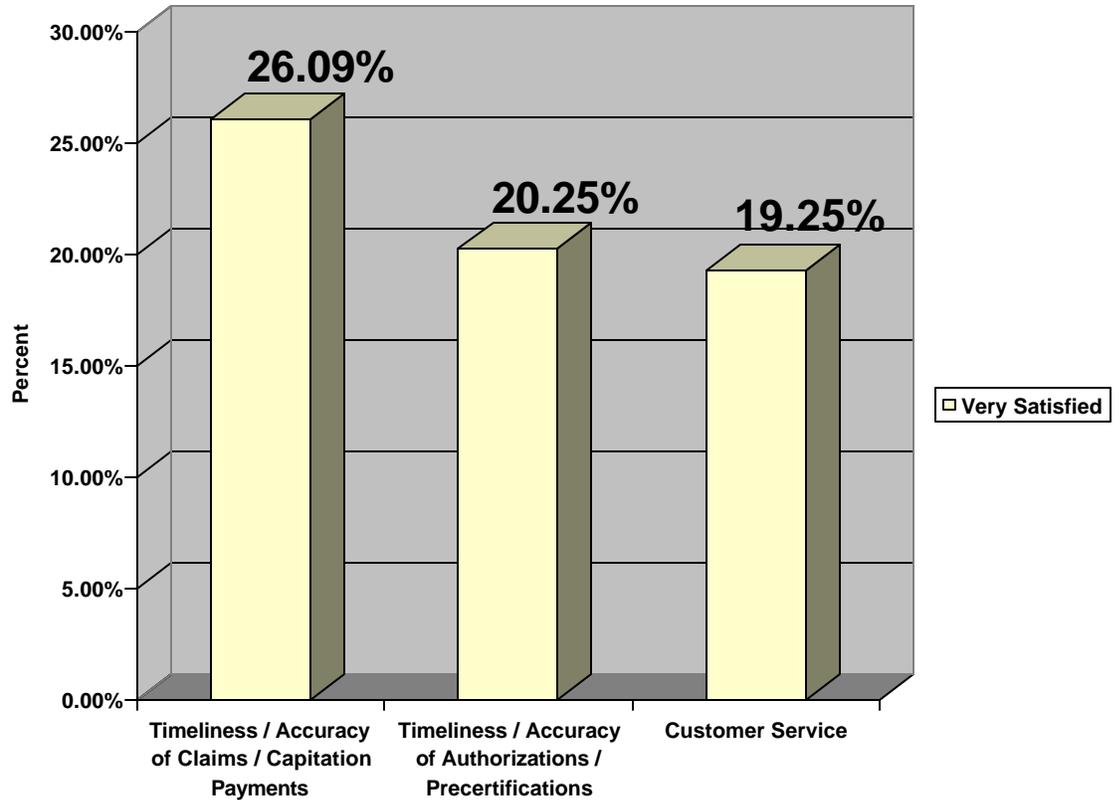


Figure 1. Areas of Highest Provider Satisfaction with NorthSTAR

Areas of the Lowest Satisfaction

Figure 2 presents the three individual questions from the two NorthSTAR program domains with the highest proportion of respondents indicating they were **very dissatisfied**. All three areas were in the administrative and organizational processes domain and included the amount of paperwork associated with NorthSTAR, followed by the adequacy of reimbursement and amount of phone work.

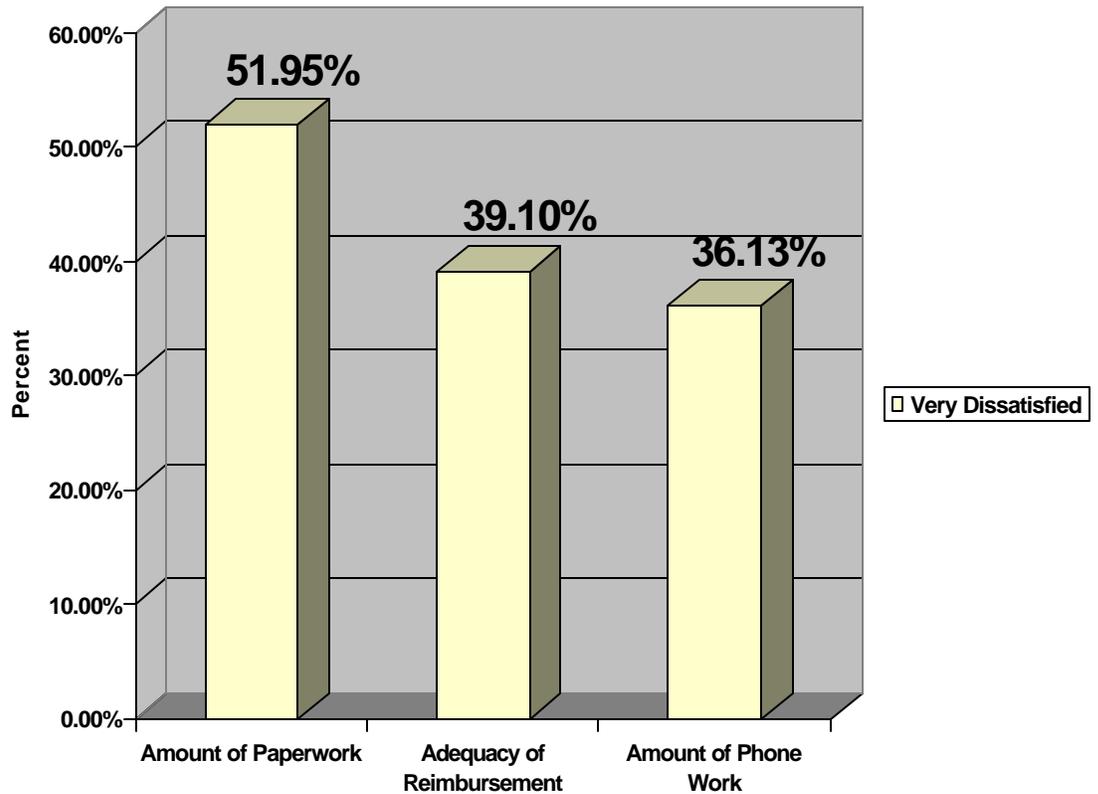


Figure 2. Areas of Lowest Provider Satisfaction with NorthSTAR

Satisfaction by Provider Type

Table 5 presents the results of respondents' satisfaction stratified by occupation⁴. In summary:

