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Government Human Services Consulting

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State of Florida

# Florida's Capitation Rate Review

## Product C

# Contents

Section 1

# Executive Summary

## 1.1 Purpose and Scope of Review

Pursuant to Contract No. OP2502 (Contract), the Florida Legislature, through the Office of Program Policy Analysis and Government Accountability (OPPAGA), engaged Mercer Health & Benefits LLC (Mercer) — an independent actuarial firm — to conduct an actuarial review of Florida's Medicaid managed care capitation rate-setting process. This independent actuarial review consists of three separate deliverables. Product C (this document) is the third and final deliverable under the Contract.

Below is a summary of the previous two deliverables, and this report:

- Product A: A review of the rate-setting processes in Florida's Medicaid program over the past five years. The review encompassed a qualitative evaluation of the development and certification of capitation rates across multiple programs focusing on consistencies and deviations in the process over the five years reviewed. A particular focus was on a mid-year rate adjustment applied in the most recent rate year to recognize the Statewide Medicaid Managed Care (SMMC) reprocurement. Mercer identified *potential vulnerabilities* in the rate-setting process that warranted further review (see Product C).
- Product B: An analysis of Florida's Medicaid capitation rate-setting process and cycle compared to the ones used by California, Georgia, New York, Pennsylvania, Tennessee, and Texas. Product B evaluated Florida's delivery system design, actuarial methodology, draft and final rate development procedures, rate adjustment frequency, oversight mechanisms, medical loss ratio requirements, and the integration of state directed payments. In Product B, Mercer determined Florida's rate-setting process and cycle are structurally sound and comparable in design and operational complexity to the comparison states. Mercer proposed targeted refinements to strengthen Florida's rate-setting process.
- Product C: Mercer reviews the technical accuracy in the calculation of capitation rates as well as a review of the overall reasonableness of the capitation rate setting process for a subset of the Medicaid managed care programs during two rating years ending in 2024 and 2025. Product C considers data and information that was not available when Mercer drafted Product A. Product C was not intended to nor does it re-develop or re-certify the rates. In Product C, Mercer explores more in depth the *potential vulnerabilities* identified in Product A.

## 1.1 Limitations and Disclosures

Product C was prepared for OPPAGA and presents Mercer's review of the rate-setting process applied to the specified Florida Medicaid managed care programs for rating periods ending in

2024 and 2025. Product C was prepared in compliance with Mercer's 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 C does not constitute a legal opinion. Mercer disclaims any representations or warranties regarding the content of this document to third parties. The information contained within Product C 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 C or its appendices.[1]

This review is founded upon documentation, models, and data supplied by Florida's Agency for Health Care Administration (AHCA), its contracted actuary (Milliman, Inc.), and other involved parties. Mercer has not: independently audited or reviewed raw encounter-level or claims-level data; reconstructed complete alternative rate certifications; nor issued a new actuarial soundness certification. The findings in Product C represent professional actuarial judgment based on the information available at the time of the review, but they do not constitute legal, audit, or actuarial soundness conclusions regarding any of the Medicaid managed care capitation rates Mercer analyzed.

Mercer actuaries' review and opinion are limited to the payments made from AHCA to the managed care organizations (MCOs), and are contained herein addressing the following, as requested by OPPAGA: an independent professional actuarial opinion on the appropriateness, reasonableness, accuracy, and completeness of the rate setting work, including an assessment of whether the methodologies, assumptions, and data used were appropriate and correctly applied, identifying any errors or omissions, and opining on the materiality and potential impact of each finding.

## 1.2 Background

AHCA is the single state agency that administers the State's Medicaid programs, which include the following programs:

- SMMC Program: This program has three sub-programs covering different types of services, and capitation rates are developed separately: Managed Medical Assistance (MMA), Long-Term Care (LTC), and Dental.

[1] "Affiliated Marsh entities" refers to other companies within the Marsh corporate family (typically Marsh McLennan and its subsidiaries) that are related to Marsh through common ownership or control. The phrase is used to clarify that certain services, communications, or contractual obligations may involve Marsh and/or one or more of these related entities (for example, Marsh LLC and other Marsh or Marsh McLennan group companies), depending on the engagement, geography, or regulatory requirements.

- Program of All Inclusive Care for the Elderly (PACE).
- Non-Emergency Transportation Waiver (CNET).
- Intellectual and Developmental Disabilities Comprehensive Managed Care (ICMC).

This report provides a detailed review of the development of the capitation rates for these programs. The rating periods reviewed for each program are as follows and do not include all five rate years referenced in Product A:

- SMMC (MMA, LTC, and Dental)
  - Rate Year (RY) 2023/2024: October 1, 2023 through September 30, 2024
  - RY 2024/2025 Pre Invitation to Negotiate (ITN): October 1, 2024 through January 31, 2025
  - RY 2024/2025 post-ITN: February 1, 2025 through September 30, 2025
  - The ITN process was a reprocurement of the managed care organizations (MCOs) that participate in the SMMC program that was effective February 1, 2025. The ITN process launched the implementation of new MCO contracts, which included a new regional alignment (see Appendix C), changes to the MCOs assigned to each region, and the shift of behavior analysis (BA) services from the fee-for-service delivery system to the MMA contract amongst other items.[2] The addition of BA services was a material addition to the services covered under the MMA contract.
- PACE
  - State Fiscal Year (SFY) 2023/2024 and SFY 2024/2025
- CNET
  - Calendar Year (CY) 2024 and CY 2025
- ICMC
  - RY 2024/2025 was the first year of rate development for the ICMC program, with the pilot effective October 1, 2024; therefore, our review covered this single rating period.

## 1.3 Summary of Conclusions

Product C consisted of a review of the technical accuracy in the calculation of capitation rates as well as a review of the overall reasonableness of the capitation rate setting process. This review was completed for multiple programs within the Florida Medicaid program, including SMMC, PACE, CNET, and ICMC.

[2] The Florida Medicaid program has covered behavior analysis services since 2012.

Based on the documentation and underlying data that Mercer received, as well as discussions with AHCA and its contracted actuary, the rate development processes for the PACE, CNET, and ICMC programs, as well as the Dental and LTC programs within SMMC, were generally found to be reasonable and consistent with practices in use for other programs of similar size and complexity. For these specific programs, the calculations of the capitation rates appear to be technically accurate, and the process used to develop the rates was consistent with federal regulations and actuarial standards. Our report summarizes these processes and offers some recommendations for improving the processes.

With respect to the MMA program within SMMC, the investigation of *potential vulnerabilities* from Product A produced several substantive observations and recommendations regarding the MMA rate-setting process. A summary of the most critical issues is included here, while a more detailed discussion can be found in the body of this report.

Effective February 1, 2025, the MMA program was reprocured and coverage responsibility for certain benefits changed as a result. Most notably, BA services for members with autism were incorporated as a managed care covered benefit in the MMA program under the new managed care contracts resulting from the reprocurement process. Previously this benefit was covered for MMA enrolled beneficiaries through the fee-for-service (FFS) delivery system.

The development of the MMA capitation rates used statewide rate cell factors, the effects of which were more pronounced with the incorporation of BA services into the managed care contracts. The issues are described below along with potential indirect impacts as a result of this process. Additionally, recommendations and alternatives that may address associated risks are outlined throughout this report and summarized in Section 7.

### 1.3.1 MMA Statewide Rate Cell Factors

As detailed in Product A, AHCA's contracted actuary classifies eligible Medicaid populations into rate groups and projects benefit expenses at this level for each rating region. Rate groups are broader classifications of members than rate cells. Rate cells are the level at which capitation rates are paid by AHCA to the Managed Care Organizations (MCOs). Once benefit expenses are projected for each rating region and rate group, statewide rate cell factors are used to allocate projected benefit expenses to the rate cell level.

While this approach is one of many actuarial techniques that may be utilized in the development of Medicaid managed care rate-setting, its use is not common in situations with large, relatively stable populations such as MMA. This technique also introduces additional complexities into the rate-setting process, as the introduction (or removal) of non-uniform rating adjustments may necessitate a recalibration of the statewide rate cell factors in order to ensure the results produced are still reasonable and appropriate at the rate cell level.

AHCA's contracted actuary has used this process for at least four rating cycles prior to RY 2024/2025, producing results that appeared relatively reasonable. The introduction of BA services in the RY 2024/2025 post-ITN rates, however, highlighted a key risk in the continued use of this approach.

As was noted in Product A, historical per member costs patterns for BA services varied significantly across the rating regions in Florida, with per member BA service costs showing 20 –

or more – times higher in Region I (Miami-Dade County) than the lowest cost region. Likewise, the majority of the historical costs were concentrated in the TANF 1 year to 13 years rate cell, while most other rate cells saw very limited, if any, BA service cost impact. The introduction of this adjustment in the RY 2024/2025 post-ITN rates should have prompted a review and recalibration of the statewide rate cell factors, because these services were very concentrated in certain rate cells and varied significantly by region. Based on the documentation and underlying data that Mercer received, as well as discussions with AHCA and its contracted actuary, we find that the rates are technically correct in terms of applied calculations; however, the results produced for a group of individual rate cells are not reasonable because the methodological approach of using statewide rate cell factors was not recalibrated.

Table 1 demonstrates several of the large unanticipated changes in rates at the region, rate group, and rate cell level as compared to the RY 2024/2025 pre-ITN rating period.

**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% |
| 11 | I | TANF Non-SMI | 55+ years | $519.69 | $651.68 | 25.4% |

*Severe Mental Illness

Through additional requests and interviews with AHCA and its contracted actuary since the release of Product A, AHCA's contracted actuary noted that projected PMPMs at the region and rate cell level are calculated and used to derive the statewide rate cell factors. As a result of this follow up, Mercer received the underlying base data benefit cost PMPMs and associated member months at a detailed service category level by region and rate cell in addition to projected benefit cost PMPMs and associated projected member months at a detailed service category level by region and rate cell. Prior to this, only data at the region and rate group level had been provided through the rate certification exhibits. This data was received for all three contract periods reviewed: RY 2023/2024, RY 2024/2025 pre-ITN, and RY 2024/2025 post-ITN.

From a review of this additional information, significant differences in projected PMPM spend were observed when comparing the projections at the region and rate cell level to the projected costs derived from the use of statewide rate cell factors.

Table 2 shows the differences for the TANF non-SMI 1–13 Years rate cell across regions in the RY 2024/2025 pre-ITN contract period, which is prior to the inclusion of BA services into the rates. From this table, it is observed that the two sources provide significantly different projected benefit PMPMs, with the statewide rate cell factor application showing projected benefit PMPMs ranging from 9.9% higher to 12.0% lower than what was projected at the region and rate cell, depending on the rating region.

**Table 2: Rate Year 2024/2025 Pre-ITN: TANF Non-SMI, 1–13 Years Projected Benefit Cost Per Member Per Month**

| Pre-ITN Region | Adjusted Base Member Months | Projected PMPMs by Rate Cell | PMPMs with Statewide Rate Cell Factors Applied | % Difference |
|---|---|---|---|---|
| 1 | 484,908 | $124.37 | $136.26 | 9.60% |
| 2 | 513,678 | $120.05 | $131.97 | 9.90% |
| 3 | 1,238,970 | $127.54 | $135.06 | 5.90% |
| 4 | 1,529,558 | $126.95 | $131.54 | 3.60% |
| 5 | 768,740 | $142.51 | $156.05 | 9.50% |
| 6 | 2,157,545 | $131.30 | $133.63 | 1.80% |
| 7 | 1,900,582 | $148.66 | $146.12 | -1.70% |
| 8 | 1,010,633 | $135.00 | $133.30 | -1.30% |
| 9 | 1,369,951 | $153.45 | $148.88 | -3.00% |
| 10 | 1,237,006 | $131.72 | $138.00 | 4.80% |
| 11 | 2,052,418 | $174.51 | $153.52 | -12.00% |

When BA services became covered in the RY 2024/2025 post-ITN period, the differences become much greater.

Table 3 shows the same information as the prior table, but for the RY 2024/2025 post-ITN contract period. Within this period, BA services are included in projected benefit expenses. The magnitude of the differences is greater, with the statewide rate cell factors producing projected benefit PMPMs ranging from 31% higher to 26% lower depending on the rating region.

**Table 3: Rate Year 2024/2025 Post-ITN: TANF Non-SMI, 1–13 Years Projected Benefit Cost Per Member Per Month**

| Post-ITN Region | Adjusted Base Member Months | Projected PMPMs by Rate Cell | PMPMs with Statewide Rate Cell Factors Applied | % Difference |
|---|---|---|---|---|
| A | 1,001,017 | $118.07 | $154.78 | 31.10% |
| B | 2,769,724 | $129.39 | $157.56 | 21.80% |
| C | 767,465 | $148.72 | $183.03 | 23.10% |
| D | 2,157,287 | $147.30 | $162.42 | 10.30% |
| E | 1,893,957 | $169.43 | $178.33 | 5.30% |
| F | 1,012,069 | $195.58 | $183.77 | -6.00% |
| G | 1,362,662 | $215.72 | $200.72 | -7.00% |
| H | 1,236,255 | $187.26 | $187.89 | 0.30% |
| I | 2,050,166 | $342.67 | $255.09 | -25.60% |

A significant observation in Tables 2 and 3 is population sizes. The TANF non-SMI 1–13 Years rate cell is very credible from a membership size standpoint, with the smallest base data size being approximately 484,000 member months in the pre-ITN period and approximately 767,000

member months in the post-ITN period. Within capitation rate setting, smaller populations are subject to more volatility and can be less credible. When the group is small, a few unusual cases can make the rate swing up or down, so the estimate is less dependable. However, that is not the case with this rate cell in any region. The application of statewide rate cell factors for these fully credible large rate cells should be revisited.

While this analysis shows there are large differences at the rate cell level, AHCA's contracted actuary applies the statewide rate cell factors in a budget neutral fashion. As a result of this approach, while there are certain rate cells that are over- or under-funded depending on the region, there are also rate cells in each rate group that are over- or under-funded in the opposite direction to maintain budget neutrality. For the TANF non-SMI rate group, the general pattern is that if the 1–13 Years rate cell is too low (in the case of Region I), the other rate cells within that rate group are too high. Conversely, if the 1–13 Years rate cell is too high (in the case of Region A), the other rate cells within that rate group are too low. This observation aligns with the previous table showing decreases in Region A for the 0–2 Month and 55+ Years rate cells from pre-ITN to post-ITN and increases in Region I for the same rate cells. As a result of this, total capitation revenue paid out across all rate cells within a rate group is not significantly impacted, but the rates at the rate cell level do not align with projections done by AHCA's contracted actuary at the region and rate cell level.

Per 42 Code of Federal Regulations (CFR) 438.4(b)(5), payments from any rate cell must not cross-subsidize or be cross-subsidized by payments for any other rate cell. The methodology used in the development of capitation rates at the rate cell level and resulting cell-level discrepancies may not be consistent with this requirement. Moreover, while payments in total for the MMA program may be appropriate, individual MCOs will likely gain or lose revenues based on their relative population mix across cells.

Furthermore, Actuarial Standards of Practice (ASOP) 56 (Modeling) addresses actuarial modeling and the actuary's responsibility to validate that the model output is valid, meets its intended purpose, and produces reasonable results (see sections 3.1.6(e) and 3.6.2(c)). The statewide rate cell factor model, as applied in the Rate Year 2024/2025 Post-ITN rates, does not produce PMPMs for all regions and rate cells that are reasonable in comparison to the Rate Year 2024/2025 Pre-ITN rates after accounting for the changes in covered services between the rating periods. Consequences of using the statewide rate cell factor approach are described below.

## Potential Indirect Impact

Under the managed care contract AHCA has with its MCOs, the MCOs are required to utilize value-based purchasing arrangements.[3] These are arrangements between MCOs and providers that link payments for services to quality and better outcomes. To the extent a value-based payment arrangement from the MCOs to providers uses the capitation rates paid to the MCOs, there could be a downstream impact realized by the providers. For example, the TANF non-SMI 1–13 Years rate cell in Region I is underfunded when compared to expectations by region and

[3] Florida Agency for Health Care Administration, Statewide Medicaid managed care (SMMC) new program highlight: Value-based purchasing (Oct. 18, 2024), https://ahca.myflorida.com/content/download/25260/file/SMMC%20Value%20Based%20Purchasing%20Highlight_10182024.pdf.

rate cell. Based on this, it is possible that reimbursement in value-based payment arrangements to certain providers in that region is negatively impacted. Even though the region as a whole may be adequately funded for an MCO, providers who primarily serve younger populations (e.g. pediatricians) may be disadvantaged.

### 1.3.2 BA Risk Corridor Implications

With the inclusion of BA services to the managed care contracts, AHCA and its contracted actuary elected to implement a one-sided risk corridor with respect to BA services. The one-sided risk corridor means that the BA component of the total capitation rates is subject to a review of how close actual BA expenditures are to the projected BA expenditures included in the rates. The State can recoup funds from an MCO(s) if the actual BA expenditures are less than the value of the BA rate component. One of the reasons this was done was due to significant increases in BA costs across recent years in the FFS delivery system. By moving the benefit into managed care and with the implementation of a one-sided risk corridor, MCOs may be incentivized to manage BA service utilization to avoid potential losses, while realizing potential savings for the State.

In the risk corridor calculation, a BA rate target is needed for the comparison of actual BA expenditures to the amount built into the rates. To that end, AHCA's contracted actuary provided an exhibit within the original rate certification showing the BA risk corridor target per member per month (PMPMs) at the region and rate cell level. Necessarily, the BA risk corridor target needs to be lower than the total capitation rate, since BA is a sub-component of a broader rate. To derive the projected BA benefit costs in the rates, AHCA's contracted actuary used the projected BA spend as part of the underlying projected spend at the region and rate cell level. However, there are five instances where the original BA-specific PMPMs used in the risk corridor are greater than the total capitation rate itself. These instances are shown in Table 4. This is not a reasonable outcome and is a consequence of the statewide rate cell factor approach in the calculation of the capitation rates.

**Table 4: Rate Cells with Higher Behavior Adjustment Per Member Per Month than Total Capitation Rate Per Member Per Month**

| Region | Rate Group | Rate Cell | Final Capitation Rate – Exhibit 7 | BA PMPM – Exhibit 36A |
|---|---|---|---|---|
| I | TANF SMI Non-Specialty | 6–13 Years | $1,443.62 | $1,576.27 |
| I | TANF SMI Specialty | 6–13 Years | $1,463.35 | $1,557.39 |
| I | SSI* Medicaid Only Non-SMI | 1–13 Years | $1,537.75 | $1,580.56 |
| I | SSI Medicaid Only SMI Non-Specialty | 6–13 Years | $1,707.80 | $2,752.13 |
| I | SSI Medicaid Only SMI Specialty | 6–13 Years | $1,724.37 | $2,719.16 |

*Supplemental Security Income

After the RY 2024/2025 post-ITN contract period began, AHCA's contracted actuary changed the amounts subject to the BA risk corridor. In this process, two items were changed. First the starting point BA rate component was updated from what was provided in the original rate certification, partly due to the targets being greater than the total rate in some instances. Second, due to unanticipated shifts in enrollment from non-Children's Medical Services Plan (CMS Plan)

rate cells to the CMS Plan, AHCA's contracted actuary reallocated the restated BA dollars on a budget neutral basis across different rate groups and rate cells within a region.

This approach gives rise to two potential vulnerabilities:

- The starting point risk corridor targets are different between the rate certification and the BA risk adjustment exhibits. In some cases, the amounts are significantly different. The driver of the discrepancy is the underlying capitation rate issues due to the application of statewide rate cell factors.
- As the risk corridor targets were changed after the rating period, the approach may not be consistent with 42 CFR 438.6(b)(1), which indicates that risk sharing arrangements cannot be modified after the start of the rating period.

## 1.4 Recommendations and Considerations

Based on the observations noted regarding the application of statewide rate cell factors, Mercer has the following recommendations for changes in the development of the capitation rates for the MMA program.

### 1.4.1 Recommendation 1

AHCA and its contracted actuary should consider consolidating rate cells for the MMA program within the TANF Non-SMI, TANF SMI, SSI Medicaid Only Non-SMI, SSI Medicaid Only SMI, and Child Welfare rate groups to include only a child and adult split, with a potential split for newborn rate cells, as opposed to the detailed age and gender rate cells currently used. Under this recommendation, statewide rate cell factors would not be used in the development of rates by rate cell. Base data could be grouped by the rate cells that only vary by children and adults, and the rates calculated from this base data. A simpler rate cell structure can be expected to address or reduce issues similar to the inclusion of BA services. Since BA services are predominantly utilized by children, this alternative approach would have allocated the BA service costs more appropriately into the rate cells specific to children.

This recommendation would also align capitation rate development in the MMA program with rate cell structure trends nationally. Most Medicaid managed care rate setting processes have broader rate cells and let health-status based risk adjustment processes account for not only the age/gender demographic mix of the underlying MCO enrolled populations, but also for health characteristics as well. There is already a health-status based risk adjustment process in place within the MMA program, so the usefulness of detailed rate cells by age and gender is significantly diminished.

