Georgia Health Initiative

Insights on Medicaid in Georgia

Overview & Context

Jan. 2025

PART

1

What is Health Insurance?

HEALTH INSURANCE COVERAGE

National Perspective

Introduction

The United States has long recognized the importance of health insurance in facilitating access to care and providing financial protection against the high cost of health care services. Health insurance covers a portion of the cost of medical expenses in exchange for monthly premium payments, helping individuals access necessary care without overwhelming financial burdens. Fundamental to health insurance is the concept of risk pooling, where the costs of unforeseen medical expenses can be spread across a group of people who have varying degrees of medical needs, thereby reducing the risk or financial burden on any individual in the group.

Health insurance may help pay for doctors' services, hospital care, medications, rehabilitation stays, medical equipment, or a portion of home health care when someone is sick or injured. It can also reduce costs for preventive care, such as annual check-ups, flu shots, child vaccinations, and certain wellness screenings, often covering these services fully.

Types of Health Insurance

In 2023, 92% of the U.S. population had health insurance coverage. Sources of coverage can generally be grouped into one of two categories - private and public. Private insurance can be obtained through a person's employer or by purchasing through a state or federal Health Insurance Marketplace, which in part may be subsidized by government tax credits or deductions, or by purchasing directly from an insurance company. An estimated 178 million Americans were covered by employment-based coverage in 2023, making it the largest source of health insurance coverage in the U.S. Publicly funded insurance programs are collectively the second-largest source of health insurance in the country and include Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and other publicly financed programs. Medicare and Medicaid are the two largest public programs, each insuring nearly 63 million people in 2023.

TABLE 1.

NUMBER OF PEOPLE COVERED BY DIFFERENT TYPES OF HEALTH INSURANCE – 2023

Coverage Type	Individuals Covered (in thousands)
Total	**331,700**
Any health plan	**305,200**
Any private plan	216,800
Employment-based	178,200
Direct-purchase	33,850
Marketplace coverage	13,320
TRICARE	8,721
Any public plan	120,400
Medicare	62,550
Medicaid	62,700
VA and CHAMPVA	3,171
Uninsured	**26,440**

Source: U.S. Census Bureau. (2024). Current Population Survey Annual Social and Economic Supplement (ASEC) Data. https://www.census.gov/data/datasets/time-series/demo/cps/cps-asec.html. Numbers in thousands. Population as of March 2024. The estimates by type of coverage are not mutually exclusive; people can be covered by more than one type of health insurance during the year. Private health insurance includes coverage provided through an employer or union, coverage purchased directly, or TRICARE. In the CPS ASEC, individuals are considered to be uninsured if they did not have health insurance coverage for the entire calendar year.

How Health Insurance Works

Health insurance can be complex, and its specific features may vary based on the type of insurance (e.g., employer-based coverage or Medicaid) or the plan involved. However, the basic concept is that the insurer guarantees payment for routine health care and unexpected health events, and the insured (also known as the policyholder or the member) often pays a smaller fee or premium to the insurer in exchange for protection from making the entire payment for those services.

Under private health insurance, members typically pay a monthly premium for the plan. Most insurance plans also have a deductible, which is the amount the member must pay out of pocket for care until the insurer begins to pay a portion of medical costs. For example, once the deductible has been met an insurer may pay 80% of medical costs and the insured may pay 20%, which is called “coinsurance.” In addition to paying for health care costs, health insurance plans often provide extra no-cost programs to their members, including discounts on health and wellness services and incentive programs for engaging in specified healthy activities (such as weight loss or smoking cessation efforts).

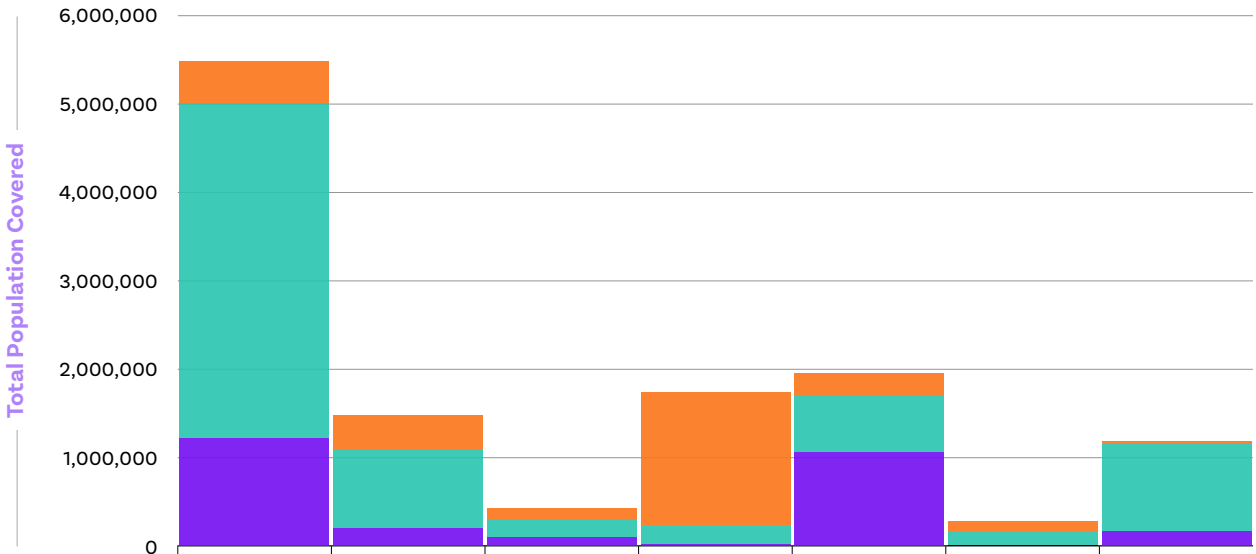
HEALTH INSURANCE COVERAGE

Georgia Perspective

Sources of coverage for Georgians in 2023 are presented in *Figure 1*.

FIGURE 1.

GEORGIA HEALTH COVERAGE BY COVERAGE TYPE – 2023

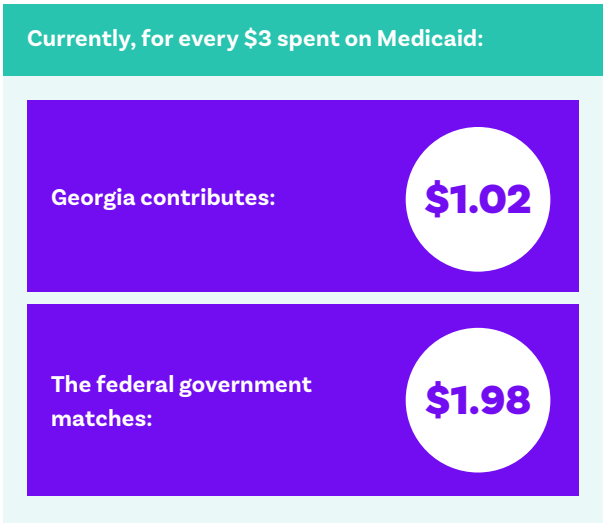


Ages	Employer	Direct-Purchase	TRICARE	Medicare	Medicaid	VA	Uninsured
65+	497,000	412,000	132,000	1,579,000	255,000	122,000	18,000
19-64	3,965,000	917,000	207,000	223,000	672,000	165,000	1,044,000
<19	1,279,000	216,000	110,000	19,000	1,109,000	7,000	171,000

Source: U.S. Census Bureau. (2023). Health Insurance Coverage Status and Type of Coverage by State and Age for All Persons: 2023. https://www2.census.gov/programs-surveys/demo/tables/health-insurance/2024/acs-hi/hi05_acs.xlsx.

Medicaid

Georgia's Medicaid system provides health coverage to certain low-income individuals and families, including children, pregnant women, some parents, and individuals who are elderly or have disabilities. Medicaid is operated by states through an agreement with the federal Centers for Medicare and Medicaid Services (CMS) and jointly funded by the state and the federal government. The joint funding arrangement follows a methodology called Federal Medical Assistance Percentage (FMAP), which establishes a percentage rate annually specific to each state.



