2006 Survey of

Arizona Health Care Cost Containment System Providers

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- AHCCCS's Central Office Strategic Planning staff provided many hours of technical assistance to ensure the quality of the survey design and implementation.
- AHCCCS contracted health plans offered suggestions and information that proved useful in survey design and data collection.
- AHCCCS executive staff, specifically Director, Anthony D. Rodgers, Chief Medical Officer, Marc Leib, M.D., and Dental Director, Robert Birdwell, D.D.S., provided feedback on survey design and endorsed this study in letters that were included with the questionnaire.
- The Arizona Medical Association, the Arizona Osteopathic Medical Association, the Arizona Dental Association, and the Arizona Medical Group Management Association lent support by providing letters of endorsement for this project.

Purpose

This report summarizes the results of the 2006 Arizona Health Care Cost Containment System (AHCCCS) Provider Survey of primary care physicians (PCPs), specialists, office managers, and dental providers. The survey was sponsored by AHCCCS, Arizona's Medicaid program. It was conducted by the Center for Health Information & Research (CHIR), a research center located within the School of Computing and Informatics in Arizona State University's (ASU) Ira A. Fulton School of Engineering, in conjunction with the survey firm International Communications Research (ICR).

The purpose of this survey is to determine what AHCCCS providers think about the AHCCCS program in general as well as what they think about the individual health plans with which they contract. Survey responses allow for comparison between AHCCCS-contracted health plans and assessment of the AHCCCS program in general. Responses will be used by individual health plans to guide quality improvement activities and by AHCCCS to support monitoring and contracting processes.

Contents

Executive Summary

Success in maintaining a comprehensive system of care for members of the Arizona Health Care Cost Containment System (AHCCCS) is fundamentally dependent on the cooperation of the network of providers contracted with AHCCCS managed care plans. The satisfaction and general opinions of the health care providers, directly involved in the delivery of services, offer insight into the ways in which system characteristics affect the quality of care delivered to members. Further, they offer an opportunity to identify, examine, and correct the concerns that could ultimately affect network adequacy.

A variety of studies have described the consequences of physician dissatisfaction. Dissatisfaction has been linked to poor clinical judgment, substandard medical care, reduced continuity of care, patient dissatisfaction, and patient non-compliance. Ultimately, studies indicate that if areas of physician dissatisfaction are not addressed, health plans stand to lose their best physicians, pay higher rates to remaining provider groups due to shrinking networks, face access-to-care problems, experience cost increases resulting from the need to recruit and train new providers, and see a reduction in patient satisfaction and quality of care.

This report summarizes the results of the 2006 Survey of AHCCCS Providers, which included customized questionnaires for Primary Care Physicians (PCPs), Specialists, Office Managers, and Dentists, all of whom serve members through one or more health plans. Questionnaires differed by provider type and were designed to assess overall provider satisfaction as well as provider expectations and experiences related to individual health plan performance. Although responses to the majority of questions came from multiple choice options or rating scales, providers also had an opportunity to offer narrative comments.

Overall findings indicate that health care providers continue to have a more positive attitude toward AHCCCS managed care plans than they do toward either commercial plans or managed care in general. Despite this overall conclusion, the percentage of providers who feel positive about AHCCCS has decreased since the 1998 survey, particularly among PCPs and dentists who previously described their attitudes as "positive" and now describe them as "neutral."

More specific emerging themes address:

Communication and Access to Technology

Providers indicate an overwhelming preference to accomplish health plan communications via mail and telephone, and continue to report limited access to newer technology. Whereas 86% report access to a fax machine, only 48% report access to the internet and only 42% report access to email. This is clearly an important consideration when communicating with provider offices, and will require significant attention in future projects related to electronic records and health information exchange.

Administrative Requirements

Providers indicate a general desire to reduce paperwork and administrative procedures; they are particularly concerned with the requirements surrounding the authorization process. As commercial plans move away from more restrictive HMO models to more liberal PPO models, it is likely that provider expectations will follow suit. Some studies suggest a link between physicians' perceptions of clinical autonomy and their satisfaction with managed care. Physicians are most dissatisfied when they perceive barriers to good patient care.

Claims Processes

Despite reported limitations in access to technology, 62% of medical offices and 68% of dental offices state they are capable of submitting claims electronically. Provider comments suggest that a major barrier to electronic claims submission is the attachments required to process claims. Desired improvements in health plan claims' operations and electronic claims submission rates may require health plans to reassess the value of requiring selected attachments.

Less than one half of both medical and dental providers believe that their clean claims are processed within 30 days. This is despite federal and contractual requirements that 90% of clean claims be processed within 30 days of receipt by the health plan. A perception of timely claims payment is likely to affect overall provider satisfaction with a health plan.

Provider Network Availability

Providers indicate a need for improved specialty networks. Medical specialties reported to be the most difficult to obtain for AHCCCS members include dermatology, gastroenterology, neurology, and orthopedics. Dental specialties reported to be the most difficult to obtain for AHCCCS members include periodontics, oral surgery, and endodontics.

Access to Non-Formulary Drugs

Based on survey responses and narrative comments, a substantial number of providers want improved access to non-formulary drugs when they feel it is necessary for good patient care. This attitude may be influenced by continued emphasis on generic drug use and comparisons with the tiered options available in commercial plans. It is important to keep in mind that AHCCCS has one of the highest rates of generic drug use and the lowest pharmacy costs among all Medicaid plans, and that provider dissatisfaction with policies regarding non-formulary drugs is an issue nationwide.

Ancillary Services

Ancillary services with the highest percentage of "poor" ratings are:

- Dental services
- Pharmacy services
- Durable Medical Equipment services
- Transportation services

Most ancillary services in rural communities received only a slightly higher percentage of "poor" ratings than those in urban counties. Rural DME services, however, received a considerably higher percentage of "poor" ratings than urban DME services.

Utilization Patterns

Considerable variation exists among health plans related to the extent their respective providers feel informed of individual utilization patterns. Findings may offer an opportunity for benchmarking and improvement activities.

Translation Services

A notable number of offices indicate they do not use interpreters to assist patients who do not speak English. Rather, they ask family members or medical/dental office staff to serve as translators. Among the many concerns about using family members in particular as translators are issues related to translation accuracy and privacy concerns. It will be valuable to compare this finding with related responses to the AHCCCS Member Satisfaction Survey for a better understanding of the impact of this issue.

Dental-Specific Issues

Dental offices report a perceived "no-show" rate of 30%. This is notably higher than that perceived by medical offices (10%), and is significant to dental offices because of the way in which dental appointment time is reserved. Dental appointments typically involve more direct provider time, and there is less opportunity to double book patients than in medical offices. Patient "no-shows" are often identified as a significant barrier to dental provider participation. When asked to rate the support they received from health plans in addressing patient "no shows," the highest response on a scale of 1-5 was 2.49. This suggests that additional support from plans might be needed to deal with this issue.

The American Dental Association (ADA) now recommends that children be seen by a dentist when the first tooth erupts or no later than age one. Only 42% of responding dentists indicated that they accept children at that age, indicating that additional work with the dental community may be necessary to develop a workforce that will support this new recommendation.

Provider Comments

In general, providers' narrative comments amplify the structured survey findings. In some instances, narrative findings raised unanticipated issues. Specifically, narrative comments indicated confusion among providers and a need for additional training regarding the care coordination and billing process for members enrolled in Medicare Part D (particularly members enrolled with plans functioning as Special Needs Plans). Finally, providers' narrative comments reinforced structured survey findings related to individual health plans. Health plan specific remarks will be forwarded to respective plans along with structured survey findings to be used for identification of quality improvement opportunities.

Background

The AHCCCS Program and Provider Network

AHCCCS, the first state-wide managed care Medicaid program in the country, was created as a partnership between the State and both public and private managed care health plans. Via a competitive bidding process, AHCCCS awards contracts to acute care health plans for the care of its membership. Contracts are awarded by Geographic Service Area (GSA; *Figure 1*) so that members are able to select from at least two AHCCCS acute care health plans. Currently, eight acute care health plans (excluding the Children's Medical and Dental Plan [CMDP] for foster children) provide care to AHCCCS members (*Table 1*).

Table 1. AHCCCS Health Plans by Numbers of Enrollment, 2006

Abbreviated name	*Health plan*	*Enrollment as of 06/01/06*
APIPA	Arizona Physicians IPA	274,914
HC AZ	Health Choice Arizona	111,155
MHP	Maricopa Health Plan	34,796
PHS	Pima Health System	27,251
UFC	University Family Care	9,996
MCP	Mercy Care Plan	242,767
PHP/CC	Phoenix Health Plan/ Community Connection	92,871
Care 1st	Care 1st Health Plan	29,186

Note: The numbers represent AHCCCS acute care coverage throughout the entire state of Arizona. Numbers retrieved from the AHCCCS website at: http://www.azahcccs.gov/Statistics/Enrollment/Acute/Enrollment.asp.

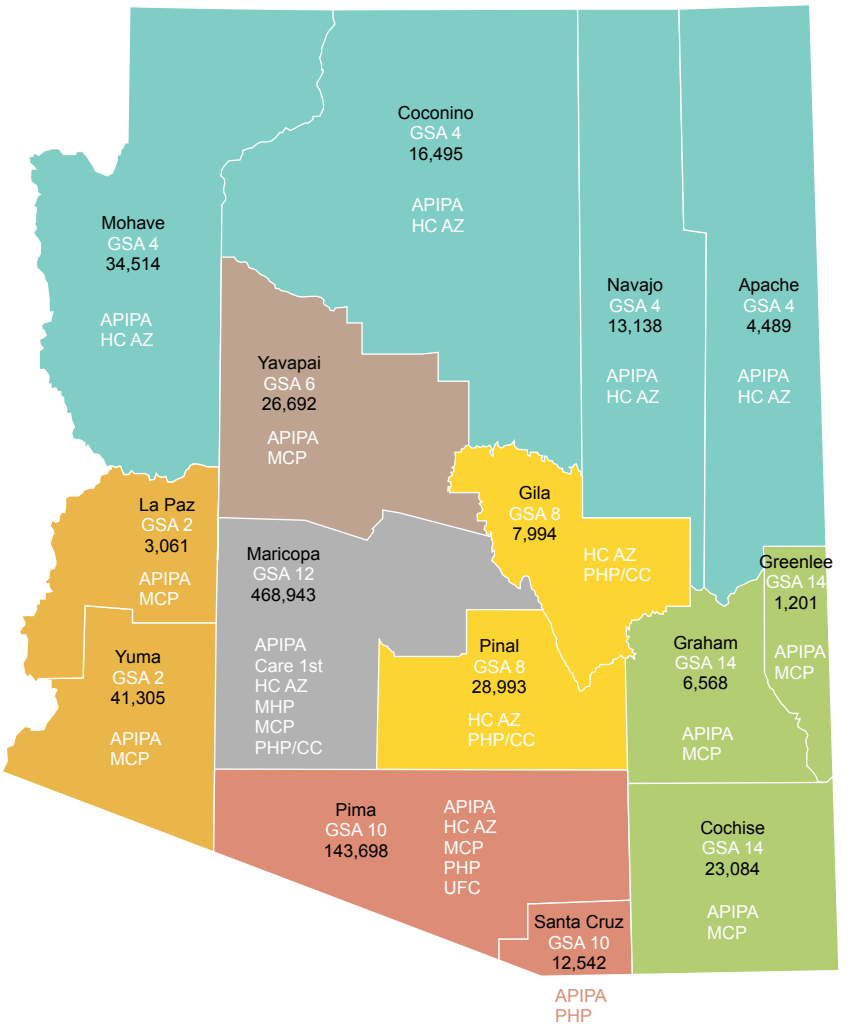
AHCCCS contracts require health plans to develop and maintain a provider network sufficient to provide all covered services, and access to care is expected to be equal to or better than the community norms. In turn, health plans require PCPs to manage medical care, referrals to specialists, hospital visits, and other services for their patients. Over 85% of primary care providers in Arizona participate in one or more of the AHCCCS health plans (AHCCCS, 2004).

The AHCCCS program provides Medicaid recipients with access to private physician and dental networks, allowing individual members to choose both their health plan and their PCP. Mainstreaming members into private provider offices is a critical element in the success of the AHCCCS acute care program. Uncomplicated access to primary and preventive care leads to a quality and cost-effective program. Thus, provider satisfaction and, ultimately, continued participation in the AHCCCS program is essential.

History of Provider Surveys

Historically, individual health plans have conducted periodic surveys of their respective provider networks. The only AHCCCS-wide provider survey, however, occurred in 1998 (physicians and office managers) and 1999 (dentists). Results indicated that physicians, particularly those in metropolitan areas, were generally positive about the AHCCCS program. In fact, they were more positive about AHCCCS and its health plans than they were about managed care in general and commercial managed care plans. In particular, their assessments of the specialty networks and associated referral policies were favorable. Recommended improvements included more efficient administrative procedures, faster payment for services, and reduced wait time when phoning the health plans.

Figure 1. Map of GSAs



GSA No.	Health Plan Enrollment
2	44,367
4	68,635
6	26,692
8	36,987
10	156,240
12	468,943
14	30,853

Total Health Plan Enrollment: 832,717

Dentists were also positive about AHCCCS and its contracted health plans. They were particularly satisfied with the change from a program that was primarily capitated to one based on fee-for-service reimbursement. At the time, some dentists noted that improved reimbursement helped increase provider participation and, therefore, enhanced access for patients. Recommended improvements included more efficient administrative procedures, faster payment for services, and greater ease in reaching plan representatives. Dentists also believed that, when compared to other patients, AHCCCS children had a higher incidence of dental decay, less understanding of dental hygiene, and were less likely to keep appointments.

Impact of a Changing Environment on Survey Results

In addition to providing a fresh assessment of provider satisfaction with AHCCCS and its contracted health plans, current survey results afford an opportunity for some high level comparison with results received in 1998-99. Since that time, there have been significant changes in the health care marketplace in general and the AHCCCS program in particular. It is helpful to remain aware of the major changes that may impact provider assessments.

Perhaps the most noteworthy change since the previous provider survey is the significant increase in the Arizona and AHCCCS populations. As the Medicaid agency for one of the fastest growing states in the nation, AHCCCS has seen its membership grow to over one million. The percent of Arizonans receiving AHCCCS services increased from 9% in 1998 to 18% in 2005. Ultimately, this increase is a result of multiple factors, including unprecedented population growth, an increase in the numbers of uninsured, and expansions in eligibility criteria.

Other changes that could impact provider assessments relate to changes in managed care in general. Commercial managed care plans have become increasingly less restrictive. Some have converted to a preferred provider model, eliminating referral and prior authorization requirements. As commercial managed care plans relax requirements, it is likely that providers may expect AHCCCS plans to do the same. Some high level comparison of the results presented here with those received in 1998-99 may lend perspective in this regard.

Methodology

Sample Selection

Sample selection for the Provider Surveys was accomplished through Arizona HealthQuery (AZHQ), a community health data warehouse maintained by ASU's CHIR. AZHQ, funded by ASU and St. Luke's Health Initiatives, contains demographic and administrative health care information on more than seven million people who have received health care in Arizona. AHCCCS is a founding member of AZHQ and, along with more than 40 other contributing data partners, contributes enrollment and encounter data on health care services. AZHQ data on health care services provided to AHCCCS members for SFY 2005 were used to select the survey sample. This is an unusually large survey sample; because exclusions were few, the sample represents nearly 98% of all AHCCCS providers in 2005. Criteria for sample selection were:

- PCPs – any providers, contracted with at least one AHCCCS health plan, whose specialties were listed as family practice, general practice, internal medicine, gerontology, or pediatrics. To be included in this sample, PCPs must have had at least 20 health care encounters with AHCCCS members during SFY 2005.

- Specialists – all other physicians who accept AHCCCS members except specialists who do not have an ongoing relationship with their patients (e.g., hospitalists, pathologists). Surveyed specialists

must have had at least 20 health care encounters with AHCCCS members during the year. The current survey included an additional 59 specialties that were not surveyed in the previous (1998) survey. [1]

- Dental Offices – all dentists contracted to provide care to AHCCCS members were included, regardless of the number of encounters during the year.

- Office Managers – all office managers of physicians who met inclusion criteria noted above were included in the survey. Office managers for dentists were not included in the survey sample but may have provided responses in the Dental Office surveys.

Table 2. Sample Population

Sample Population	Numbers of Sample Population
PCPs	2,633
Specialists	2,999
Dentists	729
Office Managers	1,295
TOTAL	7,656

[1] The 1998 survey included only the following specialties: internal medicine, cardiology, cardiovascular medicine, pulmonary disease, obstetrics/gynecology, obstetrics only, orthopedic surgery, pediatric cardiology, pediatric surgery, neonatal/perinatal medicine, psychiatry, and surgery.

All exclusions were approved by CHIR and AHCCCS. Using these selection criteria, 7,656 individuals were included in the survey sample as noted in *Table 2*.

The degree to which the survey results represent the population of interest, can be demonstrated by a comparison of the characteristics of actual respondents with the characteristics of the population of interest. Although the percentage of actual respondents is important, the ultimate test of representation is the similarity between the characteristics of survey respondents and the characteristics of the population. These characteristics are compared in *Table 3*.

Among PCPs and specialists, the respondents tend to overrepresent the groups of providers who have the largest number of patient encounters in a year (greater than 500). The distribution of encounters among dental respondents matched the distribution in their respective population. In terms of location, the interview data tend to overrepresent the percentage of providers in rural areas, in part, because the selection process tended to oversample smaller plans.

In summary, the survey results are slightly biased toward higher volume providers and have a slight bias in terms of the percentage of rural providers relative to the population statistics. In comparison to the total sample population, the survey results tend to somewhat overrepresent the opinions and perceptions of the providers who give care to the largest number of patients, with higher response representation of providers from rural practices.

