

**Demonstration to Integrate Care for Dual Eligible Individuals
(One Care- H7419- Tufts Health Public Plan)
CY 2017 Final Rate Report
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MassHealth, in conjunction with the Centers for Medicare and Medicaid Services (CMS), is releasing the final Medicaid and Medicare component of the CY 2017 rates for the Massachusetts Demonstration to Integrate Care for Dual Eligible Individuals (One Care). Effective January 1, 2017, these rates replace the Demonstration rates included in the CY 2016 rate report.

The general principles of the rate development process for the Demonstration have been outlined in the three-way contract, as amended, between CMS, the Commonwealth of Massachusetts, and the One Care plans (Medicare-Medicaid Plans).

Included in this report are final CY 2017 Medicaid rates and Medicare county base rates and information supporting the estimation of risk adjusted Medicare components of the rate.

I. Components of the Capitation Rate

CMS and MassHealth will each contribute to the global capitation payment. CMS and MassHealth will each make monthly payments to One Care plans for their components of the capitated rate. One Care plans will receive three monthly payments for each enrollee: one amount from CMS reflecting coverage of Medicare Parts A/B services, one amount from CMS reflecting coverage of Medicare Part D services, and a third amount from MassHealth reflecting coverage of Medicaid services.

The Medicare Parts A/B rate component will be risk adjusted using the Medicare Advantage CMS-HCC and CMS HCC-ESRD models. The Medicare Part D payment will be risk adjusted using the Part D RxHCC model. To risk adjust the Medicaid component, MassHealth's methodology assigns each enrollee to a rating category (RC) according to the individual enrollee's clinical status and setting of care.

Section II of this report provides information on the MassHealth component of the capitation rate. Section III includes the Medicare Parts A/B and Medicare Part D components of the rate. Section IV includes information on the savings percentages and quality withholds. Section V includes information on risk mitigation. Section VI provides summaries of the MassHealth base data.

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II. MassHealth Component of the Rate – CY 2017

MassHealth county rates are included below, accompanied by supporting information pertinent to their development. This content includes historical base data production details, adjustments applied to the historical base data, and trend factors used to project historical base data forward to the contract period.

MassHealth Component of Rate:

MassHealth rates for CY 2017 effective January 1, 2017 through December 31, 2017 are listed below, by Massachusetts county and MassHealth rating category for the Demonstration. The rates below do not include application of the 1.25% quality withhold (see Section IV). The rates below do include the savings percentage of 0.25% (see Section IV) for Demonstration Year 4.

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MassHealth Component of County Rate Effective January 1, 2017 through December 31, 2017						
County	C1 – Community Other	C2A – Community High Behavioral Health	C2B – Community Very High Behavioral Health	C3A – High Community Need	C3B – Very High Community Need	F1 – Facility- based Care
Essex	\$126.95	\$443.42	\$719.10	\$3,108.66	\$5,414.80	\$9,529.75
Franklin	\$126.09	\$432.65	\$701.29	\$2,973.50	\$5,185.18	\$9,003.10
Hampden	\$126.09	\$432.65	\$701.29	\$2,973.50	\$5,185.18	\$9,003.10
Hampshire	\$126.09	\$432.65	\$701.29	\$2,973.50	\$5,185.18	\$9,003.10
Middlesex	\$126.95	\$443.42	\$719.10	\$3,108.66	\$5,414.80	\$9,529.75
Norfolk	\$126.95	\$443.42	\$719.10	\$3,108.66	\$5,414.80	\$9,529.75
Plymouth	\$136.75	\$463.27	\$751.77	\$3,240.58	\$5,640.96	\$7,667.92
Suffolk	\$126.95	\$443.42	\$719.10	\$3,108.66	\$5,414.80	\$9,529.75
Worcester	\$126.09	\$432.65	\$701.29	\$2,973.50	\$5,185.18	\$9,003.10
Statewide*	\$126.85	\$439.04	\$711.85	\$3,051.58	\$5,316.17	\$9,341.29

* Rate applies to eligible One Care members living in one of the five counties excluded from the One Care service area (Barnstable, Berkshire, Bristol, Dukes, and Nantucket).

Historical Base Data Development:

The historical Medicaid and Medicare-Medicaid crossover expenditures for SFY2014 and SFY2015, with incurred but not reported (IBNR) completion adjustments applied, formed the historical base data used to develop the MassHealth component of the rates.

The historical base data can be created by taking Medicaid and crossover expenditures reported in the MassHealth Information Sharing Package shared with One Care plans, using the mapping provided below to map detailed base data categories of service to rate development categories of service, mapping One Care counties to geographic regions (see *Counties and Regions* subsection), and applying the completion factors included below. For convenience, per member per month (PMPM) expenditures with IBNR are provided at the end of this report in Section VI for Medicaid and crossover claims by calendar year, region, rating category and category of service.

Rating Categories:

MassHealth assigns members to a rating category based on institutional status (long-term facility versus community), diagnosis information, and the minimum data set — home care (MDS–HC) assessment tool. Because rates are set based on historical FFS claims data, for rate-setting purposes, MassHealth stratifies members into rating categories using a proxy method, which is summarized in the table below.

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Rating Category	Description
F1: Facility-Based Care	<p><u>Demonstration Process</u> Includes individuals identified by MassHealth as having a long-term facility stay of more than 90 days. Applicable facilities include nursing facilities, chronic rehabilitation, and psychiatric hospitals.</p> <p><u>Proxy Method</u> The base data for this rating category was developed based on member months and expenditures in a facility beyond the first 90 days. Applicable facilities include nursing facilities, chronic rehabilitation, and psychiatric hospitals.</p>
C3: Community Tier 3	<p><u>Demonstration Process</u> Includes individuals who do not meet F1 criteria and for whom a MDS-HC assessment indicates:</p> <ul style="list-style-type: none"> • Have a skilled nursing need to be met by the One Care plan seven days a week. • Have two or more activities of daily living (ADL) limitations, and three or more days a week of skilled nursing needs to be met by the One Care plan. • Have four or more ADL limitations. <p><u>Proxy Method</u> The base data for this rating category was developed based on member months and expenditures not in F1 that are within episodes of three plus consecutive months in which a member is in a facility and/or using more than \$500 in community-based long-term services and supports (LTSS).</p>

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C2: Community Tier 2 Demonstration Process

Includes individuals who do not meet F1 or C3 criteria and who have one or more of the following behavioral health diagnoses listed by ICD-10 code, validated by medical records, reflecting an ongoing, chronic condition such as schizophrenia or episodic mood disorders, psychosis, or alcohol/drug dependence, not in remission:

- F10.20-F10.29, excluding F10.21.
- F11.20-F11.29, excluding F11.21.
- F12.20-F12.29, excluding F12.21.
- F13.20-F13.29, excluding F13.21.
- F14.20-F14.29, excluding F14.21.
- F15.20-F15.29, excluding F15.21.
- F16.20-F16.29, excluding F16.21.
- F18.20-F18.29, excluding F18.21.
- F19.20-F19.29, excluding F19.21.
- F20.0-F20.9, F25.0-F25.9 (schizophrenia).
- F28, F9 (other psychosis).
- F30.0-F30.9 (bipolar).
- F31.0-F31.9 (bipolar).
- F32.0-F32.9 (major depression).
- F33.0-F33.9 (major depression).
- F34.8, F34.9, F39 (mood disorders).

Proxy Method

The base data for this rating category was developed based on member months and expenditures not in F1 or C3, who had any claims in the Medicaid FFS data with a qualifying diagnosis (listed above) and/or non-outpatient claims in the Medicare–Medicaid crossover or Medicare FFS data with a qualifying diagnosis (listed above).

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Rating Category	Description
C1: Community Tier 1 — Community Other	<p><u>Demonstration Process</u></p> <p>Includes individuals in the community who do not meet the F1, C3, or C2 criteria.</p> <p><u>Proxy Method</u></p> <p>The base data for this rating category was developed based on member months and expenditures not in F1, C3, or C2.</p>

After an enrollee is assessed, the MDS-HC assessed rating category may differ from the rating category into which he or she was proxied at enrollment. To address this issue, MassHealth began making retroactive rating category adjustments to plans' monthly capitation payments in October 2014, compensating plans for up to 3 months of difference between assessed and proxied rating categories.

C2 Rating Category Split

In order to further mitigate risk of adverse risk selection to One Care plans, MassHealth will further refine the C2 RC, classifying enrollees into:

- C2A: Community Tier 2 – Community High Behavioral Health
- C2B: Community Tier 2 – Community Very High Behavioral Health

The C2B rating category includes all the requirements of the 2013 C2-Community High Behavioral Health rating category, but also includes criteria related to specific co-morbid behavioral health and substance abuse conditions. The C2B rating category will include individuals with at least one mental health diagnosis (ICD-10 F20.0-F20.9, F25.0-F25.9, F30.0-F30.9, F31.0-F31.9, F32.0-F32.9, F33.0-F33.9, F28, F29, F34.8, F34.9, or F39), **and** at least one substance abuse diagnosis (ICD-10 F10.20-F10.29, F11.20-F11.29, F12.20-F12.29, F13.20-F13.29, F14.20-F14.29, F15.20-F15.29, F16.20-F16.29, F18.20-F18.29, or F19.20-F19.29). Any individual that meets the overall C2 criteria, but does not meet the C2B criteria, would be classified as C2A.

C3 Rating Category Split

In order to further mitigate risk of adverse risk selection to One Care plans, MassHealth will further refine the C3 RC, classifying enrollees into:

- C3A: Community Tier 3 – High Community Need
- C3B: Community Tier 3 – Very High Community Need

The C3B rating category includes all the requirements of the 2013 C3-High Community Needs rating category, but also includes criteria related to specific diagnoses. The C3B rating category will include individuals with a diagnosis of Quadriplegia (ICD-10 G80.0 or G82.50-G82.54), ALS (ICD-10 G12.21), Muscular Dystrophy (ICD-10 G71.0 or G71.2), and/or Respirator Dependence (ICD-10 Z99.11 or Z99.12). Any individual that meets the overall C3 criteria, but does not meet the C3B criteria, would be classified as C3A.

