HEALTH MANAGEMENT ASSOCIATES

Unpacking the One Care Procurement Databook:

Key Observations to Strengthen the One Care Program and to Advance Health Equity for Persons Eligible for the Program

Health Management Associates, July 16, 2019

Ellen Breslin, *Principal*
Eric Hammelman, *Principal*
Anissa Lambertino, *Senior Consultant*

Webinar Agenda

TIMER: to present for 50 minutes and to take questions for 10 minutes.

- Webinar Purpose
- The One Care Program
- The One Care Databook: Inpatient, Emergency Department, Long-Term Services and Supports (LTSS)
- A Strong One Care Program
- Geospatial Maps
- Medicare Part D Scripts
- Questions
- **RESOURCE SECTION: Available upon request.**

The Purpose of the Webinar

The purpose of this webinar is to unpack the contents of the MassHealth One Care Databook. In this webinar, we will share our key observations to strengthen the One Care program and to advance health equity for One Care enrollees.

- MassHealth released the One Care databook to provide information about the One Care "Target Population" in support of the procurement of the One Care program (May 2019).

- The **One Care Target Population** ("target population") provides data about individuals who are eligible for the One Care program but are not currently enrolled in the program. The target population is 21-64 years of age and are simultaneously enrolled in MassHealth and Medicare. The target population receives their services on a fee-for-service basis.

- The **One Care Databook** (the "databook") contains demographic, cost and utilization data for Calendar Years 2016 and 2017 (CY2016 and CY2017). drawing from several sources of data. The databook contains historical base fee-for-service data, unadjusted. The target population has been assigned to rating categories (or risk categories) using the base data as a proxy for risk; this assignment does not consider assessment data. The assessment data is important, however. Assessments may/will change the assignments to rating categories.

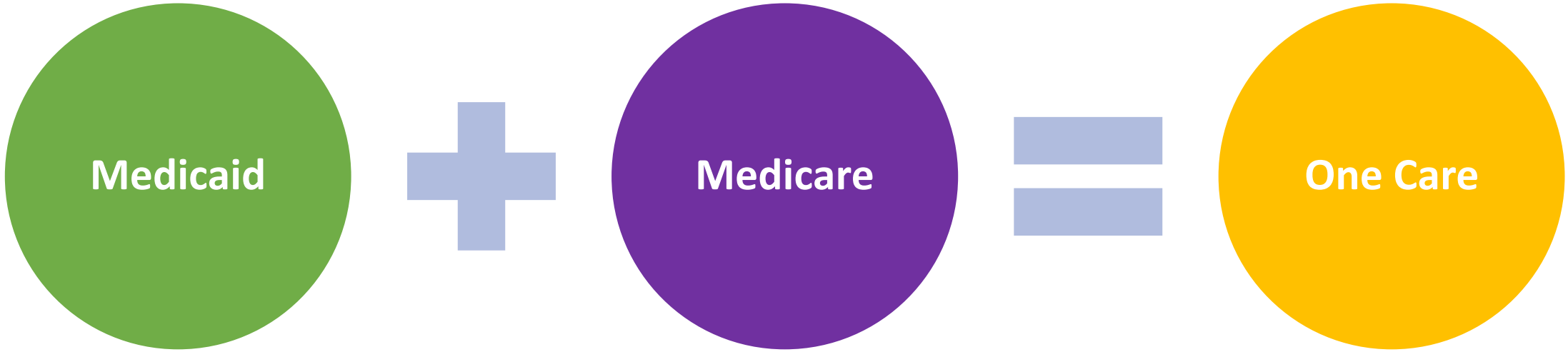
- **The data presented does not reflect adjustments to the data during the capitation rate development process.**

The One Care Program

The Massachusetts One Care program, which went out to bid this year, is an 1115A Duals Demonstration (both a Financial Alignment Demonstration and a state demonstration) for dually eligible Medicare and Medicaid beneficiaries age 21-64 at the time of enrollment and living with disabilities. To assist potential bidders, the state released a Databook containing historical demographic, cost and utilization information for individuals who are eligible for One Care but not currently enrolled.

The One Care Program

- MassHealth and the Centers for Medicare and Medicaid Services (CMS) each contribute to the global capitation payment.
- MassHealth and CMS each make monthly payments to One Care plans for their components of the capitated rate.
  - MassHealth makes a monthly payment for each enrollee reflecting coverage of Medicaid services.
  - CMS makes two monthly payments for each enrollee: one amount from CMS reflecting coverage of Medicare Parts A/B services and one amount from CMS reflecting coverage of Medicare Part D services.



One Care in Context

- MassHealth
  - 1.8 million persons and $16 billion (MassHealth spending only)
  - MassHealth programs: managed care, integrated care, and fee-for-service program
  - Delivery System Reform Incentive Payment (DSRIP) program started in 2018
  - New entities: Accountable care organizations (ACOs) and Community Partners (CPs)
  - Third Party Administrator (TPA) for Long-Term Services and Supports (LTSS)

- Integrated programs
  - One Care Program. Senior Care Options (SCO), and Program of All-Inclusive Care for the Elderly (PACE)
  - Two One Care plans today

- EOHHS vision
  - Expand integrated care programs (One Care and SCO)
  - Redesign the Behavioral Health (BH) system

The One Care Databook

Data for the One Care Target Population

The databook defines the target population as those who are eligible for the One Care program but are not enrolled in the One Care Program.

- Who is eligible for the One Care program?
  - **Age 21-64**
  - Had Medicare Part A and Part B Coverage
  - Did not have other comprehensive insurance
  - Was not enrolled in Medicare Advantage and/or Medicare managed care

- Excluded:
  - Individuals enrolled in any Massachusetts Home-and-Community-based Services (HCBS) Waiver programs
  - Individuals utilizing intermediate care facilities for individuals with intellectual disabilities

The One Care Databook: Data Sources

MassHealth and Centers for Medicare and Medicaid Services (CMS):
Data for the Target Population (Not Currently Enrolled in the One Care Program)

One Care Plans: Data for One Care Enrollees

MEDICAID FFS DATA

(1) Medicaid and (2) Medicare-Medicaid crossover fee-for-service (FFS) data

Data collected directly from EOHHS's Medicaid Management Information System (MMIS) for the January through December 2016 (CY2016) and January through December 2017 (CY2017) time periods, including all claims paid through April 9, 2018, for the actuarially equivalent target population.

MEDICARE PART A AND PART B FFS DATA

Medicare Part A and Part B FFS data received from CMS's Medicare-Medicaid Coordination Office via the State Data Resource Center (SDRC) process for the CY2016 and CY2017 time periods, including all claims paid through August 3, 2018, for the actuarially equivalent target population.

MEDICARE PART D PRESCRIPTION DRUG EVENT (PDE) DATA

Medicare Part D PDE utilization data collected via the SDRC process for the CY2016 and CY2017 time periods for the actuarially equivalent target population.

DEMOGRAPHIC

Demographic information was obtained from MMIS eligibility records for the CY2016 and CY2017 time periods for the actuarially equivalent target population. For purposes of this databook, member months represent MMIS Eligibility months, which may contain partial months.

ONE CARE PLAN EXPERIENCE

CY 2017 financial information summarized for the two One Care plans for the enrolled population

The Basic Facts – Getting Your Bearings

- In Calendar Year 2017 (CY 2017), the One Care Target Population stood around **109,375**, defined as MassHealth members between the ages of 21 and 64 and covered under Medicare and MassHealth, otherwise known as the dually eligible population

- Total MassHealth and Medicare A/B spending on the target population totaled **$2.3 billion** in CY 2017. This excludes Medicare Part D spending

    - Spending on Inpatient and Long-Term Care and Skilled Nursing Facilities account for about **40 percent** of total MassHealth + Medicare A/B spending
    - Spending on Medicaid-funded Community Long-Term Services and Supports (LTSS) accounts for about **20 percent** of total MassHealth + Medicare A/B spending
    - Spending on all LTSS accounts for about **30 percent** of total MassHealth and Medicare A/B spending

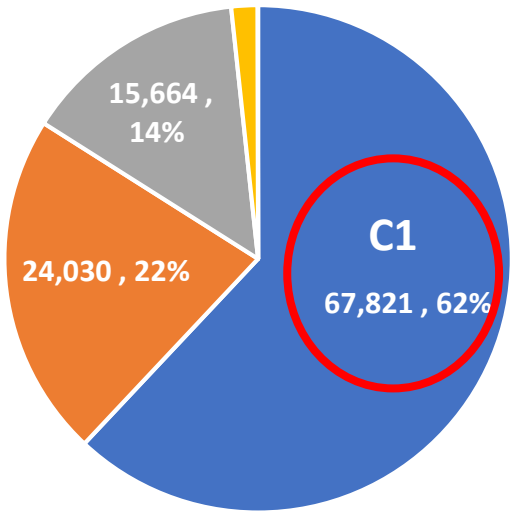
- **High use of Inpatient and Emergency Department** by One Care enrollees: very high use among persons with high Behavioral Health needs (risk stratified into Rating Category C2)