- None of the Nurse/Nurse Practitioners expressed dissatisfaction with the program. Approximately 55 percent of Psychiatrist/Psychologists expressed dissatisfaction (somewhat/very dissatisfied) with the program.
- The proportion of licensed professionals⁵ expressing satisfaction with the program ranged from zero percent among the three Licensed Master Social Workers to 33 percent among the Licensed Chemical Dependency Counselors.

Table 5. Satisfaction Level by Respondent Provider Type

Occupation	n	Average Score mean ± sd	Very Satisfied n (%)	Somewhat Satisfied n (%)	Neutral n (%)	Somewhat Dissatisfied n (%)	Very Dissatisfied n (%)
Psychiatrist/Psychologist	40	2.50 ± 1.07	0 (0.00%)	11 (27.50%)	7 (17.50%)	14 (35.00%)	8 (20.00%)
Nurse/Nurse Practitioner	4	3.40 ± 0.72	0 (0.00%)	2 (50.00%)	2 (50.00%)	0 (0.00%)	0 (0.00%)
Licensed Professional Counselor	67	2.71 ± 1.08	5 (7.46%)	14 (20.90%)	19 (28.36%)	19 (28.36%)	10 (14.93%)
Licensed Social Worker	18	2.75 ± 1.09	0 (0.00%)	6 (33.33%)	3 (16.67%)	8 (44.44%)	1 (5.56%)
Licensed Marriage Family Therapist	23	2.42 ± 1.07	2 (8.70%)	2 (8.70%)	5 (21.74%)	10 (43.48%)	4 (17.39%)
Licensed Master Social Worker	3	2.42 ± 0.36	0 (0.00%)	0 (0.00%)	1 (33.33%)	2 (66.67%)	0 (0.00%)
Licensed Chemical Dependency Counselor	15	2.87 ± 1.15	1 (6.67%)	4 (26.67%)	3 (20.00%)	4 (26.67%)	3 (20.00%)
Office Staff	14	2.01 ± 0.97	0 (0.00%)	0 (0.00%)	5 (35.71%)	3 (21.43%)	6 (42.86%)
Other	12	1.98 ± 0.93	0 (0.00%)	0 (0.00%)	4 (33.33%)	3 (25.00%)	5 (41.67%)

⁴ Only respondents with calculable satisfaction scores are presented (at least five of the seven items answered).

⁵ Licensed professions include the occupations: Licensed Professional Counselor, Licensed Social Worker, Licensed Marriage Family Therapist, Licensed Master Social Worker, and Licensed Chemical Dependency Counselor.

Satisfaction by Tenure and Intensity

Table 6 displays the results of the analyses of respondents' satisfaction⁶ by the amount of time they have worked with the NorthSTAR program and then by the percentage of their patients who were NorthSTAR clients. In summary:

- Amount of time provider has worked with NorthSTAR clients: The average score was very similar across all categories.
- Percentage of patients who were NorthSTAR clients: Providers with the greatest percentage of their clients enrolled in NorthSTAR (over 75%) had the lowest average satisfaction score.

Table 6. Satisfaction Level by Tenure and Intensity of Involvement

Health Plan	n	Average Score mean ± sd	Very Satisfied n (%)	Somewhat Satisfied n (%)	Neutral n (%)	Somewhat Dissatisfied n (%)	Very Dissatisfied n (%)
Time Involved in NorthSTAR							
Under 6 Months	3	2.63 ± 1.67	0 (0.00%)	1 (33.33%)	1 (33.33%)	0 (0.00%)	1 (33.33%)
6 Months – 1 Year	22	2.56 ± 1.06	0 (0.00%)	6 (27.27%)	7 (31.82%)	4 (18.18%)	5 (22.73%)
Over 1 Year	123	2.63 ± 1.08	5 (4.07%)	28 (22.76%)	29 (23.58%)	41 (33.33%)	20 (16.26%)
NorthSTAR clients as a Proportion of all Clients							
Less than 25%	88	2.67 ± 1.08	3 (3.41%)	23 (26.14%)	20 (22.73%)	30 (34.09%)	12 (13.64%)
25-49%	30	2.70 ± 1.05	1 (3.33%)	7 (23.33%)	9 (30.00%)	7 (23.33%)	6 (20.00%)
50-74%	17	2.70 ± 1.19	1 (5.88%)	4 (23.53%)	4 (23.53%)	4 (23.53%)	4 (23.53%)
Over 75%	13	2.20 ± 1.01	0 (0.00%)	2 (15.38%)	4 (30.77%)	3 (23.08%)	4 (30.77%)

⁶ Only respondents with calculable satisfaction scores are presented (at least five of the seven items answered).

Health Care Delivery and Quality

Table 7 presents the analysis of provider perception of the impact of NorthSTAR on healthcare delivery and quality. In summary:

- The majority of respondents stated that NorthSTAR does not decrease access to care. Almost half (45.22%) stated the program does not decrease continuity of care.
- Equal proportions of respondents believed that NorthSTAR increases/does not affect (45.51%) and decreases (45.51%) quality of care for patients.
- The majority of respondents (63.92%) indicated that NorthSTAR increases their administrative costs.

