

# Evaluation of Florida's Minority Physician Network (MPN) Program

**Final Project Report  
April 6, 2004**

Christy Harris Lemak, Ph.D.  
Allyson G. Hall, Ph.D.  
Christopher E. Johnson, Ph.D.  
Praveen Saxena  
Catie Aftuck  
Carianne Johnson

**Prepared by  
The Department of Health Services Administration  
and  
The Florida Center for Medicaid and the Uninsured  
College of Public Health & Health Professions  
University of Florida**

**Under contract to  
Florida Agency for Health Care Administration  
Division of Medicaid**



**UNIVERSITY OF  
FLORIDA**





**Table of Contents**

EXECUTIVE SUMMARY ..... 1

    Key Programmatic Elements of the MPNs..... 1

    MPN Program Development and Implementation ..... 2

    Pilot Program Performance ..... 3

    Key Strengths of the MPN Program..... 4

    Key Challenges for the Agency..... 4

    Conclusion..... 5

BACKGROUND AND SIGNIFICANCE..... 7

    MediPass Pilot Program ..... 7

    Minority Physician Network Program..... 7

    Evaluation Methods..... 9

DESCRIPTION OF THE MINORITY PHYSICIAN NETWORKS ..... 11

    Florida NetPASS ..... 11

    PhyTrust..... 11

    Contractual Relationship with Agency..... 12

    Provider Network ..... 14

    Membership..... 18

    Program Structure..... 21

    Administrative Structure..... 22

PROGRAM DEVELOPMENT ..... 25

    “SuperGroup” ..... 25

    Communication ..... 25

    Disenrollment of MPN Beneficiaries ..... 26

    Lessons Learned ..... 26

MPN PERFORMANCE ..... 29

    Physician Satisfaction..... 29

    PCP Perspective on MPN..... 30

    Quality of Care ..... 32

COST EFFECTIVENESS ANALYSIS AND FINANCIAL RESULTS ..... 33

    Overview ..... 33

    Medical Expenditure Analysis..... 33

    Shared Savings Analysis ..... 36

    Agency Resources ..... 40

    Conclusions and Discussion ..... 41

SUMMARY AND RECOMMENDATIONS..... 43

EVALUATION LIMITATIONS..... 45

APPENDIX..... 47

    Financial Analysis Methodology..... 47

REFERENCES ..... 59

**List of Tables**

Table 1: Overview of Original MPN Contracts ..... 13

Table 2: Primary Care Physicians by Ethnicity, Fall 2003 ..... 15

Table 3: MPN Primary Care Physicians by Type, Fall 2003 ..... 17

Table 4: MPN Enrollment by Month Palm Beach, Broward, and Miami-Dade Counties  
11/1/2001 – 5/1/2003 ..... 20

Table 5: Summary of Administration FTEs by Month Selected Dates  
11/1/2001 – 7/1/2003 ..... 23

Table 6: Physician Comments on the MPNs..... 29

Table 7: Beneficiaries with a Diagnosed Chronic Disease By Program September 2002..... 34

Table 8: Adjusted Predicted Expenditures PMPM Overall and By County  
February 2002 – February 2003..... 36

Table 9: Summary of Savings Compared to the UPL by MPN October 2001 –  
December 2002 ..... 37

Table 10: Advanced Administrative Fees October 2001 – December 2002..... 38

Table 11: Reconciliation Payments Made (Owed) by MPN October 2001 –  
December 2002 ..... 39

Table 12: Administration FTEs and Salary Expenses for the Agency (MPN Program and  
MediPass) 1/1/2002 and 1/1/2003 ..... 40

Table A-1: Variable Specification for Medical Expenditure Analyses..... 50

Table A-2: Evaluation of Florida’s Minority Physician Network (MPN) Program PhyTrust  
Administration FTEs by Month, Selected Dates 11/1/2001 – 7/1/2003 ..... 52

Table A-3: Evaluation of Florida’s Minority Physician Network (MPN) Program Florida  
NetPASS Administration FTEs by Month, Selected Dates  
11/1/2001 – 7/1/2003 ..... 53

Table A-4: Evaluation of Florida’s Minority Physician Network (MPN) Program  
Descriptive Statistics Palm Beach, Miami-Dade, and Broward Counties  
Combined February 2002 – February 2003 ..... 54

Table A-5: Evaluation of Florida’s Minority Physician Network (MPN) Program  
Descriptive Statistics—Miami-Dade County February 2002 – February 2003..... 55

Table A-6: Evaluation of Florida’s Minority Physician Network (MPN) Program  
Descriptive Statistics—Broward County February 2002 – February 2003 ..... 56

Table A-7: Evaluation of Florida’s Minority Physician Network (MPN) Program  
Descriptive Statistics—Palm Beach County February 2002 – February 2003 ..... 57

**List of Figures**

Figure 1: Primary Care Physicians by Ethnicity, Fall 2003 Source: Florida NetPASS,  
PhyTrust..... 16

Figure 2: Primary Care Physicians by Type, Fall 2003 Source: Florida NetPASS,  
PhyTrust..... 17

Figure 3: MPN Enrollment by Month Palm Beach, Broward, and Miami-Dade Counties  
11/1/2001 – 5/1/2003 ..... 19

Figure A-1: Evaluation of Florida’s Minority Physician Network (MPN) Program MPN  
Primary Care Physicians Locations by County Fall 2003 ..... 51

## **EXECUTIVE SUMMARY**

In 2001, Florida's Agency for Health Care Administration (AHCA) initiated a series of "Pilot Projects" to explore alternative managed care models for the MediPass primary care case management program. The intent of the pilot program was to see if providing enhanced medical management services decreases the costs of operating the MediPass program.

One of the Pilot Projects is the Minority Physician Network (MPN) program. Under the MPN program, the Agency contracted with two physician-owned organizations in which the majority of physicians are members of racial and ethnic minority groups: Florida NetPASS and PhyTrust. Each MPN consists of a network of primary care physicians (PCPs) and manages an enrollment of MediPass beneficiaries.

Both MPN organizations have grown fairly rapidly since the inception of the pilot program. As of May 1, 2003 (the end of the study period), total MPN enrollment included 53,234 beneficiaries in Miami-Dade, Broward, and Palm Beach Counties. This represented about 24 percent of the total MediPass enrollment in these counties. In South Florida, Florida NetPASS has 313 PCPs serving Palm Beach, Broward, and Miami-Dade counties and PhyTrust has 129 PCPs in Broward and Miami-Dade counties. Currently, MPN enrollment is over 73,000 beneficiaries and includes providers in Medicaid Areas 5 (Pasco and Pinellas Counties) and 6 (Hardee, Highlands, Hillsborough, Manatee, and Polk).

### **Key Programmatic Elements of the MPNs**

#### ***Information dissemination and Utilization Management***

The MPNs use an information approach to managing care and working with the PCPs in their networks. PhyTrust and Florida NetPASS distribute periodic performance reports to their physicians. Each of the MPN organizations has invested in computer systems to track and analyze beneficiary and provider data. The organizations use sophisticated, proprietary information systems and highly qualified staff to work with the data provided by the Agency monthly. The information system tools and managed care experience of these organizations are a key strength of the MPN program.

#### ***Payment Methodology***

In general, payments to the MPN organizations include a \$3.00 management fee paid to PCPs on a per member per month (PMPM) basis, fee-for-service reimbursement for medical services, and a process for calculating and distributing savings that are shared by the Agency and the MPN. The extent of the "savings" is determined through periodic calculation of the PMPM costs compared to the applicable Upper Payment Limits (UPL). The actual formula and procedures used for payment to the MPNs varied by organization and contract period.

#### ***Outsourcing Administrative Services***

The MPNs conduct primary care provider credentialing and beneficiary services that were previously performed by Florida Medicaid. The process of outsourcing these services to the

MPNs represents an innovation for the Agency that has eased some administrative burden but also called for new forms of Agency oversight.

### ***Physician Incentive Plans***

The MPNs were authorized to institute physician incentive plans that were in compliance with federal regulations regarding physician incentives utilized by Medicaid managed care organizations. PhyTrust's physician incentive plan was included in its application and has been used since the program began in November of 2001. Florida NetPASS submitted a physician incentive plan to the State and received approval for the plan. To date, however, Florida NetPASS has not implemented its physician incentive plan.

### **MPN Program Development and Implementation**

As with any new program, there were implementation issues and challenges at the beginning of the MPN program. During the initial implementation, the administration of the MediPass pilot programs by the Agency required additional personnel resources to monitor the programs and to educate and train the MPNs on MediPass and Agency policies. Overall, the Agency and the MPNs experienced challenges in three main areas: (1) issues related to the SuperGroup identification number; (2) communication between the Agency and the pilot programs; and (3) questions about providers disenrolling certain MediPass beneficiaries.

### ***SuperGroup***

The MPN application stated that participating organizations would become Medicaid providers. That meant that all PCPs in an MPN would be assigned a single Medicaid provider number (the Super Group number—one for PhyTrust and one for Florida NetPASS). As the programs were developed, however, the Agency gave considerable latitude to the programs. PhyTrust's original contract did not include the "SuperGroup" model; therefore, it did not conduct provider credentialing and member service functions. At the same time, Florida NetPASS did use the "SuperGroup" model and, thus, it was responsible for conducting credentialing and member services. Agency staff reported that this distinction between the two groups made the MPN program difficult to manage. In order to eliminate confusion, the Agency required PhyTrust to comply with the "SuperGroup" model under the new contract.

### ***Communication Issues***

Because the Agency did not have changes made in its information systems to create specific reporting and analysis functions for the pilot projects, Agency officials said they had a hard time getting required reports regarding the pilot programs. The programs were new and different, which meant that almost all analyses and reporting had to be conducted by hand. Area Offices also reported that the implementation of numerous MediPass pilot programs, in the same area, at the same time, added to the Agency's administrative burden.

### ***Disenrolling Beneficiaries***

The Agency expressed concern over whether or not the MPNs were moving the more difficult beneficiaries out of their networks into regular MediPass by requesting disenrollment of non-compliant beneficiaries. This issue is important because evidence that physicians are not willing to deal with complex or “difficult” beneficiaries would mean that these beneficiaries are left in “regular MediPass.” In reviewing this issue, no systematic attempts to “dump” expensive beneficiaries or high users were identified.

### **Pilot Program Performance**

In general, Florida's Minority Physician Networks offer an improved alternative to traditional MediPass. The private and “local” aspect of the MPNs offer opportunities to monitor and support providers in ways the current MediPass program has not achieved. Performance was evaluated in three areas: physician satisfaction, quality of care, and cost effectiveness and financial performance.

#### ***Physician Satisfaction***

PCPs interviewed by the research team expressed a high degree of satisfaction with the pilot program. PCPs noted that the periodic reports permitted increased monitoring of medications and beneficiary contact with other providers. Furthermore, they liked the increased administrative support provided by the program. Physicians in PhyTrust also noted that the financial incentive was a major source of satisfaction.

#### ***Quality of Care***

In general, there are limited data to evaluate the quality of care and beneficiary satisfaction with the MPNs. PhyTrust has conducted a beneficiary satisfaction survey and the results were very positive. While the evaluation cannot identify whether overall quality of care improved or declined in the MPN program, there is reason to believe that the specific monitoring and reporting of beneficiary information gives PCPs improved opportunities to monitor the appropriate use and quality of care provided to MPN beneficiaries.

#### ***Cost-Effectiveness and Financial Performance***

The limited time and resources of this evaluation prohibited a comprehensive cost effectiveness analysis. The financial impact of the MPN program was evaluated in three ways. First, the actual **medical expenditures** in the MPNs were compared to MediPass for the same time period and geographic area using data from the paid claims from February 2002 through February 2003.<sup>1</sup> Second, an analysis of the **shared savings** achieved by the MPNs was conducted using the same payment methodology employed by the Agency. Third, the financial analysis took into consideration the **time and effort** spent by the Agency to administer the MPN program.

---

<sup>1</sup> See full report for a description of alternative methodologies used to calculate cost savings.

**Medical Expenditure Analysis.** This analysis demonstrated that the medical expenditures experienced by the MPNs were lower than the expenditures of the average MediPass population when controlling for beneficiary race, age, gender, geographic region, and eligibility category.

**Shared Savings Analysis.** An analysis was conducted of the “shared savings” achieved by the MPNs using the payment methodology established in the contracts between each MPN and the Agency. This analysis revealed that during the first 15 months of operation, the MPNs saved approximately \$8.3 million when comparing their paid claims experience to the established UPL used by the Agency to estimate the average cost per beneficiary. A total of \$4.1 million of this “savings” was shared with the MPNs.

**Time and Effort.** Finally, the Agency estimated the cost of administering the MPN program by documenting the number of person hours (FTEs) and the associated salaries required to run the MPN program. The FTEs required to run the MPNs were reduced from 14.55 in 2002 to 13.65 in 2003, the second full year of the program.

In summary, the results of the analyses suggest that the MPNs have saved the Agency money during the initial two years of operation in the South Florida region. The MPNs provide extensive utilization management and sophisticated reporting software to reduce medical expenditures as compared to the unmanaged MediPass program.

#### **Key Strengths of the MPN Program**

- Reduction in medical expenditures per member per month.
- Beneficiary utilization management and local management of providers.
- High degree of satisfaction among providers enrolled in the program.
- Sophisticated information technology and medical management expertise.

