Georgia Health Initiative

2026

Insights on Medicaid in Georgia

Data & Trend Analyses

1

Introduction

Overview

2026

One year ago, Georgia Health Initiative® (the Initiative) first published *Insights on Medicaid in Georgia: Data & Trend Analyses* and we were pleased to learn that it served as a valuable resource for a number of partners across different sectors. Now we are excited to share the *2026 Insights on Medicaid* edition of our organization's signature publication.

Within the twelve months between the 2025 and 2026 editions of this resource, much has happened at the federal level that already has and will continue to affect health coverage in Georgia. In July 2025, H.R.1 (legislation otherwise known as the "One Big Beautiful Bill Act" and hereinafter referenced as H.R.1) was passed into law introducing changes to Georgia's health care landscape, including our Medicaid program.

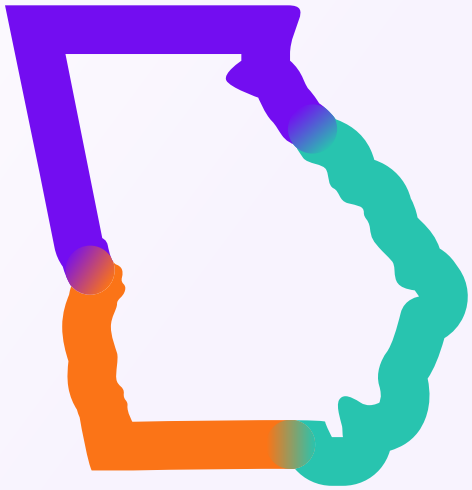
For purposes of the *2026 Insights on Medicaid* edition, the State Priorities and National Updates section contains certain details of changes posed by H.R.1 and what they will mean for our state Medicaid program. In addition, included throughout other sections of the publication are references to areas where H.R.1 will have an impact.* While the publication speaks to some of the changes due to H.R.1, especially those already in effect or planned to take effect in the near future, it does not include all changes. For a more comprehensive overview of key H.R.1 provisions that will have implications to our state in terms of projected changes to health coverage as well as economic impact, we invite you to read our Policy Report entitled, *Impact of Federal Policy Changes to Georgia's Health Care Landscape*, that was published in November 2025.

Changes such as those introduced in H.R.1 underscore the dynamic nature of the Medicaid program as a joint federal-state program administered at the state level. That is why we at the Initiative are committed to releasing this publication on an annual basis.

Each year, *Insights on Medicaid* will share and analyze the most recent data and information available on Medicaid enrollment, covered benefits and services, service delivery, financing, and summaries of prioritized areas of focus for Georgia's program and trends seen nationally as well. The State Priorities section of each publication will reflect what state leaders in Georgia have identified as areas of focus to improve Medicaid program operations and outcomes for enrolled members.

As an organization comprised of experts in health policy, communications, community engagement, and philanthropy, the Initiative team is pleased to make available comprehensive resources like *Insights in Medicaid in Georgia* in service of working with multi-sector partners toward a healthier Georgia.

* With the exception of the National Updates section of this publication which is largely focused on H.R.1 policy implementation, note that all other areas where H.R.1 provisions have implications to Georgia's Medicaid program will be denoted via teal font.



Medicaid Program

Established in 1965, Medicaid is a state-federal program jointly funded by both the federal government and individual states. It is administered by each state in accordance with federal guidelines to help provide health care services for certain low-income individuals and families, including children, pregnant women, some parents, and individuals who are elderly or have certain disabilities. Medicaid eligibility is defined by both categorical eligibility, which means the populations covered, and financial eligibility, which refers to the income level or threshold at which individuals categorically eligible may qualify for coverage.

States must operate their Medicaid programs following requirements set forth by federal law and by the Centers for Medicare and Medicaid Services (CMS), including covering certain mandatory populations and benefits, as well as out-of-pocket cost limits. Federal law also allows states some flexibility within established parameters in certain aspects of program design, such as covering voluntary populations and benefits, determining provider payment rates, and choosing between fee-for-service or managed care arrangements. These program design flexibilities mean Medicaid programs can look very different in each state.

Medicaid in Georgia is operated under an agreement between CMS and the Georgia Department of Community Health (DCH), which serves as the state's designated Medicaid agency. Medicaid service delivery in Georgia primarily occurs through Care Management Organizations (CMOs), who contract with DCH.

Brief Background *(continued)*

FIGURE 1-1.
GEORGIA MEDICAID AT-A-GLANCE (2025)

Georgia's Medicaid Population

- **20.8%** of Georgians are covered by Medicaid
- Medicaid covered **42%** of Georgia births in 2024, down from 45% in 2023
- **48%** of Georgia's children are covered by Medicaid
- **73%** of Georgia's nursing home residents are covered by Medicaid
- **17.2%** of Medicaid members are also enrolled in Medicare
- As of June 2025, almost **321,000** Medicaid members were working. This reflects almost **59%** of all enrolled adults, age 19-64
- **62.9%** of all Medicaid members are children

Service Delivery & Utilization

- **72.4%** of Medicaid members receive services through a CMO
- **94.2%** of children enrolled in Medicaid receive services through a CMO
- Aged, Blind, and Disabled (ABD) members see a physician **14** times per year on average while Low Income Medicaid (LIM) members average **around six** visits per year
- **52.24%** of all Primary Care Providers (PCPs), **62%** of all pediatricians, and all of the state's acute care hospitals participate in Medicaid

Expenditures & Financing

- The federal government pays **$0.66** of every **$1** Georgia spends on Medicaid services delivery
- Around **66%** of total expenditures cover services for **24.6%** of the total Medicaid population (Medicaid's ABD members)
- **41.5%** of Medicaid spending goes to CMOs to provide benefits primarily for LIM and PeachCare for Kids® (PCK) populations
- ABD per member per month costs are almost **6** times greater than for PCK members, and **7.5** times greater than for LIM
- Hospitals received about **$2.25 Billion** in directed payments and another **$584 Million** in Disproportionate Share Hospital payments in State Fiscal Year (SFY) 2025

NOTE: Sources for the information in Figure 1-1 are cited throughout this report.

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Eligibility & Enrollment

Medicaid Enrollment Overview

2026

Public Health Insurance Programs Operated by the Georgia Department of Community Health (DCH)

DCH administers **Medicaid**, **PeachCare for Kids®**, and the **Georgia Pathways to Coverage™** program. Together these programs covered 2.2 million individuals in Georgia in 2025 and will spend approximately $18.87 billion on services in SFY 2026.

Medicaid

Medicaid covers certain low-income individuals and families, including children, pregnant women, some parents, and individuals who are elderly or have disabilities. The joint funding arrangement between the federal government and each state follows a methodology called Federal Medical Assistance Percentage (FMAP), which establishes a percentage rate annually specific to each state. Low-income families and children are predominantly served under Georgia's Medicaid managed care model, and members who are elderly or have disabilities receive benefits directly from DCH.

PeachCare for Kids®

Georgia's Children's Health Insurance Program (CHIP), named PeachCare for Kids (PCK), covers children in Georgia under the age of 19 whose family income is too high to qualify for Medicaid but less than or equal to 247% of Federal Poverty Level (FPL). Based on income and the child's age, some families may be required to make co-payments. As a program, PCK is distinct from Medicaid. But PCK's coverage resembles Medicaid coverage, and includes preventive services and acute medical care, vision, and dental care. The only exception is non-emergency medical transportation (NEMT), which is a covered benefit for Medicaid but not for PCK, although each CMO covers NEMT as a value added benefit for PCK members.

Pathways to Coverage™

Georgia's Pathways to Coverage™ (Pathways) program, authorized by an 1115 demonstration and launched July 1, 2023, offers Medicaid coverage to eligible Georgians ages 19-64 who have a household income of up to 100% of the FPL, complete qualifying activities for at least 80 hours per month, and fulfill reporting requirements. Qualifying activities include, but are not limited to:

- Full-time or part-time employment
- On-the-job training
- Job readiness assistance programs
- Enrollment in higher education
- A stay in a skilled nursing facility/hospital
- Community service
- Relative caregiving
- Vocational education training
- Parent or legal guardian of a child under the age of six

Medicaid Enrollment Overview

2026

FIGURE 2-1.

MEDICAID MEMBER POPULATIONS

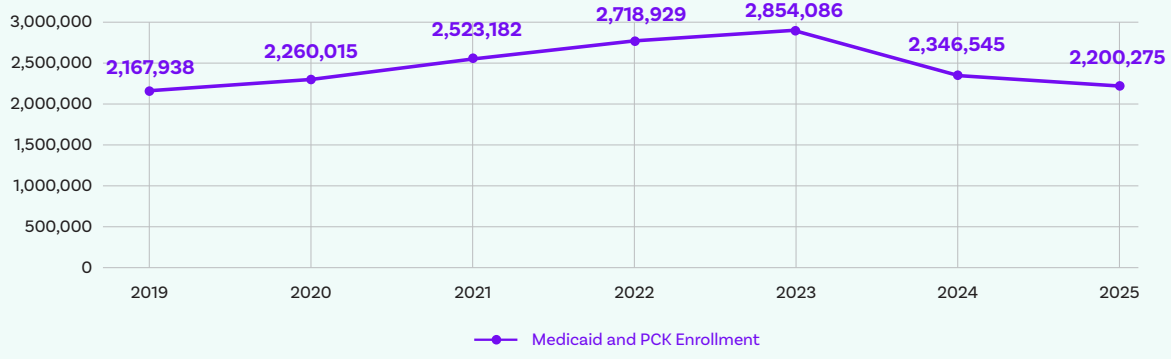
Mandatory Populations	Optional Populations
The populations that states must cover to be eligible for federal funding: • Children (under age 19) in families with income below 138% of the FPL • People who are pregnant with income below 138% of the FPL • Certain parents or caretakers with very low incomes • Most seniors and people with disabilities who receive cash assistance through the federal Supplemental Security Income (SSI) program	**The populations for which states have the option to cover:** • People listed in the "mandatory" groups with income exceeding the limits for mandatory coverage • Seniors and people with disabilities who are not receiving SSI with income below the poverty line • Individuals classified as "medically needy," whose income is above the state's Medicaid eligibility limit but who have high medical expenses, such as nursing home care, that reduce their disposable income below the eligibility limit • People with higher incomes who need long-term services and support

Medicaid Enrollment Overview

One in five Georgians (21%) has health coverage through Medicaid.[2.1] Enrollment moderately increased between State Fiscal Years (SFYs) 2019 and 2025, from 2.17 million to just over 2.20 million enrollees. Despite the dramatic enrollment increase during the COVID-19 public health emergency (PHE), enrollment trends have effectively "returned to normal."

FIGURE 2-2.

GEORGIA MEDICAID AND PCK POINT-IN-TIME ENROLLMENT (SFY 2019-SFY 2025)



Source: Department of Community Health (DCH) enrollment data. Retrieved September 26, 2025.

NOTE: Enrollment reflects Medicaid and PCK enrollment in June of each year; except for 2019, which reflects July 2019.

20.8% As of July 2024, 20.8% of Georgians received health care through Medicaid compared to a national average of 21.3%.

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

17.2% 17.2% of Medicaid members are also dually eligible for Medicare (in part or in full).

Georgia Medicaid enrollment peaked at over 2.8 million[2.2] in 2023 as a result of the PHE, during which states could not disenroll members in exchange for receipt of enhanced federal funding. As of June 2025, enrollment had fallen to 2.2 million according to DCH, slightly higher than pre-pandemic counts.

2.1 U.S. Census Bureau. (2024). GA County Population Estimates.

2.2 DCH Enrollment data. July 2019-June 2025. Requested data received September 26, 2025.

2.3 U.S. Census Bureau. (2024). GA County Population Estimates.

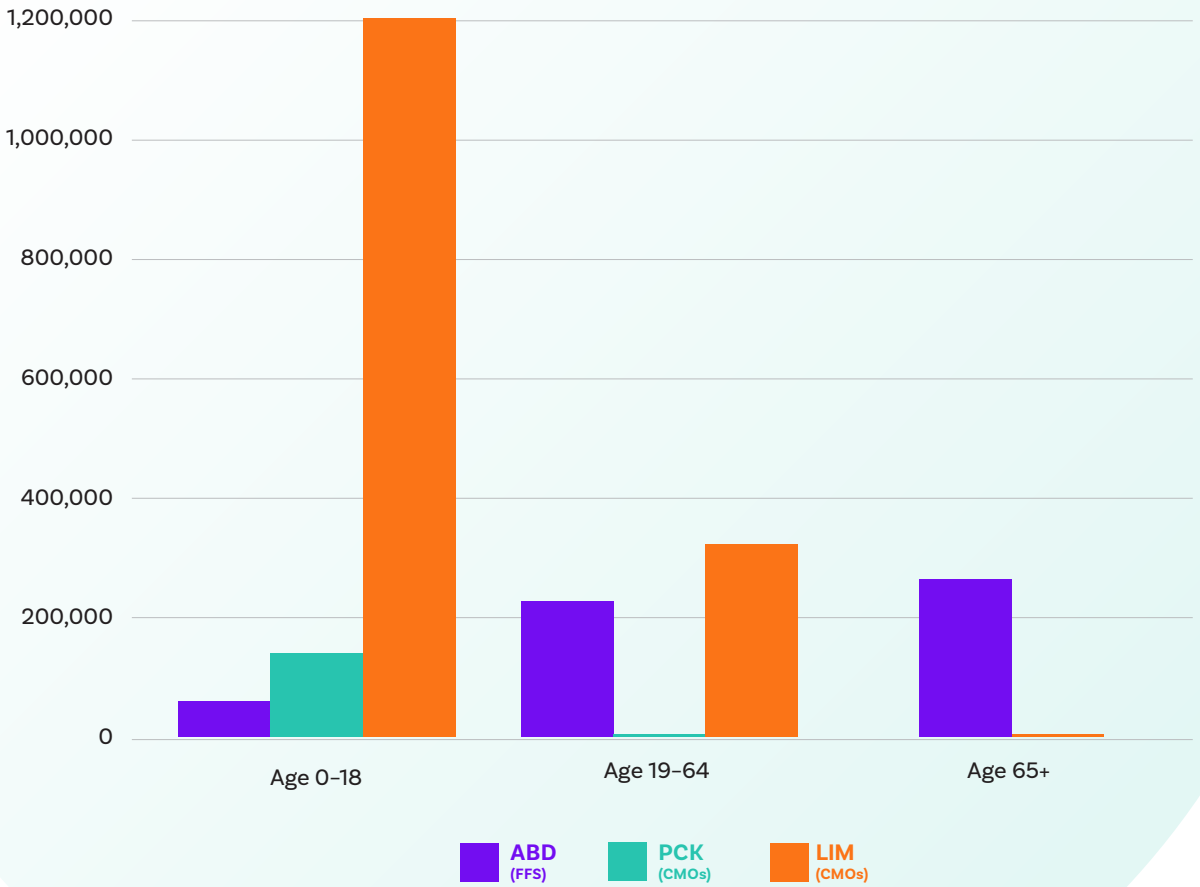
Medicaid Enrollment by Age and Eligibility Category

2026

Georgia has not fully expanded its Medicaid program to low-income childless adults (but does have a partial expansion under Pathways), and generally serves a younger average population as compared to other states. In June 2025, 63% of the Medicaid population was younger than 19. Aged, Blind, and Disabled (ABD) Medicaid is the one category in which members throughout the age span are enrolled, as individuals of any age can be blind or disabled. The vast majority of Georgia Medicaid members (72.4% or 1.59 million) are in managed care and served by one of three currently contracted care management organizations (CMOs).[2.4] The CMOs serve both Low Income Medicaid (LIM) members and PCK members, a partnership with DCH known as Georgia Families®. About 607,000 members are in fee-for-service (FFS) Medicaid.[2.5]

FIGURE 2-3.

MEDICAID AND PCK ENROLLEES BY AGE AND ELIGIBILITY CATEGORY (JUNE 2025)



Source: DCH Enrollment data (June 2025).

2.4 Most LIM members are assigned to managed care while ABD members remain in the FFS system. The contracted care management organizations will change with the next procurement cycle project expected to become effective in July 2027.

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

Medicaid and PCK Enrollment by County

2026

Medicaid and PCK members live in every county in Georgia. Nearly 25% of rural county residents are covered by Medicaid, compared to just over 19% of urban residents covered by Medicaid.

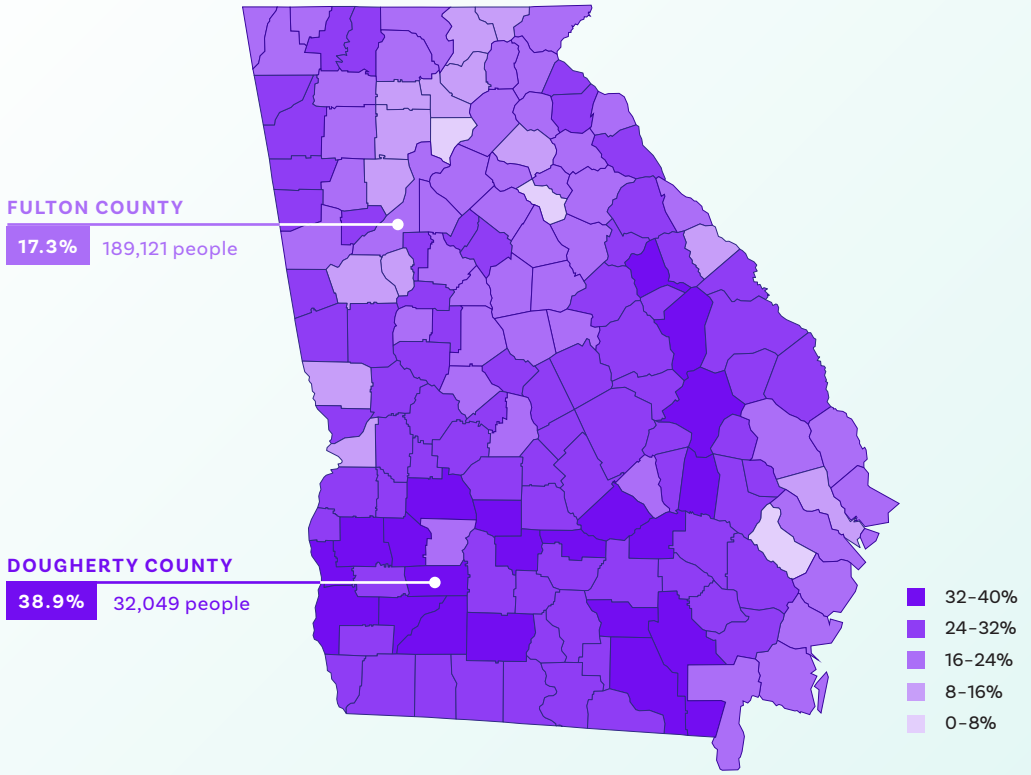
Rural counties in Georgia are less populated and tend to experience higher levels of poverty. So while the **numbers of those enrolled** in Medicaid are higher in the more densely populated, urban areas of the state, the **percentages of the overall county population enrolled** in Medicaid are higher in rural areas of the state.

