Acute/CRS RFP Survey Questions

SurveyMonkey

1. Should AHCCCS mandate Managed Care Organizations participating in the Acute Care Program to also offer products as Qualified Health Plans on the Exchange market?

	Response Percent	Response Count
Yes	54.5%	12
No	45.5%	10
Comments:		9
answered question		22
skipped question		0

2. Should AHCCCS utilize enhanced Auto Assignment Algorithms to achieve a minimum membership for Managed Care Organizations participating in the Acute Care Program?

	Response Percent	Response Count
Yes	61.9%	13
No	38.1%	8
Comments:		5
answered question		21
skipped question		1

3. If AHCCCS allows the enhanced Auto Assignment Algorithm, should the time period be limited?

		Response Percent	Response Count
Yes, the time period should be limited		**71.4%**	**15**
No, the time period should not be limited		28.6%	6
		Comments:	6
		answered question	**21**
		skipped question	**1**

4. If the time period is limited, should the period be six months maximum, as in the previous RFP cycle, or some other timeframe?

		Response Percent	Response Count
Yes, six months maximum		42.9%	9
No, something other than six months		**57.1%**	**12**
		If No, please comment on the duration of the Auto Assignment Algorithm:	8
		answered question	**21**
		skipped question	**1**

5. Should AHCCCS allow Acute RFP Offerors bidding in Maricopa and/or Pima counties only to elect not to receive any Dual eligible members and therefore to not have to participate in the Duals Demonstration or as a D-SNP?

	Response Percent	Response Count
Yes - Offerors bidding in Maricopa and/or Pima counties should be able to choose whether to serve Dual eligible members	**54.5%**	**12**
No - Offerors bidding in Maricopa and/or Pima counties should be required to serve Duals eligible members	45.5%	10
	Comments:	7
	answered question	**22**
	skipped question	**0**

6. AHCCCS is exploring the option of implementing a new inpatient hospital payment methodology effective October 1, 2013. How much time is needed to implement a new payment methodology for claims with dates of services beginning October 1, 2013?

	Response Percent	Response Count
4-6 months prior	13.6%	3
6-8 months prior	31.8%	7
8-12 months prior	**50.0%**	**11**
Other	4.5%	1
	Specify other timeframe below:	6
	answered question	**22**
	skipped question	**0**

7. Can Managed Care Organizations participating in the Acute Care Program achieve a goal of sending a significant percentage (e.g. greater than 60%) of remittance advices electronically (this includes the HIPAA 5010 835 transaction format, compliant web options, etc.) to providers?

		Response Percent	Response Count
Yes		**75.0%**	**15**
No		25.0%	5
	If No, please comment below:		9
	answered question		**20**
	skipped question		**2**

8. Do challenges exist with implementing electronic remittance advices to providers, both within your organization and for the providers?

		Response Percent	Response Count
Yes, there are challenges (please describe below)		**71.4%**	**15**
No, there are no challenges		28.6%	6
	If 'Yes,' specify challenges:		13
	answered question		**21**
	skipped question		**1**

9. This survey is for all interested stakeholders. Please identify the best description of your role in the healthcare system:

	Response Percent	Response Count
Consumer	0.0%	0
Member/Representative	0.0%	0
Plan	**54.5%**	**12**
Provider	18.2%	4
Advocacy Group	0.0%	0
Other	27.3%	6
	If Other, please identify:	5
	answered question	**22**
	skipped question	**0**

