The Public Health Emergency Medicaid Unwinding: Georgia's Redeterminations Experience

May 2025

Table of Contents

Executive Summary

Introduction

Georgia Health Initiative® (the Initiative) is a non-profit, private foundation partnering with others to change systems and advance bold ideas to improve the health of all people in Georgia. In service of this goal, we commission timely and sound research and analysis to fill information gaps and create resources to elevate shared dialogue around issues critical to health. When commissioning reports like *The Public Health Emergency Medicaid Unwinding: Georgia's Redeterminations Experience*, the Initiative greatly relies on the ideas, inputs, and insights from partners across sectors to inform their development.

The conceptual idea for this research was initiated by non-profit partners in Georgia. These partners were striving to gain a more comprehensive understanding of the impact of the Federal COVID-19 Public Health Emergency (PHE)'s coverage for Medicaid and Children's Health Insurance Program (CHIP)-enrolled individuals and potential lessons that could be gleaned from what occurred. The Initiative engaged Health Management Associates (HMA), a leading independent national research and consulting firm in the health care industry, to conduct a retrospective analysis of what occurred during the PHE, assess the populations most greatly affected, and identify opportunities for present and future improvements to the Medicaid and CHIP programs. Recognizing the need to better understand the experiences of those most personally affected, the Initiative likewise engaged PerryUndem, a non-partisan research firm, to conduct focus groups with Georgia Medicaid and CHIP enrollees. PerryUndem also conducted stakeholder interviews with Georgia physicians who see a significant proportion of Medicaid and/or CHIP members as patients in their practice.

This report provides a brief overview of the PHE, the continuous enrollment provision and unwinding of this provision, and core components of high functioning systems, and highlights key considerations for improvement. While the catalyst for this report is Georgia's unwinding process and outcomes, that experience and the findings to follow illuminate opportunities to inform ongoing operations and policy decisions.

Summary of Findings

During the PHE, state Medicaid agencies were held to a continuous enrollment provision to protect member health care coverage during the pandemic. This led to substantial growth in Medicaid and CHIP enrollment. Additionally, during the course of the pandemic, states had the option to seek PHE-related flexibilities to promote access to care for members and ease administrative functions for the state. Among several flexibilities granted to Georgia was the option to forego the redetermination of eligibility at the member's annual renewal date. For over three years, no redeterminations were conducted for Georgia's existing Medicaid and CHIP members. Following the end of the PHE, states were required to roll back, or unwind, the flexibilities and changes instituted during the PHE and return to pre-pandemic operations, including re-initiating the annual renewal process.

When Georgia began its unwinding process in May 2023, total Medicaid enrollment had increased 30.3%—from 2.2 million members in March 2020 to 2.9 million members in June 2023. The state made extensive preparations for the unwinding, investing in a media campaign, dedicated website, mobile app, and robotic automation processes (bots). The state hired and trained 1,371 new eligibility workers between January 2023 and March 2024 and offered overtime pay to current workers to support outreach and redetermination processing. The state also implemented a staggered approach to managing the large number of redeterminations to be completed, which helped manage the workload and align renewals with other benefit programs, but did not adequately anticipate what became a significant backlog in renewal processing.

From the members' perspective, there were a number of communications and systems challenges encountered. Members indicated not receiving or not understanding renewal notices and largely remained unaware of state-run marketing campaign efforts. Members attempting to contact assigned caseworkers were often met with full voicemail boxes, and they likewise experienced issues in using the mobile app to upload required documents as a part of the renewal process. This likely contributed to high procedural termination rates (terminations due to technical issues or failure to respond to notices). As required of all states, Georgia reported monthly its progress on completing its annual renewals to the Centers for Medicare and Medicaid Services (CMS) and also shared information via an online dashboard. However, certain information, such as challenges the state was encountering, was not widely shared with external partners. There was some involvement of non-governmental partners, such as application assisters, community-based organizations, and managed care plans, in redetermination efforts. In retrospect, however, many believe that opportunities were missed to tap into additional resources who could have assisted the state in working toward their shared goal of ensuring coverage for all those eligible.

Despite these challenges, Georgia showed improvement by the end of the unwinding period and after, with an increase in the rate of ex parte renewals (auto-renewals not requiring the member's involvement) and a decrease in procedural terminations. These improvements were likely due to a combination of factors including implementation of an updated policy midway through the unwinding period which led to the higher ex parte renewals, new eligibility workers becoming proficient at their tasks, and other policy and operational shifts aimed at boosting renewals.

Once the unwinding period was completed, Georgia's Medicaid enrollment dropped to under 2.4 million members, the 12th highest decrease nationally at almost a 22% loss. Even with these losses, total enrollment still remained higher than pre-pandemic levels. This stands to reason as Georgia's Medicaid enrollment has grown annually on average at about 2%, which is notable but far from the 10% average

experienced during the pandemic. However, the composition of Georgia's enrollment had shifted during this timeframe, with fewer members in CHIP (called PeachCare for Kids® (PCK) in Georgia) and Aged, Blind, and Disabled eligibility groups as a percentage of the total enrollment as compared with pre-pandemic levels. As of November 2024, total enrollment had continued to decline gradually and now is slightly lower than levels that would have been expected based on normal annual growth in our state, posing questions as to why.

This report examines changes to Georgia's Medicaid and CHIP membership during and following the pandemic and discusses the factors that influenced those changes. It highlights several elements essential to effective eligibility and enrollment processes that warrant greater attention by the state to operational practices and for any future strategic quality and process improvement planning:

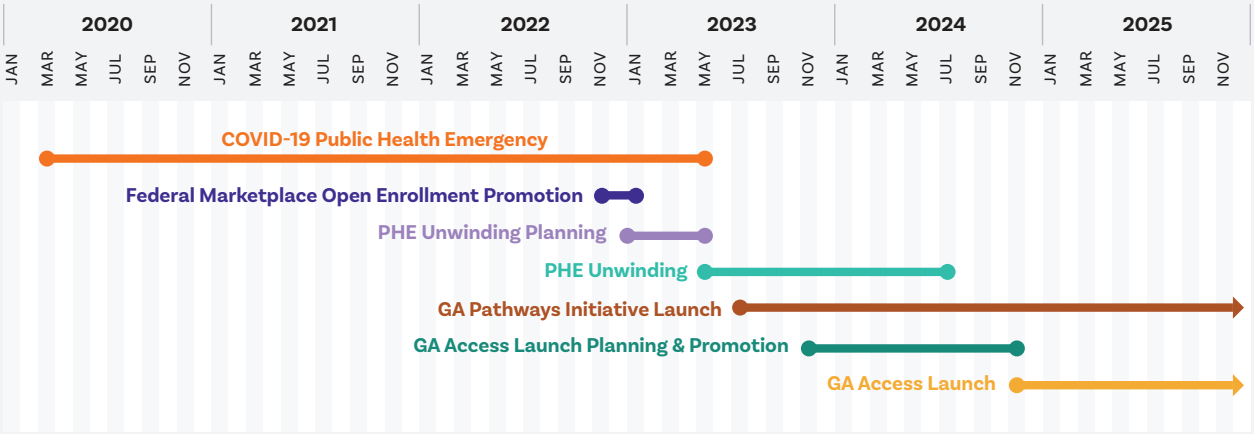
- **Member-centric.** Our findings point to the importance of being more deeply attuned to understanding Georgia's Medicaid and CHIP members—how they communicate, how their attention is engaged—and intentional about applying a member-centric focus to policy, operational, and other decisions.
- **Interconnectivity.** All operational management decisions should recognize the interconnectivity between various system components and their interdependencies. Policy decisions and related timing need to consider all possible impacts across the system, and implementation planning should consider the consequences of the ripple effects for each component. The connections between system components and the strength and investment in maintaining those connections should not be taken for granted or undervalued. These connective components include agreements between the Georgia Department of Community Health (DCH) and Department of Human Services (DHS), DHS and its eligibility system vendor, DCH and its Care Management Organizations (CMOs), as well as partnerships with community-based organizations and other partners engaged in or in a position to facilitate eligibility operations, and more.
- **Resources and Capacity.** The state should consider prioritizing updates to its information systems and use of technology to take advantage of automation that would enhance efficiency and efficacy and modernize communications with members. Additionally, evaluating the eligibility infrastructure and network to evaluate the cost-benefit of increasing points of access at the local level would be worthwhile. The state ended the practice of community based out stationed eligibility workers during the pandemic and they were not fully reinstated to support the redetermination process. This decision increased the challenges members faced when seeking assistance in completing their renewal. Finally, leveraging authorized assisters and other partner organizations with broader roles and greater authority could improve efficiency and provide a valuable return on investment.
- **Partner Engagement.** The state would be well-served to consider the value of community capital that could be optimized via opportunities to build trust and resiliency through consistent, transparent, meaningful, and bi-directional partnerships in eligibility operations.
- **Health Care Coverage Data Collecting and Tracking.** While the state was able to track the movement of some Georgians who lost their Medicaid eligibility through the determination process and transitioned to other coverage, we lack a clear picture of those who did not. Discussion around the importance of and responsibility for tracking these data to inform the state's goals of reducing the numbers of uninsured may be of benefit.

Key Takeaways

As further detailed throughout the remainder of this report, key takeaways from the unwinding process that can inform ongoing and future improvements include the following:

- **Communication.** Clear (easy to understand), multi-media (multiple accessible channels), and timely communication with Medicaid members is essential. Simplifying notices, using color-coded envelopes, and engaging partners and authorized assisters to reinforce messaging can help reduce confusion and improve response rates.
- **Technology.** Continued investment in technology enhancements, such as mobile-friendly portals and automated processes, can streamline the renewal process and reduce administrative burden. A well-built, high functioning system with the ability to make quick updates within the technological system is critical. The state could consider alternative verification methods and enhance data collection and analysis to support timely and accurate eligibility determinations.
- **Staffing.** Ensuring appropriate staffing levels, sufficient retention policies that reduce turnover, and timely and robust training for eligibility workers is also crucial.
- **Timing.** Adequately anticipating the time required to plan for such a complex and critical endeavor and beginning the planning as early as possible is essential. The roll out of multiple initiatives during the unwinding (e.g., planning and transitioning to Georgia Access, the state-based marketplace, and promotion of Georgia Pathways to Coverage™) led to competing priorities, system challenges, and confusion among members. In planning and implementing future initiatives, the state should minimize simultaneous execution of numerous changes and instead prioritize and stagger changes to the extent possible to avoid overwhelming the system, its stakeholders, and customers. Refer to the figure below for a timeline of the multiple overlapping initiatives.

TIMELINE OF UNWINDING AND OTHER STATE INITIATIVES



Studying what happened during the unwinding period provides a valuable opportunity to evaluate Medicaid operations, systems, and processes to identify lessons learned and areas for improvement. These lessons learned provide critical insight on how Georgia can implement systems changes to improve its Medicaid and CHIP eligibility and enrollment processes, achieve greater system efficiencies, and contribute strategically to its goal of increasing health care coverage for uninsured Georgians.

Research Methodology, Approach, and Limitations

The HMA project team utilized a research approach that combined qualitative and quantitative data analysis to gain a comprehensive understanding of what occurred during the unwinding in Georgia and how members were impacted, and to identify opportunities for future improvements. Detailed methodological information about each aspect of the research approach, as well as additional data visualizations and supplemental information are housed in a separate Appendix document, which may be made available upon request. HMA's research approach included:

- **An Environmental Scan.** The project team conducted a review of publicly available reports, media articles, press releases, and other documents to identify context and trends and inform the key informant interviews.
- **Review and Analysis of Available Data.** HMA secured Georgia Medicaid Management Information System (MMIS) enrollment data including enrollment by month, county of residence, race, sex, and age to help identify data patterns and trends. The team also leveraged Centers for Medicare and Medicaid Services (CMS) datasets, presentations, guidance, and reports along with publicly available individual state enrollment and redeterminations data.
- **Key Informant Interviews and Focus Groups.**
  - HMA facilitated key informant interviews with various stakeholder groups, including Georgia advocacy groups and application assisters, Georgia DCH leadership, representatives from Georgia Medicaid CMOs, and national Medicaid policy experts that provided a forum for qualitative information gathering and identification of opportunities for future improvements.
  - HMA incorporated data about how Georgia Medicaid members and providers serving those members were affected by the unwinding based on recent focus groups and interviews conducted by PerryUndem.

The research team reviewed relevant data, reports, and policy documents to identify trends, patterns, and key challenges. Stakeholder interviews and focus group data captured firsthand insights from individuals and health care providers impacted by the unwinding. These insights supported a deeper understanding of the experiences, challenges, and opportunities for improvements than what could be gleaned through quantitative data alone. The integration of these complementary methods provides a comprehensive assessment featuring findings that are both data driven and informed by the lived experiences of those most impacted by unwinding efforts.

Georgia's DCH is the designated state Medicaid agency responsible for managing the state's operations for Medicaid enrollment and delivery of health care service. DCH contracts with DHS to conduct eligibility determination (housed in its Division of Family and Children Services (DFCS)) which includes responsibility for contracting with the state's eligibility information system vendor. Thus, both departments were instrumental in the unwinding redetermination process.

Our research approach was predicated on the assumption that both state agencies would participate by providing key informant interviews and eligibility and enrollment data. Our analysis was limited by the data we were able to access, including:

- **Limited access to key informants.** The research team was unable to secure key informant interviews with certain stakeholders. With the transition in administration at the federal level, the team was unable to complete an interview with current CMS staff. HMA was also unable to obtain key informant interviews with DHS leadership and call center management. In addition, other Georgia based stakeholders were not available for interview in light of existing conflicts.
- **Limited access to data.** Some key data sources necessary to complete robust analyses were not available. The agencies that produce and retain eligibility and enrollment data were unable to provide certain requested details around redeterminations, including the reasons for disenrollment, demographic breakdowns, and reliable race and language data. Additionally, the ability to conduct desired analyses required coordination between state agencies to combine separately housed data elements. The shared responsibilities and silos that exist across and between DCH and DHS made it difficult to fully understand the impact of the unwinding. This limited our ability to evaluate the potential for disproportionate impact of the unwinding on specific demographic groups.
- **Inconsistent data.** DCH was a critical source of data related to redetermination outcomes and enrollment in Georgia before, during, and after the unwinding. However, we found some inconsistencies that made it impossible to ascertain a single source of accuracy—particularly related to redetermination data. For example, although CMS required reporting of ex parte renewals, in a separately published report, DCH's enrollment dashboard additionally depicted "early" ex parte renewals processed due to a SNAP and/or TANF redetermination before the designated Medicaid renewal month. Further, Georgia published two differing visualizations of their ex parte data—one depicting the early ex parte renewals occurring from June 2023 through April 2024 and the other from November 2023 through March 2024.

Georgia's Medicaid Unwinding Experience

Jointly funded by the state and federal government and administered at the state level, Medicaid provides coverage to eligible very low-income parents and low-income dependent children, pregnant women, people with disabilities, and older adults, as well as some individuals with specific health conditions. Nationally, Medicaid covers one in five people, and in Georgia, Medicaid covers just under 20% of all Georgians.[1,2] The U.S. Department of Health and Human Services declared a public health emergency, in response to the COVID-19 pandemic, effective March 11, 2020.[3] The Families First Coronavirus Response Act (FFCRA) in March of 2020 instituted several options to help states address the pandemic,[4] including a requirement for continuous Medicaid and CHIP enrollment, in exchange for enhanced federal funding. This contributed to substantial enrollment growth during the pandemic.

In Georgia, Medicaid covers:

- 2 in 5 children
- 5 in 7 nursing home residents
- 2 in 9 Medicare beneficiaries
- 3 in 10 working-age adults with disabilities
- 1 in 10 adults ages 19-64

In December 2022, Congress passed the Consolidated Appropriations Act (CAA), which resulted in the end of continuous enrollment and initiated the Medicaid PHE unwinding process. Unwinding refers to the steps each state took to roll back the flexibilities and changes it had instituted to address the PHE and return to normal, pre-pandemic operations and regulatory compliance.

CMS required states to develop and submit an unwinding plan detailing their planned approach to complete the redeterminations. CMS provided states some flexibility in how they would implement their unwinding processes. These included:

- **Number of months to complete unwinding.** States had a 14-month window to begin and complete this process. CMS recommended that states take the full 14 months to complete unwinding and most states, including Georgia, did. A few states, like Arkansas, selected a shorter timeline of eight to 11 months while several states, like Alaska and New York, elected to take more time to complete the redeterminations process.

1 Alice Burns, Elizabeth Hinton, Robin Rudowitz, and Maiss Mohamed, "10 Things to Know About Medicaid", KFF, Feb 18, 2025, https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid/#:~:text=Medicaid%20is%20the%20primary%20program,things%20to%20know%20about%20Medicaid

2 "MEDICAID IN GEORGIA" KFF, August 2024, https://www.kff.org/interactive/medicaid-state-fact-sheets/

3 The PHE officially ended May 11, 2023.

4 Additional options and flexibilities states could adopt to respond to the pandemic included: Telehealth requirement waivers; Provision of services via providers licensed out-of-state; Allowable HCBS program changes; Temporary adjustment to benefits; Prior authorization waivers.

- **When to start the unwinding process.** States could start their unwinding process as soon as March 2023, with the first disenrollments to occur April 2023. Most states started their unwinding process in April or May 2023, with the first disenrollments starting in May or June 2023, respectively. Georgia elected to start the unwinding process in May 2023.

- **How to prioritize redeterminations.** Some states prioritized redeterminations based on factors such as the likelihood of being ineligible for coverage or length of time continuously enrolled in Medicaid. This strategy was expected by states to result in a higher percentage of disenrollments earlier in the unwinding rather than being spread across the full unwinding period. This was seen as advantageous due to the expected drop in federal match funds six months into the unwinding[5] and approximately half of states elected to adopt this strategy. Georgia did not adopt this strategy.

