

PUBLIC PERCEPTIONS

Stakeholder Feedback (Consumers, Providers, and other Stakeholders)

Gathering information and input from HealthChoice consumers, providers, and those participating in the program in other capacities are important tools for gauging the program's effectiveness and shortcomings. Is the program working for consumers and providers? In what ways is the program falling short? How could HealthChoice do a better job of meeting various stakeholder needs? The Department has sought to answer these questions on an ongoing basis through the use of routinely collected quantitative information and, more recently, through extensive collection of qualitative data at forums, focus groups, and hearings with numerous stakeholder and constituency groups.

Ongoing Quantitative Monitoring Efforts

As part of its ongoing quality and performance monitoring efforts, the Department operates a telephone hotline for consumers and providers, conducts annual or biannual consumer and provider satisfaction surveys, and collects enrollment data on the incidence of enrollees changing MCOs. Each of these activities provides timely, ongoing information on various aspects of consumer satisfaction with the HealthChoice program.

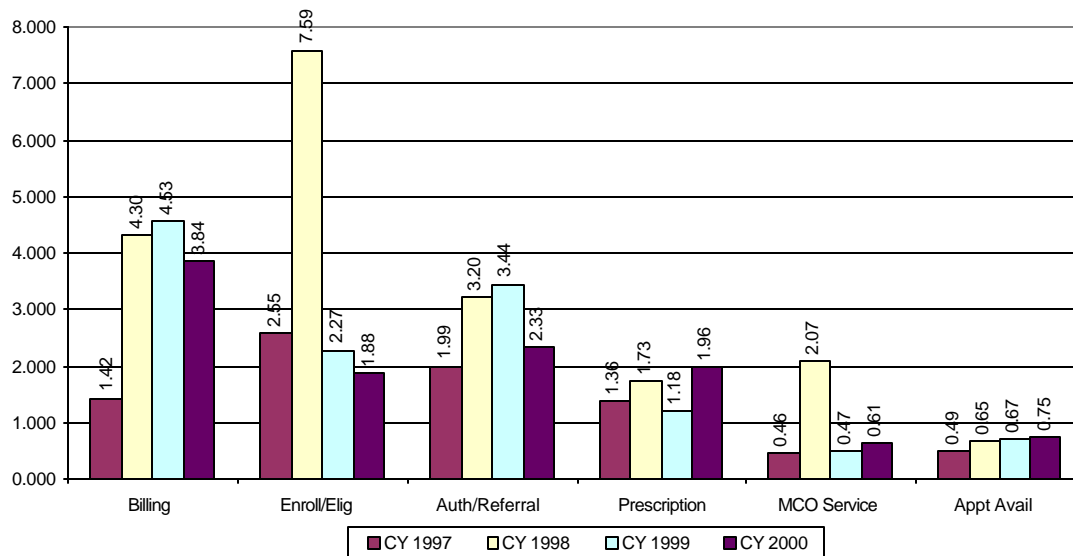
Consumer Complaints – Enrollee Action Line. The Enrollee Action Line is a statewide, customer service, telephone hotline operated by the Department's Division of HealthChoice Customer Relations. Enrollee Action Line, or "hotline" staff field questions and complaints from HealthChoice enrollees during normal business hours; enrollees may leave messages after hours.

- Background. Hotline staff can usually answer questions and inquiries - simple requests for information - during the consumer's call. A call is a "complaint" if it involves medical care or access to care issues requiring staff intervention with MCOs, local health departments, or other groups to be resolved. Less than five percent of hotline calls are recorded as complaints. Most hotline calls are informational requests that are handled during the call. A discussion of trends and changes in the rate of various types of complaints over the course of the program is presented below.

In the past, the Department grouped complaints into five categories: billing, enrollment, access, treatment and "other". More recently, the Department has expanded the number of complaint categories to twelve in order to understand the nature of many of the access and treatment complaints. Currently, complaints are grouped into the following categories: billing; enrollment and eligibility; authorization and referral; prescription medications; MCO services; appointment availability; PCP

assignment; care management; quality of care; provider service; office access; and a small number of complaints that fall outside these categories, labeled “other.” Because the number of complaints falling into the latter six categories has been quite small, only data from the six leading complaint categories are presented here.

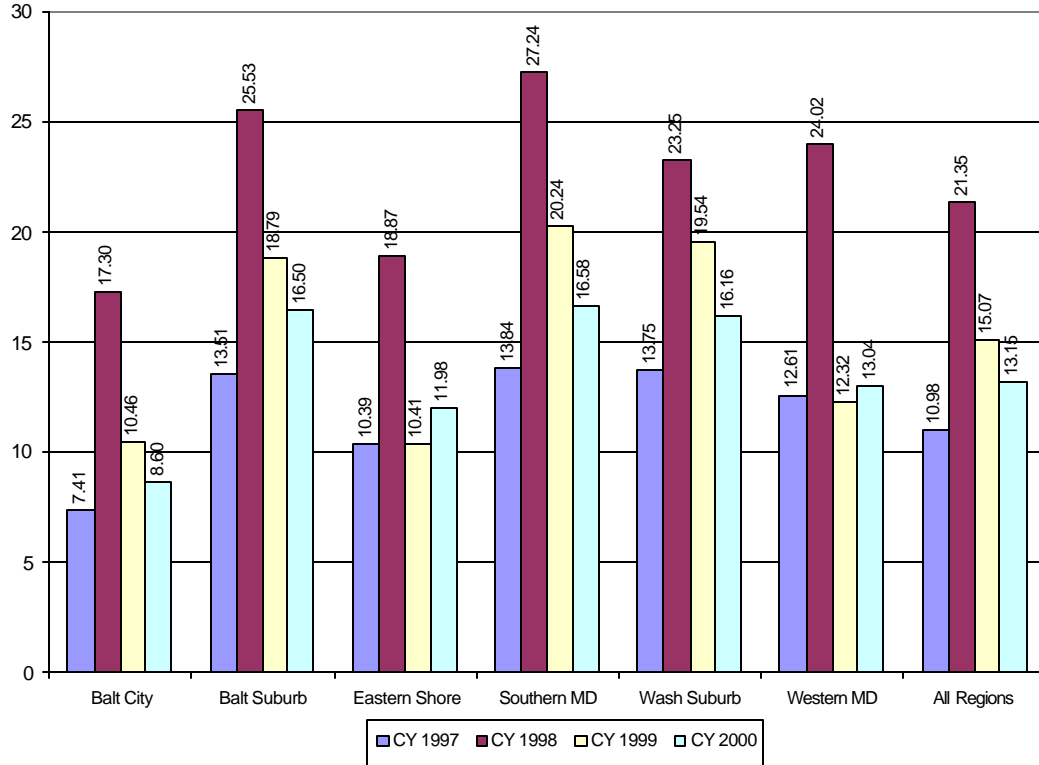
Figure III-63: Enrollee Action Line Complaint Rate per Thousand Enrollees by Reason and Year



