# *Florida's Medicaid Reform*

## *Health Plan Workshop*

### *Baker, Clay, and Nassau Counties*

### *November 1, 2006*

### *9:00 am – 12:00 noon*

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# *Introductions*

***Lisa Broward***

***Field Office Manager***

***Medicaid Area 4***

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# Rate Setting


## Dyke Snipes

## Assistant Deputy Secretary for Medicaid


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# *Comprehensive and Catastrophic Components of Financing*

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# State Reinsurance Component
## (Catastrophic Component of Premium)

- *A single set of benefits:*
  - *Beneficiaries see their chosen set of benefits.*
  - *Transition between Comprehensive and Catastrophic component is transparent to the beneficiary.*
  - *Continuous coverage of benefits.*
- *All Plans must provide all Services.*
- *Comprehensive Component covers the cost of most services for most Medicaid beneficiaries:*
  - *Plan is financially responsible up to a set threshold.*
  - *The threshold for 2006 was $50,000 PMPY.*
  - *Represents approximately 90% of total premium in aggregate.*

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# State Reinsurance Component (Catastrophic Component of Premium) (continued)

- *Comprehensive risk is always borne by the health plan; catastrophic risk may be borne by the plan or the state:*
  - *All care continues to be managed by the health plans.*
  - *Whether a plan accepts catastrophic risk is transparent to the beneficiary.*
- *Catastrophic Component represents the cost of the limited number of Medicaid beneficiaries who have significant medical needs in any particular year:*
  - *Takes effect after threshold is reached. (currently $50,000 PMPY)*
  - *Comprises approximately 10% of total premium in aggregate.*

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# State Reinsurance Component
## (Catastrophic Component of Premium)
### (continued)

- *Once the threshold is met for an enrollee, AHCA provides catastrophic 're-insurance' by paying individual claims fee for service for that enrollee through the remainder of the contract year.*
- *Claims are paid directly to the health plan.*
- *Claims are paid at 95% of the Medicaid rate.*
- *The health plan will continue to receive a capitation payment for that enrollee.*

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# Why Introduce the Catastrophic Component?

- *To encourage new managed care entities to enter the market:*
  - *All PSNs and HMOs in areas where there are no HMOs currently operating may limit their financial risk by electing to take financial responsibility only for the Comprehensive component.*
    - *If so, they get less premium, and the state acts as reinsurer for the Catastrophic component.*
- *To encourage managed care entities to participate in rural and medically underserved areas.*

# Reform Rates

- *Medicaid Reform Rates for the Comprehensive component will be made available by February 1, 2007.*
  - *The comprehensive only rates will be based on current year reform rates but can be used by plans for modeling and budgeting purposes.*
- *Medicaid Reform Rates for the current year of September 2006 through August 2007 can be obtained from the Medicaid reform website at:*

***http://ahca.myflorida.com/Medicaid/medicaid_reform/provider/index.shtml***

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# Premium Based

- *OLD: Premiums were based on Fee-For-Service data for the entire population subject to managed care. Standard adjustments were made across the board with slight variation depending on the area of the state.*
- *NEW: Premiums are based on Fee-For-Service data and encounter data for the target population.*
  - *Premiums are established on an annual basis and effective from September – August of each year.*

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# *Premium Based (continued)*

- *Specific changes:*
  - *Encounter data will become a major component of the premium calculation.*
  - *Kick payments:*
    - *Separate payments will be made on behalf of the beneficiary for labor and delivery cost and transplant services. These costs are no longer included in the calculation of the premium.*
    - *Kick payments for these services allow the agency to more appropriately reimburse the plan for services provided to these beneficiaries.*
  - *HIV/AIDS:*
    - *Premiums for beneficiaries that meet the Agency definition of an HIV/AIDS beneficiary will be based on a methodology using HIV/AIDS historical data only.*

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# *Premium Based (continued)*

- *Changes to the premium calculation along with the risk adjustment process allow for more accurate allocation of funds.*
- *Plans that are paid fee-for-service will be monitored against the capitated premium as a benchmark.*
- *The use of encounter data and full risk adjustment for premium calculation will be phased in over the next two to three years.*
- *This transition will allow the state to more appropriately allocate funding to the plans.*