Table 7. Health Care Delivery and Quality

Delivery and Quality of Care	Impact of NorthSTAR			
	Increases n (%)	Does not affect n (%)	Decreases n (%)	Don't Know n (%)
Access to Care	82 (52.90%)	10 (6.45%)	51 (32.90%)	12 (7.74%)
Continuity of Care	58 (36.94%)	13 (8.28%)	63 (40.13%)	23 (14.65%)
Quality of Care	53 (33.97%)	18 (11.54%)	71 (45.51%)	14 (8.97%)
Administrative Costs	101 (63.92%)	31 (19.62%)	18 (11.39%)	8 (5.06%)

Discussion

In summary, this study examined the level of satisfaction of the population of behavioral health providers who served at least one client in the NorthSTAR program in 2000. Information was gathered through a mailed survey, using a valid, reliable instrument developed by THQA for the study of all health providers in Texas. The adjusted response rate was more than 70 percent, and respondents were representative of the population of NorthSTAR behavioral health providers.

The majority of respondents were seasoned providers with more than 10 years of experience in their specialty and over a year of experience serving NorthSTAR clients. Over one-half of respondents were in solo practices and were paid on a fee-for-service basis. NorthSTAR clients, in general, comprised less than 25 percent of their clients.

A number of important findings were noted. Across occupation types, between 30 and 50 percent of respondents expressed either neutral or some level of satisfaction with the program. The majority of Psychiatrists/Psychologists and Licensed Marriage and Family Therapists reported being dissatisfied.

Among the two domains where satisfaction was noted, the NorthSTAR program was well received by many study participants. In particular, approximately 50 percent or more of respondents were very/somewhat satisfied with:

- Coverage for treatment/clinical services
- The levels of customer service received.

Administratively, the program presents similar challenges to these providers as were noted in the literature. In particular, NorthSTAR providers were dissatisfied with the amount of telephone and paperwork required.

NorthSTAR providers deviated from other MMC providers in one major respect. Information from the literature suggests that MMC providers expressed higher levels of satisfaction as the proportion of MMC clients increased among their practices. This study found the opposite to be true for behavioral health providers: NorthSTAR providers expressed lower levels of satisfaction with the program as the proportion of NorthSTAR clients increased.

These results and the providers responses should be interpreted within the context of NorthSTAR implementation since the NorthSTAR waiver represented significant process shifts and major system changes for all participating behavioral health providers. For example, as the provider

network has been expanded, some small practice and solo providers have been brought into the larger network of providers. Some are new to the managed care reporting and administrative requirements. There is also a proportion of Medicaid providers who were accustomed to traditional fee-for-service billing arrangements with less emphasis on utilization review and service authorization processes. A third group of providers consists of those associated with community mental health centers who were traditionally funded by large block grants from the State and were not required to bill for service units in the same way they are now.

Appendix A

Summary of Reviewed Literature on Provider Satisfaction

Study	Sample Size/Method	Mode Of Data Collection	Satisfaction Questions	Follow-Up/ Response Rate	Result
Anderson, (1998); Army Medical Center	Patients, nurses, licensed vocational nurses (LVNs); convenience sample	Workload Management Scale for Nursing (WMSN) data obtained from existing hospital data, Work Environment Scale (WSN) given to nurses in military hospital	No "satisfaction" questions; Moos WSN and WMSN given	Number of questionnaires given to nurses and response rate not reported	Study primarily focused on patient satisfaction and correlation with provider satisfaction – sketchy information on providers
Bailey, et al. (1997); TennCare	1,181 members of the Tennessee Chapter of theACP; random sample	Mail survey	No "satisfaction" questions: assessed problems providing for patient care via TennCare, rating of TennCare overall and with regard to specific program characteristics	306 responses (26% rate) with unspecified follow-up methods	Majority of doctors felt inadequate reimbursement was problem; problems in dealing with TennCare system (i.e., complex & confusing rules, obtaining needed meds for patients, treatment coverage, care delays awaiting approval, specialist referrals); rated overall system unfavorably
Bates, et al. (1998); Dimensions and Correlates of Physician work satisfaction	777 physicians in Marion County, Indiana	Mail survey	Used "satisfaction" questions addressing relationships with patients, clinical autonomy, office resources, and professional relationships	42%, two mailings and a post card reminder	Four dimensions of satisfactions were identified; physicians with a high percentage of capitated care patients were not enthusiastic about the effects of managed care on their practice

Summary of Reviewed Literature on Provider Satisfaction (continued)

Study	Sample Size/Method	Mode Of Data Collection	Satisfaction Questions	Follow-Up/ Response Rate	Result
Byers, et al. (1999)	All physicians, nurses, physician assistants in 9 clinics at 3 Army medical centers	Mailed	Used "satisfaction" questions	No follow-up method given, response rate: doctors 46%, nurses, 76%, physician assistants 41%	All groups similar in satisfaction ratings, most satisfied with the care they give, perceived autonomy was the best predictor of job satisfaction
Eliason, et al. (2000); Physicians personal values and practice satisfaction	Stratified random sample of 1,224 practicing family physicians	Mail survey	Used the Schwartz values questionnaire and three questions addressing satisfaction with their practice	712 usable surveys, 58% response rate; three mailings 6 weeks apart	The value of benevolence was positively associated with practice satisfaction, and most often expressed by family physicians. Universalism was rated important by physicians with a large percentage of underserved patients in their practice.
Feldman, et al. (1998); Effects of managed care on quality of care, physician-patient relationships and ethical practice issues	1,011 primary care physicians in Pennsylvania, in 1996	Mail Survey	Developed a survey to assess how managed care affects physician-patient relations, physicians ability to carry out ethical obligations, and quality of care provided to patients	559 usable surveys, 55% response rate; two mailings	Primary care physicians expressed that managed care had a neutral impact on some aspects of quality of care, and a negative impact on other aspects

Summary of Reviewed Literature on Provider Satisfaction (continued)