➤ **Findings.** Since the program’s inception, administrative issues have generated the most complaints, followed by access to specialty care and problems related to medications. In CY 1998, the first full year of the program, Enrollment/eligibility and MCO service complaints were disproportionately high relative to other years. The MCO service complaint category includes problems with an MCO’s internal grievance process, telephone customer service, nurse hotline or other MCO administrative staff, and MCO failure to provide outreach services when requested by the PCP. It is likely that these spikes in enrollment/eligibility and MCO service complaints in 1998 are attributable to two factors. First, there continued to be a substantial number of enrollees changing MCOs throughout the entire first year of the HealthChoice program. Second, the implementation of the MCHP program in July 1998, which brought in 35,000 new children in its first six months, also is likely to be partly responsible. The higher rate of billing and enrollment complaints, relative to other issues over the course of the program is probably related to the program’s complex eligibility rules and requirements. The level of prescription-related complaints, which increased in CY 2000, may reflect a disconnect between the MCOs and their Pharmacy Benefit Managers (PBMs) that could delay a PBM’s timely recognition of enrollee beneficiaries. The increased level of pharmacy complaints in CY 2000 may also reflect

issues surrounding formulary drugs, the practitioners' lack of familiarity with the formulary, and consumer discontent with generic substitutions.

Figure III-64: Enrollee Action Line Complaint Rate per Thousand Enrollees by Region and Year



- **Complaints by region.** Analysis of overall complaint data by region also shows that during the first four years of the program, the rate of complaints in most regions has declined. The Eastern Shore, which experienced an overall increase in complaints during the last two years, is an exception. Over the last four years, the complaint rate generally has been lower in Baltimore City and on the Eastern Shore than the statewide average. In contrast, Baltimore County, Southern Maryland, and the Washington Suburban regions have experienced consistently higher than average overall complaint rates during this four year period, particularly in the last two years. It is unclear why this is the case in these three areas.
- **Discussion.** On average, the Enrollee Action Line receives over 100,000 calls each year. Of these, the number that are categorized as complaints is small (roughly 5,000 in CY 1999 and CY 2000). The low volume of complaints relative to inquiries may be attributable to the fact that most hotline calls do not involve immediate medical issues, access to care issues, or a denial of services. Rather, most involve more general questions about eligibility or enrollment or simply the need for more

education and information on how to negotiate the MCO and HealthChoice systems.

Overall, the proportion of HealthChoice enrollees contacting the hotline (26 percent) for any reason, while significant, is not large relative the program's total enrollment. Information from consumer focus groups and forums suggests that a larger proportion of HealthChoice consumers could benefit from the services provided by the Enrollee Action Line. It is possible that only one quarter of consumers call the hotline because only a small number are aware that the hotline is a resource available to them. Moreover, it is also possible that more consumers do not call because they have little confidence in the Department's and the hotline's ability to actually resolve their issues to their satisfaction. Finally, it may be that a number of consumer questions, problems and complaints are resolved by the MCOs themselves.

It is difficult to draw conclusions from this complaint data that can be generalized to the entire HealthChoice population. In order to gain additional insight on this topic, the Department probed this issue in the consumer focus groups. Additional information can be found in subsequent sections on consumer input.

Consumer Satisfaction Survey

Overview. The Consumer Assessment of Health Plans Survey (CAHPS) is the primary tool for assessing consumer satisfaction and experiences with care in the commercial, Medicaid, and Medicare markets. Different survey instruments are used for adult and child Medicaid enrollees. Given a valid survey sample and a sufficient response rate, CAHPS results are comparable among the different state Medicaid programs and between Medicaid and commercial populations.

Consumers report a high level of satisfaction with HealthChoice; however, there have been concerns about the validity of this information because of survey sampling problems and low response rates. In 1998, the Medicaid adult consumer satisfaction survey had a response rate of 30 percent (2,727 returned surveys), with most of the responses coming from two rural counties. In 1999, the survey had a response rate of 22 percent (2,204 returned surveys). The chart below describes the results of the 1999 Medicaid adult CAHPS conducted in Maryland.

Figure III-65: 1999 Consumer Assessment of Health Plans Survey (CAHPS) Results

	HealthChoice	MD Commercial Plans	National CAHPS***
Getting Needed Care*	78%	75%	74%
Getting Care Quickly*	85%	77%	78%
Personal Doctor	75%	NA	73%
How Well Doctors communicate	87%	89%	89%
*Indicates composite measures			
**The National CAHPS percentages are derived only from those plans reporting CAHPS as part of HEDIS.			

Discussion. Although CAHPS satisfaction scores for the HealthChoice program are in line with those of other states' Medicaid and commercial managed care programs, the shortcomings of the HealthChoice data make such comparisons inappropriate. The 1998 HealthChoice CAHPS sample was highly skewed towards enrollees in two counties, and in both 1998 and 1999, the survey response rate was unacceptably low. Efforts are currently underway to conduct a methodologically sound survey that will yield reliable results. Results will be available in early 2002. Given the concerns with the validity of the information from the consumer satisfaction survey, the Department has used consumer forums to get a better sense of current satisfaction with the program.

Provider Satisfaction Survey

Overview. The Department conducted Provider Satisfaction Surveys in 1998 and 1999. The results are reported below. In each of these years, the Department mailed surveys to a sample of participating physicians. In 1998, the physician satisfaction survey had a response rate of 31 percent (387 returned surveys). In 1999 the response rate dropped to 11 percent.