#### **Key Challenges for the Agency**

- The Agency needs better information about the costs associated with running the program, in order to identify the “bottom line” financial implications of the MPNs.
- The Agency must set clear, measurable objectives for the MPN program. Agency officials, the MPNs, and the providers should clearly understand expectations and objectives of the program.
- Alternative cost savings and payment methodologies should be considered. The current method may underestimate the actual medical expenditures experienced by the MediPass program and the MPNs.
- The Agency should evaluate and monitor the MPNs on a regular basis in order to determine the effectiveness of the program in meeting its expectations and objectives.

On-going monitoring will also allow the Agency and MPNs to incorporate lessons learned into the policies and procedures used to govern the program.

- The Agency should consider better coordination in areas of the state where multiple pilot programs are in operation.

### **Conclusion**

The MPNs appear to make MediPass work better by (1) offering providers timely beneficiary utilization information and (2) managing the networks at the local level. The result is a program with the potential to lower utilization and expenditures that is well received by Medicaid providers. Based on the results of the evaluation, it is recommended that the Agency consider expanding the MPNs into additional Medicaid areas, once it addresses some of the issues identified in this report.

**This page intentionally left blank.**

## **BACKGROUND AND SIGNIFICANCE**

### **MediPass Pilot Program**

In 2001, Florida's Agency for Health Care Administration ("the Agency") initiated a series of "Pilot Projects" to explore alternative managed care models for the Medicaid program. The intent of the pilot programs was to test new Primary Care Case Management models to determine if providing medical management services to providers improves access and the quality of care, and decreases the costs of operating the MediPass program. The Agency entered into agreements with an administrative services organization (ASO) and a managed services organization (MSO) to provide primary care case management, to manage referrals to specialty care, to maintain comprehensive medical records which document the continuum of care provided, and to adhere to the quality-of-care standards established for the Medicaid managed care program. The general concept assumes that alternative managed care models could result in the provision of cost-effective, quality health care for MediPass beneficiaries.

In general, the Pilot Projects use a payment methodology that includes a management fee paid on a per member per month (PMPM) basis, fee-for-service reimbursement for medical services, and a process for calculating and distributing "savings" that are shared by the Agency and the Pilot Project entity. The extent of "savings" is determined through quarterly calculation of PMPM costs compared to the applicable Upper Payment Limits (UPL) established by the Agency to estimate the cost on a PMPM basis for Medicaid beneficiaries.

The 2001 – 2002 Florida General Appropriations Act identified pilot programs that would include the development of improved approaches to managing access and utilization, the establishment of physician-owned and -operated managed care organizations with Medicaid experience, the establishment of at least one pilot that is a predominately minority physician network, and utilization of a shared savings payment methodology that is budget neutral.

### **Minority Physician Network Program**

One of the MediPass Pilot Projects is the Minority Physician Network (MPN) program. Under this program, the Agency contracted with two organizations in which the majority of physicians are members of racial and ethnic minority groups. One network, Florida NetPASS, is a network that originally served Miami-Dade, Broward, and Palm Beach Counties. The other network, PhyTrust, is a physician network that originally served Miami-Dade and Broward Counties. Both of the MPNs began operations in late 2001 and have recently expanded to the Tampa Bay area. The implicit premise in the formation of these networks is that minority physicians have limited access to the MediPass program and that targeted case management may improve the quality and access of care provided by and for minorities, of which a disproportionate high number are enrolled in Medicaid. In addition, the networks offer alternative mechanisms for managing the care and costs of Medicaid enrollees.

Continuing increases in the cost of medical care threaten the viability of Medicaid programs in numerous states, and most have responded with various cost-containment initiatives (Smith et al., 2004). In Florida, programs have included aggressive use of HMOs, case management programs, an innovative prescription drug cost containment program, a "provider service

network” demonstration, and other mechanisms. The MPN Pilot Project offers yet another model for structuring the way that care and expenditures can be managed in this sector.

The official genesis of the program was the Florida FY 2001 – 2002 General Appropriations Act. The Act authorized several MediPass pilot projects.

Specifically:

“The Agency for Health Care Administration shall establish methods to improve the quality of care and the cost effectiveness of the MediPass program. The method shall include, but is not limited to the establishment of a pilot (or pilots) to test new approaches to better manage the access to and utilization of appropriate health care services. The agency shall contract with physician owned and operated organizations which have experience in managing care for the Medicaid and Medicare programs and at least one pilot shall utilize a predominately minority-physician network with a history of providing services to Medicaid populations. The agency is authorized to develop a payment methodology which may include shared savings with contractors but shall not increase spending relative to current appropriations.”

To summarize, the key elements of the GAA FY 2001 – 2002 included:

- The development of improved approaches to managing access and utilization;
- The establishment of physician-owned and -operated managed care organizations with Medicaid experience;
- The establishment of at least one pilot that is a predominately minority physician network; and
- The utilization of a shared savings payment methodology that is budget neutral.

The Application for Participation in the MediPass Pilot Program defined a Minority Physician Network as a network in which more than 50% of the physicians in the network are minority physicians. The original application identified different types of pilots, including “Predominately Minority Physician Network Pilots” and “Physician Owned and Operated Network Pilots.”

The MPNs were authorized to serve the following categories of beneficiaries:

- Recipients of assistance under the TANF (Temporary Assistance for Needy Families) program
- Sixth Omnibus Budget Reconciliation Act (SOBRA) children
- Individuals receiving Supplemental Social Security Income (SSI) without Medicare coverage
- Children in foster care or subsidized adoption arrangements

Thus, these categories of beneficiaries would not be eligible for participation in a Minority Physician Network:

- Eligible Medicaid recipients who are domiciled or living in an institution
- Those receiving hospice services
- Those who also have Medicare or other major health insurance coverage

- Those whose Medicaid eligibility has been determined through the Medically Needy program
- Children with special needs enrolled in the Children's Medical Services Network (CMS)
- Women who, due to pregnancy, change SOBRA categories
- Children who receive Prescribed Pediatric Extended Care Services
- Recipients in a Medicaid Disease Management Initiative

The MPNs must include all services currently required of MediPass providers. Further, MPNs would not be responsible for managing the physician components of ophthalmologic services, mental health, or family planning services.

### **Evaluation Methods**

The Agency contracted with the University of Florida in October 2003 to conduct an evaluation of the Minority Physician Networks. The purpose of the evaluation was to assure the Agency that the program is achieving its intended goal of reducing cost while maintaining health care quality and access to the Medicaid program. The University was charged with helping the Agency make a decision about whether or not to expand the networks based on their ability to achieve savings and to maintain high provider and beneficiary satisfaction through the development of an innovative care and case management program.

Qualitative organizational analyses and quantitative analysis were used in the evaluation. Qualitative methods were used to examine data collected from interviews with the minority physician network's stakeholders, administrators, and providers, and the Agency staff located in the local area offices and Tallahassee headquarters.

In addition, evaluators reviewed and examined hundreds of documents and records, including the MPN applications, the MPN contracts and amendments, reports submitted by the MPNs to the Agency, and public information regarding organizational elements of the MPN.

The quantitative methods were used to analyze the cost effectiveness of the MPN program. To construct the data, 3,891,555 member-month records covering a period of 19 months (November 2001 to May 2003 inclusive) were used. These separate claims files were merged into one claim file with 22,387,881 records. The date range for these claims was 11/01/2001 to 05/31/2003, the initial contract period.

In sum, evaluators performed analyses of the 2002 – 2003 expenditures using the Rand Health Insurance 2-part model (Brook, Ware, et al. 1983). They examined member-month data between February 2002 and February 2003 for both total paid claims and total billed claims. The full details of this method are described in the Appendix.

**This page intentionally left blank.**

## **DESCRIPTION OF THE MINORITY PHYSICIAN NETWORKS**

The Agency initiated an open application process to solicit potential Minority Physician Networks for participation in the MediPass pilot program. The networks were required to be predominately minority and physician owned and operated or non-physician owned and operated. Two organizations, Florida NetPASS and PhyTrust, entered into contracts with Florida Medicaid in November of 2001 to operate their networks in the south Florida area.

The two contracted MPN organizations are similar in many ways but different in others. Both organizations were physician-owned and predominantly minority organizations that met the requirements of the pilot project. Each organization was looking to improve on the existing MediPass program.

### **Florida NetPASS**

Florida NetPASS was organized to bring together the administrative and operational capabilities of three of Florida's largest managed services organizations. Its Board of Directors is comprised of representatives from each of these organizations. The representatives are also principals of the firms that make up the combined Florida NetPASS organization (HS1 NetPASS, Inc.; Care NetPASS, LLC; and Physician Consortium Services, LLC). Essentially, Florida NetPASS exists to provide medical management and administrative services ("back office support") to large payers and providers such as the Agency. The mission of Florida NetPASS is to implement new information-based care management approaches to help make improvements in both the cost and quality of care within Florida's MediPass program.

The philosophy of Florida NetPASS (FNP) is that physicians are the "solution, not the problem." They believe in giving physicians information to manage the care of their beneficiaries and then "leaving them alone to do their job." Their approach to the MPN is to use population management techniques—to manage the top 3 – 4 percent of beneficiaries who use the majority of the resources. Florida NetPASS stakeholders referred to the importance of information technology and managed care "tools" that would improve on the existing MediPass program. They also described how their ultimate MediPass program was very different from the original concept they developed mostly due to the rules, requirements, and limitations of working within the Medicaid program. Thus, their focus on information and population management was described as "the only tool we have left."

Florida NetPASS has also developed a health benefits program for the low income uninsured. While this program is not directly related to the MPN, it demonstrates the firm's commitment to and involvement with issues of access and insurance for the underserved in South Florida.

### **PhyTrust**

PhyTrust was established in South Florida in October 1997. It provides the day-to-day management of Access CMO, a minority-owned and -governed physician network. In general, PhyTrust focuses on the physician and supporting the physician. Stakeholders described their philosophy as one that places the physicians in the center of patient care and "where respect between patient and physician creates the trust." PhyTrust is a medical service organization

focused on developing and managing physician-owned networks of primary care physicians, many of whom are racial and ethnic minorities, in order to provide quality and cost-effective care to those who need it most. PhyTrust's mission is providing Medicaid beneficiaries greater access to quality health care through physician-owned networks and delivering substantial cost savings to state Medicaid programs.

The PhyTrust model of health care emphasizes primary care, which reduces health care costs, improves outcomes of care, preserves the centrality of the doctor-patient relationship, while simultaneously empowering physicians and making them accountable for the quality and outcomes of the care they provide their patients.

PhyTrust directors suggested that they were working to "radically increase beneficiary access to PCPs." When asked to describe radical access, the following characteristics were mentioned: availability of walk-in appointments, night/evening/weekend hours, outreach to chronic illness beneficiaries, giving patients provider cell phone numbers, and providers making house calls. PhyTrust leaders believe that "doctors trust PhyTrust, so patients trust doctors."

Another important note is that the PhyTrust organization provided ample evidence of their commitment to improving the access to and quality of care for minority populations in Florida. They view the MPNs as a way to support minority physicians and enable them to keep serving these populations (and improve their financial survival when they do).

PhyTrust has an active community relations function. They are very involved in programs to support access to care, health awareness and other issues for minority populations. PhyTrust remains active in the political/legislative process in the area of minority health and disparities. They believe that the MPN is an incredible program that state and community leaders are willing to stand up for.

### **Contractual Relationship with Agency**

Due to the different approaches to managed care and the differences in organizational history and philosophy, the initial approaches to establishing a minority physician network were quite unique. These differences were reflected in the initial contracts between Florida NetPASS and the Agency and PhyTrust and the Agency. Table 1 (next page) provides an overview of the key differences in the original MPN contracts.

**Table 1: Overview of Original MPN Contracts**

	<b>PhyTrust (PT)</b>	<b>Florida NetPASS (FNP)</b>
<b>Effective Dates:</b>	11/1/01 – 6/30/03	11/1/01 – 6/30/03
<b>Contract Amount:</b>	\$1,974,843	\$1,959,945
<b>Reporting Requirements:</b>	Few Specified	Standard (List from Application)
<b>PCP Credentialing:</b>	Agency	FNP
<b>Provider Billing</b>	Individual PCP	Super Group ID
<b>Administrative Fee:</b>	\$10 PMPM	\$12 PMPM initially
<b>Reduced to \$9 PMPM</b>		
<b>Case Management Fee:</b>	\$3 PMPM to PCPs	\$3 PMPM to PCPs
<b>Shared Savings Method:</b>	<p><u>Two Scenarios:</u></p> <p>(1) If total claims paid are equal to or above UPL, no shared savings, PT repays 100% of administrative fees paid that quarter.</p> <p>(2) If claims paid are below UPL, savings shared 50%-50%, minus administrative fees paid for that quarter.</p>	<p><u>Three Scenarios:</u></p> <p>(1) If total claims paid are above the UPL, no shared savings, FNP repays 100% of administrative fees paid that quarter.</p> <p>(2) If claims paid are below UPL but above Medicaid HMO capitation rates, FNP receives 30% of savings, minus administrative fees paid that quarter.</p> <p>(3) If claims are below Medicaid HMO capitation rates, FNP receives 40% of savings, minus administrative fees paid that quarter.</p>

In April 2003, the Agency solicited new applications for a continuation of the minority physician networks under the MediPass pilot program. The new application extended the pilot projects into Medicaid Areas 5 (Pasco and Pinellas Counties) and 6 (Hardee, Highlands, Hillsborough, Manatee, and Polk Counties). It also continued the project through June of 2005. The new application was designed to bring the two networks in line with one another, requiring them to adhere to the same payment methodology and operational procedures.

