



New Hampshire Medicaid Care Management Focus Groups Summary Report Year One

A report detailing the results of focus groups and qualitative interviews held with individuals receiving Medicaid benefits in the State of New Hampshire to explore their experience with the Medicaid Care Management Program.

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Horn Research would like to express our deep gratitude to all of the individuals who took time to share their experiences with us. The thoughtfulness and openness expressed by every participant offered us the opportunity to provide what we believe is an informative and revealing first look at New Hampshire's Medicaid Care Management Program.

We would also like thank the State of New Hampshire's Department of Health and Human Services (DHHS) and Health Services Advisory Group, Inc. (HSAG) for giving Horn Research the opportunity to assist in examining this important change in New Hampshire's Medicaid program.

EXECUTIVE SUMMARY

Introduction

In support of the HSAG's external quality review of New Hampshire's Medicaid Care Management Program, Horn Research was contracted to gather qualitative data from Medicaid beneficiaries regarding their experience with the transition to the Medicaid Care Management Program. In conjunction with DHHS, Horn Research identified four Key Points of Inquiry to explore during data collection efforts: *Experience with Medicaid Care Management; Access to Care; Quality of Care and Care Management; and Information Needs*. For Year One of the contract, Horn Research conducted four focus groups and stakeholder interviews with target Medicaid beneficiaries during May 2014.

Methodology

The DHHS provided Horn Research a "blind" list of all Medicaid beneficiaries in Hillsborough County and Belknap County with identification numbers, managed care provider, gender, age, and eligibility category. From this list, Horn Research selected a random sample of beneficiaries that was proportionately representative of the eligibility categories reflected in the Medicaid population in New Hampshire.

Multiple recruitment efforts, including letters, emails and telephone calls, were employed to encourage participation and resulted in all groups being filled to capacity. However, due to illness, work constraints and child care issues, a number of participants were unable to attend the focus groups as scheduled causing a lower than anticipated turnout. These individuals were offered the opportunity to participate in a telephone interview to ensure that their opinions were reflected in the survey results. A total of 36 individuals participated in the project.

Results

When all focus groups and telephone interviews were completed, the information was analyzed by identifying, coding and categorizing primary patterns in the data. The consistent patterns found in the analysis of the data and the representative sample supports the validity of the information gathered, but should not be assumed to be *statistically* representative of the whole population. The information provided in this report should be used to identify salient issues relevant to the population, provide contextual information for the larger assessment process, and identify avenues for further research.

Experience with Medicaid Care Management

In order to understand their knowledge of and engagement with Medicaid Care Management and their MCO, participants were asked to describe how they chose their MCO, what they liked best and least about their MCO, and any problems they have experienced. Participants said they had sufficient notification of the change to managed care, but did not feel adequately prepared to decide between MCOs. Most participants selected the MCO that included their primary care physician in the network rather than the MCO that provided the best coverage for their needs. Overall, participants said they did not understand their MCO and did not know how to find out or understand coverage details. Several participants said they experienced significant delays in receiving their benefit cards.

Access to Care

A key to understanding how well the Medicaid Care Management Program is performing is to identify whether participants have experienced improved or diminished access to doctors, specialists, medications, and ancillary services. Overall, participants said the access to their doctors has stayed the same. The main concerns expressed about access were related to medications and specialists. Many participants said they had experienced challenges with medications not being covered under the new MCO and delays in receiving prescriptions and referrals to specialists due to the pre-authorization process. Participants expressed concern about reduced access to dental care as a component of preventive care. They did not understand that dental benefits are provided by the State Medicaid system and not the MCOs.

Quality of Care and Care Management

An exploration of the quality of the health care participants have received as well as how well their care has been coordinated offered a rich source of information from the focus groups. Participants were asked to assess the quality of their providers and care coordination, describe their role in their health care and share whether they feel they are or can be active participants in coordinating their care. Participants were evenly divided on the assessment of the quality of their primary care physician, but did not necessarily relate that to their MCO. For those that required care coordination, most felt their care was coordinated adequately. Nearly all participants felt they had an active role in make decisions about their and their children's health care.

Information Needs

The focus groups also explored the information that participants most want to receive from their MCOs, including information about health education, providers, and benefits/coverage and how they would prefer to receive it. In general, participants did not report receiving useful information from their MCO. Most said they had not received any information at all. Information on physician quality and clear information on benefits and coverage were most frequently mentioned as information needs and desires. While a small number of participants were comfortable and preferred online resources, the majority of people said they preferred to receive information in hard-copy format.

Improvements to MCO and Medicaid

Participants were asked to suggest the one improvement they would make to their MCO and to Medicaid overall. In general, participants had difficulty distinguishing between the roles of the MCO and Medicaid which resulted in some overlap in responses for improvements for each. Overall, participants would like to see their MCO expand their benefits to include more dental care and prescription medications. Participants would like Medicaid to expand eligibility to include more adults and to provide clearer information on eligibility rules.

Recommendations

Improve Benefit and Coverage Information

A clear and concise overview of plan benefits provided in easy to understand language would be a positive improvement for beneficiaries. Including a comprehensive list of covered medications would also assist beneficiaries in more effectively deciding which MCO best meets their needs.

Improve Prescription Pre-Authorization Process

Streamlining the process to review beneficiaries' medical history before requiring testing of cheaper medications and reducing or eliminating pre-authorization for medications required for long-term and/or permanent health conditions would be beneficial. Additionally, reducing the timeframe for the pre-authorization would be a favorable improvement. Some of the issues expressed by participants regarding pre-authorization may have been due to the requirement for MCOs to honor pre-authorizations for prescription during the first 90 days of enrollment. This requirement may have resulted in members needing approval for medications previously used in within the 90 day period. This issue may not persist once the members transition to their MCO's formulary. It would be beneficial to explore participants' experience with prescription medications in future focus group activities.

