State of Florida
Agency for Health Care Administration
Statewide Medicaid Managed Care Invitation to Negotiate
Attachment C: Cost Proposal Instructions and Rate Methodology Narrative

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EXHIBITS

I. OVERVIEW OF COST PROPOSAL INSTRUCTIONS

The purpose of this document is to provide respondents with instructions for completing the Statewide Medicaid Managed Care (SMMC) Cost Proposal ("cost proposal") required in Attachment A of this solicitation.

This document provides instructions and guidance to respondents as they complete their cost proposals. The format of the cost proposal templates follows the general format of the methodology used by the Agency for Health Care Administration (Agency) and its consulting actuaries to develop actuarially sound Managed Medical Assistance (MMA) and Long-term Care (LTC) program capitation rates in recent years. The Agency anticipates using a similar methodology ("Agency's rate methodology") to assess the reasonability and competitiveness of respondent cost proposals.

Respondents will include the following components in their cost proposals, depending on their SMMC plan type (defined below):

1. MMA program capitated plan cost proposal template in Excel format
2. LTC program capitated plan cost proposal template in Excel format
3. Non-benefit expense cost proposal template in Excel format
4. MMA Actuarial Memorandum and certification
5. LTC Actuarial Memorandum and certification

Respondents can choose to participate in the SMMC program as either a Capitated Managed Care Plan ("capitated plan") or as a Fee-for-Service (FFS) Provider Service Network (PSN), as defined in Section A.1.A.17 of Attachment A of this solicitation. All respondents should complete one of the following two cost proposal templates depending on whether they are proposing to become a capitated plan or a FFS PSN as outlined below:

- ***Capitated plan cost proposal template*** (Exhibit C-1 - Florida SMMC ITN - Capitated Plan Cost Proposal Template). Respondents proposing to become a capitated plan should complete the capitated plan cost proposal template, which is included as Exhibit C-1. This Excel file includes three distinct components:

    1. The MMA component of the capitated plan cost proposal template ("MMA cost proposal template"), which includes Worksheets M.1 through M.12 in the Excel file

    2. The LTC component of the capitated plan cost proposal template ("LTC cost proposal template"), which includes Worksheet L.1 in the Excel file

    3. The non-benefit expense component of the capitated plan cost proposal template ("non-benefit expense cost proposal template"), which includes Worksheet N.1 in the Excel file

- ***FFS PSN cost proposal template*** (Exhibit C-2 - Florida SMMC ITN - FFS PSN Cost Proposal Template). Respondents proposing to become a FFS PSN should complete the FFS PSN cost proposal template, which is included as Exhibit C-2. This Excel file includes only a non-benefit expense cost proposal template for FFS PSNs.

The Excel cost proposal templates can be accessed in the following location:

http://ahca.myflorida.com/procurements/index.shtml

The cost proposal instructions and rate methodology narrative uses the word "members" to refer to all Medicaid recipients, including recipients receiving services through the FFS program and individuals enrolled in capitated plans or FFS PSNs.

Please note that throughout the remainder of this document, the term "non-benefit expense cost proposal template" is used to refer to the non-benefit expense component of both the capitated plan cost proposal template and the FFS PSN cost proposal template. All respondents, whether they are proposing to become a capitated plan or a FFS PSN, must follow all instructions related to the non-benefit expense cost proposal template (except in situations where the instructions are indicated to apply to only capitated plans or only FFS PSNs – in which case respondents need only follow the instructions for their own proposed type of plan).

Respondents should review this entire document before completing any of the cost proposal templates. Additionally, both the capitated plan cost proposal template and the FFS PSN cost proposal template include a tab at the beginning of each Excel file containing general inputs and basic instructions, which respondents should also review before completing any cost proposal templates.

This document is structured in the following sections:

- Section I – General instructions for the SMMC cost proposal submission.
- Section II – The Agency's MMA rate methodology and detailed instructions for the MMA cost proposal template.
- Section III – The Agency's LTC rate methodology and detailed instructions for the LTC cost proposal template.
- Section IV – Instructions for the non-benefit expense cost proposal template.
- Section V – Important caveats and limitations that apply to this document and to Exhibits C-1 through C-6.

SMMC Plan Types

The cost proposal requirements vary according to the respondent's chosen plan type. The Agency intends that the contracts resulting from this solicitation will be for one of the following plan types:

- ***Comprehensive Long-term Care Plan ("Comprehensive Plan")*** – A Managed Care Plan that is eligible to provide Managed Medical Assistance services and Long-term Care services to eligible recipients.
- ***Long-term Care Plus Plan ("LTC Plus Plan")*** – A Managed Care Plan that is eligible to provide Managed Medical Assistance services and Long-term Care services to eligible recipients enrolled in the Long-term Care program. This plan type is not eligible to provide services to recipients who are only eligible for MMA services.
- ***Managed Medical Assistance Plan ("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 eligible for Long-term Care services.

- ***Specialty Plan*** – A Managed Care Plan that is eligible to provide MMA services to eligible recipients who are defined as a specialty population in the resulting Contract.

Table 1 summarizes the cost proposal components that each respondent must submit, depending on which SMMC plan type they are proposing and whether they are proposing to be a capitated plan or a FFS PSN.

Table 1
Statewide Medicaid Managed Care Program
Cost Proposal Submission Requirements for Each SMMC Plan Type

SMMC Plan Type	MMA Cost Proposal	LTC Cost Proposal	Non-Benefit Expense Cost Proposal	MMA Act Memo and Certification	LTC Act Memo and Certification
Capitated Plan					
Comprehensive Plan	Yes	Yes	Yes	Yes	Yes
LTC Plus Plan	Yes	Yes	Yes	Yes	Yes
MMA Plan	Yes	No	Yes	Yes	No
Specialty Plan	Yes	No	Yes	Yes	No
FFS PSN					
Comprehensive Plan	No	No	Yes	Yes	Yes
LTC Plus Plan	No	No	Yes	Yes	Yes
MMA Plan	No	No	Yes	Yes	No
Specialty Plan	No	No	Yes	Yes	No

SMMC Data Book

The Agency posted a data book providing relevant background information that prospective plans will find useful in the development of their response to this solicitation. The data book consists of a comprehensive set of utilization and spending data consistent with actuarial rate-setting practices and standards. It includes a description of the data sources and all adjustments applied to the data to produce the data book. The data book consists of the following information:

- Statewide Medicaid Managed Care Data Book
  - Cover Letter for SMMC Data Book (dated March 30, 2017)
  - MMA Data Book Narrative and Appendices (dated March 30, 2017)
  - LTC Data Book Narrative and Appendices (dated March 30, 2017)
  - MMA Addendum 1 (dated April 7, 2017)
- Data book public meeting materials (dated April 12, 2017)
- Data book question and answer document (dated June 27, 2017)

- Final Statewide Medicaid Managed Care Data Book

  – Cover Letter for SMMC Data Book (dated June 16, 2017)
  – MMA Data Book Narrative and Appendices (dated June 16, 2017)
  – LTC Data Book Narrative and Appendices (dated June 16, 2017)

All data book materials can be accessed in the following location (**Exhibit C-7**, Statewide Medicaid Managed Care Data Book):

- **http://ahca.myflorida.com/procurements/index.shtml**

Respondents must consider the information in the SMMC data book when developing their cost proposals and completing the cost proposal template, but they are not obligated to rely on it in developing their own proposals. Respondents are not restricted to the data and summaries provided by the Agency for use in preparing the cost proposal; however, they are required to complete the cost proposal template. Respondents are allowed to develop and use other data sources as needed to prepare a competitive cost proposal. The structure of the cost proposal template allows flexibility for respondents to use base data and adjustments different than those presented in the SMMC data book and in the cost proposal instructions and rate methodology narrative. Respondents are solely responsible for research and preparation of the cost proposal.

Respondents should exclude all state plan dental service costs when developing their cost proposals. Per 409.973 (5)(b) F.S., coverage of state plan dental services for Florida Medicaid members will be provided through a different managed care program and will be handled as part of a separate procurement process. For the purpose of the cost proposal, please assume all state plan dental services for procedure codes starting with “D” are excluded from the MMA program. The Agency retains the right to change covered and excluded codes.

The SMMC data book includes state plan dental services in the following service categories in the MMA data book appendices. This information should be excluded from respondent cost proposals.

- Encounter data (service category and description):

  – M6.1: Dental FFS

- Achieved Savings Rebate (ASR) financial data (ASR lines and descriptions):

  – 6.2: Dental Subcapitation
  – 6.4: Dental Service Settlements

- Agency FFS data (“buckets” and descriptions):

  – 23: Child Dental
  – 26: Adult Dental Services

SMMC Rate Regions

The Agency intends to negotiate actuarially sound capitation rates for each of the 11 rate regions listed in Table 2. The regions are identical to the regions currently used in the SMMC program.

Table 2
Statewide Medicaid Managed Care Program
Rate Region Definitions

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

General SMMC Cost Proposal Instructions

Respondents must follow the instructions provided below:

1. Respondents must submit a separate cost proposal for each individual rate region in which they are proposing to participate in the SMMC program.

    a. For each applicable region, respondents proposing to become a capitated plan should submit a single capitated plan cost proposal template that includes a completed MMA cost proposal template, a completed LTC cost proposal template (when applicable), and a completed non-benefit expense cost proposal template.

    b. For each applicable region, respondents proposing to become a FFS PSN should submit the FFS PSN cost proposal template for non-benefit expenses.

    c. Respondents proposing to become a Specialty Plan serving a customized specialty population can submit multiple cost proposal templates for each region if they are proposing to serve more than one customized specialty population.

2. Respondents must submit cost proposals using the Agency's cost proposal template. Respondents are to enter information only in cells shaded peach. Respondents must not change any formulas in the cost proposal template and must submit the cost proposal template with the original sheet and workbook protection intact.

3. Within the cost proposal template, respondents must enter their organization name and the region to which the cost proposal template applies on the 'Instructions & General Inputs' tab. Additionally, respondents should use the following file naming convention when submitting their cost proposal templates:

    a. Respondents should replace the "Region XX" portion of the cost proposal template Excel file name with the region to which the particular cost proposal template applies (e.g., "Region 1") before submitting their cost proposal.

    b. Respondents should replace the "Respondent Name" portion of the cost proposal template Excel file name with their own organization's name before submitting their cost proposal.

    c. Aside from the file name changes described in items 3.a and 3.b, respondents should not change the name of the cost proposal template Excel file that is accessed from the location referenced above.

4. Respondents must enter a numeric value into each and every peach cell on all required tabs for their chosen SMMC plan type (except for the Respondent Organization Name input, the Proposed Specialty Population input in Worksheet M.11, and the adjustment factor name inputs on the various tabs, which can be input as text). If numeric values are not entered into each and every required peach cell, the cost proposal template will not appropriately calculate a proposed capitation rate from the respondent's input base data and adjustments. If a particular adjustment factor, per member per month (PMPM) amount, or per delivery amount does not apply for a given region, rate group, or service category, respondents should enter a 1.000 multiplicative adjustment factor or a $0.00 additive cost in the required input cells to allow the cost proposal template to appropriately calculate a proposed capitation rate.

5. All cells other than respondent inputs have been protected. A 'Work Area' worksheet has been included in the template and left unprotected for the use of the respondent to share additional information with the Agency, as needed.

6. Do not insert rows or columns in the template, or use the "cut" command on any cells within the template. If the respondent requires more columns for adjustments than provided, please combine adjustments so that they can be entered into the number of columns in the template and include a description of each adjustment and its value in the Actuarial Memorandum that accompanies the cost proposal template (along with Excel numerical support as needed).

7. Respondents completing the capitated plan cost proposal template should complete the applicable MMA cost proposal template and LTC cost proposal template worksheets before completing the non-benefit expense cost proposal template worksheet. The non-benefit expense cost proposal template for capitated plans uses conditional formatting to apply dark shading to the rows for the rate groups that do not include a calculated projected service cost in the MMA or LTC worksheets.

