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State of Florida

Comparison of Florida's Medicaid Capitation Rate-Setting Process to the Processes Used by Other States

Product B

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Section 1

Executive Summary

Purpose and Scope of Review

Pursuant to Contract No. OP2502 (Contract), the Florida Legislature, through the Office of Program Policy Analysis and Government Accountability (OPPAGA), engaged Mercer Health & Benefits LLC (Mercer) to conduct an independent actuarial review of Florida's Medicaid managed care capitation rate setting process.

This independent actuarial review consists of three separate deliverables:

- The first, "Product A," documents a review of Florida's Medicaid managed care rate setting process for rate years (RY) 2020/2021 through 2024/2025. Product A is a precursor to Product C, whereby the review encompasses the development of the capitation rates; rate methodologies and assumptions; the mid-year capitation rates and adjustments; and offers actuarial observations for consideration as further review and analysis in Product C.
- The second, "Product B," is this document and examines how Florida's approach to Medicaid managed care capitation rate setting aligns with those of large and diverse comparison states, particularly as it applies in the context of mid-year rate changes.
- The final deliverable, "Product C," will provide an in-depth analysis of the Florida Medicaid managed care capitation rate setting process to provide clear and independent professional actuarial opinions on the appropriateness, reasonableness, accuracy, and completeness of the rate setting- work.

This report provides a comprehensive analysis of Florida's Medicaid capitation rate setting process and compares it to the processes employed in California, Georgia, New York, Pennsylvania, Tennessee, and Texas. The review evaluates delivery system design, actuarial methodology, draft and final rate development procedures, rate adjustment frequency, oversight mechanisms, medical loss ratio (MLR) requirements, and the integration of state directed payments (SDPs).

The report is structured to support legislative oversight, appropriations review, and policy evaluation. It identifies similarities and differences across states, evaluates structural strengths and vulnerabilities in rate development practices, and highlights significant developments during the past five years, including COVID-era risk mitigation policies and the rapid expansion of directed payment mechanisms.

Limitations and Disclosures

This document, designated as Product B, was prepared for the Florida Legislature and presents Mercer's review of the managed care capitation rate setting process in Florida compared to other states. The preparation of Product B by Mercer for the Florida Legislature was conducted in compliance with the contractual obligations, and its content may not be appropriate for alternative uses.

This report has been prepared under the direction of Colby Schaeffer, ASA, MAAA, and Rachel Butler, ASA, MAAA, who are members of the American Academy of Actuaries and meet its US Qualification Standard for issuing the statements of actuarial opinion herein. To the best of Mercer's knowledge, there are no conflicts of interest in performing this work.

Product B does not constitute a legal or professional opinion. Mercer disclaims any representations or warranties regarding the content of this document to any third parties. The information contained within Product B or its appendices does not establish any duty or liability between Mercer, Marsh, affiliated Marsh entities, or their employees and third parties. Neither Mercer, Marsh, affiliated Marsh entities, nor their employees bear responsibility for any actions taken by third parties based on the contents of Product B or its appendices.

With respect to Florida, this review is founded upon documentation, models, and data supplied by the Agency for Health Care Administration (AHCA), its contracted actuarial firm Milliman, Inc. (Milliman), and other involved parties. With respect to the listed comparison states, this review is founded upon publicly available documentation and qualitative information supplied by interviews with state staff and other actuaries. Mercer has:

- Not independently audited raw encounter-level or claims-level data beyond what was necessary to assess the actuarial methodology
- Not reconstructed complete alternative rate certifications
- Not issued a new actuarial soundness certification
- Not provided legal or audit conclusions regarding statutory compliance or actuarial soundness

The findings herein represent professional actuarial judgment based on the information available at the time of the review. Should additional documentation or data be made available, conclusions may need to be revisited.

Summary of Findings

The analysis draws on state rate certifications, interviews with state Medicaid agency staff and external actuaries, publicly available data, and internal research. Interviews were held with all comparison states except for Georgia, who validated information we shared with them. Qualitative information such as program descriptions, nomenclature, populations, and services may be inferred from such interviews, past experience, or publicly available information. Where appropriate, especially with statistics and numerical references, there are citations for sources of

information. All comparison states share foundational similarities: capitation rates must be certified as actuarially sound under federal Medicaid regulations (42 Code of Federal Regulation (CFR) Part 438), rates are based on historical encounter and claims experience, and managed care serves as the dominant delivery system. All comparison states also retain rate amendment authority and use some form of profit control or risk mitigation mechanism such as minimum MLR requirements, risk corridors, or experience rebate structures.

However, meaningful differences exist in how the comparison states structure their rate setting processes. Key areas of variability include the management of newer services that exhibit high-cost growth, oversight of managed care organization (MCO) profitability, and transparency with MCOs, State Legislative and Executive Leadership and stakeholders.

There are other comparison states that, like Florida, limit or entirely avoid instances of mid-year capitation rate amendments; Pennsylvania is one such example. Some comparison states, including Tennessee, limit mid-year adjustments to policy-driven circumstances and build anticipated changes into initial rate assumptions — an approach that supports both budget discipline and predictable planning for MCOs. Florida has issued mid-year amendments with meaningful fiscal magnitude, most recently driven by the new contract and procurement start date and the inclusion of applied behavioral analysis (ABA) therapy services in managed care rates. Establishing a defined cost or impact criteria for when capitation rate amendments require the state Medicaid agency to provide additional advance notice to State Legislative and Executive Leadership, along with a defined communication plan and information for the legislature when adjustments exceed a specified threshold, could strengthen fiscal governance.

As noted in the “Product A” report, ABA therapy was the dominant driver of Florida's 22.6% capitation rate increase from Rate Year 2023/2024 to 2024/2025, with underlying medical trend (estimated at approximately 4.2% absent program changes) only accounting for a small percent of the increase. Florida's decision to carve ABA into MMA capitation rates distinguishes it from states such as Texas, which effectively carves out ABA from MCO risk while continuing to accumulate experience data. The manner in which Florida incorporated this benefit into the capitation rates appears to introduce volatility in the capitation rates by rate cell, with unexpected rate changes seen in rate cells not expected to be impacted materially by the inclusion of ABA services. This mostly appears to be driven in part by the application of statewide rate cell factors, due to significant regional cost variation. Even though Florida has a one-sided risk corridor, the carve-in approach introduced greater volatility in rate cell-level changes than peer states experienced — driven in part by the application of statewide rate cell factors to a service with significant regional cost variation. As experience develops, Florida may want to evaluate whether the current structure continues to best support rate stability and predictability across rate cells.

Including any service in a managed care arrangement requires extensive encounter data validation. Texas maintains a rigorous encounter data validation framework, including external quality review organization (EQRO) certification, quarterly financials reconciliation, meetings with financial reporting and auditing teams, and reconciling to a third data source from the MCOs. Florida's carve-in of ABA created new and substantial data monitoring obligations that require significant rigor. In light of Federal audit findings on ABA, which confirmed improper payments exceeding $198 million and separate potentially improper payments of $410 million across four

states (Indiana, Colorado, Maine, and Wisconsin)[1] states should provide ABA-specific billing oversight and cannot rely on MCO self-governance alone. Florida could review their monitoring efforts, and if deemed necessary, further enhance existing ABA-specific utilization benchmarks, provider-level audit review thresholds, and standardized encounter data reporting requirements.

With respect to transparency, there are comparison states like Texas that publish detailed actuarial rate setting methodology reports — including base data periods, trend factors, and MCO comment periods — with over a decade of public documentation. California is formalizing its rate development timeline. Florida's current process has not historically provided equivalent transparency to the public. Formalizing the publication of rate methodology documentation would align Florida with comparison state standards and improve transparency.

Florida maintains MLR and Administrative Savings Requirement (ASR) provisions, which are foundational. However, some comparison states apply more strategic risk-sharing techniques that aim to protect both MCO and state resources. Given the magnitude of recent ABA-driven rate increases and associated MCO profitability impacts, Florida could evaluate whether its current mechanisms are optimally structured for the present program environment.

Overall Assessment

Florida's managed care program is structurally sound and broadly comparable to comparison states in design and operational complexity. The findings in this report represent targeted refinements. Florida operates under requirements of actuarial soundness, uses managed care as its primary delivery mechanism, and faces the same cost and quality challenges confronting large Medicaid programs nationally. The observations and any associated recommendations contained in this report are intended to strengthen an already functional framework and further improve transparency.

This report identifies best practices observed across comparison states, including structured rate timelines, robust encounter data validation, formal MCO comment periods, and transparent methodology publication, and assesses how Florida's current process compares to these practices. The report concludes with considerations for how Florida may strengthen its rate setting process considering these comparisons.

[1] HHS OIG, *Indiana Made at Least $56 Million in Improper Fee-for-Service Medicaid Payments for Applied Behavior Analysis Provided to Children Diagnosed With Autism*, A-09-22-02002 (Dec. 2024), https://oig.hhs.gov/documents/audit/10123/A-09-22-02002.pdf; HHS OIG, *Colorado Made at Least $77.8 Million in Improper Fee-for-Service Medicaid Payments for Applied Behavior Analysis Provided to Children*, A-09-24-02004 (Feb. 2026), https://oig.hhs.gov/documents/audit/11493/A-09-24-02004.pdf; HHS OIG, *Maine Made at Least $45.6 Million in Improper Fee-for-Service Medicaid Payments for Rehabilitative and Community Support Services Provided to Children Diagnosed With Autism,* A-01-24-00006 (Jan. 2026), https://oig.hhs.gov/documents/audit/11447/A-01-24-00006.pdf; HHS OIG, *Wisconsin Made at Least $18.5 Million in Improper Fee-For-Service Medicaid Payments for Applied Behavior Analysis Provided to Children Diagnosed With Autism,* A-06-23-01002 (July 2025), https://www.aapc.com/codes/webroot/upload/general_pages_docs/document/A-06-23-01002.pdf?utm_

Section 2

Introduction

Medicaid Delivery Systems

There are two predominant delivery systems in Medicaid — fee-for-service (FFS) and managed care.[2] Most states use a mix of FFS and managed care, and Medicaid beneficiaries may receive some or all services through an MCO.[3,4,5]

Medicaid Fee-for-Service

In FFS, providers bill the state for each individual service they provide and are paid directly by the state.[6] Generally, states determine the FFS rate, meaning the dollars a provider (e.g., physician, hospital, nursing facility) receives for a specific service, and the federal government pays a percentage of each claim.[7] The Social Security Act requires that FFS "payments be consistent with efficiency, economy, and quality of care, and are sufficient to provide access equivalent to the general population."[8] FFS rates in Medicaid are generally lower relative to Medicare or private insurance.[9]

Medicaid Managed Care

Since the 1990s, the number of Medicaid beneficiaries in managed care has increased dramatically.[10] States began using managed care to deliver services to healthy Medicaid populations (e.g., children and parents).[11] However, recently, states are using managed care for many populations, including individuals with disabilities or long-term care needs.[12] Medicaid enrollees may receive some or all services through an MCO.[13]

The state Medicaid agency pays an MCO a per member per month (PMPM) fee, sometimes referred to as a "capitation payment" or "capitated rate," which is certified by an actuary to cover

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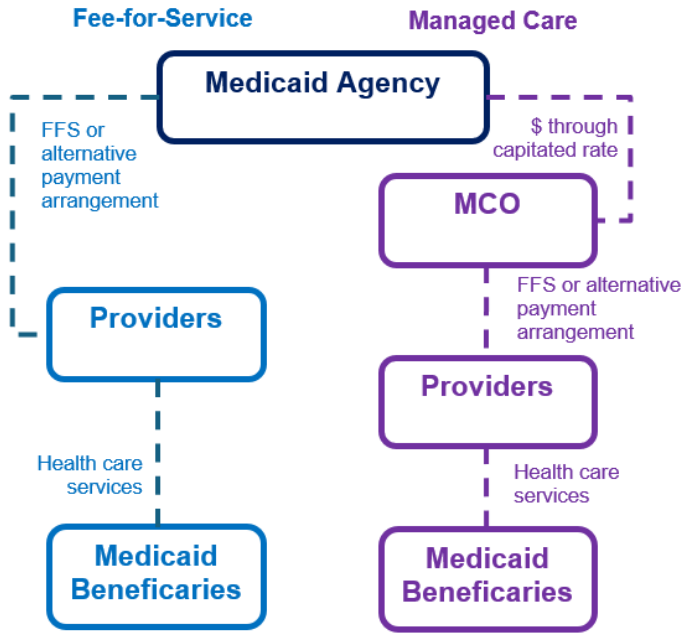
[2] A general overview of the Medicaid program and its fee-for-service (FFS) and managed care delivery systems is available in Product A. Mercer, Florida Medicaid Capitation Rate Review Product A (Mar. 31, 2026) [hereinafter Mercer Product A].
[3] CRS, *Medicaid: An Overview*, R43357, 16 (Apr. 30, 2025), https://www.congress.gov/crs_external_products/R/PDF/R43357/R43357.22.pdf [hereinafter CRS Medicaid Overview].
[4] Part 438 of Title 42 of the Code of Federal Regulations contains the federal regulations governing Medicaid managed care programs.
[5] NAMD, *Why Did They Do It That Way? Managed Care*, https://medicaiddirectors.org/resource/understanding-managed-care/ (last visited Feb. 16, 2026) [hereinafter NAMD Managed Care].
[6] CRS Medicaid Overview.
[7] MACPAC, *Provider Payment and Delivery Systems*, www.macpac.gov/medicaid-101/provider-payment-and-delivery-systems/ (last visited Feb. 16, 2026).
[8] MACPAC Payment and Delivery.
[9] *Id.*
[10] CRS Medicaid Overview.
[11] *Id.*
[12] CRS Medicaid Overview.
[13] *Id.*

all Medicaid beneficiaries enrolled with the MCO (enrollees).[14] In exchange, the MCO handles multiple functions, such as developing a provider network, paying providers for services received by enrollees, applying utilization management controls (e.g., prior authorization), and coordinating care for enrollees.[15] The functions the MCO is responsible for, and the services it must provide to enrollees, are set in a contract between the Medicaid agency and the MCO.[16] Figure 1 provides a flow chart to help illustrate high-level differences between a Medicaid FFS delivery system and a Medicaid Managed Care delivery system.

Figure 1: Fee-for-Service versus Managed Care Delivery System



Under a managed care delivery system, two key parties are central to rate development and financial management: the State actuary and contracted MCOs.

The State actuary's responsibilities include:

- Rate development: Responsible for the technical calculation of capitation rates based on historical cost data, projected trends, and non-benefit costs
- Certification: Provides formal actuarial certifications confirming that the rates are actuarially sound and developed according to generally accepted actuarial principles and federal standards

[14] NCLS, *Medicaid Managed Care 101*, www.ncsl.org/health/medicaid-managed-care-101 (last updated Sep. 21, 2023).
[15] NAMD Managed Care.
[16] *Id.*

- Modeling and analysis: Analyzes emerging medical experience, marketplace trends, and the impact of policy changes to ensure rates accurately reflect the risk profile of the enrolled population

The contracted MCOs' responsibilities include:

- Reporting: Submits regular MLR reports, financial statements, and "fraud, waste, and abuse" reports to the state to inform future rate setting cycles
- Reconciliation: Reconciles monthly capitation payments against eligibility files, and report discrepancies
- Risk assumption: Operates under a risk model, assuming responsibility if the actual cost of providing services exceeds the fixed PMPM capitation

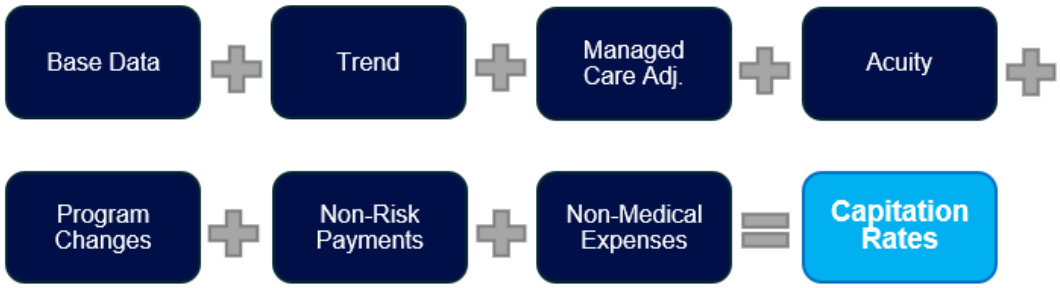
Managed Care Capitation Rates

In the managed care delivery system, states set the capitation rates that must comply with federal requirements. Arguably the most important federal requirement is for the PMPM to be *actuarially sound*, that is, it must be "projected to provide for all reasonable, appropriate, and attainable costs that are required by the contract for … the time period and population covered."[17,18] Federal regulations also require states to develop PMPMs in accordance with actuarial standards of practice (ASOPs) issued by the Actuarial Standards Board.[19-20]

To develop and certify capitation rates as actuarially sound, actuaries must use methodologies that comply with applicable ASOPs. States are required to follow all applicable ASOPs, but ASOP No. 49, Medicaid Managed Care Capitation Rate Development and Certification, is critical as it defines "actuarially sound/actuarial soundness" in Medicaid.[21] In this document, the term *Rate Development Methodology* denotes the process actuaries use to develop and certify the rates.[22] Figure 2 provides an overview of the *Rate Development Methodology*.

[17] SSA § 1903(m)(2)(A)(iii), 42 US.C. § 1396b(m)(2)(A)(iii); 42 C.F.R. § 438.4(a).
[18] Federal regulations also require states to develop PMPMs in accordance with actuarial standards of practice (ASOPs) issued by the Actuarial Standards Board (ASB). *See* 42 C.F.R. §§ 438.4 through 438.7; *see also* The Centers for Medicare and Medicaid Services, *2025-2026 Medicaid Managed Care Rate Development Guide for Rating Periods Starting Between July 1, 2025 and June 30, 2026*, 2 (Aug. 2025), https://www.medicaid.gov/medicaid/managed-care/downloads/2025-2026-medicaid-rate-guide-082025.pdf [hereinafter CMS Managed Care 2025 Rate Development Guide].
[19] 42 C.F.R. §§ 438.4 through 438.7.
[20] CMS Managed Care 2025 Rate Development Guide.
[21] Actuarial Standards Board (ASB), *ASOP No. 49, Medicaid Managed Care Capitation Rate Development and Certification*, Doc. No. 179, 2 (Mar. 2015), https://www.actuarialstandardsboard.org/wp-content/uploads/2015/03/asop049_179.pdf [hereinafter ASOP No. 49].
[22] This process is also commonly known as the "rate setting process." Product A describes the *Rate Development Methodology*.

