LEGISLATIVE AUDIT COMMISSION

Performance Audit of
Medicaid Managed Care Organizations

January 2018

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RECOMMENDATIONS - 6

Accepted - 3
Implemented - 3

Background

On May 31, 2017, House Resolution No. 100 was adopted and directed the Office of the Auditor General to conduct an audit of Medicaid Managed Care Organizations (MCOs), which included a comparison of State expenditures between MCOs and the Medicaid fee-for-service program for FY16. The Resolution contained nine specific determinations.

Traditionally, Illinois has paid medical providers (physicians, hospitals, dentists, etc.) directly on a fee-for-services basis. Fee-for-service is a payment method where providers are paid an agreed upon rate for each encounter or service provided.

TOTAL MEDICAID COSTS FOR FEE-FOR-SERVICE AND MANAGED CARE
By Fiscal Year as of June 23, 2017

State Fiscal Year	Total Cost Managed Care	Total Cost Fee-for-Service	Total Cost All Medicaid
FY08	$212,829,112	$10,037,469,550	$10,250,298,662
FY09	$233,606,434	$10,480,434,906	$10,714,041,340
FY10	$248,990,625	$11,028,626,667	$11,277,617,292
FY11	$246,753,932	$11,436,171,812	$11,682,925,744
FY12	$662,241,526	$11,494,258,772	$12,156,500,298
FY13	$840,602,476	$10,708,692,013	$11,549,294,489
FY14	$1,351,423,766	$10,761,879,245	$12,113,303,011
FY15	$4,890,727,525	$9,449,003,874	$14,339,731,399
FY16	$7,110,312,919	$7,613,160,197	$14,723,473,116

Note: MCO costs reported are incurred costs, regardless of when paid.
Source: Medicaid cost data provided by HFS on June 23, 2017.

On January 25, 2011 Public Act 96-1501 amended the Illinois Public Aid Code and mandated that HFS increase the percentage of Medicaid clients whose Medicaid services are paid through managed care organizations (MCOs). MCOs are not paid on a fee-for-service basis; they are paid using monthly capitation rates. According to the contract, FY16 capitation rates were required to be actuarially sound.

The cost of Medicaid increased between FY08 and FY16. The annual total medical costs increased by $4.4 billion, or 44%, from FY08 to FY16.

In July 2014, MCO enrollment of Family Health Plan and Affordable Care Act populations became mandatory. Integrated Care Plan enrollment became mandatory in all regions with two or more MCOs offering plans. Roll out of all managed care programs was completed by late spring 2015. As managed care enrollment became mandatory, the number of enrollees in managed care increased dramatically to almost 1.62 million in FY15, up from 460,524 in FY14.

TOTAL MEDICAL ASSISTANCE ENROLLEES
Enrollees as of the last day of the fiscal year

State Fiscal Year	Total Managed Care	Total Fee-for-Service	Total All Medicaid
FY08	174,821	2,185,932	**2,360,753**
FY09	190,653	2,322,021	**2,512,674**
FY10	195,971	2,457,191	**2,653,162**
FY11	201,776	2,547,377	**2,749,153**
FY12	248,865	2,539,260	**2,788,125**
FY13	309,709	2,501,202	**2,810,911**
FY14	460,524	2,682,660	**3,143,184**
FY15	1,619,874	1,612,799	**3,232,673**
FY16	2,029,064	1,164,386	**3,193,450**

Report Conclusions

- Auditors determined that the Department of Healthcare and Family Services (HFS) did not maintain the complete and accurate information needed to adequately monitor $7.11 billion in payments made to and by the 12 MCOs during FY16.

- Auditors determined that as of November 1, 2017, HFS could not provide information to address several of the nine audit determinations found in House Resolution No. 100. Specifically, HFS could not provide auditors with the following information:
  - ✓ all paid claims to Medicaid providers by the MCOs in FY16;
  - ✓ Medicaid provider claims denied by MCOs in FY16;
  - ✓ the administrative costs incurred by MCOs in FY16;
  - ✓ the coordinated care costs incurred by MCOs in FY16; and
  - ✓ Medical Loss Ratio (MLR) calculations since calendar year 2012.

