Guidehouse

State of Tennessee

Department of Finance and Administration
Bureau of TennCare

Preliminary Medicaid Capitation Rate Ranges for the Non-CHOICES, CHOICES, and CoverKids Programs and Additional Informational Program Reports for CY22 MCO Reprocurement

January 27, 2021

Mr. Zane Seals
TennCare
Chief Financial Officer
Finance & Administration
State of Tennessee
310 Great Circle Road
Nashville, TN 37243

Subject: Preliminary Actuarial Rate Ranges for Tennessee Managed Care Organizations and Additional Informational Program Reports for CY22 MCO Reprocurement

Dear Mr. Seals:

We have calculated preliminary budget-neutral actuarially-sound capitation rate ranges for the Managed Care Organizations (MCOs) participating in the State's Managed Medicaid Program for the contract period January 1, 2022 through December 31, 2022 (CY22).

These are preliminary rate ranges that may be updated for future changes in claim experience, benefit adjustments, trends, or other impacts to the program costs before the contract period begins.

These rate ranges rely on CY19 base data, which was validated for the purposes of developing the CY21 capitation rates. Due to inherent utilization changes resulting from the COVID-19 pandemic, we will not rely on CY20 data to develop the CY22 rates. We expect to rely on refreshed CY19 encounter data later this year to develop the final CY22 rates, meaning that the data will include additional runout. Furthermore, rate-setting assumptions will be reviewed later in the year and likely will vary from those selected for the CY21 rates. Thus, the final rates for CY22 are expected to change, perhaps substantially, and may not necessarily fall within the rate ranges provided in this report.

The following report describes the methods used to calculate these rates and has been organized to largely follow CMS' '2020-2021 Medicaid Managed Care Rate Development Guide' for convenience.

Please let us know if you have any questions regarding these capitation rate ranges or the methods that were used in the calculation.

Sincerely,

Sterling Felsted, ASA, MAAA

January 27, 2021
Date

Guidehouse

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Executive Summary

Introduction

The State of Tennessee, Bureau of TennCare has retained Guidehouse Consulting to provide actuarial and consulting services related to the development of actuarially sound capitation rates for their Non-CHOICES, CHOICES, and CoverKids programs. This report provides a description of the development of preliminary risk neutral rate ranges for these programs for the CY22 contract period. Note that the capitation rate ranges presented in this report are preliminary and illustrative only. Updated rates will be developed using more recent experience and will reflect updated impacts due to program changes either not yet available or not yet evaluated. At the time of this writing, we expect to use CY19 encounter claims as the base data for the CY22 rates. However, in developing updated CY22 rates, it is the actuaries' intention to follow similar methodologies as those presented in this report.

This document has been organized to follow the outline of the '2020-2021 Medicaid Managed Care Rate Development Guide'.

Timeframe of Expected Deliverables

In order to establish expectations, the following timeline presents current target dates for key deliverables related to the CY22 rates:

CY22 Rate Development		
Task #	**Description**	**Target Date**
1	Request supplemental data from MCOs (admin, nonsystem, etc.)	31-Mar-21
2	Receive supplemental data from MCOs (admin, nonsystem, etc.)	10-May-21
3	Work with MCOs to understand data variances	May - June
4	Request information on reverification from MCOs	2-Aug-21
5	Receive information on reverification from MCOs	25-Aug-21
6	Deliver Draft Rate Exhibits to TennCare	31-Aug-21
7	Deliver Draft Rate Info to MCOs	3-Sep-21
8	Rates Meeting with MCOs	10-Sep-21
9	Deliver Final Certification with Exhibits to State	24-Sep-21
10	Request updated census data for risk adjustment	12-Jul-22
11	Receive updated census data for risk adjustment	26-Jul-22
12	Communicate Risk Adjustment Results	15-Nov-22
13	Draft Risk Adjustment Letters	15-Nov-22
14	Deliver Final Rate Risk Adjustment Exhibits and Letters	21-Nov-22
15	Revise 2021 Rates to Correct for Directed Payment Distribution	15-Mar-23

Summary of Budget Neutral Rate Ranges

CMS has mandated that 'pass-thru' payment arrangements previously handled outside the capitated rate structure transition to a directed payment arrangement within the capitated rates in accordance with 42 CFR §438.6. Due to different contracting arrangements and claim volume between MCOs and providers, Guidehouse recognizes that actual payment dispersals may vary significantly between MCOs even for a given rate cell and region. Thus, the projected amounts to be paid out to the MCOs is expected to vary as well. In developing capitation rates, Guidehouse first develops 'core' rates by region and rate cell but without MCO-specific directed payment applications. These 'core' rates apply to each and every rate cell for all MCOs. More detail regarding Tennessee's directed payments is provided in Section 1.A.ii.(c).(v) of

this document.

The table below outlines the preliminary 'core' capitation rate ranges for Non-CHOICES rate cells without the directed payments allocations for the contract period January 1, 2022 through December 31, 2022.

Aid Category	Age Group	East		Middle		West	
		Minimum	Maximum	Minimum	Maximum	Minimum	Maximum
Medicaid (TANF & Related)							
	Age Under 1	$ 841.37	$ 877.41	$ 751.70	$ 784.75	$ 622.51	$ 650.85
	Age 1 - 13	$ 145.94	$ 155.15	$ 139.89	$ 148.59	$ 114.15	$ 121.39
	Age 14 - 20 Female	$ 236.87	$ 251.02	$ 229.85	$ 243.49	$ 204.82	$ 216.99
	Age 14 - 20 Male	$ 160.46	$ 170.20	$ 159.39	$ 168.98	$ 156.90	$ 166.24
	Age 21 - 44 Female	$ 334.39	$ 353.49	$ 340.03	$ 359.18	$ 295.92	$ 312.81
	Age 21 - 44 Male	$ 233.31	$ 246.52	$ 238.13	$ 251.64	$ 263.14	$ 277.38
	Age 45 - 64	$ 385.19	$ 407.24	$ 379.37	$ 400.80	$ 357.26	$ 377.66
	Age 65+*	$ 385.19	$ 407.24	$ 379.37	$ 400.80	$ 357.26	$ 377.66
Uninsured/Uninsurable**							
	Age Under 1	$ 841.37	$ 877.41	$ 751.70	$ 784.75	$ 622.51	$ 650.85
	Age 1 - 13	$ 145.94	$ 155.15	$ 139.89	$ 148.59	$ 114.15	$ 121.39
	Age 14 - 19 Female	$ 236.87	$ 251.02	$ 229.85	$ 243.49	$ 204.82	$ 216.99
	Age 14 - 19 Male	$ 160.46	$ 170.20	$ 159.39	$ 168.98	$ 156.90	$ 166.24
Disabled							
	Age <21	$ 1,734.55	$ 1,818.12	$ 1,576.46	$ 1,653.53	$ 1,559.64	$ 1,634.39
	Age 21+	$ 899.87	$ 946.15	$ 1,046.97	$ 1,100.02	$ 975.43	$ 1,026.06
Duals/Waiver Duals							
	All Ages	$ 166.48	$ 175.23	$ 213.38	$ 224.96	$ 188.75	$ 199.19

* Experience combined with Age 45 - 64 rate cell due to low volume

** Set equal to Medicaid (TANF & Related) rate due to low volume

The table below outlines the preliminary 'core' capitation rate ranges for CHOICES rate cells without the directed payments allocations for the contract period January 1, 2022 through December 31, 2022.

Aid Category	East		Middle		West	
	Minimum	Maximum	Minimum	Maximum	Minimum	Maximum
Duals CHOICES 1&2 Combined	$ 5,277.73	$ 5,454.50	$ 5,327.97	$ 5,505.57	$ 5,397.95	$ 5,577.13
Non-Duals CHOICES 1&2 Combined	$ 6,958.61	$ 7,211.05	$ 7,088.35	$ 7,344.80	$ 7,136.99	$ 7,393.73
Duals - CHOICES 3	$ 1,502.57	$ 1,536.61	$ 1,686.43	$ 1,726.21	$ 1,791.20	$ 1,833.61
Non-Duals - CHOICES 3	$ 3,950.53	$ 4,100.11	$ 4,114.24	$ 4,271.01	$ 4,037.59	$ 4,188.22

The table below outlines the 'core' capitation rate ranges for CoverKids rate cells for the contract period January 1, 2022 through December 31, 2022. Note that the existing directed payment arrangements that apply to the CHOICES and Non-CHOICES programs do not apply to the CoverKids program.

Aid Category	Age Group	Statewide* Minimum	Statewide* Maximum
CoverKids			
	Age 0-1	$ 431.98	$ 455.67
	Age 2-5	$ 106.55	$ 112.83
	Age 6-10	$ 87.66	$ 92.77
	Age 11-18 Male	$ 116.89	$ 123.78
	Age 11-18 Female	$ 149.54	$ 158.42
	Age Over 18 Male**	$ 116.89	$ 123.78
	Age Over 18 Female	$ 539.56	$ 569.56

* All CoverKids capitation rates set at the statewide level

** Experience combined with Age 11-18 Male rate cell due to low volume

The per member per month rate structure is split to recognize differences in cost by geographic region, TennCare eligibility groups, and age/gender. Note that for Non-CHOICES, the Uninsured / Uninsurable rate cells were rated jointly with the Medicaid (TANF & Related) rate cells due to a significant reduction in membership over the last several years. Also, the Medicaid Age 65+ rate cell is being rated jointly with the 'Age 45-64' rate cell due to decreased membership in the former.

Additionally, we note that the CoverKids rates are being developed at the statewide level as opposed to the regional level due to the low volume per rate cell. Lastly, the 'Age Over 18 Male' rate for the CoverKids population will be rated jointly with the 'Age 11 to 18 Male' rate as few males over 18 should be in the program.

In addition to the cost of health care services, all rates include an explicit administrative cost allowance and a provision for necessary taxes.

Limitations

The information contained in this document, including the enclosures, has been prepared for the Bureau of TennCare for inclusion in a request for proposal (RFP). The document demonstrates the preparation of preliminary actuarially sound capitation rate ranges for the State of Tennessee's Managed Medicaid Program and Children's Health Insurance Program (CHIP). It is our understanding that the information contained in this document may be utilized in a public document. To the extent that the information contained in the document is provided to third parties, the document should be distributed in its entirety. Any user of the data must possess a certain level of expertise in actuarial science and healthcare modeling so as not to misinterpret the data presented.

The information contained in this document was prepared as documentation for the preliminary CY22 Medicaid MCO actuarially sound capitation rate ranges for the State of Tennessee. The information may not be appropriate for any other purpose. Additionally, the rate ranges are developed in aggregate for the Medicaid and CHIP managed care program and may not be appropriate for any specific managed care organization. Each managed care organization should evaluate the rates in the context of their own experience, expenses, capital and surplus, and profit requirements prior to agreeing to contract with the

Bureau of TennCare.

Data Reliance

The information contained in this document was developed from data and information provided to Guidehouse by TennCare and the MCOs. Detailed data has been validated to financial records provided by the Bureau of TennCare. We did not audit the data, but we reviewed the data for reasonableness and consistency in addition to the financial record validation and determined that the data is appropriate and reasonable for purposes of the rate development. There are no concerns about the availability or quality of the data. To the extent the data, information or any guidance provided to Guidehouse was not complete, accurate, or consistent with the costs, design or structure of the program, the capitation rates presented in this document may require modification to ensure actuarial soundness.