8. Cost proposals are to be quoted for the 12 month period of October 2018 – September 2019, which we will refer to as rate year 18/19 (RY 18/19). If necessary, the Agency will adjust the final negotiated capitation rates for each region to reflect appropriate service cost trend, seasonality, and program change impacts based on the final implementation schedule.

9. Adjustments to the base data and projection factors, including unit cost and utilization trend, must be input as a one-time adjustment to the data (i.e., not as an annualized trend rate). Given that respondents may use different base data periods, the trend period from the midpoint of the base period to the midpoint of the rate year (i.e., April 1, 2019) will need to be calculated by each respondent.

10. Cost proposals are to be quoted net of patient responsibility, third party liability (TPL) recoveries, and fraud, waste, and abuse recoveries.

11. Respondents must include an Actuarial Memorandum and actuarial certification in support of their cost proposal. The required contents of the Actuarial Memorandum are discussed in the next section.

Actuarial Memorandum and Certification Requirement – General

Each respondent must provide detailed documentation in the form of an Actuarial Memorandum describing how the respondent's cost proposal was developed.

- Respondents completing the MMA cost proposal template as a capitated plan must submit a single MMA Actuarial Memorandum covering all regions. The single MMA Actuarial Memorandum must be submitted for each region to accompany each regional cost proposal. The MMA Actuarial Memorandum is required to correspond to the sections of the MMA cost proposal template and the non-benefit expense cost proposal template. Additional details on the MMA Actuarial Memorandum requirements for capitated plans are described below under "Actuarial Memorandum and Certification Requirement – Capitated Plans."

- Respondents completing the LTC cost proposal template as a capitated plan must submit a single LTC Actuarial Memorandum covering all regions. The single LTC Actuarial Memorandum must be submitted for each region to accompany each regional cost proposal. The LTC Actuarial Memorandum is required to correspond to the sections of the LTC cost proposal template and the non-benefit expense cost proposal template. Additional details on the LTC Actuarial Memorandum requirements for capitated plans are described below under "Actuarial Memorandum and Certification Requirement – Capitated Plans."

- Respondents completing the FFS PSN cost proposal template must submit either one or two Actuarial Memorandums, depending on their chosen SMMC plan type:

  – FFS PSNs proposing to become a Comprehensive Plan or an LTC Plus Plan must submit a single MMA Actuarial Memorandum covering all regions and a single LTC Actuarial Memorandum covering all regions. Each Actuarial Memorandum must be submitted for each region to accompany each regional cost proposal. Each Actuarial Memorandum is required to correspond to the sections of the FFS PSN cost proposal template.

  – FFS PSNs proposing to become an MMA Plan or a Specialty Plan must submit a single MMA Actuarial Memorandum covering all regions. The single MMA Actuarial Memorandum must be submitted for each region to accompany each regional cost proposal. The FFS PSN MMA Actuarial Memorandum is required to correspond to the sections of the FFS PSN cost proposal template.

Additional details on the MMA Actuarial Memorandum and LTC Actuarial Memorandum requirements for FFS PSNs are described below under "Actuarial Memorandum and Certification Requirement – FFS PSNs."

Actuarial Memorandum and Certification Requirement – Capitated Plans

For respondents proposing to become a capitated plan, the MMA Actuarial Memorandum and the LTC Actuarial Memorandum must each include the following information:

1. ***Cost Proposal Base Period Data:*** Document the source of the base data used for developing the respondent's cost proposal, including the time period, covered population, data sources, justification for selecting the base data source, and other pertinent information. If the data book data is blended with any other sources, or if more than one year of data is used, please identify the weights used for the blending and provide the pre-blended values.

2. ***Cost Proposal Adjustments to Starting Base Period Data:*** Document all adjustments made to the base data that are related to historical data quality or completeness. For each adjustment, describe the data sources and methodology used to calculate the adjustment factors. For respondents using data other than the data book as a starting point, provide explanations for how the respondent's data was adjusted for differences in acuity and member mix distributions relative to the base data shown in the data book, and discuss the credibility of the data used. If experience from other state Medicaid programs is used for these adjustments, please identify the state, clarify if that state's program is FFS or managed care, and discuss the credibility of the data used.

3. ***Trend:*** Describe the data sources and methodology used to develop the utilization and unit cost trend factors of the cost proposal template. Respondents must include information regarding annualized trend assumptions by rate group, region, historical delivery system (for MMA), and service category, including the time period used for trending. Justify why negative trends were applied to any category of service, or any category of service where no trend adjustment is made. Describe how the trend was developed for subcapitated services, if applicable. If the assumed trends vary by year rather than one overall annualized trend, each year of trend should be documented. If experience from other state Medicaid programs is used, please identify the state, clarify if that state's program is FFS or managed care, and discuss the credibility of the data used.

4. ***Provider Contracting Adjustments:*** Document the respondent's estimated provider contracting levels as a percentage of Florida Medicaid FFS reimbursement rates by rate group, region, and service category. Describe how the respondent developed the factors shown in the cost proposal template to adjust the provider reimbursement levels in the base period data to reflect its estimated provider contracting levels for RY 18/19. For MMA, provide the percentage of the respondent's hospital and physician network in each region that is already under contract in advance of this cost proposal submission, as well as the percentage of the respondent's hospital and physician network contracts that are expected to be tied to Florida Medicaid FFS reimbursement rates.

5. ***Managed Care Savings Adjustments:*** Document each managed care savings adjustment shown in the cost proposal template. For each managed care initiative, please provide the following information and document the data sources and methodology used to calculate the adjustment factors by rate group, region, historical delivery system (for MMA), base data source, and service category:

    - Description of the managed care initiative
    - Implementation timing

- Involvement of other organizations
- Internal or external costs of developing and administering the initiative
- Development of net cost savings by rate group, region, historical delivery system (for MMA), base data source, and service category. Include support for the data, assumptions, and methodology underlying the net savings projection.

6. ***Other Cost Proposal Adjustments (Multiplicative):*** Document each additional multiplicative adjustment used in the cost proposal template. Describe the reason for each adjustment and the data sources and methodology used to calculate the adjustment factors. If experience from other state Medicaid programs is used for these adjustments, please identify the state, clarify if that state's program is FFS or managed care, and discuss the credibility of the data used.

7. ***Other Cost Proposal Adjustments (Additive):*** Document each additional additive adjustment used in the cost proposal template. Describe the reason for each adjustment and the data sources and methodology used to calculate the adjustment amounts. If experience from other state Medicaid programs is used for these adjustments, please identify the state, clarify if that state's program is FFS or managed care, and discuss the credibility of the data used.

8. ***Proposed Administrative Allowance:*** Document the respondent's proposed administrative allowance for each rate group and region. Please document the following for each of the 12 administrative cost categories in the non-benefit expense cost proposal template:

   - Source of information used to develop the proposed administrative allowance
   - Methodology used to properly depreciate start-up costs (if applicable)
   - Methodology used to allocate administrative costs between MMA and LTC (if applicable)
   - Methodology used to allocate administrative costs to each rate group for MMA
   - Methodology used to allocate administrative costs to each rate group for LTC (if applicable)
   - Methodology used to allocate administrative costs to each rate region (if applicable)
   - The percentage of each administrative cost category that is related to local Florida plan expenses
   - The percentage of each administrative cost category that is allocated from a related corporate entity (such as a parent corporation)
   - Methodology used to allocate corporate expenses to the local entity (if applicable)
   - Expected volume of business used to develop the administrative allowance

   If different methodologies are used to allocate different types of costs, please document all applicable methodologies used.

9. ***Proposed Gain / Loss Margin:*** Document the respondent's proposed gain / loss margin for each rate group and region.

10. ***Membership:*** Document the respondent's sensitivity testing of the proposed capitation rates to changes in the enrollment membership by rate group and region. Provide a detailed description of the methodology and provide testing results.

11. ***Statement of Rate Adjustments Excluded from Cost Proposal:*** Respondents must include a statement that their cost proposal excludes adjustments for the items shown in Section II.F (for MMA) and Section III.F (for LTC) of the cost proposal instructions and rate methodology narrative.

Respondents can also list other potential rate adjustments they believe should be considered as part of the negotiation process but are excluded from the respondent's cost proposal. Respondents must clearly note the additional excluded items and explain why the adjustments were excluded.

12. ***Actuarial Certification:*** The Actuarial Memorandum must include an actuarial certification signed by a qualified Member of the American Academy of Actuaries that the respondent's cost proposal is actuarially sound and complies with Actuarial Standard of Practice No. 49 – Medicaid Managed Care Capitation Rate Development and Certification, and that proposed capitation rates are projected to provide for all reasonable, appropriate, and attainable costs during the time period for which they are intended. Respondents proposing to become a Specialty Plan covering a new customized specialty population are allowed to submit a qualified actuarial certification. Respondents proposing to become any other SMMC plan type must submit an unqualified actuarial certification.

13. ***Supporting Exhibits:*** Large numerical exhibits must be submitted in Excel with active formulas retained.

Please number the response sections of the Actuarial Memorandum to match the numbering above. If the respondent's Actuarial Memorandum references information provided elsewhere in this solicitation response, please identify its exact location (file name, page number, SRC number, etc.).

Actuarial Memorandum and Certification Requirement – FFS PSNs

For respondents proposing to become a FFS PSN, the MMA Actuarial Memorandum and the LTC Actuarial Memorandum must each include the following information:

1. ***Proposed Administrative Allowance:*** Document the respondent's proposed administrative allowance for each rate group and region. Please document the following for each of the 12 administrative cost categories in the non-benefit expense cost proposal template:

   - Source of information used to develop the proposed administrative allowance
   - Methodology used to properly depreciate start-up costs (if applicable)
   - Methodology used to allocate administrative costs between MMA and LTC (if applicable)
   - Methodology used to allocate administrative costs to each rate group for MMA
   - Methodology used to allocate administrative costs to each rate group for LTC (if applicable)
   - Methodology used to allocate administrative costs to each rate region (if applicable)
   - The percentage of each administrative cost category that is related to local Florida plan expenses
   - The percentage of each administrative cost category that is allocated from a related corporate entity (such as a parent corporation)
   - Methodology used to allocate corporate expenses to the local entity (if applicable)
   - Expected volume of business used to develop the administrative allowance

   If different methodologies are used to allocate different types of costs, please document all applicable methodologies used.

2. ***Proposed Gain / Loss Margin:*** Document the respondent's proposed gain / loss margin for each rate group and region.

3. ***Membership:*** Document the respondent's sensitivity testing of the proposed administrative allowance and gain / loss margin to changes in the enrollment membership by rate group and region. Provide a detailed description of the methodology and provide testing results.

4. ***Actuarial Certification:*** The Actuarial Memorandum must include an actuarial certification signed by a qualified Member of the American Academy of Actuaries that the respondent's cost proposal is actuarially sound and complies with Actuarial Standard of Practice No. 49 – Medicaid Managed Care Capitation Rate Development and Certification, and that the proposed administrative allowance and gain / loss margin are projected to provide for all reasonable, appropriate, and attainable costs during the time period for which they are intended. Respondents proposing to become a Specialty Plan covering a new customized specialty population are allowed to submit a qualified actuarial certification. Respondents proposing to become any other SMMC plan type must submit an unqualified actuarial certification.

5. ***Supporting Exhibits:*** Large numerical exhibits must be submitted in Excel with active formulas retained.

Please number the response sections of the Actuarial Memorandum to match the numbering above. If the respondent's Actuarial Memorandum references information provided elsewhere in this solicitation response, please identify its exact location (file name, page number, SRC number, etc.).

II. MMA COST PROPOSAL TEMPLATE INSTRUCTIONS

This section of the cost proposal instructions and rate methodology narrative provides a detailed discussion of the Agency's MMA rate methodology and more detailed instructions for the MMA cost proposal template. This section applies only to respondents proposing to become capitated plans providing MMA services (i.e., this section does not apply to respondents proposing to become FFS PSNs). This section is organized into the following subsections:

A. Section A provides specific instructions for the MMA cost proposal that supplement the general SMMC cost proposal instructions presented in Section I of this document.

