Statewide Medicaid Managed Care Data Book Public Meeting

Thursday, January 5, 2023

SMMC DATA BOOK PUBLIC MEETING

While we have not yet entered the statutory blackout period as described in s. 287.057(25), due to the upcoming competitive procurements relating to the Statewide Medicaid Managed Care Program, we will not have any discussions relating to the scope, evaluation or negotiation of those procurements.

As stated in s. 287.057(25), F.S., "Respondents to this solicitation or persons acting on their behalf may not contact, between the release of the solicitation and the end of the 72-hour period following the agency posting the notice of intended award, excluding Saturdays, Sundays, and state holidays, any employee or officer of the executive or legislative branch concerning any aspect of this solicitation, except in writing to the procurement officer or as provided in the solicitation documents. **Violation of this provision may be grounds for rejecting a response**."

SMMC DATA BOOK PUBLIC MEETING

- The Agency will be accepting questions regarding the Data Book until COB today (January 5, 2023).

- Please email your questions to MDA_ACTUARIAL@ahca.myflorida.com

SMMC Invitation to Negotiate – Data Book Presentation

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5 JANUARY 2023

SMMC ITN – Data Book Presentation

Agenda

- MMA Data Book
  - MMA Program Background
  - Overview of MMA Data Book Contents
  - MMA Data Book Structure
  - MMA Eligibility Data
  - MMA Claims Data Sources and Adjustments
  - Adjustments Not Included in the MMA Data Book
- LTC Data Book
  - LTC Program Background
  - Overview of LTC Data Book Contents
  - LTC Eligibility Data
  - LTC Claims Data Sources and Adjustments
  - LTC Data Book Structure
  - Adjustments Not Included in the LTC Data Book

MMA Data Book

MMA Program Background

MMA Program Background

- Statewide Medicaid Managed Care (SMMC) Managed Medical Assistance (MMA) program
- Full-risk Medicaid managed care program
- Provides primary care, acute care, behavioral health, and pharmacy services to Medicaid beneficiaries
- SMMC MMA program was originally implemented between May 1, 2014 and August 1, 2014, with implementation dates varying by region
- The Agency subsequently re-procured managed care plan contracts which became effective on the following dates

SMMC MMA Region Implementation Dates	
Implementation Date	**Region/Plan Contracts Effective**
December 1, 2018	Regions 9, 10, 11 (excluding CMS Plan)
January 1, 2019	Regions 5, 6, 7, 8 (excluding CMS Plan)
February 1, 2019	Regions 1, 2, 3, 4 (excluding CMS Plan), and all regions for CMS Plan

- **Region definitions under next set of SMMC contracts will change from the current definition.**

MMA Program Background *(continued)*

- Each plan is paid a capitation rate per member per month (PMPM) that varies by a member's region, rate group, and rate cell
- Certain maternity services (for non-dual eligible members not enrolled in CMS Plan) are removed from the PMPM capitations rates and instead are paid through a maternity kick payment on a per-delivery basis
- The MMA program also includes a budget-neutral Prescribed Drug 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 (RY 22/23), the PDHRP pays 80% of the costs above a $350,000 member-level threshold
  - Inclusion of this information in the MMA data book does not imply the continued use of the PDHRP nor does it imply that the PDHRP methodology will stay the same if it continues

MMA Program Background

Plan Types

- Currently nine standard capitated plans and five specialty capitated plans
- Nine standard capitated plans cover wide range of members, depending on plan type
  - ***Comprehensive Plan*** – A managed care plan that is eligible to provide both 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
  - ***MMA Plan*** – A managed care plan that is eligible to provide MMA services to eligible recipients not enrolled in the LTC
- Each ***specialty plan*** covers one of the following targeted groups:
  - Child welfare
  - Children with chronic conditions
  - Human immunodeficiency virus (HIV) / acquired immunodeficiency syndrome (AIDS)
  - Serious mental illness (SMI)

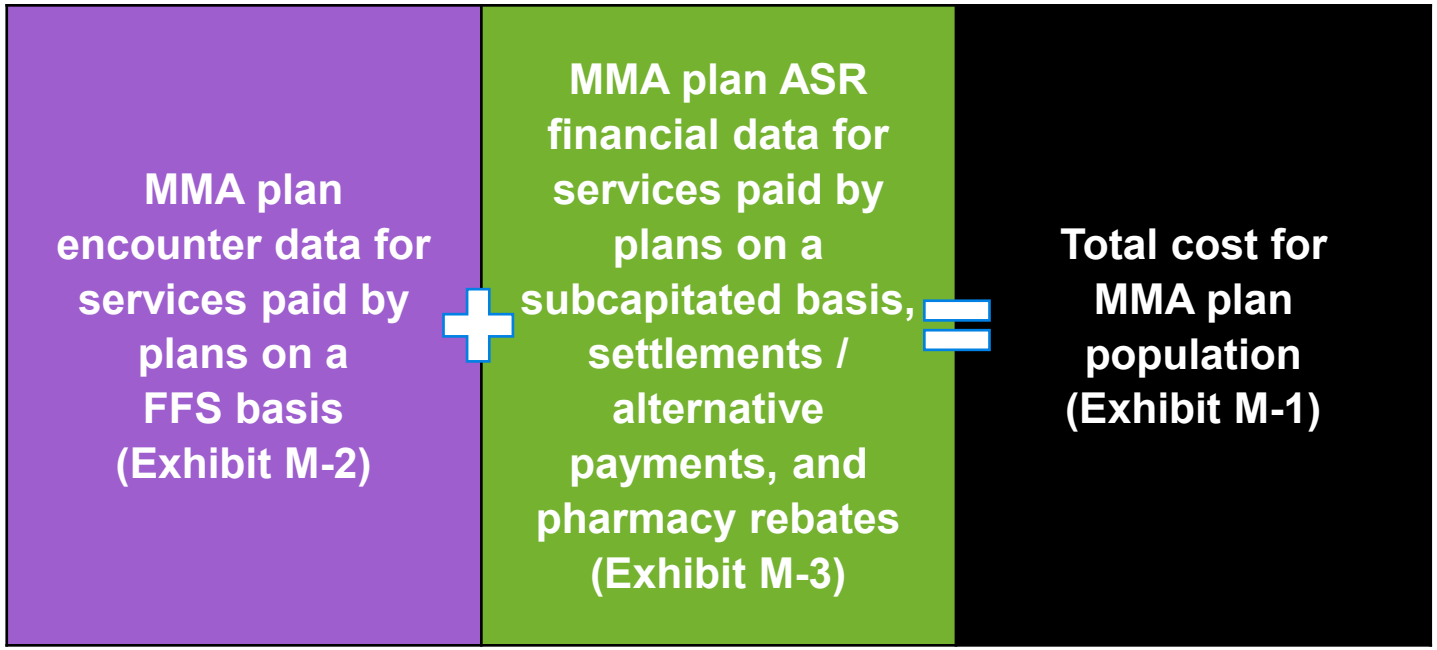
Overview of MMA Data Book Contents

Overview of MMA Data Book Contents

- Historical data spans Calendar Year (CY) 2019, CY 2020, and the first half of CY 2021 (January 2021 to June 2021) service dates
  - Claim payment or submission runout through December 31, 2021
  - Represents the most recently available claim cost data that has been validated for capitation rate development and includes six months of runout
  - Includes historical data exclusively from the current set of managed care plan contracts
- For managed care plan / region contracts that became active on February 1, 2019, the MMA data book excludes historical cost data prior to the effective date of the contract
  - Throughout the data book, CY 2019 refers to the data period used for 2019 claims included in the MMA data book, despite some plan / region combinations including data beginning in February 2019
  - Membership information is included and identified for January 2019 for these situations
- 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 through the time of the merger or acquisition

