

Issues Related to
The Implementation of Medicaid and PeachCare
Care Management in Georgia

January 2008

Directed by:

CMO Initiatives Group

A Coalition of Health and Human Services Organizations Concerned about
the Provision of Health Care to Georgia's Medicaid/PeachCare Population

Based on a Survey Conducted by the University of Georgia
Survey Research Center

This study was funded by:
The Governor's Council on Developmental Disabilities
HealthCare Georgia Foundation
Easter Seals of Northeast Georgia
The Georgia Dental Association

Executive Summary

The purpose of this research was to assess the stability of access to health care providers for close to one million individuals with Medicaid or PeachCare who were required to enroll into the Care Management Organization Program implemented by the Department of Community Health between June 2006 and October 2007. Advocates were concerned that information they were collecting from stories in the field did not align with what the Department of Community Health reported, or with the CMO representatives' reports on their progress to the DCH board or the legislature. It was determined that a third party, objective survey research project would be valuable to gain another perspective on the implementation of the CMO initiative.

The data presented here was collected from phone surveys conducted by the University of Georgia Survey Research Center between October and December of 2007. The Survey was designed in consultation with the University of Georgia Survey Research director, specifically to assess whether the Medicaid/PeachCare provider network was as robust as the CMOs and the Department contended, if certain provider groups had limited access to services more than others, and to solicit the opinion of the provider community on the success of the CMO initiative. Calls to over 4,000 randomly selected providers listed in the three CMO catalogues netted 793 completed surveys, a statistically valid sample.

Results suggest that, although they are listed in the provider network as actively serving Medicaid/PeachCare patients in a CMO, some of the providers indicated that they are either no longer seeing Medicaid/PeachCare patients, or that they are limiting the access to new patients. These findings apply in a number of key categories including mental health, primary care and clinics, dental, and therapies. The results lend support to what advocates had been hearing anecdotally.

Providers were asked to rate the CMO initiative and were invited to offer open-ended comments on their opinion of the success of the CMO initiative implementation. The response was overwhelmingly negative; of 227 individual comments, only 13 were mainly positive. Providers cited problems with excessive paperwork, unresponsive customer service, claims processing, the need to deal with multiple systems, prior authorization requirements and service coverage issues.

These findings point to concerns needing attention from policymakers. This report offers a number of recommendations.

Background

In June of 2006, the State of Georgia began undertaking for the Medicaid/PeachCare population the largest roll out of managed care in the history of the country. Within 12 months, close to one million covered lives would be included in one of three Care Management Organizations (CMOs) that contracted with the state. From the beginning, there were numerous issues with the implementation, but it became clear in the board meetings for the Department of Community Health that there was no systematic or objective data collection on the issues that the board or staff from DCH was hearing about anecdotally. The legislature determined to hold off judgment or action until the care management had achieved a full year of implementation, which was completed in October 2007.

During the summer of 2007, advocates began meeting to discuss concerns they were hearing from their respective populations, in particular, issues related to the provision of dental services, therapies, other services provided to young children with disabilities under part c of IDEA, as well as access to both primary care and medical specialties. The coalition of advocates decided to pay for a third party survey primarily to explore whether access to healthcare providers that accepted Medicaid/PeachCare and under the CMO plan had been compromised and to discern critical issues affecting providers.

Survey Methodology

The Survey Research Center at the University of Georgia was hired to conduct a random phone survey of providers listed under the three CMOs, and a questionnaire was developed by the group in consultation with the researchers at the University of Georgia.

Between October 3 and December 4, 2007, 793 interviews with randomly selected health care providers enrolled in the CMO network regarding current CMO practices were completed by telephone or fax. The random sample of 4,004 health care providers was drawn from online searchable databases of the three CMOs serving Georgia, Amerigroup, Wellcare, and Peach State. The cooperation rate for the survey was 65.2% (See Table 1, Appendix). The following table presents the characteristics of the respondents by provider type and telephone area code.

Characteristics of Providers

	n	%
<i>Type of Provider:</i>		
Medical Specialists	74	9.3
Surgery/Surgery Specialists	30	3.8
Mental Health	47	5.9
Dental	64	8.1
Vision	34	4.3
Therapies	11	1.4
Primary Care	207	26.1

Pharmacy	248	31.3
Clinic	44	5.5
Other	34	4.3
TOTAL	793	100.0

Geographic Area of Interview:

229 (Southwest)	87	11.0
404 (Inner Metro Atlanta)	108	13.6
478 (Outer Metro Atlanta)	82	10.3
678 (Inner Metro Atlanta)	49	6.2
706 (North)	121	15.3
770 (Outer Metro Atlanta)	266	33.5
912 (Southeast)	76	9.6
Other	4	0.4
Total	793	99.9

(Note: The provider groupings were determined by a panel from the CMO initiative to facilitate analysis. See Appendix 3 for the specific providers included in each group.)

Assuming a random sample of healthcare providers was obtained, the theoretical standard error of estimates produced for the full sample is .0177, and the sampling margin of error is +/- 3.5% at the 95 percent confidence interval. As with any sample survey, other sources of error, such as error associated with the wording of questions are possible.

The following presents the major findings of the survey, and poses questions and recommendations to the Department of Community Health and the General Assembly toward correcting or improving the implementation of care management for the Medicaid/PeachCare populations in Georgia.

