DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

State Demonstrations Group

April 30, 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 Managed Care Risk Mitigation 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 February 4, 2022. This report covers the demonstration period from March 1, 2020 through June 30, 2021. CMS determined that the Final Report, submitted on November 12, 2024, and revised on March 12, 2025, 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: 2025.04.30 08:54:34 -04'00'

Danielle Daly
Director
Division of Demonstration Monitoring and Evaluation

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

Final report – Managed Care Risk Mitigation COVID-19 PHE Section 1115 Demonstration

Revised version April 7, 2025

IOWA Health and Human Services

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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 submitted an 1115 COVID-19 demonstration application to address the COVID-19 public health emergency (PHE). The waiver requested authority for exemption from the regulatory prohibition in 42 CFR §438.6(b)(1) to permit retroactive risk sharing.

Iowa's goal during the Managed Care Risk Mitigation COVID-19 PHE demonstration period is to add a risk-sharing arrangement, specifically a risk corridor, to support Iowa in making appropriate, equitable payments during the COVID-19 PHE to help maintain beneficiary access to care.

Centers for Medicare & Medicaid Services (CMS) determined that Iowa's demonstration promoted the objectives of the Medicaid program and approved the demonstration on February 4, 2022. This approval permitted Iowa to enter into or modify a risk mitigation arrangement with its managed care organizations (MCOs) and prepaid ambulatory health plans (PAHPs), also known as managed care plans (MCPs).

As part of the approval, CMS required the state to monitor and evaluate the impacts of the demonstration. CMS expects Iowa to undertake data collection and/or analyses that are meaningful but not unduly burdensome for the state. Specifically, the state was directed to focus on qualitative methods and descriptive statistics to address evaluation questions that will support understanding the successes, challenges, and lessons learned in implementing the demonstration.

The items approved and subject to evaluation under the approved 1115 demonstration are:

- Capitation rates reflecting health insurance providers fee, Nursing Facility COVID-19 Relief Rate (NF CRR) payments and risk corridor.
- NF CRR payments and risk corridor reconciliation for SFY20 and SFY21.
- Original rate certification for SFY20 and SFY21.
- Original rate certification for the Dental Wellness Plan that includes risk corridor for SFY21.

Table 1 outlines the applicable rating periods.

Table 1: Rating Periods

HealthLink	Dental Wellness Plan
07/01/2019-06/30/2020	
07/01/2020-12/31/2020	07/01/2020-06/30/2021
01/01/2021-06/30/2021	

Evaluation questions and hypotheses

This evaluation aims to determine the impact of the exemption on appropriate and equitable payments to an MCP during a PHE.

Evaluation Question 1: To what extent did the retroactive risk mitigation implemented under the demonstration authority result in more accurate payments to the MCPs?

Hypothesis 1: The final medical expenditure payments to the MCPs from the state will more accurately reflect the actual costs of providing the medical services rendered than what was originally included in the capitation rates.

Evaluation Question 2: 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?

Hypothesis 2: The state will be able to identify the benefits and successes of adding a risk-sharing mechanism that would not have been realized if the demonstration authority were not in place.

Evaluation Question 3: What were the principal lessons learned 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 the means for negotiating appropriate risk mitigation strategies with its MCPs. The lessons learned from this demonstration may be incorporated into MLR audit processes, medical expenditure analyses, and review of administrative expenditures from the MCPs.

Evaluation Question 4: What retroactive risk-sharing agreements did the state ultimately negotiate with the MCPs under the demonstration authority?

Hypothesis 4: The state will be able to show the types of negotiated risk-sharing agreements with the MCPs, the terms of the negotiated risk-sharing agreements, and that they are mutually beneficial and provide appropriate, actuarially sound rates.

Descriptive Analyses

For evaluation questions assessing payments to MCPs, the state calculated the standard summary statistics to report findings using claims data and MLR submissions.

