Institute for Child Health Policy at the University of Florida
Texas External Quality Review Organization

Texas Medicaid Managed Care and the Children's Health Insurance Program

Physical Health Provider Office Survey

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Executive Summary

The fiscal year 2008 Annual Physical Health Provider Office Survey Report summarizes the results of the surveys of physical health-care providers participating in certain Texas Medicaid managed care programs and the Children's Health Insurance Program (CHIP) in 2008. The Institute for Child Health Policy (ICHP), the external quality review organization for Texas Medicaid and CHIP, conducted the surveys of providers participating in STAR, STAR+PLUS, and CHIP to assess managed care organization (MCO) compliance with specific requirements for Texas Medicaid and CHIP, as defined by HHSC. The 2008 surveys included all MCOs participating in STAR, STAR+PLUS, and CHIP as of April 1, 2008. CHIP dental provider survey results were submitted to HHSC in a separate report.

The report includes findings from several different quality "domains," or subject areas. Overall, providers participating in STAR, STAR+PLUS, and CHIP indicated satisfaction with serving as a participating provider. Specifically, providers indicated high satisfaction (70 percent or higher) in the following areas:

- Timely authorizations or prior authorization as needed.
- Care coordination participation.
- Opportunity to participate in disease management programs.
- Courteous and knowledgeable provider hotline staff.

While comparatively high performance was achieved for many measures, there were several areas where improvement could be made, such as communication with providers and sharing of emergency room visit information. Specifically, providers participating in STAR, STAR+PLUS, and CHIP indicated low satisfaction (less than 60 percent) in the following areas:

- Documentation of the behavioral health/mental health services provided to patients outside the office.
- Notification when patients are treated in a hospital emergency room.
- Documentation of the care provided to patients in a hospital emergency room.

Additionally, it should be noted that with a nine percent response rate to the mailed surveys, the ability to analyze and compare provider responses by MCO and service area is substantially limited. Low response rates may be attributed in part to the landfall of Hurricane Ike, incorrect or incomplete addresses, and multiple survey sets sent to the same provider office. The reader is cautioned regarding the strength of the comparison, due to the low response rates.

Based on the fact that the low response rates reduce the ability to rely on the survey results for making program improvements, HHSC staff intends to take the following actions to improve survey response rates:

1. Send a single survey tool to each provider sampled, rather than one survey tool to the provider and one to the office manager, which clearly identifies items that can be addressed by any staff and items that must be addressed by the provider.
2. Revise the survey tool to apply to both primary care physicians and specialists to ensure specialists see the tool as applicable.
3. Identify those providers who participate in multiple programs and/or with multiple MCOs and ensure they receive no more than two separate surveys to reduce the response burden on individual providers and offices.
4. Increase the number of weeks the provider has to reply from four to five weeks, and mail a reminder postcard of the impending deadline at the beginning of the fourth week.
5. Encourage the MCOs, through the designated HHSC staff, to communicate to their contracted providers the importance of assisting with quality improvement efforts such as provider satisfaction surveys.

In summary, the report highlights many areas of excellent or satisfactory performance. However, it also points to areas where performance needs to improve. For these areas, HHSC is establishing a plan to investigate the reasons for less than satisfactory performance and to work with MCOs to address those factors that will foster better performance in the future.

Introduction

This report summarizes the results of the surveys of physical health providers participating in Texas Medicaid managed care programs and the Children's Health Insurance Program (CHIP) in 2008. The Institute for Child Health Policy (ICHP) as the External Quality Review Organization (EQRO) for Texas Medicaid and CHIP conducted the surveys on behalf of the Texas Health and Human Services Commission (HHSC).

Provider office surveys were conducted to assess managed care organizations' (MCOs') compliance with specific requirements for Medicaid and CHIP as defined by HHSC. The 2008 surveys included all MCOs participating in STAR, STAR+PLUS, CHIP, and the CHIP Exclusive Provider Organization (EPO), as of April 1, 2008. Providers in the CHIP Dental network were also surveyed. The results of the dental surveys were submitted to HHSC in a separate report.

This assessment of MCO compliance was previously conducted by phone contact and reported annually as "Spot Checks." The calls used a review of specific scenarios to evaluate the MCOs' effectiveness in educating or otherwise supplying the provider with the information needed to comply with specific requirements in the care of Medicaid and/or CHIP enrollees. Due to the intensive nature of the

telephonic data collection technique, a limited number of providers were contacted annually. ICHP proposed use of a mailed survey tool to increase the sample size and response rates by MCO.

Methods

ICHP submitted a proposed scannable data collection tool that could be mailed to the providers' offices for completion by the provider or office manager. HHSC requested a tool be developed to collect data from both the office manager and provider. HHSC further requested the inclusion of several specific items to address areas of emphasis in MCO – provider relations.

Researchers sampled from each MCO's provider network for each line of business in which the MCO participated. Primary Care Providers (PCPs) and Specialist Providers were the focus for the 2008 study. ICHP used P92 and P94 (STAR and STAR+PLUS) and A020 (CHIP) individual MCO directories for sampling and determined provider status using Provider Type and Provider Specialty codes. **Tables 1** and **2** indicate the types and specialty codes deemed eligible for the survey. Sampling was done by MCO plan code to ensure a representative random sample of providers from all service areas in each MCO.

Table 1. STAR, STAR+PLUS, and CHIP Included Provider Type

Medicaid Provider Type Value	Medicaid Provider Type Description	A020 CHIP Provider Type Value	A020 CHIP Provider Type Description
10	Advanced Practice Nurse (APN)	10	FNP, PNP
19	Physician (DO)	19	Physician (DO)
20	Physician (MD)	20	Physician (MD)
21	Physician (DO Group)	21	Physician (DO Group)
22	Physician (MD Group)	22	Physician (MD Group)
46	Federally Qualified Health Centers (FQHC)	46	Federally Qualified Health Centers (FQHC)
78	Rural Health Clinic – Free Standing/Independent (RHC)	78	Rural Health Clinic –Independent (RHC)

Table 2. STAR, STAR+PLUS, and CHIP Included Provider Specialty

TMHP Value	TMHP Description – Values for STAR and STAR+PLUS	A020 CHIP Value	A020 CHIP Description
08	Family Practice/General Practice	08	Family Practice/General Practice

11	Internal Medicine	11	Internal Medicine
15	OB/GYN (DO)	15	OB/GYN (DO)
16	OB/GYN (MD)	16	OB/GYN (MD)
37	Pediatrics	37	Pediatrics
38	Geriatrics		
77	Rural Health Clinic (Independent)	77	Rural Health Clinic
85	Rural Health Clinic (Provider)		

Table 3 indicates the number of target surveys by program, the number of surveys mailed out, the number of completed surveys received, and the number of surveys returned undelivered. Response rate was calculated as the number of surveys completed divided by the number of surveys mailed minus the number of surveys returned undelivered. Appendix A presents the same information for each MCO in the three programs.