Georgia Medicaid covers about 2.3 million individuals and spends approximately $14.9 billion[1]. Low-income families and children are predominantly served under Georgia's Medicaid managed care model, and members who are elderly or have disabilities receive benefits directly from the state's designated Medicaid agency, the Department of Community Health.

PeachCare for Kids®

Georgia's Children's Health Insurance Program (CHIP), named PeachCare for Kids® (PCK), provides health coverage to uninsured children in Georgia under the age of 19 whose family income is too high to qualify for Medicaid but less than or equal to 247% of Federal Poverty Level (FPL). Based on income and the child's age, some families may be required to make co-payments. PCK coverage resembles Medicaid coverage, with the exception of non-emergency medical transportation, and includes preventive services and acute medical care, vision and dental care. As of April 2024, 187,902 children were enrolled in PCK, down from a high of 207,243 in December 2023 prior to eligibility redeterminations that resumed following the end of the federal public health emergency declaration.[i] Total annual spending for State Fiscal Year 2025 is estimated at $636 million.[2] PCK expenditures are federally matched through a formula known as Enhanced Federal Medical Assistance Percentage (eFMAP). Georgia's eFMAP for 2025 is 76.23%.[3]

[i] During the COVID-19 public health emergency (PHE), states were required to maintain all members as eligible on Medicaid. Once PHE ended in May 2023, all Medicaid members had to go through the redetermination process to maintain Medicaid coverage.

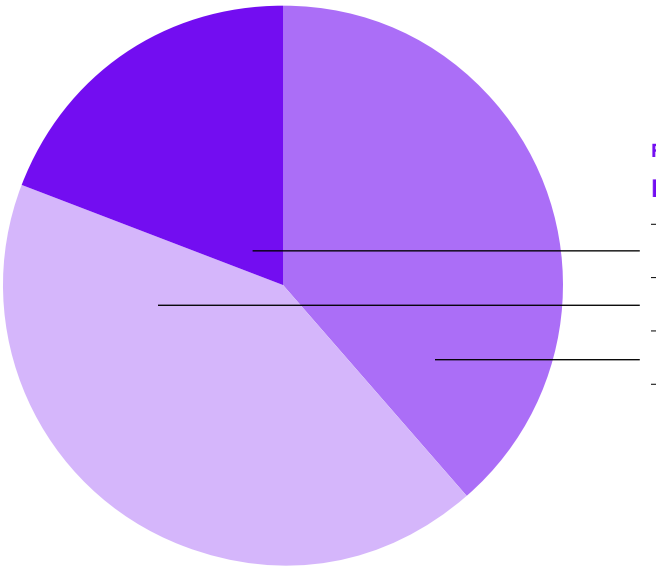


FIGURE 2.

PCK ENROLLMENT BY AGE (APRIL 2024)

Ages 1–5	19%
Ages 6–12	42%
Ages 13–18	38%

Source: DCH OAPI. (2024, September 17). KPI Analytics Dashboard. https://public.tableau.com/app/profile/dch.oapi/viz/KPIAnalyticsDashboard/LandingPage. Accessed October 17, 2024.

Pathways to Coverage™

Not represented above in *Figure 1* is enrollment for those in Georgia's new Pathways to Coverage™ ("Pathways") program. Pathways, which launched July 1, 2023, offers Medicaid coverage to eligible Georgians ages 19-64 who have a household income of up to 100% of the FPL and complete qualifying activities for at least 80 hours per month. Qualifying activities include:

- Employment
- On-the-job training
- Job readiness assistance
- Community service
- Higher education through enrollment in public and private universities and technical colleges
- Participation with the Georgia Vocational Rehabilitation Agency (GVRA)

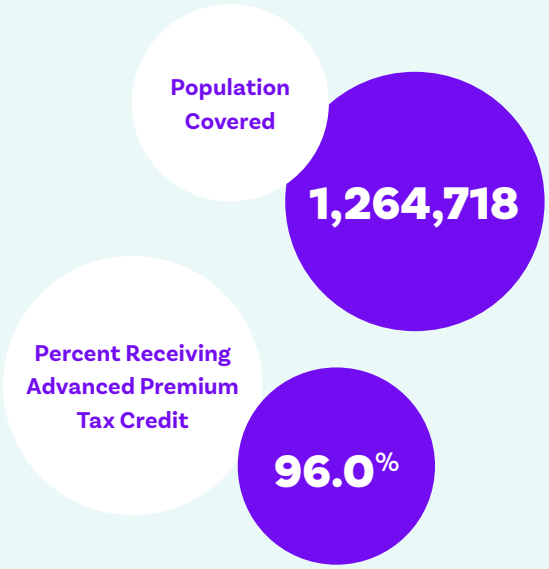
As of October 2024, approximately 5,120 individuals were enrolled in Pathways.

Affordable Care Act (ACA) Marketplace

The Direct-Purchase health insurance coverage plan category includes those who have purchased coverage through the Affordable Care Act (ACA) Marketplace. In 2024, over 1.3 million Georgians signed up for coverage, an almost 44% increase over 2023, where 879,084 Georgians selected Marketplace plans.

Of those who enrolled in a Marketplace plan in 2024, 96% received an advance premium tax credit (APTC). The APTC is a refundable, advanceable federal tax credit which helps to cover the cost of premiums for plan coverage purchased through the Marketplace. To qualify, total household income for the year must be between 100% and 400% of the FPL, and an individual can't be claimed as a dependent on another person's filing or eligible for any other type of health insurance.[4]

ACA Marketplace Coverage – 2024



Source: Center for Medicare & Medicaid Services. (2024). Health Insurance Marketplaces 2024 Open Enrollment Report. https://www.cms.gov/files/document/health-insurance-exchanges-2024-open-enrollment-report-final.pdf. Accessed November 25, 2024.

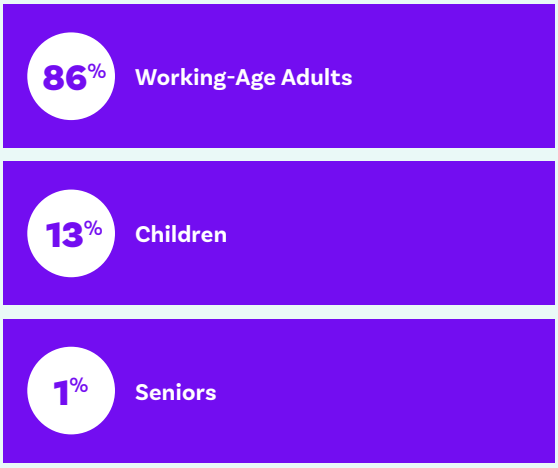
The American Rescue Plan Act (ARPA) of 2021 extended and expanded APTCs for individuals with incomes above 400% of the FPL and provided an increase to the subsidy for those below 400%. These enhancements, originally set to expire on January 1, 2023, were extended through the end of 2025 by the Inflation Reduction Act (IRA). If enhancements expire, an estimated 336,000 Georgians could become uninsured as a result of premium increases that would occur.[5]

In February 2023, Governor Brian P. Kemp initiated plans to establish a State-based Exchange (SBE) as an alternative for Georgians using the Marketplace Federal Platform (SBE-FP). Effective for Open Enrollment 2025, which began in November 2024 and runs through January 16, 2025, the Georgia SBE, Georgia Access, replaced the SBE-FP and is now the platform Georgians must use to sign up for direct-purchase coverage.

Georgia's Uninsured

As of the 2022 Census, Georgia has 1.24 million uninsured individuals, more than 11% of the state's population. Georgia's uninsured rate has decreased in recent years but remains substantially higher than the national average of 8%. Contributing factors include Georgia's decision not to expand Medicaid under the ACA, which primarily affects adults who earn too much to qualify for Medicaid but not enough to afford private insurance. Georgia also experiences lower Medicaid and CHIP participation rates for children as compared to other states, which may be due to administrative burdens or other barriers.