Discussion. The majority of providers surveyed are satisfied with many aspects of the HealthChoice program, and the percentage of surveyed providers who express satisfaction was higher in 1999 than in 1998 for each category. Notably, drug formularies received the lowest rating in 1998 and the second lowest rating in 1999. This is consistent with the findings from the provider forums, discussed below. The number of physicians who participated in this survey was very small, and there are no comparable measures from the period prior to HealthChoice. Information gathered at provider forums offers a more current and detailed perspective on provider experiences in the program.

Annual Right to Change

Overview. The proportion of enrollees electing to change MCOs during their annual right to change period is in some respects a measure of enrollee satisfaction with their plan. In general, once a HealthChoice enrollee has selected an MCO, they remain with that plan for one year. Once a year, in the month of the anniversary of their enrollment, enrollees may elect to change plans. It is important to note, however, that HealthChoice enrollees may also change MCOs at any time during the year for cause. “Cause” is defined in the program’s Operational Protocol to include: transportation hardship (e.g., the enrollee has moved, and now lives a great distance from his or her provider); dissatisfaction with auto-assignment; desire to keep all family members in the same MCO; change in foster care placement; and, in certain circumstances, the enrollee’s PCP no longer participating in the enrollee’s MCO.

Discussion. The proportion of enrollees who exercise their annual right to change may be a useful proxy for consumer satisfaction. For instance, the relative rate of enrollee-initiated changes among the plans could be used to identify a problem with a particular plan. In Maryland to date, only a small proportion (1.66 percent in CY 1999 and 1.97 percent in CY 2000) of enrollees who are eligible to change MCOs during their annual right-to-change period elect to do so. (Data from the state’s previous enrollment broker for CY 1997 and CY 1998 were not available. Hence, only data from the latter years of the program are presented here.) Firm conclusions are difficult to draw from this low percentage. However, the small number of enrollees who choose to switch plans during their annual right to change may indicate that enrollees are largely satisfied with their MCO plans.

The Department also examined disenrollments for cause – namely, change due to transportation hardship, change in order to keep the family in one MCO, and change because of dissatisfaction with auto-assignment. In all of these cases both the volume and rate of consumer switching declined between CY 1999 and CY 2000.

Switching due to a transportation hardship – usually because a family moves – declined from 5,331 (15.24 per 1,000 HealthChoice enrollees) in CY 1999 to 4,663 (12.11 per 1,000 HealthChoice enrollees) in CY 2000. Similarly, changing MCOs to maintain all family members' enrollment in the same plan also decreased from (28.33 per 1,000 HealthChoice enrollees) to (25.4 per 1,000 HealthChoice enrollees) between CY 1999 and CY 2000. Finally, switching plans because of dissatisfaction with auto-assignment followed the same pattern. While the overall number of individuals who were auto-assigned dropped between CY 1999 and CY 2000, the percentage of the enrollees who were auto-assigned and changed plans declined as well (from 15.5 percent in CY 1999 to 7.6 percent in CY 2000).

It is unlikely, however, that the decreased incidence of enrollees changing plans is related to consumer satisfaction. The number of enrollees switching plans due to transportation hardship occurs when people move from one jurisdiction to another. This is likely to be related to larger workforce and demographic issues. Moreover, the number of enrollees who change MCOs to maintain the continuity of family members' enrollment in a single MCO is likely to decrease as the program ages. This is because, as it matures, consumers become more familiar with the program, and, most importantly, they establish and retain a primary care provider with whom they are comfortable. Drawing clear conclusions as to why there has been a decline in the number of enrollees changing MCOs after auto-assignment is not currently possible.

Public Input - Community Forums, Focus Groups, Meetings with Stakeholders and Public Hearings.

As part of the evaluation, the Department initiated a broad, multi-faceted public input process, soliciting feedback about the performance of HealthChoice from consumers, providers and other stakeholder groups. Altogether, the Department conducted over 80 meetings across all regions of the State. The major findings of the different stakeholder groups are briefly described below. Consumer input was gathered through several mechanisms:

- Consumer focus groups – HealthChoice parents: The first mechanism for soliciting input was a series of 17 meetings across the State with focus groups composed of parents of children enrolled in HealthChoice. Some of the HealthChoice parents were also HealthChoice enrollees themselves. Each focus group was composed of seven to ten participants. These groups provided the Department with an opportunity for lengthy, in-depth dialogue with consumers about the program. An independent contractor facilitated these groups.
- Community Forums: The second mechanism used for gathering consumer input was 14 community forums attended by over 280 HealthChoice

consumers. These were larger meetings designed to solicit feedback from a broader cross section of the HealthChoice population. Consumers participating in these forums were asked about their problems and issues concerning the HealthChoice program.

- Consumer focus groups - parents of special needs children: The third mechanism used for gathering consumer input was three focus groups composed of the parents of children with special health care needs. A total of 36 parents, all of whom had at least one special needs child enrolled in a HealthChoice MCO, participated in these groups, which were also facilitated by an independent contractor.

Findings - Summary of General Comments Across All Consumer Groups, Forums and Meetings. In general, many participants described themselves as satisfied with the coverage and quality of care that they or their children, or both receive through the HealthChoice program. Participants value the health care coverage the program provides, and they typically express high praise for their primary care providers.

- Specialty care. Access to specialty care, however, appears to be a problem. In rural areas, participants speak of having to drive well over an hour to see a specialist. Participants in both urban and rural areas describe long waits, in some instances four to six weeks or more, to get an appointment with a specialist.
- Dental services. Most participants throughout the state cited an insufficient number of dental providers as a major problem with HealthChoice. A number of participants also voiced concerns about the quality of dental care received and the competency of some of the program's dental providers.
- Pharmacy services. Most participants, including those with special needs, are satisfied with the program's pharmacy coverage, although some consumers report frustration with physicians' lack of familiarity with MCO formularies and what consumers perceive as frequent MCO formulary drug changes. Consumers express frustration and confusion when physicians prescribe medication that is not on their MCO's formulary. For some, this situation has resulted in delays in starting medication (for example, when the pharmacist could not reach the physician to correct the problem) or paying for the prescription out-of-pocket.
- Transportation services. The majority of participants are unaware that HealthChoice offers transportation services. However, parents of special needs children who had used these services had many negative comments. Several cited numerous problems with scheduling and

