IT'S HEALTH CARE, NOT WELFARE

Key Programmatic Elements Needed to Ensure Provider Participation in the Medicaid Health Care Program

Submitted to

The Oklahoma Health Care Authority

December 31, 2003

In partial completion of an interagency agreement. Article IV, Section 4. 4. DFPM shall conduct provider focus groups, including primary care and specialists, to identify the key programmatic elements needed to ensure provider participation.

Health Care Not Welfare Project

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IT'S HEALTH CARE, NOT WELFARE

EXECUTIVE SUMMARY

Key Programmatic Elements Needed to Ensure Provider Participation in the Medicaid Health Care 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 second 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. Physicians and other health care providers were surveyed to enumerate the key changes that would be necessary to ensure the participation of all providers in a reformed Medicaid program. A provider is defined as any individual or institution delivering health care services in Oklahoma eligible to receive Medicaid payment for those services. Although providers from all areas of health care are included, the study reported here focuses on physicians.

A total of 241 health care professionals from across Oklahoma participated in this study. The distribution of providers broken down by provider type is shown in Table 1.

Table 1: Number of Study Participants by Provider Type

Provider Type	n	%
MDs	147	62%
Pharmacists	24	10%
Facility Administrators	22	9%
DOs	16	7%
Nurses/Nurse Practitioners	12	5%
PAs	9	4%
Dentists	8	3%
Total Responses	**238**	
No Response	**3**	
Total Surveys	**241**	

Respondents represent DFPM faculty physicians and providers, urban and rural practices, all specialties, and all types of health care facilities and programs. Most currently participate in Medicaid; 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 key programmatic changes must be implemented to make Medicaid more acceptable to all health care providers?*
2. *Should the Medicaid system maintain financial reserves?*
3. *How should any new monies allocated for Medicaid be spent?*
4. *Do demographic variables, such as type of provider and practice location, influence responses to the above questions?*

*Requiring patients to be more responsible for their own health care will be discussed in a later report.

METHODS

An 11-item survey (Appendix A) was designed for this study; many of the questions had multiple parts.* A document describing the reform options was also developed and disseminated (Appendix B). Surveys and materials were pilot-tested by DFPM faculty.

Subjects were drawn from DFPM faculty, Oklahoma State Board of Licensure, Oklahoma State Medical Association, the Oklahoma Academy of Family Physicians, the State Board of Osteopathic Physicians, the Private Pharmacists of Oklahoma and other medical groups, and personal contact. A post-card survey was mailed to approximately 13,500 physicians and other providers inviting them to participate in discussions about Medicaid reform; 843 providers returned the post-card survey (described in another report), of whom 363 expressed interest in participating in further discussions. A total of 241 providers—163 physicians and 78 non-physician providers—completed the survey. No provider who wanted to participate was excluded. Data were entered into a database and analyzed using a standard statistical database program (SPSS).

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

Participants were asked to rank the key program elements that would have to be addressed to make Medicaid a viable health care program (Table 2). Increased reimbursement ranked first (mean=4.58, on a scale of 1-5, with 1 being not at all important, and 5, very important). Reducing the hassle and red tape ranked second (mean =4.03), followed closely by easier pre-authorizations (mean=4.01).

After controlling for demographic variables, no differences by provider type were found. The focus of this study was on physicians, thus MDs and DOs represent a significant portion of the responders (69%). Physicians are influential players in health care. Successful implementation of a Medicaid reform program will require that their concerns be acknowledged. These results, therefore, have important implications for health care policymakers.

Table 2. Key Programmatic Changes Necessary to Secure Provider Participation in Medicaid

Rank	Item	Mean
1	**Increase Reimbursement**	**4.58**
2	**Reduce "Hassle"**	**4.03**
3	**Easier Pre-authorizations**	**4.01**
4	Greater Access to Specialists	3.86
5	Chronic Disease Management	3.72
6	Fewer Restrictions on Visits	3.64
7	12 Mo. Eligibility Period	3.56
8	Fewer Restrictions: Prescriptions	3.32
9	Fewer Restrictions: Inpatient Days	3.23
10	Case Management Services	2.99
11	Financial Incentives for Volume	2.57

DISCUSSION

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.[1] This figure does not include the countless number of underinsured.[1,2] Health care costs are rising at an alarming rate, forcing states to scramble to find funding for Medicaid services. According to a 1996 study, Oklahoma spent 20% of its state budget on Medicaid, the highest budget percentage of any state.[3] To control costs, states restrict eligibility, reduce benefits, and often severely limit physician reimbursement, making participation in Medicaid a financial hardship on practitioners.

For practitioners, the gratification of providing health care is often overshadowed by paper-

* Items 6 and 7 on the survey will be described in the next report

work, low or no reimbursement, and a morass of covered and uncovered services, eligibility regulations, and third-party payers.[2] Consequently, many are opting out of government programs such as Medicare[4] and Medicaid). When they do, they report reduced overhead saving them time and money, increased profits, and a more responsive patient population.[*] Recent increases in medical malpractice (as much as 82% in some cases) are also forcing 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."

In this study, we asked providers what programmatic changes would be necessary for them–those who are currently serving Medicaid populations and those who are not–to participate in government-sponsored health care. The following were recurrent themes and mirror national studies on this topic:

- Fair reimbursement for services rendered
- Access to consultants based on physician and patient decision making and need
- Straightforward eligibility, benefits and authorization for service process
- Printed and accessible formulary
- Adequate notification of program changes

CONCLUSIONS & RECOMMENDATIONS

Study Conclusions

- Reimbursement for Medicaid services must be increased to an acceptable and financially viable level.
- Eligibility and pre-authorization regulations, formulary policies and other administrative requirements must be streamlined to reduce overhead and frustration.
- Providers and patients must have control of clinical decision making to provide the best patient care possible.

Recommendations

Reimbursement was the primary concern of providers. However, results indicate that streamlining administrative tasks (eg, verifying eligibility, pre-authorizations, prescriptions, getting claims paid) could reduce the overhead associated with Medicaid, making the system more cost effective for providers, saving them time and money. If that can occur, our study found that providers might be willing to negotiate on reimbursement percentage. Possibilities for streamlining program administration are:

1. Electronic systems that facilitate administration and reduce red tape could yield a higher return on investment. Such systems could increase provider satisfaction and increase the likelihood that they would continue to participate in a reformed Medicaid program.

2. Web-based eligibility, pre-authorization and formulary are feasible, and new technology can enable such a system to be effectively safeguarded for privacy. Comments from providers indicate that such a system would be well-received.

3. A web-based question, answer and comment system could be created to help providers get answers to their questions in a timely manner. Providers expressed frustration with not being able to talk to anyone about the problems they were having. They also expressed enthusiasm for the **pharmacy hotline**. More programs like the pharmacy hotline, especially electronic systems, could vastly improve provider acceptance of an expanded Medicaid program.

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

Limitations of this Study

The participants in this study represent all major health care provider groups in Oklahoma. As participants were volunteers and had specific issues and concerns, their views may not represent those of the larger group of providers statewide. However, the issues that emerged in this study are consistent with issues expressed in large, national studies and therefore can be used by policymakers to make decisions about health care programs in Oklahoma.

[*] Requiring patients to be more responsible for their own health care will be discussed in a later report.

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IT'S HEALTH CARE NOT WELFARE

Key Programmatic Elements Needed to Ensure Provider Participation in the Medicaid Health Care Program

ABSTRACT

Background: This report describes the second 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). OHCA, on behalf of the State of Oklahoma, under the authority of Sec. 1115 of the Social Security Act, 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 $18,300; 200% of FPL would be approximately $37,000 for a family of four, see Figure 2.) Figure 1 shows the 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.

