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State Level Special Issue–Part 2

# Evaluating Florida's Medicaid Provider Services Network Demonstration

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**Research Objective.** To evaluate the design, development, and implementation of Florida's Medicaid provider service network (PSN) demonstration, and the implications of that demonstration for subsequent Medicaid Reform in Florida.

**Data Sources, Data Collection.** Organizational analyses were based on archival and enrollment data obtained from Florida's Medicaid program and the South Florida Community Care Network, as well as key informant interviews. Closely related fiscal analyses utilized Medicaid claims data from March 1999 through October 2001 extracted from the Florida Medicaid Management Information System.

**Study Design.** The organizational analyses reported here were based on a structured case study research design.

**Principal Findings.** Almost every aspect of the development of the new organizational form (PSN) took longer and was more difficult than anticipated. Prior organizational experience with insurance functions proved to be an asset. While fiscal analyses indicated that the program saved the state of Florida a significant amount of money, tracking the precise origin of the savings proved to be challenging.

**Conclusions.** By most standards, the PSN program was observed to meet its stated objectives. Based in part on this conclusion, the state chose to extend the use of PSNs within its 2006 Medicaid Reform initiative.

**Key Words.** Medicaid, provider service networks, PSO, evaluation design/research

State policies and actions are an integral part of our nation's health policy framework. This is particularly obvious in the case of Medicaid, a program for which the states share fiscal obligations and have primary administrative responsibility. Concerns regarding the quality of care provided to enrollees and the financial viability of Medicaid programs in the states are among today's "hot topics" in the health policy arena (The Kaiser Commission on Medicaid and the Uninsured 2006). While the issues are not new, the current conversation may differ from those of previous years because the

contemporary political and policy context includes serious consideration of much greater state flexibility in the structuring of Medicaid and the delivery of health care to Medicaid enrollees (Finegold, Wherry, and Schardin 2004; Rowland et al. 2006). At present, a great deal of state interest is focused on moving Medicaid payment systems toward a more intensely managed form of managed care (Bailit, Burgess, and Roddy 2004; Kaye 2005).

In considering and pursuing the opportunities deriving from increased flexibility, states frequently begin with overall philosophical preferences and then review past experiences to focus their efforts on Medicaid policy initiatives that are consistent with those preferences *and* have some demonstrated promise of success. To a significant degree, the observation of prior experience is focused on the outcomes of demonstrations that have been implemented with the authority of a Section 1115 Waiver. While the Deficit Reduction Act of 2005 (DRA) may create new and increased avenues for states to pursue program variation, the historic purpose of waivers has not simply been to change programs, but to test ideas or new approaches to program implementation. Formally, they are "Research and Demonstration Waivers," explicitly acknowledging the role of observation and research as to the impact of the demonstration. The research part of this function is not always achieved, because that aspect of waiver-based Medicaid program changes typically takes a back seat to program implementation. Furthermore, except for privately funded initiatives such as the State Coverage Initiatives Program (http://www.statecoverage.net) and the State Health Access Data Center (http://www.shadac.umn.edu/), there is no convenient clearinghouse for systematically disseminating demonstration research findings that might prove

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valuable for subsequent program modifications or to other states as they contemplate policy interventions. Effective July 1, 2006, Florida embarked on a 5-year research and demonstration project that may significantly change its Medicaid program. One element of the Florida reform initiative is the inclusion of provider service networks (PSNs) among the managed care organizations that may be used to organize and deliver care to Medicaid enrollees. The decision to include PSNs in the 2006 reform initiative is explicit in both the enabling legislation (FL Gen. Laws ch. 2005-358 [2005]) and in the state's waiver application. Absent such inclusion, PSNs would not be part of the current reform initiative. The decision to include the PSN option in the current reform initiative derived, in part, from the evaluation research findings from a previous Medicaid demonstration. The purposes of this article are to describe key findings from that prior evaluation and to note the linkages to Florida's current Medicaid Reform initiative.

