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State of Florida

Florida Medicaid Capitation Rate Review

Product A

Contents

Section 1

Executive Summary

Purpose and Scope of Review

Pursuant to Contract No. OP2502 (Contract), the Florida Legislature, through the Office of Program Policy Analysis and Government Accountability, engaged Mercer Health & Benefits LLC (Mercer) to conduct an independent actuarial review of Florida's Medicaid managed care capitation rate-setting process.

This independent actuarial review consists of three separate deliverables:

- The first, "Product A," is this document and is described in more detail below.
- The second, "Product B," will examine how Florida's approach to Medicaid managed care capitation rate-setting aligns with those of large and diverse peer states, particularly as it applies in the context of mid-year rate changes.
- The final deliverable, "Product C," will provide an in-depth analysis of the Florida Medicaid managed care capitation rate-setting process to provide clear and independent professional actuarial opinions on the appropriateness, reasonableness, accuracy, and completeness of the rate-setting work.

In this document (Product A), Mercer reviews managed care capitation rate-setting process for a subset of Florida's Medicaid managed care programs occurring during rate years (RYs) 2020/2021 through 2024/2025. This review encompasses:

- The development and certification of prospective capitation rates
- The methodologies, assumptions, and data sources used in each annual rate cycle
- The documentation and governance of actuarial decision-making
- The rating period in which a mid-year capitation rate adjustment was implemented

While one focus of legislative inquiry involved the mid-year rate adjustment implemented during the review period, this review is broader in scope. It evaluates the full rate-setting framework across multiple RYs to determine:

1. Whether the processes used to develop annual capitation rates were consistent across rating periods
2. Whether deviations from established methodologies were adequately supported and documented

3. Whether the timing and rationale for any in-period (mid-year) adjustments were consistent with federal Medicaid managed care requirements
4. Whether the overall rate-setting framework reflects transparency, actuarial rigor, and compliance with applicable standards

This report does not re-develop or re-certify capitation rates. Product A does not quantify financial impact. Rather, it evaluates the integrity, consistency, and regulatory alignment of the rate-setting process during RYs 2020/2021 through 2024/2025.

Limitations and Disclosures

This document, designated as Product A, was prepared for The Florida Legislature and presents Mercer's review of the managed care capitation rate-setting process applied to the specified Florida Medicaid managed care programs for RYs 2021/2022 through 2024/2025. The preparation of Product A by Mercer for The Florida Legislature was conducted in compliance with the contractual obligations, and its content may not be appropriate for alternative uses.

This report has been prepared under the direction of Rachel Butler, ASA, MAAA, Katharina Katterman, ASA, MAAA, and Rob O'Brien, ASA, MAAA, who are members of the American Academy of Actuaries and meets its US Qualification Standard for issuing the statements of actuarial opinion herein. To the best of Mercer's knowledge, there are no conflicts of interest in performing this work.

Product A does not constitute a legal or professional opinion. Mercer disclaims any representations or warranties regarding the content of this document to any third parties. The information contained within Product A or its appendices does not establish any duty or liability between Mercer, Marsh, affiliated Marsh entities, or their employees and third parties. Neither Mercer, Marsh, affiliated Marsh entities, nor their employees bear responsibility for any actions taken by third parties based on the contents of Product A or its appendices.

This review is founded upon documentation, models, and data supplied by the Agency for Health Care Administration (AHCA), its contracted actuarial firm Milliman, Inc. (Milliman), and other involved parties. Mercer has:

- Not independently audited raw encounter-level or claims-level data beyond what was necessary to assess the actuarial methodology;
- Not reconstructed complete alternative rate certifications;
- Not issued a new actuarial soundness certification; and
- Not provided legal or audit conclusions regarding statutory compliance or actuarial soundness.

The findings herein represent professional actuarial judgment based on the information available at the time of the review. Should additional documentation or data be made available, conclusions may need to be revisited. Any gaps in documentation or concerns regarding

methodology are identified as potential vulnerabilities. The identification of a potential vulnerability does not inherently indicate that the established rates are unreasonable; rather, it highlights areas meriting further actuarial analysis and quantitative evaluation under Product C.

Summary of Findings

In reviewing documentation for the various programs across multiple rate years, the rate-setting process performed by AHCA's contracted actuary appears to be generally consistent. The processes of selecting a base data period, trending costs into the future contract period, accounting for policy changes, and including provisions for non-medical expenses were similar across programs and rate years reviewed.

A key difference for the RY 2024/2025 rating period was AHCA's reprocurement of the Managed Care Organizations (MCOs), effective February 1, 2025, which coincided with changes in coverage responsibility for certain benefits within the managed care program. Most notably, Behavioral Analysis (BA) services were incorporated as a managed care covered benefit in the Managed Medical Assistance (MMA) program under the new managed care contracts resulting from the reprocurement process. Between RYs 2020/2021 and 2023/2024, relatively few preliminary observations were identified across Florida's four Medicaid managed care programs regarding actuarial soundness and best practices in the development of Medicaid managed care capitation rates. However, in RY 2024/2025, the combination of continuous coverage unwinding, MCO reprocurement, and the carve-in of BA services notably increased volatility in the Statewide Medicaid Managed Care (SMMC) rates. This confluence of events created substantially more opportunities for actuarial, documentation, or regulatory issues to arise.

Determining if these potential concerns materially impacted Florida's Medicaid budget is beyond the scope of this report. Mercer will evaluate each of the preliminary observations in Products B and C, respectively, to make such determinations.

Mid-Period Rate Adjustments

Mid-year adjustments to capitation rates may be necessary for a variety of reasons. In some instances, states have discretion over whether and how to implement an adjustment, if at all, while in others, the state is required to make mid-year rate updates to comply with federal regulations and actuarial soundness requirements. A best practice for certifying actuaries is to document the reasons for potential rate amendments within the original rate certification. Federal regulations often allow states to make rate changes of less than 1.5% in magnitude without requiring a revised certification letter be sent to the Centers for Medicare and Medicaid Services. These rate changes are communicated to the Centers for Medicare and Medicaid Services consistent with the accompanying contract amendment with the managed care organization (MCO), but no rate certification is required.

Within Florida's SMMC program, capitation rates were adjusted after the initial certification in several years. Some adjustments required updated rate certifications, while others were small enough to not require a new certification. For example, the MMA capitation rates for RY 2023/2024 were updated in December 2023, retrospective to the start of the rating year (October

2023). This update accounted for new information on provider contracting and updated member redetermination data.

For SMMC RY 2024/2025, mid-year rate adjustments were both necessary and required to meet the federal regulations and ensure actuarial soundness in the program's rates. The only way to avoid mid-year rate adjustments would have been to change the operational start date of the new contract cycle to the start of the annual rating period. Given a new set of contracts effective part way through the rating period, it was necessary for rates to be separately developed for the period covered by the prior contract and the period covered by the new contract. Federal regulations require that states issue a new rate certification to align with the new contract's start date, to ensure that the capitation rates remain actuarially sound for the contract period.

In addition, there were changes to required covered services, geographic regions, and the operating MCOs effective February 1, 2025. New services required to be covered in the contract, such as the newly carved-in BA services most certainly necessitated a revision to the capitation rates. Prior to February 1, 2025, AHCA covered and paid for these services outside of managed care and the capitation rates did not reflect these costs.

Having two separate sets of rates within RY 2024/2025 was necessary to ensure compliance with federal regulations, maintain the financial integrity of the program, and support continued access to required Medicaid benefits.

Preliminary Observations

Mercer's preliminary observations fall into three broad categories. First, several observations relate to the application of actuarial standards of practice, particularly with respect to data validation and modeling decisions in the development of capitation rates. Second, some observations reflect potential deviations from common industry practices used in Medicaid managed care rate development. Third, several observations relate to documentation in the rate-setting process. None of these observations alone indicate that the resulting capitation rates are inappropriate; however, the observations represent areas where additional validation or analysis may be warranted.

Within this section, Mercer identifies certain components of the capitation rate-setting process as "potential vulnerabilities." Potential vulnerabilities can be due to the specific circumstances of RY 2024/2025 related to the reprocurement, or they can apply to multiple rate years Mercer reviewed.

Determining whether these potential vulnerabilities materially impacted Florida's Medicaid budget is beyond the scope of this report. Additional details and analyses are needed to understand the impact. These observations are summarized below and will be evaluated further in Products B and C.

Inclusion of Behavioral Analysis Services in the Capitation Rates

Mercer identified several potential vulnerabilities related to the inclusion of BA services within the capitation rates. These concerns include the application of statewide rate cell factors in the rate

calculations, as well as the disproportionately large BA service costs reported in Region I (Miami-Dade County).

Statewide Rate Cell Factors

In developing capitation rates by rate cell, AHCA's contracted actuary classifies populations into rate groups and projects medical spend at this level. Rate groups are broader classifications of members than rate cells, which are the level for which capitation rates are paid by AHCA to the MCOs. After projecting medical costs by rate group, the contracted actuary applies statewide rate-cell factors to allocate projected costs down to the rate cell level. This process is intended to be budget neutral and has been consistently applied throughout all rate years reviewed within the MMA program.

As noted earlier, BA services became covered managed care benefits effective February 1, 2025, following the reprocurement. Consequently, these services were incorporated into rate development. Mercer's review of the documentation revealed that BA services costs per member in Region I (Miami-Dade County) were significantly higher than the rest of the state. Depending on the rate group, BA base data revealed BA costs per member in Region I were up to 20 times — or more — higher than in the lowest-cost region. This indicates substantial regional disparities in BA service costs across Florida.

For capitation rates effective after the reprocurement, AHCA's contracted actuary included BA costs within projected benefit costs at the rate group level and continued to use statewide rate cell factors to allocate costs by rate cell. Mercer's primary concern is the continued reliance on statewide rate cell factors despite the pronounced regional variation in BA costs per member.

To illustrate this area of sensitivity, Table 1 shows examples of the final capitation rates by rate cell for two regions for two separate rate cells, comparing the RY 2024/2025 rates before (pre-ITN RY 2024/2025) and after (post-ITN RY 2024/2025) the reprocurement. The application of statewide rate cell factors may have caused unexpected changes in capitation rates at the rate cell level. The rate certification documentation provided by AHCA's contracted actuary does not provide a rationale for using statewide rate cell factors in this context.

Table 1: Final Capitation Rates by Rate Cell

				Final Capitation Rates		
Pre-ITN Region	**Post-ITN Region**	**Rate Group**	**Rate Cell**	**Pre-ITN RY 2024/2025**	**Post-ITN RY 2024/2025**	**% Change**
1 and 2	A	TANF Non-SMI	0–2 months	$2,208.12	$1,874.23	-15.1%
1 and 2	A	TANF Non-SMI	55+ years	$458.72	$412.51	-10.1%
11	I	TANF Non-SMI	0–2 months	$2,509.13	$3,007.97	19.9%

				Final Capitation Rates		
Pre-ITN Region	Post-ITN Region	Rate Group	Rate Cell	Pre-ITN RY 2024/2025	Post-ITN RY 2024/2025	% Change
11	I	TANF Non-SMI	55+ years	$519.69	$651.68	25.4%

In Table 1, Regions 1 and 2 during the pre-ITN period were combined to form Region A in the post-ITN period. Consequently, the pre-ITN rates are weighted together to produce the pre-ITN rates displayed.

The rate cells shown in Table 1 are chosen for this example as these populations are not likely to be materially impacted by the inclusion of BA services, since BA services are most heavily utilized by children older than 2 months old. While the addition of BA services is not the only change reflected in the updated contracts and capitation rates for the post-ITN period, the magnitude of the changes displayed in Table 1 are unexpected for the rate cells displayed. Additional documentation or explanation from AHCA and its contracted actuary is needed to clarify the drivers behind these changes.

To further illustrate this sensitivity, we observe an impact to the non-BA services included in the capitation rates as a result of the BA service carve-in and the continued use of statewide rate cell factors. As an example, Table 2 displays a comparison of the pre-ITN RY 2024/2025 rates to the post-ITN RY 2024/2025 when BA services costs are removed for Region I for the TANF non-SMI ages 1-13 rate cell.

Table 2: Capitation Rates with Behavioral Analysis Services Removed

				Capitation Rates – BA Services Removed		
Pre-ITN Region	Post-ITN Region	Rate Group	Rate Cell	Pre-ITN RY 2024/2025	Post-ITN RY 2024/2025	% Change
11	I	TANF Non-SMI	1–13 years	$183.20	$141.51	-22.8%

It is unclear why the pre-ITN rate, which excludes BA services, decreased by 23% when compared to the post-ITN rate with BA services removed for comparison purposes.

The budget-neutral application of statewide rate cell factors limits concerns that the total RY 2024/2025 capitation funding for the MMA program will have varied materially from what was intended, however, the reliance on the same statewide rate cell factor methodology that was used in the pre-ITN RY 2024/2025 and prior rates in developing the post-ITN RY 2024/2025 rates may result in the following impacts, which require further investigation in Product C:

- Distortions in the capitation rates by region and rate cell may result in the total capitation paid for one or more of the MCOs being under- or over-funded, relative to what AHCA intended if the actual enrollment by rate cell varies significantly from projections.

- MCOs with more favorable enrollment patterns could potentially realize excess profits, while MCOs with less favorable enrollment patterns could be forced to operate at a loss. Over time, such misalignment may compromise program financial integrity of MCOs that are under-funded, possibly affecting their ability to pay claims in a timely manner and destabilizing the program.
- Capitation rate reductions for non-BA services could lead to strain in the negotiation process between MCOs and providers, particularly for value-based purchasing arrangements. If an MCO is paid a significantly lower amount for the same set of services, it creates challenges in negotiations between the MCO and its providers which may lead to high levels of dissatisfaction among certain providers.

Large Variability in Behavioral Analysis Costs across Regions

Through review of the documentation provided by AHCA for the RY 2024/2025 Post-ITN period, significant variation in BA costs per member was noted across the rating regions within the SFY 2022/2023 base data. Region I (Miami-Dade County) showed BA costs per member that were 20 times (or more) higher than costs observed in the lowest cost region, depending on the rate group.

This widely varying BA experience was used to form the rate adjustments associated with the inclusion of BA services into the managed care contracts. In the development of the capitation rates, the SFY 2022/2023 base data was used in addition to trend factors designed to project the BA cost expenditures into the RY 2024/2025 rating period. The trend factors were developed by reviewing more recent BA cost experience (from August 2023 through July 2024) and then projecting BA spend beyond this more recent time period using recently observed trends by region and rate cell.

Additionally, the BA component of the capitation rates is subject to a one-sided risk corridor, where the state will recoup funds from the MCOs if the capitation revenue paid to the MCOs significantly exceeds actual MCO BA-related expenditures.

Due to the significance of the inclusion of this service into the managed care contracts, additional follow up with AHCA and its contracted actuary is needed to review the decisions made for the inclusion of these services into the capitation rates. As part of Product C, Mercer will continue our review to investigate what steps AHCA's contracted actuary took to validate that the significant variability in expenses was reasonable and accurate. Further, it is important to better understand whether alternatives to the rate setting process for BA services were discussed by AHCA and its contracted actuary and the rationale behind decisions if alternatives were considered.

Retrospective Risk Adjustment of Only Behavioral Analysis Services For the Children's Medical Services Plan

During the post-ITN RY 2024/2025 period, documentation indicated an unanticipated shift of members into the Children's Medical Services (CMS) Plan from other plans within the SMMC program. The CMS Plan is a specialized health plan for children requiring extensive preventive and ongoing care. Originally, the CMS Plan was not subject to the risk-adjustment process, necessitating an adjustment to the rates to account for this unanticipated shift in enrollment.

AHCA's contracted actuary determined that members shifting into the CMS Plan utilized BA services at a higher rate than average, AHCA elected to make an adjustment to the BA portion of the rates for both the CMS Plan and other rate cells within the program, as the original BA rate assumptions did not reflect this membership change. To address this, the contracted actuary applied a retrospective BA-specific risk adjustment methodology to shift BA costs budget neutrally within a region, aligning the BA portion of the capitation rates with the membership shifts.

While Mercer agrees that an adjustment was necessary to address differing utilization patterns resulting from the unanticipated member shifts, it appears that no adjustments were made for any services other than BA services. There is potential that the rates may have warranted updates for non-BA services as well, depending on the volume of members who shifted to the CMS Plan and their associated cost profiles.

This may result in the following impacts, which require further investigation in Product C:

- Additional unanticipated movement of members between the CMS Plan and other MCOs may result in the total capitation paid to one or more of the MCOs (including the CMS Plan) being under- or over-funded, relative to what AHCA intended.
- MCOs with more favorable experience could potentially realize excess profits, while MCOs with less favorable experience could be forced to operate at a loss. Over time, such misalignment may compromise program financial integrity of MCOs that are under-funded, possibly affecting their ability to pay claims in a timely manner and destabilizing the program.
- Capitation rate reductions for non-BA services could lead to strain in the negotiation process between MCOs and providers, particularly for value-based purchasing arrangements. If an MCO is paid a significantly lower amount for the same set of services, it creates challenges in negotiations between the MCO and its providers which may lead to high levels of dissatisfaction among certain providers.
- Given the high-risk nature of the CMS Plan's enrollment, compromising its financial integrity would present unique issues relative to the other MCOs that serve the program.

