Georgia Health Initiative

Data & Trend Analyses

Insights on Medicaid in Georgia

January 2025

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Introduction

Introduction & Overview

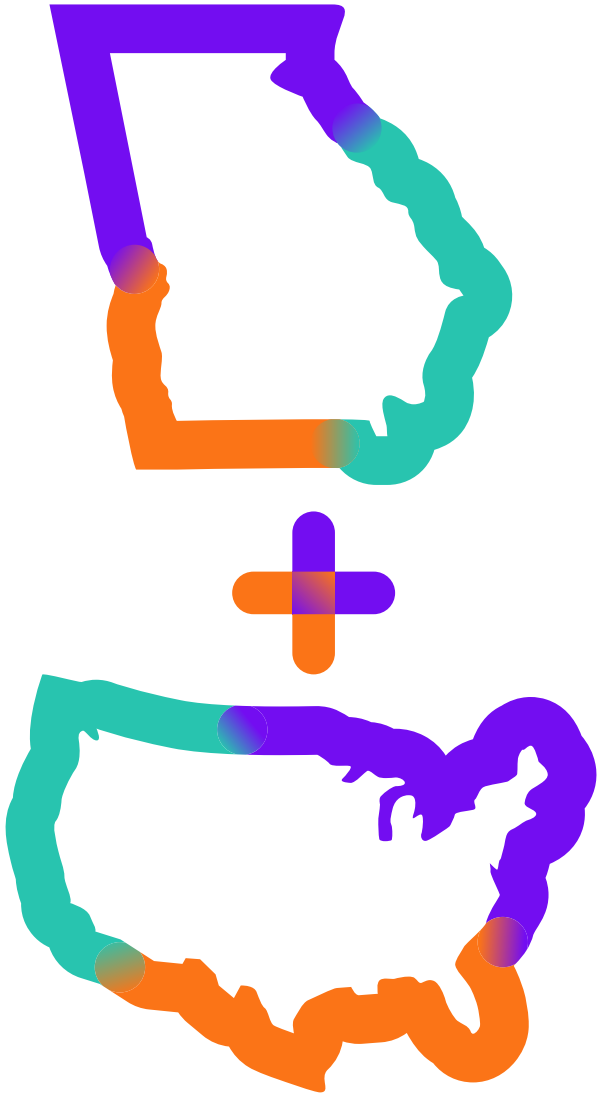
Georgia Health Initiative is pleased to share this compendium resource that provides a synopsis of data and trend analyses specific to Medicaid in Georgia. We hope this annual publication proves a comprehensive, timely, and sound source of data and insight to all who, like us, recognize the important role that Medicaid plays in providing coverage to 2.3 million individuals and supporting our state's health care infrastructure and overall economy.

This publication presents the most recent data and information available on Medicaid enrollment, covered benefits and services, service delivery, financing, and summarizes state priorities (as shared by key decisionmakers) as well as national trends. This compendium of data and insights is part of a suite of resources intended to support a comprehensive understanding of Medicaid's role in Georgia's health care system.

For more background information and context about sources of health insurance, the Medicaid program overall, and the governance of Georgia's Medicaid program, we invite you to review a companion resource, entitled *Insights on Medicaid in Georgia: Overview and Context*, available on our website. While key terms have been described and defined throughout this compendium, we have also developed a *Glossary* that can assist in reading through this information.

Partners in Possibility

Brief Background



Medicaid is a joint state-federal program that provides coverage to certain low-income individuals and families, including children, pregnant women, some parents, and individuals who are elderly or have certain disabilities. Medicaid in Georgia is operated through an agreement between the federal Centers for Medicare and Medicaid Services and the Georgia Department of Community Health (DCH), our state's designated Medicaid agency, and is jointly funded by the federal government and by the state.

Eligibility for Medicaid is defined through categorical eligibility (i.e., populations covered) and financial eligibility (i.e., the income level or threshold at which individuals within the populations can be covered). Georgia has significant flexibility in deciding what services are covered for Medicaid members, which include both mandatory and optional services. Health care service delivery through Medicaid is largely done through Managed Care Organizations (referred to as Care Management Organizations or CMOs in Georgia), who contract with DCH.

Brief Background *(continued)*

FIGURE 1.

GEORGIA MEDICAID AT-A-GLANCE (2025)

Georgia's Medicaid Population

- **18.8%** of Georgians are covered by Medicaid
- Medicaid covers **46%** of Georgia births
- **41.7%** of Georgia's children are covered by Medicaid
- **74%** of Georgia's nursing home residents are covered by Medicaid
- **18%** of Medicaid members are also enrolled in Medicare
- In State Fiscal Year 2024, almost **402,000** Medicaid members were working

Service Delivery and Utilization

- **75%** of Medicaid members receive services through a CMO
- **58%** of all Medicaid members are children but **96%** of children enrolled in Medicaid receive services through a CMO
- Aged, Blind, and Disabled (ABD) members see a physician **10** times per year on average while Low Income Medicaid (LIM) members average **3-4** visits.
- **63%** of all Primary Care Providers and all of the state's acute care hospitals participate in Medicaid.

Expenditures & Financing

- Every **$1** Georgia spends on Medicaid services delivery is reimbursed at **$0.66** from the federal government
- **$16.57 Billion** was spent in 2024 for Medicaid services
- **54%** of total expenditures cover services for **23%** of the total Medicaid population for Medicaid's ABD members
- **40%** of Medicaid spending goes to CMOs to provide benefits primarily for LIM and PeachCare for Kids® (PCK) populations
- ABD per member per month costs are almost **9.5** times greater than for PCK members, and **7** times greater than for LIM
- Hospitals received about **$2.3 Billion** in directed payments and another **$2.25 Billion** in Disproportionate Share Hospital payments

NOTE: All sources for the information in Figure 1 are cited throughout this report.

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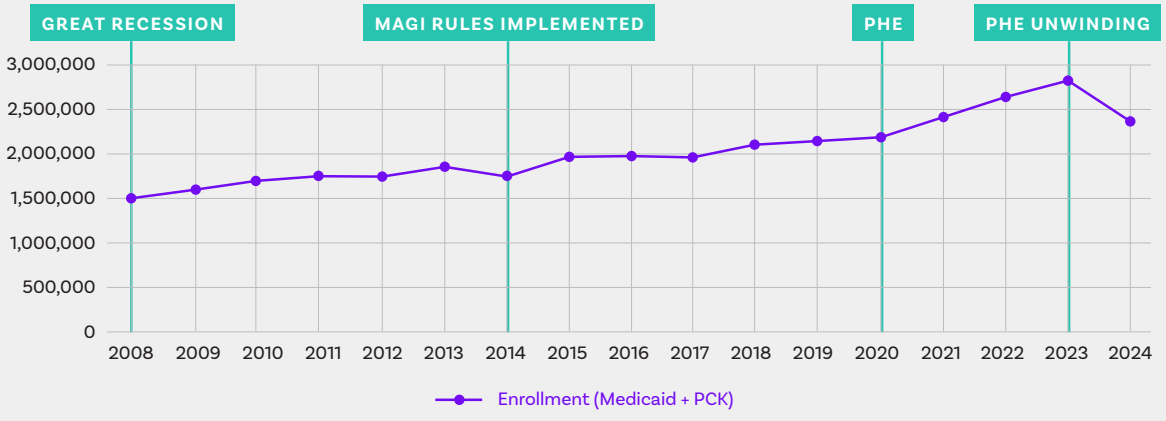
Eligibility & Enrollment

Medicaid Enrollment Overview

Nearly one in five Georgians (19%) has health coverage through Medicaid. In the two decades between State Fiscal Year (SFY) 2000 and 2020, enrollment increased from 1.3 million[2.1] to almost 1.9 million, an average rate of growth of just over 2% each year. Several factors, including Georgia's total population growth, rising poverty rates, the aging of the population, and state policy decisions have contributed to Medicaid growth.

FIGURE 2-1.
GEORGIA MEDICAID AND PEACHCARE FOR KIDS® (PCK) POINT-IN-TIME ENROLLMENT (2008-2024)



Sources: Data.Medicaid.Gov (2017-2024) and Monthly Medicaid and CHIP Application and Enrollment Reports (2014-2016).
NOTE: Enrollment reflects Medicaid and PCK enrollment in June of each year. "MAGI" refers to Modified Adjusted Gross Income.

Enrollment peaked at 2.8 million[2.2] in 2023 as a result of the federal public health emergency (PHE), during which states could not disenroll members in exchange for receipt of enhanced federal funding. As of June 2024, enrollment had fallen to 2.3 million according to the Department of Community Health (DCH), which is higher than pre-pandemic counts by over 100,000 and relatively on par with the average rate of enrollment growth for the state.

Nearly 1 in 5
Georgians (19%) has health coverage through Medicaid

18.8%
As of July 2023, 18.8% of Georgia residents received health care through Medicaid compared to a national average of 21.3%.

81%
On average, 81% of Medicaid members have experienced continuous enrollment for 10-12 months.

18%
18% of Medicaid members are also dually eligible for Medicare (in part or in full).

2.1 DCH Annual Report. (2000). https://dch.georgia.gov/document/publication/fy00-annual-report/download.

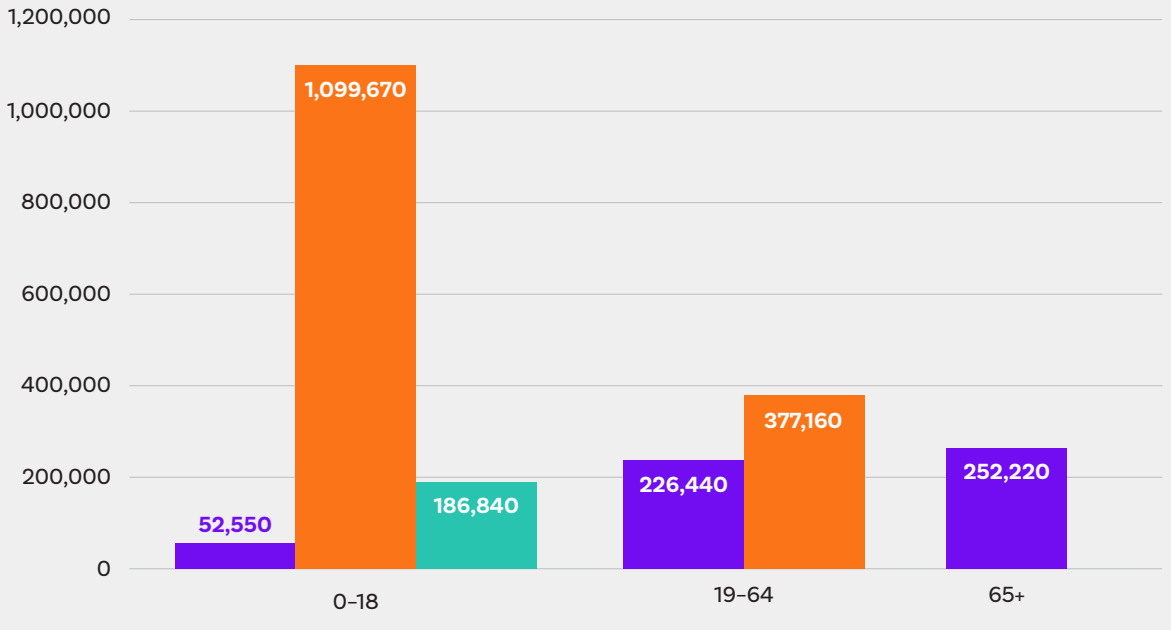
2.2 DCH OAPI KPI Analytics Dashboard. (n.d.) Medicaid Enrollment.

Medicaid Enrollment by Age and Eligibility Category

Because Georgia has not expanded its program, Medicaid generally serves a younger average population as compared to other states. In April 2024, the average age of the Georgia Medicaid member was 16 (excluding dual eligible Medicare enrollees whose average age was 66). Aged, Blind, and Disabled (ABD) Medicaid is the one category in which members throughout the age span are enrolled, as individuals of any age can be blind or disabled. The vast majority of Georgia Medicaid members (1.82 million) are in managed care and served by one of three currently contracted care management organizations (CMOs).[2.3] The CMOs serve both Low Income Medicaid (LIM) members and PCK members, a partnership with DCH known as Georgia Families®. About 590,000 members are in fee-for-service (FFS) Medicaid.[2.4]

FIGURE 2-2.

MEDICAID ENROLLEES BY AGE AND ELIGIBILITY CATEGORY (APRIL 2024)



Source: DCH OAPI KPI Analytics Dashboard. (n.d.) Medicaid Enrollment.

2.3 Most LIM members are assigned to managed care while ABD members remain in the FFS system. The contracted care management organizations will change with the next procurement cycle project to become effective in July 2026.

2.4 DCH Member Report. (November 2023 – January 2024). Medicaid Enrollment by CMO and FFS Health Plan.

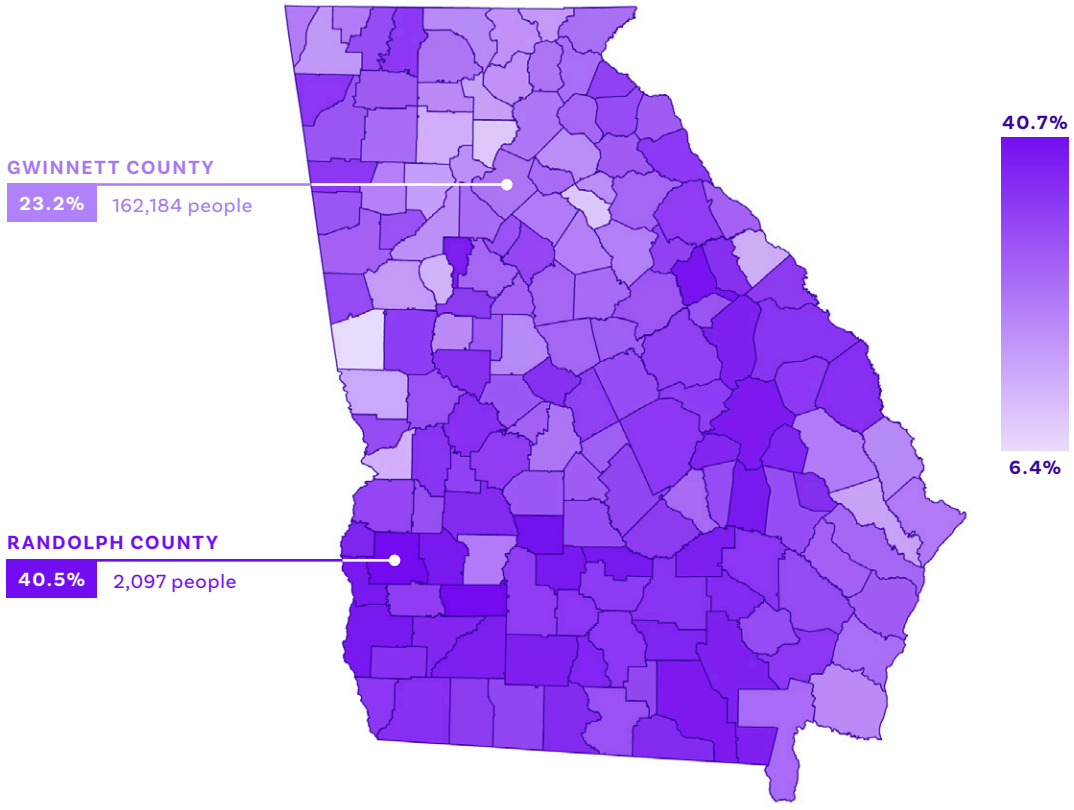
Medicaid Enrollment by County

There are Medicaid members in every county in Georgia. Overall Medicaid enrollment is higher in the more densely populated areas of the state. However, the less populated and more rural counties of Georgia tend to have higher levels of poverty and consequently have higher percentages of their population enrolled in Medicaid as compared to their urban counterparts, with as many as 43% of county residents receiving Medicaid coverage.

For example, while there are 162,184 people enrolled in Medicaid in **Gwinnett County** (the highest enrollment in the state), this translates to only 23.2% of the total county population. By contrast, **Randolph County** only has 2,097 people enrolled in Medicaid, but this translates to 40.5% of the total county population.

FIGURE 2-3.

PERCENTAGE OF COUNTY POPULATION ENROLLED IN MEDICAID (JULY 2023)



Sources: DCH Enrollment Data. Medicaid Enrollment by County. U.S. Census Bureau. Projected population by County. (2023).