Snapshot of Georgia's Uninsured Population



Source: U.S. Census Bureau: (n.d.) https://data.census.gov/.

Georgia's overall uninsured rate for children has consistently been higher than many other states, ranking 39th in the nation in 2023.[6] Geographic disparities with limited access to healthcare providers is a compounding issue for the uninsured who live in rural regions. Being uninsured often leads to delayed medical care, higher rates of preventable conditions, and worse overall health outcomes. Uninsured individuals are less likely to seek necessary preventive services and may rely on costly emergency care.

The Health Care Safety Net

Certain providers, known as safety net providers, help fill gaps within the health care system by providing some health care services such as primary care, preventive services, and emergency care to uninsured and underinsured individuals. These safety net entities rely heavily on funding from state dollars and federal grants (e.g., block grants from the federal Substance Abuse and Mental Health Services Administration and Administration on Community Living). While federal grant dollars cannot count as the state share for drawing down federal match through Medicaid funds, at least some subset of state fund dollars could be leveraged to further stretch the impact of the state's investment.[ii]

[ii] State and grant funding is often used to cover not otherwise Medicaid eligible individuals' services and would not be eligible for state share to draw down Medicaid match.

In Georgia, the safety net is comprised of public or community hospitals, the state's Departments of Public Health (DPH) and Behavioral Health and Developmental Disabilities (DBHDD), and other community health centers. The state supports the safety net in different ways including through direct supplemental funding to certain providers. The providers who comprise the safety net are included in the table below.

TABLE 2.

SAFETY NET PROVIDERS IN GEORGIA

Hospitals	Over 100 acute care and public hospitals provide free care including 47 public, critical access hospitals. The state issues payments to these hospitals through the federal Disproportionate Share Hospital program.
Public Health	18 public health districts and county health departments under DPH offer clinic- and home-based health promotion and disease prevention services.
Behavioral Health	22 Community Service Boards serve as the DBHDD's public safety net arm and provide services to individuals with limited income, who are uninsured or underinsured, or who have Medicaid.
Federally Qualified Health Centers (FQHCs)	35 FQHCs provide primary and other health care services through 330 outpatient clinic sites to individuals with incomes below 200% of the FPL. 669,000 patients were served by FQHCs in 2022 (29% Medicaid, 12% Medicare, 27% uninsured, and 32% private pay).[7]
Rural Health Clinics (RHCs)	Established to improve access to services across the state, 95 RHCs provide primary care in underserved rural areas.

PART

2

What is Medicaid?

MEDICAID

What is it?

Medicaid in Detail

Medicaid is a publicly funded health insurance program authorized by Title XIX of the Social Security Act in 1965. A joint federal-state program administered at the state level, Medicaid provides coverage for health care and long-term care services to eligible very low-income parents[iii] and low-income dependent children, pregnant women, people with disabilities, and older adults, as well as some individuals with specific health conditions. In some states, Medicaid also covers certain adults with low incomes. As of July 2024, almost 79.6 million individuals were enrolled in Medicaid throughout the country, including approximately 2.3 million Georgians.[8] Medicaid enrollment nationally is almost evenly split among eligible children and adults (excluding the Medicare-enrolled elderly).

Medicaid enrollment fluctuations reflect an inverse response to changes in the economy. During periods of economic downturn or recession, Medicaid enrollment rises as more people become eligible due to job loss, increased poverty, or a decline in employer-sponsored health insurance coverage. Conversely, when the economy improves and people return to work or have higher incomes, Medicaid enrollment tends to decrease as fewer people meet the eligibility criteria. Once deemed eligible, each enrollee has a right to access all Medicaid benefits for which they meet medical necessity criteria. The state cannot limit enrollment or benefits to control costs. States must prepare ahead for enrollment fluctuations by reserving funds during times of prosperity to cover the costs of increased enrollment and service delivery costs during economic downturns.

States must follow certain requirements in their Medicaid programs, determined by CMS, including requiring coverage of certain mandatory populations and benefits. However, federal rules allow states to cover additional optional populations and benefits. States also can establish their own Medicaid provider payment rates within federal requirements and can pay for services through fee-for-service or managed care arrangements. These flexibilities in program design mean Medicaid programs can look very different in each state.

Because Medicaid is intended to provide insurance to those who could not otherwise afford it, federal law places strict limits on costs that Medicaid members can be required to pay, the services to which these costs can apply, and the groups who can be required to pay. Federal law also specifies mandatory and optional benefits for Medicaid, whereas rules for private insurers are less prescriptive.

[iii] In most states that have not expanded Medicaid, the eligibility for adults over 21 is very limited. Parents of dependent children are typically ineligible if their income exceeds just 42 percent of the poverty line.

How do Medicare and Medicaid Differ?

Medicaid and Medicare, both publicly financed health insurance programs created in 1965, differ in key ways. Medicare is a fully federal program that provides health coverage for individuals ages 65 and older, certain individuals who are receiving treatment for end-stage renal disease (ESRD), and some individuals with disabilities younger than 65 who qualify for Social Security benefits. Medicare provides broad coverage of health care services but only limited long-term care. Because Medicare is administered at the federal level, eligibility criteria and benefits do not vary between states. Medicaid, on the other hand, is state-administered and provides coverage to low-income individuals, including some seniors and people with disabilities. Because Medicaid is administered at the state level, eligibility criteria and benefits vary from state to state.

Nearly 13 million[9] low-income seniors and people with disabilities, called "dual eligibles," are enrolled in both Medicare and Medicaid. Some dual eligibles are eligible to receive full Medicaid benefits, while others qualify for a Medicare Savings Program (MSP) eligibility group. For individuals in an MSP, federal rules require state Medicaid programs to pay Medicare premiums, deductibles, or coinsurance for certain people enrolled in Medicare Parts A or B. Medicaid is always considered a "payer of last resort," so, for individuals eligible for coverage under both programs, Medicare is the program primarily responsible paying for services covered by both programs and Medicaid pays last.

How Do Medicaid and CHIP Differ?

CHIP was created in 1997 and provides health coverage to children in families with incomes too high to qualify for Medicaid, but who are unable to afford private coverage. States can set up CHIP as a separate program, as an expansion of Medicaid, or both. All states have expanded children's coverage through CHIP, and some states also cover low-income pregnant individuals in their CHIP programs. CHIP is funded by both the federal government and states but covers fewer people than Medicaid, with approximately 7 million enrolled in the program nationally as of June 2024. Because CHIP was also designed to be more affordable than private or commercial insurance, federal law imposes limits on the cost-sharing that states can require of CHIP members. However, these limits are less strict than Medicaid due to the comparatively higher incomes of families in CHIP. Unlike Medicaid, federal CHIP funding is a block grant rather than a permanent part of the federal budget and must be periodically reauthorized by Congress. CHIP funding is currently authorized through 2027.

MEDICAID

How Is It Operated?

State Plans

A Medicaid State Plan is the agreement between a state and the federal government describing how that state will administer its program. The State Plan provides assurance that it will follow federal rules for program operation and establishes the basis to claim federal matching funds to operate the program. The State Plan sets out categories of individuals to be covered, services to be provided, provider reimbursement methodologies, and state program administrative activities.

When a state is planning to change its program policies or operational approach, it sends a State Plan amendment (SPA) to CMS for review and approval. States also submit SPAs to make corrections or update their Medicaid or CHIP State Plan with new information.

Medicaid Waivers and Demonstrations

In addition to operating the Medicaid program under the State Plan, Medicaid law allows states to apply to CMS for waivers of certain sections of the Social Security Act to enact a variation or alternative to program policy or operations. Requests are made through Medicaid waivers and Medicaid 1115 demonstrations and must be approved by CMS. *Table 3* highlights Medicaid waiver and demonstration options most commonly used by states and what the option allows the state to implement or vary in the Medicaid program.

TABLE 3.