Redetermination Acuity Adjustment

In RY 2024/2025, the acuity adjustment represents one of the most consequential adjustments within the rate development process. Across all non-CMS Plan populations within MMA, this adjustment accounts for an approximate 20% increase in capitation rates. Mercer has identified the following potential vulnerabilities in the development of the acuity adjustment:

- The adjustment methodology excludes 100% of members classified as redetermined and deemed ineligible. While certain members were excluded from this classification (i.e., new members, members who died, pregnant/postpartum women, and members who resumed enrollment within 90 days), the adjustment may potentially overstate the impact if normal enrollment churn, or the typical volume of disenrollments, is not considered.

- The adjustments by rate cell raise questions about credibility because they are significant and variable, and AHCA and its contracted actuary did not provide documentation concerning the results or the application of actuarial judgment in determining the final adjustments.
- The treatment of sub-capitated services in the acuity adjustment is unclear. Sub-capitated services involve fixed payments and may not be impacted by acuity changes to the same extent as FFS services.

Further evaluation of the redetermination acuity adjustment, relative to industry best practices, will be performed. Depending on those findings, this may result in the following impacts, which would then require further investigation in Product C:

- If it is determined that significant, known elements of the redetermination process were not modeled in the redetermination acuity adjustment methodology, it may be necessary to revise the calculations. This may or may not result in a material change to the final capitation rates.

Section 2

Medicaid Overview

Medicaid is a Joint Federal-State Program

Medicaid is a joint federal-state program that provides health care coverage to different groups of low-income individuals. Federal law sets broad requirements, but Medicaid varies across states, as federal law allows flexibilities for each state to establish (within some parameters) its own eligibility criteria, benefit packages, payment policies, and administrative structures.[1]

As a joint federal-state program, Medicaid is subject to federal and state legal requirements. Title XIX of the Social Security Act (SSA) is its federal legal backbone.[2] The Centers for Medicare and Medicaid Services[3], an agency within the US Department of Health and Human Services, is the primary federal entity responsible for administering the program. As authorized by the SSA, the Centers for Medicare and Medicaid Services issues federal Medicaid regulations and guidance.[4]

Federal law requires each state to designate a "single state agency" to administer the state's Medicaid program.[5] AHCA is the single state agency that administers the State's Medicaid programs.[6] As such, AHCA enacts State regulations governing Florida's Medicaid programs.[7]

The federal and state governments are jointly responsible for financing Medicaid. The State covers a percentage of expenditures using state funds, and the difference is covered by federal dollars.[8] The Federal Medical Assistance Percentage (FMAP) determines the federal share for most services.[9] As an entitlement program, all eligible individuals have a right to Medicaid coverage. Thus, by law, the State must enroll eligible individuals, and the federal government must contribute the applicable FMAP for their medically necessary services.[10]

Medicaid Eligibility Groups

Historically, people eligible for Medicaid include low-income children and their parents, pregnant women, people with disabilities, and people aged 65 years and older.[11] Coverage of some

[1] MACPAC, *Medicaid 101*, www.macpac.gov/medicaid-101/ (last visited Feb. 11, 2026) [hereinafter MACPAC Medicaid 101].
[2] Title XIX of the Social Security Act (SSA) appears in the United States Code (U.S.C.) as §§1396–1396v, subchapter XIX, chapter 7, Title 42. Regulations relating to Title XIX are contained in chapter IV, Title 42, and subtitle A, Title 45, CFR.
[3] The Centers for Medicare and Medicaid Services's Center for Medicaid and CHIP Services serves as the focal point for the formulation, integration, and implementation of national policies "and operations relating to Medicaid, the CHIP, and the BHP." The Centers for Medicare and Medicaid Services, *Center for Medicaid & CHIP Services*, https://www.cms.gov/cmcs (last visited Feb. 14, 2026).
[4] Most federal Medicaid regulations are in Title 42 of the *Code of Federal Regulations* (42 C.F.R. §§ 430-456.725).
[5] SSA §§ 1902(a)(4)-(5), 42 U.S.C. §§ 1396a(a)(4)-(5); 42 C.F.R. § 431.10.
[6] Fla. Statute § 409.902(a).
[7] FL Admin Code R 59G-1.001 (The Florida AHCA adopts rules to comply with Chapter 409 of the Florida Statutes (F.S.)).
[8] SSA § 1905(b), 42 U.S.C. § 1396d(b); MACPAC Medicaid 101.
[9] The FMAP ranges from 50% to 83% across states. *Id.*
[10] *Id.*
[11] MACPAC, *Eligibility*, www.macpac.gov/medicaid-101/eligibility (last visited Feb. 11, 2026) [hereinafter MACPAC Eligibility].

eligibility groups is mandated by federal law. For instance, pregnant women with incomes at or below 133% of the federal poverty level[12] are a mandatory eligibility group. However, states may voluntarily cover additional groups beyond federal minimums.[13]

Medicaid eligibility groups are usually defined by the populations they cover (e.g., children, pregnant women, individuals with disabilities) and the financial eligibility requirements applicable to the group.[14] "Each eligibility pathway specifies the group of individuals covered by the pathway (i.e., *categorical criteria*), the financial requirements applicable to the group (i.e., *financial criteria*), whether the pathway is mandatory or optional, and the extent of the state's discretion over the pathway's requirements."[15] Also, to qualify for certain benefits, such as LTSS[16], individuals must meet functional eligibility criteria to demonstrate they have difficulty performing activities necessary for self-care and independent living.[17] Regardless of eligibility pathway, all applicants must meet federal and state requirements regarding residency, immigration status, and citizenship.[18]

If a Medicaid beneficiary has another source of health care coverage, such as employer-sponsored insurance or Medicare, Medicaid is generally the "payer of last resort."[19] This means that the other insurers pay for the expenses of the covered service first, and Medicaid accounts for any remaining obligation on the claim.[20] Medicaid may also pay for some cost sharing charged to low-income Medicare beneficiaries.[21]

Medicaid Benefits

Federal law requires states to cover 18 mandatory Medicaid benefits, but states may choose to cover additional optional benefits.[22] Examples of mandatory benefits include inpatient and outpatient hospital services, physician services, laboratory and x-ray services, and NEMT to medical care.[23] Examples of optional benefits are adult dental services, prescription drugs, and hospice.[24]

Generally, within a state, Medicaid benefits must: be equivalent in amount, duration, and scope for all beneficiaries (referred to as comparability of services or "comparability")[25]; be the same throughout the state (referred to as "statewideness")[26]; and give beneficiaries freedom of choice among providers enrolled with the state's Medicaid program (referred to as freedom of choice of

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[12] SSA §§ 1902(a)(10), 42 U.S.C. §§ 1396a(a)(10).
[13] For example, some states allow pregnant women with incomes above 133 percent of the federal poverty level to enroll in Medicaid. MACPAC Eligibility.
[14] *Id.*
[15] CRS, *Medicaid: An Overview*, R43357, 4 (Apr. 30, 2025), https://www.congress.gov/crs_external_products/R/PDF/R43357/R43357.22.pdf [hereinafter CRS Medicaid Overview].
[16] LTSS includes institutional care and home- and community-based services (HCBS). Individuals with different types of physical and cognitive disabilities use LTSS. MACPAC, LTSS, www.macpac.gov/topic/long-term-services-and-supports/ (last visited Feb. 11, 2026) [hereinafter MACPAC LTSS].
[17] MACPAC Eligibility.
[18] CRS Medicaid Overview at 4.
[19] MACPAC Eligibility.
[20] *Id.*
[21] *Id.*
[22] MACPAC, *Benefits*, www.macpac.gov/topic/benefits/ (last visited Feb. 12, 2026) [hereinafter MACPAC Benefits].
[23] Medicaid, *Mandatory & Optional Medicaid Benefits*, https://www.medicaid.gov/medicaid/benefits/mandatory-optional-medicaid-benefits (last visited Feb. 24, 2026).
[24] MACPAC Benefits.
[25] SSA § 1902(a)(10)(B), 42 U.S.C. § 1396a(a)(10)(B).
[26] SSA § 1902(a)(1), 42 U.S.C. § 1396a(a)(1).

providers).[27] However, the breadth of coverage for a benefit (i.e., amount, duration, and scope) varies by state.[28] For individuals older than 21 years, states may limit the extent to which a covered benefit is available by defining medical necessity criteria and the benefit's amount, duration, and scope.[29]

Individuals under 21 years old are entitled to a mandatory benefit not available to other Medicaid eligibility groups, called EPSDT services.[30] First, in addition to including all "mandatory" benefits, EPSDT requires states to cover an array of additional services: screening, vision, dental, hearing services, and *any medically necessary service listed in the Medicaid statute* (including optional services not otherwise covered by a state).[31] Second, EPSDT restricts the state's ability to impose hard limits or caps on medically necessary services for individuals under 21 years old.[32]

Medicaid Administration

Federal law gives states flexibility to set the confines of their Medicaid programs. Thus, although all states cover the same mandatory eligibility groups (e.g., low-income families, people with disabilities), there is great variation across state Medicaid programs.[33] In the "state plan," each state formalizes the nature and scope of its Medicaid program (e.g., who is eligible, what services are covered, how payments are set).[34] The state plan is a formal agreement between the state and the Centers for Medicare and Medicaid Services delineating how the state will administer its program, and the Centers for Medicare and Medicaid Services must approve the plan for the state to access federal Medicaid funds.[35]

State Plan and State Plan Amendments

Among other things, in the state plan, the state provides assurances that it will abide by federal rules; indicates which optional groups, services, or programs it will cover; and describes the standards to determine eligibility, providers' reimbursement methodologies, and program administration processes.[36] Through a state plan amendment, states can request the Centers for Medicare and Medicaid Services to approve changes to the state plan.[37-38]

In addition to traditional Medicaid benefits, states may offer optional benefits only to certain populations by adopting state plan options specified in the SSA.[39] Some of these *state plan options* do not include federal requirements applicable to traditional state plan benefits (e.g.,

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[27] SSA § 1902(a)(23), 42 U.S.C. § 1396a(a)(23).
[28] MACPAC Benefits.
[29] For example, yearly limits on the number of physical therapy sessions. *See id.*
[30] SSA § 1902(a)(43)(D), 42 U.S.C. § 1396a(a)(43)(D); MACPAC, *EPSDT in Medicaid*, www.macpac.gov/subtopic/epsdt-in-medicaid/ (last visited Feb. 12, 2026) [hereinafter MACPAC EPSDT].
[31] *Id.* (emphasis added).
[32] *Id.*
[33] NAMD, *Why Did They Do It That Way? Eligibility Policy*, https://medicaiddirectors.org/resource/why-did-they-do-it-that-way-eligibility-policy/ (last visited Feb. 19, 2026).
[34] SSA § 1902(a), 42 U.S.C. § 1396a(a); SSA § 1904, 42 U.S.C. § 1396c; 42 C.F.R. §§ 431.10, 431.15; MACPAC, *State Plan*, www.macpac.gov/state-plan/ (last visited Feb. 12, 2026) [hereinafter MACPAC State Plan].
[35] *Id.*
[36] *Id.*
[37] 42 C.F.R. §§ 431.12, 430.14-430.20, and 447.256.
[38] State plan amendments are needed, for example, to comply with changes in state or federal law. In other instances, to change a provider's payment methodology or to add and/or remove optional benefits. MACPAC State Plan.
[39] CRS Medicaid Overview at 14.

Statewideness, Comparability).[40] An example is PACE[41], which provides comprehensive medical and social services to frail individuals, most of whom are dually eligible for Medicare and Medicaid benefits (Duals).[42,43,44]

Medicaid Waivers

The SSA authorizes the Secretary of Department of Health and Human Services (HHS), at his/her discretion, to waive some federal statutory requirements to give states more flexibility to operate their Medicaid programs.[45] Through a waiver, the Secretary may allow the state to implement its Medicaid program in a manner that does not comply with Comparability, Statewideness, Freedom of Choice, and/or other requirements (*see* Medicaid Benefits section *supra*).[46] All states operate one or more waivers, which are commonly referred to by the section of the SSA that gives the Secretary of HHS authority to waive statutory requirements (e.g., "1115 waiver", "1915(c) waiver").[47]

Waivers are categorized as "program" or "research and demonstration" waivers.[48] Program waivers, in Sections 1915(b)[49] and 1915(c)[50] of the SSA, can be used to modify delivery systems and implement home and community based services (HCBS) respectively.[51] In turn, the "research and demonstration" waivers in Section 1115 allow states to test new approaches to program financing and delivery.[52] States use waivers for different purposes, including offering a special benefit package to a subset of Medicaid beneficiaries[53] or restricting beneficiaries to a managed care provider network.[54]

Waivers are subject to heightened federal scrutiny (relative to standard state plan requirements) and may require lengthy applications and negotiations with the Centers for Medicare and Medicaid Services; be limited in duration and subject to renewal and independent evaluation; and conditioned on adhering to limits on federal expenditures.[55] Generally, the greater the waiver flexibility, the greater the scrutiny (i.e., the requirements the state must meet).[56]

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[40] *Id.*
[41] SSA § 1934, 42 U.S.C. § 1396u-4; 42 C.F.R. §§ 460.2-460.210; MACPAC, *Chapter 4: Understanding the Program of All-Inclusive Care for the Elderly*, www.macpac.gov, 94 (June 2025), https://www.macpac.gov/wp-content/uploads/2025/06/MACPAC_June-2025-Chapter-4.pdf [hereinafter MACPAC Chapter 4].
[42] Medicaid, *Program of All-Inclusive Care for the Elderly*, https://www.medicaid.gov/medicaid/long-term-services-supports/program-of-all-inclusive-care-for-elderly (last visited Feb. 15, 2026) [hereinafter Medicaid PACE].
[43] Most PACE participants are eligible for Medicare and Medicaid (Duals), but Dual eligibility is not a requirement. Individuals in PACE that do not qualify for Medicaid cover the expense that the state Medicaid program would otherwise cover (e.g., the "long-term care portion of the PACE benefit and a premium for Medicare Part D drugs." The Centers for Medicare and Medicaid Services, *Quick Facts about PACE*, CMS Publication No. 11341, 3 (Jan. 2008), https://www.cms.gov/medicare/health-plans/pace/downloads/externalfactsheet.pdf
[44] Section 3 describes the PACE program as specified in the SSA and Florida's PACE Program.
[45] 42 C.F.R. § 430.25(b); CRS Medicaid Overview at 21.
[46] 42 C.F.R. § 430.25; MACPAC, *Waivers*, www.macpac.gov/medicaid-101/waivers/ (last visited Feb. 14, 2026) [hereinafter MACPAC Waivers 101].
[47] MACPAC Waivers 101.
[48] MACPAC, *Waivers*, www.macpac.gov/subtopic/overview/ (June 24, 2019) [hereinafter MACPAC Waivers].
[49] 1915(b) waivers allow states to modify their delivery systems by waving "comparability, statewideness, and/or freedom of choice" requirements. MACPAC, *1915(b) Waivers*, www.macpac.gov/subtopic/1915b-waivers/ (May 9, 2022).
[50] 1915(c) waivers waive "comparability" requirements, to allow states to "offer home- and community-based services (HCBS) to limited groups of enrollees as an alternative to institutional care" and cap the number of HCBS-eligible individuals. MACPAC, 1*915(c) Waivers*, https://www.macpac.gov/subtopic/1915-c-waivers/ (June 24, 2019) [hereinafter MACPAC 1915(c) HCBS].
[51] MACPAC Waivers.
[52] *Id.*
[53] For example, to waive federally required eligibility and benefit provisions "to explore new approaches to the delivery of and payment for acute care and LTSS." MACPAC Waivers 101.
[54] *Id.*
For example, for purposes of federal expenditures, 1115 Waivers must be "budget neutral", 1915(b) Waivers must be "cost effective", and 1915(c) Waivers must be "cost neutral". MACPAC Waivers.
[56] *Id.*

Each waiver authority has a purpose. For example, 1915(c) HCBS waivers allow states to tailor services to specific populations to meet their Long-Term Services and Supports (LTSS) needs in their home or community rather than in an institutional setting.[57] HCBS waivers can be tailored to specific populations based on age or diagnosis, such as autism, traumatic brain injury, or HIV/AIDS.[58] They also allow states to cover a range of HCBS (including services not covered in the Medicaid state plan) only for the specific population with the LTSS need.[59] States can use different waivers concurrently.[60] Although waivers are not programs listed in the SSA, the terms program and waiver are sometimes used interchangeably.