Results

Some Providers Dropping Out

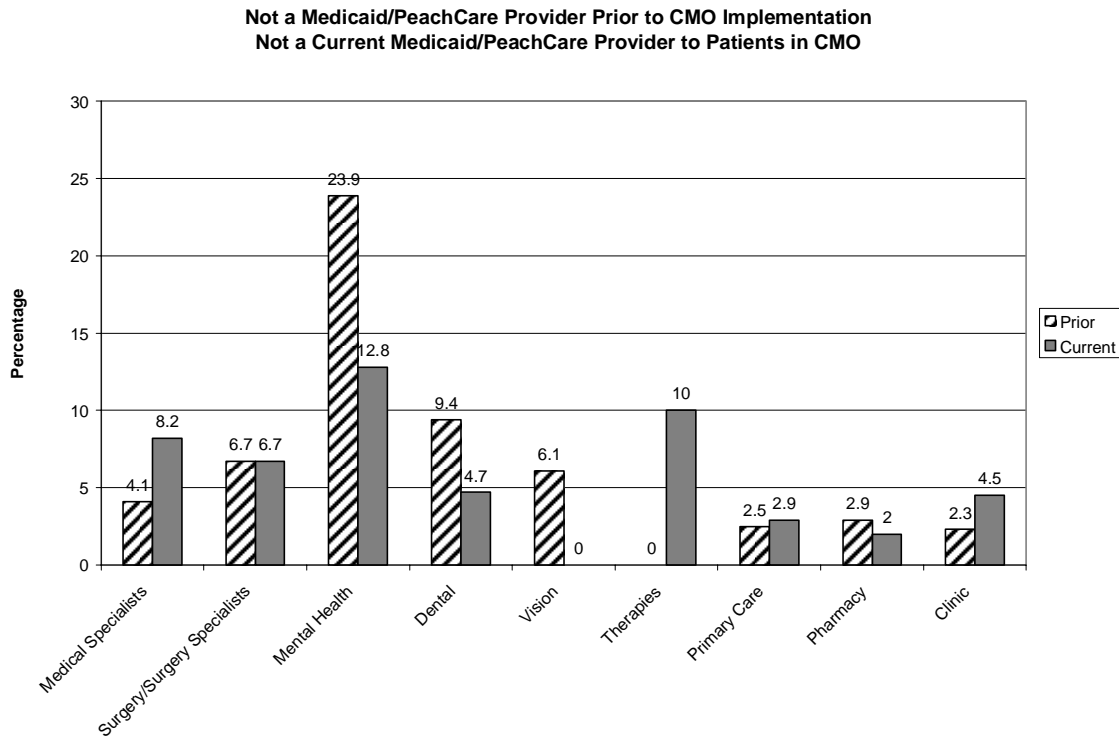
The news from the field was that providers were dropping Medicaid/PeachCare patients or cutting back on service to them due to the administrative burdens of prior authorization, claim denial and appeal procedures, lack of customer service and low reimbursement rates. The survey asked the following questions:

Q - Okay, to begin, were you a Medicaid Provider prior to the implementation of the Care Management Organization initiative?

Q - Are you now a Medicaid Provider to patients in a Care Management Organization?

The Survey showed that 95.1% of Georgia healthcare providers interviewed indicated being a Medicaid/PeachCare provider prior to CMO implementation. 96.8% of

healthcare providers reported filing claims for CMO patients, but only 89.1% reported still taking new, unlimited Medicaid and PeachCare patients. (85.8% reported still seeing fee-for-service Medicaid/PeachCare patients. See Appendix B for Fee-for-Service data.) The following table presents the percentage of surveyed providers who *were not Medicaid/PeachCare providers before* CMO implementation and the percentage of surveyed providers who *are not current Medicaid/PeachCare providers to patients in a CMO*.



Nearly one in four Mental Health providers said they were not providing services to Medicaid/PeachCare patients prior to CMO implementation, although about half that number say they are not providing services to Medicaid/PeachCare/PeachCare patients now under the CMOs; still, there appears to be a net gain for that group. Of Vision providers, 6.1% were not taking Medicaid/PeachCare patients before, but none report not serving them now.

On the other hand, the chart shows that despite being listed in the CMO catalogues and being counted as active providers, a portion of the providers report not seeing Medicaid/PeachCare patients in the CMOs. All of the Therapists surveyed said they had provided services to Medicaid/PeachCare patients prior to CMO implementation, but one in ten said they are not seeing Medicaid/PeachCare patients under the CMOs. Also of concern is that the percentage of Medical Specialists not seeing Medicaid/PeachCare patients doubled from 4.1% prior to implementation of CMOs to 8.2% (one in twelve) after implementation. These results echo what advocates have been hearing, that

obtaining services from specialists and therapists has been particularly difficult for Medicaid/PeachCare patients.

Some Providers Serving Lower Proportions of Medicaid/PeachCare Patients Than Before CMOs

The survey asked,

Q - What percentage of your patients were Medicaid or PeachCare patients prior to CMO implementation?

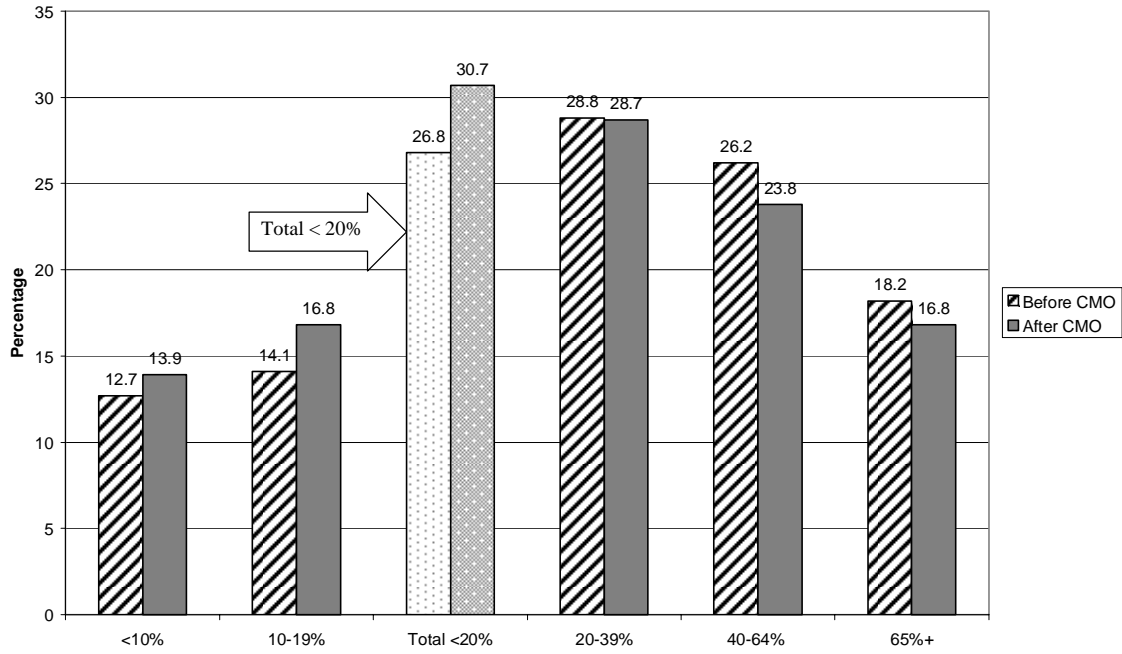
Q - What percentage of your patients now are Medicaid or PeachCare patients?

Some of the providers have lower proportions of Medicaid or PeachCare members in their practices now than they did prior to implementation of care management. Across all provider types, 44% of healthcare providers reported forty or more percent of their patients were Medicaid or PeachCare patients prior to CMO implementation, while 28.8% reported twenty to thirty-nine percent Medicaid/PeachCare patients, 14.1% between ten and nineteen percent, and 12.7% less than ten percent. However, certain provider groups indicate greater shifts in the percentage of their Medicaid/PeachCare patient load from before to after CMO implementation.

