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IT'S HEALTH CARE, NOT WELFARE

Appropriate Rate Structure for Services Rendered and Estimated Percent of Co-Pays Collected Under the Medicaid Program

Submitted to

The Oklahoma Health Care Authority

January 31, 2004

In partial completion of an interagency agreement, Article IV, Section 4. 0. DFPM shall provide consulting and issue a report indicating the estimated percentage of co-payments being collected in the current program, and Section 4.2. DFPM shall provide consulting services and issue a report conveying an appropriate rate structure for services considering an increased number of program beneficiaries and increased co-payments or coinsurance.

Health Care Not Welfare Project

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IT'S HEALTH CARE, NOT WELFARE

EXECUTIVE SUMMARY

Appropriate Rate Structure for Services Rendered and Estimated Percent of Co-Pays Collected Under the Medicaid Program

The Oklahoma Health Care Authority (OHCA), on behalf of the State of Oklahoma, is requesting a five-year Medicaid Research and Demonstration Waiver to redesign the current Medicaid program in Oklahoma. The key objectives of the program, It's Health Care Not Welfare, are:

1. Patient Responsibility
2. Effective Purchasing
3. Acceptable Provider Reimbursement
4. Flexible Benefits
5. Expanded Eligibility
6. Budget Predictability

This study is the third in a series of studies by the Department of Family & Preventive Medicine (DFPM), University of Oklahoma Health Sciences Center (OUHSC), on the impact of Medicaid reforms on stakeholders and combines two contract elements: (4.0) What is the estimated percentage of co-payments collected by providers from Medicaid recipients? (4.2) What is an appropriate rate structure for Medicaid services as a percent of Medicare? A provider is defined as any individual or institution delivering health care services in Oklahoma eligible to receive Medicaid payment for those services.

Surveys were mailed to approximately 13,500 Oklahoma health care providers; 846 surveys were returned (6.27% response rate). The distribution of participants broken down by provider type is shown in Table 1.

Table 1: Number of Study Participants by Provider Type (n=846)

Provider Type	n	%
Administrators	3	0.4%
ARNPs	5	0.6%
Dentists	62	7.3%
DOs	36	4.3%
MDs	283	33.5%
PAs	15	1.8%
Pharmacists	54	6.4%
Unidentified	388	45.9%
Total	**846**	

Respondents represent DFPM faculty physicians and providers, urban and rural practices, all specialties, and all types of health care facilities and programs. Many are currently Medicaid providers; some have participated in the past and opted out; some do not now nor have ever participated in Medicaid.

The study was designed and conducted to answer the following questions:

1. *What percentage of allowed co-payments do providers estimate they are currently collecting from Medicaid clientele for services rendered?*
2. *What do providers feel would be a fair reimbursement rate, as a percentage of the current Medicare reimbursement, for services rendered to Medicaid clientele?*
3. *Do demographic variables, such as type of provider type or practice location, influence responses to any of these questions?*

closer to 100% of Medicare. However, discussions with providers indicate that a reduction in administrative red tape could offset increases in reimbursement thereby making the system more cost-effective.

For providers, the gratification of taking care of patients is often overshadowed by paperwork, low or no reimbursement, and a morass of

CONCLUSIONS & RECOMMENDATIONS

Study Conclusions

- Reimbursement for Medicaid should be increased to approximately 100% of Medicare; streamlined administrative processes could reduce overhead and improve the cost-benefit of providing services.
- Explore methods to increase the percentage

METHODS

A post-card survey (Appendix A) was designed to collect answers to the study questions. The survey was pilot-tested by DFPM faculty. The final survey, which included a letter of introduction and a description of the project, was mailed to approximately 13,500 physicians and other providers; 846 providers completed and returned the survey; 388 failed to designate a provider type and were excluded from some of the data sets. Subjects were drawn from DFPM faculty, and state health care organizations and associations such as Oklahoma State Board of Licensure, Oklahoma State Medical Association, Oklahoma Academy of Family Physicians, State Board of Osteopathic Physicians, Private Pharmacists of Oklahoma. Data were entered into a database and analyzed using a standard statistical database program (SPSS).

The inclusion criterion for rate structure data set was applicability of the Medicare rate structure to services. Providers who identified themselves as dentists (n=62) and pharmacists (n=54) were excluded from the provider analysis for this data set because the Medicare fee structure is not applicable. All other responders, including those who failed to designate a provider type were included in the combined data set for analysis (n=730); 67 respondents did not answer the question leaving an n of 663. All surveys were included in the co-payment analysis data set.

More than 850 providers attended presentations and/or participated in discussion groups. Four hundred and thirty eight (438) comments and opinions expressed by participants were hand-recorded by program staff and entered into an Excel spreadsheet for analysis. The discussion process also provided a forum for project staff to educate physicians and other providers about the Medicaid reform options.

RESULTS

4.0. Appropriate Rate Structure (physicians, hospital administrators, nurse practitioners, and physician assistants). Data were analyzed to determine the appropriate rate structure for Medicaid services, as a percent of the Medicare fee schedule. After excluding dentists and pharmacists (Medicare rate structure does not apply for their services), 730 surveys remained; 67 respondents did not answer the question leaving a total of 663 responses (Table 2). Analysis revealed that a reimbursement rate approaching 100% of Medicare would be appropriate for Medicaid services.

Table 2. Fair Reimbursement for as a Percent of Medicare (combined data, n=663*)

		95% CI of the Mean	
Median	Mean	Lower	Upper
100.0%	99.7%	97.0%	102.4%

A slight difference in reimbursement rate was noted between urban and rural practitioners. Data analysis yielded an average of 100.8% of Medicare for urban providers compared with 99.2% for rural providers.

Data for providers with a Positive to Very Positive opinion of Medicaid yielded on average a rate of 98.6% of Medicare; for providers with a Very Negative opinion, the rate was 104.9% of Medicare. Fair reimbursement for current Medicaid providers averaged 99.8% of Medicare compared with 92.2% for those who were not current Medicaid providers.

4.2. Amount of Co-Pay Collected (all groups). All providers were asked to estimate what percent of allowed co-payments they currently collected from Medicaid recipients and how sure they were of their responses. Providers reported collecting only 29.0% of the co-payment amounts from Medicaid recipients (95% confidence interval, 26.7%-31.3%).

DISCUSSION

Until January 2004, the Medicaid rate structure for physician and non-physician providers (excluding dentists and pharmacists) was 60%-70% of Medicare. On January 1, 2004, the rate was increased to approximately 90%. Providers indicated that the appropriate rate should be

*Excludes dentists (62), pharmacists (54), no answer (67)

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IT'S HEALTH CARE NOT WELFARE

Appropriate Rate Structure for Services Rendered and Estimated Percent of Co-Pays Collected Under the Medicaid Program

ABSTRACT

Background: This report describes the third in a series of studies for the Oklahoma Health Care Authority (OHCA) by the University of Oklahoma Health Sciences Center (OUHSC) Department of Family & Preventive Medicine (DFPM). On behalf of the State of Oklahoma, under the authority of Sec. 1115 of the Social Security Act, OHCA, is requesting a five-year Medicaid Research and Demonstration Waiver to redesign the current Medicaid program in Oklahoma. The reform options would extend Medicaid coverage to working adults and families with incomes up to 200% of the federal poverty level (FPL) (Figure 1). (The federal poverty for a family of four is $18,400; 200% of FPL would be approximately $37,000 for a family of four, see Figure 2.)

Figure 1 shows the income eligibility criteria for current beneficiaries and for the expansion group (Uninsured). Required co-payments, co-insurance, deductibles, and one-time enrollment fees, collected on a sliding scale based on income, are being considered to expand the financial viability of the program and create greater beneficiary responsibility for their health care.

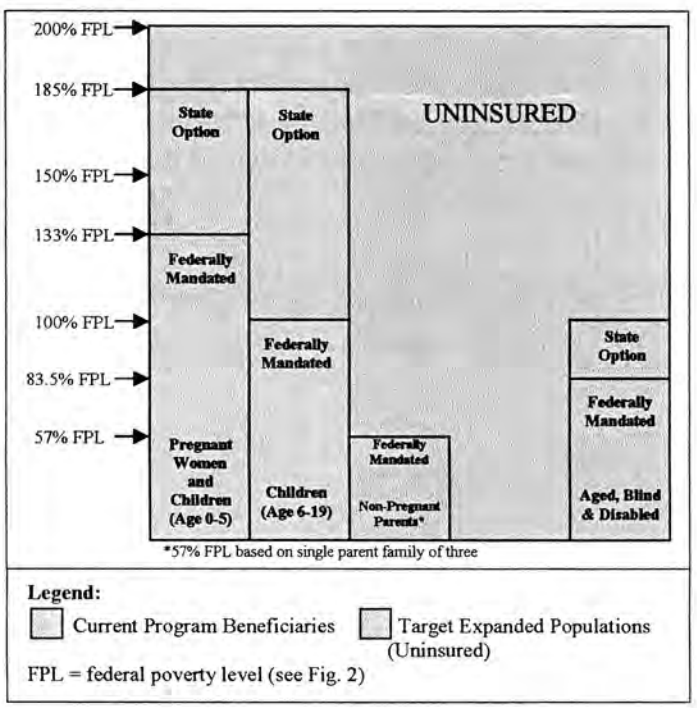


Figure 1. Current and Expansion Medicaid Eligibility

Family Size	Annual (Monthly) Income by Federal Poverty Level			
	100%	133%	185%	200%
1	$8,980	$11,943	$16,613	$17,960
	($748)	($995)	($1,384)	($1,497)
2	$12,120	$16,120	$22,422	$24,240
	($1,010)	($91,343)	($1,869)	($2,020)
3	$15,260	$20,296	$28,231	$30,520
	($1,272)	($1,691)	($2,353)	($2,543)
4	$18,400	$24,472	$34,040	$36,800
	($1,533)	($2,039)	($2,837)	($3,067)
5	$21,540	$28,648	$39,849	$43,080
	($1,795)	($2,387)	($3,321)	($3,590)
6	$24,680	$32,824	$45,658	$49,360
	($2,057	($2,735)	($3,805)	($4,113)

Figure 2. Current Federal Poverty Levels Based on Family Size and Income*

*Source: Oklahoma Health Care Authority, 2003

Purpose: This study was conducted to fulfill two contract items:

Item 4.0. Determine an appropriate rate structure for services, as a percent of Medicare, considering increased program beneficiaries and increased co-pay dollars.

Item 4.2. Estimate the amount of co-pays providers are currently collecting from Medicaid patients.

Three major questions were developed to extract the information.

1. *What do providers feel would be a fair reimbursement rate, as a percentage of the current Medicare reimbursement, for services rendered to Medicaid clientele?*
2. *What percentage of allowed co-payments do providers estimate they are currently collecting from Medicaid clientele for services rendered?*
3. *Do demographic variables, such as type of provider type or practice location, influence responses to the above questions?*

Subjects: Subjects included in this study were physicians (MDs and DOs), physician assistants (PAs) nurse practitioners (ARNPs), hospital administrators, pharmacists and dentists in Oklahoma. The distribution of provider types represented in this study is shown in Table 2.

Table 3: Distribution of Provider Types Represented in this Study (n=846)

Provider Type	n	%
Administrators	3	0.4%
ARNPs	5	0.6%
Dentists	62	7.3%
DOs	36	4.3%
MDs	283	33.5%
PAs	15	1.8%
Pharmacists	54	6.4%
Unidentified	388	45.9%
Total	**846**	

Subjects were identified from state and county medical societies and associations, licensure boards, personal contact, and word of mouth. Faculty from the OUHSC Department of Family & Preventive Medicine (DFPM) pilot-tested all materials and participated in discussions and data analysis

Methods: A short post-card survey (Appendix A) was mailed to 13,500 physicians and other health care providers statewide; 846 providers completed and returned the survey. The survey asked providers (1) what would be an appropriate rate structure for providing Medicaid services, as a percent of Medicare, and, (2) to estimate the current percentage of co-pay dollars they (providers) are collecting from Medicaid beneficiaries and how confident they were in their response. All study materials were pilot tested by DFPM faculty, and their feedback was used to revise the survey tools.

Survey data were analyzed using a standard statistical software program (SPSS). All responses were included in the analysis of the estimates of co-payments collected. Only responses from physicians (MDs and DOs), physician assistants (PAs), nurse practitioners (ARNPs), and hospital administrators were included in the rate structure analysis as these

are the only provider groups for which Medicaid reimbursement can be based on Medicare.

Qualitative data (e.g., comments and suggestions) were collected from more than 850 physicians and other providers who attended group presentations and/or participated in informal individual and small focus-type group discussions. DFPM clinical faculty (which is comprised of MDs, DOs and PAs) were the first group of clinicians to participate in the focus-type discussion groups. Statewide discussions yielded four hundred and thirty eight (438) comments which were hand-recorded by project staff and entered into an Excel spreadsheet, coded for theme, and used to enrich the quantitative survey data. Research faculty from DFPM advised program staff on analytical methods used in this study.

Results

4.0 Appropriate Rate Structure

Across the board, providers (physicians, ARNPs, administrators and PAs) indicated that a fee structure approaching 100% of Medicare would be appropriate for providing services to Medicaid beneficiaries (Table 4).

Table 4. Fair Reimbursement as a Percent of Medicare (all responses, n=663*)

Mean	Median	95% CI of the Mean	
		Lower	Upper
97.7%	100.0%	97.0%	102.4%

However, a concomitant reduction in the administrative responsibilities including streamlining of pre-authorization, eligibility verification, and claims processing procedures, would save time and effort for providers and their staff, and should accompany a fair fee structure. A combination of increased reimbursement and reduced overhead will make Medicaid more cost-effective for providers; and thus providers would be more likely to continue participating in Medicaid.

* Analysis excluded dentists (n=62) and pharmacists (n=54); 67 did not answer the question.

Data were analyzed to determine the appropriate rate structure for Medicaid services, as a percent of the Medicare fee schedule. Dentists and pharmacists were excluded from this analysis because the Medicare rate structure does not apply for their services.

A slight difference in reimbursement rate was noted between urban and rural practitioners. Data analysis yielded an average of 100.8% of Medicare for urban providers compared with 99.2% for rural providers.

Data for providers with a Positive to Very Positive opinion of Medicaid yielded on average a rate of 98.6% of Medicare; for providers with a Very Negative opinion, the rate was 104.9% of Medicare. Fair reimbursement for current Medicaid providers averaged 99.8% of Medicare compared with 92.2% for those who were not current Medicaid providers.

4.2. Amount of Co-Pay Collected (all groups). All providers were asked to estimate what percent of allowed co-payments they currently collected from Medicaid recipients and how sure they were of their responses. Providers reported collecting only 29.0% of the co-payment amounts from Medicaid recipients (95% confidence interval, 26.7%-31.3%).

Conclusions: If Medicaid is to expand and extend eligibility to low-income working adults and their families, administrative processes such as pre-authorization, eligibility verifications and claims payment, should be streamlined.

Across the board, providers felt that a reimbursement structure that approaches 100% of Medicare would be fair and appropriate. However, discussions with physicians and other health care providers strongly suggest that they would be willing to negotiate reimbursement rates if the administrative burden of providing Medicaid services could be reduced and if patients could be required to accept greater financial and personal responsibility for their health care.

Physicians and other health care providers who have opted out of Medicaid report that their

profits went up, their administrative overhead decreased, saving them both time and money, the frustration level of staff decreased, and providers' overall job satisfaction increased. Providers also report that non-Medicaid patients are typically more responsible, less demanding, and less complex than Medicaid patients. These findings reflect national studies, which report that physicians across the country are opting out of government programs in record numbers, mostly due to overhead, red tape and frustration.[2]

Expanding eligibility to provide coverage for low income, working adults and their families is the right thing to do. Such a program change could infuse the Medicaid system with a group of beneficiaries who are willing and able to share in the cost of their health care. Including stakeholder groups in the design and implementation of the program will give them ownership and improve buy-in thus improving the likelihood that an expanded Medicaid program will be successful.

1. INTRODUCTION

The United States loses from $65 billion to $130 billion annually when people who are uninsured get sick and/or die early, according to an Institute of Medicine (IOM) report released in 2003. The IOM report found that it would cost less to "simply insure" the more than 41 million Americans who now lack health insurance.[4] The Physicians' Working Group on Single-Payer National Health Insurance and other national studies report similar findings.[1] The uninsured are four times more likely to require costly emergency room or hospital care. In addition, a recent Associated Press article noted that emergency room use is on the rise for insured individuals, as well as the uninsured, which drives the costs of health care even higher. Costs are estimated to be rising at 7% annually, premiums are increasing at an alarming rate of 14% annually; and health care is eating up 13% of our gross national product (GNP).[5] Lack of access to physicians on a timely basis is speculated to be the reason for increased ER use among patients with other access to health care.[6]

Across the country, states and communities are trying to come to grips with the growing discontent among physicians and other health care providers over low reimbursement for services rendered under government programs such as Medicaid and Medicare. In addition, increasing overhead and administrative red tape combined with increasing demands for accountability in the form of coding, audits, and other reporting mechanisms have made participating in government health care programs even more burdensome for providers, especially for physicians and their office staff.

In 1998, legislation was passed allowing physicians to "opt out" of providing services under Medicare. A similar option exists in Oklahoma for physicians and other health care providers who participate in Medicaid. Providers who have opted out report reduced overhead and improved job satisfaction with little if any loss of income.[2]

Amid the growing discontent with the health care system, health care providers, particularly physicians are offering radical ideas to bring the debate over health care access to the forefront. The Physician's Working Group for Single-Payer National Health Insurance speculated that profit taking by third party payers—not physician fees, hospital costs, or prescription drugs—was the leading cause of rising health care costs. If third party payers were eliminated, the Group concluded, the U.S. could successfully and economically provide quality health care services to everyone, equally.[1]

Physicians and other health care providers express frustration at the administrative burden piled on by multiple payers with multiple formularies, benefits programs, and authorization and pre-authorization requirements that take up so much of their time and that of their staff. Consequently, many are reducing the number of insurance plans they accept and are opting out of government-sponsored programs, which, in turn, contributes to the problem of lack of access to providers by individuals. Lack of access to physicians, specifically specialists within the Medicaid system, is a common frustration voiced by program beneficiaries seeking health care along with physicians and other health care providers seeking consultants.

Many states have begun devising programs to cope with diminishing funds, increasing demands of Medicaid program beneficiaries, and the exodus of providers from the system. In Oregon, one of the first states to enact sweeping health care reform legislation, health care services are graded and rationed based on cost-effectiveness, cost containment, and community needs. The grass roots efforts in Oregon attracted the attention of the federal government and of other states.[7]

Tennessee established TennCare (the Tennessee equivalent of SoonerCare in Oklahoma), with a stimulus built-in to draw physicians back into the Medicaid program. The program controls physicians' access to "middle class patients" as a mechanism to ensure their participation in the state's Medicaid program. This "carrot and stick" approach, described in a an article published in 1995, is one of the more draconian approaches but, serves to highlight the desperation of states attempting to cope with the problem of a shortage of Medicaid providers.[8]

Quite to the contrary, the physicians who participated in this study were anything but greedy. Many provide and sponsor free care local community clinics. The comments below, gathered from small focus group discussions, are typical of the providers who participated in this study.

> (Comment from a specialist) "It is easier for me to see patients free rather than deal with the hassle"
>
> "In fact with the hassle we have in filing and refiling, we'd almost be willing to see these patients free."
>
> "We are trying to set up a free clinic here because we would rather provide the care in this way than deal with the hassle from Medicaid."