More specifically, the new application included provisions allowing a physician incentive plan, requiring networks to credential PCPs, and requiring efforts to reduce pharmaceutical expenditures. In addition, the application stated that MPNs must use a single Medicaid provider number (or "SuperGroup"). Finally, the monthly administrative fee was set at \$12 PMPM for each organization.

### **Provider Network**

Each MPN organization established a primary care physician (PCP) network by employing Agency authorized marketing materials and recruitment strategies. Both MPNs depended on their existing physician networks and business relationships to build the foundation of their primary care network for the MediPass Pilot program. In addition to enrolling their existing providers, the networks used the following strategies to build their provider networks:

- Word of mouth;
- Provider relations departments;
- Marketing representatives;
- Information management and utilization management systems that employed information technology; and
- Provider training and monthly in-services on patient and other medical management tools.

A key part of the minority physician network program is providing physicians with information that can be used to improve the quality of care and the management of their medical practice. Both PhyTrust and Florida NetPASS provide the primary care physicians in their networks with provider profiles on pharmacy use, the utilization of services by their beneficiaries, and how physicians compare to their peers. These profiles are an important tool against fraud and abuse in that the profiles identify when the PCP did not write a prescription or when billed or reimbursed services have codes that do not match the services ordered or rendered by the PCP.

The providers in the MPNs also benefit from the mandatory assignment process used by Florida Medicaid to assign beneficiaries to providers and managed care organizations. Florida NetPASS and PhyTrust began the MediPass pilot project using the existing network of physicians that they worked with on other managed care programs. Some physicians saw the possibility of getting more beneficiaries through mandatory assignments by contracting with the MPN program, thus stimulating Florida NetPASS' growth in numbers of providers and beneficiaries. PhyTrust providers were incentivized by the generous physician incentive plan established by PhyTrust.

As shown in Figure A-1 (Appendix), the MPNs began their operations in South Florida. Both Florida NetPASS and PhyTrust began operations in November of 2001 in Miami-Dade and Broward Counties. Florida NetPASS expanded their operation to include Palm Beach County.

In April of 2003, both networks expanded to the Tampa-St. Petersburg area (Medicaid Areas 5 and 6).

Florida NetPASS has 313 PCPs serving Palm Beach, Broward, and Miami-Dade counties. In the two counties served by PhyTrust, there are 129 Medicaid PCPs. In each of the counties, MPN physicians are distributed throughout the geographic regions with the exception of the southern part of Miami-Dade County (e.g., near Homestead).

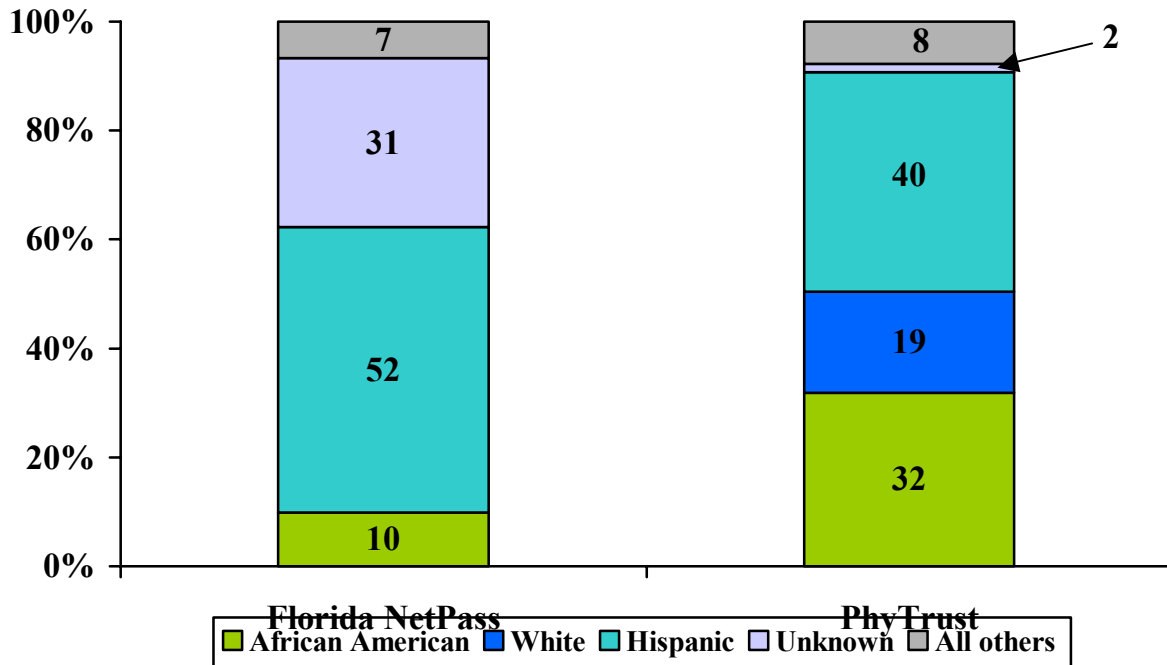
The majority of MPN PCPs are racial or ethnic minorities (Table 2). For Florida NetPASS, approximately 10% are African-American, 52% are Hispanic, and 6% are Asian. This compares to PhyTrust PCP ethnic distribution of 32% African-American, 40% Hispanic, and 7% Arabic (Figure 1 – next page).

**Table 2: Primary Care Physicians by Ethnicity, Fall 2003**

	Total MPN		Florida NetPASS		PhyTrust	
	N	%	N	%	N	%
<b>African American</b>	72	16.3	31	9.9	41	31.8
<b>Caucasian</b>	24	5.4	0	0.0	24	18.6
<b>Hispanic</b>	216	48.9	164	52.4	52	40.3
<b>Asian</b>	20	4.5	19	6.1	1	0.8
<b>Arabic</b>	9	2.0	0	0.0	9	7.0
<b>Native American</b>	2	0.5	2	0.6	0	0.0
<b>Unknown</b>	99	22.4	97	31.0	2	1.6
<b>Total</b>	442	100.0	313	100.0	129	100.0

Source: Florida NetPASS, PhyTrust

**Figure 1: Primary Care Physicians by Ethnicity, Fall 2003**



Source: Florida NetPASS, PhyTrust

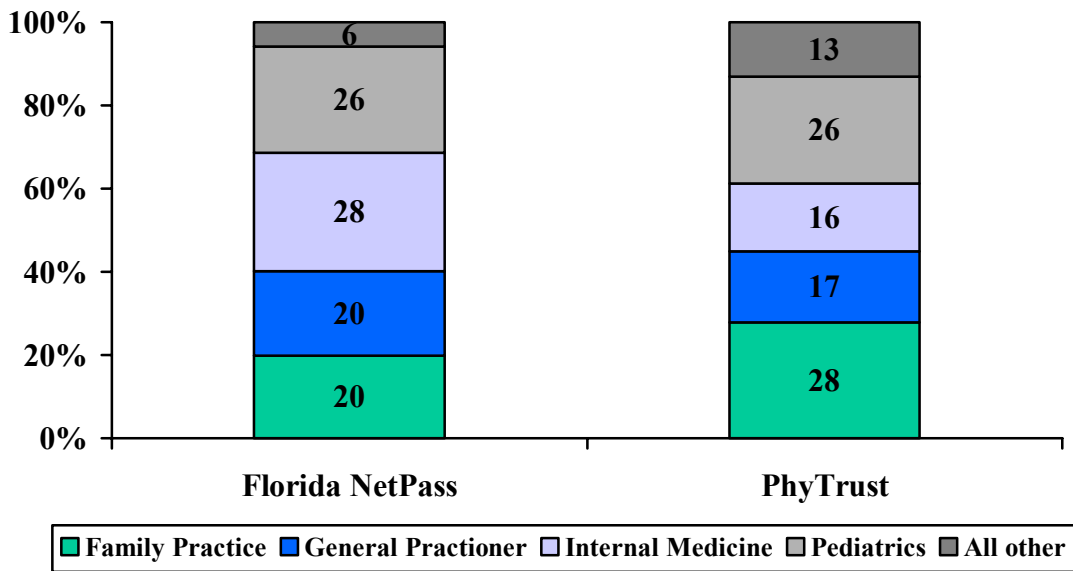
All types of primary care physicians are represented in the MPNs as shown in Table 3 and Figure 2 (next page). There are some differences in the mix of PCP types between the two MPN organizations. Notably, PhyTrust has a higher proportion of family practice PCPs (e.g., 28% versus 20% for Florida NetPASS) and Florida NetPASS has a higher percentage of internal medicine PCPs (e.g., 28% versus 16% for PhyTrust). The differences in PCP distribution may have some implications for the potential cost savings accruing to each organization. For example, internal medicine specialists may be more likely to see sicker patients, lowering the potential for substantial savings when comparing the actual medical expenditures to the UPL, an estimate of the average PMPM costs of serving a Medicaid beneficiary.

**Table 3: MPN Primary Care Physicians by Type, Fall 2003**

	Total MPN		Florida NetPASS		PhyTrust	
	N	%	N	%	N	%
<b>Family Practice</b>	98	22.2	62	19.8	36	27.9
<b>General Practice</b>	86	19.5	64	20.4	22	17.1
<b>Internal Medicine</b>	110	24.9	89	28.4	21	16.3
<b>Multiple Specialties</b>	20	4.5	4	1.3	16	12.4
<b>OB/GYN</b>	14	3.2	13	4.2	1	0.8
<b>Pediatrics</b>	113	25.6	80	25.6	33	25.6
<b>Pulmonary</b>	0	0.0	0	0.0	0	0.0
<b>Gynecologist</b>	1	0.2	1	0.3	0	0.0
<b>Total</b>	442	100.0	313	100.0	129	100.0

Source: Florida NetPASS, PhyTrust

**Figure 2: Primary Care Physicians by Type, Fall 2003**



Source: Florida NetPASS, PhyTrust

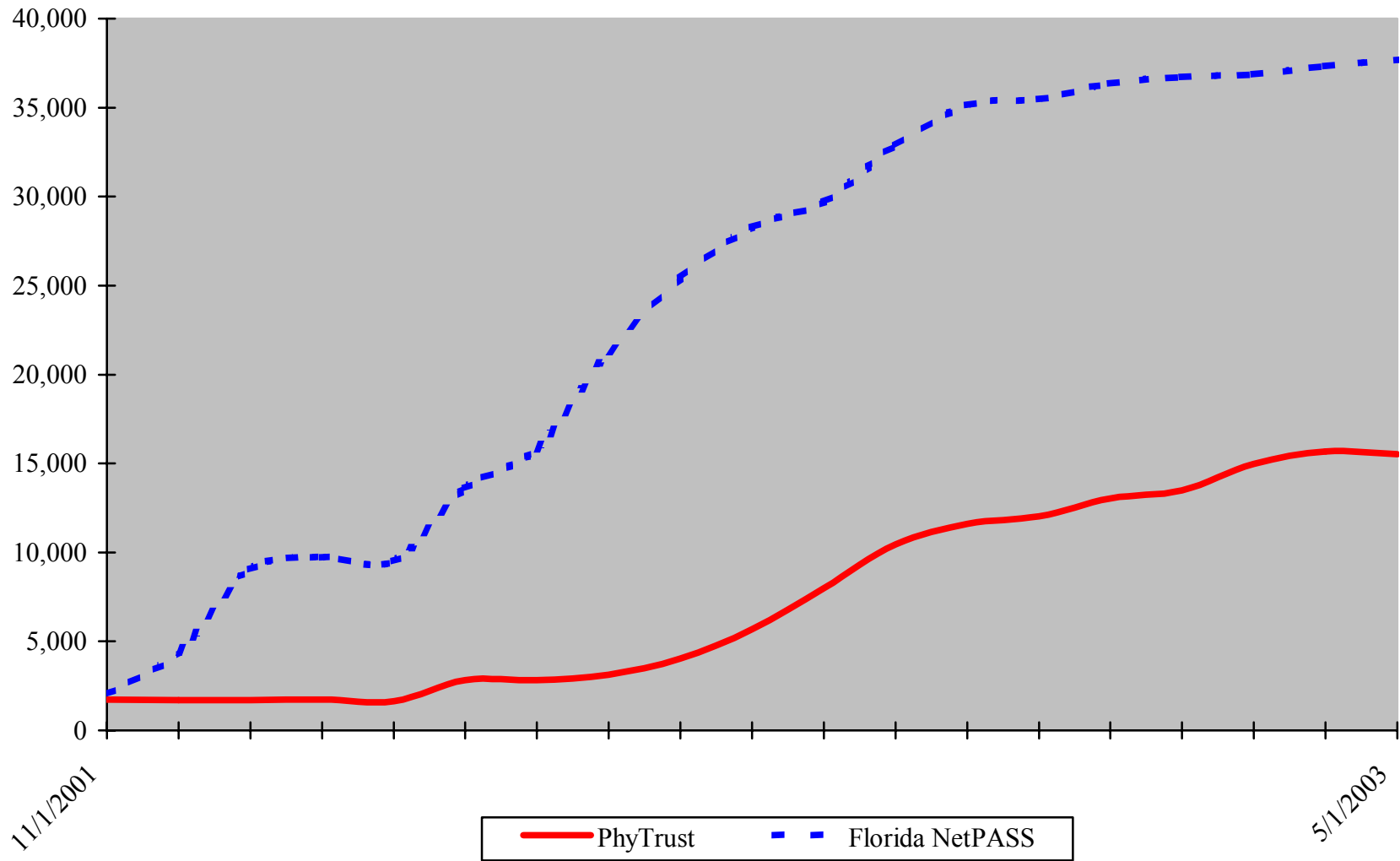
## **Membership**

Over the first nineteen months of MPN operations, the MPNs grew to include over 53,000 members in 3 Florida counties. PhyTrust grew to over 15,500 members and Florida NetPASS grew to over 37,700 members in the three South Florida counties. When combined with MediPass enrollment in the same areas, PhyTrust began as 1% of the total MediPass membership and it grew to about 7%, while Florida NetPASS began with about 1% and it grew to include nearly 17% of all MediPass beneficiaries in these areas (see Figure 3 and Table 4 on pages 19 and 20).

