Demonstration to Integrate Care for Dual Eligible Individuals (One Care) - Commonwealth Care Alliance CY 2015 Updated Final Rate Report January 14, 2016

MassHealth, in conjunction with the Centers for Medicare and Medicaid Services (CMS), is releasing updated final Medicaid and Medicare components of the CY 2015 rates for the Massachusetts Demonstration to Integrate Care for Dual Eligible Individuals (One Care). These adjustments were available to One Care plans through execution of contract amendments and are conditional upon continued participation in the demonstration through December 31, 2016. In accordance with the Three-Way Contract as amended and restated in December 2015, these updates to the rates replace the Demonstration rates included in the CY 2015 rate report dated March 5, 2015.

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

Included in this report are final CY 2015 Medicaid rates and Medicare county base rates for One Care plans that executed the above described contract amendments. The final CY 2015 Medicare A/B and Medicaid rates included in this report reflect the elimination of the savings percentage for Demonstration Year 2. The final rates also reflect an increase of 5% to the FFS component of the Medicare A/B rate for non-ESRD beneficiaries. The reduction to the quality withhold amount is reflected in the quality withhold section of this report.

I. Components of the Capitation Rate

CMS and MassHealth will each contribute to the global capitation payment. CMS and MassHealth will each make monthly payments to One Care plans for their components of the capitated rate. One Care plans will receive three monthly payments for each enrollee: one amount from CMS reflecting coverage of Medicare Parts A/B services, one amount from CMS reflecting coverage of Medicare Part D services, and a third amount from MassHealth reflecting coverage of Medicaid services.

The Medicare Parts A/B rate component will be risk adjusted using the Medicare Advantage CMS-HCC and CMS HCC-ESRD models. The Medicare Part D payment will be risk adjusted using the Part D RxHCC model. To adjust the Medicaid component, MassHealth's methodology assigns each enrollee to a rating category (RC) according to the individual enrollee's clinical status and setting of care.

Section II of this report provides information on the MassHealth component of the capitation rate. Section III includes the Medicare Parts A/B and Medicare Part D components of the rate. Section IV includes information on the savings percentages and quality withholds. Section V includes information on risk mitigation.

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II. MassHealth Component of the Rate – CY 2015

MassHealth county rates are included below, accompanied by supporting information pertinent to their development. This content includes historical base data production details, adjustments applied to the historical base data, and trend factors used to project historical base data forward to the contract period.

MassHealth Component of Rate:

Updated MassHealth rates for CY2015 effective January 1, 2015 through December 31, 2015 are listed below, by Massachusetts county and MassHealth rating category for the Demonstration. These adjustments were available to One Care plans through execution of contract amendments in December 2015 and are conditional upon continued participation in the demonstration through December 31, 2016. In accordance with the contract amendments, the quality withhold (see Section IV) and the savings percentage (see Section V) have both been reduced to 0% for Demonstration Year 2.

MassHealth Component of County Rate Effective January 1, 2015 through December 31, 2015						
County	**C1 – Community Other**	**C2A – Community High Behavioral Health**	**C2B – Community Very High Behavioral Health**	**C3A – High Community Need**	**C3B – Very High Community Need**	**F1 – Facility-based Care**
Essex	$125.64	$400.88	$608.28	$2,928.86	$5,678.51	$9,549.09
Franklin	$117.97	$372.05	$564.57	$3,042.13	$5,230.77	$8,416.49
Hampden	$117.97	$372.05	$564.57	$3,042.13	$5,230.77	$8,416.49
Hampshire	$117.97	$372.05	$564.57	$3,042.13	$5,230.77	$8,416.49
Middlesex	$125.64	$400.88	$608.28	$2,928.86	$5,678.51	$9,549.09
Norfolk	$125.64	$400.88	$608.28	$2,928.86	$5,678.51	$9,549.09
Plymouth	$147.76	$470.21	$713.53	$2,911.99	$5,771.61	$8,192.29
Suffolk	$125.64	$400.88	$608.28	$2,928.86	$5,678.51	$9,549.09
Worcester	$117.97	$372.05	$564.57	$3,042.13	$5,230.77	$8,416.49

Rate Enhancements:

CMS and MassHealth identified additional costs in fee-for-service (FFS) to consider in the development of the MassHealth component of the capitation rates, including: updated MassHealth administrative costs in FFS; Elder Affairs Home Care program; Health Safety Net (HSN) dental wrap services; certain behavioral health services; and behavioral health services and substance use disorder treatment and complex care management available in One Care.

These adjustments were available to One Care plans following execution of contract amendments in December 2015 and are conditional upon continued participation in the demonstration through December 31, 2016. The impact on the rates, by region and rating category were as follows:

Region	C1	C2A	C2B	C3A	C3B	F1
Eastern	8.6%	12.1%	13.5%	2.4%	4.3%	7.6%
Western	8.1%	11.8%	13.3%	15.8%	4.7%	9.5%
The Cape	11.7%	13.3%	14.5%	0.0%	4.3%	10.3%

Historical Base Data Development:

The historical Medicaid and crossover expenditures for SFY2012 and SFY2013, with incurred but not reported (IBNR) completion adjustments applied, formed the historical base data used to develop the MassHealth component of the rates.