# Transplant Kick Payments
# Duval county

## Effective September 1, 2006 – August 31, 2007

| CPT Code | Transplant CPT Code Description | Children/Adolescents or Adult | Payment Amount |
|---|---|---|---|
| 32851 | lung single, without bypass | Children/Adolescents | $320,800.00 |
| 32851 | lung single, without bypass | Adult | $238,000.00 |
| 32852 | lung single, with bypass | Children/Adolescents | $320,800.00 |
| 32852 | lung single, with bypass | Adult | $238,000.00 |
| 32853 | lung double, without bypass | Children/Adolescents | $320,800.00 |
| 32853 | lung double, without bypass | Adult | $238,000.00 |
| 32854 | lung double, with bypass | Children/Adolescents | $320,800.00 |
| 32854 | lung double, with bypass | Adult | $238,000.00 |
| 33945 | heart transplant with or without recipient cardiectomy | Children/Adolescents | $162,000.00 |
| 33945 | heart transplant with or without recipient cardiectomy | Adult | $162,000.00 |
| 47135 | liver, allotransplation, orthotopic, partial or whole from cadaver or living donor | Children/Adolescents | $122,600.00 |
| 47135 | liver, allotransplation, orthotopic, partial or whole from cadaver or living donor | Adult | $122,600.00 |
| 47136 | liver, heterotopic, partial or whole from cadaver or living donor any age | Children/Adolescents | $122,600.00 |
| 47136 | liver, heterotopic, partial or whole from cadaver or living donor any age | Adult | $122,600.00 |

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# Labor and Delivery Kick Payments
# Duval county

## Effective September 1, 2006 – August 31, 2007

| CPT Code | Obstetrical Delivery CPT Code Description | Payment Amount |
|---|---|---|
| 59409 | Vaginal delivery only | $4,097.62 |
| 59410 | Vaginal delivery including postpartum care | |
| 59515 | Cesarean delivery including postpartum care | |
| 59612 | Vaginal delivery only, after previous cesarean delivery | |
| 59614 | Vaginal delivery only, after previous cesarean delivery including postpartum care | |
| 59622 | Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery including postpartum care | |

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# *HIV/AIDS Rates*
# *Duval county*

## *Effective September 1, 2006 – August 31, 2007*

| HIV / AIDS | Capitation Rate |
|---|---|
| HIV (no Medicare) | $953.48 |
| AIDS (no Medicare) | $2,136.97 |
| HIV - SSI /Parts A & B, SSI Part B only | $179.89 |
| AIDS - SSI /Parts A & B, SSI Part B only | $252.22 |

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# *Risk-Adjusted Premium*


***Karen Chang***

***AHC Administrator***


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# *Risk-Adjustment*

- *Effective September 1, 2006, the Agency will risk adjust plan premiums in accordance with FL Statute.*
- *Initially the Agency will use the Medicaid Rx model to risk adjust rates.*
- *The Agency will move to the Chronic Illness and Disability Payment System (CDPS), a diagnostic based risk adjustment model.*

# *Reasons to Risk Adjust*

- *Risk Adjusted Rates:*
  - *A process to predict health care expenses based on chronic diagnoses.*
  - *Distributes capitation payments across health plans based on the health risk of the members enrolled in each health plan.*
  - *Captures adverse selection without using experience rating (health status, not health use).*
  - *Rate allocation, not rate setting.*
- *Risk Adjustment Process:*
  - *Better matches payment to risk.*
  - *Pay for the risk enrolled.*

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# How Florida is Doing Risk Adjustment

- *Rx Encounter Data Collection and Rx Risk Model:*
  - *Collecting Rx encounter data quarterly from all Health Plans statewide.*
  - *Validating Rx encounter data.*
  - *Processing Rx encounters and FFS claims through a pharmacy based risk adjustment model (Medicaid Rx).*
  - *The Medicaid Rx model and risk process calculates risk scores for individual plan enrollees.*
  - *Monthly risk adjusted premiums are generated based on individuals enrolled in Reform Plans.*
  - *Individual risk scores are updated quarterly using new pharmaceutical information received quarterly from FFS claims and encounters.*

# *Medicaid Rx*

- *Certain conditions (AIDS, asthma, diabetes, etc.) use particular pharmaceuticals and have a strong link to future health care costs.*
- *Statistical models correlate historical diagnoses/ pharmaceutical utilization to likelihood of future health care cost.*
- *Individuals assigned a "risk score."*
- *Individual risk scores generate premium, based on beneficiary's predicted needs.*