Study	Sample Size/Method	Mode Of Data Collection	Satisfaction Questions	Follow-Up/ Response Rate	Result
Foulke, et al. (1998)	A comparison of academic and community physicians attitudes and behavioral intentions toward managed care	Mail Survey	Developed a survey to assess quality of care, cost-effectiveness, inevitability of managed care growth, and need and intentions to adapt to managed care	436 usable responses, 129 academic physicians, and 307 community physicians	Community physicians had less negative attitudes than academic physicians toward the impact of managed care on the quality of care, but no differences were identified between the two groups with regard to cost-effectiveness, inevitability, or need to adapt to managed care
Kerr, et al. (1997); California (CA) study of capitated versus noncapitated	1,138 primary care physicians in 89 CA physician practice groups sampled	Mail survey	Used "satisfaction" questions. Studied the relationship of provider with patient, quality of care they provided, their ability to use their judgment selecting treatments, and their ability to refer to specialists	80% response rate, initial mailing followed up with one more mailing, one phone call; \$20 incentive	Physicians less satisfied with every measure for capitated patients than non-capitated patients
Kerr, et al. (2000); Physician satisfaction and aspects of utilization management (UM)	1,138 primary care physicians from 89 capitated physicians groups	Mail survey	Asked questions about UM policies used in their groups and satisfaction with delivered care, specifically autonomy, quality of care, and administrative burden	910 usable surveys, 80% response rate; \$20 incentive	Denial rate and turnaround time were negatively associated with satisfaction; groups provided with guidelines were relatively more satisfied on these dimensions and educational programs eased administrative burden

Summary of Reviewed Literature on Provider Satisfaction (continued)

Study	Sample Size/Method	Mode Of Data Collection	Satisfaction Questions	Follow-Up/ Response Rate	Result
The MedStat Quality Catalyst [®] Program (1998)	30,000 physicians in 22 commercial markets	Mail survey	Used "satisfaction" questions	Unspecified	7 of 10 physicians were against managed care
Probst, et al. (1997)	All providers of care at a University teaching clinic during July, 1995	Survey placed on patients' charts for physicians; patients interviewed	Used "satisfaction" question about visit	100% response rate for physicians	Physicians were satisfied (50%) or very satisfied (38%) the majority of the time with their patient encounters; patients were satisfied most of the time
Salive (1997)	All graduates of general practice medical residencies between 1979-1989 (n=1,070)	Mailed	Used "satisfaction" questions	2 follow-up mailings, 73% response rate with job satisfaction questions completed	Most physicians were satisfied (44%) or very satisfied (44%) with their job
Silverstein and Kirkman-Liff, Silverstein (1995, 1997) AHCCCS	300 surveyed, 171 completed	Mail survey	One "satisfaction" question; plan characteristics (paperwork, etc.), reimbursement, attitude toward Medicaid patients	Survey, one follow-up mailing, one phone call, 64% response	Reimbursement drives physician satisfaction and willingness to participate in MMC
THQA/TDH Primary Care Provider Satisfaction with MMC (1999)	Random sample of 1,237 PCPs	Mail survey	20 satisfaction questions about various clinical and administrative aspects of MMC	Telephone follow-up, second mailing, 33.6% response rate	Overall tendency toward dissatisfaction; physicians less satisfied than non-physicians; some questions elicited more satisfied/ dissatisfied responses than others

Summary of Reviewed Literature on Provider Satisfaction (continued)

Study	Sample Size/Method	Mode Of Data Collection	Satisfaction Questions	Follow-Up/Response Rate	Result
THQA/TDH Long Term Care Provider Satisfaction with STAR+PLUS MMC (1999)	Entire population of 444 LTC providers	Mail survey	13 satisfaction questions about various service and administrative aspects of MMC	Telephone follow-up, second mailing, 40.8% response rate	Overall tendency toward dissatisfaction; tendency for providers with more years in service to be less satisfied

Provider Satisfaction Survey Development

Survey Development

In the 1999 Evaluation Work Plan, THQA committed to the task of measuring provider satisfaction with MMC. Discussions with the TDH, physicians, and health research professionals indicated that several clinical and administrative issues might affect provider satisfaction and, therefore, needed to be addressed by the survey. The issues addressed in the study are listed below:

- Providers' ability to obtain what they need to treat their patients
- Availability and accessibility of a specialist network
- Ease of referrals
- Claims payment
- Authorizations and pre-certifications
- Paperwork
- Customer service.

Although many of the existing instruments contained questions about these issues, few (if any) attempted to measure satisfaction with these issues or in general. Consequently, the decision was made to create a new instrument to measure provider satisfaction with MMC in the State of Texas. The resulting instrument was intended to offer a psychometrically sound way to identify areas in which providers are most and least satisfied and identify possible factors that predict satisfaction.

In order to get a sense of the types of items and issues that should be represented in the survey, THQA began the project by searching for and reviewing existing instruments. THQA reviewed surveys developed by the Texas Agriculture and Mechanical University (Texas A&M) and the University of New Mexico, as well as two State of Texas surveys. These surveys contained questions about providers' experiences with Medicaid and/or Managed Care — including billing and payment questions, interactions with plans, provider-patient interactions, and perceived quality of care — but contained few, if any, questions about provider satisfaction. Consequently, the questions on these surveys provided insight as to what issues should be covered in a new provider satisfaction survey, but they did not address how new questions might be phrased.

As part of the instrument development process, THQA sought assistance from the Department of Health and Evaluation Sciences (DHES) at the University of Virginia Health Sciences Center. Established in 1995, the University of Virginia DHES was created to provide comprehensive and multidisciplinary scientific and analytical services to the Health Sciences Center and the rest of the University community, to State and Federal Government agencies, and to select industry partners. DHES is devoted to discovery and development of new approaches and research strategies for health and disease description, prognosis, clinical and genetic risk assessment, information transfer, biostatistical and epidemiological research, medical decision-making, and medical practice delivery for individuals and populations. This department has a reputation for assisting clinicians, administrators, and others to more precisely evaluate the efficacy of medical care and health improvement practices and, more accurately, test new approaches to the treatment of disease and to health care delivery in general.

