South Carolina Healthy Connections Prime
CY 2018 Final Medicare-Medicaid Rate Report
February 3, 2020

The Centers for Medicare & Medicaid Services (CMS), in conjunction with the State of South Carolina, is releasing the final Medicare and Medicaid component of the CY 2018 rates for the South Carolina Healthy Connections Prime program (Prime). This rate report includes the updated final Medicare rates for CY 2018, incorporating a reduction in the savings percentage from 4% to 3%.

The general principles of the rate development process for the Demonstration have been outlined in the three-way contract between CMS, South Carolina, and the participating health plans.

Included in this report are the final CY 2018 Medicaid rates and Medicare county base rates.

I. Components of the Capitation Rate

CMS and South Carolina will each contribute to the global capitation payment. CMS and South Carolina will each make monthly payments to Coordinated and Integrated Care Organization (CICOs) for their components of the capitated rate. CICOs 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 South Carolina reflecting coverage of Medicaid services.

The Medicare Parts A/B rate component will be risk adjusted using the prevailing 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, South Carolina assigns each enrollee to a rate cell according to the individual enrollee's nursing facility level of care status.

Section II of this report provides information on the South Carolina Medicaid 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 withhold.

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II. South Carolina Component of the Rate - CY 2018

This section provides an overview of the capitation rate development for the Medicaid component of the Prime program. Assessment of actuarial soundness under 42 CFR 438.4(a), in the context of this Demonstration, should consider both Medicare and Medicaid contributions and the opportunities for efficiencies unique to an integrated care program. CMS considers the Medicaid actuarial soundness requirements to be flexible enough to consider efficiencies and savings that may be associated with Medicare. Therefore, CMS does not believe that a waiver of Medicaid actuarial soundness principles is necessary in the context of this Demonstration. To ensure compliance with generally accepted actuarial practices and regulatory requirements, we referred to published guidance from the American Academy of Actuaries (AAA), the Actuarial Standards Board (ASB), the Centers for Medicare and Medicaid Services (CMS), and federal regulations. For the purposes of the development of the Medicaid component of the Prime capitation rate, "actuarial soundness" will be defined as in Actuarial Standard of Practice (ASOP) 49:

> *"Medicaid capitation rates are "actuarially sound" if, for business for which the certification is being prepared and for the period covered by the certification, projected capitation rates and other revenue sources provide for all reasonable, appropriate, and attainable costs. For purposes of this definition, other revenue sources include, but are not limited to, expected reinsurance and governmental stop-loss cash flows, governmental risk-adjustment cash flows, and investment income. For purposes of this definition, costs include, but are not limited to, expected health benefits; health benefit settlement expenses; administrative expenses; the cost of capital, and government-mandated assessments, fees, and taxes."*[1]

The capitation rate-setting process for the Prime program does not follow the Medicaid managed care capitation rate-setting methodology outlined in ASOP 49, because an alternative methodology has been prescribed by CMS. The rate-setting methodology is limited to the cost of the Medicaid program for dual eligible beneficiaries in absence of the Demonstration less the shared savings percentage. The full version of the CY 2018 Medicaid capitation rate report can be found online at https://www.scdhhs.gov/internet/pdf/f4EgxEi6ygqu2z331yBIKagJGwIxmjlL.pdf.
Note that the Medicaid component of the capitation rates were amended July 1, 2018. The full version of the July 2018 capitation rate amendment report can be found online at https://www.scdhhs.gov/internet/pdf/vnDFV690lzOIiPu51T29nEgdyLrnB3VE.pdf.

Information in this report related to the Medicaid component of the Healthy Connections Prime capitation rate provides an overview of the rate development and should not be considered comprehensive documentation of the methodology and assumptions. Review of this report should be accompanied by the CY 2018 Healthy Connections Prime Medicaid capitation rate report for full documentation of assumptions and methodology.

