One Care: MassHealth plus Medicare
Demonstration to Integrate Care for Dual Eligibles

Open Meeting

May 24, 2016 10:00 AM – 12:00 PM
1 Ashburton Place, 21st Floor
Boston, MA

Agenda for Today

- **Announcements**

- **Quality Data Performance Overview**
  - Quality Withhold Performance
  - Consumer Assessment of Healthcare Providers and Systems Survey (CAHPS)
  - Healthcare Effectiveness Data and Information Set (HEDIS)
  - Grievance Reporting

- **Financial Data**
  - Plan Financial Overview
  - Per Member Per Month (PMPM) Spending

One Care Enrollment Update

- We are very pleased to announce that Commonwealth Care Alliance (CCA) is accepting new One Care enrollments in all covered counties.
- This is a great sign that the package of financial adjustments made by MassHealth and CMS last fall is helping to bring stability to the One Care program.
- Eligible members in Suffolk and Worcester counties can now choose to enroll in One Care through either CCA or Tufts Health Unify.
- Eligible members in the following additional counties can now enroll in One Care through CCA: Essex, Franklin, Hampden, Hampshire, Middlesex, Norfolk, and Plymouth*
- To enroll in One Care, contact MassHealth Customer Service (Monday–Friday, 8:00 a.m. – 5:00 p.m.) at 1-800-841-2900 or TTY: 1-800-497-4648 (for people who are deaf, hard of hearing, or speech disabled). The call is free. For more information about One Care, please visit: www.mass.gov/masshealth/onecare.
- Please share this information with your networks, friends, and colleagues.

**Commonwealth Care Alliance's service area includes all of Plymouth County except for the towns of East Wareham, Lakeville, Marion, Mattapoisett, Wareham, and West Wareham.*

One Care Plan Procurement

- MassHealth expects to share updates about One Care plan reprocurement in the next 1-2 months.
- Watch for announcements on the Duals website (www.mass.gov/masshealth/duals), on the COMMBUYS website (www.commbuys.com), and via stakeholder emails.
- MassHealth expects that plans participating in 2018 would be able to bid on any county in Massachusetts, including for statewide coverage

QUALITY DATA PERFORMANCE OVERVIEW

One Care's Expected Outcomes

Massachusetts' Demonstration proposal to CMS projected several outcomes resulting from integrated care. Listed below are some of the high level goals:

1) Improve quality:
   - Reduce over-utilization of high-cost hospital and long-term institutional care;
   - Reduce under-utilization of community-based services and supports and outpatient care;
   - Improve chronic disease management;
   - Reduce health disparities;
   - Improve patient satisfaction;
   - Increase the use of evidence-based practices; and
   - Improve provider ADA accessibility

2) Improve outcomes:
   - Gains in health status and functional status
   - Reduce the length and number of long-term care facility stays

3) Reduce costs compared to the historical fee for service (FFS) experience for this population

4) Improve provider coordination, reduce preventable and avoidable hospitalizations, and reduce the incidence of "never" events.

Quality Monitoring in One Care is Extensive

DEMONSTRATION QUALITY MEASURES:

1) **CMS measures:**
   Metrics that CMS requires for all capitated model demonstrations under the Financial Alignment Initiative

2) **Massachusetts Specific Measures:**
   State-specific measures that MassHealth and CMS agreed to include

3) **Quality Withholds:**
   Per the three-way contract, percentage amount withheld from the capitation rate and returned to plans subject to their performance on select core and MA-specific measures

OTHER NATIONAL REPORTING REQUIRED BY CMS

1) Healthcare Effectiveness Data and Information Set (HEDIS)
2) Consumer Assessment of Healthcare Providers and Systems (CAHPS)
3) Health Outcomes Surveys (HOS)
4) Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)
5) Chronic Care Improvement Projects (CCIP)
6) Quality Improvement Projects (QIP)

ADDITIONAL SURVEYS CAPTURING SELF-REPORTED MEMBER EXPERIENCE

1) Mental Health Recovery Measure (MHRM)
2) Quality of Life Survey (adapted from the MHRM above)
3) Early Indicators Project (EIP)
4) Grievance Monitoring

Content in this Presentation:

- The intention of this presentation is to provide early examples of how the Massachusetts One Care Demonstration is meeting pre-defined goals.
- The table below lists a goal, and the corresponding data sources illustrating performance in this presentation.
- Information included in the presentation is not a comprehensive slate of all the measures captured.

GOALS OF THE ONE CARE PROGRAM	***CORRESPONDING DATA SOURCES INCLUDED IN THE PRESENTATION***
Improved quality	CAHPS Grievances Quality Withhold Payments
Improved outcomes	HEDIS

Data Sources, Measurement Periods, and Benchmarks

Data Source	Measurement Period	Benchmarks
CAHPS Survey	July 2014 – December 2014 **DY1 (Q4-Q5)**	• National Medicare Advantage Plan Average • National Medicare-Medicaid Plan (MMP) Average • Massachusetts Medicare Advantage Plan Average (includes SCO plans)

HEDIS Survey	January 2014 – December 2014
	DY1 (Q2-Q5)
		• Medicaid Managed Care Plans
		  • Performance at the 75th percentile
		  • Performance at the 90th percentile

Quality Withhold Measures	October 2013 – December 2014
	DY1 (Q1-Q5)
		• One Care Plans
		  • Pass/Fail OR
		  • Highest performing plan minus 10 percentage points

Grievance Reporting	April 2015 – December 2015 **DY2 (Q2-Q4)**	• One Care Plans
Financials	October 2013 – December 2015 **DY1 (Q1-Q5) – DY2 (Q1-Q4)**	• DY1 vs. DY2

Demonstration Year 1 (DY1): October 2013 – December 2014
Demonstration Year 2 (DY2): January 2015 – December 2015

Quality Withhold Performance

Quality Withhold Measures Overview

- A percentage amount is withheld from the capitation rate and returned to plans subject to their performance on certain quality metrics

- These metrics are drawn from both the required CMS core metrics as well as the MA specific measures

- Some measures are scored as pass or fail

- Some measures are scored by meeting a certain benchmark. Benchmarks are determined by the highest performing plan's performance minus 10 percentage points.

Core and Massachusetts Specific Reporting Requirements, including technical full specifications for the withhold measures can be found at:
https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/InformationandGuidanceforPlans.html

Comprehensive List and Description of Quality Withhold Measures

- **Core 2.1: Assessment Completed within 90 Days of Enrollment**
  - Number of assessments completed by quarter of enrollment, less members that plans are unable to locate or who refuse. Plans submit via monthly tracking tool to MassHealth.
- **Core 5.3: Consumer Advisory Board**
  - Plans submit information on each consumer advisory board and/or governance board during the annual reporting period. One template per meeting should be completed and submitted. Templates include: dates of quarterly meetings, invitees, attendees, and meeting minutes.
- **MA 5.1: Centralized Enrollee Record**
  - The percentage of members whose race, ethnicity, primary language, homelessness status, and disability type are collected and maintained in the One Care plan's Centralized Enrollee Record.
- **Encounter Data**
  - Plans must have submitted the following: Prescription Drug and Risk Adjustment files by Medicare-required timeframes AND both MassHealth and Medicare encounter test files by June 1, 2015.
- **MA 1.2: Documented Discussion of Care Goals**
  - The percentage of members who had a care plan developed in the reporting period who had at least one documented discussion of care goals in the care plan.
- **MA 1.3 Access to LTS Coordinators (LTS-Cs)**
  - Number of members with identified LTSS needs, referrals and refused referrals to LTS-Cs. (Later added number of members offered a LTS-C referral and how many members were referred or refused.) Plans submit via monthly tracking tool.

Quality Withhold Measures: Individual Plan Performance: DY1

2013 WITHHOLD MEASURES				
	Core 2.1 Completed Assessments	Core 5.3 Consumer Advisory Board	MA 5.1 ICO Centralized Enrollee Record	# Measures Passed
Benchmark	67.3%	100% compliance	Timely reporting of required elements	
CCA	75.6%	Pass	Pass	3 out of 3
FTC	77.3%	Pass	Pass	3 out of 3
Tufts	68.4%	Pass	Pass	3 out of 3

KEY
Cells highlighted in yellow did not pass
Cells highlighted in green did pass

2014 WITHHOLD MEASURES							
	Core 2.1 Completed Assessments	Core 5.3 Consumer Advisory Board	MA 5.1 Centralized Enrollee Record	Encounter Data	MA 1.2 Documented Discussion of care goals	MA 1.3 Access to LTS Coordinators	# Measures Passed
Benchmark	78.2%	100% compliance	71.7%	Successful submission	90.0%	90.0%	
CCA	64.4%	Pass	59.2%	Pass	90.0%	69.9%	3 out of 6
FTC	45.3%	Pass	81.7%	Pass	100.0%	100.0%	5 out of 6
Tufts	88.2%	Pass	65.4%	Pass	91.9%	81.2%	4 out of 6

Quality Withhold Measures: Individual Plan Performance and MassHealth Payment: DY1

2013 WITHHOLD MEASURES				
	# Measures Passed	MassHealth Quality Withhold Amount ($)	% of Earned Withhold	Earned MassHealth Quality Payment ($)
CCA	3 out of 3	$60,029	100%	$60,029
FTC	3 out of 3	$7,359	100%	$7,359
Tufts	3 out of 3	$5,908	100%	$5,908
Total One Care Plans		$73,296		$73,296

2014 WITHHOLD MEASURES				
	# Measures Passed	MassHealth Quality Withhold Amount ($)	% of Earned Withhold	Earned MassHealth Quality Payment ($)
CCA	3 out of 6	$863,766	50%	$431,883
FTC	5 out of 6	$317,903	100%	$317,903
Tufts	4 out of 6	$79,949	75%	$59,962
Total One Care Plans		$1,261,618		$809,748

KEY
Cells highlighted in yellow did not pass all measures; eligible for partial payment
Cells highlighted in green passed all measures; eligible for full payment

CCA's Response to Quality Withhold Performance

Measure	Successes, Challenges and Interventions
Completed Assessments	Rapid influx of new enrollees and large numbers of members with incorrect contact information challenged CCA's assessment operations in 2014. CCA introduced a new, more centralized management approach to assessment in mid-2014. Successful interventions included: increasing our internal assessment capacity; creating "research" staff using claims, pharmacy, EHR, and public information resources to locate hard to reach members; developing regular follow up protocols to continue outreach; developing systems of flagging unassessed members and scheduling assessments when contact was established through new claims, incoming calls to member services or hospitalizations. These methods led to 100% completion of assessments on reachable and willing members by Q3 2014, and continual reduction in percentage of unreachable/refused assessment members.
Consumer Advisory Board	CCA's Consumer Liaison successfully organized a group of enrollee participants across 4 regions, broadly representative of rating categories and demographics of the One Care population. The group continues to meet quarterly and reports on member experiences and satisfaction, and makes recommendations.
Centralized Enrollee Record	Challenges with CCA's CER included not-initially configuring the capture of detailed and accurate reporting on required data elements. While CCA's care management staff and interdisciplinary teams were conducting comprehensive evaluations and care delivery activities; the system did not always enable high standards of reporting. A new comprehensive assessment "smart form" that will enable capture of the data has been developed and will be in use by end of Q2 2016.
Documented Care Goals	CCA initially wasn't able to capture care goals that were recorded in the electronic health record. Since fixing that problem, CCA has been able to show 100% compliance with this measure.
Access to LTS Coordinators	Reporting deficits were largely responsible for low performance on this measure. Defining new reporting fields within the CER, replacement of manual processing and work with LTSC agencies on claims submission corrected the reporting lag by mid-2014, resulting in 100% compliance in offering LTSC services to ALL members the following year.

Tufts' Response to Quality Withhold Performance

- Overall, Tufts Health Plan is pleased with our strong performance on DY1 quality withhold measures for the One Care program.
- **Core 2.1 Completed Assessments**: Tufts Health Plan's leading performance on this measure is directly associated with the managed growth strategy that we have employed since launching *Tufts Health Unify* in October 2013.
- **Encounter Data**: During DY1, Tufts Health Plan successfully submitted RAPS and PDE data to CMS, and monthly encounter data to EOHHS.
- **MA5.1 Centralized Enrollee Record**: Tufts Health Plan's performance on this measure is related to incomplete documentation of member information. In response to DY1 results, Tufts Health Plan improved total performance on this measure by over 15% in DY2, driven in large part by more accurately documenting member's disability status.
- **MA1.2 Documented Discussion of Care Goals**: While Tufts Health Plan successfully passed the quality withhold threshold for this measure, we have continued to improve our internal care management system to enhance our ability to capture these discussions in the future.
- **MA1.3 Access to LTS Coordinators**: Tufts Health Plan's policy is to offer LTS Coordinators to all new members regardless of LTSS need. Because some members who have LTSS needs (based on claims data or rating category) are unreachable, referrals may not be completed within 90 days.

Consumer Assessment of Healthcare Providers and Systems Survey (CAHPS)

CAHPS Summary

- The CAHPS surveys are designed to capture accurate and reliable information from consumers about their experiences with health care.