Figure 2: Rate-Development Methodology



In Product B, Mercer analyzes the full spectrum of activities influencing the development of PMPMs. This review considers activities happening before, during, or after the *Rate Development Methodology* is started or completed, including communications between AHCA and critical stakeholders like the Florida Legislature and MCOs. In Product B, the term *Rate Setting Cycle* denotes all the activities influencing the development of PMPMs. These activities are not necessarily linear and may include iterative components.

Section 3

Overview of Medicaid Landscape by State

Mercer reviewed the *Rate Setting Cycle* activities used by states identified as "comparison states" to Florida for the purpose of this Capitation Rate Review. These states were determined to be appropriate given similarities between their Medicaid managed care programs (e.g., number of beneficiaries, budgets, populations, and services covered) and Florida's Medicaid managed care programs. Florida's six Medicaid managed care comparison states are California, Georgia, New York, Pennsylvania, Tennessee, and Texas. This Section provides an overview of the comparison states' Medicaid managed care programs and capitation rate development methodology. Table 1 shows summary data for each comparison state. These data points come from public reports, which may vary from state-reported numbers, especially with respect to managed care enrollment. Additional detail on Rate Amendments is included below Table 1.

Table 1: Medicaid Delivery System, Enrollment, and Spending by State (2024)

State	Delivery System[23]	Enrollment[24]	Medicaid Budget[25]	Spending per Enrollee[26]	Rate Amendments *(See note below)*
Florida	**Mostly managed care (70%); FFS covers the remainder.**	**4.4M total; 70% (3.1M) in MCOs**	**$37.6B (28.8% of total state budget)**	**$7,611**	**Rarely**
California	Mostly managed care (96%); FFS covers the remainder	14.9M total; 96% (14.3M) in MCOs	$156.1B (34.5% of total state budget)	$10,067	Annually (programmatic)
Georgia	Mostly managed care (69%); FFS covers the remainder	2.3M total; 69% (1.6M) in MCOs	$17.6B (23.0% of total state budget)	$6,720	Generally annual (programmatic)

[23] KFF, *Total Medicaid MCO Enrollment*, www.kff.org/medicaid/state-indicator/total-medicaid-mco-enrollment (last visited Apr. 6, 2026) [hereinafter KFF Total Medicaid MCO Enrollment].
[24] *Id.*
[25] NASBO, *2025 NASBO State Expenditure Report,* www.nasbo.org/reports-data/state-expenditure-report (last visited Apr. 6, 2026) [hereinafter NASBO 2025 Report].
[26] MACPAC, *Exhibit 23. Medicaid Benefit Spending Per Full-Year Equivalent Enrollee For Newly Eligible Adults and All Enrollees by State* (Feb. 2026), https://www.macpac.gov/publication/medicaid-benefit-spending-per-full-year-equivalent-enrollee-for-newly-eligible-adult-and-all-enrollees-by-state/ [hereinafter MACPAC Exhibit 23].

State	Delivery System[23]	Enrollment[24]	Medicaid Budget[25]	Spending per Enrollee[26]	Rate Amendments *(See note below)*
New York	Mostly managed care (68% per CMS, likely higher); FFS covers the remainder	~7.0M total; 68% (4.8M) in MCOs	$90.4B (38.5% of total state budget)	$13,001	Annually (programmatic, tight timing w/ budget)
Pennsylvania	Mostly managed care (92%); FFS covers the remainder	~3.0M total; 92% (2.7M) in MCOs	$44.7B (37.5% of total state budget)	$13,756	Rarely
Tennessee	Mostly managed care (94%); FFS covers the remainder	1.5M total; 94% (1.4M) in MCOs	$15.8B (29.7% of total state budget)	$8,057	Generally annual (programmatic)
Texas	Mostly managed care (93%); FFS covers the remainder	~4.1M total; 93% (3.8M) in MCOs	$47.7B (33.0% of total state budget)	$10,375	Annually (programmatic, directed payment timing)

To meet or maintain federal actuarial soundness requirements, states and their actuaries may need to amend rates to address material changes in the managed care programs. Additionally, CMS expects states to set rates for a 12-month period that aligns with the contract period. The table above illustrates the frequency of rate amendments for the states included in this report; however, it is important to explain the rationale in more detail. There are two basic ways that states may implement a mid-year rate adjustment. First, they may submit the rate amendment after the start of the original rating period and retroactively adjust the capitation rates back to the beginning of the rate period, effectively replacing the prior rates with revised rates. Alternatively, depending on the nature of the change, they may amend the rates to become effective at any point in the contract period and pay the new rates prospectively through the end of the contract period to align with the changes being addressed. As shown in the last column in the table above, many states use mid-year rate changes, to varying degrees, to address managed care changes that are occurring throughout the year but may not be known or fully understood before implementing the new annual rates or starting a new contract cycle.

In addition to the Florida Medicaid program's need to produce a mid-year rate amendment for the ITN/ABA managed care changes, SMMC program rates have been revised at other times using a method similar to the first one mentioned in the paragraph above. For example, the Managed Medical Assistance (MMA) capitation rates for RY 2023/2024 were updated in December 2023, retroactively effective from the start of the rating year.

Other States have implemented mid-year rate adjustments for a multitude of reasons including but not limited to pending major policy or provider fee schedule changes not known at the time the

rates were initially set, to address special contract provisions like state-directed payment programs or pass-through payments to providers, and in recent years to address the impacts of the public health emergency (PHE) followed by the unwinding of these members once the PHE ended. Additional information on the nature of each state's mid-year rate adjustments is included in the sections below.

Florida

Type of Delivery System(s)

Florida offers Medicaid managed care through comprehensive risk-based contracts with MCOs, Dental Maintenance Organizations and Program for All-inclusive Care for the Elderly (PACE) organizations. Approximately 70% of Medicaid beneficiaries are enrolled in managed care.

Medicaid Plans and Programs

Florida offers the following managed care programs:

Statewide Medicaid Managed Care (SMMC): The Agency for Health Care Administration (AHCA), which administers Medicaid and the SMMC program, utilizes four different versions of the managed care model, statewide:

- Comprehensive Plus plan: provides MMA services to MMA-eligible recipients and provides Long-Term Care (LTC) services to LTC eligible recipients. A Comprehensive Plus plan may also provide Specialty products to all specialty population enrollees.
- MMA Plus plan: provides MMA services to MMA eligible recipients (but cannot provide services to recipients eligible to receive LTC services). An MMA Plus Plan may also provide Specialty products to all specialty population enrollees.
- Select Comprehensive plan: provides MMA and LTC services to eligible recipients enrolled in LTC but cannot provide services to MMA-only recipients. A Select Comprehensive plan does not provide a Specialty product.
- Dental plan: provides preventative and therapeutic dental services to all recipients in managed care and all fully eligible fee-for-service individuals.

PACE: AHCA's Medicaid state plan includes a PACE program that serves Medicaid only[27] and Dual beneficiaries that are 55 years of age or older, meet the nursing facility Level of Care, "and reside in a designated geographic service delivery area, and can be safely served in the community."[28] PACE programs offer a holistic managed care model that addresses the spectrum of health care needs, including Medicare services and costs for dually eligible individuals.

Intellectual and Developmental Disabilities Comprehensive Managed Care (ICMC) Program: The ICMC program allows Medicaid recipients residing in the piloted geographic region with intellectual and developmental disabilities to receive comprehensive medical and home- and community-based services (HCBS) through a Medicaid managed care plan.[29] The ICMC program covers MMA services, LTC services, and developmental disability services (e.g.,

[27] AHCA, *Program of All-Inclusive Care for the Elderly (PACE), Senate Health Appropriations Presentation*, 3 (Jan. 15, 2025), https://ahca.myflorida.com/content/download/26657/file/PACE%20Presentation_AHCA%20FINAL_01132025_v2.pdf
[28] AHCA, *Program of All-Inclusive Care for the Elderly Monthly Report*, 1 (Nov. 2025) [Updated Dec. 05, 2025], https://ahca.myflorida.com/content/download/27866/file/PACE%20Report%20November.pdf [hereinafter AHCA PACE 2025 Report].
[29] AHCA, *Intellectual and Developmental Disabilities Comprehensive Managed Care Program Status Report*, 2 (Dec. 2025), https://ahca.myflorida.com/content/download/27804/file/2025%20ICMC%20Status%20Report.pdf [hereinafter AHCA ICMC Program Report].

life skills development, behavior analysis, residential habilitation, skilled nursing, respite), and is managed by a single MCO.[30]

Populations Covered

Most Medicaid recipients in Florida are enrolled in ***SMMC*** in a managed care delivery model. The populations include:[31]

- Children and families
- Pregnant women
- Low-income adults
- Many seniors and people with disabilities
- Under SMMC-LTC, adults who meet the following criteria:[32]
    - Age 65+ or 18+ with a disability
    - Are receiving nursing facility level of care

The ***PACE*** program covers:[33]

- Adults age 55+ who are:
    - Receiving nursing facility level of care
    - Eligible for Medicaid and/or Medicare
    - Able to live safely in the community

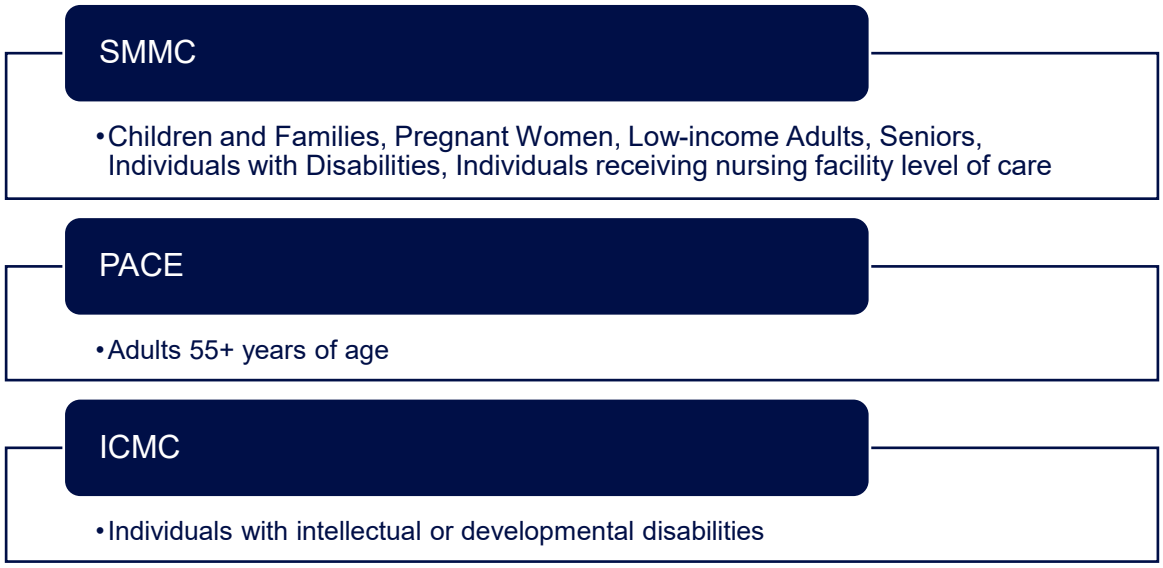
ICMC provides coverage for:[34]

- Individuals with intellectual or developmental disabilities who:
    - Are enrolled in Florida's iBudget HCBS waiver
    - Require institutional level of care

Figure 3 below provides a high-level summary of the Medicaid managed care plans and programs and the respective populations covered.

[30] Appendix B of the AHCA ICMC Program Report has a detailed list of covered services. *Id.* at 19.
[31] Florida Department of Children and Families, *Medicaid Redetermination*, www.myflfamilies.com/medicaid (last visited Apr. 15, 2026).
[32] AHCA, *Who Can Receive Long-Term Care Services*, https://ahca.myflorida.com/medicaid/statewide-medicaid-managed-care/long-term-care-program/who-can-receive-long-term-care-services? (last visited Apr. 16, 2026).
[33] AHCA, *Florida Medicaid's Covered Services and HCBS Waivers*, https://ahca.myflorida.com/medicaid/medicaid-policy-quality-and-operations/medicaid-policy-and-quality/medicaid-policy/federal-authorities/federal-waivers/program-of-all-inclusive-care-for-the-elderly? (last visited Apr. 16, 2026).
[34] AHCA, *Intellectual & Developmental Disabilities Comprehensive Managed Care*, https://ahca.myflorida.com/icmc-program (last visited Apr. 16, 2026),

Figure 3: Overview of Florida Medicaid Programs and Populations



Number and Percentage of Enrollees

As of 2024, total Medicaid enrollment was at 4.4 million members, of which 70% (3.1 million) were enrolled in any type of managed care plan.[35] Total Medicaid enrollment for 2019, the year prior to the start of the public health emergency (PHE), was 3.8 million members.[36]

Medicaid Budget Overview

In 2022, total Medicaid expenditures were $34.0 billion, which represented 32.9% of total state expenditures.[37] For perspective, Florida Medicaid's total 2019 expenditures (prior to the start of the PHE) were $25.9 billion, representing 31.4% of total state expenditures.[38] Although corresponding enrollment figures are not available, Florida Medicaid's total 2024 expenditures (partially impacted by the unwinding period) were $37.6 billion, or 28.8% of total state expenditures. The unwinding period in Florida went from April 2023 through March 2024.

[35] CMS, *Medicaid Managed Care Enrollment and Program Characteristics, 2019 Spring 2022 Updated From Summer 2021*, www.medicaid.gov, (2022), https://www.medicaid.gov/medicaid/managed-care/downloads/2019-medicaid-managed-care-enrollment-report-updated.pdf [hereinafter CMS 2019 Updated Report].
[36] *Id.*
[37] NASBO, *2024 State Expenditure Report*, https://higherlogicdownload.s3.amazonaws.com/NASBO/9d2d2db1-c943-4f1b-b750-0fca152d64c2/UploadedImages/SER%20Archive/2025_SER/2025_NASBO_State_Expenditure_Report_S.pdf [hereinafter NASBO 2024 Report].
[38] NASBO, 2020 State Expenditure Report, https://higherlogicdownload.s3.amazonaws.com/NASBO/9d2d2db1-c943-4f1b-b750-0fca152d64c2/UploadedImages/SER%20Archive/2020_State_Expenditure_Report_S.pdf [hereinafter NASBO 2020 Report].
NASBO 2025 Report.

Medicaid Spending by Service Category and Enrollee

Florida spent approximately $7,600 per full benefit enrollee on Medicaid benefits in fiscal year (FY) 2024.[39] Approximately 66% of the total spend was for managed care (including PACE) and 27% for FFS.[40]

Oversight Mechanisms

The Medicaid Quality Bureau provides feedback on the program's quality to federal and state agencies, beneficiaries, MCPs, and providers. AHCA also uses a variety of reports and dashboards to review effectiveness of the SMMC program.[41] Florida's rate setting process involves engagement with the MCOs with opportunities for reconciling data used in the rate setting process and opportunity for discussion and comments. Additionally, State Executive and Legislative offices are provided with information on draft and final rates, as well as with budget summaries. Finally, AHCA also provides information to the Consensus Estimating Conference, which includes representation from the House, Senate, and Florida Governor, to finalize AHCA budget projections.

Roles and Responsibilities of Entities Involved

Florida administers Medicaid Managed Care through AHCA. AHCA leads program design and contracts with actuaries to develop capitation rates. The contracted actuaries draft rate models using encounter and eligibility data, AHCA reviews the rate models internally for policy alignment, and the contracted actuarial firm (Milliman) finalizes and certifies the rates. Managed care plans operating under Florida's Statewide Medicaid Managed Care (SMMC) program are responsible for submitting complete and accurate encounter data to AHCA on a regular basis, as this data serves as the primary input for base period cost and utilization development. Plans are also required to maintain effective internal program integrity functions, including provider credentialing, fraud and abuse detection, and compliance with encounter data submission standards established in their contracts with the state.

Methodology and Actuarial Assumptions

Florida generally develops capitation rates for a one-year period using a prospective, experience-based approach. Florida uses encounter and claims data, reported through the Florida Medicaid Management Information System, as the basis for rates. Eligibility data provided by AHCA is also leveraged to identify eligibility and enrollment. FFS claims data are also used for services previously excluded from managed care contracts and paid through FFS. Achieved savings rebate (ASR) financial reports provide financial data for each program and are used to validate and adjust encounter data. Milliman develops base data by adjusting underlying data for incomplete reporting, changes in payment methods, and regulatory requirements.

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[39] MACPAC Exhibit 23.
[40] MACPAC Exhibit 17.
[41] AHCA, *Medicaid Quality*, https://ahca.myflorida.com/medicaid/medicaid-policy-quality-and-operations/medicaid-policy-and-quality/medicaid-quality (last visited Apr. 15, 2026).

Once base data is established, Milliman projects costs into the contract period. This is done through the application of trend, program change, and other prospective adjustment factors. Milliman then performs risk adjustment to align capitation rates with the risk profile of the enrolled members. Florida's capitation rates include provisions for administrative expenses (about 8-9% for MMA), cost of capital, and a margin for risk (2% load).

Use of Risk Mitigation Techniques

AHCA includes several programs to mitigate risk to the State and the managed care entities. Florida statute requires AHCA to implement an ASR in its Medicaid managed care programs, under which AHCA is required to collect funds from managed care entities if they achieve significant profits under the program.

The prescribed drugs high-risk pool is a budget-neutral risk pool, whereby a portion of the capitation rates is withheld and set aside to fund a pool that can be paid to the managed care entities, upon certain conditions, to address uneven distribution of high-cost members among managed care organizations.

The cell and gene therapy payment was implemented to address specific new, high-cost, low-utilization gene and cell therapies. Cell and gene therapies are typically administered only once and have low utilization but can be very costly.

Rate Adjustments

The largest drivers of capitation rate adjustments in recent years have been enrollment and acuity changes post-PHE and high trends, particularly observed for pharmacy and behavioral health.