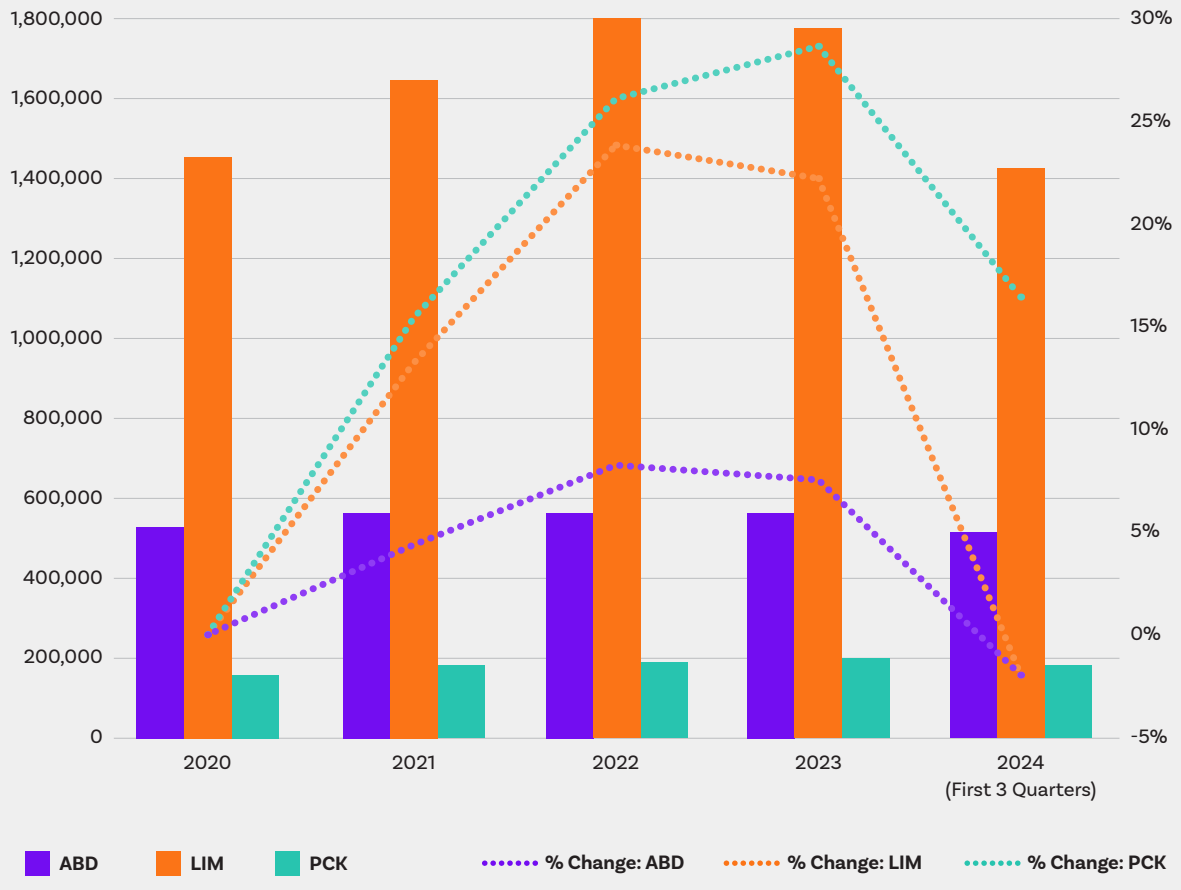
Changes in Medicaid Enrollment Associated with the Federal Public Health Emergency

Georgia experienced substantial growth in Medicaid enrollment during the federal COVID-19 PHE, with an increase of 700,000 enrollees, due to the continuous coverage provision. Beginning in May 2023, states resumed regular Medicaid eligibility reviews and redeterminations. This process, known as "unwinding," presented challenges for both states and Medicaid members, as states struggled with the volume of redeterminations processing and the need to maintain coverage for eligible individuals and discontinue coverage for individuals no longer eligible. Medicaid members experienced communication and coordination challenges in responding to renewal notices or transitioning to other coverage. Many members—689,000 in Georgia—were procedurally disenrolled because they didn't respond to notices even though some may have remained eligible.

While Georgia's rate of disenrollment was the twelfth highest in the nation, overall enrollment in Georgia Medicaid remains around 8% higher now than it was pre-PHE. Additionally, the eligibility group proportions have shifted. For example, the LIM group grew the most during the PHE from 68.3% of all Medicaid members in 2020 to 85% in 2022, but then saw the greatest reduction in enrollment during the unwinding (representing 67.3% of Medicaid members as of April 2024).

FIGURE 2-4.

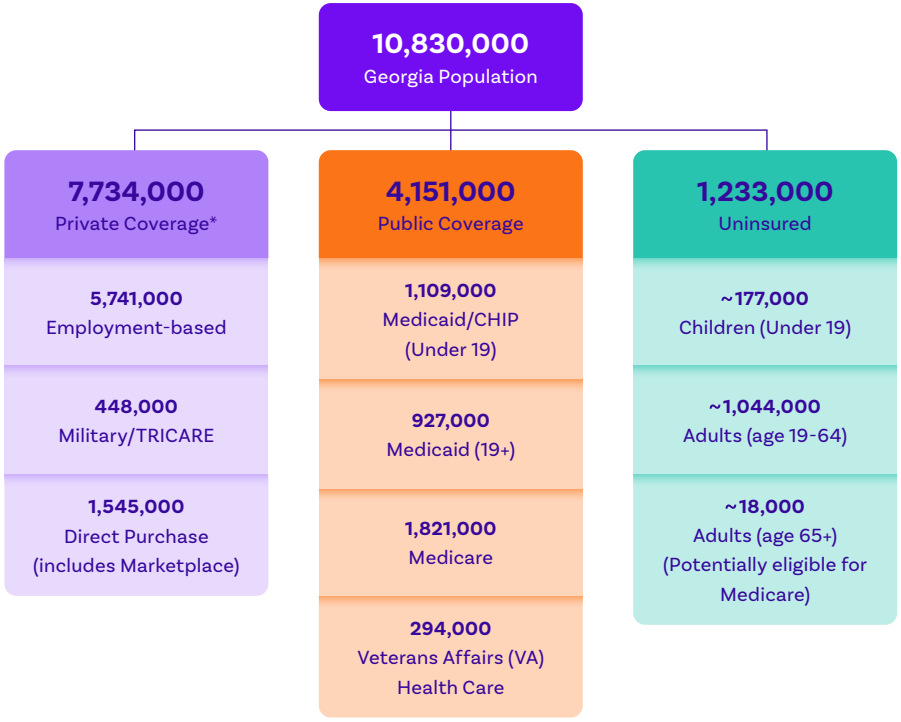
TIMELINE OF PRE- AND POST-PHE GEORGIA MEDICAID ENROLLMENT



Source: DCH Enrollment Data.

Georgians Potentially Eligible for Medicaid

FIGURE 2-5.
POPULATION OF GEORGIANS INSURED AND UNINSURED



Source: U.S. Census Bureau. (2023). American Community Survey.

*NOTE: Most forms of private coverage are subsidized in part through government tax credits or deductions. See the "Overview and Context" publication for additional details about these sources of coverage.

Of the nearly 11 million people in Georgia, an estimated 1.2 million Georgians are uninsured.[2.5] Of this total almost 12%, or around 170,000, are children ages 19 and under.[2.6] Among these 170,000 children, 89.1% are potentially eligible for Medicaid or PCK.[2.7] Several factors might prevent these children from being enrolled in Medicaid including paperwork hurdles, lack of education for parents about eligibility and how to apply, or immigration status.

Adults ages 19-64 account for 84.7% of Georgia's uninsured population (around 1.04 million individuals). Of these working age adults, about 240,500 live at or below 100% of the FPL (Federal Poverty Level).[2.8] The Georgia Pathways to Coverage™ Program has newly insured 5,120 members as of October 2024.[2.9] This represents a lower-than-expected number, which may be due to the qualifying activities requirement (at least 80 hours per month of work, higher education, volunteering or other qualifying activities), reporting requirements for qualifying activities, and lack of knowledge of the program.

If Georgia were to expand its Medicaid program, nearly 300,000 of currently uninsured Georgians aged 19-64 would gain health coverage.

2.5 U.S. Census Bureau. (2023). American Community Survey.

2.6 Of all children in Georgia, 6.4% are uninsured. 7% are 6-18 years-old and 4.8% are younger than 6.

2.7 Center on Budget and Policy Priorities. (2024, June 14). Medicaid Expansion: Frequently Asked Questions.

2.8 *Id.*

2.9 GeorgiaPathways.org. (n.d.). Data Tracker. https://www.georgiapathways.org/data-tracker.

Eligibility Groups in Georgia Medicaid

Georgians can meet Medicaid eligibility criteria through a number of different eligibility categories, which are often grouped at a summary level into either LIM, ABD, and PCK.

FIGURE 2-6.
SUMMARY OF GEORGIA'S MEDICAID ELIGIBILITY CATEGORIES GROUPED BY ABD, LIM, AND PCK WITH ENROLLMENT COUNTS (AS OF APRIL 2024)

Low-Income Medicaid (LIM) Enrollment: 1.58 million	**Aged, Blind and Disabled Medicaid (ABD)** Enrollment: 590,000	**PeachCare for Kids® (PCK)** Enrollment: 190,000
• **Right from the Start Medicaid for Pregnant Women (RSM Adults) —** Pregnant women with family incomes at or below 200%FPL. • **Right from the Start Medicaid (RSM Children) —** Children under 19 years of age whose family incomes were at or below the appropriate percentage of the FPL for their age and family size. • **Parent/Caretaker with Children Under Age 19 —** U.S. citizens or lawfully admitted immigrants who are primary caretakers for children under age 19 and whose income does not exceed $653 per month (family of four, 2024). • **Medically Needy —** Pregnant women with children whose income and/or resources exceed limits for all other LIM categories and use their medical expenses to "spend down" the difference between their income and the medically needy income level. • **Breast and Cervical Cancer Program —** Uninsured and underinsured women under 65 years old screened and diagnosed with either breast or cervical cancer by a public health department. • **Chafee Option —** Older youth (18-21) who aged out of foster care, effective July 1, 2008.[2.10] Subsequent legislation has extended the age of Medicaid eligibility for youth aging out of foster care to age 26. • **Emergency Medical Assistance (EMA) —** Immigrants, including undocumented immigrants, meeting Medicaid eligibility standards except for their immigrant status.	• **Supplemental Security Income (SSI) —** Children and adults who have disabilities, low income, and few resources who receive SSI. • **Institutionalized Care —** Individuals needing nursing home, hospice, or hospital care for 30 days or more, and Home and Community-Based Services. • **Medicare Savings Plans (MSP) —** Medicaid assistance for Medicare premiums and/or cost sharing for low-income MSP members, including those up to 135% FPL. • **Public Laws —** Six laws extending Medicaid coverage for people who have lost SSI benefits. • **Adult Medically Needy —** Individuals whose income and/or resources exceed limits for all other ABD categories but can use their medical expenses to "spend down" the difference between their income and the medically needy income level. • **Deeming Waiver (Katie Beckett Medicaid) —** Children under the age of 18 who are financially ineligible for SSI and need institutionalized care but have chosen to remain at home for lower cost care. • **Emergency Medical Assistance (EMA)** *(Can be LIM, too, but vast majority of members are eligible through ABD)* — Immigrants, including undocumented immigrants, meeting Medicaid eligibility standards except for their immigrant status. • **Refugee Medicaid Assistance —** Legal immigrants classified as refugees, asylees, Cuban/Haitian entrants, Vietnamese Americans and victims of human trafficking. Coverage of this group is federally required, and 100 percent reimbursed by the federal government. • **Hospice —** Terminally ill individuals expected to live six months or less.	• **PeachCare for Kids® (PCK)** eligible children under age 19 whose family income is too much to qualify for Medicaid but who would otherwise be uninsured because the family cannot afford health insurance.

Source: DCH OAPI KPI Analytics Dashboard. Medicaid Enrollment.

2.10 Georgia has implemented a proactive process to help former foster youth transition to adulthood. If a youth leaves care, the state will transition the individual to either the Chafee option or Former Foster Care eligibility. The process eliminates the need for the youth to complete an application.

Financial Criteria for Medicaid Eligibility

FPL, which is the basis for Medicaid and CHIP eligibility, is set by the U.S. Department of Health and Human Services and its guidelines are adjusted at least once a year. FPL is the earned income by a household annually and is deemed federally to represent the minimum income that a family requires for food, clothing, transportation, shelter, and other necessities. Poverty is defined federally as any income that falls below FPL. In 2024, the FPL for an individual was $15,060 and $31,200 for a family of four.

TABLE 2.7.
RANGE OF FINANCIAL LIMITS FOR DIFFERENT ELIGIBILITY TYPES WITHIN EACH ELIGIBILITY CATEGORY

	Aged, Blind, and Disabled		Low-Income Medicaid		PeachCare for Kids®
			Individual	*Family of 4*	
Income Limits	SSI, Medically Needy, Institutional	$317 - $2,829/month	$208 – $2,649/month	$442 – $5,720/month	$3,100/month
	Medicare Duals	$1,275 - $1,715/month			
Resource Limits	SSI, Medically Needy, Institutional	$2,000	N/A*		N/A
	Medicare Duals	$9,430			

Source: Georgia Medicaid. (n.d.) Basic Eligibility. https://medicaid.georgia.gov/how-apply/basic-eligibility.

NOTE: This table represents an abbreviated summary of Medicaid eligibility criteria. The table collapses multiple eligibility classes of assistance for illustrative purposes to convey general income and resource thresholds. For the complete list of criteria, please see the state's website, listed in the source.

*TANF recipients have a $1,000 resource limit which may apply to some LIM members.

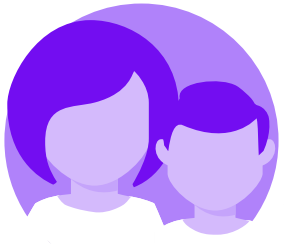
Profiles of Georgians Eligible for Medicaid

FIGURE 2-8.

ELIGIBILITY PROFILES OF MEDICAID-ENROLLED GEORGIANS (REFLECTING COMPOSITE EXAMPLES FOR ILLUSTRATIVE PURPOSES)

ABD Profile

- 34 year old male eligible for Medicaid based on disability
- Lives in a rural area
- Visits his providers frequently, about 40 times a year, primarily for behavioral health services
- Presents at the Emergency Department once a year on average
- Has 36 prescriptions filled per year
- Services cost about $12,000 annually



LIM Profile

- 36 year old mom and 10 year old son
- Live in a suburban area; Mom works a part-time minimum wage job and earns less than $6,000 per year
- Both mom and son are healthy and primarily use preventive services; between well-child and occasional sick visits, have a total of 12 doctor visits
- Service costs are about $5,000 annually for both

PCK Profile

- 11 year old girl, fewer medical needs than majority of Medicaid enrollees
- Mostly sees her physician for well-child visits and an occasional sick visit
- Takes medication for asthma and also had at least one antibiotic prescription
- Services costs are about $1,500 annually

Enrollment Processes

There are several different ways to apply for Medicaid in Georgia, with certain pathways open to everyone and others only for specific populations.