To illustrate, there are 189,121 people enrolled in Medicaid in **Fulton County** (the highest total enrollment in the state), which translates to 17.3% of the total county population.

By contrast, there are 32,049 people enrolled in Medicaid in **Dougherty County**, which translates to 38.9% of the total county population (the highest percentage of population enrollment in the state).

FIGURE 2-4.

PERCENTAGE OF COUNTY POPULATION ENROLLED IN MEDICAID (JULY 2024)



Source: DCH Enrollment Data. Medicaid Enrollment by County. U.S. Census Bureau. Projected population by County. (July 2024).

Medicaid and PCK Enrollment by County

2026

FIGURE 2-5.

GEORGIA COUNTIES WITH THE HIGHEST MEDICAID ENROLLMENT, BY TOTAL ENROLLMENT AND BY PERCENTAGE OF COUNTY RESIDENTS (2024)

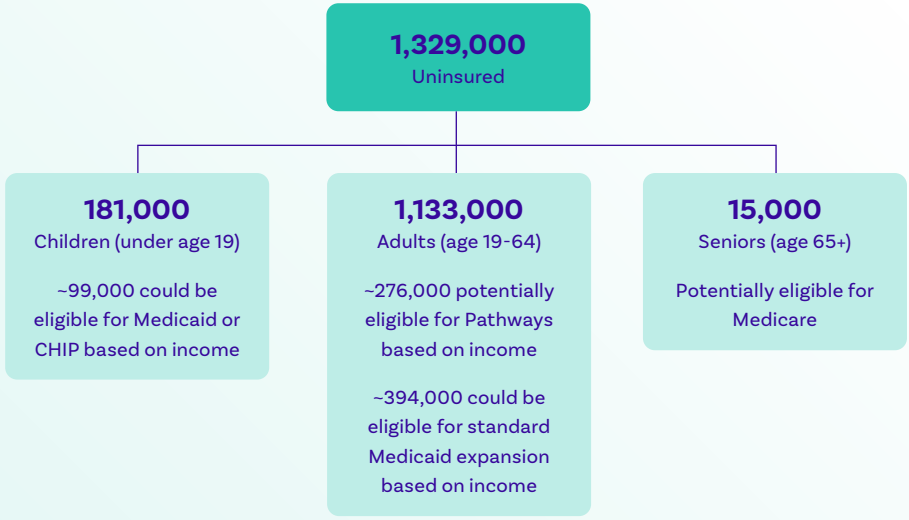
Counties with Highest Total Medicaid Enrollment	Medicaid Enrollment	Percentage of County Residents Enrolled in Medicaid
1. Fulton County	189,121	17.3%
2. Gwinnett County	187,875	18.7%
3. DeKalb County	164,573	21.4%
4. Cobb County	106,652	13.5%
5. Clayton County	94,838	31.9%

Counties with Highest Rate of County Residents Enrolled in Medicaid	Medicaid Enrollment	Percentage of County Residents Enrolled in Medicaid
1. Dougherty County	32,049	38.9%
2. Randolph County	2,311	38.0%
3. Warren County	1,890	36.7%
4. Clay County	1,017	36.1%
5. Crisp County	7,011	36.0%

Source: DCH Enrollment Data. Medicaid Enrollment by County. U.S. Census Bureau. Projected population by County. (July 2024).

Uninsured Georgians

FIGURE 2-6.
UNINSURED GEORGIANS



Source: U.S. Census Bureau. (2024). American Community Survey.

Of the approximately 11 million people in Georgia, more than 1.3 million Georgians are uninsured.[2.6] Of this total over 13%, or almost 181,000, are children under age 19.[2.7] Among these 181,000 children, up to 55% or 99,000 are potentially eligible for Medicaid or PCK based on their families' income.[2.8] Anecdotal evidence suggests that several factors may hinder these children from being enrolled in Medicaid, including administrative hurdles, lack of outreach to parents and education about eligibility and how to apply, and/or immigration status.

Adults ages 19-64 account for just over 85% of Georgia's uninsured population (around 1.13 million individuals). Of these working-age adults, more than 276,000 live at or below 100% of the FPL and could be eligible for Georgia Pathways.[2.9]

Pathways has enrolled 11,600 members as of November 2025.[2.10] Enrollment in Pathways has been consistently lower than expected, which may be due to the qualifying activities requirement, fulfillment of reporting requirements for qualifying activities, administrative challenges, and/or lack of knowledge of the program.

If Georgia were a Medicaid expansion state, over 394,000 of currently uninsured Georgians aged 19-64 could potentially gain health coverage based on their income.[2.11]

2.6 U.S. Census Bureau. (2024). American Community Survey.

2.7 Id.

2.8 Potential eligibility based on estimated income threshold of around 200% FPL.

2.9 U.S. Census Bureau. (2024). American Community Survey.

2.10 GeorgiaPathways.org (n.d.). Data Tracker. Current enrollment as of October 31, 2025. https://www.georgiapathways.org/data-tracker.

2.11 U.S. Census Bureau. (2024). American Community Survey.

Eligibility Groups in Georgia Medicaid and PCK

2026

Medicaid requirements can be met through a number of different eligibility categories, which are often grouped into either LIM, ABD, or PCK. Planning for Healthy Babies and Pathways, as 1115 waiver programs, are commonly grouped under the LIM eligibility umbrella.

FIGURE 2-7.

SUMMARY OF GEORGIA'S ELIGIBILITY CATEGORIES GROUPED BY LIM, ABD, AND PCK WITH ENROLLMENT COUNTS (JUNE 2025)

LIM Enrollment: 1,524,810

Right from the Start Medicaid for Pregnant Women (RSM Adults)
Pregnant women with family incomes at or below 220% FPL.

Right from the Start Medicaid (RSM Children)
Children under 19 years of age whose family incomes were at or below the appropriate percentage of the FPL for their age and family size. There are three groups in this category, each with different income eligibility limits: Child age 0-1: 205%, Child age 1-5: 149%, Child age 6-19: 133%.

Parent/Caretaker with Children Under Age 19
U.S. citizens or lawfully admitted immigrants who are primary caretakers for children under age 19 and whose income does not exceed $653 per month (family of four, 2024).

Medically Needy
Pregnant women with children whose income and/or resources exceed limits for all other LIM categories and use their medical expenses to "spend down" the difference between their income and the medically needy income level. For a family of four, the income limit is $442.

Women's Health Medicaid
Uninsured and underinsured women under 65 years old screened and diagnosed with either breast or cervical cancer by a public health department (renamed from the Breast and Cervical Cancer Program). The monthly income limit is $2,610 for a household of one, and $6,295 for a household of four.

Chafee Option
Older youth (18-21) who aged out of foster care, effective July 1, 2008.[2.12] Subsequent legislation has extended the age of Medicaid eligibility for youth aging out of foster care to age 26.

Emergency Medical Assistance (EMA)
Immigrants, including undocumented immigrants, meeting Medicaid eligibility standards except for their immigrant status may access emergency services only (not the full Medicaid benefit).

Medicaid Assistance for Qualified Aliens
Legal immigrants classified as refugees, asylees, Cuban/Haitian entrants, Vietnamese Americans, and victims of human trafficking. Coverage of this group is federally required, and 100 percent reimbursed by the federal government. This eligibility category will narrow significantly beginning October 1, 2026 per passage of H.R.1 which effectively eliminates eligibility for most refugees/asylees and restricts eligibility to lawful permanent residents, Cuban and Haitian entrants, people residing in the U.S. under COFA[2.13], and lawfully residing children and pregnant immigrants.

Planning for Healthy Babies (P4HB)
Eligible women, ages 18-44, otherwise ineligible for Medicaid, who are able to become pregnant, and whose family gross income is no more than 211% FPL ($2,564 per month for family of one), may retain Medicaid coverage upon termination of RSM Medicaid for Pregnant Women eligibility through enrollment in one of the P4HB programs: Family Planning or Family Planning for women who have delivered very low birth weight (VLBW) babies; or Resource Mother Outreach program for non-RSM women on traditional Medicaid plans who delivered a VLBW baby.

Georgia Pathways to Coverage™
Adults aged 19 to 64 with household income of up to 100% FPL ($15,650 per year) and who complete and report at least 80 hours of qualifying activities per month. Cannot qualify for any other type of Medicaid or be incarcerated.

Source: DCH OAPI Report. DCH Medicaid Enrollment 2022-2025.

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

2.13 COFA, Compacts of Free Association, is a set of international agreements between the United States and three Pacific Island nations: Federated States of Micronesia, Republic of the Marshall Islands, and Republic of Palau.

Eligibility Groups in Georgia Medicaid and PCK *(continued)*

FIGURE 2-7. (CONTINUED)

SUMMARY OF GEORGIA'S ELIGIBILITY CATEGORIES GROUPED BY LIM, ABD, AND PCK WITH ENROLLMENT COUNTS (JUNE 2025)

ABD Enrollment 545,689	PCK Enrollment 129,776
SSI Children and adults who have disabilities, low income, and few resources who receive SSI. **Institutionalized Care** Individuals needing nursing home, hospice, or hospital care for 30 days or more, and Home and Community-Based Services. **Medicare Savings Plans (MSP)** Medicaid assistance for Medicare premiums and/ or cost sharing for low-income MSP members, including those up to 135% FPL. **Public Laws** Six laws extending Medicaid coverage for people who have lost SSI benefits. **Adult Medically Needy** Individuals whose income and/or resources exceed limits for all other ABD categories but can use their medical expenses to "spend down" the difference between their income and the medically needy income level. **Deeming Waiver (Katie Beckett Medicaid)** Children age 18 and under who are financially ineligible for SSI and need institutionalized care but have chosen to remain at home for lower cost care. **EMA** *(Can be LIM, too, but vast majority of members are eligible through ABD)* Immigrants, including undocumented immigrants, meeting Medicaid eligibility standards except for their immigrant status may access emergency services only (not the full Medicaid benefit). **Hospice** Terminally ill individuals expected to live six months or less.	**PCK** eligible children under age 19 whose family income is too much to qualify for Medicaid but who would otherwise be uninsured because the family cannot afford health insurance. For family income at or below 247% FPL.

Source: DCH OAPI Report. DCH Medicaid Enrollment 2022-2025.

Financial Criteria for Medicaid and PCK Eligibility

2026

The FPL, which is a measure of income that serves as the basis for Medicaid and PCK financial eligibility, is set by the U.S. Department of Health and Human Services (HHS) annually. Poverty is defined as any income that falls below 100% FPL. In 2025, the FPL for an individual was $15,650 and $32,150 for a family of four.

FIGURE 2-8.
RANGE OF FINANCIAL LIMITS FOR DIFFERENT ELIGIBILITY TYPES WITHIN EACH ELIGIBILITY CATEGORY

	Aged, Blind, and Disabled		Low-Income Medicaid		PeachCare for Kids®
			Individual	*Family of Four*	
Income Limits	SSI, Medically Needy, Institutional	$317 - $2,901/month	$310 – $3,223/month	$653 – $6,617/month	$3,233/month for household of one $6,751 for household of four
	Medicare Duals	$1,135 - $1,761/month			
Resource Limits	SSI, Medically Needy, Institutional	$2,000	N/A		N/A
	Medicare Duals	$9,660			

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

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

Profiles of Georgians Eligible for Medicaid and PCK

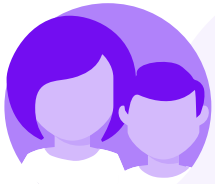
FIGURE 2-9.

ELIGIBILITY PROFILES OF MEDICAID- AND PCK- ENROLLED GEORGIANS

(Reflecting Composite Examples for Illustrative Purposes)

ABD Profile

- 56-year-old male eligible for Medicaid based on disability
- Lives in a suburban area
- Visits his providers frequently, about 48 times a year, primarily for physicians' services, pharmacy, and outpatient hospital services
- Uses Emergency Transportation and inpatient hospital services once a year on average
- Services cost about $16,500 annually



LIM Profile

- 33-year-old mom and two-year-old son
- Live in a rural area; Mom works a part-time minimum wage job and earns less than $6,000 per year
- Both mom and son are generally healthy and primarily use preventive services through their closest primary care doctors, located about 30 minutes away
- Mom primarily uses pharmacy services, sees her doctor around seven times per year to manage her diabetes, and she uses the local hospital-based rural health center once a year
- Son sees the doctor around four times a year for well-child visits and the occasional illness and gets an annual dental check
- Mom uses the community mental health center once a year to support her son's mental health and development
- Service costs are about $3,500 annually for both mom and son together

PCK Profile

- 17-year-old girl with fewer medical needs than majority of Medicaid enrollees
- Lives in Atlanta with a younger sibling and two self-employed parents (no insurance through their jobs) who make around $65,000 annually combined
- Her closest primary doctors are only a few miles away
- Mostly sees her physician for medications, an annual well-child visit, and an occasional sick visit
- Service costs are about $1,300 annually

Source: DCH PeachCare for Kids: Eligibility Criteria.
DCH Medicaid Enrollment 2022-2025.

Enrollment Processes

There are several different ways to apply for Medicaid in Georgia, some of which are open to everyone and others only to specific populations.

FIGURE 2-10.
ENTRY POINTS FOR ENROLLMENT FOR GEORGIA MEDICAID

Entry Point	Eligible Population	Description	Mechanism(s) of Enrollment
Georgia Gateway Portal	All	Georgia's online system promoted as the no-wrong-door entry point for all– including for Medicaid, PCK, and Pathways.	Online
Social Security Administration	Seniors and/or individuals diagnosed with a disability with little to no income.	Eligible individuals who apply and who are approved for Supplemental Security Income (SSI) are automatically enrolled in Medicaid.	In-person at the local Social Security Office
Division of Family and Children's Services (DFCS)	All	Individuals can walk into any county DFCS office or make an appointment to submit an application. DFCS will process the application, assist with completing the online application, and/or provide paper forms to be completed and returned to them.	In-person By mail By phone*
Public Health Departments	Pregnant women	Individuals can be certified through presumptive eligibility processes to get medical assistance the same day.	In-person
Qualified Hospitals and Community Partners (e.g., food banks, churches, associations, nursing homes)	MAGI presumptive populations and newborns	Individuals can be certified through presumptive eligibility processes to get medical assistance the same day.	In-person
Public Health Departments and Qualified Providers	Women with breast or cervical cancer	Women can receive medical assistance for cancer treatments when they are uninsured or under-insured by applying for the Women's Health Medicaid program through their local county Public Health Department.	In-person
Katie Beckett	Medically fragile children	A separate Katie Beckett/Deeming Waiver eligibility unit processes applications for children who have significant disabilities and who would otherwise be eligible to be cared for in an institution.	By mail

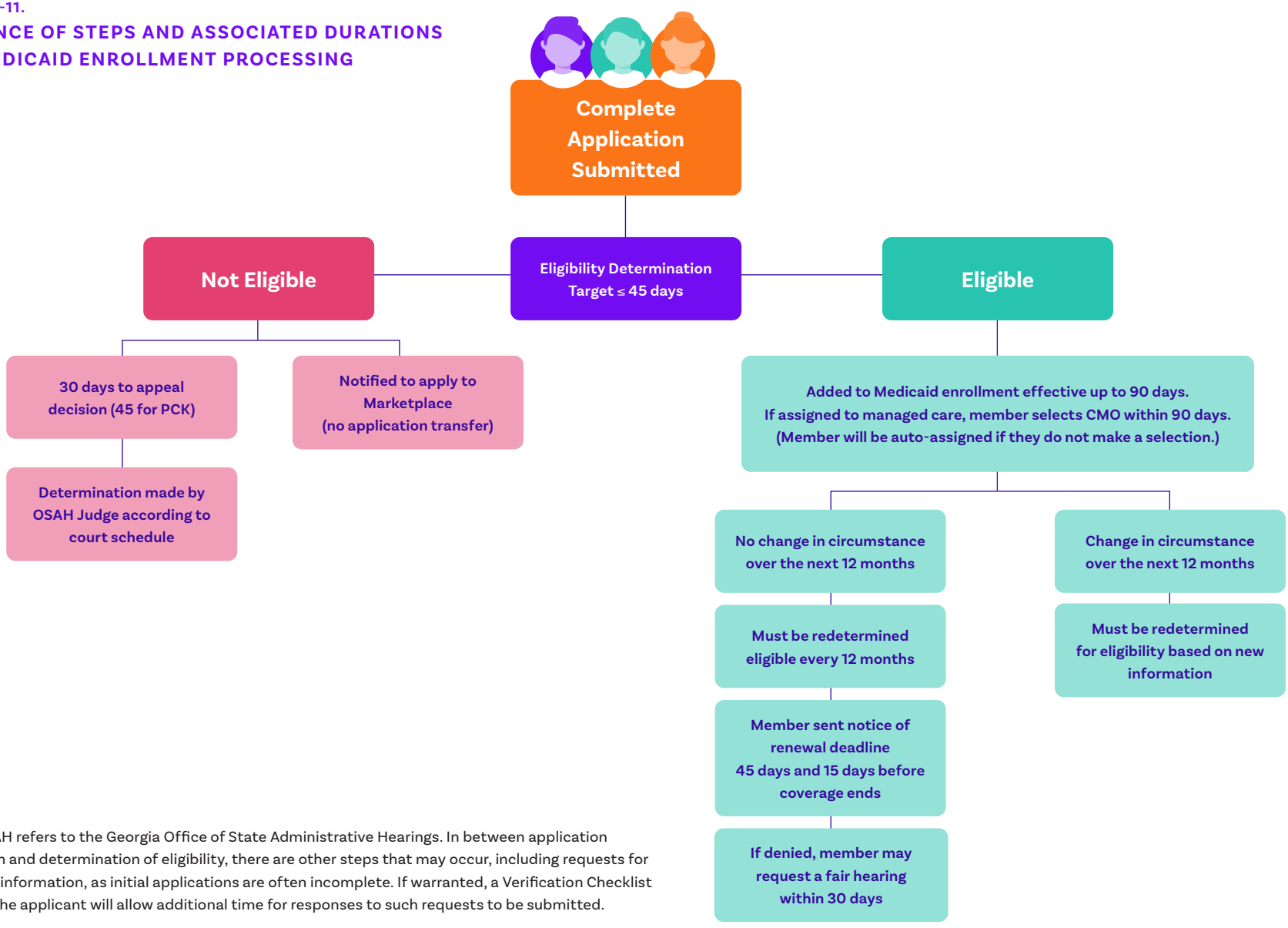
The state's **Express Lane Eligibility (ELE)** program allows children aged 19 and younger to be automatically enrolled or renewed for Medicaid or PCK® when applying for or receiving other state benefits (e.g., Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), Refugee Cash Assistance (RCA), Child Care and Parent Services (CAPS), or Women, Infants and Children (WIC), based on eligibility determined by those programs.