Use Of and Rationale for Mid-Year Rate Adjustments

Florida recently conducted mid-year effective rate changes that impacted the rates effective October 2024 through January 2025. They are generally used for significant, unanticipated changes such as policy changes, benefit updates, eligibility shifts, directed payment renewals, and recalibrated trends. Retroactive adjustments require actuarial certification and CMS documentation.

California

Type of Delivery System(s)

Medi-Cal, California's Medicaid program, offers managed care through comprehensive MCOs and the Program for All-inclusive Care for the Elderly (PACE). Approximately 96% of Medicaid beneficiaries are enrolled in an MCO.[42]

Medicaid Plans and Programs

The California Department of Health Care Services (DHCS), which administers Medi-Cal, utilizes five different managed care models, which vary across the 58 California counties[43,44]:

- **County Organized Health System Model**: comprehensive MCO (including coverage of certain managed long-term services and supports) options across 34 counties. DHCS contracts with a health plan that is created by the counties and administered by independent, local commissions established by the counties.
- **Geographic Managed Care Model**: comprehensive MCO options (including coverage of certain managed long-term services and supports) across two counties. DHCS contracts with a mix of commercial and non-profit plans that compete to serve Medi-Cal beneficiaries.
- **Regional Model**: comprehensive MCO options (including coverage of certain managed long-term services and supports) across five counties. DHCS contracts with two commercial plans in each county.
- **Single-Plan Model**: comprehensive MCO options (including coverage of certain managed long-term services and supports) across three counties. DHCS contracts with one commercial plan operated by the Local County Health Authority.
- **Two-Plan Model**: comprehensive MCO options (including coverage of certain managed long-term services and supports) across 14 counties. DHCS contracts with two health plans, a publicly run entity (a local initiative), and a commercial plan.

PACE: PACE organizations operate in multiple counties within California, but not statewide.

AIDS Health Foundation: comprehensive MCO option in Los Angeles County limited to beneficiaries aged 21 and over with an AIDS diagnosis.

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[42] KFF Total Medicaid MCO Enrollment.
[43] DHCS, Medi-Cal Managed Care Financial Reports, www.dhcs.ca.gov, https://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDFinancialReports.aspx (last visited Apr. 6, 2026).
[44] Mercer, *Medi-Cal Managed Care Capitation Rate Development and Certification* (Sep. 30, 2024), www.dhcs.ca.gov/services/Documents/DirectedPymts/CY-2025-Rate-Certification-Report.pdf

Senior Care Action Network: a Fully Integrated Dual Eligible Special Needs Plan that operates in Los Angeles, Riverside, San Bernardino, and San Diego counties.

Dental: Dental services are covered in managed care through the Dental Managed Care Program in Los Angeles and Sacramento counties, and through a pilot program in San Mateo County. For all other counties, dental services are covered through the State FFS delivery system.

Populations Covered

All Medi-Cal plans cover the following populations:[45]

- Child members (age 0 years–20 years)
- Adult members (age 21+ years)
- Affordable Care Act (ACA) expansion members
- Seniors and persons with disabilities – long-term care (SPD-LTC) members:
    - SPD members
    - Partial dual-eligible with SPD or ACA expansion aid code members
    - LTC aid code members (an aid code, sometimes called an eligibility category or basis of eligibility, is the classification assigned to a Medicaid enrollee that identifies why they qualify for the program)
- SPD-LTC/Full dual-eligible members:
    - SPD/Full dual-eligible members
    - Full dual-eligible with an ACA expansion aid code members
    - Full dual-eligible with an LTC aid code members
- Whole Child Model members

All aid codes listed above are split by members with satisfactory immigration status and members with unsatisfactory immigration status. Unsatisfactory immigration status is referred to as the UIS population. UIS members are eligible to receive the same State Plan services as members with satisfactory immigration status, but federally eligible to receive only pregnancy-related and emergency services.

California also offers full-scope coverage to beneficiaries who qualify for Medi-Cal regardless of immigration status. Full-scope coverage to these beneficiaries has been phased in for various age groups over the past several years, and now members of all ages are eligible for full-scope Medi-Cal, although a freeze of new enrollees is occurring effective January 1, 2026 for certain

[45] Mercer, *Medi-Cal Managed Care Capitation Rate Development and Certification* (Dec. 30, 2024), https://www.dhcs.ca.gov/services/Documents/DirectedPymts/CY-2025-Rate-Certification-Report.pdf

UIS members. Federal match is only available for these members for emergency-related or prenatal services, with remaining services funded with State only funds.

Figure 4 below provides a high-level summary of the Medicaid managed care plans and programs and the respective populations covered.

Figure 4: Overview of California Medicaid Programs and Populations

County Organized Health System Model

- Children (0 - 20 years of age), Adults (21+years of age), ACA Members, Seniors with Disabilities, SPD-LTC Dual Eligible Members, Whole Child Model Members

Geographic Managed Care Model

- Children (0 - 20 years of age), Adults (21+years of age), ACA Members, Seniors with Disabilities, SPD-LTC Dual Eligible Members, Whole Child Model Members

Regional Model

- Children (0 - 20 years of age), Adults (21+years of age), ACA Members, Seniors with Disabilities, SPD-LTC Dual Eligible Members, Whole Child Model Members

Single-Plan Model

- Children (0 - 20 years of age), Adults (21+years of age), ACA Members, Seniors with Disabilities, SPD-LTC Dual Eligible Members, Whole Child Model Members

Two-Plan Model

- Children (0 - 20 years of age), Adults (21+years of age), ACA Members, Seniors with Disabilities, SPD-LTC Dual Eligible Members, Whole Child Model Members

PACE

- Children (0 - 20 years of age), Adults (21+years of age), ACA Members, Seniors with Disabilities, SPD-LTC Dual Eligible Members, Whole Child Model Members, Operates in multiple counties within California, but not statewide.

AIDS

- Children (0 - 20 years of age), Adults (21+years of age), ACA Members, Seniors with Disabilities, SPD-LTC Dual Eligible Members, Whole Child Model Members, in Los Angeles County only, limited to beneficiaries aged 21 and over with an AIDS diagnosis

Senior Care Action Network

- Children (0 - 20 years of age), Adults (21+years of age), ACA Members, Seniors with Disabilities, SPD-LTC Dual Eligible Members, Whole Child Model Members, Dual Eligible Special Needs Plan that operates in Los Angeles, Riverside, San Bernardino, and San Diego counties

Dental

- Children (0 - 20 years of age), Adults (21+years of age), ACA Members, Seniors with Disabilities, SPD-LTC Dual Eligible Members, Whole Child Model Members, eligible in Los Angeles and Sacramento counties, and through a pilot program in San Mateo County. For all other counties, dental services are covered through the State FFS delivery system.

Number and Percentage of Enrollees

As of 2024, total Medi-Cal enrollment was at 14.9 million members, of which 96% (14.3 million) were enrolled in any type of managed care plan.[46] Total Medi-Cal enrollment for 2019, the year prior to the start of the public health emergency (PHE), was 12.8 million members.[47]

Medicaid Budget Overview

In 2022, total Medi-Cal expenditures were $119.0 billion, which represented 26.9% of total state expenditures.[48] For perspective, Medi-Cal's total 2019 expenditures (prior to the start of the PHE) were $88.9 billion, representing 29.6% of total state expenditures.[49] Although corresponding enrollment figures are not available, Medi-Cal's total 2024 expenditures (partially impacted by the unwinding period) were $156.1 billion, or 34.5% of total state expenditures.[50] The unwinding period in California went from June 2023 through May 2024.

Medicaid Spending by Service Category and Enrollee

Medi-Cal spent approximately $10,100 per full benefit enrollee on Medicaid benefits in fiscal year (FY) 2024[51]. Approximately 46% of the total spend was for managed care (including PACE) and 52% for FFS.[52]

Oversight Mechanisms

California's DHCS Managed Care Quality and Monitoring Division oversees Medi-Cal managed care plans' performance and quality by monitoring, quality enforcement reports, network adequacy assessments, claim/encounter data, and through audits.[53] DHCS's Capitated Rates Development Division publicly issues various reports and information related to Medi-Cal health plans, including capitation rate ranges, actuarial certifications, and rate development methodologies. The State also oversees a Medical Loss Ratio work plan.[54]

Roles and Responsibilities of Entities Involved

California's DHCS is the responsible state entity for Medi-Cal managed care rate development and certification.[55] California administers Medi-Cal managed care through five delivery models, in addition to specialty programs such as PACE, Senior Care Action Network, and Aids Health Foundation: County Organized Health System, Two-Plan, Geographic Managed Care, Regional,

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[46] KFF Total Medicaid MCO Enrollment.
[47] CMS 2019 Updated Report.
[48] NASBO 2024 Report.
[49] NASBO 2020 Report.
[50] NASBO 2025 Report.
[51] MACPAC Exhibit 23.
[52] MACPAC Exhibit 17.
[53] DHCS, *Managed Care Monitoring*, www.dhcs.ca.gov, https://www.dhcs.ca.gov/services/Pages/ManagedCareMonitoring.aspx (last accessed Apr. 7, 2026).
[54] DHCS, *Medi-Cal Managed Care Financial Reports*, https://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDFinancialReports.aspx (last visited Apr. 16, 2026).
[55] DHCS, *About DHCS*, https://www.dhcs.ca.gov/Pages/AboutUs.aspx (last visited Apr. 6, 2026).

and Single Plan structures.[56] Mercer serves as DHCS's contracted actuarial firm and has supported Medi-Cal managed care rate development since 2005.

Methodology and Actuarial Assumptions

California develops annual calendar-year rate certifications. Methodology includes base data validation, service-level trend analysis, population mix and program change adjustments, risk mitigation structures, such as risk corridors, where applicable, and explicit documentation of directed payment mechanisms.

To develop base data, California relies primarily on rate development template (RDT) submissions from each managed care plan (MCP).[57] The RDTs are financial data templates filled out by the MCPs each year that collect utilization and cost information by rate cell and service category at a level needed for rate setting.[58] This data is supplemented with encounter data, state paid FFS data (where applicable), and quarterly financial reports submitted by the MCPs as well.[59]

DHCS's contracted actuaries set capitation rates at the region-level (many counties are their own region, but other regions consist of multiple counties) using blended data across all plans operating in that region and then risk-adjust plan-specific rates using CDPS+Rx (Chronic Illness and Disability Payment System plus Medicaid Rx) risk adjustment methodology.[60]

Use of Risk Mitigation Techniques

California uses a combination of minimum MLR requirements and risk-sharing mechanisms to manage financial risk for Medi-Cal managed care plans.[61] Capitation rates are developed such that the MLR is projected to be greater than 85% in all regions.[62,63] The State will impose remittance provisions related to MLR, such that the MCPs will remit payment back to the State if the calculated actual MLR is less than 85%, up to the minimum 85% MLR amount.[64]

Additionally, DHCS has implemented multiple two-sided risk corridors for specific rating components where there is a significant amount of uncertainty regarding projected utilization of a benefit. A two-sided risk corridor means that the State would make additional payments to the MCPs if the revenue paid out in the capitation rates is too low (below a certain threshold), while the MCPs will remit payment back to the State if the revenue paid out in the capitation is too high (above a certain threshold). The risk corridors are not typically applied broadly across all components of the rates, but rather certain smaller components of the rates where significant uncertainty exists on projected costs related to the component.[65]

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[56] DHCS, *Medi-Cal Managed Care*, https://www.dhcs.ca.gov/services/Pages/Medi-CalManagedCare.aspx (last visited Apr. 7, 2026).
[57] *Id.*
[58] *Id.*
[59] *Id.*
[60] Mercer, *Medi-Cal Managed Care Capitation Rate Development and Certification* (Dec. 19, 2025), https://www.dhcs.ca.gov/dataandstats/reports/Documents/CY-2026-Rate-Certification-Report.pdf
[61] *Id.*
[62] *Id.*
[63] *Id.*
[64] *Id.*
[65] *Id.*

Rate Adjustments

In recent years, the largest drivers of capitation rate adjustments have included expanding services and covered populations, provider rate changes, acuity adjustments, delivery system reforms, and the expansion of directed payment programs. DHCS incorporates policy changes, including adjustments related to value-based payment initiatives, into base data and trend assumptions. Program changes, such as benefit changes, have also impacted the capitation rates.

Use Of and Rationale for Mid-Year Rate Adjustments

California has implemented mid-year rate adjustments for a multitude of reasons. These include instances where major policy information was not known at the time rates were set prospectively. For example, a rate amendment was applied in CY 2024 for the addition of new policy changes for a Children and Youth Behavioral Health Initiative and a Federally Qualified Health Center Alternative Payment Model. For both of these policy changes, not enough information was known prior to the rating period to incorporate into the rates, but they were policy changes that affected costs within CY 2024. As a result, capitation rates needed to be amended to include the provision of these changes within the rates. Additionally, there are instances where certain special payment arrangements, such as pass-through payments, needed to be incorporated after the rates were prospectively set. Further, since the COVID-19 pandemic, mid-year adjustments have been applied to reflect more known enrollment information due to members not disenrolling in the initial years of public health emergency (PHE) followed by the unwinding of these members once the PHE ended.

Georgia

Type of Delivery System(s)

The Georgia Department of Community Health (DCH) utilizes a comprehensive managed care model to provide benefits to roughly 70% of its Medicaid enrollees while a FFS system covers the remaining enrollees.[66]

Medicaid Plans and Programs

Georgia has four Medicaid managed care programs, contracted with one to three care management organizations (CMOs):[67]

- **Georgia Families**: state Medicaid managed care
- **Planning for Healthy Babies**: uninsured women not eligible for Medicaid/Children's Health Insurance Program (CHIP)
- **Georgia Families 360°**: foster care, adoptive assistance, and select juvenile justice system members
- **Georgia Pathways to Coverage (Pathways)**: household income must be at or below 100% of the federal poverty level (FPL)

Populations Covered

Georgia Families covers the following populations:[68]

- Low-Income Medicaid/Transitional Medical Assistance (LIM/TMA): These programs are designed for families with low income and those who recently became ineligible for LIM because of increased income.
- Refugee Medical Assistance (RMA): Refugees and other eligible non-citizens are first evaluated for standard Medicaid programs (such as LIM) and, if they do not qualify, they may receive RMA. RMA is a short-term program typically available only during a refugee's first eight months in the United States:[69,70]
    - The RMA financial eligibility threshold is 200% of the FPL.

[66] KFF Total Medicaid MCO Enrollment.
[67] Georgia Medicaid, *All Programs*, https://medicaid.georgia.gov/programs/all-programs (last accessed Apr. 5, 2026).
[68] Georgia Medicaid, *Georgia Families Frequently Asked Questions (FAQs)*, https://medicaid.georgia.gov/programs/all-programs/georgia-families/georgia-families-latest-news/georgia-familiesr-frequently (last visited Apr. 7, 2026).
[69] Georgia Medicaid, *Citizenship and Residency FAQs*, https://medicaid.georgia.gov/citizenship-and-residency-faqs (last visited Apr. 7, 2026)
[70] Georgia Department of Human Services Office of Refugee Services, *Refugee Medical Assistance (RMA)*, MAN3180 Refugee Support Services, 28 (Apr. 13, 2026) https://pamms.dhs.ga.gov/ors/_exports/man3180-refugee-support-services.pdf#refugee-medical-assistance

  - RMA covers refugees, asylees, Cuban/Haitian entrants, victims of human trafficking, and certain Amerasians and special immigrants from Iraq and Afghanistan.
  - Unlike many other legal immigrants, refugees and asylees are exempt from the standard five-year waiting period to qualify for Georgia Medicaid.
  - If a refugee starts a job and their income exceeds the program limits, they may remain eligible for transitional RMA until the end of their initial eligibility period, ensuring they do not lose health coverage while becoming self-sufficient.

- PeachCare for Kids (PCK): Georgia's version of CHIP; it provides comprehensive health insurance for uninsured children whose families earn too much to qualify for traditional Medicaid but cannot afford private insurance (reasonable monthly premiums depend on income level and number of children covered within a family; small co-payments may apply for certain services for older children)[71]
- Women's Health Medical Assistance: An early detection and treatment initiative administered by the Georgia Department of Public Health. Within the context of Georgia Families, women diagnosed with breast or cervical cancer through this program are enrolled in a specialized Medicaid category and are served by a CMO:[72]
  - Breast cancer: 40 years–64 years, females
  - Cervical cancer: 21 years–64 years, females
  - Household income must be at or below 200% of the FPL
  - Cannot have health insurance that pays for cancer treatment

Planning for Healthy Babies covers the following populations:[73]

- Family Planning only: Primary goal is to reduce the number of low birth weight and very low birth weight (VLBW) babies in Georgia by providing no-cost family planning services to women who might not otherwise qualify for Medicaid:
  - Coverage for 18 years–44 years, female.
  - Family gross income must be at or below 211% of the FPL.
  - Must be able to become pregnant and not already eligible for any other Medicaid program.
- Resource Mother Outreach: Provides peer support and guidance to women who have delivered a VLBW baby, defined as weighing less than 3 pounds, 5 ounces (1,500 grams). A resource mother is a specially trained paraprofessional who works in

[71] Georgia Department of Community Health, *PeachCare for Kids Eligibility Criteria*, https://dch.georgia.gov/peachcare-kids/eligibility-criteria (last visited Apr. 16, 2026).
[72] Georgia Medicaid, *Women's Health Medicaid*, https://medicaid.georgia.gov/womens-health-medicaid (last visited Apr. 16, 2026).
[73] Georgia Medicaid, *Eligibility*, https://medicaid.georgia.gov/programs/all-programs/planning-healthy-babies/eligibility (last visited Apr. 5, 2026).

coordination with a nurse case manager; their primary goal is to help mothers adopt healthy behaviors and manage the unique health demands of a VLBW infant:

  - Must be enrolled in a Medicaid program.
  - Have delivered a VLBW baby.
  - Covers 18 years–44 years, female.
  - Participation is generally limited to 24 months following the birth of the VLBW baby.

- Interpregnancy: Specifically designed to support women who have already delivered a VLBW baby, to improve their health before a future pregnancy:
  - Must have delivered a VLBW baby on or after January 1, 2011.
  - Cannot currently be receiving other Medicaid benefits (women already on Medicaid are only eligible for the Resource Mother component).
  - Covers 18 years–44 years, female.
  - Family gross income must be at or below 211% of the FPL.

