The Florida Medicaid MediPass Program: Current Issues

Allyson Hall, PhD
Catherine Aftuck, MHA
Christy Harris Lemak, PhD

Florida Center for Medicaid & the Uninsured
College of Public Health and Health Professions
University of Florida
352/273-5059

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TABLE OF CONTENTS

EXECUTIVE SUMMARY

This paper is one of three reports that examine specific aspects of the Florida MediPass program. It summarizes findings from interviews with MediPass primary care providers and AHCA area office staff on program operations, including physician and specialty network capacity, patient issues, and the impact of the pilot programs in South Florida. Providers and staff were asked to provide recommendations on improving the program. A second report provides results from the annual Consumer Assessment of Health Plan Survey. A third report examines the PCP network throughout the state.

Medicaid and MediPass are recognized as critical components of the healthcare safety net. As such, there was strong support from both providers and AHCA staff for the program. However, a number of important concerns emerged. These included:

- The unavailability of certain kinds of specialty care within specific regions;
- The adequacy and appropriateness of the $3 per member per month management fee;
- Confusion on the role of disease management organizations in patient care; and
- The need to streamline and make more efficient certain operational procedures such as credentialing and referral authorizations.

Changes to MediPass, however, must occur within the context of finding solutions to escalating Medicaid costs. Previous evaluations concluded that MediPass did appear to be controlling costs and utilization. However, since 1998, the Medicaid budget has grown by about $5.6 billion, or 79 percent. The 2004 – 2005 Medicaid budget is projected to be 13.8 billion, or almost 25 percent of the state budget. Thus, although MediPass appears to be adequately meeting the

needs of the patients, it currently appears to be less successful at controlling costs.

Initial analysis has shown that the Minority Physician Network and Provider Service Network demonstration programs have been somewhat successful in reducing costs associated with caring for MediPass beneficiaries. Cost savings in the demonstration programs seemed to be realized through reduction in the utilization of services relative to MediPass because fewer enrollees used services. The strong disease management components associated with each of these programs are more than likely a major reason for the reduction in cost.

INTRODUCTION

MediPass was established in 1991 as a primary care case management program designed to provide Florida Medicaid recipients with access to adequate primary care. Since its inception, the program's core element has remained essentially unchanged. Recipients select, or are assigned, a primary care provider who manages and coordinates all aspects of that beneficiary's care. The physician is contracted to provide, to assigned beneficiaries, primary care services, 24-hour access to health care, and referral and authorization for specialty and hospital services. In return, the primary care provider receives a $3 per member per month case management fee in addition to reimbursement for the provision of Medicaid services.

Since 1991 MediPass has grown significantly. The state of Florida mandates that individuals in certain eligibility categories, Temporary Assistance to Needy Families (TANF) and Supplemental Security Income without Medicare, enroll in managed care. As a result, in April 2004, about 50 percent of managed care eligible beneficiaries, over 700,000, are in MediPass. The other 50 percent are enrolled in HMOs. In response to increasing expenditures, MediPass has been subject to a number of policy changes designed to make the program more efficient. Some notable changes include the implementation of various disease management programs, the introduction of a preferred drug program, and the implementation of various pilot programs in South Florida designed to generate cost savings while ensuring high quality care.

The Agency for Health Care Administration (AHCA) periodically examines MediPass in order to assess the extent to which the program is meeting its goals and objectives. This year, AHCA contracted with the Florida Center for Medicaid and the Uninsured to conduct satisfaction surveys of MediPass beneficiaries, to assess the capacity of the existing primary care physician network, to interview providers about their experiences with the program, and to interview agency staff

about program structure and administration. Both providers and area office staff were asked to make recommendations to improve the program.

This report summarizes findings from interviews with providers and area office staff. Two other accompanying reports present findings from the beneficiary satisfaction survey and the assessment of the primary care physician capacity.[1]

METHODS

The research team interviewed MediPass staff at seven AHCA area offices. The intention of the interviews was to learn about programmatic and policy changes, administrative challenges associated with the program, and recommendations for further changes. The list of questions that were used for the area office interviews are listed in Appendix I. The questions included issues related to the primary care physician (PCP) network, continuity of care, provider profiling, beneficiaries, credentialing, case management, specialty care network, and disease management organizations (DMOs).

Provider offices with a high volume of MediPass patients throughout the state were selected and contacted for interviews. Physicians or their office managers answered questions about the office's experience with MediPass, including issues related to patients, provider procedures, and continuity of care. A total of 18 in-person or telephone interviews were conducted with providers throughout the state. One interview was with a health department, six were with pediatricians' offices, and the remaining eight were with general/family/internal medicine practice offices. Appendix II contains the office interview protocol.

[1] See Hall et al, *MediPass Primary Care Physician Network Analysis: Preliminary Findings* June 2004 and Steingraber at el *Comparing Satisfaction with Care among MediPass and HMO enrollees in South Florida* June, 2004

FINDINGS

A common theme that emerged throughout the interviews was the value and importance of Medicaid and the MediPass program in ensuring access to health care for low-income populations. While MediPass providers and staff addressed various operational concerns, most of those interviewed expressed a strong commitment to the program and its patients. For example, many of the provider offices indicated that their mission was to serve low-income vulnerable populations, and area offices noted that Medicaid and MediPass exist to serve as a healthcare safety net for these populations.