B. Section B provides an overview of the MMA cost proposal template.

C. Section C describes the MMA base data in the Agency's rate methodology and discusses issues for respondents to consider when selecting their base data.

D. Section D describes the MMA base data adjustments in the Agency's rate methodology and discusses adjustments respondents may make to their selected base data.

E. Section E discusses MMA projection assumptions that can be applied to the data.

F. Section F lists rate adjustments to exclude from respondent MMA cost proposals.

Please reference Section IV of the cost proposal instructions and rate methodology narrative for instructions related to the non-benefit expense cost proposal template for the MMA program.

A. MMA SPECIFIC COST PROPOSAL INSTRUCTIONS

In addition to the "General SMMC Cost Proposal Instructions" in Section I of this document, respondents must follow the specific MMA instructions provided below:

1. The Agency intends to negotiate actuarially sound MMA program capitation rates for each of the 11 mutually exclusive rate groups summarized in Table 3. Please refer to the MMA data book for a detailed description of each rate group. Note that each of the first ten rate groups in Table 3 is a unique population. The Agency currently funds medical services (excluding maternity services for non-dual eligible members) through capitation rates developed by rate group and paid to MMA capitated plans on a PMPM basis. The Agency currently funds maternity services (for all non-dual eligible MMA members) through a kick payment paid to MMA capitated plans once per delivery event. The MMA data book narrative describes the maternity services and delivery event definitions that must be used in the cost proposal, which are consistent with the current Maternity Kick Payment definition.

Table 3 Current MMA Program Rate Groups
TANF Non-SMI
TANF SMI
SSI Medicaid Only Non-SMI
SSI Medicaid Only SMI
SSI Dual Eligible
Child Welfare
HIV / AIDS Medicaid Only
HIV / AIDS Dual Eligible
LTC Medicaid Only
LTC Dual Eligible
Maternity Kick Payment

2. Respondents should prepare their MMA cost proposals for each rate group including members who historically received services through the following two delivery systems, as defined in the MMA data book:

    a. **MMA Capitated Plans,** including standard plans and specialty plans operating as part of the MMA program.

    b. **FFS Express Enrollment**, for populations enrolled in the Agency's FFS program during the historical data period that would now be enrolled in MMA under the Express Enrollment initiative that was implemented effective January 11, 2016.

3. Table 4 summarizes the information in items (4) – (8) below regarding the rate groups required to be included in the MMA cost proposal submission for each SMMC plan type.

Table 4
Statewide Medicaid Managed Care Program
MMA Cost Proposal Submission Requirements for Each SMMC Plan Type

Rate Group	Comprehensive	LTC Plus	MMA	HIV / AIDS	Child Welfare	SMI	Other
TANF Non-SMI	Yes	No	Yes	No	No	No	*
TANF SMI	Yes	No	Yes	No	No	Yes	*
SSI Medicaid Only Non-SMI	Yes	No	Yes	No	No	No	*
SSI Medicaid Only SMI	Yes	No	Yes	No	No	Yes	*
SSI Dual Eligible	Yes	No	Yes	No	No	Yes	*
Child Welfare	Yes	No	Yes	No	Yes	Yes	*
HIV / AIDS Medicaid Only	Yes	No	Yes	Yes	No	Yes	*
HIV / AIDS Dual Eligible	Yes	No	Yes	Yes	No	Yes	*
LTC Medicaid Only	Yes	Yes	No	No	No	No	No
LTC Dual Eligible	Yes	Yes	No	No	No	No	No
Maternity Kick Payment	Yes	Yes	Yes	Yes	Yes	Yes	*

** Other customized Specialty Plans should submit a full MMA cost proposal to the best of their ability. The capitated plan cost proposal template includes Worksheet M.11 for respondents proposing to become a new customized type of Specialty Plan.*

4. Respondents proposing to become a Comprehensive Plan must submit a cost proposal for each of the 11 rate groups.

5. Respondents proposing to become an LTC Plus Plan must submit an MMA cost proposal for the LTC Medicaid Only, LTC Dual Eligible, and Maternity Kick Payment rate groups only.

6. Respondents proposing to become an MMA Plan must submit a cost proposal for each of the 11 rate groups EXCEPT for the LTC Medicaid Only and LTC Dual Eligible rate groups.

7. Respondents proposing to become a Specialty Plan covering one of the existing MMA capitated plan specialty populations – HIV / AIDS, Child Welfare, or Serious Mental Illness (SMI) – must submit an MMA cost proposal for the applicable rate groups, as summarized below.

    a. HIV / AIDS Specialty Plan
        i. HIV / AIDS Medicaid Only rate group
        ii. HIV / AIDS Dual Eligible rate group
        iii. Maternity Kick Payment rate group (the cost proposal should reflect all members who may incur a delivery event that qualifies for a Maternity Kick Payment, not just HIV / AIDS members)

    b. Child Welfare Specialty Plan
        i. Child Welfare rate group
        ii. Maternity Kick Payment rate group (the cost proposal should reflect all members who may incur a delivery event that qualifies for a Maternity Kick Payment, not just Child Welfare members)

    c. SMI Specialty Plan
        i. TANF SMI rate group
        ii. SSI Medicaid Only SMI rate group
        iii. SSI Dual Eligible rate group (the cost proposal should reflect the entire rate group, not just SMI-specific rate cells)
        iv. Child Welfare rate group
        v. HIV / AIDS Medicaid Only rate group (the cost proposal should reflect the entire rate group, not just SMI-specific rate cells)
        vi. HIV / AIDS Dual Eligible rate group (the cost proposal should reflect the entire rate group, not just SMI-specific rate cells)
        vii. Maternity Kick Payment rate group (the cost proposal should reflect all members who may incur a delivery event that qualifies for a Maternity Kick Payment, not just SMI members)

8. Respondents proposing to become a Specialty Plan covering a new customized specialty population should submit a full MMA cost proposal to the best of their ability. If the respondent is offered a contract under this solicitation, the Agency will work with the respondent to define the customized specialty population and develop an actuarially sound method to determine appropriate capitation rates.

9. Respondents should complete a separate MMA cost proposal template for each region they are proposing to cover. Respondents should use a separate Excel file for each region. However, because the MMA cost proposal template is part of a single Excel file that also includes the LTC cost proposal template and the non-benefit expense cost proposal template, only one Excel template file that includes all three components (MMA, LTC when applicable, and non-benefit expenses) should be submitted for each region.

10. In MMA cost proposal template worksheets for rate groups that are not required for the respondent's chosen SMMC plan type, respondents should leave all inputs blank.

11. In the LTC cost proposal template (worksheet L.1), respondents proposing to become an MMA Plan or a Specialty Plan should leave all inputs blank.

12. Respondents must provide MMA cost proposals at a rate group level. The final negotiated capitation rates will be adjusted by standard rate cell factors to calculate final MMA capitation rates. For reference, Exhibit C-3 provides preliminary rate cell factors using the state fiscal year (SFY) 15/16 base data included in the data book and adjusted using the base data adjustments documented in Section II.D of the cost proposal instructions and rate methodology narrative. The Agency anticipates updating these factors using projected cost information when setting final capitation rates.

13. MMA cost proposals are to be quoted assuming a risk score of 1.0 for each rate group and region, where a risk score of 1.0 represents the average acuity of the SFY 15/16 population included in the data book for each rate group and region for the combination of the two delivery systems listed in item (2) above. Therefore, respondents using data other than the data book to complete the MMA cost proposal template are expected to normalize the data for differences between their population's risk score and 1.0 and provide supporting documentation in the Actuarial Memorandum.

14. MMA cost proposals are to be quoted assuming the SFY 15/16 data book distribution of members by rate cell within each rate group and region for the combination of the two delivery systems listed in item (2) above. Therefore, respondents using data other than the data book are expected to normalize the data for differences in their starting base data relative to the data book base data and provide supporting documentation in the Actuarial Memorandum.

15. MMA cost proposals are to be quoted considering the nature of the algorithm used by the Agency to identify the SMI population. Once a member gains the SMI designation, that member retains the SMI designation in all future time periods. Therefore, the acuity of the SMI population changes over time. The data book already adjusts historical periods to reflect the expected acuity of the SMI populations in RY 18/19. Respondents using data other than the data book will need to consider an adjustment to account for differences between their starting data and the expected acuity of both the SMI and Non-SMI populations in RY 18/19 and provide supporting documentation in the Actuarial Memorandum.

16. MMA cost proposals are to be quoted consistent with the current algorithm used by the Agency to identify the HIV / AIDS rate group. The data book already adjusts historical periods to reflect the current HIV / AIDS algorithm. Respondents using data other than the data book will need to consider an adjustment to account for differences between their starting data and the HIV / AIDS rate group in RY 18/19 and provide supporting documentation in the Actuarial Memorandum.

17. Respondents should exclude all state plan dental service costs when developing their cost proposals. Per 409.973 (5)(b) F.S., coverage of state plan dental services for Florida Medicaid members will be provided through a different managed care program and will be handled as part of a separate procurement process. For the purpose of the cost proposal, please assume all state plan dental services for procedure codes starting with "D" are excluded from the MMA program. The Agency retains the right to change covered and excluded codes.

B. MMA COST PROPOSAL TEMPLATE OVERVIEW

This section of the cost proposal instructions and rate methodology narrative provides an overview of the structure of the MMA cost proposal template. This section introduces each component of the MMA cost proposal template at a high level. Additional details about the base data, adjustments, and projection factor inputs are included in Sections II.C through II.E.

At a high level, the following worksheets are included in the MMA cost proposal template:

- Worksheets M.1 – M.10: Each existing MMA rate group (excluding the Maternity Kick Payment) has its own worksheet to project claim costs. Each of Worksheets M.1 through M.10 includes the following two components (each on a separate tab in Excel):
  - Section A, where respondents should enter their proposed base data and various adjustments as part of their cost proposals.
  - Section B, which includes a condensed summary of the information in Section A for each rate group. No input by respondents is needed on the Section B tabs.
- Worksheet M.11: Respondents proposing to become a Specialty Plan covering a new customized specialty population should complete this worksheet to project claim costs. Worksheet M.11 includes a Section A tab and a Section B tab, similar to Worksheets M.1 – M.10.
- Worksheet M.12: Respondents should complete this worksheet to project claim costs for the Maternity Kick Payment.

The worksheets are designed to allow respondents to enter information in the peach shaded cells in the top portion of the applicable worksheets to develop their cost proposals. Respondents must enter a numeric value into each and every peach cell on all required tabs for their chosen SMMC plan type (except for the Respondent Organization Name input, the Proposed Specialty Population input in Worksheet M.11, and the adjustment factor name inputs on the various tabs, which can be input as text). If numeric values are not entered into each and every required peach cell, the cost proposal template will not appropriately calculate a proposed capitation rate from the respondent's input base data and adjustments. If a particular adjustment factor, PMPM amount, or per delivery amount does not apply for a given region, rate group, or service category, respondents should enter a 1.000 multiplicative adjustment factor or a $0.00 additive cost in the required input cells to allow the cost proposal template to appropriately calculate a proposed capitation rate. Sections II.C – II.F of this document include additional details for each section of the MMA cost proposal template.

Additional information is provided by the Agency in the bottom portion of the applicable worksheets to assist respondents with completing the MMA cost proposal template. The bottom portion of Worksheets M.1 – M.10 (Section A) and M.12 are pre-populated to include the appropriate SFY 15/16 base data from the MMA data book based on the region and rate group listed in Cells D10 and D11 of each worksheet. The Agency also provides pre-populated adjustment factors for use with the SFY 15/16 base data for certain base data and provider contracting adjustments. More details regarding this information is included in Sections II.C – II.F. Note that Worksheet M.11 does not include pre-populated base data or adjustments due to the unknown nature of new specialty populations.

