Illinois COVID-19 Public Health Emergency Demonstration
Draft EVALUATION DESIGN

FINAL – CMS Approval Date 5/23/2023

A. General Information

The State of Illinois Department of Healthcare and Family Services (HFS) received approval for the new Illinois Managed Care Risk Mitigation COVID-19 Public Health Emergency (PHE) section 1115 Demonstration on February 4, 2022, as an amendment to Illinois' "Continuity of Care and Administrative Simplification" section 1115(a) Demonstration (Project # 11-W-00341/5). The Demonstration was approved retroactively to March 1, 2020 and remains in effect for sixty (60) days after the termination of the PHE including any renewal of the PHE to permit HFS to retroactively amend the risk mitigation arrangements in two contracts directly impacted by the COVID-19 PHE, as described in the table below.

Program	Rating Period	Risk Mitigation Action	Most Applicable Existing Rate Action
HealthChoice	01/01/2020-12/31/2020	Change to Risk Corridor	Illinois_HealthChoice_20200101-20201231_Certification_20220605
HealthChoice SNC DCFS	08/01/2020-12/31/2021	Added New Risk Corridor	Illinois_HealthChoice SNC DCFS_20200901-20201231_Amendment_20201211

Note: For each contract, there were several rate actions that impacted the rating period being affected by this waiver. Per CMS guidance, we have listed the two rate actions that we determined to be most applicable, as they include descriptions of the risk corridors being affected by this waiver.

In accordance with the terms and conditions of the Demonstration approval letter, HFS is required to track Demonstration expenditures and will be expected to evaluate the connection between those expenditures, the State's response to the PHE, as well as the cost-effectiveness of those expenditures. HFS is required to develop an Evaluation Design and a Final Report to synthesize all monitoring and evaluation activities and results. The Final Report must be completed no later than 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.

Towards these ends, an evaluation design is required by the Centers for Medicare and Medicaid Services (CMS). This document is submitted to meet HFS' evaluation design requirements for the COVID-19 Section 1115 Demonstration. HFS recognizes that changes to the proposed evaluation design may be required following CMS review.

This document defines research questions developed by HFS that pertain to the approved Demonstration and expenditure authorities and describes how HFS will test whether and how the approved Demonstration and expenditure authorities affect the State's response to the PHE. As described herein, the evaluation will also assess whether making appropriate, equitable payments during the PHE will help maintain beneficiary access to care.

B. Demonstration Background, Objectives, and Goals

Demonstration Background

On January 30, 2020, the Health and Human Services (HHS) Secretary declared a public health emergency in response to the COVID-19 outbreak. As a result of the PHE declaration and the declaration of a national emergency by the President of the United States on March 13, 2020, Illinois Governor JB

Pritzker announced a mandatory stay-at-home order beginning March 22, 2020. As a result of the stay-at-home order, there were dramatic shifts in utilization of medical services and widespread financial uncertainty for the State, the contracted MCOs, and the healthcare providers throughout the State of Illinois.

The Center for Medicaid and Medicare Services (CMS) issued an informational bulletin on May 14, 2020[1] which gave states several options to retroactively amend their MCO contracts to implement risk mitigation strategies for the purpose of responding to the PHE. HFS decided to implement a two-sided symmetrical risk corridor intended to protect MCOs against excessive losses and HFS against excessive MCO profits during CY 2020. The CY 2020 risk corridor provision for the HealthChoice Illinois (HCI) contract is documented in the Calendar Year 2020 HealthChoice Illinois Medicaid Managed Care Capitation Rate Certification dated June 5, 2020.

However, during this time, one of the MCOs, NextLevel, became insolvent and exited the contract effective June 30, 2020, creating market disruption at the height of the COVID-19 pandemic. Due to the unique circumstances regarding NextLevel's financial stability and the timing of its exit from the contract, HFS requested an exemption to retroactively amend NextLevel's contract to remove the risk corridor provision and modify the MLR remittance calculation though the Managed Care Risk Mitigation COVID-19 PHE Demonstration in order to mitigate further disruption and ease the administrative burden associated with the contract termination.

