

**Demonstration to Integrate Care for Dual Eligible Individuals
(One Care- H7419- Tufts Health Public Plan)
Final CY 2018 Final Medicare-Medicaid Rate Report
November 20, 2018**

MassHealth, in conjunction with the Centers for Medicare & Medicaid Services (CMS), is releasing the final Medicaid and Medicare components of the CY 2018 rates for the Massachusetts Demonstration to Integrate Care for Dual Eligible Individuals (One Care). Effective January 1, 2018, these rates replace the Demonstration rates included in the CY 2017 rate report.

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

Included in this report are the final CY 2018 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 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.

**Demonstration to Integrate Care for Dual Eligible Individuals
(One Care- H7419- Tufts Health Public Plan)
Final CY 2018 Final Medicare-Medicaid Rate Report
November 20, 2018**

II. MassHealth Component of the Rate – CY 2018

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 2018 effective January 1, 2018 through December 31, 2018 are listed below, by Massachusetts county and MassHealth rating category for the Demonstration. The rates below do not include application of the 1.5% quality withhold (see Section IV). The rates below do include the savings percentage of 0.5% (see Section IV) for Demonstration Year 5.

MassHealth Component of County Rate Effective January 1, 2018 through December 31, 2018							
County	C1 – Community Other	C2A – Community High Behavioral Health	C2B – Community Very High Behavioral Health	C3A – High Community Need	C3B – Very High Community Need	C3C – Transitional Living Program	F1 – Facility- based Care
Essex	\$160.48	\$566.63	\$793.34	\$2,872.32	\$6,088.34	\$8,385.38	\$9,703.81
Franklin	\$152.74	\$517.60	\$723.80	\$2,806.91	\$5,956.83	\$8,320.25	\$8,569.38
Hampden	\$152.74	\$517.60	\$723.80	\$2,806.91	\$5,956.83	\$8,320.25	\$8,569.38
Hampshire	\$152.74	\$517.60	\$723.80	\$2,806.91	\$5,956.83	\$8,320.25	\$8,569.38
Middlesex	\$160.48	\$566.63	\$793.34	\$2,872.32	\$6,088.34	\$8,385.38	\$9,703.81
Norfolk	\$160.48	\$566.63	\$793.34	\$2,872.32	\$6,088.34	\$8,385.38	\$9,703.81
Plymouth	\$173.82	\$613.33	\$859.51	\$3,153.42	\$6,685.21	\$7,534.88	\$8,182.39
Suffolk	\$160.48	\$566.63	\$793.34	\$2,872.32	\$6,088.34	\$8,385.38	\$9,703.81
Worcester	\$152.74	\$517.60	\$723.80	\$2,806.91	\$5,956.83	\$8,320.25	\$8,569.38
Statewide*	\$158.08	\$545.96	\$761.88	\$2,850.31	\$6,069.64	\$8,320.49	\$9,241.58

* 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).

Demonstration to Integrate Care for Dual Eligible Individuals (One Care- H7419- Tufts Health Public Plan) Final CY 2018 Final Medicare-Medicaid Rate Report November 20, 2018

Historical Base Data Development:

The historical Medicaid and Medicare-Medicaid crossover expenditures for CY 2015 and CY 2016, 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.

Rating Category	Description
F1: Facility-Based Care	<p><u>Demonstration Process</u></p> <p>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></p> <p>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>

**Demonstration to Integrate Care for Dual Eligible Individuals
(One Care- H7419- Tufts Health Public Plan)
Final CY 2018 Final Medicare-Medicaid Rate Report
November 20, 2018**

Rating Category	Description
C3C: Community Tier 3 – Transitional Living Need	<p><u>Demonstration Process</u></p> <p>Includes individuals who do not meet F1 criteria, have a type of residence equal to a board and care/assisted living/group home, and for whom a MDS-HC assessment indicates:</p> <ul style="list-style-type: none"> • Have a daily skilled need, or daily chronic and stable routine need, for which the individual requires assistance. • Have two or more activities of daily living (ADL) limitations requiring limited assistance to total dependence. • Have one or more of the traumatic brain injury diagnoses as defined by the following diagnosis codes: <ul style="list-style-type: none"> – S06.1x. – S06.2x. – S06.3x. – S06.4x. – S06.5x. – S06.6x. – S06.8x. <p><u>Proxy Method</u></p> <p>The base data for this rating category included claim and eligibility data for members not in F1 for months in which the member has claims indicating residence in a Transition Living Program (TLP) facility as of the first of that month.</p>
C3: Community Tier 3	<p><u>Demonstration Process</u></p> <p>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></p> <p>The base data for this rating category included claim and eligibility data for members not in F1 or C3C that are within episodes of three-plus consecutive months in which a member is in a facility and/or using more than \$700 in community-based long-term services and supports (LTSS).</p>

**Demonstration to Integrate Care for Dual Eligible Individuals
(One Care- H7419- Tufts Health Public Plan)
Final CY 2018 Final Medicare-Medicaid Rate Report
November 20, 2018**

Rating Category	Description
C2: Community Tier 2	<p><u>Demonstration Process</u></p> <p>Includes individuals who do not meet F1, C3C, 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:</p> <ul style="list-style-type: none"> • 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). <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, C3C, 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).</p>

**Demonstration to Integrate Care for Dual Eligible Individuals
(One Care- H7419- Tufts Health Public Plan)
Final CY 2018 Final Medicare-Medicaid Rate Report
November 20, 2018**

Rating Category	Description
C1: Community Tier 1 — Community Other	<p><u>Demonstration Process</u> Includes individuals in the community who do not meet the F1, C3C, C3, or C2 criteria.</p> <p><u>Proxy Method</u> The base data for this rating category included claim an eligibility data for members 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

MassHealth further classifies C2 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 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 includes individuals with at least one mental health diagnosis (ICD-10 F20.0-F20.9, F25.0-F25.9, F28, F9, F30.0-F30.9, F31.0-F31.9, F32.0-F32.9, F33.0-F33.9, F34.8, F34.9, or F39), **and** at least one substance abuse diagnosis (ICD-10 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, or F19.20-F19.29 excluding F19.21). 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 further classifies C3 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 C3-High Community Needs rating category, but also includes criteria related to specific diagnoses. The C3B rating category includes 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.

Demonstration to Integrate Care for Dual Eligible Individuals (One Care- H7419- Tufts Health Public Plan) Final CY 2018 Final Medicare-Medicaid Rate Report November 20, 2018

Rate Relativity Factors

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
- 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	-5.7%	-6.6%	-8.7%
C2B	33.8%	32.4%	29.5%

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

	Eastern	Western	The Cape
C3A	-4.1%	-1.4%	-1.7%
C3B	104.2%	109.9%	109.2%

C3C Rating Category

MassHealth is adding an additional RC — C3C — for members with a traumatic brain injury (TBI) (ICD-10 S06.1, S06.2, S06.3, S06.4, S06.5, S06.6, and S06.8) in the Transitional Living Program (TLP). Unlike C3A and C3B, C3C is treated as a standalone RC and is not developed through the relativity process. Members are identified as C3C through their use of TLP services and an assessment indicating a TBI diagnosis. Due to the small nature of this population, an additional year of data (CY 2014) was included in the rate development process. Rates were developed at the statewide level, with region-specific adjustments applied for the unit cost of TLP services, which vary by TLP site.

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.”

**Demonstration to Integrate Care for Dual Eligible Individuals
(One Care- H7419- Tufts Health Public Plan)
Final CY 2018 Final Medicare-Medicaid Rate Report
November 20, 2018**

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
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

**Demonstration to Integrate Care for Dual Eligible Individuals
(One Care- H7419- Tufts Health Public Plan)
Final CY 2018 Final Medicare-Medicaid Rate Report
November 20, 2018**

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.
- Berkshire.
- Bristol.
- 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
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 5, 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 2018 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 14, 2017 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.

