

MILLIMAN REPORT

State of Florida Agency for Health Care Administration

Statewide Medicaid Managed Care

Managed Medical Assistance Program Data Book

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Table of Contents

I. INTRODUCTION	1
II. ELIGIBILITY DATA	8
III. CLAIMS DATA SOURCES AND ADJUSTMENTS	19
IV. ADJUSTMENTS NOT INCLUDED IN THE MMA DATA BOOK	34
V. CAVEATS AND LIMITATIONS	35

APPENDICES (provided in Excel format)

Appendix M-1: SMMC MMA Data Book Database

Appendix M-2: SMMC MMA Data Book Summary Exhibits

- Exhibit M-1: MMA Data Book Summary
- Exhibit M-2: MMA Data Book FMMIS Encounter Data
- Exhibit M-3: MMA Data Book ASR Financial Data
- Exhibit M-4: MMA Data Book Applicable Adjustments
- Exhibit M-5: MMA Data Book Supplemental Information

I. INTRODUCTION

The Florida Agency for Health Care Administration (Agency) retained Milliman, Inc. (Milliman) to develop a data book to provide relevant historical data and background information to potential contractors responding to the Invitation to Negotiate (ITN) issued under the Statewide Medicaid Managed Care (SMMC) program pursuant to Sections 409.961 through 409.985, Florida Statutes. This report discusses the Managed Medical Assistance (MMA) program portion of the data book (MMA data book). The Long-Term Care (LTC) program portion of the data book is explained in a separate report.

The MMA data book includes summaries of historical data to assist potential contractors in gaining a general understanding of program membership and costs. Each MMA data book component is described in subsequent sections of this MMA data book narrative.

PROGRAM BACKGROUND

The MMA program is a statewide full-risk Medicaid managed care program that provides primary care, acute care, behavioral health, and pharmacy services to Medicaid beneficiaries who have been determined to meet the mandatory or voluntary eligibility requirements set out in Florida statute. The MMA program uses a managed care model where MMA members select among eligible capitated plans offered by managed care organizations.

The MMA program was originally implemented between May 1, 2014 and August 1, 2014, with implementation dates varying across the 11 rate development regions. The Agency subsequently re-procured managed care plans for the program, and the current managed care plan contracts became effective on the following dates (varying by region and plan):

- December 1, 2018: Regions 9, 10, and 11 (excluding Children's Medical Services Plan, or CMS Plan)
- January 1, 2019: Regions 5, 6, 7, and 8 (excluding CMS Plan)
- February 1, 2019: Regions 1, 2, 3, and 4 (excluding CMS Plan), and all regions for CMS Plan

Region definitions will change from the current definition. These changes will be effective for the next set of managed care plan contracts awarded under the upcoming ITN and are discussed further in Section II.

Each plan is currently paid a capitation rate per member per month (PMPM) to cover members enrolled in their plan. The capitation rates vary depending on a member's region, rate group, and rate cell (described further in Section II). Certain maternity services, for non-dual eligible members not enrolled in CMS Plan, are removed from the PMPM capitation rates and instead paid through a maternity kick payment on a per-delivery basis. Maternity services included in the maternity kick payment are described further in Section III.

The MMA program also currently includes a budget-neutral Prescribed Drugs High Risk Pool (PDHRP) risk mitigation mechanism for non-dual rate groups. A percentage of the capitation rates is withheld to fund the PDHRP. Under the current contract, for qualifying members with total qualifying drug costs exceeding a \$350,000 member-level threshold (or attachment point), the PDHRP pays MMA plans 80% of the costs above the \$350,000 threshold. The payments to plans are reduced pro rata if calculated PDHRP payouts exceed available PDHRP funds. Similarly, any remaining PDHRP funds are returned to plans in proportion to the withheld amounts if calculated PDHRP payouts are less than available PDHRP funds. Inclusion of this information in the MMA data book does not imply the continued use of the PDHRP, and it does not imply that the PDHRP methodology will stay the same if it continues.

Plan Types

The MMA program currently includes 10 health plans and 5 specialty plans. The 10 health plans cover a wide range of members, depending on plan type:

- ***Comprehensive Plan*** – A managed care plan that is eligible to provide MMA services and LTC services to eligible recipients.

- **LTC Plus Plan** – A managed care plan that is eligible to provide MMA services and LTC services to eligible recipients enrolled in the LTC program. This plan type is not eligible to provide services to recipients who are only eligible for MMA services.
- **MMA Plan** – A managed care plan that is eligible to provide MMA services to eligible recipients. This plan type is not eligible to provide services to recipients who are enrolled in the LTC program.

Each of the five **specialty plans** operating in the MMA program covers one of the following targeted groups of members:

- Child welfare
- Children with chronic conditions
- Human immunodeficiency virus (HIV) / acquired immunodeficiency syndrome (AIDS)
- Serious mental illness (SMI)

Additional Information

Additional program information is also described in later sections of this report, as well as in the Agency's summary titled, "A Snapshot of the Florida Statewide Medicaid Managed Care Program," which can be found at:

https://ahca.myflorida.com/medicaid/statewide_mc/pdf/mma/SMMC_Snapshot.pdf.

Additional program details will be provided by the Agency in the ITN.

OVERVIEW OF MMA DATA BOOK CONTENTS

The MMA data book includes historical data spanning January 2019 through June 2021 service dates, with claim payment or submission runout through December 31, 2021. The MMA data book historical data period represents the most recently available claim cost data that has been validated for capitation rate development and includes six months of runout.

Furthermore, the MMA data book includes historical cost data exclusively from the current set of managed care plan contracts. Since the current managed care plan contracts became effective February 1, 2019 for all plans in regions 1 through 4 and for CMS Plan across all regions, the MMA data book includes claim cost data beginning in February 2019 (rather than January 2019) for these situations. The MMA data book excludes historical cost data prior to the effective dates of the current contracts due to the significant program and population changes occurring with the implementation of the current contracts. In the case of a plan merging with or being acquired by another plan, data for the old plan is included beginning with the contract effective dates by plan and region (outlined above) through the time of the merger or acquisition.

While the cost data is limited in these situations, membership information for January 2019 is included (but separately identified) for all regions and plans in the MMA data book to allow potential contractors to review a complete calendar year of membership for 2019 dates of service. Additional information on the identification and exclusion of January 2019 data is included in Sections II and III.

Some exhibits included in the MMA data book are split to show data separately for service dates within January 2019 through December 2019 (CY 2019), January 2020 through December 2020 (CY 2020), and January 2021 through June 2021 (2021 H1). Throughout this report, CY 2019 refers to the data period used for 2019 claims included in the MMA data book, despite the fact that certain regions and CMS Plan include data beginning in February 2019 instead of January 2019.

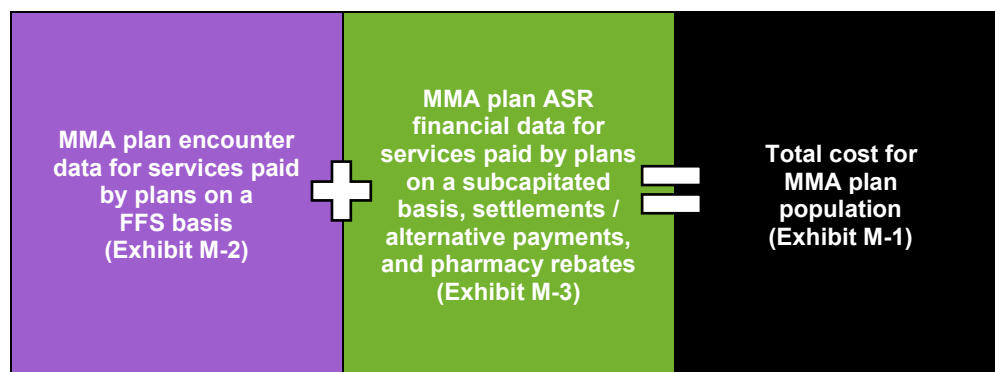
The MMA data book includes regional eligibility, utilization, and paid claims information for populations eligible for services covered under the MMA program. The MMA data book includes information from the Florida Medicaid data sources listed below:

- The Agency's eligibility data

- MMA plan encounter data, submitted through the Florida Medicaid Management Information System (FMMIS)
- MMA plan Achieved Savings Rebate (ASR) report financial data

These data sources can be combined in the following manner shown in Figure 1 to compile the historical data costs for the MMA enrolled population. Subsequent sections of this report describe the data sources, including the methodology and adjustments we applied in summarizing the data, in additional detail.

Figure 1 -- Summary of MMA Population Data Sources



The ASR reports include enrollment, revenue, and claims experience submitted by the MMA plans for each calendar quarter. The ASR template is available at the following location:

https://ahca.myflorida.com/Medicaid/statewide_mc/report_guides/asr_fin.shtml

Exhibit M-5B shows a detailed breakdown of which data source is used for each service line of the ASR template.

COVID-19 CONSIDERATIONS

The COVID-19 pandemic and determination of a federal public health emergency (PHE) have impacted health care costs significantly since March 2020. Costs changed significantly at the beginning of the pandemic, particularly due to the deferral or elimination of a significant number of non-essential services. Beyond that, MMA enrollment has increased significantly following the beginning of the PHE due to the moratorium on member redeterminations, as individuals who would typically disenroll have remained enrolled in MMA. The following impacts resulting from the COVID-19 pandemic and PHE may be reflected in the historical enrollment and cost data included in the MMA data book:

- **MMA population size and acuity:** Medicaid enrollment is currently elevated because during the PHE, MMA members are not being disenrolled due to normal eligibility redeterminations. Following the PHE, the state will begin disenrolling MMA members who are no longer eligible. Changes in the size of the population over time may impact the average acuity of the population enrolled within the MMA program.
- **Deferred and foregone services:** The COVID-19 pandemic has resulted in the deferral or elimination of a significant number of non-essential services, either through government enacted policies, the impact of social distancing on the administration of services, or personal choice.
- **COVID-19 testing and treatment costs:** Costs for these services are reflected in the historical data following the onset of COVID-19.
- **COVID-19 vaccine costs:** Costs for administration of COVID-19 vaccines are reflected in the historical data for service dates after the authorization date of a given vaccine.

- Service mix changes: In response to the pandemic, the mix of services used to treat patients has changed, such as the use of telehealth services. The service mix underlying the data book cost data has changed over time as a result of the COVID-19 pandemic.
- Other impacts related to the COVID-19 pandemic and federal PHE: The items above are not an exhaustive list of all possible impacts related to the COVID-19 pandemic and federal PHE. Users of the MMA data book may wish to consider other available research and information.

Potential contractors may want to give special consideration to these impacts when considering program membership and costs given the significant impact of these items.

MMA DATA BOOK STRUCTURE

The MMA data book includes two appendices which contain the relevant data summaries and other supporting information that comprise the MMA data book.