# *Medicaid Rx*
## *(continued)*

- *Health plans credited with risk score/premium of each individual enrolled.*
- *Collective risk scores/premiums of members generate health plan revenues/capitation tied to expected health costs.*

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# *Florida's Guiding Principles*

- *Maintains Budget Neutrality – aggregate costs will not increase.*
- *Risk Adjustment used to increase/decrease health plan capitation based on health status of enrolled population.*
- *Risk Adjustment methodology is subject to HB-3B provisions of risk corridor and phase-in.*

# Risk Adjusted Rates Illustration

| | Plan A | Plan B | Plan C | Total |
|---|---|---|---|---|
| Before Risk Adjustment | $1,000,000 | $1,000,000 | $1,000,000 | $3,000,000 |
| RAR Factor | 1.04 | .95 | 1.01 | 1.00 |
| After Risk Adjustment | $1,040,000 | $950,000 | $1,010,000 | $3,000,000 |

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# Health Plan Risk Adjusted Factor

| Plan A | Risk Adjustment Methodology | |
|---|---|---|
| Member | Risk Adj. Factor | Risk Adj. Rate |
| Jo Smith | 3.30 | $330.00 |
| Betty Jones | .43 | $43.00 |
| Doug Brown | .66 | $66.00 |
| Charlie Williams | .37 | $37.00 |
| Brad Wilson | .45 | $45.00 |
| **Total** | **1.04** | **$104.00** |

- ***All Amounts are Rounded.***
- ***Base Premium of $100 assumed.***

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# *Individual Risk Score Development*

| Plan A | | Risk Adjustment Methodology | |
|---|---|---|---|
| **Member** | **Characteristics** | **Risk Model Weights** | **Risk Adj. Factor** |
| ***Jo Smith*** | *Female, age 25 to 44* | *0.5* | *3.30 (sum of weights)* |
| | *Hypertension* | *0.4* | |
| | *Diabetes* | *2.4* | |

# *Those Affected by Risk Adjustment*

- *Every Medicaid person enrolled at least 6 months in Medicaid will receive a risk score.*
- *Risk adjusted premiums will only be produced for Health Plans in reform counties (subject to HB-3B provisions).*
- *Risk adjusted premiums will be specific to reform defined Medicaid Eligibility Groups (MEGS).*
- *Certain populations with special medical needs will not be part of the risk adjustment process as there will be a separate rate developed for them.*

# Application to Risk Adjusted Rates

- *Health Plan risk factor applied to the composite base capitation payment for the MEG and region.*
- *For Health Plans serving non-specialty populations, HB-3B calls for a 10% corridor for first 2 years, and a phase-in of risk adjusted rates.*
  - *Year 1: 25% risk adjusted; 75% 'current methodology'.*
  - *Year 2: 50% risk adjusted; 50% 'current methodology'.*
  - *Thereafter: 100% risk adjusted.*
- *'Current methodology' refers to the traditionally used capitation rate process using age and gender bands.*
- *PSNs may elect FFS payment with annual reconciliation using risk adjusted baseline.*

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# Risk Adjustment Phase-in

- *Assume a $100 PMPM Aggregate Plan rate and an Aggregate Plan risk factor of 1.04.*

| Plan A | | | | | |
|---|---|---|---|---|---|
| **Phase-In Period** | **Age / Sex %** | **Risk Adj. %** | **Age / Sex Rate** | **Risk Adj. Rate** | **Combined Rate** |
| Year 1 | 75% | 25% | $75.00 | $26.00 | $101.00 |
| Year 2 | 50% | 50% | $50.00 | $52.00 | $102.00 |
| Year 3 | 0 | 100% | $0.00 | $104.00 | $104.00 |

# Florida Medicaid Reform

## Customized Benefit Packages, Data Book & Plan Evaluation Tool Demonstration


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# Customized Benefit Packages
## Target Populations

*Target populations will be:*

- *Children and Families.*
- *Aged and Disabled.*
- *Specialty Populations:*
  - *Children with Chronic Conditions.*
  - *HIV / AIDS Patients (Capitated Plans).*

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# Customized Benefit Packages
## Plan Proposals

- *Health plans or capitated PSNs will propose one benefit package for each target population they want to serve.*
- *The health plans and PSNs can choose to offer Reform plans to any or all target populations.*
- *The base premium will be based on State Plan services.*
  - *Customized plans must be actuarially equivalent.*

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# Customized Benefit Packages
## Plan Design Guidelines