Table 3. Target Samples and Response Rates by Program and State-Wide

	Target Sample	Number Mailed	Number Completed	Number Undelivered	Response Rate (%)
STAR	1,111	2,181	176	20	8.1
CHIP	1,313	3,093	309	133	10.4
STAR+PLUS	354	748	47	3	6.3
STATE-WIDE	2,778	6,022	532	156	9.1

The surveys were conducted by mail between August and October 2008. Each provider in the sample received two different surveys, one for the provider himself/herself and one for the provider's office manager or most knowledgeable staff, along with instructions and a stamped return envelope. Some questions were identical between the two surveys and some questions were unique for each survey. The provider survey contained 25 close-ended items, while the office manager survey contained 21 close-ended questions. Respondents were asked to select the response that most closely related to their experience with the specified health plan. Respondents also had the opportunity to write comments at the end of the survey. Those comments are provided in Appendix C.

Providers and office staff initially were given four weeks to complete and return the surveys. ICHP staff called a great number of non-respondent offices for approximately three weeks, reminding them to return their surveys. Given the poor response rates, the researchers extended the data collection deadline by another month.

Results

Over 34 percent of responses across the entire physical health survey sample were from providers who were not PCPs. Of PCP responses across all programs, the most frequently reported provider specialty was Pediatrics. **Table 4** indicates the number and percent of provider specialties.

Table 4. Provider Specialty Reported

Specialty	# Responses (% of Total w/in Program)			
	STAR	**CHIP**	**STAR+PLUS**	**Total**
THSteps/EPSDT	33 (18.8%)	69 (22.7%)	5 (10.9%)	107
Pediatrics	46 (26.1%)	91 (29.9%)	9 (19.6%)	146
Family Practice	21 (11.9%)	56 (18.4%)	8 (17.4%)	85
General Practice	9 (5.1%)	11 (3.6%)	0 (0.0%)	20
OB/GYN	41 (23.3%)	39 (12.8%)	8 (17.4%)	88
Internal Medicine	8 (4.5%)	22 (7.2%)	2 (4.3%)	32
Geriatrics	3 (1.7%)	5 (1.6%)	1 (2.2%)	9
Other	68 (38.6%)	91 (29.9%)	22 (47.8%)	181
Total	**176**	**304**	**46**	**526**

The majority of providers responding across all programs state-wide reported they were in single provider practices, with the next most frequent practice type noted to be group practice. However, STAR+PLUS responses indicated more clinic practices than group practices. **Table 5** presents the distribution of responses.

Table 5. Provider Practice Type Reported

Practice Type	# Responses (% of Total w/in Program)			
	STAR	**CHIP**	**STAR+PLUS**	**Total**
Individual	97 (51.9%)	158 (45.9%)	37 (68.5%)	292

Group	66 (35.3%)	124 (36.0%)	8 (14.8%)	198
Clinic	24 (12.8%)	62 (18.0%)	9 (16.7%)	95
Total	**187**	**344**	**54**	**585**

Overall, 35 percent of respondents indicated they used physician extenders in the practice, with Nurse Practitioners being the most utilized. CHIP had the highest use of extenders at 37 percent while STAR+PLUS had the lowest at 23 percent. **Table 6** presents the extender use by program.

Table 6. Physician Extender Use Reported

Physician Extender	# Responses (% of Total w/in Program)			
	STAR	**CHIP**	**STAR+PLUS**	**Total**
Nurse Practitioner	37 (60.7%)	68 (59.6%)	7 (63.6%)	112
Nurse Midwife	4 (6.6%)	1 (0.9%)	0 (0.0%)	5
Physician Assistant	20 (32.8%)	45 (39.5%)	4 (36.4%)	69
Total	**61**	**114**	**11**	**186**

Forty-six percent of respondents reported participating in the Medicaid Managed Care or CHIP MCO for five or more years. **Table 7** presents the years participating by program and state-wide.

Table 7. Length of Time in Network Reported

Time in Network	# Responses (% of Total w/in Program)			
	STAR	**CHIP**	**STAR+PLUS**	**Total**
1 year or less	13 (9.0%)	28 (11.0%)	3 (8.6%)	44
2 to 3 years	45 (31.2%)	63 (24.7%)	14 (40.0%)	122
4 to 5 years	22 (15.3%)	44 (17.3%)	4 (11.4%)	70
5+ years	64 (44.4%)	120 (47.1%)	14 (40.0%)	198
Total	**144**	**255**	**35**	**434**

Due to the low response rate it is not possible to analyze provider responses by MCO. Results for each of the three programs evaluated are provided in Appendix A. Findings for each program are discussed below followed by a brief comparison of results across programs. The reader is cautioned regarding the strength of the comparison, due to the low response rates.