FIGURE 2-9.
ENTRY POINTS FOR ENROLLMENT FOR GEORGIA MEDICAID

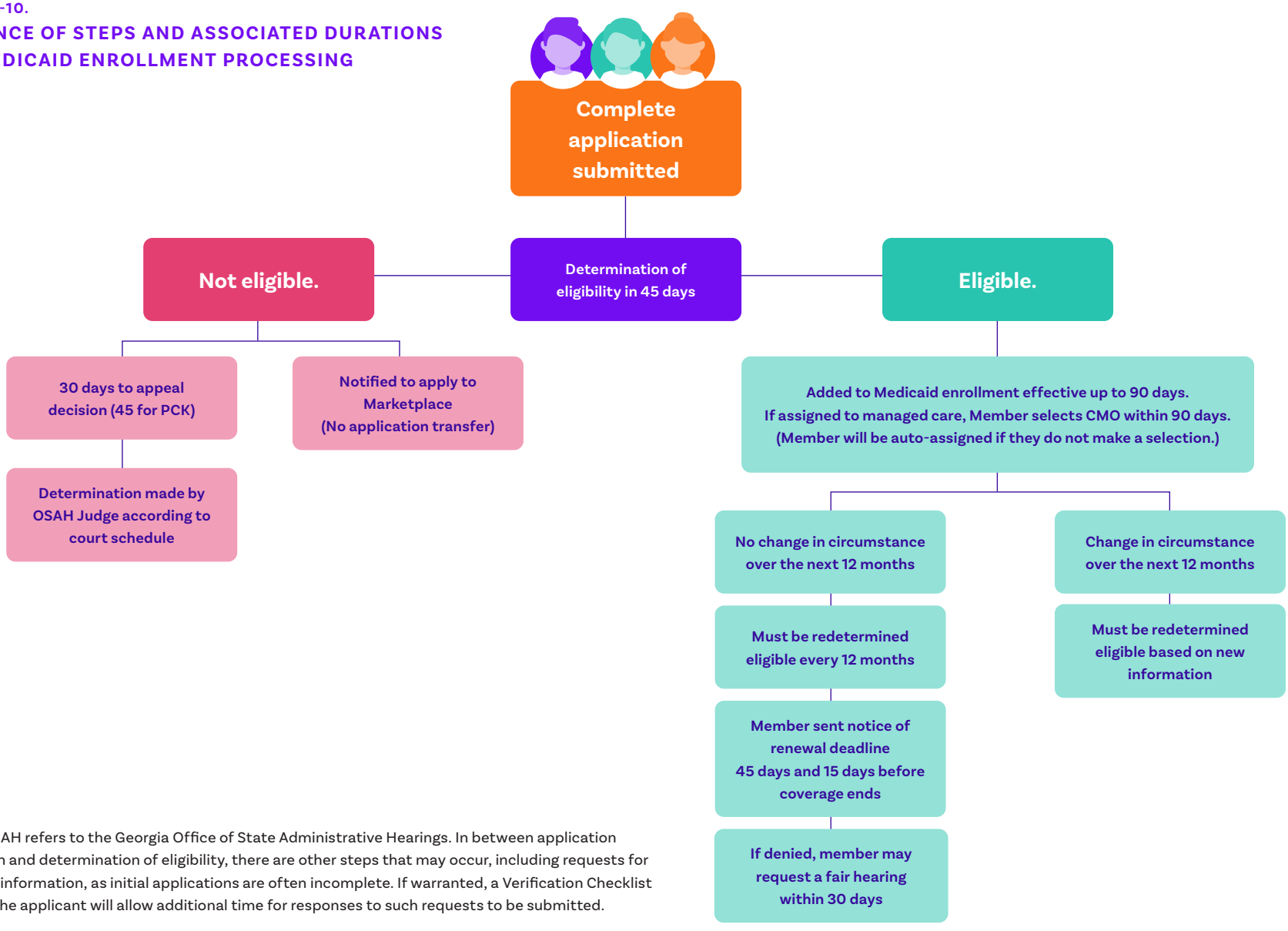
Entry Point	Eligible Population	Description	Mechanism(s) of Enrollment
Gateway	All	Georgia's online system promoted as the no-wrong-door entry point for all.	Online
Social Security Administration	Seniors and/or individuals diagnosed with a disability with little to no income.	Eligible individuals who apply and who are approved for Supplemental Security Income (SSI) are automatically enrolled in Medicaid.	Apply in-person for SSI at the local Social Security Office. SSI enrollees are then automatically enrolled in Medicaid.
Department of Family and Children's Services (DFCS)	All	Individuals can walk into any county DFCS office or make an appointment to submit an application. DFCS will process the application, assist with completing the online application, and/or provide paper forms to be completed and returned to them.	In person By mail By phone*
Community Settings	Pregnant women	Pregnant women who present in designated health care sites (e.g., hospitals, FQHCs) can be certified through presumptive eligibility processes to get medical assistance the same day.	In person
Katie Beckett Office	Medically fragile children	A separate Katie Beckett/Deeming Waiver eligibility unit processes applications for children who have significant disabilities and who would otherwise be eligible to be cared for in an institution.	By mail
Express Lane Eligibility (ELE)	Children aged 19 and younger	ELE program will automatically enroll or renew eligibility for Medicaid or PCK for children under 19 who are receiving state benefits such as Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), Refugee Cash Assistance (RCA), Child Care and Parent Services (CAPS), or Women, Infants and Children (WIC).	Automatic enrollment

*NOTE: Potential applicants may call into a DFCS office to initiate applying, but additional information or documentation may be needed to complete the process.

Medicaid Application Processing - Steps

FIGURE 2-10.

SEQUENCE OF STEPS AND ASSOCIATED DURATIONS FOR MEDICAID ENROLLMENT PROCESSING



NOTES: OSAH refers to the Georgia Office of State Administrative Hearings. In between application submission and determination of eligibility, there are other steps that may occur, including requests for additional information, as initial applications are often incomplete. If warranted, a Verification Checklist issued to the applicant will allow additional time for responses to such requests to be submitted.

Medicaid Application Processing – Volume and Duration

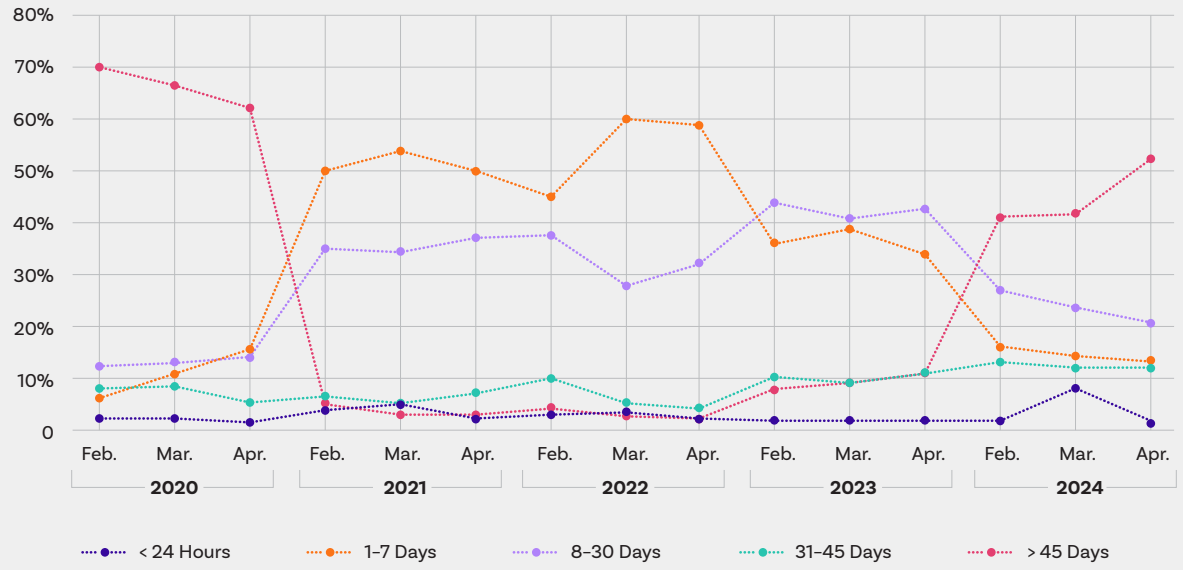
For SFY 2024, the state reported receiving 122,644 Medicaid applications —103,653 online, 16,845 on paper, and 2,146 by phone.[2.11] Georgia receives close to 50,000 Medicaid applications each month.

Standard of practice targets a turnaround time of 45 days to process a Medicaid application from time of receipt. In February 2020, 70% of applications were completed in more than 45 days while 8.7% were completed in less than 8 days. During the federal COVID-19 PHE, when only new applications were being processed, processing times decreased and the majority of applications were processed in less than 30 days.

Applications taking longer than 45 days to process trended upward from 41% in February 2024 to 52% in April 2024. However, in December 2024, DCH reported that the average processing time is 70 days, returning to pre-PHE processing times.

FIGURE 2-11.

GEORGIA MEDICAID AND CHIP APPLICATION PROCESSING TIMES (FEB 2020 – APRIL 2024)



Source: CMS. (n.d.). Medicaid Modified Adjusted Gross Income & Children's Health Insurance Program Application Processing Time Report. https://www.medicaid.gov/state-overviews/medicaid-modified-adjusted-gross-income-childrens-health-insurance-program-application-processing-time-report/index.html.

NOTE: Figure compares completion times for the same three-month period between the stated time frame based on completion in less than 24 hours, between 1-7 days, 8-30 days, 31-45 days, or over 45 days.

2.11 Georgia Department of Human Resources. (2024, November 15). Open Records Request.

3

Covered Medicaid Benefits and Services

Mandatory and Optional Medicaid Benefits

Georgia Medicaid benefits include both mandatory services each state must provide to all members and many optional services, about 50 different service programs in all.

Optional benefits authorized by the State Plan are available to any Medicaid member who meets the medical necessity criteria for each specific service. Only optional benefits available through Home and Community Based Services (HCBS) waivers have special eligibility criteria that limit the total number of members allowed to participate.

FIGURE 3-1.
KEY MANDATORY AND OPTIONAL SERVICES IN GEORGIA MEDICAID

MANDATORY Services	OPTIONAL Services
• Physician Services • Inpatient Hospital Services • Outpatient Hospital Services • Laboratory and X-Ray Services • Home Health Services • Nursing Home Care • Early and Periodic Screening, Diagnostic, and Treatment Services for Individuals under 21 • Family Planning and Supplies • Federally Qualified Health Care Center Services • Rural Health Clinic Services • Nurse Midwife Services • Non-Emergency Transportation	• Pharmacy • Dental Care for Adults • Orthotics, prosthetics and durable medical equipment • Primary care case management • Mental Health clinical services • Psychological Services • Hospice Care • Inpatient Hospital Care for Individuals under age 21 (psychiatric) • Home and Community Based Services • Podiatry Services • Portable X-Ray and CT Scan Services • Targeted Case Management • Vision Care

Source: Georgia Medicaid. (n.d.) Medicaid State Plan. https://medicaid.georgia.gov/organization/about-georgia-medicaid/medicaid-state-plan.

Key Medicaid Benefits for Children

State Medicaid programs must ensure that enrolled children are meeting their developmental milestones and, if not, that they receive treatment to correct or ameliorate the condition. This cornerstone Medicaid program benefit is called Early and Periodic Screening, Diagnostic and Treatment (EPSDT). EPSDT is federally designed to provide comprehensive and preventive health services for Medicaid members under age 21 to assure that those enrolled receive early detection and care. These services are based on the individual needs of the member, determined by their doctor or other healthcare professional, and are not limited by pre-determined limits or caps.

FIGURE 3-2.
EPSDT SERVICES

Georgia Health Check Program	Preventive health services, developmental screenings, behavioral assessments, oral, hearing and vision screenings, and immunizations.
Children's Intervention Services (CIS)	Audiology, nursing, nutrition provided by licensed dietitians, occupational therapy, physical therapy, counseling provided by licensed clinical social workers, and speech-language pathology.
Children's Intervention School Services (CISS)	The same services as in CIS but provided by an approved school system known as a Local Education Agency (LEA) for Medicaid-eligible students with an Individualized Education Program (IEP). • As of June 2022, CISS allows for LEAs to be reimbursed by Medicaid for nursing services provided to Medicaid-eligible students who do not have an IEP. This brings additional Medicaid revenue and broadened school-based health resources to school.

Under EPSDT, a child whose needs extend beyond the scope of what is covered by Medicaid may be authorized to receive additional or alternative services through certain review and approval processes. For example, a child diagnosed with autism spectrum disorder may be approved for treatment in an out-of-state facility if determined that the best therapeutic setting for that child is not available in Georgia.

Key Medicaid Benefits for Seniors and Individuals with Disabilities

Long term services and supports (LTSS) are Medicaid programs and services for individuals needing nursing care or help with daily activities on an ongoing basis due to functional limitations or other conditions. LTSS includes institutional long-term care services (e.g., nursing facility care) and home and community-based services (HCBS) which are available through HCBS waivers.

Between February 2023 and January 2024, nursing facility services were provided to 32,040 Medicaid members at an annual cost of $49,112 per member. During the same period, 58,035 members received HCBS for an average annual cost of $38,455.[3.1]

There is growing interest in expanding HCBS due to the better quality of life it offers members and its cost-effectiveness. The annual cost to the state of supporting a member in HCBS is half the cost, or less, of a nursing facility (based on comparison of expenditures between skilled care in a nursing facility and the EDWP).

Individuals with intellectual and developmental disabilities who opt for the Comprehensive Supports Waiver (COMP) and New Options Waiver (NOW) programs would be entitled to live in an Intermediate Care Facility for individuals with intellectual disabilities (ICF-IID). This would cost $162,978 per year in the ICF-IID versus $81,617 per year in the COMP waiver, or less than $15,063 in the NOW. Members receiving services through NOW typically live at home with their families, while members live in community living arrangements (i.e., group homes) in COMP.

Because these are optional services and are provided under a waiver, the number of people enrolled can be limited to a preset number of "slots," and there is often a commensurate budget allocation based on current utilization. If funding does not grow at the pace of utilization, it can result in waiting lists.

FIGURE 3-3.

OVERVIEW OF WAIVER PROGRAMS, INCLUDING NUMBER ENROLLED AND ON WAITING LIST (2024)

Waiver Program	Population Served	# Enrolled (as of Jan 2024)	Waiting List
COMP	Individuals with intellectual or developmental disability (IDD)	9,281	7,923 (as of 10/2024)
NOW		4,704	
ICWP	Adults with physical disabilities and traumatic brain injury	2,350	238 (as of 11/2024)
EDWP	Adults who are elderly and frail or disabled	41,700	0 (as of 11/2024)

Source: DCH Medicaid Analytic Dashboard. (June 2024). Waiting List – DCH Open Records Request, November 13, 2024.

3.1 DCH Medicaid Analytic Dashboard. (June 2024).

Medicaid Benefits Utilization

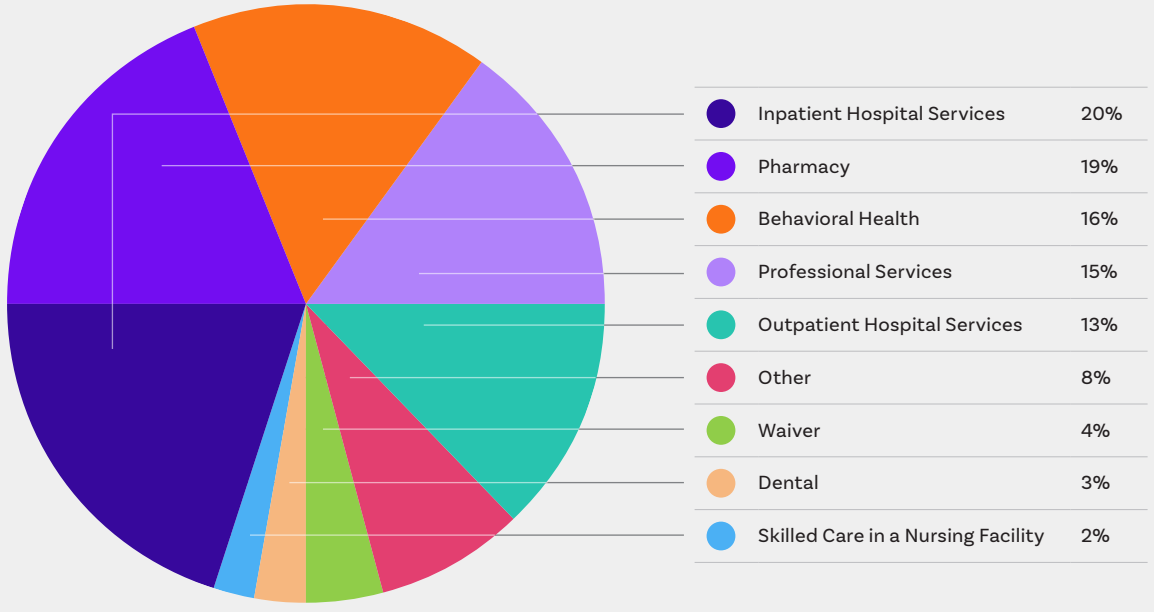
Based on expenditures data, the four largest benefit categories are:

1. **Inpatient hospital**
2. **Pharmacy**
3. **Behavioral health**
4. **Outpatient hospital**

These benefit categories represent 68% of total expenditures. Professional services (e.g., physician, dialysis, orthotics and prosthetics, vision care, and psychological services) account for another 15%.

The most utilized services by members are **professional services**, **pharmacy**, **outpatient hospital**, and **dental** services.

