New Hampshire Medicaid Care Management Focus Groups Summary Report Year Two, Fall 2014

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.

Lisa Horn, President
Horn Research LLC

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Department of Health and Human Services
Office of Medicaid Business and Policy
Concord, NH

Horn Research LLC • PO Box 148 Slaterville Springs NY • 607-316-2748 • Lisa@HornResearch.com
www.hornresearch.com

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EXECUTIVE SUMMARY

Introduction

In support of the New Hampshire Department of Health and Human Service Medicaid Care Management Program, Horn Research was subcontracted by HSAG, the State's external quality review organization, to gather qualitative data from Medicaid beneficiaries regarding their experience with the Medicaid Care Management Program over a three year period. For the first half of Year Two of the contract, Horn Research conducted two focus groups and stakeholder interviews with targeted Medicaid beneficiaries during October 2014. Horn Research, in conjunction with the DHHS and HSAG, identified four Key Points of Inquiry to explore during this period's data collection efforts: *Experience with Medicaid Care Management, Access to Care, Information Needs, and Improvements to MCO and Medicaid.*

Methodology

The DHHS provided Horn Research a blinded list of all Medicaid beneficiaries in Cheshire County and Strafford County with mapped identification numbers, MCO, 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 desired turnout. These individuals were offered the opportunity to participate in a telephone interview to ensure that their opinions were reflected in the results. A total of 20 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 experience with Medicaid Care Management and their MCO, participants were asked to describe what they liked best and least about their MCO, if they understand their plan, their experience with their MCO's member services, and their understanding of the grievance and appeals process. Participants shared generally positive experiences about their MCO. They expressed appreciation for the coverage and reported that it was easy to use. The main challenges faced by participants included confusion over what is and is not covered by their plan and a desire for expanded benefits. While a number of participants noted they had trouble understanding their plan and benefits, nearly all said they knew where to find the information they needed. Participants also said they had limited, but generally positive experiences with members services. Experience with the grievance and appeals procedure was almost non-existent.

Access to Care

In the focus groups and interviews, participants were asked to describe experience with the pre-authorization and referral processes and their access to prescriptions and preventive care. In addition, participants were asked to explain when and how they decide to use emergency room services and urgent care facilities. Overall, participants' responses revealed generally positive experiences with the pre-authorization process. Participants who noted challenges with pre-authorization remarked exclusively on the time frame it took to receive approval for medications and services and not on denial of authorization. Participants were satisfied with the process for referrals for ancillary services such as laboratory and imaging services. The vast majority of participants did not report problems in accessing medications, but some suggested that having to use specialty pharmacies rather than their regular pharmacy was challenging. Participants said they rarely used emergency room services and only did so when it was medically necessary. They indicated they felt confident in deciding when to go to an emergency room, but only a handful reported having spoken with their primary care physician about how to decide. Participants also noted very little use of urgent care facilities.

Information Needs

The focus groups and interviews also investigated the types of information that participants most want to receive from their MCOs. Participants most often mentioned wanting clear and concise information concerning their MCO's benefits and coverage and updated provider listings. In addition, participants noted an interest in alternative therapies and wellness education including any special promotions that might be available to improve their health.

Improvements to MCO and Medicaid

Participants were asked to suggest one improvement they would make to their MCO and to Medicaid overall. Participants suggested that providing access to alternative therapies and wellness opportunities would be a welcomed improvement from their MCO. Others suggested quicker turnaround on pre-authorization. Participants also reiterated wanting clear and concise information on their benefits and coverage. Participants wanted Medicaid to improve dental coverage and provide more information for the public about the availability and stability of the program since one MCO exited the market.

Comparison to Year 1 Results

In general, results from this first half of Year Two showed a marked improvement over the results from the Year One focus groups and interviews. Participants expressed more satisfaction and fewer problems with their MCO and described mostly positive experiences in key recommendation areas.

Improved Understanding of Benefit and Coverage Information/Continued Need for Simplicity

While a number of participants in this series of focus groups and interviews noted they had trouble understanding their plan and benefits, nearly all said they could call their MCO to find out any needed information. This is an improvement over Year One results when participants nearly universally said they did not understand their coverage and did not know how to access information from their MCO.

