Deloitte.

Georgia Families and Planning for Healthy Babies Programs

Medicaid Capitation Rate Certification Analysis

July 1, 2023 – June 30, 2024

June 12, 2023

Contents

Section 1: Program Overview

In partnership with the Georgia State Department of Community Health ("DCH" or "State"), Deloitte Consulting LLP ("Deloitte" or "We") was engaged to analyze and certify actuarially sound capitation rates for the Georgia Families (GF) Program and Program for Healthy Babies (P4HB) for State Fiscal Year (SFY) 2024 (July 1, 2023 – June 30, 2024).

The approach for the Deloitte analysis and rate certification is to develop actuarially sound ranges for various assumptions within the rate development process and certify specific rates that correspond to specific assumptions within the actuarially sound assumption ranges, which is consistent with Section 3.2.1 of Actuarial Standard of Practice #49 (Medicaid Managed Care Capitation Rate Development and Certification):

> "Form of the Capitation Rates (Single Rate or Capitation Rate Ranges)—The capitation rate certification may apply to a single point estimate capitation rate or a range of capitation rates. If a range of capitation rates is prepared, the contracted rates with an MCO may be at either end of the range or a point within the range. The capitation rates may vary by MCO."

The Centers for Medicare & Medicaid Services (CMS) Final rule 42 CFR Section 438.4(b) provides the conditions that must be met for capitation rates to be approved by CMS as actuarially sound and the CMS Final Rule 42 CFR Section 438.4(c) provides the conditions that must be met when developing and certifying actuarially sound rate ranges instead of a point estimate.

DCH has implemented a rate negotiation process that allows contracting care management organizations (CMOs) and their actuaries to review the capitation rate development and provide comments and feedback to DCH. The specific rates submitted by DCH are the result of the negotiation process which is informed by the rate methodology and are then certified by Deloitte actuaries to be actuarially sound if they correspond to specific assumptions that are within the actuarially sound assumption ranges developed by Deloitte.

We are providing the *SFY 2024 GF and P4HB Rate Exhibits.xlsx* document that includes exhibits quantifying the impact of the adjustments and the resulting actuarially sound rates. The rates will be adjusted as necessary to reflect any relevant programmatic changes that were not known at the time of this certification when information is available, and the rate certification will be amended if necessary.

Deloitte and the State have developed the capitation rates in accordance with the applicable Centers for Medicare & Medicaid Services provisions under 42 CFR 438 and all applicable Actuarial Standards of Practice (ASOPs). The methods used for calculating these capitation rates are consistent with the requirements of the *2023-2024 Medicaid Managed Care Rate Development Guide* as promulgated by CMS that the capitation rates be actuarially sound and appropriate for the population covered by the program. For purposes of this report, we are defining actuarial soundness consistent with ASOP No. 49, Medicaid Managed Care Capitation Rate Development and Certification. ASOP No. 49 defines that Medicaid capitation rates are "actuarially sound" if, for business for which the certification is being prepared and for the period covered by the certification, projected capitation rates, and other revenue sources provide for all reasonable, appropriate, and attainable costs.

The main changes that have occurred in the SFY 2024 rate cycle compared to the SFY 2023 cycle are:

1. DCH transitioned actuarial services from the prior actuary to Deloitte
2. The base data period has been updated from CY 2019 to CY 2021
3. The planned redetermination of eligibility due to the end of the COVID-19 public health emergency maintenance of effort (MOE) requirements.
4. Various budget initiatives impacting Medicaid managed care from the SFY 2024 legislative session

To account for the uncertainty inherent in prospective estimates and consistent with ASOP 49, actuarially sound ranges for various assumptions within the rate development were developed. The State selected payable capitation rates that correspond to assumptions within these ranges. Per the *2023-2024 Medicaid Managed Care Rate Development Guide*, this report outlines the certification of these selected capitation rates that will be paid to the participating CMOs.

Program Overview

GF and P4HB provide Medicaid benefits to enrollees in the State of Georgia through a managed care delivery system. The three CMOs are Amerigroup[1], CareSource, and Peach State Health Plan, each currently operating on a statewide basis. The CMOs receive capitation payments from the State for providing health services to the covered populations under the terms and conditions of the managed care contracts. Georgia has operated GF since 2006, authorized by a Section 1932(a) Waiver, PeachCare for Kids (PCK) since 2008 when the Partnership Program authorized the program, and P4HB since 2011, authorized by the Georgia Planning for Healthy Babies 1115 Waiver. The State has since received approval of the Georgia Planning for Healthy Babies 1115 Waiver from CMS to extend this waiver through December 31, 2029.

Covered Populations

All individuals who meet the criteria laid out in the CMO Contract Section 1.2 are eligible to be enrolled in GF. Enrollment in GF is mandatory for those meeting these criteria. The following populations are covered consistent with the CMO Contract:

- Low Income Medicaid (LIM)/Transitional Medicaid (TM)/Refugees (REF)
- Breast and Cervical Cancer (BCC)
- PeachCare for Kids (PCK)
- Planning for Healthy Babies (P4HB)

The information in this report does not cover the Georgia Families 360 (GF360) or the Pathways programs. The rate analyses for these programs will be covered in separate reports.

Medicaid
In the state of Georgia, Medicaid coverage is available to both children and adults through different eligibility groups. The groups and eligibility criteria are as follows:

- **Georgia Families**
  - LIM - Families with income at or below 100 percent of Federal Poverty Level (FPL)
  - Transitional Medicaid (TM) - Children 0-1 with income at or below 205 percent of FPL, Children 1-5 with income at or below 149 percent of FPL, Children 6-19 with income at or below 133 percent of FPL, Pregnant individuals with income at or below 220 percent of FPL
  - U.S. citizens and qualified immigrants
  - Individuals in need of treatment for breast or cervical cancer who meet the income requirements
- **PeachCare for Kids**
  - U.S. citizens and qualified immigrants
  - Georgia residents
  - Age 0-18 (eligible until 19th birthday)
  - Children ages 0-18 (eligible until 19th birthday) whose family income is at or below 247 percent of FPL.
- **Planning for Healthy Babies**

[1] Amerigroup is currently undergoing a name change and will be called Elevance Health.

- Family Planning (FP) - Uninsured individuals, ages 18 through 44, who have family income up to and including 211 percent of the FPL, who are not otherwise eligible for Medicaid or Children's Health Insurance Program (CHIP) or enrollees who are losing Medicaid coverage at the conclusion of the postpartum coverage period
- Interpregnancy (IPC) - Uninsured individuals, ages 18 through 44, who deliver a very low birth weight (VLBW) baby on or after January 1, 2011, who have family income up to and including 211 percent of FPL, who are not otherwise eligible for Medicaid or CHIP
- Resource Mother Outreach (RMO) - Individuals, ages 18 through 44, who have family income at or below 211 percent of FPL, who deliver a VLBW baby on or after January 1, 2011, and who qualify under the Low-Income Medicaid Class of Assistance, or the Aged Blind and Disabled Classes of Assistance, under the Georgia Medicaid State plan.

Covered Services

GF enrollees are eligible for the following covered services:

- Inpatient/outpatient hospital physical health, Inpatient/outpatient hospital behavioral health (MH and/or SUD), Partial hospitalization, Physician, Nurse practitioner, Rural health clinics and FQHCs, Clinic services, Lab and X-Ray
- Prescription drugs, Prosthetic devices, EPSDT, Case management, Family planning
- Dental services (medical/surgical), Dental (preventative or corrective)

At a minimum, Medicaid covered individuals are eligible to receive all Medically Necessary Services pursuant to the Georgia State Medicaid Plan. The service category descriptions that capture the covered services described in the CMO Contract for GF are detailed more thoroughly in **Section 3** of this report. The capitation rates described in this report include service expenditures specified in **Section 3**. Such Medically Necessary services shall be furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to recipients under Fee-for-Service Medicaid.

Costs associated with enhanced benefits provided by the CMOs were explicitly excluded from the underlying data used to develop managed care capitation rates. Capitation rates are based only on the cost for services covered as specified under the State Plan or directly related to providing these services.

The P4HB program provides Family Planning (FP) and Resource Mother Outreach (RMO) services. Those eligible for Interpregnancy care (IPC) receive a combination of these above services plus additional services to treat chronic conditions including primary care services.

Institution for Mental Disease

CMOs may cover services provided in an Institution for Mental Disease (IMD) for individuals ages 21-64 for a short-term period not to exceed 15 days per calendar month. CMOs may not require a covered individual to receive services in an IMD if an appropriate alternative setting is available. The member months and any costs incurred in the given month were excluded from the CY 2021 base data for enrollees who exceeded 15 days in an IMD facility for the month(s) in which they exceed 15 days. The claim information was provided by CMOs and was reviewed for appropriateness.

Section 2: Data and Information, Reliance, and Limitations

Data and Information

Various data requests were developed to collect the necessary items to be used for the rate analysis. The State, State's previous actuary, and participating CMOs provided information required for the SFY 2024 capitation rate range analysis. Data and information collected are outlined below.