- Part D spending is excluded from this presentation; however, the use of Part D scripts is described in this presentation

One Care Target Population by Rating Category

Target Population
109,375 Members

CY 2017 Members by Rating Category
(Member Months/12)



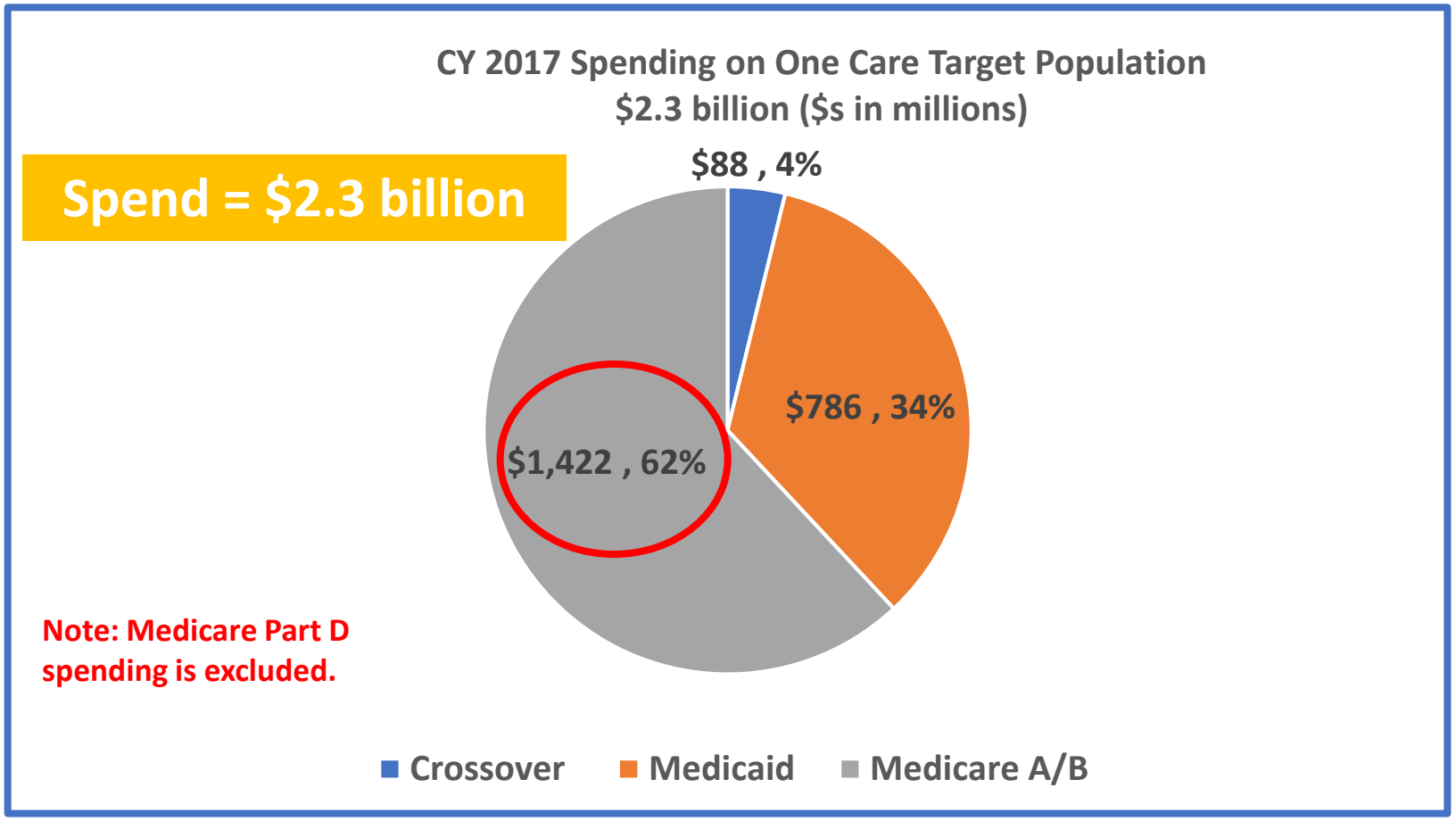
Target Population

- This pie shows the distribution of persons with Medicaid and Medicare, 21-64 years of age who are eligible for the One Care program but are not enrolled in the One Care program.
- **Based on the proxy methodology, over 60% land in the C1 "Other" category; excludes consideration of assessment data.**
- One Care enrollees are not included in these numbers.

These are rating categories (RCs)

- C1: Community Other
- C2: Community High Behavioral Health
- C3: High Community Need
- F1: Facility-Based Care
- C4: Transitional Living Need

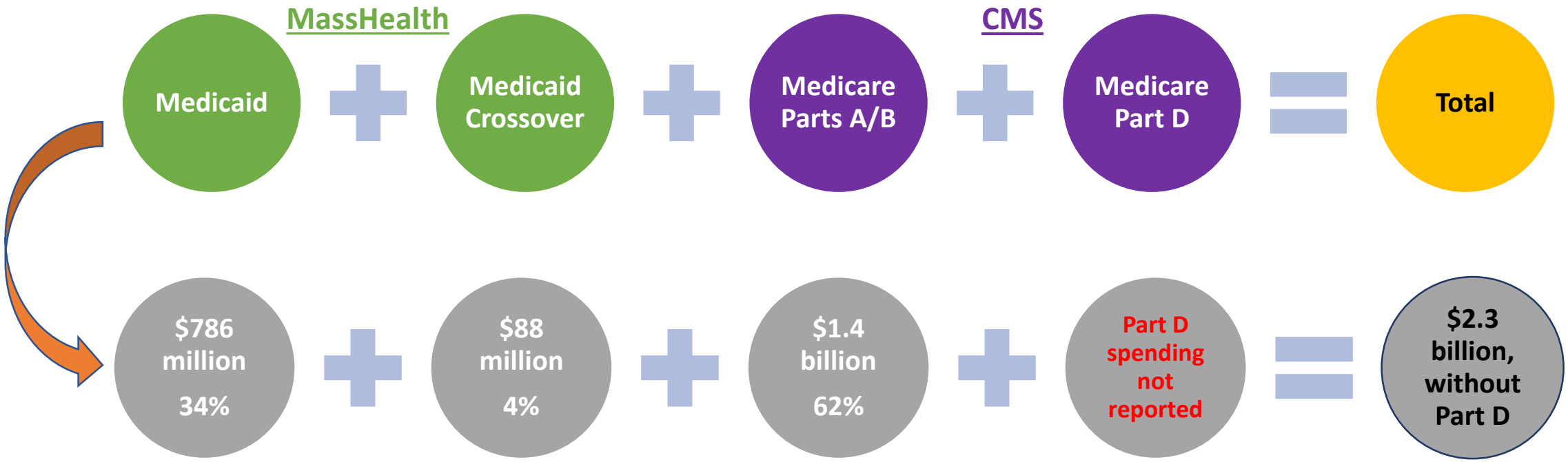
CY 2017 Spending on Target Population



Spending

- This pie shows total spending for the One Care Target Population based on claims paid by Medicaid and Medicare (Parts A and B).
- **Medicare accounts for 62% of total spending**
- This total does not include Medicare Part D claims.

Another View on $2.3 Billion in CY 2017

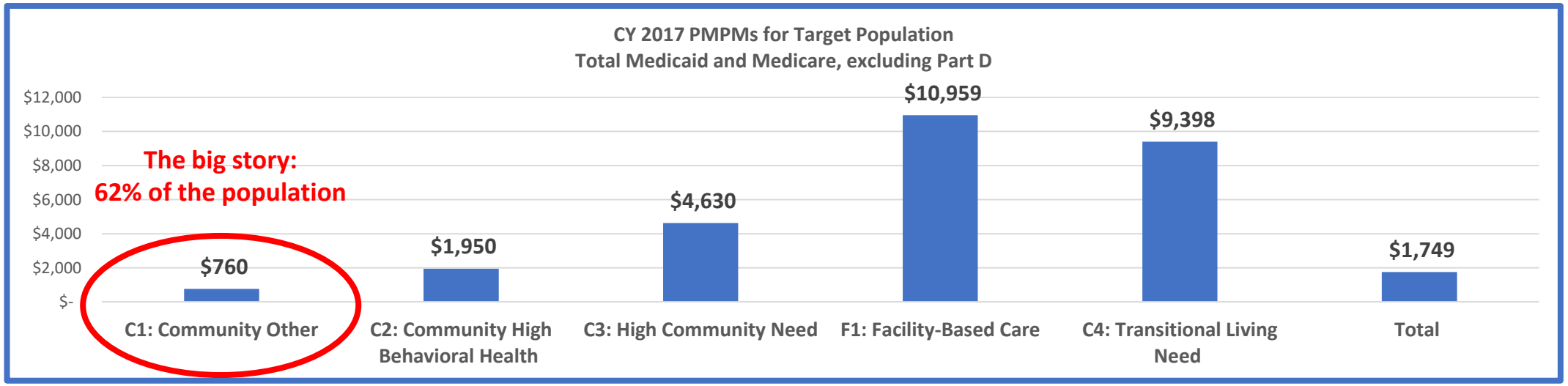


Part D spend is excluded from the databook. As a result, $2.3 billion understates total spending on One Care Target Population.