*NOTE: Potential applicants may contact the DFCS Call Center to apply, but additional information or documentation may need to be provided to complete the process.

Medicaid Application Processing - Steps

FIGURE 2-11.

SEQUENCE OF STEPS AND ASSOCIATED DURATIONS FOR MEDICAID ENROLLMENT PROCESSING



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

Medicaid Application Processing – Volume and Duration

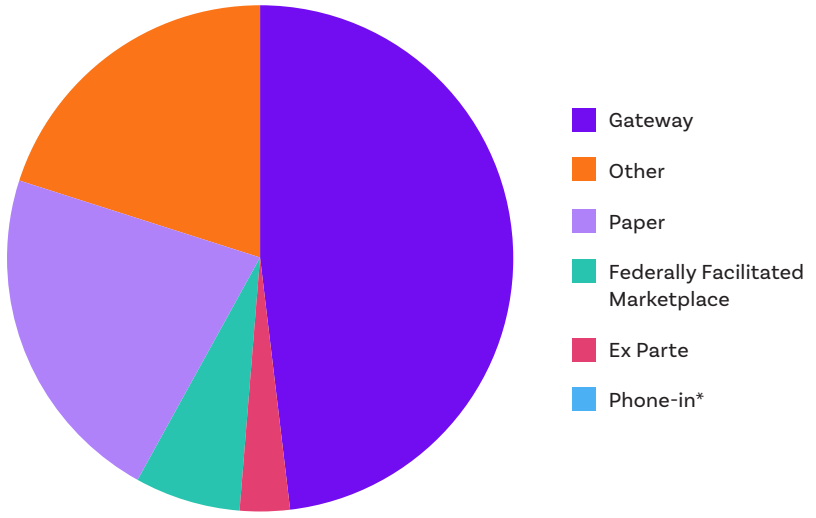
For SFY 2025, the state reported receiving over 643,000 Medicaid applications, with the vast majority of those applications coming in electronically via the customer portal (Gateway) or through a paper application.[2.14] Georgia received an average of 53,600 Medicaid applications each month.

Standard of practice targets a turnaround time of 45 days to process a Medicaid application from time of receipt. The average processing times decreased significantly during the COVID-19 PHE, when enrollees were not going through the full redetermination process. When the PHE ended, average processing times rose substantially as Georgia processed a record high number of redetermination applications.

It has now been over a year since Georgia has returned to normal redetermination processes. The state is experiencing lower applications volumes and lower processing times, with a notable increase in applications processed within 24 hours and a notable decrease in the portion of applications taking over 45 days.

FIGURE 2-12.

APPLICATION SUBMISSION METHOD (SFY 2025)



*Accounts for less than 1% of total.

Source: Department of Human Services. Medicaid applications stats July 2024-June 2025. Data received through Open Records Request.

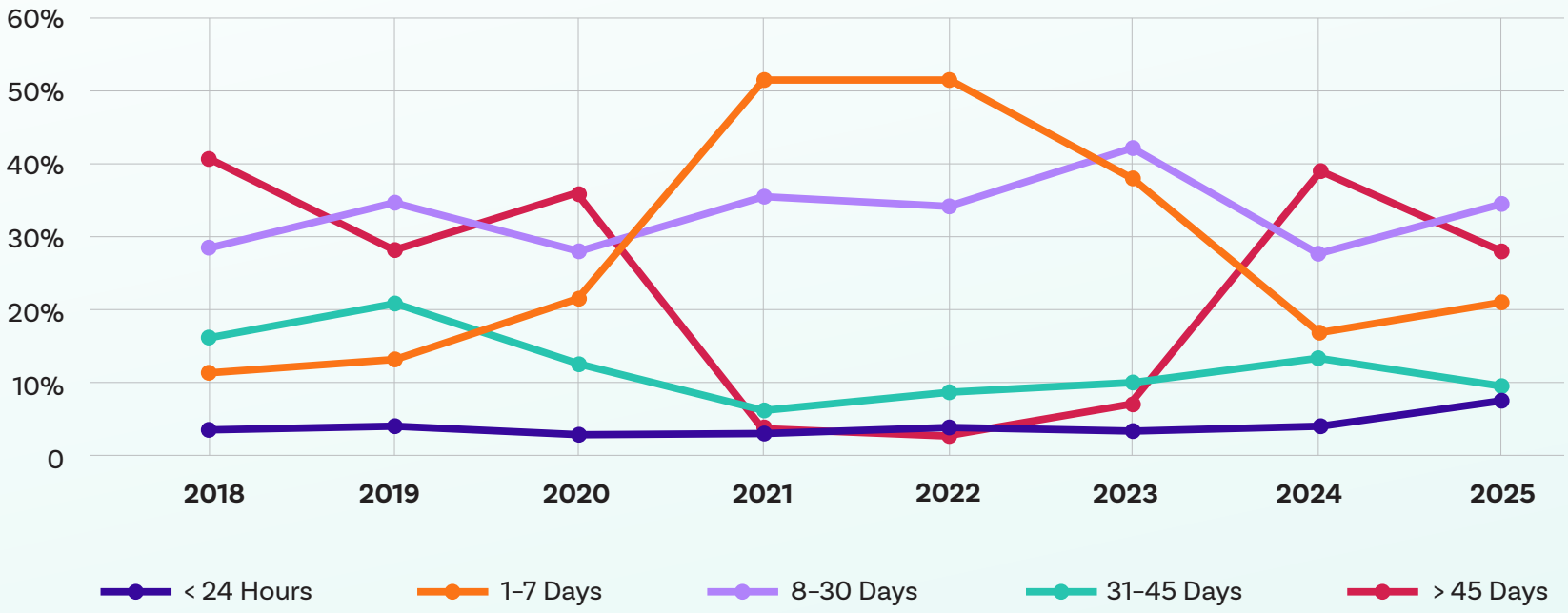
NOTE: "Other" application sources identified by DHS include the Georgia Access Referral (system identifies potentially eligible individual and refers them to the appropriate agency) and Low Income Subsidy (separate application that can overlap with the Medicaid application). Ex Parte is defined as an automatic redetermination using existing data.

2.14 Georgia Department of Human Services. Requested data received November 12, 2025.

Medicaid Application Processing – Volume and Duration *(continued)*

FIGURE 2-13.

GEORGIA MEDICAID AND PCK APPLICATION PROCESSING TIMES (SFY 2018-2025)



Source: CMS. State Medicaid and CHIP Applications, Eligibility Determinations, and Enrollment Data.

NOTE: Data reflects average monthly processing time for each state fiscal year, based on available data.

3

Covered Medicaid Benefits & Services

What is Covered?

Federal law specifies mandatory benefits that all state Medicaid programs must cover. However, each state has significant flexibility in deciding the services it covers for its Medicaid members and setting provider reimbursement rates for those services. In addition to mandatory services, states can provide multiple additional optional services within federal rules. The member's type or category of eligibility determines their available services.

How are services covered?

Different types of legal 'authorities'—official rules or permissions—allow states to cover Medicaid programs and make specific policy choices through State Plans, waivers, and 1115 Demonstrations. Each authority has designated approval periods. Both can be amended at any time, but amendments often require a 30-day public comment period for stakeholder feedback.

Figure 3-1 describes some State Plan and Medicaid waiver and demonstration options currently used by the Georgia Medicaid program.

State Plans

A Medicaid State Plan is the agreement between a state and the federal government describing how that state will administer its program. The State Plan sets out categories of individuals to be covered, services to be provided, provider reimbursement methodologies, and state program administrative activities. When a state is planning to change its program policies or operational approach, it sends a State Plan Amendment (SPA) to Centers for Medicare and Medicaid Services (CMS) for review and approval. States also submit SPAs to make corrections or update their Medicaid or Children's Health Insurance Program (CHIP) State Plan with new information. Many SPAs also require a public comment period for stakeholder feedback. The State Plan is approved indefinitely until the state chooses to amend it.

Medicaid Waivers and Demonstrations

In addition to operating the Medicaid program under the State Plan, states may request CMS approval to waive certain sections of the Social Security Act to enact a variation or alternative to program policy or operations. Requests are made through Medicaid waivers and Medicaid 1115 demonstrations. The 1115 demonstrations and any waiver authorities have to be renewed periodically.

FIGURE 3-1.
MEDICAID AUTHORITIES IN GEORGIA

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

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

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

Medicaid 1915(c) Waivers
Georgia has four 1915(c) waivers which allow for members who have disabilities to receive services at home rather than in a facility or institution.

Mandatory and Optional Medicaid Benefits

Georgia Medicaid benefits include around 50 different service programs in all, with availability of specific services depending on the member's eligibility category. Services also vary based on whether they are covered in the State Plan, Georgia's agreement with CMS describing how the program will be operated, or provided through a Home and Community Based Services (HCBS) waiver, which allows Medicaid to cover services that support individuals in their homes or communities not permissible under the State Plan.

FIGURE 3-2.
KEY MANDATORY AND OPTIONAL GEORGIA MEDICAID BENEFITS

Mandatory Services	Optional Services
• Physician services • Inpatient hospital services • Outpatient hospital services • Laboratory and X-ray services • Home health services • Nursing home care • Early and periodic screening, diagnostic, and treatment services for individuals under 21 • Family planning and supplies • Federally qualified health care center services • Rural health clinic services • Nurse midwife services • Non-emergency transportation	• Pharmacy • Dental care for adults • Orthotics, prosthetics, and durable medical equipment • Primary care case management (DME) • Mental health clinical services • Psychological services • Hospice care • Inpatient hospital care for individuals under age 21 (psychiatric) • Home and community based services • Podiatry services • Portable X-ray and CT scan services • Targeted case management • Vision care

Source: Georgia Medicaid (n.d.). Medicaid State Plan.

Key Medicaid Benefits for Children

2026

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) is a cornerstone Medicaid program requirement that ensures children receive **any medically necessary services needed** to correct or ameliorate a condition so they are best able to meet their developmental milestones. EPSDT is federally designed to provide comprehensive and preventive health services for Medicaid members under age 21 to ensure children receive early detection and care. EPSDT *is* ***not*** a specific set of services. Rather, it is a mandate that children are screened early and regularly and that when developmental issues are identified, appropriate testing and services are provided based on the individual needs of the child, as determined by their doctor or other healthcare professional, and are not limited by pre-determined limits or caps.

An example of a few foundational children's services available through the Medicaid State Plan authorized under EPSDT are described in Figure 3-3.

FIGURE 3-3.

AVAILABLE CHILDREN'S SERVICES

Georgia Health Check Program	Preventive health services, developmental screenings, behavioral assessments, oral, hearing, and vision screenings, and immunizations.
Children's Intervention Services (CIS)	Audiology, nursing, nutrition provided by licensed dietitians, occupational therapy, physical therapy, counseling provided by licensed clinical social workers, and speech-language pathology.
Children's Intervention School Services (CISS)	The same services as in CIS but provided by an approved school system known as a Local Education Agency (LEA) for Medicaid-eligible students with an Individualized Education Program (IEP), and as of June 2022, includes nursing services for Medicaid-eligible students who do not have an IEP.
Georgia Pediatric Program (GAPP)	Provides medically necessary nursing care, personal care support services, and/or behavioral support aide services for children who need skilled nursing to remain medically safe and healthy at home, are unable to engage in activities of daily living according to age-appropriate developmental milestones, or require behavior management skills building.

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

Key Medicaid Benefits for Seniors and Individuals with Disabilities 2026

Long term services and supports (LTSS) are Medicaid services for individuals needing nursing care or ongoing help with daily activities due to functional limitations or other conditions. LTSS includes institutional long-term care services (e.g., nursing facility care) and home-based services which are available through HCBS waiver programs. Institutional services are authorized by the Medicaid State Plan whereas waiver programs require the state to request permission to waive certain Medicaid rules to provide the HCBS option.

Eligibility for HCBS is based on a member needing the level of care they would otherwise get in an institution like a nursing facility or hospital. A member has to choose to receive HCBS instead of facility-based care. The number of people enrolled in each HCBS waiver can be limited to a preset number of "slots." The slots, in conjunction with the allocated budget for each waiver, allow the state to control spending. These limitations can result in waiting lists for HCBS. The current numbers of members eligible but on the waiting list for HCBS is greatest for those with intellectual and developmental disabilities and least for those who are adults with physical disabilities or traumatic brain injury (Figure 3-4).

FIGURE 3-4.

OVERVIEW OF WAIVER PROGRAMS, INCLUDING NUMBER ENROLLED AND ON WAITING LIST (STATE FISCAL YEAR (SFY) 2025)

Population Served	# Enrolled	Waiting List as of 10/2025
Individuals with intellectual or developmental disability	14,359	7,891
Adults who are elderly and frail or disabled	48,412	1,733
Adults with physical disabilities or traumatic brain injury	2,495	124

There has been growing interest by both states and CMS in expanding HCBS due to the better quality of life it offers members and its cost-effectiveness. The annual cost to the state of supporting a member in HCBS is sometimes half the cost or less of a nursing facility (based on comparison of average expenditures between skilled care in a nursing facility at $57,442 per member and the average cost for the elderly and disabled waiver at $26,930 per member annually).[3.1]

Federal grant programs have supported states in such initiatives for the last two decades, efforts which are often measured by the percentage of state spending on institutional care versus HCBS. Georgia's Medicaid HCBS expenditures as a percentage of total Medicaid LTSS spend was 59% in 2021 (these expenditures were for 90% of all LTSS users). That compares nationally, on average, to 63% of LTSS spending on HCBS for 86% of LTSS users.[3.2]

H.R.1 introduced a new option to allow for states to create HCBS waivers that do not require enrollees to meet an institutional level of care. See National Updates Section for more details.

Katie Beckett Waiver

Rather than a services waiver like HCBS, the Katie Becket Waiver, also known as the Deeming Waiver, allows the state to base eligibility on the child's income only, regardless of parental income, if the child would otherwise require institutional-level care. Children must be age 18 and under, meet the federal definition of a disability, need the level of care of a hospital or nursing facility, and be able to live at home rather than in an institution. Eligibility must be redetermined every two years. As of June 2025, 5,807 children were eligible for Medicaid services through Katie Beckett and used services averaging a total of $19,297 per year.

3.1 DCH OAPI Data Report, member, claim by COS_2025-12-01, November 2025.

3.2 CMS Trends in the Use of and Spending for Home and Community-Based Services as a Share of Total LTSS Use and Spending in Medicaid, 2019–2021, July 24, 2024.

Medicaid Benefits Utilization

2026

Based on expenditures data for SFY 2025, the four largest benefit categories are:

1. **Home and community-based services**
2. **Inpatient hospital**
3. **Nursing facility**
4. **Outpatient hospital**

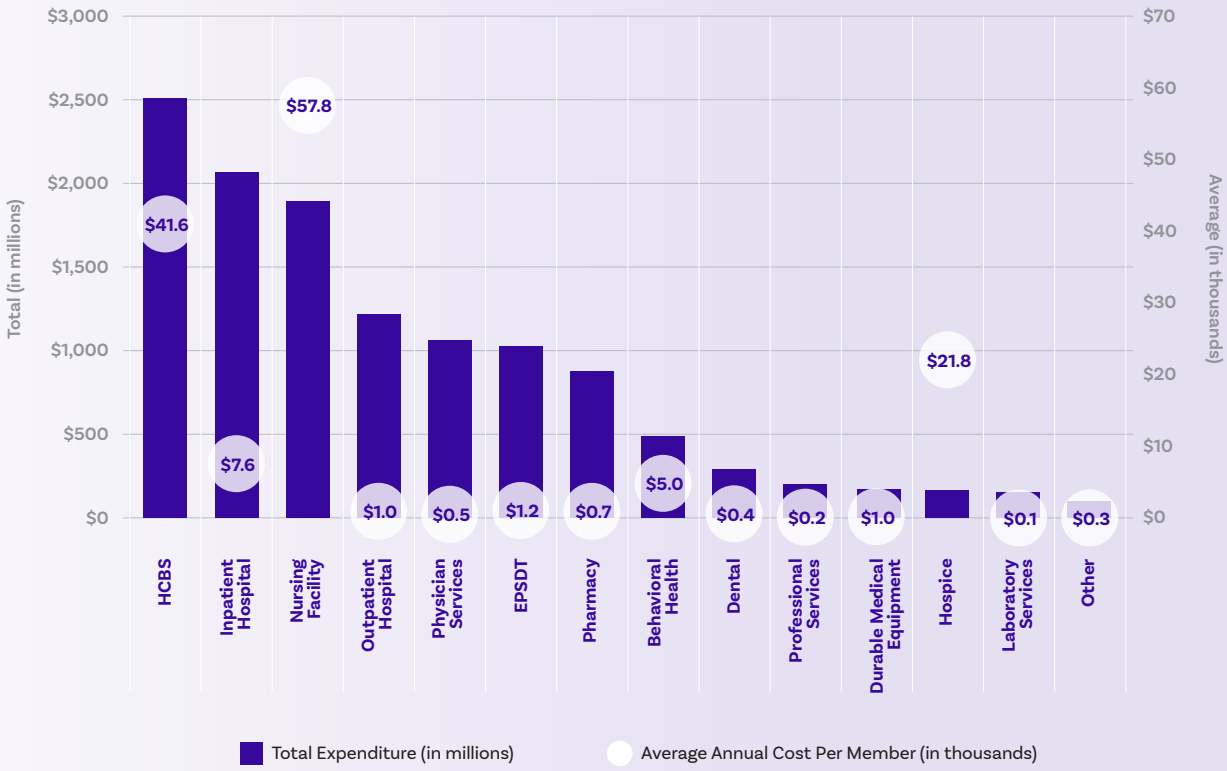
These benefit categories represent 62% of total expenditures. Physician services account for another 8%.

The most utilized[3.3] services by members are **pharmacy**, **physician services**, **laboratory services**, **outpatient hospital**, and **home and community-based services**.[3.4]

From July 2024 through June 2025, the average annual cost per Medicaid member was approximately $1,292 across all categories of service.

FIGURE 3-5.

TOTAL EXPENDITURES AND AVERAGE ANNUAL COSTS PER MEMBER, BY CATEGORY OF SERVICE (SFY 2025)



Source: DCH Expenditures by category of service. SFY 2025. Requested data received December 1, 2025.