### 1.4.2 Recommendation 2

If AHCA and its contracted actuary elect to keep the current rate cell structure with more detailed age and gender breakouts, we suggest capitation rates be calculated and documented at the region and rate cell detail level from start to finish, with base data credibility adjustments applied

for rate cells where small membership exists. In the current process, there were fully credible rate cells that were adjusted through the use of statewide rate cell factors that differed materially from projections at the region and rate cell level. Such differences could be avoided, or at least significantly mitigated, if rates are developed using the detailed rate cell level from start to finish.

### 1.4.3 Recommendation 3

If the application of statewide rate cell factors were still to be used, AHCA's contracted actuary could separate out BA and non-BA services completely given the large disparities in per member BA costs across the State. In this process, non-BA projected benefit PMPMs can be produced on their own by projecting non-BA costs at the rate group level with the application of statewide rate cell factors excluding BA services, and the same process separately done for BA services. This approach would keep the services separated.

Section 2

# Actuarial Review Framework, Information/Data, Methods, and Scope of Review

## 2.1 Independent Actuarial Review Framework

The development of Medicaid managed care rates must adhere to federal regulations and guidance.[4] Federal regulations also require states to develop per member per month (PMPMs) in accordance with and to ASOPs promulgated by the American Academy of Actuaries.[5] The review in Product C was performed by credentialed actuaries with extensive experience in Medicaid managed care rate development in accordance with applicable requirements, including:

- 42 CFR Part 438 (Medicaid Managed Care Regulations), including actuarial soundness requirements under §438.4.
- The Centers for Medicare and Medicaid Services (CMS) Rate Development Guides applicable to the relevant rating periods.
- ASOPs 1: Introductory Actuarial Standard of Practice; 12: Risk Classification (for All Practice Areas); 23: Data Quality; 25: Credibility Procedures; 41: Actuarial Communications; 45: Risk Adjustment Methodologies; 49: Medicaid Managed Care Capitation Rate Development and Certification; and 56: Modeling.

Florida's Medicaid managed care capitation rates are paid on a PMPM basis.[6] A critical federal requirement 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. States and their actuaries must follow multiple ASOPs, but ASOP No. 49 is particularly relevant as it defines actuarially sound/actuarial soundness in Medicaid programs.[7] Per ASOP No. 49, 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.[8]

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[4] SSA § 1903(m)(2)(A)(iii), 42 US.C. § 1396b(m)(2)(A)(iii); 42 C.F.R. § 438.4(a).
[5] 42 C.F.R. §§ 438.4 through 438.7.
[6] Product A includes a detailed description of the Medicaid managed care capitation rate-setting process.
[7] 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].
[8] *Id.* (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

## 2.2 Information and Data Collected

Mercer's review is based on documentation provided by Florida's Agency for Health Care Administration (AHCA) and its contracted actuary (Milliman, Inc.). Below is a list of all data and information collected and used in Product A, or added to complete Product C.

1. Rate Certification Reports for applicable rating periods, including associated rate development exhibits and cover letters.
2. Base data member months and PMPMs by rate cell and service category.
3. Rating year projected medical expense and member months by rate cell and service category.
4. Risk adjustment reports and related exhibits for Statewide Medicaid Managed Care (SMMC) Managed Medical Assistance and Long-Term Care.
5. Presentations to Managed Care Entities on rate development, including base data and draft rates presentations.
6. CMS questions on rate development and the AHCA/contracted actuary responses.
7. Responses from AHCA to Mercer's questions on the relevant Rate Years rate-setting processes.
8. AHCA Invitation to Negotiate 010-2223 SMMC Program and appendices.

## 2.3 Scope of Review

Per ASOP No. 1 section 2.10, because actuarial practice commonly involves the estimation of uncertain events, there will often be a range of reasonable methods and assumptions, and two actuaries could follow a particular ASOP, both using reasonable methods and assumptions, and reach different but reasonable results. Therefore, Mercer did not attempt to re-develop or re-certify any rates. Instead, we were contracted by the Florida Legislature's Office of Program Policy Analysis and Government Accountability (OPPAGA) to evaluate the reasonableness of the rate-setting process, data, and results used by AHCA's contracted actuary by examining, among other things:

- Mathematical accuracy of rate development exhibits given input data and assumptions.
- Key assumptions including base period selection, trend, risk adjustment methodology, and non-benefit load.
- The reasonableness of the rate setting methodology.

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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.).

Mercer's objective was to assess whether the rate-setting process used by AHCA's contracted actuary operated consistently and in accordance with federal and professional actuarial standards — not solely to analyze a single adjustment.[9]

[9] *See* Limitations and Disclosures Subsection of Executive Summary.

Section 3

# Statewide Medicaid Managed Care Program

## 3.1 Overview

Product C involved the review of Florida's capitation rate setting process Rate Year (RY) 2024 and RY 2025, which includes three separate contract periods within the Statewide Medicaid Managed Care (SMMC) program: RY 2024, RY 2025 Pre Invitation to Negotiate (ITN), and RY 2025 Post-ITN. The SMMC program consists of three separate sets of certified capitation rates, one for each of the programs embedded within SMMC (i.e., Managed Medical Assistance [MMA], Long-Term Care [LTC], and Dental). To assess the capitation rates developed by Florida's Agency for Health Care Administration (AHCA's) contracted actuary, Mercer performed the following for all programs within SMMC:

- Verified mathematical calculations — Mercer performed a technical review of the calculations, based on the documentation provided, to determine if technical calculations were internally consistent and accurate. More details of this review can be found in the subsection below titled Review of Formulas and Calculations.
- Reviewed the overall reasonableness of the capitation rates, in particular reviewing the methodology and assumptions for reasonableness — After the Review of Formulas and Calculations subsection, the remainder of this section is structured based on the development of capitation rates. There are separate subsections for each major component of the rates (Rate Structure, Base Data, Public Health Emergency Acuity Adjustment, Trend, etc.). Within each subsection, a high-level description of the process used by AHCA's contracted actuary is provided, in addition to recommendations and observations that Mercer has based on the review performed. The order of the subsections generally follows the order in which these components are applied sequentially in the rate setting process[10]

For the purposes of this review, Mercer relied on the following documentation. The documentation was created by AHCA's contracted actuary and provided to AHCA:

- RY 2023/2024 MMA final rate certification package dated December 8, 2023.
- RY 2024/2025 pre-ITN MMA final rate certification package dated November 13, 2024.
- RY 2024/2025 post-ITN MMA final rate certification package dated January 13, 2025.

[10] *See* Product A for a thorough description of the rate setting data, processes, and methodologies employed by the Florida AHCA contracted actuary in the development of the rates. Product A also provides additional context to Mercer's conclusions and recommendations below.

- RY 2023/2024, RY 2024/2025 pre-ITN, and RY 2024/25 post-ITN rate-cell-level exhibits with both base data and projected member months and benefit per member per months (PMPMs) by category of service (COS) provided to Mercer on May 26, 2026.
- Risk-Adjustment documentation letters and accompanying exhibits for the RY 2023/2024, RY 2024/2025 pre-ITN, and RY 2024/2025 post-ITN periods.
- Behavior Analysis (BA) Risk Adjustment documentation letter from the contracted actuary to AHCA dated December 16, 2025 and accompanying exhibits.

Overall, while the rate development process for certain components followed applicable federal regulations, ASOPs, and generally accepted practices, Mercer has specific observations and recommendations that are summarized in the Executive Summary and are detailed below in the Rate Cell Structure, Statewide Rate Cell Factors, and Behavior Analysis Services subsections. In the other subsections below, Mercer provides commentary on the methodologies and provides recommendations to consider for future periods, if applicable.

## 3.2 Review of Formulas and Calculations

Pursuant to the scope of work, Mercer verified the accuracy of the rate development workbooks and exhibits, and did not find any formula or calculation errors (e.g. mathematical review). This validation consisted of a technical review of capitation rates set at the region, rate group, and rate cell level, in addition to a technical review of risk-adjustment calculations. Note that the risk adjustment calculations only impact the MMA and LTC programs, since risk adjustment is not applicable to the Dental program.

### 3.2.1 Capitation Rates Calculation Review

Mercer reviewed the capitation rate certification report packages listed in the Overview section. The review included validating technical calculations, ensuring internal consistency, and assessing the reasonableness of results.

To validate the technical calculations, Mercer relied solely on the information and figures included in each rate certification package to confirm that the formulas were applied correctly as described in the rate certification package. This validation was conducted at the region and rate group level for each category of service. Additionally, because certain figures were referenced across multiple exhibits and calculation steps, Mercer verified that those figures were calculated accurately and presented consistently throughout the rate certification package.

Several exhibits in the MMA rate certification package presented the rate development process at the aggregated rate group level. To validate these exhibits, Mercer requested supplemental membership data supporting the aggregation from rate cells to rate groups. AHCA's contracted actuary provided supplemental membership information on May 26, 2026, which Mercer used to verify that the membership was aggregated appropriately from rate cells to rate groups.

Overall, while Mercer did not identify any material technical errors or inconsistencies within each rate certification package, transparency could be improved. The formulas were generally consistent with the methodology described in the rate certification package with minor discrepancies that were likely attributable to mathematical rounding differences. The calculations appeared reasonable based on the inputs and assumptions provided in the package. However,

additional explanatory footnotes or supporting detail for certain calculations by the contracted actuary could improve clarity in understanding the rate development process.

From our review during Product A, we identified that rate calculation and flow of information for the MMA program start with Exhibit 12 from the actuarial certification report, where base claim costs are transformed into projected claim cost, then to Exhibit 6, where additional adjustments are applied to the projected claim costs at the region and rate group, then to Exhibit 7, where rate cell factors, administrative allowance, and gain/loss margin are applied to arrive at the capitation rate.

Exhibit 12 of the MMA program rate certification package contains rate calculations from base period claim cost to projected period costs at the region, rate group, and service category level. This exhibit shows the application of all adjustment factors made to the base data to arrive at the projected claim cost for each region, rate group, and service category. For all regions, rate groups and service categories, Mercer verified the projection factors were correctly applied to the base period claim cost and the final projected claim costs match within the exhibit. Additionally for Exhibit 12, Mercer used the supplemental data at the region, rate cell, and service category to validate the rate aggregation methodology from rate cell level to rate group level as shown in Exhibit 12.

Mercer also reviewed consistency between Exhibit 12, Exhibit 6, and Exhibit 7, since Exhibit 6 leverages information from Exhibit 12, and subsequently Exhibit 7 leverages information from Exhibit 6. Mercer reviewed the application of adjustments within Exhibit 6, and the calculation and application of rate cell factors, administrative allowance, gain/loss margin within Exhibit 7.

For the Dental program, Exhibit 6 contains scenarios by rate cell and region, where base period claim costs are transformed into projected claim cost, then to Exhibit 2, where administrative allowance and gain/loss margin are applied to arrive at the capitation rate. Mercer verified the projection factors are correctly applied to the base period claim costs and the final capitation rate calculation appeared reasonable based on the inputs and assumptions provided within the rate certification package.

For the LTC program, Exhibit 7 through Exhibit 18 — and for post-ITN rate certification package, Exhibit 7 through Exhibit 16 — contain scenarios by rate cell and region, where base period service costs are transformed into projected services costs, then to Exhibit 4, where administrative costs and margin are applied to arrive at the capitation rate. Mercer verified the projection factors are correctly applied to the base period claim costs and the final capitation rate calculation appeared reasonable based on the inputs and assumptions provided within the rate certification package.

## 3.2.2 Risk Adjustment Calculation Review

### 3.2.2.1 MMA Risk Adjustment — Validation

- Within the MMA program, risk adjustment factors are updated on a quarterly basis. For the RY 2023/2024 contract period, these factors were updated four times within the contract period and applied to the capitation rates. For the RY 2024/2025 pre-ITN contract period, risk

adjustment factors were updated two times, one set of updates applicable to the October 2024 through December 2024 time period, and one update applicable to rates effective for January 2025. For the RY 2024/2025 post-ITN contract period, risk adjustment factors were updated three times, with the first set of factors applicable for February 2025 through March 2025. As part of the documentation provided by AHCA's contracted actuary, the following exhibits are typically released on a quarterly basis with release of updated factors:

- Chronic Illness & Disability Payment System with Pharmacy (CDPS+Rx) Prevalence Reports — these reports show counts of scored members grouped by the model categories, in addition to the cost weights applicable for each model category. Raw average risk scores by rate cells can be derived from these reports.
- All Plan Summaries — this report shows the raw risk scores that can be derived from the prevalence reports for all plans and calculates the budget neutral risk scores that are applied to the capitation rates.
- Specialty Plan Summaries (RY 2024/2025 Post-ITN only) — this report shows the calculation of specialty and non-specialty product capitation rates for members who are eligible to enroll in the specialty products.

To validate the technical calculations in the risk adjustment process, Mercer performed the following steps for all quarters in the applicable rate years:

- Reviewed risk-adjustment documentation to assess consistency between the cost weight development and application of the cost weights in the prevalence reports for each health plan.
- Within the prevalence reports, reviewed the calculation of raw risk scores by region and rate cell based on the given cost weights and scored member counts by demographic, member characteristic (non-utilizer, duration, CMS Plan eligibility), and disease categories.
- Assessed consistency between the raw risk scores calculated within the prevalence reports to those shown in the all-plan summary exhibits.
- Reviewed the calculation of budget neutral risk scores within the all-plan summary exhibits, and also reviewed the application of credibility adjustments for instances of low scored populations to validate consistent application.
- Reviewed the calculations for Child Welfare (1–13 Years and 14+ Years) raw risk score and budget neutral risk scores based on scored member months (Non-Out of Home and Out of Home) and relativity factors for the Out of Home population.
- Reviewed to validate accurate application of the budget neutral risk scores to the applicable capitation rates.

Because it was beyond the scope of the review, Mercer did not verify the counts of members by the CDPS+Rx model categories within the prevalence reports.

#### 3.2.2.2 LTC Risk Adjustment — Validation

Within the LTC program, risk adjustments factors were updated prospectively for the RY 2023/2024 and RY 2024/2025 Pre-ITN contract periods, while a retrospective process was used for the RY 2024/2025 Post-ITN period. Specific to LTC, risk adjustment factors were only updated one time for the entire contract periods for each rate year. As part of the documentation provided by AHCA's contracted actuary, reports are provided that show the counts of scored members within each model category in addition to an exhibit showing the calculation of the final budget neutral risk scores.

To validate the technical calculations in the risk adjustment process, Mercer performed the following steps for all applicable rate years:

- Reviewed risk-adjustment documentation to ensure consistency between the cost weight development and application of the cost weights in the report showing the counts of scored members within each model category.
- Reviewed the calculation of raw risk scores by region using the exhibit showing counts of scored recipients within each model category.
- Reviewed the calculation of budget neutral risk scores for all plans and regions.
- Reviewed to ensure accurate application of the budget neutral risk scores to the applicable capitation rates.
- Specific to RY24/25 Post-Implementation, reviewed the calculation of the final blended risk scores based on the normalized risk score for scored members and the 1.00 risk score applied to unscored members.
- Reviewed that the final risk scores are consistent with the values quoted on final risk-adjustment methodology documentation.

Because it was beyond the scope of the review, Mercer did not verify the counts of members by the model categories within the prevalence reports.

#### 3.2.2.3 Dental

Risk adjustment is not applicable to the dental program.

### 3.2.3 Findings and Recommendations

In terms of technical calculations affecting the capitation rates, Mercer does not have any findings or concerns.

# 3.3 Methodology and Assumption Review

## 3.3.1 Rate Structure

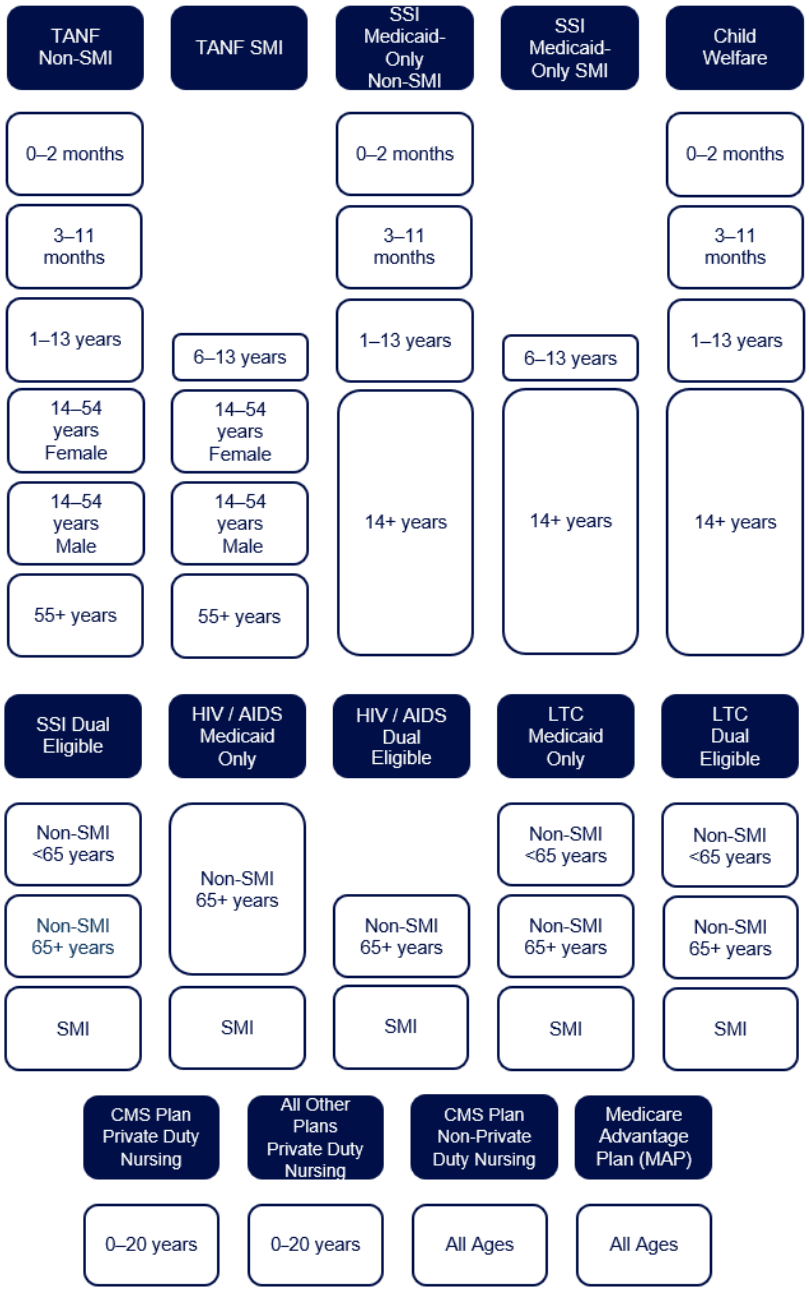
Establishing rate cells is a fundamental component in capitation rate setting and should recognize the spectrum of members receiving Medicaid. The intent is to align rate cells to recognize that medical expense profiles can be different, for example an adult versus a child or pregnancy status or a geographic region's provider systems. The rate cell is the level to which the actuary certifies the capitation payment per 42 CFR 438.4(b)(4). Furthermore, as required in 42 CFR 438.4(b)(5) for actuarially sound Medicaid managed care capitation rates, *Payments from any rate cell must not cross-subsidize or be cross-subsidized by payments for any other rate cell*. When determining a rate cell structure, the actuary's goal is to balance matching payment to risk with credibility considerations and administrative burden. The final rate cell is typically the combination of the rating region (if rates vary by geographic area) and eligibility category and/or demographics.

As noted in the Executive Summary and in Product A, AHCA's contracted actuary developed projected medical expenses at the region and rate group level. However, capitation rates are paid by AHCA and certified by its contracted actuary at the rate cell level.

### 3.3.1.1 MMA

AHCA's categorization of members into rate groups is generally consistent with eligibility groupings utilized by other similar State Medicaid programs, defined by eligibility group (Temporary Assistance for Needy Families [TANF], Supplemental Security Income [SSI], Child Welfare, CMS Plan), Medicare status (Dual Eligible and Medicaid Only), and specialty population (Serious Mental Illness [SMI], HIV/AIDS, and LTC). There are 14 rate groups as well as a maternity supplemental payment. AHCA further subdivides the rate groups into 37 rate cells for payment purposes as shown in the diagram below, where the dark blue headers are the rate groups and the rate cells are listed in Figure 1.

## Figure 1: Florida Rate Cell Groups and Rate Cells




Nationwide, detailed rate cells split by age and gender have become less common in Medicaid managed care programs over time. Prior to the wide adoption of risk adjustment within rate setting, it was common practice for states to use detailed age and gender breakouts for payment purposes. Capitation rates were paid by age and gender to more appropriately pay health plans within the same geographical rating region and rate group when age and gender demographic distributions were significantly different for each plan.