## FLORIDA'S PSN DEMONSTRATION (1997–2003)

The PSN demonstration in Florida had its origins in a 1996 executive order by which then-Governor Lawton Chiles established a Florida Medicaid Reform Task Force. This 33-member bipartisan advisory group was charged with analyzing the state's (then) $6.5 billion Medicaid program and making recommendations for its reform. At the time, there was considerable interest in provider-sponsored organizations (PSOs) as a means of improving health care while containing costs (The Lewin Group Inc. 1997). The federal government enabled PSO participation in Medicare (Davis 1997) and a few states (e.g., New York, Michigan) took steps toward that end in parts of their Medicaid programs. The core idea of the PSN/PSO is that providers are uniquely positioned to understand the care needs of their patients/enrollees. Restructuring the flow of payments directly from the paying organization (in this case the Medicaid program) to the provider was viewed as a means to eliminate "middle man" costs (primarily those of the health plan or insurance company), thus saving money without having to reduce needed care (Davis 1997; Hirschfield, Nino, and Jameson 1999). The primary concern, of course, was the degree to which provider-based organizations could or should be expected to assume risk for the "downstream" health care needs of an enrollee population. In 1997, Florida's Legislature accepted the report of the task force and authorized the establishment of up to four Medicaid PSNs, including

specification that one PSN be established in the Orlando area (FL Gen. Laws ch. 97-263 [1997]).

The legislation clearly stated that the objectives of the PSN innovation were to (1) develop a successful managed care partnership between the Agency for Health Care Administration (Florida's Medicaid agency, typically referred to as AHCA) and providers of medical care with a history of providing high volumes of care to Medicaid enrollees; (2) create and test a new health care choice (PSN) for Medicaid enrollees; (3) achieve cost savings and improve enrollee health outcomes through improved collaboration between Medicaid and local indigent health care programs; and (4) improve the quality of life for Medicaid enrollees with chronic health conditions.

The demonstration envisioned the creation of provider networks that would enroll panels of Medicaid beneficiaries and provide and manage their care. It was to have a payment model based on discounted fees for service with clear processes to (a) measure any savings achieved, and (b) ensure that the state and the PSN shared those savings. Even though the legislation specified that up to four PSNs could be developed, ultimately, only one PSN was created.

## Florida PSN Evaluation

Florida Medicaid determined that the PSN Demonstration Project should be thoroughly evaluated by an independent research organization. The evaluation consisted of three interrelated areas of observation and inquiry: (1) organizational analyses—assessing the manner in which the network(s) and related organizations pursued program objectives; (2) utilization and expenditure analyses—comparing Medicaid utilization and expenditures for PSN enrollees to those experienced in other Florida Medicaid programs, especially the state's primary care case management (PCCM) program to determine any cost savings; and (3) enrollee experience analyses—measuring enrollee satisfaction overall and with required PSN disease management programs.

The current paper is based almost entirely on the organizational analyses (Lemak et al. 2004). However, formal reports that provide details regarding each area of inquiry, research methods employed, and detailed findings are germane and can be found at: http://ahca.myflorida.com/medicaid/quality_management/mrp/projects/psn/reports.shtml

## METHODS

The organizational analyses utilized a qualitative, structured case study design that involved data collection from a variety of sources, including in-person interviews with a range of key informants, as well as documents and statistics from the state's Medicaid information system files. Interview data, the attributes of the network and its constituent organizations, and enrollment information were also obtained from the single operating PSN, the South Florida Community Care Network (SFCCN).

