



# DOAA

Georgia Department  
of Audits & Accounts

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State Auditor

February 19, 2026

Honorable Lee Hawkins  
Chairman, House Health Committee  
401-C State Capitol  
Atlanta, Georgia 30334

SUBJECT: Fiscal Note  
House Bill 1002 (LC 33 9857)

Dear Chairman Hawkins:

This bill would transfer all medical assistance coverage for foster children from care management organizations (CMOs) to the fee-for-service (FFS) Medicaid program. The transfer from CMO to FFS would occur upon expiration or renewal of the CMO contract or earlier if authorized under terms of the contract. The change applies to all foster children less than 18 years of age in a foster home or in the foster care system and to individuals who are less than 26 years of age that were in a foster home or in the foster care system until their 18<sup>th</sup> birthday. The legislation automatically repeals on December 31, 2028.

The bill is estimated to have one-time costs of \$2.5 million and annual costs of \$22.0 to \$27.6 million to the state. Annual increases are attributable to increased spending for Medicaid benefits and administration (see **Table 1**); cost estimates attributable to benefits vary depending on increases in utilization and changes to the existing CMO plan. However, it is likely the state will also experience an undetermined level of savings related to behavioral health treatment and placements for foster youth.

**Table 1: One-Time and Annual State Costs of LC 33 9857**

(\$ in millions)	Low	High
<b>Annual Costs</b>		
Benefits – <i>Additional monthly costs for foster youth in FFS and youth remaining in CMO plan</i> <sup>1</sup>	\$16.9	\$22.5
Administration – <i>Care coordination, utilization review, other</i>	\$5.1	\$5.1
<b>Total Annual Costs</b>	<b>\$22.0</b>	<b>\$27.6</b>
<b>One-Time Costs</b>		
Administration – <i>Information system updates</i>	\$2.5	\$2.5
<b>Cost Savings</b> <sup>2</sup>	<b>Unknown</b>	<b>Unknown</b>

<sup>1</sup> The state costs were calculated using a blended FY 2027 Federal Medical Assistance Percentage (FMAP) of 66.5725%. Due to a 3-month overlap between the beginning of the state fiscal year and the end of the federal fiscal year, for cost estimate purposes DCH calculates a “blended” FMAP rate utilizing one quarter of the current year’s FMAP and three quarters of the upcoming year’s FMAP.

<sup>2</sup> The Department of Human Services anticipated cost savings related to placements for foster youth and behavioral health treatment; however, we are unable to estimate these potential savings. In the first seven months of FY 2026, the agency reported spending \$2.3 million on psychiatric residential treatment facility services not approved by CMOs. If covered by Medicaid, approximately 2/3 of costs would be paid by the federal government. In the same period, the agency reported \$5.5 million spent on hoteling/emergency supervision, which it partly attributes to insufficient behavioral health services.

### **DCH Healthcare Costs**

The Department of Community Health (DCH) estimates the bill would increase Medicaid benefit costs by \$43.6 to \$60.3 million annually, with the state share of the increase between \$16.9 and \$22.5 million. DCH generated its estimates using a point-in-time analysis<sup>1</sup> that predicts increased healthcare utilization by foster youth under FFS and increased costs for members remaining in the foster youths' CMO plan. Projected costs used the assumptions below.

- **Increased healthcare utilization under FFS** – DCH covers foster youth under Georgia Families 360° (GF 360°), the CMO plan that also includes youth in adoption assistance and youth in juvenile facilities. DCH estimates foster youth currently cost \$979.74 per GF 360° member per month. Given an estimated annual membership of 14,500 foster members, \$979.74 per member per month (PMPM) results in \$170.9 million in total estimated Medicaid payment expenses for foster youth. Because the federal government supports approximately 67% of Medicaid benefits, \$57.1 of the \$170.9 million is supported by the state. However, the state receives an estimated \$3.8 of the \$57.1 million back from CMOs in the form of premium tax revenue—making its net estimated cost \$53.3 million.

Under FFS Medicaid, DCH estimates foster youth costs would increase to between \$1,124.94 and \$1,221.09 PMPM. This would increase total benefit spending to between \$196.2 and \$213.0 million—\$65.6 to \$71.2 million of which would be borne by the state. Because these represent FFS costs, the state would not receive any premium tax revenue.

