Demonstration to Integrate Care for Dual Eligible Individuals
(One Care – H7419 – Tufts Health Public Plan)
CY 2019 Final Medicare-Medicaid Rate Report
October 10, 2019

MassHealth, in conjunction with the Centers for Medicare & Medicaid Services (CMS), is releasing the final Medicaid and Medicare components of the CY 2019 rates for the Massachusetts Demonstration to Integrate Care for Dual Eligible Individuals (One Care). Effective January 1, 2019, these rates replace the Demonstration rates included in the CY 2018 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 or MMPs).

Included in this report are the final CY 2019 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.

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II. MassHealth Component of the Rate – CY 2019

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 2019 effective January 1, 2019 through December 31, 2019 are listed below, by Massachusetts county and MassHealth rating category for the Demonstration. The rates below do not include application of the 1.75% quality withhold (see Section IV). The rates below do include the savings percentage of 0.5% (see Section IV) for Demonstration Year 6.

	MassHealth Component of County Rate Effective January 1, 2019 through December 31, 2019						
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**
Bristol	$189.26	$601.87	$905.56	$2,828.11	$6,691.48	$8,506.43	$10,077.61
Essex	$189.26	$601.87	$905.56	$2,828.11	$6,691.48	$8,506.43	$10,077.61
Franklin	$168.22	$523.02	$785.34	$2,854.92	$6,755.90	$8,429.62	$9,511.42
Hampden	$168.22	$523.02	$785.34	$2,854.92	$6,755.90	$8,429.62	$9,511.42
Hampshire	$168.22	$523.02	$785.34	$2,854.92	$6,755.90	$8,429.62	$9,511.42
Middlesex	$189.26	$601.87	$905.56	$2,828.11	$6,691.48	$8,506.43	$10,077.61
Norfolk	$189.26	$601.87	$905.56	$2,828.11	$6,691.48	$8,506.43	$10,077.61
Plymouth	$181.57	$663.37	$999.33	$3,148.23	$7,451.74	$7,059.46	$8,374.37
Suffolk	$189.26	$601.87	$905.56	$2,828.11	$6,691.48	$8,506.43	$10,077.61
Worcester	$168.22	$523.02	$785.34	$2,854.92	$6,755.90	$8,429.62	$9,511.42
Statewide*	$180.86	$570.74	$855.11	$2,851.35	$6,744.54	$8,430.39	$9,772.22

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

Historical Base Data Development:

The historical Medicaid and Medicare-Medicaid crossover expenditures for CY 2016 and CY 2017, with incurred but not reported (IBNR) completion adjustments applied, formed the historical base data used to develop the MassHealth component of the rates. The exception to this was for the development of C4 rates, which incorporated an additional year of base data (CY 2015) due to the small nature of the population. C4 was previously referred to as C3C, and has since been renamed and updated accordingly.

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

Includes individuals identified by MassHealth as having a long-term facility stay of more than 90 days. Applicable facilities include nursing facilities, Chronic Disease and Rehabilitation hospitals, and psychiatric hospitals.

Proxy Method

The base data for this rating category was developed based on claim and eligibility data for members in a facility beyond the first 90 days. Applicable facilities include nursing facilities, Chronic Disease and Rehabilitation hospitals, and psychiatric hospitals.

C4: Community Tier 4 – Transitional Living Need

Demonstration Process

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:

- 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 asisstance to total dependence.
- Have one or more of the traumatic brain injury diagnoses as defined by the following diagnosis codes:
  - S06.1x.
  - S06.2x.
  - S06.3x.
  - S06.4x.
  - S06.5x.
  - S06.6x.
  - S06.8x.

Proxy Method

The base data for this rating category was developed based on 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.

C3: Community Tier 3

Demonstration Process

Includes individuals who do not meet F1 or C4 criteria and for whom a MDS-HC assessment indicates:

- 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.

Proxy Method

The base data for this rating category 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).

C2: Community Tier 2

Demonstration Process

Includes individuals who do not meet F1, C4, or C3 criteria and for whom their most recent MDS-HC assessment indicates one or more of the following behavioral health diagnoses listed by ICD-10 code, validated by medical records, reflecting an ongoing, chronic condition such as schizophrenia or episodic mood disorders, psychosis, or alcohol/drug dependence, not in remission:

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

Proxy Method

The base data for this rating category was developed based on claim and eligibility data for members not in F1, C4, or C3 with a qualifying diagnosis (listed above), who had any claims in the Medicaid FFS data and/or non-outpatient claims in the Medicare–Medicaid crossover data.

C1: Community Tier 1 — Community Other

Demonstration Process

Includes individuals in the community who do not meet the F1, C4, C3, or C2 criteria.

Proxy Method

The base data for this rating category was developed based on claim and eligibility data for members not in F1, C4, C3, or C2.

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 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.

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.

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	-7.42%	-7.88%	-6.46%
C2B: Community Very High Behavioral Health	41.15%	40.45%	42.62%
C3A: High Community Need	-4.77%	-1.58%	-5.03%
C3B: Very High Community Need	126.46%	134.05%	125.83%

C4 Rating Category

MassHealth is adding an additional RC — C4 — 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, C4 is treated as a standalone RC and is not developed through the relativity process. Members are identified as C4 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 2015) 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.

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
HCBS/Home Health	Home Health
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. Four counties are not included in any of the One Care plan service areas. Bristol County was added to the service area of one of the One Care plans for CY 2019. In addition to the four excluded counties, certain towns in Plymouth County are also not in the plans' service areas. The excluded Counties and towns are:

- Barnstable
- Berkshire
- Dukes
- Nantucket
- Plymouth: East Wareham, Lakeville, Marion, Mattapoisett, Wareham, and West Wareham

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: Franklin, Hampden, Hampshire, and Worcester Counties

The Cape: Plymouth County

As Bristol County was added to the Eastern region in CY 2019, enrollment into that county is expected to ramp up over time. Therefore, applicable claims and eligibility data for Bristol County was excluded from the base data and adjusted for separately as described in the Adjustments to Historical Base Data section.

It is possible for a One Care member to move to one of the four counties excluded from the One Care service area and maintain One Care eligibility for a period of time. For Demonstration Year 6, an "Excluded County" 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.

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 2019 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	$93.32	$86.27	$94.28	$369.10	$324.45	$368.15	$2,970.06	$2,742.75	$2,862.08
IBNR	0.54%	0.49%	0.55%	1.09%	0.85%	1.38%	0.34%	0.25%	0.34%
Pharmacy Rebates	-0.81%	-0.55%	-1.99%	-0.24%	-0.18%	-0.19%	-0.06%	-0.04%	-0.05%
Diabetic Test Strips Rebates	-0.04%	-0.02%	-0.09%	-0.01%	-0.01%	-0.01%	0.00%	0.00%	0.00%
DMH Psychiatric Claims	0.06%	0.21%	0.01%	2.45%	2.49%	4.77%	1.50%	2.62%	3.16%
Elder Affairs Home Care Program	0.11%	0.13%	0.07%	0.07%	0.08%	0.04%	1.64%	1.66%	1.57%
HSN Dental Wrap	0.26%	0.28%	0.26%	0.07%	0.07%	0.07%	0.01%	0.01%	0.01%
Diversionary BH Services	1.29%	1.51%	1.37%	4.35%	4.99%	3.82%	0.26%	0.25%	0.28%
Bristol County Adjustment	-0.31%	0.00%	0.00%	-0.28%	0.00%	0.00%	-0.31%	0.00%	0.00%
Enrollee Acuity Adjustment	4.73%	0.00%	0.00%	10.01%	3.25%	16.24%	-2.31%	-2.48%	0.00%
Data Rebalancing	40.00%	40.00%	40.00%	20.00%	27.50%	20.00%	-0.41%	-1.50%	3.50%
Adjusted Base Data	**$138.31**	**$123.26**	**$132.20**	**$524.49**	**$463.37**	**$565.76**	**$2,988.08**	**$2,761.67**	**$3,121.72**