- In FY16, HFS made multiple monthly capitation payments to MCOs for the same months for the same individuals totaling $590,237.

The audit report contains six recommendations directed to the Department of Healthcare and Family Services. The Department generally agreed with all of the recommendations except for the second part of Recommendation No. 3 related to on-site monitoring of MCOs.

The audit report provided the following information in response to the nine specific determinations. The number in parentheses notes the page number where the information was found in the Performance Audit of Managed Care Organizations.

1. Compare the total dollar amount of all reported MCO encounter data submitted to the Illinois Department of Healthcare and Family Services (HFS) during FY16 to the total dollar amount of reported claims payments made on behalf of Illinois Medicaid individuals by MCOs as reported to HFS during FY16.

   The actuary noted that they were in the process of requesting complete encounter data from each of the 12 MCOs. It was discussed that encounters related to the Division of Alcoholism and Substance Abuse (DASA), long term care (LTC), waiver services (services that allow individuals to remain in their own homes or live in a community setting, instead of in an institution), and the Medicare-Medicaid Alignment Initiative (MMAI) were not received by HFS from the MCOs. (p. 3)

2. Whether MCO encounter data is used by the Department of Healthcare and Family Services to set capitation rates.

   According to the various rate certification reports completed by the actuary for 2016, HFS did not have complete encounter data in its data warehouse, and as such, a combination of plan-reported claims information and fee-for-service claims information was used to develop the base data actuarial models. Thus, encounter data was not used to set FY16 capitation rates. (p. 3)

3. Calculate the aggregate amount of MCO capitation payments made by HFS during SFY 2016. *Note: the excluded payments include Hospital Access Payments and Hospital Access Improvement Payments.*

   Based on information provided by HFS on of June 23, 2017, the amount of MCO capitation payments made by HFS for fiscal year 2016 was $7,110,312,919. (p. 3)

4. Determine the amount of payments made by HFS to reimburse for-profit MCOs for the Affordable Care Act (ACA) Health Insurer Fee (HIF); determine if reimbursement by the State to for-profit MCOs for this HIF payment is mandated by federal Centers for Medicare & Medicaid Services (CMS).

   See answer in #5 below.

5. Determine the amount of payments made by HFS to reimburse for-profit MCOs for "gross-ups" related to the HIF payment; determine the purpose of the "gross-up" payments.

   The "gross-up" paid to the MCOs assumes a 35 percent marginal federal corporate tax rate. According to the actuary report, without the HIF and "gross-up" reimbursements, the insurer would just increase its costs to account for the cost of the HIF and lost taxes. For FY16, the amount of the "gross-up" owed to the MCOs was $52.2 million. The combined HIF and "gross-up" owed by the State to MCOs for FY16 was $137.9 million. (p. 4 and p. 19)

6. The incidence to which the MCO capitation rates contain supplemental, GRF-based payments to providers; for these payments, determine the amount of the supplemental, which providers received these payments, and whether these monies were directly tied to services actually provided. *Note: the excluded payments include Hospital Access Payments and Hospital Access Improvement Payments.*

   Based on information provided by HFS, this determination was referring to Cook County Health & Hospitals System (CCHHS) access payments. Based on information provided by HFS, in FY16, $138,398,950 in CCHHS access payments were paid to MCOs. (p. 4)

7. What administrative costs are paid to MCOs in terms of total dollars and percent of overall MCO medical-based payments.

   After numerous meetings and requests for information, HFS could not provide auditors with the actual administrative costs or other non-benefit costs, such as care coordination costs, incurred by the MCOs during FY16. (p. 4) This determination was the basis for Recommendation No. 1.

8. What is the average payout ratio for all MCOs in aggregate and for each MCO individually; for the purposes of this audit, payout ratio is defined as all paid claims to Medicaid providers made by MCOs as reported to HFS for SFY16 divided by aggregate MCO capitation payments made by HFS for SFY16.