States Implement Multiple Medicaid State Plan Options and Waivers

A state's Medicaid structure is typically referred to as a single monolithic program. However, in practice, a state operates multiple Medicaid state plan options and waivers. Thus, not every Medicaid beneficiary may be entitled to the same set of services. A beneficiary's eligibility pathway, the voluntary Medicaid state plan options the state covers, waivers, and other variables determine the services available to a specific individual.[61] The PACE and HCBS examples above illustrate these and other important nuances of Medicaid programs.

Medicaid Service Delivery Systems

There are two predominant delivery systems for Medicaid beneficiaries to receive services — fee-for-service (FFS) and managed care. The delivery system determines how the Medicaid program is structured, who is responsible for program operations, and how payments flow to providers.[62] Most states use a mix of FFS and managed care.[63]

Medicaid Fee-for-Service

In FFS, providers bill the state for each individual service they provide and are paid directly by the state.[64] Generally, states determine the FFS rate, meaning the dollars a provider (e.g., physician, hospital, nursing facility) receives for a specific service, and the federal government pays a percentage of each claim.[65] The SSA requires that FFS "payments be consistent with

[57] HCBS Waiver programs can "provide a combination of … medical services and non-medical services. Standard services include …: case management (i.e. supports and service coordination), homemaker, home health aide, personal care, adult day health services, habilitation …, and respite care." MACPAC 1915(c) HCBS. States can also propose "other" types of services that help divert or transition individuals from institutional settings" to their homes and community. *Id.*
[58] MACPAC 1915(c) HCBS.
[59] CRS Medicaid Overview at 22.
[60] For example, states may combine 1915(b) and 1915(c) waivers to offer mandatory managed care for HCBS. *Id.* at 22-23.
[61] *Id.* at 11.
[62] NCLS, Medicaid Managed Care 101, https://www.ncsl.org/health/medicaid-managed-care-101 (last updated Sep. 21, 2023) [hereinafter NCLS Medicaid Managed Care 101].
[63] NAMD, *Why Did They Do It That Way? Managed Care*, https://medicaiddirectors.org/resource/understanding-managed-care/ (last visited Feb. 16, 2026) [hereinafter NAMD Managed Care].
[64] CRS Medicaid Overview at 16.
[65] MACPAC, *Provider Payment and Delivery Systems*, www.macpac.gov/medicaid-101/provider-payment-and-delivery-systems/ (last visited Feb. 16, 2026) [hereinafter MACPAC Payment and Delivery].

efficiency, economy, and quality of care, and are sufficient to provide access equivalent to the general population."[66] FFS rates are generally lower relative to Medicare or private insurance.[67]

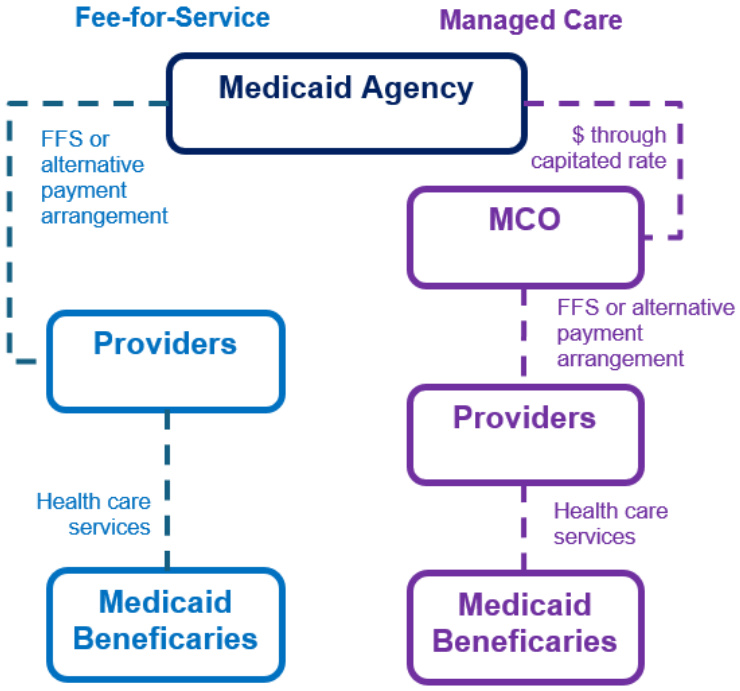
Medicaid Managed Care

Since the 1990s, the number of Medicaid beneficiaries in managed care has increased dramatically.[68] States began using managed care to deliver services to healthy Medicaid populations (e.g., children and parents).[69] However, recently, states are using managed care for many populations, including individuals with disabilities or long-term care needs.[70] Medicaid enrollees may receive some or all services through an MCO.[71-72]

The state Medicaid agency pays an MCO a per member per month (PMPM) fee — sometimes referred to as a "capitation payment" or "capitated rate" — that is certified by an actuary for each Medicaid beneficiary enrolled in the MCO (enrollee).[73-74] In exchange, the MCO handles multiple functions, such as developing a provider network, paying providers for services received by enrollees, applying utilization management controls (e.g., prior authorization), and coordinating care for enrollees.[75] The functions the MCO is responsible for, and the services it must provide to enrollees, are set in a contract between the Medicaid agency and the MCO.[76] Figure 1 provides a flow chart to help illustrate high-level differences between a Medicaid FFS delivery system and a Medicaid Managed Care delivery system.

[66] SSA § 1902(a)(30)(A), 42 U.S.C. §§ 1396a(a)(30)(A).
[67] MACPAC Payment and Delivery.
[68] CRS Medicaid Overview at 16.
[69] *Id.*
[70] *Id.*
[71] *Id.*
[72] Part 438 of Title 42 of the Code of Federal Regulations contains the federal regulations governing Medicaid managed care programs.
[73] NCLS Medicaid Managed Care 101.
[74] States set the capitation rate, but their rate development process and PMPM amount must comply with federal requirements and actuary professional standards. Section 4 discusses said requirements in detail.
[75] NAMD Managed Care.
[76] *Id.*

Figure 1: Fee-for-Service versus Managed Care Delivery System



Types of Managed Care Delivery Systems and Managed Care Organizations

Medicaid managed care varies across states as to the arrangements used and populations served, but common types of managed care delivery systems are:

- **Comprehensive risk plans:** States enter into comprehensive risk contracts[77] with MCOs to provide a comprehensive set of services (e.g., inpatient and outpatient hospital services, physician services, laboratory and x-ray services). These contracts transfer financial risk to the MCOs, so MCOs must meet solvency standards.[78] States can "carve out" some benefits (e.g., behavioral health) from these contracts, and MCOs are not responsible for carved-out benefits.[79]
- **Limited-benefit plans:** States contract with MCOs to manage or provide a narrow set of benefits (e.g., dental, inpatient mental health, combined mental health and substance use disorder inpatient benefits, NEMT). Depending on the services covered, the arrangement may be referred to as a PIHP or a prepaid ambulatory health plan PAHP.[80-81]

[77] The term "comprehensive risk contract" is defined in 42 C.F.R. § 438.2.
[78] *See* "managed care organization" definition in 42 C.F.R. § 438.2.
[79] Carved out benefits are usually delivered to beneficiaries via FFS or by a Limited-Benefit Plan. MACPAC Payment and Delivery.
[80] Medicaid, *Managed Care Entities*, https://www.medicaid.gov/medicaid/managed-care/managed-care-entities (last visited Feb. 16, 2026) [hereinafter Medicaid Managed Care Entities].
[81] The terms "prepaid inpatient health plan" and "prepaid ambulatory health plan" are defined in 42 C.F.R. § 438.2. PIHPs implement plans that cover inpatient hospital or institutional care related to specific services (e.g., mental health). Medicaid Managed Care Entities. In turn, PAHPs implement plans for specific services (e.g., dental and transportation), but they do not provide inpatient hospital or institutional services. *Id.*

As evidenced by the different types of managed care delivery systems, the term managed care alone does not tell the full story. There is great variability among the design and features of managed care programs. It is also important to note that although the PMPM is intended to cover all services under the contract for an enrollee, regardless of the enrollee's utilization, managed care contracts can be risk-based or non-risk-based. In risk-based contracts, generally, the MCO assumes risk for losses and retains profit.[82] On the other hand, non-risk-based contracts do not transfer financial risk to the contractor. States set capitation rates, but their rate development process and PMPM must comply with federal requirements.[83,84,85]

[82] The MCO loses money if the cost of services to enrollees and program administration exceeds the PMPM, and it makes a profit if they are below the PMPM. NAMD Managed Care.
[83] A detailed description of the managed care rate-setting process is discussed in Section 4.
[84] All comprehensive risk contracts are risk-based. *See* "risk contract" and "comprehensive risk contract" definitions in 42 C.F.R. § 438.2.
[85] State managed care contracts with PIHPs and PAHPs can be potential vulnerability-based or non-potential vulnerability based *See* Medicaid Managed Care Entities; *see also* "nonpotential vulnerability contract" definition in 42 C.F.R. § 438.2.

Section 3

Medicaid Programs in Florida

AHCA is the single state agency that administers the State's Medicaid programs.[86] Most Florida Medicaid beneficiaries receive benefits through managed care, but a small population is allowed to voluntarily receive them via FFS.[87-88] AHCA uses different managed care programs, and per the scope of this project this analysis focuses on four of them: SMMC, PACE, CNET[89]; and ICMC. These programs are described below.

State Medicaid Managed Care (SMMC) Program

Most Medicaid recipients get services through the SMMC program, authorized through an 1115(a) waiver and a Long-Term Care 1915(b)/(c) waiver. [90-91] SMMC includes these key programs:[92] MMA; LTC; and dental.[93] In 2023, SMMC covered more than 5 million Floridians.[94] Figure 2 provides a summary of the SMMC programs.

[86] AHCA, *Statewide Medicaid Managed Care (SMMC) New Program Highlight: Managed Medical Assistance Plan vs. Fee-for-Service*, www.ahca.myflorida.com, 1 (Jan. 15, 2025), https://ahca.myflorida.com/content/download/25693/file/Managed.
[87] *Id.*
[88] This analysis does not focus on Florida's Medicaid FFS delivery system. Thus, additional details on the Florida Medicaid populations that can receive benefits via FFS, and the types of services that they can received under FFS are omitted.
[89] The waiver program is titled "non-emergency transportation" (NET). However, the program is implemented through a capitated managed care arrangement with NET providers. Thus, the program is commonly referred to as "CNET". For consistency, this document will refer to this program as "CNET." *See* AHCA, *Florida Medicaid Non-Emergency Transportation Waiver (NET) Waiver Renewal*, (Mar. 2023), http://www.flmedicaidmanagedcare.com/ [hereinafter AHCA NET Waiver Renewal].
[90] AHCA, *Statewide Medicaid Managed Care*, http://www.flmedicaidmanagedcare.com/ (last visited Feb. 20, 2026).
[91] Health Services Advisory Group, *AHCA SFY 2023-2024 External Quality Review Technical Report*, 1 (Apr. 2025), https://ahca.myflorida.com/content/download/26439/file/FL_2023-2024_EQR_TechRpt_F1.pdf [hereinafter AHCA EQR Report].
[92] AHCA uses the terms "component" and "program" when referencing MMA, LTC, and Dental. This report will use "program." AHCA, *Statewide Medicaid Managed Care 3.0 Overview*, 2 (Feb. 17, 2026), https://ahca.myflorida.com/content/download/25090/file/Statewide [hereinafter AHCA SMMC 3.0 Presentation].
[93] *Id.*
[94] AHCA EQR Report at 2.

Figure 2: State Medicaid Managed Care Programs[95]

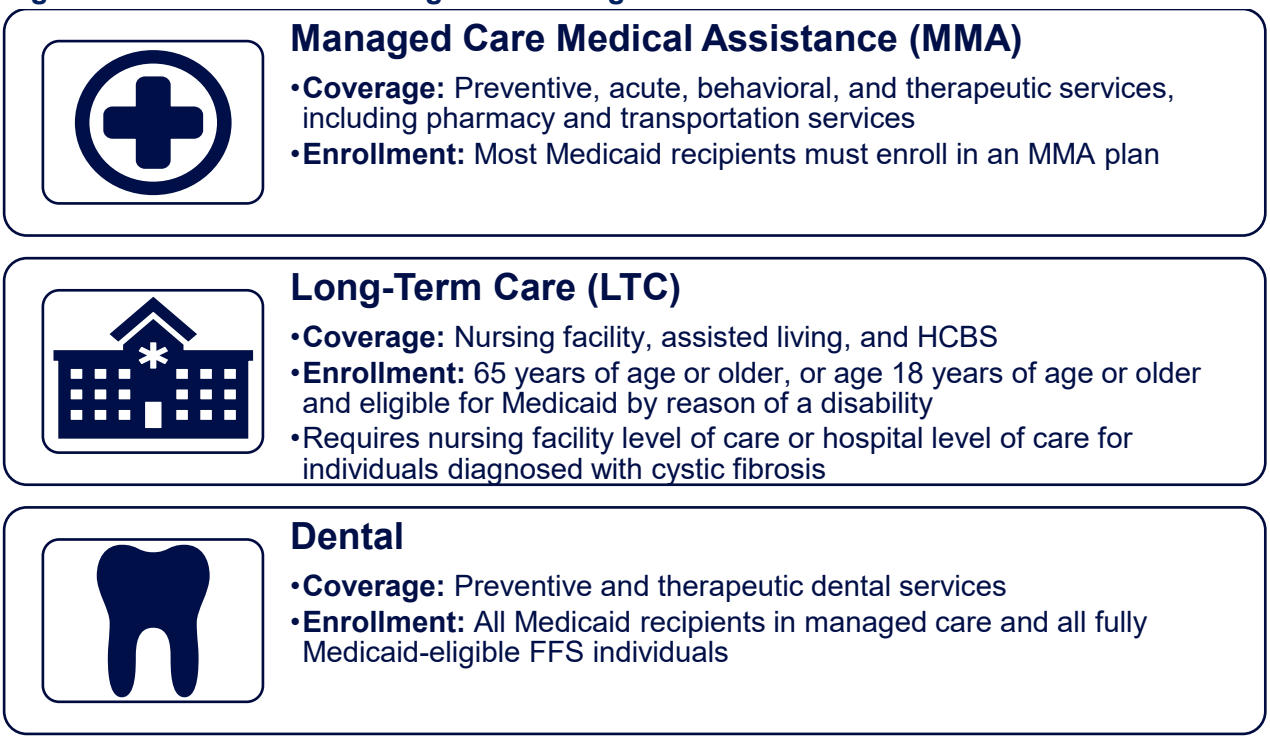


Table 3 provides a summary of program expense, average monthly enrollment, and the per member per month expense for calendar years (CY) 2023 and 2024. It also shows the variance between those two years.

Table 3: State Medicaid Managed Care Enrollment and Expenditure Trends

Program	Measure	CY 2023	CY 2024	% Change
MMA[96]	Expense (in millions)[97]	$17,027.00	$15,361.00	-9.80%
	Average Monthly Enrollment[98]	4,091,760	3,177,106	-22.40%
	Expense PMPM	$346.77	$402.91	16.20%
LTC	Expense (in millions)[97]	$5,954.00	$6,585.00	10.60%
	Average Monthly Enrollment[98]	131,943	140,643	6.60%
	Expense PMPM	$3,760.55	$3,901.46	3.70%
Dental	Expense (in millions)[97]	$426.00	$384.00	-9.80%
	Average Monthly Enrollment[98]	4,091,760	3,177,106	-22.40%
	Expense PMPM	$8.67	$10.07	16.20%

Services Covered Under the State Medicaid Managed Care Components/Programs

Each program under SMMC covers multiple services. Table 4 is a description of services that MCOs must cover under each SMMC program. MCOs may voluntarily provide additional "value-based benefits" but are not specifically reimbursed for them in the PMPM.[99]

The SMMC's MMA program provides primary and acute medical care, behavioral health, therapeutic, pharmacy, and NEMT services. Most of Florida's Medicaid recipients receive their care from a health plan that covers MMA services.[100]

Table 4: State Medicaid Managed Care's Managed Medical Assistance Minimum Covered Services[101]

Managed Medical Assistance Minimum Covered Services	
Advanced registered nurse practitioner services	Hospital inpatient and outpatient services
Ambulatory surgical treatment center services	Laboratory and imaging services
Assistive care services	Medical supply, equipment, prostheses, and orthoses
Behavioral health	Medical foster care

[95] AHCA SMMC 3.0 Presentation at 3.
[96] MMA does not include PACE.
[97] Medicaid Annual Service Expenditures.
[98] Florida Medicaid Monthly Enrollment Report.
[99] Sean Dunbar, *In-Lieu-Of Services and Value-Added Benefits*, www.macpac.gov, 6 (Dec. 8, 2022), https://www.macpac.gov/wp-content/uploads/2022/12/07_In-Lieu-Of-Services-and-Value-Added-Benefits.pdf
[100] AHCA EQR Report at 2.
[101] AHCA, *A Snapshot Statewide Medicaid Managed Care 3.0*, https://ahca.myflorida.com/content/download/25049/file/SMMC_Snapshot.pdf (last visited Feb. 21, 2026) [hereinafter AHCA SMMC 3.0 Snapshot].