Georgia Families 360° covers these populations:[74]

- Foster care/Department of Juvenile Justice
  - All youth and young adults, female and male.
  - Coverage typically continues through age 21 years, but formerly, foster-involved youth may be eligible to remain in the program until they turn 26 years old.
  - Non-secure placement youth within the Department of Juvenile Justice.
- Adoptive Assistance: Provides specialized healthcare management for children and youth adopted from the state's foster care system or identified as having special needs:
  - Eligibility is typically based on special needs factors such as being part of a sibling group, having a documented physical or mental disability, or having been in the care of a public or private agency for an extended period (usually six months to 24 months).
  - Unlike foster care members, adoptive parents have the option to opt-out of the managed care program within 90 days of enrollment and move the child to traditional FFS Medicaid.

[74] Georgia Medicaid, *Georgia Families Frequently Asked Questions (FAQs)*, https://medicaid.georgia.gov/programs/all-programs/georgia-families/georgia-families-latest-news/georgia-familiesr-frequently (last visited Apr. 7, 2026).

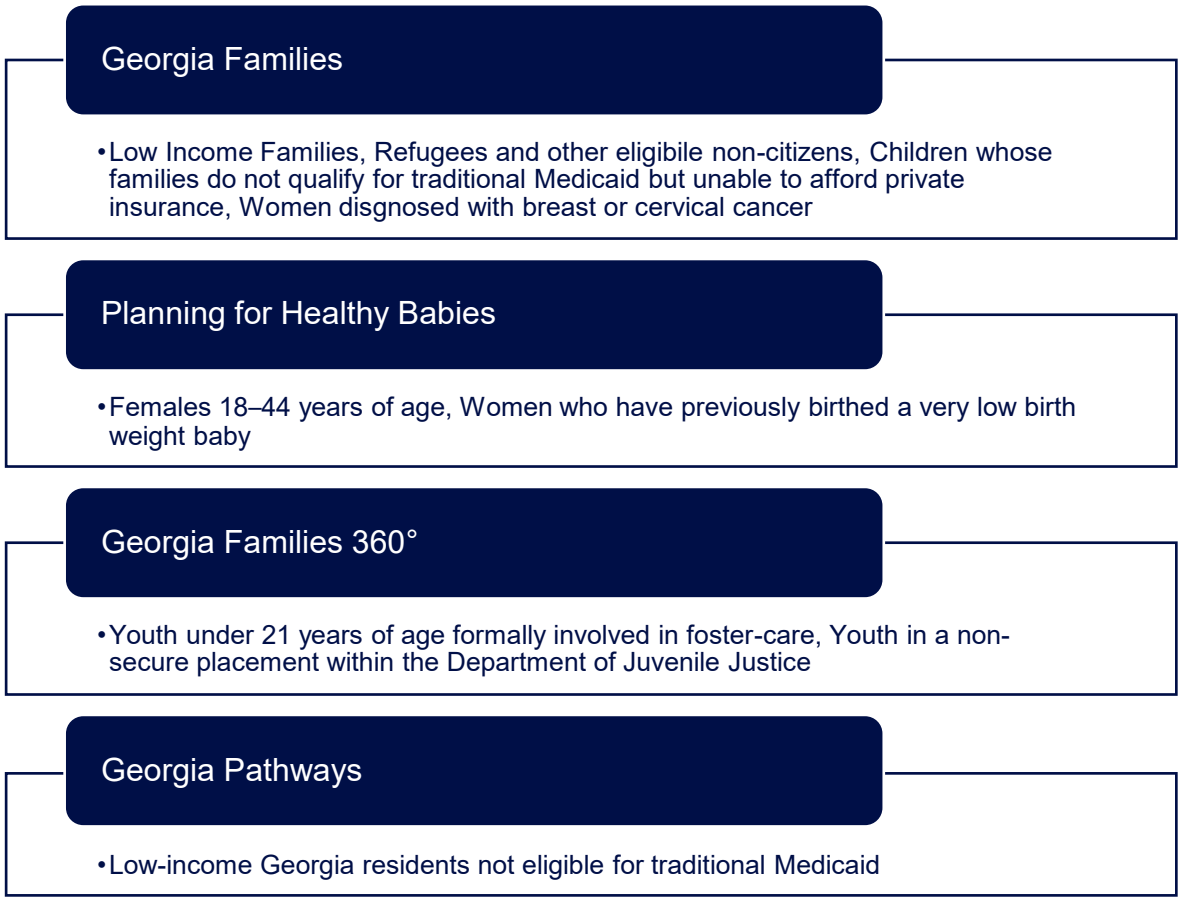
Georgia Pathways: Designed for low-income Georgia residents not eligible for traditional Medicaid. Unlike standard Medicaid, it requires members to be working or participating in specific qualifying activities to maintain coverage:[75]

- Must be a Georgia resident and a US citizen or legally residing non-citizen.
- Activity requirement: Must prove at least 80 hours per month of one or more qualifying activities:
    - Employment: Be full-time, part-time, or self-employed.
    - Education: Involved in higher education (public/private universities or technical colleges) or vocational training.
    - Job support: Involved in on-the-job training, job readiness programs, or vocational rehabilitation.
    - Community service: Volunteers to work with non-profit or community organizations.
    - Caregiving: Is providing care for a child under age six years (if the child is also on Medicaid) or relative caregiving through specific state programs.
    - Health stays: Spent time in a skilled nursing facility or hospital.
- Cannot be eligible for any other category of Medicaid and cannot be incarcerated.

Figure 5 below provides a high-level summary of the Medicaid managed care plans and programs and the respective populations covered.

[75] Georgia Pathways to Coverage, *Frequently Asked Questions*, https://pathways.georgia.gov/about-pathways/faqs (last visited Apr. 7, 2026).

Figure 5: Overview of Georgia Medicaid Programs and Populations



Number and Percentage of Enrollees

As of 2024, total Georgia Medicaid enrollment was at 2.3 million members, of whom 69% (1.6 million) were enrolled in any type of managed care plan.[76] Total Georgia Medicaid enrollment for 2019, the year prior to the start of the PHE was 1.9 million members.[77]

Medicaid Budget Overview

In 2022, total Georgia Medicaid expenditures were $15.0 billion, which represented 22.2% of total state expenditures.[78] For perspective, Georgia Medicaid total 2019 expenditures (prior to the start of the PHE) were $11.4 billion, representing 21.1% of total state expenditures.[79] Although corresponding enrollment figures are not available, Georgia Medicaid's total 2024 expenditures

[76] KFF Total Medicaid MCO Enrollment.
[77] CMS 2019 Updated Report.
[78] NASBO 2024 Report.
[79] NASBO 2020 Report.

(partially impacted by the unwinding period) were $17.6 billion, or 23.0% of total state expenditures.[80] The unwinding period in Georgia went from April 2023 through May 2024.

Medicaid Spending by Service Category and Enrollee

Georgia Medicaid spent approximately $6,700 per full benefit enrollee on Medicaid benefits in FY 2024[81]. Nearly 38% of the total spend was for managed care and 57% was for FFS.[82]

Oversight Mechanisms

Per federal regulation (42 CFR 438.602), all states must conduct independent, periodic audits of encounter and financial data submitted by the health plans and post results publicly. DCH follows this process, which serves as external verification of data accuracy and completeness.[83]

Also, as required under 42 CFR 438.10(c)(3) and 42 CFR § 438.66(e), Georgia (and other states) must publish managed care program annual reports, which include performance, compliance, and quality oversight data.[84] Periodic independent audits serve as an external check on Medicaid managed care oversight.

Roles and Responsibilities of Entities Involved

Georgia DCH administers Medicaid primarily through CMOs. DCH implemented a rate negotiation process that allows contracting CMOs and their actuaries to review the capitation rate development and provide comments and feedback to DCH. Deloitte is the contracted actuary by DCH. The specific rates submitted by DCH are the result of the negotiation process, which is informed by the rate methodology, and they are then certified by the state's actuaries to be actuarially sound if they correspond to specific assumptions that are within the actuarially sound assumption ranges developed.

Methodology and Actuarial Assumptions

DCH uses audited managed care encounter data as the primary data source used for rate development, including institutional, professional, and pharmacy claim data. Georgia's contracted actuaries also receive detailed CMO enrollment and capitation payment data, including all applicable retroactive rate cell adjustments. Each health plan provides monthly detailed CMO financial report data, including detailed expenditures and revenues at the region and rate cell-level. The CMOs also provide supplemental pharmacy rebate information.

DCH's contracted actuaries develop actuarially sound ranges for various assumptions within the rate development process and certify rates that correspond to specific assumptions within the

[80] NASBO 2025 Report.
[81] MACPAC Exhibit 23.
[82] MACPAC Exhibit 17.
[83] Georgia Medicaid, *CMO Reviews and Reports*, https://medicaid.georgia.gov/programs/all-programs/georgia-families/cmo-reviews-and-reports (last visited Apr. 6, 2026).
[84] Georgia Department of Community Health, *Medicaid Managed Care*, https://dch.georgia.gov/medicaid-managed-care (last visited Apr. 5, 2026).

actuarially sound assumption ranges. The actuaries then risk-adjust the rates using the CDPS+Rx risk adjustment methodology and prospectively incorporate directed payments into capitation rates. Rate adjustments may reflect provider payment reforms, benefit changes, or eligibility shifts.

Use of Risk Mitigation Techniques

Georgia uses several different risk-sharing mechanisms to manage financial risk. An adjustment is made to the pharmacy component of the rate to account for rebates retained by plans participating in Georgia Families and Planning for Healthy Babies. These rebates are not reflected in encounter data used as the base pharmacy data, and therefore, the base pharmacy costs would be overstated without this adjustment.

For the Georgia Families program, the State set a minimum MLR percentage at 86%, in compliance with Georgia HB 1013, which requires a minimum MLR of at least 85% starting July 1, 2023 (state fiscal year [SFY] 2024). The minimum MLR is applied separately for the PCK (CHIP population) and non-PCK populations. The Georgia Families non-PCK population includes LIM/TM/REF, Breast and Cervical Cancer (BCC), and delivery kick payment experience. The minimum MLR is not applied to the Planning for Healthy Babies program.

A managed care savings adjustment is applied to the LIM/TM/REF and PCK cohorts for members over the age of one 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.

Rate Adjustments

The largest drivers of recent capitation rate adjustments in Georgia include benefit or policy changes (including Georgia Pathways), changes to provider reimbursement, trend impacts of ABA therapy, and shifts in utilization (e.g., due to eligibility expansions or PHE unwinding).

Use Of and Rationale for Mid-Year Rate Adjustments

Rate development follows annual cycles aligned with the SFY. However, the capitation rates have typically been adjusted as necessary to reflect any relevant programmatic changes that were not known at the time of the initial certification, and the rate certification is amended if necessary.

New York

Type of Delivery System(s)

New York's Office of Health Insurance Programs utilizes a managed care model to provide benefits to most of its Medicaid enrollees, while others are excluded from managed care and receive benefits via FFS. As of 2024, approximately 68% of enrollees were enrolled in an MCO.[85] Note that while CMS national datasets indicate roughly 68% of beneficiaries are enrolled in comprehensive risk-based managed care; however, the state indicated higher penetration (near 90%) because it includes additional managed delivery systems such as Managed Long-Term Care and other specialized plan arrangements.

Medicaid Plans and Programs

New York contracts with the following Medicaid plans:

- **Mainstream managed care (MMC)**: Standard plans for adults and families that cover all basic medical services, contracting with 12 MCOs
- **Managed long-term care (MLTC)**: For individuals needing long-term care services, such as home care or adult day care, for more than 120 days, contracted with 15 MCOs[86]
- **Health and Recovery Plans (HARPs)**: Specialized plans for adults with significant mental health or substance use needs, contracting with 12 MCOs
- **HIV Special Needs Plans (HIV-SNP)**: Tailored for people living with HIV/AIDS, their children, or homeless individuals, contracting with three MCOs
- **PACE**: A comprehensive program for those 55+ years qualifying for nursing home-level care but wish to stay in their community, contracting with 10 PACE organizations
- **Medicaid Advantage Plus**: Integrated plans for those 18+ years who have both Medicare and Medicaid, contracting with 12 MCOs

Populations Covered

MMC covers the following populations:

- Low-income adults not covered under ACA Section VIII (excludes pregnant women and people with disabilities)

[85] KFF Total Medicaid MCO Enrollment.
[86] State of New York, *MLTC Plans*, https://www.health.ny.gov/health_care/managed_care/mltc/docs/mltcplans.xlsx

- Low-income adults covered under ACA Section VIII (excludes pregnant women and people with disabilities)
- Aged (65 and older), blind, or disabled children or adults
- Non-disabled children (excludes children in foster care or receiving adoption assistance)
- Children with special health care needs
- Foster care and adoption assistance children

MLTC covers the following populations:[87]

- Dual eligibles: Both Medicare and Medicaid eligible
- Are 21+ years of age
- Clinically needy: Those who require community-based long-term care services (such as home health aides or personal care) for more than 120 days
- Minimum needs test: Effective September 1, 2025, new enrollees must generally need help with three or more activities of daily living, such as bathing or dressing. For those with dementia or Alzheimer's, the requirement is help with two or more activities of daily living
- Certain groups can choose to join an MLTC plan but are not required to do so:
- Younger dual eligibles: Individuals aged 18 years–20 years, having both Medicare and Medicaid, and meeting the clinical need for nursing home-level care
- Non-dual adults: Individuals aged 18 years or older who have Medicaid only (no Medicare) and are assessed as nursing home eligible
- Medicaid buy-in for working people with disabilities: Eligible working adults requiring nursing home-level care

HARP covers the following populations:[88]

- Low-income adults
- Are 21+ years of age
- Insured only by Medicaid
- Must have a clinical diagnosis of a serious mental illness and/or a substance use disorder

[87] New York State, *MLTC Partial Capitation (MLTCP)*, https://www.health.ny.gov/health_care/managed_care/mltc/partial_cap.htm (last visited Apr. 5, 2026).
[88] Anthem Blue Cross and Blue Shield, *New York Health and Recovery Plan (HARP)*, https://www.anthembluecross.com/ny/medicaid/health-and-recovery-plan (last visited Apr. 8, 2026).

- HIV-SNP members: Individuals in an HIV-SNP who meet HARP clinical criteria are eligible for the same enhanced behavioral health benefits (e.g., HCBS) while remaining in their SNP[89]

HIV-SNP covers the following populations:[90]

- Individuals living with HIV/AIDS: Medicaid-eligible adults who have tested positive for HIV or AIDS
- Transgender and gender non-conforming individuals: All Medicaid-eligible transgender or gender non-conforming individuals can enroll, regardless of their HIV status
- Individuals experiencing homelessness: Medicaid-eligible individuals who are homeless or have unstable housing can join, regardless of their HIV status
- Dependent children: Eligible children of a member can enroll in the same SNP, even if the children are HIV-negative. This eligibility typically extends to children up to 21 years.

PACE covers the following populations:[91]

- Are 55+ years of age
- Clinically needy: Those certified by the state as eligible for nursing home-level care
- Safety: Those able to live safely in the community (at home or in a supportive setting) with the help of PACE services at the time of enrollment
- Location: Must live in a PACE service area (specific ZIP codes or counties where a PACE organization operates)

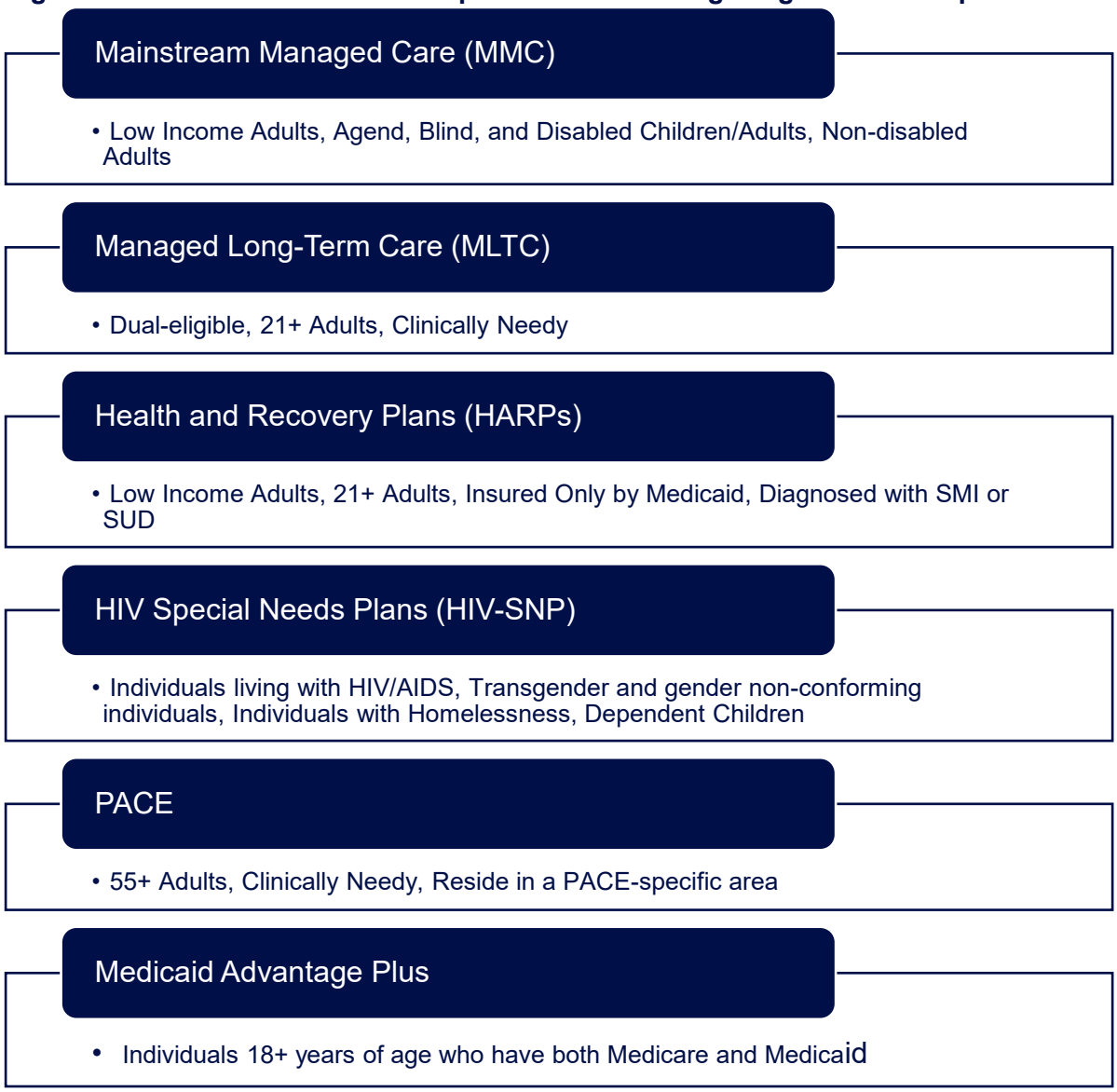
Medicaid Advantage Plus covers the following populations:

- 18+ years
- Insured by Medicaid and Medicare Part A and B
- Must be enrolled in the aligned Medicare Advantage Dual Special Needs Plan
- Must be capable of remaining at home or returning to home
- Clinically needy: Those who require community-based long-term care services (such as home health aides or personal care) for more than 120 days
- Minimum needs test: Must generally need help with two or more activities of daily living. For those with dementia or Alzheimer's, the requirement is help with one or more activities of daily living

[89] New York State, *Health and Recovery Plan (HARP)/ Behavioral Health*, https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/harp_bh/index.htm (last visited Apr. 7, 2026).
[90] New York State, *HIV Special Needs Plans (HIV SNPS)*, https://www.health.ny.gov/diseases/aids/general/resources/snps/ (last visited Apr. 6, 2026).
[91] New York State, *Program for the All-Inclusive Care for the Elderly (PACE)*, https://www.health.ny.gov/health_care/managed_care/mltc/pace.htm (last accessed Apr. 6, 2026).