- The Medicare CAHPS Survey, which has been conducted annually since 1998, is part of a group of surveys developed by a group of researchers under an agreement between CMS and the Agency for Healthcare Research and Quality (AHRQ) – researchers include:
  - American Institutes for Research
  - Harvard Medical School
  - the RAND Corporation
  - RTI International
  - These research groups are under a cooperative agreement between CMS and the Agency for Healthcare Research and Quality (AHRQ) a component of the U.S. Public Health Service

- The following data shows results from the 2015 CAHPS Survey of Medicare Advantage Prescription Drug (MA-PD) plans (which includes demonstration programs)

- The surveys include a core set of questions, with some questions grouped to form composites, or summary results, of key areas of care and service.

- Scores in the presentation were converted from the CMS case-mix adjusted mean, to illustrate a 0-100 score. The Case-Mix adjusted mean is intended to illustrate overall performance on a 1-4 scale (1 being the worse and 4 being the best).

Benchmarks:

Since this is the first year One Care plans performed the CAHPS survey there are some limitations in evaluating plan performance. Included in the graphs are a variety of benchmarks used to evaluation how the plans performed:

- National Medicare Advantage Average
- Massachusetts Medicare Advantage Average
- National Medicare-Medicaid Plan Average (other capitated Duals Demonstrations)

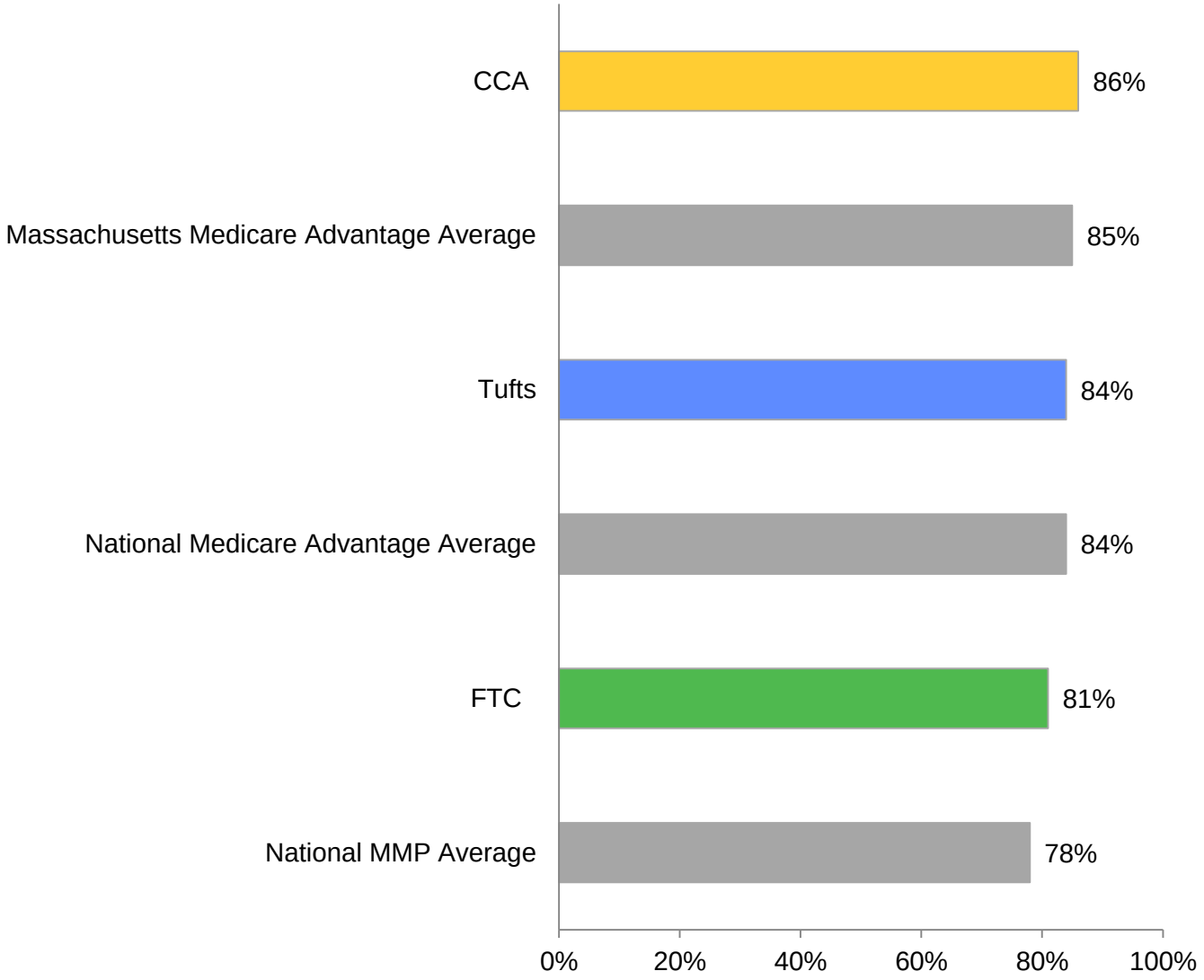
Survey Specifics

- Surveys sent out in the first half of 2015, which measure members' experiences with their plan over the previous six months.
- From each contract, 800 eligible enrollees were drawn by simple random sampling
- Plans use CMS certified vendors to field the CAHPS survey
- In order to be eligible to participate in the Medicare CAHPS survey – members must be at least 18 years of age and currently enrolled in an MA or PDP for six months

Getting Needed Care Composite

The Getting Needed Care Composite includes the questions below:

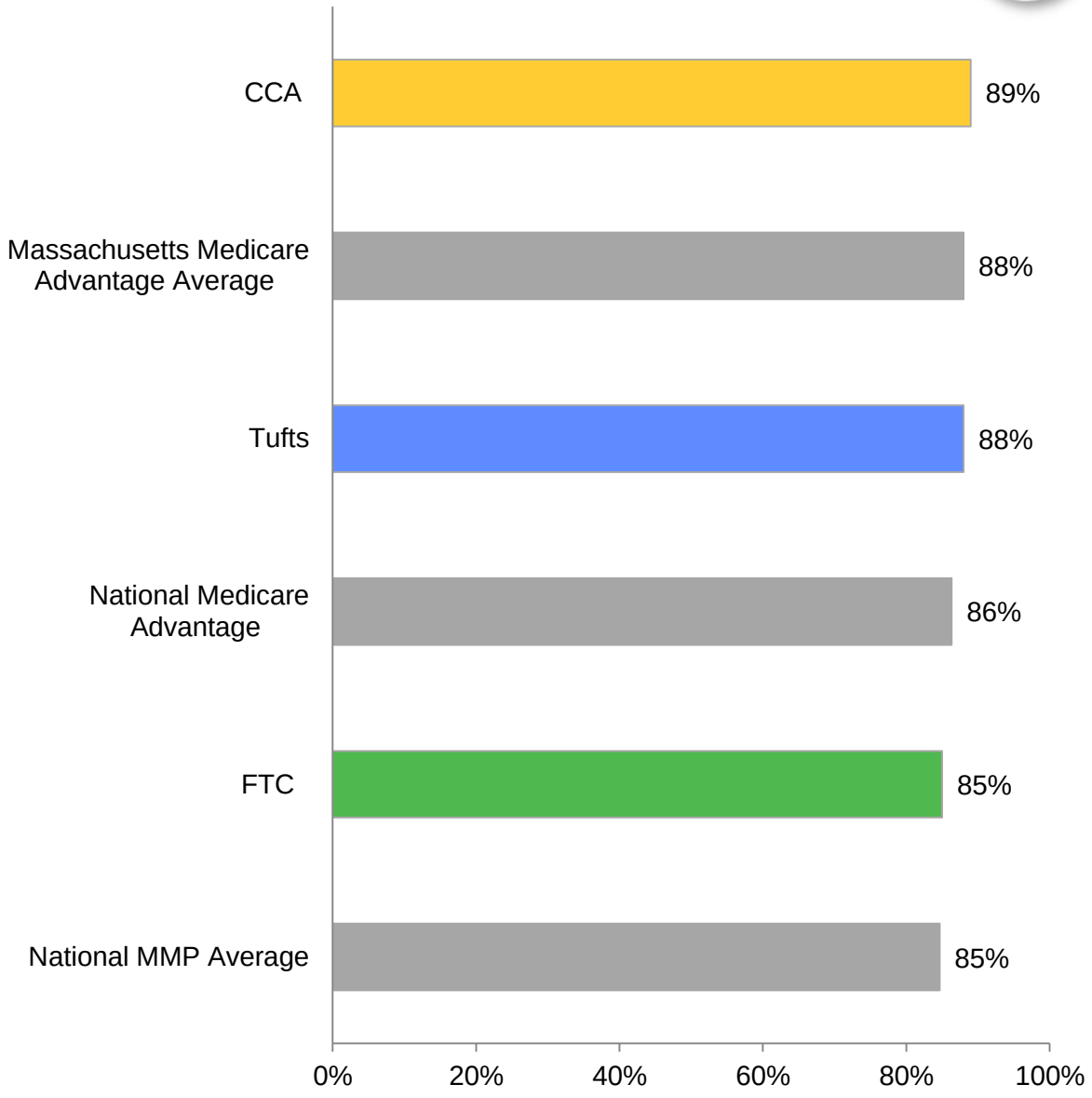
- In the last 6 months, how often was it easy to get appointments with specialists?
- In the last 6 months, how often was it easy to get the care, tests or treatment you thought you needed through your health plan?



Care Coordination Composite

The Care Coordination Composite Consists of the following 6 Questions

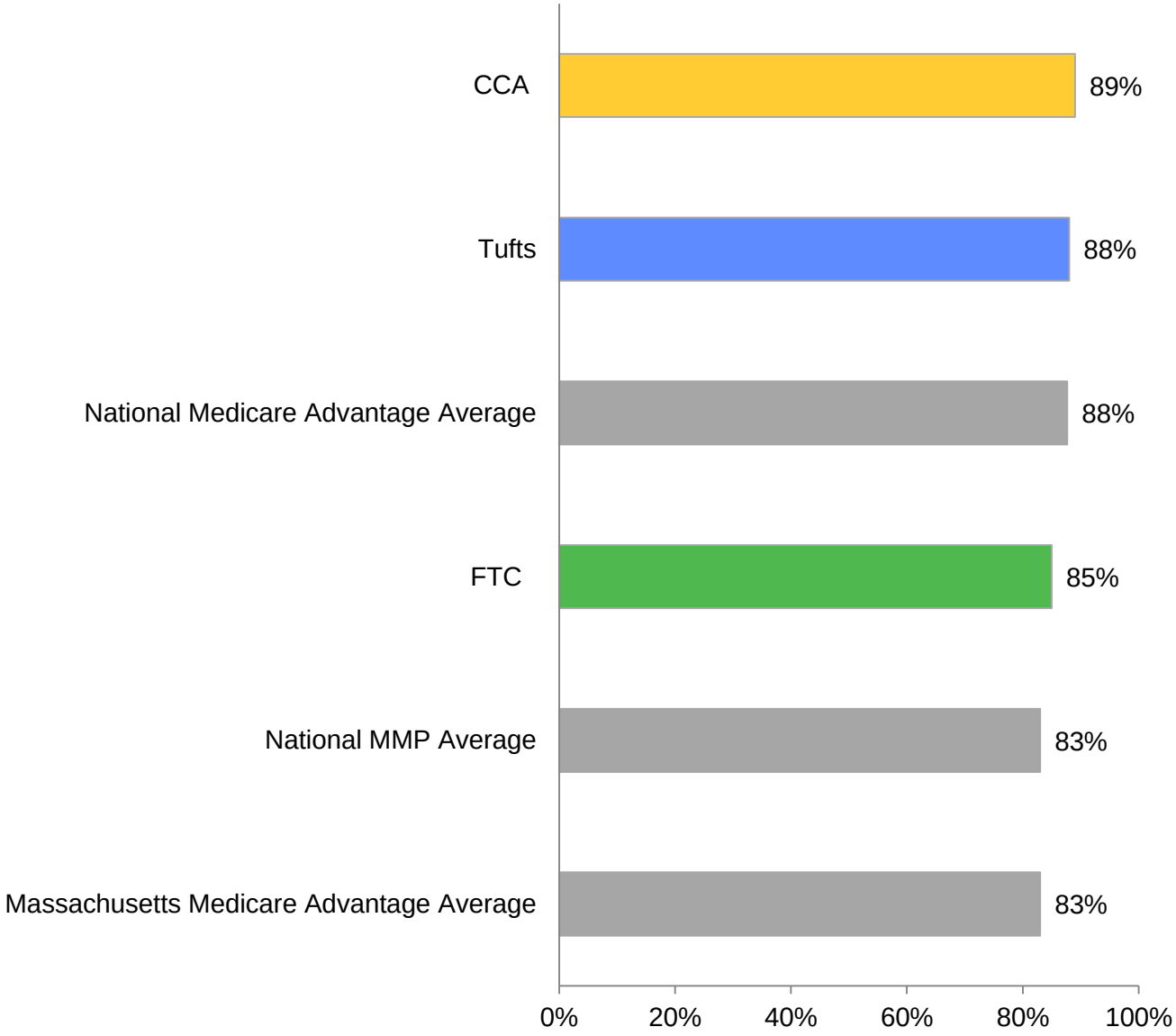
- In the last 6 months, when you visited your personal doctor for a scheduled appointment, how often did he or she have your medical records or other information about your care?
- In the last 6 months, when your personal doctor ordered a blood test, x-ray or other test for you, how often did someone from your personal doctor's office follow up to give you those results?
- In the last 6 months, when your personal doctor ordered a blood test, x-ray or other test for you, how often did you get those results as soon as you needed them?
- In the last 6 months, how often did you and your personal doctor talk about all the prescription medicines you were taking?
- In the last 6 months, did you get the help you needed from your personal doctor's office to manage your care among these different providers and services?
- In the last 6 months, how often did your personal doctor seem informed and up-to-date about the care you got from specialists?