Managed Medical Assistance Minimum Covered Services	
Birthing center services	Mental health services
Chiropractic services	Nursing care
Early intervention services	Nursing facility services for enrollees not in the LTC program
EPDST services for recipients under 21 years of age	Optical services and supplies
Emergency services	Optometrist services
Family planning services and supplies (some exceptions)	Physical, occupational, respiratory, and speech therapy
Hearing services	Podiatric services
Home health agency services	Physician services, including physician assistant services
Hospice services	Rural health clinic services
Prescription drugs	Transportation to access covered services
Renal dialysis services	Substance abuse treatment
Respiratory equipment and supplies	Healthy Start services (some exceptions)

The SMMC's LTC program provides services to individuals that are: 65 years or older, who need nursing facility LOC; 18 years or older and eligible for Medicaid by reason of disability and need nursing facility LOC; or 18 years or older with a diagnosis of cystic fibrosis and have a hospital LOC.[102] It covers care in a nursing facility or HCBS for those who can safely reside in a community setting.[103]

AHCA implements the LTC program through a capitated managed care waiver (LTC Waiver).[104] This waiver "is designed to delay or prevent institutionalization and allow" individuals "to maintain stable health while receiving services at home and in the community."[105] Services covered by the LTC waiver are offered by statewide Medicaid managed care LTC plans and MMA comprehensive plans.[106-107] These services are listed in Table 5 below.

Table 5: State Medicaid Managed Care's Long-Term Care Minimum Covered Services[108]

Long-Term Care Minimum Covered Services	
Adult companion care	Intermittent and skilled nursing

[102] AHCA, *Florida Medicaid's Covered Services and Waivers*, https://ahca.myflorida.com/medicaid/medicaid-policy-quality-and-operations/medicaid-policy-and-quality/medicaid-policy/federal-authorities/federal-waivers/florida-medicaid-s-covered-services-and-waivers, (last visited Feb. 22, 2026) [hereinafter AHCA LTC Waiver].
[103] Examples HCBS include home-delivered meals and help with activities of daily living (e.g., eating, bathing, dressing). AHCA EQR Report at 2.
[104] AHCA LTC Waiver.
[105] Individuals in the program may also be served in a nursing facility setting. *Id.*
[106] *Id.*
[107] *See* description of SMMC plans in Section 3.
[108] AHCA SMMC 3.0 Snapshot at 1.

Long-Term Care Minimum Covered Services	
Adult day health care	Medical equipment and supplies
Assisted living	Medication administration
Assistive care services	Medication management
Attendant care	Nursing facility
Behavioral management	Nutritional assessment/risk reduction
Care coordination/Care management	Personal care
Caregiver training	Personal emergency response system
Home accessibility adaption	Respite care
Home-delivered meals	Therapies: occupational, physical, respiratory, and speech
Homemaker	Transportation, non-emergency
Hospice	

The SMMC's dental program provides preventive and therapeutic dental services to all recipients in managed care, and to individuals in Medicaid FFS.[109] For children below 21 years of age, services include, "exams, screening, x-rays, sealants, fluoride, fillings and crowns, root canals, periodontics, orthodontics, extractions, sedation, and ambulatory surgical center or hospital-based dental services."[110] For adults 21 years and older, "services include exams, x-rays, dentures, extractions, sedation, and pain management."[111] Table 6 below lists the services that are covered by SMMC's Dental plan.

Table 6: State Medicaid Managed Care's Dental Covered Services [112]

Dental Minimum Covered Services	
Ambulatory surgical center or hospital-based dental services	Orthodontics
Dental exams	Periodontics
Dental screenings	Prosthodontics (dentures)
Dental x-rays	Root canals
Extractions	Sealants
Fillings and crowns	Sedation
Fluoride	Space maintainers
Oral health instructions	Teeth cleanings

[109] AHCA EQR Report at 2.
[110] *Id.*
[111] *Id.*
[112] AHCA SMMC 3.0 Snapshot.

Plans Serving State Medicaid Managed Care Enrollees

AHCA implements the SMMC program through different plans:[113]

- Comprehensive Plus plan: provides MMA services to MMA eligible recipients and provides LTC services to LTC eligible recipients. A Comprehensive Plus plan may also provide Specialty products[114] to all specialty population enrollees.
- MMA Plus plan: provides MMA services to MMA eligible recipient but cannot provide services to LTC-only recipients. An MMA Plus Plan may also provide Specialty products to all specialty population enrollees.
- Select Comprehensive plan: provides MMA and LTC services to eligible recipients enrolled in LTC but cannot provide services to MMA-only recipients. A Select Comprehensive plan does not provide a Specialty product.
- Dental plan: provides preventative and therapeutic dental services to all recipients in managed care and all fully eligible fee-for-service individuals.

MCOs serving SMMC recipients are under capitated, risk-based contracts. AHCA requires MCOs offering MMA plans or dental plans to reimburse a percentage of their payments to providers using value-based purchasing arrangements.[115]

Program of All-Inclusive Care for the Elderly (PACE) Program

PACE is a Medicare program and Medicaid state plan option that allows Duals that require a nursing facility level of care to receive Medicaid and Medicare benefits in an integrated manner in their communities rather than in a nursing home.[116-117]

States that voluntarily adopt the PACE state plan option can cover optional benefits and make them available only to this Medicaid population (participant enrollment is voluntary).[118] PACE participants have an interdisciplinary team of health professionals that coordinates their care.[119] For these individuals, PACE is the sole source of Medicaid and Medicare benefits, so they cannot enroll in the state's traditional Medicaid program.[120]

AHCA's Medicaid state plan includes a PACE program that serves Medicaid only[121] and Dual beneficiaries that are 55 years of age or older, meet the nursing facility LOC, "reside in a designated service area, and can be safely served in the community."[122] Enrollees must accept

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[113] AHCA EQR Report at 2.
[114] Specialty products serve certain SMMC beneficiaries diagnosed with a Serious Mental Illness (SMI); diagnosed with Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS); or who are in Florida's Child Welfare system. SMMC 3.0 Presentation at 42.
[115] *Id.* at 36.
[116] MACPAC Chapter 4 at 94.
[117] PACE started as a pilot, but Congress codified in the SSA what is now known as "PACE" as a permanent Medicare program and Medicaid state plan option in 1997. *See* 42 U.S.C. § 1396u-4 (Program of All-inclusive Care For The Elderly (PACE)); *see also* MACPAC Chapter 4.
[118] "Financing for the program is capped, which allows providers to deliver all services participants need rather than only those reimbursable under Medicare and Medicaid fee-for-service plans." Medicaid PACE.
[119] *Id.*
[120] PACE participants can voluntarily leave the program at any time and for any reason. *Id.*
[121] AHCA, *Program of All-Inclusive Care for the Elderly (PACE), Senate Health Appropriations Presentation*, 3 (Jan. 15, 2025), https://ahca.myflorida.com/content/download/26657/file/PACE%20Presentation_AHCA%20FINAL_01132025_v2.pdf
[122] AHCA, *Program of All-Inclusive Care for the Elderly Monthly Report*, 1 (Nov. 2025) [Updated Dec. 05, 2025], https://ahca.myflorida.com/content/download/27866/file/PACE%20Report%20November.pdf [hereinafter AHCA PACE 2025 Report].

the PACE organization as their primary care physician.[123] Florida's PACE program aims to maintain the enrollees' independence outside of a nursing facility, so HCBS is provided to them as needed.[124] The PACE organizations may also deliver other services necessary to improve or maintain the enrollee's health status.[125]

Florida PACE organizations sign a three-way agreement with AHCA and the Centers for Medicare and Medicaid Services that establishes the group of enrollees covered and details covered services, payment methodologies, and other administrative requirements.[126] Different PACE organizations serve different geographic service areas.[127] They receive "a capitated rate for Medicare services by the Centers for Medicare and Medicaid Services and a capitated rate for Medicaid services by AHCA."[128] PACE organizations receive said payments directly from AHCA and the Centers for Medicare and Medicaid Services; there is no MCO intermediary between them.

Table 7 provides a summary of program expense, average monthly enrollment, and the per member per month expense for state fiscal years 2022/2023 and 2023/2024. It also shows the variance between those two years.

Table 7: Program of All-Inclusive Care for the Elderly Enrollment and Expenditure Trends

Program	Measure	SFY 2022/2023	SFY 2023/2024	% Change
PACE[129]	Disbursements	$102,896,337	$162,858,002	58.30%
	Enrollment[130]	3,389.00	3,767.00	11.20%
	Disbursements PMPM[130]	$2,530.15	$3,602.73	42.40%

Non-Emergency Transportation Waiver (CNET) Program

Through the CNET Program, AHCA arranges the delivery of NET services to Medicaid recipients not enrolled in the SMMC Program.[131] AHCA contracts with NET providers known as "CNET plans" to deliver said services to these recipients.[132-133] AHCA reimburses CNET plans using a risk-based capitated rate.[134] CNET plans "are responsible for centralized call intake, eligibility determination, authorization of trips, scheduling and dispatching trips, and monitoring transportation providers."[135]

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[123] *Id.* at 1.
[124] *Id.*
[125] *Id.*
[126] *Id.*
[127] *See* Operational PACE Organization table. *Id.* at 4.
[128] *Id.* at 1.
[129] PACE Appropriations Report
[130] Enrollment shown is reported as 2023 and 2024. Disbursements PMPM are calculated as Disbursements/(Enrollment*12), but reported enrollment may not reflect average enrollment.
[131] AHCA, *Florida Medicaid Non-Emergency Transportation Waiver (NET) Waiver Renewal*, 2 (Mar. 2023), ahca.myflorida.com/content/download/20927/file/1915b_Non-Emergency_Transportation_Waiver_Renewal_2023-2025.pdf [hereinafter AHCA NET Waiver Renewal].
[132] *Id.* at 2-3.
[133] CNET plans are Prepaid Ambulatory Health Plan (PAHPs). *Id.*
[134] *Id.* at 5.
[135] CNET plans may provide services directly or subcontract for said services. *Id.* at 3.

AHCA implements CNET through two waivers. First, a 1915(b)(1) waiver allows AHCA to require the Medicaid beneficiaries not enrolled in the SMMC program to receive NET services only through a managed care delivery system.[136] Second, a 1915(b)(4) waiver that also requires said beneficiaries to obtain NET services only from the specified CNET plans.[137]

Table 8 provides a summary of program expense, average monthly enrollment, and the per member per month expense for calendar year 2023 and January through June of 2024.

Table 8: Non-Emergency Transportation Waiver (CNET) Enrollment and Expenditure Trends

	CY 2023	January–June 2024
Average monthly enrollment[138]	290,608	188,880
Average monthly claim cost[139]	$839,893	$710,194
Per member per month cost	$2.89	$3.76

Intellectual and Developmental Disabilities Comprehensive Managed Care (ICMC) Program

The AHCA ICMC program allows Medicaid recipients with intellectual and developmental disabilities to receive comprehensive medical and HCBS through a Medicaid managed care plan.[140] The ICMC program covers MMA services, LTC services, and developmental disability services (e.g., life skills development, behavior analysis, residential habilitation, skilled nursing, respite).[141]

The ICMC program started as a pilot in a limited number of regions in October 2024.[142] The Florida Legislature authorized its expansion statewide in 2025.[143] AHCA rebranded the pilot into what is known today as the ICMC program.[144] AHCA implements the ICMC program[145] under the authority of two waivers: a 1915(c) HCBS waiver[146] and a 1915(a) waiver.[147-148] As of December 1, 2025, 868 individuals were enrolled in the ICMC program (enrollment is voluntary).[149-150]

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[136] *Id.*
[137] *Id.*
[138] Membership reported by agency.
[139] Claims are total paid encounters reported through June 2024 and does not include IBNR assumptions.
[140] AHCA, *Intellectual and Developmental disabilities Comprehensive Managed Care Program Status Report*, 2 (Dec. 2025), https://ahca.myflorida.com/content/download/27804/file/2025%20ICMC%20Status%20Report.pdf [hereinafter AHCA ICMC Program Report].
[141] Appendix B of the AHCA ICMC Program Report has a detailed list of covered services. *Id.* at 19.
[142] In 2023, through Senate Bill 2510, the Florida Legislature created said pilot. *Id.* at 3.
[143] *Id.*
[144] Section (s.) 409.9855, F.S., sets the ICMC programmatic requirements and implementation timelines. *Id.*
[145] AHCA is responsible for managing the Program, but Florida's Agency for Persons with Disabilities (APD) is also responsible for the implementation of some components of the ICMC Program (e.g., providing a consultative resource for AHCA in the development of policies, approving a needs assessment methodology to determine functional, behavioral, and physical needs of prospective ICMC enrollees). Florida House of Representatives Bill Analysis, HB 1103, 13 (Apr. 17, 2025), https://www.flsenate.gov/Session/Bill/2025/1103/Analyses/h1103d.HHS.PDF [hereinafter HB 1103 Bill Analysis].
[146] AHCA ICMC Program Report at 3.
[147] AHCA, *Application for a 1915(c) Home and Community-Based Services Waiver*, FL.070.00.01, 221 (Oct. 1, 2025), https://ahca.myflorida.com/content/download/26740/file/IDD%20Amendment_07022025.PDF [hereinafter AHCA ICMC Waiver Application]
[148] 1915(a) waivers allow state Medicaid agencies to adopt voluntary managed care programs. Medicaid, *Managed Care Authorities*, https://www.medicaid.gov/medicaid/managed-care/managed-care-authorities (last visited Feb. 22, 2026).
[149] AHCA ICMC Program Report at 2.
[150] After the statewide expansion of the ICMC Program, the Centers for Medicare and Medicaid Services approved to increase the unduplicated number of participants to 2,108 statewide (year two). *Id.* at 9.

A single MCO plan provides LTC services and HCBS to populations requiring significant care coordination to serve ICMC participants.[151] AHCA pays the MCO using a risk-based capitation rate.[152]

[151] HB 1103 Bill Analysis at 13.
[152] AHCA ICMC Waiver Application at 314.

Section 4

Medicaid Rate-Setting Process

States pay MCOs a fixed monthly amount per member (PMPM) to provide risk-based managed care services for the benefits covered under their contracts. While states may set the capitation rates, the process used to set these rates must comply with federal requirements. Under these risk-based contracts, MCOs generally retain flexibility to negotiate how they reimburse healthcare providers.

Arguably the most important federal requirement states must comply with is for the PMPM to be *actuarially sound*, that is, it must be "projected to provide for all reasonable, appropriate, and attainable costs that are required by the contract for … the time period and population covered."[153] Federal regulations also require states to develop PMPMs in accordance with ASOPs issued by the Actuarial Standards Board.[154-155] States must follow multiple ASOPs[156], but ASOP No. 49 is particularly relevant as it defines "actuarially sound/actuarial soundness" in Medicaid programs:

> Medicaid capitation rates are "actuarially sound" if, for business for which the certification is being prepared and for the period covered by the certification, projected capitation rates and other revenue sources provide for all reasonable, appropriate, and attainable costs. For purposes of this definition, other revenue sources include, but are not limited to, expected reinsurance and governmental stop-loss cash flows, governmental risk-adjustment cash flows, and investment income. For purposes of this definition, costs include, but are not limited to, expected health benefits, health benefit settlement expenses, administrative expenses, the cost of capital, and government-mandated assessments, fees, and taxes.[157-158]

Following these federal and ASOP requirements, states use different approaches to risk-adjust the PMPM to account for different factors, such as the health status of their enrollees.[159] The next sections describe the rate-setting process used to develop actuarially sound Medicaid capitation rates, and the parties involved in said process.

