Evaluation of the Florida Medicaid MediPass Program

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Executive Summary

Over the last decade, managed care arrangements have become the dominant delivery system for providing health care services to Medicaid beneficiaries. There are two main models of Medicaid managed care: 1) *Managed Care Organizations* (MCOs) that contract with states to accept financial risk for provision of a comprehensive set of services; and 2) *Primary Care Case Management* (PCCM) programs which are a non-risk form of managed care usually involving the payment of a monthly fee to a contracted provider for care coordination services in addition to fee for services payments for medical services provided.[1] The State of Florida uses both models of managed care to provide services to its Medicaid population. MediPass is Florida Medicaid's PCCM program. MediPass provides an alternative to MCOs in the areas of the state that are served by participating managed care plans and serves as the only managed care option in some of the rural areas of the state. The goal of the MediPass program is to capitalize on the programmatic and cost saving strategies of managed care. Ideally, MediPass, and PCCM programs in general, are designed to provide Medicaid recipients with a "medical home" where they will receive appropriate and cost effective care by avoiding inappropriate Emergency Room (ER) visits and reducing the need for hospital admissions.

This evaluation examined the operational procedures and administration of the MediPass program, as well as an analysis of costs and recipient satisfaction. Overall, we found that the MediPass program achieves its goal of providing Medicaid recipients with appropriate medical care and simultaneously curbing inappropriate and over-utilization of services. The cost analysis of medical claims data for FY 98-00 shows that the MediPass population actually consumes fewer resources than would be statistically expected based on statewide Medicaid resource use while controlling for age, gender, and morbidity. The program achieves greater savings for the Temporary Assistance to Needy Families (TANF) eligibility category than for the Supplemental Security Income (SSI) eligibility category. The cost savings are particularly pronounced in the inpatient hospitalization service category across both eligibility categories, leading one to conclude that access to proper primary care results in fewer hospital admissions.

While the MediPass program is succeeding at controlling costs and utilization, this has not resulted in dissatisfaction on the part of program enrollees. Survey results from the Consumer Assessment of Health Plans (CAHPs) conducted in Dade and Broward counties indicate that MediPass enrollees report a high level of satisfaction with program interactions. This survey was conducted on enrollees in the MediPass program, the Provider Service Network (PSN) pilot project as well as all of the Health Maintenance Organizations (HMOs) serving the Medicaid population in that area of the state. The results of the surveys indicate that enrollees in all of these programs are generally satisfied, with the MediPass program receiving modestly higher levels of satisfaction than either the PSN or HMOs.

The analysis of operating procedures and program administration focused on several key functional areas: network management, credentialing, access and availability of specialists, case management, utilization review, program enhancements

[1] *Medicaid Managed Care: A Guide for States, Fifth Edition, by Neva Kaye, May 2001, National Academy for State Health Policy, Funded by the Henry J. Kaiser Family Foundation, The Health Resources and Services Administration, The David and Lucile Packard Foundation, and the Congressional Research Service.*

and alternatives to managed care, and organizational structure and functions. In this analysis, it is noted that the MediPass program has well-developed policies in almost all relevant areas. However, additional policies similar to those commonly used by Managed Care Organizations could be implemented that would allow the program to achieve administrative cost savings, as well as greater control over providers and utilization patterns. Among the strategies identified are:

- Limitation of the size of the MediPass primary care provider (PCP) network through implementation of policies that require participating providers to accept at least a minimum number of recipients
- Elimination of duplicate verification of credentials by accepting verification by other accredited plans
- Implementation of policies that require Medicaid enrolled specialists to accept MediPass patients
- Implementation of enhanced utilization review procedures to hold providers accountable for practice patterns

These strategies could result in improved management and cost savings for the MediPass program.

Overall, the MediPass program has achieved its programmatic goals of reducing healthcare costs and inappropriate utilization of services while also providing high quality care for Medicaid recipients.

Background

The MediPass program is a primary care case management (PCCM) program developed by Florida Medicaid in 1991 for the purpose of securing access for Medicaid recipients to adequate primary care, decreasing inappropriate utilization, and controlling program costs for individuals receiving services. Medicaid eligible persons either select or are assigned to a Primary Care Provider (PCP). The PCP is currently paid a fee of $3.00 per month per enrolled person to manage and coordinate the enrollee's care in addition to the customary reimbursement for Medicaid services. The goal of the MediPass program was to incorporate some of the advantages of managed care into Medicaid program administration by providing access to high quality care, ensuring that clients receive appropriate care in the proper setting, and fostering development of strong doctor-patient relationships.

As of August 2001, the MediPass population represents over 630,000 of the more than 1.5 million Florida Medicaid recipients. MediPass became available statewide in 1996 after initial implementation in the counties of Hillsborough, Manatee, Pasco, and Pinellas in 1991. Florida statutes currently mandate individuals in specific Medicaid eligibility categories, Temporary Assistance to Needy Families (TANF) and Supplemental Security Income (SSI) without Medicare, to enroll in managed care; individuals dually eligible for Medicaid and Medicare are not included in these eligibility categories. All eligible Medicaid enrollees now participate in either MediPass or in a health maintenance organization (HMO). Enrollees who did not choose either MediPass or an HMO were assigned using a formula designed to balance the number of enrollees between these programs. MediPass now covers more persons than initially enrolled in 1991 when it covered only persons eligible for benefits under Aid to Families with Dependent Children (AFDC). Currently, MediPass covers individuals eligible for Supplemental Security Income, the Work and Gain Economic Self-Sufficiency program (WAGES), and various "specialty coverages" established by the state legislature (e.g., refugee, Medications-only, foster care, and subsidized adoption populations).

A previous evaluation completed by Florida State University in 1998 assessed enrollee and provider satisfaction with the MediPass program and evaluated the cost and service use of MediPass enrollees compared to those covered under fee for service plans. This evaluation concluded that MediPass resulted in cost savings for AFDC and SSI enrollees but not for smaller groups of enrollees in the program. Cost savings were observed in all areas except pharmaceuticals. Finally, MediPass enrollees and providers reported satisfaction with the MediPass case management services.

With double-digit increases in Medicaid costs and increasingly tighter budget conditions, the Florida Legislature and the Agency for Health Care Administration (AHCA) are continuing to explore ways to increase efficiency of the Medicaid program. Legislators have proposed several amendments to Florida Statutes that would eliminate the requirement for AHCA to provide choice counseling to Medicaid recipients and to limit enrollment in MediPass to those counties that have fewer than two HMO choices.

AHCA has contracted with the Florida Center for Medicaid Issues to perform an independent evaluation of whether the MediPass program is successful in obtaining programmatic and cost benefits of managed care while also maintaining the MediPass option. This evaluation will provide a review of the organizational structure and operational procedures of the program. In addition, this report will provide analyses of health care utilization and costs, patient satisfaction, cost control measures, improved

management of the MediPass primary care physician network, improved access to primary and specialty care, and development and implementation of alternative managed care arrangements.

Operations and Program Administration

The following sections address the various areas of MediPass program administration. Each section discusses the current operating procedures for the specific program functions as well as common practices used by other entities performing these types of functions. The specific program areas addressed are: network management, credentialing, access to specialists, case management, utilization review, program enhancements and alternative programs, and organizational structure and staffing.

Network Management

The concept of network management represents the efforts of managed health plans' to exert greater control over health care providers in order to reduce unnecessary utilization and costs. Health plans contract with a limited number of providers to supply the primary and specialty care of their members. In essence, the providers agree to specific conditions and restrictions stipulated by the health plans with the goal of monitoring physician practice patterns and eliminating unnecessary and costly care in exchange for a higher volume of patients from the plan. Health plans generally implement strict monitoring of the care provided to its members to ensure that the contracted providers are following clinical and organizational guidelines.

The National Committee for Quality Assurance (NCQA) is charged with developing guidelines and awarding accreditation to managed health care organizations. Under NCQA guidelines, a health plan receives "full" credit for its network management by establishing clear standards for the number and geographic distribution of providers, specifically primary care providers.[2] Although NCQA does not set a numerical standard, it is expected that health plans do this to ensure appropriate network management.

In order to keep costs down, health plans must balance the competing goals of keeping their PCP network small enough to exert control over providers, large enough to provide adequate capacity and choice for their members, and flexible enough to adapt to increases and/or decreases in enrollment. Health plans generally recognize that very large networks that offer the maximum amount of choice are less efficient and lack many of the management features associated with a managed care delivery system.

For the purposes of network management, the MediPass program has a policy of accepting all Medicaid PCPs who apply and are approved through the credentialing process. As a result, the MediPass PCP network is enormous, with 4,685 contracted providers and/or groups statewide and has a capacity that is 10 times greater than the

[2] *Surveyor Guidelines for the Accreditation of MCOs, National Committee for Quality Assurance, effective July 1, 2001.*

enrolled MediPass population. *Table 1* illustrates the size and capacity of the MediPass network.

Table 1

MediPass Network Capacity by Area

Area	Total MediPass Enrollees	Total PCP Requested Capacity	Excess Capacity	Available Slots per Enrollee	Average # of Patients per PCP/Group	Total # of Contracted PCPs/Groups	# of PCPs/Groups with < 50 Requested Capacity	# of PCPs/Groups with < 100 Requested Capacity
Area 1	35,346	127,601	92,255	4	176	201	41	90
Area 2	46,108	351,595	305,487	8	184	250	13	25
Area 3	80,444	448,757	368,313	6	222	362	54	71
Area 4	62,497	457,725	395,228	7	179	349	41	56
Area 5	35,385	413,281	377,896	12	96	369	70	93
Area 6	61,878	581,987	520,109	9	137	451	43	66
Area 7	58,240	454,014	395,774	8	125	467	82	121
Area 8	38,572	326,012	287,440	8	142	272	51	65
Area 9	54,212	409,665	355,453	8	186	291	12	18
Area 10	33,756	623,139	589,383	18	80	424	30	52
Area 11	128,527	1,839,283	1,710,756	14	103	1,249	22	55
Total	**634,965**	**6,033,059**	**5,398,094**	**10**	**136**	**4,685**	**459**	**712**

Appendix A contains the network capacity and distribution by county, providing more detail than the above table on which counties have the greatest excess capacity. It is clear that the smaller and more rural counties have considerably less excess capacity and fewer contracted providers than the more metropolitan areas of the state. Although it is difficult to quantify exactly how much excess capacity is too much or what constitutes adequate provider choice for recipients, reasonable standards could be developed. Employer groups generally specify a required provider to patient ratio when contracting with health plans for employee health benefits. A standard ratio of providers to MediPass recipients along with some type of geographical distribution requirement could be developed to limit the size of the MediPass network. For example, the state of Texas requires that provider networks for its Medicaid PCCM and HMO programs maintain a "geographic distribution such that no client has to travel more than 30 miles to access a PCP."[3] This is similar to the MediPass program's requirement that a PCP must be available within 30 minutes of travel time. However, the MediPass program could implement additional standards that set specific PCP to member ratios that would limit the size of the PCP network. Under these types of limitations, the network could be closed by not accepting new PCPs into the MediPass network unless the standards were not being met, either because of increased enrollment or because of provider attrition.

In addition to patient to provider ratios and geographic distribution requirements, MediPass could also implement a minimum standard capacity, not allowing providers to set their requested patient capacity below a set minimum. As part of their contractual

[3] *Medicaid Managed Care Review-Final Version, Texas Health and Human Services Commission, November 1, 2000.*

agreements, most health plans require PCPs to continue accepting new patients from the plan until their panel meets a minimum threshold. The MediPass program currently allows its participating PCPs to set any maximum threshold for the number of members they will accept. There are even participating PCPs who have their cap set as low as one patient. As a result, approximately 10 percent of the contracted providers and/or groups statewide set their cap on members at a threshold of 50 or less and 15 percent of providers/groups statewide set their cap at a threshold of 100 or less. *Table 1* provides a listing of the total number of providers/groups in each area with caps of 50 and 100 patients or less. Some of these providers with very low caps could be specialists that provide care to special needs populations like Children's Medical Services (CMS) members that could be exempted from the minimum standards. However, for PCPs serving the general MediPass population, it is costly for the program to maintain these providers in terms of credentialing, training and monitoring with very little return to the program because of their unwillingness to accept more than a minimal number of MediPass patients. The MediPass program could institute a policy that would terminate providers that are unwilling to accept at least a minimum number of program enrollees. Implementation of a policy to limit the size of the MediPass provider network would require approval from federal authorities at the Center for Medicare and Medicaid Services.

Credentialing Procedures

A vital component of network management includes assuring that the quality of network providers is continually evaluated. Such levels of "quality" are often defined and assessed via a plan or network's credentialing and re-credentialing procedures. MediPass has a comprehensive, well-defined set of credentialing policies and procedures in place to assure that its providers meet high quality standards.