Expand Physician Information

Additional information on physician philosophy, experience, and specialties along with routine information such as whether they are currently accepting new Medicaid patients, location, and hours would improve beneficiaries' ability to effectively select primary care providers and specialists. Developing quality metrics and an option for user reviews may also improve beneficiaries' knowledge of options.

Tailor Health Education Materials

A more consistent effort to specifically tailor health education materials to beneficiaries based on history and needs could more effectively engage beneficiaries in proactively improving their health.

Expansion of Health Benefits

Participants agreed they would like to see an expansion of health benefits to include more services and prescription coverage. In particular, expanding preventive health benefits to include preventive dental care for adults could reduce long-term health costs.

INTRODUCTION

In support of the HSAG's external quality review of New Hampshire's Medicaid Care Management Program, Horn Research has been contracted to gather qualitative data from Medicaid beneficiaries regarding their experience with the Medicaid Care Management Program that commenced in December 2013. For Year One of the contract, Horn Research conducted four focus groups with target Medicaid beneficiaries between May 12 and May 14, 2014. Two of the focus groups were conducted in Manchester, New Hampshire and two in Laconia, New Hampshire.

Table 1. Focus Group Locations and Dates

Location	Date/Time
Manchester	May 12, 7pm-8pm
Manchester	May 13, 10am-11am
Laconia	May 13, 7pm-8pm
Laconia	May 14, 10am-11am

Four Key Points of Inquiry were developed based on material provided by DHHS to frame the information to be gathered from participants. The Key Points of Inquiry were as follows:

1. Experience with Medicaid Care Management

- Participants' understanding of and engagement with Medicaid Care Management and their Managed Care Organization (MCO) including participants' positive and negative experiences

2. Access to Care

- Participants' experience with improved or diminished access to doctors, specialists, medications, and ancillary services

3. Quality of Care and Care Management

- Participants' perception of the quality of the health care received and how well their care has been coordinated
- Participants' perception of their role in their health care and whether they can be active participants in coordinating their care

4. Information Needs

- Participants' desire for information they want to receive from their Managed Care Organizations, including provider information, and how they would prefer to receive it

METHODOLOGY

To complete the goals set forth by HSAG and DHHS to qualitatively gather information from Medicaid beneficiaries regarding their experience with the transition to the Medicaid Care Management Program, Horn Research engaged a standard qualitative data gathering process as detailed below. A total of 36 individuals participated in either a focus group or a telephone interview.

Sample Size and Composition

For Year One, two counties in New Hampshire, Hillsborough and Belknap, were targeted for data collection through the implementation of two focus groups held in each county. Eight to ten participants were targeted for each of the four groups for a total of 32-40 participants. The group size is considered ideal for focus groups by being small enough to allow everyone the opportunity to express an opinion and large enough to provide diversity of opinion. The DHHS provided Horn Research a “blind” list of all Medicaid beneficiaries in Hillsborough County and Belknap County with identification numbers, managed care provider, gender, age, and eligibility category. From this list, Horn Research selected a proportional random sample representative of Medicaid enrollment in New Hampshire for a total of 75 individuals in each county. The proportional sample was important to ensure adequate representation by all eligibility groups including those historically less likely to provide feedback to Medicaid. The DHHS then provided contact information for the sample list for use in recruitment efforts. Four of the 150 potential beneficiaries were eliminated from the list because they were in long-term care facilities or their cases were closed. The sample size proved to be sufficiently large enough to recruit the target number of participants.

Participant Recruitment

Multiple recruitment efforts were employed throughout the recruitment period. A letter (Appendix 1) explaining the project and asking for participation was sent to all 146 individuals in the sample. The letters were sent in three batches on April 1, April 9, and April 15, 2014. Starting on April 15, email follow-ups were sent to all individuals with email addresses and telephone calls were placed to those who did not have an email address. Each individual was contacted a minimum of five times via email and/or telephone. Recruitment efforts were effective with more than 10 individuals signed up for each group. However, despite extensive follow-up reminders, all four focus groups had fewer than eight participants. To address the lower than expected turnout, telephone interviews were conducted with 18 individuals who were unable to attend the groups due to illness, work constraints, child care issues, and transportation problems. A total of 36 people participated in either the focus groups or the telephone interview.

Participant Demographics

As previously mentioned, the sample list was proportionately selected to be representative of the Medicaid enrollment in New Hampshire. Table 2 details the target number of participants by eligibility category for each geographic location of the focus groups. Table 3 details the number of participants by eligibility category and location. Overall, the distribution of participants' eligibility category was consistent with the target goals mirroring the distribution of the total Medicaid enrollment with a slight over-representation of low-income adults.

Table 2. Target Number of Participants by Eligibility Category

Eligibility category	Avg. enrollment 2011	Percent of total enrollment	Target participants
Adult with disability	20,446	17%	9-12
Child with disability	1,615	1%	3-4
Low income adult	16,500	14%	5-6
Low income child	80,380	68%	14-18
<i>Total</i>	<i>118,941</i>	<i>100%</i>	<i>32-40</i>

Table 3. Number of Participants by Eligibility Category and Location

Eligibility category	Laconia	Manchester	Percent	Total participants
Adult with disability	4	4	22.2%	8
Child with disability	3	2	13.9%	5
Low income adult	3	5	22.2%	8
Low income child	7	8	41.7%	15
<i>Total</i>	<i>17</i>	<i>19</i>	<i>100%</i>	<i>36</i>

Each of the three managed care providers, Meridian Health Plan, New Hampshire Healthy Families, and Well Sense Health Plan, were represented by participants with nearly equal distributions. Table 4 shows the distribution of participants' managed care organization by location. Manchester participants were most often enrolled with Meridian and New Hampshire Healthy Families, while Laconia participants were most often enrolled with New Hampshire Healthy Families and Well Sense.