The One Care Rating Category Structure

MassHealth uses five rating categories (RCs) to stratify the risk of the population.

C1 = 62% Community Other	C2 = 22% Community Behavioral Health	C3 = 14% Community Needs	C4 = .03% Transitional Living	F1 = 2% Facility Based
Lowest $	< ===== >			Highest $



Inpatient and Emergency Department Use

The Elephant in the Room: $833.5 Million

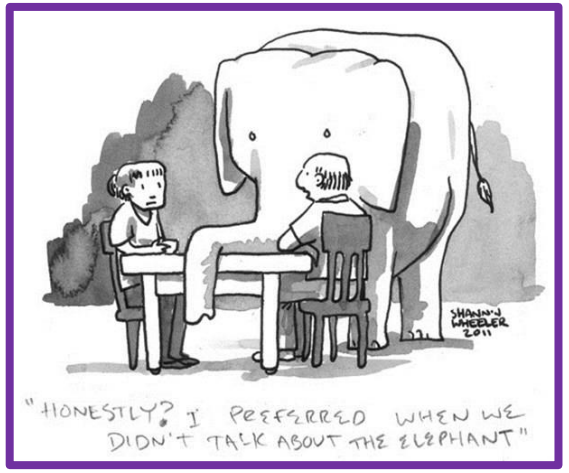
One Care Target Pop

$723.5 or about 32% of Medicaid and Medicare spend (no Part D)

One Care Enrollees

$110 million or 27% of Medicaid and Medicare spend (no Part D)

In CY 2017, $833.5 million was spent on inpatient care for the One Care Eligible population, accounting for 31% of Medicaid and Medicare A/B spend (Part D excluded)

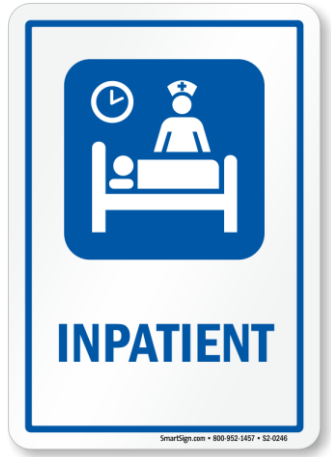


Note: Data is for CY 2017 and includes only non-Part D pharmacy costs. The purpose of this slide is to estimate inpatient spending for the One Care eligible population based on FFS and plan data.

The Elephant in the Room

Persons Identified as Eligible for One Care: All Persons						
Estimated Inpatient Spending on the One Care Eligible Population (CY 2017)						
	One Care Target Population		One Care Enrollees		All One Care Eligibles	
Members (MM/12)	109,375		17,294		126,670	
Members (% of total)	86%		14%		100%	
Service	Spending	% of Total	Spending	% of Total	Spending	% of Total
Summary 1						
Inpatient - Non-BH	$ 538,797,813	24%	$ 78,290,416	19%	$ 617,088,229	23%
Inpatient - BH	$ 184,631,698	8%	$ 31,838,371	8%	$ 216,470,069	8%
Total Inpatient	$ 723,429,512	32%	$110,128,787	27%	$ 833,558,299	31%
Total Inpatient (% of total)	87%		13%		100%	
Total w/o Part D	$2,292,120,857		$419,016,749		$2,711,137,606	
Total w/o Part D (% of total)	85%		15%		100%	
Summary 2						
Total Inpatient			$110,128,787	20%		
Part D			$132,873,499	24%		
Total w/Part D			$546,886,828			

Inpatient accounts for 31% of spend

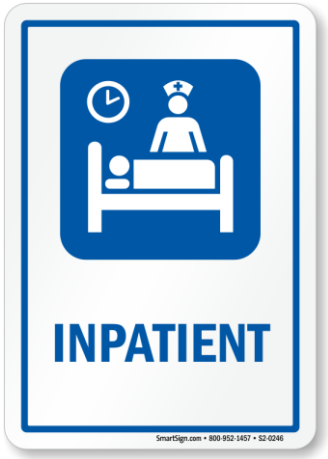


$1 of every $2 Dollars Spent on Inpatient (RC = C2)

What does health equity mean to people with disabilities?

Rating Category C2 = Community High Behavioral Health and Community Very High Behavioral Health

Persons Identified as Eligible for Rating Category C2: Behavioral Health Needs						
Estimated Inpatient Spending on the One Care Eligible Population (CY 2017) - C2						
	One Care Target Population (C2)		One Care Enrollees (C2A + C2B)		All One Care Eligibles (C2)	
Members (MM/12)	24,030		6,126		30,156	
Members (% of total)	80%		20%		100%	
Service	Spending	% of Total	Spending	% of Total	Spending	% of Total
Summary 1						
Inpatient - Non-BH	$ 164,618,135	29%	$ 14,875,487	17%	$ 179,493,622	28%
Inpatient - BH	$ 106,616,122	19%	$ 11,116,048	13%	$ 117,732,171	18%
Total Inpatient (% of Total)	$ 271,234,257	48%	$ 25,991,535	29%	$ 297,225,792	46%
Total Inpatient (% of Total, row)	91%		9%		100%	
Total (w/o Part D)	$ 562,236,001		$ 88,743,643		$ 650,979,644	
Total (w/o Part D), (% of total)	86%		14%		100%	
Summary 2						
Total Inpatient			$ 25,991,535	20%		
Part D			$ 38,731,918	30%		
Total w/Part D			$ 127,402,052			



Inpatient spending accounts for 48% of total spending

Inpatient and Emergency Dept Use for C2 & C3

Spotlight on C2: High and Very High LTSS (22% of Target Pop)

- **46% of persons used the ED**
- **40% of persons used inpatient care**
- Very few use Community LTSS

Spotlight on C3: Community Needs (14% of Target Pop)

- **31.5% of persons in this RC used the ED**
- **30% of persons used inpatient care**
- Over 90% of persons use Community LTSS

CY 2017 Data for Target Population									
Rating Categories		Members		PMPM	% Persons: ED Visits	% Persons: IP Days	% Persons: IP Admissions	% Persons: NF Days	% Persons: Community LTSS
C1	Community Other	67,821	62%	$ 760	23%	9%	9%	0%	1%
C2	Very High and High Community BH	24,030	22%	$ 1,950	46%	40%	40%	1%	3%
C3	Very High and High Community Needs	15,664	14%	$ 4,630	31%	28%	28%	6%	91%
F1	Facility Based Care	1,832	2%	$ 10,959	18%	34%	34%	81%	4%
C4	Transitional Living Need	28	0%	$ 9,398	13%	38%	38%	6%	100%
All		109,375	100%	$ 1,749	29%	19%	19%	3%	15%

Notes: Emergency department and inpatient use are based upon Medicare claims. Emergency department use resulting in an inpatient stay are excluded. Note that nursing facility and Community long-term services and supports (LTSS) are based upon Medicaid claims.

Long-Term Services and Supports (LTSS)

LTSS Rebalancing: Are We Doing Enough?

CY 2017: LTSS accounts for 47% of $1.4 b.; Inpatient accounts for 53% of $1.4 b.

Inpatient
$723.5 million,
53% of $1.4b.

LTSS
$650.5 million,
47% of $1.4 b.

Rebalancing

A rebalancing goal of 60:40 would mean an increase in spend on LTSS and other services by $174 million.