Customer Service Composite

The Customer Service Composite consists of the following questions:

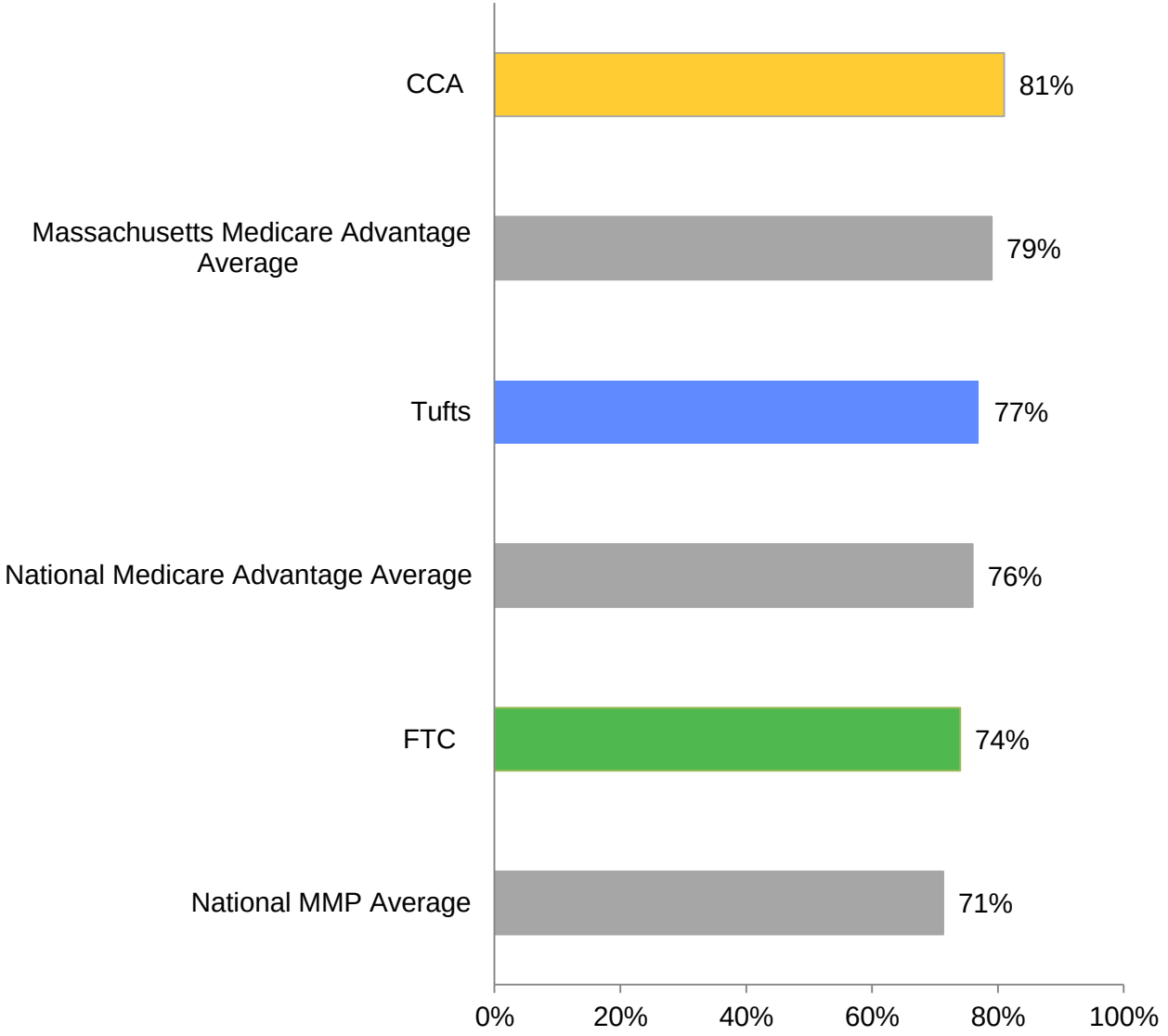
- In the last 6 months, how often did your health plan's customer service give you the information or help you needed?
- In the last 6 months, how often did your health plan's customer service staff treat you with courtesy and respect?
- In the last 6 months, how often were the forms for your health plan easy to fill out?



Getting Appointments and Care Quickly Composite

The Getting Appointments and Care Quickly Composite consists of the following questions:

- In the last 6 months, when you needed care right away, how often did you get care as soon as you thought you needed?
- In the last 6 months, not counting the times you needed care right away, how often did you get an appointment for your health care at a doctor's office or clinic as soon as you thought you needed?
- Wait time includes time spent in the waiting room and exam room. In the last 6 months, how often did you see the person you came to see within 15 minutes of your appointment time?

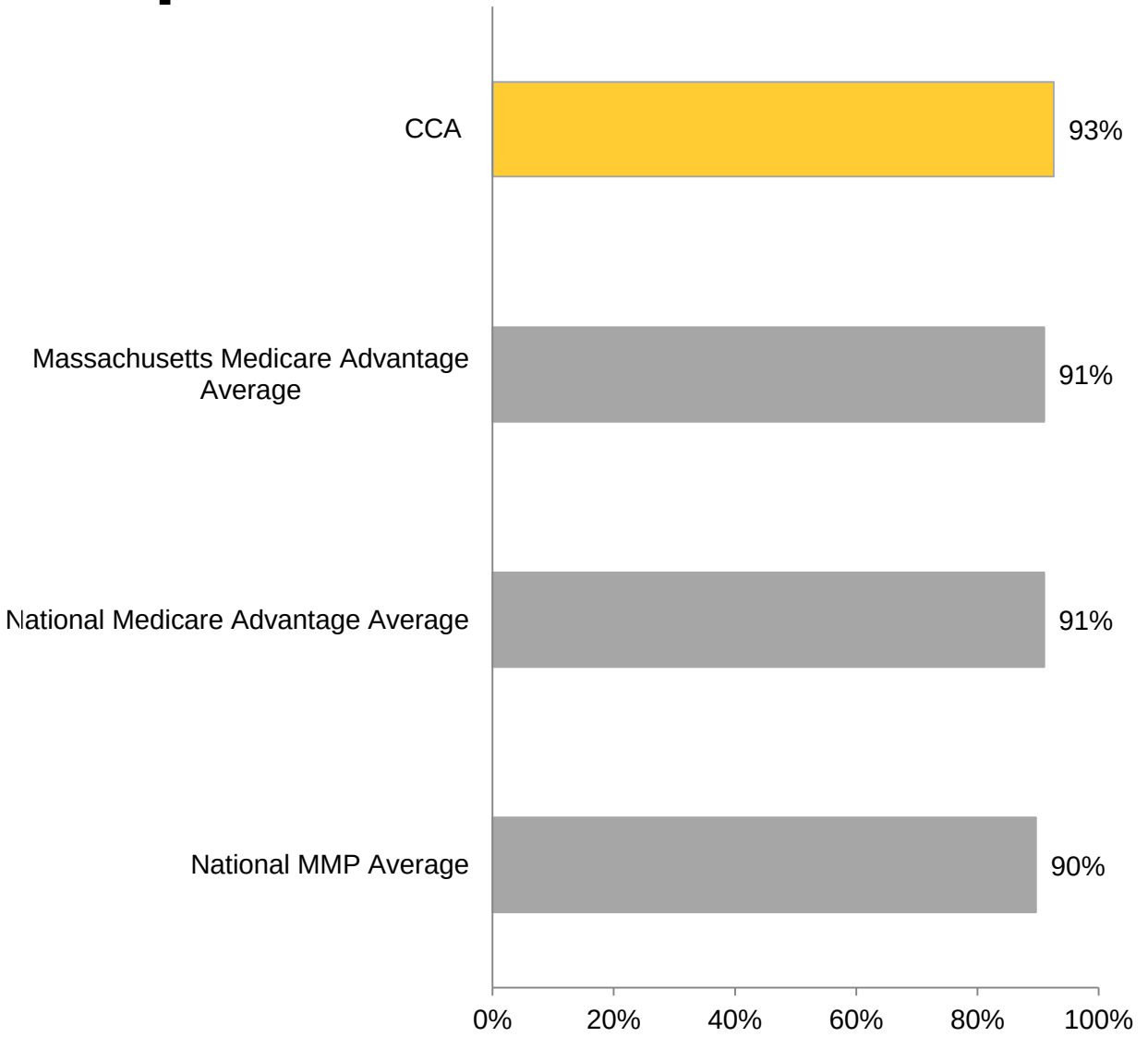


Doctors Who Communicate Well Composite*

The Doctors Who Communicate Well Composite consists of the following questions:

- In the last 6 months, how often did your personal doctor explain things in a way that was easy to understand?
- In the last 6 months, how often did your personal doctor listen carefully to you?
- In the last 6 months, how often did your personal doctor show respect for what you had to say?
- In the last 6 months, how often did your personal doctor spend enough time with you?

**Information for TUFTS and FTC is not included in this graphic as their response rate for this question was too small*



CCA's Response to CAHPS Performance

- CCA is extremely pleased with and proud of the results of the CAHPS survey.
- The results are even more remarkable when considered in light of the high needs of the members that CCA serves.
- CCA remains focused on meeting our members' needs and is in the process of implementing improvements to how we deliver our model of care to ensure that we maintain or improve on the very positive experience and high level of satisfaction reflected in the CAHPS survey results.

Tufts' Response to CAHPS Performance

- For all measures noted, Tufts Health Plan performed better than both the National Medicare Advantage Average and the MMP Average.
- Member experience in general is impacted by differences in care delivery models across MMPs.
- Given that 2015 was a baseline performance year, Tufts Health Plan will continue to monitor performance on future CAHPS surveys and will evaluate key drivers of critical measures in order to inform quality improvement opportunities.
- Since receiving the 2015 MA-CAHPS data, internal performance data have suggested that there is opportunity for improvement in member services, and activities in this area should lead to improvement in member experience.

Summary of CAHPS Survey Performance

- Overall the One Care CAHPS survey results indicate **high customer satisfaction** for outpatient care provided

- For the CAHPS composites shown:
  - ✓ **CCA and Tufts** consistently **performed better than the Medicare Advantage Average**
  - ✓ **Tufts and CCA** consistently **performed better than the MMP Average** (capitated model demonstrations)
  - ✓ In each measure, CCA members reported highest satisfaction, followed closely by Tufts members on 3 of their 4 measures

Healthcare Effectiveness Data and Information Set (HEDIS)

