ABSTRACT

Continuing increases in the cost of medical care threaten the viability of Medicaid programs. Many states have responded with cost-containment initiatives. In Florida, the Provider Service Network (PSN) demonstration project is based on a model in which a provider organization, or network of organizations, provides care to a defined population and also agrees to perform associated “insurance” functions, such as enrollee services, provider credentialing, claims processing, and quality assurance. The concept is built on an assumption that health care costs can be contained when money flows directly from payer to provider, removing the insurance “middle man” from the transaction.

Florida’s PSN uses a fee-for-service approach, with established payment limits and a linkage between payments and quality of care on a series of performance indicators. Additionally, the pilot program required implementation of disease state management programs in order to control costs and enhance outcomes for those patients with predictably expensive conditions.

CHALLENGES OF INNOVATION

The South Florida Community Care Network (SFCCN) is a unique partnership of three large public health care systems in Miami-Dade and Broward Counties: the Public Health Trust of Miami-Dade County, Memorial Healthcare System, and the North Broward Hospital District. In its first year of operation, SFCCN enrollment grew to over 24,000 enrollees.

To date, Florida’s experience demonstrates that collaboration between the state and providers involves a great deal of time and complexity. In retrospect, it is clear that the Medicaid program was challenged (and not entirely successful) in efforts to balance the flexibility and provider input deriving from the Invitation to Negotiate mechanism against the convenience of clear, rigid rules for the bidding and negotiation processes.

In addition, the SFCCN found that establishing necessary organizational relationships among network partners was more difficult, time consuming and complicated than anticipated. These experiences suggest that provider organizations interested in this or similar models must deal with the uncertainty of unknown fiscal consequences associated with an innovative, largely undefined program. Furthermore, the SFCCN and state have learned much about the complexities of executing the financial and quality performance aspects of the PSN model. Specifically, there are challenges in (1) defining and measuring clinical performance; and (2) conducting financial reconciliation in a routine and timely fashion. Overall, key benefits of the PSN model include increased collaboration among three of the state’s largest safety net providers and immediate success in provider-developed disease state management initiatives in the key clinical areas of diabetes, asthma, and high-risk pregnancy.
**Enrollee Satisfaction with Health Care Provided by the PSN**

Enrollee satisfaction with the PSN was assessed by a telephone interview using the Consumer Assessment of Health Plans Survey (CAHPS) and comparisons with similar data from enrollees in other Medicaid programs.

PSN enrollees were surveyed in the spring of 2001, with interviews conducted in English, Spanish and Creole.

Overall, Florida’s Medicaid enrollees reported high levels of satisfaction with their care. MediPass, Florida’s primary care case management program, scored highest of all the managed care programs studied, but the PSN was only slightly lower. Differences among the programs were slight.

**Evaluating the Cost of the New Program**

Determining the price tag of the PSN demonstration is challenging, since costs are computed so differently for various Medicaid programs.

In part because they were set at a percentage discount of existing MediPass rates, the preliminary payments for the PSN during the period from November 2000 through February 2001 for patients who had transitioned from MediPass to the PSN were about $18 less per member-month for the PSN than for MediPass.

When the withholds and administrative fees are added, the per member-month payments to the PSN were very similar to those for MediPass. Because “savings” were defined as the difference between the PSN payments and an established Upper Payment Limit, the allocation of an agreed share of those savings pushed the average PSN payment to $392.47 per member-month, compared to $366.67 for MediPass. It should be noted that these estimates do not adjust for inflation, and do not account for any administrative savings the PSN might have accomplished by absorbing functions that would otherwise have been performed by the Florida Medicaid program.

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