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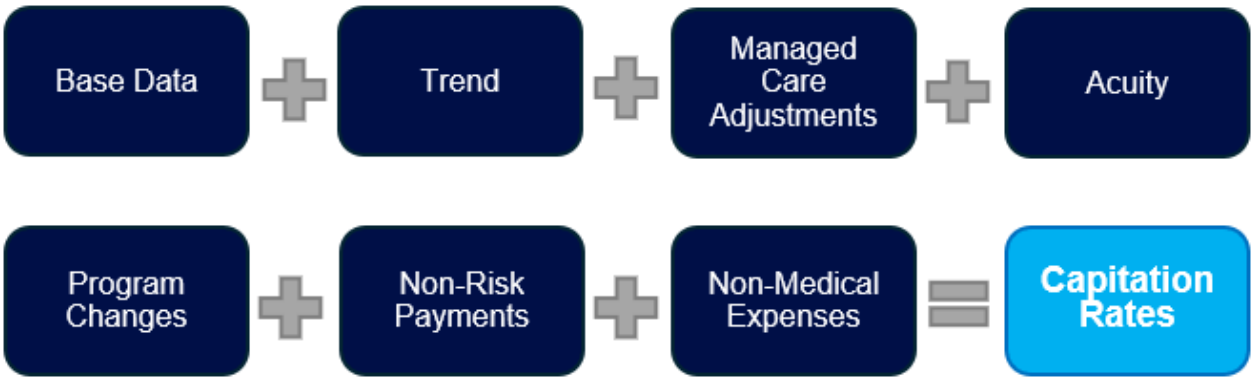
[153] SSA § 1903(m)(2)(A)(iii), 42 US.C. § 1396b(m)(2)(A)(iii); 42 C.F.R. § 438.4(a).
[154] 42 C.F.R. §§ 438.4 through 438.7.
[155] The Centers for Medicare and Medicaid Services, *2025-2026 Medicaid Managed Care Rate Development Guide for Rating Periods Starting Between July 1, 2025 and June 30, 2026*, 2 (Aug. 2025), https://www.medicaid.gov/medicaid/managed-care/downloads/2025-2026-medicaid-rate-guide-082025.pdf [hereinafter CMS Managed Care 2025 Rate Development Guide].
[156] *E.g.*, the Actuarial Standards of Practice (ASOPs) No.: 5 (Incurred Health and Disability Claims); 12 (Potential vulnerability Classification (for All Practice Areas); 23 (Data Quality); 25 (Credibility Procedures); 41 (Actuarial Communications); 45 (The Use of Health Status Based Potential vulnerability Adjustment Methodologies); 49 (Medicaid Managed Care Capitation Rate Development and Certification); and 56 (Modeling). *Id.* at 5.
[157] Actuarial Standards Board (ASB), *ASOP No. 49, Medicaid Managed Care Capitation Rate Development and Certification*, Doc. No. 179, 2 (Mar. 2015), https://www.actuarialstandardsboard.org/wp-content/uploads/2015/03/asop049_179.pdf [hereinafter ASOP No. 49].
[158] ASOP No. 49 also includes multiple definitions particularly relevant for Medicaid. For instance, it defines "base data" and "Disproportionate Share Hospital (DSH) Payments." *Id.* at 2.
[159] NCLS Medicaid Managed Care 101.

Rate-Setting Processes Background

Medicaid managed care capitation rates are the monthly payments from the state to MCOs to cover the cost of care for Medicaid-eligible members. Capitation rates are developed on a PMPM basis and may vary by population. Since the capitation rates are predetermined amounts, MCOs assume financial risk under this payment arrangement. If MCOs provide care for less than the projected costs, they may retain the differences as profit, but if actual costs exceed the projected amount, then the MCOs bear the loss. State actuaries are responsible for developing and certifying that these rates are actuarially sound, as defined in ASOP 49. The following sections outline the key components of this rate-setting process. Figure 3 below provides a high-level view of the capitation rate-setting process. This outline will be followed as appropriate in the program-specific descriptions later in this section.

Figure 3: Rate-setting Process



Form and Structure of Medicaid Managed Care Capitation Rates

Medicaid managed care capitation rates are developed for a specific rating period, which typically aligns with the state's contract year. Rates are usually developed separately for different groups of members, called rate cells, which group people together who have similar risk characteristics, or acuity. These groups are structured to reflect variation in expected costs based on factors such as demographics, geographic location, and qualifying events. Capitation rates can also be developed as a range, consistent with 42 CFR 438.4(c). This means any rate within that range can be paid to MCOs, as long as it meets the federal requirements. Capitation rates are first developed at the statewide level, then MCO-specific adjustments are applied to reflect the differences in member health acuity for each MCO.

Base Data

The base data serve as the foundational starting point for Medicaid capitation rate development. These data include detailed historical information on utilization and unit costs by service categories and enrollment to project the expected future costs. All rate adjustments described in

the following sections are applied relative to the base data, so it is critical to validate the base data to ensure they are appropriate. Key considerations when selecting base data include:

- Time period: Must be from the three most recent complete years prior to the rating period. Typically covers one year.[160]
- Various data sources can be considered:
  - Managed care encounter data: Detailed claim level records submitted by MCOs that include provided services, utilization, and paid amounts under the managed care arrangement.[160]
  - MCO financial reports: Summaries of MCOs' overall revenue, expenses, and other financial information used to understand the costs not captured in FFS claims and encounter data.
  - FFS claims: Historical records of medical claims paid by Medicaid that can be used to develop capitation rates for populations transitioning from FFS to managed care.
- Eligible population and covered services: To ensure the data accurately reflects the eligible population and covered services.

Claim Cost Trends

Trend assumptions reflect the expected changes in the cost of covered services between the base data period and the rating period. Trend is typically comprised of two main components: utilization trend and unit cost trend. The utilization trend captures expected changes in the utilization of services, and the unit cost trend captures expected changes in per unit costs. These trend factors are generally developed as annual percent changes based on historical experience and are applied to the base data to project costs to the rating period. Trend assumptions should not include the impact of adjustments addressed separately, such as programmatic change adjustments described below, so as to avoid double-counting impacts.[161]

Programmatic Change Adjustments

Programmatic change adjustments reflect the expected impact of known changes in policy, benefit coverage, reimbursement arrangements, or program structure that are not captured in claim cost trends. These adjustments are applied to the base data to reflect the differences between the base period and the rating period. When programmatic changes are expected to have material impact, adjustments are developed separately from trend assumptions to itemize the impact and avoid double-counting.

[160] 42 C.F.R. § 438.5(c).
[161] 42 C.F.R. § 438.5(d).

Non-Medical Expenses

Non-medical expenses include costs associated with administration and operations of the Medicaid managed care program that are not included in projected medical claim costs. These expenses typically include administrative costs, care management, taxes, assessments, fees, and underwriting gain. If the state imposes a minimum MLR requirement, non-medical expenses cannot exceed 15% of total capitation payments.[162]

Statewide Medicaid Managed Care (SMMC) Program

Overview

The SMMC program was reprocured through Florida's ITN process. New contracts for the MMA, LTC, and Dental programs were effective February 1, 2025. Federal regulation and guidance require that Medicaid managed care capitation rates are developed for rating periods that align with the contracts for which they are applicable. Furthermore, rate development must align with the populations and services covered under the contract. There were several contract changes made to the SMMC program through the ITN.

Therefore, AHCA was required to produce two different rate packages for RY 2024/2025. The "pre-ITN" rates were effective from October 1, 2024 to January 31, 2025, and reflected populations and services covered under the contract effective for that period. The "post-ITN" rates were effective February 1, 2025 through September 30, 2025, and reflected populations and services covered under the new contract.

At a high level, the rate development methodology was consistent between the pre-ITN and the post-ITN rate development. Where deviations occurred, these were driven by the need to address changes in the contract governing each period. Within each rate development component section, Mercer will detail any differences in the methodology for the pre-ITN and post-ITN rate development.

Mercer also reviewed the rate development processes for the four prior rating cycles (RY 2020/2021 through RY 2023/2024) and noted any further differences between RY 2024/2025 and prior periods.

Rate Structure

AHCA makes capitation payments to the MCOs through two main mechanisms: capitation rates paid for each beneficiary each month by rate cell, and supplemental payments payable to an MCO when one of their members gives birth.

- Rate Cells: Establishing rate cells is a fundamental component in Medicaid managed care capitation rate setting, serving as a critical mechanism to ensure payments accurately reflect the expected healthcare costs of diverse enrollee populations. Rate cells are subgroups of

[162] 42 C.F.R. § 438.5(e).

Medicaid beneficiaries grouped together using characteristics such as age, eligibility status, health condition, or geographic location. Each rate cell is assigned a distinct capitation rate that corresponds to the anticipated cost of providing care to that specific group. The purpose of rate cells is to enhance the precision of payment methodologies, promote equity, and support the financial sustainability of Medicaid managed care programs. From an actuarial perspective, rate cells enable effective risk stratification by grouping enrollees with similar expected utilization and cost patterns for payment purposes.

- Maternity supplemental payment: The use of a maternity supplemental payment is a common practice in Medicaid managed care rate setting, in which states make supplemental payments to the MCOs if a beneficiary gives birth. In this case, the cost to provide the delivery services is removed from the rate cell payments and provided when the delivery event occurs to recognize that the most costly episode of care occurs with the birth.

The following subsections describe the typical rate cell structure used by AHCA in the capitation rates for the SMMC program, as well as any deviations to the typical process that occurred in the RY 2024/2025 post-ITN period.

Managed Medical Assistance (MMA)

The rate cell structure in the MMA program is very consistent throughout the rate years reviewed. Within the rate development process, the contracted actuary distinguishes between rate groups and rate cells. Rate groups are broader rating categories (such as TANF and SSI populations, for example), while rate cells can consist of age and gender breakouts within a rate group. The contracted actuary projects claim cost PMPMs at the rate group level and then applies statewide rate-cell factors to further break the capitation rates into rate cells. Rate cells represent the groupings for which capitation rate payments are made to the MCOs. It should also be noted that there are rate groups for members who qualify for specialty products such as those members identified as having a SMI. Prior to the reprocurement and new contracts, effective February 1, 2025, members who qualified for a specialty product were automatically enrolled in a specialty rate group (and hence rate cell). The tables in Appendix B: Rate Cell Groups and Rate Cells shows the rate groups and rate cells within the MMA program.

Additionally, there were consistently 11 rating regions within the SMMC program prior to the reprocurement. After the reprocurement, the rating regions changed, with a total of nine rating regions. A map showing these changes in regions is included as Appendix C: Previous and Current SMMC Regions.

Deviations in the Rate Year 2024/2025 Rating Period – Managed Medical Assistance (MMA)

Due to the reprocurement and new contracts, effective February 1, 2025, main updates to the rate cell structure were the updated rating regions (from 11 to nine, as noted previously) and a change in the rate structure for members who qualify for a specialty product.

For members who qualify for specialty products, they will no longer be automatically enrolled in the specialty product. Members now have to opt in to the specialty product. As a result, MCOs receive a capitation payment additional rate cells are now applicable for members who opt into the specialty product versus those who do not.

Long-Term Care (LTC)

To be eligible for the LTC program, members must be at least 18 years old and eligible for placement in a nursing facility as assessed by the Department of Elder Affairs. The rate cell structure in the LTC program is the same for all rate years. Capitation rates are developed separately for the HCBS and non-HCBS rate groups within the LTC program. The HCBS rate group largely consists of members who do not reside in a long-term care or hospice facility, while the non-HCBS rate group consists of beneficiaries who do reside in one of those facilities.

For payment purposes, these separately developed rates are blended together each month based on the distribution of HCBS and non-HCBS members in a given month. Within the RY 2024/2025 rate year (both pre-ITN and post-ITN), the non-HCBS rates are developed separately for members dually eligible for Medicaid and Medicare and those that are not dual eligible. The monthly blend between the HCBS and non-HCBS rate groups includes a dual and non-dual split. In rate years prior to RY 2024/2025, the non-HCBS rate group did not distinguish between dual and non-dual members. Due to the re-procurement effective February 1, 2025, the only modification in the rate cell structure in the LTC program is that the number of regions went from 11 to nine, consistent with the update for MMA.

Dental

The rate cell structure for the dental program remained consistent in all rate years. The only modification was in the RY 2024/2025 post-ITN period, in which the number of regions went from 11 to nine, consistent with MMA and LTC programs.

Base Data

Typical Approach

The contracted actuary developed the base data for each program (MMA, LTC, and Dental) separately but employed a consistent overall approach across programs.

The base data period selection balances the need for the data to be available and relatively complete against the need for more substantial trend adjustments when selecting an older time period. The base data selected for rate development by the contracted actuary has varied year-to-year based on contract start dates and efforts to avoid atypical utilization patterns. The contracted actuary typically selected a 12-month base period and avoided the use of the CY 2020 time period as base data, as it was heavily affected by the COVID-19 pandemic. In certain programs, years, and regions, the base data covered only 11 months due to the start date of contracts from the prior ITN process in late 2018 and early 2019. In these cases, an adjustment was applied to annualize the data and account for seasonal utilization patterns

- Across programs, the contracted actuary utilized the following primary data sources, commonly employed in managed care rate development:
- Eligibility data: Provided by AHCA, this data identifies members' Medicaid eligibility and program enrollment information.

- Encounter data: Reporting through the Florida Medicaid Management Information System (FMMIS), this data captures the services provided to the members, used for services paid on an FFS basis.
- Financial submissions: Achieved Savings Rebate (ASR) financial reports provide financial data for each program and are used for services not paid on an FFS basis and also serve to validate and adjust encounter data.

The contracted actuary also utilized additional data sources, as needed, to support changes in the program. For example, FFS claims data is used as the base data for services that were previously excluded from managed care contracts and paid through FFS, but would be covered by the managed care plans in the contract period. Additionally, in older rating periods, the contracted actuary relied on special encounter feeds instead of the FMMIS due to the early stage of encounter reporting to the Agency.

These data sources were integrated to produce the primary base data metrics: member months (MMs), service utilization, unit costs, and PMPM costs by region, rate cell, and service category.

The contracted actuary applied specific exclusions to the base data to ensure alignment across all data sources and to reflect the populations and services specific to each program. The contracted actuary and AHCA performed data validation processes to ensure accuracy and consistency.

The contracted actuary also made adjustments to the base data including adjusting the encounter data to align with ASR totals, removing claims costs for non-state covered services, taking into account services that have been provided in the base period but for which payment is not yet received, costs covered through third party liability, and removal of extended stays in IMD.

Deviations in Rate Year 2024/2025 Post-ITN

The overall base development process for the RY 2024/2025 rate development was very similar to the prior rating periods that were reviewed.

In comparing the post-ITN and pre-ITN base data processes, they were largely consistent across both periods. In fact, each part of the base data process was identical except for these key differences:

- BA services (MMA only): BA services were incorporated into the MMA managed care program only in the post-ITN contract. Consequently, FFS claims data for these services were excluded from the pre-ITN base data but included post-ITN. The time period used for the base data BA services and all other categories of medical services was the same.
    - The member months displayed on the BA service category line in the contracted actuary's accompanying rate exhibits did not match those displayed for other service categories, creating discrepancies in the total lines. There was no documentation explaining this deviation. Absent an explanation, we would expect the time periods to be consistent for the BA services base data and member months, and the member months not to vary by service category.

- ASC/Outpatient services: Certain outpatient and ASC services previously covered under MMA or FFS were reassigned to the dental program in the post-ITN contract. These services were excluded from the pre-ITN dental base data but included post-ITN. Although these services appeared in MMA base data for both periods, post-ITN MMA rate development adjusted to remove them.
- SMI and HIV Case-Finding Algorithm (MMA only): New algorithms for SMI and HIV were introduced post-ITN. Consequently, member experience for these populations were reclassified into new rate cells in the post-ITN base data.
- Regional Restructure: (all programs): The post-ITN contract consolidated the previous 11 regions into nine, combining historic Regions 1 and 2 into Region A, and Regions 3 and 4 into Region B. Other regions were renamed but remained unchanged.

Public Health Emergency Population Acuity Adjustments

The COVID-19 public health emergency (PHE) and related maintenance of effort (MOE) requirements led to unprecedented increases in Medicaid enrollment. Both the MOE requirements and the subsequent unwinding significantly influenced the health acuity — the expected healthcare needs and costs — of the enrolled population. Actuarial adjustments to Medicaid managed care rates were necessary to reflect these changes.

Beginning in March 2020, MOE provisions halted typical disenrollment processes, causing Medicaid enrollment to surge by over 50% in Florida's MMA program. This enrollment increase included many lower-acuity (lower-cost) members who otherwise would have disenrolled. Effective March 31, 2023, the MOE requirements ended, and states resumed eligibility redeterminations over a 12-month period. Enrollment decreased, and average acuity increased as lower-acuity members disenrolled. Not all disenrollments during unwinding represent "excess" enrollment during MOE. Disenrollments occur in "normal" periods, and a portion of the disenrollment during the unwinding reflects normal churn.

When there are significant changes in enrollment, it is actuarial best practice to consider prospective acuity adjustments for the change from the base period to the rating period. The Centers for Medicare and Medicaid Services require documentation of how the PHE and subsequent unwinding are addressed in rate development.

The development of acuity adjustments varied based on how the base data period and the rating period fit into the timeline of the PHE and subsequent unwinding. There was, therefore, no "typical" approach across rating periods.

Rate Development Approach of Rate Year 2024/2025 Post-ITN

The base data period of SFY 2022/2023 included "excess" members enrolled due to MOE, while the rating period reflected a post-unwinding environment.

The contracted actuary applied acuity adjustments to the MMA and Dental programs, but did not apply adjustments to the LTC program, justified by stable enrollment and eligibility criteria that is

tied to medical necessity. The adjustment methodology was similar for MMA and for dental non-medically needy:

- Excluded certain groups (new enrollment within 12 months, members who died, postpartum coverage expansions)
- Reassigned members to updated rate groups to reflect eligibility changes at redetermination
- Classified remaining members as redetermined and found ineligible if they had multiple months without Medicaid enrollment after unwinding began
- Calculated the base period PMPM costs before and after removing the members classified as redetermined and found ineligible, to quantify adjustment impact

The adjustment effectively removed 100% of members classified as redetermined and found ineligible and did not differentiate between “excess” members and “normal” churn.

The dental medically needy group was adjusted separately due to monthly eligibility determinations and significant monthly enrollment churn.