[1] http://www.actuarialstandardsboard.org/asops/medicaid-managed-care-capitation-rate-development-and-certification/

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The basis for the Medicaid rates began with costs developed prior to the application of the Medicare and Medicaid composite savings percentages established by the State and CMS, informed by estimates from CMS and its contractors. The final Medicaid capitation rates were set consistent with 42 CFR 438.4(a) in combination with the following qualifications:

- the rate development does not follow the methodology outlined in ASOP 49 because an alternative methodology has been prescribed by CMS;
- The Medicare capitation rates were established by CMS; and,
- The Medicare and Medicaid composite savings percentages (3% in CY 2018) were established by the State and CMS.

Table 1 illustrates the proposed monthly capitation rates for each rate cell for Prime Program Medicaid benefits. The 3% shared savings percentage for Demonstration Year 3 of the program, as outlined in section IV of this report, has been applied to these rates.

Table 1
South Carolina Department of Health and Human Services
Healthy Connections Prime Program – Medicaid Component
Effective Calendar Year 2018

Rate Cell	Medicaid Rate
Community	$ 85.61
Nursing Facility	$ 5,415.85
HCBS Waiver	$ 1,176.57
HCBS Waiver – Plus Rate	$ 3,411.33

Please note that Table 1 includes the Prime Medicaid capitation rates effective January 1, 2018. The Medicaid component of the capitation rates were amended July 1, 2018 and the full version of the July 2018 capitation rate amendment report can be found online at https://www.scdhhs.gov/internet/pdf/vnDFV690lzOIiPu51T29nEgdyLrnB3VE.pdf.

Please note:

- The capitation rates reflect the current benefit package for CY 2018 approved by the State and CMS as of the date of this report. The rates will be revised appropriately if applicable policy and program changes occur for this period.

- The Nursing Facility capitation rate was developed based on projected gross nursing facility rates. On an individual basis, SCDHHS will deduct the actual patient pay liability amount from the 2018 Nursing Facility capitation rate shown in Table 1 and pay the net capitation rate to the coordinated and integrated care organizations (CICOs).

- The HCBS Waiver – Plus rate was calculated as the HCBS Waiver base rate plus two-thirds of the difference between the institutional portion of the Nursing Facility rate (less an estimated average daily patient liability amount of $32.90) and the waiver services portion of the HCBS Waiver base rate.

COVERED POPULATION

Target Population

The target population for the Prime program was limited to full Medicare-Medicaid dual eligible individuals who are age 65 and over and entitled to benefits under Medicare Parts A, B, and D. The Prime program is offered in all counties with at least one operating CICO and includes individuals enrolled in the Community Choices Waiver, HIV/AIDS Waiver and Ventilator Dependent Waiver.

Excluded Populations

The following populations are not eligible for the Prime program and are excluded from enrollment:

- Any member month where an individual's age was under 65;
- Any member month where an individual is enrolled in the PACE program
- Any member month where an individual was identified as partial eligible. These individuals consisted of those with the following payment categories in the eligibility data:
  - 90 – Qualified Medicare Beneficiary;
  - 48 – Qualifying Individual;
  - 52 – Specified Low Income Medicare Beneficiary.
- Any member month where an individual was either not receiving any Medicare Part A or Part B premiums from the State, or where they were only receiving a Medicare Part A premium payment from the State (and not a Part B premium payment).

The following criteria were not evaluated due to limitations in the data:

- Medicare Part D enrollment
- Eligibility for ESRD services

Additional detail related to the eligible and excluded populations can be found in the three-way contract between SCDHHS, CMS, and the participating CICOs.

The following describes each of the distinct populations covered by the Prime program which correspond directly with the capitation rate cells.

Home and Community-Based Services (HCBS) Waiver Population

This population includes individuals participating in one of the non-Developmentally Disabled 1915(c) waiver programs operating in South Carolina.