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

Table 2: Analytic Table

Evaluation Questions	Hypotheses	Data Source	Analytic Approach
1. To what extent did the retroactive risk mitigation implemented under the demonstration authority result in more accurate payments to the MCPs?	The final medical expenditure payments to the MCPs from the state will more accurately reflect the actual costs of providing the medical services rendered than what was originally included in the capitation rates.	MLR Submissions and Claims Data	Descriptive analysis
2. 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 state will be able to identify the benefits and successes of adding a risk-sharing mechanism that would not have been realized if the demonstration authority were not in place.	Staff Interviews	Qualitative analysis
3. What were the principal lessons learned that could inform future demonstration flexibilities in the face of a PHE?	The state will be able to document for any future PHEs the means for negotiating appropriate risk mitigation strategies with its MCPs. The lessons learned from this demonstration may be incorporated into MLR audit processes, medical expenditure analyses, and review of administrative expenditures from the MCPs.	Staff Interviews	Qualitative analysis
4. What retroactive risk-sharing agreements did the state ultimately negotiate with the MCPs under the demonstration authority?	The state will be able to show the types of negotiated risk-sharing agreements with the MCPs, the terms of the negotiated risk-sharing agreements, and that they are mutually beneficial and	Document Review	Qualitative Analysis

Evaluation Questions	Hypotheses	Data Source	Analytic Approach
	provide appropriate, actuarially sound rates.		

Findings

Evaluation Question 1:
To what extent did the retroactive risk mitigation implemented under the demonstration authority result in more accurate payments to the MCPs?

Response:
The risk mitigation implemented by the Iowa Department of Health and Human Services (HHS) resulted in more accurate payments to the Medicaid managed care organizations (MCO) and dental Prepaid Ambulatory Health Plans (PAHP). The purpose of the risk mitigation arrangements was to address uncertainty associated with the COVID-19 Public Health Emergency and its impact on capitation rates.

Each risk mitigation arrangement was described in the MCO and PAHP contracts and rate certification letters. The capitation rates were developed in accordance with CMS guidance, 42 CFR 42 §438.4, the rate development standards in 42 CFR §438.5, and generally accepted actuarial principles and practices. Risk corridors were evaluated based on MCO / PAHP encounter, claims, and financial data.

The risk corridors resulted in more accurate payments as demonstrated by the results of the risk corridor evaluations. Please refer to the results and amounts of recoupments or payments in Response to Evaluation Question 4.

Evaluation Questions 2 and 3: the State conducted interviews with Medicaid agency staff and MCO representatives to gather insight into implementation and operational considerations. A total of eight interviews were conducted, five with State staff and three with MCO representatives. A semi-structured interview guide was developed to ensure consistency across interviews, focusing on themes such as policy intent, operational challenges, stakeholder communication and outcomes of risk mitigation strategies.

Interview notes were taken during each session and reviewed using a thematic coding approach. For example, the notes were reviewed to highlight specific pieces of text that related to the research questions. If the respondent talks about ‘shared goals, transparency in decision, incentives and share accountability’ that is identified under the theme ‘Encouraging MCO collaboration.’ The themes identified for questions 2 and 3 are outlined below.

Question 2: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?

Response:

After interviewing staff members involved in implementing the risk corridor during the PHE, several key benefits were identified:

1. **Financial Protection and Stability**: The demonstration allowed the state to implement risk corridors, providing a financial cushion for both the state and managed care organizations (MCOs) during unpredictable utilization shifts. Without the demonstration authority, such financial adjustments might have been slower or less feasible.
2. **Timely Adjustments to Changing Conditions**: Under the demonstration authority, the state was able to modify capitation payments to address the real-time needs of the population. For instance, increased payments or shared-risk adjustments helped manage utilization changes due to COVID-19, such as the surge in telehealth demand. These adjustments ensured that MCOs had the flexibility to provide care without compromising financial viability.
3. **Encouraging MCO Collaboration**: By implementing risk-sharing measures, the state created incentives for MCOs to work collaboratively and share data for the benefit of enrollees, fostering a more cooperative managed care environment. Without the demonstration's added flexibility, MCOs might have operated more conservatively, potentially limiting access and innovation.

