DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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State Demonstrations Group

April 24, 2026

Drew Gonshorowski
Director of Medicaid & Long Term Care
Nebraska Department of Health and Human Services
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Dear Director Gonshorowski:

The Centers for Medicare & Medicaid Services (CMS) completed its review of Nebraska's Final Report for the Managed Care Risk Mitigation COVID-19 Public Health Emergency (PHE) amendment to the section 1115 demonstration entitled, "Nebraska Substance Use Disorder Program" (Project No: 11-W-10025/7). This report covers the demonstration period from October 2020 to December 2021. CMS determined that the Final Report, submitted on October 25, 2024 and revised on February 11, 2025 is in alignment with the CMS-approved Evaluation Design, and therefore, approves the state's Final Report.

In accordance with STC #42, the approved Final Report may now be posted to the state's Medicaid website within 30 days. CMS will also post the Final Report on Medicaid.gov.

States are responsible for following all applicable federal law and regulations when they claim and use federal Medicaid funds and must fully comply with all applicable Medicaid statutes and regulations under a section 1115 demonstration, except where specific provisions have been expressly waived or identified as not applicable for that demonstration. This obligation includes all requirements in Title XIX of the Social Security Act and implementing regulations governing provider screening and enrollment activities, pre- and post-payment review claiming, payment methodologies and rate-setting, utilization controls, and program integrity including processes to identify, investigate, and refer suspected fraud, and methods to receive complaints and identify questionable practices. States must maintain effective systems and safeguards to prevent, detect, and address any fraud, waste, or abuse (FWA) in the delivery of and payment for Medicaid services, including referrals to law enforcement when appropriate.

States should have heightened monitoring and oversight mechanisms in place featuring robust internal controls to identify and remediate all vulnerabilities (including, but not limited to, FWA and beneficiary access issues) inherent in service areas approved as part of a demonstration. At any time, CMS may request that the state provide a plan detailing the state's systems and

safeguards to prevent, detect, and address any FWA relative to this demonstration. Failure to meet program integrity obligations under federal statutes and regulations or under the terms and conditions of this demonstration approval may result in compliance actions or other enforcement measures that could include requirements to develop and implement corrective action plans, withholdings, deferrals, disallowances, and termination of demonstration authority.

We sincerely appreciate the state's commitment to evaluating the Managed Care Risk Mitigation COVID-19 PHE amendment under these extraordinary circumstances. We look forward to our continued partnership on the Nebraska Substance Use Disorder Program section 1115 demonstration. If you have any questions, please contact your CMS demonstration team.

Sincerely,

Danielle Daly
Director
Division of Demonstration Monitoring and Evaluation

cc: Tyson Christensen, State Monitoring Lead, CMS Medicaid and CHIP Operations Group

NEBRASKA

Good Life. Great Mission.

Department of Health and Human Services

Nebraska Substance Use Disorder Program

Project No. 11-W-10025/7

Emergency Demonstration Amendment –
Managed Care Risk Mitigation COVID-19 PHE

Final Report

February 11, 2025

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A. General Background Information

On March 13, 2020, pursuant to Section 1135(b) of the Act, the Secretary of Health and Human Services invoked his authority to waive or modify certain requirements of Titles XVIII, XIX, and XXI of the Act because of the consequences of the COVID-19 pandemic. As a result, on March 22, 2020, the Centers for Medicare & Medicaid Services (CMS) announced a Section 1115 demonstration opportunity available to states under title XIX (Medicaid) of the Act. In response, the Nebraska Department of Health and Human Services (Nebraska MLTC) submitted a Managed Care Risk Mitigation COVID-19 Public Health Emergency (PHE) Section 1115 demonstration application on November 12, 2021. On January 18, 2022, CMS approved the application as an amendment under the "Nebraska Substance Use Disorder Program" section 1115(a) demonstration (Project Number 11-W-10025/7).

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

Nebraska MLTC submits to CMS the Final Report for this demonstration 18 months after either the expiration of the demonstration approval period or the end of the latest rating period covered under the state's approved expenditure authority, whichever comes later. The Final Report will include all applicable elements required by 42 CFR 431.428.