Instrument Development

The survey instruments were developed through a collaborative effort by CHIR, AHCCCS, and ICR. Questions used in the 1998 physician and office manager survey and the 1999 dental survey were reviewed

Table 3. Profile of Sample Population

	PCPs		Specialists		Dental Offices		Office Managers	
	Total	*Respondent*	*Total*	*Respondent*	*Total*	*Respondent*	*Total*	*Respondent*
Location								
Maricopa County	61%	55%	63%	57%	67%	59%	62%	51%
Pima County	23%	21%	25%	24%	13%	17%	19%	16%
All other counties	16%	24%	12%	20%	19%	24%	19%	33%
*Number of AHCCCS member encounters**								
Less than 100	12%	8%	14%	11%	100%	100%	--	--
101-250	15%	14%	17%	16%	0%	0%	--	--
251-500	20%	17%	22%	22%	0%	0%	--	--
More than 500	53%	61%	48%	51%	0%	0%	--	--
Number of AHCCCS health plans listed on the questionnaire (up to 3 health plans could be listed)								
1 Health Plan	21%	17%	22%	18%	26%	22%	21%	17%
2 Health Plans	27%	29%	26%	28%	25%	29%	28%	35%
3 Health Plans	52%	54%	52%	54%	49%	49%	50%	48%

Note: *The number of encounters for office managers is not captured in AZHQ.

and included in the 2006 survey when applicable. The first drafts of the survey instruments were tested with a focus group representing six of the eight AHCCCS health plans in diverse geographic areas of the state. The focus group was conducted to solicit information regarding the information needs of the health plans so that these needs could be addressed in the survey instrument. Focus group participants identified two major areas they felt needed to be addressed in survey questions; 1) attitudes toward AHCCCS health plans and 2) the health plans' managed care processes (e.g., prior authorizations, case management, claims inquiry, etc.).

Several focus group participants recommended including selected key components of managed care processes. They included "ease of the process," "timeliness of the process," "communications about the process," and the "impact of technology upon the process." Participants were primarily concerned with the impact of these components on prior authorizations, provider network/referrals, quality management, and claims and claims inquiry.

CHIR staff also met with selected representatives of health plans to solicit feedback for the survey tool design. After compiling this information and examining the previous 1998/1999 surveys, CHIR drafted preliminary tools. ICR, the survey subcontractor, along with AHCCCS staff, collaborated with CHIR to develop and finalize the survey tools. A unique tool was developed for each type of provider—PCP, specialist, dental office, and office manager.

Once the tools were finalized, each survey was individualized utilizing a system of "plan insertion" to ensure a representative plan sample. To accomplish this, CHIR and ICR reviewed the number of encounters for AHCCCS members from the eight different AHCCCS plans. Taking into account the smaller plans that provide services to a smaller number of individuals, specific plans were inserted into surveys that represented the plans with which the providers had the most contact and, if a smaller plan was identified in the encounter data, it was always inserted in the survey. Thus, in an effort to ensure enough data was gathered for the smaller plans, some questionnaires may not have included larger plans with which providers had more encounters. Final approval of the survey questionnaires and plan insertion analysis was obtained from the AHCCCS Central Office staff.

Survey Administration and Data Collection

CHIR contracted with ICR to administer the survey and collect the data. ICR used the finalized survey instruments and was provided with the names, addresses, telephone and fax numbers, and email addresses (where applicable) for all potential respondents. Providers in the sample could respond to the survey by completing a mailed hard copy, completing an electronic copy online, or answering questions during a telephone interview between February 1, 2006 to May 30, 2006. Information regarding the online questionnaire was made available to providers in the sample through a mailed invitation listing a web address and a unique password to access the survey. All potential respondents were mailed an individualized survey packet to complete. All telephone surveys used the Computer Assisted Telephone Interviewing (CATI) system. CATI ensures that all questions follow "logical skip patterns and that the listed attributes are automatically rotated, eliminating 'question position' bias" (ICR, 2006).

Several attempts were made by ICR to contact the potential respondents. The process for survey administration was as follows:

- An *advance letter* was mailed to the office explaining the upcoming survey and its importance. The letters were on official AHCCCS letterhead and signed by an authorized representative.

- The *initial mailing* was sent via priority mail with a personalized letter on sponsor letterhead, with letters of endorsement attached, and a self-addressed stamped envelope.
- A *postcard reminder* was mailed two weeks after the initial mailing.
- A *second mailing* was sent via U.S. mail or fax one week after the postcard reminder. The protocol for this mailing is identical to the 'initial mailing.'
- All non-respondents received a *telephone follow-up* by experienced interviewers.
- During the telephone follow-up, ICR *instantly faxed* over the questionnaire.

Table 4 shows the timeline used by ICR to contact each office manager, physician, and dental office to complete the survey.

Table 4. ICR Schedule

Tasks	*Month (M) 1*	*Early M2*	*Late M2*	*Early M3*	*Late M3*	*Early M4*	*Late M4*	*M5*
Start-up								
Questionnaire Development/ Formatting/Printing								
Pre-notification Letters								
1st Questionnaire Mailing								
Reminder Postcard								
2nd Questionnaire Mailing								
Telephone Follow-up								
Deliverable Preparation								
Final Deliverables								

Source: ICR, 2006.

Analyses

Potential respondents were sent a custom survey instrument with health plan specific questions and general overall impression questions. All returned surveys were included in the analysis and descriptive statistics were produced. In some cases the number of responses for an individual health plan were small but, nevertheless, the results were included in the report. Percentages based on small numbers are imprecise and should be interpreted with caution. All questions included a response of "not enough experience" to answer. Unless noted, responses of "don't know" or "not enough experience" have been excluded from the percentages in the report. Some results may reflect the average of all health-plan specific responses. As some respondents answered for more than one health plan, the number of responses noted will be higher than the actual number of respondents.

Results

Response Rates

The overall response rate for this survey was 51.9%.

Dentists	65.5%
Office Managers	53.8%
PCPs	50.7%
Specialists	48.6%
OVERALL	51.9%

Source: ICR, 2006.

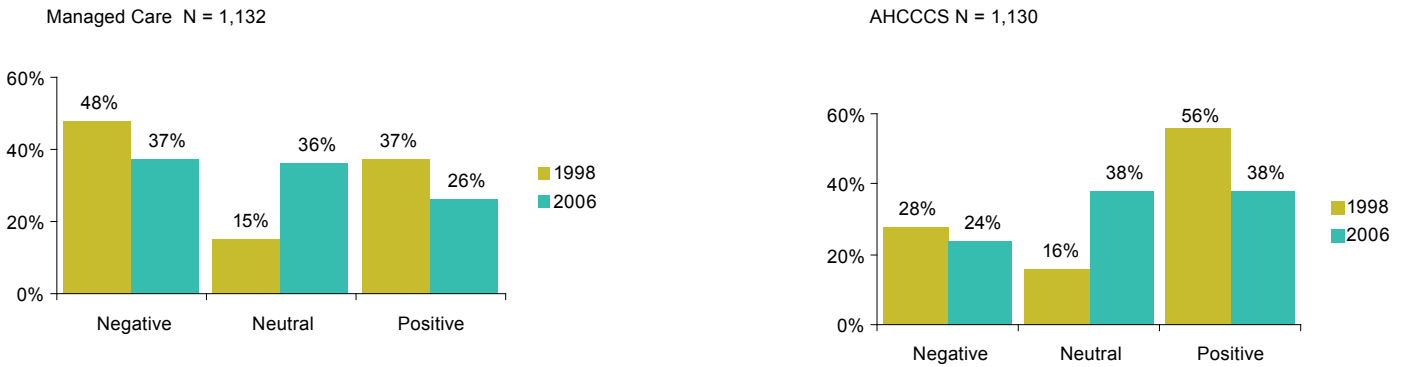
Dental providers demonstrated the highest response rate followed by Office Managers, PCPs, and Specialists.

Managed Care/AHCCCS

Managed Care

Office managers responding to the survey indicated that an average of 53% (standard deviation [*SD*] of 26.79) of physicians' patients were enrolled in a managed care plan. Because this question was not asked in 1998, it is not possible to compare this percentage with a previous one. On a national level, however, it is well documented that, whereas enrollment in private sector HMOs peaked in 1999 and has declined since then, enrollment in Medicaid HMOs grew between 1990 and 2002 from approximately one million to over 17 million (Draper, Hurley, & Short, 2004).

Figure 2. Attitude of PCPs & Specialists, Combined, Toward Managed Care in General and AHCCCS in Particular

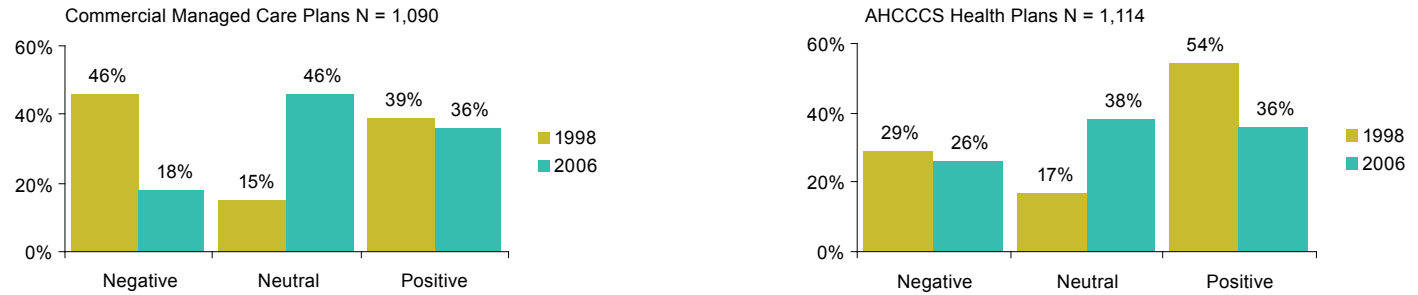


Note: 1, 2 = Negative. 3 = Neutral. 4, 5 = Positive. Responses of "don't know/not enough experience to answer" and non-responses are excluded from percentages.

In the current survey, the percentage of physicians (PCPs and specialists combined) reporting they feel neutral towards managed care in general more than doubled since the 1998/1999 survey, increasing from 15% in 1998/1999 to 36% in 2006 (*Figure 2*). Changes in provider attitudes toward the AHCCCS program in general were similar. For example, the percent of physicians who feel neutral about the AHCCCS program increased from 16% in 1998/1999 to 38% in 2006 (*Figure 2*). This increase was largely due to a decrease in the number of providers who have positive attitudes toward AHCCCS program. In 1998/1999, 56% of the providers had a positive attitude toward AHCCCS program in general compared to 38% in 2006 (*Figure 2*).

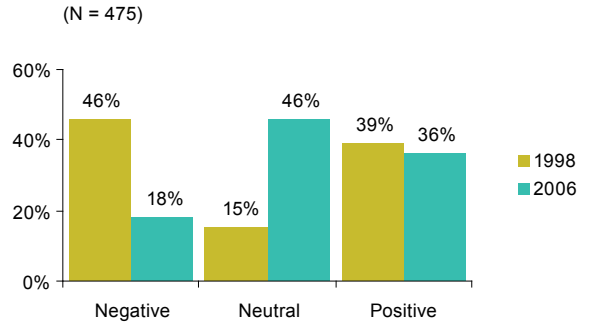
Although, in 1998/1999, AHCCCS physicians were more positive about the AHCCCS plans with which they contracted than about other commercial managed care plans, this is no longer the case. Currently, 36% of AHCCCS physician respondents have a positive attitude toward both AHCCCS health plans and the other commercial managed care plans with which they contract. Further, they feel less negative (18%) toward commercial managed care plans than they did in 1998/1999 (46%; *Figure 3*).

Figure 3. Attitude of PCPs & Specialists, Combined, Toward Managed Care Plans with which They Currently Contract



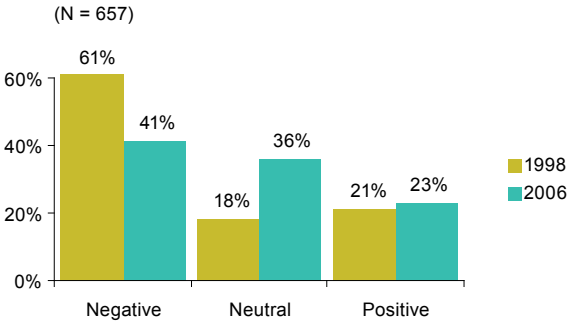
Note: 1, 2 = Negative. 3 = Neutral. 4, 5 = Positive. Responses of "don't know/not enough experience to answer" and non-responses are excluded from percentages.

Figure 3a. PCPs' Attitude toward Managed Care in General



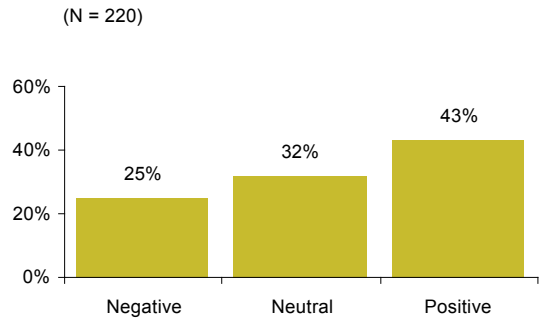
Note: 1, 2 = Negative. 3 = Neutral. 4, 5 = Positive. Responses of "don't know/not enough experience to answer" and non-responses are excluded from percentages.

Figure 3b. Specialists' Attitude toward Managed Care in General



Note: 1, 2 = Negative. 3 = Neutral. 4, 5 = Positive. Responses of "don't know/not enough experience to answer" and non-responses are excluded from percentages.

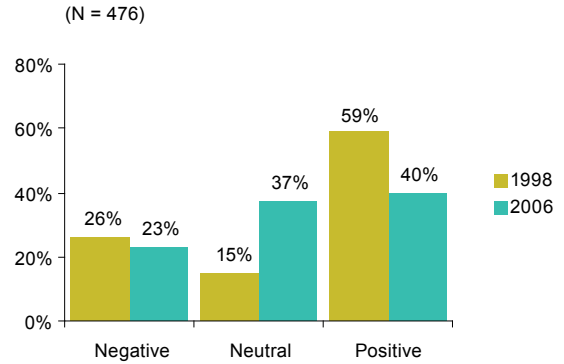
Figure 3c. Dental Offices' Attitude toward Managed Care in General



Note: 1, 2 = Negative. 3 = Neutral. 4, 5 = Positive. Responses of "don't know/not enough experience to answer" and non-responses are excluded from percentages.

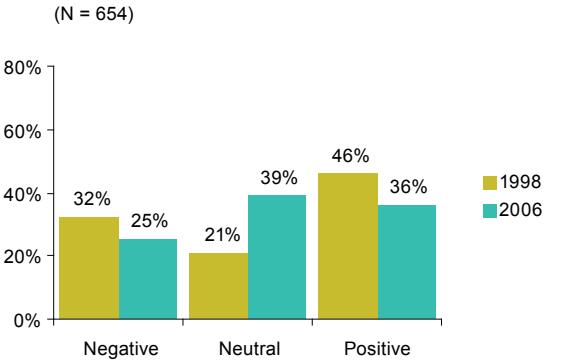
When PCPs and specialists are viewed separately, the percentage of PCPs who expressed negative attitudes toward managed care in general declined markedly from 46% in 1998/1999 to 18% in 2006, and the percentage of specialists who expressed a negative attitude toward managed care in general declined from 61% in 1998/1999 to 41% in 2006 (*Figures 3a and 3b*). In 2006, 25% of dental respondents surveyed had a negative attitude about managed care in general compared to 43% with a positive attitude (data not available for 1998/1999; *Figure 3c*).

Figure 4a. PCPs' Attitude toward AHCCCS in General



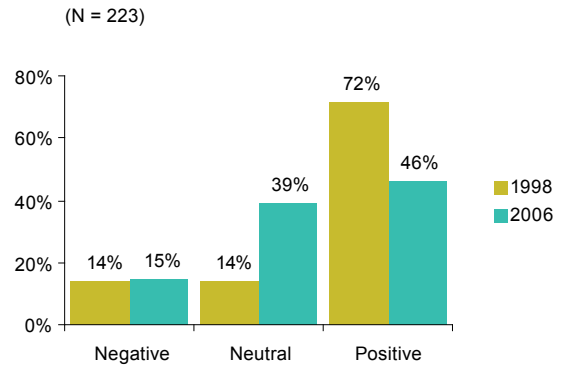
Note: 1, 2 = Negative. 3 = Neutral. 4, 5 = Positive. Responses of "don't know/not enough experience to answer" and non-responses are excluded from percentages.

Figure 4b. Specialists' Attitude toward AHCCCS in General



Note: 1, 2 = Negative. 3 = Neutral. 4, 5 = Positive. Responses of "don't know/not enough experience to answer" and non-responses are excluded from percentages.

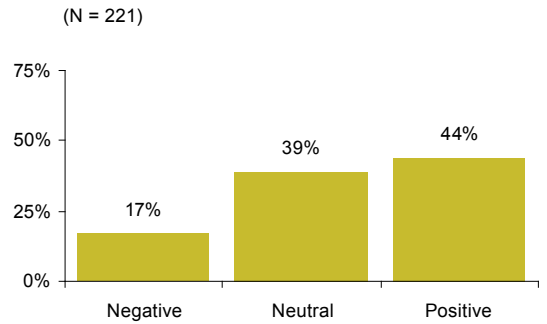
Figure 4c. Dental Offices' Attitude toward AHCCCS in General



Note: 1, 2 = Negative. 3 = Neutral. 4, 5 = Positive. Responses of "don't know/not enough experience to answer" and non-responses are excluded from percentages.

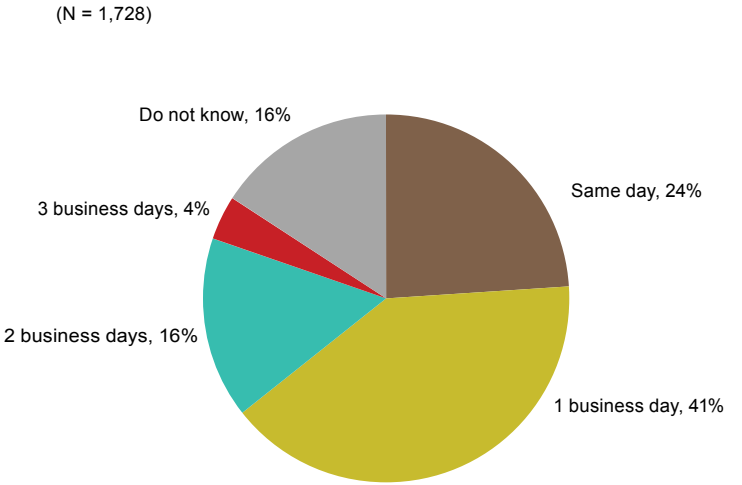
When asked about attitudes toward the AHCCCS program in general, similar but less dramatic declines in the percentage of providers with negative attitudes were noted. The percentage of PCPs with a positive attitude toward the AHCCCS program decreased from 59% to 40%, and the percentage of specialists with a positive attitude decreased from 46% to 36% (*Figures 4a and 4b*). The largest decline was seen with the dental respondents, with a decline in positive attitudes toward the AHCCCS program from 72% in 1998/1999 to 46% in 2006 (*Figure 4c*).