Over 40 semi-structured, in-person, key informant interviews were conducted with administrators, physician leaders, and others directly responsible for PSN planning and operations including individuals from the SFCCN, other organizations not awarded PSN contracts, administrators at AHCA and other knowledgeable interested parties. The interviews followed common interview protocols specific to the type of respondents. In addition, publicly available PSN reports and documents including responses to the Invitation to Negotiate (ITN), the final PSN contract, routine reports to AHCA, and other documents were reviewed. Quantitative data including membership size, composition, and growth in the PSN were collected every 6 months. Where available, comparable information was obtained regarding other Medicaid delivery/financing mechanisms operating within the service area of the PSN. The specific comparison organizations/types included Florida's PCCM program (MediPass) and Medicaid health maintenance organizations (HMOs).

### *Findings*

Because the PSN demonstration in Florida laid important groundwork for the state's current efforts to reform Medicaid the development of this alternative managed care organization form merits careful review. The process can be described in six distinct phases from planning and initiation of the demonstration (1996–1998) through implementation of the first PSN in 2000 and its initial years of operation.

*Phase I: Government Initiatives for Changing Medicaid (September 1996–February 1998).* The PSN demonstration began with a political/policy interest in examining and perhaps reforming some aspects of Florida's Medicaid program. This phase included appointment of a Medicaid Reform Task Force, its activities, its recommendations for Medicaid to contract with PSNs on a demonstration basis, the necessary legislative action and AHCA's

development of a competitive bidding process to develop and create PSNs in Florida. It is noted that the task force included significant representation from provider organizations, especially those with a history of participating in Medicaid. This certainly influenced a core philosophical interest in provider-centered initiatives.

Florida's Medicaid program sought participation in the demonstration by issuing an ITN. Using this device, as distinct from a more routine request for proposals (RFP), was intended to accomplish several goals. First, it was hoped that the flexibility of the ITN mechanism would elicit the views of provider organizations and create a collaborative process in which contractual arrangements would emerge from an iterative exchange of ideas between the proposing organizations and the Medicaid agency. Second, it was hoped that this approach would allow combinations of diverse organizations to form collaborative networks for the specific purpose of participating in the demonstration. For example, AHCA officials expressed some interest in the prospect that one or more of Florida's rural health networks might either lead or participate in the creation of PSNs. Similar aspirations about a potential role for community health centers were also noted.

*Phase II: Provider Responses (February–March 1998).* Upon the issuance of the ITN, Florida health care providers were faced with deciding whether and how to participate. Clearly, there had been enough informal prior conversation to ensure that technical issuance of the ITN was anticipated by many of the state's leading safety net hospitals. On the other hand, interested parties were required to submit a letter of intent to participate within 2 weeks of the formal issuance. That was obviously insufficient time for organizations with little or no prior history of collaboration to even begin the conversations necessary if they were to seriously contemplate the creation of a new organizational entity.

Even among the safety net hospitals which might be expected to form the core of a PSN, the relative value of this new approach was not obvious. Most of those hospitals had a long history of participation in the Medicaid program. They knew how to get people qualified and enrolled in the program. Notwithstanding their ongoing concerns about payment rates, these hospitals were familiar with and could count on a known level of Medicaid payment. At first blush, the "discounted fee-for-service (FFS)" payment model proposed for the PSN sounded like a means whereby safety net

organizations could volunteer to receive even lower rates than those currently in force. It was sensible for such organizations to consider carefully whether there was a realistic likelihood that they could accomplish cost savings sufficiently in excess of the "discount" to justify their participation. On the other hand, nothing guaranteed that the current rates would remain in place, and the proposed new model gave the provider organizations a new level of control.

Furthermore, providers were in some senses trapped by their own rhetoric. Over the years, administrative leadership, especially in hospitals, had expressed the view that providers of care were in a better position than HMOs to serve effectively as care-managers. The state's proposed PSN program effectively challenged those organizations to walk their own talk. Ultimately, AHCA received 20 letters of intent. Half were from organizations that would later participate in full proposals. AHCA held a bidders conference to respond to questions from potential participants.

AHCA officials took aggressive steps to meet with numerous organizations throughout the state in hopes of encouraging participation. By the formal deadline 6 weeks later, full proposals were received from seven potential PSNs. Two applicants were from the Panhandle/Pensacola region; three were from the West Central/Tampa Bay region; and one application came from each of the South Florida area, the Central Florida/Orlando area, and the North Central Florida area.