Overview of MMA Data Book Contents

Summary of MMA Population Data Sources



COVID-19 Considerations

- COVID-19 pandemic and federal public health emergency (PHE) have impacted health care costs significantly since March 2020
- 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
    - MMA enrollment is currently elevated due to members not being disenrolled as a result of the PHE
    - Changes in population size over time may impact the average acuity of the enrolled population
  - Deferred and foregone services
  - COVID-19 testing, treatment, and vaccine costs
  - Service mix changes
  - Other impacts related to the COVID-19 pandemic and federal PHE

MMA Data Book Structure

MMA Data Book Structure

Appendix M-1: “Database” components

- Appendix M-1 includes the following on separate tabs:
  - Data dictionary
  - Rate cells by rate group
  - Service categories
  - Eligibility data
  - IP & OP encounter data
  - All other encounter data
  - ASR financial data
  - Maternity kick episodes
- The encounter data included in Appendix M-1 is adjusted to account for differences relative to the ASR financial data and to remove the estimated value of expanded benefits

MMA Data Book Structure

Appendix M-2: Summary Exhibits

- Exhibit M-1: MMA data book summary
  - Exhibit M-1A: Summarizes the total claim costs per member per month (PMPM) by rate group, region, and time period (combined across data sources)
    - Excluding costs applicable to maternity kick payment
  - Exhibit M-1B: Summarizes total maternity cost per delivery from FMMIS encounter data by region and time period
  - Exhibit M-1C: Summarizes member month count from Agency eligibility data by rate group, region, and time period
  - The encounter data included in Exhibit M-1 is adjusted to account for differences relative to the ASR financial data and to remove the estimated value of expanded benefits

MMA Data Book Structure

Appendix M-2: Summary Exhibits *(continued)*

- Exhibit M-2A through M-2M: FMMIS encounter data
  - 13 capitated plan rate groups
  - Member months, claim costs PMPM, annual utilization per 1,000 members, and average unit cost by region, service category, and time period
  - The encounter data included in Exhibit M-2 is adjusted to account for differences relative to the ASR financial data and to remove the estimated value of expanded benefits
- Exhibit M-3A through M-3M: ASR report financial data
  - 13 capitated plan rate groups
  - Member months and claim costs PMPM for subcapitation, settlements, and pharmacy rebates by region, ASR line, and time period

MMA Data Book Structure

Appendix M-2: Summary Exhibits *(continued)*

- Exhibit M-4: MMA data book applicable adjustments
  - Exhibit M-4A: FMMIS encounter data to ASR financial data completion adjustment
    - Already reflected in Appendix M-1 and Exhibits M-1 and M-2 as needed
  - Exhibit M-4B: Adjustment factors to remove expanded benefits from the FMMIS encounter data
    - Already reflected in Appendix M-1 and Exhibits M-1 and M-2 as needed
  - Exhibit M-4C: Historical MMA plan provider contracting levels
    - Percent of Florida Medicaid FFS reimbursement
    - 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
  - Exhibit M-4D: Historical MMA plan expanded benefit cost by benefit
    - Based on plan reporting of expanded benefit costs in ASR reports

MMA Data Book Structure

Appendix M-2: Summary Exhibits *(continued)*

- Exhibit M-5: MMA data book supplemental information
  - Exhibit M-5A: MMA mandatory, voluntary, and excluded populations
  - Exhibit M-5B: Data sources included by benefit expense ASR line
  - Exhibit M-5C: Reallocation factors by rate group and rate cell applied to ASR financial data
  - Exhibit M-5D: Florida Medicaid program changes since January 1, 2019

MMA Eligibility Data

MMA Eligibility Data

MMA Covered Populations

- 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
  - Data book includes any members who voluntarily enrolled in MMA during the historical data period, but excludes members who did not enroll in MMA
- See Exhibit M-5A for listing of types of members for each population

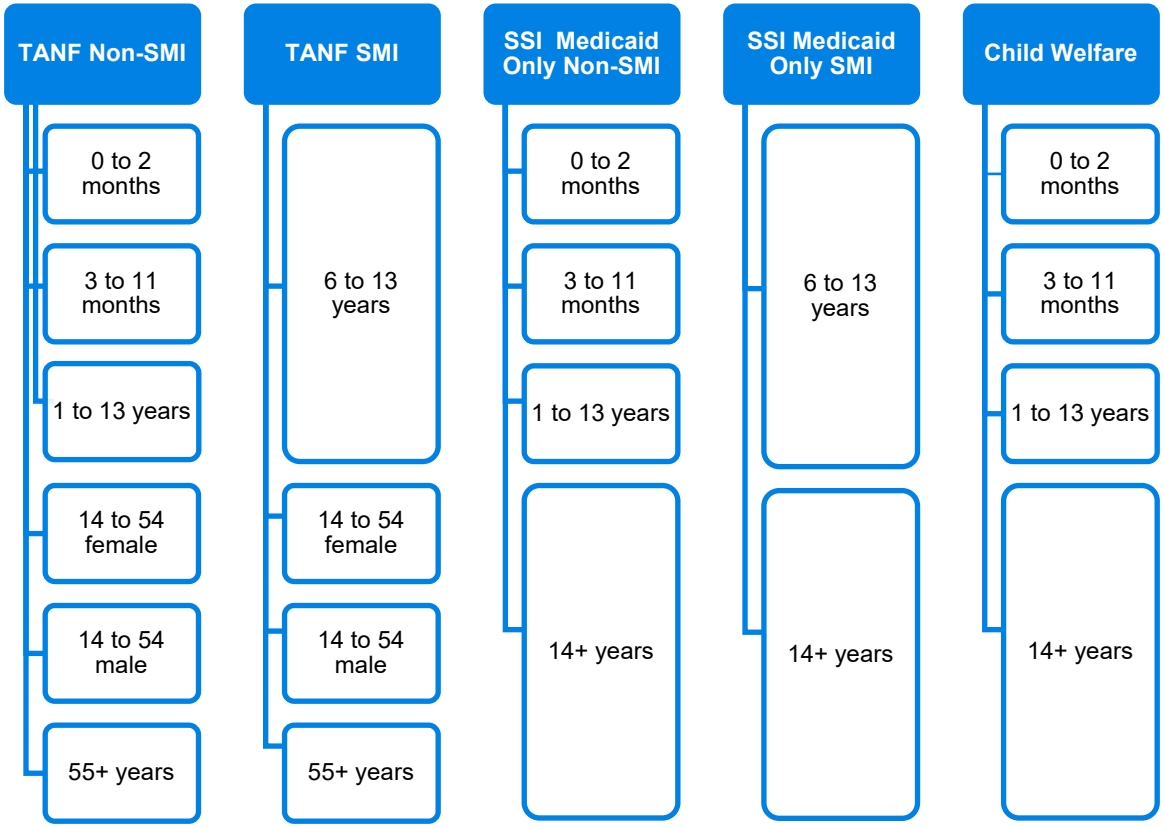
MMA Eligibility Data

Delivery System Assignment

- Two distinct delivery systems during historical data period within MMA data book
  - Children's Medical Services Plan (CMS Plan)
    - Offered through the Florida Department of Health (Department)
    - Effective February 1, 2019, the Department contracts with a single managed care plan to provide services through CMS Plan on a full-risk basis
  - MMA Capitated Plan
    - 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 as Medicare Advantage Plan (MAP) members, are included in data book
- Dual eligible members in a Dual Eligible Special Needs Plan (D-SNP) are excluded given these members are currently covered through separate D-SNP contracts