**Demonstration to Integrate Care for Dual Eligible Individuals
(One Care- H7419- Tufts Health Public Plan)
Final CY 2018 Final Medicare-Medicaid Rate Report
November 20, 2018**

Category of Service	Medicaid Claims Completion Factors		Crossover Claims Completion Factors	
	CY 2015	CY 2016	CY 2015	CY 2016
Inpatient-Non-MH/SA	1.030	1.089	0.999	1.062
Inpatient MH/SA	1.030	1.094	0.999	1.055
Hospital Outpatient	1.000	1.007	1.000	1.009
Outpatient MH/SA	1.000	1.008	1.000	1.009
Professional	1.000	1.008	1.000	1.006
HCBS/Home Health	1.000	1.002	1.000	1.000
LTC Facility	1.000	1.008	1.000	1.011
Pharmacy (Non-Part D)	1.000	1.009	1.000	1.000
DME and Supplies	1.000	1.009	1.000	1.026
Transportation	1.000	1.010	1.000	1.013
All Other	1.000	1.010	1.000	1.000
All Services	1.003	1.012	1.000	1.022

The HCBS/Home Health factors were applied to TLP services included in the development of the C3C rates. All claims occurring in CY 2014 were considered complete.

Pharmacy Rebates:

The 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 18.4% 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 CY 2015 and CY 2016. 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 \$0.3M in potential rebates in CY 2015 and CY 2016 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 3.4% in pharmacy rebates for this population.

Acuity Adjustment

The base FFS data represents both members who eventually enrolled in One Care and those that did not. MassHealth evaluated historical data from multiple years that separately identified members who enrolled in One Care, and compared those PMPMs to the overall base. Through this analysis, it was determined that there were several RCs where the acuity of the eventual enrollees differed materially from the overall base. An adjustment was created at the aggregate to reflect this differential, and then converted to be applied at the COS level. In aggregate, the adjustments below have been applied to reflect differences in the acuity level of the One Care enrollees.

Region	C1	C2	C3	C3C	F1
Eastern	7.8%	16.0%	-3.7%	0.0%	0.0%
Western	0.0%	4.4%	-2.4%	0.0%	0.0%
The Cape	0.0%	4.6%	-5.0%	0.0%	0.0%

**Demonstration to Integrate Care for Dual Eligible Individuals
(One Care- H7419- Tufts Health Public Plan)
Final CY 2018 Final Medicare-Medicaid Rate Report
November 20, 2018**

Other Rate Adjustments:

Dental Benefit Changes and HSN Dental Wrap:

The MassHealth dental benefit for adults was reduced effective July 2010; coverage was restored for fillings prior to the base data period. 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 this benefit change:

Region	C1	C2	C3	F1
Eastern	2.9%	2.4%	0.6%	2.2%
Western	2.8%	3.0%	2.0%	4.3%
The Cape	3.2%	3.6%	2.7%	5.0%

In addition, adult MassHealth members can receive coverage for the full scope of dental services prior to July 2010 benefit reductions through hospitals and Community Health Centers (CHCs) through the Commonwealth’s Health Safety Net. These costs are not included in the FFS base data and therefore must be added into the rates. A 0.9% adjustment was made to the All Other COS for most RCs to account for these added services. Due to the inclusion of CY 2014 in the base data, this analysis was replicated for the C3C RC, and the result is a 0.8% adjustment to the All Other COS.

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 2018 One Care capitation rates include the costs of providing the Elder Affairs Home Care Program, including the Basic and Enhanced Community Options Program levels.

Region	C1	C2	C3	C3C	F1
Eastern	1.5%	1.5%	1.8%	0.0%	1.5%
Western	1.5%	1.5%	1.7%	0.0%	1.5%
The Cape	1.5%	1.5%	1.6%	0.0%	1.5%

**Demonstration to Integrate Care for Dual Eligible Individuals
(One Care- H7419- Tufts Health Public Plan)
Final CY 2018 Final Medicare-Medicaid Rate Report
November 20, 2018**

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 for Inpatient MH/SA and Outpatient MH/SA COS:

DMH Psychiatric Claims (Inpatient MH/SA)

Region	C1	C2	C3	C3C	F1
Eastern	72.4%	65.8%	79.0%	0.0%	11.9%
Western	337.9%	123.0%	215.9%	0.0%	213.6%
The Cape	0.0%	127.8%	105.5%	0.0%	464.6%

DMH Psychiatric Claims (Outpatient MH/SA)

Region	C1	C2	C3	C3C	F1
Eastern	0.1%	0.4%	0.7%	0.0%	0.0%
Western	0.0%	0.0%	0.0%	0.0%	0.0%
The Cape	0.3%	1.3%	4.5%	0.0%	0.0%

Diversionary Behavioral Health:

Costs for certain diversionary behavioral health services that are covered under the One Care program for non-institutionalized members are not included in the FFS base data. The CY 2018 rates include adjustments to the Outpatient MH/SA COS for the costs of covering these services. These diversionary behavioral health services include the following:

- Acute Treatment Services for Substance Use Disorders (Level III.7).
- Community Support Program.
- Psychiatric Day Treatment.
- Recovery Support Navigator.
- Structured Outpatient Addiction Program.

Region	C1	C2	C3	C3C	F1
Eastern	18.4%	18.7%	18.7%	19.9%	0.0%
Western	19.6%	19.8%	19.8%	19.9%	0.0%
The Cape	18.6%	18.6%	18.6%	19.9%	0.0%

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

**Demonstration to Integrate Care for Dual Eligible Individuals
(One Care- H7419- Tufts Health Public Plan)
Final CY 2018 Final Medicare-Medicaid Rate Report
November 20, 2018**

current moratorium is still in effect and MassHealth will continue to request extensions. The overall result of these changes to the HCBS/Home Health expense line is demonstrated below:

Region	C1	C2	C3	C3C	F1
Eastern	0.0%	0.0%	-14.0%	0.0%	0.0%
Western	0.0%	0.0%	-9.6%	0.0%	0.0%
The Cape	0.0%	0.0%	-7.7%	0.0%	0.0%

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 changes to the HCBS/Home Health COS:

Region	C1	C2	C3	C3C	F1
Eastern	-0.1%	0.0%	-0.6%	0.0%	-0.1%
Western	-0.1%	0.0%	-1.1%	0.0%	-0.6%
The Cape	-0.1%	-0.2%	-0.9%	0.0%	0.0%

Community Support Program (CSP) Services for Chronically Homeless Individuals

Effective in 2018, 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	C3C	F1
Eastern	6.3%	6.4%	6.4%	0.0%	0.0%
Western	0.8%	0.8%	0.8%	0.0%	0.0%
The Cape	7.4%	7.5%	-7.5%	0.0%	0.0%

Transitional Living Program Unit Cost

Due to the small population and relative stability of non-TLP services across regions, the C3C rates were developed at the statewide level. However, TLP payment rates vary by facility. Three providers are located in the Eastern region, while one is located in The Cape region. Utilization in each region was aggregated and used to develop an average expected unit cost in CY 2018.