Improved Prescription Pre-Authorization Process

Participants' responses revealed improved experiences with the pre-authorization process compared with Year One. In Year One, many participants said they had experienced challenges with medications not being covered and delays in receiving prescriptions and referrals to specialists due to the pre-authorization process. Far fewer participants in the current round of data collection noted challenges with pre-authorization process. Those who did remarked exclusively on the length of time it took to receive approval for the authorization and not on the denial of authorization.

Desired Health Education Materials More Clearly Defined
In Year One, participants noted wanting health information tailored to their needs, but did not offer many ideas of the types of materials that would be useful. Participants in this first half of Year Two offered more specific ideas on what types of support and information would help them be proactive in improving their health including assistance with nutrition, exercise, and alternative therapy.

Shift in Perspective on Managed Care
In Year Two focus groups and interviews, participants frequently referred to their coverage as *insurance* which was a marked departure from Year One. In Year One, participants uniformly referred to their coverage as Medicaid. This shift gave the general impression that the stigma of participation in Medicaid has been reduced with the implementation of managed care.

Recommendations

Improve Benefit and Coverage Information
While there was a marked improvement in participants' understanding of their benefits and ability to access support from member services, participants continue to request a clear and concise overview of plan benefits provided in easy to understand language.

Improve Communication around Program Changes
Participants expressed confusion and concern over several aspects of the Medicaid Care Management Program including whether pre-authorization is required for emergency room care, the use of specialty pharmacies, and the stability of the program after the withdrawal of one of the MCOs. Proactive communication from the MCOs and Medicaid explaining these and any future changes may improve participants' understanding and reduce anxieties.

Ensure Participants are Informed of Grievance and Appeals Process
Half of the focus group participants indicated that they had not heard of the grievance and appeals process available through their MCO. Improved communication to ensure that participants are aware of the process and how to use it may improve their overall health care experience.

Continue Efforts to Improve the Pre-Authorization Process
While far fewer participants reported problems with the pre-authorization process than in Year 1, a notable number expressed challenges with the turnaround time to receive approval for their medications. Continued efforts to improve this process will ensure that participants are receiving needed medications in a timely manner.

Expand Wellness Opportunities
Participants reported a desire to receive more support and information to improve their health through opportunities to eat healthier, exercise, and explore non-pharmaceutical alternative therapies. These options follow current trends in health insurance.

Expansion of Health Benefits
Participants continued to advocate for expanding preventive health benefits to include preventive dental care for adults to 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 the first half of Year Two of the contract, Horn Research conducted two focus groups with target Medicaid beneficiaries on October 24 and October 25, 2014. One focus group was conducted in Keene, New Hampshire and one in Rochester, New Hampshire.

Table 1. Focus Group Locations and Dates

Location	Date/Time
Keene	October 24, 6:30pm-7:30pm
Rochester	October 25, 10:00am-11:00am

Four Key Points of Inquiry were developed based on material provided by DHHS to frame the information to be gathered from participants during this round of focus groups. 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 MCO including participants' experiences with their MCO's member services department and grievance and appeals process

2. **Access to Care**
   - Participants' experience with the pre-authorization process for prescriptions and services, access to preventive care, the process for receiving referrals, and the use of emergency room services and urgent care facilities

3. **Information Needs**
   - Participants' desire for information they want to receive from their MCO

4. **Improvements to MCO and Medicaid**
   - Participants' suggestions for improvements to their MCO and Medicaid

METHODOLOGY

To complete the goals set forth by DHHS to qualitatively gather information from Medicaid beneficiaries regarding their experience with the Medicaid Care Management Program, Horn Research engaged a standard qualitative data gathering process as detailed below. A total of 20 individuals participated in either a focus group or a telephone interview.

Sample Size and Composition

For the first half of Year Two, two counties in New Hampshire, Cheshire and Strafford, were targeted for data collection through the implementation of one focus groups held in each counties. Eight to ten participants were targeted for each of the two groups for a total of 16-20 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 blinded list of all Medicaid beneficiaries in Cheshire County and Strafford County with mapped identification numbers, MCO, 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 100 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. DHHS then provided contact information for the sample list for use in recruitment efforts. The sample size proved to be sufficiently large enough to recruit the target number of participants. Of note, Medicaid Care Management members enrolled in the fall of 2014 and as part of the NH Health Protection Program were excluded from the sample.