Figure 5. Attitude of Dental Offices toward AHCCCS Health Plans they Contract with Now



Note: 1, 2 = Negative. 3 = Neutral. 4, 5 = Positive. Responses of "don't know/not enough experience to answer" and non-responses are excluded from percentages.

Figure 6. Average Reasonable Time to Wait for Electronic Response, All Providers



When asked about their attitudes towards the AHCCCS health plans with which they contract, dental respondents reported feeling more positive (44%) or neutral (39%) than negative (17%; *Figure 5*).

Communication

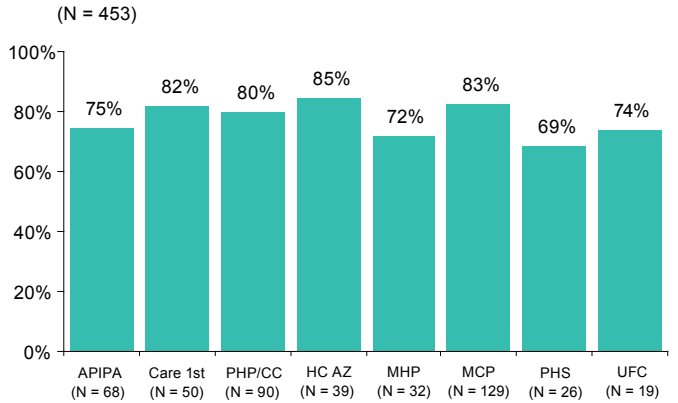
Accessibility

Customer Service

For other than eligibility verification, the telephone is the most common mode of communication used by providers when contacting health plans. All provider types and office managers believe the average reasonable time to wait on the telephone to speak to a plan representative should be less than five minutes (*SD* 5.06).

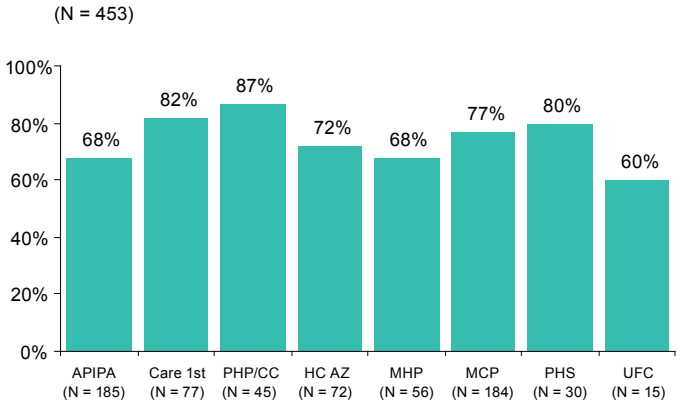
When questioned specifically about electronic responses, 65% of all providers indicated that responses to electronic correspondence should occur within one business day or less (*Figure 6*). The results were similar regardless of provider type. Office managers and dental offices were also asked what they believed to be a reasonable time to wait for a response from the health plans related to operational activities for eligibility verification, concurrent review, prior authorizations, pharmacy coverage, specialty availability, case management, and claims inquiries. Office managers and dental offices expect a very quick turnaround on eligibility verification with a median response time of one hour. For all other areas, they expect a median response time of 24 hours.

Figure 7a. Dental Respondents – Is the Provider Manual Useful?



Note: Providers were asked to rate on a 5 point scale. 3, 4, 5 = "Useful." "Not Useful" (1, 2) is not shown. Responses of "don't know/not enough experience to answer'" and non-responses are excluded from percentages.

Figure 7b. Office Managers – Is the Provider Manual Useful?



Note: Providers were asked to rate on a 5 point scale, 3, 4, 5 = "Useful." "Not Useful" (1, 2) is not shown. Responses of "don't know/not enough experience to answer" and non-responses are excluded from percentages.

Plan Notices

The dental offices and office managers were asked several questions about notifications of plan revisions. Overall, the respondents believe the median number of days to provide an adequate notice of health plan revisions and fee schedule revisions is 30 days, with response ranges from one day to 365 days.

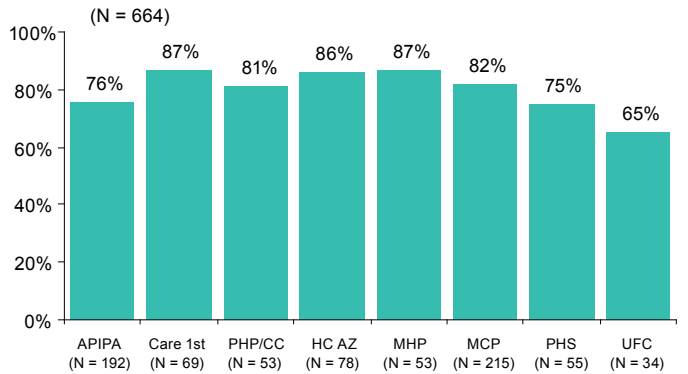
Provider Manual

As demonstrated in *Figures 7a and 7b*, the majority of dental offices and office managers find the plans' provider manuals useful. When averaged across health plans, approximately 75% of respondents believe the manual is useful (see Table A1 in Appendix for health plan details).

Training

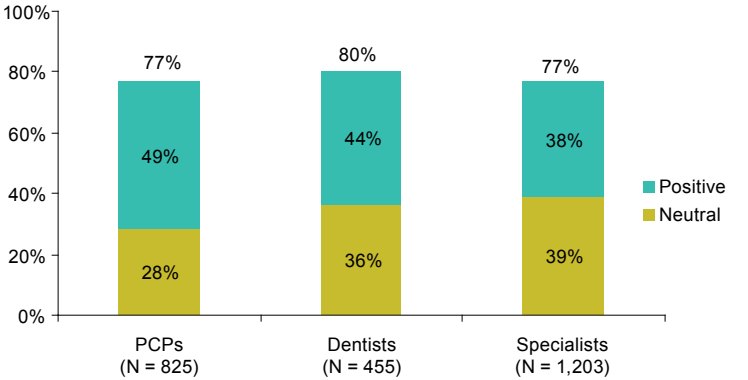
The office managers and dental offices were also asked to evaluate, by plan, the adequacy of the training provided regarding policies and procedures for eligibility verification, utilization management, prior authorization, pharmacy services, specialty network referral, case management, claims submission requirements, EPSDT requirements, and covered services. When averaged across plans, the office managers ranked training for eligibility verification highest. Using a scale of one to five, with five being "completely adequate," 56% of office managers ranked the training provided either 4 or 5. Office managers gave the lowest ranking to training for case management services. On the same scale of one to five, with one being "completely inadequate," 29% gave case management training a rating of 1 or 2. When averaged across plans, dental

Figure 8. PCPs – How Useful is Feedback You Receive from Health Plans Following Site Review or Audit?



Note: Providers were asked to rate on a 5 point scale, 3, 4, 5 = "Useful." "Not Useful" (1, 2) is not shown. Responses of "don't know/not enough experience to answer" and non-responses are excluded from percentages.

Figure 9. PCPs, Dental Respondents, & Specialists – Experience with Contracting Process



Note: Neutral response = 3, Positive response = 4 or 5, responses of negative, 1 or 2 are not shown. Responses of "don't know/not enough experience to answer'" and non-responses are excluded from percentages. This graph shows the average of all plan-specific responses; some providers answered for more than one plan.

respondents also rated the training for eligibility verification the highest with 58% of all respondents rating the training as higher than adequate (4 or 5). Dental respondents rated the training on the specialty network as the lowest; 23% indicated the training was less than adequate (see Tables A2 and A3 in Appendix for health plan details).

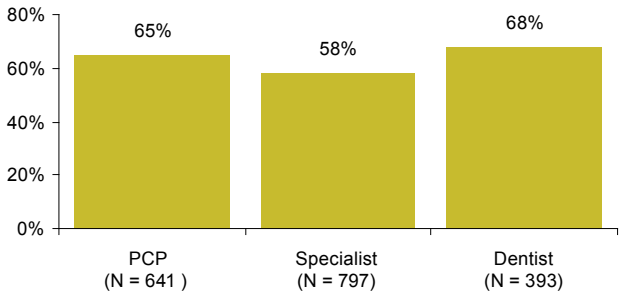
Audits

PCPs were asked to rate the health plans on the ability to minimize disruptions during site visits and on the usefulness of the feedback received from health plans following an audit or site review. Approximately one-third of the respondents said they did not know or did not have enough experience to answer these questions. When averaged across all plans, 91% of the PCPs who did respond indicated there is little to no disruption (scores of 3, 4, and 5 combined). *Figure 8* shows the feedback from the plans is useful (scores of 3, 4, and 5 combined).

Contracting

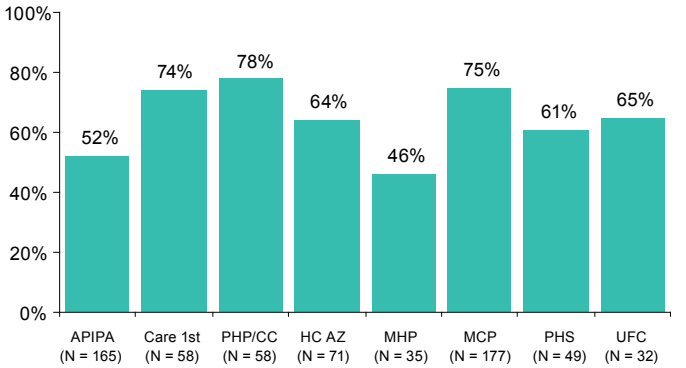
When asked to rate their experience with the contracting process on a 5 point scale, where 1 is completely negative and 5 is completely positive, the majority of PCPs, dental respondents, and specialists had either a neutral or positive experience (*Figure 9*). Averaged across all plans, 77% of PCPs, 80% of dental respondents and 77% of specialists believe the process was either neutral (score of 3) or positive (scores 4 and 5). Health plan details are available in Appendix Table A18.

Figure 10. Medical or Dental Director Accessibility, Overall



Note: "Relatively Inaccessible" (1, 2) is not shown. 3, 4, 5 = "Relatively Accessible." Responses of "don't know/not enough experience to answer" and non-responses are excluded from percentages. This graph reflects the average of all plan-specific responses, some providers answered for more than one health plan.

Figure 11a. PCPs – Medical Director Accessibility by Plan



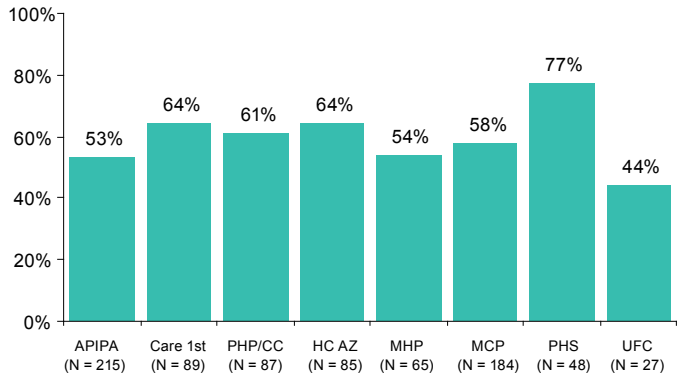
Note: "Relatively Inaccessible" (1,2) is not shown. 3, 4, 5 = "Relatively Accessible." Responses of "don't know/not enough experience to answer" and non-responses are excluded from percentages.

Plan Medical/Dental Director Availability

PCPs, specialists, and dental offices were asked to evaluate, on a scale of 1 to 5, the accessibility of the health plans' medical director or dental director. The percentage who responded "don't know/not enough experience" to this question was higher than the percentage who responded "don't know/not enough experience" to any other item. Nearly one half of PCPs (43%) and specialists (49%) and nearly one quarter of dental respondents (23%) said they do not have enough experience to answer this question. Of the providers who did answer the question, the majority, averaged across all plans, believe the medical or dental director is relatively accessible (*Figure 10*).

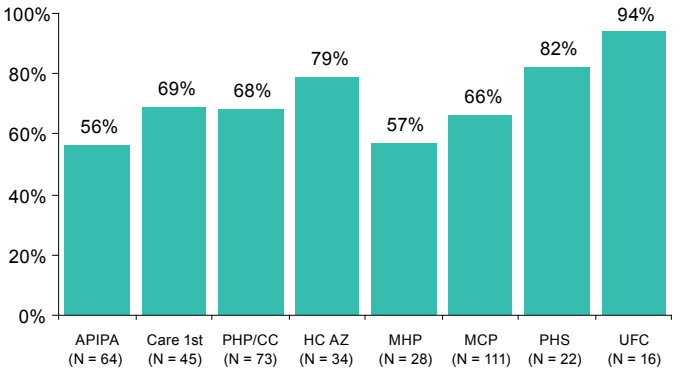
As evident in *Figure 11a*, there are some differences when examining the accessibility of the medical director by plan. Providers were asked to evaluate the accessibility of the medical director for up to three health plans. PCPs gave the highest rates of accessibility for the medical directors of PHP/Community Connection, Mercy Care Plan, and Care 1st. Maricopa Health Plan and APIPA, on the other hand, had the lowest rates of accessibility. Care 1st (N = 58), PHP/Community Connection (N = 58), and Maricopa Health Plan (N = 35) had fewer numbers of doctors reporting, which may impact the results. Further, 67% of PCPs asked to evaluate the accessibility of the medical director for Maricopa Health Plan said they "don't know/do not have enough experience."

Figure 11b. Specialists – Medical Director Accessibility by Plan



Note: "Relatively Inaccessible" (1, 2) is not shown. 3, 4, 5 = "Relatively Accessible." Responses of "don't know/not enough experience to answer" and non-responses are excluded from percentages.

Figure 11c. Dental Respondents – Dental Director Accessibility by Plan

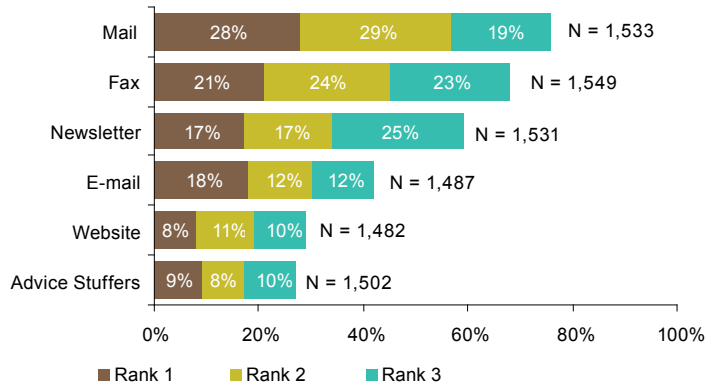


Note: "Relatively Inaccessible" (1, 2) is not shown. 3, 4, 5 = "Relatively Accessible." Responses of "don't know/not enough experience to answer" and non-responses are excluded from percentages.

Overall, ratings of specialists' access to health plan medical directors are slightly lower than those related to PCPs (*Figure 11b*). For some health plans they are higher while for others they are lower. Again, the number of respondents may impact results.

For dental respondents with experience contacting a dental director or dental program manager, 66% believe that the Mercy Care Plan director is relatively accessible compared to 56% for the APIPA plan (*Figure 11c*). Overall, ratings of dental providers' access to health plan dental directors are higher than those related to either PCPs or specialists. The low ratings given to APIPA and MHP dental director accessibility are consistent with the lower ratings of medical director accessibility for these same health plans.

Figure 12. All Providers & Office Managers Combined - Preference of Modes of Communication Used by AHCCCS Health Plans, Top 3 of 6



Note: Providers were asked to rank the items from 1 to 6. Top 3 responses for each category are shown. Responses of "don't know/not enough experience to answer" and non-responses are excluded from percentages.

Method of Communication

All respondents were asked to rank their preference from most preferred (1) to least preferred (6) for the different methods of communication used by AHCCCS health plans for any type of information. Across all providers, the mode ranked the highest is mail and the lowest is check advice stuffers (*Figure 12*).

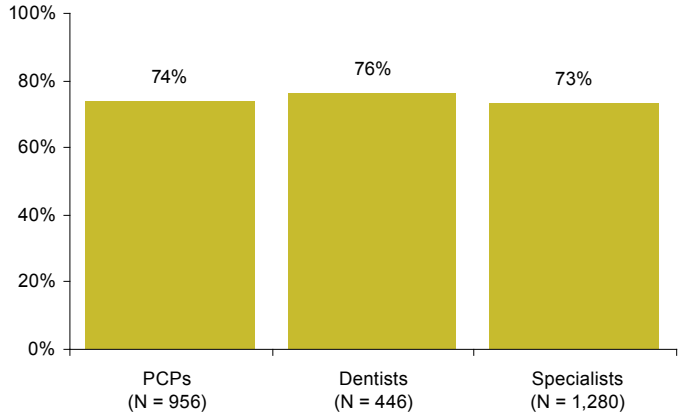
The preferred method may be influenced by the types of communication resources available in the office. When office managers were asked about which communication methods are available, 86% reported access to a fax, 48% reported access to the internet, and 42% reported access to email.

Office managers were asked which types of communication they use for interacting with AHCCCS health plans and other payers or insurers about selected operations or activities. There were no differences by insurer type. The telephone is the dominant mode of communication across all operational areas regardless of the type of insurer. In addition to the telephone, the offices rely on the health plans' websites for eligibility verification, verifying the availability of the specialist network and checking on the status of a claim. They also use the fax in addition to the telephone for concurrent review, prior authorization, and pharmacy coverage.