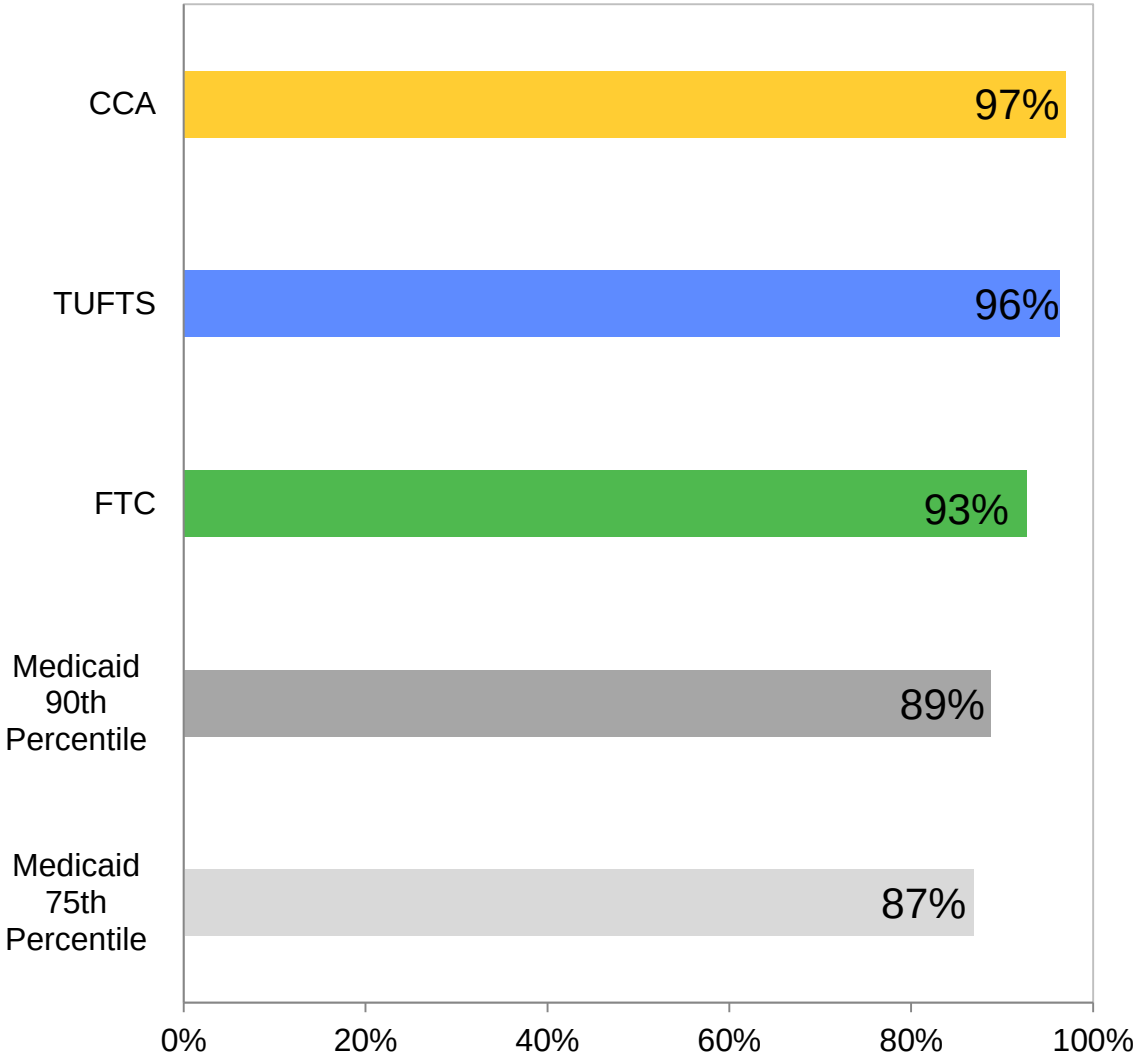
HEDIS Summary

- HEDIS data shown is from January 1, 2014 - December 31, 2014 reported in June of 2015
  - These are the most up-to-date HEDIS data available
- "HEDIS is a tool used by more than 90 percent of America's health plans (Medicaid, Medicare, and Commercial) to measure performance on important dimensions of care and service."
- Because so many plans collect HEDIS data, and because the measures are so specifically defined, HEDIS makes it possible to compare the performance of health plans on an "apples-to-apples" basis.
- Employers, consultants, and consumers use HEDIS data to help them select the best health plan for their needs.
- To ensure the validity of HEDIS results, all data is rigorously audited by certified auditors using a process designed by the National Committee of Quality Assurance (NCQA) .
- To ensure the measure slate is up to date, new specifications are released each year. NCQA has a Committee on Performance Measurement, consisting of employers, consumers, health plans and others, who collectively decide on HEDIS content.
- "HEDIS results are included in Quality Compass, an interactive, web-based comparison tool that allows users to view plan results and benchmark information."
- NCQA's benchmarks include percentiles, which show the health plan range of performance across the nation. Percentiles in this presentation are specific to Medicaid, meaning only Medicaid plans are included in these calculations.
- In this presentation, **the NCQA Medicaid 75th and 90th percentiles** are included in each graph. These percentiles are mainly used as a benchmark/ comparative data for plans.
  - 75th Percentile shows top 25% of performance
  - 90th Percentile shows top 10% of performance

FOR MORE INFORMATION on HEDIS visit:
http://www.ncqa.org/HEDISQualityMeasurement/WhatisHEDIS.aspx

Adults' Access to Preventative/Ambulatory Health Services

- The Adults' Access to Preventative Ambulatory Health Services measure is intended to show access/ availability of care.
- The measure illustrates the percentage of members 20 years and older who had an ambulatory or preventative care visit.
- Each plan scored well above the Medicaid 90th percentile indicating Massachusetts One Care members are accessing preventative services at a much higher rate than the average Medicaid enrollee.

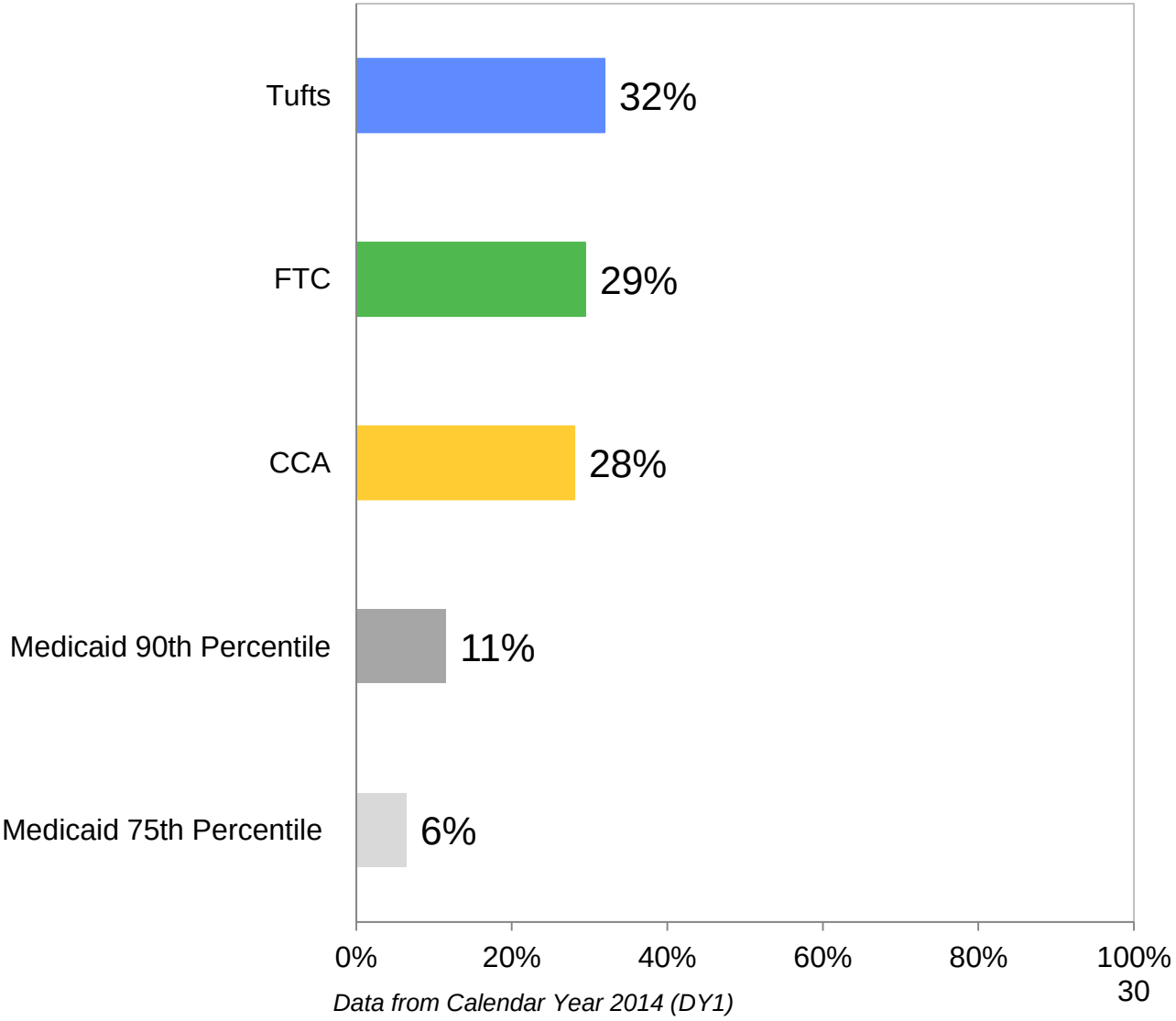


Data from Calendar Year 2014 (DY1)

Identification of Alcohol and Other Drug Services

This measure summarizes the number and percentage of members with an alcohol and other drug claim who received the following chemical dependency services during the measurement year:

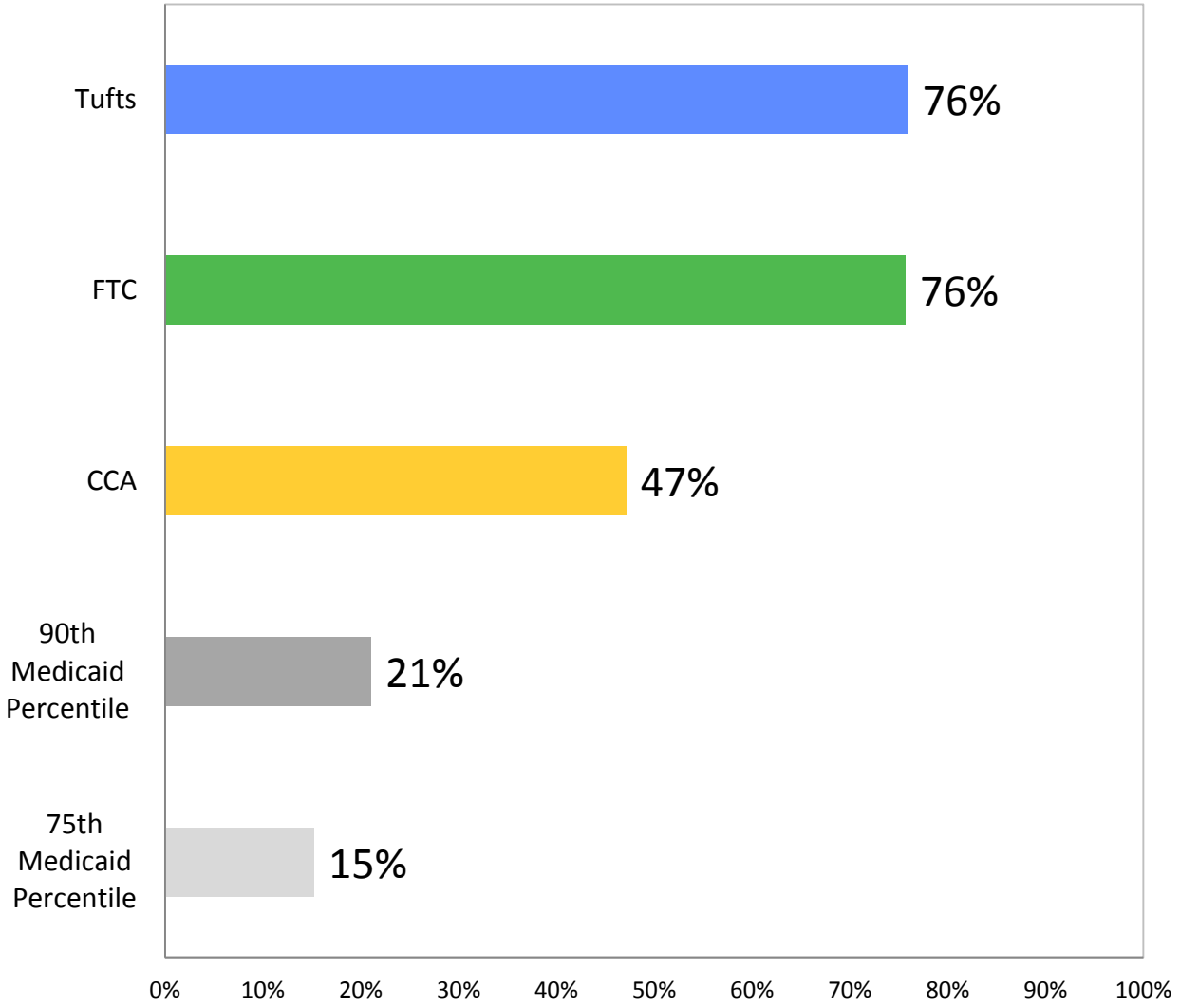
- Any service
- Inpatient
- Intensive outpatient or partial hospitalization
- Outpatient or ED



Data from Calendar Year 2014 (DY1)

Behavioral Health Service Utilization

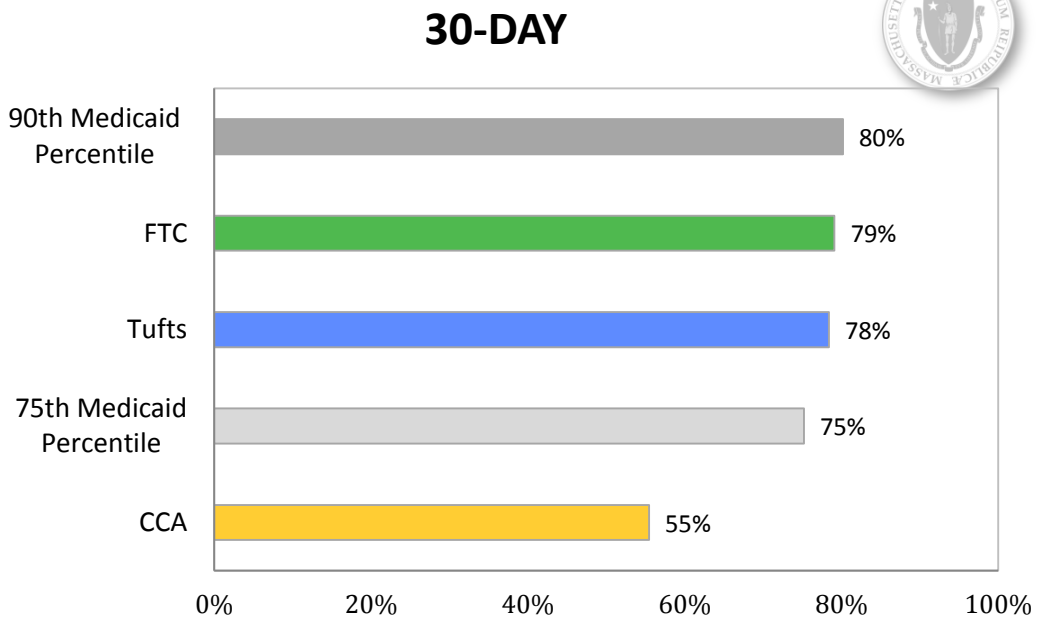
- The measure illustrates the percentage of membership who received the following behavioral health services: inpatient, intensive outpatient or partial hospitalization, outpatient or ED
- The data informs us that both Tufts and CCA members utilize behavioral health services more frequently than the 90th Medicaid Percentile
- All Massachusetts One Care plans show their members accessing BH services at a high frequency – much greater than standard Medicaid only Managed Care Plans