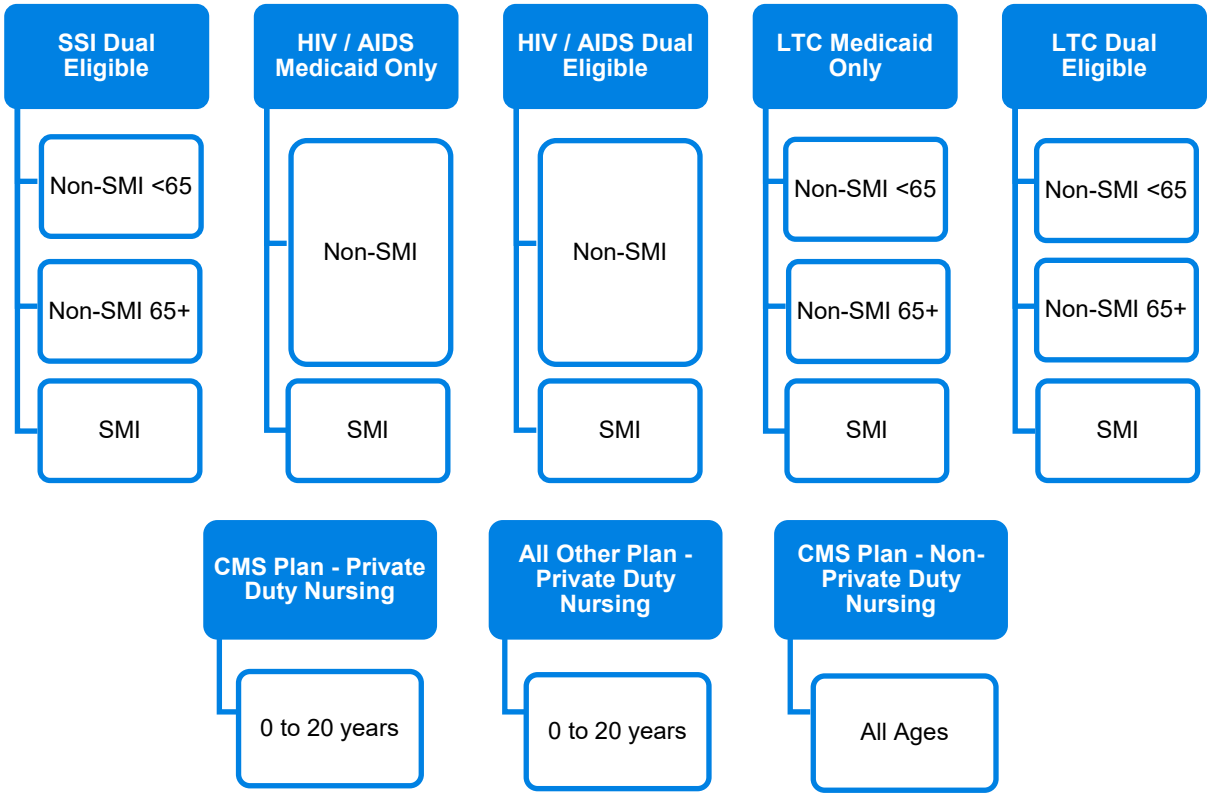
MMA Eligibility Data

Current Rate Group and Rate Cell Assignment



MMA Eligibility Data

Current Rate Group and Rate Cell Assignment *(continued)*



MMA Eligibility Data

MMA Rate Group Determination

- All members in the CMS Plan delivery system are assigned to one of the two CMS Plan rate groups
- Other members that qualified for multiple specialty populations were assigned based on the following hierarchy:
  1. LTC
  2. PDN
  3. Child Welfare
  4. HIV / AIDS
- Medicare Advantage Plan (MAP) members are included in the MMA data book
  - 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

MMA Eligibility Data

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
  - Once an individual has been flagged with SMI, they will always be flagged with SMI
- 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
  - Average RY 22/23 SMI assignment criteria are modeled and applied separately for CY 2019, CY 2020, and first half 2021 (2021 H1)
- The Agency's 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

MMA Eligibility Data

HIV/AIDS Population

- 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
- 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
  - Average RY 22/23 HIV / AIDS assignment criteria are modeled and applied separately for CY 2019, CY 2020, and first half 2021 (2021 H1)
- The Agency's 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.

MMA Eligibility Data

LTC – Nursing Facility Utilizers

- Beginning with the current contract effective dates, MMA plans became responsible for covering nursing facility (NF) services for recipients aged 18 and older who are not enrolled in the LTC program
- The Agency subsequently identified some additional members receiving NF services who should be enrolled in the LTC program and clarified other coverage scenarios
- We adjust the rate group assignment in the historical data in the MMA data book to reflect the following types of members as LTC Medicaid Only or LTC Dual Eligible, depending on their Medicare status
  - 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
    - 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:
    - 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
    - Members must be assigned an institutional care program (ICP) code while enrolled in MMA in order to be shifted due to this criterion

MMA Eligibility Data

Private Duty Nursing

- Data book identifies members using historical PDN claims consistent with the Agency's current PDN member classification criteria
  - Rate groups specific to PDN members were introduced to the MMA program beginning with October 2019 (but not before)
  - The Agency revised the PDN member classification algorithm for October 2020 and subsequent months
- To improve 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
- 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 incurral period
  - A PDN service hour is defined as one unit of service for procedure code S9123 or S9124
  - Recipient must also be under age 21

MMA Eligibility Data

Private Duty Nursing – Sample Flagging Illustration

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

[1] The 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.

MMA Eligibility Data

Region Assignment

- The SMMC program groups Florida counties into regions according to definitions outlined in Florida Statute
- The regional mappings will be condensed from 11 to 9 regions beginning with the new capitated plan contracts, as shown below

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

MMA Eligibility Data

Member Month Exclusions

- Member month records not assigned a valid rate group, rate cell, region, or other critical demographic category
  - Only 224 member months statewide over 30-month data book period
  - Claims for these member months are also excluded
- Some member months are included in eligibility data but have their claim costs excluded
  - Members who were enrolled during a given month, but associated with claim cost data that is inaccurate or not representative due to data quality issues or unique enrollment situations
  - When analyzing average claim costs or utilization, these member months need to be excluded
  - Identified through “MMA Plan-Specific Exclusion” field
  - Member months have already been excluded from the annual utilization / 1,000 and claim cost PMPM values as needed in Appendix M-2

MMA Eligibility Data

MMA Plan-Specific Exclusion Situations

- Unreliable Claims Data – All Encounter and ASR Claims Excluded
  - Excluded due to data quality concerns (impacts one plan)
  - Excludes 66,591 member months
- LTC Plus Plan Non-LTC Membership – All Encounter and ASR Claims Excluded
  - Reflects members who were enrolled in the LTC Plus plan for MMA services while being eligible for, but not yet enrolled in, the LTC program (no longer possible)
  - Excludes 2,772 member months

MMA Eligibility Data

MMA Plan-Specific Exclusion Situations *(continued)*

- Pre-Implementation Membership – All Encounter and ASR Claims Excluded
  - January 2019 member months in regions 1 through 4 (A and B) or in 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 (3,221 member months)
  - Member months 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
  - Plans operating in regions 1 through 4 (A and B) both before and after the February 1, 2019 effective date
  - January 2019 costs in ASR data cannot be isolated due to quarterly reporting
  - January 2019 member months should be included for ASR financial data analysis but excluded for other cost information (553,714 member months)

MMA Eligibility Data

MMA Risk Score Assignment

- Aggregate population risk score information based on quarterly risk adjustment process for MMA program during historical base data period
  - Developed custom cost weights using Florida Medicaid experience and version 6.3 or version 6.4 of the Chronic Illness and Disability Payment System plus Prescription Drug (CDPS + Rx) mappings of ICD-9 and ICD-10 diagnostic data and NDCs to condition categories
  - Separate regression models to develop cost weights for TANF Non-SMI, TANF SMI, SSI Medicaid Only Non-SMI, and SSI Medicaid Only SMI populations
  - TANF Non-SMI model has separate cost weights for children (<19) and adults (19+)
  - Each scored individual receives a demographic relative cost weight and can have multiple disease categories
  - Member only scored if there is at least six months of Medicaid eligibility data during historical study period

MMA Eligibility Data

MMA Risk Score Assignment *(continued)*

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.

