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?*

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*)

Median	Mean	95% CI of the 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)

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 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.[3] When they do, providers report reduced overhead saving them time and money, increased profits, and a more responsive and responsible clientele. Recent increases in medical malpractice (as much as 82%) forces many providers to make difficult decisions about the financial solvency of their medical practice. As one provider said, "I can't help anyone if I'm out of business."

Providers from all groups report collecting less than 30% of required co-pays from Medicaid beneficiaries. Low reimbursement combined with difficulty collecting even a nominal co-pay from patients, contributes to frustration and dissatisfaction. By law, providers must see Medicaid patients whether or not they receive the patient's co-pay. Although the financial impact this has on medical practices may be mitigated somewhat by the increase in reimbursement rate, a concomitant reduction in administrative red-tape and increased patient responsibility would make the program more cost-effective. (Providers and even patients, contend that paying even nominal cost-sharing contributes to patient ownership of and increased responsibility for their health care.)

Solutions voiced by providers include streamlining eligibility verification and pre-authorization, correcting problems with auto-assignment, which moves patients from physician to physician often without their knowledge or consent, long lag times between claims submission and reimbursement and changes to benefits that eliminate or reduce payment for services previously rendered.

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 of Medicaid patients paying the required co-payments.
- Providers report collecting only about 30% of co-pays from Medicaid patients which creates a financial burden for practitioners.

Recommendations

1. Increase reimbursement to approximately 100% of Medicare.

2. Explore methods and policies to increase the percentage of Medicaid patients paying the required co-payments. Providers report collecting less than 30% of co-pays from Medicaid patients. A bonus program for highest percentage of co-pays collected might be explored.

3. Streamline administrative processes to make providing Medicaid services more cost-effective. Efficient and accurate electronic systems for pre-authorization, eligibility verification, and filing and tracking claims should be investigated. Services such as the Pharmacy hotline would be well received.[3]

4. Provider participation in the design and implementation of any reformed program would help ensure success.

Limitations of this Study

Study participants represent all major provider groups in Oklahoma. The data were collected via a broad post-card survey and are thus subject to the biases associated with this type of data collection. Participants were volunteers and had specific issues and concerns, thus their views may not represent the larger group of providers statewide. However, the issues that emerged are consistent with large, national studies and can be used by policymakers to make decisions about health care programs in Oklahoma.

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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.

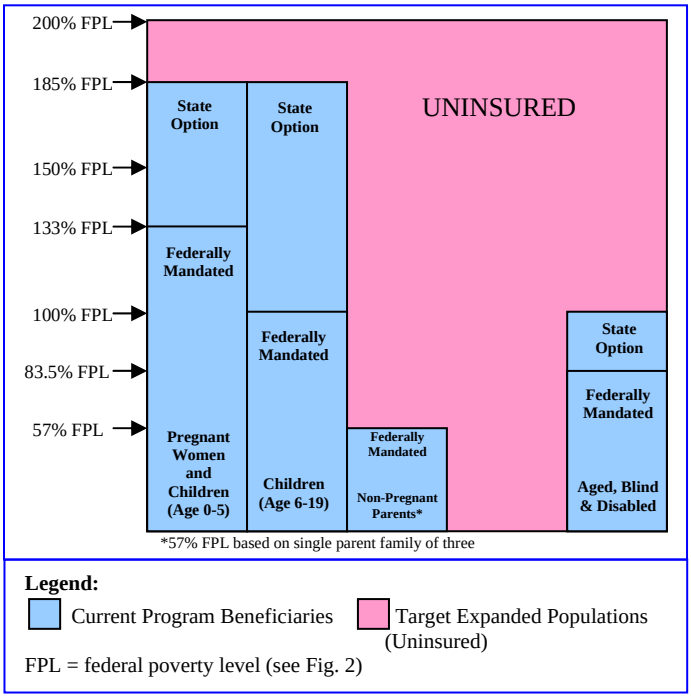


Figure 1. Current and Expansion Medicaid Eligibility

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 stream-lining 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)