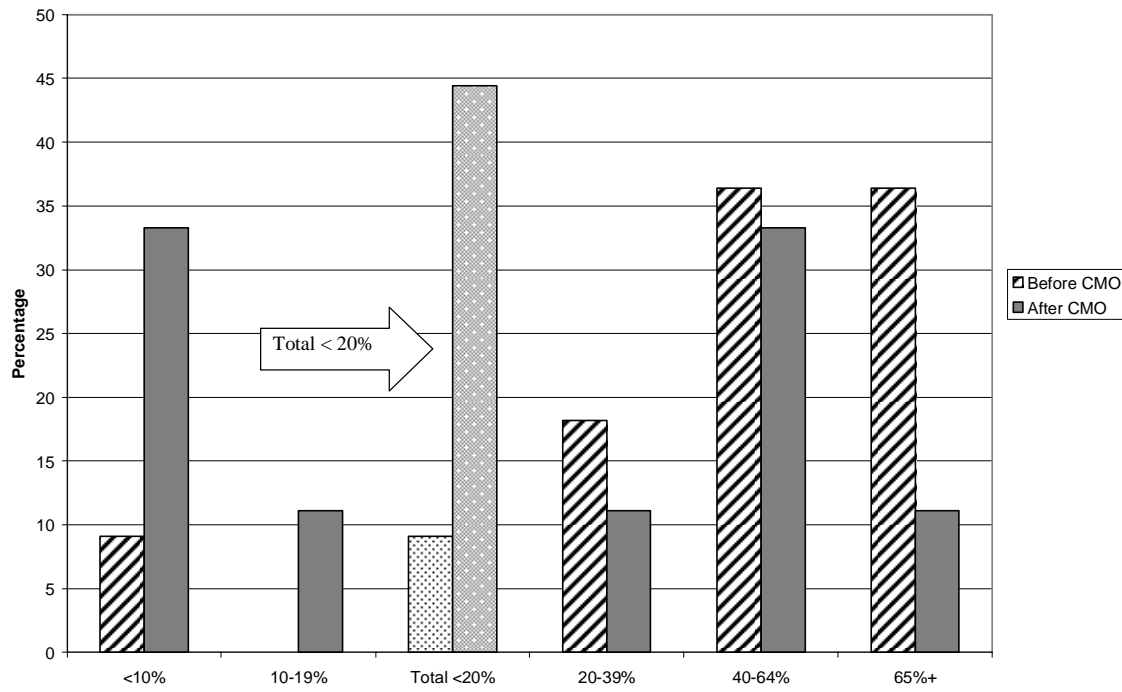
- Among dentists, 30% say that fewer than one in 5 of their patients have Medicaid or PeachCare now, as opposed to 19.3% before CMOs.
- The figures for mental health professionals are 39.5% and 31.3% respectively. This might be explained by the fact that nearly 24% of the mental health providers said they had not been Medicaid/PeachCare providers prior to CMO implementation, except and over half that number (12.8%) say they are not currently providing Medicaid/PeachCare services.
- Among therapists, the numbers are the most striking: 44.4% have fewer than 19% of patients enrolled in Medicaid or PeachCare, up from the 9.1% who reported a low proportion of Medicaid/PeachCare patients before CMO implementation.
- Vision providers appear to have higher proportions of these patients now; only 18.8% say their practices include fewer than 20%, in contrast to the 30.4% who reported low rates of Medicaid and PeachCare patients before CMOs.
- Even primary care providers are more likely to report that their proportions of Medicaid/PeachCare patients are declining.

The following charts present this data visually.

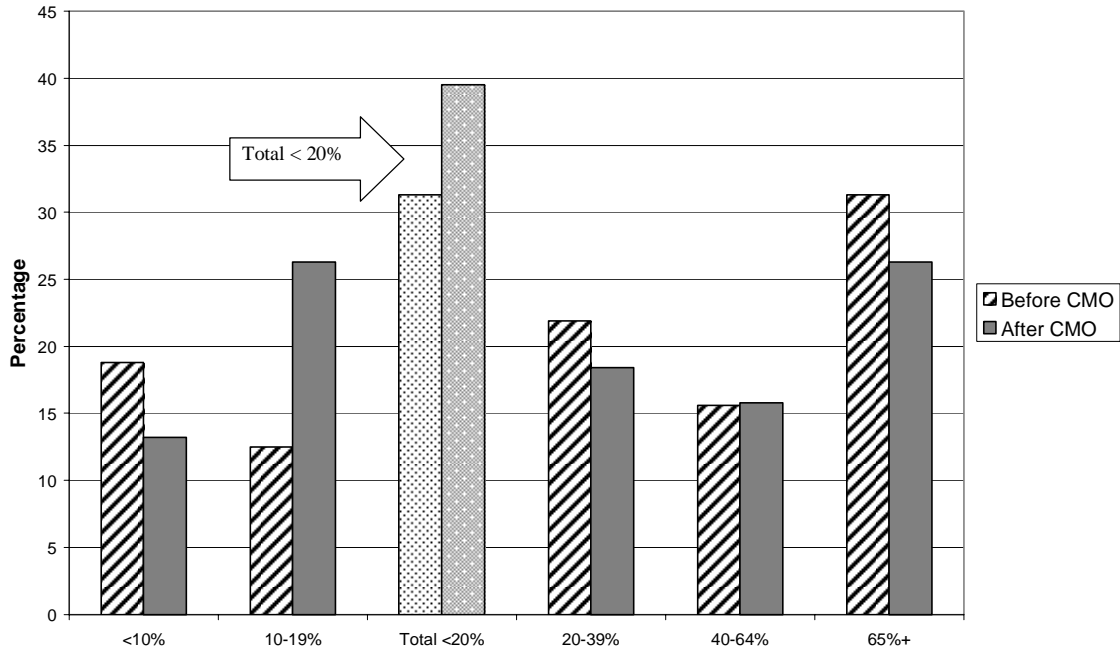
**Percent of Practice Medicaid/PeachCare Before and After CMO Implementation
All Providers**