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 200 individuals in the sample. The letters were sent on September 18, 2014. Starting on October 1, 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. Several individuals expressed an interest in participating, but cited conflicts with child care, transportation, and work schedules. Eight individuals signed up for the Keene focus group and ten for the Rochester group. However, despite extensive follow-up reminders, turnout for both focus groups was lower than expected with four in attendance in Keene and five in Rochester. As a result, telephone interviews were conducted with 11 individuals who were unable to attend. A total of 20 people participated in either the focus groups or the telephone interview.

Participant Demographics

Participants were proportionately selected to be representative of the Medicaid enrollment in New Hampshire, with oversampling to allow for sufficient representation from smaller populations such as children with disabilities. Table 2 details the target number of participants by eligibility category for each geographic location of the focus groups.

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%	4-5
Child with disability	1,615	1%	2-3
Low income adult	16,500	14%	2-3
Low income child	80,380	68%	8-9
Total	*118,941*	*100%*	*16-20*

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 with a slight over-representation of low-income adults and child with disability, and slight under-representation of low income children.

Table 3. Number of Participants by Eligibility Category and Location

Eligibility category	Keene	Rochester	Total participants
Adult with disability	0	4	4
Child with disability	2	2	4
Low income adult	2	3	5
Low income child	4	3	7
Total	*8*	*12*	*20*

Table 4 shows the distribution of participants' MCO by location. Both of the MCOs, New Hampshire Healthy Families and Well Sense Health Plan, were represented by participants, but more participants were enrolled with Well Sense. Keene participants were nearly evenly enrolled between MCOs, while Rochester participants were most often enrolled with Well Sense.

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

MCO	Keene	Rochester	Total
NH Healthy Families	3	3	6
Well Sense Health Plan	5	9	14
Total	*8*	*12*	*20*

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 experience with Medicaid Care Management and their MCO, participants were asked to describe what they liked best and least about their MCO, if they understand their plan, their experience with their MCO's member services, and their understanding of the grievance and appeals process. Participants shared generally positive experiences about their MCO. They expressed appreciation for the coverage and reported that it was easy to use. The main challenges faced by participants included confusion over what is and is not covered by their plan and a desire for expanded benefits. While a number of participants noted they had trouble understanding their plan and benefits, nearly all said they knew where to find the information they needed. Participants also said they had limited, but generally positive experiences with members services. Experience with the grievance and appeals procedure was almost non-existent.

MCO – Positive Impressions

Focus group participants largely expressed gratitude and appreciation for the availability of health coverage for their families. One participant said, *"I love it. I've never gotten help from the state before, but now I'm in between job and have health issues. I feel very grateful to have it."* Others noted that they appreciated the different types of benefits they received through their MCO including vision services, prescription coverage and safety items for their children. A participant said, *"I've had coverage to go to an eye care doctor and have all of the testing I needed to get a better pair of glasses. I'm pleased with the eye doctor that I have."* Another noted, *"I do like that you have the ability to get helmets for your kids. They're very into keeping your kids safe."* Participants noted that they felt that their MCO's member services department was friendly and helpful and that their benefits were easy to use. One participant shared, *"Any time I call customer service, there aren't long wait times. My questions get answered directly and I'm not transferred. I had to order a breast pump and it was the easiest process. They gave me the referral number, I called and got it two days later. It was really quick and easy. And something that I needed because I had to go back to school."*

MCO – The Challenges

When asked about the most challenging aspects of their MCO, for the most part, participants said they had no problems or issues. The most frequently noted problem was related to confusion about what services are covered by their MCO. Three participants described problems managing the relationships between other insurance companies and their MCO. Two participants use their MCO as secondary insurance and have had significant difficulties maintaining consistent coverage while their primary insurance and MCO work out payment agreements. One participant explained, *"My boys have multiple therapies, and the Medicaid MCO was supposed to kick in in July and I'm still fighting. It's a whole 'Who is paying, I'm not paying, I'm not paying more than (the primary insurance) will pay.' We aren't getting anywhere, and right now the providers are stopping therapy because they can't just keep seeing them not knowing if they are going to get paid."* Another participant shared that when her insurance company from her previous employer did not cancel her coverage as it should have, it created confusion and difficulties with her Medicaid MCO. She said she spent months trying to get it resolved. A participant expressed fear and confusion on whether her on-going treatment would be covered, *"I just want to make sure my doctors are covered for the five years of my treatment. It is confusing, I have a degree, I'm educated and I find it so confusing."* Several other participants expressed fears that their MCO would pull out of the Medicaid program and leave them without coverage.

