Demonstration to Integrate Care for Dual Eligible Individuals (One Care)
CY 2021 Final Medicare-Medicaid Rate Report
January 1, 2021 through December 31, 2021

The Centers for Medicare & Medicaid Services (CMS), in conjunction with MassHealth, is providing final information regarding the Medicare and Medicaid component of the CY 2021 rates for the Massachusetts Demonstration to Integrate Care for Dual Eligible Individuals (One Care).

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 Massachusetts Executive Office of Health and Human Services (EOHHS), and the One Care plans (Medicare-Medicaid Plans).

Included in this report are the final CY 2021 Medicare county base rates and Medicaid rates. *Please note, this rate report incorporates updates to the Medicare rates for 2021, given the suspension of sequestration from January 1, 2021 through December 31, 2021 per the Consolidated Appropriations Act, 2021, enacted December 27, 2020, and H.R. 1868, enacted on April 14, 20201; more information is available in the HPMS memo "Medicare Advantage/Prescription Drug System (MARx) May 2021 Payment – INFORMATION" released on April 28, 2021.*

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 includes MassHealth Base Data summaries.

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MassHealth Component of County Rate

Effective January 1, 2021 through December 31, 2021

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I. MassHealth Component of the Rate – CY 2021

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:

The following MassHealth rates are listed below, by Massachusetts county and MassHealth rating category. The rates below include the savings percentage of 0.5% (see Section IV) for Demonstration Year 8 and do not include the application of the 1.75% quality withhold (see Section IV):

(1) CY 2021 rates effective January 1, 2021 through June 30, 2021

(2) CY 2021 ARPA add-on rates effective July 1, 2021 through December 31, 2021. The temporary rate increase provides additional support for Medicaid home- and community-based services (HCBS)

(3) CY 2021 rates, inclusive of ARPA add-on rates, effective July 1, 2021 through December 31, 2021

The Statewide rates apply to eligible One Care members living in one of the two counties excluded from the One Care service area (Dukes, Nantucket) for Demonstration Year 8.

	MassHealth Component of County Rate Effective January 1, 2021 through June 30, 2021						
County	**C1 – Community Other**	**C2A – Community High Behavioral Health**	**C2B – Community Very High Behavioral Health**	**C3A – High Community Need**	**C3B – Very High Community Need**	**C4 – Transitional Living Program**	**F1 – Facility-based Care**
Barnstable	$213.48	$719.06	$1,223.71	$3,220.10	$8,196.43	$7,850.60	$7,804.26
Berkshire	$192.93	$482.26	$815.52	$2,994.47	$7,619.66	$7,850.60	$9,717.66
Bristol	$215.75	$598.61	$1,016.08	$2,815.99	$7,163.41	$7,850.60	$10,088.85
Essex	$215.75	$598.61	$1,016.08	$2,815.99	$7,163.41	$7,850.60	$10,088.85
Franklin	$192.93	$482.26	$815.52	$2,994.47	$7,619.66	$7,850.60	$9,717.66
Hampden	$192.93	$482.26	$815.52	$2,994.47	$7,619.66	$7,850.60	$9,717.66
Hampshire	$192.93	$482.26	$815.52	$2,994.47	$7,619.66	$7,850.60	$9,717.66
Middlesex	$215.75	$598.61	$1,016.08	$2,815.99	$7,163.41	$7,850.60	$10,088.85
Norfolk	$215.75	$598.61	$1,016.08	$2,815.99	$7,163.41	$7,850.60	$10,088.85
Plymouth	$213.48	$719.06	$1,223.71	$3,220.10	$8,196.43	$7,850.60	$7,804.26
Suffolk	$215.75	$598.61	$1,016.08	$2,815.99	$7,163.41	$7,850.60	$10,088.85
Worcester	$192.93	$482.26	$815.52	$2,994.47	$7,619.66	$7,850.60	$9,717.66

Statewide	$206.02	$557.84	$939.39	$2,921.39	$7,351.34	$7,850.60	$9,793.40

	MassHealth ARPA Add-On Rate Effective July 1, 2021 through December 31, 2021						
County	**C1 – Community Other**	**C2A – Community High Behavioral Health**	**C2B – Community Very High Behavioral Health**	**C3A – High Community Need**	**C3B – Very High Community Need**	**C4 – Transitional Living Program**	**F1 – Facility-based Care**
Barnstable	$2.87	$26.46	$45.61	$241.01	$616.09	$ -	$ -
Berkshire	$2.88	$15.63	$26.94	$224.46	$573.79	$ -	$ -
Bristol	$3.10	$21.78	$37.54	$212.12	$542.25	$ -	$ -
Essex	$3.10	$21.78	$37.54	$212.12	$542.25	$ -	$ -
Franklin	$2.88	$15.63	$26.94	$224.46	$573.79	$ -	$ -
Hampden	$2.88	$15.63	$26.94	$224.46	$573.79	$ -	$ -
Hampshire	$2.88	$15.63	$26.94	$224.46	$573.79	$ -	$ -
Middlesex	$3.10	$21.78	$37.54	$212.12	$542.25	$ -	$ -
Norfolk	$3.10	$21.78	$37.54	$212.12	$542.25	$ -	$ -
Plymouth	$2.87	$26.46	$45.61	$241.01	$616.09	$ -	$ -
Suffolk	$3.10	$21.78	$37.54	$212.12	$542.25	$ -	$ -
Worcester	$2.88	$15.63	$26.94	$224.46	$573.79	$ -	$ -
Statewide	$3.00	$19.52	$33.36	$219.46	$555.40	$ -	$ -

	MassHealth Component of County Rate Effective July 1, 2021 through December 31, 2021						
County	**C1 – Community Other**	**C2A – Community High Behavioral Health**	**C2B – Community Very High Behavioral Health**	**C3A – High Community Need**	**C3B – Very High Community Need**	**C4 – Transitional Living Program**	**F1 – Facility-based Care**
Barnstable	$216.35	$745.52	$1,269.32	$3,461.10	$8,812.52	$7,850.60	$7,804.26
Berkshire	$195.82	$497.89	$842.46	$3,218.93	$8,193.46	$7,850.60	$9,717.66
Bristol	$218.86	$620.38	$1,053.61	$3,028.11	$7,705.66	$7,850.60	$10,088.85
Essex	$218.86	$620.38	$1,053.61	$3,028.11	$7,705.66	$7,850.60	$10,088.85
Franklin	$195.82	$497.89	$842.46	$3,218.93	$8,193.46	$7,850.60	$9,717.66

Hampden	$195.82	$497.89	$842.46	$3,218.93	$8,193.46	$7,850.60	$9,717.66
Hampshire	$195.82	$497.89	$842.46	$3,218.93	$8,193.46	$7,850.60	$9,717.66
Middlesex	$218.86	$620.38	$1,053.61	$3,028.11	$7,705.66	$7,850.60	$10,088.85
Norfolk	$218.86	$620.38	$1,053.61	$3,028.11	$7,705.66	$7,850.60	$10,088.85
Plymouth	$216.35	$745.52	$1,269.32	$3,461.10	$8,812.52	$7,850.60	$7,804.26
Suffolk	$218.86	$620.38	$1,053.61	$3,028.11	$7,705.66	$7,850.60	$10,088.85
Worcester	$195.82	$497.89	$842.46	$3,218.93	$8,193.46	$7,850.60	$9,717.66
Statewide	$209.02	$577.36	$972.75	$3,140.85	$7,906.74	$7,850.60	$9,793.40

Historical Base Data Development:

The Medicaid and Medicare-Medicaid crossover fee-for-service (FFS) data, collected directly from EOHHS's MMIS, represents CY2017 claims and eligibility with dates of service from January 1, 2019 through December 31, 2019, and includes all records processed by EOHHS through April 15, 2020. Note, the claims data used for base development is adjusted to include historical enrollee contribution to care amounts.