10. Additional comments:

	Response Count
	7
answered question	**7**
skipped question	**15**

Q1. Should AHCCCS mandate Managed Care Organizations participating in the Acute Care Program to also offer products as Qualified Health Plans on the Exchange market?		
1	Capstone Health Plan has partnered with CRS for years. Coordination of benefits/services are provided timely, efficiently and accurately and is done so with friendly staff.	Jul 26, 2012 11:34 AM
2	UniCare encourages AHCCCS to not require MCOs participating in the Acute Care Program to also offer a Qualified Health Plan (QHP) on the Exchange. Doing so will limit the ability of MCOs and health plans to bring new and innovative care models to the state, limit patient choice, and limit the potential of competitive pricing due to lack of plan depth. Increasing MCO and health plan choice will increase plan participation, encourage competition and result in higher quality plans.	Jul 11, 2012 3:10 PM
3	AHCCCS should not mandate Managed Care Organizations participating in the Acute Care Program to also offer products as Qualified Health Plans on the Health Insurance Exchange. However, AHCCCS should favor those proposals/bids, that have an exchange strategy encompassing care coordination to ensure continuity of care for the churn population.	Jun 29, 2012 5:14 PM
4	AHCCCS should not dictate what products outside of Mediciad that plans offer. In lieu of offering its own exchange product, an AHCCCS plan could develop a close relationship/partnership with an organization that does offer exchange products. Plans that see this as a competative advantage shoudl have the option to do this without AHCCCS dictating what business we are in outside of Arizona Mediciad.	Jun 23, 2012 4:03 AM
5	This would be a benefit to eligibles and would promote coordination and continuity of care.	Jun 22, 2012 12:58 PM
6	This should not be a requirement of receiving a bid however if a plan does not participate then they should have an agreement with a commercial/exchange company that would allow for a smooth transition of care, both from and to the plan.	Jun 19, 2012 4:28 PM
7	Yes, only if the requirements to be on the Exchange match the AHCCCS requirements and do not include all QHP current requirements, such as NCQA. Another option is to allow AHCCCS plans to partner with a commercial plan to coordinate members who churn between exchange and ahcccs.	Jun 19, 2012 8:53 AM
8	This puts smaller MCOs out of the running, or forces them to divide their workforce between commercial and AHCCCS care. Additionally, the purpose of the Exchange is to make plan selection easy enough for individuals that they shouldn't need to be directed to choosing a commercial plan with their current MCO. Finally, this woul be moot in the event that the USSC overturns PPACA.	Jun 1, 2012 2:03 PM
9	There are other ways managed care organizations contracted with AHCCCS contracts can partner with health plan organizations other than becoming a QHP.	May 17, 2012 8:31 AM

Q2. Should AHCCCS utilize enhanced Auto Assignment Algorithms to achieve a minimum membership for Managed Care Organizations participating in the Acute Care Program?

1	Members need to choose for themselves. It's about choice not assignment.	Jul 26, 2012 11:34 AM
2	UniCare suggests that an enhanced auto-assignment algorithm should be used as described above. Understanding that incumbent MCOs may continue to operate under the new contract; we also suggest that the new algorithm give auto-assignment preference to new MCOs entering the state. This will enable new MCOs to attain the minimum membership threshold needed to operate.	Jul 11, 2012 3:10 PM
3	Enhanced algorithms should be used as the individual membership in each individual GSA is at a level or greater for a plan to achieve profitability.	Jun 29, 2012 5:14 PM
4	A company coming into a new state contract should allow for membership build, not be given a gift of membership. The plans that have been in the AHCCCS program from the beginning earned their membership, this should not be different for new plans or low membership existing plans. Good quality and service brings members to a health plan.	Jun 19, 2012 4:28 PM
5	It takes years for plans to become established in this very mature market so the time for a new plan to achieve that 50,000 membership mark, which makes a significant difference in the abiltiy for a plan to balance admin expense is critical. enhancing the AA algorithm is one way to assist in this process.	May 17, 2012 8:31 AM

Q3. If AHCCCS allows the enhanced Auto Assignment Algorithm, should the time period be limited?		
1	N/A	Jul 26, 2012 11:34 AM
2	As discussed previously, UniCare supports a new algorithm which would grant auto-assignment preference to new MCOs entering the state. This will enable new MCOs to attain the minimum membership threshold needed to operate while gaining brand recognition. MCOs that have been renewed for this contract should maintain their minimum membership threshold; UniCare suggests a minimum time period of 12 months. After this initial year, we would suggest the possibility of at least an additional 6 month extension, should the new MCOs need additional assistance attaining the minimum membership. After the enhanced auto-assignment period, we would suggest moving to a quality-based algorithm. This process would be phased in after the MCOs have sufficient data to demonstrate performance. We would suggest the program consider: • Use of a limited set of metrics. UniCare suggests the program utilize six HEDIS measures, • Account for both performance relative to competitors and improvement • Include statistical difference The quality based auto-assignment should not be implemented prior to at least one full calendar contract year. Additionally, if AHCCS were to include improvement as part of the scoring, then UniCare would request at least two full calendar contract years prior to implementation.	Jul 11, 2012 3:10 PM
3	The time period should be limited to no more than 6 months.	Jun 29, 2012 5:14 PM
4	Instead of time period and in order to be viable, we propose a threshold.	Jun 22, 2012 12:58 PM
5	If AHCCCS decides to allow this membership gift to low membership plans or new plans, then there should definitely be a time limit of max, 3 months. Remember, during this time period, existing health plans over 50,000 members are “capped” through no fault of their own which equates to a loss of membership and revenue	Jun 19, 2012 4:28 PM
6	The 6 month period offered during the 2008 RFP was the first time this effort was attempted and it seemed to go well, perhaps trying this same period of time again is the way to go to see if the success continues.	May 17, 2012 8:31 AM