MMA Eligibility Data

MMA Risk Score Assignment *(continued)*

- Inclusion of risk score information does not imply risk adjustment will or will not apply to any given MMA program population going forward and does not imply continued use of the current CDPS+Rx model
- 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 in the data book are assigned using the member's projected rate group, while the quarterly risk adjustment process assigns a risk score based on the member's actual rate group in a given month
- Risk scores are not comparable across different rate groups or different capitation rate years because separate risk models apply
- Risk scores shown are raw, or unnormalized, risk scores
- "Unscored" members receive the same average risk score as the average of the scored members in that cohort
- Certain cohorts show "N/A" for the risk score in the data book due to insufficient information
- Risk score adjustments made outside of CDPS+Rx (e.g., PDN or Child Welfare risk score adjustments) are not reflected in the data book
- Risk scores may be impacted by COVID-19, the federal PHE, and data quality / completeness

MMA Claims Data Sources and Adjustments

MMA Plan Encounter Data & ASR Financial Data

Data Validation Process

- The Agency and Milliman went through an extensive data validation process to review MMA plan data
- Some of the aspects of this validation process include the following:
  - The Agency reviewed multiple iterations of ASR financial data for internal consistency and validated the FMMIS encounter data
  - Milliman performed detailed analyses of numerous aspects of the FMMIS encounter data and ASR financial data and a comparison between the two
  - Milliman provided plan-specific data summaries and questions to all plans based on a review of the data sources and comparisons of the ASR financial data to the FMMIS encounter data
  - Milliman held one-on-one meetings with plan representatives on several occasions to further discuss data with plans
  - Plans provided responses to the data questions and additional data as needed

MMA Plan Encounter Data & ASR Financial Data

Data Validation Process *(continued)*

- Limitations of validation process
  - We did not audit the data or validate every possible outcome
  - Data anomalies, inconsistencies, or errors may exist
    - May have a larger relative impact when reviewing more detailed cuts of data
    - May impact utilization metrics more than claim payment amounts because we prioritized claim payment amounts over utilization in our validation
  - Certain detailed cuts of data may also lack credibility

MMA Plan Encounter Data

Summary and Uses

- The FMMIS encounter data is the primary data source for services paid by plans on a FFS basis
- Excluded encounter data for subcapitated services and other non-claim based payments (e.g., settlements) since the ASR financial data is the primary source of these services, with limited exceptions
- Runout includes claims submitted to FMMIS through December 2021
- Data includes all claims submitted by plans into FMMIS for relevant claim types
  - Including claims paid by plans, but flagged as rejected or “denied” for technical reasons in FMMIS system

MMA Plan Encounter Data

Summary and Uses *(continued)*

- The below table summarizes each FMMIS claim type used in the data book

FMMIS Encounter Data Claim Types	
Claim Type	**Claim Type Description**
I	Inpatient
A	Inpatient Crossover
O	Outpatient
C	Outpatient Crossover
06[1]	Ambulatory Surgery Center
P	Pharmacy
Q	Compound Drug
M	Professional
B	Professional Crossover
L	Long-Term Care

[1] All claim types are assigned by FMMIS, except for claim type "06" which is assigned by Milliman. All non-crossover claims with a provider type of 06 (ASC) are classified as claim type 06, regardless of their original classification as a facility or professional claim.

MMA Plan Encounter Data

De-Duplication of FMMIS Encounter Data

- Remove claim records that are not the final version of a claim
  - 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 (based on Agency list)
  - 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)
  - Claims denied by the plans with one exception based on plan feedback
    - For non-crossover hospital services, claims in situations where all lines on a given claim are indicated as denied by the plan
    - For all other services, any claim record that is indicated as denied by the plan

MMA Plan Encounter Data

De-Duplication of FMMIS Encounter Data *(continued)*

- Additional inpatient claim de-duplication
  - Claim header records developed based on line level information
  - Claims removed based on same recipient ID, plan, provider ID, and first date of service as another claim, as well as analysis of other fields
  - Claims combined for interim claims or additive adjustments
- Additional outpatient and ASC claim de-duplication
  - Claim header records developed based on line level information
  - Header claims removed if same recipient ID, plan, provider ID, first date of service, last date of service, and billed or paid amount as another claim
  - Removal of duplicate lines within the same header claim
  - Combination of non-duplicate lines from separate ICNs for single visit

MMA Plan Encounter Data

De-Duplication of FMMIS Encounter Data *(continued)*

- Additional pharmacy claim de-duplication
  - Claim records with same recipient ID, plan ID, provider ID, date of service, NDC, and units billed as another claim record
- Additional de-duplication for all other claims
  - Claim records with same recipient ID, billing provider ID, treating provider ID, first date of service, last date of service, revenue code, procedure code, and modifiers as another claim record

MMA Plan Encounter Data

FMMIS Encounter Data Exclusions

- Exclude FMMIS encounter data claims covered by the LTC program
  - For non-crossover hospital and ASC services, as well as pharmacy services, we assume all claims are MMA covered services
  - For all other claims for LTC rate group members:
    - Use LTC plan ID if it results in a reasonable comparison of cost relative to the ASR financial data
    - Use analysis of service-specific information to identify LTC program claims in other situations
  - For non-LTC members projected to enroll in LTC, 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)

MMA Plan Encounter Data

FMMIS Encounter Data Exclusions *(continued)*

- Exclude all Dental Program claims identified with a dental plan ID or claim type ‘D’ (dental)
- Exclude all subcapitated claims identified
  - Claims reported with contract type code 05 or 06, with two exceptions
  - Claims identified using unique logic provided by plans for each subcapitated vendor
- Claim exclusions based on member who incurred them
  - 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)
  - Members who do not map to a valid rate group or rate cell (less than 0.01% of FMMIS encounter data claims)
  - 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)

MMA Plan Encounter Data

FMMIS Encounter Data Exclusions *(continued)*

- Exclude claims associated with the "MMA Plan-Specific Exclusion" field within the "Eligibility Data" tab of Appendix M-1
  - Claims incurred after December 31, 2020 for a plan with unreliable data.
  - Members enrolled in an LTC Plus plan, but not in an LTC rate group
  - January 2019 incurred claims for members in regions A or B or in CMSN
  - Claims for a plan that exited the MMA program or exited the member's region following the current contract implementation dates
  - 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 merger or acquisition
- Member months associated with these situations also are excluded when calculating average utilization and claim cost values using FMMIS encounter data in Appendix M-2

