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

• Financial Data
  o Plan Financial Overview
  o 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 COMMBUYYS 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
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
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.

<table>
<thead>
<tr>
<th>GOALS OF THE ONE CARE PROGRAM</th>
<th>CORRESPONDING DATA SOURCES INCLUDED IN THE PRESENTATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improved quality</td>
<td>CAHPS, Grievances, Quality Withhold Payments</td>
</tr>
<tr>
<td>Improved outcomes</td>
<td>HEDIS</td>
</tr>
</tbody>
</table>
# Data Sources, Measurement Periods, and Benchmarks

<table>
<thead>
<tr>
<th>Data Source</th>
<th>Measurement Period</th>
<th>Benchmarks</th>
</tr>
</thead>
</table>
| CAHPS Survey                 | July 2014 – December 2014<br><br>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<br><br>DY1 (Q2-Q5) | • Medicaid Managed Care Plans  
• Performance at the 75th percentile  
• Performance at the 90th percentile |
| Quality Withhold Measures    | October 2013 – December 2014<br><br>DY1 (Q1-Q5) | • One Care Plans  
• Pass/Fail OR  
• Highest performing plan minus 10 percentage points |
| Grievance Reporting          | April 2015 – December 2015<br><br>DY2 (Q2-Q4) | • One Care Plans |
| Financials                   | October 2013 – December 2015<br><br>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](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

<table>
<thead>
<tr>
<th>Core 2.1 Completed Assessments</th>
<th>Core 5.3 Consumer Advisory Board</th>
<th>MA 5.1 ICO Centralized Enrollee Record</th>
<th># Measures Passed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benchmark</td>
<td>67.3%</td>
<td>Timely reporting of required elements</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CCA</th>
<th>75.6%</th>
<th>Pass</th>
<th>Pass</th>
<th>3 out of 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>FTC</td>
<td>77.3%</td>
<td>Pass</td>
<td>Pass</td>
<td>3 out of 3</td>
</tr>
<tr>
<td>Tufts</td>
<td>68.4%</td>
<td>Pass</td>
<td>Pass</td>
<td>3 out of 3</td>
</tr>
</tbody>
</table>

## 2014 Withhold Measures

<table>
<thead>
<tr>
<th>Core 2.1 Completed Assessments</th>
<th>Core 5.3 Consumer Advisory Board</th>
<th>MA 5.1 ICO Centralized Enrollee Record</th>
<th>Encounter Data</th>
<th>MA 1.2 Documented Discussion of care goals</th>
<th>MA 1.3 Access to LTS Coordinators</th>
<th># Measures Passed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benchmark</td>
<td>78.2%</td>
<td>71.7%</td>
<td>Successful submission</td>
<td>90.0%</td>
<td>90.0%</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CCA</th>
<th>64.4%</th>
<th>Pass</th>
<th>59.2%</th>
<th>Pass</th>
<th>90.0%</th>
<th>69.9%</th>
<th>3 out of 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>FTC</td>
<td>45.3%</td>
<td>Pass</td>
<td>81.7%</td>
<td>Pass</td>
<td>100.0%</td>
<td>100.0%</td>
<td>5 out of 6</td>
</tr>
<tr>
<td>Tufts</td>
<td>88.2%</td>
<td>Pass</td>
<td>65.4%</td>
<td>Pass</td>
<td>91.9%</td>
<td>81.2%</td>
<td>4 out of 6</td>
</tr>
</tbody>
</table>

**Key**
- Cells highlighted in yellow did not pass
- Cells highlighted in green did pass
# Quality Withhold Measures: Individual Plan Performance and MassHealth Payment: DY1

## 2013 WITHHOLD MEASURES

<table>
<thead>
<tr>
<th># Measures Passed</th>
<th>MassHealth Quality Withhold Amount ($)</th>
<th>% of Earned Withhold</th>
<th>Earned MassHealth Quality Payment ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td>CCA</td>
<td>3 out of 3</td>
<td>$60,029</td>
<td>100%</td>
</tr>
<tr>
<td>FTC</td>
<td>3 out of 3</td>
<td>$7,359</td>
<td>100%</td>
</tr>
<tr>
<td>Tufts</td>
<td>3 out of 3</td>
<td>$5,908</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Total One Care Plans</strong></td>
<td></td>
<td><strong>$73,296</strong></td>
<td></td>
</tr>
</tbody>
</table>