3.3 Most utilized determined based on greatest overall number of member claims in SFY 2025.

3.4 DCH Expenditures by category of service. SFY 2025. Requested data received December 1, 2025.

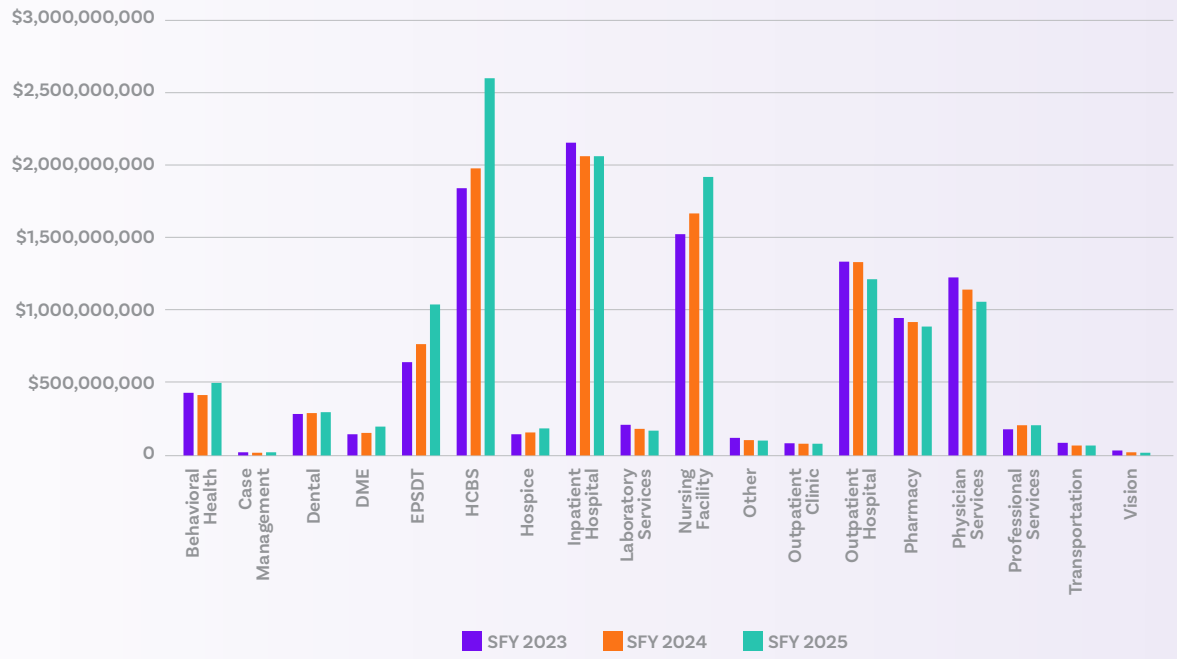
Service Utilization Rates and Costs

Figure 3-6 depicts Medicaid and PCK expenditures by category of service between SFY 2023 and SFY 2025. In terms of **dollars**, the largest increases in this time frame were for HCBS, nursing facility, and EPSDT services. In terms of **percentages**, the largest increases in this time frame were for EPSDT, HCBS, and DME. Notably, increased expenditures for HCBS, nursing facility, and hospice services align with national population aging trends.

In terms of **dollars**, the largest decreases in this time frame were for physician services and outpatient hospital services. In terms of **percentages**, the largest decreases in this time frame were for laboratory services, vision services, and physician services.

FIGURE 3-6.

MEDICAID AND PCK EXPENDITURES BY CATEGORY OF SERVICE (SFY 2023-SFY 2025)



Source: DCH Expenditures by Category of Service, SFY 2023-SFY 2025. Requested data received December 1, 2025.

Access to Georgia Medicaid Providers

Medicaid enrolls most Georgia-licensed health care practitioner types plus facilities such as hospitals, nursing homes, and community mental health centers. In 2025, a total of 58,709 providers (physicians, therapists, diagnosticians, etc.) were enrolled in care management organizations (CMOs) provider networks and 71,023 in the Medicaid fee-for-service (FFS) system.[3.5] This represents an increase in the total number of participating providers for both CMO and FFS enrollees between 2024 and 2025. Notably, in 2024, 52% of all Primary Care Providers (PCPs) and 62% of all pediatricians were accepting Medicaid.[3.6]

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

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

CMOs must demonstrate that at least 90% of their members in each county have access to a provider according to geographic access standards, unless the result is due to circumstances outside their control. The majority of geo-access standards are met by the CMOs on a regular basis but scoring below 90% regularly occurs for certain provider types. For example, access standards for 24-Hour Pharmacies may be unachievable because many are not open 24/7.

FIGURE 3-7.

GEOGRAPHIC ACCESS STANDARDS BY PROVIDER TYPE

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

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

3.5 DCH OAPI Data Report, Provider Count All Tabs. Accessed November 18, 2025.

3.6 Georgia Physician Workforce Dashboard, 2023-2024. Accessed 11/18/25. https://prod.insights.georgia.gov/views/StateofGeorgiaPhysicianWorkforce/PhysicianWorkforceOverview?%3Aembed=y&%3Aiid=1&%3AisGuestRedirectFromVizportal=y

4

Medicaid Operations & Infrastructure

Operational Structure & Service Delivery System

Medicaid Service Delivery Overview

Medicaid delivers health care services through two primary models:

Fee-for-Service (FFS): Members may select to go to any actively Medicaid-enrolled provider. Providers bill Medicaid directly for covered services and are reimbursed at established rates. Some services may require prior authorization, which is managed by the state agency or a contracted vendor. Minimal care coordination or care management is offered only in association with certain services. In Georgia, Aged, Blind and Disabled (ABD) and certain other members excluded from managed care receive their services through this model.

Managed Care: The Department of Community Health (DCH) contracts with Care Management Organizations (CMOs) to coordinate and manage member services. The state pays CMOs a fixed monthly, per-member (capitated) rate, determined by factors such as age, health status, and location of members. CMOs are responsible for delivering all necessary services within this payment structure, assuming financial risk if costs exceed the capitated amount. Members select from approved providers in the CMO's network. In Georgia, Low Income Medicaid (LIM), and PeachCare for Kids® (PCK) members must be enrolled in managed care.

FIGURE 4-1.

KEY DIFFERENCES BETWEEN FFS & MANAGED CARE

Function	Fee for Service	Managed Care
Administration	DCH	DCH contracts with CMOs
Enrollment	Automatically enrolled	Member selects or is assigned to CMO plan
Provider Access	Any Medicaid provider	Providers in the CMO network
Payment	State pays providers per service	State pays CMO a fixed monthly rate per member
Reimbursement	Fixed rates for all providers	Negotiated rates may vary by provider and CMO
Care coordination	Limited, member-driven	Care coordination built into service delivery model
Utilization management	Limited prior authorization	Prior authorization used more to control service utilization
Value and cost	Payment per service	Payment tied to outcomes

Managed Care Organizational Infrastructure

2026

DCH procures and oversees contracts with CMOs to arrange for delivery of benefits and health care services to Medicaid and PCK members under the Georgia Families® program. CMOs are charged with:

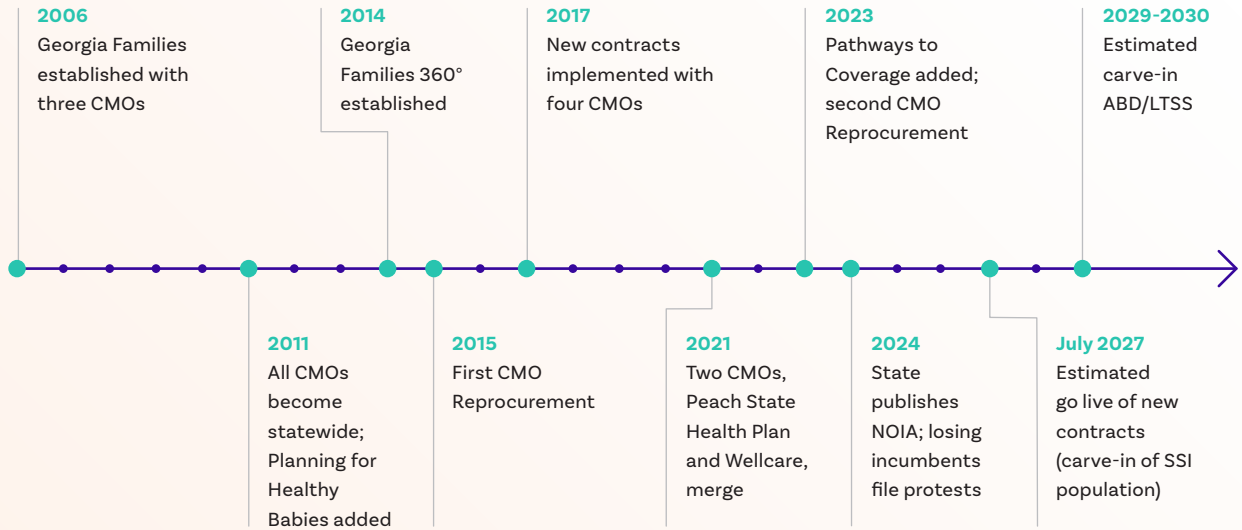
- Expanding access to healthcare services and providers
- Enhancing care quality through utilization management and care coordination
- Ensuring timely and effective healthcare delivery
- Educating members on accessing care, specialist referrals, member benefits, and wellness programs

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

The latest procurement cycle in 2023 resulted in a notice of intent to award (NOIA) to three new CMOs, retaining only one incumbent. Protests were filed and caused a delay to processes. Implementation of new CMO contracts is now scheduled for July 2027.

FIGURE 4-2.

TIMELINE OF THE EVOLUTION OF MEDICAID MANAGED CARE IN GEORGIA



NOTE: "SSI" refers to Supplemental Security Income; "ABD" refers to Aged, Blind, and Disabled Medicaid; "LTSS" refers to Long-Term Services and Supports and "Carve-in" refers to additional populations previously in FFS who will move to managed care.

Managed Care Organizational Infrastructure *(continued)*

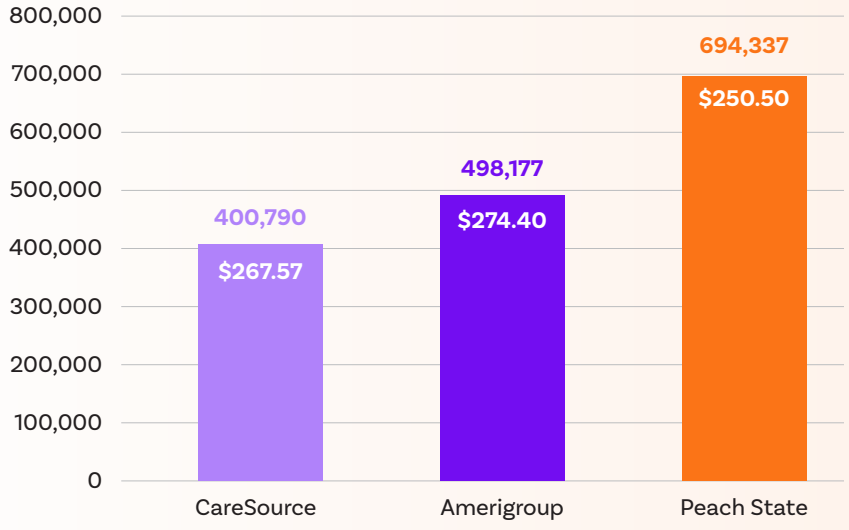
Certain groups remain excluded from Georgia Families, such as Medicare recipients, members of federally recognized tribes, hospice and nursing home residents, and participants in specific ABD Medicaid waiver programs like Katie Beckett. The program requires mandatory enrollment for certain categories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

- LIM (including Pathways and Planning for Healthy Babies members)
- Pregnant women and children under Right from the Start Medicaid (RSM)
- Newborns of Medicaid-covered women
- Women with breast or cervical cancer under age 65
- Refugees (due to H.R.1, effective October 1, 2026 refugees will no longer be eligible for Medicaid and PCK)

Currently, three CMOs cover approximately 1.6 million (72%) of Georgia's Medicaid members through the managed care program. Payments for populations enrolled in managed care account for 41.5% of total Medicaid expenditures.[4.1]

FIGURE 4-3.

AVERAGE MEMBER ENROLLMENT AND CAPITATED RATES FOR CMOs (JUNE 2025)



Source: DCH. Enrollment and CMO payment amount. June 2025. Requested data received December 1, 2025.

4.1 DCH. Total Spend, by CMO and FFS. Requested data received December 1, 2025.

CMO Operational Features

Figure 4-4 presents selected operational features that illustrate how CMOs in Georgia are intended to function according to current contract requirements that have been in effect since July 2017, and which largely mirror the original CMO design from 2006. This list is not exhaustive but is intended to highlight key operational features of managed care that distinguish it from FFS. Major responsibilities assigned to CMOs are more fully delineated in the CMO contracts that DCH oversees.

FIGURE 4-4.

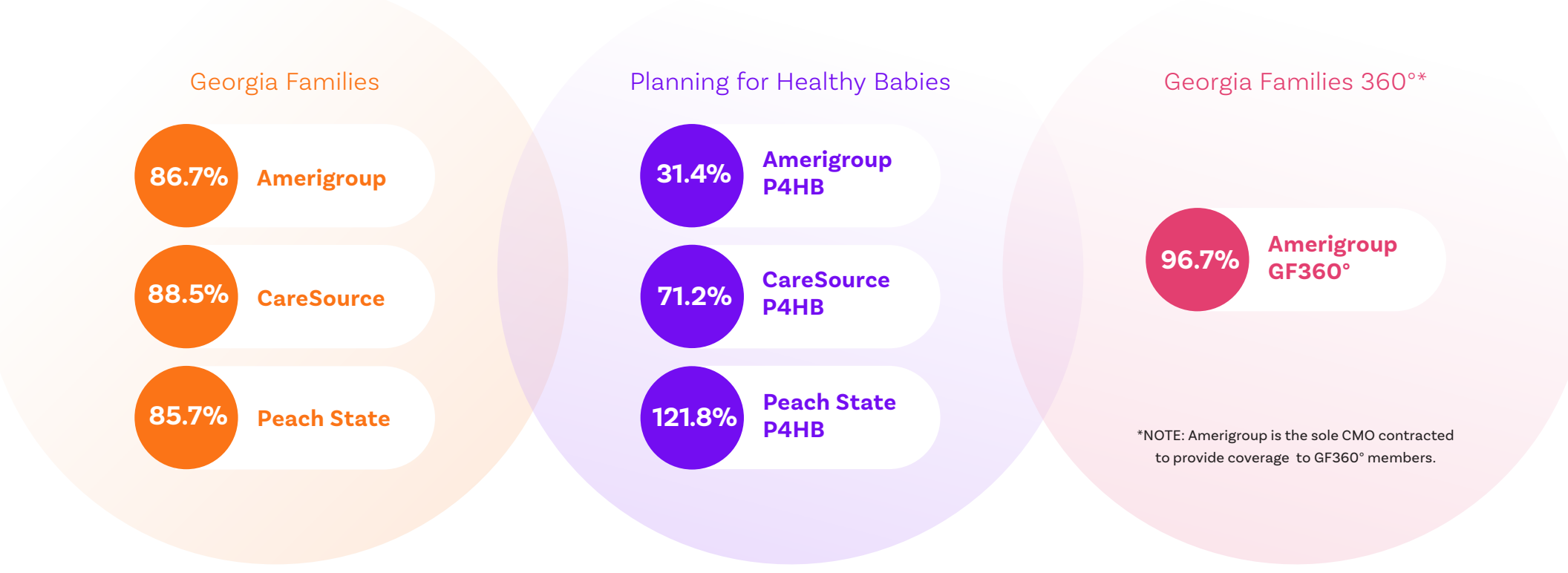
SELECTED CARE MANAGEMENT OPERATIONAL FEATURES

Feature	Description
Assignment	Upon enrollment, members may select a CMO. If no selection is made, members are assigned to a plan through a passive enrollment process. Members can choose a new plan during their annual enrollment period and can also change or opt-out for substantiated cause at any time.
Policies	CMOs must follow policies established by the state, including programmatic requirements about benefit coverage. CMOs can also choose to establish their own additional policies. For example, different prior authorization protocols across CMOs may require health care providers to submit different information for the same service, depending on the CMO to which it's being submitted.
Population Management	Population management refers to the strategies and processes used by CMOs to coordinate and oversee services for members and includes care coordination, health monitoring, and member engagement, among other approaches intended to improve health outcomes and manage costs for defined populations.
Disease Management	Disease management programs are to be employed to improve the health of individuals and reduce associated costs from preventable health complications by identifying and treating chronic conditions more quickly and more effectively, thus slowing the progression of those diseases and reducing acute risk.
Risk Assessment	CMOs are to conduct extensive data analytics and use risk modeling to assign members to certain risk categories which are used to align population health and disease management supports with the level of need for members' health conditions.
Capitated Payments	CMOs receive a fixed amount of funding through capitation payments, which are intended to cover all members' needed clinical services and administration costs. Capitated payments incentivize CMOs to provide care in a cost-efficient way. To maximize profits or stay within capitation budgets, CMOs may engage in cost-cutting measures which can result in diminished care quality.
Medical Loss Ratio (MLR)	MLR is the proportion of total capitation payments spent on clinical services and quality improvement. The minimum MLR for Medicaid managed care per federal rules is 85%.[4.2] The remaining 15% is used to cover all administrative and operational expenses and profit. Under the new Georgia contracts, CMOs will be held to an 86% MLR threshold. If the CMO cannot demonstrate a MLR of greater than 86%, they must return 100% of the monetary difference between the actual MLR and 86%.
Internal Auditing and Quality Improvement	CMOs are to routinely conduct their own internal audits and review data on a regular basis to evaluate performance and to look for opportunities and areas to target for improvement. CMOs also must produce and submit reports to DCH on a monthly, quarterly, and annual basis to demonstrate compliance with both performance and contract requirements. Examples of data and information CMOs may review periodically include claims, cost, and quality data; member and provider program effectiveness; complaints and appeals data; provider, member, and advisory council satisfaction; and services requiring cost-benefit of prior authorization.

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

As noted in Figure 4-4, MLR within Medicaid represents the percentage of total capitation payments spent on clinical services and quality improvement. The minimum MLR for Medicaid managed care per federal rules is 85%. Plan-specific reported MLR rates for 2024 are depicted in Figure 4-5.

FIGURE 4-5.
REPORTED PLAN-SPECIFIC 2024 MLR RATES.[4.3]



4.3 Georgia Managed Care Program Annual Reports 2024.

Managed Care Accountability

2026

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

DCH Monitoring

CMO contracts define performance requirements and outline processes for requiring corrective action plans and assessing liquidated damages for failing to meet requirements. It is unclear how regularly DCH has used these methods to manage CMO performance, as that is not made public. The state has historically had a small team dedicated to supporting and monitoring CMO operations. Recognizing that this team is under-resourced, DCH's FY2025 budget included a $1.5 million increase to add 20 staff positions to monitor, evaluate, and improve oversight of the CMOs with an emphasis on both data analytics staff and technology services needed to improve CMO oversight activities.[4.4] Several of these positions were filled in 2025. Staff in these roles will analyze and validate dozens of reports that the CMOs submit monthly and quarterly against the current contract reporting requirements in effect since July 2017.

Audits

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

A standing committee of the Board of Community Health is the Care Management Committee. Board members meet quarterly to review findings of audits of CMO activities.