Table 4. Number of Participants by Managed Care Organization and Location

MCO	Laconia	Manchester	Total
Meridian Health Plan	3	8	11
NH Healthy Families	6	7	13
Well Sense Health Plan	8	4	12
<i>Total</i>	<i>17</i>	<i>18</i>	<i>36</i>

Data Collection Process

The focus groups and telephone interviews were led by an experienced facilitator with responses captured in real-time with a note-taker and electronically with two digital recorders. Focus groups and interviews were directed by a Focus Group Guide (Appendix 2) developed to address the Key Points of Inquiry. The focus groups lasted approximately 1–1 ½ hours while telephone interviews lasted approximately 20-25 minutes. All participants received a summary of the purpose of the project prior to the interview, and at the beginning of the interview, the facilitators read a statement verifying the confidentiality of the information collected during the sessions. All participants received a \$20 gift card in appreciation for their participation in the project, and the focus group participants were eligible for up to \$5 for travel reimbursement.

Data Analysis and Validity

When all focus groups and telephone interviews were completed, the information was analyzed by identifying, coding, and categorizing primary patterns in the data. The consistent patterns found in the analysis of the data and the representative sample supports the validity of the information gathered, but should not be assumed to be *statistically* representative of the whole population. The information provided in this report should be used to identify salient issues relevant to the population, provide contextual information for the larger assessment process, and identify avenues for further research.

EXPERIENCE WITH MEDICAID CARE MANAGEMENT

In order to understand their knowledge of and engagement with Medicaid Care Management and their MCO, participants were asked to describe how they chose their MCO, what they liked best and least about their MCO, and any problems they have experienced. Participants said they had sufficient notification of the change to managed care, but did not feel adequately prepared to decide between MCOs. Most participants selected the MCO that included their primary care physician in the network rather than the plan that best covered their needs. Overall, participants said they did not understand their plan and did not know how to find out or understand coverage details. Several participants said they experienced significant delays in receiving their benefit cards.

The MCO Selection Process

Participants were asked to describe their experience transitioning from the *old* Medicaid system to the *new* managed care system. In general, participants agreed they had been sufficiently informed about the change by the State, but felt ill-prepared to choose their provider. The majority of participants said they did not understand the distinctions between plans and struggled to understand the medical language in the literature. One participant said, *"I couldn't understand what they sent me, so by getting the gist from everybody else, from looking online, I decided to go with the one my doctor fell under. Some doctors are under all of them, but we ended up with Meridian because that's the only one that took my kids' doctor."* Most participants reported choosing their MCO simply because their current doctor was covered under the plan. One participant said, *"I chose my new plan because they had my doctor. Some doctors fell under all of them. I chose this one because they were the only one that took my doctor. I have to have this doctor – I've been with her for 10 years!"* A handful of participants indicated they had reviewed each plan's coverage and decided based on which benefits were most advantageous for their situation. Three participants noted they had already switched providers which they said was a very simple and efficient process. A couple of participants said they chose the MCO based on recommendation from their case manager and doctor's office.

MCO – The Good News

The majority of participants said it was difficult to say what they liked best about their MCO because it was still a very new relationship. About a third of participants said they appreciated the continuity of services, that there were no big changes to their coverage, and that they were able to keep their doctor. One participant noted that she appreciated the free benefits provided by her MCO. She said, *"They sent a car seat for each child. My daughter got a dental care package which was really nice. They sent helmets for their bikes. I thought that was great. Just because what they offered for the kids was so great, I chose it for myself."*

Dealing with the MCO and the Plan

The vast majority of participants noted they had problems with their benefit cards. Many noted that it took several months before they received their new cards. One participant said, *"I didn't get my kids' cards until late February or early March so it was a long time. When I would bring them into the doctor they would ask for their card and I'd tell them I hadn't gotten it. It did take a long time to get everything I needed to bring the kids to the doctor."* Another said, *"If we'd have had an emergency, we'd have been up the creek without a paddle."* Some participants said they still had not received their new cards and others said the cards they received had incorrect information.

About a third of respondents expressed concern about a reduction in dental benefits, decreased prescription coverage and limited emergency room visits. One participant said, *“I live at the emergency room and now they limit you to 2 visits every six months to a year period and I’m like have you seen my health issues? There’s no way.”* Another suggested the reduction in benefits wasn’t significant saying, *“It has a few less benefits than we had before but I don’t think it’s that big of a deal. They didn’t cover a couple things.”*

The bulk of participants said they did not understand their plan or the benefits and coverage provided. One participant said, *“We go and if it’s accepted, it is. If it’s not, we pay out of pocket. I haven’t received information as far as what’s covered, what’s not that is specific to us.”* The participants were divided concerning whether they felt they knew where they could find information. About half indicated they didn’t know where to call, whereas the other half felt they had a place to go to get their questions answered. One woman said, *“Oh, I probably don’t understand as much as I should, but I do know that if I needed to find something out, I could.”* Not all participants were convinced that calling for help would be effective. A participant said, *“I think I could call the MCO, I guess. I asked them once before, but way the way they explained it was like Chinese to me.”* Other participants said they had access to a case manager that was helpful in explaining details and providing support. A small number of participants felt they had a clear grasp of their plan. As one participant said, *“The basic coverage is the same as with Medicaid. There aren’t any real changes as far as that. It’s more procedural and policy.”* One participant expressed frustration in trying to get answers to her questions. She said, *“I have tried. I got the phone number off the website. I called and they didn’t know the answer to my question and gave me another phone number. When I called that number I got a bunch of menu options, but never got a person.”*

A couple of participants said they had trouble managing guardianship issues with their MCO. One participant with an adult daughter with a disability said, *“Even though I’m her mom and legal guardian, trying to talk to them on the phone was a challenge. They said they had to get her permission to talk to me, so instead of talking to me, they’d keep asking her the questions. I had trouble faxing the guardianship papers to them. It didn’t work so I called back and they again said we can’t talk unless your daughter gives permission. I said I’m not calling about that I’m trying to fax you the documents so you have it to talk to me. They gave me another fax number and that one didn’t work either. Tried 8 times with each number and finally had to mail it. Such a pain. It was like pulling teeth to try to talk to them.”*

Selecting a Primary Care Physician

As previously noted, most participants said they kept the same primary care physician when they enrolled in their MCO. The few participants who did not maintain a primary care physician said they did not have trouble finding and selecting a provider. One participant selected hers based on a referral from a family member; another received a referral from a hospital; and two suggested it was a trial and error process of going through a list and calling providers.