Rate Year 2024/2025 Post-ITN versus Pre-ITN

The RY 2024/2025 post-ITN and pre-ITN rate developments used the same base data period, and both rating periods are after the conclusion of PHE unwinding. They used identical methodologies, with the following deviations:

- MMA: The aggregate impact quoted in the rate certification is identical between the two rating products; however, the factors by rate cell vary between the rating periods.
- Dental: The aggregate impact and the rate cell impacts vary slightly between rating periods

Trends and Projected Benefit Costs

Once base data is established, it is necessary to project costs into the contract period. This is done through application of trend factors, program changes, and other prospective adjustment factors. Trend factors are intended to capture underlying utilization pattern shifts and cost growth within the program, absent any updated policies. Program changes reflect policy decisions or structural modifications to the program that are intended to alter eligibility, benefits, reimbursement arrangements, or delivery requirements. Other prospective adjustment factors address contractor specific changes or expected efficiencies, such as plans having lower contracted fees or reducing total cost of care with a robust care management program. Together, these factors help fine tune capitation rates for the contract period. They help ensure payment rates reflect expected changes in utilization, cost, or financial risk, and as a result informing the program budget for the contract period.

This subsection describes the typical process used by the contracted actuary to project benefit costs and any variations that occurred in RY 2024/2025.

The contracted actuary documents the development of trend assumptions and other projection factors in the certification report to support the projection of base period data to the rating period. These adjustments are described below.

Trend

Trend factors are typically developed separately for utilization changes and unit cost changes. Trends, or trend factors, are typically displayed as annualized factors. These are then applied from the midpoint of the base period to the midpoint of the rating period by compounding the factors for the length of the projection period.

Typical Process

The contracted actuary develops separate trend assumptions for utilization and unit cost through a review of various data sources, including multiple years of Florida program experience, market research to consider drug pipeline changes, and experience in other state Medicaid programs. The contracted actuary also considered its proprietary model based on nationwide trend research for dental trend development. Some immaterial programmatic changes occurring between the base period and the rating period may be implicitly reflected within these utilization or unit cost trend assumptions. Other material programmatic changes are applied explicitly as a separate adjustment.

In MMA, utilization trends vary by service category grouping, but only vary by rate group or rate cell for certain services:

- Pharmacy varies by rate group and by rate cell for TANF Non-SMI
- Private duty nursing and nursing facility vary by rate group
- Acute services (inpatient, outpatient, professional) are applied uniformly to all rate groups
- BA services (RY 2024/2025 post-ITN only) are applied by rate cell and region

Unit cost trends are developed similarly, except unit cost projections for certain services that are subject to changes in the Florida Medicaid fee schedule. These changes are addressed separately, explicitly accounting for the differences in fee schedule from base period to rating period. Fee change factors vary by region and rate group or rate cell.

In the LTC program, both utilization and unit cost trends vary by service category but are applied uniformly by rate group and occasionally vary by region. Aggregated regional trend factors are based on projected service mix distribution.

In the Dental program, both utilization and unit cost trends vary by service category grouping but are applied uniformly by rate group and region.

Deviations in Rate Year 2024/2025 Post-ITN

The selected annualized trend factors either vary slightly or are identical between the RY 2024/2025 pre-ITN and post-ITN period. Such variations appear reasonable given the

different projection periods, particularly for pharmacy, as the expected drug pipeline includes additional changes in the later period.

The length of the projection period also varies between the two rating periods. They both have the same base period with a midpoint of January 1, 2023. The pre-ITN rating period has a midpoint of December 1, 2024 and the post-ITN rating period has a midpoint of June 1, 2025. Therefore, the factors are applied for 23 months in the pre-ITN rates and for 29 months in the post-ITN rates.

BA services were applicable only to the post-ITN rating period for MMA. The utilization trend development and application varied significantly from other services. The contracted actuary first trended the SFY 2022/2023 data to reflect actual experience from a more recent period (August 2023 through July 2024) and then projected forward the additional 16 months to the rating period. The prospective trend was based on the observed historical trend by region and separated by CMS Plan versus all other rate groups. The total trend varied by region and rate cell.

Managed Care Adjustments

Provider Contracting Adjustment

This MMA program adjustment reflects changes in managed care plan payment levels relative to Florida Medicaid FFS reimbursement rates between the base period and the rating period. The adjustment is intended to capture shifts in how plans contract with providers, independent of other pricing elements like trend. This adjustment is developed and applied similarly across all rate years reviewed. The contracted actuary developed plan-specific contracting factors by region, eligibility, and broad service category using a combination of encounter data, ASR financial data, and a reimbursement survey. This adjustment also takes into consideration any applicable state directed payments, including minimum and maximum fee schedules imposed by the State.

For RY 2024/2025 post-ITN, additional adjustments were made to account for the reprocurement, including plans exiting the MMA program, entering the MMA program, or expanding into new regions.

Managed Care Savings Adjustment

This adjustment accounts for negotiated commitments made by the plans in the managed care contracts through the ITN process to reduce medical costs by having improved medical outcomes through managed care initiatives and case management. These commitments have changed with each new contract implementation and include incremental improvements or cost reductions for each additional year within the contract. These commitments are, therefore, compounded based on the number of years from the base period to the rating period.

The RY 2024/2025 pre-ITN and prior rating periods were subject to efficiency commitments to reduce potentially preventable events and improve birth outcomes. The RY 2024/2025 post-ITN rating period was subject to overall managed care savings and improving birth outcomes. The adjustment varied from pre-ITN to post-ITN due to the changes in the contractual requirements.

Program Changes

The rate certifications include various projection factors to account for program changes between the base period and the rating period. In general, a rate-setting exercise seeks to reflect all material changes from the base period to the rating period, including contractual changes, policy changes, new legislation, and changes to the people and/or services covered under the contract.

The methodologies for program changes vary depending on the type of program change and the data available. Methodologies appear fairly consistent across rate years for similar types of changes.

Items Specific to Rate Year 2024/2025 Post-ITN

There are a variety of program changes that were specific to the post-ITN period due to changes in the terms of the contract effective after the ITN or the difference in the time period covered under the rates. These include:

- Carve-in of BA services, as documented in other sections of this report (MMA only)
- Medicaid fee schedule changes from SFY 2024/2025 to post-ITN RY 2024/2025 due to the rating period including months after the conclusion of SFY 2024/2025
- Change in the auto-assignment policy for voluntary members in MMA. Voluntary members are given the choice of enrolling in MMA or remaining in FFS. If no active choice was made, these members historically remained in FFS; however, under the new contract, these members are enrolled in MMA. This change was expected to have an impact on the enrollment volume and relative cost acuity
- The carve-out of certain dental services in an outpatient hospital or ASC setting from MMA (the carve-in of those same services to dental are covered in the base data)

Seasonality

Benefit service utilization can vary throughout the year. For example, flu season and back-to-school can lead to utilization in particular months that vary from the average within a year. This variance is referred to as seasonality. Seasonality adjustments were applicable to both the pre-ITN and post-ITN RY 2024/2025 rating periods, as they both covered non-annual periods. The adjustments varied by rating period based on the months covered within each.

Risk Adjustment

Capitation rates are typically set as an average across multiple MCOs for each rating region and rate cell. Once the regional rates are set, risk adjustment is a common practice in Medicaid managed care rate setting to adjust the rates to be MCO-specific. Risk-adjustment processes generally use a risk-adjustment model and methodology to compare the health status of each MCO’s enrolled populations, which forms the basis for the adjustment. Per federal regulations, the application of risk-adjustment in capitation rate setting must be budget neutral, which means

the total projected costs for the State are the same before and after the application of risk adjustment.

In the SMMC program, risk adjustment is applied to the capitation rates for the MMA and LTC programs. As noted previously, risk adjustment is a common practice used in capitation rate setting to adjust regional average capitation rates to be MCO-specific. Based on a comparison of the health status characteristics of each MCO's enrolled population, the risk adjustment process adjusts the regional average capitation rates to be higher for MCOs with higher relative disease burden and lower for MCOs with lower relative disease burden. Important considerations in a risk adjustment methodology include, but are not limited to, the following:

- Selection and calibration of an appropriate risk adjustment model
- Applicable rate cells to which risk adjustment is applied
- Implementation schedule and frequency of updates
- Data collection and validation

This subsection provides a description of typical risk adjustment process used by the contracted actuary, and deviations that occurred due to the reprocurement effective February 1, 2025.

Managed Medical Assistance (MMA)

Within the MMA program from RY 2020/2021 through RY 2024/2025, the contracted actuary administered a consistent risk-adjustment process described below. Due to the RY 2024/2025 post-ITN rate update, deviations to the typical process occurred. See below for a summary of the approach used for different components of the risk adjustment process, followed by a subsection on deviations made for post-ITN RY 2024/2025 period:

- Risk adjustment model: The contracted actuary used the publicly available, academically developed, Chronic Illness and Disability Payment System with Medicaid Rx (CDPS+Rx) risk adjustment model in all rate years reviewed, with periodic adjustments to the model to optimize its predictive accuracy. The CDPS+Rx risk adjustment model was created by researchers from the University of California, San Diego, and was built for Medicaid populations. CDPS+Rx uses diagnosis information and demographics to assess the health status characteristics of each MCO's population.
- Rate cells subject to risk adjustment: The contracted actuary has consistently applied the risk-adjustment process to the same rate cells throughout the rate years reviewed.
- Implementation schedule and frequency of updates: The contracted actuary updates MMA risk adjustment calculations on a quarterly basis. In a typical year, the risk-adjustment factor calculations are done prospectively, in that they are completed and implemented prior to the effective date of the calculations.
- Data collection and validation: The contracted actuary employs a consistent and thorough data validation process with the MCOs that has been consistent for all rate years.

Deviations in the Rate Year 2024/2025 Post-ITN Period

Due to the reprocurement and new contracts effective February 1, 2025, there were several special considerations for the RY 2024/2025 post-ITN rates.

- Risk adjustment model: With the addition of BA services into the contracts and capitation rates, the CDPS+Rx model calibration was updated to include these services.
- Retrospective risk adjustment: Due to the reprocurement and the uncertainty of MCO enrollment patterns a retrospective risk adjustment process was performed. In this process, final risk-adjustment factors were calculated after enrollment into each MCO was known. This differs from the typical prospective calculation done by the contracted actuary, in which enrollment from a prior month is used to support a calculation to be used in a future period.
- Risk adjustment of BA services across rate cells in a region: Within the SMMC program, the CMS Plan is a specialty plan that only covers certain children with chronic health conditions, and historically this plan has not been subject to the risk adjustment process (a standalone rate is set for the CMS Plan). Once the RY 2024/2025 post-ITN period began, there were unanticipated shifts in members migrating to the CMS Plan, and this necessitated an update to the distribution of BA service PMPMs across rate cells and rate groups within a region. As a result of this, the contracted actuary applied a special BA risk-adjustment process to redistribute BA service-related PMPM costs to different rate cells and rate groups within a region on a budget neutral basis. After the BA costs were shifted across rate cells and rate groups within a region, the typical CDPS+Rx risk adjustment process was applied to the capitation rates.
- Risk adjustment across the specialty and non-specialty products: Members eligible to enroll in specialty products have to voluntarily opt in to the specialty product as a result of the reprocurement. Due to uncertainty in knowing which members would enroll in the specialty product, the contracted actuary used actual enrollment in the specialty and non-specialty products to risk adjust the capitation rate specific to the specialty and non-specialty products.

Long-Term Care (LTC)

Within the LTC program, a customized HCBS risk-adjustment process was first applied in RY 2023/2024. This customized HCBS risk-adjustment process uses functional assessment data for members in the LTC program to predict costs specific to the HCBS rate group within the LTC program. The general process applied was generally consistent for the two years reviewed (RY 2024/2025), with expected differences due to ongoing maintenance of the model and the use of more recent data.

Specific to the RY 2024/2025 post-ITN period, HCBS risk adjustment scores were updated based on more recent assessment data than the pre-ITN period and also a retrospective process was done, in which April 2025 was used to classify members into an MCO, compared to a prospective process performed in the pre-ITN period.

Dental

Capitation rates in the dental program are not subject to risk adjustment. This is consistent for all rate years, from RY 2020/2021 through RY 2024/2025.

Non-Medical Expenses

In addition to benefit expenses, capitation rates include provisions for administrative expenses, cost of capital, and a margin for potential vulnerability or contingency.

Administrative Expense

Typical Process

The development of projected administrative expenses is similar across the three programs and across recent rate years. The contracted actuary considers contractual changes, changes in cost over time, staffing and non-staffing administrative requirements, and overall program context. The contracted actuary summarized administrative expense data from a prior period for the program, adjusted for contractual requirements and data anomalies, removed non-allowable expenses, and trended the data forward to the rating period. For the MMA and LTC programs, the administrative expenses were reported across both programs, and the projected administrative expenses, therefore, had to be allocated between the two programs.

The RY 2024/2025 rates (both pre-ITN and post-ITN) also include adjustments for the changes in enrollment due to the PHE unwinding. As some administrative expenses are fixed costs and some are variable with membership, claims volume, etc., it is appropriate to adjust for large changes in enrollment.

The projected administrative expense is then allocated to rate cells. For the MMA program, the administrative expense PMPMs differ by member eligibility and age grouping, reflecting differences in member characteristics and expected administrative intensity, but do not vary by region. For each of the LTC and dental programs, the same PMPM is applied uniformly across all regions and rate cells.

The CMS Plan administrative expense also included provision for additional administrative requirements performed by the Department of Health.

Rate Year 2024/2025 Post-ITN versus Pre-ITN

The administrative expense development for the LTC program and the dental program was similar for the pre-ITN and post-ITN periods. However, for the MMA program, there were changes in the contract post-ITN that necessitated an adjustment.

All SMMC programs post-ITN contracts included new negotiated administrative cost efficiencies. The administrative expense PMPMs were reduced to reflect these efficiencies. The MMA program also included considerations for additional case management caseloads for specialty products and administrative costs associated with the carve-in of BA services.

The post-ITN rates were further adjusted mid-rating year, effective July 1, 2025, to remove the CMS Plan provision for Department of Health administration due to legislation that transitioned the responsibility to AHCA.

Underwriting Gain

Capitation rates include provisions for cost of capital and the level of potential vulnerability in the program. Plans need to hold capital to meet payment obligations and solvency requirements. The rate certifications refer to this provision as the “gain/loss margin.”

The gain/loss margin was 2% of revenue for all rate groups and regions, for MMA and dental across all rate years reviewed, and for the LTC program, for all rate years through the RY 2024/2025 pre-ITN period. The LTC program margin was reduced to 1.5% in the RY 2024/2025 post-ITN rating period. The change is documented as being the result of negotiations between the Agency and the LTC plans in the new contract.

Special Contract Provisions

AHCA employed special contract provisions that must be considered by the actuary in terms of developing the capitation rates. These include all applicable risk-sharing programs, incentive programs, withhold arrangements, and state-directed payments. These special provisions must be considered by the actuary in developing the capitation rates. Below is a description of these arrangements applicable to the SMMC contracts and rates.

Risk-Sharing Mitigation

In its contracts with the MCOs, AHCA has included three programs to mitigate risk to the State and the MCOs. These three programs are the risk corridor for behavioral analysis services, achieved service rebates, and a risk pool for prescribed drugs.

Risk Corridor for Behavioral Analysis Services

With the carve in of the BA services, AHCA and the contracted actuary implemented a one-sided risk corridor to limit financial risk to AHCA should the amount included for the provision of these services in the capitation rates be excessive compared to the actual cost to provide the services in the post-ITN rate period. Since the pre-ITN rates did not include the BA services, the risk corridor was not included. The contracted actuary cited the need for a risk corridor to protect against significant deviation in expected cost. The one-sided corridor was used in place of implementing a managed care saving assumption in rate development, meaning that the contracted actuary did not reduce the expected cost of BA services for managed care efficiencies, but rather, implemented a risk corridor that allows AHCA to collect a portion of the capitation rates back from the MCOs if actual cost is lower than what was included for these services in the capitation rates. As of the writing of this report, there is no information on whether the RY 2024/2025 period resulted in savings.

Achieved Savings Rebate (ASR)

Florida statute requires AHCA to implement an achieved savings rebate in its Medicaid managed care programs. Under this requirement, AHCA is required to collect funds from the MCOs if they achieve significant profits under the program. Under the ASR program, MCOs retain 100% of the margin percentage up to and including 5%; retain 50% of the margin percentage above 5% and up to 10%; plans do not retain any of the margin percentage above 10%. Plans that exceed agency-defined quality metrics in the reporting period may retain an additional 1% margin percentage. Because this is a long-standing statutory requirement, no changes were made in the RY 2024/2025 pre-ITN and post-ITN contracts.