**Demonstration to Integrate Care for Dual Eligible Individuals
(One Care- H7419- Tufts Health Public Plan)
Final CY 2018 Final Medicare-Medicaid Rate Report
November 20, 2018**

MassHealth applied an adjustment to project the aggregate statewide TLP base data to a CY 2018 region-specific figure. No additional trend was applied to the TLP COS. The Western region unit cost was assumed equal to the statewide average. While there are no TLP providers in the Western region, a rate was developed in the event that a member in the Western region uses TLP services and MassHealth must pay a rate. The impact to the base TLP COS is shown in the table below:

Region	TLP Services
Eastern	1.4%
Western	0.5%
The Cape	-10.8%
Statewide	0.5%

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:

Nursing Facility Rebase

MassHealth made several changes to nursing facility reimbursements from the start of the FFS base data to the end of CY 2018, 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)

The estimated combined impact of these changes to nursing facility reimbursements is a 0.7% increase to the long term care (LTC) facility COS for each most RCs. Due to the inclusion of CY 2014 in the base data, the C3C RC is impacted by the adjustments in CY 2014 and the C3C LTC facility COS is increased by 1.3%.

Durable Medical Equipment Rate Change

Effective March 1, 2018, MassHealth changed 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 as displayed below:

Region	C1	C2	C3	C3C	F1
Eastern	-2.4%	-2.4%	-2.7%	-2.8%	-2.4%
Western	-2.4%	-2.4%	-2.8%	-2.8%	-2.6%
The Cape	-2.1%	-2.0%	-2.8%	-2.8%	-2.6%

**Demonstration to Integrate Care for Dual Eligible Individuals
(One Care- H7419- Tufts Health Public Plan)
Final CY 2018 Final Medicare-Medicaid Rate Report
November 20, 2018**

Home- and Community Based-Services Fee Changes

These changes were found specifically within the adult foster care, personal care/fiscal intermediary services, and continuous skilled nursing rate increases. Taking into account the multiple effective dates for these fee changes across the various services, the following adjustments were made to the HCBS line:

Region	C1	C2	C3	C3C	F1
Eastern	1.1%	0.3%	1.9%	0.0%	0.8%
Western	1.8%	0.6%	3.3%	0.0%	2.1%
The Cape	1.1%	0.2%	2.1%	0.0%	0.8%

Acute Hospital Inpatient Fee Change

Effective March 1, 2018, MassHealth implemented a fee schedule increase for acute inpatient hospital services. Acute inpatient claims were adjusted for the 2.6% increase. Crossover claims were analyzed for the impact of the fee schedule change after Medicare Part A deductibles and cost sharing. The total impact to the inpatient expense lines are provided in the tables below:

Acute Hospital Inpatient Fee Change (MH/SA)

Region	C1	C2	C3	C3C	F1
Eastern	1.9%	2.9%	1.3%	0.0%	0.1%
Western	2.9%	2.7%	1.6%	0.0%	0.2%
The Cape	7.1%	2.0%	1.0%	0.0%	0.3%

Acute Hospital Inpatient Fee Change (Non-MH/SA)

Region	C1	C2	C3	C3C	F1
Eastern	6.0%	4.8%	2.5%	3.7%	0.2%
Western	7.8%	6.2%	4.5%	3.7%	0.2%
The Cape	6.8%	8.1%	2.9%	3.7%	0.7%

Inpatient Chronic Rehabilitation Hospital Fee Change

Effective October 1, 2017, in conjunction with a new assessment for these hospitals, MassHealth implemented a fee schedule increase for inpatient services provided at chronic and rehabilitation hospitals. The change primarily impacts the Inpatient-Non-MH/SA COS as demonstrated in the following table. Additionally, the adjustment impacted the Inpatient MH/SA and All Other COS for F1 in the Eastern region by 0.1% and 0.5% respectively.

Inpatient Chronic Rehabilitation Hospital Fee Change (Non-MH/SA)

Region	C1	C2	C3	C3C	F1
Eastern	0.4%	0.0%	3.1%	0.0%	6.8%

**Demonstration to Integrate Care for Dual Eligible Individuals
(One Care- H7419- Tufts Health Public Plan)
Final CY 2018 Final Medicare-Medicaid Rate Report
November 20, 2018**

Western	0.0%	0.0%	0.2%	0.0%	0.0%
The Cape	0.0%	0.0%	13.7%	0.0%	17.9%

Acute Hospital Outpatient Fee Change

Effective December 31, 2016, MassHealth transitioned its acute outpatient hospital payment method from Payment Amount per Episode Adjudicated Payment per Episode of Care (APEC). The APEC payment will vary based on the weight assigned to the claim, utilizing the Enhanced Ambulatory Patient Grouping System. The payment method change is expected to have a modest impact to the Medicaid Only RCs as well as the Institutional Dual RC.

In addition, effective March 1, 2018, MassHealth implemented a fee schedule increase for acute outpatient hospital services. Acute outpatient claims were adjusted for the 2.6% increase. Crossover claims were analyzed for the impact of the fee schedule change after Medicare cost sharing. The total impact to the outpatient expense lines are provided in the tables below:

Acute Hospital Outpatient Fee Change (MH/SA)

Region	C1	C2	C3	C3C	F1
Eastern	2.4%	0.2%	0.3%	0.3%	0.1%
Western	1.2%	0.2%	0.3%	0.3%	0.2%
The Cape	0.2%	0.1%	0.1%	0.3%	0.0%

Acute Hospital Outpatient Fee Change (Non-MH/SA)

Region	C1	C2	C3	C3C	F1
Eastern	10.5%	10.5%	8.7%	10.9%	2.2%
Western	11.0%	11.1%	10.0%	10.9%	2.3%
The Cape	11.1%	10.4%	8.3%	10.9%	1.9%

Professional Fee Change

Effective October 20, 2017, MassHealth implemented a fee schedule increase for CHCs of 14.5%. Effective March 1, 2018, MassHealth implemented fee schedule increases of 5.5% for professional services; including, medicine, radiology, surgery, and anesthesia. Professional claims were adjusted for the rate increases. Crossover claims were analyzed for the impact of the fee schedule changes after Medicare cost sharing. The total impact to the professional COS is provided below:

Region	C1	C2	C3	C3C	F1
Eastern	22.9%	18.9%	21.5%	26.0%	22.0%
Western	23.4%	20.3%	22.9%	26.0%	22.1%
The Cape	24.6%	21.1%	23.6%	26.0%	26.1%

**Demonstration to Integrate Care for Dual Eligible Individuals
(One Care- H7419- Tufts Health Public Plan)
Final CY 2018 Final Medicare-Medicaid Rate Report
November 20, 2018**

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	C3C	F1
Eastern	0.0%	0.0%	0.0%	0.1%	0.1%	0.0%	8.0%
Western	0.0%	0.0%	0.0%	0.1%	0.2%	0.0%	9.8%
The Cape	0.0%	0.0%	0.0%	0.1%	0.1%	0.0%	12.0%

Trend Factors Applied to Adjusted Historical Base Data:

The following trend factors have been applied for 30 months from the midpoint of the base period (January 1, 2016) to the midpoint of the contract period (July 1, 2018) for most RCs. However, for C3C rates, trend was applied for 37.5 months from the midpoint of the base period (July 1, 2015) to the midpoint of the contract period (August 16, 2018).

Annual trend factors were developed separately for each major COS. Minor programmatic changes were considered in the development of trend factors.