- Audited Managed Care encounter claims data, including institutional, professional, and pharmacy claims data with dates of service from January 1, 2019 through October 31, 2022, paid through October 31, 2022
- Detailed CMO enrollment and capitation payment data from January 1, 2019 through October 31, 2022, including all applicable retroactive rate cell adjustments through October 31, 2022
- Crosswalks provided by DCH to identify Medicaid eligibility groups, aid categories, categories of service and regions in the encounter/eligibility data
- Monthly detailed CMO Financial Report data by health plan from January 1, 2019 through September 30, 2022; reported data includes detailed expenditures and revenues at the region and rate cell-level consistent with 42 § 438.8 Medical loss ratio (MLR) standards and CMO Contract Section 4.18.2.3.
- Supplemental pharmacy rebate information for CY 2021
- Lists and descriptions of historical, concurrent, and planned changes to the GF and P4HB programs
- Fiscal estimates and supporting models provided by the State
- SFY 2024 estimated managed care enrollment by cohort and region
- Supplemental quarterly summaries representing non-risk COVID-19 vaccine administration payments to CMOs for the period of January 1, 2021 through June 30, 2022
- Counts and demographic distributions of COVID-19 vaccines administered in Georgia; counts of COVID-19 tests in Georgia by day and DCH Vaccination Data through December 2021
- CMO-specific methodology to identify IMD stays and the number of IMD claims that exceeded the 15-day limit in CY 2021

In addition to the information provided by the State and participating managed care plans, the following items were also considered in the SFY 2024 capitation rate range analysis:

- Publicly available utilization and cost increase studies published by CMS, the SOA, the Kaiser Family Foundation, Magellan, and other state Medicaid programs
- Economic data/indicators from the U.S. Bureau of Labor Statistics (BLS), the U.S. Bureau of Economic Analysis, and the Federal Reserve
- Publicly available State Medicaid Plan and State Plan Amendments for Georgia
- Publicly available studies, reports and information utilized for individual adjustments
- Publicly available data regarding drug patent approvals and expirations occurring or anticipated to occur during the rating period

Appendix C details the publicly available studies that were utilized in the development of the SFY 2024 capitation rates. This section includes all sources that were utilized other than sources provided by the State of Georgia or participating managed care plans. The scope of the capitation rate development and the intended use of the analysis being performed was considered in order to

determine the nature of the data needed. Additionally, actuarial standards on utilizing imperfect data and considering the quality of data were used in the actuarial analysis as outlined in ASOP No. 23, *Data Quality*. The data used in the analysis were determined to be credible unless otherwise noted and are reasonable data sources to develop capitation rates for GF and P4HB services offered to the State of Georgia's Medicaid population.

Reliance and Limitations

In developing the SFY 2024 capitation rates, it was assumed that the CMO contracts for GF and P4HB and all Georgia Medicaid program specifics will be approved by CMS without modifications.

Data provided by the State, State's previous actuary, and participating health plans as detailed above was relied upon. We have reviewed the data for reasonableness and consistency during the course of our work; however, we have not audited any of the data we have received. If the underlying data or information provided is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete. Please note that some data sources were provided by third parties who also audited the data provided. We relied on the integrity of the audits performed by these third parties.

This report provides a detailed description of the methodology used in collaboration with DCH to develop the selected capitation rates. The capitation rates have been solely prepared for the State of Georgia and should not be reproduced in any form without the prior consent of Deloitte and should not be relied upon by any entity other than the State of Georgia nor for any other purpose than that expressly stated in this document.

Capitation rates developed by Deloitte and DCH are based on actuarial analysis of future GF program costs for SFY 2024. It may be expected that actual experience will vary from the values shown in this report. The methods used for estimating these rates are consistent with CMS requirements detailed in the *2023-2024 Medicaid Managed Care Rate Development Guide* and all applicable actuarial guidance.

Section 3: Rate Analysis Methodology

Overview

This section provides an overview of the rate analysis process used in the development of the actuarially sound capitation rates, including an overview of the rate cohorts, regions, and category of service (COS) groupings utilized in the development of the rates and the adjustments that were applied.

The primary base data sources for the GF and P4HB rate cells that were used in the development of the SFY 2024 GF and P4HB capitation rates were encounter data and enrollment data provided by the State's encounter data auditor and CMO Financial Reports supplied by each CMO. Please refer to **Section 4** of this report for further detail on the base data.

For GF and P4HB, the following adjustments were applied in the rate analysis process, which are consistent with the *2023-2024 Medicaid Managed Care Rate Development Guide* released in May 2023:

- Base data adjustments
- Program changes not reflected in the base data
- Trend factors to project costs forward to the rating period
- Efficiency adjustments
- Credibility and smoothing
- Non-medical expense loads for administrative costs, underwriting gain, and taxes
- Risk mitigation

Differences between the GF and P4HB rate analysis processes are described within subsequent sections of this rate certification.

The various steps used in the development of the capitation rates are described in the remaining sections of this report.

Rate Structure

Based on discussions with the State on historical rate structures and analysis of cost variation by rate cohort, age, and geographic area within the data, the rate structure for the GF rate cells is summarized as follows:

- Eighteen individual cohorts based on population, member age, member sex, Children's Health Insurance Program (CHIP) status, and diagnosis (i.e., Deliveries and BCC cohort)
- Six regional groupings

P4HB capitation rates are set by eligibility group on a statewide basis.

Rate Cohorts

For GF, separate capitation rates were developed for the following rate cohorts, which are either defined by a combination of covered population, age cohort, and sex, or diagnosis.

Table *1* and **Table 2** below show each GF and P4HB rate cohort.

Table 1 – SFY 2024 GF Capitation Rate Groupings by Population and Cohort

GF Category of Aid	Cohort
LIM/TM/REF	0-2 Months, Male and Female
	3-11 Months, Male and Female
	1-5 Years, Male and Female
	6-13 Years, Male and Female
	14-20 Years, Female
	14-20 Years, Male
	21-44 Years, Female
	21-44 Years, Male
	45-64 Years, Female
	45-64 Years, Male
PCK	0-2 Months, Male and Female
	3-11 Months, Male and Female
	1-5 Years, Male and Female
	6-13 Years, Male and Female
	14-20 Years, Female
	14-20 Years, Male
BCC	All ages
Delivery Kick	Maternity Delivery/Kick Payment

In addition to the monthly rates paid for these LIM/TM/REF, PCK, and BCC populations, the State has a separate kick payment that is made to GF plans for a maternity delivery event. Delivery Kick Payments are one-time payments made to the CMO for the delivery of a Georgia Families newborn. This is also known as the Delivery Kick Payment.

Table 2 - SFY 2024 P4HB Capitation Rate Groupings by Population and Cohort

P4HB Rate Cells	Cohort
P4HB	Family Planning
	Interpregnancy
	Resource Mother Outreach

Regional Groups

Capitation rates were developed for six regional groupings for GF; P4HB capitation rates were developed on a statewide basis due to data credibility issues.

The counties that make up the six GF rate regions are reflected in **Table 3**. Additionally, **Appendix B** contains a map of the different regions in the State for the GF program, as provided by the State.

Table 3 - Region/County Mapping

Region	Counties
Atlanta	Barrow, Bartow, Butts, Carroll, Cherokee, Clayton, Cobb, Coweta, DeKalb, Douglas, Fayette, Forsyth, Fulton, Gwinnett, Haralson, Henry, Jasper, Newton, Paulding, Pickens, Rockdale, Spalding, Walton
Central	Baldwin, Bibb, Bleckley, Chattahoochee, Crawford, Crisp, Dodge, Dooly, Harris, Heard, Houston, Johnson, Jones, Lamar, Laurens, Macon, Marion, Meriwether, Monroe, Muscogee, Peach, Pike, Pulaski, Talbot, Taylor, Telfair, Treutlen, Troup, Twiggs, Upson, Wheeler, Wilcox, Wilkinson

Region	Counties
East	Burke, Columbia, Emanuel, Glascock, Greene, Hancock, Jefferson, Jenkins, Lincoln, McDuffie, Putnam, Richmond, Taliaferro, Warren, Washington, Wilkes
North	Banks, Catoosa, Chattooga, Clarke, Dade, Dawson, Elbert, Fannin, Floyd, Franklin, Gilmer, Gordon, Habersham, Hall, Hart, Jackson, Lumpkin, Madison, Morgan, Murray, Oconee, Oglethorpe, Polk, Rabun, Stephens, Towns, Union, Walker, White, Whitfield
Southeast (SE)	Appling, Bacon, Brantley, Bryan, Bulloch, Camden, Candler, Charlton, Chatham, Effingham, Evans, Glynn, Jeff Davis, Liberty, Long, McIntosh, Montgomery, Pierce, Screven, Tattnall, Toombs, Ware, Wayne
Southwest (SW)	Atkinson, Baker, Ben Hill, Berrien, Brooks, Calhoun, Clay, Clinch, Coffee, Colquitt, Cook, Decatur, Dougherty, Early, Echols, Grady, Irwin, Lanier, Lee, Lowndes, Miller, Mitchell, Quitman, Randolph, Schley, Seminole, Stewart, Sumter, Terrell, Thomas, Tift, Turner, Webster, Worth

Categories of Service

The base data used for the rate analysis for the GF rate cells was organized by the following COS.

Table 4 - Category of Service Descriptions (GF Rate Cells)

Category of Service	Description
Inpatient Medical & Surgical	Medical and Surgical costs for routine and ancillary services for members in an inpatient setting.
Inpatient Newborn	Inpatient care costs for newborn enrollees.
Inpatient Mental Health (MH)	Inpatient treatment expenses for mental health and substance abuse stays.
Inpatient Other	Includes all other inpatient services not related to Medical and Surgical, Newborn, or Mental Health.
Outpatient Emergency Room (ER)	Health care procedures, treatments or services provided in a hospital emergency room needed to evaluate or stabilize an emergency situation.
Outpatient Surgery	Outpatient surgery expenses for "same-day" procedures.
Outpatient Radiology	Includes outpatient imaging services.
Outpatient Laboratory	Laboratory expenses on an outpatient basis.
Outpatient MH	Outpatient mental health and substance abuse treatment expenses.
Outpatient Other	Includes all other outpatient services not related to ER, Surgery, Radiology, Laboratory, and Mental Health.
Professional Evaluation & Management (E&M)	Professional service costs associated with diagnosing and treating an illness or injury.
Professional Surgery	Includes professional costs associated with office-based surgeries.
Professional Radiology	Includes physician imaging services.
Professional Lab	Laboratory expenses conducted by a physician.
Professional MH	Professional treatment expenses for mental health and substance abuse.
Professional Ambulance/Transportation	Professional service expenses for Ambulance/Transportation services.
Professional DME/Supplies	Durable medical equipment and other supplies.
Professional Other	Professional service costs not relating to E&M, Surgery, Radiology, Lab, MH, Ambulance/Transportation, or DME/Supplies.
Home Health Care	Home health services including home health aide, therapeutic/private duty/preventive nursing, and medical social services.

