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

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

State Demonstrations Group

May 8, 2024

Stephen Smith
Director of TennCare
Tennessee Department of Finance and Administration
310 Great Circle Road Nashville, TN 37243

Dear Director Smith:

The Centers for Medicare & Medicaid Services (CMS) completed its review of the Final Report for the Tennessee Managed Care Risk Mitigation COVID-19 Public Health Emergency amendment to the section 1115 demonstration entitled, "TennCare III" (Project No: 11-W-00369/4). This report covers the demonstration period from March 1, 2020 – May 11, 2023. CMS determined that the Final Report, submitted on April 15, 2024, is in alignment with the CMS-approved Evaluation Design, and therefore, approves the state's Final Report.

In accordance with STC #98, 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 Managed Care Risk Mitigation COVID-19 PHE amendment under these extraordinary circumstances. We look forward to our continued partnership on the TennCare III 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: 2024.05.08 10:38:46 -04'00'

Danielle Daly
Director
Division of Demonstration Monitoring and Evaluation

cc: Tandra Hodges, State Monitoring Lead, CMS Medicaid and CHIP Operations Group

Division of TennCare

TennCare III Demonstration

Project No. 11-W-00369/4

Emergency Demonstration Amendment

COVID-19 PHE Managed Care Risk Mitigation

Draft Final Evaluation Report

April 15, 2024

Table of Contents

A. Executive Summary

In 2022, Tennessee received approval of demonstration authority to implement a risk corridor for its managed care plans in response to the COVID-19 public health emergency. This report presents the results of the state's evaluation of its implementation of this demonstration authority. The results of the evaluation indicate that the demonstration authority was effective in promoting the objectives of Medicaid and in ensuring appropriate and equitable managed care payments were made during the COVID-19 public health emergency.

B. Background

In 2020, the Secretary of Health and Human Services issued a determination that COVID-19 represented a nationwide public health emergency (PHE). Tennessee's Medicaid program, which operates under the authority of an 1115 demonstration known as TennCare and which goes by the name "TennCare," was a key component of Tennessee's response to the COVID-19 PHE and of the state's public safety net more broadly.

Under the TennCare demonstration, Tennessee operates the entirety of its Medicaid program under the auspices of a single, statewide managed care service delivery system. The sudden and unforeseen emergence of the COVID-19 PHE represented a challenge to Medicaid managed care programs like TennCare, since these programs rely on actuarially certified capitation payments to managed care organizations (MCOs) as their primary mechanism for furnishing medical assistance to Medicaid beneficiaries. Federal managed care regulations at 42 CFR § 438.6(b)(1) place limitations on the extent to which such risk-sharing arrangements may be modified after the start of a contract rating period. In the unique and unforeseen circumstances of the COVID-19 PHE, this restriction created a risk that the state's capitation payments to its MCOs would not be appropriate to provide for all reasonable, appropriate, and attainable costs contemplated in Tennessee's MCO contracts.

On January 7, 2022, Tennessee submitted an application to CMS for an amendment to the TennCare demonstration that would allow the state to retroactively modify risk-sharing mechanisms under TennCare's managed care program if such modifications were determined to be necessary, notwithstanding the regulatory prohibition at 42 CFR § 438.6(b)(1). Tennessee's goal in seeking this demonstration authority was to add a risk-sharing arrangement, specifically a risk corridor, to support making appropriate, equitable payments to MCOs during the course of the COVID-19 PHE to help maintain beneficiary access to care.

CMS approved the state's requested demonstration authority on January 28, 2022. On June 24, 2022, Tennessee submitted an evaluation design to CMS, in which the state described how it proposed to understand the successes, challenges, and lessons learned in implementing this approved risk mitigation authority. On July 27, 2022, CMS approved Tennessee's evaluation design. The approved evaluation design is attached to this report as Appendix A.