CMS required states to submit monthly data for monitoring, including the number of redeterminations, renewals or terminations of eligibility, and whether the process was automated or manual. States also had to report metrics like call center wait times and abandonment rates. Non-compliance could lead to loss of enhanced federal funding.

How Medicaid Unwinding Unfolded in Georgia

Understanding how unwinding unfolded in Georgia requires an analysis of Medicaid growth prior to the unwinding, the loss of members' coverage during the unwinding, and the implications of the redetermination process including transitions to other coverage.

Georgia's Medicaid Growth Prior to the Unwinding

Medicaid and CHIP experienced unprecedented enrollment growth during the pandemic. Due to continuous enrollment, over the course of the PHE total enrollment nationwide grew approximately 30.5% — from 71.4 million members in February 2020 to 93.1 million members in June 2023. The greatest growth was in adult enrollment (43.0%),[6] with a substantial portion of that enrollment impacted by the five[7] states expanding Medicaid[8] coverage just before or during the PHE.

Medicaid and CHIP enrollment in Georgia grew at a rate close to the national average, approximately 30.3% — from 2.2 million members in March 2020 to 2.9 million members in June 2023.[9] By comparison, before the pandemic Georgia Medicaid and CHIP enrollment grew less than 3.8% from June 2017 through February 2020.[5] See **Exhibit 1**.

5 CMS. SHO#23-002. RE: RE: Medicaid Continuous Enrollment Condition Changes, Conditions for Receiving the FFCRA Temporary FMAP Increase, Reporting Requirements, and Enforcement Provisions in the Consolidated Appropriations Act, 2023. Published 1/27/2023. https://www.medicaid.gov/federal-policy-guidance/downloads/sho23002.pdf

6 Source: Data.Medicaid.gov. State Medicaid and CHIP Applications, Eligibility Determinations, and Enrollment Data. https://data.medicaid.gov/dataset/6165f45b-ca93-5bb5-9d06-db29c692a360?conditions%5b0%5d%5bproperty%5d=reporting_period&conditions%5b0%5d%5bvalue%5d=202002&conditions %5b0%5d%5boperator%5d=%3D&conditions%5b1%5d%5bproperty%5d=preliminary_or_updated&conditions%5b1%5d%5bvalue%5d=U&conditions%5b1%5d%5boperator%5d=%3D. Retrieved 2/26/2025. Child enrollment grew 17.8%. Total Medicaid and CHIP enrollment grew 30.5%.

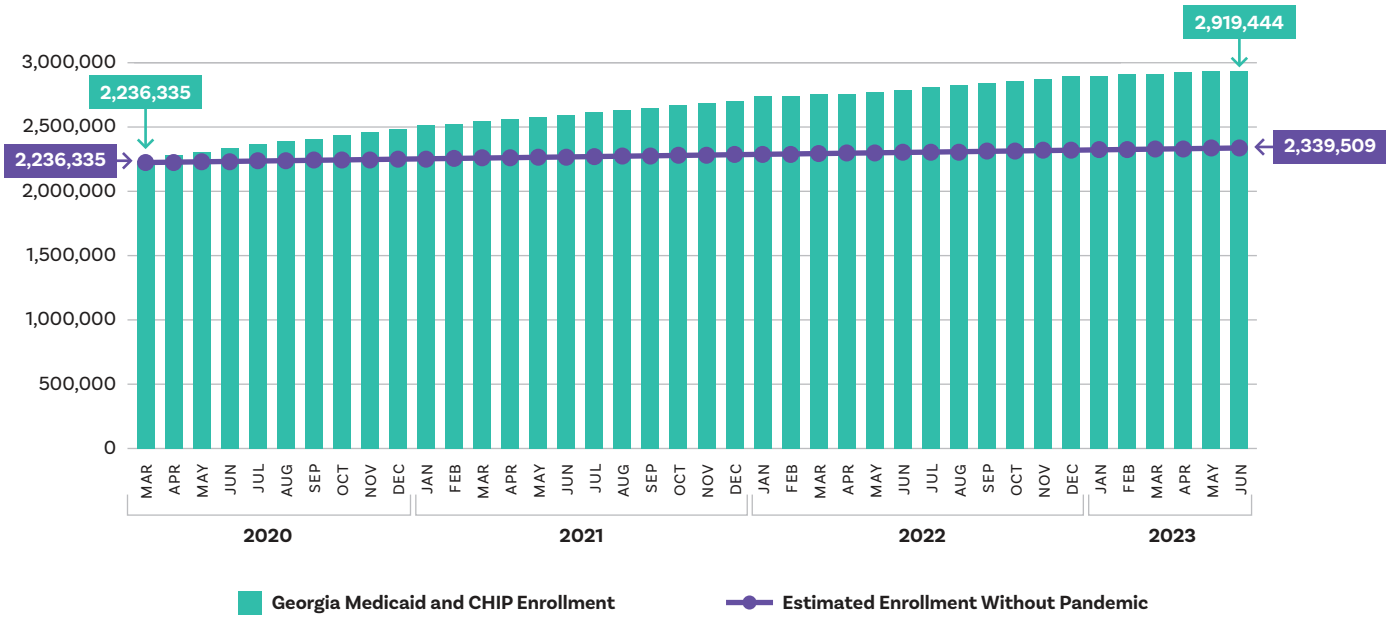
7 Idaho and Utah (1/1/2020); Nebraska (10/1/2020); Oklahoma and Missouri (7/1/2021); South Dakota (7/1/2023); North Carolina (12/1/2023)

8 Medicaid Expansion became available under the Affordable Care Act, passed in 2010. A Supreme Court decision in 2012 made Medicaid Expansion optional for states to expand coverage to non-disabled adults with income up to 138% Federal Poverty Level (FPL). While many states adopted Medicaid Expansion when it first became available in 2014, other states have gradually adopted the policy, including during the pandemic. The combination of expansion and economic conditions making more individuals eligible for Medicaid accelerated Medicaid enrollment in those late-adopting states. As of March 2025, ten states (including Georgia) have declined adopting Medicaid expansion.

9 Sources: OAPI Enrollment Data. March 2020-December 2024 monthly data. Provided March 25, 2025. CMS. State Medicaid and CHIP Applications, Eligibility Determinations, and Enrollment Data, updated March 28, 2025. https://data.medicaid.gov/dataset/6165f45b-ca93-5bb5-9d06-db29c692a360. Accessed April 24, 2025. Estimated enrollment based on average monthly enrollment change June 2017 through Feb 2020 (0.12%).

EXHIBIT 1.

GEORGIA'S MEDICAID AND CHIP ENROLLMENT GROWTH DURING THE COVID-19 PUBLIC HEALTH EMERGENCY



Sources: DCH. Members by CMO and Aid Category, 2020-2025. Open Records Request. Received March 25, 2025, CMS. State Medicaid and CHIP Applications, Eligibility Determinations, and Enrollment Data, updated March 28, 2025. https://data.medicaid.gov/dataset/6165f45b-ca93-5bb5-9d06-db29c692a360. Accessed April 24, 2025.

Medicaid and CHIP populations in Georgia that saw the greatest enrollment growth during the pandemic are illustrated in **Exhibit 2**.

EXHIBIT 2.

GEORGIA POPULATIONS WITH GREATEST PHE MEDICAID AND CHIP ENROLLMENT GROWTH

Age	Adults aged 19-44, followed by teens age 13-18
Gender	Females
Race	Individuals who identified as Caucasian or Black had the greatest **numbers** of enrollment growth. Individuals who identified as Other or did not specify race had the greatest **rates** of enrollment growth.
Service System	CMO Members
Eligibility Category	Individuals in the Low-Income Medicaid group (parents and their children)
Counties	Paulding, Long, Henry, Effingham, and Forsyth counties had the greatest **rates** of enrollment growth. Gwinnett, Fulton, DeKalb, Cobb, and Clayton counties had the greatest **numbers** of enrollment growth.

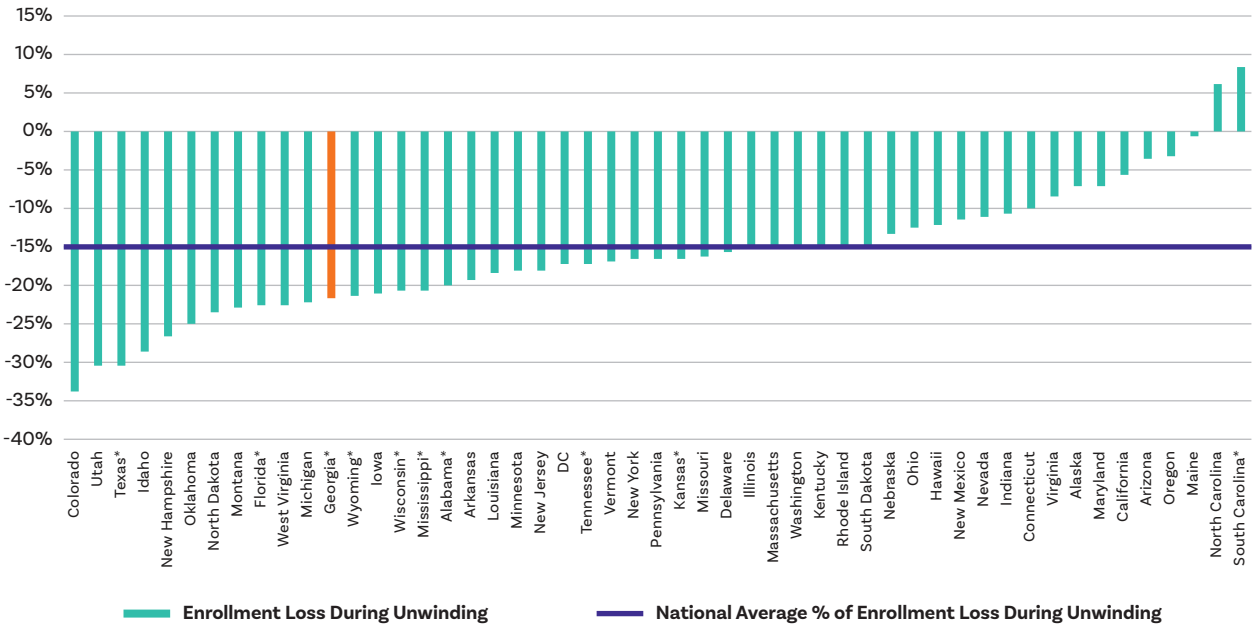
Source: OAPI Enrollment Data. March 2020-December 2024 monthly data. Provided March 25, 2025.

Georgia's Medicaid Losses During the Unwinding

To determine the impact of unwinding on member enrollment, we examined the changes in enrollment by state, by eligibility group, by delivery system, and by characteristics such as age and race. Georgia had the 12th highest rate of enrollment decrease over the course of the Medicaid unwinding (-21.8% from beginning to end)[10] as compared to an average decrease of 14.8% nationally, as presented in **Exhibit 3**.

EXHIBIT 3.

NATIONAL MEDICAID ENROLLMENT CHANGES FROM BEGINNING TO END OF UNWINDING, BY STATE



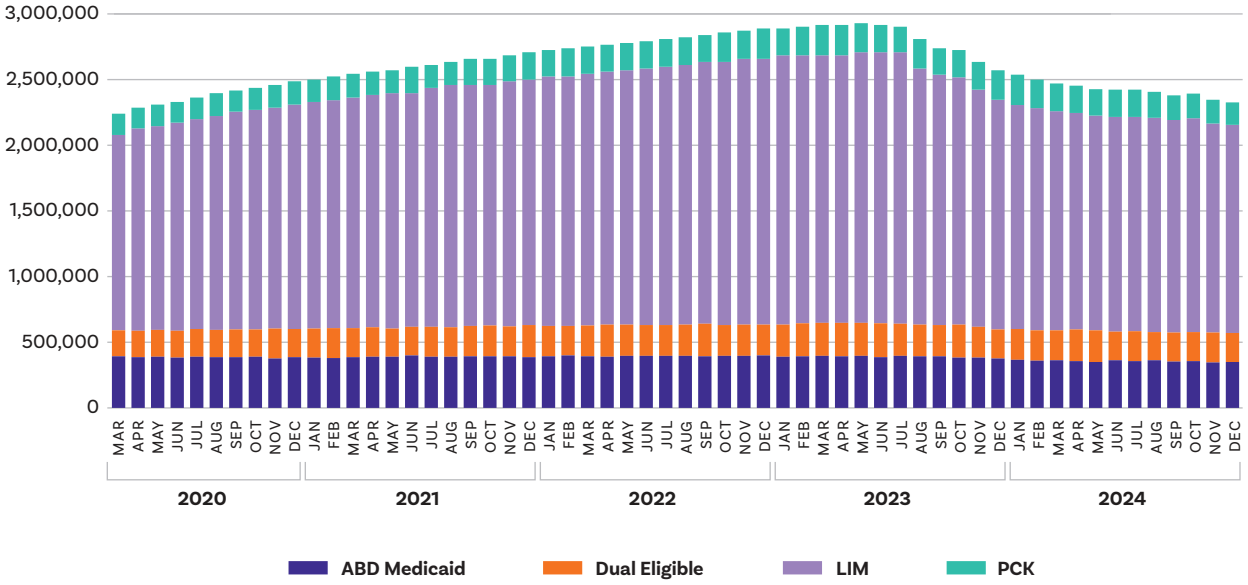
Source: CMS Monthly Unwinding Reports; Individual state monthly enrollment reports. Gathered March 2023 through December 2024. Note: States with * indicate non-Expansion states. South Carolina, one of the ten remaining non-Expansion states as of December 2024, changed its Medicaid and CHIP enrollment reporting during the unwinding, giving the appearance of enrollment growth. While we do not believe this reflects actual enrollment growth, we do not have another reliable data source to counter it. Alaska, DC, and New York were still completing their unwinding processes as of December 2024, so the final national average enrollment decrease and enrollment changes for these states are subject to change.

Within Georgia, eligibility groups are classified as: Aged, Blind, and Disabled (ABD), Low Income Medicaid (LIM), PCK, and Dual Eligible. Out of these four eligibility groups, the ABD group, which generally remains relatively stable, experienced a surprising enrollment decrease and a net enrollment loss since March 2020. Georgia's ABD population experienced only a modest 1.4% enrollment increase during the PHE and has ultimately lost 10.9% of its pre-pandemic enrollment (see **Exhibit 4**). Part of the decline may be related to anecdotal reports that there were issues with the ABD renewal process and timely delivery of notices, resulting in inappropriate denials across all ABD age groups during the PHE, the unwinding, and post-unwinding.

10 CMS Monthly Enrollment Data

EXHIBIT 4.

MEDICAID ENROLLMENT BY ELIGIBILITY GROUP IN GEORGIA



Sources: Department of Community Health open records request. Received 3/21/2025; CMS. State Medicaid and CHIP Applications, Eligibility Determinations, and Enrollment Data, updated March 28, 2025. https://data.medicaid.gov/dataset/6165f45b-ca93-5bb5-9d06-db29c692a360. Accessed April 24, 2025. Estimated enrollment based on average monthly enrollment change June 2017 through Feb 2020 (0.12%) assumes ongoing growth.

The other three eligibility categories had substantially higher enrollment increases over the PHE, and Georgia's Dual Eligible and PCK eligibility groups retained much of that enrollment growth as of the end of December 2024. As expected, the LIM group, comprised primarily of parents/caretakers and children, experienced the largest enrollment decrease during the unwinding but remains larger than it was pre-pandemic.

Analysis also included a review of enrollment impacts by delivery systems. **Exhibit 5** illustrates the different characteristics of the populations served through Managed Care and Fee-for-Service in Georgia.

EXHIBIT 5.

CHARACTERISTICS BY DELIVERY TYPE

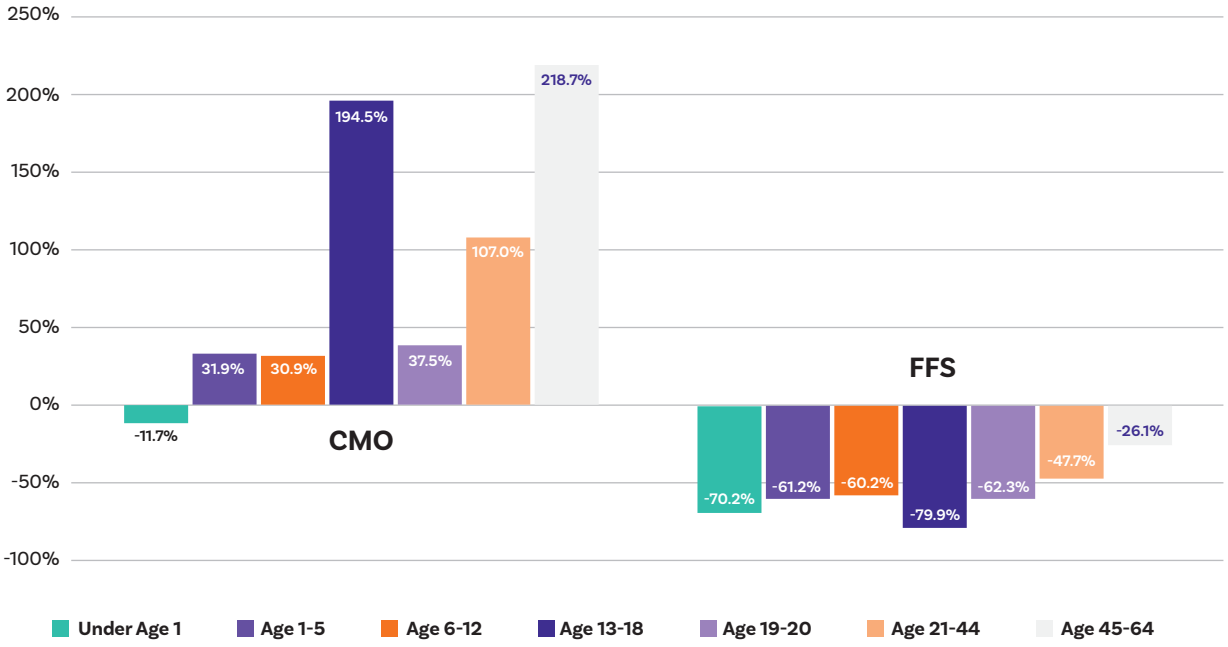
	Managed Care	Fee- for-Service
Health Status	Non-disabled	Disabled or Elderly
Population	Children (including foster care) and Adults	Mostly Adults
Eligibility	MAGI (no asset limits)	Non-MAGI (asset limits)
Common Eligibility Category	LIM and PCK	ABD

Please see glossary of terms for definitions.