The historical base data can be created by taking Medicaid and crossover expenditures reported in the MassHealth Information Sharing Package shared with One Care plans, using the mapping provided below to map detailed base data categories of service to rate development categories of service, mapping One Care counties to geographic regions (see *Counties and Regions* subsection), and applying the completion factors also included below. For convenience, per member per month (PMPM) expenditures with IBNR are provided at the end of this report in Section VI for Medicaid and crossover claims by calendar year, region, rating category and category of service.

Rating Categories:

MassHealth assigns members to a rating category based on institutional status (long-term facility versus community), diagnosis information, and the minimum data set — home care (MDS–HC) assessment tool. Because rates are set based on historical FFS claims data, for rate-setting purposes MassHealth stratifies members into rating categories using a proxy method, which is summarized in the table below.

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Rating Category	Description
F1: Facility-Based Care	Demonstration Process Includes individuals identified by MassHealth as having a long-term facility stay of more than 90 days. Applicable facilities include nursing facilities, chronic rehabilitation, and psychiatric hospitals. Proxy Method The base data for this rating category was developed based on member months and expenditures in a facility beyond the first 90 days. Applicable facilities include nursing facilities, chronic rehabilitation, and psychiatric hospitals.
C3: Community Tier 3	Demonstration Process Includes individuals who do not meet F1 criteria and for whom a MDS-HC assessment indicates: • Have a skilled nursing need to be met by the One Care plan seven days a week. • Have two or more activities of daily living (ADL) limitations, and three or more days a week of skilled nursing needs to be met by the One Care plan. • Have four or more ADL limitations. Proxy Method The base data for this rating category was developed based on member months and expenditures not in F1 that are within episodes of three plus consecutive months in which a member is in a facility and/or using more than $500 in community-based long-term services and supports (LTSS).

Rating Category	Description
C2: Community Tier 2	Demonstration Process Includes individuals who do not meet F1 or C3 criteria and who have one or more of the following behavioral health diagnoses listed by ICD-9 code, validated by medical records, reflecting an ongoing, chronic condition such as schizophrenia or episodic mood disorders, psychosis, or alcohol/drug dependence, not in remission: • 295.xx. • 296.xx. • 298.9x. • 303.90, 303.91, 303.92. • 304.xx excluding 304.x3. Proxy Method The base data for this rating category was developed based on member months and expenditures not in F1 or C3, who had any claims in the Medicaid FFS data with a qualifying diagnosis (listed above) and/or non-outpatient claims in the Medicare–Medicaid crossover or Medicare FFS data with a qualifying diagnosis (listed above).
C1: Community Tier 1 — Community Other	Demonstration Process Includes individuals in the community who do not meet the F1, C3, or C2 criteria. Proxy Method The base data for this rating category was developed based on member months and expenditures not in F1, C3, or C2.

After an enrollee is assessed, the MDS-HC assessed rating category may differ from the rating category into which he or she was proxied at enrollment. To address this issue, MassHealth began making retroactive rating category adjustments to plans' monthly capitation payments in October 2014, compensating plans for up to 3 months of difference between assessed and proxied rating categories.

C2 Rating Category Split

In order to further mitigate risk of adverse risk selection to One Care plans, MassHealth further refined the C2 RC, classifying enrollees into:

- C2A: Community Tier 2 – Community High Behavioral Health
- C2B: Community Tier 2 – Community Very High Behavioral Health

The C2B rating category includes all the requirements of the 2013 C2-Community High Behavioral Health rating category, but also includes criteria related to specific co-morbid behavioral health and substance abuse conditions. The C2B rating category will include individuals with at least one mental health diagnosis (295.xx, 296.xx, 298.9x), **and** at least one substance abuse diagnosis (303.90,

303.91, 303.92, 303.93, 304.xx). Any individual that meets the overall C2 criteria, but does not meet the C2B criteria, would be classified as C2A.

C3 Rating Category Split

In order to further mitigate risk of adverse risk selection to One Care plans, MassHealth further refined the C3 RC, classifying enrollees into:

- C3A: Community Tier 3 – High Community Need
- C3B: Community Tier 3 – Very High Community Need

The C3B rating category includes all the requirements of the 2013 C3-High Community Needs rating category, but also includes criteria related to specific diagnoses. The C3B rating category will include individuals with a diagnosis of Quadriplegia (ICD-9 344.0x and 343.2x), ALS (ICD-9 335.20), Muscular Dystrophy (ICD-9 359.0x and 359.1x), and/or Respirator Dependence (ICD-9 V461x). Any individual that meets the overall C3 criteria, but does not meet the C3B criteria, would be classified as C3A.