	F1: Facility-Based Care			C4: Transitional Living Need		
Adjustment	**Eastern**	**Western**	**The Cape**	**Eastern**	**Western**	**The Cape**
Base Data	$8,198.23	$7,278.14	$6,108.72	$8,001.99	$8,001.99	$8,001.99
IBNR	2.22%	2.10%	1.72%	0.08%	0.08%	0.08%
Pharmacy Rebates	-0.01%	0.00%	-0.03%	-0.02%	-0.02%	-0.02%
Diabetic Test Strips Rebates	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
DMH Psychiatric Claims	3.24%	16.23%	11.12%	N/A	N/A	N/A
Elder Affairs Home Care Program	0.01%	0.01%	0.01%	N/A	N/A	N/A
HSN Dental Wrap	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Diversionary BH Services	0.04%	0.05%	0.08%	0.12%	0.12%	0.12%
Bristol County Adjustment	-0.92%	0.00%	0.00%	N/A	N/A	N/A
Enrollee Acuity Adjustment	0.00%	0.00%	0.00%	N/A	N/A	N/A
Data Rebalancing	0.00%	-5.00%	0.00%	N/A	N/A	N/A
Adjusted Base Data	**$8,575.25**	**$8,209.34**	**$6,908.48**	**$8,017.04**	**$8,017.01**	**$8,017.00**

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 9, 2018 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 Claims Completion Factors		Crossover Claims Completion Factors	
Category of Service	**CY 2016**	**CY 2017**	**CY 2016**	**CY 2017**
Inpatient - Non-BH	1.010	1.081	1.003	1.074
Inpatient BH	1.010	1.084	1.003	1.071
Hospital Outpatient	1.001	1.008	0.999	1.005
Outpatient BH	1.001	1.009	0.999	1.005
Professional	1.001	1.009	1.000	1.002
HCBS/Home Health	1.000	1.002	1.000	1.000
LTC Facility	1.000	1.010	1.000	1.013
Pharmacy	1.000	1.009	1.000	1.000
DME & Supplies	1.000	1.008	1.002	1.014
Transportation	1.000	1.008	1.002	1.008
All Other	1.000	1.008	1.000	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 2015 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 17.9% 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 ages 21-64 during CY 2016 and CY 2017. This percentage was then applied to the base data. In addition, MassHealth has an agreement in place for supplemental rebates on diabetic test strips. MassHealth estimated that there is an additional 0.9% in potential rebates in CY 2016 and CY 2017 on diabetic test strips for the dual-eligible population.

Department of Mental Health Psychiatric Claims

The One Care program covers inpatient and outpatient psychiatric claims costs from Department of Mental Health (DMH) facilities, but not all costs are reflected in the historical base data. To account for these costs, adjustments were applied to the Inpatient BH and Outpatient BH COS.

Elder Affairs Home Care Program

The Elder Affairs Home Care Program is an State-funded benefit for individual's ages 60 and above 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 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. The CY 2019 rates include the costs of providing the Elder Affairs Home Care Program, including the Basic and Enhanced Community Options Program levels.

Health Safety Net — Dental Wrap

One Care members can receive the full scope of dental services (defined as the scope of services prior to EOHHS benefit reductions in July 2010). In FFS, certain dental services were only available for members ages 21 and above through acute hospitals and CHCs through the Commonwealth's Health Safety Net (HSN); therefore, these services were not included in the FFS base data and must be added into the rates. As dental benefits are restored to the FFS population across time, reimbursement for the services transitions from the HSN to FFS. An adjustment was made to add these services into the base using HSN dental expenditures for One Care eligible members.

Diversionary Behavioral Health

Costs for certain diversionary BH services that are covered under the One Care program for non-institutionalized members are not included in the FFS base data. The CY 2019 rates include adjustments for the costs of covering these services. These diversionary BH services include the following:

- Community Support Program
- Structured outpatient addiction program
- Intensive outpatient program
- Program of assertive community treatment

Bristol County Adjustment

Bristol County was added to the service area of one of the One Care plans for CY 2019. MassHealth reviewed both the relative cost of Bristol County to the rest of the Eastern region as well as projected enrollment ramp-up in the county through CY 2019 to develop an adjustment to the base data.

Enrollee Acuity Adjustment

The base FFS data represents both members who eventually enrolled in One Care and those that have not enrolled to date. 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 rating categories 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.

Data Rebalancing

Prior to finalizing the medical component of the capitation rates, the PMPM values and relationships among and between rating categories 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 rating categories 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 2019 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.

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Adjustment	**Eastern**	**Western**	**The Cape**	**Eastern**	**Western**	**The Cape**	**Eastern**	**Western**	**The Cape**
CSP Services for Chronically Homeless Individuals	0.65%	0.10%	1.19%	2.07%	0.32%	3.01%	0.15%	0.02%	0.24%
Home Health Policy Changes	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-12.75%	-8.43%	-6.67%
Acute IP Hospital Fee Change	0.53%	0.46%	1.09%	0.89%	0.67%	0.84%	0.15%	0.13%	0.08%
Chronic Disease and Rehabilitation Hospital Fee Change	0.02%	0.00%	0.21%	0.02%	0.02%	0.00%	0.09%	0.02%	0.10%
HCBS Fee Changes	0.12%	0.13%	0.06%	0.02%	0.04%	0.01%	2.00%	3.08%	2.13%
DME Fee Change	-0.06%	-0.18%	-0.20%	-0.01%	-0.05%	-0.03%	-0.03%	-0.06%	-0.06%
Acute OP Hospital Fee Change	2.76%	4.29%	3.62%	0.93%	1.14%	0.96%	0.13%	0.26%	0.24%
Professional Fee Changes	0.09%	-0.01%	0.25%	0.16%	0.04%	0.17%	0.01%	-0.02%	0.01%
CHC Fee Change	4.91%	1.18%	1.77%	0.87%	0.32%	0.53%	0.12%	0.06%	0.08%
BH Fee Changes	1.29%	1.89%	1.84%	3.08%	3.69%	3.81%	0.37%	0.30%	0.42%
TLP Unit Cost	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Nursing Facility Rate Changes	0.02%	0.01%	0.01%	0.01%	0.01%	0.01%	0.04%	0.03%	0.05%
SUD Services	0.05%	0.06%	0.06%	0.18%	0.21%	0.14%	0.02%	0.01%	0.01%
All Program Changes	**10.74%**	**8.15%**	**10.27%**	**8.48%**	**6.52%**	**9.78%**	**-10.08%**	**-4.89%**	**-3.56%**