Category of Service	C1	C2	C3	C3C	F1
Inpatient-Non-MH/SA	1.0%	2.0%	2.0%	2.0%	2.0%
Inpatient MH/SA	1.0%	2.0%	2.0%	2.0%	2.0%
Hospital Outpatient	3.0%	3.0%	2.5%	2.5%	2.5%
Outpatient MH/SA	3.0%	3.0%	2.5%	2.5%	2.5%
Professional	3.0%	3.0%	2.5%	2.5%	2.5%
HCBS/Home Health	3.0%	3.0%	3.0%	3.0%	3.0%
LTC Facility	1.8%	1.8%	1.8%	1.8%	1.8%
Pharmacy (Non-Part D)	5.4%	2.4%	1.9%	1.9%	1.9%
DME and Supplies	5.0%	4.8%	2.0%	2.0%	2.5%
Transportation	5.0%	4.8%	2.0%	2.0%	2.5%
All Other	5.0%	4.8%	2.0%	2.0%	2.5%

Data Rebalancing

Prior to finalizing the medical component of the capitation rates, the PMPM values and relationships among and between RCs were compared with the prior year's rates as well as One Care plan-reported experience data. To better reflect the relationships that exist in the experience data, adjustments were made to rebalance funds among RCs without impacting the aggregate base data. This rebalancing adjustment was used for all community RCs as shown below:

**Demonstration to Integrate Care for Dual Eligible Individuals
(One Care- H7419- Tufts Health Public Plan)
Final CY 2018 Final Medicare-Medicaid Rate Report
November 20, 2018**

Region	C1	C2	C3	C3C	F1
Eastern	15.0%	2.5%	-4.4%	0.0%	0.0%
Western	25.0%	15.0%	-5.0%	0.0%	0.0%
The Cape	27.5%	25.0%	2.5%	0.0%	0.0%

Administrative Expenses:

An adjustment has been applied to the MassHealth component of the rate for CY 2018 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	C3C	F1
Admin	\$17.67	\$22.00	\$24.41	\$47.93	\$84.10	\$84.10	\$113.21
BH Care Management	\$1.19	\$5.17	\$6.97	\$2.84	\$5.28	\$5.28	\$0.00
Complex Care Management	\$9.09	\$14.89	\$18.12	\$49.69	\$98.22	\$98.22	\$0.00

**Demonstration to Integrate Care for Dual Eligible Individuals
(One Care- H7419- Tufts Health Public Plan)
Final CY 2018 Final Medicare-Medicaid Rate Report
November 20, 2018**

III. Medicare Components of the Rate – CY 2018

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 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: The CY 2018 Medicare A/B Baseline County rates are provided below.

The rates represent the weighted average of the CY 2018 FFS Standardized County Rates, updated to incorporate the adjustments noted below, and the Medicare Advantage projected payment rates for CY 2018, based on the expected enrollment of beneficiaries from Medicare FFS and Medicare Advantage prior to the demonstration at the county level.

Bad Debt Adjustment: The FFS component of the CY 2018 Medicare A/B baseline rate has been updated to reflect a 1.77% 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 and the Original Fee-for-Service Medicare programs. The adjustment for CY 2018 in Medicare Advantage is 5.91%. For 2018, 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

**Demonstration to Integrate Care for Dual Eligible Individuals
(One Care- H7419- Tufts Health Public Plan)
Final CY 2018 Final Medicare-Medicaid Rate Report
November 20, 2018**

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.

**Demonstration to Integrate Care for Dual Eligible Individuals
(One Care- H7419- Tufts Health Public Plan)
Final CY 2018 Final Medicare-Medicaid Rate Report
November 20, 2018**

2018 Medicare A/B Baseline PMPM, Non-ESRD Beneficiaries, Standardized 1.0 Risk Score, by Demonstration County¹					
County	2018 Published FFS Standardized County Rate	2018 Updated Medicare A/B FFS Baseline (updated by CY 2018 bad debt adjustment)	2018 Updated Medicare A/B Baseline (incorporating updated Medicare A/B FFS baseline and Medicare Advantage component)	2018 Medicare A/B Baseline, Savings Percentage Applied (after application of .5% savings percentage)	2018 Final Medicare A/B PMPM Payment (2% sequestration reduction applied and prior to quality withhold)
Essex	\$858.29	873.48	\$873.21	\$868.84	\$851.46
Franklin	741.49	754.61	754.88	751.11	736.09
Hampden	757.63	771.04	771.26	767.40	752.05
Hampshire	773.79	787.49	787.77	783.83	768.15
Middlesex	859.13	874.34	873.95	869.58	852.19
Norfolk	911.59	927.73	927.30	922.66	904.21
Plymouth	952.23	969.08	968.71	963.87	944.59
Suffolk	877.82	893.36	892.98	888.52	870.75
Worcester	834.92	849.70	849.56	845.31	828.40

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 2018 CMS will apply the full prevailing Medicare Advantage coding intensity adjustment of 5.91%.

**Demonstration to Integrate Care for Dual Eligible Individuals
(One Care- H7419- Tufts Health Public Plan)
Final CY 2018 Final Medicare-Medicaid Rate Report
November 20, 2018**

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 2018 Massachusetts ESRD dialysis state rate, updated to incorporate the impact of sequestration-related rate reductions. The CY 2018 ESRD dialysis state rate for Massachusetts is \$7,921.56 PMPM; the updated CY 2018 ESRD dialysis state rate incorporating a 2% sequestration reduction and prior to the application of the quality withhold is \$7,763.13 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 2018 Massachusetts ESRD dialysis state rate updated to incorporate the impact of sequestration-related rate reductions. The CY 2018 ESRD dialysis state rate for Massachusetts is \$7,921.56 PMPM; the updated CY 2018 ESRD dialysis state rate incorporating a 2% sequestration reduction and prior to the application of the quality withhold is \$7,763.13 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.

**Demonstration to Integrate Care for Dual Eligible Individuals
(One Care- H7419- Tufts Health Public Plan)
Final CY 2018 Final Medicare-Medicaid Rate Report
November 20, 2018**

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).

2018 Medicare A/B Baseline PMPM, Beneficiaries with ESRD Functioning Graft Status, Standardized 1.0 Risk Score, by Demonstration County		
County	2018 3.5% bonus County Rate (Benchmark)	2018 Sequestration-Adjusted Medicare A/B Baseline (after application of 2% Sequestration reduction)
Essex	\$845.42	\$828.51
Franklin	823.05	806.59
Hampden	812.56	796.31
Hampshire	829.89	813.29
Middlesex	867.72	850.37
Norfolk	897.92	879.96
Plymouth	937.95	919.19
Suffolk	864.65	847.36
Worcester	843.27	826.40

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.

**Demonstration to Integrate Care for Dual Eligible Individuals
(One Care- H7419- Tufts Health Public Plan)
Final CY 2018 Final Medicare-Medicaid Rate Report
November 20, 2018**

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 2018 is \$57.93 and the CY 2017 Low-Income Premium Subsidy Amount for Massachusetts is \$35.58. 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 \$57.48. 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: \$160.34 PMPM
- Reinsurance: \$260.79 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.

**Demonstration to Integrate Care for Dual Eligible Individuals
(One Care- H7419- Tufts Health Public Plan)
Final CY 2018 Final Medicare-Medicaid Rate Report
November 20, 2018**

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 5	January 1, 2018 through December 31, 2018	0.50%

Quality Withhold

The quality withhold percentages applied to the Medicaid and Medicare A/B components of the rate will be 1.50% for Demonstration Year 5. CMS strongly encourages the One Care Plans to review the DY 5 methodology and plan ahead to maximize the chances of fully recouping the withheld amounts.

More information is available at:

<https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/Downloads/QualityWithholdGuidanceDY2-503142018.pdf>

State Specific for Massachusetts:

https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/Downloads/MAQualityWithholdGuidanceDY2-5_03162018.pdf

**Demonstration to Integrate Care for Dual Eligible Individuals
(One Care- H7419- Tufts Health Public Plan)
Final CY 2018 Final Medicare-Medicaid Rate Report
November 20, 2018**

V. Risk Mitigation

The three-way contract and contract amendment established 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 5. 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 5, 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.

**Demonstration to Integrate Care for Dual Eligible Individuals
(One Care- H7419- Tufts Health Public Plan)
Final CY 2018 Final Medicare-Medicaid Rate Report
November 20, 2018**

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.