MMA Plan Encounter Data

FMMIS Encounter Data Exclusions *(continued)*

- Exclude all encounter records submitted after December 31, 2020 for the plan with unreliable data
  - These records appear unreliable in addition to claims incurred in 2021 H1
- Exclude hemophilia drugs not covered by MMA
- Limit HIV / AIDS Dual Eligible pharmacy data to drugs covered by Medicaid
- Exclude any amounts identified as over-the-counter (OTC) drug claims that are classified as expanded benefits
  - Additional adjustments for expanded benefits needed because identification is limited to OTC drugs and is not comprehensive

MMA Plan Encounter Data

FMMIS Encounter Data Adjustments

- Rely on encounter data instead of ASR data in one situation where a capitated plan subcapitates mental health claims with a related party
  - Re-classified encounter data from Mental Health & Substance Abuse Subcapitation (**M5.2**) to Mental Health & Substance Abuse FFS (**M5.1**)
- Re-classify claims with a claim type of I, A, O, C, or 06 to 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)
- Adjust Medicaid provider IDs and provider types for hospital and ASC claims (to improve de-duplication and categorization)
  - Using “base” provide ID and NPI identification
  - Using additional information for two specific providers with ID changes
- Reflect the full plan paid amount for the final version of each adjusted claim, for one plan where claim adjustment records reflected only the incremental paid adjustments

MMA Plan Encounter Data

FMMIS Encounter Data – Service Categorization

- Split hospital inpatient claim (claim type I) into the following:
  - ***Maternity (M2.1a):*** Claims for non-dual eligible, non-CMS Plan members with one of five APR-DRGs
  - ***Newborn (M2.1b):*** Claims with one of several APR-DRGs
  - ***Mental Health & Substance Abuse (M2.1c):*** Claims with one of several APR-DRGs
  - ***Non-DRG (M2.1d):*** Claims for the following types of providers and services (not subject to APR-DRG reimbursement in Florida Medicaid FFS):
    - Provider types 04 (state mental hospital), 05 (community behavioral health services), and16 (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 Medicaid provider ID or NPI
    - Medicaid provider IDs used only for tuberculosis patients
    - Claims for newborn hearing tests
  - ***Transplant Services (M2.7.1):*** Claims identified using a combination of surgical procedure codes, CPT codes, and age, based on the Agency's definition of transplants subject to global case rates in Florida Medicaid FFS
  - ***All Other DRG (M2.1e)***
- 3M™ version 39 APR-DRGs assigned using 3M™ Core Grouping Software (CGS), based on data and additional edits / adjustments to mitigate errors

MMA Plan Encounter Data

FMMIS Encounter Data – Service Categorization *(continued)*

- Split hospital outpatient and ASC claims (claim types O and 06) into the following:
  - ***Hospital Outpatient Emergency Room FFS – EAPG (M2.3):*** Claims with one of five emergency room revenue codes and a hospital provider type 01 or 04
  - ***Ambulatory Surgery Center (ASC) FFS (M2.4a):*** Claims with provider type 06 (ASC)
  - ***Hospital Outpatient FFS Non-ER / Non-ASC – EAPG (M2.4b):*** All remaining outpatient claims with provider type 01 or 04
  - ***Hospital Outpatient FFS Non-ASC – Non-EAPG (M2.4c):*** All remaining outpatient claims
    - Also includes claims for Medicaid provider IDs used only for tuberculosis patients and claims for newborn hearing tests (not paid under EAPGs in Florida Medicaid FFS)
    - Excludes claims for injectable drugs (addressed later)

MMA Plan Encounter Data

FMMIS Encounter Data – Service Categorization *(continued)*

- Split crossover claims (claim types A, B, and C) into the following:
  - ***Hospital Crossover Services FFS (M2.Xa):*** Claims with claim types A or C
  - ***Professional Crossover Services FFS (M3.Xa):*** Claims with claim type B
- Split pharmacy claims (claim types P and Q) into the following categories based on Medi-Span database mapping:
  - ***Prescription Drugs FFS – Generic (M8.a)***
  - ***Prescription Drugs FFS – Brand (M8.b)***
  - ***Prescription Drugs FFS – Specialty (M8.c)***
    - Specialty classes identified based on a review of multiple factors including cost, drug characteristics, and industry classifications
  - ***Prescription Drugs FFS – Other / Not Identified (M8.d)***

MMA Plan Encounter Data

FMMIS Encounter Data – Service Categorization *(continued)*

- Split professional, long-term care, and other ancillary services (claim types M and L) into the following:
  - ***Professional Maternity FFS (Matern)***
    - Only claims for non-CMS Plan and non-dual eligible members
    - Must meet one of the following criteria:
      - Physician delivery procedure code
      - Physician global delivery procedure code (portion attributable to delivery costs)
      - Physician procedure code that may accompany a delivery – counted as a delivery cost, but not used to identify unique delivery events
  - ***Professional Injectable Drugs FFS (M3.J):*** Injectable drugs with a HCPCS code beginning with 'J,' limited to claims for non-dual eligible members
    - Also includes claims with a claim type of "O" or "06" but without an EAPG-based provider type of 01, 04, or 06
  - ***Mental Health & Abuse FFS (M5.1):*** Categorized using the ASR service category mapping logic
  - ***Transportation FFS (M7.1):*** Categorized using the ASR service category mapping logic
  - ***Private Duty Nursing FFS (M9.1a):*** Claims with procedure code S9123 or S9124

MMA Plan Encounter Data

FMMIS Encounter Data – Service Categorization *(continued)*

- ***Home Health FFS (M9.1b):*** Claims categorized using the ASR service category mapping logic or if the claim reflects procedure code T1020
- ***Personal Care FFS (M9.1c):*** Claims with procedure codes S9122 or T1019
- ***Nursing Facility FFS (M9.2.1):*** Claims with provider types 09 or 10 and one of ten revenue codes
- ***Hospice FFS (M9.2):*** Claims with provider type 15 or with revenue codes 0182-0185 or 0650-0659
- ***DME FFS (M9.3):*** Categorized using the ASR service category mapping logic
- ***All Other State Plan Services FFS (M9.4):*** Categorized using the ASR service category mapping logic
- Milliman *Health Cost Guidelines*™ (*HCG*s) grouper used to categorize the remaining claims into the following:
  - ***Primary Care FFS (M3.1)***
  - ***Specialty Care FFS (M3.2)***
  - ***Mental Health & Substance Abuse FFS (M5.1)***
  - ***Transportation FFS (M7.1)***
  - ***Home Health FFS (M9.1b)***
  - ***Other State Plan Services FFS (M9.4)***

MMA Plan Encounter Data

FMMIS Encounter Data to ASR Financial Data Completion Adjustment

- Intended to account for the discrepancy between FMMIS encounter data and the ASR financial data for FFS services
  - Allows a complete set of FMMIS encounter data cost information to be included
- Developed using FMMIS encounter data summarized on a consistent basis as the ASR data
  - FMMIS encounter data with runout through December 31, 2021
  - Audited CY 2019 ASR financial data (including IBNP amounts and prior year adjustments in CY 2020 ASR reports)
  - Audited CY 2020 ASR financial data (IBNP not included; prior year adjustments in 2021 Q4 ASR reports are included)
  - 2021 Q4 ASR financial data (IBNP not included)
- Separate pharmacy and non-pharmacy claim adjustments by time period
  - Pharmacy claims – Adjustment calculated by plan and region depending on relationship of plan costs in the context of the plan's PBM pricing arrangement
  - Non-pharmacy claims – Adjustment accounts for the total claim dollar difference between FMMIS encounter data and ASR financial data by plan, region, and broad rate group (dual eligible, LTC Medicaid only, all other rate groups)
  - Composited to rate group and region level for each time period

