Slide 1

One Care: MassHealth plus Medicare

Demonstration to Integrate Care for Dual Eligibles

Open Meeting

May 24, 2016, 10:00 AM – 2:00 PM

1 Ashburton Place, 21st Floor

Boston, MA

Slide 2

Agenda for Today

* Announcements
* Quality Data Performance Overview
	+ Quality Withhold Performance
	+ Consumer Assessment of Healthcare Providers and Systems Survey (CAHPS)
	+ Healthcare Effectiveness Data and Information Set (HEDIS)
	+ Grievance Reporting
* Financial Data
	+ Plan Financial Overview
	+ Per Member Per Month (PMPM) Spending

Slide 3

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](http://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.*

Slide 4

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](http://www.mass.gov/masshealth/duals)), on the COMMBUYS website ([www.commbuys.com](http://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

Slide 5

QUALITY DATA PERFORMANCE OVERVIEW

Slide 6

One Care’s Expected Outcomes

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

1) Improve quality:

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

2) Improve outcomes:

* Gains in health status and functional status
* Reduce the length and number of long-term care facility stays

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

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

Slide 7

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

1. Massachusetts Specific Measures:

State-specific measures that MassHealth and CMS agreed to include

1. 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

Slide 8

Content in this Presentation:

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

GOALS OF THE ONE CARE PROGRAM

Improved quality

CORRESPONDING DATA SOURCES INCLUDED IN THE PRESENTATION

CAHPS

Grievances

Quality Withhold Payments

GOALS OF THE ONE CARE PROGRAM

Improved outcomes

CORRESPONDING DATA SOURCES INCLUDED IN THE PRESENTATION

HEDIS

Slide 9

Data Sources, Measurement Periods, and Benchmarks

Demonstration Year 1 (DY1): October 2013 – December 2014

Demonstration Year 2 (DY2): January 2015 – December 2015

Data Source: CAHPS Survey

Measurement Period: July 2014 – December 2014, DY1 (Q4-Q5)

Benchmarks:

* National Medicare Advantage Plan Average
* National Medicare-Medicaid Plan (MMP) Average
* Massachusetts Medicare Advantage Plan Average (includes SCO plans)

Data Source: HEDIS Survey

Measurement Period: January 2014 – December 2014, DY1 (Q2-Q5)

Benchmarks:

* Medicaid Managed Care Plans
	+ Performance at the 75th percentile
	+ Performance at the 90th percentile

Data Source: Quality Withhold Measures

Measurement Period: October 2013 – December 2014, DY1 (Q1-Q5)

Benchmarks:

* One Care Plans
	+ Pass/Fail OR
	+ Highest performing plan minus 10 percentage points

Data Source: Grievance Reporting

Measurement Period: April 2015 – December 2015, DY2 (Q2-Q4)

Benchmarks:

One Care Plans

Data Source: Financials

Measurement Period: October 2013 – December 2015, DY1 (Q1-Q5) – DY2 (Q1-Q4)

Benchmarks:

DY1 vs. DY2

Slide 10

Quality Withhold Performance

Slide 11

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.

Slide 12

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.