**Demonstration to Integrate Care for Dual Eligible Individuals
(One Care- H7419- Tufts Health Public Plan)
Final CY 2018 Final Medicare-Medicaid Rate Report
November 20, 2018**

Base Data Summary

Region: Eastern

Period: Calendar 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	375,454	375,454	375,454	124,311	124,311	124,311	88,209	88,209	88,209	12,521	12,521	12,521
Inpatient - Acute	\$ 6.11	\$ 1.84	\$ 7.95	\$ 11.20	\$ 7.14	\$ 18.34	\$ 13.40	\$ 45.17	\$ 58.57	\$ 33.89	\$ 1,749.28	\$ 1,783.17
Inpatient MH/SA	\$ 0.10	\$ 0.09	\$ 0.18	\$ 21.22	\$ 23.81	\$ 45.03	\$ 19.90	\$ 76.70	\$ 96.61	\$ 9.62	\$ 1,688.67	\$ 1,698.29
Hospital Outpatient	\$ 16.79	\$ 1.04	\$ 17.82	\$ 20.84	\$ 1.54	\$ 22.38	\$ 24.35	\$ 1.73	\$ 26.08	\$ 51.22	\$ 1.01	\$ 52.23
Outpatient MH/SA	\$ 4.61	\$ 4.23	\$ 8.85	\$ 7.47	\$ 142.90	\$ 150.37	\$ 5.23	\$ 69.10	\$ 74.32	\$ 3.62	\$ 27.21	\$ 30.82
Professional	\$ 9.46	\$ 2.22	\$ 11.67	\$ 12.98	\$ 11.08	\$ 24.07	\$ 12.99	\$ 5.01	\$ 18.00	\$ 11.21	\$ 3.29	\$ 14.51
HCBS/Home Health	\$ 0.00	\$ 4.85	\$ 4.85	\$ 0.00	\$ 11.67	\$ 11.67	\$ 0.00	\$ 2,681.01	\$ 2,681.01	\$ 0.00	\$ 32.91	\$ 32.91
LTC Facility	\$ 0.80	\$ 0.34	\$ 1.13	\$ 1.69	\$ 0.86	\$ 2.55	\$ 28.58	\$ 30.62	\$ 59.20	\$ 124.54	\$ 4,113.35	\$ 4,237.89
Pharmacy (Non-Part D)	\$ 0.00	\$ 4.54	\$ 4.54	\$ 0.00	\$ 4.48	\$ 4.48	\$ 0.00	\$ 6.39	\$ 6.39	\$ 0.00	\$ 3.70	\$ 3.70
DME & Supplies	\$ 1.92	\$ 4.22	\$ 6.14	\$ 1.56	\$ 3.87	\$ 5.43	\$ 8.42	\$ 26.48	\$ 34.90	\$ 4.61	\$ 27.16	\$ 31.77
Transportation	\$ 0.04	\$ 5.46	\$ 5.50	\$ 0.23	\$ 45.28	\$ 45.52	\$ 0.14	\$ 96.17	\$ 96.30	\$ 0.46	\$ 61.80	\$ 62.27
All Other	\$ 0.00	\$ 20.43	\$ 20.43	\$ 0.00	\$ 26.04	\$ 26.04	\$ 0.00	\$ 37.77	\$ 37.77	\$ 0.00	\$ 69.75	\$ 69.75
Total Medical	\$ 39.81	\$ 49.26	\$ 89.07	\$ 77.20	\$ 278.70	\$ 355.90	\$ 113.02	\$ 3,076.14	\$ 3,189.16	\$ 239.17	\$ 7,778.13	\$ 8,017.30

Region: Eastern

Period: Calendar Year 2016

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	374,720	374,720	374,720	129,175	129,175	129,175	94,821	94,821	94,821	12,074	12,074	12,074
Inpatient - Acute	\$ 4.79	\$ 1.64	\$ 6.43	\$ 12.27	\$ 8.06	\$ 20.33	\$ 15.47	\$ 35.32	\$ 50.79	\$ 30.44	\$ 1,464.58	\$ 1,495.02
Inpatient MH/SA	\$ 0.09	\$ 0.15	\$ 0.24	\$ 20.10	\$ 22.99	\$ 43.09	\$ 14.88	\$ 52.96	\$ 67.84	\$ 10.64	\$ 1,619.24	\$ 1,629.87
Hospital Outpatient	\$ 16.28	\$ 0.92	\$ 17.21	\$ 21.82	\$ 1.48	\$ 23.30	\$ 25.12	\$ 2.14	\$ 27.26	\$ 61.90	\$ 1.22	\$ 63.11
Outpatient MH/SA	\$ 5.00	\$ 5.94	\$ 10.94	\$ 8.31	\$ 134.64	\$ 142.94	\$ 5.70	\$ 64.71	\$ 70.41	\$ 4.08	\$ 24.57	\$ 28.65
Professional	\$ 10.52	\$ 2.46	\$ 12.98	\$ 14.32	\$ 12.55	\$ 26.88	\$ 14.34	\$ 5.23	\$ 19.56	\$ 12.73	\$ 2.87	\$ 15.59
HCBS/Home Health	\$ 0.00	\$ 4.87	\$ 4.87	\$ 0.00	\$ 12.13	\$ 12.13	\$ 0.00	\$ 2,589.13	\$ 2,589.13	\$ 0.00	\$ 27.88	\$ 27.88
LTC Facility	\$ 0.69	\$ 0.44	\$ 1.13	\$ 2.04	\$ 0.94	\$ 2.98	\$ 27.13	\$ 32.72	\$ 59.85	\$ 112.80	\$ 4,298.73	\$ 4,411.53
Pharmacy (Non-Part D)	\$ 0.00	\$ 4.47	\$ 4.47	\$ 0.00	\$ 4.00	\$ 4.00	\$ 0.00	\$ 6.11	\$ 6.11	\$ 0.00	\$ 2.59	\$ 2.59
DME & Supplies	\$ 1.74	\$ 3.82	\$ 5.55	\$ 1.62	\$ 3.96	\$ 5.58	\$ 7.13	\$ 26.68	\$ 33.80	\$ 4.17	\$ 28.54	\$ 32.71
Transportation	\$ 0.04	\$ 5.60	\$ 5.64	\$ 0.25	\$ 39.76	\$ 40.01	\$ 0.20	\$ 91.06	\$ 91.26	\$ 0.61	\$ 61.07	\$ 61.68
All Other	\$ 0.00	\$ 21.19	\$ 21.19	\$ 0.00	\$ 26.17	\$ 26.17	\$ 0.00	\$ 43.13	\$ 43.13	\$ 0.00	\$ 72.82	\$ 72.82
Total Medical	\$ 39.15	\$ 51.50	\$ 90.66	\$ 80.73	\$ 266.68	\$ 347.41	\$ 109.96	\$ 2,949.18	\$ 3,059.13	\$ 237.35	\$ 7,604.10	\$ 7,841.46

General 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)
Final CY 2018 Final Medicare-Medicaid Rate Report
November 20, 2018**