   Since HFS did not monitor or track all encounter information for the 12 MCOs or monitor the expenditures for DASA, LTC, waiver services, and MMAI costs during FY16, there was not complete and accurate information for auditors to calculate the average payout ratio. Additionally, since HFS did not have the total for all paid claims to Medicaid providers by the 12 MCOs more than 16 months after the end of FY16, auditors determined that HFS lacked sufficient monitoring of payments made to and by the 12 MCOs during FY16. (p. 5)

9. What the denial rates are for MCOs and for fee-for-service providers billing the HFS; determine whether there is a higher denial rate for services paid by MCOs.

   HFS also could not provide auditors with any valid data to document encounters denied by the MCOs for FY16. (p. 5) This determination was the basis for Recommendation No. 4.

RECOMMENDATIONS

1. The Illinois Department of Healthcare and Family Services (HFS) should monitor the actual administrative costs incurred by its managed care organizations to ensure that the administrative costs do not exceed what is allowed by contract.

Finding: HFS did not adequately monitor the actual administrative costs, care coordination costs, or other non-benefit costs incurred by the MCOs during FY16. According to the 2016 Medicaid Managed Care Rate Setting Consultation Guides published by the federal CMS, the administrative costs for MCOs are contained within the "projected non-benefit costs." Included in the non-benefit costs are the following cost categories:

- Administrative costs;
- Care coordination and care management;
- Provision for margin (includes profit margin, operating margin, risk margin, contingency margin, cost of capital, or underwriting gain);
- Taxes, fees, and assessments; and
- Other material non-benefit costs.

In June 2017, auditors requested that HFS provide the non-benefit costs paid to MCOs by category. During the meeting on July 5, 2017, HFS officials indicated that HFS could not break out the non-benefit costs, which includes administrative costs.

During the next few months, auditors continued to try to obtain the administrative costs from HFS and were subsequently directed by HFS to meet with its actuary. A meeting with the actuary and HFS was held on September 5, 2017, where the actuary indicated that they did not currently have the actual administrative cost figures paid to MCOs in FY16, but were working to obtain them from the MCOs. The actuary believed they would have the information by the end of October 2017. During the meeting, the actuary indicated that administrative costs are approximately 13% of the total capitation rates paid; however, the actuary said that was not an actual documented percentage. If an estimate of 13% was used to determine the administrative costs for FY16, the administrative cost for $7.11 billion would be approximately $924.3 million.

Auditors also reviewed HFS monitoring documents, such as actuary reports and MCO financial audits, and found nothing that identified the actual administrative costs or the actual costs for care coordination and care management paid to the MCOs. The actuary produces bi-annual rate certification reports, which are submitted to HFS. Auditors reviewed both rate certification reports by plan for FY16 and determined that there was not a set percentage for administrative cost for all plans.

For example, the rate certification reports show that the administrative cost portion of the capitation rate for the Affordable Care Act plan in 2016 was 13%, while the administrative portion for the Integrated Care Program was 7.5% plus $40 per member per month for nursing home enrollees and $25 per member per month for all other enrollees. The

administrative cost portion for the Family Health Plan for the second half of FY16 was 12.85% for non-delivery rates and 3.5% for the delivery case rates. Since these administrative cost rates all vary by plan and by enrollee type and HFS could not provide all encounter data for all enrollees, auditors could not estimate or determine the administrative costs for FY16.

As of November 1, 2017, neither the actuary nor HFS provided the MCO administrative cost information. Without an accounting of actual administrative costs incurred by the MCOs, it is unclear how HFS monitored the costs incurred by the MCOs and how future rates were set to ensure that the MCOs were compensated correctly for administering $7.11 billion in capitation payments received during FY16.

HFS Response: The Department concurs with the recommendation and, in fact, already monitors such costs. HFS collects information from each MCO regarding spending on administrative costs as part of the overall data collection process for rate setting. If the MCO exceeds the amount allowed by contract, the costs come out of their profit. If the MCO spends less than the administrative costs included, they can keep the difference as profit, up to the limits of the Medical Loss Ratio (MLR). This additional MCO spending data was provided to the Auditor.