	F1: Facility-Based Care			C4: Transitional Living Need		
Adjustment	**Eastern**	**Western**	**The Cape**	**Eastern**	**Western**	**The Cape**
CSP Services for Chronically Homeless Individuals	0.00%	0.00%	0.00%	N/A	N/A	N/A
Home Health Policy Changes	0.00%	0.00%	0.00%	N/A	N/A	N/A
Acute IP Hospital Fee Change	0.07%	0.07%	0.09%	0.01%	0.01%	0.01%
Chronic Disease and Rehabilitation Hospital Fee Change	1.17%	0.04%	0.90%	N/A	N/A	N/A
HCBS Fee Changes	0.01%	0.01%	0.01%	N/A	N/A	N/A
DME Fee Change	0.00%	-0.01%	0.00%	0.06%	0.06%	0.06%
Acute OP Hospital Fee Change	0.05%	0.03%	0.10%	0.18%	0.18%	0.18%
Professional Fee Changes	0.01%	0.02%	0.04%	-0.03%	-0.03%	-0.03%
CHC Fee Change	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
BH Fee Changes	0.05%	0.06%	0.09%	0.23%	0.23%	0.23%
TLP Unit Cost	N/A	N/A	N/A	2.79%	1.85%	-15.08%
Nursing Facility Rate Changes	0.84%	0.96%	1.09%	0.00%	0.00%	0.00%
SUD Services	0.00%	0.00%	0.00%	N/A	N/A	N/A
All Program Changes	**2.22%**	**1.19%**	**2.33%**	**3.27%**	**2.32%**	**-14.69%**

Community Support Program Services for Chronically Homeless Individuals

Community Support Program (CSP) Services for Chronically Homeless Individuals are available to One Care enrollees in 2019 and are not reflected in the FFS base data. 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 use of CSP Services for Chronically Homeless Individuals.

Home Health Policy Changes

MassHealth made several home health policy changes in CY 2016 to control the rising costs of Home Health services. This included 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 six-month moratorium on new applications for home health agencies, which was initially approved by CMS in February 2016. The moratorium is still in effect.

Acute Inpatient Hospital 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% fee increase. Crossover claims were analyzed for the impact of the fee schedule change after Medicare Part A deductibles and cost sharing.

Chronic Disease and Rehabilitation Hospital Fee Change

Effective October 1, 2017, MassHealth implemented a fee schedule increase for services provided at Chronic Disease and Rehabilitation hospitals. Inpatient claims in the base data prior to the effective date were repriced to the new fees and the Crossover claims were analyzed for the impact of the fee schedule change after Medicare deductibles and cost sharing.

Home- and Community-Based Services Fee Changes

There were multiple rate changes affecting the HCBS/Home Health COS including:

- Adult Foster Care rate decrease varying by code, effective May 5, 2017 and proposed rate increase effective May 1, 2019 with an expected annual impact of 0.8%.
- Adult Day Health proposed rate increase effective May 1, 2019 with an expected annual impact of 2.9%.
- PCA rate increases totaling approximately 7.1% in aggregate, effective on multiple dates.
- Continuous skilled nursing rate increases totaling approximately 13.4% in aggregate, effective on multiple dates.

Claims for the affected services in the base data were repriced using the new fee schedules to determine an adjustment.

Durable Medical Equipment Fee Change

Effective March 1, 2018, MassHealth revised its fee schedule for durable medical equipment (DME), oxygen, and respiratory therapy equipment. Claims for the affected services in the base data were repriced using the new 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 Outpatient Hospital Fee Change

Effective December 31, 2016, EOHHS transitioned its acute outpatient hospital payment method from Payment Amount per Episode (PAPE) to Adjudicated Payment per Episode of Care (APEC). The APEC payment varies based on the weight assigned to each individual claim, utilizing the Enhanced Ambulatory Patient Grouping System. The PAPE payment did not vary by claim, but was based on an average case weight by hospital. The target population had a higher average case weight than the general FFS population; therefore, the average cost per episode increased in the transition from PAPE to APEC. Mercer compared the average cost per episode for the claims paid under PAPE to those paid under APEC by region and RC to determine an adjustment.

Professional Fee Changes

Effective March 1, 2018, MassHealth implemented fee schedule increases of for professional services; including, medicine, radiology, surgery, and anesthesia. 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.

CHC Fee Change

MassHealth implemented a fee schedule increase for CHCs effective October 20, 2018. In addition, MassHealth implemented an updated fee schedule for CHCs effective January 1, 2019, which includes further increases as well as establishing new fees for individual mental health visits. 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.

Behavioral Health Fee Changes

MassHealth implemented an updated fee schedule for Psychiatric Day Treatment Services effective January 25, 2019. Additionally, MassHealth has implemented an updated fee schedule for mental health services provided in CHCs and CMHCs, effective in January 2019. 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.

Transitional Living Program Unit Cost

Due to the small population and relative stability of non-TLP services across regions, the C4 rates were developed at the statewide level. However, there are differences between TLP payment rates for the various sites that provide the service. 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 2019.

MassHealth applied an adjustment to project the aggregate statewide TLP base data to a CY 2019 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 EOHHS must pay a rate.

Nursing Facility Rate Changes

MassHealth made several changes to nursing facility reimbursements which are not fully captured in the FFS base data period, including the following:

- Nursing facility rate increase (effective November 2015)
- Nursing facility rate increase (effective October 2016)
- Nursing facility rate increase (effective October 2017)
- Nursing facility rate increase (effective October 2018)
- Nursing facility rate increase (effective January 2019)

The estimated the combined impact of these changes to nursing facility reimbursements to be a 1.7% increase to the Long-Term Care (LTC) Facility COS for most RCs. Due to the inclusion of CY 2015 in the base data, the C4 RC is impacted by the adjustments in 2015 and the C4 LTC Facility COS is increased by 1.9%.

Substance Use Disorder Services

Effective January 1, 2019, recovery support navigator services and recovery coaching were added to the One Care benefit. Also effective no sooner than January 1, 2019, ASAM 3.1 level of care SUD services, including Residential Rehabilitation Services (RRS) co-occurring capable and Enhanced Residential Rehabilitation Services for Dually Diagnosed, will be 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 financial analysis provided by EOHHS, which included projected utilization and costs per service for the new benefits.

Trend

Trend was applied for 30 months from the midpoint of the base period (January 1, 2017) to the midpoint of the contract period (July 1, 2019) for most RCs. However, for C4 rates, trend was applied for 36 months from the midpoint of the base period (July 1, 2016) to the midpoint of the contract period (July 1, 2019). Trend factors were developed separately for each RC, as well as Medicaid-only and crossover claim types. Trend factors for each major COS were developed within each RC. Minor programmatic changes were considered in the development of trend factors.

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	1.00%	4.48%	3.98%	3.98%	4.02%
Inpatient BH	1.00%	4.48%	3.98%	0.00%	4.02%
Hospital Outpatient	3.02%	2.51%	1.51%	1.51%	1.97%
Outpatient BH	3.02%	2.51%	1.51%	1.51%	1.97%
Professional	3.02%	2.00%	1.49%	1.49%	2.82%
TLP Services	N/A	N/A	N/A	0.00%	N/A
HCBS/Home Health	3.02%	3.02%	3.02%	3.02%	3.02%
LTC Facility	1.00%	1.00%	1.00%	1.00%	1.00%
Pharmacy	4.02%	6.05%	5.93%	5.93%	3.35%
DME & Supplies	1.99%	2.01%	2.01%	2.01%	1.50%
Transportation	1.99%	2.01%	2.01%	2.01%	1.50%
All Other	1.99%	2.01%	2.01%	2.01%	1.50%

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.