In addition, HFS also requested CMS authority to retroactively revise the risk corridor period from February 2020 through December 2020 to September 2020 through December 2021 for the new YouthCare contract. The Department of Children and Family Services (DCFS) Youth in Care population was previously covered by HFS on a fee-for-service basis but moved to managed care effective September 1, 2020 (implementation was delayed from February 2020). During the contract amendment negotiations, HFS and the YouthCare MCO, Meridian, agreed to a revision of the risk corridor for this population given the remaining uncertainties with the pandemic and the lack of managed care experience for this population. However, other remaining contractual items were still be negotiated, such that the contract was not formally executed by both parties prior to the effective date of the updated federal regulations. As a result, HFS requested an exemption from 42 CFR 438.6(b)(1) to retroactively add a risk corridor for the period from September 2020 through December 2021 using the Managed Care Risk Mitigation COVID-19 PHE Demonstration.

This evaluation will discuss key considerations for HFS and other stakeholders as it relates to these two risk mitigation provisions authorized via the Managed Care Risk Mitigation COVID-19 PHE Demonstration.

Demonstration Objectives

The Demonstration will assist Illinois in promoting the objectives of the Medicaid statute and is expected to help the State furnish medical assistance in a manner intended to protect, to the greatest extent possible, the health, safety, and welfare of individuals and providers who may be affected by COVID-19.

The primary objectives under this 1115 Demonstration are:

- To support HFS in making appropriate, equitable payments during the PHE to help maintain beneficiary access to care.
- To support HFS in mitigating the effects of market disruption and change occurring during the pandemic to help maintain beneficiary access to care.

Through the modifications of risk sharing mechanisms for both NextLevel and the YouthCare population,

[1] https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/cib051420.pdf

HFS seeks to make more appropriate, equitable payments that support the maintenance of provider capacity, State administrative capacity, and beneficiary access to care during the PHE.

C. Evaluation Design Questions and Hypothesis

This section and subsequent sections of this document are informed by the Special Methodological Considerations CMS provided in supplemental guidance for monitoring and evaluating COVID-19 PHE Medicaid Section 1115 Demonstrations:

- CMS is not requiring states to submit budget neutrality calculations for COVID-19 section 1115(a) demonstrations.
- Given the nature of the demonstration and the challenges faced in delivering services during the PHE, CMS does not expect states to develop an extensive set of monitoring metrics and evaluation hypotheses that would prove burdensome to collect and analyze.
- The focus of the state's final evaluation report should be to respond to qualitative research questions aimed at understanding the challenges presented by the COVID-19 PHE to the Medicaid program, how the flexibilities of this demonstration assisted in meeting these challenges, and any lessons that may be taken for responding to a similar PHE in the future.
- States are required to track administrative costs and demonstration expenditures, including administrative and program costs, for demonstration beneficiaries, and assess how these outlays affected the state's response to the PHE.
- States may find it feasible to compare utilization patterns among demonstration beneficiaries to other Medicaid beneficiaries for periods prior to the onset of the pandemic.

This Demonstration will test whether and how the exemption from 42 CFR 438.6(b)(1) and expenditure authorities affected the State of Illinois' response to the PHE, and how they affected coverage and expenditures.

The following questions and associated hypothesis will assist in evaluating the main objectives and goals of this Demonstration.

Question 1: What retroactive risk sharing agreements did the state ultimately negotiate with the managed care plans under the Demonstration authority?

Hypothesis: The State anticipates that the retroactive risk sharing agreements ultimately negotiated with both NextLevel and YouthCare will demonstrate that they were mutually beneficial and furthered the objectives of Medicaid.

- *NextLevel:* The retroactive removal of the risk corridor provision and modification of the MLR remittance calculation from a plan exiting the market during the PHE was mutually beneficial and furthered the objectives of Medicaid.