Providers' major concerns with the Medicaid system in Oklahoma, particularly reimbursement, had to do with fairness and reasonable return for services rendered in good faith. All providers expressed frustration with the red tape and the administrative burden, and lack of timely response by Medicaid regarding coverage, eligibility, formulary and pre-authorizations. In addition, many providers stated that for the time and effort their staff spent coordinating Medicaid benefits, filing and refiling claims, and waiting for reimbursement for services rendered, they would rather provide services for free.

This report describes the level of reimbursement, as a percent of the Medicare fee structure, that providers in Oklahoma felt would be reasonable and fair for providing Medicaid services. In addition, the report addresses concerns expressed by providers about expanding Medicaid. Most felt that structural and programmatic changes to make Medicaid more responsive and financially viable should be initiated before expanding eligibility and increasing the size of the Medicaid population.

Currently, providers report collecting less than 30% of required co-pays from Medicaid beneficiaries. They expressed concerns about whether current Medicaid administration policies would be adequate to handle an influx of participants into the Medicaid system and that the system could become further financially comprised.

The results of Medicaid reform in Oklahoma could have implications for other states and for the nation as a whole as the U.S. attempts to deal with burgeoning inflation in the health care industry. The number of uninsured in American continues to grow at an alarming rate; more than 41 million are uninsured and countless more are underinsured. Government health care programs try to take up the slack but, more and more providers are opting out of Medicare and Medicaid due, in large part, to growing disenchantment with a health care system that forces them to ask first, "What insurance do you have?" rather than, "What brought you in to see me today?"

The purpose of the study reported here is four-fold:

(1) To educate physicians and other health care providers in Oklahoma about potential reforms to the current Medicaid system.

(2) To determine a fair level of reimbursement, as a percent of Medicare, for providing Medicaid services.

(3) To estimate the current percent of co-pays collected by providers from Medicaid beneficiaries in order to develop policies regarding patient financial responsibility.

(4) To define and elucidate providers' opinions of the current Medicaid program.

Three study questions were designed to elucidate the key goals of this study.

1. *What do providers feel would be a fair reimbursement rate, as a percentage of the current Medicare reimbursement, for services rendered to Medicaid clientele?*
2. *What percentage of allowed co-payments do providers estimate they are currently collecting from Medicaid clientele for services rendered?*
3. *Do demographic variables, such as type of provider type or practice location, influence responses to the above questions?*

2. METHODS

Subjects

Table 5: Study Participants by Provider Type (n=846)

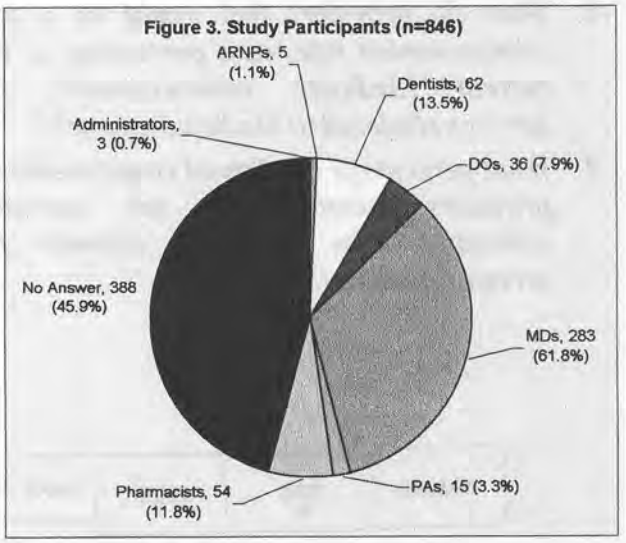
Provider Type	n	%
Administrators	3	0.4%
ARNPs	5	0.6%
Dentists	62	7.3%
Dos	36	4.3%
MDs	283	33.5%
PAs	15	1.8%
Pharmacists	54	6.4%
No Response	388	45.9%
Total	**846**	

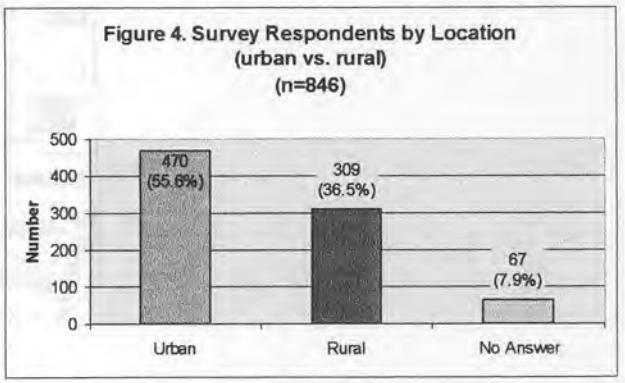
Subjects in this study were drawn from the Oklahoma State Board of Licensure, Oklahoma State Medical Association, the Oklahoma Academy of Family Physicians, the Oklahoma Hospital Association, the Private Pharmacists of Oklahoma and other medical groups, personal contact by DFPM faculty, and word of mouth.

A brief post-card survey (Appendix A) was distributed to approximately 13,500 physicians and other health care providers statewide. the purpose of the survey was three-fold: (1) to inform providers of possible changes to the Medicaid program, (2) to invite their input into this study by answering the questions on the survey, and (3) to invite them to participate in discussions on this topic with members of our project staff. Eight-hundred and forty-six (846) providers completed and returned the survey. The results of that survey are presented here.

Of the 846, 361 expressed interest in participating in additional discussions. Two questions from the survey captured data that will be included in this report (fair reimbursement by opinion of Medicaid and fair reimbursement as a function of Medicaid provider status). The remaining data were described in an earlier report.[3]

The number and types of providers who completed the post-card survey are shown in Figure 3. Participants were from urban and rural practice sites. Data analysis was performed to determine whether practice location had an impact on providers' responses. Figure 4 shows the breakdown of study participants by urban and rural site. The distribution of study participants across the state is shown in Figure 5.





Clinical faculty from the OUHSC Department of Family & Preventive Medicine also participated in this study, along with other providers on the OUHSC campus. DFPM faculty pilot tested all study materials and had significant input into the design and methods used for this study.

Instruments

A brief survey designed to answer two of the contract questions – fair reimbursement (4.2) and amount of co-pays currently collected (4.0) – was developed and mailed to approximately 13,500 physicians and health care providers statewide. A copy of the survey is attached in Appendix A.

The survey focused on answering the three major study questions.

1. *What do providers feel would be a fair reimbursement rate, as a percentage of the current Medicare reimbursement, for services rendered to Medicaid clientele?*
2. *What percentage of allowed co-payments do providers estimate they are currently collecting from Medicaid clientele for services rendered?*
3. *Do demographic variables, such as type of provider type or practice location, influence responses to the above questions?*

In addition to collecting quantitative data from the survey, program staff made presentations and held one-on-one or small focus-type group discussions with physicians and other health care providers to educate them about the health care issues and reform options, and to gather qualitative data to enrich the quantitative data collected from the surveys. A copy of the education document distributed to providers is appended (Appendix B) along with the materials developed to organize and conduct the discussion groups (Facilitator's Guide for Provider Groups, Appendix C, and Small Group Checklist, Appendix D).

Consent forms were developed in accordance with University of Oklahoma Health Science Center (OUHSC) human subjects protection policies. All instruments and overall project methodology were submitted to the OUHSC's Institutional Review Board (IRB) for approval. The project received exempt status from the OUHSC IRB in July 2003. Because of the exemption, consent forms to participate in this study were not required.

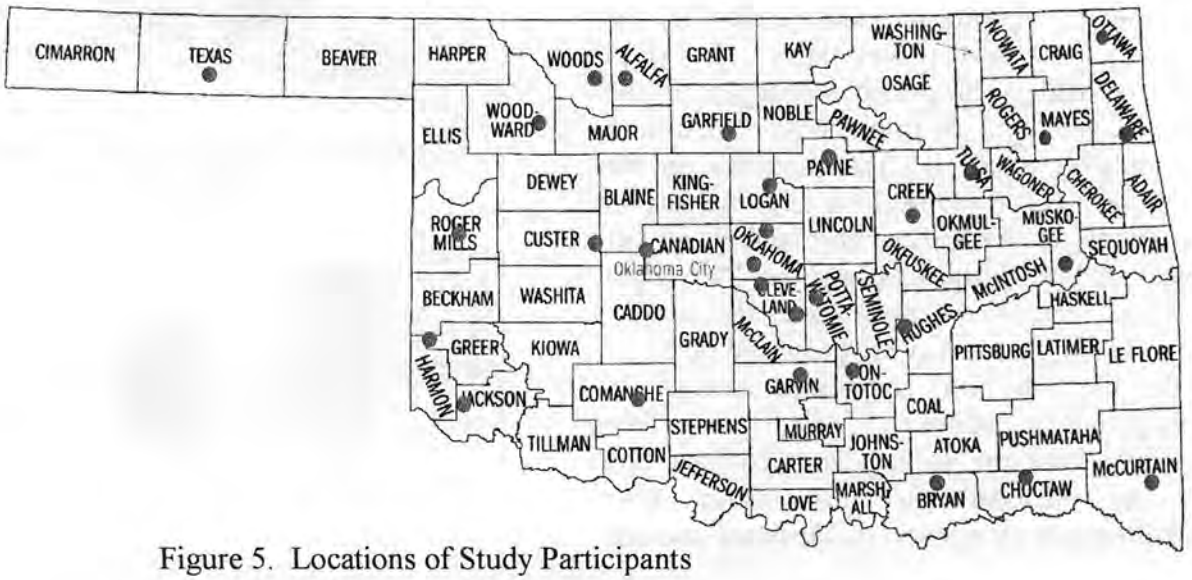


Figure 5. Locations of Study Participants

DFPM physician and provider faculty provided valuable feedback on the construction of this report. DFPM researchers assisted with the IRB process and with the development of the survey instrument.

Individual Interviews and Small Groups

As described above, physicians and other health care providers were given the opportunity to discuss health care issues — particularly their opinion of the current Medicaid program and what key changes should be instituted to make Medicaid a quality health care delivery program for the uninsured and underinsured, and to make it viable and attractive for health care providers. Small groups were conducted according to a Facilitator's Guide (Appendix C) and using traditional and well-publicized methods.[9] Preplanning was accomplished using a Small Group Meeting Checklist (Appendix D) developed by project staff.

Approximately 850 physicians and other health care providers across Oklahoma (see Figures 4 and 5) attended presentations and/or participated in discussions with project staff. All group discussions were led by a facilitator and often by an assistant facilitator. The facilitator was responsible for guiding the session, asking questions, and probing for clarification. Both the facilitator and the assistant facilitator took notes to assure that pertinent comments, attitudes and opinions were recorded accurately. Notes from the facilitator(s) were transcribed, coded for theme and nonverbal communication, and entered into an Excel spreadsheet for interpretation (Appendix E).

It was determined, based on pilot sessions with Department of Family & Preventive Medicine faculty physicians and health care providers, that audio- and/or video-recording of sessions would adversely impact the honesty of the participants' responses. Participants were much less inhibited by an individual taking notes. Although this reduced somewhat the ability of the staff to gather information, the comfort of the participants and their willingness to be honest about the topic were deemed more important. Because the purpose of the report is to provide honest attitudes and opinions rather than actual verbal and nonverbal data, note-taking was adopted for information gathering. We acknowledge that this is a limitation of this study and discuss this further under the Limitations of This Study section in the Results below.

Data Analysis

Data from the survey was entered into a Microsoft Access database to be organized and refined. Clean data were then analyzed using a standard statistical software program (SPSS). Pearson correlations, significance, and case summaries were run where appropriate. The findings are reported in the Results section. A summary of the raw data from this study can be found in Appendix F. (A statistical glossary of terms is also included, Appendix G.) Research faculty at DFPM assisted with the development of analytical tools and methods, along with providing training and technical assistance to project staff.

Data sets were created for:

1. Fair Reimbursement by Provider Type
   a. All responders
   b. Physician responders
   c. Non-physician responders
2. Fair Reimbursement by Practice Site (urban vs. rural)
3. Fair Reimbursement by Opinion of Medicaid
4. Fair Reimbursement by Medicaid Provider Status
5. Estimated Co-Pay Collected by Provider Type (all responders)
6. Estimated Co-Pay by Practice Site (urban vs. rural)

7. Confidence in Estimates of Co-Payments Collected (all responders)

Qualitative data, collected by observers and coded by theme and nonverbal communication, were entered into an Excel spreadsheet and analyzed by project staff. Data from that analysis is described in the Results section. Appendix E contains a copy of the Excel spreadsheet summarizing the comments and suggestions from the provider focus groups and individual discussions.

3. EDUCATIONAL COMPONENT

A significant education component was included in this study. A document (Appendix B) describing the current crisis in health care in Oklahoma was developed, and goals of a possible Medicaid reform program were elucidated. Physicians and other health care providers were informed, during small, focus-type group discussions, of the epidemic of uninsured and underinsured Oklahomans – 650,000 Oklahomans have no coverage, 450,000 are able-bodied adults who are either employed, looking for work, or employable, and 200,000 are children – including the impact the uninsured and underinsured have on the economy as a whole and on rising costs of health care in particular. During these group encounters, providers were invited to ask questions and express their concerns and feelings about the current Medicaid system and about the possibility of an expanded program that would extend services to individuals and families with incomes up to 200% of the federal poverty level.

According to the Physicians' Working Group on Single-Payer National Health Insurance and other national studies, the U.S. spends $65-$135 billion to provide health care for the 41 million uninsured.[1] This figure does not reflect the costs of health care for the countless number of underinsured individuals. The uninsured are four times more likely to require costly emergency room or hospital care, a significant portion of the health care expenditures. Uninsured women are more likely to die from breast cancer than insured women, and the uninsured, in general, tend to get sicker and die earlier than those with health coverage. The U.S. health care system is stratified; there is one health care system for those with financial resources, and a second, less effective system for those without.[10]

In order to solicit provider comments and suggestions about how to level the health care playing field in Oklahoma, project staff provided information materials and discussion points aimed at educating them about the goals of Medicaid reform and the desire of the Oklahoma Health Care Authority to address the issues and concerns the providers raise about such an expanded program. As key players in the health care marketplace, physicians and other health care providers represent a major force for change.

Project staff made a number of formal and informal presentations at hospital staff meetings, and medical association group gatherings such as the Oklahoma Hospital Association, the Oklahoma Physicians Research/ Resource Network convocations, and the Oklahoma Healthcare Coordinators. Over 850 providers attended these discussion and information sessions.

A series of open-ended, structured questions designed both to inform physicians and other health care providers about the current Medicaid system and the reform options were developed to gather data and stimulate discussion during the small group sessions. Comments, hand-recorded by program staff, were assigned themes, coded, and then entered in an Excel spreadsheet. Table 6 shows the themes, with their definitions, identified during discussion group session.

Comments were hand-recorded with pen and paper rather than by audio- or video recording at the request of the group participants. DFPM faculty felt they could be more forthcoming if the discussions were not electronically recorded.

Some of the questions asked during small focus group discussions were:

1. If you were able to make changes to the Medicaid program, what would those be?
2. What obstacles do you see to accessing medications for the Medicaid population?
3. If there were more Oklahomans insured, what would be the impact to the health care in Oklahoma?
4. If you could choose the top 3 most important items in Medicaid reform, what would they be?
5. Should providers be paid more at the expense of caring for more individuals? Oregon has forced citizens of its state to make this decision.

The question, "If there were more Oklahomans insured, what would be the impact to health care in Oklahoma?" was designed to get providers talking and thinking about an expanded insured population. Some responses to this question were:

> "There should be a place to send those individuals who show up in the ER without a primary physician to refer back to. Most providers will not take the risk of a patient who does not have insurance." <AMIABLE>* (code: 5, use of pcp vs ER)

> "There would be improved access depending where you spent your money." (code: 6, access)

In addition to providing data for this study, the discussion sessions served four extremely important functions.

Table 6. Themes and Definitions Used to Categorize Data from Group Discussions†

Theme	Definition
1. Eligibility	Rules and regulations governing eligibility for Medicaid
2. Prescriptions	Limit on Rx meds
3. Hassle	Red tape associated with providing Medicaid services
4. Medicaid Program	Programmatic issues, benefits, etc.
5. PC Physicians or ER	Use of primary care physician vs. ER use by beneficiaries
6. Access	Access to health care services, providers
7. Preventive Care	Coverage for preventive services
8. Reimbursement	Provider reimbursement for services.
9. Co-Pay	Patients paying a portion of their health care
10. Participation	Factors influencing provider participation
11. Chronic Disease Mgmt	Management of chronic illnesses such as diabetes, asthma; includes services of nurse educator, etc.
12. Medicaid $ Issues	General financial issues
13. Patient Responsibility	Holding patients accountable and responsible
14. Other	Comments relative to health care but not to this project

(1) Provided program staff with the opportunity to educate providers about the OHCA reform options to get them thinking and discussing Medicaid reform.

(2) Gave providers permission to speak their minds about the current Medicaid system in a safe, anonymous environment.

(3) Created the sense among the providers that OHCA was listening to them; and thus, may have helped to increase trust by providers for OHCA and the Medicaid program.

(4) Practitioners were able to express their concerns and to feel that they are contributing to statewide health care reform.

* Comments in brackets (< >) represent a noteworthy nonverbal communication.

† The content of this table is repeated in the Results section as Table 7 for ease of use and clarity.

4. RESULTS

A total of 846 physicians and other health care providers completed the post-card survey. All surveys were validated and analyzed as described below. Although several respondents failed to answer one or more of the questions on the survey, all surveys were included to the extent possible; missing data are shown with the analysis of each item. A method for gathering and organizing verbal responses during focus-type small group discussions was developed.

Data were analyzed as follows:

(1) **Qualitative data** (comments, opinions, and nonverbal communication) were hand-recorded by the facilitator(s) as notes and observations from individual and group meetings and were entered into an Excel spreadsheet as described in a previous report.[3] Themes associated with the objectives of this report will be used to enrich and enhance the results from the survey.

(2) **Quantitative data** from the post-card survey was entered into a Microsoft Access database and organized into data sets as described under Methods (above). The resulting data were then analyzed using a standard statistical software program (SPSS Predictive Analytical Software). A summary of the raw data is included with this report in Appendix F. (A glossary of statistical terms used in this report is included in Appendix G.)

Survey results were analyzed and are summarized below.

Qualitative Data: Comments, Themes, and Nonverbal Communication from Group Discussions

Facilitators made note of comments and nonverbal cues from physician and non-physician providers during individual and focus-type group discussions and presentations. A coding system that identified themes relevant to the study goals was developed. Codes were applied to the comments recorded by facilitators during one-on-one meetings or small group focus-type meetings ,and/or to the answers from program staff in response to questions during meetings and presentations. Staff also captured some nonverbal responses.

Comments were coded and exported into an Excel spreadsheet to generate charts and graphs. A complete list of provider comments from the discussion groups can be found in Appendix E. Table 7 (pp 15) is a list of the themes and a brief definition of each. Themes in the Excel spreadsheet in Appendix E have been truncated. The complete theme and its corresponding truncation can be found at the bottom of each page of Appendix E.

Comments and themes were used by program staff to develop a flavor for the attitudes and opinions expressed on the survey forms and appear throughout this report where relevant.

