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

State Demonstrations Group

June 26, 2025

Kelly Cunningham
Medicaid Administrator
Illinois Department of Healthcare and Family Services
201 South Grand Ave. East
Springfield, IL 62763-0001

Dear Administrator Cunningham:

The Centers for Medicare & Medicaid Services (CMS) has completed its review of Illinois Final Report for the Managed Care Risk Mitigation COVID-19 Public Health Emergency (PHE) amendment to the section 1115 demonstration entitled, "Illinois Continuity of Care and Administrative Simplification" (Project No: 11-W-00341/5). This report covers the demonstration period from March 1, 2020 through the end of the PHE. CMS determined that the Final Report, submitted on December 19, 2024, is in alignment with the CMS-approved Evaluation Design, and therefore, approves the state's Final Report.

The approved Final Report may now be posted to the state's Medicaid website within 30 days. CMS will also post the Final Report on Medicaid.gov.

We sincerely appreciate the state's commitment to evaluating the COVID-19 PHE demonstration under these extraordinary circumstances. We look forward to our continued partnership on Illinois section 1115 demonstration. If you have any questions, please contact your CMS demonstration team.

Sincerely,

DANIELLE DALY -S
Digitally signed by DANIELLE DALY -S
Date: 2025.06.26 11:18:15 -04'00'

Danielle Daly
Director
Division of Demonstration Monitoring and Evaluation

cc: Courtenay Savage, State Monitoring Lead, CMS Medicaid and CHIP Operations Group

Final Evaluation Report on Illinois Managed Care Risk Mitigation COVID-19 Public Health Emergency (PHE) Section 1115 Demonstration

December 18, 2024

Contents

Section I: Executive Summary

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 Demonstration (Project # 11-W-00341/5). The demonstration period was March 1, 2020 through June 30, 2023. The demonstration was approved effective March 1, 2020, permitting HFS to retroactively amend the risk mitigation arrangements in two contracts directly impacted by the COVID-19 PHE. In accordance with the terms and conditions of the demonstration approval letter, HFS was required to develop an evaluation design for the Centers for Medicare and Medicaid Services (CMS) approval and submit a final evaluation report by December 2024, 18 months after the end of the demonstration period. See *Attachment 1* for the final approved evaluation design. This final evaluation report examines how the approved demonstration and expenditure authorities affected the state's response to the PHE.

Demonstration Objectives

The primary objectives under this demonstration were:

- 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.

Populations Impacted

There were two distinct populations impacted by the demonstration:

- *Individuals covered by managed care organization (MCO) NextLevel Health (NextLevel) in the Chicago area*. This included 350,778 total NextLevel member months covered under the 6-month period (January 2020 through June 2020), for a monthly average of 58,463 members.
- *Youth in the foster care system covered by MCO Meridian Health Plan*. This included 324,436 Youth in Care member months covered under the Meridian Health Plan contract over the 16-month demonstration period (September 2020 through December 2021), for a monthly average of 20,277 members.

Evaluation Questions and Methodology

The evaluation questions and methodology of this report are aligned with the evaluation design approved by CMS on May 23, 2023.[1]

As suggested by previous CMS guidance, the focus of the state's final evaluation is to respond to qualitative research questions aimed at understanding the challenges presented by the

[1] https://www.medicaid.gov/sites/default/files/2023-05/il-continuity-care-admin-risk-mitigation-amendmnt-eval-design-05232023.pdf

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. The specific evaluation questions within this report were designed to understand the risk sharing mitigation activities that were ultimately carried out by the demonstration, the challenges in implementing changes to risk mitigation, and the impact of those changes. Additionally, evaluation questions explore the potential consequences of not making retroactive risk mitigation changes.

The methodology for addressing the evaluation questions includes both 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 demonstration not occurred.

Results

Overall, the results summarized in this report demonstrate that the desired impact was achieved through demonstration activities. Allowing for retroactive changes to the risk corridor and medical loss ratios supported HFS in making appropriate, equitable payments during the PHE to help maintain beneficiary access to care. The changes also worked to mitigate the effects of market disruption during the pandemic to help maintain beneficiary access to care.