> *"We have a social mission, one of advocacy for sick low-income people."*
> *Physician Office Manager*

The program appears to be meeting the needs of its patients, particularly in terms of assuring that there is an adequate primary care physician network (although there are a few geographic areas of concern) and overall patient satisfaction with the program. However, the unavailability of certain kinds of specialist physicians, confusion about the role of disease management organizations, and the adequacy and appropriateness of the $3 case management fee were some of the major concerns among providers and AHCA personnel. In addition, the overall positive view on the role of MediPass must be observed within the context of increasing costs associated with the Medicaid program. Florida spends roughly one quarter of its budget on the Medicaid program, and costs are expected to continue to grow. As currently configured, MediPass's ability to curtail costs appear limited.

MediPass Operations

Area Office Responsibilities

The duties of the local office were similar across the state. The responsibilities included physician recruitment and credentialing, physician training, quality assurance, and outreach to beneficiaries.

Most offices felt that the roles of the area office were clearly defined and communicated. The area offices defined the responsibility of the head office as developing policy and oversight of area offices. These area offices call the head office when necessary, for questions they have or the clarification of certain policies. One area office noted that they recently received a handbook from the head office. However, they had not received a previous updated handbook since 1996.

Area Office Recommendation: The Agency needs to develop standard rules and regulations for the basic responsibilities of the program. Not all area offices do things the same way. Send periodic updates of the area office manual.

Most area offices felt that there were not enough people to do the large amount of work. MediPass-related staffing was not sufficient to support the program. Some area offices have had to hire contract workers. While this is helpful in reducing workload, it is not the most optimal solution to the program since contracted workers are often not committed to program's mission and area office employees have a "more hands-on feel for the community."

With the exception of credentialing, the area offices did not feel that any of their responsibilities could be moved to the head office; the area office was more familiar with the community and it was better to keep the jobs at this level. In addition to familiarity with Medicaid, they were familiar with community resources and knew whom to call if they needed any favors.

Area Office Recommendation: The Agency should analyze workforce capacity at the area office level.

Area offices were concerned with the multiple databases in MediPass that "do not talk to each other." One area office supervisor said that her office was "forever maintaining databases," so that everyone is working from the same thing. It was also mentioned that general communication had improved with the head office. Several offices mentioned the monthly conference calls hosted by the head office were extremely beneficial.

Area Office Recommendation: AHCA databases need to be simplified and able to "talk to each other" in order to reduce the amount of time spent maintaining them.

Beneficiary Assignment

Most area offices are responsible for auto-assignment of beneficiaries to a managed care arrangement. Only one area office stated that they are not responsible for auto-assignment. Once the physician is accepted into the network, MediPass assigns the provider a maximum number of patients. The office has the option of decreasing this number.

The assignment of beneficiaries (i.e., auto assignment) to primary care physicians (PCPs) is similar in most of the areas. Beneficiaries have 90 days to choose a PCP once they have enrolled in Medicaid. If they do not choose a PCP, a mandatory assignment is made. Mandatory assignment is conducted once a month for the pool of beneficiaries that have not selected a PCP. They are assigned based on their geographic location (zip code matrix), age, family unit (the area tries to keep families at the same provider), specialty, etc.

The list of MediPass patient assignments is updated once per month by Affiliated Computer Services (ACS) Medicaid's fiscal agent, and a hard copy is mailed to providers. Providers also can access the list via the Internet. These monthly beneficiary enrollment lists supplied to providers are useful. Providers mentioned that they routinely contacted patients who were unknown to them but appeared on their beneficiary list.

Some providers expressed concern about their ability to routinely verify patient eligibility and provider assignment. Providers can verify eligibility either by using the services of an outside vendor (e.g., MediFax), accessing the Internet or calling a toll-free telephone number. However, providers in small or solo practices complained that they do not have access to the Internet and that using the services of an outside vendor is often cost prohibitive. In addition, providers complained that the toll-free number is frequently busy.

Area Office Recommendation: The Agency should streamline the MediPass application process by asking providers if they are interested in MediPass up front (i.e., when they apply to become a Medicaid provider). Time and resources are wasted when providers have to apply for Medicaid and then MediPass.

Credentialing

The area offices are responsible for credentialing providers. This process used to be performed by the head office in Tallahassee. For the initial credentialing of new doctors, the doctor must submit a resume, DEA certificate, DOH license, and proof of hospital privileges (or something showing that they have a "buddy doctor" that will admit for them). Other factors considered when accepting a new physician into the network include positive results from a site visit (proper handicap parking, posted patient rights, record review, etc.), office hours, and a National Practitioner Database inquiry. This information is then sent to the head AHCA office.