ACCESS TO CARE

A key to understanding how well the Medicaid Care Management Program is performing is to identify whether participants have experienced improved or diminished access to doctors, specialists, medications, and ancillary services. Overall, participants said the access to their doctors has stayed the same. The main concerns expressed about access were related to medications and specialists. Many participants said they had experienced challenges with medications not being covered under the new MCO and delays in receiving prescriptions and referrals to specialists due to the pre-authorization process. Participants expressed concern about reduced access to dental care as a component of preventive care. They did not understand that dental benefits are provided by the State Medicaid system and not the MCOs.

Access to PCP

For the most part, participants said access to their primary care physicians has not changed. A few participants said that they had to wait a longer period of time to schedule their appointments. Others said any limitations on access were due to internal doctor's office issues and not because of the MCO. A couple of participants said their doctor had left the practice and they were having to deal with a temporary doctor, while another said their doctor was semi-retired and had limited hours.

Access to Medications

By far, access to medications and prescriptions was noted by participants as being the most challenging change associated with managed care. About a third of participants said they had not had any problems with their prescription coverage, but a majority said that access to medication had gotten worse. Some participants said that medications that were prescribed or had been previously prescribed were not covered by the MCO. One woman said, *"The old Medicaid used to cover whatever the doctor wrote as a prescription. My daughter got a really bad concussion and started having regular migraines. The doctor wrote a couple prescriptions that the new insurance wouldn't cover. And for another medication, they wouldn't cover the amount so they had to lessen the dosage for her prescription. I've never had that issue before and my oldest is 17. For myself, I've only tried filling a few prescriptions and two of them didn't work."* Some participants shared that they had to go through the process of trying other medications prior to being authorized to receive the prescription that had already been proven to work for them. A participant said, *"I have gastritis. I have a hiatal hernia. I've also had gastric bypass. I have Crohns. The only thing that works for me is Previcid. I've tried everything else under the sun. They did not work. That's why I was on Previcid. The new insurance comes and says you have to try all those other medications before you get the ones you want. They don't check your medical records."* Pre-authorization for other types of medical supports were also noted as problems for participants. One woman shared, *"My daughter needed a knee brace and they refused to pay for that. They tried all the different ones and fitted her. The MCO paid for the appointment, but when it came time to pick the brace up, they said they weren't paying for it."* She decided not to pursue the brace saying, *"I didn't call. I'm not fighting with them. I didn't call about the knee brace because I don't want to rock the boat over a knee brace compared to what my daughter has already used insurance wise."*

The other main issue noted by participants was the pre-authorization process for medications. A large proportion of participants said they had experienced problems with pre-authorization. Some noted that the requirement for pre-authorization for on-going medications was particularly challenging for them. One woman said, *"They require pre-authorizations every 3 months. He's been on it for 2 years. It works for him. Just give it to him."* Participants also agreed that the delay in getting their medications due to

the pre-authorization process was problematic. One woman summarized, *“When people need medication it’s because they need medication now, not because they need medication in two weeks.”* Another participant described her experience, *“I have to go get shots in my back and elbow for pain management. Before I could make an appointment and be in two days later. Now it’s two weeks because of insurance.”* Another described her son’s experience with a delay in receiving his medication as drastically affecting his ability to manage in school and at home which affected the whole family and classroom. Other participants noted that the limited window of time to pick up prescriptions in the pre-authorization process was difficult to manage as well.

It is important to note that the state mandated that the MCOs honor pre-authorizations for prescription during the first 90 days of enrollment. After that time, Medicaid members were required to follow the formulary guidelines established by the MCOs. This process may have resulted in members needing approval for the medications they had previously used within the first 90 days. This appeared to have been cumbersome for some participants, but the issue may not persist as members transition to their MCO’s formulary.

Access to Specialists

The majority of participants said that they had not had a need for specialist care since being enrolled in managed care. For those that did, most said they had experienced no change in their access to specialists. A handful of participants reported challenges with pre-authorization for treatment by specialists. One participant shared, *“When my daughter had Medicaid, I never had to worry about getting referrals before. If we did, it flowed really smoothly. With the managed care, I didn’t realize that they needed prior authorization and a plan to treat and all sorts of things. My daughter was going to physical therapy and she was just at a good point where it was actually starting to help and the managed care provider said they were going to have to shut her off until they figured out a treatment plan and that could take a few weeks.”* She said she decided to switch to a different MCO to continue the treatment. Another commented that her child’s complex needs made coordinating and finding specialists challenging. *“My primary care physician said ADHD wasn’t his specialty. My daughter needs other doctors for certain things and my primary care physician says he doesn’t do that, and we have to find a specialist. How long is that going to take? It’s crazy.”*

Access to Transportation

Nearly all participants said they did not utilize Medicaid transportation services or received transportation reimbursement. Several said they had never heard of it and others said they did not need it. The few participants who used transportation services expressed dissatisfaction with the process. One woman described, *“I have to take my daughter to Dover every week and it is 100 miles round trip so I thought I might as well apply. When I was doing it through my MCO, at first they told me I just needed to call it in and I didn’t need to fill out any forms. And then a month later, they said I did need to fill out forms. Why didn’t they know this before? So I did it all and the payments they sent me made no sense. They overpaid some, paid some things twice, paid some things not at all. It was a mess. I always get this woman who doesn’t understand my accent at the transportation management company. You can’t fax information to them. Giving information to these people is like giving birth. My daughter goes to the appointment every week at the same time. They said they could only schedule four appointments at a time. And when I sent the address, they said it was a high school. She goes there every week. Twenty years ago it was a high school. Now it’s a doctor’s office. But they pay for the gas and it helps. I have gotten reimbursed somewhat successfully for the 400 miles per week that I drive for that.”* Other participants said that it would be helpful to have more information about transportation reimbursement as they frequently have difficulty getting to appointments. One participant said, *“I’ve actually had to*

change appointments to work around my schedule because I only had enough gas if I could do everything at the same time. If I had reimbursement, that might make a difference.”