Georgia, like many states, relies heavily on managed care plans (referred to as CMOs in Georgia) to coordinate care for generally healthy populations, including pregnant women, parents and caregivers, and children. During the pandemic, enrollment grew for both managed care and fee-for-service populations. As the unwinding started, individuals in managed care lost coverage as expected, while enrollment of individuals in fee-for-service continued to increase by 3.6% for the first four months of the unwinding and declined during the remainder of the unwinding period. Managed Care enrollment remained higher than pre-pandemic; however, fee-for-service enrollment was lower than before the pandemic. See **Exhibit 6** below.

EXHIBIT 6.

PERCENT CHANGE IN GEORGIA MEDICAID ENROLLMENT: CMO VS. FFS BY AGE, FEBRUARY 2020 THROUGH DECEMBER 2024



Source: Department of Community Health open records request. Received 2/7/2025.

Despite substantial enrollment losses throughout the unwinding, enrollment in managed care remained higher in December 2024 than pre-pandemic—a 7.7% net increase. This may be due to multiple factors, including CMO supplemental efforts such as independent marketing, outreach, and collaboration efforts to retain members.

The HMA project team strove to analyze the impact of the unwinding by race and ethnicity based on available data. It is important to note, however, that race is an optional reported field; it therefore serves as more of an indicator rather than a reliable data source. In addition, both the willingness of members to opt into answering this question, as well as how they choose to answer it, may change over time as social and political contexts shift.

Based on the data analyzed, all groups (Black, White, Asian, and Latino/Hispanic) decreased in enrollment during the unwinding. Latinos/Hispanics also experienced enrollment losses during the PHE continuous coverage period prior to the unwinding—a time of otherwise unprecedented growth in enrollment. As part of our analysis, we asked key informants about this curious and counter-intuitive trend. They made

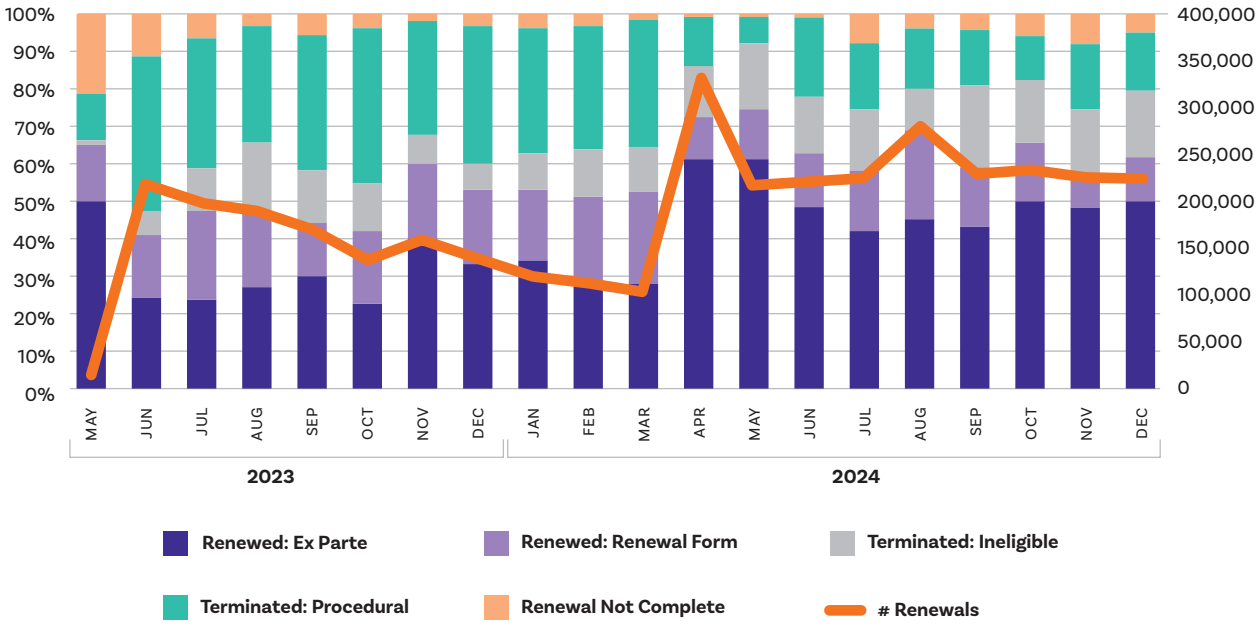
reference to the 2019 Federal Public Charge rule,[11] which allowed officials to consider the use of previously excluded programs, such as Medicaid and CHIP, when determining changes in immigration statuses. The rule was withdrawn in March 2021, but may have had a chilling effect on program enrollment, particularly among Latino/Hispanic people living in mixed immigration status households, even if their children were US citizens. Key informant interviews conducted with those working directly with members indicated it was common during this period for Latino/Hispanic families to request voluntary disenrollment based upon advice from immigration attorneys instructing them to do so due to the change in Public Charge rule.

Georgia's Redetermination Data & Implications

Georgia reported metrics to CMS monthly as required, displayed in **Exhibit 7**. These metrics highlighted the number of Medicaid and CHIP members due for redetermination in a given month, along with their redetermination outcome (coverage renewed, coverage terminated, or still pending). These data also provide insights on whether the renewal or termination occurred automatically or as a result of the member responding to the renewal notice.

EXHIBIT 7.

GEORGIA REDETERMINATION OUTCOMES BY MONTH



Source for May 2023-April 2024 data: DCH. Current Period-Point in Time. Accessed 3/27/2025. https://app.powerbigov.us/view?r=eyJrIjoiNGY3ZGM4NTQtZDE5MS00ZDk5LTk1YzgtYTgyZGQ2ZjdlOTRjIiwidCI6IjUxMmRhMTBkLTA3MWItNGI5NC04YWJjLTllYzQwNDRkMTUxNiJ9&pageName=ReportSectionc446ca21b7983d474637 .Source for May-July 2024 data: Data.Medicaid.gov. State Medicaid and CHIP Eligibility Processing Data. Last Updated January 15, 2025. Accessed January 31, 2025. https://data.medicaid.gov/dataset/5abea2e0-3f8e-4b49-a50d-d63d5fd9103c .Source for August 2024-December 2024 data: DCH. Open records request for August-December 2024 reports. Received 3/26/2025.Note: Starting in April 2024, Georgia started processing "normal" annual redeterminations, in addition to the redeterminations specific to the unwinding process.

11 Source: Federal Register. Inadmissibility on Public Charge Grounds. Published by Homeland Security Department on 8/14/2019 https://www.federalregister.gov/documents/2019/08/14/2019-17142/inadmissibility-on-public-charge-grounds. Retrieved 3/12/2025.

The data demonstrate that successful member renewals, whether through the ex parte process or through the submission of a renewal form, increased slightly from the first half to the second half of the unwinding, with a noticeable increase in successful renewals following the end of the unwinding. Correspondingly, Georgia's termination rates decreased, resulting in substantially lower procedural termination rates and higher ineligibility determination rates following the end of the unwinding. **Exhibit 8** below provides an example to further highlight this observation.

EXHIBIT 8.

COMPARISON OF GEORGIA RENEWAL RATES FROM AUGUST 2023 TO AUGUST 2024

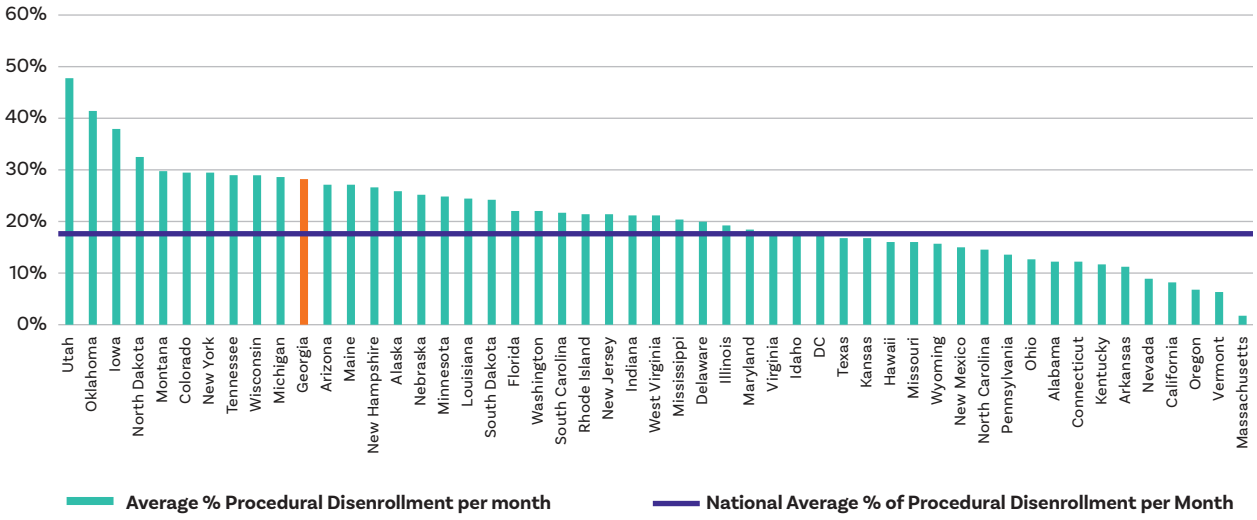
		August 2023 (Unwinding Month)	August 2024 (Post-Unwinding Month)
Successful Renewals	Ex parte Renewal	27.6%	45.2%
	Renewal Form	19.6%	22.1%
	Total Renewals	**47.2%**	**67.3%**
Terminations	Procedural Termination	30.9%	16.1%
	Ineligibility Determination	18.8%	12.8%
	Total Terminations	**49.7%**	**28.9%**
Pending Decision	**Total Eligibility Decisions Pending (not completed) for Reporting Period**	**3.1%**	**3.8%**
Total	**Total Redeterminations in Reporting Period**	**100%**	**100%**

Source for August 2023 data: DCH. Current Period-Point in Time. Accessed 3/27/2025. https://app.powerbigov.us/view?r=eyJrIjoiNGY3ZGM4NTQtZDE5MS00ZDk5LTk1YzgtYTgyZGQ2ZjdlOTRjIiwidCI6IjUxMmRhMTBkLTA3MWItNGI5NC04YWJjLTllYzQwNDRkMTUxNiJ9&pageName=ReportSectionc446ca21b7983d474637. Source for August 2024 data: DCH. Open records request for August-December 2024 reports. Received 3/26/2025. Note: Starting in April 2024, Georgia started processing "normal" annual redeterminations, in addition to the redeterminations specific to the unwinding process.

Georgia's average monthly procedural disenrollment rates (28.1%) were higher than the national monthly average (17.6%). Georgia had the 11th highest procedural termination rates (following UT, OK, ID, NV, MT, CO, ND, TN, WV, and MI), as illustrated in **Exhibit 9**.

EXHIBIT 9.

AVERAGE PROCEDURAL TERMINATIONS PER MONTH BY STATE

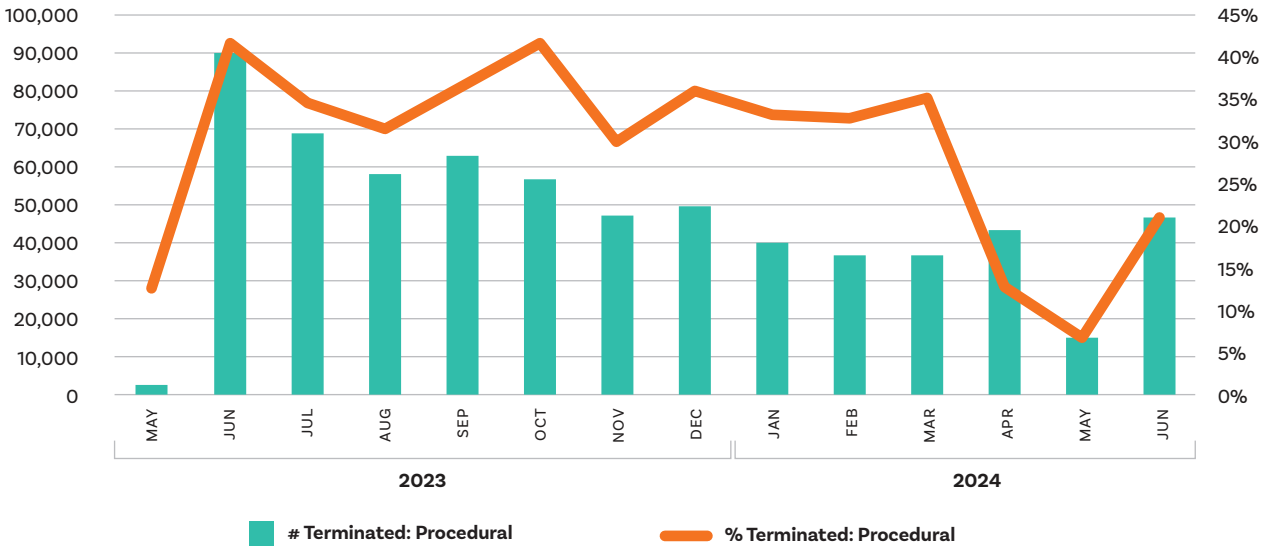


Source: Data.Medicaid.gov. State Medicaid and CHIP Eligibility Processing Data. Last Updated January 15, 2025. Accessed January 31, 2025. https://data.medicaid.gov/dataset/5abea2e0-3f8e-4b49-a50d-d63d5fd9103c

Generally, Georgia saw a gradual decrease in the number of procedural terminations during the unwinding from June 2023 through May 2024, with a particularly stark drop in the rate from March 2024 to May 2024, as demonstrated in **Exhibit 10**.

EXHIBIT 10.

AVERAGE PERCENTAGE OF PROCEDURAL TERMINATIONS PER MONTH IN GEORGIA



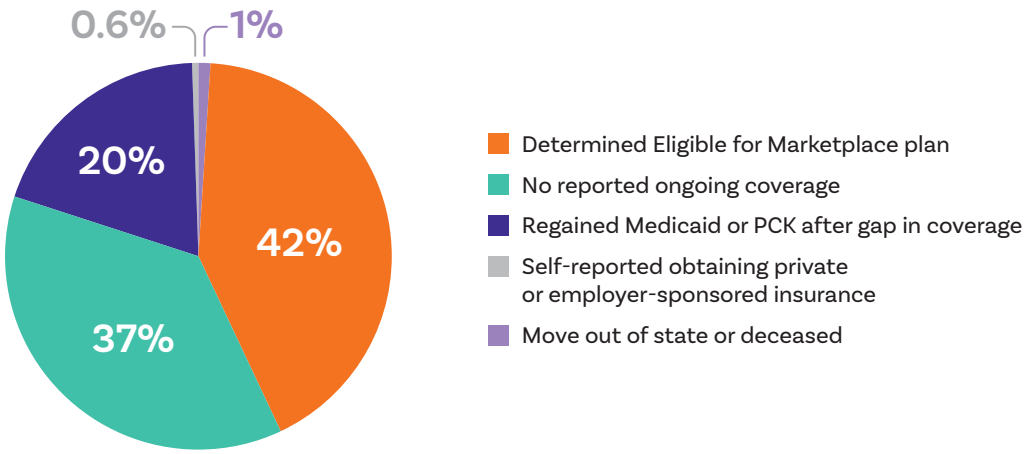
Source: Data.Medicaid.gov. State Medicaid and CHIP Eligibility Processing Data. Last Updated January 15, 2025. Accessed January 31, 2025. https://data.medicaid.gov/dataset/5abea2e0-3f8e-4b49-a50d-d63d5fd9103c

Georgians' Transitions from Medicaid/CHIP to Other Coverage

During the course of the unwinding, some members transitioned from Medicaid/CHIP to other forms of coverage. This shift was the result of various factors, including changes in eligibility and the unwinding of PHE-related policies. As depicted in **Exhibit 11**, according to DCH,[12] of the 838,874 individuals found ineligible during the unwinding, a substantial portion were determined eligible for Marketplace plans, but no additional information around coverage status was known for over a third of the individuals found ineligible.

EXHIBIT 11.

