

Comprehensive Health Coverage Commission

JULY 2025 REPORT

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Pursuant to O.C.G.A. § 49-4-156, the Comprehensive Health Coverage Commission is tasked with reviewing opportunities related to reimbursement and funding for Georgia healthcare providers, quality improvement of healthcare for Georgia's low-income and uninsured populations, and service delivery and coordination enhancements.

Since the date of the Commission's creation and, more acutely since its first report issued in December 2024, the healthcare landscape in Georgia, and across the country, has shifted. During this dynamic time of changing priorities, rules, and funding, the Commission has not formally met. Once the landscape becomes clearer and the programs and rules that support healthcare options are clarified, the Commission may be able to reconvene to develop further recommendations.

In lieu of recommendations, this second Report includes the progress on implementing the Commission's earlier recommendations, evaluation of the current federal landscape, and evolving direction of the administration.

As our federal partners continue to implement the final H.R.1, and as formal direction is provided from the Centers for Medicare and Medicaid Services (CMS), we may then be able to evaluate opportunities to carry forward the mission of the CHCC.

Regardless of the landscape or how it may evolve, we will continue our efforts to improve the healthcare of Georgia's most vulnerable population in the most effective way possible.

Thank you for your continued support and interest in this important topic.

Caylee Noggle, Chair

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Introduction

This report is the second bi-annual report from the Commission. This report provides an overview of the Commission's recommendations as described in the December 1, 2024, report, including the proposed revision to the qualifying activity reporting timeframe for the Georgia Pathways to Coverage Program, and an additional qualifying activity for caregivers of children under the age of 6.

Additionally, this report provides a summary of the provisions of the final H.R.1, which became law on July 4, 2025, and the potential impact to Medicaid. Additional considerations may be provided as the landscape continues to evolve. Once these changes and their impact to Georgia are more fully understood, The Commission will be better positioned to continue researching future opportunities to improve access to health care for the low-income and uninsured populations.

December 2024 Report Highlights

The Commission transmitted its first report on December 1, 2024, outlining efforts to date. The report included a summary of the CHCC initial meetings and opportunities identified by the Commission for enhancing healthcare coverage and quality, including:

1. **Continuous Enrollment for Children:** Implementing administrative simplifications to ensure uninterrupted Medicaid coverage for eligible children from birth to age 6, which could positively impact their school readiness.
2. **Maternal and Infant Health Improvements:** Expanding eligibility in the Planning for Healthy Babies program to include mothers of Low-Birth-Weight babies, thereby providing them with essential care and services.
3. **HIV Medicaid Inclusion:** Continuing efforts to include individuals living with HIV in Medicaid eligibility for earlier access to treatment options.
4. **Georgia Pathways to Coverage Improvements:** Streamlining administrative processes during waiver renewals to enhance participant experience, including the reporting of qualifying activities timeline.
5. **Provider Reimbursement Studies:** Conducting studies to assess current reimbursement rates and identify areas for targeted increases to meet market needs.
6. **Healthcare Workforce Expansion:** Exploring policies to expand Georgia's healthcare workforce, including graduate medical education opportunities.
7. **Incentives for Participation:** Examining ways to encourage Medicaid member and provider participation to improve access to care.

The Commission also noted the potential for leveraging federal funding and addressing fraud to support program changes. However, as the federal landscape evolves, particularly under the new administration, the CHCC aims to remain adaptable and focused on its mission of evaluating opportunities to improve healthcare for all Georgians.

Update on CHCC Recommendations and Current Landscape

The State of Georgia has requested in the recent Georgia Pathways to Coverage waiver renewal to remove the monthly qualifying activity reporting and require qualifying activity reporting at initial eligibility and annually. The requirements for individuals to complete qualifying activities of 80 hours monthly remains. Additionally, the State has requested a new qualifying activity for caregivers of

children under the age of six. To meet this qualifying activity, the caregiver must be the parent or guardian of the child, and the child must be a member of Medicaid or PeachCare for Kids.