To assist with instrument design, THQA provided DHES with some of the available research on provider satisfaction and surveys previously used in Texas and New Mexico. DHES reaffirmed the belief that a new, rather than an existing, instrument was needed for the project in Texas — especially given that provider satisfaction was of primary interest.

DHES sent a first draft of questions and recommendations for the study on November 19, 1999. THQA shared this draft with the Texas Department of Health (TDH), other state agencies, and medical professional associations to receive comments about the survey content and suggestions to improve response rates. Initially, a key goal of the project was to compare physicians' satisfaction with specific plans. This implied that the questions on the survey should reference a specific plan for each provider. However, a review of the Medicaid enrollment files indicated that over half of all Medicaid providers in the State of Texas are affiliated with multiple MMC plans. Because the majority of physicians belong to more than one plan, it seemed unlikely that they could accurately differentiate between the plans as they attempted to express their opinions. It seemed reasonable to hypothesize that providers could distinguish between plans on the basis of specific positive and/or negative experiences. But for the most part, providers' responses would reflect their general perceptions of MMC.

Based on these concerns, it was decided that questions should target satisfaction with MMC in general. An additional question was added to allow providers to indicate which single plan (if any) had most influenced their responses. The definition of satisfaction for the purposes of this

project was also carefully examined. As alluded to in the literature review, there does not appear to be a standard definition of “satisfaction,” either within or across disciplines. If each provider defined “satisfaction” differently, then each response option might also be interpreted differently, and so the same response given by two different providers might not have the same meaning. In order to mitigate this problem, the definition of “satisfaction” intended for this project was provided in the survey instructions. The positive endpoint, “very satisfied,” was defined as “I would not make major changes to Medicaid Managed Care on the issue in question.” The negative endpoint, “very dissatisfied,” was defined as “I have considered dropping out of Medicaid Managed Care based on the issue in question.” Providing these definitions, in addition to reducing variability in interpretation and possibly maximizing internal consistency of responses, gives some basis for deciding which issues covered in the survey are the most likely candidates for further evaluation and change. For example, if providers’ responses on a topic like specialty care are all in the “very dissatisfied” direction, then they may be indicating, at least in theory, that the specialty care issue is critical to their participation in MMC.

Once the final question and instruction wording issues were resolved, DHES conducted a pilot test of the primary care survey. THQA provided the DHES staff with the names, telephone numbers, and fax numbers of 200 Texas MMC providers randomly selected from a listing provided by the TDH. From January 6, 1999, to January 20, 1999, DHES attempted to contact and survey these providers. Five providers were surveyed by phone, and 100 providers received faxed copies of the survey. The remaining 95 providers could not be reached due to incorrect or unavailable contact information. A total of 27 providers completed the survey. This represents an unadjusted response rate of 13.5 percent (27/200). After adjusting for poor contact information, the response rate was 25.7 percent (27/105). Although the response rate was somewhat lower than desired, the results of this test were generally positive.

Preliminary psychometric analyses reported by DHES indicated that all items appeared to perform well (the reported reliability coefficient was .8738). Based on this information, THQA sought and received final TDH approval of the survey content and format. A few caveats should be made regarding the information obtained from the pilot test. Generally, pilot tests are recommended in order to explore the interpretability and performance of survey items prior to administering the survey to a larger sample of the population. In order for the pilot test to provide useful information about the survey, the pilot test must be designed and carried

out according to certain requirements. These requirements are listed below:

- The sample for the pilot should be drawn from the same population as the intended respondents.
- The pilot instrument should contain the same questions intended for use in the larger survey effort.
- A sufficient response rate should be obtained during the pilot.

Meeting these requirements helps ensure that the responses and reactions obtained during the pilot test are representative of what is obtained from the intended respondents. If the pilot test meets these requirements, then revisions to the survey can be justified as being necessary to produce accurate, representative information. The positive psychometric properties of the survey found in the pilot and the deadlines imposed by contract requirements did not clearly indicate a need for further revision. Thus, we proceed with the larger administration.

Psychometric analyses, including factor analysis and alpha reliability analyses, were conducted to assess the dimensionality and quality of the 20 satisfaction items. Principal axis and principal components extraction methods were used in deriving the factor solution. Four main criteria were used to evaluate the solution: Kaiser's rule (retain factors with eigen values greater than 1.0), scree plot, item loadings, and interpretability of factors. Although two factors were extracted according to Kaiser's rule, the acceptability of this solution was questionable.

The eigen value greater-than-one criterion, while common, has a tendency to overestimate the number of factors (Stevens, 1996). Examination of the scree plot and the item loadings in the unrotated solution suggested a unidimensional scale — the first factor explained over 50 percent of the variance, and all item loadings exceeded 0.4 on the first factor (and did not exceed 0.4 on the remaining factors). The interpretation of the one factor solution is that providers are either satisfied or not — there were not, in this case, additional discernible factors contributing to providers' evaluations.

Only 225 of the 416 providers who responded answered at least 6 of the first 8 survey questions. These questions pertained to clinical care, and the survey instructions requested that respondents skip these questions if they were not directly involved in clinical care. Additional analyses revealed that respondents who answered the first 8 survey questions were more likely than those who skipped the first 8 questions to:

-
- Indicate “primary care physician” or “specialty care physician” as their occupation ($\chi^2 = 169.97$, $df=1$, $p < .001$; physician $n=172$, nonphysician $n=24$)
 - Respond to the initial survey ($n=169$) rather than follow-up ($n=56$) contact ($\chi^2 = 139.17$, $df=1$, $p < .001$).

Associations between when surveys were completed, which questions were answered, and the people likely to respond raised concerns about the utility of the first 8 items for comparing providers. Differences in motivation to respond would be expected between providers who responded initially and those who responded at follow-up — and these differences would likely influence their satisfaction ratings. Thus, the first 8 items were analyzed for physicians only, but then omitted from all subsequent analyses intended for comparisons among all respondents (including nurses, administrators, and others).