	Percent of Total Medical		
Rating Category	**Eastern**	**Western**	**The Cape**
C1: Community Other	0.03%	0.01%	0.02%
C2A: Community High Behavioral Health	0.00%	0.00%	0.00%
C2B: Community Very High Behavioral Health	0.00%	0.00%	0.00%
C3A: High Community Need	0.11%	0.08%	0.14%
C3B: Very High Community Need	0.07%	0.05%	0.09%
C4: Transitional Living Need	0.00%	0.00%	0.00%
F1: Facility-Based Care	7.79%	7.77%	12.06%

Non-Medical Expense Load

An adjustment has been applied to the MassHealth component of the rate for CY 2019 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	$27.07	$27.07	$27.07
C2A: Community High Behavioral Health	$39.72	$39.72	$39.72
C2B: Community Very High Behavioral Health	$48.43	$48.43	$48.43
C3A: High Community Need	$89.16	$89.16	$89.16
C3B: Very High Community Need	$180.49	$180.49	$180.49
C4: Transitional Living Need	$184.59	$184.59	$184.59
F1: Facility-Based Care	$100.82	$100.82	$100.82

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 (MA) projected payment rates for each year, weighted by the proportion of the enrolled population that would otherwise be enrolled in each program in the absence of the Demonstration. The Medicare Advantage baseline spending includes costs that would have occurred absent the Demonstration, such as quality bonus payments for applicable Medicare Advantage plans.

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

Medicare A/B Component Payments: The final CY 2019 Medicare A/B Baseline County rates are provided below.

The final rates represent the weighted average of the CY 2019 FFS Standardized County Rates, updated to incorporate the adjustment noted below, and the Medicare Advantage projected payment rates for CY 2019 based on the actual enrollment of beneficiaries from Medicare FFS and Medicare Advantage prior to demonstration enrollment at the county level.

These rates reflect the rate change as finalized in the August 30, 2018 HPMS memorandum titled "Updates to MMP Medicare A/B Rate Methodology for CY 2019" and initially described in the July 11, 2018 HPMS memorandum titled "Proposed Update to MMP Medicare A/B Rate Methodology for CY 2019." As described in these memos, rather than continuing to use the historical MA versus FFS weighting prior to the demonstration of *demonstration-eligible beneficiaries,* beginning in CY 2019, CMS is re-basing the weighting based on the pre-enrollment status of *actual MMP enrollees.* This approach looks at the beneficiaries enrolled in the demonstration, by county, and assesses whether they were in MA or original Medicare FFS prior to enrolling in their current MMP. For the CY 2019 rates, this approach examined the pre-demonstration enrollment status of MMP enrollees during the second quarter of CY 2018 (as of April 2018).

Bad Debt Adjustment: The FFS component of the CY 2019 Medicare A/B baseline rate has been updated to reflect a 1.94% 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 2019 in Medicare Advantage is 5.90%. For 2019, CMS will apply the full prevailing Medicare Advantage coding intensity adjustment.

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

under the Demonstration, CMS will reduce non-exempt portions of the Medicare components by 2%, as noted in the sections below.

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

2019 Medicare A/B Baseline PMPM, Non-ESRD Beneficiaries, Standardized 1.0 Risk Score, by Demonstration County [1]					
County	**2019 Published FFS Standardized County Rate**	**2019 Updated Medicare A/B FFS Baseline** (updated by CY 2019 bad debt adjustment)	**2019 Updated Medicare A/B Baseline** (incorporating updated Medicare A/B FFS baseline and Medicare Advantage component)	**2019 Medicare A/B Baseline PMPM, Savings Percentage Applied** (after application of 0.5% savings percentage)	**2019 Final Medicare A/B PMPM Payment** (2% sequestration reduction applied and prior to quality withhold)
Bristol	$919.14	$936.97	$936.97	$932.29	$913.64
Essex	897.61	915.02	911.21	906.65	888.52
Franklin	804.97	820.59	820.59	816.49	800.16
Hampden	810.62	826.35	837.52	833.33	816.66
Hampshire	824.34	840.33	840.33	836.13	819.41
Middlesex	897.17	914.58	914.04	909.47	891.28
Norfolk	951.25	969.70	966.82	961.99	942.75
Plymouth	990.14	1,009.35	1,009.35	1,004.30	984.21
Suffolk	901.90	919.40	916.01	911.43	893.20
Worcester	884.49	901.65	897.92	893.43	875.56

[1] Rates do not apply to beneficiaries with End-Stage Renal Disease (ESRD) or those electing the Medicare hospice benefit.

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 2019 Massachusetts ESRD dialysis state rate, updated to incorporate the impact of sequestration-related rate reductions. The CY 2019 ESRD dialysis state rate for Massachusetts is $8,642.34 PMPM; the updated CY 2019 ESRD dialysis state rate incorporating a 2% sequestration reduction and prior to the application of the quality withhold is $8,469.49 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 2019 Massachusetts ESRD dialysis state rate updated to incorporate the impact of sequestration-related rate reductions. The CY 2019 ESRD

dialysis state rate for Massachusetts is $8,642.34 PMPM; the updated CY 2019 ESRD dialysis state rate incorporating a 2% sequestration reduction and prior to the application of the quality withhold is $8,469.49 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.

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).

2019 Medicare A/B Baseline PMPM, Beneficiaries with ESRD Functioning Graft Status, Standardized 1.0 Risk Score, by Demonstration County		
County	**2019 3.5% bonus County Rate (Benchmark)**	**2019 Sequestration-Adjusted Medicare A/B Baseline** (after application of 2% Sequestration reduction)
Bristol	$928.33	$909.76
Essex	906.59	888.46
Franklin	923.70	905.23
Hampden	930.19	911.59
Hampshire	915.02	896.72
Middlesex	928.57	910.00
Norfolk	936.98	918.24
Plymouth	975.29	955.78
Suffolk	910.92	892.70
Worcester	915.45	897.14

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, 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 2019 is $51.28 and the CY 2019 Low-Income Premium Subsidy Amount for Massachusetts is $36.20. 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 2019 is $50.98. 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 Commonwealth Care Alliance, are plan-specific and will be same for all counties, as shown below.

- Low income cost-sharing: $168.56 PMPM
- Reinsurance: $259.44 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.

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IV. Savings Percentages and Quality Withholds

Savings Percentages

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

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

Year	Calendar dates	Savings percentage
Demonstration Year 6	January 1, 2019 through December 31, 2019	0.5%

Quality Withhold

The quality withhold is 1.75% in Demonstration Year 6.

More information about the Demonstration Year 6 is available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/Downloads/MAQualityWithholdGuidanceDY2-5_03162018.pdf

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 6. 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 6, 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

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Period: Calendar Year 2016
Region: Eastern