Rate Relativity Factors

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The rate relativity process used to develop the capitation rates for the C2A/C2B and C3A/C3B rating categories can be described at a high level as:

- Relative total costs of C2A/C2B and C3A/C3B to the overall C2 and C3 rating categories, respectively, were developed using the base data.
- Projected costs for the C2 and C3 rating categories were developed by region following the same process as was used for CY 2013 rates.
- The C2A/C2B and the C3A/C3B relativity factors were applied to the total projected medical PMPM for the C2 and C3 rating categories, respectively, to develop projected costs for the C2A/C2B and C3A/C3B rating categories.
- Adjustments for administration, seasonality, savings and enrollee contribution to care were applied to produce the final capitation rates.

The C2A and C2B rate relativity factors applied to the C2 projected expenditures are:

	Eastern	Western	The Cape
C2A	-9.7%	-9.9%	-16.6%
C2B	49.3%	49.0%	37.9%

The C3A and C3B rate relativity factors applied to the C3 projected expenditures are:

	Eastern	Western	The Cape
C3A	-2.9%	-0.7%	-1.3%
C3B	69.6%	73.4%	72.4%

Category of Service Mapping:

The following is a category of service mapping between the services reflected in the MassHealth base data and the service categories used in the rate development process. Descriptions of the MassHealth detailed categories of service can be found in Section 3 of the MassHealth Information Sharing Package, “Base Data Detail.”

Medicaid Claims:

Rate Development Category of Service	MassHealth Base Data Detailed Category of Service
Inpatient – Non-MH/SA	IP – Non-Behavioral Health
Inpatient MH/SA	IP – Behavioral Health
Hospital Outpatient	Hospital Outpatient
Outpatient MH/SA	Outpatient BH
Professional	Professional
HCBS/Home Health	Community LTSS
LTC Facility	LTC
Pharmacy (Non-Part D)	Non-Part D Pharmacy

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DME and Supplies	DME and Supplies
Transportation	Transportation
All Other	Other Services

Crossover Claims:

Rate Development Category of Service	MassHealth Base Data Detailed Category of Service
Inpatient – Non-MH/SA	IP – Non-Behavioral Health
Inpatient MH/SA	IP - Mental Health IP – Substance Abuse
Hospital Outpatient	HOP – ER / Urgent Care HOP - Lab / Rad HOP – Other HOP – Pharmacy HOP – PT/OT/ST
Outpatient MH/SA	HOP - Behavioral Health Prof – Behavioral Health
Professional	Prof – HIP Visits Prof – Lab / Rad Prof – OP Visits Prof – Other
HCBS/Home Health	Home Health
LTC Facility	SNF Hospice
DME and Supplies	DME and Supplies
Transportation	Transportation

Counties and Regions:

Rates will be paid on a Massachusetts county and MassHealth rating category basis. Rates, however, have been developed regionally. Five counties are not included in any of the One Care plan service areas:

- Barnstable.
- Bristol.
- Berkshire.
- Dukes.
- Nantucket.

As the Demonstration does not currently operate in these counties, any applicable claims and eligibility data for these counties has been removed from the base data. The resulting geographic classifications are as follows:

Eastern: Essex, Middlesex, Norfolk and Suffolk counties
Western: Franklin, Hampden, Hampshire and Worcester counties

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The Cape: Plymouth county

It is possible for a One Care member to move to one of the five counties excluded from the One Care service area and maintain One Care eligibility. For Demonstration Year 4, a “statewide” rate was developed. Because there is a high likelihood that these members are using the same service providers that they were when they were in the One Care service area, this rate is a statewide, weighted average rate based on the counties that are part of the One Care service area.

Adjustment information below is provided by geographic region.

Adjustments to Historical Base Data:

As detailed in Section 4 of the three-way contract, rates have been developed based on expected costs for this population had the Demonstration not existed. The adjustments included below have been made to the historical base data to reflect the benefits and costs that will apply in CY 2017 to fee-for-service dual eligible individuals. As described above, most adjustments specific to the C2 and C3 rating categories are made prior to the application of C2A/C2B and C3A/C3B relativity factors to the projected rates.

Historical Base Data Completion Factors:

The MassHealth base data do not reflect an estimate for IBNR expenditures. Medicaid and crossover claims processed by MassHealth through April 5, 2016 are reported in the MassHealth base data. To construct the historical base data, the following completion factors have been applied to both the Medicaid data and the crossover data reported in the Data Book.

Category of Service	Medicaid Claims Completion Factors		Crossover Claims Completion Factors	
	SFY 2014	SFY 2015	SFY 2014	SFY 2015
Inpatient-Non-MH/SA	1.000	1.019	1.000	1.015
Inpatient MH/SA	1.000	1.018	1.000	1.015
Hospital Outpatient	1.000	1.001	1.000	1.008
Outpatient MH/SA	1.000	1.001	1.000	1.008
Professional	1.000	1.001	1.000	1.006
HCBS/Home Health	1.000	1.000	N/A	N/A
LTC Facility	1.000	1.001	1.000	1.009
Pharmacy (Non-Part D)	1.000	1.005	N/A	N/A
DME and Supplies	1.000	1.005	1.001	1.008
Transportation	1.000	1.005	1.001	1.009
All Other	1.000	1.005	N/A	N/A
All Services	1.000	1.003	1.000	1.009

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Redeterminations:

The Centers for Medicare & Medicaid Services (CMS) require states to review Medicaid eligibility annually. MassHealth suspended this process in October 2013 due to system difficulties. Between February 2015 and December 2015, EOHHS processed renewals for all members impacted by the suspension, which included members in FFS. As of January 2016, EOHHS restored its annual Medicaid renewal process. Consequently, the base data was adjusted to allow a consistent comparison in the performance period.

For this adjustment, MassHealth provided a list of members identified as ineligible for MassHealth during redetermination through December 2015. Enrollment and claims data for these members were identified and excluded from the base data. The impact of this adjustment is shown below:

Region	C1	C2	C3	F1
Eastern	0.1%	0.1%	0.0%	0.0%
Western	0.3%	0.0%	0.0%	-0.2%
The Cape	0.1%	0.3%	0.1%	0.0%

Transitional Living Program:

In recognition of the level of care required for members in Transitional Living Programs, MassHealth is in the process of developing a new rating category to compensate plans appropriately for these members. Until this new rating category is developed and implemented, MassHealth will pay for all services related to the Transitional Living Program outside of the capitation rates. The following adjustments were made to account for the removal of these services from the HCBS/Home Health line of the base data:

Region	C1	C2	C3	F1
Eastern	-1.3%	-0.5%	-0.4%	0.0%
Western	0.0%	0.0%	0.0%	0.0%
The Cape	-0.8%	0.0%	-0.1%	0.0%

Relational Modeling:

For some regions, there was only a limited amount of experience available, which can create rate volatility over time. To mitigate some of these unanticipated changes at the region level, adjustments were made to shift funds among regions without impacting the aggregate cost for the RC overall. This relational modeling was used for all RCs as shown below:

Region	C1	C2	C3	F1
Eastern	-0.1%	-0.4%	-0.1%	-1.0%
Western	-0.3%	0.0%	0.0%	2.2%
The Cape	6.7%	8.1%	1.6%	0.0%

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Other Rate Adjustments:

Primary Care Fee Increase in the ACA:

In accordance with ACA Section 1202, MassHealth raised its payment rates for primary care in January 2013. While primary care tends to be covered under Medicare for dual eligible members, this fee increase impacted the FFS Medicaid cross-over claim costs for primary care. MassHealth discontinued the ACA Section 1202 fee increases on January 1, 2015. Because a portion of the base data for CY 2017 included these increased payments, an adjustment was made to remove the impact of the fee increase from the professional line as demonstrated below:

Region	C1	C2	C3	F1
Eastern	-27.9%	-28.0%	-37.1%	-47.3%
Western	-29.5%	-31.6%	-43.8%	-51.1%
The Cape	-22.9%	-27.4%	-29.7%	-56.5%

MassHealth Home Health Appeals:

Some home health claims originally paid by MassHealth are eventually paid by Medicare. Information on the amount recovered is captured on a cash basis rather than date of service basis and is not specific to the target duals population. Based on the most recent available information on recovery dollars for the entire state (all 14 counties), a reasonable estimate of Medicare home health for target duals included in the base data is approximately \$50,000 annually. To account for the removal of the five counties that are not included in one of the One Care plans service areas, the \$50,000 annual figure was applied to the SFY2014 and SFY2015 base data for the entire state, and the adjustment was applied to the county-excluded base.

Pharmacy Rebates:

The MassHealth One Care historical base data does not reflect potential Federal Omnibus Budget Reconciliation Act (OBRA) rebates. Potential OBRA rebates on non-Part D drugs comprise an estimated 11.3% of total pharmacy spending for the entire state. This rebate percentage is based on forecasts developed by MassHealth for all dual eligible members (including partial duals and waiver participants) in the state under the age of 65 during SFY2014 and SFY2015. This percentage was then applied to the base data reflecting the excluded counties. In addition, MassHealth has an agreement in place for supplemental rebates on diabetic test strips. MassHealth estimated that there is approximately \$0.8M in potential rebates in SFY2014 and SFY2015 on diabetic test strips for the entire dual eligible population. This number was adjusted to reflect the target duals population and is expected to produce an extra 7.4% in pharmacy rebates for this population.