Appendix M-1

Appendix M-1 includes the “database” components for each data source to allow potential contractors to create their own customized summaries of the MMA data book information. Due to the volume of information in these databases, the file “08.05.2022 - Appendix M-1 - MMA Data Book Database.xlsx” presents Appendix M-1 in Excel format. Appendix M-1 includes the following components (each on a separate tab):

- **Data Dictionary:** A list of the fields included in the database for each data source, a description for each field, and a list of the possible values for each field
- **Rate Cells by Rate Group:** A list of the different rate cells included in the MMA data book for each rate group (also presented in Figure 2 in this narrative)
- **Service Categories:** A list of the service categories applicable to each data source for claim costs
- **Eligibility Data:** A database containing summaries of the membership underlying the MMA data book, as well as the members’ average risk scores, by region, rate group, rate cell, and other key variables
- **IP & OP Encounter Data:** A database containing encounter data for hospital inpatient, outpatient, and ambulatory surgery center (ASC) services paid by the MMA plans on a fee-for-service (FFS) basis
- **All Other Encounter Data:** A database containing encounter data for all other (i.e., non-hospital) services paid by the MMA plans on a FFS basis, as well as hospital crossover services
- **ASR Financial Data:** A database containing data for subcapitated services, settlements, and other non-encounterable claim costs from the ASR financial reports submitted by MMA plans
- **Maternity Kick Episodes:** A database containing counts of unique deliveries that underlie the maternity costs included in the encounter data databases

Appendix M-2

Appendix M-2 includes several summary exhibits to allow potential contractors to gain a general understanding of the utilization and cost data by data source. Additionally, Appendix M-2 also includes additional supplemental information to assist in understanding the data presented. Due to the volume of information in these exhibits, Appendix M-2 is presented in a series of five Excel files. Each Excel file follows a naming convention that includes “Appendix M-2” followed by the exhibit number. Appendix M-2 includes the following exhibits:

- **Exhibit M-1: MMA Data Book Summary**

- **Exhibit M-1A** shows the total claim costs PMPM, combined across the data sources described previously, for members historically enrolled in an MMA plan. Separate summaries are provided for CY 2019, CY 2020, and 2021 H1 incurred claims. The summary for each time period shows data separately for each rate group and region and illustrates how the costs from the different historical data sources can be combined to calculate the overall PMPM cost for members historically enrolled in an MMA plan. Certain maternity costs are excluded from this exhibit (and separately summarized in Exhibit M-1B) because the current MMA program capitation rate structure includes a maternity kick payment. *The encounter data included in Exhibit M-1A has been adjusted to account for differences relative to the ASR financial data and to remove the estimated value of expanded benefits, as described further in Section III.*
- **Exhibit M-1B** shows the maternity cost per delivery consistent with the definition used for the maternity kick payment. Separate summaries are provided for CY 2019, CY 2020, and 2021 H1 incurred claims. The summary for each time period includes member months, unique deliveries, and average claim cost per delivery by region. *The encounter data included in Exhibit M-1B has been adjusted to account for differences relative to the ASR financial data, as described further in Section III.*
- **Exhibit M-1C** summarizes member months included in the MMA data book by region and rate group. Separate summaries are provided for CY 2019, CY 2020, and 2021 H1 dates.
- **Exhibit M-2: MMA Data Book FMMIS Encounter Data**
 - **Exhibits M-2A through M-2M** show encounter data separately for each rate group. Separate summaries are shown for CY 2019, CY 2020, and 2021 H1 incurred claims. Each summary, specific to a given rate group and time period, includes member months by region, as well as claim costs PMPM, annual utilization per 1,000 members, and average unit cost by region and service category. The encounter data included in the MMA data book is limited to services paid by the MMA plans on a FFS basis. *The encounter data included in Exhibit M-2 has been adjusted to account for differences relative to the ASR financial data and to remove the estimated value of expanded benefits, as described further in Section III.*
- **Exhibit M-3: MMA Data Book ASR Financial Data**
 - **Exhibits M-3A through M-3M** show ASR report financial data separately for each rate group. Separate summaries are shown for CY 2019, CY 2020, and 2021 H1 incurred claims. Each summary, specific to a given rate group and time period, includes member months by region and claim costs PMPM by region and ASR line. The ASR financial data included in the MMA data book is limited to subcapitated services, settlements, and other non-encounterable claim costs.
- **Exhibit M-4: MMA Data Book Applicable Adjustments**
 - **Exhibit M-4A** shows the FMMIS encounter data to ASR financial data completion adjustment factors, which are applicable to the FMMIS encounter data to account for differences relative to the ASR financial data. Separate sets of factors are shown for CY 2019, CY 2020, and 2021 H1 incurred claims. Additionally, the factors are calculated separately for pharmacy and non-pharmacy services and for each region and rate group. The development of these factors is described further in Section III.

The application of these adjustment factors to the encounter data is shown within the relevant database tabs of Appendix M-1. Additionally, the encounter data shown in Exhibits M-1 and M-2 already includes the application of these adjustment factors as needed. We apply the FMMIS encounter data to ASR financial data completion adjustment factors to both the utilization and claim payment amounts, thereby keeping the implied average unit cost the same before and after the adjustment, because we assume that differences between the data sources are primarily due to duplicated or missing records in the encounter data.

- **Exhibit M-4B** shows expanded benefit adjustment factors, which are applicable to the FMMIS encounter data to remove the estimated value of expanded benefits that are included in the encounter data. Expanded benefits are not Florida Medicaid State Plan services, but they are currently offered by the

MMA plans outside of the capitation rates (i.e., at the plan's expense) as part of their contracts with the Agency. Because expanded benefits are plan-specific and are not covered by the Florida Medicaid State Plan, we present most of the MMA data book information with expanded benefit costs removed. Exhibit M-4D provides additional information regarding the cost of specific expanded benefits.

Since our identification and exclusion of individual expanded benefits in the encounter data is not comprehensive, these expanded benefit adjustment factors are necessary to properly exclude the value of expanded benefits. Separate sets of factors are shown for CY 2019, CY 2020, and 2021 H1 incurred claims. Additionally, the factors are calculated separately for each rate group, rate cell, and service category. The development of these factors is described further in Section III.

The application of these adjustment factors to the encounter data is shown within the relevant database tabs of Appendix M-1. Additionally, the encounter data shown in Exhibits M-1 and M-2 already includes the application of these adjustment factors as needed. We apply the expanded benefit adjustment factors to both the utilization and claim payment amounts, thereby keeping the implied average unit cost the same before and after the adjustment, because we assume that most expanded benefits result in additional utilization.

- **Exhibit M-4C** shows estimated historical MMA plan provider contracting levels as a percent of Florida Medicaid FFS reimbursement, based on reimbursement survey information reported by MMA plans. Information is shown for hospital inpatient, hospital outpatient, and ASC services that would be subject to reimbursement under the All Patient Refined Diagnosis Related Groups (APR-DRG) and Enhanced Ambulatory Patient Groups (EAPG) payment systems in the Florida Medicaid FFS program based on 3M™ APR-DRG and EAPG information.

These estimated average MMA plan provider contracting levels are implicit in the cost data summarized elsewhere in the MMA data book. To estimate historical MMA plan costs at Florida Medicaid FFS reimbursement levels, a user of the data book could divide a set of costs in the data book by the corresponding factor(s) shown in Exhibit M-4C.

Separate sets of provider contracting levels are shown for July 1, 2019 and January 1, 2021 to provide two points of reference during the historical data period included in the MMA data book. July 1, 2019 reimbursement survey information has been aggregated across plans using CY 2019 claim cost data to develop average contracting levels by region, rate group, and broad service category. Similarly, January 1, 2021 reimbursement survey information has been aggregated across plans using 2021 H1 claim cost data to develop average contracting levels by region, rate group, and broad service category.

- **Exhibit M-4D** shows historical MMA plan expanded benefit costs by time period (CY 2019, CY 2020, and 2021 H1). The exhibit provides the average, minimum, and maximum reported PMPM costs for each expanded benefit covered by plans. Please note, the PMPM values shown in the exhibit only consider members associated with a plan offering a particular benefit who reported costs for that benefit. While other components of the MMA data book are generally focused on costs exclusive of expanded benefits, this exhibit is intended to allow potential contractors to understand the historical value of each expanded benefit that has been offered at the MMA plan's expense.

Note, in some cases plans may have provided estimated values when reporting their expanded benefit costs or used different reporting methodologies in situations where they had difficulty identifying expanded benefit costs. Additionally, different plans may have offered different benefit levels for certain expanded benefits historically. As a result, the exhibit is intended only to give a high-level summary of the historical value of a given expanded benefit. The costs shown in Exhibit M-4D may not be appropriate for predicting future expanded benefit costs.

- **Exhibit M-5: MMA Data Book Supplemental Information**

- **Exhibit M-5A** outlines the MMA mandatory, voluntary, and excluded populations.

- **Exhibit M-5B** summarizes the data sources included for each benefit expense ASR line. This exhibit includes the ASR report instructions that MMA plans are given, as well as additional information regarding which data source (encounter data or ASR financial data) Milliman used for each service category in the MMA data book.
- **Exhibit M-5C** shows reallocation factors by rate group and rate cell that are applied to the ASR financial data. These factors were applied to the subcapitated, settlement, and other ASR financial data when re-allocating the total payments in the ASR financial data across the different rate cells. Additional information on the reallocation process is provided in Section III.
- **Exhibit M-5D** provides a list of Florida Medicaid MMA program changes since January 1, 2019. These program changes may impact costs reflected in the MMA data book or may impact future costs of the MMA program.

MMA Data Book Narrative

The remainder of this MMA data book narrative includes the following information in addition to the attached database files and summary exhibits:

- Section II describes the eligibility data used to both define the MMA eligible population and summarize the claims data to develop the MMA data book.
- Section III describes the claims data and adjustments made to the data to develop the MMA data book.
- Section IV outlines adjustments that have not been included in the MMA data book.
- Section V includes caveats and limitations on the use of the MMA data book.

II. ELIGIBILITY DATA

This section of the MMA data book narrative describes the method for defining the MMA eligible population and summarizing the data. The source of this data includes detailed member-level eligibility files provided by the Agency for CY 2019, CY 2020, and 2021 H1 dates of service. These eligibility files contain one record for each member in each month they were enrolled in Florida's Medicaid program. Exhibit M-1C provides a high-level summary of the member months included in the MMA data book by year, region, and rate group.

The remainder of this section discusses the following information related to the eligibility data included in the MMA data book:

- MMA covered populations
- Delivery system assignment
- MMA rate group assignment
- MMA rate cell assignment
- Region assignment
- Member month exclusions
- Risk score assignment

MMA COVERED POPULATIONS

The MMA program serves two primary types of Medicaid-eligible members based on eligibility option:

- **Mandatory eligibility populations:** Medicaid-eligible members who are mandated to enroll in MMA.
- **Voluntary eligibility populations:** Medicaid-eligible members who are not required to enroll in the MMA program but may choose to enroll on a voluntary basis.

Exhibit M-5A contains a list of MMA mandatory, voluntary, and excluded populations. All mandatory eligibility populations were required to enroll in MMA in the historical data period and are therefore reflected in the MMA data book. For the voluntary eligibility populations, the MMA data book includes any Medicaid-eligible members who voluntarily enrolled in the MMA program in the historical data period. The MMA data book excludes those members who did not enroll in MMA during the historical data period.

DELIVERY SYSTEM ASSIGNMENT

The MMA data book includes information for populations receiving services from two distinct delivery systems within the MMA program during the historical data period:

- **CMS Plan delivery system:** Includes members enrolled in CMS Plan, which is offered through the Florida Department of Health (Department). Prior to February 1, 2019, the Department covered members through the Children's Medical Services Network (CMS Network, or CMSN) and contracted with two integrated care systems to administer CMSN services on a non-risk basis. Effective February 1, 2019, the Department contracts with a single managed care plan to provide services through CMS Plan on a full-risk basis. Because of the unique contractual arrangement for this plan, it is classified as its own member delivery system.
- **MMA Capitated Plan delivery system:** Includes members enrolled in capitated standard plans and specialty plans operating as part of the MMA program, excluding CMSN or CMS Plan.

Members enrolled in an MMA plan and the same entity's non-Special Needs Plan (non-SNP) Medicare Advantage plan, currently known in the MMA program as Medicare Advantage Plan (MAP) members, are included in the MMA data book and classified into one of the two delivery systems described above. However, the MMA data book excludes dual eligible members in a Dual Eligible Special Needs Plan (D-SNP) given that these members are currently covered through separate D-SNP contracts.

MMA RATE GROUP ASSIGNMENT

The MMA data book assigns each Medicaid beneficiary to one of the broad rate groups listed below, based on the rate groups currently used for capitation rate development within the MMA program:

- **TANF Non-SMI:** Includes eligible members not meeting the criteria for SMI, for the Temporary Assistance for Needy Families (TANF) / Aid to Families with Dependent Children (AFDC), General Assistance, Omnibus Budget Reconciliation Act (OBRA) Children, Foster Care, Pregnant Women, MediKids, MEDS infants < 1 with poverty level C, and Children's Health Insurance Program (CHIP) members with poverty level C populations.
- **TANF SMI:** Includes SMI eligible members at least six years old for the TANF / AFDC, General Assistance, OBRA Children, Foster Care, Pregnant Women, and CHIP members with poverty level C populations.
- **SSI Medicaid Only Non-SMI:** Includes non-SMI eligible Supplemental Security Income (SSI) and related eligible members who do not have Medicare coverage.
- **SSI Medicaid Only SMI:** Includes SMI eligible SSI and related eligible members at least six years old who do not have Medicare coverage.
- **SSI Dual Eligible:** Includes SSI and related eligible members that have full Medicare benefits (Parts A and B) or Medicare Part B only coverage.
- **Child Welfare:** Medicaid-eligible children and adolescents who are less than 18 years old and have an open case for child welfare services in the Department of Children and Families (DCF) Florida Safe Families Network (FSFN).
- **HIV / AIDS:** Recipients who are HIV positive but asymptomatic, recipients with symptomatic HIV disease, and recipients with Centers for Disease Control and Prevention (CDC) defined AIDS. The HIV / AIDS population is further split by those members who are dual eligible and those members who are only eligible for Medicaid.
- **LTC:** Recipients who are enrolled in the SMMC LTC program in addition to the MMA program. The LTC population is further split between those members who are dual eligible and those members who are only eligible for Medicaid.
- **CMS Plan – Private Duty Nursing:** Includes individuals under age 21 enrolled in CMS Plan who meet the Agency-defined private duty nursing (PDN) utilization threshold.
- **All Other Plan – Private Duty Nursing:** Includes individuals under age 21 enrolled in plans other than CMS Plan who meet the Agency-defined PDN utilization threshold.
- **CMS Plan – Non-Private Duty Nursing:** This rate group reflects all members enrolled in CMS Plan who do not meet the criteria of the PDN rate group.