The initial credentialing process takes approximately one month. Area offices complained that it is a long, drawn out process that involves a lot of paperwork. Offices would like to be able to streamline the process, but they were unsure how to do this. Re-credentialing is done every two years and generally area offices thought that this timeframe is adequate. However, one office mentioned that they were looking at changing this to every three years. As a result of re-credentialing, providers are rarely dropped from the program. Instances in which a provider was not re-credentialed included the provider not believing it was beneficial to be re-credentialed and a physician leaving town without ensuring that patients had access to on-call services.

Disease Management Organizations

MediPass beneficiaries who have been diagnosed with diabetes, HIV/AIDS, asthma, congestive heart failure, hemophilia, congestive heart failure, and end-stage renal disease are enrolled in disease management programs. As stipulated by the 1997 Florida legislature, the disease management program was designed to ”promote and measure: health outcomes, improved care, reduced inpatient hospitalization, reduced emergency room visits, reduced costs, and better educated providers and patients”. The program was also to bring an enhanced connection between the patient and the provider, thereby making a significant impact on health outcomes and improved quality of life for patients with chronic disease.[2] The MediPass disease management program focuses broadly on patient care management, including medical services and lifestyle counseling for specific diseases.[3] The Agency contracts with disease management organizations (DMO) for these services.

Providers and area office staff expressed mixed views on the value of the disease management programs to the MediPass program. Overall, it appeared

[2] Agency for Health Care Administration, *Disease Management* www.fdhc.state.fl.us/Medicaid/Disease_Management/index.shtml, downloaded on June 21, 2004
[3] Wheatley B Disease Management: Findings from Leading State Programs State Coverage Initiatives, Vol. III (3) December 2002

as if there were a lack of knowledge on the precise role of the DMO in patient care. Providers recalled that they received lists indicating which of their patients were enrolled in a DMO. However, several of the providers said that neither they nor their patients could recall any encounter with a DMO caseworker. Physicians recalled receiving very little educational materials or other programmatic information from the DMOs. One physician's office mentioned that it is confusing to elderly patients when they receive communication from both their DMO and MediPass.

Providers that did have some experience with the disease management programs acknowledged that the program seemed to enhance patient satisfaction, but there was no evidence that the overall quality of care had improved. Finally, providers questioned why "outsiders" are necessary in the management of their patients. These providers felt that they could "manage their own patients." They viewed disease management as a duplicated effort that was expensive and time consuming.

Area offices believed that DMOs added to the overall "confusion" of MediPass for providers. One area office was particularly concerned that the DMOs may not understand that MediPass patients are often "hard to reach and were difficult to serve," and that significant resources were needed to meet their needs. In addition, area offices were concerned that patients appeared to be arbitrarily assigned to a DMO, often without a clear demonstration of need. Area offices reported not seeing any measurable changes as a result of DMOs, although they could recount anecdotal stories of patients who have benefited from the program.

There was also some concern among area offices about providing DMO case workers with relevant medical documents. This confusion was intensified with the implementation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Area Office Recommendation: The roles of DMOs need to be better defined and communicated to both providers and beneficiaries. Policies should be established and DMOs should somehow be included in the initial MediPass training.

Provider Authorizations

Specialists and other providers must seek authorization from the PCP in order to be reimbursed for services delivered to a PCP's patient. Several provider offices complained about the time involved in the authorization process. It was time consuming and in some instances, an additional employee had to be hired to handle authorizations. This was of particular concern to the health department. Large numbers of people seek STD, HIV, and family planning services from the health department because they did not wish to be seen by their regular PCP. Hence, the health department has to seek authorization from the PCP for a large percentage of their patient visits.

Doctors mentioned that they themselves were not involved in the authorization process—consequently it had evolved into a system of office clerks simply "exchanging authorization numbers." As such, the role of the PCP in monitoring utilization has become relatively minor. One doctor mentioned that he received calls from other providers requesting his authorization number for approval of services for patients he did not know or for services he did not request.

Provider Performance

Area offices reported that the fiscal intermediary, ACS, develops utilization reports that are mailed to providers. These reports compare physicians' performances to their "peer group." Some area offices also received more detailed reports that enabled them to identify over- and under-utilizers.

Although some offices were familiar with profiles they received from other health plans, very few office managers or physicians recalled receiving reports from ACS or MediPass. Among those who did, none found the reports particularly useful or meaningful. In particular they were concerned about whether the comparisons with the peer group were appropriate. The ”o” (for over some threshold or relative to their peers) and ”u” (for under some threshold or relative to their peers) indications provided no sense of how much they differed from their peers and why. When asked about the kinds of information they would want to have on a profile, most mentioned that pharmaceutical/drug utilization information would be very important.

In South Florida, several of the physicians reported being in MediPass for one office and in one of the pilot programs in another location.[4] When asked about performance reports, these physicians spoke favorably of the reports supplied by the minority physician network pilot programs. These reports alerted providers to patients who may be seeing other physicians, who may have been hospitalized, or who may be on medications not prescribed by the PCP.