Improving Care through Value Based Programs

The state has employed the use of Value Based Programs (VBP) in a limited fashion only with the Georgia Families 360° CMO (the state's specialty plan for children in foster care and receiving adoption assistance, and juvenile justice involved youth), though all Georgia CMOs engage their providers in Quality Incentive Programs, Pay for Performance Programs (P4P), and Negotiated Risk and Shared Savings programs. These programs provide additional payments and incentives for focusing on preventive and chronic care services that align with DCH quality goals and CMO contractual objectives. Examples of VBP payments for improvement in targeted health outcomes and measures include additional payment for providing certain services tied to maternal health and chronic care management. This is an area of focused priority that the state is looking to employ when the new, updated CMO contracts are executed following the contract awards.

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

CMO Quality Overview

2026

CMOs are rated annually on quality of performance and member experience by the National Committee for Quality Assurance (NCQA) according to scoring from the Healthcare Effectiveness Data and Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS). Based on a five-star scale, in which one star conveys poor performance and five stars convey excellent performance, Georgia's health plans were rated at three stars in 2025.[4.5]

Common indicators of health status are tracked according to HEDIS, a national tool used by CMS for standardized reporting across states and health plans. A subset of key measures of Georgia's clinical quality performance highlighted in Figure 4-6 were selected based on alignment with the state's quality priorities around behavioral health, maternal health, and chronic disease. The state's aggregate average ranking by measure across CMOs is presented in comparison to national averages, where one star represents poor performance and five stars represent excellent performance comparatively.

In this subset, CMO performance in behavioral health-related measures were generally higher than other measures. Maternal health measures trend low with one or two stars and one three-star exception. Children's well-care measures (immunizations and body mass index (BMI) percentile assessment) are consistently low to very low with no rating higher than two stars. Chronic disease measures also trended low, with one four-star outlier rating.

FIGURE 4-6.
SELECT NCQA HEALTH PLAN REPORT CARD MEASURES AND AGGREGATE AVERAGE NATIONAL PERCENTILE RANKING (★ = POOR PERFORMANCE; ★★★★★ = EXCELLENT PERFORMANCE).

Measure	Amerigroup Community Care of GA	CareSource Georgia	Peach State Health Plan	Aggregate Average National Ranking
Behavioral health care coordination	★★★	★★★	★★½	★★½
Child and adolescent well-care	★★	★½	★★	★★★
Cancer screening	★★½	★★½	★★★★½	★★½
Asthma control	★★	★★★★	★★★	★½
Diabetes management	★½	★★	★★½	★
Heart disease	★	★½	★★	Not Available
Prenatal checkups	★	★★★	★★	★
Postpartum care	★	★★	★★	★
All-cause inpatient readmissions	★★★★★	★★★	★★★	★★★★

Source: NCQA Health Plan Report Cards, Current Health Plan Ratings Final Results, https://www.ncqa.org/hedis/reports-and-research/ncqas-health-plan-ratings-2025/.

NOTE: The 2025 NCQA Health Plan Ratings are based on data from calendar year 2024 and reflect a weighted average of multiple measures.

4.5 The 2025 NCQA Health Plan Ratings are based on data from calendar year 2024 and reflect a weighted average of multiple measures.

CMO Quality Overview - Member Satisfaction 2026

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

- Child scores in **Rating of All Health Care** and **Rating of Specialist Seen Most Often** increased from 2023 scores significantly.
- Adults' **Rating of Personal Doctor** is significantly higher than the 2023 national average.
- Georgia Families 360° members rated three of the four measures higher than the 2023 national average scores. The remaining measure, however, was rated significantly lower than the national average.
- Most Adult measures scored higher in 2024 as compared to 2023, with the exception of **Customer Service** which was down from 89% (2023) to 86% (2024).

CAHPS results indicate that Georgians' experience is mixed across measures and populations.

FIGURE 4-7.

CAHPS MEMBER EXPERIENCE MEASURES (2024)

Statewide Georgia Families and PCK Measure	Adult	Children
Getting needed care	79%	84%
Getting care quickly	78%	89%
How well doctors communicate	94%	95%
Customer service	86%	90%
Advising smokers and tobacco users to quit	62%	--
Discussing cessation medications	37%	--
Discussing cessation strategies	31%	--
Rating of all health care	76%	88% ▲
Rating of personal doctor	87%	91%
Rating of specialist seen most often	84%	89% ▲
Rating of health plan	76%	87%
Statewide Georgia Families 360° Measure*	**Adult**	**Children**
Getting care quickly	--	93%
How well doctors communicate	--	97%
Customer service	--	95% +
Rating of health plan	--	79%

2024 score is statistically significantly HIGHER than the 2023 national average.

2024 score is statistically significantly LOWER than the 2023 national average.

▲ 2024 score is statistically significantly higher than the Georgia 2023 score.

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

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

*Qualifying Note: This measure had a low response rate and may not be representative of a larger sample.

Each CMO is contractually required to identify and engage in Performance Improvement Projects (PIPs) to achieve significant improvement in targeted areas. The most recent available scoring is from calendar year 2023 and shows all three Georgia Families CMOs had overarching PIP topics in common: Timely Prenatal Care and High Risk or Complex Case Management Enrollment.

PIPs are evaluated by an External Quality Review Organization (EQRO) to validate that any reported improvement links to the quality improvement strategies and activities conducted by the CMO during the project and addresses CMS required outcomes—the quality, timeliness, and accessibility of care and services.

FIGURE 4-8.
PERFORMANCE INDICATOR SCORING RESULTS

	Timely Prenatal Care		High Risk or Complex Case Management Enrollment	
Measurement Period	**1 (Q2 2022)**	**2 (Q2 2023)**	**1 (Q1 2022)**	**2 (Q2 2023)**
Amerigroup	↓	↓	↓	↑
CareSource	↓	↔	↔	↔
Peach State Health Plan	↑	↑	↑	↑

↑ Statistically significant improvement over the baseline measurement period (p value < 0.05)
↔ Not statistically significant improvement or decline from the baseline measurement period
↓ Statistically significant decline over the baseline measurement period (p value < 0.05)

Source: DCH External Quality Review Annual Technical Report (2023) https://dch.georgia.gov/document/document/ga2023-24eqrannualreportf1/download.

Based on evaluation findings, the EQRO makes recommendations to each CMO for improvement. For Amerigroup, which did not achieve significant improvement, it was recommended that barriers associated with the target population be reassessed and targeted interventions developed. For CareSource, which demonstrated improvement in programmatic intervention approaches, recommendations focused on ongoing reassessment of barriers to ensure interventions are responsive to current barriers. For Peach State Health Plan, which sustained statistically significant improvement over the baseline, the EQRO recommended ongoing evaluation of the effectiveness of each intervention using the outcomes to determine each intervention's next steps.

As proposed in the model contracts for the next CMO contract cycle once awarded and implemented, CMOs may associate value-based purchasing performance targets with PIPs.[4.6]

Example Interventions for Prenatal Care

- Initiated targeted live telephonic outreach to members who did not complete the OB Screener $100 incentive for providers who submit an early notice of pregnancy (NOP) form prior to the second trimester of pregnancy.
- Weekly interactive text message to members reminding of the importance of a prenatal visit, rewards information, and support for completing care.
- Obstetric practice consultant identified high-volume obstetric providers and enrolled them in the plans' obstetric quality incentive program.

4.6 State of Georgia Department of Community Health 2023 External Quality Review Annual Technical Report, March 2024.

Next Steps for Georgia's Managed Care Program

2026

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

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

Following DCH's evaluation of bids and selection process in December 2024, the state posted notice of intent to award four managed care contracts to incumbent CareSource and three new entrants: Humana, Molina, and UnitedHealthcare. Unsuccessful bidders filed protests alleging scoring errors, bias, and procedural violation and the losing incumbents filed lawsuits. On November 10, 2025, the state issued a protest decision rejecting the protests and upholding the awards.[4.7] At the time of finalizing this publication, no court decision had been rendered.

Originally scheduled to be operational by July 1, 2026, the new CMO contracts are now targeted to go live July 1, 2027, following contract negotiations, implementation planning, and readiness review. Current CMO contracts will be extended until then. Members enrolled in the three incumbent CMOs (CareSource, Amerigroup, and Peach State Health Plan) will transition to the new plans through an Open Enrollment choice period wherein members can select their plan followed by an assignment process if no selection is made.

4.7 Protest Decision_RFP 41900_DCH0000133_GA F, Georgia Procurement Registry, https://ssl.doas.state.ga.us/gpr/eventDetails?eSourceNumber=41900-DCH0000133&sourceSystemType=ps.

FIGURE 4-9.
ANTICIPATED CHANGES IN NEW CMO PROGRAM

Georgia Medicaid State-wide Preferred Drug List (SPDL)	• A single list of prescription and non-prescription drugs which will be covered by all Georgia CMOs.
Certified Community Behavioral Health Clinics (CCBHCs)	• Designated clinics that provide 24-hour crisis care, evidence-based practices, care coordination with local primary care and hospital partners, and integration with physical health care.
Closed-Loop Referral Management	• Members will complete a Social Determinants of Health (SDOH) screening, and if a need is identified, a community-based organization will respond to that need. Confirmation that the needed services were provided will be relayed back to the CMO, providers, and DCH.
Behavioral Health Homes (BHHs)	• Increase in CMO contracts with behavioral health providers to serve integrated primary care, behavioral health services, and social services and supports for adults and children diagnosed with mental illness or related conditions in BHHs.

Focus on Quality and Strengthening the Service Continuum	• Requirements for CMOs to:
	  • Achieve NCQA Health Equity Plus Accreditation.
	  • Address health related social needs.
	• Offer enhanced Value-Added Services and addition of In Lieu of Services.

CMO Community Reinvestment Plans	• Requirements to identify population health strategies aligned with the DCH Quality Strategic Plan and to make data-driven investments to address members' nonmedical risk factors (e.g., housing, food, etc.). • Reinvestment contributions are voluntary, except in the case of a required reinvestment as a result of deficiencies in meeting VBP Performance Targets.
State Monitoring	• Enhanced access to advanced analytics to monitor CMOs and providers.

5

Medicaid Expenditures & Financing

How Medicaid is Financed

Financing for Medicaid is based on a partnership between states and the federal government with each state responsible for a portion of the costs and the federal government providing matching funds.

Federal Share

The federal government's share is determined by the Federal Medical Assistance Percentage (FMAP), which is recalculated annually based on a state's per capita income relative to the national average. Among states, FMAP ranges from 50% to 83%. Some programs, like the Children's Health Insurance Program (CHIP) and Medicaid Affordable Care Act (ACA) expansion, receive an enhanced federal match (up to 85% for CHIP and 90% for ACA expansion). Administrative costs are usually matched at 50%, but certain activities (such as information system upgrades or anti-fraud efforts) may receive a higher match.

State Share

Georgia's General Assembly decides how to fund the state's share. Federal law requires that at least 40% of the state's contribution comes directly from the state, while up to 60% can be sourced from local governments (such as cities or counties). Most of the state share is typically funded through general state revenues, but states can use additional mechanisms to maximize federal matching funds:

- **Intrastate Governmental Transfers:** Local government entities (like counties) may transfer funds to the state Medicaid agency before payments are made, increasing the state share.
- **Provider Taxes/Fees:** States may levy taxes or fees on private healthcare providers (e.g., hospitals, nursing facilities), regardless of whether they participate in Medicaid. However, due to H.R.1, as of July 4, 2025, states' provider tax rates are frozen at current levels and no further increases are allowed. See the State Priorities & National Updates sections of this publication for further details.
- **Certified Public Expenditures:** Governmental providers such as county-operated nursing homes pay for Medicaid-covered services, and these costs can be counted toward the state share.

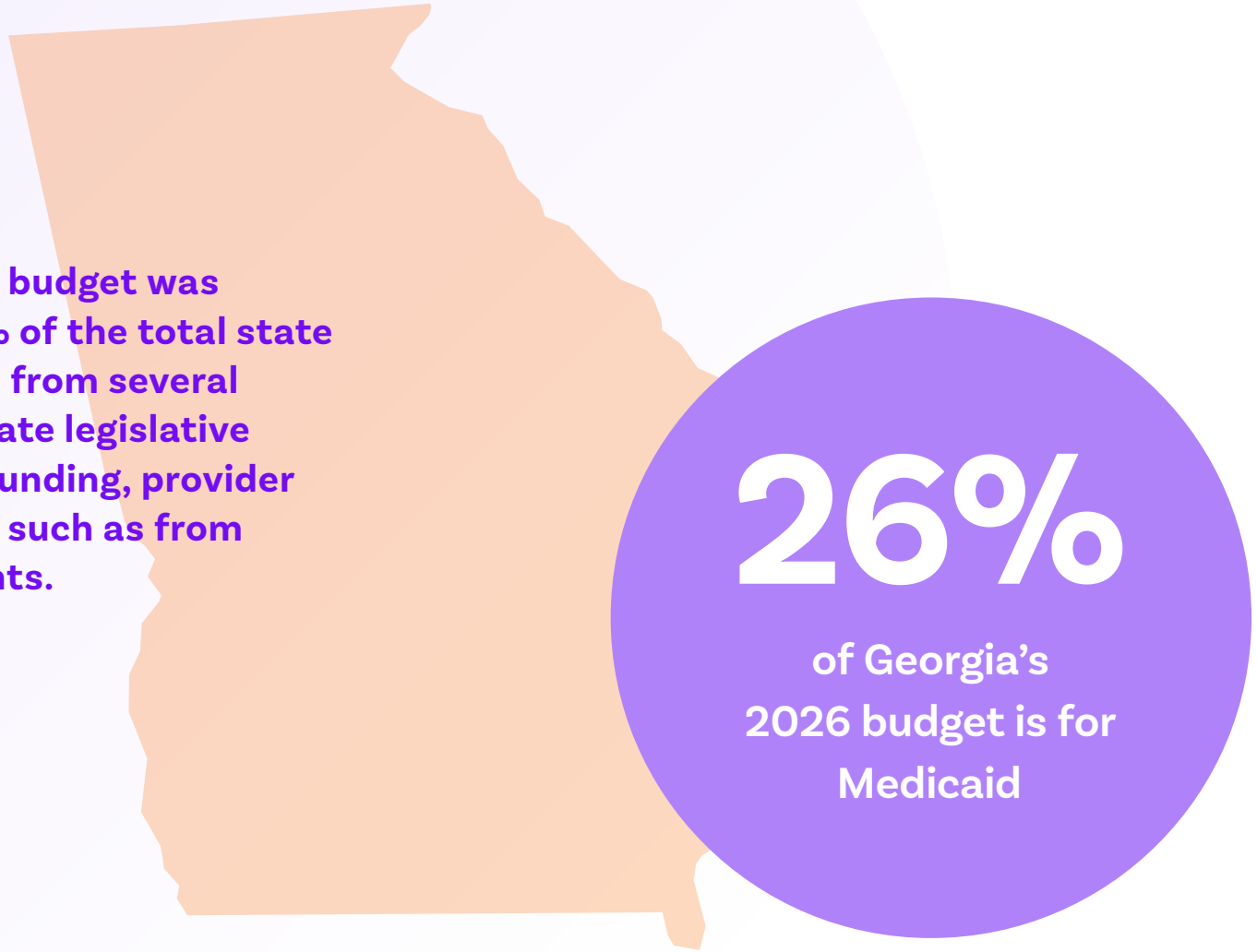
Premiums and Cost Sharing

States may require some Medicaid members to contribute to their healthcare costs through premiums or cost sharing (such as copayments, coinsurance, or deductibles). However, federal rules strictly limit who can be charged, which services are affected, and the amounts to ensure Medicaid remains affordable for low-income populations.

Overview of the Medicaid Budget in Georgia

2026

Georgia's 2026 Medicaid budget was $18.87 billion, about 26% of the total state budget.[5.1] Funding comes from several key sources, including state legislative appropriations, federal funding, provider taxes, and other sources such as from grants or legal settlements.



26%

of Georgia's 2026 budget is for Medicaid

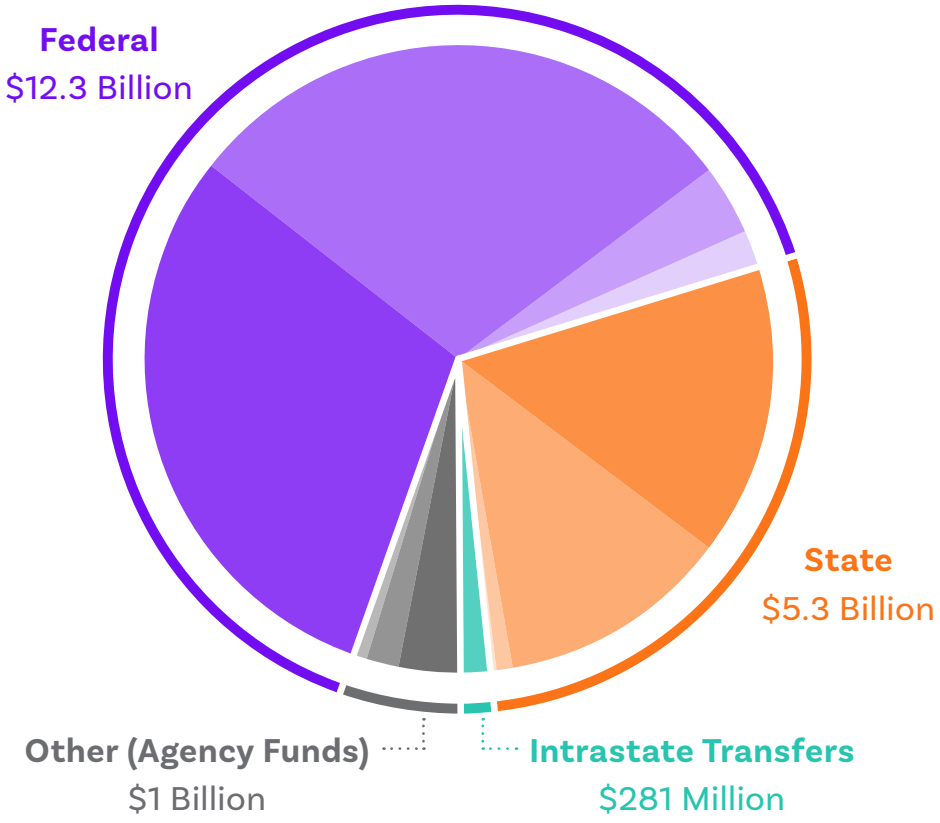
5.1 Governor's Budget Report; State Fiscal Year July 1, 2025 – July 30, 2026.

Overview of the Medicaid Budget in Georgia

2026

FIGURE 5-1.

MEDICAID BUDGET IN GEORGIA BY SOURCES OF FUNDING FOR STATE FISCAL YEAR (SFY) 2026



Federal Low Income Medicaid (LIM)	$5.8 Billion
Federal Aged, Blind, and Disabled (ABD)	$5.5 Billion
Federal Indigent Care Trust Fund (ICTF)	$671.4 Million
Federal PeachCare for Kids® (PCK)	$379.4 Million
State ABD	$2.8 Billion
State LIM	$2.2 Billion
State PCK	$122.7 Million
State ICTF	$52.9 Million
Intrastate Transfers ABD	$267.3 Million
Intrastate Transfers LIM	$13.4 Million
Intrastate Transfers PCK	$151,783
Other (Agency Funds) LIM	$639.1 Million
Other (Agency Funds) ICTF	$286.6 Million
Other (Agency Funds) ABD	$97.6 Million
Total	**$18.87 Billion**

Source: Governor's Budget Report; State Fiscal Year July 1, 2025 - July 30, 2026.