All members in the CMS Plan delivery system are assigned to one of the two CMS Plan rate groups. Members in the MMA Capitated Plan delivery system are assigned to one of the other rate groups. For cases where a member is eligible for multiple specialty populations (excluding members enrolled in CMS Plan), the member is assigned to a rate group in our historical period data using the following hierarchy. This hierarchy is consistent with the Agency's classification for capitation payment purposes:

1. LTC
2. PDN
3. Child Welfare
4. HIV / AIDS

MAP members are included in the MMA data book and classified into an SSI Dual Eligible, HIV / AIDS Dual Eligible, or LTC Dual Eligible rate group and rate cell. While the current MMA capitation rate development structure includes a separate rate cell for MAP members, the current intention is to remove this rate cell beginning with the implementation of this procurement and pay managed care plans based on the MAP member's original classification of rate group and rate cell.

The Agency eligibility data included in the MMA data book reflects the rate groups and rate cells in effect during each given month within the historical data period. In order to reflect the historical data on a consistent basis reflecting the current state of the program, members are reclassified into rate groups for several reasons as outlined in the following sub-sections.

SMI Population

The Agency's SMI assignment algorithm uses data back to January 2013 (for diagnostic data) and back to March 2013 (for pharmacy data) to identify SMI individuals, meaning that once an individual has been flagged with SMI, they will always be flagged with SMI.

For purposes of identifying the SMI population for both broad rate groups and specific rate cells in the historical data period, we apply the Agency's SMI assignment algorithm using diagnostic and pharmacy data prior to and including the historical data period. The MMA data book reflects an SMI population consisting of individuals who would have met the October 2022 through September 2023 (RY 22/23) SMI assignment criteria, on average, during a given year in the historical data period. In other words, the average RY 22/23 SMI assignment criteria are modeled separately for CY 2019 eligibility data, CY 2020 eligibility data, and 2021 H1 eligibility data, so that the data from each year independently reflects the average RY 22/23 SMI assignment criteria. The RY 22/23 time period is used as the basis for the SMI assignment criteria because it is the latest capitation rate year for which SMI flags can be modeled using the available data.

Beginning in October 2019, the Agency began using all 25 diagnosis codes included on claims data to flag SMI members rather than four diagnosis codes as used historically. The Agency did not introduce all 25 diagnosis codes for flagging SMI individuals back to January 2013 when SMI flagging began. Rather, the Agency included diagnosis codes 5 through 25 on the most recent month of paid claims used in generating the SMI flags each month, starting with the flags applicable for October 2019 capitation payments.

Based on the Agency algorithm and modeling the average RY 22/23 SMI assignment criteria, the SMI flagging process applied to each year in the historical data period is based on an average of 121.5 months of diagnostic data and 119.5 months of pharmacy data. Similarly, diagnosis codes 5 through 25 are used for an average of 42.5 months for purposes of developing SMI flags for each year in the MMA data book. Using these periods of diagnostic and pharmacy data reflects the expected increase in the SMI population over time (through RY 22/23) due to the permanent nature of SMI identification for an individual.

The Agency's current SMI identification algorithm can be found at the following location:

https://ahca.myflorida.com/medicaid/statewide_mc/pdf/2018-23_Contract_Mats/SMI_Algorithm_Codes_202207.xlsx.

HIV / AIDS Population

Similar to SMI, the Agency algorithm for identifying HIV / AIDS members historically used four diagnosis codes included on the claims data. Beginning with the flags applicable for October 2019 capitation payments, the Agency introduced the use of all 25 diagnosis codes to identify HIV / AIDS members. For example, the set of flags for October 2019 capitation payments used August 2019 paid claims, and each month of flags following relies on all 25 diagnosis codes in a subsequent month of paid claims.

We adjust the historical data in the MMA data book to reflect an HIV / AIDS population consisting of individuals who would have met the RY 22/23 HIV / AIDS assignment criteria (including the additional diagnosis codes, where appropriate) during the historical data period. The HIV / AIDS assignment criteria are modeled separately on the eligibility data for each separate year of historical data (CY 2019, CY 2020, and 2021 H1). The RY 22/23 time period

is used as the basis for the HIV / AIDS assignment criteria to be consistent with the SMI flagging time period, and because it is the latest capitation rate year for which HIV / AIDS flags have been modeled.

The Agency's current HIV / AIDS identification algorithm can be found at the following location:

https://ahca.myflorida.com/medicaid/statewide_mc/pdf/2018-23_Contract_Mats/HIV-AIDS_Algorithm_Codes_202207.xlsx.

LTC – Nursing Facility Utilizers

Beginning with the current contract effective dates (varying from December 2018 through February 2019 as shown in Section I), MMA plans became responsible for covering nursing facility services for recipients aged 18 and older who are not enrolled in the LTC program. The covered nursing facility services include Medicare crossover payments prior to LTC program enrollment, nursing facility stays for members awaiting enrollment into the LTC program, and any other Medicaid covered nursing facility services for members who are enrolled in MMA but not in the LTC program. MMA plans are only responsible for nursing facility claims with a first date of service after a recipient is enrolled in MMA; the Agency's FFS program pays for any nursing facility stay with a first date of service prior to a recipient's MMA program enrollment if the recipient is not enrolled in the LTC program.

After the addition of these services to the MMA program, the Agency determined some members receiving nursing facility services outside of the LTC program should be enrolled in the LTC program. Additionally, the Agency clarified short-term nursing facility coverage requirements for MMA plans under various scenarios. As a result, the historical data period shown in the MMA data book does not fully reflect expected enrollment in the LTC program for future periods. We worked with the Agency to identify the following types of members who are assumed to move to the LTC program:

- **Members with an end-dated Level of Care (LOC):** Members historically enrolled in the LTC program who subsequently lost Medicaid eligibility had an LOC that was end-dated within the Agency's enrollment system. The Agency identified a number of members in this situation and, therefore, manually re-enrolled them into the LTC program in early 2019. Additionally, the Agency made operational changes to delay the process of end-dating a member's LOC going forward.
- **Members with a nursing facility stay greater than 120 days:** Members with a nursing facility stay of greater than 120 continuous days. Based on feedback from MMA plans and nursing facilities, the Agency expects all members in this situation to be transitioned to the LTC program no later than their 120th day in a nursing facility, with some members transitioning sooner, such that the average time in a nursing facility for MMA members in this situation is less than 120 days. However, to avoid under-estimating the MMA program claim liability for nursing facility services while these transitions are operationalized, we assume the average time in a nursing facility for these members will be approximately 120 days. Members must be assigned an institutional care program (ICP) code while enrolled in MMA in order to be shifted due to this criterion.

These members were historically included in rate groups other than the LTC Medicaid Only and LTC Dual Eligible rate groups, but they are expected to transition to those rate groups upon LTC program enrollment. We, therefore, adjust the rate group assignments in the historical data in the MMA data book to reflect each of these types of members as LTC Medicaid Only or LTC Dual Eligible, depending on their Medicare status. The rate group assignment for nursing facility utilizers in the MMA data book reflects the Agency's expectations for future enrollment patterns.

This adjustment increases the population identified for LTC rate groups in CY 2019 by 12,312 member months and in CY 2020 by 4,829 member months on a projected basis and decreases the population identified for other rate groups by the same amount.

Private Duty Nursing

Rate groups specific to PDN members were introduced to the MMA program beginning with October 2019. Separate PDN rate groups currently exist for members enrolled in CMS Plan and for members enrolled in all other MMA plans.

However, to improve data credibility, the capitation rates for all PDN members in the MMA program are currently based on the combined medical costs of qualifying members enrolled in both CMS Plan and all other MMA plans.

In addition to the fact that the PDN rate group breakout did not exist prior to October 2019, the Agency also revised the PDN member classification algorithm for October 2020 and subsequent months. As a result, we identify members using historical PDN claims incurred prior to and during the historical data period consistent with the Agency's current PDN member classification criteria.

The current PDN member classification criteria requires a member to incur 120 or more total hours of PDN services in **at least one month** in a historical three-month incurrual period (described further below). A PDN service hour is defined as one unit of service for procedure code S9123 or S9124, as reported on a claim paid through the Agency's FFS program or on an encounter claim accepted by FMMIS. FMMIS rejected claims and claims paid at \$0 are excluded when calculating a member's total PDN service hours during a given month. In addition to the service hour criteria, a recipient must also be under age 21 as of the last day of the month prior to the month of PDN rate group assignment to qualify for the PDN rate group.

The Agency prospectively assigns members to the PDN rate group based on total PDN service hours incurred in any one of three historical months. PDN service hours from each of the three consecutive historical months are totaled with runout through a specific date. Hours from the oldest historical month are totaled with three months of claim payment runout, hours from the middle historical month are totaled with two months of claim payment runout, and hours from the most recent historical month are totaled with one month of claim payment runout. To allow sufficient time for both the claims payment runout and for the Agency to collect the data and assign a PDN flag to members for capitation payment purposes, a member is classified into the PDN rate group two months after the final runout month.

To further illustrate the current PDN rate group assignment on a sample time period, Table 1 shows the incurred months and claim runout to be used by the Agency to identify members qualifying for one of the PDN rate groups for RY 22/23.

Table 1
PDN Rate Group Assignment Illustration
Sample Illustration Using RY 22/23 Flagging Months

Capitation Rate Payment Month	Incurred Months Used for PDN Member Identification ¹			End of Claim Runout Period for Incurred Months
	Incurred Month #1	Incurred Month #2	Incurred Month #3	
October 2022	May 2022	June 2022	July 2022	August 31, 2022
November 2022	June 2022	July 2022	August 2022	September 30, 2022
December 2022	July 2022	August 2022	September 2022	October 31, 2022
January 2023	August 2022	September 2022	October 2022	November 30, 2022
February 2023	September 2022	October 2022	November 2022	December 31, 2022
March 2023	October 2022	November 2022	December 2022	January 31, 2023
April 2023	November 2022	December 2022	January 2023	February 28, 2023
May 2023	December 2022	January 2023	February 2023	March 31, 2023
June 2023	January 2023	February 2023	March 2023	April 30, 2023
July 2023	February 2023	March 2023	April 2023	May 31, 2023
August 2023	March 2023	April 2023	May 2023	June 30, 2023
September 2023	April 2023	May 2023	June 2023	July 31, 2023

¹The PDN identification algorithm requires a member to incur 120 or more hours of PDN services in any one of the three historical months to qualify for the PDN rate group in the capitation rate payment month.

To emulate the current PDN rate group assignment on the historical data in the MMA data book, we identify members using PDN claims incurred prior to and during the historical data period consistent with the previously outlined timing pattern and other technical criteria developed by the Agency. Additionally, our flagging process is consistent with our expectations for how we anticipate PDN service claims to be coded in the future, particularly in situations where valid historical claims may not meet the technical requirements for inclusion in the Agency's identification process. For example, while the Agency will use only FMMIS encounter data and FFS data to identify members for the PDN rate

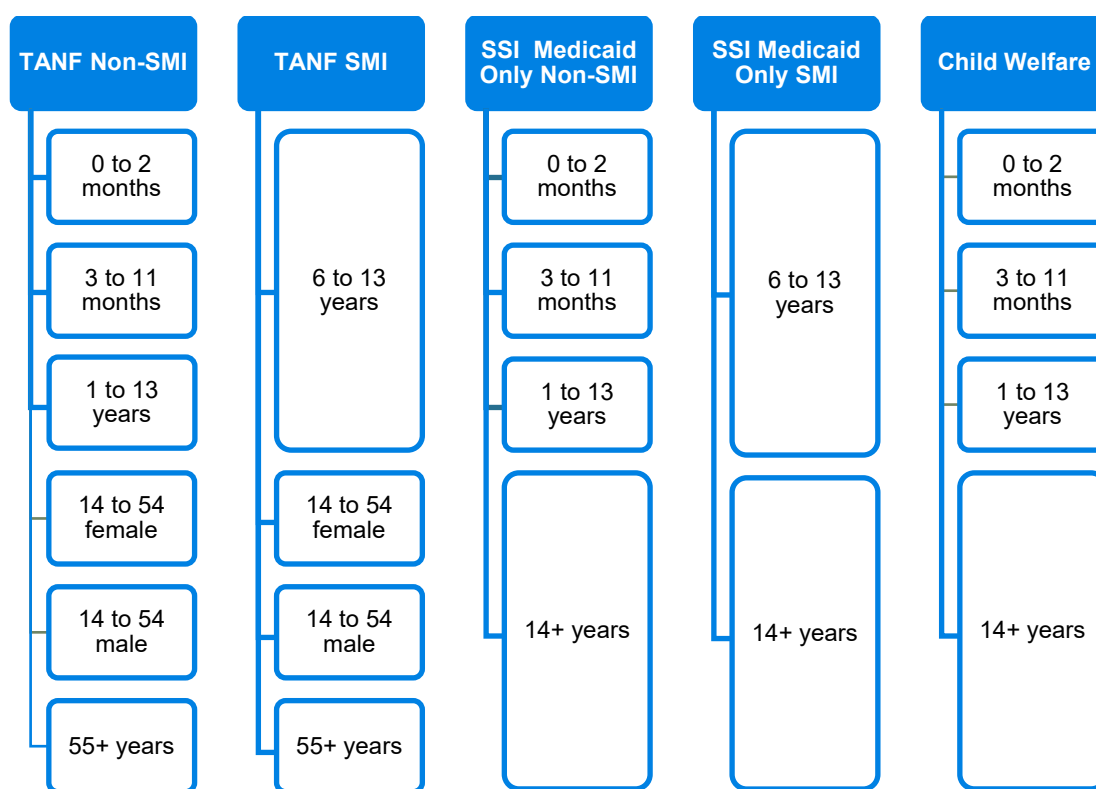
groups, we assume that any legitimate claims currently missing from the FMMIS data will be included in future periods. As a result, our process to identify members during the historical data period for the PDN rate groups includes both FMMIS data and special feed encounter data in addition to FFS data.

