

**2010 Cost-Effectiveness Audit Report
December 31, 2010**

Minority Physician and Provider Service Networks

Time Periods	Member Months	Description	Amount
Sep 2008 - February 2009	1,845,787	Net Program Cost	\$484,182,079.64
		HMO Payment Amount*	\$487,257,172.66
		Difference	\$3,075,093.02

* As required under s. 409.91211, F.S., the HMO payment is fully risk-adjusted in the 2008-09 reconciliation period. In the rest of the state and for the Minority Provider Networks, the HMO payment is not fully risk-adjusted.

Note: Net Program Cost includes PMPM costs (either capitated or fee for service), administrative fees (if not recovered through the reconciliation process), case management fees, and shared savings distributions.

Attachment A = Summary of 2010 Cost-Effectiveness Reporting

Attachment B = Managed Care Plan Contracts Subject to s. 409.912(44), F.S.

Summary of 2010 Cost-Effectiveness Reporting

Section 409.912(44), Florida Statutes, requires the Agency for Health Care Administration (Agency) to annually post the cost-effectiveness results of entities identified as managed care plans in section 409.9122, F.S. Entities identified as managed care plans include minority physician networks, the pediatric emergency room diversion projects, exclusive provider organizations, and provider service networks. Section 409.912(44), F.S., stipulates that contracts with the specified managed care plans as defined in s. 409.9122(2)(f), F.S., which are not cost effective, may not be renewed.

Each year the analysis of cost effectiveness is completed after a specified amount of time has passed after the end of the time period being reviewed. This allows for claims submission for dates of service in the time period being reviewed. It also provides the entity being reviewed an opportunity to review the claims data and Medicaid recipients included in the specified time period. The 2010 Cost-Effectiveness Report (report) provides the audit results for the reconciliation periods finalized after the December 31, 2009 legislative report. This spans the time period September 1, 2008, through August 31, 2009.

The report compares the net program costs for the MPN and PSN programs to the HMO capitation payment rate. The net program costs include the per-member per-month costs incurred by the state for contracted services (both capitated and fee-for-services), administrative fees not recovered through the annual reconciliation, and shared savings distributions.

Attachment B lists the ten managed care plan contracts subject to cost-effectiveness reporting. Five managed care plan contracts have reportable results for the September 1, 2008 through August 31, 2009 time period as indicated on the report. Five managed care plan contracts are not reported as their contract ended prior to the end of the reconciliation period, their contract ended and their reconciliation was handled through cost settlement, or their contract began after the reconciliation period being reported began.

The results do not affect renewal of current contracts this year. Currently, there are no active minority physician network contracts.

The Agency is posting these results to comply with the annual statutory posting requirement.

The following provides a brief summary of terms used in the report.

Member Months	The total number of months in which members included in the reconciliation period were enrolled in the managed care plans being reported.
Net Program Cost	<p>Costs consist of:</p> <ul style="list-style-type: none"> • Fee-for-service medical claims costs for contract services provided to enrollees for which the managed care plans are responsible, • Administrative costs paid to the managed care plans, • Primary care case-management fees paid to the managed care plans, and • Shared savings distributions or repayments. • Credits are given for pharmacy rebates realized in the fee-for-service plans
HMO Payment Amount	<p>The HMO Payment Amount is the discounted capitation rate. The capitation rate analysis includes:</p> <ul style="list-style-type: none"> • The case mix adjustments upon which the HMO capitation rates are based (age, gender, eligibility and geographic area). • Whether the plans are subject to Medicaid Reform requirements. Section 409.91211(8), F.S., provides slightly different capitation rate development for Reform managed care plans. For Reform populations beginning September 1, 2008, the capitation rates are fully risk-adjusted.
Difference	The Net Program Cost minus the HMO Payment Amount

Attachment B

**Managed Care Plan Contracts
Subject to Section 409.912(44), Florida Statutes**

Plan Type		Entity Name	Reconciliation Period Reported		Contract Active
1.	Minority Physician Network	Florida NetPASS	N/A*		No
2.	Minority Physician Network	Access Health Solutions LLC	9/1/08 – 2/28/09 3/1/09 – 8/31/09		No
3.	Pediatric Emergency Room Diversion Project	Pediatric Associates Care Plus	N/A*		No
4.	Provider Service Network	South Florida Community Care Network	Non-Reform	9/01/08 – 8/31/09	Yes
			Reform	9/01/08 – 8/31/09	
5.	Provider Service Network	Shands Jacksonville dba First Coast Advantage	Reform	9/01/08 – 8/31/09	Yes
6.	Specialty Plan for Children with Chronic Conditions	Florida Department of Health Children's Medical Services	Reform	9/01/08 – 8/31/09	Yes
7.	Provider Service Network	Access Health Solutions LLC	Reform	9/01/08 – 8/31/09	No
8.	Provider Service Network	Florida NetPASS LLC	N/A*		No
9.	Provider Service Network	Pediatric Associates LLC	N/A*		No
10.	Provider Service Network	Better Health, LLC	N/A**		Yes

* Plan ceased operations; entered into a purchase agreement

** Plan began operations after the beginning of the reconciliation period; a full reconciliation period is not available for this report