Preventive Care

The majority of participants said they had experienced no change in their access to preventive care since switching to managed care. For those who expressed concerns, the sole issue they mentioned was dental care. Participants did not understand that dental benefits are provided by the State Medicaid system and not the MCOs. They were worried about reduced access to dental care and orthodontic care for children as well as insufficient access to dental care for adults. Participants agreed that dental care should be considered preventive care and is vital to good health. One participant noted, *“It’s cheaper to get a filling right away than to wait for years and have it pulled.”* Participants also generally agreed that they had experienced challenges finding a dentist who accepts Medicaid.

QUALITY OF CARE AND CARE MANAGEMENT

An exploration of the quality of the health care participants have received as well as how well their care has been coordinated offered a rich source of information from the focus groups. Participants were asked to assess the quality of their providers and care coordination, describe their role in their health care and share whether they feel they are or can be active participants in coordinating their care. Participants were evenly divided on the assessment of the quality of their primary care physician, but did not necessarily relate that to their MCO. For those that required care coordination, most felt their care was coordinated adequately. Nearly all participants felt they had an active role in make decisions about their and their children’s health care.

Quality of Primary Care Physician

Participants were evenly split in their assessment of their primary care physicians. Half said they had a good relationship with their physician and that he/she understood their needs. One participant described her physician, *“He’s very friendly. Can’t think of anything I don’t like about him.”* Another said, *“The children have the same pediatrician – he’s fantastic. He’s absolutely wonderful. With my physician, we may have disagreed here and there, but she’s good.”* Another said, *“Actually for the first time in a while, I have a doctor who will sit and talk to me. He has his nurse move appointments if I have more issues than he expects. It’s been a while since I had that.”* The other half were very unhappy with their primary care physicians. One said, *“There is nothing I like about my primary care physician.”* Several participants said they felt the doctor treated them poorly because they are on Medicaid. One said, *“I feel like my doctor thinks ‘You’re on Medicaid so I’m going to treat you badly.’ I have had BCBS and they do treat you differently.”* Other participants said they felt their physicians were insulting and dismissive. One woman said, *“I went to the doctor to talk about depression. He told me not to be a baby. I felt dismissed.”* Another shared, *“I walked in and the doctor said in front of my daughter ‘How delayed is she?’ I’m not going to talk to someone like that. I’m not going to answer that question. I’ll drive further to see a doctor I like and respect.”*

Care Coordination

The majority of participants said their providers communicated well and worked well together to coordinate their and their children’s care. One participant said, *“The providers and specialists work together really well. I have a psychiatrist, a counselor, another counselor, a doctor at the methadone program, they are the best. I feel like they talk to each other.”* Another said, *“Mine do. I have my PCP*

that prescribes me medication and pain management that prescribes medications and other doctors that prescribe medication. I have 3-5 specialists so it's important for them to talk to one another. It's important because of the pain management prescriptions. They do that very well which is great." A handful of participants said that they do not need their providers to communicate and coordinate with each other either because they only have a primary care physician or they do not need them to work together. A participant said, "They don't work together. They don't talk, at least I don't think they do. But I don't have any problems because they don't." Another said, "I go back and forth and say what's going on. They can coordinate, but I don't know if they actually do that. I tell them what's going on, and that's about it. It's fine the way it is. They don't need to coordinate with each other." A few participants said they felt their care coordination was not working well for them. One woman shared, "There are times my doctor receives information and I don't hear from her about what her vision is about managing my care." Another said with the transition to adult services from child services for her daughter their care coordination got worse. "When she was in school, anybody we asked would come to an IEP meeting. Now they don't talk."

Role in Care

The vast majority of participants said they play a very active role in managing their and their children's health care. They said they feel their doctors respect their role and voice in the process and felt listened to and valued. One woman said, "I have several providers, a psychiatrist, a counselor, another counselor, a doctor... they are the best. I feel like they talk to each other and I feel part of the conversation. I don't feel like anybody is doing anything behind my back." Many participants said they proactively advocate for themselves and their children with health providers. One person noted, "I think you are the best person to be advocating for your child because you see them. You know them; you know their little idiosyncrasies." Another said, "You have to. Take that role and own it." A few participants said they wanted to take an active role in their health care, but did not feel like they could. One participant said, "Actually at this time I don't feel like I have very much control over what happens for all of us. That may be because I'm not understanding the process. For example, I don't know what medications are approved or not and why. And obviously if they're denied, I can't afford them. I don't feel like I have any say as far as what's happening." Other participants felt that their lack of an active role was due to difficulties communicating with their physician. One participant shared, "I never had a doctor that I could not talk to or leave a message to. I never had a problem like this before this is all new to me." Only two participants said they had not tried to be actively involved. One stated, "I haven't tried, so I don't know. I haven't had to make any decisions. The only thing I had to do was to choose the managed care provider." The other said, "I'm assuming that if I tried to, I would be able to, but I really haven't tried too much. I'm easily aggravated."

INFORMATION NEEDS

The focus groups also explored the information that participants most want to receive from their MCOs, including information about health education, providers, and benefits/coverage and how they would prefer to receive it. In general, participants did not report receiving useful information from their MCO. Most said they hadn't received any information at all. Information on physician quality and clear information on benefits and coverage were most frequently mentioned as information needs and desires. While a small number of participants were comfortable and preferred online resources, the majority of people said they preferred to receive information in hard-copy format.