The current MediPass enrollment credentialing procedures are in line with industry standards as defined by NCQA. Initial site visits are done by local offices in an appropriate time frame and credentials are verified using NCQA approved sources. Upon completion of site visit and primary source verification, providers are assigned to one of five categories. The current policy identifies three of the five categories of applicants as eligible for presentation to a credentialing committee for final enrollment approval. The remaining two categories represent providers who are denied eligibility for enrollment in MediPass.

While the current MediPass credentialing policies meet the NCQA guidelines, there are some notable differences. NCQA does not quantify the acceptable or unacceptable number of paid malpractice claims to determine enrollment eligibility. The NCQA guideline simply states that this information must be reviewed prior to enrollment approval. The current MediPass credentialing policy, provided in *Appendix B*, clearly identifies that "providers who have paid three or more malpractice claims within the past five years based on the date of act/omission," will be denied enrollment. Secondly, NCQA guidelines require that network providers be re-credentialed every three years as opposed to the current MediPass re-credentialing guidelines of every two years. NCQA also requires an evaluation of member complaints and reviews of under- and over-utilization during the re-credentialing process. The current MediPass policy states that the provider file, including member complaints and utilization review reports, should be forwarded to headquarters at the time of re-credentialing. However, interviews with

local area office personnel reveal that files are not routinely requested in the re-credentialing process.

The above differences reveal the subtle, more stringent standards for credentialing required by MediPass, relative to NCQA guidelines. The absolute criteria of denying applicants with three or more paid malpractice claims is addressed differently by NCQA accredited health plans. Although NCQA guidelines do not give explicit numbers, NCQA accredited health plans do look at paid malpractice claims, and do consider this in their application process. There is a high probability that an applicant to these networks would be denied enrollment with at least three paid malpractice claims in a 5-year span. Thus, in reality, MediPass credentialing has virtually the same standards as those of NCQA accredited health plans.

However, there is one practice followed by numerous health plans that is not used by the MediPass program in its initial credentialing of providers. Many NCQA accredited health plans delegate their primary source verification by accepting letters of approval from other NCQA fully accredited health plans. At the Florida Primary Care Case Management Workshop (November 2001) it was identified that ACS, the current contractor for network management and credentialing for Texas' PCCM program, currently delegates this component of their credentialing process as well. This delegation eliminates duplication of primary source verification. Although this delegated process is provided for in the MediPass credentialing policies (Appendix B) as an option for re-credentialing of existing MediPass PCPs, the MediPass provider enrollment form or checklist does not offer the option to provide an approval or reappointment letter to serve in lieu of primary source "duplicate" verification. Thus, providers entering the process are not aware of this option. This primary source verification is time intensive for MediPass staff, especially in light of the current size of the MediPass network.

If the option to waive initial credentials verification based on a provider's enrollment in an approved NCQA accredited plan was more widely implemented, the MediPass credentialing process could be streamlined. This would eliminate duplicate verification, which would decrease administrative costs, resources, and the time required for a provider to become credentialed. This policy change would not result in compromised quality. This has been confirmed with the Texas PCCM program, which has already implemented this practice.

Access and Availability to Specialists

Access and availability of certain specialists, is one of the most pressing problems in the MediPass program. The problem is not unique to the MediPass program, but is a problem throughout Florida Medicaid. Medicaid area offices identify this as one of the top complaints they encounter. Ostensibly, MediPass enrollees have access to all specialists enrolled as providers in the Florida Medicaid program; however, this does not match the reality faced by program participants. In reality, in the private office setting, a Medicaid enrolled specialist has the ability to accept as many or as few referrals of Medicaid or MediPass patients as he or she chooses. Many specialists simply choose not to accept referrals of these patients when they are not presented in an emergency setting that requires them to accept the patient.

Interviews with specialists as well as prior published studies reveal that the primary cause of this limited access and availability is physician reimbursement rates.[4] Currently reimbursement rates average 57 percent of the Medicare fee schedule. These rates are significantly lower than those found in state PCCM programs that do not have limited access to specialists. An expert with the North Carolina Access program reported that specialist access in their PCCM program is not a problem because reimbursement rates are comparable to Medicare. Specialists frequently have increased overhead costs relative to PCPs. These include capital costs as well as significantly higher liability insurance. Many specialist providers claim that they lose money when they see a Medicaid or MediPass patient.

In a previous survey conducted by AHCA of dermatologists and orthopedic surgeons, those that do enroll as Medicaid providers indicate that their motivation is civic duty and contribution to the community, not financial gain.[4] In today's atmosphere of decreased physician reimbursement rates throughout the medical profession, fewer providers are willing to provide services with reimbursement rates that do not at least cover their basic overhead costs.

Although MediPass recipients report few problems in getting referrals to specialists when they perceived they needed one, getting a referral does not ensure getting an appointment. In an analysis of Medicaid beneficiary access to physician specialists compared to projected provider need, 14 out of 24 specialty areas were lower than the lowest estimate of need based on population.[4] Of the remaining 10 specialties where access was greater than the lowest estimate, 4 of those specialties were hospital based physician specialists (Radiologists, Anesthesiologists, Pathologists and Emergency Medicine).[4] It is often through ER visits and hospital admissions that specialty access is granted. Anecdotal evidence suggests that many specialty providers enroll in Medicaid to assure that they will be reimbursed when "obligated" to see Medicaid recipients in these hospital settings. However, if an ailment is stabilized by an ER provider who recommends follow up care with a particular specialist, the on-call physician often denies follow-up in his or her office setting claiming that they do not accept Medicaid (MediPass) patients.

Currently, MediPass has no standards in place to assure availability or access of specialty care practitioners. NCQA requires accredited health plans to have quantifiable and measurable standards for specialty care access.[2] Standards such as determining an acceptable ratio of members to specialty access or using zip code analysis are acceptable measures. In conjunction with access standards, health plans, including Medicaid HMOs, define acceptable time frames (availability) for which a specialist must see a patient with a type of symptom, i.e., within two weeks for non-urgent cases. These time frames are monitored by patient complaints and enforced via contractual agreement.

MediPass and Medicaid do not require physician accountability for availability. If guidelines were established to assure specialist access, this would still not resolve the issue of availability. Implementing a minimum requirement of non-emergent visits for specialists will deter providers who are not willing to see Medicaid patients outside of the ER setting from enrolling as Medicaid providers. If a specialist were required to see, for example, a minimum of six non-emergent Medicaid patients a month, a provider would need to decide if it was in his or her best interest to see ER and hospital patients pro-bono or agree to see a limited number Medicaid/MediPass office visits per month.

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[4] *Access to Medicaid Physician Specialists, Agency for Health Care Administration, November 2000.*

Implementing such a policy would result in one of two things: a cost savings for the Medicaid program for ER visits by specialists only credentialed for this reason or a more equitable distribution of the financial burden to specialists who do participate in Medicaid.

Case Management

Providers who enroll as PCPs in the MediPass program are required to sign an Agreement for Participation in MediPass that stipulates the case management functions required of the providers. In general, the agreement states that participating providers must "provide primary care services; make referrals for specialty care when medically necessary and appropriate; follow the results of referrals and maintain overall responsibility for the health care of recipients even while under the care of a specialist; maintain a comprehensive medical record which documents the continuum of care provided; adhere to quality-of-care standards established for MediPass; and cooperate to the greatest extent possible with disease management organizations." More specifically, in carrying out the above listed duties, MediPass PCPs are required to contact all newly enrolled members at least twice to attempt to arrange for an initial preventive health screening and follow-up preventive screenings based on a set schedule, attempt to obtain medical records from any known previous PCPs and maintain the patient record to MediPass standards, and provide 24-hour coverage to provide consultation, triage, and, if necessary, approval of emergency room usage or specialty referral. In exchange for these and other case management services, MediPass PCPs receive $3 per enrolled member per month (pm/pm). Some discussion of reducing the case management fee to $2 pm/pm has taken place in recent years. This reduction could result in some providers deciding not to continue participation in the program.

The MediPass program provides training to all newly enrolled PCPs to explain these policies and requirements. However, it is not required that the providers attend these training sessions. It is only necessary that the enrolled provider send a representative from his or her staff to attend the training. Because of this lack of direct contact with providers, some PCPs do not fully understand their case management responsibilities, especially in regard to newer program functions. For example, area offices report that PCPs are confused about the role of the Disease Management Organizations (DMO) and are suspicious of interference with the care of their patients. This lack of understanding may hamper the effectiveness of the DMOs to provide services to their clients. In addition to confusion about some of the functions, PCPs are often unable to fulfill other case management obligations. For example, although it is required that PCPs attempt to contact patients regarding preventive visits, they often find that reliable phone numbers and/or addresses cannot be obtained. If providers are unable to contact assigned members, it is unreasonable to expect the PCPs to provide the level and frequency of preventive care set forth by the program.

The MediPass program provides PCPs with information regarding its expectations for primary care case management through its printed materials (provider agreement, policies and procedures) and training programs. However, participating providers do not always read the fine print and understand all of the requirements or are unable to make serious efforts at compliance because of data limitations. In order to alleviate some of these problems, the MediPass program could provide some on-site

(i.e., at physician offices) training for providers to ensure that PCPs truly understand case management expectations and new program initiatives. This on-site training could cover the basics of what is expected under their case management obligations. Under this type of arrangement, providers could still send staff to the regular orientation sessions to learn details about program administration, such as billing procedures that the providers do not generally engage in.

Utilization Review

The functions of case management are designed to control the over-utilization of medical services; specifically, to decrease or eliminate unnecessary hospital admissions, emergency room visits, and visits to specialists. According to this model, the resulting care to patients would be more cost effective because care would be provided in appropriate settings and only when necessary. Utilization Review is a mechanism developed by health plans to evaluate the practice patterns of the providers contracted to supply care to its members. "Utilization review aims at assessing and affecting the use of services and serves as a mechanism for quality assessment in the context of inappropriate utilization."[5] In conducting this process, health plans generally analyze hospital admission rates, ER visits, and comparisons across individual or group practices of specific procedures and diagnostic codes to assess compliance with practice guidelines. Plans may also engage in more in-depth audits to assess the appropriateness of hospital admissions or lengths of stay.

The MediPass program issues a Provider Utilization Summary report that is mailed to participating PCPs. The report compares physicians and/or groups within a specific geographic area against other physicians/group practices in the same practice category (i.e., general and family practice, internal medicine, pediatrics). For example, pediatricians in Escambia County are only compared to other pediatricians or pediatric groups in that county. The Provider Utilization Summary (*Appendix C*) lists several areas for comparison: office visits, ER visits, outpatient visits, physician referrals, lab and x-ray procedures, therapy procedures, durable medical equipment, number of MediPass patients and average cost per patient. This information is mailed to providers with the aim of providing information to PCPs to allow self-comparisons with peers. The MediPass program does not set explicit thresholds or benchmarks for PCPs to assess their compliance with program guidelines. PCPs in the program report that these summaries are difficult to understand and do not provide guidance on when or if they are meeting or not meeting expected standards. In other cases, PCPs report that the comparisons are not fair because some PCPs may care for MediPass patients that are significantly "sicker" than those of other PCPs.

With these same issues to address, some other states' PCCM programs have instituted a more complex physician profiling mechanism. For example, North Carolina uses a physician profiling system that takes into account the age, gender, and morbidity levels of patients in the practice being profiled as well as the patients in the comparison group. *Appendix D* contains a sample PCP profile from North Carolina's Access program.

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[5] *Introduction to Health Services, 4th Edition, Edited by Stephen J. Williams, Sc.D., and Paul R. Torrens, M.D., M.P.H., Delmar Publishers Inc.1993, Albany, New York.*

This type of physician profiling could improve the MediPass program's ability to monitor the quality of care and utilization of resources provided by participating PCPs. MediPass program officials could use it to identify utilization outliers, PCPs who either allow unnecessary referrals or admissions, as well as PCPs who are under-serving their enrolled members. This information could be used to enhance the program's efforts to incorporate utilization review into the network management and re-credentialing functions. The MediPass program is currently implementing procedures to flag providers with excessive approval of ER visits that are deemed non-emergent and bring those providers up for peer review. One of the problems with the mechanism being implemented is that it does not account for the age, gender, and morbidity of the patients, thus allowing for PCPs under review to claim that excessive or inappropriate utilization is due to the illness levels of their patients. The physician profiling report would be perceived by PCPs as a more readable, realistic, and fair mechanism.