Office managers indicated that, for AHCCCS health plans, the telephone (45%) and fax (40%) are the still the most common methods used. Only 7% indicated they use the plan's website for prior authorization. When interacting with commercial insurers, office managers indicated that telephone (43%) and fax (29%) are also the most common methods used for prior authorization. However, 14% use the commercial insurer's website for this purpose. This is double the percentage that use an AHCCCS health plans website.

Dental offices were asked the same question about the types of communication they use for interacting with AHCCCS health plans and other payers or insurers. Again, there was no difference by type of insurer. As with office managers, the telephone is the dominant mode of communication used by dental offices for all operations with the exception of prior authorizations. For both AHCCCS health plans and other insurers, dental offices use mail the most when interacting with the plans about issues related to prior authorization.

Figure 13. PCPs, Dental Offices, & Specialists -How Understandable is Communication You Receive from Health Plans Explaining Denial of Services Overall?

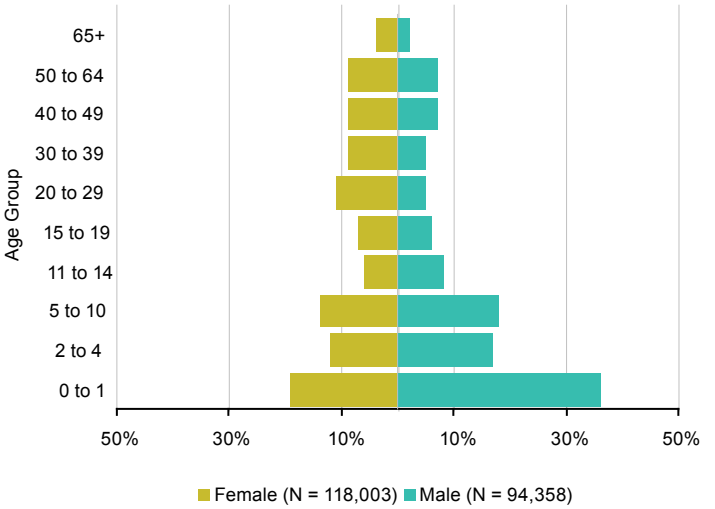


Note: Providers were asked to rate on a 5 point scale, 3, 4, 5 = "Understandable." "Not Understandable" (1, 2) is not shown. Responses of "don't know/not enough experience to answer" and non-responses are excluded from percentages. This graph reflects the average of all plan-specific responses; some providers answered for more than one health plan.

Figure 13 demonstrates that, overall, the majority of providers find the communication from the health plans related to denial of services understandable. Health plan specific details are available in Appendix Table A4. Additionally, dental respondents were asked how well they understand the health plan's complaint and grievance process. The majority of respondents (75%) reported they find the process understandable.

When asked about how well the plans keep them informed about utilization patterns, 63% of PCPs report the plans keep them informed (scores of 3, 4, and 5). Health plan specific details are available in Appendix Table A5.

Figure 14a. PCPs – Distribution of Patients by Age and Gender, 2005 AHCCCS Encounter Data

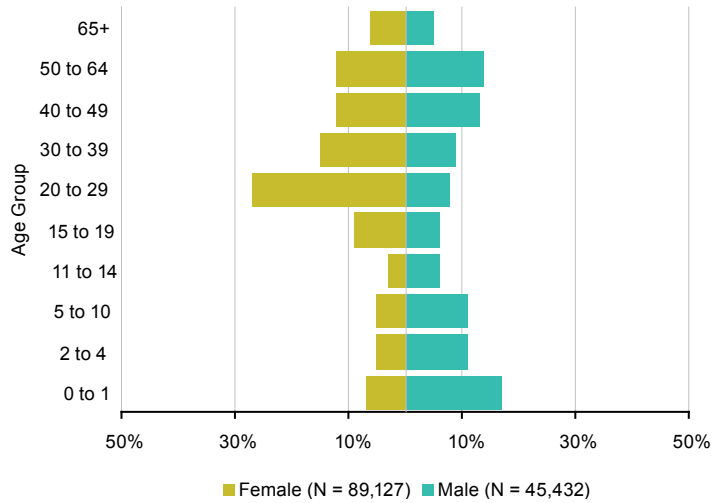


Source: AZHQ SFY 2005 encounter data.

Relationship with AHCCCS Members

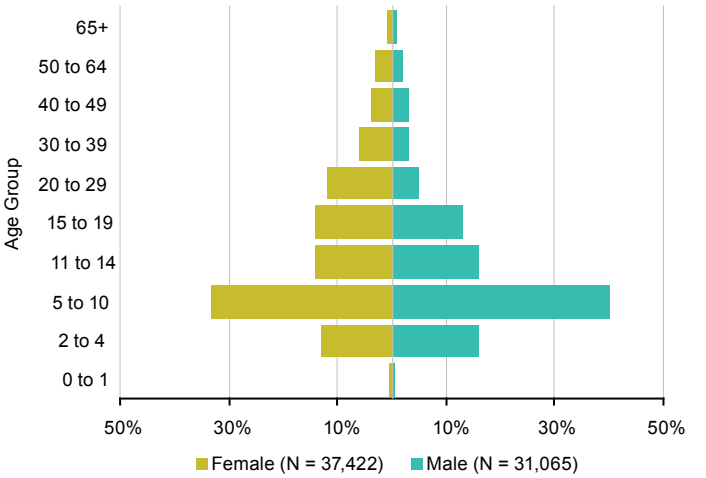
Contracted providers were surveyed about several aspects of their relationships with AHCCCS members. As discussed early in the report, AHCCCS encounters available in AZHQ were used during the sample selection process to determine providers' AHCCCS patient volume. Using the same encounters from the sample selected, it is possible to examine age and gender of the patients seen by the PCPs, specialists, and dental offices who responded to the survey.

Figure 14b. Specialists – Distribution of Patients by Age and Gender, 2005 AHCCCS Encounter Data



Source: AZHQ SFY 2005 encounter data.

Figure 14c. Dental Offices – Distribution of Patients by Age and Gender, 2005 AHCCCS Encounter Data



Source: AZHQ SFY 2005 encounter data.

Figures 14a-14c illustrate age and gender distribution among provider types. All provider types see more females than males, although some differences exist by age group. For example, both PCPs and specialists see a higher percentage of male infants (ages 0-1) than female infants (ages 0-1). PCPs and specialists see a greater percentage of females (ages 20-40) than males in the same age category. Finally, dental providers see a higher number of females overall, but again there are differences by age group. The largest group of AHCCCS members seen by dental survey respondents includes children between the ages of five and ten.

Forty-two percent of dental office respondents said they accept children for their initial office visit at one year of age or at first tooth eruption. Another 42% of dental office respondents said they accept children at two and three years of age for their initial office visit. Seventy-eight percent of dental offices report treating children with special needs. Out of those who reported to not treat this population, 40% cited insufficient training as their reason, 38% cited incompatibility with office practice, and 19% cited inadequate reimbursement.

Figure 15. Approach Used By Provider When Patient Speaks another Language, Office Manager and Dental Office Combined

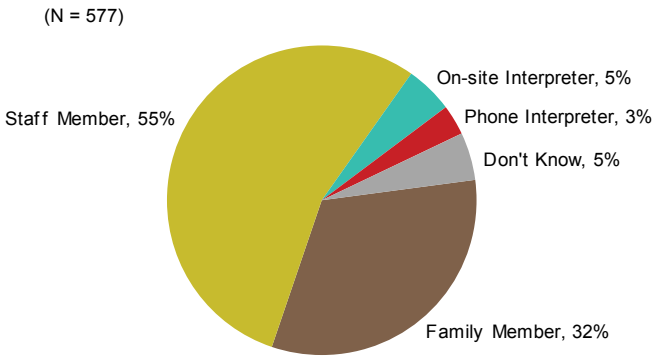
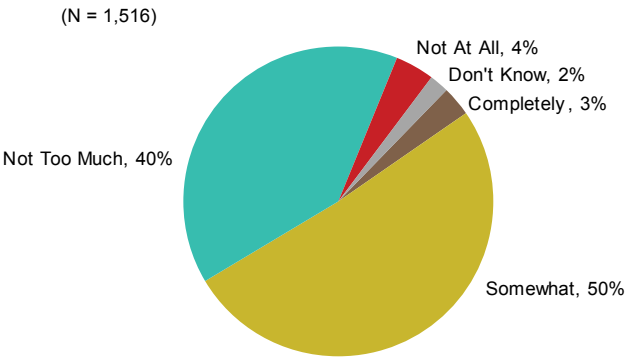


Figure 16. AHCCCS Member Follow Through, Office Managers, PCPs, & Specialists Combined



As demonstrated in *Figure 15*, when office managers and dental offices were asked about their approach to communicating with a patient who speaks a language not native to the provider, over one half of respondents said they used the assistance of a staff member. Approximately one third used a family member and only 8% used trained interpreters, either on-site or telephonically.

In addition, office managers and dental offices were asked to estimate the percentage of AHCCCS members who did not show up at all for their scheduled appointments. Office managers estimated approximately 17% (*SD* 17.52) of their AHCCCS members were no-shows; dental offices reported approximately 29% (*SD* 16.08) were no-shows.

Figure 16 details respondents' perception of AHCCCS member follow through on "patient responsibilities". Fifty percent feel that AHCCCS members follow through "somewhat" and a full 40% "not too much."

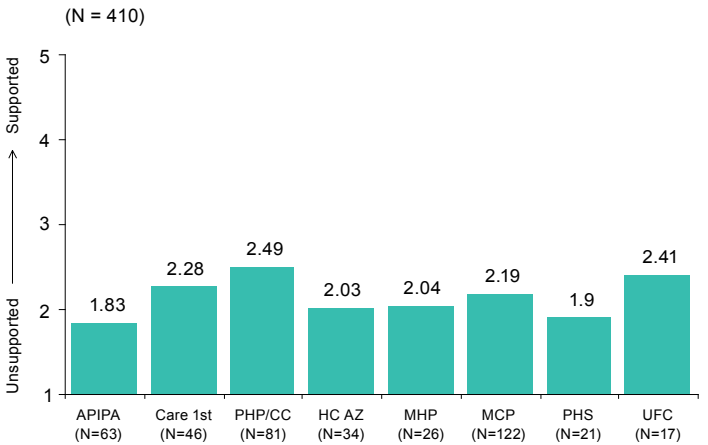
As evident in *Table 5*, office managers differed when asked to rate how often AHCCCS patients arrive for their scheduled appointments on time. Although approximately one third reported patients arrive on time "always" or "frequently"; nearly another third reported patients arrive on time "rarely" or "never."

Table 5. Response of Office Managers about On-Time Arrival Time of Patients

(N = 359)

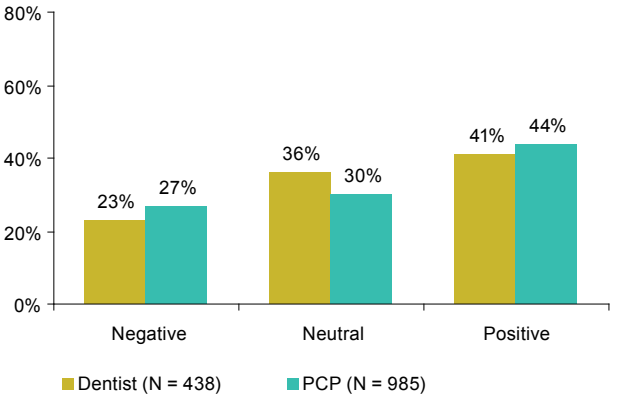
Response	Always	Frequently	Occasionally	Rarely	Never	Don't Know
Percent	3%	34%	31%	27%	2%	3%

Figure 17. Average Level of Support for No-Shows by Plan, Dental Respondents, Mean Score



Note: Respondents were asked to rate on a 5 point scale where 1 = "they do not support you" and 5 = "completely supportive." Responses of "don't know/not enough experience" and non-responses were excluded from calculations.

Figure 18. Attitude of Dental Respondents & PCPs toward Adequacy of Specialist Network



Note: Providers were asked to rate on a 5 point scale, 1, 2 = Negative, 3 = Neutral, 4, 5 = Positive. Responses of "don't know/not enough experience to answer" and non-responses are excluded from percentages. This graph reflects the average of all plan-specific responses; some providers answered for more than one health plan.

Figure 17 depicts the opinion of dental office staff on how well contracted health plans support them when patients fail to keep appointments. Based on a scale of 1 (unsupportive) to 5 (supportive), the highest score given to any health plan was 2.49 (PHP/CC) followed by 2.41 (UFC).

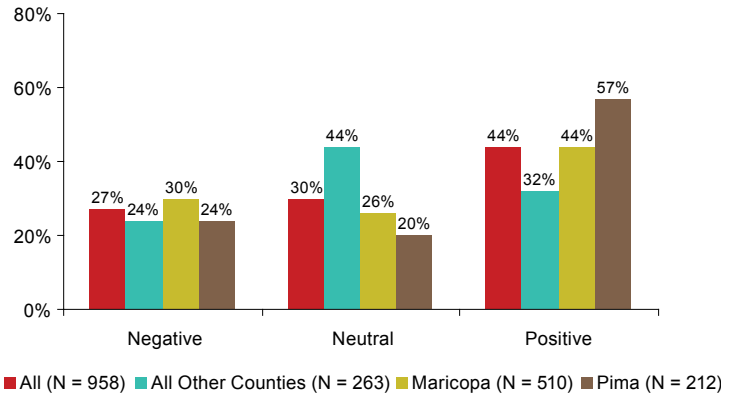
Referrals & the Provider Specialty Network

The survey included several questions asking PCPs, specialists, and dental respondents about their experiences with the plan's specialty care network. The providers were asked to evaluate the plan's referral process and policies and the adequacy of the network based on a number of characteristics. The attitudes were measured using a 5 point scale, where 1 means "completely negative" and 5 means "completely positive."

Characteristics of Specialty Network

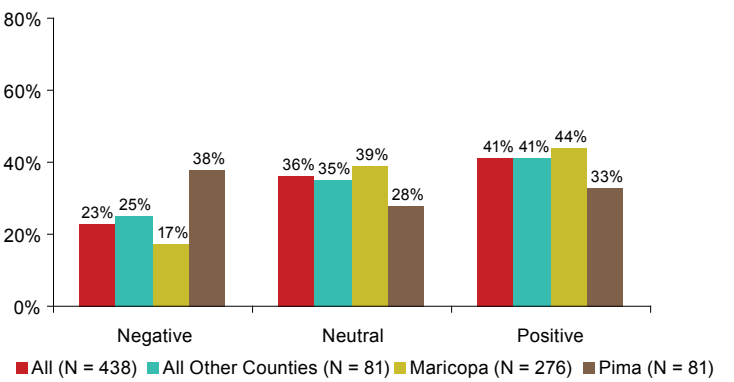
Figure 18 indicates that 74% of PCPs and 77% of dental respondents were either neutral or felt the plan's network of specialists was adequate (health plan detail is in Appendix Tables A6 and A8). PCPs who were pediatricians were less likely to find the network adequate than other types of PCPs; 66% of pediatricians found the network adequate compared to 73% of other PCPs. This difference may be related to the

Figure 19. PCPs – Adequacy of Specialty Network by County



Note: Providers were asked to rate on a 5 point scale, 1,2 = Negative, 3 = Neutral, 4, 5 = Positive. Responses of "don't know/not enough experience to answer" and non-responses are excluded from percentages. This graph shows the average of all plan-specific responses; some providers answered for more than one plan.

Figure 20. Dental Offices – Adequacy of Specialty Network by County



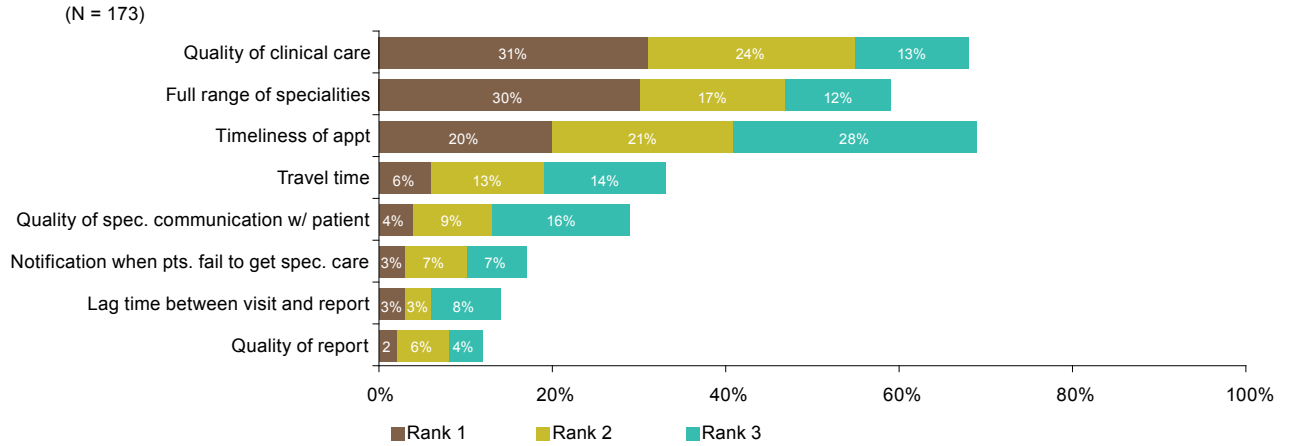
Note: Providers were asked to rate on a 5 point scale, 1,2 = Negative, 3 = Neutral, 4, 5 = Positive. Responses of "don't know/not enough experience to answer" and non-responses are excluded from percentages. This graph shows the average of all plan-specific responses; some providers answered for more than one plan.

shortage of pediatric specialists in Arizona as well as the limited number of pediatric specialists outside of Maricopa County. The question was asked slightly differently in 1998/1999, which limits comparability. However, at that time a higher percentage of PCPs (89%) indicated the specialist network was adequate ("yes, definitely" and "yes, somewhat").

As shown in *Figure 19*, PCPs in Pima County were the most satisfied with the adequacy of specialty network, with 57% of PCPs responding positively to the network. PCPs practicing in counties other than Maricopa or Pima were much more likely to feel neutral about the network, 44% of PCPs felt neutral about the adequacy compared to 26% of PCPs in Maricopa County and 20% of PCPs in Pima County.