Participants also noted challenges with receiving sufficient coverage for vision services and dental services as well as services considered non-medically necessary. One participant said, *"For kid's they don't cover wisdom teeth removal. I have two sons with fatty tumors (on their heads) and they won't cover removal for that because it's considered non-medical."* Other participants noted problems with pre-authorization including having to wait for procedures and having to go through extra steps before receiving care. A couple of participants remarked on the unavailability of prescriptions at their pharmacies and trouble with transportation including the long turnaround time for reimbursement and the long lead time required for scheduling transportation.

Understanding of Plan

When asked whether they felt like they understand their plan, participants expressed a range of responses. About half of participants said they adequately understand their plan and coverage. About a third of participants said they do not pay much attention to their coverage and just accept whatever happens. One participant shared, *"I don't know. I pretty much just go along with whatever."* Another said, *"I don't really pay attention – if it covers what I need, then it's all set."* A handful of participants said they do not understand their plan and feel stressed that they do not know what will be covered. One participant described his concern about having his hearing aids covered. He said, *"I have hearing aids from the Lyons Club. I'm deaf in both ears and I'm sure my doctor would say it is medically necessary because I can't hear without them. I'm sure Well Sense won't cover the $4,000 pair I have now. They might cover a cheaper pair, but it won't be as good and I'll have a harder time hearing. I did call [the MCO] and they said they'd cover two. I haven't talked to my audiologist yet, but I can guess he'll say I'll get two, but they are going to be cheap. The ones I have had for two years are slipping, and I don't want to have to wait. I want a backup pair. I'm going to talk to my doctor, but I don't know if it's done that way."* Another participant said, *"My thing is hospital stays. I don't know how often you can do that. If you're sick and want to stay the hospital, they might deny that."* The majority of participants said that they felt they could call their MCO to get answers to their questions.

Member Services

Participants were asked to describe their experience utilizing their MCO's member services department. Overall participants reported minimal contact with the member services department. About half of respondents said they had not called at all while the other half said their limited experience had been positive. One participant said, *"I've called and I've been very happy. Everyone is helpful, respectful."* Another noted, *"My son needs special formula that I have to get through them. I've called them a few times and they've directed me where I've needed to go. It's always been the right place - which is good!"* Only one participant said she had difficulty with the member services department. She explained, *"I've called a couple times, but they seem a little iffy. They don't always know what's covered when you call, they are like 'um, I think we do…' so that's been hard."*

Grievances and Appeals

The vast majority of participants did not have any experience with their MCO's grievance and appeals process. About half said they were not aware of the process at all. The other half said they understood how to engage with the process if it became necessary in the future. Only one participant said he had used the grievance procedure to resolve access to pain medications. He indicated that the process was challenging for him to manage due to his problems focusing from his attention deficit hyperactivity disorder (ADHD) and previous history with drug abuse. He said he had previously been "blacklisted" for medication seeking and that it was difficult to get anyone to believe he needed the pain medication for his current health condition.

ACCESS TO CARE

In the focus groups and interviews, participants were asked to describe experience with the pre-authorization and referral processes and their access to prescriptions and preventive care. In addition, participants were asked to explain when and how they decide to use emergency room services and urgent care facilities. Overall, participants' responses revealed generally positive experiences with the pre-authorization process. Participants who noted challenges with pre-authorization remarked exclusively on the time frame it took to receive approval for medications and services and not on denial of authorization. Participants were satisfied with the process for referrals for ancillary services such as laboratory and imaging services. The vast majority of participants did not report problems in accessing medications, but some suggested that having to use specialty pharmacies rather than their regular pharmacy was challenging. Participants said they rarely used emergency room services and only did so when it was medically necessary. They indicated they felt confident in deciding when to go to an emergency room, but only a handful reported having spoken with their primary care physician about how to decide. Participants also noted very little use of urgent care facilities.