This report presents the results of Tennessee's evaluation of the temporary risk mitigation authority that was approved during the COVID-19 PHE. This report has been prepared in accordance with the state's approved evaluation design. This evaluation design served as a guide for evaluating Tennessee's Managed Care Risk Mitigation COVID-19 PHE Section 1115 demonstration and developing the federally required Final Report.

Tennessee's Final Report is organized as follows:

- **Section A.** Executive Summary
- **Section B.** Background
- **Section C.** Evaluation Questions and Hypotheses
- **Section D.** Methodology
- **Section E.** Methodological Limitations
- **Section F.** Results
- **Section G.** Conclusion, Interpretations, Lessons Learned, and Recommendations

C. Evaluation Questions and Hypotheses

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

Figure 1. Hypotheses and Research Questions

Research Questions (RQ)	
Hypothesis 1 – The demonstration will facilitate attaining the objectives of Medicaid.	
RQ 1.1	What retroactive risk sharing agreements did the state ultimately negotiate with the managed care plans under the demonstration authority?
RQ 1.2	In what ways during the PHE did the demonstration support adding or modifying one or more risk sharing mechanisms after the start of the rating period?
RQ 1.3	What problems may have been caused by the application of section 438.6(b)(1) during the PHE that would have undermined the objectives of Medicaid, and how did the exemption address or prevent these problems?
RQ 1.4	What were the principal challenges associated with implementing the retroactive risk mitigation strategies from the perspectives of the state Medicaid agency and Medicaid managed care plans?
RQ 1.5	What actions did the state take to address challenges presented by the implementation of retroactive risk mitigation strategies? To what extent were those actions successful in the context of the PHE?
RQ 1.6	What were the principal lessons learned for any future PHEs in implementing the demonstration flexibilities?
Hypothesis 2 – The authority will support TennCare in making appropriate, equitable payments during the COVID-19 PHE to help with maintenance of beneficiary access to care that would have otherwise been challenging due to the prohibitions in Section 438.6(b)(1).	
RQ 2.1	To what extent did the retroactive risk sharing implemented under the demonstration authority result in more accurate payments to the managed care plans?

D. Methodology

This section provides details on the methodology used for the evaluation, including data sources, analytic methods, and evaluation approach.

Section D.1 summarizes the data used to conduct the evaluation.

Section D.2 outlines the analytic methods used to conduct the evaluation.

Section D.3 details the evaluation approach Tennessee used to evaluate each hypothesis.

1. Data Sources

Tennessee compiled data for the evaluation from qualitative and quantitative data sources including staff interviews, MCO Medical Loss Ratio (MLR) reports, claims/encounter data, and rate development exhibits.

Document Review

To examine information related to the risk corridor negotiated with the managed care plans, Tennessee conducted a review of relevant documentation (i.e., managed care contracts).

Staff Interviews

The state conducted an interview with key Medicaid agency staff involved with the risk corridor program to evaluate if the demonstration authority facilitated attaining the objectives of Medicaid and supported Tennessee in making equitable payments to MCOs during the COVID-19 PHE to help with maintaining beneficiary access to care.

MCO MLR Reports

MCOs submit regular MLR reports to the state which provide aggregate revenue, claims costs, and other financial metrics for the purposes of calculating MLRs. Tennessee examined calendar year (CY) 2020 monthly MLR submissions to evaluate, in part, to what extent the risk sharing implemented under the demonstration authority resulted in more accurate payments to the MCOs.

Claims/Encounter Data

Tennessee used claims cost data, collected and validated regularly by TennCare's third party actuaries, to estimate the unforeseeable impact of COVID-19 on benefit utilization patterns. This forms the basis of the standard 'encounter data' the actuary relies on for rate development.

CY 2020 Rate Development Exhibits

TennCare examined the CY 2020 Rate Development Exhibits, provided by TennCare's actuaries, that contained target MLRs by program, as calculated during rate development. TennCare examined these exhibits to evaluate, in part, to what extent the risk sharing implemented under the demonstration authority resulted in more accurate payments to the MCOs.