Category of Service	Description
Dental	Expenses for dental services provided. Includes all dental services for children up to age 21 and emergency dental services for adults over the age of 21.
Vaccines for Children (VFC)	Costs related to providing vaccines through the federal Vaccines for Children program.
Federally Qualified Health Center (FQHC)	Covered services provided at FQHCs.
Pharmacy	Prescription drugs.
Kick - Facility	Includes facility costs associated with obstetrical delivery events.
Kick - Professional	Includes professional costs associated with obstetrical delivery events.

The experience utilized for the rate development for the Interpregnancy and Family Planning rate cells in the P4HB were organized by the categories of service shown in **Table 5** below.

Table 5 - Category of Service Descriptions (P4HB rate cells)

Category of Service	Description
Inpatient	Routine and ancillary services to P4HB enrollees in an inpatient setting.
Outpatient	Services provided to P4HB enrollees in an outpatient setting for diagnosis or treatment.
Professional E&M	Professional service costs associated with diagnosing and treating an illness or injury.
Professional Other	Professional service costs other than E&M.
Dental	Expenses for dental services provided to P4HB enrollees.
Pharmacy	Prescription drugs.

Resource Mother Outreach is calculated as a case management rate and is not developed at a category of service level.

Services not covered under GF

For the SFY 2024 rating period, services not covered under the GF benefit package for GF enrollees as specified in the CMO Contract are not included and instead covered under FFS. Only State Plan services and 1115 services are included in the SFY 2024 capitation rates.

CMOs have confirmed there are no current or expected in-lieu-of-service arrangements for consideration in SFY 2024 capitation rates.

Services not covered under P4HB

For the SFY 2024 rating period, services not covered under the P4HB benefit package for P4HB enrollees as specified in the CMO Contract are not included and instead covered under FFS. Only State Plan services and 1115 services are included in the SFY 2024 capitation rates.

CMOs have confirmed there are no current or expected in-lieu-of-service arrangements for consideration in SFY 2024 capitation rates.

Impacts of COVID-19 Pandemic

The following impacts of the pandemic and the COVID-19 Public Health Emergency (PHE) and continuous coverage requirement were considered when developing capitation rates for SFY 2024.

- The federal Consolidated Appropriations Act, 2023 enacted December 29, 2022 requires states to resume eligibility redetermination and process all redeterminations by the end of May 2024. The State indicated that disenrollment from GF and P4HB as a result of the resumption of

eligibility redeterminations would be processed on a rolling basis each month through the disenrollment period. For the purposes of developing the capitation rates for SFY 2024, it was assumed that disenrollment would occur uniformly over a 12-month timeframe.

- The impact of the end of the continuous coverage requirement and subsequent unwinding were considered in the development of the administrative, pharmacy, and medical costs. The estimated impact was incorporated through adjustments related to Medicaid churn, acuity changes from the base period through the rating period due to the ongoing maintenance of eligibility requirement and upcoming redeterminations, and in the development of trend. These impacts are described further in **Sections 5 and 6**.

- COVID-19 vaccine administrations are not paid through the capitation rate and are removed from the base data. The base data adjustment is described further in **Section 4**.

Section 4: Base Data Development

The selection and development of base data detailed in this section is consistent with CMS provisions under 42 CFR 438.5(c) and with the guidance detailed in the *2023-2024 Medicaid Managed Care Rate Development Guide*.

Available Data Sources

As described in **Section 2** of this report, two potential data sources were considered: encounter data and CMO-reported financial data. Rates were primarily based on encounter data, which was provided the State's encounter claims audit vendor. CMO reported-financial data was used to support some rate analyses as described throughout this certification. The following table provides a comparison of the two data sources available for medical and pharmacy base data. Both data sources were adjusted to be on the same basis by removing the value-added services and quality improvement activities for the comparison and data was restricted to January 1, 2021 to December 31, 2021 in order to perform a direct comparison of costs below.

Table 6 - Comparison of Available Data Sources

Data Characteristic	CMO Financial Data	Encounter Data
Service Dates Time Period	Monthly data from January 2019 through September 2022	Customizable time periods from 1/1/2019 through 9/30/2022
Payment Runout	Runout through 10/31/2022	Runout through 10/31/2022
Accuracy	Reflects incurred claims and non-claims expenditures as reported by CMO Reports are required to be certified by managed care plans and are evaluated for reasonableness	Less than 1% lower than CMO Financial data for CY 2021 in total for GF and approximately 2.5% lower than CMO financial data for CY 2021 in total for P4HB
Granularity	Aggregate information split by month, plan, region, and rate cohort	Claim level detail by month, plan, region, rate cohort, and category of service

CMO Financial Report and encounter data were reviewed for year over year differences, overall reasonableness, and consistency between the data sources.

Selected Base Data

The CY 2021 audited managed care encounter data was selected as the primary data source for the medical and pharmacy base data. This data includes detailed, claim-level records, which were then aggregated by COS. Claims were paid through October 2022 which allowed for 10 months of runout from the end of CY 2021.

Data Quality

The State's encounter claims audit vendor was relied upon for all encounter data used for rate setting. We did not audit this data but did perform checks for reasonableness including comparisons with CMO Financial Reports. The CMO-reported MLR data and financial data were also reviewed for accuracy and completeness.

The state has a high level of confidence in the CMO encounter data based on the third-party ongoing review to validate the monthly invoice files against the CMO check registers. However, there are still slight discrepancies between the total PMPM costs reported in the CMO encounter data and CMO-reported financial data. The **Under Reporting** section details the adjustments made to account for the difference in costs between these two sources.

Based on our data review and validation for the data completeness, accuracy, and consistency, the data used to develop the SFY 2024 capitation rates was found to be of appropriate quality and suitable for developing actuarially sound rates. FFS data was not utilized or provided for this analysis.

Base Data Adjustments

The base data was reviewed to validate that the expenses reflect the population and services included in the GF and P4HB benefit packages. Through this process, the following adjustments were considered and applied to the underlying base data. The below base data adjustments are applicable to both the GF and P4HB programs unless otherwise specified.

Base Data Adjustments to Encounter Data:

Removed from Base Data

- Incarcerated Member Exclusion
- Non-Risk COVID-19 Vaccine Exclusion
- Capitated Encounters
- Value-Added Services
- Pharmacy Rebates

Added to Base Data

- Non-System Payments
- Vaccines for Children
- Sub-Capitated Payments
- Incurred But Not Reported (IBNR)
- Under Reporting

The impact of the base data adjustments at a regional and rate cohort level are provided in Exhibits 1A and 2 for GF and Exhibit 1B for P4HB in the accompanying "*SFY 2024 GF and P4HB Rate Exhibits.xlsx* file.

Incarcerated Member Exclusion

The incarcerated member exclusion excludes the costs and member months for Medicaid enrollees while incarcerated. Incarcerated members are identified through the individual member's capitation data.

Non-Risk COVID-19 Vaccine Exclusion

The **COVID-19 vaccine administration costs were removed from the pharmacy encounter base data as the CMOs are not at risk for these costs. The CMOs are reimbursed for the administration of the COVID-19 vaccines outside of the capitation rates. The COVID-19 vaccine claims were identified using NDC.**

Capitated Encounters

Some of the CMOs have sub-capitated arrangements for portions of the State Plan-approved benefit package with subcontractors, referred to as sub-capitated providers. The encounter claims submitted for these sub-capitated services do not reflect the actual CMO expenses incurred to provide these services as the CMOs pay these sub-capitated providers through separate sub-capitation payments. Therefore, these capitated encounters are removed from the base data and as discussed below, are replaced with the actual payments CMOs make to their sub-capitated providers to reflect the actual

costs incurred by the CMOs. Capitated encounters are identified using the capitated vendor list provided by the State's encounter claims audit vendor.

Value-Added Services

The CMO-reported costs for value-added services from the CY 2021 plan financial data were removed from the base data. CMOs reported value-added services on a statewide and category of aid-specific basis and encounter data for related categories of service was leveraged to remove the value-added services costs by rate cell.

Pharmacy Rebates

An adjustment was made to the pharmacy component of the rate to account for rebates retained by plans participating in GF and P4HB. These rebates are not reflected in the encounter data used as the base pharmacy data, and therefore, the base pharmacy costs would be overstated without this adjustment.

The CMOs provided historical and estimated rebate information at the rate cell level from CY 2019 through the third quarter of CY 2022 in the plan-submitted financial data. CY 2021 reported rebates were analyzed to develop a downward adjustment applied to the pharmacy base data. CY 2021 rebate information was compared to CY 2019 through Q3 CY 2022 rebate information to validate the reasonableness of the data provided by the plans and the magnitude of the applied adjustment.

Non-System Payments

Non-system payments made to providers that were not otherwise included in the encounter base data that reflect covered expenses for the CMOs were added to the CY 2021 base data. CMOs reported their non-system payment amounts at the statewide and major category of service level; these values were allocated across rate cells and appropriate service categories using base encounter data for related categories of service, consistent with the SFY 2023 rate development. Any non-system claims payments reported for administrative, non-State plan services, or medical management services were not added to the base data. The non-system payments were reviewed for reasonableness and consistency over the data periods provided (CY 2019 through Q3 CY 2022) but relied on the CMOs for reporting accuracy.