Medicare Improvements for Patients and Providers Act:

Effective in January 2013 and again in January 2014, coinsurance for outpatient mental health services under Medicare Part B changed, now resembling coinsurance levels of other physical health services under Medicare Part B. Medicaid's portion of the Medicare Part B coinsurance for outpatient mental health services decreased from 40% in 2012 to 35% in 2013 and to 20% in 2014. The following table displays this impact to the Outpatient MH/SA COS:

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Region	C1	C2	C3	F1
Eastern	-3.9%	-0.3%	-0.7%	-2.2%
Western	-3.0%	-0.5%	-1.0%	-1.7%
The Cape	-2.4%	-0.2%	-0.5%	-2.1%

Dental Benefit Changes:

The MassHealth dental benefit for adults was reduced effective July 2010. Effective January 1, 2013, MassHealth restored composite fillings for front teeth to the adult dental benefit. Effective March 1, 2014, MassHealth restored its adult dental benefit to include:

D2140 - AMALGAM ONE SURFACE, PRIMARY OR PERMANE
D2150 - AMALGAM TWO SURFACES, PRIMARY OR PERMAN
D2160 - AMALGAM THREE SURFACES, PRIMARY OR PERM
D2161 - AMALGAM FOUR OR MORE SURFACES PRIMARY O
D2332 - RESIN-THREE SURFACES
D2335 - RESIN - FOUR/MORE SURFACES INVOLVING IN
D2391 - RESIN-BASED COMPOSITE-ONE SURFACE, POST
D2392 - RESIN-BASED COMPOSITE SURFACES,POSTERIO
D2393 - RESIN-BASED COMPOSITE 3 OR MORE SURFACE
D2394 - RESIN-BASED COMPOSITE 4+ SURFACES, POST

Effective May 15, 2015, MassHealth restored its denture benefits to include:

D5110 – COMPLETE DENTURES (INCLUDING ROUTINE POST-DELIVERY CARE)
D5120 – COMPLETE DENTURES (INCLUDING ROUTINE POST-DELIVERY CARE)
D5211 – PARTIAL DENTURES (INCLUDING ANY CONVENTIONAL CLASPS, RESTS, AND TEETH)
D5212 - PARTIAL DENTURES (INCLUDING ANY CONVENTIONAL CLASPS, RESTS, AND TEETH)

The adjustments below have been applied to the All Other COS historical base data to reflect the net effect of these benefit changes:

Region	C1	C2	C3	F1
Eastern	45.7%	41.9%	15.2%	6.7%
Western	43.4%	39.0%	18.2%	12.5%
The Cape	46.1%	46.7%	21.5%	17.4%

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In addition, a 6.7% adjustment was made to the All Other COS for all RCs to account for the fact that MassHealth members can receive the full scope of dental services (defined as the scope of services prior to MassHealth benefit reductions in July 2010) through hospitals and community health centers through the Commonwealth’s Health Safety Net. These costs are not included in the FFS base data.

Gender Reassignment Coverage:

In CY 2015, the Commonwealth started to cover costs of gender reassignment procedures for transgender individuals meeting clinical guidelines for gender dysphoria. These costs are not included in the FFS base data. Prevalence rates were reviewed from studies related to gender reassignment, as well as potential cost of services for gender reassignment procedures. A small upward adjustment was made to the inpatient — non- MH/SA COS to cover the costs associated with gender reassignment procedures:

Region	C1	C2	C3	F1
Eastern	0.2%	0.1%	0.0%	0.0%
Western	0.2%	0.1%	0.0%	0.0%
The Cape	0.1%	0.1%	0.0%	0.0%

Elder Affairs Home Care Program:

The Home Care Program is a state-funded benefit for individuals ages 60+ that includes limited care coordination, and a package of community support services beyond what members can access through the State plan, including homemaker, personal care, respite services, and non-medical transportation. These services overlap with the expanded community supports benefit list in the One Care three-way contract. When MassHealth members who are eligible for these services and who have been receiving them from Elder Affairs enroll in One Care, they are disenrolled from the Home Care program. The CY 2017 One Care capitation rates include a 1.9% adjustment to the HCBS/Home Health COS for only the C3 rating category for the additional costs of providing Home Care program services.

Department of Mental Health Psychiatric Claims:

The One Care program covers inpatient and outpatient psychiatric claims costs from Department of Mental Health facilities, but not all costs are reflected in the historical base data. To account for these costs, the following adjustments were applied to the C2 and F1 populations for Inpatient MH/SA and Outpatient MH/SA COS:

Region	C2 - Inpatient	C2 - Outpatient	F1 - Inpatient	F1 - Outpatient
Eastern	35.2%	1.2%	23.6%	1.1%
Western	82.7%	0.0%	500.8%	0.0%
The Cape	40.9%	1.7%	623.8%	1.3%

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Diversionsary Behavioral Health:

Certain diversionsary behavioral health services that are covered under the One Care program for non-institutionalized members are not included in the FFS base data. The CY2017 rates include a 15.8% adjustment to the Outpatient MH/SA COS for the costs of covering these services for the C1, C2, and C3 populations. These diversionsary behavioral health services include the following:

- Enhanced acute treatment services
- Inpatient/dual diagnosis level III A detox
- Community support
- Day treatment
- Recovery support navigator
- Structured outpatient addictions program

Home Health Policy Changes:

MassHealth made several home health policy changes in CY 2016, including using Prior Authorization to review requests for home health services after a specific number of services are provided (effective March 1, 2016) to ensure all services provided by Home Health Agencies are medically necessary. Additionally, the state requested a moratorium on new applications for home health agencies. This request was approved by CMS in February 2016 and again in August 2016. The current moratorium expires in February 2017. Lastly, MassHealth intends to change their current reimbursement structure for home health services in CY 2017. The overall result of these changes to the HCBS/Home Health expense line is demonstrated below:

Region	C1	C2	C3	F1
Eastern	-6.5%	-9.4%	-5.5%	-3.1%
Western	-5.8%	-9.0%	-3.0%	-2.5%
The Cape	-3.5%	-8.2%	-3.1%	-1.0%

Personal Care Attendant Sick Time and Fiscal Intermediary (FI) Administration

Effective July 1, 2015, the Massachusetts Earned Sick Time Law allows PCAs to accrue paid sick time. Additionally, effective January 1, 2016, MassHealth is considered a joint employer of Personal Care Attendants (PCAs) for the purposes of the Fair Labor Standards Act (FLSA). Consistent with the FLSA, MassHealth is required to provide PCAs with travel pay and overtime. MassHealth is paying for any overtime and travel costs outside the One Care capitation rates; however, the additional fiscal intermediary (FI) administration expenses associated with reporting and tracking costs associated with PCA overtime and travel costs is included in the capitation rates.

The PCA earned sick leave and FI administrative expense adjustments reflect the PCA mix of services, resulting in the following increases to the HCBS/Home Health COS:

Region	C1	C2	C3	F1
Eastern	0.2%	0.0%	0.2%	0.1%

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Region	C1	C2	C3	F1
Western	0.3%	0.1%	0.4%	0.4%
The Cape	0.2%	0.1%	0.3%	0.2%

Community Support Program (CSP) Services for Chronically Homeless Individuals

Effective February 1, 2017, new services for the chronically homeless will be provided to One Care members. An adjustment was made to the rates based on a financial analysis provided by MassHealth which included projected enrollment and costs per member for the new program. The new services resulted in the following increases to the Outpatient MH/SA COS:

Region	C1	C2	C3	F1
Eastern	3.6%	3.4%	3.4%	0.0%
Western	0.7%	0.7%	0.7%	0.0%
The Cape	2.1%	2.0%	2.0%	0.0%

Provider Payment Changes:

MassHealth made several changes to FFS fee schedules that were not fully reflected or not reflected at all in the base data:

Community Mental Health Center

Rate increases for non-evaluation and management codes for mental health services in community health centers and mental health centers were effective January 1, 2014. Further increases were effective on June 1, 2016. These changes resulted in an increase to the Outpatient MH/SA COS as displayed below:

Region	C1	C2	C3	F1
Eastern	2.6%	2.6%	3.6%	5.5%
Western	4.2%	4.1%	5.1%	6.2%
The Cape	3.9%	3.5%	3.7%	5.7%

Nursing Facility Rebase

MassHealth made several changes to nursing facility reimbursements from the start of the FFS base data to the end of CY 2017, including the following:

- Nursing facility rates rebase (effective October 2014)
- Nursing facility rates decrease (effective November 2014)
- Nursing facility rates increase (effective November 2015)
- Nursing facility rates increase (effective October 2016)

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The estimated combined impact of these changes to nursing facility reimbursements is a 2.4% increase to the long term care (LTC) facility COS for each RC.

Durable Medical Equipment Rate Change

Effective July 1, 2017, MassHealth is expected to change its fee schedule for durable medical equipment (DME), oxygen and respiratory therapy equipment. These changes resulted in the following decreases to the DME and Supplies COS a displayed below:

Region	C1	C2	C3	F1
Eastern	-1.1%	-1.1%	-1.3%	-1.2%
Western	-1.1%	-1.1%	-1.3%	-1.3%
The Cape	-1.0%	-0.9%	-1.3%	-1.1%

Home- and Community Based-Services Fee Increases

Between July 1, 2013 and December 31, 2017, MassHealth adjusted or plans to adjust multiple long-term service fee schedules. These changes were found specifically within the adult foster care, day habilitation, and personal care/fiscal intermediary services. Taking into account the multiple effective dates for these fee increases and decreases across the various services, the following adjustments were made to the HCBS line:

Region	C1	C2	C3	F1
Eastern	0.7%	-0.1%	1.5%	1.6%
Western	1.0%	0.1%	3.0%	3.5%
The Cape	0.1%	-0.7%	1.6%	3.2%

Enrollee Contributions to Care:

The MassHealth historical base data reflect costs net of contributions to care or patient-paid amounts (PPA) paid by individuals in facilities. These costs have been included in rates through the adjustments displayed below, and enrollee contributions to care will be deducted from capitation payments on an individual enrollee basis. These adjustments are based on, and have been applied to, both Medicaid only and crossover claims.