   Increased Support for Vulnerable Populations: The demonstration enabled MCOs to adopt risk-sharing arrangements that ensured continuous service for high-risk populations during the PHE. This additional protection likely helped prevent service interruptions that could have disproportionately impacted individuals with chronic conditions or other high-need demographics.

Evaluation Question 3:

What were the principal lessons learned that could inform future demonstration flexibilities in the face of a PHE?

Response:
After interviewing staff members involved in the implementation of the risk corridor during the PHE, the following lessons learned were captured:

1. **Develop a Documentation Framework**: Things happened quickly during the PHE, and since most staff worked from home, much of the documentation related to the implementation of the risk corridor was exchanged via email. It became difficult to keep track of where things stood and what action items

needed completion. To avoid this situation in the future, Iowa HHS decided to develop a standardized template for documenting risk mitigation strategies used during the demonstration. This template includes sections for stakeholder inputs and decision-making processes, helping Iowa HHS track action items related to the implementation of the risk corridor and document decisions made, as well as feedback provided by stakeholders (MCPs, HHS leadership, SMEs).

2. **Analyze Existing Data**: Iowa HHS did not have data from the current risk corridor demonstration, as this was the first time it was implemented. However, Iowa HHS partnered with its actuary, who researched and analyzed the available data to inform decisions and discussions. The actuarial vendor also pulled data from other states in comparable situations to review what they had available.
3. **Analyze Medical and Administrative Expenditures**: Future analyses should include comprehensive evaluations of both medical and administrative expenditures. Understanding how resources were allocated during the demonstration will provide insights into more efficient spending and resource management during future emergencies.
4. **Flexibility and Adaptability**: The ability to adapt quickly to changing circumstances proved vital during the demonstration. Future frameworks should allow for flexibility in response strategies, enabling MCPs and the state to pivot based on emerging data and evolving public health challenges.

Evaluation Question 4:
What retroactive risk-sharing agreements did the state ultimately negotiate with the MCPs under the demonstration authority.

Response:
Iowa HHS implemented risk mitigation strategies for its Health Link and Dental Wellness Plan contracts. Table 1 outlines the program, risk mitigation strategies and impacted contract periods included in the approved demonstration followed by discussion of each risk corridor.

Table 1 – Risk Mitigation Strategies

Program	Risk Corridor Description	Contract Periods Impacted
Iowa Health Link	Nursing Facility COVID-19 Relief Rate	• SFY20 (July 1, 2019 – June 30, 2020) • Six-Months SFY21 (July 1, 2020 – Dec 31, 2020) • Six-Months SFY21 (Jan 1, 2021 – June 30, 2021)
	Program-Wide	• Six-Months SFY21 (Jan 1, 2021 – June 30, 2021)

Dental Wellness Plan (DWP)	Program-Wide	• SFY21 (July 1, 2020 – June 30, 2021)

NF CRR Risk Mitigation Overview

Iowa HHS incorporated a risk corridor for Medicaid managed care plans specific to expenditures associated with the March 13, 2020, implementation of nursing facility COVID-19 Relief Rate (NF CRR). The NF CRR payments were available to Medicaid certified skilled nursing facilities (SNF) and nursing facilities (NF) during the federal public health emergency. The purpose of the CRR payments was to provide financial assistance to facilities that incurred unexpected costs when caring for members who were diagnosed with or quarantined for potential COVID-19.

CRR payments were $300 per day made to eligible facilities for each Medicaid enrollee residing in a designated isolation of COVID-19 facility who:

1. Was discharged from a hospital to the nursing facility; or
2. Was pending test results for COVID-19; or
3. Had a positive COVID-19 diagnosis.