## 2014 WITHHOLD MEASURES

<table>
<thead>
<tr>
<th># Measures Passed</th>
<th>MassHealth Quality Withhold Amount ($)</th>
<th>% of Earned Withhold</th>
<th>Earned MassHealth Quality Payment ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td>CCA</td>
<td>3 out of 6</td>
<td>$863,766</td>
<td>50%</td>
</tr>
<tr>
<td>FTC</td>
<td>5 out of 6</td>
<td>$317,903</td>
<td>100%</td>
</tr>
<tr>
<td>Tufts</td>
<td>4 out of 6</td>
<td>$79,949</td>
<td>75%</td>
</tr>
<tr>
<td><strong>Total One Care Plans</strong></td>
<td></td>
<td><strong>$1,261,618</strong></td>
<td></td>
</tr>
</tbody>
</table>

### 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

<table>
<thead>
<tr>
<th>Measure</th>
<th>Successes, Challenges and Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Completed Assessments</td>
<td>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.</td>
</tr>
<tr>
<td>Consumer Advisory Board</td>
<td>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.</td>
</tr>
<tr>
<td>Centralized Enrollee Record</td>
<td>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.</td>
</tr>
<tr>
<td>Documented Care Goals</td>
<td>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.</td>
</tr>
<tr>
<td>Access to LTS Coordinators</td>
<td>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.</td>
</tr>
</tbody>
</table>
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)
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).

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

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)
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?

<table>
<thead>
<tr>
<th>Composite</th>
<th>National MMP Average</th>
<th>FTC</th>
<th>Massachusetts Medicare Advantage Average</th>
<th>Tufts</th>
<th>National Medicare Advantage Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>CCA</td>
<td></td>
<td></td>
<td>86%</td>
<td></td>
<td>85%</td>
</tr>
<tr>
<td>Massachusetts Medicare</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>84%</td>
</tr>
<tr>
<td>Advantage Average</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>84%</td>
</tr>
<tr>
<td>Tufts</td>
<td></td>
<td>84%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FTC</td>
<td></td>
<td>81%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>National Medicare Advantage</td>
<td></td>
<td></td>
<td>84%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>78%</td>
</tr>
</tbody>
</table>
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?
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?
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?

<table>
<thead>
<tr>
<th>Composite</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>CCA</td>
<td>81%</td>
</tr>
<tr>
<td>Massachusetts Medicare Advantage Average</td>
<td>79%</td>
</tr>
<tr>
<td>Tufts</td>
<td>77%</td>
</tr>
<tr>
<td>National Medicare Advantage Average</td>
<td>76%</td>
</tr>
<tr>
<td>FTC</td>
<td>74%</td>
</tr>
<tr>
<td>National MMP Average</td>
<td>71%</td>
</tr>
</tbody>
</table>
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
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.
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)

- Tufts: 32%
- FTC: 29%
- CCA: 28%
- Medicaid 90th Percentile: 11%
- Medicaid 75th Percentile: 6%
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)
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 75\textsuperscript{th} percentile, illustrating a strong performance.

Data from Calendar Year 2014 (DY1)
CCA’s Response to HEDIS Data

<table>
<thead>
<tr>
<th>Measure</th>
<th>Successes, Challenges and Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to Preventative / Ambulatory Services</td>
<td>CCA is pleased with the findings and is working to maintain the high level of access reflected in this measure.</td>
</tr>
<tr>
<td>Identification of Alcohol and Other Drug Services</td>
<td>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.</td>
</tr>
<tr>
<td>Behavioral Health Service Utilization</td>
<td>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.</td>
</tr>
<tr>
<td>Follow-up Hospitalization for Mental Illness</td>
<td>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.</td>
</tr>
<tr>
<td>Average LOS General Hospital / Acute Care</td>
<td>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.</td>
</tr>
</tbody>
</table>
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

**ICO Current Grievance Reporting Process**

**AVENUES TO FILE A GRIEVANCE**
- Make a grievance by contacting CMS directly
- Make a grievance by contacting MassHealth Directly
- Make a grievance by contacting the Ombudsman
- Make a grievance by contacting the plan