Auditors' Comment: The additional administrative expense data provided by HFS was not actual administrative costs incurred by the MCOs as required by House Resolution Number 100. Additionally, the administrative expense data was not provided until January 5, 2018, after the completion of the audit. Also, the data provided was for calendar year 2016 and not fiscal year 2016, and did not contain an explanation or a methodology that described exactly how the administrative expenses were calculated and what specific source documentation was used. The email accompanying the administrative expense data noted it was "not what the language in the resolution asked for..."

HFS Updated Response: Implemented. HFS collects information from each MCO regarding spending on administrative costs as part of the overall data collection process for rate setting. As part of the 2019 rate development, more recent administrative cost data has been collected. Our actuary summarizes and presents it to HFS as part of the annual rate development process.

2. The Illinois Department of Healthcare and Family Services should:

- **calculate the Medical Loss Ratios since calendar year 2012 as required by the MCO contracts; and**
- **determine whether the State should be reimbursed by MCOs due to overpayment.**

Findings: According to HFS officials, HFS had not calculated the required annual Medical Loss Ratio (MLR) since calendar year 2012. Had HFS calculated the MLR as required by its contracts with the MCOs, HFS would have had the administrative cost information in

order to monitor the MCOs more effectively and efficiently. Without these MLR calculations, HFS did not reconcile the payments made to the MCOs for more than four years.

The MLR is defined in the contracts as total plan benefit expense divided by total capitation revenue (see MLR definition details in the adjacent text box). The Public Aid Code requires contracts with MCOs to have a minimum MLR of 85 percent.

Medical Loss Ratio (MLR) =

$$\frac{\textit{Benefit Expense}}{\textit{Revenue}}$$

Benefit Expense =

- Paid Claims (Encounters);
- Incurred But Not Paid Claims;
- Provider Incentive Payments;
- Care Coordination Expenses (personnel costs attributable to this contract); and
- Other (services not capable of being sent as encounter data).

Revenue =

Capitation Payments minus annual fee minus supplemental capitation payments to allow contractor to preserve access to hospital services

Source: HFS contracts with MCOs.

The MCO contracts contain a section titled Medical Loss Ratio Guarantee, which requires that HFS shall calculate the MLR within 90 days following the six month claims run-out period following the coverage year. The MCOs then have 60 days to review HFS' calculation. If the MCO did not meet its MLR set by the contract, the MCO is required to refund the State the difference.

As of July 5, 2017, HFS officials indicated that the contractually required MLRs had not been calculated since calendar year 2012. As of November 1, 2017, no information was received to support the MLR calculations for any calendar year other than 2012. According to the contracts between HFS and the MCOs, the State requires health plans to maintain a minimum medical loss ratio of 85% for the Family Health Population/Affordable Care Act plans and the Medicare-Medicaid Alignment Initiative and 88% for the Integrated Care Program plans.

Fiscal year capitation payment data was provided by HFS, which shows that for FY13 through FY16, HFS paid MCOs $14.2 billion. Without the MLR calculations, HFS cannot reconcile what was paid to the MCOs. HFS noted that in 2012, the last time it calculated the MLR rates, it recovered almost $21.7 million from ICP plans alone. HFS has not determined whether the MCOs were overpaid by the State in calendar years 2013, 2014, 2015, and 2016.

HFS Response: The Department concurs with the recommendation. MLR calculations were delayed while capitation payments were finalized. Due to system issues, some adjustments had to be made manually after the 18 month lookback period. The MLR calculations have been completed for 2013 and 2014 for the Integrated Care Program (ICP). Data to calculate the Family Health Plan (FHP) MLR for July 2014 – December 2015, and ICP for 2015, has been requested from the MCOs and was due to the Department by December 15th. Data has now been received from most plans. Additionally, a methodology has been developed in consultation with our actuaries to estimate MLR before the

calculation can be made in order to track and monitor potential recoupments and report them on financial statements.

HFS Updated Response: Implemented.