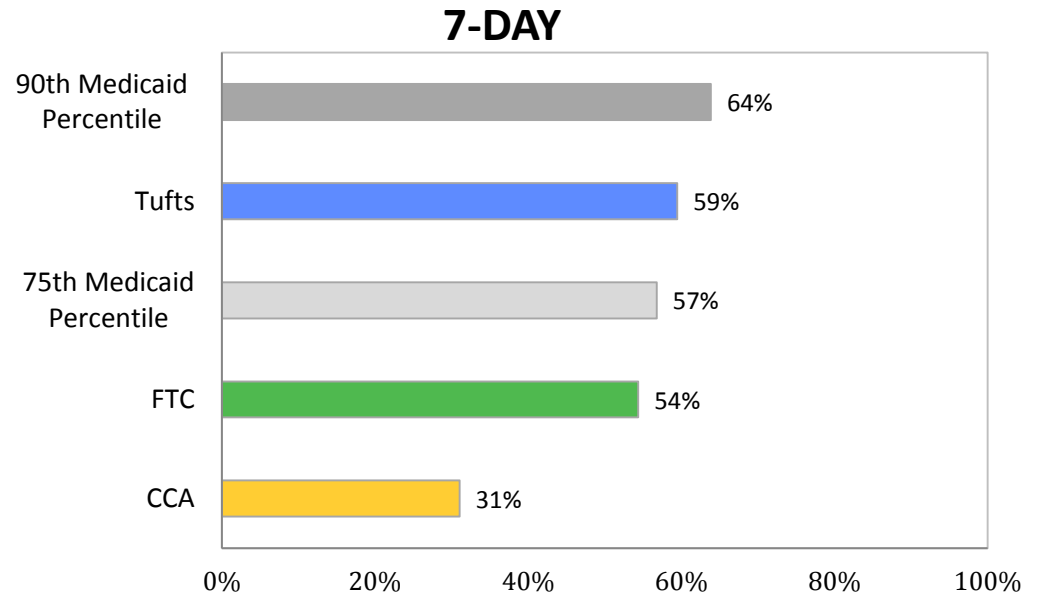


Data from Calendar Year 2014 (DY1) – HEDIS Measure Mental Health Utilization: MPT

Follow-Up Hospitalization (FUH) for Mental Illness

- This measure is intended to illustrate the percentage of hospital discharges for mental illness that were followed up by an appropriate mental health outpatient visit, intensive outpatient encounter, or partial hospitalization with a mental health practitioner:
  - 30 day chart shows % of discharges for which the member received follow-up within 30 days
  - 7 day chart shows % of discharges for which the member received follow-up within 7 days
- All plans show an increased follow-up from 7 to 30 days



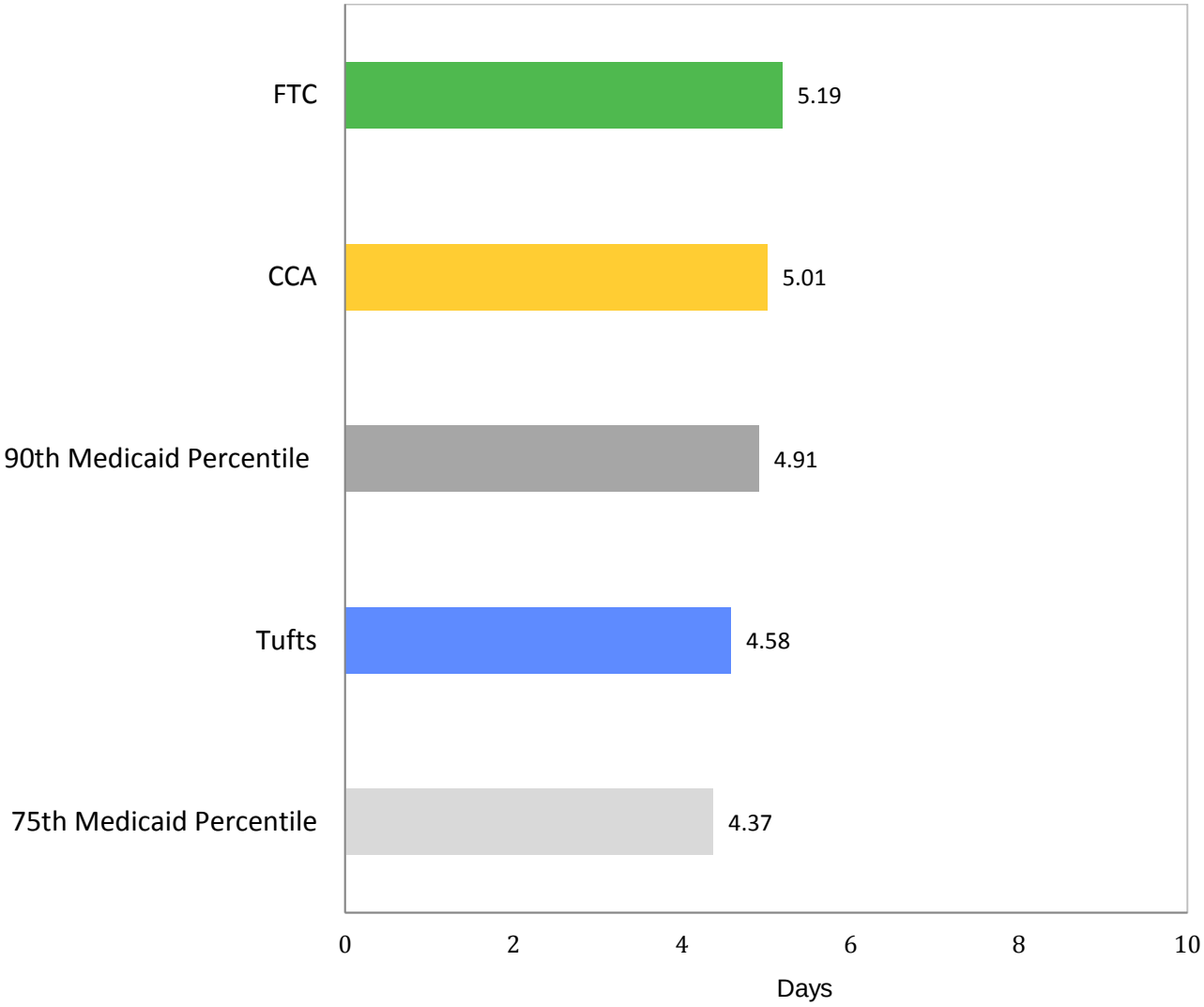


Data from Calendar Year 2014 (DY1)

Average Length of Stay General Hospital/ Acute Care

- This measure illustrates the average acute inpatient length of stay (LOS) for the following categories:
  - Total inpatient
  - Maternity
  - Surgery
  - Medicine

- All 3 plans performed above the 75th percentile, illustrating a strong performance



Data from Calendar Year 2014 (DY1)

CCA's Response to HEDIS Data

Measure	Successes, Challenges and Interventions
Access to Preventative / Ambulatory Services	CCA is pleased with the findings and is working to maintain the high level of access reflected in this measure.
Identification of Alcohol and Other Drug Services	CCA recognizes that identification, referral to treatment and support in recovery for members with alcohol and/or substance use disorder is an important and often under-resourced component of most care delivery models. As many of our members have faced stigma and discrimination in the past, they have been challenged in disclosing alcohol or substance use disorders. In response to this, CCA has received technical assistance from the MA Department of Public Health to develop a pilot program around Screening, Brief Intervention and Referral to Treatment for substance use disorders (SBIRT). We have also worked to strengthen our internal capacity to provide appropriate support, and are currently in the process of implementing a naloxone co-prescribing program that will further open the door to more discussions and collaborative engagement of our members struggling with alcohol and/or substance use.
Behavioral Health Service Utilization	CCA is encouraged to report that our overall utilization of outpatient and community behavioral health services appears to be increasing relative to our acute and inpatient utilization. We believe that this reflects improvements in access amongst our members to appropriate outpatient behavioral health resources, and anticipate that this will continue as we engage members in ongoing care.
Follow-up Hospitalization for Mental Illness	CCA has engaged heavily in building clinical programs to ensure that we provide support to our members who have been hospitalized for mental illness. Since mid-2015, CCA instituted a new policy that ensures that all members hospitalized for mental illness are tracked by the internal behavioral health staff and are seen by a behavioral health clinician within 48 hours of their discharge. This has resulted in an improvement in our most recent metrics.
Average LOS General Hospital / Acute Care	Average LOS for inpatient care is dependent on a multitude of factors, including medical complexity of the member, as well as their post-discharge care needs. CCA continues to partner with hospitals, post-acute care settings and our members and caregivers to support effective, timely hospitalizations and appropriate care transitions.

Tufts' Response to HEDIS Data

- Tufts Health Plan's performance on the Identification of Alcohol and Other Drug Services measure suggests that its Model of Care, which is designed around an interdisciplinary approach and encompasses a wide range of behavioral and social services that address substance use and related issues, is impacting member care.

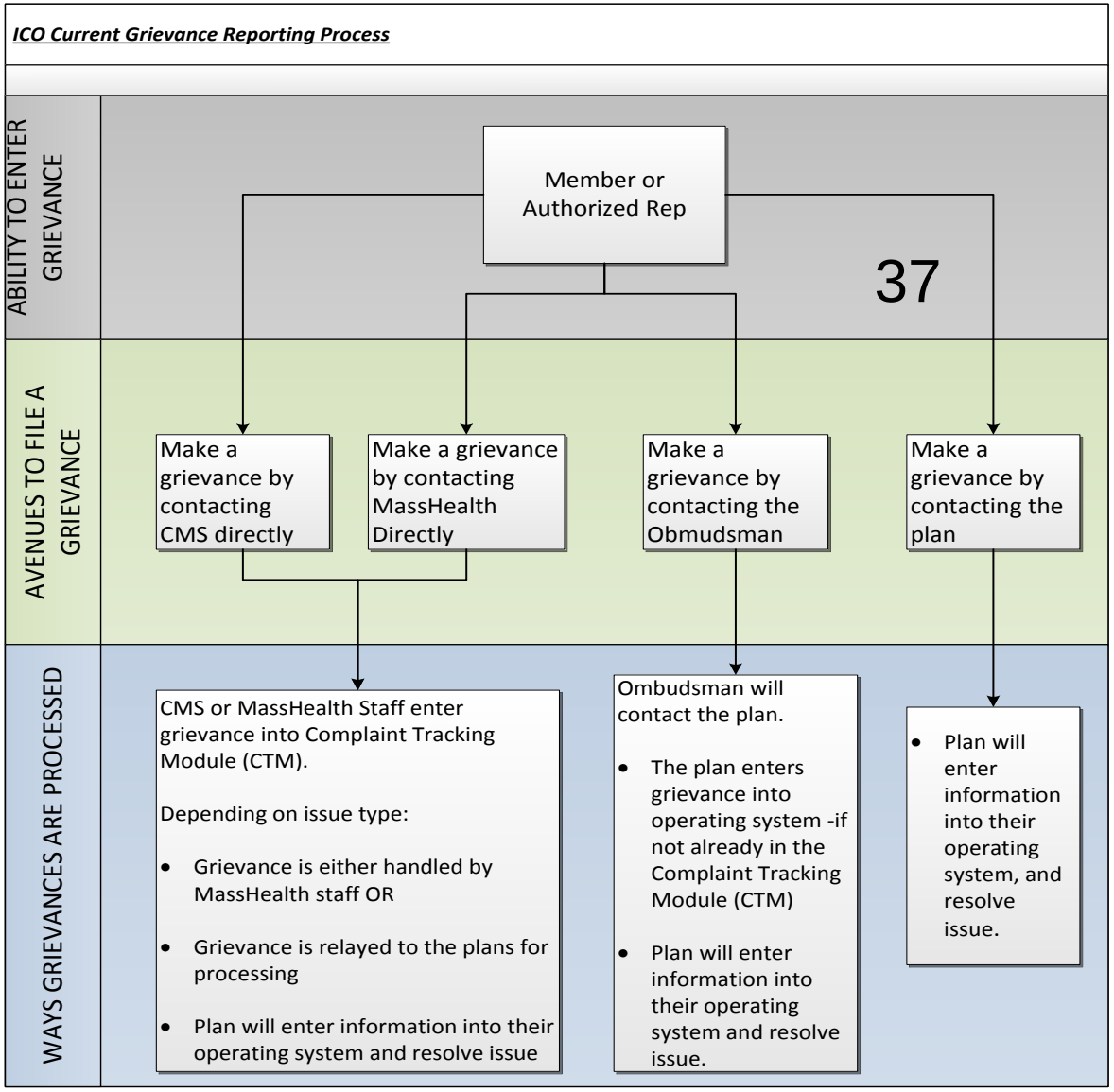
- Performance on the Behavioral Health Services Utilization measure reflects the member profile of the Tufts Health Plan's One Care (*Tufts Health Unify*) Program, which includes behavioral health and substance use as a both a primary condition, as well as related co-morbid conditions.