Milliman identified the population in the rate-setting process by assigning to the HCBS Waiver population any member month where an individual contains any of the following codes in the eligibility data indicating recipient of a special program (RSP):

- **CLTC**: Community Choices Waiver
- **HIVA**: HIV/AIDS Waiver
- **VENT**: Ventilator Dependent Waiver

Nursing Facility Population

This population includes individuals residing in a nursing facility who meet the state definition of nursing home level of care and who are not enrolled in a home and community-based services (HCBS) waiver. This rate cell was established for Demonstration-enrolled individuals who transition from the community to a nursing facility and elect to remain in the Demonstration. We identified the nursing facility population in the capitation rate-setting process using the following criteria:

- Any dual-eligible individual with at least one day of service in an institution (DHHS nursing home, Department of Mental Health (DMH) nursing home, nursing home swing beds, hospice room & board, or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)) and denoted as meeting the nursing home level of care criteria based on the payment category field in the SCDHHS eligibility data.
- Any Prime-eligible member who has incurred more than three consecutive months of nursing facility services following the month of admission, yet did not contain a nursing facility level of care payment category on the eligibility record.

The capitation rate for this rate cell was developed based on projected gross nursing facility rates. On an individual basis, SCDHHS will deduct the actual patient pay liability amount from the Nursing Facility capitation rate shown in Table 1 and pay the net capitation rate to the CICOs.

Community Residents Population

This population includes all other qualifying individuals who were not previously categorized. This population is comprised of Demonstration-eligible individuals who are neither institutionalized nor participating in a 1915(c) waiver program.

“Plus” Rates

For Prime program participants who transition between settings of care, additional considerations will be taken when assigning the capitation rate cell payment. Demonstration Plans will receive “Plus” rates for certain individuals to encourage transition from institutional care to the community setting.

Individuals who require HCBS waiver services once moved to the community will receive the Waiver Plus rate. In addition, for the first three months an individual in the community setting requires HCBS waiver services, the HCBS Waiver Plus rate will be applied. This rate was calculated as the HCBS Waiver base rate plus two-thirds of the difference between the institutional portion of the Nursing Facility rate (less an estimated average patient liability amount) and the waiver services portion of the HCBS Waiver base rate.

The Plus rates will be paid for a three-month period following discharge from a nursing facility to an HCBS waiver. For an individual transitioning to a nursing facility from the community, the health plan will receive the member’s base rate from the place of transfer for the first three months in the nursing home.

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EXPERIENCE DATA ADJUSTMENTS REFLECTED IN THE MEDICAID CAPITATION RATES

The base fee-for-service (FFS) experience for calendar year (CY) 2015 and CY 2016 was adjusted for the following components to produce the Medicaid portion of the Prime capitation rates:

- Completion
  - Completion factors were developed by rate cell and applied to base data at the provider type level. The base periods of CY 2015 and CY 2016 provide for 9 months of claims payment runout from the end of CY 2016.
- Trend
  - Trend rate assumptions were developed for the populations and services covered under the proposed Dual Demonstration program based on claims experience data from January 1, 2014 through December 31, 2016.
- Policy and program changes (both historical and prospective)
  - Adjustments were made for known policy and program changes that were made by SCDHHS during the historical base experience period as well as those that are planned as of the date of this report for CY 2018.
- Risk Selection
  - A prospective risk selection factor was applied to the base capitation rate to account for cost differences of individuals enrolled in the Demonstration. Evaluation of historical CY 2016 PMPM costs of members enrolled in the Demonstration and the Prime-eligible population represented in the unadjusted base data indicated a variance between the two populations. Individuals enrolled in Prime exhibited significantly higher utilization of waiver services that hose Prime-eligible individuals in the base data who have not enrolled in Prime. As such, a selection factor of 1.085 was applied to the total HCBS Waiver PMPM cost after application of trend, program changes, and rating period adjustments. No other selection factor was applied to the Prime population.
- Other Adjustments
  - Historical adjustment to reflect Hospice Room and Board Services on a gross rate basis for the Nursing Facility rate cell only.
  - Leap year adjustment to account for the extra day of institutional utilization in the CY 2016 base data that is not anticipated in the CY 2018 contract year. The leap year impact was assumed to be immaterial to all other (i.e., non-institutional) categories of service.
  - Enrollment in the Prime program is limited to individuals who are eligible for Medicare Parts A, B, and D benefits; however, limitations in the eligibility data we receive from SCDHHS do not allow for identification of individuals **enrolled** in Medicare Part A in the development of the base data cost models. Therefore, a Medicare Part A program adjustment was applied to

account for the estimated impact of individuals included in the CY 2015 and CY 2016 base data without Medicare Part A coverage.