Enhancements and Alternatives

The Agency for Health Care Administration (AHCA) is engaged in on-going activities to improve heath care access and outcomes while also seeking ways to further control Medicaid expenditures. In 1997, the Florida Legislature authorized the Agency to contract with Exclusive Provider Organizations (EPOs) and Provider Service Networks (PSNs) for the purpose of purchasing cost effective health care for Medicaid recipients. These initiatives are aimed at producing alternative managed care arrangements that reduce administrative costs, while providing high quality, appropriate care for Medicaid recipients. The South Florida Community Care Network (SFCCN) is a PSN contracted with the agency as a demonstration project and began operations on March 1, 2000. The SFCCN was designed to capitalize on the principle that costs are better managed when health care dollars are transferred directly from payer to provider, thus eliminating additional costs from intermediate ("middle man") insurance and health care organizations. The PSN demonstration project attempts to strengthen relationships between AHCA and high-volume providers in order to take advantage of existing managed care interventions, to increase coordination between Medicaid and local indigent health care programs, to improve health outcomes and cost savings for clients, and to enhance the quality of life for recipients with chronic health conditions. The SFCCN is currently being evaluated for cost-effectiveness and patient satisfaction. In addition to the PSN demonstration project, the Agency is issuing a Request for Proposals (RFP) to contract with EPOs as another alternative to traditional managed care. The EPOs would be licensed insurance providers with requirements similar to traditional HMOs with some added flexibility in the regulations. The focus of these contracting arrangements is to bring managed care to the counties that do not have participating Medicaid HMOs and are currently only served by MediPass. These organizations would provide additional options to Medicaid recipients required to enroll in managed care. This would allow the Agency the advantage of providing care to recipients on a pre-paid or fixed sum basis.

In addition to these projects, the Agency has also expanded the MediPass program in 1997 to contract with disease management organizations (DMOs) to provide disease management services for enrolled recipients living with diabetes, HIV/AIDS, asthma, and hemophilia. DMOs are private companies that specialize in disease management for the purpose of reducing costs and improving health care outcomes for patients with chronic illnesses. They offer an integrated approach to the treatment of

chronic illness by coordinating support and provision of services among patients and physicians. The Legislature expanded Florida's disease management initiative in 1998 to include patients with hypertension, cancer, end stage renal disease, and sickle cell anemia. Eligible recipients are automatically enrolled in the disease management program, but may cancel enrollment at any time. Six percent of the MediPass population meets the criteria for the diseases that the Agency currently manages. This initiative is still in development and is currently being evaluated to determine its effectiveness in reducing costs and improving health outcomes.

Another pilot project, the MediPass Pilot Projects/Pediatrics ER Diversion Projects, is aimed at improving primary care case management and preventative services for pediatric enrollees of the MediPass program. AHCA intends to capitalize on existing physician-patients relationships and services provided through managed care organizations, while incorporating mechanisms designed to improve access, control costs, and improve health outcomes. AHCA would also like to aid the development of minority-physician networks through this program. Providers are responsible for providing or coordinating referrals for Child Health Check-ups (EPSDT), specialty health care services, dental care, and Healthy Start services for infants under age 12 months. Service providers must also arrange for coverage of services, consultation, and approval of services 24 hours per day, seven days a week. Eligible enrollees are recipients of the Work and Gain Economic Self-Sufficiency (WAGES) programs, created in 1997 to replace the AFDC program after it was revised through the federal welfare legislation in 1996; individuals receiving AFDC-related Medicaid Assistance Only; Sixth Omnibus Budget Reconciliation Act (SOBRA) children; individuals receiving Supplemental Security Income (SSI) without Medicare coverage; and children in foster care or subsidized adoption arrangements.

The above projects are examples of the Agency's continuing efforts to design and implement programs that enhance the provision of health services and improve the health outcomes of Medicaid patients. Over the past several years, AHCA has initiated several managed care and disease management programs aimed at improving access, strengthening patient-physician relationships, controlling costs, and improving heath care outcomes.

Organizational Structure and Functions

An organization's structure and functional division of labor often determine success or failure regardless of the quality of staff or written policies and procedures. If an organization is poorly structured, success in one department may actually cause difficulties in another. The MediPass program employs intelligent and capable staff and has developed clear and thorough policies and procedures. However, despite these assets, the nature of the MediPass organizational structure lends itself to fragmentation that often results in a duplication of effort.

Duplication of effort was most apparent in the tracking and maintenance of provider data. The Agency's headquarter staff maintains databases of PCP provider data elements as well as do many area offices. Each area office interviewed had created their own PCP provider information databases and maintained their own set of pertinent fields. This redundancy is not only duplication but may also add to discrepancies in data. Currently, no procedure exists to assure the changes in area office databases are communicated to headquarters. In conjunction, area offices

maintain lists of specialty providers who are actually willing to see MediPass patients as directories for their PCPs. These directories seemed essential to all area offices and their PCPs and might be more efficiently managed if a centralized database could hold this information for all areas of the state.

Both the headquarters as well as area offices produce training materials and newsletters. Local offices admit that in light of recent staffing cuts, these initiatives are the first to be sacrificed for more pressing job responsibilities. Area offices contend that provider bulletins on Explanation of Benefits (EOB) forms sent to PCPs do not provide for an effective communication format. These EOBs are rarely seen by the providers and are dependant on office staff educating their providers. It is apparent via their production of newsletters that area offices have issues that require heightened provider awareness. These area offices interact often with one another to resolve issues and obtain advice on difficult issues. If area issues were centrally communicated to headquarters, perhaps a publication containing area-specific issues could be produced or added to the existing Medicaid Bulletin.

These examples are representative of duplication as well as fragmentation of duties between headquarters and area offices. These problems are further evidenced by area offices being unclear about the intricacies of some policies. For example, area offices all communicated a lack of clarity in the role they play in the credentialing process. This lack of clarity exists despite a well-defined and comprehensive credentialing policy written by headquarters. The tracking of complaints represents another area of fragmentation. Both area offices and headquarters receive complaints from providers and members but no central database is used to capture these issues despite a credentialing policy component to review such complaints upon re-credentialing.

In the process of conducting this evaluation, it became obvious that although policies were understood and thought effective by headquarters' staff, area office staff were often less clear about their roles within the same policies. Existing policies often fail to predict the unique situations that arise in the field. Under the current policies, area office staff lacks the authority to deviate from policies to address repeated problems. For example, headquarters has a policy that termination letters must be received from providers when disenrolling from the MediPass program. Even if many attempts to obtain such a letter are unsuccessful and verbal communication has been provided to headquarters and the area office, PCPs continue to appear as active providers in the MediPass program. Area office personnel have no authority to make the changes that would assist the program in maintaining the most accurate information regarding program participation, phone number changes, and address changes. Strict implementation of these types of policies results in difficulties for area offices that must continually maintain provider files on PCPs that have left the program and separate databases containing correct contact information. Uniform databases need to be created to meet the needs of both headquarters and area offices. Area offices should be empowered to update these central or networked databases since they are the front line where information is most likely to be communicated.

Improved coordination and communication between the Agency's headquarter staff and area offices would improve the efficiency and effectiveness of the MediPass program's administration.

Program Cost Analysis

In order to provide an evaluation of program costs, Medicaid claims were obtained from the three most recently completed fiscal years. Complete claims data for Fiscal Years 1997-98 through 1999-00 was analyzed using CompareCare™, data processing software provided by ACS, Inc. The CompareCare™ software is designed to organize, classify, and adjust health care claims data based on age, gender, morbidity, eligibility category and program participation. Adjustments are made based on the Adjusted Clinical Groups (ACG) methodology which assigns a single value describing an individual's health status to each individual in the population. The ACG considers all diagnoses from all settings and provider types to assign individual values. The values obtained from all individuals in the population are then used to predict the expected resource use for the specified group over one year.

Using this software, MediPass program costs in the inpatient hospital, physician and professional (includes physician fees, durable medical equipment and transportation), outpatient facility, and pharmacy service categories were analyzed in comparison to a standard group. In these comparisons, the statewide Medicaid population (excluding HMO enrollees and enrollees over age 65) was used as the standard group. While controlling for age, gender and morbidity levels of the recipients, the software produces an expected dollar value for the costs that the MediPass program would have used if the program recipients used resources **at the same rates as the standard population**. *Table 2* provides the expected and actual costs and per member per month costs for all service categories for the entire MediPass program which includes all recipients enrolled in the MediPass program.

According to *Table 2*, the MediPass program achieves total cost savings per member per month of $32.59 for FY 97-98, $40.66 for FY 98-99, and $38.54 for FY 99-00. The greatest savings are realized in the Inpatient Hospitalization and Physician/Professional service categories with very modest savings being realized in the Outpatient Facility and Pharmacy service categories.

Table 2

MediPass Expected vs. Actual Costs - All Eligibility Categories

FY	Service Category	Expected $	Expected PM/PM	Actual $	Actual PM/PM	Savings PM/PM
1997-98	Inpatient	464,345,503.84	79.01	346,292,994.08	58.92	20.09
	Physician/Prof	582,690,762.71	99.15	513,920,927.70	87.45	11.70
	Outpatient Facility	77,235,264.06	13.14	73,013,867.10	12.42	0.72
	Pharmacy	306,958,501.90	52.23	306,493,192.43	52.15	0.08
	All Services	1,431,230,032.52	243.53	1,239,720,981.31	210.94	**32.59**
	Total Member Months FY 97-98		5,877,065			
1998-99	Inpatient	417,117,327.83	79.88	299,421,500.39	57.34	22.54
	Physician/Prof	546,306,747.18	104.62	455,698,696.43	87.27	17.35
	Outpatient Facility	70,377,491.58	13.48	66,670,417.58	12.77	0.71
	Pharmacy	350,153,538.04	67.05	349,842,337.48	67.00	0.06
	All Services	1,383,955,104.63	265.03	1,171,632,951.88	224.37	**40.66**
	Total Member Months FY 98-99		5,221,890			
1999-00	Inpatient	437,265,300.18	72.17	316,653,901.26	52.27	19.91
	Physician/Prof	588,188,005.49	97.08	487,163,497.78	80.41	16.67
	Outpatient Facility	79,292,961.90	13.09	76,703,087.99	12.66	0.43
	Pharmacy	437,671,710.94	72.24	428,411,611.55	70.71	1.53
	All Services	1,542,417,978.51	254.59	1,308,932,098.58	216.05	**38.54**
	Total Member Months FY 99-00		6,058,523			

Analysis of the Temporary Assistance for Needy Families (TANF) eligibility category illustrates that total per member per month savings are greater for this specific eligibility category than for the program in general. *Table 3* provides the expected and actual total and per member per month costs for all service categories for MediPass enrollees in the TANF eligibility category.

Table 3						
MediPass Expected vs. Actual Costs - TANF Eligibility Category						
FY	**Service Category**	**Expected $**	**Expected PM/PM**	**Actual $**	**Actual PM/PM**	**Savings PM/PM**
1997-98	Inpatient	143,006,548.78	46.19	83,185,402.01	26.87	19.32
	Physician/Prof	245,897,057.88	79.43	188,872,730.46	61.01	18.42
	Outpatient Facility	37,127,799.00	11.99	36,331,906.99	11.74	0.26
	Pharmacy	88,248,079.22	28.51	62,054,829.54	20.04	8.46
	All Services	514,279,484.89	166.12	370,444,869.00	119.66	**46.46**
	Total Member Months FY 97-98		3,095,844			
1998-99	Inpatient	109,716,868.54	43.66	61,499,672.22	24.47	19.19
	Physician/Prof	213,194,624.41	84.84	161,020,923.14	64.08	20.76
	Outpatient Facility	30,321,880.09	12.07	29,768,497.37	11.85	0.22
	Pharmacy	88,890,687.46	35.37	65,371,978.19	26.01	9.36
	All Services	442,124,060.50	175.94	317,661,070.92	126.41	**49.53**
	Total Member Months FY 98-99		2,512,871			
1999-00	Inpatient	118,677,233.58	43.11	65,555,390.87	23.81	19.29
	Physician/Prof	226,728,302.70	82.35	174,111,178.42	63.24	19.11
	Outpatient Facility	32,806,318.67	11.92	33,056,255.00	12.01	(0.09)
	Pharmacy	111,358,076.00	40.45	73,831,962.57	26.82	13.63
	All Services	489,569,930.94	177.82	346,554,786.86	125.87	**51.94**
	Total Member Months FY 99-00		2,753,204			

According to *Table 3*, the MediPass program achieves cost savings for the TANF population in all years and service categories except the Outpatient Facility category in FY 99-00. In FY 97-98 and 98-99 the savings in this category are very small. In contrast, the savings in all other service categories: Inpatient Hospitalization, Physician and Professional Services and Pharmacy are significant for the TANF population.

Analysis of the Supplemental Security Income (SSI) eligibility category illustrates that total per member per month savings are minute compared to the savings achieved with the TANF population. *Table 4* provides the expected and actual total and per member per month costs for all service categories for MediPass enrollees in the SSI eligibility category.