Slide 13

Quality Withhold Measures: Individual Plan Performance: DY1

2013 WITHHOLD MEASURES

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

Core 2.1 Completed Assessments

Benchmark: 67.3%

CCA: 75.6%, highlighted in green

FTC: 77.3%, highlighted in green

Tufts: 68.4%, highlighted in green

Core 5.3 Consumer Advisory Board

Benchmark: 100% compliance

CCA: Pass, highlighted in green

FTC: Pass, highlighted in green

Tufts: Pass, highlighted in green

MA 5.1 ICO Centralized Enrollee Record

Benchmark: Timely reporting of required elements

CCA: Pass, highlighted in green

FTC: Pass, highlighted in green

Tufts: Pass, highlighted in green

2013 WITHHOLD MEASURES

# Measures Passed

CCA: 3 out of 3

FTC: 3 out of 3

Tufts: 3 out of 3

2014 WITHHOLD MEASURES

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

Core 2.1 Completed Assessments

Benchmark: 78.2%

CCA: 64.4%, highlighted in yellow

FTC: 45.3%, highlighted in yellow

Tufts: 88.2%, highlighted in green

Core 5.3 Consumer Advisory Board

Benchmark: 100% compliance

CCA: Pass, highlighted in green

FTC: Pass, highlighted in green

Tufts: Pass, highlighted in green

MA 5.1 Centralized Enrollee Record

Benchmark: 71.7%

CCA: 59.2%, highlighted in yellow

FTC: 81.7%, highlighted in green

Tufts: 81.7%, highlighted in yellow

Encounter Data

Benchmark: Successful submission

CCA: Pass, highlighted in green

FTC: Pass, highlighted in green

Tufts: Pass, highlighted in green

MA 1.2 Documented Discussion of care goals

Benchmark: 90.0%

CCA: 90.0%, highlighted in green

FTC: 100.0%, highlighted in green

Tufts: 91.9%, highlighted in green

MA 1.3 Access to LTS Coordinators

Benchmark: 90.0%

CCA: 69.9%, highlighted in yellow

FTC: 100.0%, highlighted in green

Tufts: 81.2%, highlighted in yellow

2014 WITHHOLD MEASURES

# Measures Passed

CCA: 3 out of 6

FTC: 5 out of 6

Tufts: 4 out of 6

Slide 14

Quality Withhold Measures:

Individual Plan Performance and MassHealth Payment: DY1

2013 WITHHOLD MEASURES

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.

2013 WITHHOLD MEASURES

CCA

Measures Passed: 3 out of 3, highlighted in green

MassHealth Quality Withhold Amount: $60, 029

% Earned Withhold: 100%, highlighted in green

Earned MassHealth Quality Payment: $60, 029

FTC

Measures Passed: 3 out of 3, highlighted in green

MassHealth Quality Withhold Amount: $7,359

% Earned Withhold: 100%, highlighted in green

Earned MassHealth Quality Payment: $7,359

Tufts

Measures Passed: 3 out of 3, highlighted in green

MassHealth Quality Withhold Amount: $5,908

% Earned Withhold: 100%, highlighted in green

Earned MassHealth Quality Payment: $5,908

Total One Care Plans

MassHealth Quality Withhold Amount: $73,296

Earned MassHealth Quality Payment: $73,296

2014 WITHHOLD MEASURES

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.

2014 WITHHOLD MEASURES

CCA

Measures Passed: 3 out of 6, highlighted in yellow

MassHealth Quality Withhold Amount: $863,766

% Earned Withhold: 50%, highlighted in yellow

Earned MassHealth Quality Payment: $431,883

FTC

Measures Passed: 5 out of 6, highlighted in green

MassHealth Quality Withhold Amount: $317,903

% Earned Withhold: 100%, highlighted in green

Earned MassHealth Quality Payment: $317,903

Tufts

Measures Passed: 4 out of 6, highlighted in yellow

MassHealth Quality Withhold Amount: $79,949

% Earned Withhold: 75%, highlighted in yellow

Earned MassHealth Quality Payment: $59,962

Total One Care Plans

MassHealth Quality Withhold Amount: $1,261,618

Earned MassHealth Quality Payment: $809,748, highlighted in yellow

Slide 15

CCA’s Response to Quality Withhold Performance

Measure: Completed Assessments

Successes, Challenges and Interventions: 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.

Measure: Consumer Advisory Board

Successes, Challenges and Interventions: 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.

Measure: Centralized Enrollee Record

Successes, Challenges and Interventions: 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.

Measure: Documented Care Goals

Successes, Challenges and Interventions: 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.

Measure: Access to LTS Coordinators

Successes, Challenges and Interventions: 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.

Slide 16

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.

Slide 17

Consumer Assessment of Healthcare Providers and Systems Survey (CAHPS)

Slide 18

CAHPS Summary

* The CAHPS surveys are designed to capture accurate and reliable information from consumers about their experiences with health care.
	+ The Medicare CAHPS Survey, which has been conducted annually since 1998, is part of a group of surveys developed by a group of researchers under an agreement between CMS and the Agency for Healthcare Research and Quality (AHRQ) – researchers include:
	+ American Institutes for Research
	+ Harvard Medical School
	+ the RAND Corporation
	+ RTI International
	+ These research groups are under a cooperative agreement between CMS and the Agency for Healthcare Research and Quality (AHRQ) a component of the U.S. Public Health Service
	+ The following data shows results from the 2015 CAHPS Survey of Medicare Advantage Prescription Drug (MA-PD) plans (which includes demonstration programs)
* The surveys include a core set of questions, with some questions grouped to form composites, or summary results, of key areas of care and service.
* Scores in the presentation were converted from the CMS case-mix adjusted mean, to illustrate a 0-100 score. The Case-Mix adjusted mean is intended to illustrate overall performance on a 1-4 scale (1 being the worse and 4 being the best).

