A. General Provisions

Providers participating in the Florida Medicaid Managed Care program must be reimbursed based on capitation rates calculated for the applicable contract year. Capitation rates are calculated separately for ten service areas, four service categories, and eight age and gender bands. Expenditures for community mental health care programs and expenditures for children enrolled in the Children's Medical Services Program are not included in this calculation. Capitation rates for providing comprehensive behavioral health programs are added to the capitation rates for HMOs calculated pursuant to this rule. The methodology for calculating capitation rates for comprehensive behavioral health services is not included in this rule.

The Florida Medicaid Management Information System (FMMIS) maintains the database of claims, eligibility and enrollment information for calculating the capitation payment methodology described in this rule. The Children's Medical Services (CMS) database contains the eligibility file for children served by CMS, and the FMMIS maintains the database for determining the actual amounts spent annually.

B. Definitions

1. Age and Gender Bands - means capitation rate variables by age and gender

2. Applicable State Fiscal Years:
   a. SFY 1 means the year three years prior to the applicable contract year
   b. SFY 2 means the year two years prior to the applicable contract year
   c. SFY 3 means the year one year prior to the applicable contract year
   d. SFY 4 means the applicable contract year

3. Capitation Payment (CAP) - means the prepaid fixed monthly rate paid by the Agency to an HMO for each enrolled HMO member to provide covered services needed by each member during the month as specified in each contract.

4. Discount Factor (D) - equals the percentage of the projected payment limit that is allocated to each service area as referenced in Table 2.

5. Medicaid Eligibility Groups for the Purpose of this Rule mean:
a. Individuals receiving Temporary Assistance for Needy Families (TANF).
b. Individuals receiving Supplemental Security Income but are not eligible for Medicare.
c. Individuals receiving Supplemental Security Income and are eligible for Medicare Part A and B.
d. Individuals receiving Supplemental Security Income and are eligible for Medicare Part B only.

6. Payment Limit (PL) – means the projected cost for HMO covered services in a Medicaid fee-for-service system, including MediPass costs and fee-for-service costs attributable to recipients enrolled for a portion of a year in a managed care plan or waiver program, but excluding the fee paid to primary care physicians for MediPass enrollees, actual expenditures for children enrolled for reimbursement under the CMS program, and other excluded groups as described in Section 10.3 of the HMO contract. The final capitation rate paid to HMOs is calculated as a percentage of the PL by taking into consideration age and gender factors, service area, other discount factors, and eligibility category expenditures. Pursuant to 42 CFR 438.6, the final capitation rates must be actuarially sound. Medicaid payment for a defined scope of services to be furnished to a defined number of recipients may not exceed the cost to the agency of providing those same services on a fee-for-service basis to an actuarially equivalent population group.

F.S. 409.9124 limits the projected weighted average rate on a per member per month basis to the per member per month rate adopted by the Florida Legislature.

7. Service Categories or HMO Capitation Categories mean:

a. Hospital/ Medical Services - all HMO covered services not falling into the three other HMO capitation categories specified in subparagraph 7.b., c., and d. These include: hospital inpatient, hospital outpatient, physician services, prescribed medicine, lab and x-ray, family planning, home health services, EPSDT Screening, child vision, child hearing, nurse practitioner, birthing center, rural health services, physical therapy, speech therapy, occupational therapy, respiratory therapy, clinic, physician assistant, dialysis center services, and Medicare dual eligible crossover expenditures.
b. Dental Services - dental services are an optional covered benefit in the HMO contract.
c. Transportation Services - transportation services are an optional covered benefit in the HMO contract.
d. Prescription Drug Rebates - rebates from drug manufactures collected by the agency on fee-for-service (FFS) prescription drugs.
8. Service Areas for the purpose of this rule are composed of the following counties:
   - Service Area 5. -- Pasco and Pinellas Counties.
   - Service Area 6. -- Hillsborough, Manatee, Polk, Hardee, and Highlands Counties.
   - Service Area 7. -- Seminole, Orange, Osceola, and Brevard Counties.
   - Service Area 8. -- Sarasota, DeSoto, Charlotte, Lee, Glades, Hendry, and Collier Counties.
   - Service Area 9. -- Indian River, Okeechobee, St. Lucie, Martin, and Palm Beach Counties.
   - Service Area 10. -- Broward County.
   - Service Area 11. -- Monroe and Dade Counties.

