DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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Baltimore, Maryland 21244-1850

State Demonstrations Group

January 7, 2025

Rebecca Curtiss
Acting Director
Iowa Medicaid Enterprise
Iowa Department of Human Services
Des Moines, Iowa 50319

Dear Acting Director Curtiss:

The Centers for Medicare & Medicaid Services (CMS) completed its review of the Final Report for the Continuous Coverage for Individuals Aging out of CHIP COVID-19 Public Health Emergency (PHE) amendment to the section 1115 demonstration entitled, "Iowa Wellness Plan (IWP)" (Project No: 11-W-00289/7), approved on January 27, 2022. This report covers the demonstration period from March 1, 2020 through July 31, 2021. CMS determined that the Final Report, submitted on July 3, 2024, and revised on October 28, 2024, is in alignment with the requirements set forth in the demonstration's Special Terms and Conditions (STCs), and therefore, approves the state's Final Report.

The approved Final Report may now be posted to the state's Medicaid website within 30 days, per 42 CFR 431.424(c). CMS will also post the approved Final Report on Medicaid.gov.

We sincerely appreciate the state's commitment to evaluating the COVID-19 PHE demonstration amendment. We look forward to continuing our partnership on the IWP section 1115 demonstration. If you have any questions, please contact your CMS demonstration team.

Sincerely,

Danielle Daly -S

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Date: 2025.01.07 08:08:55 -05'00'

Danielle Daly
Director
Division of Demonstration Monitoring and Evaluation

cc: Lee Herko, State Monitoring Lead, CMS Medicaid and CHIP Operations Group

STATE OF IOWA DEPARTMENT OF

Health AND Human SERVICES

EVALUATION

Continuous Coverage for Individuals Aging out of CHIP: PHE Section 1115 Demonstration

July 2024

IOWA
HHS

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Background Information

In response to the section 1115(a) demonstration opportunity announced to states on March 22, 2020, in State Medicaid Director Letter (SMDL) #20-002, Iowa (the State) submitted an 1115 COVID-19 demonstration application to address the COVID-19 public health emergency (PHE). The waiver requested authority to provide continued eligibility for CHIP enrollees who turned 19 during the PHE and who are otherwise ineligible for Medicaid because they have income above 133 percent of the federal poverty level (FPL). Iowa's goal during the demonstration period was to ensure adequate coverage and access to critical services in response to the COVID-19 PHE, which is in alignment with CMS' overarching stated goal of maintenance of coverage during the PHE.

CMS approved this demonstration request on January 27, 2022. A technical correction for this approval was then issued on March 16, 2022, providing expenditure authority starting March 1, 2020, and ending July 31, 2021. As part of the approval, CMS required the state to monitor and evaluate the impacts of the demonstration. This included testing whether and how the approved expenditure authority affected the state's response to the PHE, along with analyzing costs. The evaluation period for the demonstration is March 1, 2020, through July 31, 2021.

Overall, this demonstration permitted the State to provide continued eligibility for 2,900 CHIP beneficiaries. Ninety percent (2,610 beneficiaries) had full CHIP coverage under the State's Hawki program. The remaining ten percent (290 beneficiaries) were eligible for Hawki dental-only coverage.

Evaluation Questions and Hypotheses

This evaluation aims to determine whether providing continued eligibility during a PHE to an otherwise ineligible population ensured adequate coverage and critical access to services, as was the goal of the amendment.

Evaluation Question 1: To what extent do enrollees with continued eligibility due to the waiver access preventive and routine healthcare services?

Hypothesis 1: Enrollees with continued eligibility will access healthcare services.

Evaluation Question 2: What was the cost of the extended period of coverage?

Hypothesis 2: Providing continued eligibility will ensure continued access to preventive and routine services while not significantly impacting the cost of the demonstration.

Evaluation Question 3: What were the State's experiences regarding implementation of the extended coverage that could inform future demonstration flexibilities in the face of a PHE?