- timeliness of pickups. Several parents of special needs children reported missing appointments because drivers were late.
- Vision services. Participants appear pleased with the program's vision care and benefits, although parents of HealthChoice-enrolled children uniformly noted the extremely poor quality and unaesthetic appearance of the eyeglass frames.
 - Billing problems. Billing is also a source of frustration for many HealthChoice enrollees. A substantial number of parents of HealthChoice enrolled children reported receiving bills for services. The reasons behind this are somewhat unclear. It appears that some parents are unaware of MCO emergency room policies or are simply unable or unwilling to comply with them. Additionally, program eligibility issues appear to be a likely cause of some billing errors.
 - Stigma. Finally, some - but not all - participants report that they feel some stigma as a result of their enrollment in HealthChoice. Whether real or not, some parents of HealthChoice-enrolled children perceive that they are treated differently because they have public coverage. For the most part, these individuals report that it is the attitude and conduct of the reception and front office staff in their medical provider's office that lead to this perception - not that of providers or MCO staff.

Medical Home & Access to Care

Primary Care Provider. Most consumers report that they have a primary care provider, who they hold in high regard, and with whom they appear to have maintained a positive, ongoing relationship over a number of years. Parents are aware of their children's need for preventive services, although it is less clear the degree to which children are receiving the full range of recommended preventive care services. Some parents reported receiving reminders - mostly from their physician's office and to a lesser degree from their health plan - reminding them about scheduling or keeping appointments for preventive services.

Appointments. Most parents report the ability to make appointments for both routine and urgent care in a timely manner. Some participants in Baltimore City were less satisfied than participants in other regions with the amount of time it took them to get in to see their provider.

Carve-outs.

The majority of those who commented in detail on issues related to HealthChoice's carve-out services were parents of HealthChoice-enrolled children. It is important to keep in mind that only a very small number of parents

across all of the groups reported having children who needed speech therapy, occupational therapy, or physical therapy services. While a larger number of parents had children requiring mental health services, focus group participants and their children were not among the seriously and persistently mentally ill, nor did any of the children appear to have substance abuse issues. Virtually all of the focus group participants whose children had used the mental health system had diagnoses of attention deficit hyperactivity disorder (ADHD), attention deficit disorder (ADD), conduct disorder, or mild to severe depression. Finally, as noted previously in the substance abuse section of this document, HealthChoice consumers in the adult population – as well as providers and MCOs – report difficulty in coordinating somatic and behavioral health care services.

The impact of carve-outs, at least among young early and pre-adolescent children enrolled in HealthChoice, appears to be complicated and varies by region. Overall, consumers in certain rural regions have fewer complaints and seem pleased with both the outpatient mental health services and the occupational therapy, physical therapy and speech therapy services that their children receive. From their perspective, coordination of care for these services is less of a problem. In Southern Maryland and Western Maryland, awareness of mental health services and access to them appears to be satisfactory if not good. The picture in the state's urban and suburban communities, however, is more complicated.

Parents in urban and suburban areas reported feeling somewhat on their own with respect to mental health services. Some of these parents said that their health plan did not cover mental health services and appeared not to recognize that mental health services are, in fact, part of the HealthChoice benefit package. These parents seemed to be unaware that mental health services are offered as part of HealthChoice through the State's Administrative Services Organization (ASO). Moreover, urban and suburban parents who knew about the Maryland Health Partners (MHP) network did not report being satisfied with the access to services or the quality of care they were receiving through the network.

Specific Populations

Spanish Speaking Enrollees. In two forums conducted in Baltimore City and Silver Spring, Spanish speaking HealthChoice participants generally expressed satisfaction with the coverage and care that they are receiving through the HealthChoice program. Latino forum participants raised several issues, however, that the Department had not heard from other groups.

- Appointment scheduling. Latino forum participants reported long waits to schedule appointments for both urgent and preventive care, and lengthy in-office waiting times once they arrived for their appointments. It appears that many Latino enrollees seek care in clinics that schedule "block appointments," in which numerous patients are intentionally assigned

identical appointment times. Patients generally all arrive at close to the same time, and the provider sees them in the order in which they arrived. This approach means very long in-office waiting times for the majority of patients. Block appointments are very convenient and economical for the provider, as patients who are no-shows do not mean significant down time for the provider. This approach to scheduling is, however, extremely inconvenient for patients.

- Language and office staff. Spanish speaking enrollees also said that they had difficulty understanding their physicians, most of whom were not fluent in Spanish. While most felt that the doctors' demeanor was appropriate, Silver Spring participants felt that office staff was disrespectful, unhelpful, and unkind. In addition, Latino participants seemed unaware that their MCO could provide translation services.
- Enrollment and re-enrollment processes. Latino participants expressed more difficulty with the HealthChoice enrollment and re-enrollment processes than other enrollees. Participants in the Latino groups suggested that the Department indicate whether or not providers in the Provider Directory were fluent in Spanish. Additionally, they suggested that the Department print virtually all forms and letters in Spanish. Moreover, they noted that it would be helpful if the Department mailed families a letter indicating that they had in fact received re-certification and would continue to be covered by the program. Otherwise, participants said, they have no idea if their application was received, processed and accepted.

Children with Special Health Care Needs. As discussed previously, the Department contracted with an independent contractor to conduct several focus groups with parents of HealthChoice-enrolled children with special health care needs. These groups were not composed of the parents of children with very similar disease specific conditions; rather, the groups were made up of parents of children with a wide range of problems, from exclusively mental health concerns to chronic illnesses such as diabetes and brittle bone disease. With few exceptions, parents in these groups voiced mainly the same concerns as those in other groups, such as problems accessing specialty and dental care, fatigue with the number of HealthChoice MCO transitions, and struggles navigating and understanding the HealthChoice and MCO systems. Moreover, their degree of concern about these issues was also similar.

- Therapies, case management, and transportation services. Given the greater need for specialized services in this population, certain findings from the focus groups are a greater concern with respect to this population. While it is not clear whether the children in these groups actually may have needed therapy services, the apparent lack of awareness among participants that these carve-out services are available

is likely to be problematic. Moreover, many special needs parents seem unaware of the MCOs' provision of case management services. With one or two exceptions, most special needs parents do not appear to be benefiting from regular contact with a case manager concerning their child's care or progress with care. In addition, some special needs parents report having difficulty understanding and navigating the MCO and HealthChoice system. While some special needs parents note that they received a great deal of written information from their MCOs, they found it more confusing than helpful. Finally, in contrast to parents of children without special needs, parents of special needs children, as discussed earlier in the public input section, had a greater awareness of and more experience with HealthChoice transportation services.