Base Data Summary

Region: Western

Period: Calendar 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	195,977	195,977	195,977	73,408	73,408	73,408	51,674	51,674	51,674	4,896	4,896	4,896
Inpatient - Acute	\$ 3.14	\$ 0.93	\$ 4.07	\$ 6.76	\$ 1.00	\$ 7.76	\$ 11.77	\$ 10.31	\$ 22.08	\$ 26.37	\$ 1,151.95	\$ 1,178.33
Inpatient MH/SA	\$ 0.11	\$ 0.00	\$ 0.11	\$ 20.52	\$ 13.10	\$ 33.62	\$ 13.70	\$ 21.81	\$ 35.51	\$ 4.89	\$ 189.93	\$ 194.81
Hospital Outpatient	\$ 11.74	\$ 0.90	\$ 12.63	\$ 16.33	\$ 1.27	\$ 17.60	\$ 22.16	\$ 1.52	\$ 23.68	\$ 61.93	\$ 1.84	\$ 63.77
Outpatient MH/SA	\$ 3.85	\$ 7.12	\$ 10.97	\$ 6.61	\$ 146.24	\$ 152.86	\$ 4.37	\$ 62.60	\$ 66.96	\$ 4.41	\$ 34.36	\$ 38.77
Professional	\$ 10.26	\$ 1.79	\$ 12.04	\$ 13.07	\$ 3.49	\$ 16.56	\$ 13.80	\$ 2.62	\$ 16.42	\$ 12.55	\$ 1.91	\$ 14.46
HCBS/Home Health	\$ 0.00	\$ 5.91	\$ 5.91	\$ 0.00	\$ 13.64	\$ 13.64	\$ 0.00	\$ 2,435.92	\$ 2,435.92	\$ 0.00	\$ 30.52	\$ 30.52
LTC Facility	\$ 0.69	\$ 0.55	\$ 1.24	\$ 1.05	\$ 0.71	\$ 1.76	\$ 23.16	\$ 28.27	\$ 51.44	\$ 133.17	\$ 4,768.83	\$ 4,902.00
Pharmacy (Non-Part D)	\$ 0.00	\$ 2.67	\$ 2.67	\$ 0.00	\$ 2.68	\$ 2.68	\$ 0.00	\$ 6.28	\$ 6.28	\$ 0.00	\$ 4.98	\$ 4.98
DME & Supplies	\$ 2.12	\$ 3.47	\$ 5.59	\$ 1.63	\$ 3.08	\$ 4.71	\$ 10.56	\$ 41.45	\$ 52.02	\$ 7.19	\$ 35.82	\$ 43.01
Transportation	\$ 0.04	\$ 4.63	\$ 4.68	\$ 0.16	\$ 40.48	\$ 40.64	\$ 0.18	\$ 77.69	\$ 77.87	\$ 0.18	\$ 48.30	\$ 48.47
All Other	\$ 0.00	\$ 23.79	\$ 23.79	\$ 0.00	\$ 35.92	\$ 35.92	\$ 0.00	\$ 51.30	\$ 51.30	\$ 0.00	\$ 40.88	\$ 40.88
Total Medical	\$ 31.95	\$ 51.76	\$ 83.71	\$ 66.14	\$ 261.61	\$ 327.74	\$ 99.70	\$ 2,739.78	\$ 2,839.48	\$ 250.68	\$ 6,309.33	\$ 6,560.02

Region: Western

Period: Calendar Year 2016

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	224,466	224,466	224,466	91,811	91,811	91,811	62,489	62,489	62,489	4,790	4,790	4,790
Inpatient - Acute	\$ 3.46	\$ 0.14	\$ 3.60	\$ 10.03	\$ 1.78	\$ 11.82	\$ 15.20	\$ 12.63	\$ 27.83	\$ 39.48	\$ 1,426.02	\$ 1,465.50
Inpatient MH/SA	\$ 0.05	\$ 0.15	\$ 0.19	\$ 15.13	\$ 7.68	\$ 22.80	\$ 9.87	\$ 20.10	\$ 29.97	\$ 4.73	\$ 211.09	\$ 215.82
Hospital Outpatient	\$ 12.06	\$ 1.45	\$ 13.51	\$ 17.95	\$ 1.72	\$ 19.68	\$ 23.31	\$ 1.93	\$ 25.25	\$ 58.73	\$ 0.72	\$ 59.45
Outpatient MH/SA	\$ 3.77	\$ 7.64	\$ 11.42	\$ 7.47	\$ 134.80	\$ 142.27	\$ 5.02	\$ 61.09	\$ 66.11	\$ 4.47	\$ 29.87	\$ 34.34
Professional	\$ 11.26	\$ 1.81	\$ 13.08	\$ 14.40	\$ 3.36	\$ 17.77	\$ 15.13	\$ 1.83	\$ 16.96	\$ 15.40	\$ 1.09	\$ 16.49
HCBS/Home Health	\$ 0.00	\$ 5.17	\$ 5.17	\$ 0.00	\$ 12.47	\$ 12.47	\$ 0.00	\$ 2,403.14	\$ 2,403.14	\$ 0.00	\$ 26.44	\$ 26.44
LTC Facility	\$ 0.41	\$ 0.26	\$ 0.68	\$ 1.59	\$ 1.14	\$ 2.73	\$ 21.00	\$ 31.96	\$ 52.96	\$ 116.01	\$ 4,908.24	\$ 5,024.25
Pharmacy (Non-Part D)	\$ 0.00	\$ 2.51	\$ 2.51	\$ 0.00	\$ 2.67	\$ 2.67	\$ 0.00	\$ 6.38	\$ 6.38	\$ 0.00	\$ 1.55	\$ 1.55
DME & Supplies	\$ 1.90	\$ 2.76	\$ 4.65	\$ 1.83	\$ 3.04	\$ 4.87	\$ 9.85	\$ 35.31	\$ 45.16	\$ 4.81	\$ 36.64	\$ 41.45
Transportation	\$ 0.06	\$ 4.44	\$ 4.49	\$ 0.27	\$ 32.78	\$ 33.05	\$ 0.17	\$ 69.87	\$ 70.04	\$ 0.41	\$ 45.52	\$ 45.93
All Other	\$ 0.00	\$ 23.13	\$ 23.13	\$ 0.00	\$ 37.25	\$ 37.25	\$ 0.00	\$ 51.40	\$ 51.40	\$ 0.00	\$ 32.88	\$ 32.88
Total Medical	\$ 32.96	\$ 49.46	\$ 82.43	\$ 68.67	\$ 238.69	\$ 307.37	\$ 99.55	\$ 2,695.63	\$ 2,795.18	\$ 244.02	\$ 6,720.07	\$ 6,964.09

General 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)
Final CY 2018 Final Medicare-Medicaid Rate Report
November 20, 2018**