COVERAGE OUTCOMES FOR THOSE FOUND INELIGIBLE DURING THE UNWINDING REDETERMINATION PROCESS

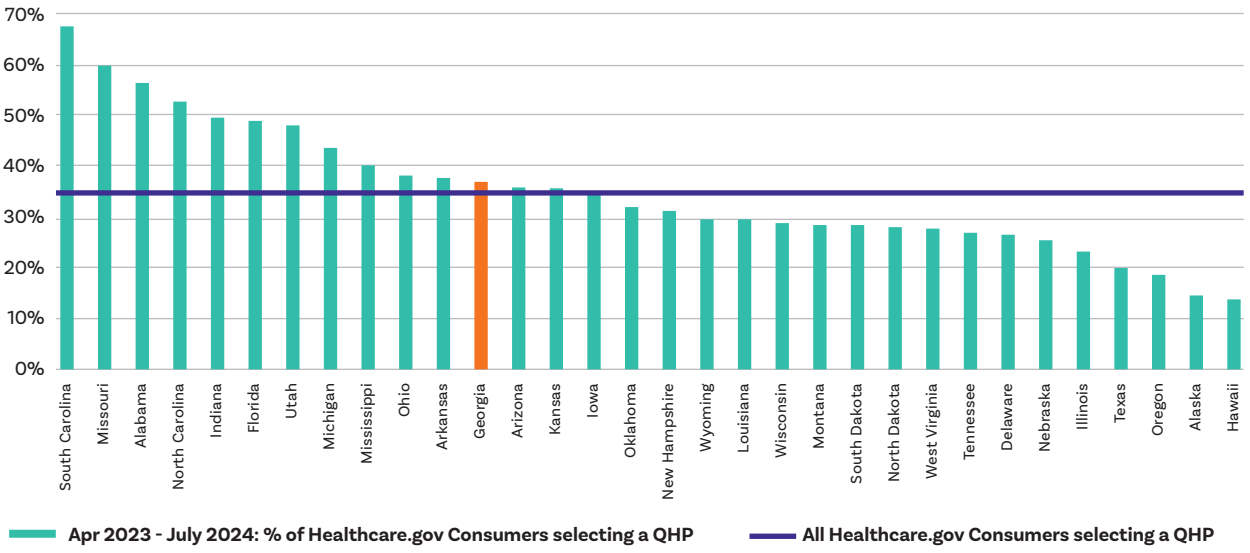


During the unwinding, Georgia utilized the federal Marketplace platform known as Healthcare.gov. As such, transitions from Medicaid to the Marketplace were reported using Healthcare.gov. In general, the proportion of individuals transitioning and selecting a plan was higher in federal Marketplace states than in states with a state-based Marketplace (SBM). The rate of individuals completing the process in Georgia was just above average compared to other federal Marketplace states (see **Exhibit 12**).

12 Source: Georgia Department of Community Health. DCH Releases Cumulative Medicaid Redetermination Data for Unwinding-to-Date. https://dch.georgia.gov/document/document/final-cumulative-medicaid-redetermination-press-release-12624/download. Press release December 6, 2024.

EXHIBIT 12.

TRANSITION FROM MEDICAID AND CHIP TO MARKETPLACE—FEDERAL MARKETPLACE STATES



Source: Data.Medicaid.gov. Healthcare.gov Transitions Marketplace Medicaid Unwinding Report. Updated December 27, 2024. https://data.medicaid.gov/dataset/5636a78c-fe18-4229-aee1-e40fa910a8a0. Retrieved 3/12/2025.

Although there are no data to verify why certain states like Georgia had a higher uptake of Marketplace coverage compared to other states, there are several points of consideration:

- **Lack of Medicaid expansion.** Most of the states with the highest rates of individuals selecting coverage on the federal Marketplace, including Georgia, were those that have not expanded their Medicaid programs. For those losing Medicaid or CHIP coverage without employer-provided options, the Marketplace provided the only viable option for affordable coverage.
- **Enhanced premium tax credits.** Individuals purchasing plans on the Marketplace could apply for enhanced premium subsidies. Individuals with 100-150% FPL income could purchase coverage for $0 per month. DCH estimates that 64% of individuals, or around 970,000 Georgians in the Marketplace, have one of these $0 plans.[13] *
- **Increased awareness about the Marketplace.** Georgia first launched a public awareness campaign for Georgia Access in the fall of 2023 including local outreach and awareness efforts around the unwinding.
- **Inherent incentives for CMO facilitation.** As all three CMOs offer qualified health plans on the Marketplace, there was motivation for the CMOs to further facilitate a transition to the Marketplace for individuals losing Medicaid or CHIP coverage.

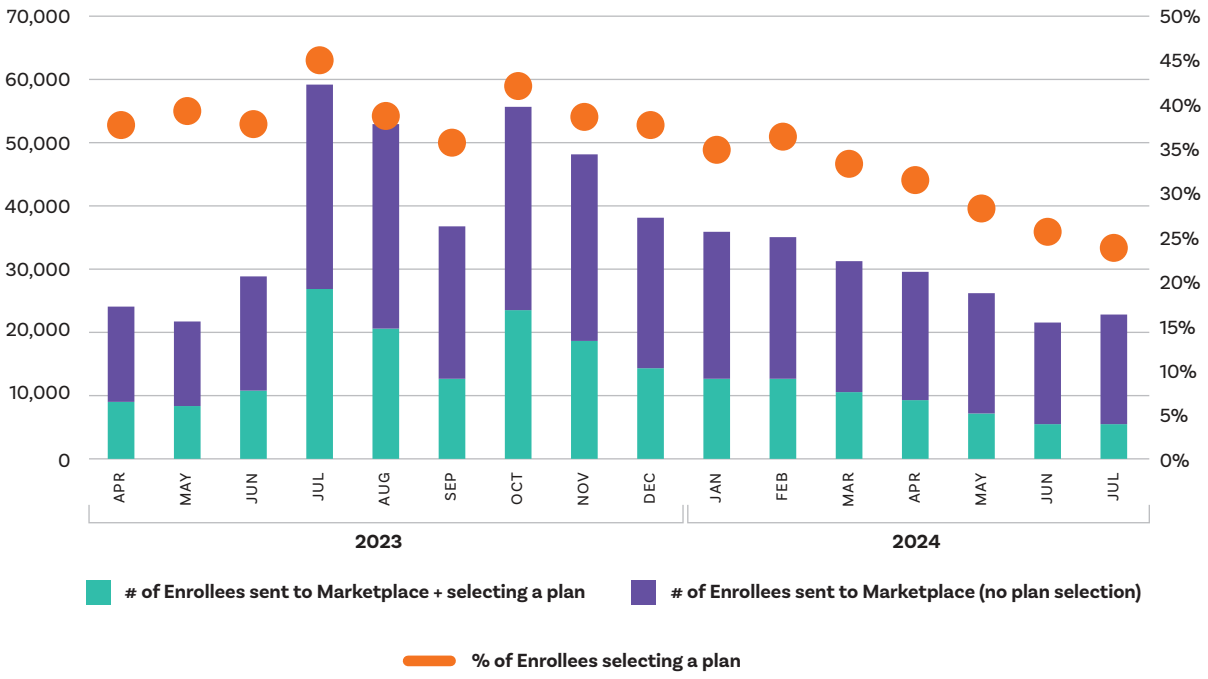
13 Sources: Department of Community Health. Georgia Uninsured and Marketplace Population Data, August 2024. https://dch.georgia.gov/document/document/georgia-uninsured-and-marketplace-data-august-2024-002/download Accessed 4/24/2025; CMS.gov. Marketplace 2025 Open Enrollment Period Report: National Snapshot. January 17, 2025. https://www.cms.gov/newsroom/fact-sheets/marketplace-2025-open-enrollment-period-report-national-snapshot-2. Retrieved 4/24/2025.

* Enhanced premium tax credits are scheduled to expire at the end of 2025 unless Congress extends them. This expiration would result in premium increases for most Marketplace enrollees.

From April 2023 through July 2024, nearly 570,000 of the 940,000 people terminated from Medicaid coverage (~60%) had their account transferred to the federal Marketplace or accessed Healthcare.gov on their own. Of those, nearly 210,000 people completed an application, were approved, and selected a qualified health plan (QHP) (see **Exhibit 13**).

EXHIBIT 13.

TRANSITIONS FROM MEDICAID TO MARKETPLACE IN GEORGIA



Source: Data.Medicaid.gov. Healthcare.gov Transitions Marketplace Medicaid Unwinding Report. Updated December 27, 2024. https://data.medicaid.gov/dataset/5636a78c-fe18-4229-aee1-e40fa910a8a0. Retrieved 3/12/2025 and 4/10/2025.

The volume of individuals in Georgia moving to the Marketplace and selecting a QHP was highest in July 2023. The volume of case transfers to the Marketplace with a QHP selection remained relatively high through the fall of 2023, coinciding with marketing efforts around Georgia's new SBM. However, starting in December 2023, the average rate of Marketplace transfers with a QHP enrollment decreased significantly through the remainder of the unwinding. This suggests that although these former Medicaid or CHIP members may have been eligible for Marketplace coverage through the special enrollment period, the messaging around the limited open enrollment period for the Marketplace may have been a deterrent to SBM enrollment.

Discussion

Analyzing data related to the Medicaid unwinding in Georgia illuminated several critical themes and findings. These findings highlight the unique and unprecedented nature of the unwinding, the varied effects on members and service delivery systems, as well as the challenges faced in processing redeterminations. In addition, the findings reflect a notable lack of a systematic method for tracking

members who became uninsured. Understanding these aspects is essential for comprehending the full impact of Medicaid unwinding in Georgia. A high-level summary of these findings include:

- **Unprecedented Medicaid and CHIP enrollment growth.** Enrollment growth during the PHE contributed to unprecedented Medicaid and CHIP enrollment loss during the unwinding.
- **Enrollment trends followed anticipated patterns.** Trends typically followed expected patterns, including the small net increase in the number of members enrolled in Medicaid or CHIP after the unwinding, greater retention rates among managed care enrollees, women, and children, and consistent enrollment trends across regions.
- **Improvements in the final months of unwinding.** In the final months of the unwinding, Georgia demonstrated several CMS-promoted indicators of improvement, including an increase in automated renewals, an increase in the rate of individuals completing the redetermination process, and a decrease in terminations for individuals who did not complete the redetermination process.
- **Race is difficult to measure.** Race, an historically difficult measure to capture, particularly when reporting is optional, is likely becoming a more inconclusive measure as more individuals report "other" or do not report—particularly for children.
- **Information on transitions to other forms of coverage is limited.** Limited data around transitions to other forms of coverage mean rough estimates around impact to rates of uninsured or commercial insurance market.

Several factors and variables make it difficult to fully understand the impact of the unwinding in Georgia, including:

- **Patterns in enrollment changes are difficult to analyze.** The significant growth in enrollment during the PHE followed by evolving federal guidance and state policy decisions during the unwinding created disenrollment patterns that were difficult to explain.
- **Varied enrollment trends.** While some trends followed expected patterns, such as higher retention rates among managed care enrollees, women, and children, and consistent trends across regions, these patterns leave room for ambiguity in understanding the overall impact.
- **Improvement indicators.** Georgia showed improvement in several CMS-promoted indicators, like increased automated renewals and higher completion rates of the redetermination process. However, these improvements do not provide a complete picture of the overall effectiveness and outcomes of the unwinding process.
- **Inconclusive race data.** The increasing number of individuals, especially children, reporting "other" or not reporting their race has made it challenging to analyze demographic impacts accurately.
- **Limited coverage transition data.** The lack of detailed data on transitions to other forms of coverage means that estimates on the impact on uninsured rates or the commercial insurance market are rough and incomplete.

Fundamental Components to Support Medicaid & CHIP Eligibility and Enrollment

Georgia was one of the six states identified prior to the start of the unwinding as having a "red flag" for all five factors that Georgetown University Center for Children and Families (CCF) identified that are known to impact enrollment outcomes for children, including:[14]

1. The lack of continuous eligibility
2. An ex parte rate under 50%
3. Having separate Medicaid and CHIP programs
4. Charging premiums or enrollment fees requiring some families to pay to transition to a CHIP program
5. Charging premiums or enrollment fees for individuals below 200% FPL

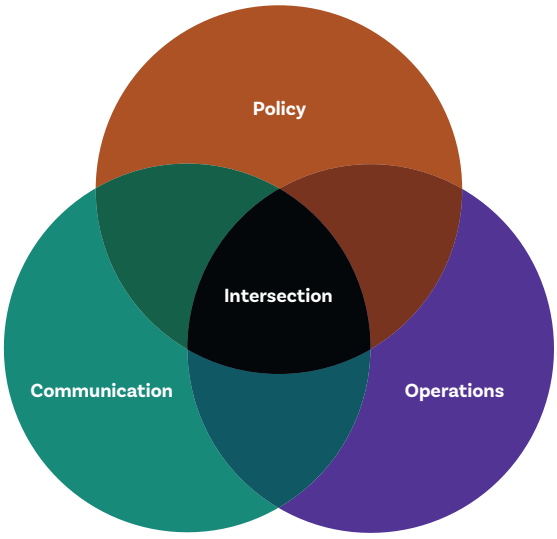
These red flag factors are examples of policy choices and operational practices that are intrinsic to a state's eligibility and enrollment (E&E) performance and outcomes.

To better understand the results of Georgia's unwinding, the HMA team used their knowledge of fundamental E&E processes to examine what happened before and during the unwinding period with policy, communications, and operations—the three fundamental components necessary to effectively administer Medicaid eligibility and enrollment.[15]

Understanding these core components and how they interact is foundational to ensuring successful operations. Decisions from each component are interconnected and mutually dependent as depicted in **Exhibit 14**. Impacts from decisions will have a ripple effect across all three components, and through the entire system. For example, a policy decision made in isolation of timely and accurate communication and operational readiness can result in confusion, misinformation, and administrative burden.

EXHIBIT 14.

FUNDAMENTAL COMPONENTS OF ELIGIBILITY AND ENROLLMENT



In addition to the red flag characteristics already present in the system prior to the unwinding, Georgia's unwinding outcomes were influenced by decisions and approaches in each of these three fundamental components. The following subsections provide insight into the actions of the state, what actually occurred, the challenges encountered, and a discussion of related promising practices and considerations for the state in each of these fundamental areas of **policy**, **communications**, and **operations**.

14 Tricia Brooks, What Can States Do to Reduce Risk of Children Unfairly Losing Health Insurance, Center for Children and Families (CCF), February 22, 2022, https://ccf.georgetown.edu/2022/02/22/what-can-states-do-to-reduce-risk-of-children-unfairly-losing-health-insurance/

15 Note: These components align well with the four unwinding categories Georgia's Department of Audit and Accounts used in their September 2022 Medicaid Unwinding report. Greg S. Griffin and Lisa Kieffer, Medicaid Unwinding Status of State Efforts to Prepare for the End of Continuous Coverage, Georgia Departments of Audits and Accounts (DOAA), September 22, 2024

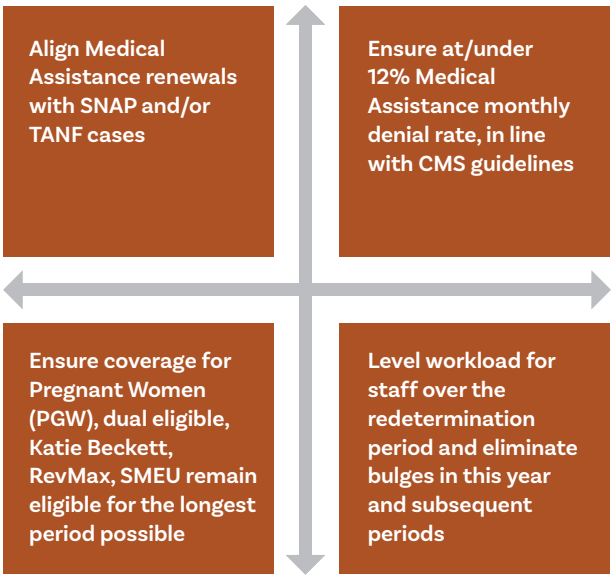
Policy

As a joint state and federal program, Medicaid policy decisions play a key role in shaping operations. Policy decisions made during the PHE had widespread effects, including affecting how well the system could return to normal following the end of continuous enrollment. In preparation for the PHE unwinding, following guidance from CMS, states were required to select one of four risk-based approaches for their redetermination strategy. States also had the option to create a state specific approach.

Unlike other states which opted to prioritize a population and/or time based approach, Georgia elected to create a state developed approach that staggered redeterminations over multiple months while targeting four specific metrics[16] as also depicted in **Exhibit 15**: the alignment of Medicaid and CHIP renewals with SNAP and/or TANF cases; ensuring a denial rate at or below 12% to comply with CMS guidance; ensuring coverage for special populations such as pregnant women and dual eligibles; and the elimination of "bulges" in staff workload.

EXHIBIT 15.

GEORGIA'S REDETERMINATION APPROACH



Source: DHS and DCH. Plan for Medicaid Redetermination. February 2023. Katie Beckett, RevMax, and SMEU refer to Medicaid eligibility groups and/or eligibility determination entities.

Georgia had to make several policy decisions, both related and unrelated to the PHE, while simultaneously returning to regular operations. Some of these decisions helped during the unwinding process. Others, such as the development and deployment of Georgia Pathways and the planned transition to an SBE,[17] which were intended to alleviate gaps in coverage for some members, created competing priorities due to the impact on operations and technology systems. Examples of policy decision options include:

- The decision to continue or pause the annual renewal processes to maintain eligibility operations or refocus priorities to manage resources during the PHE.
- The selection of 1902(e)(14)(A) waivers granting state flexibilities.

16 Georgia DHS and DCH. Plan for Medicaid Redetermination. February 2023. https://dhs.georgia.gov/media/19256/download. Katie Beckett, RevMax, and SMEU refer to Medicaid eligibility groups and/or eligibility determination entities.