**ABILITY TO ENTER GRIEVANCE**
- Member or Authorized Rep

**WAYS GRIEVANCES ARE PROCESSED**
- CMS or MassHealth Staff enter grievance into Complaint Tracking Module (CTM).
- Depending on issue type:
  - Grievance is either handled by MassHealth staff OR
  - Grievance is relayed to the plans for processing
  - Plan will enter information into their operating system and resolve issue
- Ombudsman will contact the plan.
  - The plan enters grievance into operating system - if not already in the Complaint Tracking Module (CTM)
  - Plan will enter information into their operating system and resolve issue.
- Plan will enter information into their operating system, and resolve issue.
# Grievance Categories

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

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>DESCRIPTION</th>
<th>EXAMPLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>BP: Dental</td>
<td>Dissatisfaction with dental services / plan dental restrictions</td>
<td>Upset dental implant was not approved</td>
</tr>
<tr>
<td>BP: Part C, Medicaid,</td>
<td>Dissatisfaction with plans covered services/ plan restrictions</td>
<td>Upset PCA services not approved</td>
</tr>
<tr>
<td>Supplemental</td>
<td></td>
<td></td>
</tr>
<tr>
<td>BP: Part D</td>
<td>Dissatisfaction with the plans covered prescription drugs</td>
<td>Upset brand name drugs not approved</td>
</tr>
<tr>
<td>Enrollment</td>
<td>Dissatisfaction with the enrollment broker</td>
<td>Self-selected and placed in wrong plan</td>
</tr>
<tr>
<td>MassHealth</td>
<td>Dissatisfaction with MassHealth</td>
<td>Incorrectly dis-enrolled from One Care</td>
</tr>
<tr>
<td>Medicare</td>
<td>Dissatisfaction with services provided by Medicare</td>
<td>Received incorrect information from Medicare</td>
</tr>
<tr>
<td>Network/Access</td>
<td>Dissatisfaction surrounding provider access/ availability</td>
<td>Preferred provider not in network</td>
</tr>
<tr>
<td>Other</td>
<td>Any grievance that does not fit into one of the pre-existing categories</td>
<td></td>
</tr>
<tr>
<td>Plan Management</td>
<td>Dissatisfaction with the plan oversight</td>
<td>Care Coordinator is unresponsive</td>
</tr>
<tr>
<td>Plan Marketing Materials</td>
<td>Dissatisfaction with marketing materials received from the plan</td>
<td>Too many materials sent</td>
</tr>
<tr>
<td>Provider</td>
<td>Dissatisfaction with a provider</td>
<td>Rude office manager at specialist’s office</td>
</tr>
<tr>
<td>Quality of Care</td>
<td>Dissatisfaction with the quality of care received</td>
<td>Provided incorrect medication</td>
</tr>
<tr>
<td>Transportation</td>
<td>Dissatisfaction with transportation services provided</td>
<td>Transportation no-shows/late arrivals</td>
</tr>
</tbody>
</table>
April 2015 – December 2015
Percentage of Plan Membership with Grievances

- **CCA - % of membership**
  - April_15: 2.21%
  - May_15: 1.99%
  - June_15: 1.63%
  - July_15: 2.13%
  - Aug_15: 2.49%
  - Sept_15: 2.64%
  - Oct_15: 3.04%
  - Nov_15: 2.54%
  - Dec_15: 1.77%

- **CCA - # of Grievances**
  - April_15: 227
  - May_15: 206
  - June_15: 170
  - July_15: 224
  - Aug_15: 266
  - Sept_15: 281
  - Oct_15: 322
  - Nov_15: 262
  - Dec_15: 181

- **Tufts - % of membership**
  - April_15: 0.81%
  - May_15: 0.49%
  - June_15: 1.61%
  - July_15: 1.02%
  - Aug_15: 2.34%
  - Sept_15: 1.42%
  - Oct_15: 1.79%
  - Nov_15: 1.56%
  - Dec_15: 1.21%

- **Tufts - # of Grievances**
  - April_15: 15
  - May_15: 9
  - June_15: 29
  - July_15: 18
  - Aug_15: 41
  - Sept_15: 26
  - Oct_15: 37
  - Nov_15: 32
  - Dec_15: 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