Interpretations and Recommendations

During the PHE, it was essential for the state to have the flexibility to take action in a manner that was best for the overall health care delivery system at that time. While this flexibility was particularly important during the pandemic, the additional flexibility afforded states could be beneficial during any time of provider uncertainty. For example, exceptions to 42 CFR 438.6(b)(1) for catastrophic market disruptions, like an MCO going out of business, would allow states to evaluate the implications of the broader delivery system and take retroactive risk mitigation actions to support the overall delivery system.

Through this waiver, the state learned that the process of retroactively amending and implementing risk mitigation agreements is relatively simple. Specifically, the operational processes for implementing risk mitigation strategies are often completed after the performance period has ended through a reconciliation process; therefore, the retroactive nature of the change does not impact the process of calculations, making it administratively simple to effectuate.

Section II: Demonstration Background Information

On January 30, 2020, the United States Department of Health and Human Services (HHS) Secretary declared a PHE in response to the COVID-19 pandemic. Subsequent to 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 HFS, the contracted MCOs, and healthcare providers throughout the State of Illinois.

CMS issued an informational bulletin on May 14, 2020[2] 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.

During this time, one HCI MCO, 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 Medical Loss Ratio (MLR) remittance calculation through 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 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 MCO contract with Meridian Health Plan. 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 Meridian Health Plan 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 being determined, such that the contract was not formally executed by both parties prior to the effective date of managed care regulations finalized by CMS in 2020 through the Medicaid and Children's Health Insurance Program Managed Care Final Rule.[3] 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 related to these two risk mitigation provisions authorized via the Managed Care Risk Mitigation COVID-19 PHE Demonstration.

Demonstration Objectives

The demonstration was intended to assist Illinois in promoting the objectives of the Medicaid program and was 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 have been affected by the PHE.

The primary objectives under this demonstration were:

- 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.

[2] https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/cib051420.pdf
[3] 85 *Fed. Reg.* 72754-72844 (Nov. 13, 2020), https://www.govinfo.gov/content/pkg/FR-2020-11-13/pdf/2020-24758.pdf.

Through the retroactive modifications of risk sharing mechanisms for both NextLevel and Meridian Health Plan, HFS sought to make more appropriate, equitable payments that supported the maintenance of provider capacity, state administrative capacity, and beneficiary access to care during the PHE.

Section III: Evaluation Questions and Hypotheses

This demonstration tested whether and how the exemption from 42 CFR 438.6(b)(1) and expenditure authorities affected the State of Illinois' response to the PHE, including any impacts to coverage and expenditures. This section details the evaluation design questions and hypotheses approved by CMS in the Evaluation Design. For each evaluation question, HFS included a separate hypothesis specific to each of the retroactive risk mitigation strategies utilized by HFS during the PHE to assist in evaluating how each of the strategy's supported the objectives and goals of this demonstration.

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

Hypothesis: The state anticipates that the retroactive risk sharing agreements ultimately negotiated with both NextLevel and Meridian Health Plan 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.
- *Meridian Health Plan (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.
- *Meridian Health Plan (YouthCare):* The addition of the risk corridor for Meridian Health Plan led to more accurate payments during a time of uncertainty as HFS added a new population to managed care during a PHE.

Question 3: 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 organizations? 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?

Hypothesis: 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 corridor provision for 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.
- *Meridian Health Plan (YouthCare):* The implementation challenges associated with adding a retroactive risk sharing mechanism were *de minimis*, as the demonstration allowed HFS to implement a risk corridor that had been previously determined, but not yet contractually executed, to achieve more equitable and accurate payments during the PHE.

Question 4: To what extent did the retroactive risk sharing implemented under this demonstration result in more appropriate and equitable payments to the managed care organizations?

Hypothesis: 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 2020 that resulted from NextLevel's exit from the program more equitably measured the MLR for purposes of calculating a remittance.
- *Meridian Health Plan (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 Meridian Health Plan contract created more accurate payments to the MCO and protected the MCO against excessive losses and HFS against excessive MCO profits.