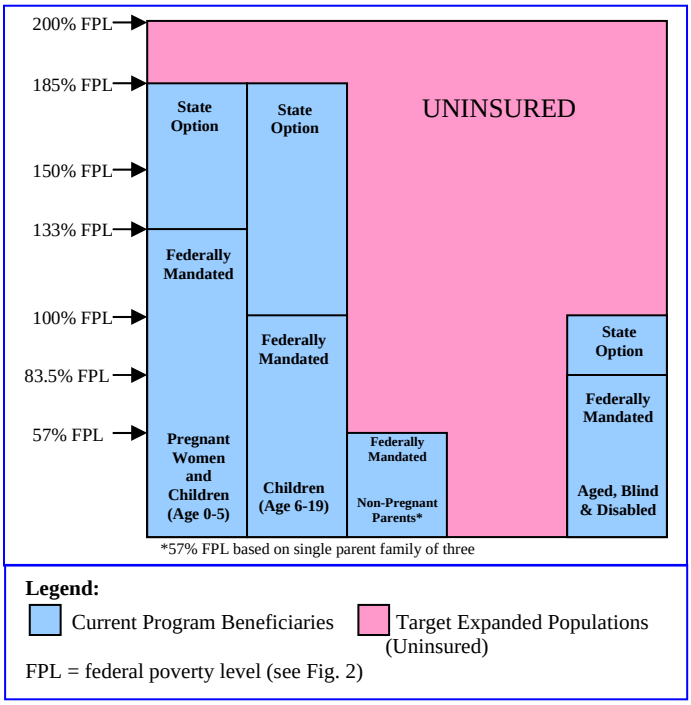

Figure 1. Current and Expansion Medicaid Eligibility

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: The study reported here was conducted to discover the attitudes and opinions of physicians and other health care providers statewide toward reforms to the current Medicaid program. Four major questions were posed:

1. *What key programmatic changes must be implemented to make Medicaid more acceptable to health care providers?*
2. *Should the Medicaid system maintain financial reserves?*
3. *How should any new monies allocated for Medicaid be spent?*
4. *Do demographic variables such as type of provider and practice location, influence the responses to these questions?*

Subjects: At the request of OHCA, this study examined mainly the concerns and issues of physicians (MDs and DOs) in Oklahoma. However, other health care providers were included in the study as well. (The mix of provider types in this study is shown in Table 1.) 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. A total of 241 health care providers (163 physicians and 78 non-physician providers) completed the study survey.

Methods: An 11-item survey was developed and administered to 241 providers. (Two of the items, numbers 6 and 7 regarding reimbursement, will be discussed in a later report.) As mentioned above, materials were pilot tested by DFPM faculty, and their feedback was used to revise the survey tools. In addition, more than 850 physicians and other providers 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. Four hundred and thirty eight (438) comments 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: Low reimbursement was ranked first by providers as the key issue to be addressed in the Medicaid reform program (see Table 2). The second and third ranked issues were excessive administrative burden (hassles) and difficult pre-authorization procedures. When asked in focus groups, providers expressed frustration with the costly red tape and overhead associated with providing Medicaid services and with not being able to easily contact Medicaid to get answers to questions, verify benefits and eligibility, or get claims paid.

Table 3: Participants in this Study by Provider Type, Number and Percent (n=241)

Provider Type	n	%
Facility Administrators	22	9%
Nurses/Nurse Practitioners	12	5%
Dentists	8	3%
DOs	16	7%
MDs	147	62%
PAs	9	4%
Pharmacists	24	10%
Total Responses	**238**	
No Response	**3**	
Total Surveys	**241**	

Of the physicians and other health care providers who have opted out of Medicaid, most reported that their profits went up, their administrative overhead decreased saving them both time and money, the frustration level of staff decreased, and their overall job satisfaction increased. 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.[4] They also report an increase in the level of responsibility of their patient population.*

Table 4. Key Programmatic Changes Necessary to Secure Provider Participation in Medicaid

Rank	Item	Mean
1	**Increase Reimbursement**	**4.58**
2	**Reduce "Hassle"**	**4.03**
3	**Easier Pre-authorizations**	**4.01**
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* Requiring patients to be more responsible for their own health care will be addressed in a later report.

Conclusion: A program that simplifies access to care is the program providers in our study are searching for. This study strongly indicates that physicians and other health care providers would be willing to negotiate reimbursement rates if the administrative burden of providing Medicaid services could be alleviated. Electronic systems, such as web-based eligibility verification and pre-authorization, expedited claims processing, and fair and reasonable reimbursement for services rendered in a timely fashion could provide sufficient financial incentive to make Medicaid participation economically viable for providers.

This report describes the programmatic changes that a group of 241 physicians and other health care providers in Oklahoma felt were essential for Medicaid to be viable in Oklahoma.

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 approximately 41 million Americans who now lack health insurance.[1] The Physicians' Working Group on Single-Payer National Health Insurance and other national studies report similar findings.[2] 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.[4]

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.[2]

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, in particular to specialists within the Medicaid system, is a common frustration voiced by program beneficiaries seeking health care as well as by 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, the first state 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 in fact provide free care and sponsor 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."

The participants' 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 attempting to coordinate Medicaid benefits, file claims filed, and waiting for reimbursement for services rendered, they would rather provide services for free.

Providers are the backbone of the health care system. This report describes the needed programmatic changes to the Medicaid system in Oklahoma in order for that system to be attractive and manageable for providers, particularly for physicians. 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 health care costs. The growing number of uninsured and underinsured (more than 41 million Americans), and the growing disenchantment of physicians and other providers with the 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 was three-fold:

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

(2) To determine the programmatic changes that should be made to the Medicaid program in order to ensure -

  (a) that current Medicaid providers would continue to participate in the program, and,

  (b) that the providers, especially specialists, who do not currently participate in Medicaid would consider entering the system.

(3) To define and elucidate providers' opinion of the current Medicaid program.

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

1. *What key programmatic changes must be implemented to make Medicaid more acceptable to all health care providers?*
2. *Should the Medicaid system maintain financial reserves?*
3. *How should any new monies allocated for Medicaid be spent?*
4. *Do demographic variables, such as type of provider and practice location, influence responses to the above questions?*

2. METHODS

Subjects

Table 5. Study Participants by Provider Type, Number and Percent

Provider Type	n	% of responders
MDs	147	62%
Pharmacists	24	10%
Facility Administrators	22	9%
DOs	16	7%
Nurses/Nurse Practitioners	12	5%
PAs	9	4%
Dentists	8	3%
Total Responses	**238**	
No Response	**3**	
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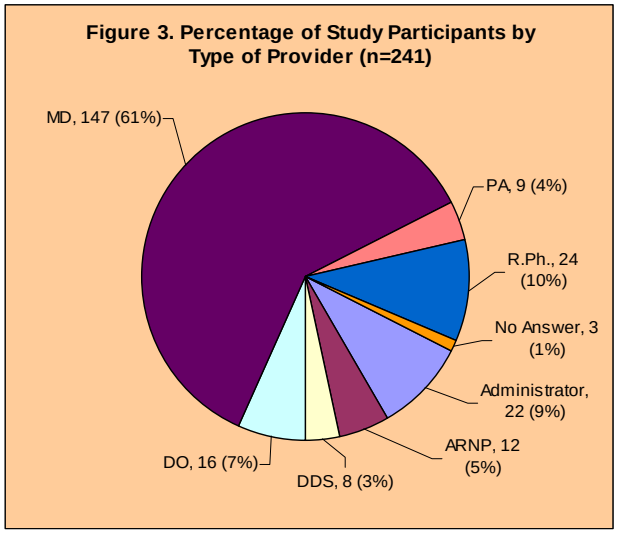
Subjects in this study were drawn from the Oklahoma State Board of Licensure, Oklahoma State Medical Association, the Oklahoma Academy of Family Physicians, the Private Pharmacists of Oklahoma and other medical groups, personal contact by DFPM faculty, and word of mouth. A brief post-card survey* was distributed to approximately 13,500 physicians and other health care providers statewide informing them of possible changes to Medicaid and inviting them to participate in discussions on this topic with members of our project staff. (Appendix C is a sample letter sent to physicians inviting them to participate in this study). The number and types of providers who participated in the overall study are shown in Table 5.