Region	C1	C2A	C2B	C3A	C3B	F1
Eastern	0.0%	0.0%	0.0%	0.1%	0.1%	7.7%
Western	0.0%	0.0%	0.0%	0.1%	0.2%	9.2%
The Cape	0.0%	0.0%	0.0%	0.1%	0.0%	11.3%

Trend Factors Applied to Adjusted Historical Base Data:

The following trend factors have been applied for 36 months from the midpoint of the base period (July 1, 2014) to the midpoint of the contract period (July 1, 2017):

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Category of Service	C1	C2	C3	F1
Inpatient-Non-MH/SA	3.0%	3.0%	3.0%	3.0%
Inpatient MH/SA	3.0%	3.0%	3.0%	3.0%
Hospital Outpatient	3.0%	3.0%	2.0%	3.0%
Outpatient MH/SA	3.0%	3.0%	2.0%	3.0%
Professional	2.0%	2.0%	2.0%	2.0%
HCBS/Home Health	2.0%	2.0%	2.0%	2.0%
LTC Facility	2.0%	2.0%	2.0%	1.8%
Pharmacy (Non-Part D)	4.0%	4.0%	3.0%	3.0%
DME and Supplies	5.0%	5.0%	2.5%	2.5%
Transportation	5.0%	5.0%	2.5%	2.5%
All Other	5.0%	5.0%	2.5%	2.5%

Administrative Expenses:

An adjustment has been applied to the MassHealth component of the rate for 2017 to reflect the estimated transfer of administrative costs from MassHealth to the One Care plans. These amounts were developed by MassHealth based on a review of their administrative costs, dividing the costs into three components: administrative, behavioral health care management, and complex care management. The following PMPMs have been added to each county rate by RC:

Adjustment	C1	C2A	C2B	C3A	C3B	F1
Admin	\$14.13	\$16.65	\$18.86	\$38.02	\$56.51	\$84.73
BH Care Management	\$1.17	\$4.88	\$7.51	\$2.82	\$4.29	\$0.00
Complex Care Management	\$8.47	\$12.56	\$16.15	\$47.25	\$77.25	\$0.00

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III. Medicare Components of the Rate – CY 2017

Medicare A/B Services

CMS has developed baseline spending (costs absent the Demonstration) for Medicare Parts A and B services using estimates of what Medicare would have spent on behalf of the enrollees absent the Demonstration. With the exception of specific subsets of enrollees as noted below, the Medicare baseline for A/B services is a blend of the Medicare Fee-for-Service (FFS) Standardized County Rates, as adjusted below, and the Medicare Advantage projected payment rates for each year, weighted by the proportion of the target population that would otherwise be enrolled in each program in the absence of the Demonstration. The Medicare Advantage baseline spending includes costs that would have occurred absent the Demonstration, such as quality bonus payments for applicable Medicare Advantage plans.

Both baseline spending and payment rates under the Demonstration for Medicare A/B services are calculated as PMPM standardized amounts for each Demonstration county. Except as otherwise noted, the Medicare A/B portion of the baseline is updated annually based on the annual FFS estimates and benchmarks released each year with the annual Medicare Advantage and Part D rate announcement, and Medicare Advantage bids (for the applicable year or for prior years trended forward to the applicable year) for products in which potential Demonstration enrollees would be enrolled absent the Demonstration.

Medicare A/B Component Payments: CY 2017 Medicare A/B Baseline County rates are provided below. The rates represent the weighted average of the CY 2017 FFS Standardized County Rates, updated to incorporate the adjustments noted below, and the Medicare Advantage projected payment rates for CY 2017, based on the expected enrollment of beneficiaries from Medicare FFS and Medicare Advantage prior to the demonstration start at the county level.

Please Note: *In CY 2016, CMS updated the FFS component of the Medicare A/B baseline rate to better align One Care Plan payments with Medicare fee-for-service costs, by offsetting underprediction in the CMS-HCC risk adjustment model for full-benefit dual eligible beneficiaries in the community. In CY 2017 CMS will implement a new HCC risk adjustment model across all of Medicare Advantage, as well as for Medicare-Medicaid Plans, that will increase risk scores for community full-benefit dual eligible beneficiaries in order to address this underprediction issue. As a result, CMS will not be making such an adjustment to the FFS component of the Medicare A/B baseline in 2017. While this means that the standardized (non-risk adjusted) rates generally decline from CY 2016 to CY 2017, we expect these decreases will be offset by implementation of the new risk adjustment model.*

The FFS component of the CY 2017 Medicare A/B baseline rate has been updated to reflect a 1.74% upward adjustment to account for the disproportionate share of bad debt attributable to Medicare-Medicaid enrollees in Medicare FFS (in the absence of the Demonstration).

Coding Intensity Adjustment: CMS annually applies a coding intensity factor to Medicare Advantage risk scores to account for differences in diagnosis coding patterns between the Medicare Advantage

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and the Original Fee-for-Service Medicare programs. The adjustment for CY 2017 in Medicare Advantage is 5.66%. For 2017, CMS will apply the full prevailing Medicare Advantage coding intensity adjustment and there will be no upward adjustment to the Medicare A/B baseline rates to offset this reduction in the risk scores.

Impact of Sequestration: Under sequestration, for services beginning April 1, 2013, Medicare payments to providers for individual services under Medicare Parts A and B, and non-exempt portions of capitated payments to Part C Medicare Advantage Plans and Part D Medicare Prescription Drug Plans are reduced by 2%. These reductions are also applied to the Medicare components of the integrated rate. Therefore, under the Demonstration, CMS will reduce non-exempt portions of the Medicare components by 2%, as noted in the sections below.

Default Rate: The default rate will be paid when a beneficiary's address on record is outside of the service area. The default rate is specific to each One Care Plan and is calculated using an enrollment-weighted average of the rates for each county in which the One Care Plan participates.

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2017 Medicare A/B Baseline PMPM, Non-ESRD Beneficiaries, Standardized 1.0 Risk Score, by Demonstration County¹					
County	2017 Published FFS Standardized County Rate	2017 Updated Medicare A/B FFS Baseline (updated by CY 2017 bad debt adjustment)	2017 Updated Medicare A/B Baseline (incorporating updated Medicare A/B FFS baseline and Medicare Advantage component)	2017 Medicare A/B Baseline PMPM, Savings Percentage Applied (after application of 0.25% savings percentage)	2017 Final Medicare A/B PMPM Payment (2% sequestration reduction applied and prior to quality withhold)
Essex	\$864.04	\$879.07	\$878.78	\$876.58	\$859.05
Franklin	745.69	758.67	758.91	757.01	741.87
Hampden	758.00	771.19	771.19	769.26	753.87
Hampshire	772.47	785.91	786.14	784.18	768.50
Middlesex	851.58	866.40	865.73	863.57	846.30
Norfolk	887.01	902.44	902.03	899.78	881.78
Plymouth	927.48	943.62	943.26	940.90	922.08
Suffolk	877.03	892.29	891.94	889.70	871.91
Worcester	831.91	846.39	846.00	843.89	827.01

¹ Rates do not apply to beneficiaries with End-Stage Renal Disease (ESRD) or those electing the Medicare hospice benefit. See Section IV for information on savings percentages.

Note: For CY 2017 CMS the full prevailing Medicare Advantage coding intensity adjustment of 5.66%.

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The Medicare A/B PMPMs above will be risk adjusted at the beneficiary level using the prevailing CMS-HCC risk adjustment model.

Beneficiaries with End-Stage Renal Disease (ESRD): Separate Medicare A/B baselines and risk adjustment apply to enrollees with ESRD. The Medicare A/B baselines for beneficiaries with ESRD vary by the enrollee's ESRD status: dialysis, transplant, and functioning graft, as follows:

- **Dialysis:** For enrollees in the dialysis status phase, the Medicare A/B baseline is the CY 2017 Massachusetts ESRD dialysis state rate, updated to incorporate the impact of sequestration-related rate reductions. The CY 2017 ESRD dialysis state rate for Massachusetts is \$7,761.76 PMPM; the updated CY 2017 ESRD dialysis state rate incorporating a 2% sequestration reduction and prior to the application of the quality withhold is \$7,606.52 PMPM. This will apply to applicable enrollees in all Demonstration counties and will be risk adjusted using the prevailing HCC-ESRD risk adjustment model.
- **Transplant:** For enrollees in the transplant status phase (inclusive of the 3-months post-transplant), the Medicare A/B baseline is the CY 2017 Massachusetts ESRD dialysis state rate updated to incorporate the impact of sequestration-related rate reductions. The CY 2017 ESRD dialysis state rate for Massachusetts is \$7,761.76 PMPM; the updated CY 2017 ESRD dialysis state rate incorporating a 2% sequestration reduction and prior to the application of the quality withhold is \$7,606.52 PMPM. This will apply to applicable enrollees in all Demonstration counties and will be risk adjusted using the prevailing HCC-ESRD risk adjustment model.
- **Functioning Graft:** For enrollees in the functioning graft status phase (beginning at 4 months post-transplant) the Medicare A/B baseline is be the Medicare Advantage 3.5-star county rate/benchmark (see table below). This Medicare A/B component will be risk adjusted using the prevailing HCC-ESRD functioning graft risk adjustment model.

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A savings percentage will not be applied to the Medicare A/B baseline for enrollees with ESRD (inclusive of those enrollees in the dialysis, transplant and functioning graft status phases).

2017 Medicare A/B Baseline PMPM, Beneficiaries with ESRD Functioning Graft Status, Standardized 1.0 Risk Score, by Demonstration County		
County	2017 3.5% bonus County Rate (Benchmark)	2017 Sequestration-Adjusted Medicare A/B Baseline (after application of 2% Sequestration reduction)
Essex	\$851.08	\$834.06
Franklin	827.72	811.17
Hampden	784.53	768.84
Hampshire	828.47	811.90
Middlesex	838.81	822.03
Norfolk	873.70	856.23
Plymouth	913.57	895.30
Suffolk	863.87	846.59
Worcester	819.43	803.04

Beneficiaries Electing the Medicare Hospice Benefit: If an enrollee elects to receive the Medicare hospice benefit, the enrollee will remain in the Demonstration but will obtain the hospice services through the Medicare FFS benefit. The One Care plan will no longer receive the Medicare A/B payment for that enrollee. Medicare hospice services and all other Original Medicare services will be paid under Medicare FFS. One Care plans and providers of hospice services will be required to coordinate these services with the rest of the enrollee's care, including with Medicaid and Part D benefits and any additional benefits offered by the One Care plans. One Care plans will continue to receive the Medicare Part D and Medicaid payments, for which no changes will occur.