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 below.

F1: Facility-Based Care

Demonstration Process

Enrollees will be classified as Facility-based Care if they have been identified by MassHealth as having a stay exceeding ninety (90) days in a nursing facility, chronic or rehabilitation hospital, or a psychiatric hospital.

Proxy Method

The base data for this RC was developed based on claim and eligibility data for members in a facility beyond the first 90 days. Applicable facilities include nursing facilities, chronic or rehabilitation hospitals, and psychiatric hospitals.

C4: Community Tier 4 – Transitional Living Need

Demonstration Process

Enrollees will be classified as Transitional Living Need if they do not meet F1 criteria, have a type of residence equal to a board and care/assisted living/group home, and their most recent Minimum Dataset – Home Care (MDS-HC) assessment indicates they meet all the following criteria:

- 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 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 ICD-10 diagnosis codes:
  - S06.1 (Traumatic cerebral edema)
  - S06.2 (Diffuse traumatic brain injury)
  - S06.3 (Focal traumatic brain injury)
  - S06.4 (Epidural hemorrhage)
  - S06.5 (Traumatic subdural hemorrhage)
  - S06.6 (Traumatic subarachnoid hemorrhage)
  - S06.8 (Other specified intracranial injuries)

Proxy Method

The base data for this RC was developed based on claim and eligibility data for members not in F1 for months in which the member had claims indicating residence in a Transitional Living Program (TLP) setting as of the first of that month.

C3B: Community Tier 3 — Very High Community Needs

Demonstration Process

Includes individuals who do not meet F1 or C4 criteria, and for whom a MDS-HC assessment indicates at least one of the following criteria:

- Have a daily skilled need, or daily chronic and stable routine need, for any qualifying treatments or programs, for which the enrollee requires assistance.
- Have a skilled need, or a chronic and stable routine need, for which the enrollee requires assistance, at least three (3) days per week for any qualifying treatment or program along with two (2) or more ADL impairments requiring more than supervision.
- Have four or more ADL impairments requiring more than supervision.
- Have four or more ADL impairments (including those requiring only supervision), and have moderately to severely impaired cognitive decision making skills.

- Have four or more ADL limitations (including those requiring only supervision), and have one or more of the following Behavioral Health (BH) diagnoses, confirmed in medical records that are chronic or ongoing:
  - F10.2-F10.29 excluding F10.21 (substance use disorder [SUD])
  - F11.2-F11.29 excluding F11.21 (SUD)
  - F12.2-F12.29 excluding F12.21 (SUD)
  - F13.2-F13.29 excluding F13.21 (SUD)
  - F14.2-F14.29 excluding F14.21 (SUD)
  - F15.2-F15.29 excluding F15.21 (SUD)
  - F16.2-F16.29 excluding F16.21 (SUD)
  - F18.2-F18.29 excluding F18.21 (SUD)
  - F19.2-F19.29 excluding F19.21 (SUD)
  - F20-F20.9, F25-F25.9 (schizophrenia)
  - F28, F9 (other psychosis)

All activities will contribute to the ADL impairment count, but limitations dressing upper body and limitations dressing lower body together will be treated as a single ADL. Supervision needs will contribute to the ADL impairment count only if there is a corresponding cognitive deficit or select BH diagnosis also present, and if there are 4 or more ADL impairments.

The individuals meeting one of the above criteria must also have one or more of the following conditions as defined by the following ICD-10 diagnosis codes:

- G12.21 (ALS)
- G71.0, G71.2 (muscular dystrophy)
- G80.0, G82.50, G82.51, G82.52, G82.53, G82.54 (quadriplegia)
- Z99.11, Z99.12 (respirator dependence)

Proxy Method

The base data for this RC was developed based on claim and eligibility data for members not in F1 or C4 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) and has one or more of the following conditions:

- G12.21 (ALS)
- G71.0, G71.2 (muscular dystrophy)
- G80.0, G82.50, G82.51, G82.52, G82.53, G82.54 (quadriplegia)
- Z99.11, Z99.12 (respirator dependence)

Additionally, if a member was determined to be C3B in any of the previous three years and still meets the C3A criteria, but did not have claims with a qualifying diagnosis code in the base period plus one-year prior, the member remained in the C3B RC.

C3A: Community Tier 3 — High Community Needs

Demonstration Process

Includes individuals who do not meet F1, C4, or C3B criteria and for whom an MDS-HC assessment indicates at least one of the following criteria:

- Have a daily skilled need, or daily chronic and stable routine need, for any qualifying treatments or programs, for which the enrollee requires assistance.
- Have a skilled need, or a chronic and stable routine need, for which the enrollee requires assistance, at least three (3) days per week for any qualifying treatment or program along with two (2) or more ADL impairments requiring more than supervision.
- Have four or more ADL impairments requiring more than supervision.
- Have four or more ADL impairments (including those requiring only supervision) and have moderately to severely impaired cognitive decision making skills.
- Have four or more ADL limitations (including those requiring only supervision), and have one or more of the following BH diagnoses, confirmed in medical records that are chronic or ongoing:
  - F10.2–F10.29 excluding F10.21 (SUD)
  - F11.2–F11.29 excluding F11.21 (SUD)
  - F12.2–F12.29 excluding F12.21 (SUD)
  - F13.2–F13.29 excluding F13.21 (SUD)
  - F14.2–F14.29 excluding F14.21 (SUD)
  - F15.2–F15.29 excluding F15.21 (SUD)
  - F16.2–F16.29 excluding F16.21 (SUD)
  - F18.2–F18.29 excluding F18.21 (SUD)
  - F19.2–F19.29 excluding F19.21 (SUD)
  - F20–F20.9, F25-F25.9 (schizophrenia)
  - F28, F9 (other psychosis)

All activities will contribute to the ADL impairment count, but limitations dressing upper body and limitations dressing lower body together will be treated as a single ADL. Supervision needs will contribute to the ADL impairment count only if there is a corresponding cognitive deficit or select BH diagnosis also present, and if there are four or more ADL impairments.

Proxy Method

The base data for this RC was developed based on claim and eligibility data for members not in F1, C4, or C3B 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 LTSS.

C2B: Community Tier 2 — Community Very High Behavioral Health

Demonstration Process

Includes individuals who do not meet F1, C4, C3B, or C3A, and their most recent MDS-HC assessment indicates one or more of the Mental Health (MH) or Substance Use Disorder (SUD) diagnoses listed below. Diagnoses must be confirmed in medical records, and be chronic or ongoing, defined by the following ICD-10 diagnosis codes:

SUD diagnosis codes:

- F10.2–F10.29 excluding F10.21
- F11.2–F11.29 excluding F11.21
- F12.2–F12.29 excluding F12.21
- F13.2–F13.29 excluding F13.21
- F14.2–F14.29 excluding F14.21
- F15.2–F15.29 excluding F15.21
- F16.2–F16.29 excluding F16.21
- F18.2–F18.29 excluding F18.21
- F19.2–F19.29 excluding F19.21

MH diagnosis codes:

- F28, F9 (other psychosis)
- F20–F20.9, F25–F25.9 (schizophrenia)
- F30–F30.9 (bipolar)
- F31–F31.9 (bipolar)
- F32–F32.9 (major depression)
- F33–F33.9 (major depression)
- F34.8–F34.9, F39 (mood disorders)

Additionally, their most recent MDS-HC assessment and/or other information sources reflect one or more specific diagnoses or other characteristics indicative of higher than average costs for this rating tier.

