

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-25-26
Baltimore, Maryland 21244-1850



State Demonstrations Group

January 30, 2026

Stuart Portman
Executive Director, Division of Medical Assistance Plans
Department of Community Health
2 Martin Luther King Jr. Drive SE
East Tower 18th Floor
Atlanta, Georgia 30303-3159

Dear Director Portman:

The Centers for Medicare & Medicaid Services (CMS) completed its review of Georgia's Final Report for their Managed Care Risk Mitigation COVID-19 1115 Demonstration Amendment to the section 1115 demonstration entitled "Planning for Healthy Babies" (Project Number 11-W00249/4), approved on October 29, 2010. This report covers the demonstration period from March 1, 2020, through May 11, 2023. CMS determined that the Final Report, submitted on November 14, 2025, and finalized on December 31, 2025, is in alignment with the CMS-approved Evaluation Design, and therefore approves the state's Final Report.

The approved Final Report may now be posted on the state's Medicaid website. CMS will also post the approved Final Report on Medicaid.gov.

We sincerely appreciate the state's commitment to evaluating the COVID-19 PHE amendment. If you have any questions, please contact your CMS demonstration team.

Sincerely,

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DANIELLE DALY -S
Date: 2026.01.30
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Danielle Daly
Director
Division of Demonstration Monitoring and Evaluation

Enclosure cc: Etta Hawkins, State Monitoring Lead, CMS Medicaid and CHIP
Operations Group

Georgia Managed Care P4HB COVID-19 Risk Mitigation Report Responses to Evaluation Questions

The Georgia State Department of Community Health

January 2026

Introduction

This report provides responses to the evaluation questions outlined in the Georgia Managed Care Risk Mitigation Planning for Healthy Babies (P4HB) COVID-19 1115 Demonstration Amendment Evaluation Design provided in Appendix A which was approved March 13, 2024. This report summarizes the results of the retroactive risk mechanism and was developed through interviews with key Georgia State Department of Community Health (“DCH” or “State”) staff and by using actual historical managed care financial data. The projected enrollment affected by this amendment was approximately 1,430,792 from the signing actuary at the time for SFY2020 rate development.

Qualitative Analysis

Hypothesis 1 - The demonstration will facilitate attaining the objectives of Medicaid.

EQ 1.1: What retroactive risk sharing agreements did the state ultimately negotiate with the CMOs under the demonstration authority?

The State entered into retroactive risk sharing agreements with its care management organizations (CMOs) under the demonstration authority. These arrangements took the form of retrospective risk corridors and required the CMOs to meet specified medical loss ratio (MLR) thresholds, as defined in state contracts and rate certifications. The tables below outline the SFY 2020 risk corridor in place for the LIM/BCC/Delivery, PCK, and GF360 populations.

LIM, BCC, Delivery MLR	CMO Gain/Loss Share	State Gain/Loss Share
<85.0%	0%	100%
85.0% to 87.0%	50%	50%
87.0% to 89.0%	100%	0%
89.0% to 91.0%	50%	50%
≥91.0%	20%	80%

PCK MLR	CMO Gain/Loss Share	State Gain/Loss Share
<85.0%	0%	100%
85.0% to 85.5%	50%	50%
85.5% to 87.5%	100%	0%
87.5% to 88.0%	50%	50%
≥88.0%	20%	80%

GF360 MLR	CMO Gain/Loss Share	State Gain/Loss Share
<85.0%	0%	100%
85.0% to 93.0%	100%	0%
≥93.0%	20%	80%

EQ 1.2: What were challenges associated with implementing the retroactive risk mitigation strategies? How did the state address these challenges?

The State reported minimal difficulties in implementing retroactive risk mitigation strategies, such as risk corridors and MLR requirements. Collaboration among State staff, CMOs, and federal partners contributed to a smooth process. Technical support and clear guidance were available when needed, and no significant barriers were identified during the implementation of these measures.

EQ 1.3: What were the lessons learned from the COVID-19 PHE Medicaid Section 1115 demonstration waiver for any future PHEs?