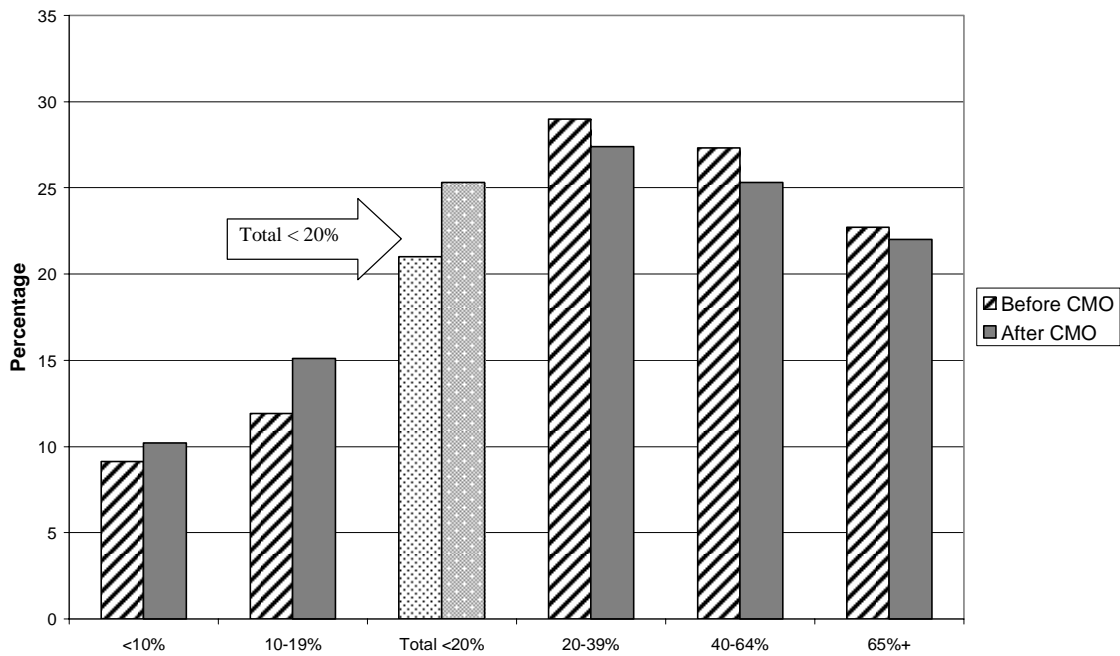
**Percent of Practice Medicaid/PeachCare Before and After CMO Implementation
Therapies**



**Percent of Practice Medicaid/PeachCare Before and After CMO Implementation
Mental Health**

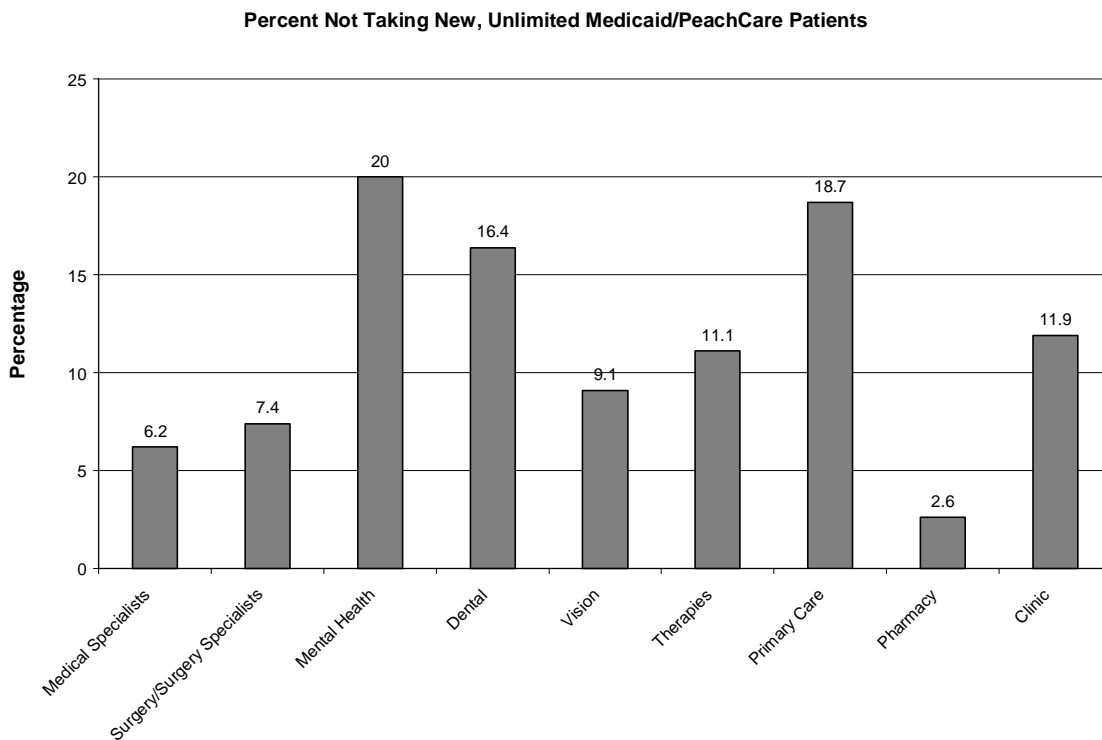


**Percent of Practice Medicaid/PeachCare Before and After CMO Implementation
Primary Care**



Some Providers Not Accepting New, Unlimited Medicaid/PeachCare Patients

Another concern heard by advocates from the field was that individuals eligible for Medicaid or PeachCare were having difficulty locating a provider that would accept them as a new patient. Across all categories, 96.8% of health care providers reported currently filing claims for CMO patients, but only 89.1% reported taking new unlimited Medicaid and PeachCare patients. The following chart displays the percentage of each type of provider indicating that they were NOT accepting new, unlimited Medicaid/PeachCare patients. Unlimited means any Medicaid/PeachCare patient, regardless of age, relationship to existing patient (such as sibling, or newborn of enrolled patient), condition, or provider capacity.



Reasons for not taking new Medicaid/PeachCare patients without qualification ranged from age (which would be appropriate for providers in a specific practice such as pediatrics), condition of the patient, refusal to work with a particular CMO, or administrative burden. For example, they only take a few CMO patients a day, or only take them in one of their offices and not another because of the paperwork or difficulty in handling referrals.

These results indicate that

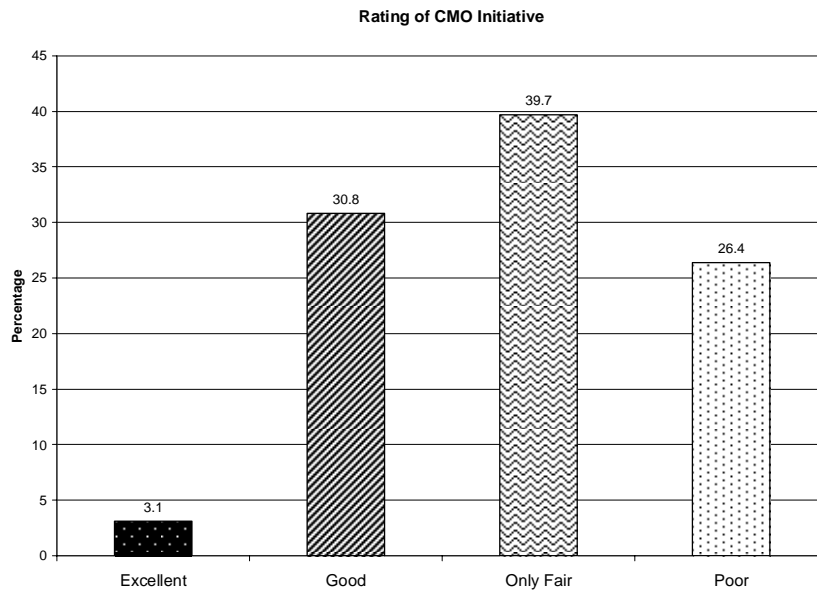
- 1 in 5 mental health providers
- 1 in 5.3 primary care providers
- 1 in 6.1 dentists,
- 1 in 8.4 clinics
- 1 in 9 therapists

are restricting acceptance of new Medicaid/PeachCare patients. These results are spread fairly evenly among the three CMOs.