Hypothesis 3: The State will be able to document for any future PHEs strategies for maintaining enrollee coverage and encouraging access to healthcare services. The lessons learned from this demonstration may be incorporated into eligibility determination processes and enrollee outreach strategies.

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Methodology

ANALYTIC METHODS

As part of the 1115 demonstration approval, CMS required Iowa to develop a "simplified" evaluation design that did not undertake evaluations that would prove overly burdensome and impractical for data collection or analyses but rather focused on using qualitative methods and descriptive statistics to understand how this flexibility helped Iowa respond to the COVID-19 PHE. As such, Iowa used qualitative and descriptive statistical methods to conduct the evaluation.

QUALITATIVE ANALYSIS AND DATA SOURCES

The State collected qualitative data through interviews with State and managed care organization (MCO) staff. Interviews focused on experiences regarding implementation of the extended coverage approved for the demonstration group. The goal was to identify the effectiveness of the approved flexibility and identify what challenges may remain in the face of any future PHE. Interviews included the questions identified in Table 1: Interview Questions.

Table 1: Interview Questions

Interview Group	Interview Questions
MCO Staff	1. What strategies did the MCOs use to engage CHIP beneficiaries turning age 19 during this PHE? 2. What were the principal challenges experienced with MCO engagement of CHIP beneficiaries turning age 19 during this PHE? 3. What strategies did the MCOs pursue to address those challenges?
State Staff	1. What were the lessons learned around implementation of extended coverage to CHIP beneficiaries turning age 19 during this PHE, that could inform the eligibility determination process in future PHEs? 2. What were the lessons learned around State staff communication with the MCOs regarding extended coverage of CHIP beneficiaries turning age 19 during this PHE, that could inform the eligibility determination process in future PHEs?

DESCRIPTIVE ANALYSES AND DATA SOURCES

For evaluation questions assessing utilization and cost, the State calculated standard summary statistics to report findings. The data sources were:

1. Encounter data
2. Capitation payments

Table 2 outlines the evaluation questions, hypotheses, data sources, measures, and analytic approaches for this evaluation.

Table 2: Analytic Table

Evaluation Questions	Hypotheses	Data Source	Measure	Analytic Approach
1. To what extent do enrollees with continued eligibility due to the waiver access preventive and routine healthcare services?	Enrollees with continued eligibility will access preventive and routine healthcare services.	Encounter Data	Summary of encounters by type of service:[1] • Dental visits • Vision visits • Professional claim[2]	Descriptive analysis

2. What was the cost of the extended period of coverage?	Providing continued eligibility will ensure continued access to preventive and routine services while not significantly impacting the cost of the demonstration.	Capitation Payments	Spending per member per month:
			• Total
			• By the following service types:
			  ○ Dental visit
			  ○ Vision visit
			  ○ Professional claim[3]
				Descriptive analysis

3. What were the State's experiences regarding implementation of the extended coverage that could inform future demonstration flexibilities in the face of a PHE?	The State will be able to document for any future PHEs strategies for maintaining enrollee coverage and encouraging access to healthcare services. The lessons learned from this demonstration may be incorporated into eligibility determination processes and enrollee outreach strategies.	MCO and State Staff Interviews	Interview question set, including the following: • What strategies were used to engage individuals who turned 19 during the approved timeframe of the demonstration? • What were the principal challenges experienced with MCO engagement of CHIP members turning age 19 during the demonstration? • What strategies were utilized to address those engagement challenges?	Qualitative analysis

[1] The State's evaluation design originally included the following HEDIS measures: Annual Dental Visit (ADV) and Child and Adolescent Well-Care Visits (WCV). However, in implementing the evaluation, it was determined these measures could not be replicated due to the waiver enrollment period and population not fully aligning with the measure specifications.

[2] Updated from the state's evaluation design's reference to "professional office visits" to represent utilization more fully.

[3] *Id.*

Analytic Methods and Methodological Limitations

Descriptive analysis used Iowa's Medicaid Management Information System (MMIS) databases for encounter, demographic, eligibility, and enrollment information. Data obtained from various sources were reviewed for missing values, inconsistent patterns, and outliers to ensure quality and appropriateness of the data for analyses required by the evaluation design.