FIGURE 3-4.
EXPENDITURES BY CATEGORY OF MEDICAID SERVICE (FEB 2023 - JAN 2024)



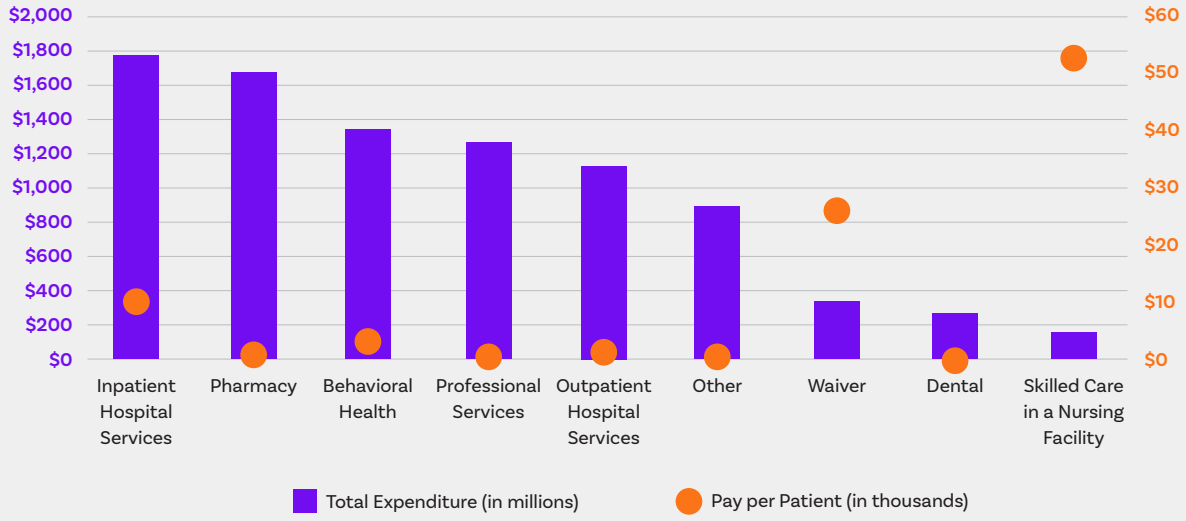
Source: DCH Medicaid Analytic Dashboard. (June 2024).

Service Utilization Rates and Costs

From February 2023 to January 2024, the average annual cost per Medicaid member was $4,242. Nursing facility services had the highest cost, twice as much as HCBS, and almost five times the cost of an inpatient hospital stay. Dental services represent the lowest cost per member. Five programs – inpatient and outpatient hospital, pharmacy, behavioral health, and professional services (e.g. physical therapy) – each account for over $1 billion in spending. Some services, like pharmacy, had high spending but low per-person costs due to heavy utilization, while nursing facility and waiver services had higher per-person costs but lower utilization.

FIGURE 3-5.

SERVICE UTILIZATION RATES AND COSTS FOR (NON-MEDICARE) MEDICAID MEMBERS (FEB 2023 – JAN 2024)



Source: DCH Medicaid Analytic Dashboard. (June 2024.) | NOTE: Excludes members with Medicare coverage.

On average, Medicaid paid for 11,000 office visits for every 1,000 ABD members, and almost 4,000 office visits for every 1,000 PCK members and LIM members.

The 2022 national average of hospital admissions per 1,000 population was 95 compared to Georgia's 88.[3.2]

The 2022 national average of emergency room visits per 1,000 population was 411 compared to Georgia's 374.[3.3]

3.2 KFF. (n.d.) Hospital Admissions per 1,000 Population by Ownership Type. https://www.kff.org/other/state-indicator/admissions-by-ownership/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

3.3 KFF. (n.d.) Hospital Emergency Room Visits per 1,000 Population by Ownership Type. https://www.kff.org/other/state-indicator/emergency-room-visits-by-ownership/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

Access to Georgia Medicaid Providers

Georgia Medicaid enrolls most licensed health care provider types, including physicians, therapists, and Board Certified Behavior Analysts, who will become licensed in 2025. In 2023, a total of 76,346 traditional medical providers (physicians, therapists, diagnosticians, etc., but not including facility-type providers) were enrolled in CMO provider networks and 72,547 in the Medicaid FFS system.

Medicaid also enrolls facilities like hospitals, nursing homes, and community mental health, but not assisted living centers. Some facilities, such as personal care homes and community living arrangements, are not enrolled providers but an approved setting in which to deliver Medicaid-reimbursed services.

Most Medicaid providers must be credentialed by the state. Credentialing is a required process for all providers who also enroll to provide services to members in CMO networks. The credentialing process validates that the provider or facility is qualified to enroll according to established policy and to confirm that the provider, provider organization, and its owners pass criminal background and other checks.

CMOs are subject to standards regarding their provider network to ensure there is adequate access by members to providers in their geographic area. Standards address members' proximity to specific provider types based on urban and rural areas.

FIGURE 3-6.

GEOGRAPHIC ACCESS STANDARDS BY PROVIDER TYPE

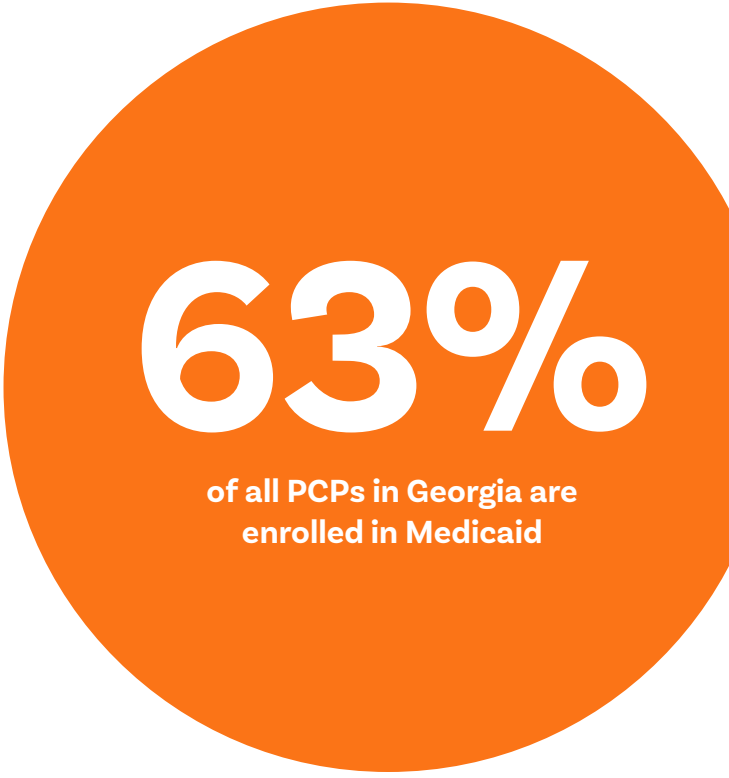
Provider Type	Urban	Rural
Primary Care Providers (PCPs) and Pediatricians	Two within 8 miles	Two within 15 miles
Obstetric Providers	Two within 30 minutes or 30 miles	Two within 45 minutes or 45 miles
Physician Specialists and Dental, Vision, and Therapy Providers	One within 30 minutes or 30 miles	One within 45 minutes or 45 miles
Hospitals and Mental Health Providers	One within 30 minutes or 30 miles	One within 45 minutes or 45 miles
Pharmacies	One 24/7 location within 15 minutes or 15 miles	One 24/7 location (or has an afterhours emergency phone number and pharmacist on call) within 30 minutes or 30 miles

Source: DCH. (n.d.) Network Adequacy. https://dch.georgia.gov/medicaid-managed-care/network-adequacy.

Access to Georgia Medicaid Providers *(continued)*

CMOs quarterly submit Network Adequacy Reports to DCH to demonstrate that at least 90% of their members in each county have access to a provider according to geographic access standards. CMOs are subject to corrective action if access falls below 90%, unless the scoring is the result of circumstances outside their control. The majority of geo-access standards are met by the CMOs on a regular basis but scoring below 90% regularly occurs for certain providers. For example, access standards for 24-Hour Pharmacies may be unachievable because there aren't many open 24/7. It might be equally as challenging for access to Hematology/Oncology physicians in rural areas because there just aren't that many available.

Of all PCPs in Georgia, about 5,300 or 63% are enrolled in Medicaid. All of the state's acute care hospitals are enrolled in Medicaid.



4

Medicaid Operations and Infrastructure

Managed Care Organizational Infrastructure

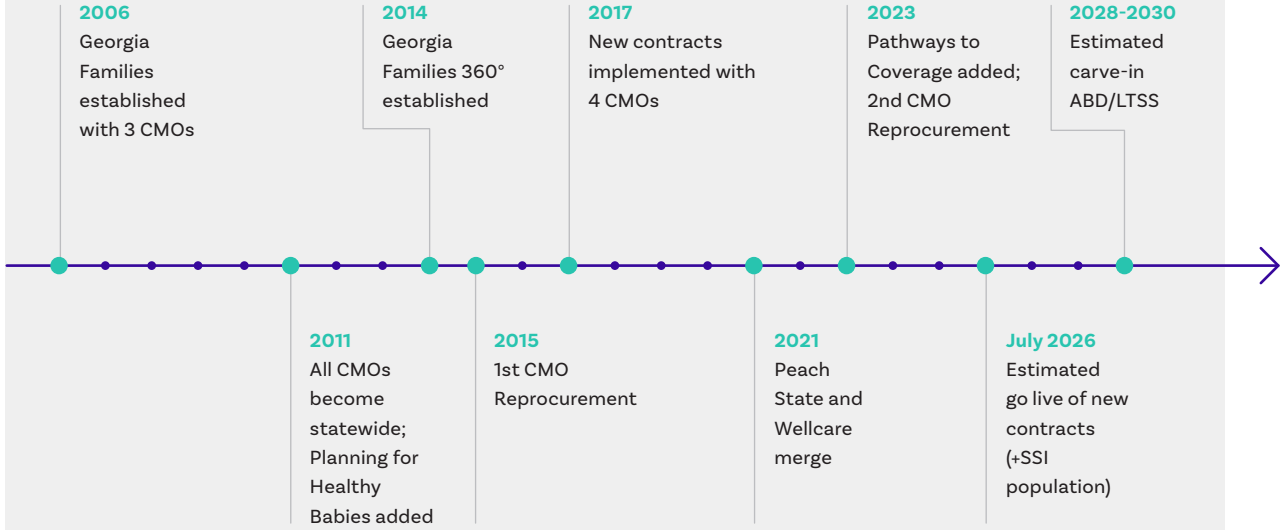
The Georgia Department of Community Health (DCH) oversees contracts with Care Management Organizations (CMOs) to arrange for delivery of benefits and health care services to Medicaid and PeachCare for Kids® (PCK) members under the Georgia Families® program. CMOs are charged with:

- Expanding access to healthcare services and providers
- Enhancing care quality through utilization management and care coordination
- Ensuring timely and effective healthcare delivery
- Educating members on accessing care, specialist referrals, member benefits, and wellness programs

Launched in 2006 for only select member populations, Georgia's managed care program has evolved to also include PCK, Planning for Healthy Babies, children involved in the child welfare and juvenile justice systems, and Georgia Pathways to Coverage participants.

FIGURE 4-1.

TIMELINE OF THE EVOLUTION OF MEDICAID MANAGED CARE IN GEORGIA



NOTE: Peach State and Wellcare are the names of two of the state's contracted CMOs. "SSI" refers to Supplemental Security Income; "ABD" refers to Aged, Blind, and Disabled Medicaid; "LTSS" refers to Long-Term Services and Supports.

Managed Care Organizational Infrastructure *(continued)*

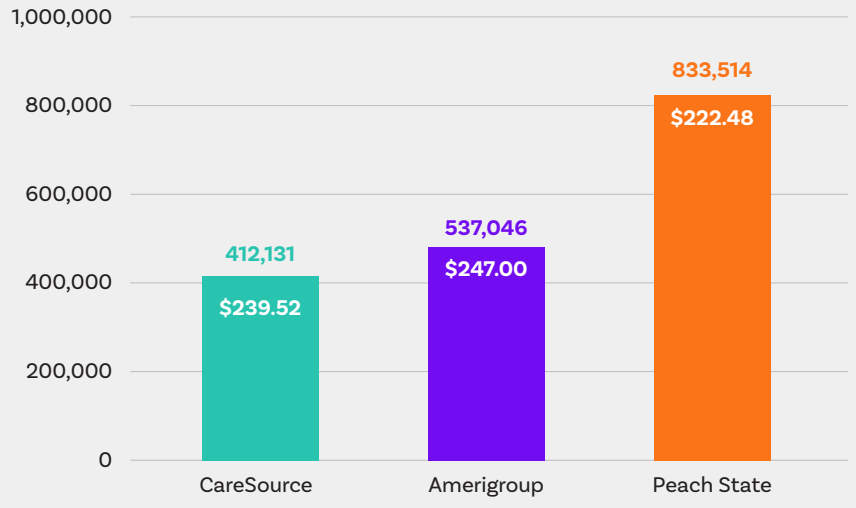
Certain groups remain excluded from Georgia Families, such as Medicare recipients, members of federally recognized Indian tribes, hospice and nursing home residents, and participants in specific Medicaid waiver programs like Katie Beckett. The program requires mandatory enrollment for specific categories of Medicaid and PCK members, including:

- Low-Income Medicaid (LIM) recipients
- Pregnant women and children under Right from the Start Medicaid (RSM)
- Newborns of Medicaid-covered women
- Women with breast or cervical cancer under age 65
- Refugees

Currently, three CMOs[4.1] cover approximately 1.7 million (75%) of Georgia's Medicaid members through the managed care program. Payments for populations enrolled in managed care account for 40% of total Medicaid expenditures.[4.2]

FIGURE 4-2.

AVERAGE MEMBER ENROLLMENT AND CAPITATED RATES FOR CMOS (Q1 OF 2024)



Source: DCH Medicaid Analytic Dashboard. (June 2024).

4.1 See more information about the status of Georgia's CMOs later in this section, under Next Steps for Georgia's Managed Care Program.

4.2 DCH OAPI KPI Analytics Dashboard. (June 2024). Medicaid Enrollment.

CMO Operational Features

Figure 4-3 presents selected operational features that illustrate how managed care functions in Georgia. This list is not exhaustive but is intended to highlight key operational features of managed care that distinguish it from FFS. Major responsibilities assigned to CMOs are more fully delineated in the CMO contracts that DCH oversees.

FIGURE 4-3.
SELECTED CARE MANAGEMENT OPERATIONAL FEATURES

Feature	Description
Assignment	Upon enrollment, members may select a CMO. If no selection is made, members are assigned to a plan through a passive enrollment process. Members can choose a new plan during their annual enrollment period and can also change or opt-out for substantiated cause at any time.
Policies	CMOs must follow policies established by the state, including programmatic requirements about benefit coverage. CMOs can also choose to establish their own additional policies. For example, different prior authorization protocols across CMOs may require health care providers to submit different information for the same service, depending on the CMO to which it's being submitted.
Population Management	Population management refers to the strategies and processes used by CMOs to coordinate and oversee services for members and includes care coordination, health monitoring, and member engagement, among other approaches.
Disease Management	Disease management programs are designed to improve the health of individuals and reduce associated costs from preventable health complications by identifying and treating chronic conditions more quickly and more effectively, thus slowing the progression of those diseases.
Risk Assessment	CMOs conduct extensive data analytics and use risk modeling to assign members to certain risk categories to align population health and disease management supports with the level of need for members' health conditions.
Capitated Payments	CMOs receive a fixed amount of funding through capitation payments, which are intended to cover all members' needed clinical services and administration costs. Capitated payments incentivize CMOs to provide care in a cost-efficient way. To maximize profits or stay within capitation budgets, CMOs may engage in cost-cutting measures which can result in diminished care quality.
Medical Loss Ratio (MLR)	MLR is the proportion of total capitation payments spent on clinical services and quality improvement. The minimum MLR for Medicaid managed care per federal rules is 85%.[4.3] The remaining 15% is used to cover all administrative and operational expenses and profit. Under the new Georgia contracts, CMOs will be held to an 86% MLR threshold. If the CMO cannot demonstrate a MLR of greater than 86%, they must return 100% of the monetary difference between the actual MLR and 86%.
Internal Auditing and Quality Improvement	CMOs routinely conduct their own internal audits and review data on a weekly/monthly basis to evaluate performance and to look for opportunities and areas to target for improvement. CMOs also must produce and submit reports to DCH on a monthly, quarterly, and annual basis to demonstrate compliance with both performance and contract requirements. Examples of data and information that CMOs may review periodically include claims, cost, and quality data; member and provider program effectiveness; complaints and appeals data; provider and member satisfaction surveys and advisory councils; and services requiring prior authorization.

4.3 Effective July 1, 2022, the Medicaid and CHIP Managed Care Final Rule (CMS-2408-F), requires Medicaid managed care organizations to spend at least 85% of the premiums they collect on direct medical care for their beneficiaries, rather than on administrative costs or profits.

MLR

For 2024, the projected MLR rates for Georgia's CMOs based on rate certification appear compliant with the 85% threshold.

FIGURE 4-4.
PROJECTED MLR RATES FOR GEORGIA'S CMOs (2024)

Program	MLR	MLR with Quality Improvement
Georgia Families 360°	85.24%	90.28%
Georgia Families	88.4%	89.9%
PCK	87.2%	88.9%

Sources: Georgia Families 360 Program Medicaid Capitation Rate Certification Analysis. (2023, July 1 – 2024, June 30). Georgia Families and Planning for Healthy Babies Programs Medicaid Capitation Rate Certification Analysis (2023, July 1 – 2024, June 30). HMA Information Services, Georgia Market Overview based on S&P Global Market Intelligence, NAIC.