- *Levels of amount, scope and duration are flexible.*
  - *Certain services must be provided at least to current State Plan coverage levels.*
  - *Other services must be provided at least to meet benefit sufficiency standards.*
  - *Remaining services must be offered, but amount, scope and duration are flexible.*
- *Reform plans can enhance any service above current State Plan levels.*
- *Reform plans can add services not currently covered under the State Plan.*

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# Customized Benefit Packages
## Plan Design Guidelines (continued)

- Some services are required at least to current State Plan limits:
  - Emergency care.
  - Maternity care and other services to pregnant women.
  - EPSDT and other services to children.
  - Hospital inpatient care.
  - Non-emergent transportation.
  - Outpatient mental health services.
  - Physician and physician extender services.
  - Hemophilia drugs, chemotherapy and dialysis.
  - Motorized wheelchairs and high cost prosthetics.

# Customized Benefit Packages
## Plan Design Guidelines (continued)

- *Some services are required and tested for benefit sufficiency:*
  - *Hospital outpatient services.*
  - *Durable medical equipment.*
  - *Home health care.*
  - *Prescription drugs.*

# Customized Benefit Packages
## Plan Design Guidelines (continued)

- *Some services are required to be offered, but amount, scope and duration are flexible:*
  - *Chiropractic care.*
  - *Adult dental services.*
  - *Adult vision services.*
  - *Adult hearing services.*
  - *Physical and respiratory therapy.*
  - *Podiatrist care.*

- *Standards will be reviewed and may be updated annually.*

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# Customized Benefit Packages
## Plan Proposals

- *AHCA will provide a standardized benefit template that plans can use to convey proposed benefit packages.*
  - *Standardized benefit form and benefit definitions enhance comparability among plans.*
  - *Template designed to facilitate comparison of Reform benefit packages to employer-sponsored plans.*
  - *Completed benefit form, once approved by AHCA, will form the basis of the contractual agreement between AHCA and plans on the benefit package.*

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# Customized Benefit Packages
## Plan Proposals (continued)

- *Additional benefits proposed must be supported with PMPM projection and supporting documentation.*
- *The Agency will evaluate the thresholds on an annual bases and may revise them as appropriate.*

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# Customized Benefit Packages
## Plan Review and Approval

- *Two components of AHCA benefit plan approval:*
  - *Actuarial equivalence:*
    - *How does the value of proposed benefits compare to historical Medicaid for the average member of the population?*
    - *Ensures that overall level of benefits is appropriate.*
  - *Sufficient to meet medical needs:*
    - *Are key medical services provided at sufficient levels?*
    - *Must cover medical service needs of all children and most adults in the population.*

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# Customized Benefit Packages
## Plan Review – Actuarial Equivalence

- *Data-driven; relies on detailed claims data that illustrates medical services used by the target population.*
- *Evaluates the benefits covered, limits and cost sharing in the proposed plan, given the population's historical utilization pattern.*
- *Source data will be trended to the contract period, but will not be adjusted for managed care effects.*
- *Uses the Medicaid Fee for Service (FFS) reimbursement structure as the common financial scale to weigh the value of State Plan services versus the proposed benefits.*

# Customized Benefit Packages
## Plan Review – Benefit Sufficiency

- *AHCA developed a pre-set standard for each service subject to sufficiency testing.*
  - *Example: "must meet the needs of 98.5% of adults in the target population."*
- *Standards will be reviewed and may be updated annually.*
- *Standards for first year are 98.5% for all four tested services, for all three populations, except for Children and Families Home Health services, which is 99.85%.*
- *The Agency will evaluate the thresholds on an annual basis and may revise them as appropriate.*

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# Customized Benefit Packages