2. Analytic Methods

As part of the approval of the state's risk mitigation demonstration authority, CMS required Tennessee to conduct a "simplified" version of the 1115 demonstration evaluation framework that focuses on using qualitative methods and descriptive statistics to understand how the approved flexibility helped Tennessee respond to the COVID-19 PHE. Accordingly, Tennessee conducted the evaluation using the following qualitative and descriptive statistics methods.

Qualitative Analysis

The state collected qualitative data through interviews with key staff at the Medicaid agency. Specifically, evaluators conducted a joint interview with TennCare's Chief Financial Officer and Director of Policy. Evaluators analyzed the takeaways from that joint interview to identify themes or patterns within the interview responses.

Descriptive Analyses

For research questions assessing payments to managed care plans, the state calculated standard summary statistics to report findings.

3. Evaluation Approach

Figure 2 outlines the hypotheses, RQs, outcome measures, data sources, and analytic approaches for Tennessee's evaluation.

Figure 2. Analytic Table

Research Question	Outcome Measure(s)	Data Source(s)	Analytic Approach
Hypothesis 1 – The demonstration will facilitate attaining the objectives of Medicaid.			
RQ 1.1: What retroactive risk sharing agreements did the state ultimately negotiate with the managed care plans under the demonstration authority?	- Type(s) of risk sharing agreement(s) negotiated with the managed care plans - Terms of negotiated risk sharing agreement(s)	- Document review	- Qualitative analysis
RQ 1.2: In what ways during the PHE did the demonstration support adding or modifying one or more risk sharing mechanisms after the start of the rating period?	- Benefits/successes of adding a risk sharing mechanism that would not have been realized if the demonstration authority were not in place	- TennCare Staff Interview	- Qualitative analysis
RQ 1.3: What problems may have been caused by the application of section 438.6(b)(1) during the PHE that would have undermined the objectives of Medicaid, and how did the exemption 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)	- TennCare Staff Interview	- Qualitative analysis
RQ 1.4: What were the principal challenges associated with implementing the retroactive risk mitigation strategies from the perspectives of the state Medicaid agency and Medicaid managed care plans?	- Description of challenges (if any) related to implementing the risk sharing agreement(s) with the managed care plans	- TennCare Staff Interview	- Qualitative analysis

Research Question	Outcome Measure(s)	Data Source(s)	Analytic Approach
RQ 1.5: What actions did the state take to address challenges presented by the implementation of retroactive risk mitigation strategies? To what extent were those actions successful in the context of the PHE?	- Description of actions taken by Tennessee to address the challenges identified (if any) in RQ 1.4 - Description of how these actions were successful	- TennCare Staff Interview	- Qualitative analysis
RQ 1.6: What were the principal lessons learned for any future PHEs in implementing the demonstration flexibilities?	- Description of lessons learned for future PHEs in implementing the demonstration flexibilities	- TennCare Staff Interview(s)	- Qualitative analysis
Hypothesis 2 – The authority will support TennCare in making appropriate, equitable payments during the COVID-19 PHE to help with maintenance of beneficiary access to care that would have otherwise been challenging due to the prohibitions in Section 438.6(b)(1).			
RQ 2.1: To what extent did the retroactive risk sharing implemented under the demonstration authority result in more accurate payments to the managed care plans?	- MLRs by program prior to the application of the risk corridor, both at an aggregate-level as well as de-identified MCO-specific - MLRs by program after application of the risk corridor, both at an aggregate-level as well as de-identified MCO-specific - Target MLR by program as calculated during rate development - TennCare utilization trend metrics - Per Member Per Month (PMPM) - Units per 1,000 members	- Monthly MCO MLR Submissions - TennCare Claims Data - CY 2020 Rate Development Exhibits	- Descriptive analysis

E. Methodological Limitations

Based on the terms of the approval of this amendment and guidance from CMS, the state's evaluation design for this amendment focused primarily on qualitative methods and descriptive statistics. These methods have certain generally known limitations. Specifically, it is generally not possible to make causal inferences based on these methods alone. Nonetheless, these methods are still useful in supporting the understanding of the successes, challenges, and lessons learned in implementing the demonstration authority.