Section I. Medicaid Managed Care Rates

The capitation rate ranges developed for this document are actuarially sound for the purposes of MCO procurement using published guidelines from the American Academy of Actuaries (AAA), the Actuarial Standards Board, the Centers for Medicare and Medicaid Services (CMS), and federal regulations to ensure compliance with generally accepted actuarial practices and regulatory requirements. Specifically, the following are referenced during the development of the managed care capitation rates:

- Actuarial standards of practices applicable to Medicaid managed care rate setting which have been enacted as of the capitation rate certification date, including:
    - ASOP 1: Introductory Actuarial Standard of Practice
    - ASOP 5: Incurred Health and Disability Claims
    - ASOP 12: Risk Classification (for All Practice Areas)
    - ASOP 23: Data Quality
    - ASOP 25: Credibility Procedures
    - ASOP 41: Actuarial Communications
    - ASOP 45: The Use of Health Status Based Risk Adjustment Methodologies
    - ASOP 49: Medicaid Managed Care Capitation Rate Development and Certification; and
- Section 1903(m) of the Social Security Act and Federal Regulation 42 CFR 438.6(c). The regulation requires that the capitation rates be actuarially sound, meaning that they are certified by an actuary that meets the standards set forth in 42 CFR 438.6(c), appropriate for the covered population and services, and have been developed in accordance with generally accepted actuarial practices and principles.

Throughout this document, the term “actuarially sound” will be defined consistent with the language in ASOP 49 as follows:

> “*Medicaid capitation rates are “actuarially sound” if, for business for which the certification is being prepared and for the period covered by the certification, projected capitation rates and other revenue sources provide for all reasonable, appropriate, and attainable costs. For purposes of this definition, other revenue sources include, but are not limited to, expected reinsurance and governmental stop-loss cash flows, governmental risk adjustment cash flows, and investment income. For purposes of this definition, costs include, but are not limited to, expected health benefits, health benefit settlement expenses, administrative expenses, the cost of capital, and government-mandated assessments, fees, and taxes*.”
>
> --ASOP 49: Section 2.1*

*(*http://www.actuarialstandardsboard.org/asops/medicaid-managed-care-capitation-rate-development-and-certification/*)*

1. General Information

A. Rate Development Standards

i. Annual Basis

The actuarially sound capitation rate ranges for Non-CHOICES, CHOICES, and CoverKids programs have been calculated to be effective for the 12-month rate period effective January 1, 2022 through December 31, 2022 (CY22).

ii. Required Elements for an Acceptable Rate Certification

(a) *Actuarial Certification*

An actuarial certification will be provided for the final capitation payments once they have been developed.

(c) *Program Information*

(i) Medicaid Managed Care Programs Covered in this Certification

Managed care plans

The State currently contracts with three managed care organizations (MCOs) to operate the capitated managed care program for the State's Non-CHOICES and CHOICES populations. Each MCO currently operates on a statewide basis. The three MCOs receive capitation payments from the State for providing health benefits to the covered population under the terms and conditions of the managed care contracts.

Historically, BlueCare has contracted with the State to provide benefits to the CHIP program under a fee-for-service (FFS) arrangement. However, beginning January 1, 2021 for CY21, the State contracted with BlueCare, Amerirgoup, and United Healthcare (the State's existing MCOs for the Non-CHOICES and CHOICES programs) to provide services for this population statewide. Under this arrangement, the three MCOs receive capitation payments from the State for managing health services for the covered population under the terms and conditions of the managed care contracts.

Covered benefits

The benefits covered in this program, and therefore included in the capitation rates, include comprehensive physical health services and behavioral health services. Pharmacy and dental services are carved out of the program and are paid on a FFS basis, and thus are excluded from rate development. The pharmacy costs are passed through the MCOs to the PBM using the following method:

- PBM bills MCO for drug costs of the MCO's members
- MCO bills TennCare for the costs as a pass-through
- TennCare pays the MCO through lump sum payments
- MCO passes the payments through to the PBM.

Please reference the RFP for additional information on pharmacy payments.

Our rate development methodology involves categorizing and projecting member experience by the

following service categories:

Physical Health

Data for physical health claims is received from the MCOs servicing each region and is mapped into four major service categories: Inpatient Hospital, Outpatient Hospital, Professional Services and Home Health.

Inpatient Hospital

Defined as admission data received in the standard UB92 format but does not include a grouped DRG. The data is formatted into admission episodes and run through the MS-DRG Grouper for all hospital admission claims.

The resulting DRGs are summarized and grouped into the following:

Major Category	MS-DRG
Medical	052-103, 121-125, 146-159, 175-208, 280-316, 368-395, 432-446, 533-566, 592-607, 637-645, 682-700, 722-730, 754-761, 776-782, 808-816, 831-833, 834-849, 862-872, 913-923, 933-935, 945-951, 963-965, 974-977, 998
Surgical	003-004, 011-013, 020-042, 113-117, 129-139, 163-168, 215-274, 326-358, 405-425, 453-520, 570-572, 573-585, 614-630, 653-675, 707-718, 734-750, 769-770, 799-804, 817-819, 820-830, 853-858, 901-909, 927-929, 939-941, 955-959, 969-970, 981-989
Maternity	765-766, 767-768, 774-775, 783-788, 796-798, 805-807
Newborn	789-793, 794-795
Other	001-002, 005-010, 014-017, 652-652, 876-876, 880-887, 894-897, 999

Outpatient Hospital

Outpatient Hospital procedures are prioritized for a claim based on the revenue codes included on the total claim record. A hierarchy is used to determine the main reason for the outpatient visit. Once determined, the data can be summarized appropriately.

Outpatient Category of Care Description	Main Reason for Visit	Revenue Codes Mapping	Hierarchy Ranking
ER	ER	450-459	1
Surgery	Surgery	360-369;490-499;790-799	2
Cardiac Cath	Surgery	481	3
Birthing Center	Other	720-722;724	4
Maternity-Non-delivery	Other	723; 729	5
Observation Unit-Bed	Other	760-769	6
Dialysis	Other	800-809;820-889	7
Outpatient Rehab	Other	420-449	8
Mental Health/Substance Abuse	Other	900-919;944-945	9
Therapeutic Radiology	Radiology	330-339	10
Nuclear Medicine	Radiology	340-349	12
MRI	Radiology	610-619	13
CT Scan	Radiology	350-359	14
Other Cardiology	Other	480;482-489	15
Diagnostic Radiology	Radiology	320-329	16
Other Imaging	Radiology	400-409	17
Laboratory/Pathology	Laboratory	310-312;314;318-319	18
Laboratory	Laboratory	300-307;309	19
Hospital Outpatient/Other	Other	Services not included elsewhere	20

If an outpatient claim lacks any revenue codes, procedure codes are also utilized to define some of the categories above, but they represent less than one tenth of one percent of the total claims submitted based on paid volume.

Home Health (Includes Private Duty Nursing) and Hospice

The Guidehouse data team developed the following criteria to identify Home Health and Hospice claims:

1. Home Health
   i. Any Claim Type of “Home Health” identified in the MCO data
   ii. Provider Primary Taxonomy Description for Home Health, Home Health Aide or Home Infusion;
   iii. Private Duty Nursing claims are identified by the following procedure codes: T1000-T1003, S9123-S9124 or revenue codes 550-559
2. Hospice claims are identified by any Claim Type for Hospice identified in the MCO data.

If one of the first three criteria is met, the claim is classified as a home health claim. If only the last criteria is met, the claim is classified as a hospice claim. For home health and hospice related claims that do not meet these parameters, their claims are mapped into either the ‘Professional - Other Medicine’ or ‘Outpatient Hospital – Other’ categories.

Professional

The final physical health service category, Professional services, includes all physical healthcare services not addressed above. Professional services primarily consist of physician services, but it also includes a variety of other miscellaneous services summarized in the table below.

Report Grouping	Service Category	HCPCS Code
Other	Anesthesia	00100 – 02020
Surgery	Surgery - Non-Maternity	10021 – 36414
Other	Venipuncture	36415 – 36415
Surgery	Surgery - Non-Maternity	36416 – 58999
Maternity	Surgery – Maternity – Non-Delivery	59000 – 59399
Maternity	Surgery - Maternity – Deliveries	59400 – 59410
Maternity	Surgery - Maternity – Non-Delivery	59411 – 59509
Maternity	Surgery - Maternity – Deliveries	59510 – 59515
Maternity	Surgery - Maternity – Non-Delivery	59516 – 59609
Maternity	Surgery - Maternity – Deliveries	59610 – 59622
Maternity	Surgery - Maternity – Non-Delivery	59623 – 59899
Surgery	Surgery - Non-Maternity	59900 – 69990
Radiology	Radiology	70010 – 79999
Lab	Pathology/Lab	80047 – 89399
Other	Immunizations/Injections/Infusions	90281 – 90799
Other	Psychiatry	90801 – 90911
Other	Miscellaneous	90912 – 90917
Other	Other Medicine	90918 – 91299
Other	Ophthalmology – Exams	92002 – 92014
Other	Ophthalmology – Services	92015 – 92499
Other	Other Medicine	92502 – 92599
Other	Cardiovascular	92950 – 93799
Other	Other Medicine	93875 – 94799
Other	Allergy Tests/Treatment	95004 – 95199
Other	Other Medicine	95250 – 95250
Other	Miscellaneous	95805 – 96149
Other	Other Medicine	96150 – 96155
Other	Chemotherapy	96400 – 96571
Other	Other Medicine	96900 – 96999
Other	Physical Medicine	97001 – 98943
Other	Other Medicine	99000 – 99099
Other	Anesthesia	99100 - 99140
Other	Other Medicine	99141 - 99199
Evaluation & Management	E&M - Office Visits	99201 – 99215
Evaluation & Management	E&M - Inpatient Visits	99217 – 99239
Evaluation & Management	E&M – Consultations	99241 – 99275
Evaluation & Management	E&M - Emergency Room/Critical Care	99281 – 99292
Evaluation & Management	E&M - Inpatient Visits	99295 – 99333
Evaluation & Management	E&M - Office Visits	99341 – 99350
Evaluation & Management	E&M – Miscellaneous	99354 – 99380
Evaluation & Management	E&M - Preventive Visits/Well Baby	99381 – 99387
Evaluation & Management	E&M - Preventive Visits/Well Baby	99391 – 99429
Evaluation & Management	E&M - Preventive Visits/Well Baby	99431 – 99436
Evaluation & Management	E&M – Miscellaneous	99440 – 99499
Ambulance/Transportation	Ambulance/Transportation	A0000 - A0999

Report Grouping	Service Category	HCPCS Code
Other	HCPCS	A1000 - A4205
Other	DME/Supplies	A4206 - A5200
Other	HCPCS	A5201 - A5499
Other	DME/Supplies	A5500 - A5513
Other	HCPCS	A5514 - A5999
Other	DME/Supplies	A6000 - A9999
Lab	Pathology/Lab	ATP02 - ATP22
Other	HCPCS	B0000 - B4033
Other	DME/Supplies	B4034 - B9999
Other	HCPCS	C0000 - C9999
Appliances/DME	DME/Supplies	E0000 - E9999
Other	Venipuncture	G0000 - G0001
Other	HCPCS	G0002 - G0007
Other	Immunizations/Injections/Infusions	G0008 - G0010
Other	HCPCS	G0011 - G0429
Other	Pathology/Lab	G0430 - G0435
Other	HCPCS	G0436 - G0629
Other	Pathology/Lab	G6030 - G6058
Other	HCPCS	G6059 - G9999
Other	HCPCS	H0000 - I9999
Other	Immunizations/Injections/Infusions	J0120 - J8499
Other	Chemotherapy	J8501 - J9999
Appliances/DME	DME/Supplies	K0000 - K9999
Appliances/DME	DME/Supplies	L0000 - L9999
Other	HCPCS	M0000 - V9999
Lab	Pathology/Lab	P2028 - P9615
Other	HCPCS	P9616 - R0069
Ambulance/Transportation	Ambulance/Transportation	R0070 - R0070
Radiology	Radiology	R0071 - R0074
Ambulance/Transportation	Ambulance/Transportation	R0075 - R0076
Other	HCPCS	R0077 - S0214
Ambulance/Transportation	Ambulance/Transportation	S0215 - S0215
Other	HCPCS	S0216 - S9974
Ambulance/Transportation	Ambulance/Transportation	S9975 - S9975
Other	HCPCS	S9976 - S9991
Ambulance/Transportation	Ambulance/Transportation	S9992 - S9992
Other	HCPCS	S9993 - T2000
Ambulance/Transportation	Ambulance/Transportation	T2001 - T2003
Other	HCPCS	T2004 - T2004
Ambulance/Transportation	Ambulance/Transportation	T2005 - T2005
Other	HCPCS	T2006 - T2006
Ambulance/Transportation	Ambulance/Transportation	T2007 - T2007
Other	HCPCS	T2008 - T2048
Ambulance/Transportation	Ambulance/Transportation	T2049 - T2049
Other	HCPCS	T2050 - V9999

Behavioral Health

Behavioral Health (BH) data is also received from the MCOs. Guidehouse's data team developed the following criteria to identify Behavioral Health claims:

1. Any Claim Type of "Mental Health" identified in the MCO data;
2. Provider Primary Taxonomy Description for Mental Health or Substance Abuse;
3. Revenue codes 114, 116, 124, 126, 134, 136, 144, 146, 154, 156 or 204 are included on the total claim record;
4. Revenue codes 513, 944, 945, 953, 961 or 900-919 and ICD10 diagnosis code F01-

F69 are included on the total claim record.