*Phase III: Government Evaluation of Provider Proposals (April–May 1998).* Proposals were evaluated by AHCA staff and a national consulting firm. Assessment involved assigning points to each of 19 proposal components, with multiple raters evaluating each proposal. In addition to training AHCA evaluators, the consulting firm actually scored two portions of the proposals (quality assurance and financial aspects). Oral presentations were made by six applicants. Out of a maximum possible 2,000 points, the final scores differed by only 210 points, ranging from a highest score of 1,392 and a lowest score of 1,183. SFCCN had the highest score.

*Phase IV: Provider Reactions, Protests, and Resolution (Summer 1998).* The fourth phase included an extended period of response from applicant entities. The reactions ranged widely, from relatively innocuous requests for clarification or explanation, to more strident calls to AHCA leadership, or contact with legislative allies. Formal protests were filed by two applicants. AHCA ceased

all contract negotiations until the protest issues could be resolved. At the same time, state officials encouraged competing bidders to collaborate and create regional PSNs. At the end of this phase, AHCA was in formal negotiations with the SFCCN (the top-ranked bidder), a regional network targeting the three-county West Central/Tampa Bay area, a second regional network focusing on several counties covering the state's entire northern tier (including the Panhandle/Pensacola and North Central PSN applicants), and the statutorily mandated PSN in the Central Florida/Orlando area.

*Phase V: Contract Negotiations (September 1998–March 2000).* The fifth phase of the PSN demonstration included protracted contract negotiations between AHCA and the various organizations proposing to become PSNs. The applicant in the Central Florida/Orlando area opted out of the demonstration, citing its negative experiences with the Medicare PSO process as the chief reason. The Tampa Bay and North Florida PSNs were unable to sustain sufficient interest or create the required level of common ground among the many parties involved. By late 1999, all PSN conversations and negotiations ceased in these two regions. Ultimately, the SFCCN was the only PSN to successfully negotiate a contract with AHCA.

*Phase VI: Implementation and Operations of the SFCCN (March 2000–Present).* On March 1, 2000, the SFCCN and AHCA executed a 3-year contract, officially creating a Medicaid PSN in the south Florida area comprised of Broward and Miami-Dade Counties. The SFCCN is a unique partnership of three large public health care systems in Broward and Miami-Dade counties: the Public Health Trust of Miami-Dade County, Memorial Healthcare System (based in Hollywood), and the North Broward Hospital District (based in Fort Lauderdale). Some administrative functions of the network are centralized, including enrollee services, development of disease management programs, quality improvement, and AHCA reporting. Each partner health system handles claims processing, medical management, provider relations, financial reconciliation, disease management implementation, and other PSN functions.

The SFCCN obtained enrollees through voluntary and mandatory assignment processes. In the beginning, recipient entry into the SFCCN was driven by the transition of PCCM primary care physicians into the PSN. If a Medicaid enrollee's physician joined the network, the recipient was given the option to (a) follow the physician into the PSN, (b) stay in PCCM with another

physician, or (c) join a Medicaid HMO. The PSN staggered enrollment throughout the first year, a strategy that resulted in growth from about 3,500 initial enrollees in March 2000 to about 24,000 in March 2001. Enrollment gradually declined to about 16,000 as of the middle of 2002 and then stabilized at around 18,000 where it remained throughout the period under consideration here. Virtually all significant changes in the number of enrollees could be attributed to state regulatory and assignment policies. Although no Medicaid enrollees were forced to enter the PSN against their expressed wishes, the degree to which the PSN benefited from the assignment of Medicaid enrollees who did not actually select a program (and were hence assigned) varied over time. When the PSN shared in those assignments, enrollment increased; when assignments went exclusively to HMOs, the PSN enrollment declined. Summed over the demonstration period, most of the enrollment was in Miami-Dade County (approximately 20,000 enrollees or nearly 7 percent of local Medicaid beneficiaries), with about 4,000 enrollees in Broward County (about 4 percent of Medicaid beneficiaries there).