MMA Plan Encounter Data

Adjustment to Remove Expanded Benefits

- Expanded benefits are not Florida Medicaid State Plan services, but are currently offered by the MMA plans outside of the capitation rates
- Expanded benefits were not able to be explicitly identified in FMMIS encounter data in a comprehensive manner
- This adjustment effectively reduces the FMMIS encounter data paid claims data by a net level of expanded benefit costs as reported in the ASR financial data for FFS services
- We explicitly exclude encounter data records identified as OTC drug claims that are classified as expanded benefits.
- We then perform the following steps to remove the remaining expanded benefits
  - Assign each type of expanded benefit reported in the ASR reports to one or more FMMIS encounter service categories
  - Adjust the reported dollars in those encounter service categories on a plan level consistent the amounts reported in the ASR reports

MMA ASR Financial Data

Summary and Uses

- Capitated plans submit ASR financial reports on a quarterly basis and a year-end report with three months runout
- Primary data source for services paid by plans on a subcapitated basis, settlement / alternative payment (AP) amounts, and other non-encounterable payments
- Used to validate encounter data submissions for claims paid by plans on FFS basis

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

MMA ASR Financial Data

ASR Financial Data Exclusions

- Exclude costs associated with the “MMA Plan-Specific Exclusion” field within the “Eligibility Data” tab of Appendix M-1
  - 2021 ASR financial data for the plan with unreliable data
  - All costs for members enrolled in an LTC Plus plan, but not in an LTC rate group
  - Use the following approach to account for January 2019 claims in the quarterly ASR reporting:
    - For plans exiting regions 1-4 (A & B) following the last re-procurement, we excluded Q1 cost data from the CY 2019 ASR reports.
      - Also applies to a CMSN transportation arrangement that ended after January 2019
    - For plans that were new to regions 1-4 (A & B) following the last re-procurement, we include the CY 2019 ASR reports for all quarters.
    - For plans continuing to operate in regions 1-4 (A & B) following the last re-procurement, we include the CY 2019 ASR reports for all quarters.
  - ASR financial data for plans no longer participating in MMA after the current contract effective dates
- Additionally exclude the following costs
  - Subcapitated and settlement / AP costs for dental services
  - Any amounts reported for expanded benefits category
  - Reinsurance premiums and recoveries
  - Costs attributed to premium deficiency reserves

MMA ASR Financial Data

ASR Financial Data Adjustments

- Adjust for instances where costs are misreported, based on information from plans
- Adjust CY 2019 and CY 2020 reported medical costs based on the prior calendar year adjustments reported in the CY 2020 audited and 2021 Q4 ASR reports, respectively
- For the related party arrangement where we use FMMIS encounter data instead of ASR financial data for subcapitation costs, we exclude the associated subcapitated costs from the ASR financial data
- Re-allocate total payments for subcapitated services and other services in ASR financial data across rate groups and rate cells
  - Based on encounter data for FFS claim payments made by plans for similar service categories
  - No change to total medical costs for any given plan, region, and service category
  - Reallocation based on CY 2019 data for all data periods
  - Separate re-allocation factors by rate group and rate cell

MMA ASR Financial Data

ASR Financial Data Adjustments *(continued)*

- Split Mental Health & Substance Abuse Subcapitation (**5.2**) into inpatient and non-inpatient based on splits in encounter data
  - Mental Health & Substance Abuse Subcapitation – Inpatient Costs (**5.2a**)
  - Mental Health & Substance Abuse Subcapitation – All Other Costs (**5.2b**)
- Split Other Services Subcapitation (**9.5**) into PDN and non-PDN based on plan responses:
  - Other Services Subcapitation – PDN Costs (**9.5a**)
  - Other Services Subcapitation – All Other Costs (**9.5b**)
- Re-classify certain claims for dual eligible members:
  - Hospital Crossover Services Subcapitation and Settlements / AP (**2.Xb**): Hospital subcapitation and settlements / AP claims (2.6 and 2.7) for members in dual eligible rate groups
  - Professional Crossover Services Subcapitation and Settlements / AP (**3.Xb**): Professional subcapitation and settlements / AP (3.5 and 3.7) claims for members in dual eligible rate groups
- Remove estimated portion of ASR costs for members enrolled in separate D-SNP contract based on encounter data and member mix

Adjustments Not Included in the MMA Data Book

Adjustments Not Included in the MMA Data Book

- IBNR claim adjustments
  - Except that a small amount of IBNR is implicit in the FMMIS encounter data to ASR financial data completion adjustment 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

Adjustments Not Included in the MMA Data Book *(continued)*

- 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

LTC Data Book

LTC Program Background

LTC Program Background

- Statewide Medicaid Managed Care (SMMC) Long-Term Care (LTC) program
- Full-risk Medicaid managed care program
- Covers long-term supports and services for nursing facility-eligible members 18 years of age and older
- SMMC LTC program was originally implemented between August 1, 2013 and March 1, 2013, with implementation dates varying by region
- The Agency subsequently re-procured managed care plan contracts which became effective on the following dates

SMMC LTC Region Implementation Dates	
Implementation Date	**Region Contracts Effective**
December 1, 2018	Regions 9, 10, 11
January 1, 2019	Regions 5, 6, 7, 8
February 1, 2019	Regions 1, 2, 3, 4

- **Region definitions under next set of SMMC contracts will change from the current definition.**

LTC Program Background *(continued)*

- Covered populations
  - Nursing home eligibility determined based on CARES tool
  - Mandatory enrollment for most eligibles as shown in Appendix L-1
- Covered services
  - State plan covered LTC services listed in Appendix L-2
  - Duplicative LTC and Managed Medical Assistance (LTC) services covered under the LTC program:
    - Assistive care services
    - Home health services
    - Medical equipment and supplies
    - Therapy services including occupational, physical, respiration, and speech
    - Transportation to LTC services

LTC Program Background *(continued)*

- Each plan is paid a regional capitation rate per member per month (PMPM) that is set based on blend of HCBS and Non-HCBS rates
  - Separate rates developed for individuals only using home and community-based services (HCBS) and for individuals using nursing facility or hospice services (Non-HCBS)
  - Existing members assigned to rate cell based on examination of utilization up to three months prior to the beginning of the rate period
  - New members assigned based on utilization and eligibility prior to LTC enrollment
  - Member rate cell assignment does not change during the rate year; updated each rate year
  - Blend of HCBS and Non-HCBS rates updated monthly for members joining and leaving program

LTC Program Background *(continued)*

- Legislated transition percentage
  - Blended regional capitation rate adjusted for legislated transition percentage
  - Annual transition percentage varies from 0% to 3%, depending upon HCBS penetration
  - Annual transition percentage phased-in by 0.25% per month until required percentage reached

Application of Annual Transition Percentage		
HCBS Population	**Annual HCBS Target**	**Notes**
X<62%	X+3%	Projected not yet meeting the initial 65% threshold
62%<=X<63%	X+3%	Projected meets initial 65% threshold and ensures the total adjustment does not exceed 3%
63%<=X<65%	66%	Projected meets initial 65% threshold and ensures adjustment over 65% does not exceed 1%
65%<=X<74%	X+1%	Projected not yet meeting the final 75% threshold
74%<=X<75%	75%	Projected meets final 75% threshold
75%<=X	X%	Historical meets final 75% threshold