	Amerigroup	Wellcare	Peach State
<i>Taking New, Unlimited Medicaid /PeachCare Patients:</i>			
Yes	91.8	90.8	89.7
No	8.2	9.2	10.3

Most Providers Rate CMO Initiative Only Fair or Poor

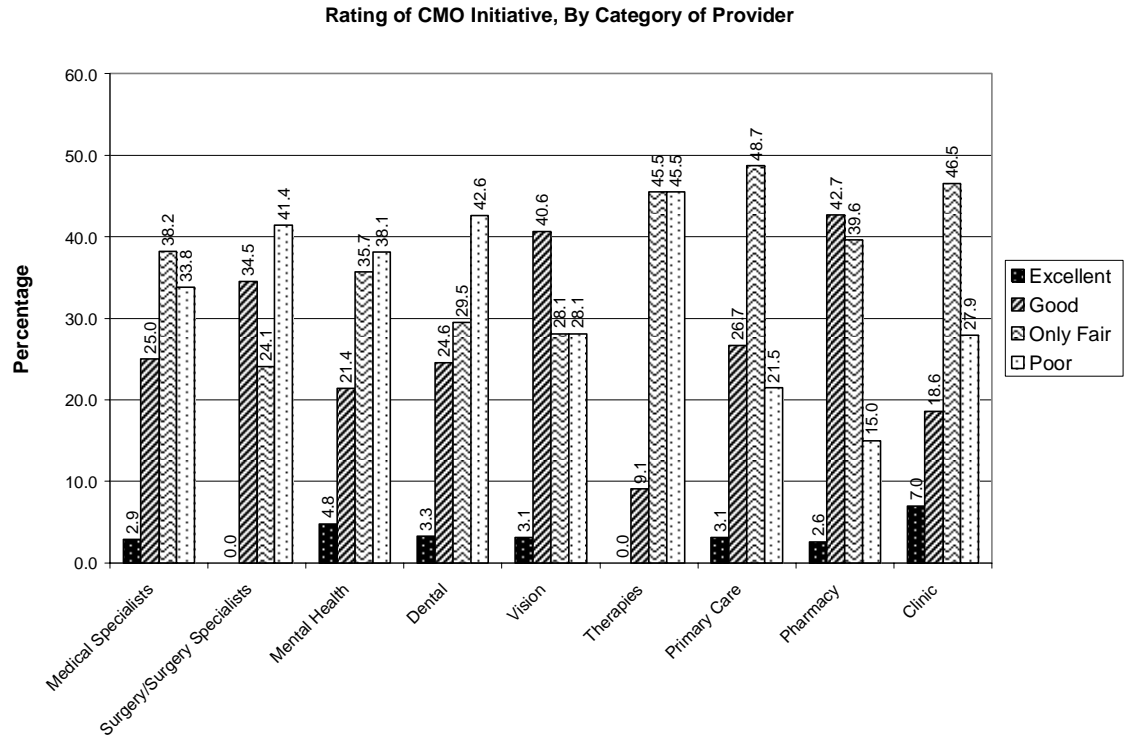
Finally, the survey posed the question, “How would you rate the Care Management Organization initiative since its implementation? Would you rate it as excellent, good, only fair, or poor?” A majority of health care providers (66.1%) report the Care Management Organization initiative as Poor (26.4%) or Only Fair (39.7%), while 33.9% rate the CMO initiative as Good (30.8) or Excellent (3.1%)



This result varied slightly by region. Nearly 3 in 4 providers in the Southeast region rated the CMO initiative as Only Fair or Poor as compared to 68.3% in Southwest, 64.3 in North, 65.5 in Outer Metro Atlanta and 62.3% in Inner Metro.

The following table illustrates the rating of CMO implementation by provider type. Nearly two-thirds of all providers rated the CMO initiative as Poor (26.4%) or Only Fair (39.7%).

- Therapists gave the least favorable overall ranking with 91% saying the initiative was Only Fair or Poor with the two designations equally split.
- Therapists, Dentists and Surgeons/Surgical Specialists registered the most intense unhappiness; over 40% of each giving the initiative a rating of Poor. This result is consistent with anecdotal information.
- Pharmacies and vision providers were far more likely than others to rate the CMO initiative as Excellent or Good (45.3% and 43.7% respectively). Within these totals, Excellent ratings were rare; 7% of clinics rated the effort as Excellent, but no other group exceeded 5%.



In addition, measures of dissatisfaction did not vary greatly among the different CMOs, as illustrated in the table below.

In general, not considering individual CMO organizations, how would you rate the Care Management Organization initiative since its implementation? Would you rate it as excellent, good, only fair, or poor?

	Amerigroup	Wellcare	Peach State
Excellent	2.8	2.9	3.3
Good	30.7	33.2	32.9
Only Fair	41.2	39.5	39.7
Poor	25.3	24.4	24.0

Finally, the survey gave respondents an opportunity to comment in an open-ended response, on anything else they wished to share with the surveyor on the implementation of care management. This item netted 22 pages of predominantly negative comments.