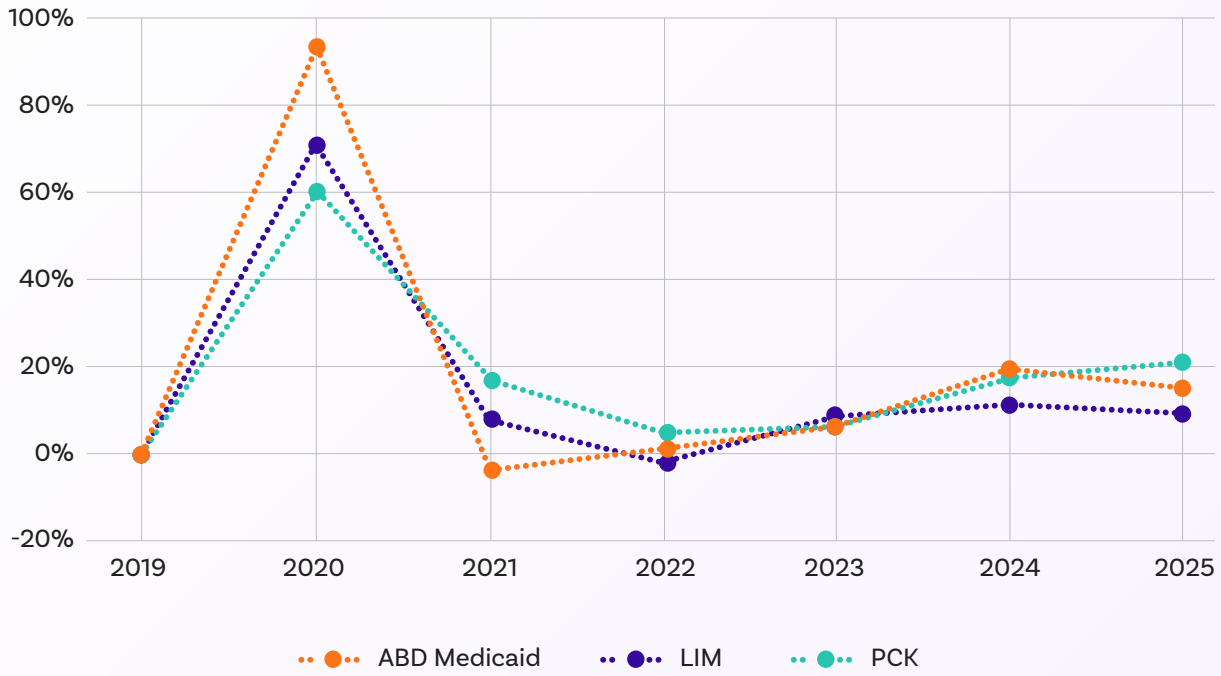
Represents the amount of Medicaid funding appropriated for SFY 2026. Actual expenditures, which may exceed the appropriations based on utilization and other factors, are not available at this time. Expenditure reports, specifically Budget Compliance Reports, are published at the end of each calendar year by the State Accounting Office for the prior state fiscal year.

Recent Medicaid Cost Trends

Average per person costs within Medicaid are rising, driven by increased utilization and reimbursement rates for some service providers. ABD members typically have higher utilization and require some of the costliest services to address their complex health needs. The rise in average costs is also driven by the end of the COVID-19 public health emergency, with many younger, healthier enrollees losing coverage, leaving an older and sicker enrolled population—a change that is more noticeable in the traditionally healthier LIM and PCK populations. Georgia's population and cost trends are consistent with other states.

FIGURE 5-2.

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



Source: DCH. Enrollment Expenditures. (2019-2025). Received via data request.

Federal and State Medicaid Funding

The most significant portion of Medicaid funding is provided by the federal government through the FMAP. Georgia's FMAP rate has fluctuated between 66-67% over the last several years and will be 66.63% for Federal Fiscal Year (FFY) 2027 (Oct 1, 2026-Sept 30, 2027). The federal government therefore covers approximately two-thirds of the state's Medicaid costs of providing benefits. The remaining third is predominantly comprised of state general funds plus other revenues, such as provider taxes allocated specifically for Medicaid services by the General Assembly's appropriations act each year. For the State Fiscal Year (SFY) 2026 budget, the total state portion contributed for Medicaid will be approximately $6.2 billion and the total federal match will be approximately $11.7 billion.

The Children's Health Insurance Program (CHIP) receives an enhanced federal match, therefore all PCK services require significantly less state share—currently less than 24%.

The FMAP for the administrative costs of running Medicaid are generally 50%, but in some instances can be up to 75% and 90%. The total value of Georgia's federal administrative Medicaid match was $359 million for 2025.

FIGURE 5-3.

GEORGIA'S FMAP OVER TIME

Year	FMAP %	State Share %	Public Health Emergency (PHE) Enhanced FMAP%	CHIP Enhanced %
2019	67.62	32.38	–	100.00
2020*	67.30	26.50	73.50	93.00
2021*	67.03	26.77	73.23	81.26
2022*	66.85	26.95	73.05	81.14
2023*	66.02	27.78	72.22	80.55
2024	65.89	34.11	–	76.12
2025	66.04	33.96	–	76.23
2026	66.40	33.60	–	76.48
2027	66.63	33.37	–	76.64

*The state received an extra 6.2 percentage points added to the FMAP for these years as a result of the Public Health Emergency (PHE). This increase was phased out after 2023.

Sources: KFF. (n.d.). Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier. https://www.kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier/ and Enhanced Federal Medical Assistance Percentage for CHIP. https://www.kff.org/other/state-indicator/enhanced-federal-matching-rate-chip/. Federal Register. November 29, 2024. Federal Financial Participation in State Assistance Expenditures. Federal Register. November 28, 2025. Federal Financial Participation in State Assistance Expenditures. https://www.federalregister.gov/documents/2025/11/28/2025-21332/federal-financial-participation-in-state-assistance-expenditures-federal-matching-shares-for.

While FMAP rates fluctuate from year to year, there has been a 0.99 percentage point decrease in the FMAP between 2019 and 2027, meaning a greater percentage of state funds were needed to offset the decrease in federal match. However, with the FMAP increasing slightly since 2024, the SFY 2026 budget would require slightly less state funding due to the adjustment from 65.89% to 66.40%, an increase of 0.36%.

State Funding Sources for Medicaid

2026

Georgia assesses certain provider fees or taxes, including on hospitals, nursing facilities, and ambulance providers, which help generate additional revenue for the Medicaid program. The funding through provider fees is also matched at the regular FMAP rate, drawing down another two-thirds federal funding to help cover facilities' costs. Federal regulations limit the amount of provider taxes that can be used as the state share of Medicaid payments to 6% of an industry's net patient revenue. Additionally, as a result of recent federal policy changes included within H.R.1, Georgia will be prohibited from creating new provider taxes or increasing the rates of existing ones beyond the levels in place as of July 4, 2025.

Georgia also receives funding through grants, legal settlements, or other federal programs. For example, during the pandemic, Georgia received federal COVID-19 relief funds, an enhanced match of 6.2 percentage points.[5.2] In prior years, the state was awarded a Balancing Incentive Payment Program grant, which provided enhanced match for state spending on Home and Community-Based Services (HCBS) over the four-year life of the grant. Occasionally, Georgia Medicaid benefits from legal settlement dollars. For example, Georgia has received a total of approximately $4 billion from the national tobacco settlement since 1998.

FIGURE 5-4.

SOURCES OF STATE FUNDS ACROSS MEDICAID PROGRAMS WITHIN SFY 2026 BUDGET

Medicaid State Funds Source	ABD	LIM	PCK	TOTAL	% OF TOTAL
Ambulance Provider Fees	$9,381,009	$0		$9,381,009	0.2%
Hospital Provider Payment	$46,800,000	$417,400,000		$464,200,000	8.6%
Nursing Home Provider Fees	$159,000,000	$0		$159,000,000	2.9%
State General Funds	$2,672,500,000	$1,690,000,000	$128,000,000	$4,490,500,000	83.1%
Tobacco Settlement Funds	$6,400,000	$142,200,000		$148,600,000	2.8%
Total State Funds	**$2,893,081,009**	**$2,249,600,000**	**$128,000,000**	**$5,270,681,009**	**100%**

Source: Georgia General Assembly. (2025). HB 68 General appropriations; SFY 2026.

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

Sources of Supplemental Payments to Medicaid

2026

Supplemental payments refer to any Medicaid payments that are made outside of base claim payments.

The state makes supplemental payments, or directs care management organizations (CMOs) in the case of Directed Payment Programs, to support qualifying providers that serve a significant number of Medicaid members and uninsured Georgians.

Supplemental payments to hospitals help offset costs of providing uncompensated care (Disproportionate Share Hospital payments), cover some of the gap in hospital and physician reimbursement between fee-for-service (FFS) Medicaid and Medicare rates (Upper Payment Limit payments), and support teaching hospitals with the cost of training residents (Graduate Medical Education (GME) program).[5.3]

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

Sources of Supplemental Payments to Medicaid *(continued)*

Disproportionate Share Hospital Program (DSH)

DSH payments are a mechanism states can use to help hospitals cover uncompensated care costs for services provided to Medicaid and uninsured patients. The amount of DSH payments a state can make are limited based on an annual federal allotment. DSH, like other Medicaid programs, requires a state share amount to draw down the federal match. In SFY 2025, Georgia's federal DSH allotment was $385.6 million, allowing for maximum gross DSH payments of $583.8 million. Almost $53 million of the state share for Georgia's DSH payments comes from state funds, with the remaining $150.3 million coming from intrastate governmental transfers (IGTs).[5.4] The program distributes payments based on each hospital's uncompensated care costs, ensuring that facilities offering essential services to vulnerable communities receive necessary funding. To qualify for DSH payments, hospitals must meet federal criteria which include having a Medicaid inpatient utilization rate of at least one percent.

Intrastate Governmental Transfers (IGT)

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

Indigent Care Trust Fund (ICTF)

A separate fund in the State Treasury, ICTF is funded by provider fees and other sources[5.5] and provides a separate accounting for the collection and distribution of DSH payments and other Medicaid payments that use these sources for the state share. Provider groups pay into the ICTF through IGTs (public entities only) and through provider fees. Along with about $53 million in state funds to support the DSH program, these funds are then used as the state share to draw down federal funds for over $2.2 billion in Medicaid payments.

State Share	Federal Match
State Funds: $52,882,042 Provider Fees: $698,085,721 Agency Funds: $166,991,119	$1,741,460,574

5.4 DCH Indigent Care Trust Fund. FY2025 ICTF Financial Memo. https://dch.georgia.gov/document/document/fy-2025-ictf-memo/download.

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

Sources of Supplemental Payments to Medicaid *(continued)*

Upper Payment Limit (UPL)

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

DCH currently makes UPL payments to:

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

As of the date of publication, $43 million had been issued to outpatient hospitals and $32.6 million for public ambulance providers for 2025. The others remain pending Centers for Medicare and Medicaid Services (CMS) review.[5.6]

Directed Payment Programs (DPPs) Through Managed Care

Similar to supplemental payments in FFS, states can use State Directed Payments, or DPPs, to make targeted payments to certain providers through managed care to address the gap between rates paid by CMOs and other payers. DPPs require annual approval from CMS and must advance at least one of the goals and objectives outlined in the state's quality strategy.

Georgia has worked collaboratively with providers to identify most needed areas of supplemental enforcement. For SFY 2025, Georgia received approval for multiple DPPs totaling over $2.2 billion in Medicaid payments (See Figure 5-6.). The state share is funded through IGTs and provider taxes, with federal matching at the state's regular FMAP.[5.7]

As originally designed, unlike FFS, which is limited to an UPL based on estimated Medicare levels, DPPs could pay up to an average commercial rate of reimbursement. However, to comply with H.R.1, current DPPs will have to be reduced by ten percentage points per year starting in 2028 until payments reach 110% of the equivalent Medicare rate. Initial projections estimate a loss of $5.4 billion in federal funds by 2034. See more detailed discussion of H.R.1 impacts in the Federal Updates section.[5.8]

5.6 DCH Open Records Request, December 1, 2025.

5.7 DCH. (n.d.). State Directed Payment Programs. https://dch.georgia.gov/programs/state-directed-payment-programs; DCH Requested data received December 1, 2025.

5.8 Georgia Health Initiative. (2025, November). *Impact of Federal Policy Changes to Georgia's Health Care Landscape*. https://georgiahealthinitiative.org/wp-content/uploads/2025/11/Impact-of-Federal-Policy-Changes-to-Georgias-Health-Care-Landscape_Report_November_2025.pdf.

Sources of Supplemental Payments to Medicaid *(continued)*

For SFY 2026, Georgia has proposed to CMS three new DPPs valued at an estimated total of $2.9 Billion; two to supplement hospitals that deliver babies and provide other obstetric services and a third to increase eligible hospitals[5.9] funding for critical services and reduce disparities in Medicaid reimbursement:

- Private Rural Obstetrics - $117.5 million (provider-funded state share)
- Public Rural Obstetrics - $161.3 million (IGT-funded state share)
- Strengthening the Reinvestment of a Necessary-workforce in Georgia (STRONG) HIP - $2.6 billion (IGT and provider funded state share)

These new DPP proposals were submitted by DCH to CMS in June 2025 prior to passage of H.R.1, which introduced new policy changes. No response from CMS has been received as of the date of publication.

FIGURE 5-6.
LIST OF 2025 DPPs IN GEORGIA

Type of DPP	Distribution of Funds in SFY 2025 (Total: $2.25 Billion)
Physician DPP	Distributed almost $242 million to eligible physicians and practitioners who are affiliated with a governmental teaching hospital.
Hospital DPP for Public Hospitals[5.9]	Distributed over $371 million.
Hospital DPP for Private Hospitals	Distributed almost $267 million across all private, acute hospitals excluding general cancer hospitals, free-standing children's hospitals, and rehabilitative/psychiatric/long term acute hospitals.
Georgia Advancing Innovation to Delivery Equity (GA-AIDE)	Distributed over $511 million to improve patient quality of care for Grady Memorial, the largest single provider of Medicaid services, Phoebe Putney, and Colquitt Regional Hospitals.
Strengthening the Reinvestment of a Necessary Workforce in Georgia (GA-STRONG)	Distributed over $856 million to 21 qualified teaching hospitals with at least five full-time equivalent residents to encourage workforce retention and incentivize patient care in geographic medical workforce shortage areas.

Source: Georgia General Assembly. (2025). HB 68 General appropriations; SFY 2026.

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

Sources of Supplemental Payments to Medicaid *(continued)*

Nursing Facility Supplemental Quality Payments

Georgia Medicaid certified nursing facilities with 50% or more Medicaid long-term residents are eligible to receive supplemental quality incentive payments for quality-of-care improvements. Beginning in SFY 2022, the General Assembly appropriated $12 million in state funds plus an additional $26,232,673 in one-time funding for the SFY 2022 amended budget to provide supplemental quality incentive payments to eligible skilled nursing facilities for a total of $115 million. The base funding for these quality incentives remains $12 million annually. For SFY 2026, with federal match, another $36 million in total funds will be disbursed for SFY 2026 performance measure results.[5.10] Funding is based on nursing facilities' demonstration of improvement in select performance measures including:

- Percent of high-risk long-stay residents with pressure ulcers
- Percent of long-stay residents who received antianxiety or hypnotic medication
- Percent of long-stay residents who received antipsychotic medication
- Percent of long-stay residents with a urinary tract infection

Updating measures allows for nursing facilities to focus on new areas of needed improvement. Starting in SFY 2027, Georgia will have updated quality measures, which will include:

- Percent of long-stay residents who received antipsychotic medication
- Percent of long-stay residents with a urinary tract infection
- Percent of long-stay residents who lose too much weight
- Percent of long-stay residents experiencing one or more falls with major injury

Graduate Medical Education (GME)

Hospitals with accredited GME programs receive a GME Supplemental payment including a base funding amount. Certain GME programs are eligible for increased funding with amounts determined based on state priorities and need. Base funding uses a formula of $49,000 per resident.[5.11] The increased funding "bumps" for 2024 were:

- Family Medicine: $33,000 / Full time employee (FTE) resident
- OB/GYN: $33,000 / FTE resident
- General Pediatrics: $28,500 / FTE resident
- Pediatric Specialty Programs: $13,500 / FTE resident[5.12]

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

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

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

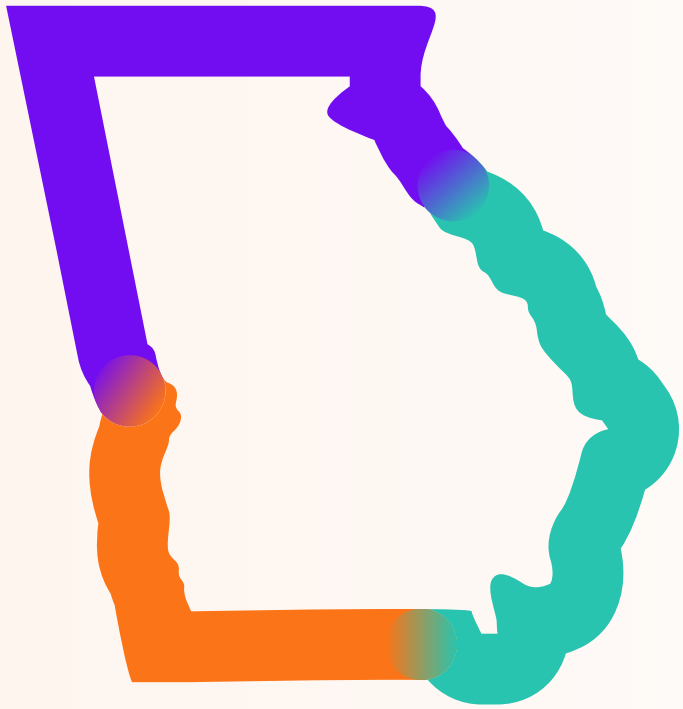
5.12 Id.

6

State Priorities & National Updates

State Priorities - Brief Introduction

Informed by reviews of existing materials and stakeholder interviews conducted with leaders in the state, including state agency officials, several priority areas for enhancements to Georgia's Medicaid program emerged. A snapshot of these issues, including updates to those included in the *2025 Insights on Medicaid* publication, is provided in this resource. These priorities are intended to shed light on the major initiatives necessitating a heightened amount of time and attention from the Department of Community Health (DCH) and other state officials working on Medicaid policy and operations.