[Math: $1.4 b. x 60% = $824 million]

Total spending for LTSS and Inpatient = $1.4 billion

CY 2017	Medicaid	Crossover	Medicare	Total LTSS	Total Spending	%
LTSS						
Community LTSS	$ 439,012,600			$ 439,012,600	$ 2,295,259,705	19%
LTC/SNF	$ 105,416,996	$ 8,634,255	$ 49,648,740	$ 163,699,991	$ 2,295,259,705	7%
Home Health			$ 39,382,787	$ 39,382,787	$ 2,295,259,705	2%
Hospice			$ 8,367,466	$ 8,367,466	$ 2,295,259,705	0%
Total LTSS	**$544,429,596**	**$ 8,634,255**	**$ 97,398,992**	**$ 650,462,843**	**$2,295,259,705**	**28%**
Inpatient						
Non-Behavioral Health	$ 37,686,024	$ 13,125,653	$ 487,986,136	$ 538,797,813	$ 2,295,259,705	23%
Behavioral Health	$ 50,799,775	$ 6,688,323	$ 127,143,600	$ 184,631,698	$ 2,295,259,705	8%
Total Inpatient	**$ 88,485,799**	**$19,813,976**	**$615,129,737**	**$ 723,429,512**	**$2,295,259,705**	**32%**
Total	**$632,915,395**	**$28,448,231**	**$712,528,729**	**$1,373,892,355**	**$2,295,259,705**	
Total LTSS	**86%**	**30%**	**14%**	**47%**		
Spending on IP v LTSS	**6.15**	**0.44**	**0.16**	**0.90**		

How Do We Get There?
A Strong One Care Program

First: Ground the One Care Program in Health Equity

What does health equity mean to people with disabilities?
"fair and just opportunity to be as healthy as possible"

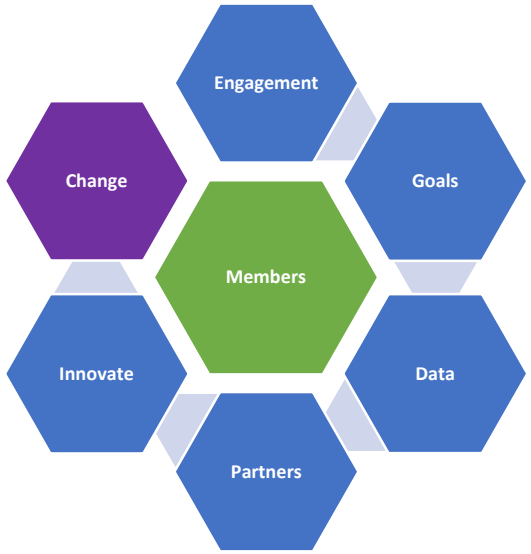
BOX 8. HEALTH EQUITY DEFINED BY THE ROBERT WOOD JOHNSON (RWJ) FOUNDATION

In a 2017 report published by the Robert Wood Johnson (RWJ) Foundation, the foundation concludes that there is no common understanding of what health equity means, while offering this definition: "health equity means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care.[35]

Second: Develop a Response

BREAKING THE CODE BOOK:

Plans have the flexibility to provide more person-centered interventions by breaking the status quo in service delivery.



Commit to Health Equity and Wellness Goals

Collect, track and analyze the data		Cultivate community partnerships; Diversify the workforce, e.g. CHWs
Go upstream to address root causes	Engage the population that you serve	Address high needs of all populations including behavioral health

Partner with community organizations to de-medicalize services

Geospatial Maps:
County Variations in Poverty and Spend

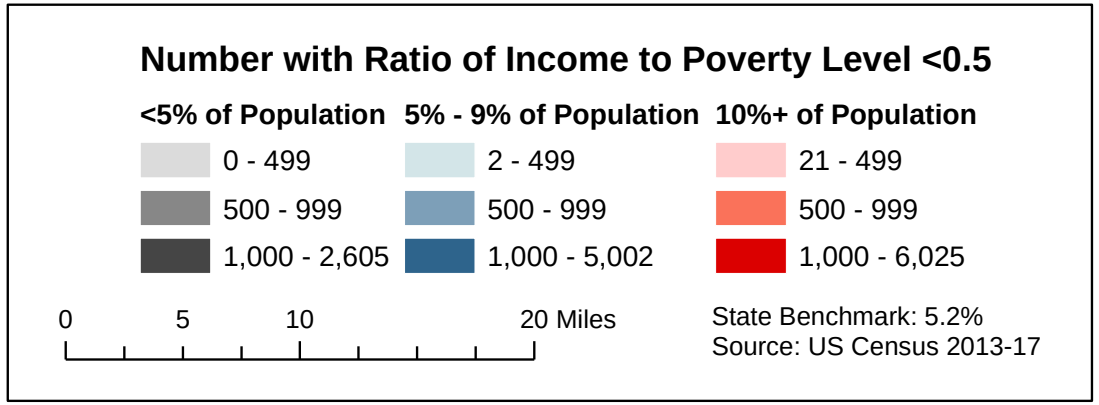
REAL WORLD APPLICATIONS OF MAPPING

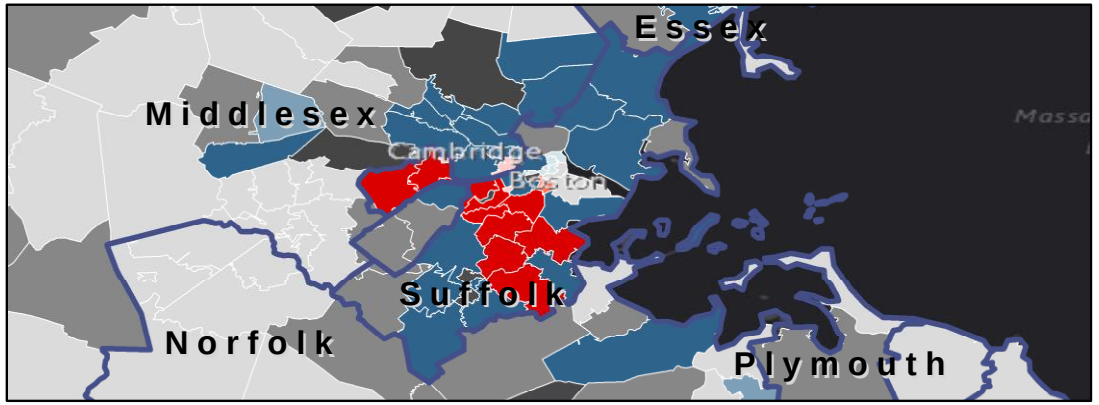
How does identification of geospatial patterns and relationships inform the best decisions?

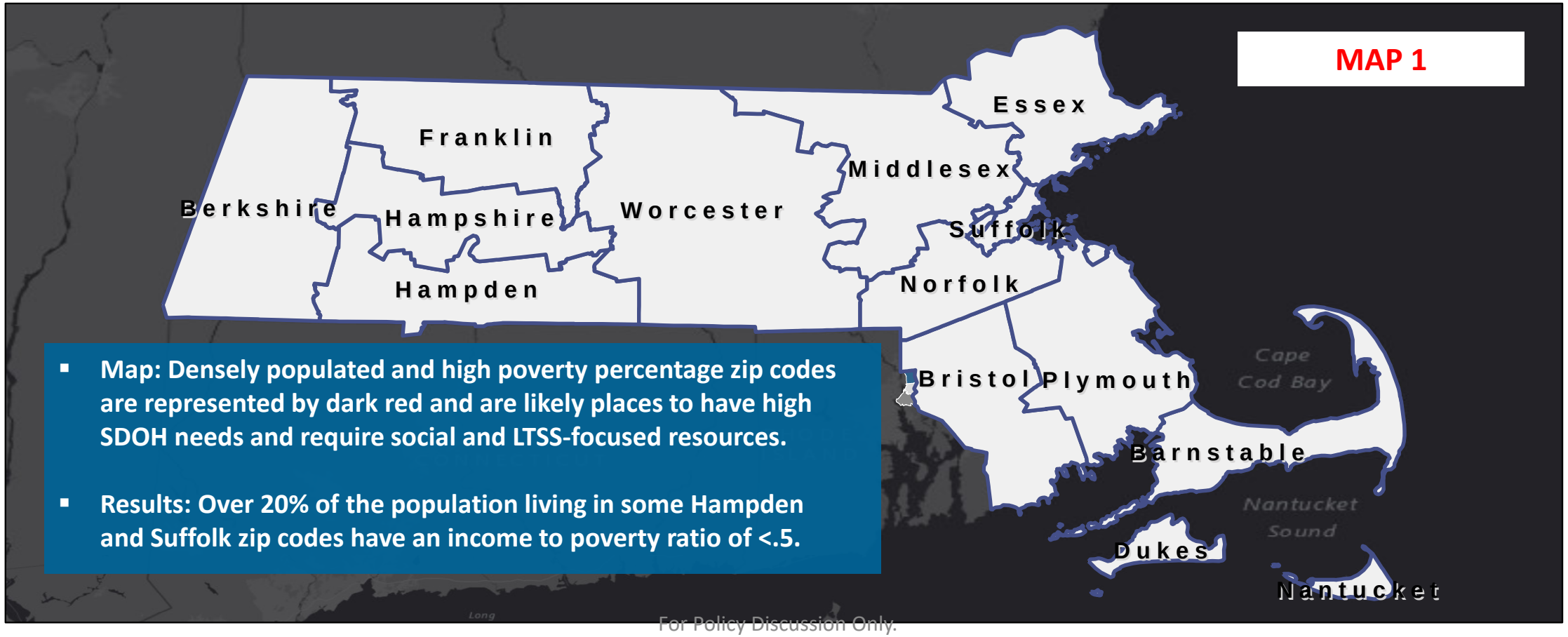
- **Expansion or Transformation of Services**
- **Cost-Effective Resource Distribution**
- **Identify Key Focus Areas and Populations**
- **Identification of Pockets of Innovation for Replication in Other Areas**
- **Derive Predictions and Trends**