Table 4						
MediPass Expected vs. Actual Costs - SSI Eligibility Category						
FY	**Service Category**	**Expected $**	**Expected PM/PM**	**Actual $**	**Actual PM/PM**	**Savings PM/PM**
1997-98	Inpatient	294,133,142.97	184.02	246,512,682.25	154.22	29.79
	Physician/Prof	258,630,085.49	161.81	270,842,037.48	169.45	(7.64)
	Outpatient Facility	27,317,660.31	17.09	24,718,096.54	15.46	1.63
	Pharmacy	202,168,171.77	126.48	230,074,388.70	143.94	(17.46)
	All Services	782,249,060.54	489.39	772,147,204.97	483.07	**6.32**
	Total Member Months FY 97-98		1,598,406			
1998-99	Inpatient	279,523,530.98	184.22	224,583,166.40	148.01	36.21
	Physician/Prof	244,827,145.18	161.36	239,606,943.02	157.92	3.44
	Outpatient Facility	26,787,986.33	17.65	24,753,377.24	16.31	1.34
	Pharmacy	240,772,228.55	158.68	268,225,049.21	176.78	(18.09)
	All Services	791,910,891.04	521.92	757,168,535.87	499.02	**22.90**
	Total Member Months FY 98-99		1,517,306			
1999-00	Inpatient	280,780,832.82	185.69	231,383,340.28	153.02	32.67
	Physician/Prof	238,467,283.69	157.70	233,302,237.32	154.29	3.42
	Outpatient Facility	27,224,297.74	18.00	25,624,624.09	16.95	1.06
	Pharmacy	293,800,964.01	194.30	329,885,857.41	218.16	(23.86)
	All Services	840,273,378.25	555.70	820,196,059.10	542.42	**13.28**
	Total Member Months FY 99-00		1,512,110			

The greatest savings for the SSI population are achieved in the Inpatient Hospitalization service category. The total savings per member per month are mitigated by the lack of savings in the Pharmacy service category. However, the claims data being analyzed is prior to the implementation of Medicaid's Pharmacy Cost Control Program which did not begin until August 2000. Analysis of FY 00-01 when it becomes available may provide evidence that the cost control procedures put in place have a positive effect on the per member per month pharmacy costs for MediPass enrollees in the SSI eligibility category.

It should be noted that the CompareCare™ software was customized to account for the specific program characteristics of the Florida Medicaid program. In using the software and creating the comparisons provided, some limitations in the data and analysis have been observed. For example, claims data for the "Medication's Only" eligibility category are currently included in the statewide data which may account for some anomalies in the data since Medicaid pays for these recipients' pharmaceuticals, but not for their medical care. This group is small in size and thus, should not create large problems in the data. However, creating a comparison group that does not include the "Medication's Only" population would allow for more accurate comparisons to be made. Another example is the exclusion of enrollees over age 65. This exclusion was made to remove claims for individuals who are dually enrolled in Medicare and Medicaid since the payments made by Medicaid do not reflect the accurate costs and morbidity levels for individuals in this group. However, by just excluding enrollees over ago 65,

some dually enrolled individuals are still included since they are under age 65 and eligible for Medicare because of a disability status. Again, this does not amount to a large number of cases, but does result in limiting the ability to make valuable comparisons. In addition, because of limitations in the groups available for comparison, the observed differences illustrated above may be understated since the MediPass population is included in the standard population and thus expected values are based on the combined resource usage experience of the MediPass and non-MediPass populations of the Florida Medicaid program. It is obvious that further customization of the program could reduce some of the limitations to the program and provide Medicaid with a powerful tool for assessing resource usage and enhancing data-driven decision-making abilities.

Summary of Recipient Survey Data

A sample of enrollees (n=3469) in Florida's HMO, PSN and MediPass programs were surveyed to assess their satisfaction with their health care provider and service delivery. Data were collected by telephone using a standardized patient satisfaction questionnaire, the Consumer Assessment of Health Plans Survey (CAHPS). The CAHPS survey is a standardized instrument developed to help consumers identify the best health care plans. Because of time constraints for the evaluation, existing survey data from the Provider Service Network (PSN) Demonstration Project Evaluation was obtained and analyzed to provide a proxy measure of MediPass recipient satisfaction. Since the data for the PSN project was collected only for Dade and Broward counties, it may not be representative of the state as a whole. However, the data provided here is representative of previous results of MediPass recipient satisfaction. A statewide survey of MediPass recipients will be conducted and reported as an addendum to this report later in the year.

In general, participants in HMO, PSN and MediPass programs reported a high level of satisfaction with the medical care they receive as well as the administrative process and procedures associated with their medical care. Respondents indicated that they experienced few or no problems in finding a personal doctor, obtaining referrals, or having to delay care while waiting for program approvals, and very few respondents have called or written to express complaints about either HMO, PSN and MediPass programs. Greater than 75% of respondents reported satisfaction in their relationship with primary care physicians or other health care providers, rating positively such items as listening carefully, explaining things clearly, and spending sufficient time with patients. Similarly, most respondents reported staff at their physician's office staff to be respectful, helpful and courteous.

Differences between HMO, PSN and MediPass programs were modest, with observed differences tending to indicate a higher level of satisfaction among MediPass participants. *Appendix E* contains tables of all actual data collected including specific questions asked, response frequencies and percentages, and standard errors.

Methodology

Analysis of Operations and Program Administration

Analysis of the operations and program administration is based on extensive reviews of all available policies, procedures and documents obtained from the MediPass program, as well as reviews of all relevant Medicaid, Primary Care Case Management (PCCM), and managed care literature. In addition, in-depth interviews of Agency personnel from the headquarters and a sampling of the Area Offices were conducted. FCMI also held a workshop to discuss PCCM best practices with national and state experts.

Program Costs Analysis

The program cost analysis was conducted using the CompareCare™ software developed by AdvanceMed, Inc. and installed as part of the Florida Rapid Entry to Enhanced Data Online for Medicaid (FREEDOM) information system provided by ACS, Inc. (formerly Consultec, Inc.), Florida Medicaid's fiscal agent. CompareCare™ uses the Adjusted Clinical Group (ACG) classification method. This methodology enables comparison of different patient groups by controlling for important factors, such as age, gender, and morbidity, which influence utilization and medical costs. Using this system, expected values are calculated using the standard population of all Florida Medicaid recipients. Expected costs are produced based on the MediPass population and the statewide Medicaid population adjusted to have equal distributions of age, gender, and morbidity levels and the resource usage experienced by the statewide Medicaid population. This allows for comparisons between actual costs and expected costs to calculate cost savings. This methodology may result in some understatement of observed differences since the MediPass population is included in the standard population and thus expected values are based on the combined resource usage experience of the MediPass and non-MediPass populations of the Florida Medicaid program.

Recipient Survey

For analysis of recipient satisfaction, a random sample of adult Medicaid enrollees (n=3469) in HMO, PSN and MediPass programs in Dade and Broward counties were surveyed by telephone regarding their satisfaction, using a standardized patient satisfaction questionnaire, the Consumer Assessment of Health Plans Survey (CAHPS).

The sample was constructed through a series of steps. First, participating HMOs provided the survey lab with lists of enrollees that were "randomly selected" and included current address and telephone information. Each HMO was asked to provide a list of 2000 enrollees. Information on precisely how the HMOs extracted the lists is sparse and the lists received were highly variable. Some contained more than 2000 cases, some less, while some HMOs provided lists in waves, some in a single transmittal. Many entries had no telephone numbers; many others had non-functional numbers (out-of-date, incorrect, disconnected, etc.). Despite these and other issues, 3469 interviews were completed to form the statewide sample.

Since the final distribution of Medicaid plans differed from the known HMO market share, post-stratification was performed using a procedure outlined by Aday[6]. Post-stratification weights were calculated by dividing known market share proportion for each Medicaid plan by its corresponding proportion observed in the sample. The final weight was then obtained by scaling the post-stratification weights so that the number of cases was down weighted to equal the actual sample size. The scaling step consisted of dividing each post-stratification weight by the mean of all the computed post-stratification weights.

[6] Designing and conducting health surveys: a comprehensive guide by Lu Ann Aday; foreword by Ronald M. Andersen, Jossey-Bass Publishers, 1996, San Francisco, CA.

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APPENDIX A: MEDIPASS NETWORK CAPACITY

MediPass Network Capacity by County

County	Total MediPass Enrollees	Total PCP Requested Capacity	Excess Capacity	Available Slots per Enrollee	Average # of Patients per PCP/Group	Total # of Contracted PCPs/Groups*	# of PCPs/Groups with < 50 Requested Capacity	# of PCPs/Groups with < 100 Requested Capacity
Escambia	18,473	61,735	43,262	3	169	109	22	52
Okaloosa	8,493	22,093	13,600	3	243	35	8	13
Santa Rosa	5,120	28,676	23,556	6	125	41	8	21
Walton	3,260	15,097	11,837	5	204	16	3	4
Area 1 Totals	**35,346**	**127,601**	**92,255**	**4**	**176**	**201**	**41**	**90**
Bay	13,593	78,184	64,591	6	216	63	4	8
Calhoun	1,471	11,220	9,749	8	147	10	0	1
Franklin	922	17,899	16,977	19	61	15	0	0
Gadsden	4,001	18,150	14,149	5	364	11	0	0
Gulf	1,219	15,825	14,606	13	102	12	0	1
Holmes	2,383	13,875	11,492	6	238	10	0	0
Jackson	4,359	43,899	39,540	10	168	26	0	0
Jefferson	916	8,450	7,534	9	153	6	0	0
Leon	9,375	71,006	61,631	8	195	48	8	14
Liberty	556	5,350	4,794	10	185	3	0	0
Madison	1,602	17,602	16,000	11	134	12	1	1
Taylor	2,380	16,495	14,115	7	198	12	0	0
Wakulla	1,072	11,200	10,128	10	179	6	0	0
Washington	2,259	22,440	20,181	10	141	16	0	0
Area 2 Totals	**46,108**	**351,595**	**305,487**	**8**	**184**	**250**	**13**	**25**
Alachua	13,192	66,066	52,874	5	269	49	13	14
Bradford	2,057	18,350	16,293	9	206	10	0	0
Citrus	5,712	44,157	38,445	8	133	43	11	12
Columbia	6,043	27,578	21,535	5	288	21	1	3
Dixie	1,593	12,060	10,467	8	319	5	0	0
Gilchrist	1,093	7,137	6,044	7	219	5	0	0
Hamilton	1,647	4,449	2,802	3	275	6	0	0
Hernando	2,666	30,220	27,534	11	90	30	3	7
Lafayette	603	4,150	3,547	7	151	4	0	0
Lake	7,748	71,185	63,437	9	129	60	9	11
Levy	2,646	15,480	12,834	6	139	19	3	4
Marion	18,967	72,591	53,624	4	316	60	12	16
Putnam	6,955	34,010	27,055	5	316	22	1	3
Sumter	5,405	18,350	12,945	3	676	8	0	0
Suwannee	3,272	14,999	11,727	5	234	14	1	1
Union	825	7,975	7,150	10	138	6	0	0
Area 3 Totals	**80,444**	**448,757**	**368,313**	**6**	**222**	**362**	**54**	**71**
Baker	1,190	14,825	13,635	12	99	12	0	1
Clay	3,312	46,951	43,639	14	79	42	4	6
Duval	30,710	279,836	249,126	9	171	180	20	25
Flagler	1,780	0	-1,780	0	N/A	0	0	0
Nassau	1,530	7,930	6,400	5	170	9	3	3
St. Johns	4,497	19,338	14,841	4	196	23	8	9
Volusia	19,478	88,845	69,367	5	235	83	6	12
Area 4 Totals	**62,497**	**457,725**	**395,228**	**7**	**179**	**349**	**41**	**56**