The claim is then categorized into the following subcategories:

BH Inpatient Hospital

Inpatient Behavioral Health services are identified by an "Inpatient" Claim Type identified in the MCO data.

BH Outpatient Hospital, In-Home Services, Supported Housing, 23-Hour, Intensive Outpatient, Partial Hospitalization and Transportation

Outpatient Behavioral Health services are prioritized for a claim based on the revenue codes or procedure codes included on the total claim record. A hierarchy is used to determine the main reason for the outpatient visit. Once determined, the data can be summarized appropriately.

Behavioral Health Outpatient Category of Care Description	Revenue Codes Mapping	Procedure Codes Mapping	Hierarchy Ranking
Partial Hospitalization	250, 251, 253, 904, 909, 911, 912	H0035	1
Intensive Outpatient	905, 906, 919	H0015, S9480	2
23-Hour	760-762	99219	3
Supported Housing	229, 1003	H0043, H0044	4
In-Home Services	902, 910	S9127, T1030 only or H0037, H2016 and place of service is "Home"	5
Crisis Services Team		H2011, S9484, S9485, T2034	6
Healthlink		S0280, G9003	7
Other Outpatient	Services not included elsewhere		8

Behavioral Health Transportation is typically partially subcontracted and the capitated amount paid is not linked to submitted claim data. The MCO non-system payment summaries are used to supplement the transportation claim amounts submitted in the claim data. For sub-capitated payments, the associated utilization is estimated based on the transportation services utilization from the claim data; however, this can result in non-credible utilization and unit cost estimates because the majority of the transportation expenditures are from the sub-capitated payments. The PMPM amounts are correct for these service categories, but the utilization and unit cost amounts should not be relied on for accuracy.

LTC Health Care

For CHOICES claims, LTC claim data was mapped into two major service categories: Nursing Home and Home and Community Based Services.

Determination of Units

Encounter records are classified into the detailed service categories discussed above. After grouping and categorizing the claims, the final stage links the eligibility data and further summarizes into the rate cells.

In this summarization process, unit counts are made for each service category. The following table details the types of units that are counted for each detailed service category. In the table, "Services" indicates the actual unit counts recorded on each claim. "Claims" refers to a count of "1" for each claim record in the

historical database. “Days” are used for inpatient units and represent the inpatient length of stay.

Categories used for Non-CHOICES and CoverKids Claims

Major Category	Units Counted
Physical Health	
Inpatient Hospital	Days
Outpatient Hospital*	Claims
Professional	Services
Home Health	Days
Hospice	Days
DME/Supplies	Claims
Transportation/Ambulance	Claims
Behavioral Health	
Inpatient Hospital	Days
Outpatient Hospital	Claims
Professional	Services

*Radiology and Laboratory Units Counted as Services

Categories used for CHOICES Claims

	Major Category	Units Counted
Acute Healthcare	Inpatient Hospital	Days
	Outpatient Hospital	Claims
	Professional	Services
	Home Health	Days
	Hospice	Days
	Mental Health	Combination Days, Claims, Services
Long Term Care	Nursing Home	Days
	HCBS	Services

For inpatient admissions that do not have room and board revenue codes detailed, the days are assumed to be the length of the admission. For other service categories, the numbers of units are assumed to be a minimum of 1. This is implemented to compensate for data anomalies.

The claim data is completed for incurred but not paid claims through actuarial completion factors developed by Guidehouse actuaries. The claim data is also supplemented with other data sources because some services are paid through other aggregated payment methods, such as capitation, and payment information for these services is not available from the claim data.

Covered areas and ages of program

The ‘Non-CHOICES’ and ‘CHOICES’ programs currently operate on a statewide basis and have been in operation for more than a decade. For these programs, the state is split into three regions to develop regional capitation rates for each rate cell. The three regions are East, West and Middle. Each region is made up of a mutually exclusive list of counties.

The CoverKids (CHIP) program was previously funded on a fee-for-service, statewide basis with

BlueCare acting as the State's third-party administrator (TPA) prior to January 1, 2021. The program transitioned to managed care beginning on January 1, 2021. Capitation rates will be set on a statewide basis under this arrangement (i.e., no regional differences in rates).

(ii) Covered Rating Period

The rating period covered by this actuarial report is January 1, 2022 through December 31, 2022.

(iii) Covered Populations

Non-CHOICES

The covered "Non-CHOICES" populations under this program include those eligible for TennCare Medicaid or TennCare Standard. TennCare Medicaid includes the traditional low-income Medicaid children and caregivers, disabled children and adults, and those eligible for both Medicaid and Medicare. TennCare Standard is a State specific eligibility group including children only. There are no differences in covered benefits between these two other than cost sharing.

CHOICES

Effective July 1, 2012, the Bureau of TennCare modified the Level of Care (LOC) criteria to determine medical eligibility for the CHOICES program. Applicants wishing to receive long term services and supports (LTSS) under Medicaid undergo a person-centered assessment and options counseling process, including a functional assessment (a Pre-Admission Evaluation or level of care application), to determine eligibility in one of three groups for TennCare CHOICES.

- CHOICES 1 is for individuals who meet the NF LOC and are receiving long-term Nursing Facility (NF) services.
- CHOICES 2 is for individuals who meet the NF LOC that are primarily receiving Home and Community-Based Services (HCBS) as an alternative to NF care.
- CHOICES 3 is for individuals enrolled after the implementation of the LOC change who do not meet the new NF LOC standard but who are "at risk" of institutionalization and are receiving a more moderate package of HCBS to delay or prevent the need for NF placement.

The TennCare CHOICES 1 & 2 rate structure are combined rate ranges designed to cover acute services – excluding retail pharmacy – and long term services and supports for all individuals who meet the NF LOC criteria and are receiving LTSS, including individuals residing in a NF (CHOICES 1) and those receiving HCBS (CHOICES 2).

The TennCare CHOICES 3 rate structure is designed to cover acute services (excluding retail pharmacy) and HCBS, limited to a $15,000 annual cap on HCBS which excludes any home modification services.

The per member per month capitation rates for CHOICES were developed by program type – CHOICES 1, 2 and 3 – further segmented by Medicare status – Dual and Non-Dual. The per member per month (PMPM) capitation rate ranges were developed for these categories to appropriately reflect the risk and service setting of the eligibility groups. The CHOICES 1 and 2 capitation rates are then blended based on an expected distribution of membership across service settings for the period (i.e., NF versus HCBS). The MCOs are paid based on the capitation rate cells shown on the following table within each region:

Aid Category	Duals Status
CHOICES 1 & 2	Duals
	Non-Duals
CHOICES 3	Duals
	Non-Duals

CoverKids

The covered CHIP population under this program includes the traditional low-income children and pregnant women, beyond those covered under traditional Medicaid.

(iv) Eligibility and Enrollment Criteria

TennCare Medicaid

TennCare Medicaid is available for both children and adults. There are many different eligibility groups under TennCare Medicaid. In general, the primary groups covered by TennCare Medicaid will include the following, though additional requirements relating to income, size of household, financial resources, etc. may apply:

- Children under age 21;
- Pregnant women;
- Single parents or caretakers of a minor child (the child must live with the covered adult and be a close relative);
- Two-parent families with a minor child living at home when one of the parents:
    - Has lost their job or had their work hours cut, or
    - Has a health or behavioral health problem expected to last at least 30 days;
- Women in need of treatment for breast or cervical cancer; and
- People who are receiving Supplemental Security Income.

Additionally, the following population is part of TennCare Medicaid, but is not an eligible class of members for the services provided under these capitation rates. Instead, their services are included under the CHOICES program. A person who:

- Lives in a nursing home and has income below $2,313 per month (as of 2019); or
- Receives other long-term care services paid by TennCare.

TennCare Standard

TennCare Standard is only available to children under age 19 who are already enrolled in TennCare Medicaid and:

- Who lack access to group health insurance through their parents' employer; or
- Their time of eligibility is ending, and they will no longer qualify for TennCare Medicaid.

The Department of Human Services (DHS) will determine if they qualify for TennCare Standard. There are two ways the members can qualify and keep their healthcare benefits: as 'Uninsured' or as Medically Eligible ('Uninsurable'). Both are defined below:

1. Uninsured

To qualify as uninsured:

- The child's eligibility through TennCare Medicaid must be ending;

- The child must be under the age of 19;
- The child must lack access to group health insurance through their own job or a parent's job; and
- The child's family income must be below 200 percent of the Federal Poverty Level.

If the family's income is above 200 percent of poverty, the child may qualify for TennCare Standard as Medically Eligible.

2. Medically Eligible ('Uninsurable')

To qualify as "medically eligible":

- The child must be under the age of 19;
- The child must have a health condition which makes the child "uninsurable", (or unable to access private health insurance because of his/her health condition); and
- The child must lack access to group health insurance through his/her job or a parent's job.

The per member per month capitation rates are developed by category of aid to appropriately reflect the risk of the eligibility groups. We also differentiated by age and gender. Specifically, the rates are developed for the following rate cells within each region.

Aid Category	Age Group
Medicaid (TANF & Related)	Age Under 1
	Age 1 – 13
	Age 14 - 20 Female
	Age 14 - 20 Male
	Age 21 - 44 Female
	Age 21 - 44 Male
	Age 45 – 64
	Age 65+
Uninsured/Uninsurable	Age Under 1
	Age 1 – 13
	Age 14 - 19 Female
	Age 14 – 19 Male
Disabled	Age <21
	Age 21+
Duals/Waiver Duals	All Ages

CHOICES

To qualify for and remain in CHOICES 1 and 2, members must:

- Need the level of care provided in a nursing home; and
- Qualify for Medicaid long-term services and supports.

To qualify for Medicaid long-term services and supports:

- the member income cannot be more than $2,205 per month;
- The total value of the member's possessions cannot be more than $2,000 (not including the member's home); and
- The member cannot have given away or sold anything for less than what it is worth in the last five (5) years.

To qualify for and remain in CHOICES 3, members must:

- Be "at risk" of needing the level of care provided in a nursing home unless you receive home care;

and
- Be receiving SSI (Supplemental Security Income) payments from the Social Security Administration.

CoverKids

Children are eligible for coverage if:

- They are under 19 years of age on the date of application;
- They are Tennessee residents;
- They are not eligible for or enrolled in TennCare;
- They are U.S. citizens or qualified non-citizens. (examples of documents to prove qualified alien status include Form I-551 or Form I-94); and
- Their household income is at or below 250% of federal poverty level (FPL).

Pregnant women qualify for this coverage if:

- They are Tennessee residents;
- They are not eligible for or enrolled in TennCare; and
- Their household income is at or below 250% of federal poverty level (FPL). For a family size of 2 that is $43,100 per year. For a family of four that is $65,500 per year.