Given the simplified nature of the evaluation, Iowa did not encounter methodological limitations. The State used standardized interview questions and limited the number of interview questions to address potential limitations of an interview methodology. Calculations were based on data supplied by Iowa's MCOs and dental plans as reported in encounter data that is validated by MMIS systems edits. While the data has been assessed as complete, to the extent encounter data was not submitted for a visit, those services are not captured in the calculations for this demonstration.

Findings

Evaluation questions 1 and 2 assessed utilization and cost. Evaluation question 3 assessed the State's experience with implementing the extended coverage. This also included MCO engagement strategies.

EVALUATION QUESTION 1: To what extent do enrollees with continued eligibility due to the waiver access preventive and routine healthcare services?

This measure includes demonstration enrollees who accessed preventive and routine healthcare services. The encounter data for the three types of services (dental, vision, and professional) by month for the measurement period is included in Table 3.

Table 3: Demonstration Enrollees with a Visit by Service Type

Performance Measure 1a: Number of distinct demonstration enrollees with a dental visit by month and year																	
	2020										2021						
	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul
Total Number of Enrollees	2,900	2,900	2,900	2,900	2,900	2,900	2,900	2,900	2,900	2,900	2,900	2,900	2,900	2,900	2,900	2,900	2,900
Number of Enrollees with a Dental Visit	124	8	92	188	217	206	124	103	113	206	186	115	143	151	136	45	41
Percent of Enrollees with a Dental Visit	4.3%	0.3%	3.2%	6.5%	7.5%	7.1%	4.3%	3.6%	3.9%	7.1%	6.4%	4.0%	4.9%	5.2%	4.7%	1.6%	1.4%

Performance Measure 1b: Number of distinct demonstration enrollees with a professional claim by month and year																	
	2020										2021						
	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul
Total Number of Enrollees	2,610	2,610	2,610	2,610	2,610	2,610	2,610	2,610	2,610	2,610	2,610	2,610	2,610	2,610	2,610	2,610	2,610
Number of Enrollees with a Professional Claim	551	379	426	497	600	542	558	562	568	556	543	502	590	669	530	210	153
Percent of Enrollees with a Professional Claim	21.1%	14.5%	16.3%	19.0%	23.0%	20.8%	21.4%	21.5%	21.8%	21.3%	20.8%	19.2%	22.6%	25.6%	20.3%	8.0%	5.9%

Performance Measure 1c: Number of unique demonstration enrollees with a vision visit by month and year																	
	2020										2021						
	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul
Total Number of Enrollees	2,610	2,610	2,610	2,610	2,610	2,610	2,610	2,610	2,610	2,610	2,610	2,610	2,610	2,610	2,610	2,610	2,610
Number of Enrollees with a Vision Visit	155	64	109	148	176	171	162	178	181	178	174	137	156	157	146	67	49
Percent of Enrollees with a Vision Visit	5.9%	2.5%	4.2%	5.7%	6.7%	6.6%	6.2%	6.8%	6.9%	6.8%	6.7%	5.2%	6.0%	6.0%	5.6%	2.6%	1.9%

Overall, 2,142 unique demonstration enrollees (73.8%) accessed at least one dental, vision, or professional service.[4] Table 4 provides a breakout by month.

Table 4: Unique Demonstration Enrollees With any Service

Performance Measure 1d: Number of unique demonstration enrollees with any service type by month and year																	
2020										2021							
Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul
701	410	526	681	818	757	706	717	731	782	748	644	755	830	675	259	193

EVALUATION QUESTION 2: What was the cost of the extended period of coverage?