Figure 6 below provides a high-level summary of the Medicaid managed care plans and programs and the respective populations covered.

Figure 6: Overview of New York Capitation Rate Setting Programs and Populations



Number and Percentage of Enrollees

As of 2024, total New York Medicaid enrollment was nearing 7 million members, of whom 68% (4.8 million) were enrolled in an MCO.[92] Total New York Medicaid enrollment for 2019, the year prior to the start of the PHE was 6.1 million members.

Medicaid Budget Overview

In 2022, total New York Medicaid expenditures were $74.2 billion, which represented 35.4% of total state expenditures.[93] For perspective, New York Medicaid total 2019 expenditures (prior to the start of the PHE) were $60.4 billion, representing 35.3% of total state expenditures.[94] Although corresponding enrollment figures are not available, New York Medicaid's total 2024 expenditures (partially affected by the unwinding period) were $90.4 billion, or 38.5% of total state expenditures.[95] The unwinding period in New York ran from April 2023 through May 2024.

Medicaid Spending by Service Category and Enrollee

New York Medicaid spent roughly $13,000 per full benefit enrollee on Medicaid benefits in FY 2024.[96] Approximately 55% of the total spend was for managed care (including PACE).[97]

Oversight Mechanisms

New York's oversight is anchored in executive agency authority (Office of the Medicaid Inspector General [OMIG] and Department of Health) and independent audit functions (State Comptroller). New York's OMIG conducts audits and program integrity reviews of Medicaid MCOs to evaluate compliance with contractual and regulatory obligations. These include desk reviews and contractual performance audits under Social Services Law.[98] The New York State Comptroller's Office performs independent audits of Medicaid managed care oversight, including provider networks and claims payment controls, generating recommendations for improved program monitoring and controls.[99]

Roles and Responsibilities of Entities Involved

New York administers managed care through the New York State Department of Health. Behavioral health integration materially influences rating cell structure and trend assumptions.

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[92] KFF Total Medicaid MCO Enrollment.
[93] NASBO 2024 Report.
[94] NASBO 2020 Report.
[95] NASBO 2025 Report.
[96] MACPAC Exhibit 23.
[97] MACPAC Exhibit 17.
[98] New York State Office of the Medicaid Inspector General, *Audit*, https://omig.ny.gov/audit (last visited Apr. 7, 2026).
[99] *E.g.*, New York State Comptroller, *Medicaid Program – Oversight of Managed Care Provider Networks*, Report 2023-S-20, 1 (Oct. 2025), https://www.osc.ny.gov/files/state-agencies/audits/pdf/sga-2026-23s20.pdf

Deloitte is the contracted actuary by New York Medicaid for purposes of capitation rate development.

Methodology and Actuarial Assumptions

The New York State Department of Health's rate setting relies heavily on MMC encounter data. The encounter data is compared to other health plan submitted financial reports to identify underreporting.

New York develops capitation rates using the encounter and financial experience, after adjusting for underreporting and trending forward for utilization, unit price, and policy changes. Rates vary by region, eligibility, and program type. New York incorporates directed payments into certified capitation rates. For programs that are risk adjusted, health plan medical premium is differentiated with 3M's Clinical Risk Group (CRG) methodology. MLTSS premium is risk-adjusted with bespoke models using member assessment data.

Use of Risk Mitigation Techniques

New York has separate MLR requirements of greater than 89% in place for MMC, MLTC, and HARP; 86% for PACE; and 85% for HIV-SNP. The MLR standard is applied separately for each program. The State requires remittance if the minimum MLR is not met.

Rate Adjustments

The largest drivers of capitation rate adjustments include enrollment, acuity shifts, and ABA costs.

Use Of and Rationale for Mid-Year Rate Adjustments

As seen in other states, New York Medicaid performs capitation rate adjustments (could be mid-year or retroactive to beginning of rating period) due to substantial policy changes, provider payment initiatives, or other major deviations in experience. The timing with New York's rating period being the same as the state budget year (April 1) makes it difficult to have all components of rate changes ready with the original rates.

Pennsylvania

Type of Delivery System(s)

The Department of Human Services (DHS) oversees Pennsylvania's Medicaid managed care program, which covers nearly 92% of Pennsylvania's Medicaid recipients.[100]

Medicaid Plans and Programs

Pennsylvania operates three primary managed care programs under the umbrella name HealthChoices:

- **Physical HealthChoices**: This is the mandatory managed care program for most Medicaid recipients (including children and adults) who do not require long-term care services and are not on Medicare, contracting with six MCOs.[101]
- **Behavioral HealthChoices**: This program manages mental health and substance use disorder services. Unlike physical health plans, where you might choose a provider, you are automatically assigned to a behavioral health MCO based solely on your county of residence. Every Medicaid recipient in a specific county uses the same behavioral health MCO, and there are five MCOs.[102]
- **Community HealthChoices**: This is a mandatory MLTSS program, contracting with three MCOs.[103]

Populations Covered

Physical HealthChoices provides benefits for the following populations:[104]

- Low-income adults: Adults aged 19 years–64 years, with incomes at or below 133% of the FPL, as well as those covered under the ACA expansion (Section VIII)
- Children: Non-disabled children under age 21 years, including those in low-income families
- Pregnant women: Individuals qualifying for medical assistance due to pregnancy
- Parents and caretakers: Individuals caring for children under age 21 years

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[100] KFF Total Medicaid MCO Enrollment.
[101] Commonwealth of Pennsylvania, *Physical HealthChoices*, https://www.pa.gov/agencies/dhs/resources/medicaid/hc (last visited Apr. 4, 2026).
[102] Commonwealth of Pennsylvania, *Behavioral HealthChoices*, https://www.pa.gov/agencies/dhs/resources/medicaid/bhc (last visited Apr. 4, 2026).
[103] Commonwealth of Pennsylvania, Community HealthChoices, https://www.pa.gov/agencies/dhs/resources/medicaid/chc (last visited Apr. 4, 2026).
[104] Mercer, *Commonwealth of Pennsylvania Calendar Year 2025 HealthChoices Physical Health Databook*, www.pa.gov, (May 16, 2024), https://www.pa.gov/content/dam/copapwp-pagov/en/dhs/documents/healthchoices/hc-services/documents/All-Zones-HealthChoices-CY-2025-Contract-Year-Databook.pdf

- Individuals with disabilities (under 21 years of age): Children with special healthcare needs or those who are blind or disabled but do not require long-term services and supports (LTSS)
- Specific medical groups: Individuals enrolled in the BCC program

Behavioral HealthChoices provides benefits for nearly all Pennsylvanians enrolled in Medicaid (medical assistance) and requiring mental health or substance use disorder services. Because behavioral health is a "carve-out" program, its coverage extends to populations that are otherwise split between Physical HealthChoices and Community HealthChoices. This population includes:

- Medicaid-eligible adults: Any adult aged 19 years–64 years enrolled in Medicaid for their physical health care
- Children and adolescents: All children under age 21 years of age enrolled in Medicaid, including those with special healthcare needs or disabilities, receive behavioral health services through this program
- Pregnant women: Individuals qualifying for Medicaid due to pregnancy
- Dual eligibles: Individuals aged 21 years and older eligible for both Medicare and Medicaid; although their physical health and long-term care are managed by Community HealthChoices, their behavioral health benefits remain "carved out" and are managed by their county's Behavioral HealthChoices MCO
- Low-income parents and caretakers: Individuals caring for dependent children under 21 years of age, who meet Medicaid income requirements

Community HealthChoices provides benefits for individuals who require a nursing facility level of care or are eligible for both Medicare and Medicaid. This population includes:[105]

- Dual eligibles: Individuals enrolled in both Medicare (Part A and/or Part B) and Medicaid (medical assistance), regardless of whether they need long-term care services
- Nursing facility residents: Adults living in a private or county nursing facility whose care is paid for by Medicaid
- Waiver recipients: Individuals receiving LTSS through specific home and community-based waivers, including:
    - Attendant care
    - Independence
    - Aging
    - COMMCARE: Community Care, a specialized (HCBS) waiver designed specifically for individuals with a traumatic brain injury

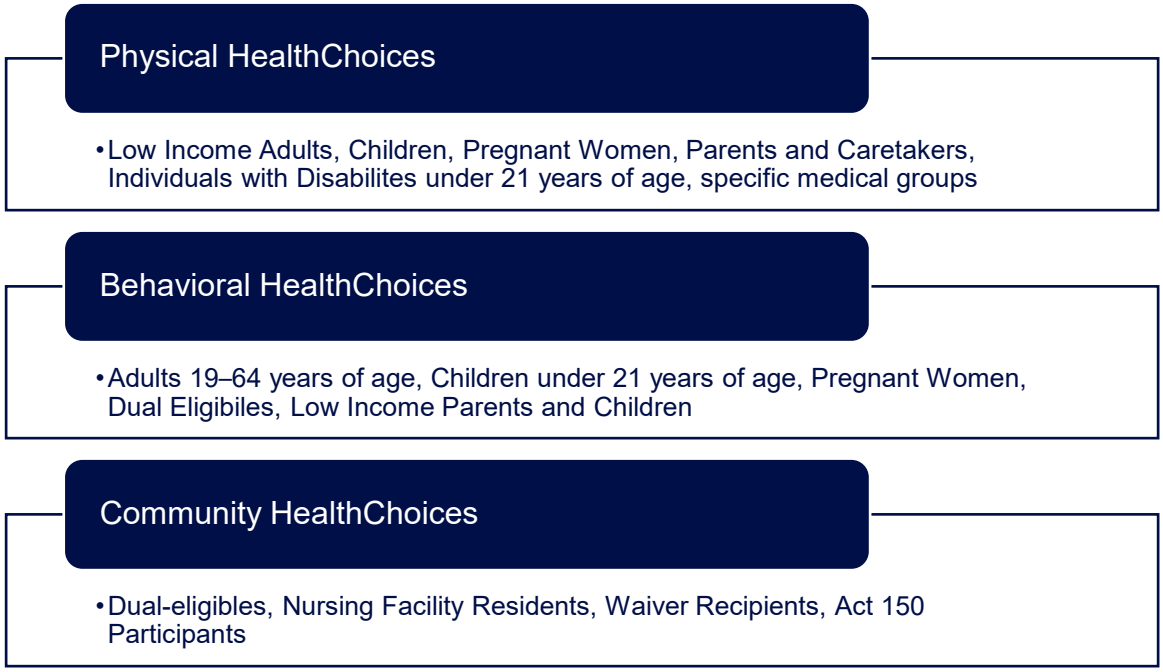
[105] Commonwealth of Pennsylvania, *Community HealthChoices*, https://www.pa.gov/agencies/dhs/resources/medicaid/chc (last visited Apr. 4, 2026).

    - Omnibus Budget Reconciliation Act: Only for those determined to be clinically eligible for a nursing facility level of care, typically individuals with severe developmental and physical disabilities

- Act 150 Participants: Individuals in the Act 150 program who are also dually eligible for Medicare and Medicaid. Act 150 provides supports and services to people living in their own homes. Services include —but are not limited to — bathing, toileting, and dressing. All supports are designed to allow individuals to stay in their own homes instead of living in nursing homes; ensure their safety; and help individuals to live as independently as possible within the community setting.[106]

Figure 7 below provides a high-level summary of the Medicaid managed care plans and programs and the respective populations covered.

Figure 7: Overview of Pennsylvania Capitation Rate Setting Programs and Populations



Number and Percentage of Enrollees

As of 2024, total Pennsylvania Medicaid enrollment was approximately 3.0 million members, of whom 92% (2.7 million) were enrolled in an MCO.[107] Total Pennsylvania Medicaid enrollment for 2019, the year prior to the start of the PHE was 2.8 million members.[108]

[106] Pennsylvania Office of Long-Term Living, *ACT 150,* www.pa.gov/content/dam/copapwp-pagov/en/dhs/documents/pa-community-care/documents/act150.pdf (last visited Apr. 6, 2026).
[107] KFF Total Medicaid MCO Enrollment.
[108] CMS 2019 Updated Report.

Medicaid Budget Overview

In 2022, total Pennsylvania Medicaid expenditures were $48.0 billion, which represented 39.6% of total state expenditures.[109] For perspective, Pennsylvania Medicaid total 2019 expenditures (prior to the start of the PHE) were $32.4 billion, representing 36.4% of total state expenditures.[110] Although corresponding enrollment figures are not available, Pennsylvania Medicaid's total 2024 expenditures (partially affected by the unwinding period) were $44.7 billion, or 37.5% of total state expenditures.[111] The unwinding period in Pennsylvania ran from April 2023 through June 2024.

Medicaid Spending by Service Category and Enrollee

Pennsylvania Medicaid spent approximately $13,800 per full benefit enrollee on Medicaid benefits in FY 2024[112]. Around 79% of the total spend was for managed care (including PACE) and 19% for FFS.[113]

Oversight Mechanisms

Pennsylvania's DHS administers HealthChoices Medicaid managed care programs and is responsible for overall policy, contracts, and monitoring. This includes the managed care quality strategy, the Managed Care Program Annual Report, the Network Adequacy and Assurance Report, and managed care plan ownership information.[114]

The Auditor General’s department initiated a performance audit of state contracts and oversight of pharmacy benefit managers used by the Pennsylvania DHS HealthChoices Medicaid Program in 2023.[115]

Federal Office of Inspector General (OIG) audits also take place. For one of them, Pennsylvania correctly invoiced rebates to manufacturers for most physician-administered drugs dispensed to enrollees of Medicaid MCOs.

Roles and Responsibilities of Entities Involved

Pennsylvania’s DHS oversees the HealthChoices managed care program. DHS contracts with Mercer as the actuaries to develop and certify capitation rates.

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[109] NASBO 2024 Report.
[110] NASBO 2020 Report.
[111] NASBO 2025 Report.
[112] MACPAC Exhibit 23.
[113] MACPAC Exhibit 17.
[114] Commonwealth of Pennsylvania, *Managed Care Quality Strategy, Managed Care Program Annual Report (MCPAR), And Other Federally Required Reporting*, https://www.pa.gov/agencies/dhs/resources/medicaid/managed-care-quality-strategy (last visited Apr. 4, 2026).
[115] Press Release, Pennsylvania Auditor General, Auditor General DeFoor Launches Performance Audit into Pharmacy Benefit Manager Oversight (Oct. 11, 2023), https://www.paauditor.gov/auditor-general-defoor-launches-performance-audit-into-pharmacy-benefit-manager-oversight/

Methodology and Actuarial Assumptions

Pennsylvania uses plan-submitted financial, encounter, and eligibility data to develop capitation rates.

DHS's contracted actuaries adjust financial and encounter data for completion, programmatic changes, trend, and risk-sharing mechanisms, to develop prospective capitation rates by rating region and eligibility group. The actuaries risk-adjust the Physical HealthChoices rates using the CDPS+Rx methodology.

Use of Risk Mitigation Techniques

The Department uses supplemental risk mitigation techniques to match payment to risk among the MCOs. In addition to risk adjustment, these techniques include home nursing risk sharing and high-cost risk pool for children over age one year, in which the Department will reimburse MCOs for a portion of claims above a threshold. For MCO members in the "under age one" eligibility category, there is a separate risk-sharing arrangement that helps mitigate risk to the MCOs for the small, volatile under one year old population, for which risk adjustment is not performed.

Rate Adjustments

The largest drivers of capitation rate adjustments are enrollment and acuity impacts driven by PHE unwinding.

Use of and Rationale for Mid-Year Rate Adjustments

Although mid-year capitation rate amendments are not common in Pennsylvania, the rates were amended for Behavioral HealthChoices in the latter half of 2024 due to the impact of Medicaid enrollment unwinding and nuances of the program. The Commonwealth has also, at times, adjusted capitation rates within the 1.5% corridor, which is a rate modification strategy available to all states per CMS rate setting guidance.

Tennessee

Type of Delivery System(s)

Nearly all (94%) of Tennessee's Medicaid population is enrolled in an MCO.[116] The MCOs are overseen by the Division of TennCare, which is the name of Tennessee's Medicaid program.

Medicaid Plans and Programs

The bulk of TennCare members are enrolled in either a non-CHOICES or a CHOICES plan, which are offered by one of three statewide MCOs. **Non-CHOICES** is nomenclature for the acute care services whereas the LTSS program is called **CHOICES** because it offers eligible individuals alternatives to traditional nursing home care, specifically providing the choice to receive long-term care services at home or in community-based settings. A small portion of members are enrolled in TennCare Select, which is a specialized statewide managed health plan designed specifically for vulnerable populations and members with complex health needs.