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

Of the 843 providers (a response rate of 6%) who returned the post-card survey, 43 percent (363) expressed interest in participating in the study reported here. A total of 241 providers (out of 363 - 163 physicians and 78 non-physician providers) completed the 11-item survey designed for this study (see Appendix A for a copy of the survey). Although the contractual emphasis of this study was on physicians, no provider who was interested in participating was excluded. Figure 3 shows the percentage of providers by type who participated in this study. The location of study participants statewide is shown in Figure 4.



Instruments

An 11-item survey instrument (Appendix A) was designed to gather demographic data about each provider and his or her practice, and

*Detailed results from the other questions on the post-card survey will be disseminated in a later report

beliefs, attitudes, and opinions about a Medicaid reform program. The survey focused on answering these four major study questions.

1. *What key programmatic changes must be implemented to make Medicaid more acceptable to all health care providers?*
2. *Should the Medicaid system maintain financial reserves?*
3. *How should any new monies allocated for Medicaid be spent?*
4. *Do demographic variables, such as type of provider and practice location, influence responses to the above questions?*

Two of the survey questions, items 6 and 7, will be analyzed in a later report.

A brief information document describing the current Medicaid program and the reform options under consideration was developed (Appendix B). This document was disseminated to providers who participated in the individual and group discussions or who requested study materials via phone, fax or by viewing the study web site at www.fammed.ouhsc.edu/hcnw.

In addition to collecting quantitative data from surveys, 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 Facilitator's Guide for Provider Groups (Appendix D), which includes how the groups should be conducted, introductory remarks and additional questions, ice breakers, etc. was developed and utilized at group sessions. A Small Group Checklist (Appendix E) was developed to assist in the planning and organization of group sessions. The questions developed can be found in the comments spreadsheet (Appendix F).

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

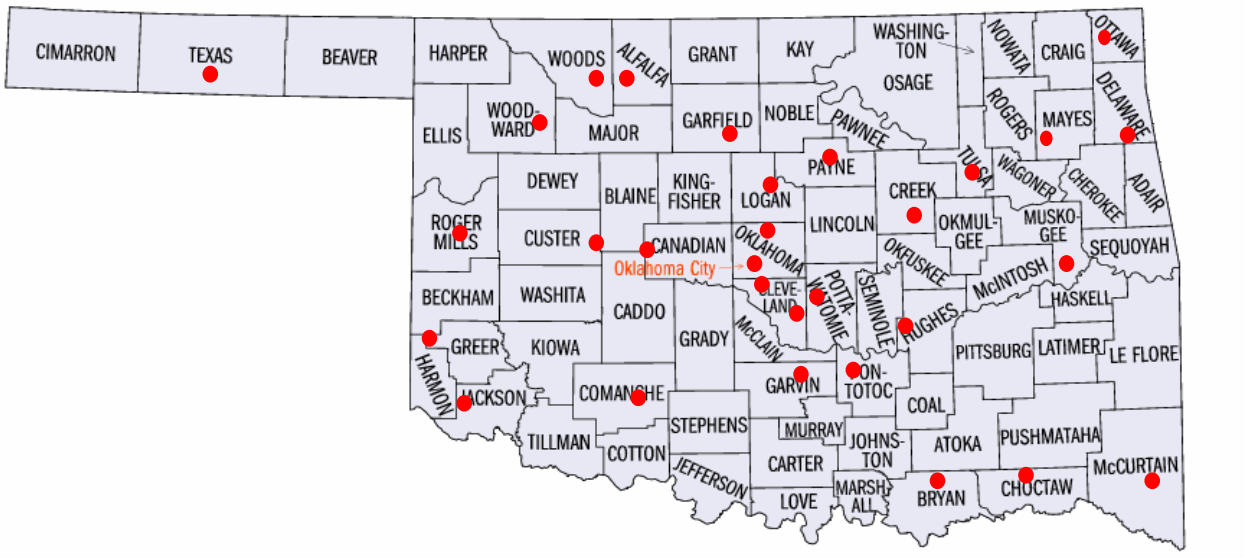


Figure 4. Locations of Study Participants in Oklahoma

the exemption, consent forms to participate in this study were not required.

DFPM physician and provider faculty pilot tested and provided valuable feedback on the construction of this document. 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 D) and using traditional and well-publicized methods.[9] Preplanning was accomplished using a Small Group Checklist (Appendix E) developed by project staff.

Approximately 850 physicians and other health care providers across Oklahoma (see Figure 4) 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 F).

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, and the findings are reported in the Results section. A summary of the raw data from this study can be found in Appendix H. Research faculty at DFPM assisted with the development of analytical tools and methods, along with providing training and technical assistance to project staff.

A glossary of statistical terms is included in Appendix G to facilitate understanding of the raw data.

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 F 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 – and of 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.[2] 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 Academy of Family Physicians, 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 to both inform physicians and other health care providers about the current Medicaid system and the reform options were developed to gather data and to stimulate discussion during the small group sessions. Comments, hand-recorded by program staff, were assigned themes, coded and then entered in an Excel spreadsheet. A complete listing of the questions and comments from these sessions can be found in Appendix F. 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. They 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.

Figure 5 shows one of the questions and how the responses were coded for data analysis.

Figure 5. Example of Comment Data Analysis

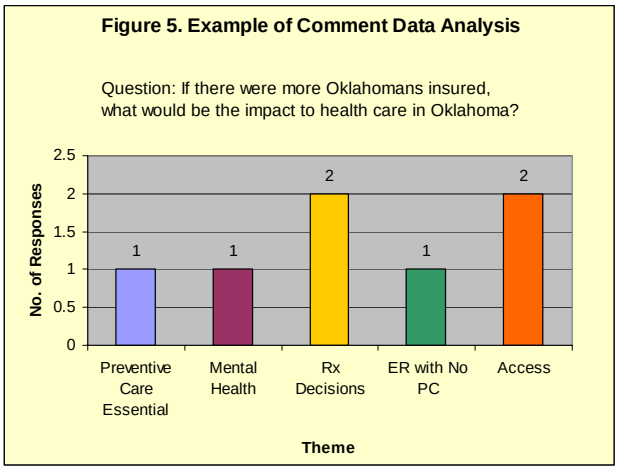


Table 6. Themes and Definitions Used to Categorize Data from Group Discussions*

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

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 (as shown in Figure 5) 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)

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

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

"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.

(1) It gave program staff the opportunity to educate providers about the OHCA reform options and get them thinking and talking about Medicaid reform.

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

(3) It 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) The discussions gave the practitioners an opportunity to express their concerns and to feel that they are contributing to statewide health care reform.

4. RESULTS

A total of 241 physicians (163) and other health care providers (78) completed the 11-item 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 in the study; 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 were entered into an Excel spreadsheet. A set of general themes for the comments was developed (see Tables 6 and 7 and Appendix F) and responses were coded by program staff. Qualitative data were used to enrich and enhance the results from the survey.

(1) **Quantitative data** from the 11-item* survey was entered into a Microsoft Access database and organized. The resulting data were then analyzed using a standard statistical software program (SPSS). A summary of the raw data is included with this report in Appendix H. Comparisons were made among provider types to discover whether any variable (e.g., type of provider, location, etc.) had a statistically significant impact on any of the questions in the survey.