The main lesson learned is that states need flexibility in Medicaid policies during emergencies like the COVID-19 PHE. The Centers for Medicare & Medicaid Services (CMS) flexibility allowing states to retroactively adjust rate-setting supported states’ ability to respond effectively to unexpected cost fluctuations and allow continued access to care for members. For future public health emergencies, the State notes that it will be important for CMS to

provide similar flexibilities, either through existing waiver authority or by creating a process for emergency program/rate adjustments, so states can efficiently react and keep their Medicaid programs stable.

In addition, throughout the COVID-19 PHE, DCH was successful in maintaining consistent labor rates for nurses and physicians by centralizing to a statewide negotiation. This approach helped prevent program volatility and supported fair distribution of resources, which contributed to the smooth administration of Medicaid services throughout the COVID-19 PHE.

EQ 1.4: What problems would have been caused by the application of 438.6(b)(1) during the PHE that would have undermined the objectives of Medicaid?

The sudden and unpredictable costs caused by the COVID-19 PHE would have made it difficult to determine more appropriate payments to CMOs. Without the flexibility to retroactively implement risk corridors, states may have paid at-risk capitation rates that did not more closely match payment to risk for the CMOs within the program and risk undermine the goal of maintaining stability and access to care for Medicaid beneficiaries during the COVID-19 PHE.

EQ 1.5: In what ways during the PHE did the demonstration support adding or modifying one or more risk sharing mechanisms after the start of the rating period?

The flexibility to add new risk mitigation arrangements after the rating period had started allowed the State to adjust payments to CMOs to better match the sudden shifts in healthcare utilization and costs caused by the emergency. As a result, payments aligned better with actual conditions, helping Medicaid continue to meet its goals despite the uncertainty around the COVID-19 PHE.

Quantitative Analysis

Hypothesis 2 - The authority will support DCH in making appropriate, equitable payments during the COVID-19 PHE to help with maintenance of beneficiary access to care that would have otherwise been challenging due to the prohibitions in Section 438.6(b)(1).

EQ 2.1: What were the results of these changes to Medicaid CMOs' financials? Did the CMOs avoid material losses as a result of implementing retroactive risk sharing agreements?

Following the use of retroactive risk sharing agreements, the financial results for Medicaid CMOs showed a range of outcomes. The results of the CMO financials varied, and some CMOs recouped payments and some had payments based on the results of the risk corridor. In many cases, more money flowed out from the State to the CMOs, which helped lessen the impact of potential losses during periods of higher-than-expected costs. The risk corridor limited the probability of large gains or losses for the CMOs in the period of uncertainty surrounding the COVID-19 PHE.

EQ 2.2: To what extent did the retroactive risk sharing implement under the demonstration authority result in more accurate payments to the managed care plans?

The risk corridor allowed final payments to the CMOs to align more closely with the MLR targets set in the agreement. Retroactive adjustments allowed payment amounts to reflect actual spending and the intended balance between costs for medical services and administrative expenses. As a result, the CMOs received funding based on their actual performance within the boundaries described by the risk corridor outlined above.

Appendix A

DEPARTMENT OF HEALTH & HUMAN SERVICES
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Baltimore, Maryland 21244-1850



State Demonstrations Group

March 13, 2024

Stuart Portman
Executive Director, Division of Medical Assistance Plans
Department of Community Health
2 Martin Luther King Jr. Drive, SE
East Tower 18th Floor
Atlanta, Georgia 30303-3159

Dear Executive Director Portman:

The Centers for Medicare & Medicaid Services (CMS) approved the Evaluation Design for the Georgia Managed Care Risk Mitigation COVID-19 Public Health Emergency (PHE) section 1115 demonstration amendment to the “Georgia Planning for Health Babies” section 1115(a) demonstration (Project No: 11-W-00249/4). We sincerely appreciate the state’s commitment to meeting the requirement for an Evaluation Design as was stipulated in the amendment approval letter dated January 18, 2022.