Pre-Authorization Process

About half of participants said they either had not had any experience or had good experiences with the pre-authorization process for prescriptions or services. A couple of participants said they had had problems before which they attributed to their previous MCO, but that they did not have any issues with their current MCO. The primary challenge noted by participants who had difficulty with the pre-authorization process was the length of time it took to get authorization. One participant said, *"It was this whole disaster with pre-authorization. We called back and forth and I went to the pharmacist and she said it was only twelve dollars so I just paid it. I finally got the pre-authorization a month later. Luckily it wasn't a 600 dollar one."* Another said, *"It's like a waiting game. I have to get a lot of procedures done, one right after another...now I have to wait. They said it has something to do with insurance. When I call I ask if they forgot about me. They said they sent the paper through to the insurance and now we are waiting, and they say the insurance hasn't gotten through."* One participant said they felt it was the pharmacy's fault for not calling for the pre-authorization in a timely manner saying, *"I've had that when I come back for a prescription [after dropping it off], I've had to wait overnight for a preauthorization."* Another said, *"They take time. It is very time consuming if you need it right away. You have to wait for the doctor to fax it to the pharmacy and wait for authorization. It wasn't long for me it was a couple of days, but others have to wait."* Only one participant reported being denied authorization for pain medication.

Access to Medications

Generally, participants said they had not experienced any difficulties accessing prescription medications with the exception of one participant who said he had problems accessing pain medication due to being "black listed" at the hospital. A handful of participants noted that they were challenged by having to go to different pharmacies in order to get their medications or paying a higher cost at some pharmacies. One participant said, *"I have problems with my progesterone. I get it at one place and they give it to me free or for three dollars. Another will charge me sixty dollars. I don't argue, I just get it."* A participant noted concerns about needing to go use a specialty pharmacy to fill her prescription. She said, *"I hate medicine coming in the mail. I want to go down to the pharmacy and get it. I don't have time to sign for the medicine, I work."* Another said, *"I've always gone to Walgreens for my medication, and now they don't fill some of my prescriptions. First they said it has something to do with the law change. Then they told me it has something to do with my insurance, but my doctor said that's not true. I feel like I have to*

go to a hundred different places. I am running all over the place which made me feel like some kind of drug addict."

Access to Preventive Care

All of the participants indicated that they had not experienced any problems accessing preventive care. One participant noted that she was unsure of the extent of her future coverage for preventive care saying, *"I'm pretty sure after pregnancy I'm covered for 6 weeks afterwards. I'm pretty sure you're dropped after that. I'm getting a birth control before that 6 weeks are over and I'm hoping that's covered. So I might have issues, but that's a couple of weeks away."* Another noted the lack of preventive dental for adults sharing, *"I have (access) to other stuff, but not for my dental. I wish I could get it for dental because my teeth aren't perfect. I could get some of it fixed so I wouldn't need dentures by 30. Unfortunately that might happen."* The participants did not understand that dental benefits are provided by the State Medicaid system and not the MCOs.

Access to Referrals

Participants were asked to describe their experience receiving referrals from their primary care physician to ancillary services such as laboratory services, radiology, and imaging. All participants said that they had not experienced any challenges in the referral process. One participant said she gets blood work done regularly for her medication and has had good experiences. Another noted, *"My doctor just automatically sent it over. I had no problems at all."*

Emergency Room Use

Respondents were also asked about their experience using the emergency room for their and their children's health care needs. The majority of respondents said they had not or have very infrequently used the emergency room since enrolling with their MCO. They said they typically only go to the emergency room when the doctor's office is closed or when the situation is particularly dire. Participants reported using the emergency room for medical crises such as broken bones, severe asthma attacks, and vomiting that will not stop. A handful of participants noted using the emergency room when they may have been able to go to a doctor's office instead. One participant said she sometimes used the emergency room when she did not have transportation to get to the doctor's office on short notice. She explained, *"To get transportation, you have to call ahead of time. If it's an emergency they should give you emergency transportation."* Another noted that she used the emergency room due to the unavailability of her doctor saying, *"The doctor has limited hours, so I have to use the ER (emergency room) for medical needs. I don't get sick during the hours he is open."* A participant also said he did not have a primary care doctor and as a result went to the emergency room for care.

