The 2013 Minnesota Pilot Provider Survey

Health Care Administration

March 2014

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Legislative Report

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Tables and Figures

I. Executive Summary

As required by the Minnesota Legislature (Minnesota Session Laws Chapter 108, Article 4, Section 30), the Department of Human Services (DHS) initiated a pilot survey of providers of pediatric home health care services and children's mental health services. The purpose of this survey was to identify and measure issues that arise in dealing with the management of the Medical Assistance program.

The main goal of the pilot provider survey was to evaluate the feasibility and value of implementing an annual provider survey as a component of continuous quality improvement of the Medical Assistance (MA) program administration.

We discovered several logistical issues during the implementation of the pilot survey. We need to consider and address these issues in order to obtain a larger sample size and more reliable results in any future surveys. Issues include the need to

- expand the list of potential survey participants beyond a limited number of particular specialties.
- improve accuracy of provider mailing addresses.
- use multiple means of survey delivery and response.
- support the survey with the resources that will provide more meaningful and reliable results that can be used for quality improvement.

This report also includes the findings of the pilot provider survey regarding MCO performance.

- Providers generally reported a moderate amount of satisfaction with managed care organizations (MCOs), both in terms of overall satisfaction and across most specific business functions. Far more providers were satisfied than dissatisfied with the overall performance of their MCO.
- Approximately 20 percent of providers explicitly expressed dissatisfaction with the overall performance of the managed care organization (MCO) about which they were surveyed. This percentage was similar to (or greater than) the dissatisfaction expressed regarding specific business functions. One exception was the business function of appeals, of which more than 40 percent of providers expressed dissatisfaction.
- There did not appear to be significant differences among MCOs in terms of provider satisfaction. However, it should be noted that the sample sizes within MCOs were fairly small, which limits the ability to draw strong inferences from the data.

II. Legislation

Minnesota Session Laws Chapter 108, Article 4, Section 30 states

> To assess the efficiency and other operational issues in the management of the health care delivery system, the commissioner of human services shall initiate a provider survey. The pilot survey shall consist of an electronic survey of providers of pediatric home health care services and children's mental health services to identify and measure issues that arise in dealing with the management of Medical Assistance. To the maximum degree possible, DHS will use existing technology and seek interns to analyze the results.

The survey questions must focus on seven key business functions provided by medical assistance contractors:

1. provider inquires;
2. provider outreach and education;
3. claims processing;
4. appeals;
5. provider enrollment;
6. medical review; and
7. provider audit and reimbursement.

The commissioner must consider the results of the survey in evaluating and renewing managed care and fee-for-service management contracts.

The commissioner shall report by January 15, 2014 the results of the survey to the chairs of the health and human services policy and finance committees. The commissioner also shall make recommendations on the value of implementing an annual survey with a rotating list of provider groups as a component of the continuous quality improvement system for Medical Assistance.

III. Introduction

This report is submitted to the Legislature as required by Minnesota Session Laws Chapter 108, Article 4, Section 30 – Pilot Provider Input Survey.

As directed by the Legislature, the Minnesota Department of Human Services (DHS) conducted a pilot survey of providers of pediatric home health care services and children's mental health services. This survey identified and measured issues that arise in dealing with the management of the Medical Assistance program.

The survey provided feedback from providers regarding their satisfaction with managed care organizations (MCOs) during business interactions, including provider inquiries, provider outreach and education, claims processing, appeals, provider enrollment, medical review, provider audit and reimbursement and prior authorization. The goals of the pilot provider survey were

1. to evaluate the feasibility and value of implementing an annual provider survey as a component of continuous quality improvement of the Medical Assistance program, and

2. to collect information regarding provider satisfaction with MCOs.

DHS selected providers for the survey based on managed care encounter claims data, choosing providers that were paid for pediatric home health care or children's mental health services rendered during calendar year 2012 and that had at least a minimum amount of claims experience with Blue Plus, Medica or UCare.

DHS chose these three MCOs based on their having the largest number of claims submitted to DHS for the two types of services specified in the legislation. Their selection would provide the best probability of a sufficient responses from which to draw conclusions.

The mode of survey administration was web-based, using Snap survey software. From a total sample of 1,289 providers, a relatively modest number of survey respondents provided useable data (N = 298).

This public report summarizes results from the 2013 administration of the pilot survey. This report provides the following:

- A description of critical issues related to the feasibility and usefulness of future provider survey efforts.

- An overview of provider satisfaction with MCO performance, both overall and by business function.

- Recommendations for improving the provider survey in future years.

Sections IV ,V and VI of this report provide detailed information regarding the selection of participants, the survey design and execution, the survey administration, logistical issues, the analysis plan, the quantitative study results and future recommendations.

Section IV; subsection A summarizes the development of the sampling plan used to draw providers for the 2013 pilot survey.

Section IV; subsection B gives a detailed presentation of the questionnaire design and execution.

Section IV; subsection C describes the survey administration.

Section IV; subsection D describes logistical issues of interest as they relate to the feasibility of future survey efforts.

Section V; subsection A discusses the analysis plan for the study results.

Section V; subsection B presents the quantitative results of the study regarding MCO performance, both overall performance and performance by business functions.

Section VI provides future recommendations.

IV. Research Design

Sampling

DHS developed the sampling frame for the pilot survey through a multi-stage process.

1. First, DHS identified potential providers based on managed care encounter claims data submitted to DHS and processed by the Medicaid Management Information System (MMIS). Specifically, DHS identified billing providers on managed care encounter claims for mental health services and home health care services with service dates during calendar year 2012 where the recipient was 17 years or younger. Appendix A lists procedure codes used to identify pediatric home health care and children's mental health services.

   Home health care providers included home health agencies and private duty nursing providers. We identified mental health providers through encounter claims

   - with mental health procedure codes,
   - with appropriate categories of service (such as mental health or case management-mental health) and
   - with mental health providers, including hospitals, rehabilitation agencies, social workers, marriage and family therapists, various treatment facilities, and clinical nurse practitioners.

   In order to associate each provider with one MCO for the purposes of the pilot survey, DHS associated providers who billed multiple MCOs for pediatric home health or children's mental health services with the MCO with which they had the largest number of claims.

2. DHS elected to conduct the pilot survey among providers associated with the three MCOs that submitted the largest volume of Medical Assistance claims for children's mental health and home health care services rendered during 2012. Those MCOs were Blue Plus, Medica, and UCare.

   DHS also elected to not include consolidated provider organizations in the pilot survey because the inclusion of consolidated providers would introduce different units of observation (Blalock, 1972) to the survey. For example, a consolidated provider organization may include several clinics, agencies or service locations while a non-consolidated provider may consist of a single clinic, agency or a sole practitioner. This is an important issue to consider, as mixing individual-level and group-level units of observation are generally problematic for analysis purposes.

   DHS staff also excluded providers if they could not find their National Provider Identifier (NPI) in MMIS.

   The sampling frames of providers were compiled separately for each selected MCO.

In order to establish that the provider in question had an acceptable level of contact with the MCO in question, DHS applied a rule whereby all providers with less than 10 claims during the calendar year were excluded from the sampling frame.

Finally, a small number of encounter claims for mental health services had billing provider types that were inconsistent with mental health services (for example, opticians and medical supply companies). These providers were eliminated from the sampling frame, and unique provider lists for Blue Plus, Medica and UCare were established.

3. The total providers originally obtained from MMIS numbered 969 for Blue Plus, 1894 for Medica, and 1046 for UCare. After applying the aforementioned filters, the final sampling frame consisted of 344 providers for Blue Plus, 761 for Medica, and 385 providers for UCare.

   In determining the appropriate sample size for the survey, DHS aimed for an acquired sample size that would allow for a four percent margin of error under a 95 percent confidence level, assuming a survey return rate of 60 percent. The numbers of providers selected for sampling for Blue Plus and UCare were small and all of the providers were invited to participate in the survey. For Medica, a simple random sampling method was used to select 560 providers. Therefore, the final desired sample sizes were

   - 344 providers for Blue Plus,
   - 560 providers for Medica, and
   - 385 providers for UCare.

Questionnaire Design and Execution

Survey Summary. We modeled this survey after a survey conducted for the Centers for Medicare and Medicaid Services (CMS) regarding provider satisfaction with Medicare contractors (Mathematica Policy Research, Inc., 2011). The survey contained 76 total items, including items by business function, open-ended questions and descriptive questions.

Business function	Number of survey items
Provider inquiries	7
Provider outreach and education	18
Claims processing	8
Appeals	10
Provider enrollment	6
Medical review	8
Provider audit and reimbursement	7

All scales that examined business functions had a high degree of internal consistency. The full survey is in Appendix B.

Survey Administration

On September 27, 2013, DHS distributed, using the MN-ITS provider mailbox system, a pre-notification letter that

1. introduced the survey and encouraged participation by all sampled providers.

2. asked selected providers to identify an individual within their organization who regularly interacts with MCOs and is able to answer questions about business interactions with MCOs.

3. asked the provider to supply an email address for that individual by completing an electronic document linked on DHS's website.

On October 7, 2013, DHS sent a second letter to the providers encouraging participation in the survey and again asking for contact information of an individual who could complete the survey.

In addition, for those providers outside the MN-ITS system, DHS employees contacted providers by phone in an effort to collect email addresses and other contact information needed for administering the survey. These efforts yielded 168 providers who provided valid email addresses while the remaining providers were not linked with electronic contact information.

The first round of electronic surveys was sent on October 24, 2013, with paper mailings sent slightly later, on November 1, 2013. The paper mailing contained a link to the electronic survey in the text of the letter.

Approximately three weeks later, participants who received paper letters and who did not respond to the survey requests received a reminder letter, which again explained the nature of the survey and emphasized the importance of the survey and provider response.

Individuals who had provided DHS with an email address received a reminder email approximately 10 days after the initial invitation. Provider survey data was primarily collected in November and December of 2013, and the survey was open until December 13, 2013.

The survey took approximately 10 to 15 minutes to complete. A shorter timeframe in completing the survey occurred for some providers as a result of skips in the questionnaire, which were generated if the section in question (such as medical reviews) was not applicable to the provider.

Overall, 298 – which equates to an overall response rate of approximately 26% -- providers returned the survey with useable data, with

- 103 surveys (approximately 33%) from Blue Plus,
- 67 surveys (approximately 14%) from Medica, and
- 128 surveys (approximately 37%) from UCare.

Worth noting is that a number of providers had outdated or incorrect address information on file with DHS, which led to a number of mailing returns; approximately 13 percent of potential providers were not reached due to this issue. This information appears in Table 1 on the next page.

Table 1. Population Size, Calculation Filters, and Sample Size/Return Rate Information

	BluePlus	Medica	UCare
Met Claims Criteria	969	1894	1046
Excluded Providers	625	1133	661
Final Sample Size	344	560*	385
Undeliverable Surveys	28	96	38
Returned Surveys	103	67	128
Response Rate	32.59%	14.40%	36.88%

Note. Response rate was calculated by (Returned Surveys)/(Final Sample Size – Undeliverable Surveys).

*A simple random sampling method was only used for Medica, because Blue Plus and UCare did not contain enough providers in the final sample size to meet the desired precision estimates of DHS.

Logistical Issues

There were several logistical issues to consider with respect to the administration of the survey, both for this initial pilot survey and, most especially, for improvement purposes in the event of future provider survey efforts. These issues will be categorized across two elements: identifying the sample and contacting the sample.

1. **Identifying the sample**. For this initial survey effort, DHS used only a select group of providers as a result of the constraints provided by the legislative language. Specifically, the legislative language indicated that the pilot survey consist of "providers of pediatric home health care services and children's mental health services." The specificity of the types of providers targeted by the pilot survey significantly limited the potential sample size, which in turn limits the ability to draw inferences from the survey results. This also limits the generalizability of the survey results to the Medical Assistance provider population.

   Other issues limited the potential sample size used by DHS, even given the constraints of the legislative language. One such issue was the exclusion of consolidated providers by DHS. This was done to avoid mixing individual-level analysis with group-level analysis, vis-à-vis providers.

Even after consolidated provider organizations were excluded, an issue was found with regards to the existence of both organizational (e.g., clinic or agency) NPIs and individual (e.g., clinician) NPIs as billing providers in encounter claims data. Specifically, it appeared that some providers billed under an organization NPI in some cases and used an individual-level NPI in other cases, which meant that some provider entities were represented multiple times in the survey sample.

2. **Contacting the Sample**. The second major area for future improvement involves contacting the representative sample of providers.

    - **MN-ITS system**
      Early in the survey process, DHS attempted to contact providers through the MN-ITS system in order to obtain email addresses for providers. The response to this contact through the MN-ITS system was modest, which could indicate that providers might not interact with the MN-ITS system with regularity and therefore other methods of contacting providers may be more effective. This is especially relevant considering that the MN-ITS system is the primary method for providers to receive communications at the present time. Additionally, not all providers listed as billing providers for the selected services in managed care encounter data had MN-ITS mailboxes. This may include providers who provide Medical Assistance services via managed care only and are not enrolled with DHS to provide services via fee-for-service.

    - **Paper Mailing**
      The mode of survey also deserves closer examination. The overwhelming majority of providers in this study were contacted through a paper mailing that contained a link to the survey. Consequently, the participant had to manually type a fairly long URL into their web browser to access the survey. DHS believes it is fairly likely that this process caused a loss of at least some potential survey participants, owing to the burden imposed by manually typing the long URL into a web browser.