TYPES OF MEDICAID WAIVERS AND DEMONSTRATIONS

Authority Type	Purpose
1915(b) Waivers	• Allow states to waive Medicaid requirements of comparability, statewideness, and freedom of choice. States often use this authority to implement managed care delivery systems within their Medicaid programs. It allows states to limit the number or type of providers that can provide certain Medicaid services, limit the geographic area a program is offered in (such as providing managed care in only specific counties), or limit the providers that Medicaid members can choose to receive services from, except for emergencies.

1915(c) Waivers	• Allow state Medicaid programs to provide home and community-based services (HCBS), within federal guidelines, to meet the needs of people who prefer to receive long-term care services and supports in their home or community, rather than in an institutional setting.
	• These programs may provide a combination of medical services and non-medical services that often include the following:
	  • case management
	  • homemaker
	  • home health
	  • personal care
	  • adult day health

1115 Demonstrations	• Allow states to test new Medicaid program ideas that aren't typically allowed under other federal requirements. The changes must further the objectives of the Medicaid program, such as delivering more cost efficient and higher quality care to Medicaid members. These changes must be budget-neutral for the federal government, meaning the federal government's Medicaid costs do not increase due to the demonstration compared to what it would have otherwise spent. • Section 1115 demonstrations have been used for a wide range of purposes, such as delivery system reform, expanding substance use disorder treatment benefits, improving mental health service systems, improving care transitions for incarcerated individuals returning to their communities, and designing alternative coverage models for otherwise ineligible populations, such as expanding coverage to the ACA Medicaid expansion population.

MEDICAID

Who Is Covered?

Eligibility for Medicaid is usually defined by categorical eligibility (i.e., the type of populations covered) and financial eligibility (i.e., the income level or threshold at which individuals within the populations can be covered). Within these categories, federal law outlines mandatory and optional populations for coverage. Sometimes Medicaid members, many of whom are within the aged or disabled category, may also have long-term care, or long term services and supports (LTSS), needs. Generally, individuals in need of these services must also meet functional criteria based on an assessment of an individual's physical and cognitive abilities, including ability to perform activities of daily living, and other factors, or disease or condition-specific criteria set by the state for those services.

FIGURE 3.

MEDICAID MEMBER POPULATIONS

Mandatory Populations	Optional Populations
The populations, for whom the Medicaid program was originally developed, that states must cover to be eligible for federal funding, including:	**The populations for which states have the option to cover. All states have opted to cover the following populations:**
• children (through age 18) in families with income below 138% of the FPL • people who are pregnant with income below 138% of the FPL • certain parents or caretakers with very low incomes • most seniors and people with disabilities who receive cash assistance through the federal Supplemental Security Income (SSI) program	• people listed in the "mandatory" groups with income exceeding the limits for mandatory coverage • seniors and people with disabilities who are not receiving SSI with income below the poverty line • "medically needy" people whose income exceeds the state's Medicaid eligibility limit but who have high medical expenses, such as for nursing home care, that reduce disposable income below the eligibility limit • people with higher income who need long-term services and supports

Beyond the optional populations included in *Figure 3* above, the ACA[iv] newly allowed states to include another "optional" population in their Medicaid programs, non-elderly adults with income up to 138% of the FPL, with the aim of reducing the number of uninsured individuals throughout the country.

As of October 2024, 40 states (Georgia not being one of them) have expanded Medicaid to this newly optional group.

[iv] The full name of the health care reform law that authorized this optional population is the "Patient Protection and Affordable Care Act." However, it is more commonly referred to as the Affordable Care Act or "ACA."

MEDICAID

What Is Covered?

Each state has significant flexibility in deciding the services it covers for its Medicaid members and setting provider reimbursement rates for those services. While some services are mandatory under federal law, states can provide multiple additional optional services within broad federal rules. The category of the member's eligibility determines their available services.

Under federal law, there are two main service or benefit packages for state Medicaid programs - traditional benefits and alternative benefit plans (ABPs). For traditional Medicaid benefits, states are required to cover specific services listed in federal law and may decide to cover certain other services. ABPs, however, do not have a specific list of items or services the state must cover. Instead, states may provide Medicaid benefits defined by reference to an overall coverage benchmark, or comparison, to one of three commercial insurance products, such as the health plan in which state employees are enrolled or another benchmark approved by CMS. States are required to provide ABP benefits for the ACA Medicaid expansion population and may cover other populations through an ABP. However, federal law states certain vulnerable populations cannot receive ABP benefits and must be provided with traditional benefits. (Of note, Georgia does not have ABPs.)

State Medicaid payment varies by state and by provider type but generally must be set by a state in a manner that is cost efficient and sufficient to ensure members have adequate access to services. Rates are approved by CMS, and states may choose a variety of ways for setting these rates, such as mirroring Medicare rates for the same service.

Required and Optional Services

Services that state Medicaid programs are required to provide or may provide vary based on whether the individual is receiving traditional benefits or benefits under an ABP. *Table 4* provides examples of mandatory and optional services for each package.

TABLE 4.

EXAMPLES OF MEDICAID MANDATORY AND OPTIONAL SERVICES

Benefit Package	Mandatory Benefits	Optional Benefits
Traditional Benefits	• Hospital services (inpatient and outpatient) • Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services for members under 21 • Physician services • Transportation to medical care • Home health • Medication assisted treatment (MAT) • Family planning services • Nursing facility services	• Prescription drugs • Physical, occupational, and speech therapy • Dental services for adults • Personal care services • Hospice • Eyeglasses • Prosthetics • Inpatient psychiatric services for individuals under age 21
ABP	• EPSDT services for members under 21 • Hospitalization services • Family planning services • Emergency and nonemergency medical transportation • Prescription drugs • Mental health and substance use disorder services • Rehabilitative services • Maternity and newborn care	• States can carefully target the needs of specific groups by offering multiple ABPs, each targeted to the healthcare needs of the group (such as children or adults within the group). For special-needs subgroups, states also have the option to offer traditional benefits or enroll members in an ABP.

MEDICAID

How are Services Delivered?

Medicaid, like any insurance program, does not provide health care services directly. Instead, a state agency that operates the Medicaid program relies on a system for delivering services to enrolled members. There are typically two types of service delivery systems.

The first and original type is a fee-for-service (FFS) delivery system. Under FFS, Medicaid members may choose from any provider within an approved network who contract directly with the state agency. When a member receives services that are covered by Medicaid, the provider bills Medicaid directly and gets paid an established rate associated with the delivery of that particular service. If some services require authorization in advance for the services to be provided, the state agency, or often a contracted vendor, will conduct that prior authorization review.

The second type of delivery system is managed care.

What is Managed Care?

Managed care is a health care delivery system organized to manage cost, utilization, and quality by delegating service delivery to organizations known generally as managed care organizations (MCOs). (Of note, in Georgia, managed care entities are referred to as Care Management Organizations, or "CMO"s.) State Medicaid agencies select and contract with MCOs, typically through a public procurement process, to help manage and coordinate all the services members receive. This coordination involves making sure that each member gets the right kind and amount of services based on the MCO's assessment of the members' needs. States opt for the managed care service delivery model because it may result in more appropriate utilization of services and better quality outcomes and cost controls, while also reducing the Medicaid agency's administrative responsibilities. It also allows for more flexible benefits and holds a single entity accountable for integrating and coordinating care across multiple providers for each member.