Children under Age One

The Department also conducted a focus group with mothers of children under one, who had been enrolled in HealthChoice during their pregnancy. The purpose of this group was assessing whether consumers were experiencing problems accessing care for their newborns. While this is clearly an important issue for providers, consumers do not appear to experience problems getting their child assigned to a PCP, making timely appointments, or receiving recommended care.

Administrative Issues

Administrative Burden. Consumers complain of "administrative burden" with both the Medicaid program and their MCO. The parents of children enrolled in HealthChoice through the Maryland Children's Health Program (MCHP) are more likely to have experience with employer-based managed care plans. Such experience helps MCHP parents navigate MCO rules concerning referrals, emergency room use, and provider networks. Managed care policies and processes may be more confusing to lower income parents, particularly those with special needs children who use services frequently.

Application Process.

- Mail and local health department processes. Many MCHP parents who enrolled their children in HealthChoice entirely through the mail were very pleased with the process. These parents reported enrollment to be smooth, easy and relatively quick. Parents who enrolled at the local health department had similarly positive comments.
- Department of Social Services. Lower income participants who were simultaneously seeking enrollment in other social service programs, however, reported less satisfaction and greater frustration with the process. Because they were also applying for other forms of assistance in

addition to HealthChoice, these individuals enrolled through their local Department of Social Services (DSS). Typically long waits, long forms, detailed questions, and harried staff were characteristic of these individuals' enrollment experiences, particularly in Baltimore City and Baltimore County. Notably, this was not the case in Western or Suburban Maryland. It is important to mention that the Department and DSS have recently reduced the application form down to six pages for those applying for multiple programs. Thus perhaps consumers will find the application process for multiple programs less time consuming and onerous in the future.

- *Spanish Language Application and Outreach.* Many participants felt that outreach efforts and the application process targeted at the Hispanic population should be sure to incorporate Spanish-language outreach, application, and education materials. Specifically, participants suggested that reapplication materials be sent to Spanish-speaking families in Spanish.

MCO Transitions. A majority of participants expressed their fatigue with the program's numerous MCO transitions and the frequency with which providers dropped out of the program. Consumers discussed how these events threatened continuity of care. The MCO transitions were perceived as extremely disruptive. Many participants expressed a desire for greater program stability.

Enrollee Hotlines. Most consumers indicate that they have little experience calling the MCO and Enrollee Action line numbers on the back of their MCO cards. It is unclear whether and to what extent this is because they assume a call to a hotline will not resolve their issue or because they have not had problems necessitating a call. Those who have called a hotline have trouble remembering which hotline (their MCO's or the Department's) they contacted. Moreover, those who reported calling experiencing mixed results. Many enrollees seem to find other HealthChoice parents the best source of information, as these individuals may have experience working through similar problems.

Program Changes Suggested by Consumers. Several changes suggested by consumers were discussed or alluded to above - namely, fewer transitions, greater provider retention, additional dentists and specialists, improved communication and information concerning the availability or advisability of certain HealthChoice services, efficient transportation services, and greater availability of Spanish language materials. Several consumers, particularly working parents, wished that the program could be expanded to provide coverage for them. Several also recommended that the program further relax rules concerning the requirement that participants remain in their chosen MCO for one year.

Advocates

In addition to face-to-face meetings with consumers, the Department held a centralized meeting with advocacy organizations. An independent contractor facilitated the meeting. In general, advocates raised serious concerns about the HealthChoice program.

Medical Home. Advocates said that HealthChoice had failed to provide a medical home. They were concerned that historic provider relationships had been disrupted and that auto-assignment of patients had been devastating. They said that the complexity of the system with different MCOs and different rules had led to confusion for consumers.

Provider Issues. They expressed concerns about the adequacy of the provider network, particularly regarding dentists and specialists, and issues about the inaccuracy of the provider directory.

Carve-outs. Various advocacy groups had differing opinions about carve-outs. Some said that carve-outs added to the complexity of the program and were confusing for patients. Some suggested that carve-outs afforded consumers greater access and, therefore, more services should be carved out or self-referred. One participant expressed a positive experience with access-to-care under the mental health carve-out.

Case Management. Advocates also said that HealthChoice was not providing sufficient case management services. Some said that MCOs do not have enough case management staff and thus only respond to urgent situations. Many advocates stated that MCOs only do administrative case management, rather than helping enrollees and providers to coordinate a broad range of medical, social, and educational services.

Vulnerable Populations. In general, advocates expressed strong concerns about access to care for vulnerable populations. In particular, advocates raised concerns about the following populations: pregnant women, adolescents, immigrants, children in foster care and kinship care, and HIV/AIDS patients.

Department's Performance. They expressed mixed feelings about the Department's performance and responsiveness to their concerns. When asked about working with the Department, some advocates stated that the Department is accessible, but not always responsive. Some said that Department staff was trying to make the program work, but they were under-funded and under-staffed. Others believe that the Department is obstructionist. Some advocates stated that the Department was in alliance with MCOs because they want managed care to work to the exclusion of listening to other options and suggestions.

Enrollee Complaints. Several advocates said that they believed that consumers do not call the Department's complaint line when they have problems. Advocates were concerned about denials of care and believed that consumers were not being notified when a service was denied.

Program Changes Suggested by Advocates. Advocates recommended the following changes for the HealthChoice program:

- Increase funding.
- Eliminate HealthChoice, and replace it with a primary care case management (PCCM) program.
- Phase in PCCM where networks are falling apart.
- Stop administrative case management.
- Allow chronic and disabled enrollees to go to wherever needed.
- Invest in better computer system.
- Provide efficient case coordination.
- Maximize federal funding opportunities.
- Enhance and create a more visible role for local health departments.
- Study best practices.
- Collaborate with Health Care for All.
- Correct disconnect with eligibility and access between the Department of Human Resources and the Department.
- Improve coordination with all departments (Department of Human Resources, Maryland State Department of Education, and Department of Juvenile Justice).
- Better educate consumers about the program, its rules and requirements.
- Carve out the foster care and kinship care populations.
- Become more proactive in monitoring care and enforcing standards of care at the provider level.