Each worksheet in the MMA cost proposal template is split into several components, as follows:

- Worksheets M.1 – M.10 are the MMA cost proposal templates for each of the existing rate groups listed in Table 3 other than the Maternity Kick Payment. Each worksheet has two components (found on separate tabs in the Excel template):

  – ***Section A – Buildup of Cost Proposal from Starting Base Data:*** Includes two primary sections – the detailed development of the respondent's MMA cost proposal in Rows 20 – 129, and additional information to assist respondents with completing the MMA cost proposal template in Rows 135 – 244. This tab includes the following column group components, which are discussed in the MMA data book narrative and in more detail in the remainder of this document:

    - Data Categories
    - Cost Proposal Base Period Data
    - Cost Proposal Adjustments to Starting Base Period Data
    - Adjusted Base Data
    - Trend
    - Provider Contracting Adjustments
    - Managed Care Savings Adjustments
    - Other Cost Proposal Adjustments (Multiplicative)
    - Other Cost Proposal Adjustments (Additive)
    - Projected Claim Cost

  – ***Section B – MMA Cost Proposal Summary:*** Includes a condensed summary of the information in Section A. No input by respondents is needed on this tab.

- Worksheet M.11 is the MMA cost proposal template for a custom specialty population rate group other than the rate groups listed in Table 3. Respondents completing this section should follow the same instructions as those provided for Worksheets M.1 – M.10. Unlike Worksheets M.1 – M.10, additional information to assist respondents with completing the MMA cost proposal template is not available given the unknown nature of new specialty populations. Specialty Plans completing this Worksheet must use alternative data sources to complete this worksheet. Similar to Worksheets M.1 through M.10, all respondent inputs are in Section A, and Section B includes a condensed summary of the information in Section A. Please note that Worksheet M.11, Section A includes an input in cell D11 where respondents completing Worksheet M.11 should enter a description of their proposed specialty population.

- Worksheet M.12 is the MMA cost proposal template for the Maternity Kick Payment. Worksheet M.12 includes similar information as Worksheets M.1 – M.10. Specifically, the tab includes two primary sections: the detailed development of the respondent's MMA cost proposal in Rows 21 – 29 of the worksheet, and additional information to assist respondents with completing the MMA cost proposal template in Rows 34 – 42. The column group headings are the same as those shown in Section A of Worksheets M.1 – M.11, but with fewer columns (since some adjustment factors do not apply when projecting a cost per delivery as opposed to a cost PMPM). Because Worksheet M.12 contains fewer service categories than Worksheets M.1 through M.11, Worksheet M.12 is not divided into Section A and Section B.

- There is a blank "Work Area" tab for respondents to use when compiling their MMA, LTC, or non-benefit expense cost proposals. It is provided as a workspace for respondents to use as needed to convey additional information to the Agency.

C. MMA BASE DATA

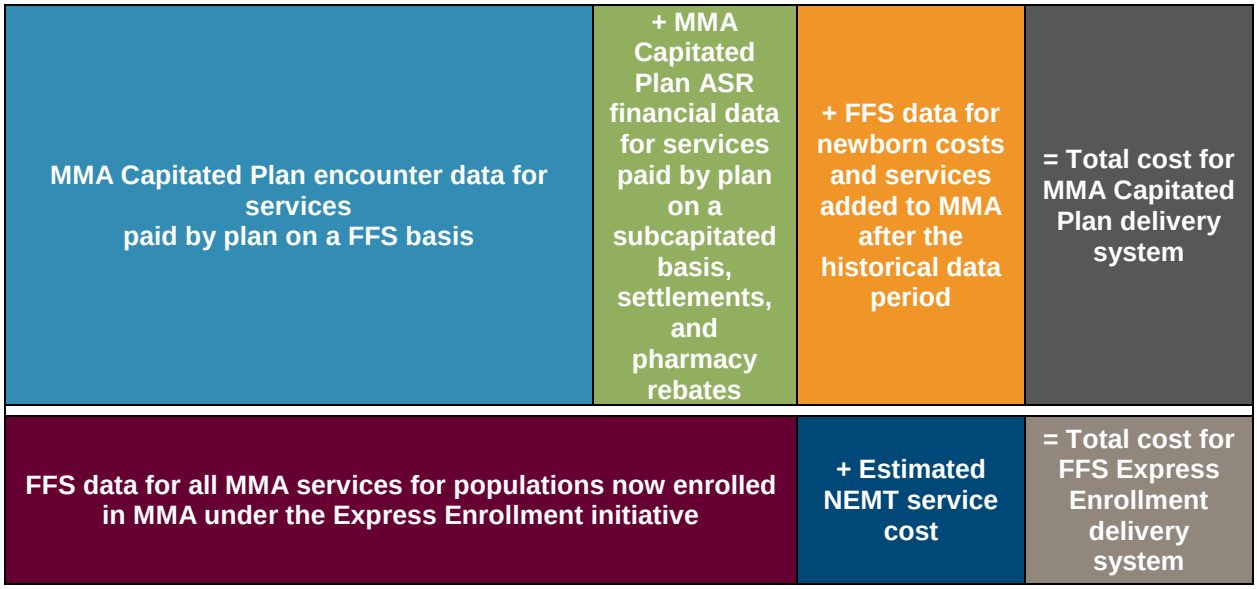
The first step in the Agency's rate methodology is establishing a set of base claims and enrollment data for each delivery system, rate group, region, and service category.

The Agency's rate methodology will use data from the MMA data book as its base data starting point to review respondent cost proposals. While the MMA data book provides multiple years of historical data, the Agency has selected the one-year time period of SFY 15/16 as its base data starting point. SFY 15/16 is the second full year of implementation of the MMA program, and as such, reflects the most recent available data and excludes the first year of the program where a significant portion of the population was transitioned into MMA from the FFS program. Additionally, given the size of the current MMA membership, one year of data provides a credible data set for cost proposal development. Respondents must consider the information in the MMA data book when developing their cost proposals and completing the cost proposal template, but they are not obligated to rely on it in developing their own proposals. Respondents are encouraged to develop and use other data sources as needed to prepare a competitive cost proposal.

Rows 135 – 244 (Worksheets M.1 – M.10, Section A) and Rows 34 – 42 (Worksheet M.12) of the MMA cost proposal template are pre-populated to include the appropriate SFY 15/16 base data from the MMA data book based on the region and rate group listed in Cells D10 and D11 of Worksheets M.1 – M.10 (Section A) and Worksheet M.12. Pre-populated base data is included in separate sections for the MMA Capitated Plan and FFS Express Enrollment delivery systems, with subtotals and blended amounts shown in Rows 137 – 139 (Worksheets M.1 – M.10, Section A) and Rows 36 – 38 (Worksheet M.12) of the MMA cost proposal template.

Figure 1 illustrates how the relevant data sources from the MMA data book are combined across the MMA Capitated Plan and FFS Express Enrollment delivery systems as part of the Agency's capitation rate methodology. The pre-populated base data in the bottom portion of Worksheets M.1 – M.10 (Section A) and Worksheet M.12 include the relevant data according to Figure 1 for the given rate group and respondent-selected region. As noted previously, the state plan dental service categories in the MMA data book are excluded because coverage of state plan dental services for Florida Medicaid members will be provided through a different managed care program. Additionally, similar to the summary exhibits in Appendix M-2 of the MMA data book, certain FFS data services provided to newborn members who will be immediately enrolled in MMA in the future are shown at a more aggregate level in the pre-populated base data than what is shown in the MMA data book database detail at the individual bucket level.

Figure 1 – Summary of MMA Population Data Sources for the MMA Capitated Plan and FFS Express Enrollment Delivery Systems



Please note that while non-emergency medical transportation (NEMT) data for the FFS Express Enrollment delivery system is excluded from the MMA data book due to concerns with the credibility of the data, an estimate of the SFY 15/16 NEMT service costs for this population is included as part of the Agency's base period data in the MMA cost proposal template. We estimated the claim cost PMPM for these services for each region and rate group based on the MMA Capitated Plan delivery system transportation claim cost PMPM, adjusted to exclude the ambulance claims that are already in the FFS data for the FFS Express Enrollment delivery system. The estimated NEMT costs for the FFS Express Enrollment delivery system are included in the "NEMT" line (Row 244 in Section A of Worksheets M.1 – M.10) of the pre-populated portion of the MMA cost proposal template.

Below are additional instructions for respondents related to completing the base data portion of the MMA cost proposal template:

- Respondent cost proposals must consider the combination of the MMA Capitated Plan and FFS Express Enrollment delivery system membership and base data to reflect the anticipated enrollment under the MMA program in RY 18/19, including selecting an appropriate blending percentage in the "Member Delivery System Blending Percentage" column of Worksheets M.1 – M.11 (Section A) and Worksheet M.12. However, respondents using data from a source other than the MMA data book may enter zero cost for the FFS Express Enrollment portion of the template if using data that completely reflects a time period when Express Enrollment was active (after January 11, 2016).

- The MMA cost proposal template service categories and delivery systems are defined in the MMA data book and cannot be changed by the respondents.

- Respondents must enter their choice of base data Claim Cost PMPM and Member Delivery System Blending Percentage in Cells M25 through M129 and Cell N23, respectively, of Section A of Worksheets M.1 – M.11 of the MMA cost proposal template. Please note that respondents should enter the Member Delivery System Blending Percentage for the MMA Capitated Plan delivery system in cell N23, and cell N24 will automatically populate with the complement of that value for the FFS Express Enrollment delivery system, such that the total percentages add up to 100%.

- Respondents must enter their choice of base data Claim Cost Per Delivery and Member Delivery System Blending Percentage in Cells K26 through K29 and Cell L24, respectively, of Worksheet M.12 of the MMA cost proposal template. Similar to Worksheets M.1 through M.11, respondents should enter the Member Delivery System Blending Percentage for the MMA Capitated Plan delivery system in cell L24, and cell L25 will automatically populate with the complement of that value for the FFS Express Enrollment delivery system, such that the total percentages add up to 100%.

- As discussed previously, respondents can choose to use the pre-populated base data in the MMA cost proposal template or alternate sources of base data to complete their cost proposals. Respondents are not restricted to the base data and summaries provided by the Agency for use in preparing the cost proposal. Respondents are allowed to develop and use other data sources as needed to prepare a competitive cost proposal.

- For non-dual eligible rate groups, maternity costs should be completely excluded from Worksheets M.1 – M.11 and included in Worksheet M.12 since they are part of the Maternity Kick Payment. For dual eligible rate groups, maternity costs should be included in Worksheets M.1 – M.11 in the corresponding non-maternity inpatient or professional service categories, since the Maternity Kick Payment does not apply for dual eligible rate groups. Please note that the MMA data book data already includes any maternity costs for dual eligible rate groups in the corresponding non-maternity inpatient or professional service categories.

- Respondents must use the same definitions for maternity services that the Agency uses in developing the Maternity Kick Payment and in triggering a Maternity Kick Payment. This is the same definition that underlies the maternity service categories in Worksheet M.12 of the MMA cost proposal template, and it is described in additional detail in the MMA data book narrative.

- Respondents must document the source of the base data used for developing the respondent's cost proposal, including the time period, covered population, data sources, justification for selecting the base data source, and other pertinent information as part of the Actuarial Memorandum to be submitted with the cost proposal.

D. MMA BASE DATA ADJUSTMENTS

The second step in the Agency's rate methodology is developing adjustments to the base data to account for issues related to historical data quality or completeness. The pre-populated base data adjustments in the Agency's rate methodology are described below, followed by additional instructions for respondents related to these adjustments. The Agency will apply the adjustments outlined in this section to the base data to assess the reasonability and competitiveness of respondent cost proposals. Respondents may want to consider these base data adjustments, but they are not obligated to use them in developing their own proposals. Respondents are encouraged to develop and use other data sources as needed to prepare a competitive cost proposal.

Expanded Benefit Adjustment

Expanded benefits are provided by the currently contracted MMA capitated plans outside of the capitation rates as part of their contract with the Agency. As discussed in the MMA data book narrative, the data book excludes any amounts reported by the capitated plans in the expanded benefits service category, since expanded benefits are funded by individual MMA capitated plans and are excluded from the medical costs used to set the MMA capitation rates. However, some MMA capitated plans have historically reported costs for expanded benefits in MMA-covered service categories rather than in the expanded benefits category. Therefore, the base data from the MMA data book needs to be adjusted to exclude the cost of expanded benefits not already excluded from the base data.