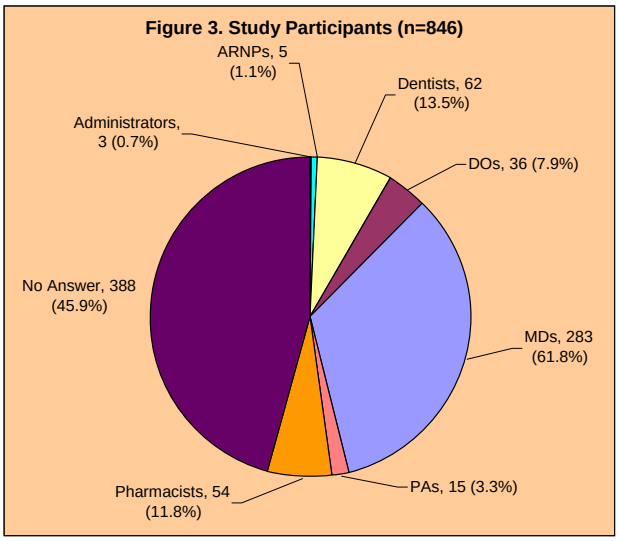
Provider Type	n	%
Administrators	3	0.4%
ARNPs	5	0.6%
Dentists	62	7.3%
Dos	36	4.3%
MDs	283	33.5%
PAs	15	1.8%
Pharmacists	54	6.4%
No Response	388	45.9%
Total	**846**	

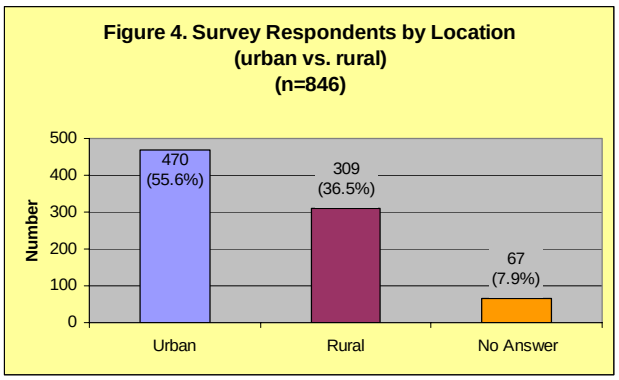
Subjects in this study were drawn from the Oklahoma State Board of Licensure, Oklahoma State Medical Association, the Oklahoma Academy of Family Physicians, the Oklahoma Hospital Association, the Private Pharmacists of Oklahoma and other medical groups, personal contact by DFPM faculty, and word of mouth.

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.