F. Results

This section provides detailed observations by research question, organized by hypothesis.

Hypothesis 1: The demonstration will facilitate attaining the objectives of Medicaid.

This hypothesis examines whether the managed care risk mitigation demonstration authority facilitated attaining the objectives of Medicaid. The state's findings are organized by RQ below.

RQ 1.1 What retroactive risk sharing agreements did the state ultimately negotiate with the managed care plans under the demonstration authority?

In alignment with CMS recommendations at the time, the state retrospectively established two-way risk corridors with the MCOs for the CHOICES and Non-CHOICES programs, as detailed in the rate certifications submitted to CMS as well as the managed care contracts.

RQ 1.2 In what ways during the PHE did the demonstration support adding or modifying one or more risk sharing mechanisms after the start of the rating period?

The demonstration supported establishment of two-way risk corridors within the managed care plans for the CHOICES and Non-CHOICES programs. Absent this authority, Tennessee would have been unable to adjust its payments to its MCOs to account for the significant changes in utilization observed during the COVID-19 PHE. This authority made it possible for TennCare to make appropriate payments to the managed care plans and ensure the appropriate spending of taxpayer dollars.

RQ 1.3 What problems may have been caused by the application of section 438.6(b)(1) during the PHE that would have undermined the objectives of Medicaid, and how did the exemption address or prevent these problems?

The unforeseen emergence of the COVID-19 PHE introduced a high level of uncertainty into the costs of providing care to Medicaid beneficiaries under Tennessee's managed care contracts. Without the flexibility to establish risk corridors under this demonstration authority, Tennessee would have lacked the ability to manage the spend of public dollars and would have led to the payment of managed care rates that were not appropriate for the circumstances.

RQ 1.4 What were the principal challenges associated with implementing the retroactive risk mitigation strategies from the perspectives of the state Medicaid agency and Medicaid managed care plans?

According to the state staff interviewed for this evaluation, the state did not encounter any notable challenges with implementing the risk corridor. The state indicated that staff in the division of managed care policy at CMS provided timely and useful assistance in conceiving and implementing the risk corridor flexibility.

RQ 1.5 What actions did the state take to address challenges presented by the implementation of retroactive risk mitigation strategies? To what extent were those actions successful in the context of the PHE?

The state did not encounter any challenges with implementing the risk corridor. The state was able to coordinate with the MCOs, relevant stakeholders, and CMS to ensure successful implementation.

RQ 1.6 What were the principal lessons learned for any future PHEs in implementing the demonstration flexibilities?

Providing flexibility around the non-application of 42 CFR § 438.6(b)(1) was critical in helping to ensure appropriate managed care rates were in place during the COVID-19 pandemic. If and when state Medicaid programs are faced with future emergencies or unforeseen circumstances that have a material impact on costs under managed care contracts, CMS should again indicate its willingness to use its authority under Section 1115 to provide states with similar flexibility. Ensuring that this flexibility is available to address future emergencies will help ensure appropriate rates as well as access to care for beneficiaries, just as it did in the instance of the COVID-19 PHE. Alternately, CMS could also consider revising 42 CFR § 438.6(b)(1) to allow for "good cause" retroactive adjustments to risk-sharing arrangements—subject to CMS approval—so that CMS and states have the flexibility needed to respond to emergencies and other unforeseen circumstances without resorting to special demonstration authority.

Hypothesis 2: The authority will support TennCare in making appropriate, equitable payments during the COVID-19 PHE to help with maintenance of beneficiary access to care that would have otherwise been challenging due to the prohibitions in Section 438.6(b)(1).

This hypothesis examines whether this demonstration authority supported Tennessee in making appropriate, equitable payments during the COVID-19 pandemic. See below the state's findings, organized by RQ.

RQ 2.1 To what extent did the retroactive risk sharing implemented under the demonstration authority result in more accurate payments to the managed care plans?