Proxy Method

The base data for this RC was developed based on claim and eligibility data for members not in F1, C4, C3B, or C3A who had at least one MH diagnosis and at least one SUD diagnosis, as defined above, found on any claims in the Medicaid FFS data and/or non-outpatient claims in the Medicare-Medicaid crossover FFS data.

C2A: Community Tier 2 — Community High Behavioral Health

Demonstration Process

Includes individuals who do not meet F1, C4, C3B, C3A, or C2B criteria with at least one MH or SUD diagnosis, which is chronic or ongoing, defined by the ICD-10 diagnosis codes listed under C2B.

Proxy Method

The base data for this RC was developed based on claim and eligibility data for members not in F1, C4, C3B, or C3A who had at least one MH diagnosis or SUD diagnosis, as defined above, found on any claims in the Medicaid FFS data and/or non-outpatient claims in the Medicare-Medicaid crossover FFS data.

C1: Community Tier 1 — Community Other

Demonstration Process

Includes individuals in the community who do not meet the F1, C4, C3B, C3A, C2B, or C2A criteria.

Proxy Method

The base data for this RC was developed based on claim and eligibility data for members not in F1, C4, C3B, C3A, C2B, or C2A.

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 use disorder conditions. The C2B rating category includes individuals with one or more specific diagnoses or other characteristics indicative of higher than average costs for this rating tier. Any individual that meets the overall C2 criteria, but does not meet the C2B criteria, would be classified as C2A.

Rating Category Stratification

In order to further mitigate risk of adverse selection to One Care plans, the Community Tier 2 (C2) and Community Tier 3 (C3) RCs were each stratified into two subpopulations, A and B, as described above. Medical cost projections for these RCs were developed in aggregate for the entire C2 and C3 populations, and then a rate relativity factor was employed to produce final rates for the subpopulations.

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.

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:

- Projected costs for the C2 and C3 rating categories were developed by region.
- Relative total costs of C2A/C2B and C3A/C3B to the overall C2 and C3 rating categories, respectively, were developed using the base data and One Care plan-reported financial experience.
- 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.

	Relativities as a Percent of Total Medical		
Rating Category	**Eastern**	**Western**	**The Cape**
C2A: Community High Behavioral Health	-9.5%	-9.8%	-7.4%
C2B: Community Very High Behavioral Health	55.9%	55.5%	59.6%
C3A: High Community Need	-4.1%	-1.7%	-3.8%
C3B: Very High Community Need	145.0%	151.3%	145.9%

C4 Rating Category

Due to the small nature of this population, an additional two years of data (CY2017 and CY2018) was included as base data 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:

One Care plan covered services include, but are not limited to, inpatient hospital, outpatient hospital, BH, emergency room, Long-term Care (LTC) facility, Home- and Community-based Services (HCBS), home health, durable medical equipment (DME) and supplies, transportation, dental, and professional services, including primary care physician, specialty physician, clinic services, and professional or

independent laboratory and radiology services. The services covered under the One Care contract are grouped into the following categories of service (COS):

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Medicaid Claims:

Rate Development Category of Service	MassHealth Base Data Detailed Category of Service
Inpatient BH	IP – Behavioral Health
Inpatient – Non-BH	IP – Non-Behavioral Health
Hospital Outpatient	Hospital Outpatient
Outpatient BH	Outpatient BH
Professional	Professional
HCBS/Home Health	Community LTSS
LTC Facility	LTC
Pharmacy	Non-Part D Pharmacy
DME & 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 BH	IP – Mental Health IP – Substance Use Disorder
Inpatient – Non-BH	IP – Non-Behavioral Health
Hospital Outpatient	HOP – ER / Urgent Care HOP – Lab / Rad HOP – PT / OT / ST HOP – Pharmacy HOP – Other
Outpatient BH	HOP – Behavioral Health Prof – Behavioral Health
Professional	Prof – HIP Visits Prof – OP Visits Prof – Lab / Rad Prof – Other
LTC Facility	SNF
Transportation	Transportation
DME & Supplies	DME and Supplies

Counties and Regions:

Rates will be paid on a Massachusetts county and MassHealth rating category basis. Rates, however, have been developed regionally. Two counties are not included in either of the One Care plans' service areas for RY21: Dukes and 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: Bristol, Essex, Middlesex, Norfolk, and Suffolk Counties.

Western: Berkshire, Franklin, Hampden, Hampshire, and Worcester Counties.

The Cape: Barnstable and Plymouth Counties.

It is possible for a One Care member to move to one of the two counties excluded from the One Care service area and remain enrolled due to requirements to maintain a member's One Care enrollment for a period of time. For RY21, a "Statewide" rate was developed. Because there is a high likelihood that these members are using the same service providers that they were when located within in the One Care service area, this rate is a statewide, weighted average rate that is based on the counties that are part of the One Care service area.

Adjustments to Historical Base Data:

As detailed in Section 4 of the One Care 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 2021 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.

The chart below summarizes the impact of all individual base data adjustments by rating category. Each adjustment is later described in more detail.

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	C1: Community Other			C2: Community High Behavioral Health			C3: High Community Need		
Adjustment	**Eastern**	**Western**	**The Cape**	**Eastern**	**Western**	**The Cape**	**Eastern**	**Western**	**The Cape**
Base Data	$103.47	$94.86	$105.48	$412.11	$371.74	$483.77	$2,804.00	$2,776.54	$3,076.51
IBNR	0.8%	0.7%	0.8%	1.4%	1.1%	1.9%	1.1%	0.9%	1.2%
Pharmacy Rebates	-0.4%	-0.3%	-0.4%	-0.1%	-0.1%	-0.1%	0.0%	0.0%	0.0%
Diabetic Test Strips Rebates	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Department of Mental Health Psychiatric Claims	0.0%	0.0%	0.0%	0.2%	0.0%	0.3%	0.1%	0.0%	0.1%
Elder Affairs Home Care Program	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	1.6%	1.7%	1.5%
Diversionary Behavioral Health	1.4%	1.7%	1.7%	5.0%	6.2%	4.4%	0.3%	0.2%	0.3%
Enrollee Acuity Adjustment	4.6%	0.0%	1.0%	10.0%	0.0%	9.7%	0.0%	-2.5%	-1.0%
Home Health Policy Changes	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	-1.2%	-1.0%	0.0%
Berkshire Service Area	0.0%	0.4%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Plymouth Service Area	0.0%	0.0%	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	-0.1%
Data Rebalancing	65.0%	65.0%	65.0%	25.0%	25.0%	20.0%	-6.3%	1.0%	-2.5%
Adjusted Base Data	$181.96	$160.70	$179.75	$604.40	$498.59	$678.86	$2,677.41	$2,787.34	$3,061.28