Rate Relativity Factors

The rate relativity process used to develop the capitation rates for the C2A/C2B and C3A/C3B rating categories can be described at a high level as:

- Relative total costs of C2A/C2B and C3A/C3B to the overall C2 and C3 rating categories, respectively, were developed using the base data.
- Projected costs for the C2 and C3 rating categories were developed by region following the same process as was used for CY 2013 rates.
- The C2A/C2B and the C3A/C3B relativity factors were applied to the total projected medical PMPM for the C2 and C3 rating categories, respectively, to develop projected costs for the C2A/C2B and C3A/C3B rating categories.
- Adjustments for administration, seasonality, savings and enrollee contribution to care were applied to produce the final capitation rates.

The C2A and C2B rate relativity factors applied to the C2 projected expenditures are:

	Eastern	Western	The Cape
C2A	-9.4%	-8.5%	-8.9%
C2B	37.4%	38.8%	38.3%

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

	Eastern	Western	The Cape
C3A	-6.7%	-6.8%	-9.4%
C3B	78.0%	77.8%	72.8%

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Category of Service Mapping:

The following is a category of service mapping between the services reflected in the MassHealth base data and the service categories used in the rate development process. Descriptions of the MassHealth detailed categories of service can be found in Section 3 of the MassHealth Information Sharing Package, "Base Data Detail."

Medicaid Claims:

Rate Development Category of Service	MassHealth Base Data Detailed Category of Service
Inpatient – Non-MH/SA	IP – Non-Behavioral Health
Inpatient MH/SA	IP – Behavioral Health
Hospital Outpatient	Hospital Outpatient
Outpatient MH/SA	Outpatient BH
Professional	Professional
HCBS/Home Health	Community LTSS
LTC Facility	LTC
Pharmacy (Non-Part D)	Non-Part D Pharmacy
DME and Supplies	DME and Supplies
Transportation	Transportation
All Other	Other Services

Crossover Claims:

Rate Development Category of Service	MassHealth Base Data Detailed Category of Service
Inpatient – Non-MH/SA	IP – Non-Behavioral Health
Inpatient MH/SA	IP - Mental Health IP – Substance Abuse
Hospital Outpatient	HOP – ER / Urgent Care HOP - Lab / Rad HOP – Other HOP – Pharmacy HOP – PT/OT/ST
Outpatient MH/SA	HOP - Behavioral Health Prof – Behavioral Health
Professional	Prof – HIP Visits Prof – Lab / Rad Prof – OP Visits Prof – Other
HCBS/Home Health	Home Health
LTC Facility	SNF Hospice
DME and Supplies	DME and Supplies
Transportation	Transportation

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Historical Base Data Completion Factors:
The MassHealth base data do not reflect an estimate for IBNR expenditures. Medicaid and crossover claims processed by MassHealth through December 2013 are reported in the MassHealth base data. To construct the historical base data, the following completion factors have been applied to both the Medicaid data and the crossover data reported in the Data Book.

	Medicaid Claims Completion Factors	
Category of Service	**SFY 2012**	**SFY 2013**
Inpatient – Non-MH/SA	1.001	1.022
Inpatient MH/SA	1.001	1.022
Hospital Outpatient	1.000	1.007
Outpatient MH/SA	1.000	1.007
Professional	1.000	1.007
HCBS/Home Health	1.010	1.013
LTC Facility	1.000	1.008
Pharmacy (Non-Part D)	1.000	1.008
DME & Supplies	1.000	1.008
Transportation	1.000	1.008
All Other	1.000	1.008
All Services	1.005	1.012

	Crossover Claims Completion Factors	
Category of Service	**SFY 2012**	**SFY 2013**
Inpatient – Non-MH/SA	1.001	1.035
Inpatient MH/SA	1.001	1.035
Hospital Outpatient	1.005	1.027
Outpatient MH/SA	1.005	1.027
Professional	1.005	1.027
HCBS/Home Health	1.000	1.000
LTC Facility	1.001	1.010
Pharmacy (Non-Part D)	1.006	1.056
DME & Supplies	1.006	1.056
Transportation	1.006	1.056
All Other	1.006	1.056
All Services	1.003	1.028

Counties and Regions:
Rates will be paid on a Massachusetts county and MassHealth rating category basis. Rates, however, have been developed regionally. Five counties are not included in any of the One Care plan service areas:

- Barnstable.
- Bristol.
- Berkshire.
- Dukes.
- Nantucket.

Since the Demonstration does not currently operate in these counties, any applicable claims and eligibility data for these counties has been removed from the base data. The resulting geographic classifications are as follows:

Eastern:	Essex, Middlesex, Norfolk and Suffolk counties
Western:	Franklin, Hampden, Hampshire and Worcester counties
The Cape:	Plymouth county

Adjustment information below is provided by geographic region.