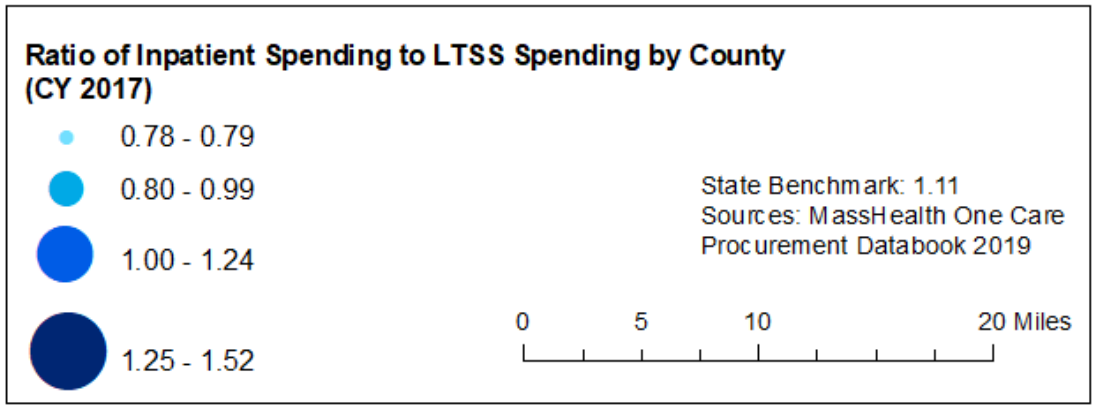
“Your zip code is a better predictor of your health than your genetic code."

MELODY GOODMAN
assistant professor at Washington University in St. Louis


Number with Ratio of Income to Poverty Level <0.5
<5% of Population
0 - 499
500 - 999
1,000 - 2,605
5% - 9% of Population
2 - 499
500 - 999
1,000 - 5,002
10%+ of Population
21 - 499
500 - 999
1,000 - 6,025
0
5
10
20 Miles
State Benchmark: 5.2%
Source: US Census 2013-17


Essex
Middlesex
Cambridge
Boston
Suffolk
Norfolk
Plymouth

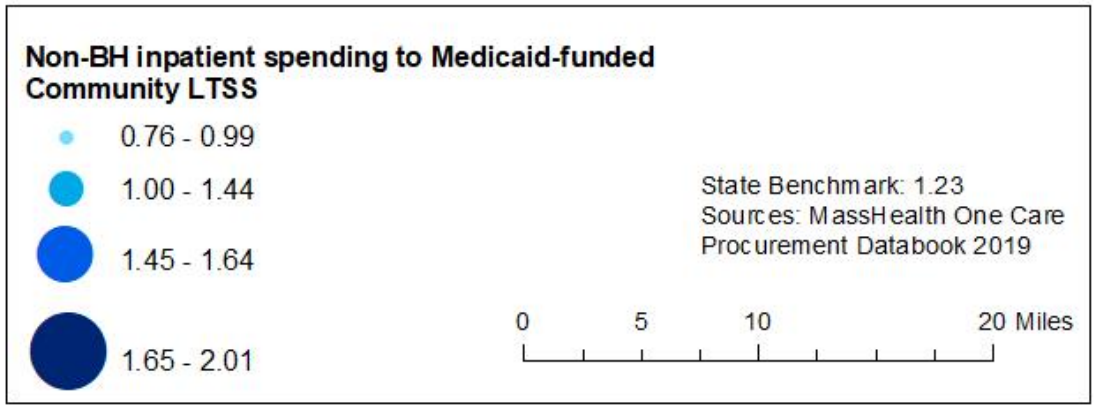

MAP 1
Franklin
Berkshire
Hampshire
Worcester
Hampden
Essex
Middlesex
Suffolk
Norfolk
Bristol Plymouth
Cape Cod Bay
Barnstable
Nantucket Sound
Dukes
Nantucket
Map: Densely populated and high poverty percentage zip codes are represented by dark red and are likely places to have high SDOH needs and require social and LTSS-focused resources.
Results: Over 20% of the population living in some Hampden and Suffolk zip codes have an income to poverty ratio of <.5.

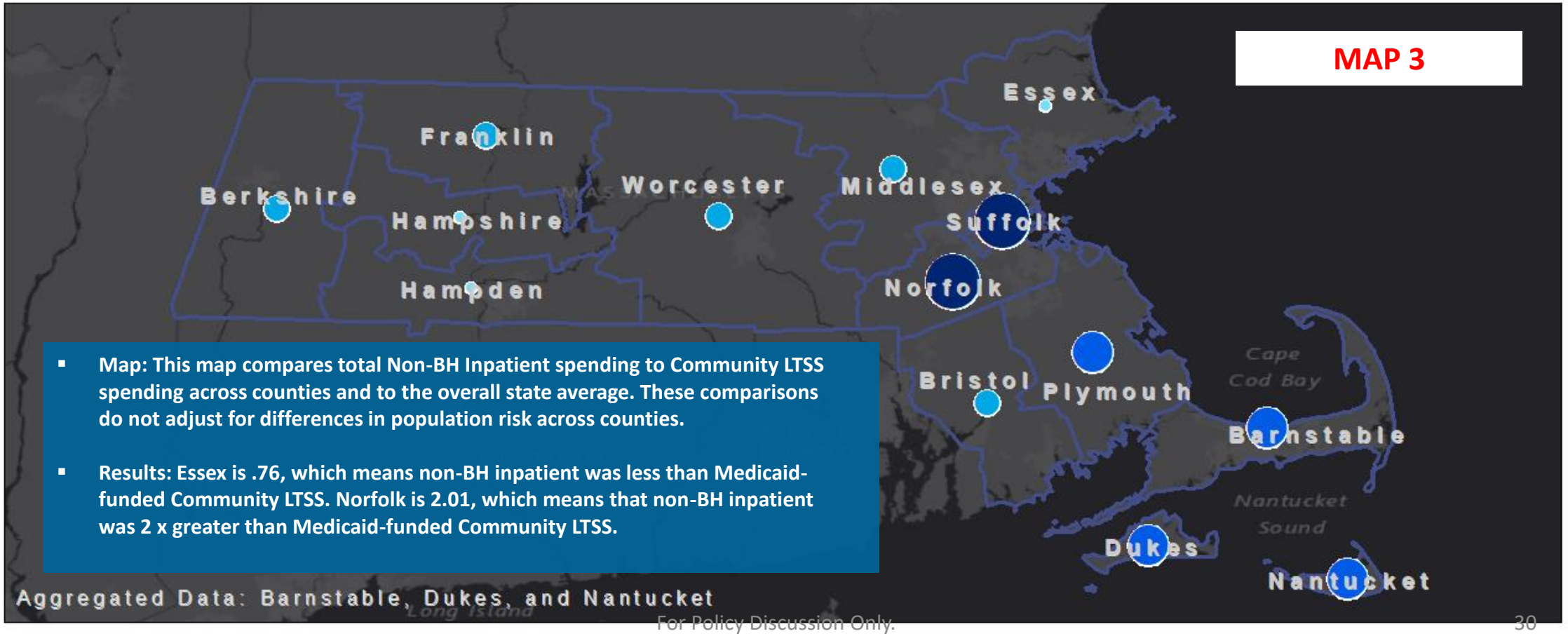


MAP 2

- **Map: This map compares total Inpatient spending to LTSS spending across counties and to the overall state average. These comparisons do not adjust for differences in population risk across counties.**
- **Results: Essex fell into the lowest category with a ratio of .78, which means inpatient spending was lower than LTSS spending. Suffolk was the highest with a ratio of 1.52, which means inpatient spending was higher than LTSS spending. (LTSS = institutional + community)**