Table 7. Themes and Definitions for Provider Comments (n=438)

Theme	Definition
1. Eligibility	Rules and regulations governing eligibility for Medicaid
2. Prescriptions	Limit on Rx meds
3. Hassle	Red tape associated with providing Medicaid services
4. Medicaid Program	Programmatic issues, benefits, etc.
5. PC Physicians or ER	Use of primary care physician vs. ER use by beneficiaries
6. Access	Access to health care services, providers
7. Preventive Care	Coverage for preventive services
8. Reimbursement	Provider reimbursement for services.
9. Co-Pay	Patients paying a portion of their health care
10. Participation	Factors influencing provider participation
11. Chronic Disease Mgmt	Management of chronic illnesses such as diabetes, asthma; includes services of nurse educator, etc.
12. Medicaid $ Issues	General financial issues
13. Patient Responsibility	Holding patients accountable and responsible
14. Other	Comments relative to health care but not to this project

Table 8. Number of Comments by Theme (n=438)

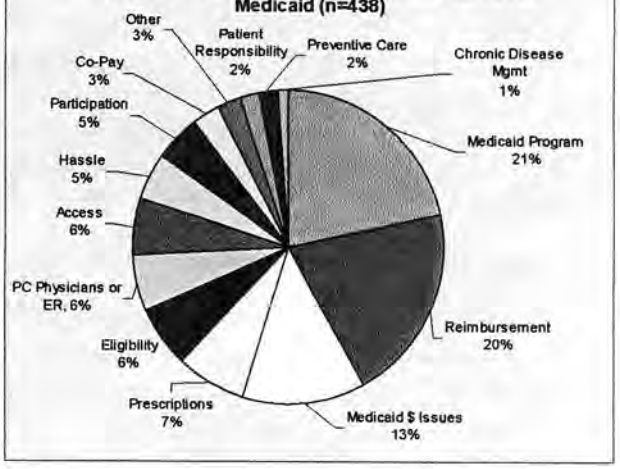
Medicaid Program	95
Reimbursement	88
Medicaid $ Issues	56
Prescriptions	32
Eligibility	28
PC Physicians or ER	25
Access	25
Hassle	23
Participation	21
Co-Pay	12
Other	11
Patient Responsibility	9
Preventive Care	8
Chronic Disease Mgmt	5

Table 8 shows the number of comments by theme. Comments, suggestions, and opinions of the current Medicaid program (coded in the theme "Medicaid Program") were the most prevalent (96), followed by comments and suggestions about reimbursement (87) and general issues raised about Medicaid funding (56). Following are two excerpts from the comments about the overall Medical program.

> "Another key part to making things better would be an outlet for everyone to vent – everyone is so upset about the Medicaid system – until we all work through that, nothing positive will come from us – we won't be able to fix it."

> "Compared to other 3rd party payers, Medicaid is not that bad."

Figure 6. Distribution of Provider Comments About Medicaid (n=438)



Of particular interest in the comments about Medicaid funding were those associated with the survey question on whether OHCA should be given a financial reserve base. Verbally, providers were both positive and negative about this possibility.

In general, despite negative or pessimistic attitudes expressed during discussions, physicians and other health care providers were receptive to reforms of the current Medicaid program. While some expressed enthusiasm for the process, many others were skeptical that the program could be repaired.

Quantitative Data: Survey Responses

The post-card survey contained two of the contract questions and two additional questions to provide a demographic variable and a confidence variable.

1. Under the Medicaid reforms, as a physician and a taxpayer, considering an increased number of eligible patients and required co-payments, what percent of the Medicare fee schedule would be a fair reimbursement for your colleagues providing Medicaid services?

☐80%,
☐90%
☐100%
☐110%
☐120%
☐Other_____

2. As a health care professional who provides services to Medicaid patients, what percent of allowed co-payments from these patients do you currently collect? (Check your best guess).

☐<10%
☐10-25%
☐25-50%
☐50-75%
☐>75%

3. At what level of confidence did you answer question #2?

☐Very confident
☐Confident
☐Somewhat confident
☐Not at all confident

4. Please answer below what best describes your practice. (Please check and list).

☐Urban ☐Rural

5. Please list your practice area or specialty.

_____

Fair Reimbursement as a Percent of Medicare

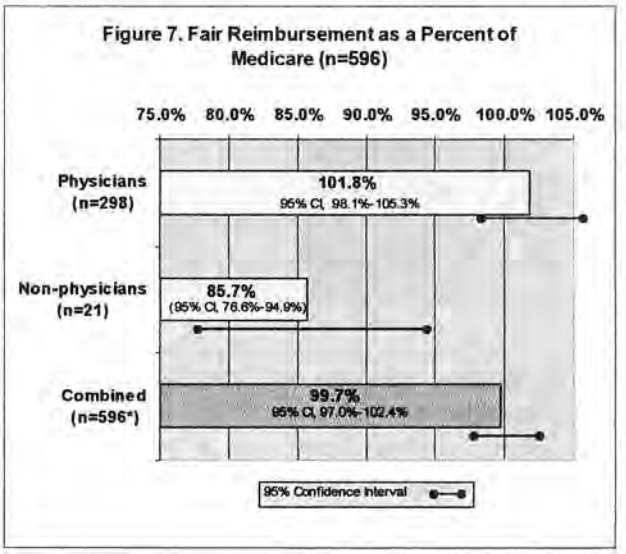
Table 9. Mean and Median Fair Reimbursement as a Percent of Medicare (n=596)

Provider Type	Mean	Median	95% CI of the Mean
Physicians	101.8%	100.0%	98.1%-105.5%
Non-physicians*	85.7%	90.0%	76.6%-94.9%
All Providers†	99.7%	100.0%	97.0%-102.4%

*Includes ARNPs, PAs, and administrators

†Includes Physicians, ARNPs, PAs, and administrators; excludes all respondents who identified themselves as dentists and pharmacists. 67 respondents failed to answer this question.

Provider Type: Of the 846 providers who completed the survey, 62 identified themselves as dentists and 54, as pharmacists. After excluding dentists (n=62) and pharmacists (n=54), for whom the Medicare fee structure is not relevant, 663 surveys remained; 67 respondents failed to answer the question. Data from 596 surveys were analyzed to determine the mean and median reimbursement (Table 9).

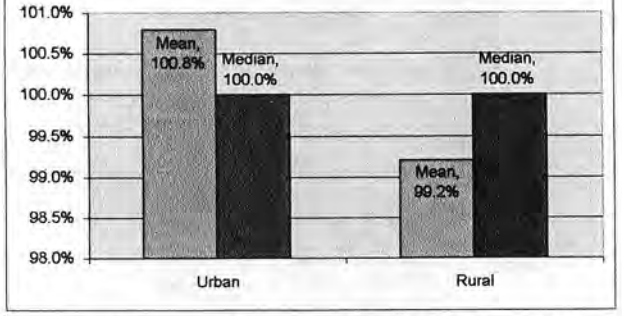


Data were analyzed by **provider type** (Figure 7). The analysis yielded an average reimbursement structure of 101.8% (95% confidence interval, 98.1%-105.3%) for physicians (MDs and DOs) for non-physician providers (ARNPs, hospital administrators, PAs, excluding dentists and pharmacists), the acceptable rate was 85.7% (95% CI, 76.6%-

94.9%). Analysis of responses for all providers combined (excluding dentists and pharmacists) yielded a mean of 99.7% (95% CI, 97.0%-102.4%). Thus, a fee structure that approaches 100% of Medicare would be appropriate for all provider groups.

Practice Location. Practice locations of providers in this study were fairly evenly mixed between urban (470) and rural (309) locations (67 respondents did not indicate practice location, see Figure 4). Urban practitioners selected a somewhat higher reimbursement as a percent of Medicare (100.8%, 95% CI, 97.6%-104.1%) compared to rural practitioners (99.2%, 95% CI, 94.0%-104.5%). The median for both groups was 100% of Medicare (Figure 8). The results indicate that practice location made little difference in the suggested appropriate fee structure rate.*

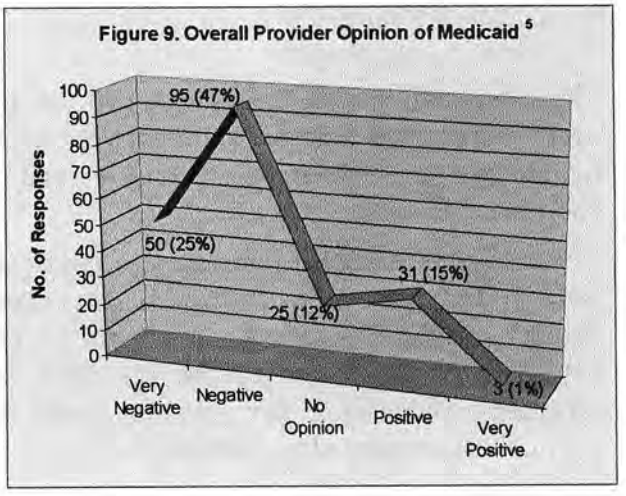
Figure 8. Fair Reimbursement as a Percent of Medicare by Practice Site (Urban vs. Rural)



*Data excludes providers who identified themselves as dentists or pharmacists.

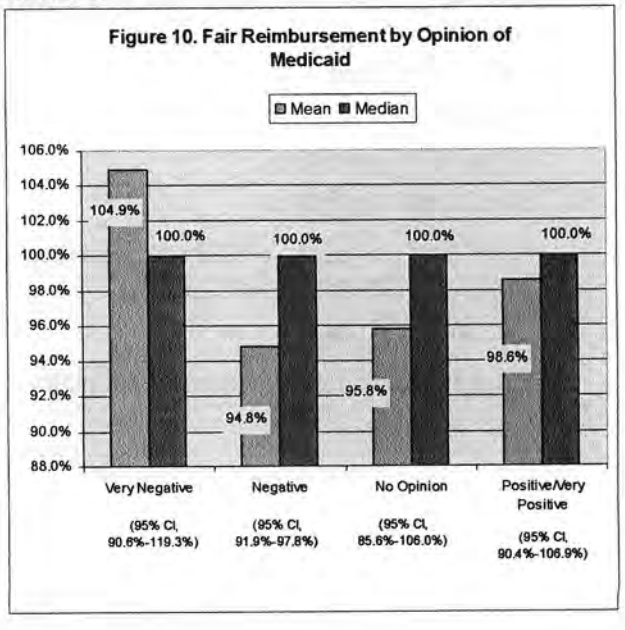
Opinion of Medicaid: In a previous study, providers were asked to rank their feelings about the state's Medicaid program, from Very Negative (1) to Very Positive (5) (Figure 9).[3]

Figure 9. Overall Provider Opinion of Medicaid [5]



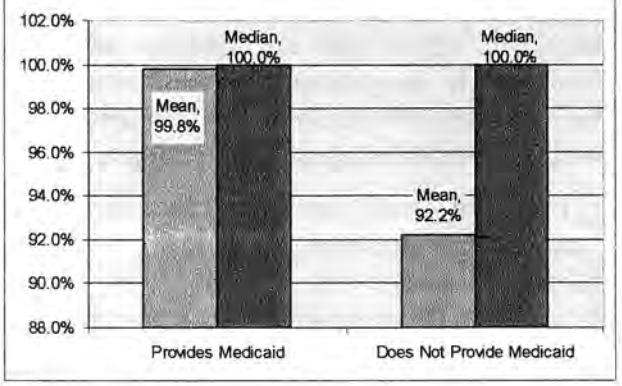
Only 34 providers had a Positive to Very Positive (combined for this analysis) opinion of the current Medicaid program compared to 145 providers with a Negative to Very Negative opinion. No conclusions can be drawn from the analysis per se. However, based on discussions with providers and the slight trend in the data shown in Figure 10, providers with a more positive opinion of Medicaid might accept a somewhat reduced reimbursement rate than providers with a negative opinion. Reducing administrative burden on providers could improve their opinion of Medicaid and, therefore, could possibly affect their opinion on the appropriate fee structure for Medicaid services.

Figure 10. Fair Reimbursement by Opinion of Medicaid



Current Medicaid Provider Status: We analyzed whether current status as a Medicaid provider influenced reimbursement rate (Figure 11). It is interesting to note that for current Medicaid providers, 99.8% percent of Medicare would be appropriate compared with 92.2% for providers who do not currently participate in Medicaid. Based on comments from providers, one possible explanation for this difference is that current providers understand the overhead and expense associated with Medicaid and have experience with the challenges of providing care for current Medicaid beneficiaries (see Discussion section below).

Figure 11. Fair Reimbursement by Current Medicaid Provide Status

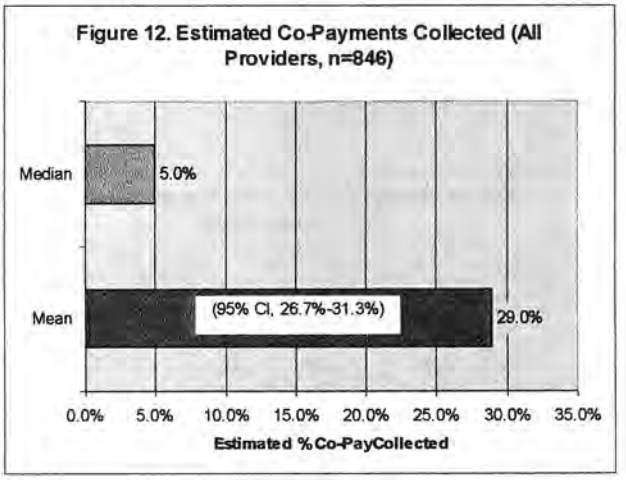


Reducing the administrative burden and building patient responsibility into the system could alleviate some of the problems for providers and make the system more cost effective.*

Estimated Amount of Co-Payments Collected

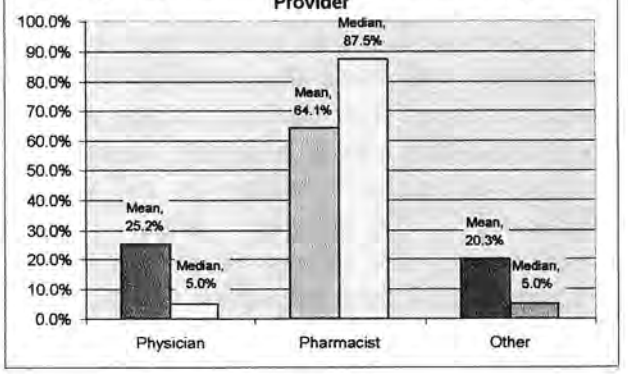
Respondents to this survey reported collecting somewhat less than 30% of all co-pays due from Medicaid patients (Figure 12).

Figure 12. Estimated Co-Payments Collected (All Providers, n=846)



Pharmacists reported collecting the highest percentage of co-pays (mean, 64.1%, median, 87.5). Physicians reported collecting only an average of 25.2%; the median collection percentage reported by physicians was 5%. Other provider groups (dentists, hospitals, nurses, PAs) reported collection only 20.3% of required co-pays) (Figure 13).

Figure 13. Estimated Co-Payments Collected by Type of Provider

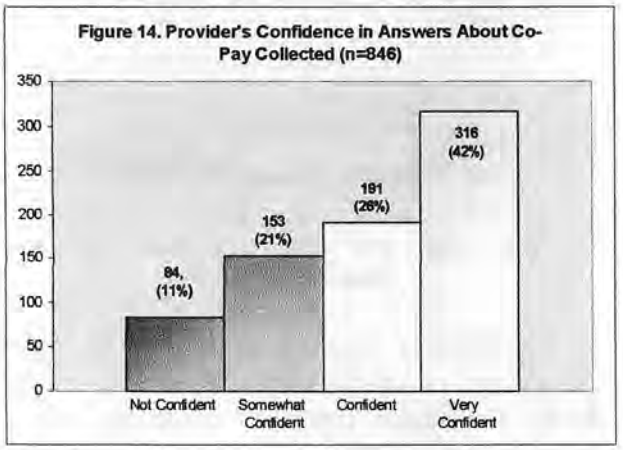


Confidence in Answers About Co-Pay Collected

Providers were asked to estimate how confident they were in their answers to the question about co-pays (Figure 14). Although many providers did not answer this question (no answer = 102), most indicated they were very confident in their estimates of co-payments collected from Medicaid patients. Combined with the data on co-payment percentages, it seems reasonable to

* As of December 31, 2003, Heartland, UniCare and Prime Advantage (SoonerCare Plus HMOs) were eliminated. Providers will be monitoring the manner in which the termination of these programs is handled, specifically regarding reimbursement for services previously rendered.

assume that Medicaid providers are collecting only a small percent (30%) of even nominal co-pay amounts from their Medicaid patients.



Limitations of the Study

There are two major limitations to this study: lack of random sampling and small sample size. A third, less important limitation was the decision not to use electronic data recording devices.

(1) Random sampling was not possible in this study, nor was there any intention to create a random group. The method of data collection was a shot-gun survey approach; we mailed the survey to every provider in the available databases (Oklahoma State Medical Association, the State Board of Medical Licensure and from physician and health care associations, Oklahoma Hospital Association, Oklahoma Academy of Family Physicians, Pharmacy Providers of Oklahoma, and hospitals; approximately 13,500 surveys were mailed. Providers who responded were most likely to be interested in the topic and have issues and concerns. The lack of randomization limits the generalizability of these results to the population of all physicians and health care providers in Oklahoma.

The participants in this study represent all major health care provider groups in Oklahoma. By design and by contractual agreement, most of the participants were physicians. Because participants were volunteers, many had specific issues and concerns. Their views may not represent those of the larger group of providers statewide.

However, study results are similar to those of other studies in the literature,[3,7,9,10] and can, therefore, be utilized by policymakers, in addition to other relevant information, when making decisions about changes and reforms to the Medicaid program.

(2) Small sample size is a second limitation. Project staff sent out 13,500 post-cards inviting practitioners to participate in a study to provide input to OHCA about possible reforms to the Medicaid program; 846 practitioners returned the post-card, a response rate of only 6%. However, given that our findings mirror the findings of large-scale national studies, we believe that policymakers can use these results with a reasonable degree of confidence.

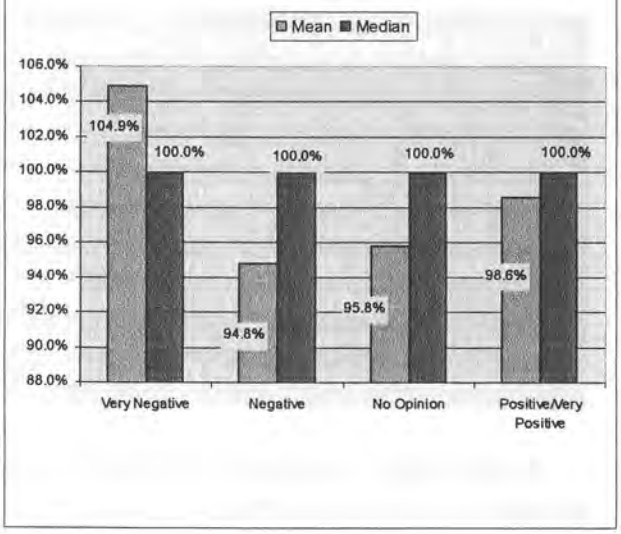
(3) A third, less important limitation of this study is that **electronic devices were not used to record comments data** nor were standard procedures for measuring verbal and nonverbal responses used for analyzing results of the group and individual sessions. Nonverbal data and comments and opinions from the focus-type group discussions, presentations and individual interviews were hand-recorded using paper and pen by the facilitator and/or assistant facilitator. During pilot studies with DFPM faculty, participants expressed a degree of discomfort, with electronic recording (audio or video) of the sessions. Participants stated during pilot testing they would be much more forthcoming and honest if no electronic recordings of the discussion were made, and thus their anonymity could be assured. Because honesty in the attitudes, opinions, and suggestions of participants was paramount for the success of this project, a less invasive system of note taking was employed. The spreadsheet of comments and nonverbal communication along with the theme codes are attached in Appendix E.