Like overall Florida Medicaid, the MPNs serve a large number of minority members. For the time period and geographic region, about 80% of MediPass and MPN members were non-white. More specifically, the membership composition was roughly 30% Black and approximately 40% Hispanic in MediPass and in the MPNs.

The geographic mix of the MPNs by county has varied over time. In the beginning, both organizations were predominately (over 90%) based in Miami-Dade County. By May 2003, however, PhyTrust was split 30% in Broward County (4,570 members) and 70% in Miami-Dade (10,862 members) while Florida NetPASS membership was divided with approximately 12% Broward (4,628 members), 61% Miami-Dade (23,107 members) and 26% in Palm Beach County (9,968 members).

**Figure 3: MPN Enrollment by Month**  
**Palm Beach, Broward, and Miami-Dade Counties**  
**11/1/2001 – 5/1/2003**



Source: AHCA

**Table 4: MPN Enrollment by Month  
Palm Beach, Broward, and Miami-Dade Counties  
11/1/2001 – 5/1/2003**

Month	Total MPN		PhyTrust		Florida NetPASS		MediPass		Total
	N	% Total	N	% Total	N	% Total	N	% Total	
11/1/2001	3,770	1.9	1,740	0.9	2,030	1.0	190,722	98.1	194,492
12/1/2001	6,124	3.2	1,709	0.9	4,415	2.3	187,649	96.8	193,773
1/1/2002	10,751	5.6	1,704	0.9	9,047	4.7	181,689	94.4	192,440
2/1/2002	11,431	6.0	1,717	0.9	9,714	5.1	179,287	94.0	190,718
3/1/2002	11,140	5.8	1,627	0.9	9,513	5.0	179,515	94.2	190,655
4/1/2002	16,414	8.67	2,816	1.5	13,598	7.1	175,217	91.4	191,631
5/1/2002	18,651	9.7	2,822	1.5	15,829	8.2	174,458	90.3	193,109
6/1/2002	24,415	12.3	3,117	1.6	21,298	10.8	173,549	87.7	197,964
7/1/2002	29,439	14.7	4,028	2.0	25,411	12.7	170,949	85.3	200,388
8/1/2002	33,961	16.7	5,684	2.8	28,277	13.9	168,978	83.3	202,939
9/1/2002	37,684	18.4	7,989	3.9	29,695	14.5	167,536	81.6	205,220
10/1/2002	43,312	20.8	10,454	5.0	32,858	15.8	164,718	79.2	208,030
11/1/2002	46,737	22.0	11,608	5.5	35,129	16.6	165,371	78.0	212,108
12/1/2002	47,497	22.1	12,021	5.6	35,476	16.5	167,374	77.9	214,871
1/1/2003	49,375	22.8	13,015	6.0	36,360	16.8	167,077	77.2	216,452
2/1/2003	50,212	22.8	13,493	6.1	36,719	16.7	170,299	77.2	220,511
3/1/2003	51,867	23.5	14,988	6.8	36,879	16.7	169,205	76.5	221,072
4/1/2003	53,006	24.0	15,668	7.1	37,338	16.9	168,285	76.0	221,291
5/1/2003	53,243	23.8	15,531	6.9	37,703	16.8	170,657	76.2	223,891

Source: AHCA

## **Program Structure**

The intent of the Medicaid Pilot Projects was to explore the feasibility of alternative and, presumably, improved Medicaid managed care plans. A key feature of the MPNs included their ability to develop and manage physician networks on a local level. The pilot projects application stated that participating organizations would become Medicaid providers, that is, be assigned a single Medicaid identification number or "SuperGroup" ID. In addition, the MPNs were required to credential providers, conduct member services, and other functions as described below. During the program development and contract negotiation process, however, the Agency gave the MPNs considerable flexibility regarding their specific implementation strategies. Later, the Agency required that both organizations adhere to a standard set of program elements.

### ***Provider Credentialing***

The MPNS are required to credential the primary care providers enrolled in their respective networks. At the inception of the program in November 2001, Florida NetPASS established a credentialing program as a primary means of cost containment. PhyTrust did not initiate their credentialing program until July 2003.

### ***Physician Incentive Plans***

The MPNs were authorized to institute physician incentive plans that were in compliance with federal regulations regarding physician incentives utilized by Medicaid managed care organizations. PhyTrust's physician incentive plan was included in its application and has been used since the program began. Before September 2003, all incentives were based on "efficiency" only—that is, physicians were eligible for bonuses if their beneficiary expenditures were below those that were expected according to the UPL. Currently, PhyTrust has a multi-faceted financial incentive program. Specifically, the maximum potential bonus for each PCP is determined by: (1) efficiency performance (shared savings by PCP as a percent of all shared savings that quarter) and (2) Quality Adjustment Score (based on six quality measures, including: child health check-ups, adult health screenings, welcome letters, provider education meetings attended, authorized referrals notified to PhyTrust, and beneficiary satisfaction with care). Florida NetPASS submitted a physician incentive plan to the State and received approval for the plan. To date, however, the Florida NetPASS incentive plan has not been implemented.

### ***Information Systems***

Both of the MPNs use an information approach to managing care and working with the PCPs in their networks. Florida NetPASS provides their physicians with comprehensive monthly and quarterly reports. A provider representative visits each Florida NetPASS PCP to answer questions about the program and the reports. Florida NetPASS reports identify the physicians' MediPass beneficiaries and show the utilization by those beneficiaries (services ordered by any physician, hospitalizations, pharmacy, etc.). They also compare the PCPs to their peers on a variety of measures. PhyTrust distributes similar monthly and quarterly reports to the PCPs in their network. PhyTrust hosts monthly in-services and trainings for their PCPs and quarterly meetings in addition to the distribution of a quarterly newsletter.

Each of the MPN organizations has invested in computer systems to track and analyze beneficiary and provider data. These organizations use sophisticated, proprietary information systems and highly qualified staff to work with the data provided by the Agency monthly. The information system tools and managed care experience of these organizations are a key strength of the MPN program.

### ***Utilization/Medical/Case Management***

Both MPN organizations are actively engaged in a variety of utilization management, population management, and case management activities. Each organization has developed specialty referral processes and forms (though these are not always used by PCPs).

In addition to PCP reports and profiling, PhyTrust uses nurses in hospitals to monitor beneficiary progress, communicate back with PCPs, and develop discharge plans. PhyTrust has established a unique relationship with KePro that allows them to concurrently review inpatient hospitalizations to make sure ordered services are given that day and for feedback to the PCPs on beneficiary progress, needs, and discharge.

Florida NetPASS uses its monthly "InforMed" reports to help PCPs manage patient care. Their population management program focuses on those patients who are "heavy users" or those who have specific chronic illnesses. A Florida NetPASS physician meets with the PCPs of beneficiaries that have been identified as high utilizers to assist the PCP with the medical management process. In addition, Florida NetPASS has a pharmacy cost reduction initiative underway, including examination of generic use and comparing pharmacy use and costs among physician peer groups.

### ***Member Services***

Each MPN provides required member services to beneficiaries, such as notifying beneficiaries that their provider is enrolled in the MPN, maintaining appropriate medical records, and maintaining internal complaints and grievance procedures.

### **Administrative Structure**

The MPNs provided information about their administrative structure by reporting on the FTEs dedicated to various MPN functions. As summarized in Table 5<sup>2</sup>, for the standard functions of enrollment, enrollee services, provider contracting, provider credentialing, financial management, and medical management, the MPNs relied on approximately 1.0 FTE per 1000 members after the first 18 months of existence. When other functions were included (these were defined by the MPNs), the administrative complement for the MPNs grew to 1.53 for PhyTrust and 1.24 for Florida NetPASS (per 1000 members). In both organizations, medical management represents the largest administrative aspect (8/49 FTEs for PhyTrust and 7/39.75 for Florida NetPASS in July 2003).

---

<sup>2</sup> See Tables A-2 and A-3 in the Appendix for more detail

**Table 5: Summary of Administration FTEs by Month  
Selected Dates 11/1/2001 – 7/1/2003**

Function:	PhyTrust			Florida NetPASS	
	Start-Up	7/1/2003		Start-Up	7/1/2003
Recipient Enrollment and Disenrollment Tracking	1.00	1.00		0.25	2.00
Enrollee Services, Education, Outreach	1.00	3.00		0.25	1.00
Provider Contracting and Relations	3.00	7.00		5.00	13.00
Provider Credentialing	0.00	0.75		0.25	1.25
Financial Management (Including Claims Management, Reconciliation)	2.00	3.00		2.00	2.50
Medical Management (Case Management, Population Management)	4.00	8.00		4.00	7.00
Grievance and Appeals Resolution	0.00	0.25		0.25	0.25
Quality Monitoring	1.00	1.00		0.00	0.25
Program Development and Oversight	1.00	1.00		2.00	3.00
Information Management	4.00	4.00		1.00	2.00
<b>Subtotal FTEs:</b>	17.00	29.00		15.00	32.25
<b>Subtotal FTEs per 1000 Members</b>	9.95	0.91		3.39	0.80
<i>Other (Specify Functions):</i>			<i>Other (Specify Functions):</i>		
Senior Staff	3.00	4.00	Referrals	3.00	6.00
Administrative Staff	1.00	4.00	Credentialing Committee	0.50	0.50
Consultants	5.00	9.00	Mailroom/Admin	1.00	1.00
Accounting/A/P/H/R	2.00	3.00			
<b>Grand Total FTEs:</b>	28.00	49.00		19.50	39.75
<b>Grand Total FTEs per 1000 Members:</b>	16.38	1.53		4.41	1.24

Source: PhyTrust, Florida NetPASS

**This page intentionally left blank.**

## **PROGRAM DEVELOPMENT**

The Minority Physician Network program is one of the MediPass pilot projects designed to provide an alternative to the traditional MediPass fee-for-service program available to Medicaid providers. During the 2001 Legislative session, the Legislature authorized the Agency to develop alternative approaches to managing access and utilization of services within the MediPass program. The Agency was charged with establishing primary care and case management organizations that were physician owned and operated. The Legislature intended for at least one of the organizations to be a predominately minority physician network. The Agency established the parameters of the program and ultimately contracted with two minority physician-owned and operated networks.

As with any new program, there were implementation issues and challenges at the beginning of the program. During the initial implementation, the administration of the MediPass pilot programs by the Agency required additional personnel resources to monitor the programs and to educate and train the MPNs on MediPass and Agency policies. Overall, the Agency and the MPNs experienced challenges in three main areas: (1) issues related to the SuperGroup; (2) communication between the Agency and the pilot programs; and (3) issues related to disenrollment of certain beneficiaries by the MPNs.

### **“SuperGroup”**

In the original contract between PhyTrust and the Agency, PhyTrust did not handle credentialing and member services because they did not operate with a “SuperGroup” provider identification number. At the same time, Florida NetPASS was using the “SuperGroup” model and Florida NetPASS was responsible for credentialing the PCPs in their network and for providing informational services to members. Agency staff reported that this distinction between the two groups made the MPN program difficult to manage. In order to eliminate confusion, the Agency required PhyTrust to comply with the “SuperGroup” model under its new contract. Essentially, this means that all PCPs in an MPN are assigned a single Medicaid provider number (the SuperGroup number - one for PhyTrust and one for Florida NetPASS). When billing for MPN beneficiaries, the PCP uses the SuperGroup number instead of his or her unique Medicaid provider number.

### **Communication**

Because the Agency did not have changes made in its information systems to create specific reporting and analysis functions for the pilot projects, Agency officials said they had a difficult time getting required reports regarding the pilot programs. The programs were new and different, which meant that almost all analyses and reporting had to be conducted by hand. Area Offices also reported that the implementation of numerous MediPass pilot programs in the same area at the same time added to the administrative burden experienced by the Area Offices.

Florida NetPASS and PhyTrust held regularly scheduled teleconferences with Agency staff to address program issues, including:

- contract issues
- provider credentialing
- hospital inpatient utilization
- reconciliation methodology
- physician incentive program
- claims processing
- child health check-up requirements
- mandatory assignments
- provider enrollment and disenrollment policies
- management of disease management population
- provider credentialing
- beneficiary/PCP alignment
- reporting requirements

### **Disenrollment of MPN Beneficiaries**

The Agency expressed concern over whether or not the MPNs were moving the more difficult beneficiaries out of their networks into regular MediPass by requesting disenrollment of non-compliant beneficiaries. This issue is important because evidence that physicians are not willing to deal with complex or “difficult” beneficiaries would mean that these beneficiaries are left in “regular MediPass.” In general, these requests have to do with (1) fraud/abuse (drug seeking), (2) clinical non-compliance, and (3) lack of contact. Each MPN has specific processes in place to deal with physicians’ requests to disenroll beneficiaries from their practices.

When the evaluation team asked for information on requests to disenroll beneficiaries, each MPN provided it to the evaluators, including lists of patients, length of time with the PCP, and type of non-response or non-compliance. In reviewing this data, no systemic attempts to “dump” expensive beneficiaries or high users were identified.