A comprehensive description of the adjustments utilized in the capitation rate-setting process, as well as the actual factors that were applied by category of service, population and applicable time period are available in the full Medicaid report at https://www.scdhhs.gov/internet/pdf/f4EgxEi6ygqu2z331yBIKagJGwIxmjlL.pdf.

DATA RELIANCE

The following information was provided by SCDHHS to develop the actuarially sound capitation rates for the Calendar Year 2018 contract period.

- Detailed fee-for-service claims data incurred January 1, 2014 through December 31, 2016 and paid through September 2017
- Detailed fee-for-service enrollment data for period January 1, 2014 through December 31, 2016
- Enrollees in a Dual Eligible Special Needs Plan (D-SNP) during the base period
- Additional gross adjustment expenditure information outside the MMIS claims system
- Summary of policy and program changes through calendar year 2018 (including changes to fee schedules and other payment rates)
- Monthly passive enrollment estimates for August 2017 through December 2018

Although the data were reviewed for reasonableness, the data was accepted without audit. To the extent the data was incomplete or was otherwise inaccurate, the information presented in this report will need to be modified. It should be emphasized that capitation rates are a projection of future costs based on a set of assumptions. Results will differ if actual experience is different from the assumptions contained in this letter. SCDHHS provides no guarantee, either written or implied, that the data and information is 100% accurate or error free. The capitation rates provided in this document will change to the extent that there are material errors in the information that was provided.

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III. Medicare Components of the Rate – CY 2018

Medicare A/B Services

CMS has developed baseline spending (costs absent the Demonstration) for Medicare 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, as adjusted below, 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 is 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 prior years trended forward to the applicable year) for products in which potential Demonstration enrollees would be enrolled absent the Demonstration.

Medicare A/B Component Payments: CY 2018 Medicare A/B Baseline County rates are provided below.

The final rates for CY 2018 are the CY 2018 FFS Standardized County Rates, updated to incorporate the adjustments noted below. The CY 2018 Medicare A/B rate component payments do not include projected costs associated with Medicare Advantage, as enrollment of beneficiaries into the Demonstration from Medicare Advantage plans is expected to be minimal.

Bad Debt Adjustment: The FFS component of the CY 2018 Medicare A/B baseline rate has been updated to reflect a 1.77% 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).

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 2018 in Medicare Advantage is 5.91%. For 2018, CMS will apply the full prevailing Medicare Advantage coding intensity adjustment and there is no upward adjustment to the Medicare A/B baseline rates to offset this reduction in the risk scores. While this means that the standardized (non-risk adjusted) rates are generally flat from CY 2017 to CY 2018, we expect risk score increases as a result of plan coding activity.

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,

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under South Carolina Healthy Connections Prime CMS will reduce non-exempt portions of the Medicare components of the integrated rate 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 CICO and is calculated using an enrollment-weighted average of the rates for each county in which the CICO participates.