Under Tennessee's managed care program, capitation rates are developed for Non-CHOICES and CHOICES populations. The CY20 rates were initially developed so that the MCOs would achieve MLRs of 89.1% for Non-CHOICES and 92% for CHOICES, around 90% in aggregate for both programs. During CY20, the unforeseeable impacts of the COVID-19 pandemic significantly decreased utilization of services. In response, Tennessee's actuaries worked with the state to decrease the rates to reflect this decrease in utilization. As a result, the Non-CHOICES rates were decreased by 5.8%, and the CHOICES rates were decreased by 1.9%. However, options to retroactively adjust most assumptions in capitation rates are, by design, limited. Even with these adjustments, had the risk mitigation strategy made possible by this demonstration not been available to the state, the MLRs for the CHOICES and Non-CHOICES programs would have ended up at 86.3%, with two of the state's three MCOs achieving an MLR of less than CMS' preferred minimum MLR of 85% (as put forward in each annual 'Medicaid Managed Care Rate Development Guide') for the Non-CHOICES program. Figure 3 outlines the initial MLR target, MLR without adjustment, MLR prior to risk corridor, and MLR post risk corridor for the Non-CHOICES and CHOICES programs.

Figure 3. MLRs for Non-CHOICES and CHOICES Programs

Program	Initial MLR Target	MLR without Adjustment	MLR Prior to Risk Corridor	MLR Post Risk Corridor
Non-CHOICES	89.1%	79.5%	85.3%	86.3%
CHOICES	92.0%	87.2%	89.1%	89.4%
Total	**89.9%**	**81.6%**	**86.3%**	**87.2%**

At the final count, the risk corridor made possible by this demonstration raised the aggregate MLR from 86.3% to 87.2%, recouping $56.4 million across both CHOICES and Non-CHOICES that would have otherwise been retained by the MCOs. This realignment brought two of the three MCOs in each program closer to the initial targets set by the actuaries in rate development.

G. Conclusions, Interpretations, Lessons Learned, and Recommendations

In conclusion, this demonstration authority effectively supported Tennessee in attaining the objectives of Medicaid, making appropriate and equitable payments to managed care plans, and ensuring appropriate use of taxpayer dollars during the extraordinary and unforeseen circumstances of the COVID-19 pandemic. The state believes CMS should consider adopting similar flexibilities when faced with future public health emergencies so that states with managed care programs are able to ensure that payments to managed care plans are appropriate and equitable.

Appendix A
Evaluation Design

Division of TennCare

TennCare III Demonstration

Project No. 11-W-00369/4

Emergency Demonstration Amendment – Managed Care Risk Mitigation Strategies

Evaluation Design

June 20, 2022

Table of Contents

A. General Background Information

On March 13, 2020, pursuant to Section 1135(b) of the Act, the Secretary of Health and Human Services invoked his authority to waive or modify certain requirements of Titles XVIII, XIX, and XXI of the Act as a result of the consequences of the COVID-19 pandemic. As a result, on March 22, 2020, the Centers for Medicare & Medicaid Services (CMS) announced a Section 1115 demonstration opportunity available to states under title XIX (Medicaid) of the Act. In response, Tennessee submitted a Managed Care Risk Mitigation COVID-19 Public Health Emergency (PHE) Section 1115 demonstration application on January 7, 2022. On January 28, 2022, CMS approved the application as an amendment under the "TennCare III" section 1115(a) demonstration (Project Number 11-W-00369/4).

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

As part of the demonstration's Monitoring and Evaluation Requirements, CMS requires Tennessee to develop a "simplified" Evaluation Design to understand the successes, challenges, and lessons learned in implementing the demonstration. This Evaluation Design addresses CMS' Managed Care Risk Mitigation COVID-19 Public Health Emergency (PHE) Medicaid Section 1115 Demonstration: Guidance for Monitoring and Evaluation Requirements.