17 Georgia Governor's Office of Planning and Budget Medicaid Unwinding Plan Assessment Final Report, April 10, 2023, Prepared by Alvarez & Marsal Public Sector Services, LLC

- The choice of data sets used for electronic verification of eligibility during the ex parte renewal process (e.g., not leveraging a robust combination of income data sources such as federal or state tax data, quarterly state wage data, case data known to the state, and commercial data sets like The Work Number, can limit a state's ex parte success rate).
- The implementation of enrollment policies, such as 12-month continuous enrollment for children and post-partum women, to reduce churn.[18]

Actions Undertaken

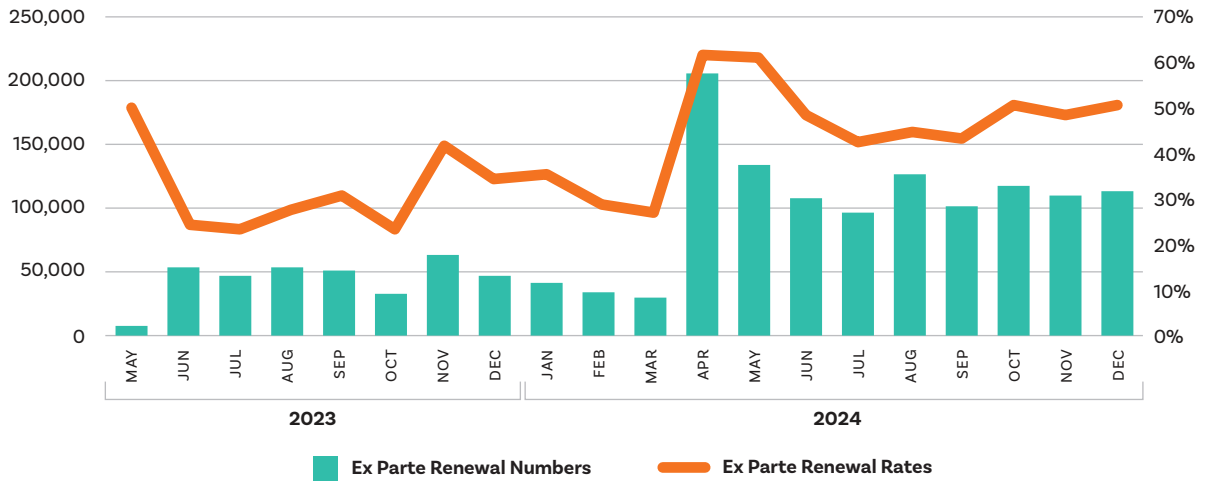
The federal government offered the use of several waivers to streamline the unwinding process. These waivers were intended to increase automatic renewals, reduce administrative burdens, and prevent loss of coverage due to procedural issues. Georgia obtained approval from CMS for seven federal waivers, which was seen as a success by stakeholders. States could also pause annual renewals under the continuous enrollment provision. In March 2020, Georgia was one of the states that suspended renewals during the PHE period. This policy decision initially relieved an administrative burden. However, it also resulted in members going years without completing renewals or receiving notifications and eligibility workers not processing redeterminations, key factors impacting member communications and operations.

What Occurred and Challenges Encountered

In May 2023, Georgia's unwinding process started slowly with fewer redeterminations than other states, leading to high renewal rates and low termination rates (see **Exhibit 16**). When the total of renewals processed increased in June 2023, automated renewal rates decreased, and termination rates increased.

EXHIBIT 16.

EX PARTE RENEWALS IN GEORGIA, BY MONTH



Source for May 2023-April 2024 data: DCH. Current Period-Point in Time. Accessed 3/27/2025. https://app.powerbigov.us/view?r=eyJrIjoiNGY3ZGM4NTQtZDE5MS00ZDk5LTk1YzgtYTgyZGQ2ZjdlOTRjIiwidCI6IjUxMmRhMTBkLTA3MWItNGI5NC04YWJjLTllYzQwNDRkMTUxNiJ9&pageName=ReportSectionc446ca21b7983d474637 .Source for May-July 2024 data: Data.Medicaid.gov. State Medicaid and CHIP Eligibility Processing Data. Last Updated January 15, 2025. Accessed January 31, 2025. https://data.medicaid.gov/dataset/5abea2e0-3f8e-4b49-a50d-d63d5fd9103c. Source for August 2024-December 2024 data: DCH. Open records request for August-December 2024 reports. Received 3/26/2025.

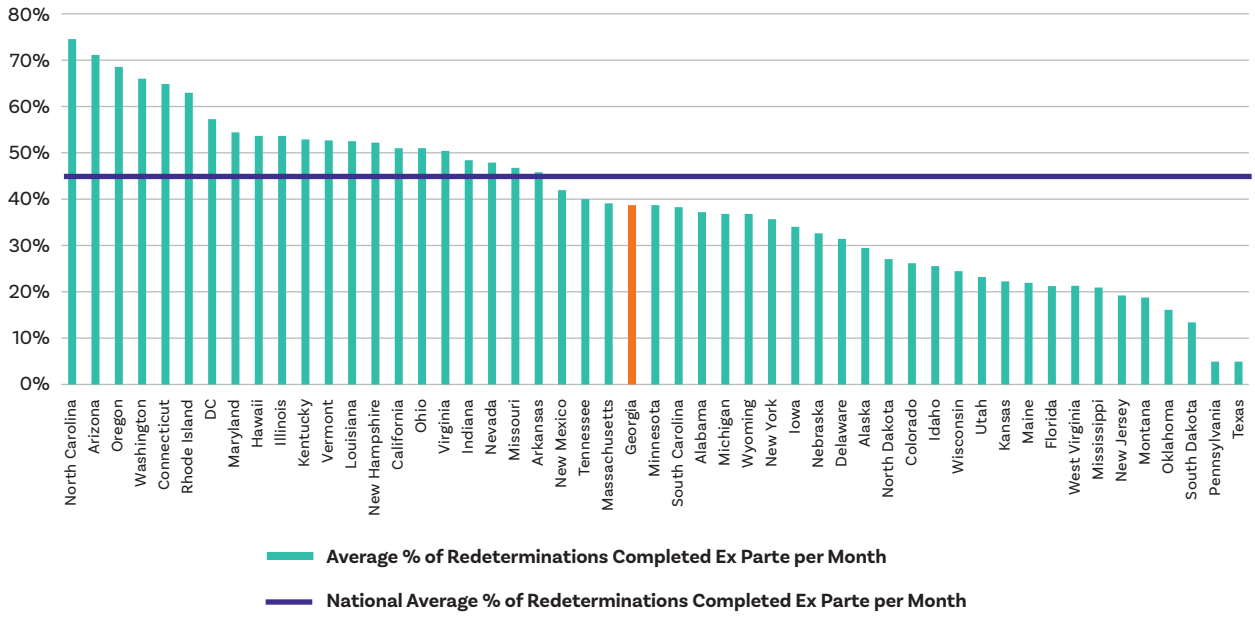
18 Georgia implemented this provision in January in 2024, midway through the unwinding.

Challenges with the limited use of data sources for ex parte renewals were apparent over the course of the unwinding. Despite making several improvements to the ex parte process, including increased use of SNAP and TANF data which led to a 55% increase in the percentage of ex parte renewals as a portion of all redeterminations from June 2023 to April 2024, Georgia still fell below the national ex parte rate average as shown in **Exhibit 17**.[19]

During the unwinding period, about 39% of Georgia's monthly redeterminations were renewed through ex parte. This rate is similar to states like North Carolina, Kentucky, Virginia, and Tennessee, but slightly below the national average of 45%. For comparison, prior to the pandemic, Georgia reported that its ex parte renewal rates were within a broad range of 25-50%.[20]

EXHIBIT 17.

AVERAGE REDETERMINATIONS COMPLETED BY EX PARTE PER MONTH, BY STATE



Source: Data.Medicaid.gov. State Medicaid and CHIP Eligibility Processing Data. Last Updated January 15, 2025. Accessed January 31, 2025. https://data.medicaid.gov/dataset/5abea2e0-3f8e-4b49-a50d-d63d5fd9103c

In addition, the decision to launch the Georgia Pathways initiative in July 2023 resulted in competing priorities for system enhancements. The state made the policy decision to delay the processing of non-ABD redeterminations to align with the launch of the Georgia Pathways program, anticipating that an estimated 200,000 Medicaid members would transition to Georgia Pathways at renewal. As a result of this delay, the unwinding period was reduced from 12 months to 11 months.[21]

19 https://dch.georgia.gov/document/document/final-cumulative-medicaid-redetermination-press-release-12624/download

20 Source: KFF. Medicaid and CHIP Eligibility, Enrollment, and Cost Sharing Policies as of January 2020: Findings from a 50-State Survey. https://www.kff.org/report-section/medicaid-and-chip-eligibility-enrollment-and-cost-sharing-policies-as-of-january-2020-findings-from-a-50-state-survey-enrollment-and-renewal-processes/ Retrieved 3/31/2025.

21 Georgia Governor's Office of Planning and Budget Medicaid Unwinding Plan Assessment Final Report April 10, 2023, Prepared by Alvarez & Marsal Public Sector Services, LLC

Promising Practices

The following policy opportunities have been included for consideration to support timely and accurate eligibility determinations:

- **Automating SNAP and TANF data.** Members are often eligible for various benefit programs. Data from one program, like SNAP or TANF, can be used for Medicaid determinations. Automating data verifications from these sources can improve efficiency and streamline the enrollment and renewal processes without worker intervention.
- **Expansion of trusted sources for ex parte renewals.** Expanding use of credible and reliable data sources like state tax data, quarterly wage information, and commercial sources such as the Work Number, can enhance accuracy and lower administrative costs by increasing ex parte renewal rates. Policy development related to this expansion includes determining cascading logic based on the state's view of the reliability and accuracy of these data sources.
- **Financial support for authorized assisters.** Georgia is one of 27 states that allow authorized entities or assisters to submit facilitated applications, and to view notices and renewal information. Seventeen[22] of those states, not including Georgia, also provide financial support to assisters through grants or contracts to aid in supporting members.
- **Leverage partnerships with CMOs.** Some states have realized the benefit of partnering with CMOs to support members with the renewal process. Facilitating this partnership would entail implementing policies that allow for the sharing of relevant member information, including renewal dates and status, and for CMOs to help complete paper and online renewal forms.

22 Medicaid and CHIP Eligibility, Enrollment, and Renewal Policies as States Resume Routine Operations - Report - 10634 | KFF

Key Policy Considerations for Georgia Moving Forward

The policy decisions and challenges identified through this assessment present an opportunity to apply lessons learned and identify opportunities for improvement in future policy decisions. States have considerable flexibility in the design and administration of their Medicaid programs, provided they adhere to federal guidelines. The following approaches could help position Georgia for future success in enhancing eligibility and enrollment policies:

- **Exploration of additional verification methods.** Consider expanding the use of automated electronic verification sources to assist with maintaining eligibility and enrollment and decrease both member and worker administrative burden.
- **Leverage operational data.** Integrating regular processes to review, monitor, and analyze operational data on applications and renewals in addition to eligibility outcome and member enrollment data can be a powerful tool to inform policy decisions. While data monitoring and analysis are important following major policy changes, it is just as critical to monitor data for ongoing operations to set baselines which allow for quick identification of unintended consequences due to changes in policy or processes, or from external factors like demographic changes or economic shifts.
- **Expansion of authorized assisters.** The expansion and financing of authorized assisters trained in application completion, document uploads, and navigating Geogia's Medicaid and CHIP systems can provide support to members while reducing application errors and delays. Expanded use of assisters can also help build trust in the eligibility process by providing a community-based, human centered approach to serving members while reducing burden on call centers and eligibility workers.
- **Leverage partnerships with CMOs.** Leverage existing partnerships with CMOs to support and engage members in completing renewal paperwork and encouraging members to complete renewals following a reminder to support members in retaining coverage.

Communications

Clear and timely communication with Medicaid members is crucial for maintaining health care coverage. Member communications about Medicaid are often complex and full of jargon, creating confusion about requirements, next steps, and/or actions by the agency. This confusion can lead to delays in responding, which in turn can increase eligibility churn, eligibility rework, duplicate applications, and more appeals for state agencies.

To assist states with their unwinding efforts, CMS created customizable notice templates[24] for member communication about redeterminations. CMS also shared effective outreach strategies, such as using plain language, leveraging community partnerships, and employing multiple communication channels to reach diverse populations. Resources included guidance on federal regulations compliance and reducing inappropriate disenrollments.

Stakeholder Feedback Highlights

Members expressed frustration over unclear termination notices, often lacking specific reasons or required actions. Many found out about termination through providers rather than direct communication. Members called for more transparency, more accessible information, and greater clarity about the appeals processes.

Stakeholders emphasized the importance of clear and consistent messaging across multiple sources. One recommendation was for renewal forms to explicitly and clearly state required actions, reasons, and processes.

Actions Undertaken

To prepare for the unwinding and in an attempt to reduce communication issues, Georgia invested in a media campaign primarily focused on educating members on renewing eligibility. It is our understanding that members were not engaged or included in the planning for or review of these outreach strategies or materials. In late 2022 into 2023, efforts first centered around encouraging members to update contact information, then shifted to focus on educating them to retain coverage and avoid gaps. Key messages were shared through media and digital marketing to keep members informed.

The media campaign focused on community events, TV and radio ads in English and Spanish, social media outreach, digital advertising, bus shelter signage, and billboards. Phase one resulted in "…over 82 million total impressions across TV, newspaper, radio, billboards, digital screens, cash jackets, streaming audio, streaming video, YouTube, Twitter, Facebook, Instagram, and Google Ad Words."[23]

A dedicated redetermination micro website, "Stay Informed Stay Covered," was developed to serve as the primary source of unwinding information. The website provided updates on unwinding efforts such as regular partner briefings, informational videos for members, and access to community education resources available in seven languages.

23 Alvarez & Marsal Public Sector Services, LLC, April 10, 2023, The State of Georgia's readiness for the Public Health Emergency (PHE) Medicaid Continuous Coverage Requirement Unwinding: Final Report, Georgia's Office of Health Strategy and Coordination (OHSC)

24 Unwinding and Returning to Regular Operations after COVID-19 | Medicaid

What Occurred and Challenges Encountered

Georgia engaged in outreach efforts with community partners, CMOs, hospitals, and schools to support communication and reduce member terminations. The state participated in more than 100[25] community events alongside community partners to keep members informed about redetermination efforts. To ensure coverage for children, the state partnered with the Georgia Department of Education (DOE), disseminating messaging about redeterminations across school districts via social workers, school nurses, and wraparound coordinators.

To encourage members to update their contact information, a known challenge in communicating with Medicaid members, Georgia dedicated American Rescue Plan Act (ARPA) funding to provide one-time cash assistance of up to $350 for active members who updated their contact information.[26]

Targeted communications efforts included focused outreach to members who had previously demonstrated difficulty responding to requests, including those with disabilities and residents in rural areas. Additional outreach efforts included:

- Hosting community events in rural areas
- Development of provider newsletters and engagement events
- Social media ads and radio ads
- Community roundtable events and in person renewal events
- Partnering with pharmacies to include renewal information in prescription bags
- Editorials in local newspapers about the redetermination process and efforts
- Development and distribution of materials to school systems and to individuals who had not logged into the online eligibility system for a period of time
- Direct outbound calls and text messages to members

Findings from key informant interviews, focus groups, and the environmental scan revealed several outreach-related challenges during the unwinding. For example, members in rural areas were difficult to reach due to broadband issues. Traditional communication approaches, such as mail, encountered delays caused by inaccurate addresses, impacting the timely delivery of important information. Members with limited English proficiency also faced challenges because they were unable to receive notices through the portal in their primary spoken language.

This review of communication strategies and initiatives indicates that despite investments in communication efforts, challenges persisted during the unwinding. These challenges caused confusion for members and ultimately delays in determining eligibility, with those in some population groups experiencing termination of eligibility.

25 https://dch.georgia.gov/document/document/final-cumulative-medicaid-redetermination-press-release-12624/download

26 Alvarez & Marsal Public Sector Services, LLC, April 10, 2023, The State of Georgia's readiness for Public Health Emergency (PHE) Medicaid Continuous Coverage Requirement Unwinding: Final Report, Georgia's Office of Health Strategy and Coordination (OHSC). Reflects the percentage of people who were due for redetermination, were not eligible for ex parte renewal, and completed the redetermination process by providing the supplemental information requested by the state. Rates do not include individuals with pending redeterminations.

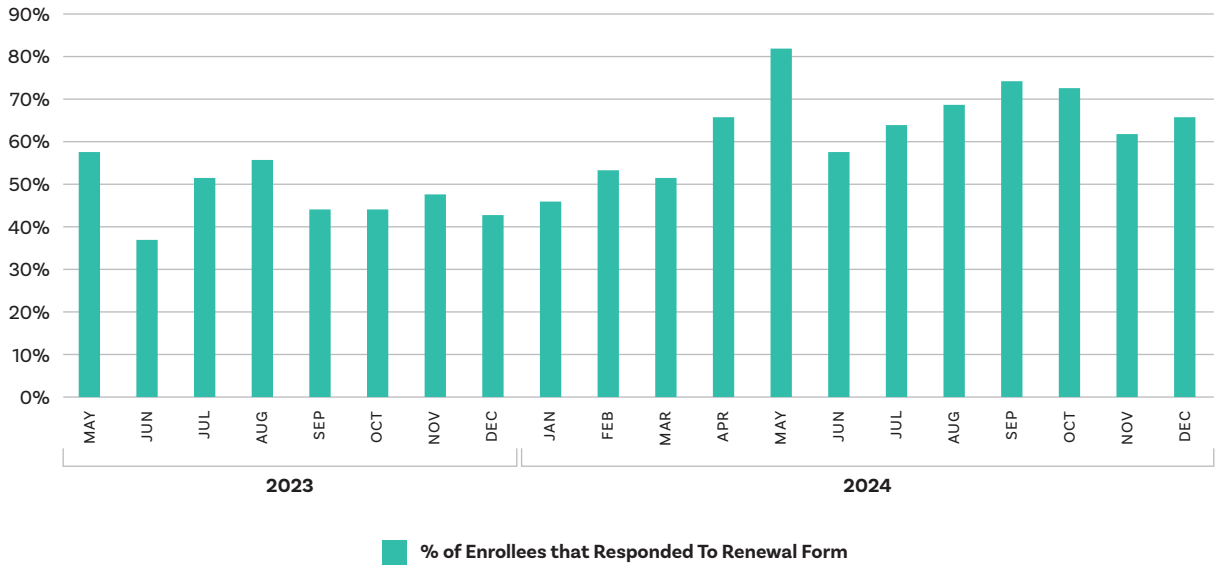
Non-MAGI populations, such as elderly and disabled members, faced accessibility challenges due to mobility and transportation limitations, although partnerships with nursing facilities and associations provided some outreach assistance.