- Tufts Health Plan's performance on the FUH measure for the One Care (*Tufts Health Unify*) Program is consistent with its performance in other product lines. Tufts Health Plan has identified this as an area of opportunity and is exploring strategies to improve performance related to care transitions.

- Tufts Health Plan is performing better than the Medicaid 75th percentile on the Average Length of Stay measure, which is as expected

Grievance Reporting

Definition and Grievance Intake Process



Grievance Definition:

Complaint surrounding any services provided by the health plan

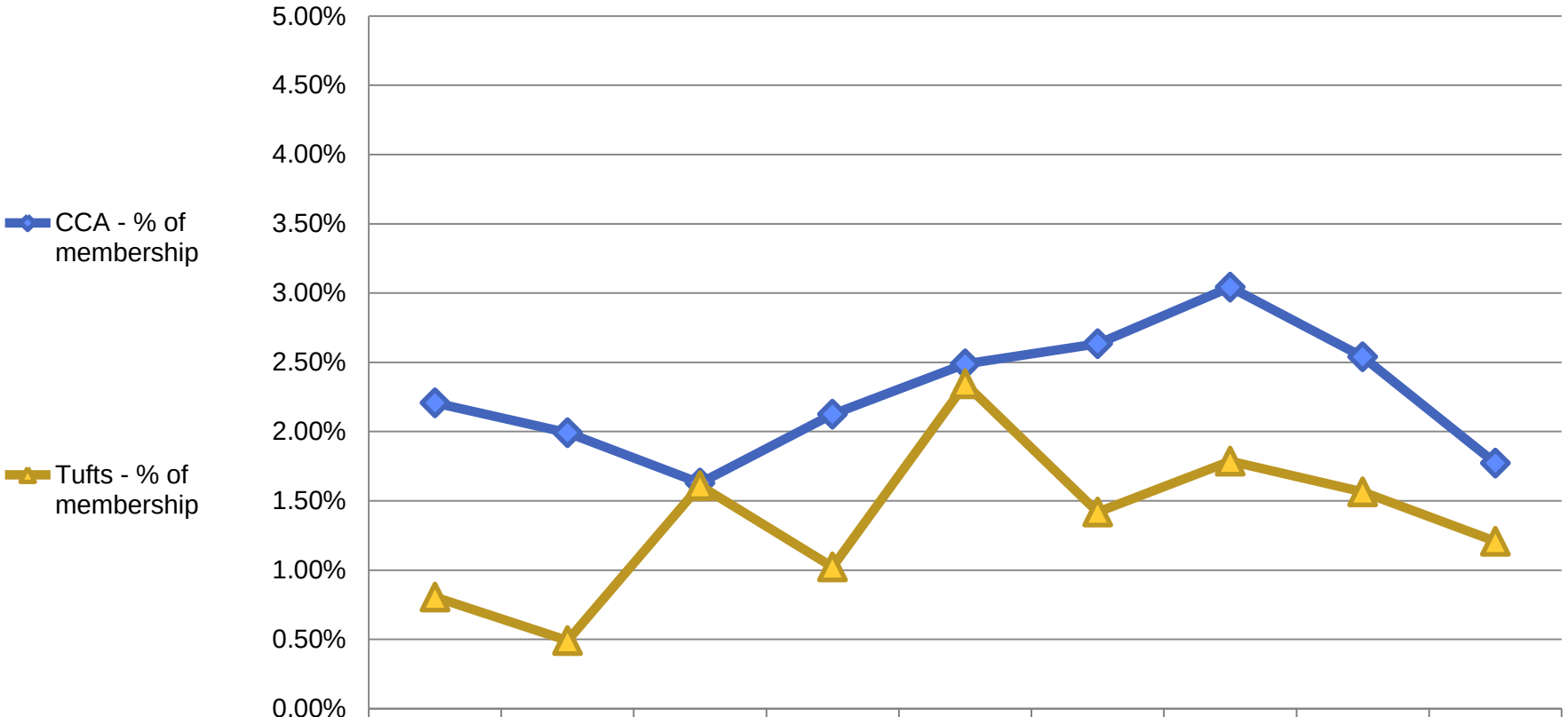
Grievance Categories

- Members may submit grievances to the One Care Ombudsman, MassHealth, or CMS.
- Grievances are recorded electronically and grouped in the categories below.

CATEGORY	DESCRIPTION	EXAMPLE
BP: Dental	Dissatisfaction with dental services / plan dental restrictions	Upset dental implant was not approved
BP: Part C, Medicaid, Supplemental	Dissatisfaction with plans covered services/ plan restrictions	Upset PCA services not approved
BP: Part D	Dissatisfaction with the plans covered prescription drugs	Upset brand name drugs not approved
Enrollment	Dissatisfaction with the enrollment broker	Self-selected and placed in wrong plan
MassHealth	Dissatisfaction with MassHealth	Incorrectly dis-enrolled from One Care
Medicare	Dissatisfaction with services provided by Medicare	Received incorrect information from Medicare
Network/Access	Dissatisfaction surrounding provider access/ availability	Preferred provider not in network
Other	Any grievance that does not fit into one of the pre-existing categories	
Plan Management	Dissatisfaction with the plan oversight	Care Coordinator is unresponsive
Plan Marketing Materials	Dissatisfaction with marketing materials received from the plan	Too many materials sent
Provider	Dissatisfaction with a provider	Rude office manager at specialist's office
Quality of Care	Dissatisfaction with the quality of care received	Provided incorrect medication
Transportation	Dissatisfaction with transportation services provided	Transportation no-shows/late arrivals

April 2015 – December 2015

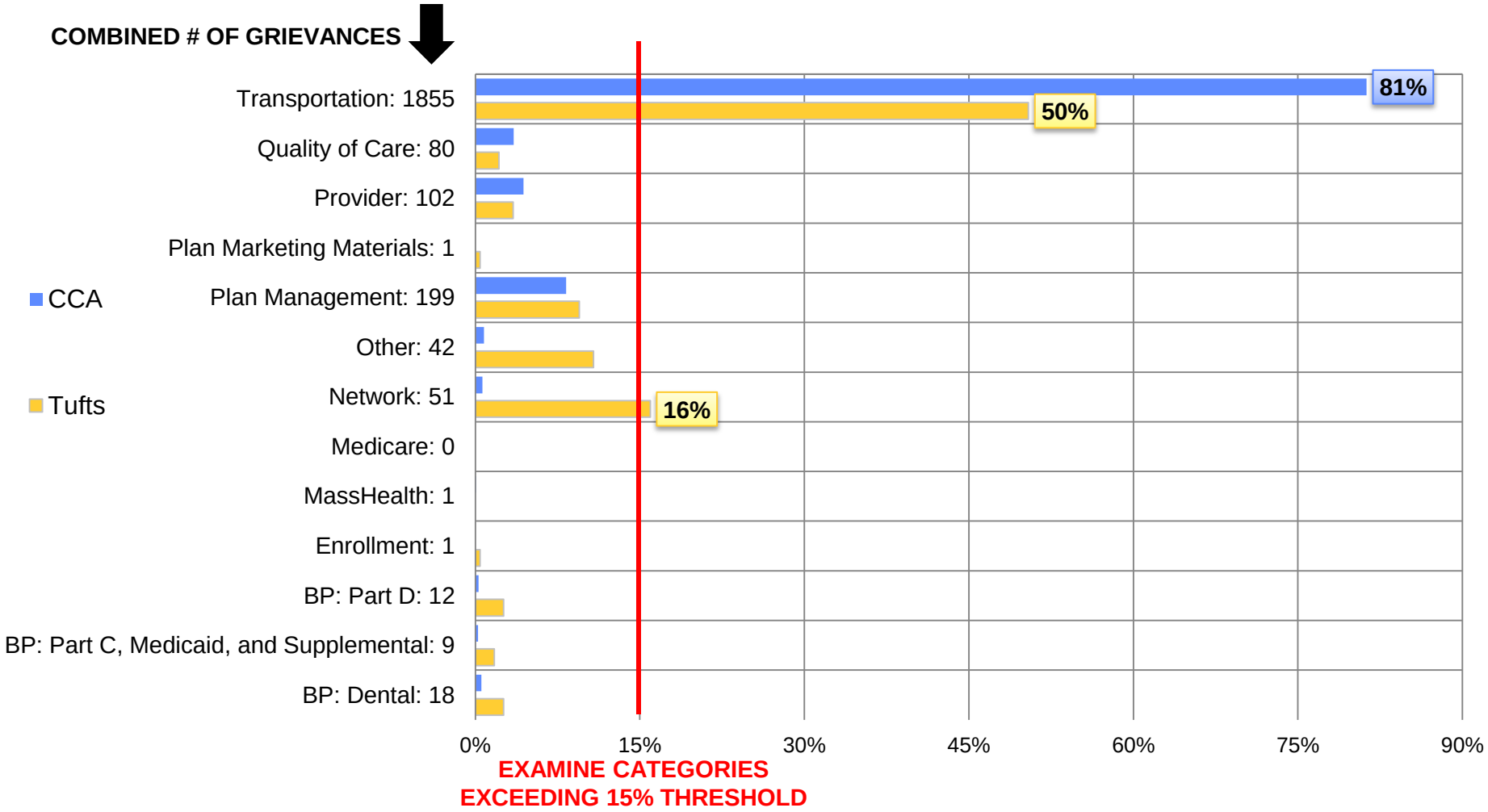
Percentage of Plan Membership with Grievances



	April_15	May_15	June_15	July_15	Aug_15	Sept_15	Oct_15	Nov_15	Dec_15
CCA - % of membership	2.21%	1.99%	1.63%	2.13%	2.49%	2.64%	3.04%	2.54%	1.77%
CCA - # of Grievances	227	206	170	224	266	281	322	262	181
Tufts - % of membership	0.81%	0.49%	1.61%	1.02%	2.34%	1.42%	1.79%	1.56%	1.21%
Tufts - # of Grievances	15	9	29	18	41	26	37	32	25

April 2015 – December 2015 Grievances

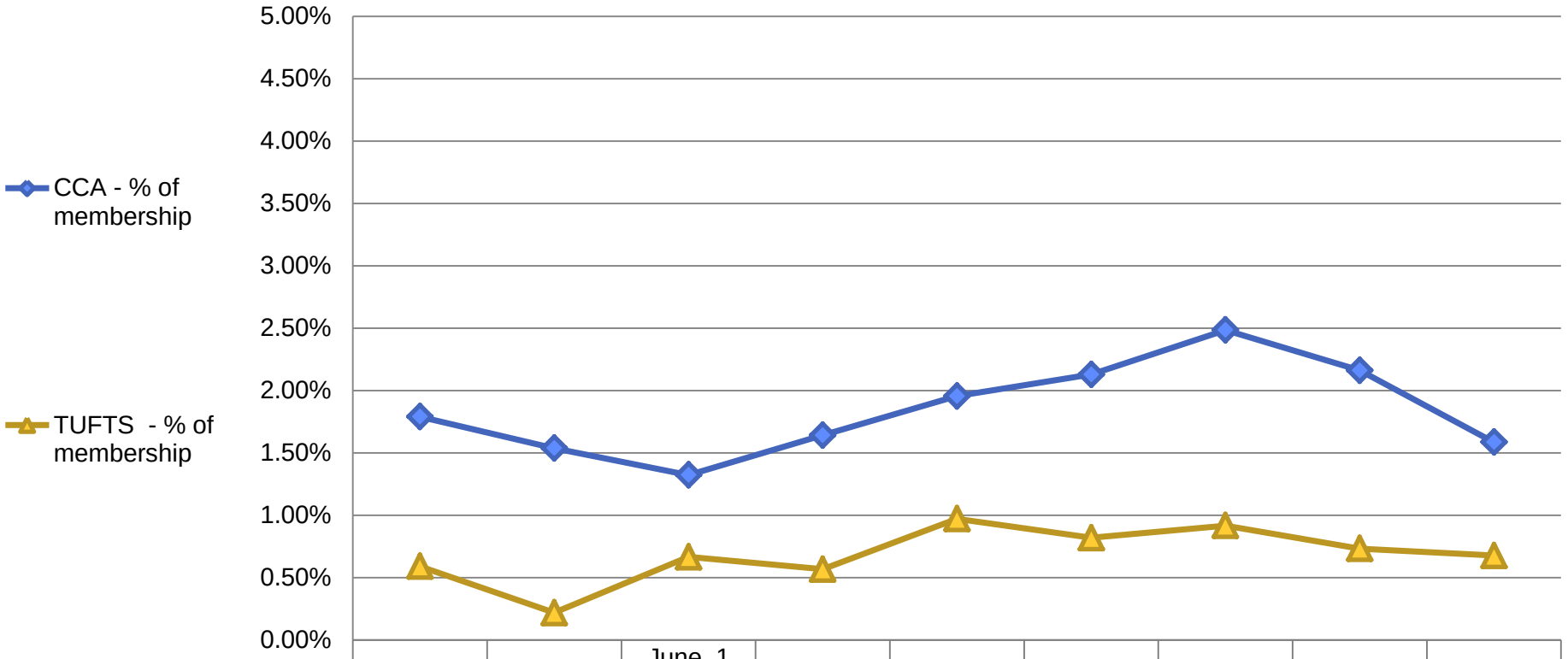
Percentage of Total Grievances by Category



Data includes only grievances Q2 2015-Q4 2015. Grievance data collected prior to this period was not assigned to categories.