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Medicare Part D Services

The Part D plan payment will be the risk adjusted Part D national average monthly bid amount (NAMBA) for the payment year, adjusted for payment reductions resulting from sequestration applied to the non-premium portion of the NAMBA. The non-premium portion will be determined by subtracting the applicable regional Low-Income Premium Subsidy Amount from the risk adjusted NAMBA. To illustrate, the NAMBA for CY 2017 is \$61.08 and the CY 2017 Low-Income Premium Subsidy Amount for Massachusetts is \$34.83. Thus, the updated Massachusetts Part D monthly per member per month payment for a beneficiary with a 1.0 RxHCC risk score applicable for CY 2017 is \$60.56. This amount incorporates a 2% sequestration reduction to the non-premium portion of the NAMBA.

CMS will pay an average monthly prospective payment amount for the low income cost-sharing subsidy and Federal reinsurance amounts; these payments will be 100% cost reconciled after the payment year has ended. These prospective payments, as proposed and attested to by Tufts Health Public Plan, are plan-specific and will be same for all counties, as shown below.

- Low income cost-sharing: \$175.11 PMPM
- Reinsurance: \$281.40 PMPM

The low-income cost sharing and reinsurance subsidy amounts are exempt from mandatory payment reductions under sequestration.

A savings percentage will not be applied to the Part D component of the rate. Part D payments will not be subject to a quality withhold.

Additional Information: More information on the Medicare components of the rate under the Demonstration may be found online at: <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/JointRateSettingProcess.pdf>

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IV. Savings Percentages and Quality Withholds

Savings Percentages

One of the components of the capitated financial alignment model is the application of aggregate savings percentages to reflect savings achievable through the coordination of services across Medicare and Medicaid. This is reflected in the rates through the application of aggregate savings percentages to both the Medicaid and Medicare A/B components of the rates.

CMS and MassHealth established composite savings percentages for each year of the Demonstration, as shown in the table below. The savings percentage will be applied to the Medicaid and Medicare A/B components of the rates, uniformly to all population groups, unless otherwise noted in this report. The savings percentage will not be applied to the Part D component of the joint rate.

Year	Calendar dates	Savings percentage
Demonstration Year 4	January 1, 2017 through December 31, 2017	0.25%

Quality Withhold

The quality withhold percentage applied to the Medicaid and Medicare A/B components of the rate for 2017 (Demonstration Year (DY) 4) will be 1.25%.

More information about the DY 4 quality withhold methodology is available at:
<https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/DY2and3QualityWithholdGuidance042916.pdf>.

State Specific for Massachusetts:

<https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/DY2and3QualityWithholdGuidanceMass.pdf>

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V. Risk Mitigation

The three-way contract, as amended, includes risk corridors to mitigate risk in the event of disproportionate enrollment of high need individuals in some One Care plans or adverse enrollment selection across the Demonstration as a whole.

Risk Corridors

Risk corridors have been established for Demonstration Year 4. The Demonstration will utilize a tiered One Care plan-level symmetrical risk corridor to include all Medicare A/B and Medicaid eligible service and non-service expenditures, rounded to the nearest one tenth of a percent. The risk corridors will be reconciled after application of any high-cost risk pool (HCRP) or risk adjustment methodologies (e.g. CMS-HCC), and as if One Care plans had received the full quality withhold payment.

For Demonstration Year 4, for gains and/or losses of less than or equal to 4%, the One Care plan bears 100% of the risk. For the portion of gains and/or losses from 4.1% through 8.0%, the One Care plan bears 50% of the risk and MassHealth and CMS share in the other 50%. For the portion of gains and/or losses of 8.1% and greater, the One Care Plan bears 100% of the gain/loss.

The Medicare and Medicaid contributions to risk corridor payments or recoupments will be in proportion to their contributions to the Medicare A/B and MassHealth components of the capitation rate.

VI. MassHealth Base Data Summaries

Summary PMPMs for Medicaid and crossover claims from the MassHealth base data are included below, followed by summary PMPMs including IBNR and relational adjustments. Expenditures are reported by fiscal year, geographic region, rating category, and rate development category of service. Combined across fiscal years, the Medicaid and crossover data represents the historical base data used to develop the MassHealth component of the rates.

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Base Data Summary

Region: Eastern

Period: Fiscal Year 2014

Category of Service	C1: Community Low Risk			C2: Community High Risk			C3: Community NHC			F1: Facility-Based Care		
	Crossover PMPM	Medicaid PMPM	Total PMPM	Crossover PMPM	Medicaid PMPM	Total PMPM	Crossover PMPM	Medicaid PMPM	Total PMPM	Crossover PMPM	Medicaid PMPM	Total PMPM
Member Months	394,162	394,162	394,162	123,340	123,340	123,340	79,693	79,693	79,693	12,781	12,781	12,781
Inpatient - Acute	\$ 5.66	\$ 1.12	\$ 6.78	\$ 12.79	\$ 6.24	\$ 19.02	\$ 17.11	\$ 40.11	\$ 57.22	\$ 14.58	\$ 1,571.05	\$ 1,585.63
Inpatient MH/SA	\$ 0.14	\$ 0.12	\$ 0.25	\$ 23.54	\$ 23.95	\$ 47.49	\$ 20.24	\$ 81.97	\$ 102.21	\$ 8.06	\$ 1,818.11	\$ 1,826.17
Hospital Outpatient	\$ 17.83	\$ 1.19	\$ 19.02	\$ 22.43	\$ 1.44	\$ 23.88	\$ 26.00	\$ 2.57	\$ 28.57	\$ 47.22	\$ 0.89	\$ 48.11
Outpatient MH/SA	\$ 6.27	\$ 4.86	\$ 11.13	\$ 9.42	\$ 147.23	\$ 156.65	\$ 7.28	\$ 72.84	\$ 80.12	\$ 6.65	\$ 26.43	\$ 33.08
Professional	\$ 16.80	\$ 2.98	\$ 19.78	\$ 25.50	\$ 12.16	\$ 37.66	\$ 29.70	\$ 6.91	\$ 36.61	\$ 38.17	\$ 3.66	\$ 41.83
HCBS/Home Health	\$ 0.00	\$ 3.66	\$ 3.66	\$ 0.00	\$ 10.27	\$ 10.27	\$ 0.00	\$ 2,325.71	\$ 2,325.71	\$ 0.00	\$ 37.90	\$ 37.90
LTC Facility	\$ 0.77	\$ 0.34	\$ 1.11	\$ 1.81	\$ 0.57	\$ 2.38	\$ 33.07	\$ 34.25	\$ 67.32	\$ 112.38	\$ 3,961.40	\$ 4,073.78
Pharmacy (Non-Part D)	\$ 0.00	\$ 4.12	\$ 4.12	\$ 0.00	\$ 4.08	\$ 4.08	\$ 0.00	\$ 5.58	\$ 5.58	\$ 0.00	\$ 2.96	\$ 2.96
DME & Supplies	\$ 1.88	\$ 3.52	\$ 5.41	\$ 1.46	\$ 2.57	\$ 4.03	\$ 10.25	\$ 28.33	\$ 38.58	\$ 7.31	\$ 32.08	\$ 39.39
Transportation	\$ 0.05	\$ 4.66	\$ 4.70	\$ 0.19	\$ 36.26	\$ 36.45	\$ 0.25	\$ 95.39	\$ 95.63	\$ 0.59	\$ 58.58	\$ 59.17
All Other	\$ 0.00	\$ 14.23	\$ 14.23	\$ 0.00	\$ 16.62	\$ 16.62	\$ 0.00	\$ 32.26	\$ 32.26	\$ 0.00	\$ 50.13	\$ 50.13
Total Medical	\$ 49.40	\$ 40.80	\$ 90.20	\$ 97.14	\$ 261.40	\$ 358.54	\$ 143.89	\$ 2,725.92	\$ 2,869.80	\$ 234.97	\$ 7,563.19	\$ 7,798.16