Reanalysis of the factor solution using only the last 12 satisfaction items (items 9-18, 20, and 21) also suggested a one-factor solution. Only one factor had an eigen value over 1.0, and this factor explained about 57 percent of the total variance in the last 12 items. All item loadings were over 0.65. Based on these results, a one factor solution was accepted and interpreted as indicating that respondents were either satisfied or not satisfied. Cronbach’s alpha was calculated to evaluate the reliability of the test.

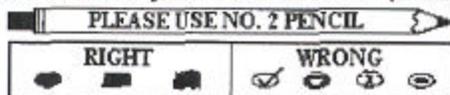
The reliability of the complete scale, which applies only to those providers who completed all 20 items, was 0.9711. The reliability of the last 12 items of the scale was 0.9524, and all item to total correlations were over 0.5. No items stood out as contributing negatively to reliability of the test, and there was no evidence that the scale would be significantly improved by excluding any of the items. These results suggest that these items were highly related, measured primarily one thing, and could be combined to create a satisfaction scale. Due to the systematic tendency of nonphysicians to skip the first 8 questions (discussed above), the overall satisfaction scale scores were calculated using only the last 12 items.

Texas Medicaid Managed Care NorthSTAR Provider Satisfaction Survey (2001)

You have been selected to participate in a survey to gauge satisfaction levels with NorthSTAR. This information will be aggregated and sent to the TDH, TXMHMR, and TCADA for review. Your views are very important, and suggestions will be used to improve the program. At no time will you be identified personally to any agency.

When indicating your responses, consider "very satisfied" to mean, "I would not make major changes to NorthSTAR on the issue in question" and "very dissatisfied" to mean, "I have considered dropping out of NorthSTAR based on the issue in question."

Please restrict your answers to the questions to your personal experiences within the last six months.



Section I. How satisfied are you with NorthSTAR in the following areas related to clinical care? Please fill in one bubble only. If you are not involved in clinical care, please proceed directly to Section II.

1. How satisfied are you that NorthSTAR provides appropriate coverage of treatment or clinical services according to nationally recognized standards of care?

- Very Satisfied
 Somewhat Satisfied
 Neutral
 Somewhat Dissatisfied
 Very Dissatisfied
 Not Applicable
 Don't Know

2. How satisfied are you that NorthSTAR provides appropriate coverage of health promotion or disease prevention according to nationally recognized standards of care?

- Very Satisfied
 Somewhat Satisfied
 Neutral
 Somewhat Dissatisfied
 Very Dissatisfied
 Not Applicable
 Don't Know

3. How satisfied are you with NorthSTAR's coverage of prescription drug benefits for the patients in your practice?

- Very Satisfied
 Somewhat Satisfied
 Neutral
 Somewhat Dissatisfied
 Very Dissatisfied
 Not Applicable
 Don't Know

Section II. How satisfied are you with NorthSTAR in the following areas related to administration and organization? Please fill in one bubble only. If you do not have personal experience in one of these areas, please fill in "Not applicable."

4. How satisfied are you with the amount of paperwork required by the NorthSTAR plans?

- Very Satisfied
 Somewhat Satisfied
 Neutral
 Somewhat Dissatisfied
 Very Dissatisfied
 Not Applicable
 Don't Know

5. How satisfied are you with the amount of phone work required by the plans in NorthSTAR?

- Very Satisfied
 Somewhat Satisfied
 Neutral
 Somewhat Dissatisfied
 Very Dissatisfied
 Not Applicable
 Don't Know

6. How satisfied are you with the customer service provided by NorthSTAR plans to providers and office staff?

- Very Satisfied
 Somewhat Satisfied
 Neutral
 Somewhat Dissatisfied
 Very Dissatisfied
 Not Applicable
 Don't Know

7. How satisfied are you with the timeliness and accuracy of claims/capitation payments from the NorthSTAR plans?

- Very Satisfied
 Somewhat Satisfied
 Neutral
 Somewhat Dissatisfied
 Very Dissatisfied
 Not Applicable
 Don't Know

8. How satisfied are you that NorthSTAR provides adequate reimbursement for your services?

- Very Satisfied
 Somewhat Satisfied
 Neutral
 Somewhat Dissatisfied
 Very Dissatisfied
 Not Applicable
 Don't Know

9. How satisfied are you with the ease of obtaining authorizations/precertifications from the NorthSTAR plans?

- Very Satisfied
 Somewhat Satisfied
 Neutral
 Somewhat Dissatisfied
 Very Dissatisfied
 Not Applicable
 Don't Know

10. How satisfied are you with the timeliness and accuracy of obtaining requested authorizations/precertifications from the NorthSTAR plans?

- Very Satisfied Somewhat Satisfied Neutral Somewhat Dissatisfied Very Dissatisfied Not Applicable Don't Know

11. How satisfied are you with the provider education opportunities provided by the NorthSTAR plans?

- Very Satisfied Somewhat Satisfied Neutral Somewhat Dissatisfied Very Dissatisfied Not Applicable Don't Know

12. How satisfied are you with the appeals process at the plan level of NorthSTAR?

- Very Satisfied Somewhat Satisfied Neutral Somewhat Dissatisfied Very Dissatisfied Not Applicable Don't Know

13. How satisfied are you with your ability to impact quality management and/or quality assurance activities?

- Very Satisfied Somewhat Satisfied Neutral Somewhat Dissatisfied Very Dissatisfied Not Applicable Don't Know

Section III. The last set of questions relates to overall feelings about NorthSTAR.

14. Do you feel that NorthSTAR increases, decreases, or does not affect access to care for patients?

- Increases Decreases Does not affect Not applicable Don't know

15. Do you feel that NorthSTAR increases, decreases, or does not affect the continuity of care for patients?

- Increases Decreases Does not affect Not applicable Don't know

16. Do you feel that NorthSTAR increases, decreases, or does not affect quality of care for patients?

- Increases Decreases Does not affect Not applicable Don't know

17. Do you feel that NorthSTAR increases, decreases, or does not affect your administrative costs?

- Increases Decreases Does not affect Not applicable Don't know

If increases or decreases, please explain how and by how much.