As Medicaid managed care capitation rate setting has matured, health status-based risk adjustment has become more widely adopted nationally within rate setting. With health status-based risk adjustment, many states pay capitation rates at a broader level than age and gender rate cells, such as capitation rates set for newborns, non-newborn children, and adults. A budget neutral health status-based risk-adjustment process is then applied to the broader capitation rates (while noting that newborn rate cells are generally not risk adjusted). The risk-adjustment process evaluates each health plan's enrolled population and adjusts health plan revenue based on the disease characteristics of their population, instead of simply using age and gender rating alone. Literature suggests that the application of health status-based risk adjustment is a better predictor of health care spend than age and gender rating alone. Since the MMA program utilizes a health status-based risk adjustment process, detailed rate cells may not be necessary.

One advantage of setting capitation rates at broader levels than age and gender is the size of the populations for which rates are set. When more detailed age and gender rate cells are used, the underlying credibility of each rate cell becomes smaller, due to fewer members classified within each rate cell. In the case of Florida's MMA program, the program is of sufficient size that many of the detailed rate cells are credible on their own, such as TANF Non-SMI 1–13 Years, which had more than 766,000 adjusted member months in the SFY 2022–2023 base period for the smallest region (Region C). However, some rate cells are not credible on their own, such as TANF Non-SMI 0–2 Months or TANF Non-SMI 55+ years in several regions, or many of the Child Welfare rate cells.

Many similar Medicaid programs in other states split the TANF population into only two or three rate cells: child and adult, using either an 18 years old, 19 years old, or 21 years old age break, and sometimes with rate cells specific to beneficiaries under 1 year old. An over/under 21 age split helps to align the program benefits by rate cell, as members under 21 years old are eligible for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT). When using consolidated rate cells, if there are material changes in the underlying demographics over time, these can be accounted for through base data or prospective adjustments. Differences in demographic mix by health plan can be addressed through the risk adjustment process.

#### 3.3.1.2 LTC

The LTC program rate cell structure is a blended rate of Home and Community Based Services (HCBS) and non-HCBS members by region, separately developed for dual eligibles and Medicaid only members. For Managed Long-Term Services and Supports programs, this is a common rate cell structure. In Florida's LTC program, the blend percentage of HCBS and non-HCBS by plan is updated on a monthly basis to determine each month's capitation rate. In many states, the blend is set prospectively for the full rating period; however, there are a variety of reasonable approaches.

#### 3.3.1.3 Dental

The Dental program utilizes a consolidated rate cell structure, with five rate cell groupings, and rates developed on a statewide basis for the two smaller rate cells and developed by region for the three other rate cells. The rate cells all include an age 21 split, which is appropriate as

children under 21 years old have a comprehensive dental benefit, whereas adults have a more limited benefit. The rate cell structure also separates medically needy from members with standard Medicaid eligibility and separates dual eligible adults from Medicaid only adults. The rate cell structure is reasonable and aligns with common practice across other Medicaid dental programs.

#### 3.3.1.4 Findings and Recommendations

***Recommendation 1:*** *Consider consolidating rate cells for the MMA program within the TANF non-SMI, TANF SMI, SSI Medicaid Only non-SMI, SSI Medicaid Only SMI, and Child Welfare rate groups to include only a Child/Adult split***.**

The current detailed rate cells appear appropriate given the size of the program so long as there are other mechanisms in the rate development process that are used to address low credibility rate cells (recommendations on these processes are detailed in subsequent sections). However, consolidating rate cells diminishes the operational burden as it reduces the number of rate cells and can simplify the rate development process. The exhibits provided in the rate certification and shared with the participating health plans show the development of the projected benefit expense at the rate group level. Since rates are finalized at the rate cell level, there is a transparency gap in the development of the adjustments to stratify the rates into rate cells that could be mitigated if rate cells were consolidated.

In addition, the current rate cells combine children age 14 years old and above with adults. Mercer recommends reassigning these into child and adult rate cells, defined as under/over age 21 years old, in order to align the rate cells with Medicaid benefit differences due to EPSDT.

Finally, health status-based risk adjustment is currently applied in the MMA program. Since the risk adjustment process has the effect of better matching payment to health plan risk through the review of disease characteristics and demographics of each health plan's population, the need for detailed age and gender is less important. The rate setting process could be simplified by updating the rate cell structure as noted.

### 3.3.2 Base Data Development and Adjustments

The contracted actuary's base data development approach was fairly consistent across each of the SMMC programs. The base data typically represented an annual period, were sufficiently recent for each rate development period, and represented the people and services covered under the applicable managed care contract. The base data development and base data adjustment process follows generally accepted actuarial practices. It was outside of the scope of our review to validate the technical accuracy of the base data itself. Our review and recommendations are based on a review of the methodology and information presented by the Agency's contracted actuary.

#### 3.3.2.1 Recommendations

***Base Data Recommendation 1:*** *Consider allocating Achieved Savings Rebate (ASR) financial data based on utilization data under the subcapitation arrangement.*

A potential issue exists in how ASR financial data for non-fee-for-service (non-FFS) services is allocated within the MMA program. The ASR financial data is reported in aggregated groups rather than detailed rate cells. AHCA's contracted actuary allocated costs for subcapitated services to rate cells based on the distribution of encounters in similar FFS service categories. However, the services covered under subcapitation may differ from those under FFS contracts. For example, a pediatric primary care clinic under subcapitation may not align precisely with the broader primary care category used in FFS data. This mismatch introduces uncertainty in cost allocation.

***Base Data Recommendation 2:*** *Consider developing and applying the encounter to ASR completion adjustment with more granularity in the MMA program.*

The adjustment applied to complete encounter data to ASR totals was uniform across all non-pharmacy services, despite underreporting typically varying across providers and service types. This broad approach may mask important differences.

***Base Data Recommendation 3:*** *Consider developing and applying Incurred But Not Reported (IBNR) adjustments by payer for all programs.*

IBNR adjustments were applied broadly rather than tailored by payer, despite different managed care organizations (MCOs) typically having differences in reporting and payment patterns. We suggest separating estimations to capture these differences.

***Base Data Recommendation 4:*** *Consider applying and documenting adjustments for long-term Institution for Mental Diseases (IMD) for LTC.*

Federal regulations require removal of all data from the base data for members aged 21 years-64 years with more than 15 days at an IMD in any given calendar month. From a federal perspective, these members are not considered Medicaid-eligible in that month. To maintain compliance, all of the members' experience (eligibility, IMD services, and non-IMD services) should be removed from the base data, even if the program does not cover the actual IMD services. While no IMD services were included in the LTC program base data, members with IMD experience covered outside these programs were present in the base data. The LTC rates did include such an adjustment in RY 2023/2024, but no documentation was noted that AHCA's contracted actuary reviewed or applied an adjustment in RY 2024/2025 pre-ITN or post-ITN. In a follow-up question sent to AHCA and AHCA's contracted actuary, they indicated that any adjustment for LTC enrollees is immaterial, since very few LTC enrollees meet the criteria to be excluded. While we do agree this is an immaterial item, this represents a federal compliance risk.

### 3.3.3 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. During this time, states were barred from disenrolling most Medicaid recipients even if their eligibility status changed, with some minor exceptions. Both the MOE requirements during the PHE and the subsequent unwinding of members off from Medicaid after the PHE, significantly influenced the expected health care 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 healthier, lower cost members who stayed enrolled in the program and who otherwise would have been disenrolled. Effective March 31, 2023, the MOE requirements ended, and states resumed eligibility redeterminations over a 12-month period (i.e., the unwinding process). Enrollment decreased, and average expected health care costs per member increased as lower cost members were disenrolled.

Given that these adjustments were specific, and tailored to, the applicable rating periods given the time-limited impact of the PHE and the unwinding process, Mercer does not have recommendations specific to these adjustments for future rate development processes. However, Mercer includes commentary below on the methodologies and adjustments employed by the contracted actuary in the rating periods reviewed. It should be noted that acuity adjustments related to the PHE and unwinding were unprecedented and notoriously difficult to project for actuaries across all states. Actuaries took a wide range of approaches when attempting to address this unique series of events and many states utilized two-sided risk corridors during these time periods due to the uncertainty of how the unwind of enrollees would impact remaining per member cost levels.

AHCA's contracted actuary applied adjustments to both the MMA and Dental programs for all three rating periods reviewed in this report. No adjustments were applied to the LTC program. It was common, across states, not to apply adjustments to similar populations as those enrolled in the LTC program, as these members were less impacted by the MOE and unwinding due to the eligibility requirements for the program.

For RY 2023/2024 rates for both MMA and Dental, the contracted actuary reviewed available data eligibility and redetermination data to project, statewide by rate cell, the portion of people who would be disenrolled in the rating period due to the unwinding and their relative acuity. This assumption-driven approach, informed by available data, was a common approach for this time period.

For RY 2024/2025 rates (both pre-ITN and post-ITN) for both MMA and Dental, the contracted actuary had actual disenrollment information for the entirety of the unwinding period. The contracted actuary utilized a purely data driven approach, and removed all members present in the base data period who were disenrolled during the unwinding process with a few notable exceptions (members who joined during the base period or were within 12 months of their original enrollment date, members who died, members within 12 months of a delivery, and members who were originally disenrolled, but were reenrolled within 90 days).

***Acuity Observation 1:*** *Adjustments reflected a potentially excessive removal of disenrolled members for RY 2024/2025.*

The adjustment methodology removes 100% of members classified as redetermined and found ineligible and not meeting the exception criteria noted above. This approach may have overstated the impact of the adjustment.

Not all disenrollments during the unwinding process represent *excess* enrollment due to the MOE. Disenrollments occur in *normal* periods, and a portion of the disenrollment during the unwinding process reflects normal churn. In any given year, there will be members who will

disenroll upon their next redetermination date. A *normal* mix of members would include a portion of these members.

For this particular adjustment, Mercer would have recommended exercising actuarial judgment to adjust the data-driven results to account for the portion of members that represent a *normal* level of disenrollment. In this review, Mercer has the advantage of reviewing actual enrollment volume in the rating period for the MMA program, which is post-unwinding. In total, the actuary's adjustment assumed approximately 35% of the population would disenroll. The actual reduction in membership was approximately 90% of that projected. With the information available to Mercer for review, it is difficult to classify the difference entirely to the disenrollment assumptions, as there may be other enrollment dynamics at play. However, many Medicaid programs continued to see decreases in enrollment after the unwinding process.

Mercer modeled the potential impact of overstating the disenrollments if the contracted actuary had assumed 10% of those redetermined represented a *normal* volume of leavers (e.g. persons disenrolled) in the data. As the acuity assumption reflected the actual base experience for all members who disenrolled, this would also need to be adjusted slightly. As a sensitivity test, Mercer modeled the impact to non-BA services assuming that members had a cost profile exactly equal to the broader group of leavers or halfway in between the group of leavers and group of stayers. Results vary by rate cell, based on the initial magnitude of the adjustment. In aggregate, under the latter scenario, the non-BA projected benefit cost PMPM would have been 0.8% lower for MMA and 0.7% lower for Dental. Under the former scenario, the aggregate PMPMs would be 1.6% lower for MMA and 1.4% lower for Dental.

As noted previously, this was a complex issue with different methodologies being employed by different actuaries. Our observation does not negate the approach used by the contracted actuary. Instead, we present this as an additional factor that does not appear to have been considered.

### 3.3.4 Trend

Trend factors are used to project costs from the base period to the contract period. They are necessary to account for changes in service utilization patterns and changes in the cost of services over time. Trend factors were developed separately for utilization changes and unit cost changes. These were 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. This conforms with standard actuarial practice, and Centers for Medicare & Medicaid Services (CMS) guidance, to separately project utilization and unit costs. The contracted actuary also accounted for many material programmatic changes explicitly as separate adjustments. For example, in MMA, no unit cost trend was applied to several categories, as a separate explicit adjustment was made for fee schedule changes. It is appropriate to separate known or expected material changes from trend, which supports better transparency and avoids convoluting trend with policy and other programmatic changes.

The granularity to which the contracted actuary developed and applied trend varied broadly within the MMA program. Acute services (inpatient, outpatient, professional) were applied uniformly to all rate groups, rate cells, and regions. For example, in RY 2024/2025 (both pre-ITN and post-ITN), the contracted actuary applied a -2.0% annual utilization trend to all four inpatient

service categories across all regions and rate cells. In contrast, the pharmacy trends varied by rate group, only varied by rate cell for TANF Non-SMI, but did not vary across rate cells for other rate groups, and did not vary by region. The most granular trends were applied to BA service utilization for RY 2024/2025 post-ITN, which varied by rate cell and region, with significant variation. The BA service utilization trend was developed in two parts. First, the base data was trended forward to a more recent 12-month period (August 2023 through July 2024) by region and rate cell, reflecting actual experience. Second, the remaining projected trend was applied by region, projecting that trend would continue as observed in historic trend. The second part of the BA trend did not vary by rate group or rate cell, with the exception of CMS Plan versus All Other Plan.

In the Dental and LTC program, trends vary by service category but are uniform by rate group.

The contracted actuary documented a variety of data sources used to develop trends for non-BA services. These include multiple years of Florida program experience, market research for drug pipeline changes, experience in other state Medicaid programs, as well as use of their own company's internal proprietary model based on nationwide trend research. The data sources are consistent with general actuarial practices.

Historic program experience is typically the main data reviewed in setting trends, typically with multiple years of data reviewed by month and/or on a rolling basis. However, historic trends are not necessarily indicative of future trends. Trend development is both an art and a science and requires the use of the actuary's professional judgment. It was outside the scope of work for Mercer to independently evaluate the selected trend factors and did not have access to the data reviewed by the contracted actuary in developing the trends. However, given the granularity at which the trends were applied, Mercer did not identify any factors that appeared unreasonable.

#### 3.3.4.1 Recommendations

***Trend Recommendation 1:*** *Consider more granularity in the acute service trend factors for MMA.*

Acute services make up the majority of the projected benefits in the MMA program. This broad approach may obscure important differences by population, potentially leading to inaccurate rate estimates.

For example, the -2.0% annualized trend noted above was applied to all inpatient utilization across all regions, rate groups, rate cells, and all four inpatient categories. This led to an outsized negative impact for certain rate cells. For example, the majority of the TANF non-SMI 0–2 Month rate cell benefit costs are inpatient, due to the birth event for the newborn. The contracted actuary has Hospital Inpatient FFS — Newborn as an individual category of service in the rate development process but applied the same -2.0% trend to the category.

Mercer recommends exploring additional granularity, such as considering further delineation by category of service (such as evaluating inpatient newborn, inpatient behavioral health, and the remaining inpatient separately), considering varying trends by population (rate cell groupings, child/adult, or other splits), and consider varying trends by region.

## 3.3.5 Other Adjustments

Within the development of the projected benefit PMPMs in the SMMC programs, there are additional adjustments applied beyond the base data adjustments, redetermination acuity adjustments, and trend adjustments described previously.

For the MMA program, this includes the many individual adjustments described in the rate certification and documented in the accompanying exhibits. These include, but are not limited to, items such as provider contracting adjustments, managed care efficiency adjustments, seasonality adjustments, and state fee schedule changes for certain services.

For the LTC program, this includes fee schedule changes for nursing facility and hospice services, a personal needs allowance adjustment, a legislative provider rate increase adjustment, a managed care savings adjustment, and a seasonality adjustment.

For the Dental program, this includes a seasonality adjustment and a dental provider incentive program adjustment.

Mercer does not have the requisite data available to replicate all of these adjustments. However, we did review the reasonableness of the adjustments applied. From our review, these other adjustments applied in the rate setting process appear to be reasonable and appropriate.

## 3.3.6 Statewide Rate Cell Factors

In the LTC and Dental programs, the buildup of the projected benefit expenses is done at the rate cell level. However, in the MMA program, the projected benefit expense, as documented by the contracted actuary, is developed at the region and rate group level. This is documented in Exhibit 12 of the rate certification package. As a last step in the process, statewide rate cell factors are applied to the projected benefit expense PMPMs by region and rate cell to produce the projected benefit expense PMPM by rate cell. A normalization step is applied so that this step is budget neutral for each region and rate group, which means the total projected dollars before the application of the factors and after the application of the factors are the same. This is documented in Exhibit 7 within the rate certification package for the MMA program.

### 3.3.6.1 Observations

***Observation 1:*** *Actuarial Soundness Concerns by Rate Cell for MMA.*

Within our scope of work, Mercer evaluated the rate development process, the appropriateness and reasonableness of methodologies and assumptions and compliance with ASOPs and federal regulation. As noted in the Rate Cell Structure section of this report, the rate cell is the level to which the actuary certifies the capitation payment per 42 CFR 438.4(b)(4) and the level at which the State makes capitation payments. Therefore, it is at this level of detail to which we assess the contracted actuary's rate development process.

Although the development of projected medical expenses are presented in Exhibit 12 by region and rate group, the underlying base data was developed by region and rate cell and several of the adjustments were developed and applied specific to each rate cell, such as the population

acuity adjustments, BA trends, and certain other adjustments. Through interview questions and responses from AHCA and its contracted actuary, they clarified that the benefit costs are projected separately by region and rate cell. For the region and rate group combinations displayed in the rating exhibits, all values represent an aggregation of the underlying region and rate cell information. It is these more detailed rate cell level projections that are used to develop the statewide rate cell factors.

As part of our review process, the contracted actuary provided Mercer with the base data member months and PMPMs, and projected member months and projected benefits cost PMPMs at the region and rate cell level for all three sets of rates reviewed.

Although the total funding in the rates for the MMA program as a whole may be appropriate due to the normalization step applied, the contracted actuary's process of applying a statewide rate cell factor results in final projected benefit costs, and subsequently final capitation rates, at the region and rate cell level that do not appear to provide for all reasonable, appropriate, and attainable costs specific to each rate cell.

In follow-up interviews with AHCA and their Contracted Actuaries, the Contracted Actuaries indicated that the application of statewide rate cell factors helps in situations where rate cells have small membership and hence credibility concerns. Mercer recognizes that adjustments are needed to account for any low credibility rate cell. However, there are many fully credible rate cells in the MMA program which are heavily adjusted through the application of statewide rate cell factors. These issues are exacerbated in the RY 2024/2025 post-ITN period when BA services were added to the MMA program, as the PMPMs for these services varied significantly by region and are specific to non-newborn children, particularly prevalent in the age 1–13 years rate cells. However, even prior to the BA inclusion, in the RY 2024/2025 pre-ITN rating period, the final projected benefit costs calculated using the statewide rate cell factors showed significant variation from the rate cell level projected benefit costs.

For example, the TANF non-SMI 1–13 Years rate cell is the largest rate cell in the MMA program in every region. However, the final projected cost ranged from 12.0% lower to 9.9% higher than what was individually projected for that rate cell. In the post-ITN period with the BA services inclusion, the range increased to -25.6% to +31.1%. This is summarized by region in Table 5 and 6.

**Table 5: Rate Year 2024/2025 Pre-ITN: TANF Non-SMI, 1–13 Years Projected Benefit Cost Per Member Per Month (PMPM)**

| Pre-ITN Region | Adjusted Base Member Months | Projected PMPMs by Rate Cell | PMPMs with Statewide Rate Cell Factors Applied | % Difference |
|---|---|---|---|---|
| 1 | 484,908 | $124.37 | $136.26 | 9.60% |
| 2 | 513,678 | $120.05 | $131.97 | 9.90% |
| 3 | 1,238,970 | $127.54 | $135.06 | 5.90% |
| 4 | 1,529,558 | $126.95 | $131.54 | 3.60% |
| 5 | 768,740 | $142.51 | $156.05 | 9.50% |
| 6 | 2,157,545 | $131.30 | $133.63 | 1.80% |
| 7 | 1,900,582 | $148.66 | $146.12 | -1.70% |
| 8 | 1,010,633 | $135.00 | $133.30 | -1.30% |
| 9 | 1,369,951 | $153.45 | $148.88 | -3.00% |
| 10 | 1,237,006 | $131.72 | $138.00 | 4.80% |
| 11 | 2,052,418 | $174.51 | $153.52 | -12.00% |

**Table 6: Rate Year 2024/2025 Post-ITN: TANF Non-SMI, 1–13 Years Projected Benefit Cost Per Member Per Month (PMPM)**

| Post - ITN Region | Adjusted Base Member Months | Projected PMPMs by Rate Cell | PMPMs with Statewide Rate Cell Factors Applied | % Difference |
|---|---|---|---|---|
| A | 1,001,017 | $118.07 | $154.78 | 31.10% |
| B | 2,769,724 | $129.39 | $157.56 | 21.80% |
| C | 767,465 | $148.72 | $183.03 | 23.10% |
| D | 2,157,287 | $147.30 | $162.42 | 10.30% |
| E | 1,893,957 | $169.43 | $178.33 | 5.30% |
| F | 1,012,069 | $195.58 | $183.77 | -6.00% |
| G | 1,362,662 | $215.72 | $200.72 | -7.00% |
| H | 1,236,255 | $187.26 | $187.89 | 0.30% |
| I | 2,050,166 | $342.67 | $255.09 | -25.60% |

In order for the application of statewide rate cell factors to produce appropriate results for each rate cell, the relativities for each underlying rate cell to the broader rate group must be similar by region. This does not hold true when reviewing projected costs at the region and rate cell level compared to the statewide rate cell factors utilized. For example, in the post-ITN period, the cost relativity for the TANF non-SMI 1–13 Years in Region I is 1.178 when using projected expenses at the region and rate cell level. Within the development of projected medical expenses at the rate cell level shown in Exhibit 7, the statewide relativity is 0.863. In the RY 2024/2025 pre-ITN period, the analogous values were 0.862 in Region I and 0.752 statewide.