5. DISCUSSION

The results of our study indicate that Medicaid providers in Oklahoma feel a fair and reasonable reimbursement for services rendered under Medicaid would be a structure approaching 100% of the Medicare fee structure. This finding held true for providers in urban and rural areas, although those in urban areas indicated a somewhat higher percentage (100.8%) compared with providers practicing in rural areas (99.2%).

This was also true for current providers as well as for those who are not currently providing services, although current providers felt a higher percent would be appropriate compared with non-Medicaid providers (99.8%-92.2%) (Figure 16). One possible explanation for this is that current providers understand the administrative burden of the system and have experience with the challenges of caring for current Medicaid beneficiaries.

Figure 15. Fair Reimbursement by Opinion of Medicaid



Most providers surveyed had a negative to very negative opinion of Medicaid (72%). Although providers with a negative opinion of Medicaid tended to indicate a fractionally higher percentage of reimbursement (98.7%) than those with a positive opinion of Medicaid (98.6%), the difference was insignificant In addition, despite an overall negative opinion of Medicaid, most providers (82%) in this study participate in the Medicaid program, which corresponds to a study of physicians in the TennCare Medicaid program.[13] Negative opinion of Medicaid notwithstanding, 85.6% of physicians surveyed participate in the TennCare program due to a strong sense of professional responsibility.

Other studies describe similar findings regarding opinion of Medicaid. A study of Louisiana dentists found that providing Medicaid services was a source of dissatisfaction for providers. Issues from that study mirror what we heard from providers in this study: administrative hassles and lack of patient responsibility as measured by frequent broken appointments were cited as primary concerns.[14]

A study of physician satisfaction with Medicaid, conducted among physicians in Missouri reported similar findings, with a primary complaint of lack of physician autonomy. Only 29.8% of physicians participating in traditional fee-for-service Medicaid reported being satisfied with that program.[15]

An overwhelming number of providers (82%) surveyed in a previous study[3] favored extending health care services to Oklahoma's poorest and most at risk. Many are willing to, and do, see patients in free community clinics

and forego co-pays and deductibles for patients whom they know are struggling.

"It is easier for me to see patients free rather than deal with the hassle."

Unlike some studies implying that financial remuneration is the most important factor motivating physicians and other health care providers,[8] the providers who participated in our study were concerned, caring practitioners. Their concerns regarding reimbursement were based primarily on their need to support themselves and their families, to ensure a safe and stable work environment for their clinic staff, and to provide high quality health care services for their patients.

"It costs me more administratively to 'chase' the reimbursement dollars than the amount itself."

Reducing the administrative burden and building patient responsibility into the system could alleviate some of the problems for providers and make the system more cost effective.*

Providers expressed hope that by expanding coverage to uninsured workers a patient base comprised of individuals who are more willing to share responsibility for health care, both financially and personally, would be generated.

There is a crisis in health care in America. Annually, the estimated 41 million uninsured in the U.S. cost the economy from $65 to $130 billion.[4] This figure does not include the countless number of underinsured.[1,2] Health care costs are rising at an equally alarming rate – forecasters predict double digit increases in health costs again in 2004 for the 5th consecutive year[16] – forcing states to scramble to find funding for Medicaid services. A study, published in 1996, showed that Oklahoma spent 20% of its state budget on Medicaid, the highest budget percentage of any state.[11] To control costs, states restrict eligibility, reduce benefits, and often severely limit physician reimbursement and even eliminate payment for services already rendered, making participation in Medicaid a financial hardship on practitioners.

For physicians and other health care providers, the gratification of providing health care is often overshadowed by paperwork, low or no reimbursement for services and a morass of covered and uncovered services, eligibility regulations, and third-party payers.[1] Consequently, many are opting out of government programs such as Medicare[2] and Medicaid (this study). When they do, they report reduced overhead expenditures due to decreased administrative red tape, increased profits, and a more responsive and responsible patient population. Recent increases in medical malpractice (as much as an 82% in some cases) have also forced providers to take a hard look at the financial stability of their medical practices. As one provider said, "I can't help anyone if I'm out of business."

"Levels of Medicaid—too confusing—make it all the same—different co-pays are confusing. Make it so the first thing out of my mouth when I'm contacting a specialist is not 'Do you take SoonerCare?' Eligibility and pre-authorization regulations, formulary policies and other administrative requirements must be streamlined to reduce overhead and frustration."

In this study, we asked providers what they thought would be a fair reimbursement structure

* As of December 31, 2003, OHCA eliminated the SoonerCare Plus program as a participant option. This eliminated Heartland, UniCare and Prime Advantage HMO's as options from the Medicaid program. Providers will be monitoring the manner in which the termination of these programs is handled, specifically regarding reimbursement for services previously rendered.

for providing health care services for an expanded Medicaid population (as a percent of Medicare). Across the board, providers thought that Medicaid should be reimbursed at the same rate (100%) as Medicare. This seemed "fair" to them.

"There are all kinds of laws that mandate us (docs) to see patients – why shouldn't the state be mandated to pay for it!"

The physicians and other health care providers interviewed for this study were frustrated and angry about reimbursement issues: the difficulty of processing claims and the length of time they would wait to be reimbursed, or told that no reimbursement would be forthcoming for the services they had already rendered.

The following are comments representative of providers' feelings about reimbursement, co-payments and patient responsibility.

"The practice filed 261 total claims and 40% were denied because the 'referral was not attached'. The referral was attached all 3 times it was submitted. We believe that they deny the claim so that it will take longer and they will not have to pay us as much."

1. Reimbursement

"Medicaid is expanding their services, without sufficient reimbursement – basically you are asking physicians to expand their services and what they provide and then pay nothing more."

"I want to help these people and I have trouble saying no, but I have to support myself and my family."

"In 1995 there were 1,100 dentist providers in the state. Now the number has gone down to 100. There is no way that 100 dentists can serve the population they're being asked to handle. It is because of the reimbursement issue. Those 100 left are only seeing patients FFS. The credibility of the HCA is a definite issue."

"I completely did away with the adult Medicaid population in my practice because of the reimbursement. Occasionally I will add a mother to my practice when she is pregnant and her other children are already in my practice."

"Currently, I am now taking home 25% of what I made in 1989."

2. Collecting Co-Payments

"All patients must have some co-pay. They must have some responsibility in their own health care."

"Co-pays are random, especially for surgeries, we don't know what the co-pay is until after the procedure is done. Then we can't collect from the patient"

"The co-pay is useless. Remove the co-pay or make it enough that it makes a difference in the choice the client makes."

"Implement a sliding scale co-pay. That feature might make it more attractive to providers."

"If you expand the program and pay better for the expanded population, then the providers will choose that population to see and the Medicaid population will still be without providers."

3. Patient Responsibility

"(If OHCA could offer some kind of malpractice coverage to take care of the Medicaid population and have an arbitration board instead of going to court) this would help with physician's concerns that Medicaid patients are the most likely to sue you"

"Sociology should be taught in high school so the patients can see where this kind of health care is taking us. These patients don't fill out the right paperwork so the burden of the health care costs falls back on the physician."

"I've had an uninsured patient tell me, 'with the cost of health insurance, my family and I will take my chances. Don't you know the law – if

something really bad happens to me – they have to take care of me down there (OU), it's the law.' This patient seems to make a good living, which is just the mentality."

Providers felt strongly that they were fulfilling their role and being responsible by caring for patients.

"It seems like the working uninsured would be a better population to serve."

They also felt strongly that patients in the Medicaid population were far more likely to feel entitled to health care and to transfer responsibility for their own health and well-being to providers or others (Medicaid, social workers, etc.) than to accept even a small portion of the responsibility themselves.

"Personal responsibility needs to be promoted."

Providers feel that patients must be required to pay something for their health care to force them to accept responsibility for their own health care.

In addition, it might be useful to assemble discussion groups with leaders from all the various stakeholder populations (businesses, providers and beneficiaries) to discuss the points of contention and brainstorm about how to solve these problems.

It is the overall finding of this report and of a previous report[3] that by and large the physicians and other health care providers who participated in these studies cared a great deal about providing quality health care to all segments of the population. Even those who have opted out of Medicaid continue to provide services in free or community clinics or to patients in own clinics.

The providers issues were regarding fairness and accepting responsibility. Reimbursement for services should be fair. In an article about home health care services, it was recently reported that a "plumber could earn more [than a physician] for a house call." Under the current reimbursement system, a nurse would be paid more than a physician for one hour spent caring for a patient in their home.[17]

Physicians and other providers reported that "fair" reimbursement for providing health care services to the Medicaid population would be 100% of Medicare. A concomitant reduction in the administrative hassle associated with Medicaid would make the program cost effective for providers so they can "stay in business and continue to take care of people."

As this process evolves, physicians and other health care providers of all specialty types and from all areas of the state could be involved in designing and implementing health care reform. This would ensure provider buy-in to whatever system is developed, and would ease some of the tensions that exist between providers and the state agencies.

The results of this study should be viewed with optimism. In general, providers feel that the current Medicaid system is broken. Many have lost their faith in government health care programs. It will be important for OHCA to rebuild trust, eliminate the feeling that there is an adversarial relationship between providers and the system, and develop programs that meet the needs of the uninsured and underinsured in Oklahoma. If providers are given an active roll in planning and implementing changes to Medicaid, it is more likely they will be satisfied with the new system and that they, in turn, will encourage their colleagues to participate.

6. CONCLUSIONS AND RECOMMENDATIONS

Study Conclusions

- **Approximately 100% of Medicare** is a fair reimbursement rate for provision of Medicaid services.
- **In general, providers in Oklahoma collect less than 30% of co-pay amounts** from Medicaid patients.

Recommendations

1. **Reimbursement** for services rendered should be fair and reasonable to assure financial viability for providers serving Medicaid patients.
2. **Collecting co-pays** from Medicaid patients is problematic. A system that will generate the co-pay dollars but perhaps remove practitioners from the role of collection agent should be investigated. It is possible that some iteration of the health savings accounts (a health co-pay "credit card") can be designed to accomplish this goal. Implement innovative programs to help providers increase co-pay collections. A bonus or other program could be considered. Also, a best practices approach may reveal what is working for some providers and may provide insights for other practitioners.
3. A significant **reduction in administrative hassle** could result in an improved overall opinion of OHCA and the Medicaid program by physicians and other health care providers, thus making Medicaid participation more attractive.

"All patients must have some co-pay. They must have some responsibility in their own health care."

4. **Patients must be empowered** to accept responsibility for their own health care. Required co-pays and other methods to ensure patient accountability should be investigated.
5. **Provider participation** in the design and implementation of the program would help ensure success.
6. **A public relations and educational effort** aimed at enlightening physicians and other health care providers about the goals and objectives of the Medicaid program, the costs and benefits of an expansion of the program as well as an honest appraisal of the downsides (short- and long-term) of the reform options would be helpful in achieving buy-in to any reform program.
7. **Talk with non-Medicaid providers to determine why they are not providing care for Medicaid clientele.** Inviting those who currently do not participate in Medicaid to be part of the discussion could improve the overall opinion of the Medicaid program and encourage non-providers to enter the system.

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8. APPENDICES

A. Health Care Provider Survey

B. Education Document

C. Small Group Facilitator's Guide

D. Small Group Meeting Checklist

E. Comments and Impressions from Group Participants

F. Summary Data

G. Glossary of Statistical Terms

H. Biographical Sketches of Program Staff

Appendix A

Health Care Provider Survey

Dear Colleague:

Would **you** like to see changes in Oklahoma's Medicaid system?

Would **you** like to see Medicaid physician and other provider rates increased?

Would **you** like to see more Oklahomans insured?

The expertise of the staff and faculty of the Department of Family and Preventive Medicine at the University of Oklahoma Health Sciences Center has been enlisted to find out what you think about Medicaid reforms and how you would change the system to best meet the health care needs of uninsured Oklahomans. Enclosed is a brief overview of Medicaid reform goals and ideas, including a proposal to allow some beneficiaries to buy into Medicaid.

At the bottom of this page is a short survey. After you complete this survey, please return it by tearing off the pre-paid postcard and dropping it in the mail, or you may fax it to (405) 271-8800. **As part of this study there will be statewide forums to allow physicians and other health care providers the opportunity to express their views on how to provide health care for Oklahomans in a manner and at a cost that is acceptable to you as a taxpayer and health care professional.** We invite you to take part in these forums, as you are an integral part of health care in Oklahoma. For more information, please visit our website at http://www.fammed.ouhsc.edu/hcnw/ or contact our project staff by e-mail at Medicaid-Study-Staff@ouhsc.edu or (405) 271-8000, Extension 31720.

Thank you for your time and consideration.

Sincerely,

Steven A. Crawford, MD
The Christian N. Ramsey, Jr, MD., Endowed Chair in Family Medicine
Professor and Chair
Department of Family and Preventive Medicine

PLEASE RETURN SURVEY BY MAIL, TEAR PRE-PAID CARD AT PERFORATED EDGE OR BY FAX – (405) 271-8800

Please tear here

---

1. Under the Medicaid reforms, as a physician and a taxpayer, considering an increased number of eligible patients and required co-payments, what percent of the Medicare fee schedule would be a fair reimbursement for your colleagues providing Medicaid services? Please list a percentage. _____ %

2. As a health care professional who provides services to Medicaid patients, what percent of allowed co-payments from these patients do you currently collect? (Please check your best guess).
   ☐<10% ☐10-25% ☐25-50% ☐50-75% ☐>75%

3. At what level of confidence did you answer question #2?
   ☐Very confident ☐Confident ☐Somewhat confident ☐Not at all confident

4. Please answer below what best describes your practice. (Please check and list).
   ☐Urban or ☐Rural Please list your practice area/specialty and zip code _____
   Are you a Primary Care Specialist? ☐Yes ☐No

5. We will be conducting discussions with physicians and other health care providers statewide to collect advice and input on possible Medicaid reform and ways to improve the system. Would you be interested in meeting with members of our staff to discuss these issues further?
   ☐Yes ☐No

6. Contact information. Complete the section below ONLY if you wish to participate in discussions with our staff. A policy on confidentiality is being developed and will be available at all meetings.

Name _____
Address _____
City State Zip Daytime phone number ( )

Thank you for completing and returning this important survey by Friday, August 29, 2003.

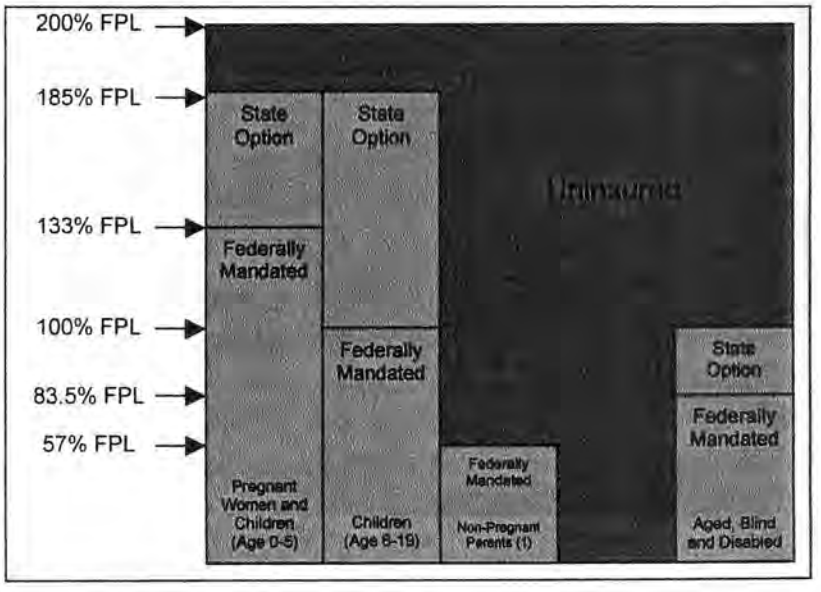
Appendix B

Education Document

Medicaid and the Uninsured

"It's Health Care, Not Welfare"

- Estimated 450,000 Oklahomans under 200% FPL are uninsured.
- Only 38% of businesses with less than 50 employees offer health insurance.
- Federal poverty level (FPL) for a family of 4 = **$18,000/year**.
- Average cost of health insurance premium for an Oklahoma family = **$9,500/year**.
- Uninsured individuals are 4 times more likely to require costly emergency or hospital care.



(1) 57% FPL based on single parent family of three.

GOALS OF MEDICAID REFORM

1. **Healthier Oklahomans** – Improve health status of Oklahomans through improved access to health care by providing health insurance.

2. **Eligibility** - Provide access to health insurance to the uninsured by defining eligibility without regard to traditional welfare categories.

3. **Effective Purchasing** – Allow purchase of health insurance and provide partial program financing through the use of options such as subsidizing existing employer sponsored insurance plans (i.e. vouchers), offering buy-in arrangements for small employers to Medicaid and/or commercial insurance plans; and requiring beneficiaries to pay a fair portion of their health care costs.

4. **Benefits** - Develop flexible benefit packages based on medical appropriateness and patient needs.

5. **Patient Responsibility** - Use cost-sharing and other approaches to promote appropriate utilization and personal responsibility.

6. **Provider Reimbursement** – Determine a more appropriate rate structure for physicians and other health care providers. The Oklahoma Health Care Authority needs to be a responsible participant in the health care marketplace, while ensuring access for the uninsured.

Appendix C

Small Group Facilitator's Guide

SMALL GROUP FACILITATOR'S GUIDE
(PHYSICIAN/PROVIDER)

_____Arrive 30 minutes – 1 hour prior to session – prepare presentation items, flip charts, surveys, etc. Remember to have available detailed project and OHCA information.

_____As participants enter – Greet, nametags (first name only), ask participant to fill out survey prior to group discussion, refreshments, collect surveys and begin focus group **on time**.

Introduction

Introduce self/team
Name – title and group facilitator (include some background of facilitator)
Name – title and assistant moderator/observer/note taker

Explanation of Group Discussion
The purpose of this informal group discussion is to collect information on health insurance and the state's Medicaid program, as a physician or other health care provider within the state of Oklahoma. Your feedback and information will be used to compile a report and then presented to the Oklahoma Health Care Authority (OHCA), the agency that oversees Medicaid in Oklahoma. For your information, Medicaid is a jointly funded and administered state and federal program to provide basic health care services to at risk and low income children and families. Medicaid was initiated as a component of Welfare. Traditionally, to be eligible for Medicaid, you had to be eligible for Welfare. OHCA is studying reforms of Medicaid eligibility in order to provide health care coverage beyond traditional Welfare eligibility. In Oklahoma, for example, the Federal government pays about 70% of the Medicaid program while Oklahoma pays the other 30%. In 2002, the total cost of the program in Oklahoma was $2.4 billion, $2 billion of which came from Federal sources. Approximately 550,000 Oklahomans received Medicaid benefits in 2002. Currently, approximately 650,000 Oklahomans are without health insurance coverage, 200,000 of whom are children. At this time OHCA has an opportunity to apply for a Health Insurance Flexibility Act (HIFA) Waiver, which would allow them flexibility to modify the Medicaid program without federal constraints. This waiver could potentially expand health insurance benefits to low-income workers within the state of Oklahoma (under 200% Federal Poverty Level (FPL) which for a family of 4 is approximately $36,800/annually). This expansion could offer a direct "buy-in" to the current Medicaid program or offer a voucher for recipients to purchase health insurance.