- MLRs for 2013 – 2015 for all MCOs have been calculated and shared with the MCOs. The plans are in their 60 day review period, and any comments or questions are due to HFS by August 5, 2018.
- ACA risk corridor (done in lieu of MLR for ACA population since their history was unknown before enrollment) has been calculated, plans have reviewed and responded. For three continuing plans who owed a refund, the amounts due were recouped from their capitation payments on June 7, 2018. For plans who are not continuing who owed refunds, the plans were invoiced and HFS is awaiting payment.
- MLR for CountyCare for all covered populations has been completed, reviewed, and funds were recouped with an adjustment to the capitation payments processed June 21, 2018.
- MLR for 2016 data has been collected and our actuaries are developing draft calculations, which are due to HFS at the end of July.
- MLR estimates for 2017 (updated from estimate prepared last year with more complete data) and 2H2018 are scheduled to be prepared by mid-August as part of our annual GAAP reporting.

3. The Illinois Department of Healthcare and Family Services should:

- **require all managed care organizations to submit all Medicaid provider payment data for all services (including DASA, LTC, and waiver services); and**
- **perform on-site reviews of the MCOs' financial data systems and test the completeness and accuracy of the data reported to HFS that is used to monitor the payments made to Medicaid providers.**

Finding: HFS could not provide auditors with the total amount of all paid claims to Medicaid providers by the MCOs, medical loss ratio calculations, or MCO administrative denied claim data for FY16.

The actuary noted that they were in the process of requesting complete encounter data from each of the 12 MCOs. It was discussed that encounters related to the Division of Alcoholism and Substance Abuse (DASA), long term care (LTC), waiver services (services that allow individuals to remain in their own homes or live in a community setting, instead of in an institution), and the Medicare-Medicaid Alignment Initiative (MMAI) were not received by HFS from the MCOs.

MCO ENCOUNTERS ACCEPTED BY HFS Fiscal Year 2016	
Health Plan	**Encounters Accepted by HFS**
Aetna Better Health	$735,813,499.93
County Care	585,670,116.62
Family Health Network/Comm Care Alliance IL	399,148,649.22
Harmony Health Plan	259,440,812.06
Health Alliance Connect	357,210,740.91
Blue Cross Blue Shield IL	618,619,436.00
Cigna-HealthSpring	39,725,644.22
Humana Health Plan	30,953,816.62
IlliniCare Health Plan	757,597,703.64
Meridian Health Plan	573,226,552.11
Molina Healthcare of Illinois	290,211,850.57
NextLevel Health	24,610,362.43
Total	**$4,672,229,184.33**
Source: FY16 Encounter Utilization Monitoring report provided by HFS.	

When asked about the total amount of claims paid to Medicaid providers by the MCOs in FY16, HFS reported it established the Encounter Utilization Monitoring (EUM) to help improve the encounter submissions by MCOs to HFS. The EUM compares the encounters submitted by the MCOs which are accepted by the MMIS (Medicaid Management Information System) to the amount of claims paid by MCOs to Medicaid providers which are self-reported quarterly to HFS. The quarterly self-reported encounters for FY16 totaled $5.1 billion. The encounters reported by the MCOs (minus DASA, LTC, waiver services, and MMAI) are run through a series of edit checks in HFS' MMIS. After the edits were run, HFS accepted $4.67 billion.

HFS indicated that no on-site fiscal monitoring was done to ensure that complete and accurate data was available to determine the total paid claims to Medicaid providers by MCOs for the $7.11 billion paid to the MCOs in FY16. Medicaid spend data was provided to HFS by the MCOs, but was self-reported and auditors found no actual reviews or testing of the MCOs' payment systems by HFS. Thus, auditors had no assurance that the encounter data submitted to HFS included actual paid encounters.

HFS Response: The Department partially concurs with the recommendation. During the period audited, the Department was unable to accept certain claim types (LTC, Waiver, and DASA) in the encounter system. The Department can now accept all encounter types in order to collect all provider payments submitted by MCOs. LTC encounters have been accepted by the MMIS for dates beginning with January 2017 and, effective January 1, 2018, the MMIS can accept Waiver and DASA encounters as well. Quarterly reporting is already in place to track encounter submissions against MCO reported financial data and sanctions are applied when the MCO does not meet the minimum submission requirements.