Base Data Summary

Region: The Cape

Period: Calendar 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	54,935	54,935	54,935	21,493	21,493	21,493	10,872	10,872	10,872	1,668	1,668	1,668
Inpatient - Acute	\$ 7.69	\$ 0.23	\$ 7.93	\$ 11.43	\$ 0.00	\$ 11.44	\$ 26.37	\$ 36.79	\$ 63.16	\$ 35.50	\$ 451.30	\$ 486.81
Inpatient MH/SA	\$ 0.02	\$ 0.00	\$ 0.02	\$ 14.24	\$ 29.64	\$ 43.88	\$ 8.13	\$ 57.01	\$ 65.15	\$ 6.74	\$ 169.97	\$ 176.70
Hospital Outpatient	\$ 12.39	\$ 0.63	\$ 13.02	\$ 15.17	\$ 1.24	\$ 16.40	\$ 20.53	\$ 2.96	\$ 23.49	\$ 57.58	\$ 0.02	\$ 57.60
Outpatient MH/SA	\$ 2.96	\$ 6.24	\$ 9.19	\$ 4.77	\$ 131.36	\$ 136.13	\$ 4.48	\$ 64.03	\$ 68.51	\$ 6.74	\$ 40.23	\$ 46.97
Professional	\$ 11.29	\$ 1.44	\$ 12.72	\$ 15.45	\$ 3.07	\$ 18.52	\$ 15.52	\$ 1.70	\$ 17.22	\$ 16.38	\$ 1.31	\$ 17.69
HCBS/Home Health	\$ 0.00	\$ 3.84	\$ 3.84	\$ 0.00	\$ 7.53	\$ 7.53	\$ 0.00	\$ 2,461.73	\$ 2,461.73	\$ 0.00	\$ 47.20	\$ 47.20
LTC Facility	\$ 0.90	\$ 0.34	\$ 1.24	\$ 1.00	\$ 0.49	\$ 1.49	\$ 42.91	\$ 44.65	\$ 87.56	\$ 171.08	\$ 4,421.75	\$ 4,592.83
Pharmacy (Non-Part D)	\$ 0.00	\$ 17.49	\$ 17.49	\$ 0.00	\$ 2.80	\$ 2.80	\$ 0.00	\$ 4.93	\$ 4.93	\$ 0.00	\$ 7.22	\$ 7.22
DME & Supplies	\$ 2.33	\$ 3.93	\$ 6.26	\$ 2.30	\$ 2.36	\$ 4.67	\$ 10.77	\$ 41.33	\$ 52.10	\$ 4.44	\$ 24.92	\$ 29.36
Transportation	\$ 0.10	\$ 6.66	\$ 6.77	\$ 0.17	\$ 60.72	\$ 60.88	\$ 0.63	\$ 171.69	\$ 172.31	\$ 0.42	\$ 69.02	\$ 69.44
All Other	\$ 0.00	\$ 20.01	\$ 20.01	\$ 0.00	\$ 25.66	\$ 25.66	\$ 0.00	\$ 46.35	\$ 46.35	\$ 0.00	\$ 44.96	\$ 44.96
Total Medical	\$ 37.68	\$ 60.81	\$ 98.48	\$ 64.53	\$ 264.86	\$ 329.39	\$ 129.35	\$ 2,933.17	\$ 3,062.52	\$ 298.88	\$ 5,277.91	\$ 5,576.79

Region: The Cape

Period: Calendar Year 2016

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	56,063	56,063	56,063	23,232	23,232	23,232	11,866	11,866	11,866	1,579	1,579	1,579
Inpatient - Acute	\$ 6.03	\$ 1.93	\$ 7.96	\$ 14.78	\$ 1.74	\$ 16.52	\$ 17.19	\$ 13.62	\$ 30.81	\$ 52.99	\$ 549.85	\$ 602.84
Inpatient MH/SA	\$ 0.05	\$ 0.00	\$ 0.05	\$ 13.11	\$ 35.29	\$ 48.40	\$ 10.22	\$ 51.59	\$ 61.81	\$ 3.42	\$ 222.92	\$ 226.35
Hospital Outpatient	\$ 11.94	\$ 0.62	\$ 12.56	\$ 17.22	\$ 1.38	\$ 18.60	\$ 19.62	\$ 3.63	\$ 23.24	\$ 67.10	\$ 0.74	\$ 67.85
Outpatient MH/SA	\$ 2.91	\$ 8.27	\$ 11.18	\$ 5.06	\$ 121.26	\$ 126.32	\$ 4.21	\$ 64.08	\$ 68.29	\$ 4.21	\$ 46.97	\$ 51.19
Professional	\$ 12.49	\$ 1.23	\$ 13.72	\$ 16.97	\$ 2.88	\$ 19.85	\$ 16.53	\$ 4.62	\$ 21.15	\$ 14.08	\$ 0.62	\$ 14.70
HCBS/Home Health	\$ 0.00	\$ 3.87	\$ 3.87	\$ 0.00	\$ 9.03	\$ 9.03	\$ 0.00	\$ 2,381.26	\$ 2,381.26	\$ 0.00	\$ 37.52	\$ 37.52
LTC Facility	\$ 0.60	\$ 0.24	\$ 0.84	\$ 1.81	\$ 1.68	\$ 3.49	\$ 32.51	\$ 40.52	\$ 73.04	\$ 104.73	\$ 4,565.60	\$ 4,670.34
Pharmacy (Non-Part D)	\$ 0.00	\$ 15.40	\$ 15.40	\$ 0.00	\$ 3.81	\$ 3.81	\$ 0.00	\$ 5.71	\$ 5.71	\$ 0.00	\$ 2.93	\$ 2.93
DME & Supplies	\$ 1.85	\$ 3.51	\$ 5.36	\$ 1.83	\$ 3.65	\$ 5.48	\$ 7.28	\$ 43.74	\$ 51.02	\$ 4.65	\$ 19.92	\$ 24.56
Transportation	\$ 0.12	\$ 6.66	\$ 6.78	\$ 0.43	\$ 54.26	\$ 54.69	\$ 0.36	\$ 139.60	\$ 139.96	\$ 0.68	\$ 78.80	\$ 79.48
All Other	\$ 0.00	\$ 21.29	\$ 21.29	\$ 0.00	\$ 26.06	\$ 26.06	\$ 0.00	\$ 55.56	\$ 55.56	\$ 0.00	\$ 43.05	\$ 43.05
Total Medical	\$ 35.98	\$ 63.02	\$ 99.00	\$ 71.22	\$ 261.05	\$ 332.27	\$ 107.93	\$ 2,803.94	\$ 2,911.87	\$ 251.87	\$ 5,568.93	\$ 5,820.79

General 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)
Final CY 2018 Final Medicare-Medicaid Rate Report
November 20, 2018**

Base Data Summary

Region: Statewide

Period: Calendar 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	626,366	626,366	626,366	219,212	219,212	219,212	150,755	150,755	150,755	19,085	19,085	19,085
Inpatient - Acute	\$ 5.32	\$ 1.42	\$ 6.74	\$ 9.74	\$ 4.38	\$ 14.12	\$ 13.78	\$ 32.62	\$ 46.39	\$ 32.11	\$ 1,482.60	\$ 1,514.71
Inpatient MH/SA	\$ 0.09	\$ 0.05	\$ 0.15	\$ 20.30	\$ 20.80	\$ 41.10	\$ 16.93	\$ 56.47	\$ 73.40	\$ 8.15	\$ 1,171.46	\$ 1,179.61
Hospital Outpatient	\$ 14.82	\$ 0.96	\$ 15.78	\$ 18.77	\$ 1.42	\$ 20.19	\$ 23.33	\$ 1.74	\$ 25.07	\$ 54.52	\$ 1.14	\$ 55.66
Outpatient MH/SA	\$ 4.23	\$ 5.31	\$ 9.54	\$ 6.92	\$ 142.89	\$ 149.81	\$ 4.88	\$ 66.50	\$ 71.38	\$ 4.09	\$ 30.18	\$ 34.27
Professional	\$ 9.87	\$ 2.01	\$ 11.88	\$ 13.25	\$ 7.76	\$ 21.01	\$ 13.45	\$ 3.95	\$ 17.41	\$ 12.01	\$ 2.77	\$ 14.77
HCBS/Home Health	\$ 0.00	\$ 5.09	\$ 5.09	\$ 0.00	\$ 11.93	\$ 11.93	\$ 0.00	\$ 2,581.19	\$ 2,581.19	\$ 0.00	\$ 33.54	\$ 33.54
LTC Facility	\$ 0.77	\$ 0.40	\$ 1.18	\$ 1.41	\$ 0.77	\$ 2.18	\$ 27.76	\$ 30.82	\$ 58.58	\$ 130.82	\$ 4,308.46	\$ 4,439.28
Pharmacy (Non-Part D)	\$ 0.00	\$ 5.09	\$ 5.09	\$ 0.00	\$ 3.71	\$ 3.71	\$ 0.00	\$ 6.25	\$ 6.25	\$ 0.00	\$ 4.34	\$ 4.34
DME & Supplies	\$ 2.02	\$ 3.96	\$ 5.98	\$ 1.66	\$ 3.46	\$ 5.12	\$ 9.33	\$ 32.68	\$ 42.01	\$ 5.26	\$ 29.19	\$ 34.44
Transportation	\$ 0.04	\$ 5.31	\$ 5.35	\$ 0.20	\$ 45.19	\$ 45.39	\$ 0.19	\$ 95.28	\$ 95.47	\$ 0.39	\$ 58.97	\$ 59.35
All Other	\$ 0.00	\$ 21.45	\$ 21.45	\$ 0.00	\$ 29.31	\$ 29.31	\$ 0.00	\$ 43.03	\$ 43.03	\$ 0.00	\$ 60.18	\$ 60.18
Total Medical	\$ 37.16	\$ 51.06	\$ 88.22	\$ 72.26	\$ 271.62	\$ 343.87	\$ 109.63	\$ 2,950.53	\$ 3,060.17	\$ 247.34	\$ 7,182.82	\$ 7,430.16