Communication with Providers

The level of communication between area offices and providers appears to vary by area. Both physicians and staff in areas with small numbers of providers have more ongoing telephone contact with each other relative to areas with a large number of providers. Physician contact with area offices in larger areas seems to be limited to specific problem solving, quality control, and general training activities. For example, in one area with several PCPs, providers were visited only once every two years. In contrast, one office manager in an area with a small number of providers reported that she is on a first-name basis with her area office and that she “loves them to death.” But, overall, most providers

[4] In one location, a provider appeared to be both in MediPass and the MPN pilot program. It was unclear whether the MediPass number was retained exclusively for patients in disease management programs

indicated that they have relatively little interaction with the area offices and it was usually via telephone. However, when they needed to communicate with the area offices, they generally had no problems. Other forms of communication included mail-outs (e.g., outreach materials and invitations to trainings) and quarterly newsletters that inform providers of trainings and changes in the program.

All of the area offices have similar procedures for training providers. They all provide on-site training for new providers. In one area, monthly trainings were held at the area office and were mandatory for new providers. If it seemed that a provider was not doing what they were supposed to do, the area office required that the provider participate in additional training.

Area Office Recommendation: The Agency needs to continue and perhaps improve its communication efforts to ensure that beneficiaries and providers are receiving correct information and have a strong understanding of how the MediPass program operates. Training of participating specialty physicians in MediPass billing practices is particularly important since this group tends to have a higher rates of claims denials. Additional training on billing has the potential to lead to less physician dropout and more new physicians entering the program.

Quality Assurance

A number of area offices are involved in quality assurance activities. For example, in one office each month 10 providers are selected for in-depth reviews. These providers are selected based on their performance and are generally outliers. Selected physician offices are requested to pull certain charts, which are mailed to the area office. If nurse reviewers detect a problem, providers are asked to send a letter documenting how they intend to correct the problem. The area offices will then follow-up periodically to ensure that corrective action has been taken. This office also conducts periodic checks to ensure that offices provide 24-hour access to their patients. This periodic check generally

begins within 30 days after a provider has been accepted into the network. The area office will call after hours to see if the doctor responds within 30 minutes. If the doctor fails to comply, they will check the doctor again within three months. The area office reports that only about five percent of the physicians fail the access test. However, among physicians participating in the Minority Physician Network pilot program, the percentage of providers failing the access test is much higher.

Outreach to Beneficiaries

Area offices conducted a great deal of community outreach programs to teach patients about the MediPass program. However, there was a general sense that patients did not understand the program. This problem stemmed from many different sources: patients did not receive or read communication mailed to them from area offices and the Department of Children and Families (DCF), and physician offices provided a great deal of misinformation. As one area office staffer stated, “The only people that understand Medicaid is Medicaid” and “this is why all inquires about the program should be directed to Medicaid offices”.

Physician Network

Primary Care Physicians

Area office coordinators generally felt that the sizes of the PCP network in their areas are adequate. However, many stated that within their jurisdiction there are areas that are problematic and could use more PCPs. Munroe County, located in South Florida, has a shortage of primary care physicians, mostly because the cost of living is high and doctors report that they cannot afford to practice there. Consequently, the area office proactively recruits providers in Munroe County, but not in any other part of their area. Volusia and Flagler Counties also do not have an adequate network size. This is especially

problematic in Flagler County because it is one of the fastest growing counties in the state, but currently has only two PCP providers with open panels.[5]

Although most providers do not place caps on enrollment, they are allowed to and often do place limits on the kinds of patients they see (e.g., children or women only). As a result, composition of the PCP network varies from area to area. Therefore, while the overall number of PCPs may appear adequate, certain segments of the population may not have quality access to a provider. For example, in one area, older patients have difficulty finding a PCP because most of the providers have decided to only accept children. Some areas stated that the majority of the network's doctors are pediatricians and others said that they lack pediatricians and the majority of the network is family practice. One provider's office did report that they had to stop taking new MediPass patients because of its inability to handle the volume. This office was the only pediatrician in that area that accepted MediPass and had become overwhelmed.

Reasons for PCP shortages in other areas included disenrollment due to dissatisfaction with reimbursement and problems with billing and authorization. In the northeastern region of Florida, one area office cited recent malpractice insurance difficulties as a cause of physicians dropping from the network. With rising premiums, providers reported that they were no longer able to afford malpractice insurance. Not having malpractice insurance could affect their credentialing status. Providers also left the network because they had retired or had moved from the area. However, discussions with office staff revealed that there does not seem to be a significant amount of physician turnover throughout the state. Physicians tend to remain loyal to the Medicaid program. When a physician drops from the network, another physician is usually added, and overall the network remains balanced.

[5] See Hall et al *MediPass Primary Care Network Analysis: Preliminary Findings,* June 2004

The area offices offered several reasons why physicians joined the network. These included trying to build up their practice (i.e., new practices), the $3 per member per month (PMPM) case management fee as an incentive, and legitimately wanting to assist Medicaid patients and make a difference.

Case Management Fee

Providers who participate as PCPs are required to agree to provide primary care services, referrals for specialty care, follow the results of the referral, and maintain overall responsibility for the health of the beneficiaries on their panel. Specific responsibilities include contacting new enrollees to arrange for an initial preventive screening appointment, maintain patient records, and to provide 24-hour coverage. In return providers receive a $3 case management fee in addition to fee for service reimbursement.