	F1: Facility-Based Care			C4: Transitional Living Need		
Adjustment	**Eastern**	**Western**	**The Cape**	**Eastern**	**Western**	**The Cape**
Base Data	$9,243.86	$8,987.64	$7,205.07	$8,382.15	$8,382.15	$8,382.15
IBNR	3.5%	3.4%	3.0%	-8.9%	-8.9%	-8.9%
Pharmacy Rebates	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Diabetic Test Strips Rebates	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Department of Mental Health Psychiatric Claims	0.3%	0.4%	0.3%	N/A	N/A	N/A
Elder Affairs Home Care Program	0.0%	0.0%	0.0%	N/A	N/A	N/A
Diversionary Behavioral Health	0.0%	0.0%	0.0%	0.1%	0.1%	0.1%
Enrollee Acuity Adjustment	0.0%	0.0%	0.0%	N/A	N/A	N/A

Home Health Policy Changes	0.0%	0.0%	0.0%	N/A	N/A	N/A
Berkshire Service Area	0.0%	-0.5%	0.0%	N/A	N/A	N/A
Plymouth Service Area	0.0%	0.0%	0.0%	N/A	N/A	N/A
Data Rebalancing	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Adjusted Base Data	$9,604.85	$9,287.60	$7,444.81	$7,637.91	$7,637.91	$7,637.91

Historical Base Data Completion Factors:

The MassHealth base data does not reflect an estimate for IBNR expenditures. Medicaid and crossover claims processed by MassHealth through April 15, 2020 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.

	Medicaid	Crossover
Category of Service	**CY 2019**	**CY 2019**
Inpatient - non-BH	1.052	1.062
Inpatient BH	1.053	1.061
Hospital Outpatient	1.000	1.000
Outpatient BH	1.000	1.000
Professional	1.000	1.000
TLP Services	1.007	1.000
HCBS/Home Health	1.007	1.000
LTC Facility	1.024	1.021
Pharmacy	1.006	1.000
DME & Supplies	1.006	1.021
Transportation	1.006	1.017
All Other	1.006	1.000

The HCBS/Home Health factors were applied to TLP services included in the development of the C4 rates. All claims occurring in CY 2019 were considered complete.

Pharmacy Rebates

The historical FFS base data does not reflect potential Federal Omnibus Budget Reconciliation Act (OBRA) rebates. Potential OBRA rebates on non-Part D drugs represent approximately 8.62% of total pharmacy spending for the entire state. This rebate percentage is based on forecasts developed by EOHHS for all dual eligible members (including partial duals and waiver participants) in the state under the age of 65 during CY2019. This percentage was applied to the base data. In addition, EOHHS has an agreement in place for supplemental rebates on diabetic test strips. EOHHS estimated that there is an additional 0.76% in potential rebates in CY2019 on diabetic test strips for the dual-eligible population. The combined rebates for CY2017 through CY2019 applied to C4 were 10.19%.

Diversionary Behavioral Health

Certain diversionary BH services covered under One Care for non-institutionalized members are not included in the FFS base data. These diversionary BH services include the following:

- Community support program, including for chronically homeless individuals
- Structured outpatient addiction program
- Intensive outpatient program

- Program of assertive community treatment

Utilization for the listed services in other managed care programs for similar populations was reviewed to determine an adjustment. Other diversionary BH services were already reflected in the FFS base data.

Elder Affairs Home Care Program

Costs of providing the Elder Affairs Home Care Program, including the Basic and Enhanced Community Options Program levels, were approved by CMS for inclusion in One Care capitation rates. The Home Care Program is a Commonwealth-funded benefit for individuals ages 60 and above, which 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 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 due to the potential overlap in services.

Department of Mental Health Psychiatric Claims

The One Care program covers inpatient and outpatient psychiatric claims costs from Department of Mental Health (DMH) facilities. Certain costs are not reported in the MMIS, and therefore are not reflected in the historical base data used for rate setting. To account for these reimbursements made outside of MMIS, adjustments were applied to Inpatient BH and Outpatient BH COS.

Enrollee Acuity Adjustment

The base FFS data represents both members who eventually enrolled in One Care and those that did not. Historical data from multiple years was evaluated, which separately identified members who enrolled in One Care, and compared those PMPMs to the overall base. Through this analysis, it was determined 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.

Service area expansion

Berkshire County and the remainder of the towns in Plymouth County are expected to be added to the service area of the One Care plans for RY21.A review was conducted on both the relative cost of Berkshire County to the rest of the Western region and the towns of Plymouth County to the rest of the Cape region as well as projected enrollment ramp-up in the county and towns through RY21 to develop an adjustment to the base data.

Home Health Policy Changes

EOHHS has made several home health policy changes in recent years, including strengthening the prior authorization rules for home health agencies, effective March 1, 2016.

Analysis of historical home health spending going back several years shows that overall levels of home health spending showed substantial decreases from March 2016 through the base data period. The base data was adjusted to reflect cost levels that would have been expected during the base period after the policy changes are fully realized.

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 applied to all community RCs.

Programmatic Changes

Known modifications in covered populations, covered services, and payment methodologies effective after the start of the historical base data period are captured by program change adjustments; changes in fee schedules are also included. MassHealth reviewed program changes that will affect the cost, utilization or demographic structure of the program prior to, or during, CY 2021 and whose effect was not included within the adjusted base data.

The impacts of each individual program change are summarized in the chart below. Each program change is later described in more detail.

Demonstration to Integrate Care for Dual Eligible Individuals
(One Care)
CY 2021 Final Medicare-Medicaid Rate Report
January 1, 2021 through December 31, 2021

	C1: Community Other			C2: Community High Behavioral Health			C3: High Community Need		
Adjustment	**Eastern**	**Western**	**The Cape**	**Eastern**	**Western**	**The Cape**	**Eastern**	**Western**	**The Cape**
Home- and Community-Based Services Fee Changes	0.2%	0.2%	0.1%	0.1%	0.1%	0.1%	1.8%	2.4%	1.5%
Professional Fee Changes	-0.2%	0.1%	-0.2%	0.0%	0.1%	0.0%	0.1%	0.0%	0.1%
Behavioral Health Fee Changes	0.2%	0.2%	0.2%	0.4%	0.3%	0.4%	0.0%	0.0%	0.0%
ATS/CSS	0.0%	0.0%	0.0%	1.5%	2.4%	1.2%	0.0%	0.0%	0.0%
Nursing Facility Rate Changes	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%	0.0%	0.1%
RRS	0.1%	0.1%	0.1%	0.6%	0.8%	0.5%	0.1%	0.1%	0.1%
RSN/RC/ASAM	0.0%	0.0%	0.0%	0.1%	0.1%	0.1%	0.0%	0.0%	0.0%
Pharmacy Partial Copay Elimination	0.3%	0.3%	0.3%	0.1%	0.1%	0.1%	0.0%	0.0%	0.0%
Opioid Treatment Program Part B Coverage	-0.2%	-0.6%	0.0%	-9.6%	-10.7%	-5.7%	-0.2%	-0.3%	-0.2%
IP/OP Psychiatric Hospital	0.1%	0.0%	0.1%	5.6%	2.3%	7.2%	0.6%	0.2%	0.9%
All Program Changes	0.6%	0.3%	0.6%	-1.7%	-5.0%	3.5%	2.7%	2.6%	2.6%