Georgia Pathways to Coverage Renewal

The Georgia Pathways to Coverage® Section 1115 Demonstration Waiver aims to enhance healthcare access, affordability, and quality for Georgians while promoting self-sufficiency through employment. The program introduces a new eligibility pathway for working individuals who do not qualify for Medicaid, requiring them to engage in 80 hours per month of qualifying activities (like employment, community service, or education) and have an income up to 100% of the Federal Poverty Level (FPL).

The Georgia Department of Community Health (DCH) issued public notice of the intent to submit a Section 1115 Demonstration Waiver Extension Application to the Centers for Medicare & Medicaid Services (CMS) on January 21, 2025, and has subsequently submitted the application to CMS.

Georgia is seeking an extension of the original Demonstration with some modifications to improve the member experience, engagement, and provide support for participation in employment and employment-related activities. Key proposed changes include:

1. Removal of monthly qualifying activity reporting as a requirement for participation qualifying activity reporting will still be required at initial eligibility and annual renewal
2. Addition of qualifying activity types for program eligibility
3. Addition of a retroactive coverage policy, with coverage effective the first of the month in which the application was received
4. Removal of premiums and Member Rewards Accounts
5. Request reporting on a quarterly basis only per original Special Terms and Conditions

These adjustments are expected to improve the member experience to participate in the Pathways program, allowing Care Management Organizations to focus on engaging members in employment-related activities rather than monitoring compliance with monthly reporting. Overall, the changes aim to facilitate a smoother transition for individuals into the insurance market.

Enhanced Premium Tax Credit Expiration

Enhanced temporary subsidies were passed as part of the American Rescue Plan Act (ARPA) in 2021, which included two years of enhanced subsidies for 2021 and 2022. The Inflation Reduction Act (IRA) was passed in 2022, and extended these enhanced subsidies for an additional three years, which will end after 2025.

During the 2025 Open Enrollment Period, 1,510,852 Georgia consumers selected a plan, which is a 16% increase from the prior year Open Enrollment Period.¹ Currently, there is little indication of extending these enhanced premium tax credits, which would be expected to drive up premium costs for consumers. The expiration of these tax credits would likely have a significant impact on Georgians and healthcare providers, as many individuals would lose or opt out of coverage and move into an uninsured category.

¹ [Health Insurance Exchanges 2025 Open Enrollment Report](#)

H.R.1 Impact to Medicaid

The 2025 Federal Budget Reconciliation Bill became law on July 4, 2025. It is important to note that many of the provisions will require formal direction from CMS and have varying effective dates. While not all provisions detailed below will impact Georgia, it is important for consideration given the Commission's objective in identifying:

- Opportunities related to reimbursement and funding for Georgia healthcare providers, including premium assistance programs.
- Opportunities related to quality improvement of healthcare for Georgia's low-income and uninsured populations.
- Opportunities to enhance service delivery and coordination of healthcare among and across state agencies.

The provisions impacting Medicaid in H.R.1 include, but is not limited to the following:

- **Cost Sharing:** States may charge premiums and cost-sharing for Medicaid enrollees within limits, and certain populations and services are exempt from cost-sharing.
 - **Provision:** Eliminating enrollment fees or premiums for expansion adults. Imposes cost sharing, with explicit exemption of primary care, mental health, substance use disorder and limits cost sharing for prescription drugs to nominal amounts. Maintains the 5% of family income cap on out-of-pocket cost. Exempts services provided by federally qualified health centers, behavioral health clinics and rural health clinics.
- **Coverage for Lawfully Present Immigrant Children and Pregnant People and State Funded Coverage of Undocumented Immigrants:** States have an option to waive the five-year waiting period for Medicaid eligible immigrants after obtaining qualified status. This also extends coverage to certain lawfully present immigrants without a qualified status in Medicaid and in Children's Health Insurance Programs.
 - **Provision:** Reduction of the expansion match rate for states that provide health coverage or financial assistance to purchase health coverage for individuals who do not have a qualified status and are not lawfully residing children or pregnant adults. Clarifies that health coverage for individuals without a qualified status does not include coverage for lawfully residing children or pregnant adult covered under the Medicaid or CHIP option for these groups.
- **Federal Medical Assistance Percentage (FMAP) for Emergency Medicaid:** Emergency Medicaid reimburses hospitals for the cost of emergency care provided to immigrants who would qualify for Medicaid except for their immigration status, which hospitals are required to provide under federal law.
 - **Provision:** Limits federal matching payment for Emergency Medicaid for individuals who would otherwise be eligible for expansion coverage except for their immigration status to the state's regular FMAP.
- **Work Requirements:** Conditions Medicaid eligibility on meeting a work or reporting requirement.
 - **Provision:** Requirement for states to condition Medicaid eligibility for individuals ages 19-64 applying for coverage or enrolled through the Affordable Care Act (ACA) expansion group on working or participating in qualifying activities for at least 80 hours