While the 2024 rates may still reflect heightened utilization from the pandemic, previous MLRs do not suggest as strongly that a significant portion of capitation payments have historically gone directly toward member care. For 2022, plan MLR rates were:[4.4]

79.6% Amerigroup

82.8% CareSource

75.3% Peach State

4.4 HMA Information Services, Georgia Market Overview based on S&P Global Market Intelligence, NAIC.

Managed Care Accountability

DCH uses a combination of monitoring and oversight activities to hold CMOs accountable for performance and improvement activities. Activities include regular meetings, contractually required CMO operational and quality performance reporting, corrective action plans, and independent audits of CMO performance and compliance with contract terms.

DCH Monitoring

CMO contracts define performance requirements and outline processes for requiring corrective action plans and assessing liquidated damages for failing to meet requirements. It is unclear how regularly DCH has used these methods to manage CMO performance as that is not made public. The state has historically had a small team dedicated to supporting and monitoring CMO operations. Recognizing this team is under resourced, DCH's FY2025 budget includes a $1.5 million increase to add 20 staff positions to monitor, evaluate, and improve oversight of the CMOs with an emphasis on both data analytics staff and technology services needed to improve CMO oversight activities.[4.5]

Audits

Annual and biannual operational and quality performance audits are performed by independent auditors to evaluate CMOs' contract compliance. Audits focus on timeliness of service, access to care, network adequacy, turn around and response times, and quality of care and outcomes provided by CMOs. Audit reports are publicly available.

Improving Care through Value Based Programs

With the exception of Georgia Families 360° (the state's specialty plan for children in foster care and other child welfare involved youth), and even though not a formal, contractually required program, all Georgia CMOs offer Value Based Programs (VBP), Quality Incentive Programs, Pay for Performance Programs (P4P) and Negotiated Risk and Shared Savings programs in various forms to their providers. These programs provide additional payments and incentives for focusing on preventive and chronic care services that align with DCH quality goals and CMO contractual objectives. Examples of VBP payments for improvement in targeted health outcomes and measures include additional payment for providing certain services tied maternal health and chronic care management.

4.5 Governor's Office of Planning and Budget. (2024). AFY 2024 and FY 2025 Governor's Budget Report. https://opb.georgia.gov/budget-information/budget-documents/governors-budget-reports.

CMO Quality Overview

CMOs are rated annually on quality performance and on member experience by the National Committee for Quality Assurance (NCQA) according to scoring from the Healthcare Effectiveness Data and Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS). Based on a five-star scale where 1 is poor and 5 is excellent, all three of Georgia's health plans were rated at or below 3 stars.[4.6]

Common indicators of health status are tracked according to the HEDIS, a national tool used by CMS for standardized reporting across states and health plans. A subset of key measures of Georgia's clinical quality performance indicates strong healthcare management of adults with diabetes and ensuring pregnant women get at least one prenatal doctor's visit in their first trimester. Children's measures are not as strong, often demonstrating that fewer than 50% of the members considered in the measure received the desired intervention. National Medicaid averages should be considered in evaluating these outcomes. For example, in comparison to national averages, Georgia's results for the percentage of children who received 6 well-child visits in their first 15 months is ranked in the 50th-74th percentile according to NCQA scales.[4.7]

An external review of quality outcomes is conducted annually on CMO performance relative to established quality measures which predominantly align with HEDIS as required by CMS for state tracking and reporting. For measurement year 2022 as reported in the 2023 External Quality Review report (issued March 2024), of 24 quality strategy performance metrics compared to target rates, 7 were met, 3 were within range, and 14 were not met. Compared to national Medicaid health management organization performance according to the NCQA Quality Compass for HEDIS measurement year 2021, the table on the next page conveys example strengths and weaknesses found in quality outcomes based on the aggregate Georgia Families average and for Georgia Families 360° and PCK.

4.6 The 2024 Health Plan Ratings are based on data from calendar year 2023. One CMO rated 2.5 stars.

4.7 A higher percentile indicates better performance.

CMO Quality Overview *(continued)*

FIGURE 4-5.

SUMMARY OF CMO STRENGTHS AND WEAKNESSES FOR MEASUREMENT YEAR 2022

	Quality	Access	Timeliness
Strengths	● Asthma Medication ratio for Adults-51-64 ● **Diabetes Short-Term Complications Admission Rate**	● **Developmental Screening in the First Three Years of Life** ● Well-Child Visits in the First 15 Months of Life ● Immunizations for Adolescents-Combination 1 ● Child & Adolescents Well-Care Visits ● Cervical Cancer Screening ● Chlamydia Screening—16–20 Years	● Ambulatory Care—ED Visits ● **All-Cause Readmissions**
Weaknesses	● Controlling High Blood Pressure ● Hemoglobin A1c Control for Patients With Diabetes	● Breast Cancer Screening ● Cervical Cancer Screening ● Chlamydia Screening	● Prenatal and Postpartum Care

Comparison to Measurement Year 2021

● Improved in Measurement Year 2022 as compared to Measurement Year 2021

● Declined in Measurement Year 2022 as compared to Measurement Year 2021

● No significant difference across Measurement Years 2021 and 2022

NOTE: Bolded text indicates measures where Georgia met or exceeded the national 50th percentile of all state results from the Medicaid Child and Adult Core Set of measures.

CMO Quality Overview - Member Satisfaction

Georgia's CMOs use the CAHPS Member Experience of Care to collect information from members about their experience with healthcare services, focusing on key areas that reflect the quality and effectiveness of care. The CAHPS survey is designed to capture feedback on several dimensions of the healthcare experience, including access to care, communication with providers, and overall patient satisfaction.

- The highest scoring measure was How Well Doctors Communicate, rated at 90.83% by adults and 93.17% for children.
- The overall experience rating for All Health Care was 75.40% for adults and 84.01% (down from 2022) for children.
- Of Composite Measures, Customer Service was 88.94% (up from 2022) for adults and 86.45% (down from 2022) for children.

CAHPS results indicate that Georgians' experience is mixed across several measures:

FIGURE 4-6.
CAHPS MEMBER EXPERIENCE MEASURES (2023)

CAHPS results indicate that Georgians' experience is ***below the national average*** in several measures:		
Georgia Families and PCK Measure	**Adult**	**Children**
Getting Needed Care	76.39%	81.22%
Medical Assistance With Smoking and Tobacco Use Cessation Items: Discussing Cessation Medications Discussing Cessation Strategies	 31.79% 28.82%	
Rating of Health Plan	74.25%	
Rating of All Health Care		84.01%
Rating of Specialist Seen Most Often		78.86%
CAHPS results indicate that Georgians' experience is ***significantly higher than the national average*** in several measures:		
Georgia Families 360° Measure		**Children**
Getting Care Quickly		92.51%
How Well Doctors Communicate		98.37%
Rating of Personal Doctor		93.46%

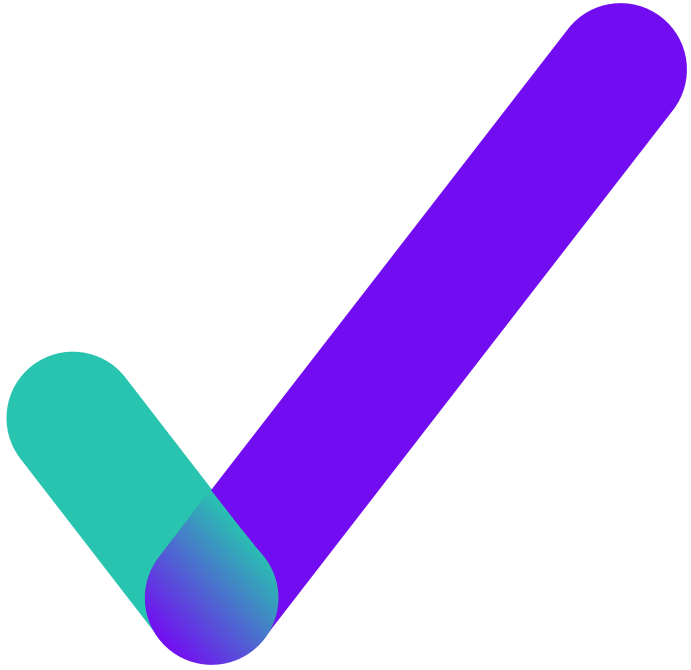
Source: DCH. (March 2024). 2023 External Quality Review Report.

NOTE: Scores absent from the table above reflect those that did not fall below the national average for their respective Measure.

Quality Improvement

Each CMO is contractually required to identify and engage in Performance Improvement Projects (PIPs) to achieve significant improvement in targeted areas. Per the most recent External Quality Review (2023), all three Georgia Families CMOs had overarching PIP topics in common: Timely prenatal care and high risk or complex case management enrollment.

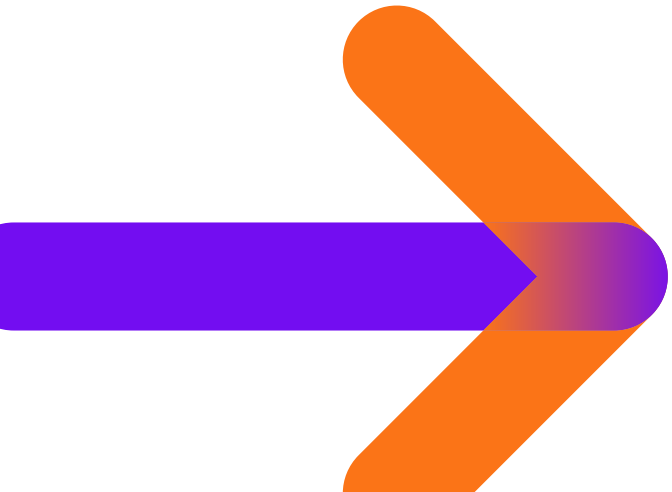
Georgia has not widely used VBP programs to incentivize quality performance and target measures where improvement is needed as many states have. Since inception in 2014, the state implemented a VBP program for Georgia Families 360° to encourage high standards of performance around targeted measures. Originally focused on timely access to clinical assessments, the VBP measures have more recently followed select HEDIS measures reflecting the high incidence of children with behavioral health needs. As of the last audited performance outcomes for calendar year 2021, 2 of 4 established VBP measures were achieved. To fund the VBP, the state withheld 5% of the CMO's capitation payment which was eligible to be earned back based on quality performance. With successful achievement of 50% of the measures, the health plan earned approximately $4.17 Million of the withhold. The VBP program was terminated at the end of 2024, the mechanics for which were adjusted to comply with managed care rules. The state's focus going forward is on plans for implementing value-based arrangements under the new CMO contracts.[4.8]



4.8 Insights and information were shared during interviews conducted with DCH staff to inform the development of this resource.

Next Steps for Georgia's Managed Care Program

In September 2023, DCH released a Request for Proposals (RFP) to select new vendors to serve members in Georgia Families® and Georgia Families 360° (foster care and child welfare involved youth). Goals for CMO re-procurement were to identify proposals that represent the best value to the Medicaid program and CMOs with demonstrated expertise and experience improving quality of care and population health outcomes, especially related to maternal mortality and morbidity, behavioral health, and chronic disease management. Other key priorities focus on health equity, access improvement, and meaningful interventions to address health related social needs, closed-loop referrals, value-added services, and In Lieu Of Services.



The RFP reflected the state's intent to expand managed care to include ABD eligible populations for the first time through a phased-in approach, first adding certain SSI recipients (those not dually eligible for Medicare or receiving Home and Community-Based Services) to managed care at the implementation of the new contracts. In contract Year 3, additional ABD populations are projected to be added.

In December 2024 the state posted notice of intent to award four managed care contracts based on DCH's evaluation and selection process to incumbent CareSource and three new entrants: Humana, Molina, and UnitedHealthcare. The new CMO contracts are scheduled to be operational by July 1, 2026, following contract negotiations, implementation planning, and readiness review. Members enrolled in the three incumbent CMOs (CareSource, Amerigroup, and Peach State Health Plan) will transition to the new plans through an assignment process wherein members can select or be assigned to a plan if no selection is made.

Next Steps for Georgia's Managed Care Program *(continued)*

FIGURE 4-7.

ANTICIPATED CHANGES IN NEW CMO PROGRAM

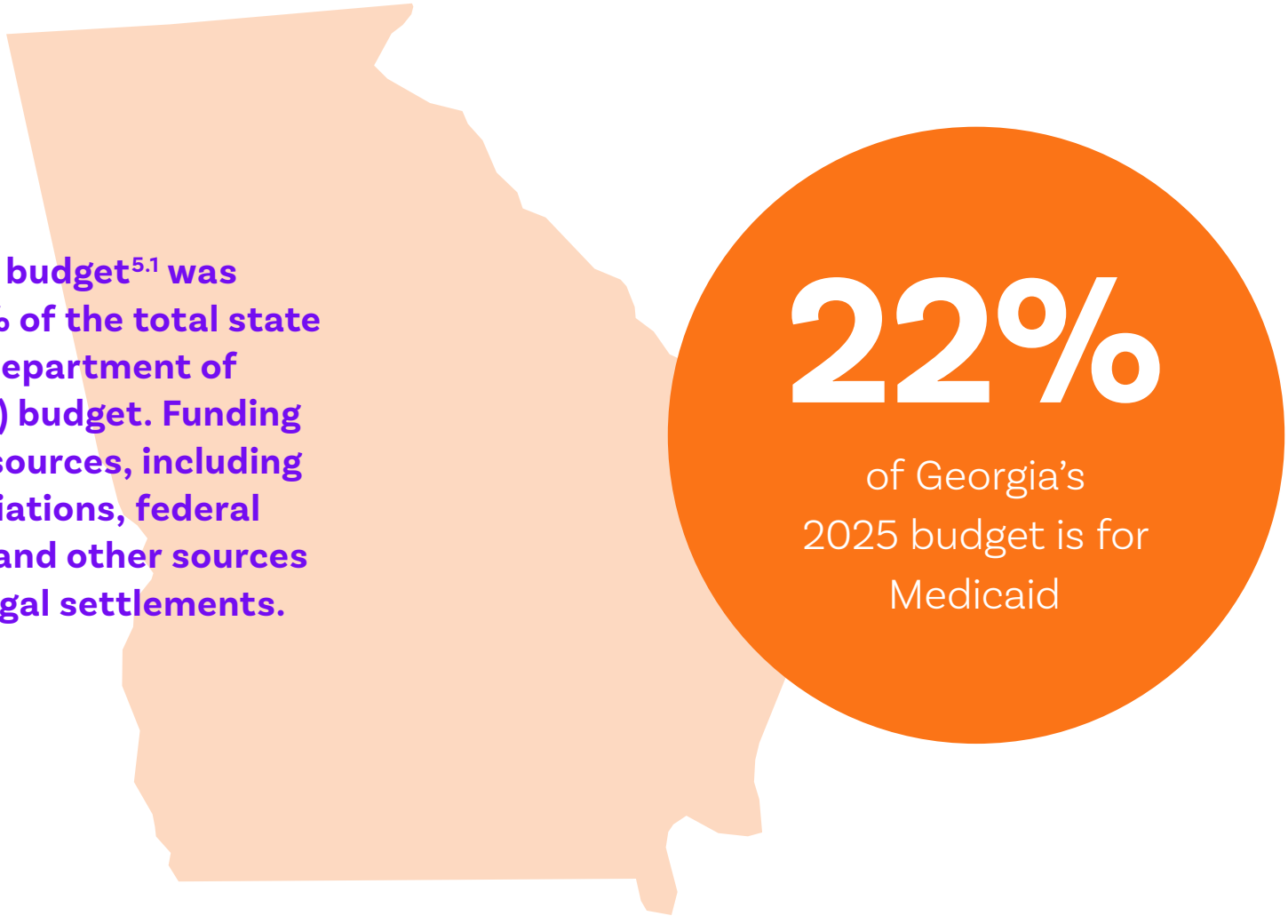
Georgia Medicaid State-wide Preferred Drug List (SPDL)	• A single list of prescription and non-prescription drugs which will be covered by all Georgia CMOs.
Certified Community Behavioral Health Clinics (CCBHCs)	• Designated clinics that provide 24-hour crisis care, evidence-based practices, care coordination with local primary care and hospital partners, and integration with physical health care.
Closed-Loop Referral Management	• Members will complete a Social Determinants of Health (SDOH) screening, and if a need is identified, a community-based organization will respond to that need. Confirmation that the needed services were provided will be relayed back to the CMO, providers, and DCH.
Behavioral Health Homes (BHHs)	• Increase in CMO contracts with behavioral health providers to serve integrated primary care, behavioral health services, and social services and supports for adults and children diagnosed with mental illness in BHHs.
Focus on Health Equity and Inclusion	• Requirements for CMOs to achieve NCQA Health Equity Plus Accreditation. • New CMO staffing requirements to hire dedicated staff responsible for leading efforts to reduce disparities among diverse members and creating strategies to address social factors (e.g., addressing SDOH). • Enhanced Value-Added Services and In Lieu of Services.
CMO Community Reinvestment Plans	• Requirements to identify population health strategies aligned with the DCH Quality Strategic Plan, and to include investments to address nonmedical risk factors (e.g., housing, food, etc.) for members in a data-driven manner. • Reinvestment contributions are voluntary, except in the case of a required reinvestment as a result of deficiencies in meeting VBP Performance Targets.
Monitoring	• Enhanced access to advanced analytics to monitor CMOs and providers.