### **Lessons Learned**

As the project approaches its third year of operation, the learning curve seems to be leveling for the MPNs and the Agency. In recent interviews, the staff in the Medicaid Area Offices noted the utilization management program, the use of the Super Group model, and the use of inpatient case managers as primary benefits of the program. Overall it was felt that the MPN model is a good alternative to traditional MediPass and managed care.

During interviews with the MPNs, stakeholders identified lessons learned in the implementation process and offered ways to improve the program.

#### ***Lessons Learned***

- The doctor-patient relationship is key to creating a successful program.
- Having a knowledgeable and attentive contract manager is key to facilitating the relationship between the Agency and the Network.

- The MPNS are giving physicians tools that enable the PCCM program to work the way it is supposed to work.
- Let computers do whatever they can (e.g., use the best medical management technology available).

***Recommendations***

- The Agency should focus on oversight, not micromanagement.
- The Agency should improve the administration of payments in order to assure timely and accurate distributions to the networks.
- The MPNs would like to improve the referral authorization process through the development of a unique authorization number.
- Develop a beneficiary realignment process that would allow the MPNs to quickly and easily change PCP assignments based on who beneficiaries are actually seeing. This would assure the patient-doctor relationship is maintained.
- The MPNs would like the flexibility to use different physician reimbursement models.
- The MPNs recommend a risk-adjusted UPL methodology.

**This page intentionally left blank.**

**MPN PERFORMANCE**

The performance of the MPNs was measured by examining:

- (1) provider satisfaction;
- (2) quality of care and beneficiary satisfaction; and
- (3) cost effectiveness and financial impact.

**Physician Satisfaction**

The research team interviewed twenty current and former MPN PCPs (including approximately 10 PhyTrust and 10 Florida NetPASS physicians). Interviewed PCPs were identified by the MPNs and Medicaid Area Office staff. PCPs who had left the MPNs were also contacted. In general, physicians were very satisfied with the MPNs, as illustrated by specific comments in Table 6.

**Table 6: Physician Comments on the MPNs**

<b><u>PhyTrust</u></b>	<b><u>Florida NetPASS</u></b>
<p><i>Good communication.</i></p> <p><i>Local, personal relationship (“we know who to call”).</i></p> <p><i>Helps me provide better care to my patients (e.g., screenings, check-ups, Rx).</i></p> <p><i>Case managers in hospital really help.</i></p> <p><i>Financially, I am doing better under PhyTrust.</i></p> <p><i>I like the financial incentives.</i></p> <p><i>I am pleased with how this is run.</i></p> <p><i>They listen to us, they like our ideas.</i></p> <p><i>Quarterly meetings are good.</i></p> <p><i>I have more knowledge about how Medicaid works.</i></p> <p><i>Sometimes expectations for stuff from me is too quick (e.g., credentialing).</i></p>	<p><i>This is not an HMO (and I’m glad).</i></p> <p><i>Good communication (“we know who to call”).</i></p> <p><i>Lots of information provided to me.</i></p> <p><i>This helps independent physicians.</i></p> <p><i>We are a busy practice, this helps us know more about our patients.</i></p> <p><i>FNP prevents patients from “doctor shopping”.</i></p> <p><i>FNP finds loopholes, fraud, inappropriate use.</i></p> <p><i>I am getting my patients to call me, not go to the ER.</i></p> <p><i>FNP focuses on quality, not volume.</i></p> <p><i>With FNP, I better manage care so my patients come back.</i></p> <p><i>I would like them to help me in other areas (beyond costs, Rx).</i></p> <p><i>I’d like to know more about what is going on in the “big picture”.</i></p>

PCPs agreed that the following aspects of the MPN program were positive improvements over MediPass.

***Monthly Utilization Reports***

PCPs said that monthly reports permit increased monitoring of medications and beneficiary utilization of providers other than their assigned PCP. In fact, physicians said they found out

about beneficiaries they had never seen and the report helped them develop ways to reach out to those beneficiaries or get them assigned to the doctor who does provide their primary care. Physicians said that the MPNs' detailed beneficiary utilization data helped them detect fraud and abuse and inappropriate use in the system in ways that MediPass never had. In general, providers liked the profiling and peer comparisons that helped them know where they stand relative to their peers.

### ***Physician Incentive Plan***

For PhyTrust PCPs, the financial incentives were a major source of satisfaction.

### ***Administrative Support***

PCPs and their office staff said the MPNs gave them a contact person who can "interface" with the Agency. Some suggested that the MPNs were particularly helpful to small physician practices and foreign-trained doctors who need administrative support and help understanding how the health care system works. Overall, most providers said that the MPNs represented a good alternative to the "dreaded Medicaid HMOs."

### **PCP Perspective on MPN**

During the evaluation, the PCPs shared their perspective on the implementation of the MPN program. In general, the PCPs expressed satisfaction with the MPNs' yet they did note areas for improvement.

### ***Provider-Beneficiary Relations***

Some PCPs perceived a "loss" of beneficiaries in the MPNs. While evaluators found that PCPs did not actually lose beneficiaries, there was a process that often took a few months whereby beneficiaries were assigned to the MPN SuperGroup ID. Or, if beneficiaries lost eligibility and then regained it, there was a more complex process of getting those patients reassigned to the same doctor.

### ***Two Lists (Disease Management and MPN Beneficiaries)***

Also confusing for PCPs was that they were now getting two lists of beneficiaries (one for MPN and another for Disease Management beneficiaries). Some reported that they did not have any contact with Medicaid Disease Management staff.

### ***Non-compliant Patients***

MPN physicians were sometimes confused about their ability (or inability) to disenroll non-compliant beneficiaries. Some PCPs expressed frustration with patients they viewed as "difficult"—that is, those patients who did not comply with their medical advice or did not come to see them on a regular basis. In some cases, these same patients were seeing other MediPass providers without the management of their care by their designated PCPs. The physicians said that it was impossible to improve care (or reduce costs of care) for these patients.

One example was a pediatrician who expressed frustration with parents who continued to use the emergency department even after he had repeatedly instructed them to call him first. Another physician described the numerous contacts (by phone and in writing) that her office had made asking patients to come see her for routine well visits and care. Many patients never responded. The PCP knew that the patients were getting care, because their utilization showed up on her monthly MPN report, but she did not know how to change those patients' behavior. In this case, the physician's financial bonus would be lower because she was not able to get all well visits performed and, potentially because other physicians (not the PCP) were ordering tests and prescriptions that she could not verify as appropriate (even though she was the PCP).

One PCP has a very high percentage of HIV-positive members, for whom he recommends various courses of treatment, which he expects to be followed. When physician orders are simply disregarded, the physicians themselves become frustrated, and generally recommend that the patients seek treatment elsewhere.

It is not surprising that more of these requests would be made under the MPNs than in the regular MediPass program. The ongoing oversight and financial implications for physicians lead them to be more aware of the beneficiaries in their panel and those beneficiaries' utilization of other providers and medications not ordered by the PCP. This information was not available to providers under MediPass.

### ***Mandatory Assignments***

Some providers also noted that they had not seen the membership increase they had hoped for through mandatory assignments with the MPNs. Most said "I'd like more MPN beneficiaries."

### ***Specialty Care Access***

A key issue for Medicaid in general is the availability of specialists. Technically, the network of Medicaid specialists is identical for MediPass and MPNs. In the interviews, the evaluation team heard conflicting comments about the availability of specialty care in South Florida. For example, here are some of the comments the evaluation team heard from PCPs and MPN staff:

*There are enough specialists.*

*There are not enough specialists.*

*Fewer specialists take Medicaid.*

*Some specialists only take Medicaid for inpatient business.*

*Easier to get specialists in MPNs than in Medicaid HMOs.*

*Some specialists say they don't take Medicaid (but they really do—they only take referrals from certain PCPs).*

*For those specialists who accept Medicaid, wait times for appointments are long.*

When PCPs mentioned specialty shortages, they were in the following specialty areas: Dentistry, Urology, Neurosurgery, Rheumatology, and Medical Orthopedics.

Because the MPNs cannot contract directly with specialists, they cannot directly improve access to specialty care in the markets they serve. It was clear that personal and informal relationships among PCPs and specialists were very important. The MPN organizations reported that they would work with PCPs to find specialists. They also said they have encouraged specialists who work with them on other managed care plans (not MediPass) to also participate in the MPN program. There was anecdotal evidence that some specialists have applied for Medicaid because of the MPNs.

### ***Provider Participation***

Evaluators found no evidence of a systematic exit from the MPNs by Medicaid PCPs. Over the course of MPN operations, fewer than 10 physicians in total requested to leave the MPNs. Attempts were made to contact several of these physicians and evaluators spoke to one who said that there was confusion about what the MPN was and a decision was made after one month to leave. Thus, there are not a significant number of physicians who are leaving the MPNs (and the findings on provider satisfaction support this notion).

Evaluators also explored the issue of whether Medicaid (not MediPass) physicians were in the MPNs. To understand this, Medicaid data from the Agency was used. No major trend with respect to non-MediPass physicians in the MPNs was identified. More specifically, in December 2003, there were 347 MPN providers in Miami-Dade and Broward counties (by definition, they were all Medicaid providers). Of these, only 9 were not MediPass providers.

### **Quality of Care**

Due to the time and resource limitations, this evaluation does not include a comprehensive report on patient satisfaction and quality of care. In general, there are limited data or evidence to examine the quality of care and beneficiary satisfaction in this program. Both organizations have outlined processes for collecting quality data and acknowledge the importance of quality assurance. However, at the time of this evaluation, only the PhyTrust beneficiary satisfaction survey results (which are very positive) have been submitted to the Agency.

The contracts with the MPNs specified that HEDIS-type reporting should be used to measure the quality of care. Florida NetPASS, in particular, does not believe that the HEDIS system is appropriate for this program and has raised some specific data and methods limitations that would limit their ability to use the HEDIS model.

In general, the evaluation cannot identify whether overall quality of care has improved or declined in the MPN program. There is, however, enhanced oversight of physician behavior in these programs. In addition, the specific monitoring and reporting of beneficiary utilization gives PCPs the opportunity to better monitor the appropriate use and quality of care provided to beneficiaries.

## **COST EFFECTIVENESS ANALYSIS AND FINANCIAL RESULTS**

### **Overview**

Due to the limited time and resources for this evaluation, it was not possible to conduct a complete cost effectiveness analysis of the MPN program. A comprehensive analysis typically includes: (1) an assessment of the costs of implementing and operating a health care program and (2) an assessment of the "effectiveness" or the impact of the program on quality of care, the appropriate use of services, and clinical health outcomes.

In this evaluation, the research team evaluated the financial impact of the MPN program using three different measures of cost effectiveness:

- (1) A statistical analysis of the medical expenditures in the MPNs and in MediPass for the same time period and geographic areas;
- (2) An analysis of the "shared savings" achieved by the MPNs using the UPL methodology outlined in the MPN contracts with the State; and
- (3) An analysis of the Agency resources used to implement and operate the MPN program.

The multiple analyses provide three unique opportunities to assess the financial impact of the MPN program. First, the medical expenditure analysis compares MPN medical expenditures to MediPass expenditures for beneficiaries in the same geographic area during the same time period. In the medical expenditure analysis, the costs of serving a Medicaid beneficiary in the MediPass program is compared to the cost of treating a beneficiary in the MPN program with similar demographics using retrospective data.

The "shared savings" methodology compares the actual MPN expenditures to the anticipated costs of serving a Medicaid beneficiary as gleaned in the Medicaid UPL, a benchmark established by the Agency for the purposes of analyzing and predicting the costs of numerous Medicaid programs and services. This method of analysis is used by the Agency to determine the savings achieved by the MPNs and the share of the savings that will be distributed to the MPNs on a quarterly basis.

The third financial analysis considers the Agency's administrative and operational expenses. The Agency must assess the personnel and physical resources used by the Agency to operate the MPN program, in order to determine the true costs of operation. The following analysis estimates the personnel costs by examining the change in resources used to administer the MPN and the MediPass programs.

### **Medical Expenditure Analysis**

#### ***Methods***

To construct the data used in the medical expenditure analysis, the evaluators used 3,891,555 member-month records covering a period of 19 months (November 2001 to May 2003, inclusive). These separate claims files were merged into one claim file with 22,387,881 records.

The data range for these claims were 11/01/2001 to 05/31/2003. Provider Service Network (PSN) and Pediatric Associates Medicaid demonstration enrollees were excluded from the medical expenditure analysis. PSN enrollees have their care managed within the demonstration program and not by MediPass. The Pediatric Associates Medicaid demonstration involves the mandatory assignment of children to a large pediatric medical group practice in South Florida. In both cases, it was felt that these enrollees do not represent typical MediPass enrollee expenditures and were removed from the data. Further, the data set excluded the Children's Medical Services enrollees.

The data utilized in this analysis included the remaining MediPass beneficiaries. Beneficiaries in Disease Management organizations (DMO) during the study period were included in the analysis. Presently, DMO beneficiaries represent 16% of the MediPass population. There are no DMO enrollees in the MPN population, however the MPNs do serve individuals with chronic diseases, such as HIV/AIDS, hemophilia, end stage renal diseases (ESRD), sickle cell, congestive heart failure (CHF), hypertension, asthma, and diabetes. Approximately, 20% of the MediPass population has chronic diseases; whereas 15.7% of PhyTrust beneficiaries have chronic diseases and 12.3% of Florida NetPASS beneficiaries have chronic diseases. The following table is a snapshot of the number and percent of the beneficiaries in MediPass and the MPNs with various chronic diseases during the month of September 2002.