    - **Accuracy of Provider Mailing Addresses**
      Another major issue that we will need to address in future survey efforts is the accuracy of provider mailing address data on file with DHS. Approximately 13 percent of paper letters sent to providers were returned due to incorrect address information. This is an issue that will need to be taken into account when constructing sample size estimates in future surveys. Obtaining perfect address information for mailing is likely not possible. Consequently, future survey efforts should adjust estimates to reflect this problem, and, if possible, eliminate address problems that arise from addresses not being deliverable as currently listed. For example, some addresses have abbreviations for address indicators such as street and center that make the letter in question undeliverable. However, it is important to note that DHS is limited as field constraints within MMIS sometimes necessitate the use of abbreviations that are not recognized by the United States Postal Service.

3. **Positive Attributes**. While this was a pilot survey, there were several positive features within this study that should be carried over into future survey efforts, if applicable.

    - **Survey Items**. The first positive element was the survey items themselves. The survey appeared to be of reasonable length, and the items within each business function seemed to show a great deal of internal consistency on a psychometric front (per *coefficient alpha*—see Cronbach, 1951). The items were modeled after a survey conducted for the Centers for Medicare and Medicaid Services (CMS) regarding provider satisfaction with Medicare contractors (Mathematica Policy Research, Inc., 2011).

    - **Provider Responses**. A second strength was provider response to the open-ended and qualitative questions within the survey. Responses to these questions were generally thorough and informative. If DHS can obtain larger sample sizes in future surveys, they could use content analysis to identify critical themes regarding MCO performance that might be missed by the more quantitative survey items.

    - **Breadth of Business Functions and Survey Items.** Finally, the breadth of business functions and survey items can allow for many interesting research questions to be answered if sample sizes are increased to an appreciable degree. For example, DHS could evaluate which business functions are most important with respect to overall satisfaction with MCO performance or what individual elements *within* a business function are most important with respect to overall satisfaction with that business function.

V. Analysis

The analysis section of this report is divided into two parts: an analysis plan and a results section.

Analysis Plan

1. **Frequency Distributions**. Some results related to satisfaction are presented in the form of frequency distributions as these are a readily accessible means of summarizing providers' assessments of MCO performance. The distributions report the proportions of providers responding *very satisfied, satisfied, neither satisfied nor dissatisfied, dissatisfied, and very dissatisfied*. All reported frequencies are computed as a percentage of respondents that provided a scored rating. As such, responses of *don't know* and *non-applicable* are not included nor is missing data.

2. **Calculation of Mean Satisfaction Scores**. Mean satisfaction scores were computed using two different methods. Both methods assigned values to satisfaction categories in the same way: a value of one for very dissatisfied, two for dissatisfied, three for neither satisfied nor dissatisfied, four for satisfied, and five for very satisfied.

    - The first method, the Overall Satisfaction Score, computes the MCO score as the mean of all responses to the survey which asked providers to rate their *overall* satisfaction with MCO performance *within* a given business function (there were eight such functions).

    - The second method calculates the business function component scores, and is computed by taking the average of all valid responses within a particular business function, using the aforementioned assignment system.

Results

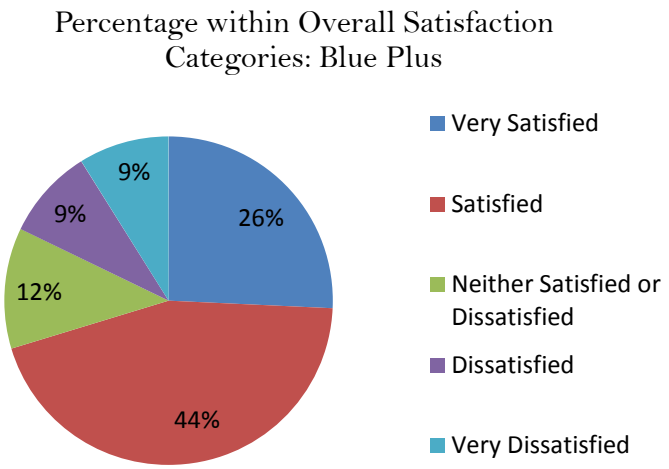
This section describes provider satisfaction with the performance of the MCOs as measured by responses to the 2013 Provider Pilot Survey (PPS).

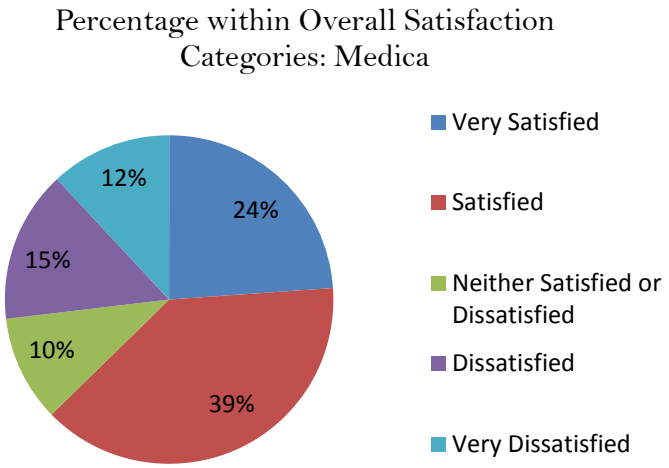
1. **Single Item Overall Performance Score by MCO.** Table 2 shows the distribution of overall provider satisfaction with MCO performance, separated by studied MCO for the single item question that asks providers to evaluate MCO overall performance. In general, results followed a similar pattern, and there was not a significant degree of difference among the MCOs in response pattern, χ^2 (8, N = 296) = 10.96, p = .21. As before, results were strongly skewed, since most providers indicated satisfaction with their MCO as opposed to dissatisfaction. These results can be seen graphically in Figure 1.

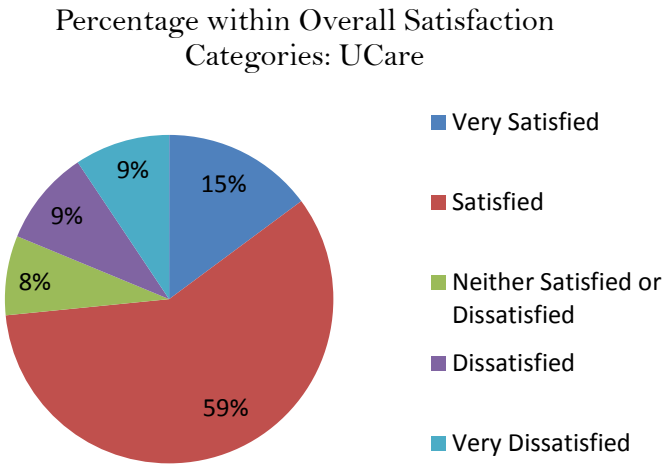
Table 2. Percentage within Overall Satisfaction Categories: By MCO

	Very Dissatisfied	Dissatisfied	Neither Satisfied or Dissatisfied	Satisfied	Very Satisfied
Blue Plus	8.91	8.91	11.88	44.55	25.74
Medica	11.94	14.93	10.45	38.81	23.88
UCare	9.38	9.38	7.81	58.59	14.84

Figure 1. Percentage within Overall Satisfaction Categories







2. **Overall Mean Satisfaction Scores by MCO**. As previously mentioned, DHS also examined a calculated overall satisfaction mean score, in an effort to capture the multidimensional nature of MCO performance. The average overall satisfaction score was on the satisfied (as opposed to dissatisfied) section of the Likert-scale for Blue Plus (M = 3.52, SD = 0.82), Medica (M = 3.44, SD = 0.86), and UCare (M = 3.53, SD = 0.80). There were no significant mean differences among MCOs.

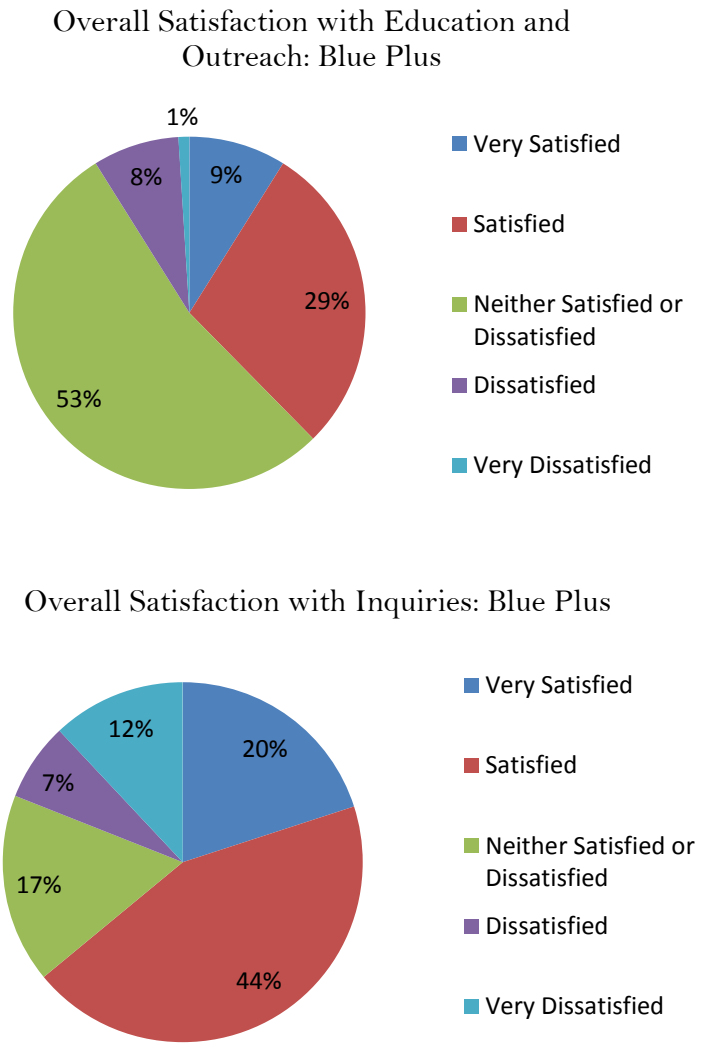
3. **Single Item Business Function Satisfaction Scores by MCO.** Tables 3 to 5 show the distribution of provider satisfaction with MCO performance in the last 12 months before the survey, with respect to overall satisfaction with specific business functions. Responses are generally skewed, as there were more satisfied responses than dissatisfied responses. For most functions, a strong majority of the responders indicated satisfaction. However, for appeals, nearly half of providers indicated dissatisfaction and for education and outreach,

approximately half of providers indicated neither satisfaction nor dissatisfaction. Where significance testing was appropriate, there were also no significant differences among MCOs in response pattern for any business function. These results can be seen graphically in Figures 2a through 4b on pages 16 through 27.

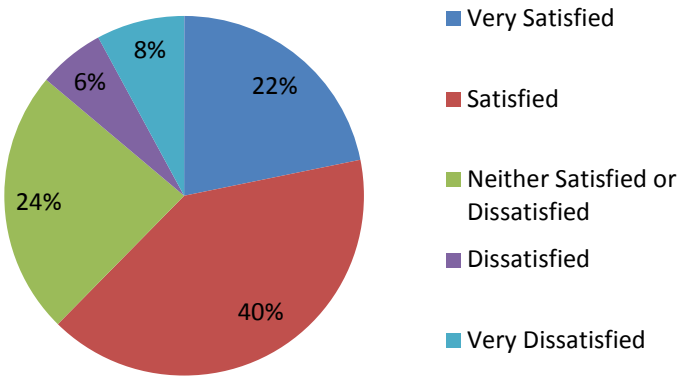
Table 3. Percentage within Single Item Business Function Overall Satisfaction Categories: Blue Plus

	N	Very Dissatisfied	Dissatisfied	Neither Satisfied or Dissatisfied	Satisfied	Very Satisfied
Inquiries	100	12.00	7.00	17.00	44.00	20.00
Education and Outreach	101	0.99	7.92	53.47	28.71	8.91
Claims	101	7.92	5.94	23.76	40.59	21.78
Appeals	27	7.47	37.04	29.63	25.93	0.00
Enrollment	40	5.00	7.50	10.00	57.50	20.00
Medical Review	11	9.09	0.00	54.55	36.36	0.00
Audits	4	0.00	25.00	25.00	50.00	0.00
Prior Authorization	35	5.71	5.71	25.71	51.43	11.43

Figure 2a. Percentage within Single Item Business Function Overall Satisfaction Categories: Blue Plus



Overall Satisfaction with Claims: Blue Plus



Overall Satisfaction with Appeals: Blue Plus

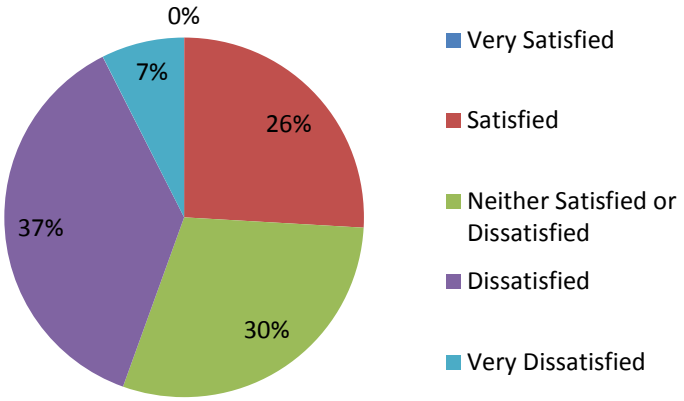


Figure 2b. Percentage within Single Item Business Function Overall Satisfaction Categories: Blue Plus