Given that the modeling included budget-neutral normalization adjustments, the aggregated PMPMs by region do appear appropriate at the rate group level.

Under the managed care contract, the MCOs are required to utilize value-based purchasing arrangements. These arrangements can take a variety of forms and Mercer does not have insight into the MCOs' contracts with providers. While the use of value-based purchasing is mandated, the methodology used in those arrangements within the contract between the MCO and the providers is not mandated. MCOs and providers should have separate considerations for the populations and services covered under these arrangements and develop an appropriate methodology for that arrangement. However, if the payment arrangement from the MCOs to providers is based on, or makes reference to, the capitation rates the MCO receives from the State, there could be a downstream impact realized by the providers. For example, in the example noted above, the TANF non-SMI capitation rate for 1–13 Years is underfunded in Region I, since the projected benefit cost PMPM at the region and rate cell level is $342.67, while the application of statewide rate cell factors produces $255.09 (approximately 26% lower than projected). Based on this, it is possible that reimbursement to certain providers in that region is negatively impacted. Even though the region as a whole may be adequately funded for the MCO (if their enrollment mix is similar to the assumed region average), some providers (e.g. pediatricians) primarily serve the 1–13 Years rate cell, and do not serve adults.

### 3.3.6.2 Recommendations

Mercer recommends revising the methodology for determining final projected benefit PMPMs by rate cell.

***Rate Cell Recommendation 1:*** *Consider consolidating rate cells for the MMA program within the TANF non-SMI, TANF SMI, SSI Medicaid Only non-SMI, SSI Medicaid Only SMI, and Child Welfare rate groups to include only a Child/Adult split.*

This is the same recommendation noted above in the Rate Cell Structure subsection. If the rate cell structure is reconfigured to be less detailed, rates could be developed directly at the rate cell level and eliminate the rate group to rate cell factor approach. Any region and rate cell combinations that are not fully credible on their own could incorporate credibility adjustments by relational modeling to other more credible and similar rate(s) cells and blending (see Rate Cell Recommendation 2 below). If this approach had been employed in the rating periods reviewed, the total projected rate would not have materially differed; however, each certified rate cell would have been more appropriate for the members and services covered under the rate cell. Specifically, if a child rate cell existed up to age 21, the vast majority of BA service costs would be included in this rate cell.

***Rate Cell Recommendation 2:*** *With no change to the rate cell structure, consider employing credibility adjustments to the rate cell projections, as needed, in replacement of the statewide rate cell factor application.*

In the contracted actuary's current process, projected benefit costs are developed by rate cell as part of the underlying work (though not shared with the MCO plans or CMS). Rather than consolidating these to a rate group level and applying a statewide factor to return to the rate cell level, Mercer recommends using these rate-cell-level projections directly. If the base member

months underlying the rate cell are not fully credible, based on a selected threshold (e.g., 24,000 member months), the projected benefit costs for that rate cell could be blended with an appropriate reference rate.

Mercer modeled one potential variation of the credibility adjustment approach as follows:

- Use a classic credibility formula, with an appropriate member month threshold for full credibility, to determine the weighting to place on the rate-cell-level projection.
- Calculate a reference rate:
  - Calculate the statewide rate for the rate cell.
  - Calculate category of service specific regional factors by comparing on a mix-adjusted basis, i.e., the average PMPMs for the region in question compared to the average PMPMs statewide rolled up on the mix of members in the region in question.
  - Multiply by the statewide rate by the regional factor.
- Blend the rate-cell-level projection with the reference rate.

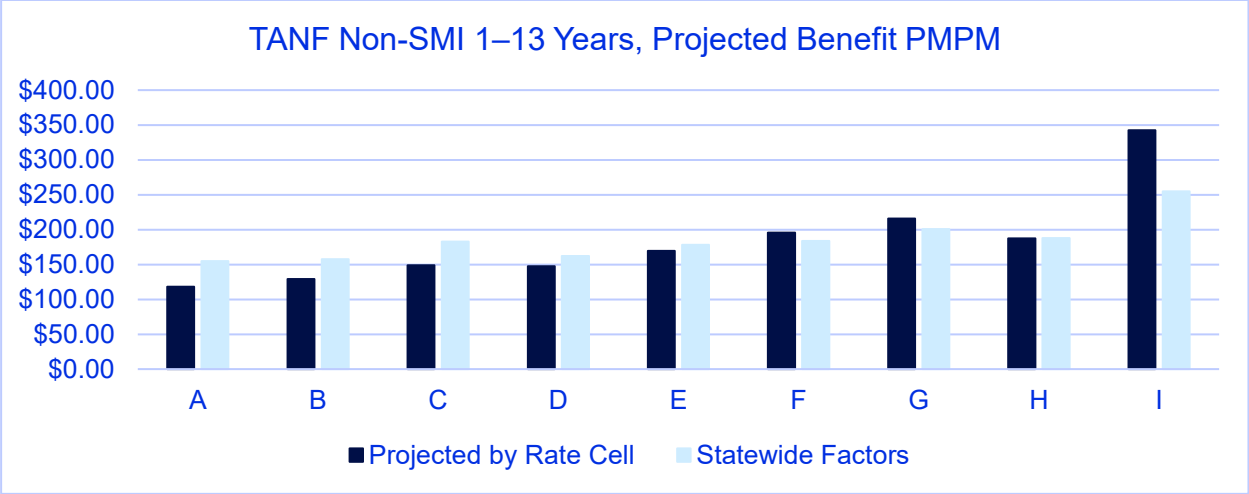
An example of this process, using a 24,000 member month threshold for full credibility, is summarized in Table 7 for the RY 2024/2025 post-ITN rating period for TANF Non-SMI 0–2 Months in Region C.

**Table 7: Credibility Adjusted Base Data Calculation Example**

| Component | Value |
|---|---|
| **Adjusted Base Member Months** | 16,866 |
| **Credibility** | 83.8% |
| **TANF Non-SMI 0–2 Months Region C Projected Benefit Cost PMPM** | $2,679.40 |
| **Statewide Average PMPM for TANF Non-SMI 0–2 Months** | $2,063.95 |
| **Category of Service-Weighted Regional Factor** | 1.190 |
| **Reference Rate** | $2,455.77 |
| **Credibility Adjusted Projected Benefit Cost PMPM** | $2,643.24 |
| **Projected Benefit Cost PMPM with Statewide Rate Cell Factor** | $2,027.47 |

Many of the rate cells are fully credible and would not require further adjustment. For example, the TANF Non-SMI 1–13 Years rate cell is very large within every rating region and would be fully credible. A comparison of the recommended method (projected by rate cell) against the existing method (statewide rate cell factors) is illustrated in Figure 2 for this population.

**Figure 2: TANF Non-SMI 1–13 Years, Projected Benefit Per Member Per Month (PMPM)**




***Rate Cell Recommendation 3:*** *Revisit methodologies and models used regularly, particularly when there are material changes to the program.*

In every rating cycle, the methodologies and models used in the prior rating cycle should be reviewed to consider continued appropriateness to the current rating cycle. This review should be done both conceptually at the start of the process – and then the outputs of the modeling/methodology should be reviewed at the end of the process. If a model or methodology provided reasonable results in the past but does not produce reasonable results in its current use, that model should be discarded or adjusted to fit the circumstances.

In the case of the statewide rate cell factors model, the introduction of BA services in the RY 2024/2025 post-ITN period represented a large-scale change to the MMA program. The discrepancies between the region/rate cell capitation rates and the region/rate cell underlying projections were exacerbated due to the large variation in BA services across regions and the fact that these services were heavily concentrated in certain rate cells. One potential improvement to the model employed by the contracted actuary would have been to adjust the BA and non-BA services separately (i.e., develop statewide rate cell factors for BA services and also separately for the remainder of the services). For example, the statewide rate cell factor used by the contracted actuary for TANF Non-SMI 1–13 Years was 0.863. If that factor had been developed separately (i.e., split factor as shown in Figure 3 and Figure 4) for BA and non-BA, the factors would have been 1.750 for BA and 0.714 for non-BA.

This improvement would have been particularly helpful, given that there was a risk corridor specific to the BA services in the RY 2024/2025 post-ITN managed care contract. The BA PMPMs by rate cell used as the starting point for the risk corridor calculations would have more appropriately reflected what was projected for that service.

Illustrative examples of the impact of Rate Cell Recommendation 2 and Rate Cell Recommendation 3 relative to the statewide rate cell factor approach are shown in Figure 3 and Figure 4 for RY 2024/2025 both pre-ITN and post-ITN.

**Figure 3: Region A, TANF Non-SMI, 0–2 Months Projected Benefit Per Member Per Month (PMPM)**

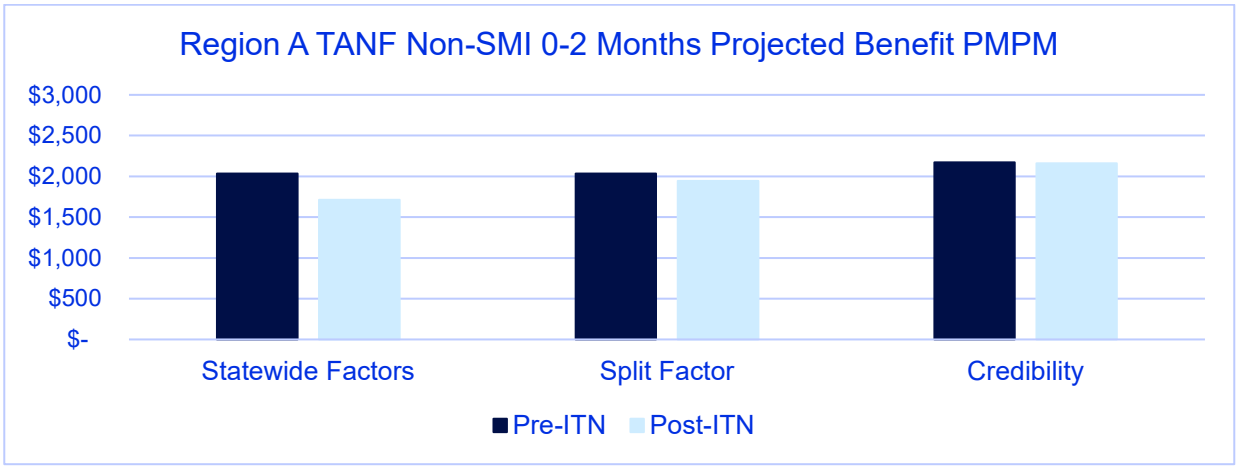
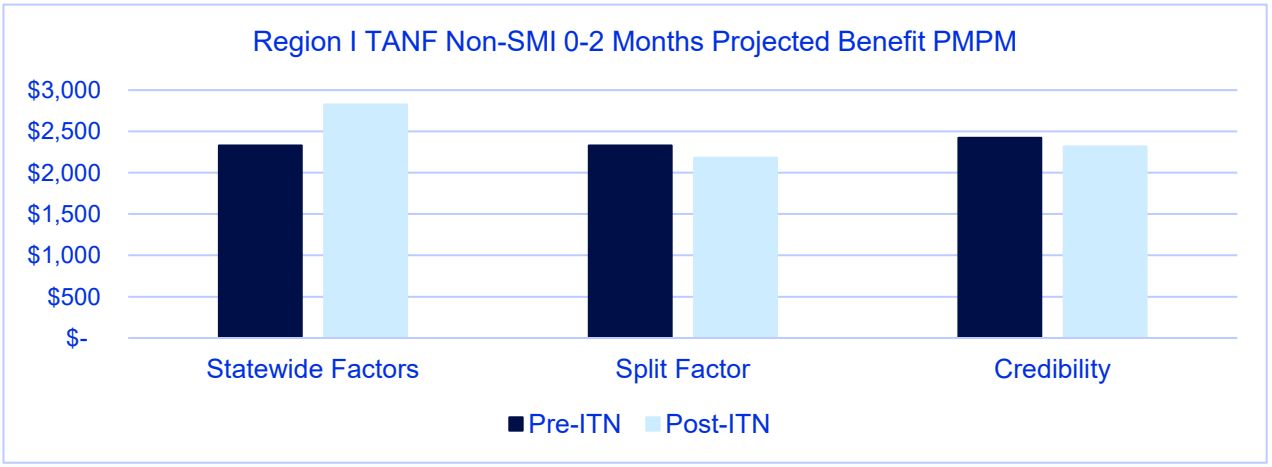



**Figure 4: Region I, TANF Non-SMI, 0–2 Months Projected Benefit Per Member Per Month (PMPM)**




## 3.3.7 Non-Benefit Expenses

In addition to provisions for projected benefit expenses, capitation rates include provisions for non-benefit expenses. This includes administrative expenses expected to be incurred by health plans in addition to a provision for underwriting gain, which includes components for the cost of capital and risk margin.

Importantly, per 42 CFR 438.4(b)(9), capitation rates should be developed such that the health plans should reasonably achieve a medical loss ratio of at least 85%, which means that at least 85% of the capitation rates should be spent directly on benefit expenses. As a result, non-benefit provisions in the rates need to be at most 15% of the total capitation rates.

In the development of administrative provisions within the rates, AHCA's contracted actuary reviewed historical health plans administrative reporting from the ASR financial reports, reviewed contractual requirements, and surveyed the health plans specific to their administrative

requirements and projections. Additionally, specific to the unwinding of members due to the end of the PHE, AHCA's contracted actuary used a fixed and variable approach to account for significant member reductions from the base data period to the projected contract periods, which is a reasonable approach to take.

For all programs, the non-benefit load within the capitation rates is always less than 15% in the aggregate for each region across all rate cells.

The methodology used by AHCA's contracted actuary in the assumptions for non-benefit expenses appeared reasonable.

## 3.3.8 Behavior Analysis Services

BA services were added to the MMA program effective February 1, 2025 with the onset of the Post-ITN re-procurement. For the RY 2023/2024 and RY 2024/2025 Pre-ITN rating periods, BA services were covered by the State in the FFS delivery system and not considered in the capitation rates as a result. This subsection is only applicable to the RY 2024/2025 Post-ITN period.

### 3.3.8.1 Development of Projected BA Expenses

With the addition of BA services into the managed care contracts in the Post-ITN RY 2024/2025 rating period, AHCA's contracted actuary incorporated this benefit into the capitation rates. The incorporation of BA services in the rates was done similarly to other services with the establishment of base data and the application of trend and other adjustments to derive the projected medical expenses for the contract period. This process is described below.

- Base Data — State FFS data from SFY 2022–2023 was used as the historical base data source specific to members in the MMA program. The base data presented in the rate exhibits specific to BA services is net of the members removed as part of the redetermination rebasing adjustment.
- Trend — Only utilization trend factors were applied for BA services. To derive the utilization trend factors, the State's contracted actuary first trended the base experience to a more recent, 12-month period after the base data period based on actual experience (August 2023 through July 2024). Then, assumed utilization trends were applied to trend BA service utilization from the more recent period to the contract period, based on historical trends observed at the region and CMS Plan versus All Other Plan level.
- Other Adjustments — The other adjustments applied to BA services are the following:
  - Provider Contracting — The contracted actuary applied a provider contracting adjustment to project unit cost levels for BA services into the rating period, leveraging provider contracting information submitted by the MCOs.
  - Managed Care Savings — The broad managed care savings factors described previously were applied to the BA services.

– Legislative Appropriations — This adjustment accounts for a BA services fee schedule change as part of legislative appropriations.

The steps above are shown at the region and rate group level within the rate exhibits provided by AHCA. The total projected medical expenses across all services (including BA services) are then subject to statewide rate cell factors to derive projected medical costs at the region, rate group, and rate cell level, as described previously.

While the development of the BA component of the rates was shown at the region and rate group level of detail, the contracted actuary first developed the underlying BA service projections at the region, rate group, and rate cell level of detail and aggregated the detailed projections to the region and rate group level of detail.

### 3.3.8.2 Risk Corridor

While BA services were covered in the FFS delivery system (prior to its inclusion in MMA), BA service utilization was increasing at a rapid pace. Partly due to these large increases in BA service utilization, BA services were moved into the MMA program in the post-ITN period. A goal of moving this benefit into managed care was to achieve cost savings through better management of the benefit by the MCOs. However, limited information was available to reasonably estimate the impact of the potential managed care savings for BA services. As a result, AHCA implemented a one-sided risk corridor specific to BA services. This means that the contracted actuary set a rate or target specific to BA services (part of the broader rate), and if an MCO's actual BA expenditures are a predefined amount lower than the target amounts built into the rates, the State would recoup funds paid out to the MCOs. However, being a one-side risk corridor, the State is not at risk to pay more if actual BA expenditures are higher than the BA capitation revenue.

The structure of the risk corridor was such that the MCOs would be incentivized to manage the BA benefit effectively and allow AHCA to share in a portion of the managed care savings achieved by the plans. AHCA utilized a tiered shared savings structure that was dependent on the differential between actual BA service expenditures compared to the projected BA spend within the capitation rates. The parameters of the corridor were as follows:

- If an MCO's actual BA service expenditures were greater than 95% of the projected BA amounts in the capitation rates, the MCO does not return any capitation revenue to AHCA.
- If an MCO's actual BA service expenditures were between 90% and 95% of the projected BA amounts in the capitation rates, the MCO returns capitation revenue back to AHCA in the amount of 50% of the differential between the MCO's actual BA expenditures and 95% of the capitation revenue.
- If an MCO's actual BA service expenditures were less than 90% of the projected BA amounts in the capitation rates, the MCO returns to AHCA 100% of the differential between the MCO actual BA expenditures and 90% of the capitation revenue, in addition to 50% of the differential between 90% and 95% of the BA capitation revenue.

In the original rate certification, AHCA's contracted actuary documented the capitation revenue specific to BA services at the region, rate group, and rate cell level in Exhibit 36A. These PMPMs

were the original amounts to be used in the denominator of the risk corridor calculation for each region, rate group, and rate cell. For each health plan's targeted BA PMPMs, the amount was still subject to a risk adjustment factor, which would be calculated retrospectively consistent with the broader retrospective CDPS+Rx risk-adjustment process.

### 3.3.8.3 BA Risk Adjustment

After the rating period began, the State's contracted actuary deemed it was necessary to update the BA portion of the capitation rates, citing an unanticipated shift of members who utilize BA services at a higher-than-average rate from the non-CMS Plan to the CMS Plan. As a result, the contracted actuary implemented a BA risk adjustment process. The purpose of this process was to re-distribute BA expenditures assumed in the rates across rate cells and rate groups within each region. The process was budget neutral, such that the same total expenditures specific to BA services assumed in the capitation rates remained the same before and after the adjustment. Additionally, a result of this process was to calculate the risk corridor targets for each MCO.

The specific process is described below:

- Capitation rates by region and rate cell were separated into BA and non-BA rate components. To do this, the contracted actuary used the ratio of projected BA spend to total projected spend at the region, rate group, and rate cell level of detail. This ratio was applied to the final capitation rates to derive the BA component of the capitation rates. It should be noted that the BA rate component calculated in this step does not align with the BA rate components shown in Exhibit 36A within the original rate certification exhibits and are therefore not consistent with the original rate development.
- Once the BA component of the capitation rate was developed, it was redistributed across rate groups and rate cells within each region, by calculating member level utilization per 1,000 statistics and tracking which rate group and rate cell each member was enrolled in during the actual fiscal year 2024/2025 rating period. This was done in a budget neutral fashion and done by quarter (February 2025–March 2025, April 2025–June 2025, and July 2025-September 2025). The result of this step was an updated BA rate component for each region, rate group, and rate cell by quarter. As a result, the total capitation rates by region, rate group, and rate cell changed on a quarterly basis with this update as well.
- Additionally, this process was used to set the BA risk corridor targets for each MCO. Using the same process of calculating member level calendar year 2024 utilization per 1,000 statistics for BA services, members were also tracked at the health plan, rate group, and rate cell for each region, and this was used to calculate the risk corridor target for each MCO by region, rate group, and rate cell.

### 3.3.8.4 Actuarial Review

Based on our review, certain rate development components in the inclusion of BA services into the RY 2024/2025 post-ITN rates appear to be reasonable. Namely, the use of SFY 2022–2023 base data and the application of the various adjustments (trend and other adjustments) to arrive at the projected medical expenses at the region and rate group level appear to be reasonable. Further, the concept of a one-sided risk corridor is reasonable as well, given the substantial rise

in BA-related costs in the FFS delivery system and the rationale to incentivize health plans to manage and control BA costs effectively.