Georgia experienced an increase in the number of disenrolled eligible individuals and children, often due to procedural errors and processes, over the course of the unwinding. This included the disenrollment of entire families, even though it may have been only the parent who was no longer eligible, not the children. Almost half of the focus group participants with children received initial denials for their children's coverage after going through the redetermination process. Participants also reported challenges obtaining support, such as having to call multiple times to reach an eligibility worker, calls going to voicemail boxes that were full, and not receiving timely call backs. This led to a lapse in coverage lasting two or more months for some children of focus group participants, although all were re-enrolled after appealing the decision, reaching out to an eligibility worker or supervisor, and/or providing additional information.

Despite CMS encouraging states and partners to conduct outreach and engagement early and often with members at risk of losing coverage, Georgia's outreach and engagement efforts did not meaningfully impact renewal response rates. Georgia's response rates stayed relatively consistent until the final months of the unwinding (see **Exhibit 18**). This likely indicates that member engagement remained consistent throughout the unwinding and individuals experiencing redetermination at the end of the unwinding and beyond benefited from the increased public awareness and refinement of the unwinding processes.

EXHIBIT 18.

PERCENT OF GEORGIA MEDICAID AND CHIP MEMBERS THAT RESPONDED TO RENEWAL FORM[27]



Source for May 2023-April 2024 data: DCH. Current Period-Point in Time. Accessed 3/27/2025. https://app.powerbigov.us/view?r=eyJrIjoiNGY3ZGM4NTQtZDE5MS00ZDk5LTk1YzgtYTgyZGQ2 ZjdlOTRjIiwidCI6IjUxMmRhMTBkLTA3MWItNGI5NC04YWJjLTllYzQwNDRkMTUxNiJ9&pageName= ReportSectionc446ca21b7983d474637 . Source for May-July 2024 data: Data.Medicaid.gov. State Medicaid and CHIP Eligibility Processing Data. Last Updated January 15, 2025. Accessed January 31, 2025. https://data.medicaid.gov/dataset/5abea2e0-3f8e-4b49-a50d-d63d5fd9103c. Source for August 2024-December 2024 data: DCH. Open records request for August-December 2024 reports. Received 3/26/2025.

27 Reflects the percentage of people who were due for redetermination, were not eligible for ex parte renewal, and completed the redetermination process by providing the supplemental information requested by the state. Rates do not include individuals with pending redeterminations.

The number and percentage of individuals that renewed through the use of the pre-populated renewal form generally outpaced the number and percentage of individuals that were determined ineligible and subsequently lost coverage. This result is expected, as individuals who thought they were ineligible would be less likely to complete the process.

Despite the efforts and investment in communications, Georgia faced several challenges during the unwinding. These challenges related to both communicating with members and members' ability to communicate with eligibility workers. Stakeholders articulated several specific challenges, including:

- Some participants heard about unwinding through social media, news stories, non-profit organizations, and friends, but few, if any, participants recalled receiving official information explaining the unwinding.
- Some participants noted that they received confusing information from their eligibility worker about what paperwork to provide and when to submit it.
- Some participants learned of the results of the renewal process through a mailed notice, but others only found out when seeking health care services when the doctor's office informed them their children were no longer covered.
- Some who lost coverage said the communication they received from Medicaid did not provide clear details about why they or their children were denied, and they had to contact the program to learn more.
- Outreach materials often contained complex terminology that was often not understood. For example, "redetermination" and "unwinding" were not familiar terms to members.
- Incomplete or inaccurate addresses resulted in 84,000 pieces of returned mail with no defined process on how to handle returned mail.

Promising Practices

To improve future communication, the following promising practices could help clarify information, reduce confusion about eligibility, and minimize eligibility churn and rework:

- **Readability and simplified language.** Evaluation of notices to determine opportunities to add language that simplifies messages to appropriate reading levels. Using simple language, bold fonts, and icons improves comprehension. Although legal citations are necessary, avoiding bureaucratic jargon and using plain language without acronyms can aid in clearer communication. For example, renewal and redetermination notices in California and Michigan use simple, easy to follow instructions and highlight the requested action from the member.
- **Use of text messaging.** The use of text messaging has been a successful communication approach with members in other states, such as Indiana, reducing the delays in the delivery of paper notices. Use of text messaging to remind members of upcoming renewals followed by outbound calls and emails improves the timeliness of communication with members.

- **Use of color coding.** Specialized and color-coded envelopes can be used to highlight the importance of Medicaid notices that require action. These envelopes prevent members from mistaking them for junk mail. For example, Massachusetts and Minnesota use this method to distinguish renewal notices from other types of governmental mail. This can be paired with messaging such as "When you see blue, it is time to renew!"
- **Message testing.** Consider a member advisory committee to review and simplify communication, ensuring it uses plain language, removes jargon, and meets reading level standards. Specialized subgroups, such as a Spanish language committee, can also ensure that translations are accurate and understood in the community. Virginia utilized a group of application assisters whose primary language was Spanish to regularly vet newly translated materials.

Key Communication Considerations for Georgia Moving Forward

The communication challenges and barriers identified throughout this assessment offer a chance to improve member communication. A strong communications infrastructure that addresses these issues could position Georgia for future success in ensuring timely health care access for members. Opportunities for consideration include:

- **Robust communication plan.** The creation of a communication plan inclusive of key messages, tools such as use of text messaging, and monitoring guidelines. Implementing and maintaining a communication plan can help support, prioritize, and align communications with initiatives such as grants to community partners.
- **Message testing and notice simplification.**
  - Development of a member advisory group to help with message testing and other improvements to ensure readability and understanding.
  - Simplification of notices and other communications through the use of icons, bold language, and colored envelopes to support timely member action.
  - Availability of notices and communications in preferred languages to ensure non-English-speaking members have access to necessary information.
- **Real time access to necessary information.** Improvements to ensure ease of access to necessary information.
- **Communication with Federal partners.** Improved and dedicated communication pathways by the state with Federal partners to ensure a clear understanding of deadlines.

Operations

Eligibility and enrollment operations for Medicaid and CHIP encompass staffing, systems technology, and data and reporting. These components work together like interconnected puzzle pieces to provide a strong foundation for effective eligibility operations. Staff are a critical face of customer service. They intervene to address complex cases and resolve issues in case processing. In addition, they play a vital role in quality assurance and monitoring operational processes. The information technology (IT) systems used to support eligibility processing help streamline manual processes and should facilitate improved efficiency and accuracy. Finally, tracking and reporting application processing and eligibility determination data are essential for informing operational strategic planning and corrective actions to include shifts in staffing levels, identification of necessary IT fixes, adjustments to processes, changes in member communication messaging, and informed policy decisions.

Actions Undertaken

In preparation for the unwinding, Georgia took several key steps to enhance its operational capacity. First, by April 1, 2023, DHS hired over 200 new eligibility workers. In addition, 170 state staff members and 50 temporary staff members were added to the call center.[28]

Second, Georgia made strategic investments in technology to assist with the expected volume of Medicaid renewals. This included making the website for Georgia Gateway (Georgia's integrated system and portal for determining eligibility across multiple public benefit programs) mobile-friendly, launching a Georgia Gateway mobile app, and introducing robotic automation (bots) to perform certain eligibility tasks. With 84% of U.S. households earning $30,000 a year or less and 89% of households earning between $30,000 and $70,000 a year having smartphones,[29] ensuring that the Gateway member portal is mobile-friendly was a critical enhancement to the Gateway website. This enhancement combined with the implementation of a Gateway mobile app allows members to update their case information and upload documents conveniently, improving access to the renewal process.

Stakeholder Feedback Highlights

Members highlighted that outdated information, in the mobile app and online systems, led to loss of services for many members.

Members recommended reviewing caseworker caseloads, as overwhelmed caseworkers may have resulted in processing issues.

Other stakeholders reported significant workforce challenges affecting the ability to process applications and renewals, due to a high number of open positions. Improved user interface design and testing of state eligibility systems and addressing long-standing issues with the Gateway portal were recommended. Out stationed eligibility workers helped make renewals more accessible but call center issues persisted. Stakeholders indicated data transparency and consistency is necessary to understand impact

28 Georgia Governor's Office of Planning and Budget Medicaid Unwinding Plan Assessment Final Report April 10, 2023, Prepared by Alvarez & Marsal Public Sector Services, LLC

29 "Mobile Fact Sheet", Pew Research Center, November 13, 2024, https://www.pewresearch.org/internet/fact-sheet/mobile/

The bots were originally introduced to assist Georgia's eligibility workers in processing SNAP and TANF cases. DHS then leveraged this successful technology for Medicaid case processing as part of the preparation for the unwinding. DHS identified common manual processes performed by eligibility workers and introduced bots to automate some of those Medicaid processes, including:[30]

- Preparing renewal information submitted through the Gateway portal, for an eligibility worker to review and make a determination, by automatically checking data sources and adding the information reported.
- Performing verification checks on Supplemental Security Income (SSI) and automating case notes including authorizing the case.
- Creating manual Medicaid notices and case notes.
- Processing Medicaid or CHIP-only on-line applications by automatically checking data sources and adding the information reported.
- Identifying red flags and generating notes for eligibility worker review for reported changes submitted through the Gateway portal.
- Processing ex parte applications submitted automatically by checking data sources, adding case notes and identifying red flags for eligibility worker review to include temporary approval of non-MAGI renewals.

Additional early efforts aimed to improve internal workflows included the launch of the "Go Paperless" initiative, encouraging members to sign up and use the Gateway portal to stay informed. Preparation efforts focused on improving technology and implementing system enhancements, creating efficiencies, automating systems to reduce workloads, increasing staffing levels to address rising demands, and boosting face-to-face interactions with members.

What Occurred and Challenges Encountered

Although performing annual renewals to redetermine Medicaid members' eligibility is nothing new to Medicaid programs, the unprecedented volume of renewals to be completed each month during the unwinding as well as the number of new eligibility workers heightened the need for effective technology to automate and streamline processes. A well-functioning Medicaid eligibility and enrollment system that maximizes the use of automated, data-driven ex parte renewals is the key tool states leveraged to reduce administrative burden for members, reduce the manual workload for eligibility staff, and ultimately retain eligible members[31]. National experts view those states with the highest ex parte rates as the most successful states in the unwinding.

30 Alvarez & Marsal Public Sector Services, LLC, April 10, 2023, "The State of Georgia's readiness for the Public Health Emergency (PHE) Medicaid Continuous Coverage Requirement Unwinding: Final Report", Georgia's Office of Health Strategy and Coordination (OHSC)

31 "Unwinding Watch: Tracking Medicaid Coverage as Pandemic Protections End", Center for Budget and Policy Priorities (CBPP), September 30, 2024, https://www.cbpp.org/research/health/unwinding-watch-tracking-medicaid-coverage-as-pandemic-protections-end?item=29306

Staffing. Even with the significant investment in workforce, Georgia faced challenges. Like many states, Georgia experienced issues with eligibility staff turnover and increased training needs due to inexperienced staff and the need for additional staffing capacity and support to manage the historically high volume of monthly renewals. However, Georgia had a higher number of open positions compared to other states, which affected its eligibility determination and renewal processing capacity. Stakeholders reported that workforce challenges significantly impacted their ability to process applications and renewals, with about a third of states reporting a significant impact and another third reporting a moderate impact.[32]

Even with Georgia's efforts to staff up for the unwinding, the state began the unwinding with 250 fewer DHS eligibility staff than at the beginning of the PHE in February 2020.[33] Training new eligibility workers takes time, especially for correctly processing Medicaid applications. Training modules commonly focus on system functionality and processing straightforward applications rather than complex ones. Additionally, the unwinding's shifting start date made it difficult to predict when to begin the recruiting, hiring, and training of new workers.

To address some of the staffing issues and resulting renewal redetermination processing issues, Georgia announced in mid-December 2023 that the state would use its remaining ARPA funds ($54 million) for additional contracted staffing, process and eligibility system improvements, and financial incentives to increase eligibility worker capacity. In a press release, the state outlined essential elements of the initiative scheduled to begin in January 2024, approximately mid-way through the unwinding. These efforts included:[34]

- **Staff augmentation:** Adding 99 contracted staff to assist DFCS eligibility staff in the backlog of Medicaid renewals.
- **Change request processing team:** Adding 55 contracted staff to assist DFCS eligibility staff with processing Medicaid-only change requests.
- **Overtime and stipends:** Offering DFCS eligibility workers overtime and stipends to incentivize management of Medicaid workload.
- **Call center support:** Assigning contracted staff to assist with outreach to members to decrease the chances of administrative closures.
- **Email box support:** Adding 10 contracted staff to monitor and respond to Medicaid-related email sent to DFCS eligibility staff.
- **Process improvement:** Reviewing eligibility task routing and technology to streamline the eligibility process and expanding the Express Lane Eligibility (ELE) policy to support enrollment of children.

32 Stakeholder Engagement Interview: Georgetown Center for Children and Families

33 Alvarez & Marsal Public Sector Services, LLC, April 10, 2023, The State of Georgia's readiness for the Public Health Emergency (PHE) Medicaid Continuous Coverage Requirement Unwinding: Final Report, Georgia's Office of Health Strategy and Coordination (OHSC)

34 https://dch.georgia.gov/document/document/final-cumulative-medicaid-redetermination-press-release-12624/download

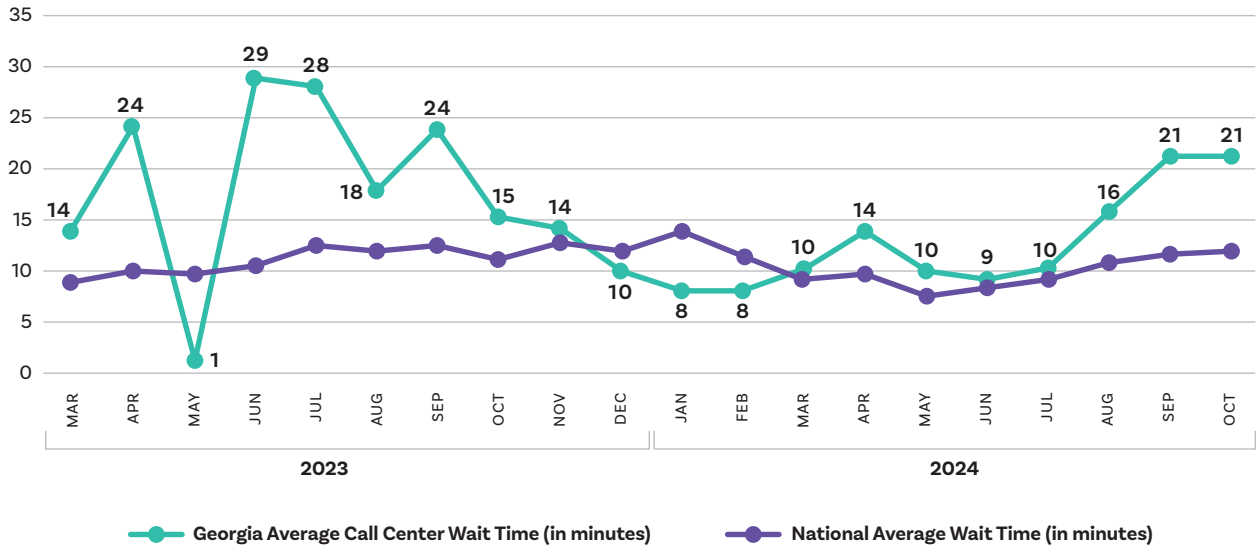
Ultimately, Georgia reported hiring 1,371 new eligibility workers from January 2023-March 2024. The State also offered overtime pay to current eligibility workers to support outreach to Medicaid members and process redeterminations. However, many focus group participants noted high turnover with their individual case workers, and some believe the turnover rate with Medicaid eligibility workers was more significant due to increased caseloads and worker burnout.

Member Call Center. While the use of call centers is intended to provide timely information for members and reduce disruptions for eligibility workers, stakeholders indicated that members faced difficulties with the call center, including auto disconnect and long wait times. In addition, stakeholders indicated that call center staff, when reached, did not always have experience with the relevant program, making it difficult to address the members' needs effectively.

The average call center wait times improved during the unwinding period but began to rise again in July 2024 as demonstrated in **Exhibit 19**. Georgia had the 38th highest average wait time of 15.2 minutes from March 2023 to October 2024, while the national average was 10.7 minutes.

EXHIBIT 19.