In accordance with 42 CFR 431.424(c), the approved Evaluation Design may now be posted to the state’s Medicaid website within 30 days. CMS will also post the approved Evaluation Design on Medicaid.gov.

Consistent with the approved Evaluation Design, the draft Final Report will be due to CMS 18 months after either the expiration of the amendment approval period or the end of the latest rating period covered under the state’s approved expenditure authority, whichever comes later.

We sincerely appreciate the state’s commitment to evaluating the Managed Care Risk Mitigation COVID-19 PHE amendment. We look forward to our continued partnership on the Georgia Planning for Health Babies demonstration. If you have any questions, please contact your CMS demonstration team.

Sincerely,
Digitally signed by **Danielle Daly**
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-S Danielle 
Daly
Director

Division of Demonstration Monitoring and Evaluation

cc: Etta Hawkins, State Monitoring Lead, Medicaid and CHIP Operations Group

Managed Care Risk Mitigation COVID-19 1115 Demonstration Amendment Evaluation Design

Introduction

The objective of this Section 1115 Waiver is to assist the Georgia Department of Community Health (DCH) in making appropriate and equitable payments to Georgia’s Care Management Organizations (CMO) by allowing DCH to implement retroactive risk-sharing mechanisms. These mechanisms could result in increased or decreased payments to Georgia’s Care Management Organizations based upon significant fluctuations in utilization during the COVID-19 pandemic. Effective retroactively to March 1, 2020, Georgia Families and Georgia Families 360 programs have a risk sharing arrangement between the CMOs and the State. Under this arrangement, the state and CMOs have agreed to share profits or losses if aggregate covered expenditures fall above or below certain thresholds. The 1115 Waiver authority permits DCH to add or modify a risk-sharing arrangement with a CMO after the start of the applicable rating period. Additionally, this authority exempts DCH from complying with the current requirements in section 42 CFR 438.6(b)(1) until the end of the PHE.

This 1115 demonstration is deemed budget neutral, and does not impact eligibility, enrollment or coverage of Medicaid members.

Rating Periods Under the Purview of this Expenditure Authority

- 7/1/2019 – 6/30/2020; Georgia Families & Planning for Healthy Babies (Risk Corridor)
- 7/1/2019 – 6/30/2020; Georgia Families 360 (Risk Corridor)
- 7/1/2020 – 6/30/2021; Georgia Families & Planning for Healthy Babies (Risk Corridor)
- 7/1/2020 – 6/30/2021; Georgia Families 360 (Risk Corridor)

Qualitative Analysis

DCH will analyze interviews, surveys, and actual vs expected costs to conduct a narrative analysis. The narrative analysis will discuss the results of the retroactive risk sharing mechanism.

Quantitative Analysis

The State will use actual vs expected costs, utilization, and financial data to provide a descriptive analysis providing a summarizing the results of the retroactive risk mechanism.

Evaluation Questions, Data Sources, and Analytic Approach

Hypothesis 1 - The demonstration will facilitate attaining the objectives of Medicaid			
Evaluation Question	Anticipated Measure(s)	Data Source(s)	Analytic Approach
EQ 1.1: What retroactive risk sharing agreements did the state ultimately negotiate with the CMOs under the demonstration authority?	Type(s) or risk sharing agreements negotiated with the CMOs; Terms of negotiated risk sharing agreement(s)	Staff interviews and/or survey; Document review	Qualitative Analysis