Populations Covered

Non-CHOICES covers the following populations:[117]

- Children: Individuals under 21 years, including those with low income, medically needy status or those in the Katie Beckett program who do not need institutional-level care. The Katie Beckett program provides medical assistance to children under age 18 with disabilities or complex medical needs who live at home and do not otherwise qualify for Medicaid due to their parents' income or resources.[118]
- Pregnant women: Low-income pregnant women, typically including coverage for 60 days postpartum
- Parents or caretakers: Low-income parents or close relatives caring for a minor child living in their home
- Individuals with specific medical needs: This includes women needing treatment for BCC
- SSI recipients: Individuals receiving SSI who do not currently require nursing home-level care
- Select Medicare beneficiaries: Low-income seniors or disabled individuals who may only receive help with Medicare cost-sharing rather than full LTSS

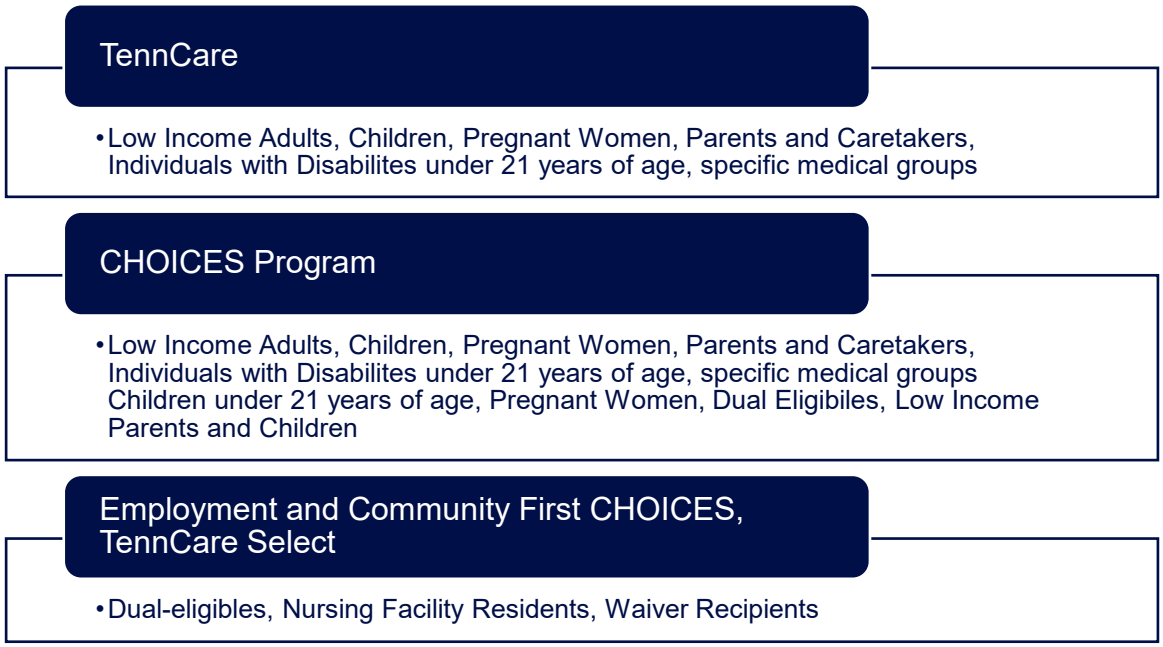
[116] KFF Total Medicaid MCO Enrollment.
[117] Division of TennCare, TennCare Medicaid, https://www.tn.gov/tenncare/members-applicants/eligibility/tenncare-medicaid.html(last visited Apr. 6, 2026).
[118] TennCare, *Chapter: Katie Beckett*, TennCare Policy Manual No. 115.035, *www.tn.gov/content/dam/tn/tenncare/documents/KatieBeckett115.035.pdf*

CHOICES covers the following LTSS populations:[119]

- Medical need: Must require assistance with daily living activities (e.g., bathing, dressing, eating)
- Financial Status: Must receive SSI or qualify for Medicaid LTC
- Individuals with intellectual or developmental disabilities are typically covered under a separate program called Employment and Community First CHOICES.[120]
- General risk groupings for CHOICES are as follows:
  - CHOICES 1: Individuals of all ages who require and receive care in a nursing facility
  - CHOICES 2: Seniors (65+ years) and adults (21+ years) with physical disabilities who qualify for nursing home-level care but choose to receive HCBS instead
  - CHOICES 3: Seniors (65+ years) and adults (21+ years) with disabilities who do not meet the full nursing home level of care but are "at risk" of needing it without moderate home care support

Figure 8 below provides a high-level summary of the Medicaid managed care plans and programs and the respective populations covered.

Figure 8: Overview of Tennessee Capitation Rate Setting Programs and Populations



[119] Division of TennCare, *CHOICES*, https://www.tn.gov/tenncare/long-term-services-supports/choices.html (last visited Apr. 5, 2026).
[120] Division of TennCare, *Employment and Community First CHOICES*, https://www.tn.gov/tenncare/long-term-services-supports/employment-and-community-first-choices.html (last visited Apr. 7, 2026).

Number and Percentage of Enrollees

As of 2024, total TennCare enrollment was at 1.5 million members, of whom 94% (1.4 million) were enrolled in a comprehensive managed care plan.[121] Total TennCare enrollment for 2019, the year prior to the start of the PHE, was 1.6 million members.[122]

Medicaid Budget Overview

In 2022, total TennCare expenditures were $14.0 billion, which represented 32.2% of total state expenditures.[123] For perspective, TennCare total 2019 expenditures (prior to the start of the PHE) were $11.5 billion, representing 33.9% of total state expenditures.[124] Although corresponding enrollment figures are not available, TennCare's total 2024 expenditures (partially affected by the unwinding period) were $15.8 billion, or 29.7% of total state expenditures.[125] The unwinding period in Tennessee ran from April 2023 through May 2024.

Medicaid Spending by Service Category and Enrollee

TennCare spent approximately $8,100 per full benefit enrollee on Medicaid benefits in FY 2024[126]. Approximately 68% of the total spend was for managed care (including PACE) and 28% for FFS.[127]

Oversight Mechanisms

Tennessee's comptroller conducts audits of TennCare and requires that MCO contracts include audits of business transactions by licensed CPA firms, subject to comptroller approval. These can act as external actuarial/financial audits of managed care operations.[128]

Under the Department of Commerce and Insurance, this division monitors managed care entities' financial responsibility, stability, and integrity and publishes financial reports and independent review summaries.[129]

Although Tennessee does extensive fiscal audits and compliance examinations, responsibility for managed care oversight is split between TennCare (contract compliance) and independent audits.

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[121] KFF Total Medicaid MCO Enrollment.
[122] CMS 2019 Updated Report.
[123] NASBO 2024 Report.
[124] NASBO 2020 Report.
[125] NASBO 2025 Report.
[126] MACPAC Exhibit 23.
[127] MACPAC Exhibit 17.
[128] Tennessee Comptroller of the Treasury, *Performance Audit Report Division of TennCare* (Oct. 2024), https://comptroller.tn.gov/content/dam/cot/sa/advanced-search/2024/pa24026.pdf
[129] Tennessee Department of Commerce & Insurance, *The TennCare Oversight Division*, https://www.tn.gov/commerce/tenncareoversight.html (last visited Apr. 7, 2026).

Roles and Responsibilities of Entities Involved

The MMC capitation rate setting process for Tennessee is a collaborative, multi-step cycle designed to ensure actuarial soundness and federal compliance. The main entities involved are the Bureau of TennCare (Tennessee's Medicaid agency), the state's actuary (Guidehouse), and the contracted MCOs.

TennCare's responsibilities include oversight and policy, retaining ultimate authority over the State Plan and developing the rules and regulations governing program matters. It is also responsible for data collection, gathering and validating enrollment and claims data, often utilizing third-party actuaries to estimate trends and utilization patterns. In addition, TennCare manages contracts by monitoring MCO performance and managing the financial reconciliation of PMPM capitation payments. Finally, TennCare handles rate submission by formulating and submitting formal rate certifications and "preprints" (formal proposals to CMS that outline how they intend to direct payments to specific providers) for state directed payments to federal regulators for final approval.

Methodology and Actuarial Assumptions

TennCare's contracted actuaries primarily rely on historical detailed MCO claim data, supplemented by non-system payment data from MCO-submitted and summarized MLRs to develop capitation rates. They apply three types of explicit assumptions to the base benefit costs to develop projected benefit costs: trend factors, managed care savings factors, and benefit/program change factors.

The actuaries develop trends factors that vary by major service category and by major aid category. They represent the ongoing utilization and unit cost trends for the covered population, with no consideration for new managed care savings initiatives and new program changes to be effective beyond the base period. They then use regression analysis to analyze the most recent 48 months of completed experience data by major service category and aid category and review the trends for statistical significance and benchmark them against trends provided by the MCOs and CMS reported national Medicaid specific trends for reasonableness. The actuaries then use actuarial judgement to finalize trends for service categories with unexpected regression results.

The contracted actuaries develop managed care savings factors that vary by major service category and by major aid category. They represent the impact of new managed care savings activities the State expects from the MCOs, to be performed beyond the base period. Then they perform comparative analysis at the major service category level among the three participating plans after normalizing for region and rate cell mix differences. This analysis helps to inform additional managed care savings opportunities that the MCOs expect to materialize. Additionally, MCOs report their new managed care activities to implement in the contract period and their savings estimate for these activities. The final savings factors are determined based on a combined consideration of the actuary's data analyses and MCOs' reported savings estimates.

Then the actuaries develop benefit/program change factors that vary by region, major service category, and rate cell that represent the rate impact of the State-initiated program changes and benefit changes beyond the base period. The actuary then estimates the impacts at both the rate cell and service category level by applying the benefit changes to the base data at claim level.

The actuary re-prices all base claims using the proposed provider reimbursement rate changes and benefit utilization changes and then compares the repriced amounts to the base amounts for the impact. Risk adjustment is applied using the Johns Hopkins Adjusted Clinical Groups system methodology.

Use of Risk Mitigation Techniques

TennCare temporarily used risk corridors to manage risk but moved away from using them after 2021. Starting in 2023, TennCare began requiring an 85% minimum MLR and requires remittance payments if the 85% MLR is not met. Tennessee gives MCOs the option to remit funds to the State and/or use them towards community reinvestments.[130]

Rate Adjustments

The largest drivers of capitation rate adjustments recently have included the PHE unwinding and expansion of state directed payments.[131]

Use Of and Rationale for Mid-Year Rate Adjustments

Over recent rate setting- cycles, TennCare adjusted capitation rates mid-year with rate certification amendments. The impetus has been more so due to programmatic reasons such as legislatively required fee schedule changes and other small benefit changes that occur due to the annual budget every summer.

[130] KFF, *Results from an annual Medicaid Budget Survey For State Fiscal Years 2025 and 2026* (Nov. 2025), https://files.kff.org/attachment/report-results-from-an-annual-medicaid-budget-survey-for-state-fiscal-years-2025-and-2026.pdf
[131] Division of TennCare, *TennCare Annual Report Fiscal Year 2023* (Sep. 2024), https://www.tn.gov/content/dam/tn/tenncare/archive/TennCareAnnualFY23.pdf

Texas

Type of Delivery System(s)

Approximately 93% of Texas' Medicaid population is enrolled in a comprehensive managed care plan.[132]

Medicaid Plans and Programs

The Texas Health and Human Services Commission (HHSC) administers four separate managed care programs:[133]

- **STAR (State of Texas Access Reform)**: Low-income children, pregnant women, and families, contracts with 16 MCOs
- **STAR Kids**: Disabled children (acute care and LTSS), contracts with nine MCOs
- **STAR Health**: Foster care, contracts with one MCO
- **STAR+PLUS**: Adults with disabilities and dual eligibility (LTSS), contracts with seven MCOs.

Populations Covered

STAR provides benefits for the following populations:[134]

- Low-income children and newborns: Children from birth up to 21 years who meet specific income requirements
- Pregnant women: Childbearing women of any age who have a family income at or below 185% of the FPL
- Low-income families: Families and caretakers who qualify for the Temporary Assistance for Needy Families (TANF) program
- Foster care transitioners: Individuals in the Adoption Assistance or Permanency Care Assistance programs may also be eligible for STAR benefits[135]

STAR Kids serves children and youth aged 20 years old and younger, who have Medicaid through SSI or 1915(c) waiver programs. It covers the following populations:[136]

- SSI recipients: Those who receive SSI and SSI-related Medicaid

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[132] KFF Total Medicaid MCO Enrollment.
[133] Texas Health and Human Services Commission (HHSC), *Medicaid and CHIP Members*, https://www.hhs.texas.gov/services/health/medicaid-chip/medicaid-chip-members (last visited Apr. 5, 2026).
[134] Texas HHSC, *STAR Medicaid Managed Care Program*, https://www.hhs.texas.gov/services/health/medicaid-chip/medicaid-chip-members/star-medicaid-managed-care-program (last visited Apr. 4, 2026).
[135] Texas HHSC, *Adoption Assistance or Permanency Care Assistance*, https://www.hhs.texas.gov/services/health/medicaid-chip/medicaid-chip-programs-services/foster-care-youth/adoption-assistance-or-permanency-care-assistance (last visited Apr. 4, 2026).
[136] Texas HHSC, *STAR Kids*, https://www.hhs.texas.gov/services/health/medicaid-chip/medicaid-chip-members/star-kids (last visited Apr. 4, 2026).

- Dual eligibles: Those who are covered by both Medicaid and Medicare
- Waiver program participants: Those receiving services through various home and community-based waiver programs, including:
    - Medically Dependent Children Program
    - Youth Empowerment Services
    - Intellectual and Developmental Disability waivers, such as Community Living Assistance and Support Services, Deaf Blind with Multiple Disabilities, HCBS, or Texas
- Home Living Facility residents: Those who live in a nursing facility or a community-based intermediate care facility for individuals with an intellectual disability or related conditions[137]
- Medicaid Buy-In: Are enrolled in the Medicaid Buy-In program[138]

STAR Health covers children and youth in the following groups, according to the same population structure and risk groupings as Star Kids:[139]

- Department of Family and Protective Services conservatorship: Children and youth under age 18 years, who are currently in the state's foster care system
- The Adoption Assistance or Permanency Care Assistance program: Children in the process of transitioning from STAR Health to other Medicaid programs such as STAR or STAR Kids
- Extended foster care: Young adults ages 21 years and younger who have a voluntary extended foster care placement agreement
- Former Foster Care Children: Youth ages 20 years and younger who were in foster care at age 18 years or older and were receiving Medicaid at that time

STAR+PLUS provides benefits for the following populations: Note that dual-eligible members received benefits through the Medicare-Medicaid Plan through the end of 2025:[140]

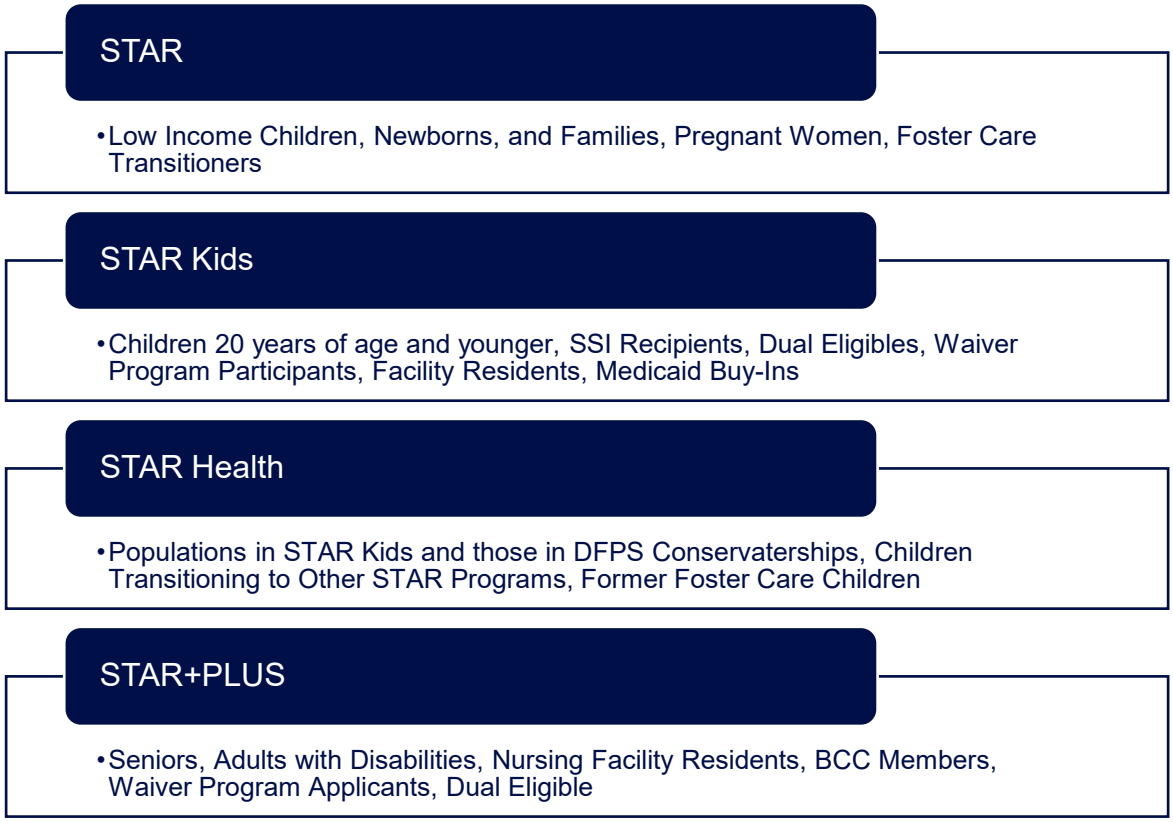
- Seniors (Age 65+ years): Older adults meeting Medicaid income and asset requirements
- Adults with disabilities (Age 21+ years): Individuals who receive SSI benefits or otherwise meet disability criteria
- Nursing facility residents: Adults age 21 years or older living in a nursing home and receiving Medicaid while there

[137] Community First Health Plans, *STAR Kids*, https://medicaid.communityfirsthealthplans.com/members/star-kids/ (last visited Apr. 7, 2026).
[138] *Id.*
[139] Texas HHSC, *STAR Health*, https://www.hhs.texas.gov/services/health/medicaid-chip/medicaid-chip-programs-services/foster-care-youth/star-health (last visited Apr. 6, 2026).
[140] Texas HHSC, *STAR+PLUS*, https://www.hhs.texas.gov/services/health/medicaid-chip/medicaid-chip-members/starplus (last visited Apr. 5, 2026).