Question 5: 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?

Hypothesis: 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.

Meridian Health Plan (YouthCare): Without retroactive risk sharing implementation, there would have been a greater risk of inaccurate payments to Meridian Health Plan 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 changes to managed care regulations in the Managed Care Final Rule related to retroactive risk sharing mechanisms are outweighed by the harms of not allowing the risk corridor, as there was agreement in fact between HFS and Meridian Health Plan on the necessary revisions to the risk corridor prior to the date the contract amendment was fully executed.

Section IV: Methodology

Evaluation Design Overview

The primary evaluation activities included both 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. *Figure 1: Analytic Table* below details the questions, data sources and analytic approach used in the evaluation. The demonstration evaluated the net effect of HFS implementing risk mitigation strategies after the start of the rating period compared to the effect had CMS not permitted retroactive risk mitigation to occur during the 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 were 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. Therefore, the evaluation sought to capture the net effect of the application of retroactive risk mitigation.

Population Characteristics and Evaluation Period

The target populations evaluated in this demonstration include:

- NextLevel
    - *Description*: HealthChoice Illinois is a Medicaid managed care program that serves a variety of populations in the state of Illinois. The program covers non-disabled children and adults, disabled adults, Affordable Care Act expansion adults, special needs children, and those who need long-term services and supports. 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. Cook County is highly populated and includes the City of Chicago and surrounding suburbs. NextLevel's members were disproportionately located in underserved areas, relative to other MCOs operating 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*: HFS examined the NextLevel data for a 6-month period from January through June 2020.

- Meridian Health Plan
    - *Description*: YouthCare is a health care program covering children in the care of or formerly in the care of the DCFS. This demonstration is specifically related to the Youth in Care population. Youth in Care beneficiaries are initially enrolled with Meridian Health Plan but may be enrolled in another HealthChoice Illinois MCO thereafter. More than 99% of Youth in Care members are enrolled in the YouthCare program.
    - *Population Estimate*: There were 324,436 Youth in Care member months covered under the Meridian Health Plan contract over the 16-month demonstration period, for a monthly average of 20,277 members.
    - *Time Period for Data*: Meridian Health Plan was evaluated on quality expenses and claims incurred over a 16-month period from September 2020 through December 2021.

Evaluation Measures

HFS approached this evaluation design through a mix of qualitative and quantitative analytic approaches, as described in *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 organizations 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 organizations?	• 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 organizations?	• 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.	• Financial data • Staff interviews	• Quantitative analysis • Qualitative analysis

	• Description of equitable impacts of the demonstration		
RQ5: What problems does the state anticipate would have been caused by the application of 42 CFR §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 42 CFR § 438.6(b)(1)	• Staff interviews	• Qualitative analysis

Data Sources and Analytic Measures

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. A review was conducted of all relevant documents that were 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. Interviews were conducted with key staff involved in the implementation of the retroactive risk mitigation mechanisms to assess the qualitative aspects of this demonstration. Staff interviews provided 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 statistically representative samples.
- Financial Data. Financial data was submitted by NextLevel and Meridian Health Plan through Encounter Utilization Monitoring (EUM) reports and ad hoc supplemental data submissions. The EUM submissions are reviewed 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. This financial data was also reviewed as a part of this evaluation.

Other Information

- Independent Evaluator Selection Process. Per CMS instructions, this evaluation is state-led, and no independent evaluator is required.
- Evaluation Budget. At the time this evaluation design was submitted to CMS, no demonstration funds were allocated to evaluation activities.
- Timeline and Major Milestones. The table below highlights the major milestones and deliverables associated with this Demonstration and the related evaluation activities.