Provider Responses to Specific Queries - STAR

Eighty-four percent of the STAR providers responding indicated they were satisfied as a participating provider in the STAR MCO they were evaluating in the survey. There were four survey questions, however, where less than 60 percent of respondents stated agreement:

- The health plan provides me with information related to inappropriate use of the emergency room by my patients. (58%)
- I receive documentation of the BH/MH services provided to my patients outside of my office setting. (54%)
- I receive notification when my patients are treated in a hospital Emergency Department. (48%)
- I receive documentation of the care provided to my patients in the Emergency Department. (47%)

Provider Responses to Specific Queries - CHIP

Eighty percent of the CHIP providers responding indicated they were satisfied as a participating provider in the CHIP MCO they were evaluating in the survey. There were four survey questions, however, where less than 60 percent of respondents stated agreement:

- The health plan provides me with information related to inappropriate use of the emergency room by my patients. (55%)
- I receive documentation of the BH/MH services provided to my patients outside of my office setting. (45%)
- I receive notification when my patients are treated in a hospital Emergency Department. (42%)
- I receive documentation of the care provided to my patients in the Emergency Department. (38%)

Provider Responses to Specific Queries – STAR+PLUS

Sixty-four percent of the STAR+PLUS providers responding indicated they were satisfied as a participating provider in the STAR+PLUS MCO they were evaluating in the survey. There were four survey questions, however, where less than 60 percent of respondents stated agreement:

- I am given opportunities to provide feedback to the health plan to improve the quality of care for my patients and specialty. (55%)
- I receive notification when my patients are treated in a hospital Emergency Department. (48%)
- I receive documentation of the care provided to my patients in the Emergency Department. (43%)
- I receive documentation of the BH/MH services provided to my patients outside of my office setting. (21%)

Provider Responses to Specific Queries – Program Comparison

Three of the four queries receiving less than 60 percent agreement for STAR and CHIP were related to the MCOs' communications regarding member use of emergency room services. STAR+PLUS providers also rated two of the emergency room use items at less than 60 percent agreement. These communications are important elements in involving the providers to ensure their patients have access

to care in the appropriate setting. Providers participating in all three programs indicated less than 60 percent agreement with the statement that they received documentation of BH/MH services rendered by other providers. This finding is of concern because this communication between the PCP and other providers of BH/MH care can be important in ensuring continuity of care.

Overall, STAR+PLUS providers were the only ones to indicate less than 60 percent agreement with the statement about being provided opportunities to provided feedback to the MCO to improve quality of care. However, this was also scored lower than most other statements in STAR and CHIP, as those providers agreed with this statement only 62 percent of the time. MCOs are required in their contracts to involve participating providers in specific activities, including quality improvement efforts. Some of this involvement is mandatory, such as ensuring the MCO has access to medical records for quality review. The survey finding would suggest, however, that many providers do not feel their input is used in these improvement processes.

Summary and Recommendations

With nine percent responses to mailed surveys, the ability to analyze and compare provider responses by MCO and service area is substantially limited. Efforts to improve response rates, specifically phone calls to provider offices, revealed many offices had not received the initial mailing. Some of these difficulties in the Harris service area were attributed to Hurricane Ike, which made landfall September 13, in the middle of the survey time period. However, others appeared to be related to incorrect or incomplete addresses. This latter issue raises concern with the accuracy of the MCO provider files.

Response rates may have also been affected because each provider office received two companion surveys, one for the provider and one for the office manager. In addition, as sampling was done by MCO, some provider offices received multiple survey sets if the provider participated in more than one state program and/or MCO. This could have been perceived as overly burdensome or confusing to the involved provider office staff or they simply may have felt the surveys required too much time to complete.

Following preliminary discussion of findings with HHSC, ICHP is recommending the following survey changes to improve processes and, hopefully, response rates:

6. Send a single survey tool to each provider sampled, clearly identifying items that can be addressed by any staff and those where the provider's response is required.
7. Revise the survey tool to apply to both PCPs and specialists and to ensure specialists see the tool as applicable.
8. Identify those providers who do participate in multiple programs and/or with multiple MCOs and ensure they receive no more than two separate surveys to reduce the response burden on individual providers and offices.
9. Increase the number of weeks from mailing to response deadline from four to five weeks and mail a reminder postcard of the impending deadline at the beginning of the fourth week.

10. Encourage the MCOs, through their HHSC-designated Health Plan Managers, to communicate to their contracted providers the importance of assisting with quality improvement efforts such as satisfaction surveys.

Even though it was not possible to compare MCOs due to the low response rates, ICHP recommends that HHSC share the general findings by program for STAR and CHIP with the participating MCOs, with particular emphasis on the need to communicate with providers regarding their assigned patients' use of emergency room services and the need to ensure increased communication between BH/MH providers and PCPs. It is not recommended that HHSC share the STAR+PLUS results due to the extremely low response rate.

Appendix A: Target Samples and Response Rates by Program and MCO

	Target Sample	Number Mailed	Number Completed	Number Undelivered	Response Rate (%)
STAR					
Aetna	83	176	16	2	9.2
AMERIGROUP	91	226	24	-	10.6
Community First	79	167	11	1	6.6
Community Health Choice	92	160	12	2	7.6
Cook Children's	73	147	8	2	5.5
Driscoll	67	126	23	4	18.9
El Paso First	65	163	15	2	9.3
FirstCare	69	157	12	2	7.7
Molina	87	155	9	2	5.9
Parkland Community	80	99	9	1	9.2
Superior	92	202	11	2	5.5
Texas Children's	87	127	6	-	4.7
UniCare	60	125	14	-	11.2
United Healthcare	86	151	6	-	4.0
Total	**1,111**	**2,181**	**176**	**20**	**8.1**
CHIP					
Aetna	82	206	26	15	13.6
AMERIGROUP	91	228	27	23	13.2
Community First	77	127	18	5	14.8
Community Health Choice	89	177	15	12	9.1

Cook Children's	73	184	25	8	14.2
Driscoll	67	155	19	16	13.7
El Paso First	67	149	15	28	12.4
FirstCare	64	159	19	-	12.0
Mercy	47	118	8	3	7.0
Molina	82	205	20	-	9.8
Parkland Community	74	185	12	-	6.5
Seton	82	205	16	1	7.9
Superior	92	233	27	16	12.4
Superior EPO	93	236	16	2	6.8
Texas Children's	88	220	26	-	11.8
UniCare	59	137	7	1	5.1
United Healthcare	86	169	13	3	7.8
Total	**1,313**	**3,093**	**309**	**133**	**10.4**
STAR+PLUS					
AMERIGROUP	91	225	18	2	8.1
Evercare	90	172	1	1	0.6
Molina	86	174	16	-	9.2
Superior	87	177	12	-	6.8
Total	**354**	**748**	**47**	**3**	**6.3**

Appendix B: Provider Responses to Specific Queries by Program

Table B1. Provider Responses to Specific Queries - STAR

1 & 2: Reported as number/percent of applicable/known responses that agree or disagree (excludes "Don't Know" and "Not Applicable" from denominator).