The Department does not agree that on-site reviews by HFS of MCO financial data systems are necessary to test completeness and accuracy of data submitted to HFS that is used to monitor provider payments. However, in the fall of 2017, HFS procured the services of Myers and Stauffer, Certified Public Accountants, to assist in closing out contractual obligations under MCO contracts in effect during the period from July 1, 2014 through December 31, 2017 for the ICP, FHP, Affordable Care Act and Managed Long Term

Services and Supports programs. This engagement, which will include on-site visits, will provide a comprehensive analysis of MCO provider payments and liabilities and inform HFS of ways to enhance its MCO monitoring process with respect to payments made to Medicaid providers.

HFS Updated Response: Implemented. The items listed in the Corrective Action Plan are complete. HFS is accepting all encounters for HealthChoice IL with services dates on and after 1/1/2018.

There are approximately 50,000 HFS Medicaid recipients in this project. All IL MMAI MCOs have been submitting encounters for all services types (i.e., 100% of encounters) to CMS since the beginning of the project in 2015. HFS has a data use agreement with CMS and has acquired the MMAI encounter data from CMS and has provided it to the HFS consulting actuary, Milliman, Inc. Milliman's purpose in receiving the data is to perform rate setting analyses for HFS. The plan has been that HFS would conduct any additional analyses using the CMS encounter data once Milliman learned to work with the CMS MMAI encounter data and can both supply a copy of the data to HFS and support HFS in understanding the data structure.

Milliman informed HFS in June 2018 that it was having difficulty processing the MMAI encounter data and would not be able to fully conduct its analyses until late 2018 or early 2019. To address its need for MMAI encounter data for rate analysis, Milliman has requested ad hoc data reports directly from the MMAI MCOs. Once Milliman has worked through the data issues, it will then be able to assist HFS as planned. HFS has had several discussions with Federal CMS regarding challenges with the MMAI data. Federal CMS communicates States other than Illinois also have challenges. Federal CMS has offered to provide data reports to HFS if Milliman is not able to successfully work through data issues in the coming months. HFS has responded that it believe that the issues with Milliman's challenges will get resolved.

4. The Illinois Department of Healthcare and Family Services should:

- **provide clear guidance to the MCOs for reporting denied claims; and**
- **ensure that the MCOs provide the denied claims to HFS as required by contract.**

Finding: HFS could not provide auditors with any valid data to document encounters denied by the MCOs for FY16. Like the encounter data, MCOs are required to provide denial data to HFS at least monthly. The contracts state that "Contractor shall submit administrative denials in the format and medium designated by the Department." Auditors requested denial data from HFS, and according to its July 13, 2017, written response, HFS indicated that some of the MCOs did not provide the denial data for FY16.

Two different types of reports on denials were provided to auditors to address this determination; however, HFS indicated that neither report should be used as the reports

were not valid and had not been vetted or audited. HFS officials also noted that HFS had never given MCOs clear guidance on how to report denied claims. Without complete and accurate denied claim data, HFS cannot determine whether the MCOs are appropriately denying claims submitted by Medicaid providers.

According to HFS officials, HFS did not track denied and rejected fee-for-service claims in a way that could be used to determine which claims were denied.

HFS Response: The Department concurs with the recommendation. The Department will provide clear instructions to the MCOs regarding reporting of denied claims.

HFS Updated Response: Accepted. The Department's instructions to MCOs regarding reporting administrative denials are complete. However, before MCOs can successfully submit administrative denials, edits specific to administrative denials need to be relaxed in the current MMIS. Also, the current Pharmacy Benefit Management System (PBMS) called Change Healthcare does not accept administrative denials and that system also needs to be modified. The estimated date of completion for both of these steps in 2/1/2019.