(v) Special Contract Provisions

There are no special contract provisions included in the rate development for CY2022 other than the State's directed payments. CMS has mandated that 'pass-thru' payment arrangements previously handled outside the capitated rate structure transition to a State directed payment arrangement within capitated rates in accordance with 42 CFR §438.6. Due to different contracting arrangements and claim volumes between MCOs and providers, Guidehouse recognizes that actual payment dispersals may vary significantly between MCOs even for a given rate cell and region. Thus, the projected amounts to be paid out to the MCOs are expected to vary as well. In developing the preliminary capitated rate ranges for CY22, Guidehouse first developed 'core' rates by region and rate cell excluding the MCO-specific directed payment applications. These 'core' rates apply to every rate cell for all MCOs and are comparable to the capitation rates that have been developed in prior years.

As the MCOs have little control over the directed payment amounts, the State intends to mitigate MCO risk exposure. This involves adjusting the amounts paid out to each MCO when the rates are amended late in 2022 (and perhaps even after 2022) so that the difference between what the MCOs pay providers and the actual amount included in the rates is minimized.

The approved and applicable directed payment arrangements that the State expects to be incorporated into the Non-CHOICES and CHOICES rates during the CY22 contract period are as follows:

- Hospital Directed Payment: uniform percentage increase for hospitals, which applies to all inpatient and outpatient claims;
- Emergency Medical Services (EMS) Directed Payments: Uniform dollar increase for EMS services;
- Medication Therapy Management (MTM) Directed Payments: MTM minimum fee schedule;
- PCMH Activity and Practice Transformation Payments
- PCMH Outcome Payments: value-based purchasing model for PCMHs;

- Physician UPL Directed Payments;
- Health Link Outcome Payments.

The amounts associated with these directed payments in the CY21 contract period are as follows, showing the split between the Non-CHOICES and CHOICES programs:

Total CY2021 Directed Payment Amounts w/ Premium tax			
Directed Payment	**Non-CHOICES**	**CHOICES**	**Total**
Hospital	$ 632,203,950	$ 15,144,296	$ 647,348,245
PCMH Activity & Transformation	$ 29,204,952	$ 580,411	$ 29,785,363
EMS	$ 26,834,428	$ 1,503,456	$ 28,337,883
Physician UPL	$ 15,783,819	$ 317,963	$ 16,101,782
PCMH Outcome	$ 12,750,913	$ 241,786	$ 12,992,698
Health Link Outcome	$ 5,736,168	$ 112,981	$ 5,849,148
MTM	$ 1,100,143	$ 30,177	$ 1,130,320
Total	**$ 723,614,371**	**$ 17,931,069**	**$ 741,545,440**

Note that these amounts include provisions for the State's 6% premium tax.

(vi) Retroactive Rate Adjustments

Not applicable; this rate development documentation covers no retroactive rate adjustments for the rate period as several months' retroactive rate cell assignment adjustments have already been incorporated in the base data.

iii. Rate Differences

The resulting capitation rate differences between different rate cells are solely based on valid rate development standards and represent the expected underlying benefit and non-benefit cost differences among different rate cells. No rate difference is based on the rate of federal financial participation associated with the covered populations.

iv. Cross-Subsidization of Capitation Rates

Not applicable; no capitation rate is developed with the intent to cross-subsidize between different rate cells or between programs.

v. Rate Development Consistent with Timing of Program Changes

The assumptions used to develop the preliminary capitation rate ranges are consistent with the effective dates of changes to the Medicaid managed care program. Additional details are provided in the program change section.

vi. Minimum MLR Requirements

In accordance with CMS guidance, the preliminary capitation rate ranges have been developed so that the MCOs will reasonably achieve an MLR greater than 85% for each program.

There is no minimum Medical Loss Ratio in place, although we note that, for the CY21 rate-setting period, each of the CHOICES, Non-CHOICES, and CoverKids programs utilized a two-way risk corridor as a risk

mitigation strategy for both the MCOs and the State. The State will determine if the two-way risk corridor is appropriate for continued inclusion in the CY22 rate-setting period.

vii. Demonstration of Actuarially Sound Principles in Rate Development

(a) *Rate Adjustment Requirements*

All adjustments to the capitation rate ranges, or to any portion of the capitation rate ranges, are developed to reflect reasonable, appropriate, and attainable costs in the actuary's judgement. All rate adjustments are included in the actuarial certification.

(b) *Rate Adjustments Outside the Rate Setting Process*

The rate setting process includes all known rate adjustments. Any additional appropriate adjustments related to further program changes during CY22 will be incorporated into a set of amended rates in a separate document.

(c) *Contracted Rates Match Certified Rate*

Consistent with 42 CFR §438.7(c), the final contracted rates for each cell before the incorporation of MCO-specific directed payments will match the capitation rates without directed payments in the final certifications.

viii. Rates Effective for the Entire Rating Period

The rate certification will pertain to the entire 12-month rating period.

ix. Rate and Contract Amendments

The final CY22 certifications will be for new rates effective during the contract period (CY22). Any future program changes for CY22 will then be submitted as a separate rate amendment letter document outside that rate certification.

B. Appropriate Documentation

i. Documentation

This report includes supporting documentation for all data, assumptions, and methods used in the development of the preliminary capitation rate ranges.

ii. The Use of Rate Ranges in Rate-Setting

The preliminary rate ranges developed in this report were developed by allowing ranges of potentially appropriate assumptions. However, for the actual CY22 contracting period, capitation rates will be specified and certified, as opposed to rate ranges.

iii. Index

The report is structured to follow the documentation requirement as specified in the 2020-2021 Medicaid Managed Care Rate Development Guide. The table of contents is the index to this report. It specifies the section number and page number for all required items described in the rate development guide. The sections that are not relevant for this rate document are noted as “Not applicable” in the report.

iv. Rates for which the State Receives a Different FMAP

The State FMAP applies to Non-CHOICES and CHOICES rate ranges included in this rate document. For the CoverKids population, the State receives a different FMAP than the regular state FMAP. However, this enhanced FMAP applies to the whole CoverKids population and their services.

v. Previous Rating Periods

(a) *Comparison to Prior Final Certified Rates*

Each year, capitation rates are compared against the prior year rates as part of the certification documentation.

(b) *Rate Development Information*

Information related to rate development is included in the relevant sections of rate certification. The index specifies where such information may be found within the rate certification.

vi. Known Amendments

The CY22 rates will incorporate all known, approved program changes at the time of certification. However, to the extent that additional program changes are made after the writing of the certification, amendments will be submitted for CMS approval.

2. Data

A. Rate Development Standards

i. Data Standards for Rate Development

(a) *Data Provided by the State*

The state provided validated MCO data (including detailed claim data, enrollment data, and other financial data) and FFS data (for CHIP) to Guidehouse for the development of CY22 capitation rates. This data included persons covered and claims incurred or paid during the period January 2017 through March 2020.

(b) *Base Data Selected*

The most recent two years (CY18 and CY19) of validated MCO data were used as the base data for the development of the preliminary CY22 rate ranges. More specifically, the most recent two years (CY18 and CY19) of detailed MCO claim data and FFS claim data (for CHIP) along with enrollment data were the primary data sources used for the rate ranges shown in this document. The detailed claim data contains claim line level details such as medical procedure codes, diagnosis codes, and member Medicaid IDs. The detailed enrollment data contains the rate cell assignment for each member in each month.

The most recent two years (CY18 and CY19) of MCO non-system payments, MCO MLR reports, and MCO audited financial statements were used to supplement the base data for payments made outside the claim system.

The most recent two years (CY18 and CY19) of MCO MLR reports and MCO audited financial statements were used as the primary data source for the base administrative data.

Consistent with prior rate-setting periods, 100% credibility was given to CY19, the most recent base period, meaning CY18 was only used for comparative purposes.

We note that, in the absence of extraordinary circumstances, the base data would be refreshed, meaning that the CY22 rates would normally rely on completed CY20 data instead of CY19 as listed above. However, due to inconsistent utilization patterns during CY20 related to the COVID-19 pandemic, the actuaries may use refreshed CY19 data to develop the CY22 rates.

(c) *Base Data Origin*

Base data was derived from the experience of the Medicaid population covered in the prior contract periods and represents the population to be covered in the new contract period.

For CHIP, base data was derived from the experience of the population covered in the prior contract periods by the State's TPA and represents the population to be covered in the new contract period.

(d) *Deviation from Using Medicaid Base Data*

Not applicable; there is no deviation from the base data standard. All base data used for CY22 rate development is no older than from the four most recent and complete years prior to the rating period.

B.Appropriate Documentation

i. Data Requested and Received

The State provides all data requested by Guidehouse. For the purpose of this preliminary CY22 rate range development, we requested and received the following data from the Bureau of TennCare:

- Detailed MCO claim data, including home health, inpatient hospital, outpatient hospital, professional, and mental health claim data with dates of service from January 1, 2016 through December 31, 2019, paid through March 31, 2020;
- Detailed FFS claim data for CHIP, including home health, federally qualified health center (FQHC), inpatient hospital, outpatient hospital, professional, and mental health claim data with dates of service from January 1, 2018 through December 31, 2019, paid through May 31, 2020;
- Summarized claim and eligibility data from the State's TPA (BlueCare of Tennessee);
- Detailed eligibility data for the MCO enrollees from January 1, 2017 through June 30, 2020, including all applicable retroactive rate cell adjustments;
- Summaries of aggregated MCO non-system payments, such as sub-capitated expenses, incurred for the period January 1, 2016 through December 31, 2019, paid through March 31, 2020;
- MCO MLR reports for the most recent three years: January 2017 through March 2020. The MLR reports include summarized claim expenditures as well as sub-capitated medical service payments, lump sum payments and administrative costs; and
- MCO-audited financial statements for the most recent three years: CY17-CY19.

Additionally, Guidehouse received high-level enrollment projections for both CHOICES and Non-CHOICES members from the State of Tennessee that reflect anticipated retroactive adjustments, through December 2020. This supplemental information assists with the calculation of the impact of reverification efforts on eligibility and cost per member per month (PMPM).

It is expected that, for the development of the final CY22 rates, an additional year of all the data above will be provided over the course of the rate development period.

ii. Data Description

(a) *Rate Certification Requirements*

(i) Types of Data

As described in Section I, item 2Bi above, the data used includes health plan detailed claim data from the MCOs, health plan enrollment data, and health plan financial data. FFS data was used to the extent necessary for the CHIP population.

(ii) Data Age or Time Period

As described in Section I, item 2Bi above, the data used includes the incurred dates from January 1, 2016 through December 31, 2019 for health plan claim and enrollment data. The health plan financial data are provided on an annual basis for the most recent three calendar years: 2017, 2018, and 2019.

(iii) Data Sources

The health plan detailed claim data and enrollment data were extracted from the State's claim system. The health plan annual MLR data was self-reported by the three plans using the templates designed by Guidehouse. The MLR data was compared against audited financial statements (e.g. NAIC statements), downloaded by Guidehouse from the NAIC website. Guidehouse compared the data between the two sources for reasonableness.

BlueCare of Tennessee, as the State's TPA, provided CoverKids claim data. The summarized claim and eligibility data were compared against encounters and supplemental data for accuracy. Guidehouse compared the data between the two sources for reasonableness.

(iv) Data for sub-capitated arrangements

As reported in the MCO MLR reports, several sub-capitated arrangements were used by the plans during the base periods. The aforementioned claim data provided by the MCOs did not contain sufficient detail regarding costs associated with subcontracted arrangements, thus a separate detailed data extract was collected from the MCOs. In addition to sub-capitated arrangements paid outside the claim system, the MCO MLR reports also reported other lump-sum payments outside the claim system. We refer to these aggregate payments collectively as "non-system payments". The total non-system payments accounted for 3.2% of total completed claim payments for the entire Non-CHOICES program. Due to this low volume, of which the sub-capitated arrangements only form a portion, we would not consider the cost from sub-capitated arrangements to be significant. In accordance with the CMS' bulletin from May 15, 2015, the MCO reported costs under sub-capitated arrangements excluded appropriate administrative costs.