- *YouthCare:* The retroactive addition of a risk corridor to support the addition of a new population to managed care during the PHE was mutually beneficial and furthered the objectives of Medicaid.

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: Due to the unforeseen nature and significance of the PHE, the Demonstration provided the necessary regulatory flexibility to allow HFS to adapt to the changing environment after the start of the rating period.

- *NextLevel:* The removal of the risk corridor provision and modification of the MLR

remittance calculation for NextLevel after the start of the rating period facilitated their smooth exit from the managed care program during the PHE, mitigating impacts to beneficiaries.

- *YouthCare:* The addition of the risk corridor for YouthCare led to more accurate payments during a time of uncertainty as HFS added a new population to managed care during a PHE.

<u>Question 3</u>**: What were the principal challenges associated with implementing the retroactive risk mitigation strategies from the perspective of the state Medicaid agency and Medicaid managed care plans? 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?**

<u>Hypothesis:</u> Any administrative challenges associated with implementing the retroactive risk mitigation strategies were able to be addressed, and the beneficial outcomes of the retroactive risk mitigation actions justified any identified implementation challenges.

- *NextLevel:* The removal of the risk sharing mechanism with Next Level after the start of the rating period eliminated administrative challenges associated with effectuating the risk mitigation mechanisms that were put in place prior to the PHE.

- *YouthCare:* The implementation challenges associated with adding a retroactive risk sharing mechanism were *de minimus*, as the Demonstration allowed HFS to implement a risk corridor that had been previously negotiated, but not yet executed, to achieve more equitable and accurate payments during the PHE.

<u>Question 4:</u> **To what extent did the retroactive risk sharing implemented under this Demonstration result in more appropriate and equitable payments to the managed care plans?**

<u>Hypothesis:</u> The State anticipates that the retroactive modifications to the risk sharing mechanisms resulted in more appropriate and equitable payments to the MCOs.

- *NextLevel:* Because only a partial year of data would have been available to calculate the risk corridor receivable or payable, the State anticipates that removing the risk corridor resulted in more appropriate payments. Similarly, the inclusion of payments for dates of service prior to 2019 that resulted from NextLevel's exit from the program more accurately measured the MLR for purposes of calculating a remittance.

- *YouthCare*: With increased uncertainty in utilization brought on by the COVID-19 pandemic, as well as the delayed implementation associated with the addition of a new population in managed care, the State anticipates that the retroactive modification of the risk corridor for the DCFS Youth in Care population in the YouthCare contract created more accurate payments to managed care plans and protected the MCO against excessive losses and HFS against excessive MCO profits.

<u>Question 5:</u> **What problems does the state anticipate would 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?**

<u>Hypothesis:</u> The State anticipates that 438.6(b)(1) may have harmed the managed care organizations or the State had there not been an exemption.

- *NextLevel*: The PHE exacerbated staffing shortages and the availability of administrative capacity. Without the elimination of the risk corridor and modification to the MLR, there would have been an inequitable and unreasonable remittance payment owed to the

State. Given the insolvency of the MCO, the administrative work needed to calculate and pursue possible remittance payments would have undermined the objectives of Medicaid during the PHE. The State anticipates that the exemption from 42 CFR §438.6(b)(1) during the PHE mitigated the potential impacts of market disruption caused by an MCO exit during a time of significant uncertainty.

- *YouthCare*: Without retroactive risk sharing implementation, there would have been a greater risk of inaccurate payments to the YouthCare MCO due to the uncertainty of utilization brought on by the PHE and introduction of a new population into managed care. In this case, the harms contemplated by the 2020 managed care final rule related to retroactive risk sharing mechanisms are outweighed by the harms of not allowing the YouthCare risk corridor, as there was agreement in fact between HFS and Meridian on the necessary revisions to the risk corridor prior to the date the contract amendment was fully executed.