Date	Description
March 1, 2020	Official start date of COVID-19 Demonstration
August 3, 2022	Initial draft of COVID-19 PHE Evaluation Design Due
February 10, 2023	Updated draft of COVID-19 PHE Evaluation Design Due
June 30, 2023	Official end of the COVID-19 Demonstration Period

December 30, 2024	Last date to submit evaluation (18 Months after expiration of PHE)

Section V: Methodological Limitations

The primary objective of the demonstration was to support HFS in making appropriate, equitable payments during the PHE to help maintain beneficiary access to care. HFS includes reporting on population and expenditure trends in this evaluation of the effects of the application of the Managed Care Risk Mitigation COVID-19 PHE Demonstration and also includes analyses that are qualitative and descriptive, including key informant interviews and document review, consistent with CMS guidance. The methodology investigates the overall impact of permitting retroactive risk mitigation generally, 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 believe there are significant methodological limitations impacting the conclusions derived through this evaluation.

Section VI: Results

The results of the demonstration are summarized below. Overall, the desired impact was achieved and most of the original hypotheses were accurate and supported by the demonstration activities. Any variance from hypothesis to practice are noted below.

Question 1: What retroactive risk sharing agreements did the state ultimately negotiate with the managed care organizations?

HFS anticipated that the retroactive risk sharing agreements negotiated with both NextLevel and Meridian Health Plan would demonstrate that they were mutually beneficial and furthered the objectives of Medicaid. The actual risk sharing agreements negotiated with both MCOs are described below. The ability to retroactively alter the risk sharing agreements did prove to be mutually beneficial to the state and to the MCOs.

NextLevel

The HealthChoice contract, under which NextLevel was operating, was revised for the calendar year 2020. The existing risk corridor language was removed, and MLR contract language was added to the contract for calendar year 2020. Contract language can be found in *Attachment 2*.

YouthCare

The Meridian Health Plan YouthCare contract was drafted with the following risk corridor provisions related to a risk corridor. The risk corridor percentages were not revised. However, the risk corridor period was retroactively revised from February 2020 through December 2020 to September 2020 through December 2021. This reflects the delay in implementation of enrollment for the Youth in Care population.

- *7.23.2.1* In the event Contractor's risk corridor ratio is greater than 102.0%, the Department shall reimburse Contractor the target amount multiplied by:
  - *7.23.2.1.1* 50.0% multiplied by [risk corridor ratio less 102.0%], if the risk corridor ratio is less than or equal to 104.0%; or
  - *7.23.2.1.2* 1.0% plus 80.0% multiplied by [risk corridor ratio less 104.0%], if the risk corridor ratio exceeds 104.0%.
- *7.23.2.2* In the event Contractor's risk corridor ratio is less than 98.0%, The Department will recoup from Contractor the target amount multiplied by:

- *7.23.2.2.1* 50.0% multiplied by [98.0% less risk corridor ratio], if the risk corridor ratio is greater than or equal to 96.0%; or
- *7.23.2.2.2* 1.0% plus 80.0% multiplied by [96.0% less risk corridor ratio], if the risk corridor is less than 96.0%.

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?

HFS hypothesized that the demonstration would provide regulatory flexibility to allow HFS to adapt to the changing environment after the start of the rating period. The experience supports that the demonstration provided the regulatory flexibility to allow HFS to adapt to the change in the environment that occurred after the start of the rating period as a result of the PHE.

NextLevel

The removal of the risk corridor and modification of the MLR remittance calculation had the intended effects of facilitating a smoother exit from the managed care program during the PHE and mitigating impacts to beneficiaries. Due to going out of business in June 2020, NextLevel 2020 claims experience included months most impacted by suppressed utilization related to the PHE. Additionally, NextLevel did not have claims experience that would include the recovery of that utilization in the second half of 2020, unlike the other MCO claims experience. The MLR calculation performed in November 2021, with all historical claims paid, found no remittance required from Next Level. The state was able to confirm this.

YouthCare

The addition of a risk corridor for Meridian Health Plan led to more accurate payments during a time of uncertainty as HFS implemented enrollment of a new population to managed care during the PHE. HFS and Meridian Health Plan 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 being negotiated such that the contract amendment was not executed by both parties prior to the effective date of 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.

Question 3: 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 organizations? 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?

HFS hypothesized that any administrative challenges associated with implementing the retroactive risk mitigation strategies would be addressed, and the beneficial outcomes of the retroactive risk mitigation actions would justify any identified implementation challenges. This hypothesis was supported by the experiences of the demonstration.