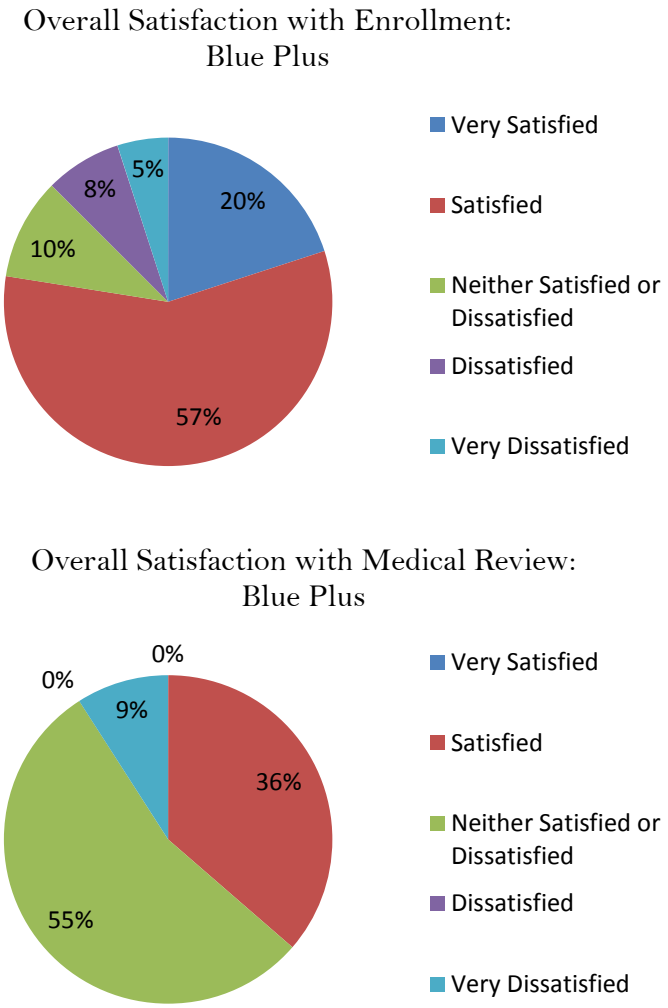
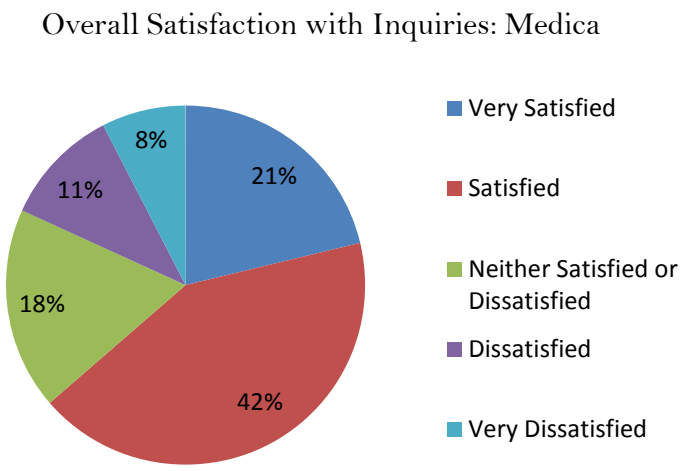


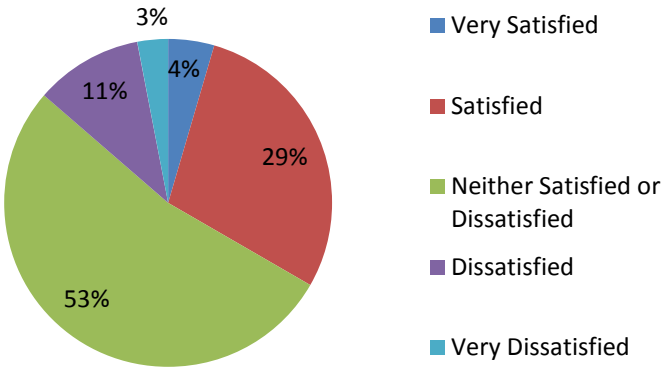
Table 4. Percentage within Single Item Business Function Overall Satisfaction Categories: Medica

	N	Very Dissatisfied	Dissatisfied	Neither Satisfied or Dissatisfied	Satisfied	Very Satisfied
Inquiries	66	7.57	10.61	18.18	42.42	21.21
Education and Outreach	66	3.03	10.61	53.03	28.79	4.55
Claims	67	7.46	16.42	22.39	38.81	14.93
Appeals	25	8.00	32.00	28.00	28.00	4.00
Enrollment	38	7.89	15.79	13.16	44.74	18.42
Medical Review	17	5.88	17.65	11.76	41.18	23.53
Audits	13	0.00	15.38	7.69	76.92	0.00
Prior Authorization	44	4.55	9.09	18.18	40.91	27.27

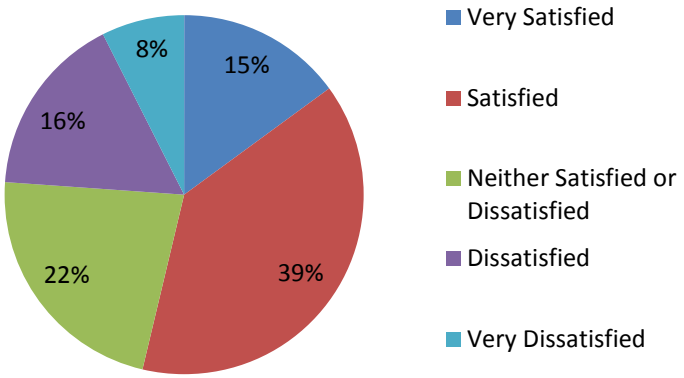
Figure 3a. Percentage within Single Item Business Function Overall Satisfaction Categories: Medica



Overall Satisfaction with Education and Outreach: Medica



Overall Satisfaction with Claims: Medica



Overall Satisfaction with Appeals: Medica

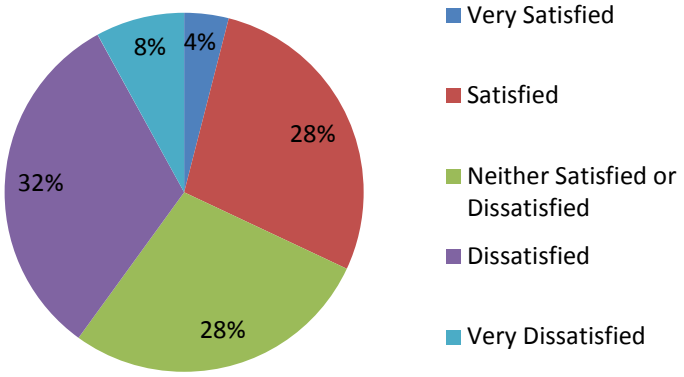
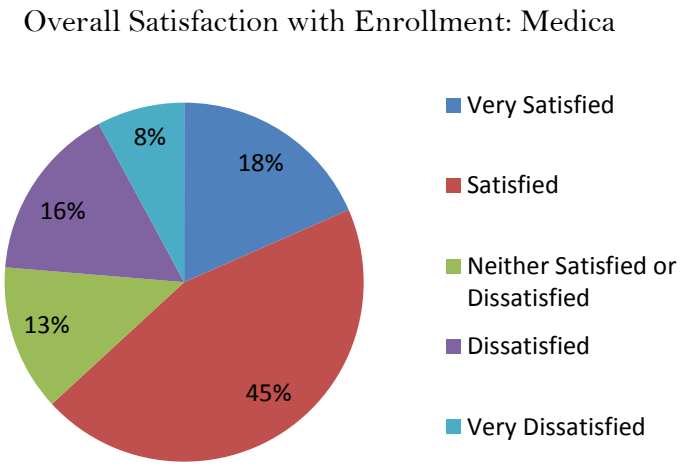
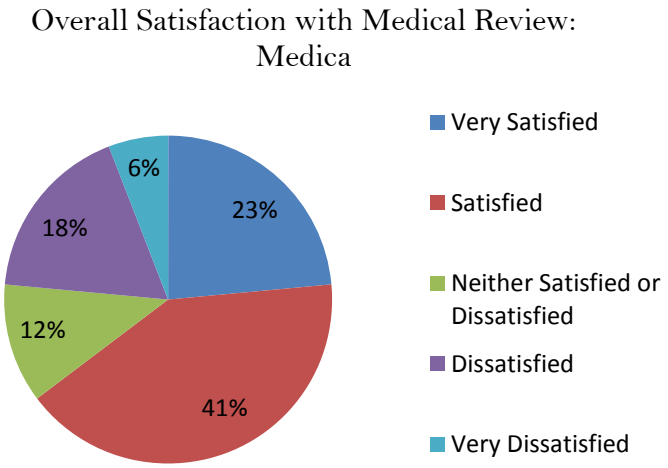
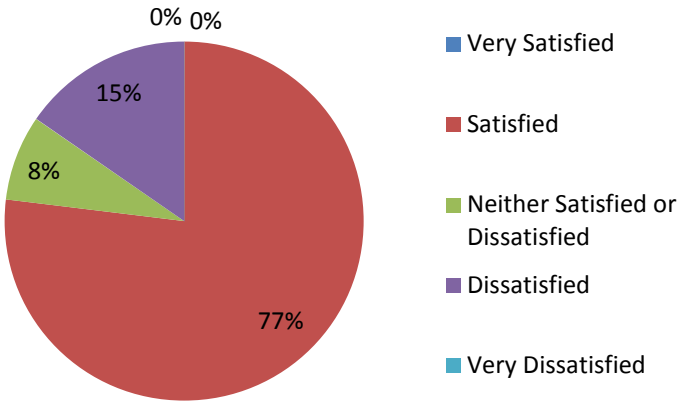


Figure 3b. Percentage within Single Item Business Function Overall Satisfaction Categories: Medica

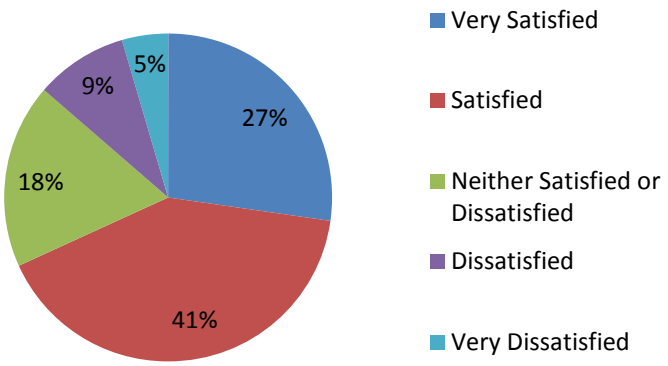




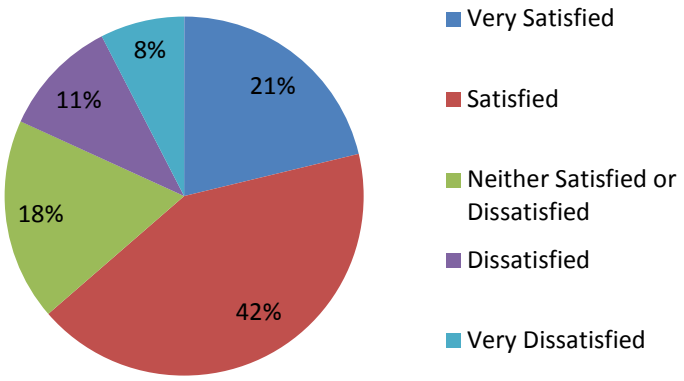
Overall Satisfaction with Audits: Medica



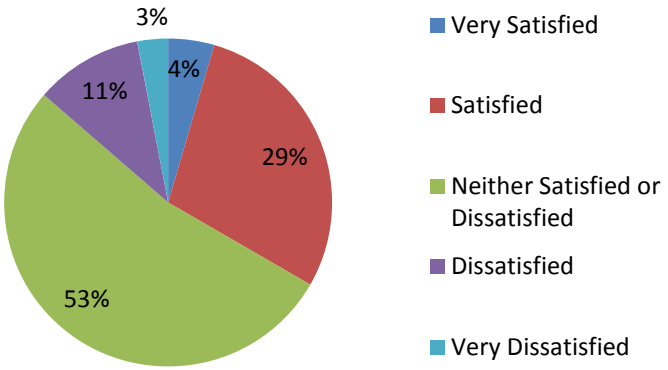
Overall Satisfaction with Prior Authorization: Medica



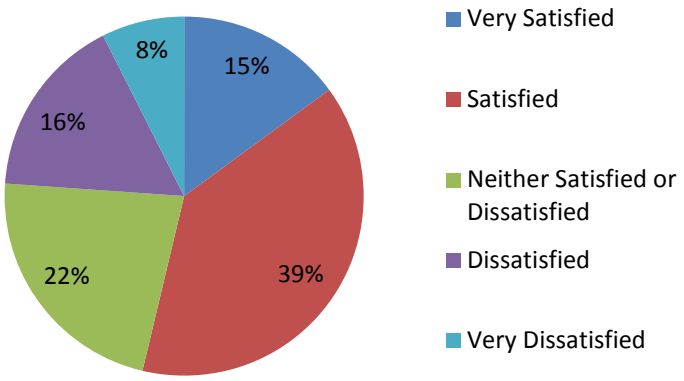
Overall Satisfaction with Inquiries: Medica