Benchmarks:

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

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

Survey Specifics

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

Slide 19

Getting Needed Care Composite

The Getting Needed Care Composite includes the questions below:

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

Chart indicating benchmarks and performance of plans on the Getting Needed Care Composite Measure

* CCA: 86%
* Massachusetts Medicare Advantage Average:85%
* Tufts: 84%
* National Medicare Advantage Average: 84%
* FTC: 81%
* National MMP Average:78%

Slide 20

Care Coordination Composite

*The Care Coordination Composite Consists of the following 6 Questions*

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

Chart indicating benchmarks and performance of plans on the Care Coordination Composite

CCA: 89%

Massachusetts Medicare Advantage Average: 88%

Tufts: 88%

National Medicare Advantage Average:86%

FTC: 85%

National MMP Average:85%

Slide 21

Customer Service Composite

*The Customer Service Composite consists of the following questions:*

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

Chart indicating benchmarks and performance of plans on the Care Coordination Composite

CCA: 89%

Tufts: 88%

Massachusetts Medicare Advantage Average: 88%

FTC: 85%

National MMP Average: 83%

National Medicare Advantage Average:83%

Slide 22

Getting Appointments and Care Quickly Composite

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

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

Bar chart indicating benchmarks and performance of plans on the Getting Appointments and Quickly Composite in descending order:

* CCA: 81%
* Massachusetts Medicare Advantage Average: 79%
* Tufts: 77%
* National Medicare Advantage Average: 76%
* FTC: 74%
* National MMP: Average: 71%

Slide 23

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?

Bar chart indicating benchmarks and performance of plans on the Getting Appointments and Quickly Composite in descending order. Note: Information for TUFTS and FTC is not included in this graphic as their response rate for this question was too small

* CCA: 93%
* Massachusetts Medicare Advantage Average: 91%
* National Medicare Advantage Average: 91%
* National MMP: Average: 90%

Slide 24

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.

Slide 25

Tuft’s 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.

Slide 26

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

Slide 27

Healthcare Effectiveness Data and Information Set (HEDIS)

Slide 28

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](http://www.ncqa.org/HEDISQualityMeasurement/QualityMeasurementProducts/QualityCompass.aspx), 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

Slide 29

Adults’ Access to Preventative/Ambulatory Health Services

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

Bar chart indicating benchmarks and performance of plans on Adults’ Access to Preventative/Ambulatory Health Services in descending order:

* CCA: 97%
* Tufts: 96%
* FTC: 93%
* Medicaid 90th Percentile: 89%
* Medicaid 75th Percentile: 87%

Data from Calendar Year 2014 (DY1)

Slide 30

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

Bar chart indicating benchmarks and performance of plans on Identification of Alcohol and Other Drug Services in descending order:

* Tufts: 32%
* FTC: 29%
* CCA: 28%
* Medicaid 90th Percentile: 11%
* Medicaid 75th Percentile: 6%

Data from Calendar Year 2014 (DY1)

Slide 31

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

Bar chart indicating benchmarks and performance of plans on Identification of Behavioral Health Service Utilization in descending order:

* Tufts: 76%
* FTC: 76%
* CCA: 47%
* Medicaid 90th Percentile: 21%
* Medicaid 75th Percentile: 15%

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

Slide 32

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

Bar chart titled: 30 Day, indicating benchmarks and performance of plans on follow-ups after hospitalization for mental illness within 30 days, in descending order:

* Medicaid 90th Percentile: 80%
* FTC: 79%
* Tufts: 78%
* Medicaid 75th Percentile: 75%
* CCA: 55%

Bar chart titled: 7 Day, indicating benchmarks and performance of plans on follow-ups after hospitalization for mental illness within 7 days, in descending order:

* Medicaid 90th Percentile: 64%
* Tufts: 59%
* Medicaid 75th Percentile: 57%
* FTC: 54%
* CCA: 31%

Data from Calendar Year 2014 (DY1)

Slide 33

Average Length of Stay General Hospital/Acute Care

* This measure illustrates the average acute inpatient length of stay (LOS) for the following categories:
	+ Total inpatient
	+ Maternity
	+ Surgery
	+ Medicine
* All 3 plans performed above the 75th percentile, illustrating a strong performance

Bar chart indicating benchmarks and performance of plans on Average Length of Stay General Hospital/Acute Care in descending order:

* FTC: 5.19
* CCA: 5.01
* Medicaid 90th Percentile: 4.91
* Tufts: 4.58
* Medicaid 75th Percentile: 4.37

Data from Calendar Year 2014 (DY1)

Slide 34

CCA’s Response to HEDIS Data

Table with measures in first column and success, challenges and interventions in the second column

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

Slide 35

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

Slide 36

Grievance Reporting

Slide 37

Definitions and Grievance Intake Process

* Grievance Definition: *Complaint surrounding any services provided by the health plan*
* A graphic depicts the current grievance reporting process and includes the following information:
	+ A Member or Authorized rep has the ability to enter grievance
	+ The following are avenues to enter a grievance:
		- Enter by contacting CMS directly
		- Enter by contacting MassHealth Directly
		- Enter by contacting Ombudsman
		- Enter by contacting the plan
	+ If CMS or MassHealth are contacted directly, then the grievance is processed by CMS or MassHealth staff who 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
	+ If the Ombudsman is contacted directly, the grievance is processed by the Ombudsman who 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
	+ If the Plan is contacted directly, the grievance is processed by the plan which will enter information into their operating system, and resolve issue.

Slide 38

Grievance Categories

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

CATEGORY: BP: Dental

DESCRIPTION: Dissatisfaction with dental services / plan dental restrictions

EXAMPLE: Upset dental implant was not approved

CATEGORY: BP: Part C, Medicaid, Supplemental

DESCRIPTION: Dissatisfaction with dental services / plan dental restrictions

EXAMPLE: Upset PCA services not approved

CATEGORY: BP: Part D

DESCRIPTION: Dissatisfaction with the plans covered prescription drugs

EXAMPLE: Upset brand name drugs not approved

CATEGORY: Enrollment

DESCRIPTION: Dissatisfaction with the enrollment broker

EXAMPLE: Self-selected and placed in wrong plan

CATEGORY: MassHealth

DESCRIPTION: Dissatisfaction with MassHealth

EXAMPLE: Incorrectly dis-enrolled from One Care

CATEGORY: Medicare

DESCRIPTION: Dissatisfaction with services provided by Medicare

EXAMPLE: Received incorrect information from Medicare

CATEGORY: Network/Access

DESCRIPTION: Dissatisfaction surrounding provider access/ availability

EXAMPLE: Preferred provider not in network

CATEGORY: Other

DESCRIPTION: Any grievance that does not fit into one of the pre-existing categories

EXAMPLE: No example

CATEGORY: Plan Management

DESCRIPTION: Dissatisfaction with the plan oversight

EXAMPLE: Care Coordinator is unresponsive

CATEGORY: Plan Marketing Materials

DESCRIPTION: Dissatisfaction with marketing materials received from the plan

EXAMPLE: Too many materials sent

CATEGORY: Provider

DESCRIPTION: Dissatisfaction with a provider

EXAMPLE: Rude office manager at specialist’s office

CATEGORY: Quality of Care

DESCRIPTION: Dissatisfaction with the quality of care received

EXAMPLE: Provided incorrect medication

CATEGORY: Transportation

DESCRIPTION: Dissatisfaction with transportation services provided

EXAMPLE: Transportation no-shows/late arrivals

Slide 39

Plotted point line graph labeled “April 2015 - December 2015 Percentage of Plan Membership with Grievances”

Graph plots points showing the relative percent of plan members for CCA and Tufts that filed grievances from April 2015 to December 2015 CCA’s plotted point line is in blue and Tuft’s line is in yellow. The blue line representing CCA begins at 2.21% dips slightly through June 2015, then rises slowly to 3.04% in October 2015, and then falls more sharply through December 2015 to 1.77%. The yellow line representing Tufts begins at .81% in April and then jumps up and down each month through October 2015 at 3.04%, when it gradually slopes down through December 2015 and ends at 1.77%.