Adjustments to Historical Base Data:
As outlined in Appendix 6 of the MOU for this Demonstration and further detailed in Section 4 of the three-way contract, rates have been developed based on expected costs for this population had the Demonstration not existed. The adjustments included below have been made to the historical base data to reflect the benefits and costs that will apply in CY2015 to fee-for-service dual eligible individuals. As described above, most adjustments specific to the C2 and C3 rating categories are made prior to the application of C2A/C2B and C3A/C3B relativity factors to the projected rates.

Primary Care Fee Increase in the ACA:
In accordance with ACA Section 1202, MassHealth raised its payment rates for primary care in January 2013. While primary care tends to be covered under Medicare for dual eligibles, this fee increase impacted the FFS Medicaid cross-over claim costs for primary care. MassHealth has opted to discontinue the ACA Section 1202 fee increases on January 1, 2015. Because a portion of the base data for RY15 included these increased payments, an adjustment was made to remove the impact of the fee increase from the professional line.

MassHealth Home Health Appeals:
The MassHealth historical base data include some home health service payments that have been subsequently appealed by MassHealth and billed to Medicare. Successful appeals are not adjusted in the MassHealth claims system due to the mechanism by which MassHealth processes such recoupments. Information on the amount recovered is captured on a cash basis rather than date of service basis and isn't specific to the target duals population. Annually, recoveries total approximately $2.4M to $3.8M for the entire dual-eligible population. Target duals represent about 40% of all duals (including partial duals), and staff involved in these recoveries anecdotally suspect

appeals for home health provided to duals with disabilities are less likely than appeals for home health provided to seniors, based on the nature of the services provided. Therefore, a reasonable estimate of Medicare home health included in the base data is approximately $1M annually. The $1M annual approximation was based on recovery dollars for the entire state (all 14 counties). To account for the removal of the five counties that are not included in one of the One Care plans service areas, the $1M annual figure was applied to the SFY2012 and SFY2013 base data for the entire state, and the adjustment was applied to the county-excluded base.

Personal Care Attendant (PCA) Overtime:
Based on information available at the time of rate development, MassHealth's actuary assumed that effective July 1, 2015, MassHealth would be considered a joint employer of PCAs for the purposes of the Fair Labor Standards Act (FLSA). Consistent with the FLSA, MassHealth would be required to cover eligible overtime pay for PCA services. MassHealth anticipated a 5.6% increase to PCA service costs related to this change for RY15. This figure was adjusted to reflect the mix of services in the HCBS/Home Health service category, by rating category.

Pharmacy Rebates:
The MassHealth One Care historical base data does not reflect potential Federal Omnibus Budget Reconciliation Act (OBRA) rebates. Potential OBRA rebates on non-Part D drugs comprise an estimated 4.3% of total pharmacy spending for the entire state. This rebate percentage is based on forecasts developed by MassHealth for all dual eligibles (including partial duals and waiver participants) in the state under the age of 65 during SFY2013. This percentage was then applied to the base data reflecting the excluded counties. In addition, MassHealth now has an agreement in place for supplemental rebates on diabetic test strips. MassHealth estimated that there is approximately $1.37M in potential rebates in SFY2012 and SFY2013 on diabetic test strips for the entire dual eligible population. This number was adjusted to reflect the target duals population and is expected to produce an extra 5.1% in pharmacy rebates for this population.

Medicare Improvements for Patients and Providers Act:
As of January 1, 2013, Medicare Part D began covering barbiturates (used in the treatment of epilepsy, cancer, or a chronic mental health disorder) and benzodiazepines. For the first 18 months of the SFY2012 and SFY2013 base period, these drugs were covered by MassHealth. Mercer reviewed historical pharmacy experience for these specific drugs and made a downward adjustment to reflect the shift of responsibility from Medicaid to Medicare Part D for payment for these medications.

Dental Benefit Changes:
The MassHealth dental benefit for adults was reduced effective July 2010. Effective January 1, 2013, MassHealth restored composite fillings for front teeth to the adult dental benefit. Effective March 1, 2014, MassHealth restored its adult dental benefit to include:

D2140 - AMALGAM ONE SURFACE, PRIMARY OR PERMANE
D2150 - AMALGAM TWO SURFACES, PRIMARY OR PERMAN
D2160 - AMALGAM THREE SURFACES, PRIMARY OR PERM

D2140 - AMALGAM ONE SURFACE, PRIMARY OR PERMANE
D2161 - AMALGAM FOUR OR MORE SURFACES PRIMARY O
D2332 - RESIN-THREE SURFACES
D2335 - RESIN - FOUR/MORE SURFACES INVOLVING IN
D2391 - RESIN-BASED COMPOSITE-ONE SURFACE, POST
D2392 - RESIN-BASED COMPOSITE SURFACES,POSTERIO
D2393 - RESIN-BASED COMPOSITE 3 OR MORE SURFACE
D2394 - RESIN-BASED COMPOSITE 4+ SURFACES, POST

Effective May 15, 2015, MassHealth restored its denture benefits to include:

D5110 – COMPLETE DENTURES (INCLUDING ROUTINE POST-DELIVERY CARE)
D5120 – COMPLETE DENTURES (INCLUDING ROUTINE POST-DELIVERY CARE)
D5211 – PARTIAL DENTURES (INCLUDING ANY CONVENTIONAL CLASPS, RESTS, AND TEETH)
D5212 - PARTIAL DENTURES (INCLUDING ANY CONVENTIONAL CLASPS, RESTS, AND TEETH)

The adjustments below have been applied to the All Other COS historical base data to reflect the net effect of these benefit changes.