For CHIP, there were no sub-capitated arrangements included in the base period according to the State's TPA. There were, however, episode of care payments included in the base period. The expenses associated with this alternative payment arrangement made up less the 0.1% of the base period used for CY22 rate development.

The total amounts of non-system payments added into the Non-CHOICES CY22 rates are shown below:

		CY2019			
Databook Service Category	Non Claims System Payments	East Region	Middle Region	West Region	Total
OP - Other	Care management and 'Pay for Performance' provider bonuses	$ 498,291	$ 640,821	$ 422,800	$ 1,561,912
Prof - Evaluation & Management	Provider capitation and performance payments	$ 253,121	$ 609,219	$ 7,215,670	$ 8,078,010
Prof - Transportation	Non Emergency Transportation capitation for physical health services	$ 24,062,043	$ 26,252,503	$ 20,762,861	$ 71,077,407
Prof - Other	Vision capitation and payments, Chiropractic capitation	$ 4,583,877	$ 5,724,390	$ 4,264,305	$ 14,572,572
MH - Outpatient	CMHA capitation, CMHA settlements, Mobile Crisis/Crisis Respite payments	$ 3,313,698	$ 6,230,625	$ 2,460,839	$ 12,005,162
MH - Grants	Grant Payments	$ 642,346	$ -	$ -	$ 642,346
MH - Transportation	Non Emergency Transportation capitation for behavioral services	$ 2,601,376	$ 3,288,114	$ 1,575,261	$ 7,464,751
Total		**$ 35,954,751**	**$ 42,745,672**	**$ 36,701,737**	**$ 115,402,160**

The total amounts of non-system payments added into the CHOICES CY22 rates are shown below:

Region	Service Category	January 2018 - December 2018	January 2019 - December 2019
East Region	Mental Health	$ 49,556	$ 46,216
	Professional	$ 1,210,109	$ 1,210,350
	Nursing Home	$ 21,869,741	$ -
	Total	**$ 23,129,406**	**$ 1,256,566**
Middle Region	Mental Health	$ 70,664	$ 67,578
	Professional	$ 1,288,695	$ 1,317,045
	Nursing Home	$ 20,068,521	$ -
	Total	**$ 21,427,881**	**$ 1,384,623**
West Region	Mental Health	$ 33,686	$ 31,318
	Professional	$ 890,786	$ 901,440
	Nursing Home	$ 14,722,395	$ -
	Total	**$ 15,646,867**	**$ 932,758**
Statewide	Mental Health	$ 153,906	$ 145,112
	Professional	$ 3,389,590	$ 3,428,835
	Nursing Home	$ 56,660,658	$ -
	Total	**$ 60,204,153**	**$ 3,573,947**

Note that the Nursing Home amounts include the Nursing Facility Acuity & Quality payments, which transitioned into the 'per diem' amounts in the base data starting July 1, 2018. This means that the 2018 amounts should be roughly half what the 2017 amounts are, and that the above is appropriate.

The total amounts of non-system payments added into the CoverKids CY22 rates are shown below:

	Calendar Year 2019							
	CoverKids							
Service Category	Age Under 2	Age 2 - 5	Age 6 - 10	Age 11 - 18 Female	Age 11 - 18 Male	Age 18+ Male	Age 18+ Female	All CHIP
IP - Other	$ 1,235	$ 4,822	$ 8,113	$ 6,552	$ 6,575	$ 154	$ 4,396	$ 31,848
Total	**$ 1,235**	**$ 4,822**	**$ 8,113**	**$ 6,552**	**$ 6,575**	**$ 154**	**$ 4,396**	**$ 31,848**

We reviewed these non-system payments for reasonableness and reporting consistency over the data periods but relied on MCOs for accuracy. Any non-system payment paid for non-state plan services or for the administrative component of the provision of state plan services were removed from inclusion into the base claim data. Additionally, the non-system payments representing the state plan services were allocated to the applicable regions, rate cells, and service by the MCOs, consistent with last year's rate development.

(b) *Data Availability and Quality*

(i) Data Validation

Data completeness

For state provided detailed claim data, we reviewed the data to ensure that we had all needed data elements including plan name, region, rate cell, diagnosis codes, procedure codes, provider IDs, member IDs, paid amounts, paid units, incurred dates, paid dates, etc. The data was also reviewed to ensure that the data fields are populated as expected.

For state provided enrollment data, we reviewed the data to ensure that the data included all requested fields including plan name, region, rate cell, eligibility code, first eligibility date, last eligibility date, and eligible days for each consecutive eligibility span, etc. The data was also reviewed to ensure that the data fields are populated as expected.

For MCO reported MLR data, we reviewed the data to ensure that the plans completed the templates as instructed so we would have reported non-system payments and administrative expenditures with requested breakouts in addition to the payments paid inside the claim system.

The review process is an iterative process with several rounds of questions and answers among the State, Guidehouse, and the health plan teams. With all completeness issues resolved, the data is considered to be complete for the purpose of rate development.

Data accuracy

The State has a high level of confidence in the MCO claim data based on its ongoing review to validate the monthly invoice files (detail paid claim data) against the MCO check registers and the MLR reports submitted each month to check for accuracy. In addition, Guidehouse performed the following steps to validate the data for accuracy to the extent practical:

- The member IDs and the dates of service on the claims are matched up with the eligibility file. If any claim included on the MCO claim files did not have a matching eligibility record for the corresponding date of service, the claim was not included in the base period.
- The detailed claim and enrollment data were used to calculate PMPM paid amounts split by major service category and by incurred month and by plan. The calculated monthly PMPMs were then reviewed to identify any unexpected value in any month or unusual patterns over the base periods and unexpected variances among the participating plans. Any identified issues were further investigated through a more detailed claim data review until fully resolved or explained.
- Each plan's reported administrative costs and total claim payment were compared to the amounts reported in its own audited financial statements for overall accuracy, recognizing that a certain level of variance is expected due to the use of different run-out periods between the two reports for the same incurred year.

Note that no explicit adjustment was made to the base data for fraud, waste and abuse recoveries since such recoveries, if any, are expected already to be reflected in the MCO claim data. Additionally, sanctions and liquidated damages are handled outside of the capitation rates and so are not considered in any part of the rate-setting process, including the base data and data used for trend, etc.

Data consistency

The data was reviewed for consistency by plan between different data sources: detailed claim data, aggregate monthly MLR submissions, and audited financial statements. Variances between these

sources was within appropriate levels and consistent with prior rating periods.

Guidehouse also evaluated the consistency of the data between the CoverKids populations and the TANF populations. The resulting comparison indicated that the encounter data included the appropriate level of detail for purposes of 2021 rate development.

(ii) Actuary's Assessment of the Data

Based on our data review and validation for the data completeness, accuracy, and consistency, we find the data used to develop the CY22 capitation rate ranges to be of appropriate quality, suitable for developing actuarially sound rates.

For CHIP, the actuaries at Guidehouse determined it was appropriate to make several data enhancement via data blending and true-up factors as cited above. After reviewing the resulting data for completeness, accuracy, and consistency, we find the data used to develop the CY22 capitation rate ranges to be of appropriate quality and suitable for developing actuarially sound rates.

(iii) Data Concerns

We have not identified any material concerns on the availability and quality of the data for the Non-CHOICES and CHOICES programs.

For CoverKids, although the claim files appear to be complete in the sense that no fields or portions of member costs are omitted, there remains a concern that the detailed claim files are missing members. With no other data to reconcile to other than the TPA's high level summary, we will monitor managed care experience as it becomes available.

(c) *Actuary's Determination of Data Appropriateness*

As in prior years, a combination of MCO detailed claim and enrollment data and MLR data are used as the primary data sources for CY22 rate range development. Given that the data has been deemed to be complete, accurate, and consistent and reflects the managed care plans' recent experience in providing the covered services to the covered populations under the State's managed care program, we determined the data to be appropriate and suitable for rate development.

For CoverKids, a portion of the encounter data was determined to be insufficiently consistent with TPA data submissions. We relied on TPA claim and eligibility data for that portion instead. With those enhancements, we consider the resulting data set to be appropriate for CY22 rate development. We will continue to work towards validating and reconciling the encounter data so that it can be the primary data source for future rate setting periods.

(d) *Reliance or Use of Data Book*

There is no reliance or use of an external data book for the development of these preliminary rate ranges.

iii. Data Adjustments

(a) *Credibility Adjustments*

The base data used to develop CY22 capitation rates for the program is fully credible for most rate cells. However, the Uninsured/Uninsurable rate cells have experienced significant decreases in enrollment during and after the recommencement of reverification. Our analysis suggests that many members who

would have been classified as Uninsured / Uninsurable are now being classified into the corresponding Medicaid (TANF & Related) rate cells. The decreasing enrollment coupled with the fact that there is no difference in benefits or cost sharing between the groups warrants rating the corresponding age groups jointly to add credibility. The experience for each of the 'Uninsured / Uninsurable' rate cells was incorporated into the experience for the corresponding Medicaid (TANF & Related) rate cells and the rates for both groups were determined jointly based on the similarities of the risk profiles and medical service needs between the two categories.

In addition, a comparison of annual regional data over the last several years indicated a high level of volatility in the Non-CHOICES Medicaid Age over 65 rate cell. As a result, the capitation rate for this rate cell is now being set with the Non-CHOICES Medicaid Age 45-64 rate cell.

For the CoverKids program, Guidehouse determined that the level of exposure attained by the M5M rate cell (Males 19 and older) is insufficient for the purposes of rate development. As a result, the CHIP males age 19 and older rate cell has been combined with the CHIP males age 11 and older rate cell. Males age 19 and older are not specifically eligible for the CHIP program, so we expect the capitation rates for this population to continue to be developed jointly with the Males 11-18 rate cell (M4M).

No credibility adjustment was made for other rate cells.

(b) *Completion Adjustments*

The incurred but not paid (IBNP) claims as of March 31, 2020 for the incurred base period January 1, 2018 to December 31, 2019 were estimated using IBNP models from Guidehouse actuaries and combined with the most recent 4-year period of TennCare specific payment pattern which includes the historical payment data for claims incurred and paid from April 1, 2016 through March 31, 2020. The detailed completion factors were developed by major service and aid categories as shown in Exhibit 2. With three months of payment run-out, the factors are relatively small.

For CoverKids, the incurred but not paid (IBNP) claims as of May 31, 2020 for the incurred base period January 1, 2019 to December 31, 2019 were estimated using IBNP models from Guidehouse's actuaries and the most recent 1-year period of TennCare specific payment pattern which includes the historical payment data for claims incurred and paid from January 1, 2019 through May 31, 2020. The detailed completion factors were developed by major service categories as shown in Exhibit 3. With five months of payment run-out, the factors are relatively small.

However, based on additional validation against TPA financial reports, it was determined that, in addition to the completion factors, the claim data needed to be increased via an underreporting factor. In aggregate, claims were increased 1.2% and enrollment data was increased 0.2% to match summarized supplemental reports from BlueCare.

(c) *Data Errors Found*

No errors were found having a material impact on the base data.

(d) *Program Change Adjustments*

Adjustments were made to account for the retrospective and prospective TennCare MCO programmatic changes effective January 1, 2019 or later. The adjustments were derived by applying the benefit and provider reimbursement changes against the actual claims incurred for members from January 1, 2019 through December 31, 2019. The adjustments were applied at the rate cell level for each affected service

category. All applicable known program and contract changes since the prior actuarial certification are reflected in this certification and in the certified rates herein.