2018 Medicare A/B Baseline PMPM, Non-ESRD Beneficiaries, Standardized 1.0 Risk Score, by Demonstration County[1]				
County	**2018 Published FFS Standardized County Rate**	**2018 Updated Medicare A/B FFS Baseline** (updated by CY 2018 bad debt adjustment)	**2018 Medicare A/B Baseline PMPM, Savings Percentage Applied** (after application of 3% savings percentage)	**2018 Final Medicare A/B PMPM Payment** (2% sequestration reduction applied and prior to quality withhold)
Abbeville	$864.76	$880.07	$853.67	$836.60
Aiken	762.66	776.16	752.88	737.82
Allendale	742.22	755.36	732.70	718.05
Anderson	826.89	841.53	816.28	799.95
Bamberg	800.12	814.28	789.85	774.05
Barnwell	802.22	816.42	791.93	776.09
Beaufort	840.10	854.97	829.32	812.73
Berkeley	805.03	819.28	794.70	778.81
Calhoun	820.23	834.75	809.71	793.52
Charleston	795.16	809.23	784.95	769.25
Cherokee	710.63	723.21	701.51	687.48
Chester	773.34	787.03	763.42	748.15
Chesterfield	727.48	740.36	718.15	703.79
Clarendon	756.03	769.41	746.33	731.40
Colleton	783.48	797.35	773.43	757.96
Darlington	798.31	812.44	788.07	772.31
Dillon	756.49	769.88	746.78	731.84
Dorchester	815.52	829.95	805.05	788.95
Edgefield	783.01	796.87	772.96	757.50
Fairfield	752.74	766.06	743.08	728.22
Florence	777.28	791.04	767.31	751.96
Georgetown	$818.46	$832.95	807.96	791.80
Greenville	749.91	763.18	740.28	725.47
Greenwood	844.40	859.35	833.57	816.90
Hampton	770.53	784.17	760.64	745.43
Horry	790.34	804.33	780.20	764.60
Jasper	842.62	857.53	831.80	815.16

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2018 Medicare A/B Baseline PMPM, Non-ESRD Beneficiaries, Standardized 1.0 Risk Score, by Demonstration County[1]				
County	**2018 Published FFS Standardized County Rate**	**2018 Updated Medicare A/B FFS Baseline** (updated by CY 2018 bad debt adjustment)	**2018 Medicare A/B Baseline PMPM, Savings Percentage Applied** (after application of 3% savings percentage)	**2018 Final Medicare A/B PMPM Payment** (2% sequestration reduction applied and prior to quality withhold)
Kershaw	781.84	795.68	771.81	756.37
Lancaster	811.20	825.56	800.79	784.77
Laurens	815.13	829.56	804.67	788.58
Lee	751.72	765.03	742.08	727.24
Lexington	783.95	797.83	773.90	758.42
McCormick	844.23	859.17	833.39	816.72
Marion	750.18	763.46	740.56	725.75
Marlboro	720.22	732.97	710.98	696.76
Newberry	799.78	813.94	789.52	773.73
Oconee	771.68	785.34	761.78	746.54
Orangeburg	760.06	773.51	750.30	735.29
Pickens	789.09	803.06	778.97	763.39
Richland	760.26	773.72	750.51	735.50
Saluda	803.21	817.43	792.91	777.05
Spartanburg	725.84	738.69	716.53	702.20
Sumter	$744.20	$757.37	734.65	719.96
Union	789.41	803.38	779.28	763.69
Williamsburg	789.45	803.42	779.32	763.73
York	777.13	790.89	767.16	751.82

[1]Rates do not apply to beneficiaries with ESRD or those electing the Medicare hospice benefit. See Section IV for information on savings percentages.

Note: For CY 2018 CMS will apply the full prevailing Medicare Advantage coding intensity adjustment of 5.91%.

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

Beneficiaries with End-Stage Renal Disease (ESRD): Separate Medicare A/B baselines and risk adjustment models 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 2018 South Carolina ESRD dialysis state rate, updated to incorporate the impact of sequestration-related rate reductions. The CY 2018 ESRD dialysis state rate for South Carolina is $6,968.83 PMPM; the updated CY 2018 ESRD dialysis state rate incorporating a 2% sequestration reduction and prior to the application of the quality withhold is $6,829.45 PMPM. This applies to applicable enrollees in all counties and will be risk adjusted using the prevailing HCC-ESRD risk adjustment model.