APPENDIX A: MEDIPASS NETWORK CAPACITY

MediPass Network Capacity by County

County	Total MediPass Enrollees	Total PCP Requested Capacity	Excess Capacity	Available Slots per Enrollee	Average # of Patients per PCP/Group	Total # of Contracted PCPs/Groups*	# of PCPs/Groups with < 50 Requested Capacity	# of PCPs/Groups with < 100 Requested Capacity
Pasco	11,412	94,674	83,262	8	116	98	17	24
Pinellas	23,973	318,607	294,634	13	88	271	53	69
Area 5 Totals	**35,385**	**413,281**	**377,896**	**12**	**96**	**369**	**70**	**93**
Hardee	3,552	19,050	15,498	5	296	12	0	0
Highlands	5,036	41,575	36,539	8	157	32	0	3
Hillsborough	33,557	348,235	314,678	10	123	273	28	42
Manatee	5,677	52,252	46,575	9	135	42	8	12
Polk	14,056	120,875	106,819	9	153	92	7	9
Area 6 Totals	**61,878**	**581,987**	**520,109**	**9**	**137**	**451**	**43**	**66**
Brevard	13,220	98,372	85,152	7	119	111	21	32
Orange	35,495	243,493	207,998	7	151	235	41	60
Osceola	5,249	48,358	43,109	9	94	56	6	7
Seminole	4,276	63,791	59,515	15	66	65	14	22
Area 7 Totals	**58,240**	**454,014**	**395,774**	**8**	**125**	**467**	**82**	**121**
Charlotte	4,487	17,952	13,465	4	214	21	3	4
Collier	10,550	71,257	60,707	7	229	46	9	12
DeSoto	2,863	30,031	27,168	10	179	16	0	1
Glades	47	1,545	1,498	33	24	2	0	0
Hendry	3,359	37,368	34,009	11	177	19	0	1
Lee	12,478	120,758	108,280	10	117	107	25	30
Sarasota	4,788	47,101	42,313	10	78	61	14	17
Area 8 Totals	**38,572**	**326,012**	**287,440**	**8**	**142**	**272**	**51**	**65**
Indian River	5,036	22,148	17,112	4	296	17	2	2
Martin	3,848	33,900	30,052	9	124	31	0	4
Okeechobee	3,316	17,125	13,809	5	276	12	0	0
Palm Beach	28,808	278,540	249,732	10	153	188	9	11
St Lucie	13,204	57,952	44,748	4	307	43	1	1
Area 9 Totals	**54,212**	**409,665**	**355,453**	**8**	**186**	**291**	**12**	**18**
Broward	33,756	623,139	589,383	18	80	424	30	52
Area 10 Totals	**33,756**	**623,139**	**589,383**	**18**	**80**	**424**	**30**	**52**
Dade	125,129	1,815,435	1,690,306	15	103	1,218	17	47
Monroe	3,398	23,848	20,450	7	110	31	5	8
Area 11 Totals	**128,527**	**1,839,283**	**1,710,756**	**14**	**103**	**1,249**	**22**	**55**
Statewide Totals	**634,965**	**6,033,059**	**5,398,094**	**10**	**136**	**4,685**	**459**	**712**

*MediPass allows providers to enroll as individuals or as groups so the number of actual providers is understated.

APPENDIX B: MEDIPASS CREDENTIALING POLICIES

I. CRITERIA FOR ENROLLMENT:

1. Providers enrolling in the MediPass program agree to adhere to the terms specified in the Medicaid Provider Agreement and the Agreement for Participation in MediPass.

2. The Agreement for Participation in MediPass includes credentialing standards that follow the policies and procedures of the MediPass Credentialing initiative and the provider must:

   a. Have sent a completed Medicaid agreement with a copy of each provider's current medical, nursing, or physician's assistant license to Medicaid's fiscal agent and be an approved Medicaid provider. The practitioner's active licensure shall suffice in lieu of professional liability coverage requirements.

   b. Have no current license revocation or suspension of the provider's state license by the state licensing board.

   c. Have no sanctions in effect on the primary care provider by Medicaid or Medicare.

   d. Have no ongoing investigation(s) by Medicaid Program Integrity, Medicare, Medical Quality Assurance or other governmental entities, with the exception of routine utilization reviews, including SURS reviews. This requirement applies to new applicants only.

   e. Have privileges in good standing at the hospital designated as the primary admitting facility by the primary care provider, or, if the provider does not have admitting privileges, privileges in good standing at the hospital by another provider with whom the primary care provider has entered into an arrangement for hospital coverage.

   f. Have submitted copies of valid Drug Enforcement Administration (DEA) certificates, if prescribing controlled substances.

   g. Have attested that the total active patient load (all populations with Medicaid Fee-For-Service, Medicaid Prepaid Health Plan, Health Maintenance Organization [HMO], Provider Service Network [PSN], Medicare or commercial coverage) is no more than 3,000 patients per primary care provider. An active patient is one that is seen by the professional a minimum of three times per year.

   h. Have received a satisfactory MediPass credentialing site visit survey.

   i. Have attested to the correctness/completeness of the MediPass provider's application.

j. Have made a statement regarding any history of loss or limitation of privileges or licensure activity.

k. Have submitted a current curriculum vitae which includes educational history and at least five years of work history with an explanation of any gaps of more than 30 days that appear within the five-year work history.

l. Have submitted detailed information regarding cases resulting in judgments within the past five years.

3. Only providers serving as primary care providers will undergo the credentialing process. This will apply to MDs, DOs, ARNPs, and PAs who serve as primary care providers. Credentialing of ARNPs and PAs when used as extenders is not required because they are working under the direct supervision of a credentialed MediPass provider. The monitoring and enforcement of this collaborative agreement is a responsibility of Medicaid.

II. AREA OFFICE CREDENTIALING PROCESS:

1. Upon receipt of a complete application package, a MediPass staff member will review the package for accurate completion of the following:

a. Agreement for Participation in MediPass and MediPass Provider Enrollment Form containing original signatures. Faxed or photocopied forms are not acceptable.

b. Copy of a current curriculum vitae which includes educational history and work history for the past five years with an explanation of any gaps of more than 30 days in work experience.

c. Completion of the "Verification of Hospital Privileges" form indicating the facility where admissions occur and the signature of the provider who admits the patients.

d. Copy of current DEA certificate, if applicable.

2. Following the receipt of a correctly completed credentialing package, area office staff will perform a credentialing site visit. Then the completed application and site survey will be forwarded to the Credentialing Liaison at headquarters for further processing of the application.

3. After three attempts are made by area office staff to obtain information, one of which must be via certified mail, the area office may close the file of the new applicant.

In order to terminate the participation of a currently enrolled MediPass provider, three attempts to request recredentialing information necessary for completion of the recredentialing process must be made. The first request for recredentialing information takes place when the provider is sent the recredentialing letter (generated by FRAES) 120 days prior to the physician's recredentialing date. The

provider has 60 days to respond. If a completed credentialing package is not received within 60 days, area office staff will need to make two additional attempts to gather the necessary documentation. One of these attempts must be made via certified letter. If a completed credentialing package is not received following the three attempts, then a termination letter and documentation to support the closure must be sent to headquarters for processing and final approval.

III. Headquarter's Credentialing Process:

1. Upon receipt of a completed credentialing package and site survey, the headquarters network management team (within the Bureau of Medicaid Program Development) will process the application by doing the following:

a. Reviewing the application to ensure receipt of the curriculum vitae, five-year work history, DEA certificate, hospital verification form, application, enrollment form, educational history, site survey containing area staff's comments and recommendations and verification of the provider's cap.

b. Printing of FMMIS screens to verify the DEA number, medical license number, address, phone number, Social Security number, and cap of the provider.

c. Opening an application in FRAES for the purpose of updating and tracking provider credentialing/recredentialing information and activities.

d. Producing and mailing letters to the Agency's Program Integrity Unit to determine if there are any open investigations on new provider applicants and a hospital privilege letter to the hospital designated on the "Verification of Hospital Privilege" form to verify the status of the provider's privileges at the hospital.

e. Searching the Department of Health Web site to verify the status of theprovider's medical license.

f. Querying the National Practitioner Data Bank to determine if there have been any malpractice settlements on behalf of the physician or any adverse actions (loss of clinical/licensure privileges) taken against the provider.

g. Searching the Heath and Human Service Office of the Inspector General Website to review the Reinstatement/Exclusion Report to determine if any Medicare or Medicaid sanctions have been taken against the provider by the Office of the Inspector General.

IV. ASSIGNMENT OF PROVIDERS TO CATEGORIES:

Upon completion of the verification process, provider applications will be assigned to one of the following categories and presented to the Credentialing Committee:

Category 1: Providers who have been credentialed within the past 18 months by another group whose credentialing or accreditation process includes standards at least comparable to MediPass. These groups include Medicaid HMOs, HMOs with full NCQA accreditation and JCAHO-accredited networks. Providers in one of these networks will be enrolled in MediPass upon receipt of an approval or reappointment letter and evidence of a satisfactory report on a credentialing site survey conducted within the past 12 months.

Category 2: Providers who have been credentialed by groups discussed in Category 1 more than 18 months ago, but within the past 24 months. These providers will receive provisional approval to participate in MediPass upon receipt of an approval or reappointment letter and evidence of a satisfactory report on a credentialing site survey conducted within the past 12 months, but will be re-evaluated by headquarters credentialing liaisons after receipt of evidence of their re-credentialing by the entities outlined in Category 1. Documentation indicating the provider has been re-credentialed by one of the aforementioned groups must be received by the MediPass program at least 60 days before the scheduled re-credentialing date.

Category 3:Providers who are not eligible or are disqualified from participation in the MediPass program due to circumstances that are not in the best interest of the Agency. These circumstances may include, but are not limited to:

a. Providers who do not possess an active Florida medical, nursing, or physician assistant license (or, for providers within 50 miles of Florida, an active license to practice in their home state);

b. Providers currently under Medicaid or Medicare sanction;

c. Providers who prescribe controlled substances and do not possess DEA certification;

d. Providers who at the time of initial application are under investigation for fraud or abuse, with the exception of routine utilization reviews including SURS;

e. Providers who do not have active admitting privileges and who have not made an arrangement for hospital coverage with an individual who possesses such privileges;

f. Providers who have limitations or conditions on their licensure due to acts of sexual misconduct;

g. Providers who have paid three or more malpractice claims (judgments) within the past five years based on the date of act/omission;

h. Providers who have materially misrepresented facts on application materials; and/or

i. Providers who were previously terminated and upon reapplication did not have the support of the area office. Documentation indicating current findings that support the area office recommendation must be submitted to headquarters for consideration during the credentialing process.

Category 4: Providers who have "exceptions" identified during the verification phase. This would include:

a. Providers receiving an unsatisfactory report on the credentialing site survey;

b. Providers whose Florida professional licenses have limitations or restrictions;

c. Providers who have a history of loss or limitation of hospital privileges not related to administrative functions, i.e. quality of care issues;

d. Providers having paid any malpractice court judgments within the past three years (based on the National Practitioner Data Bank [NPDB] query date). If the date the physician supplies supporting information about the judgment is past the 3-year mark, the provider file will continue to be handled as a category 4 since the judgment date was within 3 years of the NPDB query date;

e. Providers who have been previously found to be out of compliance with the terms and conditions of Medicaid or MediPass agreements;

f. Providers who have had their license suspended or revoked by another state;

g. Providers who have been identified as having patients that are overutilizers of emergency room services;

h. Providers who have been identified as pharmaceutical outliers by the prescribed drug utilization review committee;

i. Other discrepancies that cannot be resolved by credentialing staff; and

j. These providers will be considered individually by the Credentialing Committee as described subsequently under "Credentialing Committee Actions."

Category 5: Providers who have met the criteria specified in the MediPass Credentialing Standards (Section I) that do not fall into categories 1 through 4. The names of these providers will be furnished to the Credentialing Committee as having met criteria and will be enrolled in

MediPass or continue their participation in MediPass upon completion of verifications.

V. CREDENTIALING COMMITTEE COMPOSITION:

The MediPass Credentialing Committee consists of five members: two physicians, two nurses, and the MediPass Program Administrator or designee. A quorum is defined as having at least three members consisting of one physician, one nurse, and the MediPass Program Administrator or designee. All committee members are appointed or reappointed every two years by the Chief of Medicaid Program Development.

VI. CREDENTIALING COMMITTEE ACTIONS:

1. The Credentialing Committee will be provided with a list of providers meeting the criteria specified in Categories 1, 2, and 5 for its consideration and approval.

2. The Credentialing Committee will be provided with a list of providers in Category 3 who are not eligible or are disqualified from participation in the MediPass program at the current time and the reason(s) for non-eligibility. If appropriate, the committee may recommend further action on the part of the provider.

3. The Credentialing Committee will consider the complete file of applicants in Category 4, to include the nature of the exception noted, extenuating circumstances, and whether the exception is related to the provision of medical care. Members will then vote for one of the following actions:

   a. Approve

   b. Deny

   c. Obtain further information

   d. Require additional action be taken by the provider

   e. Conditionally credential

In order to approve a MediPass provider, a simple majority of Credentialing Committee members must be present and voting.

VII. RE-APPLICATION OF MEDIPASS PROVIDERS:

Providers who are denied participation in MediPass will be informed of the MediPass Credentialing Committee's decision. A provider may re-apply at any time.

VIII. RE-CREDENTIALING OF MEDIPASS PROVIDERS:

1. All MediPass providers will be re-credentialed every two years. Four months prior to the expiration of the original credentialing date, a notice will be sent to the provider, along with a package of re-credentialing materials and instructions for completion of the forms. If the provider has not responded within 60 days with the necessary documentation, area office staff will make two additional attempts to gather the needed information from the provider. One of these attempts must be via certified mail.