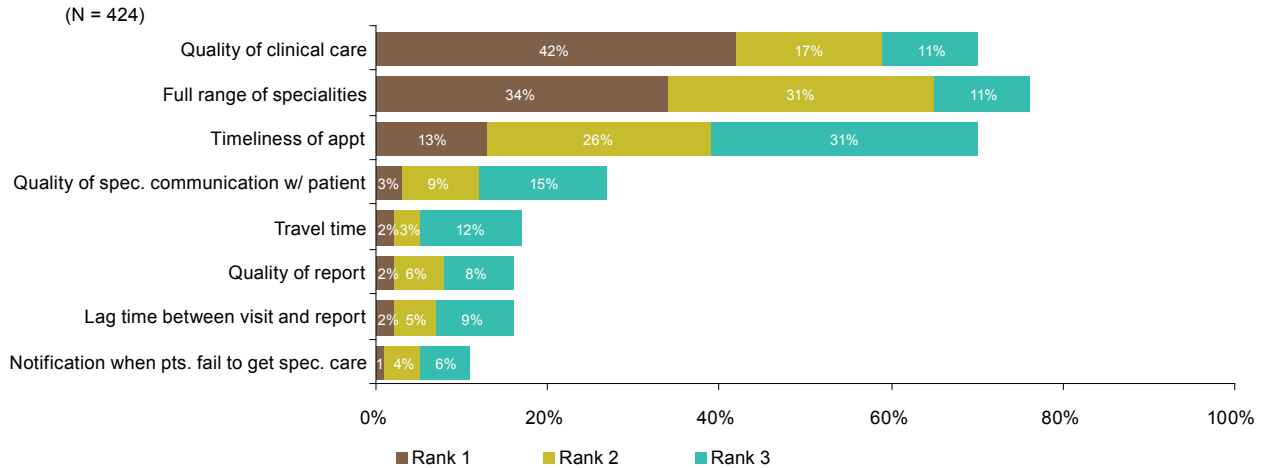
Dental respondents in Maricopa County were more likely to have positive or neutral attitudes toward the specialty network (*Figure 20*). Eighty-three percent of Maricopa County respondents felt neutral or positive toward the adequacy of the network compared to 61% of Pima County respondents and 76% of dental respondents in other counties.

Figure 21a. Dental Respondents - Rank of General Importance to a Specialty Referral Network, Top 3 of 8



Note: Providers were asked to rank the items from 1 to 8. Top 3 responses for each category are shown. Responses of "don't know/ not enough experience to answer" and non-responses are excluded from percentages.

Figure 21b. PCPs - Rank of General Importance to a Specialty Referral Network, Top 3 of 8



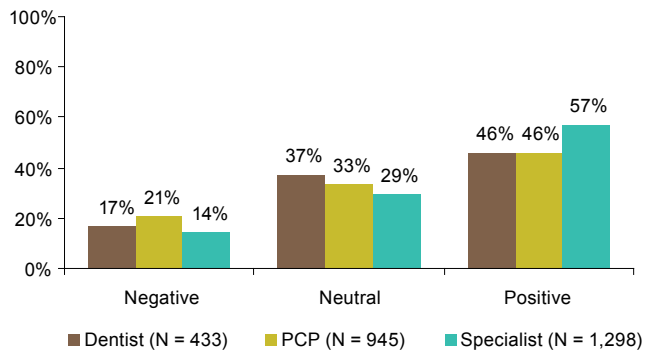
Note: Providers were asked to rank the items from 1 to 8. Top 3 responses for each category are shown. Responses of "don't know/not enough experience to answer" and non-responses are excluded from percentages.

PCPs and dental respondents report the "quality of clinical care," the "availability of a full range of specialties," and "timeliness of appointment" as the most important characteristics of a specialty network (*Figures 21a and 21b*)

Referral Process

PCPs referred approximately 27% (*SD* 20.84) of their AHCCCS plan patients to a specialist in the past six months (29% of PCPs indicated they did not know or did not answer this question). Dental respondents referred 12% (*SD* 13.30) of their AHCCCS patients to a specialist in the past six months (13% of dental respondents indicated they did not know or did not answer the question).

Figure 22. Attitude of Dental Respondents, PCPs, & Specialists toward Adequacy of Plan's Policies on Specialty Referral



Note: Providers were asked to rate on a 5 point scale, 1,2 = Negative, 3 = Neutral, 4, 5 = Positive. Responses of "don't know/not enough experience to answer" and non-responses are excluded from percentages. This graph reflects the average of all plan-specific responses; some providers answered for more than one health plan.

Figure 22 shows that PCPs, dental respondents, and specialists demonstrated similar attitudes regarding health plan policies in support of referrals. All were generally positive about how well they thought the plan's policies support appropriate referrals; only 17% of PCPs, 21% of dental respondents, and 14% of specialists had negative attitudes toward the plan's referral policies. Health plan detail is available in Appendix Tables A6 – A8.

Table 6 summarizes specialist and PCP recommendations to improve referrals for specialty care. Although seventy-six percent of specialists believe the information received from providers was adequate, when they were asked to list the single most important action health plans could take to improve referrals to specialty care, the response with the highest percentage was to "have PCPs send more information" (12%). PCPs believe "contracting with more specialists" or "having more specialists in the network" was the most important action plans could take to improve referrals.

According to PCPs, the most difficult types of specialty care to obtain for AHCCCS patients are dermatology, gastroenterology, and neurology (*Table 7a*).

For dental respondents, the most difficult types of specialty care to obtain are from periodontists, oral surgeons, and endodontists (*Table 7b*).

Table 6: Single Most Important Action Health Plans Could Take to Improve Referrals for Specialty Care

Type of Action to Improve Referrals, PCPs (N= 495)	*Percent*
Contract with more specialists/more specialists in network	30%
No answer	17%
None	10%
Other	6%
Self-refer/no referrals/no preauthorization for referrals	4%
Streamline/simplify process	4%
Pay specialists more/higher reimbursement	4%
Allow more specialist follow-ups	3%
Eliminate preauthorization's/use paper referrals	3%
Improve communication	3%

Type of Action to Improve Referrals, Specialists (N = 678)	*Percent*
No answer	22%
PCPs send more information	12%
Self-refer/no referrals/no preauthorization for referrals	10%
None	9%
Timely receipt of referrals	5%
Other	5%
Streamline/simplify process	4%
Educate PCPs	4%
Patient education about process	4%
Improve communication	4%

Table 7a: Top 10 Types of Specialty Care Most Difficult to Obtain, PCPs

(N = 924)

Type of Specialty Care	*Percent*
Dermatology	14%
Gastroenterology	8%
Neurology	8%
Orthopedics	7%
Endocrinology	5%
Rheumatology	5%
Other	4%
Pain Management	4%
Psychiatry/mental health	3%
Neurosurgery	2%

Note: PCPs were asked to list 5 types of specialty care most difficult to obtain. Table reflects sums of all answers.

Table 7b: Types of Specialty Care Most Difficult to Obtain, Dental Respondents

(N = 322)

Type of Specialty Care	*Percent*
Periodontist	55%
Oral Surgeon	47%
Endodontist	41%
Pedodonist	27%
Orthodontist	4%

Note: Dental respondents may have indicated more than one type of specialty care. Average of all plan-specific responses; some providers answered for more than one health plan. Dental survey recipients were given a choice of identified types of specialty care when asked this question.

Claims/Reimbursement Process

In the 1998/1999 surveys, questions were asked about provider satisfaction with reimbursement rates and processes. Again in 2006, respondents were surveyed for opinions related to claims but with a focus on the claims process. Currently, 62% of office managers reported they submit claims electronically to plans with which they are contracted. Out of the respondents who do not currently submit electronically, 57% reported they would like to be able to do so. Sixty-eight percent of dental office respondents reported they were capable of submitting electronic claims.

Figure 23 shows the results, by plan, of dental respondents when asked if they had been encouraged to submit electronically. This question was not asked of other provider types surveyed.

Figure 23. Has the Health Plan Encouraged You to Submit Claims Electronically? Dental Office Response

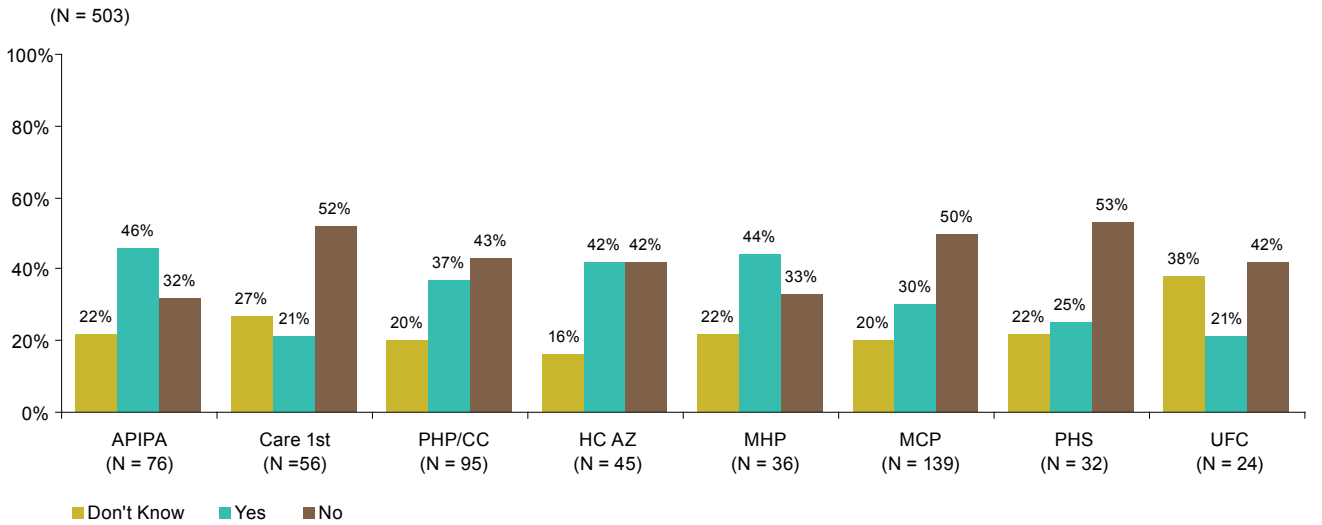
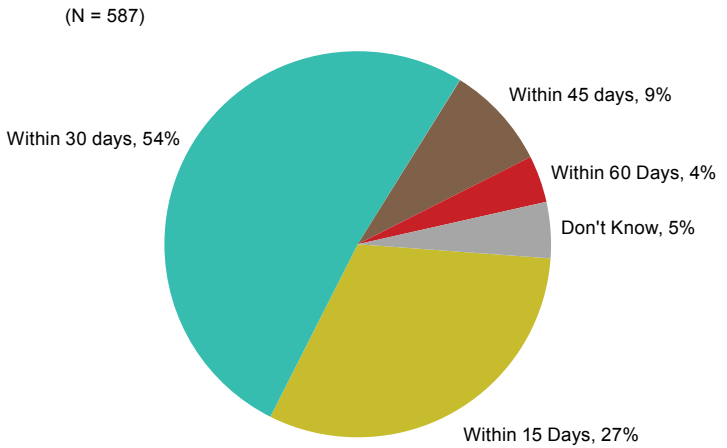


Figure 24. Reasonable Time to Expect Payment after Clean Claim Submission, Dental Office and Office Manager Response Combined

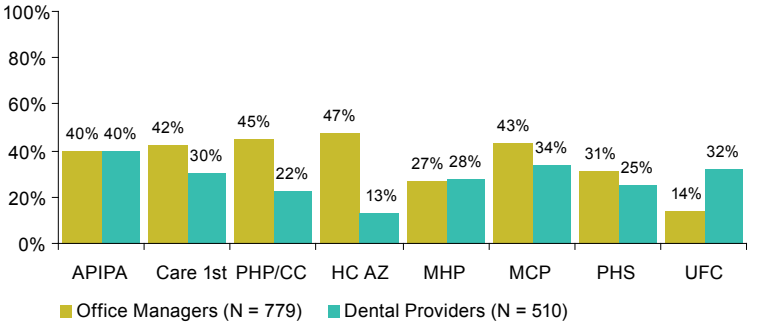


Out of 587 office manager and dental office respondents, the majority (54%) reported payment should be received within 30 days of a clean claim submission. Twenty-seven percent feel payment should be expected within 15 days (*Figure 24*).

When office managers and dental offices were asked to estimate how many days it typically takes plans to pay the clean claims submitted (*Figure 25*), 39% of responding office managers reported to receive payment within 30 days. Twenty-nine percent of dental office respondents said they received payment within 30 days. See Appendix Table A9 for health plan details.

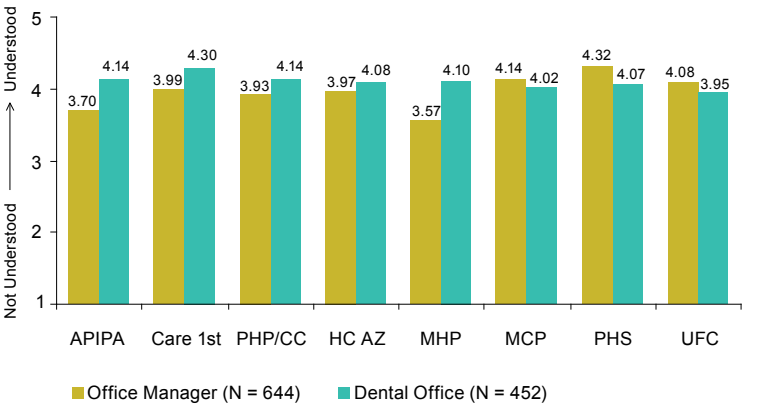
When asked if payment summaries are easy to understand, office managers and dental offices typically responded favorably. *Figure 26* shows that respondents reported that all plans' payment summaries rated at least a 3.5 on a scale of 1 to 5.

Figure 25. Percent of Payments Received within 30 Days of a Submitted Clean Claim, Office Managers and Dental Office Response



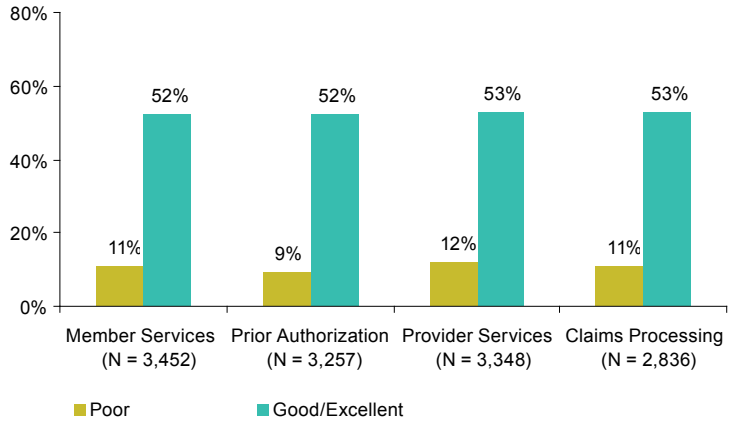
Note: Responses of "don't know/not enough experience" and non-responses are excluded from percentages.

Figure 26. Understandability of Payment Summaries by Plan, Dental Office and Office Manager Response



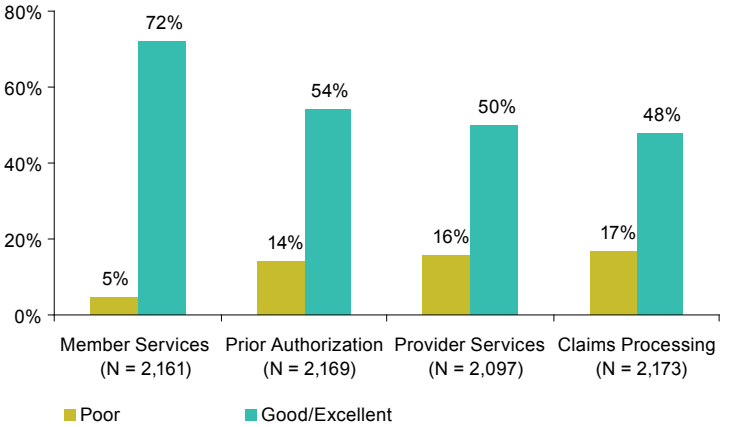
Note: Providers were asked to rate on a 5 point scale, 1,2 = "Not Understandable", 3 = Neutral, 4, 5 = "Understandable." Responses of "don't know/not enough experience to answer" and non-responses are excluded from percentages.

Figure 27. Office Managers – Evaluation of Plan Operations



Note: Responses of fair are not shown. Responses of "don't know/not enough experience to answer" and non-responses are excluded from percentages. This graph shows the average of all plan-specific responses; some providers answered for more than one plan.

Figure 28. Dental Respondents – Evaluation of Plan Operations



Note: Responses of fair are not shown. Responses of "don't know/not enough experience to answer" and non-responses are excluded from percentages. This graph shows the average of all plan-specific responses; some providers answered for more than one plan.

Relationship with AHCCCS Health Plans

Plan Operations

Office managers and dental offices were asked to rate the performance of each plan in the operational areas of member services, prior authorization, provider services, and claims processing. For each operational area, respondents were asked to evaluate the following aspects using the ratings "excellent," "good," "fair," or "poor": *getting through to someone who can help you, time on hold for calls, timeliness of issue resolution, courtesy of plan representative, and accuracy of responses*. Scores for each of these aspects were summed to derive an overall score for each operational area.

Figure 27 indicates that, across all plans, the majority of office managers indicated that the plans were operating in the "good" or "excellent" range for all operational areas. Health plan details are located in Appendix Tables A10a and A10b.

As indicated in *Figure 28*, dental offices gave especially high marks to member services, with 72% (across all plans) giving a rating of "excellent" or "good." Dental respondents gave the lowest marks to claims processing; overall 48% of dental respondents believe the plans are providing "good" or "excellent" service in this area.