Statement	1 - Agree	2 - Disagree
1. The health plan provides me with information related to:		
• disease management program(s) available for my patients	84 (80.8%)	20 (19.2%)
• changes in clinical practice guidelines, protocols, or medical policy	99 (78.0%)	28 (22.0%)
• THSteps periodicity schedules.	78 (83.0%)	16 (17.0%)
• program changes	98 (83.8%)	19 (16.2%)
• timeliness of setting appointments for THSteps and other services	68 (84.0%)	13 (16.0%)
• case management services available for my patients	82 (74.5%)	28 (25.5%)
• inappropriate use of the emergency room by my patients	50 (58.1%)	36 (41.9%)
2. I receive timely authorizations or prior authorization when needed.	125 (84.5%)	23 (15.5%)
3. My claims are paid accurately.	112 (78.9%)	30 (21.1%)
4. My claims are paid timely.	102 (73.9%)	36 (26.1%)
5. I receive documentation of the BH/MH services provided to my patients outside of my office setting.	42 (53.8%)	36 (46.2%)
6. I receive notification when my patients are treated in a hospital Emergency Department.	56 (47.9%)	61 (52.1%)
7. I receive documentation of the care provided to my patients in the Emergency Department.	55 (46.6%)	63 (53.4%)
8. I participate in care coordination for my patients.	103 (86.6%)	16 (13.4%)
9. My patients are given opportunities to participate in disease management programs if needed.	73 (88.0%)	10 (12.0%)
10. The provider hotline staff and provider representatives with this health plan are knowledgeable and courteous.	87 (84.5%)	16 (15.5%)
11. In the past year, I have needed information which the health plan could not/did not provide.	37 (39.4%)	57 (60.6%)
12. I am given opportunities to provide feedback to the health plan to improve the quality of care for my patients and specialty.	68 (61.8%)	42 (38.2%)
13. I have had at least one visit from a provider representative since joining this health plan's network.	90 (69.8%)	39 (30.2%)
14. Overall, I am satisfied as a participating provider in this health plan.	117 (83.6%)	23 (16.4%)

Table B2. Provider Responses to Specific Queries - CHIP

1 & 2: Reported as number/percent of applicable/known responses that agree or disagree (excludes "Don't Know" and "Not Applicable" from denominator).

Statement	1 - Agree	2 - Disagree
1. The health plan provides me with information related to:		
• disease management program(s) available for my patients	129 (71.3%)	52 (28.7%)
• changes in clinical practice guidelines, protocols, or medical policy	151 (72.9%)	56 (27.1%)
• THSteps periodicity schedules.	149 (79.7%)	38 (20.3%)
• program changes	187 (82.0%)	41 (18.0%)
• timeliness of setting appointments for THSteps and other services	132 (72.9%)	49 (27.1%)
• case management services available for my patients	137 (71.7%)	54 (28.3%)
• inappropriate use of the emergency room by my patients	88 (54.7%)	73 (45.3%)
2. I receive timely authorizations or prior authorization when needed.	198 (78.3%)	55 (21.7%)
3. My claims are paid accurately.	176 (73.3%)	64 (26.7%)
4. My claims are paid timely.	171 (73.4%)	62 (26.6%)
5. I receive documentation of the BH/MH services provided to my patients outside of my office setting.	64 (45.1%)	78 (54.9%)
6. I receive notification when my patients are treated in a hospital Emergency Department.	87 (41.6%)	122 (58.4%)
7. I receive documentation of the care provided to my patients in the Emergency Department.	82 (37.8%)	135 (62.2%)
8. I participate in care coordination for my patients.	204 (87.9%)	28 (12.1%)
9. My patients are given opportunities to participate in disease management programs if needed.	147 (87.5%)	21 (12.5%)
10. The provider hotline staff and provider representatives with this health plan are knowledgeable and courteous.	139 (81.8%)	31 (18.2%)
11. In the past year, I have needed information which the health plan could not/did not provide.	65 (39.4%)	100 (60.6%)
12. I am given opportunities to provide feedback to the health plan to improve the quality of care for my patients and specialty.	116 (62.0%)	71 (38.0%)
13. I have had at least one visit from a provider representative since joining this health plan's network.	164 (70.7%)	68 (29.3%)
14. Overall, I am satisfied as a participating provider in this health plan.	204 (79.7%)	52 (20.3%)

Table B3. Provider Responses to Specific Queries – STAR+PLUS

1 & 2: Reported as number/percent of applicable/known responses that agree or disagree (excludes "Don't Know" and "Not Applicable" from denominator).

Statement	1 - Agree	2 - Disagree
1. The health plan provides me with information related to:		
• disease management program(s) available for my patients	20 (64.5%)	11 (35.5%)
• changes in clinical practice guidelines, protocols, or medical policy	25 (71.4%)	10 (28.6%)
• THSteps periodicity schedules.	17 (68.0%)	8 (32.0%)
• program changes	26 (70.3%)	11 (29.7%)
• timeliness of setting appointments for THSteps and other services	21 (65.6%)	11 (34.4%)
• case management services available for my patients	25 (69.4%)	11 (30.6%)
• inappropriate use of the emergency room by my patients	16 (61.5%)	10 (38.5%)
2. I receive timely authorizations or prior authorization when needed.	30 (73.2%)	11 (26.8%)
3. My claims are paid accurately.	25 (61.0%)	16 (39.0%)
4. My claims are paid timely.	25 (62.5%)	15 (37.5%)
5. I receive documentation of the BH/MH services provided to my patients outside of my office setting.	5 (20.8%)	19 (79.2%)
6. I receive notification when my patients are treated in a hospital Emergency Department.	15 (48.4%)	16 (51.6%)
7. I receive documentation of the care provided to my patients in the Emergency Department.	13 (43.3%)	17 (56.7%)
8. I participate in care coordination for my patients.	26 (81.2%)	6 (18.8%)
9. My patients are given opportunities to participate in disease management programs if needed.	18 (75.0%)	6 (25.0%)
10. The provider hotline staff and provider representatives with this health plan are knowledgeable and courteous.	22 (73.3%)	8 (26.7%)
11. In the past year, I have needed information which the health plan could not/did not provide.	12 (36.4%)	21 (63.6%)
12. I am given opportunities to provide feedback to the health plan to improve the quality of care for my patients and specialty.	18 (54.5%)	15 (45.5%)
13. I have had at least one visit from a provider representative since joining this health plan's network.	25 (62.5%)	15 (37.5%)
14. Overall, I am satisfied as a participating provider in this health plan.	28 (63.6%)	16 (36.4%)