Overall Satisfaction with Education and Outreach: Medica



Overall Satisfaction with Claims: Medica



Overall Satisfaction with Appeals: Medica

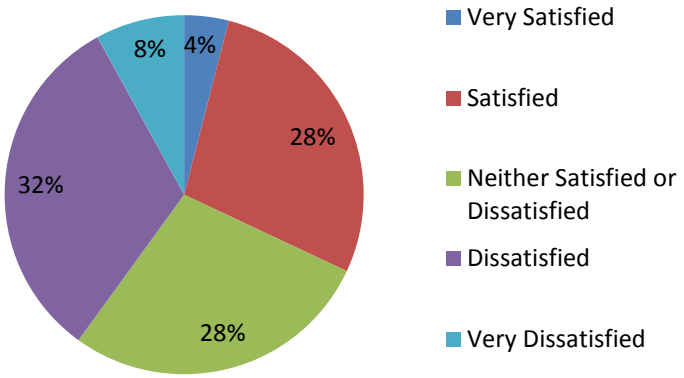
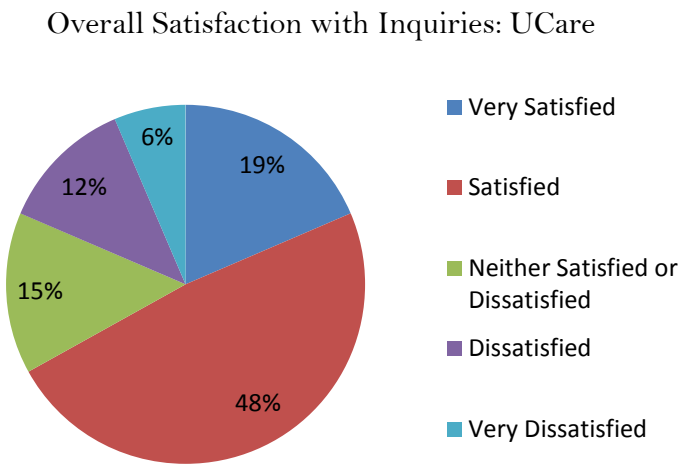


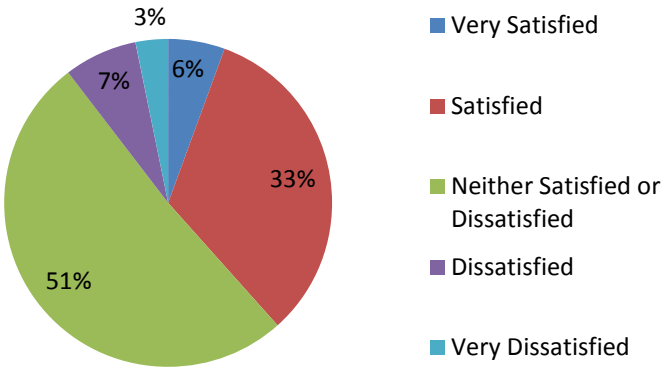
Table 5. Percentage within Single Item Business Function Overall Satisfaction Categories: UCare

	N	Very Dissatisfied	Dissatisfied	Neither Satisfied or Dissatisfied	Satisfied	Very Satisfied
Inquiries	124	6.45	12.10	14.52	48.39	18.55
Education and Outreach	125	3.20	7.20	51.20	32.80	5.60
Claims	127	6.30	14.96	15.75	46.46	16.54
Appeals	39	12.82	35.90	23.08	25.64	2.56
Enrollment	78	5.13	14.10	14.10	46.15	20.51
Medical Review	16	0.00	6.25	12.50	68.75	12.50
Audits	22	4.55	13.64	22.73	45.45	13.64
Prior Authorization	79	5.06	10.13	20.25	41.77	22.78

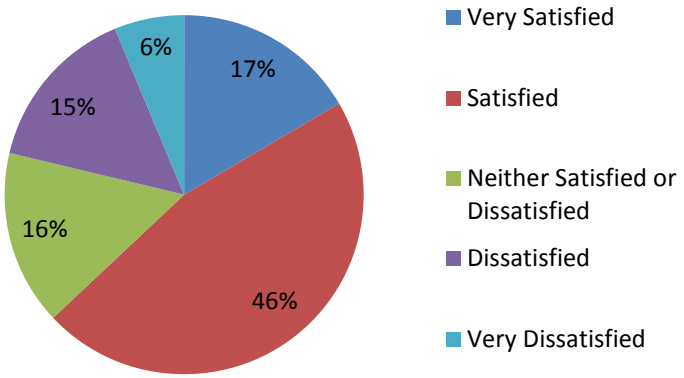
Figure 4a. Percentage within Single Item Business Function Overall Satisfaction Categories: UCare



Overall Satisfaction with Education and Outreach: UCare



Overall Satisfaction with Claims: UCare



Overall Satisfaction with Appeals: UCare

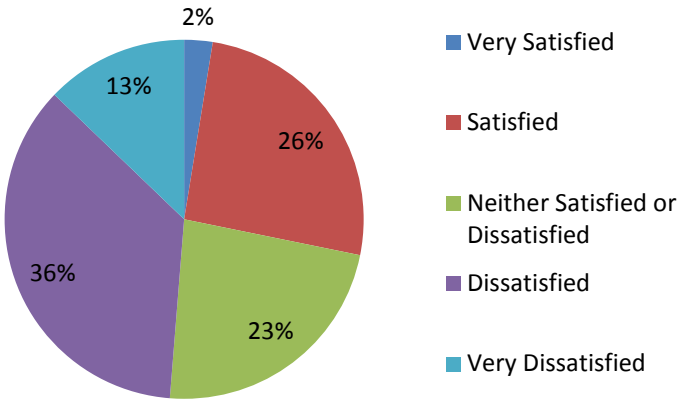
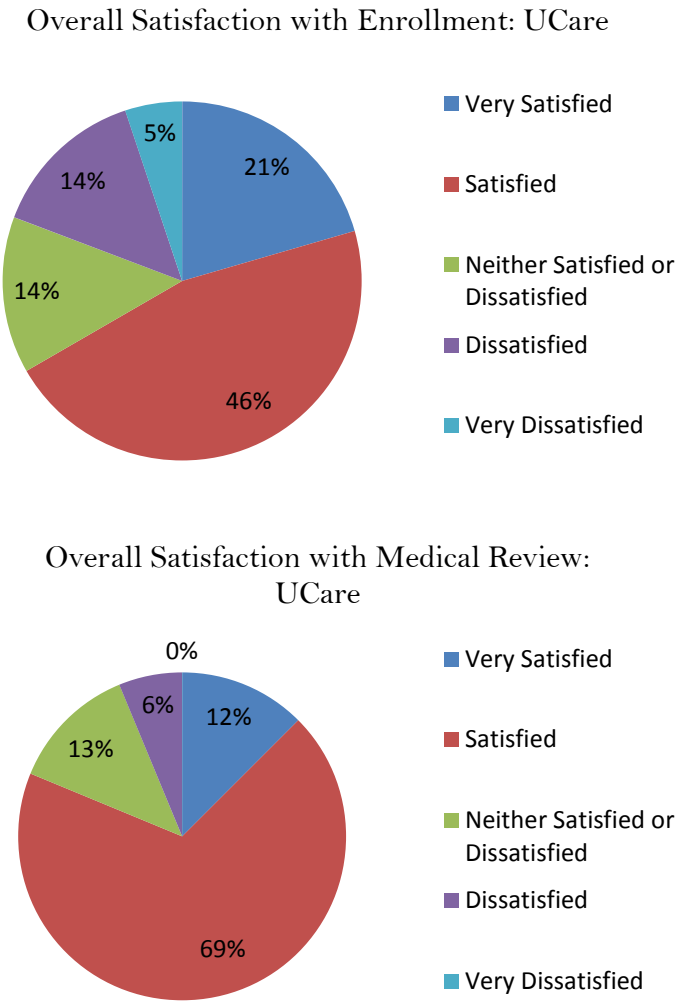
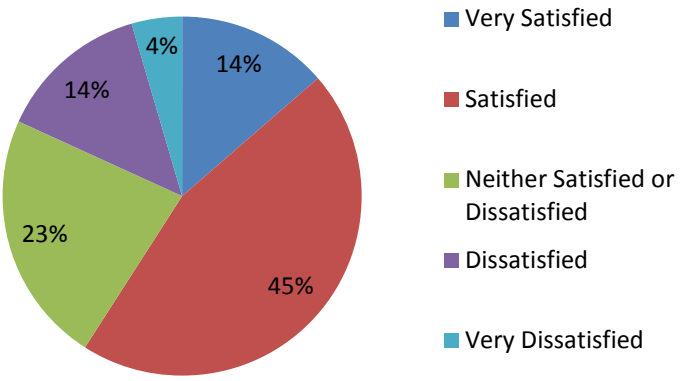


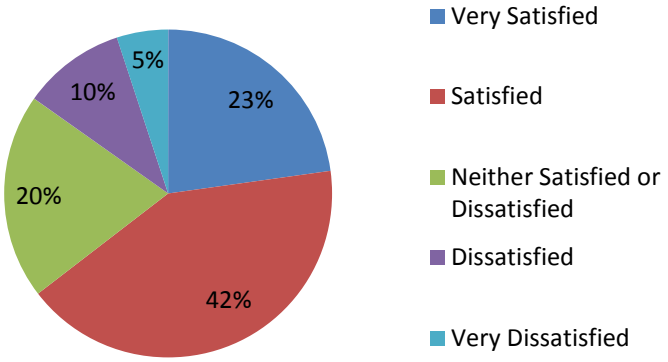
Figure 4b. Percentage within Single Item Business Function Overall Satisfaction Categories: UCare



Overall Satisfaction with Audits: UCare



Overall Satisfaction with Prior Authorization: UCare



4. **Business Function Component Mean Scores by MCO**. Table 6 shows the distribution of business function satisfaction mean scores, separated by MCO. Results across MCOs indicated there was not a significant degree of difference amongst the MCOs in mean satisfaction for the business functions. These results are listed in Table 6. It should be noted that for some business functions, such as appeals and medical reviews, there were fewer than 20 participants within an MCO, which limits the ability to find significant differences.

Table 6. Mean Performance within Business Function Component Categories: By MCO

	Blue Plus			Medica			UCare		
	Mean	SD	N	Mean	SD	N	Mean	SD	N
Inquires	3.76	1.07	96	3.80	1.08	62	3.68	1.03	126
Education and Outreach	3.63	0.85	42	3.92	0.64	28	3.76	0.75	61
Claims	3.82	1.02	94	3.64	1.05	57	3.69	0.98	125
Appeals	3.12	0.90	27	3.13	0.90	24	3.04	0.98	38
Enrollment	3.95	0.95	42	3.80	0.92	38	3.90	0.95	77
Medical Review	3.32	0.88	12	3.73	0.89	18	3.85	0.76	18
Audits	3.15	0.75	4	3.90	0.85	14	3.57	1.04	23
Prior Authorization	3.74	0.95	36	3.92	0.99	47	3.77	0.97	83

Note. Means are scored on a one to five scale (1= very dissatisfied, 2= dissatisfied, 3 = neither dissatisfied or satisfied, 4 = satisfied, 5 = very satisfied).

5. **Item Level Information.** Some individual level items were noticeably different than other items within the business function in question. For example, the following satisfaction items contained an average mean score that was noticeably lower *or* higher than other items within their business function.

    - **Ease of submitting claims** (Claims). This item had a noticeably higher mean (M = 4.15) than other items within the business function of claims, which generally ranged from about 3.6 to 3.8. This finding was consistent across all MCOs.

    - **Promptness of [MCO] in resolving claims-related issues** raised by [the provider] (Claims). This item had a noticeably lower mean (M = 3.40) than other items within the business function of claims, which generally ranged from about 3.6 to 3.8. This was particularly true for UCare, which had a score of 3.31, approximately 0.3 to 0.4 units lower than other claims items.

    - **Timeliness of appeal decisions** [MCO] made (Appeals). This item had a noticeable lower mean (M = 2.69) than other items within the business function of appeals, which generally ranged from 3.0 to 3.2. This finding extended to Blue Plus and UCare most of all, and Medica to a lesser extent.

    - **Professionalism and courtesy of [MCO]'s representatives throughout provider audit activities** (Audits). This item had a noticeably higher mean (M = 4.00) than other items within the business function of audits, which generally ranged from 3.5 to 3.7. This finding was especially true for Medica, which had a mean score of 4.29, approximately 0.4 to 0.5 units higher than other audit items.

    - **[MCO]'s ability to fully resolve problems without [the provider] having to make multiple inquiries** (Inquiries). For Medica and UCare, this item had a noticeably lower mean (M = 3.47 and M = 3.44, respectively) than other items within the business function of inquiries, which generally ranged from about 3.7 to 3.9.

6. **Qualitative Comments**. There were a number of qualitative comments that deserve to be mentioned in this report. It should be mentioned first, however, that more formal and definitive content analysis is not present in this study, given the quality and quantity of the obtained data. Therefore, the comments listed in this section should be interpreted as just a sampling of comments from individual providers and not as indicative of any general or long-term trend. A full list of qualitative comments from providers can be seen in Appendix C.

    An example of a negative comment is the following:

    "*In registering our PCAs with [MCO], we have not been consistently notified when the registration process is completed. Unfortunately, we are now dealing with untimely filings of billings because of the lack of communication that the registration process is completed and billing can ensue. This has been a huge frustration for us.*"

In contrast, here is a more positive comment:

"[MCO] is great health plan and doing very good job serving the community so far. We just need [MCO] to have monthly bulletin information to all the contracted providers for updates."