Category of Service	C1: Community Other			C2: Community High Behavioral Health			C3: High Community Need			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	375,147	375,147	375,147	130,513	130,513	130,513	93,429	93,429	93,429	12,257	12,257	12,257
Inpatient - Non-BH	$ 4.92	$ 2.29	$ 7.21	$ 13.90	$ 10.28	$ 24.19	$ 17.09	$ 46.54	$ 63.63	$ 33.03	$ 1,624.00	$ 1,657.03
Inpatient BH	$ 0.09	$ 0.07	$ 0.16	$ 23.57	$ 30.52	$ 54.09	$ 17.00	$ 61.89	$ 78.89	$ 9.65	$ 1,737.07	$ 1,746.71
Hospital Outpatient	$ 16.20	$ 0.92	$ 17.12	$ 21.71	$ 1.56	$ 23.26	$ 25.28	$ 2.21	$ 27.48	$ 62.42	$ 1.25	$ 63.67
Outpatient BH	$ 5.04	$ 5.91	$ 10.95	$ 8.42	$ 135.01	$ 143.43	$ 5.78	$ 65.04	$ 70.82	$ 4.01	$ 24.29	$ 28.30
Professional	$ 10.42	$ 2.37	$ 12.78	$ 14.26	$ 12.66	$ 26.92	$ 14.36	$ 5.35	$ 19.71	$ 13.06	$ 3.11	$ 16.17
HCBS/Home Health	$ 0.00	$ 5.07	$ 5.07	$ 0.00	$ 12.54	$ 12.54	$ 0.00	$ 2,591.54	$ 2,591.54	$ 0.00	$ 27.98	$ 27.98
LTC Facility	$ 0.65	$ 0.46	$ 1.11	$ 1.89	$ 0.98	$ 2.88	$ 28.25	$ 34.64	$ 62.89	$ 115.71	$ 4,276.16	$ 4,391.88
Pharmacy	$ 0.00	$ 4.41	$ 4.41	$ 0.00	$ 4.23	$ 4.23	$ 0.00	$ 6.38	$ 6.38	$ 0.00	$ 3.80	$ 3.80
DME & Supplies	$ 1.75	$ 4.11	$ 5.86	$ 1.61	$ 4.56	$ 6.16	$ 7.07	$ 28.05	$ 35.12	$ 4.37	$ 28.86	$ 33.23
Transportation	$ 0.04	$ 5.62	$ 5.67	$ 0.26	$ 39.58	$ 39.84	$ 0.20	$ 91.57	$ 91.77	$ 0.61	$ 61.28	$ 61.89
All Other	$ 0.00	$ 21.65	$ 21.65	$ 0.00	$ 26.32	$ 26.32	$ 0.00	$ 41.24	$ 41.24	$ 0.00	$ 81.39	$ 81.39
Total Medical	**$ 39.10**	**$ 52.88**	**$ 91.99**	**$ 85.61**	**$ 278.25**	**$ 363.86**	**$ 115.03**	**$ 2,974.44**	**$ 3,089.47**	**$ 242.86**	**$ 7,869.20**	**$ 8,112.05**

Period: Calendar Year 2017
Region: Eastern

Category of Service	C1: Community Other			C2: Community High Behavioral Health			C3: High Community Need			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	358,435	358,435	358,435	119,738	119,738	119,738	85,391	85,391	85,391	11,962	11,962	11,962
Inpatient - Non-BH	$ 5.35	$ 0.64	$ 5.99	$ 14.91	$ 9.22	$ 24.13	$ 21.17	$ 47.66	$ 68.84	$ 43.69	$ 1,635.61	$ 1,679.30
Inpatient BH	$ 0.05	$ 0.05	$ 0.11	$ 19.19	$ 32.98	$ 52.17	$ 12.01	$ 70.39	$ 82.39	$ 6.34	$ 1,842.14	$ 1,848.48
Hospital Outpatient	$ 22.00	$ 0.75	$ 22.75	$ 29.70	$ 1.43	$ 31.13	$ 32.21	$ 1.84	$ 34.05	$ 63.90	$ 0.90	$ 64.80
Outpatient BH	$ 4.42	$ 5.75	$ 10.17	$ 7.36	$ 140.49	$ 147.85	$ 4.95	$ 62.01	$ 66.96	$ 4.55	$ 23.83	$ 28.38
Professional	$ 10.24	$ 2.75	$ 12.99	$ 13.97	$ 11.67	$ 25.64	$ 14.55	$ 3.88	$ 18.43	$ 15.94	$ 1.19	$ 17.12
HCBS/Home Health	$ 0.00	$ 5.54	$ 5.54	$ 0.00	$ 12.32	$ 12.32	$ 0.00	$ 2,316.60	$ 2,316.60	$ 0.00	$ 28.14	$ 28.14
LTC Facility	$ 0.61	$ 0.56	$ 1.17	$ 2.31	$ 1.06	$ 3.37	$ 25.52	$ 35.33	$ 60.85	$ 124.70	$ 4,316.00	$ 4,440.70
Pharmacy	$ 0.00	$ 4.10	$ 4.10	$ 0.00	$ 5.88	$ 5.88	$ 0.00	$ 12.72	$ 12.72	$ 0.00	$ 5.96	$ 5.96
DME & Supplies	$ 1.53	$ 3.53	$ 5.05	$ 1.55	$ 4.03	$ 5.58	$ 7.55	$ 26.67	$ 34.22	$ 6.22	$ 36.45	$ 42.67
Transportation	$ 0.06	$ 6.71	$ 6.77	$ 0.22	$ 44.38	$ 44.61	$ 0.20	$ 97.04	$ 97.23	$ 0.30	$ 59.64	$ 59.95
All Other	$ 0.00	$ 20.06	$ 20.06	$ 0.00	$ 22.14	$ 22.14	$ 0.00	$ 47.11	$ 47.11	$ 0.00	$ 71.05	$ 71.05
Total Medical	**$ 44.26**	**$ 50.44**	**$ 94.71**	**$ 89.23**	**$ 285.58**	**$ 374.81**	**$ 118.15**	**$ 2,721.25**	**$ 2,839.40**	**$ 265.64**	**$ 8,020.90**	**$ 8,286.54**

Demonstration to Integrate Care for Dual Eligible Individuals
(One Care – H7419 – Tufts Health Public Plan)
CY 2019 Final Medicare-Medicaid Rate Report
October 10, 2019

Period: Calendar Year 2016
Region: Western

Category of Service	C1: Community Other			C2: Community High Behavioral Health			C3: High Community Need			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	224,991	224,991	224,991	92,613	92,613	92,613	62,094	62,094	62,094	4,813	4,813	4,813
Inpatient - Non-BH	$ 3.50	$ 0.53	$ 4.04	$ 10.19	$ 2.17	$ 12.36	$ 15.18	$ 13.41	$ 28.59	$ 41.01	$ 1,443.01	$ 1,484.02
Inpatient BH	$ 0.04	$ 0.11	$ 0.16	$ 16.83	$ 8.06	$ 24.89	$ 11.25	$ 24.82	$ 36.07	$ 4.71	$ 254.48	$ 259.19
Hospital Outpatient	$ 11.94	$ 1.39	$ 13.33	$ 17.35	$ 1.67	$ 19.02	$ 22.87	$ 1.96	$ 24.83	$ 59.58	$ 0.62	$ 60.20
Outpatient BH	$ 3.74	$ 7.65	$ 11.39	$ 7.51	$ 134.62	$ 142.13	$ 5.05	$ 61.71	$ 66.76	$ 4.46	$ 29.99	$ 34.45
Professional	$ 11.24	$ 1.85	$ 13.09	$ 14.39	$ 3.38	$ 17.77	$ 15.17	$ 2.01	$ 17.18	$ 16.75	$ 1.84	$ 18.59
HCBS/Home Health	$ 0.00	$ 5.30	$ 5.30	$ 0.00	$ 12.87	$ 12.87	$ 0.00	$ 2,373.37	$ 2,373.37	$ 0.00	$ 25.97	$ 25.97
LTC Facility	$ 0.36	$ 0.25	$ 0.62	$ 1.56	$ 1.10	$ 2.66	$ 21.27	$ 32.79	$ 54.06	$ 115.61	$ 4,906.52	$ 5,022.13
Pharmacy	$ 0.00	$ 2.55	$ 2.55	$ 0.00	$ 2.73	$ 2.73	$ 0.00	$ 6.46	$ 6.46	$ 0.00	$ 2.24	$ 2.24
DME & Supplies	$ 1.94	$ 2.88	$ 4.82	$ 1.87	$ 3.11	$ 4.98	$ 9.71	$ 36.71	$ 46.41	$ 5.07	$ 37.66	$ 42.73
Transportation	$ 0.05	$ 4.44	$ 4.49	$ 0.28	$ 32.68	$ 32.96	$ 0.17	$ 70.50	$ 70.67	$ 0.40	$ 45.85	$ 46.26
All Other	$ 0.00	$ 22.77	$ 22.77	$ 0.00	$ 38.24	$ 38.24	$ 0.00	$ 52.01	$ 52.01	$ 0.00	$ 33.16	$ 33.16
Total Medical	**$ 32.82**	**$ 49.74**	**$ 82.56**	**$ 69.98**	**$ 240.64**	**$ 310.62**	**$ 100.65**	**$ 2,675.76**	**$ 2,776.41**	**$ 247.60**	**$ 6,781.32**	**$ 7,028.92**