The NF CRR risk mitigation was effective for three Medicaid managed care contract periods:

1. Contract period: July 1, 2019 to June 30, 2020 - - note the risk corridor was effective for services incurred March 13, 2020 through June 30, 2020.
2. Contract period: July 1, 2020 – December 31, 2020 (SFY21a)
3. Contract period: January 1, 2021 – June 30, 2021 (SFY21b)

NF CRR Risk Corridor Terms

The NF CRR risk corridor was developed in accordance with CMS guidance and was structured to recoup or remit funds +/- 1.0% around the NF CRR amounts estimated and the actual NF CRR payments. The risk corridor calculation was specific to the following populations:

- Custodial Care Nursing Facility < 65 years old
- Custodial Care Nursing Facility 65+ years old
- Non-Dual Skilled Nursing Facility

Tables 2 – 4. present risk corridor details and evaluation results (recoupment or payment) for each contract year the risk mitigation was effective. The state evaluated eligibility, encounter, and claims data to determine the risk corridor results. The tables include the number of NF CRR days evaluated, member months, and recoupment or payment amounts.

Table 2 - NF CRR Risk Corridor: State Fiscal Year 2020

Contract Period: July 1, 2019 – June 30, 2020 - *NF CRR effective March 13, 2020*

Risk Corridor Details

- NF CRR PMPM of $40.77 established for the three NF/SNF rate cohorts for the full SFY20 year.
- Actual member months for members in these rate cohorts were multiplied by $40.77 PMPM to calculate NF CRR revenue.
- Actual NF CRR payment amounts, based on actual paid claims data, were evaluated and compared to NF CRR revenue.
- The state recouped NF CRR payments if the MCO NF CRR payments were less than 99% of the NF CRR revenue. Recoupment amounts are outlined below.

Managed Care Organization (MCO)	NF CRR Days Evaluated	Member Months Evaluated	Recoupment Amount from MCO	Payment Amount to MCO
Amerigroup of Iowa	991	85,321	$3,146,451.80	$0
Iowa Total Care	1,302	65,477	$2,252,202.32	$0
Total	**2,293**	**150,798**	**$5,398,654.12**	**$0**

Table 3 - NF CRR Risk Corridor: State Fiscal Year 2021a (six-month period)

Contract Period: July 1, 2020 – December 31, 2020

Risk Corridor Details

- NF CRR PMPM of $40.77 established for the three NF/SNF rate cohorts.
- Actual member months for members in these rate cohorts were multiplied by $40.77 PMPM to calculate NF CRR revenue.
- Actual NF CRR payment amounts, based on actual paid claims data, were evaluated and compared to NF CRR revenue.
- The state remitted additional NF CRR payments if the MCO NF CRR payments were above 101% of the NF CRR revenue. The MCO remittances are outlined below.

Managed Care Organization (MCO)	NF CRR Days Evaluated	Member Months Evaluated	Recoupment Amount from MCO	Payment Amount to MCO
Amerigroup of Iowa	7,496	40,044	$0	$599,880.18
Iowa Total Care	7,461	30,803	$0	$969,903.31
Total	**14,957**	**70,847**	**$0**	**$1,569,783.49**

Table 4 - NF CRR Risk Corridor: State Fiscal Year 2021b (six-month period)

Contract Period: January 1, 2021 – June 30, 2021				
Risk Corridor Details • NF CRR PMPM of $7.47 established for the three NF/SNF rate cohorts. Note, the change to PMPM was informed by emerging NF CRR data. • Actual member months for members in these rate cohorts were multiplied by $7.47 PMPM to calculate NF CRR revenue. • Actual NF CRR payment amounts, based on actual paid claims data, were evaluated and compared to NF CRR revenue. • The state recouped NF CRR payments if the MCO NF CRR payments were less than 99% of the NF CRR revenue. Recoupment amounts are outlined below.				
Managed Care Organization (MCO)	**NF CRR Days Evaluated**	**Member Months Evaluated**	**Recoupment Amount from MCO**	**Payment Amount to MCO**
Amerigroup of Iowa	881	37,119	$10,206.14	$0
Iowa Total Care	623	28,701	$25,352.51	$0
Total	**1,504**	**65,820**	**$35,558.65**	**$0**

NF CRR Risk Corridor Reconciliation Approach and Methodology

Per the Health Link MCO contract language, the NF CRR risk corridor evaluation included evaluating the following data elements:

1. Person-level nursing facility claims information from each Health Link MCO for the periods covered by the NF CRR policy.
2. Person-level nursing facility encounter data.
3. Person-level state capitation and eligibility data.