C. Payment Limit Calculation

1. The following formula shall be used to calculate the Payment Limit (PL):

   \[ PL = (AP/CM) \times IF \times IBNR \times TPL \times ADM \times AGD, \]
   where:

   - **AP** - equals amount paid for HMO covered services rendered under the MediPass program, minority networks, Emergency Room Diversion and other related projects, and the standard Medicaid fee-for-service system for SFY 1 and SFY 2 the most recent two years available for eligibility groups, age and gender bands, and service areas equivalent to the managed care population.
   - **CM** - means the total number of months of eligibility for all HMO eligible Medicaid recipients in the fee-for-service system corresponding to the HMO covered services in the fee-for-service system during the applicable base fiscal years (SFY 1 + SFY 2).
   - **IF** - equals the Medicaid cost inflation factor approved by the Florida Legislature applicable to projected covered Medicaid expenditures for the applicable contract year (SFY 4). Each year prior to establishing new managed care rates, the agency shall review all prior year adjustments for changes in trend, and shall reduce or
eliminate those adjustments which are not reasonable and/or which reflect policies or programs which are not in effect.

**IBNR** - equals an estimated percentage of the total amount of claims incurred during the applicable fiscal year that have not yet been submitted to the Agency for Health Care Administration (agency). This calculation is based upon an evaluation of SFY 1. As the expenditures in each SFY of the base include the 12 months of the referenced year (months 1-12) plus the following 6 months (months 13-18), the evaluation for the period of claims incurred but not reported includes claims paid from 19-30 months after the beginning of SFY 1. This evaluation is determined statewide and includes all covered service categories.

**TPL** - equals third party liability recovery adjustments, which is the Agency's estimated percentage of third party liability recovery based on the average of the actual amounts recovered for SFY 1 and SFY 2.

**ADM** - means the administrative load percentage

**AGD** - equals age and gender adjusted total costs factors

2. The calculation of the PL consists of the following five steps:

**Step 1: Identify Age and Gender Bands**

The following age and gender bands are used to calculate the PL for each eligibility category for SFY 4.

<table>
<thead>
<tr>
<th>Eligibility Group</th>
<th>Age/Gender Bands (age in years unless otherwise noted)</th>
</tr>
</thead>
<tbody>
<tr>
<td>TANF/AFDC</td>
<td>Months 0-2 Months 3-11 1 - 5 6 - 13 14 - 20 Male</td>
</tr>
<tr>
<td>SSI - no Medicare</td>
<td>Months 0-2 Months 3-11 1 - 5 6 - 13</td>
</tr>
<tr>
<td>SSI Medicare Part A and B</td>
<td>Under 65 65 and over</td>
</tr>
<tr>
<td>SSI Medicare Part B only</td>
<td>All ages combined</td>
</tr>
</tbody>
</table>

**Step 2: Calculate Statewide Age and Gender Factors**
Separate age and gender factors for each eligibility category and capitation rate category with two years of experience data are calculated as follows:

1. Summarize SFY 1 statewide Fee for Service (FFS) cost data by eligibility category and service category for all HMO covered services. Total costs are summarized into the four capitation rate categories: hospital/medical, dental, transportation, and drug rebates.

2. Trend SFY 1 data to SFY 2 using the actual historical trend from SFY 1 to SFY 2.

3. Summarize statewide SFY 2 FFS cost data by eligibility category and service category for all HMO covered services. Total costs are summarized into the four capitation rate categories: hospital/medical services, dental services, transportation services, and drug rebates.

4. Calculate the composite SFY 2 statewide per eligible cost per month (PMPM) by age and gender band, eligibility category, and capitation rate category. The composite is calculated as a weighted average of trended SFY 1 costs and SFY 2 costs based on each year's statewide eligibility months in each age and gender band.

5. Calculate the statewide age and gender factors as the ratio of the age and gender band PMPM cost to the overall PMPM cost for the eligibility category.

**Step 3: Calculate Estimated SFY 4 FFS Costs by Eligibility Category and Service Area**

The estimated SFY 4 FFS costs for each service area and eligibility category is calculated by combining all age and gender band costs to develop the all ages service-area-wide estimated costs for the four capitation rate categories. The estimated SFY 4 FFS cost is calculated as follows:

1. Summarize the SFY 1 data for each service area by eligibility category and service category for all HMO covered service categories. Costs are summarized in the four capitation rate categories.

2. Trend the SFY 1 data to SFY 4 using the product of:
   a. The actual historical trend from SFY 1 to SFY 2; and
   b. The SFY 2 to SFY 4 inflation factors approved by the Florida Legislature.
3. Summarize the SFY 2 cost data for each service area by eligibility category and service category for all HMO covered services. Costs are summarized into the four capitation rate categories.