5

Medicaid Expenditures & Financing

Overview of the Medicaid Budget in Georgia

Georgia's 2025 Medicaid budget[5.1] was $14.63 Billion, about 22% of the total state budget and 94% of the Department of Community Health (DCH) budget. Funding comes from several key sources, including state legislative appropriations, federal funding, provider taxes, and other sources such as from grants or legal settlements.

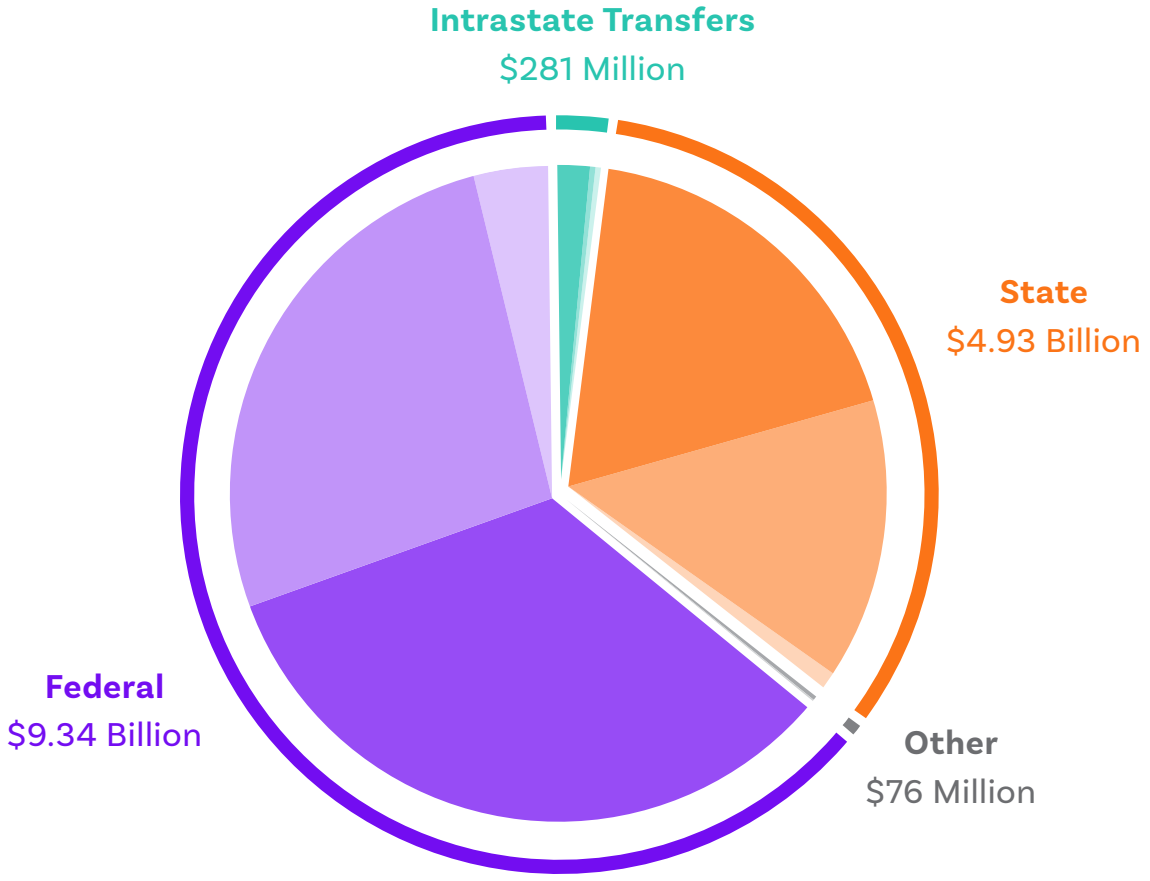


5.1 Georgia General Assembly. (2024). HB 916 General appropriations; State Fiscal Year July 1, 2024 - July 30, 2025.

Overview of the Medicaid Budget in Georgia *(continued)*

FIGURE 5-1.

TOTAL SPENDING ON MEDICAID IN GEORGIA (BY SOURCES OF FUNDING) FOR STATE FISCAL YEAR (SFY) 2025



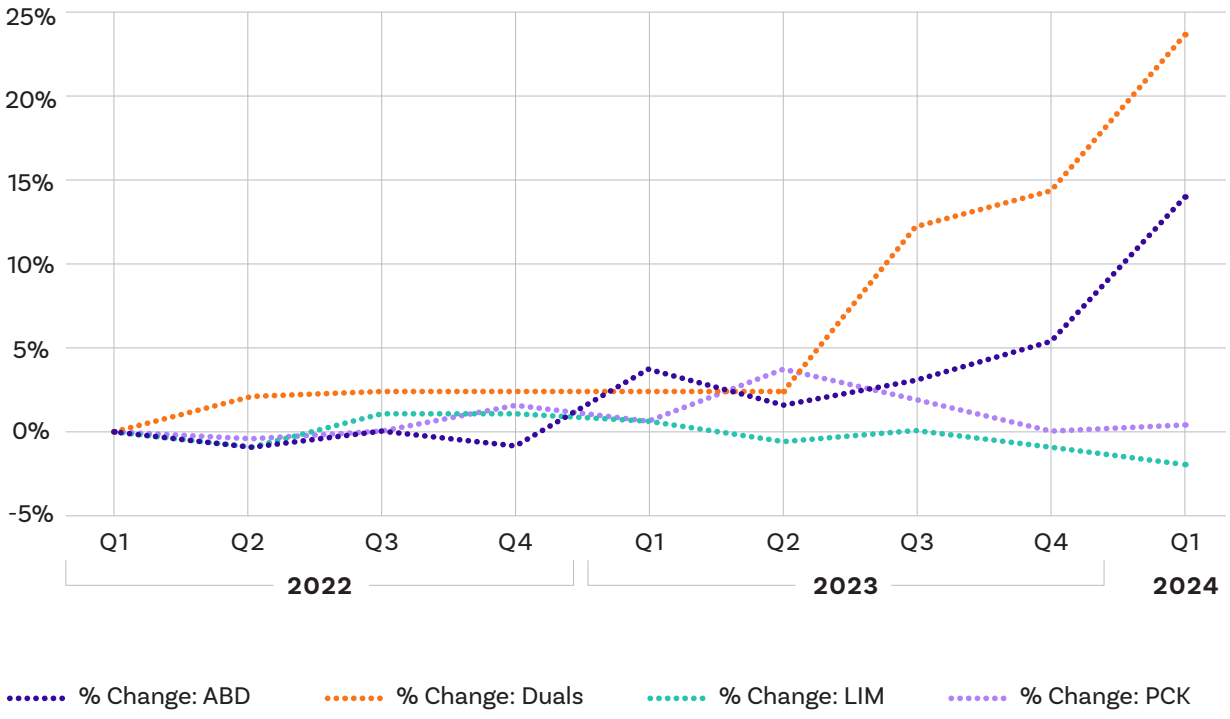
Federal ABD	$4.9 Billion
Federal LIM	$3.9 Billion
Federal PCK	$511.9 Million
State ABD	$2.8 Billion
State LIM	$2.1 Billion
State PCK	$124.1 Million
Intrastate Transfers ABD	$267.3 Million
Intrastate Transfers LIM	$13.4 Million
Intrastate Transfers PCK	$151,783
Other ABD	$63.3 Million
Other LIM	$12.3 Million
Total	**$14,627,615,990**

Recent Medicaid Cost Trends

The Medicaid budget is impacted by a rising trend in costs for the ABD and dual eligible populations due to increased utilization and reimbursement rates for some of their service providers. This is minimally offset by the decrease in the number of Low Income Medicaid (LIM) enrollees during the Medicaid unwinding and a small recent decrease in the average cost for LIM members. Monthly costs for LIM and PeachCare for Kids® (PCK) members have historically been and continue to be fairly static. These population and cost trends are consistent with other states. Post-Public Health Emergency unwinding, state Medicaid populations are generally comprised of older and sicker individuals as compared to pre-pandemic, leading to higher costs.

FIGURE 5-2.

CHANGES IN AVERAGE PER MEMBER PER MONTH (PMPM) EXPENDITURES ACROSS ELIGIBILITY POPULATIONS



Source: DCH Medicaid Analytic Dashboard. (June 2024).

Federal and State Medicaid Funding

The most significant portion of Medicaid funding is provided by the federal government through the Federal Medical Assistance Percentage (FMAP). Georgia's FMAP rate has fluctuated between 66-67% over the last several years and will be 66.04% for 2025. The federal government therefore covers approximately two-thirds of the state's Medicaid costs of providing benefits. The remaining third is predominantly comprised of state general funds plus other revenues, such as provider taxes allocated specifically for Medicaid services by the General Assembly's appropriations act each year. For the SFY2025 budget, the total state portion contributed for Medicaid was $4.93 billion and the total federal match was about $10 billion.

The Children's Health Insurance Program (CHIP) receives an enhanced federal match, therefore all PCK services require significantly less state share — currently less than 24%. The FMAP for the administrative costs of running Medicaid are generally 50%, but in some instances up to 75% and 90%. The total value of Georgia's federal administrative Medicaid match is $359 million for 2025.

TABLE 5.3.
GEORGIA'S FMAP OVER TIME

Year	FMAP %	State Share %	PHE Enhanced %	CHIP Enhanced %
2019	67.62	32.38	—	100.00
2020	67.30	26.50	73.50	93.00
2021	67.03	26.77	73.23	81.26
2022	66.85	26.95	73.05	81.14
2023	66.02	27.78	72.22	80.55
2024	65.89	34.11	—	76.12
2025	66.04	33.96	—	76.23
2026	66.40	33.60		

Sources: KFF. (n.d.). Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier. https://www.kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier/ and Enhanced Federal Medical Assistance Percentage for CHIP. https://www.kff.org/other/state-indicator/enhanced-federal-matching-rate-chip/. Federal Register. (2024, November 29). Federal Financial Participation in State Assistance Expenditures. https://www.federalregister.gov/documents/2024/11/29/2024-27910/federal-financial-participation-in-state-assistance-expenditures-federal-matching-shares-for.

While FMAP rates fluctuate from year to year, there has been a 1.58 percentage point decrease in the FMAP between 2019 and 2025, meaning a greater percentage of state funds are needed to offset the decrease in federal match.[5.2] For example, in the SFY 2024 budget, due to the adjustment from 65.89% to 66.04%, an increase of $102.3 million in needed state share allocation was reflected in the budget to maintain the same level of benefits.[5.3] During the PHE, the state received an extra 6 percentage points added to each year's FMAP which was subsequently phased out.

5.2 *Id.*

5.3 Office of the Governor. (2023, May 5). HB 19 Fiscal Year 2024 Appropriations Act (Act 351).

State Funding Sources for Medicaid

Georgia assesses certain provider fees or taxes, including on hospitals, nursing facilities, and ambulance providers, which help generate additional revenue for the Medicaid program. The funding through provider fees is also matched at the regular FMAP rate, drawing down another two-thirds federal funding to help cover facilities' costs. Federal regulations limit the amount of provider taxes that can be used as the state share of Medicaid payments to 6% of an industry's net patient revenue.

Georgia also receives funding through grants, legal settlements, or other federal programs. For example, during the pandemic, Georgia received federal COVID-19 relief funds, an enhanced match of 6.2%.[5-4] In prior years, the state was awarded a Balancing Incentive Payment Program grant, which provided enhanced match for state spending on Home and Community-Based Services (HCBS) over the four-year life of the grant. Occasionally, Georgia Medicaid benefits from legal settlement dollars. For example, Georgia has received approximately $3.4 billion from the national tobacco settlement since 1998, which requires four major tobacco companies to make annual payments to states.

FIGURE 5-4.
SOURCES OF STATE FUNDS ACROSS MEDICAID PROGRAMS (WITHIN SFY 2025 BUDGET)

Medicaid State Funds Source	ABD	LIM	PCK	TOTAL	% OF TOTAL
Ambulance Provider Fees	$9,381,009	$0		$9,381,009	0.2%
Hospital Provider Payment	$41,840,441	$369,150,111		$410,990,552	8.3%
Nursing Home Provider Fees	$152,886,715	$0		$152,886,715	3.1%
State General Funds	$2,545,370,237	$1,567,462,534	$124,111,399	$4,236,944,170	85.9%
Tobacco Settlement Funds	$6,191,806	$117,870,545		$124,062,351	2.5%
Total State Funds	$2,755,670,208	$2,054,483,190	$124,111,399	$4,934,264,797	100%

Source: Georgia General Assembly. (2024). HB 916 General appropriations; State Fiscal Year July 1, 2024 - July 30, 2025.

5-4 Enhanced funding for FY 2020-2023 of a 6.2 percentage-point increase made available through the Families First Coronavirus Response Act and subsequent amendments.

Sources of Supplemental Payments to Medicaid

Supplemental payments refer to any Medicaid Fee For Service (FFS) payments that are made outside of the base claim payments. The state makes supplemental payments to support qualifying hospitals, nursing facilities, and ambulance providers that serve a significant number of Medicaid members and uninsured Georgians. Supplemental payments to hospitals help offset costs of providing uncompensated care (Disproportionate Share Hospital payments), cover some of the gap in hospital and physician reimbursement between FFS Medicaid and Medicare rates (Upper Payment Limit payments), and support teaching hospitals with the cost of training residents (Graduate Medical Education program). [5.5]

5.5 DCH. (n.d.). Supplemental Payments. https://dch.georgia.gov/providers/provider-types/hospital-providers/supplemental-payments.

Sources of Supplemental Payments to Medicaid *(continued)*

Disproportionate Share Hospital Program (DSH)

DSH payments are a mechanism states can use to help hospitals cover uncompensated care costs for services provided to Medicaid and uninsured patients. The amount of DSH payments a state can make are limited based on an annual federal allotment. DSH, like other Medicaid programs, requires a state share amount to draw down the federal match. In SFY24, Georgia's federal DSH allotment was $382.2 million, allowing for maximum gross DSH payments of $567.1 million. About $52 million of the state share for Georgia's DSH payments comes from state funds, with the remaining $141 million coming from intrastate governmental transfers (IGTs). The program distributes payments based on each hospital's uncompensated care costs, ensuring that facilities offering essential services to vulnerable communities receive necessary funding. To qualify for DSH payments, hospitals must meet federal criteria which include having a Medicaid inpatient utilization rate of at least 1%.

Intrastate Governmental Transfers (IGT)

IGTs are financial transactions from a state or local government entity to another governmental entity within the state. In Georgia, public hospitals and public hospital-based nursing facilities transfer funds which are then used as "state share" funds to secure additional federal Medicaid funding in compliance with Medicaid rules.

Indigent Care Trust Fund (ICTF)

A separate fund in the State Treasury, ICTF is funded by provider fees and other sources[5.6] and provides a separate accounting for the collection and distribution of DSH payments and other Medicaid payments that use these sources for the state share. Provider groups pay into the ICTF through IGTs (public entities only) and through provider fees. Along with about $53 million in state funds to support the DSH program, these funds are then used as the state share to draw down federal funds for over $2.2 billion in Medicaid payments.

FIGURE 5-5.
2024 TOTAL ICTF VALUE: $2,252,110,655

State Share	Federal Match
State Funds: $52,882,042 Provider Fees: $529,613,536 Agency Funds: $157,738,751	$1,529,597,471

5.6 ICTF is funded by a combination of state appropriations, provider fees and payments, breast cancer automobile tag fees, voluntary intrastate transfers, federal funds, ambulance licensing fees, and Certificate of Need (CON) penalties.

Sources of Supplemental Payments to Medicaid *(continued)*

Upper Payment Limit (UPL)

Federal regulations limit aggregate Medicaid FFS reimbursement based on UPL. For hospitals and nursing facilities, the UPL is defined as a reasonable estimate of what Medicare would pay for the same services. Georgia uses UPL-based supplemental payment programs for multiple provider types. The UPL payments are structured to pay the difference between the Medicaid base FFS payments and the estimated amount that Medicare would have paid for the same services. As with other Medicaid payments, about two-thirds of UPL payments come from federal funding with the remaining one-third coming from the state. For these programs, the state funding is provided by IGTs and provider taxes.