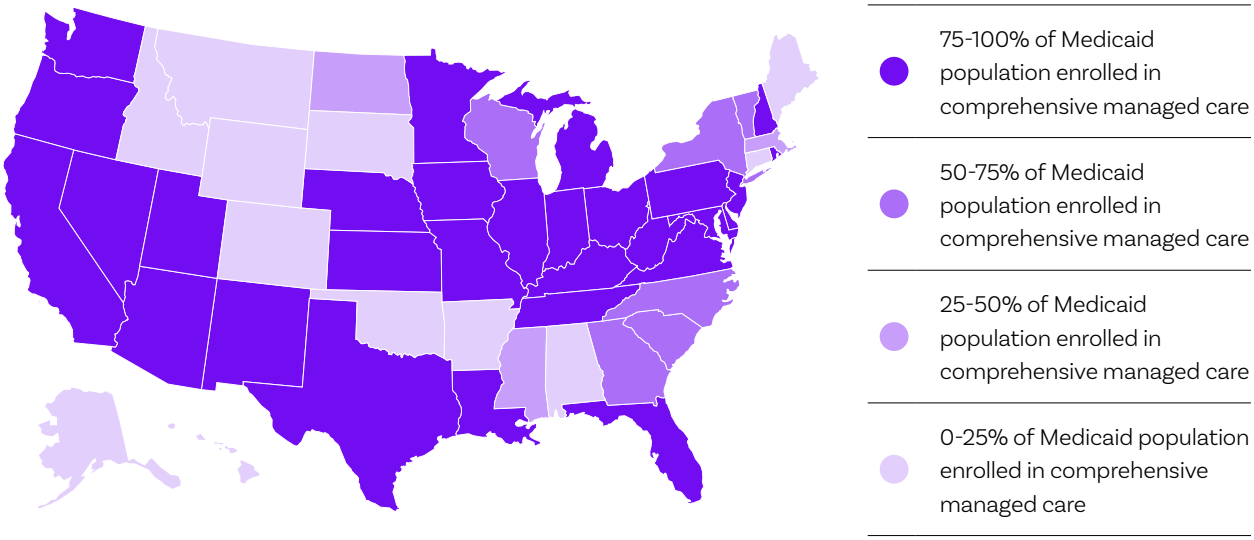
Instead of paying MCOs for each service delivered, the state pays a set monthly amount per member in its plan. That set amount may vary based on the member's profile including age, gender, medical conditions, where they live, and other factors. The per member per month (PMPM) amount, called a capitated rate, is established in advance each year based on historical service use, costs, and demographic characteristics. This payment to the MCO is the maximum the MCO will receive for direct services[v] and, in exchange, the MCO is responsible for providing all the services each member needs. This is considered a "risk-based" arrangement because the MCO is at risk of spending more if the member's needs exceed the PMPM amount the MCO has been paid by the state.

[v] In addition to capitation payments, the MCOs also receive directed payments for which the MCOs serve as a pass through. Directed payments offset population-based uncompensated care and do not provide direct service reimbursement.

Managed care has become the primary method of delivering Medicaid services, with 42 states using capitated managed care.[10] Of those 42 states, 33 provide all Medicaid services only through their contracted MCOs, while in the other states, some services or some populations may be excluded (carved-out), of managed care. Over 74% of all Medicaid members nationally receive their services through an MCO.[11] *Figure 4* below reflects the managed care enrollment across the country.

FIGURE 4.

PERCENT OF MEDICAID POPULATION IN MANAGED CARE



Source: https://data.medicaid.gov/dataset/79692ea5-21e1-56bf-8149-97d437120c4b/data?conditions[0][property]=year&conditions[0][value]=2022&conditions[0][operator]=%3D

In states that use some but not all managed care, Medicaid members may get all of their health care services through the MCO, while other Medicaid members may get some services through the MCO and other services through the state's FFS system, or even another MCO. For example, a state might enroll its entire population into managed care to receive medical/physical care but carve-out behavioral health care or LTSS. A Medicaid member who receives behavioral health services in that state would be enrolled in the MCO while also receiving behavioral health services through traditional FFS channels. There are also other models where states still have all services under managed care, but contract with different MCOs delivering services for different needs. Alternatively, a single MCO may serve a specific population, such as children involved in the child welfare system, because it is such a highly specialized group.

States have more regularly used managed care to provide services to non-disabled Medicaid members, typically low-income children and families. Those with disabilities have more complex and costly needs, and states have generally been more deliberate about when and how these Medicaid members are included in managed care, although in recent years states have increasingly explored carving additional populations into managed care.

Difference Between Fee-For-Service and Managed Care

The Medicaid FFS and managed care models both cover eligible low-income members but differ functionally and in member experience. In the FFS model, it is assumed that members will utilize health care services as needed. Under the managed care model, there is a focus on coordinated care, where a specialized entity is accountable for improving member experience and outcomes, and managing costs. *Table 5* provides a comparison of the differences between FFS and managed care across several domains.

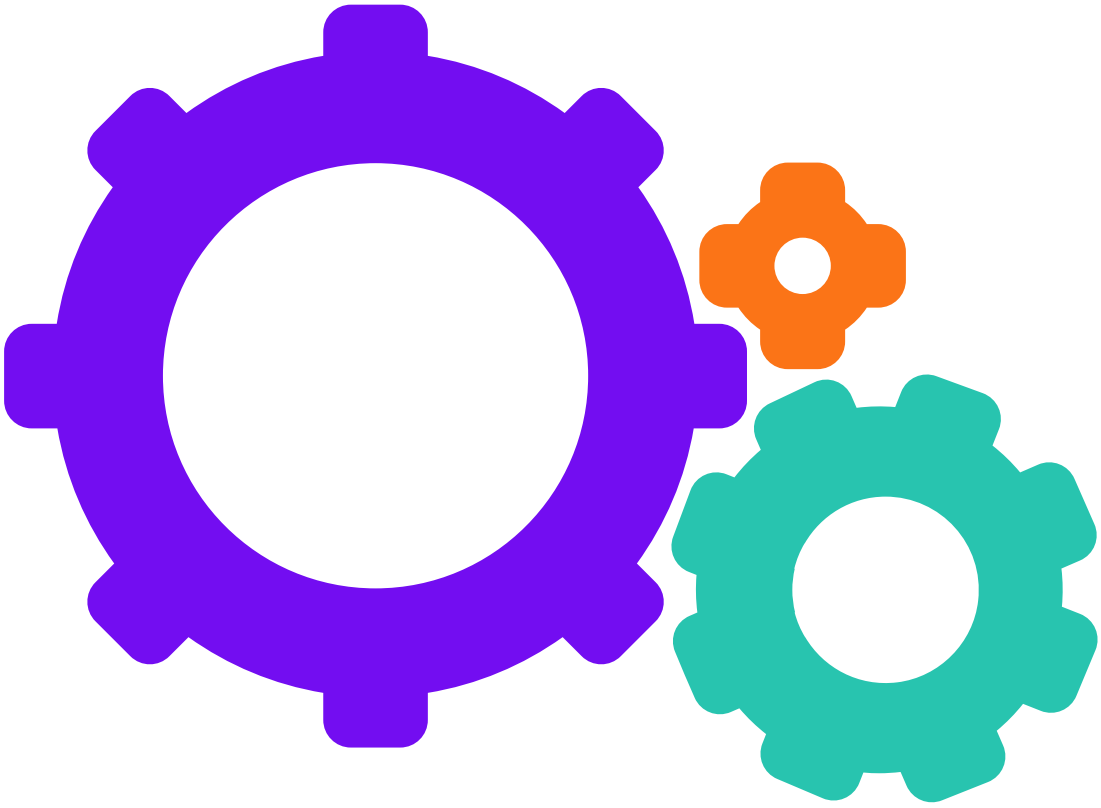


TABLE 5.