Quality of Information Received

Overall, when asked about information and educational materials they had received from their MCO, participants said they either had not received any information or the information they received was not helpful. One participant said, *"I glance over it, I don't learn anything new from it. I don't need it."* Another described, *"My son has ADHD and has since he was little. He's 12 and NOW they are sending me stuff on ADHD. You're behind. If they had transferred the history, they'd know. Save the information for a family with a new diagnosis. If it's something new, then fine send something. If not don't bother."* Another participant said, *"With the old Medicaid I was getting information too. With the new MCO, I get nothing and she (my daughter) gets information about issues she has had all along and isn't helpful."* A number of participants who had not received information said they would be interested in receiving education materials from their MCO. One participant said, *"No, I haven't received any, but that would be helpful. Maybe new different things they come up with, maybe educational lists on cold facts for kids, stuff like that. Those things are great things to have as reminders."* A couple of participants said they had received information for their kids, but not for themselves. One participant said, *"I never got information for myself and I'm on over 20 different medications. What about me? I'd be open to more preventive information. I'd be open to somebody helping manage my all my specialists. It does get tiring and stressful. They assume I can do this all by myself. It is very frustrating."* Another agreed, saying, *"No, I never received anything. My son has asthma, so it would be good. I would like to know more information."* A handful of people said they had received some helpful information. One woman mentioned she had received diabetes self-management tips that were helpful and supportive. Another said some of the information she had received about asthma had been useful. Another participant said, *"My daughter is autistic and she's pre-diabetic. She got the diagnosis from the doctor right at the time she was enrolled in care management. They sent me all sorts of information about the pre-diabetes and diabetes and stuff about autism. It was helpful."*

Physician Information Desired

When asked what types of information about physicians they would most want access to from their MCOs, participants offered a wide variety of ideas and suggestions. Several participants said they would like access to some sort of quality ratings for physicians. One participant said, *"I wish there was a rating system that would make it really easy for me to choose a doctor."* Other participants suggested a system that allowed consumer reviews to be collected and disseminated. One participant said, *"I'd like access to experiences from people like us; statements about their experiences with each doctor. Like if you went to a doctor and he was awful and I was about to bring my daughter there I would want to know what you had to say first."* Some disagreed with this saying they were not sure they could rely on quality ratings or user reviews. One woman remarked, *"Say the three of us all went to the same health care center. We all have the same doctor. You could have completely different opinions and experiences. Everyone has to test it for themselves."* Several participants said they would like to have access to a doctor's philosophy toward treatment and the amount of time they are willing to spend with patients. One participant suggested, *"A couple of sentences in their own words about their philosophy. You know, I tend to take a more natural approach. I try physical therapy before drugs. Something that tells a little bit about what you can expect when you go."* Another said, *"I like when a doctor sits and talks to me and listens to me - doesn't just give me a pill. I've been known to call and find out what a normal appointment time for the doctor is and if they are willing to extend appointment times. If they're not, I don't go there."* Doctors' personalities and bedside manner are also factors participants would like to have access to in some way. One participant shared, *"Some people are born to be this kind of person. It's like they get it. I don't care what degree you got or who you treat or whatever. It's who you are as a person and how you live it. And you should be able to see within the first 5 minutes of meeting the doctor whether the doctor is a good doctor who is going to listen and take care of you well or not."* Other participants said they wanted very

practical information such as whether the doctor is accepting new patients or if there is a wait list, their specialties, number of years of experience, and credentials. A few participants noted they would like their MCO to provide information on what specific abbreviations for credentials mean. One participant said, “LPN, RN, NP, - all those letters. What the heck is that? I don't know what that means.”

Desired Information

By far the most frequently mentioned type of information participants would like to receive from their MCO is an overview of their benefits and coverage. Participants agreed they would like the information to be provided in easily understandable language and provide a cohesive list of what is covered and not covered. One participant said, “I would like more information on coverage. What all things they actually do cover would be nice including doctors, specialists, transportation. And it would be nice to know the general stuff without having to read 500 pages to find it out. Literally I got the big packets with 50 sheets of paper. I got 5 or 6 different ones of those in the first month. I kept getting envelopes.” Another said, “Information on benefits – so you know what you are paying for. You don't want to make a mistake and have them not paying for it. In an easy way; not in a big complicated way.” Participants also agreed that reducing medical jargon would be helpful. One participant said, “Discussing what is covered and not covered is fine, but do it in a non-medical terminology way. A lot of people don't understand medical terminology. You have to make it very helpful like a children's book. I think if they do that a lot of people would be less stressed.” Another said, “Everything should be simpler for people to understand. Not everybody understands at the same level.” Participants also mentioned wanting to have access to health education materials that are relevant to their needs, updated health and dental provider lists concerning providers currently accepting Medicaid, process guidance about getting coverage or using benefits, and free benefits provided by the MCOs.

Best Way to Receive Information

When asked how they would most like to receive information from their MCO, the majority of participants said they would rather receive hard-copy materials in the mail. A handful of people prefer email and online options. And a few said they would prefer being able to call for information or receive telephone/text reminders. A number of participants said that being able to choose method of contact would be best.

IMPROVEMENTS TO MCO AND MEDICAID

Participants were asked to suggest the one improvement they would make to their MCO and to Medicaid overall. In general, participants had difficulty distinguishing between the roles of the MCO and Medicaid which resulted in some overlap in responses for improvements for each. Overall, participants would like to see their MCO expand their benefits to include more dental care and prescription medications. Participants would like Medicaid to expand eligibility to include more adults and to provide clearer information on eligibility rules.