The state evaluated these data sources to ensure that the MCO-submitted claims data was consistent with the encounter data collected by the state. Additionally, the state assessed each nursing facility claim and encounter to ensure that the MCO's claims data and encounter data reflected accurate NF CRR days and payments. The state sought clarification and corrections to the data for discrepancies or questions. The data used to calculate the reconciliation amounts were not impaired or limited in any way that impacted the accuracy or completeness of the reconciliation.

The state evaluated the NF CRR claims/encounter data for the applicable period reconciliation period against the MCO capitation and eligibility data to ensure that each encounter was valid for enrolled Medicaid members classified in the following aid category groups for the dates of service reflected in the claims/encounter data:

- Custodial Care Nursing Facility < 65 years old

- Custodial Care Nursing Facility 65+ years old
- Non-Dual Skilled Nursing Facility

The reconciliation results, including supporting claims and eligibility information, were presented to each Health Link MCO for review and feedback. Following a period of review, the Health Link MCOs agreed with the reconciliations, and the state recouped or remitted payment in accordance with the Health Link NF CRR risk corridor contract language.

Iowa Health Link Managed Care Program Risk Mitigation Overview

DHS implemented a program-wide risk corridor for IA Health Link MCO program for the six-month period between January 1, 2021 and June 30, 2021. Prior periods, (July 1, 2019 – June 30, 2020 and July 1, 2020 – December 31, 2020), did not include a program-wide risk corridor.

Health Link Program-Wide Risk Corridor Terms

The risk corridor was developed based on the aggregate MLR percent experience for all populations and covered services for each MCO. The gain and loss share for the MCO and DHS for the different risk corridor bands are outlined in Table 5 below.

Table 5: SFY21b January 1, 2021 – June 30, 2021 Risk Corridor Arrangement

Risk Corridor Band		Gain / Loss Share	
Min Threshold %	**Max Threshold %**	**MCO**	**State**
0.0%	89.8%	0%	100%
89.8%	92.3%*	100%	0%
92.3%*	94.8%	100%	0%
94.8%	94.8%+	0%	100%

**The target MLR of 92.3% is based on the weighted average of total non-medical load amounts built into the SFY21b rates using the CY19 enrollment distribution. The actual target used for the final reconciliation may vary slightly based on the actual population distribution for the MCO during the six-month contract period. To the extent the target MLR varies from 92.3% using the actual MCO enrollment mix during the contract period, the risk corridor bands will still be +/- 2.5% from the revised target MLR.*

The risk corridor reconciliation was applied prior to the calculation of the minimum MLR and any recoupments necessary between the MCO and State was incorporated as an adjustment to revenue prior to the minimum MLR calculation. The risk corridor results were determined based on evaluation of MCO encounter, claims, and financial data. The results of the program-wide risk corridor are outlined in Table 6.

Table 6 – Health Link Program-Wide Risk Corridor: State Fiscal Year 2021b (six-month period)

Contract Period: January 1, 2021 – June 30, 2021			
Risk Corridor Details • Prior to evaluating the program-wide risk corridor the NF CRR risk corridor was evaluated. The results of the NF CRR risk corridor were incorporated into the revenue component of the program-wide risk corridor evaluation.			
Managed Care Organization (MCO)	**Member Months**	**Recoupment Amount from MCO**	**Payment Amount to MCO**
Amerigroup of Iowa	2,606,810	$24,473,892.17	$0
Iowa Total Care	1,864,141	$5,395,797.04	$0
Total	**4,470,951**	**$29,869,689.21**	**$0**

Health Link Risk Corridor Reconciliation Approach and Methodology

Per the Health Link MCO contract language, the risk corridor evaluation included evaluating the following data elements:

1. Person-level nursing facility encounter data.
2. Health Link MCO submitted financial reporting.
3. Results of separately conducted medical loss ratio review for the contract period.
4. Person-level state capitation and eligibility data.