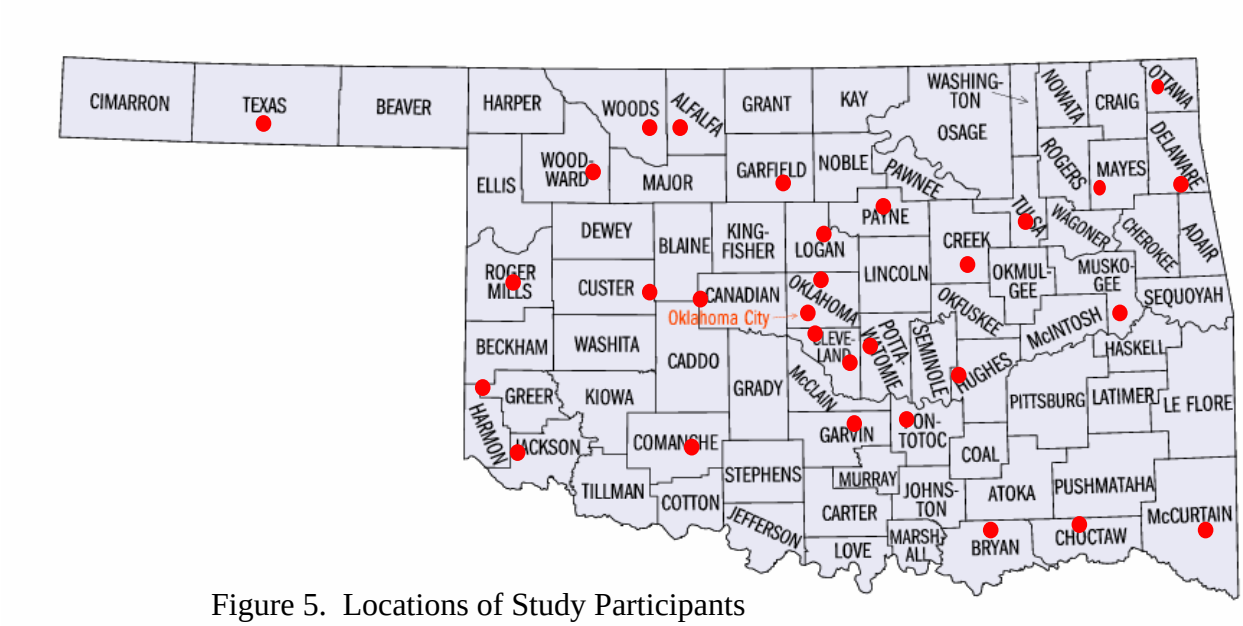


Figure 5. Locations of Study Participants

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

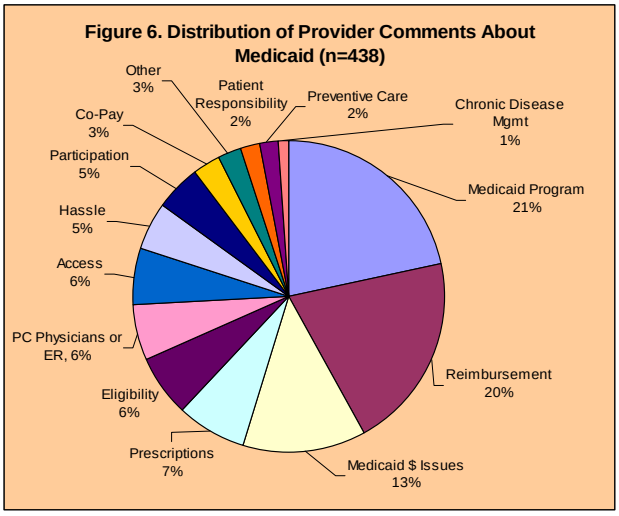
Table 8. Number of Comments by Theme (n=438)

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."



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

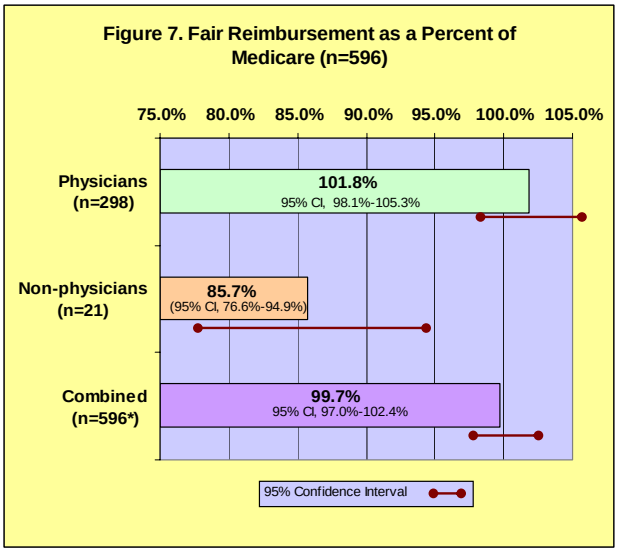
Table 9. Mean and Median Fair Reimbursement as a Percent of Medicare (n=596)

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.

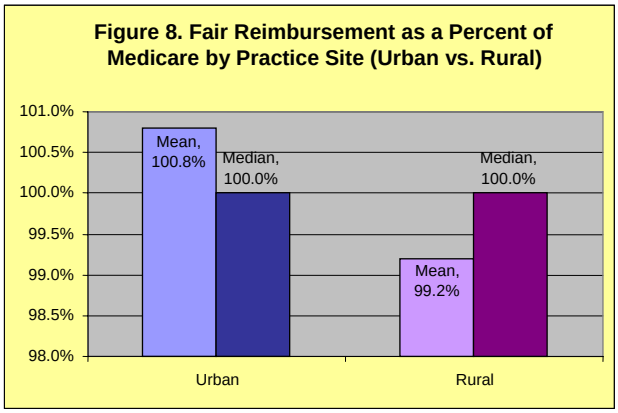
Provider Type: Of the 846 providers who completed the survey, 62 identified themselves as dentists and 54, as pharmacists. After excluding dentists (n=62) and pharmacists (n=54), for whom the Medicare fee structure is not relevant, 663 surveys remained; 67 respondents failed to answer the question. Data 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%-