Region: Eastern

Period: Fiscal Year 2015

Category of Service	C1: Community Low Risk			C2: Community High Risk			C3: Community NHC			F1: Facility-Based Care		
	Crossover PMPM	Medicaid PMPM	Total PMPM	Crossover PMPM	Medicaid PMPM	Total PMPM	Crossover PMPM	Medicaid PMPM	Total PMPM	Crossover PMPM	Medicaid PMPM	Total PMPM
Member Months	370,327	370,327	370,327	112,989	112,989	112,989	85,471	85,471	85,471	12,684	12,684	12,684
Inpatient - Acute	\$ 5.00	\$ 1.72	\$ 6.72	\$ 11.74	\$ 7.18	\$ 18.93	\$ 15.17	\$ 33.06	\$ 48.23	\$ 29.28	\$ 1,601.84	\$ 1,631.12
Inpatient MH/SA	\$ 0.16	\$ 0.08	\$ 0.24	\$ 22.45	\$ 24.82	\$ 47.26	\$ 15.57	\$ 76.35	\$ 91.93	\$ 8.13	\$ 1,612.00	\$ 1,620.13
Hospital Outpatient	\$ 17.70	\$ 1.19	\$ 18.89	\$ 21.24	\$ 1.40	\$ 22.64	\$ 25.44	\$ 2.20	\$ 27.65	\$ 46.78	\$ 0.76	\$ 47.54
Outpatient MH/SA	\$ 5.06	\$ 5.31	\$ 10.38	\$ 7.96	\$ 149.98	\$ 157.94	\$ 5.66	\$ 70.74	\$ 76.41	\$ 4.06	\$ 27.84	\$ 31.90
Professional	\$ 12.94	\$ 2.38	\$ 15.32	\$ 18.44	\$ 10.24	\$ 28.67	\$ 19.44	\$ 4.07	\$ 23.51	\$ 24.74	\$ 2.88	\$ 27.61
HCBS/Home Health	\$ 0.00	\$ 3.71	\$ 3.71	\$ 0.00	\$ 9.27	\$ 9.27	\$ 0.00	\$ 2,575.97	\$ 2,575.97	\$ 0.00	\$ 29.13	\$ 29.13
LTC Facility	\$ 0.78	\$ 0.29	\$ 1.06	\$ 1.85	\$ 0.98	\$ 2.83	\$ 30.08	\$ 31.16	\$ 61.24	\$ 130.78	\$ 4,006.82	\$ 4,137.60
Pharmacy (Non-Part D)	\$ 0.00	\$ 4.75	\$ 4.75	\$ 0.00	\$ 3.62	\$ 3.62	\$ 0.00	\$ 6.13	\$ 6.13	\$ 0.00	\$ 2.74	\$ 2.74
DME & Supplies	\$ 1.86	\$ 3.75	\$ 5.61	\$ 1.74	\$ 3.05	\$ 4.79	\$ 9.32	\$ 27.44	\$ 36.76	\$ 4.46	\$ 32.63	\$ 37.08
Transportation	\$ 0.05	\$ 5.04	\$ 5.10	\$ 0.23	\$ 47.26	\$ 47.49	\$ 0.21	\$ 98.39	\$ 98.60	\$ 1.33	\$ 60.45	\$ 61.78
All Other	\$ 0.00	\$ 16.60	\$ 16.60	\$ 0.00	\$ 20.84	\$ 20.84	\$ 0.00	\$ 33.21	\$ 33.21	\$ 0.00	\$ 62.97	\$ 62.97
Total Medical	\$ 43.54	\$ 44.82	\$ 88.37	\$ 85.64	\$ 278.63	\$ 364.28	\$ 120.90	\$ 2,958.74	\$ 3,079.64	\$ 249.56	\$ 7,440.05	\$ 7,689.61

Notes:

1. In some cases totals may not equal the sum of their respective column components due to rounding.

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Base Data Summary

Region: Western

Period: Fiscal Year 2014

Category of Service	C1: Community Low Risk			C2: Community High Risk			C3: Community NHC			F1: Facility-Based Care		
	Crossover PMPM	Medicaid PMPM	Total PMPM	Crossover PMPM	Medicaid PMPM	Total PMPM	Crossover PMPM	Medicaid PMPM	Total PMPM	Crossover PMPM	Medicaid PMPM	Total PMPM
Member Months	221,566	221,566	221,566	75,011	75,011	75,011	50,841	50,841	50,841	5,375	5,375	5,375
Inpatient - Acute	\$ 3.87	\$ 1.01	\$ 4.88	\$ 9.91	\$ 1.38	\$ 11.29	\$ 10.51	\$ 15.15	\$ 25.66	\$ 15.72	\$ 990.98	\$ 1,006.70
Inpatient MH/SA	\$ 0.15	\$ 0.07	\$ 0.22	\$ 23.47	\$ 12.71	\$ 36.18	\$ 11.13	\$ 21.85	\$ 32.98	\$ 5.55	\$ 195.78	\$ 201.32
Hospital Outpatient	\$ 12.46	\$ 0.59	\$ 13.05	\$ 17.54	\$ 0.58	\$ 18.13	\$ 22.46	\$ 1.36	\$ 23.81	\$ 50.28	\$ 0.66	\$ 50.95
Outpatient MH/SA	\$ 5.30	\$ 7.73	\$ 13.02	\$ 9.68	\$ 147.60	\$ 157.29	\$ 7.02	\$ 61.89	\$ 68.91	\$ 5.61	\$ 28.31	\$ 33.92
Professional	\$ 18.79	\$ 2.02	\$ 20.80	\$ 25.98	\$ 3.79	\$ 29.77	\$ 32.79	\$ 2.16	\$ 34.95	\$ 41.78	\$ 2.98	\$ 44.77
HCBS/Home Health	\$ 0.00	\$ 3.38	\$ 3.38	\$ 0.00	\$ 6.66	\$ 6.66	\$ 0.00	\$ 2,191.18	\$ 2,191.18	\$ 0.00	\$ 22.93	\$ 22.93
LTC Facility	\$ 0.70	\$ 0.48	\$ 1.18	\$ 0.99	\$ 0.92	\$ 1.91	\$ 27.89	\$ 26.74	\$ 54.63	\$ 132.32	\$ 4,587.62	\$ 4,719.94
Pharmacy (Non-Part D)	\$ 0.00	\$ 4.36	\$ 4.36	\$ 0.00	\$ 3.83	\$ 3.83	\$ 0.00	\$ 6.68	\$ 6.68	\$ 0.00	\$ 8.85	\$ 8.85
DME & Supplies	\$ 2.07	\$ 2.83	\$ 4.90	\$ 1.67	\$ 2.47	\$ 4.13	\$ 13.17	\$ 37.25	\$ 50.42	\$ 4.47	\$ 46.09	\$ 50.56
Transportation	\$ 0.07	\$ 4.83	\$ 4.89	\$ 0.22	\$ 38.25	\$ 38.47	\$ 0.27	\$ 76.77	\$ 77.04	\$ 1.63	\$ 51.88	\$ 53.51
All Other	\$ 0.00	\$ 15.64	\$ 15.64	\$ 0.00	\$ 23.75	\$ 23.75	\$ 0.00	\$ 42.71	\$ 42.71	\$ 0.00	\$ 35.52	\$ 35.52
Total Medical	\$ 43.40	\$ 42.93	\$ 86.33	\$ 89.47	\$ 241.94	\$ 331.41	\$ 125.25	\$ 2,483.73	\$ 2,608.98	\$ 257.36	\$ 5,971.60	\$ 6,228.97

Region: Western

Period: Fiscal Year 2015

Category of Service	C1: Community Low Risk			C2: Community High Risk			C3: Community NHC			F1: Facility-Based Care		
	Crossover PMPM	Medicaid PMPM	Total PMPM	Crossover PMPM	Medicaid PMPM	Total PMPM	Crossover PMPM	Medicaid PMPM	Total PMPM	Crossover PMPM	Medicaid PMPM	Total PMPM
Member Months	173,583	173,583	173,583	60,526	60,526	60,526	48,260	48,260	48,260	4,936	4,936	4,936
Inpatient - Acute	\$ 4.02	\$ 0.23	\$ 4.25	\$ 7.73	\$ 1.09	\$ 8.82	\$ 14.80	\$ 14.66	\$ 29.46	\$ 17.96	\$ 1,029.63	\$ 1,047.60
Inpatient MH/SA	\$ 0.09	\$ 0.00	\$ 0.09	\$ 25.05	\$ 11.60	\$ 36.65	\$ 11.49	\$ 15.43	\$ 26.93	\$ 16.19	\$ 230.37	\$ 246.56
Hospital Outpatient	\$ 12.48	\$ 0.81	\$ 13.30	\$ 16.39	\$ 1.05	\$ 17.45	\$ 22.73	\$ 1.30	\$ 24.03	\$ 56.72	\$ 1.82	\$ 58.54
Outpatient MH/SA	\$ 4.12	\$ 8.92	\$ 13.04	\$ 7.19	\$ 157.49	\$ 164.67	\$ 4.64	\$ 61.48	\$ 66.12	\$ 4.34	\$ 28.52	\$ 32.86
Professional	\$ 14.80	\$ 2.06	\$ 16.86	\$ 18.74	\$ 3.98	\$ 22.72	\$ 22.38	\$ 2.68	\$ 25.07	\$ 24.20	\$ 2.26	\$ 26.45
HCBS/Home Health	\$ 0.00	\$ 3.05	\$ 3.05	\$ 0.00	\$ 7.72	\$ 7.72	\$ 0.00	\$ 2,333.67	\$ 2,333.67	\$ 0.00	\$ 25.44	\$ 25.44
LTC Facility	\$ 0.75	\$ 0.48	\$ 1.24	\$ 1.25	\$ 0.68	\$ 1.93	\$ 22.47	\$ 28.69	\$ 51.17	\$ 136.24	\$ 4,769.89	\$ 4,906.13
Pharmacy (Non-Part D)	\$ 0.00	\$ 3.13	\$ 3.13	\$ 0.00	\$ 3.12	\$ 3.12	\$ 0.00	\$ 6.64	\$ 6.64	\$ 0.00	\$ 6.25	\$ 6.25
DME & Supplies	\$ 2.39	\$ 3.28	\$ 5.67	\$ 1.58	\$ 2.24	\$ 3.82	\$ 11.86	\$ 41.45	\$ 53.31	\$ 6.95	\$ 45.79	\$ 52.74
Transportation	\$ 0.06	\$ 4.93	\$ 4.99	\$ 0.19	\$ 45.49	\$ 45.68	\$ 0.18	\$ 81.05	\$ 81.24	\$ 0.70	\$ 45.94	\$ 46.64
All Other	\$ 0.00	\$ 21.09	\$ 21.09	\$ 0.00	\$ 26.45	\$ 26.45	\$ 0.00	\$ 44.06	\$ 44.06	\$ 0.00	\$ 48.60	\$ 48.60
Total Medical	\$ 38.72	\$ 47.98	\$ 86.70	\$ 78.12	\$ 260.91	\$ 339.03	\$ 110.56	\$ 2,631.13	\$ 2,741.69	\$ 263.29	\$ 6,234.52	\$ 6,497.81

Notes:

1. In some cases totals may not equal the sum of their respective column components due to rounding.

**Demonstration to Integrate Care for Dual Eligible Individuals
(One Care- H7419-Tufts Health Public Plan)
CY 2017 Final Rate Report
February 13, 2017**