## Plan Proposals (continued)

| BENEFITS | You Pay* | Plan Limit |
|---|---|---|
| Hospital Inpatient / Behavioral Health | $3 / admit | 45 days combined^ |
| Hospital Inpatient / Physical Health | $0 | |
| Transplant Services | | No limit^ |
| Hospital Outpatient / Surgery | | |
| Lab / X-ray | | |
| Hospital Outpatient Services (non-emergency) | | $200 / yr |
| Outpatient Therapy (physical / respiratory) | | $100 / yr |
| Emergency Room | | No limit^ |
| Ambulatory Surgery | | |
| Dialysis Services | | |
| Chemotherapy Services | | |
| Primary Care Physician / ARNP/PA | | 1 visit / day |
| Specialty Physician | | |
| Clinic (FQHC, RHC) | | |
| Maternity / Family Planning Services | | No limit^ |
| Home Health Services | | 15 visits / yr |
| Chiropractor | $1 / visit | 24 visits / yr |
| Podiatrist | $2 / visit | 12 visits / yr |
| Dental Services | $0 | dentures / emergency |
| Vision Services | | 2 pair glasses^ |
| Hearing Services | | 1 device / 1 evaluation per 3 yrs |
| Outpatient / Mental Health | $2 / visit | **SAME |
| Outpatient / Pharmacy*** | $0 | $5,400 / yr |
| Non-emergency Transportation | | No limit^ |
| Ambulance | | |
| Durable Medical Equipment**** | | $100 / yr |
| EXTRA SERVICES<br>Contact the plan for more details | Over the Counter Pharmacy - $25 per household per month<br>Adult Dental - Exams / Cleanings / Fillings / Extractions / X-rays<br>Circumcision - Routine for babies under twelve weeks | |

*Example of approved benefits package for Duval (Children and Families)*

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# Data Book

- *AHCA will publish a Reform Data Book with historical utilization patterns of all four target populations.*
- *Source data.*
  - *Fee for service enrollees only, excludes:*
    - *HMO enrollees.*
    - *Institutionalized enrollees.*
    - *DCF ADM Residential Treatment enrollees.*
    - *Sub-acute Inpatient Psychiatric Program enrollees.*
    - *Behavioral Health Overlay Services enrollees.*
    - *HomeSafeNet enrollees.*
  - *Includes services provided between July 1, 2004 – June 30, 2006.*
  - *Excludes services provided during retro eligibility periods.*

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# Data Book
## (continued)

- *Example tables from Data Book:*
  - *Summary tables.*
  - *Continuance tables.*
  - *Claims probability tables.*

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# Benefit Plan Evaluation Tool

- *Contains base historic data for each Medicaid group, updated annually.*
- *Online version for plans to test potential designs.*
- *User input:*
  - *Plan identifying information.*
  - *Target region(s) and population(s).*
  - *Benefit design:*
    - *Service-specific coverage, including limits and cost-sharing.*
    - *Additional benefits offered.*

# *Benefit Plan Evaluation Tool (continued)*

- *Model calculation, performed for each target Medicaid group.*
  - *Uses data about historic medical service use, trended to program year.*
  - *Uses current Medicaid FFS reimbursement structure.*
  - *Evaluates the benefits covered, limits, and cost sharing in the proposed plan.*
  - *Calculates the proposed plan's expected claim cost.*
  - *Compares the proposed plan's expected claim cost to historic baseline.*

# *Benefit Plan Evaluation Tool (continued)*

- *Report of Results:*
  - *Model will provide output showing the results of the design on both tests, and detail of services that failed, if applicable.*
  - *User can download an Excel file that contains a completed benefit design form for electronic submission with the Reform application.*

# Benefit Plan Evaluation Tool
## Demo

- *Demo today of the online evaluation tool plans can use to test their Reform benefit packages before submission to AHCA.*
- *Evaluation results viewable online, and Excel workbook will be produced for download.*
  - *Downloadable workbook produces completed benefit grid and results.*
  - *Plan can submit the workbook electronically to AHCA with its Reform application.*

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# Fee for Service Provider Service Network Reconciliation


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# Cost Effectiveness

- *Existing Statute:*
  - *Pursuant to s. 409.912 (44), F.S., the Agency shall ensure that any Medicaid Managed Care plan, as defined in s. 409.9122(2), F.S., whether paid on a capitated basis or a shared savings basis, is cost-effective.*
  - *Managed Care plans include HMOs, EPOs, MPNs, CMS and Pediatric ER Diversion Programs.*
- *Under Reform:*
  - *Under Reform this applies to Provider Service Networks (PSN) that elect a shared savings methodology.*

# *Cost Effectiveness (continued)*

- Contracts which are not cost-effective may not be renewed.
- Cost effectiveness is defined as costs, including claims costs and administrative costs, that do not exceed payments that would have been made to HMOs.