Improvements to MCOs

The most frequently mentioned improvement participants suggested for their MCO was the expansion of coverage to improve access to dental care, prescription medications, and to allow more adults to participate. One participant said, “I wish they would cover dental including cleanings for adults twice a year and fillings. I know a lot of people who would have a lot more teeth right now if they could have dental care. Most people on Medicaid are on a fixed income. They don't have the money to spend \$200

to get their teeth cleaned every 6 months or for a filling so they wait until they have to have them pulled.” Another said, “We can’t afford Obama-care for two people. It’s just too expensive. My kids have Medicaid. I said if I’m on my deathbed, take me to the hospital. Other than that, I tough it out. I wish we could get something like Medicaid for us because I haven’t been to a doctor for a while. I’ve hurt myself so many times and I just take it like a champ.” Another agreed saying, “I think if they covered the whole family that’s what I would suggest. It’s fine if they have a co-pay or whatever, but they need to cover the adults. And some type of dental even if you have a co-pay. I’d be happy with that. But they only cover extractions - what is that?” The next most frequently offered response was to eliminate or improve the pre-authorization process for medications. A common refrain among participants was, “When people need medication it’s because they need medication now, not because they need medication in two weeks.” Another suggested that the doctor should be in charge deciding medications, “I think most time, if a doctor is prescribing it then they’ve probably tried the other ones or know for some reason that those will not work for this specific person. The constant pre-authorizations have to go.” Participants also mentioned improving the type of information they receive from the MCO including a better overview of coverage and participating providers; more providers including doctors and dentists; a user-friendly website; and benefit cards that are sturdier.

Improvements to Medicaid

The most frequently mentioned improvement to Medicaid was to increase the number of providers accepting Medicaid. In particular, participants said they would like more specialists and dentists available. One participant said, “The state of New Hampshire needs a lot more child psychiatrists. There are very few and if you don’t like the first one or two. I would like somebody to do something more than just give her meds. I’d like somebody to suggest other treatments.” Another said it’s hard to find specialists for people with disabilities with complex needs. A handful of participants said they would prefer that Medicaid go back to the way it was. One participant said, “Medicaid wasn’t broken to begin with. The only issue with Medicaid was the dental.” Other participants said expanding Medicaid eligibility would be a priority improvement for them. One said, “It would be so nice if it wasn’t so hard to qualify for it.” On a related note, participants would like more explicit information on eligibility guidelines for receiving Medicaid. One participant shared, “Maybe a more clear cut guidelines as for the financial cut-offs to know who can get it and who can’t. It’s a mystery. And if you’re on it, can you stay on it? Can you pay if your situation changes? Is it a possibility to stay on it for some number of months? That sort of thing.” Participants also suggested better communication would be helpful particularly about the doctors and providers available, information on coverage and benefits, and other potential help available.

DIFFERENCES BETWEEN PARTICIPANTS

In general, participants from Manchester and Laconia did not express different experiences or opinions. A couple of notable differences between locations included that Laconia residents were more likely to report greater challenges having access to adequate numbers of providers, in particular, dentists. Laconia participants also more frequently noted delays in receiving their benefits cards and not receiving information from their MCOs. Participants who had a disability or were parents of a child with a disability were much more likely to express dissatisfaction with the pre-authorization process for medications. Parents of low-income eligible children were more likely to say they appreciated the help they receive and are grateful for the coverage, but would like expanded coverage for the whole family. No major distinctions between responses based on MCO were discernible from the data.

CONCLUSION AND KEY RECOMMENDATIONS

The focus groups held in Manchester, New Hampshire and Laconia, New Hampshire in May of 2014 provided valuable information into the participant's experience in the State of New Hampshire's Medicaid Care Management Program that commenced in December 2013. Due to the sample size, the information presented in this report should not be assumed to be statistically representative of the entire population in the Medicaid Care Management Program in New Hampshire. The data generated during the focus groups can be used to identify issues and concerns that may warrant further exploration. Below is a summary of the salient points expressed by the focus group participants.

Improve Benefit and Coverage Information

Participants consistently expressed a lack of understanding of what benefits their MCO offers and confusion on how and where to find out information on coverage. A clear and concise overview of plan benefits provided in easy to understand language would be a positive improvement for beneficiaries. Including a comprehensive list of covered medications would also assist beneficiaries in more effectively deciding which MCO best meets their needs.

Improve Prescription Pre-Authorization Process

Participants nearly unanimously agreed that the pre-authorization process for medications was creating challenges in managing their and their children's health care. Streamlining the process to review beneficiaries' medical history before requiring testing of cheaper medications and reducing or eliminating pre-authorization for medications required for long-term and/or permanent health conditions would be beneficial. Additionally, reducing the timeframe for the pre-authorization would be a favorable improvement. As noted, the requirement for MCOs to honor pre-authorizations for prescription during the first 90 days of enrollment may have resulted in members needing approval for medications previously used in within the 90 day period. It would be beneficial to explore participants' experience with prescription medications in future focus group activities.

Expand Physician Information

Overall, participants reported wanting access to more information about physicians. Additional information on physician philosophy, experience and specialties along with routine information such as whether they are currently accepting new Medicaid patients, location, and hours would improve beneficiaries' ability to effectively select primary care providers and specialists. Developing quality metrics and an option for user reviews may also improve beneficiaries' knowledge of options.

Tailor Health Education Materials

Participants reported a desire to receive health education information from their MCO, but most had either not received any or had received ineffective and impractical material. A more consistent effort to specifically tailor health education materials to beneficiaries based on history and needs could more effectively engage beneficiaries in proactively improving their health.

Expansion of Health Benefits

Participants agreed they would like to see an expansion of health benefits to include more services and prescription coverage. In particular, expanding preventive health benefits to include preventive dental care for adults could reduce long-term health costs.

APPENDIX 1. RECRUITMENT LETTER

Dear,

I am writing to ask for your help with a project about New Hampshire Medicaid Care Management. The Department of Health and Human Services hired Horn Research to gather opinions from people like you to better understand the experience you're having meeting your and your family's health care needs.

We would like to invite you to a focus group where you can share your feelings and ideas about Medicaid Care Management. Because we are only asking a small number of people to take part, **your participation is very important**. You can help us understand what is working and what is not working, and receive a ***\$20 gift card*** as a thank you for your time.