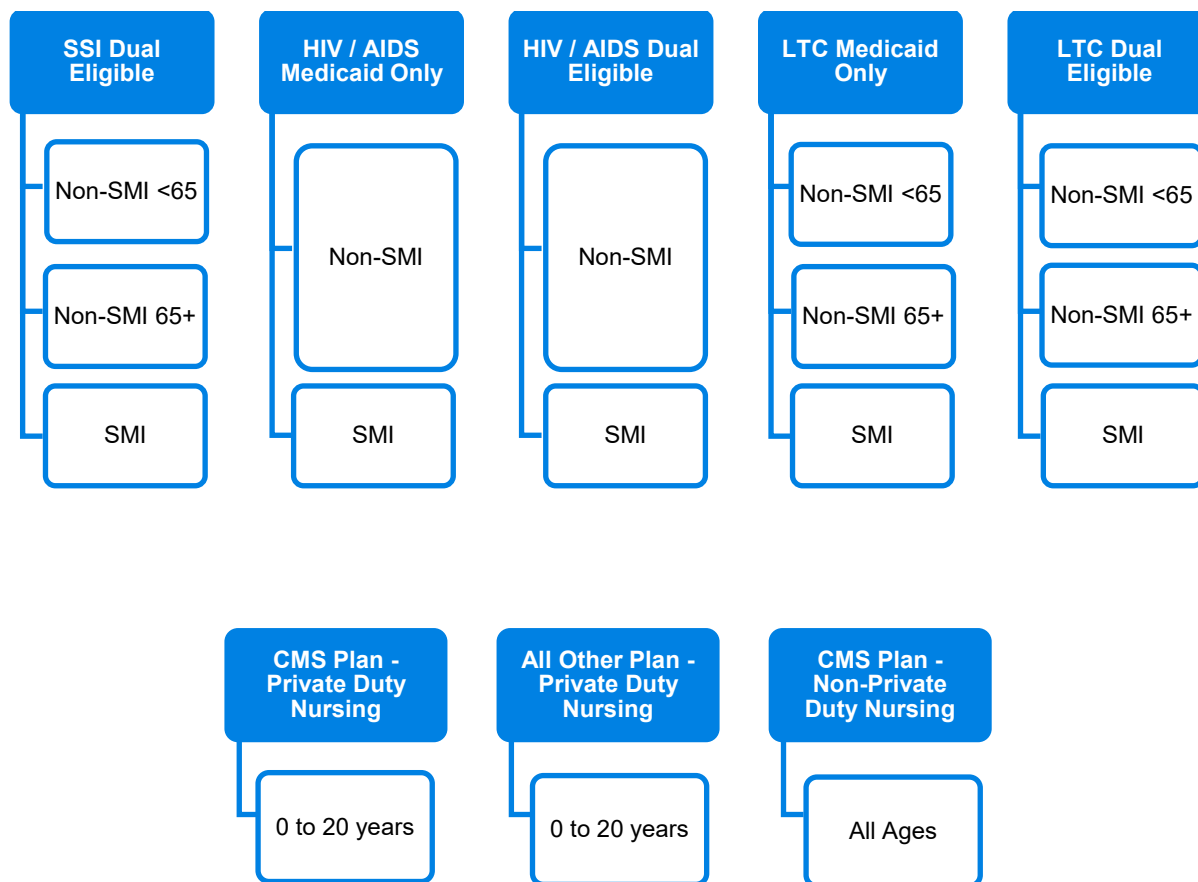
MMA RATE CELL ASSIGNMENT

Each rate group included in the MMA data book is further broken down into specific rate cells, based on the rate cell structure currently used for capitation rate development within the MMA program. Each rate cell is defined by a combination of age, gender, and SMI status within each rate group. The rate cell breakouts currently used in the MMA program for each rate group are shown in Figure 2 and on the “Rate Cells by Rate Group” tab in Appendix M-1.

Consistent with the initial rate group classification for MAP members described above, these members are classified in the appropriate dual eligible rate cell in the MMA data book. Additionally, because the SMI rate groups include only members who are at least six years old, the rate cells for these rate groups begin at age six.

Figure 2 – Summary of MMA Rate Cells by Rate Group





The historical ASR financial data does not contain sufficient information to split out costs for individual rate cells. Therefore, we make additional adjustments to the ASR financial data summaries as necessary to categorize these costs at the rate cell level, as further outlined in Section III of this report.

REGION ASSIGNMENT

The SMMC program groups Florida counties into regions according to definitions outlined in Florida Statute. Grouping counties together to form regions also helps to increase the credibility of claims experience. The regional mappings will be condensed from 11 to 9 regions beginning with the new capitated plan contracts, as shown in Table 2.

Table 2
State of Florida
SMMC Region Definitions

New Region	Old Region	Counties
A	1	Escambia, Okaloosa, Santa Rosa, and Walton
A	2	Bay, Calhoun, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty, Madison, Taylor, Wakulla, and Washington
B	3	Alachua, Bradford, Citrus, Columbia, Dixie, Gilchrist, Hamilton, Hernando, Lafayette, Lake, Levy, Marion, Putnam, Sumter, Suwannee, and Union
B	4	Baker, Clay, Duval, Flagler, Nassau, St. Johns, and Volusia
C	5	Pasco and Pinellas
D	6	Hardee, Highlands, Hillsborough, Manatee, and Polk
E	7	Brevard, Orange, Osceola, and Seminole
F	8	Charlotte, Collier, DeSoto, Glades, Hendry, Lee, and Sarasota
G	9	Indian River, Martin, Okeechobee, Palm Beach, and St. Lucie
H	10	Broward
I	11	Miami-Dade and Monroe

The region for each member included in the MMA data book is based on the following hierarchy:

1. MMA plan ID that is specific to a region.
2. LTC capitated plan ID that is specific to a region.
3. County of residence information in the Agency's eligibility file.

MEMBER MONTH EXCLUSIONS

If a member is not assigned a valid rate group, rate cell, region, or other critical demographic category in the data, we exclude the member month and associated claims from the MMA data book. This situation only occurs for 224 member months statewide during the January 2019 through June 2021 historical data period, so the impact is insignificant.

Additionally, certain member month records are included in the eligibility data shown in the MMA data book but have their claim costs excluded from the data book. Because the claim costs are excluded in these situations, the member month records also need to be excluded when calculating average annual utilization / 1,000 or PMPM claim cost values. The affected member months are for members who were enrolled in the MMA program during the given month, but their claim costs are not anticipated to be representative for the current or future state of the MMA program due to data quality issues or unique enrollment situations. These members were still valid MMA members during the historical data period and may be considered for analysis that does not involve utilization or claim costs (e.g., when analyzing historical membership).

The "Eligibility Data" tab of Appendix M-1 includes a field called "MMA Plan-Specific Exclusion" to indicate situations in which a given set of member months should be excluded for determining average utilization or claim costs. The members identified for exclusion from utilization and claim cost analysis are identified with one of the following values in the "MMA Plan-Specific Exclusion" field:

- **Unreliable Claims Data – All Encounter and ASR Claims Excluded:** Member months in this situation do not have any claims included in the MMA data book due to data quality concerns. This situation only impacts a single plan and only impacts 2021 H1 data, resulting in the exclusion of 66,591 member months.
- **LTC Plus Plan Non-LTC Membership – All Encounter and ASR Claims Excluded:** Member months in this situation reflect members who were enrolled in the LTC Plus plan for MMA services while being eligible for, but not yet enrolled in, the LTC program. The Agency has since made operational changes, such that members enrolling in an LTC Plus plan will no longer express enroll into MMA. As a result, we assume that situations where members are enrolled in the LTC Plus plan, but not an LTC rate group, will not occur going

forward; instead, members in this situation will remain in FFS for the partial month prior to their enrollment in both the MMA and LTC programs at the same time. This exclusion impacts 2,772 member months.

- **Pre-Implementation Membership – All Encounter and ASR Claims Excluded:** As described previously, the MMA data book includes historical cost data exclusively from the current set of managed care plan contracts. As a result, this value in the “MMA Plan-Specific Exclusion” field identifies the following types of member months that need to be excluded when analyzing MMA data book cost information:
 - January 2019 member months for regions 1 through 4 or CMSN (275,550 member months).
 - Member months under a plan that exited the MMA program or exited the member’s region following the current contract implementation dates, where the member remained enrolled in the old plan temporarily (3,221 member months).
 - Member month records for dates after the implementation date of a merger or acquisition, enrolled in a plan that no longer participates in the program due to the merger or acquisition (4 member months).
- **Pre-Implementation Membership – ASR Included; All Encounter Claims Excluded:** Some plans operating in regions 1 through 4 covered members in these regions both before and after the February 1, 2019 effective date for the current contracts. Because ASR financial data is reported on a quarterly basis, January 2019 specific costs cannot be identified and removed from the ASR financial data in these situations. Therefore, for these specific situations, the January 2019 member months need to be included when analyzing ASR financial data but excluded when comparing to other cost information. This situation impacts 553,714 member months.

The associated member months for each of these situations have already been excluded from the annual utilization / 1,000 and claim cost PMPM values as needed in Appendix M-2. Additional information regarding the exclusion of claims for these member cohorts is provided in subsequent sections.

RISK SCORE ASSIGNMENT

The MMA data book eligibility data includes aggregate population risk score information based on risk scores determined as part of the quarterly risk adjustment process for Florida’s MMA program during the historical data period. The MMA risk score information can be found in the “Eligibility Data” tab of Appendix M-1.

For each capitation rate year, custom cost weights were developed using Florida Medicaid experience and version 6.3 or 6.4 of the University of California San Diego’s Chronic Illness and Disability Payment System plus Prescription Drug (CDPS+Rx) mappings of ICD9 and ICD10 diagnostic data and NDCs to condition categories. Separate regression models were used to develop cost weights for the TANF Non-SMI, TANF SMI, SSI Medicaid Only Non-SMI, and SSI Medicaid Only SMI rate groups. The TANF Non-SMI risk model includes separate cost weights for children (under age 19) and adults (ages 19+).

Each scored individual receives a demographic relative cost weight and can have multiple disease categories assigned depending on that individual’s health status. For each member, the weights for all of the disease categories assigned are combined with demographic information to calculate a total individual risk score. Member-level diagnostic and pharmacy information from FFS and encounter data was examined during a one-year study period to determine applicable disease categories. The age and gender of the individual as of the mid-point of each one-year study period is used to determine the applicable demographic category. A given member is only scored if they have at least six months of Medicaid eligibility during the one-year study period.