4. Trend the SFY 2 data to SFY 4 (the applicable contract year) using the SFY 2 to SFY 4 inflation factors approved by the Florida Legislature.

5. Calculate the composite SFY 4 service area PMPM costs by service area, eligibility category, and capitation rate category. The composite is calculated as a weighted average of SFY 1 costs and SFY 2 costs based on each year’s service area specific eligible months.

**Step 4: Adjust the Costs for Incurred But Not Reported (IBNR) Claims, Third Party Liability (TPL) Recoveries, and the Administrative Load (ADM)**

The estimated SFY 4 (applicable contract year) costs are adjusted by the following variables to account for expenditures and revenues not included in regular claims data:

1. **IBNR Claims:** A certain percentage of claims are paid after each year's data is summarized. The agency summarizes each state fiscal year of data six months after it ends. The IBNR adjustment reflects an estimate of the claims that will be paid after December 31 for incurred but not reported claims. The estimated claims amount is added to the expenditures for combined SFY 1 and SFY 2 to reflect the total fee-for-service costs.

2. **Third Party Liability (TPL) Adjustment:** The claims data does not include all of the TPL recoveries realized by the agency. Based on an average of SFY 1 and SFY 2 TPL data, the SFY 4 cost estimates are adjusted downward to reflect the TPL recoveries. This adjustment includes only those recoveries that are not already reflected in the claims data. The TPL adjustment factors are calculated separately for each eligibility category, and may vary annually.

3. **Administrative Load (ADM) Adjustment:** This adjustment reflects the factor used in the capitation rates for administrative expenses in compliance with applicable federal laws and regulations.
After incorporating these two adjustments, a PL for each service area and eligibility category is calculated.

**Step 5: Apply Statewide Age and Gender Factors**

The final PL for SFY 4 by service area, eligibility category, and age and gender band is calculated as follows:

1. Start with the service area-specific SFY 4 PL calculated in Steps 3 and 4 for each service area, eligibility category, and capitation rate category.

2. Determine the service area's average age and gender factor for each eligibility category and capitation rate category using the service area-specific eligible months and statewide age and gender factors.

3. Normalize the statewide age and gender factors by dividing by the average age and gender factor for each capitation rate category.

4. Multiply the service area-specific SFY 4 PL by the normalized age and gender factors to calculate the age and gender band PL for each service area, eligibility category, and capitation rate category.

**D. Methodology for SSI Medicare Part B Only**

The "SSI-Medicare Part B Only" eligibility category does not have separate age and gender bands.

The "SSI-Medicare Part B Only" PL is calculated as follows:

1. Summarize the SFY 1 FFS data for each service area by service category for HMO covered services. Costs are summarized into the four capitation rate categories.

2. Trend the SFY 1 to SFY 4 data using the product of:
   a. The actual historical trend from SFY 1 to SFY2; and
   b. The SFY 2 to SFY 4 inflation factors approved by the Florida Legislature.

3. Summarize the SFY 2 data for each service area by service category for all HMO covered services. Costs are summarized into the four capitation rate categories.
4. Trend the SFY 2 data to SFY 4 using the new SFY 4 inflation factors approved by the Florida Legislature.

5. Calculate the composite SFY 4 service area PMPM costs by service area and capitation rate category. The composite is calculated as a weighted average of projected SFY 1 costs and projected SFY 2 costs based on each year's service area-specific eligible months.

6. Adjust for IBNR claims, TPL recoveries, and ADM load.

7. Calculate the HMO capitation rate by multiplying the PL by the discount factors specified for each service area.

E. CAPITATION PAYMENT RATE CALCULATION

The capitation payment (CAP) limit is adjusted by area and eligibility group by a discount factor as shown in Table 2. The capitation payment, the fixed amount paid monthly by the agency's fiscal intermediary for each Medicaid recipient enrolled under contract during the payment period, is calculated based on the following formula:

\[ \text{CAP} = \text{PL} \times D \times TA, \text{ where:} \]

- **PL** - is the payment limit
- **D** - equals a percentage of the projected PL (the discount factor)
- **TA** - the trend adjustment necessary to remain within F.S. 409.9124. The final weighted average rate for all eligibility groups shall not exceed the per member per month amount adopted by the Florida Legislature.

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<th>Service Area</th>
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<th>SSI- Medicare Part A and B</th>
<th>SSI- Medicare Part B only</th>
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