Period: Calendar Year 2017
Region: Western

Category of Service	C1: Community Other			C2: Community High Behavioral Health			C3: High Community Need			F1: Facility-Based Care		
	Crossover PMPM	Medicaid PMPM	Total PMPM	Crossover PMPM	Medicaid PMPM	Total PMPM	Crossover PMPM	Medicaid PMPM	Total PMPM	Crossover PMPM	Medicaid PMPM	Total PMPM
Member Months	221,371	221,371	221,371	83,527	83,527	83,527	57,284	57,284	57,284	5,132	5,132	5,132
Inpatient - Non-BH	$ 3.87	$ 0.17	$ 4.04	$ 12.41	$ 3.79	$ 16.20	$ 18.90	$ 14.67	$ 33.57	$ 39.82	$ 1,417.02	$ 1,456.84
Inpatient BH	$ 0.02	$ 0.00	$ 0.02	$ 18.01	$ 10.27	$ 28.28	$ 7.80	$ 47.50	$ 55.30	$ 4.82	$ 783.69	$ 788.51
Hospital Outpatient	$ 19.67	$ 0.96	$ 20.63	$ 26.07	$ 1.44	$ 27.52	$ 35.05	$ 1.88	$ 36.93	$ 72.61	$ 1.15	$ 73.76
Outpatient BH	$ 3.66	$ 8.01	$ 11.67	$ 6.23	$ 146.56	$ 152.80	$ 4.77	$ 51.80	$ 56.57	$ 4.92	$ 30.54	$ 35.46
Professional	$ 11.03	$ 1.96	$ 12.99	$ 13.99	$ 3.87	$ 17.86	$ 13.93	$ 2.95	$ 16.88	$ 18.80	$ 0.66	$ 19.46
HCBS/Home Health	$ 0.00	$ 5.67	$ 5.67	$ 0.00	$ 13.05	$ 13.05	$ 0.00	$ 2,272.69	$ 2,272.69	$ 0.00	$ 30.14	$ 30.14
LTC Facility	$ 0.34	$ 0.41	$ 0.76	$ 1.31	$ 1.10	$ 2.41	$ 17.08	$ 38.18	$ 55.26	$ 103.02	$ 4,852.75	$ 4,955.78
Pharmacy	$ 0.00	$ 2.82	$ 2.82	$ 0.00	$ 4.01	$ 4.01	$ 0.00	$ 7.25	$ 7.25	$ 0.00	$ 1.84	$ 1.84
DME & Supplies	$ 1.67	$ 2.54	$ 4.21	$ 1.67	$ 2.64	$ 4.32	$ 9.78	$ 37.69	$ 47.47	$ 6.62	$ 51.58	$ 58.20
Transportation	$ 0.06	$ 5.46	$ 5.52	$ 0.22	$ 38.96	$ 39.18	$ 0.24	$ 76.96	$ 77.21	$ 0.46	$ 52.24	$ 52.70
All Other	$ 0.00	$ 21.73	$ 21.73	$ 0.00	$ 34.15	$ 34.15	$ 0.00	$ 47.15	$ 47.15	$ 0.00	$ 39.17	$ 39.17
Total Medical	**$ 40.31**	**$ 49.73**	**$ 90.04**	**$ 79.92**	**$ 259.85**	**$ 339.78**	**$ 107.56**	**$ 2,598.71**	**$ 2,706.27**	**$ 251.08**	**$ 7,260.78**	**$ 7,511.86**

Demonstration to Integrate Care for Dual Eligible Individuals
(One Care – H7419 – Tufts Health Public Plan)
CY 2019 Final Medicare-Medicaid Rate Report
October 10, 2019

Period: Calendar Year 2016

Region: The Cape

Category of Service	C1: Community Other			C2: Community High Behavioral Health			C3: High Community Need			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	49,865	49,865	49,865	21,176	21,176	21,176	10,686	10,686	10,686	1,341	1,341	1,341
Inpatient - Non-BH	$ 6.72	$ 2.23	$ 8.95	$ 16.92	$ 1.51	$ 18.42	$ 16.25	$ 12.25	$ 28.49	$ 64.91	$ 622.07	$ 686.98
Inpatient BH	$ 0.05	$ 0.00	$ 0.05	$ 13.66	$ 45.26	$ 58.92	$ 7.85	$ 64.88	$ 72.73	$ 3.07	$ 314.17	$ 317.24
Hospital Outpatient	$ 11.94	$ 0.48	$ 12.43	$ 17.42	$ 1.34	$ 18.76	$ 21.11	$ 2.38	$ 23.50	$ 68.86	$ 2.35	$ 71.21
Outpatient BH	$ 2.84	$ 8.42	$ 11.26	$ 5.08	$ 121.40	$ 126.48	$ 4.39	$ 66.14	$ 70.53	$ 4.19	$ 49.39	$ 53.58
Professional	$ 12.43	$ 1.25	$ 13.68	$ 16.75	$ 2.60	$ 19.35	$ 16.92	$ 4.80	$ 21.72	$ 14.46	$ 2.82	$ 17.28
HCBS/Home Health	$ 0.00	$ 3.15	$ 3.15	$ 0.00	$ 8.21	$ 8.21	$ 0.00	$ 2,375.77	$ 2,375.77	$ 0.00	$ 9.87	$ 9.87
LTC Facility	$ 0.52	$ 0.28	$ 0.80	$ 1.97	$ 1.95	$ 3.92	$ 32.06	$ 42.62	$ 74.68	$ 106.27	$ 4,574.66	$ 4,680.93
Pharmacy	$ 0.00	$ 18.38	$ 18.38	$ 0.00	$ 4.06	$ 4.06	$ 0.00	$ 6.17	$ 6.17	$ 0.00	$ 13.21	$ 13.21
DME & Supplies	$ 1.77	$ 3.30	$ 5.07	$ 1.80	$ 3.34	$ 5.14	$ 7.29	$ 47.47	$ 54.76	$ 5.18	$ 21.18	$ 26.37
Transportation	$ 0.11	$ 5.57	$ 5.68	$ 0.51	$ 54.74	$ 55.25	$ 0.40	$ 137.74	$ 138.14	$ 0.67	$ 81.58	$ 82.26
All Other	$ 0.00	$ 21.16	$ 21.16	$ 0.00	$ 25.18	$ 25.18	$ 0.00	$ 61.70	$ 61.70	$ 0.00	$ 49.21	$ 49.21
Total Medical	**$ 36.39**	**$ 64.22**	**$ 100.61**	**$ 74.09**	**$ 269.59**	**$ 343.68**	**$ 106.26**	**$ 2,821.93**	**$ 2,928.19**	**$ 267.61**	**$ 5,740.52**	**$ 6,008.13**