Views on the adequacy of the case management fee are mixed. Some providers and area office staff thought the fee is sufficient and should not be increased or decreased. Others maintained that some upward adjustment is needed, especially if the provider has a large number of chronically ill patients or is in a rural area. Several physicians noted that the $3 fee does not sufficiently cover the patient case management services they are expected to provide. As one physician office manager noted, “It isn’t even close enough to cover all of the work involved.” Another commented that their office was “giving all it has got to support the patients and $3 was not enough to cover this.” These comments were heard mostly at physician practices where the largest proportions of patients were on MediPass.

Area offices were concerned that many physicians do not appropriately manage their patients and therefore should not be eligible for a case management fee. They argued that MediPass does very little to hold physicians accountable for ensuring that appropriate case management and primary care services are delivered.

Area Office Recommendation: The monthly fee paid to participating providers should be performance based. Physicians who meet some pre-established performance criteria would receive a higher case management fee.

Specialty Physicians

Access to specialty care is a problem statewide. Every area stated that more specialists are needed. However, the extent of the problems varies considerably across the state. Not all specialties are uniformly unavailable throughout the state. In general, specialties that are problematic include: orthodontics, dermatology, neurology, dental, orthopedics, ENT, oral surgery, and pain management. In one area, there are only two orthodontists for the seven counties. Patients that are able to secure a specialist appointment are often placed on long wait lists. Area offices were quick to point out that they did not believe that PCPs were referring heavily to specialists.

In getting patients appointments with specialists, both area offices and providers rely on established relationships. Providers rely on professional relationships developed with other privately insured patients in establishing specialist contacts for their Medicaid patients. One provider noted that he would refer a Medicaid patient to a specialist only if he had referred at least five privately insured patients to that provider. AHCA staff said that they “begged and pleaded” when necessary. They also called other area offices for the names of specialty providers. Area offices with established relationships with some providers in specialty offices are careful not to bombard one office with too many MediPass patients.

Often patients must be transported great distances to receive specialty care. Travel distance is especially problematic when patients have to return for

follow-up appointments. One area office mentioned that it was bothersome that a doctor could be paid $35, but instead MediPass spent $110 to transport patients to another area. The money is expended, but in the wrong place. Physicians' offices reported that patients may have to pay out of pocket if MediPass specialty providers are unavailable in their area. Alternatively, patients may go through emergency rooms to obtain needed care. Specialists that do accept MediPass patients generally have a two- to three-month wait time for an appointment.

The problem with access to specialty care was referred to as a "crisis." Area offices and physicians speculate that the reimbursement offered by MediPass to specialists is not sufficient. Additionally, specialists do not like the paperwork (claims and billing) involved with the program and often find the patients "difficult to manage." These issues are generally beyond the control of area offices. One staff member noted, "Specialty care is there; we just can't access it." The few specialists that initially agree to accept MediPass patients are often left with no choice but to refuse new MediPass patients because their practices are at capacity levels.

Area Office Recommendation: The Agency should consider the feasibility of setting standards for the specialty care network and actively recruiting to meet these standards. An analysis needs to be conducted to understand how to encourage specialist participation in the MediPass program.

Patient Issues

Continuity of Care

Overall, the area offices felt that seeing the same provider every time and having continuity of care was important. One response was that continuity of care was what "MediPass is for." One area office staff member stated that MediPass provides a great advantage in terms of continuity compared to the old fee-for-service Medicaid because "it puts someone in charge of the patient."

Area offices reported that ”doctor shopping” appears to be on the decline because very few beneficiaries change providers unless something drastic happens or unless the patient is trying to hide something.

Doctor’s offices complained that mandatory assignments can disrupt continuity. Patients fail to select their original PCP upon reenrollment in the Medicaid program. These patients are then assigned to another provider by the area office. One office mentioned that they worked particularly hard at making sure their existing patients were reassigned to them upon re-enrollment in Medicaid.

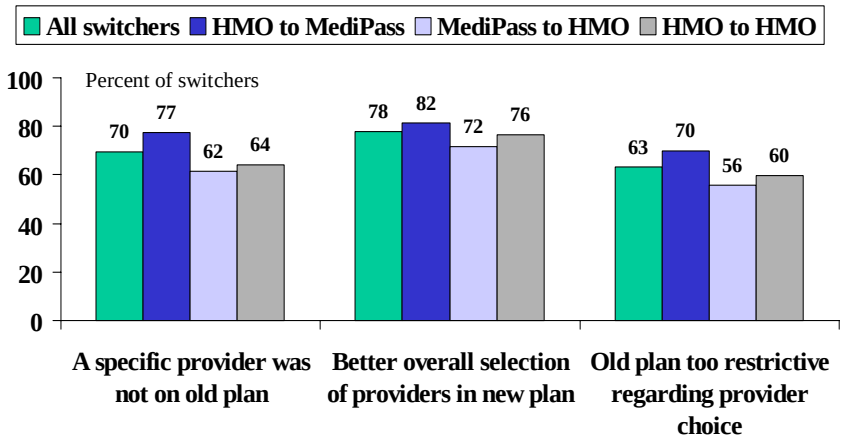
Within large group practices, most offices make an effort to assign a specific physician who sees the patient at each visit. Providers feel that this is important because it creates a better line of communication between the patient and provider. There are some cases (i.e., group practices) in which the patient is not assigned to an individual doctor within the group. Some reasons for this included shorter waiting times for the patient and familiarizing patients with each of the doctors in the office. In these instances, patients who were assigned to the group see different doctors, physicians assistants, or ARNPs at each visit. The area offices may sometimes receive complaints from beneficiaries if they are not seeing “their” physician.