Appendix C: Provider and Staff Comments to Survey

Health Plan Code	Health Plan Name	Study ID	Respondent	Comment
49	Aetna-CHIP	03087	Mgr	I love Francis. I think she does a great job. If I leave her a message she always manages to resolve my issue.
49	Aetna-CHIP	03109	Prov	One time I wasn't paid for a circumcision because the baby (boy) was named "Morgan" and they said it was a girl's name.
49	Aetna-CHIP	03116	Prov	No questions regarding timeliness of reimbursements.
6B	Aetna-CHIP	04235	Mgr	We have multiple issues regarding filing. Changes to filing requirements not notified. We find out when we receive rejections. We spend hours doing, redoing and redoing again to get claims filed. We follow instructions over and over but so far results have not been positive. I have never seen a rep from Medicaid.
6B	Aetna-CHIP	04268	Mgr	Why can't the insurance be "Universal" so the providers don't have to jump through "hoops" for each insurance??
6B	Aetna-CHIP	04289	Prov	It's not for the best interest of the patient if they hop from one provider to another for their convenience. Often times I get new patients (but established patients of another provider) because they could not get an immediate appt with their doctor.
6B	Aetna-CHIP	04298	Mgr	The referral authorization process is the slowest of any other CHIP program and it is sometimes difficult to find doctors who take the insurance.

Health Plan Code	Health Plan Name	Study ID	Respondent	Comment
6B	Aetna-CHIP	4365	Mgr	We are not on the Aetna Chip network but occasionally need to bill for hospital services. Because we are not on the network they pay us less! This is NOT right as Medicaid fee schedules are already low and to be penalized for not participating is wrong. We are already on 2 CHIP plans and cannot manage being on another one. We should be paid the Medicaid fee schedule regardless if we are on the network or not!
67	Aetna-STAR	20806	Prov	Reimbursement too low. Too difficult to collect unpaid claims.
67	Aetna-STAR	21018	Prov	Only see maybe 1 referral per month for subspecialty (pediatric cardiac) evaluation.
67	Aetna-STAR	21149	Mgr	We never see any provider reps in our office.
84	AMERIGROUP-CHIP	06139	Mgr	Obtaining referrals is horrendous. Patients continually comment on how difficult it is to find doctors in their area in their network.
84	AMERIGROUP-CHIP	06139	Prov	It's worse than you can imagine. Nightmare comes to mind.
84	AMERIGROUP-CHIP	06200	Prov	There should be somebody who will let us know once a month for [illegible] particularly Billing/Claims.
7N	AMERIGROUP-CHIP	04837	Prov	The time to speak with a representative is longer than 7 minutes & even longer.
7N	AMERIGROUP-CHIP	04874	Prov	The reimbursement for Anesthesiologists is grossly out of touch with the quality of the professional care rendered to the patients.
7N	AMERIGROUP-CHIP	04904	Prov	I rarely (almost never) see patients on this plan.
7N	AMERIGROUP-CHIP	04905	Prov	Claims are never accurate reimbursements.

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9A	AMERIGROUP-CHIP	06327	Mgr	This is for all CHIP Plans - We have received different information from people versus written information. This is crazy to have these plans request different information than TMHP has. This is a State Plan.
9A	AMERIGROUP-CHIP	06337	Mgr	It would be great to get notice of ER use.
9A	AMERIGROUP-CHIP	06373	Prov	Well, they still have me under my previous TAX ID & Pin # from 3 years ago despite innumerable calls to change. They seem very disorganized to me. Rather frustrating exercise trying to get hold of anybody who knows anything.
63	AMERIGROUP-STAR	20017	Prov	Amerigroup's failure to follow the NPI only needed for billing has created issues across the board. Requiring tax money for billing does what for Amerigroup? It has made it difficult for billing purposes.
63	AMERIGROUP-STAR	20112	Prov	We only see OB patients.
63	AMERIGROUP-STAR	20213	Mgr	Claims - need improved management.
63	AMERIGROUP-STAR	20213	Prov	Service has improved but has continued to need much attention.
71	AMERIGROUP-STAR	20064	Mgr	It is very hard for our office staff to find a specialist of any kind that works with Amerigroup and when we do find one the appt isn't given until 2 or 3 months.
71	AMERIGROUP-STAR	20067	Prov	I need service for children obesity & nutrition problems. Amerigroup has none.
71	AMERIGROUP-STAR	20120	Prov	Claims should be paid in a timely manner.
71	AMERIGROUP-STAR	20242	Prov	Texas Medicaid has a pre-authorized medication list and providers must call for prescription meds not on the PA list. The list is incomplete (ex. Augmentin not

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				covered at 200mg strength, but covered at 400 mg per PA) which inhibits patient care.
19	AMERIGROUP-STAR+PLUS	10448	Prov	Limited specialists - my staff is told to look for specialists to contract with.
19	AMERIGROUP-STAR+PLUS	10616	Mgr	Amerigroup has my provider setup in their system 3 different ways. We have been working with our provider relations rep to get their internal error fixed. With my provider setup 3 different ways it causes claims to not be paid or paid incorrectly. Also does not allow new patients to choose as PCP. This all depends on which customer service representative they speak with. This has been an ongoing issue for 9 months as of today. We believe in offering our patients a choice of Medicaid managed care plans, but if we continue to get no resolution to these ongoing problems we will have no choice but to stop taking the plan.
54	AMERIGROUP-STAR+PLUS	10472	Prov	We have very few Amerigroup STAR+PLUS patients.
54	AMERIGROUP-STAR+PLUS	10521	Mgr	Issues are often encountered. One is resolved and another is on the horizon. Efforts to resolve issues are endless.
54	AMERIGROUP-STAR+PLUS	10547	Mgr	We are having trouble with prior authorizations. We are unable to contact our provider Rep.
54	AMERIGROUP-STAR+PLUS	10666	Mgr	Supervisors, Rep are not being helpful; they don't know much about anything else besides we got it from the website.
19	AMERIGROUP-STAR+PLUS	10587	Mgr	Need more Specialists to be in network; like orthopedic doctors.
03	Community First-CHIP	00423	Mgr	It is difficult to determine exact rules for ER patients referred to our specialty office. Do patients need referrals from PCP? If so, why isn't the ER informing the patients