*Lessons Learned from the PSN Development Process*

Several issues affected the process of moving from 20 letters of intent to one operational PSN. First, there was confusion about the PSN concept. Few people in Florida had a clear understanding of the PSN concept or its potential value as an organizing principle for the delivery of services to Medicaid enrollees. Of particular concern were expectations about whether the PSN was a genuinely new organizational form, a "modified PCCM" program, or a "modified Medicaid HMO" program. The degree to which the new organizations would be at risk for the costs of care received by their enrollees was subject to endless conversation and no definitive resolution.

Second, the ITN process used instead of the more directive RFP approach created unanticipated issues. The mechanism itself is not commonly used in Florida, so both the Medicaid program and prospective participants had a limited experience base from which to proceed. Some bidders found the approach to be a complex, unwieldy, ambiguous, and sometimes difficult competitive process. In addition, organizations opted to develop and submit PSN proposals for various reasons. In some instances the motivation was a long-standing mission to serve the indigent and meet community needs. In other cases participation was a defensive strategy or was based on political considerations.

There was considerable skepticism about the fairness of the process. One cause was AHCA's late decision to require bidders to make oral presentations in Tallahassee, a requirement that had not been included as a part of the original ITN. Further, some organizations believed the whole process simply took too long. The ITN process would ultimately take almost 2 years, with slowing momentum and growing disinterest.

Finally, PSN leadership reported that prior experience in managing "the insurance functions" was essential to bring the PSN on line and maintaining its activities. Taking steps that effectively transferred these functions to a provider entity required the latter organization to obtain knowledge about how to manage enrollment, receive, record and submit claims, resolve issues with claims, and otherwise perform these activities. Such knowledge is not inherently available in provider-centered entities.

### *Other Measures of Demonstration Effectiveness*

*Financial Performance.* The state had great interest in whether or not the PSN created cost savings, mainly in the narrow sense of whether or not the Medicaid program had lower expenditures than it would have in the absence of the PSN. Overall, utilization and expenditure analyses indicated that Florida spent less money on PSN enrollees than it might have expected to spend for those same enrollees had there been no PSN, and the state spent less money on PSN enrollees than it would have spent for a comparable group of beneficiaries in PCCM or the FFS portion of the Medicaid program. The amount of these savings was estimated to be about $30 million.

Specifically, a series of utilization and payment evaluation studies (Vogel et al. 2004) analyzed expenditure data on behalf of PSN enrollees. Analyses included both cross-sectional and pre–post comparisons, controlling for factors that may influence or contribute to an observed differences in expenditures. Results were adjusted for inflation. The "pre–post" comparisons observed expenditures on behalf of enrollees who had been participants in the Medicaid program before the establishment of the PSN and who transitioned into the new program. The key finding was that the Medicaid program's payments for these beneficiaries were slightly lower during their PSN enrollment than during a comparable prior enrollment period in PCCM, ceteris paribus.

Cross-sectional multivariate analyses were also pursued. Specifically, for a defined period of time during the PSN implementation, utilization and payments for MediPass, Medicaid FFS, and PSN beneficiaries were

compared. These analyses examined whether statistically significant differences existed among these three Medicaid programs in utilization of care and/or payments to providers. Consistent with the pre–post analyses, these comparisons found that Medicaid payments to the PSN were lower than those made on behalf of comparison groups of PCCM and FFS enrollees.

Estimated total savings were derived in two distinct ways. AHCA and the PSN pursued a reconciliation and shared saving process that compared (a) the amounts that would have been paid based on the upper payment limit (UPL) had all of the same enrollees consumed the same care in the PCCM program to (b) the actual payments made to the PSN. The difference between the two resulting figures was just over $30 million. A separate independent analysis calculated the difference between the actual per member per month payments to the PSN and those occurring for the comparison group of MediPass enrollees. The sum of this observed difference over the PSN enrollment during the 36-month duration of the demonstration, resulted in a closely comparable estimate.