Satisfaction

Providers and area office staff reported that the MediPass program is well liked by patients. Area offices commented that many beneficiaries speak highly of their provider and are satisfied with the care they receive. Positive comments that the area offices receive about the program include provider accessibility, patients can see the doctors when needed, and availability of doctors after hours.

Providers and some area offices said that beneficiaries that have been assigned to a HMO want to return to MediPass. Recent survey findings revealed that of 353 patients who switched managed care options within the last year, 45 percent switched from an HMO to MediPass, 22 percent switched from MediPass to an HMO, and 33 percent switched from one HMO to another.[6] Providers and area offices said that the patients switching from MediPass to an HMO perceived that MediPass has a better choice of primary care and specialty care provider within the MediPass program. Survey results showed that this statement was generally true for all beneficiaries regardless of the kind of managed care arrangement they left (Figure 1).

Figure 1: Reasons for Switching Managed Care Arrangement



2004 Medicaid Switcher Survey

Negative comments heard by both area and physician's offices included long waits to get an appointment and being assigned to the wrong provider. Physicians' offices complained that Medicaid patients were often not compliant, and that there were a lot of no-show appointments with this population.

[6] Hall et al, *Medicaid Managed Care 'Switchers'. Characteristics and Reasons for Switching*, June 2004

Furthermore, a few providers speculated that some Medicaid patients might actually be ineligible for programs based on known income and available assets.

Providers' offices have developed a number of innovative ways to enhance the services provided to their MediPass patients. One office, for example, provided a bus that traveled into the community to collect patients and bring them in for care. Several offices said that they used outreach workers to locate no-show and non-compliant patients. Another office strived to prescribe what they referred to as "simpler medication" and worked hard to get patients involved in their treatment plans. Finally, many providers sent welcome letters to new patients encouraging them to make an appointment.

Impact of MediPass Demonstration Programs

Several MediPass pilot programs are in operation in Miami-Dade and Broward Counties. These pilot programs include the Provider Service Network (PSN), the Minority Physician Networks (MPN) and the Pediatric Associates program. The PSN and MPN programs are fairly similar in principle. Essentially, these programs are designed to shift MediPass administrative and other functions to third parties such as health plans and large physician group practices (in the case of the MPN) and safety-net providers (as in the case of the PSN). The premise is that by providing incentives, these third parties would be encouraged to achieve cost savings for the Medicaid program. Both programs are characterized by strong disease management or care management components.[7]

Were they Successful?

[7] See Duncan R. P., et al., *Evaluating Florida's Medicaid Provider Service Network (PSN) Demonstration Project Summary Report*, Department of Health Services Administration, University of Florida, forthcoming, and Lemak, et al., *Evaluation of Florida's Minority Physician Network Final Report*, Florida Center for Medicaid and the Uninsured, University of Florida, April 6, 2004.

Initial analysis has shown that the MPN and PSN innovations have been somewhat successful in reducing costs associated with caring for MediPass beneficiaries. Cost savings in the demonstration programs seemed to be realized through reduction in the utilization of services relative to MediPass because fewer enrollees used services. (However, among utilizers, expenditures were not significantly impacted). The MPNs appear to make MediPass better by (1) offering providers timely beneficiary utilization and (2) by managing the networks at a local level.

Demonstration Program Expansion Considerations

These programs have had important consequences for MediPass in South Florida. First, by definition, these programs exclude several categories of Medicaid beneficiaries (e.g., dual eligibles, CMS children, etc.). As increasing numbers of providers become involved in these programs, their eligible patients become enrolled in the pilot program networks. Generally speaking, chronically ill patients enrolled in MediPass disease management organizations remained outside the pilot programs, as did some other beneficiaries with complex medical and social needs. The result was that the South Florida area offices defined themselves (that is, MediPass) as the “plan that cared for the sickest patients.” They emphasized the increasing needs for true case management and coordination of medical and social services for “regular MediPass” beneficiaries.

Second, as pilot programs were developed and implemented, area offices struggled with the coordination and management of different programs with different rules and oversight requirements. Providers were often confused about the different programs and the appropriate way to manage and bill different types of beneficiaries. For example, when providers had DMO patients and were members of the Minority Physician Network (MPN), they received two lists of MediPass members. Since the DMO patients are not part of the MPN pilots, providers must bill using the MPN “SuperGroup ID” for the MPN beneficiaries and bill for the DMO patients using their own unique Medicaid provider

identification number. In some pilot programs, credentialing is done by the pilot organization. In other programs, credentialing is done by the Agency.