As part of the RY 17/18 MMA capitation rate development process, current MMA capitated plans provided supplemental information with the estimated value of additional expanded benefits not reported in the expanded benefits line. The expanded benefit adjustment is calculated in several different ways, depending on service category:

- The factors to remove some costs from the pharmacy categories were calculated based on an analysis of over-the-counter pharmacy costs not covered by Medicaid but included in the base period encounter data.

- The factors to remove additional costs from other encounter data service categories were based on additional expanded benefit costs identified by capitated plans but not reported in the expanded benefits category of the encounter data.

The pre-populated adjustments in Column P (Section A of Worksheets M.1 – M.10) or Column N (Worksheet M.12) of the MMA cost proposal template reflect the two components of the expanded benefit adjustment described above. For reference, Exhibit C-4 provides a summary of the pre-populated adjustment factors that can be applied to the pre-populated SFY 15/16 base data.

IBNR Adjustment

The SFY 15/16 base data that is pre-populated in the MMA cost proposal template includes varying amounts of claims payment runout. Therefore, the base data needs to be adjusted to include the IBNR claims liability for claims that are estimated to be paid after the paid through date of the base data. The pre-populated adjustments in Column Q (Section A of Worksheets M.1 – M.10) or Column O (Worksheet M.12) of the MMA cost proposal template are the Agency's estimated IBNR liability based on a detailed analysis of claims payment patterns by data source, service category, and rate group. For reference, Exhibit C-5 provides a summary of the pre-populated IBNR adjustment factors that can be applied to the SFY 15/16 base data.

Third Party Liability Adjustment

The Agency developed two adjustments related to TPL to adjust the base data to be net of any TPL collections, shown in the pre-populated adjustments in Column R (Section A of Worksheets M.1 – M.10) or Column P (Worksheet M.12):

- FFS Data: The FFS claims data provided by the Agency excluded certain TPL and fraud, waste, and abuse recoveries received outside the claims system. The Agency estimated a factor of 0.967 to account for these recoveries for SFY 15/16.

- Dual Eligible Populations: Some Medicaid members receive services as Medicaid-only members but later are retroactively identified as dual eligible members. As a result, their claims may have been initially paid assuming Medicaid was the primary payer. MMA Capitated Plan encounter and ASR financial data for dual eligible members does not always accurately reflect retroactive restatements. Therefore, using the resulting PMPM claim costs based on encounter and financial data for MMA Capitated Plan dual eligible members without adjustment would overstate the Medicaid costs for dual eligible members. The pre-populated adjustment factor (0.920 for the SSI Dual Eligible rate group, 1.000 for all other rate groups) reflects a reasonable expectation of the ability of capitated plans to pursue and recover claims payments for retroactive dual eligible members, based on analysis completed by the Agency.

Missing Data Acuity Adjustment

The pre-populated SFY 15/16 base data from the data book excludes data from capitated plans that did not report credible data as documented in the data book. The SFY 15/16 data needs to be adjusted to reflect the average acuity of the entire population including the excluded plans. The pre-populated adjustments in Column S (Section A of Worksheets M.1 – M.10) of the MMA cost proposal template are based on two considerations:

- An analysis of risk scores for the excluded plans compared to risk scores for the included plans by rate group, rate cell, and region

- An analysis of the mix of membership by rate cell within each rate group in each region, for the plans with all or some data excluded relative to the membership mix for plans with all data included

Additional Instructions for Respondents

Rows 135 – 244 (Section A of Worksheets M.1 – M.10) and Rows 34 – 42 (Worksheet M.12) of the MMA cost proposal template are pre-populated with the Agency-calculated adjustments to the pre-populated SFY 15/16 base data from the data book based on the region and rate group listed in Cells D10 and D11 of Worksheets M.1 – M.10 (Section A) and Worksheet M.12 of the MMA cost proposal template. Respondents can choose to use these adjustments or enter an alternate set of adjustments.

Below are additional instructions for respondents as they complete the base data adjustment section of the MMA cost proposal template:

- Respondents must make appropriate adjustments to the base data in Columns P – U (Section A of Worksheets M.1 – M.11) and Columns N – R (Worksheet M.12) of the MMA cost proposal template.

- Depending on what data the respondent selects for use as base data, the adjustments listed above may or may not be necessary. Respondents using alternate sources of base data must carefully consider how these adjustments need to be accounted for in their cost proposals.

- Respondents can use Columns T and U (Section A of Worksheets M.1 – M.11) or Columns Q and R (Worksheet M.12) of the MMA cost proposal template for any other base data adjustments applied to the base data not already described above and excluded from the other base data adjustment columns and the projection assumption columns. Respondents should enter a descriptive title in the peach shaded cells at the top of each “other” adjustment column where any values other than 1.000 are entered.

- The Actuarial Memorandum provided by respondents must clearly document the assumptions and methodology used in applying adjustments to the base data, particularly if the respondent uses an alternative data source.

E. MMA PROJECTION ASSUMPTIONS

The adjusted base data shown in Column V (Section A of Worksheets M.1 – M.11) or Column S (Worksheet M.12) of the MMA cost proposal template must be projected to RY 18/19 in order to produce the projected claims cost in the MMA cost proposal template. The Agency's rate methodology considers four types of projection adjustments:

- Trend adjustments
- Provider contracting adjustments
- Managed care savings adjustments
- Other adjustments (multiplicative or additive)

The rest of this section of the document discusses these four types of projection adjustments and provides additional instructions for respondents within each section.

Trend Adjustments

The adjusted base data calculated in Column V (Section A of Worksheets M.1 – M.11) or Column S (Worksheet M.12) must be projected to the midpoint of RY 18/19 (April 1, 2019) to account for expected changes in the utilization and unit cost of covered services. The pre-populated SFY 15/16 base data from the data book has a midpoint of January 1, 2016; therefore, it should be trended for 39 months in order to project cost to RY 18/19.

The Agency's rate methodology considers the following types of trend:

- ***Utilization Trend:*** These factors will be applied at a service category level in Column W of Worksheets M.1 – M.11 (Section A) of the MMA cost proposal template. Note that the Agency does not anticipate applying utilization trend to Maternity Kick Payment costs, given that the Maternity Kick Payment corresponds to a fixed basket of services. Any changes in the number of births from the base period to the projection period will result in corresponding changes in the number of kick payments made to capitated plans.

- ***Unit Cost Trend:*** These factors will be applied at a service category level in Column X of Worksheets M.1 – M.11 (Section A) and in Column T of Worksheet M.12 of the MMA cost proposal template. Respondents should **exclude** the impact of changes to Florida's FFS Medicaid reimbursement rates from SFY 15/16 to RY 18/19. The Agency will adjust the final negotiated rates to reflect the impact of changes in hospital, physician, and other FFS reimbursement rates and payment policies. Respondents should **include** unit cost trend to the RY 18/19 time period for prescription drug services.

Below are additional instructions for respondents as they complete the trend adjustment section of the MMA cost proposal template:

- Respondents using alternate sources of base data will need to calculate the trend period based on the midpoint of the base data to the midpoint of RY 18/19 (April 1, 2019).

- Each trend factor must be input as a one-time multiplicative factor to the adjusted base data (i.e., do not input annualized trends).

- Prescription drug trends should incorporate the program change that removed the review of a member's specific Metavir fibrosis score as a part of the prior authorization process to receive hepatitis C drug treatment (effective June 17, 2016). Prior to this change, The Agency's clinical authorization criteria required evidence that the member's Metavir fibrosis score was at least an F3 or F4. If the member's Metavir fibrosis score was lower than F3, the request had to be reviewed by a physician to determine medical necessity. Table 5 below illustrates the historical claim patterns observed after this program change was implemented, through the first quarter of 2017.

Table 5
Average Monthly Hepatitis C Drug Costs Relative to February 2016 – May 2016 Average Costs

Time Period	Relativity
July 2016 – December 2016	1.94
January 2017 – March 2017	1.48

- Trend adjustments must exclude the impact of base data adjustments, provider contracting adjustments, managed care savings adjustments, and other adjustments explicitly included in the MMA cost proposal template so that the impact of each factor is only considered once.

- All trend adjustments must clearly be documented in the Actuarial Memorandum. The trend adjustments must be described separately for unit cost and utilization trends and separately for each service category grouping used.

Provider Contracting Adjustments

The Agency's rate methodology includes multiplicative adjustments for changes in provider contracting levels from the base data period to RY 18/19. Columns Y – AA (Section A of Worksheets M.1 – M.11) or Columns U – W (Worksheet M.12) of the MMA cost proposal template are intended to adjust for changes in expected capitated plan provider contracting levels between the base period and RY 18/19. The adjustment factors are presented differently for hospital and professional services in the MMA Capitated Plan delivery system vs. all other services.

For hospital and professional services in the MMA Capitated Plan encounter data and ASR financial data (other than the "Hospital Inpatient FFS – Per Diem Psychiatric Hospital" service category), the adjustment includes two parts:

- ***Part 1: Back Out Historical Implied Contracting Levels to 100% of Medicaid FFS for Select Services:*** In Column Y (Section A of Worksheets M.1 – M.11) or Column U (Worksheet M.12) of the MMA cost proposal template, respondents should estimate the average provider contracting level compared to the Florida Medicaid FFS reimbursement rates in place during the base period. For example, if the average contracting level in the base period was 105% of Florida Medicaid FFS rates, the adjustment in this column would be calculated as 0.952 (= 1 / 1.05). The impact of this adjustment is to adjust the base period paid claims to estimate contracting at 100% of Florida Medicaid FFS rates.

The pre-populated adjustments shown in Rows 135 – 244 of Column Y (Section A of Worksheets M.1 – M.10) or in Rows 34 – 42 of Column U (Worksheet M.12) estimate SFY 15/16 provider contracting levels compared to Florida Medicaid FFS reimbursement rates based on plan survey responses weighted by MMA Capitated Plan encounter data and ASR financial data claims by rate group and region. For the dual eligible rate groups, the pre-populated Agency factors are labeled as "N/A" since we did not have credible data to calculate the contracting factors in these situations given that Medicare is the primary payer for most hospital and professional services provided to dual eligible members. Respondents should complete this column for all rate groups, including the dual eligible rate groups.

For reference, Exhibit C-6 provides the relative level of plan provider contracting compared to FFS reimbursement rates in effect during the SFY 15/16 time period by rate group, region, and broad service category based on reimbursement survey information reported by capitated plans covering members during this time period. The pre-populated adjustment factors in the MMA cost proposal template are calculated as 1 divided by the historical reimbursement levels.

- ***Part 2: Apply Expected Future Contracting Levels (Relative to Medicaid FFS) for Select Services:*** In Column Z (Section A of Worksheets M.1 – M.11) or Column V (Worksheet M.12) of the MMA cost proposal template, respondents should estimate their average RY 18/19 hospital contracting level compared to the Florida Medicaid FFS reimbursement rates in place during RY 18/19. For example, if a respondent estimates their average contracting level in RY 18/19 will be 102% of Florida Medicaid FFS rates, this adjustment should be entered as 1.020.

For all other services, the adjustment includes a single component:

- ***Overall Contracting Adjustment Relative to Historical Levels for Remaining Services:*** In Column AA (Section A of Worksheets M.1 – M.11) or Column W (Worksheet M.12) of the MMA cost proposal template, respondents should estimate their average provider contracting levels compared to the average contracting levels in the base period data.

  – For services paid by MMA capitated plans in the base period (i.e., encounter data and ASR financial data claims for the MMA Capitated Plan delivery system), the adjustment should reflect the respondent's estimated average contracting level compared to the average capitated plan contracting level in the base period. For example, if the respondent believes that its contracting level in the rate year will be 2% lower than the average of all capitated plans in the base period, this adjustment should be entered as 0.980.

  – For services paid by the FFS program in the base period (i.e., FFS data for members in the MMA Capitated Plan delivery system, as well as all claims for members in the FFS Express Enrollment delivery systems), the adjustment should reflect the respondent's estimated average contracting level compared to Florida Medicaid FFS rates. For example, if the respondent estimates its contracting level in RY 18/19 will be 102% of Florida Medicaid FFS rates, this adjustment should be entered as 1.020.