	F1: Facility-Based Care			C4: Transitional Living Need		
Adjustment	**Eastern**	**Western**	**The Cape**	**Eastern**	**Western**	**The Cape**
Home- and Community-Based Services Fee Changes	0.0%	0.0%	0.0%	N/A	N/A	N/A
Professional Fee Changes	0.2%	0.2%	0.4%	0.0%	0.0%	0.2%
Behavioral Health Fee Changes	0.0%	0.0%	0.0%	0.1%	0.0%	0.0%
ATS/CSS	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Nursing Facility Rate Changes	1.2%	1.4%	1.6%	0.0%	0.0%	0.0%
RRS	0.1%	0.1%	0.1%	N/A	N/A	N/A
RSN/RC/ASAM	0.0%	0.0%	0.0%	N/A	N/A	N/A
Pharmacy Partial Copay Elimination	0.0%	0.0%	0.0%	0.1%	0.1%	0.1%
Opioid Treatment Program Part B Coverage	0.0%	0.0%	0.0%	N/A	N/A	N/A

IP/OP Psychiatric Hospital	0.2%	0.1%	0.2%	N/A	N/A	N/A
All Program Changes	1.8%	1.8%	2.4%	0.2%	0.1%	0.3%

Professional Fee Changes

EOHHS implemented multiple fee schedule changes for professional services including adjustments for Clinical Laboratory Services, Ambulance and Wheelchair Van Services, Vision Services and Community Health Centers (CHCs).

Claims for the affected services in the base data were repriced using the new fee schedules on a claim-by-claim basis. Crossover claims were adjusted for Medicare deductibles and cost sharing. The repriced amounts were compared to the amount paid in the base data to determine an adjustment.

Behavioral Health Fee Changes

EOHHS has multiple fee schedule changes for BH for which an adjustment was developed, including changes to provider rates for Psychiatric Day Treatment, Mental Health (MH) services provided in CHCs and Mental Health Centers.

Claims for the affected services in the base data were repriced using the proposed fee schedule on a claim-by-claim basis. Crossover claims were adjusted for Medicare deductibles and cost sharing. The repriced amounts were compared to the amount paid in the base data to determine an adjustment.

Acute Treatment Services and Clinical Stabilization services (ATS/CSS)

Effective July 1, 2021 EOHHS made a fee schedule change for Acute Treatment Services/Clinical Stabilization Services ATS/CSS services. Claims for the affected services in the base data were repriced using this fee schedule on a claim-by-claim basis. Crossover claims were adjusted after consideration of the Medicare deductibles and cost sharing. The repriced amounts were compared to the amount paid in the base data to determine an adjustment.

Inpatient and Outpatient psychiatric hospital changes

EOHHS made a fee schedule change for IP and OP psychiatric hospitals for which an adjustment was developed. Claims for the affected IP and OP services for base data prior to the effective date were repriced using the final fee schedule on a claim-by-claim basis. Crossover claims were adjusted for Medicare deductibles and cost sharing. The repriced amounts were compared to the amount paid in the base data prior to the effective date to determine an adjustment.

FFSEs

The final base data, adjusted for programmatic changes and trend represents the FFSE medical cost for each RC and region. Once FFSEs have been developed, the process for developing the actuarially sound Medicaid managed care capitation rate ranges and the final Medicaid capitation rates diverges.

COVID-19 Considerations

Due to limited information available at the time of RY21 rate development, potential effects of the COVID-19 public health emergency were included in the development of the One Care capitation rate ranges through rate range width selection. There exists a wide array of potential COVID-19 impacts, including items that may both increase the risk to a One Care plan (e.g., COVID-19 vaccine administration, testing, and treatment, worsening acuity due to delayed/deferred services) and those that may reduce the risk to a One Care plan (e.g., reduced utilization of acute care and HCBS). Further, some of these factors may only have limited impact on the Medicaid liability for a One Care plan. Because of these competing factors, it is challenging to estimate whether overall rate adjustments would be directionally positive or negative.

However, the various COVID-19 impacts do introduce additional variability into the rate development process. In order to represent the potential for more volatile One Care plan experience in RY21, Mercer widened the trend ranges by approximately 0.5% annually at both the lower and upper bound assumptions for all community RCs. As more information regarding COVID-19 emerges, the impact on One Care may be evaluated and may result in contract changes or a capitation rate update.

Nursing Facility Rate Changes

EOHHS made several changes to nursing facility rates, which are not fully captured in the FFS base data period or became effective during the contract period. An adjustment was made for changes occurring after the beginning of the base period through October 2020.

The combined impact of these changes to nursing facility rates is estimated to be a 2.35% increase to the Long-Term Care (LTC) COS.

Substance Use Disorder Services

Effective January 1, 2019, American Society of Addiction Medicine (ASAM) 3.1 level of care SUD services, including Residential Rehabilitation Services (RRS) co-occurring capable and co-occurring enhanced services, recovery support navigator services, and recovery coaching were added to the One Care benefit. These services are not reflected in the FFS base data. An adjustment was made to the rates based on a review of emerging experience as well as financial analyses provided by EOHHS, which included projected utilization and costs per service for the new benefits.

Pharmacy Partial Copay Elimination

Effective September 25, 2019, MassHealth members are exempt from copays for smoking cessation products and medications. Additionally, effective July 1, 2020, additional populations and services are included in the MassHealth copay exclusion criteria. Members at or below 50% of the federal poverty

level and those considered "referred eligible" are no longer subject to copays. Also effective July 1, 2020, members are exempt from copays when filling all aspirin, statin, and SUD treatment prescriptions and preventive services graded A and B by the United States Preventative Services Task Force. Payments to pharmacies by all payers, including MassHealth, will increase due to fewer copays collected from members. Lastly, effective July 1, 2021, members above 50% federal poverty level have a 2% cap on copays. While One Care enrollees are not subject to copays, the population that is eligible for, but not enrolled in, One Care is subject to copays.

The copays in the base data by rate cell for applicable members and services to were analyzed to determine the amount of copays eliminated based on the criteria above and developed a program change to capture the increases for these additional costs in RY21 for members eligible for, but not enrolled in, One Care.

Opioid Treatment Program Part B Coverage

Section 205 of the SUPPORT Act established a new Medicare Part B benefit for opioid use disorder treatment services furnished by OTPs effective January 1, 2020. Medicare had not previously covered OTPs. The Medicare proposal sets the copayment to zero at least through the 2020 time period; therefore, there will be no Medicaid liability for OTP services beyond the standard deductible for all Part B services. Further analysis was done to ascertain the impact to the base data of removing Medicaid liability for OTP services to develop an adjustment.

Trend

Trend was applied for 24 months from the midpoint of the base period (July 1, 2019) to the midpoint of the contract period (July 1, 2021) for most RCs. However, for C4 rates, trend was applied for 36 months from the midpoint of the base period (July 1, 2018) to the midpoint of the contract period (July 1, 2021).

The resulting trend factors applied to the base data for both Medicaid-only and crossover data are shown below:

	Annualized Trend Factors				
Category of Service	**C1**	**C2**	**C3**	**C4**	**F1**
Inpatient - non-BH	2.5%	3.5%	4.0%	4.0%	3.0%
Inpatient BH	2.5%	3.5%	4.0%	0.0%	3.0%
Hospital Outpatient	3.0%	2.0%	1.0%	1.0%	4.0%
Outpatient BH	3.0%	2.0%	1.0%	1.0%	4.0%
Professional	1.0%	1.5%	2.0%	2.0%	0.0%
TLP Services	N/A	N/A	N/A	0.0%	N/A
HCBS/Home Health	2.0%	2.0%	2.0%	2.0%	2.0%
LTC Facility	0.0%	0.0%	0.0%	0.0%	0.0%

Pharmacy	5.0%	5.0%	3.0%	3.0%	3.0%
DME & Supplies	1.0%	1.0%	3.0%	3.0%	1.0%
Transportation	2.5%	3.5%	3.0%	3.0%	2.0%
All Other	1.0%	1.0%	3.0%	3.0%	1.0%

Non-Medical Expense

An adjustment has been applied to the MassHealth component of the rate for CY 2021 to reflect the estimated transfer of administrative costs from EOHHS to the One Care plans. These amounts were developed by MassHealth based on a review of administrative, BH care management, and complex care management costs. The PMPMs below have been added to each rating category.