B. Evaluation Questions and Hypotheses

Figure 1 outlines the hypotheses and research questions (RQs) related to understanding the successes, challenges, and lessons learned in implementing the demonstration.

Figure 1. Hypotheses and Research Questions

Research Question (RQ)	
Hypothesis 1 – The demonstration will facilitate attaining the objectives of Medicaid.	
RQ 1.1	What retroactive risk sharing agreements did the state ultimately negotiate with the managed care plans under the demonstration authority? Nebraska Response: Nebraska implemented a MLR Based Risk Corridor for the contract periods of October 1, 2020 to December 31, 2020, and January 1, 2021 to December 31, 2021. The MLR-based risk corridor was applicable only to the new adult expansion population that began receiving benefits on October 1, 2020. The target MLR is calculated as 100% minus the rating administrative load. The risk corridor recoupments/payouts are treated as an adjustment to revenue. For example, if the aggregate MLR target results in 88.0%, the calculation will be conducted in a way that the Medical PMPM experience relative to the adjusted revenue (after risk corridor payments/recoupments) will be no more than 90.0%, and no less than 86.0%.
RQ 1.2	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?

	Nebraska Response: The demonstration supported the program in adding the previously described MLR based risk corridor for the newly eligible adult expansion population. This was important as the program went live during the Public Health Emergency (PHE), the capitation rates are based heavily on assumptions (since there is not prior experience to be used as a basis for rate development) and is all based on data prior to the beginning of the PHE. The demonstration gave the state an avenue to comply with federal requirements and ASOP requirements as well as ensuring appropriate risk was mitigated for both the state and the MCOs
RQ 1.3	What problems may have been caused by the application of section 438.6(b)(1) during the PHE that would have undermined the objectives of Medicaid, and how did the exemption address or prevent these problems? Nebraska Response: The state would have not been able to implement the previously described MLR based risk corridor for the newly eligible adult expansion population, absent the exemption. This would have resulted in a situation whereby the Nebraska Medicaid program and the MCOs in the state would have not had appropriate risk mitigation in place for this new population, for which previous experience was not available for the purposes of rate setting. This would have resulted in the potential for either the MCOs or the program to have unreasonable financial risk. The exemption allowed the state to appropriately mitigate unreasonable financial risks, while allowing for appropriate risk levels for a managed care program.
RQ 1.4	What were the principal challenges associated with implementing the retroactive risk mitigation strategies from the perspectives of the state Medicaid agency and Medicaid managed care plans? Nebraska Response: The state did not experience any significant or notable challenges implementing the retroactive risk mitigation strategies. Nebraska had planned to implement the previously described MLR based risk corridor for the newly eligible expansion population. Nebraska had included the details of the risk mitigation in the actuary certification letter, but it was not documented in MCO contracts, per the new Managed Care Rule, creating the need for the exemption.
RQ 1.5	What actions did the state take to address challenges presented by the implementation of retroactive risk mitigation strategies? To what extent were those actions successful in the context of the PHE? Nebraska Response: The state communicated with all stakeholders regarding the circumstances. This included technical assistance calls with CMCS, the state contracted actuary, Nebraska leadership, and Nebraska managed care organizations. The communications allowed all stakeholders to be involved in the conversation and understand the challenge at hand and provide input into the solution.
RQ 1.6	What were the principal lessons learned for any future PHEs in implementing the demonstration flexibilities? Nebraska Response: The state has learned to put in place practices to ensure that any risk mitigation strategies being implemented and documented in certification letters must also be similarly documented in contract amendments, and vice versa. Additionally, the state learned that open dialogue and communication among stakeholders allows for consistent understanding and collaboration towards an amenable outcome.
Hypothesis 2 – The authority will support the Department 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).	
RQ 2.1	To what extent did the retroactive risk sharing implemented under the demonstration authority result in more accurate payments to the managed care plans? Nebraska Response: The retroactive risk sharing implemented allowed the state to reimburse the managed care plans more accurately for medical costs for the newly eligible expansion members, which went live during the COVID-19 Pandemic. For example,

for the period of October 1, 2020 – December 2020, one of the MCO's experienced higher medical expenses than what was loaded in the rates. Having this risk mitigation in place allowed for the department to retroactively compensate the MCO for the appropriate amount of beneficiary medical expense that was not in the prospective capitation rate.