Vaccines for Children

The Vaccines for Children Program is a federally funded program where children enrolled in CHIP/PCK are supplied vaccines free of charge. The CMOs are responsible for providing these vaccines to their PCK enrollees, though these are not captured in the encounter data as the health plans pay these costs through separate mechanisms. The CMO-reported Vaccines for Children costs were then incorporated into the PCK base data only and therefore, this adjustment is not applicable to the P4HB program.

Sub-Capitated Payments

The base data has been adjusted to include plan-reported expenditures for sub-capitated covered provided in the CMO financial data. Sub-capitated payments were reported at the statewide level and by major category of aid (LIM/TM/REF and BCC, PCK, and P4HB). Sub-capitated payment costs were allocated to rate cells proportionally by member month for the given category of aid for applicable categories of service.

Incurred But Not Reported (IBNR)

The CMOs reported their IBNR values by rate cell and major category of service in the plan financial data. The CMO-reported IBNR estimates were reviewed by individual CMO and across the program. After analyzing the available IBNR data, an adjustment by category of aid and major category of service was applied to the CY 2021 base data using the plan reported IBNR amounts to adjust base data to include the estimated IBNR amounts.

Under Reporting

The CY 2021 encounter data was adjusted to align with the costs reported in the plan-reported financial data for the pharmacy and medical data. To determine the variance between the encounter pharmacy data and CMO Financial Report pharmacy data, the two data sources were adjusted so they were comparable for the purposes of this analysis. To do this, the encounter data was adjusted to remove value-added service claims and the quality improvement activities as reported from the CMO financials.

After normalizing the data sources to be on a comparable basis, it was observed that the encounter data varied from the CMO Financial Report data by category of aid. Adjustments were made to reconcile the encounter data to the CMO Financial Report audited financial data.

Note that no under reporting adjustments were applied to Vaccine for Children costs.

Section 5: Program Change Adjustments

Explicit adjustments were made to account for the GF and P4HB programmatic changes between the base data period and the rating period. This is consistent with applicable actuarial guidance regarding the rate setting methodology. Programmatic changes occurring during the base period data were applied before trend. Programmatic changes, including new benefits, with effective dates after the base period were applied after trend.

Program change adjustments were made for the medical and pharmacy components of the rate separately. The program change adjustments are categorized as follows and the adjustments were applied in the following order for medical and pharmacy separately:

- Pre-trend benefit adjustments
- Post-trend adjustments

Table 7 - Program Change Adjustments

DCH Program Change	Category	Effective Date	Medical/Pharmacy
Increase to Dental Fee Schedules	Pre-Trend	7/1/2021	Medical
Increase to Primary Care and OB/GYN Fee Schedules	Pre-Trend	7/1/2021	Medical
15-Day Institutions for Mental Disease Exclusion	Pre-Trend	N/A	Medical and Pharmacy
Increase to Dental Fee Schedules	Post-Trend	7/1/2022	Medical
Increase to OB/GYN Fee Schedules	Post-Trend	7/1/2022	Medical
Donor Milk	Post-trend	7/1/2022	Medical
Independent Pharmacies Dispensing Fee Increase	Post-Trend	7/1/2022	Pharmacy
Medical Nutritional Therapy	Post-Trend	7/1/2022	Medical
Long-Term Acute Care/Inpatient Rehabilitation Facilities Increase	Post-Trend	7/1/2022	Medical
Psychiatric and Behavioral Healthcare Management	Post-Trend	7/1/2022	Medical
Leap Year	Post-Trend	N/A	Medical and Pharmacy
Redetermination Acuity Adjustment	Post-Trend	7/1/2023	Medical and Pharmacy
Churn	Post-Trend	7/1/2023	Medical and Pharmacy
Applied Behavioral Analysis (ABA)	Post-Trend	N/A	Medical
Psychiatric Residential Treatment Facilities (PRTF) Reimbursement Increase	Post-Trend	7/1/2023	Medical
Behavioral Health Aide	Post-Trend	7/1/2023	Medical
Developmental and Behavioral Health Screening and Testing	Post-Trend	7/1/2023	Medical
Extended Postpartum Coverage	Post-Trend	7/1/2022	Medical and Pharmacy
Credibility & Smoothing	Post-Trend	N/A	Medical and Pharmacy

The below adjustments are applicable to the GF program only, unless otherwise specified. Exhibit 3 in the *SFY 2024 GF and P4HB Rate Exhibits.xlsx* file highlights the impact of the program change adjustments.

Pre-Trend Benefit Adjustments

This section details the benefit adjustments between the base period and the rating period. As these adjustments have effective dates during the base period, they were applied before trend.

Increase to Dental Fee Schedules

Effective July 1, 2022, a 3% increase was applied to the reimbursement for following dental procedure codes: D2140, D2150, D2160, D2330, D2331, D2332, D2335, D2393, D2394, D2930, D2931, D3220, D7111, D7140, and D7210.

Paid and utilization data for the affected dental procedure codes from January 1, 2021 through June 30, 2021 was summarized by category of aid, cohort, and region. The increase in cost by rate cell was estimated by multiplying the utilization by procedure code by the increase in the associated fee schedule.

This program change adjustment is applicable to the GF and P4HB programs.

Increase to Primary Care and OB/GYN Fee Schedules

Effective July 1, 2021 the reimbursement rate for 18 procedure codes increased from the 2014 Medicare rates to the 2020 Medicare rates for all physicians. The relevant procedure codes are 90472, 99230, 99204, 99212, 99213, 99214, 99215, 99223, 99232 99233, 99284, 99285, 99391, 99392, 99393, 99394, and 99480.

Paid and utilization data for the 18 procedure codes from January 1, 2021 through June 30, 2021 was summarized by category of aid, cohort, and region. The increase in cost by rate cell was estimated by multiplying the utilization by procedure code by the increase in the associated fee schedule.

This program change adjustment is applicable to the GF and P4HB programs.

15-Day Institutions for Mental Disease (IMD) Exclusion

The IMD exclusion prohibits the use of federal funding for care provided to most patients in IMD facilities larger than 16 beds. The exclusion is applicable to all Medicaid enrollees under the age of 65, except for payments for inpatient psychiatric services provided to beneficiaries under age 21. IMD stays greater than 15 days were identified in the CY 2021 base period using plan reported IMD data and the claims and member months were removed from the base data for the Medicaid beneficiaries exceeding 15 days in an IMD facility for the month(s) in which they exceed 15 days.

Post-Trend Benefit Adjustments

This section details the benefit changes between the base period and the rating period. As these adjustments have effective dates after the base period, they were applied after trend.

Increase to Dental Fee Schedules

Effective July 1, 2022, the reimbursement for two dental extraction codes was increased 10% and the reimbursement for 17 dental restorative codes was increased 7%. The 10% increase applies to dental codes D7140 and D7210. The 7% increase applies to dental codes D2160, D2330, D2331, D2332, D2335, D2393, D2394, D2931, D3220, D7111, D2140, D2150, D2930, D0220, D0270, D0272, and D0274.

Paid and utilization data for the affected dental procedure codes from January 1, 2021 through December 31, 2021 was summarized by category of aid, cohort, and region. The increase in cost by rate cell was estimated by multiplying the utilization by procedure code by the increase in the associated fee schedule. The percent impact of the fee schedule increase was applied to estimated SFY 2024 dental costs.

This program change adjustment is applicable to the GF and P4HB programs.

Increase to OB/GYN Fee Schedules

Effective July 1, 2022, the reimbursement for several OB/GYN procedure codes was increased to the 2020 Medicare fee schedule. The increase to the 2020 Medicare fee schedule applies to the following procedure codes: 59400, 59500, 59610, and 59618/

Paid and utilization data for the affected OB/GYN procedure codes from January 1, 2021 through December 31, 2021 was summarized by category of aid, cohort, and region. The increase in cost by rate cell was estimated by multiplying the utilization by procedure code by the increase in the associated fee schedule. The percent impact was applied to estimated SFY 2024 medical costs.

Donor Milk Program

Effective July 1, 2022, donated breastmilk was eligible for reimbursement by Medicaid for covered children 6 months old and younger. The State provided a SFY 2023 fiscal estimate of the cost covering donor milk which was validated for reasonability and adjusted for SFY 2024 using the estimated number of babies covered by Medicaid with Low Birth Weight in SFY 2024 and allocated out by rate cell by the proportion of the estimated SFY 2024 member months 6 months old and younger.

Independent Pharmacies Dispensing Fee Increase

Effective July 1, 2022, the State increased the dispensing fees for medications dispensed at independent pharmacies for recipients enrolled in a Medicaid managed care plan to $10.63 per prescription.

DCH provided a list of independent pharmacies, including provider identification codes. The dispensing fees, prescription count, and paid data for drugs dispensed at independent pharmacies where script count, dispensing fee quantity, and paid amount was greater than zero were summarized from January 1, 2021 through December 31, 2021 by rate cell using the provider identification codes. The percent impact to the pharmacy category of service by rate cell was estimated by repricing the dispensing fees at $10.63 and the percent impact was applied to projected SFY 2024 pharmacy costs.

This program change adjustment is applicable to the GF and P4HB programs.

Medical Nutrition Therapy (MNT) Reimbursement

Effective July 1, 2022, the unit cost paid for MNT procedure codes 97802 (Medical Nutrition Assessment) and 97803 (Medical Nutrition Re-assessment) were increased for the Fee-for-Service (FFS) Medicaid program and DCH indicated that the managed care program would have the same percent increases as the FFS increases. Also effective July 1, 2022, procedure code 97804 (Medical Nutrition Group Therapy) was added as a covered service.