Q4. If the time period is limited, should the period be six months maximum, as in the previous RFP cycle, or some other timeframe?		
1	N/A	Jul 26, 2012 11:34 AM
2	As stated in Question 3, the time period should be a minimum of 12 months with the possibility of additional extensions. New plans will likely need at least 12 months of enhanced auto-assignment to gain successful market penetration, branding, and member loyalty.	Jul 11, 2012 3:10 PM
3	Instead of time period and in order to be viable, we propose a threshold.	Jun 22, 2012 12:58 PM
4	Three months max.	Jun 19, 2012 4:28 PM
5	One year would be a more appropriate time frame	Jun 5, 2012 8:58 PM
6	Nine Months	Jun 5, 2012 5:29 PM
7	During the duration of the contract.	Jun 1, 2012 3:49 PM
8	Long enough to create actuarily sound membership numbers.	Jun 1, 2012 1:59 PM

Q5. Should AHCCCS allow Acute RFP Offerors bidding in Maricopa and/or Pima counties only to elect not to receive any Dual eligible members and therefore to not have to participate in the Duals Demonstration or as a D-SNP?

1	UniCare suggests requiring all Acute RFP Offerors to participate in the Duals Demonstration. Allowing MCOs to elect not to serve the Dual populations will create member confusion, breaks in continuity of care, provider confusion, and potential eligibility disruptions. Lastly, allowing MCOs to elect not to serve duals is contrary to AHCCCS' intent and goals to provide an integrated care delivery and payment program that allows members to access care from one health plan rather than multiple plans.	Jul 11, 2012 3:10 PM
2	Let competition dictate	Jun 23, 2012 4:03 AM
3	Promotes coordination of care	Jun 22, 2012 12:58 PM
4	If AHCCCS and CMS desire to have full integration of the members health care, then this should be a requirement. On the other hand, if they do not wish to participate, they should make a formal arrangement with a plan for transition of care.	Jun 19, 2012 4:28 PM
5	This should only be considered if dually eligible members are only assigned to plans that are participating in the dual demonstration project or D-SNP.	Jun 19, 2012 8:53 AM
6	But membership should not be passive...allow an optout but have it all as an opt in in the beginning	Jun 7, 2012 8:23 AM
7	This is a tough question. Although I answered Yes - there is a "but" - I understand the importance of plans being flexible and very much believe in the concept of the dual demonstration project. However, following our last meeting on the topic, I came away disappointed and questioning the value that the demonstration will bring over our current environment. Too many of the processes in the demo that could be merged, appear to be following a path of remaining seperate and I fear that we will end up not achieving much, if any, administrative efficiences, which would allow for more dollars to go toward things like supplemental benefits for members and even more, I fear the potential of confusing these members more than they are today.	May 17, 2012 8:31 AM

Q6. AHCCCS is exploring the option of implementing a new inpatient hospital payment methodology effective October 1, 2013. How much time is needed to implement a new payment methodology for claims with dates of services beginning October 1, 2013?

1	UniCare has experience implementing the APR-DRG inpatient pricing methodology. From a system perspective, it will take 2 – 3 months to fully implement APR-DRG to replace an existing methodology. This timeline, at a high level, includes requirements, loading data, updating providers and testing. It does not factor in provider notification and education. The variable would be the actual data and calculations provided by the state. We have found similarity in multiple implementations of APR-DRG but need to have some flexibility if the calculations presented are more complex or different from what we do today.	Jul 11, 2012 3:10 PM
2	Implementation should be similar to OPFS migration, ideally 8-12 months planning prior to go-live.	Jun 29, 2012 5:14 PM
3	12-18 months. This is a BIG change to the payment methodology of the #1 cost driver of the entire program and needs to be carefully thought out and carefully implemented. I don't like the fact that one of the main reason given for implementing on 10/1/13 is so that any new plans recieving AHCCCS contract awards dont have to implement a per diem payment methodology then switch to a new methodology. Quite frankly, that is their cost of doing business and should not dictate the timeline for implementing this accross the entire program.	Jun 23, 2012 4:03 AM
4	Would be a new contract holder therefore we do not have concerns with time frame.	Jun 22, 2012 12:58 PM
5	6-8 Months implementation time. We currently utilize a web based tool for 1 segment of our business and this is a manual process. This change would require an integration of a new software product directly into our claim processing system to eliminate the manual work. We would need to find a vendor that had software that integrates with an AS400 system after AHCCCS makes it's decision on which DRG product to use.	Jun 19, 2012 4:28 PM
6	8 - 12 months is necessary, but 6-8 months may be feasible if AHCCCS provides enough supporting information (companion guides, feedback while testing, etc.) to help contractors ensure accurate payment methodology implementation.	Jun 1, 2012 3:49 PM