- **Transplant**: For enrollees in the transplant status phase (inclusive of the 3-months starting with the transplant), the Medicare A/B baseline is the CY 2018 South Carolina ESRD dialysis state rate updated to incorporate the impact of sequestration-related rate reductions. The CY 2018 ESRD dialysis state rate for South Carolina is $6,968.83 PMPM; the updated CY 2018 ESRD dialysis state rate incorporating a 2% sequestration reduction and prior to the application of the quality withhold is $6,829.45 PMPM. This applies to applicable enrollees in all counties and will be risk adjusted using the prevailing 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 the Medicare Advantage 3.5% bonus county rate/benchmark (see table below). This Medicare A/B component will be risk adjusted using the prevailing HCC-ESRD functioning graft risk adjustment model.

A savings percentage is not applied to the Medicare A/B baseline for enrollees with ESRD (inclusive of those enrollees in the dialysis, transplant and functioning graft status phases).

2018 Medicare A/B Baseline PMPM, Beneficiaries with ESRD Functioning Graft Status, Standardized 1.0 Risk Score, by Demonstration County		
County	**2018 3.5% bonus County Rate (Benchmark)**	**2018 Sequestration-Adjusted Medicare A/B Baseline** (after application of 2% Sequestration reduction)
Abbeville	$876.76	$859.22
Aiken	875.15	857.65
Allendale	817.53	801.18
Anderson	855.83	838.71
Bamberg	823.85	807.37
Barnwell	830.30	813.69
Beaufort	869.50	852.11
Berkeley	893.58	875.71

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2018 Medicare A/B Baseline PMPM, Beneficiaries with ESRD Functioning Graft Status, Standardized 1.0 Risk Score, by Demonstration County		
County	**2018 3.5% bonus County Rate (Benchmark)**	**2018 Sequestration-Adjusted Medicare A/B Baseline** (after application of 2% Sequestration reduction)
Calhoun	914.10	895.82
Charleston	882.63	864.98
Cherokee	842.10	825.26
Chester	827.64	811.09
Chesterfield	826.75	810.22
Clarendon	823.84	807.36
Colleton	840.28	823.47
Darlington	856.19	839.07
Dillon	854.40	837.31
Dorchester	844.06	827.18
Edgefield	839.78	822.98
Fairfield	861.89	844.65
Florence	862.78	845.52
Georgetown	847.11	830.17
Greenville	888.64	870.87
Greenwood	853.77	836.69
Hampton	855.29	838.18
Horry	826.42	809.89
Jasper	872.11	854.67
Kershaw	867.84	850.48
Lancaster	819.07	802.69
Laurens	874.23	856.75
Lee	846.85	829.91
Lexington	870.18	852.78
McCormick	844.23	827.35
Marion	860.83	843.61
Marlboro	827.41	810.86
Newberry	825.94	809.42
Oconee	824.73	808.24
Orangeburg	824.38	807.89
Pickens	875.89	858.37
Richland	843.89	827.01
Saluda	913.03	894.77
Spartanburg	885.52	867.81
Sumter	827.15	810.61
Union	823.98	807.50
Williamsburg	824.79	808.29
York	862.61	845.36

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 CICOs 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. CICOs 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 CICOs. CICOs will continue to receive the Medicare Part D and Medicaid payments, for which no changes will occur.

Medicare Part D Services

The Part D plan payment is 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 2018 is $57.93 and the CY 2018 Low-Income Premium Subsidy Amount for South Carolina is $23.03. Thus, the updated South Carolina Part D monthly per member per month payment for a beneficiary with a 1.0 RxHCC risk score applicable for CY 2018 is $57.23. 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.

- South Carolina low income cost-sharing: $186.33 PMPM
- South Carolina reinsurance: $138.63 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 South Carolina 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.

Year	Calendar dates	Savings percentage
Demonstration Year 1	February 1, 2015 – December 31, 2016	1%
Demonstration Year 2	January 1, 2017 – December 31, 2017	2%
Demonstration Year 3	January 1, 2018 – December 31, 2018	3%

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 increase to 2% in Demonstration Year 2 and 3% in Demonstration Year 3. We strongly encourage the CICOs to review the DY 3 methodology and plan ahead to maximize the chances of fully recouping the withheld amounts.
More information about the DY 2 and 3 quality withhold methodology is available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/DY2and3QualityWithholdGuidance042916.pdf.