**2019 Florida Long-Term Care (LTC)**

**Provider Satisfaction Survey**

**Florida Agency for Health Care Administration (AHCA) is interested in your satisfaction with the Florida Medicaid plans. Your responses will be kept completely confidential. If you have questions about this survey, please call [Survey Vendor Name] at [toll-free phone number].**

**Please be sure to fill the response circle completely. Use only black or blue ink or dark pencil to complete the survey.**

 **Correct Incorrect**

 **Mark Marks**

|  |
| --- |
| **The questions in this survey will refer to [Health Plan Name] as "this health plan." Please think of that health plan as you answer the survey. Please answer all questions based on your experiences with this health plan in the last 6 months.** |

 **1. Please indicate the long-term care services you provide. (Mark all that apply)**

 ⭘ Adult Companion Care

 ⭘ Adult Day Health Care

 ⭘ Assisted Living

 ⭘ Assistive Care Services

 ⭘ Attendant Care

 ⭘ Behavioral Management

 ⭘ Care Coordination/Case Management

 ⭘ Caregiver Training

 ⭘ Home Accessibility Adaption

 ⭘ Home-delivered meals

 ⭘ Homemaker

 ⭘ Hospice

 ⭘ Intermittent and Skilled Nursing

 ⭘ Medical Equipment and Supplies

 ⭘ Medication Administration

 ⭘ Medication Management

 ⭘ Nutritional Assessment/Risk Reduction

 ⭘ Nursing Facility

 ⭘ Personal Care

 ⭘ Personal Emergency Response System

 ⭘ Respite Care

 ⭘ Occupational, Physical, Respiratory, or Speech Therapy

 ⭘ Transportation, Non-emergency

 ⭘ Other (Please list below)

 \_\_\_\_\_\_\_\_\_\_\_\_

 **2. How many years have you provided these types of long-term care services?**

 ⭘ 1-5 years

 ⭘ 6-10 years

 ⭘ 11-15 years

 ⭘ 16-20 years

 ⭘ 21 years or more

 **3. How many years have you been a Medicaid provider?**

 ⭘ 1-5 years

 ⭘ 6-10 years

 ⭘ 11-15 years

 ⭘ 16-20 years

 ⭘ 21 years or more

 **4. How many years have you been in this health plan's provider network?**

 ⭘ Less than 1 year

 ⭘ 1-5 years

 ⭘ 6-10 years

 ⭘ 11 years or more

 **5. Do you participate in any of this health plan's provider incentive programs?**

 ⭘ Yes

 ⭘ No

 **6. Are you contracted under a value-based purchasing agreement with this health plan?**

 ⭘ Yes

 ⭘ No

⭘ Don’t know

 **7. How satisfied are you with this health plan?**

 ⭘ Very satisfied

 ⭘ Satisfied

 ⭘ Dissatisfied

 ⭘ Very dissatisfied

 **8. How would you rate this health plan compared to all other Medicaid health plans with which you contract?**

 ⭘ Well above average

 ⭘ Somewhat above average

 ⭘ Somewhat below average

 ⭘ Well below average

 ⭘ I do not contract with other Medicaid health plans

 **9. How satisfied are you with your ability to obtain member-level information (e.g., eligibility, benefit coverage, recent admissions and discharges) from this health plan?**

 ⭘ Very satisfied

 ⭘ Satisfied

 ⭘ Dissatisfied

 ⭘ Very dissatisfied

 **10. How satisfied are you with this health plan's materials (e.g., manuals/handbooks, newsletters, policies)?**

 ⭘ Very satisfied

 ⭘ Satisfied

 ⭘ Dissatisfied

 ⭘ Very dissatisfied

 **11. How satisfied are you with your provider relations representative (e.g., ability to answer questions and resolve problems, timeliness)?**