  – Exhibit C-6 provides the relative level of plan provider contracting compared to FFS reimbursement rates in effect during the SFY 15/16 time period by rate group, region, and broad service category based on reimbursement survey information reported by capitated plans covering members during this time period.

Below are additional instructions for respondents as they complete the provider contracting adjustments section of the MMA cost proposal template:

- Provider contracting adjustments must exclude the impact of base data adjustments, trend, managed care savings adjustments, and other adjustments explicitly included in the MMA cost proposal template so that the impact of each factor is only considered once.

- All provider contracting adjustments must be clearly documented in the Actuarial Memorandum.

Managed Care Savings Adjustments

The Agency's rate methodology includes consideration of additional managed care savings that respondents can achieve for both the MMA Capitated Plan base data and the FFS Express Enrollment base data compared to historical managed care efficiency.

Below are additional instructions for respondents as they complete the managed care savings adjustments section of the MMA cost proposal template:

- The MMA cost proposal template includes room for multiplicative adjustment factors to account for up to five different managed care savings initiatives in Columns AB – AF of Section A in Worksheets M.1 – M.11 and up to two different managed care savings initiatives in Columns X and Y in Worksheet M.12 of the MMA cost proposal template. If a respondent has more managed care initiatives than is allowed in the worksheets, the "Other Cost Proposal Adjustment" columns may be used to enter additional managed care adjustments.

- Respondents should enter a descriptive title in the peach shaded cells at the top of each managed care savings adjustment column where any values other than 1.000 are entered.

- Managed care savings adjustments must exclude the impact of base data adjustments, trend, provider contracting adjustments, and other adjustments explicitly included in the MMA cost proposal template so that the impact of each factor is only considered once.

- For each managed care savings adjustment provided, respondents must thoroughly document the following items in the Actuarial Memorandum that accompanies the MMA cost proposal template:

  – Description of the managed care initiative
  – Implementation timing
  – Involvement of other organizations
  – Internal or external costs of developing and administering the initiative
  – Development of net cost savings by rate group, region, historical delivery system, base data source, and service category. Include support for the data, assumptions, and methodology underlying the net savings projection.

Other Adjustments

Columns AG – AP (Section A of Worksheets M.1 – M.11) or Columns Z – AC (Worksheet M.12) of the MMA cost proposal template allow respondents to enter any other adjustments to their cost proposal that are not part of the Agency's rate methodology.

- ***Other Cost Proposal Adjustments (Multiplicative):*** Allows respondents to input other multiplicative adjustments. These adjustments must be input as a factor that will be applied to the base data. Input 1.000 if there is no adjustment.

- ***Other Cost Proposal Adjustments (Additive):*** Allows respondents to input other additive adjustments. These adjustments must be input as a PMPM amount (for Section A of Worksheets M.1 – M.11) or as a per delivery amount (for Worksheet M.12) to be added to the base data. Please note that since the base period costs have already been blended between the MMA Capitated Plan and FFS Express Enrollment delivery systems, each additive adjustment should be entered only once to determine the impact on the final proposed capitation rate. Respondents should enter additive adjustments in the rows for the MMA Capitated Plan delivery system only. (Respondent inputs for additive adjustments are not permitted in the rows for the FFS Express Enrollment delivery system.) Input $0.00 if there is no adjustment.

Respondents should enter a descriptive title in the peach shaded cells at the top of each "other" adjustment column where any values other than a 1.000 multiplicative factor, $0.00 PMPM, or $0.00 per delivery are entered. Note that any other adjustments that are made by respondents must exclude the impact of base data adjustments, trend, provider contracting adjustments, and managed care savings adjustments explicitly included in the MMA cost proposal template so that the impact of each factor is only considered once. Additionally, each of the other adjustments included in the respondent's cost proposal must be separately documented in the Actuarial Memorandum.

F. RATE ADJUSTMENTS EXCLUDED FROM MMA COST PROPOSAL

The following items are excluded from the cost proposal and capitation rate negotiation process for the MMA program. As described in Section I, respondents must include a statement in the Actuarial Memorandum that their cost proposal excludes adjustments for the items shown here. The Agency will adjust the final negotiated capitation rates to reflect the impact of these items as necessary:

1. Any seasonality adjustments needed for differences in timing between the RY 18/19 period assumed for the cost proposal and the actual program implementation schedule.

2. Adding nursing facility services for adults that are excluded from the SMMC LTC program as a covered benefit under MMA. The projected cost of these services is not available at this time due to issues related to LTC program Express Enrollment. The Agency retains the right to pay capitation rates adjusted for individual patient responsibility each month. This applies to MMA nursing facility and hospice services.

3. Subject to CMS approval, transition of Medicaid recipients receiving home and community-based waiver services through the Project AIDS Care, Traumatic Brain Injury, and Adult Cystic Fibrosis waivers into the LTC Program, which will move these members into the LTC Medicaid Only or LTC Dual Eligible rate groups.

4. Implementation of LTC program Express Enrollment, which will transition more members into the LTC Medicaid Only and LTC Dual Eligible rate groups faster.

5. The enrollment of certain CMSN members into MMA capitated plans resulting from the Florida Department of Health's rescreening process that identified CMSN members that did not meet current CMSN enrollment criteria. This program change transitioned more members into MMA capitated plans during the second half of 2015.

6. Restructuring of the existing MMA rate group structure, risk adjustment process, or other changes, if necessary, to develop actuarially sound rate mechanisms for any new specialty populations covered by one or more Specialty Plans.

7. Application of final rate cell factors to final negotiated rates by rate group and region.

8. Florida Medicaid FFS hospital, physician, and other provider reimbursement rates in effect for RY 18/19.

9. Costs related to the inclusion of the Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) wraparound payments which make up the difference between capitated plan payments and the Agency's encounter reimbursement rates.

10. Costs related to the MMA Physician Incentive Program (MPIP). The MMA data book data reflects a time period prior to the October 2016 implementation of the MPIP and therefore fully excludes all costs associated with the MPIP.

11. Compliance with the Medicaid managed care regulation published by the Centers for Medicare and Medicaid Services that disallows capitation payments eligible for the federal match for members aged 21 to 64 with a stay of more than 15 days in a given calendar month in an Institute for Mental Disease (IMD).

12. The July 1, 2016 program change that provided Medicaid eligibility to lawfully residing children if they meet all other eligibility requirements (previously, most children had to be lawfully residing in the United States at least five years before they qualified for Medicaid services).

13. Development of the medical school faculty physician group value based purchasing arrangement (if necessary).

14. Development of the revised organ transplant kick payment amount.

15. Development of the Behavioral Health Reform Waiver Services enhanced payment amount for temporary housing assistance and other supportive behavioral health services.

16. Other program changes excluded from the cost proposal instructions and rate methodology narrative.

17. Costs related to the federal health insurance provider fee (HIPF).

III. LTC COST PROPOSAL TEMPLATE INSTRUCTIONS

This section of the cost proposal instructions and rate methodology narrative provides a detailed discussion of the Agency's LTC rate methodology and more detailed instructions for the LTC cost proposal template. This section applies only to respondents proposing to become capitated plans providing LTC services (i.e., this section does not apply to respondents proposing to become FFS PSNs). This section is organized into the following subsections:

A. Section A provides specific instructions for the LTC cost proposal that supplement the general SMMC cost proposal instructions presented in Section I of this document.

B. Section B provides an overview of the LTC cost proposal template.

C. Section C describes the LTC base data in the Agency's rate methodology and discusses issues for respondents to consider when selecting their base data.

D. Section D describes the LTC base data adjustments in the Agency's rate methodology and discusses adjustments respondents may make to their selected base data.

E. Section E discusses LTC projection assumptions that can be applied to the data.

F. Section F lists rate adjustments to exclude from respondent LTC cost proposals.

Please reference Section IV of the cost proposal instructions and rate methodology narrative for instructions related to the non-benefit expense cost proposal template for the LTC program.

A. LTC SPECIFIC COST PROPOSAL INSTRUCTIONS

In addition to the "General SMMC Cost Proposal Instructions" in Section I of this document, respondents must follow the specific LTC instructions provided below:

1. The Agency intends to negotiate actuarially sound LTC program capitation rates for the following two mutually exclusive rate groups:

    a. Home and community based services (HCBS)
    b. Non-HCBS

    For a particular rate period, LTC members enrolled prior to the start of the period are assigned to a rate group consistent with the most recent location of care (LOC) identifiable in the three months prior to the rate period (i.e., July to September 2017 for the October 2017 – September 2018 rate period). If the most recent LOC is an institution (nursing facility or hospice) the member is assigned to the Non-HCBS rate group. If the most recent LOC is in the community the member is assigned to the HCBS rate group. New LTC members are assigned to a rate group based on an examination of their service utilization patterns or eligibility shortly prior to SMMC LTC enrollment. Member rate group assignment does not change during a rate period unless new information becomes available about the LOC utilized by the new member *prior* to the rate period.

2. Capitation payments to capitated plans are based on a blend of the HCBS and non-HCBS monthly regional rates according to the capitated plan-specific mix of members across the rate groups, adjusted for a legislated "transition percentage", as outlined in 409.983(5), Florida Statutes. As part of the legislation, the transition percentage of 3% for RY 18/19 is applied until no more than 35% of a capitated plan's members in a particular region are located in institutional settings. Respondents should not apply any adjustments for the blending of the HCBS and non-HCBS rates in their cost proposal or the 3% transition percentage.

3. The Agency currently reimburses LTC plans monthly net of the projected average patient responsibility values. Therefore, all values included in the LTC cost proposal should be net of patient responsibility. The Agency retains the right to change from paying capitation rates reflecting the average patient responsibility to those adjusted for individual member level responsibility each month. This applies to LTC nursing facility, hospice, and community services. If the capitation rate payment basis changes, negotiated rates will be adjusted to be gross of patient responsibility.

4. Respondents proposing to become a Comprehensive Plan or an LTC Plus Plan must submit an LTC cost proposal. Respondents proposing to become an MMA Plan or Specialty Plan should not submit an LTC cost proposal.

5. Respondents should complete a separate LTC cost proposal template for each region they are proposing to cover. Respondents should use a separate Excel file for each region. However, because the LTC cost proposal template is part of a single Excel file that also includes the MMA cost proposal template and the non-benefit expense cost proposal template, only one Excel template file that includes all three components (MMA, LTC, and non-benefit expenses) should be submitted for each region.

B. LTC COST PROPOSAL TEMPLATE OVERVIEW

This section of the cost proposal instructions and rate methodology narrative provides an overview of the structure of the LTC cost proposal template. This section introduces each component of the LTC cost proposal template at a high level. Additional details about the base data, adjustments, and projection factor inputs are included in Sections III.C through III.E.

Worksheet L.1 is the only worksheet in the LTC cost proposal template. At a high level, Worksheet L.1 is designed to allow respondents to enter information in the peach shaded cells. Respondents must enter a numeric value into each and every peach cell on all required tabs for their chosen SMMC plan type (except for the Respondent Organization Name input and the adjustment factor name inputs on the various tabs, which can be input as text). If numeric values are not entered into each and every required peach cell, the cost proposal template will not appropriately calculate a proposed capitation rate from the respondent's input base data and adjustments. If a particular adjustment factor or PMPM amount does not apply for a given region, rate group, or service category, respondents should enter a 1.000 multiplicative adjustment factor or a $0.00 PMPM additive cost in the required input cells to allow the cost proposal template to appropriately calculate a proposed capitation rate.

The top section of the Worksheet L.1 is for the HCBS rate group and the bottom section is for the Non-HCBS rate group. Sections III.C - III.F of this document include additional details for each section of the LTC cost proposal template.