* Two questions from the survey, items 6 and 7, will be discussed in a later report.

Survey results were analyzed by survey item number. The results below summarized the findings from the survey in order.

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, to comments made on written survey instruments, and/or to the answers from program staff in response to questions during meetings and presentations. Staff also captured some nonverbal responses.

Comments directly from surveys were entered into a Microsoft Access database. Data were coded and merged with discussion group comments, then exported into an Excel Spreadsheet to generate charts and graphs. A copy of the complete list of provider comments can be found in Appendix F. Table 7 (below) is a list of the themes and a brief definition of each. Themes in the Excel spreadsheet in Appendix F have been truncated. The complete theme and its corresponding truncation can be found at the bottom of each page of Appendix F.

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
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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)

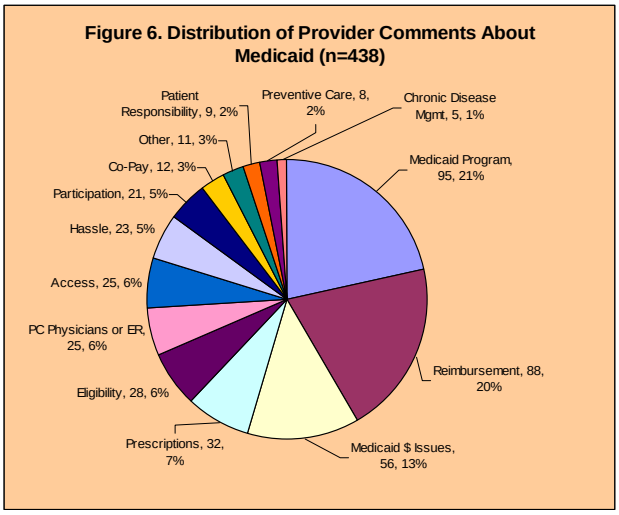
Medicaid Program	95
Reimbursement	88
Medicaid $ Issues	56
Prescriptions	32
Eligibility	28
PC Physicians or ER	25
Access	25
Hassle	23
Participation	21
Co-Pay	12
Other	11
Patient Responsibility	9
Preventive Care	8
Chronic Disease Mgmt	5

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

1. Type of provider

The types of providers included in this study are shown in Table 5 and Figure 3 (page 7). To facilitate data analysis and presentation we grouped the providers as follows:

Physicians (MDs and DOs) (163)

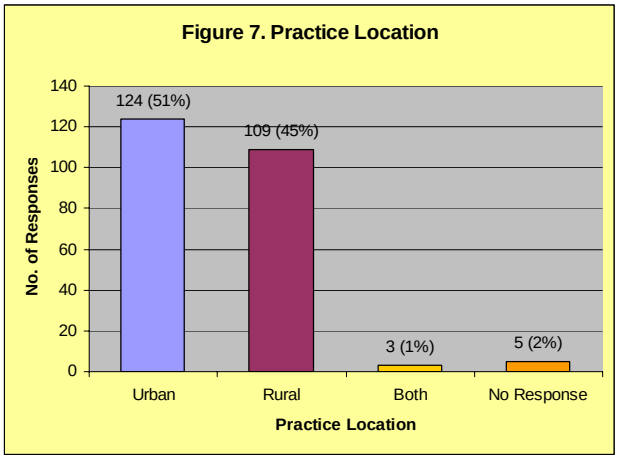
Pharmacists (24)

All other providers (54)

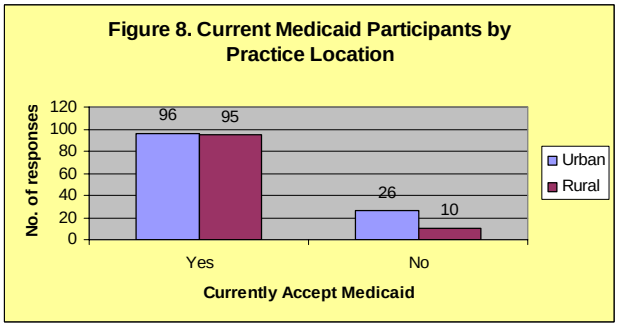
This grouping was made strictly on the basis of total number of surveys received. Data analysis suggests that provider type did not have a statistically significant impact on any study variable.

2. Practice Location (Urban v. Rural)

The practice locations of providers in this study were fairly evenly mixed between urban and rural locations. A small number (3) had locations in both urban and rural areas. Five (5) participants did not respond to the question.

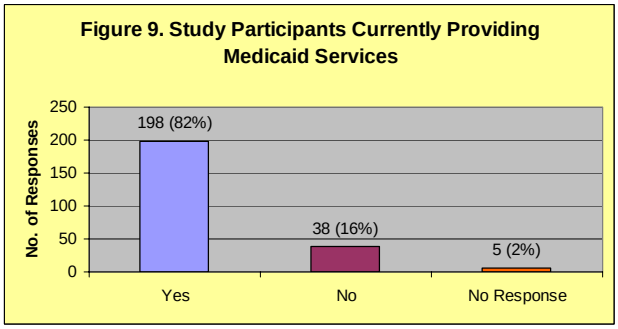


There were no significant differences between urban and rural physicians and other health care providers for any of the variables measured. Opinion of Medicaid, likeliness to participate in an expanded program, supporting financial reserves for the Medicaid system, etc., were ranked equally among urban and rural practices. However, rural practitioners were somewhat more likely (p=.015) to be currently providing Medicaid services than urban practitioners (Figure 8).



3. Participation in Medicaid (Yes v. No)

The majority of participants in this study are currently providing services under Medicaid. Of the 236 physicians and other providers who answered the question, 82% (198) are current Medicaid providers; only 16% (38) are not current providers. Five providers did not respond to the question.

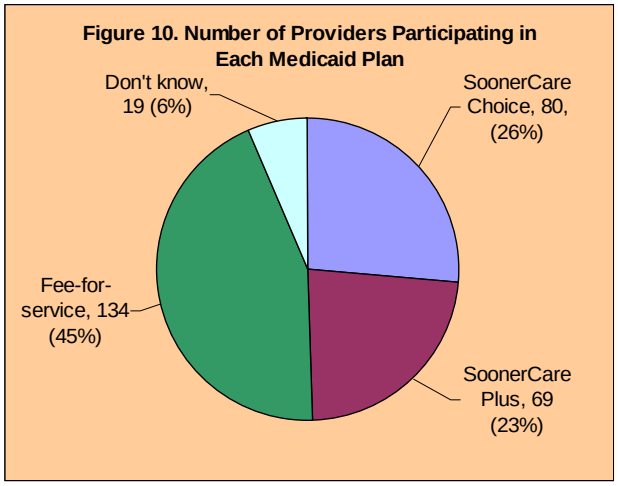


Regardless of their opinion of the Medicaid program, most physicians and other providers chose to continue providing Medicaid services. Many, however, expressed concerns and discontent with the system, indicating the possibility that some may opt out if satisfactory reforms are not instituted. The comment below from a provider who has recently opted out of Medicaid is typical of the sentiment among study participants.

> "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 [for

specific problems] are not getting the care they need. I just can't get the claims paid."

4. *Breakdown of Medicaid Participation by Plan*



One hundred ninety eight out of the 241 providers who participated in this study were current Medicaid providers. Figure 10 shows the distribution of providers by Medicaid plan; some providers participated in more than one plan. The vast majority of providers participated in the current fee-for-service plan (134 of 198). About a quarter participated in SoonerCare Choice (80 providers, 26%) and in SoonerCare Plus (69, 23%). This coincides with comments received indicating lack of enthusiasm for the managed care options.*

> "Medicaid is even more disorganized now than when they started the HMOs in 1995. It seems like a disaster over all. It needs [to be] more in tune with what is really happening out here."