Finally, here is an example of a more varied comment that contained both positive and negative elements:

"*I think that the business processes are good, but some of the policies are not so good, particularly as it applies to testing prior authorization. I have seen many children who are misdiagnosed because no testing was utilized and I have been able to rule out mental health disorders with testing, thus saving the insurance company money*."

7. **Results Conclusion**. One of the major goals of this study was to examine provider satisfaction with MCO performance. To that end, it appears that providers, on average, indicated a moderate level of satisfaction with MCO performance. Approximately 20 percent of providers indicated they were dissatisfied with MCO performance, with the business function of appeals receiving the most dissatisfaction amongst providers. Finally, we gave a sampling of qualitative comments and item-level information that could possibly be informative to MCOs going forward.

   While these results should not be taken as conclusive given the sample sizes and data involved, these results can be taken at an exploratory level within MCO to potentially focus process improvement efforts. Future studies with higher quality data will lead to a stronger foundation for statistical inferences and process improvement.

VI. Report recommendations

As previously stated, this report was designed with two main goals in mind, which were

1. analysis of the feasibility of future provider survey efforts, and
2. evaluation of MCO performance according to providers.

In evaluating future survey feasibility, DHS came across a number of issues that deserve examination. These recommendations center around two major themes. The first theme is how to identify a representative sample of providers while the second theme is how to best contact the representative sample of providers.

1. Expand the list of potential survey respondents beyond providers of particular specialties to include a broader representation of the Medical Assistance provider population. Subgroup analysis can be conducted with specific provider types if sufficient data is collected.

2. Have DHS work with providers and MCOs to improve the quality of and currency of provider address data, and add email address data. Although it is likely impossible to obtain and maintain perfect mailing addresses, to the degree mailing accuracy is improved, so too is the degree to which DHS will be able to contact providers and potentially increase the sample size of the survey.

3. Consider multiple modes of delivery for future provider surveys. Ideally, using multiple methods of delivery will lead to an increased response rate, as this effect has been illustrated in previous research (Dillman & Messer, 2010). This will also help reduce the difficulties associated with having providers type URLs into a web browser manually or providers not checking their MN-ITS mailbox.

4. Maintain the item-level content of the survey as it currently exists. The survey itself appears to possess a relatively high level of validity and should be used in future explorations of MCO performance. Primarily, benchmarks can be set for performance using the survey and then evaluated across survey efforts.

5. If possible, extend the timeframe of the data collection period so that data collection can continue until there is a sufficient sample size to answer more detailed, specific, and actionable research questions. Ideally, DHS will have enough time in data collection to simultaneously

    - respond to unexpected disturbances in the data collection process, and
    - collect enough data to make detailed and nuanced actionable observations and recommendations.

    All else being equal, a longer data collection timeframe will aid in this effort.

6. Ultimately, DHS can only recommend a continuation of the provider survey if the changes noted above can be made and supported with the resources that will provide more meaningful and reliable results which can be used for quality improvement. In terms of frequency, DHS recommends the provider survey take place every three years on a rolling basis. That is, provider sampling takes place every three years in a *continuous* manner until enough quality data is collected that research questions can be adequately addressed (see recommendation five).

VII. References

Blalock, H. M. (1972). *Social Statistics*. New York: McGraw–Hill Book Co., Inc

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Dillman, D., & Messer, B. (2010). Mixed-Mode Surveys. In P. Marsden & J. Wright *Handbook of Survey Research* (2nd edn) San Diego: Emerald 499-526.

Mathematica Policy Research, Inc. (2011). Medicare Contractor Provider Satisfaction Survey (MCPSS) Public Report 2011.

VIII. Appendixes

Appendix A: Definitions

Definition of children's mental health services

- Recipient age 17 and younger
- CPT and HCPCS codes:
  - 90801 – 90899 (any modifier OK for general MH services – UA modifier indicates CTSS)
  - 96101, 96102, 96103, 96116-96120 (no modifier needed) (psychological testing and neuropsychological assessment)
  - 99499 with HE modifier (psychiatric consultation to a PCP)
  - H0031 (Crisis Assessment/Intervention in ER)
  - H0035 with HA modifier (Partial Hospitalization – under age 18)
  - H0046 (MH Provider Travel Time)
  - H2012, H2014, H2015, H2019 – all with UA modifier (CTSS)
  - M0064 (Brief Office Visit for Medication Monitoring/Change)
  - S9484 with UA modifier (Children's Crisis Response Services)
  - T1017 and T1023 with HE modifier (MH - Targeted Case Management)

Definition of pediatric home care services

- Recipient age 17 and younger
- Procedure codes (use regardless of modifiers):
  - T1021 (Home Health Aide or CNA visit)
  - T1003 (LPN/LVN Services)
  - S9129 (Occupational therapy in the home)
  - S9131 (PT in the home per Diem)
  - S9128 (Speech therapy in the home)
  - S5181 (Home Health Respiratory Therapy, per day)
  - T1002 (RN Services)
  - T1030 (RN Home Care per diem)

Note: The definition of pediatric home care services excludes PCAs.

Appendix B: Provider Survey

Pilot Satisfaction
Survey of Medicaid Providers
Blue Plus

The MN Department of Human Services (DHS) has selected your practice or facility to participate in a pilot satisfaction survey of providers. We know that your time is valuable and greatly appreciate your willingness to participate in this very important study to assess your satisfaction with the Managed Care Organization, Blue Plus. If you work with more than one MCO, **please make sure you answer the questions only about Blue Plus.** Throughout the survey, when we refer to "you" in the questions, we mean your organization as a whole.

- To navigate between pages, use the BACK and NEXT buttons at the bottom of each page. DO NOT USE THE BACK BUTTON ON YOUR BROWSER.
- You can print the survey questions by clicking PRINT button on any of the survey screens.
- If you cannot complete the survey in one sitting, you can save your answers by clicking SAVE. Follow the instructions on the screen to complete the survey later.
- When you have completed the survey, be sure to click SUBMIT at the end of the last screen.

Enter your NPI

Please verify your Provider Name. If this is not your provider name, close the survey without submitting and begin again using the link sent to you. You must enter your NPI again. Please make sure the number is entered correctly.

Provider Name: {Q1}

About Your Practice or Facility and Overall Satisfaction with Blue Plus
Please answer the following questions about your practice or organization.

Approximately how long have you been a Medical Assistance (MA) provider?

Years ☐ Months ☐

Approximately how long have you worked with Blue Plus to serve Medical Assistance (MA) beneficiaries in Minnesota?

Years ☐ Months ☐

Thinking about ALL your interactions with Blue Plus in the **last 12 months**, how satisfied have you been with their **overall** performance?

- ☐ Very dissatisfied
- ☐ Dissatisfied
- ☐ Neither satisfied nor dissatisfied
- ☐ Satisfied
- ☐ Very satisfied

How many full-time employees are there in your practice/facility? ☐

Section A: Provider Inquiries

While answering the following questions, think about your experiences in the **last 12 months** involving any inquiries or questions you or any other persons in your practice or facility make to Blue Plus ONLY.

In the **last 12 months**, which method(s) have you used to communicate with Blue Plus for inquiries? (**CHECK ALL THAT APPLY**)

- ☐ *Telephone call with a Blue Plus representative*
- ☐ *Automated telephone system (IVR)*
- ☐ *Web*
- ☐ *Email*
- ☐ *Mail*
- ☐ *Fax*
- ☐ *Other. Please specify the method used.* [ ]

In the **last 12 months**, which method have you used **most often** to communicate with Blue Plus?

- ☐ *Telephone call with a Blue Plus representative*
- ☐ *Automated telephone system (IVR)*
- ☐ *Web*
- ☐ *Email*
- ☐ *Mail*
- ☐ *Fax*
- ☐ *Other. Please specify the method used.* [ ]

Please specify the method used most often.

[ ]

In the last 12 months, how satisfied have you been with

	Very Dissatisfied	Dissatisfied	Neither Satisfied or Dissatisfied	Satisfied	Very Satisfied	Don't Know	N/A
The ease of submitting provider inquiries to BluePlus							
The promptness of BluePlus in responding to your inquiries							
The consistency of responses from BluePlus about your inquiries							
BluePlus's ability to fully solve problems without you having to make multiple inquiries							

In the **last 12 months**, what is your **overall** satisfaction with Blue Plus's provider inquiry activities?

- ☐ Very dissatisfied
- ☐ Dissatisfied
- ☐ Neither satisfied nor dissatisfied
- ☐ Satisfied
- ☐ Very satisfied

Section B: Provider Outreach and Education

While answering the following questions, think about your experiences in the **last 12 months** involving the training resources provided by Blue Plus ONLY. These resources include web-based training, newsletters, bulletins, workshops/seminars, videos, on-site training, demonstrations, reference materials, CDs, MCO website, email lists, etc.

In the **last 12 months**, what education and training resources of Blue Plus have you used? (**CHECK ALL THAT APPLY**)

- ☐ *Web-based training*
- ☐ *MCO website*
- ☐ *In-person training/workshops*
- ☐ *Teleconferences*
- ☐ *Hard copy materials*
- ☐ *Email materials*
- ☐ *Other*
- ☐ *None used*

The next few questions are about your satisfaction with Blue Plus's performance in outreach and education.

	Very Dissatisfied	Dissatisfied	Neither Satisfied or Dissatisfied	Satisfied	Very Satisfied	Don't Know	N/A
The ease of accesing or participating in the training offered by BluePlus							
The expertise of BluePlus's provider education and training staff							
The professionalism and courtesy of Blue Plus's training and education representatives?							

The next few questions are about your satisfaction with Blue Plus's performance in the following categories:

- face-to-face training,
- non face-to-face training (i.e., webinars, teleconferences) and
- educational materials or information resource availability.

Face-to-Face Training
If you have received in-person training in the **last 12 months**, how satisfied have you been with the...

	Very Dissatisfied	Dissatisfied	Neither Satisfied or Dissatisfied	Satisfied	Very Satisfied	Don't Know	N/A
Availability of training							
Clarity of information presented							
Detail of topics covered							
Relevance of training to meet your specific needs							

Non Face-to-Face Training
If you have participated in non face-to-face training (i.e., webinars, teleconferences) in the **last 12 months**, how satisfied have you been with the...

	Very Dissatisfied	Dissatisfied	Neither Satisfied or Dissatisfied	Satisfied	Very Satisfied	Don't Know	N/A
Availability of training							
Clarity of information presented							
Detail of topics covered							
Relevance of training to meet your specific needs							

Education Materials or Information Resources
If you have received educational materials or information resources from Blue Plus in the **last 12 months**, how satisfied have you been with the...

	Very Dissatisfied	Dissatisfied	Neither Satisfied or Dissatisfied	Satisfied	Very Satisfied	Don't Know	N/A
Amount of educational materials or information resources							
Accessibilitry of educational materials or information resources							
Clarity of information							
Relevance of the educational materials of information resources to meet your specific needs							

For which of the following topics would you like to see more training and education materials from Blue Plus? (**CHECK ALL THAT APPLY**)

- ☐ Claims processing
- ☐ Payment policy
- ☐ Local coverage determination
- ☐ Enrollment
- ☐ Appeals
- ☐ Audit and reimbursement
- ☐ Practice guidelines
- ☐ Evidence based practice
- ☐ Other

Please specify other topic(s) you would like to see.

In the **last 12 months**, what is your **overall** satisfaction with Blue Plus's outreach and educational activities?

- ☐ Very dissatisfied
- ☐ Dissatisfied
- ☐ Neither satisfied nor dissatisfied
- ☐ Satisfied
- ☐ Very satisfied

Section C: Claims Processing

While answering the following questions, think about your experiences in the **last 12 months** involving claims processing activities with Blue Plus ONLY.

In the **last 12 months**, how satisfied have you been with the

	Very Dissatisfied	Dissatisfied	Neither Satisfied or Dissatisfied	Satisfied	Very Satisfied	Don't Know	N/A
Accuracy of BluePlus's claims editing							
Timeliness of notification from Blue Plus that a claim will not be paid (including denied or returned claims)?							
Clarity of the remittance advice you received from Blue Plus?							
Ease of correcting claims?							
Promptness of Blue Plus in resolving claims-related issues raised by you							
Correctness of the information Blue Plus provided in response to claims-related issues you raised							

In the **last 12 months**, what is your **overall** satisfaction with Blue Plus's claims processing activities?

- ☐ Very dissatisfied
- ☐ Dissatisfied
- ☐ Neither satisfied nor dissatisfied
- ☐ Satisfied
- ☐ Very satisfied

Section D: Appeals

While answering the following questions, think about your experiences in the **last 12 months** involving appeals activities with Blue Plus ONLY.

In the **last 12 months**, has your practice or facility had an appeal to Blue Plus?

☐ Yes ☐ No

In the **last 12 months**, how satisfied have you been with...

	Very Dissatisfied	Dissatisfied	Neither Satisfied or Dissatisfied	Satisfied	Very Satisfied	Don't Know	N/A
The mechanisms that Blue Plus offers for exchanging information about appeals?							
Blue Plus's responsiveness, attentiveness, and availability during the process of appeals?							
The professionalism and courtesy of Blue Plus's representatives during the appeals process?							
The timeliness of appeal decisions Blue Plus made?							
Ease of correcting claims?							
The clarity of explanations of appeal decisions Blue Plus made?							
The consistency of appeals decisions by Blue Plus for claims that have been denied?							

Thinking about your most recent appeal to Blue Plus, how long did it take to get the final decision on the appeal from BluePlus?

Days ☐

In the **last 12 months**, what is your **overall** satisfaction with Blue Plus's appeals process?