LTC Program Background *(continued)*

- The LTC program also includes a budget-neutral Community High Risk Pool (CHRP) risk mitigation mechanism for the HCBS rate group
  - A percentage of the capitation rates is withheld to fund the CHRP
  - Under the current contract (RY 22/23) 80% of member expenditures greater than $6,000 per month are eligible to be reimbursed by the CHRP
  - At the end of the rate period, if CHRP funds are inadequate to reimburse all pooled claims, the pooled claims will be funded on a proportional basis to each capitated plan.
  - If CHRP funds exceed the level of pooled claims, excess CHRP funds will be returned to the capitated plans on a PMPM basis.
  - Inclusion of this information in the LTC data book does not imply the continued use of the CHRP nor does it imply that the CHRP methodology will stay the same if it continues

Overview of LTC Data Book Contents

LTC Data Summary

- Historical data spans Calendar Year (CY) 2019, CY 2020, and the first half of CY 2021 (January 2021 to June 2021) service dates
  - Claim payment or submission runout through June 30, 2021
  - Represents the most recently available claim cost data that has been validated for capitation rate development
  - Includes historical data exclusively from the current set of managed care plan contracts

- Data sources:
  - Eligibility Files – Detailed eligibility files from the Agency enrollment system
  - Encounter Data – Special feed encounter data submission to Agency for the purpose of capitation rate setting. This data set was provided by each capitated plan due to incomplete LTC claims reported in the FMMIS encounter data.
  - Achieved Savings Rebate (ASR) Financial Data – Each calendar year quarter the capitated plans submit program enrollment, revenue, and claim experience for the LTC program, separated by quarter, region, and HCBS and Non-HCBS populations
  - Provider contracting summaries for HCBS services provided during capitation rate development by capitated plans

LTC Data Book Exhibits

- Exhibit L-1: LTC Data Book Summary – Historical Rate Group Basis
- Exhibit L-2: LTC Data Book Summary – Projected Rate Group Basis
- Exhibit L-3: LTC Provider Contracting Summaries
- Exhibit L-4: LTC Data Book Supplemental Information
  - Exhibit L-4A outlines LTC mandatory, voluntary, and excluded populations
  - Exhibit L-4B includes definitions of each service category included in Exhibits L-1 and L-2
  - Exhibit L-4C provides a list of Florida Medicaid LTC program changes since January 1, 2019
  - Exhibit L-4D includes the average, minimum, and maximum reported PMPM costs for each time period for each expanded benefit covered by plans

COVID-19 Considerations

- COVID-19 pandemic and federal public health emergency (PHE) have impacted health care costs significantly since March 2020
- The following impacts resulting from the COVID-19 pandemic and PHE may be reflected in the historical enrollment and cost data included in the LTC data book:
  - Population size and acuity
    - During the PHE there has been a decrease of members enrolling into nursing facilities, impacting the mix of individuals in the Non-HCBS and HCBS rate groups
  - Deferred and foregone services
    - Adult day care centers were closed early in the pandemic, and we have observed a slow return to pre-PHE utilization for these services.
  - Service mix changes
  - Other impacts related to the COVID-19 pandemic and federal PHE

LTC Eligibility Data

LTC Eligibility Data

LTC Covered Populations

- Mandatory Eligibility Populations
  - Medicaid-eligible members who are mandated to enroll in LTC
- Voluntary Eligibility Populations
  - Medicaid-eligible members who are not required to enroll in the LTC program, but may choose to enroll on a voluntary basis
  - Data book includes any members who voluntarily enrolled in LTC during the historical data period, but excludes members who did not enroll in LTC
- See Exhibit L-4A for listing of types of members for each population

LTC Eligibility Data

Region Assignment

- The SMMC program groups Florida counties into regions according to definitions outlined in Florida Statute
- The regional mappings will be condensed from 11 to 9 regions beginning with the new capitated plan contracts, as shown below

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

LTC Claims Data Sources and Adjustments

LTC Plan Encounter Data & ASR Financial Data

Data Validation Process

- The Agency and Milliman went through an extensive data validation process to review LTC plan data
- Some of the aspects of this validation process include the following:
  - The Agency reviewed multiple iterations of ASR financial data for internal consistency and validated the special feed encounter data
  - Milliman performed detailed analyses of numerous aspects of the special feed encounter data and ASR financial data and a comparison between the two
  - Milliman provided plan-specific data summaries and questions to all plans based on a review of the data sources and comparisons of the ASR financial data to the special feed encounter data
  - Milliman held one-on-one meetings with plan representatives on several occasions to further discuss data with plans
  - Plans provided responses to the data questions and additional data as needed

LTC Plan Encounter Data & ASR Financial Data

Data Validation Process *(continued)*

- Limitations of validation process
  - We did not audit the data or validate every possible outcome
  - Data anomalies, inconsistencies, or errors may exist
    - May have a larger relative impact when reviewing more detailed cuts of data
    - May impact utilization metrics more than claim payment amounts because we prioritized claim payment amounts over utilization in our validation
  - Certain detailed cuts of data may also lack credibility

LTC Plan Encounter Data

Summary and Uses

- The special feed encounter data is the primary data source for services paid by plans on a FFS basis
- Excluded encounter data for subcapitated services and other non-claim based payments (e.g., settlements) since the ASR financial data is the primary source of these services, with limited exceptions
- In addition, excluded encounter data for transportation services due to under reporting
- Data adjustments / exclusions:
  - Excluded data without a valid eligibility record for given month (< 0.1% of claims)
  - For capitated plans with mis-categorized or incorrectly reported data, we adjusted the data using supplemental information provided by the capitated plans
  - Encounter data attributed to expanded benefits are excluded

LTC Plan Encounter Data

Summary and Uses

- Runout aligned to claim runout included in ASR financial data for comparable time periods

Encounter Data Paid Date Limitations	
Data Period	**Paid-Date Cutoff**
January 2019 through December 2019	March 31, 2020
January 2020 through December 2020	March 31, 2021
January 2021 through June 2021	June 30, 2021

LTC ASR Financial Data

Summary and Uses

- Capitated plans submit ASR financial reports on a quarterly basis and a year-end report with three months runout
- Primary data source for services paid by plans on a subcapitated basis, settlement / alternative payment (AP) amounts, transportation, and other non-encounterable payments
- Used to validate encounter data submissions for claims paid by plans on FFS basis

ASR Report Service Dates and Runout Dates for LTC Data Book		
Data Period (Dates of Service)	**ASR Submission**	**Paid Date Cutoff**
January 2019 – December 2019	CY 2019 Audited	March 31, 2020
January 2020 – December 2020	CY 2020 Audited	March 31, 2021
January 2021 – June 2021	2021 Q2	June 30, 2021

LTC ASR Financial Data

Summary and Uses

- Data adjustments / exclusions:
  - For capitated plans with mis-categorized or incorrectly reported data, we adjusted the data using supplemental information provided by the capitated plans
  - Case management costs reported by capitated plans in each region were reallocated between the HCBS and Non-HCBS rate groups to be consistent with the 60:100 ratio included in the SMMC contract
  - Expanded benefits are not included in the LTC data book, but are provided as a supplemental exhibit (Exhibit L-4D) for informational purposes only. These services are not funded through the LTC capitation rates.