	PMPM		
Rating Category	**Eastern**	**Western**	**The Cape**
C1: Community Other	$25.99	$25.99	$25.99
C2A: Community High Behavioral Health	$37.05	$37.05	$37.05
C2B: Community Very High Behavioral Health	$48.02	$48.02	$48.02
C3A: High Community Need	$81.65	$81.65	$81.65
C3B: Very High Community Need	$173.39	$173.39	$173.39
C4: Transitional Living Need	$173.39	$173.39	$173.39
F1: Facility-Based Care	$89.22	$89.22	$89.22

III. Medicare Components of the Rate – CY 2021

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 enrolled population in each program prior to 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 Demonstration enrollees were enrolled prior to Demonstration.

Medicare A/B Component Payments: The final CY 2021 Medicare A/B Baseline County rates are provided below.

The final rates represent the weighted average of the CY 2021 FFS Standardized County Rates, updated to incorporate the adjustment noted below, and the Medicare Advantage projected payment rates for CY 2021, based on the actual 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 2021 Medicare A/B baseline rate will be updated to reflect a1.93% 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 2021, as in Medicare Advantage, is 5.90%.

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%. As noted above, sequestration is suspended from *January 1, 2021 through December 31, 2021 and thus CMS will not reduce the non-exempt portions of the Medicare components of the integrated rate during this time period.*

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.

2021 Medicare A/B Baseline PMPM, Non-ESRD Beneficiaries, Standardized 1.0 Risk Score, by Demonstration County[1]					
Medicare-Medicaid Plans	**County**	**2021 Published FFS Standardized County Rate**	**2021 Updated Medicare A/B FFS Baseline** (updated by CY 2021 bad debt adjustment)	**2021 Updated Medicare A/B Baseline** (incorporating updated Medicare A/B FFS baseline and Medicare Advantage component)	**2021 Medicare A/B Baseline PMPM, Savings Percentage Applied** (after application of 0.50% savings percentage and prior to quality withhold
CCA	Barnstable	$1,091.54	$1,112.61	$1,112.61	$1,107.05
CCA	Berkshire	1,001.68	1,021.01	1,021.01	1,015.90
CCA	Bristol	1,001.64	1,020.97	1,020.71	1,015.61
CCA	Essex	974.57	993.38	993.19	988.22
CCA	Franklin	884.63	901.70	901.70	897.19
CCA	Hampden	896.08	913.37	915.64	911.06
CCA	Hampshire	892.20	909.42	909.42	904.87
CCA and Tufts	Middlesex	976.07	994.91	994.47	989.50
CCA	Norfolk	1,025.45	1,045.24	1,044.36	1,039.14
CCA	Plymouth	1,073.56	1,094.28	1,094.28	1,088.81
CCA and Tufts	Suffolk	954.09	972.50	971.23	966.37
CCA and Tufts	Worcester	974.83	993.64	991.06	986.10

[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.

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 2021 Massachusetts ESRD dialysis state rate. The CY 2021 ESRD dialysis state rate for Massachusetts is $8,912.67 PMPM, prior to the application of the quality withhold. 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 2021 Massachusetts ESRD dialysis state rate. The CY 2021 ESRD dialysis state rate for Massachusetts is $8,912.67 PMPM, prior to the application of the quality withhold. 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.

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). Note that effective January 1, 2021, MMPs (like all Medicare Advantage plans) will no longer be responsible for organ acquisition costs for kidney transplants; such costs will be excluded from these rates and covered under Medicare FFS.

2021 Medicare A/B Baseline PMPM, Beneficiaries with ESRD Functioning Graft Status, Standardized 1.0 Risk Score, by Demonstration County		
Medicare-Medicaid Plans	**County**	**2021 3.5% bonus County Rate (Benchmark)**
CCA	Barnstable	$1,075.17
CCA	Berkshire	1,036.74
CCA	Bristol	1,011.66
CCA	Essex	1,008.68
CCA	Franklin	1,015.11
CCA	Hampden	994.65
CCA	Hampshire	990.34
CCA and Tufts	Middlesex	1,010.23
CCA	Norfolk	1,010.07
CCA	Plymouth	1,057.46
CCA and Tufts	Suffolk	987.48
CCA and Tufts	Worcester	1,008.95

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.

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. 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 2021 is $43.07 and the CY 2021 Low-Income Premium Subsidy Amount for Massachusetts is $35.16. 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 2021 is $43.07.

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 each One Care plan, are plan-specific and will be same for all counties, as shown below.

One Care Plan	Low income cost-sharing	Reinsurance
H0137 – Commonwealth Care Alliance	$239.00 PMPM	$341.00 PMPM
H7419 – Tufts Health Public Plan	$171.84 PMPM	$254.95 PMPM

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:
https://www.cms.gov/files/document/capitatedmodelratesettingprocess03192019.pdf

II. Savings Percentages and Quality Withholds

Note: *This preliminary content assumes One Care continues into CY 2021 under current CY 2020 terms for most financial parameters and is provided for informational purposes only.*

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. The savings percentage will not be applied to the Part D component of the joint rate.

Year	Calendar dates	Savings percentage
Demonstration Year 8	January 1 through December 31, 2021	0.50%

Quality Withhold

The quality withhold is 1.75% in Demonstration Year 8.

More information about the quality withhold methodology is available in the CMS core and state-specific quality withhold technical notes, which are posted at the following link: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/MMPQualityWithholdMethodologyandTechnicalNotes.html

V. Risk Mitigation

Risk Corridors

Risk corridors have been established for Demonstration Year 8. 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 risk adjustment methodologies (e.g. CMS-HCC), and as if One Care plans had received the full quality withhold payment.

For Demonstration Year 8, for gains and/or losses of 0 through 2.0%, the One Care plan bears 100% of the gain/loss. For the portion of gains and/or losses from 2.1% 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.

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VI: MassHealth Base Data Summaries

Notes:

Data reflected in these exhibits represent only Medicaid liability for the target population that is eligible for, but not enrolled in, the One Care Program. In some cases, totals may not equal the sum of their respective column components due to rounding.