- ☐ Very dissatisfied
- ☐ Dissatisfied
- ☐ Neither satisfied nor dissatisfied
- ☐ Satisfied
- ☐ Very satisfied

Section E: Provider Enrollment

While answering the following questions, think about your experiences in the **last 12 months** involving provider enrollment activities with Blue Plus ONLY.

In the **last 12 months**, have you gone through the enrollment process with Blue Plus, including updates to enrollment information?

☐ Yes ☐ No

In the **last 12 months**, how satisfied have you been with...

	Very Dissatisfied	Dissatisfied	Neither Satisfied or Dissatisfied	Satisfied	Very Satisfied	Don't Know	N/A
Blue Plus's ability to answer questions specific to your situation in relation to the provider enrollment process?							
The consistency of Blue Plus's responses or decisions in the process of enrollment?							
The professionalism and courtesy of Blue Plus's representatives during the provider enrollment process							
Blue Plus's responsiveness, attentiveness, and availability during the process of enrollment?							

In the **last 12 months**, what is your **overall** satisfaction with Blue Plus's enrollment process?

- ☐ Very dissatisfied
- ☐ Dissatisfied
- ☐ Neither satisfied nor dissatisfied
- ☐ Satisfied
- ☐ Very satisfied

Section F: Medical Review

While answering the following questions, think about your experiences in the **last 12 months** involving medical review (utilization management and quality improvement) activities with Blue Plus ONLY.

In the **last 12 months**, have you had a medical review?

☐ Yes ☐ No

In the **last 12 months**, how satisfied have you been with...

	Very Dissatisfied	Dissatisfied	Neither Satisfied or Dissatisfied	Satisfied	Very Satisfied	Don't Know	N/A
Availability of timely updates from Blue Plus on policy in medical review?							
Clarity of the notification (letter, phone call, etc.) from Blue Plus that your claims were selected for medical review?							
Professionalism and courtesy of Blue Plus's representatives throughout the medical review process?							
Clarity of the explanations of Blue Plus's medical review decisions?							
Follow-through that Blue Plus provided after medical review decisions?							
Consistency of Blue Plus's medical review decisions?							

In the **last 12 months**, what is your **overall** satisfaction with Blue Plus's medical review activities?

- ☐ Very dissatisfied
- ☐ Dissatisfied
- ☐ Neither satisfied nor dissatisfied
- ☐ Satisfied
- ☐ Very satisfied

Section G: Provider Audit

While answering the following questions, think about your experiences in the **last 12 months** involving claim audit activities with Blue Plus ONLY.

In the **last 12 months**, have you been audited by Blue Plus?

☐ Yes ☐ No

In the **last 12 months**, how satisfied have you been with the...

	Very Dissatisfied	Dissatisfied	Neither Satisfied or Dissatisfied	Satisfied	Very Satisfied	Don't Know	N/A
Availability of timely updates from Blue Plus on policy on provider audits?							
Professionalism and courtesy of Blue Plus's representatives throughout provider audit activities?							
Clarity of Blue Plus's instructions during the audit process?							
Timeliness of Blue Plus's decisions about adjustments to claims payments?							

Clarity of Blue Plus's explanations for decisions about adjustments to your interim payments?							
Consistency of Blue Plus's medical review decisions?							

In the **last 12 months**, what is your **overall** satisfaction with Blue Plus's provider audit activities?

- ☐ Very dissatisfied
- ☐ Dissatisfied
- ☐ Neither satisfied nor dissatisfied
- ☐ Satisfied
- ☐ Very satisfied

Section H: Prior Authorization

While answering the following questions, think about your experiences in the **last 12 months** involving prior authorization by Blue Plus ONLY.

In the **last 12 months**, have you applied to Blue Plus for a prior authorization?

☐ ☐ Yes ☐ No

In the **last 12 months**, how satisfied have you been with the...

	Very Dissatisfied	Dissatisfied	Neither Satisfied or Dissatisfied	Satisfied	Very Satisfied	Don't Know	N/A
Professionalism and courtesy of Blue Plus's representatives throughout the prior authorization process?							
Clarity of Blue Plus's instructions during the prior authorization process?							

Timeliness of Blue Plus's decision in the prior authorization process?							
cClarity of Blue Plus's explanations for decisions on the prior authorization?							

In the **last 12 months**, what is your **overall** satisfaction with Blue Plus's prior authorization process?

- ☐ Very dissatisfied
- ☐ Dissatisfied
- ☐ Neither satisfied nor dissatisfied
- ☐ Satisfied
- ☐ Very satisfied

Additional comments about Blue Plus and about this survey

We are interested in any additional comments you have about Blue Plus's business processes with providers. (**Responses only up to 256 characters will be saved.**)

We are also interested in any comments you have about this survey, including how valuable you think this survey is, how often you are willing to participate in a survey like this and how to improve the questions in future surveys. (**Responses only up to 256 characters will be saved.**)

Thank you for completing this survey! Click on submit button to send.

Appendix C: Qualitative Comments from Providers

Note: Some comments are very slightly edited, in order to anonymize the provider and/or MCO in question.

- *Would like to be informed on training programs on the topics checked in the survey. Also any information and/or directions on starting/maintaining Electronic Health Records (EHR) at my facility will be helpful. Thanks.*

- *Would appreciate more training sessions closer to our location in Southwestern Minnesota. Teleconferences are not possible in our small office with only one office staff on duty.*

- *Wish when looking up clients on the web portal that the individuals ID# would be present. Appeals would not take so long, because when they do it becomes untimely filing for any other insurance to be billed.*

- *When I've submitted case management charges, I've had claims deny due to no rendering provider in box 24 J with [MCO]. When I've submitted to a regular [MCO] plan, there doesn't need to be a rendering provider for the claim to get paid. With straight Medical Assistance they will not allow a rendering provider on the claim. Why the difference with [MCO]?*

- *We see many [MCO] members and the ease of use is outstanding. In enrolling new providers and adding credentialed providers to our site, my only complaint would be the amount of time it takes to receive confirmation of the add. However, I do not feel that the processing time is excessive. Finally, with [MCO] parting ways with BHP we have had some questions with the contract and rates, but I assume this is isolated to our experience. Any time I've called I have been treated very well.*

- *We love working with [MCO]. Their provider center is very helpful and we also love how the website has been coming along to provide us with even more independence in finding answers for the clients we service.*

- *We have not encounter any significant issues with [MCO] in processing claims*

- *We have had trouble with one of our clinician's hyphenated name getting kicked out on claims, and making them denied. The last name and NPI match, but they still get kicked out. That is a little frustrating.*

- *We have had no adverse issues with [MCO]. We are very satisfied in the manner in which they process and pay claims. They handle prior auths very well. Our only complaint is the affiliation process for new PCAs. We must wait at least 4-5 weeks for DHS to issue UMPI numbers to new employees and then another 4-5 weeks for [MCO] to affiliate in their system before we can bill for PCAs services. This is a long time to pay an employee and not be able to bill for their services. This problem is not unique to [MCO]. All the companies we provide services in conjunction with have similar procedures.*

- *We have had a very hard time with [MCO] this past seven months getting claims paid. They send them back to our clearing house right away and then they tell us they never received the claim, they then review them for over two weeks and then decline them, we have been fighting to attain payments over seven months and it keeps adding up. They have been very hard to work with and very hard to attain payment from, we bill the other Medicaid providers the exact same way and attain payment just fine, we have been doing this for eight years, but now just the last seven months they have been so difficult.*

- *We have experienced significant problems with [MCO]'s authorization requirements and processes for certain psychotropic medications. 1. We are told by [MCO] they will not authorize Abilify, an atypical antipsychotic, until we have tried the other medications listed (list these). Abilify is less likely to cause weight gain, lipid changes, and sedation than the other antitypical antipsychotics (for example: Risperdal, Seroquel, Xyprexa, Geodon). We are a child and adolescent psychiatric group that sees a large number of patients covered by Medical Assistance. Many of these patients (90% or more) who are prescribed these medications have a history of trauma and/or complex trauma. We prescribe these for young patients who experience psychosis, as an adjunct to an antidepressant for those suffering depression, occasionally to decrease reactivity. Abilify is chemically different than other atypical antipsychotic medications. This medication is a partial agonist which normalizes dopamine, rather than blocking dopamine. 2. Adderall XR is routinely not covered; we are told by [MCO] to first try Adderall or the methylphenidate, Strattera. The disadvantage of these non-long-acting medications is that they require multiple dosing throughout the day, which increases rebound effects and decreases the likelihood of medication compliance. This is particularly important for children and adolescents as they cannot self-administer these medications and are attending school and after school activities during most of the year. The managed care organization will not authorize two supplies (one for home and one for school). This requires the school nurse and the parent/caregiver and also the after school activity setting to tightly coordinate and carefully divided up the medications on a weekly basis, which is practically impossible. For safety reasons, parents cannot hand the medication to children to take to school with them; the Rx must be hand delivered directly to the school nurse office, and this is an "access to care" burden.*

- *We have been very pleased with [MCO] and don't agree with the 2 insurance only plan for PMAP clients. Our experience with [MCO] has been less than satisfactory. I do not believe they can manage the volume of clients they will be getting.*

- *We have been battling well over a year regarding underpayment on claims. Early in 2013 with all of the take-back adjustments was a very time consuming venture, just to find out we still were not being paid correctly, and still are not to date. We have had numerous claims denied stating they were "duplicate" claims; however, they were actually separate claims by different providers. Claims are not processed the same on any given day, some pay correctly, others pay correctly, some deny for duplicate claims. It just doesn't appear all payment processors are all on the same page.*

- *We have applied to be in network CTSS providers but have been denied twice. The reason given was that there is not enough need in the area, yet on average, 25% of our caseload has [MCO] PMAP coverage. Requesting authorizations and getting paid correctly has been a full time job, with authorized clean claims sometimes not getting paid correctly for more than a year, and only after many phone calls and numerous reprocessing attempts. We are still waiting on payments on 2012 claims that were billed correctly and repeatedly paid incorrectly. We do not have these numerous issues with any other payers. [MCO] is now denying all H0004 UA claims. After many, many phone calls and claims being reprocessed only to still pay $0, we were told that they can no longer pay the H0004 UA code for therapy as it is not a DHS code. H0004 UA is the code they have instructed us to use when requesting authorizations and the code they have authorized for all therapies since we began billing [MCO] PMAP. No other payer has used this code.*

- *We have always found [MCO] to have exceptional provider customer service. We are very disheartened to have counties in the area drop [MCO] as an option for our PMAP patients. It severely limits choices and creates problems for mental health consumers in our area.*

- *We had an audit and nothing was clarified. It took too long to have the problem corrected on their end, after I corrected some of the problems on my end and our clearinghouse. I had to make several phone calls to the call center, emails, spoke with a supervisor and finally got a liaison rep. to help. I think it would be nice to have an assigned representative from [MCO] that agencies can call. Also, it takes way too long for [MCO] to reprocess the claims that have been denied.*

- *We enjoy working with [MCO].*

- *We don't do our own billing. We use Paragon Billing.*

- *We are very satisfied with [MCO]'s business process. We hope to continue to work with [MCO].*

- *We are quite unhappy with their closed network and have trouble getting our new clinicians on the network. This translates into trouble getting patients in to see clinicians in a timely manner. We are also terribly unhappy with the rates of reimbursement. They pay substantially lower than patients on straight MA. They have not provided a cost of living increase in over a decade. The first rate adjustment in years was last year and it went down instead of up.*

- *We are disappointed that [MCO] will not continue to be a choice for our PMAP clients after January 1st, 2014. We have been very satisfied-they have been the easiest company to deal with in ALL areas and are very consistent in the information provided.*

- *Very hard to get responses to inquiries. Takes multiple calls/emails to multiple people. Finally threatened to call MN A.G.'s office. Little follow thru Inconsistent answers from [MCO] staff. Different answer to same question depending on who you talk to. No diagnosis code on Service Auth. no indication of spend down.*

- *Very efficient entity to deal with. Prompt and accurate.*

- *Very dissatisfied with the automated call system for providers and had some issues from April until September when their system suddenly started incorrectly processing claims and denying payment on almost every claim. Process is now corrected and working correctly. Would like to see a specific call-in for public programs/PMAP questions*

- *[MCO]'s turnaround time for payment to us, with a couple of exceptions, has significantly improved. We have been working with some very time-intensive clients (TPRs) which I believe should be given more consideration for the time we bill, but this has not always been the case.*

- *[MCO]'s performance in timely payment of clean claims, and appealed claims has been abysmal. Staff is courteous and helpful although new staff tends to not be well-informed. We do have problems getting follow up on claims and issues.*

- *[MCO] staff have been very professional, knowledgeable and helpful.*

- *[MCO] reps have always been willing to meet with us when we have requested it, for very large billing issues. However, the agreements made during those meetings have not been followed through upon by [MCO] reps, and we have written off a lot of money that we were told we would not have to do.*

- *[MCO] needs to process claims more correctly. Would have been more helpful to be more informed of the new authorization process prior to November 1, 2013.*

- *[MCO] is great health plan and doing very good job serving the community so far. We just need [MCO] to have monthly bulletin information to all the contracted providers for update.*

- *[MCO]is a consumer-focused organization efficient, cost-effective, and well-structured to assist the provider in serving client needs.*

- *[MCO] has very helpful provider representatives, and are very courteous on the phone. I have not had any issues with unprofessionalism with them at all. They have been very good to work with.*

- *[MCO] has decided that since the new CPT codes indicate 45 minute units and not 50 they can pay the provider less and then require authorization for those clients who have traditionally been given 55-60 minutes. We work with chronic and dual diagnosis clients and requiring authorization for 55-60 minute units is very time consuming given the population. we have traditionally used most of the 50-55 minutes for client contact and continue to do so therefore, we need to have authorization more often.*

- *[MCO] has consistently been the most difficult PMAP for our business to deal with. The authorization process has often been drawn out and very tedious for our providers and the turn around on authorization decisions has been very slow often causing providers to end up being unpaid for a number of services. There have been many issues with the timing of filing authorization requests as providers have attempted to send the requests early and been denied, but then are stuck sending the authorizations after they have already billed for sessions and been denied causing an administrative billing back up and significant delay in payment. We have also had some difficulty with clarity in what information is required for authorizations as some claims seem to be processed fine with only the authorization form and some they requested treatment plans, diagnostic assessments, etc.*

- *[MCO] does not respond to contract questions. They have a limited amount of knowledge of mental health services and less about chemical health.*

- *[MCO] does a good job. Sometimes claims get turned down, and even the [MCO] rep cannot explain it. Then the claim goes back into another pile and takes forever to get processed, which I think is wrong. But overall, good job.*

- *Typically [MCO]has been very easy to deal with but more online training would be appreciated.*

- *Timely Filing huge issue: When you decide timely filing do you go back date of service or date of last activity? Clients have other insurance this takes time since we are not allowed to be participating providers. also how does that work when you take back a*

payment from 2 years previous due to other insurance added later and incorrectly to state system, do you verify with clients before take back.