Q7. Can Managed Care Organizations participating in the Acute Care Program achieve a goal of sending a significant percentage (e.g. greater than 60%) of remittance advices electronically (this includes the HIPAA 5010 835 transaction format, compliant web options, etc.) to providers?

1	Providers need choices.	Jul 26, 2012 11:34 AM
2	UniCare supports generation and processing of all HIPAA covered transactions including the Electronic Remittance Advice (X12 835). Any provider requesting generation and receipt of the 835 will be accommodated. Once a provider has enrolled for ERA/835, they will have the option of also receiving the paper remittance, but our standard is to cease paper remittance distribution for any provider that elects to receive an 835. As such, any provider enrolling for electronic remittances through the 835, should be receiving 100% of their remittances electronically from that moment on. Our ability to meet a 60% threshold of all remittances throughout our company is fully dependent upon providers' interest and request for enrollment as UniCare cannot force providers to move to the 835 if they do not have the technology available to auto-post/reconcile the X12 format).	Jul 11, 2012 3:10 PM
3	Providers have struggled implementing 5010 835 transactions and therefore are not readily able to receive and process the transaction accurately. If AHCCCS were to implement this requirement, plans and providers would need several years to achieve is measure. We believe that MCOs need to be able to send 835 transactions at the request of any willing provider, but requiring plans to achieve a significant percentage at this time would be challenging.	Jun 29, 2012 5:14 PM
4	AHCCCS should mandate and monitor plan's ability to provide remits electronically and address any outliers rather than mandate a certain result that plans do not have ultimate control of. In this case providers must be willing and able to support. Again, let competition drive these things. If I can provide better service (and reduce my costs) to my providers by providing, supporting, promoting electronic remits 60-70-80% let competition motivate.	Jun 23, 2012 4:03 AM
5	Projected by 7/30/12 the capability to pull and download file from the web portal. This would bring us to 100% capability of electronic remittance.	Jun 19, 2012 4:28 PM
6	Providers generally ask for paper along with electronic remittance advice for their reconciliation purpose.	Jun 19, 2012 8:53 AM
7	Providers are not always interested in setting up electronic trading with agencies.The testing required for a smaller population make it 'a waste' for some providers and they elect not to trade.	Jun 1, 2012 3:49 PM
8	With time, I believe the answer is yes. However, I am not certain what the correct timeframe is...we have many providers that are just not ready for the eletronic remittance advices or EFT and I think both need to go hand in hand - tied together since the plans already have a EFT requirement.	May 17, 2012 8:31 AM
9	If some providers can not or will not accept an electronic remittance, it will be difficult to hold the MCO to a benchmark. The benchmark should be the % of providers that want electronic.	May 16, 2012 3:45 PM