Time Period:	January 1, 2019 to December 31, 2019
Region:	Eastern

	C1: Community Other			C2: Community High Behavioral Health		
Category of Service	**Crossover PMPM**	**Medicaid PMPM**	**Total PMPM**	**Crossover PMPM**	**Medicaid PMPM**	**Total PMPM**
Member Months	444,720	444,720	444,720	152,812	152,812	152,812
Inpatient - non-BH	$ 6.18	$ 1.65	$ 7.83	$ 17.64	$ 11.07	$ 28.70
Inpatient BH	$ 0.14	$ 0.62	$ 0.76	$ 22.13	$ 45.36	$ 67.49
Hospital Outpatient	$ 22.14	$ 0.47	$ 22.61	$ 23.98	$ 1.31	$ 25.29
Outpatient BH	$ 3.76	$ 6.88	$ 10.64	$ 6.11	$ 145.87	$ 151.97
Professional	$ 12.05	$ 2.20	$ 14.25	$ 15.65	$ 10.20	$ 25.84
HCBS/Home Health	$ -	$ 5.32	$ 5.32	$ -	$ 12.60	$ 12.60
LTC Facility	$ 0.67	$ 0.45	$ 1.12	$ 2.32	$ 1.25	$ 3.57
Pharmacy	$ -	$ 4.73	$ 4.73	$ -	$ 6.57	$ 6.57
DME & Supplies	$ 2.06	$ 3.69	$ 5.75	$ 1.83	$ 4.20	$ 6.03
Transportation	$ 0.05	$ 8.08	$ 8.13	$ 0.20	$ 59.38	$ 59.58
All Other	$ -	$ 22.31	$ 22.31	$ -	$ 24.48	$ 24.48
All Services	$ 47.05	$ 56.41	$ 103.47	$ 89.85	$ 322.27	$ 412.11

	C3: High Community Need			F1: Facility-Based Care		

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Category of Service	Crossover PMPM	Medicaid PMPM	Total PMPM	Crossover PMPM	Medicaid PMPM	Total PMPM
Member Months	100,832	100,832	100,832	15,666	15,666	15,666
Inpatient - non-BH	$ 25.30	$ 43.64	$ 68.94	$ 39.07	$ 1,790.78	$ 1,829.85
Inpatient BH	$ 12.78	$ 118.82	$ 131.60	$ 20.08	$ 2,003.32	$ 2,023.41
Hospital Outpatient	$ 29.80	$ 1.40	$ 31.20	$ 78.75	$ 9.63	$ 88.38
Outpatient BH	$ 4.15	$ 58.78	$ 62.93	$ 4.34	$ 29.29	$ 33.63
Professional	$ 15.68	$ 4.33	$ 20.01	$ 14.76	$ 1.63	$ 16.39
HCBS/Home Health	$ -	$ 2,185.38	$ 2,185.38	$ -	$ 28.32	$ 28.32
LTC Facility	$ 31.79	$ 47.35	$ 79.14	$ 117.29	$ 4,967.08	$ 5,084.37
Pharmacy	$ -	$ 12.70	$ 12.70	$ -	$ 3.35	$ 3.35
DME & Supplies	$ 9.31	$ 30.61	$ 39.92	$ 7.86	$ 24.98	$ 32.84
Transportation	$ 0.24	$ 117.48	$ 117.73	$ 0.45	$ 70.31	$ 70.76
All Other	$ -	$ 54.44	$ 54.44	$ -	$ 32.57	$ 32.57
All Services	$ 129.07	$ 2,674.94	$ 2,804.00	$ 282.60	$ 8,961.26	$ 9,243.86

Time Period:	January 1, 2019 to December 31, 2019
Region:	Western

	C1: Community Other			C2: Community High Behavioral Health		
Category of Service	**Crossover PMPM**	**Medicaid PMPM**	**Total PMPM**	**Crossover PMPM**	**Medicaid PMPM**	**Total PMPM**
Member Months	202,240	202,240	202,240	73,677	73,677	73,677
Inpatient - non-BH	$ 3.70	$ 0.39	$ 4.09	$ 11.78	$ 1.70	$ 13.48
Inpatient BH	$ 0.03	$ 2.58	$ 2.61	$ 19.81	$ 25.57	$ 45.38
Hospital Outpatient	$ 18.58	$ 0.38	$ 18.96	$ 20.57	$ 0.98	$ 21.55

Outpatient BH	$ 3.45	$ 8.50	$ 11.95	$ 5.82	$ 162.18	$ 168.00
Professional	$ 11.32	$ 2.30	$ 13.62	$ 14.45	$ 4.13	$ 18.58
HCBS/Home Health	$ -	$ 5.84	$ 5.84	$ -	$ 12.45	$ 12.45
LTC Facility	$ 0.47	$ 0.68	$ 1.14	$ 1.93	$ 2.08	$ 4.01
Pharmacy	$ -	$ 3.26	$ 3.26	$ -	$ 4.80	$ 4.80
DME & Supplies	$ 2.20	$ 3.50	$ 5.70	$ 2.09	$ 3.45	$ 5.53
Transportation	$ 0.08	$ 7.01	$ 7.09	$ 0.28	$ 53.36	$ 53.65
All Other	$ -	$ 20.60	$ 20.60	$ -	$ 24.32	$ 24.32
All Services	**$ 39.83**	**$ 55.04**	**$ 94.86**	**$ 76.73**	**$ 295.01**	**$ 371.74**

	C3: High Community Need			F1: Facility-Based Care		
Category of Service	**Crossover PMPM**	**Medicaid PMPM**	**Total PMPM**	**Crossover PMPM**	**Medicaid PMPM**	**Total PMPM**
Member Months	52,264	52,264	52,264	5,930	5,930	5,930
Inpatient - non-BH	$ 16.70	$ 21.71	$ 38.41	$ 36.45	$ 1,515.99	$ 1,552.44
Inpatient BH	$ 7.27	$ 40.16	$ 47.43	$ 6.49	$ 1,653.87	$ 1,660.36
Hospital Outpatient	$ 32.77	$ 1.08	$ 33.86	$ 80.28	$ 16.45	$ 96.73
Outpatient BH	$ 3.79	$ 47.03	$ 50.82	$ 3.82	$ 26.07	$ 29.90
Professional	$ 14.85	$ 5.60	$ 20.45	$ 18.61	$ 2.09	$ 20.70
HCBS/Home Health	$ -	$ 2,322.46	$ 2,322.46	$ -	$ 11.04	$ 11.04
LTC Facility	$ 20.44	$ 42.66	$ 63.11	$ 91.25	$ 5,355.36	$ 5,446.61
Pharmacy	$ -	$ 9.54	$ 9.54	$ -	$ 3.17	$ 3.17
DME & Supplies	$ 10.47	$ 38.78	$ 49.26	$ 8.61	$ 49.38	$ 58.00

Transportation	$ 0.20	$ 90.73	$ 90.93	$ 1.12	$ 59.10	$ 60.22
All Other	$ -	$ 50.27	$ 50.27	$ -	$ 48.48	$ 48.48
All Services	**$ 106.50**	**$ 2,670.04**	**$ 2,776.54**	**$ 246.63**	**$ 8,741.00**	**$ 8,987.64**

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Time Period:	January 1, 2019 to December 31, 2019
Region:	The Cape