Aggregated Data: Barnstable, Dukes, and Nantucket





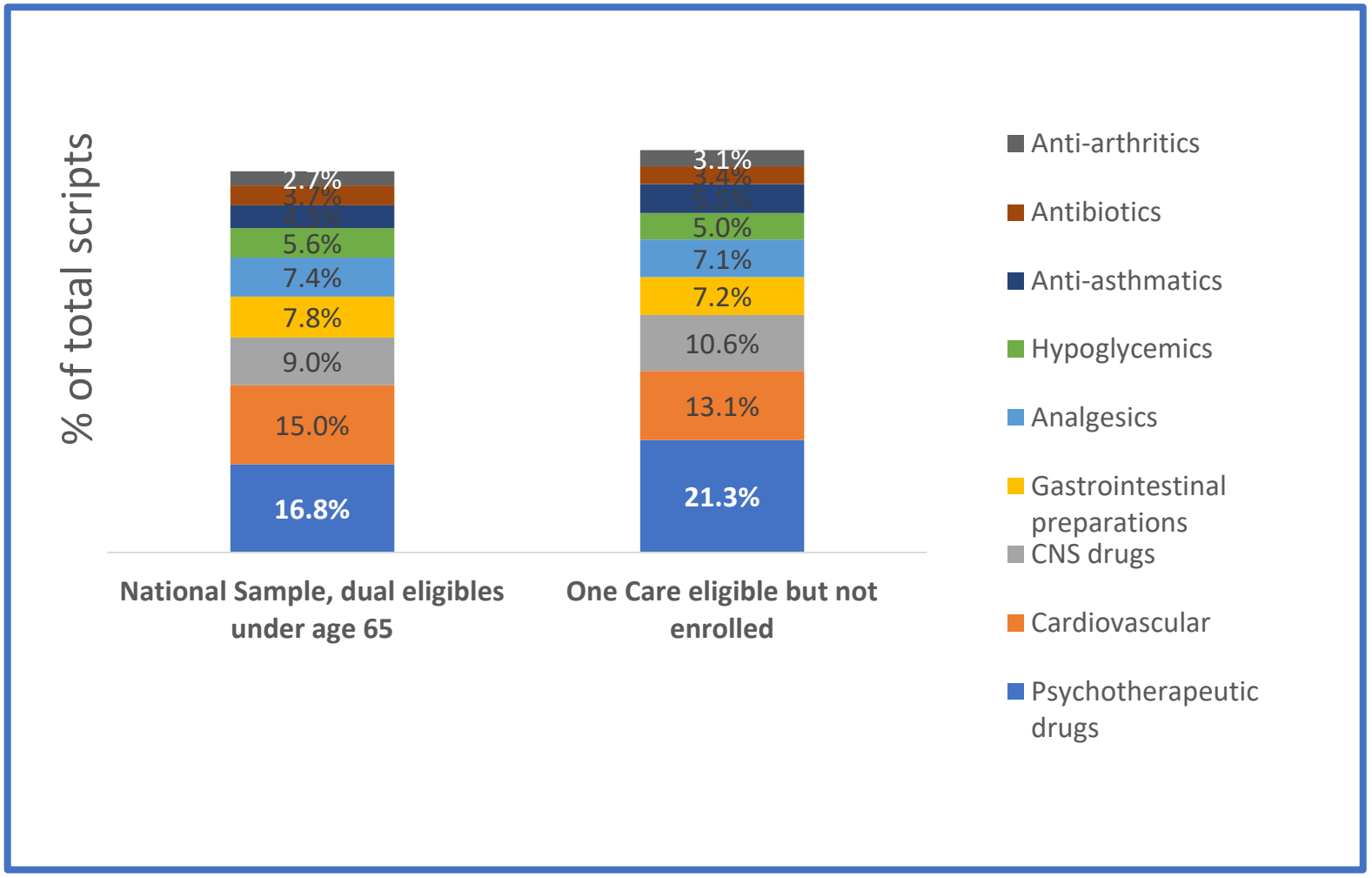
- **Map: This map compares total Non-BH Inpatient spending to Community LTSS spending across counties and to the overall state average. These comparisons do not adjust for differences in population risk across counties.**
- **Results: Essex is .76, which means non-BH inpatient was less than Medicaid-funded Community LTSS. Norfolk is 2.01, which means that non-BH inpatient was 2 x greater than Medicaid-funded Community LTSS.**

Notes for Maps 1, 2, and 3

Map	Title	About the Map	Variables and Calculations	Key Findings
Map 1	**Number with ratio of income to poverty level <0.5 (2013-17)**	This map identifies zip code ratios <0.5 which is an indication that individuals or families are not close to meeting their economic needs. Densely populated and high poverty percentage zip codes are represented by dark red.	Variable: (1) Number with ratio of income to poverty level <0.5; 2) Population for whom poverty status is determined. Calculation: Percentage calculated for state and for counties by dividing number <0.5 by population for whom poverty status is determined.	The state benchmark is 5.2%. Individuals or families in counties with populations of 1,000 or more and the highest percentage of ratios <0.5 were: Suffolk and Hampden (>20%).
Map 2	**Ratio of Inpatient Spending to LTSS Spending by County (CY 2017)**	This map compares total Inpatient spending to LTSS spending across regions and to the overall state average. These comparisons do not take adjust for differences in population risk across counties	Variables: (1) Total Inpatient Spending; (2) Total LTSS Spending. Calculation: Ratio of Inpatient spending to LTSS spending calculated by dividing inpatient spending by LTSS spending	State ratio is 1.11, which means that inpatient spending is 1.11 1% more than LTSS spending for the state. County ratios range between: .78 (Essex) to 1.52 (Suffolk)
Map 3	**Ratio of Non-BH Inpatient Spending to Medicaid-Funded Community LTSS Spending by County (CY 2017)**	This map compares total Non-BH Inpatient spending to Community LTSS spending across regions and to the overall state average. These comparisons do not take adjust for differences in population risk across counties	Variables: (1) Total Non-BH Inpatient Spending; (2) Total Community LTSS Spending. Calculation: Ratio between non-BH inpatient and LTSS spending calculated by dividing non-BH inpatient spending by Community LTSS spending	State ratio is 1.23 for the state, which means that 23% more spent on non-BH inpatient spending than community LTSS. County ratios range between: .76 (Essex) to 2.01 (Norfolk)

CY 2016 Medicare Part D for the One Care Target Population

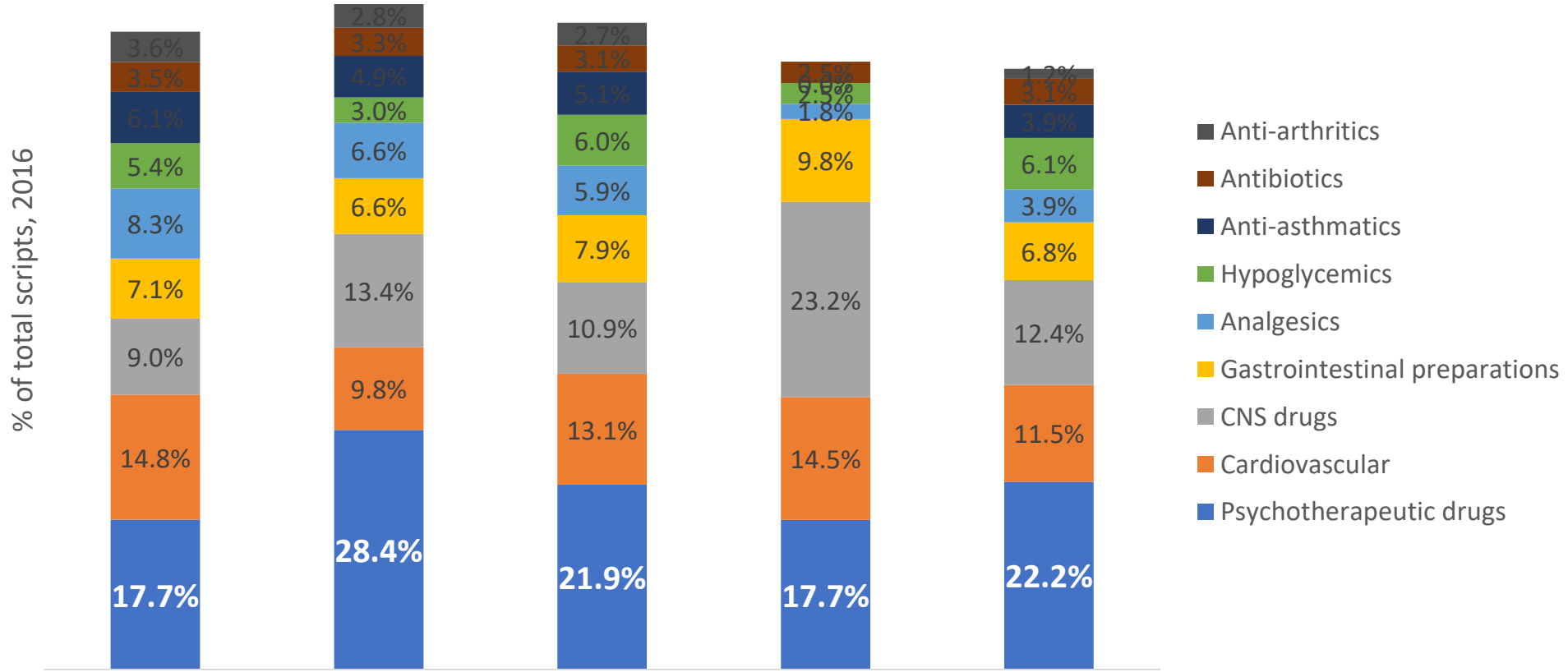
Part D Scripts by Class of Drug, 2016
One Care Target Population vs Comparable National Sample



Compared to a similar population nationwide, Part D prescriptions for the One Care Target Population (eligible but not enrolled) were:

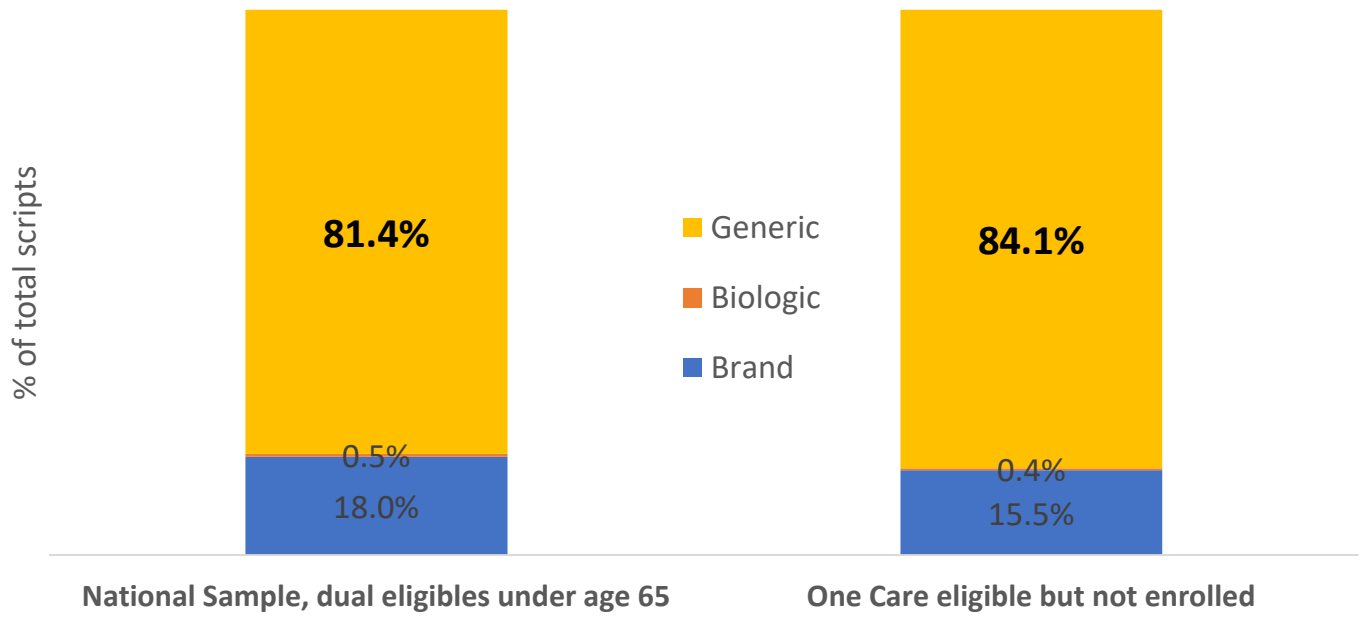
- More likely to be for psychotherapeutic drugs
  - 21.3% for One Care eligible vs. 16.8% for national sample
- More likely to be for CNS drugs
  - 10.6% for One Care eligible vs. 9.0% for national sample
- Less likely to be for cardiovascular drugs
  - 13.1% for One Care eligible vs. 15.0% for national sample

Part D Scripts by Class of Drug, 2016, for One Care Eligible Population



As expected, psychotherapeutic drugs were used most frequently by the One Care Target population by members in RC C2: High Behavioral Health (BH)

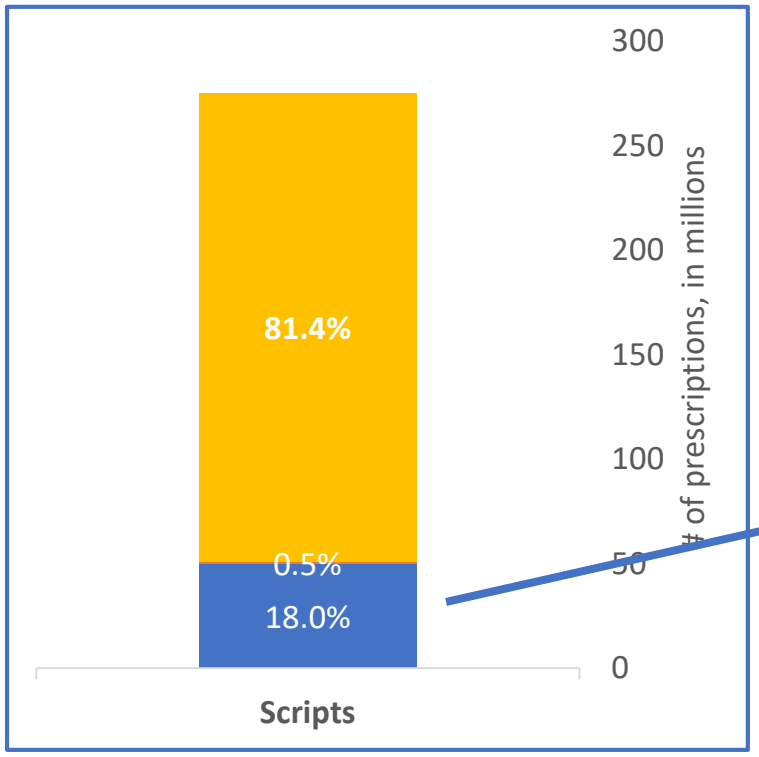
Part D Scripts by Brand/Generic Status, 2016
One Care Target Population vs Comparable National Sample



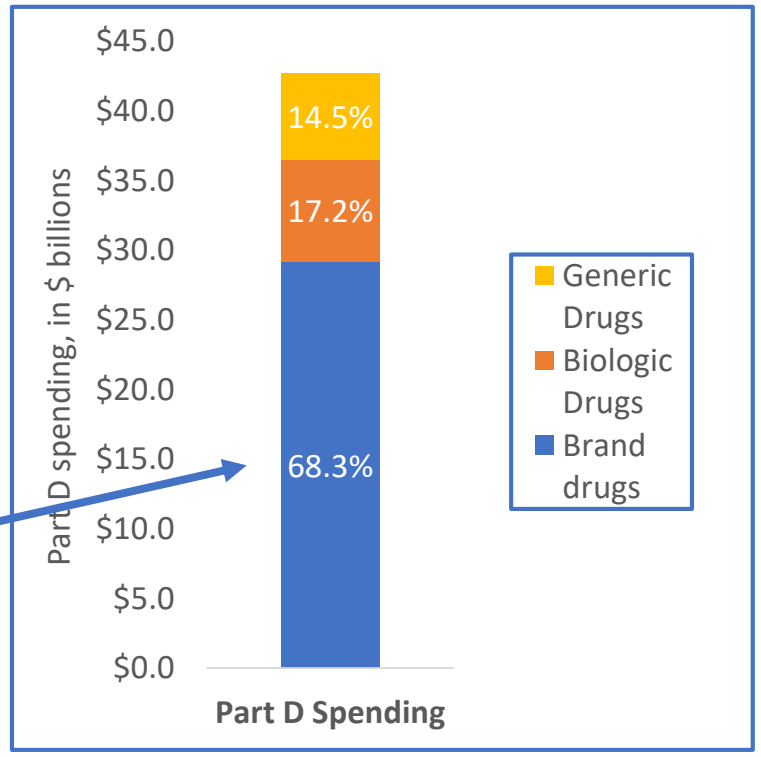
The One Care eligible population had a higher generic dispensing rate compared to a similar group of Part D enrollees from a national sample