A handful of participants said their doctor had spoken with them about when to use the emergency room versus when to come to the office. Others who had not spoken with their doctor suggested they knew when and when not to use the emergency room.

Urgent Care Use

Overall, participants reported little to no experience with urgent care facilities. A handful of parents said they take their children to an urgent care clinic if they are sick during times their doctor's office is closed. One parent explained her rationale for choosing urgent care over the doctor's office, *"If one of the kids is sick, it is sometimes easier to go to a walk-in clinic rather than making an appointment with the doctor. They might not have an available appointment, but at the urgent care I can see a doctor right away."*

Barriers to Care

Participants had a very few comments related to what barriers they have faced in accessing care for themselves or their children. The lone issue mentioned was related to reductions in mental health care. One participant said, *"They are cutting back on mental health. It's more like crisis therapy."*

INFORMATION NEEDS

The focus groups and interviews also investigated the types of information that participants most want to receive from their MCOs. Participants most often mentioned wanting clear and concise information concerning their MCO's benefits and coverage and updated provider listings. In addition, participants noted an interest in alternative therapies and wellness education including any special promotions that might be available to improve their health.

Types of Information Desired

When asked about information and educational materials they would like to receive from their MCO, participants most often said they want more information concerning what services are covered under their plan. Participants want this information provided in a more concise and simple manner. One participant said, *"We were given a book when we first joined, but it's extremely big."* Another said, *"I want something you don't need a degree to figure out. Simplify the information."* Another said, *"I want a box. I want it to say 'these are pre-authorization-required medications.' I don't have time to look through. I need to know right now."* Several participants also indicated they would like an updated provider list from their MCO. A handful of participants said they would like information on any types of special promotions that might be available through the MCO including nutritional supports such as dieticians and coupons for healthy food products and opportunities for health and dental screening. Other participants noted interest in receiving information concerning alternative therapies and nutritional guidance for countering side effects from medications. One participant said she would like to see information about current health issues facing the community. She said, *"Things like what is currently going on – such as Ebola or the upper respiratory virus. People are freaking out and scared. They need information on vaccinations and reassurance and information on the situation. It would be also be nice to have information about if your child was to become sick and had symptoms what you should look for. Especially with flu season coming up."* Another participant noted that she would like more information related to her on-going eligibility for coverage. She said, *"I think the only question and concern I'm going to have is just the financial part of it. When I do start working again, where I'm going to fall in with that coverage."*

IMPROVEMENTS TO MCO AND MEDICAID

Participants were asked to suggest one improvement they would make to their MCO and to Medicaid overall. Participants suggested that providing access to alternative therapies and wellness opportunities would be a welcomed improvement from their MCO. Others suggested quicker turnaround on pre-authorization. Participants also reiterated wanting clear and concise information on their benefits and coverage. Participants wanted Medicaid to improve dental coverage and provide more information for the public about the availability and stability of the program since one MCO exited the market.

Improvements to MCOs

Overall, participants said their experience with their MCO was positive, but several had suggestions that would improve their experience. Participants suggested various options including providing access to alternative therapies, healthy foods, and wellness opportunities. A participant said, *"Give me some information on alternative therapies. I'm sure it would be cheaper for someone who prefers natural options. It would be more cost effective and have fewer side effects."* Another mentioned, *"I have diabetes and the last six months I've been struggling to afford the food I need and I can't stabilize my blood sugar. I can't afford the stuff that's healthy, with the high cost and reduced food stamps. I think something should be done for those on a special diet like diabetes, high blood pressure, and celiac disease. Something like coupons or a WIC (Women, Infants and Children)-like program."* Another said, *"I think it would be cool if they covered reimbursement for the gym, YMCA (Young Men's Christian Association), exercise, stuff like that."*

Participants also noted concerns about pre-authorization and emergency room visits. One participant said, *"The pre-authorization should be quicker. It doesn't seem to matter if it's life threatening or not."* Other participants noted concern and confusion about whether emergency room trips required pre-authorization. One said, *"I was at a group recently and they were told that you're supposed to call before you go to the ER. What am I supposed to do, call you when I'm unable to breathe?"* Another remarked, *"Our 6 year old had a seizure, I was pacing and they didn't have a bed. I never would've thought to call my insurance company. I shouldn't have thought to call them. They don't do anything immediately. No one on the other end has the authority to give authorization."*