Worksheet L.1 is split into several components, as follows:

- Data Categories

- Agency Starting Point Base Period Data for October 2018 – September 2019 Capitation Rate Certification
- Cost Proposal Base Period Data
- Cost Proposal Adjustments to Starting Base Period Data
- Adjusted Base Data
- Trend
- Provider Contracting Adjustments
- Managed Care Savings Adjustments
- Other Cost Proposal Adjustments (Multiplicative)
- Other Cost Proposal Adjustments (Additive)
- Projected Service Cost

There is also a blank "Work Area" tab for respondents to use when compiling their LTC, MMA, or non-benefit expense cost proposals. It is provided as a workspace for respondents to use as needed to convey additional information to the Agency.

C. LTC BASE DATA

The first step in the Agency's rate methodology is establishing a set of base claims and enrollment data for the HCBS and Non-HCBS rate groups, for each region and service category.

The Agency's rate methodology will use data from the LTC data book as its base data starting point to review respondent cost proposals. While the LTC data book summarizes historical enrollment and claims information from the following data sources for the first three rate years of the LTC program, the Agency has selected the one-year time period of RY 15/16 as its base data starting point, which is the most recent, complete rate year available. Respondents must consider the information in the LTC data book when developing their cost proposals and completing the cost proposal template, but they are not obligated to rely on it in developing their own proposals. Respondents are encouraged to develop and use other data sources as needed to prepare a competitive cost proposal.

- Eligibility Files – Detailed eligibility files from the Agency enrollment system.

- Encounter Data – Encounter data submission to the Agency for the purpose of capitation rate setting.

- 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 rate groups.

LTC capitation rates are paid to capitated plans as a blend of HCBS and non-HCBS rate groups, with a mandated transition percentage per year from non-HCBS to HCBS until a 65% HCBS penetration is realized within a region by a plan. This transition percentage was 2% in RY 13/14 and RY 14/15 and increased to 3% for RY 15/16 and beyond. Each year, members are assigned a flag that assigns the member to a particular rate group for the entire rate year.

Since the rate group transition impact is applied outside of the HCBS and Non-HCBS rate group rate development, it is imperative that the base data and the resulting rate for each rate group exclude the impact of historical member transitions between locations of care that would trigger a new rate group flag for the next rate year and consider only the base experience based on the projected rate group basis for each member.

There is no perfect way to know the location of care (nursing facility and institutional hospice versus other) in which members would have been treated in absence of member rate group transitions. However, looking at the location of care for the first and last months of the experience period, as well as the timing of any location changes, a reasonable approximation of the rate group costs absent member transitions can be created. Such an algorithm only shifts historical membership and service costs between rate groups and does not change the historical experience in total. The application of this algorithm converts the experience from a historical rate group basis to a projected rate group basis. Please refer to the LTC data book for additional information on the projected rate group basis algorithm.

In the LTC data book both the encounter data and ASR financial data for RY 15/16 are shown under a historical rate group basis and a projected rate group basis. This base data on a projected rate group basis from Exhibits 3C and 3D in the LTC data book are included in Columns F to H of the LTC cost proposal template.

Encounter data and ASR financial data for RY 15/16 were blended together using weights between 15% and 50% of encounter data, varying based upon the regional relationships between the data sources. The ASR data is generally recognized as the most accurate picture of LTC program expenditures, and the annual ASR reports are formally audited. Therefore we place more weight on the ASR data when there are discrepancies between the ASR data and encounter data. The specific weights were chosen to meet the following criteria at a regional level:

- Because of modest concerns about the allocation of members and costs between the HCBS and non-HCBS rate groups in the ASR data, the same encounter data weighting was applied to both rate groups within each region.

- Larger weights were applied to encounter data in regions with smaller variances between ASR data and encounter data.

- The total impact of blending data sources, combined across rate groups, decreases as the variation between ASR data and encounter data decreases.

- The total impact of blending data sources using the chosen blending percentages does not change the base data in comparison to the ASR data, combined across rate groups, by more than 0.5% in any given region.

- ASR data was solely relied upon for the following services due to underreporting in the encounter data:

  – Case Management Services
  – Subcapitated LTC Services
  – LTC Service Settlements
  – TPL and Fraud / Abuse Recoveries
  – Incentive Payments

The blending percentages are shown in Column I of the LTC cost proposal template.

The result of blending encounter data and ASR data reduces the total LTC services by 0.17% across both the HCBS and Non-HCBS rate groups on a statewide basis compared to solely using ASR data. Blended base data is shown in Column J of the LTC cost proposal template. Respondents can choose to use this starting data or an alternate set of base data to develop their cost proposal.

The base data the respondent uses as the starting basis for their cost proposal should be input in Column K of the LTC cost proposal template.

D. LTC BASE DATA ADJUSTMENTS

The second step in the Agency's rate methodology is developing adjustments to the base data to account for issues related to historical data quality or completeness. The Agency will apply the adjustments outlined in this section to the base data to assess the reasonability and competitiveness of respondent cost proposals. Respondents may want to consider these base data adjustments, but they are not obligated to use them in developing their own proposals. Respondents are encouraged to develop and use other data sources as needed to prepare a competitive cost proposal.

Note that the expanded benefit, TPL, and missing data acuity adjustments that are part of the Agency's MMA rate methodology are not relevant to the Agency's LTC rate methodology because these adjustments do not apply to the LTC base data.

IBNR Adjustment

Neither the encounter data nor ASR data in the LTC data book were adjusted for estimates of IBNR claims after the paid dates shown in Table 5 below. Therefore, the base data needs to be adjusted to include the IBNR claims liability for claims that are estimated to be paid after the paid through date of the base data.

Table 5
Paid Date by Data Period

Data Period	Paid Date Cutoff
Q3 2013 – Q4 2013	March 31, 2014
Q1 2014 – Q4 2014	March 31, 2015
Q1 2015 – Q4 2015	March 31, 2016
Q1 2016 – Q3 2016	December 31, 2016

For reference, Column L includes pre-populated IBNR adjustments that can be applied to the RY 15/16 data book information based upon IBNR estimates included in the ASR data for this time period. Please note that the IBNR estimates in the ASRs are across all services and are not available at a detailed category of service level. The respondent can choose to use these adjustments or enter an alternate set of adjustments in Column M of the LTC cost proposal template. Respondents using alternate sources of base data must carefully consider how the IBNR adjustment needs to be accounted for in their cost proposals.

Other Base Data Adjustments

Other adjustments to the base data should be input in Columns N and O of the LTC cost proposal template. Respondents should enter a descriptive title in the peach shaded cells at the top of each "other" adjustment column where any values other than 1.000 are entered.

E. LTC PROJECTION ASSUMPTIONS

The adjusted base data in Column P must be projected to RY 18/19 in order to produce the projected service cost in the LTC cost proposal template. The Agency's rate methodology considers four types of projection adjustments:

- Trend adjustments
- Provider contracting adjustments
- Managed care savings adjustments
- Other adjustments (multiplicative or additive)

The rest of this section of the document discusses these four types of projection adjustments and provides additional instructions for respondents within each section.

Trend Adjustments

The adjusted base data in Column P must be projected to the midpoint of RY 18/19 (April 1, 2019) to account for expected changes in the utilization and unit cost of covered services. The pre-populated RY 15/16 base data from the data book has a midpoint of April 1, 2016; therefore, it should be trended for 36 months in order to project cost to RY 18/19.

The Agency's rate methodology considers the following types of trend.

- ***Utilization Trend:*** These factors will be applied at a service category level in Column Q of Worksheet L.1. These utilization trends should also include any service mix or "acuity intensity" PMPM impacts within each rate group anticipated when members transition between rate groups. However, utilization trend *should exclude* the impact of lower nursing facility utilization *across rate groups* attributable to increased community-based treatment over time.

- ***Unit Cost Trend:*** These factors will be applied at a service category level in Column R of Worksheet L.1. The Agency will reprice all nursing and hospice facility claims in the base data to the September 1, 2018 per diems once available. ***Therefore, respondents should enter 1.00 trend values for the nursing facility and hospice lines.*** If values other than 1.00 are input the respondent must provide an explanation in the LTC Actuarial Memorandum.

Below are additional instructions for respondents as they complete the trend adjustment section of the LTC cost proposal template:

- Respondents using alternate sources of base data will need to calculate the trend period based on the midpoint of the base data to the midpoint of RY 18/19 (April 1, 2019).

- Each trend factor must be input as a one-time multiplicative factor to the adjusted base data (i.e., do not input annualized trends).

- Trend adjustments must exclude the impact of base data adjustments, provider contracting adjustments, managed care savings adjustments, and other adjustments explicitly included in the LTC cost proposal template so that the impact of each factor is only considered once.

- All trend adjustments must clearly be documented in the Actuarial Memorandum. The trend adjustments must be described separately for unit cost and utilization trends and separately for each service category grouping used.

Provider Contracting Adjustments

The Agency's rate methodology includes multiplicative adjustments for changes in provider contracting levels from the base data period to RY 18/19. Column S of the LTC cost proposal template is intended to adjust for changes in expected capitated plan provider contracting levels between the base period and RY 18/19.

Capitated plans must pay the Agency's published per diem fee schedules for nursing facilities and hospice facilities. ***Therefore a 1.00 should be entered in Column S for these services.*** If values other than 1.00 are input the respondent must provide an explanation in the LTC Actuarial Memorandum.

For all other services, respondents should estimate their average provider contracting levels compared to the average contracting levels in the base period data. For services paid by LTC capitated plans in the base period, the adjustment should reflect the respondent's estimated average contracting level compared to the average capitated plan contracting level in the base period. For example, if the respondent believes that its contracting level in the rate year will be 2% lower than the average of all capitated plans in the base period, the adjustment in Column S should be entered as 0.980.

Below are additional instructions for respondents as they complete the provider contracting adjustments section of the LTC cost proposal template:

- Provider contracting adjustments must exclude the impact of base data adjustments, trend, managed care savings adjustments, and other adjustments explicitly included in the LTC cost proposal template so that the impact of each factor is only considered once.

- All provider contracting adjustments must be clearly documented in the Actuarial Memorandum.

Managed Care Savings Adjustments

The Agency's rate methodology includes consideration of additional managed care savings that respondents can achieve compared to historical managed care efficiency.

Cost savings to be achieved by the respondent relative to the base period data used in the cost proposal should be input as multiplicative factors in Columns T to X of the LTC cost proposal template. If a respondent has more managed care initiatives than is allowed in the worksheet, the "Other Cost Proposal Adjustment" columns may be used to enter additional managed care adjustments. For each managed care savings adjustment provided, respondents must thoroughly document the following items in the Actuarial Memorandum that accompanies the LTC cost proposal template:

- Description of the managed care initiative
- Implementation timing
- Involvement of other organizations
- Internal or external costs of developing and administering the initiative
- Development of net cost savings by rate group, region, and service category. Include support for the data, assumptions, and methodology underlying the net savings projection.

Respondents should enter a descriptive title in the peach shaded cells at the top of each managed care savings adjustment column where any values other than 1.000 are entered. Managed care savings adjustments must exclude the impact of base data adjustments, trend, provider contracting adjustments, and other adjustments explicitly included in the LTC cost proposal template so that the impact of each factor is only considered once.

Other Adjustments

Columns Y to AH of the LTC cost proposal template allow respondents to enter any other adjustments to their cost proposal that are not part of the Agency's rate methodology.

- ***Other Cost Proposal Adjustments (Multiplicative):*** Allows respondents to input other multiplicative adjustments. These adjustments must be input as a factor that will be applied to the base data. Input 1.00 if there is no adjustment

- ***Other Cost Proposal Adjustments (Additive):*** Allows respondents to input other additive adjustments. These adjustments must be input as a PMPM amount to be added to the base data. Input $0.00 if there is no adjustment.

Respondents should enter a descriptive title in the peach shaded cells at the top of each "other" adjustment column where any values other than a 1.000 multiplicative factor or $0.00 PMPM are entered. Note that any other adjustments that are made by respondents must exclude the impact of base data adjustments, trend, provider contracting adjustments, and managed care savings adjustments explicitly included in the LTC cost proposal template so that the impact of each factor is only considered once. Additionally, each of the other adjustments included in the respondent's cost proposal must be separately documented in the Actuarial Memorandum.