Ancillaries

All health plans are responsible for providing ancillary services in their geographic region. PCPs, specialists, and office managers were asked to rate their experience with ancillary services as either poor, fair, good, or excellent. Plan breakout tables for each provider type are available in the Appendix in Tables A12 – A14.

Not all providers have experience with the ancillary services. *Table 8* shows the percent of respondents who said they don't know or do not have enough experience to evaluate the service.

Table 8: Ancillary Services Percent Answered "Don't Know/Not Enough Experience"

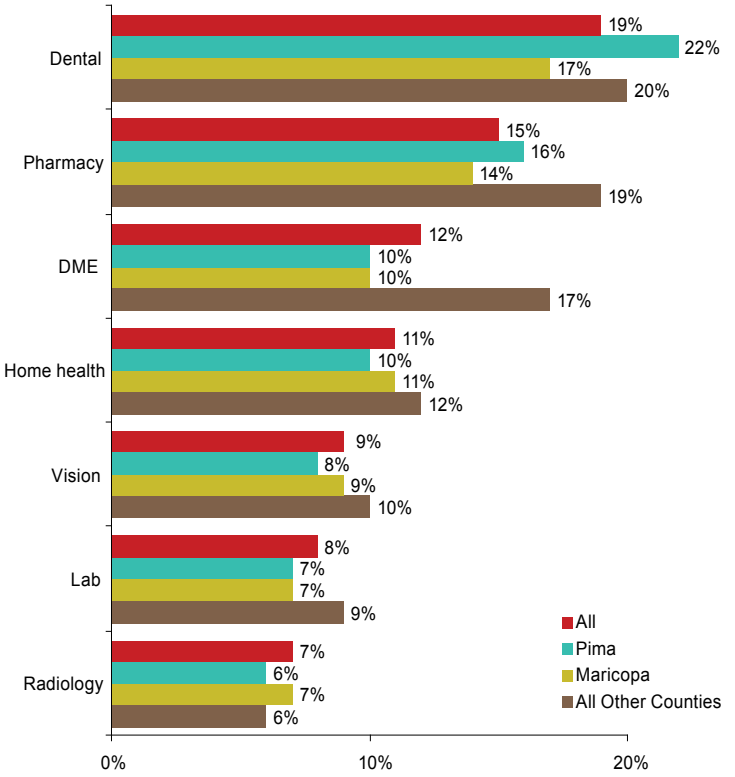
	County of Respondent		
	All Other	Maricopa	Pima
PCPs, Specialists and Office Managers Combined			
Durable Medical Equipment (DME)	36%	49%	47%
Laboratory Services	21%	33%	31%
Radiology Services	21%	31%	30%
Home Health Services	42%	52%	49%
Pharmacy Services	19%	32%	27%
PCPs and Office Managers Combined			
Vision Services	44%	44%	44%
Dental Services	45%	50%	45%
Office Managers			
Transportation	31%	35%	42%

Figure 29 represents the percent of providers by county who rate their experience with an ancillary service as poor. For most ancillary services, there was little variation by geographic region when a poor rating was assigned. Durable medical equipment (DME) was the exception with respondents in counties other than Pima and Maricopa assigning poor ratings much more frequently (17% compared to 10% of the time). For the majority of services, there are more providers in counties other than Pima or Maricopa who rate the services as poor. Specialists were not asked rate their experience with the following ancillary services: transportation, vision, and dental.

In the 1998/1999 survey, office managers were asked to report whether they had experienced "no problems," "minor problems," or "big problems" for ancillary services. The different scales used in the 2006 survey (excellent, good, fair, or poor) make it difficult to compare the change in responses over time, but in 1998/1999, office managers indicated their biggest problems were with transportation services, pharmacy services and durable medical equipment.

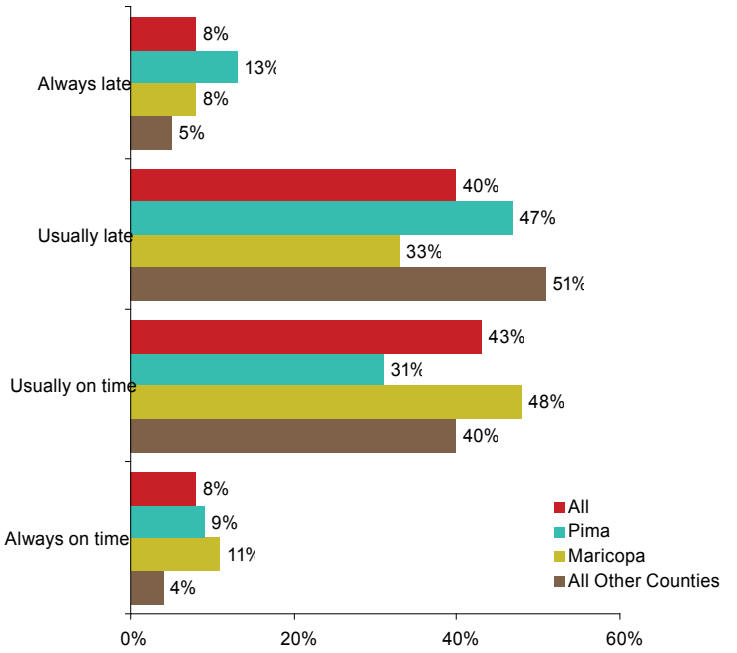
In the 1998/1999 report, office managers said some of the problems with transportation were related to long waits, unreliability, and inflexibility. In 2006, office managers were asked to evaluate the transportation services provided by each plan. *Figure 30* reflects the evaluation by county (see Appendix Table A15 for health plan details). Across all plans, office managers said that approximately 48% of the time, the transportation services are either usually late or always late, and always on time only 8% of the time, indicating that although there have been improvements since 1998/1999, office managers still do have concerns about transportation services.

Figure 29. PCPs, Specialists, & Office Managers Combined – Rating of Poor for Ancillary Service



Note: Only the percentage of respondents indicating "poor" is shown. Responses of "excellent," "good," and "fair" are not shown. Responses of "don't know/not enough experience to answer" and non-responses are excluded from percentages. This graph shows the average of all plan-specific responses; some providers answered for more than one plan.

Figure 30. Office Managers Evaluation of Transportation Services



Note: Responses of "don't know/not enough experience to answer'" and non-responses are excluded from percentages. This graph shows the average of all plan-specific responses; some providers answered for more than one plan.

Formularies

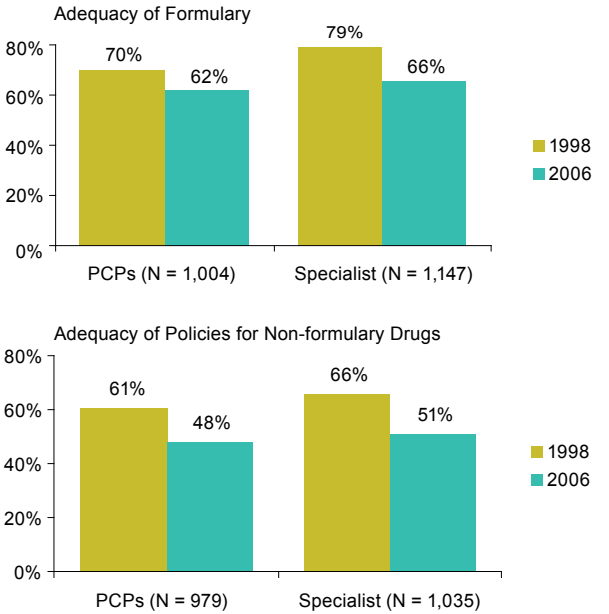
AHCCCS has no single state-wide prescription drug formulary. Each health plan, within broad state and federal guidelines, develops their own formulary, prior authorization policies, and pharmacy networks. The health plans are at full risk for the cost of the prescription drugs as part of their monthly capitation (AHCCCS, 2006).

PCPs and specialists were asked to rate the adequacy of the health plan's formulary on a scale of 1 to 5 where 1 is "not adequate" and 5 is "completely adequate." Approximately 12% of PCPs and 25% of specialists said they did not have enough experience to rate the adequacy of the formulary. Of respondents, 62% of PCPs and 66% of specialists responded that they believe the formulary is adequate (scores of 3, 4, and 5; *Figure 31*). The overall mean ranking for all plans (see Appendix Table A16) was 2.79 (*SD* 1.08), three plans had a higher mean than the average, Care 1st at 2.84 (*SD* 1.05), Mercy Care Plan at 3.03 (*SD* 1.09) and University Family Care at 2.81 (*SD* 1.14). Plan level results are available in Appendix Tables A16 – A17. In the 1998/1999 survey, physicians were more satisfied with the formulary, 70% of PCPs and 79% of specialists indicated they found the formulary either somewhat adequate or definitely adequate.

When asked to evaluate how adequate are the policies on access to non-formulary drugs, less than half of the PCPs (48%) and half of the specialists (51%) rated the policies as adequate. In 1998/1999, 61% of PCPs and 66% of specialists believed the health plans provided adequate access to non-formulary drugs.

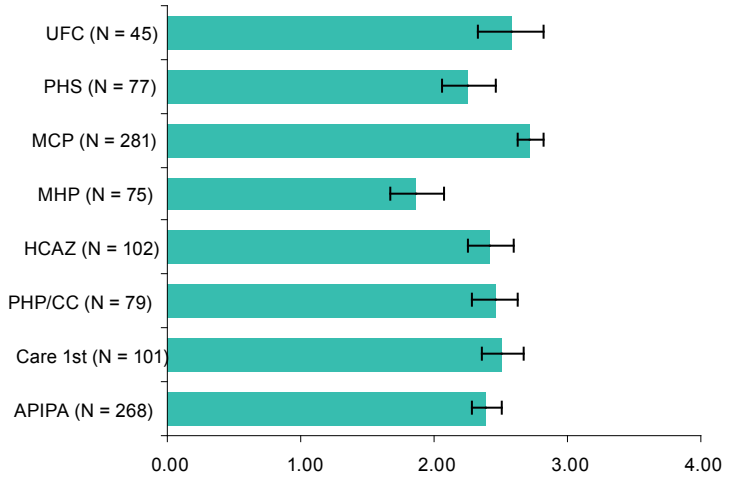
Although the use of formularies is widespread in managed care, a national representative survey of physicians found that overall; nearly half of physicians surveyed believe that formularies have a negative effect on the quality and efficiency of medical care (Landon, Reschovsky, & Blumenthal, 2004). The study also found that physicians' attitudes are influenced by the trouble of dealing with multiple formularies. This reflects some of the comments from AHCCCS providers – "One formulary for all plans would avoid many hours of wasted time," "Merge all plans into one single plan with uniform formulary, specialists and patient benefits," and "I would like to see a single AHCCCS payer instead of multiple plans so policies, procedures, formularies, and providers are uniform."

Figure 31. Attitude of PCPs & Specialists Toward Formulary



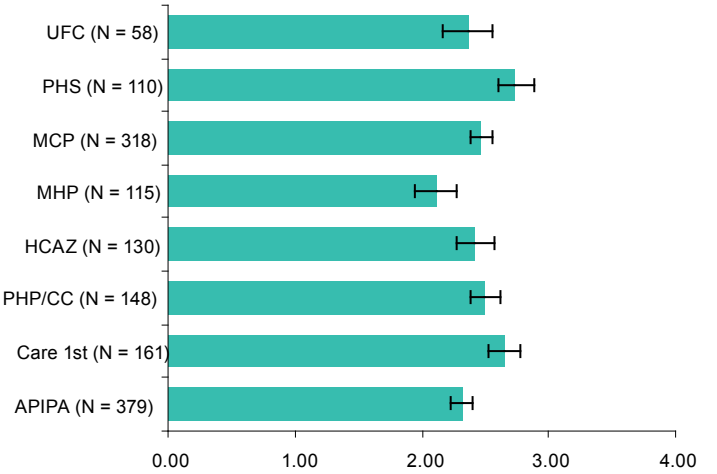
Note: Of the responses shown, 3, 4, 5 = Adequate. Responses of 1,2 are not shown. Responses of "don't know/not enough experience to answer" and non-responses are excluded from percentages. Ns reflect only the 2006 survey. This graph shows the average of all plan-specific responses; some physicians answered for one than one plan.

Figure 32. PCPs – Overall Experience with Plan



Note: Respondents rated plans as "poor" (1), "fair" (2), "good" (3), or "excellent" (4). Responses of "don't know/not enough experience to answer" and non-responses are excluded from percentages.

Figure 33. Specialists – Overall Experience with Plan



Note: Respondents rated plans as "poor" (1), "fair" (2), "good" (3), or "excellent" (4). Responses of "don't know/not enough experience to answer" and non-responses are excluded from percentages.

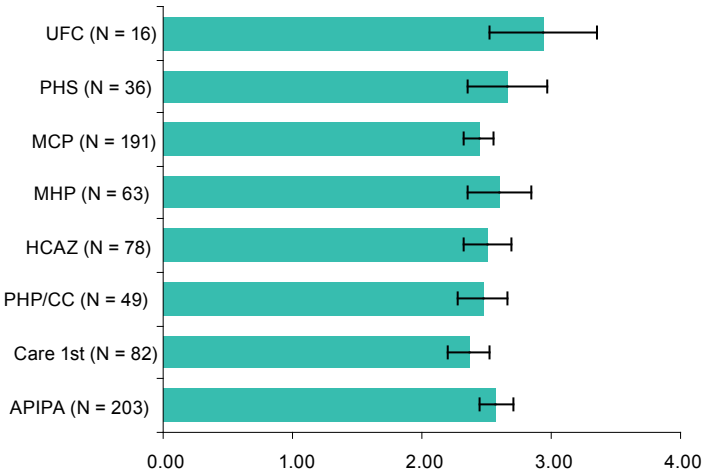
Overall Plan Experience

Respondents were asked to indicate their overall experience with each plan using a scale of poor, fair, good or excellent. *Figures 32 – 35* indicate the mean rating given to each plan by provider type where 1 is the lowest score and 4 is the highest score. The majority of plans received a score of fair or good, with some variations by provider type. The 95% confidence interval is also shown on each bar graph. The interval represents the range of values, given the data, which is likely to include the population mean. Wider intervals indicate lower precision; narrow intervals indicate greater precision.

When PCPs were asked what can be done to improve the plans, the most common suggestions were to improve the formularies and the specialty network.

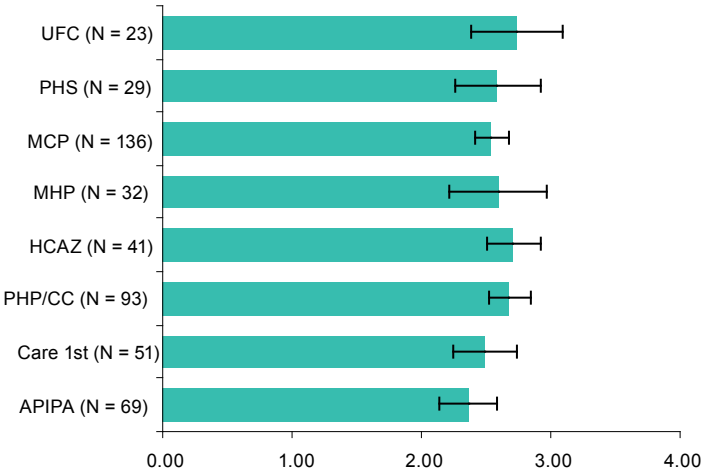
When specialists were asked what can be done to improve the plans, the most common suggestions were to increase reimbursement and improve the formulary, followed by improve authorization processes, claims processing, and communication. The specialists gave a mean score of greater than 2 for all plans.

Figure 34. Office Managers – Overall Experience with Plan



Note: Respondents rated plans as "poor" (1), "fair" (2), "good" (3), or "excellent" (4). Responses of "don't know/not enough experience to answer" and non-responses are excluded from percentages.

Figure 35. Dental Respondents – Overall Experience with Plan

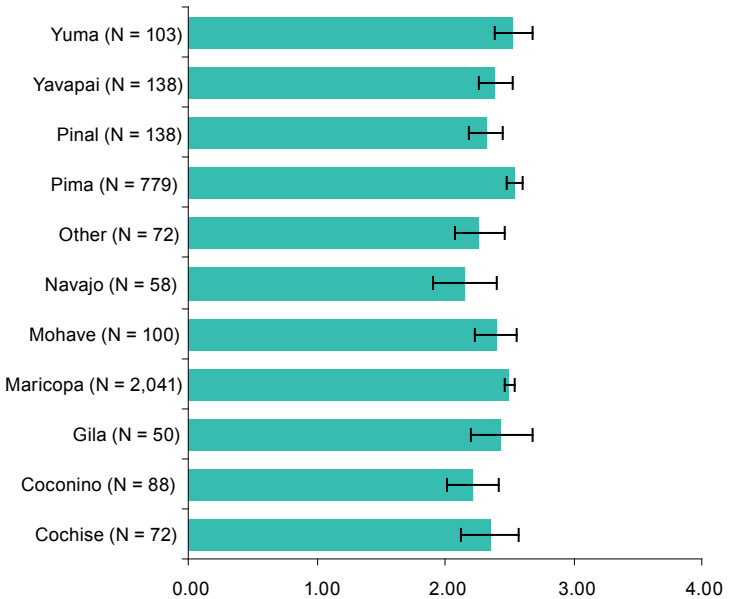


Note: Respondents rated plans as "poor" (1), "fair" (2), "good" (3), or "excellent" (4). Responses of "don't know/not enough experience to answer" and non-responses are excluded from percentages.

Among office managers and dental offices, all the plans had a mean score greater than 2.3 (*Figures 34 and 35*). The office managers cited improving customer service (e.g., hold time) and improving communication with providers as the most important things that could be done to improve the plans.

Dental respondents cited improving the authorization process, increasing reimbursement, improving the reimbursement process, and increasing the scope of covered services as the most important things that could be done to improve the plans, followed by improving communication and customer service.