Participants also reiterated they would like better and clearer information from their MCO. A participant said, *"I think if they could just have answers and make it less confusing."* Another said she would like, *"more information on the doctors that accept it. Because when you get your insurance, you don't know who accepts it and have to make a million phone calls to find one."*

Improvements to Medicaid

The most frequently mentioned improvement to Medicaid was to include more and better dental coverage. One participant summed it up as, *"Change the dental care for adults to get preventative care. It's not just kids that need good teeth, adults do too. As we get older, it's going to get worse. You would think they'd want to prevent denture costs. Think about all the kids too and make sure they have everything that they need."*

Participants would also like better information from Medicaid. One participant said it would be good for Medicaid to share information on the program more widely. She said, *"I know a lot of people who don't have health insurance. I knew the state law changed for Medicaid, that's why I signed up for it. I had a lot of doctor bills and was paying out of pocket. Get the knowledge out there about how it's changed."*

Another participant said she thinks people are concerned the current MCOs will pull out of the state and cause difficulties in the future. She said, *"Anything related to the state depends on the budget and the state may be changing the rules. Insurance companies do not go without profit, they're a business. I get it. I'm a business major, but people need answers and are not being given the information."*

Two participants mentioned expanding coverage to include wellness and nutrition options. One said she would like improved turnaround on reimbursement for transportation.

DIFFERENCES BETWEEN PARTICIPANTS

In general, participants from Keene and Rochester did not express different experiences or opinions. 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 and services. Parents of low-income eligible children were more likely to say they appreciated the help they receive and are grateful for the coverage. The only distinctions between responses based on MCO affiliation were with respect to emergency room use. All of the participants who reported having spoken with their doctor about when to seek emergency room care versus when to come to the office were enrolled with Well Sense.

COMPARISON TO YEAR ONE RESULTS

In general, results from this first half of Year Two showed a marked improvement over the results from the Year One focus groups and interviews. Participants expressed more satisfaction and fewer problems with their MCO and described mostly positive experiences in key recommendation areas.

Improved Understanding of Benefit and Coverage Information/Continued Need for Simplicity
While a number of participants in this series of focus groups and interviews noted they had trouble understanding their plan and benefits, nearly all said they could call their MCO to find out any needed information. This is an improvement over Year One results when participants nearly universally said they did not understand their coverage and did not know how to access information from their MCO. However, as with Year One, participants again expressed wanting clear and concise information on their MCO's benefits and updated provider listings.

Improved Prescription Pre-Authorization Process
Participants' responses also revealed improved experiences with the pre-authorization process compared with Year One. In Year One, many participants said they had experienced challenges with medications not being covered and delays in receiving prescriptions and referrals to specialists due to the pre-authorization process. Far fewer participants in the current round of data collection noted challenges with pre-authorization process. Those who did remarked exclusively on the length of time it took to receive approval for the authorization and not on the denial of authorization.

Desired Health Education Materials More Clearly Defined
In Year One, participants noted wanting health information tailored to their needs, but did not offer many ideas of the types of materials that would be useful. Participants in this first half of Year Two offered more specific ideas on what types of support and information would help them be proactive in improving their health including assistance with nutrition, exercise, and alternative therapy.

Continued Focus on Expanded Benefits
As with Year One, participants continued to express a desire for expanded dental coverage for adults and children.

Shift in Perspective on Managed Care
In Year Two focus groups and interviews, participants frequently referred to their coverage as *insurance* which was a marked departure from Year One. In Year One, participants uniformly referred to their coverage as Medicaid. This shift gave the general impression that the stigma of participation in Medicaid has been reduced with the implementation of managed care. One participant said she would prefer not to have a Medicaid card at all and to be able to use her MCO card for everything. She said, *"We do have MCO cards, but we have Medicaid cards too. I hate that name. There's a stigma. I hate that word. I don't want to tell people I'm on it. It's like a label. We are working people."*

CONCLUSION AND KEY RECOMMENDATIONS

The focus groups held in Keene, New Hampshire and Rochester, New Hampshire in October 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
While there was a marked improvement in participants' understanding of their benefits and ability to access support from member services, participants continue to request a clear and concise overview of plan benefits provided in easy to understand language.