DCH currently makes UPL payments to:

- Hospitals (inpatient and outpatient services)
- Nursing Homes (hospital based)
- Physician (attending and mid-level)
- Ground Ambulance Providers (hospital based)
- Intermediate Care Facilities (state owned)

Directed Payments Programs (DPPs) Through Managed Care

Similar to supplemental payments in FFS, states can use DPPs to make targeted payments to certain providers through managed care. Unlike FFS, which is limited to an UPL based on estimated Medicare levels, DPPs can pay up to an average commercial rate. DPPs also require annual approval from CMS and must advance at least one of the goals and objectives outlined in the state's quality strategy. Georgia has been innovative in the use of new DPPs to increase provider funding of critical services for the Medicaid population and strengthen the healthcare workforce, working collaboratively with providers to identify most needed areas of supplemental enforcement. For SFY 2025, Georgia received approval for multiple DPPs totaling over $2.3 billion in Medicaid payments, with the state share funded through IGTs and provider taxes, with federal matching at the state's regular FMAP.[5.7]

FIGURE 5-6.
LIST OF CERTAIN DPPS IN GEORGIA

Physician DPP	Scheduled to distribute approximately $244 Million to eligible physicians and practitioners who are affiliated with a governmental teaching hospital for SFY2025.
Hospital DPP for Public Hospitals[5.8]	Scheduled to distribute approximately $400 Million.
Hospital DPP for Private Hospitals	Scheduled to distribute over $235 Million in SFY2025 across all private, acute hospitals excluding general cancer hospitals, free-standing children's hospitals, and rehabilitative/ psychiatric/long term acute hospitals.
Georgia Advancing Innovation to Delivery Equity (GA-AIDE)	Scheduled to distribute over $586 Million to improve patient quality of care for Grady Memorial, the largest single provider of Medicaid services, Phoebe Putney, and Colquitt Regional Hospitals.
Strengthening the Reinvestment of a Necessary Workforce in Georgia (GA-STRONG)	Scheduled to distribute over $875 Million to 21 qualified teaching hospitals with at least five full-time equivalent residents to encourage workforce retention and incentivize patient care in geographic medical workforce shortage areas.

5.7 DCH. (n.d.). State Directed Payment Programs. https://dch.georgia.gov/programs/state-directed-payment-programs.

5.8 Public hospitals are defined as all state and non-state government hospitals, excluding Critical Access Hospitals.

Sources of Supplemental Payments to Medicaid *(continued)*

Nursing Facility Supplemental Quality Payments

Georgia Medicaid certified nursing facilities with 50% or more Medicaid long-term residents are eligible to receive supplemental quality incentive payments for quality-of-care improvements. Beginning in SFY 2022, the General Assembly appropriated $12 million in state funds plus an additional $26,232,673 in one-time funding for the SFY 2022 amended budget to provide supplemental quality incentive payments to eligible skilled nursing facilities for a total of $115 million. The base funding for these quality incentives remains $12 million annually. For SFY 2025, with federal match, another $36 million in total funds will be disbursed for SFY 2024 performance measure results.[5.9] Funding is based on nursing facilities' demonstration of improvement in select performance measures including:

- Long-stay residents who received an antianxiety or hypnotic medication
- Long-stay residents who received an antipsychotic medication
- Long-stay residents with a urinary tract infection

Graduate Medical Education (GME)

Hospitals with accredited GME programs receive a GME Supplemental payment including a base funding amount. Certain GME programs are eligible for increased funding, the amounts determined based on state priorities and need. Base funding uses a formula of $44,000 per resident.[5.10] The increased funding "bumps" for 2024 were:

- Family Medicine: $28,500 / FTE resident
- OB/GYN: $28,500 / FTE resident
- General Pediatrics: $28,500 / FTE resident
- Pediatric Specialty Programs: $13,500 / FTE resident[5.11]

In addition to hospitals, Community Service Boards (the state's safety net providers for individuals with behavioral health conditions and intellectual or developmental disabilities) with accredited GME programs are also eligible for GME supplemental payments. GME payments to all eligible providers are made in quarterly installments.

5.9 DCH. (n.d.). Supplemental Quality Incentive Payments. https://dch.georgia.gov/providers/provider-types/nursing-home-providers/supplemental-quality-incentive-payments.

5.10 DCH. (n.d.). Graduate Medical Education (Direct and Indirect). https://dch.georgia.gov/graduate-medical-education-direct-and-indirect.

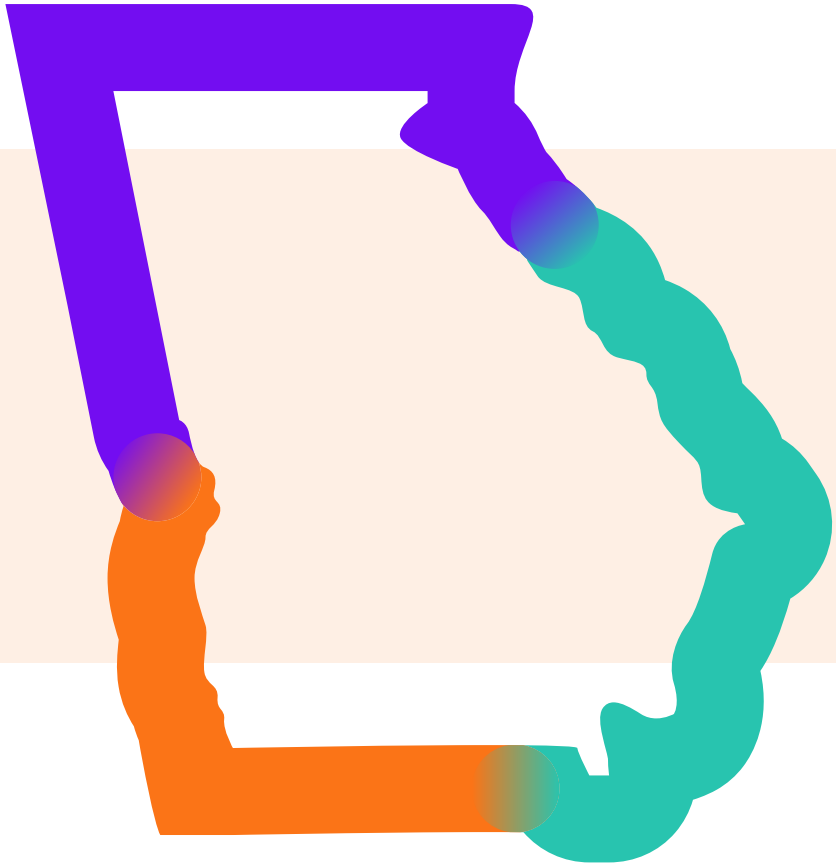
5.11 *Id.*

6

State Priorities & National Trends

State Priorities – Brief Introduction

Informed by reviews of existing materials and stakeholder interviews conducted with leaders in the state, several issues emerged as areas of priority for enhancements to Georgia's Medicaid program. A snapshot of these issues is provided in this resource, organized across different areas of focus.



State Priority - Coverage Enhancements

In the 2024 Georgia legislative session, state lawmakers established the Comprehensive Health Coverage Commission (Commission) to research, assess, and identify options the legislature should consider to improve coverage for uninsured and low-income Georgians and identify opportunities for quality improvement and improved service delivery and coordination. Interim reports and ultimately a final report in December 2026 will lay out options for the General Assembly to consider. While large-scale systems change initiatives are not likely until the 2027 state legislative session, legislation to establish small or foundational initiatives could result from discussion of options presented in interim Commission reports. Planned reviews[6.1] by the Commission that could lead to such legislation and corresponding appropriations include areas included in Figure 6-1 to the right.

FIGURE 6-1.
AREAS OF EXPLORATION FOR THE COMMISSION

- How existing Medicaid services and waiver programs and improvements could be modified to reach additional uninsured and low-income Georgians
- Analyses of certain Medicaid provider funding mechanisms and impact of varied provider reimbursement mechanisms to support Medicaid services
- Whether programs, waivers, and policy options implemented in other states could be beneficial or modified to be a fit for Georgia
- Policy and modeling around Medicaid waivers
- Policy and modeling around certain health outcomes prevalent in Georgia's low-income and uninsured populations
- Potential improvements in coordinating healthcare quality and service delivery among the state's public health agencies

6.1 Comprehensive Health Coverage Commission. December 2024 Report, available at: https://dch.georgia.gov/comprehensive-health-coverage-commission.

State Priority - Quality Improvement Priorities

Georgia Medicaid's Quality Strategy for 2024–2026 is driven by the state's top health priorities for improving Maternal and Child Health, Behavioral Health, and Chronic Diseases. Each of these areas was selected based on their wide-ranging impact on health outcomes and healthcare costs, the disparities evident across demographics, and the significant role that social determinants of health play in each. By prioritizing these areas, Georgia aims to improve both the quality of healthcare services and health equity outcomes statewide, addressing preventable conditions and promoting better health management among at-risk populations.

Maternal and Child Health

Georgia reports some of the highest maternal mortality rates in the nation. Geographic barriers further impact access to maternal healthcare, particularly in rural and underserved areas, where women often face limited provider availability and long travel distances. Additionally, Georgia's rates of low birth weight and preterm births surpass national averages, placing infants at higher risk for chronic health issues. Recognizing that maternal and child health outcomes serve as foundational indicators of a community's overall health, these challenges emphasize the need for Medicaid-supported initiatives that address these critical issues and promote equitable care.

FIGURE 6-2.
MATERNAL HEALTH INDICATORS, 2020-2024

Number of mothers who died within 12 months of delivery	293
Number of neonatal deaths	684
Number of mothers who had their prenatal visits	42,545
Number of mothers who had their first prenatal visit in first trimester	26,226
Number of mothers with at least one chronic condition • Asthma – 6,818 (11.4%) • Behavioral Health – 15,749 (27.1%) • Coronary Artery Disease – 52 (0.1%) • Chronic Obstructive Pulmonary Disease (COPD) – 1,541 (2.2%) • Diabetes – 971 (1.9%) • Hypertension – 4,392 (8.9%)	83,456

Source: Presentation from Opening Session of the Georgia Medicaid Fair as shared by DCH Leadership

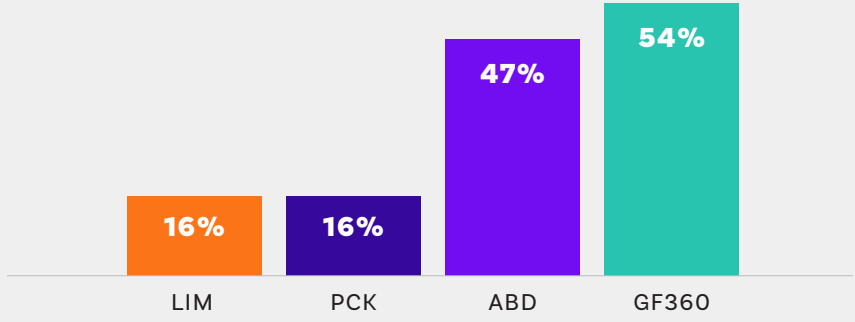
State Priority - Quality Improvement Priorities *(continued)*

Behavioral Health

Behavioral health services are a critical area for state reform, as Georgia faces high rates of unmet mental health needs, workforce shortages, and significant disparities in access to behavioral health services across different populations and regions. Georgia's behavioral health infrastructure has been under strain due to increasing rates of substance use disorders and co-occurring mental health issues, particularly since the COVID-19 pandemic. The need for behavioral health services is prevalent across populations to varying degrees. Nineteen percent (19%) of Medicaid members utilized behavioral health services between February 2023 - January 2024. As a percentage of total Georgia Families 360° children, 54% are receiving behavioral health services, even though up to 80%[6.2] of children in foster care can have significant mental health issues.

FIGURE 6-3.

PERCENT OF MEDICAID MEMBERS UTILIZING BEHAVIORAL HEALTH SERVICES



Source: DCH Medicaid Analytic Dashboard, June 2024

NOTE: LIM refers to Low Income Medicaid, PCK refers to PeachCare for Kids®, ABD refers to Aged, Blind, Disabled Medicaid, and GF360 refers to Georgia Families 360°.

Chronic Diseases

In addition to the behavioral health needs that cut across eligibility groups, the top ten conditions of Medicaid members include diseases like diabetes, hypertension, coronary artery disease, asthma, COPD, and congestive heart failure. Many pregnant women in Medicaid experience at least one and often multiple of these chronic diseases including behavioral health disorders. Through the care management organizations (CMOs), collaborative care models are intended to bring together obstetricians, primary care providers, and specialists to deliver coordinated, patient-centered care to address both acute needs and chronic health conditions as an approach to managing chronic conditions in pregnant women and improving outcomes for mothers and infants.

6.2 National Conference of State Legislatures. (2019, November 1). Mental Health and Foster Care. https://www.ncsl.org/human-services/mental-health-and-foster-care.

State Priority - Systems Operations Enhancements

FIGURE 6-4.
STATE SYSTEMS OPERATION ENHANCEMENTS

Priority	Opportunity
CMO procurement 2023-2026	Implementation of new CMO contracts includes opportunities for raising quality standards, moving to value-based reimbursement for improved outcomes, and improving care coordination for newly added populations into managed care.
Procurement for new Eligibility Determination information system 2025-2028 (estimated)	The procurement of a new Medicaid Integrated Eligibility System is an opportunity to streamline the eligibility determination process, improving the integration of various services, and providing more responsive, user-friendly interfaces for both applicants/members and administrators.
Procurement for new Medicaid Management Information System (MMIS) modules	Procuring Georgia's MMIS Claims Module, offers potential for long-term benefits of improved claims processing, enhanced compliance, and data analytics, making this a key opportunity for the state to optimize its Medicaid program.
State Directed Payment Programs	Maintenance of programs securing over $2.3 billion in new funding for Medicaid services, predominately for hospital uncompensated care.
Rural stabilization grants for Graduate Medical Education 2024-2025	Designed to attract and retain medical professionals in rural areas, these grants can address healthcare workforce shortages, improve access to care, and promote long-term economic and community stability in underserved regions. Awarded hospitals in 2024 received between $250,000 and $1 million each.
Program of All-Inclusive Care for the Elderly (PACE) procurement	A priority of the Governor's office, PACE will help bolster the state's system of long-term services and supports (LTSS) by providing a vehicle to help elderly members stay at home longer with better quality outcomes and help the state use funds more effectively.

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State Priority - Systems Operations Enhancements *(continued)*

Priority	Opportunity
Juvenile Justice community services coverage 2024-2025	Effective January 1, 2025, in compliance with the Consolidated Appropriations Act, 2023 (CAA), for Medicaid and Children's Health Insurance Program (CHIP) youth detained through the juvenile justice system, the state is required to provide diagnostic and case management services for 30 days pre- and post-release. Multiple policy, practice, and system changes are required to ensure youth are screened, referred to, and access services such that they are more likely to remain stable in the community, reducing the risk of further detention.
Implementation of Qualified Residential Treatment Programs (QRTPs)	QRTPs, a new provider type, respond to the state's needs to fill gaps in the continuum of care for children in foster care, enabling them to be served in less restrictive placement settings using a therapeutic approach that will ultimately help families stay together.
Expansion of Certified Community Behavioral Health Clinic (CCBHCs)	Expansion of CCBHCs is aimed at improving access to and the quality of behavioral health services, enhancing service integration, addressing the needs of individuals with complex health challenges, and improving overall health outcomes while reducing costs in the long term.
Policy manual updates and standardization	Georgia Medical Assistance Plans' initiative to update and standardize policy manuals is driven by the need to improve clarity, compliance, efficiency, and transparency, and reduce administrative burdens for both providers and the administration.