The state evaluated these data sources to ensure that the MCO-submitted claims data was consistent with the encounter data collected by the state. The state sought clarification and corrections to the data for discrepancies or questions. The data used to calculate the reconciliation amounts were not impaired or limited in any way that impacted the accuracy or completeness of the reconciliation.

The reconciliation results, including supporting claims and eligibility information, were presented to each Health Link MCO for review and feedback. Following a period of review, the Health Link MCOs agreed with the reconciliations, and the state recouped or remitted payment in accordance with the Health Link risk corridor contract language

Iowa Dental Wellness Plan Program Risk Mitigation Overview

DHS implemented a program-wide risk corridor for the Dental Wellness Program (DWP) program for SFY21 (July 1, 2020 – June 30, 2021).

DWP Program-Wide Risk Corridor Terms

The risk corridor was developed based on the aggregate MLR percent experience for all populations and covered services for each MCO. The gain and loss share for DWP plans and DHS for the risk corridor bands for SFY21 are outlined in Table 7.

Table 7: SFY21 July 1, 2020 – June 30, 2021 Risk Corridor Arrangement

Risk Corridor Band		Gain / Loss Share	
Min Threshold %	**Max Threshold %**	**PAHP**	**State**
0.0%	88.0%	0%	100%
88.0%	90.0%	100%	0%
90.0%	92.5%	100%	0%
92.5%	92.5%+	0%	100%

The risk corridor reconciliation was applied prior to the calculation of the minimum MLR and any recoupments necessary between the MCO and State was incorporated as an adjustment to revenue prior to the minimum MLR calculation. The risk corridor results were determined based on evaluation of MCO encounter, claims, and financial data. The results of the risk corridor for SFY21 is outlined in Table 8.

Table 8 – DWP Risk Corridor: State Fiscal Year 2021

Contract Period: July 1, 2020 – June 30, 2021

Risk Corridor Details

- The overall MLR risk corridor percentage was calculated as total adjusted medical expenditures divided by the total capitation rate for the SFY21 period.
- Adjusted claims expenditures included services covered by the DWP contract. Items such as fraud, waste, and abuse, and administrative expenditures that improve health care quality were not considered in the numerator of the MLR risk corridor calculation.
- The cost of value-add services was allowed to be included within the medical expenditures portion of the risk corridor calculation for the SFY21 contract period; however, these were not included within the development of the SFY21 capitation rates.

Prepaid Ambulatory Health Plan (PAHP)	**Member Months**	**Recoupment Amount from PAHP**	**Payment Amount to PAHP**
Delta Dental of Iowa	2,920,073	$7,726,741.11	$0
MCNA Dental of Iowa	1,654,604	$3,063,671.67	$0
Total	**4,574,677**	**$10,790,412.78**	**$0**

DWP Risk Corridor Reconciliation Approach and Methodology

Per the DWP dental plan contract language, the risk corridor evaluation included evaluating the following data elements:

1. Person-level nursing facility encounter data.
2. Dental plan submitted financial reporting.
3. Results of separately conducted medical loss ratio review for the contract period.
4. Person-level state capitation and eligibility data.

The state evaluated these data sources to ensure that the dental plan submitted claims data was consistent with the encounter data collected by the state. The state sought clarification and corrections to the data for discrepancies or questions. The data used to calculate the reconciliation amounts were not impaired or limited in any way that impacted the accuracy or completeness of the reconciliation

The reconciliation results, including supporting claims and eligibility information, were presented to each DWP dental plan for review and feedback. Following a period of review, the dental plans agreed with the reconciliations, and the state recouped or remitted payment in accordance with the DWP risk corridor contract language.