<table>
<thead>
<tr>
<th></th>
<th>April_15</th>
<th>May_15</th>
<th>June_15</th>
<th>July_15</th>
<th>Aug_15</th>
<th>Sept_15</th>
<th>Oct_15</th>
<th>Nov_15</th>
<th>Dec_15</th>
</tr>
</thead>
<tbody>
<tr>
<td>CCA - % of membership</td>
<td>1.79%</td>
<td>1.54%</td>
<td>1.32%</td>
<td>1.64%</td>
<td>1.96%</td>
<td>2.13%</td>
<td>2.48%</td>
<td>2.16%</td>
<td>1.59%</td>
</tr>
<tr>
<td>CCA - # of Grievances</td>
<td>184</td>
<td>159</td>
<td>138</td>
<td>173</td>
<td>209</td>
<td>227</td>
<td>263</td>
<td>223</td>
<td>162</td>
</tr>
<tr>
<td>TUFTS - % of membership</td>
<td>0.59%</td>
<td>0.22%</td>
<td>0.67%</td>
<td>0.57%</td>
<td>0.97%</td>
<td>0.82%</td>
<td>0.92%</td>
<td>0.73%</td>
<td>0.68%</td>
</tr>
<tr>
<td>TUFTS - # of Grievances</td>
<td>11</td>
<td>4</td>
<td>12</td>
<td>10</td>
<td>17</td>
<td>15</td>
<td>19</td>
<td>15</td>
<td>14</td>
</tr>
</tbody>
</table>
April 2015 – December 2015 Grievances

Percentage of Plan Membership with Network

Grievances

<table>
<thead>
<tr>
<th></th>
<th>April_15</th>
<th>May_15</th>
<th>June_15</th>
<th>July_15</th>
<th>Aug_15</th>
<th>Sept_15</th>
<th>Oct_15</th>
<th>Nov_15</th>
<th>Dec_15</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CCA - % of membership</strong></td>
<td>0.00%</td>
<td>0.02%</td>
<td>0.02%</td>
<td>0.01%</td>
<td>0.05%</td>
<td>0.00%</td>
<td>0.03%</td>
<td>0.00%</td>
<td>0.01%</td>
</tr>
<tr>
<td><strong>CCA - # of Grievances</strong></td>
<td>0</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>5</td>
<td>0</td>
<td>3</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td><strong>TUFTS - % of membership</strong></td>
<td>0.00%</td>
<td>0.05%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.29%</td>
<td>0.22%</td>
<td>0.53%</td>
<td>0.44%</td>
<td>0.34%</td>
</tr>
<tr>
<td><strong>TUFTS - # of Grievances</strong></td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>5</td>
<td>4</td>
<td>11</td>
<td>9</td>
<td>7</td>
</tr>
</tbody>
</table>
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)

<table>
<thead>
<tr>
<th>Demo Year 1 Q1-Q5 (10/1/13-12/31/14)</th>
<th>CCA</th>
<th>Tufts</th>
<th>FTC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Spending</td>
<td>$291,804,133</td>
<td>$30,853,089</td>
<td>$108,103,203</td>
</tr>
<tr>
<td>Total Revenue</td>
<td>$256,946,563</td>
<td>$30,391,126</td>
<td>$97,102,556</td>
</tr>
<tr>
<td>Interim Risk Corridor Payment</td>
<td>$16,467,408</td>
<td>TBD</td>
<td>TBD</td>
</tr>
<tr>
<td>Net Income</td>
<td>$(18,390,162)</td>
<td>$(461,963)</td>
<td>$(11,000,647)</td>
</tr>
<tr>
<td><strong>Net Gain/Loss</strong></td>
<td>-6.7%</td>
<td>-1.5%</td>
<td>-11.3%</td>
</tr>
<tr>
<td>Average Member Months</td>
<td>7,239</td>
<td>1,081</td>
<td>4,135</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Demo Year 2 - Q1-Q4 (1/1/15-12/31/15)</th>
<th>CCA</th>
<th>Tufts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Spending</td>
<td>$386,131,698</td>
<td>$51,329,878</td>
</tr>
<tr>
<td>Total Revenue</td>
<td>$385,715,219</td>
<td>$54,341,571</td>
</tr>
<tr>
<td>Net Income</td>
<td>$(416,478)</td>
<td>$3,011,693</td>
</tr>
<tr>
<td><strong>Net Gain/Loss</strong></td>
<td>-0.1%</td>
<td>5.5%</td>
</tr>
<tr>
<td>Average Member Months</td>
<td>10,403</td>
<td>1,906</td>
</tr>
</tbody>
</table>