The data from the plotted line chart is included below:

April 2015

For CCA 227 grievances were filed, totaling 2.21% of membership

For Tufts 15 grievances were filed, totaling 0.81% of membership

May 2015

For CCA 206 grievances were filed, totaling 1.99% of membership

For Tufts 9 grievances were filed, totaling 0.49% of membership

June 2015

For CCA 170 grievances were filed, totaling 1.63% of membership

For Tufts 29 grievances were filed, totaling 1.61% of membership

July 2015

For CCA 224 grievances were filed, totaling 2.13% of membership

For Tufts 18 grievances were filed, totaling 1.02% of membership

August 2015

For CCA 266 grievances were filed, totaling 2.49% of membership

For Tufts 41 grievances were filed, totaling 2.34% of membership

September 2015

For CCA 281 grievances were filed, totaling 2.64% of membership

For Tufts 26 grievances were filed, totaling 1.42% of membership

October 2015

For CCA 322 grievances were filed, totaling 3.04% of membership

For Tufts 37 grievances were filed, totaling 1.79% of membership

November 2015

For CCA 262 grievances were filed, totaling 2.54% of membership

For Tufts 32 grievances were filed, totaling 1.56% of membership

December 2015

For CCA 181 grievances were filed, totaling 1.77% of membership

For Tufts 9 grievances were filed, totaling 0.49% of membership

Slide 40

Graph titled “April 2015 – December 2015 Grievances Percentage of Total Grievances by Category”

A bar graph shows the percent of grievances in each grievance category for CCA, whose bars are in blue, and Tufts, whose bars are in yellow. There is a red line at 15% of grievances labeled “examine categories exceeding 15% threshold.” The data points for grievances categories that exceed the 15% threshold are highlighted on the chart and include the categories of Transportation for CCA (81%) and Tufts (50%) and Network for Tufts (16%).

Chart has a note which states “*Data includes only grievances Q2 2015-Q4 2015. Grievance data collected prior to this period was not assigned to categories”*

Transportation

CCA 81% of grievances

Tufts 50% of grievances

Quality of care

CCA 3.51% of grievances

Tufts 2.16% of grievances

Provider

CCA 4.39% of grievances

Tufts 3.45% of grievances

Plan Marketing Materials

CCA 0% of grievances

Tufts 0.43% of grievances

Plan Management

CCA 8.27% of grievances

Tufts 9.48% of grievances

Other

CCA 0.79% of grievances

Tufts 10.78% of grievances

Network

CCA 0.65% of grievances

Tufts 15.95% of grievances, the chart rounds this value to 16% of grievances

Medicare

CCA 0% of grievances

Tufts 0% of grievances

MassHealth

CCA 0.05% of grievances

Tufts 0% of grievances

Enrollment

CCA 0% of grievances

Tufts 0.43% of grievances

BP: Part D

CCA 0.28% of grievances

Tufts 2.59% of grievances

BP: Part C, Medicaid, and Supplemental

CCA 0.23% of grievances

Tufts 1.72% of grievances

BP: Dental

CCA 0.56% of grievances

Tufts 2.59% of grievances

Slide 41

Plotted point line graph labeled “April 2015 – December 2015 Percentage of Plan Membership with Transportation Grievances”

Graph plots points showing the relative percent of plan members for CCA and Tufts that filed transportation grievances from April 2015 to December 2015 CCA’s plotted point line is in blue and Tuft’s line is in yellow. The line representing CCA begins in April 2015 at 1.79% and dips slightly to 1.32% in June 2015, rises gradually to 2.48% in October 2015 and then dips to 1.59% in December 2015. The line representing Tufts begins at .59% in April 15, dips to .22% in May 2015, then rises and then remains relatively stagnant between June 2015 at .67% and December 2015 at .68%,