Because of complexities such as this, the area offices must conduct extensive training and hand-holding with providers (and beneficiaries) before, during, and after physicians join pilot programs. Ironically, the pilot programs were designed to reduce administrative hassles for the Agency. However, area offices are usually the first place that providers and beneficiaries call when they are confused about what to do or how to do it. These and other factors associated with Medicaid pilot programs must be understood and anticipated as the pilots expand to other parts of the state (e.g., Tampa and Jacksonville).

SUMMARY AND CONCLUSIONS

Medicaid and MediPass are recognized as critical components of the healthcare safety net. As such there was strong support from both providers and AHCA staff for the program. However, a number of important concerns emerged. These include:

- The unavailability of certain kinds of specialty care within specific regions;
- The adequacy and appropriateness of the $3 per member per month management fee;
- Confusion on the role of disease management organizations in patient care; and
- The need to streamline and make more efficient certain operational procedures such as credentialing and referral authorizations.

However, in light of increasing costs associated with the Medicaid program, these concerns must be addressed as part of an overall strategy to reduce expenditures while maintaining and enhancing quality of care. Existing payment structures and mechanisms do little to encourage physicians to engage in cost saving and quality improvement activities.

APPENDIX I: PROTOCOL FOR AREA OFFICE INTERVIEWS

Evaluation of Florida's Medicaid MediPass Program
Questions for AHCA Area Offices

The Florida Center for Medicaid and the Uninsured has been contacted through AHCA to conduct an evaluation of the MediPass program. The most recent evaluation conducted three years ago concluded the following:

- MediPass consumes fewer resources than expected;
- Excess capacity exists within the primary care network;
- The need to implement enhanced utilization review procedures to hold providers responsible for practice patterns; and
- High rates of satisfaction.

The purpose of this evaluation was to build on this information and to gather information about the challenges, successes and changes in the MediPass program in the last three years. It will also offer an opportunity to give any thoughts on MediPass.

PCPs

This set of questions will focus on PCPs. We are interested in learning about the PCP network, relations with providers and PCP training and education.

How would you characterize the size of the PCP network in your area?
Too large or too small to manage?
Any changes needed?
Any changes over time?
Are PCPs more/less reluctant to join the PCP network?

Describe the PCPs in the area network.
Who are they (family practice, pediatricians, internal medicine, etc.)?
Lack of /too much of any kind?

How long do PCPs generally serve in the MediPass network?

Do you know why PCPs join and leave the MediPass program?

What kinds of comments do you hear about the program and the patients from PCPs?

What forms of communication does the area office use to communicate with/educate/ train/provide feedback to PCPs?

What forms of communication does you use to inform providers (and their office staff) of changes in the MediPass program?

How extensive is PCP orientation and training for MediPass? What's involved?

Is there ever a need for additional PCP training? Do you monitor this?

Continuity of Care

One of the areas we have been investigating through the evaluation is continuity of care. We have asked providers whether or not patients see the same provider every time and if they feel continuity of care is important.

How easy is it to maintain continuity of care for patients in the program?

Provider Profiling

The head office has asked us to investigate the feasibility of provider profiling within the program. Provider profiling uses performance reports of providers to compare to peers and identify outliers and improve provider performance.

To your knowledge, are there any provider profiling activities that are now ongoing within the agency?

Do you think that profiling activities could be implemented into MediPass?

What performance measurements do you feel are needed?

Do you think MediPass PCPs would be influenced by performance reports? Why or why not?

Beneficiary Assignment

What factors are used in making PCP assignments?

How often are the patient lists updated (i.e., list of patients that are assigned to each doctor)?

What is the current system in place for providers to verify eligibility? What could be done to improve this system for providers?

How are patients educated about the MediPass program? Are they assisted with selecting a doctor and informed of the purpose of MediPass?

Credentialing

What is the current PCP credentialing process? Does it include all needed elements?

Are there ways to streamline the process?

What should headquarter/area office roles be with regard to credentialing? (What currently happens? What would be most efficient?)

Is Medicaid successful in attracting top-tier PCPs in the community?

How often are PCPs credentialed? How often should PCPs be credentialed?

On average, how many PCPs are dropped from the program each year? For what reasons?

To what extent are PCP performance standards set, communicated, and measured?

Is PCP quality of care used in the credentialing process?

Case Management Fee
Do you think that providers understand what is expected for the $3 PMPM fee?

Do you feel that $3 PMPM is sufficient?

Specialists
Through our provider interviews, we have heard that access to specialty care is a problem statewide.

How do you feel about the specialty care network available to MediPass beneficiaries?
What can the Agency do to improve this situation?
Do you have any ideas for improving the specialty care network?

Do PCPs use specialists appropriately?
Is this a problem?
Are PCPs relying too heavily on specialists?

To what extent do PCPs help patients locate specialists?