Demonstration enrollees received medical benefits through one of two MCOs: Iowa Total Care or Wellpoint Iowa (formerly known as Amerigroup Iowa). Dental coverage was provided

[4] Note the overall 2,142 unique demonstration enrollees who accessed at least one service does not total the number of enrollees listed in Table 3 as it represents a non-duplicated count. An enrollee ma have, for example, accessed both a vision and a professional service or accessed services across multiple months. The enrollee is counted one time to arrive at 2,142 unique demonstration enrollees having accessed at least one service.

to demonstration enrollees by Delta Dental, and orthodontia was reimbursed fee-for-service (FFS). Therefore, all benefits provided to demonstration enrollees, except for orthodontia, were reimbursed via a capitated arrangement. The tables below provide an overview of the fiscal impact of the demonstration through multiple different measures. First, Table 5 provides the overall claims reimbursement during the demonstration.

Table 5: Claims Reimbursement by Service Type

Service Type	Total Claims Paid[5]
Dental	$508,403
Vision	$459,128
Professional	$1,557,024
Total	**$2,524,555**

Tables 6, 7, and 8 outline the total capitation payments made to the MCOs for demonstration enrollees.

Table 6: Capitation Payments to Iowa Total Care for Demonstration Enrollees

	Annual Member Months - Iowa Total Care							
	Member	Total		Total Cost		State Cost		
Capitation Rate Cell	Months	Gross	Net	Gross	Net	Gross	Net	State Match Rate
SFY20 CHIP								
CHIP - Hawki	3,236	155.33	152.23	$502,719	$492,665	$56,908	$55,770	11.32%
SFY21 CHIP								
CHIP - Hawki	9,709	155.33	152.23	$1,508,158	$1,477,994	$296,353	$290,426	19.65%

[5] Rounded to the nearest dollar.

Table 7: Capitation Payments to Wellpoint Iowa for Demonstration Enrollees

	Annual Member Months – Wellpoint Iowa							
	Member	Total		Total Cost		State Cost		
Capitation Rate Cell	Months	Gross	Net	Gross	Net	Gross	Net	State Match Rate
SFY20 CHIP								
CHIP - Hawki	7,204	154.04	150.96	$1,109,650	$1,087,457	$125,612	$123,100	11.32%
SFY21 CHIP								
CHIP - Hawki	21,611	154.04	150.96	$3,328,951	$3,262,372	$654,139	$641,056	19.65%

Table 8: Total Capitation Payments to MCOs for Demonstration Enrollees

	Annual Member Months - Combined MCO							
	Member	Total		Total Cost		State Cost		
Capitation Rate Cell	Months	Gross	Net	Gross	Net	Gross	Net	State Match Rate
SFY20 CHIP								
CHIP - Hawki	10,440	$154.44	$151.35	$1,612,370	$1,580,122	$182,520	$178,870	11.32%
SFY21 CHIP								
CHIP - Hawki	31,320	$155.33	$152.23	$4,837,109	$4,740,367	$950,492	$931,482	19.65%

Table 9 outlines the total capitation payments made to Delta Dental for demonstration enrollees. The data is broken out by number of enrollees who had full Hawki versus Hawki dental-only coverage during the demonstration.

Table 9: Total Capitation Payments to Delta Dental for Demonstration Enrollees

	Annual Member Months – Delta Dental							
	Member	Total		Total Cost		State Cost		
Capitation Rate Cell	**Months**	**Gross**	**Net**	**Gross**	**Net**	**Gross**	**Net**	**State Match Rate**
SFY20 Hawki								
Regular Hawki Dental	10,440	$22.06	$21.62	$230,306	$225,700	$26,071	$25,549	11.32%
SFY21 Hawki								
Regular Hawki Dental	31,320	$22.06	$21.62	$690,919	$677,101	$135,766	$133,050	19.65%
SFY20 Hawki								
Hawki Dental Only	1,160	$22.06	$21.62	$25,590	$25,078	$2,897	$2,839	11.32%
SFY21 Hawki								
Hawki Dental Only	3,480	$22.06	$21.62	$76,769	$75,233	$15,085	$14,783	19.65%

Tables 10 and 11 provide the overall cost of medical and dental capitation payments, and orthodontia services paid FFS during the demonstration.