- *This was a little hard to answer because there have been 2 processes used in the last 12 months, BHP & now [MCO] is doing their own authorizations. We typically did not have problems with BHP but are dissatisfied with the new process. Even though I did one of the teleconferences, we didn't have the correct form to use and couldn't find it online for a while. I've also asked about the credentialing of LPC's. No one has gotten back to me.*

- *This survey was difficult for me to fill out as a provider. Most of the questions I have no idea about, as they are processes that are done by the billing department, intake, etc. and as a provider I have no involvement in.*

- *They took longer time to affiliate new PCA to the system.*

- *They need to do more training with claims processing workers. We have had issues on a single check that some claims were paid correctly while other were paid incorrectly for same service. This has been going on for the whole year. They still have not corrected the issue and it is still happening after a year of being told about this issue and have had to run numerous report to correct all the claims and are still owe us over 3500.00 for this same issue.*

- *They have system wide issues at times that take months to resolve resulting in huge impact on the receivables for our agency. Difficult to get to the right people to get issues addressed and then you get no resolution date.*

- *They are still not paying the new reimbursement rate for PMAP HCBS. We have requested and informed them multiple times, yet it is still not resolved. We have had to get attorneys involved to deal with [MCO]'s improper handling of client services and claims. We have had to write off services due to [MCO]'s failure to pay even when it is their fault. They fail to pay clean claims within 30 days and have multiple internal issues that result is payment delays and serious cash flow hardships.*

- *There were a few times when the payments seemed to take longer than usual to come through from [MCO]. Interest was paid on the payments.*

- *The reimbursement levels for psychiatry could be higher--with our overhead (and we are frugal) we do not break even on psychiatry.*

- *The new system for submitting mental health claims does not work. It takes ten minutes and two transfer to leave a message for someone who will call back sometime in the next few days, but I never know when so I do not know if I will be available. If they call while I am out the I cannot connect with them at the number they leave and I have to leave*

another message and someone else will call me back at some indiscriminate amount of time.

- *The new process for prior authorization is very confusing and inefficient. They were not prepared to handle the level of calls and have not been timely to faxes. Also there have been many reprocessed claims this year due to claims being processed incorrectly by [MCO].*

- *The enrollment for individual P.C.A.'s takes way too long. We wait 60 days from D.H.S. and another 60 days from [MCO] we cannot bill or get reimbursed for 150 days and we have to put about the entire payroll. This gets quite costly.*

- *The credentialing process with [MCO] is lengthy and time consuming. It would be nice if they went with the uniform MN credentialing site. Re-authorization can be inconsistent on occasion. They have gotten better at explaining why services are not approved. At times when calling to check benefits for residential admission, cases are inadvertently opened before the client was admitted or even approved for admission. Day treatment CTSS is working well.*

- *The BHP reps were awesome to work with in provider credentialing. Great customer service! However, the provider enrollment/credentialing process takes too long. We have some companies that credential and get back to us in 30 days or faster.*

- *Stop combining multiple remits in one file*

- *Staff have always been very patient and very professional. Thank you for your efforts!*

- *Sorry my answers are so neutral. I am just a child psychologist in private practice and have a billing service that handles administrative issues re payment. Don't have many [MCO] cases.*

- *Shall have update provider with training of the new policy and regulation by the state and individual health requirement. As I have mentioned before that shall be indicated the individual staff to be responsible for each department to make sure that the provider receive the clean message for every providers.*

- *Satisfied with [MCO]'s business processes and interactions. Will continue to work with [MCO] if the Department of Human Services uses [MCO] for Medical Assistance in the future.*

- *Responses primarily are regarding [MCO] Behavioral Health. Other than VERY slow recredentialling, complete with documents being lost twice, I am very satisfied.*

- *Regarding TCM rates - rates changes should be communicated by DHS and Carver County should not have to send this information.*

- *Prior authorizations for our home care clients have always been an issue. We are in rural southwest Minnesota were services for the elderly are limited. We have a blind 88yo who lives in a town with a population of less than 800. We have repeatedly requested every 2wk SNV for her due to blindness, fragile health status and to monitor medication use and set up. This has been refused and we have been given only 1 SNV/month. We do make the 2nd visit but at the lower PHNV rate or at N/C. The client lives 26 miles from the CHS Office and has no relatives in her home town.*

- *Prior Authorizations for home care. Had one situation where we received an authorization and [MCO] eliminated one month of payment and did not inform us of this.*

- *Please ask my billing service Paragon Billing, inc to complete survey as they will likely have feedback more useful to you.*

- *Payment from [MCO] takes way to long after submission. Have a 2-3 times where a glitch in there computer system has kicked claims for no reason. Have tried faxing info to resolve a problem and they couldn't find up to 3 times.*

- *Overall, we have only a moderate amount of our clients that are on [MCO]. I have no problem claiming thru Mn-E-Connect and payments are very punctual.*

- *Overall, the only thing we have not been satisfied with is the processing time of requests such as provider enrollment and requesting for authorization.*

- *Overall we have had positive interactions with [MCO].*

- *Overall satisfied. We had an issue with one claim during the changeover of management.*

- *Overall satisfaction with most of the interactions with [MCO]. Have found concerns with the timely filing limits, especially when [MCO] initially processes the claims, and then later comes back and recoups for timely filing. Also, it is very time consuming to have to send so many medical records and documentation to support our services, and then at times we find out that these medical records were not included in the claim review as they seem to have been misplaced even though we have faxed them and indicated attachments on our electronic claim, thus resulting in a denied claim. Thank you.*

- *Our practice is small so we rarely have the need to interact with [MCO], but when we do, we have had no problems and are satisfied with them.*

- *Our main issues with [MCO] are claims in general and enrolling PCAs. Replacing claims take forever and regular claims take about a month. Also Enrolling PCAs take longer than the time [MCO] says it will take. Other than that, we think everything is smooth.*

- *Our homecare agency has experienced several problems with the billing administrative end of [MCO]. We have SEVERAL claims issued that have been left unpaid for several months. Representatives that we have called have failed to return our calls back and have not resolved the issues that they have said they would look into. This has left our company without several clients' reimbursement. This is extremely time consuming and has left several issues outstanding between our agency and [MCO]. We have worked as a [MCO] provider for 8 years and never have experienced this problem until this year.*

- *Our experience with [MCO] and their staff has been very positive. We have not had the same experience with other health plans.*

- *Optum seems to have taken over [MCO] in the past 12 months. This is what has created all the problems! [MCO] was wonderful to deal with prior to this change. Optum is out of state and for profit and cannot operate within MN. [MCO] is now their liason. Optum is part of [MCO] - another nightmare. Optum auditors will not meet in person and do not really understand the psych eval process or how the 90791 (former 90801) and 96101 codes are used in crisis intervention. Or prior to 2013, how they are reported in one report/evaluation. I feel like I have been educating them, to no avail! They have been responsive, but the audit has taken over one year! I know I do my billing correctly but I am an outlier, (with just doing crisis work as a consultant) and they don't know how to adjust for that. I have not owed them any money, but they were not consistent in their audit requests and what type of charts they wanted. Even though prior auths were used by [MCO] in 2008-2010, Optum tried to implement their rules as far back as 2008. I know how to defend my billing practices and have never had a problem with any of the PMAPS, including DHS, when audited in the past. Optum is not doing an efficient job and seems to be only interested in finding errors to collect money and not in what (the correct psychological procedures) is in the bet interest of their patient load. I first received a notice for the audit in October 2012 and it is still not resolved, but I have had no contact with them since August of 2013. I realize they are a very large organization, and their rep was professional, but I am not happy with their process, especially with their request to send my patient files by mail out of state, and then they were forwarded to another rep out of state etc. I had a conference call with two out of state reps - one from Salt Lake city and another from Florida in July. I am not forwarding any more files and have requested that they come into MN and meet with me if they need additional information.*

- *Only issue we had, was [MCO]keeping up with modifier changes.*

- *Only difficulty I encountered with [MCO] was when we were paid by [MCO] for seeing a client (child) who we thought had [MCO] as primary insurance, then later it turned out the client had some other form of insurance that was primary and [MCO] was secondary. It was a real pain to clean that mess up. Wish [MCO] had been able to determine that they were the secondary payer prior to paying us, rather than paying us and then demanding money back.*

- *Of all of the insurance carriers I contract with [MCO] is the easiest and fastest paying. I do miss the ability to choose "all claims" when checking past payments. It was faster and easier than adding dates of service. That's all. Otherwise very satisfied and customer service is helpful.*

- *Need to send out paper copies of remittances with checks. Make the referral process easier, counties state it is [MCO]'s reassessment process and [MCO] will state it is the county's responsibility. More clarity of the appeal process.*

- *My only concern has been the number of claims that [MCO] has reprocessed in the past few months. I have been fro take backs on one or two cents per claim. Their communication and remits were not very clear. They are however easy to work with in all other aspects.*

- *My interactions with [MCO] staff have been very positive since I became a provider.*

- *My experience with [MCO] was satisfactory up to 11/01/2013. They did not renew a contract with BHP (who managed their credentialing and authorization processes and with whom I was very satisfied) and have brought those functions in-house. Since then, my claims are all in limbo and seem to have been pended indefinitely. Many are almost 30 days old. Also, I was asked sign a new contract, which I was told contained no changes. However, my reimbursement rate from them is now $25 less than it was pre 11/01/2013.*

- *My answers are biased because of a recent PA request. I was on hold for 20 minutes and finally hung up. I called back again a few minutes later and was on hold for another 35 minutes and the rep hung up on me as I was giving her the client ID number. I was so upset that I went online to find a number to call a rep directly from [MCO], who was most gracious and really tried hard to resolve the issue, but she could not do the PA and gave me a different number to call. I actually got through that next time and the PA was done in 5 min. I spent over an hour trying to get a PA and this is not acceptable, the hold times or being hung up on.*

- *[Provider] has had extensive issues with [MCO] and has had claims recouped over one year later and is still waiting to hear on that appeal. The authorization requests for extension of services for PMAP and court-ordered cases over 24 sessions often get*

denied or go unanswered and again, go unpaid, or are paid and then recouped. The interface between MNe-connect and Availaity is a real problem and held up payment for over 60 hours of service for over 6 months, and there are still sporadic issues. It took weeks of calls to finally find someone in a position of authority who could help work out the computer problems between MNe and Avail and even then it took hours (easily 30) to work it out. We had to threaten filing a grievance at the MN Dept of HS to get any action. We are currently waiting for a recoupment appeal from over a year ago. Additionally, payment is sporadic and unreliable with claims processing 2 to 3 weeks prior to payment. Then BCBS dropped their payment rate to $67/session for a reduction of 25% which is difficult, particularly with all of the other problems. Their one redeeming factor is that I can almost always talk to a person when I call, they may not be able to help, but they are almost always nice.