Chart describing each plotted point on the graph

April 2015

For CCA 184 grievances were filed, totaling 1.79% of membership

For Tufts 11 grievances were filed, totaling 0.59% of membership

May 2015

For CCA 159 grievances were filed, totaling 1.54% of membership

For Tufts 5 grievances were filed, totaling 0.22% of membership

June 2015

For CCA 138 grievances were filed, totaling 1.32% of membership

For Tufts 12 grievances were filed, totaling 0.67% of membership

July 2015

For CCA 173 grievances were filed, totaling 1.64% of membership

For Tufts 10 grievances were filed, totaling 0.57% of membership

August 2015

For CCA 209 grievances were filed, totaling 1.96% of membership

For Tufts 17 grievances were filed, totaling 0.97% of membership

September 2015

For CCA 227 grievances were filed, totaling 2.13% of membership

For Tufts 15 grievances were filed, totaling 0.82% of membership

October 2015

For CCA 263 grievances were filed, totaling 2.48% of membership

For Tufts 19 grievances were filed, totaling 0.92% of membership

November 2015

For CCA 223 grievances were filed, totaling 2.16% of membership

For Tufts 15 grievances were filed, totaling 0.73% of membership

December 2015

For CCA 162 grievances were filed, totaling 1.59% of membership

For Tufts 14 grievances were filed, totaling 0.68% of membership

Slide 42

Plotted point line graph labeled “April 2015 – December 2015 Percentage of Plan Membership with Network Grievances”

Graph plots points showing the relative percent of plan members for CCA and Tufts that filed network grievances from April 2015 to December 2015 CCA’s plotted point line is in blue and Tuft’s line is in yellow. The line representing CCA is stays low and flat with grievances fluctuating between 0 and 5. The line representing Tufts is also low and flat with a slight increase in August 2015 to 5 and in October 2015 to 11, the number grievances lowered slightly in November and December to 9 and 7 resprectively.

Chart describing each plotted point on the graph

April 2015

For CCA 0 grievances were filed, totaling 0% of membership

For Tufts 0 grievances were filed, totaling 0% of membership

May 2015

For CCA 2 grievances were filed, totaling 0.02% of membership

For Tufts 1 grievances were filed, totaling 0.05% of membership

June 2015

For CCA 2 grievances were filed, totaling 0.02% of membership

For Tufts 0 grievances were filed, totaling 0% of membership

July 2015

For CCA 1 grievances were filed, totaling 0.01% of membership

For Tufts 0 grievances were filed, totaling 0% of membership

August 2015

For CCA 5 grievances were filed, totaling 0.05% of membership

For Tufts 5 grievances were filed, totaling 0.29% of membership

September 2015

For CCA 0 grievances were filed, totaling 0% of membership

For Tufts 4 grievances were filed, totaling 0.22% of membership

October 2015

For CCA 3 grievances were filed, totaling 0.03% of membership

For Tufts 11 grievances were filed, totaling 0.53% of membership

November 2015

For CCA 0 grievances were filed, totaling 0% of membership

For Tufts 9 grievances were filed, totaling 0.44% of membership

December 2015

For CCA 1 grievances were filed, totaling 0.01% of membership

For Tufts 7 grievances were filed, totaling 0.34% of membership

Slide 43

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

Slide 44

CCA’S Response to Transportation 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

Slide 45

Tufts’ Response to Network and Transportation 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.

Slide 46

Financial Data

Slide 47

Plan Financials

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

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

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

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

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

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

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

Slide 48

PMPM Service Spending by Plan and Rating Category

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

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

*Notes: PMPMs reflect claims as reported by the plans as of a certain date; incorporating additional claims will change these numbers.*

*For DY2, FTC reported information through program exit (2015 Q1 – Q3) with claims through 10/31/15; CCA and Tufts information reflects full Demo*

*Year with claims through 1/31/16*

Slide 49

CCA – PMPM

Pie Chart Titled: DY1 Avg. PMPM: $2,205

* IBNR: 2%
* Inpatient Acute: 14%
* Inpatient Mental Health/Substance Abuse: 5%
* Long Term Care Facility: 1%
* Outpatient/Professional: 21%
* Outpatient – Mental Health/Substance Abuse: 6%
* Pharmacy: 27%
* Transportation: 3%
* Community Long-Term Services and Supports: 16%
* All Other: 5%