> "Prior to SoonerCare, every physician in this town shared the responsibility for caring for the Medicaid patients, now Dr. ____ … is the only one who takes the Medicaid HMO. It would be much better to see the system go back to fee for service."

These results indicate that reform options, which incorporate a fee-for-service approach, might be more attractive to practitioners.

5. *Medicaid Policy: Support OHCA Maintaining Financial Reserves*

We asked study participants the following question to solicit their views on a financial reserve system that would give OHCA a financial base on which to operate the Medicaid program.

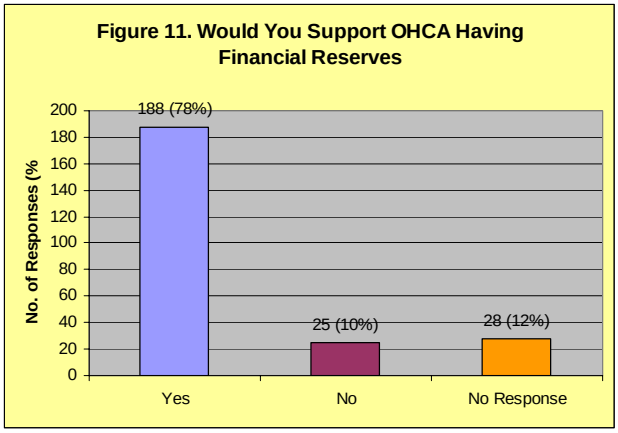
> **Would you support OHCA having financial reserves?** "Some of the swings in Medicaid policies occur because OHCA does not have financial reserves; therefore, changes in policy must often be made to meet fiscal and budgetary constraints. Initially, establishing these reserves would create some short-term funding issues, but with financial reserve, policy could remain stable for 1 year increments."

During discussions with providers about this subject, comments were generally negative. The comment below is typical of the responses we heard.

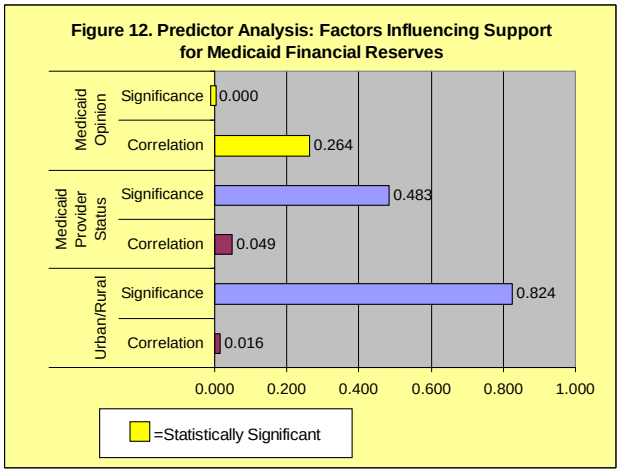
> "I would not trust OHCA with any cash reserves."

Yet, by a large margin (78%, 188 out of 241), physicians and other providers who took part in this study supported the creation of a financial reserve system. Regardless of the generally negative opinion with which most providers regard OHCA specifically, and government in general, they recognized the practicality of having a stable financial base to underwrite the Medicaid system.

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



A predictor analysis was performed analyzing the responses to this question which showed that providers with a Positive opinion of OHCA and the current Medicaid program were significantly more likely to support a financial reserve system than those with No Opinion to a Very Negative opinion.



Questions 6 and 7, regarding reimbursement, will be analyzed in a later report.

8. Medicaid Policy: Should OHCA have greater checks over fraud (which would increase administrative oversight) or should administrative burden be reduced.

Fraud in all areas of health care services – providers, patients and payers – is a problem we all pay for. Many of the providers who confided in us expressed alarm at patients' fraudulent disregard for Medicaid rules regarding co-payments, for example.

> "I see a pack of smokes in their pocket but they can't shell out $2.00 for their co-pay. And we can't make them, either."

Participants also expressed concern that provider fraud was pursued much more aggressively than patient fraud.

> "Medicaid eligibility is a huge issue – constant monitoring is needed to prevent fraud."

> "The problem is not physician fraud, it is definitely patient fraud."

> "Fraud is occurring in the county offices where the applicant is approved. Fraud is not with the providers, it is at the recipient level."

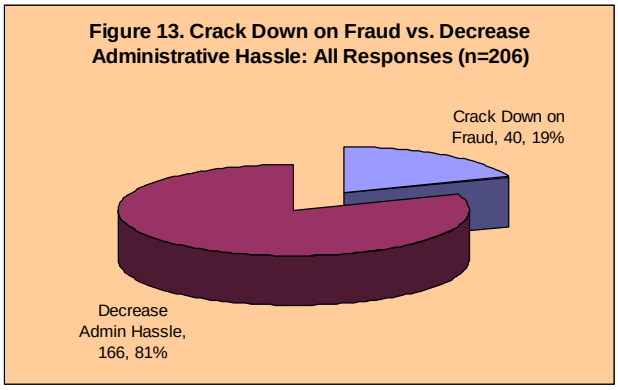
But to track down and eliminate fraudulent practices by providers or beneficiaries is costly and contributes to the administrative burden associated with Medicaid. To understand providers' opinions on the subject of controlling fraud and abuse in the Medicaid program compared to the need to decrease the administrative burden such a control program would involve, we asked providers the following question:

> **Would you prefer that state (OHCA) require more stringent compliance (e.g., documentation, coding requirements) possibly increasing "administrative hassle" for you, or fewer "checks and balances" to decrease "administrative hassle" which could possibly increase program fraud?**

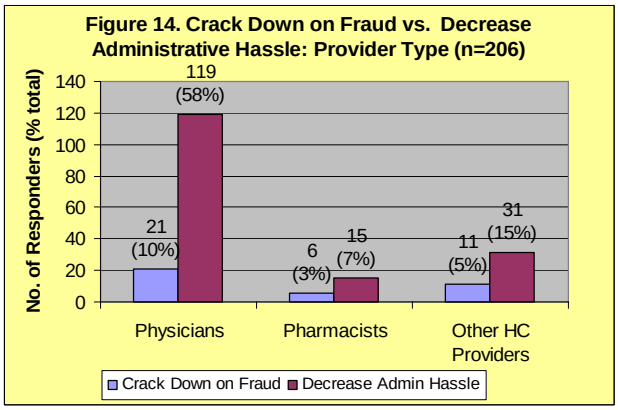
Sixty-eight percent (166) of the 206 providers who responded to this question were opposed to any intervention for fraud that would involve an increase in the amount of paperwork and red tape (Figure 13).

A typical comment from group discussions on the topic of the administrative burden associated with fraud control was:

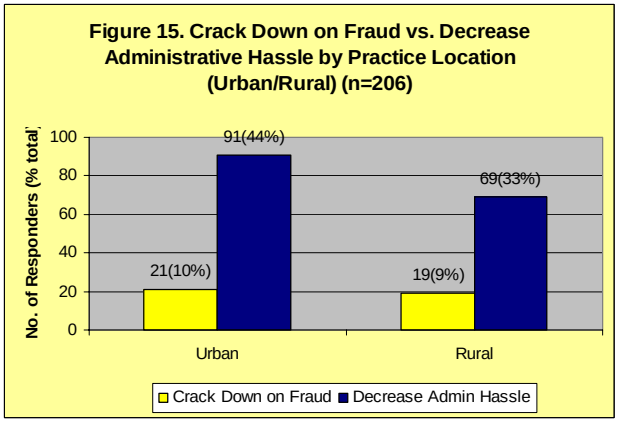
"There must be an easier way to catch fraud in the system – maybe audit every 250 claims filed instead of each one."