Table 10: Total Demonstration Costs by State Fiscal Year (SFY)

	SFY20 (Mar-20-Jun 20)			SFY21		
	Total	***Federal***	***State***	***Total***	***Federal***	***State***
CHIP-Hawki	$1,612,370	$1,429,849	$182,520	$4,837,109	$3,886,617	$950,492
Regular Hawki Dental	$230,306	$204,236	$26,071	$690,919	$555,154	$135,766
Hawki Dental Only	$25,590	$22,693	$2,897	$76,769	$61,684	$15,085
Orthodontia	$123,714	$109,710	$14,004	$164,952	$132,539	$32,413
	$1,991,980	$1,766,488	$225,492	$5,769,749	$4,635,993	$1,133,756

Table 11: Total Demonstration Costs

	Fiscal Impact		
	Total	***Federal***	***State***
CHIP-Hawki	$6,449,478	$5,316,466	$1,133,012
Regular Hawki Dental	$921,226	$759,389	$161,836
CHIP Dental Only	$102,358	$84,377	$17,982
Orthodontia	$288,666	$242,249	$46,417
	$7,761,728	$6,402,481	$1,359,248

EVALUATION QUESTION 3: What were the State's experiences regarding the implementation of the extended coverage that could inform future demonstration flexibilities in the face of a PHE?

This measure includes interviews with the two MCOs with which the state had contracts during the evaluation period (Iowa Total Care and Wellpoint Iowa [formerly known as Amerigroup Iowa]) and two Iowa HHS staff members. Summary of the responses is included in Table 12.

Table 12: Interview Responses

Performance Measure 3a: MCO Interviews	Responses
What strategies did the MCOs use to engage CHIP beneficiaries turning age 19 during this public health emergency?	MCO 1: • "During the PHE, [we] relied heavily on partners in the community (such as community-based organizations (CBO's), faith-based organizations (FBO's) and others) to ensure information about continued eligibility was provided to members. • Utilized a multi-channel communications approach for disseminating education during the PHE. Text messages, emails, postcards, and social media channels were all frequently used and measured for ROI. These same channels were also utilized during the renewal campaign that was launched near the end of the PHE. • Call centers were also prepared with talking points that addressed a variety of issues and impacts during the PHE. Many of these talking points underscored continued eligibility for populations who would have otherwise lost coverage." MCO 2: • "Did not have a specific strategy to outreach to CHIP beneficiaries turning age 19. These members would have been included in any of the standard methods for identifying members with special health care needs and/or additional care coordination and SDOH needs. Because of the PHE, members would not lose

Performance Measure 3a: MCO Interviews	Responses
	Medicaid eligibility when aging out of CHIP, which is supported by data analytics that the MCO completed on this member cohort."
What were the principal challenges experienced with MCO engagement of CHIP beneficiaries turning age 19 during this public health emergency?	MCO 1: • "One of the most significant challenges in engaging any member during the PHE was the limitation of in-person interactions during the COVID-19 spread. The MCO had to rely heavily on finding ways to engage with members or other organizations that support members through virtual means. To that end, virtual interagency meetings, coalition meetings or other virtual forums with multiple organizations were utilized that provided opportunities to share information. • Conducted a variety of virtual meetings with CBO's that support young adults during the PHE such as schools, LGBTQ centers, food banks, libraries, and others. When resource fairs were made available, the MCO also participated in these. Drive-through resource fairs became a popular option during the PHE and would cater to opportunities such as back-to-school or food drives." MCO 2: • "Did not identify nor experience any principal challenges engaging CHIP beneficiaries turning age 19."

How did the MCOs modify engagement strategies to address the principal challenges identified in question 2?	MCO 1:
	• "Did not do a lot of modification during the PHE because of the inherent limitations noted above (namely the ability to meet in-person). As restrictions were gradually lifted, [we were] able to resume more of an at-person presence at CBO's, FBO's, and the outlets noted above.
	• Continued to utilize a lot of the communications channels noted above, but adapted a more robust approach to the number of times channels such as texting or email were used to improve engagement.
	• Utilized existing communications, such as new member welcome packets or quality-driven initiatives to encourage health screenings, to include information about the PHE for all populations (including CHIP beneficiaries)."
	