KEY DIFFERENCES BETWEEN MEDICAID FEE-FOR-SERVICE AND MANAGED CARE DELIVERY SYSTEMS

	Fee-for-Service	Managed Care
Administration	Administered by the State Medicaid agency	Administered through contracts with the State Medicaid agency
Enrollment	Members are automatically enrolled when determined eligible	Members select the MCO plan in which they want to enroll, or they will be assigned; opportunities to select a different plan are generally limited to once a year
Provider Access	Member may choose to go to any Medicaid enrolled provider as often as they want	Members may still exercise choice from any provider in the MCO network for approved services, but they may be limited in the type of providers they can see and how often
Payment Mechanisms	State Medicaid agency pays providers directly or through a fiscal agent	State Medicaid agency pays MCO a PMPM, capitated rate associated with each member
Provider Reimbursement	A set reimbursement rate for each service is established and each provider gets paid the same amount for the same service	While often based on the FFS fee schedule, providers and MCOs may negotiate reimbursement rates, which may be influenced by supply vs. demand, location, and other factors
Care Objective	A member's symptoms are addressed in each provider visit	A member's needs are viewed holistically, and treatment is preventive as well as responsive to acute onset of symptoms
Care Coordination	Coordinating one's care is largely left up to the member unless they happen to receive services which include a care coordinator or case manager (e.g., HCBS); Members will seek health care if something is wrong	Care coordination and integration is inherent in service delivery; Members are directed to care to prevent illness and manage conditions
Utilization Management	States will apply prior authorization requirements to certain services and provider types, but these are often limited, and they typically will review on a case-by-case basis and not in conjunction with other services the member is receiving	MCOs use prior authorization processes, which are intended to support appropriate service utilization (the right service, at the right time, in the right place) in consideration of all other services the member is receiving
Value	Providers are paid for each service they deliver regardless of outcome	MCO and provider payment is often tied to member health outcomes
Cost	Lack of controls on utilization and lack of attention to preventive care can inadvertently lead to greater costs	Focus on health outcomes seeks to shift spending on preventive care to avoid more expensive costs associated with untreated conditions

Fee Schedules

With very limited exceptions, state Medicaid agencies establish the reimbursement rate in advance for every Medicaid-covered service or procedure. This is regularly referred to as the FFS fee schedule and is detailed in the State Plan for each Medicaid program (e.g., physician services, nursing facility services, behavioral health services, etc.) or in applicable waiver documents. These rates must align with federal regulations ensuring that payments for services are consistent with efficiency, economy, and quality of care and sufficient to support access,[12] often mirroring federally set Medicare pricing.

In contracts with MCOs, states often cite the FFS fee schedule as the floor, or the minimum reimbursement amount the MCO is required to pay to the provider. However, the MCO has general latitude to negotiate rates it will pay to each provider. Approximately half of states with managed care mandate minimum provider reimbursement rates in their MCO contracts for critical services, such as inpatient and outpatient hospital services and primary care physician services. Slightly less than half of the same states require MCOs to align with provider reimbursement rate increases adopted in FFS.[13]

MCOs are also often required to engage in value-based reimbursement initiatives, paying their provider network based on established quality measures such as operating efficiencies or improvement in health outcomes for the Medicaid members they are serving. In some states, the Medicaid agency will prescribe the extent to which this is expected of the MCO. Often the state's payment to the MCO is dependent on the MCO demonstrating its providers are achieving targeted outcomes, and may require the MCO share value-based payment earnings with the providers who were instrumental in achieving the desired outcomes.

MEDICAID

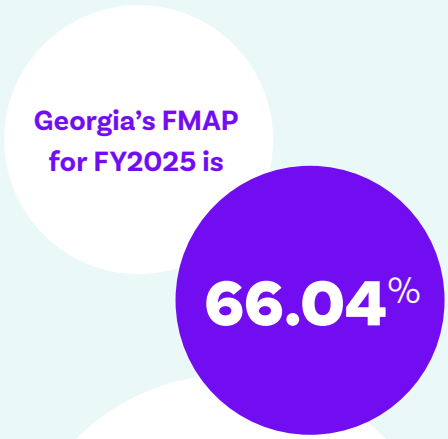
How Is It Paid For?

Medicaid is jointly funded by the federal government and states. Of total national expenditures in 2023, 69% of funds were federal dollars while the aggregate states' shares made up the remaining 31%.

Federal Share

The federal share of Medicaid funding to the state is determined by a state's FMAP. FMAP is determined annually, and it varies by state using a formula in federal law that considers the state's average per capita income relative to the national average. By law, FMAP must be between 50% and 83%.[14]

Federal matching funds may also vary based on the type of service, population covered, or state activity. For example, states can receive enhanced FMAP (E-FMAP) for CHIP and the Medicaid ACA expansion population. E-FMAP can have a higher maximum than FMAP. The CHIP amount is state dependent, calculated based on the state's FMAP with a maximum of 85%, while the amount for the Medicaid ACA expansion population is 90% and does not vary by state. Additionally, state-approved Medicaid administrative activity costs are generally matched at 50% by the federal government, but some activities, such as costs of upgrading computer and data systems for member eligibility and provider claims processing and efforts to combat Medicaid fraud, receive a higher federal match.



Source: KFF. (n.d.) Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier. https://www.kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

State Share

Each state decides how to finance its share of the Medicaid program, with state legislatures playing a key role in selecting financing options. Federal law requires that at least 40% of the state's share be financed directly by the state and up to 60% may come from local government, such as from cities or counties. While most of the state share usually comes from general funds, states often use at least one of the additional methods in *Table 6* to fund the state share.

TABLE 6.

STATE MEDICAID FUNDING MECHANISMS

Funding Mechanism	Description
Intrastate Governmental Transfers	This type of transaction happens when a government entity (e.g., a county) transfers funds to the state's Medicaid agency before a Medicaid payment is made in order to increase the state share.
Provider Taxes (also sometimes called Provider Fees or Healthcare-related Taxes)	These are fees or taxes charged to all private providers in a particular provider category (e.g., hospitals, intermediate care facilities, or nursing facilities). These fees or taxes are charged to private providers in the category regardless of whether they are a Medicaid provider or accept Medicaid patients.
Certified Public Expenditures	These occur when a government entity, which includes governmental providers (e.g., a county-operated nursing facility), pays for Medicaid-covered services that are eligible for financial match. The costs incurred by the governmental provider can be used to support the state share.

Increasing the state share through any of these mechanisms allows states to draw down more federal funding without raising state general fund expenditures. This enables states to stretch legislatively appropriated state dollars for Medicaid services further and often helps cover the cost of initiatives that are integral to advancing quality care such as funding provider rate increases. Provider taxes are a common source of this funding, used by all states except Alaska. Most states (39) have chosen to implement multiple categories of these taxes, as shown in *Figure 5*.

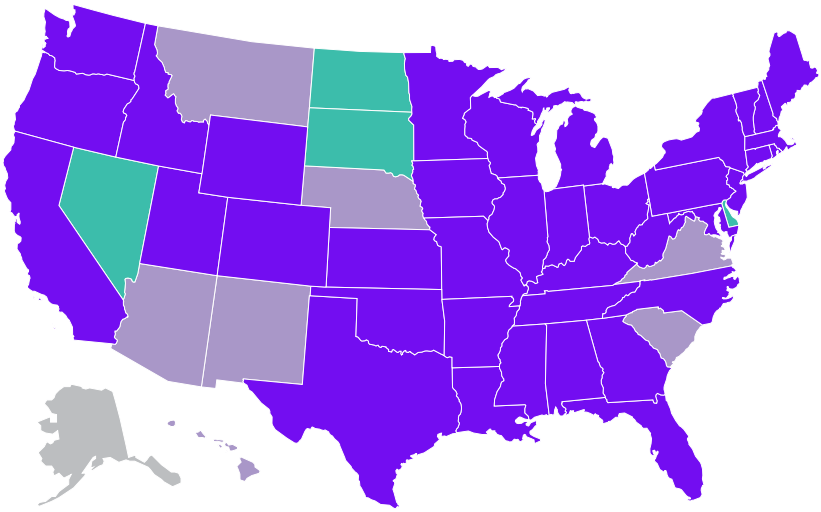


FIGURE 5.

STATES WITH PROVIDER TAXES OR FEES IN PLACE IN FISCAL YEAR 2023

- 3+ Provider Taxes/Fees (39 states including DC)
- 2 Provider Taxes/Fees (7 states)
- 1 Provider Tax/Fee (4 states)
- No Provider Taxes/Fees (1 state)

Source: KFF. (2023, November 14). Amid Unwinding of Pandemic-Era Policies, Medicaid Programs Continue to Focus on Delivery Systems, Benefits, and Reimbursement Rates: Results from an 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-provider-rates-and-taxes/. DC is included in counts of states with 3+ taxes/fees. 2022 survey data used for states that did not respond to the 2023 survey (FL, MN, SC).