April 2015 – December 2015 Grievances

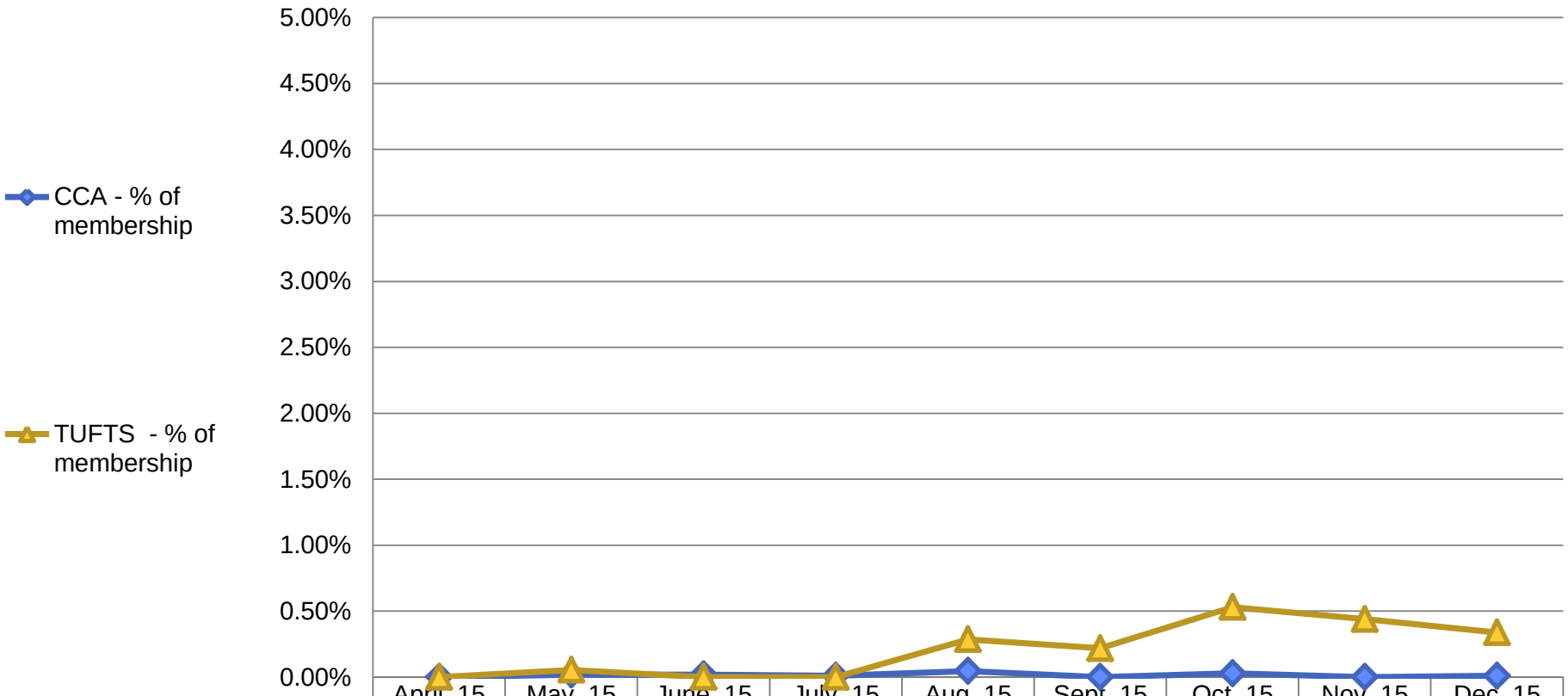
Percentage of Plan Membership with Transportation Grievances



	April_15	May_15	June_15	July_15	Aug_15	Sept_15	Oct_15	Nov_15	Dec_15
CCA - % of membership	1.79%	1.54%	1.32%	1.64%	1.96%	2.13%	2.48%	2.16%	1.59%
CCA - # of Grievances	184	159	138	173	209	227	263	223	162
TUFTS - % of membership	0.59%	0.22%	0.67%	0.57%	0.97%	0.82%	0.92%	0.73%	0.68%
TUFTS - # of Grievances	11	4	12	10	17	15	19	15	14

April 2015 – December 2015 Grievances

Percentage of Plan Membership with Network Grievances



	April_15	May_15	June_15	July_15	Aug_15	Sept_15	Oct_15	Nov_15	Dec_15
CCA - % of membership	0.00%	0.02%	0.02%	0.01%	0.05%	0.00%	0.03%	0.00%	0.01%
CCA - # of Grievances	0	2	2	1	5	0	3	0	1
TUFTS - % of membership	0.00%	0.05%	0.00%	0.00%	0.29%	0.22%	0.53%	0.44%	0.34%
TUFTS - # of Grievances	0	1	0	0	5	4	11	9	7

MassHealth Grievance Oversight Process

- Currently plans report grievances directly to MassHealth on a monthly basis.

- These Grievance Reports are circulated to a variety of One Care staff including:
  - MassHealth Leadership
  - MassHealth Contract Management
  - MassHealth Quality Staff
  - CMS Counterparts

- Staff review reports and identify any areas of concern, or questions they may have to further discuss with the plans.

- Areas of concern/questions are then sent to the plans and discussed during the bi-weekly contract management meetings.

- During bi-weekly contract management meetings, plans provide responses on the previously identified grievances concerns/ questions.

- Additionally grievance data is aggregated by quality staff and shared with the plans, allowing plans to
  - Proactively identify areas of concerns, and
  - Implement strategies to improve plan operations and member satisfaction

- Plan responses illustrating past, previous, and current strategies are shown on the following slides.

CCA's Response to Grievance Data

Background/Context

- 81% of CCA's grievances are transportation related
- Transportation utilization consistently increasing – April 2016 average is over 20,000 rides per month.
- Grievances decreasing each month despite steady increases in utilization.
- Complaints consistently remain less than 1% of trip volume.
- The decrease in complaints is attributed to numerous efforts and interventions (see right).
- Top 3 issues are:
  - Vendor/driver lateness
  - Vendor/driver no-shows
  - Customer service, including clerical errors

INTERVENTIONS

Lateness

- Implemented a one hour pick-up window for Boston and Greater Boston
- Observed immediate improvement in member satisfaction
- Reinforced communications policy for vendors to notify CCA when they are late so CCA can call the member and provider offices as appropriate

No-shows and Lateness

- Reduce volume of rides to no-show and late vendors
- Work with vendor to address issues impacting lateness, no-shows, customer service
- Annual vendor meetings and regular communication to vendors via fax and email blasts

Other

- Staff trainings to address data entry errors that result in member complaints at CCA and transportation broker
- Staff is held accountable for errors made

Improvements to Existing Operations

- Implementation of skills-based routing prompts within Transportation toll-free line
- Ongoing efforts with member education
- CCA and broker leadership met in December 2015 to agree upon ongoing improvement strategies

Innovations

- Implementation of portal for CCA staff: directly schedule in broker's portal
- Improving interactive voice response solutions - Members to confirm rides

Tufts' Response to Grievance Data

TRANSPORTATION

- Less than 1% of all rides result in a grievance.
- In general, members complain that:
  - their ride was late for the scheduled pick up;
  - did not show; or
  - in some cases, members grieved that the transport showed up too early.
- Staff review all transportation grievances with contracted vendors to resolve the specific grievance, and identify opportunities for improvement.
- In 2015, Tufts Health Plan enhanced the oversight function for transportation vendors, added multiple companies to the network, and ended a relationship with a vendor.
- Despite increasing membership enrollment and utilization, Tufts Health Plan improved performance of its transportation network according to grievance trends.
- Tufts Health Plan continues to monitor transportation-related grievances and will implement additional changes as necessary in the future.

NETWORK

- Network-related grievances were filed by 0.5% of members during the reporting period.
- Majority of network grievances received following FTC exit from One Care
- Most often, members grieve that their PCP or specialist is not in network.
- Customer service and care management staff work individually with these members to identify in-network providers to satisfy their needs.
- Tufts Health Plan's provider network meets or exceeds proximity access requirements for facilities and providers.
- In Fall 2015, Tufts Health Plan passed CMS's new network adequacy requirements for Medicare-Medicaid Plans.
- Membership and utilization patterns are consistently monitored against network adequacy requirements; if gaps are identified, Tufts Health Plan pursues contracts with relevant providers as expeditiously as possible.

FINANCIAL DATA

Plan Financials

- **CCA and Tufts saw significant improvements in their financials for DY2** (2015) compared to DY1 (2013/2014)
- In DY2, MassHealth and CMS implemented rate enhancements and program efficiencies in order to stabilize the One Care program
- DY1 information does not account for additional risk corridor payments to the plans (amounts are still being finalized)

Demo Year 1 Q1-Q5 (10/1/13-12/31/14)

	CCA	Tufts	FTC
Total Spending	$ 291,804,133	$ 30,853,089	$ 108,103,203
Total Revenue	$ 256,946,563	$ 30,391,126	$ 97,102,556
Interim Risk Corridor Payment	$ 16,467,408	TBD	TBD
Net Income	$ (18,390,162)	$ (461,963)	$ (11,000,647)
Net Gain/Loss	*-6.7%*	*-1.5%*	*-11.3%*
Average Member Months	7,239	1,081	4,135

Demo Year 2 - Q1-Q4 (1/1/15- 12/31/15)

	CCA	Tufts
Total Spending	$ 386,131,698	$ 51,329,878
Total Revenue	$ 385,715,219	$ 54,341,571
Net Income	$ (416,478)	$ 3,011,693
Net Gain/Loss	*-0.1%*	*5.5%*
Average Member Months	10,403	1,906

Notes on DY1: *DY1 data is based on financial reports submitted to MassHealth by the plans for October 2013 – December 2014, updated in October 2015. Revenue was adjusted to include quality incentive payments to all plans and Interim Risk Corridor Payment line reflects payment made to CCA. Revenue excludes interim risk corridor payment to FTC and Tufts and final risk corridor payments for all qualifying plans (amounts TBD).*

Notes on DY2: *FTC financials not included due to plan exiting the program on 9/30/15. CCA and Tufts spending includes claims runout through 1/31/16 as reported to MassHealth. Revenue was adjusted to include rate enhancement payments for 2015 made by MassHealth in February 2016. (CMS's rate enhancement payments were included in CCA's and Tufts' revenues as reported to MassHealth.) The rate enhancement payments were made available through execution of contract amendments and are contingent on continued participation in the Demonstration through December 2016. Revenue excludes any future Medicaid reconciliation payments for RY15 rate enhancements, and potential risk corridor payments or recoupments for qualifying plans.*

PMPM Service Spending by Plan and RC

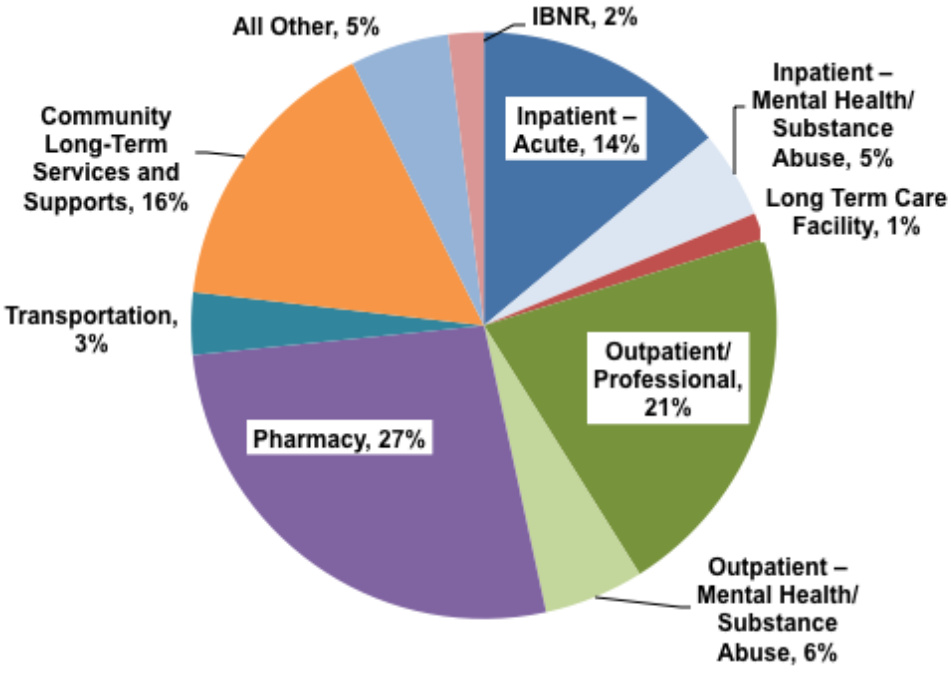
	C1: Community Other			C2A: Community High Behavioral Health			C2B: Community Very High Behavioral Health		
	DY1	DY2	Δ	DY1	DY2	Δ	DY1	DY2	Δ
CCA	$ 1,246	$ 1,364	9%	$ 1,907	$ 1,871	-2%	$ 3,053	$ 2,849	-7%
Tufts	$ 1,135	$ 1,596	41%	$ 1,220	$ 1,312	7%	$ 1,828	$ 2,215	21%
FTC	$ 937	$ 896	-4%	$ 1,385	$ 1,295	-6%	$ 2,039	$ 2,126	4%
Avg. All Plans	$ 1,110	$ 1,244	12%	$ 1,594	$ 1,643	3%	$ 2,471	$ 2,435	-1%
	C3A: High Community Needs			C3B: Very High Community Needs			F1: Facility Based Care		
	DY1	DY2	Δ	DY1	DY2	Δ	DY1	DY2	Δ
CCA	$ 4,067	$ 4,012	-1%	$ 8,220	$ 8,384	2%	$10,558	$10,219	-3%
Tufts	$ 3,516	$ 3,914	11%	$ 5,836	$ 4,232	-27%	$ 6,211	$ 5,428	-13%
FTC	$ 4,299	$ 4,190	-3%	$ 6,205	$ 6,828	10%	$ 8,234	$ 3,260	-60%
Avg. All Plans	$ 4,066	$ 4,042	-1%	$ 8,007	$ 8,143	2%	$ 8,218	$ 9,370	14%