per month; Requires states to verify that individuals applying for coverage meet requirements for 1 or more consecutive months preceding the month of application and that individuals who are enrolled meet requirements for 1 or more months between the most recent eligibility redetermination (at least twice per year); Specifies that if a person is denied or disenrolled due to work requirements, they are also ineligible for subsidized Marketplace coverage; Mandates that states exempt certain adults, including parents of dependent children and those who are medically frail, from the requirements; The provision also caps the “look-back” for demonstrating compliance with work requirements at application to three months; limits exemptions to parents with children ages 13 and under; Specifies seasonal workers meet requirements if average monthly income meets specified standard; Requires states to use data matching “where possible” to verify whether an individual meets the requirements or qualifies for an exemption; Allows the Secretary to exempt states from compliance with the new requirements until no later than December 31, 2028.

- Georgia is the only state with a Medicaid work requirement waiver in place. These requirements at the Federal level may result in changes to Georgia’s program or waiver renewal.
- **Eligibility Determinations:** States must renew eligibility every 12 months for Medicaid enrollees whose eligibility is based on MAGI and must renew eligibility at least every 12 months for enrollees whose eligibility is based on age 65+ or disability.
 - **Provision:** Requires states to conduct eligibility redeterminations at least every 6 months for Medicaid expansion adults and requires the Secretary to issue guidance within 180 days of enactment.
 - More frequent eligibility checks for Medicaid enrollees may impose a significant administrative burden on the state and Medicaid members, likely resulting in greater churn.
- **Eligibility and Enrollment Final Rule:** CMS Issued two separate rules, collectively referred to as the Eligibility and Enrollment final rule. The first rule reduces barriers to enrollment in Medicare Savings Programs, which provides Medicaid coverage of Medicare premiums and cost sharing for low-income Medicare beneficiaries. The second rule streamlines application and enrollment processes in Medicaid, aligns renewal policies for all Medicaid enrollees, facilitates transitions between Medicaid, CHIP, and subsidized Marketplace coverage, and eliminates certain barriers in CHIP.
 - **Provision:** Delay in implementation of both final rules until January 1, 2035 and prohibits the Secretary from implementing, administering, or enforcing certain provisions in both rules until October 1, 2024.
- **Provider Taxes:** States are permitted to finance the non-federal share of Medicaid spending through multiple sources, including health care related taxes (or “provider taxes”). Federal rules specify provider taxes must be broad-based and uniform and may not hold providers harmless.
 - **Provision:** Prohibits states from establishing any new provider taxes or from increasing the rates of existing taxes; Provision overlaps with a proposed rule released May 12, 2025; Reduces the safe harbor limit for states that have adopted the ACA expansion by 0.5% annually starting in fiscal year 2028 until the safe harbor limit reaches 3.5% in FY

2032; New limit applies to taxes on all providers except nursing facilities and intermediate care facilities.