Examples of Comments

Administrative/Systemic Problems: Paperwork, prior authorizations, lack of, or unresponsive customer service, time to process claims, different procedures for each CMO

- I have someone coming from the organization to talk to me. We have lost hundreds of thousands of dollars with the changeover. It has been a horrible nightmare trying to get the money back. There's never a supervisor to talk with. We have made numerous calls to the Governor's office. They're taking months and months to make claims. They've cut services for children. I could go on and on.
- Everything has been horrible since the CMOs have been started. I haven't been paid by Peach State since July, and I will now only take straight Medicaid.
- Provider reps do not return phone calls or emails. They are very slow to correct errors in their systems, which often means long delays in reimbursement.
- Amerigroup has lowered its fee schedule below the current rates for Medicaid. They have also denied all the "global" charges for OB, stating we must bill out visits separately which is against HIPPA rules and AMA guidelines. When we bill these visits separately they then deny the charges that are over 3 months old.
- A lot of people don't know what program they are in, so the patients have to figure it out and it's frustrating. It would be good if the patients received their numbers.
- Billing was a lot easier before. Now we have to bill three different ways. Take a couple weeks to get paid for services. For example, being paid now (10/24) for services on October 6th.
- I think that the trouble that we have is that there is a lot of switching back and forth that is very time consuming.
- I do know that it has delayed surgeries that we cannot get the CMOs to authorize, which has led to a delay in their care and that can result in negative outcomes.
- It has caused an increase in paperwork, manpower, and confusion, and has limited the ability of the specialists.
- It is better than it was a year ago, but there are problems getting claims paid. The communication between the CMOs and the people who do the claims—there is not good communication on how they want the claims done. It has not necessarily helped the patient. I know families listed with one of the CMOs and it has made it harder for them.
- It's not been the easiest system to deal with and it continues to be difficult to deal with. Things change quickly and they don't always let us know ahead of time.
- Each one has different regulations and need to be consistent.

- I wish I had better access to customer service. The way they handle it, we have to wait on the line for a long time. I cannot do anything quickly. They should be much more available for us.
- Pain in the neck to get them to provide credentials and therefore we do not accept any CMOs.
- Patients have a hard time knowing which CMO they have. They need to educate the patients.
- Presently reviewing Medicaid b/c patient claims have not been paid correctly or even paid as agreed. Rules change frequently. When Medicaid rules change, we receive only 1-2 days notification (Ex.: August 30th notifies to changes effective September 1st). There are four different plans with different rules and different pay. Too time consuming and too confusing. Adults and kids, multiple coverages, all different.
- Sorry, poor, slow response. Don't seem to really care about the patients. Worse than before and pay is eleven months down the line, where as before you could depend on it in 30 days.
- The doctors are not pleased with the rate they are getting. It's confusing and they cannot perform in their career to the fullest extent.
- The patients are not happy with it. I get less fees and patients do not know what services they get and which ones they don't. Confusion on how to file claims and hard to reach.
- They don't pay at all and they are hard to deal with; it seems like they pick and choose what they want to pay.
- It takes entirely too much time on the telephone to get procedures approved and or referrals
- Since they have lowered the fees by 25%, we have considered not seeing our existing Medicaid and PeachCare patients.
- The CMO's don't cover the same procedures that Medicaid covers including some immunizations! On Wellcare, prior approval is required even for wart removals.
- Their websites often have incorrect info regarding eligibility of patients. They continue to assign new adult patients to our practice even though we informed them from the beginning that we only accept new children Medicaid patients
- We always think about discontinuing seeing patients in CMOs because of frustration of dealing with them and we feel they cheat the physicians.

Special Needs/Disabilities

- That has been a terrible experience and I feel badly for the families that are on CMOs right now because they are being denied needed services. So I'm very concerned for those families, especially ones with special needs kids.
- The ones with special needs certainly need to be taken care of.
- They need to get rid of CMOs. It's devastating for the families. We serve children with disabilities and they do not need to be linked into the system. They just need to get services.

- Yes, poor reimbursement to providers, poor to none. Difficulty receiving prescriptions and necessary documentation and limited therapy sessions. It's a very poor program for special needs patients.

Children and Families

- I think it has put up a lot of barriers for children and their families seeking services. Families do not understand new protocol. We are non-profit and it makes a difference on how we answer questions.
- [Us] grownups can make do but children are getting a bum deal and there are a lot of drugs we cannot get them to pay for when the children are suffering. It is just not right and children are suffering and they are not the ones in charge of their families' financial situations.
- This sounds political but I think the initiative is wonderful, but the application is the trouble. When I say we have lots of problems, basically we had a child who had a CATHA score and it said he needed help. He was failing and now he's on the honor roll. Then they said he was doing too well so they wouldn't help him. Now he plays football so he needs more medicine, but his physician refused. The CMO just said he'd have to go into crisis and then we can help him again. One of his diagnoses is ADHD. And now he has to fail to do well again. It's frustrating. And we see cases like these every week.
- I think the children of Georgia are going without services because the CMOs as set up at this time, make it almost impossible to work with these patients (pediatrics). The standards that the CMOs use are based on an adult population and do not take into account children. The CMOs, particularly Amerigroup, don't know what each part is doing. Not worth time and frustration.
- I think they knew exactly what they were doing; decreasing the amount paid to therapists; it decreases the chance that someone is doing what they are good at. Quality caregivers are now backing out and children are suffering now because poor quality care is being provided.
- I think it's awful the way they are treating the children. I think they should let ACS take it back over.
- I would say that the main problem is that we have children who meet the criteria, they say they have to go through extra authorization and my office provides the authorization and they still deny these children. These children fit the criteria to be seen in my office. CMOs say they can't provide services.
- It's very sad for patients. Fees have been cut so much, kids really suffering. It has put a lot of businesses out of business and left many without care. It is the worst!!!
- They are absolutely horrible. They have absolutely ruined the Medicaid and PeachCare patients. We had no problem seeing children on Medicaid. We would continue if they were not on CMO forever. They have ruined the system.

Pharmaceutical

- A lot of problems exist in the pharmacy: getting formulas on time and paying claims on time.
- It was a nightmare when it started; gotten better. I don't believe it is doing what it is supposed to do, seems to have pharmacy problems, problems with formulary.
- Just that they are putting an undue burden on pharmacists. They audited pharmacies, saying they were using dummy physician numbers and we were hit for several thousand dollars and my understanding is that they are strapped for money and felt they could get some from pharmacies. And we are getting undue audits that they hit us up for and if everything isn't exactly right, they have to bill us.
- The CMOs should coordinate and allow pharmacists more [of a] role.
- Not much notice for pharmacists about which medications are covered.
- They don't want to pay pharmacies for counseling, but they expect the pharmacists to act as counselors for CMOs.
- They have made restrictions on certain medications for certain patients and require more substitutions which usually increases time for patients to get prescriptions.
- Incompetent. Waste of money for tax payers, and waste of time for pharmacists. It is impossible to deal with.
- Increase in time and labor due to formulary restrictions for both pharmacy employees and physician employees.
- Perhaps if they just broaden the formulary. Since they went in to these three categories [less] drugs are covered.
- There are so many restrictions that require additional work. It makes it more difficult to fill prescriptions. About 20-25% aren't covered on the plans that people have so we have to make phone call after phone call. I think part of the problem is that the doctors aren't informed about which medicines are covered.
- They can update the formularies so that kids can get medication.
- They cut off a lot of medication that I feel is necessary for our patients.
- They have the most restrictive formularies and it makes it very difficult to treat a child.