Base Data Summary

Region: The Cape

Period: Fiscal Year 2014

Category of Service	C1: Community Low Risk			C2: Community High Risk			C3: Community NHC			F1: Facility-Based Care		
	Crossover PMPM	Medicaid PMPM	Total PMPM	Crossover PMPM	Medicaid PMPM	Total PMPM	Crossover PMPM	Medicaid PMPM	Total PMPM	Crossover PMPM	Medicaid PMPM	Total PMPM
Member Months	50,123	50,123	50,123	20,190	20,190	20,190	9,952	9,952	9,952	1,493	1,493	1,493
Inpatient - Acute	\$ 5.47	\$ 1.19	\$ 6.66	\$ 12.78	\$ 3.34	\$ 16.13	\$ 13.36	\$ 25.72	\$ 39.08	\$ 10.45	\$ 523.07	\$ 533.51
Inpatient MH/SA	\$ 0.00	\$ 0.66	\$ 0.66	\$ 15.75	\$ 22.21	\$ 37.96	\$ 11.82	\$ 68.26	\$ 80.08	\$ 3.24	\$ 99.48	\$ 102.72
Hospital Outpatient	\$ 13.14	\$ 0.75	\$ 13.89	\$ 17.22	\$ 1.75	\$ 18.97	\$ 20.06	\$ 3.61	\$ 23.66	\$ 66.33	\$ 1.28	\$ 67.61
Outpatient MH/SA	\$ 3.98	\$ 6.11	\$ 10.09	\$ 7.76	\$ 142.62	\$ 150.38	\$ 5.37	\$ 64.38	\$ 69.75	\$ 9.60	\$ 39.02	\$ 48.62
Professional	\$ 18.98	\$ 1.38	\$ 20.36	\$ 27.57	\$ 2.43	\$ 30.00	\$ 31.10	\$ 2.02	\$ 33.11	\$ 47.72	\$ 4.87	\$ 52.58
HCBS/Home Health	\$ 0.00	\$ 2.27	\$ 2.27	\$ 0.00	\$ 3.98	\$ 3.98	\$ 0.00	\$ 2,282.28	\$ 2,282.28	\$ 0.00	\$ 50.82	\$ 50.82
LTC Facility	\$ 0.69	\$ 0.23	\$ 0.92	\$ 4.39	\$ 0.62	\$ 5.01	\$ 51.47	\$ 43.24	\$ 94.71	\$ 146.41	\$ 4,698.79	\$ 4,845.20
Pharmacy (Non-Part D)	\$ 0.00	\$ 3.48	\$ 3.48	\$ 0.00	\$ 103.42	\$ 103.42	\$ 0.00	\$ 5.42	\$ 5.42	\$ 0.00	\$ 15.88	\$ 15.88
DME & Supplies	\$ 2.05	\$ 3.03	\$ 5.08	\$ 1.96	\$ 1.94	\$ 3.90	\$ 13.30	\$ 36.14	\$ 49.44	\$ 25.61	\$ 32.05	\$ 57.66
Transportation	\$ 0.15	\$ 6.11	\$ 6.26	\$ 0.46	\$ 52.61	\$ 53.07	\$ 0.71	\$ 150.34	\$ 151.05	\$ 1.21	\$ 66.93	\$ 68.13
All Other	\$ 0.00	\$ 15.64	\$ 15.64	\$ 0.00	\$ 15.19	\$ 15.19	\$ 0.00	\$ 31.12	\$ 31.12	\$ 0.00	\$ 52.84	\$ 52.84
Total Medical	\$ 44.46	\$ 40.84	\$ 85.31	\$ 87.91	\$ 350.11	\$ 438.02	\$ 147.17	\$ 2,712.53	\$ 2,859.70	\$ 310.55	\$ 5,585.02	\$ 5,895.57

Region: The Cape

Period: Fiscal Year 2015

Category of Service	C1: Community Low Risk			C2: Community High Risk			C3: Community NHC			F1: Facility-Based Care		
	Crossover PMPM	Medicaid PMPM	Total PMPM	Crossover PMPM	Medicaid PMPM	Total PMPM	Crossover PMPM	Medicaid PMPM	Total PMPM	Crossover PMPM	Medicaid PMPM	Total PMPM
Member Months	51,990	51,990	51,990	20,232	20,232	20,232	10,621	10,621	10,621	1,638	1,638	1,638
Inpatient - Acute	\$ 8.95	\$ 0.91	\$ 9.86	\$ 10.89	\$ 1.19	\$ 12.08	\$ 27.65	\$ 46.77	\$ 74.42	\$ 74.18	\$ 554.61	\$ 628.79
Inpatient MH/SA	\$ 0.08	\$ 0.00	\$ 0.08	\$ 14.80	\$ 22.32	\$ 37.12	\$ 10.77	\$ 56.76	\$ 67.53	\$ 2.91	\$ 63.32	\$ 66.23
Hospital Outpatient	\$ 12.85	\$ 0.48	\$ 13.33	\$ 15.58	\$ 1.63	\$ 17.21	\$ 20.82	\$ 3.18	\$ 24.00	\$ 59.96	\$ 0.00	\$ 59.96
Outpatient MH/SA	\$ 2.97	\$ 6.66	\$ 9.63	\$ 5.93	\$ 138.88	\$ 144.81	\$ 4.53	\$ 70.58	\$ 75.11	\$ 6.41	\$ 46.49	\$ 52.90
Professional	\$ 15.57	\$ 1.45	\$ 17.03	\$ 21.20	\$ 3.64	\$ 24.85	\$ 23.64	\$ 1.63	\$ 25.27	\$ 36.94	\$ 1.67	\$ 38.61
HCBS/Home Health	\$ 0.00	\$ 2.81	\$ 2.81	\$ 0.00	\$ 4.02	\$ 4.02	\$ 0.00	\$ 2,371.42	\$ 2,371.42	\$ 0.00	\$ 55.69	\$ 55.69
LTC Facility	\$ 1.32	\$ 0.40	\$ 1.72	\$ 1.99	\$ 0.21	\$ 2.20	\$ 50.79	\$ 38.46	\$ 89.26	\$ 168.02	\$ 4,482.93	\$ 4,650.95
Pharmacy (Non-Part D)	\$ 0.00	\$ 12.23	\$ 12.23	\$ 0.00	\$ 3.15	\$ 3.15	\$ 0.00	\$ 6.43	\$ 6.43	\$ 0.00	\$ 5.58	\$ 5.58
DME & Supplies	\$ 2.45	\$ 3.27	\$ 5.71	\$ 2.00	\$ 2.10	\$ 4.09	\$ 11.97	\$ 35.72	\$ 47.69	\$ 5.04	\$ 30.01	\$ 35.05
Transportation	\$ 0.14	\$ 6.55	\$ 6.69	\$ 0.28	\$ 61.89	\$ 62.16	\$ 0.73	\$ 171.07	\$ 171.80	\$ 0.47	\$ 68.42	\$ 68.89
All Other	\$ 0.00	\$ 16.34	\$ 16.34	\$ 0.00	\$ 21.30	\$ 21.30	\$ 0.00	\$ 34.10	\$ 34.10	\$ 0.00	\$ 34.46	\$ 34.46
Total Medical	\$ 44.34	\$ 51.09	\$ 95.43	\$ 72.66	\$ 260.33	\$ 332.99	\$ 150.90	\$ 2,836.11	\$ 2,987.01	\$ 353.92	\$ 5,343.18	\$ 5,697.10

Notes:

1. In some cases totals may not equal the sum of their respective column components due to rounding.

**Demonstration to Integrate Care for Dual Eligible Individuals
(One Care- H7419-Tufts Health Public Plan)
CY 2017 Final Rate Report
February 13, 2017**

Base Data Summary

Region: Statewide

Period: Fiscal Year 2014

Category of Service	C1: Community Low Risk			C2: Community High Risk			C3: Community NHC			F1: Facility-Based Care		
	Crossover PMPM	Medicaid PMPM	Total PMPM	Crossover PMPM	Medicaid PMPM	Total PMPM	Crossover PMPM	Medicaid PMPM	Total PMPM	Crossover PMPM	Medicaid PMPM	Total PMPM
Member Months	665,851	665,851	665,851	218,541	218,541	218,541	140,486	140,486	140,486	19,649	19,649	19,649
Inpatient - Acute	\$ 5.05	\$ 1.09	\$ 6.14	\$ 11.80	\$ 4.30	\$ 16.10	\$ 14.46	\$ 30.06	\$ 44.51	\$ 14.58	\$ 1,332.74	\$ 1,347.32
Inpatient MH/SA	\$ 0.13	\$ 0.14	\$ 0.28	\$ 22.79	\$ 19.93	\$ 42.73	\$ 16.35	\$ 59.24	\$ 75.59	\$ 7.01	\$ 1,243.73	\$ 1,250.74
Hospital Outpatient	\$ 15.69	\$ 0.96	\$ 16.65	\$ 20.27	\$ 1.18	\$ 21.45	\$ 24.30	\$ 2.20	\$ 26.50	\$ 49.51	\$ 0.86	\$ 50.37
Outpatient MH/SA	\$ 5.77	\$ 5.91	\$ 11.68	\$ 9.36	\$ 146.93	\$ 156.29	\$ 7.05	\$ 68.28	\$ 75.33	\$ 6.59	\$ 27.90	\$ 34.49
Professional	\$ 17.63	\$ 2.54	\$ 20.16	\$ 25.86	\$ 8.39	\$ 34.25	\$ 30.92	\$ 4.84	\$ 35.76	\$ 39.89	\$ 3.57	\$ 43.45
HCBS/Home Health	\$ 0.00	\$ 3.46	\$ 3.46	\$ 0.00	\$ 8.45	\$ 8.45	\$ 0.00	\$ 2,273.95	\$ 2,273.95	\$ 0.00	\$ 34.79	\$ 34.79
LTC Facility	\$ 0.74	\$ 0.38	\$ 1.12	\$ 1.77	\$ 0.69	\$ 2.46	\$ 32.50	\$ 32.17	\$ 64.67	\$ 120.42	\$ 4,188.73	\$ 4,309.15
Pharmacy (Non-Part D)	\$ 0.00	\$ 4.15	\$ 4.15	\$ 0.00	\$ 13.17	\$ 13.17	\$ 0.00	\$ 5.97	\$ 5.97	\$ 0.00	\$ 5.55	\$ 5.55
DME & Supplies	\$ 1.96	\$ 3.26	\$ 5.21	\$ 1.57	\$ 2.48	\$ 4.05	\$ 11.52	\$ 32.11	\$ 43.64	\$ 7.92	\$ 35.91	\$ 43.83
Transportation	\$ 0.06	\$ 4.82	\$ 4.88	\$ 0.23	\$ 38.45	\$ 38.68	\$ 0.29	\$ 92.54	\$ 92.83	\$ 0.92	\$ 57.38	\$ 58.30
All Other	\$ 0.00	\$ 14.80	\$ 14.80	\$ 0.00	\$ 18.93	\$ 18.93	\$ 0.00	\$ 35.96	\$ 35.96	\$ 0.00	\$ 46.34	\$ 46.34
Total Medical	\$ 47.03	\$ 41.51	\$ 88.54	\$ 93.65	\$ 262.91	\$ 356.57	\$ 137.38	\$ 2,637.32	\$ 2,774.70	\$ 246.84	\$ 6,977.50	\$ 7,224.34