- **Increased PMPM costs for remaining members** – The removal of foster children from GF 360° is also estimated to increase PMPM costs for remaining plan members. This is because a reduction in plan membership results in increased costs associated with increased risk. Under the current GF 360° plan, DCH spends an estimated \$26.9 million in state funds annually to cover youth in adoption assistance and DJJ facilities, net of premium tax revenues. Under the bill, estimated costs for these groups would increase to \$31.5 million net of premium taxes.

It should be noted that transitioning foster children from managed care to FFS could impact DCH's contract with the GF 360° CMO. In 2024, DCH completed a procurement process for the GF 360° CMO, which occurred under the assumption foster children would be included in plan coverage. The new contract is scheduled to begin in FY 2027, although DCH has the option to renew its current contract through FY 2028.

DCH also reported the need to develop and implement a plan for the transition from GF 360° to FFS to ensure no gaps in coverage for foster youth occur. Prior to the transition of foster youth from FFS to managed care in 2014, DCH reported convening stakeholder focus groups, conducting public hearings, chairing a Joint Task Force that included six state agencies, and developing a Children & Families task force that included healthcare providers. Similar planning activities associated with the return to FFS could result in additional DCH or other state agency costs.

### **Administrative Costs**

Under managed care, a portion of the costs the state pays to the CMO is used for administrative activities such as care coordination and utilization management, as well as corporate profit. In the absence of managed care, the state would assume responsibility for the administration of foster youths' Medicaid care. DCH and the Department of Behavioral Health and Developmental Disabilities (DBHDD) reported a combined \$7.6 million in annual and one-time costs for administrative activities.

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<sup>1</sup> DCH noted that its analysis did not use actuarial methods.

*DCH Costs*

DCH estimates the bill would result in an additional \$1.7 million in annual state costs, which reflects a need to hire 41 staff (director, call center agents, registered nurses) to operate member and provider call centers dedicated to foster youth coverage. In addition, DCH reported a one-time need for \$2.5 million in state funds to update its information technology systems, which would ensure full integration of care and case management for foster youth.

*DBHDD Costs*

DBHDD assists DCH in administering behavioral healthcare under FFS Medicaid, including administering services for Community Behavioral Health Rehabilitation, the New Option Waiver (NOW), and the Comprehensive Support Waiver Program (COMP). To build its capacity to administer behavioral health services for foster youth, it reported an additional \$3.4 million in state costs associated with the bill:

- **Administrative service organization activities (\$1.0 million)** – DBHDD’s administrative service organization (ASO) conducts provider certification, annual quality reviews, prior authorization, and utilization review and management for behavioral health services covered by FFS Medicaid. DBHDD currently contracts with agencies to provide services, while the CMO contracts with individual providers. DBHDD anticipates the need to add 200-300 providers for the foster care population.
- **Staff (\$597,000)** – DBHDD would need additional staff for clinical oversight and coordination across state agencies. This includes staff that would support provider enrollment, policy, and information technology, as well as a member of staff that would serve as the ASO liaison.
- **Community Service Board capacity (\$1.7 million)** – Community Service Boards (CSBs) reduced their child-serving workforce to match the reduction in population served. DBHDD estimated the need for funds to provide technical assistance, training, and personnel development for CSBs, which serve as the safety net for behavioral healthcare.

**Potential DHS Cost Savings**

The Department of Human Services (DHS), which administers the state’s foster care program through the Division of Family and Children Services (DFCS), noted that a significant portion of the foster care population requires behavioral health services. In the first seven months of FY 2026, DHS reported spending \$2.3 million for psychiatric residential treatment facility (PRTF) placements not approved by the CMO. In these instances, DHS determined that a youth needed treatment and the resulting costs were borne entirely by the state (i.e., no federal Medicaid funds supported the costs). DHS staff noted behavioral health coverage is more frequently authorized under FFS Medicaid, which could lead to a reduction in DHS PRTF costs because FFS Medicaid is supported by both state and federal Medicaid funding.

DHS also attributed a portion of its “hoteling/emergency supervision” costs to gaps in CMO coverage for behavioral health services. Staff noted foster care placements fail at a higher rate for youth who lack sufficient services, resulting in higher hoteling costs. DHS reported spending \$5.5 million on hoteling/emergency supervision in the first seven months of FY 2026.

Respectfully,



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