Subsequent analyses have indicated that these lower expenditures reflected, in part, reductions in utilization (especially of outpatient services) and may reflect some differences in the medical circumstances (risk profiles) of enrollees in the various programs ( Johnson et al. 2006). But regardless of the precise origin of the savings, by 2004 the state concluded that it had spent less on the PSN enrollees than it might have expected to spend for those or a comparable group of beneficiaries had they been participating in PCCM or FFS Medicaid.

*Patient Satisfaction.* The experiences of PSN enrollees, especially their satisfaction with this new organizational form, were also of interest to the state. Dollar savings accompanied by patient dissatisfaction would not be considered a success. Telephone surveys (using CAHPS-style questionnaires) were conducted with PSN enrollees and a PCCM comparison sample. In general, both the PSN and PCCM enrollees reported high levels of satisfaction with the medical care they received, and the concomitant administrative processes and procedures. There were some modest but statistically significant differences between the two programs in the scores given by enrollees. In general, where there were differences, PCCM had the more positive scores. For example, PSN enrollees reported somewhat longer waits between making an appointment and seeing the health care provider for routine care and somewhat greater difficulty in seeing a specialist. The PSN

scores were similar to national Adult Medicaid 2003 data from the National CAHPS Benchmarking Database Chartbook (U.S. Agency for Healthcare Research and Quality 2003). On balance, the state concluded that the levels of PSN enrollee satisfaction were reasonably comparable to those of other managed approaches to health care delivery.

### *Summary of Evaluation Findings*

This particular version of a PSO met most of the goals specified by the state of Florida in seeking an alternative approach to delivering services to Medicaid enrollees. The demonstration confirmed that a PSO centered around traditional safety net providers and hospitals with historic commitments to Medicaid patients can be a viable mechanism in which the state could continue to support those entities *and* obtain the services it sought for Medicaid enrollees in a fiscally responsible manner.

Specifically, the PSN saved the state of Florida a significant amount of money while avoiding extreme sacrifices in the quantity of care delivered to the participating enrollees and their satisfaction with the care received. The organizational processes necessary to create a state-level administrative means to establish and manage a PSN program, and the analogue processes in which provider entities came together to form networks were more difficult and time consuming than had been anticipated. But the demonstration indicated that those difficulties could be overcome and a provider-sponsored network could be established and organized around historically high volume providers of care to Medicaid enrollees. Further, the resulting entity could deliver care in a manner that achieved its own expressed objectives and met at least some of the expectations of the Medicaid program, while preserving the levels of care expected by enrollees. Hurley and Somers (2003) note the emergence of collaborative, partnering relationships among Medicaid programs, managed care organizations and safety net providers as a particularly promising sign of maturing relationships among these entities in the provision of care to Medicaid enrollees in several states.

The demonstration and evaluation findings reveal lessons of potential value to other states contemplating the development of similar provider-centered organizations as part of their Medicaid programs. Indeed, the MCO Qualification Guidelines and the Program Standards promulgated by New York in the implementation of that state's Section 1115 Waiver program reflect some understanding of these lessons (New York State Department of Health 2004, 2007). Michigan has also taken steps to create provider networks

(Michigan Medicaid Long-Term Care Task Force 2004). These provider networks focus on services to elders, and the federal government describes them as a "Promising Practice" (Schaeffer, Justice, and Horvath 2004). Clearly, Florida learned the importance of scrupulous attention to the fairness (and demonstrable appearance of fairness) in all bidding and communication processes. Similarly, states must consider carefully the relative value of flexibility and negotiation. Too much room for ongoing and sometimes informal discussion can have the effect of paralyzing a process. It may also lead participants to perceive that other organizations are obtaining advantage. Clarity and consistency in terms (including formally stated definitions of key words and phrases) are essential. And all participants should assume that all processes involving multiple public and private organizations will take longer—much longer—than expected.