Populated within the tables that follow are the identified Medicaid priorities that emerged based on stakeholder interviews and reviews and analysis of existing material. The priorities are organized based on type, recognizing that these categories are not mutually exclusive. Following the tables is additional content and context to further elaborate on certain priority areas identified—namely maternal health and behavioral health.

Of note and as indicated within the tables, a subset of these priorities are those continued from the previous year, which were included and identified as such within our *2025 Insights on Medicaid in Georgia* publication.

FIGURE 6-1.
IDENTIFIED AREAS OF PRIORITY FOR GEORGIA MEDICAID: DELIVERY SYSTEM

Area of Priority	Opportunity Presented
Care Management Organization (CMO) procurement 2023-2026*	New contracts are anticipated to start July 2027, providing an opportunity for raising quality standards, moving to value-based reimbursement for improved outcomes and improving care coordination for newly added populations in managed care.
Pharmacy Benefit Administrative Services Procurement	Through a multi-state procurement led by Georgia, the state can select vendors for pharmacy benefit administration, clinical management, drug rebate, and fraud prevention with the goal of improving medication access, cost management, and program integrity for Medicaid members statewide. An initial Notice of Intent to Award (NOIA) in October 2025 allowed the state allowed DCH to conduct a down-select process to determine final vendor participation through a state-specific Participating Addendum.
Comprehensive Health Coverage Commission*	The Comprehensive Health Coverage Commission (Commission) was established in 2024 to research, assess, and identify options the legislature should consider to improve coverage for uninsured and low-income Georgians and identify opportunities for quality improvement and improved service delivery and coordination. The Commission's initial work plan included priority areas selected through a survey of Commission members. These included: • How existing Medicaid services and waiver programs and improvements could be modified to reach additional uninsured and low-income Georgians • Analyses of certain Medicaid provider funding mechanisms and impact of varied provider reimbursement mechanisms to support Medicaid services • Whether programs, waivers, and policy options implemented in other states could be beneficial or modified to be a fit for Georgia • Policy and modeling around Medicaid waivers • Policy and modeling around certain health outcomes prevalent in Georgia's low-income and uninsured populations • Potential improvements in coordinating healthcare quality and service delivery among the state's public health agencies[6.1] However, due to changes in federal policies in 2025, particularly the uncertainties that exist after the passage of H.R.1, the Commission is in the process of reconsidering its work plan and possible recommendations. At their 2025 meeting in late October, members discussed updated priorities and interim alternative recommendations. Because of these adjustments and the timeline for updating the work plan and reports, any major changes based on the Commission's findings likely won't occur until at least the 2027 legislative session. Per the legislation passed which created the Commission, this body will remain in place until December 31, 2026, unless extended by the General Assembly prior to the end of this year.

*Indicates those areas of priorities that were previously identified and reflected within the *2025 Insights on Medicaid in Georgia* publication.

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

FIGURE 6-2.
IDENTIFIED AREAS OF PRIORITY FOR GEORGIA MEDICAID: INFORMATION TECHNOLOGY

Area of Priority	Opportunity Presented
Integrated Eligibility System (IES) and Medicaid Management Information System (MMIS) changes to implement H.R.1 provisions (estimated 2025-2027)	To align with H.R.1 provisions, the following changes to IES/Gateway or MMIS may include: • Revising the definition of "qualified alien" to remove groups no longer included in the federal definition (e.g. asylees, refugees, and parolees) • Reflecting two rather than three months of retroactive eligibility • Indicating a home equity limit of $1 million for Medicaid eligibility for long-term care • Updating work requirement or community engagement policies as necessary pending additional CMS guidance • Ensuring capability to meet H.R.1's heightened compliance and oversight mandates (e.g., increased member and provider status audits, verification of member addresses, quarterly Death Master File checks)
Procurement for new Eligibility Determination information system (estimated 2025-2028)*	Procurement of a new Medicaid IES would support systems goals of streamlining the eligibility determination process, improving the integration of various services, and providing more responsive, user-friendly interfaces for both applicants/members and administrators.
Medicaid Enterprise Systems Transformation (MEST) Program and Georgia CareConnect	DCH is transitioning from the Georgia Medicaid Management Information System (GAMMIS) to the Georgia CareConnect platform to support the goals of streamlining processes, improving data sharing for healthcare providers, enhancing member services, and helping to ensure compliance with CMS requirements. Implementation is underway and roll-out of new features will occur in successive release phases (estimated 2026-2027) such that CareConnect becomes the new centralized hub for providers, DCH employees, and other users.

*Indicates those areas of priorities that were previously identified and reflected within the *2025 Insights on Medicaid in Georgia* publication

State Priorities – New and Expanded Benefits

FIGURE 6-3.

IDENTIFIED AREAS OF PRIORITY FOR GEORGIA MEDICAID: NEW AND EXPANDED BENEFITS

Area of Priority	Opportunity Presented
Implementation of Certified Community Behavioral Health Clinic (CCBHC) Model*	Implementation of the CCBHC model is aimed at improving access to and the quality of behavioral health services, enhancing service integration, addressing the needs of individuals with complex health challenges, and improving overall health outcomes while reducing costs in the long term. The first three CCBHCs begin operations January 2026.
Program of All-Inclusive Care for the Elderly (PACE) Procurement*	PACE can help bolster the state's system of long-term services and supports (LTSS) by providing a vehicle for elderly members to stay at home longer with better quality outcomes and to help the state use funds more effectively. PACE has been added to the Medicaid State Plan and in 2025, DCH conducted a Request for Proposal (RFP) process inviting qualified organizations to propose models for new PACE service sites in designated "Special Health Focus Service Areas." Bids were due mid-May 2025 and contract awards are expected to be announced in early 2026.
Implementation of Qualified Residential Treatment Programs (QRTPs)*	QRTPs, a new provider type, helps to fill gaps in the continuum of care for children in foster care, allowing these children to be served in less restrictive placement settings using a therapeutic approach that can help families stay together. The QRTP state plan amendment was approved by CMS in October 2025, though as of the date of publication it has yet to be implemented.

*Indicates those areas of priorities that were previously identified and reflected within the *2025 Insights on Medicaid in Georgia* publication

FIGURE 6-4.
IDENTIFIED AREAS OF PRIORITY FOR GEORGIA MEDICAID: FUNDING

Area of Priority	Opportunity Presented
State Directed Payment (SDP) Programs*	Georgia continues to leverage SDPs to provide supplemental funding for Medicaid services, predominantly to address hospital uncompensated care. In 2025, these programs provided over $2.2 billion in funding, with 2026 proposed revisions currently under CMS review. Notably, H.R.1 introduces significant changes to SDPs, capping new SDPs at 110% of Medicare and reducing payments for existing SDPs by ten percentage points each year starting January 1, 2028 until they reach 110% of Medicare.
Rural Health Transformation Program (RHTP)	Created under H.R.1, Georgia submitted its application for grant funding under the RHTP. Through DCH, Georgia's application requested support for 29 strategies across five initiatives: transforming rural health sustainability, strengthening the continuum of care, improving access through mobile and telehealth solutions, growing the healthcare workforce, and leveraging technology innovation. Georgia's total request for the entire five-year period is $1.43 billion. Award notifications from Centers for Medicare and Medicaid Services (CMS) are expected by December 31, 2025, after which DCH will receive its program budget. More details about RHTP are provided in this chapter's Federal Updates section.

*Indicates those areas of priorities that were previously identified and reflected within the *2025 Insights on Medicaid in Georgia* publication

FIGURE 6-5.
IDENTIFIED AREAS OF PRIORITY FOR GEORGIA MEDICAID: QUALITY IMPROVEMENT

Area of Priority	Opportunity Presented
Behavioral Health*	Georgia continues to address gaps in the behavioral health care continuum with a strong focus on children's behavioral health needs. The state has or is in the process of introducing new programs targeted to high-risk, high-acuity youth including the Therapeutic Care Model and Community Sustainability Model, and improving access to services that support family stability and prevent abandonment after discharge from facilities. For children as well as for adults with serious mental illness, substance use disorders, or co-occurring conditions, the state is launching CCBHCs in January 2026.
Maternal Health*	Georgia strives to understand and address root causes of current maternal health outcomes by conducting a deep dive into data regarding the provision and coordination of care (e.g., Are services not being provided or is it a data lag problem? Are all eligible women receiving services? At what point are services initiated?) to inform ongoing strategies and programmatic implementation.
Transition to Value-Based Care	Georgia is implementing payment reforms to improve outcomes such as through more meaningful value-based care models and by moving beyond traditional payment models and modernizing them (e.g., opportunities to unbundle maternal health payment models to support quality improvement goals and better enable data-driven accountability).
Overhaul of Quality Measurement	Georgia is shifting toward custom state measures rather than relying solely on national benchmarks. The state plans to identify more meaningful measures to evaluate outcomes and incorporate these into new CMO contracts and associated value-based reimbursement agreements.
Chronic Conditions*	Georgia continues to identify improvements in chronic disease management as an area of priority, as reflected in its 2024-2026 Quality Strategy. Given that approximately 15% of Georgia Medicaid members have been diagnosed with three or more chronic conditions and that clinical quality indicators assessed across the three Georgia Families® CMOs are lower-than-average, DCH continues to take steps to improve chronic conditions.[6.2]

*Indicates those areas of priorities that were previously identified and reflected within the *2025 Insights on Medicaid in Georgia* publication

6.2 KFF Fact Sheet, Medicaid in Georgia, May 2025. https://files.kff.org/attachment/fact-sheet-medicaid-state-GA.
State of Georgia Department of Community Health 2023 External Quality Review Annual Technical Report, March 2024.

State Priority - Maternal and Child Health

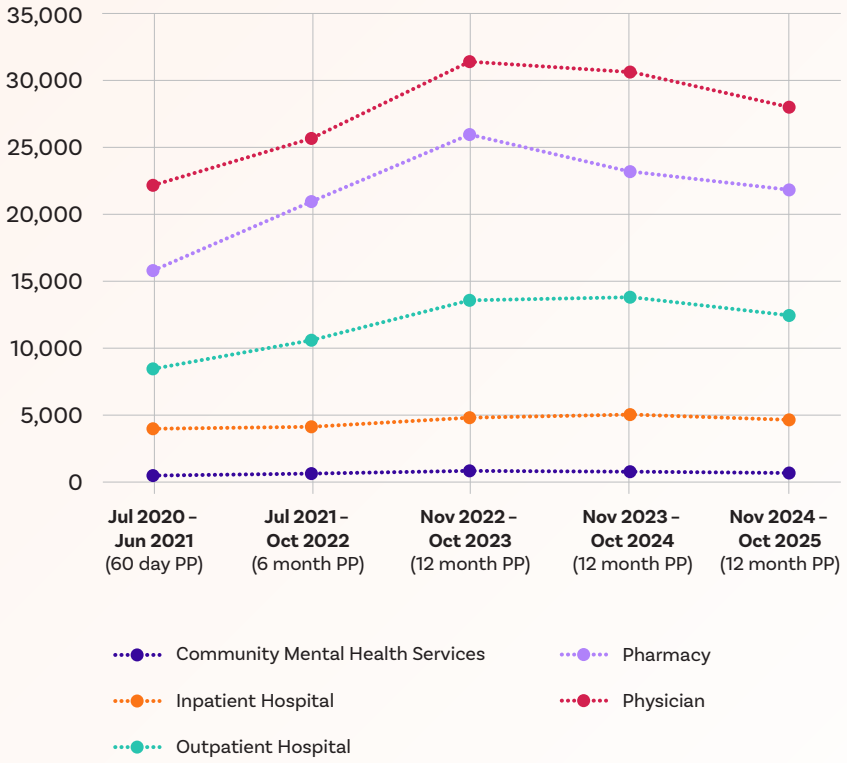
Georgia Medicaid's Quality Strategy for 2024–2026 is reflective of the state's identified health priorities for improving Maternal and Child Health, Behavioral Health, and Chronic Diseases. Each of these areas were selected based on their wide-ranging impact on health outcomes and healthcare costs, the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

Maternal and Child Health

Recognizing that maternal and child health outcomes serve as foundational indicators of a community's overall health, DCH has in place Medicaid-supported initiatives to address these critical issues. DCH is monitoring a number of maternal health indicators, including utilization of services following implementation of 12-month postpartum Medicaid coverage. Georgia's decision to expand postpartum coverage from 60 days to 12 months is showing signs of increased access to care. As depicted in Figure 6-6, the average number of members accessing critical health services each month increased substantially when the postpartum coverage period was extended. Although utilization in late 2024 through late 2025 was slightly lower than in previous years, the number of enrollees for that same time frame was also lower.

FIGURE 6-6.

AVERAGE MONTHLY NUMBER OF UNIQUE RIGHT FROM THE START (RSM) MOTHER MEMBERS USING SERVICES, BY LENGTH OF POSTPARTUM PERIOD (PP)



Source: DCH Data Request. Category of Service (COS) by RSM Mothers using those COS, by length of postpartum period. July 2020-October 2025. Requested data received December 4, 2025.

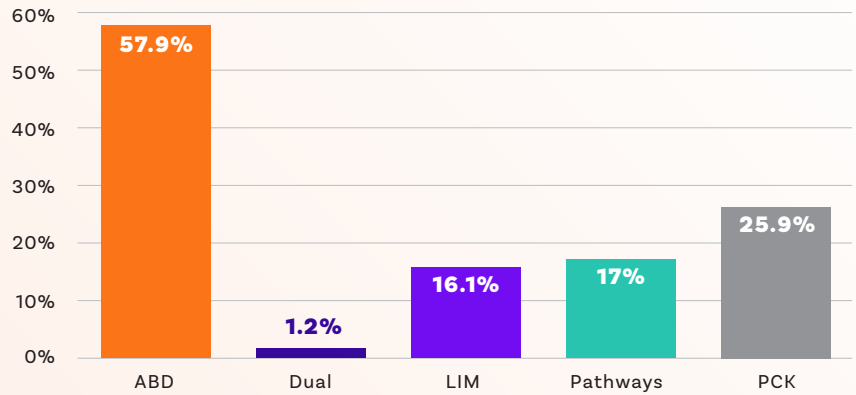
State Priority - Behavioral Health

Behavioral Health

Georgia continues to face high rates of unmet mental health needs, workforce shortages, and significant variation in access to behavioral health services across different populations and regions. As of June 2025, 41 counties (1 in 4) did not have any contracted behavioral health providers for Medicaid and PeachCare for Kids® (PCK) members, meaning that those residents would have to go to a different county to access care.[6.3]

FIGURE 6-7.

PERCENT OF MEDICAID MEMBERS UTILIZING COMMUNITY MENTAL HEALTH SERVICES, SFY 2025



Source: DCH Data request. Distinct users, by category of service and category of aid.

SFY 2025 Georgia 2024 Budgetary Compliance Report. SFY 2025.

Georgia's behavioral health infrastructure has been under strain due to increasing rates of substance use disorders and co-occurring mental health issues. The need for behavioral health services is prevalent across populations to varying degrees, and utilization rates increased between 2023 and 2025. Around 20% of Medicaid members utilized community mental health services between July 2024 and June 2025. Children were some of the greatest utilizers of community mental health services in State Fiscal Year (SFY) 2025, including foster care children.[6.4]

Mental Health Parity

Georgia's House Bill 1013, the Mental Health Parity Act, grew out of the Behavioral Health Reform and Innovation Commission's call to modernize the state's behavioral health system and enforce parity between mental and physical health coverage. Passed in 2022, the law addressed strengthening oversight across insurance, courts, education, and health systems; expanding crisis and involuntary treatment options; and directing initiation of new workforce and data-integration initiatives. Importantly, the Act also applies to Georgia Medicaid and requires Medicaid CMOs to comply with parity standards.

Since enactment, HB 1013 has contributed to annual parity-compliance reporting, statewide data dashboards, formal tracking of parity violations, workforce-support programs, and crisis-system expansion. In August 2025, the Insurance Commissioner issued a roughly $20 million fine split among 22 health insurance companies due to the identification of 6,000 combined violations of the law across these entities. As a tool for oversight and accountability, the Act lays out a critical blueprint for improving transparency, coordination, accountability, and coverage protections.[6.5]

6.3 DCH Data Request. Provider Type by County and CMO. SFY 2025.

6.4 National Conference of State Legislatures. Mental Health and Foster Care. https://www.ncsl.org/human-services/mental-health-and-foster-care.

6.5 Office of Commissioner of Insurance and Safety Fire. Commissioner King to Fine Insurers over $20 Million for Mental Health Parity Violations. August 15, 2025. Available at: https://oci.georgia.gov/press-releases/2025-08-15/commissioner-king-fine-insurers-over-20-million-mental-health-parity.

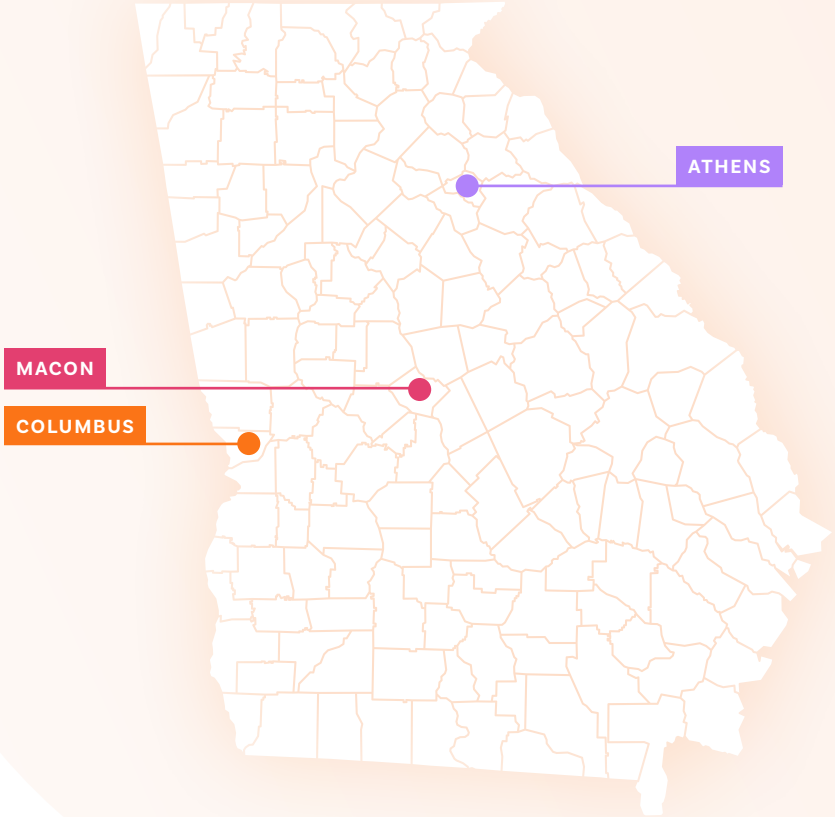
State Priority - Behavioral Health *(continued)*

Certified Community Behavioral Health Clinics

Georgia is undertaking a system redesign of its Community Service Boards (CSBs)—the state's behavioral-health safety-net agencies—by transitioning them to the CCBHC model. This CCBHC model establishes a standardized, statewide framework for delivering comprehensive mental health and substance use disorder treatment services, with integrated primary and behavioral health care for individuals with serious mental illness, substance use disorders, and co-occurring conditions.