We will be holding two sessions in your area, which will be filled on a first come, first reserved basis:

Mon., May 12, 7:00PM - 8:00PM at Families in Transition, 161 S. Beech St. Manchester

Tues., May 13, 10:00AM – 11:00AM at Families in Transition, 161 S. Beech St. Manchester

Tues., May 13, 7:00PM – 8:00PM at Tardif Park House, 51 Crescent St. Laconia

Wed., May 14, 10:00AM – 11:00AM at Tardif Park House, 51 Crescent St. Laconia

You only need to come to **ONE** group to receive the \$20 gift card. There will be free snacks and drinks and transportation reimbursement. All information you share will be kept completely private and will not affect your benefits or health care in any way; no one from Medicaid or the managed care programs will be there. Your name and personal information will never be made public in any way.

If you would like to sign up for one of the focus groups, please call Horn Research toll-free at **(888) 316-1851** or email at Lisa@HornResearch.com to answer a few questions and register.

Thank you for sharing your experience and thoughts about New Hampshire Medicaid Care Management.

Sincerely,

Lisa Horn
President

APPENDIX 2. FOCUS GROUP/INTERVIEW GUIDE

Introduction

Thank you for your willingness to participate in this focus group. Your feedback is very important and will help the State of New Hampshire make some important decisions about Medicaid Care Management. We want to know about your experiences so the program can work better for you and others in the future. *I want to remind you that your participation will not affect the benefits and services you receive through Medicaid Care Management.*

1. I am interested in all of your ideas, comments, and suggestions.
2. I'd like to hear from everyone.
3. There are no right or wrong answers to the questions.
4. All comments—both positive and negative—are welcome. Please don't worry about offending me with anything you might say—it's important that I know your opinions and feelings.
5. Please feel free to agree or disagree with one another. We would like to have many points of view.
6. I'd like this to be a group discussion, so you do not need to wait for me to call on you.
7. This discussion is being audio-taped, to make sure we don't miss anything important in our notes. No one at Medicaid or the managed care programs will listen to this tape. Before coming into the room you signed a release giving us permission to audio-tape you during this discussion. All comments are confidential.
8. Please speak one at a time, so that the tape recorder can pick up everything.
9. Also on the release you signed, you agreed to respect the confidentiality of others in the group. This is very important. We will do our best to ensure that your identity remains confidential, but we need you to do your part in keeping everyone's name and what they said confidential.

Let's start with some introductions – let's go around the room and everyone can tell us your first name and your favorite thing to do.

I. Experience with Medicaid Care Management

Each of you is either covered by Medicaid or is the parent of a child receiving Medicaid benefits. In New Hampshire, Medicaid benefits are now provided by one of three Medicaid Managed Care organizations: NH Healthy Families, Meridian Health Plan and Well Sense Health Plan.

We want to start with a few questions about how well this new Managed Care program is working for you so far.

1. First, can you tell me how long have you/your child received Medicaid benefits?
2. Can you tell me about your experience with the change from the "old" Medicaid system to the new Medicaid Care Management program? How did you learn about the change? (probe: Did you get a letter? Did another professional help you?)

3. Do you like your Managed Care Organization? What do you like best? (probe: Can you tell me about a good experience you've had?)
4. What are the most challenging experiences you've had with the Managed Care organization you're using? (probe: Have you had any problems so far?)
5. Do you feel like you understand your plan? If you have a question, do you have someone you can call/contact for support? Who do you call if you need help? If you did call, how easy has it been to get to answers or resolutions to issues or questions?

II. Access to Care

Next let's talk about your experience with your doctor. With the new plan, you should have selected a primary care physician.

1. What was your experience like with selecting a primary care physician? Was it easy to find and select someone? How did it compare to the "old" system of selecting a doctor? Was it more difficult? In what ways? What criteria did you use in choosing?
2. Has your ability to get in to see your doctor changed? Can you describe those changes? (Probe: Would you say it is easier or more difficult to get in to see your doctor with the new plan?)
3. Have there been any changes in getting the medicines that you/your child need? If you have more difficulty, can you describe why it's been harder?
4. Have you been able to see the specialists that you need? If not, do you know why you haven't been able to?
5. And what about your access to Medicaid transportation and/or transportation reimbursement? If this is something you use, how would you describe the process? What are the best experiences you've had? What are the most difficult experiences you've had? What could make it better?
6. What about access to any other types of care, such as preventive care, has your access to these types of care improved? Has it gotten worse? Do you want access to this type of care or are you not interested in it? (probe: preventive care includes things like routine exams, wellness visits, immunizations/vaccines, screening tests for diabetes, cholesterol, - NOT emergency care, visits when you/your child are sick.)
7. Do you receive information and education on how to improve your/your child's health (such as information on how to manage chronic illnesses like diabetes, asthma, etc.) Do you like receiving this kind of information? Do you use it? Do you have any problems with the information?

III. Quality of Care and Care Management

Now let's talk about your experience with doctors and other service providers (such as psychologists, nutritionist, etc.) and how they work together and with you.

1. Have you gone to the doctor since December 1, 2013? How would you describe your relationship with your primary care provider? Does he/she understand your needs? What do you like best about your primary care provider? What do you like least about your primary care provider?
2. How would you describe your care coordination? Do you feel that your different doctors and providers work together well? Have you had any problems? Do you want your health providers to work together in this way? Do you want to be involved with it? (probe: by care coordination we mean, the ways your doctors and providers working together and with you to make sure your health is taken care of in the best way)
3. How would you describe your role and responsibility in your health care? Are you able to actively participate in decisions about your health care – do you have a chance to share your opinion and what you want? Do you want to participate? How would you like to participate?

IV. Information Needs

1. What kinds of information about doctors would you like to have access to? (probe: Do you want just basic name/address; or if doctor is accepting new patients; or physician quality?)
2. What other kinds of support and information would you most like to receive from your Managed Care Organization? (probe: details on coverage/benefits, information on physician quality, health education materials)
3. What's the best way for you to receive information such as information about available doctors and other providers (psychologists, nutritionists, etc.)? (probe: Would you rather get the information via mail, email, website, telephone, or in-person?)
4. If your Managed Care organization were going to make one improvement, what would you recommend? If Medicaid was going to make one improvement, what would it be?