**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

<table>
<thead>
<tr>
<th>Plan</th>
<th>C1: Community Other</th>
<th>C2A: Community High Behavioral Health</th>
<th>C2B: Community Very High Behavioral Health</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>DY1</td>
<td>DY2</td>
<td>Δ</td>
</tr>
<tr>
<td>CCA</td>
<td>$1,246</td>
<td>$1,364</td>
<td>9%</td>
</tr>
<tr>
<td>Tufts</td>
<td>$1,135</td>
<td>$1,596</td>
<td>41%</td>
</tr>
<tr>
<td>FTC</td>
<td>$937</td>
<td>$896</td>
<td>-4%</td>
</tr>
<tr>
<td>Avg. All Plans</td>
<td>$1,110</td>
<td>$1,244</td>
<td>12%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Plan</th>
<th>C3A: High Community Needs</th>
<th>C3B: Very High Community Needs</th>
<th>F1: Facility Based Care</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>DY1</td>
<td>DY2</td>
<td>Δ</td>
</tr>
<tr>
<td>CCA</td>
<td>$4,067</td>
<td>$4,012</td>
<td>-1%</td>
</tr>
<tr>
<td>Tufts</td>
<td>$3,516</td>
<td>$3,914</td>
<td>11%</td>
</tr>
<tr>
<td>FTC</td>
<td>$4,299</td>
<td>$4,190</td>
<td>-3%</td>
</tr>
<tr>
<td>Avg. All Plans</td>
<td>$4,066</td>
<td>$4,042</td>
<td>-1%</td>
</tr>
</tbody>
</table>

- 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

<table>
<thead>
<tr>
<th>Member Months</th>
<th>DY1</th>
<th>DY2</th>
</tr>
</thead>
<tbody>
<tr>
<td>C1</td>
<td>56,898</td>
<td>42,984</td>
</tr>
<tr>
<td>C2A</td>
<td>20,976</td>
<td>27,966</td>
</tr>
<tr>
<td>C2B</td>
<td>3,432</td>
<td>5,262</td>
</tr>
<tr>
<td>C3A</td>
<td>25,670</td>
<td>46,750</td>
</tr>
<tr>
<td>C3B</td>
<td>1,406</td>
<td>1,650</td>
</tr>
<tr>
<td>F1</td>
<td>203</td>
<td>229</td>
</tr>
<tr>
<td>Total</td>
<td>108,585</td>
<td>124,841</td>
</tr>
</tbody>
</table>

**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

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.

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.
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

<table>
<thead>
<tr>
<th>% Member Months</th>
<th>CCA</th>
<th>Tufts</th>
<th>Eligible Population</th>
<th>CCA</th>
<th>Tufts</th>
<th>Eligible Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>C1</td>
<td>52.4%</td>
<td>41.2%</td>
<td>65.1%</td>
<td>34.4%</td>
<td>30.1%</td>
<td>67.6%</td>
</tr>
<tr>
<td>C2A</td>
<td>19.3%</td>
<td>39.1%</td>
<td>16.8%</td>
<td>22.4%</td>
<td>40.7%</td>
<td>14.1%</td>
</tr>
<tr>
<td>C2B</td>
<td>3.2%</td>
<td>8.3%</td>
<td>3.1%</td>
<td>4.2%</td>
<td>13.0%</td>
<td>3.5%</td>
</tr>
<tr>
<td>C3A</td>
<td>23.6%</td>
<td>11.0%</td>
<td>13.0%</td>
<td><strong>37.4%</strong></td>
<td>15.9%</td>
<td><strong>13.0%</strong></td>
</tr>
<tr>
<td>C3B</td>
<td>1.3%</td>
<td>0.3%</td>
<td>0.7%</td>
<td>1.3%</td>
<td>0.2%</td>
<td>0.7%</td>
</tr>
<tr>
<td>F1</td>
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<td>Total</td>
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- 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

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*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

- **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

**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.
DISCUSSION
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