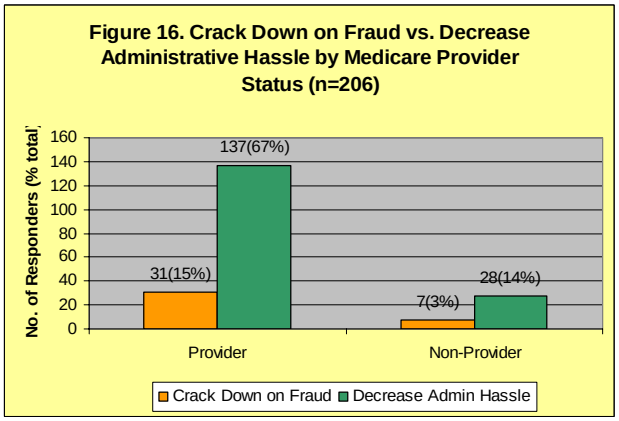


We analyzed responses to this question by provider type (figure 14),* practice location (Figure 15), and status as a Medicaid provider (figure 16). None of these variables had a statistically significant impact the overall result.

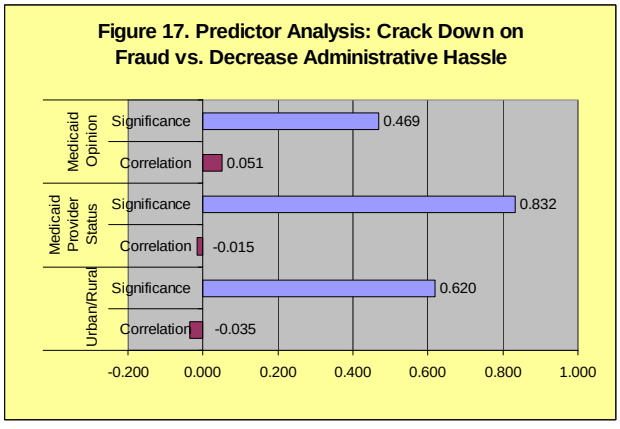


* For this study, providers were grouped as follows to facilitate data analysis: physicians (MDs and DOs), pharmacists, and all other health care providers.





We performed a predictor analysis (Figure 17) to determine the effect, if any, that provider type, practice location, and opinion of the current Medicaid program had on the strength of the respondents' views of cracking down on fraud or decreasing administrative hassle.



Although providers with a higher opinion of Medicaid were somewhat more likely to be

willing to take on a greater administrative burden to assist OHCA in reducing fraud and abuse, the difference was negligible. In all, providers heavily favor reducing the administrative red tape associated with Medicaid regardless of the purpose of the additional paperwork.

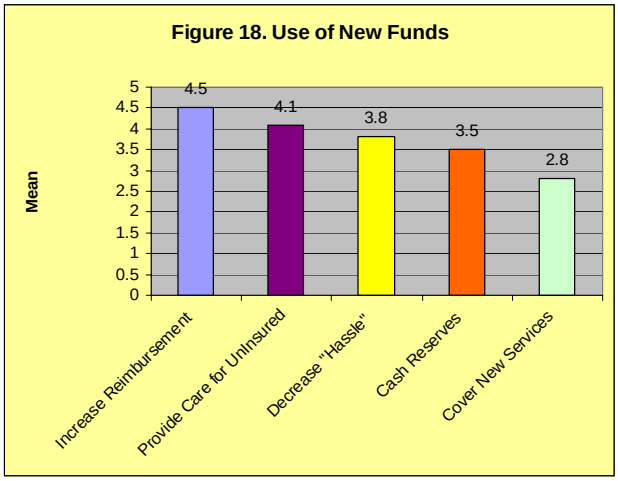
9. Use of New Funds

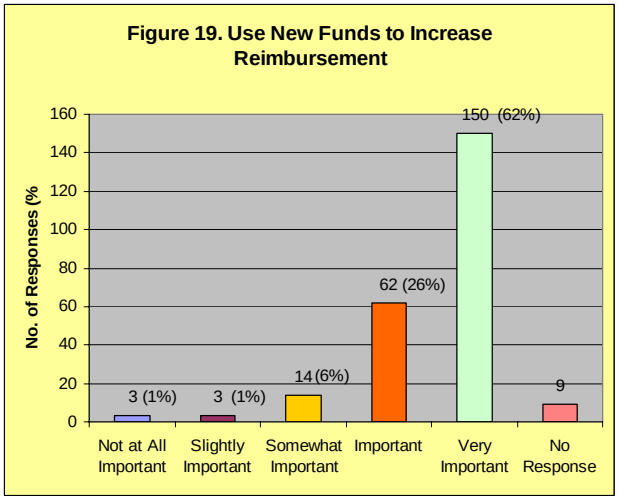
We asked the study group about how they would like to see any new funds that might come into the Medicaid system allocated. Table 9 and Figure 18 show the order in which providers would like to see any new funding spent.

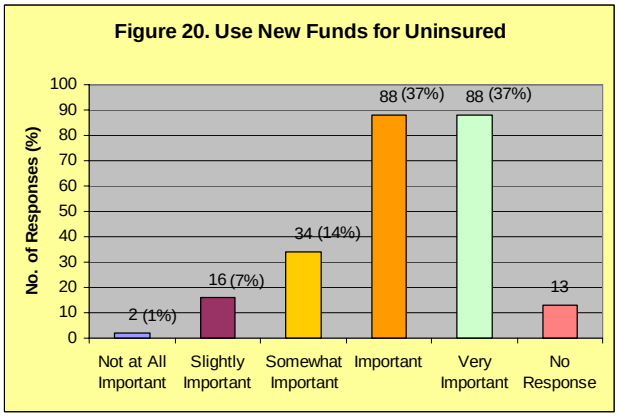
Table 9. Mean Ranking of Use of New Funds

Rank	Item	Mean
1	**Increase Reimbursement**	**4.5**
2	**Provide Care for Uninsured**	**4.1**
3	Decrease "Hassle"	3.8
4	Cash Reserves	3.5
5	Cover New Services	2.8

Predictably, increased reimbursement for services (Figure 19) ranked first among the 241 physicians and other health care providers who participated in this study, followed closely by their desire to see health care extended to the uninsured (Figure 20).







These results indicate that it is likely that physicians and other health care providers would support the reform options and the expansion of Medicaid to cover low-income adults and families, provided reimbursement for services was fair and the new program did not jeopardize current or future increases in reimbursement.

10. Program changes to make Medicaid more attractive to providers

Increased reimbursement was ranked first out of eleven possible Medicaid programmatic change options, followed closely by reduced administrative burdens and streamlined pre-authorization processes. On a scale of 1-5 (with 1 being Not at All Important and 5 being Very Important), providers rated increased reimbursement at a mean 4.58; reduced administrative

hassle rated 4.03 and easier pre-authorizations rated 4.01 (Table 10).