	C1: Community Other			C2: Community High Behavioral Health		
Category of Service	**Crossover PMPM**	**Medicaid PMPM**	**Total PMPM**	**Crossover PMPM**	**Medicaid PMPM**	**Total PMPM**
Member Months	74,347	74,347	74,347	27,405	27,405	27,405
Inpatient - non-BH	$ 6.52	$ 0.07	$ 6.59	$ 18.55	$ 18.97	$ 37.52
Inpatient BH	$ 0.06	$ -	$ 0.06	$ 18.67	$ 93.14	$ 111.80
Hospital Outpatient	$ 21.27	$ 0.45	$ 21.72	$ 23.77	$ 0.96	$ 24.73
Outpatient BH	$ 4.33	$ 8.61	$ 12.94	$ 6.94	$ 151.13	$ 158.07
Professional	$ 12.43	$ 1.70	$ 14.13	$ 17.12	$ 5.58	$ 22.70
HCBS/Home Health	$ -	$ 4.35	$ 4.35	$ -	$ 12.63	$ 12.63
LTC Facility	$ 0.89	$ 0.31	$ 1.20	$ 2.74	$ 2.06	$ 4.80
Pharmacy	$ -	$ 4.79	$ 4.79	$ -	$ 4.95	$ 4.95
DME & Supplies	$ 2.28	$ 4.61	$ 6.89	$ 2.40	$ 4.52	$ 6.92
Transportation	$ 0.13	$ 10.80	$ 10.93	$ 0.52	$ 74.20	$ 74.72
All Other	$ -	$ 21.89	$ 21.89	$ -	$ 24.93	$ 24.93
All Services	**$ 47.92**	**$ 57.57**	**$ 105.48**	**$ 90.71**	**$ 393.05**	**$ 483.77**

	C3: High Community Need			F1: Facility-Based Care		
Category of Service	**Crossover PMPM**	**Medicaid PMPM**	**Total PMPM**	**Crossover PMPM**	**Medicaid PMPM**	**Total PMPM**
Member Months	14,176	14,176	14,176	2,458	2,458	2,458
Inpatient - non-BH	$ 23.59	$ 56.77	$ 80.37	$ 43.25	$ 644.84	$ 688.09
Inpatient BH	$ 18.91	$ 157.95	$ 176.86	$ 9.61	$ 971.29	$ 980.90

Hospital Outpatient	$ 28.65	$ 1.17	$ 29.82	$ 76.23	$ 16.89	$ 93.12
Outpatient BH	$ 5.71	$ 70.46	$ 76.17	$ 8.27	$ 14.20	$ 22.47
Professional	$ 17.91	$ 3.06	$ 20.97	$ 20.12	$ 2.33	$ 22.45
HCBS/Home Health	$ -	$ 2,274.53	$ 2,274.53	$ -	$ 17.12	$ 17.12
LTC Facility	$ 41.47	$ 68.96	$ 110.42	$ 119.09	$ 5,071.06	$ 5,190.15
Pharmacy	$ -	$ 9.32	$ 9.32	$ -	$ 2.14	$ 2.14
DME & Supplies	$ 12.38	$ 29.03	$ 41.41	$ 9.01	$ 12.23	$ 21.24
Transportation	$ 0.78	$ 185.43	$ 186.20	$ 1.24	$ 104.58	$ 105.82
All Other	$ -	$ 70.44	$ 70.44	$ -	$ 61.57	$ 61.57
All Services	**$ 149.40**	**$ 2,927.11**	**$ 3,076.51**	**$ 286.82**	**$ 6,918.25**	**$ 7,205.07**

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Region:	All

	C1: Community Other			C2: Community High Behavioral Health		
Category of Service	**Crossover PMPM**	**Medicaid PMPM**	**Total PMPM**	**Crossover PMPM**	**Medicaid PMPM**	**Total PMPM**
Member Months	721,307	721,307	721,307	253,894	253,894	253,894
Inpatient - non-BH	$ 5.52	$ 1.14	$ 6.66	$ 16.04	$ 9.20	$ 25.24
Inpatient BH	$ 0.10	$ 1.10	$ 1.20	$ 21.08	$ 44.77	$ 65.85
Hospital Outpatient	$ 21.05	$ 0.44	$ 21.49	$ 22.97	$ 1.18	$ 24.14
Outpatient BH	$ 3.73	$ 7.52	$ 11.24	$ 6.11	$ 151.17	$ 157.28
Professional	$ 11.89	$ 2.18	$ 14.06	$ 15.46	$ 7.94	$ 23.40
HCBS/Home Health	$ -	$ 5.37	$ 5.37	$ -	$ 12.56	$ 12.56
LTC Facility	$ 0.64	$ 0.50	$ 1.14	$ 2.26	$ 1.57	$ 3.83
Pharmacy	$ -	$ 4.33	$ 4.33	$ -	$ 5.88	$ 5.88
DME & Supplies	$ 2.12	$ 3.73	$ 5.85	$ 1.96	$ 4.02	$ 5.98
Transportation	$ 0.06	$ 8.06	$ 8.12	$ 0.26	$ 59.24	$ 59.49
All Other	$ -	$ 21.79	$ 21.79	$ -	$ 24.48	$ 24.48
All Services	**$ 45.12**	**$ 56.15**	**$ 101.26**	**$ 86.13**	**$ 322.00**	**$ 408.13**

	C3: High Community Need			F1: Facility-Based Care		
Category of Service	**Crossover PMPM**	**Medicaid PMPM**	**Total PMPM**	**Crossover PMPM**	**Medicaid PMPM**	**Total PMPM**
Member Months	167,272	167,272	167,272	24,054	24,054	24,054
Inpatient - non-BH	$ 22.47	$ 37.90	$ 60.37	$ 38.85	$ 1,605.94	$ 1,644.79

Inpatient BH	$ 11.58	$ 97.56	$ 109.14	$ 15.66	$ 1,811.71	$ 1,827.37
Hospital Outpatient	$ 30.63	$ 1.28	$ 31.92	$ 78.87	$ 12.05	$ 90.92
Outpatient BH	$ 4.17	$ 56.10	$ 60.27	$ 4.61	$ 26.96	$ 31.57
Professional	$ 15.61	$ 4.62	$ 20.23	$ 16.26	$ 1.81	$ 18.07
HCBS/Home Health	$ -	$ 2,235.77	$ 2,235.77	$ -	$ 22.91	$ 22.91
LTC Facility	$ 29.06	$ 47.72	$ 76.78	$ 111.05	$ 5,073.43	$ 5,184.48
Pharmacy	$ -	$ 11.43	$ 11.43	$ -	$ 3.18	$ 3.18
DME & Supplies	$ 9.93	$ 33.03	$ 42.97	$ 8.16	$ 29.70	$ 37.86
Transportation	$ 0.28	$ 114.88	$ 115.16	$ 0.70	$ 71.05	$ 71.74
All Other	$ -	$ 54.49	$ 54.49	$ -	$ 39.46	$ 39.46
All Services	**$ 123.74**	**$ 2,694.78**	**$ 2,818.52**	**$ 274.16**	**$ 8,698.19**	**$ 8,972.36**

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Region:	All

	C4: Transitional Living Need		
Category of Service	**Crossover PMPM**	**Medicaid PMPM**	**Total PMPM**
Member Months	968	968	968
Inpatient - non-BH	$ 25.23	$ -	$ 25.23
Inpatient BH	$ -	$ -	$ -
Hospital Outpatient	$ 43.98	$ 0.98	$ 44.96
Outpatient BH	$ 1.65	$ 49.86	$ 51.51
Professional	$ 10.67	$ 0.75	$ 11.42
TLP Services	$ -	$ 6,746.22	$ 6,746.22
HCBS/Home Health	$ -	$ 470.26	$ 470.26
LTC Facility	$ 2.25	$ 5.94	$ 8.19
Pharmacy	$ -	$ 23.50	$ 23.50
DME & Supplies	$ 26.81	$ 142.06	$ 168.87
Transportation	$ 0.00	$ 48.78	$ 48.78
All Other	$ -	$ 17.41	$ 17.41
All Services	**$ 110.60**	**$ 7,505.76**	**$ 7,616.36**