AVERAGE GEORGIA CALL CENTER WAIT TIMES COMPARED TO NATIONAL AVERAGE



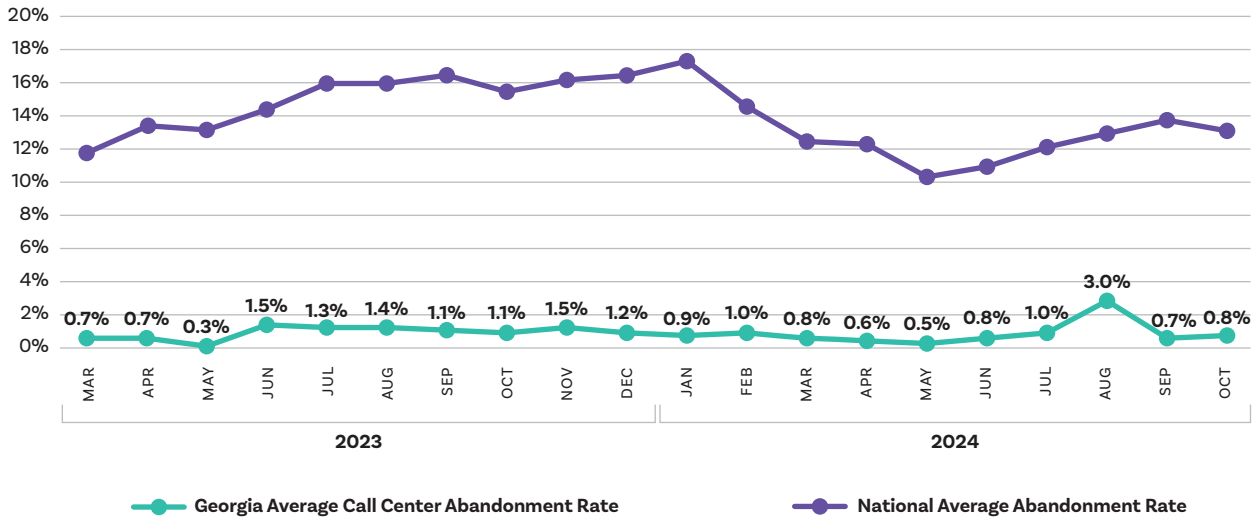
Source: Data.Medicaid.gov. Medicaid and CHIP CAA Reporting Metrics. Updated October 31, 2024. https://data.medicaid.gov/dataset/ebcfc16f-8291-4c61-82a4-055846d72f3a. Retrieved 3/12/2025.

Georgia's average call center abandonment rates, a key measure of a call center's performance, remained low throughout the unwinding, compared to other states, as depicted in **Exhibit 20** below. Georgia had the second lowest rate (1.0%) from March 2023 to October 2024, only behind Wyoming (0.3%), while the national average was 13.5%. This low rate usually indicates a high-performing call center, but it could have been due to a technique used to reduce abandonment rates such as taking callers' contact information for callbacks or asking them to call back later. Although some states expressly prohibit their call center vendors from utilizing this strategy due to the additional outbound and inbound call volume it creates,

in February 2023, data indicated that the DHS call center had a 70% "courtesy disconnect" rate, asking members to call back later due to high volumes rather than addressing their needs during the call.[35]

EXHIBIT 20.

AVERAGE GEORGIA CALL CENTER ABANDONMENT RATES COMPARED TO NATIONAL AVERAGE



Source: Data.Medicaid.gov. Medicaid and CHIP CAA Reporting Metrics. Updated October 31, 2024. https://data.medicaid.gov/dataset/ebcfc16f-8291-4c61-82a4-055846d72f3a. Retrieved 3/12/2025.

Systems Technology. Although Georgia made important investments in technology to streamline the renewal process for both eligibility workers and members, Georgia also experienced technology-related challenges. These included flexibility limitations with the state's E&E system, competing information technology (IT) priorities, new work-around processes, and glitches with the Gateway online portal.

Like many states across the country, Georgia's Gateway utilizes a Deloitte E&E System to manage Medicaid and CHIP cases and determine eligibility. As of April of 2023, Deloitte had contracts with 25 states to design, develop, implement, or maintain and operate states' E&E systems.[36] However, in a state assessment of Georgia's E&E system in January of 2024, the state noted that the system "…lacks flexibility and adaptability, limiting Georgia's ability to serve its customers efficiently, improve the customer and worker experience across all programs, ensure data security, reduce benefit errors and fraud, and advance the state's goal of streamlining eligibility."[37] This inflexibility hindered Georgia's ability to quickly implement changes during the mandated unwinding period.

35 Alvarez & Marsal Public Sector Services, LLC, April 10, 2023, The State of Georgia's readiness for the Public Health Emergency (PHE) Medicaid Continuous Coverage Requirement Unwinding: Final Report, Georgia's Office of Health Strategy and Coordination (OHSC)

36 Rachana Pradhan and Samantha Liss, "Medicaid for Millions in America Hinges on Deloitte-Run Systems Plagued by Errors", KFF Health News, June 24, 2024, https://kffhealthnews.org/news/article/medicaid-deloitte-run-eligibility-systems-plagued-by-errors/

37 Integrated Eligibility System (IES) Assessment, Georgia Department of Community Health, Office of Information Technology, January 17, 2024, https://www.documentcloud.org/documents/24549649-georgia-ies-business-assessment-statement-of-requirements

Staff also faced competing IT priorities with the associated change requests (CRs) for the implementation of initiatives including:

- Work-around technology via bots to automate processes that were not automated in the state's E&E base system.
- Addressing issues with the recently enhanced Gateway Portal.
- Changes needed to reinstate annual renewals and coverage terminations due to the unwinding.
- Revising ex parte renewal logic to ensure the determinations were made at an individual member level and to reinstate children whose coverage was procedurally terminated following an inappropriate household level ex parte process.
- Changes needed to support the implementation of the new Pathways program on July 1, 2023, as well as the transition from the Federally Facilitated Marketplace (FFM) to Georgia's SBE on November 1, 2023.

According to stakeholders, Georgia had multiple IT projects and CRs underway before the unwinding, requiring prioritization and coordination. This complicated the unwinding process due to the need to balance the various system changes. KFF Health News reported Georgia's 35 CRs for the Gateway E&E system in 2023, noting Deloitte's estimate that it "...would take more than 104,000 hours of work... [or] an equivalent of 50 years of work if someone worked 52 weeks a year at 40 hours a week" to complete the changes.[38]

Technology work arounds to the Georgia's E&E system. Bots were implemented to automate processes that were not automated in the Deloitte system. They were used for a number of otherwise manual processes. The bots performed:

- **Some ex parte renewals.** The bots processed ex parte renewals for members who had approved SNAP or TANF benefits. In addition, the bots assisted eligibility workers in quickly verifying information through electronic data sources in the approved verification hierarchy.
- **Automated processing of information submitted on the Gateway portal.** The bots screened information entered in the portal to identify potential issues, compared the information to electronic data sources, processed uploaded documents, transcribed handwritten information, and entered data provided in the customer portal in the eligibility system. The bots also provided policy reference links to support eligibility workers in reviewing and processing the case when needed.
- **Population of Office of State Administrative Hearings (OSAH) fair hearing forms.** Bots were used to populate some parts of the OSAH fair hearing forms for DHS staff.

38 Rachana Pradhan and Samantha Liss, "Errors in Deloitte-Run Medicaid Systems Can Cost Millions and Take Years To Fix", KFF Health News, September 5, 2024, https://kffhealthnews.org/news/article/deloitte-run-medicaid-systems-errors-cost-millions-take-years-to-fix/

Although "staff stated the bots can process multiple cases within minutes"[39] and management seemed to view the bots positively, the key informant interviews did not provide clarity regarding related success or accuracy rates during the unwinding. A readiness evaluation indicated more development time and administrative and issue resolution processes were needed to support the new bots. "Even minor system changes have the potential to require significant reconfigurations of how bots operate in their environment. Because bots need to be assigned tasks and deployed daily, team capacity spent resolving issues for one or several bot functions can impact other workstreams."[40]

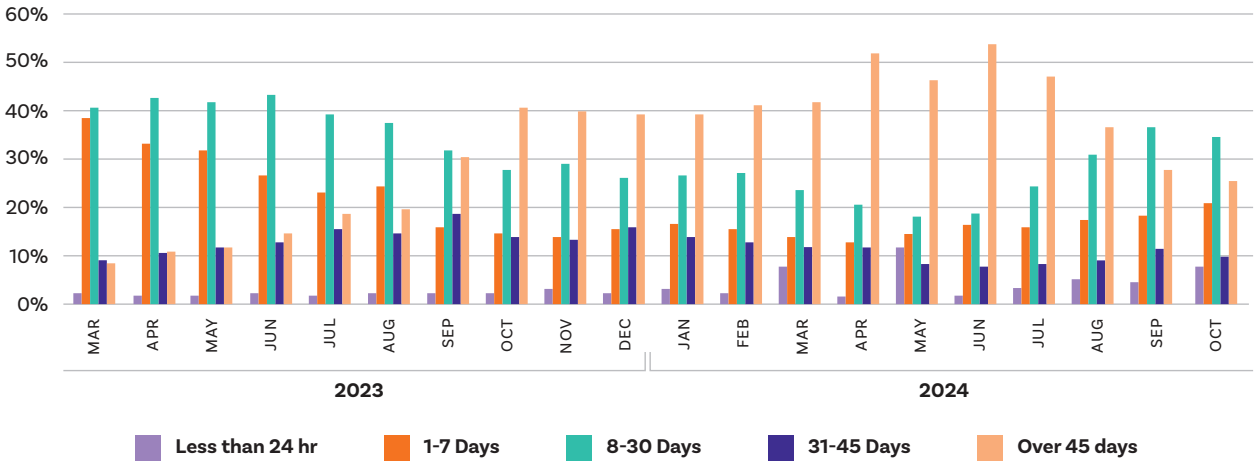
Gateway portal challenges. The portal was a key tool for Georgia's Medicaid and CHIP members in the unwinding to update contact information and complete renewals. However, members and stakeholders identified difficulties in using it.

Georgia stakeholders interviewed reported that the Gateway portal, despite enhancements, was not sufficiently mobile-friendly. They highlighted technical issues such as timeouts, lost tracking numbers, difficulties in accessing and updating renewal forms and significant delays in uploaded documentation visibility, which further complicated the renewal process. Focus group members reported often having to resubmit forms electronically and eventually visit Medicaid offices in person to ensure coverage, often facing barriers like transportation, childcare, and conflicting work schedules.

Other indicators of operational challenges. Application processing times are one of the primary indicators of efficient and streamlined operations. CMS requires states to process applications for non-aged or disabled populations within 45 days and encourages states to leverage automated processes and electronic data matching to expedite this. During the unwinding, many states, including Georgia, faced delays due to high application volume and workforce shortages. **Exhibit 21** shows a notable increase in application processing times over 45 days during the unwinding.

EXHIBIT 21.

GEORGIA'S MEDICAID APPLICATION PROCESSING TIMES



Source: Data.Medicaid.gov. Medicaid and CHIP CAA Reporting Metrics. Updated October 31, 2024. https://data.medicaid.gov/dataset/ebcfc16f-8291-4c61-82a4-055846d72f3a. Retrieved 3/12/2025.

39 Georgia Department of Audits & Accounts, September 2022, "Medicaid Unwinding Status of State Efforts to Prepare for the End of Continuous Coverage"

40 Alvarez & Marsal Public Sector Services, LLC, April 10, 2023, "The State of Georgia's readiness for the Public Health Emergency (PHE) Medicaid Continuous Coverage Requirement Unwinding: Final Report", Georgia's Office of Health Strategy and Coordination (OHSC)

41 Source: Data.Medicaid.gov. Medicaid and CHIP CAA Reporting Metrics. Updated October 31, 2024. https://data.medicaid.gov/dataset/ebcfc16f-8291-4c61-82a4-055846d72f3a. Retrieved 3/12/2025.

Georgia's key application processing rates for March 2023-October 2024[41] were as follows:

- Georgia had one of the lowest rates of 1-day processing in the nation (3.6%, same as New Jersey). Single-day processing is an indicator of a highly automated E&E system that has electronic data sources integrated into the system processes to automatically verify application information without worker interventions. Only four states (IN, MS, NV, and ND) were lower. Nationally, an average of 34.8% of applications were processed in less than 1 day.
- Georgia was around the middle of the nation for rates of 1-week processing times (20.3%). Nationally, an average of 19.7% of applications were processed in 1-7 days.
- Georgia was 34th for its average percentage of applications processed in 31-45 days (12.2%). Nationally, an average of 9.8% of applications were processed in 31-45 days.
- Georgia had the 4th highest average rate of applications that took more than 45 days to process (32.5%). The only other states with a greater average percentage of applications taking more than 45 days to process were New Mexico (34.1%), Texas (34.2%), and Alaska (43.4%). Nationally, an average of only 9.6% of applications took more than 45 days to process.

Operational Data and Reporting

The availability of reliable applications and eligibility processing data is key to informing program operations, yet states vary greatly both in how readily available these data are to management and how transparently key application processing measures are shared with stakeholders.

CMS required reporting. The CAA required states to provide monthly reports on activities related to eligibility renewals, call center operations, and transitions to Marketplace coverage. Additionally, CMS took steps during the unwinding to make key renewal and call center data publicly available through July 2024 which was the end of the unwinding period for most states. These monthly reports helped monitor states' progress and served as potential indicators of any issues with the redetermination process. In many cases, this was the first time these state-specific data were shared regularly with the public.

The CMS monthly reports included information such as:

- Number of members due for renewal/redetermination
- Renewals received, pending, and processed within a given timeframe
- Number of members that had coverage renewed at redetermination
  - Number of renewals that occurred ex parte (automated renewal)
  - Number of renewals that occurred via renewal form (member took action and was determined eligible to keep Medicaid)
- Number of members that had coverage terminated at redetermination
  - Number of terminations that occurred via renewal form (member took action and was determined ineligible for Medicaid)
  - Number of terminations that occurred for procedural or administrative reasons

- Number of members due for renewal, but renewal pending at the end of the month
- Medicaid fair hearings pending more than 90 days

These reports reflected a point-in-time count but failed to show the impact of enrollment churn, where people who lost coverage returned to Medicaid. News outlets reported the high termination counts without reflecting individuals who used the grace period to complete their redetermination without a gap in coverage or who had coverage reinstated. States faced criticism for these reports, so many began publishing their own supplemental unwinding data, including public dashboards to provide stakeholders, advocates, and media access to current enrollment, disenrollment, and renewal status data.

Additionally, states varied in the precise way they defined, collected, and reported data. The lack of specific definitions for key data metrics was particularly challenging for comparing performance across states.

Georgia's unwinding data and reporting. Georgia published some renewal outcome data during the unwinding independent of the CMS published reports, along with monthly press releases. These reports largely aligned with CMS reporting requirements but include supplemental estimates around the procedural determinations that, based on eligibility indicator data, were likely for ineligible individuals. Detailed redetermination outcomes by demographic characteristics were not available at the time of this report, limiting the opportunity to identify populations that may have been adversely affected by the unwinding.

Although not publicly available, DCH provided supplemental demographic breakdowns for the enrollment data in response to data requests. These data provided insights around key demographic traits like member age, gender/sex, county and region of residence, and eligibility category (including whether the individual was served through a managed care plan or the state's fee-for-service program). DCH also provided available race data but noted the unreliability of this data, as reporting is optional, and sources are inconsistent.[42]

Promising Practices

To enhance productivity and efficiency, and strengthen eligibility and enrollment operations, the following promising practices were identified for consideration:

- **Robust training.** Development of robust initial and ongoing eligibility training, inclusive of on demand job aids and training resources, and side-by-sides with senior workers to support learning objectives. Virginia uses a multi-week step down nesting model for new eligibility workers at the Cover Virginia central processing unit following classroom training and exams, for example. In addition, offering scenario based, specialized training to address common errors improves timeliness and increases accuracy of eligibility determinations.

42 Race data can be reported by the individual member, a provider, or other entity helping the member complete the application. It is self-reported without a consistent set of definitions.

- **Performance reports and dashboards.** Development of key performance indicators (KPIs), reports, and dashboards allow visibility into eligibility operations and when routinely utilized can help identify workload capacity issues and other performance concerns such as aged applications to help ensure compliance.
  - Robust operational dashboards are an essential tool for management to assess workload and staff capacity across the statewide eligibility enterprise and enable adjustments in staffing patterns or workflows in real time or near real time. For example, South Carolina's Eligibility and Enrollment team uses an operational dashboard for real time workload tracking, allowing leadership to redeploy staff resources as necessary to meet timeliness requirements.
  - Development of standard operating procedures and performance standards that set internal KPIs processing deadlines to monitor and manage processing time. For example, the standard processing expectation for paper applications in Colorado is within two days of receipt.
  - Effective performance management includes the use of performance-based contracting for vendors ranging from data entry services to call center operations. For example, Virginia has a robust set of operating standards, performance metrics, and related nonperformance penalties for its call center contractor to ensure performance meets contractual requirements.

- **Accuracy of contact information.** Timely access to accurate member contact information is essential for successful eligibility processing and meeting CMS timeliness requirements. To ensure agencies have access to accurate contact information, the following best practices should be considered:
  - Effective application design to ensure the collection of all required information, with field edits and real-time address verification for online applications and renewals.
  - Verification processes that utilize reliable electronic data sources and internal processes to quickly identify and address inconsistencies, such as timely processing of returned mail.
  - Use of an integrated eligibility system with automated workflows and connection to a system of record, such as a golden record or master person index (MPI). For example, Connecticut Department of Social Services implemented an Enterprise Master Person Index (EMPI) in January 2016. Their EMPI uniquely identifies individuals across several systems with DSS and Connecticut's SBM providing the core data for an enterprise solution that maintains current demographic data for individuals across all subscribing systems.

- **Automated processes.** Technology systems designed to allow for automatic ingestion and trigger processing are much more likely to be processed in near- to real-time than systems that require manual intervention.
  - Promotion of online applications and renewals. States that receive the majority of applications via an online platform with automated processing capabilities enhance timeliness and lessen eligibility workers' administrative tasks. For example, Florida improved application processing following the increase in online application submissions.
  - The creation of specialized teams and/or task-based processing support timely resolution for complex case types. For example, the use of specialized teams in South Carolina allows eligibility workers to maintain their focus on processing applications by sending complex cases to the specialty team for resolution.

- **Online portal enhancements.** Development of online portals with consumer assisted features like help text, chat support, and FAQs. Additionally, robust customer portals also offer real or near real time status verification. For example, applicants completing a multi-benefit application in Colorado can utilize a chat feature and receive real time assistance.
- **Application and renewal forms.** Use of simplified, yet comprehensive application and renewal forms, such as streamlined, auto populated forms to help improve the likelihood of completion. These online forms should be structured in a dynamic way (e.g., skip logic) to ensure only relevant questions are asked for those applying and with field edits to limit input errors.