Region: Statewide

Period: Fiscal Year 2015

Category of Service	C1: Community Low Risk			C2: Community High Risk			C3: Community NHC			F1: Facility-Based Care		
	Crossover PMPM	Medicaid PMPM	Total PMPM	Crossover PMPM	Medicaid PMPM	Total PMPM	Crossover PMPM	Medicaid PMPM	Total PMPM	Crossover PMPM	Medicaid PMPM	Total PMPM
Member Months	595,900	595,900	595,900	193,747	193,747	193,747	144,352	144,352	144,352	19,258	19,258	19,258
Inpatient - Acute	\$ 5.06	\$ 1.22	\$ 6.27	\$ 10.40	\$ 4.65	\$ 15.05	\$ 15.96	\$ 27.92	\$ 43.88	\$ 30.20	\$ 1,366.11	\$ 1,396.30
Inpatient MH/SA	\$ 0.13	\$ 0.05	\$ 0.18	\$ 22.46	\$ 20.43	\$ 42.89	\$ 13.85	\$ 54.55	\$ 68.40	\$ 9.75	\$ 1,126.15	\$ 1,135.90
Hospital Outpatient	\$ 15.75	\$ 1.02	\$ 16.78	\$ 19.14	\$ 1.31	\$ 20.45	\$ 24.20	\$ 1.97	\$ 26.17	\$ 50.45	\$ 0.97	\$ 51.42
Outpatient MH/SA	\$ 4.61	\$ 6.48	\$ 11.09	\$ 7.51	\$ 151.17	\$ 158.67	\$ 5.24	\$ 67.63	\$ 72.87	\$ 4.33	\$ 29.60	\$ 33.93
Professional	\$ 13.71	\$ 2.21	\$ 15.92	\$ 18.82	\$ 7.60	\$ 26.42	\$ 20.73	\$ 3.43	\$ 24.16	\$ 25.64	\$ 2.61	\$ 28.25
HCBS/Home Health	\$ 0.00	\$ 3.44	\$ 3.44	\$ 0.00	\$ 8.24	\$ 8.24	\$ 0.00	\$ 2,479.92	\$ 2,479.92	\$ 0.00	\$ 30.45	\$ 30.45
LTC Facility	\$ 0.82	\$ 0.35	\$ 1.17	\$ 1.68	\$ 0.81	\$ 2.48	\$ 29.06	\$ 30.87	\$ 59.93	\$ 135.34	\$ 4,242.90	\$ 4,378.24
Pharmacy (Non-Part D)	\$ 0.00	\$ 4.93	\$ 4.93	\$ 0.00	\$ 3.41	\$ 3.41	\$ 0.00	\$ 6.32	\$ 6.32	\$ 0.00	\$ 3.88	\$ 3.88
DME & Supplies	\$ 2.07	\$ 3.57	\$ 5.64	\$ 1.72	\$ 2.70	\$ 4.41	\$ 10.36	\$ 32.73	\$ 43.10	\$ 5.14	\$ 35.78	\$ 40.92
Transportation	\$ 0.06	\$ 5.14	\$ 5.20	\$ 0.22	\$ 48.23	\$ 48.46	\$ 0.24	\$ 97.94	\$ 98.18	\$ 1.09	\$ 57.41	\$ 58.50
All Other	\$ 0.00	\$ 17.88	\$ 17.88	\$ 0.00	\$ 22.64	\$ 22.64	\$ 0.00	\$ 36.90	\$ 36.90	\$ 0.00	\$ 56.86	\$ 56.86
Total Medical	\$ 42.21	\$ 46.29	\$ 88.50	\$ 81.94	\$ 271.19	\$ 353.12	\$ 119.65	\$ 2,840.19	\$ 2,959.84	\$ 261.95	\$ 6,952.71	\$ 7,214.67

Notes:

1. In some cases totals may not equal the sum of their respective column components due to rounding.

Demonstration to Integrate Care for Dual Eligible Individuals (One Care- H7419-Tufts Health Public Plan) CY 2017 Final Rate Report February 13, 2017

Base Data Adjustments

Rating Category: Community Low Risk

PMPM

Adjustment	Eastern	Western	The Cape	Statewide
Base data	\$ 89.31	\$ 86.49	\$ 90.46	\$ 88.59
Completion	\$ 0.28	\$ 0.23	\$ 0.34	\$ 0.27
Closed Redets Removal	\$ 0.08	\$ 0.22	\$ 0.13	\$ 0.13
TLP Service Removal	\$ (1.12)	\$ 0.00	\$ (0.69)	\$ (0.76)
Relational Adjustment	\$ (0.09)	\$ (0.26)	\$ 6.07	\$ 0.40
Final adjusted base data	\$ 88.46	\$ 86.68	\$ 96.30	\$ 88.63

Percentage Impact

Adjustment	Eastern	Western	The Cape	Statewide
Base data				
Completion	0.3%	0.3%	0.4%	0.3%
Closed Redets Removal	0.1%	0.3%	0.1%	0.1%
TLP Service Removal	-1.3%	0.0%	-0.8%	-0.9%
Relational Adjustment	-0.1%	-0.3%	6.7%	0.5%
Total base data adjustment	-1.0%	0.2%	6.5%	0.0%

Rating Category: Community High Behavioral Health

PMPM

Adjustment	Eastern	Western	The Cape	Statewide
Base data	\$ 361.28	\$ 334.81	\$ 385.45	\$ 355.53
Completion	\$ 0.94	\$ 0.74	\$ 0.83	\$ 0.86
Closed Redets Removal	\$ 0.22	\$ (0.01)	\$ 1.10	\$ 0.24
TLP Service Removal	\$ (1.85)	\$ 0.00	\$ 0.00	\$ (1.08)
Relational Adjustment	\$ (1.44)	\$ 0.00	\$ 31.35	\$ 2.43
Final adjusted base data	\$ 359.15	\$ 335.54	\$ 418.72	\$ 357.99

Percentage Impact

Adjustment	Eastern	Western	The Cape	Statewide
Base data				
Completion	0.3%	0.2%	0.2%	0.2%
Closed Redets Removal	0.1%	0.0%	0.3%	0.1%
TLP Service Removal	-0.5%	0.0%	0.0%	-0.3%
Relational Adjustment	-0.4%	0.0%	8.1%	0.7%
Total base data adjustment	-0.6%	0.2%	8.6%	0.7%

Rating Category: High Community Need

PMPM

Adjustment	Eastern	Western	The Cape	Statewide
Base data	\$ 2,978.39	\$ 2,673.61	\$ 2,925.43	\$ 2,872.55
Completion	\$ 2.77	\$ 1.65	\$ 3.01	\$ 2.41
Closed Redets Removal	\$ 1.30	\$ 0.65	\$ 2.04	\$ 1.14
TLP Service Removal	\$ (12.83)	\$ 0.00	\$ (3.85)	\$ (7.88)
Relational Adjustment	\$ (2.97)	\$ 0.00	\$ 48.22	\$ 1.79
Final adjusted base data	\$ 2,966.66	\$ 2,675.91	\$ 2,974.85	\$ 2,870.01

Percentage Impact

Adjustment	Eastern	Western	The Cape	Statewide
Base data				
Completion	0.1%	0.1%	0.1%	0.1%
Closed Redets Removal	0.0%	0.0%	0.1%	0.0%
TLP Service Removal	-0.4%	0.0%	-0.1%	-0.3%
Relational Adjustment	-0.1%	0.0%	1.6%	0.1%
Total base data adjustment	-0.4%	0.1%	1.7%	-0.1%

Rating Category: Facility-Based Care

PMPM

Adjustment	Eastern	Western	The Cape	Statewide
Base data	\$ 7,744.09	\$ 6,357.67	\$ 5,791.74	\$ 7,222.89
Completion	\$ 35.12	\$ 16.37	\$ 12.08	\$ 28.36
Closed Redets Removal	\$ (2.14)	\$ (10.01)	\$ 0.00	\$ (3.97)
TLP Service Removal	\$ 0.00	\$ 0.00	\$ 0.00	\$ 0.00
Relational Adjustment	\$ (77.77)	\$ 139.57	\$ 0.00	\$ (15.51)
Final adjusted base data	\$ 7,699.30	\$ 6,503.59	\$ 5,803.82	\$ 7,231.77

Percentage Impact

Adjustment	Eastern	Western	The Cape	Statewide
Base data				
Completion	0.5%	0.3%	0.2%	0.4%
Closed Redets Removal	0.0%	-0.2%	0.0%	-0.1%
TLP Service Removal	0.0%	0.0%	0.0%	0.0%
Relational Adjustment	-1.0%	2.2%	0.0%	-0.2%
Total base data adjustment	-0.6%	2.3%	0.2%	0.1%