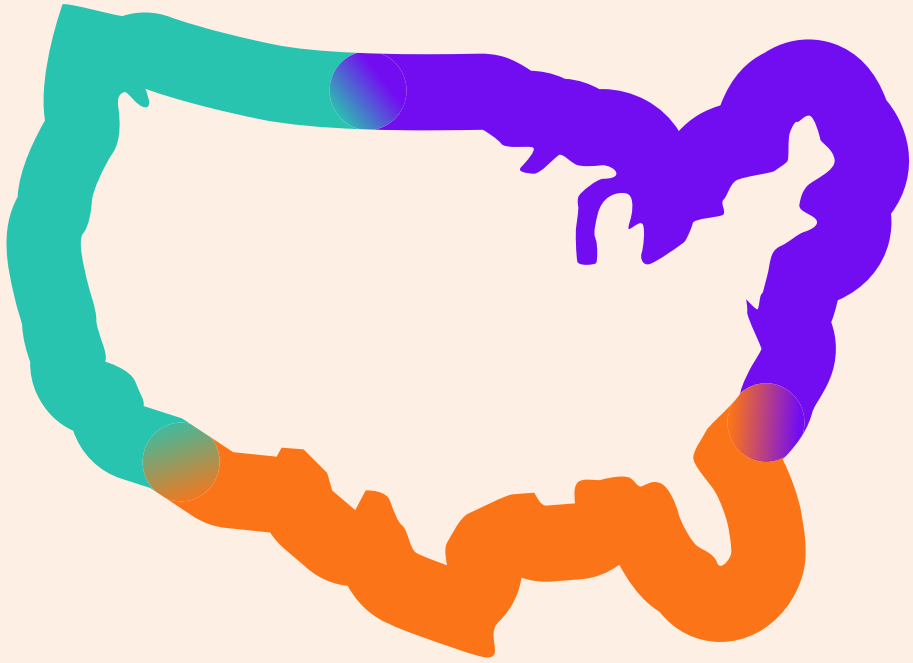
State Priority - Program Integrity Priorities and Audits

Regular audits of the Medicaid program are conducted both by Georgia Department of Audits and Accounts (DOAA) and by the Centers for Medicare and Medicaid Services (CMS), findings from which drive performance improvement for the state as led by the Department of Community Health (DCH) Office of the Inspector General.

National Trends – Overview

This section contains a selection of key trends to highlight based on activities and initiatives that are garnering the attention of Medicaid stakeholders both nationally and locally. These trends are categorized by type: eligibility, benefits, and financing. It is noted if such trends are reflected in the Georgia landscape.

Many recent trends have been prompted by the Biden administration's goal of making health care more accessible and equitable across the country. The implications of the November 2024 election on these trends are yet to be seen; however, changes are likely as the priorities of the incoming administration generally differ from the outgoing administration. The trends included in future updates to this publication will be aligned with the evolution of trends consistent with each administration's goals and priorities.



National Trends – Eligibility & Enrollment

States have enacted many policy initiatives throughout the history of the Medicaid program related to enrollment. In recent years, since the passage of the Affordable Care Act (ACA), a notable trend in Medicaid eligibility has been the expansion of Medicaid to low-income adults with incomes up to 138% of the Federal Poverty Level (FPL). Another recent eligibility trend is the increase in state adoption of continuous eligibility (CE) and continuous enrollment policies.

FIGURE 6-5.
ELIGIBILITY TRENDS

Trend	Description	States
Medicaid Expansion	Under the ACA, states have been expanding Medicaid coverage to low-income adults with incomes up to 138% FPL. States receive a 90% federal match for services provided to this population. Expansion states report positive impacts in uninsured population, cost savings, and access. The American Rescue Plan Act (ARPA) provides an additional 5 percentage point increase in regular federal matching rate for two years after expansion for states that had not yet expanded at the time ARPA passed (2021).	All states plus DC *except* AL, FL, KS, GA, MS, SC, TN, TX, WI, and WY
Continuous Eligibility (CE) and Enrollment	To minimize temporary loss of Medicaid associated with churn when members disenroll and re-enroll within a short period of time, states are adopting CE and enrollment policies that extend the requirement to provide 12-month CE for children for longer periods of time or for other targeted populations. CE is a key factor in ensuring stable coverage, access to care, and improved health outcomes without the requirement of additional paperwork and regardless of changes in family circumstances.	CA, CO, HI, KS, NM, MA, MN, NC, NJ, NY, OR, PA, WA

National Trends - Benefits

Recent trends include a significant number of states adding new Medicaid benefits or enhancing existing benefits. These additions fall into multiple categories, but the most common include expanded pregnancy and post-partum services, additional mental health and substance use disorder (SUD) benefits, dental services, and a continued focus on services to address Health Related Social Needs (HRSN).

FIGURE 6-6.
BENEFITS TRENDS

Trend	Description	States
Pregnancy and Postpartum Services	More than one out of every four Medicaid and CHIP members are females ages 15–49[6.3] and more than 40% of births nationwide are financed by Medicaid.[6.4] Given these statistics, Medicaid must be central to any comprehensive maternal health redesign in the United States, and state Medicaid programs are intensifying efforts on maternal health improvement including expanding the scope of pregnancy care, expanding mental health coverage, and adding coverage for doulas in an effort to increase positive birth experiences, leading to a potential long-term cost-savings over time for Medicaid programs.[6.5] States have also widely adopted the ARPA and CAA option to expand postpartum coverage to 12 months.	Extended Postpartum Coverage Beyond 60 Days: All states *except* AR.[6.6] Doula Services: AZ, CA, CO, DC, DE, FL, IL, KS, MA, MD, MI, MN, MO, NJ, NV, NY, OK, OR, VA, RI, WA
Behavioral Health Services	Mental health and SUD services, collectively behavioral health services, continue to be one of the most frequent categories of benefit expansions since 2016.[6.7] Behavioral health services for children are comprehensive due to Medicaid's Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit, but vary for adult members. The full range of behavioral health services covered under Medicaid is not easily quantifiable, but recent trends include a particular focus on enhancing crisis services and expanding the availability of other services at home and in the community.[6.8] Crisis services have generally been the category with the lowest coverage rate across states; however, more recently, higher coverage rates are being seen, likely in part due to ARPA's provision of a new option and enhanced federal funding for states to provide community-based mobile crisis intervention services. The CCBHC Medicaid Demonstration Program expansion has additionally been a notable trend, with the Department of Health and Human Services having the ability to add 10 states to the program every two years to further increase access to crisis and behavioral health care in the community, including providing reimbursement through Medicaid for the full cost of services that CCBHCs provide, at higher, more competitive rates than community mental health centers previously received for Medicaid eligible individuals.	Approved Mobile Crisis SPAs: AL, AZ, CA, CO, IN, KY, MA, MT, NC, NY, OR, WA, WI, WV Participating in CCBHC Medicaid Demonstration Program: AL, IA, IL, IN, MI, MO, KS, KY, ME, NH, NJ, NM, NV, NY, OK, OR, RI, VT

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6.3 CMS. (May 2024). 2024 Medicaid & CHIP Beneficiaries at a Glance: Maternal Health. https://www.medicaid.gov/medicaid/benefits/downloads/2024-maternal-health-at-a-glance.pdf.

6.4 KFF. (n.d.). Births Financed by Medicaid. https://www.kff.org/medicaid/state-indicator/births-financed-by-medicaid/?activeTab=map&currentTimeframe=0&selectedDistributions=percent-of-births-financed-by-medicaid&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

6.5 National Academy for State Health Policy. (2024, April 16). State Medicaid Approaches to Doula Service Benefits. https://nashp.org/state-tracker/state-medicaid-approaches-to-doula-service-benefits/.

6.6 KFF. (2024, December 2). Medicaid Postpartum Coverage Extension Tracker. https://www.kff.org/medicaid/issue-brief/medicaid-postpartum-coverage-extension-tracker/.

6.7 KFF. (2023, March 17). Medicaid Coverage of Behavioral Health Services in 2022: Findings from a Survey of State Medicaid Programs. https://www.kff.org/mental-health/issue-brief/medicaid-coverage-of-behavioral-health-services-in-2022-findings-from-a-survey-of-state-medicaid-programs/.

6.8 KFF. (2024, October 23). Annual Medicaid Budget Survey for State Fiscal Years 2024 and 2025. https://www.kff.org/report-section/50-state-medicaid-budget-survey-fy-2024-2025-benefits/.

National Trends - Benefits *(continued)*

Trend	Description	States
Services to Address HRSN	In both 2021 and 2023, CMS released guidance on better addressing HRSN, acknowledging many Medicaid and CHIP members may face challenges related to affordable and accessible housing, efficient transportation, safe neighborhoods, strong social connections, access to nutritious food, and opportunities for meaningful employment.[6.9] The guidance includes a framework of services and supports to address HRSN that CMS considers allowable, which has bolstered HRSN 1115 initiatives in many states.	21 states approved: [6.10] AZ, AR, CA, DE, DC, FL, HI, IL, MD, MA, MT, NJ, NM, NY, NC, OR, RI, TN, UT, VT, VA, WA 15 states with provisions pending with CMS:[6.11] AR, CA, CT, DC, HI, KY, ME, NC, OR, PA, RI, UT, VT, WA, WV
Pre-Release Services	In early 2023, CMS released guidance encouraging states to apply for a new section 1115 demonstration opportunity to test transition-related strategies to support re-entry and care transitions for incarcerated individuals. This newly announced opportunity allows states to partially waive the statutory policy that prohibits Medicaid from paying for services provided during incarceration except for inpatient services. Under this new opportunity, states may offer coverage of pre-release services 30 to 90 days before the expected date of release from an incarceration setting.	11 states approved:[6.12] CA, IL, KY, MA, MT, NH, NM, OR, UT, VT, WA 15 states with provisions pending with CMS:[6.13] AZ, AR, CT, CO, DC, HI, LA, MD, MI, NC, NJ, NY, PA, RI, WV
Dental Benefits	States are required to provide comprehensive dental services for children under the EPSDT benefit. Despite dental services for adults being considered an optional benefit, states are increasingly expanding coverage from limited dental services (e.g., emergency services) to more comprehensive dental services for adults.	States already providing adult dental beyond emergency services: 40 plus DC[6.14] States recently beginning or expanding adult dental benefits: GA, HI, KY, MD, MI, NH, TN[6.15,6.16]

6.9 CMS. (2021, January 7). Opportunities in Medicaid and CHIP to Address Social Determinants of Health (SDOH). https://www.medicaid.gov/federal-policy-guidance/downloads/sho21001.pdf.

6.10 KFF. Medicaid Waiver Tracker: Approved and Pending Section 1115 Waivers by State. https://www.kff.org/medicaid/issue-brief/medicaid-waiver-tracker-approved-and-pending-section-1115-waivers-by-state/.

6.11 *Id.*

6.12 KFF. Medicaid Waiver Tracker: Approved and Pending Section 1115 Waivers by State. https://www.kff.org/medicaid/issue-brief/medicaid-waiver-tracker-approved-and-pending-section-1115-waivers-by-state/.

6.13 *Id.*

6.14 KFF. (2024, May 29). Variation in Use of Dental Services by Children and Adults Enrolled in Medicaid or CHIP. https://www.kff.org/medicaid/issue-brief/variation-in-use-of-dental-services-by-children-and-adults-enrolled-in-medicaid-or-chip/.

6.15 Medicaid. (2024, August 8). Georgia State Plan Amendment 24-0005. https://www.medicaid.gov/medicaid/spa/downloads/GA-24-0005.pdf.

6.16 NBC News. (2023, September 24). Many states are expanding their Medicaid programs to provide dental care to their poorest residents. https://www.nbcnews.com/health/health-news/many-states-are-expanding-medicaid-programs-provide-dental-care-poores-rcna117077.

National Trends - Financing

Medicaid spending has important implications for federal and state governments at all times, as well as for providers and local governments. Particularly in response to the rise in Medicaid enrollment during the COVID-19 federal Public Health Emergency and related spending and fiscal challenges, states continue to implement a number of strategies to lower program costs while balancing this with the goal of better health outcomes for members.

FIGURE 6-7.
FINANCING TRENDS

Trend	Description	States
Value-Based Care and Alternative Payment Models (APM)	Value-based care is a range of health care delivery and payment models designed to realign financial incentives to improve patient outcomes and increase provider flexibility to provide high-value care. The term is often interchangeably used with the term alternative payment models (APMs). Use of APMs in Medicaid continues to gain traction as states seek to improve healthcare quality and reduce costs. Under these models, data driven targets for achieving quality measures and medical expenditure targets are set, which are then aligned to a reimbursement structure that is based on whether the targets are met.[6.17]	States can implement APMs in a wide range of ways and target various services or provider types based on the state's goal. Included below is a non-exhaustive list of common recent examples. APMs that include behavioral health providers: AZ, MA, NY, PA, OR, TX, WA[6.18] APMs for LTSS (mainly nursing facilities): CA, CO, FL, IA, ID, IL, IN, KS, NM, NY, MA, MD MI, MN, OH, OK, TN, TX, VT, WA[6.19]

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6.17 CMS. (n.d.). Alternative Payment Models and the Quality Payment Program. https://www.cms.gov/priorities/innovation/about/alternative-payment-models.

6.18 National Conference of State Legislatures. (2023, December 20). Value-Based Care in State Medicaid Programs. https://www.ncsl.org/health/value-based-care-in-state-medicaid-programs.

6.19 ASPE. (2022, August 18). State Use of Value-Based Payment in Nursing Facilities. https://aspe.hhs.gov/sites/default/files/documents/c112eecf913024d1a00d5db17555a56b/state-vbp-nursing-facility.pdf.

National Trends - Financing *(continued)*

Trend	Description	States
Efforts to Address Pharmacy Costs	Managing Medicaid pharmacy expenditures has been a long-standing policy priority for Medicaid programs, and Medicaid spending on prescription drugs continues to rise.[6.20] States are required under the federal Medicaid Drug Rebate Program to cover almost all FDA-approved drugs from rebating manufacturers, but many states are implementing various strategies to address rising pharmacy costs. One strategy utilized to address rising drug costs is to carve pharmacy benefits out of the managed care benefit in an effort to negotiate better drug prices directly with manufacturers and reduce administrative costs.[6.21] Pharmacy cost containment initiative trends are expected to be a continued trend to watch as almost three-quarters of states implemented, plan to implement, or expanded initiatives to contain prescription drug costs in Fiscal Year (FY) 2024 or FY 2025 with value-based arrangements (VBAs) with pharmaceutical manufacturers as the most common tactic planned, particularly for high-cost drugs such as those for treatment of hepatitis C[6.22]	States carving pharmacy out of managed care: CA, MO, ND, NY, OH, TN, WI, WV, OR[6.23] States that utilize/plan to utilize a hybrid model under which managed care pharmacy benefits are managed by a single pharmacy benefit manager: KY, LA, MS[6.24]
State Directed Payment Programs (DPPs)	In 2016, CMS updated the regulations for Medicaid managed care and created a new option allowing states to direct Managed Care Organizations to pay providers according to specific rates or methods. These "directed payments" can be used to establish minimum or maximum fee schedules for certain types of providers, to require participation in value-based payment arrangements, or to make uniform payment rate increases. Over the past several years, the number of directed payment arrangements continued to grow for all directed payment types, with the largest number of directed payments being uniform rate increases.[6.25] Specifically, the use of DPPs grew from 250 approved between July 1, 2021 to February 1, 2023 to 302 approved between February 1, 2023 to August 1, 2024, a 21% increase in the number of unique arrangements approved.[6.26]	Most states that operate a managed care program have implemented at least one DPP. Fee For Service states and those that *have not implemented* any DPP include:[6.27,6.28] AK, AL, CT, CO, ID, LA, ME, MT, ND, SD, WY

6.20 KFF. (2024, October 11). Recent Trends in Medicaid Outpatient Prescription Drugs and Spending. https://www.kff.org/medicaid/issue-brief/recent-trends-in-medicaid-outpatient-prescription-drugs-and-spending/.

6.21 Bendicksen, L., Kesselheim, A.S. (2022). Anticipated efficiencies, real costs: Medicaid managed care organizations and the pharmacy benefit. https://pmc.ncbi.nlm.nih.gov/articles/PMC10373034/.

6.22 KFF. (2024, October 11). Recent Trends in Medicaid Outpatient Prescription Drugs and Spending. https://www.kff.org/medicaid/issue-brief/recent-trends-in-medicaid-outpatient-prescription-drugs-and-spending/.

6.23 KFF. (2023, November 14). Annual Medicaid Budget Survey for State Fiscal Years 2023 and 2024. https://www.kff.org/report-section/50-state-medicaid-budget-survey-fy-2023-2024-pharmacy/.

6.24 *Id.*

6.25 Medicaid and CHIP Payment and Access Commission. (October 2024). Directed Payments in Medicaid Managed Care. https://www.macpac.gov/publication/directed-payments-in-medicaid-managed-care/.

6.26 *Id.*

6.27 U.S. Government Accountability Office. (2023, December 14). Medicaid Managed Care: Rapid Spending Growth in State Directed Payments Needs Enhanced Oversight and Transparency. https://www.gao.gov/products/gao-24-106202.

6.28 Medicaid. (n.d.). Approved State Directed Payment Preprints. https://www.medicaid.gov/medicaid/managed-care/guidance/state-directed-payments/approved-state-directed-payment-preprints.

Conclusion & Acknowledgements

Georgia Health Initiative is pleased to release this resource to help connect, inform, and spark action to improve health for all people in Georgia. We hope the information contained in this annual publication is helpful to all partners across sectors throughout the state.

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