The State provided a fiscal estimate of the cost of incorporating the MNT program changes into the managed care program for SFY 2023. Paid amounts, utilization, and unique utilizer counts were summarized for procedure codes 97802 and 97803 from January 1, 2021 through December 31, 2021 by rate cell. The SFY 2023 fiscal estimate was validated for reasonability and split out by category of service based on the underlying categories of service to which the CY 2021 data was allocated (Professional – Other, FQHC, and Outpatient – Other), trended forward to SFY 2024, and allocated out by rate cell using the distribution of the MNT utilizers.

Long-Term Acute Care Hospitals & Inpatient Rehabilitation Facilities Increase

Effective July 1, 2022, the per diem reimbursement rate increased by 10% for long-term acute care hospitals (LTAC) and inpatient rehabilitation facilities (IRF). The State provided a list of the relevant facilities and Provider Specialty Codes. Inpatient paid and utilization data from January 1, 2021 through December 31, 2021 was summarized by facility, rate cell, and category of service in combination with the Provider Specialty Codes. A 10% increase in cost was applied to estimate the impact of this program change adjustment. The percent impact of the reimbursement increase was applied to the projected SFY 2024 for the IP – Medical & Surgical and IP – Other categories of service.

Psychiatric and Behavioral Healthcare Management

Effective July 1, 2022, Case Management Services were expanded using procedure codes, 99446, 99447, 99448, and 99449, 99484, 99492, 99493, and 99494. The State provided an SFY 2023 fiscal estimate of the costs of adding these new Case Management procedure codes and indicated that members who are already using case management codes will not have additional utilization of the new codes and that utilization will be limited to patients who have received Community Mental Health services.

Unique utilizer counts were summarized from January 1, 2021 through December 31, 2021 of members who have not utilized case management services and who have received Community Mental Health. The SFY 2023 fiscal estimate was validated for reasonability, trended forward to SFY 2024 and allocated out to non-maternity rate cells according to the distribution of these utilizer pulls.

This program change adjustment is applicable to the GF and P4HB programs.

Leap Year

The upcoming rating period of July 1, 2023 through June 30, 2024 has 366 days due to the "leap" day on February 29, 2024. Conversely, the selected base period of January 1, 2021 through December 31, 2021 has 365 days. An adjustment was applied to all categories of service to increase the costs paid in the rating period to cover this additional day of service.

This program change adjustment is applicable to the GF and P4HB programs.

Redetermination Acuity Adjustment

Effective March 1, 2020, a PHE was declared. Under the Maintenance of Effort requirements, members that would typically be disqualified for Medicaid were allowed to remain in Medicaid programs. As part of the Consolidated Appropriations Act, 2023, the State is required to return to normal eligibility and enrollment operations which includes redetermining eligibility for members who are enrolled in Medicaid under Maintenance of Effort requirements but no longer qualify for Medicaid benefits. The State indicated that disenrollment from GF and P4HB as a result of the resumption of eligibility redeterminations would be processed on a rolling basis each month through the disenrollment period. For the purposes of developing the redetermination acuity adjustment, it was assumed that disenrollment would occur uniformly over a 12-month timeframe.

Using the most recent CDPS+Rx cost weights and risk score assignments based on CY 2019 and CY 2021 scoring periods, the average risk score changes were analyzed to understand how the acuity of the population changed due to the impact of the MOE requirement. From the analysis, lower levels of acuity were observed across the Georgia Families and P4HB programs as a result of the continuous coverage requirement. The observed decline in population acuity from CY 2019 to CY 2021 was assumed to continue beyond CY 2021 until redeterminations occur. As redeterminations occur, acuity is expected to begin to return to pre-PHE levels due to the end of the continuous coverage requirement. The redetermination adjustment estimates the expected change in acuity, measured by risk score, and corresponding PMPM cost changes as members are redetermined on a monthly basis throughout SFY 2024.

This program change adjustment is applicable to the GF and P4HB programs.

Churn

The federal Consolidated Appropriations Act, 2023 enacted December 29, 2022 requires states to resume eligibility redetermination and process all redeterminations by the end of May 2024. The State indicated that disenrollment from GF and P4HB as a result of the resumption of eligibility redeterminations would be processed on a rolling basis each month through the disenrollment period. As eligibility redeterminations are processed, the impact of Medicaid beneficiaries losing coverage and subsequently re-enrolling in the program within a short period of time will likely occur. This phenomenon is often referred to as "Medicaid Churn". As a result of the continuous coverage requirement that existed during the PHE, Medicaid Churn rates were estimated to be minimal during the CY 2021 base period. Because there is expected to be a difference in the rates of Medicaid Churn

between the base period and the rating period, an adjustment was required to address this phenomenon.

To estimate the impact of Medicaid Churn during the rating period, an estimate was developed for reduced capitation payments and member months due to Medicaid churn in the rating period that will not be accompanied by a proportional reduction in claim costs since churning members are assumed to be healthier than average. This assumption was developed using the expected leavers from Medicaid due to the end of the continuous coverage requirement throughout SFY 2024, leavers from Medicaid due to steady state churn throughout SFY 2024, historical joiners and leavers from the Medicaid program observed from CY 2019 to the first 9 months of CY 2022 and national studies on the rates of churn prior to the public health emergency.

This program change adjustment is applicable to the GF and P4HB programs.

Applied Behavioral Analysis

Effective July 1, 2017, select autism codes were offered as new services with newly enrolled applied behavioral analysis (ABA) therapy providers. Applied Behavioral Analysis consists of an intensive therapeutic program for children with autistic spectrum disorders. These services aim to improve social behaviors by typically working with a practitioner one-on-one.

Historical and emerging data were analyzed to evaluate ABA costs captured in the CY 2021 base data compared to growth in more recent periods. Compared to historical data periods, CY 2021 includes a significant amount of ABA costs for the LIM/TM/REF and PCK members under 21 years old which will be trended to the SFY 2024 rating period based on the Professional – Other trend rate. However, emerging data indicates growth in ABA costs for the program outpaces the selected trend rate.

A separate analysis was performed to evaluate ABA-specific trends using emerging utilization and unit cost data to quantify a rating adjustment to reflect the increase in estimated cost for SFY 2024 in addition to the amount projected forward from the base period.

Psychiatric Residential Treatment Facilities (PRTF) Reimbursement Increase

Effective July 1, 2023, the reimbursement at PRTF sites of service is increased to 75% of the Medicare Inpatient – Rehabilitation rate.

Paid and utilization data at PRTF sites of service from January 1, 2021 through December 31, 2021 was summarized by category of aid, cohort, and region. The increase in cost by rate cell was estimated by multiplying the utilization by the increase in the reimbursement rate. The percent impact was applied to projected SFY 2024 medical costs.

Behavioral Health Aide

Effective July 1, 2023, utilization of behavioral health aides is a covered service in the GF program. DCH provided a fiscal estimate of the cost of this new service for SFY 2024. The fiscal estimate calculated the projected cost of Behavioral Health Aide utilization in SFY 2024 by estimating the children autism and behavioral health disorders who are currently high utilizers of personal care services. The fiscal estimate was evaluated for reasonableness and allocated out by rate cell based on the projected distribution of utilizers of behavioral health aides. The utilizers of behavioral health aides were estimated to be children 21 years old and younger with autism diagnoses and behavioral health disorders.

Developmental and Behavioral Health Screening and Testing

Effective July 1, 2023, the reimbursement for behavioral screening and testing codes will increase to the 2021 Medicare equivalent rate. The increase applies to procedure codes 96112 and 96113. Paid and utilization data for the affected procedure codes from January 1, 2021 through December 31, 2021 was summarized by category of aid, cohort, and region. The increase in cost by rate cell was estimated by multiplying the utilization by procedure code by the increase in the associated fee

schedule. The percent impact of the fee schedule increase was applied to projected SFY 2024 medical costs.

Postpartum Coverage Extension to 12 Months

Effective November 1, 2022, CMS approved two state plan amendments which extend Medicaid state plan benefits to one year for postpartum individuals with incomes up to 220 percent of the federal poverty level. The purpose of this extension is to decrease postpartum maternal morbidity and mortality.

During the CY 2021 base data time-period, due to the Public Health Emergency Maintenance of Effort requirements, postpartum individuals continued to receive coverage. Given that the CY 2021 data used included these members, the estimated impact of the Postpartum coverage extension is included in the base data and no explicit adjustment was made.

Credibility & Smoothing

Credibility

Due to low membership in the CY 2021 base data that was used to develop the SFY 2024 capitation rates for the PCK 0-2 months and PCK 3-11 months rate cells, a credibility adjustment was utilized to account for random statistical variation related to the number of enrollees. The credibility adjustment was developed by comparing the relative post-trend PMPM cost of the LIM/TM/REF 0-2 months rate cells to the PCK 0-2 months rate cells the LIM/TM/REF 3-11 months rate cells to the PCK 3-11 months rate cells.

Smoothing

A smoothing adjustment was applied to each region such that the statewide age/gender PMPM relativities were maintained across rate cells while preserving budget neutrality.

This adjustment is applied using post-trend PMPMs separated by the following population groups:

- All LIM/TM/REF rate cells and the BCC rate cell
- All PCK rate cells

Section 6: Trend

The trend estimates the increase in overall expenditures of providing health care services from the base period to the rating period.