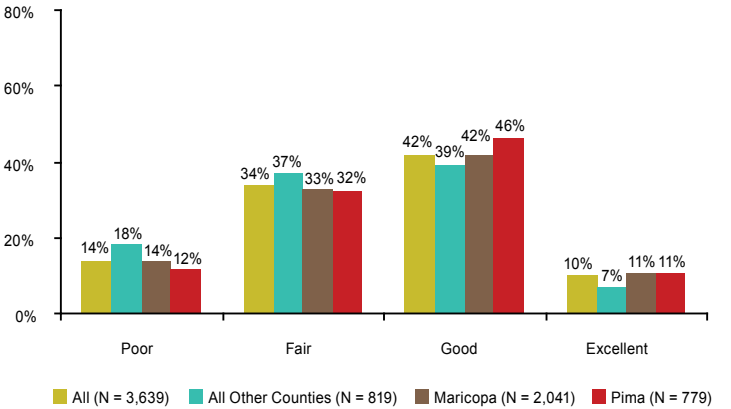
Figure 36. All Respondents – Overall Experience by County



Note: Respondents rated plans as "poor" (1), "fair" (2), "good" (3), or "excellent" (4). Responses of "don't know/not enough experience to answer" and non-responses are excluded from percentages. This graph shows the average of all plan-specific responses; some providers answered for more than one plan. Other includes Apache, Graham, Greenlee, La Paz, & Santa Cruz.

Figure 36 presents the overall experience by county for all respondents combined (PCPs, specialists, dental offices and office managers). Respondents located in the counties of Maricopa and Pima reported higher ratings of overall satisfaction with the health plans than respondents located in other counties.

Figure 37. All Respondents – Overall Experience by County



Note: Responses of "'don't know/'not enough experience to answer" and non-responses are excluded from percentages. This graph shows the average of all plan-specific responses; some providers answered for more than one plan.

As shown in *Figure 37*, the respondents in counties other than Maricopa and Pima were more likely to rate a health plan as poor. Eighteen percent of respondents in all other counties indicated their overall experience with a health plan was poor compared to 14% of respondents in Maricopa County and 12% of respondents in Pima County. Overall, only 10% of respondents gave ratings of excellent to the health plans, with respondents in Maricopa and Pima rating plans slightly higher at 11%, and respondents in all other counties rating plans lower at 7%.

Recommendations

Based on survey findings, it is recommended that AHCCCS-contracted health plans:

- Continue to monitor, control, and improve the timeliness and accuracy of claims payments.
- Promote electronic claims submission and address provider issues related to attachments required for processing.
- Improve the timeliness of responses related to requests for authorization.
- Increase accessibility to health plan Medical and Dental Directors and other key staff. They must be readily available to accept and return calls from providers and address related matters.
- Support an AHCCCS-wide evaluation of provider networks to determine whether the described need for selected specialties results from statewide workforce issues or AHCCCS health plan contract issues.
- Consider ways to improve individual utilization reporting to providers.
- Improve health plan communication and processes related to provider requests for non-formulary drugs.
- Educate providers so they understand why family members should not serve as translators for patients. In particular, inform them of available alternative resources (i.e., Language Line).
- Collaborate with the Arizona Department of Health Services (ADHS) and the Arizona Dental Association (ADA) to increase the percentage of dental providers who accept young children.
- Improve health plan support of dental providers with members who do not keep their dental appointments.
- Consider focused assessments of poorly rated ancillary services to determine reasons for poor ratings (e.g., not available, poor quality).
- Ensure that providers have received special training related to coordination with Special Needs Plans (SNPs) and Medicare Part D.

Appendix

Table A1. Usefulness of Health Plan's Provider Manual

	Usefulness of health plan's provider manual (Office Manager)				*Usefulness of health plan's provider manual (Dental)*			
	Mean (SD)	*Useful*	*Not Useful*	*Base N for 100%*	*Mean (SD)*	*Useful*	*Not Useful*	*Base N for 100%*
APIPA	2.98 (1.21)	68%	32%	185	3.28 (1.17)	75%	25%	68
Care 1st	3.40 (1.03)	82%	18%	77	3.60 (1.21)	82%	18%	50
PHP/CC	3.58 (1.03)	87%	13%	45	3.59 (1.10)	80%	20%	90
HC AZ	3.14 (1.20)	72%	28%	72	3.41 (0.99)	85%	15%	39
MHP	3.21 (1.22)	68%	32%	56	3.22 (1.29)	72%	28%	32
MCP	3.28 (1.13)	77%	23%	184	3.51 (1.10)	83%	17%	129
PHS	3.57 (1.43)	80%	20%	30	3.12 (1.24)	69%	31%	26
UFC	3.33 (1.80)	60%	40%	15	3.32 (1.38)	74%	26%	19
TOTAL	3.23 (1.19)	74%	26%	664	3.44 (1.15)	79%	21%	453

Note: *SD* = Standard Deviation

Note: Neutral answers of 3 are not shown. Scores of 1, 2 = Not Useful, 4, 5 = Useful.

Table A2. Office Manager – Adequacy of Training on Policies and Procedures Related to Plan Services

	APIPA		Care 1st		PHP/CC		HC AZ		MHP		MCP		PHS		UFC	
Type of Service	Above	Below	Above	Below	Above	Below	Above	Below	Above	Below	Above	Below	Above	Below	Above	Below
Eligibility Verification	52%	24%	58%	21%	70%	9%	56%	11%	43%	43%	64%	13%	55%	19%	47%	33%
	(N = 184)		(N = 73)		(N = 43)		(N = 66)		(N = 54)		(N = 174)		(N = 31)		(N = 15)	
Utilization Management	42%	29%	48%	28%	50%	24%	38%	22%	27%	50%	51%	20%	44%	19%	17%	50%
	(N = 162)		(N = 64)		(N = 38)		(N = 55)		(N = 48)		(N = 148)		(N = 27)		(N = 12)	
Prior Authorization	46%	29%	55%	18%	56%	19%	47%	19%	41%	43%	59%	15%	45%	29%	29%	36%
	(N = 182)		(N = 71)		(N = 43)		(N = 68)		(N = 54)		(N = 165)		(N = 31)		(N = 14)	
Pharmacy Services	39%	29%	58%	22%	51%	22%	44%	23%	38%	44%	50%	16%	29%	25%	25%	42%
	(N = 165)		(N = 60)		(N = 41)		(N = 61)		(N = 50)		(N = 153)		(N = 28)		(N = 12)	
Special Network Referral	41%	30%	60%	21%	61%	20%	45%	20%	36%	43%	55%	17%	43%	29%	42%	42%
	(N = 165)		(N = 68)		(N = 41)		(N = 66)		(N = 53)		(N = 160)		(N = 28)		(N = 12)	
Case Management	35%	35%	43%	28%	56%	19%	45%	34%	31%	40%	48%	20%	41%	30%	17%	58%
	(N = 153)		(N = 60)		(N = 36)		(N = 58)		(N = 48)		(N = 144)		(N = 27)		(N = 12)	
Claims Submission Requirements	47%	30%	52%	18%	55%	15%	51%	24%	46%	31%	54%	16%	48%	12%	15%	31%
	(N = 166)		(N = 66)		(N = 40)		(N = 67)		(N = 48)		(N = 154)		(N = 25)		(N = 13)	
EPSDT Requirements	51%	26%	55%	23%	59%	18%	52%	24%	43%	33%	56%	14%	52%	14%	33%	42%
	(N = 153)		(N = 60)		(N = 34)		(N = 58)		(N = 46)		(N = 145)		(N = 21)		(N = 12)	
Covered Services	44%	31%	51%	20%	60%	19%	56%	19%	37%	33%	55%	19%	48%	13%	25%	38%
	(N = 183)		(N = 71)		(N = 42)		(N = 68)		(N = 54)		(N = 172)		(N = 31)		(N = 16)	

Note: Survey respondents were asked to rate "adequacy" on a scale of 1 to 5 with 1 being "completely inadequate" and 5 being "completely adequate." For purposes of this table comparison, neutral answers of 3 are not shown. Scores of 1,2 = Below, 4,5 = Above.

Table A3. Dental – Adequacy of Training on Policies and Procedures

	APIPA		Care 1st		PHP/CC		HC AZ		MHP		MCP		PHS		UFC	
Type of Service	Above	Below	Above	Below	Above	Below	Above	Below	Above	Below	Above	Below	Above	Below	Above	Below
Eligibility Verification	54%	17%	59%	14%	63%	14%	60%	9%	52%	17%	59%	14%	62%	19%	53%	11%
	(N = 69)		(N = 49)		(N = 88)		(N = 35)		(N = 29)		(N = 116)		(N = 26)		(N = 19)	
Prior Authorization	48%	30%	40%	24%	51%	18%	51%	26%	40%	23%	47%	18%	50%	29%	75%	15%
	(N = 67)		(N = 50)		(N = 94)		(N = 35)		(N = 30)		(N = 127)		(N = 28)		(N = 20)	
Dental Specialty Referral Network	44%	21%	27%	31%	47%	22%	53%	14%	45%	26%	43%	21%	48%	26%	53%	21%
	(N = 63)		(N = 48)		(N = 90)		(N = 36)		(N = 31)		(N = 122)		(N = 27)		(N = 19)	
Claims Submission Requirements	45%	29%	53%	16%	54%	18%	55%	24%	59%	28%	52%	20%	52%	15%	53%	16%
	(N = 66)		(N = 49)		(N = 90)		(N = 38)		(N = 32)		(N = 128)		(N = 27)		(N = 19)	
Covered Services	49%	20%	48%	28%	49%	25%	53%	24%	47%	25%	56%	18%	54%	14%	50%	20%
	(N = 69)		(N = 50)		(N = 91)		(N = 38)		(N = 32)		(N = 128)		(N = 28)		(N = 20)	

Note: Survey respondents were asked to rate “adequacy” on a scale of 1 to 5 with 1 being “completely inadequate” and 5 being “completely adequate.” For purposes of this table comparison, neutral answers of 3 are not shown.

Table A4. Understandability of Health Plan's Communication about Denials

	Understandability of health plan's communication about denials (PCPs)				*Understandability of health plan's communication about denials (Specialists)*				*Understandability of health plan's communication about denials (Dental)*			
	Mean (SD)	*Under-standable*	*Not Under-standable*	*Base N for 100%*	*Mean (SD)*	*Under-standable*	*Not Under-standable*	*Base N for 100%*	*Mean (SD)*	*Under-standable*	*Not Under-standable*	*Base N for 100%*
APIPA	3.13 (1.15)	69%	31%	247	3.05 (1.23)	66%	34%	345	3.15 (1.14)	73%	27%	67
Care 1st	3.39 (1.18)	76%	24%	93	3.47 (1.13)	83%	17%	138	3.42 (1.10)	80%	20%	45
PHP/CC	3.35 (1.14)	79%	21%	75	3.31 (1.11)	77%	23%	134	3.24 (1.14)	77%	23%	86
HC AZ	3.17 (1.14)	73%	27%	100	3.24 (1.21)	71%	29%	125	3.10 (1.22)	65%	35%	40
MHP	2.97 (1.35)	62%	38%	69	3.05 (1.18)	71%	29%	101	3.07 (1.34)	67%	33%	30
MCP	3.47 (1.11)	81%	19%	262	3.22 (1.19)	73%	27%	288	3.30 (1.07)	77%	23%	128
PHS	3.13 (1.22)	66%	34%	71	3.70 (1.12)	81%	19%	96	3.46 (1.14)	82%	18%	28
UFC	3.28 (1.23)	74%	26%	39	3.28 (1.17)	74%	26%	53	3.55 (1.18)	82%	18%	22
TOTAL	3.26 (1.17)	74%	26%	956	3.24 (1.19)	73%	27%	1,280	3.27 (1.14)	76%	24%	446

Note: *SD* = Standard Deviation

Note: Survey respondents were asked to rate "understandability" on a scale of 1 to 5 with 1 being "not understandable at all" and 5 being "completely understandable." For purposes of this table comparison, neutral answers of 3 are not shown. Scores of 1,2 = Not Understandable, 4,5 = Understandable.

Table A5. PCPs - Indicate How Well Plan Keeps You Informed of Utilization Patterns

	Utilization Patterns PCPs			
	Mean (SD)	*Informed*	*Not Informed*	*Base N for 100%*
APIPA	2.64 (1.13)	61%	39%	213
Care 1st	2.56 (1.31)	51%	49%	93
PHP/CC	2.76 (1.26)	64%	36%	67
HC AZ	2.84 (1.10)	70%	30%	87
MHP	2.46 (1.23)	51%	49%	63
MCP	3.17 (1.23)	75%	25%	243
PHS	2.53 (1.19)	49%	51%	59
UFC	2.73 (0.91)	61%	39%	33
TOTAL	2.79 (1.21)	63%	37%	858

Note: *SD* = Standard Deviation

Note: Neutral answers of 3 are not shown. Scores of 1,2 = Not Informed, 4, 5 = Informed.

Table A6. PCPs – Adequacy of Referral Networks

	Does the health plan have an adequate network of specialists?					*Does the health plan's referral policy work?*				
	Mean (SD)	*Positive*	*Neutral*	*Negative*	*Base N for 100%*	*Mean (SD)*	*Positive*	*Neutral*	*Negative*	*Base N for 100%*
APIPA	3.32 (1.17)	46%	32%	22%	255	3.36 (1.11)	47%	32%	21%	242
Care 1st	3.07 (1.14)	38%	29%	34%	98	3.36 (1.01)	45%	35%	20%	97
PHP/CC	3.07 (1.11)	36%	34%	30%	74	3.29 (1.07)	41%	36%	23%	70
HC AZ	2.89 (1.12)	28%	38%	34%	100	3.11 (1.07)	37%	39%	24%	100
MHP	2.71 (1.24)	27%	30%	43%	70	2.99 (1.20)	35%	32%	32%	68
MCP	3.39 (1.14)	50%	28%	22%	270	3.54 (1.02)	50%	35%	15%	254
PHS	3.27 (1.33)	50%	20%	30%	74	3.13 (1.32)	46%	22%	32%	72
UFC	3.70 (1.13)	66%	20%	14%	44	3.40 (1.21)	50%	26%	24%	42
TOTAL	3.22 (1.19)	44%	30%	27%	985	3033 (1.11)	46%	33%	21%	945

Note: *SD* = Standard Deviation

Note: Survey respondents were asked to rate their experience on a scale from 1 to 5 with 1 being "completely negative" and 5 being "completely positive." Scores of 1, 2 = Negative; 3 = Neutral; 4, 5 = Positive.

Table A7. Specialists – Adequacy of Referral Networks

	Do the plan's policies support appropriate referrals from PCPs?					*Is the information received from the PCPs adequate when they refer patients?*				
	Mean (SD)	*Positive*	*Neutral*	*Negative*	*Base N for 100%*	*Mean (SD)*	*Positive*	*Neutral*	*Negative*	*Base N for 100%*
APIPA	3.55 (1.12)	55%	29%	16%	357	3.26 (1.16)	44%	33%	23%	361
Care 1st	3.74 (1.08)	63%	25%	12%	141	3.43 (1.05)	48%	36%	17%	149
PHP/CC	3.66 (0.99)	57%	35%	8%	133	3.36 (1.12)	51%	25%	24%	138
HC AZ	3.57 (1.03)	55%	31%	14%	120	3.25 (1.21)	45%	28%	27%	120
MHP	3.31 (0.98)	43%	38%	19%	97	3.06 (1.10)	38%	37%	26%	104
MCP	3.59 (1.06)	57%	29%	14%	290	3.31 (1.18)	44%	33%	23%	304
PHS	3.75 (1.07)	67%	20%	13%	103	3.25 (1.18)	46%	31%	23%	104
UFC	3.56 (1.12)	60%	25%	16%	57	3.02 (1.30)	39%	25%	36%	56
TOTAL	3.59 (1.07)	57%	29%	14%	1,298	3.27 (1.16)	45%	32%	24%	1,336

Note: *SD* = Standard Deviation

Note: Survey respondents were asked to rate their experience on a scale from 1 to 5 with 1 being "completely negative" and 5 being "completely positive." Scores of 1, 2 = Negative; 3 = Neutral; 4, 5 = Positive.

Table A8. Dental Respondents – Adequacy of Referral Networks

	Does the health plan have an adequate network of specialists?					*Does the health plan's referral policy work?*				
	Mean (SD)	*Positive*	*Neutral*	*Negative*	*Base N for 100%*	*Mean (SD)*	*Positive*	*Neutral*	*Negative*	*Base N for 100%*
APIPA	3.07(1.22)	37%	33%	30%	67	3.30 (1.09)	39%	39%	21%	61
Care 1st	3.31 (1.16)	42%	38%	20%	45	3.56 (1.08)	51%	36%	13%	45
PHP/CC	3.40 (0.90)	42%	45%	13%	83	3.59 (1.00)	55%	33%	12%	85
HC AZ	3.18 (1.47)	45%	21%	34%	38	3.49 (1.14)	51%	26%	23%	39
MHP	3.31 (1.04)	38%	48%	14%	29	3.64 (1.06)	54%	36%	11%	28
MCP	3.27 (1.05)	41%	36%	23%	128	3.28 (1.04)	39%	43%	18%	128
PHS	3.33 (1.07)	44%	33%	22%	27	3.08 (1.22)	44%	28%	28%	25
UFC	3.00 (1.18)	43%	24%	33%	21	3.14 (1.17)	45%	36%	18%	22
TOTAL	3.25 (1.11)	41%	36%	23%	438	3.39 (1.08)	46%	36%	17%	433

Note: *SD* = Standard Deviation

Note: Survey respondents were asked to rate their experience on a scale from 1 to 5 with 1 being "completely negative" and 5 being "completely positive." Scores of 1, 2 = Negative; 3 = Neutral; 4, 5 = Positive.

Table A9. Typical Number of Days to Receive Payment on Clean Claims Submitted, Office Managers and Dental Offices

	< 22 days		22 – 30 days		31 – 60 days		> 60 days		Don't know	
	Office Managers	Dental Offices	Office Managers	Dental Offices	Office Managers	Dental Offices	Office Managers	Dental Offices	Office Managers	Dental Offices
APIPA	12%	9%	28%	31%	32%	35%	13%	15%	15%	10%
Care 1st	10%	4%	32%	26%	32%	39%	7%	18%	21%	14%
PHP/ CC	7%	3%	38%	19%	29%	63 %	2%	5%	24%	9%
HC AZ	7%	4%	40%	9%	31%	64%	9%	9%	14%	13%
MHP	10%	6%	17%	22%	21%	44%	13%	13%	39%	13%
MCP	12%	4%	31%	30%	34%	49%	8%	8%	16%	8%
PHS	0%	3%	31%	22%	15%	56%	10%	9%	44%	9%
UFC	0%	0%	14%	32%	32%	48%	5%	4%	50%	16%
TOTAL	10%	5%	30%	25%	30%	50%	9%	10%	21%	11%

Note: For purposes of this table comparison, numbers have been rounded to the nearest hundredth.