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				prior to calling our office?
03	Community First-CHIP	00423	Prov	As a specialist it would help to know specifics in ER abuse or overrun and how to manage patients.
03	Community First-CHIP	00588	Mgr	Our physicians are hospitalists and do not have regular clinical visits. Hospital only patient adult care.
03	Community First-CHIP	00739	Prov	Absolutely minimal specialist availability resulting in patients being sent to ER. This is done as per advice of MCO. Four months waiting time for derma consult. No pediatric gastroenterologist to refer to in San Antonio, TX. MCO advice – send them to Austin, Corpus Christy or McAllen, TX. This is very poor quality service & increased liability.
03	Community First-CHIP	00754	Prov	It would be nice not to need an authorization for eye exams for medical problems. Patients who have problems really don't worry about getting authorizations. They first call for appointments and then we have to initiate authorizations because they don't know they have to have one.
7Y	Community Health Choice-CHIP	05738	Prov	There is no way for us to know when Chip patients are eligible for services. We have had major problems with our claims being paid accurately. The provider hotline staff and provider reps are very unfamiliar with N.P. (Nurse Practitioner) practices. Big problem finding Specialist to see CHC patients- all cannot drive to Houston or Galveston.
7Y	Community Health Choice-CHIP	05744	Mgr	Very difficult to contact provider Rep. Phone calls are not answered, especially when we have to refer a patient to a specialist.

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7Y	Community Health Choice-CHIP	05744	Prov	Very difficult to contact Provider Rep. Phone calls are not in a timely manner. Only
7Y	Community Health Choice-CHIP	05894	Prov	We've never seen our Rep in our office. Phone reps are nice enough, but sometimes seem put off to have to answer questions.
79	Community Health Choice-STAR	21609	Mgr	We have not had a visit from our Community Health Rep in over 2 years.
79	Community Health Choice-STAR	21723	Prov	The professionalism of some of the upper level management team is severely deficient and affects my desire to continue providing care under this plan.
04	Cook Children's-CHIP	00859	Mgr	Our only complaint is that when we call to inquire about a claim we are limited to only two claims per call. Which we understand more can be time consuming but when all claims are regarding the same patient it is extremely frustrating to have to hang up and call again sometimes only for a third claim. Other than this we are satisfied.
04	Cook Children's-CHIP	00915	Prov	There seem to be some payment issues and lots of denials.
04	Cook Children's-CHIP	00945	Mgr	We are contracted with Cook Children Health Plan. We are not contracted with and do not see children from Cooks CHIP-STAR plan.
04	Cook Children's-CHIP	00950	Prov	It would be much more efficient if we didn't have to pre-auth certain things. If we are a preferred provider and probably the only one, it would make sense to make things sufficient.
04	Cook Children's-CHIP	00957	Mgr	Cooks is great. We appreciate their support.

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04	Cook Children's-CHIP	01038	Prov	The Health Plan failed to provide participation of specialist in some areas.
04	Cook Children's-CHIP	01043	Mgr	We have several unpaid claims that date back to July 2007. I have put in several hours trying to get these resolved. Have worked with your claims dept. which cannot ever answer any questions as to why still unpaid. Finally got our Rep involved and now it has been another 3 months and they are still NOT paid. When I spoke with the claims department, I would ask for a supervisor but was never allowed to. I was always told she was in a meeting and would return my call. I still have not received a call from her!! It is August 28.
66	Cook Children's-STAR	22044	Prov	Thank you for always helping the office with any issues we have with insurance or patient care; and for having representatives that come to the office to see if we need anything or to help with a problem.
05	Driscoll-CHIP	01227	Prov	My patients have problems renewing their plan when it elapses.
05	Driscoll-CHIP	01389	Prov	Prior authorization process is too long and I have nothing to steer me in the right direction as to what needs to be met for authorizations. I have not received any info from your plan re: THSteps.
05	Driscoll-CHIP	01423	Mgr	I wish CHIP had their own network of doctors where we do not have to get authorization of all physicians are capped. What are we going to accomplish by wasting time for authorization? (Doctor is going to make same revenue.) All CHIP providers bound to see CHIP patients regardless of medical problems.
05	Driscoll-CHIP	01423	Prov	CHIP program must consider paying separate charges for hospitalization, so CHIP client gets justification. Lots of physicians do not want to treat 7 days for 815 dollars. Please start paying for extensive work.

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82	Driscoll-STAR	27812	Mgr	When calling for claim status the representatives are very nice and helpful.
82	Driscoll-STAR	27812	Prov	Although it has room for improvement DCHP plan is far better than other plans I am enrolled with for Medicaid. However, there is a lot needs to happen better.
82	Driscoll-STAR	27818	Mgr	Please educate the participants in this health plan. Most do not understand how the plan works. We have a lot of problems with choosing a PCP. Not bringing money for co-pays on CHIP programs. I totally disagree with giving money for transportation to an office visit. Hey they already get free insurance. Participants need to be responsible for something. Not keeping appointments.
82	Driscoll-STAR	27823	Mgr	In the past years we have had various problems, but I honestly have to say it has gotten a lot better. At this time it's been GREAT!
82	Driscoll-STAR	27849	Prov	Direct deposit was a pain and did not work.
82	Driscoll-STAR	27853	Mgr	We have not had problems with this health plan. We are very satisfied with the service. Thanks!
82	Driscoll-STAR	27855	Prov	Overall, the plan is manageable. The minor deficiencies encountered were handled in a timely manner.
82	Driscoll-STAR	27855	Mgr	1. For mistakes in our billing we were never notified about it, we found it ourselves and had it corrected. 2. On electronic payment, despite the fact that the forms were completed last year, we were not notified of some deficiencies until 8 months later. 3. Still not on electronic payment despite the reassurance that we are already on it and this was 3 months ago. So frustrating because it is affecting our working capital!!