Metric	NTC	UHC	WellCare
Earned Revenue	$19,855,604	$19,780,184	$17,540,358
Risk Corridor Medical Expense	$17,847,764	$17,648,325	$17,347,507
MLR Experience	89.89%	89.22%	98.90%
Risk Corridor MLR Target	88.02%	87.97%	87.93%
Upper Corridor MLR (Target + 2%)	90.02%	89.97%	89.93%
Lower Corridor MLR (Target - 2%)	86.02%	85.97%	85.93%
Percent Above/Below Corridor Bands	0.00%	0.00%	8.97%
Risk Corridor Recoupment/(Payback)	$0	$0	$1,750,108
Adjusted MLR	89.89%	89.22%	89.93%

Similarly, for the period of January 1, 2021 – December 31, 2021, the retroactive risk sharing implemented allowed the state to ensure it did not overpay for newly eligible expansion members that began being covered by the program during the COVID-19 Pandemic. Having this risk mitigation in place allowed for the department to retroactively adjust MCO payments to more closely align to the appropriate beneficiary medical expenses for the period.

Metric	HBN	NTC	UHC
Earned Revenue	$151,867,457.75	$179,255,203.30	$177,143,002.84
Risk Corridor Medical Expense	$127,677,767.90	$140,391,847.90	$141,545,184.34
MLR Experience	84.1%	78.3%	79.9%
Risk Corridor MLR Target	88.2%	88.4%	88.3%
Upper Corridor MLR (Target + 2%)	90.2%	90.4%	90.3%
Lower Corridor MLR (Target - 2%)	86.2%	86.4%	86.3%
Percent Above/Below Corridor Bands	2.2%	8.1%	6.4%
Risk Corridor Recoupment/(Payback)*	$3,811,281.06	$16,772,091.24	$13,211,894.36
Adjusted MLR	86.2%	86.4%	86.3%

Positive dollar amounts reflect payment amounts due from each MCO to the State/Federal Government.

C. Methodology

This section details Nebraska's methodology for the evaluation of the demonstration, including data sources, analytic methods, and evaluation reporting periods.

Section C.1 summarizes the data used to prepare the Final Report. Section C.2 describes the Department's analytic methods used for the Evaluation.

Section C.3 includes analytic tables that detail the evaluation approach for each hypothesis. The analytic tables outline the planned research questions, outcome measures, data sources, and analytic approaches.

1. Data Sources

The department compiled data for the Evaluation from qualitative and quantitative data sources including interviews and meetings with state staff, the state's contracted actuary, and managed care organizations. The state also compiled and analyzed state and managed care organization reported data with the state's contracted actuary.

Document Review

The state reviewed the contract between the department and managed care organizations, the rating period actuary certification letter, and end of contract period reconciliation report from the actuary.

Department Staff Interviews

The department met with state staff involved in the implementation of the risk corridor. The department also met with the state's contracted actuary responsible for establishing managed care organization capitation payments and calculation end of contract period financial outcomes. As part of this process, the department also engaged the managed care organizations in Nebraska subject to the risk corridor.

MCO Medical Loss Ratio (MLR) Reports

MCOs submitted quarterly medical loss ratio (MLR) reports throughout the demonstration period and for two years following the demonstration containing summarized revenue, claims costs, and other financial metrics for the purposes of tracking and forecasting anticipated MLRs and the impact of the affected population's risk mitigation included in this demonstration.

State Medicaid Claims Data

The department used MCO claim level detail and other supported cost data reported to the state through encounters and supplemental files. The department's actuaries analyzed this data and performed reasonableness assessments to use this data to evaluate the actual experience during the COVID-19 Pandemic to the affected population.

CY 2020 Rate Development Exhibits

The department's actuaries provided CY 2020 and CY2021 Rate Development Exhibits, as well as end of contract period evaluations, inclusive of the risk mitigation covered in this demonstration for both CY2020 and CY2021. The department examined these Exhibits to evaluate, in part, to what extent the risk sharing implemented under the demonstration authority resulted in more accurate payments to the MCOs.