We have asked you to attend this session, because we believe you are an expert in your field and your comments, opinions and feedback are very important.

We have asked you to attend this session, because we believe you are an expert in your field and your comments, opinions and feedback are very important.

Explanation of Roles

- Facilitator: Guides the session – asks questions, probes for clarification, cues assistant moderator/observers, if necessary.
- Assistant Moderator/Observers: To make notes to identify general themes, verbal and non-verbal communication (gestures, emotion, feelings, etc.). Typically, does not participate in the discussion
- Participant's role: To represent yourself – give your opinions, views, ideas and feedback.

Confidentiality

Because your feedback is so important to us – we want to ensure we have accurate records. Although, we are not recording this discussion, _____, the Assistant Moderator/Observer, will be taking notes throughout our discussion. No one will be specifically named; only the information collected from this session, and from others like it, will be compiled into reports and submitted to OHCA over the coming months. Our final report will be submitted, March 31, 2004. The parties having access to this information are the University of Oklahoma Health Sciences Center and OHCA. Remember if there are OHCA staff present announce.

Guidelines to Making the Group Discussion Work Well

- Realizing everyone's time is very important – we will begin and end this session on time.
- Openly sharing your views, thoughts, feelings and opinions.
- Only one person speaking at a time.
- Speaking only for yourself and letting others do the same.
- Giving everyone "air time" and taking the initiative to speak your "fair share".
- Maintain confidences shared throughout this meeting.

- (If appropriate) Review evaluation form – this is our report card. You each have an evaluation form. At the end of our session, please take 2 minutes to complete our report card to let us know how we are doing.

- Before we get started are there any questions or concerns?

Participant Introductions (If appropriate)
Some of you may not know the other group members, let's go around the table and introduce one another (ice breakers can be used here - ask them to reveal something other than their name – can be fun, serious, etc. - depends on the group).

Begin Group Discussion

Suggested Discussion Questions

1. By a show of hands, how many of you accept Medicaid or are a Medicaid provider?
2. Again, by a show of hands, how many of you provided services to Medicaid patients in the past – and have stopped? Why?
3. If you are allowed by law to collect Medicaid co-pays in your office – what percentage is collected?
4. In relation to Medicare (or another appropriate rate structure for their given field) – In your opinion, what would be an appropriate reimbursement rate for services provided for Medicaid patients?
5. If more Oklahomans were insured, what effect do you feel it might have on our health care system?
6. In your opinion, what would be the best way to ensure more Oklahomans had health insurance?
7. As a physician or other provider, would you support individuals and/or employers being able to "buy-in" to our current Medicaid program? Why/why not?
8. Consider one of your very close family member (child/spouse/parent) were a Medicaid recipient in the current system – what would you think of the system?
9. As a physician or other health care provider, in your opinion, what are the top 3 most important needs or changes necessary for our state's Medicaid system?
10. Change hats – as a taxpayer would those 3 items be equally as important to you?
11. If you woke up tomorrow morning and were in charge of Oklahoma's Medicaid program – what would you do, what would you change?
12. Essentially, there are four specific areas that affect the budget in the

Medicaid system – 1) different services provided, 2) eligibility groups, 3) physician/provider reimbursement, 4) utilization control (such as role of the HMO) – how would you balance these areas to make the system work – and maintain budget neutrality? Would you restrict enrollment, stop providing certain services, adjust reimbursement?

13. If group is large enough – role-play - break off into 3 groups – recipients, physicians/providers and administration – ask specific questions and have groups answer.

Closing

In closing, are there any final questions? Again, thank you for taking time to participate in this discussion. We realize how valuable your time is and your thoughts and feedback are very important to us. Please feel free to contact us if we might be of assistance. Collect the evaluation form (if utilized).

Appendix D

Small Group Meeting Checklist

The University of Oklahoma
Health Sciences Center

Focus Group Type: **Scheduled Date:** **Location:** **Time:** **Address:** **City:** **Phone:**	**Group Facilitator:** **Directions:** **Document complete?**	**Focus Group Materials Compiled**/initials: 1. Surveys—all 3 2. Self addressed envelopes 3. Project Overview/Press Release 4. OHCA annual reports 5. OHCA education hand-outs (economy sheet, etc), 6. Evaluation forms 7. Notepad, pens/pencils 8. Business card

Date contacted Initials	Participant Name	Phone	Letter of Confirmation/ date	Confirmed participant by phone/date	Confirmed location by phone (day before)	Comments

Overnight accommodations needed? Initials/	Ensure car maintenance is complete, i.e. oil gas, etc./Initials
1. SH or DB -- find hotel in focus group location for $55 per night—ask for government rate. 2. Call 3 hotels in the area of focus group, choose hotel that will best suit project group, 3. Send names of hotels and rates to Angela PRIOR to going (at least one week in advance) – 4. Angela will fax rates to accounts payable – 5. Get hotel bill indicating 0 (zero) balance – 6. Submit travel claim to Angela upon return - Purchasing will reimburse at actual hotel cost.	**Mileage start:** **Mileage return:**

Congressperson:
Date Notified:
Congressperson:
Date Notified:
Congressperson:
Date Notified:

Appendix E

Comments and Impressions from Group Participants

Comments from Providers

Group ID	People Present	Question	Comment	Theme Code
812 FG4	6	13. How would you insure more Oklahomans?	Increase coverage to underserved population.	1ei
812 FG4	6	13. How would you insure more Oklahomans?	Figure out some way to cover the more indigent population.	1ei
1017 FG68	5	16. What are some of the "access to care" issues?	Recommendation: Make it VERY clear by card, etc. who is covered and who is not covered. Now it is a guessing game. The eligibility changes so often that you don't know if you will get paid for the visit or not.	1ei
107 FG60	7	17. Where is the accountability of this organization?	The limit on hospital days is very difficult for us. We are discharging individuals who have no business being discharged.	1ei
930 FG56	9	19. Q. & A. -What would incentivize recipients to discontinue having children, or smoking, etc.?	Limit the number of people who access the system so that you can give a better quality of care.	1ei
102 FG58	8	20. Unanswered Questions...?	Why is Indian Health recommending that their clients apply for Medicaid when Indian Health can pay for the health care? Why is Medicaid primary over Indian Health Care?	1ei
812 FG1	7	3. If you had to choose the top 3 important items in Medicaid reform, what would they be?	Confirming eligibility and determining the beneficiary's access to health care—6 to 12 month eligibility is suggested.—currently time/resources spent to verify.	1ei
107 FG60	7	4. If you were able to make Medicaid changes, what would those be?	Make eligibility decisions based on medical need. Healthy people need not to be on Medicaid.	1ei
1022 FG71	8	4. If you were able to make Medicaid changes, what would those be?	Eligibility should be looked at: pts drive better cars, boats, dress better, sculpted nails, groomed hair, etc.	1ei
1028 FG76	6	6. General Unsolicited Comments	PA has a rural health clinic, 30% of practice is Medicaid, 30% commercial and 30% self-pay. I even have teachers who qualify for Medicaid	1ei
102 FG58	8	6. General Unsolicited Comments	This hospital sees lots of self-pay patients. They are the highest uninsured county but have the fewest Medicaid population	1ei
1029 FG77	8	6. General Unsolicited Comments	"In Kansas we are implementing a clinic 5 nights per week for the working uninsured only. They must have a job and have no insurance".	1ei
113 FG79	6	7. Informal Discussion	You know some of the teachers are even on Soonercare—heck, even our own employees.	1ei
725 FG3	46	7. Informal Discussion	Patients should not be eligible for Medicaid if they are able to work – many of the patients I see are capable of working	1ei
725 FG3	46	7. Informal Discussion	Medicaid eligibility is a huge issue – constant monitoring is needed to prevent fraud	1ei
930 FG56	9	7. Informal Discussion	People who seem like they ought to be able to afford insurance, i.e. teachers, coaches have SoonerCare because they can not afford insurance.	1ei
930 FG56	9	7. Informal Discussion	There should be some CAP on the amount of usage the same person can have.	1ei
	8	7. Informal Discussion	Education of the adult patients as to how this program works, how their health care card works, i.e. a video where they sign up. They should have to sign that they understand the process.	1ei
115 FG81	7	7. Informal Discussion	Individuals who apply for Medicaid should be told that this is a temporary fix until they can get back on their feet	1ei
115 FG81	7	7. Informal Discussion	We have experienced women who come for their first OB visit with insurance and then when they come to the next visit they don't have the insurance but they have Medicaid	1ei
1015 FG65	8	7. Informal Discussion	Comment from physician: "I don't understand why the University can't get my patients in, if they won't take my Medicaid patients, they won't get my commercial patients either".	1ei
1023 FG72	8	7. Informal Discussion	Many people in the Muskogee area will be interested in an expanded Medicaid insurance plan since two plants have gone out of business very recently.	1ei

1ei=Eligibility
2pr=Rx
3hsl=Hassle
4prog=Mediciad Program
5pcp=PC Phy or ER
6ac=Access
7cm=Prevention/Care
8re=Reimburse
9pa=Co-pay
10part=Participation
11cd=Chronic Disease Mgmt
12mmo=Medicaid $ issues
13pt=patient responsibility
14ot=Other

Group ID	People Present	Question	Comment	Theme Code
1023 FG72	8	7. Informal Discussion	When patients present at the Indian Hospital they are asked how much money do you make and if they are eligible for Medicaid they sign them up	1ei
1023 FG72	8	7. Informal Discussion	Why is there no proof of assets or income in order to qualify for Medicaid?	1ei
1022 FG71	8	7. Informal Discussion	Hispanics have borrowed Social Security card and insurance card. They file with DHS using different names.	1ei
99 FG39	2	7. Informal Discussion	".another thing is eligibility – it was so frustrating that I could work kids from the same family and one or more of them wouldn't be eligible – because I saw them on Tuesday and not Wednesday – what day is their card good on? – completely ridiculous things like that."	1ei
Tulsa	9	7. Informal discussion	Babies should be left on the Mom's eligibility for at least 30 days after birth. Then OHCA should move the baby to their own eligibility after 30 days. Right now it's the Mom's responsibility and she doesn't do it. Then we don't get paid for the care.	1ei
812 FG1	7	1. If there were more Oklahomans insured, what would be the impact to the health care in Oklahoma?	Physician management key to getting patients prescriptions that they need, i.e. coordination of care. <AMIABLE>	2pr
812 FG1	7	1. If there were more Oklahomans insured, what would be the impact to the health care in Oklahoma?	If pharmacists are more involved with the patient's care, they may be able to make recommendations that would decrease the number of prescriptions the patients would need to have.	2pr
1016 FG67	5	18. Even if there was a surplus, what would happen to it?	Probably at least one patient a week is hospitalized because they didn't have dollars to purchase their medication	2pr
1029 FG77	8	19. Q. & A. Why isn't there a website that shows us the current specialists that are available for referral?	That would help pharmacists with preauthorizations.	2pr
113 FG79	6	19. Q. & A.Administrative hassles?	ADHA Meds. The rules changed but we weren't notified. Now every RX has to be preauthorized	2pr
812 FG1	7	2. What obstacles does the group have to access pharmaceuticals for the Medicaid population?	Medicaid is a real puzzle to work out because of the way medications are written for, physicians should put a 100 unit restriction on the prescription especially for chronic medications. Write for more than a 30 day supply.	2pr
812 FG1	7	2. What obstacles does the group have to access pharmaceuticals for the Medicaid population?	Heartland recently changed to the 100 units maintenance formulary. Also diabetics do not have to use their punches for diabetic supplies. Also HIV patients don't have to use a punch for their medications either.	2pr
1029 FG77	8	2. What obstacles does the group have to access pharmaceuticals for the Medicaid population?	Drug Reps don't come over here so we don't have the samples to help our patients with. Physician should have input as to what drugs are selected for their "punches". There should not be unlimited drug coverage for these patients. They would over use that service as well	2pr
1017 FG68	5	2. What obstacles does the group have to access pharmaceuticals for the Medicaid population?	3 RX limit makes our job hard	2pr
812 FG1	7	3. If you had to choose the top 3 important items in Medicaid reform, what would they be?	Revamp the need for prior authorizations before filling a prescription	2pr
812 FG1	7	3. If you had to choose the top 3 important items in Medicaid reform, what would they be?	3 prescriptions per month very largest issue	2pr
812 FG1	7	4. If you were able to make Medicaid changes, what would those be?	Coordination of service so that medication can be monitored and used more effectively by the patients.	2pr
812 FG1	7	4. If you were able to make Medicaid changes, what would those be?	Medicaid already does a pretty good job of tracking drug use IF the beneficiary uses their card to purchase the drug. Cash sales are not tracked.	2pr

1ei=Eligibility
2pr=Rx
3hsl=Hassle
4prog=Mediciad Program
5pcp=PC Phy or ER
6ac=Access
7cm=Prevention/Care
8re=Reimburse
9pa=Co-pay
10part=Participation
11cd=Chronic Disease Mgmt
12mmo=Medicaid $ issues
13pt=patient responsibility
14ot=Other

Group ID	People Present	Question	Comment	Theme Code
1016 FG67	5	6. General Unsolicited Comments	Medicaid provides medication for children if they need it.	2pr
1029 FG77	8	6. General Unsolicited Comments	I've been trying to work with a patient with Hypopyloria. The health care authority will not let me use the recommended drug of choice until I have conducted an out of date breath test and have a biopsy with a gastroenterologist (a specialist that doesn't exist in this area). It seems like to pay for the medication would be less expensive and also be more efficient.	2pr
1015 FG65	8	6. General Unsolicited Comments	Estimated use of Xanax, Soma, Lortab—60% goes right back out on the street	2pr
1027 FG75	10	6. General Unsolicited Comments	Pharmacist indicates he sometimes feels like a traffic cop when the patient presents with their RX—the patient may show eligible at the physician's office but when they come to get their RX either their health plan will not allow them to get the RX the physician has prescribed or the patient is no longer on the program. The pharmacist is stuck there in the middle between the patient and HCA	2pr
1015 FG65	8	7. Informal Discussion	Nicotine patches ought to be free.	2pr
99 FG40	3	7. Informal Discussion	F.P. Phy. - Regarding 3 script limit – "I have lots of pts who've stopped taking meds they need but cannot afford – therefore without those meds (with 3 script limit) they become sicker, require more care – I guess one way to look at it is they die faster...that costs the state less."	2pr
930 FG57	9	7. Informal Discussion	Pharmacist: the nursing home called for "Protonics" for one of their Medicaid patients who was in desperate need of it. The pharmacists provided the medication and now can not be reimbursed for it but the drug had already been provided. The patient suffers in a system like this.	2pr
930 FG57	9	7. Informal Discussion	In a small town, you can't add the cost of returning to the drug store to get a prescription filled for a mother whose baby has a high temp and has just gotten out of the ER. Those small town folks can find him.	2pr
930 FG57	9	7. Informal Discussion	There is a free clinic in Weatherford that some people in the community use. They may go in the middle of the night to see a physician in Weatherford and then come back and wake up the pharmacists in Watonga to get the prescription filled—"the WalMart pharmacy was closed".	2pr
1016 FG67	5	7. Informal Discussion	Chronic Disease needs unlimited refills	2pr
102 FG58	8	7. Informal Discussion	Pharmacist hopes that the State will comply with the Medicare laws with regard to medications	2pr
115 FG81	7	7. Informal Discussion	Something needs to be done about the 3 prescription limit. There should be something different for those individuals who have chronic disease	2pr
1015 FG65	8	7. Informal Discussion	The case worker should investigate if it is determined that there is prescription drug abuse.	2pr
1015 FG65	8	7. Informal Discussion	Issue with Medicare/Medicaid patients. Nursing home patients get RXs paid for but Medicaid doesn't reimburse for the RX.	2pr
1015 FG65	8	7. Informal Discussion	The dispensing fee has been cut; I'd at least like to recoup the reimbursement for albuteral"	2pr
1015 FG65	8	7. Informal Discussion	Chronic Disease needs to have unlimited prescriptions for that disease. The number of RXs should be tied to the particular disease.	2pr
1015 FG65	8	7. Informal Discussion	Medicaid would save dollars if they would illicit pharmacists to help with drug consultations, i.e. generic drugs or a different combination that would work equally as well at less cost."	2pr
1027 FG75	10	7. Informal Discussion	The way we treat our people in Oklahoma is embarrassing and a joke. I take care of dialysis patients. Having only 3 drugs for these patients is absurd. Medicare pays for no drugs. We even have to contemplate whether or not to consider a Medicaid patient for a transplant because they will not be able to afford the drugs once the transplant has taken place. This system has seriously impacted my ability to provide health care. You know, I would do it for free if I could get the drugs for my patients.	2pr

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1017 FG68	5	7. Informal Discussion	If you look at the drug abuse in the Medicaid system, someone who has RXs for Lortab, Soma, and Xanax altogether—they could make about $70,000 per year ($8 per pill) and keep enough for themselves	2pr
910 FG45	14	10. Should providers be paid more at the expense of providers care for fewer beneficiaries? Oregon has forced the citizens of their state to make this decision on how to spend the funds.	Comment from a specialist: "It is easier for me to see patients free rather than deal with the hassle"	3hsl
1017 FG68	5	16. What are some of the "access to care" issues?	We might be interested in providing service to an expanded population if ALL the details can be worked out, but right now, we'd rather see a patient service discounted 50% than see Medicaid patients and deal with the hassles	3hsl
1017 FG68	5	17. Where is the accountability of this organization?	In fact with the hassle we have in filing and refilling, we'd almost be willing to see these patients free.	3hsl
113 FG79	6	19. Q. & A. What are some of the solutions?	Do something with the rules that change monthly, i.e. having to reapply every month	3hsl
1023 FG72	8	7. Informal Discussion	Preauthorizations for ADHD are such a hassle—we take care of so many kids every day and that has to be a preauth for them EVERY SINGLE TIME. Why can't you look at your computer and tell me what drugs this patient has been on and what is going to authorized and what is not.	3hsl
99 FG39	2	7. Informal Discussion	"It's not even that it is that difficult for me – in some ways it is easier – but for my staff it is terrible hassle – it is not worth it. The hassle sets a bad precedence for my office – their bonuses are based on collections, etc. Let me put it this way – I have 9 employees – I'd be better off letting 1 person go than to continue to mess with this (Medicaid)."	3hsl
1016 FG67	5	7. Informal Discussion	The hassle of paperwork needs to be reduced, increase reimbursement for what we do (pharmacist) and incentive to do more, i.e. help with triaging patients, helping patients making decisions, counselling regarding disease management. The HCA should use pharmacist to help patients make decision regarding their pharmaceutical purchasing decisions.	3hsl
930 FG56	9	7. Informal Discussion	We are trying to set up a free clinic here because we would rather provide the care in this way than deal with the hassle from Medicaid	3hsl
930 FG56	9	7. Informal Discussion	Always getting a pre-cert from SoonerCare is a problem—there ought to be things for specific diagnosis that are pre-approved	3hsl
930 FG56	9	7. Informal Discussion	"When we went into practice 3 years ago, we considered taking SoonerCare. The office manager advised us that we would have to have one full time FTE to handle all the paperwork that would be involved in participating. WE choose not to spend the dollars."	3hsl
1029 FG77	8	7. Informal Discussion	I never get the same person twice to help me when I'm trying to work out the problem with a claim. It would be useful to have a contact person who would always be there to ask questions. I feel like when I call I am "on hold" forever. I'm rarely on hold with commercial insurance	3hsl
1015 FG65	8	7. Informal Discussion	It is an insult to the physician to ask them to explain why they ordered a routine lab or RX. They've been practicing this same way and now they must have an explanation".	3hsl
1027 FG75	10	7. Informal Discussion	The reimbursement for orthodontics is very much a hassle. We are capitated but on those FFS items we bill and bill and are not paid. This has happened so much that we will not participate in the HMO any longer. We will see the rural health patients. Those that are on Medicaid due to cranial/facial problems, i.e. Clefs, are not getting the care they need. I just can't get the claims paid.	3hsl
1024 FG74	8	7. Informal Discussion	Administrative hassles from a dentistry standpoint—we get less reimbursement but it is easier to file.	3hsl