5. The Illinois Department of Healthcare and Family Services should:

- **ensure multiple monthly capitation payments are not being made for the same Medicaid recipients;**
- **immediately identify and remove all duplicative recipients from its eligibility data; and**
- **recoup any overpayment of duplicate capitation payments.**

Finding: During a review of FY16 capitation payments made to MCOs by HFS, auditors determined that HFS made multiple monthly capitation payments for the same month for the same recipient. Auditors determined that there were 302 individual social security numbers that had more than one recipient identification number assigned for which multiple capitation payments were made.

Auditors questioned a total of $590,237 in duplicative capitation payments for 302 individual social security numbers in FY16. In each instance, two payments were made for the same social security number for the same eligibility period. Auditors could not determine which payment was the correct payment and which payment was the duplicate; therefore, all $590,237 was questioned.

Auditors determined that this continued to occur in FY17 as well. A review of the FY17 capitation payments showed an additional $465,336 in duplicative payments. Therefore, for FY16 and FY17, auditors questioned a total of $1,055,573 in duplicative capitation payments to MCOs.

HFS Response: The Department concurs with the recommendation. Processes are in place to remove duplicate clients when they are identified by HFS or the MCOs. Once

identified, corrections are made and overpayments are recouped. The Department will review its existing processes and provide any necessary enhancements to achieve this objective.

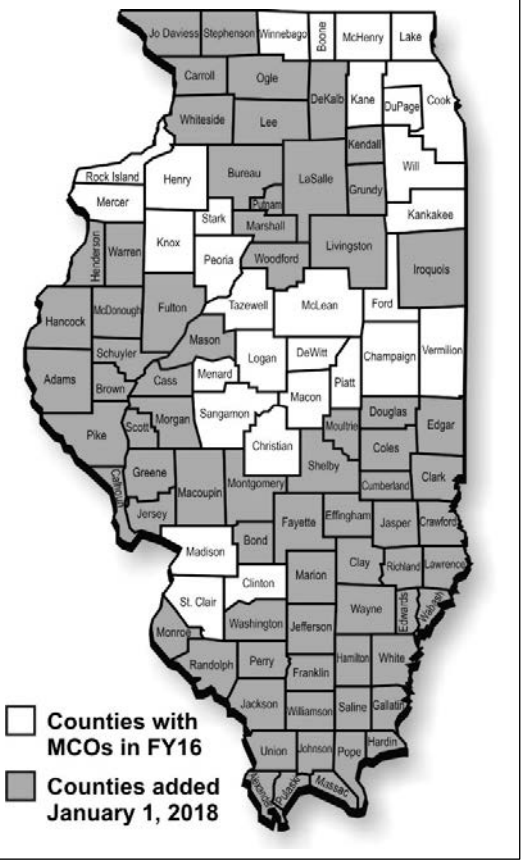
HFS Updated Response: Accepted, No Update.

6. The Illinois Department of Healthcare and Family Services should ensure that it effectively monitors the newly awarded MCO contracts to ensure compliance with all contractual provisions.

Finding: On August 11, 2017, the Department of Healthcare and Family Services awarded new contracts for the delivery of health care services in Illinois. According to the new Managed Care Organization Request for Proposals (RFP), the State sought four to seven MCOs to provide managed care Statewide, thus adding 72 counties to the existing coverage area.

According to the RFP, the new contracts are effective on January 1, 2018, and will assign 683,000 recipients into MCOs from the counties that currently do not have Medicaid managed care (see map). The contracts are for an initial four year term and include an option to renew for up to an additional four years. The stated goal outlined in the RFP was to increase participation in managed care in Illinois to 80%. The new contracts will require extensive documentation provided by the MCOs.

NEW MANAGED CARE COVERAGE
As of January 1, 2018



NEW MANAGED CARE PROVIDERS As of January 1, 2018
STATEWIDE
Blue Cross Blue Shield of Illinois Harmony Health Plan IlliniCare Health Plan Meridian Health Molina Healthcare of IL
COOK COUNTY ONLY
CountyCare Health Plan
DCFS YOUTH
IlliniCare Health Plan
Source: HFS.

HFS Response: The Department concurs with the recommendation. The Department will monitor the newly awarded MCO contracts to ensure compliance with all contractual provisions.

HFS Updated Response: Accepted, No Update.