Cost Implications of Brand vs Generic, 2016 National Sample Population

Scripts



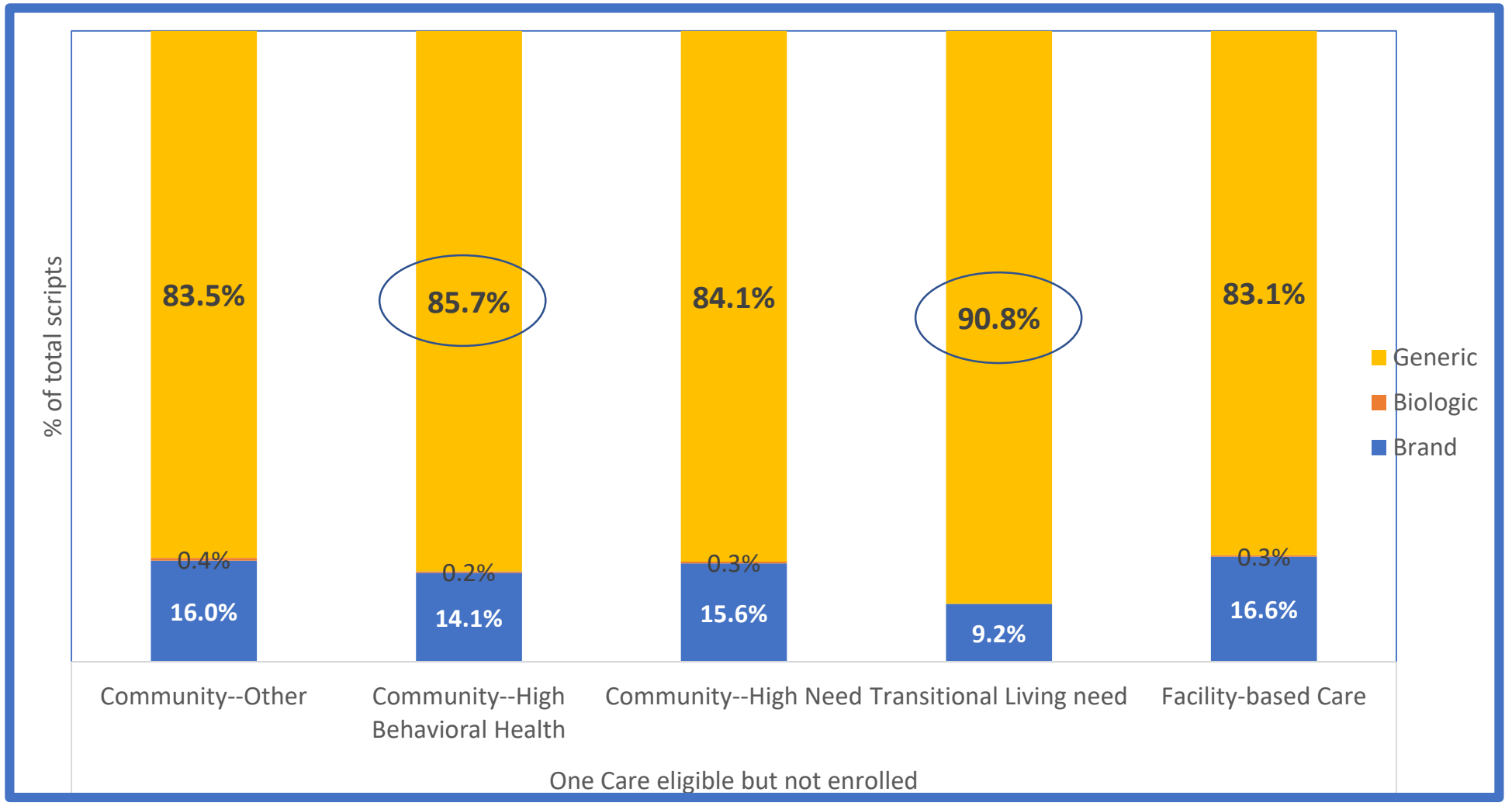
Spending



Nationally among dually-eligible enrollees under the age of 65:

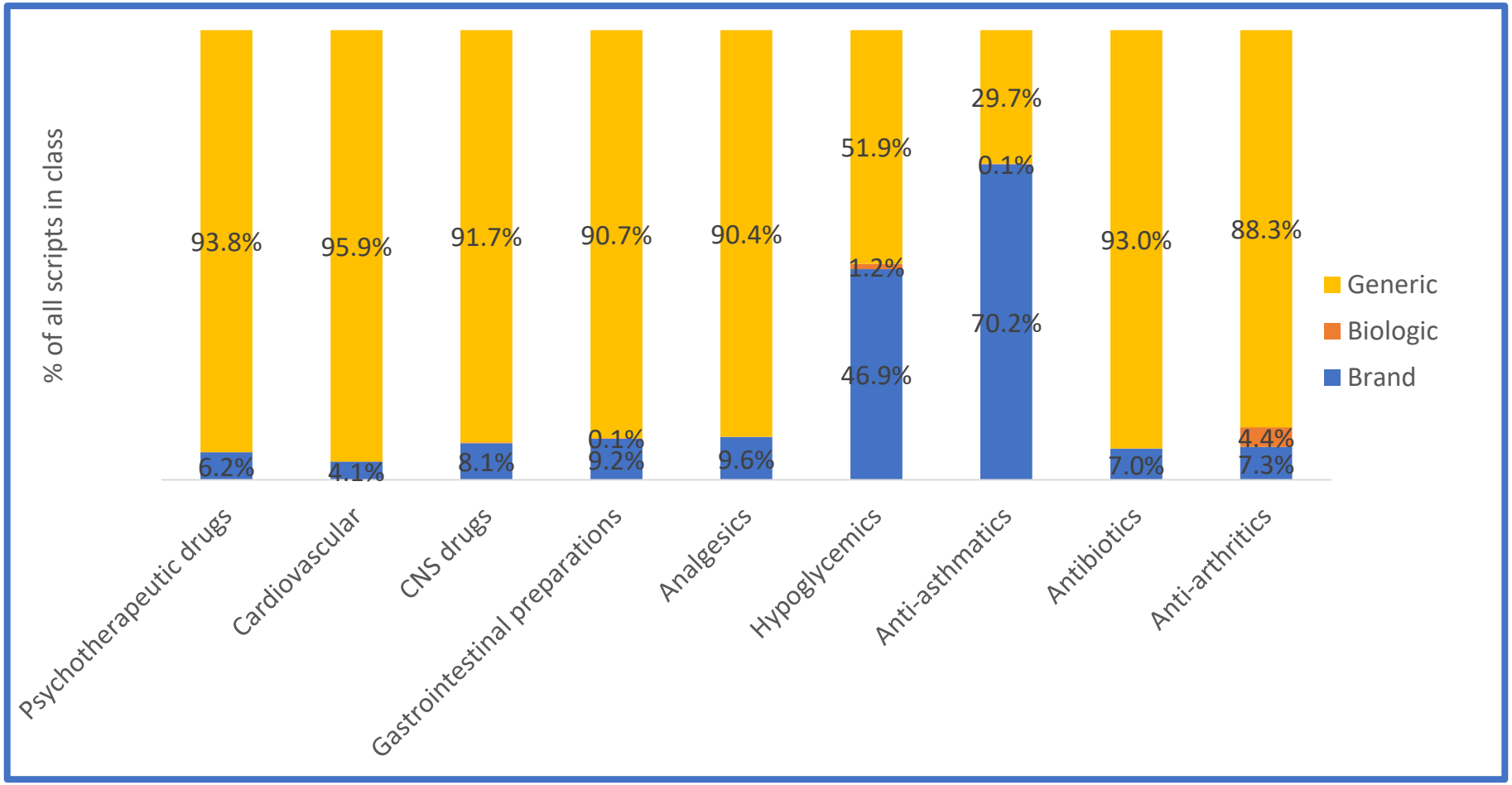
- Brand drugs represented 18% of scripts and 68% of Part D spending
  - Brand drugs cost on average $589 per script
- Biologic drugs represented 0.5% of scripts and 17% of Part D spending
  - Biologic drugs cost on average $5,017 per script
- Generic drugs represented 81% of scripts and 15% of Part D spending
  - Generic drugs cost on average $28 per script

Part D Generic Rates for One Care Target Pop by RC



Generic dispensing rates are highest for One Care Target population in two rating categories: C2 (High Behavioral Health) and C4 (Transitional Living Need)

Part D Patterns for One Care Target Population, 2016



The generic dispensing rate was above 90% for 7 of the top 9 drug classes

- In hypoglycemics, insulin represents the most common brand drug used, and there is currently no generic available.
- In anti-asthmatics, Ventolin represents the most common brand drug used. An authorized generic version was released on in January 2019, so its utilization is not reflected in this chart.

Key Takeaways for Part D

- Part D spending by One Care plans accounted for 23% of total spending for One Care enrollees
  - It's unclear if the eligible-but-not enrolled population has a similar ratio
  - There are differences in risk between the FFS and plan spending
  - Nonetheless, Part D spending represents a sizeable share of total spending

- For the One Care Target population (eligible-but-not enrolled), the generic dispensing rate (GDR) is notably higher than an equivalent population drawn from a national sample
  - The target One Care population has an 84.1% GDR
  - A national sample of under-65 dually eligible individuals has an 81.4% GDR
  - Based on the distribution, One Care plans could face challenges in saving on costs by increasing the use of generic drugs

- Only two of the top nine classes of drugs have a GDR below 90%
  - Hypoglycemics, influenced largely by brand-only insulin, have a GDR of 51.9%
  - Anti-asthmatics, influenced largely by a historically brand-only asthma inhalers, have a GDR of 29.7%

Data Notes for Part D

- The Part D data for the One Care Target Population (eligible but not enrolled) is based upon the One Care Procurement Databook, Exhibit 14
- National Drug Codes (NDCs) were mapped to brand/generic status using data from the Federal Drug Administration (FDA) Orange book to determine method of approval
  - "Brand" measured as any drug approved via a New Drug Application (NDA)
  - "Biologic" measured as any drug approved via a Biologic License Application (BLA)
  - "Generic" measured as any drug approved via an Abbreviated New Drug Application (ANDA)
- Drug Class determined by mapping NDCs to First Data Bank (FDB) drug category
- National sample taken from the 2016 Medicare Current Beneficiary Survey (MCBS)

THANK YOU FOR JOINING TODAY

- **Questions and Answers (10 minutes)**
- **HMA Webinar Team**
- Please feel free to contact us if you have any questions:

Ellen Breslin, Boston
ebreslin@healthmanagement.com

Eric Hammelman, Chicago
ehammelman@healthmanagement.com

Anissa Lambertino, Chicago
alambertino@healthmanagement.com