Gender Reassignment Coverage:
In RY15, the Commonwealth will cover costs for services related to gender reassignment procedures for individuals with transgender/gender identity disorder. Prevalence rates were reviewed from studies related to gender reassignment, as well as potential cost of services for gender reassignment procedures. MassHealth is including the following small upward adjustments to the inpatient — non- MH/SA COS to cover the MassHealth costs associated with gender reassignment procedures.

Enrollee Contributions to Care:
The MassHealth historical base data reflect costs net of contributions to care or patient-paid amounts (PPA) paid by individuals in facilities. These costs have been included in rates through the adjustments displayed below, and enrollee contributions to care will be deducted from capitation payments on an individual enrollee basis. These adjustments are based on, and have been applied to, both Medicaid only and crossover claims.

Trend Factors Applied to Adjusted Historical Base Data:

The following trend factors have been applied for 36 months from the midpoint of the base period (July 1, 2012) to the midpoint of the contract period (July 1, 2015).

Medicaid Trends by Category of Service	C1	C2	C3	F1
Inpatient — Non-MH/SA	3.5%	3.5%	4.0%	3.5%
Inpatient MH/SA	4.5%	4.5%	5.5%	5.0%
Hospital Outpatient	3.5%	3.5%	3.0%	3.5%
Outpatient MH/SA	4.8%	4.3%	4.3%	4.8%
Professional	4.5%	4.5%	3.5%	3.5%
HCBS/Home Health	3.9%	4.4%	4.4%	4.4%
LTC Facility	2.9%	2.9%	2.9%	2.9%
Pharmacy (Non-Part D)	4.0%	4.0%	3.5%	3.0%
DME and Supplies	3.0%	3.0%	3.0%	2.0%
Transportation	4.5%	4.5%	4.5%	4.5%
All Other	4.5%	4.5%	4.5%	3.0%

Crossover Trends	C1	C2	C3	F1
All Services	4.5%	4.5%	3.0%	3.0%

Relational Modeling:

Prior to finalizing the medical component of the capitation rates, the projected PMPM values (after trend and program changes) were compared with the prior year's rates. Mercer used this information, along with base data from prior year's rates, to identify any unexpected changes at the region level. For some regions, there was only a limited amount of experience available, which can create rate volatility over time. To mitigate some of these unanticipated changes, adjustments were made to shift funds among regions without impacting the aggregate cost for the rating category overall. This relational modeling was used for the C1, C2, and F1 rating categories as shown below:

Region	C1	C2	C3	F1
Eastern	1.010	0.990	1.000	1.008
Western	1.005	0.991	1.000	0.980
The Cape	0.921	1.092	1.000	0.991

Medicaid Administrative Expenses:

An administrative adjustment of has been applied to the MassHealth component of the rate for 2015 to reflect the transfer of administrative costs from MassHealth to the One Care plans. The amount has been added to each county rate for each rating category.

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III. Medicare Components of the Rate – CY 2015

Medicare A/B Services

CMS has developed baseline spending (costs absent the Demonstration) for Medicare Parts A and B services using estimates of what Medicare would have spent on behalf of the enrollees absent the Demonstration. With the exception of specific subsets of enrollees as noted below, the Medicare baseline for A/B services is a blend of the Medicare Fee-for-Service (FFS) Standardized County Rates and the Medicare Advantage projected payment rates for each year, weighted by the proportion of the target population that would otherwise be enrolled in each program in the absence of the Demonstration. The Medicare Advantage baseline spending includes costs that would have occurred absent the Demonstration, such as quality bonus payments for applicable Medicare Advantage plans.

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

Medicare A/B Component Payments: CY 2015 Medicare A/B Baseline County rates are provided below. The rates represent the weighted average of the CY 2015 FFS Standardized County Rates, updated to incorporate the adjustments noted below, and the Medicare Advantage projected payment rates for CY 2015 based on the expected enrollment of beneficiaries from Medicare FFS and Medicare Advantage in CY 2015 at the county level. The rates weight the FFS and Medicare Advantage components at the same weighting as used to set 2014 rates. However, CMS has updated the Medicare Advantage component based on 2015 Medicare Advantage bids for products that serve (or would have served) potential Demonstration enrollees.