The operational processes for risk corridor reconciliation are normally done after the performance period is complete, so the retroactive nature of the contract change did not impact the process of calculations. The changes were applied to reconciliations that had not yet started. This allowed for a smooth process with few administrative challenges.

NextLevel

The most significant challenge in implementing the demonstration was working with an entity that was going out of business. NextLevel had significantly reduced staffing and limited administrative capacity to provide data and respond to requests throughout the process. This led to delays that would likely not have occurred if working with a fully staffed entity. For instance, some providers had questions about payments from NextLevel that were not able to be resolved. In order to overcome this challenge, the state worked to gather attestations from providers that confirmed the payments made were valid. Additionally, the state had staffing challenges and additional responsibilities during the PHE which would have been exacerbated in the absence of the demonstration. This flexibility eliminated administrative challenges associated with effectuating the risk mitigation mechanisms that were put in place as a result of the PHE.

YouthCare

In working with Meridian Health Plan, there were no significant challenges in implementing the retroactive risk corridor. The proposed formula for the risk corridor was determined prior to contract amendment execution. The demonstration allowed HFS to formally incorporate that agreement into the contract, which supported a relatively easy implementation with no notable challenges.

Question 4: To what extent did the retroactive risk sharing implemented under this demonstration result in more appropriate and equitable payments to the managed care organizations?

HFS hypothesized that retroactive modifications to the risk sharing mechanisms would result in more appropriate and equitable payments to the MCOs. This hypothesis was supported by the demonstration experience.

NextLevel

In working with NextLevel, only a partial year of data would have been available to calculate the risk corridor receivable or payable. By removing the risk corridor, more appropriate payments were made in 2020. Similarly, the inclusion of payments for dates of service prior to 2020 that resulted from NextLevel's exit from the program more equitably measured the MLR for purposes of calculating a remittance. The fiscal impact of removing the risk corridor and allowing NextLevel to include additional claims in the MLR Remittance calculation for CY 2020 was a reduction of a state receivable from NextLevel of approximately $14.6 million.

YouthCare

With the 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 anticipated that the retroactive modification of the risk corridor for the DCFS YouthCare population in the Meridian Health Plan contract would create more accurate payments to the MCO and protect the MCO against excessive losses and HFS against excessive MCO profits. This was supported by the demonstration experience. Although the result of the risk corridor was that Meridian Health Plan did not have a risk corridor settlement, it benefited both the state and the health plan to have the mechanism in place to financially protect both parties.

Question 5: 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?

The state hypothesized that without the exemption to 42 CFR §438.6(b)(1) there would have been harm to the MCOs.

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 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.

Providers were already strained by the situation with NextLevel going out of business. If the claims with dates of service prior to 2020 were not added to the MLR calculation, NextLevel would have been required to pay an MLR remittance. The demonstration allowed NextLevel's limited financial resources to be directed to provider payments during the PHE.

YouthCare

Without retroactive risk sharing implementation, there would have been a greater risk of inaccurate payments to Meridian Health Plan 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 were outweighed by the harms of not allowing the risk corridor, as there was agreement in fact between HFS and Meridian Health Plan on the necessary revisions to the risk corridor prior to the date the contract amendment was fully executed.

Section VII: Conclusions

The demonstration was effective in achieving the stated objectives. The demonstration assisted Illinois in promoting the objectives of the Medicaid managed care program and helped 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 affected by COVID-19.

The primary objectives under this demonstration were:

- 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 Meridian Health Plan, HFS was able to make more appropriate, equitable payments that supported the maintenance of provider capacity, state administrative capacity, and beneficiary access to care during the PHE.

Section VIII: Interpretations, Policy Implications, and Interactions with Other State Initiatives

It is critical for states to have flexibility to take action to support the overall health care delivery system. This flexibility could be beneficial during any time of provider or market uncertainty, not just during a PHE. Exceptions to 42 CFR 438.6(b)(1) for catastrophic disruptions like an MCO going out of business would allow states to look at the implications to the broader delivery system and take actions that support the delivery system. The purpose of the rule was to make sure that states were not amending risk mitigation based on actual results. This waiver demonstrates how retroactive changes may be necessary to protect the best interests of the state Medicaid program and the delivery system as a whole.