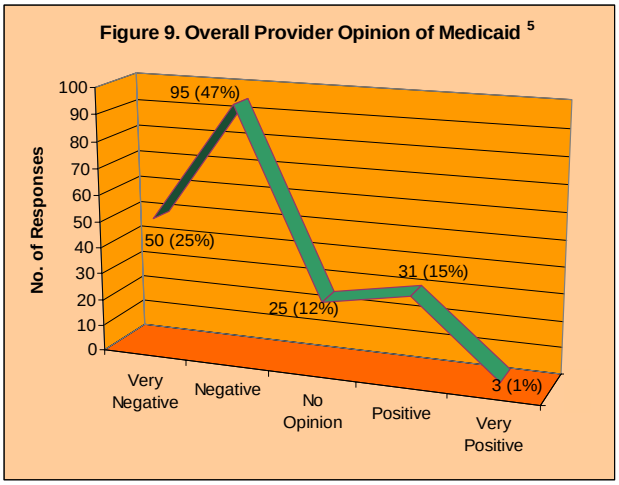
94.9%). Analysis of responses for all providers combined (excluding dentists and pharmacists) yielded a mean of 99.7% (95% CI, 97.0%-102.4%). Thus, a fee structure that approaches 100% of Medicare would be appropriate for all provider groups.

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.*

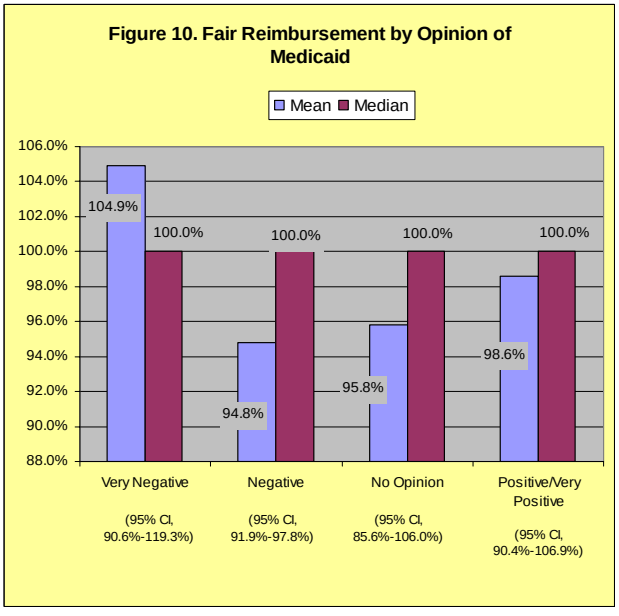


*Data excludes providers who identified themselves as dentists or pharmacists.

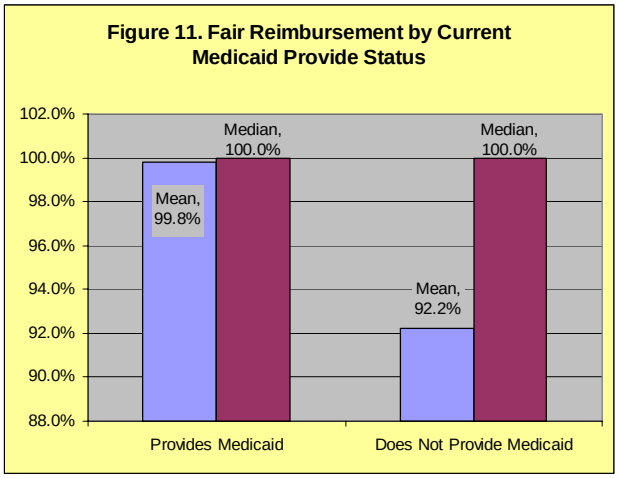
Opinion of Medicaid: In a previous study, providers were asked to rank their feelings about the state's Medicaid program, from Very Negative (1) to Very Positive (5) (Figure 9).[3]



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.