2. All information relevant to the provider, including tracking information such as complaints, grievances, applicable utilization reports, etc., will be kept in the provider's file at the area office and forwarded to headquarters for consideration during the re-credentialing process.

IX. CONFIDENTIALITY and DISCLOSURE OF CREDENTIALING INFORMATION:

1. Provider files undergoing credentialing will be kept in locked file cabinets. Access to those files will be restricted to only those staff members who have signed a confidentiality statement and who must access the files for the sole purpose of discharging their respective responsibilities. Additionally, all members of the credentialing committee will sign confidentiality statements.

2. Data (excluding information revealed by the National Practitioner DataBank) obtained during the credentialing process may be disclosed in the following circumstances:

   a. With the consent of the provider involved**;**

   b. When authorization is received from the Agency for Health Care Administration General Counsel's office pursuant to a Public Records Release;

   c. If requested in writing by any professional licensing board; or

   d. To fulfill reporting requirements by state or federal law.

Effective 4/1/2001

FLMS3100-R001

FLMS3100-R001 FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION PAGE 1
MEDICAID MANAGEMENT INFORMATION SYSTEM RUN DATE 09/23/01
M E D I P A S S P R O V I D E R U T I L I Z A T I O N S U M M A R Y
FOR DATES OF SERVICE 06/01/01 THROUGH 06/30/01

DISTRICT: 01
COUNTY: 17 - ESCAMBIA
GROUPING: GEN AND FAM PRACTICE

PROVIDER	OFFICE VISITS	EMERGENCY ROOM VISITS*	OUTPATIENT VISITS	PHYSICIAN REFERRALS	HOSPITAL ADMISSIONS	LAB & XRAY PROCEDURES	THERAPIES	DME	# OF MEDIPASS PATIENTS	AVERAGE COST PER PATIENT
	********** SERVICES AUTHORIZED PER 100 PATIENTS **********									
(0100765-23) SHMG/CARRIAGE HILLS FCC	3.51	4.39	1.75	20.18	0.00(U)	51.75	0.00(U)	1.75	114	$17.14
(0100765-25) SHMG/PERDIDO BAY FCC	9.85	3.03	3.03	15.91	0.00(U)	43.94	0.00(U)	3.03	132	$25.31
(0100765-26) SHMG/MILESTONE FCC	6.45	3.23	6.45	14.52	0.00(U)	3.23	0.00(U)	0.00(U)	62	$29.97
(0100765-28) SHMG/PACE FCC	35.59	3.39	10.17	21.19	0.00(U)	37.29	0.00(U)	0.00(U)	118	$43.40
(0404381-00) ROBINS, ROSS AARON	0.00(U)	0.00(U)	0.00(U)	16.67	0.00(U)	16.67	0.00(U)	0.00(U)	6	$11.77
(0417041-00) BELK, WILLIAM W.	0.00(U)	8.33	30.56(O)	38.89	0.00(U)	25.00	0.00(U)	8.33	36	$81.70
(0445975-00) DELAROSA, CARMEN R. MD	0.00(U)	2.94	7.35	17.65	0.00(U)	2.94	0.00(U)	2.94	68	$19.56
(0483184-00) DU LIENG, KIM T. MD	20.56	0.93	0.00(U)	2.80	0.00(U)	28.04	0.00(U)	0.00(U)	107	$13.42
(0490792-00) FRENCH, BARBARA O. MD	75.00(O)	0.00(U)	75.00(O)	75.00	0.00(U)	25.00	0.00(U)	1600.00(O)	4	$100.73
(0492621-00) MAY, JOHN L.	0.00(U)	5.26	10.53	63.16	0.00(U)	57.89	0.00(U)	36.84	19	$63.05
(0508730-00) BROWN, JOHN G., D.O.	50.00(O)	0.00(U)	0.00(U)	0.00(U)	0.00(U)	0.00(U)	0.00(U)	0.00(U)	2	$13.15
(0515639-00) BELLARD, RICKY L., M.D.	0.00(U)	9.62	36.54(O)	44.23	0.00(U)	7.69	0.00(U)	0.00(U)	52	$60.02
(0517291-00) DINOLOV, VAL J., M.D.	5.26	0.00(U)	10.53	21.05	0.00(U)	31.58	0.00(U)	15.79	19	$23.06

* EMERGENCY ROOM DATA REFLECTS THE MEDIPASS PROVIDERS AUTHORIZATION OF EMERGENCY ROOM TREATMENT FOR NON-EMERGENCY SITUATIONS.

APPENDIX D: North Carolina Access Program Physician Profile

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PCP Utilization

Age Gender and ACG Adjusted

Dollar Basis: Allowed

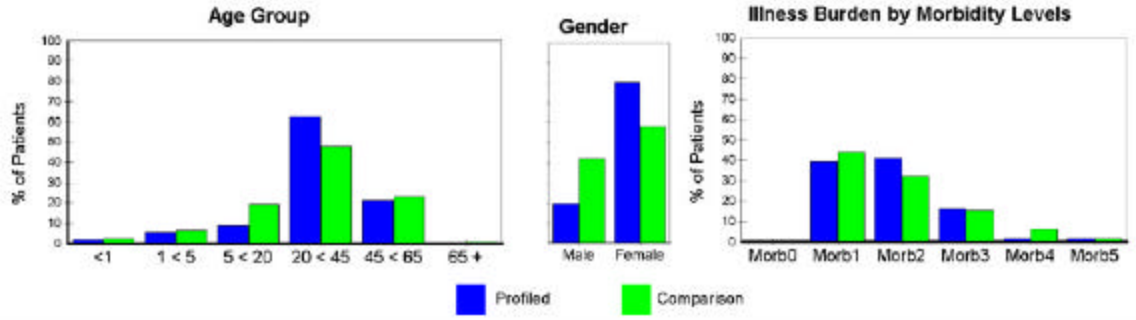
I. Identifying Information

Name
Location

Zip
ID PROV19826
Specialty Family Practice

Reporting Period	01/01/1999 to 12/31/1999
Comparison Group	NETWORK001
Profiled Morbidity Index	1.09
Comparison Morbidity Index	1.00

II. Patient Characteristics



III. Utilization Summary

	Patient Count	($) PMPM	Total ($)	Comparison Patient Count	Comparison ($) PMPM	Comparison Total ($)	Utilization Index ($)
Professional	52	40.92	29,565	22,605	37.77	12,400,387	0.89
Pharmacy	43	15.99	11,554	17,174	15.55	5,108,233	0.86
Outpatient	7	3.17	2,290	2,969	6.54	2,146,076	0.41
Lab/Radiology	30	4.27	3,084	6,579	1.61	529,577	1.88
Inpatient	3	10.27	7,420	1,114	10.32	3,389,769	1.21
Home Health	1	0.85	615	313	0.58	190,254	2.31
ER	4	1.19	861	2,321	2.91	955,882	0.35

IV. Utilization Highlights

	Patient Count	($) PMPM	Total ($)	Comparison Patient Count	Comparison ($) PMPM	Comparison Total ($)	Utilization Index ($)
Prof-Diagnostic Radiology	18	3.75	2,707	3,136	3.48	586,772	0.81
Prof-Diagnostic Ultrasound	5	0.72	519	1,011	1.25	210,267	0.37
Prof-Evaluation and Management	44	12.44	8,988	10,624	12.25	2,065,705	0.81
Prof-Medicine	29	8.68	6,274	4,914	5.30	894,027	1.42
Prof-Surgery Maternity/Delivery	2	2.83	2,045	272	2.32	390,748	0.94
Rx-Anti-Infectives	23	1.14	826	4,066	1.01	170,463	0.83
Rx-Antiasthmatics	2	0.45	326	744	0.33	54,968	1.20
Rx-Antihistamines	2	0.63	453	1,151	0.79	133,668	0.62
Rx-Gastrointestinal	7	2.97	2,143	1,056	1.43	241,700	1.74
Rx-Hypoglycemics	0	0.00	0	241	0.41	69,215	0.00
Rx-Psychotherapeutics	5	3.34	2,416	1,678	2.83	476,827	0.93

PWIO_P8_DEMO
v.1.0.0

08/06/2001

PractiScan™

APPENDIX E: Recipient Survey Satisfaction Data Tables

Age	PSN			MediPass			HMO		
	n=510			n=499			n=1168		
	Frequency	Percent	Standard Error	Frequency	Percent	Standard Error	Frequency	Percent	Standard Error
18-24	73	14.3	1.55	150	30.1	2.05	239.0	16.3	0.46
25-34	66	12.9	1.49	59	11.8	1.45	262.0	17.9	0.19
35-44	107	21	1.8	129	25.9	1.96	257.0	17.5	0.21
45-54	97	19	1.74	88	17.6	1.71	192.0	13.1	0.21
55-64	117	22.9	1.86	66	13.2	1.52	218.0	14.9	0.20
65 or older	50	9.8	1.32	7	1.4	0.53	297.0	20.3	0.35
Sex	**PSN**			**MediPass**			**HMO**		
	n=517			n=506			n=1555		
	Frequency	Percent	Standard Error	Frequency	Percent	Standard Error	Frequency	Percent	Standard Error
Male	159	30.8	2.03	84	16.6	1.66	420.0	27.0	0.14
Female	358	69.2	2.03	422	83.4	1.66	1135.0	73.0	0.08
Q3. Received New Doctor or Nurse When Enrolled	**PSN**			**MediPass**			**HMO**		
	n=501			n=482			n= 1525		
	Frequency	Percent	Standard Error	Frequency	Percent	Standard Error	Frequency	Percent	Standard Error
Yes	138	27.5	2	136	28.2	2.05	697.8	45.8	0.107
No	363	72.5	2	346	71.8	2.05	827.0	54.2	0.096
Q4. How Much of a Problem to Get Satisfactory Doctor or Nurse	**PSN**			**MediPass**			**HMO**		
	n=136			n=135			n=671		
	Frequency	Percent	Standard Error	Frequency	Percent	Standard Error	Frequency	Percent	Standard Error
Big Problem	16	11.8	2.77	14	10.4	2.63	72.3	10.8	0.31
Small Problem	15	11	2.7	11	8.1	2.36	45.9	6.8	0.41
No Problem	105	77.2	3.61	110	81.5	3.36	552.7	82.4	0.12

APPENDIX E: Recipient Survey Satisfaction Data Tables

Q5. Has a Personal Doctor or Nurse	PSN			MediPass			HMO		
	n=513			n=504			n=1549		
	Frequency	Percent	Standard Error	Frequency	Percent	Standard Error	Frequency	Percent	Standard Error
Yes	317	61.8	2.15	358	71	2.02	1147.0	73..7	0.84
No	196	38.2	2.15	146	29	2.02	408.0	26.3	0.13

Q6. Rating of Personal Doctor or Nurse	PSN			MediPass			HMO		
	n=310			n=356			n=1083		
	Frequency	Percent	Standard Error	Frequency	Percent	Standard Error	Frequency	Percent	Standard Error
0 through 6	26	8.4	1.58	21	5.9	1.25	99.0	9.1	0.94
7 or 8	48	15.5	2.06	45	12.6	1.76	192.0	17.7	0.29
9 or 10	236	76.1	2.43	290	81.5	2.06	792.0	73.1	0.19

Q7. Needed a Specialist	PSN			MediPass			HMO		
	n=515			n=503			n=1540		
	Frequency	Percent	Standard Error	Frequency	Percent	Standard Error	Frequency	Percent	Standard Error
Yes	215	41.7	2.18	205	40.8	2.19	721.0	46.8	0.11
No	300	58.3	2.18	298	59.2	2.19	819.0	53.2	0.10

Q8. How Much of a Problem to Get Referral for Specialist	PSN			MediPass			HMO		
	n=212			n=205			n=712		
	Frequency	Percent	Standard Error	Frequency	Percent	Standard Error	Frequency	Percent	Standard Error
Big Problem	43	20.3	2.77	27	13.2	2.37	116.0	16.2	0.25
Small Problem	23	10.8	2.14	16	7.8	1.88	87.0	12.2	0.30
Not a Problem	146	68.9	3.19	162	79	2.85	510.0	71.6	0.13

Q9. Saw a Specialist	PSN			MediPass			HMO		
	n=511			n=501			n=1539		
	Frequency	Percent	Standard Error	Frequency	Percent	Standard Error	Frequency	Percent	Standard Error
Yes	177	34.6	2.11	189	37.7	2.17	653.0	42.4	0.11
No	334	65.4	2.11	312	62.3	2.17	886.0	57.6	0.09