CMS has increased the FFS component of the CY 2015 Medicare A/B rate by 5% for One Care plans following execution of contract amendments in December 2015, and conditional upon continued participation in the demonstration through December 31, 2016, reflecting the unique circumstances in Massachusetts and the One Care demonstration. This adjustment will be applicable for all 12 months of CY 2015 and will largely occur through retroactive payment adjustments.

The Medicare A/B component of the rate includes the following adjustment:

- The FFS component of the CY 2015 Medicare A/B baseline rate has been updated to reflect a 1.71% upward adjustment to account for the disproportionate share of bad debt attributable to Medicare-Medicaid enrollees in Medicare FFS (in the absence of the Demonstration). This 1.71% adjustment applies for CY 2015 and will be updated for subsequent years of the Demonstration.

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The FFS component of the CY 2015 Medicare A/B baseline rates has been updated to fully incorporate the most current hospital wage index and physician geographic practice cost index. In contrast to One Care rate-setting for 2014, when CMS made an adjustment specific to One Care, these adjustments are fully included in the 2015 standardized FFS county rates. As such, no One Care-specific adjustment is necessary for 2015.

Coding Intensity Adjustment: CMS annually applies a coding intensity factor to Medicare Advantage risk scores to account for differences in diagnosis coding patterns between the Medicare Advantage and the Original Fee-for-Service Medicare programs. The adjustment for CY 2015 in Medicare Advantage is 5.16%. For CY 2014, based on the special enrollment processes for One Care, CMS established the FFS component of the Medicare A/B baseline in a manner that did not lead to lower amounts due to this coding intensity adjustment.

As described in the three-way contract, in CY 2015 CMS will apply a coding intensity adjustment based on the anticipated proportion of Demonstration enrollees in CY 2015 with prior Medicare Advantage experience and/or Demonstration experience based on the Demonstration's enrollment phase-in as of September 30, 2014. CMS' calculations take into account planned passive enrollment and rates of opt-out and engagement in the passive enrollment process. For One Care, the applicable 2015 coding intensity adjustment is 2.71%.

Operationally, due to systems limitations, CMS will still apply the full coding intensity adjustment factor to the risk scores but has increased the FFS component of the Medicare A/B baseline for non-ESRD beneficiaries and the Medicare A/B baseline for beneficiaries with an ESRD status of functioning graft to offset this (by increasing these amounts by a corresponding percentage). The coding intensity factor will not be applied to risk scores for enrollees with an ESRD status of dialysis or transplant during the Demonstration, consistent with Medicare Advantage policy.

After 2015, CMS plans to apply the full prevailing Medicare Advantage coding intensity adjustment.

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

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

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2015 Medicare A/B Baseline PMPM, Non-ESRD Beneficiaries, Standardized 1.0 Risk Score, by Demonstration County[1]						
County	**2015 Published FFS Standardized County Rate**[2]	**Update to FFS Standardized County Rate** (5% update)	**2015 Updated Medicare A/B FFS Baseline** (updated by CY 2015 bad debt adjustment)	**2015 Medicare A/B Baseline Preliminary** (increased to offset application of modified coding intensity adjustment factor in 2015)[3]	**2015 Updated Medicare A/B Baseline** (incorporating updated Medicare A/B FFS baseline and Medicare Advantage component)	**2015 Final Medicare A/B PMPM Payment** (2% sequestration reduction applied)
Essex	$818.45	$859.37	$874.07	$896.02	$895.44	$877.53
Franklin	700.39	735.41	747.99	766.77	766.89	751.55
Hampden	724.52	760.75	773.75	793.19	793.09	777.23
Hampshire	718.77	754.71	767.61	786.89	786.80	771.06
Middlesex	817.95	858.85	873.53	895.47	894.28	876.39
Norfolk	836.70	878.54	893.56	916.00	915.23	896.93
Plymouth	871.84	915.43	931.09	954.47	953.77	934.70
Suffolk	866.34	909.66	925.21	948.45	947.82	928.86
Worcester	800.62	840.65	855.03	876.50	875.52	858.01

[1] Rates do not apply to beneficiaries with End-Stage Renal Disease (ESRD) or those electing the Medicare hospice benefit. See Section IV for information on savings percentages.

[2] This is fully "repriced," and therefore this rate report does not show the repricing adjustments shown in the CY 2014 rate report.

[3] For CY 2015 CMS has calculated and applied a coding intensity adjustment (the modified CY 2015 coding intensity adjustment factor) proportional to the anticipated proportion of Demonstration Enrollees in CY 2015 with prior Medicare Advantage experience and/or Demonstration experience based on the Demonstration's enrollment phase-in as of September 30, 2014. Operationally, due to systems limitations, CMS will still apply the coding intensity adjustment factor to the risk scores but has increased the FFS component of the Medicare A/B baseline for non-ESRD beneficiaries to offset this. Specifically, CMS has increased the Medicare A/B baseline by a corresponding percentage; the CY 2015 Medicare FFS A/B Baseline is divided by [1(the standard CY 2015 coding intensity adjustment factor of 5.16% minus the Massachusetts-specific modified CY 2015 coding intensity adjustment factor of 2.71%)] to determine the CY 2015 Final Medicare FFS A/B Baseline.