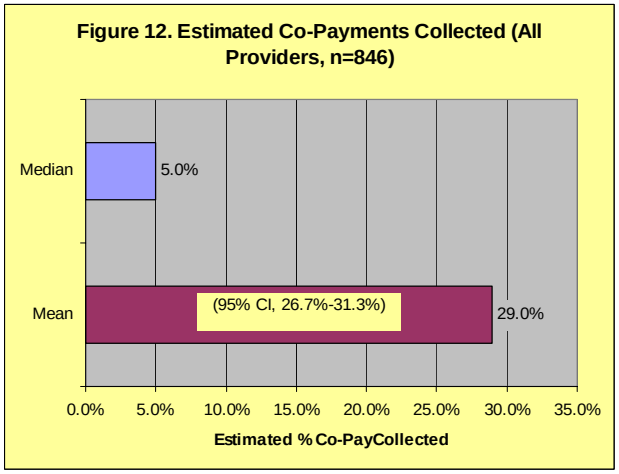
Current Medicaid Provider Status: We analyzed whether current status as a Medicaid provider influenced reimbursement rate (Figure 11). It is interesting to note that for current Medicaid providers, 99.8% percent of Medicare would be appropriate compared with 92.2% for providers who do not currently participate 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).



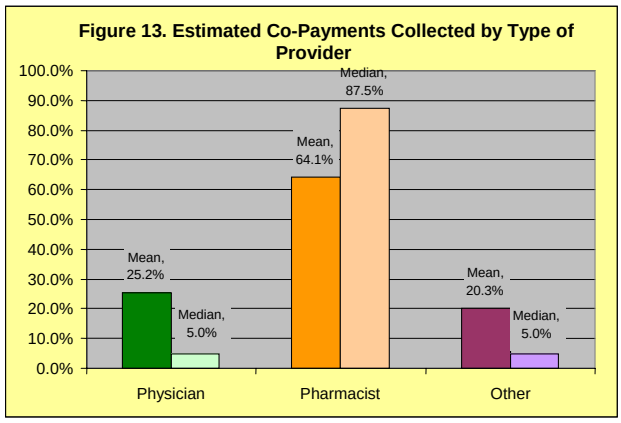
Reducing the administrative burden and building patient responsibility into the system could alleviate some of the problems for providers and make the system more cost effective.*

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).



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).

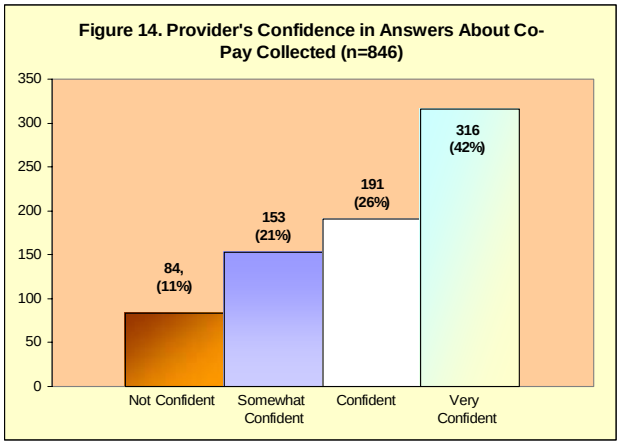


Confidence in Answers About Co-Pay Collected

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.

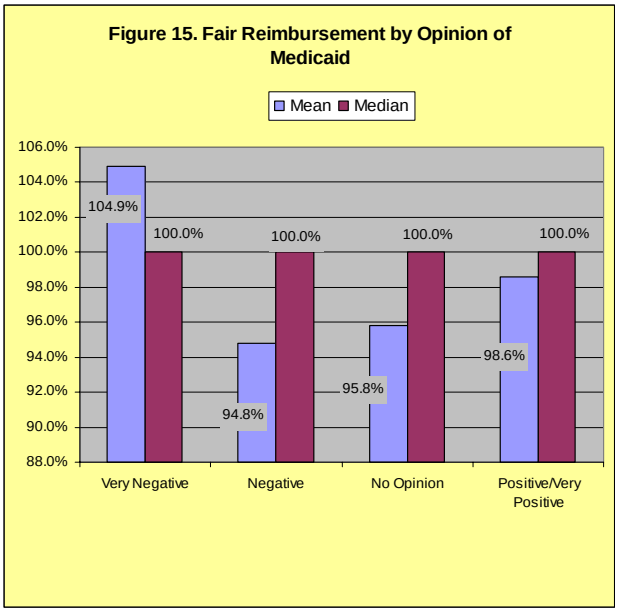
(2) **Small sample size** is a second limitation. Project staff sent out 13,500 post-cards inviting practitioners to participate in a study to provide input to OHCA about possible reforms to the Medicaid program; 846 practitioners returned the post-card, a response rate of only 6%. However, given that 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.



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