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1024 FG74	8	7. Informal Discussion	Administrative hassles from anaesthesiologist—the turn around is quicker but we are paid less.	3hsl
1017 FG68	5	7. Informal Discussion	We take Medicaid because we really feel like it is a charity, a service to the community. However, we have decided not to take the HMO Medicaid because the paperwork is requiring another FTE to handle.	3hsl
1017 FG68	5	7. Informal Discussion	Our PA is moving to a private practice because when she tries to work out the problems with her Medicaid patients, she is on hold for 30 minutes or longer. She just wants to deal with commercial insurance now	3hsl
1113 FG85	11	7. Informal Discussion	There is no "order" sometimes our patient lists come alphabetically – well when we receive $ the patients are not listed alphabetically. Its confusing intentionally – we don't have time to go through all of that. They (OHCA) need to be consistent and uniform.	3hsl
Tulsa		7. Informal discussion	Credentialing to participate in Medicaid is ridiculous. The paperwork is incredible.	3hsl
1113 FG85	11	8. General comments recorded by note-taker during Informal Discussion	Lots of anger and frustration among the group	3hsl
		8. General comments recorded by notetaker during informal discussion	(Since EDS in Tulsa) Pre-authorizations are getting easier. The (OHCA) should do more like that, to reduce the administrative red tape.	3hsl
107 FG60	7	1. If there were more Oklahomans insured, what would be the impact to the health care in Oklahoma?	Mental Health should definitely be part of the insurance plan.	4prog
812 FG4	6	15. How would you convince small business to purchase insurance through the Health Care Authority for their employees?	State finance the endeavor—make the owners participate	4prog
812 FG4	6	15. How would you convince small business to purchase insurance through the Health Care Authority for their employees?	Make the services like the Indian hospitals	4prog
812 FG4	6	15. How would you convince small business to purchase insurance through the Health Care Authority for their employees?	Give the HSC the funding and let them work out how to furnish the services throughout the state—work it out on a sliding scale basis—positive in that those individuals would have up to date care but would have to put up with learners and a variety of care givers.	4prog
812 FG4	6	15. How would you convince small business to purchase insurance through the Health Care Authority for their employees?	Do away with current waste in the system—There is too much fragmentation, duplication, and unnecessary services in current health care. There should be more coordinaton of services in Primary Care.	4prog
812 FG4	6	15. How would you convince small business to purchase insurance through the Health Care Authority for their employees?	Educate population towards prevention	4prog
812 FG4	6	16. What are some of the "access to care" issues?	Bring the public health system back under the coordination with Medicaid services—link them in some way so that they function as a team rather than separately.	4prog
1017 FG68	5	16. What are some of the "access to care" issues?	Prior to SoonerCare, every physician in this town shared the responsibility for caring for the medicaid patients, now Dr. Robbeson in Wynnewood is the only one who takes the Medicaid HMO. It would be much better to see the system go back to fee for service	4prog
113 FG79	6	16. What are some of the "access to care" issues?	Do something with the auto assign. It is so embarrassing for patients to show up where they have been going and then find out they have been assigned so someone else they didn't ask for.	4prog

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113 FG79	6	17. Where is the accountability of this organization?	This isn't managed care; it is "unmanaged care"	4prog
1016 FG67	5	17. Where is the accountability of this organization?	Make all the billing processes the same—make the system simple enough that there is one place to send the claim and the same place is the place to call and get help	4prog
1023 FG72	8	17. Where is the accountability of this organization?	I'm dropping out of caring for the Medicaid population. Many people that I see are working and receiving some type of assistance. Those that have mastered the abuse of the system are educating the rest.	4prog
1023 FG72	8	17. Where is the accountability of this organization?	I wonder with the economy and budget as it is now, how many employees the Health Care Authority has laid off to make their own "sacrifice".	4prog
1023 FG72	8	17. Where is the accountability of this organization?	If you add another layer of bureaucracy especially with the Health Care Authority overseeing the process, that would be a big mistake. WHY would we want to participate in that? It seems like now more money is spent denying our claims than paying for the service	4prog
1023 FG72	8	17. Where is the accountability of this organization?	I believe that the moral authority of the OHCA is lacking and there are decisions that have been made without input from providers who are part of the system that they need to care for their clients	4prog
1029 FG77	8	19. Q. & A. How are you really going to be able to help these patients?"	"Everyone feels like this program is a game	4prog
113 FG79	6	19. Q. & A. How can you expand a rotten system when we can't take care of the current population?	DO NOT EXPAND THIS PROGRAM UNTIL YOU HAVE THE CURRENT ONE FIXED!	4prog
930 FG56	9	19. Q. & A. -Solutions for problems with generational use of Medicaid system?	Start young to educate the population; incentivize them to change their lifestyle.	4prog
113 FG79	6	19. Q. & A. What are some of the solutions?	Fix the auto assign	4prog
1015 FG65	8	20. Unanswered questions...	How do the Indian Hospitals care for their patients? Maybe we could learn from what they do.	4prog
1022 FG71		20. Unanswered questions...	Regulations are so difficult to understand and manage. Can't it be simpler?	4prog
102 FG58	8	20. Unanswered Questions...?	Is the illegal alien population affecting Medicaid (the State's ability) to help those individuals who have lived in this country their entire life but the health care is going to pay for someone who is here illegally?	4prog
102 FG58	8	4. If you were able to make Medicaid changes, what would those be?	Expanding the Medicaid population would only hurt the hospital	4prog
107 FG60	7	4. If you were able to make Medicaid changes, what would those be?	Whatever the plan is for those working uninsured, it should not have the Medicaid stigma associated with it. These will be people who are working and need help with their health insurance needs	4prog
1113 FG85	11	4. If you were able to make Medicaid changes, what would those be?	Fix the shop (OHCA) with a new shopkeeper and new shop keeping staff	4prog
725 FG3	46	6. General Unsolicited Comments	Australia's system is good – they retrain their disabled and maintain them in the work force in another capacity – they are able to work. They don't know any different." (In relation to disability here in US)	4prog
812 FG1	7	6. General Unsolicited Comments	"Medicaid doesn't get the respect it should for the good it actually does do. News media, etc. need to reflect it in a more positive light"	4prog
812 FG1	7	6. General Unsolicited Comments	"Patients, no matter what income, have a tendency to move around in the health care system"	4prog
812 FG4	6	6. General Unsolicited Comments	Re: "Turning Point" grants - Defined as grants funded by Robert Wood Johnson to work at the community levels to encourage the community to get involved in determining the health care needs of their communities and how to make those solutions become realities	4prog
812 FG4	6	6. General Unsolicited Comments	Re: "Turning Point" grants -This grant is being worked on in 44 counties in Oklahoma	4prog

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812 FG4	6	6. General Unsolicited Comments	Re: "Turning Point" grants - how many physicians are involved with this project? The individual from the health department indicated that although the physician groups were small, they were growing because they could actually have an impact in the health of their own community.	4prog
812 FG4	6	6. General Unsolicited Comments	Re: "Turning Point" grants - how many physicians are involved with this project? OSMA is also working with this project to encourage physicians to participate.	4prog
99 FG40	3	6. General Unsolicited Comments	F.P. Phy. - "This project/expansion is being done for pure political reasoning – the democrats are just scared of losing control – because of this – if it happens it won't be done correctly and it will continue to be under funded."	4prog
99 FG40	3	6. General Unsolicited Comments	F.P. Phy. - "The state and federal government is devoid of morality – they've lost all concept of what's good for the people."	4prog
99 FG40	3	6. General Unsolicited Comments	F.P. Phy. - "This project is being done on too small of a scale – it needs to be more public."	4prog
1016 FG67	5	6. General Unsolicited Comments	Suggestion when putting this insurance into advertisement: "put a face to the process", i.e. this is Joe Smith and he works as a housekeeper in a small community. He has a family of 4 and even though he has access to health care through his work, he can't afford to purchase insurance through his employer for his family—PUT A FACE WITH IT.	4prog
115 FG81	7	6. General Unsolicited Comments	The phone people at OHCA seem to be a lot more helpful when we have problems	4prog
113 FG79	6	6. General Unsolicited Comments	Mississippi, North Carolina, and Tennessee have been successful in implementing a program similar to this one.	4prog
1027 FG75	10	6. General Unsolicited Comments	The Oregon plan is the only plan which is currently in place similar to the one that is being proposed in Oklahoma. As far as we know, the plan seems to be working although there are always tradeoffs for providing priority health care	4prog
1023 FG72	8	6. General Unsolicited Comments	"Find the best way to skin the cat and DO IT THAT WAY!"	4prog
1016 FG67	5	6. General Unsolicited Comments	There needs to be a patient advocate to help navigate the system.	4prog
1016 FG67	5	6. General Unsolicited Comments	There is a free clinic in Lawton	4prog
1029 FG77	8	6. General Unsolicited Comments	"I feel assassinated by adult Medicaid"	4prog
1029 FG77	8	6. General Unsolicited Comments	ADHD—I can't get approval for Stratera.	4prog
113 FG79	6	6. General Unsolicited Comments	This system is an Good Old Boy System	4prog
1015 FG65	8	6. General Unsolicited Comments	"I would like to have the freedom for the provider and I (pharmacist) to work together to take care of the patient rather than working against one another"	4prog
1027 FG75	10	6. General Unsolicited Comments	I am in favour of this plan, globally, I believe that it is a good plan. These are the patients that are usually the high risk patients who don't have insurance and ride their 4 wheelers, etc.	4prog
1023 FG72	8	6. General Unsolicited Comments	If the Licensure Board imposes the policy that we must all be Medicare providers in order to be licensed, we just move to another state	4prog
1023 FG72	8	6. General Unsolicited Comments	Can moral authority be regained? I think Fogarty runs the HCA like a mafia boss using threats when needed to get his point across	4prog
725 FG3	46	7. Informal Discussion	Medicaid patients should go only to the teaching hospitals/clinics – faculty should stay faculty and private practice should be private practice	4prog
725 FG3	46	7. Informal Discussion	All the federal government insurance systems are broken...Medicare, Indian Health Services, Medicaid and Tri-Care	4prog
Faculty Retreat		7. Informal Discussion	"It is not health care if we keep patients disabled by enabling them to use the system"	4prog

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99 FG39	2	7. Informal Discussion	"I'll see 4 year old kids that might need hospitalization/anesthesia/etc and I can't wait 2 months for a pre-auth – come on!"	4prog
99 FG39	2	7. Informal Discussion	"Industry standards (reasonable and customary) must be met and right now they are not."	4prog
99 FG40	3	7. Informal Discussion	Hosp. Admin. - "Another item that's ridiculous is the 3 visit max per home health visit."	4prog
930 FG57	9	7. Informal Discussion	Question: Can Medicaid make pre-authorizations be available on-line?	4prog
1029 FG77	8	7. Informal Discussion	Some type of electronic access to patient records would be helpful so that when a patient was received from another physician, the knowledge of previous work-ups would be available.	4prog
115 FG81	7	7. Informal Discussion	The system is not Physician fraud, it is definitely patient fraud	4prog
1022 FG71	8	7. Informal Discussion	MediCare pays for overnight observation – 23 hrs. 59 min. Medicaid won't, even when its medically necessary.	4prog
1113 FG85	11	7. Informal Discussion	There has been adversity from the "get-go" – when they transitioned into Soonercare Choice – they (OHCA) came down here and said – this is what we are doing, we don't care if you like it – you have to see these patients!	4prog
725 FG3	46	7. Informal Discussion	The entire Medicaid system is so broken, it should be dissolved. It cannot be rebuilt	4prog
725 FG3	46	7. Informal Discussion	I use the Medicaid system to my advantage – as an ENT, May through October is slow for me – I sign up to accept Medicaid for that time, when business picks up I drop it	4prog
725 FG3	46	7. Informal Discussion	Eliminate the Medicaid program all together – if a physician sees an indigent patient – give the physician a tax break	4prog
99 FG39	2	7. Informal Discussion	"Expansion – how can they expand – they can't even handle what they have?"	4prog
99 FG39	2	7. Informal Discussion	"There must be an easier way to catch fraud in the system – maybe audit every 250 claims filed instead of each one."	4prog
99 FG40	3	7. Informal Discussion	Hosp. Admin. - "You know it's funny....a few years ago most area hospitals were in support of UPL and went to OHCA to ask for it – we wanted to do it, but they said NO – now UPL has been crammed down the hospitals throats because of the budget crisis, but when we wanted it no one supported it."	4prog
99 FG40	3	7. Informal Discussion	F.P. Phy. - "Medicaid is expanding their services, without sufficient reimbursement – basically you are asking physicians to expand their services and what they provide and then pay nothing more."	4prog
99 FG40	3	7. Informal Discussion	F.P. Phy. - "As for expanding the program – I think it would be criminal and it would be the state attempting to de-fraud the taxpayers."	4prog
99 FG40	3	7. Informal Discussion	F.P. Phy. - "I've ordered testing (anemia – hemicult?) that is standard care and 2 of the 3 tests were rejected –this is standard care – who is making up the regulations?"	4prog
99 FG40	3	7. Informal Discussion	F.P. Phy. - "I know what might make the system better.... An impartial state commission with public hearings and public reports – this commission would be significantly made up of medical community (appointed by the Governor, but recommended by the OSMA). This would be at least a good way to start..."	4prog
99 FG40	3	7. Informal Discussion	F.P. Phy. - "If they'd stop expanding coverage – we wouldn't have these problems."	4prog
99 FG40	3	7. Informal Discussion	F.P. Phy. - "Another key part to making things better would be an outlet for everyone to vent – everyone is so upset about the Medicaid system – until we all work through that, nothing positive will come from us – we won't be able to fix it."	4prog
930 FG57	9	7. Informal Discussion	Pharmacist: compared to other 3rd party payers, Medicaid was not bad.	4prog
102 FG58	8	7. Informal Discussion	The hospital administrator said that every year they must reapply to be a rural health clinic. None of the surrounding states have that requirement	4prog
930 FG56	9	7. Informal Discussion	"I am concerned that I will do something that will not be appropriate".	4prog

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1029 FG77	8	7. Informal Discussion	"Sometimes the reassignment seems deliberate so they (OHCA) don't have to pay. I have a mother who has 3 children all under the age of 3. When she had the last child, she went to add the baby. The baby is assigned and she isn't assigned to me at all, she is assigned to someone who doesn't even know her".	4prog
115 FG81	7	7. Informal Discussion	Our clinic has decided not to take any of the Medicare/Medicaid patients at all. Because Medicaid will not pay the balance and we can't afford to take no payment like that. With the increase cost of malpractice we just can't afford it	8re
115 FG81	7	7. Informal Discussion	When Medicaid was fee for service, there was still a problem	4prog
113 FG79	6	7. Informal Discussion	Medicaid is even more disorganized now than when they started the HMOs in 1995. It seems like a disaster over all. It needs a change of leadership to someone who is more in tune with what is really happening out here.	4prog
1015 FG65	8	7. Informal Discussion	Fraud is occurring in the county offices where the applicant is approved. Fraud is not with the providers it is at the recipient level	4prog
1024 FG74	8	7. Informal Discussion	In 1995 there were 1100 dentist providers in the state. Now the number has gone down to 100. There is no way that 100 dentists can serve the population they're being asked to handle. It is because of the reimbursement issue. Those 100 left are only seeing patients FFS. The credibility of the HCA is a definite issue	4prog
1023 FG72	8	7. Informal Discussion	It seems like the system ought to be streamlined so that it isn't as confusing as it is—there is no continuity between the systems, i.e. formularies are different, etc. Some patients in SoonerCare don't even have enough specialists to take care of the current people enrolled	4prog
1023 FG72	8	7. Informal Discussion	36 pediatric residents graduated last year from Oklahoma. Only 2 stayed within the state, what is wrong with that picture? Why would they want to stay in a state that doesn't pay them for their services?	4prog
1023 FG72	8	7. Informal Discussion	If this program does go through and the working poor do have a chance to purchase health insurance FOR SURE TAKE IT OUT FROM UNDER THE HCA. It doesn't matter if we try to ask if something can be changed because NOTHING IS EVER DONE	4prog
1113 FG85	11	7. Informal Discussion	There is no one at OHCA who is responsible enough to oversee this program.	4prog
1113 FG85	11	7. Informal Discussion	Fix what you have before you expand	4prog
1113 FG85	11	7. Informal Discussion	What few doc's that take it (Medicaid) now – won't take it if it keeps expanding.	4prog
1113 FG85	11	7. Informal Discussion	Every time we turn around OHCA is pulling the rug out from beneath us – whether it's billing, reimbursement or actually providing the care – I don't trust them (OHCA).	4prog
1113 FG85	11	7. Informal Discussion	Auto assignment is a huge issue – OHCA and DHS do not match	4prog
930 FG57	9	7. Informal Discussion	One of the physicians indicated that it is difficult for him when the patient is auto-assigned to him, he has never seen the patient, yet the patient shows up at the specialist office, the specialist sees the patient and calls to have the primary care physician approve the visit. The primary care physician does not want deny payment to the specialist that he may have to have for someone else that he did see. Patients accept no responsibility for not following the rules.	4prog
1029 FG77	8	7. Informal Discussion	When the patients are auto reassigned, all the work ups have to be redone. Just think how much money that is costing the HCA! I've been seeing these patients for years, all of a sudden they are reassigned and the next physician tries to figure out what is going on.	4prog