Pie Chart Titled: DY2 Avg. PMPM: $2,641

* IBNR: 4%
* Inpatient Acute: 14%
* Inpatient Mental Health/Substance Abuse: 4%
* Long Term Care Facility: 1%
* Outpatient/Professional: 19%
* Outpatient – Mental Health/Substance Abuse: 5%
* Pharmacy: 28%
* Transportation: 4%
* Community Long-Term Services and Supports: 14%
* All Other: 6%

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

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

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

Slide 50

Tufts – PMPM Service Spend

Pie Chart Titled: DY1 Avg. PMPM: $1,504

* IBNR: 1%
* Inpatient Acute: 22%
* Inpatient Mental Health/Substance Abuse: 5%
* Long Term Care Facility: 2%
* Outpatient/Professional: 19%
* Outpatient – Mental Health/Substance Abuse: 5%
* Pharmacy: 28%
* Transportation: 3%
* Community Long-Term Services and Supports: 10%
* All Other: 6%

Pie Chart Titled: DY2 Avg. PMPM: $1,940

* IBNR: 7%
* Inpatient Acute: 17%
* Inpatient Mental Health/Substance Abuse: 5%
* Long Term Care Facility: 1%
* Outpatient/Professional: 17%
* Outpatient – Mental Health/Substance Abuse: 4%
* Pharmacy: 29%
* Transportation: 3%
* Community Long-Term Services and Supports: 12%
* All Other: 4%

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Member Months | DY1 |  | DY2 |  |
| C1 | 6,689 | 41% | 6,875 | 30% |
| C2A | 6,342 | 39% | 9,306 | 41% |
| C2B | 1,346 | 8% | 2,972 | 13% |
| C3A | 1,791 | 11% | 3,637 | 16% |
| C3B | 43 | 0% | 50 | 0% |
| F1 | 7 | 0% | 28 | 0% |
| Total | 16,218 | 100% | 22,868 | 100% |

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

*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.*

Slide 51

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

Note: In the chart below, percentages 20% or higher than comparison group are marked with an asterisk (\*) and percentages 20% lower than the comparison group are marked with a carrot (^)

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| %Member Months | DY1 |  |  | DY2 |  |  |
|  | CCA | Tufts | Eligible Population | CCA | Tufts | Eligible Population |
| C1 | 52.4% | 41.2%^ | 65.1%\* | 34.4%^ | 30.1%^ | 67.6%\* |
| C2A | 19.3% | 39.1%\* | 16.8%^ | 22.4% | 40.7%\* | 14.1%^ |
| C2B | 3.2% | 8.3% | 3.1% | 4.2% | 13.0% | 3.5% |
| C3A | 23.6% | 11% | 13.0% | 37.4%\* | 15.9% | 13.0%^ |
| C3B | 1.3% | 0.3% | .7% | 1.3% | .2% | .7% |
| F1 | .2% | 0.0% | 1.3% | .2% | .1% | 1.1% |
| Total | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |

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

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

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

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

Slide 52

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

* On average, **Pharmacy** Per Member Per Month (PMPM) spending across all rating categories (RCs) increased
	+ - 10%+ increase across all RCs for members in CCA
		- 40%+ increase for C1, C3A, and F1 members in Tufts
* **Inpatient Acute Hospital** PMPM spending
	+ - Reduction for C2A and C3A members across both plans (ranging from 3-29%)
		- 20-30% increase for C1 members across both plans
* **Inpatient Mental Health/Substance Abuse** PMPM spending
	+ - 34-50% decrease for C2A and C2B members in CCA
		- 1% decrease for C2A and 32% increase for C2B members in Tufts
* **Community Long-Term Services and Supports (LTSS)** PMPM spending
	+ - Reduction across all RCs for CCA members:
			* May be explained by shift to more complex RCs (e.g., C1 member at high-end of C1 cost range that moves to C3A could be at the low end of C3A cost range, lowering both average PMPMs)
		- 64% increase for C1, and decreases for C2B and C3B members in Tufts
* Proportionate spending and comparisons between years in all service areas could change as IBNR for DY2 comes down over time

*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.*

Slide 53

Discussion

Slide 54

Visit us at: [www.mass.gov/masshealth/onecare](http://www.mass.gov/masshealth/onecare)

Email us at: OneCare@state.ma.us