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82	Driscoll-STAR	27864	Mgr	Clients need more education about plan.
02	El Paso First-CHIP	00034	Prov	As a provider I seldom pay any attention to the insurance carried responsible for paying my patients bills. Therefore, I cannot say whether El Paso First is better or worse than the competition. Like most providers I only wish that the Medicaid products paid a larger % of our actual charges.
37	El Paso First-STAR	22617	Mgr	I have felt that is has been difficult to work with OB case managers. I have often brought my complaints up to the medical director and the CEO. Plan not understanding car coordination between specialty facilities for diabetes management and assistance for provider referral to non network providers such as Urology, Endocrinology, and Mental Health. We have just began as participating providers for the prenatal program (CHIP) and it has been frustrating in trying to get care necessary for the benefit of the unborn child realizing that the required for mother affects the baby.
37	El Paso First-STAR	22678	Prov	There has been much improvement in the timeliness and accuracy of claims payments in the past 1-2 years.
37	El Paso First-STAR	22763	Prov	Please reimburse @ a higher rate. Also do consider increasing the panel of patients automatically assigned to NEC Pediatrics. We feel confident (humbly) that we provide quality care and will continue to do so.
06	FirstCare-CHIP	01673	Prov	We try to get our patients to participate in disease management programs but usually meet resistance from the CHIP insurance co. CHIP patients tend to be non-compliant. We have never been visited by a CHIP provider rep since we joined the CHIP program as a provider.

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06	FirstCare-CHIP	01810	Mgr	When we do not get payment on one of our lines submitted on a claim we appeal and then you pay what we appeal and take back what you paid the first time. We have to appeal multiple times to get it corrected. You start a recoup then we get a letter that says they want us to send a refund then on the next R/S we get the additional money recouped.
06	FirstCare-CHIP	01854	Mgr	Dr [name] is a Radiologist and it is hard to get authorization numbers for our patients. The hospital gets the numbers and we get the number from them. There are times when they do not get numbers.
06	FirstCare-CHIP	01883	Mgr	Dr [name], MD, P.A., does not see patients. He provides professional interpretation of medical imaging. He is not a primary physician for anyone, only receives referrals. Thank you!
50	FirstCare-STAR	23610	Mgr	We like being able to check eligibility and claim status online.
50	FirstCare-STAR	23716	Mgr	Patients that are SSI when claims have to go to TMHP are always trouble!
50	FirstCare-STAR	23780	Prov	“Clinics” send referrals for patients under the patients IP# when it needs to be for one specific physician. Appeals process is not efficient.
08	Mercy-CHIP	02028	Prov	The restriction of valved holding chambers ("spacers") to 1 dispensed per 6 months is an unreasonable restriction. (Note that this is a Medicaid ruling, not limited to this specific plan. We have very few patients under this plan.
08	Mercy-CHIP	02126	Mgr	I am happy to be seeing patients enrolled through this plan.
08	Mercy-CHIP	02126	Prov	Overall I've been happy to be of service to patients in the community in need of

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				mental health services.
7T	Molina-CHIP	05031	Mgr	You should be evaluating Texas Children's Health Plan and Americaid. We have terminated with both (not yet effective).
7T	Molina-CHIP	05083	Mgr	We have seen only one representative but has never been helpful or been able to help us with any problems. We have with Molina CHIP or Molina Medicaid. We are very disappointed with Molina.
7T	Molina-CHIP	05110	Prov	My main service is sleep disorder mgmt.
7T	Molina-CHIP	05172	Prov	We would strongly recommend adding the phone numbers of the patients that have Molina and list in the PCP Roster list. The phone numbers help us contact the patients faster.
7T	Molina-CHIP	05273	Mgr	Need more contact with Reps.
7T	Molina-CHIP	05273	Prov	Need to pay better for office visits.
7G	Molina-STAR	24847	Prov	I may drop out due to chronic and endless problems with Molina.
7G	Molina-STAR	25044	Prov	I am not satisfied with Molina. Molina cheats the doctors.
7J	Molina-STAR	24851	Mgr	Most of the time claims are paid timely and accurately. However, there have been times when claims are being denied for lack of authorization and have to be submitted several times always with proof before being paid.
46	Molina-STAR+PLUS	14455	Prov	My claims are paid accurately but it takes forever. Who is my Provider Rep? I can never get correct information. Claims address etc...

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7S	Molina-STAR+PLUS	14500	Prov	We have had several claims issues that are still unresolved. We would like periodic visits from our Rep.
9	Parkland-CHIP	02421	Prov	THSTEPS & Medicaid do things differently than all other payers, separate rules, separate electronic filing requirements & kill trees & [illegible]messages & changes so often.
09	Parkland-CHIP	02514	Mgr	We see very few patients - not accepting new enrollees unless they are already patients in our practice.
09	Parkland-CHIP	02518	Mgr	When our provider services rep changed the last time we were not notified of who the new rep was or how to contact them.
09	Parkland-CHIP	02518	Prov	I phoned program yesterday to receive a list of OB/GYN providers for a pregnant 16 year old in my practice and was told by your customer service rep to look on the web. When I told her the program was down, she said "I don't know how to help you". She ultimately got help from someone else and gave me two names of two doctors who were not on the plan.
09	Parkland-CHIP	02557	Mgr	Please update our info.
93	Parkland-STAR	25210	Mgr	Online access would make things much easier for those rare times we see your patients.
93	Parkland-STAR	25341	Prov	We receive specimens from referring physicians. Might be more accurate to have this completed by the PCP.
93	Parkland-STAR	25461	Prov	We are starting to see more UniCare patients because Parkland is so hard to get our money from that we work hard for. Our billing dept spends more time fighting

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				for our money than doing our own job.
93	Parkland-STAR	25461	Mgr	We are constantly denied for dumb reasons. For instance, we submit a C-Section and assist and they pay the assist and NOT the surgeon. If a patient receives a tubal we NEVER get it paid without a fight. We have been told to fax it with the denial but never got paid. We have to fax them to our rep. Appeals Dept is HORRIBLE! They say they never get them- we spend $5.25 on certified mail and they say they never received. I RARELY FILL SURVEYS OUT BECAUSE NOTHING EVER CHANGES!
56	Seton-CHIP	03355	Mgr	Seton staff under this program is extremely helpful always.
56	Seton-CHIP	03392	Prov	Far better than Superior Medicaid.
56	Seton-CHIP	03479	Mgr	I think Seton has done a great job. You can always talk to a person - usually a very experienced person who knows what they are talking about - always courteous, caring and professional. Any problems we've ever had are usually related to gaps in eligibility.
56	Seton-CHIP	03511	Mgr	Put your money towards better reimbursement. We can do our job without your "help".
56	Seton-CHIP	03511	Prov	Forget all the Frills. I can do my job without your "help" … put your money into better reimbursement. Otherwise, I'll drop you just like everyone else is doing.
56	Seton-CHIP	03631	Mgr	No one checks on us anymore since the one time that they came we never get accurate payment or timely consideration.
56	Seton-CHIP	03631	Prov	I would like education on submitting medical claims because it seems like we never receive payment.