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115 FG81	7	7. Informal Discussion	Auto assignment screws up Peds immunizations. When the PCP is changed they don't go to the new physicians and wait until they have a problem. Then when they come to me and they aren't my patient, I can't take care of them	4prog
910 FG45	14	9. Question was asked of HCNW Rep: How would individuals enroll in this special insurance for the uninsured?	HCNW answer: Currently, OHCA can not give us specifics as to how this would happen. There continue to be open questions on what and how services should be covered. Medicaid insurance to the working uninsured would be expanded by individual "buy in". The enrollees probably would have to go to DHS to apply. There is also still a question about how the premiums would be collected and how the implementation would proceed. It is thought that premiums would be collected through one payment system and the application process would be through another agency.	4prog
910 FG45	14	9. Question was asked of HCNW Rep: How would individuals enroll in this special insurance for the uninsured?	Participant comment: "Fix the disability system"	4prog
910 FG45	14	9. Question was asked of HCNW Rep: How would individuals enroll in this special insurance for the uninsured?	If some people see this program as an extension of Medicaid, they will stay away from it.	4prog
910 FG45	14	9. Question was asked of HCNW Rep: How would individuals enroll in this special insurance for the uninsured?	When managed care came out for Medicaid, the patients began to expect more for less—at NO cost to them. With this new system, consideration should be given to co-pay, deductibles and also holding the patients to greater accountability.	4prog
812 FG1	7	1. If there were more Oklahomans insured, what would be the impact to the health care in Oklahoma?	There would be a place to send those individuals who show up in the ER without a primary physician to refer back to. Most providers will not take the risk of a patient who does not have insurance. <AMIABLE>	5pcp
107 FG60	7	1. If there were more Oklahomans insured, what would be the impact to the health care in Oklahoma?	If the expansion takes place, the OHCA should consider the current specialty physician access. Unicare patients are being sent to Tulsa and Lawton for ENT. There is only one Rheumatologist and 1 Pediatric Neurologist available for us to us and those are at OU Medical Center. The access to those physicians is abysmal.	5pcp
812 FG4	6	12. What is the providers' best guess on co-payment rates?	Most of the Medicaid population tend to use the ER mostly. One participant suggested that in rural Ers the uninsured patients greatly outnumber the Medicaid population in accessing ER care. Undocumented population usually access the Health Department system	5pcp
102 FG58	8	16. What are some of the "access to care" issues?	Patients need better education on the utilization of the Ers. They get the cards and they think they have free health care wherever they go	5pcp
113 FG79	6	16. What are some of the "access to care" issues?	I'd like to see how much the ER charges are alone—sometimes with this population, they don't feel like they have an option—they can't get in to see their physician so they go to the ER. ALSO, they don't have any accountability in the ER. ER docs get the brunt of the problems—people who can't wait any longer because they don't have insurance and they kept thinking they would get better	5pcp
1017 FG68	5	16. What are some of the "access to care" issues?	We deal fairly frequently with referrals to Pediatric Neurology. When the claim is denied to that specialist, he/she is no longer willing to see the Medicaid patients.	5pcp
113 FG79	6	19. Q. & A. What are some of the solutions?	Stable group of primary care providers	5pcp
1029 FG77	8	6. General Unsolicited Comments	"We have a large population from California who are non-compliant and bounce from one provider to another.	5pcp
115 FG81	7	6. General Unsolicited Comments	We saw a baby in the ER with a seizure disorder. The ER physician sent the kid home with his mother. Not one neurologist in this state would take this kid—it was life threatening. Finally we got a physician in Gainesville to take the kid	5pcp

1ei=Eligibility
2pr=Rx
3hsl=Hassle
4prog=Mediciad Program
5pcp=PC Phy or ER
6ac=Access
7cm=Prevention/Care
8re=Reimburse
9pa=Co-pay
10part=Participation
11cd=Chronic Disease Mgmt
12mmo=Medicaid $ issues
13pt=patient responsibility
14ot=Other

Comments from Providers

Group ID	People Present	Question	Comment	Theme Code
725 FG3	46	7. Informal Discussion	On emergency room visits – "(if MTALA-not sure if that is correct?) would allow reform...the theory is appropriate, but the system doesn't work!	5pcp
930 FG57	9	7. Informal Discussion	Use some kind of tracking system for high utilization of the ERs. The Ers are costly places to run.	5pcp
102 FG58	8	7. Informal Discussion	Individuals who actually call before going to the emergency room should be commended in some way for following appropriate guidelines	5pcp
930 FG56	9	7. Informal Discussion	SoonerCare clinic operated by the Hospital—inundated by patients and unable to take care of specialty needs because the specialists will not take these patients	5pcp
115 FG81	7	7. Informal Discussion	I have been in private practice 4 months. I worked in the ER for 4 years. I decided not to take any adult Medicaid because there is nowhere to refer adults to. I like taking care of moms and babies but I just can't afford to take care of the entire family unit. The bottom line is reimbursement	5pcp
115 FG81	7	7. Informal Discussion	These people don't understand the PCP concept. My daughter was pregnant and if I hadn't helped her get through the system, she would have been lost	5pcp
115 FG81	7	7. Informal Discussion	9 out of 10 patients who present to the ER don't need to be there—there should be at least a $10 to 20 copay	5pcp
1024 FG74	8	7. Informal Discussion	ER access—may be a result of too many Medicaid patients not able to see their PCPs or not having enough PCPs. Their PCP may tell them to go to the ER if they can not wait. Some may not be assigned to a provider close to their home so they use the ER as their PCP. Actually, some may not even know who their PCP is! They are not held accountable so they are not and misuse the system	5pcp
1024 FG74	8	7. Informal Discussion	As a provider in the ER, we have to provide service to these patients. Even if you put the barrier with regard to medical screening it still will be easier to take care of the patient and send them on their way than to deal with the fall out from trying to send them somewhere else that won't take them. It would be great if they could at least pay $10-20. I think that would deter most of them	5pcp
1024 FG74	8	7. Informal Discussion	MWC ER utilization has gone up 30% since the OU Med Center put up their barrier	5pcp
1023 FG72	8	7. Informal Discussion	I am a Family Practioner. The patient was followed at the Indian Health Service for prenatal care. The patient presented in the ER for delivery. I can not get paid for that delivery and apparently won't get paid	5pcp
1023 FG72	8	7. Informal Discussion	What is the incentive not to use the ER? NONE	5pcp
107 FG60	7	7. Informal Discussion	There is a huge utilization of the ER which is the most expensive care provided by a hospital. The Mediciad population uses the ER more than 6 times that of those who are self pay or insured. ER physicians should screen the patients and is they are not there for an urgent problem, recomend they see their physician in the morning or pay a set amount to be seen. That would mean the education of ER physicians.	5pcp
1022 FG71	8	7. Informal Discussion	Out of towners utilize ER.	5pcp
1022 FG71	8	7. Informal Discussion	There is no incentive to not be seen in ER	5pcp
930 FG56	9	8. General comments recorded by note-taker during Informal Discussion	Use of the ER point of much discussion. There is no disincentive not to use it. It seems more convenient to the patient, i.e. after work AND "I don't have to pay anything".	5pcp
812 FG1	7	1. If there were more Oklahomans insured, what would be the impact to the health care in Oklahoma? <NEUTRAL>	There would be improved access depending where you spent your money.	6ac
910 FG45	14	10. Should providers be paid more at the expense of providers care for fewer beneficiaries? Oregon has forced the citizens of their state to make this decision on how to spend the funds.	Medicaid should provide more subspecialties to see patients, i.e.only one neurologist in OKC that patients can be sent to.	6ac

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14ot=Other

Group ID	People Present	Question	Comment	Theme Code
812 FG4	6	16. What are some of the "access to care" issues?	In rural Oklahoma, patients don t want to be identified as "welfare".	6ac
812 FG4	6	16. What are some of the "access to care" issues?	Figure out what to do with Mental Health services so that primary care providers know what is happening to their patients. Limit of acute services, 3 visits to crisis center is probably not best continuity of care.	6ac
812 FG4	6	16. What are some of the "access to care" issues?	There should be some kind of individual case management of each patient and coordination of services including social services, medications, and mental health should be under one coordinator who helps the patient navigate the system. The primary care physician should be the primary one in the pile who coordinates or oversees that care. If we don't fill in the gaps, the dysfunctional care continues	6ac
1029 FG77	8	19. Q. & A. "How are you going to pile more people into a system when there are already too many adults, no prescription accessibility, and the auto assign of the patients doesn't work?	Patients end up in odd-ball places—completely away from where they live or where they have transportation to."	6ac
812 FG1	7	4. If you were able to make Medicaid changes, what would those be?	Monitor beneficiary fraud. There seem to be young health people who have access to care and children and older patients who do not. "I am not opposed to beneficiary mothers having health care, I think they should have some but there should be a deductible or something in place that would limit their access".	6ac
99 FG40	3	6. General Unsolicited Comments	F.P. Phy. - "I know of an Endocrinologist that won't see Medicare patients. It is not because of reimbursement – it is because that physician cannot take care of the patient (routine testing) because of the restrictions – I think that happens with Medicaid as well."	6ac
115 FG81	7	6. General Unsolicited Comments	I have never been successful in getting patients referred to the University for adults at all	6ac
1029 FG77	8	6. General Unsolicited Comments	Provider who practices in both states (Oklahoma and Arkansas): "90% if Arkansas physicians participate in Medicaid which also gives us better access to specialists".	6ac
99 FG39	2	7. Informal Discussion	"There should be a way that Medicaid patients could access the (dental) schools –they could be entered into a system for easy access - it shouldn't be so difficult."	6ac
99 FG40	3	7. Informal Discussion	Hosp. Admin. - "Because many of the Medicaid recipients are generational – they aren't educated about access. They may be with a physician for awhile and be auto assigned – many of them have no idea what to do or where to go."	6ac
99 FG40	3	7. Informal Discussion	Hosp. Admin. - "Did you know for access to a pediatric neurologist consult we have to send people to Tulsa – these are typically people with no transportation."	6ac
99 FG40	3	7. Informal Discussion	Hosp. Admin. - "Patients here in this community aren't able to get the consultations they need, because of their insurance (Medicaid) we are unable to get specialists to see them."	6ac
1016 FG67	5	7. Informal Discussion	Determine how to have insurance that has the specialist care. One good thing about Prime Advantage is that they help the primary care physician find a specialist for the patient to see	6ac
1028 FG76	6	7. Informal Discussion	It worries me because if I have to send a patient to the neurosurgeon there isn't one for me to send my patient to that doesn't have to wait almost a year.	6ac
1028 FG76	6	7. Informal Discussion	Oklahoma should consider regional areas of care, i.e. for acute care there would be centers for stabilization, i.e. heart attacks, etc	6ac
102 FG58	8	7. Informal Discussion	Specialty physicians participating in Medicaid are non-existent	6ac
102 FG58	8	7. Informal Discussion	Specialists will take care of the patient if the hospital assures the specialist that the hospital will pay for the procedure	6ac
930 FG56	9	7. Informal Discussion	Top providers here limit the number of Medicaid deliveries in town that they will take	6ac
930 FG56	9	7. Informal Discussion	Access to specialists is almost non existent. Neurology is the number one problem. I saw the patient in early September, neurology at OU Medical center can see them in February. Private practice neurologists will not take Medicaid. Access to ENT specialists are also a problem—especially for kids.	6ac

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Group ID	People Present	Question	Comment	Theme Code
115 FG81	7	7. Informal Discussion	We have no access to specialist in this area	6ac
1027 FG75	10	7. Informal Discussion	There is a huge problem now in access for children to medical services. If you add 450,000 people how will you be able to care for the children? I think the only way to increase providers is to increase reimbursement	6ac
1023 FG72	8	7. Informal Discussion	If the patients want a particular specialist, sometimes, they just come up with the money to pay for it. They have $$ to pay for what they want	6ac
1113 FG85	11	7. Informal Discussion	OHCA is forcing us (docs) to practice outside the standard of care (regarding access)	6ac
812 FG1	7	1. If there were more Oklahomans insured, what would be the impact to the health care in Oklahoma?	Preventive Care seems to be essential since the amount of care to stay healthy seems to be less that what is being provided because the patients are more complicated. <ChEERFUL>	7cm
910 FG45	14	10. Should providers be paid more at the expense of providers care for fewer beneficiaries? Oregon has forced the citizens of their state to make this decision on how to spend the funds.	Suggestion that Medicaid consider a bare bones formulary for chronic disease that the patients would be able to have access to, i.e. diabetic medications, ace inhibitors, beta blockers, diuretics. These would be easily accessible to those individuals who would need these essential medications to keep them out of the hospitals. Also hospitals might consider funding a Primary Care managed care group that would see individuals in a chronic disease model in order to keep patients out of the hospital and medications regulated. One Dr. thought that the Hospital Foundation did that years ago and that is what funded the women's clinics in Tulsa.	7cm
107 FG60	7	4. If you were able to make Medicaid changes, what would those be?	Maybe everyone should be covered for preventive care and have Medicaid only for the catastrophic illnesses	7cm
1015 FG65	8	6. General Unsolicited Comments	Which is cheaper, a hospital stay or Plavix (example)"	7cm
1017 FG68	5	6. General Unsolicited Comments	Free clinic in Pauls Valley called "Good News Clinic". It is held one Saturday per month at the Health Department and the first 25 people are seen.	7cm
115 FG81	7	7. Informal Discussion	The Medicaid patient is the least compliant and they have the most health problems	7cm
115 FG81	7	7. Informal Discussion	Pay people on SoonerCare to have their preventive measures, ,i.e. GYN exam, childhood immunizations, etc.	7cm

Appendix F

Summary Data

Short Survey Results

Frequencies - Breakdown of Provider Types

Statistics

Provider Type

N	Valid	846
	Missing	0

Provider Type

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Admin	3	.4	.4	.4
	ARNP	5	.6	.6	.9
	DDS	62	7.3	7.3	8.3
	DO	36	4.3	4.3	12.5
	MD	283	33.5	33.5	46.0
	PA	15	1.8	1.8	47.8
	R.Ph.	54	6.4	6.4	54.1
	Unknown	388	45.9	45.9	100.0
	Total	846	100.0	100.0	

Summarize - Fair Reimbursement (ALL*)

***No R.Ph. or DDS as they are not Applicable**

Case Processing Summary

	Cases					
	Included		Excluded		Total	
	N	Percent	N	Percent	N	Percent
Fair Reimbursement - ALL*	663	78.4%	183	21.6%	846	100.0%

Case Summaries

Fair Reimbursement - ALL*

Mean	Median
99.6742	100.0000

T-Test - Fair Reimbursement (ALL*)

One-Sample Statistics

	N	Mean	Std. Deviation	Std. Error Mean
Fair Reimbursement - ALL*	663	99.6742	35.44076	1.37641

One-Sample Test

	Test Value = 0					
	t	df	Sig. (2-tailed)	Mean Difference	95% Confidence Interval of the Difference	
					Lower	Upper
Fair Reimbursement - ALL*	72.416	662	.000	99.6742	96.9716	102.3769

Summarize - Fair Reimbursement (Physcian)

Case Processing Summary

	Cases					
	Included		Excluded		Total	
	N	Percent	N	Percent	N	Percent
Fair Reimbursement - Physicians	298	35.2%	548	64.8%	846	100.0%

Case Summaries

Fair Reimbursement - Physicians

Mean	Median
101.7852	100.0000

Summarize - Fair Reimbursement (Other**)

** Includes ARNP, PA, and Administrators

Case Processing Summary

	Cases					
	Included		Excluded		Total	
	N	Percent	N	Percent	N	Percent
Fair Reimbursement - Other**	21	2.5%	825	97.5%	846	100.0%

Case Summaries

Fair Reimbursement - Other**

Mean	Median
85.7143	90.0000

T-Test - Fair Reimbursement (Physicians)

One-Sample Statistics

	N	Mean	Std. Deviation	Std. Error Mean
Fair Reimbursement - Physicians	298	101.7852	32.11093	1.86014

One-Sample Test

	Test Value = 0					
	t	df	Sig. (2-tailed)	Mean Difference	95% Confidence Interval of the Difference	
					Lower	Upper
Fair Reimbursement - Physicians	54.719	297	.000	101.7852	98.1245	105.4460

T-Test - Fair Reimbursement (Other**)

One-Sample Statistics

	N	Mean	Std. Deviation	Std. Error Mean
Fair Reimbursement - Physicians	298	101.7852	32.11093	1.86014
Fair Reimbursement - Other**	21	85.7143	20.08020	4.38186

One-Sample Test

	Test Value = 0					
	t	df	Sig. (2-tailed)	Mean Difference	95% Confidence Interval of the Difference	
					Lower	Upper
Fair Reimbursement - Physicians	54.719	297	.000	101.7852	98.1245	105.4460
Fair Reimbursement - Other**	19.561	20	.000	85.7143	76.5739	94.8547

Summarize - Fair Reimbursement Urban/Rural*

Case Processing Summary

	Cases					
	Included		Excluded		Total	
	N	Percent	N	Percent	N	Percent
Fair Reimbursement - Urban*	405	47.9%	441	52.1%	846	100.0%
Fair Reimbursement - Rural*	216	25.5%	630	74.5%	846	100.0%

Case Summaries

	Fair Reimbursement - Urban*	Fair Reimbursement - Rural*
Mean	100.8370	99.2222
Median	100.0000	100.0000

T-Test - Fair Reimbursement by Urban/Rural*

One-Sample Statistics

	N	Mean	Std. Deviation	Std. Error Mean
Fair Reimbursement - Urban*	405	100.8370	33.38262	1.65880
Fair Reimbursement - Rural*	216	99.2222	39.13324	2.66268

One-Sample Test

	Test Value = 0					
	t	df	Sig. (2-tailed)	Mean Difference	95% Confidence Interval of the Difference	
					Lower	Upper
Fair Reimbursement - Urban*	60.789	404	.000	100.8370	97.5761	104.0980
Fair Reimbursement - Rural*	37.264	215	.000	99.2222	93.9739	104.4705

Summarize - Co-Payments Collected

Case Processing Summary

	Cases					
	Included		Excluded		Total	
	N	Percent	N	Percent	N	Percent
Copayments Collected	727	85.9%	119	14.1%	846	100.0%

Case Summaries

Copayments Collected

Mean	Median
28.9821	5.0000

T-Test - Co-Payments Collected

One-Sample Statistics

	N	Mean	Std. Deviation	Std. Error Mean
Copayments Collected	727	28.9821	31.55485	1.17030

One-Sample Test

	Test Value = 0					
	t	df	Sig. (2-tailed)	Mean Difference	95% Confidence Interval of the Difference	
					Lower	Upper
Copayments Collected	24.765	726	.000	28.9821	26.6845	31.2797

Summarize - Co-Payments Collected by Provider Type

Case Processing Summary

	Cases					
	Included		Excluded		Total	
	N	Percent	N	Percent	N	Percent
Co-Payments Collected - Physicians	278	32.9%	568	67.1%	846	100.0%
Co-Payments Collected - Pharmacists	49	5.8%	797	94.2%	846	100.0%
Co-Payments Collected - Other	61	7.2%	785	92.8%	846	100.0%

Case Summaries

	Co-Payments Collected - Physicians	Co-Payments Collected - Pharmacists	Co-Payments Collected - Other
Mean	25.2068	64.1327	20.2869
Median	5.0000	87.5000	5.0000

T-Test - Co-Payments Collected by Provider Types

One-Sample Statistics

	N	Mean	Std. Deviation	Std. Error Mean
Co-Payments Collected - Physicians	278	25.2068	29.42710	1.76492
Co-Payments Collected - Pharmacists	49	64.1327	33.23508	4.74787
Co-Payments Collected - Other	61	20.2869	27.23011	3.48646

One-Sample Test

	Test Value = 0					
					95% Confidence Interval of the Difference	
	t	df	Sig. (2-tailed)	Mean Difference	Lower	Upper
Co-Payments Collected - Physicians	14.282	277	.000	25.2068	21.7325	28.6812
Co-Payments Collected - Pharmacists	13.508	48	.000	64.1327	54.5864	73.6789
Co-Payments Collected - Other	5.819	60	.000	20.2869	13.3129	27.2608

Summarize - Co-Payments Collected by Urban/Rural

Case Processing Summary

	Cases					
	Included		Excluded		Total	
	N	Percent	N	Percent	N	Percent
Co-Payments Collected - Urban	411	48.6%	435	51.4%	846	100.0%
Co-Payments Collected - Rural	277	32.7%	569	67.3%	846	100.0%