Table 3 below identifies the capitation rate year and diagnosis / NDC study period used for each calendar quarter falling within the historical data period of the MMA data book:

Table 3 SMMC MMA Program Risk Adjustment Time Periods			
Calendar Quarter	Corresponding Capitation Rate Year ¹	Study Period Beginning Incurred Date	Study Period Ending Incurred Date
2019 Q1 (A) ²	RY 18/19	April 1, 2017	March 31, 2018
2019 Q1 (B) ²	RY 18/19	April 1, 2017	March 31, 2018
2019 Q2	RY 18/19	July 1, 2017	June 30, 2018
2019 Q3	RY 18/19	October 1, 2017	September 30, 2018
2019 Q4	RY 19/20	January 1, 2018	December 31, 2018
2020 Q1	RY 19/20	April 1, 2018	March 31, 2019
2020 Q2	RY 19/20	July 1, 2018	June 30, 2019
2020 Q3	RY 19/20	October 1, 2018	September 30, 2019
2020 Q4	RY 20/21	January 1, 2019	December 31, 2019
2021 Q1	RY 20/21	April 1, 2019	March 31, 2020
2021 Q2	RY 20/21	July 1, 2019	June 30, 2020

¹ The annual capitation rate year runs from October through September (with the exception of RY 18/19, which began with the current contract effective dates varying by region and plan). RY 18/19 includes current contract effective dates through September 30, 2019. RY 19/20 includes October 2019 through September 2020. RY 20/21 includes October 2020 through September 2021.

² For 2019 Q1, separate risk scores were used before and after February 1, 2019. The (A) time period includes only January 2019, while the (B) time period includes February 2019 and March 2019.

The following nuances and important caveats apply regarding the risk scores presented in the MMA data book:

- Inclusion of CDPS+Rx risk score information in the MMA data book **does not imply the continued use of the current CDPS+Rx model in the MMA program, and it also does not imply that risk adjustment will or will not apply to any given MMA program population going forward.**
- Risk score information is only provided for the four MMA program rate groups that are currently risk adjusted using CDPS+Rx: TANF Non-SMI, TANF SMI, SSI Medicaid Only Non-SMI, and SSI Medicaid Only SMI.
- Risk scores shown in the database are assigned from one of the rate group specific risk score models using the member's projected rate group (which is developed as described in prior sub-sections). The quarterly risk adjustment process assigns a risk score based on the member's actual rate group in a given month (as opposed to a projected rate group).
- Since separate risk models apply to different rate groups, risk scores are not comparable across different rate groups. Similarly, because the risk models are recalibrated for each capitation rate year, risk scores are not comparable across different capitation rate years.
- The risk scores shown are raw, or unnormalized, risk scores. The average risk score does not necessarily equal 1.0 for the total population or for any given subset of the population. (Historically in the MMA program, for risk adjusted populations, the capitated plans' capitation rates are adjusted based upon budget neutral risk scores which aggregate to 1.0 by regional rate cell.)

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- In developing the average risk score for the demographic categories in the eligibility file, “unscored” members received the same average risk score as the average of the scored members in that cohort. This methodology is consistent with how MMA risk scores are currently applied. Note, the “0-2 Months” and “3-11 Months” rate cells do not have any risk scores assigned given that sufficient data is not available to score members in these situations. Additionally, some other records in the database may have “N/A” listed for the risk score due to a lack of sufficient data to score the members in that row.
 - The MMA risk adjustment process has included adjustments for PDN members and for Child Welfare in-home / out-of-home status at various points during the historical data period. However, these adjustments were applied outside of the CDPS+Rx based regression model used for scoring individual members and are not reflected in the risk scores shown in the MMA data book.
 - COVID-19 and the federal PHE may impact risk scores to varying degrees across different time periods. Utilization reductions during a given study period may cause diagnosis and NDC information (and resulting risk scores) to be underreported. Additionally, time periods of significant membership growth may have a higher than normal portion of unscored members.

III. CLAIMS DATA SOURCES AND ADJUSTMENTS

This section of the MMA data book narrative describes the claims data sources and discusses adjustments made to the data sources to develop the MMA data book. The following aspects of the data are addressed:

- Data validation process
- MMA plan encounter data
- MMA plan ASR financial data

DATA VALIDATION PROCESS

The Agency and Milliman went through an extensive data validation process to review MMA plan data included in the data book. This review and validation were originally undertaken as part of the October 2021 through September 2022 (RY 21/22) and RY 22/23 capitation rate development processes and also support the summarization of the data in the MMA data book.

First, the Agency reviewed multiple iterations of ASR financial data for internal consistency and helped to validate the FMMIS encounter data. We also performed a review of the data for validation purposes. This review included detailed analysis of numerous aspects of the FMMIS encounter data and ASR financial data, as well as a comparison between the two data sources.

We provided plan-specific data summaries and data validation questions to all plans based on review of the data sources and comparisons of the ASR financial data to FMMIS encounter data. Additionally, we held one-on-one meetings with plan representatives on several occasions between December 2020 and April 2022, in which we discussed the data with plans. After receiving additional FMMIS encounter data and ASR data submissions, as well as written responses to the data questions, we summarized the historical data for use in both capitation rate development and the development of this data book.

While we have performed a considerable amount of data review and validation, it is not practical to validate every possible outcome, and we did not audit the data. As a result, data anomalies, inconsistencies, or errors may exist, and these situations may have a larger relative impact when reviewing more detailed cuts of data. Additionally, our review and validation prioritized claim payment amounts over utilization counts; as a result, data anomalies, inconsistencies, or errors may impact utilization metrics to a greater degree than claim payment amounts. Users of the MMA data book should be aware of the limitations of the data when reviewing it.

Additionally, while a significant amount of detail is available in the appendices, particularly Appendix M-1, certain detailed cuts of data with low volume may lack credibility.

MMA PLAN ENCOUNTER DATA

The FMMIS encounter data is the primary data source for claims paid by plans on a FFS basis. We exclude FMMIS encounter data for subcapitated services and other non-claim-based payments (e.g., settlements), with limited exceptions as described below, since the ASR financial data is the primary source for these services.

The FMMIS encounter data reflects dates of service (dates of admission for inpatient claims) in CY 2019, CY 2020, and 2021 H1, with runout for claims submitted through December 31, 2021. The MMA data book does not account for incurred but not reported (IBNR) claims liability for claims incurred in CY 2020 or 2021 H1.

The Agency provided the FMMIS encounter data to Milliman. The FMMIS encounter data provided to Milliman includes all claims submitted by plans into FMMIS for the relevant claim types – including claims that were paid by plans but flagged as rejected for technical reasons in the FMMIS system. We reviewed the data and applied a de-duplication process (described in additional detail below) prior to including it in the MMA data book. Additionally, we performed additional processing steps as needed to appropriately categorize and aggregate the data.

The FMMIS encounter data reflects a wide variety of claim types assigned by the FMMIS encounter system. We use the claim type to stratify claims and assign service categories that are comparable to the ASR financial data (described further in a later subsection). Table 4 below outlines each FMMIS claim type used in the MMA data book:

Table 4 FMMIS Encounter Data Claim Types	
Claim Type	Claim Type Description
I	Inpatient
A	Inpatient Crossover
O	Outpatient
C	Outpatient Crossover
06	Ambulatory Surgery Center
P	Pharmacy
Q	Compound Drug
M	Professional
B	Professional Crossover
L	Long-Term Care

The FMMIS encounter system assigns the inpatient, outpatient, and long-term care claim types using the bill type code on institutional claims. Additional fields are used to distinguish between Medicare crossover claims and claims where Medicaid is the primary payer for inpatient and outpatient services. Pharmacy claims and compound drug claims are separately classified into claim types “P” and “Q.” All other claims are identified with claim type “M” (non-crossover) or “B” (crossover). We create an additional claim type for ASC services, since these services may be reported on either institutional or professional claim forms. We assign all non-crossover claims with a provider type of 06 (ASC), regardless of the original reported claim type, to be classified as claim type 06 for purposes of summarizing the encounter data.

The service category breakouts for the FMMIS encounter data, discussed further below, are assigned by Milliman to provide additional details for various services.

We modify the FMMIS encounter data for the following items, each of which is described further in the subsequent sections:

- De-duplication of FMMIS encounter data
- FMMIS encounter data exclusions and adjustments
- Service categorization
- FMMIS encounter data to ASR financial data completion adjustment
- Adjustment to remove expanded benefits

De-Duplication of FMMIS Encounter Data

For various reasons, numerous claims are included in the FMMIS encounter data set multiple times. To remove the excess records and include a unique set of claims paid by MMA plans, we de-duplicate the data. We worked with the Agency to develop the de-duplication logic that is applied to the data.

The first goal of the de-duplication process is to remove any claim record that is not the final version of the claim. Therefore, the following claim records are removed for all FMMIS claim types:

- Any claim record included in the data set multiple times under the same internal control number (ICN) and line number.
- Any claim for which the Agency later received a resubmission. We identify these claims using an Agency table listing all “old” claims that were later resubmitted.
- Any claim record automatically generated in the Agency’s system to close out a voided claim.

- Any claim identified by an ICN that was adjusted by a later claim.
- Any claim record that voids another claim (since the original claim has already been removed).

Beyond these steps, the process differs for non-crossover hospital and ASC claims and all other claims.

For non-crossover hospital and ASC claims (claim types I, O, and 06), we next take the following steps:

- **Remove claims denied by the payer**, in situations where all lines on a given claim are indicated as denied by the payer (i.e., the claim is denied at the header level). For any claim with at least one line paid by the plan (i.e., paid at the header level), we retain the claim in the data set. Within the claims paid at the header level, we retain all claim lines (including those flagged as denied by the plan) to properly capture billed amounts and other fields at a header level, but we do not include paid amounts from any claim line flagged as denied by the plan.

As part of this step, for one plan's data incurred prior to January 1, 2021, we adjust the reported paid / denied status from denied to paid on claim lines with a nonzero paid amount regardless of the plan denied status, based on supplemental information from this plan. Aside from this exception, all identification of denied lines is performed solely using the plan paid / denied status on each claim line, regardless of the status assigned by FMMIS.

- **Develop claim header records**, based on information contained within associated claim detail lines. To do this, we aggregate the claim dollars across all paid lines within a claim, determine minimum and maximum dates associated with each claim, and pull other relevant header-level information from the claim detail lines. The claim header records are used in other aspects the de-duplication process (described in the following bullets). The development of the claim header records also facilitates proper assignment of 3M™ APR-DRG and EAPG values.
- **Remove duplicate inpatient claims**, at the header level. To be considered a duplicate, a claim must have the same recipient ID, plan, provider ID, and first date of service as another claim. If all these fields are identical across multiple claims, we look at additional fields, such as admission date, last date of service, billed amount, and paid amount to determine if the claim truly appears to be a duplicate. Additional filtering logic is also applied to avoid over-identifying duplicate claims (for example, we apply logic to keep certain one-day transfer stays in the data set). We also combine the payments from different claims into a single header record per stay in situations where the claims appear to be interim claims or additive adjustments for the same hospital stay.
- **Remove duplicate outpatient and ASC claims**, at both the header level and the line level. To be considered a duplicate at the header level, a claim must have the same recipient ID, plan, provider ID, first date of service, last date of service, and billed or paid amount as another claim. After removing header level duplicates, we remove duplicates at the line level. To be considered a duplicate at the line level, a claim line must have the same recipient ID, plan, provider ID, header first date of service, line level first date of service, header last date of service, revenue code, procedure code, and modifiers as another claim line from a different claim. Additionally, in situations where separate claims appear to be submitted for a single visit, we combine these into a single claim with all non-duplicate claim lines from both original claims to assist with appropriate 3M™ EAPG assignment.

For all other claims, we use a different series of steps to identify any additional records to remove. We remove any claim record that was denied by the plan, except for one MMA plan for dates of service prior to January 1, 2021, based on plan feedback. We also remove additional duplicate records for the same person on the same day. To be considered a duplicate pharmacy claim record in this step, a record must have the same recipient ID, plan ID, billing provider ID, treating provider ID, date of service, national drug code (NDC), and units billed as another claim record. All other claim records are considered duplicates if they have the same recipient ID, billing provider ID, treating provider ID, first date of service, last date of service, revenue code, procedure code, and modifier fields as another claim record.

FMMIS Encounter Data Exclusions and Adjustments

Beyond the de-duplication process outlined above, we exclude or adjust FMMIS encounter data claims in the following situations:

- We re-classify FMMIS encounter data claims with a claim type of I, A, O, C, or 06 to be claim type M in the following instances:
 - Nursing facility claims (provider types 09 and 10)
 - Hospice claims (provider type 15 or revenue codes 0182 – 0185, 0650 – 0659)
 - PDN claims (procedure codes S9123 and S9124)

These non-hospital services sometimes meet the Agency definition of a claim type that is typically used for hospital claims, but alternative service categories are more reflective of the type of claim.