This Evaluation Design will guide the federally required Final Report and is organized as follows:

- **Section A.** General Background Information
- **Section B.** Evaluation Questions and Hypotheses
- **Section C.** Methodology
- **Section D.** Methodological Limitations
- **Section E.** Preparing the Final Report

B. Evaluation Questions and Hypotheses

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

Figure 1. Hypotheses and Research Questions

Research Question (RQ)	
Hypothesis 1 – The demonstration will facilitate attaining the objectives of Medicaid.	
RQ 1.1	What retroactive risk sharing agreements did the state ultimately negotiate with the managed care plans under the demonstration authority?
RQ 1.2	In what ways during the PHE did the demonstration support adding or modifying one or more risk sharing mechanisms after the start of the rating period?
RQ 1.3	What problems may have been caused by the application of section 438.6(b)(1) during the PHE that would have undermined the objectives of Medicaid, and how did the exemption address or prevent these problems?
RQ 1.4	What were the principal challenges associated with implementing the retroactive risk mitigation strategies from the perspectives of the state Medicaid agency and Medicaid managed care plans?
RQ 1.5	What actions did the state take to address challenges presented by the implementation of retroactive risk mitigation strategies? To what extent were those actions successful in the context of the PHE?
RQ 1.6	What were the principal lessons learned for any future PHEs in implementing the demonstration flexibilities?
Hypothesis 2 – The authority will support TennCare in making appropriate, equitable payments during the COVID-19 PHE to help with maintenance of beneficiary access to care that would have otherwise been challenging due to the prohibitions in Section 438.6(b)(1).	
RQ 2.1	To what extent did the retroactive risk sharing implemented under the demonstration authority result in more accurate payments to the managed care plans?

C. Methodology

This section provides details on the proposed methodology for the Evaluation Design, including anticipated data sources, analytic methods, and evaluation reporting periods.

Section C.1 summarizes the types of data that will be used to prepare the Final Report.

Section C.2 outlines TennCare's proposed analytic methods for the Evaluation.

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

1. Data Sources

The state will compile data for the Evaluation from qualitative and quantitative data sources including staff interviews and state and administrative data.

Document Review

To examine information related to the risk corridor negotiated with the managed care plans, the state will conduct a review of relevant documentation (e.g., managed care contracts).

Staff Interviews

The State will conduct TennCare staff interviews to evaluate if the demonstration facilitated attaining the objectives of Medicaid. Tennessee will identify TennCare interview participants based on involvement in the implementation of the risk corridor.

MCO Medical Loss Ratio (MLR) Reports

MCOs submit regular medical loss ratio (MLR) reports which provide aggregate revenue, claims costs, and other financial metrics for the purposes of calculating MLRs. TennCare will examine calendar year (CY) 2018, CY 2019, CY 2020 monthly MLR submissions to evaluate, in part, to what extent the risk sharing implemented under the demonstration authority resulted in more accurate payments to the MCOs.

TennCare Claims Data

The State will use claims cost data, collected and validated regularly by TennCare's actuaries, to estimate the unforeseeable impact of COVID-19 on utilization patterns. This forms the basis of the standard 'encounter data' the actuary relies on for rate development.

CY 2020 Rate Development Exhibits

TennCare's actuaries will provide CY 2020 Rate Development Exhibits containing target MLRs by program, as calculated during rate development. TennCare will examine these Exhibits to evaluate, in part, to what extent the risk sharing implemented under the demonstration authority resulted in more accurate payments to the MCOs.

2. Analytic Methods

As part of the 1115 demonstration approval, CMS required Tennessee to develop a "simplified" Evaluation Design that does not undertake evaluations that would prove overly burdensome and impractical for data collection or analyses, but rather focuses on using qualitative methods and descriptive statistics to understand how this flexibility helped Tennessee respond to the COVID-19

PHE. As such, Tennessee will use qualitative and descriptive statistics methods to conduct the Evaluation.

Qualitative Analysis

The state will collect qualitative data through methods such as staff interviews. Where applicable, the qualitative data will be categorized and coded systematically. The state will use thematic analysis, which is a systematic and iterative data coding and analysis process that will allow the state to identify themes or patterns within the responses.