Implementation is intended to stabilize clinic financing, improve access and care for high-need populations, strengthen the crisis continuum, and support and sustain the workforce. Effective January 1, 2026, the first certified CCBHCs are:

- **Advantage Behavioral Health Systems – Athens, GA**
- **New Horizons Behavioral Health – Columbus, GA**
- **River Edge Behavioral Health – Macon, GA**



Funding for Behavioral Health

While significant coverage of behavioral health services occurs through Medicaid, the state share for those services is paid by the Department of Behavioral Health and Developmental Disabilities (DBHDD). In addition, DBHDD provides non-Medicaid services through additional state appropriations and federal programs. Other federal funds pay for 21% and 78% of adult and children's addictive disease services respectively. For adult and children's mental health services, other federal funds pay for 5% and 17% respectively. In total, DBHDD state appropriations (70%) and other state funds account for 81% of the behavioral health services budget and 19% are federal.[6.6]

6.6 2024 Budgetary Compliance Report (reissued April 4, 2025) https://sao.georgia.gov/document/document/2024-budgetary-compliance-report-reissue-040425--UNPUBLIS.

State Priority - Behavioral Health *(continued)*

Children's Behavioral Health Care Models

A set of new services has been introduced by the state to fill gaps in the continuum of care for children with significant behavioral health needs.

The Therapeutic Care Model (TCM), approved as a state plan service by CMS effective July 1, 2025, provides a community-based, whole-person-centered program for vulnerable youth up to age 21 for whom there exists no appropriate community placement due to the intensity of their behavioral health needs. TCM features residential support, family coordination, and intensive therapies. The model is designed to help youth transition into stable community placements and adulthood. TCM will initially focus on those in foster care, with plans for broader expansion.

The Community Sustainability Model (CSM) strives to create a structured, flexible pathway to help youth avoid prolonged stays in emergency rooms and residential treatment facilities due to the lack of adequate community supports. Provided as an in-lieu-of-service through managed care, it aims to improve coordination between institutional care and home-based services by pairing intensive, family-centered wraparound supports with short-term, home-like placement options to help stabilize a child safely outside of a facility. Through assessment, clinical case management, and flexible service delivery across family homes, respite stays, and community settings, the CSM is intended to provide support needed for children to return home with appropriate supports.

Opioid Abatement Trust

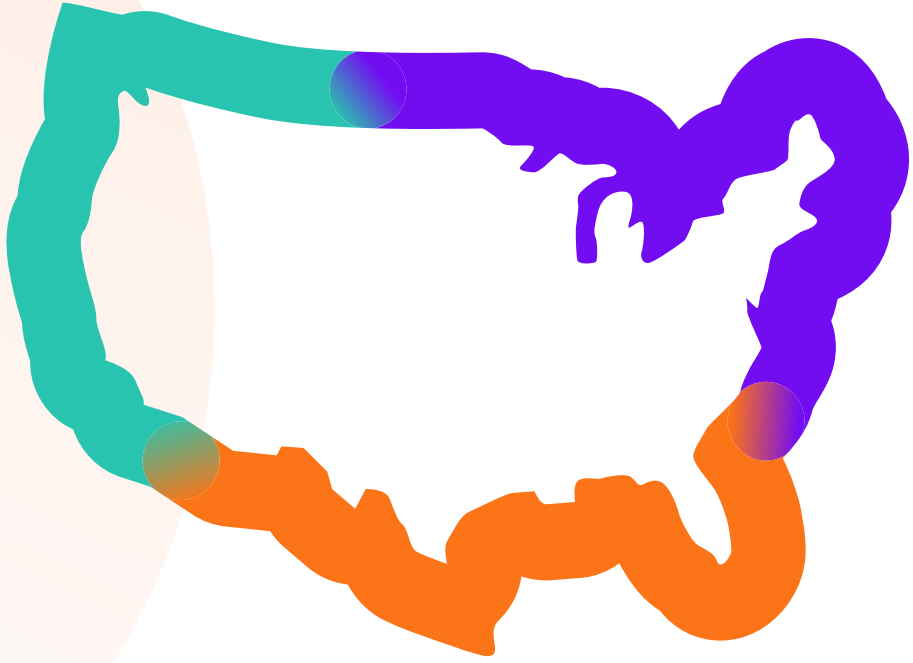
The Georgia Opioid Crisis Abatement Trust was established in 2022 to administer Georgia's portion of national opioid-settlement funds (from pharmaceutical distributors and manufacturers). Grants are awarded through a competitive application process, with funding provided to nonprofits, clinics, local governments, etc. Its first grant cycle in 2024 awarded about $70.3 million across 128 projects statewide. In its 2025 cycle, $42.48 million in grant awards were announced for 109 projects. Funded projects cover a broad range of interventions along the continuum of opioid-related care: prevention and youth-focused education, naloxone distribution and overdose-reversal programs, expansion of medication-assisted treatment, recovery support services (including peer-led community recovery), harm reduction, rural hospital and clinic capacity building, and research and evaluation efforts.

Federal Updates – Overview

2026

As referenced earlier, this section contains a selection of H.R.1 impacts that affect Georgia's Medicaid program.

As a joint federal-state program, Medicaid is ever evolving based on changes to policy, practice, and protocol implemented at both the federal and state level. Many national trends highlighted in the *2025 Insights on Medicaid in Georgia* publication have been paused and/or reversed based on the Trump administration's shift in priorities from those of the prior Biden administration. DCH, like all peer state Medicaid agencies across the country, faces critical decisions necessary to comply with federal policies. The Initiative's recently published Policy Report, *Impact of Federal Policy Changes to Georgia's Health Care Landscape*, delves into greater detail on H.R.1 provisions and their implications on coverage and economic outlook in Georgia. In the pages that follow, this publication provides a synopsis of its anticipated impact on the Medicaid program.



Federal Legislation – Medicaid Funding Changes

H.R.1 introduces significant changes to Medicaid funding, especially regarding provider taxes and state-directed payments (SDPs). In Georgia, provider taxes are fees on healthcare providers, including hospitals, ambulance services, and nursing facilities, which help cover the state's Medicaid and PCK costs. All states except Alaska use provider taxes to help finance the state share of Medicaid,[6.7] and, in Georgia, these taxes account for roughly 12% of the state's Medicaid funding, contributing just over $630 million in FY 2026 and bringing in nearly $1.5 billion in federal matching funds.[6.8] SDPs are used in Georgia and many other states to allow the state to direct CMOs to make targeted payments to specific healthcare providers serving the Medicaid population. SDPs are used to supplement base Medicaid rates, improve provider finances, address disparities in care, and incentivize better patient care outcomes. Georgia uses revenue raised by provider taxes, along with intergovernmental transfers to fund the state share of SDPs.

Georgia's use of provider taxes and SDPs will be significantly impacted by H.R.1, as described in Figure 6-8, reducing federal revenue to Georgia and likely lowering payments to Medicaid providers.

FIGURE 6-8.

H.R.1 MEDICAID FUNDING CHANGES

Topic	H.R.1 Requirement
Provider Taxes	**Overview of Provision** The law prohibits the implementation of new provider taxes or increasing the rates of existing provider taxes across all states. It also prohibits differential tax rates that advantage high Medicaid volume providers or tax Medicaid units of service more heavily. Additionally, for Medicaid expansion states, which does not include Georgia, it also reduces the pre-H.R.1 6% cap on provider taxes by 0.5 percentage points per year beginning in 2028, until the cap reaches 3.5% in 2032. **Implication for Georgia** Provider taxes play an essential role in Georgia's Medicaid financing, with these funds helping to pay for 12% of the state's Medicaid and PCK funding and to secure matching federal funds. The new restrictions limit Georgia's ability to generate needed funds through provider taxes to cover any funding gaps caused by H.R.1 or to meet future health care needs.

6.7 Alice Burns, Elizabeth Williams, Anna Mudumala, Elizabeth Hinton, and Robin Rudowitz, "5 Key Facts About Medicaid and Provider Taxes," KFF, December 1, 2025. https://www.kff.org/medicaid/5-key-facts-about-medicaid-and-provider-taxes/.

6.8 Georgia Budget & Policy Institute: Georgians Could See Hospital Closures and Reduced Health Coverage Due to Medicaid Changes in New Federal Law at https://coverga.org/?jet_download=11cb6b85df507385433ad72879dfe1c727e362b3.

FIGURE 6-8.
H.R.1 MEDICAID FUNDING CHANGES (CONTINUED)

Topic	H.R.1 Requirement
State-directed Payments (SDPs)	**Overview of Provision** SDPs permit states to direct CMOs to pay providers or facilities in specific ways, such as setting uniform rates or adopting particular payment models. Previous CMS regulations permitted states to use the average commercial rate as the upper limit for certain directed payments, instead of the typically lower Medicare rate. H.R.1 introduces several changes to SDPs, including capping the total payment rate for inpatient hospital and nursing facility services at 110% of the Medicare payment rate for non-expansion states such as Georgia.* It grandfathers SDPs higher than these rates if they were submitted prior to enactment of H.R.1 for rural hospitals and prior to May 1, 2025, for all other providers. Any of these grandfathered SDPs exceeding 110% of Medicare will be phased down annually by ten percentage points beginning in federal fiscal year 2028 until they reach the limit. **Implication for Georgia** Georgia relies on five SDPs across a range of provider types to supplement lower Medicaid reimbursement rates. These SDPs are currently based on a percentage of the average commercial equivalent versus the generally lower Medicare rate mandated by H.R.1. This policy change is anticipated to reduce provider revenue over time.
Rural Health Transformation Fund (RHTF)	**Overview of Provision** H.R.1 creates the RHTF that dedicates $50 billion in grants for states to use between FYs 2026 and 2030 to cover certain costs for rural health care efforts. Eligible facilities include rural health clinics and community health centers but not stand-alone practices. **Implication for Georgia** Georgia submitted its application, detailing plans to improve access, outcomes, technology, partnerships, and workforce development and is awaiting award announcement. The State Priorities section provides additional details about DCH's RHTF application.

*NOTE: For Medicaid expansion states, the cap is 100% of the Medicare rate.

Federal Legislation – Medicaid Eligibility & Enrollment Changes 2026

H.R.1. also makes significant changes to Medicaid eligibility and enrollment policies. Georgia is a Medicaid non-expansion state, but it does operate the Pathways to Coverage™ (Pathways) program through its 1115 demonstration. Pathways launched in July 2023 and currently provides coverage to 11,600 adults with incomes up to 100% of the Federal Poverty Level (FPL).[6.9] Under H.R.1, states must adopt new work reporting requirements for the Medicaid expansion population and in expansion-like programs, such as Pathways, effective January 1, 2027. Notably, the Georgia Pathways 1115, which received reapproval by CMS in September 2025, was only reapproved through December 31, 2026,[6.10] with the expectation that Georgia will be required to subsequently align Pathways with H.R.1's work and community engagement reporting provisions effective in 2027.

Figure 6-9 highlights the anticipated changes to Pathways to comply with H.R.1's work reporting requirements, also called community engagement, and other H.R.1 provisions impacting eligibility and enrollment in Georgia's Medicaid and PCK programs.

FIGURE 6-9.
H.R.1 ELIGIBILITY AND ENROLLMENT CHANGES

Topic	H.R.1 Requirement
Medicaid community engagement	**Overview of Provision** By December 31, 2026, individuals ages 19-64 who are eligible for Medicaid via ACA expansion, or an expansion-like program such as Pathways, will have to document that they work, attend school, or volunteer at least 80 hours/month. A person denied or disenrolled for not meeting the requirement is ineligible for subsidized Affordable Care Act (ACA) Marketplace coverage. **Implication for Georgia** Pathways already requires similar reporting requirements, which may be leveraged to ensure compliance with H.R.1 requirements. However, the current Pathways work and other qualifying activities reporting requirement generally has more restrictive criteria (e.g., Pathways does not exclude former foster youth and has more limited caregiver exceptions) compared to those included in H.R 1. The state will need to modify existing processes and policies as CMS has noted the need for Georgia to comply with the new federal provisions related to the Medicaid work and community engagement requirement that goes into effect after December 31, 2026.[6.11]

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

6.10 U.S. Department of Health and Human Services. (September 23, 2025). CMS temporary extension approval. https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ga-pathway-to-covrg-cms-tmpry-extn-aprvl-09232025.pdf.

6.11 Id.

FIGURE 6-9.
H.R.1 ELIGIBILITY AND ENROLLMENT CHANGES (CONTINUED)

Topic	H.R.1 Requirement
Retroactive eligibility	**Overview of Provision** Medicaid law currently allows enrollees to receive coverage of Medicaid benefits for services received prior to the date their application was filed. Effective January 1, 2027, H.R.1 shortens this retroactive coverage period from the current three months to two months for non-expansion enrollees. **Implication for Georgia** Implementing this change will affect individuals who seek care without prior Medicaid enrollment due to timing or life circumstances, who apply when they are hospitalized or experiencing a life event such as pregnancy. A reduced retroactive window will contribute to uninsured hospital costs, provider reluctance to admit new patients at risk, and gaps in care, and the increased financial burdens may deter individuals from seeking care.
Immigrant Medicaid eligibility	**Overview of Provision** Effective October 1, 2026, H.R.1 narrows the definition of qualified immigrants eligible for Medicaid and PCK, restricting coverage to lawful permanent residents; certain Cuban and Haitian entrants; Citizens of the Freely Associated States (COFA migrants) lawfully residing in the United States; and lawfully residing children and pregnant individuals in states (including Georgia) that opted into the Immigrant Children and Health Insurance Assistance (ICHIA) Provision, which allows states to provide Medicaid coverage to any lawfully residing children and pregnant women by waiving the five-year waiting period for Medicaid. **Implication for Georgia** This change excludes many legal immigrants, such as refugees, asylees, parolees, and trafficking victims, from Medicaid and PCK.

FIGURE 6-9.
H.R.1 ELIGIBILITY AND ENROLLMENT CHANGES (CONTINUED)

Topic	H.R.1 Requirement
Additional provisions addressing enrollment issues and concerns	**Overview of Provision** H.R.1 includes many additional requirements addressing Medicaid eligibility and enrollment, with various effective dates over the next ten years. These include: • Effective upon passage, H.R.1 imposes a ten-year moratorium on implementation or enforcement of provisions in two rules finalized by the prior administration intended to enhance efficiencies and ease administrative burdens for individuals to enroll in and maintain Medicaid and CHIP coverage. In effect, the law delays or pauses implementation of many provisions in the two rules until October 2034. Unlike several H.R.1 measures directed at expansion or expansion-like populations, these deferred procedures will also impact processes for Aged, Blind, and Disabled (ABD) populations. • Effective January 1, 2027, states are required to verify eligibility against a Death Master File on a quarterly basis to ensure deceased individuals are not enrolled in Medicaid. • Effective January 1, 2027, states are also required to establish standardized processes to regularly update address information. • Effective October 1, 2029, the law requires a new national federal database to be built that will identify individuals simultaneously enrolled in Medicaid in more than one state. **Implication for Georgia** Georgia will need to comply with these provisions and plan steps in advance of the varying implementation dates listed in the legislation.

Federal Legislation – Additional Medicaid Provisions

H.R.1 also includes additional provisions likely to impact Georgia's Medicaid program over time. These measures introduce new policy options, require updates and decisions regarding compliance and oversight, and will impact administrative efforts for Georgia Medicaid, including staff, providers, and members in the near future, detailed in Figure 6-10 below.

FIGURE 6-10.
ADDITIONAL H.R.1 MEDICAID CHANGES

Topic	H.R.1 Requirement
New 1915(c) Home and Community Based Services (HCBS) waiver option	**Overview of Provision** H.R.1 introduces a new, optional pathway for states to apply for a Section 1915(c) HCBS waiver for individuals who do not meet existing institutional level of care criteria. **Implication for Georgia** If Georgia chooses this new option, available beginning July 1, 2028, the state could expand HCBS services to a broader population provided the program met certain requirements, including demonstrating the new waiver(s) would not increase wait times for those who do need institutional-level care and demonstrating it will not increase costs.
Provider screening requirements	**Overview of Provision** Currently, states must terminate a provider's Medicaid participation if that provider has been terminated from Medicare or from another state's Medicaid program. H.R.1 now mandates that, effective January 1, 2028, states conduct status checks at enrollment, reenrollment, and on a monthly basis to determine whether providers have been terminated from Medicare or any other state Medicaid program. **Implication for Georgia** These changes are anticipated to increase state and provider administrative efforts.

Federal Legislation – Additional Medicaid Provisions *(continued)*

FIGURE 6-10.
ADDITIONAL H.R.1 MEDICAID CHANGES (CONTINUED)

Topic	H.R.1 Requirement
Provider participation and oversight	**Overview of Provision** H.R.1 bars Medicaid participation by certain providers of abortion services (including Planned Parenthood) for one year (July 4, 2025 – July 4, 2026) although the status of this provision remains subject to ongoing legal challenges. The legislation also delays implementation and enforcement of the nursing home staffing final rule established by the prior administration in 2024, which set minimum staffing standards for long-term care facilities. Under H.R.1, CMS must delay implementation and enforcement of these requirements until September 30, 2034. **Implication for Georgia** The impact of these changes remain unclear at present.
Payment Error Rate Measurement (PERM)	**Overview of Provision** H.R.1 revised Medicaid PERM requirements, designed to measure payments in the Medicaid and CHIP programs not meeting statutory, regulatory, or administrative requirements, with each state being reviewed once every three years. The H.R.1 revisions restrict CMS from waiving state financial penalties for errors above three percent and broaden which audits count toward this rate beginning October 1, 2029. After that date, the difference between the state's PERM error rate and the statutory acceptable level (3%) will be subtracted from the state's FMAP. **Implication for Georgia** This has a potential for significant financing consequences for states across the nation as the national improper payment rate for Medicaid and CHIP programs was 5.09% as of fiscal year 2024.[6.12] Notably, Georgia's recent PERM rates have been significantly lower than the fiscal year 2024 average and below the 3% statutory threshold.[6.13] The state must maintain, and possibly enhance, its efforts to assure Medicaid and PCK payments align with program requirements to minimize potential withhold of federal funding.

6.12 Centers for Medicare & Medicaid Services, PERM Error Rate Findings and Reports. https://www.cms.gov/data-research/monitoring-programs/improper-payment-measurement-programs/payment-error-rate-measurement-perm/perm-error-rate-findings-and-reports

6.13 DCH (Stuart Portman) Presentation at the October 22, 2025 Comprehensive Health Commission Meeting. Recording is available on YouTube at https://www.youtube.com/watch?v=8RzS9pC1k9E.

Conclusion & Acknowledgements

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