Effective July 1, 2016 (and ongoing):

- Per 42 CFR § 435.916, all Medicaid agencies are required to verify members' eligibility on at least an annual basis. However, reverification efforts have been inconsistent in Tennessee since January 2014, which can directly affect the relative acuity of a Medicaid population. More recently, reverification efforts have been suspended in Tennessee for reasons related to the COVID-19 pandemic. No adjustment has been calculated for these preliminary CY22 rate ranges, but adjustments have been used in the past for the Non-CHOICES program to at least partially account for acuity changes related to reverification efforts. It is our expectation that adjustments will be needed for the final CY22 rates once more information is known with regards to the intended levels of reverification and the acuity of the populations. However, the preliminary capitation rate ranges shown in this document have not been adjusted to account for acuity differences due to changing reverification efforts.

Effective March 2020:

- Changes in healthcare utilization patterns as a result of the COVID-19 pandemic are expected to continue through the CY22 contract period. However, due to the unknown nature of these impacts, the actuaries have not adjusted the base data for these preliminary rate ranges. Instead, the actuaries will develop rate adjustments to account for these impacts later in the year with ongoing experience and feedback from the MCOs.

Effective January 1, 2021:

- The actuaries expect that a portion of the increase in telehealth services due to the pandemic will persist in the long-term, resulting in overall rate decreases in some areas as some office visits and other current utilization shifts to telehealth.

(e) *Payment or Service Exclusions from the Data*

Not applicable; the program does not allow the MCOs to offer any enhanced benefits. Therefore, there is no exclusion of payments and services from the detailed claim data provided by the State for value-added services. There were some claims found in the data where the member IDs in the claim file did not match the eligibility file. Such claims were excluded from the base data. No other exclusions were made to the base data

3. Projected Benefit Costs and Trends

A. Rate Development Standards

i. Rates Based on Allowed Services Only

The preliminary rate ranges are based only upon contracted services covered under the State Plan and the State's 1115 and 1915(b) waivers and so are based solely upon the services allowed in 42 CFR§438.3(c)(1)(ii) and 438.3(e). Pharmacy and dental services are carved out from the program and are thus not included in these rate ranges. Additionally, the TennCare program does not allow the MCOs to offer any enhanced benefits so no value-added services were included in the rate ranges. Please note that the allowed services do include in-lieu-of services as cost-effective alternative services that MCOs may provide without obtaining prior approval from TennCare.

ii. Assumption Variation Not Based on FMAP Variation

No variation in assumptions across covered populations is based on the variation of rate of federal financial participation associated with the covered populations.

iii. Trend Assumptions Based on Actual Experience

Consistent with 42 CFR §438.5(d), projected benefit cost trend assumptions are reasonable and developed in accordance with generally accepted actuarial principles and practices.

The benefit cost trend assumptions were primarily developed based on the last four years of actual experience of the covered populations. Other factors considered in the trend assumptions are prospective trend inputs provided by the MCOs, Medicaid trends used in other states for similar populations, and CMS projected 10-year trends for Medicaid programs at the national level. Please note that the trends excluded the impact of incremental care management savings to be achieved in the contract period and program changes, which are estimated and applied to the rate ranges explicitly under managed care savings assumptions and program change adjustment assumptions.

For the CoverKids population, due to a lack of reliable historical claim data, the benefit cost trend assumptions were primarily developed based on the last four years of actual experience of the covered populations in the State's Medicaid Temporary Assistance for Needy Families (TANF) program. More specifically, Guidehouse actuaries leveraged the historical experience from the children in the TANF program, including pregnant women in order to isolate a comparable population in terms of costs. Other factors considered in the trend assumptions are CHIP trends used in other states for similar populations and CMS projected 10-year trends for Medicaid and CHIP programs at the national level. Please note that the trends excluded the impact of incremental care management savings to be achieved in the contract period and program changes, which are estimated and applied to the rates explicitly under managed care savings assumptions and program change adjustment assumptions.

iv. Consideration of In-Lieu-of Services in Cost Projections

In-lieu-of services are included as other covered state plan services in the base data used for trend development. There is no separate and standalone trend development for in-lieu-of services in the cost

projection.

v. Inclusion of Short-Term IMD Stay in Cost Projections

The TennCare program does include the short-term IMD stay as an allowable in-lieu-of service in the rates. However, per CMS guidance, the CY22 rates will use unit costs associated with providers delivering the same services as opposed to the unit costs of IMD services.

However, note that no adjustment to the data is made to exclude IMD stays over 15 days as these are not allowed by the State.

B.Appropriate Documentation

i. Summary of Projected Benefit Costs

Exhibits 1a-1d provide the projected benefit costs by region, rate cell, and service category.

ii. Development of Projected Benefit Costs

(a) *Data, Assumptions, and Methodologies*

Data Used

The primary data source used to develop CY22 capitation rate ranges is the historical detailed MCO claim data and TPA claim data (CHIP) along with encounter data from CY19 with a supplement of non-system payment data from CY19 as reported in the MCOs' summarized MLR. Please note that four years of historical data was used to develop experience-based trends, but the most recent year of historical data was used as base benefit costs for projection to the contract period. However, credible historical data for the CoverKids population was not available. As a result, we relied on trends by service category for TANF children (in the Non-CHOICES program). Four years of historical data from TANF children was used to develop experience-based trends, while 17 months of CoverKids specific data were used for developing IBNP factors.

Assumptions

In the development of projected benefit costs, we applied four types of explicit assumptions to the base benefit costs: trend factors, managed care savings factors, benefit/program change factors, and population acuity adjustments.

The trend factors were developed to vary by major service category and by major aid category. They represent the ongoing utilization and unit cost trends for the covered population with no consideration for new managed care savings initiatives and new program changes to be effective beyond the base period.

The managed care savings factors were developed to vary by major service category and by major aid category. They represent the impact of new managed care savings activities the State expects to be performed by the MCOs beyond the base period.

The benefit/program change factors were developed to vary by region, major service category, and rate cell. They represent the rate impact of the State initiated program changes and benefit changes beyond

the base period.

The population acuity adjustments (referred to as reverification adjustments in Section I.2.b.iii.(d)) were developed to vary by rate cell and applied to all service categories. They represent the overall risk profile change at the rate-cell level due to the ongoing eligibility reverification efforts. Although reverification efforts have recommenced, they are not expected to be significant between the base period and the projected period. As a result, average enrollment is expected to increase from the base period to the projection period.

Methodologies

For trend development, regression analysis was used to analyze the most recent 48 months of completed experience data by major service category and aid category. The regressed trends were then reviewed for statistical significances and benchmarked with MCO provided trends and CMS reported national Medicaid specific trends for reasonableness. Actuarial judgement was used to determine the final trends for service categories with unexpected regressed trends.

For Non-CHOICES managed care savings factors, comparative analysis was performed at the major service category level among the three participating plans after normalization for region and rate cell mix differences. Such analysis helped to inform additional managed care savings opportunities that the MCOs are expected to materialize. Additionally, MCOs reported new managed care activities and initiatives to implement in the contract period along with savings estimates for these activities. The final savings factors were determined based on a combined consideration of Guidehouse's data analysis and MCOs' reported savings estimates.

However, considering the maturity of the CHOICES program as well as the limited potential to affect the majority of the costs for members requiring LTSS, no managed care savings were incorporated into the CHOICES rates.

For CoverKids, Guidehouse examined the PMPM cost relativities in other states between CHIP and TANF children populations. Guidehouse then compared TennCare's CHIP and TANF PMPM and unit cost relativities between programs. The results indicated that, due to the efficiencies that already exist within the program and potential relative inefficiencies that could ensue from new managed care organizations being introduced to the program, no managed care savings factors were needed for the development of the preliminary CY22 CHIP rate ranges.

For applicable benefit and program change factors, Guidehouse estimated the impacts at both the rate cell and service category level by applying the benefit changes to the base data at claim level. Essentially, Guidehouse re-priced all base claims using the proposed provider reimbursement rate changes and benefit utilization changes and then compared the repriced amounts to the base amounts for the impact.

(b) *Material Changes from Prior Certification*

There are no material changes to the data and methodologies used to develop this year's trends, manage care savings factors, and benefit/program change factors.

iii. Benefit Cost Trends

(a) *Required Elements*

(i) Data and Assumptions Used for Trend Development

Description of data and assumptions

The primary data source used for benefit cost trend development is the detailed MCO claim data. The data was completed for IBNP and converted into monthly PMPM cost summaries on an incurred basis by major service category and population groups (TANF/Uninsured, Disabled, and Duals) before being used for trend analysis.

Trend based on actual experience or other data

The data used for trend development is derived from all three health plans' combined actual experience for the covered Medicaid population and covered services under the TennCare program.

(ii) Trend Development Methodologies

The trend was developed primarily using a regression method based on the most recent 48 months of calculated monthly service utilization and unit cost PMPMs with a split between the TANF, Disabled, and Duals groups. The regressed trends were then reviewed for statistical significance and reasonableness alongside trend expectations submitted by the MCOs and other sources and adjusted to reflect the certifying actuaries' best estimates of future trend.

(iii) Comparison Used in Analysis

The following charts show the PMPM trend incorporated into the rate ranges by major service category and by major population group.

Non-CHOICES

		Trend Rates	
Aid Category	**Service Category**	**Minimum**	**Maximum**
TANF / Uninsured	Home Health	4.5%	5.5%
TANF / Uninsured	Hospice	0.0%	1.0%
TANF / Uninsured	Inpatient	1.8%	2.8%
TANF / Uninsured	Outpatient	1.0%	3.0%
TANF / Uninsured	Professional	1.0%	3.0%
TANF / Uninsured	Professional - Other	1.0%	3.0%
TANF / Uninsured	Mental Health	2.8%	4.8%
Disabled	Home Health	5.5%	6.5%
Disabled	Hospice	5.5%	6.5%
Disabled	Inpatient	1.3%	2.3%
Disabled	Outpatient	0.8%	2.8%
Disabled	Professional	1.3%	3.3%
Disabled	Professional - Other	1.3%	3.3%
Disabled	Mental Health	3.5%	5.5%
Duals	Home Health	0.0%	1.0%
Duals	Hospice	6.5%	7.5%
Duals	Inpatient	0.0%	1.0%
Duals	Outpatient	6.0%	8.0%
Duals	Professional	3.0%	5.0%
Duals	Professional - Other	3.0%	5.0%
Duals	Mental Health	0.0%	2.0%

CHOICES

Service Category	Trend Rates	
	Minimum	Maximum
Home Health Care	0.00%	1.00%
Inpatient	2.25%	3.25%
Outpatient	0.75%	2.75%
Professional	3.50%	5.50%
Mental Health	5.00%	7.00%
Nursing Home	2.25%	3.50%
HCBS	3.50%	4.50%

CoverKids

Aid Category	Service Category	Trend Rates	
		Minimum	Maximum
CoverKids	FQHC	0.5%	2.5%
CoverKids	Home Health	4.5%	7.0%
CoverKids	Inpatient	0.0%	1.5%
CoverKids	Outpatient	0.5%	2.5%
CoverKids	Professional	0.5%	2.5%
CoverKids	Mental Health	0.0%	2.0%

(b) *Benefit cost trend components*

(i) Trend Components

The projected benefit cost trends were separated into utilization trend and unit cost trend. Each trend component was developed based on its own component of historical trend experience.

(ii) Explanation for Not Separating Utilization from Unit Cost for Trend Development

Not applicable; both utilization and unit cost trends were analyzed.

(iii) Other Trend Components Included

Not applicable; no other trend components were included. Trends were developed on a statewide basis and no regional variation was analyzed for trend. Additionally, the impact of incremental managed care savings and program changes are accounted for separately through their own assumptions.

(c) *Explanation for Variations in Cost Trends*

(i) Medicaid Populations

The underlying trend drivers vary between TANF/Uninsured, Disabled, and Duals populations due to the use of different mixes of services for different mixes of conditions. Variations of trends by the two major

population groups were also noticed in the historical data.

(ii) Rate Cells

Not applicable.

(iii) Subset of Benefits within a Service Category

Not applicable.

(d) *Material Adjustments to Cost Trends*

Not applicable. While historical trends were not the sole basis for trend assumptions, neither were any explicit adjustments made to the cost trend assumptions.