- Medicaid for BCC members: Women aged 18 years–64 years participating in this specific program
- Waiver Program applicants: Adults who do not get SSI but need the type of services provided through the STAR+PLUS HCBS waiver to live in the community rather than a facility
- Special populations-dual eligibles:
    - Medicare and Medicaid: Individuals covered by both (dual eligible) can join STAR+PLUS
    - Care coordination: For these members, Medicare remains the primary payer for regular healthcare (doctor visits, hospital stays), while STAR+PLUS provides LTSS such as personal assistance and adult day care

Figure 9 provides a high-level summary of the Medicaid managed care plans and programs and the respective populations covered.

Figure 9: Overview of Texas Medicaid Programs and Populations



Number and Percentage of Enrollees

As of 2024, total Texas Medicaid enrollment was approximately 4.1 million members, of whom 93% (3.8 million) were enrolled in a comprehensive managed care plan.[141] Total Texas Medicaid enrollment for 2019, the year prior to the start of the PHE, was 3.9 million members.

Medicaid Budget Overview

In 2022, total Texas Medicaid expenditures were $55.4 billion, which represented 40.4% of total state expenditures.[142] For perspective, Texas Medicaid total 2019 expenditures (prior to the start of the PHE) were $35.4 billion, representing 29.3% of total state expenditures.[143] Although corresponding enrollment figures are not available, Texas Medicaid's total 2024 expenditures (partially affected by the unwinding period) were $47.7 billion, or 33.0% of total state expenditures.[144] The unwinding period in Texas ran from April 2023 through May 2024.

Medicaid Spending by Service Category and Enrollee

Texas Medicaid spent roughly $10,400 per full benefit enrollee on Medicaid benefits in FY 2024[145]. Approximately 67% of the total spend was for managed care (including PACE) and 29% for FFS.[146]

Oversight Mechanisms

Increases to most capitation rates require approval by the Legislative Budget Board and the Governor. However, the practical effect of approval may be limited, as rates in all states must ultimately be certified as actuarially sound to be implemented.[147] While Texas must develop actuarially sound capitation rates and coordinate federal reviews, there are also requirements that HHSC submit most capitation rate changes to the Legislative Budget Board, Governor's Office, and State Auditor 45 days prior to implementation pursuant to a statutory requirement established in the General Appropriations Act.[148]

Additional oversight beyond the rate setting process has HHSC enforcing contract compliance through corrective action plans, liquidated damages, and suspension of new member enrollments.[149] Eligibility monitoring involves audits from HHSC of "qualified entities" to ensure accurate, timely, and compliant presumptive eligibility determinations.[150] The Texas OIG utilizes prepayment reviews, claim auditing, and post-payment reviews to identify improper billing and

[141] KFF Total Medicaid MCO Enrollment.
[142] NASBO 2024 Report.
[143] NASBO 2020 Report.
[144] NASBO 2025 Report.
[145] MACPAC Exhibit 23.
[146] MACPAC Exhibit 17.
[147] Texas HHSC, *Overview of Medicaid Setting and Supplemental Payments – Acute Care* (Nov. 2024), www.hhs.texas.gov/sites/default/files/documents/nov-2024-smmcac-agenda-item-5b.pdf
[148] General Appropriations Act, 89th Leg., R.S., Art. III, § 12, Tex. Gen. Laws [II-115].
[149] Texas HHSC, *Managed Care Organization Sanctions*, https://www.hhs.texas.gov/services/health/medicaid-chip/managed-care-contract-management/managed-care-organization-sanctions (last visited Apr. 5, 2026).
[150] 1 Tex. Admin. Code § 366.261 (2024), https://texas-sos.appianportalsgov.com/rules-and-meetings?$locale=en_US&interface=VIEW_TAC_SUMMARY&queryAsDate=04%2F08%2F2026&recordId=171055

fraud. One such state audit of the rate setting- process occurred during the period FY 2021–FY 2023.[151] Texas Medical Foundation Health Quality Institute also conducts retrospective medical record reviews to assess medical necessity and policy compliance.[152]

Roles and Responsibilities of Entities Involved

Texas administers Medicaid managed care through STAR, STAR Kids, Star Health, and STAR+PLUS programs. Texas works with an outside actuary (Rudd and Wisdom) to develop and certify capitation rates. Rate setting reports are published online with detailed actuarial documentation.

Methodology and Actuarial Assumptions

To ensure the reliability of encounter data used for rate development, Texas relies primarily on certified encounter data, which is validated through several processes. The State's EQRO formally certifies encounter data, as required by the Texas Administrative Code. Also, MCOs submit audited Financial Statistical Reports (FSRs) quarterly, allowing the State to reconcile data against financials. Texas also maintains a third data set, which tracks claims lag information from MCOs. Actuaries meet quarterly with the Financial Review Advisory Committee to identify anomalies, investigate outliers, and resolve data inconsistencies.

Texas' contracted actuaries develop capitation rates using the validated historical encounter and financial data, trended for utilization and cost changes, and adjusted for benefit, eligibility, and provider payment changes. The rates are risk adjusted using the CDPS+Rx risk adjustment methodology.

Use of Risk Mitigation Techniques

To manage financial risk for MCOs, Texas operates a non-risk treatment approach in certain cases, combined with an experienced rebate system. The rebate structure functions as a one-sided risk corridor, triggered when MCO profit levels exceed defined thresholds. As a result, the corridor typically produces a maximum weighted profit of around 7%.

Rate Adjustments

The largest drivers of capitation rate adjustments in recent years have been provider rate increases and utilization changes.

Provider reimbursement changes have been a major driver of rate adjustments, including increases for nursing facilities, rural hospitals, and physicians. These increases are largely

[151] Texas HHSC Office of Inspector General, *OIG Review of MCO Cost Avoidance and OIG Efforts in Medicaid Managed Care* (Feb. 25, 2022), https://oig.hhs.texas.gov/sites/default/files/documents/OIG-Rider-104-Report-2-25-2022.pdf
[152] TMF Health Quality Institute, *Surveillance and Utilization Review Services*, https://tmf.org/Our-Work/Program-Integrity/Surveillance-and-Utilization-Review-Services (last visited Apr. 5, 2026).

legislative or policy driven. Also, the expansion of directed payment programs has greatly affected managed care financing.

Like most states, Texas experienced utilization shifts following the unwinding of the COVID-19 PHE. Texas also implemented the postpartum eligibility extension, which affected program enrollment and cost projections.

Additionally, there have been large increases in attendant care spending, which has become an important cost driver.

Use Of and Rationale for Mid-Year Rate Adjustments

Texas regularly issues mid-year rate amendments, although these do not necessarily apply to every program. Common triggers include policy changes, COVID-19-related adjustments, pharmacy formulary changes, and PHE-related utilization shifts.

Acuity adjustments have been particularly large in the STAR program. By contrast, STAR Kids and STAR+PLUS have experienced fewer adjustments. Recent updates included significant increases in certain specific risk groups, including children (~10%–15% increases), adults (~30% increases), and pregnant women (even higher increases in some cases).

Texas publishes all actuarial reports publicly on the HHSC website, with more than 10 years of historical reports available. The reports included on this website are the same reports submitted to CMS for review and approval.

Section 4

Cross-State Comparison and Analysis

Key Similarities

Similarities exist across minimum services and general funding structure for every state Medicaid program. All the comparison states have significant managed care presence and must follow federal regulations and CMS rate setting guidance.

Several prominent market trends have been observed across the six states and nationally. First, utilization of ABA therapy has grown substantially in recent years, driven by rising autism diagnoses and expanded Medicaid coverage. Second, the PHE unwinding has resulted in large swings in enrollment, changes in acuity, and administrative challenges. Third, state directed payments have seen continued growth, allowing Medicaid agencies to make targeted payments to providers to help achieve specific programmatic goals.

Across all states, CMS MMC rate development guidance and actuarial soundness requirements produce broad methodological consistency. All states are required to certify capitation rates as actuarially sound in compliance with federal MMC regulations (42 CFR Part 438). External actuaries play a central role in both Florida and the six comparison states, either as primary rate developers or independent reviewers/certifiers. Each state relies heavily on managed care as the primary delivery mechanism for Medicaid services. Like Florida, all the comparison states have moved significant populations — including many LTSS and behavioral health enrollees — into managed care over the past decade.

Each state relies primarily on historical MCO encounters or claims data as the foundation for capitation rate development. Trend factors, acuity adjustments, and program-specific assumptions are applied to base period experience to project rates to the prospective contract period.

All states retain the authority to amend capitation rates, whether these are mid-year or retroactive to the start of the rating period. Drivers of rate amendments typically include significant policy changes, benefit carve-ins or carve-outs, PHE-related utilization shifts, and legislative provider rate increases. Furthermore, all states employ some form of profit control or risk mitigation — including MLR minimums, risk corridors, or experience rebate programs — to prevent plans from getting an unfair advantage and to protect state budget exposure.

Key Differences

Differences arise in structural delivery models of every state Medicaid program. However, with respect to capitation rate development, the key differences amongst Florida and the comparison states deal with rate amendments, emerging services like ABA therapy, risk mitigation, and state oversight.

Capitation Rate Amendments

While federal regulations (42 CFR Part 438) set requirements for how and when states can amend capitation rates, every state approaches rate amendments differently. Pennsylvania is similar to Florida in that there have been very few rate amendments. Florida amended rates recently for the behavior analysis carve-in, and Pennsylvania revisited their behavioral health rates just once in the last five years. Pennsylvania leverages the +/- 1.5% rate change mechanism that states can employ without the need for an official rate amendment. Meanwhile, other states have regular mid-year or retro rate amendments. Texas has a highly structured annual rates plan with rates effective September 1, but the capitation rates need amending annually, sometimes for program changes but, most often, for directed payment updates. California frequently experiences rate amendments due to program changes and other information not yet known to the Medicaid agency or their certifying actuaries at the time of the initial rate development. California also had significant acuity-driven adjustments to the PHE Unwinding. Georgia and Tennessee have regularly made rate amendments for similar reasons. Staff from TennCare reported they generally limit rate amendments to truly policy-driven circumstances.

Emerging Services

New benefits and service offerings can pose a financial risk to Medicaid programs. One such emerging service is behavior analysis services, also known as ABA therapy in many other states. ABA spending has grown dramatically across Florida and all six comparison states, driven by rising autism diagnoses, expanded legal coverage mandates, and per-hour reimbursement structures. States are responding differently: Georgia implemented aggressive rate cuts; Texas uses a non-risk carve-out to limit managed care exposure; Florida absorbed ABA into capitation, producing large rate increases; California and Pennsylvania are still evolving their approaches.

In comparison to Florida, a critical distinction among states is whether ABA therapy is included inside capitation rates or treated as a non-risk carve-out. Among the comparison states, Texas is the only state that explicitly treats these services as non-risk carve-out with managed care. This means that experience is tracked separately and accumulated before being incorporated into capitation rates — an important contrast to Florida’s recent carve-in, which included the services in capitation rates without tracking costs separately and allowing those costs to stabilize prior to inclusion in the capitation rates. Texas has seen high growth in spending since ABA therapy was launched as a Medicaid benefit in September 2022. Spending has roughly doubled each SFY since launch, primarily due to increased utilization driven by expanded coverage, increased awareness, and an increase in diagnoses. However, the growth rate may now be leveling off according to HHSC. Texas's approach represents a deliberate policy choice to cover ABA services separately first, so they can track costs and usage before including it capitation payments — a notable contrast to Florida's carve-in approach.

Many other states have integrated ABA into managed care capitation and apply utilization management controls, but ABA has often been a subject of rate amendments due to the initial base data adjustment not keeping up with emerging experience. In California, ABA therapy is covered as a Medi-Cal benefit, and utilization and costs have grown substantially with increasing autism diagnoses and expanded coverage. Georgia has been covering ABA therapy as a Medicaid benefit since 2018. Medicaid utilization peaked in 2023 at 341% of 2019 levels. Prior to

mid-2025 rate reductions, Georgia's maximum Medicaid reimbursement rate for technician-administered ABA was approximately $305.24/hour, which is significantly higher than Florida ($49.04). In July 2025, Georgia implemented sizable rate cuts: 48% reduction for behavior technician-delivered direct therapy (dropped to ~$74.80/hour) and a 37% reduction for physician/board-certified behavioral analyst delivered therapy. Georgia has since moved toward stricter utilization controls, more frequent reauthorizations, and increased auditing. In New York, their Medicaid program integrates behavioral health (including ABA) significantly into its managed care rate structure through HARPs and mainstream MMC programs. Tennessee also covers ABA as a benefit, and although the program has been managing the budget carefully, ABA spend trends are notable. Pennsylvania covers ABA through its managed care programs, and it is one of several high-growth behavioral health services.

Risk Mitigation

Whether it is volatile enrollment periods, such as the PHE unwinding or significantly growing service lines like ABA therapy, there are policy tools available to states to financially control these and provide assurances to both the state and their managed care plans. These can include minimum MLR thresholds, rebates that are paid back to the state if profits are too high, and two-sided risk corridor structures. Florida has such risk mitigation protocols in place with MLR and ASR requirements which impact the program broadly as opposed to a specific service. Other states do this as well with some variation. Tennessee used risk corridors because of COVID, and removed them in 2022, but still has an 85% minimum MLR provision in effect. Pennsylvania has an MLR remittance in place with respect to MCO profit margins that is done on a tiered basis. Texas has a one-sided experience rebate corridor that is also tiered.

State Oversight of Capitation Rates

Another important distinction with states is how capitation rates go from draft form to final and where there is legislative oversight and budget alignment between the state and Medicaid agency. States vary in their oversight and some of the comparison states have more of a structured process when it comes to legislative oversight. For instance, Texas has rates approved by their Legislative Budget Board. California reviews capitation rates as the rate development process tracks alongside the executive budget cycle. When preliminary/draft rates are ready in August and finalized at the end of September, this informs the November budget estimates, which are then revisited the following May, pending any rate amendments. In Mercer’s experience across many other states, an alignment such as that, between the timing of rate development and state budget communications, is helpful to streamline expectations of all stakeholders, including legislative committees, the Governor’s Budget Office, the Medicaid agency, MCOs, and providers.

Best Practices

Oversight mechanisms include actuarial certification, CMS review, external quality review, inspector general audits, and legislative oversight. Based on interviews with state Medicaid actuaries and external consulting firms, review of rate certifications, and cross-state analysis, the

following best practices have been identified across comparison states. These represent approaches that support rate accuracy, MCO accountability, public transparency, and fiscal sustainability.

Structured and Consistent Rate Development Calendars

A well-defined, transparent rate development schedule is widely recognized as a best practice in Medicaid managed care rate setting. When states establish and stick to a predictable timetable, it benefits all stakeholders: MCOs can develop more accurate financial projections and better prepare for changes, providers gain greater certainty around reimbursement, and state budgets and legislative processes are better informed.

Several states have made notable progress in formalizing these best practices. Texas, for example, operates under a clearly defined rate development framework with rates effective September 1 each year and a detailed weekly project plan. This predictability allows MCOs to prepare financial projections, reduces administrative uncertainty, and supports legislative planning. California has also been working towards formalizing its rate setting timeline in which preliminary rates are communicated to MCOs in August and final rates are issued by the end of September—providing plans with meaningful notice prior to the January 1 effective date. California is also working to reduce the frequency of mid-year rate amendments, recognizing that amendments can cause administrative friction. Florida generally has a clearly defined rate development calendar, but timelines have changed during re-procurement years.

As Medicaid managed care programs continue to grow in complexity, the importance of a structured, well-communicated rate calendar will only increase. States that have not yet formalized their timelines have an opportunity to adopt this practice, not only as an efficiency measure but as a meaningful signal of the states' partnerships with their contracted plans.

Transparent Methodology and MCO Engagement

Some states publish actuarial reports on their agency websites. This is typically the decision of state agencies rather than the actuaries that represent them. Still, this level of transparency is often seen as best practice. Florida only shares final published rate tables while other states, such as California, Pennsylvania, and Texas, publish actuarial reports showing details on the methodology behind the rate development. For instance, Texas has more than ten years of historical reports available. The rate development process includes a formal comment period, multiple draft rate iterations before finalization, and the ability for plans to review the data used in rate development. MCOs understand the process clearly even when they disagree with results. This level of transparency — making the actuarial basis for rates accessible to plans and the public — is widely recognized as a governance best practice.

Robust Encounter Data Validation

Texas operates one of the more structured encounter data validation processes among comparison states. As required of all states under 42 CFR § 438.350, certified encounter data is formally validated by the state's EQRO under the Texas Administrative Code. MCOs submit

FSRs quarterly, which are audited and reconciled against encounter data, typically within a ~2% variance tolerance. Claims lag information is tracked in a dedicated third dataset. Actuaries meet quarterly with the Financial Reporting and Analysis Committee to identify anomalies and resolve data inconsistencies.

Deliberate Treatment of High-Growth, High-Uncertainty Services

Texas's decision to treat ABA therapy as a non-risk carve-out (tracking experience separately before incorporating it into capitation rates) reflects a deliberate, evidence-based approach to managing services with immature utilization data. The program launched in September 2022, and spending approximately doubled each SFY before beginning to level off. Treating ABA as non-risk during this period allowed both the state and MCOs to accumulate sufficient claims experience before incorporating in capitation rates, reducing the risk of over- or under-pricing. This approach is a recognized best practice when introducing high-cost, high-growth services into managed care: gather experience first and then incorporate risk.

Appropriately Calibrated Risk-Sharing Mechanisms

Tennessee, Texas, and Pennsylvania each employ well-designed risk mitigation structures that balance MCO financial sustainability with state accountability. Tennessee used risk corridors in 2020 and 2021 during COVID-related uncertainty and removed them once the environment stabilized, demonstrating that risk-sharing tools should be situationally applied rather than permanent fixtures. From 2023 onward, Tennessee has operated under an 85% minimum MLR requirement, creating a floor on plan spending. Texas's one-sided rebate corridor (under which MCOs retain varying levels of profit at different bands before having to return all such gains) is calibrated to protect against windfalls while still maintaining plan viability. Pennsylvania uses risk adjustment techniques including LTSS risk sharing and high-cost risk pool for children over age one year, in which the Department will reimburse MCOs for a portion of claims above a threshold. Pennsylvania also has a separate risk-sharing arrangement for MCO members in the volatile “under age one” eligibility category.