APPENDIX E: Recipient Survey Satisfaction Data Tables

Q10. Rating of Specialist	PSN			MediPass			HMO		
	n=168			n=187			n=633		
	Frequency	Percent	Standard Error	Frequency	Percent	Standard Error	Frequency	Percent	Standard Error
0 through 6	21	12.5	2.56	15	8	1.99	70.0	10.9	1.87
7 or 8	24	14.3	2.71	22	11.8	2.36	110.0	17.3	0.38
9 or 10	123	73.2	3.43	150	80.2	2.92	454.0	71.7	0.24
Q11. Specialist Same as Personal Doctor	**PSN**			**MediPass**			**HMO**		
	n=175			n=188			n=645		
	Frequency	Percent	Standard Error	Frequency	Percent	Standard Error	Frequency	Percent	Standard Error
Yes	65	37.1	3.66	50	26.6	3.23	209.0	32.4	0.20
No	110	62.9	3.66	138	73.4	3.23	436.0	67.6	0.13
Q12. Called Doctor's Office for Self During Regular Hours	**PSN**			**MediPass**					
	n=515			n=501			n=1546		
	Frequency	Percent	Standard Error	Frequency	Percent	Standard Error	Frequency	Percent	Standard Error
Yes	170	33	2.07	189	37.7	2.17	577.0	37.3	0.11
No	345	67	2.07	312	62.3	2.17	969.0	62.7	0.09
Q13. Received Needed Help or Advice	**PSN**			**MediPass**			**HMO**		
	n=166			n=189			n=568		
	Frequency	Percent	Standard Error	Frequency	Percent	Standard Error	Frequency	Percent	Standard Error
Never or Sometimes	65	39.2	3.8	40	21.2	2.98	175.0	8.1	0.31
Usually	20	12	2.53	14	7.4	1.91	86.0	22.7	0.30
Always	81	48.8	3.89	135	71.4	3.29	307.0	15.1	0.16
Q14. Made Appointment for Regular Health Care	**PSN**			**MediPass**			**HMO**		
	n=513			n=502			n=1543		
	Frequency	Percent	Standard Error	Frequency	Percent	Standard Error	Frequency	Percent	Standard Error
Yes	273	53.2	2.21	298	59.4	2.19	911.0	59.0	0.09
No	240	46.8	2.21	204	40.6	2.19	633.0	41.0	0.11

APPENDIX E: Recipient Survey Satisfaction Data Tables

Q15. Got Appointment for Regular Health Care as Soon as Wanted	PSN			MediPass			HMO		
	n=265			n=295			n=899		
	Frequency	Percent	Standard Error	Frequency	Percent	Standard Error	Frequency	Percent	Standard Error
Never or Sometimes	78	29.4	2.8	43	14.6	2.06	213.0	23.8	0.29
Usually	28	10.6	1.89	43	14.6	2.06	154.0	17.1	0.22
Always	159	60	3.02	209	70.8	2.65	532.0	59.1	0.12

Q16. Days Waited Between Making Appointment and Seeing Provider for Routine Care	PSN			MediPass			HMO		
	n=257			n=282					
	Frequency	Percent	Standard Error	Frequency	Percent	Standard Error			
Same Day to 3 Days	93	36.2	3	185	65.6	2.83			
4-14 Days	73	28.4	2.82	74	26.2	2.62			
15-29 Days	27	10.5	1.92	7	2.5	0.93			
30 Days or More	64	24.9	2.7	16	5.7	1.38			

Q17. Had Illness or Injury Needing Immediate Care	PSN			MediPass			HMO		
	n=515			n=506			n=1548		
	Frequency	Percent	Standard Error	Frequency	Percent	Standard Error	Frequency	Percent	Standard Error
Yes	169	32.8	2.07	170	33.6	2.1	542.0	35.0	0.12
No	346	67.2	2.07	336	66.4	2.1	1006.0	65.0	0.09

Q18. Got Immediate Care for Illness or Injury as Soon as Wanted	PSN			MediPass			HMO		
	n=167			n=166			n=536		
	Frequency	Percent	Standard Error	Frequency	Percent	Standard Error	Frequency	Percent	Standard Error
Never or Sometimes	56	33.5	3.66	29	17.5	2.96	117.0	21.8	0.37
Usually	14	8.4	2.15	14	8.4	2.16	82.0	15.2	0.29
Always	97	58.1	3.83	123	74.1	3.41	337.0	63.0	0.15

APPENDIX E: Recipient Survey Satisfaction Data Tables

Q19. Days Waited Between Trying to Get Care and Seeing Provider for Illness or Injury	PSN			MediPass			HMO		
	n=161			n=167					
	Frequency	Percent	Standard Error	Frequency	Percent	Standard Error			
Same Day	99	61.5	3.85	110	65.9	3.68			
1-3 Days	24	14.9	2.82	29	17.4	2.94			
4-14 Days	14	8.7	2.23	23	13.8	2.67			
15 or More Days	24	14.9	2.82	5	3	1.32			

Q20. Number of Times Went to Emergency Room for Care for Self	PSN			MediPass			HMO		
	n=512			n=499			n=1546		
	Frequency	Percent	Standard Error	Frequency	Percent	Standard Error	Frequency	Percent	Standard Error
None	312	60.9	2.16	348	69.7	2.06	1057.0	67.9	0.09
1-2 Times	171	33.4	2.09	116	23.2	1.89	401.0	25.9	0.98
3-5 Times	18	3.5	0.81	27	5.4	1.01	70.0	4.5	0.69
6 or More Times	11	2.1	0.64	8	1.6	0.56	19.0	1.0	0.70

Q21. Number of Times Went to Doctor's Office or Clinic for Care for Self	PSN			MediPass			HMO		
	n=503			n=488			n=1501		
	Frequency	Percent	Standard Error	Frequency	Percent	Standard Error	Frequency	Percent	Standard Error
None	143	28.4	2.01	107	21.9	1.87	384.0	25.6	0.15
1-4 Times	220	43.7	2.21	207	42.4	2.24	800.0	53.2	0.20
5-9 Times	87	17.3	1.69	127	26	1.99	208.0	13.9	0.19
10 or More Times	53	10.5	1.37	47	9.6	1.34	109.0	7.3	0.26

Q22. How Much of a Problem to Get Necessary Care	PSN			MediPass			HMO		
	n=354			n=378			n=1105		
	Frequency	Percent	Standard Error	Frequency	Percent	Standard Error	Frequency	Percent	Standard Error
Big Problem	45	12.7	1.78	28	7.4	1.35	92.0	8.3	0.29
Small Problem	56	15.8	1.94	55	14.6	1.82	137.0	12.4	0.24
Not a Problem	253	71.5	2.4	295	78	2.13	876.0	79.2	0.09

APPENDIX E: Recipient Survey Satisfaction Data Tables

Q23. Delays While Waiting for Approval from Program	PSN			MediPass			HMO		
	n=350			n=377			n=1105		
	Frequency	Percent	Standard Error	Frequency	Percent	Standard Error	Frequency	Percent	Standard Error
Big Problem	45	12.9	1.79	28	7.4	1.35	91.0	8.2	0.28
Small Problem	42	12	1.74	38	10.1	1.55	145.0	13.1	0.22
Not a Problem	263	75.1	2.31	311	82.5	1.96	869.0	78.7	0.09

Q24. Waited More Than 15 Minutes Past Appointment Time to See Provider	PSN			MediPass			HMO		
	n=357			n=376			n=1088		
	Frequency	Percent	Standard Error	Frequency	Percent	Standard Error	Frequency	Percent	Standard Error
Never or Sometimes	168	47.1	2.65	248	66	2.45	670.0	61.6	0.15
Usually	48	13.4	1.81	25	6.6	1.29	136.0	12.5	0.23
Always	141	39.5	2.59	103	27.4	2.3	281.0	25.8	0.16

Q25. Office Staff at Doctor's Office Were Courteous and Respectful	PSN			MediPass			HMO		
	n=359			n=378			n=1107		
	Frequency	Percent	Standard Error	Frequency	Percent	Standard Error	Frequency	Percent	Standard Error
Never or Sometimes	45	12.5	1.75	35	9.3	1.49	131.0	11.8	0.39
Usually	21	5.8	1.24	18	4.8	1.1	92.0	8.3	0.28
Always	293	81.6	2.05	325	86	1.79	884.0	79.8	0.09

Q26. Office Staff at Doctor's Office Were Helpful	PSN			MediPass			HMO		
	n=356			n=375			n=1098		
	Frequency	Percent	Standard Error	Frequency	Percent	Standard Error	Frequency	Percent	Standard Error
Never or Sometimes	67	18.8	2.07	50	13.3	1.76	188.0	14.1	0.34
Usually	38	10.7	1.64	45	12	1.68	141.0	12.8	0.23
Always	251	70.5	2.42	280	74.7	2.25	768.0	70.0	0.10

APPENDIX E: Recipient Survey Satisfaction Data Tables

Q27. Doctor or Other Provider Listened Carefully	PSN			MediPass			HMO		
	n=358			n=378			n=1106		
	Frequency	Percent	Standard Error	Frequency	Percent	Standard Error	Frequency	Percent	Standard Error
Never or Sometimes	48	13.4	1.8	36	9.5	1.51	137.0	12.4	0.42
Usually	30	8.4	1.47	19	5	1.13	120.0	10.8	0.25
Always	280	78.2	2.18	323	85.4	1.82	849.0	76.8	0.10

Q28. Had Hard Time Speaking With or Understanding Doctor Because of Differing Languages	PSN			MediPass			HMO		
	n=359			n=380			n=1110		
	Frequency	Percent	Standard Error	Frequency	Percent	Standard Error	Frequency	Percent	Standard Error
Never or Sometimes	323	90	1.59	355	93.4	1.27	1046.0	94.3	0.18
Usually	10	2.8	0.87	5	1.3	0.59	21.0	1.9	0.60
Always	26	7.2	1.37	20	5.3	1.15	43.0	3.9	0.43

Q29. Doctor Explained Things so You Could Understand	PSN			MediPass			HMO		
	n=356			n=377			n=1110		
	Frequency	Percent	Standard Error	Frequency	Percent	Standard Error	Frequency	Percent	Standard Error
Never or Sometimes	54	15.2	1.9	56	14.9	1.83	150.0	13.5	2.43
Usually	31	8.7	1.5	19	5	1.13	103.0	9.3	0.27
Always	271	76.1	2.26	302	80.1	2.06	857.0	77.2	0.09

Q30. Doctor Showed Respect for What You Had to Say	PSN			MediPass			HMO		
	n=357			n=377					
	Frequency	Percent	Standard Error	Frequency	Percent	Standard Error	Frequency	Percent	Standard Error
Never or Sometimes	33	9.2	1.54	32	8.5	1.44	123.0	11.1	0.39
Usually	31	8.7	1.49	20	5.3	1.16	119.0	10.7	0.25
Always	293	82.1	2.03	325	86.2	1.78	865.0	78.1	0.09

APPENDIX E: Recipient Survey Satisfaction Data Tables

Q31. Doctor Spent Enough Time With You	PSN			MediPass			HMO		
	n=356			n=377			n=1098		
	Frequency	Percent	Standard Error	Frequency	Percent	Standard Error	Frequency	Percent	Standard Error
Never or Sometimes	65	18.3	2.05	56	14.9	1.83	199.0	18.1	0.29
Usually	41	11.5	1.69	44	11.7	1.66	158.0	14.3	0.22
Always	250	70.2	2.43	277	73.5	2.28	742.0	67.5	0.10

Q32. Rating of All Health Care, from All Doctors and Health Providers	PSN			MediPass			HMO		
	n=355			n=378			n=1082		
	Frequency	Percent	Standard Error	Frequency	Percent	Standard Error	Frequency	Percent	Standard Error
0 through 6	38	10.7	1.64	39	10.3	1.57	142.0	13.2	0.60
7 or 8	88	24.8	2.29	66	17.5	1.96	239.0	22.1	0.24
9 or 10	229	64.5	2.54	273	72.2	2.31	701.0	64.8	0.17

Q33. Needed an Interpreter to Speak with Doctor or Other Health Provider	PSN			MediPass			HMO		
	n=517			n=505			n=1546		
	Frequency	Percent	Standard Error	Frequency	Percent	Standard Error	Frequency	Percent	Standard Error
Yes	65	12.6	1.46	29	5.7	1.04	114.0	7.4	0.27
No	452	87.4	1.46	476	94.3	1.04	1432.0	92.6	0.07

Q34. How Often You Received a Needed Interpreter	PSN			MediPass			HMO		
	n=64			n=29			n=107		
	Frequency	Percent	Standard Error	Frequency	Percent	Standard Error	Frequency	Percent	Standard Error
Never or Sometimes	18	28.1	5.67	5	17.2	7.14	41.0	39.3	0.67
Usually	2	3.1	2.19	2	6.9	4.79	10.0	9.3	0.72
Always	44	68.8	5.84	22	75.9	8.09	56.0	52.5	0.37