F. RATE ADJUSTMENTS EXCLUDED FROM LTC COST PROPOSAL

The following items are excluded from the cost proposal and capitation rate negotiation process for the LTC program. As described in Section I, respondents must include a statement in the Actuarial Memorandum that their cost proposal excludes adjustments for the items shown here. The Agency will adjust the final negotiated capitation rates to reflect the impact of these items as necessary.

Nursing Facility / Hospice Rate Changes

The nursing facility and hospice facilities per diem rates are updated effective September 1 of each year. Milliman will reprice all nursing and hospice facility claims in the base data to the September 1, 2018 per diems once the amounts are available and will apply the repricing adjustment to the negotiated rates.

Community High Risk Pool (CHRP)

In addition to separate HCBS and non-HCBS rate group blending, the LTC program also includes a budget-neutral CHRP risk mitigation mechanism for the HCBS rate group. A percentage of HCBS rates is withheld to fund the CHRP. Seventy-five percent of member expenditures greater than $7,500 per month ("pooled claims") 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 regional pooled claims will be funded on a proportional basis for each capitated plan. If CHRP funds exceed the level of pooled claims, excess CHRP funds will be returned to capitated plans on a PMPM basis. The Agency retains the right to update the withhold percentage on a quarterly basis, if needed. Inclusion of this information does not imply the continued use of CHRP, and it does not imply that the methodology of CHRP will stay the same if it continues.

Respondents should not adjust their HCBS estimates to reflect projected withholds or recoveries from the CHRP.

Transition Percentage

Capitation payments to capitated plans are based on a blend of the HCBS and non-HCBS rate group monthly rates according to the capitated plan-specific mix of members across the rate groups, adjusted for a legislated "transition percentage", as outlined in 409.983(5), Florida Statutes. As part of the legislation, the transition percentage is applied until no more than 35% of a capitated plan's members in a particular region are placed in institutional settings. The transition percentages are as follows:

- Rate Year 13/14 – 2%
- Rate Year 14/15 – 2%
- Rate Year 15/16 and later – 3%

Respondents should not apply any adjustments for the blending of the HCBS and non-HCBS rates in their cost proposal.

Patient Responsibility Changes

The Agency currently reimburses LTC plans monthly net of the projected average patient responsibility values. It then periodically settles retrospectively with plans to actual patient responsibility amounts. If the change in patient responsibility, on a percentage basis, is greater than the overall cost change for those members, then costs on a net basis will be dampened. If the change in patient responsibility is lower than the overall cost change for those members, then costs on a net basis will be amplified. The Agency will adjust the respondent's cost proposal for the impact of changes in patient responsibility between the base period and RY 18/19.

The Agency retains the right to change from paying capitation rates reflecting the average patient responsibility to those adjusted for individual member level responsibility each month. This applies to LTC nursing facility, hospice, and community services. If the capitation rate payment basis changes, negotiated rates will be adjusted to be gross of patient responsibility.

Seasonality Adjustment

The Agency will adjust the final negotiated rates for any seasonality adjustments needed for differences in timing between the RY 18/19 period assumed for the cost proposal and the actual program implementation schedule.

Program Changes

The following program changes are anticipated to have a material impact to the LTC program. The Agency will adjust the final negotiated rates to reflect the impact of these items as necessary.

1. The following waiver populations will transition into the LTC program for receipt of their home and community-based services, subject to CMS approval:

    a. Project AIDS Care
    b. Traumatic Brain and Spinal Cord Injury
    c. Adult Cystic Fibrosis

2. Implementation of LTC program Express Enrollment, which will enroll members into the LTC program more quickly.

3. Other program changes excluded from the cost proposal instructions and rate methodology narrative.

IV. NON-BENEFIT EXPENSE COST PROPOSAL TEMPLATE INSTRUCTIONS

This section of the cost proposal instructions and rate methodology narrative provides detailed instructions for the non-benefit expense cost proposal template. This section applies to all respondents, including all SMMC plan types and both capitated plans and FFS PSNs. All respondents must complete the non-benefit expense cost proposal template for each individual rate region in which they are proposing to participate in the SMMC program.

The Agency's rate methodology will consider an allowance for respondents' administrative costs and gain / loss margin. Worksheet N.1 is the non-benefit expense cost proposal template for all SMMC plan types. In the capitated plan cost proposal template, Worksheet N.1 is included as one of the worksheets (along with the MMA cost proposal template worksheets and the LTC cost proposal template worksheets). In the FFS PSN cost proposal template, Worksheet N.1 is included as the primary worksheet for the cost proposal.

Respondents completing the capitated plan cost proposal template should complete the applicable MMA cost proposal template and LTC cost proposal template worksheets before completing the non-benefit expense cost proposal template worksheet. The non-benefit expense cost proposal template for capitated plans uses conditional formatting to apply dark shading to the rows for the rate groups that do not include a calculated projected service cost in the MMA or LTC worksheets. As a result, after a respondent completes the appropriate MMA and LTC worksheets (depending on the respondent's chosen SMMC plan type), respondents only need to complete the rows for the rate groups that are not shaded. Respondents should enter 0 member months, 0 deliveries, $0.00 PMPM, or $0.00 per delivery in the peach cells in the rows that are shaded.

Respondents must provide the following information in Worksheet N.1 of the cost proposal template for the applicable rate groups. The information varies slightly between the capitated plan cost proposal template and the FFS PSN cost proposal template, as indicated below.

- ***Historical Regional Member Months (Delivery Count for Maternity Kick Payment):*** Automatically calculates the number of member months or deliveries for each rate group for the region (excluding new specialty populations), using SFY 15/16 member months and delivery counts for the MMA program and October 2015 – September 2016 member months on a projected rate group basis for the LTC program. Note that this section is formula driven, so no input by the respondent is needed.

- ***Respondent Assumed Member Months (Delivery Count for Maternity Kick Payment):*** Respondents must input their assumed member months or delivery count by rate group. The Actuarial Memorandum should document how the respondent's administrative costs would change given a different level of awarded member months.

- ***Proposed Administrative Allowance:*** Respondents must enter their proposed administrative allowance in Worksheet N.1 of the cost proposal template. The administrative allowance must be input on a PMPM basis (per delivery for the Maternity Kick Payment) with administrative costs divided among the categories based on the definitions shown in Table 6. Respondents can vary the input administrative allowances by rate group and region.

Table 6
Administrative Cost Categories for Non-Benefit Expense Cost Proposal Template

Administrative Cost Category	Description
Claims	Mailroom and Claims Preparation Data Capture Adjudication COB / TPL / Subrogation Adjustments and Rework Audit and Training Claim System File Setup and Configuration Management and Administration
Provider Network Development and Management	Provider Service Provider Appeals Provider Contracting Credentialing Provider Profiling Management and Administration
Customer Service	Customer Service Calls and Education Customer Complaints and Grievances Training and Auditing Management and Administration
Membership	Enrollment, Termination, Change Premium Billing and Reconciliation Management and Administration
Utilization Review	Utilization Review, Referral, and Authorization Management and Administration
Quality Management	Quality Management (Clinical Quality) Management and Administration
Case and Disease Management	Case Management[1] Disease Management Wellness and Health Coaching Management and Administration
Other Healthcare Services	Medical Directors Medical Policy Development and Management Medical Informatics Behavioral Health Management Pharmacy Services and Management Other Healthcare Services Management and Administration
Business Development / Marketing / Sales	Advertising and Promotion Product Development and Management Market Research Sales, Account Management, and Sales Support Communication and Materials Management and Administration

Table 6 (Continued)
Administrative Cost Categories for Non-Benefit Expense Cost Proposal Template

Administrative Cost Category	Description
Finance	Accounting Finance Financial Reporting Actuarial and Rating Experience and Trend Reporting Management and Administration
Information Systems	Operations and Support Systems, Network, and Desktop Maintenance Software Setup and Maintenance Development and Integration Application Development and Programming Data Exchange, Warehouse and Analytics Management and Administration
Other Management and Administration	Executive Leadership (CEO, COO) and Support Human Resources Legal Compliance and Risk Management Public Policy and Communication Facilities and Purchasing Other

[1] *All MMA case management costs, as well as indirect LTC case management costs (e.g., supervision of case managers) should be included as non-benefit expenses. For the LTC program, direct case management costs should be excluded from the non-benefit expenses; respondents completing the LTC cost proposal template should instead include direct case management costs in Worksheet L.1.*

- ***Total Administrative Allowance:*** Automatically calculates the administrative allowance on a PMPM basis (per delivery for the Maternity Kick Payment). Note that this section is formula driven, so no input by the respondent is needed.

- ***Gain / Loss Margin:*** Respondents must enter their proposed gain / loss margin in Worksheet N.1 of the cost proposal template. The gain / loss margin must be stated as a PMPM amount (per delivery for the Maternity Kick Payment) and can vary by rate group and region.

- ***(FFS PSN cost proposal template only) Final Non-Benefit Expense:*** Automatically calculates the respondent's total non-benefit expense cost proposal by rate group. Note that this section is formula driven, so no input by the respondent is needed.

- ***(Capitated plan cost proposal template only) Cost Proposal Service Cost:*** Automatically calculates the total cost proposal service costs from Worksheets M.1 – M.12 and L.1. Note that this section is formula driven, so no input by the respondent is needed.

- ***(Capitated plan cost proposal template only) Final Capitation Rate:*** Automatically calculates the respondent's final capitation rate by rate group as the sum of the cost proposal service cost, total administrative allowance, and gain / loss margin. Note that this section is formula driven, so no input by the respondent is needed.

- ***(Capitated plan cost proposal template only) Administrative Allowance Percentage:*** Automatically calculates the administrative allowance as a percentage of the capitation rate. Note that this section is formula driven, so no input by the respondent is needed.

- ***(Capitated plan cost proposal template only) Gain / Loss Margin Percentage:*** Automatically calculates the gain / loss margin as a percentage of the capitation rate. Note that this section is formula driven, so no input by the respondent is needed.

Respondents should exclude any projected costs related to the federal health insurance provider fee (HIPF). The Agency will adjust the final negotiated capitation rates to reflect HIPF liability as necessary.

The non-benefit expense assumptions must be clearly documented in the MMA and LTC Actuarial Memorandums.

V. CAVEATS AND LIMITATIONS

Milliman relied on several sources of FFS and SMMC capitated plan cost and eligibility data to develop the cost proposal instructions and rate methodology narrative (and associated exhibits), including detailed Agency eligibility data, Agency FFS data, capitated plan ASR financial data submissions, capitated plan encounter data, and other supporting information from the Agency. **Milliman did not audit any of the data sources**, but did assess the data for reasonableness as documented in this narrative and in the SMMC data book narratives.

Milliman relied on the Agency for the accuracy of its eligibility data and FFS data and for the collection and processing of the encounter data and ASR financial data. Milliman relied on the capitated plans to provide accurate financial data and encounter data as certified by the plans. If the data used is inadequate or incomplete, the results will be likewise inadequate or incomplete.

Capitated plan experience under SMMC will differ from the historical SMMC data book data due to health care trend, managed care savings, provider reimbursement changes, program changes, transitions of members between HCBS and Non-HCBS rate groups, and many other factors. It is certain that actual experience will not conform exactly to the assumptions used in respondent cost proposals or the Agency's rate methodology. Actual amounts will differ from projected amounts to the extent that actual experience is better or worse than expected.

The cost proposal instructions and rate methodology narrative (and associated exhibits) were prepared solely to provide assistance to the Agency in administering this solicitation. This information may not be appropriate for other purposes. Milliman does not intend to benefit and assumes no duty or liability to other parties who receive this work. The cost proposal instructions and rate methodology narrative (and associated exhibits) and the SMMC data book should only be reviewed in their entirety.

The information contained in the cost proposal instructions and rate methodology narrative (and associated exhibits) are technical in nature and are dependent upon specific assumptions and methods. No party should rely on the information contained in the cost proposal instructions and rate methodology narrative (and associated exhibits) 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 report authors are actuaries at Milliman, members of the American Academy of Actuaries, and meet the qualification standards for performing the analyses in this report.

This report is subject to the terms and conditions of the October 22, 2014 contract between the Agency and Milliman.