### *Implications and Consequences for State Policy*

The PSN experience and the findings from the evaluation had a significant impact on subsequent state health policy in Florida. The state's highly publicized current initiative in Medicaid Reform can be traced to early 2004 when leadership in then Governor Jeb Bush's office and AHCA began to consider options for addressing numerous issues in the state's Medicaid program (Duncan et al. 2006). From the outset, these discussions were grounded in the kind of conversation noted above, that is, ideas had to be consistent with the political and philosophic preferences of a relatively conservative, Republican administration; there was great interest in budget implications and a perceived need to save money, but not if the only means to do so involved draconian sacrifices in the provision of needed care; and there was strong belief that the desired outcome could be accomplished if the Medicaid program could be reformed in a manner that would reduce the role of government, inject the competitive forces and consumer preferences of the private market, and achieve a more manageable level of state oversight.

Specifically, the state sought to reform its Medicaid program in a manner that reflected four principles: patient responsibility and empowerment, marketplace decisions, bridging public and private coverage, and a sustainable growth rate in the program's budget (Florida Agency for Health Care Administration 2005). The key means to pursuing reform consistent with these principles became the creation of an environment in which managed care organizations would establish various programs and compete for the opportunity to serve Medicaid enrollees. The MCOs could not offer programs

with a benefit mix that was in any meaningful way below current Medicaid coverage, but they would have flexibility in care management and could offer "extra" benefits that might be attractive to prospective enrollees. MCOs would be paid on the basis of risk-adjusted premium rates, such that those plans accepting sicker patients or enrollees with more severe health circumstances would be paid at higher rates. MCOs would be monitored by AHCA and held responsible for the care received by "their" enrollees. By virtue of this latter element, it was expected that AHCA would be contracting with, and hence establishing oversight for, a small number of organizational entities, at most a few dozen. This would represent a radical departure from the current model in which Florida Medicaid offers more than 47 different service types in its benefit package through 91 separate contract organizations and almost 70,000 participating providers, all operating within the requirements of 20 different federal waivers (Bush 2005).

It was understood that while adapting to this new model would require existing Medicaid HMOs to significantly modify their current procedures, such organizations were well positioned to become participating health plans in the Medicaid Reform demonstration. There was substantial concern, however, expressed by numerous advocacy groups, some legislators, and other participants in the process about a reform model that would have the effect of making Florida Medicaid an "HMO-only" program. Furthermore, AHCA retained a commitment to work with and support the safety net hospitals that had for several decades been the core providers of service to Medicaid patients. Opportunities for provider-based organizations, including physician networks, perhaps rural health networks, PSOs, PSNs, or other entities to participate in Medicaid Reform were encouraged and supported throughout the complex discussions, legislation, waiver application, and program design and implementation steps that culminated in the implementation of Florida's Medicaid Reform demonstration. PSNs were noted in the statute, and in the state's implementation plan. Without this encouragement and the provision of a legal process to include the PSN option there is no reason to believe that provider-based managed care organizations would emerge and "come to the table" as part of Medicaid Reform in Florida.

The previous experiences of the SFCCN, and the evaluation research regarding that organization's creation and operation provided a critical means to ensure at the least one organizational mechanism whereby non-HMO entities could participate in the reform demonstration and thus obviate the concerns of those who opposed any reform that would have the effect of moving all Medicaid enrollees into HMOs. As of the July 1, 2006 start date, 12

organizations (nine HMOs and three PSNs) had contracted with AHCA to serve as managed care organizations in the reform demonstration. Since that time, at least one additional PSN has been formally created and is participating. Others are in various stages of consideration and development. Thus Florida's experiment in Medicaid PSNs continues to evolve.

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