HFS wanted to reduce the disruption caused by NextLevel's exit from the program. Providers were already strained by the situation with NextLevel going out of business. As noted by state staff, "It was a painful process that would have been even more painful without this waiver. It would have taken a lot longer and required more staff time to resolve without the retroactive flexibility at a time when staff were spread thin due to the PHE."

If the claims with dates of service prior to 2020 were not added to the MLR calculation, NextLevel would have been required to pay an MLR remittance. The demonstration allowed NextLevel's limited resources to be directed to provider payments during the PHE.

In the case of Meridian Health Plan, the terms of the risk corridor were not technically retroactively changed. It was simply an issue of timing of contract amendment execution and a delay in program implementation. A time of transition like moving a new population into managed care is another example of a time when flexibility may be needed by the states.

Section IX: Lessons Learned and Recommendations

Through this waiver, the state learned that the process of retroactively altering risk corridor agreements and implementing new agreements is relatively simple. The operational processes for risk corridor reconciliation are normally done after the performance period is complete, so the retroactive nature of the change does not impact the process of calculations. When the changes are applied to reconciliations that have not yet started, it allows for a smooth process with few challenges.

Another lesson demonstrated by the activities that lead up to this waiver is that states cannot anticipate every situation that may occur. It is important for states to have the flexibility to address issues as they arise. If there can be guardrails established that allow for retroactive changes for catastrophic disruptions like an MCO going out of business or delivery system failure, it would allow states to look at the implications to the broader delivery system and take actions that support the delivery system.

Section X: Attachments

Attachment 1. CMS-Approved Evaluation Design

Attachment 2. HFS and NextLevel Memorandum of Understanding

NextLevel

Through a Memorandum of Understanding, HFS and NextLevel acknowledged and agreed to changes to Contract's Section 7.10 and its subsections which revised the calendar year 2020 Medical Loss Ratio (MLR) calculation:

7.10 MEDICAL LOSS RATIO GUARANTEE

7.10.1 Contractor shall calculate, and report to the Department, a medical loss ratio (MLR) for each calendar year (MLR reporting year), consistent with MLR standards in 42 CFR 438.8(a). The MLR calculation shall be determined as set forth below; however, the Department may adopt NAIC reporting standards and protocols after giving written notice to Contractor.

7.10.2 The minimum MLR is 85 percent (85%). The Department retains the right to adjust the minimum MLR in adherence to 42 CFS §438.8.

7.10.3 MLR Calculations.

7.10.3.1 Contractor shall calculate the MLR for each Coverage Year as the ratio of the numerator (as defined in accordance with 42 CFR 438.8(e)) to the denominator (as defined in accordance with 42 CFR 438.8(f)) with nine (9) months of claims run out; and

7.10.3.2 For the purpose of an MLR remittance as described in section 7.10.8, Contractor shall calculate the MLR for each Coverage Year as the ratio of the numerator (as defined in accordance with 42 CFR 438.8(e)) to the denominator (as defined in accordance with 42 CFR 438.8(f)) with eighteen (18) months of claims run out.

7.10.3.3 For calendar year 2020, Contractor shall calculate the numerator in 7.10.3.2 inclusive of Department-approved Provider settlement payments for dates of service prior to calendar year 2020. These Provider settlement payments were required by the Illinois Department of Insurance as part of Contractor's close-out of operations effective June 30, 2020.

7.10.4 For each MLR calculation, Contractor shall:

7.10.4.1 include each of Contractor's expenses under only one (1) type of expense, unless a portion of the expense fits under the definition of, or criteria for, one (1) type of expense and the remainder fits into a different type of expense, in which case the expense must be prorated between types of expenses; and

7.10.4.2 report expenditures that benefit multiple contracts or populations, or contracts other than those being reported, on pro rata basis.