Descriptive Analyses

For research questions assessing payments to managed care plans, the state will calculate standard summary statistics to report findings.

3. Analytic Table

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

Figure 2. Analytic Table

Research Question	Outcome Measure(s)	Data Source(s)	Analytic Approach
Hypothesis 1 – The demonstration will facilitate attaining the objectives of Medicaid.			
RQ 1.1: What retroactive risk sharing agreements did the state ultimately negotiate with the managed care plans under the demonstration authority?	- Type(s) of risk sharing agreement(s) negotiated with the managed care plans Terms of negotiated risk sharing agreement(s)	- Document review	- Qualitative analysis
RQ 1.2: In what ways during the PHE did the demonstration support adding or modifying one or more risk sharing mechanisms after the start of the rating period?	- Benefits/successes of adding a risk sharing mechanism that would not have been realized if the demonstration authority were not in place	- TennCare Staff Interview(s)	- Qualitative analysis
RQ 1.3: What problems may have been caused by the application of section 438.6(b)(1) during the PHE that would have undermined the objectives of Medicaid, and how did the exemption 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)	- TennCare Staff Interview(s)	- Qualitative analysis
RQ 1.4: What were the principal challenges associated with implementing the retroactive risk mitigation strategies from the perspectives of the state Medicaid agency and Medicaid managed care plans?	- Description of challenges (if any) related to implementing the risk sharing agreement(s) with the managed care plans	- TennCare Staff Interview(s)	- Qualitative analysis
RQ 1.5: What actions did the state take to address challenges presented by the implementation of retroactive risk mitigation strategies? To what extent were those actions successful in the context of the PHE?	- Description of actions taken by Tennessee to address the challenges identified (if any) in RQ 1.4 - Description of how these actions were successful	- TennCare Staff Interview(s)	- Qualitative analysis

Research Question	Outcome Measure(s)	Data Source(s)	Analytic Approach
RQ 1.6: What were the principal lessons learned for any future PHEs in implementing the demonstration flexibilities?	- Description of lessons learned for future PHEs in implementing the demonstration flexibilities	- TennCare Staff Interview(s)	- Qualitative analysis
Hypothesis 2 – The authority will support TennCare in making appropriate, equitable payments during the COVID-19 PHE to help with maintenance of beneficiary access to care that would have otherwise been challenging due to the prohibitions in Section 438.6(b)(1).			
RQ 2.1: To what extent did the retroactive risk sharing implemented under the demonstration authority result in more accurate payments to the managed care plans?	- MLRs by program prior to the application of the risk corridor, both at an aggregate-level as well as de-identified MCO-specific - MLRs by program after application of the risk corridor, both at an aggregate-level as well as de-identified MCO-specific - Target MLR by program as calculated during rate development - TennCare utilization trend metrics - Per Member Per Month (PMPM) Units per 1,000 members	- Monthly MCO MLR Submissions - TennCare Claims Data - CY 2020 Rate Development Exhibits	- Descriptive analysis

D. Methodological Limitations

Given the simplified nature of this Evaluation Design, Tennessee does not anticipate encountering extensive methodological limitations. However, there are a few limitations the state may encounter, which are described below.

- **Qualitative Analysis.** The main analytic approach TennCare will use in this Evaluation is qualitative analysis. There are a few widely known limitations to the qualitative analysis approach such as difficulty to demonstrate rigor, dependency of an individual's skills on research quality, and bias. TennCare will do its best to minimize these limitations, for example, by creating a scripted interview template.
- **Staff Interviews.** The State plans to conduct a limited number of TennCare staff interviews to evaluate RQs 1.2 – 1.6. The State will schedule interviews with the critical TennCare staff members that were involved in the development and implementation of the risk corridor. If any of the critical staff members involved in the development and implementation of the risk corridor depart TennCare prior to the interview, it may be difficult to fully evaluate RQs 1.2 – 1.6.

E. Preparing the Final Report

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