- Simplify all monitoring in order to encourage provider participation in networks.
- Institute real-time claims payment.
- Recruit and retain providers.

Provider Forums

A total of individual 184 providers participated in 20 discussion group meetings held throughout the State. Nine of these meetings were regional meetings for physicians; five were regional meetings for office managers. The Department conducted one centralized meeting for each of the following provider groups: advanced practice nurses, school-based health clinics, pharmacists, dentists, FQHCs and hospitals. In total, over 200 people participated in these meetings.

Findings – all provider groups. Below we have summarized the main findings across all of the provider groups broken down by (1) reimbursement and administrative followed by (2) issues related to medical care. Subsequently, we provide more detailed information about the findings for several specific provider groups when opinions in these groups differed sufficiently from those articulated in the majority of provider groups. Specifically, a more detailed discussion of the findings from the groups with office managers, school-based health clinics, advanced practice nurses, pharmacists, dentists and federally qualified health centers are provided below.

- Reimbursement and administrative issues.
 - *Reimbursement rates.* The leading concern for the majority of providers is the low reimbursement rates in Maryland's Medicaid and HealthChoice programs. Many blame low reimbursement for provider withdrawals and insufficient provider networks. Physicians displayed a thorough understanding of the current rate structure compared to Medicare rates. Moreover, the majority felt that Maryland Medicaid rates are too low to maintain provider participation in the program. There were important exceptions, however. PCPs who receive capitated payments report satisfaction with their payment rates. In addition, several physicians noted that HealthChoice EPSDT rates are actually higher than the commercial rate.
 - *Administrative burdens.* All provider groups – physicians, advanced practice nurses, hospitals, pharmacists, school-based health clinics, dentists, and Federally Qualified Health Centers (FQHCs) cited the administrative burdens of participating in the program.

Specially, they mentioned: the administrative hassles of working with several MCOs (referrals, preauthorization, and formularies); eligibility verification; newborn eligibility and assignment issues; long telephone waiting times for MCO and Department staff; paperwork volume required to comply with EPSDT and other quality oversight requirements; educating patients on how the program works; educating patients about appropriate use of emergency rooms; and outreach and care coordination for patients.

- *Timely payment.* Both physicians and office managers noted problems with timeliness of payment and hassles associated with submitting claims. Although some providers stated that the timeliness of payments had improved, others continue to identify this as a problem. Several providers recommended that MCOs and MHP accept electronic claims and that the Department establish a process to reconcile payment issues.
- *Auto-assignment.* Some providers were concerned that auto-assignment had resulted in a lack of continuity of care for HealthChoice enrollees. In particular, FQHCs were concerned that auto-assignment resulted in loss of their historic patients.
- *Provider directories.* A majority of providers were concerned about inaccurate MCO and MHP provider directories. They expressed a need to have an accurate provider directory available on the Internet.

➤ Care issues.

- *Primary care – medical home.* Many providers acknowledged that HealthChoice had resulted in greater access to primary care. Most view the physician or clinic as patient's medical home, and most physician providers believed that they have furnished a medical home for their patients. Some hospital participants believed that the establishment of a medical home was one of the more successful aspects of the program. Other hospital participants, however, believed that emergency room utilization was increasing – a possible indication that the appropriate level-of-care may not be taking place at the PCP level – and that the large number of plan transitions did not support the conclusion that HealthChoice has provided a medical home for patients.

Some health officers echoed these statements, also citing alleged increases in emergency room use, and a lack of preventive care as evidence that the program had failed to create a medical home. In contrast, some local health department staff stated that more

people are better served and that for primary care a medical home was created.

- *Specialty care access and coordination.* Numerous providers in various provider groups voiced concerns about access to specialty care, mental health services, dental services and coordination of care among different providers. Many also voiced concerns about the lack of consistency between different MCO formularies.
- *Case management.* Coordination with carve-out services was believed to be difficult. Most providers stated that they believed that the burden for case management was on the provider and not on the MCO. Many said that they thought the program's case management requirements should be better defined. Several local health department staff believed case management should be locally provided.

Findings – Specific Provider Groups. This portion of the chapter sets forth more detailed information about the findings, as drawn from specific provider groups when the group's opinion differed significantly from those articulated in the majority of provider groups.

➤ Office managers.

- *Administrative issues – eligibility, network information.* Office managers cited problems with eligibility verification, auto-assignment, and newborn issues. They reported having to spend considerable time trying to determine whether patients were HealthChoice-eligible. In addition, they felt frustrated by their inability to obtain accurate network provider information from the MCOs.
- *Formulary.* Office managers cited the desirability of establishing one prescription drug formulary for all Medicaid consumers. They want a simple regulatory system that is uniform across the entire Medicaid program.
- *Prompt payment.* Office managers stated that the MCOs should pay providers on time and that the Department should fine those MCOs that failed to do so.
- *Transportation, case management, appointments, and inappropriate ER use.* Office managers believed that they were spending too much time arranging for transportation and case management services for HealthChoice clients. They felt strongly that HealthChoice consumers should be more responsible about

keeping appointments and using the emergency room appropriately.

- *Frustration.* Finally, office managers expressed frustration that they are responsible for various activities that are integral to the provision of high quality, comprehensive patient care, yet few take the time to listen to and address their concerns.

➤ *School-based health clinics.*

- *Limitations on number and type of services; reimbursement.* Staff at school-based health clinics expressed frustration at the limitations placed on the services for which they can receive reimbursement. They want the state to change the regulations that limit the number of times their clinics can see a child. They say that they are providing many services to the Medicaid population but are not being reimbursed. They report that under HealthChoice, only two percent of their clinic costs are covered as compared to forty percent under the MAC program.
- *Appropriateness as care-delivery site; dental services.* School-based health clinic providers feel strongly that they are perhaps the best place for HealthChoice enrolled children to receive timely services. They believe that some children experience long waiting times before getting in to see their PCP, and that some PCPs have problems locating their clients. Because of their proximity to many HealthChoice children, school-based health clinics state that they have little problem locating clients and assisting them to get in for timely care. Moreover, clinic directors believe that they can provide better care to the non-English speaking HealthChoice population than many of these individuals are currently receiving. Clinic directors also report that they are providing dental services to elementary school children, many of whom have serious dental issues, and they believe that they should be reimbursed for the provision of these services. Clinic directors also stated that coordination between mental health and substance abuse services is problematic for many children and adolescents enrolled in HealthChoice.
- *School-based health clinics as MCO subcontractors, PCPs.* School-based clinics wanted the Department to help them obtain service contracts with MCOs. Most importantly, however, they wanted the Department to allow them to become primary care providers. This, they believed, would be a step toward eliminating some of the existing problems with HealthChoice.