Key Operational Considerations for Georgia Moving Forward

States need efficient operations to ensure timely health care access for members, reduce unnecessary administrative costs, and improve the quality of eligibility determinations. The operational challenges encountered during unwinding and examined in this report provide an opportunity to identify improvements to Georgia's eligibility and enrollment operations. To improve efficiency and effectiveness, the state may consider the following:

Staffing

- **Investment in efforts to reduce staff turnover.** While overtime pay is helpful in the short term, overtime can worsen burnout and increase staff turnover. Long-term solutions may include an examination of roles, responsibilities, hiring requirements, and pay compared to other state and private sector positions. In addition, consider opportunities for internal promotion, recognition programs, and incentives for quality goals as well as production goals.
- **Increased investment in a robust staff training program.** Historically, Medicaid agencies could rely on a core of long-term Medicaid eligibility workers. This is no longer true in many localities. New workers need a robust and on-going formal multimodal training program to support them.
- **Improvements in eligibility worker availability.** Members need quicker access to their case status information. Considerations for increasing access to assigned eligibility workers and case status information include:
  - Offering extended office hours both during the week and on Saturdays.
  - Integrating out stationed eligibility workers back into the community such as at community health centers.
  - Investing in adequate staffing and training of call center staff as well as access to detailed eligibility case notes to address members' calls.
  - Enhancing member portal and mobile app functionality to provide detailed status information and documentation requests.

Systems Technology

- **Focus on additional Gateway system improvements.**
  - **Prioritize fixes to core stakeholder complaints.** Addressing system timeouts, glitches, processing issues such as address updates, and problems with document tracking numbers will facilitate greater use of the online portal and mobile app and help lower processing time.
  - **Continue online portal and mobile app enhancements.** As members increasingly rely on cell phones as their primary means of communication, focusing on improving the functionality and usability of a broad range of online tools for members and assisters will assist in reducing the manual processes performed by eligibility workers.
  - **Incorporate user testing into regular processes.** Consider more robust system testing requirements that incorporate user testing and feedback on functionality from members and assisters when they are the end users.
- **Procurement for an operational audit.** Conducting an internal operational audit to capture lessons learned and document system deficiencies from a user perspective—both eligibility workers' and members'—to also include a review of the E&E system and workflows will identify key opportunities for improvement. Consider one area of focus to include issues causing application processing timeliness issues.

Data and Reporting

- **Data sharing requirements.** Continuing efforts to improve data quality and transparency, revisiting requirements for data sharing related to eligibility determinations and related coding from DHS to DCH would enhance data collection and trend analyses to better monitor eligibility processes. Establishing a joint data governance team that meets regularly to ensure data definitions and reporting are in alignment across DHS and DCH is important to support these efforts.
- **Produce standing operational reports.** Joint development of operational dashboards for use by DHS and DCH would include a wide range of reports showing various views of application and renewal submission and processing status data, eligibility determination data, and enrollment data. Once developed, these reports could be produced automatically on regular schedule (e.g., daily, weekly, monthly) and published internally to support the operations team in improved forecasting in real-time staffing and workflows adjustments. Additionally, now that the State has an SBM, the tracking of account transfers and the movement between the programs should be considered as another set of standing reports included in the state's dashboards.

Conclusion

The unwinding served as a valuable opportunity to evaluate Medicaid operations, systems, and processes to identify lessons learned and areas for improvement. The lessons learned serve as an opportunity to highlight the implications for Georgia as the state moves forward with future system improvements and enhancements to support ongoing operations.

The research culminating in this report revealed disconnects between fundamental components of the E&E ecosystem. Systems that recognize the interconnectedness of their core components and understand that changes to one component affect the others and the entire system will reap the benefits of improved efficiency and more thoughtful problem solving. For example, environments that invest in building agile and integrated eligibility systems, routinely testing system performance, creating robust communication infrastructure, and increasing understanding of federal policies will be better positioned to rapidly adjust and pivot operations to ensure timely eligibility determinations and Medicaid coverage for populations who rely on these services.

The experience and lasting impacts of the unwinding can continue to inform and shape health policy and systems designed to ensure health care access into the future. Efforts can focus on improving communications, streamlining transitions across alternative coverage options, increasing state staff capacity and expertise, and exploring enhancements in technology systems to prevent future impacts on members.

For questions or inquiries related to this report, please contact Cindy Zeldin, Vice President of Health Policy and Government Affairs at cindy@georgiahealthinitiative.org.

Summary of Key Takeaways

Georgia's unwinding and subsequent disenrollment of members due to procedural errors, communication barriers, and technology system errors and inaccuracies provides compelling evidence for a more in-depth audit of the Medicaid E&E system to analyze root causes and identify solutions.

The decisions made in the planning stages of the unwinding resulted in impacts to the intersecting eligibly system components. Although Georgia's approach was generally strong and inclusive of some best practices, planning and execution likely did not occur early enough, did not fully leverage key partners, and did not adequately engage members.

As demonstrated throughout this report, the complex components of **policy**, **communications**, and **operations** are interconnected and mutually dependent. Decisions made in isolation without the knowledge or foresight of the impact of these decisions result in program inefficiencies and barriers for members. This is evident in the unwinding outcomes, feedback, and observations from stakeholders, and ultimately the impact of the unwinding on members.

Policy decisions, including the use of federal waivers, opting for a state-developed approach to unwinding with staggered redeterminations over multiple months, alongside implementing new initiatives and returning to normal operations, created challenges for the technology system and caused confusion for members.

The development of a robust communication and marketing strategy for Georgia was an investment that should be commended. However, the results of these efforts did not align with the intended outcome. Stakeholder feedback indicated communications were not consistently received, contained confusing information, and were not easily accessible in the Gateway system. Stakeholders also reported difficulties obtaining assistance through support systems such as the call center, an eligibility worker, or a supervisor.

Geogia's inability to provide key renewal processing and outcome data from the state's E&E system for this report may indicate these data are not readily available for the state's internal use. This could be a significant limiting factor in the state's ability to identify trends, monitor quality, support strategic planning, and inform operations and policy decisions in real-time.

Exhibit 22 provides a high-level summary of the importance of the eligibility components, the promising practices, and key considerations for Georgia as it moves beyond the unwinding and seeks to make lasting system improvements.

EXHIBIT 22.

Summary of Key Component Takeaways

Policy

As a joint state and federal program, Medicaid policy decisions serve as a foundation to guide operations and inform member communications. As a core component of a high functioning system, the policy decisions made before and during the PHE impacted both members as well as the success of the system's ability to unwind from the continuous enrollment requirement. Factors such as the number and type of waivers requested and policy decisions regarding how and when to begin redeterminations impacted members.

Within the context of policy decisions moving forward, Georgia leaders may wish to consider the following:

Key Considerations:

- **Exploration of alternative verification methods.** The exploration and ultimate policy decision related to the use of alternate verification methods to assist with maintaining eligibility and enrollment.
- **Leverage operational data.** Integrating regular processes to review, monitor, and analyze operational data on applications and renewals in addition to eligibility outcome and member enrollment data can be a powerful tool to inform policy decisions.
- **Leverage authorized assisters.** The use of authorized assisters trained in application completion, document uploads, and navigating the Medicaid system provides support to members while reducing application errors and delays.
- **Leverage partnerships with CMOs.** Leverage existing partnerships with CMOs to support and engage members in completing renewal paperwork, encouraging members to complete renewals following a reminder to support members in retaining coverage.

Promising Practices:

- **Automating SNAP and TANF data.** Consistent use of data and information in programs such as SNAP and TANF through automation to increase efficiency and help streamline the renewal process.
- **Expansion of trusted sources for ex parte renewals.** Expansion of credible data sources can help improve accuracy and reduce administrative costs.
- **Financial support for authorized assisters.** Some states provide financial support to assisters through grants or contracts to support members.
- **Leverage partnerships with CMOs.** Implement changes that allow for the sharing of relevant member information such as renewal dates and paperwork and allow CMOs to support with the completion of paper and online renewal forms.

Communications

Timely and accurate yet simple communication with Medicaid members is essential in maintaining coverage to ensure access to health care. Communications directed toward members are often complex and contain jargon that often create confusion for members related to what is required for next steps and the action taken by the agency. Communications are impacted by many factors; these factors all contribute to the success of communicating with members. Factors such as the complexity of notices, timeliness, and accessibility of communications impact a member's likelihood of accurately and timely responding.

Within the context of communication decisions moving forward, Georgia leaders may wish to consider the following:

Key Considerations:

- **Robust communication plan.** The creation of a communication plan inclusive of key messages, tools such as text messaging, and monitoring guidelines to prioritize and align communications.
- **Message testing and notice simplification.** Simplification of notices and other communications, availability of notices and communications in multiple languages and development of a member advisory group to provide support for message testing.
- **Real time access to necessary information.** Improvements to ensure ease of access to necessary information.
- **Communication with federal partners.** Improved and dedicated communication pathways with federal partners to improve clarity around deadlines.

Promising Practices:

- **Readability and simplified language.** Evaluation of notices to determine opportunities to add language that simplifies messages to appropriate reading levels, in addition to the use of simple language, bold font, and icons.
- **Use of text messaging.** Use of text messaging to remind members of upcoming renewals followed by outbound calls and emails improves the timeliness of communication with members.
- **Use of color coding.** The use of specialized and color-coded envelopes to draw attention and alert the members of the importance of notice and provide clear directions that an action is required.
- **Message testing.** The creation of a member advisory committee to support the review of communications and notices.

Operations

Eligibility and enrollment operations encompass staffing, systems technology, and data and reporting. Like interconnected pieces of a puzzle, staff, technology, and data must work together to form the foundation for strong eligibility operations. Georgia's eligibility and enrollment system lacked needed automation to streamline processes and reduce reliance on manual worker intervention. As a result, the system required work-arounds such as the addition of bots as well as support from additional contracted surge staff.

Within the context of operational decisions moving forward, Georgia leaders may wish to consider the following:

Key Considerations:

- **Staffing.** Investing in efforts to reduce staff turnover by examining roles, responsibilities, hiring requirements, and pay, and offering internal promotions, recognition programs, and incentives for quality and production goals. Other considerations include increased investment in robust, ongoing training programs for new eligibility workers and increased access to eligibility workers.
- **Systems Technology.** Prioritizing Gateway system improvements that address core stakeholder complaints and document tracking problems to enhance the online portal and mobile app. Incorporating user testing and feedback into regular processes can improve functionality for members and assisters. Additionally, conducting an internal operational audit to capture lessons learned and document system deficiencies.
- **Data and Reporting.** Improving data quality and transparency by revisiting data sharing requirements related to eligibility determinations and between DHS and DCH. Establishing a joint data governance team to ensure alignment in data definitions and reporting and the development of operational dashboards to provide comprehensive reports.

Promising Practices:

- **Robust training.** Development of robust initial and ongoing eligibility training, inclusive of on-demand job aids and training resources to support eligibility worker capabilities.
- **Performance reports and dashboards.** Development of key performance indicators, reports, and dashboards to allow for greater visibility into the eligibility process.
- **Accuracy of contact information.** Timely access to accurate member contact information through effective application design, verification processes, and use of integrated eligibility systems.
- **Automated processes.** Use of technology systems designed to allow for automatic ingestion and trigger processing to support near- to real-time processing.
- **Online portal enhancements.** Development of online portals with consumer assisted features like help text, chat support, and FAQs to enhance member support.
- **Application and renewal forms.** Use of simplified, yet comprehensive application and renewal forms, such as streamlined, auto populated forms to help improve the likelihood of completion.

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Glossary of Frequently Used Terms[43]

Abandonment Rate	The percentage of calls where the caller disconnects before the call center customer service representative (CSR) answers the call.
Average Wait Time	Also known as the Average Speed to Answer, Average Wait Time refers to answer, this metric represents time it takes for a caller to connect with a CSR.
Care Management Organization (CMO)	An entity that is organized for the purpose of providing or arranging health care. It has been granted a certificate of authority by the Commissioner of Insurance as a health maintenance organization and contracts with providers to furnish health care services on a capitated basis to members on a statewide basis.
Churn	The disenrollment and then re-enrollment of Medicaid and CHIP members within a short period of time. This is a measure commonly used to evaluate program efficiency and is viewed as an indicator of the percentage of individuals who are likely to remain eligible but are disenrolled due to administrative barriers.
Disenrollment/ Termination	Ending health care coverage with the Medicaid program by enrollee request, death, or as a result of an eligibility redetermination.
Eligibility	Meeting the requirements for coverage under Medicaid and/or CHIP.
Eligibility Category	Used to distinguish for what Medicaid or CHIP coverage group an individual qualifies. While Medicaid and CHIP eligibility pathways include many specific categories of eligibility, each generally fits within a higher-level grouping category based on the circumstances by which the member is eligible for coverage. These are: • Aged, Blind, and Disabled (ABD): The ABD Medicaid group typically includes adults aged 65 and older, people who are legally blind, and individuals who have a disability as defined by the Social Security Administration. This group must meet specific income and asset requirements to qualify for Medicaid. • Low Income Medicaid (LIM): LIM is a medical assistance program for low-income people of all ages. It includes coverage for pregnant individuals, children, certain very low-income parents, seniors, and those with disabilities or who need nursing home care. • PeachCare for Kids (PCK): PCK is Georgia's separate health coverage program for children not eligible for Medicaid, also known as Children's Health Insurance Program (CHIP). The program provides comprehensive health benefits including primary, preventive, specialist, dental, and vision care at little to no cost to qualifying families.

43 Primary Definition Sources: Data.CMS.gov. Medicare and Medicaid Summary Statistics Glossary. Last modified 10/30/2024. https://data.cms.gov/resources/medicare-and-medicaid-summary-statistics-glossary. Retrieved 3/13/2025; CMS.gov. Glossary. https://www.cms.gov/glossary?term=ex+parte&items_per_page=10&viewmode=grid. Retrieved 3/13/2025; Medicaid.gov. Ex Parte Renewal: Strategies to Maximize Automation, Increase Renewal Rates, and Support Unwinding Efforts. Published 10/20/2022. https://www.medicaid.gov/resources-for-states/downloads/ex parte-renewal-102022.pdf. Retrieved 3/13/2025. Includes Research Team defined terms.

Enrollment	The process of being found eligible for coverage under Medicaid or CHIP; may sometimes refer to the total population enrolled in Medicaid or CHIP.
Ex Parte Process	Redetermining eligibility based on reliable information available to the agency without requiring information from the individual (also known as auto-renewal, passive renewal, or administrative renewal).
Express Lane Eligibility	An automated enrollment process for new applicants or renewing members under the age of 19 who are also receiving Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), Refugee Cash Assistance (RCA), Childcare and Parent Services (CAPS), or Women, Infants and Children (WIC).
Fee-for-Service (FFS)	A program where the state Medicaid agency establishes fee levels for covered services and pays participating providers directly for each service they deliver to Medicaid beneficiaries.
Georgia Pathways to Coverage (Georgia Pathways)	An initiative that allows individuals with income up to 100% of the federal poverty level (FPL) an opportunity to engage in eligible work, school, or volunteer activities to obtain Medicaid coverage
Health Insurance Marketplace	The Health Insurance Marketplace (also known as the "Marketplace" or "exchange") provides health plan shopping and enrollment services through websites, call centers, and in-person help. Individuals can apply for qualified health plans and subsidies. • Health Insurance Marketplace®: The federal government operates the Health Insurance Marketplace®, available at HealthCare.gov. Georgians could use this website to shop for health insurance coverage through the 2024 plan year. • State Based Marketplace: States can run their own health insurance marketplace and set up their own website for state residents to shop and apply for health insurance. Georgia launched its SBM, Georgia Access, for health coverage in 2025.
Medicaid Managed Care	A health care delivery system that provides Medicaid or CHIP health benefits and additional services through contracted arrangements between state Medicaid agencies and CMOs.
Modified Adjusted Gross Income (MAGI)	This is an income methodology used to determine eligibility for CHIP and most children, pregnant women, and parents in Medicaid. It considers taxable income and tax filing relationships to determine financial eligibility for Medicaid and CHIP.

Non-MAGI	The MAGI methodology is not used for Medicaid eligibility for aged, blind, and disabled groups and taxable income and tax filing relationships are not considered. Instead, eligibility is determined using traditional budget units and considers the individual's income and countable resources and assets. These eligibility groups include: • Individuals receiving SSI • Medicare Savings Programs • Poverty level (100% FPL) aged or disabled individuals
Procedural Termination	Termination as a result of administrative issues such as the failure to return required verifications or failure to respond to renewal requests and not as a result of a full determination of eligibility. As such, members may in fact still be eligible for Medicaid or CHIP.
Qualified Health Plan (QHP)	An insurance plan certified by the Health Insurance Marketplace®, provides essential health benefits, follows established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximum amounts), and meets other requirements under the Affordable Care Act.
Redetermination	The process of reviewing member eligibility to continue receiving Medicaid benefits. The review ensures that a member still meets eligibility requirements, such as income, residency, and disability status.
Renewal	The process of confirming that an individual continues to meet the requirements for coverage under the Medicaid program.
Special Enrollment Period (SEP)	A time outside the yearly Open Enrollment Period to sign up for health insurance. One can qualify for a Special Enrollment Period for certain life events, including losing health coverage, moving, getting married, having a baby, or adopting a child, or if your household income is below a certain amount.
Supplemental Nutrition Assistance Program (SNAP)	A federal program that provides food-purchasing assistance for low- and no-income people to help them maintain adequate nutrition and health. It is often referred to as the "food stamps program."
Temporary Assistance for Needy Families (TANF)	A block grant program that provides $16.6 billion annually to states, territories, the District of Columbia, and federally recognized Indian tribes. These TANF jurisdictions use federal TANF funds to provide income support to families with children with low-income, as well as to provide a wide range of services (e.g., work-related activities, childcare, and refundable tax credits) designed to accomplish the program's four broad purposes.

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