EQ 1.2: What were challenges associated with implementing the retroactive risk mitigation strategies? How did the state address these challenges?	Description of challenges (if any) related to implementing the risk sharing agreement(s) with the plans	Staff interviews and/or survey	Qualitative Analysis
EQ 1.3: What were the lessons learned from the COVID-19 PHE Medicaid Section 1115 demonstration waiver for any future PHEs?	Description of implementation process, including challenges encountered, solutions developed, and successes or opportunities for improvement	Staff interviews and/or survey; Document review	Qualitative Analysis
EQ 1.4: What problems would have been caused by the application of 438.6(b)(1) during the PHE that would have undermined the objectives of Medicaid?	How the demonstration authority addressed or prevented problems related to the application of 438.6(b)(1)	Staff interviews and/or survey; Document review	Qualitative Analysis
EQ 1.5: In what ways during the PHE did the demonstration support adding or modifying one or more risk sharing mechanisms after the start of the rating period?	Benefits/successes of adding a risk sharing mechanism that would not have been realized without the demonstration authority	Staff interviews and/or survey	Qualitative Analysis
Hypothesis 2 - The authority will support DCH in making appropriate, equitable payments during the COVID-19 PHE to help with maintenance of beneficiary access to care that would have otherwise been challenging due to the prohibitions in Section 438.6(b)(1)			
Evaluation Question	Anticipated Measure(s)	Data Source(s)	Analytic Approach
EQ 2.1: What were the results of these changes to Medicaid CMOs' financials? Did the CMOs avoid material losses as a result of implementing the retroactive risk sharing agreements?	Aggregate SFY 2020 gain/loss amounts with SFY 2020 and SFY 2020 risk corridor parameters Comparisons of gain/loss using risk corridor parameters	SFY 2020 Claims Data	Quantitative Analysis
EQ 2.2: To what extent did the retroactive risk sharing implemented under the demonstration authority result in more accurate payments to the managed care plans?	MLRs prior to the application of the risk corridor, both at an aggregate-level as well as CMO-specific. MLRs after application of the risk corridor, both at an aggregate-level as well as CMO-specific	MLR Calculations State Medicaid Claims Data SFY 2020 Rate Development Exhibits	Quantitative Analysis

The specific data sources proposed in the table above to be utilized for this evaluation are detailed below, including a description of data quality and any applicable data limitations:

- Document Review: DCH will conduct a review of all relevant documents that are related to the retroactive risk mitigation mechanisms implemented through this Demonstration, including but not limited to the managed care plan contracts, applicable amendments, and documentation of relevant program changes occurring during the PHE.
- Staff Interviews: DCH will conduct interviews with key staff involved in the implementation of the retroactive risk mitigation mechanisms, including internal DCH staff and, if possible, external health plan staff, to assess many of the qualitative aspects of this Demonstration. Staff interviews will provide critical narrative information about the operationalization of the Demonstration and whether it facilitated the state in meeting the purpose of the Demonstration. However, like all subjective interviews, common limitations associated with this data source are biases and statistical representative samples. DCH hopes to mitigate these data source limitations by interviewing both State and CMO staff, as well as supplementing with quantitative data where applicable.
- Financial Data: DCH will use financial data submitted by Amerigroup, CareSource, and Peach State through Quarterly Financial Reports and ad-hoc supplemental data submissions. DCH reviews the Quarterly Financial Reports on a quarterly basis to ensure reporting accuracy, including comparisons to encounter data, previous submissions, and other data sources. Any issues identified in these reviews are communicated to the CMOs, who are instructed to correct the issues in subsequent submissions. For significant issues or reports that are used to calculate final MLR results, CMOs are instructed to correct the issues and resubmit. Ad hoc data submissions are occasionally needed for items that cannot be easily reported in the Quarterly Financial Reports, such as

detail on provider settlements.

Methodological Limitations

The primary objective of the Demonstration is to support DCH in making appropriate, equitable payments during the PHE to help maintain beneficiary access to care throughout the pandemic. DCH will be reporting population and expenditure trends in its evaluation of the Managed Care Risk Mitigation COVID-19 PHE Demonstration and will also include analyses that will be qualitative and descriptive, such as key informant interviews and document review, consistent with CMS guidance. The methodology will investigate whether permitting retroactive risk mitigation in general is linked to more appropriate payments to the CMOs and

mitigated disruption in beneficiary access to care during the PHE. For the methodology utilized and the scope of the evaluation, we do not anticipate any major methodological limitations.