- We exclude FMMIS encounter data claims covered by the LTC program. Our logic varies by category of service and plan.
 - For non-crossover hospital and ASC claims (claim types I, O, and 06) and pharmacy (claim types P and Q) services, we assume all claims are MMA covered services and do not classify any of these claims as LTC program claims.
 - For all other claims for LTC rate group members, we use varying approaches by plan to classify claims as part of the LTC program based on how each plan populates the LTC plan ID. For each plan, we first compared FMMIS encounter data assigned to an MMA plan ID and LTC rate group relative to the ASR financial data to analyze the alignment of claims. Based on this comparison, we use one of the following approaches for each plan:
 - For plans where the comparisons were relatively consistent, we identify a claim as an LTC program claim if it is reported using an LTC plan ID.
 - For plans where the comparisons between the data sources were not consistent between programs, we identify a claim as an LTC program claim if it meets the criteria to be an LTC covered service rather than based on the plan ID submitted on the claim.
 - For non-LTC members projected to enroll in LTC under the rate group modifications described in Section II, an LTC plan ID is not present on any of the claims. As these members are expected to be enrolled in the LTC program, we identify claims that meet the criteria to be an LTC covered service and exclude such claims for these members (excluding claim types I, O, 06, P, and Q).
- We exclude all FMMIS encounter data claims for services covered by capitated dental plans as part of the Dental program. This includes all claims with a Dental plan ID reported on the claim or with a dental claim type 'D'.
- We exclude subcapitated claims identified in the FMMIS encounter data, with two exceptions outlined below. Within the FMMIS encounter data, plans predominantly report subcapitated claims using a contract type code of 05 or 06. However, we reviewed the FMMIS encounter data relative to the ASR financial data to align the FFS and subcapitated claims reported in each data source and found that using the contract type code logic alone did not sufficiently identify subcapitated services within the FMMIS encounter data. Therefore, we asked plans how to identify subcapitated services within the FMMIS encounter data. Based on plan responses, we incorporate plan-specific logic to identify and exclude claims associated with various subcapitated vendors:
 - All claims reported with contract type code 05 or 06, with two exceptions (one exception for a related party arrangement outlined below, and one exception where these codes appeared to over-identify subcapitated claims for a plan).

- Claims identified in the FMMIS encounter data using unique logic provided by plans for each subcapitated vendor.
- In one situation where a plan subcapitates mental health services with a related party entity, we rely on the FMMIS encounter data instead of the ASR financial data. In this situation, the subcapitated encounter data appears to be adequately reported and reflects the true costs underlying the related party subcapitation arrangement. We therefore re-classify this plan's FMMIS mental health encounter data from subcapitated to FFS. We include these amounts in the FMMIS encounter data summaries in the MMA data book.
- We exclude the following types of claims based on the member who incurred the claim:
 - Claims for recipient IDs that do not match to a member month in the Agency's eligibility file (less than 0.1% of FMMIS encounter data claims).
 - Claims for members who do not map to a valid rate group or rate cell (less than 0.01% of FMMIS encounter data claims).
 - Claims for Medicare-eligible members who are enrolled in a D-SNP and covered through a separate D-SNP contract, or who are otherwise not enrolled in an MMA plan during the month of the claim (less than 0.1% of FMMIS encounter data claims).
- We exclude claims associated with the exclusions outlined in the "MMA Plan-Specific Exclusion" field within the "Eligibility Data" tab of Appendix M-1:
 - Claims incurred in 2021 H1 for the plan with unreliable data. *This exclusion corresponds to the member months identified as "Unreliable Claims Data – All Encounter and ASR Claims Excluded" within the eligibility database.*
 - All costs for members enrolled in an LTC Plus plan, but not in an LTC rate group. *This exclusion corresponds to the member months identified as "LTC Plus Plan Non-LTC Membership – All Encounter and ASR Claims Excluded" within the eligibility database.*
 - January 2019 incurred claims for members enrolled in regions 1 through 4 or in CMSN. The FMMIS encounter data provides the appropriate claim-level detail to limit claims to only those incurred after the February 1, 2019 regional and CMS Plan implementation date. *This exclusion corresponds to all of the member months identified as "Pre-Implementation Membership – ASR Included; All Encounter Claims Excluded" and to a portion of the member months identified as "Pre-Implementation Membership – All Encounter and ASR Claims Excluded" within the eligibility database.*
 - Claims for a plan that exited the MMA program or exited the member's region following the current contract implementation dates. *This exclusion corresponds to a portion of the member months identified as "Pre-Implementation Membership – All Encounter and ASR Claims Excluded" within the eligibility database.*
 - Claims for incurred dates after the implementation date of a merger or acquisition, for a member enrolled in a plan that no longer participates in the program due to the merger or acquisition. *This exclusion corresponds to the remaining portion of the member months identified as "Pre-Implementation Membership – All Encounter and ASR Claims Excluded" within the eligibility database.*

Because we exclude claim costs, the member months associated with these specific members also are excluded when calculating average annual utilization per 1,000 members and PMPM claim cost values using FMMIS encounter data in Appendix M-2.

- In addition to excluding claims incurred in 2021 H1 for the plan with unreliable data, we also exclude all encounter records submitted after December 31, 2020 for earlier dates of service for this plan because these

encounter data records also appear to be unreliable. As a result, this plan's encounter data effectively has claim submission runout through December 31, 2020 rather than December 31, 2021.

- We exclude a small amount of pharmacy and injectable drug claims (approximately 0.01% of total non-hospital claims) for hemophilia drugs that are not covered by MMA.
- Given the significant pharmacy costs for HIV / AIDS Dual Eligible members and the expectation that plans will work with these members more closely than other dual eligible members to determine their needs and coverage prior to providing services, we limit these members' pharmacy data to drugs covered by Medicaid (resulting in a reduction in claims of \$5.0 million across the 30 months of historical data).
- We exclude any amounts identified as over-the-counter (OTC) drug claims that are classified as expanded benefits. Expanded benefits are not Florida Medicaid State Plan services, but they are currently offered by the MMA plans outside of the capitation rates (i.e., at the plan's expense) as part of their contracts with the Agency. Because expanded benefits are plan-specific and are not covered by the Florida Medicaid State Plan, we present most of the MMA data book information with expanded benefit costs removed.

Since our identification and exclusion of individual expanded benefits in the encounter data is limited to OTC drug claims and is not comprehensive, expanded benefit adjustment factors are necessary to properly exclude the value of expanded benefits. These adjustments factors are described further in a subsequent subsection.

- For one plan, claim adjustment records in the FMMIS encounter data reflected incremental paid adjustments rather than the revised total paid amounts intended to replace the original claim. In this situation we received additional data from the plan in order to adjust the FMMIS encounter paid amount to reflect the full plan paid amount for the final version of each adjusted claim.
- We adjust the Medicaid provider IDs and provider types associated with hospital and ASC claims. We first map each claim to the "base" provider ID and provider type for a given Medicaid provider ID. Additionally, we further adjust the provider ID and provider type on some claims using national provider identifier (NPI) information (for providers not mapped initially) and to identify claims expected to be billed under a separate ID for the same organization during later periods (for two impacted providers). For any unmapped providers, the "IP & OP Encounter Data" tab of Appendix M-1 shows a provider ID of "N/A."

Service Categorization

In addition to the adjustments described above, we classify claims into service categories based on the claim type and other information included in the data. The tab "Service Categories" in Appendix M-1 includes a list of the encounter data service categories that are included in the MMA data book. Additional information on the service categories is also shown in Exhibit M-5B. The logic applied to categorize the different types of services is described below.

Hospital Inpatient Services

Using the FMMIS hospital inpatient data (claim type I), we create service category M2.1 (Hospital Inpatient FFS) and develop several more detailed service categories to show the mix of hospital inpatient services. Many of the detailed inpatient service categories are based on 3M™ APR-DRGs assigned to the encounter data. We used the 3M™ Core Grouping Software (CGS) to assign version 39 APR-DRGs, based on information reported in the data, as well as additional edits and adjustments we made to mitigate grouping errors.

The MMA data book includes the following detailed hospital inpatient service categories:

- **M2.1a: Hospital Inpatient FFS – Maternity.** We classify non-dual, non-CMS Plan claims with one of five delivery APR-DRGs (539, 540, 541, 542, or 560) into this service category to align with the set of inpatient services currently covered by the maternity kick payment.

- **M2.1b: Hospital Inpatient FFS – Newborn.** We classify claims with one of several APR-DRGs (580, 581, 583, 588, 589, 591, 593, 602, 603, 607 - 609, 611 - 614, 621 - 623, 625, 626, 630, 631, 633, 634, 636, 639, 640, or 863) into this service category.
- **M2.1c: Hospital Inpatient FFS – Mental Health & Substance Abuse.** We classify claims with one of several APR-DRGs (740, 750 – 760, 770, 772 – 776, or 817) into this service category.
- **M2.1d: Hospital Inpatient FFS – Non-DRG.** We classify inpatient claims for the following types of providers and services into this service category. The FFS Medicaid payment rates for these providers or services are based on per diems or alternate methods instead of APR-DRGs:
 - Provider type 04 (state mental hospital), provider type 05 (community behavioral health services), or provider type 16 (Statewide Inpatient Psychiatric Program, or SIPP).
 - Free-standing psychiatric hospitals, identified based on the Medicaid provider ID.
 - Other institutions for mental diseases (IMDs), identified based on the Medicaid provider ID or NPI.
 - Medicaid provider IDs used only for tuberculosis patients.
 - Claims for newborn hearing tests.
- **M2.7.1: Transplant Services.** We classify claims into this service category using a combination of surgical procedure codes, CPT codes, and age, based on the Agency's definition of heart, liver, lung, and multivisceral / intestinal transplants where Florida Medicaid FFS reimbursement is based on global case rates instead of APR-DRGs.
- **M2.1e: Hospital Inpatient FFS – All Other DRG.** We classify all remaining inpatient claims into this service category if they do not meet the criteria for one of the previous inpatient categories. Services in this category meet the criteria for APR-DRG reimbursement in the Florida FFS Medicaid program.

[Hospital Outpatient and ASC Services](#)

Using the FMMIS hospital outpatient and ASC data (claim types O and 06), we create service categories M2.3 (Hospital Outpatient FFS: ER) and M2.4 (Hospital Outpatient FFS: Other than ER). We further break these categories into more detailed service categories, which are reflected in the MMA data book:

- **M2.3: Hospital Outpatient Emergency Room FFS – EAPG.** We classify claims into this service category based on an emergency room revenue code (0450, 0451, 0452, 0456, or 0459) and a valid hospital provider type of 01 (general hospital) or 04 (state mental hospital). These emergency room claims would be paid under EAPGs in Florida's FFS Medicaid program.
- **M2.4a: Ambulatory Surgery Center FFS.** We classify claims with an ASC provider type (provider type 06) into this service category.
- **M2.4b: Hospital Outpatient FFS Non-ER / Non-ASC – EAPG.** We classify remaining outpatient claims that do not meet either the emergency room or ASC criteria into this category if the claim has a valid hospital provider type of 01 or 04 and would therefore be paid under EAPGs in Florida's FFS Medicaid program.
- **M2.4c: Hospital Outpatient FFS Non-ASC – Non-EAPG.** We classify claims all remaining outpatient claims, except those for injectable drugs, into this category if the claim does not have a provider type of 01, 04, or 06 and would therefore not be paid under EAPGs in Florida's FFS Medicaid program. Claims billed under Medicaid provider IDs used only for tuberculosis patients and claims for newborn hearing tests are also included in this service category regardless of provider type because they are not paid under EAPGs in Florida's FFS Medicaid program.

[Medicare Crossover Services](#)

We classify crossover claims (claim types A, B, and C) into unique service categories since Medicare is the primary payer for these claims:

- **M2.Xa: Hospital Crossover Services FFS.** We classify hospital FFS claims with claim types A and C into this service category.
- **M3.Xa: Professional Crossover Services FFS.** We classify professional FFS claims with claim type B into this service category.