The Medicare A/B PMPMs above will be risk adjusted at the beneficiary level using the existing CMS-HCC risk adjustment model.

There is a downward movement in the CY 2015 FFS standardized county rates compared to the CY 2014 FFS standardized county rates. However, this downward movement is partly offset by methodological changes CMS made to calculate risk adjustment normalization factors. This update in the methodology has an effect of increasing the risk scores. For more information on normalization factors, please refer to the Rate Announcement letter from April 07, 2014, located at: http://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2015.pdf

Beneficiaries with End-Stage Renal Disease (ESRD): Separate Medicare A/B baselines and risk adjustment apply to enrollees with ESRD. The Medicare A/B baselines for beneficiaries with ESRD vary by the enrollee's ESRD status: dialysis, transplant, and functioning graft, as follows:

- **Dialysis**: For enrollees in the dialysis status phase, the Medicare A/B baseline is the CY 2015 Massachusetts ESRD dialysis state rate, updated to incorporate the impact of sequestration-related rate reductions. The CY 2015 ESRD dialysis state rate for Massachusetts is $7,720.35 PMPM; the updated CY 2015 ESRD dialysis state rate incorporating a 2% sequestration reduction is $7,565.94 PMPM. This applies to applicable enrollees in all Demonstration counties and will be risk adjusted using the existing HCC-ESRD risk adjustment model.

- **Transplant**: For enrollees in the transplant status phase (inclusive of the 3-months post-transplant), the Medicare A/B baseline is be the CY 2015 Massachusetts ESRD dialysis state rate updated to incorporate the impact of sequestration-related rate reductions. The CY 2015 ESRD dialysis state rate for Massachusetts is $7,720.35 PMPM; the updated CY 2015 ESRD dialysis state rate incorporating a 2% sequestration reduction is $7,565.94 PMPM. This applies to applicable enrollees in all Demonstration counties and will be risk adjusted using the existing HCC-ESRD risk adjustment model.

- **Functioning Graft:** For enrollees in the functioning graft status phase (beginning at 4 months post-transplant) the Medicare A/B baseline is be the Medicare Advantage 3.5-star county rate/benchmark (see table below). This Medicare A/B component will be risk adjusted using the existing HCC-ESRD risk adjustment model.

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2015 Medicare A/B Baseline PMPM, Beneficiaries with ESRD Functioning Graft Status, Standardized 1.0 Risk Score, by Demonstration County			
County	**2015 3.5-Star County Rate (Benchmark)**	**2015 Final Medicare A/B PMPM Baseline** (increased to offset application of modified coding intensity adjustment factor in 2015)*	**2015 Sequestration-Adjusted Medicare A/B Baseline** (after application of 2% Sequestration reduction)
Essex	$828.91	$849.73	$832.74
Franklin	816.82	837.33	820.58
Hampden	803.28	823.46	806.99
Hampshire	797.83	817.87	801.51
Middlesex	834.04	854.99	837.89
Norfolk	849.99	871.34	853.91
Plymouth	870.66	892.52	874.67
Suffolk	894.62	917.08	898.74
Worcester	800.62	820.73	804.32

*For CY 2015 CMS has calculated and applied a coding intensity adjustment (the modified CY 2015 coding intensity adjustment factor) proportional to the anticipated proportion of Demonstration Enrollees in CY 2015 with prior Medicare Advantage experience and/or Demonstration experience based on the Demonstration's enrollment phase in as of September 30, 2014. Operationally, due to systems limitations, CMS will still apply the coding intensity adjustment factor to the risk scores but has increased the Medicare A/B baseline for beneficiaries with an ESRD status of functioning graft to offset this. Specifically, CMS has increased the Medicare A/B baseline by a corresponding percentage; as above, the CY 2015 Updated Medicare A/B Baseline is divided by [1-(the standard CY 2015 coding intensity adjustment factor of 5.16% minus the Massachusetts-specific CY 2015 modified coding intensity adjustment factor of 2.71%)) to determine the CY 2015 Final Medicare A/B Baseline. For beneficiaries with an ESRD status of functioning graft, the prospective payment will not include the adjustment to offset the application of coding intensity adjustment factor; this payment adjustment will be made on a retrospective basis.

Beneficiaries Electing the Medicare Hospice Benefit: If an enrollee elects to receive the Medicare hospice benefit, the enrollee will remain in the Demonstration but will obtain the hospice services through the Medicare FFS benefit. The One Care plan will no longer receive the Medicare A/B payment for that enrollee. Medicare hospice services and all other Original Medicare services will be paid under Medicare FFS. One Care plans and providers of hospice services will be required to coordinate these services with the rest of the enrollee's care, including with Medicaid and Part D benefits and any additional benefits offered by the One Care plans. One Care plans will continue to receive the Medicare Part D and Medicaid payments, for which no changes will occur.