Disease Management
What disease management programs are offered in your area?

Do you believe that the disease management organizations offered to MediPass patients have been effective in reducing costs and improving health outcomes?

To what extent has the disease management program enhanced the MediPass program?

Patients
How satisfied do you think patients are with the care they receive from MediPass providers?

What kinds of complaints and/or compliments have you received from patients?

Any specific challenges related to racial/ethnic diversity among the patient population?

Any other kinds of challenges associated with patients.

MediPass Organized Structures/Staffing/Functions

We are interested in learning more about the roles of the area office and the division of labor between the head office and the area offices.

General responsibilities of the area offices: Tell us about the responsibility of the area office in relation to MediPass.

Would you discuss the organization of the area office?

Are headquarters and area office roles properly defined and communicated?
Is there a clear understanding of roles of the head office and the area office?

Is MediPass-related staffing appropriate/sufficient to support the program?

Is there a need for shifting any roles between the head and state offices?

Closing

What are some of the changes/improvements that have recently been made to the program?

What can be done to build upon successes or improve MediPass?
Recommendations for future changes?

What are some of the challenges?

Is MediPass meeting the needs of consumers?

Is there anything else you would like to tell us about the program?

APPENDIX II: PROTOCOL FOR PROVIDER INTERVIEWS

Evaluation of Florida's Medicaid MediPass Program
Questions for Providers/Office Staff

Introduction
The Florida Center for Medicaid and the Uninsured (FCMU) at the University of Florida is conducting an evaluation of the MediPass program on behalf of the Agency for Health Care Administration. The evaluation will be conducted under the direction of Dr. Allyson Hall who is the research director for FCMU.

Your participation in this research is voluntary and you do not have to answer any of the questions you choose not to.

The main goal of this evaluation is to:
Examine program **practices and procedures**;
Examine the **primary and specialty care capacity** of the physician network; and
Examine **provider profiling activities** within the program.

In order to accomplish these objectives, FCMU will be conducting either in-person or telephone interviews with MediPass providers with a large number of Medicaid patients. The interviews will mainly focus on policies and procedures associated with MediPass. Through this process, FCMU hopes to learn about the challenges and success of MediPass. The interviews will provide an opportunity for those interviewed to suggest changes to the program. Please note that the individual interviewee's identities will be kept confidential.

General Questions

Tell us about your practice
- Population Served
- Number of Providers→ Do they all serve MediPass patients?
- Payer Mix

Number of patients seen from MediPass?
- Office Hours

Your position at the office

Are you taking new MediPass patients? Why or why not?
Why does your office take MediPass patients? How did your office get involved?
How long have you accepted MediPass?

Tell us about your experience with MediPass.
- Good things
- Problems

Recommendations

Patient/Provider

What is your experience with getting specialty referrals?

Do you agree with the patient/PCP caps?
If patient/PCP cap were decreased how would it affect business? Would it give other players a chance to play?
Increased?

Talk about the process of managing patients.
How frequently do they change PCPs.
Problems with data (phone numbers, ID numbers)

What is the process for verifying eligibility of MediPass patients?

Medicaid is interested in innovative approaches that your office uses to better manage MediPass patients and the needs of the patients (e.g., extended hours, quality issues). Do you have any that you would be interested in sharing with us?

Continuity of Care
Is the patient assigned to a specific physician?
Do they see same physician every time they visit the office?

Physician Profiling
AHCA is considering implementing physician profiling. We are interested in what you think about physician profiling**.**

Currently…
What measurements do you use to track quality of care?
Do you compare quality measures with other doctors?

If MediPass were to institute provider profiling…
What do you think the effects would be?
What measurements would be helpful to compare in order to change behavior?
What incentives would be necessary to change physician behavior?

Have you participated in physician profiling with any other insurers?

May we contact you in the future for further assistance with developing physician profiling (i.e., questionnaire)?

MediPass Program

Tell us about your experience and relationship with AHCA staff? (supportive, not supportive?)

What are the administrative challenges associated with being involved with MediPass?
Positive things?
Has PCP practice management changed in any way to accommodate MediPass requirements?

Would you talk about your experience with the following areas of MediPass:

Billing and claims processing (claims submission, payments, levels of reimbursement, etc.)

Case management

Is the $3/month case management fee sufficient to achieve adequate member case management?
Has the Agency properly explained the PCP case management role to you?
Do you know what is expected for the $3 fee?

Patient Issues

Patient issues (including access to specialists, access to ancillary services, care coordination, other patient care issues)

Disease Management
Are any of your patients in DMOs?

Do you believe that the disease management organizations offered to MediPass patients have been effective in reducing costs and improving health outcomes?
Do disease management organizations (DMOs) aid the MediPass PCPs?

Closing

Is MediPass meeting your expectations?

Is MediPass a good way to provide care to low-income families?

Is MediPass meeting the needs of consumers?

To what extent do PCPs rely on Medicaid business?

Are there any new problems?

Have you noticed any changes to the program in the last 3 years?

Any suggestions you can offer to improve MediPass in the future?