[Pharmacy Services](#)

We classify FMMIS pharmacy claims (claim types P and Q) into one of several more detailed prescription drug categories. We categorize the pharmacy claims into brand and generic categories based on a Medi-Span database mapping by NDC. Additionally, our internal pharmacy experts identify specific therapeutic classes to categorize as specialty drugs based on a review of multiple factors including cost, drug characteristics, and industry classifications. Both are methodologies similarly used by the pharmacy industry. The following pharmacy claim categories are used in the MMA data book:

- **M8.a: Prescription Drugs FFS – Generic**
- **M8.b: Prescription Drugs FFS – Brand**
- **M8.c: Prescription Drugs FFS – Specialty**
- **M8.d: Prescription Drugs FFS – Other / Not Identified** (i.e., anything that does not fall into categories M8.a through M8.c)

[Professional and Other Services](#)

The remaining claims include professional, long-term care, and other ancillary services (claim types M and L). These claims reflect a wide array of different types of services and, therefore, require more precise mappings to develop categorization of these services. We use a combination of the ASR financial data service category mapping logic, customized categorization, and the Milliman *Health Cost Guidelines*TM (HCGs) grouper to stratify these claim types. The ultimate service categories are generally consistent with the ASR financial data, with further breakouts in some cases. Our initial step is to classify claims to specific service categories using the ASR financial data service category mapping and customized logic similar to that used in recent years for capitation rate development:

- **Matern: Professional Maternity FFS.** For purposes of identifying claims for non-CMS Plan and non-dual eligible members that are currently included as part of the MMA program maternity kick payment definition, we develop a separate service category for all non-facility claims that meet one of the following criteria:
 - One of eight physician delivery procedure codes (59409, 59410, 59514, 59515, 59612, 59614, 59620, or 59622). We move the full cost for these services to category “Matern.”
 - One of four physician global maternity service procedure codes (59400, 59510, 59610, or 59618). Since these procedure codes include some services that do not happen concurrently with the actual delivery event, we move the estimated portion of these claims that is attributable to the delivery event to category “Matern.” We calculate the estimated portion attributable to delivery costs by dividing the facility relative value unit (RVU) of the corresponding delivery-specific procedure code (59410, 59515, 59614, or 59622, respectively) by the facility RVU of the global procedure code. Note, the remainder of the payment is assigned to the service category where the claim would otherwise be classified.
 - One of eleven physician procedure codes (59412, 59414, 59525, 01958, 01960 to 01963, or 01967 to 01969) that may accompany a delivery event near the time of the delivery. We classify claims with these

procedure codes as part of the total maternity delivery costs (category “Matern”), but we do not use the presence of these codes alone to count unique delivery events in the “Maternity Kick Episodes” tab of Appendix M-1 or in Exhibit M-1B of Appendix M-2.

- **M3.J: Professional Injectable Drugs FFS.** This category reflects all claims for injectable drugs with a HCPCS code beginning with ‘J,’ limited to claims for non-dual eligible members. In addition to claim type M (shown in the ‘All Other Encounter Data’ tab of Appendix M-1), this category also includes claims with a claim type of “O” or “06” but without an EAPG-based provider type of 01, 04, or 06 (shown in the ‘IP & OP Encounter Data’ tab of Appendix M-1).
- **M5.1: Mental Health & Substance Abuse FFS.** Claims are categorized into M5.1 using the list of MMA and LTC mixed services categorized as mental health & substance abuse according to the ASR service category mapping logic.
- **M7.1: Transportation FFS.** Claims are categorized into M7.1 using the ASR service category mapping logic.
- **M9.1a: Private Duty Nursing FFS.** To isolate the specific PDN service costs included in the encounter data, this PDN-specific service category reflects all claims with procedure codes S9123 or S9124. All costs incurred under these two procedure codes are categorized into this service category, including both costs for members in the PDN rate group and residual costs for members who do not qualify for the PDN rate group in a given month.
- **M9.1b: Home Health FFS.** Claims are categorized into M9.1b using the ASR service category mapping logic or if the claim reflects procedure code T1020.
- **M9.1c: Personal Care FFS.** To isolate the specific personal care service costs included in the encounter data, this service category reflects all claims with procedure codes S9122 or T1019.
- **M9.2.1: Nursing Facility FFS.** We classify all nursing facility services that would be reimbursed under the Agency’s nursing facility per diem rates into this broad service category. The Agency defines nursing facility claims as having provider types 09 or 10 and one of ten revenue codes (0100, 0101, 0180, 0181, 0183, 0184, 0185, 0186, 0188, or 0189). All nursing facility claims are included in the MMA data book net of historical patient responsibility.
- **M9.2: Hospice FFS.** This service category reflects all services with provider type 15 or with revenue codes 0182 – 0185 or 0650 – 0659.
- **M9.3: DME FFS.** Claims are categorized into M9.3 using the ASR service category mapping logic.
- **M9.4: All Other State Plan Services FFS.** Claims are categorized into M9.4 using the ASR service category mapping logic.

Following this detailed logic, claims remain that have not been categorized. In order to fully allocate all services, we assign a broad service category using the HCGs grouper. The grouper uses a comprehensive set of medical codes to categorize claims at a detailed level. Since these categories do not align with the ASR service categories, we develop a mapping to assign each detailed HCGs grouper category to a service category consistent with the ASR report. Most significantly, we create categories M3.1 and M3.2 to reflect physician services. Specifically, the following categories are included in this mapping:

- **M3.1: Primary Care FFS**
- **M3.2: Specialty Care FFS**
- **M5.1: Mental Health & Substance Abuse FFS**
- **M7.1: Transportation FFS**
- **M9.1b: Home Health FFS**
- **M9.4: Other State Plan Services FFS**

FMMIS Encounter Data to ASR Financial Data Completion Adjustment

Based on the results of our comparison between ASR financial data and FMMIS encounter data, the two data sources reflect differences in total paid claims for services paid on a FFS basis. Because the ASR reports are ultimately audited and because of known limitations with the FMMIS encounter data, we believe the ASR financial data is a more representative source for total paid claims within the MMA program. As a result, to account for this discrepancy and include a complete set of cost information in the MMA data book, we apply a FMMIS encounter data to ASR financial data completion adjustment.

To develop this adjustment, we summarized the FMMIS encounter data on a consistent basis as the ASR data in terms of types of claims included (e.g., expanded benefits are included in both sources for this comparison to avoid misalignment in their identification). To compare the FMMIS data and ASR financial data on a consistent time period basis, we rely on the following information in developing this adjustment for each of the following three distinct time periods:

- **CY 2019 service dates:** We compared FMMIS encounter data with submission runout through December 31, 2021 to audited CY 2019 ASR financial data and the prior year adjustments from the audited CY 2020 ASR financial data, including the incurred but not paid (IBNP) amounts. The inclusion of IBNP amounts in the ASR financial data implicitly accounts for estimated runout through December 31, 2021 (comparable to the encounter data), as well as a small amount of additional plan estimated IBNP beyond that point. As a result, the encounter data for CY 2019 dates of service is assumed to be complete after the application of these adjustments.
- **CY 2020 service dates:** We compared FMMIS encounter data with submission runout through December 31, 2021 to audited CY 2020 ASR financial data and the prior year adjustments from the 2021 Q4 ASR financial data. Plan-reported IBNP amounts are not included because the runout dates are already consistent between data sources.
- **2021 H1 service dates:** We compared FMMIS encounter data with submission runout through December 31, 2021 to information from 2021 H1 as reported in the 2021 Q4 ASR financial data. Plan-reported IBNP amounts are not included because the runout dates are already consistent between data sources.

For each year of incurred claims, this adjustment is calculated and applied separately for pharmacy claims and non-pharmacy claims.

Pharmacy Claims

For pharmacy claims, we first compared the amount of pharmacy claims identified in the ASR financial data with the amount of pharmacy claims identified in the FMMIS encounter data at a plan level for each time period. The level of difference between sources varies by plan and is also impacted by the nature of each plan's pharmacy benefit manager (PBM) pricing arrangement during each time period. Based on information from plans, we expect the claim payment amounts in the FMMIS encounter data to represent the amounts paid by the PBM to the pharmacies; however, some plans indicated that the ASR financial data includes the amount paid by the plan to the PBM, which is generally higher than the amount paid to the pharmacy in the case of a spread pricing arrangement. Therefore, we took the following steps, depending on the relationship between the two data sources and the nature of the PBM pricing arrangement for each plan and time period:

- For situations where **a difference is not expected** between the two data sources, we calculate a FMMIS pharmacy claims adjustment for each plan and time period. This adjustment results in the FMMIS data effectively matching the ASR financial data. This applies both to situations where a plan had a "pass-through" pricing arrangement with their PBM in a given time period, as well as any situation where a plan had a spread pricing arrangement but reported both data sources on a consistent basis for a given time period. However, for one plan with known limitations in the ASR data reporting for pharmacy services, we rely directly on the FMMIS encounter data.

- For situations where the **ASR financial data is expected to be higher** than the FMMIS data (due to reflecting amounts paid to the PBM under a spread pricing arrangement), we reviewed the relationship in the payment amounts between the two data sources and attempted to confirm whether the relationship was representative of their PBM spread pricing arrangement. For most plans in this situation in a given time period, the relationship makes sense in the context of the given plan's PBM pricing arrangement, so we are able to rely on the plan's FMMIS encounter data directly. However, for one plan with a PBM spread pricing arrangement, the observed relationship between the FMMIS data and the ASR financial data does not accurately reflect the PBM spread pricing arrangement. Therefore, we adjust the FMMIS pharmacy data for this plan to an appropriate level relative to the ASR financial data, based on other information about the plan's differential between the amount paid to pharmacies and the amount paid to the PBM.

The intended end result of the pharmacy claim adjustments is to ensure that all FMMIS pharmacy data is reported at a level consistent with the amount paid to the pharmacies by plan, region, and time period, net of any incremental PBM spread amount. This adjustment is applied in total across all pharmacy services for all rate groups within a plan, region, and time period combination. Additional costs to MMA plans associated with PBM spread pricing or administrative fees are typically considered separately, as part of the administrative costs, when we develop capitation rates.

Non-Pharmacy Claims

For non-pharmacy claims, we separately compared the amount of all non-pharmacy claims identified in the ASR financial data with the amount of claims identified in the FMMIS encounter data at a plan, time period, region, and broad rate group level. Rate groups are split into three breakouts:

- Dual eligible rate groups: SSI Dual Eligible, HIV / AIDS Dual Eligible, and LTC Dual Eligible
- LTC Medicaid Only
- All other rate groups

The rate group breakouts account for differences in dual eligible claim reporting and allocation between the MMA and LTC programs within the FMMIS encounter data and ASR financial data. If the data were reported and categorized consistently in both sources, we would expect the two data sources to match for each rate group breakout. Since the two data sources do not match, we calculate an adjustment factor to account for the difference. The adjustment factor is based on the total claim dollar difference between sources across all non-pharmacy claims for each plan, time period, region, and rate group breakout.

Calculation of Final Adjustments

Within the pharmacy and non-pharmacy adjustments, we separately accounted for Zolgensma claims that were not accepted in FMMIS encounter data submissions. Due to the high cost of Zolgensma claims, these claims were allocated to adjust the time period, plan, region, and rate group in which the claim was incurred in the historical data period.

Based on the application of pharmacy and non-pharmacy adjustments to the data, we determine composite pharmacy and non-pharmacy adjustments at the time period, region, and rate group level based on the mix of plan data by time period within each region and rate group. Exhibit M-4A shows the factors that are ultimately applied to the data by time period, region, and rate group.

The application of these adjustment factors to the encounter data is shown within the relevant database tabs of Appendix M-1. Additionally, the encounter data shown in Exhibits M-1 and M-2 already includes the application of these adjustment factors as needed.

Adjustment to Remove Expanded Benefits

Expanded benefits are not Florida Medicaid State Plan services, but they are currently offered by the MMA plans outside of the capitation rates (i.e., at the plan's expense) as part of their contracts with the Agency. Because expanded benefits are plan-specific and are not covered by the Florida Medicaid State Plan, we present most of the MMA data book information with expanded benefit costs removed.

As described previously, we explicitly exclude any encounter data records identified as OTC drug claims that are classified as expanded benefits. However, since our identification and exclusion of individual expanded benefits in the encounter data is limited to OTC drug claims and is not comprehensive, expanded benefit adjustment factors are necessary to properly exclude the value of expanded benefits.

The expanded benefit adjustment accounts for this exclusion by effectively reducing the summarized paid claims data to a level net of expanded benefit costs. For all applicable services aside from OTC drug services, the expanded benefit adjustment factors account for the value of additional expanded benefits that are identified in the MMA plan ASR financial data but not identified in the encounter data. We first assign each type of expanded benefit service reported in the ASR reports to one or more corresponding FMMIS encounter service categories. We then adjust the reported dollars in those encounter data service categories on a plan level consistent with the amounts reported in the ASR reports. The reduction in costs for all expanded benefits, with the exception of one category, is applied exclusively to adults age 21 and over. Additionally, only FFS expanded benefits reported in the ASR reports are removed from the FMMIS encounter data dollars as part of this adjustment.

Ultimately, we confirm the total claims removed from the summarized data (including this adjustment, the exclusion of OTC claims from the FMMIS encounter data, and the exclusion of subcapitated and settlement expanded benefit costs reported in the ASR financial data) reconcile to the total claims reported as expanded benefits in the ASR financial data. Exhibit M-4B documents the expanded benefit adjustment factors applied to the encounter data by rate cell, service category, and time period.