Table 10. Key Programmatic Changes Necessary to Secure Provider Participation in Medicaid

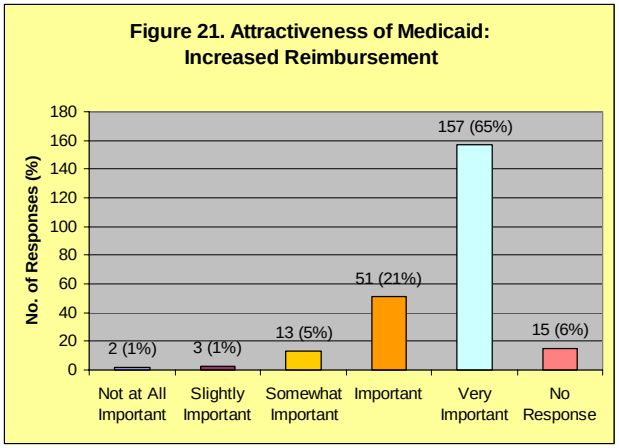
Rank	Item	Mean
1	**Increase Reimbursement**	**4.58**
2	**Reduced "Hassle"**	**4.03**
3	**Easier Pre-authorizations**	**4.01**
4	Greater Access to Specialist	3.86
5	Chronic Disease Management	3.72
6	Fewer Restrictions on Visits	3.64
7	12 Mo. Eligibility Period	3.56
8	Fewer Restrictions - Prescriptions	3.32
9	Fewer Restrictions - Inpatient Days	3.23
10	Case Management Services	2.99
11	Financial Incentives for Volume	2.57

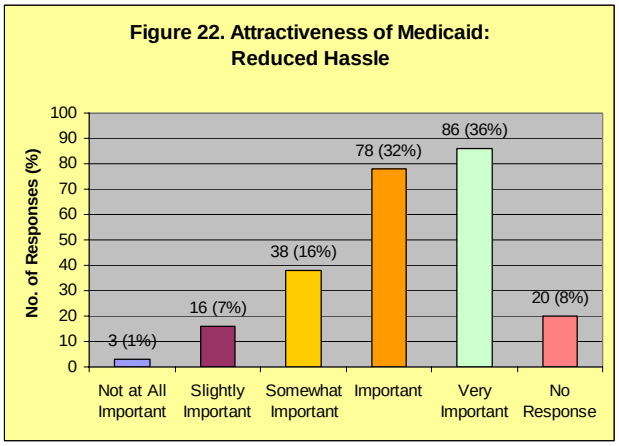
Fewer limits and restrictions on prescriptions, which was mentioned often during the focus and discussion groups as being a priority, ranked 8th (mean, 3.32). Typical comments about the three prescription limit include:

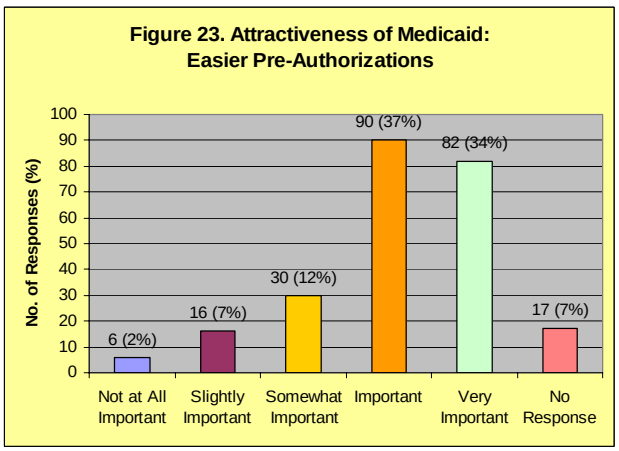
> "I have lots of patients who've stopped taking meds they need but cannot afford – therefore without those meds (with 3 script limit) they become sicker, require more care – I guess one way to look at it is they die faster…that costs the state less."

> "Something needs to be done about the 3 prescription limit. There should be something different for those individuals who have chronic disease."

Financial incentives for taking care of a high volume Medicaid recipients was ranked last (mean, 2.57).







It is possible that reducing the administrative burden on practices and streamlining authorization and eligibility procedures could improve the financial aspects of providing Medicaid services. During our discussions, many providers spoke of reimbursement as being a separate issue but linked to profitability and

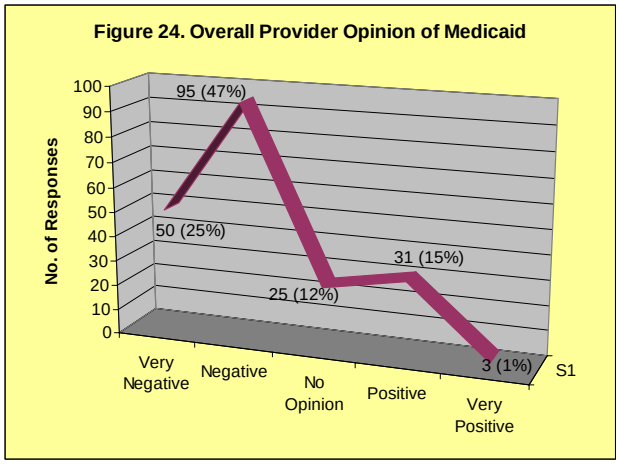
financial viability. Reimbursement was defined as the amount paid for services rendered. Profitability and financial viability of being a Medicaid provider, however, was more often linked to the costs to the practice associated with administering the program: staff and physician time to process claims, verify eligibility, obtain pre-authorization, etc. Comments from one physician in Enid reflect this sentiment:

> "My office manager - a great gal…she's been with me for years, very efficient, was going to quit because getting claims paid by Medicaid was so frustrating. Now, my choice was stop taking Medicaid or lose her. I chose to stop Medicaid and guess what, we're all happier and haven't seen any drop in income."

11. Opinion of Current Medicaid Program

Providers were asked to rank their feelings about the state's Medicaid program, from Very Negative (1) to Very Positive (5). Seventy-two percent (140) of respondents who answered this question had a Negative (47%, n=95) to Very Negative (25%, n=50) opinion of the current program. Only 1% (n=3) expressed a very positive opinion of Medicaid. Thirty-seven (18%, n=37) did not respond to this question.

Figure 24. Overall Provider Opinion of Medicaid



Predictably, providers who participated in this study had a negative to very negative opinion of the current Medicaid program. Comments, such as those below, were typical of the frustration and anger that providers expressed about their interactions with Medicaid.

> "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."
>
> (Family Physician) "There are all kinds of laws that mandate us (docs) to see patients – how dare I be mandated to see a patient when you (the state) are refusing to pay for it!" <ANGRY>
>
> (Family Physician) "Physicians are mandated to see patients - yet we are unfunded." <ANGRY>
>
> (Family Physician) "This (denial to be part of Unicare) is a good example of our Medicaid system – their (OHCA) employees are dispirited, despondent and seem to have low morale – because all day long they are telling doctors – No you cannot do this."
>
> "This system is totally immoral and unethical – you know I didn't know I was this upset about Medicaid until I started talking about it – I'm angry!" <ANGRY>

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 because of the short study duration (June 2003 to October 2003). The lack of randomization limits the generalizability of these results to the population of all physicians and health care providers in Oklahoma. Participants in this study were volunteers, recruited through word of mouth and personal invitation, from the roles of the Oklahoma State Medical Association, the State Board of Medical Licensure and from physician and health care associations and groups (e.g., Oklahoma Academy of Family Physicians, Pharmacy Providers of 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; 843 practitioners returned the post-card, a response rate of only 6%. However, 363 of the 843 (43%) answered that they would like to participate further. Program staff were able to collect survey data from 241 (29%) physicians and other practitioners. 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 F.

5. DISCUSSION

Despite an overwhelmingly negative opinion of the Medicaid program by physicians and other health care providers, most (82%) favored extending health care services to Oklahoma's poorest and most at risk. Many are willing, 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 reimbursement concerns were based primarily not on a desire to get rich, but were based 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.

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.[1] 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[12] -- 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.[3] 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.[2] Consequently, many are opting out of government programs such as Medicare[4] 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."

"I can't help anyone if I'm out of business."

In this study, we asked providers what programmatic changes would be necessary for them – those currently serving Medicaid populations and those who are not – to participate in a reformed, expanded Medicaid health care system. The issues raised by

Oklahoma providers mirror national studies on this topic. Table 11 shows the recurrent themes and the program changes identified by physicians and other health care providers across Oklahoma.