Premiums and Cost Sharing

Although states have the option of requiring some groups of Medicaid members to contribute to the cost of some of their health care, there are specific rules states must follow and limits on who may be charged these fees, the services to which the fees may apply, and the amount that may be charged. This is designed to keep access to health care affordable for low-income populations, encourage continued coverage, and reduce financial burden on members.

Medicaid defines “cost sharing” as any copayment, coinsurance, deductible, or other similar charge and “premium” as any enrollment fee, premium, or other similar charge.[15] Federal rules generally limit the amount of costs a family may be required to pay (cost-sharing and premiums combined) in Medicaid to no more than 5% of family’s income, which a state can opt to apply either monthly or quarterly. *Figure 6* shows an example of what this 5% maximum could look like for a pregnant individual and a family of four at varying income levels.

FIGURE 6.

EXAMPLES OF COST SHARING CALCULATED

Member Type	Monthly Income	%FPL	Maximum Monthly Out-of-Pocket Limit
Pregnant Woman	$318	~18% FPL	$16
	$3,748	220% FPL	$187
Family of 2 Adults, 2 Young Children	$442	17% FPL	$22
	$3,874	149% FPL	$194

PART

3

Medicaid in Georgia

Governance

Structure

As Georgia's designated state Medicaid agency, the Department of Community Health (DCH) is responsible for administration and oversight of the state Medicaid program. Georgia's Medicaid program operates under DCH through the Division of Medical Assistance Plans (MAP). MAP provides oversight of Medicaid and PCK through management of direct operations and with the support of multiple contractors. This involves developing and implementing policies on allowable services and service delivery, administering the state's managed care program, overseeing member eligibility and enrollment into Medicaid including assignment to the state's MCOs, known in Georgia as CMOs, managing the budget for related expenditures, and monitoring for compliance with state and federal regulations.

DCH contracts with the Georgia Department of Human Services (DHS) to conduct eligibility determinations through the county-based Division of Family and Children Services (DFCS). DHS operates the state's integrated eligibility system, Georgia Gateway, that processes applications for multiple programs in addition to Medicaid, including Women, Infants and Children (WIC), Supplemental Nutrition Assistance Program (SNAP), Childcare and Parent Services (CAPS); Temporary Assistance for Needy Families (TANF), Refugee Assistance, and Low Income Home Energy Assistance Program (LIHEAP).

TABLE 7.

DCH OPERATIONAL INFRASTRUCTURE

DCH's Division of Medical Assistance Plans partners with other DCH offices in the administration and monitoring of Medicaid:	DCH supports Medicaid operations through vendor contracts for:
• **Healthcare Facility Regulation Division (HFRD)** licenses, certifies, and regulates healthcare facilities • **Office of Inspector General (OIG)** reviews Medicaid providers and members to reduce waste and mitigate fraud and abuse • **Office of Information Technology** manages both internal and vendor-operated information systems which support Medicaid operations • **Office of Analytics and Performance Improvement (OAPI)** provides data and analytics for program planning and improvement • **Division of Financial Management** provides Medicaid budgeting, accounting, and reimbursement services	• **Medicaid Management Information System (MMIS)** – the technology solution for claims processing and related functions • **Medical Management and Utilization Review** – for FFS, reviews prior authorization requests and conducts service utilization reviews • **Pharmacy Benefits Manager** – for FFS, administers pharmacy benefits including claims processing and manages pharmacy rebates

Medical Care Advisory Committee (MCAC)

The MCAC is comprised of up to 14 appointed individuals and provides DCH a line of sight into Medicaid operations from the perspective of physicians and other provider types, Medicaid members and advocates, and public health department representatives, among others. The MCAC puts forth input on Medicaid health policy with the goal of enhancing the quality of care delivered to members.

Office of State Administrative Hearings

If Medicaid benefits have been denied, reduced, or terminated, a member has the right to appeal that decision to the Georgia Office of State Administrative Hearings (OSAH). OSAH provides individuals with the opportunity to challenge decisions they feel are unjust, ensuring disputes are settled according to legal standards. The process can be challenging and time-consuming to navigate for the member who must submit an appeal and request a hearing within 30 days of the notification of the adverse decision, as well as provide documentation to support their case (e.g., medical records, letters from healthcare providers, etc.). Once an appeal has been filed, the state is legally required to continue to provide the same level of services the member was already receiving until the OSAH review process is concluded. After reviewing the evidence,

the OSAH judge will issue a ruling on the original decision made by DCH. If either party disagrees with the ruling, they may be eligible to appeal to a higher authority. In 2023, OSAH heard 3,916 Medicaid-related cases.

Medicaid System Operations Management and Enhancements

In 2024 and into 2025, DCH is focusing on several initiatives, either intended to bolster system operations or provide opportunities for system enhancements through contractually required re-procurements. Collectively, staff attention to these initiatives has and will continue to require intensive, long-term allocation of resources over the next few years.

- **Medicaid Enterprise System Transformation.** An effort to modernize the Medicaid Management Information System (MMIS) into a user-friendly, integrated system that can easily work with other systems and adapt to changing needs.
- **Enterprise Analytics Solution for Everyone (EASE):** DCH implemented an enterprise-wide data analytics and warehousing solution for integrating data from multiple sources to support reporting and predicting future trends. Implementation is ongoing, and new functionalities are planned to be added.
- **Multiple DCH vendor procurements.** In December 2024, DCH completed their procurement process for the state's new CMOs, the health plans that manage benefits for the majority of Medicaid members. Additionally, DCH is in the process of re-procuring for multiple vendors on an overlapping timeline including for critical Medicaid functionalities involving both the procurement activities and the intensive aftermath of implementation. These re-procurements are for:
  - Integrated Eligibility System (IES), the DHS-managed system for receiving and processing applications for all of Georgia's publicly funded social services, including Medicaid
  - MMIS claims module, the information system through which provider claims are adjudicated and paid

Authorities

Georgia Medicaid's State Plan

The Medicaid State Plan authorizes the state's choices for coverage of mandatory and optional populations and services.

Authorization for Managed Care. Under Section 1932(a)(1)(A) of the Social Security Act, and as part of the State Plan, DCH requires mandatory enrollment of specific Medicaid beneficiaries into the Medicaid managed care program. This is a State Plan option, not a separate authority.

Georgia Medicaid's 1115 Waivers

1115 Waivers are utilized for two programs in Georgia, Planning for Healthy Babies and Georgia Pathways to Coverage™.

- **Planning for Healthy Babies** (established in 2010) – expands eligibility to women ages 18-44, including those who are not enrolled in Medicaid, for the purposes of providing a limited set of benefits for no-cost family planning services and family primary care, case management and resource management to women who give birth to low and very low weight babies. Enrolled women are not eligible for any other Medicaid benefits.
- **Georgia Pathways to Coverage™** (launched July 2023) – provides health insurance coverage to Georgians ages 19-64 with household income of up to 100% of the Federal Poverty Level (FPL); enrollees must participate in 80 hours per month of qualifying activities and have access to most of the same services available through Medicaid.

Georgia Medicaid's 1915(c) Waivers

Georgia has four 1915(c) waivers which allow for members who have disabilities to receive services at home rather than in a facility or institution. Almost 50,500 Medicaid members receive home and community-based services (HCBS) through these waiver programs.

Each authority has designated approval. The State Plan is approved indefinitely until the state chooses to amend it. The 1115 and 1915(c) authorities are initially approved for five years but have to be renewed periodically—generally every 3 years for the 1115 and every 5 years for the 1915(c). Both can be amended at any time, but amendments typically require a 30-day public comment period for stakeholder feedback.

TABLE 8.