Improve Communication around Program Changes
Participants expressed confusion and concern over several aspects of the Medicaid Care Management Program including whether pre-authorization is required for emergency room care, the use of specialty pharmacies, and the stability of the program after the withdrawal of one of the MCOs. Proactive communication from the MCOs and Medicaid explaining these and any future changes may improve participants' understanding and reduce anxieties.

Ensure Participants are Informed of Grievance/Appeals Process
Half of the focus group participants indicated that they had not heard of the grievance and appeals process available through their MCO. Improved communication to ensure that participants are aware of the process and how to use it may improve their overall health care experience.

Continue Efforts to Improve the Pre-Authorization Process
While far fewer participants reported problems with the pre-authorization process than in Year 1, a notable number expressed challenges with the turnaround time to receive approval for their medications. Continued efforts to improve this process will ensure that participants are receiving needed medications in a timely manner.

Expand Wellness Opportunities
Participants reported a desire to receive more support and information to improve their health through opportunities to eat healthier, exercise, and explore non-pharmaceutical alternative therapies. These options follow current trends in health insurance coverage and potentially could result in cost-savings and improved health outcomes.

Expansion of Health Benefits
Participants continued to advocate for expanding preventive health benefits to include preventive dental care for adults to reduce long-term health costs.

APPENDIX 1. RECRUITMENT LETTER

Dear,

The New Hampshire Department of Health and Human Services is asking for your help with a project about New Hampshire Medicaid Care Management. The Department hired Horn Research to gather opinions from people like you to better understand the experience you are 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 one session in your area, which will be filled on a first come, first reserved basis:

Friday, October 24, 2014 from 6:30pm-7:30pm
Keene State College, L.P. Young Student Center, Room 309
Madison Street, Keene NH

Saturday, October 25, 2014 from 10:00am-11:00am
Rochester Community Center, Small Meeting Room
150 Wakefield Street, Rochester NH

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 the focus group, 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,

Doris H. Lotz, MD, MPH
Medicaid Chief Medical Officer

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 two Medicaid Managed Care organizations: NH Healthy Families 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. How long have you been with your current Managed Care Organization? Do you like your current MCO? What do you like best? (probe: Can you tell me about a good experience you've had

3. What are the most challenging experiences you've had with the Managed Care organization you're currently using? (probe: Have you had any problems so far?)

4. 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?

5. Have you called your MCO's member services department (call center) to get information at any point? What was your experience like? Did you get what you needed? Were there any problems or challenges?

6. Do you feel like you understand the grievance and appeals process with your MCO if you have a problem with your coverage? Have you ever gone through an appeals process with your MCO? What happened?

II. Access to Care

Next let's talk about your experience with your access to different types of care.

1. Tell me about your experiences with the pre-authorization process for getting prescriptions and other services. How would you describe the process? What are the best and most challenging experiences you've had? Have you had an experience where you were denied prescriptions or other services through the pre-authorization process? What was that like? Was it resolved to your satisfaction? How could the process have worked more effectively for you?

2. Have you been able to get the medicines that you/your child need? If not, can you describe why not?

3. Do you have access to the preventive care you want and need? Have you had any problems accessing preventive care? 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.)

4. Tell me about the process of getting referrals from your primary care physician to other services such as radiology, laboratory services, imaging, etc. Have you been referred to any of these services? How did the process go? Did you have any challenges or problems? How would you improve the process?

5. Have you used the emergency room to provide services to you or your child? If so, how do you decide when to go to the emergency room instead of going to your primary care physician? Have you had a discussion with your primary care physician about when to go to the emergency room? How frequently do you go to the emergency room? Why do you go? Do you use other sources of care such as urgent care facilities (e.g. Minute Clinic, ConvenientMD, ClearChoiceMD)? When and why do you decide to use that type of care instead of going to your primary care physician?

6. Have you experienced any barriers to receiving any type of care you or your child needs? Can you describe the problems you've had? How have you solved these problems or gotten around the barriers? Have the barriers impacted your or your child's health? In what ways?

III. Information Needs

1. What kinds of support and information would you most like to receive from your Managed Care Organization? (probe: details on coverage/benefits, health education materials, something else?)

2. 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?