Table A10a. Office Manager – Performance of Plans in Operational Areas

	APIPA		Care 1st		PHP/CC		HC AZ		MHP		MCP		PHS		UFC	
Type of Service	G or E	Poor	G or E	Poor	G or E	Poor	G or E	Poor	G or E	Poor	G or E	Poor	G or E	Poor	G or E	Poor
Member Services	56%	14%	43%	10%	54%	11%	56%	13%	59%	11%	48%	10%	54%	13%	51%	5%
	(N = 961)		(N = 387)		(N = 253)		(N = 375)		(N = 284)		(N = 950)		(N = 167)		(N = 75)	
Prior Authorization	54%	11%	45%	10%	59%	9%	55%	10%	56%	5%	50%	8%	57%	12%	42%	7%
	(N = 926)		(N = 364)		(N = 232)		(N = 357)		(N = 262)		(N = 891)		(N = 156)		(N = 69)	
Provider Services	57%	15%	48%	11%	54%	9%	58%	13%	55%	11%	48%	11%	56%	12%	49%	6%
	(N = 942)		(N = 377)		(N = 240)		(N = 355)		(N = 275)		(N = 924)		(N = 164)		(N = 70)	
Claim Processing	58%	14%	41%	11%	52%	6%	53%	9%	57%	12%	51%	8%	57%	13%	37%	5%
	(N = 804)		(N = 343)		(N = 204)		(N = 319)		(N = 228)		(N = 750)		(N = 128)		(N = 60)	

Note: Survey respondents were asked to rate performance on a scale from “excellent” to “poor” (G or E = good or excellent). For purposes of this table comparison, neutral answers of “fair” are not shown.

Table A10b. Dental Respondents– Performance of Plans in Operational Areas

	APIPA		Care 1st		PHP/CC		HC AZ		MHP		MCP		PHS		UFC	
Type of Service	G or E	Poor	G or E	Poor	G or E	Poor	G or E	Poor	G or E	Poor	G or E	Poor	G or E	Poor	G or E	Poor
Member Services	62%	7%	77%	3%	77%	4%	82%	5%	66%	8%	70%	4%	73%	5%	83%	3%
	(N = 339)		(N = 230)		(N = 416)		(N = 190)		(N = 158)		(N = 605)		(N = 128)		(N = 95)	
Prior Authorization	49%	21%	58%	9%	58%	10%	62%	4%	45%	18%	49%	17%	53%	18%	71%	3%
	(N = 331)		(N = 219)		(N = 422)		(N = 189)		(N = 154)		(N = 633)		(N = 127)		(N = 94)	
Provider Services	38%	24%	55%	12%	53%	12%	60%	9%	45%	23%	46%	19%	56%	12%	73%	2%
	(N = 325)		(N = 208)		(N = 409)		(N = 183)		(N = 155)		(N = 600)		(N = 122)		(N = 95)	
Claim Processing	39%	26%	49%	16%	53%	12%	60%	9%	43%	26%	45%	18%	53%	17%	61%	6%
	(N = 350)		(N = 221)		(N = 415)		(N = 196)		(N = 154)		(N = 625)		(N = 123)		(N = 89)	

Note: Survey respondents were asked to rate performance on a scale from “excellent” to “poor” (G or E = good or excellent). For purposes of this table comparison, neutral answers of “fair” are not shown.

Table A12. Office Managers - Ratings of Ancillary Services (Availability of Appointments, Quality of Care, Responsiveness)

Type of Service	TOTAL		APIPA		Care 1st		PHP/CC		HC AZ		MHP		MCP		PHS		UFC	
	G or E	Poor	G or E	Poor	G or E	Poor	G or E	Poor	G or E	Poor	G or E	Poor	G or E	Poor	G or E	Poor	G or E	Poor
Durable Medical Equipment	53%	8%	53%	8%	54%	4%	54%	6%	50%	13%	59%	8%	51%	5%	53%	26%	75%	0%
	(N = 453)		(N = 125)		(N = 52)		(N = 35)		(N = 52)		(N = 37)		(N = 125)		(N = 19)		(N = 8)	
Laboratory Services	50%	9%	50%	11%	45%	8%	58%	5%	56%	12%	51%	9%	46%	8%	48%	5%	50%	0%
	(N = 522)		(N = 148)		(N = 60)		(N = 38)		(N = 59)		(N = 43)		(N = 147)		(N = 21)		(N = 6)	
Radiology	52%	6%	55%	7%	45%	7%	58%	6%	63%	3%	49%	7%	47%	7%	48%	9%	60%	0%
	(N = 526)		(N = 146)		(N = 60)		(N = 36)		(N = 59)		(N = 43)		(N = 149)		(N = 23)		(N = 10)	
Home Health Care	55%	7%	55%	5%	48%	7%	54%	7%	67%	11%	65%	14%	51%	4%	52%	10%	50%	0%
	(N = 411)		(N = 116)		(N = 44)		(N = 28)		(N = 45)		(N = 37)		(N = 112)		(N = 21)		(N = 8)	
Pharmacy Services	51%	7%	52%	7%	48%	9%	53%	8%	52%	15%	54%	7%	48%	4%	50%	8%	67%	0%
	(N = 527)		(N = 147)		(N = 56)		(N = 40)		(N = 60)		(N = 46)		(N = 145)		(N = 24)		(N = 9)	
Vision Services	57%	7%	61%	7%	50%	5%	66%	6%	59%	9%	66%	13%	49%	8%	56%	0%	50%	0%
	(N = 390)		(N = 110)		(N = 44)		(N = 32)		(N = 46)		(N = 32)		(N = 102)		(N = 16)		(N = 8)	
Dental Services	56%	10%	60%	6%	59%	10%	55%	13%	65%	9%	73%	12%	48%	10%	33%	20%	50%	13%
	(N = 361)		(N = 99)		(N = 41)		(N = 31)		(N = 43)		(N = 26)		(N = 98)		(N = 15)		(N = 8)	
Transportation Services	52%	12%	54%	11%	45%	16%	47%	11%	57%	18%	58%	12%	51%	12%	50%	17%	54%	0%
	(N = 497)		(N = 139)		(N = 56)		(N = 36)		(N = 49)		(N = 43)		(N = 137)		(N = 24)		(N = 13)	

Note: Survey respondents were asked to rate their experience on a scale ranging from “excellent” to “poor” (G or E = good or excellent). For purposes of this table comparison, neutral answers of “fair” are not shown.

Table A13. PCPs - Ratings of Ancillary Services (Availability of Appointments, Quality of Care, Responsiveness)

	TOTAL		APIPA		Care 1st		PHP/CC		HC AZ		MHP		MCP		PHS		UFC	
Type of Service	G or E	Poor	G or E	Poor	G or E	Poor	G or E	Poor	G or E	Poor	G or E	Poor	G or E	Poor	G or E	Poor	G or E	Poor
Durable Medical Equipment	53%	14%	55%	12%	51%	22%	51%	14%	45%	14%	38%	29%	62%	10%	46%	11%	57%	14%
	(N = 817)		(N = 212)		(N = 82)		(N = 63)		(N = 83)		(N = 56)		(N = 223)		(N = 63)		(N = 35)	
Laboratory Services	73%	6%	69%	8%	81%	3%	63%	7%	62%	9%	75%	6%	76%	6%	83%	3%	87%	3%
	(N = 921)		(N = 248)		(N = 96)		(N = 68)		(N = 90)		(N = 65)		(N = 246)		(N = 69)		(N = 39)	
Radiology	78%	5%	77%	5%	73%	3%	75%	8%	72%	11%	62%	11%	85%	2%	83%	3%	85%	5%
	(N = 911)		(N = 240)		(N = 93)		(N = 71)		(N = 88)		(N = 63)		(N = 247)		(N = 69)		(N = 40)	
Home Health Care	58%	10%	59%	8%	52%	12%	57%	8%	60%	13%	54%	16%	62%	7%	57%	12%	62%	9%
	(N = 701)		(N = 186)		(N = 65)		(N = 51)		(N = 67)		(N = 50)		(N = 190)		(N = 58)		(N = 34)	
Pharmacy Services	45%	20%	46%	20%	37%	19%	39%	21%	41%	22%	42%	18%	53%	14%	31%	40%	50%	26%
	(N = 927)		(N = 248)		(N = 97)		(N = 71)		(N = 88)		(N = 67)		(N = 248)		(N = 70)		(N = 38)	
Vision Services	60%	11%	57%	10%	67%	7%	54%	18%	50%	13%	43%	16%	69%	8%	57%	6%	69%	19%
	(N = 642)		(N = 169)		(N = 61)		(N = 56)		(N = 68)		(N = 37)		(N = 178)		(N = 47)		(N = 26)	
Dental Services	48%	24%	41%	26%	59%	13%	53%	24%	42%	27%	42%	29%	56%	23%	46%	22%	44%	37%
	(N = 599)		(N = 163)		(N = 54)		(N = 49)		(N = 67)		(N = 31)		(N = 162)		(N = 46)		(N = 27)	

Note: Survey respondents were asked to rate their experience on a scale ranging from “excellent” to “poor” (G or E = good or excellent). For purposes of this table comparison, neutral answers of “fair” are not shown.

Table A14. Specialists - Ratings of Ancillary Services (Availability of Appointments, Quality of Care, Responsiveness)

Type of Service	TOTAL		APIPA		Care 1st		PHP/CC		HC AZ		MHP		MCP		PHS		UFC	
	Above	Below	Above	Below	Above	Below	Above	Belowr	Above	Below	Above	Below	Above	Below	Above	Below	Above	Below
Durable Medical Equipment	51%	13%	48%	16%	54%	3%	52%	14%	57%	14%	33%	13%	55%	12%	60%	13%	41%	15%
	(N = 548)		(N = 137)		(N = 59)		(N = 64)		(N = 56)		(N = 45)		(N = 113)		(N = 47)		(N = 27)	
Laboratory Services	66%	8%	64%	7%	74%	4%	64%	10%	64%	11%	62%	11%	68%	11%	70%	7%	71%	2%
	(N = 916)		(N = 233)		(N = 114)		(N = 104)		(N = 83)		(N = 84)		(N = 183)		(N = 74)		(N = 41)	
Radiology	65%	8%	64%	7%	66%	6%	61%	10%	64%	10%	55%	18%	71%	8%	68%	1%	65%	9%
	(N = 972)		(N = 250)		(N = 116)		(N = 112)		(N = 91)		(N = 84)		(N = 203)		(N = 73)		(N = 43)	
Home Health Care	48%	16%	43%	16%	54%	11%	46%	19%	45%	18%	52%	26%	49%	14%	53%	11%	45%	18%
	(N = 583)		(N = 148)		(N = 67)		(N = 69)		(N = 51)		(N = 58)		(N = 110)		(N = 47)		(N = 33)	
Pharmacy Services	44%	15%	36%	18%	48%	7%	45%	14%	49%	18%	46%	16%	45%	16%	56%	11%	36%	17%
	(N = 956)		(N = 252)		(N = 107)		(N = 103)		(N = 91)		(N = 80)		(N = 197)		(N = 79)		(N = 47)	

Note: Survey respondents were asked to rate plan performance on a scale from 1 to 5 with 1 being “completely inadequate” and 5 being “completely adequate.” For purposes of this table comparison, neutral answers of 3 are not shown. Scores of 1, 2 = Below, 4, 5 = Above.

Table A15. Office Managers – Rate Transportation Provided by Plans

	Always On Time	*Usually On Time*	*Usually Late*	*Always Late*	*Base N for Percent*
APIPA	8%	40%	43%	9%	141
Care 1st	9%	60%	27%	4%	55
PHP/CC	22%	38%	38%	3%	32
HC AZ	8%	34%	51%	8%	53
MHP	3%	61%	30%	6%	33
MCP	8%	42%	40%	10%	142
PHS	13%	30%	48%	9%	23
UFC	0%	44%	44%	11%	9
TOTAL	9%	43%	40%	8%	488

Table A16. PCPs – Adequacy of Formulary

	Is the health plan's formulary adequate?				*Are the plan's policies on access to non-formulary drugs adequate?*			
	Mean (SD)	*Adequate*	*Not Adequate*	*Base N for 100%*	*Mean (SD)*	*Adequate*	*Not Adequate*	*Base N for 100%*
APIPA	2.77 (0.99)	64%	36%	255	2.35 (1.06)	46%	54%	252
Care 1st	2.84 (1.05)	65%	35%	104	2.51 (1.16)	52%	48%	100
PHP/CC	2.58 (0.96)	51%	49%	77	2.32 (0.98)	38%	62%	71
HC AZ	2.72 (1.11)	58%	42%	103	2.41 (1.15)	44%	56%	102
MHP	2.76 (1.15)	64%	36%	70	2.44 (1.07)	51%	49%	68
MCP	3.03 (1.09)	70%	30%	278	2.61 (1.16)	51%	49%	272
PHS	2.23 (1.19)	41%	59%	74	2.31 (1.29)	39%	61%	72
UFC	2.81 (1.14)	58%	42%	43	2.48 (1.09)	55%	45%	42
TOTAL	2.79 (1.08)	62%	38%	1,004	2.45 (1.12)	48%	52%	979

Note: *SD* = Standard Deviation

Note: Survey respondents were asked to rate their experience on a scale from 1 to 5 with 1 being "completely inadequate" and 5 being "completely adequate." For purposes of this table comparison, neutral answers of 3 are not shown. Scores of 1, 2 = Not Adequate, 4, 5 = Adequate.

Table A17. Specialists – Adequacy of Formulary

	Is the health plan's formulary adequate?				*Are the plan's policies on access to non-formulary drugs adequate?*			
	Mean (SD)	*Adequate*	*Not Adequate*	*Base N for 100%*	*Mean (SD)*	*Adequate*	*Not Adequate*	*Base N for 100%*
APIPA	2.91 (1.03)	65%	35%	310	2.56 (1.10)	53%	47%	272
Care 1st	3.06 (1.12)	71%	29%	126	2.55 (1.09)	54%	46%	114
PHP/CC	2.84 (1.11)	63%	37%	120	2.36 (1.11)	43%	57%	111
HC AZ	2.86 (1.14)	64%	36%	107	2.49 (1.15)	47%	53%	97
MHP	3.02 (1.04)	71%	29%	91	2.64 (1.02)	56%	44%	87
MCP	2.92 (1.07)	67%	33%	248	2.44 (1.09)	48%	52%	218
PHS	2.96 (1.10)	68%	32%	91	2.62 (1.17)	55%	45%	85
UFC	2.78 (1.11)	54%	46%	54	2.49 (1.08)	49%	51%	51
TOTAL	2.92 (1.08)	66%	34%	1,147	2.51 (1.10)	51%	49%	1,035

Note: *SD* = Standard Deviation

Note: Survey respondents were asked to rate their experience on a scale from 1 to 5 with 1 being "completely inadequate" and 5 being "completely adequate." For purposes of this table comparison, neutral answers of 3 are not shown. Scores of 1, 2 = Not Adequate, 4, 5 = Adequate.

Table A18. Experience with Contracting Process

	Experience with Contracting Process (PCPs)				*Experience with Contracting Process (Dental)*				*Experience with Contracting Process (Specialists)*			
	Positive	*Neutral*	*Negative*	*Base N for 100%*	*Positive*	*Neutral*	*Negative*	*Base N for 100%*	*Positive*	*Neutral*	*Negative*	*Base N for 100%*
APIPA	37%	29%	34%	218	38%	34%	27%	73	34%	37%	29%	325
Care 1st	58%	27%	15%	92	51%	32%	17%	47	47%	37%	17%	145
PHP/CC	53%	30%	17%	66	49%	34%	16%	87	43%	39%	17%	132
HC AZ	49%	28%	22%	89	54%	38%	8%	39	35%	39%	26%	115
MHP	50%	22%	28%	58	48%	38%	14%	29	30%	36%	35%	98
MCP	56%	28%	16%	225	35%	39%	26%	131	36%	45%	19%	275
PHS	51%	22%	27%	51	50%	36%	14%	28	53%	35%	13%	80
UFC	35%	31%	35%	26	57%	38%	5%	21	36%	42%	21%	33
TOTAL	49%	28%	24%	825	44%	36%	19%	455	38%	39%	23%	1,203

Note: Survey respondents were asked to rate their experience on a scale from 1 to 5 with 1 being “completely negative” and 5 being “completely positive.” Scores of 1, 2 = Negative; 3 = Neutral; 4, 5 = Positive.

References

AHCCCS. (1999). Dentists' Assessments of Arizona's AHCCCS Program and the AHCCCS Health Plans. Phoenix, AZ.

AHCCCS. (1999). Physicians' Assessments of Arizona's AHCCCS Dental Program and the AHCCCS Health Plans. Phoenix, AZ.

AHCCCS. (2004). Arizona Health Care Cost Containment System Overview, October 1, 2003 to September 30, 2004. Phoenix, AZ. Retrieved June 13, 2006 from http://www.ahcccs.state.az.us/Publications/overview/2004/AHCCCSOverview_2004.pdf.

AHCCCS. (2006). Pharmacy Discount Program. Retrieved June 19, 2006 from http://www.ahcccs.state.az.us/Service/Programs/PharmacyDiscount.asp.

Draper, D.A., Hurley, R.E., & Short, A.C. (2004). Medicaid Managed Care: The Last Bastion of the HMO? *Health Affairs, 23*(2), 155-167.

ICR. (2006). The Arizona State University/Arizona Health Care Cost Containment System 2006 AHCCCS Survey Methodology Report. Media, PA.

Landon, B.E., Reschovsky, J.D., & Blumenthal, D. (2004). Physician's Views of Formularies: Implications for Medicare Drug Benefit Design. *Health Affairs, 23*(1), 218-226.