Withholds

Prescribed Drugs High-Risk Pool (PDHRP)

The PDHRP is a budget-neutral risk pool, whereby a portion of the capitation rates is withheld and set aside to fund a pool that can be paid to the MCOs upon certain conditions. The rationale for such a risk mechanism is to address members that have high-cost drug needs and potential vulnerability that these high-cost members may not be evenly distributed among the MCOs. Withholding these funds allows AHCA to address the variance in actual experience among MCOs while maintaining a budget-neutral approach.

To be considered for the PDHRP, the MCO's member must exceed a threshold of prescription drug expenses within the rate or contract year ($400,000 in RY 2023/2024 and RY 2024/2025, and $350,000 in prior periods). Once the threshold is met, the PDHRP reimburses the MCO for 80% of the additional drugs costs above the threshold. The terms of the withhold did not change between pre-ITN and post-ITN rate development. This risk pool has been in effect since February 2019. Withhold percentage varies by rate cell but not region.

Cell and Gene Therapy Separate Additional Payment

This separate additional payment was implemented to address specific new, high-cost, low-utilization Cell and Gene Therapies (CGTs). CGTs are typically administered once and are expected to be used by a very small group of members. However, the cost for these CGTs can reach millions of dollars. Low use coupled with the high cost creates significant financial risk to AHCA and MCOs if not for this payment to address the volatility. The payment is in addition to the PDHRP and covers the $400,000 threshold, plus 15% of the cost that exceeds the threshold, with the calculations based on wholesale acquisition cost for each listed drug. This change was made after the start of the post-ITN RY 2024/2025 rates.

Rate Finalization and Communication

As part of this project, Mercer submitted written questions to AHCA and the SMMC plans to collect information on the rate development and communication process, as well as similar questions regarding discussions for the pre-ITN and post-ITN rates. AHCA provided information on the timing for developing annual capitation rates in a typical year and RY 2024/2025 and their communication with the MCOs.

Typical Rating Year

AHCA and the contracted actuary engage the plans throughout the rate development process, allowing opportunities for plans to review and confirm their plan's base data to ensure that it is appropriately aligned.

- The contracted actuary requests data from the MCOs, including ASRs, provider contracting information, and encounter data.
- MCOs have an opportunity to review and comment on their own base data and respond to questions regarding the data to ensure that it is accurate and appropriate for use in rate development.
- The contracted actuary and AHCA host all-MCO meetings as well as opportunities for individual meetings with the MCOs.
- MCOs may submit written feedback on rates for consideration by AHCA and the contracted actuary, but the rates are not negotiated.
- When rates are finalized they are provided to the MCOs, as well as a rate development methodology letter and a Q&A document that includes responses from the contracted actuary to the MCOs regarding their questions and feedback.

Rate Year 2024/2025

- In RY 2024/2025, there were two separate contracts and rates: pre-ITN and post-ITN.
- There were no individual MCO meetings due to the ongoing ITN process.
- The contracted actuary hosted rate presentations draft and post-ITN rates in September 2024, final pre-ITN rates were shared with the MCOs.
- December 2024, final post-ITN rates were shared with the MCOs, and the contracted actuary hosted a rate presentation.
- Unlike a typical rating year, the ITN process allowed for MCOs to submit managed care efficiency factors that ACHA and its contracted actuary implemented to reduce the capitation rates.
- The start date for the new contract cycle differed from prior years as result of the ITN process and resulting federally-required readiness reviews,and was not known until summer of 2024.

Programs of All-Inclusive Care for the Elderly (PACE) Program

Federal requirements (42 CFR 460.182) state that Medicaid rates for the PACE population must be less than the amount that would otherwise have been paid (AWOP) for a comparable

population age 55 years or older, meeting nursing facility level of care criteria if they had not been enrolled in PACE. The rates and AWOPs must be set in accordance with the state plan.

Florida uses the contracted actuary to calculate the AWOP. To estimate the AWOP, the services are considered in three separate categories for an equivalent non-enrolled population group:

1. LTC services covered by Medicaid.
2. Acute care services covered by Medicaid.
3. Dental services covered by Medicaid.

The projected nursing home and HCBS components, plus the acute care and dental services, are blended to establish the AWOP. The agency may implement separate AWOP for dual-eligible and Medicaid-only PACE enrollees or other subgroups.

After the AWOP amounts are calculated, the Agency will negotiate with PACE organizations a PMPM payment rate based on a percentage of the PACE AWOP.

The contracted actuary developed the AWOPs in accordance with the federal requirements and the state plan.

Amount That Would Otherwise Have Been Paid (AWOP) Methodology

The contracted actuary considered services in three categories:

1. LTC services covered by Medicaid for the population
2. Acute care services covered by Medicaid for the population
3. Dental services covered by Medicaid for the population

Long-Term Care (LTC) Services Covered by Medicaid For the Population

To develop the SFY 2025/2026 LTC costs, the contracted actuary started with the projected February 1, 2025 through September 30, 2025 (RY 2024/2025), LTC costs for the SMMC LTC program population. The seasonality factor was removed to account for the partial year base. Four adjustments were then applied:

Acute Care Services Covered by Medicaid For the Population

Similar to the LTC costs, to develop the SFY 2025/2026 acute care costs, the contracted actuary started with the projected RY 2024/2025 costs, but this time, acute costs were used for the SMMC MMA program population. Seasonality was removed, and then additional adjustments were made.

Dental Services Covered by Medicaid For the Population

To develop the SFY 2025/2026 dental costs, the contracted actuary started with the projected RY 2024/2025 dental costs for the SMMC dental program population. Seasonality was removed and further trend was applied to account for an additional seven months.

Other Considerations in Amount That Would Otherwise Have Been Paid (AWOP) Development

The AWOP must consider all costs to the State that would have otherwise been paid. This includes carved-out services paid on a FFS basis as well as considerations for rebates collected that would reduce the cost to the State.

Cost Components

The total projected cost was calculated as the sum of the LTC, acute care, dental costs, carved-out services, and the downward adjustment for rebates.

Retention Load

To finalize the AWOP, an administrative cost and gain/loss margin load is applied.

Program of All-Inclusive Care for the Elderly (PACE) Capitation Rates

The final PACE rates were set below the AWOP, consistent with 42 CFR 460.182 and the state plan.

Non-Emergency Transportation Waiver (CNET) Program

Federal Requirements and Actuarial Best Practices

The two transportation vendors for the CNET program are considered Prepaid Ambulatory Health Plans. Federal requirements that apply to the non-emergency medical transportation Prepaid Ambulatory Health Plans are found in 42 CFR 438.9 and include the actuarial soundness requirements of the managed care plans discussed above. Many of the same ASOPs also apply, particularly ASOP 5 (Incurred Health and Disability Claims), ASOP 23 (Data Quality), and ASOP 49 (Medicaid Managed Care Capitation Rate Development and Certification).

Therefore, Mercer's review of the CNET rate development processes is similar to the review of the other managed care plans as described above.

Calendar Year 2025 Non-Emergency Transportation Waiver (CNET) Rate Development Approach

The rates for the two transportation vendors were developed separately by the contracted actuary; however, the overall process of rate development is similar for both. Our commentary below will apply to both unless otherwise noted.

The analysis was focused on the rates for CY 2025. The prior three rating periods of August 2021 to July 2022, August 2022 to December 2023, and CY 2024 were also reviewed. The rate development process followed by The contracted actuary has been generally consistent from year to year, and our commentary below will apply to historical practices as well as the most recent year unless specified.

Base Data

Data Sources

The contracted actuary collected all of the required data to use in the development of the CNET rates. The primary sources of data are eligibility data provided by the Agency and historical program FMMIS encounter data. Financial data from the vendors is also collected from the CNET vendors to support validation of the encounter data and to inform administrative cost assumptions.

The contracted actuary used 12 consecutive months of experience covering calendar 2023 as the base data for rate setting. For the CY 2025 rates, this data was within the three years prior to the rate period and was collected six months after the close of the time period, meaning that the data were reasonably complete and this minimized the IBNR adjustment.

Data Validation

The contracted actuary performed validations on all data sources received. Summaries of the base data were provided to the Agency and vendors for review. Meetings were held with representatives of the plan to ask questions and explain or correct data as needed. The financial data was found to be consistent with the encounters. Through these steps, the contracted actuary determined that the base data was appropriate for rate setting.

Data Adjustments

Several adjustments were determined to be needed to ensure the base data was complete and free of errors.

Duplicate Record Removal

The eligibility and encounter data was found to contain duplicate records. The data was examined for any cases of duplicate records, and these were removed such that the most recent

and complete record was retained. This is an appropriate step to ensure the historical data does not overstate the expenses incurred.

Exclusions For Non-Eligible Claims

The contracted actuary compared the encounter claims to the eligibility data and removed any paid claims if the member was not eligible when the claim was incurred. As rates are developed on a PMPM basis, this ensures that the costs do not overstate the average per person cost.

Incurred But Not Reported Claims

A small adjustment of less than 1% is applied to the data to account for claims that were likely incurred during the base data time period but have not yet been paid. A small adjustment is reasonable given that the base data were collected six months after the end of CY 2023 to allow for additional claims to be paid and reported.

Third Party Liability

An adjustment of 1% to 2% is added to the medical cost to account for claims paid for services to members who are enrolled in managed care plans. These claims are not the responsibility of the CNET vendors, as these members are in managed care and the cost should fall to the MMA MCO. The contracted actuary cites difficulty in CNET vendors recouping these costs.

Redetermination Acuity Adjustment

The agency completed a redetermination of Medicaid eligibility following the end of the COVID-19 PHE. The base data used for CY 2025 rate setting contains the experience of many members who were disenrolled as part of this process. The contracted actuary evaluated the impact to program costs due to this and has included a rate adjustment to reflect increased average acuity of the remaining group.

The contracted actuary used the actual disenrollment data to measure the difference in utilization between the leaving and staying groups. Consideration is given to new members, deaths, and postpartum coverage changes.

The Prescribed Pediatric Extended Care (PPEC) rates were not adjusted for redetermination, and the nature of the population's eligibility is cited as the reason. These are children with complex medical needs, and unlikely to lose Medicaid eligibility. However, the provided exhibits show a drop in PPEC membership during CY 2023. Annual member months were between five and 6,000 for this time period and had been between six and 7,000 in years prior.

In prior years, the effects of the PHE were also accounted for:

1. The August 2021 to July 2022 rates were developed from pre-pandemic experience, and adjustments were included to reflect depressed utilization due to the COVID-19 pandemic, as well as increased enrollment due to the public health emergency.

2. The August 2022 to December 2023 rates were not adjusted as the base data time period and rating period are similarly impacted by the pandemic and PHE.
3. The CY 2024 rates were adjusted for the impact of the PHE unwinding using redetermination data.

Trend

The rate documentation describes how trend is informed by data from the United States (US) Energy Information Administration, Bureau of Labor Statistics, and historical CNET vendor experience. The unit cost trend is derived from a weighted average of inflation data, and the utilization component is an overall expectation of medical costs.

Non-Medical Expenses

The non-benefit component of the CNET rates includes administrative costs and an allowance for risk margin/cost of capital, or “profit margin.”

The contracted actuary documents using historical plan administrative cost data to develop the assumption for the rates, and inflation data is used to project these costs to the rating period.

The administration costs are separated into fixed and variable to better allocate the costs between the non-PPEC and PPEC rates. This was based on a review of the reported cost categories.

It is important to note that NEMT PAHPs are exempt from the federal rule that specifies a medical loss ratio (MLR) of 85% must be reasonably achievable for capitation rates to be considered actuarially sound.

Risk Corridor and Other Special Contract Payment Provisions

The agency has created a two-sided risk corridor for the CNET program. The agency will compare the actual medical expenses for each vendor over calendar 2025 compared to the rates paid and will assume the majority of the gain or loss outside of a 3% window of the expected expenses.

The CNET has no other special contract provisions such as withholds or pass-through payments. This is properly documented in the rate certification.

Intellectual and Developmental Disabilities Comprehensive Managed Care (ICMC) Program

RY 2024/2025 was the first year of rate development for the ICMC program, with the pilot effective October 1, 2024, for individuals in regions I and D. The ICMC program includes comprehensive coverage for individuals with intellectual and developmental disabilities.

The ICMC managed care program will cover services otherwise covered by SMMC, the LTC program, and the iBudget program, which is an HCBS waiver for individuals with intellectual and developmental disabilities. Coverage for SMMC and LTC programs, as described above, is consistent for the ICMC program. The services from the iBudget waiver covered under this program include:

- Behavior services
- CDC consultant
- Dietitian services
- Life skills development Level 1 (Community Inclusion)
- Life skills development Level 2 (Supported Employment)
- Life skills development Level 3 (Adult Day Training)
- Residential habilitation behavior focus
- Residential habilitation intensive behavior
- Residential habilitation live-in
- Residential habilitation standard
- Specialized mental health counseling
- Supported living Coach

Due to the limited size of membership within the ICMC program, there is only a single rate cell for each region within this program.

Base Data

The ICMC program is a pilot managed care program starting in RY 2024/2025. Data from the iBudget waiver program and SMMC LTC and MMA programs were used to develop base data. Although a specific subset of individuals for regions D and I could enroll in this program, there is not a specific list of individuals identified prior to implementation. As a result, no specific base data is available for the pilot population. The base data used to develop the initial RY 2024/2025 rates is a combination of data from several sources.

Population Acuity

The ICMC rates for RY 2024/2025 were developed without having experience specific to the population included in the ICMC program. Because the base data used for this program was not specific to the target population, the contracted actuary reviewed the base data to determine reasonability for the target population. Based on this review, adjustments were made.

Trends and Projected Benefit Costs

Because LTC and MMA RY 2024/2025 projected costs are used as the base data for those portions of the ICMC program, capitation rate, utilization trend, unit cost trend, and other adjustments are already reflected in the projected costs, as described in those respective sections above.

Risk Adjustment

Risk adjustment is not applicable to the ICMC program.

Non-Medical Expenses

The non-benefit component of the ICMC rates include administrative costs and an allowance for risk margin/cost of capital. The administrative allowance for this program is based on the administration allowance for regions D and I in the RY 2024/2025 LTC and MMA capitation rates. The risk margin included for this program is consistent with other programs in RY 2024/2025.

Special Contract Provisions

Due to this being a pilot program and focused on a small population targeted for enrollment, the agency has created a two-sided risk corridor for the ICMC program. The target loss ratio for this program is set at 94%, with the capitated plan bearing the risk for gain or loss within 3% of the target loss ratio. This results in the capitated plan either retaining any profit if the actual loss ratio is between 91% and 94%, or bearing any loss if the actual loss ratio is between 94% and 97%. For gains or losses between 3% and 6% of the target loss ratio, the Agency and capitated plan will equally split the risk. For gains or losses in excess of 6%, the Agency will bear the full risk of losses in excess of 6% and will recoup all gains in excess of 6%. With this two-sided risk corridor, the capitated plan could lose up to 4.5% or could gain up to 4.5%, with the Agency covering any additional loss or recouping any additional gains made for this program.

Parties Involved in Florida's Rate-Setting Process

AHCA and their contracted actuary develop the capitation rates for the programs listed below. This section focuses on the rate development process for the SMMC Program (MMA and LTC), and information provided by AHCA and the MCOs.

The information provided below, particularly with respect to RY 2024/2025, was collected from each of the MCOs participating in the SMMC (MMA and LTC) programs and AHCA. When asked about the impact of the procurement to the rate setting process, the MCOs did not observe any impacts that, in their opinion, were unusual with respect to the process or timing of the new contract or development of the post-ITN rates. Additional adjustments to the rates were needed to include the efficiencies negotiated through the ITN and the newly carved-in BA services, however the MCOs did not cite these adjustments as unusual or causing a delay in the process.

Mercer also met with AHCA to discuss the rate setting process from the agency's perspective. This process involves engagement with the MCOs, as described below. Executive and Legislative offices were briefed on draft and final rates and provided with budget summaries. AHCA also provided information to the Consensus Estimating Conference to finalize budget projections. While many of AHCA staff that we spoke to were not at the agency during the procurement process, they cited the start date as being impacted by MCO federal readiness review requirements, and AHCA delivered presentations to state leadership offices on the RY 2024/2025 rate development.

Typical Rate Year

Each year, the process to develop capitation rates begins in January for the upcoming rate and contract period. As referenced above, the first step is to collect data to develop the base data component of the capitation rates. Once base data sets are developed, MCO-specific data is shared with each MCO, and a meeting is held in April to discuss base data and collect feedback and additional considerations from each MCO on their specific data to ensure that the data are complete. To inform the development of the administrative component, the MCOs submit an administrative cost model survey, developed by the contracted actuary that provides information on MCO administrative costs, such the MCOs' administrative staffing costs.

In April and May, draft rate development takes place, in which the additional components of rates are developed to provide draft capitation rates. Once the draft rates are developed, a presentation is provided to the MCOs in June/July to allow for questions, comments, and feedback. Capitation rates are not negotiated with the MCOs, as they must meet the federal regulations on rate development, but MCOs are allowed to provide information, data, and feedback for consideration.

Final rates are then developed, with consideration of MCO feedback, and sent to the MCOs by September. There are no meetings with MCOs to discuss final rates, but feedback collected during the draft rate period is also provided in written format and provided back to the MCOs after the rates are finalized.