18. Do you feel that NorthSTAR patients are well informed about their benefits?

- Yes No Not applicable Don't Know

If no, please explain.

Please complete the demographic section of the survey on the next page.

Demographic Information

Please answer a few questions about yourself and your practice.

1. Are you answering more than one of these surveys for your group practice?

- Yes No Not applicable

2. What is your practice type?

- Group Solo SPN Primary Outpatient Facility
 Residential Facility Inpatient Facility
 Other, please specify _____

3. What type of patient care do you practice? (Please check all that apply)

- Chemical Dependency (CD) Adult
 Mental Health (MH) Child
 Both MH and CD Both

4. What is your primary billing type with NorthSTAR?

- Fee for service Capitation Case rate Combination
 Other, please specify _____

5. How long have you been involved with NorthSTAR in Texas?

- Less than six months Six months to 1 year >1 year

6. Approximately how many patients do you have that are enrolled in NorthSTAR?

- 0-15 16-30 31-60 61-80 81-100 100+ Not applicable

7. Approximately what percentage of the patients in your practice are enrolled in NorthSTAR?

- Less than 25% 25-49% 50-74% 75-100%

8. Which NorthSTAR plan had the most influence on your responses to this survey?
(select only one)

- Magellan
 Value Options

9. What is your occupation?

- Psychiatrist
 Psychologist
 Nurse Practitioner
 Nurse
 Physician Assistant
 Licensed Professional Counselor (LPC)
 Licensed Social Worker- Advanced Clinical Practitioner (LMSW-ACP)
 Licensed Marriage Family Therapist (LMFT)
 Licensed Master Social Worker (LMSW)
 Licensed Chemical Dependency Counselor (LCDC)
 Office Staff (such as receptionists, billing clerks, etc.)
 Other, please specify _____

10. Would you recommend participation in NorthSTAR to a colleague?

- Yes No Not applicable Don't know

If no, please explain.

11. How many years have you been in practice?

- Less than one year
 1-3 years
 4-6 years
 7-9 years
 10 years or more

12. For future reference, which method would you prefer to use in responding to surveys?

- telephone interview mail-in survey
 e-mail form electronic response via secured URL (website)
 other (please specify)

THANK YOU VERY MUCH FOR YOUR PARTICIPATION.

Please place your completed survey in the postage paid envelope provided.

Appendix C

Response-Level Frequencies of Raw Data Items⁷

Section I.								
Survey Items	Very Satisfied n (%)	Somewhat Satisfied n (%)	Neutral n (%)	Somewhat Dissatisfied n (%)	Very Dissatisfied n (%)	Not Applicable n (%)	Don't Know n (%)	Missing n (%)
1. How satisfied are you that NorthSTAR provides appropriate coverage of treatment or clinical services according to nationally recognized standards of care?	27 (16.46%)	57 (34.76%)	17 (10.37%)	21 (12.80%)	32 (19.51%)	0 (0.00%)	3 (1.83%)	7 (4.27%)
3. How satisfied are you with NorthSTAR's coverage of prescription drug benefits for the patients in your practice?	9 (5.49%)	14 (8.54%)	18 (10.98%)	26 (15.85%)	23 (14.02%)	27 (16.46%)	39 (23.78%)	8 (4.88%)

⁷ Results for Question 2 were not included in the analysis.

Response-Level Frequencies of Raw Data Items (continued)

Section II.								
Survey Items	Very Satisfied n (%)	Somewhat Satisfied n (%)	Neutral n (%)	Somewhat Dissatisfied n (%)	Very Dissatisfied n (%)	Not Applicable n (%)	Don't Know n (%)	Missing n (%)
4. How satisfied are you with the amount of paperwork required by the NorthSTAR plans?	13 (7.93%)	16 (9.76%)	10 (6.10%)	34 (20.73%)	80 (48.78%)	4 (2.44%)	1 (0.61%)	6 (3.66%)
5. How satisfied are you with the amount of phone work required by the plans in NorthSTAR?	16 (9.76%)	37 (22.56%)	18 (10.98%)	26 (15.85%)	56 (34.15%)	2 (1.22%)	2 (1.22%)	7 (4.27%)
6. How satisfied are you with the customer service provided by NorthSTAR plans to providers and office staff?	31 (18.90%)	52 (31.71%)	11 (6.71%)	28 (17.07%)	36 (21.95%)	2 (1.22%)	3 (1.83%)	1 (0.61%)
7. How satisfied are you with the timeliness and accuracy of claims/capitation payments from the North STAR plans?	42 (25.61%)	36 (21.95%)	14 (8.54%)	23 (14.02%)	44 (26.83%)	2 (1.22%)	2 (1.22%)	1 (0.61%)
8. How satisfied are you that North STAR provides adequate reimbursement for your services?	9 (5.49%)	35 (21.34%)	6 (3.66%)	45 (27.44%)	61 (37.20%)	1 (0.61%)	0 (0.00%)	7 (4.27%)

Response-Level Frequencies of Raw Data Items (continued)