Region: Statewide

Period: Calendar Year 2016

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	655,249	655,249	655,249	244,218	244,218	244,218	169,176	169,176	169,176	18,443	18,443	18,443
Inpatient - Acute	\$ 4.44	\$ 1.15	\$ 5.59	\$ 11.67	\$ 5.10	\$ 16.77	\$ 15.49	\$ 25.42	\$ 40.91	\$ 34.72	\$ 1,376.25	\$ 1,410.97
Inpatient MH/SA	\$ 0.07	\$ 0.14	\$ 0.21	\$ 17.57	\$ 18.40	\$ 35.97	\$ 12.70	\$ 40.72	\$ 53.43	\$ 8.48	\$ 1,133.97	\$ 1,142.45
Hospital Outpatient	\$ 14.46	\$ 1.08	\$ 15.54	\$ 19.93	\$ 1.56	\$ 21.49	\$ 24.06	\$ 2.17	\$ 26.23	\$ 61.52	\$ 1.05	\$ 62.57
Outpatient MH/SA	\$ 4.40	\$ 6.72	\$ 11.12	\$ 7.68	\$ 133.43	\$ 141.11	\$ 5.34	\$ 63.33	\$ 68.67	\$ 4.19	\$ 27.87	\$ 32.06
Professional	\$ 10.94	\$ 2.13	\$ 13.08	\$ 14.60	\$ 8.18	\$ 22.78	\$ 14.78	\$ 3.93	\$ 18.71	\$ 13.54	\$ 2.21	\$ 15.75
HCBS/Home Health	\$ 0.00	\$ 4.89	\$ 4.89	\$ 0.00	\$ 11.96	\$ 11.96	\$ 0.00	\$ 2,505.85	\$ 2,505.85	\$ 0.00	\$ 28.33	\$ 28.33
LTC Facility	\$ 0.59	\$ 0.36	\$ 0.95	\$ 1.85	\$ 1.09	\$ 2.93	\$ 25.24	\$ 32.99	\$ 58.23	\$ 112.94	\$ 4,479.88	\$ 4,592.83
Pharmacy (Non-Part D)	\$ 0.00	\$ 4.73	\$ 4.73	\$ 0.00	\$ 3.48	\$ 3.48	\$ 0.00	\$ 6.18	\$ 6.18	\$ 0.00	\$ 2.35	\$ 2.35
DME & Supplies	\$ 1.80	\$ 3.43	\$ 5.23	\$ 1.72	\$ 3.58	\$ 5.30	\$ 8.14	\$ 31.06	\$ 39.21	\$ 4.37	\$ 29.91	\$ 34.28
Transportation	\$ 0.05	\$ 5.29	\$ 5.34	\$ 0.28	\$ 38.51	\$ 38.79	\$ 0.20	\$ 86.63	\$ 86.83	\$ 0.56	\$ 58.55	\$ 59.11
All Other	\$ 0.00	\$ 21.86	\$ 21.86	\$ 0.00	\$ 30.32	\$ 30.32	\$ 0.00	\$ 47.05	\$ 47.05	\$ 0.00	\$ 59.90	\$ 59.90
Total Medical	\$ 36.76	\$ 51.79	\$ 88.55	\$ 75.29	\$ 255.62	\$ 330.91	\$ 105.97	\$ 2,845.34	\$ 2,951.31	\$ 240.33	\$ 7,200.26	\$ 7,440.59

General 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)
Final CY 2018 Final Medicare-Medicaid Rate Report
November 20, 2018**

Base Data Adjustments

Rating Category: Community Low Risk

PMPM

Adjustment	Eastern	Western	The Cape	Statewide
Base data	\$ 89.86	\$ 83.03	\$ 98.75	\$ 88.39
Completion	\$ 0.59	\$ 0.51	\$ 0.60	\$ 0.56
Rebalancing	\$ 13.57	\$ 20.88	\$ 27.32	\$ 17.16
Adjusted base data	\$ 104.01	\$ 104.41	\$ 126.67	\$ 106.11

Percentage Impact

Adjustment	Eastern	Western	The Cape	Statewide
Base data				
Completion	0.7%	0.6%	0.6%	0.6%
Rebalancing	15.0%	25.0%	27.5%	19.3%
Total base data adjustment	15.8%	25.8%	28.3%	20.0%

Rating Category: Community High Behavioral Health

PMPM

Adjustment	Eastern	Western	The Cape	Statewide
Base data	\$ 351.57	\$ 316.42	\$ 330.89	\$ 337.04
Completion	\$ 3.94	\$ 2.75	\$ 4.06	\$ 3.53
Rebalancing	\$ 8.89	\$ 47.88	\$ 83.74	\$ 30.01
Adjusted base data	\$ 364.40	\$ 367.05	\$ 418.69	\$ 370.59

Percentage Impact

Adjustment	Eastern	Western	The Cape	Statewide
Base data				
Completion	1.1%	0.9%	1.2%	1.0%
Rebalancing	2.5%	15.0%	25.0%	8.8%
Total base data adjustment	3.6%	16.0%	26.5%	10.0%

Rating Category: High Community Need

PMPM

Adjustment	Eastern	Western	The Cape	Statewide
Base data	\$ 3,121.80	\$ 2,815.23	\$ 2,983.90	\$ 3,002.60
Completion	\$ 10.82	\$ 6.90	\$ 10.23	\$ 9.38
Rebalancing	\$ (117.42)	\$ (141.11)	\$ 74.85	\$ (112.21)
Adjusted base data	\$ 3,015.20	\$ 2,681.03	\$ 3,068.98	\$ 2,899.78

Percentage Impact

Adjustment	Eastern	Western	The Cape	Statewide
Base data				
Completion	0.3%	0.2%	0.3%	0.3%
Rebalancing	-3.7%	-5.0%	2.5%	-3.7%
Total base data adjustment	-3.4%	-4.8%	2.9%	-3.4%

Rating Category: Facility-Based Care

PMPM

Adjustment	Eastern	Western	The Cape	Statewide
Base data	\$ 7,930.98	\$ 6,759.84	\$ 5,695.45	\$ 7,435.29
Completion	\$ 213.67	\$ 122.10	\$ 65.29	\$ 177.20
Rebalancing	\$ 0.00	\$ 0.00	\$ 0.00	\$ 0.00
Adjusted base data	\$ 8,144.65	\$ 6,881.95	\$ 5,760.74	\$ 7,612.48

Percentage Impact

Adjustment	Eastern	Western	The Cape	Statewide
Base data				
Completion	2.7%	1.8%	1.1%	2.4%
Rebalancing	0.0%	0.0%	0.0%	0.0%
Total base data adjustment	2.7%	1.8%	1.1%	2.4%