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Medicare Part D Services

The Part D plan payment is be the risk adjusted Part D national average monthly bid amount (NAMBA) for the payment year, adjusted for payment reductions resulting from sequestration applied to the non-premium portion of the NAMBA. The non-premium portion is determined by subtracting the applicable regional Low-Income Premium Subsidy Amount from the risk adjusted NAMBA. To illustrate, the NAMBA for CY 2015 is $70.18 and the CY 2015 Low-Income Premium Subsidy Amount for Massachusetts is $29.65. Thus, the updated Massachusetts Part D monthly per member per month payment for a beneficiary with a 1.0 RxHCC risk score applicable for CY 2015 is $69.37. This amount incorporates a 2% sequestration reduction to the non-premium portion of the NAMBA.

CMS will pay an average monthly prospective payment amount for the low income cost-sharing subsidy and Federal reinsurance amounts; these payments will be 100% cost reconciled after the payment year has ended. These prospective payments will be the same for all counties and are shown below for January through September 2015:

- Massachusetts low income cost-sharing: $143.80 PMPM
- Massachusetts reinsurance: $70.93 PMPM

CMS updated the LICS and reinsurance PMPMs for October through December 2015 to reduce or eliminate the large settlements that are expected to occur when CY 2015 experience is reconciled. These amounts are CCA-specific and are shown below:

- Low-income cost-sharing: $345.48 PMPM
- Reinsurance: $1,220.81 PMPM

The low-income cost sharing and reinsurance subsidy amounts are exempt from mandatory payment reductions under sequestration.

A savings percentage will not be applied to the Part D component of the rate. Part D payments will not be subject to a quality withhold.

Additional Information*:* More information on the Medicare components of the rate under the Demonstration may be found online at: http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/JointRateSettingProcess.pdf

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IV. Savings Percentages and Quality Withholds

Savings Percentages

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

CMS and MassHealth established composite savings percentages for each year of the Demonstration, as shown in the table below. The savings percentage will be applied to the Medicaid and Medicare A/B components of the rates, uniformly to all population groups, unless otherwise noted in this report. The savings percentage will not be applied to the Part D component of the joint rate. These adjustments to the savings percentages were available to One Care plans through execution of contract amendments and are conditional upon continued participation in the demonstration through December 31, 2016.

Year	Calendar dates	Savings percentage
Demonstration Year 1	October 1, 2013 through March 31, 2014	0%
	April 1, 2014 through Dec 31, 2014	1%
Demonstration Year 2	Jan 1, 2015 through Dec 31, 2015	0%
Demonstration Year 3	Jan 1, 2016 through Dec 31, 2016	0%

The change in the savings percentage for Demonstration Year 2 from 0.5% to 0% will be reflected in a retroactive payment adjustment.

Quality Withhold

In Demonstration Year 1, a 1% quality withhold will be applied to the Medicaid and Medicare A/B components of the rate. The quality withhold will be 0% in Demonstration Year 2 and 1% in Demonstration Year 3. For Demonstration Year 2, the change in quality withhold from 2% to 0% will be reflected in a retroactive payment adjustment. These adjustments to the quality withhold were available to One Care plans through execution of contract amendments and are conditional upon continued participation in the demonstration through December 31, 2016.

More information about the quality withhold methodology is available at: http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/DY1QualityWithholdGuidance060614.pdf

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V. Risk Mitigation

The MOU established two additional mechanisms, High Cost Risk Pools (HCRP) and risk corridors, to mitigate risk in the event of disproportionate enrollment of high need individuals in some One Care plans or adverse enrollment selection across the Demonstration as a whole.

High Cost Risk Pools (HCRPs)

HCRPs were eliminated for CY2015. Any amounts withheld from the rates have been refunded to the Plans.

Risk Corridors

Risk corridors have been established for Demonstration Years 1, 2, and 3. The Demonstration will utilize a tiered One Care plan-level symmetrical risk corridor to include all Medicare A/B and Medicaid eligible service and non-service expenditures, rounded to the nearest one tenth of a percent. The risk corridors will be reconciled after application of any HCRP or risk adjustment methodologies (e.g. CMS-HCC), and as if One Care plans had received the full quality withhold payment.

For Demonstration Year 2, for the portion of losses or gains of greater than 10%, the One Care plan bears 100% of the risk. For the portion of losses or gains of greater than 3% and less than or equal to 10% the One Care plan bears 50% of the risk and MassHealth and CMS share in the other 50%. For the portion of losses or gains of less than or equal to 3%, the One Care plan bears 100% of the risk.

The Medicare and Medicaid contributions to risk corridor payments or recoupments will be in proportion to their contributions to the Medicare A/B and MassHealth components of the capitation rate.