However, certain components of the rate development methodology for the inclusion of the BA services warrants commentary, which is provided below.

#### 3.3.8.4.1 Statewide Rate Cell Factors

As noted previously, BA PMPM costs are noted to be significantly different by region, with Region I showing significantly higher per member BA costs than the other regions. The application of statewide rate cell factors creates a mismatch in the amounts projected independently at the region and rate cell level versus the amounts built into the projected medical expenses across all services.

#### 3.3.8.4.2 Risk Corridor

The original target PMPMs for the BA risk corridor were provided in Exhibit 36A in the original rate certification exhibits. At the time that the rates were set, this represented the contracted actuary's best estimate of BA PMPM costs by region, rate cell, and rate group. Due to the application of statewide rate cell factors across all services in projection of medical costs, some of the BA PMPM targets displayed in Exhibit 36A do not make practical sense when compared to the total rates. Of particular issue, there are instances where the BA target PMPM in Exhibit 36A is greater than the capitation rate for certain rate cells, as shown in Table 8; therefore, the capitation is not sufficient to cover the projected BA services.

**Table 8: Final Capitation Rate and Exhibit 36A Comparison**

| Region | Rate Group | Rate Cell | Final Capitation Rate — Exhibit 7 | BA PMPM — Exhibit 36A |
|---|---|---|---|---|
| I | TANF SMI Non-Specialty | 6–13 Years | $1,443.62 | $1,576.27 |
| I | TANF SMI Specialty | 6–13 Years | $1,463.35 | $1,557.39 |
| I | SSI Medicaid Only Non-SMI | 1–13 Years | $1,537.75 | $1,580.56 |
| I | SSI Medicaid Only SMI Non-Specialty | 6–13 Years | $1,707.80 | $2,752.13 |
| I | SSI Medicaid Only SMI Specialty | 6–13 Years | $1,724.37 | $2,719.16 |

Additionally, as part of the BA risk adjustment process described by the contracted actuary, the manner in which the portion of the rates specific to BA creates either an overstatement or understatement of the projected BA costs in the rates. In this process, the starting point of the calculation was to split the capitation rate by BA and non-BA service components. As noted previously, the application of statewide rate cell factors either overstates or understates rates at the rate cell level. In Region A, the TANF Non-SMI 1–13 Years capitation rate is too high as a result of the statewide rate cell factor application, while in Region I, the TANF Non-SMI 1–13 Years capitation rate too low as a result of the statewide rate cell factor application. To derive the component of the rate specific to BA services, the contracted actuary used the Exhibit 36A BA PMPMs as a ratio of total projected spend at the region, rate group, and rate cell level. If the capitation rate is overstated, as is the case in Region A for the TANF Non-SMI 1–13 Years rate cell, then the assumed amount of the capitation rate specific to BA services is also overstated.

The opposite is true in Region I for the TANF Non-SMI 1–13 Years rate cell, since the total capitation rate is too low. When BA PMPMs in Exhibit 36A are compared to the BA PMPMs found in the BA risk adjustment exhibits, significant differences are observed.

CFR 438.6(b)(1) states that *risk-sharing mechanisms may not be added or modified after the start of the rating period*. With the update made to the BA risk corridor targets as part of the BA risk adjustment process, the target PMPMs prior to risk adjustment were changed and are inconsistent with the targets described in the rate certification. Therefore, the risk corridor was modified after the start of the rating period, which is a potential regulatory risk.

## 3.3.9 Risk Adjustment

### 3.3.9.1 MMA

Within the MMA program, capitation rates are set as an average across multiple health plans for each region and rate cell. Once the regional rates are set by rate cell, risk adjustment is applied to adjust the rates to be health plan specific. Risk-adjustment processes generally use a risk-adjustment model and methodology to compare the health status of each health plan'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.

There are many considerations when implementing a risk-adjustment process within Medicaid managed care. Listed below are important specifications used in the risk adjustment process for the MMA program.

- Risk-Adjustment Model — For all rate years reviewed, the contracted actuary used the CDPS+Rx risk adjustment model to risk adjust capitation payments in MMA program. Note the Child Welfare rate cells are not subject to the CDPS+Rx model, but rates are adjusted by each health plan's mix of Out of Home and non-Out of Home members. The contracted actuary has added multiple custom variables to the risk-adjustment model
- Applicable Rate Cells — The following rate cells are subject to the risk adjustment process within MMA.
  - TANF Non-SMI — 1–13 Years Population
  - TANF Non-SMI — 14-–54 Years Female Population
  - TANF Non-SMI — 14–54 Years Male Population
  - TANF Non-SMI — 55+ Years Population
  - TANF SMI — 6–13 Years Population
  - TANF SMI — 14–54 Years Female Population
  - TANF SMI — 14–54 Years Male Population

  - SSI Medicaid Only Non-SMI — 1–13 Years Population
  - SSI Medicaid Only Non-SMI — 14+ Years Population
  - SSI Medicaid Only SMI — 6–13 Years Population (not applicable in RY 2024/2025 Post-ITN)
  - SSI Medicaid Only SMI — 14+ Years Population
  - Child Welfare — 1–13 Years Population (not subject to CDPS+Rx)
  - Child Welfare — 14+ Years Population (not subject to CDPS+Rx)
- Data Sources — Eligibility, encounter, and State paid FFS data are the main sources used to classify members into disease conditions. The contracted actuary employs a thorough encounter data validation process with the MCOs so that the data is usable for risk-adjustment purposes.
- Update Frequency — MMA risk adjustment calculations are updated 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. For the Post-ITN RY 2024/2025 period, a retrospective process was done, where final risk-adjustment factors are based on actual enrollment in the rating period.

The general process utilized by the contracted actuary is described below, performed quarterly:

- Collect and validate data to be used in the risk adjustment — The schedule of data updates each quarter is well documented.
- Calculate individual level risk scores for scored members — For members who meet certain criteria to be scored, the contracted actuary calculates individual risk scores as the sum of the risk weights for each CDPS+Rx category a member is classified into.
- Assign members to a health plan, rate group, and rate cell using an enrollment snapshot month — This is typically done using a snapshot month prior to the time period for which the factors are used. For the RY 2024/2025 Post-ITN period, this was done retrospectively based on actual enrollment during the RY 2024/2025 Post-ITN period.
- Assign unscored members an assumed risk score — To assign assumed risk scores for the unscored population, the contracted actuary uses the average risk score for scored members by health plan, region, rate group, and rate cell.
  - Combine average risk scores for scored members and assumed risk scores for unscored members by health plan, region, rate group, and rate cell.
  - Calculate the aggregate average risk score across all health plans for each region, rate group, and rate cell.
  - Normalize each health plan risk score by dividing the health plan specific score by the region average. This creates the budget neutral plan factor.

– Apply the budget neutral plan factor to the capitation rates by health plan, region, rate group, and rate cell to arrive at the risk adjusted rates.

Specific to the RY 2024/2025 Post-ITN period, the specialty population definitions changed, and members had to voluntarily enroll into a specialty product. 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.

Overall, the risk adjustment process appeared to be reasonable and consistent with generally accepted actuarial practices. Specific to the inclusion of BA services in the RY 2024/2025 Post-ITN period, we have the following recommendation.

#### 3.3.9.1.1 Recommendation

Specific to BA services in the RY 2024/2025 Post-ITN period, the risk adjustment process could be clearer and simplified.

As noted previously, the inclusion of BA services and the statewide rate cell factors inclusive of all services (BA and non-BA combined) introduced unexpected variance in the capitation rates at the rate cell level. One alternative is to separate non-BA and BA services in the rate development process completely. In this process, the final rates would be the sum of the non-BA and BA portions of the capitation rate, with each component developed separately by region, rate group, and rate cell. Under this approach, the CDPS+Rx risk adjustment process would be applied to the non-BA rate component only, without a need to calibrate the CDPS+Rx model with a BA utilizer variable in addition to including BA-related costs into the model. The prior model without these additional items can be used. Further, the BA risk-adjustment process (described in the BA Services subsection) can be leveraged for the BA rate component. In doing this, the component of the capitation rates specific to BA would be consistent with the risk corridor targets and more easily explainable and documented. The methodology chosen by the contracted actuary used the BA risk adjustment process to arrive at the risk corridor target PMPMs, while the broader total rate, across BA and non-BA services, was risk adjusted using the CDPS+Rx model.

### 3.3.9.2 LTC

Within the LTC program, a customized HCBS risk-adjustment process was applied in RY 2023/2024 as well as both RY 2024/2025 contract periods. This customized HCBS risk-adjustment process uses functional assessment data from the Department of Elder Affairs (DOEA) for members in the LTC program to predict costs specific to the HCBS rate group within the LTC program. The model was developed using historical assessment data and cost experience for the HCBS population. In application for each rate year, more recent assessment data is used along with an enrollment snapshot month used specifically for each rating period.

The general process for the LTC risk adjustment process is similar to the process used in the CDPS+Rx process, with individual risk scores calculated for scored members in the enrollment snapshot month who had an assessment. Unscored members are those that did not have assessment data but are enrolled in the snapshot month. The end result is budget neutral plan factors applied to the HCBS portion of the LTC capitation rates.

The data specifications used for the LTC risk adjustment process for each rating period are listed in Table 9.

**Table 9: Data Specifications used for Long-Term Care Risk Adjustment Across Rating Periods**

| Specification | RY 2023/2024 | RY 2024/2025 Pre-ITN | RY 2024/2025 Post-ITN |
|---|---|---|---|
| Data used for Model Development | October 2020 through September 2021 assessment data and corresponding claims information | October 2022 through September 2023 assessment data and corresponding claims information | Same as RY 2024/2025 Pre-ITN |
| Assessment Data used for Application in Rates | Received by DOEA through June 15, 2023 | Assessment data provided late 2023/early 2024 and supplemental information provided in June 2024 and July 2024 by the LTC plans | Assessment data provided late 2024/early 2025 and supplemental information provided in June 2025 and July 2025 by the LTC plans |
| Enrollment Snapshot Month | April 2023 | April 2024 | April 2025 (applied retrospectively) |
| Phase-In Considerations | LTC risk adjustment results were phased in at 50% credibility | LTC risk adjustment results were phased in at 100% credibility | LTC risk adjustment results were phased in at 100% credibility |

The LTC risk-adjustment process appeared to be reasonable and consistent with generally accepted practices.

### 3.3.9.3 Dental

Capitation rates in the dental program are not subject to health status-based risk adjustment.

Section 4

# PACE Program

Federal requirements (42 CFR 460.182) state that Medicaid rates for the Program of All Inclusive Care for the Elderly (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.

AHCA's contracted actuary developed the AWOPs in accordance with the federal requirements and the state plan.

In general, Mercer agrees with the approach taken to develop the AWOPs. The deliverables are consistent across the tabs; and formulas and calculations seem appropriate. There were two inconsistencies that were found in *Exhibit 1 — Medicare Elig AWOP* and *Exhibit 3 — Medicaid Only AWOP*.

- The total statewide trend calculated in Exhibit 1 for Acute Care did not take the Age 55+ Adjustment into account. This is inconsistent compared to the total statewide trends calculated for LTC which are very similar calculations. There is no explicit impact of this inconsistency.
- This only applies to SFY 2025/2026 AWOP Development Exhibits
- The development of Projected SFY 2025/2026 Dental Claims per PMPM is shown differently than the development of LTC claims and Acute claims. The Age 55+ Adjustment and trend portions are not broken out separately as they are for the other programs. Mercer requested additional information from AHCA's contracted actuary, but the additional information provided did not fully align with the methodology described in the report. Mercer does not believe that this had a material impact on the AWOPs and therefore the rates.
- The same comment applies to the development of Projected FY 2024/2025 Dental Claims PMPM of *Exhibit 1 - Medicare Eligible* and *Exhibit 3 - Medicaid Only* tabs both found in *Report01 - Florida FY 2425 PACE Upper Payment Limit Development Exhibits*

## 4.1 Base Data

The base data used by AHCA's contracted actuary were the RY 2024/2025 Post-ITN rates for the SFY 2025/2026 AWOP and the RY 2023/2024 for the SFY 2024/2025 upper payment limit (UPL) for the following three programs:

- HCBS, Non-HCBS, Dual Eligible, and Non-HCBS Medicaid Only rate cells for the SMMC LTC program

- LTC Dual Eligible and LTC Medicaid Only rate cells for the SMMC MMA program
- Dual Eligible 21+ and Medicaid Only 21+ rate cells for the SMMC dental program

### 4.1.1. LTC Program Costs

#### 4.1.1.1 SFY 2025/2026 AWOP

AHCA's contracted actuary started with the projected RY 2024/2025 Post-ITN LTC costs for the SMMC LTC program population. Mercer verified that the seasonality factor was removed to account for the partial year base. Four adjustments were then applied. It was beyond the scope of Mercer's review to validate the region-to-county, age 55+ years, and acuity adjustments; however, each adjustment appeared reasonable and appropriate. Mercer validated that the trend adjustment aligned with the utilization and unit cost, patient responsibility, and managed care savings trends used in the SMMC LTC program for the appropriate rate cells and the appropriate number of months. Mercer verified that the blending percentage methodology was reasonable.

#### 4.1.1.2 SFY 2024/2025 UPL

AHCA's contracted actuary started with the projected RY 2023/2024 LTC costs for the SMMC LTC program population. Three adjustments were then applied. It was beyond the scope of Mercer's review to validate the region-to-county, and morbidity adjustments, but both adjustments appeared reasonable and appropriate. Mercer validated that the trend adjustment aligned with the utilization and unit cost used in the SMMC LTC program for the appropriate rate cells and the appropriate number of months. Mercer verified that the blending percentage methodology was reasonable.

### 4.1.2. MMA Program Costs

#### 4.1.2.1 SFY 2025/2026 AWOP

Similar to the LTC costs, to develop the SFY 2025/2026 acute care costs, AHCA's contracted actuary started with the projected RY 2024/2025 costs, but this time, acute costs were used for the SMMC MMA program population. Mercer verified that the seasonality factor was removed to account for the partial year base. Mercer verified that the age 55+ adjustment appeared reasonable and appropriate and validated that the trend adjustment was composed of utilization and unit cost and managed care savings used in the MMA program for the appropriate rate cells and the appropriate number of months.

#### 4.1.2.2 SFY 2024/2025 UPL

Similar to the SFY 2025/2026 AWOP, to develop the SFY 2024/2025 acute care costs, AHCA's contracted actuary started with the projected RY 2023/2024 costs. Mercer verified that the trend adjustment appeared reasonable and appropriate and was composed of utilization and unit cost trends used in the MMA program for the appropriate rate cells and the appropriate number of months.

## 4.1.3. Dental Program Costs

### 4.1.3.1 SFY 2025/2026 AWOP

To develop the SFY 2025/2026 dental costs, AHCA's contracted actuary started with the projected RY 2024/2025 dental costs for the SMMC dental program population. Unlike other programs, the age 55+ and trend adjustments were not separately identified. Mercer requested additional information to validate the adjustments made to the SMMC dental program population. The SFY 2025/2026 PACE AWOP Development report states that the RY 2024/2025 costs were trended to SFY 2025/2026 by applying the utilization and unit cost trend assumptions used in RY 2024/2025 SMMC Dental rate setting. However, the supplemental information provided applied statewide factors for unit cost trend, utilization trend, and the 55+ factor. This approach does not appear to align with the utilization and unit cost trend used in the RY 2024/2025 SMMC Dental rate setting, as described in the SFY 2025/2026 PACE AWOP Development report. The PMPMs were minimal in comparison to the total AWOP, so in Mercer's opinion, this does not significantly affect the AWOPs and therefore the rates.

### 4.1.3.2 SFY 2024/2025 UPL

To develop the SFY 2024/2025 dental costs, AHCA's contracted actuary started with the projected RY 2023/2024 dental costs for the SMMC dental program population. The trend adjustment was not broken out separately as it was in other programs. Mercer was able to verify that trend was set at 1% as described in the SFY 2024/2025 UPL report.

## 4.1.4. Other Considerations in AWOP Development

The AWOP must consider all costs to the State that would have otherwise been paid. This includes services paid on a FFS basis (i.e. not included in the SMMC programs) as well as considerations for rebates collected that would reduce the cost to the State.

Florida Assertive Community Treatment (FACT) services are intensive, community-based behavioral health services delivered by a multidisciplinary team and, in Florida, are typically reimbursed outside the managed care capitation arrangement on a FFS basis. Because these services are generally paid separately from SMMC MMA managed care payments, AHCA's contracted actuary made an adjustment to appropriately reflect the cost impact of FACT services that would have otherwise been paid, along with an adjustment for pharmacy rebates collected by the State for SMMC MMA members. These adjustments appeared reasonable based on the information provided; however, it was beyond the scope of Mercer's review to independently validate the underlying data or methodology supporting them.

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

- Administrative costs: AHCA's contracted actuary used the LTC administrative costs from rate reports for LTC and MMA rates as well as projected administrative costs for comparable population for the dental rates. The SMMC LTC and SMMC MMA administrative costs were trended forward at 4.0% for seven months to account for the difference between the contract periods. A 1.0% managed care savings adjustment was applied, consistent with the

procurement negotiations. This yielded a 4.5% of revenue for the Medicare-eligible population and 5.0% for the Medicaid Only population was included in the AWOPs.

- Gain/Loss margin: a 2.0% gain/loss margin was added, consistent with SMMC rate development.

#### 4.1.4.1 PACE Capitation Rates

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

##### 4.1.4.1.1 PACE Observations

There are no explicit observations of issues with the updated methodology for the SFY 2025/2026 AWOPs. The AWOPs are based on the RY 2024/2025 rates to the extent that there are any observations that would affect those rates, they may also affect the PACE AWOPs.

Section 5

# CNET Program

## 5.1 Federal Requirements and Actuarial Best Practices

The State of Florida Agency for Health Care Administration has created the Capitated Non-Emergency Transportation Program (CNET) to provide Non-Emergency Medical Transportation (NEMT) services for the Medicaid population who are not covered by another managed care program which would provide these services.

The NEMT services in Florida are delivered under a different set of regulations, those that address vendors that only provide NEMT services and are paid under a capitation model, referred to as Prepaid Ambulatory Health Plans (PAHPs). Federal requirements that apply to the NEMT PAHPs 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.

Therefore, Mercer's review of the CNET rate development processes for calendar year (CY) 2024 and CY 2025 rating periods was similar to the review of the other managed care programs as described previously. In general, AHCA's contracted actuary followed the requirements in federal regulation and guidance from applicable ASOPs. However, the following items were identified in methodology used by the contracted actuary that were considered potential issues.

## 5.2 CNET Rate Development Approach

CNET rates for CY 2024 and CY 2025 were developed separately for the two contracted vendors. The development of the CNET rates followed a standard actuarial process of using historical data to create a starting point of per-member costs, then applying trend to reflect how the costs will change from the historical period to the future rating period, then including an allowance for non-benefit costs. In addition, the historical costs were adjusted for the anticipated impact of Medicaid eligibility redetermination, and this is discussed at length in its own section of the rate documentation.

Written certification documents and corresponding exhibits were provided for each of the two vendors (ModivCare and Medical Transportation Management, Inc. [MTM]) for each year that included comprehensive documentation of each component of the rate development process. These documents, along with questions and answers from AHCA's contracted actuary, were the basis of Mercer's review. These areas of review are described in greater detail below. Our commentary below applies to both years and vendors unless otherwise noted.

## 5.2.1 Technical Review

### 5.2.1.1 Verification of Formulas and Calculations

The contracted actuary's exhibits that illustrate the components of rate development were reviewed and found to all be mathematically correct.

The CY 2024 and CY 2025 rate materials provided included exhibits illustrating how each of the regional and population specific capitation rates were built up, starting with historical per member per month costs and adding the necessary assumptions to project this cost to the rating period. The non-benefit costs are also shown explicitly.

Mercer reviewed these exhibits to verify that the rate calculations were technically correct, including:

- The base data used as a starting point reflects the appropriate experience for each rate cell.
- Incurred But Not Reported (IBNR) applied to the historical data in accordance with the documented assumption.
- The disclose annualized trend assumption is applied over the correct time period to the rating year.
- Redetermination adjustments were only applied to the Non-Prescribed Pediatric Extended Care (PPEC) population, and that this did not vary by region.
- The TPL adjustment was applied across all rate cells, without variation by region.
- The same fixed administrative cost was included as a per member per month (PMPM) amount added to the rates.
- The variable administrative cost was applied as the same percentage load across rate cells, in other words properly varying by each rate cells' different service cost.

### 5.2.1.2 Validation of Data Inputs

The description of the data process was reviewed along with consistency and reasonableness of data shown in the provided exhibits. Based on the documentation provided, the contracted actuary followed applicable federal requirements and ASOPs. Mercer identified potential vulnerabilities, which are described below

## 5.2.2 Base Data — Validate Data Inputs

To complete a validation of the data used to develop the CY 2024 and CY 2025 CNET rates, Mercer reviewed the described base data process and the supplemental data summaries but did not collect detailed encounter or financial data to develop a corresponding base data set. These materials describe a typical process of collecting data from the available sources, then validating and adjusting the data to ensure it reflects the covered population and services.