The application of these adjustment factors to the encounter data is shown within the relevant database tabs of Appendix M-1. Additionally, the encounter data shown in Exhibits M-1 and M-2 already includes the application of these adjustment factors as needed.

Exhibit M-4D provides additional information regarding the cost of specific expanded benefits.

ASR FINANCIAL DATA

Plans submit ASR financial reports on a quarterly basis throughout the year, as well as a year-end report with three months of claim payment runout. ASR financial data is the primary data source for services paid by plans on a subcapitated basis, settlement / alternative payment (AP) amounts, and other non-encounterable payments for all members. The ASR financial data is also used to validate the plan FMMIS encounter data submissions.

The MMA data book includes ASR financial data for dates of service from January 1, 2019 through June 30, 2021, using the ASR reports with runout as shown below in Table 5.

Table 5 ASR Report Service Dates and Runout Dates for MMA Data Book		
Data Period (Dates of Service)	ASR Submission	Paid Date Cutoff
January 2019 through December 2019	CY 2019 Audited	March 31, 2020
January 2020 through December 2020	CY 2020 Audited	March 31, 2021
January 2021 through June 2021	2021 Q4	December 31, 2021

The tab “Service Categories” in Appendix M-1 includes a list of the ASR financial data service categories (“ASR lines”) that are included in the MMA data book. Additional information on the service categories is also shown in Exhibit M-5B.

The following subsections describe data exclusions and other adjustments we make to the data.

ASR Financial Data Exclusions

We exclude claims from the ASR financial data included in the MMA data book in the following situations.

- We exclude 2021 ASR financial data for the plan with unreliable data. *This exclusion corresponds to the member months identified as “Unreliable Claims Data – All Encounter and ASR Claims Excluded” within the eligibility database.*
- We exclude all costs for members enrolled in an LTC Plus plan, but not in an LTC rate group. As outlined in the eligibility section, these members are expected to remain in FFS longer going forward, removing their costs from the MMA program until they enroll in an LTC plan. *This exclusion corresponds to the member months identified as “LTC Plus Plan Non-LTC Membership – All Encounter and ASR Claims Excluded” within the eligibility database.*
- ASR financial data claims for MMA plans are reported on a quarterly basis and, therefore, do not allow for January 2019 specific claims to be removed. In order to best reflect costs under the current managed care plan contracts, we take a varying approach to include or exclude each plan’s ASR financial data by region:
 - Plans exiting regions 1 through 4 following the last re-procurement did not cover services for members in February or March 2019. Additionally, the CMSN ASR report reflects subcapitated transportation costs for an arrangement that ceased to exist in February 2019. As such, in these situations, the CY 2019 ASR financial data for 2019 Q1 only reflects claims for January 2019. We excluded Q1 cost data from the CY 2019 ASR reports for these situations. *This exclusion corresponds to a portion of the member months identified as “Pre-Implementation Membership – All Encounter and ASR Claims Excluded” within the eligibility database.*
 - Plans new to regions 1 through 4 following the last re-procurement covered services for members in February and March 2019. We include the CY 2019 ASR reports for these plans for all quarters.
 - Plans continuing to operate in regions 1 through 4 covered services for members in each month of Q1 2019. As such, there is no way to remove the costs specific to January 2019 without removing the rest of 2019 Q1. We reviewed the services paid on a subcapitated basis and for other settlement / AP payments by quarter and region across CY 2019 for these plans. We determined that there was no significant difference in the PMPM costs for these services during the roll-out of the current managed care plan contracts. Therefore, we include the CY 2019 audited ASR reports (including 2019 Q1) for these plans. *This inclusion of these claims corresponds to the member months that need to be included for ASR analysis, identified as “Pre-Implementation Membership – ASR Included; All Encounter Claims Excluded” within the eligibility database.*
- We exclude ASR financial data for plans no longer participating in MMA after the current contract effective dates. Because we exclude claim costs, the member months associated with these specific members also are excluded when calculating PMPM claim cost values. *This exclusion corresponds to the remaining portion of the member months identified as “Pre-Implementation Membership – All Encounter and ASR Claims Excluded” within the eligibility database.*
- Given the introduction of the Dental Program, we exclude subcapitated and settlement / AP costs for dental services.
- We exclude any amounts reported by the plans in the expanded benefits category. For the reasons described previously, we present most of the MMA data book information with expanded benefit costs removed.
- We exclude reinsurance premiums and reinsurance recoveries so that the MMA data book excludes the impact of reinsurance arrangements.
- We exclude costs attributable to premium deficiency reserves because they are not benefit costs.

ASR Financial Data Adjustments

We also apply the following adjustments to the ASR financial data submitted by the plans:

- Through conversations with plans and written responses from the plans to data validation questions, we discovered situations where costs were misreported (e.g., some administrative costs were reported in medical service categories). In these cases, we make adjustments or corrections as necessary based on information from the plans.
- We adjust the CY 2019 reported medical costs for the subcapitation, settlement / AP, and other ASR service categories based on the prior calendar year adjustments reported by the plans in the audited CY 2020 ASR reports, to reflect the most recent information available for these services. Similarly, we adjust the CY 2020 information from the ASR reports based on the prior calendar year adjustments reported by the plans in the 2021 Q4 ASR reports.
- In the situation described above where we use FMMIS encounter data instead of ASR financial data for subcapitation costs (one MMA capitated plan for related party mental health claims), we exclude the associated subcapitated costs in the ASR financial data.
- Prior to allocating cost to each rate group and rate cell, we adjust the claims in ASR line 9.5 (Other Services Subcapitation). We split the other services subcapitated claims into the estimated portion of costs attributable to PDN and non-PDN services, based on plan responses to data validation questions. We create the following two new service categories for the ASR financial data:
 - 9.5a: Other Services Subcapitation – PDN Costs
 - 9.5b: Other Services Subcapitation – All Other Costs
- Plans often contract with subcapitated vendors on a single PMPM basis across rate groups. Additionally, the historical ASR financial data does not contain sufficient information to split out costs for individual rate cells. Therefore, we re-allocate the total payments for subcapitated services and other services used in the ASR financial data across the different rate groups and rate cells. The re-allocation is based on FMMIS encounter data for FFS claim payments made by plans for similar service categories.

Exhibit M-5C shows the reallocation factors by rate group and rate cell that are applied to the ASR financial data. The total amount of subcapitated and other ASR costs by plan, region, and service category remains the same before and after the reallocation process. The reallocation factors for all ASR reports are based on CY 2019 encounter data.

- After allocating costs to each rate group and rate cell, we further adjust the claims in ASR line 5.2 (Mental Health & Substance Abuse Subcapitation). We split the mental health subcapitated claims into the estimated portion of costs attributable to inpatient and non-inpatient services, based on the rate cell specific splits of mental health claims in the FMMIS encounter data between the inpatient category paid on an APR-DRG basis (*M2.1c: Hospital Inpatient FFS – Mental Health & Substance Abuse*) vs. the non-APR-DRG mental health categories (*M2.1d: Hospital Inpatient FFS – Non-DRG* and *M5.1: Mental Health & Substance Abuse FFS*). We create the following two new service categories for the ASR financial data:
 - 5.2a: Mental Health & Substance Abuse Subcapitation – Inpatient Costs
 - 5.2b: Mental Health & Substance Abuse Subcapitation – All Other Costs
- After allocating costs to each rate group and rate cell, we further reclassify certain costs for dual eligible members. The costs for members in dual eligible rate groups in ASR lines 2.6 (Subcapitated Hospital Services) and 2.7 (Hospital Service Settlements / AP) are reclassified as ASR line 2.Xb (Hospital Crossover Services Subcapitation and Settlements / AP). Similarly, the costs for members in dual eligible rate groups in ASR lines 3.5 (Subcapitated Professional Services) and 3.7 (Professional Settlements / AP) are reclassified as ASR line 3.Xb (Professional Crossover Services Subcapitation and Settlements / AP). Since Medicare is the primary payer for these dual eligible members, the new service categories isolate these specific claims.

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- For dual eligible members, we remove an estimate of the portion of the subcapitated and other ASR costs for members who are enrolled in a D-SNP and covered through a separate D-SNP contract. The estimate is based on the mix of these types of members compared to all dual eligible members and relative PMPM costs in the CY 2019 FMMIS encounter data for FFS claim payments made by plans for similar service categories.

IV. ADJUSTMENTS NOT INCLUDED IN THE MMA DATA BOOK

Adjustments for the following issues are not incorporated into the MMA data book. Users of the data book should be aware of these items that are not reflected in the historical data:

- IBNR claim adjustments (except that a small amount of IBNR is implicit in the FMMIS encounter data to ASR financial data completion adjustment that is applied to CY 2019 encounter data)
- Adjustments to claims for anticipated third party liability recoveries not already reflected in the data.
- Adjustments related to IMD services to comply with 42 CFR § 438.6(e)
- Any seasonality adjustments to account for partial years of data in the MMA data book.
- Acuity or population mix adjustments for missing data
- Adjustments to account for utilization changes, service mix changes, unit cost changes, population changes, or other changes over time (including changes that may be either related or unrelated to COVID-19 or the federal PHE)
- Adjustments to provider reimbursement due to legislated minimum wage increases
- Florida Medicaid FFS fee schedule changes during or after the historical data period, including the impact of final APR-DRG and EAPG Florida Medicaid FFS reimbursement rates and other FFS fee schedules
- Program changes during or after the historical data period listed in Exhibit M-5D
- Future program changes not yet known as of the MMA data book release date
- Data smoothing to improve data credibility
- Inclusion of administrative costs and plan underwriting margin
- Costs related to the pilot program in regions 5 and 7 for temporary housing assistance and supportive behavioral health services
- Prescribed Drugs High Risk Pool (PDHRP) withhold and settlement amounts
- State directed payments that may be paid as separate payment terms

V. CAVEATS AND LIMITATIONS

We prepared this report and the rest of the MMA data book for the specific purpose of assisting the Agency in publishing a data book to provide relevant historical data and background information to potential contractors responding to the Invitation to Negotiate (ITN) issued under the Statewide Medicaid Managed Care (SMMC) program pursuant to Sections 409.961 through 409.985, Florida Statutes. This report may not be appropriate, and should not be used, for other purposes.

This report and the rest of the MMA data book are intended solely for the benefit of the Agency. We understand that this material will be shared publicly by the Agency, and we recognize that materials delivered to the Agency may be public records subject to disclosure to third parties; however, Milliman does not intend to benefit, and assumes no duty or liability to, parties other than the Agency who receive this work. This material should only be distributed and reviewed in its entirety.

In preparing this material, we relied on several sources of data and information from MMA plans, the Agency, and other sources. Those data sources and information include Agency eligibility data, Agency FFS claims data, MMA plan ASR financial data submissions, MMA plan FMMIS encounter data, and other supporting information from the Agency and plans. We relied on the Agency for the accuracy of the eligibility and FFS claims data and other supporting information. We also relied on the Agency for the collection and processing of the MMA plan ASR financial data, encounter data, and other supporting information. We relied on the plans to provide accurate ASR financial data and encounter data as certified by the plan, as well as accurate follow-up information. **We did not audit any of the data sources or other information**, but we did assess the data and information for reasonableness. If the data or other information used is inadequate or incomplete, the results will be likewise inadequate or incomplete.

Milliman has developed certain models to estimate the values included in the MMA data book. The intent of the models was to process, adjust, and summarize historical data for the MMA data book. We have reviewed the models, including their inputs, calculations, and outputs for consistency, reasonableness, and appropriateness to the intended purpose and in compliance with generally accepted actuarial practice and relevant actuarial standards of practice (ASOPs). The models, including all input, calculations, and output, may not be appropriate for any other purpose.

Future MMA plan experience will differ from the contents of the MMA data book due to health care trend, managed care efficiency, provider reimbursement changes, enrollment demographic changes, the impact of the COVID-19 pandemic, the adjustments excluded from the MMA data book (described in Section IV), and many other factors. The MMA data book does not reflect projections of future costs.

The results of this report and the rest of the MMA data book are technical in nature and are dependent upon specific assumptions and methods. No party should rely on these results without a thorough understanding of those assumptions and methods. Such an understanding may require consultation with qualified professionals.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. The authors of this report are actuaries at Milliman, are members of the American Academy of Actuaries, and meet the Qualification Standards of the Academy to render the actuarial communication contained herein. To the best of our knowledge and belief, this communication is complete and accurate and has been prepared in accordance with generally recognized and accepted actuarial principles and practices.

This communication is subject to the terms and conditions of the October 12, 2021 contract between the Agency and Milliman.