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# Per Capita Capitation Benchmark (PCCB)

- *The Agency shall establish a per capita capitation benchmark (PCCB) for each Service Area in which the PSN provides services and for those services the PSN provides (including Primary Care Case Management fees).*
- *The PCCB is an Agency-established per member per month (PMPM) cost and, considered to be the capitation rate that the Agency would have paid the PSN if the PSN had been capitated.*
- *PSNs may choose capitation for transportation in which case it will not be a covered service in the PCCB.*

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# Per Capita Capitation Benchmark (PCCB) (continued)

- *Pursuant to s. 409.91211, F.S., the development of the PCCB is consistent with Medicaid Reform HMO capitation methodology and includes risk adjustment phased in at 75% of the current rate and 25% of the new rate, in the first year.*
- *Beginning September 1, 2007, the risk adjusted portion of the PCCB will be 50%.*

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# Capitation Methodology

- *The capitation rate will be partially risk adjusted.*
  - *Year 1 25% risk adjusted: 75% current methodology.*
  - *Year 2 50% risk adjusted: 50% current methodology.*
- *A 10% risk corridor will apply to non-specialty TANF/SSI plan rates for the first 2 years.*
- *The rate for risk adjustment will be specific to Medicaid Eligibility Groups (MEGS).*
- *An adjustment to the rates will be made to balance the impact of the risk corridor.*

# Fee for Service Claims Payment

- *Claims for covered services will be submitted through the PSN to the Medicaid fiscal agent.*
- *The PSN will either need to be licensed as a third party administrator (TPA) or contract with a TPA for claims review purposes.*
- *A $3 per enrollee per month primary care case management fee will be paid directly to the PSN.*

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# Administrative Allocation

- *A per member per month amount for each person enrolled in the PSN will be paid to the PSN for administrative activities.*
- *The PSN is at risk for a maximum of 50% of the administrative allocation.*
- *The administrative allocation will be calculated at a maximum of 7.5% of aggregate PCCB.*
- *An adjustment will be made during the reconciliation to account for the risk adjusted aggregate PCCB.*
- *The Agency may provide an advance of the administrative allocation not to exceed $300,000.*
  - *Advance to be repaid over the life of the contract.*

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# Cost Reconciliation Process

- *The Agency shall conduct a financial reconciliation process to determine PSN program savings and refunds due, if any.*
- *The Agency will compare actual Medicaid payments for PSN-covered services, paid for by the Agency on behalf of PSN enrollees, to the aggregate PCCB for the time period being reconciled.*
- *The reconciliation process will occur on a periodic basis, culminating with a final reconciliation for each reconciliation period.*

# *Cost Reconciliation Process*
## *(continued)*

| Dates of Service 09/07 – 08/10 | Initial Reconciliation | Annual Reconciliation |
|---|---|---|
| 09/07 - 02/08 | 09/08 | |
| 03/08 - 08/08 | 03/09 | 09/09 |
| 09/08 - 02/09 | 09/09 | |
| 03/09 - 08/09 | 03/10 | 09/10 |
| 09/09 – 02/10 | 09/10 | |
| 03/10 – 08/10 | 03/11 | 09/11 |

# Cost Reconciliation Process
## (continued)

- *If the actual Medicaid costs for PSN-covered services are less than the aggregate PCCB, then cost-savings have occurred.*
  - *Savings greater than the amount of the administrative allocation will be distributed to the PSN.*
  - *If savings do not cover the amount of the administrative allocation, the PSN will refund up to 50% of the administrative allocation.*

# Cost Reconciliation Process
## (continued)

- *If the actual Medicaid costs for PSN-covered services provided to the PSN's Enrollees are greater than the aggregate PCCB, then cost savings have not occurred.*
  - *PSN will be required to refund up to 50% of the administrative allocation it received.*
  - *The program is not cost effective and will not be renewed.*

# Cost Reconciliation Process Examples

| | Savings | Administrative Advance | Distributed to Plan | Refunded to AHCA |
|---|---|---|---|---|
| **Example 1** | $150 | $50 | $100 | $0 |
| **Example 2** | $0 | $50 | $0 | $25 |
| **Example 3** | $35 | $50 | $0 | $15 |
| **Example 4** | $25 | $50 | $0 | $25 |
| **Example 5** | $15 | $50 | $0 | $25 |

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# Cost Reconciliation Process
## (continued)

- *This method of reconciliation will provide a reasonable proxy for performance in a capitated environment.*
- *The Fee for Service PSN will transition to a full risk contract by the beginning of Year 4.*

# *Florida's Medicaid Reform*

## *Questions and Answers*

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