Medical

When developing the medical trend estimates, the following data sources were analyzed:

- Encounter data from January 2019 – October 2022
- CMO Financial Report data from January 2019 – September 2022
- CMO reported trends for CY 2019 – CY 2022
- Industry trends including Medicaid-specific CMS National Health Expenditures, Medicaid-specific Kaiser Family Foundation, other State Medicaid trends and the Consumer Price Index for medical services

The GF and P4HB experience as reported in the CMO Financial Report data and encounter data was used as the primary data sources to analyze trend because they represent the specific populations and services that are covered under Georgia's Medicaid program. Due to expected population changes occurring between the historical data available at the time of developing the SFY 2024 capitation rates and the contract period, it was necessary to apply an acuity adjustment to the historical experience to isolate the change in trend. Additionally, an IBNR adjustment was applied to the data to remove cost and utilization shifts attributable to runout.

After accounting for these adjustments, PMPM trends, which are comprised of both utilization and unit cost trends, were analyzed by time period (monthly, quarterly, annually), COS, cohort, and region to develop a range of trend rates.

In addition to the CMO Financial Report and encounter data, industry trends from a variety of sources were considered, as specified above. Both actual and observed trends for recent years were reviewed.

The trends selected in the rate development are summarized in **Table 8**, **Table 9**, and **Table 10**.

The following table details the range of annual PMPM trends by major COS; total PMPM trends displayed will vary by rate cell based on service mix These trends were selected by considering the trend sources discussed above. Consideration was also given to emerging trends in 2022 for COVID-19, program and reimbursement changes arising from State budget changes, and changes in the acuity of the population between the base period and the rating period. The impact of the end of the continuous coverage requirement and subsequent unwinding is captured in a separate adjustment outside of trend.

Table 8 – Category of Service Annual PMPM Trends – GF

Major COS	Low Estimate Trend	High Estimate Trend
Inpatient	1.7%	2.7%
Inpatient Mental Health	5.0%	7.8%
Outpatient Emergency Room	5.3%	8.3%
Outpatient Mental Health	1.4%	2.3%
Outpatient	5.7%	8.9%
Professional Mental Health	7.1%	11.0%
Professional Evaluation & Management	4.3%	6.7%

Major COS	Low Estimate Trend	High Estimate Trend
Professional	3.0%	4.7%
Home Health	0.7%	1.1%
Dental	2.1%	3.3%
Other	0.0%	0.0%
FQHC	1.4%	2.3%
TOTAL - GF	**3.6%**	**5.6%**
TOTAL - Kick	**2.0%**	**3.2%**

Table 9 – Delivery Kick Payment Annual PMPM Trends

Delivery Kick Payment COS	Low Estimate Trend	High Estimate Trend
Delivery Kick – Facility	1.7%	2.7%
Delivery Kick – Professional	3.0%	4.7%
TOTAL	**2.0%**	**3.2%**

Table 10 – Category of Service Annual PMPM Trends – P4HB

Major COS	Low Estimate Trend	High Estimate Trend
Inpatient	1.7%	2.7%
Outpatient	5.7%	8.9%
Professional Evaluation & Management	4.3%	6.7%
Professional	3.0%	4.7%
Dental	2.1%	3.3%
TOTAL	**3.2%**	**5.0%**

Trend rates were also analyzed in aggregate with all categories of service, regions, and cohorts combined. The following range of aggregate PMPM trends were observed within each source, comparing multiple time periods. These observed trends are comparable to the selected PMPM trend aggregated from the selected COS trends in the table below.

Table 11 – Observed Annualized Aggregate PMPM Medical Trends Range

Data Source	Time Period	Duration of Analysis	Annualized PMPM Trend
CMO Financial Report	CY 2019 – 3rd quarter of CY 2022	Annual	-10.9% to 14.4%
Encounter	CY 2019 – October 2022	Annual	-9.9% to 7.7%
Industry[2]	CY 2018 – CY 2023 (Proj.)	Various	-0.2% to 7.1%

Unit cost and utilization trends were analyzed separately in addition to PMPM trends. Ultimately the trend selections were not based on the separate unit cost and utilization trends as significant volatility was observed over the time periods and across categories of service. The observed PMPM trends

[2] Includes trends from Medicaid-specific CMS National Health Expenditures, Medicaid-specific Kaiser Family Foundation, and the Consumer Price Index for medical services

provided a better representation of expected future experience and were ultimately used as a contributing source to the ultimate trend selection.

For medical services, trend was applied from the midpoint of the base period to the midpoint of the rating period as shown in the table below.

Table 12 – Medical Trend Months

Base Period	Rating Period	Trend Months
January 1, 2021 – December 31, 2021	July 1, 2023 – June 30, 2024	30

The range of non-pharmacy trend assumptions along with the selected non-pharmacy assumption, developed by category of service, region, and cohort are shown in Exhibits 1A and 4A for GF and Exhibits 1B and 4B for P4HB in the accompanying *SFY 2024 GF and P4HB Rate Exhibits.xlsx* file.

Pharmacy

Pharmacy trends were developed in a similar manner as medical trends. A variety of sources were analyzed including:

- Encounter data from January 2019 – October 2022
- CMO Financial Report data from January 2019 – June 2022
- Industry trends including Magellan, Medicaid CMS National Health Expenditures and other State Medicaid trends

For the GF and P4HB experience as reported in the CMO-reported financial data and encounter data, the data was adjusted for IBNR and normalized across years to reflect changes in the acuity of the population from January 2019 through October 2022. These adjustments are applied to compare the data across different periods and remove shifts in cost and utilization attributable to runout and acuity due to the continuous coverage requirement. After accounting for these adjustments, utilization, unit cost, and overall PMPM trends were analyzed under multiple time periods, levels of detail (i.e., COS, cohort, region), and averaging methods. This analysis enabled consideration of the range of trend rates to consider and included annual, monthly, and quarterly trends.

Trend rates were analyzed by therapeutic class, regions, and cohorts. The therapeutic class trends were analyzed utilizing the encounter data experience. For each therapeutic class, high-cost drugs, drugs with expiring patents and a change in the primary drugs being utilized in each therapeutic class were analyzed and considered when developing therapeutic class trend rates.

Industry trends were also reviewed at a therapeutic class level from a variety of sources as specified above.

The following table summarizes the range of annual trends by therapeutic class. These trends were selected by considering the trend sources discussed above.

Table 13 – Therapeutic Class Annual PMPM Trends

Therapeutic Class	Low Estimate Trend	High Estimate Trend
Antiasthmatic and Bronchodilator	2.6%	3.8%
Analgesics – Anti-Inflammatory	9.0%	12.9%
Dermatological	13.3%	18.8%
ADHD/Anti-Narcolepsy/Anti-Obesity/Anorexiants	-1.8%	-2.7%
Antidiabetics	1.4%	2.0%

Therapeutic Class	Low Estimate Trend	High Estimate Trend
Antivirals	2.7%	3.9%
Endocrine and Metabolic	2.4%	3.4%
Antineoplastics and Adjunctive Therapies	0.8%	1.2%
Respiratory Agents	11.2%	15.8%
Antipsychotics/Antimanic	10.6%	15.1%
Other	3.1%	4.4%
TOTAL - GF	**4.5%**	**6.5%**
TOTAL – P4HB	**4.0%**	**5.8%**

Trend rates were also analyzed in aggregate for all regions and cohorts. The following range of aggregate PMPM trends were observed within each source, comparing multiple time periods. These observed trends are comparable to the Selected PMPM trend aggregated from the selected therapeutic class trends in the table above.

Table 14 – Observed Aggregate PMPM Pharmacy Trends

Data Source	Time Period	Duration of Analysis	Annualized PMPM Trends
CMO Financial Report	CY 2019 – 3rd Quarter of CY 2022	Annual	0.4% to 14.5%
Encounter	CY 2019 – October 2022	Annual	3.8% to 22.7%
Industry	CY 2018 – CY 2023	Various	1.5% to 7.3%

PMPM trend rates were reviewed by cohort and region to consider adjustments for observed differences across cohorts or regions; based on this review, the cohort and region-specific trends did not warrant further modification to the selected trend.

Ultimately the trend selections were not based on the separate unit cost and utilization trends as significant volatility was observed over the time periods and across categories of service. The observed PMPM trends provided a better representation of expected future experience and were ultimately used as a contributing source to the ultimate trend selection.

Pharmacy trend was applied from the midpoint of the base data to the midpoint of the rating period as shown in **Table 15** below.

Table 15 – Pharmacy Trend Months

Base Period	Rating Period	Trend Months
January 1, 2019 – December 31, 2019	July 1, 2023 – June 30, 2024	30

The range of pharmacy trend assumptions, along with the selected pharmacy assumption, developed by region and cohort are shown in Exhibits 1A and 4A for GF and Exhibits 1B and 4B for P4HB in the accompanying *SFY 2024 GF and P4HB Rate Exhibits.xlsx* file.

Section 7: Managed Care Savings Adjustment

Adjustments were made to account for improved efficiencies anticipated to be reasonably attainable by CMOs in Georgia.

Managed Care Savings Adjustment

LIM/TM/REF and PCK

A managed care savings adjustment was applied to the LIM/TM/REF and PCK cohorts for members over the age of 1 year old to reflect reasonably attainable efficiencies for each rate cell. This adjustment is based on observed efficiency opportunities by comparing each CMO acuity adjusted experience by rate cohort and region to the combined experience.

To calculate the adjustment, an efficiency ratio was calculated for each CMO within each rate cell by comparing their actual acuity adjusted CY 2021 cost to the weighted average of the acuity adjusted CY 2021 cost across CMOs for the given rate cell. The acuity adjusted actual PMPM cost for each CMO for each rate cohort and region was calculated by dividing their actual unadjusted base CY 2021 cost by the corresponding CY 2021 risk score. CY 2021 risk scores are based upon:

- Historical, State-specific cost weights consistent with the CDPS+Rx risk adjustment methodology
- CY 2021 Member-level diagnostic and claims information
- CY 2021 Enrollment

Note that CY 2021 data was used as it was the most recent complete year of risk score information available during the development of the managed care savings adjustment.