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59	Superior (EPO)-CHIP	03826	Prov	My rate is never the same - sometimes it is $62.22 - others $64.00 - it's supposed to be my Medicaid rate of $73.29!
59	Superior (EPO)-CHIP	03897	Prov	Overall Superior is doing a fine job!
59	Superior (EPO)-CHIP	03997	Prov	It takes over 45 days for claims to be paid.
59	Superior (EPO)-CHIP	03999	Prov	This is a [illegible] program with no input from providers as to choice of medications used & treatment allowed.
39	Superior-CHIP	02904	Prov	Reimbursements are extremely low for Orthopedics and when calling for status they state no claim on file, and when checking claim MD claim was transmitted.
48	Superior-CHIP	02961	Prov	No Problems!
57	Superior-CHIP	03700	Prov	We do not recommend Superior Health Plan to patients. Checks sent to wrong facility.
87	Superior-CHIP	06253	Prov	Reimbursement is lousy. Coverage is lousy.
87	Superior-CHIP	06278	Mgr	Superior Health plan whether CHIP-STAR-STAR Plus takes a very long time to get reimbursed for services rendered. I have not seen a Representative since 2007. Some Specialists i.e. ENT, and Pediatric Ophthalmologist would not even want to participate as specialist providers for Superior Plan. I believe it's due to not reimbursing on time for services rendered. I am just hoping that more specialists will participate here in Corpus Christi, TX.
1B	Superior-CHIP	02860	Prov	I really don't know much about CHIP program or the insurance aspects of practicing medicine. I try to provide the best quality of health care to all my patients

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				regardless of insurance. CHIP comes into play when making formulary choices.
40	Superior-STAR	26124	Mgr	Dr [name] is a neurologist and he performs EMG and never conduction exams – when billing for services each muscle is billed separate with a modifier of 76-and-59 signifying that this is a different charge. My claims had been getting paid up until now where your provider rep informs me that all the muscles should be billed in one line with the number of units. As far as I'm concerned this has always been billed separately and this is Medicare guidelines- Please look into this problem. Thank you.
40	Superior-STAR	26315	Mgr	We are part of UT Medicine & our corporate is responsible for the billing part. We have difficulty obtaining authorizations in a timely manner. Had 1 appt that took > 10 days to obtain.
47	Superior-STAR+PLUS	15675	Mgr	When we receive referrals from PCP's they are not knowledgeable since they don't request authorization from Superior. They just write referral on a prescription pad. This is not a referral since we need an authorization with the letter "R" in order for the referral to be authorized.
47	Superior-STAR+PLUS	15683	Mgr	We call and never talked or meet the Provider Representative.
47	Superior-STAR+PLUS	15794	Mgr	We have had great difficulty getting referrals and making sure our families bring in the correct months Medicaid card. We have not received much help from Superior on either problem. My other complaint is in claims processing. The ones that are on CHIP and have co pays. Sometimes the EOB shows patient should pay and sometimes you cover all. We never know if we should collect. The couple times that I called about who should get refund, nobody knows what we are supposed to do?

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86	Superior-STAR+PLUS	15785	Mgr	This clinic no longer does TH Steps - we send our patients to their PCP. We are a specialty clinic and do no well baby treatments. We only treat premature infants and children with special health care needs.
7M	Texas Children's-CHIP	04458	Prov	There is no box for sometimes.
7M	Texas Children's-CHIP	04537	Mgr	Delays in claim payments. Software changes frequently.
7M	Texas Children's-CHIP	04537	Prov	Claims not paid in a timely manner.
7M	Texas Children's-CHIP	04632	Mgr	Frequent problems from claims being paid incorrectly - very difficult to have these problems resolved.
9B	UniCare-CHIP	06488	Mgr	I am very disappointed with our UniCare Medicaid representative. I have co-payments due since 2006 which have not been paid. I've talked to our rep to help me and he either does not return calls or answer e-mails. We could drop off this plan but have not decided yet if we will or not. For most part, our claims are being paid except for the co-pays which now have added to a large amount.
9B	UniCare-CHIP	06705	Prov	In general I have always seen and treated Medicaid patients as any other. Many offices exclude these patients for whatever reason. I personally feel this is unconscionable.
9B	UniCare-CHIP	06730	Prov	The only problem with have with Chips is they don't cover any birth control for patients.
94	UniCare-STAR	26808	Prov	Claims unpaid

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94	UniCare-STAR	26860	Prov	Had to chase the rep down. Still waiting on payment or interest because claim paid almost 9 months to 1 year later. Poor customer service at call center, reps do not respond back or return phone calls.
94	UniCare-STAR	26921	Mgr	We are still enrolled as a participating provider, but are not currently accepting patients due to claims no being paid or not being paid in a timely manner.
7W	United Healthcare-CHIP	05425	Mgr	When verifying insurance regarding HPV vaccine was not accurate for verification given until the claim was denied. Try to appeal but not responding. The provider relations reps been receiving a call but she never returns the call regarding a claim.
7W	United Healthcare-CHIP	05482	Prov	I have not had a response back from the plan claims director in regards to old claims that have not been paid. No one will respond to me. I have to take almost $50K to TDI.
7W	United Healthcare-CHIP	05605	Mgr	When we get new personnel it takes some time to be trained.
7W	United Healthcare-CHIP	05606	Mgr	We have not had a Rep in our office since the plan was effective for our provider. We do receive monthly or quarterly updates from the plan.
7H	United Healthcare-STAR	27212	Mgr	Medicaid is not timely. CHIP is satisfactory.
7K	United Healthcare-STAR	27506	Mgr	We are periodically told that we are not “in network” and claims are denied. Then we have to call the network manager, he verifies that we are in network and the claim is finally paid. Then after a few months, claims are denied and once again we are told we are out of network.