**Table 7: Beneficiaries with a Diagnosed Chronic Disease  
By Program  
September 2002**

<i>September 2002 (Dade, Broward and Palm Beach counties)</i>		<b>MediPass</b>		<b>PhyTrust</b>		<b>NetPASS</b>	
		Members	% of Eligibles	Members	% of Eligibles	Members	% of Eligibles
<b>Chronic Disease States (Non DMO)</b>	AIDS	4,422	1.86%	66	0.91%	270	0.92%
	SICKLE CELL	1,497	0.63%	44	0.61%	177	0.60%
	HEMO	78	0.03%	5	0.07%	4	0.01%
	ESRD	1,733	0.73%	51	0.70%	94	0.32%
	CHF	3,311	1.39%	81	1.12%	235	0.80%
	DIABETES	7,937	3.33%	187	2.58%	474	1.61%
	ASTHMA	15,727	6.60%	182	2.51%	1,427	4.84%
	HYPERTENSION	13,642	5.73%	522	7.21%	941	3.19%
	<b>Total Chronic Diseases</b>	<b>48,347</b>	<b>20.29%</b>	<b>1,138</b>	<b>15.71%</b>	<b>3,622</b>	<b>12.29%</b>
<b>Total Eligibles</b>	<b>238,249</b>		<b>7,244</b>		<b>29,461</b>		

The differences between the percent of beneficiaries with a chronic disease in MediPass and the MPNs may account for differences in the total paid claims experienced by the respective programs; however, the analysis does not control for chronic disease state. Future analyses

should consider disease state and severity as a means of producing a “truer” picture of the costs associated with the average Medicaid beneficiary being served by different programs.

The Rand Health Insurance 2-part model (Brook, Ware, et al. 1983) was used to construct the statistical analysis conducted to determine the mean medical expenditures for MediPass and MPN beneficiaries. The regression analysis included statistical controls for service utilization, SSI enrollment, age of the enrollee, race of the enrollee (Hispanic, other, Asian, and white, with African-American as the referent group), and gender (male as the referent group).

### **Results**

Tables A4-A7 (in the Appendix) present the descriptive results for the sample of 2,329,210 member-months during the 13-month time period of the analysis (for mean paid claims). According to the medical expenditure analysis, the average MediPass beneficiary has higher paid claims than the average beneficiary served by the MPNs during the same time period when controlling for beneficiary eligibility category (e.g., SSI/TANF), age, race, geographic location, and gender. These factors are associated with variation in medical expenditures. In fact, they are the same factors used by the Agency to calculate the Upper Payment Limits (UPL).

Specifically, the mean paid claims for MediPass were \$354.99 PMPM compared to \$326.42 for Florida NetPASS and \$325.64 for PhyTrust.

MediPass enrollees were older than Florida NetPASS and PhyTrust during this time period and were more likely to represent a minority group across all three programs. Age, gender, and race are included to control for differences in health care utilization and severity of illness.

When comparing the MPNs to MediPass for paid claims using this statistical analysis, both Florida NetPASS and PhyTrust were roughly \$29 below the expected PMPM expenditures for MediPass enrollees.

The Miami/Dade analysis examined adjusted expenditures just for enrollees within that county. Florida NetPASS had \$26 fewer mean adjusted paid claims and PhyTrust has \$20 in fewer adjusted mean claims on a PMPM basis. Broward and Palm Beach county analyses were more in line with the total county results. In Broward, Florida NetPASS had \$43 fewer mean adjusted paid claims. PhyTrust was \$71 less for mean adjusted paid claims and \$143 mean adjusted paid claims below MediPass. Florida NetPASS was \$15 lower than MediPass for mean adjusted paid claims in Palm Beach County. PhyTrust does not operate in Palm Beach County.

Table 8 (next page) summarizes the differences in medical expenditures for MediPass, PhyTrust, and Florida NetPASS by county and overall.

***In general, the MPN program experienced lower expected expenditures than MediPass when looking at the same time period and geographic area.***

These differences between the MPNs and MediPass could change if the analysis controlled for the proportion of beneficiaries with chronic diseases. However, at this time, the Agency does not utilize risk adjustments in its predicted expenditure analyses.

**Table 8: Adjusted Predicted Expenditures PMPM  
Overall and By County  
February 2002 – February 2003**

	MediPass	Florida NetPASS	PhyTrust
<b><i>All 3 Counties:</i></b>			
Paid Claims	\$354.99	\$326.42	\$325.64
Difference		-\$28.57	-\$29.35
<b><i>Miami-Dade:</i></b>			
Paid Claims	\$368.94	\$342.64	\$348.77
Difference		-\$26.30	-\$20.17
<b><i>Broward:</i></b>			
Paid Claims	\$373.64	\$330.20	\$302.11
Difference		-\$43.44	-\$71.53
<b><i>Palm Beach:</i></b>			
Paid Claims	\$267.52	\$252.55	NA
Difference		-\$14.97	NA

**Shared Savings Analysis**

The second part of the financial analyses considers the results of the “shared savings” achieved by the MPNs as specified in their contracts with the Agency. Evaluation of the shared savings results is based on available information on the reconciliation process and payments made to the MPNs from October 2001 to December 2002 as opposed to February 2002 through February 2003 as presented in the medical expenditure analysis. Unfortunately, the reconciliation data was not available for compatible time periods.

Contractual arrangements between the Agency and the MPNs specify a “shared savings” methodology whereby MPN expenditures are compared to the UPL on a quarterly basis. That is, for savings to be shared, the actual claims payments to the MPN must be lower than the UPL established by the Agency (e.g., this is the “savings”).

Upper payment limits and capitation rates are established annually by the Agency for a set of services covered by Medicaid. The UPLs are PMPM rates that are fixed by eligibility category (e.g., TANF SSI), geographic area (e.g., Medicaid Service Area), gender and age (e.g., eight distinct age/gender categories). The UPL is further adjusted by an IBNR (incurred but not reimbursed) factor and may also be adjusted by other changes that occur in the Medicaid fee-for-service program. By design, the UPLs are dated because they are determined using Medicaid claims experience from a previous time period.

The first step in the shared savings analysis is a calculation of the difference between each MPN's actual expenditures and what would have been expected for their enrolled members using the UPL. The results by MPN for each available time period are shown in Table 9 (below).

**Table 9: Summary of Savings Compared to the UPL by MPN  
October 2001 – December 2002**

<b>Time Period (Quarter)</b>	<b>PhyTrust Member Months</b>	<b>PhyTrust Savings vs. UPL</b>	<b>PhyTrust UPL Savings PMPM</b>	<b>FNP Member Months</b>	<b>FNP Savings vs. UPL</b>	<b>FNP UPL Savings PMPM</b>
<b>10/01– 12/01</b>	3,431	\$ 246,029.06	\$ 71.71	6,454	\$ 357,989.00	\$ 55.47
<b>01/02– 3/02</b>	5,083	\$ 291,428.46	\$ 57.33	30,273	\$ 425,434.56	\$ 14.05
<b>04/02–06/02</b>	7,784	\$ 458,266.92	\$ 58.87	50,495	\$ 836,554.01	\$ 16.57
<b>07/02–09/02</b>	16,260	\$ 718,804.07	\$ 44.21	82,306	\$ 1,380,392.44	\$ 16.77
<b>10/02–12/02</b>	31,235	\$ 1,655,526.76	\$ 53.00	102,964	\$ 1,975,657.73	\$ 19.19
<b>Total: 10/01- 12/02</b>	63,793	\$ 3,370,055.27	\$ 52.83	272,492	\$ 4,976,027.74	\$ 18.26

Source: AHCA, PhyTrust, Florida NetPASS

In each period shown above, both MPNs achieved savings relative to the UPL. The PMPM savings ranged from roughly \$44 to \$72 for PhyTrust and roughly \$14 to \$55 for Florida NetPASS. For this time period, the MPN program achieved expenditures that were \$8.35 million lower than expenditures that would have been expected using the UPL.

Next, the savings on expenditures relative to the UPL is shared between the Agency and the MPN according to their contractual arrangements. More specifically, for PhyTrust the share of the savings was always a 50%-50% split between the Agency and PhyTrust. For Florida NetPASS, the Agency retained 70% of the savings initially sharing only 30% with Florida NetPASS. The split changed over time from 70%-30% to 60%-40% to 50%-50%.

Overall, the Agency shared approximately \$4.1 million of the \$8.3 million saved by the MPNs with the networks during November 2001 to December 2002. The range of savings shared with the MPNs when comparing them to the UPL (as opposed to the paid claims as in the medical expenditure analysis) is from \$22 to \$26 PMPM for PhyTrust and \$4 to \$28 PMPM for Florida NetPASS.

In addition, the Agency provided each MPN with a monthly PMPM administrative fee. The amount of this fee ranged from \$9 to \$12 PMPM, depending on the MPN and the time period. Table 10 (below) provides the detailed amount of the advanced administrative fees paid to each MPN.

**Table 10: Advanced Administrative Fees  
October 2001 – December 2002**

<b>Time Period (Quarter)</b>	<b>PhyTrust Member Months</b>	<b>PhyTrust Advanced Admin Fees</b>	<b>PhyTrust Advanced Admin Fees PMPM</b>	<b>FNP Member Months</b>	<b>FNP Advanced Admin Fees</b>	<b>FNP Advanced Admin Fees PMPM</b>
<b>Total: 10/01-12/02</b>	55,279	\$ 542,353.00	\$ 9.81	266,038	\$ 2,637,555.00	\$ 9.91

Source: AHCA, PhyTrust, Florida NetPASS

Thus, the Agency paid \$3.2 million in total administrative fees for the MPN program during this time period. The administrative fee is provided to the MPN as a risk payment; hence, all of these administrative fees are deducted from the amount of the shared savings due to the MPN at the time of its quarterly reconciliation. Alternatively, the MPN is obligated to repay any “over payment” in administrative fees resulting from limited or no savings relative to the UPL.

As shown in Table 11 (next page), the “net” reconciliation payments made (or owed) to the MPNs ranged on a PMPM basis from \$6 to \$36 to PhyTrust and from a positive \$28 to a negative \$8 for Florida NetPASS.

**Table 11: Reconciliation Payments Made (Owed) by MPN  
October 2001 – December 2002**

<b>Time Period (Quarter)</b>	<b>PhyTrust Member Months</b>	<b>Reconciliation Payments Made to (Owed by) PhyTrust</b>	<b>Reconciliation Payments Made to (Owed by) PhyTrust PMPM</b>	<b>FNP Member Months</b>	<b>Reconciliation Payments Made to (Owed by) FNP</b>	<b>Reconciliation Payments Made to (Owed by) FNP PMPM</b>
<b>10/01-12/01</b>	3,431	\$ 123,014.53	\$ 35.85	6,454	\$ 179,388.53	\$ 27.79
<b>01/02-03/02</b>	5,083	\$ 145,714.23	\$ 28.67	30,273	\$ (237,073.63)	\$ (7.83)
<b>04/02-06/02</b>	7,784	\$ 192,203.46	\$ 24.69	50,495	\$ (135,484.00)	\$ (2.68)
<b>07/02-09/02</b>	16,260	\$ 99,359.77	\$ 6.11	82,306	\$ (76,561.78)	\$ (0.93)
<b>10/02-12/02</b>	31,235	\$ 532,540.38	\$ 17.05	102,964	\$ 35,496.86	\$ 0.34
<b>Total: 10/01-12/02</b>	63,793	\$ 1,092,832.37	\$ 17.13	272,492	\$ (234,234.02)	\$ (0.86)

Source: AHCA, PhyTrust, Florida NetPASS

**Agency Resources**

The “savings” calculations above tell only part of the story in evaluating the financial implications of the MPN program for the State. The financial analysis must take into account the increased (or reduced) administrative resources for the Agency that result from the MPN program. For example, Agency FTEs may increase because of the reconciliation process. Alternatively, Agency FTEs could be lower with the MPNs because the MPNs have absorbed many of the operations related activities previously performed by AHCA (e.g., credentialing, member services).

As part of the evaluation, the Agency estimated the number of person hours (FTEs) and associated salary expenses that were required to operate the MPNs and MediPass, including Headquarters and Area Office staff (Table 12 below—note these figures do not include the time periods when the MPNs expanded to Areas 5 and 6). According to these estimates, the total number of FTEs for MediPass and the MPNs was reduced from 61.31 in January 2002 to 59.13 in January 2003. This was a reduction of about \$78,600 in direct salary expenses. Over this time, the FTEs needed to oversee the MPNs were reduced from 14.55 in 2002 to 13.65 in 2003 (a direct salary difference of about \$37,000). Of course, these reductions may have been due to things that were unrelated to the MPN program.

**Table 12: Administration FTEs and Salary Expenses for the Agency  
(MPN Program and MediPass)  
1/1/2002 and 1/1/2003**

	1/1/2002	1/1/2002	1/1/2002	1/1/2003	1/1/2003	1/1/2003
	MPNs	MediPass	Total	MPNs	MediPass	Total
<b>FTEs</b>	14.55	46.76	61.31	13.65	45.48	59.13
<b>FTEs per 1000 Members</b>	1.35	NA	NA	0.28	NA	NA
<b>Total Salary Expenses</b>	\$511,096	\$1,566,663	\$2,077,759	\$473,994	\$1,525,211	\$1,999,205
<b>Salary Expenses PMPM</b>	\$3.96	NA	NA	\$0.80	NA	NA

Source: AHCA

When analyzed on a PMPM basis, the Agency estimated that salary expenses for the MPN program were approximately \$3.96 PMPM in January 2002 and \$0.80 PMPM in January 2003. It is important to note that this reflects only the FTEs with direct involvement with the MPN and that there are other expenses associated with the MPN program that are not reflected here.