7.10.5 For each MLR calculation, Contractor shall:

7.10.5.1 base expense allocation on a generally accepted accounting method that is expected to yield the most accurate results;

7.10.5.2 apportion shared expenses, including expenses under the terms of a management contract, pro rata to the contract incurring the expense; and

7.10.5.3 ensure that those expenses that relate solely to the operation of a reporting entity, such as personnel costs associated with the adjusting and paying of claims, must be borne solely by the reporting entity and are not to be apportioned to the other entities.

7.10.6 Credibility Adjustment. For each MLR calculation:

7.10.6.1 Contractor may add a credibility adjustment, in accordance with 42 CFR 438.S(h), to a calculated MLR if the MLR reporting year experience is partially credible.

7.10.6.2 Contractor shall add the credibility adjustment, if any, to the reported MLR calculation before calculating any remittances, if required.

7.10.6.3 Contractor may not add a credibility adjustment to a calculated MLR if the Coverage Year experience is fully credible.

7.10.6.4 If Contractor's experience is non-credible, it is presumed to meet or exceed the MLR calculation standards.

7.10.7 The Contract specifies that the MCP will aggregate data for all Medicaid eligibility groups covered under the contract with the State unless the State requires separate reporting and a separate MLR calculation for specific populations. [42 CFR 438.S(i)]

7.10.8 Contractor shall refund to the State, for each Coverage Year, an amount equal to the difference between the calculated MLR and the minimum MLR multiplied by the Coverage Year revenue based on the MLR calculation prepared in accordance with section 7.10.3.2.

7.10.9 For each MLR calculation, Contractor shall submit an MLR report, in a format specified by the Department that includes, for each MLR reporting Year:

7.10.9.1 total incurred claims;

7.10.9.2 expenditures on quality-improving activities;

7.10.9.3 expenditures related to activities compliant with program integrity requirements;

7.10.9.4 non-claims costs;

7.10.9.5 premium revenue, which, for purposes of the MLR calculation, will consist of the Capitation payments, as adjusted pursuant to section 7.4, due from the Department for services provided during the Coverage Year, including withheld amounts earned and paid pursuant to section 7.9.1;

7.10.9.6 taxes;

7.10.9.7 licensing fees;

7.10.9.8 regulatory fees;

7.10.9.9 methodology(ies) for allocation of expenditures;

7.10.9.10 any credibility adjustment applied;

7.10.9.11 the calculated MLR;

7.10.9.12 any remittance owed to the State, if applicable;

7.10.9.13 a comparison of the information reported with the audited financial report;

7.10.9.14 a description of the aggregation method used to calculate total incurred claims;

and

7.10.9.15 the number of Enrollee months.

7.10.10 Data Submission. Within twelve (12) months of the end of the MLR reporting year, Contractor shall submit to the Department, in the form and manner prescribed by the Department, the data described in section 7.10.9. Benefit expense claims must be submitted as required under this Contract. For each MLR reporting year, Contractor must submit to the Department all data and information specified (including format) in 42 CFR §438.8(k) and by 43 CFR §438.242. Contractor must attest to the accuracy of all data, including benefit expense claims, and of the MLR calculation.

7.10.10.1 Contractor shall submit the MLR calculation described in section 7.10.3.1 within twelve (12) months of the end of the MLR reporting year.

7.10.10.2 Contractor shall submit the MLR calculation described in section 7.10.3.2 within twenty-one(21) months of the end of the MLR reporting year.

7.10.11 For each MLR calculation, Contractor shall require any Third-Party vendor providing claims adjudication activities to provide all underlying data associated with MLR reporting to Contractor within one hundred eighty (180) days after the end of the MLR reporting year or within thirty (30) days after a request by Contractor, whichever comes sooner, regardless of current contractual limitations, to calculate and validate the accuracy of MLR reporting.

7.10.12 In any instance where the Department makes a retroactive change to the Capitation payments for a Coverage Year(s) and the MLR report(s) for that MLR reporting year(s) has already been submitted to the Department, Contractor shall:

7.10.12.1 recalculate the MLR for all MLR reporting years affected by the change; and

7.10.12.2 submit a new MLR report meeting the applicable requirements of this Contract.