➤ Advanced practice nurses.

- *PCP classification; increased reimbursement.* Like school-based health clinic administrators, the central issue for advanced practice nurses is their desire to be classified as Primary Care Providers, as was the case under the Maryland Access to Care (MAC) program. The nurses echoed many of the concerns and comments articulated by the preceding groups. Like others, they believe that provider reimbursement for Medicaid and HealthChoice should be raised to Medicare levels, and they articulate the same concerns and recommendations as other providers with respect to Medicaid eligibility, drug formularies, and other administrative issues.
- *Expanded benefits; consumer education; financial disclosure by MCOs; limitation of pharmaceutical industry profits.* Several advanced practice nurses recommended that HealthChoice institute the following changes: provide consumers with transportation both on weekends and on short notice; better educate consumers so that they fully understand all of their options within the HealthChoice program; require MCO payment of tooth extractions for both adults and children; require MCO provision of financial information detailing how HealthChoice funds are spent; and finally, institute a cap on the profits that pharmaceutical companies are permitted to make on the sale of drugs to the Medicaid program.

➤ Pharmacists. Pharmacists reiterated the problems expressed by both consumers and physicians with varying and constantly changing MCO drug formularies. They also expressed frustration with their inability to verify enrollee eligibility during nights and weekends—the very times when enrollees are most likely to fill prescriptions. They believe that MCOs' and the Department's Eligibility Verification System (EVS) are inaccessible on weekends and after hours during the week.

➤ Dentists.

- *Access – payment rates.* Dentists expressed extreme frustration with the access to dental care under HealthChoice. Dentists acknowledge the low number of providers who choose to participate in the program and cite the Department's low dental reimbursement rates as one of the leading reasons. While they acknowledged that dental rates have increased relative to the State's MAC program, they note that rates paid by HealthChoice MCOs continue to be lower than those of neighboring state

Medicaid programs, and they note that the MCO that paid the highest dental rates is no longer participating in the program.

- *Other administrative issues.* Other administrative issues that are problematic for many dentists include the perception of a high turnover rate among MCO dental benefit managers or vendors in recent years. Increased paperwork is also a problem. A number of dental providers said that the timeliness of provider payments had improved and was no longer as problematic as it had been in the past.
- *Broken appointments; transportation; dental specialty access.* In terms of care issues, dentists cited the high proportion of appointment no-shows – 40 to 50 percent in the HealthChoice population – as a problem. Many acknowledged that transportation was a tremendous problem for their HealthChoice patients, and that many had to travel large distances in order to get to their offices. Several dentists noted that while some children seemed to be getting preventive dental care and cleanings, many that should were not getting cavities filled. In addition, several dentists cited problems finding dental specialists for their patients.
- *Dental education.* Interestingly, several dental providers pointed to a lack of awareness concerning dental hygiene and the need for better dental education in the HealthChoice population as an issue. Some noted that because Medicaid had failed to cover adult dental services for so long, many parents were uninformed about important aspects of routine oral health care and thus failed to set an appropriate example for their children. Several also noted the relationship between good dental care and workplace opportunities in later life, saying that adults often have trouble finding private sector jobs if their mouth looks particularly bad.

➤ Federally Qualified Health Centers

- *Historic provider relationship.* The most important and central concern that FQHCs have with the HealthChoice program is a disruption in the relationship between historic providers and Medicaid patients that they state has occurred as a result of HealthChoice.
- *Financial resources.* A second major concern and one that is also unique to the FQHCs is the movement away from presumptive eligibility and its reported negative effect on clinic finances. Moreover, clinic financing has been further stressed because directors report that they have had to hire more administrative staff in order to participate in the HealthChoice program. These financial stresses, in turn, have increased clinic directors' concerns about their ability to continue to have sufficient resources to adequately serve the uninsured.
- *Translation services.* Clinics also report having problems surrounding translation services. Many FQHCs report having a large non-English speaking population. Some clinics reported they are unable to obtain adequate translation services from MCOs. Others note that they are unable to obtain reimbursement for the translation services they must provide for their non-English speaking consumers .
- *Mental health, substance abuse treatment services.* They also raised concerns about mental health services. Clinic directors reported little coordination, overall, between somatic and mental health services. In addition, they reported that their clinics were currently providing a significant number of mental health and substance abuse treatment services in-house, which they believed was quite beneficial for HealthChoice recipients.
- *Transportation services.* Several FQHC providers mentioned problems with HealthChoice transportation services. They noted that transportation often stopped at the county line, a problem in suburban Maryland where Prince George's County residents sought care from Montgomery County providers and vice versa. The program's transportation services typically will only take the patient. This is a problem for a mother who has a sick child and other children, they said. Moreover, they stated that HealthChoice transportation services required consumers to arrange for their rides at least 72 hours in advance, which is particularly difficult if an individual needs urgent or specialty care. FQHCs noted that they

were continuing to provide transportation services to consumers and wanted to be reimbursed for this.

- *Consumer education.* FQHCs also noted that HealthChoice and the MCOs' systems have been very complicated for patients to understand and negotiate. This, in turn, has placed an increased educational burden on clinic staff, who must take the time to explain various program and MCO rules and requirements.
- *Dental services – reimbursement.* Additionally, the FQHCs uniformly felt that dental services were under-funded, and that the dental benefits package should be expanded to include crowns, bridges and periodontal work, the need for which is particularly acute in the HealthChoice adult population.
- *Provider funding.* In addition to many of the aforementioned concerns, clinic directors also echoed many of the issues raised by other provider groups, namely the program's inadequate provider funding and a desire to see rates raised to levels comparable to Medicare. FQHCs also raised many of the same concerns with respect to eligibility, administrative issues as other groups discussed above.