Efficiency ratios with a value greater than 1.0 indicated potential inefficiency relative to the average and ratios with a value of less than 1.0 indicated greater than average efficiency. For each ratio greater than 1.0, actuarial judgement was used to develop what reasonably attainable improvements in efficiency during the contract period. The efficiency ratios that were less than or equal to 1.0 were not modified. A weighted average efficiency adjustment was then developed for each rate cell.

The impact of the managed care adjustment developed for each rate cell is summarized in Exhibits 1A, 2, and 4A for GF in the *SFY 2024 GF and P4HB Rate Exhibits.xlsx* file.

Section 8: Non-Medical and Case Management Expenses

This section summarizes the estimated non-medical and case management expenses included in the capitation rates. Non-medical expenses include administrative expenses, underwriting gain, and premium-based taxes. The Resource Mother Case Management add-on is applicable to certain cells in the P4HB program.

Administrative Expenses

To develop the administrative expenses included in the SFY 2024 capitation rates, CY 2021 administrative expense data reported in the CMO Financial Reports was analyzed. The CMO Financial Report administrative expense data was reviewed for reasonableness. It was assumed that administrative cost data will vary by category of aid, so the administrative cost development was developed separately for the following major categories of aid: LIM/TM/REF and BCC, PCK, and P4HB.

Based on a review of the expenses reported, the CY 2021 experience was allocated into fixed and variable components. The allocated administrative fixed costs in dollars and variable administrative costs per enrollee were trended forward to the rating period. The administrative expense trends were selected based on historical and emerging CMO Financial Report experience and publicly available data sources including Georgia Consumer Price Index information published by the U.S. Bureau of Labor Statistics, the U.S. Bureau of Economic Analysis, and the Federal Reserve.

When estimating the fixed administrative expense PMPM, the impact of the end of the continuous coverage requirement and subsequent unwinding was considered as estimated enrollment is utilized in the calculation. The federal Consolidated Appropriations Act, 2023 enacted December 29, 2022 requires states to resume eligibility redetermination and process all redeterminations by the end of May 2024. The State indicated that disenrollment from GF and P4HB as a result of the resumption of eligibility redeterminations would be processed on a rolling basis each month through the disenrollment period.

Additionally, administrative expenses were added to account for several of the program changes highlighted in **Section 5** that are related to services that will have additional administrative impacts. Admin adjustments were applied for the following program change adjustments: Donor Milk, Medical Nutritional Therapy, Psychiatric and Behavioral Healthcare Management, Behavioral Health Aide, and Leap Year.

As the administrative expense base data includes pharmacy pass-through costs, the administrative expense load includes a provision for estimated SFY 2024 pharmacy pass-through costs.

The range of administrative expense assumptions, as well as the selected administrative expense assumptions, are displayed in Exhibits 4A and 4B for GF and P4HB, respectively, in the *SFY 2024 GF and P4HB Rate Exhibits.xlsx* file.

Underwriting Gain

The selected capitation rates include a provision for underwriting gain of 1.25% across all regions and cohorts. The provision for underwriting gain covers the minimum cost of capital and margin for risk of participating health plans under reasonably attainable assumptions and is consistent with similar programs and insurance products in other states and marketplaces.

The underwriting gain assumptions are shown in Exhibits 1A and 1B for GF and P4HB, respectively, in the *SFY 2024 GF and P4HB Rate Exhibits.xlsx* file.

Premium-Based Taxes

The selected capitation rates include a provision for premium-based taxes of 2.25% across all regions and cohorts as Georgia requires that all health insurance companies pay a state premium tax of 2.25%. The premium-based taxes assumptions are shown in Exhibits 1A and 1B for GF and P4HB, respectively, in the *SFY 2024 GF and P4HB Rate Exhibits.xlsx* file.

Resource Mother Case Management

The Resource Mother Case Management rate provides for a Resource Mother to support members who have delivered babies weighing less than 3 pounds, 5 ounces. The Resource Mothers provide information on parenting and healthy lifestyles and meet for follow-up visits. This rate is applicable to the enrollees in the RMO rate cell in the P4HB program, who are otherwise eligible for Medicaid, and as an add-on to the rate paid for enrollees in the Interpregnancy (IPC) rate cell in the P4HB program, who are not otherwise eligible for Medicaid.

To develop the SFY 2024 Resource Mother Case Management rate, the Resource Mother Case Management dollars from CY 2020 through the first three quarters of CY 2022 were analyzed and reviewed for reasonableness. It was determined that the CY 2021 Resource Mother Case Management can be reasonably expected to represent future costs for this program.

The CY 2021 Resource Mother Case Management dollars were divided by CY 2021 Resource Mother Case Management membership and trended forward to the rating period using the selected administrative trend rate (discussed in the administrative expenses section above).

The Resource Mother Case Management assumptions are shown in Exhibit 1B in the *SFY 2024 GF and P4HB Rate Exhibits.xlsx* file.

Section 9: Risk Mitigation

The State uses several mechanisms to mitigate risks within the GF and P4HB programs. The mechanisms described below are applied after the development of the actuarially sound rates.

Minimum Medical Loss Ratio

For the GF program, the State has set a Minimum Medical Loss Ratio (Minimum MLR or MMLR) percentage at 86% in compliance with Georgia HB 1013 which requires a minimum MLR of at least 85% starting July 1, 2023 (SFY 2024). The Minimum MLR will be applied separately for the PCK (CHIP population) and non-PCK populations. The GF non-PCK population includes LIM/TM/REF, BCC, and delivery kick payment experience. The minimum MLR will not apply to the P4HB program.

The methodology to calculate the MLR is outlined in the contract and in accordance with the standards outlined in 42 CFR §438.8. The MLR formula is calculated as (Incurred Claims + Quality Improvement Activities) / (Reported Premium – Taxes & Fees). Directed payments will be included in the SFY 2024 MLR calculation as incurred claims in the numerator and as reported premium in the denominator.

The LIM/TM/REF+BCC pricing MLR is 88.4%. Including QIA, the anticipated MLR under this minimum MLR formula is 89.9%. The PCK pricing MLR is 87.2%. Including QIA, the anticipated MLR under this minimum MLR formula is 88.9%.

The State reimbursement for the PCK minimum MLR and the LIM/TM/REF, BCC, and Kick (non-PCK) minimum MLR will be calculated based on the below ranges.

Table 16 – MLR Reimbursement

MLR	CMO Gain/Loss Share	State Gain/Loss Share
< 86%	0%	100%
≥ 86%	100%	0%

The State will implement a remittance for plans whose MLR is below the minimum MLR threshold based on the difference between the plan's actual MLR and the minimum MLR.

Risk Adjustment

To account for the varying health-risk profile across CMOs, Deloitte will apply a risk adjustment mechanism to develop plan-specific capitation rates such that the aggregate impact is budget neutral to the State. The Chronic Illness and Disability Payment System (CDPS) risk model, developed and maintained by the University of California, San Diego, is currently used for the development of risk-adjusted rates.

All rate cells of the GF program are subject to risk adjustment except for the <1 year old rate cells, the BCC rate cell, and the delivery kick payment. Risk scores are calculated semi-annually and applied retrospectively. CMOs receive risk adjusted rates based on their enrollees' relative risk scores.

The following methodology changes will impact the SFY 2024 risk adjustment process:

- The concurrent cost weights will be developed using CY 2022 costs and conditions
- The study period for member risk score assignments will be SFY 2023 for the first semi-annual risk scores and CY 2023 for the second semi-annual risk scores
- Although a new 7.0 CDPS version has been released, at this time DCH plans to use version 6.5 until impacts of the update can be quantified in a future period

Further discussions between the CMOs and DCH may dictate future methodology updates. At the time of this writing, all known methodology changes have been noted above.

All data references are specific to the GF program; the P4HB program is excluded from the risk adjustment process

- Twelve months of managed care encounter data is run through the risk model to calculate a risk score for each member.
- Newborn rate cells (0 – 2 Months, Male and Female, 3 – 11 Months, Male and Female) for both LIM/TM/REF and PCK will be excluded.
- The BCC program and the delivery kick payment will not be risk adjusted.
- Up to ten diagnoses codes are incorporated in modeling for both facility and physician claims.
- Zero and negative paid claims are excluded from risk adjustment.
- Minimum eligibility requirements must be met at three months (non-continuous) for all other members.
- CDPS-Rx risk adjustment model version 6.5 will be used.
- The data is split into two cohorts when run through CDPS to reflect the Georgia Medicaid specific cost experience and risk distribution: members age <21 (AC) and members age 21+ (AA).

Additional detail related to the risk adjustment methodology utilized to develop the risk scores applied for the SFY 2024 rates will be produced following the first six months of the SFY 2024 rating period.

Section 10: Delivery System and Provider Payment Initiatives

The State has Delivery System and Provider Payment Initiatives that require payments made by plans to providers for certain services to follow minimum fee schedules. The arrangements described in this section highlight the data, methodology and assumptions used when developing the rates.

The state has five 438.6(c) preprints applicable for this program – a Physician Directed Payment Program (DPP), a State Government and Non-State Government Hospital DPP (Gov't DPP), a Private Hospital DPP, an AIDE DPP, and STRONG DPP. All programs utilize uniform percentage increases and are paid under separate payment term.

Please note that all five DPPs cover both the state's GF and GF360 programs. The amounts in the table below are specific to anticipated payments under the GF program only. The remaining amounts from the preprints will be covered separately in the Georgia Families 360º certification.