In Mercer's opinion, the data process was appropriate and adequately disclosed according to Centers for Medicare and Medicaid Services (CMS) requirements and relevant ASOPs.

#### 5.2.2.1 Data Sources

Mercer acknowledged that the contracted actuary obtained reasonable and appropriate data to use in the development of the CNET rates.

- Eligibility data was collected directly from AHCA.
- Encounter claim data was collected from AHCA's Medicaid Management Information System.
- Financial data that also summarized the claim and member experience for the same time period is collected directly from the vendors. This is important to both validate the encounter data and to provide supplemental information, such as administrative costs.

The contracted actuary used 12 consecutive months of experience as the base data for rate setting which is a common practice. For the CY 2025 rates, this data was within three years prior to the rate period and included six months of claim runout, meeting federal requirements to use current data from the most recent, complete rating periods.

#### 5.2.2.2 Data Validation

To validate the collected data was appropriate, the contracted actuary performed validations on all data sources received. The rate documentation describes that the collected data was reviewed for completeness and consistency, that summaries of the base data were provided to AHCA and vendors for review and that meetings were held with representatives of the plans to ask questions and explain or correct data as needed. From the information provided, the financial data was also found to be consistent with the encounters.

In Mercer's opinion, the data validation process and documentation were appropriate and met CMS requirements and relevant ASOPs.

#### 5.2.2.3 Data Adjustments

The contracted actuary determined that several adjustments were needed to ensure the base data was complete and accurate.

- Duplicate Record Removal: The eligibility and encounter data was found to contain duplicate records, which were removed. This is an appropriate step to validate 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 validates that the costs do not overstate the average per person cost.
- For one vendor, 2.1% of claims were removed for CY 2024 and 8.5% were removed for CY 2025. Mercer views this as a significant adjustment and requested additional information

from AHCA. AHCA's contracted actuary also viewed this as significant and sent inquiries to the vendor, but did not receive an explanation.

- For the other vendor, 5.6% were removed for CY 2024, but this improved to 0.5% for CY 2025.
- Mercer acknowledged that AHCA's contracted actuary followed a reasonable process to explore the issue and acted appropriately in excluding these claims. However, given the magnitude of an 8.5% exclusion and the fact that it is increasing from last year, Mercer will still identify this as an issue that the Agency should be aware of and decide if further action, such as requiring the vendor to provide a corrective action plan, is warranted.

#### 5.2.2.4 Incurred but Not Reported Claims

A small adjustment of less than 1% is applied to the data for IBNR claims. This appeared reasonable given the six months of claim runout.

#### 5.2.2.5 Base Data Exhibits

The certification materials included data summaries that show the historical paid claims for each vendor by population and service type. Mercer reviewed these summaries and they appeared to support the rate documentation.

The base data shown also matches the rate development exhibits and also shows the data used to be consistent and cover the expected range of services (ambulance, taxi, etc.).

## 5.3 Methodology and Assumption Review

### 5.3.1 Review of the Reasonableness of Key Assumptions

The assumptions used to develop future costs that due to trend, redetermination, and administrative costs were evaluated against available benchmarks and sources. Each assumption was described adequately and within a reasonable range of assumptions based on the available benchmarks and sources. Several assumptions are identified as potential vulnerabilities due to the underlying uncertainty.

### 5.3.2 Review of Omissions of Important Programmatic and Policy Changes

Mercer reviewed available sources for program and policy information and is not aware of any known or anticipated changes that are not addressed in the contracted actuary's rate development.

### 5.3.3 Key Actuarial Assumptions

The historical experience data may not reflect the future per member costs of the program. An actuary must adjust this cost for all anticipated changes in the price of services and how often members will use these services. The exact effect on cost is uncertain, therefore, an actuary must use their professional judgement to apply reasonable and appropriate assumptions.

The assumptions must also be documented in accordance with federal regulation and ASOPs.

For the major rate assumptions below, Mercer did not complete a separate analysis or attempt to match the contracted actuary's methodology. Instead, we reviewed the written description and compared the approach and results to our own experience setting similar rates in other states. Where specific sources were cited, Mercer reviewed those to validate each was used appropriately.

### 5.3.4 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 other managed care plans. These claims are not the responsibility of the CNET vendors. AHCA's contracted actuary cites difficulty in recouping these costs.

AHCA's contracted actuary provided support for the adjustment given timing and collection issues beyond the vendor's control create the cost. Mercer considers that this decision is within the broad scope of actuarial judgement, and not necessarily inappropriate, but would point out that not including these claims could also be defended.

There is a possibility that these claims are included in the development of the SMMC MMA program. Without adjustment, the claims will be "double counted", meaning multiple MCE's will be paid to cover the same members claims. Although the possible overstatement to the SMMC MMA program is likely immaterial, as the amount added is approximately $250,000, in principle the rate setting process for both plans should coordinate to ensure any double counting does not occur.

### 5.3.5 Redetermination Acuity Adjustment

Eligibility redetermination following the end of the COVID-19 Public Health Emergency (PHE) has had a significant impact on the covered population and costs of Medicaid programs across the country, including Florida's CNET program. Large numbers of members were disenrolled within a short period of time, and the average cost of members exiting differed from the total population. This means that the average PMPM cost that capitation rates are meant to capture may change suddenly and by a large degree.

Gradual changes in populations allow for observing and quantifying the effects on costs with some certainty. Emerging actual experience is often unavailable or very limited for the PHE redetermination, which means estimates of the effect will have greater uncertainty.

AHCA completed a redetermination of Medicaid eligibility following the end of the COVID-19 PHE. The base data used for CY 2025 CNET rate setting contains the experience of many

members who were disenrolled as part of this process. AHCA's contracted actuary evaluated the relative costs of those remaining in the program compared to those being disenrolled, and included a rate adjustment to reflect the anticipated rise in average member costs.

The contracted actuary used the actual disenrollment data to measure the difference in utilization between the leaving and staying groups. Consideration was given to new members, deaths, and postpartum coverage changes. This eligibility data is the best source as it allows analysis of the actual historical costs for each individual in the program.

The contracted actuary determined that redetermination would remove lower cost members and result in significantly higher PMPM costs in the future. This is consistent with redetermination analysis results from other states and programs. The magnitude is an upward adjustment of 64% to the historical service costs, which means that a significant portion of the CY 2025 rate is based on the assumptions how the population will change.

Mercer did not collect the data needed to fully analyze and review the 64% rate adjustment; given that approximately half the CNET population is expected to be disenrolled, this does not appear to be an unreasonable adjustment.

The contracted actuary elected not to adjust PPEC rates, even though there were enrollment changes for this group. Service utilization is very different for PPEC members compared to otherwise healthy adults and children, and with greater uncertainty assuming a significant average cost change may be difficult to justify. The contracted actuary provided additional information and confirmed that the eligibility changes were concentrated in a single region, which support not treating the PPEC change as a redetermination issue.

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 PHE.
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.

For these, the described methodology in the rate reports is reasonable and appropriate. The magnitude of the CY 2024 adjustment to the Non-PPEC rates was much lower at about 32%, however that can be explained because at that time redetermination was expected to remove fewer people.

Mercer identified no material issue with the assumptions or methodology used to derive the redetermination adjustment but does identify this rate adjustment as a potential vulnerability. Given the magnitude of this adjustment, and the fact that this relies so much on actuarial judgement, if in practice the actual enrollment changes differ from the assumptions this can significantly impact how well the capitation rates align with the program's risk and cost.

Regarding documentation of this adjustment, Section 5 of the Calendar 2025 CNET capitation rate report cites describing the redetermination adjustment of 15.4% for ModivCare Non-

Prescribed Pediatric Extended Care (PPEC) rates and 20.3% to the MTM Non-PPEC rates, which are the percentage increases in the rates from CY 2024 to CY 2025 that can be attributed to the change in the PHE adjustment between the rate development processes. This is inconsistent with how other rate adjustments are presented in the report, which are presented as PMPM or percentage impacts to the base data PMPM.

The actual rate impact as a percentage adjustment applied to the base data is shown in the supplemental exhibits to be 64%, made to all Non-PPEC rates. A rate adjustment of this magnitude should be documented in the written report clearly and consistently.

#### 5.3.5.1 Trend

Due to the numerous uncertain drivers of cost change, actuaries often develop a range of expected growth, and any selection within this range can be defended as reasonable and appropriate. While Mercer has not constructed a trend range for CNET, the description of the Contract Actuary's trend methodology appeared reasonable

Trend assumptions for rate setting are typically divided into the projected cost of providing a service (unit cost) and the projected use of services per person per month (utilization). AHCA's contracted actuary provided documentation that describes the development of the trend assumptions for both.

To develop the assumed unit cost growth, the contracted actuary cites several cost drivers specific to transportation costs — the price of gas, the wages of drivers, and the cost of vehicle maintenance. They used several national sources of historical and projected prices. Given the small size of the CNET program, these sources include more data than the actual experience of the program cost, and it is reasonable to use these sources to construct a range of cost growth assumptions.

Mercer reviewed the Bureau of Labor Statistics and the Energy Information Administration data available online and confirms that as of 2025 gasoline prices were projected to fall, while maintenance and labor costs were expected to rise. Combined, an overall unit cost increase of approximately 4% annually appears to be within a reasonable range of assumptions.

AHCA's contracted actuary assumed utilization would grow at 2% and cites using experience of other Medicaid programs to develop this given the small size of CNET. Mercer reviewed available CMS data, which shows a very wide range of growth in transportation use throughout the country. Therefore, 2% is within a reasonable assumption range and is in line with general utilization growth assumptions that Mercer has developed for Medicaid managed care rate setting.

Average utilization between the base period and the rate period may also be affected by redetermination. As the overall rate impact of redetermination is quantified separately, the contracted actuary separated this adjustment from the development of trend, and the stated trend assumption represents only the assumed growth of the population that will remain in the program from the base data period to the rating period.

### 5.3.6 Non-Benefit Load

The non-benefit load ranged from 26% to 27% of the capitation rate, and after review Mercer believes this is reasonable both in terms of absolute funding and as a percentage of the overall capitation rates.

As a percentage of the rates, it is high compared to capitated rates for a full breadth of medical services, as non-benefit funding is generally limited by federal regulation to 15% of the premium. This regulation does not apply to transportation only programs. This is because the cost of providing a taxi or bus, compared to hospital stays or physician visits, is relatively low compared to the cost of administering the program.

The first component of the non-benefit load is the allowance for profit and risk margin. AHCA's contracted actuary included a load of 2.0% of the rate. This appears reasonable as it is in the typical range of assumptions used for managed care rates and has remained consistent for the past several years.

The remaining non-benefit load is allowance for all administrative costs required to manage the CNET program. For CY 2025, this is approximately 25%–26% of the capitation rate, which was increased from approximately 22% for CY 2024. The increase in the percentage of capitation appeared reasonable given the reduction in projected enrollment due to redetermination. The reason for this is that a portion of administrative and operating costs are fixed regardless of the number of enrollees, so as enrollment declines, the fixed cost increases on a per member basis.

A similar percentage load is applied to both the ModivCare and MTM rates, however the PMPM service cost for MTM is much lower, $2.61 compared to $12.21 in CY2025. Thus, the overall administrative dollars allocated to MTM is much lower, projected to be about $1M compared to $3M for ModivCare. This is notable because the overall population is not in line with this difference. MTM covers more people, at 1.0M annual member months, compared to ModivCare covering 700,000 annual member months.

AHCA's contracted actuary documents using historical plan administrative cost data to develop the non-benefit load assumption for the rates, and inflation data is used to project these costs to the rating period. This is in accordance with ASOPs and CMS guidance, but Mercer has not collected the detailed financial information from the brokers, nor developed a staffing model that could be used to calculate adequate funding for the CNET program.

The administration load assumption should be considered a potential vulnerability and warrants additional scrutiny beyond what is disclosed in the contracted actuary's reports. As the administration costs are relatively high as a proportion of the rates, care must be taken so that assumptions are set appropriately to ensure actuarial soundness. The wide disparity in overall funding between the two vendors should be well understood and supported by objective, accurate, and verifiable data. The agency and its contracted actuary should consider collecting information regarding the vendors' administrative expenses, which may include financial statements, customized data requests for administrative data, and questions or interviews with vendors staff to ensure that adequate and appropriate costs are included.

### 5.3.7 Risk Corridor and Other Special Contract Payment Provisions

AHCA employed a two-sided risk corridor for the CNET program. The Agency will assume the majority of the gain or loss outside of a 3% range around the target Medical Loss Ratio (MLR). In Mercer's opinion, the documentation contains adequate detail regarding the terms of this arrangement. The CNET has no other special contract provisions such as withholds or pass-through payments. This is properly documented in the rate certification.

### 5.3.8 CNET Observations and Recommendations

The following items have been identified as observations and recommendations. If noted, these items also apply to prior rate setting as well:

***Base Data Observation 1:*** *magnitude of excluded claims.*

Mercer believes this is an appropriate step in ensuring the data is appropriate for rate setting, as it validates the historical cost does not overstate the average per member cost used to build the rates. However, the amount of claims excluded for one vendor is very high at 8.5%. In the CY 2024 rate development, a smaller, but still relatively large, adjustment of 5.6% was made.

As this issue is large enough to affect the financial stability of the provider, Mercer recommends additional follow-up by AHCA and its contracted actuary to better understand the cause of this issue and whether it is being addressed by the vendors to validate that this will not be a source of future financial distress.

***Redetermination Observation 1:*** *disclosure of rate impact.*

Section 5 of the report cites describing the redetermination adjustment of 15.4% for ModivCare Non-PPEC rates and 20.3% to the MTM Non-PPEC rates, which are the percentage increases in the rates from CY 2024 to CY 2025 that can be attributed to the change in the PHE adjustment between the rate development processes. This is inconsistent with how other rate adjustments are presented in the report, which are presented as PMPM or percentage impacts to the base data PMPM.

The actual rate impact as a percentage adjustment applied to the base data is shown in the supplemental exhibits to be 64%, made to all non-PPEC rates. A rate adjustment of this magnitude should be reported clearly and consistently. Mercer recommends that in the future, all rate impacts are presented consistently.

## 5.4 Rate-Setting Assumptions Observations:

- Redetermination
  - The redetermination adjustment is a large portion of the capitation rates. Parties responsible for ensuring that capitation rates provide adequate funding for the program should fully review the data, assumptions, and methodology used to develop this adjustment and understand the fiscal impacts if actual experience differs from what is included in the rates.

- Trend
  - The CNET program small size means that trend assumptions rely more on sources outside of program specific experience. As there are a large potential number of these sources, and a wide range in interpreting and weighting these sources, the rationale for what is included or excluded as data, and what is chosen as the ultimate annual cost growth assumptions should be thoroughly reviewed.
- Non-Benefit Load:
  - The non-benefit load included in the CNET rates is a large portion of the overall payment. In addition, there is a large difference in the administrative funding provided to the two CNET vendors. Parties responsible for ensuring that capitation rates provide adequate funding for the program should fully review the actual historical costs incurred by vendors and the rationale for how the actuaries determined reasonable, appropriate, and adequate funding will be provided to each.

Each of the above was noted due to the magnitude of the adjustment and underlying uncertainty. The program's current risk corridor protects both the provider and the state from adverse experience, but Mercer recommends careful monitoring of how actual costs for the rating period compare to the assumptions.

Section 6

# Intellectual and Developmental Disabilities Comprehensive Managed Care Program

Rate year (RY) 2024/2025 was the first year of rate development for the Intellectual and Developmental Disabilities Comprehensive Managed Care (ICMC) program, with the pilot effective October 1, 2024, for individuals in Region I and Region D. The ICMC program includes comprehensive coverage for individuals with intellectual and developmental disabilities. Similar to the other programs described above, the ICMC program is subject to the actuarial soundness requirements found in 42 CFR 438.4. Relevant ASOPs also apply to this program in the development of rates.

Mercer's review of the ICMC program was similar to the other managed care programs described within this report, though the main difference was that there was no prior year certification available to be reviewed, as this is the first certification for this pilot program. The review of available data sources and assumptions used in rate development also differed from other programs due to the nature of this being a pilot program with no existing experience specific ICMC's population. In our review of the ICMC certification, we found that AHCA's contracted actuary appeared to follow the requirements in federal regulation and guidance from applicable ASOPs. Some items are noted below as observations about the ICMC rate-setting methodology, though Mercer notes that these observations are common in a rate methodology for a program with no experience specific to the covered population. Mercer's review of this rate methodology included comparisons to other programs where base data experience is unavailable for rate development.

## 6.1 Base Data

Mercer reviewed the base data process for development of ICMC rates for RY 2024/2025, but did not collect the detailed iBudget waiver data used by AHCA's contracted actuary for rate development. The iBudget waiver, administered by the Agency for Persons with Disabilities, is a Home and Community-Based waiver for eligible members with developmental disabilities. The contracted actuary also utilized the RY 2024/2025 Home and Community Based Services (HCBS) rate group capitation rates and a blend of the Supplemental Security Income (SSI) Dual Eligible, SSI Medicaid Only Non-Serious Mental Illness (SMI), SSI Medicaid Only SMI, and Temporary Assistance for Needy Families (TANF) Non-SMI rate groups in the Managed Medical Assistance (MMA) program for development of the base data for the ICMC rates.

While historical program experience is often the best source to use in developing prospective capitation rates, the development of ICMC rates required the use of similar populations and

similar services because this is a pilot program for which historical program experience does not exist. ICMC enrollees are expected to be similar to individuals on the wait list for the iBudget waiver, so use of that data source was considered reasonable and appropriate. The population served by the ICMC program and the services provided are also similar to the utilization of some populations in the current Long-Term Care (LTC) and Statewide Medicaid Managed Care (SMMC) capitation rates. Therefore, use of the base data from these existing managed care populations also is appropriate. The contracted actuary notes that the blend of the MMA capitation rates is based upon the distribution of iBudget waiver wait list recipients. Mercer did not have access to this eligibility information, but the use of this data for the weighting percentages is a reasonable data source.

In Mercer's opinion, the data sources chosen were appropriate and adequately disclosed according to Centers for Medicare & Medicaid Services requirements and relevant ASOPs.

### 6.1.1 Base Data Input Validation

The base data utilized from the RY 2024/2025 LTC and SMMC rate cells would have undergone the same validation steps described earlier in this report, for which the validation was determined to be appropriate. In the ICMC certification, no validation is described related to the iBudget waiver data utilized as a base data source. However, the contracted actuary does note review of the data with the Florida Agency for Persons with Disabilities to review and remove any services that would be duplicative of the SMMC LTC program. Mercer expects that this review would have noted any data anomalies as part of the review, so the use of this data seems appropriate, but would recommend additional disclosures on the review of this data source be included in the actuarial certification.

Mercer reviewed the base data inputs used in rate development, as well as the application of adjustments utilized to develop rates for the contract period of RY 2024/2025. Mercer validated that the base data inputs were consistent with the projected costs for the applicable rate categories used in the development of the base. Mercer noted that technically, adjustments and other assumptions used to develop RY 2024/2025 were applied correctly and appropriately. Mercer also noted that the assumptions utilized in development of rates for the pilot year of the ICMC program were reasonable. Therefore, Mercer did not have concerns with the development of the RY 2024/2025 ICMC rates.

### 6.1.2 Reasonableness of Key Assumptions

Mercer reviewed the ICMC rate development materials provided as part of the certification from the contracted actuary, which included summarized base data, adjustments for trend, and other adjustments to represent the ICMC projected program costs from the selected base data. Based on this review, Mercer determined that all adjustments and calculations were reasonable and appropriate in development of the RY 2024/2025 ICMC program rates.

Because the initial ICMC rates are not developed using experience specific to the ICMC population, there are a limited number of program change adjustments necessary to develop the rates for the initial program year. Below are two key assumptions included in the development of

ICMC rates and Mercer's review of the information provided in the certification by the contracted actuary.

### 6.1.2.1 Population Acuity

The ICMC rates for RY 2024/2025 were developed without having experience specific to the population included in the ICMC program. As described above, iBudget base data was utilized, along with projected costs for the LTC and MMA programs. Because the base data used for this program was not specific to the target population, AHCA's contracted actuary reviewed the base data to determine reasonability for the target population. Based on this review, acuity factors were applied to the iBudget average claims costs per member per month (PMPM) and the projected LTC PMPMs to reflect the expected costs of the ICMC program. These factors resulted in the lower PMPM for the iBudget portion of the base data and lower overall costs for the LTC portion. LTC acuity adjustments were applied at a service category level, with the expectation that facility costs and adult day care costs would be much lower for this population, home health costs would be slightly lower, therapy and case management costs would be higher, and transportation costs would be higher in Region D.

While additional details were not provided on the development of these acuity factors, the direction and justification for the acuity adjustments appeared reasonable. Mercer is not able to provide additional review on the magnitude of these adjustments without benchmark data or other analysis utilized by the contracted actuary.