Referrals

- I just think it is impeded care, and what we have found is we're having a hard time making referrals to doctors that will accept Medicare.
- I think the state needs to do something about it. A lot of our patients have not been able to receive care because of it. We are primarily a Medicaid office and have had a hard time finding physicians that will deal with the CMOs.
- If everyone was just on Medicaid, everything would be a lot simpler; there is a lot of paperwork involved, doctors don't do as much referring because of the amount of paperwork.

- Our problem is when we have to refer to another specialist. Many specialists are not taking any new CMO patients.
- I think the lack of specialists is biggest problem.
- It has caused an increase in paperwork, manpower, and confusion and has limited the ability of the specialists.

The 22 pages of open-ended responses contained 227 separate comments; of those, only 13 could be considered positive, and even some of those were qualified.

Positive Comments

- I feel it is a good program.
- I have spoken with a few of the care nurses and they are excellent.
- I do like that it works more like a regular insurance plan. They have a set formulary.
- It is a good program.
- It started out kind of shaky and it was mostly people not getting their cards, but it is now good.
- It's coming along.
- It's improving.
- No, I think it has been a good thing that has opened a lot of choice up to the consumer. I think it's all positive.
- No. Just keep up the good job. I feel a little different from other people. I think they are doing great.
- The system is running fairly decently. A lot better than other insurance companies do.
- They have gotten better from what I can tell. They cover more than they were. Medicaid paid a lot more than Peach State.

Professional Provider Association Interviews

In an effort to corroborate the data for this report, Voices for Georgia's Children contacted 19 different statewide health provider associations in September 2007, and 8 responded. Association representatives were asked to list and describe their top three challenges, if any, with the Georgia Families CMO program. All respondents listed many more than three challenges or complaints, ranging from five to seventeen unique complaints from each association. The eight respondents each named the same three complaints; administrative problems related to non-timely prior authorization; incorrect, inadequate and late payments; and deep concerns about limited access to care for patients, particularly regarding specialty care. "**Prior authorization problems**" was the top problem listed for four associations; "**incorrect, inadequate and late payments**" were the top problem listed by three associations, and one association listed "**limited access to care**" as its number one concern.

Recommendations

1. DCH is beginning to conduct assessments in phases through a third party contractor, Myers and Stauffer, LC. The study on implementation in the hospital setting is completed, and on the web. Numerous issues, some of them very similar to the results of this study, were cited in that report. Following will be reports on other aspects of care management implementation in the healthcare provider community. We recommend cross referencing the results of this study with the hospital study and subsequent provider studies, in order to insure that all issues are addressed.
2. Second, due to the vulnerability of young children with disabilities, the impact of CMOs on their care and treatment, and the withdrawal of many therapy providers to that population, we recommend that the Babies Can't Wait program be carved out of the CMO program, which would allow them to be treated under fee-for-service Medicaid.
3. Intense scrutiny and attention should be given to the availability and distribution of specialists in the state that are willing to serve Medicaid/PeachCare patients. Judging by the comments, in particular need are psychiatrists, neurologists, orthopedists, and dental specialties. These specialties are in particularly short supply for the pediatric population.
4. It may be worth consideration to carve dentistry out of the CMO program as well. The reimbursement rate, and frequent changes to the dental services covered have caused a great deal of instability in that area of healthcare.
5. DCH should stabilize procedures and processes across all the CMOs to ease the administrative burden on doctors, and to increase the transparency so that the standards by which care is either provided or denied are known to doctors and patients.
6. DCH should strictly monitor CMOs' compliance with federal law EPSDT requirements for screening, diagnosis and treatment for children.
7. We caution against bringing more Medicaid eligible individuals into the CMO program, such as the Aged, Blind and Disabled population as was proposed last year, until the payments and procedures with the currently enrolled population are stable.

Appendix A
Table 1

Summary of Survey Effort

	n	% Category
Interview:		
Complete	793	98.4
Partial	13	1.6
Total	806	100.0
Eligible, Non-Interview:		
First Refusal	103	5.0
Final Refusal	307	15.0
<i>Non-Contact</i>		
Respondent Never Available	42	2.1
Ans. Machine, No Message	814	39.8
Ans. Machine, Message	2	0.1
<i>Other</i>		
Language Unable	3	0.1
Misc. Unable	1	0.1
<i>Callbacks</i>		
Callback, Respondent Not Selected	9	0.4
Callback, Respondent Selected	762	37.3
Total	2043	99.9
Unknown Eligibility: Non-Interview:		
<i>Unknown if Business</i>		
Busy	182	29.6
No Answer	419	68.1
Ans. Machine	1	0.2
Technical Phone Problems	9	1.5
Unknown if Eligible: Other	4	0.6
Total	615	100.0
Not Eligible:		
Fax/Data Line	47	8.7
Non-working/disconnected		
Non-working number	57	10.6
Disconnected number	251	46.5
Technological circumstances		
Number changed	14	2.6
Cell phone	7	1.2
Call forwarding	2	0.4
Not an eligible business		
Bus/government/other Organization	13	2.4
<i>No Eligible Respondent</i>	149	27.6
Total	540	100.0
Cooperation Rate		65.2%*

*American Association for Public Opinion Research COOP3 = Interviews/(Interviews +Partials + Refusals)

Appendix B

Q7 Still Seeing Fee for Service Medicaid/PeachCare Patients:

	Yes	No
Medical Specialists	93.1	6.9
Surgery/Surgery Specialists	92.3	7.7
Mental Health	77.5	22.5
Dental	84.4	15.6
Vision	90.0	10.0
Therapies	87.5	13.5
Primary Care	89.7	10.3
Pharmacy	79.0	21.0
Clinic	90.2	9.8
Other	96.0	4.0

Appendix C

Providers by Category

	n	% Category
Medical Specialists		
Allergy Immunology	6	0.7
Cardiology	8	1.0
Dermatology	1	0.1
Diagnostic Radiology	2	0.2
Gastroenterology	6	0.7
Gynecologic Oncology	1	0.1
Hematology/Oncology	3	0.3
Interventional Radio	1	1.0
Neonatology	2	0.2
Nephrology	3	0.4
Neurology	4	0.5
Nuclear Medicine	1	0.1
Otolaryngology	9	1.1
Pain Management	1	0.1
Pediatric Cardiology	1	0.1
Pediatric Hematology	1	0.1
Physical Medical An.	1	0.1
Podiatry	11	1.4
Pulmonary Disease	2	0.2
Pulmonary Diseases	1	0.1
Radiation Oncology	4	0.5
Rheumatology	1	0.1
Sleep Disorders	1	0.1
Urology	3	0.4
Total	74	
Surgery/Surgical Specialists		