Table 17 - Directed Payment Program Payments

Description	SFY 2024 Preprint Estimate	Control Name	Type of Payment	Rate Adjustment or Separate Payment Term?
Government Hospital – IP and OP	$291,296,036	GA_Fee_IPH.OPH_Renewal_20230701-20240630	Uniform Percent Increase	Separate Payment Term
Private Hospital – IP and OP	$156,636,569	GA_Fee_IPH.OPH3_Renewal_20230701-20240630	Uniform Percent Increase	Separate Payment Term
STRONG – IP and OP	$853,677,889	GA_Fee_IPH.OPH2_Renewal_20230701-20240630	Uniform Percent Increase	Separate Payment Term
AIDE – IP and OP	$457,433,227	GA_VBP.Fee_IPH.OPH_Renewal_20230701-20240630	Uniform Percent Increase	Separate Payment Term
Physician – Physician Services	$207,572,090	GA_Fee_Oth1_Renewal_20230701-20240630	Uniform Percent Increase	Separate Payment Term

Each state directed payment preprint for the five directed payment programs was reviewed and to the best of our knowledge there are no additional directed payments not addressed in the certification.

We confirm to the best of our knowledge there are not any requirements regarding the reimbursement rates the plans must pay to any providers unless specifically specified in the certification as a directed payment or authorized under applicable law, regulation, or waiver.

The five DPPs related to hospitals and physician services are funded as separate payment terms and are not included in the final capitation rates provided in Appendix A. See Exhibit 8 in the *SFY 2024 GF and P4HB Rate Exhibits.xlsx file* for the estimated PMPM impact including estimated administrative costs and premium tax for the five DPPs by rate cell. After the close of the contract period, the actual PMPMs will be calculated, and a revised certification will be developed to account for changes to the DPP PMPMs.

Government Hospital

The Government Hospital DPP increases Medicaid payments for eligible government providers to 100% of Medicare for inpatient and outpatient services. The same uniform percentage increases are applied across all providers for inpatient and outpatient claims. Increase levels vary between inpatient and outpatient, at 32% and 16% respectively, for SFY 2024.

Private Hospital

The Private Hospital DPP increases Medicaid payments for eligible private providers to 100% of Medicare for inpatient and outpatient services. The same uniform percentage increases are applied across all providers for inpatient and outpatient claims. Increase levels vary between inpatient and outpatient, at 32% and 16% respectively, for SFY 2024.

STRONG

The STRONG DPP brings eligible teaching hospitals to rates over 100% of Medicare but less than the average commercial rate for inpatient and outpatient claims. Note that the providers are also eligible for the Gov't or Private Hospital DPP depending on ownership status. The same uniform percentage increases are applied across all providers for inpatient and outpatient claims. Increase levels vary between inpatient and outpatient, at 115% and 106% respectively, for SFY 2024.

AIDE

The AIDE DPP increases two Augusta University Medical Center and Grady Memorial Hospital's inpatient and outpatient claims to the average commercial rate. Given that these two providers are eligible for the Gov't Hospital DPP, the supplemental payment is estimated as the difference between the average commercial rate and 100% of Medicare. The increases differ between inpatient and outpatient services and provider. Average increase levels for inpatient and outpatient services are 265% and 383% respectively, for SFY 2024.

Physician

The Physician DPP increases eligible providers' physician Medicaid payments to the average commercial rate. The uniform percentage increases vary by provider group with an average of 148% for SFY 2024.

Section 11: Capitation Rate Submission

An actuarially sound ranges of assumptions were developed to account for uncertainty inherent in components of the capitation rate analyses. Each of the estimated benefit and non-benefit expense data sources and adjustments was reviewed and discussed with the State to understand levels of reasonableness and potential material uncertainty. Through this analysis, actuarially sound low-estimates and high-estimates for the trend and administrative expenses were developed based on additional sensitivity analyses of rate components to account for potential volatility. Each of these estimates was calibrated to account for volatility in the underlying data and potential differences in prospective assumptions. The low-estimates and high-estimates for these assumptions are shown in Exhibits 1A and 1B for GF and P4HB, respectively, and in Exhibits 4A and 4B for GF and P4HB, respectively, in the *SFY 2024 GF and P4HB Rate Exhibits.xlsx* file.

The resulting rate components were reviewed with the State, and the State selected the payable capitation rates for the GF and P4HB programs in SFY 2024 that correspond to specific assumptions within the actuarially sound ranges. Exhibits 1A and 1B in the *SFY 2024 GF and P4HB Rate Exhibits.xlsx* file also show the capitation rates submitted by the State, which are certified by Deloitte actuaries to be actuarially sound. Exhibits 6, 7A, and 7B provide a comparison to the SFY 2023 rates.

The rates will be adjusted as necessary to reflect any material programmatic changes that occur during the rate period.

Section 12: Actuarial Certification

I, Steve Wander, am a Principal with Deloitte Consulting LLP (Deloitte). I am a Fellow of the Society of Actuaries and a Member of the American Academy of Actuaries. I meet the Academy's qualification standards for rendering this opinion.

I, Tim FitzPatrick, am a Principal with Deloitte Consulting LLP (Deloitte). I am an Associate of the Society of Actuaries and a Member of the American Academy of Actuaries. I meet the Academy's qualification standards for rendering this opinion.

The Georgia State Department of Community Health (DCH) retained Deloitte to assist in the development of the Georgia Families (GF) and Planning for Healthy Babies (P4HB) rate development methodology, assumptions and resulting capitation rates, as well as to provide the actuarial certification required under the Centers for Medicare & Medicaid Services requirements 42 CFR 438 for the period of July 1, 2023 to June 30, 2024, for the GF and P4HB programs.

We certify that the GF and P4HB program rates are actuarially sound and satisfy the following:

- The capitation rates have been developed in accordance with applicable actuarial standards of practice.
- The capitation rates are appropriate for the Medicaid populations to be covered, and Medicaid services to be furnished under the managed care contract.
- The capitation rates meet the applicable requirements of 42 CFR 438; and
- The capitation rates submitted by DCH are based on assumptions that are within the GF and P4HB programs' actuarially sound assumption ranges developed by Deloitte, respectively.

In this capitation rate analysis for the period of July 1, 2023, to June 30, 2024, we have relied on historical claims and enrollment experience data and program information provided to us by DCH as outlined in the Data and Information, Reliance, and Limitations section. We have reviewed the data for reasonableness and consistency during the course of our work; however, we have not audited any of the data we have received. If the underlying data or information provided is inaccurate or incomplete, the results of our review may likewise be inaccurate or incomplete.

Capitation rates analyzed and assumption ranges developed by Deloitte are based on actuarial analysis of future GF and P4HB program costs for the effective period of July 1, 2023, to June 30, 2024. It may be expected that actual experience will vary from the values shown here. Deloitte has developed these rates to demonstrate compliance with the applicable CMS provisions under 42 CFR 438.

This document is solely for the information and use of the Georgia State Department of Community Health and is not for the benefit of or to be relied upon by any other person or entity. This document may not be disclosed to anyone outside the Georgia State Department of Community Health without the prior written consent of Deloitte.

Steve Wander, FSA, MAAA

Deloitte Consulting LLP

Tim FitzPatrick, ASA, MAAA

Deloitte Consulting LLP

Appendix A: Rate Exhibits

Please refer to the accompanying file *SFY 2024 GF and P4HB Rate Exhibits.xlsx* for exhibits documenting the detailed build-up of the SFY 2024 rates as referenced throughout this memorandum.

Appendix B: Regional Map

Appendix C: Outside Data Sources

The below list details information utilized in the development of the SFY 2024 capitation rates that was not provided by Georgia State or participating managed care plans.

- *2022 Milliman Medical Index,* Milliman, Inc. https://us.milliman.com/en/insight/2022-milliman-medical-index
- *CPI-All Urban Consumers U.S. Medical Care*, United States Department of Labor, Bureau of Labor Statistics. https://data.bls.gov/cgi-bin/surveymost?cu
- https://www.federalreserve.gov/monetarypolicy/fomcprojtabl20221214.htm
- *Medical Cost Trends: Behind the Numbers 2022, PWC. https://www.pwc.com/us/en/industries/health-industries/library/behind-the-numbers.html*
- *National Health Expenditure Data,* Centers for Medicare and Medicaid Services. *https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData*
- *Medicaid Enrollment & Spending Growth: FY 2022 & 2023,* Henry J Kaiser Family Foundation. https://www.kff.org/medicaid/issue-brief/medicaid-enrollment-spending-growth-fy-2022-2023/
- *Medical Pharmacy Trend Report,* Magellan Rx Management. Medical Pharmacy Trend Report 2022 by Magellan Rx Management - Issuu
- *Minimum Wage,* New York State Department of Labor. https://www.labor.ny.gov/workerprotection/laborstandards/workprot/minwage.shtm
- *Total Medicaid Expenditures*, Statistica. Medicaid expenditure total U.S. 1966-2019 | Statista
- *2022 Health Care Cost Model*, SOA. https://www.soa.org/resources/research-reports/2021/covid-19-cost-model/
- *2021 Medicare Physician Fee Schedule Changes*, CMS. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched
- Other State Medicaid Managed Care Actuarial Certifications
- *Medicaid Enrollment Churn and Implications for Continuous Coverage Policies,* KFF. *https://www.kff.org/medicaid/issue-brief/medicaid-enrollment-churn-and-implications-for-continuous-coverage-policies/*
- *An Updated Look at Rates of Churn and Continuous Coverage in Medicaid and CHIP,* MACPAC. *https://www.macpac.gov/publication/an-updated-look-at-rates-of-churn-and-continuous-coverage-in-medicaid-and-chip-abstract/*
- *Rates of Medicaid Churn and Continuous Coverage Among Children and Working-Age Adults with Disability-Related Eligibility, Mathematica.* https://www.mathematica.org/publications/rates-of-medicaid-churn-and-continuous-coverage-among-children-and-working-age-adults