Case Summaries

	Co-Payments Collected - Urban	Co-Payments Collected - Rural
Mean	28.5158	29.9097
Median	5.0000	5.0000

T-Test - Co-Payments Collected by Urban/Rural

One-Sample Statistics

	N	Mean	Std. Deviation	Std. Error Mean
Co-Payments Collected - Urban	411	28.5158	31.13042	1.53555
Co-Payments Collected - Rural	277	29.9097	32.69300	1.96433

One-Sample Test

	Test Value = 0					
	t	df	Sig. (2-tailed)	Mean Difference	95% Confidence Interval of the Difference	
					Lower	Upper
Co-Payments Collected - Urban	18.570	410	.000	28.5158	25.4973	31.5343
Co-Payments Collected - Rural	15.226	276	.000	29.9097	26.0428	33.7767

Correlations - Co-Payments Collected vs. Urban/Rural

Correlations

		Copayments Collected	Urban vs. Rural
Copayments Collected	Pearson Correlation	1	-.022
	Sig. (2-tailed)	.	.573
	N	727	688
Urban vs. Rural	Pearson Correlation	-.022	1
	Sig. (2-tailed)	.573	.
	N	688	779

Summarize

Case Processing Summary

	Cases					
	Included		Excluded		Total	
	N	Percent	N	Percent	N	Percent
Copayments Collected * Provider Type	727	85.9%	119	14.1%	846	100.0%

Case Summaries

Copayments Collected

Provider Type	Mean	Median	N
Admin	43.3333	37.5000	3
ARNP	5.0000	5.0000	4
DDS	20.8125	5.0000	40
DO	27.2500	17.5000	30
MD	24.9597	5.0000	248
PA	18.2143	5.0000	14
R.Ph.	64.1327	87.5000	49
Unknown	28.5619	17.5000	339
Total	28.9821	5.0000	727

Frequencies

Statistics

Confidence - Copayment Question Response

N	Valid	744
	Missing	102

Confidence - Copayment Question Response

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not at All Confident	84	9.9	11.3	11.3
	Somewhat Confident	153	18.1	20.6	31.9
	Confident	191	22.6	25.7	57.5
	Very Confident	316	37.4	42.5	100.0
	Total	744	87.9	100.0	
Missing	System	102	12.1		
Total		846	100.0		

LONG SURVEY RESULTS

Summarize - Fair Reimbursement (ALL*)

Case Processing Summary

	Cases					
	Included		Excluded		Total	
	N	Percent	N	Percent	N	Percent
Fair Reimbursement - ALL*	191	79.3%	50	20.7%	241	100.0%

Case Summaries

Fair Reimbursement - ALL*

Mean	Median
98.3927	100.0000

T-Test - Fair Reimbursement (ALL*)

One-Sample Statistics

	N	Mean	Std. Deviation	Std. Error Mean
Fair Reimbursement - ALL*	191	98.3927	32.62349	2.36055

One-Sample Test

	Test Value = 0					
					95% Confidence Interval of the Difference	
	t	df	Sig. (2-tailed)	Mean Difference	Lower	Upper
Fair Reimbursement - ALL*	41.682	190	.000	98.3927	93.7364	103.0489

Summarize - Fair Reimbursement by Provider Type**

Case Processing Summary

	Cases					
	Included		Excluded		Total	
	N	Percent	N	Percent	N	Percent
Fair Reimbursement - Other**	33	13.7%	208	86.3%	241	100.0%
Fair Reimbursement - Physicians	156	64.7%	85	35.3%	241	100.0%

Case Summaries

	Fair Reimbursement - Other**	Fair Reimbursement - Physicians
Mean	92.4242	99.6987
Median	100.0000	100.0000

T-Test - Fair Reimbursement by Provider Type **

One-Sample Statistics

	N	Mean	Std. Deviation	Std. Error Mean
Fair Reimbursement - Physicians	156	99.6987	35.40502	2.83467
Fair Reimbursement - Other**	33	92.4242	14.14883	2.46300

One-Sample Test

	Test Value = 0					
					95% Confidence Interval of the Difference	
	t	df	Sig. (2-tailed)	Mean Difference	Lower	Upper
Fair Reimbursement - Physicians	35.171	155	.000	99.6987	94.0991	105.2983
Fair Reimbursement - Other**	37.525	32	.000	92.4242	87.4073	97.4412

Summarize - Fair Reimbursement by Urban/Rural*

Case Processing Summary

	Cases					
	Included		Excluded		Total	
	N	Percent	N	Percent	N	Percent
Fair Reimbursement - Urban*	110	45.6%	131	54.4%	241	100.0%
Fair Reimbursement - Rural*	79	32.8%	162	67.2%	241	100.0%

Case Summaries

	Fair Reimbursement - Urban*	Fair Reimbursement - Rural*
Mean	97.0273	101.2025
Median	100.0000	100.0000

T-Test - Fair Reimbursement by Urban/Rural*

One-Sample Statistics

	N	Mean	Std. Deviation	Std. Error Mean
Fair Reimbursement - Urban*	110	97.0273	23.01514	2.19441
Fair Reimbursement - Rural*	79	101.2025	42.72163	4.80656

One-Sample Test

	Test Value = 0					
	t	df	Sig. (2-tailed)	Mean Difference	95% Confidence Interval of the Difference	
					Lower	Upper
Fair Reimbursement - Urban*	44.216	109	.000	97.0273	92.6780	101.3765
Fair Reimbursement - Rural*	21.055	78	.000	101.2025	91.6334	110.7717

Correlations - Fair Reimbursement by Urban/Rural*

Correlations

		Fair Reimbursement - ALL*	Urban vs. Rural
Fair Reimbursement - ALL*	Pearson Correlation	1	-.064
	Sig. (2-tailed)	.	.387
	N	191	183
Urban vs. Rural	Pearson Correlation	-.064	1
	Sig. (2-tailed)	.387	.
	N	183	233

Summarize - Fair Reimbursement by Medicaid Opinion

Case Processing Summary

	Cases					
	Included		Excluded		Total	
	N	Percent	N	Percent	N	Percent
Fair Reimbursement - ALL* * Medicaid Opinion	189	78.4%	52	21.6%	241	100.0%

Case Summaries

Fair Reimbursement - ALL*

Medicaid Opinion	Mean	Median
Very Negative	104.9123	100.0000
Negative	94.8132	100.0000
No Opinion	95.7895	100.0000
Positive	99.5238	100.0000
Very Positive	80.0000	80.0000
Total	98.4021	100.0000

T-Test - Fair Reimbursement by Opinion of Medicaid*

One-Sample Statistics

	N	Mean	Std. Deviation	Std. Error Mean
Fair Reimbursement - Very Negative Opinion of Medicaid*	57	104.9123	54.05430	7.15967
Fair Reimbursement - Negative Opinion of Medicaid*	91	94.8132	14.15620	1.48397
Fair Reimbursement - No Opinion for Opinion of Medicaid*	19	95.7895	21.09918	4.84048
Fair Reimbursement - Positive Opinion of Medicaid*	21	99.5238	18.63496	4.06648
Fair Reimbursement - Very Positive Opinion of Medicaid*	1[a]	80.0000	.	.

a. t cannot be computed because the sum of caseweights is less than or equal 1.

One-Sample Test

	Test Value = 0					
					95% Confidence Interval of the Difference	
	t	df	Sig. (2-tailed)	Mean Difference	Lower	Upper
Fair Reimbursement - Very Negative Opinion of Medicaid*	14.653	56	.000	104.9123	90.5697	119.2548
Fair Reimbursement - Negative Opinion of Medicaid*	63.891	90	.000	94.8132	91.8650	97.7614
Fair Reimbursement - No Opinion for Opinion of Medicaid*	19.789	18	.000	95.7895	85.6200	105.9590
Fair Reimbursement - Positive Opinion of Medicaid*	24.474	20	.000	99.5238	91.0413	108.0063

T-Test - Fair Reimbursement by Medicaid Opinion* (Consolidated)

One-Sample Statistics

	N	Mean	Std. Deviation	Std. Error Mean
Fair Reimbursement - Negative/Very Negative	148	98.7027	35.49791	2.91791
Fair Reimbursement - Positive/Very Positive	22	98.6364	18.65615	3.97750

One-Sample Test

	Test Value = 0					
	t	df	Sig. (2-tailed)	Mean Difference	95% Confidence Interval of the Difference	
					Lower	Upper
Fair Reimbursement - Negative/Very Negative	33.827	147	.000	98.7027	92.9362	104.4692
Fair Reimbursement - Positive/Very Positive	24.799	21	.000	98.6364	90.3647	106.9080

Summarize - Fair Reimbursement by Medicaid Provider Status*

Case Processing Summary

	Cases					
	Included		Excluded		Total	
	N	Percent	N	Percent	N	Percent
Fair Reimbursement - ALL* * Medicaid Provider Status	188	78.0%	53	22.0%	241	100.0%

Case Summaries

Fair Reimbursement - ALL*

Medicaid Provider Status	Mean	Median
No	92.1875	100.0000
Yes	99.8269	100.0000
Total	98.5266	100.0000

T-Test - Fair Reimbursement by Medicaid Provider Status*

One-Sample Statistics

	N	Mean	Std. Deviation	Std. Error Mean
Fair Reimbursement - Provide Medicaid*	156	99.8269	32.79500	2.62570
Fair Reimbursement - Does Not Provide Medicaid*	32	92.1875	32.89616	5.81527

One-Sample Test

	Test Value = 0					
	t	df	Sig. (2-tailed)	Mean Difference	95% Confidence Interval of the Difference	
					Lower	Upper
Fair Reimbursement - Provide Medicaid*	38.019	155	.000	99.8269	94.6401	105.0137
Fair Reimbursement - Does Not Provide Medicaid*	15.853	31	.000	92.1875	80.3272	104.0478

Appendix G

Glossary of Statistical Terms

Statistical Glossary

1. **Cases** – The number of cases (count) for all the cases measured that fit into the specified category.
2. **Mean** – The average value of all the cases measured that fit into the specified category.
3. **Median** – The "center" value for all the cases measured that fit into the specified category.
4. **Pearson Correlation Coefficient** – The *degree* of relationship between two variables.
    a. 1 – perfect correlation
    b. 0 – No correlation
    c. -1 – perfect negative correlation
5. **Percentage** – A calculated percentage of cases for a pre-defined categorical variable as compared to all the cases that fit into the specified category.
6. **Significance (p-value)** – the p-value represents the probability of error that is involved in accepting our observed result as valid, that is, as "representative of the population." For example, a p-value of .05 (i.e. 1/20) indicates that there is a 5% probability that the relation between the variables found in our sample is a "fluke."
7. **Trend Analysis** - the identification of trends within the data to determine specific categories (i.e. demographic) of data that demonstrate strong influences on the measured statistic.

Appendix H

Biographical Sketches of Program Staff

Biographical Sketches of Program Staff

Steven A. Crawford, M.D.
The Christian N. Ramsey, Jr., M.D., Endowed Chair in Family Medicine
Department of Family and Preventive Medicine

Steven A. Crawford, M.D., is the University of Oklahoma, College of Medicine's Christian N. Ramsey, Jr., M.D., Chair in Family Medicine. Dr. Crawford graduated Magna cum laude from Claremont McKenna College in 1975 and from the University of Illinois, College of Medicine in 1979. He completed his residency training at the Waco Family Practice Residency Program in 1982 and a family medicine teaching fellowship, also in Waco, in 1983. Dr. Crawford served as chair of the family medicine department at the Oklahoma City Clinic, a private for-profit, physician-owned, multi-specialty group practice, from 1989 until 1998. He has served as Professor and Chair of the Department of Family and Preventive Medicine since 1999. His prior appointments include Interim Chair, Vice-Chair, Residency Program Director, and Associate Residency Program Director at OU. He has also served as Chief of the Family Medicine Service at the OU Medical Center since 1990 and Chairman of the OU Medical Center Board of Trustees since 2000.

Dr. Crawford has served as the elected president of the Oklahoma County Medical Society in 2002 and served as the president of the Oklahoma Academy of Family Physicians in 1994. He has also served as Chair of the Oklahoma Health Care Authority's Medical Advisory Committee and in many other professional positions over his career.

Garth L. Splinter, M.D., MBA
Division Head, Primary Care Health Policy Division

Dr. Garth Splinter began his post-secondary education at the University of Oklahoma where he majored in industrial engineering, receiving his Bachelor of Science degree in 1974. He then enrolled at Harvard University's business school where he earned his MBA in 1976 He graduated from the Oklahoma University College of Medicine in 1984, with a Doctor of Medicine degree. In 1987, Dr. Splinter joined the faculty at the Oklahoma University Health Sciences Center (OUHSC) as the Director of the Health Sciences Center for Health Affairs and Rural Health Programs and part-time Medical Director for the Employees Group Insurance Board. Dr. Splinter served as his Special Assistant on Health Care Issues to Governor David Walters from 1991 – 1994. He was also the Chair of the Commission on Oklahoma Health Care and served as Principal Investigator for the Robert Wood Johnson Grant of State Initiatives on Health Care granted to the Governor's office.

In 1994, Dr. Splinter was appointed by the Governor and approved by the Oklahoma Senate as Chief Executive Officer of the newly created Oklahoma Health Care Authority, working for a seven-person board. During Dr. Splinter's five years as CEO, the Oklahoma Medicaid program was successfully converted to statewide managed care. In 1999, Dr Splinter joined the Department of Family Medicine, University of Oklahoma College of Medicine, as an Associate Professor. From 1999 to 2003, he also served as the Chief Medical Officer of the University Hospitals Trust under a contract with the University. From 2001, to the present he has served as a board member for Ribomed Biotechnologies, Inc., a biotech startup company. From 2003, to the present he has been the Director of the Primary Care Policy Division in the Department of Family Medicine, primarily overseeing the strategic plan development and implementation and overseeing individual policy studies for the State of Oklahoma.

Laine McCarthy, MLIS
Associate Professor and Writer/Analyst, Primary Care Health Policy Division

Laine McCarthy, MLIS, joined the Department of Family & Preventive Medicine on January 1, 1984 as a Research Assistant. She served as a Senior Administrative Manager and as a Technical Writer before her promotion to the rank of Instructor on January 1, 1995. In June, 1998, Ms. McCarthy was promoted to Clinical Assistant Professor, then in June 2001, she received promotion to Clinical Associate Professor. She has a BA degree in English Education from the University of Arizona-Tucson, and a Masters in Library and Information Studies from the University of Oklahoma-Norman. Ms. McCarthy is a member of Beta Phi Mu, the International Library and Information Studies Honor Society, Society of Teachers of Family Medicine, Oklahoma Library Association, American Library Association and the Medical Library Association.

During her tenure with the University, Ms. McCarthy has been the recipient of several education and training grants including two grants from the Bureau of Health Professions, Health Research and Services Administration (HRSA), US Department of Health and Human Services. The first grant was awarded in 1992 ($320,000) to establish a library in the Department of Family & Preventive Medicine, and develop and implement a residency curriculum in evidence-based medicine. The second grant, awarded in 1998 ($500,000), established a faculty information technology training program for in-house and community physicians. She has presented the results of these grant programs in several national forums including the Society of Teachers of Family Medicine and the American Academy of Family Physicians. Ms. McCarthy is also the author of numerous manuscripts and books on a variety of topics including primary prevention of microalbuminuria (published in the Journal of Family Practice), writing case reports, medical terminology and evidence-based medicine. She has participated in the design and conduct of numerous successful research projects, and currently serves as writer/analyst for the It's Health Care Not Welfare project as a faculty member in the Division of Primary Care Health Policy.

Sarah D. Hyden
Projects Coordinator, Primary Care Health Policy Division

Sarah Hyden joined the University of Oklahoma Health Sciences Center (OUHSC), Department of Family and Preventive Medicine, Primary Care Health Policy Division as Project Coordinator in May of 2003. She holds a Bachelor of Science degree from Southern Nazarene University. Prior to joining OUHSC, she spent six years in healthcare sales and marketing field, with a focus on outreach and contact management, specifically with physicians and other health practitioners. Sarah Hyden is responsible for supervision of projects within the Primary Care Health Policy Division. Additionally, ensures all work requirements and time deadlines are met; establishes protocol for completion of grants, contracts and/or Division research and analysis projects. Conducts research projects including presentations, survey administration and data collection to targeted populations throughout Oklahoma. The Primary Care Health Policy Division is currently conducting a series of studies for the Oklahoma Health Care Authority investigating opinions, attitudes and interest regarding the Medicaid expansion through statewide meetings and mailed surveys from various health care stakeholder groups including beneficiaries, low-income workers, small business employers, physicians and other health care professionals.

Denise M. Brown, PHR
Associate Project Coordinator, Primary Care Health Policy Division

Denise Brown has been in the healthcare field since 1974. Denise has been with the University of Oklahoma Health Sciences Center (OUHSC) since 1984 and joined the Department of Family and Preventive Medicine in 1989. Ms. Brown holds a Bachelor of Science degree in Social Work and is a certified Professional in Human Resources. She has an extensive background in human resource, administrative and hospital based management; including patient and employee relations. As Associate

Project Coordinator she works closely with the Projects Coordinator to develop mailing lists to strategically cover the state of Oklahoma; schedules and assists with the coordination of discussion groups; attends and provides information for discussion groups; contacts providers and participants to attend discussion groups and reviews project reports.

Rob M. How, MBA
Project Specialist, Primary Care Health Policy Division

Rob How is the project specialist for the Primary Care Health Policy Division. Rob How joined the University of Oklahoma Health Sciences Center, Department of Family Medicine in May of 2003. He obtained his Bachelors of Science in Civil Engineering and Masters in Business Administration from Colorado State University, and has approximately 10 years experience as a consultant in private industry with expertise in project coordination and administration, process and technology analysis, data and quality management, business implementations and change management. As Project Specialist, his primary responsibilities are focused on the data analysis and statistical reporting activities for the Primary Care Health Policy Division. His knowledge and experience in utilizing tools such as SPSS, MS-Excel and MS-Access allows systematical and methodical processes to collect, enter, track, analyze and report data used by the division. He is also responsible for assisting in project setup, administration and tracking, quality control and quality assurance, technology and process design and overall project support.

Kristin B. Sawyer, MLIS
Staff Assistant, Primary Care Health Policy Division

Kristin Sawyer joined the Primary Care Health Policy Division in July of 2003. She received her Master in Library and Information Studies, University of Oklahoma, Norman, Oklahoma, 1996. Kristin Sawyer's primary responsibilities are focused on the research of health information and data input for statistical appraisal. She obtains information through statewide meetings, mailed surveys, Internet databases, health-related Web sites, Congressional records, press releases, and medical literature. Other team responsibilities include co-coordinating arrangements for focus group meetings for physicians and other health care providers, business owners, and beneficiaries of health care plans and maintaining quality control and quality assurance for all data.

Shirley N. Massey
Staff Assistant, Primary Care Health Policy Division

Shirley Massey has been employed at the Health Sciences Center in the Family Medicine Department as Staff Assistant to Dr. James L. Brand, Associate Professor for the past 10 years. She attended Texas Wesleyan College in Fort Worth, Texas. Shirley has extensive experience in the health care and public relations fields including managerial experience in insurance claims, dentistry, education and health care. Shirley's role within the division has included several administrative tasks, specifically with the rural preceptor program.

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