2. Analytic Methods

As part of the 1115 demonstration approval, CMS required Nebraska 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 Nebraska respond to the COVID-19 PHE. As such, Nebraska used qualitative and descriptive statistics methods to conduct the Evaluation.

Qualitative Analysis

The department collected qualitative data through methods such as meetings with involved state staff and key stakeholders such as the state's contracted actuary and the Managed Care Organizations. Additionally, the state was able to leverage the actuary's final contract period reconciliation calculations for each contract period which contained detailed analysis of the risk mitigation covered under this demonstration.

Descriptive Analyses

For research questions that assessed payments to managed care plans, the department's actuary provided the state with the outcome of the contract periods covered by the demonstration.

3. Analytic Table

Figure 2 outlines the hypotheses, research questions, outcome measures, data sources, and analytic approaches for this Evaluation Design.

Figure 2. Analytic Table

Research Question	Outcome Measure(s)	Data Source(s)	Analytic Approach
Hypothesis 1 – The demonstration will facilitate attaining the objectives of Medicaid.			
RQ 1.1: What retroactive risk sharing agreements did the state ultimately negotiate with the managed care plans under the demonstration authority?	Type(s) of risk sharing agreement(s) negotiated with the managed care plans Terms of negotiated risk sharing agreement(s).	Documen t Review	Qualitative Analysis
RQ 1.2: 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?	Benefits/successes of adding a risk sharing mechanism that would not have been realized if the demonstration authority were not in Place.	Department Staff Interview(s)	Qualitative Analysis
RQ 1.3: What problems may have been caused by the application of section 438.6(b)(1) during the PHE that would have undermined the objectives of Medicaid, and how did the exemption	Description of how the demonstration authority addressed or prevented problems related to the application of section 438.6(b)(1).	Department Staff Interview(s)	Qualitative Analysis

address or prevent these problems?			
RQ 1.4: What were the principal challenges associated with implementing the retroactive risk mitigation strategies from the perspectives of the state Medicaid agency and Medicaid managed care plans?	Description of challenges (if any) related to implementing the risk sharing agreement(s) with the managed care plans.	Department Staff Interview(s)	Qualitative Analysis
RQ 1.5: What actions did the state take to address challenges presented by the implementation of retroactive risk mitigation strategies? To what extent were those actions successful in the context of the PHE?	Description of actions taken by Nebraska to address the challenges identified (if any) in RQ 1.4. Description of how these actions were successful.	Department Staff Interview(s)	Qualitative Analysis
Research Question	**Outcome Measure(s)**	**Data Source(s)**	**Analytic Approach**
RQ 1.6: What were the principal lessons learned for any future PHEs in implementing the demonstration flexibilities?	Description of lessons learned for future PHEs in implementing the demonstration flexibilities.	Department Staff Interview(s)	Qualitative Analysis
Hypothesis 2 – The authority will support the department 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).			
RQ 2.1: 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 MCO-specific. MLRs after application of the risk corridor, both at an aggregate-level as well as MCO-specific.	MLR Calculations State Medicaid Claims Data CY 2020 Rate Development Exhibits	Descriptive Analysis

D. Methodological Limitations

Nebraska did not experience any significant methodological limitations with respect to the evaluation of this demonstration. The department was able to gather

qualitative and quantitative information from department staff, the state's contracted actuary, and managed care organizations to effectively evaluate the demonstration.

E. Conclusion

Nebraska confirmed its hypothesis of the risk mitigation demonstration, which is that the risk mitigation strategy implemented resulted in appropriate, equitable payments during the public health emergency. The department learned that absent this risk mitigation, one managed care organization would have been underpaid for their cost of covering eligible services during calendar year 2020; and separately, all Nebraska Medicaid managed care organizations would have been overpaid in capitation, relative to their actual medical expenses in calendar year 2021. The state considers the outcome of the demonstration waiver successful in allowing the department to appropriately account for these situations as part of the end of contract period reconciliations.

The state learned the importance of ensuring that appropriate risk mitigation strategies are documented in all managed care contracts in advance of the state of the rating period to ensure proper risk mitigation is in place.