Period: Calendar Year 2017

Region: The Cape

Category of Service	C1: Community Other			C2: Community High Behavioral Health			C3: High Community Need			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	49,818	49,818	49,818	20,061	20,061	20,061	10,602	10,602	10,602	1,431	1,431	1,431
Inpatient - Non-BH	$ 4.88	$ 0.75	$ 5.63	$ 19.92	$ 7.47	$ 27.39	$ 25.83	$ 0.00	$ 25.83	$ 52.68	$ 529.19	$ 581.87
Inpatient BH	$ 0.06	$ 0.00	$ 0.06	$ 11.74	$ 79.06	$ 90.80	$ 10.14	$ 92.68	$ 102.82	$ 4.64	$ 884.12	$ 888.75
Hospital Outpatient	$ 18.73	$ 0.37	$ 19.11	$ 26.23	$ 1.11	$ 27.35	$ 34.49	$ 1.11	$ 35.61	$ 79.88	$ 0.36	$ 80.25
Outpatient BH	$ 2.80	$ 8.37	$ 11.17	$ 4.97	$ 128.97	$ 133.94	$ 3.64	$ 66.50	$ 70.14	$ 7.35	$ 31.60	$ 38.95
Professional	$ 12.53	$ 1.80	$ 14.33	$ 17.66	$ 2.65	$ 20.30	$ 16.35	$ 1.32	$ 17.67	$ 14.66	$ 0.75	$ 15.41
HCBS/Home Health	$ 0.00	$ 3.39	$ 3.39	$ 0.00	$ 6.95	$ 6.95	$ 0.00	$ 2,233.53	$ 2,233.53	$ 0.00	$ 29.93	$ 29.93
LTC Facility	$ 0.54	$ 0.20	$ 0.74	$ 1.66	$ 1.19	$ 2.85	$ 38.02	$ 57.53	$ 95.55	$ 115.69	$ 4,314.78	$ 4,430.48
Pharmacy	$ 0.00	$ 2.74	$ 2.74	$ 0.00	$ 3.99	$ 3.99	$ 0.00	$ 10.93	$ 10.93	$ 0.00	$ 7.73	$ 7.73
DME & Supplies	$ 1.62	$ 3.41	$ 5.02	$ 1.57	$ 2.62	$ 4.19	$ 7.85	$ 25.91	$ 33.76	$ 6.51	$ 16.12	$ 22.63
Transportation	$ 0.07	$ 6.36	$ 6.43	$ 0.22	$ 50.47	$ 50.69	$ 0.24	$ 133.36	$ 133.59	$ 0.64	$ 69.40	$ 70.04
All Other	$ 0.00	$ 19.33	$ 19.33	$ 0.00	$ 25.53	$ 25.53	$ 0.00	$ 36.02	$ 36.02	$ 0.00	$ 36.95	$ 36.95
Total Medical	**$ 41.23**	**$ 46.72**	**$ 87.95**	**$ 83.98**	**$ 310.00**	**$ 393.98**	**$ 136.56**	**$ 2,658.89**	**$ 2,795.45**	**$ 282.05**	**$ 5,920.94**	**$ 6,202.99**

Demonstration to Integrate Care for Dual Eligible Individuals
(One Care – H7419 – Tufts Health Public Plan)
CY 2019 Final Medicare-Medicaid Rate Report
October 10, 2019

Region: All

Category of Service	C1: Community Other			C2: Community High Behavioral Health			C3: High Community Need			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	650,003	650,003	650,003	244,302	244,302	244,302	166,209	166,209	166,209	18,411	18,411	18,411
Inpatient - Non-BH	$ 4.57	$ 1.68	$ 6.25	$ 12.76	$ 6.45	$ 19.20	$ 16.32	$ 31.96	$ 48.28	$ 37.44	$ 1,503.71	$ 1,541.15
Inpatient BH	$ 0.07	$ 0.08	$ 0.15	$ 20.16	$ 23.28	$ 43.44	$ 14.26	$ 48.23	$ 62.49	$ 7.88	$ 1,245.85	$ 1,253.73
Hospital Outpatient	$ 14.40	$ 1.05	$ 15.45	$ 19.68	$ 1.58	$ 21.27	$ 24.11	$ 2.13	$ 26.24	$ 62.15	$ 1.16	$ 63.31
Outpatient BH	$ 4.42	$ 6.71	$ 11.12	$ 7.79	$ 133.68	$ 141.47	$ 5.42	$ 63.87	$ 69.28	$ 4.14	$ 27.61	$ 31.75
Professional	$ 10.86	$ 2.10	$ 12.96	$ 14.52	$ 8.27	$ 22.80	$ 14.83	$ 4.07	$ 18.90	$ 14.13	$ 2.76	$ 16.88
HCBS/Home Health	$ 0.00	$ 5.00	$ 5.00	$ 0.00	$ 12.29	$ 12.29	$ 0.00	$ 2,496.16	$ 2,496.16	$ 0.00	$ 26.13	$ 26.13
LTC Facility	$ 0.54	$ 0.38	$ 0.92	$ 1.77	$ 1.11	$ 2.89	$ 25.89	$ 34.46	$ 60.35	$ 115.00	$ 4,462.69	$ 4,577.69
Pharmacy	$ 0.00	$ 4.84	$ 4.84	$ 0.00	$ 3.65	$ 3.65	$ 0.00	$ 6.40	$ 6.40	$ 0.00	$ 4.08	$ 4.08
DME & Supplies	$ 1.82	$ 3.62	$ 5.44	$ 1.72	$ 3.90	$ 5.63	$ 8.07	$ 32.53	$ 40.60	$ 4.61	$ 30.60	$ 35.21
Transportation	$ 0.05	$ 5.21	$ 5.26	$ 0.29	$ 38.28	$ 38.57	$ 0.20	$ 86.67	$ 86.87	$ 0.56	$ 58.73	$ 59.29
All Other	$ 0.00	$ 22.00	$ 22.00	$ 0.00	$ 30.74	$ 30.74	$ 0.00	$ 46.58	$ 46.58	$ 0.00	$ 66.44	$ 66.44
Total Medical	**$ 36.72**	**$ 52.66**	**$ 89.39**	**$ 78.69**	**$ 263.24**	**$ 341.93**	**$ 109.10**	**$ 2,853.05**	**$ 2,962.15**	**$ 245.90**	**$ 7,429.76**	**$ 7,675.66**