Section II. continued								
Survey Items	Very Satisfied n (%)	Somewhat Satisfied n (%)	Neutral n (%)	Somewhat Dissatisfied n (%)	Very Dissatisfied n (%)	Not Applicable n (%)	Don't Know n (%)	Missing n (%)
9. How satisfied are you with the ease of obtaining authorizations/ precertifications from the NorthSTAR plans?	31 (18.90%)	41 (25.00%)	17 (10.37%)	26 (15.85%)	45 (27.44%)	0 (0.00%)	3 (1.83%)	1 (0.61%)
10. How satisfied are you with the timeliness and accuracy of obtaining requested authorizations/ precertifications from the NorthSTAR plans?	33 (20.12%)	36 (21.95%)	17 (10.37%)	39 (23.78%)	33 (20.12%)	1 (0.61%)	5 (3.05%)	0 (0.00%)
11. How satisfied are you with the provider education opportunities provided by the NorthSTAR plans?	14 (8.54%)	32 (19.51%)	44 (26.83%)	21 (12.80%)	15 (9.15%)	6 (3.66%)	27 (16.46%)	5 (3.05%)
12. How satisfied are you with the appeals process at the plan level of NorthSTAR?	4 (2.44%)	11 (6.71%)	19 (11.59%)	13 (7.93%)	27 (16.46%)	23 (14.02%)	54 (32.93%)	13 (7.93%)
13. How satisfied are you with your ability to impact quality management and/or quality assurance activities?	6 (3.66%)	20 (12.20%)	27 (16.46%)	18 (10.98%)	27 (16.46%)	16 (9.76%)	46 (28.05%)	4 (2.44%)

Response-Level Frequencies of Raw Data Items (continued)

Section III.						
Survey Items	Increases n (%)	Decreases n (%)	Does not affect n (%)	Not Applicable n (%)	Don't Know n (%)	Missing n (%)
14. Do you feel that NorthSTAR increases, decreases, or does not affect access to care for patients?	82 (50.00%)	51 (31.10%)	10 (6.10%)	1 (0.61%)	12 (7.32%)	8 (4.88%)
15. Do you feel that NorthSTAR increases, decreases, or does not affect the continuity of care for patients?	58 (35.37%)	63 (38.41%)	13 (7.93%)	0 (0.00%)	23 (14.02%)	7 (4.27%)
16. Do you feel that NorthSTAR increases, decreases, or does not affect quality of care for patients?	53 (32.32%)	71 (43.29%)	18 (10.98%)	0 (0.00%)	14 (8.54%)	8 (4.88%)
17. Do you feel that NorthSTAR increases, decreases, or does not affect your administrative costs?	101 (61.59%)	18 (10.98%)	31 (18.90%)	1 (0.61%)	8 (4.88%)	5 (3.05%)

Response-Level Frequencies of Raw Data Items (continued)

Section III. continued					
Survey Items	Yes n (%)	No n (%)	Not Applicable n (%)	Don't Know n (%)	Missing n (%)
18. Do you feel that NorthSTAR patients are well informed about their benefits?	26 (15.85%)	96 (58.54%)	1 (0.61%)	37 (22.56%)	4 (2.44%)

Satisfaction Level by Participating Health Plan

Health Plan	n	Average Score mean ± sd	Very Satisfied n (%)	Somewhat Satisfied n (%)	Neutral n (%)	Somewhat Dissatisfied n (%)	Very Dissatisfied n (%)
Magellan	15	2.06 ± 0.83	0 (0.00%)	2 (13.33%)	2 (13.33%)	7 (46.67%)	4 (26.67%)
Value Options	131	2.72 ± 1.08	5 (3.82%)	35 (26.72%)	33 (25.19%)	38 (29.01%)	20 (15.27%)

References

- Cuffel, B., McCulloch, J., Wade, R., Tam, L., Brown-Mitchell, R., Goldman, W. (2000).** Patients' and providers' perceptions of outpatient treatment termination in a managed behavioral health organization. Psychiatric Services, 51(4), 469-473.
- Cunningham, R. (1997).** The impact of managed care on behavioral providers. Medicine and Health, 1-4.
- Feldman, D.S., Novack, D.H., & Gracely, E. (1998).** Effects of managed care on physician-patient relationships, quality of care, and the ethical practice of medicine. Archives of Internal Medicine, 158, 1626-1632.
- Fried, B.J., Topping, S., Morrissey, J.P., Ellis, A.R., Stroup, S., Blank, M. (2000).** Comparing provider perceptions of access and utilization in full-risk and no-risk Medicaid programs for adults with serious mental illness. Perceptions of Medicaid Programs, 27(1), 29-46.
- Hunter, J.K., Getty, C., Kemsley, M., and Skelly, A.H. (1991).** Barriers to providing health care to homeless persons: a survey of providers' perceptions. Health Values, 15(5), 3-29.
- Kerr, E. A., Hays, R. D., Mittman, B. S., Siu, A. L., Leake, B., and Brook, R. H. (1997).** Primary care physicians satisfaction with quality of care in California capitated medical groups. JAMA, The Journal of the American Medical Association, 278, 308-312.
- Kerr, E.A., Mittman, B.S., Hays, R.D., Zemencuk, J.K., Pitts, J., & Brook, R.H. (2000).** Associations between primary care physician satisfaction and self-reported aspects of utilization management. HSR: Health Services Research, 35, 333-348.
- Minick, P., Kee, C.C., Borkat, L., Cain, T., Oparah-Iwobi, T. (1999).** Nurses' perceptions of people who are homeless. West J Nurs Res, 20(3), 356-69.
- Price, J., Desmond, S., and Eoff, T. (1989).** Nurses' perceptions regarding health care of the poor (Part1). Psychological Reports, 65(3), 1043-1052.
- Silverstein, G. (1997).** Physicians' perceptions of commercial and Medicaid Managed Care plans: A comparison. Journal of Health Politics, Policy, and Law, 22 (1), 5-21.

Silverstein, G. and Kirkman-Liff, B. (1995). Physician participation in Medicaid Managed Care. Social Science and Medicine, 41(3), 355-363.

Texas Health Quality Alliance. (1999). Report on the 1999 Texas Medicaid Managed Care Provider Satisfaction Survey.
Unpublished manuscript.

Texas Health Quality Alliance. (2000). January 2000 Provider Satisfaction Survey for Medicaid Managed Care.
Unpublished manuscript.

The MEDSTAT Quality Catalyst[®] Program. (1998). National study finds seven of 10 physicians are anti-Managed care—HMOs still rank highest among physicians in several markets.
The MEDSTAT Group. (online)
http://www.medstat.com/news_conventions/jdp.html.