1915(C) WAIVERS IN GEORGIA

1915(c) Waiver	Populations Served
Comprehensive Supports Waiver Program (COMP)	Individuals with intellectual and developmental disabilities
New Options Waiver (NOW)	
Independent Care Waiver Program (ICWP)	Individuals with significant physical disabilities and traumatic brain injury
Elderly and Disabled Waiver Program (EDWP) • Community Care Services Program (CCSP) • Service Options Using Resources in a Community Environment (SOURCE)	Adults and seniors who experience limitations on their ability to perform activities of daily living for themselves and may also have chronic conditions requiring medical management

State Limitations

In 2014, the Georgia General Assembly passed House Bill 990, codified at *O.C.G.A. § 49-4-142.2*, requiring state legislative approval to expand Medicaid eligibility. However, this does not apply to annual adjustments to cost-of-living increases or other State Plan amendments. Legislative approval is not required for other types of Medicaid changes such as establishment of an 1115 demonstration waiver, for example, but it would be required for the resulting appropriations of funds. Changes to the Medicaid State Plan only require approval by the DCH Board of Directors through the process of public notice, hearing, and adoption.

Snapshot of its History

Georgia began its Medicaid program in 1967 following establishment of the federal Medicaid program in 1965. Low-income families and aged, blind, and disabled individuals have been covered under Georgia Medicaid since its inception. Initially, Georgia Medicaid covered only a limited range of services, including inpatient and outpatient hospital services, physician services, nursing facility services, and home health services. The program evolved over the years, adapting to changes in federal guidelines and state needs. Early changes to the scope of approved Medicaid benefits were part of a broader trend across the country for states to expand their Medicaid benefits to include more comprehensive services such as prescription drugs, hospice care, and non-emergency medical transportation. Additions to the State Plan for new eligibility categories also evolved over time. *Figure 7* depicts the key moments of Georgia Medicaid's evolution.

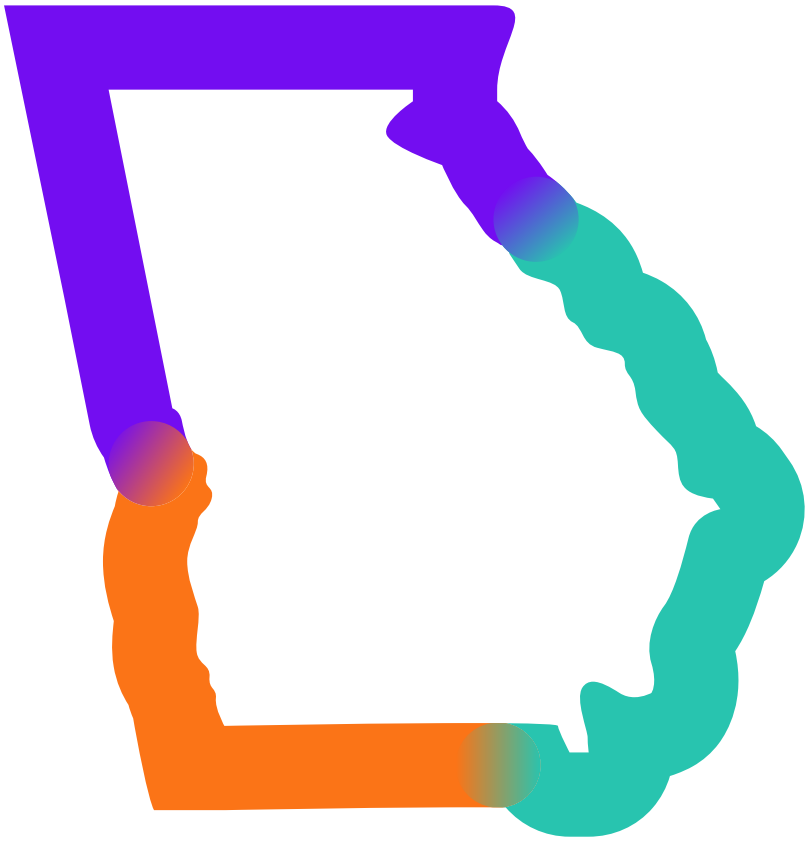
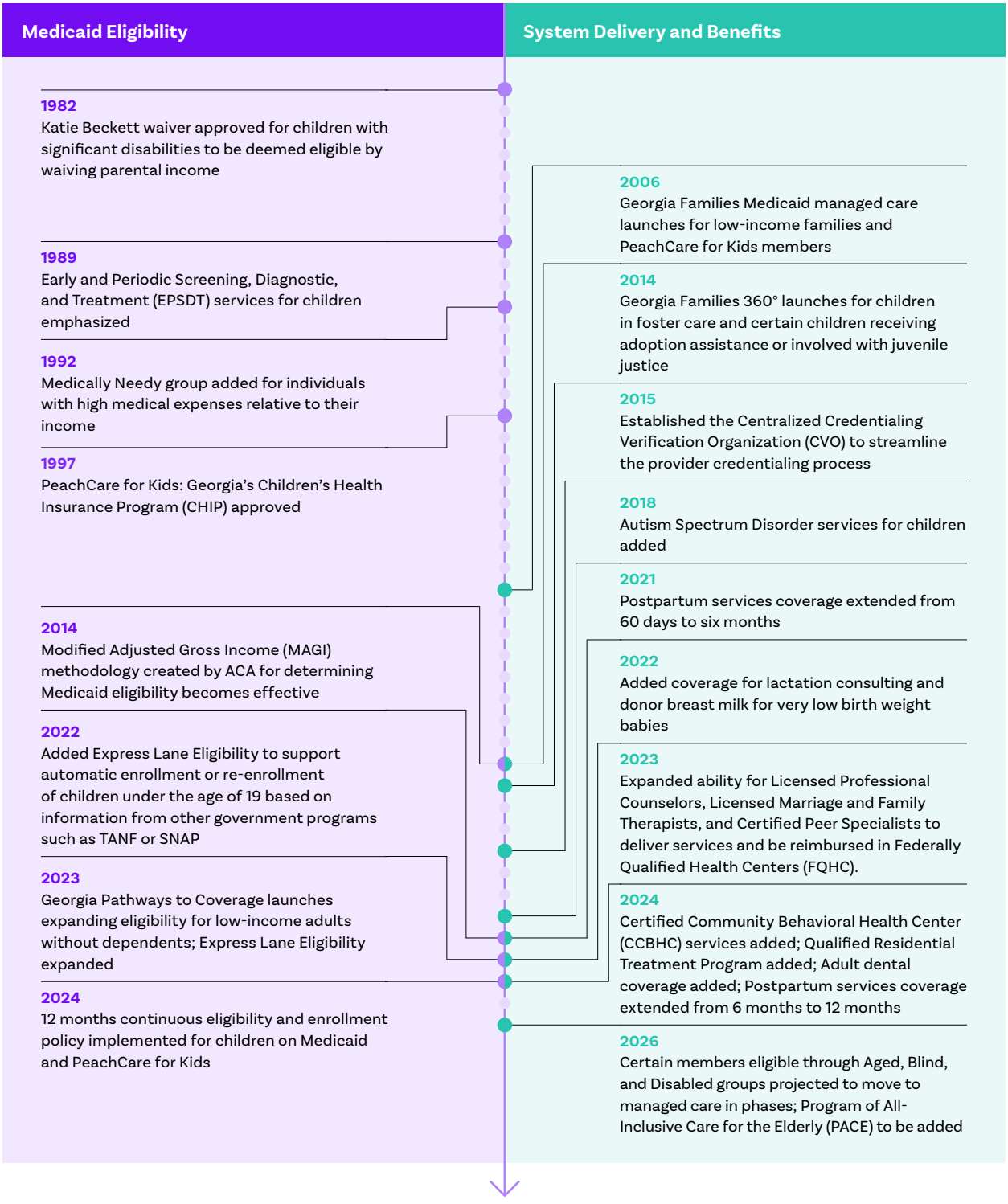


FIGURE 7.

TIMELINE OF CHANGES IMPLEMENTED TO GEORGIA'S MEDICAID PROGRAM



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