Ambulatory Surgical	1	0.1
Anesthetist, Nurse -	1	0.1
General Surgery	14	1.8
Neurosurgery	2	0.2
Orthopedic Surgery	2	0.2
Plastic and Reconstructive	2	0.2
Surgery, Colon and Rectal	1	0.1
Surgery, General	3	0.4
Surgery, Orthopedic	1	0.1
Thoracic Surgery	2	0.2
Vascular Surgery	1	0.1
Total	30	
Mental Health		
Clinical Social Work	8	1.0
Lic Professional Counselor	3	0.4
Psychiatry	11	1.4
Psychologist	24	3.0
Psychology	1	0.1
Total	37	
Dental		
Dentistry	18	2.3
Dentistry, General Prac	44	5.5
Dental Surgery	1	0.1
Periodontics	1	0.1
Total	64	
Vision		
Ophthalmology	11	1.4
Optical	2	0.2
Optometry	21	2.6
Total	34	
Therapies		
Audiologist	2	0.2
Occupational Therapy	1	0.1
Physical Therapy	3	0.4
Speech Therapy/Path	5	0.6
Total	11	
Primary Care		
Certified Nurse Practitioner	1	0.1
Family Practice	32	4.0
Family Practice	14	1.8
Family Practice 770-	1	0.1
Family Practice Nurse	4	0.5
General Practice	6	0.7
General Practice	1	0.1
Internal Medicine	36	4.5
Internal Medicine	24	3.0
Pediatric Medicine	25	3.1
Pediatrics	4	0.5
Pediatrics	35	4.4
Physicians Asst.	2	0.2
Nurse Practitioner	3	0.4

	Obstetrics/Gynecolog	3	0.4
	Obstetrics Gynecolog	15	1.9
	Obstetrics Gynecolog	1	0.1
Total		207	
Pharmacy			
	Pharmacy	248	31.3
Clinic			
	Clinic	44	5.5
Other			
	Ambulance Service Pr	1	0.1
	Coordinated Care	5	0.6
	Critical Care (Internist)	1	0.1
	Dialysis Center	2	0.2
	Dietician/Nutritionist	1	0.1
	Dme	9	1.1
	Emergency Medicine	4	0.5
	Federally Qualified	2	0.2
	GERIATRIC MEDICINE	1	0.1
	Home Health	1	0.1
	Hospice	2	0.2
	Hospital	1	0.1
	Independent Laboratory	2	0.2
	Medical Supply Company	1	0.1
	Orthotics/Prosthetic	1	0.1
Total		34	

Appendix D

Healthcare Provider Care Management Organization Survey

Hello, this is [NAME] at the Survey Research Center at the University of Georgia and we are working with the Governor's Council of Developmental Disabilities to interview health care providers in Georgia regarding the June 2006 implementation of the Care Management Organization initiative. Is [IMPORT DOCTOR NAME HERE] available to complete a 5-minute interview on experiences with the CMO initiative?

Yes

No [IS THERE A TIME I COULD SCHEDULE AN APPOINTMENT TO SPEAK WITH [IMPORT DOCTOR NAME HERE]?

[INTERVIEWER: OFFER TO SEND THE SURVEY QUESTIONS TO THE DOCTOR IN ADVANCE OF THE MEETING, AND LET THEM KNOW THE DOCTOR MAY COMPLETE THE QUESTIONS AND FAX THE RESPONSES BACK TO THE CENTER.

Great, before we get started, I need to let you know that your participation is completely voluntary. You may decline to answer any question or part of a question without penalty. You may also withdraw from the survey without penalty. Your responses will be kept confidential and

will not be released in any individually identifiable form, unless otherwise required by law. All information collected in connection with this study will be disassociated with your and your practices name once data collection is completed. The survey should take no more than 8 minutes to complete.

If you have any further questions now or during the course of this study, please contact Dr. James J. Bason, Survey Research Center, University of Georgia, Athens, GA 30602; phone: (706) 542-9082; email address: jbason@uga.edu.

Additional questions or problems regarding your rights as a research participant should be addressed to The Chairperson, Institutional Review Board, University of Georgia, 612 Boyd Graduate Studies Research Center, Athens, Georgia 30602-7411; Telephone (706) 542-3199; e-mail address IRB@uga.edu.

Q1 - Okay, to begin, were you a Medicaid Provider prior to the implementation of the Care Management Organization initiative?

- 1. Yes
 - 2. No [SKIP TO Q3]
- 9 – Refused/Don't Know

Q2- What percentage of your patients were Medicaid or PeachCare or PeachCare patients prior to CMO implementation?

_____ %

Q3 - Are you now a Medicaid Provider to patients in a Care Management Organization?

- 1. Yes
- 2. No [SKIP TO Q13]

Q4 – What percentage of your patients now are Medicaid or PeachCare patients?

_____ %

Q5 – In which CMOs are your patients enrolled

[INTERVIEWER: CODE ALL MENTIONED' PROGRAMMER – USE 'MUL' FUNCTION]

- 1. Amerigroup
- 2. Peach State
- 3. Wellcare

Q6 – Are you currently filing claims for patients enrolled in the CMOs?

- 1. Yes
- 2. No

Q7 – Are you still seeing fee for service Medicaid or PeachCare patients?

1. Yes
2. No

Q8 – Are you taking new, unlimited Medicaid or PeachCare patients?

1. Yes
2. No [SKIP TO Q10]

Q9 – How are you limiting new Medicaid or PeachCare patients?

Q10 – Have you decided to discontinue seeing your existing Medicaid or PeachCare patients?

1. Yes
2. No [SKIP TO Q13]

Q11 – Approximately what month did you inform your patients that you would no longer be taking Medicaid or PeachCare patients?

1. June 2006
2. July 2006
3. August 2006
4. September 2006
5. October 2006
6. November 2006
7. December 2006
8. January 2007
9. February 2007
10. March 2007
11. April 2007
12. May 2007
13. June 2007
14. July 2007
15. August 2007
16. September 2007

[If Q6 = '2', ASK Q12]

Q12 – What are the reasons that you are no longer providing services to Medicaid or PeachCare patients?

[INTERVIEWER: CODE ALL MENTIOND]

1. Delayed payments
2. Frequency of denied claims
3. Rate of reimbursement not adequate for service
4. Denials of prior approval requests
5. Delayed response to prior approval requests
6. Application issues (lost paperwork, waited too long for Medicaid number or CMO approval)
7. Can't get help to resolve issues or answer questions

8. Too much paperwork
9. Staff can't handle volume
10. Administrative costs too high for reimbursement
11. Other [SPECIFY _____]

Q13 – One last question, how would you rate the Care Management Organization initiative since its implementation? Would you rate it as excellent, good, only fair, or poor?

Q14 – Do you have any additional comments regarding the CMO initiative?