- Any limitation or roll back of existing provider fees could have significant implications to Georgia's healthcare delivery system.
- **Disproportionate Share Hospital Payments (DSH):** Medicaid provides DSH payments to hospitals that serve a disproportionate percentage of low-income, uninsured and Medicaid patients. The payments can be used to cover unpaid costs of care for people who are uninsured and to supplement Medicaid payment rates that often do not fully cover provider costs. The ACA called for a reduction in federal DSH allotments starting in FY 2014, but the cuts have been delayed several times.
 - **Provision:** Delays the DSH reductions through September 30, 2028.
 - DSH funds over \$400 million to Georgia hospitals that serve a high proportion of Medicaid patients.
- **State Directed Payments:** Subject to CMS approval, states may use "state directed payments" (SDPs) to require Managed Care Organizations (MCOs) to pay providers certain rates, make uniform rate increases (that are like fee-for-service supplemental payments), or to use certain payment methods.
 - **Provision:** Directs HHS to revise state directed payment regulations to cap the total payment rate for inpatient hospital and nursing facility services at 100% of the total published Medicare payment rate for states that have adopted the Medicaid expansion and at 110% of the total published Medicare payment rate for states that have not adopted the expansion; Grandfathers state directed payments approved prior to the legislation's enactment; for states that newly adopt the expansion after enactment, the cap at 100% of the Medicare payment rate applies at the time coverage is implemented even for payments that had prior approval; For grandfathered payments, reduces payments by 10% each year until they reach the allowable Medicare-related payment limit; Specifies that in the absence of published Medicare payment rates, the limit is set at the Medicaid fee-for-service payment rate; Specifies that the grandfathering clause only applies to payments submitted prior to May 1, 2025.
 - **White House Memorandum:** The White House also issued a Memorandum for the Secretary of Health and Human Services regarding Eliminating Waste, Fraud, and Abuse in Medicaid on June 6, 2025. The memorandum addresses the issue of waste, fraud, and abuse in the Medicaid program, emphasizing the need to protect taxpayer dollars and ensure that vulnerable Americans receive necessary healthcare. It highlights practices under the previous administration that permitted states to adjust funding mechanisms, such as taxing healthcare providers and returning the funds as Medicaid payments, which resulted in reimbursement rates that were sometimes nearly three times higher than Medicare rates. The memorandum states that this trend has resulted in a significant increase in state-directed payments, threatening the financial stability of Medicaid and potentially impacting access to care for seniors on Medicare. The memorandum calls for the Secretary of Health and Human Services to take action to eliminate these issues and ensure that Medicaid payment rates do not exceed those of Medicare, in order to preserve the integrity of these essential healthcare programs.

- Reducing payments to Medicaid providers, by limiting State Directed Payments or by limited payments to no more than Medicare, would result in program cuts in Georgia of over \$1 billion.
- **Medicaid Provider Screening Requirements:** Provider screening and enrollment is required for all providers in Medicaid fee-for-service or managed care networks. Additionally, the ACA requires states to terminate provider participation in Medicaid if the provider was terminated under Medicare or another state program.
 - **Provision:** Requires states to conduct checks at enrollment, reenrollment, and on a monthly basis to determine whether HHS has terminated a provider or supplier from Medicare or another state has terminated a provider or supplier from participating in Medicaid or CHIP, and Requires states to conduct quarterly checks (in addition to at provider enrollment or reenrollment) of the Social Security Administration's Death Master File to determine whether providers enrolled in Medicaid are deceased.

Closing

In closing, the CHCC remains committed to researching opportunities that may address the health care needs of Georgia's low-income and uninsured populations. The Commission has communicated their initial thoughts and ideas, which we continue to evaluate against the direction of the current administration. It is anticipated that there will be further changes outside of H.R.1, related to budget and grant items that may impact health care related programs. As an example, CMS has communicated their concern regarding Integrated Eligibility Systems (IES) and the longevity and cost of the implementation of this technology. This could have impact on the availability of federal funding for certain Medicaid technology modernization efforts.

As further direction is shared by federal administrators and the potential impact to health outcomes and access becomes clearer, the Commission will continue to evaluate opportunities to improve health care for Georgia's low-income and uninsured citizens. We appreciate the support of Governor Kemp, the Georgia General Assembly, and all stakeholders for their continued support of the CHCC.