### 6.1.2.2 Projected Benefit Costs and Trends

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 in this report.

iBudget waiver data from calendar year 2023 was utilized as the base for that portion of the projected costs, so trend is applied to project the costs to RY 2024/2025. The utilization trend applied by AHCA's contracted actuary for these costs was equivalent to the utilization trend for the HCBS fee-for-service category from RY 2024/2025 SMMC LTC capitation rate development. The unit cost trend applied to the iBudget waiver base data was 11%, which was based on information provided by the Agency to AHCA's contracted actuary.

In Mercer's opinion, the trends used in development of the ICMC rates were reasonable and appropriate. The contracted actuary has also provided adequate disclosure statements regarding the reliance on trend information for the iBudget waiver data provided by AHCA.

### 6.1.2.3 Other Programmatic and Policy Changes

In review of the ICMC rates, Mercer noted that revisions were not made to the draft rates developed and provided to AHCA on September 24, 2024, despite the fact that subsequent revisions were made to the SMMC and LTC rates. Mercer reviewed the subsequent revisions to rate cells utilized in the development of the ICMC base data and determined that the impact of

any adjustments to RY 2024/2025 rates had minimal to no impact on the ICMC rate categories. Therefore, Mercer's opinion is that adjustments to the ICMC rates were not warranted subsequent to the September 24, 2024, version of rates for the RY 2024/2025 contract period.

## 6.2 Observations and Recommendations

In the initial review of the ICMC rate certification in Product A, Mercer had identified two observations with respect to the development of the RY2024/2025 ICMC rates. The first was related to the appropriateness of the selected base data as compared to actual enrollment within the ICMC program. The second was similar and related to what the actual acuity difference would be for the population enrolled in the ICMC program compared to the assumptions applied to the base data. While these were noted, they are more a factor of this being a pilot program with no specific base data experience, rather than any assumptions or adjustments utilized by AHCA's contracted actuary in the development of these rates. Therefore, it is Mercer's opinion that the adjustments and assumptions used in development of the ICMC rates are appropriate and reasonable. From Mercer's experience with other similar programs or pilot programs for small populations, the results and projections appear reasonable for the population covered by this program.

From closer review of the data and rate setting assumptions, one suggested improvement in the development of ICMC rates is that additional information or disclosures could be provided in development of the acuity adjustments applied to the base data. In some cases, the acuity adjustments are significant and could be supported by more detailed supporting analysis or information utilized in development of the factors, such as comparisons to other populations or data sources.

Section 7

# Conclusions and Recommendations

This section consolidates Mercer's primary conclusions and recommendations as presented in Product C for ease of reference by the reader. The information included in this section is presented elsewhere in this document.

## 7.1 Summary of Primary Conclusions

Product C consisted of a review of the technical accuracy in the calculation of capitation rates as well as a review of the overall reasonableness of the capitation rate setting process. This review was completed for multiple programs within the Florida Medicaid program, including SMMC, PACE, CNET, and ICMC.

Based on the documentation and underlying data that Mercer received, as well as discussions with AHCA and its contracted actuary, the rate development processes for the PACE, CNET, and ICMC programs, as well as the Dental and LTC programs within SMMC, were generally found to be reasonable and consistent with practices in use for other programs of similar size and complexity. For these specific programs, the calculations of the capitation rates appear to be technically accurate, and the process used to develop the rates was consistent with federal regulations and actuarial standards. Our report summarizes these processes and offers some recommendations for improving the processes.

With respect to the MMA program within SMMC, the investigation of *potential vulnerabilities* from Product A produced several substantive observations and recommendations regarding the MMA rate-setting process. A summary of the most critical issues is included here, while a more detailed discussion can be found in the body of this report.

Effective February 1, 2025, the MMA program was reprocured and coverage responsibility for certain benefits changed as a result. Most notably, BA services for members with autism were incorporated as a managed care covered benefit in the MMA program under the new managed care contracts resulting from the reprocurement process. Previously this benefit was covered for MMA enrolled beneficiaries through the FFS delivery system.

The development of the MMA capitation rates used statewide rate cell factors, the effects of which were more pronounced with the incorporation of BA services into the managed care contracts. The issues are described below along with potential indirect impacts as a result of this process. Additionally, recommendations and alternatives that may address associated risks are outlined throughout this report and summarized in Section 7.

## 7.1.1 MMA Statewide Rate Cell Factors

As detailed in Product A, AHCA's contracted actuary classifies eligible Medicaid populations into rate groups and projects benefit expenses at this level for each rating region. Rate groups are broader classifications of members than rate cells. Rate cells are the level at which capitation rates are paid by AHCA to the Managed Care Organizations (MCOs). Once benefit expenses are projected for each rating region and rate group, statewide rate cell factors are used to allocate projected benefit expenses to the rate cell level.

While this approach is one of many actuarial techniques that may be utilized in the development of Medicaid managed care rate-setting, its use is not common in situations with large, relatively stable populations such as MMA. This technique also introduces additional complexities into the rate-setting process, as the introduction (or removal) of non-uniform rating adjustments may necessitate a recalibration of the statewide rate cell factors in order to validate that the results produced are still reasonable and appropriate at the rate cell level.

AHCA's contracted actuary has used this process for at least four rating cycles prior to RY 2024/2025, producing results that appeared relatively reasonable. The introduction of BA services in the RY 2024/2025 post-ITN rates, however, highlighted a key risk in the continued use of this approach.

As was noted in Product A, historical per member costs patterns for BA services varied significantly across the rating regions in Florida, with per member BA service costs showing 20 – or more – times higher in Region I (Miami-Dade County) than the lowest cost region. Likewise, the majority of the historical costs were concentrated in the TANF 1 year to 13 years rate cell, while most other rate cells saw very limited, if any, BA service cost impact. The introduction of this adjustment in the RY 2024/2025 post-ITN rates should have prompted a review and recalibration of the statewide rate cell factors, because these services were very concentrated in certain rate cells and varied significantly by region. Based on the documentation and underlying data that Mercer received, as well as discussions with AHCA and its contracted actuary, we find that the rates are technically correct in terms of applied calculations; however, the results produced for a group of individual rate cells are not reasonable because the methodological approach of using statewide rate cell factors was not recalibrated.

Table 1: Final Capitation Rates by Rate Cell in section 1.3.1 MMA Statewide Rate Cell Factors illustrates several of the large unanticipated changes in rates at the region, rate group, and rate cell level as compared to the RY 2024/2025 pre-ITN rating period.

Through additional requests and interviews with AHCA and its contracted actuary since the release of Product A, AHCA's contracted actuary noted that projected PMPMs at the region and rate cell level are calculated and used to derive the statewide rate cell factors. As a result of this follow up, Mercer received the underlying base data benefit cost PMPMs and associated member months at a detailed service category level by region and rate cell in addition to projected benefit cost PMPMs and associated projected member months at a detailed service category level by region and rate cell. Prior to this, only data at the region and rate group level had been provided through the rate certification exhibits. This data was received for all three contract periods reviewed: RY 2023/2024, RY 2024/2025 pre-ITN, and RY 2024/2025 post-ITN.

From a review of this additional information, significant differences in projected PMPM spend were observed when comparing the projections at the region and rate cell level to the projected costs derived from the use of statewide rate cell factors. Table 2: Rate Year 2024/2025 Pre-ITN: TANF Non-SMI, 1–13 Years Projected Benefit Cost Per Member Per Month found in section1.3.1 MMA Statewide Rate Cell Factors shows the differences for the TANF non-SMI 1–13 Years rate cell across regions in the RY 2024/2025 pre-ITN contract period, which is prior to the inclusion of BA services into the rates. From this table, it is observed that the two sources provide significantly different projected benefit PMPMs, with the statewide rate cell factor application showing projected benefit PMPMs ranging from 9.9% higher to 12.0% lower than what was projected at the region and rate cell, depending on the rating region.

When BA services became covered in the RY 2024/2025 post-ITN period, the differences become much greater. Table 3: Rate Year 2024/2025 Post-ITN: TANF Non-SMI, 1–13 Years Projected Benefit Cost Per Member Per Month in section 1.3.1 MMA Statewide Rate Cell Factors shows the same information as the prior table, but for the RY 2024/2025 post-ITN contract period. Within this period, BA services are included in projected benefit expenses. The magnitude of the differences is greater, with the statewide rate cell factors producing projected benefit PMPMs ranging from 31% higher to 26% lower depending on the rating region.

A significant observation in Tables 2 and 3 is population sizes. The TANF non-SMI 1–13 Years rate cell is very credible from a membership size standpoint, with the smallest base data size being approximately 484,000 member months in the pre-ITN period and approximately 767,000 member months in the post-ITN period. Within capitation rate setting, smaller populations are subject to more volatility and can be less credible. When the group is small, a few unusual cases can make the rate swing up or down, so the estimate is less dependable. However, that is not the case with this rate cell in any region. The application of statewide rate cell factors for these fully credible large rate cells should be revisited.

While this analysis shows there are large differences at the rate cell level, AHCA’s contracted actuary applies the statewide rate cell factors in a budget neutral fashion. As a result of this approach, while there are certain rate cells that are over- or under-funded depending on the region, there are also rate cells in each rate group that are over- or under-funded in the opposite direction to maintain budget neutrality. For the TANF non-SMI rate group, the general pattern is that if the 1–13 Years rate cell is too low (in the case of Region I), the other rate cells within that rate group are too high. Conversely, if the 1–13 Years rate cell is too high (in the case of Region A), the other rate cells within that rate group are too low. This observation aligns with the previous table showing decreases in Region A for the 0–2 Month and 55+ Years rate cells from pre-ITN to post-ITN and increases in Region I for the same rate cells. As a result of this, total capitation revenue paid out across all rate cells within a rate group is not significantly impacted, but the rates at the rate cell level do not align with projections done by AHCA’s contracted actuary at the region and rate cell level.

Per 42 Code of Federal Regulations (CFR) 438.4(b)(5), payments from any rate cell must not cross-subsidize or be cross-subsidized by payments for any other rate cell. The methodology used in the development of capitation rates at the rate cell level and resulting cell-level discrepancies may not be consistent with this requirement. Moreover, while payments in total for the MMA program may be appropriate, individual MCOs will likely gain or lose revenues based on their relative population mix across cells.

Furthermore, Actuarial Standards of Practice (ASOP) 56 (Modeling) addresses actuarial modeling and the actuary's responsibility to validate that the model output is valid, meets its intended purpose, and produces reasonable results (see sections 3.1.6(e) and 3.6.2(c)). The statewide rate cell factor model, as applied in the Rate Year 2024/2025 Post-ITN rates, does not produce PMPMs for all regions and rate cells that are reasonable in comparison to the Rate Year 2024/2025 Pre-ITN rates after accounting for the changes in covered services between the rating periods.

#### 7.1.1.1 Potential Indirect Impact

Under the managed care contract AHCA has with its MCOs, the MCOs are required to utilize value-based purchasing arrangements.[11] These are arrangements between MCOs and providers that link payments for services to quality and better outcomes. To the extent a value-based payment arrangement from the MCOs to providers uses the capitation rates paid to the MCOs, there could be a downstream impact realized by the providers. For example, the TANF non-SMI 1–13 Years rate cell in Region I is underfunded when compared to expectations by region and rate cell. Based on this, it is possible that reimbursement in value-based payment arrangements to certain providers in that region is negatively impacted. Even though the region as a whole may be adequately funded for an MCO, providers who primarily serve younger populations (e.g. pediatricians) may be disadvantaged.

### 7.1.2 BA Risk Corridor Implications

With the inclusion of BA services to the managed care contracts, AHCA and its contracted actuary elected to implement a one-sided risk corridor with respect to BA services. The one-sided risk corridor means that the BA component of the total capitation rates is subject to a review of how close actual BA expenditures are to the projected BA expenditures included in the rates. The State can recoup funds from an MCO(s) if the actual BA expenditures are less than the value of the BA rate component. One of the reasons this was done was due to significant increases in BA costs across recent years in the FFS delivery system. By moving the benefit into managed care and with the implementation of a one-sided risk corridor, MCOs may be incentivized to manage BA service utilization to avoid potential losses, while realizing potential savings for the State.

In the risk corridor calculation, a BA rate target is needed for the comparison of actual BA expenditures to the amount built into the rates. To that end, AHCA's contracted actuary provided an exhibit within the original rate certification showing the BA risk corridor target per member per month (PMPMs) at the region and rate cell level. Necessarily, the BA risk corridor target needs to be lower than the total capitation rate, since BA is a sub-component of a broader rate. To derive the projected BA benefit costs in the rates, AHCA's contracted actuary used the projected BA spend as part of the underlying projected spend at the region and rate cell level. However, there are five instances where the original BA-specific PMPMs used in the risk corridor are greater than the total capitation rate itself. These instances are shown in Table 4: Rate Cells with Higher

[11] Florida Agency for Health Care Administration, Statewide Medicaid managed care (SMMC) new program highlight: Value-based purchasing (Oct. 18, 2024), https://ahca.myflorida.com/content/download/25260/file/SMMC%20Value%20Based%20Purchasing%20Highlight_10182024.pdf.

Behavior Adjustment Per Member Per Month than Total Capitation Rate Per Member Per Month in section 1.3.2 BA Risk Corridor Implications. This is not a reasonable outcome and is a consequence of the statewide rate cell factor approach in the calculation of the capitation rates.

After the RY 2024/2025 post-ITN contract period began, AHCA's contracted actuary changed the amounts subject to the BA risk corridor. In this process, two items were changed. First the starting point BA rate component was updated from what was provided in the original rate certification, partly due to the targets being greater than the total rate in some instances. Second, due to unanticipated shifts in enrollment from non-Children's Medical Services Plan (CMS Plan) rate cells to the CMS Plan, AHCA's contracted actuary reallocated the restated BA dollars on a budget neutral basis across different rate groups and rate cells within a region.

This approach gives rise to two potential vulnerabilities:

- The starting point risk corridor targets are different between the rate certification and the BA risk adjustment exhibits. In some cases, the amounts are significantly different. The driver of the discrepancy is the underlying capitation rate issues due to the application of statewide rate cell factors.
- As the risk corridor targets were changed after the rating period, the approach may not be consistent with 42 CFR 438.6(b)(1), which indicates that risk sharing arrangements cannot be modified after the start of the rating period.

# 7.2 Primary Recommendations

### 7.2.1 Recommendation 1

AHCA and its contracted actuary should consider consolidating rate cells for the MMA program within the TANF Non-SMI, TANF SMI, SSI Medicaid Only Non-SMI, SSI Medicaid Only SMI, and Child Welfare rate groups to include only a child and adult split, with a potential split for newborn rate cells, as opposed to the detailed age and gender rate cells currently used. Under this recommendation, statewide rate cell factors would not be used in the development of rates by rate cell. Base data could be grouped by the rate cells that only vary by children and adults, and the rates calculated from this base data. A simpler rate cell structure can be expected to address or reduce issues similar to the inclusion of BA services. Since BA services are predominantly utilized by children, this alternative approach would have allocated the BA service costs more appropriately into the rate cells specific to children.

This recommendation would also align capitation rate development in the MMA program with rate cell structure trends nationally. Most Medicaid managed care rate setting processes have broader rate cells and let health-status based risk adjustment processes account for not only the age/gender demographic mix of the underlying MCO enrolled populations, but also for health characteristics as well. There is already a health-status based risk adjustment process in place within the MMA program, so the usefulness of detailed rate cells by age and gender is significantly diminished.

### 7.2.2 Recommendation 2

If AHCA and its contracted actuary elect to keep the current rate cell structure with more detailed age and gender breakouts, we suggest capitation rates be calculated and documented at the region and rate cell detail level from start to finish, with base data credibility adjustments applied for rate cells where small membership exists. In the current process, there were fully credible rate cells that were adjusted through the use of statewide rate cell factors that differed materially from projections at the region and rate cell level. Such differences could be avoided, or at least significantly mitigated, if rates are developed using the detailed rate cell level from start to finish.

### 7.2.3 Recommendation 3

If the application of statewide rate cell factors were still to be used, AHCA's contracted actuary could separate out BA and non-BA services completely given the large disparities in per member BA costs across the State. In this process, non-BA projected benefit PMPMs can be produced on their own by projecting non-BA costs at the rate group level with the application of statewide rate cell factors excluding BA services, and the same process separately done for BA services. This approach would keep the services separated.

## 7.3 Detailed Recommendations by Program

***SMMC – Methodology and Assumption Recommendation 1****: Consider consolidating rate cells for the MMA program within the TANF non-SMI, TANF SMI, SSI Medicaid Only non-SMI, SSI Medicaid Only SMI, and Child Welfare rate groups to include only a Child/Adult split.*

The current detailed rate cells appear appropriate given the size of the program so long as there are other mechanisms in the rate development process that are used to address low credibility rate cells (recommendations on these processes are detailed in subsequent sections). However, consolidating rate cells diminishes the operational burden as it reduces the number of rate cells and can simplify the rate development process. The exhibits provided in the rate certification and shared with the participating health plans show the development of the projected benefit expense at the rate group level. Since rates are finalized at the rate cell level, there is a transparency gap in the development of the adjustments to stratify the rates into rate cells that could be mitigated if rate cells were consolidated.

In addition, the current rate cells combine children age 14 years old and above with adults. Mercer recommends reassigning these into child and adult rate cells, defined as under/over age 21 years old, in order to align the rate cells with Medicaid benefit differences due to EPSDT.

Finally, health status-based risk adjustment is currently applied in the MMA program. Since the risk adjustment process has the effect of better matching payment to health plan risk through the review of disease characteristics and demographics of each health plan's population, the need for detailed age and gender is less important. The rate setting process could be simplified by updating the rate cell structure as noted.

***SMMC – Base Data Recommendation 1:*** *Consider allocating Achieved Savings Rebate (ASR) financial data based on utilization data under the subcapitation arrangement.*

A potential issue exists in how ASR financial data for non-fee-for-service (non-FFS) services is allocated within the MMA program. The ASR financial data is reported in aggregated groups rather than detailed rate cells. AHCA's contracted actuary allocated costs for subcapitated services to rate cells based on the distribution of encounters in similar FFS service categories. However, the services covered under subcapitation may differ from those under FFS contracts. For example, a pediatric primary care clinic under subcapitation may not align precisely with the broader primary care category used in FFS data. This mismatch introduces uncertainty in cost allocation.

***SMMC – Base Data Recommendation 2:*** *Consider developing and applying the encounter to ASR completion adjustment with more granularity in the MMA program.*

The adjustment applied to complete encounter data to ASR totals was uniform across all non-pharmacy services, despite underreporting typically varying across providers and service types. This broad approach may mask important differences.

***SMMC – Base Data Recommendation 3:*** *Consider developing and applying Incurred But Not Reported (IBNR) adjustments by payer for all programs.*

IBNR adjustments were applied broadly rather than tailored by payer, despite different managed care organizations (MCOs) typically having differences in reporting and payment patterns. We suggest separating estimations to capture these differences.

***SMMC – Base Data Recommendation 4:*** *Consider applying and documenting adjustments for long-term Institution for Mental Diseases (IMD) for LTC.*

Federal regulations require removal of all data from the base data for members aged 21 years-64 years with more than 15 days at an IMD in any given calendar month. From a federal perspective, these members are not considered Medicaid-eligible in that month. To maintain compliance, all of the members' experience (eligibility, IMD services, and non-IMD services) should be removed from the base data, even if the program does not cover the actual IMD services. While no IMD services were included in the LTC program base data, members with IMD experience covered outside these programs were present in the base data. The LTC rates did include such an adjustment in RY 2023/2024, but no documentation was noted that AHCA's contracted actuary reviewed or applied an adjustment in RY 2024/2025 pre-ITN or post-ITN. In a follow-up question sent to AHCA and AHCA's contracted actuary, they indicated that any adjustment for LTC enrollees is immaterial, since very few LTC enrollees meet the criteria to be excluded. While we do agree this is an immaterial item, this represents a federal compliance risk.

***SMMC – Trend Recommendation 1:*** *Consider more granularity in the acute service trend factors for MMA.*

Acute services make up the majority of the projected benefits in the MMA program. This broad approach may obscure important differences by population, potentially leading to inaccurate rate estimates.

For example, the -2.0% annualized trend noted above was applied to all inpatient utilization across all regions, rate groups, rate cells, and all four inpatient categories. This led to an outsized negative impact for certain rate cells. For example, the majority of the TANF non-SMI 0–2 Month rate cell benefit costs are inpatient, due to the birth event for the newborn. The contracted actuary has Hospital Inpatient FFS — Newborn as an individual category of service in the rate development process but applied the same -2.0% trend to the category.

Mercer recommends exploring additional granularity, such as considering further delineation by category of service (such as evaluating inpatient newborn, inpatient behavioral health, and the remaining inpatient separately), considering varying trends by population (rate cell groupings, child/adult, or other splits), and consider varying trends by region.