D. Methodology

Per CMS guidance, the goals of this section of the evaluation design are to describe:

1. How the evaluation will be designed;
2. Characteristics of the target and comparison populations;
3. Time periods for which data will be included;
4. Measures to be calculated to evaluate the demonstration;
5. Data sources, quality, and limitations;
6. Analytic methods used to assess the effectiveness of the demonstration; and
7. Reporting and public forum commitments.

Evaluation Design Overview

As detailed in *Figure 1: Analytic Table* below, the primary evaluation activity will include qualitative and quantitative analysis, comparing the actual managed care outcomes and payments made to the affected MCOs as a result of the Demonstration to the managed care outcomes and payments that would have otherwise been paid to the MCOs had the requirements of 42 CFR §438.6(b)(1) been applied. The Demonstration will evaluate the net effect of HFS implementing risk mitigation after the start of the rating period compared to not allowing retroactive risk mitigation during a PHE, which may have led to substantially inaccurate or inequitable payments given the severe interruption in utilization and other market disruption occurring in the State during the pandemic. The payments will still be developed in accordance with all other applicable requirements in 42 CFR §438, including §438.4 and §438.5, and generally accepted actuarial principles and practices, and the evaluation will seek to capture the net effect of the application of retroactive risk mitigation.

Characteristics of Population & Time Period for Data Evaluation

The target populations that will be evaluated in this Demonstration include:

- NextLevel
    - *Description*: NextLevel was an MCO operating under the HealthChoice Illinois contract until June 2020. NextLevel was a minority-owned MCO and operated only in Cook County. NextLevel's members were disproportionately located in underserved areas, relative to other MCOs in Cook County.
    - *Population Estimate*: There were 350,778 total NextLevel member months covered under the 6-month period (January through June 2020), for a monthly average of 58,463 members.
    - *Time Period for Data*: NextLevel HealthChoice Illinois will look at a 6-month period from January through June 2020.

- YouthCare (Meridian)
    - *Description*: YouthCare is a health plan covering children in the care of the DCFS. This Demonstration is specifically related to the Youth in Care population, which is limited to children who have not yet been adopted. Youth in Care beneficiaries are initially enrolled with

YouthCare (Meridian) but may be enrolled in another HealthChoice Illinois MCO thereafter. More than 99% of Youth in Care members are enrolled with YouthCare.

- *Population Estimate*: There were 324,436 Youth in Care member months covered under the YouthCare contract over the 16-month Demonstration period, for a monthly average of 20,277 members.
- *Time Period for Data*: YouthCare will be evaluated on quality expenses and claims incurred over a 16-month period from September 2020 through December 2021.

Evaluation Design (Measures, Data Sources, and Approach)

The State will approach this Evaluation design through a mix of qualitative and quantitative analytic approaches, as described in the *Figure 1* below.

Figure 1: Analytic Table

Research Question	Outcome Measure	Data Source	Analytic Approach
RQ1: What retroactive risk sharing agreements did the State ultimately negotiate with the managed care plans under the Demonstration authority?	• Types of risk sharing agreements negotiated with the MCOs • Terms of negotiated risk sharing agreements	• Document review	• Qualitative analysis
RQ2: 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 of removing, adding, or otherwise modifying the risk sharing mechanism that would not have been realized but for the Demonstration	• Staff interviews	• Qualitative analysis
RQ3.1: What were the principal challenges associated with implementing the retroactive risk mitigation strategies from the perspective of the state Medicaid agency and Medicaid managed care plans?	• Description of challenges (if any) related to implementation of the risk sharing agreements with the MCOs	• Staff interviews	• Qualitative analysis
RQ3.2: 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 to address challenges, as detailed in RQ 3.1 • Description of how these actions were successful	• Staff interviews	• Qualitative analysis
RQ4: To what extent did the retroactive risk sharing implemented under this Demonstration result in more appropriate and equitable payments to the managed care plans?	• Analysis of financial impacts, including quality expenses and claims incurred to determine the risk corridor and Medical Loss Ratio as defined in 42 CFR §438.8. • Description of equitable impacts of the Demonstration	• Financial data • Staff interviews	• Quantitative analysis • Qualitative analysis
RQ5: What problems does the State anticipate would 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?	• Description of how the Demonstration authority addressed or prevented problems related to the application of Section 438.6(b)(1)	• Staff interviews	• Qualitative analysis