Coordinated Budget and Rate Development Processes

California, Pennsylvania, and Tennessee each demonstrate alignment between rate development and state budget cycles. California's rate timeline tracks the executive budget process using the November estimate and May Governor's budget revision as reference points. Pennsylvania's actuarial team certifies a rate and presents a range to the Commonwealth, with budget discussion occurring in parallel. Tennessee drafts rates in conjunction with preparation of the next FY's budget. Although tension can naturally exist between actuarially justified rates and budget targets, the best practice is to structure rate and budget development concurrently, not sequentially, so that actuarial soundness drives the fiscal conversation rather than being subordinated to it.

Utilization Oversight for ABA

Georgia has implemented stricter utilization controls, more frequent reauthorizations, and enhanced auditing in response to ABA spending growth. Federal audits have found that every sampled ABA billing record in certain states had documentation or eligibility problems, with at least $198 million in confirmed improper payments and $410 million in potentially improper payments identified across four states. Best practices include requiring prior authorization and regular reauthorization for ABA hours, conducting claims-level audits for high-volume ABA providers, monitoring for billing anomalies at the provider and plan level, and establishing fraud-specific escalation protocols that trigger review when per-member ABA utilization exceeds comparison state benchmarks.

Recent Changes and Initiatives

Recent developments across states include expanded use of state directed payments, COVID-era risk mitigation strategies, managed care population expansions, and strengthened CMS documentation requirements. Key developments are summarized below by state.

Florida

ABA carve-in (2021–2024): Florida carved ABA therapy into MMA managed care capitation rates, making it a significant and growing driver of capitation increases. The RY 2023/2024 to RY 2024/2025 rate change of 22.6% was driven primarily by ABA and member acuity. Milliman estimated the underlying trend at ~4.2% without program changes.

California

Medi-Cal managed care re-procurement (2024): California completed its first full-blown managed care plan re-procurement in 2024, transitioning the two-plan structure (local initiative and commercial plan) in most counties. Subcontracted health plans were largely eliminated, effective January 1, 2024. In Los Angeles County, following a legal dispute involving Molina and Healthnet, a subcontracting arrangement was ultimately implemented.

Frequent mid-year acuity amendments: Since COVID, California has routinely issued mid-year rate amendments driven by acuity changes in TANF adult, expansion, and some TANF child populations. The state acknowledged that prospective acuity adjustments are estimates and has been actively working to reduce amendment frequency going forward.

MCO tax reconciliation: California maintains a head-based MCO tax, with a true-up and reconciliation mechanism, which influences effective rate levels.

In 2022, DHCS moved pharmacy benefits away from MCPs by launching Medi-Cal Rx, the California Medicaid fee-for-service (FFS) pharmacy benefit. The carve-out affected nearly all Medi-Cal members, and the purpose was to standardize the pharmacy benefit statewide, achieve cost savings, and enhance access to a broader pharmacy network.

The Enhanced Care Management (ECM) benefit launched statewide in January 2022 as part of the CalAIM (California Advancing and Innovating Medi-Cal) initiative. ECM provides personalized, community-based care management for Medi-Cal members with complex physical, behavioral, and social needs.

Community Supports, another key component of the CalAIM initiative, launched in January 2022. These managed care services are designed to address health-related social needs by providing alternatives to traditional medical services. The initiatives aim to provide more coordinated, person-centered care to address social determinants of health, and include housing transition services, respite care, medically tailored meals, and sobering centers.

California became the first state to offer full-scope Medicaid coverage to all low-income residents, regardless of immigration status, on January 1, 2024. This expansion built upon previous age-based expansions that already included children and older adults. The final group, covering adults aged 26-49, was finally phased in and covered with state-only funds. Coverage includes preventive care, primary care, specialist visits, and in-home supportive services. However, new enrollments for this group paused on January 1, 2026 due to budgetary pressures.

Georgia

In 2023, Georgia added a partial Medicaid expansion program with work requirements called Georgia Pathways. This expanded the program structure requiring distinct capitation rate development.

Of interest to Florida is the treatment of ABA therapy services in Georgia. ABA therapy was covered as a Medicaid benefit starting January 2018. Legislative changes, including Ava's Law and Senate Bill 118, removed age and dollar caps expanding coverage to individuals up to age 21 years and authorizing up to 40 hours per week for children under age 6 years and 25 hours per week for older children. Medicaid utilization peaked in 2023 at 341% of 2019 levels. Faced with ABA reimbursement rates far exceeding neighboring states (Georgia's maximum technician rate was ~$305.24/hour versus Florida's $49.04/hour), DCH implemented major cuts, including a 48% reduction for behavior technician-delivered therapy (down to ~$74.80/hour) and a 37% reduction for physician/board-certified behavioral analyst delivered therapy. DCH has moved toward more frequent reauthorizations, enhanced audits, and fraud-prevention protocols to manage ABA cost growth.

New York

Behavioral health integration (ongoing): New York continues integrating behavioral health services, including ABA, into mainstream managed care capitation through HARPs. This integration materially affects rating cell structure and trend assumptions.

Directed payments and behavioral health supplemental funding: New York incorporated directed payments and behavioral health supplemental funding mechanisms into certified capitation rates, requiring coordination between the rate certification process and broader financing structures.

Pennsylvania

Pennsylvania conducted a mid-year rate adjustment for its behavioral health managed care program during the PHE unwinding period. This was an unusual step given that mid-year adjustments are uncommon for the state's Medicaid programs.

The Community HealthChoices program, which is Pennsylvania's LTSS managed care program, continues to mature, with rate development methodology evolving to reflect growing program experience.

Tennessee

TennCare deployed risk corridors during 2020 and 2021 to manage COVID-related financial uncertainty and removed them by 2022 as utilization stabilized. However, for additional risk mitigation, TennCare implemented an 85% minimum MLR requirement starting in 2023, establishing a floor on plan medical spending and reducing the risk of MCO windfall gains.

Like all states, Tennessee experienced significant enrollment and utilization changes during the unwinding of the COVID PHE, which affected base data for rate development. The 2026 rate year uses 2024 as the base data period, which is the first year fully past the PHE tail. Prior to the PHE, TennCare experienced rate amendments and, as of today, the agency maintains a clear preference for limiting rate amendments to genuinely policy-driven circumstances.

Texas

Texas discontinued the Medicare-Medicaid Plan Program on December 31, 2025, consolidating its managed care structure. The state significantly expanded state directed payments, which have materially affected managed care financing and rate development complexity. This had led to a higher prevalence of capitation rate amendments.

Regarding benefit changes, Texas carved pharmacy benefits and nursing facility services into managed care, in SFY 2012 and SFY 2015 respectively, significantly expanding the scope of managed care capitation. Texas launched ABA therapy as a Medicaid managed care benefit in September 2022, treating it as a non-risk carve-out from the outset. Spending approximately doubled each SFY through 2025, with growth beginning to plateau. In addition to ABA therapy, other services remain non-risk within managed care such as very high-cost specialty drugs.

Texas also underwent multiple rate setting oversight reviews during the last several years, including a state audit of the rate setting process, OIG audits, legislatively directed audits, and external actuarial firm reviews, demonstrating a mature and accountable oversight structure.

Section 5

Conclusions and Considerations

This comparative review brings to light several important conclusions about Florida’s Medicaid capitation rate setting process and its position relative to comparison states. The following conclusions are grounded in state interview findings, rate certification analysis, publicly available data, and the cross-state comparison conducted throughout this report.

Florida Operates in a Structurally Comparable Managed Care Environment

Despite the differences noted below, Florida's managed care environment is broadly comparable to the comparison states reviewed. All states operate under actuarial soundness requirements, use managed care as the primary delivery mechanism, and face similar challenges from PHE unwinding, provider rate pressures, and high-growth behavioral health services.

Florida is not an outlier in terms of program structure or complexity of its rate setting environment. The opportunities identified in this report are refinements to a fundamentally sound framework.

Florida’s ABA Carve-In is Structurally Distinct and Fiscally Consequential

Florida’s decision to carve ABA therapy directly into MMA managed care capitation rates distinguishes it from several comparison states, most notably Texas, which explicitly treats ABA as a non-risk service while accumulating experience data. The consequences of Florida's approach are evident: ABA emerged as the dominant driver of the 22.6% overall rate increase from RY 2023/2024 to RY 2024/2025, with underlying trend estimated at ~4.2% absent program changes.

Florida may want to consider whether a carve-out or non-risk approach for ABA (like the Texas model) would better support rate stability and fiscal predictability as ABA spend continues to mature. At minimum, ABA should be tracked and reported as a discrete rate component, separate from base medical trends, to ensure transparency in rate development.

Florida's Rate Transparency Lags Behind Best Practice Peers

Florida's current process has not historically provided MCOs or the public with the same degree of actuarial methodology transparency utilized by other states. Texas publishes detailed actuarial rate setting reports publicly, with over ten years of historical documentation, and includes formal MCO comment periods and multiple draft iterations before finalization. California is also moving toward greater formality in its rate development timeline.

Florida may want to consider adopting formal publication of rate methodology documentation, including base data periods, trend factors, and ABA-specific assumptions, as a standard practice going forward.

Mid-Year Rate Amendment Practices Warrant Discipline and Documentation

Florida has issued mid-year adjustments, with the ABA carve-in representing a major recent driver. In contrast, among comparison states, TennCare demonstrated that a philosophy of limiting mid-year adjustments to genuinely policy-driven circumstances while expecting state staff to predict and plan for adjustments within the structure of annual rate cycles supports both budget discipline and MCO planning. California, by contrast, issued frequent mid-year acuity amendments since COVID-19 and is actively working to reduce their frequency.

Florida may want to adopt clearer criteria for when rate amendments are appropriate and establish communication protocols with the legislature when changes exceed a defined magnitude.

Risk Mitigation Mechanisms Are Present but Could Be More Strategically Calibrated

Florida has MLR and ASR requirements in place, which are foundational. Comparison states show more nuanced and strategically calibrated risk-sharing structures. For example, Texas's tiered rebate corridor, calibrated to allow MCO viability at reasonable profit levels while recouping windfalls above 12%, represents a model that is both fair to plans and protective of state resources. Tennessee's removal of risk corridors after COVID stabilization demonstrates situational use rather than permanent dependency on risk-sharing tools.

Florida may want to evaluate whether its MLR and ASR mechanisms are optimally designed to reflect current program dynamics, particularly given the magnitude of ABA-driven rate increases and associated MCO profitability impacts. For instance, an ABA-specific risk corridor could allow the MCOs to continue managing the benefit while mitigating arbitrary financial consequences resulting from challenges with accurately projecting ABA utilization.

Encounter Data Validation and ABA-Specific Monitoring Are Critical Going Forward

Unlike some comparison states, Florida's carve-in of ABA created significant new data monitoring needs that will require rigorous validation protocols. Specifically, Texas's structured encounter data validation framework, including EQRO certification, quarterly FSR reconciliation, Financial Reporting and Analysis Committee meetings, and a dedicated claims lag dataset, provides a model for how states can maintain data integrity at the rate development level. Federal audit findings nationally, including confirmed improper payments exceeding $198 million and potentially improper payments of $410 million across four states, underscore that ABA-specific billing oversight cannot be left to MCO self-governance alone.

Florida may want to consider establishing ABA-specific utilization benchmarks, provider-level audit triggers, and standardized encounter data reporting requirements for ABA services.

Section 6

Appendix A: Acronym List and Definitions

Actuarial Standards of Practice (ASOPs): Guidelines established by the Actuarial Standards Board to ensure actuaries perform their work with professionalism and integrity.

Applied Behavior Analysis (ABA): A kind of research-based behavior therapy for people with autism and other developmental disorders. Its goal is to see an increase in positive behaviors and a decrease in negative behaviors. Children can also learn new skills and improve their social interactions.

Affordable Care Act (ACA): A federal health care reform law enacted to expand access to affordable health insurance, improve quality, and reduce healthcare costs.

Agency for Health Care Administration (AHCA): The state agency that administers Florida's Medicaid program and oversees health care policy and regulation within the state.

Achieved Savings Rebate (ASR): A contractual financial mechanism in which managed care plans return a portion of cost savings achieved back to the state.

Breast and Cervical Cancer (BCC): An early detection and treatment program for those diagnosed with Breast or Cervical Cancer.

Code of Federal Regulations (CFR): The codified collection of federal rules and regulations that govern Medicaid program requirements and administration.

Children's Health Insurance Program (CHIP): A federal-state partnership program that provides health coverage to uninsured children in families with incomes too high for Medicaid eligibility.

Care Management Organization (CMO): An entity that is organized for the purpose of providing or managing health care.

Centers for Medicare & Medicaid Services (CMS): The federal agency that provides health coverage to more than 160 million through Medicare, Medicaid, the Children's Health Insurance Program, and the Health Insurance Marketplace.

Chronic Illness and Disability Payment System plus Medicaid Rx (CDPS+Rx): a predictive risk adjustment model that combines diagnostic and pharmacy data to forecast healthcare costs and stratify Medicaid patients by risk.

Department of Community Health (DCH): Georgia entity responsible for Medicaid, health plans, healthcare regulation, and programs aimed at improving access and quality of healthcare for the state's population.

Department of Health Care Services (DHCS): California office that administers Medi-Cal.

Department of Human Services (DHS): Department that oversees Pennsylvania's Medicaid managed care program.

External Quality Review Organization (EQRO): An independent entity that evaluates the quality, timeliness, and access to healthcare services provided by managed care organizations under Medicaid and CHIP programs.

Fee-for-service (FFS): A traditional Medicaid payment model in which providers are reimbursed individually for each service rendered.

Federal Poverty Level (FPL): An income threshold used by the U.S. government to determine eligibility for various federal and state assistance programs, based on household size and income.

Financial Statistical Report (FSR): A report submitted by the MCOs that allows the state to reconcile encounter data against financial results.

Health and Recovery Plan (HARP): Specialized plan for adults with significant mental health or substance use needs under New York Medicaid.

HIV Special Needs Plan (HIV-SNP): A specialized health plan for individuals eligible for Medicaid and living with HIV/AIDS, homeless, or transgender.

Home- and Community-Based Services (HCBS): Medicaid services that support individuals in their homes or community settings as alternatives to institutional care.

Health and Human Services Commission (HHSC): Texas entity that supports the needs of mothers, children, and families through programs such as Medicaid, CHIP, women's health, and behavioral health services.

Long-Term Care (LTC): Services and supports for individuals with chronic illness or disability that assist with activities of daily living, delivered in institutional or home- and community-based settings.

Long-Term Services and Supports (LTSS): A range of Medicaid-covered services that assist individuals with chronic illnesses or disabilities in daily living activities over an extended period.

Low-Income Medicaid (LIM): Georgia Medicaid program designed for families with low income.

Managed Care Organization (MCO): A health plan contracted to provide Medicaid services to enrollees through a network of providers under a managed care delivery model.

Managed Care Plan (MCP): A health plan contracted to provide Medicaid services to enrollees through a network of providers under a managed care delivery model.

Minimum Loss Ratio (MLR): A measure to determine the percentage of revenue spent on patient care and quality improvement.

Managed Long-Term Services and Supports (MLTSS): The delivery of long-term services and supports (LTSS) through capitated Medicaid managed care programs.

Managed Medical Assistance (MMA): Florida's Medicaid managed care program that provides comprehensive medical services through contracted health plans.

Medicaid Managed Care (MMC): The delivery of Medicaid benefits through contracted arrangements between state Medicaid agencies and managed care organizations (MCOs), who accept a set per member per month payment for services.

Office of Inspector General (OIG): An independent oversight body tasked with preventing and detecting fraud, waste, and abuse.

Office of the Medicaid Inspector General (OMIG): An independent entity within the New York State Department of Health tasked with preventing and detecting fraud, waste, and abuse.

Program of All-Inclusive Care for the Elderly (PACE): A comprehensive care program that provides community-based health and social services to eligible elderly individuals to support living independently.

Peach Care for Kids (PCK): Georgia's version of CHIP; it provides comprehensive health insurance for uninsured children whose families earn too much to qualify for traditional Medicaid but cannot afford private insurance.

Public Health Emergency (PHE): A federally declared emergency that allows for temporary changes in Medicaid policies and funding to address urgent public health needs.

Per Member Per Month (PMPM): A payment metric used in Medicaid managed care to represent the fixed monthly amount paid to health plans for each enrolled member.

Rate Development Template (RDT): A structured format used to compile and analyze data for Medicaid managed care rate development.

Refugee Medical Assistance (RMA): A Georgia program aimed at promoting the physical, mental, and social health of newly arriving refugees.

Rate Year (RY): The annual period for which set capitation rates are paid.

State Fiscal Year (SFY): The 12-month accounting period used by the state government for budgeting and financial reporting, which may differ from the calendar year.

State Directed Payments (SDPs): Mechanisms state governments use to direct the flow of healthcare funds within their Medicaid programs

Seniors and Persons with Disabilities – Long-Term Care (SPD-LTC): A type of long-term care specific to seniors and persons with disabilities.

Supplemental Security Income (SSI): A federal cash assistance program for low-income aged, blind, and disabled individuals; SSI receipt is often a factor in Medicaid eligibility.

Temporary Assistance for Needy Families (TANF): A Federal assistance program that provides financial support and services to low-income families, often linked with Medicaid eligibility.

Transitional Medical Assistance (TAM): Georgia Medicaid program designed for families who recently became ineligible for low-income Medicaid (LIM) because of increased income.

Unsatisfactory Immigration Status (UIS): An immigration category that does not meet eligibility requirements for certain public benefits, such as full-scope Med-Cal.

Very Low Birth Weight (VLBW): A designation given to infants born weighing less than three pounds, five ounces (1,500 grams), which is considered medically significant due to increased risk of health complications and developmental issues. Georgia's Planning for Healthy Babies program aims to reduce the incidence of VLBW births and support these families.

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