***SMMC – Rate Cell Recommendation 1:*** *Consider consolidating rate cells for the MMA program within the TANF non-SMI, TANF SMI, SSI Medicaid Only non-SMI, SSI Medicaid Only SMI, and Child Welfare rate groups to include only a Child/Adult split.*

This is the same recommendation noted above in the Rate Cell Structure subsection. If the rate cell structure is reconfigured to be less detailed, rates could be developed directly at the rate cell level and eliminate the rate group to rate cell factor approach. Any region and rate cell combinations that are not fully credible on their own could incorporate credibility adjustments by relational modeling to other more credible and similar rate(s) cells and blending (see Rate Cell Recommendation 2 below). If this approach had been employed in the rating periods reviewed, the total projected rate would not have materially differed; however, each certified rate cell would have been more appropriate for the members and services covered under the rate cell. Specifically, if a child rate cell existed up to age 21, the vast majority of BA service costs would be included in this rate cell.

***SMMC – Rate Cell Recommendation 2:*** *With no change to the rate cell structure, consider employing credibility adjustments to the rate cell projections, as needed, in replacement of the statewide rate cell factor application.*

In the contracted actuary's current process, projected benefit costs are developed by rate cell as part of the underlying work (though not shared with the MCO plans or CMS). Rather than consolidating these to a rate group level and applying a statewide factor to return to the rate cell level, Mercer recommends using these rate-cell-level projections directly. If the base member months underlying the rate cell are not fully credible, based on a selected threshold (e.g., 24,000 member months), the projected benefit costs for that rate cell could be blended with an appropriate reference rate.

Mercer modeled one potential variation of the credibility adjustment approach as follows:

- Use a classic credibility formula, with an appropriate member month threshold for full credibility, to determine the weighting to place on the rate-cell-level projection.
- Calculate a reference rate:
  - Calculate the statewide rate for the rate cell.
  - Calculate category of service specific regional factors by comparing on a mix-adjusted basis, i.e., the average PMPMs for the region in question compared to the average PMPMs statewide rolled up on the mix of members in the region in question.
  - Multiply by the statewide rate by the regional factor.
- Blend the rate-cell-level projection with the reference rate.

An example of this process, using a 24,000 member month threshold for full credibility, is summarized in Table 7: Credibility Adjusted Base Data Calculation Example within section 3.3.6.2 Recommendations for the RY 2024/2025 post-ITN rating period for TANF Non-SMI 0–2 Months in Region C.

Many of the rate cells are fully credible and would not require further adjustment. For example, the TANF Non-SMI 1–13 Years rate cell is very large within every rating region and would be fully credible. A comparison of the recommended method (projected by rate cell) against the existing method (statewide rate cell factors) is illustrated in Figure 2: TANF Non-SMI 1–13 Years, Projected Benefit Per Member Per Month (PMPM) within section 3.3.6.2 Recommendations for this population.

***SMMC – Rate Cell Recommendation 3:*** *Revisit methodologies and models used regularly, particularly when there are material changes to the program.*

In every rating cycle, the methodologies and models used in the prior rating cycle should be reviewed to consider continued appropriateness to the current rating cycle. This review should be done both conceptually at the start of the process – and then the outputs of the modeling/methodology should be reviewed at the end of the process. If a model or methodology provided reasonable results in the past but does not produce reasonable results in its current use, that model should be discarded or adjusted to fit the circumstances.

In the case of the statewide rate cell factors model, the introduction of BA services in the RY 2024/2025 post-ITN period represented a large-scale change to the MMA program. The discrepancies between the region/rate cell capitation rates and the region/rate cell underlying projections were exacerbated due to the large variation in BA services across regions and the fact that these services were heavily concentrated in certain rate cells. One potential improvement to the model employed by the contracted actuary would have been to adjust the BA and non-BA services separately (i.e., develop statewide rate cell factors for BA services and also separately for the remainder of the services). For example, the statewide rate cell factor used by the contracted actuary for TANF Non-SMI 1–13 Years was 0.863. If that factor had been

developed separately (i.e., split factor as shown in Figure 3 and Figure 4) for BA and non-BA, the factors would have been 1.750 for BA and 0.714 for non-BA.

This improvement would have been particularly helpful, given that there was a risk corridor specific to the BA services in the RY 2024/2025 post-ITN managed care contract. The BA PMPMs by rate cell used as the starting point for the risk corridor calculations would have more appropriately reflected what was projected for that service.

Illustrative examples of the impact of Rate Cell Recommendation 2 and Rate Cell Recommendation 3 relative to the statewide rate cell factor approach are shown in Figure 3: Region A, TANF Non-SMI, 0–2 Months Projected Benefit Per Member Per Month (PMPM) and Figure 4: Region I, TANF Non-SMI, 0–2 Months Projected Benefit Per Member Per Month (PMPM) within section 3.3.6.2 Recommendations.

***SMMC – Risk Adjustment Recommendation 1:*** *Specific to BA services in the RY 2024/2025 Post-ITN period, the risk adjustment process could be clearer and simplified.*

The inclusion of BA services and the statewide rate cell factors inclusive of all services (BA and non-BA combined) introduced unexpected variance in the capitation rates at the rate cell level. One alternative is to separate non-BA and BA services in the rate development process completely. In this process, the final rates would be the sum of the non-BA and BA portions of the capitation rate, with each component developed separately by region, rate group, and rate cell. Under this approach, the CDPS+Rx risk adjustment process would be applied to the non-BA rate component only, without a need to calibrate the CDPS+Rx model with a BA utilizer variable in addition to including BA-related costs into the model. The prior model without these additional items can be used. Further, the BA risk-adjustment process (described in the BA Services subsection) can be leveraged for the BA rate component. In doing this, the component of the capitation rates specific to BA would be consistent with the risk corridor targets and more easily explainable and documented. The methodology chosen by the contracted actuary used the BA risk adjustment process to arrive at the risk corridor target PMPMs, while the broader total rate, across BA and non-BA services, was risk adjusted using the CDPS+Rx model.

***CNET – Base Data Recommendation 1:*** *Understand and address the magnitude of excluded claims.*

Mercer believes this is an appropriate step in ensuring the data is appropriate for rate setting, as it validates the historical cost does not overstate the average per member cost used to build the rates. The amount of claims excluded for one vendor is very high at 8.5%. In the CY 2024 rate development, a smaller, but still relatively large, adjustment of 5.6% was made.

As this issue is large enough to affect the financial stability of the provider, Mercer recommends additional follow-up by AHCA and its contracted actuary to better understand the cause of this issue and whether it is being addressed by the vendors to validate that this will not be a source of future financial distress.

***CNET – Redetermination Recommendation 1:*** *Provide consistent presentation of rate impacts.*

Section 5 of the report cites describing the redetermination adjustment of 15.4% for ModivCare Non-PPEC rates and 20.3% to the MTM Non-PPEC rates, which are the percentage increases in the rates from CY 2024 to CY 2025 that can be attributed to the change in the PHE adjustment between the rate development processes. This is inconsistent with how other rate adjustments are presented in the report, which are presented as PMPM or percentage impacts to the base data PMPM.

The actual rate impact as a percentage adjustment applied to the base data is shown in the supplemental exhibits to be 64%, made to all non-PPEC rates. A rate adjustment of this magnitude should be reported clearly and consistently. Mercer recommends that in the future, all rate impacts are presented consistently.

***ICMC – Acuity Adjustments Recommendation 1****: Provide additional information on development and application of acuity adjustments to the base data.*

From closer review of the data and rate setting assumptions, one suggested improvement in the development of ICMC rates is that additional information or disclosures could be provided in development of the acuity adjustments applied to the base data. In some cases, the acuity adjustments are significant and could be supported by more detailed supporting analysis or information utilized in development of the factors, such as comparisons to other populations or data sources.

# Appendices

## Appendix A: Acronym List and Definitions

**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.

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

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

**Centers for Medicare and Medicaid Services (CMS):** The federal agency within the US Department of Health and Human services that administers the Medicare program, and partners with states in the administration of State Medicaid programs.

**Children's Medical Services Plan (CMS Plan):** 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.

**Capitated Non-Emergency Transportation (CNET):** Florida's Medicaid managed care program 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.

**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.

**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.

**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.

**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.

**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.

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

**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.

**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.

# Appendix B: Actuarial Glossary

This glossary summarizes key actuarial rate components referenced in this report and describes, at a high level, the primary basis (data sources, methodologies, or requirements) used to develop each component.

**Actuarial soundness:** The federal standard that capitation rates must be high enough to reasonably cover the expected cost of covered services for the covered population. In capitation rate setting, actuaries develop and certify rates to meet this standard and applicable regulations (e.g., 42 CFR 438.4).

**Acuity adjustment (population acuity):** A change made to reflect that the enrolled population in the rating period is expected to be sicker or healthier than the population reflected in the historical data. In capitation rate setting, this adjustment increases or decreases projected costs using information such as eligibility/redetermination experience, enrollment changes, and other indicators of member health status.

**Administrative expenses/administrative allowance:** The part of the capitation rate that pays for the plan's operating costs (for example: staffing, systems, customer service, utilization management, and compliance), not medical claims. In capitation rate setting, this amount is added on top of projected medical costs and is typically supported by plan financial reports (e.g., Achieved Savings Rebate), contract requirements, and plan surveys.

**Base data:** The historical claims/encounter costs and enrollment information used as the starting point for building future rates. In capitation rate setting, base data is validated and adjusted, then projected forward to the rating period.

**Base period:** The timeframe covered by the base data (for example, a 12-month or 24-month period). In capitation rate setting, the base period determines how much trend is applied and what known changes must be adjusted for between the base period and the rating period.

**Budget neutrality/normalization:** A rule that certain adjustments are allowed to redistribute dollars across cells or plans but must not change the total funding for a defined group. In capitation rate setting, factors are often scaled so total projected dollars are the same before and after the change (within the specified grouping, such as region and rate group).

**Budget neutral risk score**: A risk score that has been scaled so that, for a defined population, the average risk score equals a target value (often 1.00). In capitation rate setting, this keeps the overall funding level unchanged while shifting dollars to better reflect differences in expected costs across plans or rate cells.

**Completion adjustment (encounter-to-financial):** An adjustment made when encounter data is missing or incomplete compared to total paid amounts shown in financial reporting. In capitation rate setting, encounter-based costs are scaled (sometimes at a detailed service level) so that projected costs reflect the full expected paid amounts.

**Capitation rate:** A fixed payment paid to a managed care plan per enrolled member (usually stated as per member per month, or PMPM) for a defined set of services and members, regardless of how much care is used. In capitation rate setting, the capitation rate is built from

projected benefit costs plus non-benefit components (administration, taxes/fees if applicable, and margin) and must meet applicable regulatory requirements.

**Category of service:** A way of grouping healthcare spending into service types (for example: inpatient, outpatient, physician, pharmacy). In capitation rate setting, costs and assumptions (such as trend and adjustments) are often developed and documented by category because different services behave differently.

**Chronic Illness & Disability Payment System with Pharmacy model:** A diagnosis-based risk adjustment model that assigns cost weights based on medical conditions and pharmacy indicators. In capitation rate setting, this model is used to calculate member-level or cell-level risk scores that inform the risk adjustment factors applied to capitation rates.

**Credibility adjustment:** A method used when the available data is limited and results are unstable (for example, small populations or low utilization). In capitation rate setting, observed experience may be blended with a broader benchmark or more stable dataset to produce more reliable per member per month (PMPM) estimates.

**Cross-subsidization prohibition:** The requirement that one rate cell's payment level should not be intentionally used to offset underpayment in another rate cell (referenced in 42 CFR 438.4[b][5]). In capitation rate setting, this supports evaluating actuarial soundness at the rate-cell level rather than relying only on overall averages.

**Gain/loss margin/underwriting gain:** The portion of the capitation rate that provides a risk margin and return for the plan for assuming insurance risk and holding capital. In capitation rate setting, this is typically included as a percentage load on the rate and reflects the uncertainty of future costs.

**Incurred but not reported:** An estimate of claims for services already provided during the base period but not yet reported or paid at the time the base data was captured. In capitation rate setting, base-period costs are increased to reflect these late-arriving claims so projected costs start from a complete cost level.

**Institution of Mental Diseases (IMD) adjustment (21–64 exclusion):** An adjustment that removes months and costs for members ages 21–64 who spend more than 15 days in an IMD in a month, consistent with federal payment rules. In capitation rate setting, the related eligibility and service costs for those months may be removed from the base data so projected capitation payments align with allowable Medicaid payments.

**Managed care savings factor:** An adjustment that reflects expected cost differences attributable to managed care (for example, care management, network arrangements, and utilization controls) compared to a baseline. In capitation rate setting, this factor may be applied to projected costs when moving services into managed care or when delivery system changes are expected to affect utilization and/or unit costs.

**Medical loss ratio (MLR):** The percentage of capitation revenue that is spent on member healthcare services (benefits), as opposed to administration and profit. In capitation rate setting, rates are developed so plans can reasonably achieve any applicable MLR standards (for example, 85% in many Medicaid managed care programs), which can influence the allowable non-benefit load.

**Member months:** A measure of enrollment exposure equal to one member enrolled for one month. In capitation rate setting, member months are used to calculate PMPM costs, weight experience, and aggregate (or disaggregate) results across rate cells and rate groups.

**Non-benefit expenses/non-benefit load:** All components of the capitation rate other than medical benefit costs (for example: administration, taxes/fees if applicable, and margin). In capitation rate setting, these amounts are added after projecting benefit costs and may be subject to program-specific limits and disclosure requirements.

**Other adjustments (programmatic/policy):** Separate, explicit adjustments for known changes that are not captured in base data or trend (for example: fee schedule updates, benefit changes, legislation, appropriations, seasonality, or provider contracting changes). In capitation rate setting, these items are documented individually so the impact of each change is transparent.

**Per member per month (PMPM):** A way to express costs or payments as a monthly amount per enrolled member. In capitation rate setting, PMPM is the common unit used to compare historical experience, apply adjustments, and build the final capitation rate.

**Prevalence report:** A report that shows how many members are assigned to each risk category and the weights applied to those categories. In capitation rate setting, this report supports (and documents) the steps used to calculate risk scores and validate results.

**Provider contracting adjustment:** An adjustment that reflects expected changes in provider payment rates due to contract terms (for example, negotiated increases or new value-based payment arrangements). In capitation rate setting, this typically changes the unit cost assumptions for affected services based on available contracting information or plan surveys.

**Rate cell:** The most detailed payment category used for setting and certifying capitation rates, typically defined by geography and member characteristics (for example, region and eligibility/age). In capitation rate setting, rates are calculated and evaluated at the rate-cell level to support certification and compliance requirements.

**Rate group:** A broader grouping of members (for example, by eligibility category) that may combine multiple rate cells. In capitation rate setting, rate groups are often used to develop assumptions using more stable, higher-volume data, and then results are allocated to individual rate cells using member-month weights or other factors.

**Rating period (contract period):** The future time period when the capitation rates will be paid. In capitation rate setting, historical base-period experience is projected to this period using trend and other adjustments.

**Redetermination (unwinding) adjustment:** An adjustment that reflects enrollment and expected cost changes as eligibility redeterminations resume following the Public Health Emergency, which can change who remains enrolled and the overall acuity of the population. In capitation rate setting, this adjustment modifies projected costs (and sometimes enrollment assumptions) based on observed disenrollment patterns and assumptions about how enrollment will stabilize.

**Risk adjustment factor/risk score:** A factor used to adjust payments, so they better match expected costs based on member diagnoses and demographics, helping ensure plans/cells with

higher-need members receive higher payments. In capitation rate setting, risk scores are applied to redistribute capitation dollars across plans and/or rate cells and are often designed to be budget neutral.

**(CDPS+Rx) Risk Adjustment Model Risk corridor:** A contract provision that shares gains or losses when actual experience is significantly better or worse than a target (for example, outside an MLR band or spending thresholds). In capitation rate setting, a risk corridor can reduce financial risk to plans and may affect assumptions about required margin and overall rate adequacy.

**Statewide rate cell factor**: A factor used to translate a higher-level projection (for example, by region and rate group) into rate-cell-level projected benefit costs. In capitation rate setting, these factors are typically normalized so the total projected dollars for the defined group remain budget neutral after allocating to individual rate cells.

**Subcapitation allocation:** A method to assign costs for services paid under subcapitation (for example, payments made by the plan to a subcontractor) when costs are reported in aggregate rather than by rate cell. In capitation rate setting, costs may be allocated using related utilization or enrollment patterns so each rate cell reflects an appropriate share of the subcapitated services.

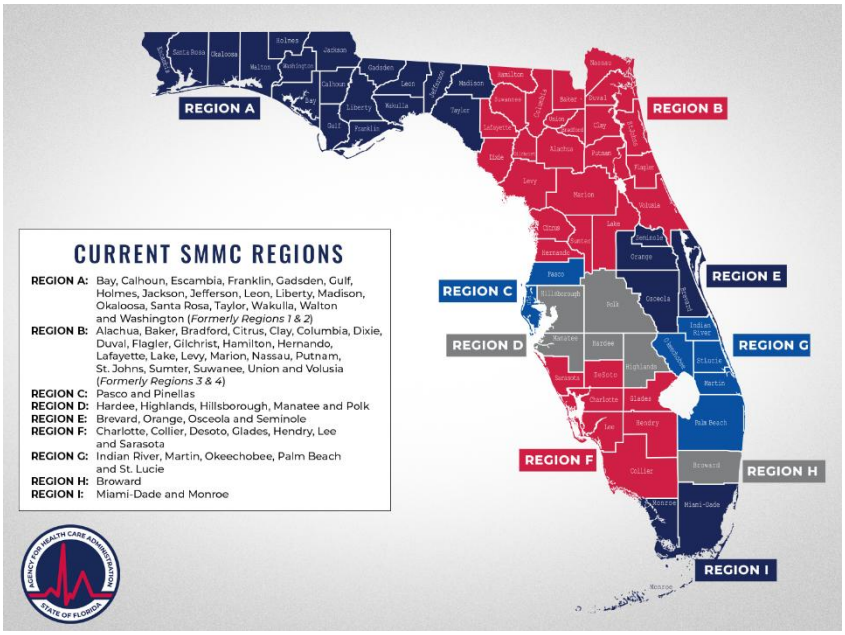
**Third party liability adjustment:** An adjustment that reflects payments expected from other responsible parties (for example, other insurers) that reduce amounts paid by Medicaid. In capitation rate setting, this reduces projected benefit costs and should be applied using a consistent, well-documented methodology due to the potential for material impact on rates.

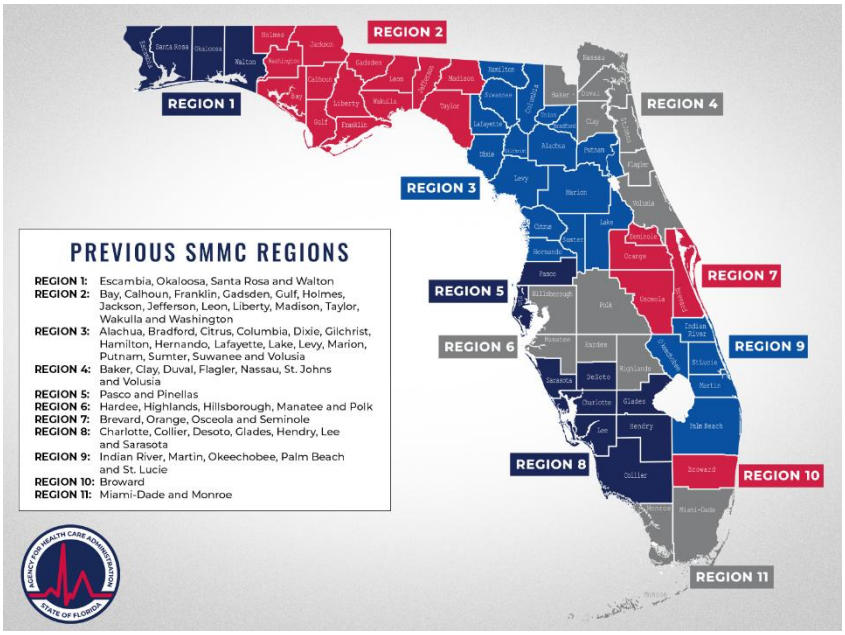
**Trend (overall):** The set of assumptions used to move costs from the base period to the rating period, reflecting expected changes over time. In capitation rate setting, overall trend is commonly built from separate utilization and unit cost trend components and is compounded over the projection period.

**Unit cost trend:** The part of trend that reflects changes in price per service (for example, fee schedule updates, wage pressure, inflation, and other cost drivers). In capitation rate setting, unit cost trend is applied to adjust the cost per visit, per day, per script, etc., from the base period to the rating period.

**Utilization trend:** The part of trend that reflects changes in how much care members use (services per member), such as shifting patterns of visits, admissions, or prescriptions. In capitation rate setting, utilization trend is applied to projected service volume per member and is typically informed by historical patterns, benchmarks, and professional judgment.

# Appendix C: Previous and Current SMMC Regions



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