Q35. Do You Have a Choice of Health Plans	PSN			MediPass			HMO		
							n=1418		
							Frequency	Percent	Standard Error
Yes							1172.0	82.7	0.08
No							246.0	17.3	0.18

Q36. Use Current Medicaid Program for All or Most of Health Care	PSN			MediPass			HMO		
	n=513			n=481			n=1161		
	Frequency	Percent	Standard Error	Frequency	Percent	Standard Error	Frequency	Percent	Standard Error
Yes	459	89.5	1.36	412	85.7	1.6	1137.0	98.0	0.08
No	54	10.5	1.36	69	14.3	1.6	23.0	2.0	0.54

Q37. Number of Months in a Row Enrolled in This Program	PSN			MediPass			HMO		
	n=487			n=453			n=925		
	Frequency	Percent	Standard Error	Frequency	Percent	Standard Error	Frequency	Percent	Standard Error
Less than 3 Months	24	4.9	0.98	16	3.5	0.87	60.0	6.5	0.32
3 to 6 Months	35	7.2	1.17	25	5.5	1.07	148.0	15.9	0.23
7 Months to 1 Year	108	22.2	1.88	56	12.4	1.55	302.0	32.6	0.16
More than 1 Year	320	65.7	2.15	356	78.6	1.93	416.0	44.9	0.14

Q38. Chose Program Yourself, or Were Told	PSN			MediPass			HMO		
	n=491			n=460			n=1133		
	Frequency	Percent	Standard Error	Frequency	Percent	Standard Error	Frequency	Percent	Standard Error
Chose Myself	221	45	2.25	229	49.8	2.33	778.0	68.7	0.10
Was Told	270	55	2.25	231	50.2	2.33	355.0	31.3	0.15

Q39. Received Information About Program When Enrolled	PSN			MediPass			HMO		
	n=497			n=475			n=1126		
	Frequency	Percent	Standard Error	Frequency	Percent	Standard Error	Frequency	Percent	Standard Error
Yes	314	63.2	2.17	268	56.4	2.28	742.0	65.9	0.10
No	183	36.8	2.17	207	43.6	2.28	384.0	34.1	0.15

Q40. How Much of Given Information Was Correct	PSN			MediPass			HMO		
	n=281			n=245			n=713		
	Frequency	Percent	Standard Error	Frequency	Percent	Standard Error	Frequency	Percent	Standard Error
All of It	181	64.4	2.86	166	67.8	2.99	438.0	61.3	0.13
Most of It	72	25.6	2.61	62	25.3	2.78	201.0	28.2	0.19
Some of It	26	9.3	1.73	17	6.9	1.63	66.0	9.2	0.33
None of It	2	0.7	0.5	0	0	-	9.0	1.3	0.87

Q41. Looked for Information in Written Materials from Program	PSN			MediPass			HMO		
	n=512			n=500			n=1530		
	Frequency	Percent	Standard Error	Frequency	Percent	Standard Error	Frequency	Percent	Standard Error
Yes	108	21.1	1.8	74	14.8	1.59	483.0	31.6	0.13
No	404	78.9	1.8	426	85.2	1.59	1047.0	68.4	0.09

Q42. How Much of a Problem to Find or Understand Information in Written Materials	PSN			MediPass			HMO		
	n=105			n=72			n=477		
	Frequency	Percent	Standard Error	Frequency	Percent	Standard Error	Frequency	Percent	Standard Error
Big Problem	26	24.8	4.23	5	6.9	3.02	40.0	8.4	0.45
Small Problem	15	14.3	3.43	7	9.7	3.52	86.0	18.0	0.31
Not a Problem	64	61	4.78	60	83.3	4.42	352.0	73.7	0.15

Q43. Called Program's Enrollee Service for Information or Help	PSN			MediPass			HMO		
	n=515			n=501			n=1531		
	Frequency	Percent	Standard Error	Frequency	Percent	Standard Error	Frequency	Percent	Standard Error
Yes	115	22.3	1.84	76	15.2	1.6	563.0	36.7	0.11
No	400	77.7	1.84	425	84.8	1.6	968.0	63.3	0.09

Q44. How Much of a Problem to Get Needed Help from Program's Enrollee Service	PSN			MediPass			HMO		
	n=113			n=75			n=554		
	Frequency	Percent	Standard Error	Frequency	Percent	Standard Error	Frequency	Percent	Standard Error
Big Problem	34	30.1	4.33	12	16	4.26	111.0	20.0	0.27
Small Problem	20	17.7	3.61	13	17.3	4.4	103.0	18.5	0.27
Not a Problem	59	52.2	4.72	50	66.7	5.48	341.0	61.5	0.14

Q45. Called or Written Program with Complaint or Problem	PSN			MediPass			HMO		
	n=516			n=503					
	Frequency	Percent	Standard Error	Frequency	Percent	Standard Error			
Yes	47	9.1	1.27	18	3.6	0.83			
No	469	90.9	1.27	485	96.4	0.83			

APPENDIX E: Recipient Survey Satisfaction Data Tables

Q46. Length of Time to Resolve Complaint	PSN			MediPass			HMO		
	n=47			n=17					
	Frequency	Percent	Standard Error	Frequency	Percent	Standard Error			
Same Day	5	10.6	4.55	2	11.8	8.05			
1 Week	3	6.4	3.6	3	17.6	9.53			
2 Weeks	1	2.1	2.13	1	5.9	5.88			
3 Weeks	1	2.1	2.13	2	11.8	8.05			
4 or More Weeks	7	14.9	5.25	3	17.6	9.53			
Still Waiting for Settlement	30	63.8	7.08	6	35.3	11.95			

Q47. Complaint or Problem Settled to Your Satisfaction	PSN			MediPass			HMO		
	n=47			n=17					
	Frequency	Percent	Standard Error	Frequency	Percent	Standard Error			
Yes	10	21.3	6.03	11	64.7	11.95			
No	10	21.3	6.03	1	5.9	5.88			
Still Waiting for Settlement	27	57.4	7.29	5	29.4	11.39			

Q48. Experience with Paperwork for Program	PSN			MediPass			HMO		
	n=507			n=502			n=1531		
	Frequency	Percent	Standard Error	Frequency	Percent	Standard Error	Frequency	Percent	Standard Error
Yes	72	14.2	1.55	45	9	1.28	254.0	16.6	0.17
No	435	85.8	1.55	457	91	1.28	1277.0	83.4	0.08

Q49. How Much of a Problem was the Paperwork for Program	PSN			MediPass			HMO		
	n=71			n=44			n=249		
	Frequency	Percent	Standard Error	Frequency	Percent	Standard Error	Frequency	Percent	Standard Error
Big Problem	12	16.9	4.48	4	9.1	4.38	38.0	15.2	0.43
Small Problem	15	21.1	4.88	10	22.7	6.39	65.0	26.0	0.36
Not a Problem	44	62	5.8	30	68.2	7.1	147.0	58.9	0.22

APPENDIX E: Recipient Survey Satisfaction Data Tables

Q50. Rating of Health Plan Now	PSN			MediPass			HMO		
	n=489			n=482			n=1480		
	Frequency	Percent	Standard Error	Frequency	Percent	Standard Error	Frequency	Percent	Standard Error
0 through 6	117	23.9	1.93	71	14.7	1.62	262.0	17.8	0.60
7 or 8	100	20.4	1.83	78	16.2	1.68	354.0	23.9	0.20
9 or 10	272	55.6	2.25	333	69.1	2.11	862.0	58.3	0.15

Q51. Rating of Overall Health Now	PSN			MediPass			HMO		
	n=509			n=502			n=1532		
	Frequency	Percent	Standard Error	Frequency	Percent	Standard Error	Frequency	Percent	Standard Error
Excellent	56	11	1.39	88	17.5	1.7	223.0	14.6	0.19
Very Good	81	15.9	1.62	71	14.1	1.56	275.0	18.0	0.16
Good	146	28.7	2.01	129	25.7	1.95	465.0	30.4	0.13
Fair	133	26.1	1.95	120	23.9	1.91	404.0	26.3	0.14
Poor	93	18.3	1.71	94	18.7	1.74	164.0	10.7	0.22

Q52. Smoked at Least 100 Cigarettes in Entire Life	PSN			MediPass			HMO		
	n=516			n=502					
	Frequency	Percent	Standard Error	Frequency	Percent	Standard Error			
Yes	187	36.2	2.12	179	35.7	2.14			
No	329	63.8	2.12	323	64.3	2.14			

Q53. How Often Currently Smoke	PSN			MediPass			HMO		
	n=187			n=179					
	Frequency	Percent	Standard Error	Frequency	Percent	Standard Error			
Every Day	73	39	3.58	86	48	3.74			
Some Days	32	17.1	2.76	40	22.3	3.12			
Not at All	82	43.9	3.64	53	29.6	3.42			

APPENDIX E: Recipient Survey Satisfaction Data Tables

Q52 and Q53. Frequency Smoked	PSN			MediPass			HMO		
	n=516			n=502					
	Frequency	Percent	Standard Error	Frequency	Percent	Standard Error			
Never	329	63.8	2.12	323	64.3	2.14			
Have Quit	82	15.9	1.61	53	10.6	1.37			
Some Days	32	6.2	1.06	40	8	1.21			
Every Day	73	14.1	1.54	86	17.1	1.68			

Q54. How Long Since You Quit Smoking	PSN			MediPass			HMO		
	n=81			n=53					
	Frequency	Percent	Standard Error	Frequency	Percent	Standard Error			
6 Months or Less	10	12.3	3.68	6	11.3	4.39			
More than 6 Months	71	87.7	3.68	47	88.7	4.39			

Q55. Number of Visits that Doctor Advised You to Quit Smoking	PSN			MediPass			HMO		
	n=110			n=124					
	Frequency	Percent	Standard Error	Frequency	Percent	Standard Error			
None	38	34.5	4.55	44	35.5	4.31			
1 Visit	13	11.8	3.09	14	11.3	2.85			
2-4 Visits	23	20.9	3.9	19	15.3	3.25			
5-9 Visits	11	10	2.87	18	14.5	3.18			
10 or More Visits	25	22.7	4.01	29	23.4	3.82			

Q56. Highest School Grade Completed	PSN			MediPass			HMO		
	n=505			n=500			n=1512		
	Frequency	Percent	Standard Error	Frequency	Percent	Standard Error	Frequency	Percent	Standard Error
8th Grade or Less	96	19	1.75	79	15.8	1.63	296.0	19.6	0.17
Some High School, but Didn't Graduate	130	25.7	1.95	150	30	2.05	356.0	23.6	0.14
High School Graduate, or GED	183	36.2	2.14	192	38.4	2.18	526.0	34.8	0.12
Some College or 2-Year College Degree	71	14.1	1.55	63	12.6	1.49	206.0	13.6	0.18
4-Year College Degree or More	25	5	0.97	16	3.2	0.79	127.0	8.4	0.40

APPENDIX E: Recipient Survey Satisfaction Data Tables

Q57 and Q58. Race/Ethnicity	PSN			MediPass			HMO		
	n=502			n=496			n=2199		
	Frequency	Percent	Standard Error	Frequency	Percent	Standard Error	Frequency	Percent	Standard Error
White Non-Hispanic	44	8.8	1.26	22	4.4	0.93	812.0	36.9	0.93
Black or African American	262	52.2	2.23	203	40.9	2.21	615.0	28.0	2.2
Hispanic	190	37.8	2.17	270	54.4	2.24	734.0	33.4	2.1
Other	6	1.2	0.49	1	0.2	0.2	38.0	1.7	0.2

Q57. Hispanic or Latino Origin or Descent	PSN			MediPass			HMO		
	n=508			n=502			n=1546		
	Frequency	Percent	Standard Error	Frequency	Percent	Standard Error	Frequency	Percent	Standard Error
Yes	190	37.4	2.15	270	53.8	2.23	734.0	47.5	0.10
No	318	62.6	2.15	232	46.2	2.23	812.0	52.5	0.09

Q58. Race	PSN			MediPass			HMO		
	n=469			n=450			n=1505		
	Frequency	Percent	Standard Error	Frequency	Percent	Standard Error	Frequency	Percent	Standard Error
White	186	39.7	2.26	230	51.1	2.36	852.0	56.6	2.4
Black or African-American	277	59.1	2.27	218	48.4	2.36	615.0	40.1	2.4
Asian	3	0.6	0.37	0	0	-	18.0	1.2	-
Native Hawaiian or Pacific Islander	0	0	-	1	0.2	0.22	9.0	0.6	0.4
American Indian or Alaska Native	3	0.6	0.37	1	0.2	0.22	11.0	0.7	0.4