	MCO 2:
	• "Did not modify any of engagement strategies; however, recently began developing an outreach strategy for members aging out of CHIP and have reached out to the other MCOs to inquire about their interest in creating similar outreach strategies for this population.
	• Developing an outreach strategy to notify members aging out of CHIP:
	  ○ Create monthly report that identifies members turning 19 six months before their 19th birthday.
	  ○ Send letter advising member is aging out of CHIP.
	  ○ Educate member on how to apply for Medicaid or Marketplace coverage as applicable."

Performance Measure 3b: HHS Interviews	Responses
What were the lessons learned around implementation of extended coverage to CHIP beneficiaries turning age 19 during this public health emergency, that could inform the eligibility determination process in future PHEs?	HHS 1: • "Iowa had minimal difficulty with implementation of extended coverage to members turning 19 during the PHE. Iowa Medicaid utilizes an automatic hierarchy for eligibility and was able to use the same methodology for both CHIP and traditional Medicaid." HHS 2: • "Iowa actually had very few pain points in implementing extended coverage to CHIP beneficiaries turning age 19 during the PHE. Since system rules have an automatic eligibility hierarchy inclusive of both Medicaid and CHIP, maintaining coverage for CHIP members who were aging out meant that the process in the system and for the eligibility workers mirrored exactly how they were handling maintaining coverage for Medicaid members as well. They actually had to implement a deviation from the 'standard' PHE processing in order to no longer maintain coverage for CHIP members who were aging out of coverage."
What were the lessons learned around State staff communication with the MCOs regarding extended coverage of CHIP beneficiaries turning age 19 during this public health emergency, that could inform the eligibility determination process in future PHEs?	HHS 1: • "Ensure timely communication and transparency to allow for seamless coverage for members." HHS 2: • "Not sure of the specific lessons learned about what would have worked better communication-wise, but it was a very similar situation in maintaining coverage for Medicaid members who were aging out of coverage groups at age 65. Maintaining everyone's coverage (Medicaid and CHIP age outs) likely simplified the MCOs understanding of eligibility process changes during the PHE as opposed to treating different populations differently."

Conclusion

Iowa's goal during the demonstration period was to ensure adequate coverage and access to critical services in response to the COVID-19 PHE. This goal was met as the demonstration permitted Iowa to provide continued eligibility for 2,900 Iowans. Without such authority, this population would have been at risk for becoming uninsured in the absence of locating and enrolling in alternative coverage options. Lack of continued healthcare coverage could have put these beneficiaries at risk for medical debt or caused them to avoid seeking medical care. Additionally, providers could have been at risk for providing otherwise uncompensated care. Based on the findings in Table 3, it is evident that enrollees with continued eligibility due to the waiver accessed preventive and routine healthcare services. During the demonstration period, 2,142 unique demonstration enrollees (73.8%) enrollees accessed at least one dental, vision, or professional service.

The MCOs contracted with the State during the demonstration were interviewed regarding their engagement strategies for CHIP beneficiaries who turned age 19 during the PHE. One MCO reported that a significant challenge in engaging members during the PHE was the limitation of in-person interactions. To address this, the MCO found ways to engage virtually such as virtual interagency and CBO meetings. The MCO also relied on partners in the community as well as multi-channel communications (i.e., text messages, emails, postcards, social media channels) and call centers to ensure education and information about continued eligibility was shared with enrollees.

Response from the two HHS staff members that were interviewed revealed that they had minimal difficulty implementing extended coverage to CHIP beneficiaries turning age 19 due to HHS' utilization of an automatic hierarchy for eligibility and ability to use the same methodology for both CHIP and Medicaid.

Lessons learned that could inform the eligibility determination process in future PHEs include ensuring timely communication between HHS and MCOs, and with beneficiaries. Whether using existing engagement strategies or newly developed ones, having strategies in place is also key to ensuring continued coverage and access to services.