Aside from engagement with the MCOs, AHCA engages with Legislative and Executive offices to provide information on draft and final capitation rates, prior to the implementation of the rates. As needed, the contracted actuary may be present to help support rate discussions with these key offices. Once rates are deemed final, the rates are submitted to CMS for review, and AHCA and its contracted actuary will respond to questions and requests necessary to receive federal approval.

Appendix A: Acronym List and Definitions

Florida Agency for Health Care Administration (AHCA): The state agency that administers Florida's Medicaid program and oversees health care policy and regulation within the state.

Ambulatory Service Centers (ASC): Facilities that provide same-day surgical and certain diagnostic or therapeutic procedures outside a hospital inpatient setting. Also commonly used to denote Ambulatory Surgical Centers.

Actuarial Standards of Practice (ASOPs): Professional guidelines established to ensure consistency and quality in actuarial work related to Medicaid rate setting and financial projections.

Achieved Savings Rebate (ASR): A contractual financial mechanism in which managed care plans return a portion of cost savings achieved back to the state.

Amount That Would Otherwise Have Been Paid (AWOP): A Medicaid cost calculation term referring to the payment amount that would have been made absent certain adjustments or offsets.

Behavioral Analysis (BA): A therapeutic approach used within Medicaid to assess and treat behavioral health conditions, often applied in developmental and mental health services.

Basic Health Program (BHP): A state option under the Affordable Care Act that offers health coverage to low-income individuals who do not qualify for Medicaid.

Code of Federal Regulations (CFR): The codified collection of federal rules and regulations that govern Medicaid program requirements and administration.

Cell and Gene Therapies (CGTs): Advanced medical treatments involving the modification or replacement of cells or genes, covered under Medicaid with specialized payment considerations.

Children's Health Insurance Program (CHIP): A federal-state partnership program that provides health coverage to uninsured children in families with incomes too high for Medicaid eligibility.

Children's Medical Services (CMS): A specialized Medicaid program in Florida that provides comprehensive health care services to children with complex medical conditions, coordinating care to support their unique health needs.

Non-Emergency Transportation Waiver (CNET): A Medicaid waiver that provides transportation services for eligible individuals to access non-emergency medical appointments and services.

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT): A mandatory Medicaid benefit providing comprehensive and preventive health care services for individuals under 21 years of age.

Fee-for-service (FFS): A traditional Medicaid payment model in which providers are reimbursed individually for each service rendered.

Federal Medical Assistance Percentage (FMAP): The federal matching rate that determines the share of Medicaid costs paid by the federal government versus the state.

Florida Medicaid Management Information System (FMMIS): The state's information system used to process Medicaid claims, manage enrollment, and support program administration.

Home- and Community-Based Services (HCBS): Medicaid services that support individuals in their homes or community settings as alternatives to institutional care.

U.S. Department of Health and Human Services (HHS): The federal agency responsible for overseeing Medicaid policy, funding, and administration through its sub-agencies, including the Centers for Medicare and Medicaid Services.

Incurred but Not Reported (IBNR): An actuarial reserve representing claims that have occurred during a period but have not yet been reported to the payer.

Intellectual and Developmental Disabilities Comprehensive Managed Care (ICMC): A managed care program designed to coordinate and deliver Medicaid services specifically for individuals with intellectual and developmental disabilities.

Institution for Mental Diseases (IMD): A facility primarily providing diagnosis, treatment, or care for individuals with mental diseases, subject to specific Medicaid payment restrictions.

Invitation to Negotiate (ITN): A procurement method used by state agencies to solicit proposals and negotiate contracts with vendors for Medicaid services or programs.

Level of Care (LOC): A clinical determination of the intensity or type of care a beneficiary requires, used for eligibility and placement decisions.

Long-term Care (LTC): Services and supports for individuals with chronic illness or disability that assist with activities of daily living, delivered in institutional or home- and community-based settings.

Long-term Services and Supports (LTSS): A range of Medicaid-covered services that assist individuals with chronic illnesses or disabilities in daily living activities over an extended period.

Managed Care Organization (MCO): A health plan contracted to provide Medicaid services to enrollees through a network of providers under a managed care delivery model.

Member Months (MMs): A measurement unit equal to one enrolled member for one month, used in utilization, experience reporting, and rate calculations.

Managed Medical Assistance (MMA): Florida's Medicaid managed care program that provides comprehensive medical services through contracted health plans.

Maintenance of Effort (MOE): A requirement that states maintain a certain level of Medicaid or related program funding or eligibility during specified periods, often linked to federal funding conditions.

Non-emergency medical transportation (NEMT): Medicaid-covered transportation services that assist beneficiaries in traveling to and from medical appointments when emergency transport is not required.

Non-Emergency Transportation (NET): Medicaid-covered transportation services that help beneficiaries access non-urgent medical appointments and services.

Program of All-Inclusive Care for the Elderly (PACE): A comprehensive care program that provides community-based health and social services to eligible elderly individuals to support living independently.

Prepaid Ambulatory Health Plan (PAHP): A managed care plan that receives a fixed payment to provide outpatient (ambulatory) services to enrolled Medicaid members.

Prescribed Drugs High-Risk Pool (PDHRP): A program designed to provide coverage or assistance for individuals with high-cost prescription drug needs.

Public Health Emergency (PHE): A federally declared emergency that allows for temporary changes in Medicaid policies and funding to address urgent public health needs.

Prepaid Inpatient Health Plan (PIHP): A Medicaid managed care model in which a health plan receives a fixed payment to provide inpatient and related services to enrolled beneficiaries.

Per Member Per Month (PMPM): A payment metric used in Medicaid managed care to represent the fixed monthly amount paid to health plans for each enrolled member.

Prescribed Pediatric Extended Care (PPEC): A Medicaid service providing specialized pediatric care and therapies for children with complex medical needs outside of hospital settings.

State Fiscal Year (SFY): The 12-month accounting period used by the state government for budgeting and financial reporting, which may differ from the calendar year.

Serious Mental Illness (SMI): A classification of mental health disorders that significantly impair functioning and require specialized Medicaid-covered treatment and support.

State Medicaid Managed Care (SMMC): Florida's program that delivers Medicaid services through managed care organizations to improve care coordination and cost-effectiveness.

State Plan Amendment (SPA): A formal revision submitted by a state to the Centers for Medicare and Medicaid Services to modify its Medicaid program's policies, benefits, or administration.

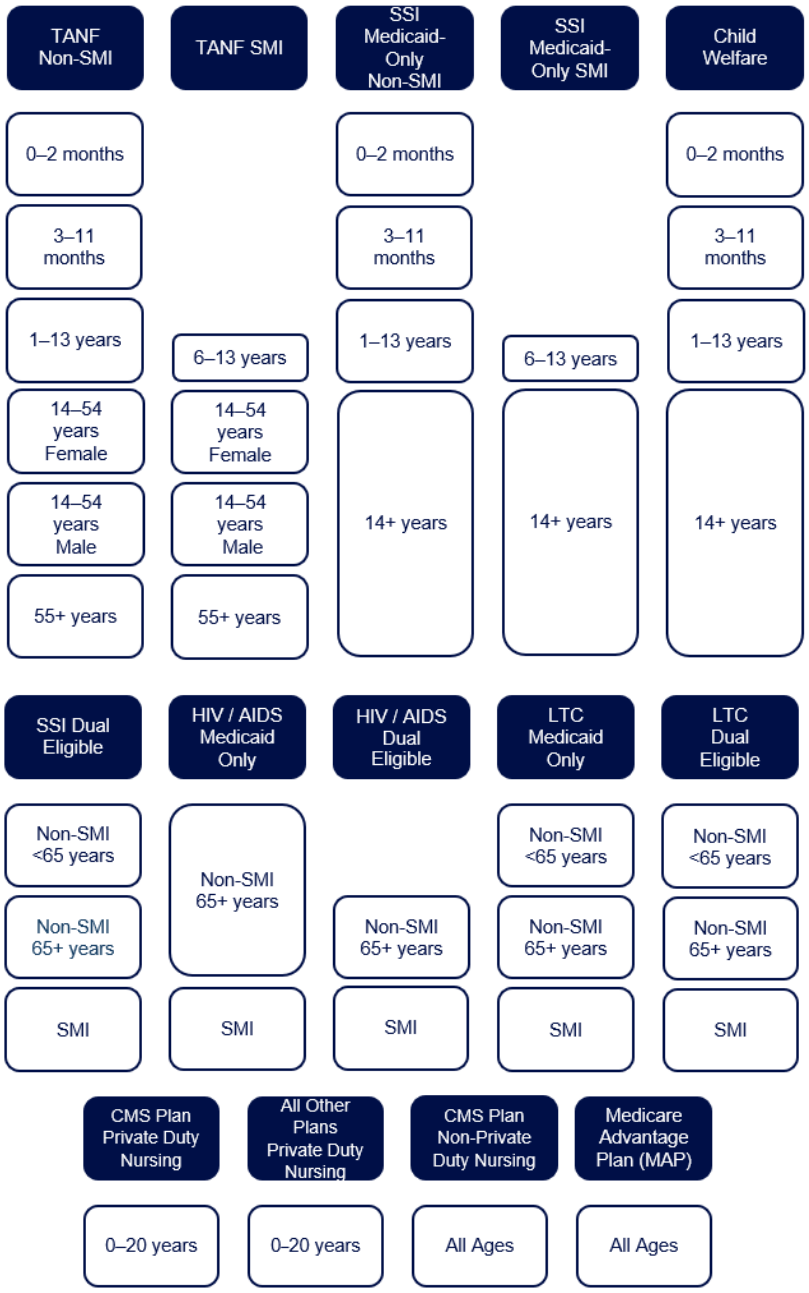
Social Security Act (SSA): The foundational federal law that established Medicaid and other social welfare programs, providing the legal framework for Medicaid eligibility and benefits.

Supplemental Security Income (SSI): A federal cash assistance program for low-income aged, blind, and disabled individuals; SSI receipt is often a factor in Medicaid eligibility.

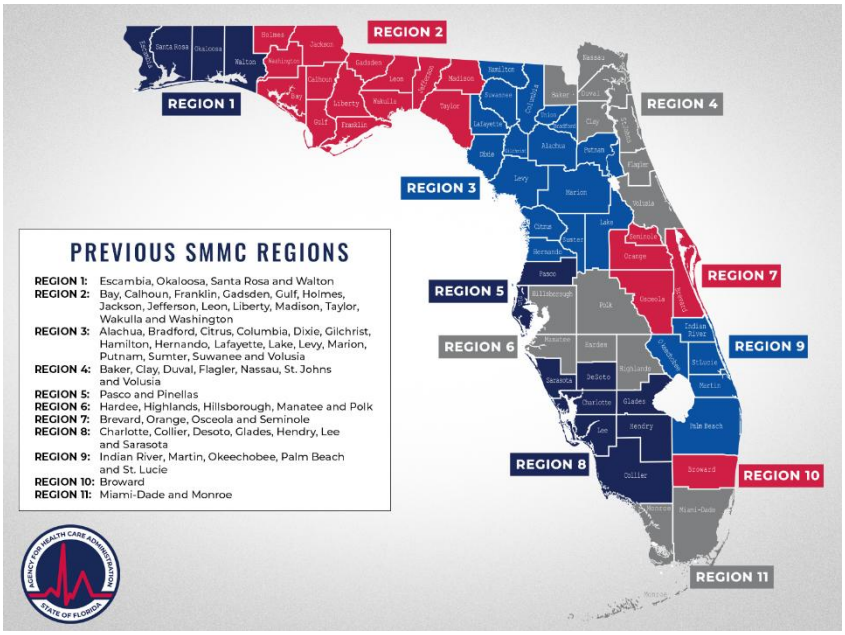
Temporary Assistance for Needy Families (TANF): A Federal assistance program that provides financial support and services to low-income families, often linked with Medicaid eligibility.

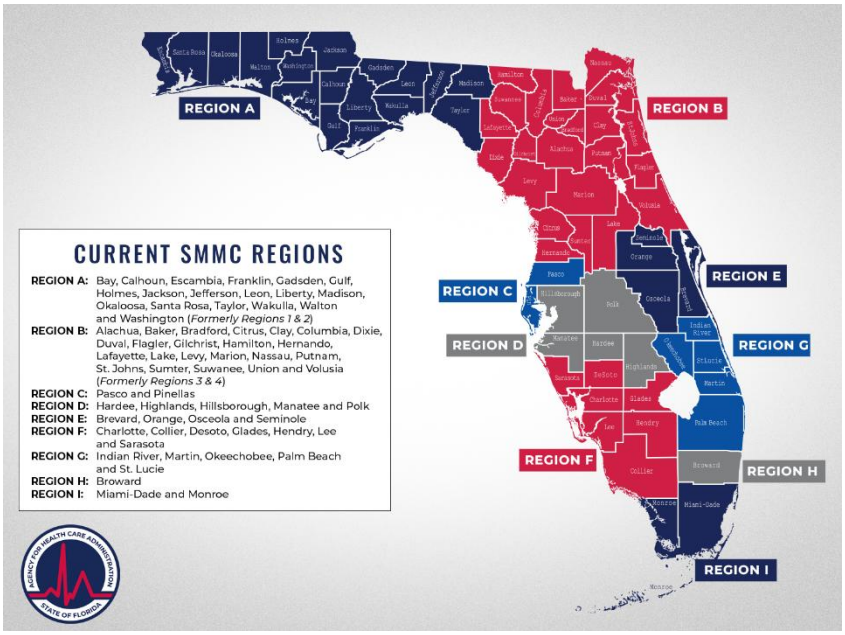
Upper Payment Limit (UPL): The maximum amount a state Medicaid program can pay for services, often set to prevent payments exceeding what Medicare or other insurers would pay.

Appendix B: Rate Cell Groups and Rate Cells



Appendix C: Previous and Current SMMC Regions





Appendix D: Independent Actuarial Review Framework

The review was conducted by credentialed actuaries and policy professionals with extensive experience in Medicaid managed care rate development and legislative review.

The evaluation was performed in accordance with:

- 42 CFR Part 438 (Medicaid Managed Care Regulations), including actuarial soundness requirements under §438.4
- The Centers for Medicare and Medicaid Services Rate Development Guides applicable to the relevant rating periods
- Applicable ASOPs, including but not limited to:
  - ASOP No. 12 Risk Classification (for All Practice Areas)
  - ASOP No. 23 Data Quality
  - ASOP No. 41 Actuarial Communications
  - ASOP No. 45 Risk Adjustment Methodologies
  - ASOP No. 49 Medicaid Managed Care Capitation Rate Development and Certification
  - ASOP No. 56 Modeling

The review included:

- Examination of annual rate certifications for RY 2020/2021, RY 2021/2022, RY 2022/2023, RY 2023/2024, and RY 2024/2025
- Review of base data selection, trend development, program changes, risk adjustment methodology, and non-benefit load components
- Analysis of any amendments to prospectively certified rates, including mid-year adjustments
- Structured interviews of MCO staff; and assessment of documentation completeness and internal controls

The objective was to assess whether the rate-setting process, across multiple fiscal years, operated consistently and in accordance with federal and professional standards — not solely to analyze a single adjustment event.

Appendix E: Information and Data Collected

Mercer's review of the Florida rate-setting process relies on the documentation provided to us by AHCA and its contracted actuary. We collected the following data and information:

1. Rate Certification Reports for the periods 2021 through 2025, including draft and final rate documentation and cover letters for each managed care program included in this report
2. Base data and rate development exhibits
3. Risk adjustment data sets for MMA and LTC
4. Presentations to MCOs on rate development, including base data and draft rates presentations
5. The Centers for Medicare and Medicaid Services questions on rate development and AHCA/the contracted actuary responses for all programs
6. MCO feedback on draft rates and AHCA/the contracted actuary responses
7. Project plans for all programs and rate development processes from RY 2021/2022 through RY 2024/2025
8. Responses from AHCA on the RY 2024/2025 procurement process and communication process
9. Responses from AHCA on the Agency's RY 2024/2025 pre-ITN and post-ITN rate-setting process
10. Responses from AHCA and the contracted actuary on other items requested that need to be discussed further to determine availability and format
11. Interview responses from SMMC MCOs on the RY 2024/2025 pre-ITN and post-ITN rate setting process and procurement process
12. AHCA ITN 010-2223 SMMC Program and appendices

Mercer requested additional information, but AHCA did not provide it in time for inclusion in Product A. The information and tasks below will allow us to perform additional review and investigate the potential vulnerabilities cited in this report. We intend to address further with the assistance of AHCA and their contracted actuary to follow through with noted items as part of Product B and Product C.

13. AHCA interviews to discuss:
    A. AHCA organizational chart to help inform key staff and roles, internal rate review and approval processes

B. Rate development and communication process, including with Legislative offices

14. Contracted Actuary interviews to discuss rate development and ask questions that will help inform Mercer of the items we have flagged as needing additional investigation

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