Program Changes Suggested by Providers.

➤ Reimbursement.

- Increase rates.
- Acceptance by MCOs and mental health providers (MHPs) of electronic claims (this would help with lost claims concerns).
- Clearly define a “clean” claim.
- Timely payment to providers by MCOs and MHP; otherwise MCOs and MHP should be required to pay.
- Reimburse providers for legitimate services regardless of the consumer's MCO or PCP.
- Establish an appeals process for disputed claims by DHMH.
- Services should not be bundled.

➤ Patient Care.

- Increase number of providers, especially specialists (in certain geographic areas and especially for dental and mental health services).

- Permit consumers to receive care from out-of-state specialty providers (e.g., as done by MPC in Western MD but not by Priority Partners on the Eastern Shore or in Western Md.)
- Improve coordination of care between MHP and the PCP
- Allow mothers to choose the MCO and the PCP for newborns
- Allow DSS workers or foster parents to choose the PCP for foster care children
- Improve coordination between the health care system and the educational system
- Improve education of HealthChoice consumers by MCOs
- Consumers need to take responsibility for keeping appointments and not abusing the system. This should include fines.
- Make generic drugs mandatory, and require enrollees to pay for the less expensive over the counter drugs.

➤ Administration.

- Do not expand MCHP unless the provider network is in place.
- Simplify EVS –swipe card would be ideal.
- MCO manuals must be accurate and on-line.
- MCOs must simplify the referral process.
- Increased supervision of MCOs by DHMH
- Eliminate the requirement for a physician to contact a patient three times.
- Determine if the consumer wishes to stay with their PCP before auto-assignment.
- Improve the responsiveness of the provider hot line.
- Carve out dental and pharmacy benefits.
- Define case management, who receives it, which entity is responsible for providing it, and ensure that the services are provided; the Department should do this.
- Establish a statewide Medical Assistance pharmacy formulary, and a statewide durable medical equipment and lab contractor.
- Establish uniform rules that the MCOs must comply with (e.g., audits).
- Provide pharmacists with feedback, when appropriate, on consumers' prescription drug histories.
- Allow advanced practice nurses and school-based health clinics to be PCPs.
- Some support for use of dental hygienists in the schools and dental students in the local health departments, or in other county locations.
- Update physicians DEA numbers (DHMH).

MCOs

The Department held one central meeting with MCO directors, facilitated by an independent contractor. In addition, Department staff conducted site visits at several MCO offices.

MCO directors stated that they believed that HealthChoice had created a medical home. They expressed frustrations about unreasonably high expectations of the program. They felt that even their successes were viewed as failures, pointing to dental care as the prime example. MCOs said the program needs adequate funding and stability. Several MCOs said that the Department should be a purchaser – articulating a set of realistic, achievable, measurable, and coherent goals for the program, and then step back to work in partnership with the MCOs in order to achieve these goals. In contrast, several MCOs stated the Department is too often highly reactive to outside comments and functions as a “micro-manager” with a regulatory mindset. Some MCOs believed that the Department is too advocacy based.

Care Issues. MCOs stated that there had been improvements with access to care, but there were concerns about the provider networks. While they believe a medical home has been created, they cite a difficulty with changing patient behavior such as inappropriate emergency room use.

They believe that their role as case managers is not understood and, like many providers, said there was no common definition of case management. Through site visits to the MCOs, the Department met and talked with many MCO case managers. Most MCOs case manage specific populations, such as pregnant women, asthmatics, diabetics, and special needs children. In addition, they have general case management processes and tools for other low-risk populations, as well as outreach and health education programs. When asked about the disconnect between the consumers’ comments that they had not received case management and the MCOs’ case management activity, they thought it may be because consumers did not have a recent contact with a case manager, may not know the term “case manager,” or that the Department failed to speak with individuals who were in active case management with a MCO.

➤ *Program changes suggested by MCOs*

- Increase funding.
- Increase program stability.
- Provide leadership and direction with realistic expectations.
- Expand coverage.
- Eliminate ESI.
- Provide Departmental assistance for provider issues and networks.
- Re-assess of carve-outs.
- Re-think timing on risk adjustment.

- Provide leadership, direction and collaboration on public health issues.
- Formalize strategic planning with MCOs.
- DHMH should be more aware of what MCOs do.
- Create formal process to review and reduce administrative burdens.

Public Hearings

A series of five regional public hearings were conducted in September and October 2001 as part of the Comprehensive HealthChoice Evaluation process. Approximately 153 people attended the hearings, and 78 people testified. Notices for the public hearings were mailed to over 400 public officials, statewide and local advisory/advocacy groups, and the HealthChoice managed care organizations (MCOs). Notices were also published in the Maryland General Assembly's weekly interim hearing schedule.

A few of the speakers at the public hearings prefaced their remarks by noting positive changes they have witnessed since the implementation of the HealthChoice program; including improved access to care through expanded eligibility and a broader benefit package, and the presence of a medical home for consumers.

Much of the testimony, however, referenced concerns about the program. Speakers were not satisfied with the level of provider participation in the program. Different groups from different regions noted a lack of all types of providers - PCPs, pediatricians, specialists, and especially dentists. Speakers also demonstrated widespread agreement with previously noted concerns about reimbursement rates and the overall administrative burden associated with HealthChoice. Other concerns raised consistently throughout the public hearings included poor coordination between mental health, substance abuse, and somatic health care; timeliness of payment; barriers to care for foster care children; difficulties with drug formularies; lack of case management, and problems with auto-assignment.

Conclusions

While various constituencies have differing, sometimes conflicting perspectives on the performance of the HealthChoice program, there are several common themes that emerge from the Department's extensive dialogue with consumers, physicians and other direct providers, MCOs, hospitals, local health departments, and advocates. All of these groups concur that funding, - physician fees in particular - the adequacy of provider networks, and network stability are the major challenges facing the HealthChoice program today.

Different groups express differing levels of satisfaction with the HealthChoice program. Interestingly, those who are most pleased with the program overall are the consumers. The Department went to considerable lengths to ensure that participants in a majority of the focus groups were selected and recruited at random. The Department recognizes that not all HealthChoice consumers are satisfied with the care that they receive and the health outcomes that result.