Period: Calendar Year 2017

Region: All

Category of Service	C1: Community Other			C2: Community High Behavioral Health			C3: High Community Need			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	629,624	629,624	629,624	223,326	223,326	223,326	153,277	153,277	153,277	18,525	18,525	18,525
Inpatient - Non-BH	$ 4.79	$ 0.48	$ 5.28	$ 14.43	$ 7.03	$ 21.46	$ 20.64	$ 32.04	$ 52.68	$ 43.32	$ 1,489.59	$ 1,532.90
Inpatient BH	$ 0.04	$ 0.03	$ 0.07	$ 18.08	$ 28.62	$ 46.71	$ 10.31	$ 63.38	$ 73.68	$ 5.79	$ 1,474.91	$ 1,480.70
Hospital Outpatient	$ 20.92	$ 0.80	$ 21.72	$ 28.03	$ 1.41	$ 29.44	$ 33.43	$ 1.80	$ 35.23	$ 67.55	$ 0.93	$ 68.47
Outpatient BH	$ 4.03	$ 6.75	$ 10.78	$ 6.73	$ 141.72	$ 148.45	$ 4.79	$ 58.50	$ 63.30	$ 4.87	$ 26.29	$ 31.16
Professional	$ 10.70	$ 2.40	$ 13.10	$ 14.31	$ 7.94	$ 22.25	$ 14.44	$ 3.36	$ 17.80	$ 16.63	$ 1.01	$ 17.64
HCBS/Home Health	$ 0.00	$ 5.41	$ 5.41	$ 0.00	$ 12.11	$ 12.11	$ 0.00	$ 2,294.44	$ 2,294.44	$ 0.00	$ 28.83	$ 28.83
LTC Facility	$ 0.51	$ 0.48	$ 0.99	$ 1.88	$ 1.09	$ 2.96	$ 23.23	$ 37.93	$ 61.16	$ 118.00	$ 4,464.60	$ 4,582.60
Pharmacy	$ 0.00	$ 3.54	$ 3.54	$ 0.00	$ 5.01	$ 5.01	$ 0.00	$ 10.55	$ 10.55	$ 0.00	$ 4.95	$ 4.95
DME & Supplies	$ 1.58	$ 3.17	$ 4.75	$ 1.60	$ 3.38	$ 4.98	$ 8.40	$ 30.73	$ 39.14	$ 6.36	$ 39.07	$ 45.42
Transportation	$ 0.06	$ 6.24	$ 6.31	$ 0.22	$ 42.90	$ 43.12	$ 0.22	$ 92.05	$ 92.26	$ 0.37	$ 58.35	$ 58.72
All Other	$ 0.00	$ 20.59	$ 20.59	$ 0.00	$ 26.93	$ 26.93	$ 0.00	$ 46.36	$ 46.36	$ 0.00	$ 59.59	$ 59.59
Total Medical	**$ 42.63**	**$ 49.90**	**$ 92.53**	**$ 85.28**	**$ 278.15**	**$ 363.43**	**$ 115.46**	**$ 2,671.14**	**$ 2,786.60**	**$ 262.88**	**$ 7,648.11**	**$ 7,910.98**

Period: Calendar Year 2015-2017

Demonstration to Integrate Care for Dual Eligible Individuals
(One Care – H7419 – Tufts Health Public Plan)
CY 2019 Final Medicare-Medicaid Rate Report
October 10, 2019

Region: All	C3C: Transitional Living Need		
Category of Service	**Crossover PMPM**	**Medicaid PMPM**	**Total PMPM**
Member Months	685	685	685
Inpatient - Non-BH	$ 19.54	$ 0.00	$ 19.54
Inpatient BH	$ 0.00	$ 0.00	$ 0.00
Hospital Outpatient	$ 63.77	$ 0.00	$ 63.77
Outpatient BH	$ 6.48	$ 80.06	$ 86.54
Professional	$ 9.02	$ 0.20	$ 9.22
TLP Services	$ 0.00	$ 7,000.35	$ 7,000.35
HCBS/Home Health	$ 0.00	$ 666.43	$ 666.43
LTC Facility	$ 4.08	$ 8.32	$ 12.41
Pharmacy	$ 0.00	$ 9.97	$ 9.97
DME & Supplies	$ 20.98	$ 69.36	$ 90.33
Transportation	$ 0.00	$ 19.78	$ 19.78
All Other	$ 0.00	$ 23.65	$ 23.65
Total Medical	**$ 123.87**	**$ 7,878.13**	**$ 8,001.99**

General Notes:

- Data reflected in this exhibit represents 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.

Demonstration to Integrate Care for Dual Eligible Individuals
(One Care – H7419 – Tufts Health Public Plan)
CY 2019 Final Medicare-Medicaid Rate Report
October 10, 2019

Individual Base Adjustments

Adjustment	C1: Community Other			C2: Community High Behavioral Health			C3: High Community Need		
	Eastern	Western	The Cape	Eastern	Western	The Cape	Eastern	Western	The Cape
Base Data	$ 93.32	$ 86.27	$ 94.28	$ 369.10	$ 324.45	$ 368.15	$ 2,970.06	$ 2,742.75	$ 2,862.08
IBNR	0.54%	0.49%	0.55%	1.09%	0.85%	1.38%	0.34%	0.25%	0.34%
Pharmacy Rebates	-0.81%	-0.55%	-1.99%	-0.24%	-0.18%	-0.19%	-0.06%	-0.04%	-0.05%
Diabetic Test Strips Rebates	-0.04%	-0.02%	-0.09%	-0.01%	-0.01%	-0.01%	0.00%	0.00%	0.00%
DMH Psychiatric Claims	0.06%	0.21%	0.01%	2.45%	2.49%	4.77%	1.50%	2.62%	3.16%
Elder Affairs Home Care Program	0.11%	0.13%	0.07%	0.07%	0.08%	0.04%	1.64%	1.66%	1.57%
HSN Dental Wrap	0.26%	0.28%	0.26%	0.07%	0.07%	0.07%	0.01%	0.01%	0.01%
Diversionary BH Services	1.29%	1.51%	1.37%	4.35%	4.99%	3.82%	0.26%	0.25%	0.28%
Bristol County Adjustment	-0.31%	0.00%	0.00%	-0.28%	0.00%	0.00%	-0.31%	0.00%	0.00%
Enrollee Acuity Adjustment	4.73%	0.00%	0.00%	10.01%	3.25%	16.24%	-2.31%	-2.48%	0.00%
Data Rebalancing	40.00%	40.00%	40.00%	20.00%	27.50%	20.00%	-0.41%	-1.50%	3.50%
Adjusted Base Data	**$ 138.31**	**$ 123.26**	**$ 132.20**	**$ 524.49**	**$ 463.37**	**$ 565.76**	**$ 2,988.08**	**$ 2,761.67**	**$ 3,121.72**

Adjustment	F1: Facility-Based Care			C3C: Transitional Living Need		
	Eastern	Western	The Cape	Eastern	Western	The Cape
Base Data	$ 8,198.23	$ 7,278.14	$ 6,108.72	$ 8,001.99	$ 8,001.99	$ 8,001.99
IBNR	2.22%	2.10%	1.72%	0.08%	0.08%	0.08%
Pharmacy Rebates	-0.01%	0.00%	-0.03%	-0.02%	-0.02%	-0.02%
Diabetic Test Strips Rebates	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
DMH Psychiatric Claims	3.24%	16.23%	11.12%	N/A	N/A	N/A
Elder Affairs Home Care Program	0.01%	0.01%	0.01%	N/A	N/A	N/A
HSN Dental Wrap	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Diversionary BH Services	0.04%	0.05%	0.08%	0.12%	0.12%	0.12%
Bristol County Adjustment	-0.92%	0.00%	0.00%	N/A	N/A	N/A
Enrollee Acuity Adjustment	0.00%	0.00%	0.00%	N/A	N/A	N/A
Data Rebalancing	0.00%	-5.00%	0.00%	N/A	N/A	N/A
Adjusted Base Data	**$ 8,575.25**	**$ 8,209.34**	**$ 6,908.48**	**$ 8,017.04**	**$ 8,017.01**	**$ 8,017.00**

General Notes:
- Base period represents CY2016 and CY2017.
- Totals may differ due to rounding.