- *[MCO] and its representatives are very easy to work with and very professional, I enjoy the relationship I have with [MCO].*

- *[MCO]'s enrollment process is questionable. We are contracted to provide PCA services, yet despite us having top provider scores in skilled care and a deep need in the community, [MCO] states they are closed to new providers- yet, they have selectively provided skilled contracts to several providers in the community in the last few years. They have thus jeopardized the continuity of care for our clients, who can only receive PCA services, but nothing else when they need it. If an entity like [MCO] receives funding from the state, there should be more guidelines about which providers are acceptable and which are not.*

- *[MCO] is the best managed care organization I have ever worked with in my 34 years doing insurance and billing. Prior authorization is uncomplicated, easy to use, and responses are quick. Reimbursement is very good, and support from case managers is excellent. Staff is ALWAYS friendly and helpful.*

- *[MCO] is still not paying the increased reimbursement rate from July 1 for HCBS. In addition, there is some glitch in their system that is not paying any homemaker claims for the past 3 months. We have had to "eat" payments owed to us due to their refusal to pay. We have had to use attorneys to fight for payments owed to us. Submitting claims, appeals, etc. is fine; but the payment side needs much improvement. Providers shouldn't have to pay for attorneys just because a client is using managed care for a Medicaid service.*

- *[MCO] is excellent with their authorization requirements, ease of authorizing services via phone calls and via the Web, as well. [MCO] has outstanding customer service from their front line people to their case management team. Don't change anything and keep up the excellent work is my recommendations! Thank you.*

- *[MCO] has been a good choice for clients at our clinic. We understand that the counties in our area (St. Cloud) have opted not to continue contracting with [MCO] for PMAP which is extremely limiting for families needing services. If DHS could do something about that situation the community at large would be better served.*

- *Longer waiting time to talk to representative, and also take more than one person to get questions resolved.*

- *IVR is of no help when calling regarding denials. I still have to talk to a representative and end up holding for 15 minutes or longer in order to talk to them. It ends up being a BIG time waster.*

- *It's a great pleasure working with [MCO]. Usually the representatives at clinical services, [MCO] provider enrollment and claims processing are very knowledgeable and are well versed with the information they provide. most of the times they are prompt in getting back to us and are very welcoming.*

- *It would be great to have [MCO] to be more electronicized, such as submission of authorizations online. HSM submission online is very confusing and time consuming to use and we are still submitting via fax. This submission would be much more easier if the questions were more like the fax form and could just attach supporting documentation to answer the questions as we do with the faxed version since it's not the clinicians submitting auth directly because their focus is on patient cares.*

- *It still takes so long for a PCA provider number to come. Well over 1 month.*

- *It seems that [MCO] will deny a claim sometimes just because.....almost if they are betting on you to give up and not seek payment because they make it a nightmare to recoup the funds. They have their own policies that are above and beyond DHS policies. Their policies do not make much sense with how PCA services work. For example, if a new client wants to switch with us today because the other company has no PCA's, so they are without help..... [MCO] has a 10 day processing policy once request is submitted until we can get it switched. So the client has to go without help while we wait for someone at [MCO] to push some buttons on a computer to make it happen. They also issue service agreements showing a client receives units for one year when internally there is a 6 month break, so we have no idea where the units are at if the client uses their units flexibly which is there right under DHS law. They say they have 30 days to pay, and it usually takes the full 30, things need to change!*

- *It needs to be easier to credential and contract with new providers.*

- *In the process of recovering funds, we should not have to provide every EOB for every date of service explaining that [MCO] is the primary.*

- *In the past 12 months, the most frustration for us is provider enrollment for the individual PCA both at DHS and [MCO]. The timeline is too long, there should be a solution to this issue, we have an employee right now that it took 60 days at DHS to process his PCA enrollment application and now we finally got his UMPI number, faxed it [MCO] on 10/01/2013, its been 28 days now, today a [MCO] Rep. said it will take another 60 days to process this individual application with [MCO] enrollment. This is just too long for someone who is trying to apply for a PCA position and like to work for an [MCO] member. It would be great if [MCO] can offer more training for providers on billing, appeal process, prior authorization and any topic on face to face or Web bar. These days we just get our resources through [MCO] Website. We did have one training session face to face from [MCO] a few years ago. And that was great, but not anymore.*

- *In registering our PCA's with [MCO], we have not been consistently notified when the registration process is completed. Unfortunately we are now dealing with untimely filings of billings because of the lack of communication that the registration process is completed and billing can ensue. this has been a huge frustration for us.*

- *In addition: [MCO]has significant issues processing and recognizing claims with multiple PCAs providing services to the same client on the same day; look up claims are not in chronological order on [MCO] website and cannot be re-sorted; most of the time requires multiple attempts from care coordinators to process service authorizations, can take up to 3 months; service authorization letters do not contain member's ID/Group numbers; process for assigning PCA provider numbers is a very long and redundant.*

- *I'm satisfied with [MCO] services, I never had any problems with [MCO] enrollment, claim processing, or processing authorization. [MCO] is really good with solving a problem and returning a phone call. I'm very happy working with them.*

- *I will pass this on to individuals on my staff or whom are contracted with us to interact with [MCO] as they will likely have more specific, comprehensive, and accurate information. My direct interaction in my role has been more limited.*

- *I was very pleased with my contact and the process with [MCO] PRIOR to the change on 11/1/13 when [MCO] took all of the mental health business in house. The current process in place to obtain authorization is very inefficient. I am hopeful that this is just a kink in the startup of the change of business and will be ironed out quickly.*

- *I use MNEConnect and the Orbit system to submit claims. The process to resubmit claims for corrections, adjustments or voids is cumbersome and can be difficult. It would be much easier to have a provider relations person via phone be able to send these claims with the updated information back for redetermination.*

- *I use Availity to submit claims, works well.*

- *I think that the business processes are good, but some of the policies are not so good. Particularly as it applies to testing prior authorization. I have seen many children who are misdiagnosed because no testing was utilized and I have been able to rule out mental health disorders with testing, thus saving the insurance company money.*

- *I only for the PA rotations other departments take care of claims etc. so I have limited knowledge is this area.*

- *I have been working with [MCO] for over seven years and experience with them has been consistently positive. The provider assistance is fortunate to have qualified and dedicated people who are patient and thorough in handling any inquiries. If I am ask as to who gets the award for timely responses, it will be given to [person]. He is the gentleman who handles PCA authorization. Any time he promises to get back to me, he does it on time. Overall, I am satisfy with [MCO].*

- *I have been very satisfied with [MCO] staff, claim process, and fees they pay for the services provided to patients.*

- *I have been satisfied with [MCO]'s handling of Mn Care clients. No issues.*

- *I do not do any direct billing. Claims are submitted through the clinic's NPI. Not sure why I received this survey.*

- *I dislike the authorization process. The website does not inform providers how many units (visits) are still available. Creates unnecessary additional work. Adjustments on the RA's are not clear nor timely. Website is not user friendly.(copy/paste function).*

- *I concerned of how my business practices, doing it right, do the right thing, reimbursement/claims payment correctly, follow rules and regulations of [MCO]. [MCO] expectations, need clarifications with [MCO], [MCO] staff are not consistent to provide answers, Especially PCA authorization Units, submitting claims, denied claims, [MCO] staff tossed me around, and much more but I forgot. Thank you.*

- *I cannot answer these questions as I do not do any insurance related activities directly.*

- *I am very happy with the ease and quickness of all of my claims for [MCO]!*

- *I am still awaiting a response from [MCO] regarding one of our [MCO] providers being enrolled in the Medicare division there. I started the process on September 12, 2013, and to this date I haven't heard anything back from [MCO] provider enrollment. This is the case with two of our providers. Also sent an appeal November 1st and haven't heard anything back to this date.*

- *I am not sure I am very helpful in answering these questions. At our clinic we have departments that deals with most of these issues in the survey...and therefore I cannot answer.*

- *I am not sure about the answers to how long our agency has been MA or [MCO] providers since we have been in existence since [date] and a CMH agency since [date]. We're going with this latter date for the number of years we've been MA providers. We've likely been [MCO] providers for as long as they've been a PMAP, but we don't have the information readily available. We have a very good relationship with [MCO], overall. I think we'd had some issues with appeals in the past, but we have been having weekly to bi-weekly phone conversations with a specific rep for several months now as we work through specific claims processing issues and appeals. The authorization representatives have been very helpful and are very professional, respectful to our staff. We enjoy working with [MCO] very much.*

- *I am not aware of any particular [MCO] trainings or resources. I have not received emails or mail re this. I use a professional billing service that deals with claims issues. Payments appear to be timely. I have been a [MCO] provider for many years.*

- *Happy with my services. I have no other comments at the moment.*

- *For the most part I have not had issues with [MCO]. My main dissatisfaction is having to use a clearinghouse (MNeconnect), there have been several times that the issues I have come across have to do with [MCO] not getting an EDI and then I have to resubmit a claim, and the only way I know is to call [MCO] and find out why a claim hasn't been paid- it's very time consuming.*

- *Financial assistance unit has encountered a high turnover in the liaison position. Continuously changes. We establish a relationship and then the person leaves the position and we start again. Also the Dental Mobile Unit has been beneficial to the area and staff have been very easy to work with.*

- *Customer service for questions I have, for the most part, has been exceptional.*

- *Credentialing process could be easier. Would like to see the process completed through the MCC. Very dissatisfied with the re-credentialing process through Aperture. Some policies are possibly out-of-state, have a different computer system and different requirements for authorizations, appeals, etc. making it hard to get issues resolved. Would like to see consistency throughout. Have had issues with providers not being updated in all computer systems causing claims to be rejected due to provider enrollment not in the system.*

- *[MCO] and [MCO] have done audits and recouped money paid for claims going back 2 years or more because these payments were made in error. Stating the client didn't have coverage for those dates of services which we can check because of. This is not our error it is their error and now 2 to 3 years later we are now supposed to bill the clients or insurance for those services if we can get ahold of the client. This is leaving clinics in a bind because of [MCO]'s error.*

- *[MCO] is very difficult to work with. It is hard to get anyone on the phone. They deny most/all psychological testing authorizations. They are rude and unprofessional on the phone. They take up to one week to return calls IE: credentialing dept which you cannot even get the phone, you have to leave a msg. They are the only insurance company like this. All the others are so much easier and simplified.*

- *Being told the claims are running 45 days for payment, expected time is 30 days. Challenges with correcting errors in being paid wrong amount for services performed. Not returning phone calls, emails, to resolve issues -- provider enrollment, follow up from submission of contract information for obtaining a contract, appeared unresponsive. confusion about auth recieved or not for early childhood daycare--who is authorize provider or not, taking greater than 90 days to provider enrolled.*

- *At one point I received an e-mail from someone during [MCO]'s separation from BHP. I submitted all my recredentialling information but then heard from another representative by phone with same request. They did not know I had submitted info and could not find it so I had to resubmit info. Worked out fine but was a little disorganized.*

- *as star home health care we are not [MCO] contracted but we get 120 non contracted provider, but it was all good how everything [MCO] proceed for us and we appreciate their professionally service*

- *As I mentioned yesterday to one of your representatives that one of your prompts should say "technical help". My specific question was how to get logged on. My password was not working. The only 2 prompts were "elig" and "claims". This survey had clear instructions, except I am assuming that the couple of pgs that I clicked "print" will print at the end of this survey.*

- *As a PMAP I have no complaints with the [MCO].*

- *As a PCA Provider, here are my main concerns: 1. There is no Case Manager name or phone number on the Service Agreements, so if we have questions we have to call the automated system. We have to trip up the automated system just to talk with someone (always a different person), who usually has to take my name and phone# to have someone call me back. 2. Enrolling Personal Care Attendants - Very Frustrating!!! MN DHS is to have 30 days to return the Individual PCA ID # they have assigned for the*

PCA. However, DHS is averaging a 40 to 50 day response. Once received, we fax that PCA ID to [MCO] so a new [MCO] Provider ID can be assigned for billing. [MCO] has up to 90 days to return this ID# to us. Therefore, we are providing services 4 to 5 months (on average) before we can even bill for services to [MCO]. The problem is that IF there are any delays or questions regarding the enrollment process, we are at risk of losing out on billing because we have reached the 6 month time limit [MCO]has for billing for services. [MCO] took back $2,300 because we had exceeded the time frame of being able to bill for services we had provided to a recipient. I called to [MCO] asking to speak to a representative and after tripping up the automated system, was told by the gentleman to not even attempt to appeal it because BCBS will stand by the 6 month delay and "place the blame back on DHS" 3. Billing & Remittance Issues: Availity's PCA-ACE is program used for billing. We have had to submit billings multiple times before we get paid from [MCO]. When I have called to Availity to resolve the issue, I am told to call [MCO]. Here again, I have to trip the automated system to be able to talk with someone, only to have them tell me to call Availity. 4. The Provider System is too automated! There needs to be a Provider Help Desk set-up like the MN DHS has, so you have people you can speak to directly without having to trip up the system just to speak to a human being. Please tell me where I can access a Billing and Remittance schedule.

- *Appeal claim still pending since 9-16-13 with no communication from [MCO] about the status of the appeal. We have noticed an improvement over the past 2 years with claim processing, accuracy and timeliness.*

- *Adding PCA Providers and correcting claims takes a very long time. Making perfect payments and sending long after clients paid and discharged causes problems.*

- *Added communications via emails with regard to education and webinars or policy changes, instead of mailing notices that get lost.*

- *In the PCA program area, when requesting prior auth's for PHN PCA assessments for children, interactions with [person] have always been positive. The promptness, accuracy and friendliness of her responses have been top-notch. 2. [MCO] new AVAILITY website for claims submission and eligibility requests is tedious and clumsy to use. I seldom use AVAILITY now and use other methods to submit electronic claims and I use the 'old' [MCO] Provider Hub website to obtain eligibility information. Provider Hub is faster & easier to use. I use AVAILITY to retrieve RA's, but only because it's the only way to do it. Two other MCO's have sites that are more user-friendly. 3. The [MCO] requirement to have claims submitted within 120 days of the date of service barely gives billing staff any 'breathing room'. But they seem to be in the driver's seat all the time. Thank you for this opportunity to comment.*

- *1 - When claims cross over to secondary the remittance is still showing the primary payer ID # on the remittance. This causes a lot of confusion and unnecessary calls to find out*

who to contact. Another issue for [MCO]: 2 - FEP plans that have given us an authorization under the policy's 'flexible benefit option' for residential claims have been a HUGE problem. I have had to call monthly to ask that the claims reprocess under this option rather than deny. Each time I am told it's corrected but each month I have to call. Often if there is a secondary they will process the claim as if the primary denied, which it did - INCORRECTLY. So then begins the calls. One client it took almost a year to resolve a secondary issue due to how the FEP plan was processing the claims.