Q8. Do challenges exist with implementing electronic remittance advices to providers, both within your organization and for the providers?		
1	Cost	Jul 26, 2012 3:36 PM
2	UniCare is fully compliant with the HIPAA Transaction and Code Sets (TCS) rules and standards to support electronic remittances defined within the X12 v5010 835 TR3. We are able to supply an 835 for any provider who requests it, but providers must secure revenue cycle management assistance from a practice management software vendor or EDI Clearinghouse to enable them to read/process and auto-reconcile the 835 with their accounts. Within the industry, the 835 transaction has not been as widely accepted and adopted by providers due to many ambiguous details within the X12 standard and Implementation Guide (TR3) resulting in multiple interpretation discrepancies amongst all payers. Many of these ambiguous details were addressed within the latest HIPAA upgrade (version 5010), but there remain some pain points amongst the industry. Specific challenges include Overpayment Recovery scenarios with use of the PLB segment, and consistent/standardized usage of the Claim Adjustment Reason Codes and Remittance Advice Remark Codes (CARC/RARC). We have implemented both in a way to ensure compliance and alignment with provider/business needs. Additionally, we have taken our approach and engaged as an industry and provider advocate to promote greater consistency and definition of new rules/requirements within X12, CAQH CORE, WEDI, and America's Health Insurance Plans (AHIP), but these remain challenges across the industry until all payers are collectively utilizing such codes in a consistent manner.	Jul 11, 2012 3:10 PM
3	As a health plan, we are able to process and send the 835 transaction however provider adoption is the biggest challenge. Many physician practitioners use billing offices that are not technologically advanced, nor do they want to invest in upgrades, to process 835 transactions due to the legacy systems that are being utilized. Investment in new Practice Management software in addition to EMR meaningful use efforts is overwhelming for them. Providers are focused on the federal dollars from the EMR reimbursement and do not see the value in process improvement of the 835 posting. Those that have embraced the technology, large group practices and facilities for the most part, are implementing the 835 however struggle for the first few months with integrating with the clearinghouses. Transparency in the denial reasons are also something that we hear from the providers as the Claim Adjustment Reason codes are very broad as opposed to the legacy system action codes.	Jun 29, 2012 5:14 PM
4	I'm not aware of any.	Jun 23, 2012 4:03 AM
5	Signaficant number of Arizona providers do not have the capability to handle electronic remittance advices.	Jun 22, 2012 12:58 PM
6	The challenge is whether the small provider offices have the needed technology. It will depend on the provider mix in smaller rural counties. Perhaps the tatget should be set differently for Metro and Rural GSAs.	Jun 19, 2012 4:28 PM
7	Providers generally ask for paper along with electronic remittance advice for their reconcilitation purpose.	Jun 19, 2012 8:53 AM
8	Some Arizona providers (especially rural providers) are unable to accept ERAs	Jun 5, 2012 8:58 PM

Q8. Do challenges exist with implementing electronic remittance advices to providers, both within your organization and for the providers?

9	Providers (both small and large) are resistant to exchange information electronically if they do not serve many AZ Medicaid members.	Jun 1, 2012 3:49 PM
10	Not all providers, especially in rural areas, are able to receive it.	Jun 1, 2012 2:03 PM
11	they get lost or there is no reply within the required 30 day period. They often do not provide clear reasons for rejections.	May 24, 2012 11:42 PM
12	See above.	May 17, 2012 8:31 AM
13	Certain providers are unable or unwilling to use electronic options.	May 16, 2012 3:45 PM

Q9. This survey is for all interested stakeholders. Please identify the best description of your role in the healthcare system:

1	Amity Foundation, Circle Tree Ranch	Jun 6, 2012 12:28 PM
2	State Agency	Jun 1, 2012 3:49 PM
3	Service Consultant	Jun 1, 2012 9:09 AM
4	atty for provider	May 16, 2012 4:09 PM
5	Concerned Citizen	May 16, 2012 3:45 PM

Q10. Additional comments:		
1	Members are given a choice between health plans. Discriminating against CRS Members and mandating enrollment into a health plan they did not choose is not a choice, nor does it take into considertaion the culture of Members living in Northern Arizona.	Jul 26, 2012 11:34 AM
2	As part of the WellPoint family of companies, UniCare brings a dedicated Medicaid business unit that was established in 1994 to serve the unique and diverse publicly funded health care programs, such as Medicaid and the Children's Health Insurance Program (CHIP). Our Medicaid Business operates one of the nation's largest Medicaid managed care organizations serving more than 1.8 million members in 10 states, including Medicaid, CHIP, low income publicly funded programs, high-risk pools, and Administrative Services Only (ASO) products. This specialized unit provides local community-based services with the resources and expertise of a national company. Arizona's Medicaid programs will benefit from this expertise, national best practices and solutions that are customized for the unique needs of Arizona's population. CareMore, a WellPoint Company, currently operates in Arizona and has a have a proven track record for providing cost-effective services, and quality outcomes. The strong presence of CareMore, combined with UniCare, provides us the ability to access the necessary resources to expand our partnership with Arizona. For further information, please contact Chad Westover, Vice President, Business Development at 805-557-6037.	Jul 11, 2012 3:10 PM
3	Thanks for the opportunity to comment	Jun 23, 2012 4:03 AM
4	This is the response from Phoenix Health Plan an existing AHCCCS provider since 1982 at the programs inception.	Jun 19, 2012 4:28 PM
5	The changes to the program are exciting	Jun 1, 2012 3:49 PM
6	The application process if too complicated and take too long in some cases over a year if I only see a couple a year I have to reapply all over if I haven't had a claim in a year.	May 24, 2012 11:42 PM
7	All of the MCO's have been making too much money (either profit or admin). A critical look at rate setting and intercompany charges that inflate expenses should be a priortiy.	May 16, 2012 3:45 PM