## **Conclusions and Discussion**

The financial results analyses suggest that the MPNs save the Agency money compared to MediPass, even after factoring out the administrative fees and reconciliation payments made and (some) of the costs of the Agency to run the Program.

More specifically, adjusted predicted expenditures for paid claims in the MPNs were significantly lower than for MediPass when compared for the same geographic region and time period. Moreover, the PMPM expenditures achieved by the MPNs were lower than what would have been expected using the Medicaid UPL. Finally, even after factoring out the administrative fees paid by the Agency; the "savings" that were shared with the MPNs; and the administrative resources of the MPNs, the Agency saves money under this initiative.

There are a number of reasons that the MPNs save money relative to MediPass. First, the MPNs provide detailed and structured utilization information to their providers. Physicians interviewed indicated that they found such information valuable to their practice and that it enhanced their ability to provide quality care to their patients. Other studies confirm increasing physician acceptance of care management tools in their practices (Walsh et al., 2002). For example, in a nationally representative sample of physicians, 51 percent of those who received provider profiles viewed these profiles positively. One-third of all physicians surveyed reported that practice profiles influenced their practice of medicine (Reed et al., 2003).

Second, the MPNs serve to provide physicians, particularly those in solo practice or who are new to the United States with strong organizational and clinical support to manage their practices. Much of the clinical support provided by the MPNs is part of the their utilization management/provider profiling activities. Studies have shown the provider profiling activities are most effective when they are coupled with enhanced feedback and educational activities such as those provided by the MPNs (Borgiel et al., 1999, Braham and Ruchline, 1985, 1987, 1990). The MPNs are able to provide feedback and education to PCPs because they are operated "locally" and can quickly and easily respond to physician issues.

Finally, the MPNs bring to their Medicaid lines of business significant experience with managed care organizations. Many of the enhanced targeted care and case management activities already occurred across all lines of business within the MPN. Consequently, the MPNs are perhaps able to employ strategies that have proven most effective in other managed care settings.

The importance of the use of physician bonuses and incentives to enhance quality of care (and ultimately lower cost) should not be understated. Increasingly, payers are using provider incentive programs to meet quality goals (Rosenthal et al., 2004, Mays et al., 2003). There is some evidence that financial incentives can have some impact on physician behavior (Hillman et al., 1989) and many managed care organizations have used incentives as a way to reduce health services use (Stoddard et al., 2003). However, the extent to which these incentive programs ultimately reduce health care costs without compromising overall quality remains unclear. Nevertheless, PhyTrust's use of an incentive program may be one reason why that organization has been able to achieve medical expenditure savings.

The finding that the MPNs appear to save money relative to MediPass must be interpreted with some caveats. First, because of time limitations the evaluation team was unable to adequately risk adjust for patient severity. This is particularly relevant with respect to the disease management patients who are excluded from the pilot programs and remain in traditional MediPass. Since these patients are sicker, they could be responsible for the higher medical expenditures associated with MediPass.

Finally, the data suggest that the MPNs are successful in reducing the expenditures relative to the UPL. This savings should be expected versus the UPL, due to the fact that the UPL is based on Medicaid expenditure data from a previous time period. In addition, the UPL is only adjusted for a few beneficiary characteristics. Some suggest that the age breakdown of the UPL and the way that newborns are assigned to MediPass vs. the MPNs may indicate a higher degree of savings than is actually experienced. Others suggest that there are additional factors, such as specific disease states that may be more precise predictors of future expenses.

## **SUMMARY AND RECOMMENDATIONS**

Florida's Minority Physician Networks appear to offer an alternative to traditional MediPass that results in savings for the Agency.

The most notable aspects of the MPN Program include:

- The private and "local" aspect of the MPNs offer opportunities to monitor and support providers in ways the current MediPass program has not achieved.
- The MPNs appear to make MediPass work better by providing providers with timely and important beneficiary information.
- The MPNs manage their PCP networks locally and offer improved communication with the Agency.
- MPN physicians are extremely satisfied with the program relative to their experience with MediPass and Medicaid HMOs.
- The MPNs save the Agency money when compared to MediPass.

### **Recommendation:**

*The Agency should address some of the challenges in the MPN program prior to expanding the program into other areas in the state.*

### ***Specific Problems the Agency Should Address:***

- The Agency needs better information about its costs to run the program in order to identify the "bottom line" financial implications of the MPNs for the Agency. For example, as administrative functions are assumed by the MPNs, what is the effect on Agency FTEs or other resources?
- The Agency must set clear, measurable objectives for the MPN program. Agency officials, the MPNs, and the providers should clearly understand expectations and objectives of the program.
- Alternative cost savings methodologies should be considered. The current method is time-consuming and may not achieve the goals of either the Agency or the MPNs. For example, a short list of utilization or expenditures could be monitored monthly or quarterly, with formal reconciliations conducted annually.
- The Agency should evaluate and monitor the MPNs on a regular basis in order to determine the effectiveness of the program in meeting its expectations and objectives. On-going monitoring will also allow the Agency and MPNs to incorporate lessons learned into the policies and procedures used to govern the program.
- The Agency should consider better coordination in areas of the State where multiple pilot programs are in operation.
- There may be different implementation issues (and costs) associated with MPN expansion. If current MPN organizations expand to other parts of the Agency, it is

reasonable to assume that the learning processes of the original pilot phase will reduce the administrative costs and hassles of expansion—especially if lessons learned by Area Office staff can be quickly transferred to other Area Offices. If, however, other organizations are awarded MPN contracts for different geographic regions, there may be new learning and implementation costs.

- The Agency must assure adequate resources to provide oversight and administration of the MPNs. With any new program (especially one that is a pilot) there will be learning, coordination, and ongoing coordination issues. The Agency must be willing to devote needed resources to MPN oversight.
- The Agency should reconsider its use of monthly administrative fees. Expansion may make the distribution of administrative fees on a monthly basis to numerous contractors impossible or improbable risking the cost-effectiveness of the overall program.

**EVALUATION LIMITATIONS**

- Due to data and time limitations, claims data were not risk-adjusted beyond the control variables. In addition, the evaluation did not examine utilization patterns for the MPNs and MediPass.
- The evaluation did not examine the networks or performance of MPN activity in Medicaid Areas 5 and 6.
- There were some reports that were specified by the MPN contracts but were not available from the Agency (e.g., monthly service utilization, specialty care referral reports).
- The MPNs have reported very little quality of care and beneficiary satisfaction data, which made the evaluation of this aspect of the pilot project impossible.
- The short time frame of the evaluation (3 months) limited the possibility of more complex and in-depth consideration of some MPN issues (e.g., more detailed examination of utilization such as ambulatory care sensitive admissions, more complex severity-adjustment, others).

**This page intentionally left blank.**

## **APPENDIX**

### **Financial Analysis Methodology**

To construct the data used in this analysis, a request was sent to Medicaid and 3,891,555 member-month records were sent that covered a period of 19 months (November 2001 to May 2003, inclusive). These separate claims files were merged into one claim file with 22,387,881 records. The data range for these claims were 11/01/2001 to 05/31/2003. Provider Service Network (PSN) and Pediatric Associates Medicaid demonstration enrollees were excluded from this analysis. PSN enrollees have their care managed within the demonstration program and not by MediPass. The Pediatric Associates Medicaid demonstration involves the mandatory assignment of children to a large pediatric medical group practice in South Florida. In both cases, it was felt that these enrollees do not represent typical MediPass enrollee expenditures and were removed from the data. Further, the data set included no CMS beneficiaries. The MediPass data included beneficiaries enrolled in Disease Management Organization programs during the study period.

Programs were run to calculate the total sum of billed and paid claims for each member-month in the 19 months of data. The Medicaid data included a “plan” variable that indicated plan type (“M” for MediPass and “P” for PSN). Additional flag variables were added to indicate which member months were also MPN enrollees and to which MPN group (e.g., Florida NetPASS, PhyTrust). Additional data provided by Florida Medicaid allowed us to identify the individual NetPASS and PhyTrust providers and link them to their enrollees. The evaluation team found 75,903 NetPASS recipients assigned to 526 providers and 49,860 PhyTrust recipients assigned to 197 providers in the entire 19-month dataset. The data were further truncated to February 2002 – February 2003. This 13-month period was chosen because it represented the MPN three months post initial startup and three months prior to the most recent available Medicaid data (May 2003).

### ***Dependent Variables***

The variables of interest in this analysis were dummy variables used to identify if an enrollee was in NetPASS, PhyTrust or in MediPass during the member month. In most cases, MediPass was the reference variable and the other plans were compared to MediPass' use and expenditures. These demonstration projects were designed to impact the overall care management of their enrollees through increased provider access to data and increased monitoring of care processes at the plan level. The evaluation team hypothesized that the demonstration programs would reduce use of services and costs associated with those services when compared to MediPass enrollee use and expenditures.

Total claims paid, total billed claims, and a dichotomous variable that represents “any use” of medical services by the beneficiary were used as dependent variables in this analysis. Total claims paid were defined as the sum of all medical claims paid for the enrollee during the member-month in question. Total billed claims were defined as all of the medical claims that were billed to Florida Medicaid during the member-month. Both variables include pharmacy, hospitalization, and other claims associated with care. A dependent variable was created to examine whether or not during the member-month an enrollee had expenditures greater than the Medicaid three-dollar case management fee.

***Control Variables***

Control variables were selected to adjust for enrollee characteristics and health status. SSI enrollees were identified using a dichotomous variable. The gender (male) and age of the enrollee during the member month were included in the analysis. The evaluation team expected males to use fewer services than female enrollees and the youngest and oldest enrollees to use more services. Dichotomous variables were created for the enrollees' race, with black enrollees being the reference group in the analysis. The evaluation team was parsimonious in the use of control variables due to a fear that because this is such a large data set, too many controls would mask real differences in use and expenditures between the plans. Table A1 lists all of the variables used in the analyses and their definitions.

***Analytic Method***

The evaluation team performed an analysis of the 2002 – 2003 expenditures using the Rand Health Insurance 2-part model (Brook, Ware, et al., 1983; Dowd, Feldman, et al., 1991). The two-part model is accurate in accommodating expenditure data where there is a large proportion of the population that have no expenditures and when the distribution of the non-zero expenditures are skewed to the right so that a natural log transformation will normalize the data. This model is also used when the assumptions of linearity pertaining to ordinary least squares regression are violated.

The model was first run as a logistic regression to predict the probability of using any services (and incurring any expenditures above the Medicaid case management fee). The second set of multivariate regression analyses used the natural log of costs as the dependent variable to predict costs conditional on whether the enrollee used any health care services. Adjusted cost ratios were obtained from exponentiated regression coefficients and costs were transformed from log dollars into dollars using Duan's smearing estimator to control for retransformation biases (Duan, 1983).

The multivariate logistic regression was combined with the multivariate linear regression by multiplying the probability of incurring any expenditure by predicted expenditure conditional on any utilization. This produced an individual enrollee's predicted total health care costs.

In more formal terms, we estimate use of services by the  $i^{th}$  enrollee in the  $S^{th}$  because many enrollees did not use services during the 13 months of the study. The expected use of services conditional on enrollment in the  $S^{th}$  plan is:

$$E(USE|S) = P(USE > 3|S) * E(USE|S, USE > 3)$$

Where we are interested in use above the \$3 enrollee management payment. Further, we are interested in observed costs (total claims or total billed claims in this case) or:

$$COSTS_i^s = (X_i^s, Z^s)\beta^s + \sigma^s\mu_i^s \text{ if } \mu_i^s > \{-(X_i, Z^s) \beta^s / \sigma^s\} \text{ and } COSTS_i^s = 0 \text{ otherwise}$$

Where  $X_i$  is a linear function of the characteristics of the enrollee and the health plan  $Z^s$ , is an  $\beta^s$  parameter vector,  $\sigma^s$  is the standard deviation of  $\mu_i^s$ , and  $\mu_i^s$  is an unobserved error. Transforming these equations gives us the estimate for the effect of health plans on costs by

comparing the predicted average observed costs (total claims or total billed claims) for all enrollees in the sample if they are enrolled in the health plan (NetPASS, PhyTrust, or MediPass). This equation is:

$$E(\text{COSTS}_i^s) = \text{Prob}(\text{COSTS}_i^s > 0) * E(\text{COSTS}_i^s | \text{COSTS}_i^s > 0)$$

When calculating the transformed dollar amounts it is also necessary to adjust these figures using Duan's smearing estimator. We must do this because the  $\text{COSTS}_i^s$  is transformed by taking the natural log of the total claims and total billed claims models when we calculate the Rand 2-part model. Once we have calculated  $E(\text{COSTS}_i^s)$ , we transform this value using the following equation:

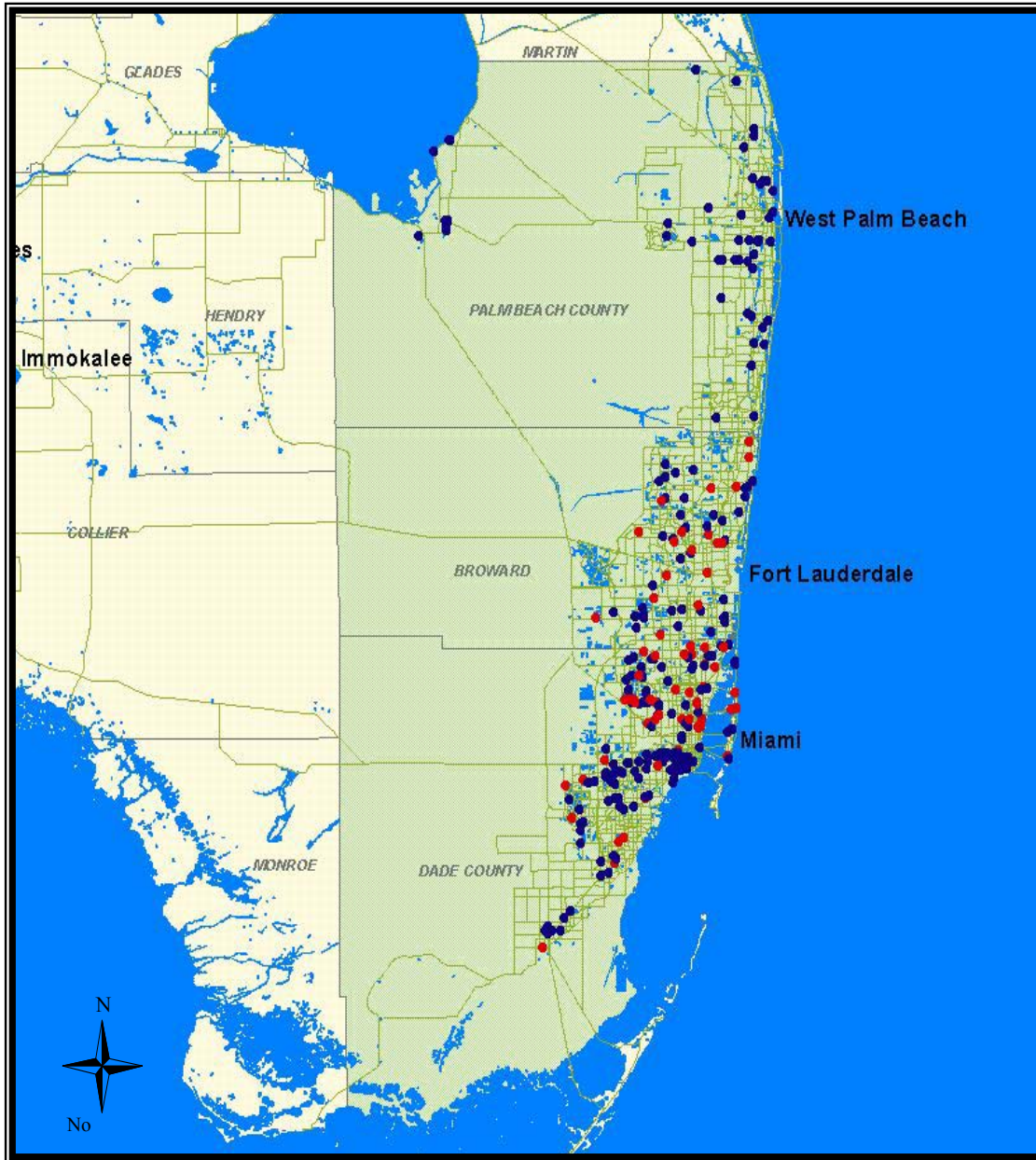
$$\text{Adj}(E(\text{COSTS}_i^s)) = \exp(E(\text{COSTS}_i^s)) * n^{-1} \sum \exp(\varepsilon_i)$$

where  $n$  are the observations and  $\varepsilon_i$  are the estimated residuals from the regression models. The smearing estimator is  $n^{-1} \sum \exp(\varepsilon_i)$ .

**Table A-1:  
Variable Specification for Medical Expenditure Analyses**

<b>Dependent Variables</b>	
Total paid claims per member-month	= Sum of all paid claims per plan enrollee for that member month
Total billed claims per member-month	= Sum of all billed claims per plan enrollee for that member month
Log (total paid claims) for users	= Natural log of total paid claims per member-month
Log (total billed claims) for users	= Natural log of total billed claims per member-month
<b>Plan Variables</b>	
NetPASS	= 1 if enrollee was a member of Florida NetPASS during the member-month
PhyTrust	= 1 if enrollee was a member of PhyTrust during the member-month
MediPass	= 1 if enrollee was a member of MediPass during the member-month
<b>Control Variables</b>	
SSI	= 1 if enrollee was under the SSI program for that member-month
Male	= 1 if enrollee was Male
Current Age	= Age of enrollee during the member-month
White	= 1 if enrollee was White
Black	= 1 if enrollee was Black
Hispanic	= 1 if enrollee was Hispanic
Asian	= 1 if enrollee was Asian

**Figure A-1:**  
**Evaluation of Florida's Minority Physician Network (MPN) Program**  
**MPN Primary Care Physicians Locations by County**  
**Fall 2003**



Source: PhyTrust, Florida NetPASS

Legend:  
Red = PhyTrust  
Blue = Florida NetPASS

**Table A-2:**  
**Evaluation of Florida's Minority Physician Network (MPN) Program**  
**PhyTrust Administration FTEs by Month, Selected Dates**  
**11/1/2001 – 7/1/2003**

<b>Function:</b>	<b>Number of Full-time Equivalent Staff Dedicated to Function</b>				
	<b>Start-Up</b>	<b>1/1/2002</b>	<b>7/1/2002</b>	<b>1/1/2003</b>	<b>7/1/2003</b>
Recipient Enrollment and Disenrollment Tracking	1	1	1	1	1
Enrollee Services, Education, Outreach	1	1	1	1	3
Provider Contracting and Relations	3	3	3	5	7
Provider Credentialing	n/a	n/a	n/a	n/a	0.75
Financial Management (Including Claims Management, Reconciliation)	2	2	2	3	3
Medical Management (Case Management, Population Management)	4	4	4	5	8
Grievance and Appeals Resolution	n/a	n/a	n/a	n/a	0.25
Quality Monitoring	1	1	1	1	1
Program Development and Oversight	1	1	1	1	1
Information Management	4	4	4	4	4
Other (Specify Functions):					
Senior Staff	3	3	4	4	4
Administrative Staff	1	1	1	2	4
Consultants	5	5	7	7	9
Accounting/A/P/H/R	2	2	2	3	3
<b>Total FTEs:</b>	28	28	31	37	49

Source: PhyTrust

**Table A-3:**  
**Evaluation of Florida's Minority Physician Network (MPN) Program**  
**Florida NetPASS Administration FTEs by Month, Selected Dates**  
**11/1/2001 – 7/1/2003**

<b>Function:</b>	<b>Number of Full-time Equivalent Staff Dedicated to Function</b>				
	<b>Start-Up</b>	<b>1/1/2002</b>	<b>7/1/2002</b>	<b>1/1/2003</b>	<b>7/1/2003</b>
Recipient Enrollment and Disenrollment Tracking	0.25	0.25	1	2	2
Enrollee Services, Education, Outreach	0.25	1	1	1	1
Provider Contracting and Relations	5	8	9	12	13
Provider Credentialing	0.25	0.25	1.25	1.25	1.25
Financial Management (Including Claims Management, Reconciliation)	2	2	2.5	2.5	2.5
Medical Management (Case Management, Population Management)	4	4	6	6	7
Grievance and Appeals Resolution	0.25	0.25	0.25	0.25	0.25
Quality Monitoring	0	0	0.25	0.25	0.25
Program Development and Oversight	2	2	2.5	3	3
Information Management	1	2	2	2	2
Other (Referrals):	3	4	4	5	6
Credentialing Committee	0.5	0.5	0.5	0.5	0.5
Mailroom/Admin	1	1	1	1	1
<b>Total FTEs:</b>	19.5	25.25	31.25	36.75	39.75

Source: Florida NetPASS

**Table A-4:**  
**Evaluation of Florida's Minority Physician Network (MPN) Program**  
**Descriptive Statistics**  
**Palm Beach, Miami-Dade, and Broward Counties Combined**  
**February 2002 – February 2003**

	<u>MediPass</u>	<u>Florida NetPASS</u>	<u>PhyTrust</u>
% SSI	24.17	19.21	25.66
Current Age	19.88	17.03	23.59
% White	12.34	11.63	10.75
% Hispanic	41.53	47.36	33.79
% Other	17.41	14.35	15.62
% Asian	0.23	0.37	0.27
% Male	46.36	46.34	46.50
Paid Claims	\$377.45	\$290.36	\$349.34

**Source: AHCA**

Note: African American and Male Gender are the Referent Category.

**Table A-5:  
Evaluation of Florida's Minority Physician Network (MPN) Program  
Descriptive Statistics—Miami-Dade County  
February 2002 – February 2003**

	<b>MediPass</b>	<b>Florida NetPASS</b>	<b>PhyTrust</b>
% SSI	24.96	18.91	25.47
Current Age	21.45	17.18	24.16
% White	06.70	06.05	07.37
% Hispanic	55.30	59.60	38.80
% Other	18.97	15.35	15.99
% Asian	00.14	00.24	00.19
% Male	45.70	46.47	44.14
Paid Claims	\$393.67	\$292.72	\$357.73

**Source: AHCA**

Note: African American Race and Female Gender are the Referent Categories (and are thus not shown here).

**Table A-6:  
Evaluation of Florida's Minority Physician Network (MPN) Program  
Descriptive Statistics—Broward County  
February 2002 – February 2003**

	<b>MediPass</b>	<b>Florida NetPASS</b>	<b>PhyTrust</b>
% SSI	25.00	25.17	26.82
Current Age	17.16	19.75	21.97
% White	24.94	22.40	20.63
% Hispanic	18.94	24.45	14.94
% Other	15.16	15.72	14.28
% Asian	0.45	01.02	0.51
% Male	47.90	45.55	43.16
Paid Claims	\$389.28	\$349.82	\$330.82

**Source: AHCA**

Note: African American race and Female Gender are the Referent Categories (and thus not shown here).

**Table A-7:  
Evaluation of Florida's Minority Physician Network (MPN) Program  
Descriptive Statistics—Palm Beach County  
February 2002 – February 2003**

	<b>MediPass</b>	<b>Florida NetPASS</b>	<b>PhyTrust</b>
% SSI	19.34	17.16	NA
Current Age	18.29	15.24	NA
% White	23.07	22.70	NA
% Hispanic	25.97	22.69	NA
% Other	12.81	10.74	NA
% Asian	0.40	0.45	NA
% Male	47.52	46.02	NA
Paid Claims	\$284.47	\$254.12	NA

**Source: AHCA**

Note: African American Race and Female Gender are the Referent Categories (and thus not shown here)

**This page intentionally left blank.**

**REFERENCES**

- Borgiel, A.E.M., Williams, I., Davis, D.A., Dunn, E.V., Hobbs, N., Hutchison, B., Wilson, C.R., Jensen, J., O'Neil, J.J.S., & Bass, M.J. (1999). *Canadian Medical Association Journal*, 161, 965-970.
- Braham, R. L., & Urchin H. S. (1985). A physician profile system. *Medical Group Management Journal*, 32, 58-62.
- Braham, R.L., & Ruchlin, H.S. (1987). Physician practice profiles: A case study of the use of audit and feedback in an ambulatory care group practice. *Health Care Management Journal*, 12, 11-16.
- Braham, R.L., & Ruchlin, H.S. (1990). Audit and feedback as a cost-effective strategy. *Medical Group Management Journal*, 37, 76-78, 80-82.
- Brook, R. H., Ware, J. E Jr., Rogers, W.H., et al. (1983) Does free care improve adults' health? Results from a randomized controlled trial. *New England Journal of Medicine*, 309: 1426-1434.
- Dowd, B., Feldman, R., Cassou, S., and Finch, M. (1991) Health plan choice and the utilization of health care services. *The Review of Economics and Statistics*, LXXIII: pp. 85-93.
- Duan, N. (1983) Smearing estimate: a nonparametric retransformation method. *Journal of the Statistics Association*, 78: 605-6120.
- Grumbach K, Osmond D, Vranizan K, Jaffe D and Bindman AB (1998) Primary Care Physicians' Experiences of Financial Incentives in Managed-Care Systems *new England Journal of Medicine* 339(21):1516-1521.
- Hillman AL, Pauly MV and Kerstein JJ (1989) How do Financial Incentives Affect Physicians' Clinical Decisions and the Financial Performance of Health Maintenance Organizations *New England Journal of Medicine* 321(2): 86-92.
- Mays GR, Hurley RE and Grossman JM (2003) Changes in Health Plans' Approaches for Managing Costs and Care *Health Services Research* 38(1 Pt 2): 375-93.
- Reed M, Devers K, and Landon B (2003) Physicians and Care Management: More Acceptance Than You Think. *Center for Studying Health System Change*
- Rosenthal MB, Fernandopulle R, Song HR, and Landon B (2004) Paying for Quality: Providers Incentives for Quality Improvement. *Health Affairs* 23: 127-141.
- Smith, V., Ramesh R, Gifford K., Ellis E., Wachino V and O'Malley (2004) States respond to fiscal pressure: A 50-state update of state Medicaid Spending Growth and Cost Containment Actions *The Henry J Kaiser Foundation*.
- Walsh EG, Osber DS, Nason CA, Porell MA, and Ascutto AJ (2002) Quality Improvement in a Primary Care Case Management Program *Health Care Financing Review* 23(4): 71-84.