LTC Data Book Structure

LTC Data Book Structure

Appendix L-1: LTC Data Book summary – Historical Rate Group Basis

- CY 2019, CY 2020, and the first half of CY 2021 (January 2021 to June 2021) service dates shown on separate tabs
- Rate group consistent with flags for given rate year
- Summarizes service category claim costs PMPM by rate group and region

Service Category Data Sources			
Encounter Data		**Achieved Savings Rebate (ASR) Reports**	
ASR Service Category	**Service Category Description**	**ASR Service Category**	**Service Category Description**
2.3 and 2.4	Nursing Facility FFS	2.15	Transportation Services FFS
2.6	Hospice FFS	2.16 and 2.17	Case Management FFS
2.11	Assisted Living FFS	2.8 and 2.19	Subcapitated LTC Services
2.12	Home Health FFS	2.9 and 2.21	LTC Services Settlements
2.13	Medical Equipment / Supplies FFS	4.5	TPL and Fraud / Abuse Recoveries
2.14	Therapy Services FFS		
2.18	HCBS FFS		

- Summarizes nursing home / institutional hospice utilization metrics by rate group and region

LTC Data Book Structure

Appendix L-2: LTC Data Book summary – Projected Rate Group Basis

- CY 2019 and CY 2020 data consistent with L-1 shown on separate tabs
- Primary managed care influence of the program is the assumed "transition percentage" applied outside of rate cell capitation development
- Therefore, base data and rates need to exclude impact of location of care transitions occurring during the year
- Goals of the projected rate cell algorithm
  - Maintain a relatively simple and understandable process that generates reasonable results for projected rate cells
  - For members enrolled beyond the base period ("continuing members"), split base period experience for members transitioning between locations of care; otherwise, keep entire base period experience in same rate cell
  - Treat non-continuing members appropriately

LTC Data Book Structure

Appendix L-2: LTC Data Book summary – Projected Rate Group Basis

Scenario 1: No Change in Location of Care from First to Last Month for Continuing Members

- Continuing members are treated in the ***same location*** of care for their first month of enrollment as their last month of enrollment within the historical data period
  - Members may have started during the middle of the historical data period
- Location of care changes will be retained in the base costs for the projected rate group
- "N" = Nursing facility care; "H" = Home and community-based care; "X" = Not enrolled

Scenario 1														
Month:	1	2	3	4	5	6	7	8	9	10	11	12	Projected Rate Group	Comments
Member A	N	N	N	N	N	H	H	N	N	N	N	N	Non-HCBS	Home or community-based costs are retained in Non-HCBS
Member B	X	X	H	H	H	H	H	N	H	H	H	H	HCBS	Month 3 is compared to month 12 to determine if an ongoing transition has occurred

LTC Data Book Structure

Appendix L-2: LTC Data Book summary – Projected Rate Group Basis

Scenario 2: Change in Location of Care from First to Last Month for Continuing Members

- Continuing members are treated in a ***different location*** of care for their first month of enrollment as their last month of enrollment within the historical data period
  - Members may have started during the middle of the historical data period
- A portion of the base period is allocated to each rate group

Scenario 2														
Month:	1	2	3	4	5	6	7	8	9	10	11	12	Projected Rate Group	Comments
Member C	N	N	N	N	N	**H**	**H**	**N**	**H**	**H**	**H**	**H**	5 mo. Non-HCBS; **7 mo. HCBS**	Month 6 is first month in HCBS; Month 8 NF experience is retained in HCBS
Member D	X	X	H	H	H	H	H	**N**	**N**	**N**	**N**	**N**	5 mo. HCBS; **5 mo. Non-HCBS**	

LTC Data Book Structure

Appendix L-2: LTC Data Book summary – Projected Rate Group Basis

Scenario 3: Non-Continuing Members

- Members leave the program throughout the year due to death or other reasons
- A member dying during a rate period does not receive a revised rate group flag, and a capitated plan is not paid a revised capitation rate
- Experience for non-continuing members is assigned a projected rate group based upon their first location of care during the historical data period to retain higher end of life costs in beginning rate group

Scenario 3														
Month:	1	2	3	4	5	6	7	8	9	10	11	12	Projected Rate Group	Comments
Member E	N	N	H	H	H	H	N	N	X	X	X	X	Non-HCBS	
Member F	X	X	H	H	H	H	H	N	N	N	X	X	HCBS	Higher NF costs are retained in the HCBS rate group

LTC Data Book Structure

Appendix L-2: LTC Data Book summary – Projected Rate Group Basis

- Projected algorithm impact does not change program enrollment or costs, but reallocates between rate groups

% of LTC Member Months by Rate Group				
	CY 2019		CY 2020	
	Projected Rate Cell		Projected Rate Cell	
Historical Rate Cell	Non-HCBS	HCBS	Non-HCBS	HCBS
Non-HCBS	40.7%	2.1%	37.6%	3.7%
HCBS	1.7%	55.4%	2.4%	56.2%

Proportion of Member Months with NF / Hospice Utilization		
Rate Group	Historical Rate Group Basis	Projected Rate Group Basis
	CY 2019	
Non-HCBS	92.1%	95.9%
HCBS	3.6%	1.3%
	CY 2020	
Non-HCBS	87.6%	95.3%
HCBS	4.7%	1.3%

LTC Data Book Structure

Appendix L-3: LTC Provider Contracting Summaries

- **Exhibit L-3A** shows the average per diem paid for nursing facilities by region for CY 2019, CY 2020, and 2021 H1.
- **Exhibit L-3B** shows the average per diem paid for hospice facilities by region for CY 2019, CY 2020, and 2021 H1.
- **Exhibit L-3C** shows the average per diem paid for assisted living facilities by region for CY 2019 and CY 2020.
- **Exhibit L-3D** shows the average per diem and per 15 minute unit paid for adult day care by region for CY 2019 and CY 2020.
- **Exhibit L-3E** shows the average per 15 minute unit paid for other HCBS services including personal care attendants, homemaker services, and companion care by region for CY 2019 and CY 2020.

LTC Data Book Structure

Appendix L-4: LTC Data Book Supplemental Information

- **Exhibit L-4A** outlines LTC mandatory, voluntary, and excluded populations.
- **Exhibit L-4B** includes definitions of each service category included in Exhibits L-1 and L-2. This exhibit includes the ASR report instructions that LTC plans are given, as well as additional information regarding which data source (special feed encounter data or ASR financial data) Milliman used for each service category in the LTC data book.
- **Exhibit L-4C** provides a list of Florida Medicaid LTC program changes since January 1, 2019. These program changes may impact costs reflected in the LTC data book or may impact future costs of the LTC program.
- **Exhibit L-4D** includes the average, minimum, and maximum reported PMPM costs for each time period for each expanded benefit covered by plans. While other components of the LTC 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 LTC plan's expense.

Adjustments Not Included in the LTC Data Book

Adjustments Not Included in the LTC Data Book

- IBNR claim adjustments
- 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 LTC 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

Adjustments Not Included in the LTC Data Book *(continued)*

- Program changes during or after the historical data period listed in Exhibit L-4C
- Future program changes not yet known as of the LTC data book release date
- Data smoothing to improve data credibility
- Inclusion of administrative costs and plan underwriting margin
- State directed payments that may be paid as separate payment terms

Caveats and Limitations on Use

- We prepared this information for the specific purpose of assisting the Agency in publishing and describing 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 communication may not be appropriate, and should not be used, for other purposes.
- This presentation and the SMMC 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 SMMC plans, the Agency, and other sources. Those data sources and information include Agency eligibility data, Agency FFS claims data, SMMC plan ASR financial data submissions, SMMC plan 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 SMMC 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 SMMC data book. The intent of the models was to process, adjust, and summarize historical data for the SMMC 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 SMMC plan experience will differ from the contents of the SMMC 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 SMMC data book, and many other factors. The SMMC data book does not reflect projections of future costs.
- The results of this presentation and the SMMC 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 presentation 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.
- Please see the complete SMMC data book dated November 18, 2022 for additional information.

Thank You!