(e) *Other Adjustments to Cost Trends*

Not applicable.

iv. Compliance with the Mental Health Parity and Addiction Equity Act

The program is currently in compliance with the Mental Health Parity and Addiction Equity Act and no additional action is expected to be needed for further compliance.

v. In-Lieu-of Services

The State has established a list of cost-effective alternative services that MCOs may provide without obtaining prior approval from TennCare. For any other service an MCO may want to provide as a cost-effective alternative, written prior approval from TennCare is required. Cost-effective alternative services have been used in the current contract year. Any in-lieu-of services or cost-effective alternative benefits that may be included in the base period have been authorized by the State and are allowable under the State's 1115 waiver. Note that the methodology of taking into account in-lieu-of services has not changed since the prior certification. The State approves in-lieu-of services on a case by case basis and such services can be associated with any of the covered services. In-lieu-of services included in the base data (which comprises less than 3% of the total expenditure) are expected to be consistent with the in-lieu-of services in the contract year. Costs related to in-lieu-of services are already incorporated into the base data, so no adjustment to accommodate their inclusion is necessary.

As stated in Section I, item3.A.vi, the State does not allow short-term IMD stays as a covered service beyond 15 days and the rate development is in compliance with 42 CFR §438.6(e).

vi. Retrospective Eligibility Periods

TennCare recognizes retroactive rate cell assignments and other minor enrollment changes, which historically have only materially affected the latest one to two months of available enrollment. These changes do not affect the claim responsibility of the managed care provider.

Guidehouse regularly requests and receives retrospective eligibility assignments from the State, which are then applied to the data. Based on prior analyses, with at least three months of runout, the vast majority of the retrospective eligibility changes are fully incorporated into the base data.

vii. Cost Impact of Material Changes since Last Rate Certification

No material changes to benefits or services have been implemented beyond those discussed in Section I,

item 2.B.iii(d).

viii. Estimated Impacts for Covered Benefit or Service Changes

These are described in Section I, item 2.B.iii(d).

4. Special Contract Provisions Related to Payment

A. Incentive Arrangements

Not applicable; TennCare does not currently have any incentive programs in place.

B. Withhold Arrangements

Not currently applicable; TennCare does not currently have any withhold programs in place. However, MCO contracts contain a provision to permit withholds from capitation payments in the event of performance deficiencies, which could include data quality.

C. Risk-Sharing Mechanisms

i. Standards

For the CY21 contract period, the State has incorporated a retrospective, two-way risk corridor to Non-CHOICES, CHOICES, and CoverKids rates in accordance with §438.4. The State has yet to determine if extending these risk corridors to CY22 is appropriate. There are no other risk-sharing mechanisms in place.

ii. Documentation

a) Description

Retrospective, two-way risk corridors were included in each of the Non-CHOICES, CHOICES, and CoverKids programs for the CY21 rates. The intent of these risk corridors was to mitigate financial uncertainty resulting from the COVID-19 public health emergency but also because CY21 was the first year the CoverKids population was covered under managed care. The methodology to calculate the MLR is outlined in the contract and in accordance with the standards outlined in 42 CFR §438.8. The State has not yet decided whether this two-way risk corridor will be in place for CY22 rates.

For the CY21 rates, the two-way risk corridor is retrospective in nature and will therefore be evaluated after sufficient time has passed following the end of the CY21 rate period as to determine the ultimate MLR for each MCO. The ultimate MLR will be compared against the MCO-specific MLR targets to determine appropriate MCO or State shares of gain / loss within the appropriate corridors.

Note that implementing this risk corridor structure should not necessitate any adjustment to the CY22 rates.

The determination of each MCO's target MLR will be directly related to the relative non-medical (administrative and risk margin assumptions) portions of the CY22 rates and the general structure of the

risk-sharing mechanism outlined in CMS guidance and generally accepted actuarial principles and practices.

b) Remittance / Payment Calculations

Risk corridor results will be applied separately to each MCO and to each program (CHOICES, Non-CHOICES, and CoverKids). Note that expenses related to fraud, waste, and abuse, and activities that improve health care quality will also be excluded. If the risk corridor is in place for CY22, the State actuaries will determine target MLRs for the CY22 risk corridor consistent with CY22 rate development and reflect the estimated administrative and risk margin levels of the 'core' rates prior to the incorporation of directed payments.

The following describes the general risk corridor structure used in the past:

Medical Loss Ratio Corridor	MCO Share of Gain / Loss in the Corridor	State / Federal Share of Gain / Loss in the Corridor
Less than (Target MLR – 4.5%)	0%	100%
(Target MLR – 4.5%) to (Target MLR – 2.5%)	50%	50%
(Target MLR – 2.5%) to (Target MLR + 2.5%)	100%	0%
(Target MLR + 2.5%) to (Target MLR + 4.5%)	50%	50%
Greater than (Target MLR + 4.5%)	0%	100%

However, CMS requires the risk corridor calculation to include directed payment amounts incorporated into the capitation payments. This will require MCO-specific risk corridors as MCOs receive and pay out different directed payment amounts.

D. Delivery System and Provider Payment Initiatives

The Tennessee Hospital Association (THA) rate variation is an agreement upon providers to have a set floor and ceiling for hospital reimbursement. For hospitals in the association, these ranges are incorporated into the contracts between the MCOs and the providers. These were implemented in full in October 2015, outside of the CY19 base data, so no changes should be necessary for the CY22 rates. Additionally, these adjustments were created to be budget neutral to the State and do not involve any additional payments to providers.

Note that none of the State's existing Directed Payment Proposals are expected to apply to the CoverKids population.

E. Pass-Through Payments

Not applicable; TennCare does not currently have any pass-through payment programs in place as defined by CMS' '*2020-2021 Medicaid Managed Care Rate Development Guide*'.

5. Projected Non-Benefit Costs

A. Rate Development Standards

i. Non-Benefit Cost Components

The projected non-benefit costs for CY22 rates include the following explicit components:

- General administrative costs
- Care coordination costs
- Risk margin
- Premium tax

Please note that cost of capital is included as part of risk margin. Please also note that there were no explicit adjustments made to the administrative load in order to comply with the parity standards of the Mental Health Parity and Addiction Equity Act as required by 42 CFR §438.3(c)(ii).

Additionally, the State allocated $53.9M to MCOs to expand and sustain their substance use disorder (SUD) networks. Out of this, $52.1M was allocated to the base data costs for the Non-CHOICES rate ranges and $1.82M was allocated to the base data costs for the CHOICES rates. No portion of these funds were allocated to the CoverKids rates.

ii. Non-Benefit Cost Development Methods

General administrative costs and care coordination costs were developed on a per member per month (PMPM) cost based on MCO reported historical costs for the base period. Risk margin is applied as a percentage of the capitation rates. Premium tax is included in the rates as a statutorily prescribed percentage of the capitation rates (currently at 6.0%). The SUD Network expansion costs were allocated based on SUD diagnosis code prevalence between regions and rate cells in the base data between Non-CHOICES, CHOICES and TennCare Select.

For CoverKids, general administrative costs and care coordination costs were developed as a per member per month (PMPM) cost based on TPA reported historical costs for the base period.

iii. Basis for Varying Assumptions by Populations

As the levels of care coordination can vary significantly between populations (such as between the generally healthy TANF population and the Disabled population for Non-CHOICES members, or between CHOICES 1, 2, and 3 members for the CHOICES members), the projected care coordination cost assumptions were developed separately for these populations. There is no variation by aid category in assumptions for other non-benefit components. The variation for each non-benefit cost component is not based on the rate of federal financial participation associated with the covered populations.

iv. Health Insurance Providers Fee (HIF)

Not applicable due to the repeal of the HIF starting in 2021.

B.Appropriate Documentation

i. Documentation Requirements

(a) *Projected Non-Benefit Cost Assumption Development*

Data

The primary data used for non-benefit cost projection is the MCO reported financial data related to non-benefit costs in their MLR reports. Guidehouse requested three years of detailed administrative data with a split between general administrative costs and care coordination costs from the MCOs as the basis for developing the administrative cost assumption for the rates. Guidehouse reviewed the data for reasonableness and consistency from year to year but did not audit the data.

Assumptions and methodology

For the Non-CHOICES, CHOICES, and CoverKids rate ranges, both the general administrative and care coordination cost components were developed on a per member per month (PMPM) basis using historical non-medical cost information provided by the MCOs. For Non-CHOICES, the care coordination cost component varies by aid category [Medicaid (TANF) and Uninsured / Uninsurable, Disabled, and Duals] to reflect more accurate allocations for the varying acuity of the members. Similarly, for CHOICES, the care coordination cost is set to vary by CHOICES group (CHOICES 1, 2, and 3). In the preliminary CY22 capitation payments, the projected non-medical cost load to the Non-CHOICES rate ranges (net of premium tax) varies between 10.8% and 11.2%. The projected non-medical cost load to the CHOICES rate ranges (net of premium tax) varies between 7.6% and 7.8%. The projected non-medical cost load to the CoverKids rates (net of premium tax) varies between 13.2% and 13.3%.

Note that these percentages include an explicit risk margin of 1.0% for Non-CHOICES and CHOICES programs and 1.0% to 1.25% for the CoverKids program. This includes the cost of capital required to operate the business. Lastly, we grossed up the premium for the 6.0% State premium tax. The detailed components of administrative allowances by rate cell are incorporated into the rate development exhibits (Exhibits 1a-1d).

(b) *Material Changes Non-Benefit Cost Projections*

There is no material change to the data and methods used to develop the projected non-benefit costs since the last rate certification.

(c) *Other Adjustments to Non-Benefit Cost Projections*

No additional adjustment is made other than trending the base general administrative costs and care coordination costs to the contract period using general inflation.

ii. Estimation of Projected Non-Benefit Costs by Major Categories

Exhibits 1a-1d include projected non-benefit costs by major components and by rate cell.

iii. Disclosure of Historical Non-Benefit Cost Data

The actuaries collected CY18 and CY19 non-benefit expense data from the three MCOs who were participating in the program for those years. In addition, the actuaries reviewed the filed NAIC statements

for calendar years 2018 and 2019 as an additional reasonableness check. After receiving the non-benefit expense data, the actuaries submitted several rounds of questions to the plans to ensure the submitted data was appropriate. This data formed the basis for the non-medical load assumptions.

iv. Health Insurer Provider Fee Approach

Not applicable.

6. Risk Adjustment and Acuity Adjustments

A. Rate Development Standards

i. Risk Adjustment

All Non-CHOICES rates are subject to risk adjustment except for dual (Medicaid and Medicare eligible) rate cells. The MCOs receive risk adjusted rates based on their enrollees' relative risk scores. The risk adjustment will apply to the 'core' rates without directed payment increases.

The CHOICES rates are not risk adjusted in the traditional sense, where the health status of individuals is measured. However, the CHOICES 1 & 2 rates will be adjusted based on the variation of the long-term care mix between CHOICES 1 and CHOICES 2 among the three plans at the rate cell level in each region. While this adjustment will pay a higher rate to the plan with a higher mix of CHOICES 1 members and a lower rate to the plan with a lower mix of CHOICES 1 members, the risk adjustment will be budget neutral to the State at the rate cell and regional level. Directed payment amounts will be excluded from the site of service adjustment. This methodology is the same as has been used in prior rate setting periods and is described in more detail below.

The State has yet to determine what risk adjustment may be appropriate to utilize for the CHIP (CoverKids) program.

ii. Risk Adjustment Methodology

The Adjusted Clinical Groups (ACG) risk model, developed and maintained by Johns Hopkins, is currently used for the development of risk adjusted rates. The state specific Resource Utilization Band (RUB) weights were used to calculate the risk score at plan level in a prospective manner for each non-dual rate cell. The risk adjustment process is modeled to be budget neutral to the State. Though the methodology is described in more detail below, all MCOs in all regions are included in the risk adjustment process.