 ⭘ Very satisfied

 ⭘ Satisfied

 ⭘ Dissatisfied

 ⭘ Very dissatisfied

 ⭘ Don't know

 **12. How satisfied are you with the network of specialists (e.g., number, availability, quality) at this health plan?**

 ⭘ Very satisfied

 ⭘ Satisfied

 ⭘ Dissatisfied

 ⭘ Very dissatisfied

 ⭘ Don't know

 **13. How satisfied were you with the credentialing process at this health plan?**

 ⭘ Very satisfied

 ⭘ Satisfied

 ⭘ Dissatisfied

 ⭘ Very dissatisfied

 ⭘ Don't know

 **14. How would you rate your level of agreement with the following statements for this health plan:**

|  | **Strongly agree** | **Agree** | **Disagree** | **Strongly disagree** |
| --- | --- | --- | --- | --- |
| **Rules and procedures for service authorizations and referrals are clear in provider handbook** | ⭘ | ⭘ | ⭘ | ⭘ |
| **Standard service authorization denial notifications are sent within 7 calendar days** | ⭘ | ⭘ | ⭘ | ⭘ |
|  **Expedited service authorization denial notifications are sent within 2 business days** | ⭘ | ⭘ | ⭘ | ⭘ |
|  **I am satisfied with the authorization process** | ⭘ | ⭘ | ⭘ | ⭘ |
|  **I am satisfied with the authorization appeal process** | ⭘ | ⭘ | ⭘ | ⭘ |

 **15. How satisfied are you with this health plan's performance in the following areas:**

|  | **Very satisfied** | **Satisfied** | **Dis-****satisfied** | **Very dis-****satisfied** |
| --- | --- | --- | --- | --- |
| **Claims submission process** | ⭘ | ⭘ | ⭘ | ⭘ |
| **Assistance with claims process** | ⭘ | ⭘ | ⭘ | ⭘ |
| **Timeliness of claims payment** | ⭘ | ⭘ | ⭘ | ⭘ |
| **Accuracy of claims payment** | ⭘ | ⭘ | ⭘ | ⭘ |
| **Resolution of claims payment problems or disputes** | ⭘ | ⭘ | ⭘ | ⭘ |
| **Timeliness of the claims appeal process** | ⭘ | ⭘ | ⭘ | ⭘ |
| **Claims denial reasons** | ⭘ | ⭘ | ⭘ | ⭘ |

 **16. How satisfied are you with the complaint resolution process related to grievances and appeals at this health plan?**

 ⭘ Very satisfied

 ⭘ Satisfied

 ⭘ Dissatisfied

 ⭘ Very dissatisfied

 ⭘ Not applicable

 **17. How satisfied are you with this health plan's case management unit performance in the following areas:**

|  | **Very satisfied** | **Satisfied** | **Dis-****satisfied** | **Very dis-****satisfied** |
| --- | --- | --- | --- | --- |
| **Timeliness of communication** | ⭘ | ⭘ | ⭘ | ⭘ |
| **Knowledge about long-term care program** | ⭘ | ⭘ | ⭘ | ⭘ |
| **Care plan for enrollees** | ⭘ | ⭘ | ⭘ | ⭘ |
| ***Nursing Facility Staff Only:*****Inclusion of nursing facility staff in care plan development process** | ⭘ | ⭘ | ⭘ | ⭘ |
| ***LTC Providers Not in a Nursing Facility:*** **Inclusion of provider staff in care plan development process** | ⭘ | ⭘ | ⭘ | ⭘ |
|  **Case manager's ability to integrate and manage services for enrollees** | ⭘ | ⭘ | ⭘ | ⭘ |
| **Overall satisfaction with quality of case management services offered** | ⭘ | ⭘ | ⭘ | ⭘ |

 **18. Who is completing this survey? (Mark all that apply)**

 ⭘ Registered Nurse

 ⭘ Licensed Practical Nurse

 ⭘ Personal Care Assistant

 ⭘ Homemaker Services Provider

 ⭘ Office Manager

 ⭘ Administrative Staff

 ⭘ Other (Please list below)

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Thank you for sharing your experience and opinions! Your answers are greatly appreciated.**

**When you are done, please use the enclosed postage-paid envelope to mail the survey to:**

**[Survey Vendor Name], [Survey Vendor Address]**