Table 11. Key Programmatic Changes and Their Corresponding Theme

Program Changes in Rank Order	Theme
1. Increase Reimbursement	Reimbursement
2. Reduced "Hassle"	Hassle
3. Easier Pre-authorizations	Medicaid Program
4. Access to Specialists	Access
5. Chronic Disease Management	Chronic Disease Mgmt
6. Fewer Restrictions on Visits	Medicaid Program
7. 12 Mo. Eligibility Period	Eligibility
8. Fewer Restrictions - Prescriptions	Medicaid Program
9. Fewer Restrictions - Inpatient Days	Medicaid Program
10. Case Management Services	Medicaid Program
11. Financial Incentives for Volume	Medicaid $ Issues

The following are comments representative of some of the various themes and program changes and provide insight into the feelings and concerns of the physicians and other health care providers in Oklahoma.

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."

"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."

2. Reduced Administrative Hassle

"Problems with auto-assignment impact every aspect of Medicaid. Patients are auto-reassigned without their knowledge or without understanding."

"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 to someone else they didn't ask for."

"Auto assignment is a huge issue – OHCA and DHS do not match."

Credentialing to participate in Medicaid is ridiculous. The paperwork is incredible.

3. Easier Pre-authorizations, eligibility verification

"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."

"Why isn't there a website that shows us the current specialists that are available for referral? That would help with preauthorizations."

"Preauthorizations … are such a hassle—we take care of so many kids every day and there has to be a preauth (preauthorization) 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 be authorized and what is not."

4. Access to consultants based on physician and patient decision making and need

"Consultants for pediatric patients are non existent. There are no neurologists or psychiatry specialists available to us due mainly to reimbursement issues."

"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."

5. Medicaid Program Changes

"There is too much fragmentation, duplication, and unnecessary services in current health care. There should be more coordination of services in Primary Care."

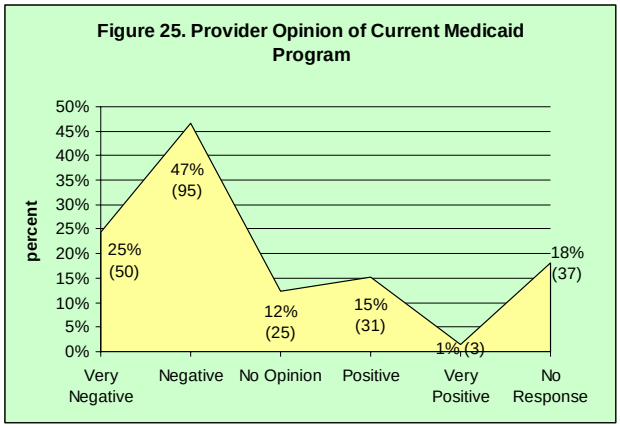
"Bring the public health system back under the coordination with Medicaid services—link them in some way so that they function as a team rather than separately."

There must be an easier way to catch fraud in the system – maybe audit every 250 claims filed instead of each one.

6. Case Management

"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."

Providers in this study had a generally negative to very negative opinion of the current Medicaid program as shown in Figure 25.



It is reasonable to assume, however, from the data and from the comments and suggestions from the discussion groups that streamlining the administrative aspects of the Medicaid system – access to benefits and prescription information, pre-authorization, eligibility, reporting, coding, continuity of care – along with making Medicaid more user-friendly by implementing electronic access and increasing the responsiveness would alleviate much of the negative opinion with which physicians view OHCA and Medicaid.

Alleviating the hard feelings would increase the likelihood that providers will support reform of the Medicaid system including a financial reserve program. It would also increase the likelihood that providers would tolerate some paperwork that would reduce fraud and abuse of the system.

Equally important, however, is the OHCA attack patient fraud with the same or a greater level of support as they employ tracking down provider fraud.

The system is not physician fraud, it is definitely patient fraud.

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.

Reimbursement for services must, of course be fair. In an article about home health care services, The Oklahoman 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.[13]

However, if the system can be effectively remodeled, and those changes are handled satisfactorily, it is possible that providers would be open to negotiation on what constitutes "fair reimbursement." This would require that a significant reduction in the administrative red tape occur and that the process of providing health care services to the uninsured and underinsured be streamlined. Utilizing electronic resources, such as the Internet, to speed up verification of eligibility, pre-

authorizations, formulary information, coverage, and even for submitting claims, are technically feasible and would be well received by providers.

As of December 31, 2003, Heartland and UniCare (Medicaid HMOs) will be terminated. Providers who participated in discussions near the end of our data collection process made comments about this process indicating that the manner in which the termination of these programs is handled will be watched carefully by providers. As Heartland and Unicare end, it is imperative that OHCA assure that providers who participated in those programs are reimbursed fairly for the services they provided in good faith. Otherwise, provider participation in any new or reformed Medicaid program will be in jeopardy.

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

- Reimbursement for services rendered. Payment must be fair, reasonable and financially acceptable for providers.
- Eligibility and pre-authorization regulations, formulary policies and other administrative requirements must be streamlined to reduce overhead and frustration.
- 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.
- Reduced costs, associated with administrative red tape, for providers could make the program more attractive as well as more financially viable.
- Providers and patients must have control of clinical decision making to provide the best patient care possible.

Recommendations

Reimbursement was the number one issue raised by the providers in this study. However, there may be ways to ameliorate some of the reimbursement problems by addressing the costs associated with administrative hassle. Verifying eligibility, pre-authorizations, prescription problems, and getting claims paid is costing too much. Solutions could include:

1. **Electronic systems** that facilitate administration and reduce red tape could yield a higher return on investment. Such systems could increase provider satisfaction and increase the likelihood that they would continue to participate in a reform Medicaid program.
2. **Web-based eligibility, pre-authorization and formulary** are feasible, and new technology can enable such a system to be effectively safeguarded for privacy. Comments from providers indicate that such a system would be well-received. For example, a system that will record patient visits to one clinic or hospital for a particular problem could be entered into a tracking system by procedure code. Providers could then follow that patient's care or be alerted to drug-seeking or other non-productive behaviors. In addition, it would provide for a sort of continuity of care among a patient population that in general defies continuity.

"Why isn't there a website that shows us the current specialists that are available for referral? That would help with preauthorizations."

3. **A web based question, answer and comment system** could be created to help providers get answers to their questions in a timely manner. Providers expressed frustration with not being able to talk to anyone about the problems they were having. They also expressed great support and enthusiasm for the **pharmacy hotline**. More programs like the pharmacy hotline, especially electronic systems, could vastly improve provider acceptance of an expanded Medicaid program.

4. **Provider participation** in the design and implementation of the program would help ensure success.
5. **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.

In order for all providers to participate in Medicaid in Oklahoma, providers would need:

1. Assurance that the state could effectively manage such a program,
2. Input into the development of the coverage package,
3. Financial and other incentives, such as the reasonable reimbursement based on fair market value,
4. Relief from the administrative burdens rampant in the current system (e.g., pre-authorization, eligibility, benefits, etc.),
5. Physician/patient control over health care decision-making.

Educational efforts could highlight such positive benefits of the reform options as:

1. A more motivated client pool (workers and their families, who are more likely to have routine screening and preventive measures such as immunizations).
2. Decreased overall health care costs over time by eliminating cost shifting that occur when uninsured use the emergency room.
3. Improved health and well-being of all Oklahomans.

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8. APPENDICES

A. Health Care Provider Survey

B. Education Document

C. Letter of Invitation

D. Small Group Facilitator's Guide

E. Meeting Checklist

F. Survey and Meeting Comments and Impressions

G. Glossary of Statistical Terms

H. Summary Data

I. Biographical Sketches of Program Staff