The specific data sources proposed in *Figure 1* to be utilized for this evaluation are detailed below, including a description of data quality and any applicable data limitations:

- Document Review: HFS 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: HFS will conduct interviews with key staff involved in the implementation of the retroactive risk mitigation mechanisms, including internal HFS 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 impacts of the Demonstration not otherwise available through the data alone. However, like all subjective interviews, common limitations associated with this data source are biases and statistical representative samples. HFS hopes to mitigate these data source limitations by interviewing both State and MCO staff, as well as supplementing with quantitative data where applicable.

- Financial Data: HFS will use financial data submitted by NextLevel and YouthCare (Meridian) through the Encounter Utilization Monitoring (EUM) reports and ad-hoc supplemental data submissions. HFS reviews the EUM submissions on a quarterly basis to ensure accuracy of the reporting, including comparisons to encounter data, previous submissions, and other data sources. Any issues identified in these reviews are communicated to the MCOs, who are instructed to correct the issues in subsequent submissions. Ad hoc data submissions are occasionally needed for items that cannot be easily reported in the EUM templates, such as detail on provider settlements.

Methodological Limitations
The primary objective of the Demonstration is to support HFS in making appropriate, equitable payments during the PHE to help maintain beneficiary access to care throughout the pandemic. HFS will be reporting population and expenditure trends in its evaluation of the effects of the application 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. HFS will not attempt to tease out each individual impact of the retroactive risk mitigation waiver authority. Rather, the methodology will investigate the overall impact of permitting retroactive risk mitigation in general, and whether the net effect of such arrangements resulted in more appropriate payments to the MCOs and mitigated disruption in beneficiary access to care during the PHE. Due to the simplified nature of this design, HFS does not anticipate significant methodological limitations.

Additional Information
Independent Evaluator Selection Process – No Attachment. Per CMS' instructions, this evaluation is state-led, and no independent evaluator is required.

Evaluation Budget – No Attachment. At the time this evaluation design was submitted to CMS, no demonstration funds are being allocated to evaluation activities.

Timeline and Major Milestones

Date	Description
March 1, 2020	Official start date of COVID-19 Demonstration
August 2, 2022	Initial draft of COVID-19 PHE Evaluation Design Submitted
February 9, 2023	Updated draft of COVID-19 PHE Evaluation Design Submitted
60 Days After End of PHE	Official end date of COVID-19 PHE Demonstration
180 Days After End of PHE	Final Report for this Demonstration

E. Reporting and Public Forum Commitments

The duration of the Demonstration is contingent on the duration of the COVID-19 PHE, which at this point in time is understood to be May 11, 2023. The State will, for each year of the Demonstration, submit the annual report required under 42 CFR §431.424(c). Evaluation and monitoring information included in the report will reflect the evaluation design and methodology described in the State's approved evaluation design. The annual report content and format will follow CMS guidelines.

The final report will consolidate Monitoring and Evaluation reporting requirements for the Demonstration. The State will submit the final report no later than 18 months after the end of the COVID-19 section 1115 demonstration authority. The final report will capture data on demonstration implementation, evaluation measures and interpretation, and lessons learned from the Demonstration, per the approved evaluation design. The State will track separately all expenditures associated with the Demonstration, including but not limited to, administrative costs and program expenditures. The annual report content and format will follow CMS guidelines. The State's final evaluation report is expected to include, where appropriate, items required under 42 CFR §431.428. The annual report information for each demonstration year will be included in the final report when submitted to CMS one year after the end of the demonstration authority.