- In aggregate, average PMPMs for members in C2 and C3 rating categories (RCs) changed less than +/- 3% between DY1 and DY2, while average PMPMs for C1 and F1 increased by 12% and 14%, respectively
- There were large variations in PMPM changes across plans and rating categories
  - CCA's PMPM spending increased for C1 and C3B, and decreased for the other rating categories
  - Tufts' PMPM spending increased in almost all community rating categories (C1 through C3A); the largest increase was 41% for C1s
  - FTC's PMPM spending increased in the highest risk community categories (C2B and C3B), but decreased in all other categories
  - PMPM spending for F1 decreased for all three plans between -3% and -60%, but increased in the aggregate once adjusted for plan caseload. Volatile spending in F1 was likely driven by very small caseload (avg. <20 members) in this rating category.

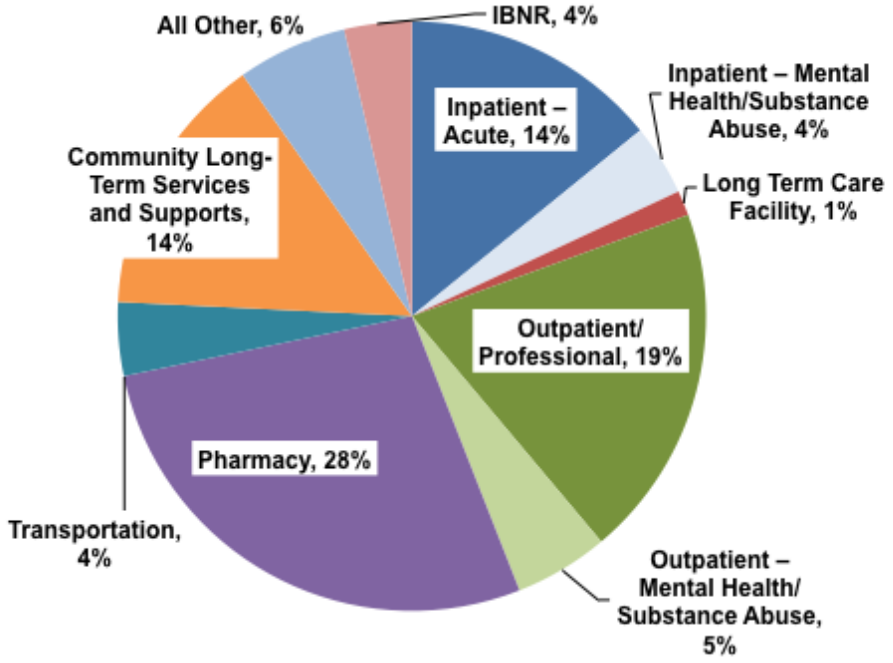
Notes: PMPMs reflect claims as reported by the plans as of a certain date; incorporating additional claims will change these numbers.
For DY2, FTC reported information through program exit (2015 Q1 – Q3) with claims through 10/31/15; CCA and Tufts information reflects full Demo Year with claims through 1/31/16

CCA – PMPM Service Spend

DY1 Avg. PMPM = $2,205



DY2 Avg. PMPM = $2,641



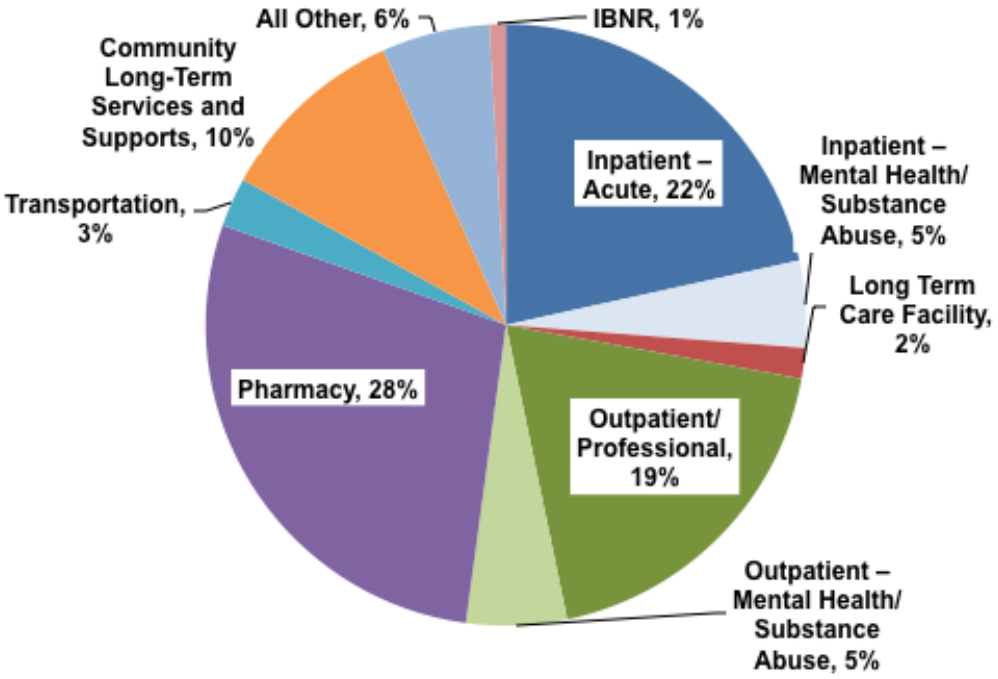
Member Months	DY1		DY2	
C1	56,898	52%	42,984	34%
C2A	20,976	19%	27,966	22%
C2B	3,432	3%	5,262	4%
C3A	25,670	24%	46,750	37%
C3B	1,406	1%	1,650	1%
F1	203	0%	229	0%
Total	108,585	100%	124,841	100%

One Care Plan medical and LTSS PMPM spending from October 1, 2013 – Dec. 31, 2015 as reported by CCA, subject to verification by MassHealth and CMS.

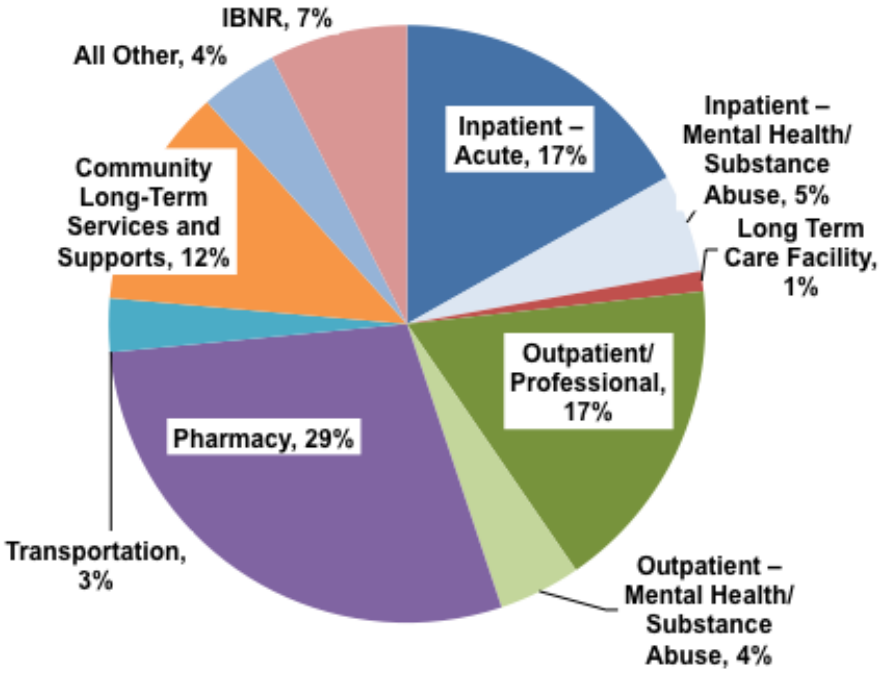
IBNR: Incurred but not reported spending is an estimate of costs that have been incurred for services provided during the reporting period, but that have not yet been billed or adjudicated. Note that data reflect spending on claims as of a certain date (through 9/30/15 for DY1 and 1/31/16 for DY2), as reported by the plan; incorporating additional claims will change these numbers. Administrative spending is not included.

Tufts – PMPM Service Spend

DY1 Avg. PMPM = $1,504



DY2 Avg. PMPM = $1,940



Member Months	DY1		DY2	
C1	16,689	41%	16,875	30%
C2A	16,342	39%	19,306	41%
C2B	1,346	8%	2,972	13%
C3A	1,791	11%	3,637	16%
C3B	3	0%	50	0%
F1	7	0%	28	0%
Total	16,218	100%	22,868	100%

One Care Plan medical and LTSS PMPM spending from October 1, 2013 – Dec. 31, 2015 as reported by Tufts, subject to verification by MassHealth and CMS.

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PMPM Service Spend Notes

- Complexity of One Care population increased significantly between DY1 and DY2
- Members with higher rating categories are enrolled in One Care at higher rates compared to their proportion of the eligible population as a whole

% Member Months	DY1			DY2		
	CCA	Tufts	Eligible Population	CCA	Tufts	Eligible Population
C1	52.4%	**41.2%**	**65.1%**	**34.4%**	**30.1%**	**67.6%**
C2A	19.3%	**39.1%**	**16.8%**	22.4%	**40.7%**	**14.1%**
C2B	3.2%	8.3%	3.1%	4.2%	13.0%	3.5%
C3A	23.6%	11.0%	13.0%	**37.4%**	15.9%	**13.0%**
C3B	1.3%	0.3%	0.7%	1.3%	0.2%	0.7%
F1	0.2%	0.0%	1.3%	0.2%	0.1%	1.1%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

>20% Higher than Comparison Group
>20% Lower than Comparison Group

- Proportion of enrolled C1s decreased significantly for both plans:
  - 52% to 34% for CCA
  - 41% to 30% for Tufts
- Percentage of enrolled C2As, C2Bs (high BH needs) and especially C3As (high LTSS needs) increased significantly within plans
  - 46% to 63% for CCA
  - 58% to 70% for Tufts

Consistent with increasing casemix complexity, average PMPMs increased between DY1 and DY2 for CCA and Tufts

Incurred but not reported (IBNR) spending is notably higher in DY2 than DY1 due to timing of available claims; we do not know if IBNR will distribute proportionately among service categories

IBNR: Incurred but not reported spending is an estimate of costs that have been incurred for services provided during the reporting period, but that have not yet been billed or adjudicated. Note that data reflect spending on claims as of a certain date (through 9/30/15 for DY1 and 1/31/16 for DY2), as reported by the plans; incorporating additional claims will change these numbers.

Notable Trends for CCA and Tufts by RC: DY2 vs. DY1

- On average, **Pharmacy** Per Member Per Month (PMPM) spending across all rating categories (RCs) increased
  - 10%+ increase across all RCs for members in CCA
  - 40%+ increase for C1, C3A, and F1 members in Tufts

- **Inpatient Acute Hospital** PMPM spending
  - Reduction for C2A and C3A members across both plans (ranging from 3-29%)
  - 20-30% increase for C1 members across both plans

- **Inpatient Mental Health/Substance Abuse** PMPM spending
  - 34-50% decrease for C2A and C2B members in CCA
  - 1% decrease for C2A and 32% increase for C2B members in Tufts

- **Community Long-Term Services and Supports (LTSS)** PMPM spending
  - Reduction across all RCs for CCA members:
    - May be explained by shift to more complex RCs (e.g., C1 member at high-end of C1 cost range that moves to C3A could be at the low end of C3A cost range, lowering both average PMPMs)
  - 64% increase for C1, and decreases for C2B and C3B members in Tufts

- Proportionate spending and comparisons between years in all service areas could change as IBNR for DY2 comes down over time

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DISCUSSION

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