Aside from the exclusion of the directed payment amounts from the risk adjustment process, this methodology is the same as has been used in prior rate setting periods and is described in more detail in the following pages.

iii. Acuity Adjustment

(a) *Type of Acuity Adjustment*

As the State has reinitiated reverification efforts starting in July 2016, the risk profile of the enrolled population in the contract period may be materially different from the base period due to the change to the member eligibility reverification process. Thus, the reverification adjustment described in Section I, item 2.B.iii(d) could be considered an acuity adjustment, though it was treated as a program change. If so, we note that this adjustment is prospectively set, though for prior rates we have made additional adjustments if actual reverification efforts deviate significantly from original expectations.

(b) *Use of Retrospective Acuity Adjustment*

Not applicable; retrospective acuity adjustment will not be used for CY22 capitation rates.

(c) *Acuity Adjustment as a Risk Mitigation Strategy*

Not applicable; the reverification adjustment, even if considered an acuity adjustment, is not included as a risk mitigation strategy.

B.Appropriate Documentation

i. Prospective Risk Adjustment (Non-CHOICES)

(a) *Data and Adjustments*

There are two types of data used for prospective risk adjustment: one for State specific weight development and the other for plan level risk score calculation.

Data used to develop TennCare specific prospective risk weights will be the most recent two years of statewide claim and eligibility data with three months of run-out for members who have at least 6 months of enrollment in year 1 and at least one month of enrollment in year 2. We called this 24-month period the "risk incurred period".

Data used to calculate plan level risk scores will be the enrollment data for the month following the open enrollment period within the contract period. We call this month the "risk measurement month".

(b) *The Risk Adjustment Model*

The Medicaid-ACG risk adjustment model, version 11.0 or newer, developed by Johns Hopkins University will be used to develop the risk scores.

To reflect the TennCare specific cost experience and risk distribution, the ACG model will be calibrated to develop TennCare specific prospective and resource utilization band (RUB) based risk weights by each Category of Aid (COA). Due to the risk similarities between Medicaid (TANF) members and Uninsured/Uninsurable members, these two COAs are combined for the development of risk weights. Therefore, there will be two sets of risk weights developed for Non-CHOICES members: one for each of the following two consolidated COAs:

- Medicaid/Uninsured/Uninsurable
- Non-Dual Disabled

For the Non-Dual Disabled category, the software generated ACGs will be grouped into 5 RUBs ranging from 1 to 5 to allow for a sufficient number of ACGs in each RUB to achieve grouping stability. For the Medicaid/Uninsured/Uninsurable category, the software generated ACGs will be grouped into 6 RUBs ranging from 0 to 5.

Data used to develop TennCare specific risk weights will be the most recent two years of statewide claim and eligibility data with three months of run-out for members who have at least 6 months of enrollment in year 1 and at least one month of enrollment in year 2. We called this 24-month period "risk incurred period".

Specifically, year 1 claim data will be used to identify individual ACG values and the corresponding RUB for each enrollee with at least 6 months of enrollment within year 1 and one month of enrollment within year 2. Then these members' paid claim and enrolled months in year 2 will be used to calculate the

PMPM cost for each RUB and each consolidated COA. Finally, the PMPM cost for each RUB will be divided by the PMPM cost across all RUBs within each consolidated COA to produce the COA specific risk weight for each RUB.

(c) *Method for Calculating Relative Risk Factors*

For members enrolled in the risk measurement month, their claim data incurred in the "risk incurred period" as defined above with three months of run-out will be used to identify their RUBs. To ensure a credible RUB at member level, only members with at least 6 months of enrollment within the risk incurred period will be assigned with the calculated RUBs. For members with less than 6 months of enrollment, no RUB will be assigned for them.

For members with assigned RUBs, their average risk weights will be calculated for each rate cell and each plan with the member level RUBs and RUB specific risk weight as calculated above. Members with no assigned RUB, regardless of their enrolled plan, are assumed to have the same risk weight as the average across all three plans of members with assigned RUB within the same rate cells.

Finally, the risk weights calculated for both members with assigned RUBs and members with no assigned RUB will be aggregated to calculate the weighted average risk weight for each plan and each rate cell as the plan specific risk scores.

(d) *Magnitude of the Risk Adjustment on Capitation Rates*

The plan specific risk scores will be normalized at the rate cell level to get an average risk score of 1.0. The normalized risk scores will be calculated for each plan at the regional and rate cell levels by dividing the plan specific raw risk score with the overall raw risk score across all three plans in that region.

With the risk neutral rate and the plan specific normalized risk score for each rate cell, the plan specific risk adjusted rate will be calculated by multiplying the plan specific normalized risk score and the rate cell's risk neutral rate (excluding the application of directed payment amounts).

The magnitude of the risk adjustment methodology on the Non-CHOICES CY19 capitation rates ranged from a 17.9% decrease to a 19.0% increase at the rate cell level. At the plan level, the overall revenue impact due to risk adjustment ranged from a 6.0% decrease to a 4.3% increase.

(e) *Predictive Assessment of the Methodology*

The ACG software does not produce R-squared values. However, Guidehouse compared the prospective risk adjustments to the CY19 rates against actual claim experience during CY18. We found that 85.6% of the adjusted regional rate cells were adjusted in the same direction as the MCO cost differences. Additionally, though historical MLRs capture much more than acuity differences, we note that our modeled MLRs by MCO after risk adjustment moved the MLR metric much closer to the program-wide target MLR for all three MCOs.

(f) *Concerns with the Risk Adjustment Process*

Though state specific ACG risk weights were not used for risk adjustment calculation, the R-squared value associated with the State specific ACG risk weights is relatively low. This implies that the majority of the cost variances at the member level could not be addressed by this risk model.

i. Prospective Risk Adjustment (CHOICES)

(a) *Data and Adjustments*

To calculate the site of service adjustment for each MCO, all that is required is the CHOICES 1 and CHOICES 2 rate projections and updated membership. TennCare will provide updated membership figures for April 2021 that take into account retroactive rate cell assignment changes and the adjustments will be calculated mid-2021.

(b) *Risk Adjustment Model*

Not applicable; the site of service adjustment does not rely on a traditional risk adjustment model.

(c) *Method for Calculating Relative Risk Factors*

The member mix of each MCO between CHOICES 1 and CHOICES 2 is measured and the revised CHOICES 1 & 2 rates are developed for each MCO, adjusting slightly as needed to maintain budget neutrality. The resulting new rates for each MCO, are blended with the regional CHOICES 1 & 2 rate using a 75% / 25% weighting to produce the final CHOICES 1 & 2 rate.

(d) *Magnitude of the Risk Adjustment on Capitation Rates*

The site of service adjustments to the CY19 rates produced adjustments ranging from a 4.4% decrease to a 6.0% increase at rate cell level. At plan level, the overall revenue impact due to risk adjustment ranged from a 1.2% decrease for one MCO to a 2.5% increase to another.

(e) *Predictive Assessment of the Methodology*

Not applicable; the adjustment methodology is not predictive in nature as it takes into account actual experience during the contract period. It is meant to mitigate significant variances in site of service distributions.

(f) *Concerns with the Risk Adjustment Process*

Guidehouse has no concerns with the risk adjustment process.

ii. Retrospective Risk Adjustment

Not applicable; no retrospective risk adjustment will be applied to CY22 rates.

iii. Other Requirements

(a) *Changes to Risk Adjustment Models since Prior Rating Period*

Not applicable; there are no material changes to the risk adjustment models since the last rating period.

(b) *Assurance that the Risk Adjustment Model is Budget Neutral*

The risk adjusted rates will be developed to be budget neutral to the State based on the projected membership for each region, rate cell, and plan.

iv. Acuity Adjustment Documentation

(a) *Reason for Acuity Adjustment*

The reverification adjustment described Section I, item 2.B.iii(d) could be considered an acuity adjustment, though historically it has been treated as a program change. As described in that section, reverification efforts for Tennessee's Medicaid managed care program have been inconsistent since 2014, which has affected the acuity of the TennCare's covered populations. The actuaries will determine if an acuity adjustment is appropriate for the CY22 rates.

(b) *Acuity Adjustment Model*

Guidehouse does not rely on risk adjustment or other published software to determine risk scores. Instead, Guidehouse developed a proprietary model to prospectively determine the expected impact of reverification. The model considers the number of reverified members as well as their average cost and measures the impact of their leaving the program at the rate cell level. Additionally, the model projects the impact of future reverification efforts using the same methodology.

(c) *Data Used to Develop Acuity Adjustment*

Guidehouse relied primarily on the existing detailed claim data for Non-CHOICES members from the State of Tennessee, including retroactive adjustments, through June 2019 as well as detailed eligibility data for the Non-CHOICES populations from the State through June 2019 as well. Moreover, the State was able to provide additional enrollment and reverification projections through December 2022.

(d) *Relationship and Potential Interactions*

Not applicable; the model used is not a true risk adjustment model and relies solely on total costs, so there are no relationships or potential interactions to disclose.

(e) *Frequency of Acuity Adjustment*

Guidehouse measures the impact of reverification twice a year.

(f) *Acuity Adjustment Incorporation into the Capitation Rates*

Any adjustments determined to be appropriate to include in the rate ranges are applied to all service category costs at the PMPM level.

(g) *Acuity Adjustment Mechanism Development*

We confirm that the assumptions used to develop the acuity adjustment mechanism were developed in accordance with generally accepted actuarial principles and practices.

Section II. Medicaid Managed Care Rates with LTSS

Managed Long-Term Services and Supports

A.Applicability of Section I

As the guidance in Section I still applies to rates that include LTSS, responses have been provided for the applicable sections above.

B.Rate Development Standards

As discussed in Section I, item 1.A.ii.d(iii), the rate cells for the CHOICES program have been structured by the long-term care setting that the beneficiary uses (non-blended) as opposed to by health care status and level of need of the beneficiaries.

C.Appropriate Documentation

i. Additional Considerations

Structure of capitation rate cells

As stated above and in Section I, item 1.A.ii.d(iii), the rate cells for the CHOICES program have been structured by the long-term care setting that the beneficiary uses (non-blended) as opposed to by health care status and level of need of the beneficiaries.

Data, assumptions, and methodology in light of overall approach

All the data, assumptions and methodologies are described in the appropriate sections under Section I. Specifically, we note that the rate ranges for the CHOICES 1 and CHOICES 2 populations are developed jointly; that is, MCOs are paid a combined CHOICES 1 & 2 rate for each member within either the CHOICES 1 or CHOICES 2 groups. This rate structure is a combined rate designed to cover acute services – excluding retail pharmacy – and long-term services and supports for all individuals who meet the NF LOC criteria and are receiving LTSS, including individuals residing in a Nursing Facility (CHOICES 1) and those receiving Home and Community Based Services (CHOICES 2). The major purpose of combining/blending the CHOICES 1 and CHOICES 2 rates is to create financial incentive for MCOs to provide LTSS in the more cost-effective community setting, instead of nursing facilities.

Other payment structures, incentives, or disincentives used to pay MCOs, PIHPs, or PAHPs.

Not applicable; TennCare does not have additional payment structures as defined in this section.

Expected utilization and unit cost effects of managing LTSS

By blending the CHOICES 1 and CHOICES 2 rates, the CHOICES program has seen the overall member mix lean slightly more toward HCBS (CHOICES 2) members over the life of the program, as intended.

Expected effect within each care setting

Incorporating LTSS into the capitation rates for the CHOICES program is expected to incentivize MCOs to promote lower levels of care, as appropriate.

ii. MLTSS Non-Benefit Costs

For the CHOICES program, the development of non-benefit costs, such as general administrative and care coordination costs, were developed entirely separate from those used for the Non-CHOICES program. These are described in Section I, subsection 5.

iii. Rate Setting Assumption Development

Analyses and historical experience used to develop rate setting assumptions are included elsewhere in the certification in Section I.

Section III. New Adult Group Capitation Rates

Not applicable. At the time of this certification, there has been no change to eligibility criteria since the prior rate-setting period (CY21).

Exhibits