South Carolina Healthy Connections Prime
CY 2019 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 2019 rates for the South Carolina Healthy Connections Prime program (Prime).

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 (Medicare-Medicaid Plans, or MMPs).

Included in this report are the final CY 2019 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 Organizations (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 2019

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 2019 Medicaid capitation rate report can be found online at https://www.scdhhs.gov/internet/pdf/SkjmG3tA3myIZwHtKOE2qFr8p62o49Ne.pdf
Note that the Medicaid component of the capitation rates were amended July 1, 2019. The full version of the July 2019 capitation rate amendment report can be found online at https://www.scdhhs.gov/internet/pdf/73IH98W8vVQPPaPEulw5BAk09OC3v8oy.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

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

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this report should be accompanied by the CY 2019 Healthy Connections Prime Medicaid capitation rate report for full documentation of assumptions and methodology.

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 2019) were established by the State and CMS.

Table 1 illustrates the proposed monthly capitation rates for each rate cell for the Prime Program Medicaid benefits. The 3% shared savings percentage for Demonstration Year 4 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 2019

Rate Cell	Medicaid Rate
Community	$ 86.44
Nursing Facility	$ 5,617.24
HCBS Waiver	$ 1,335.74
HCBS Waiver – Plus Rate	$ 3,598.85

Please note that Table 1 includes the Prime Medicaid capitation rates effective January 1, 2019. The Medicaid component of the capitation rates were amended July 1, 2019 and the full version of the July 2019 capitation rate amendment report can be found online at https://www.scdhhs.gov/internet/pdf/73IH98W8vVQPPaPEulw5BAk09OC3v8oy.pdf

Please note:

- The capitation rates reflect the current benefit package for CY 2019 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 2019 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 $33.39) 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 is enrolled in a DDSN waiver;
- 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;
  - 14 – MAO (General Hospital);
  - 50 – Qualified Working Disabled;
  - 55 – Family Planning;
  - 70 – Refugee Entrant.
- Any member month where an individual was not enrolled in both Medicare Part A and Medicare Part B coverage;
- Any member month where an individual resides in hospice or a nursing facility.

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.

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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. The nursing facility population was identified 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 from institutional care 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 and has an RSP of CLTC, HIVA, or VENT, 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 meeting the following conditions:

- Any Prime enrollee discharged from a nursing facility to an HCBS waiver.
- Any Prime enrollee, first eligible for nursing facility services or HCBS waiver services, who is served in a HCBS waiver without being admitted to a nursing facility.

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.

EXPERIENCE DATA ADJUSTMENTS REFLECTED IN THE MEDICAID CAPITATION RATES

The base fee-for-service (FFS) experience for calendar year (CY) 2017 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 period of CY 2017 provides for 9 months of claims payment runout from the end of CY 2017.
- 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, 2015 through December 31, 2017.
- 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 2019.
- Risk Selection – HCBS Waiver
  - 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 2017 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 materially higher utilization of waiver services than those Prime-eligible individuals in the base data who have not enrolled in Prime. As such, a selection factor of 1.045 was applied to the total HCBS Waiver PMPM cost after application of trend, program changes, and rating period adjustments.

- Risk Selection – Community
  - Effective January 1, 2019, SCDHHS is anticipated to passively enroll approximately 6,600 Community D-SNP members into the Prime program. Evaluation of historical CY 2017 FFS data between D-SNP members and the Prime-eligible members included in the base data indicated a variance between the two populations. The cost profile for D-SNP members is approximately 35% lower than the CY 2017 base data. Based on an estimated annual opt-out rate of 56% for D-SNP members and a relative morbidity of 0.65, a selection factor of 0.921 was applied to the total Community PMPM cost after application of trend, program changes, and rating period adjustments. The D-SNP passive enrollment is not anticipated to impact the average cost profile of the HCBS Waiver or Nursing Facility rate cells.
- Other Adjustments
  - Historical adjustment to reflect Hospice Room and Board Services on a gross rate basis for the Nursing Facility rate cell only.

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/SkjmG3tA3myIZwHtKOE2qFr8p62o49Ne.pdf.

NON-BENEFIT COSTS

Based on guidance from SCDHHS and the joint rate-setting process for the Financial Alignment's Capitated Model initiative, the non-benefit component of the capitation rate reflects the estimated non-benefit costs for Healthy Connections Prime members while in the FFS program (i.e., "absent the demonstration").

CMS-64 reports were used to estimate the average administrative expense PMPM for the Medicaid program. Table 2 illustrates the non-benefit cost PMPMs by rate cell for the CY 2019 Healthy Connections Prime program.

Table 2
South Carolina Department of Health and Human Services
Healthy Connections Prime Program – Medicaid Component
Non-Benefit Cost Allowance by Rate Cell

Rate Cell	Total
Community	$ 9.00
Nursing Facility	$ 90.00
HCBS Waiver	$ 90.00
HCBS Waiver – Plus Rate	$ 90.00

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DATA RELIANCE

The following information was provided by SCDHHS to develop the actuarially sound capitation rates for the Calendar Year 2019 contract period.

- Detailed fee-for-service claims data incurred January 1, 2015 through December 31, 2017 and paid through September 2018
- Detailed fee-for-service enrollment data for the period January 1, 2015 through December 31, 2017
- Managed care capitation rates paid to the health plans serving enrollees in the Prime program
- Summary of policy and program changes through CY 2019 (including changes to fee schedules and other payment rates)
- Enrollees in a Dual Eligible Special Needs Plan (D-SNP) during the base period
- Monthly passive enrollment estimates and member files for January 2019
- Healthy Connections Prime enrollment data by rate cell for September 2018
- Data exchange files between SCDHHS and CMS implemented by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) for July 2016 through June 2018
- CY 2017 quarterly Form CMS-64 reports detailing costs associated with Medicaid program expenditures and administrative expenses

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 2019

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 (MA) projected payment rates for each year, weighted by the proportion of the enrolled 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 the applicable year or for prior years trended forward to the applicable year) for products in which Demonstration enrollees would be enrolled absent the Demonstration.

Medicare A/B Component Payments: The final CY 2019 Medicare A/B Baseline County rates are provided below.

The final rates represent the weighted average of the CY 2019 FFS Standardized County Rates, updated to incorporate the adjustment noted below, and the Medicare Advantage projected payment rates for CY 2019 based on the actual enrollment of beneficiaries from Medicare FFS and Medicare Advantage prior to demonstration enrollment at the county level.

These rates reflect the rate change as finalized in the August 30, 2018 HPMS memorandum titled "Updates to MMP Medicare A/B Rate Methodology for CY 2019" and initially described in the July 11, 2018 HPMS memorandum titled "Proposed Update to MMP Medicare A/B Rate Methodology for CY 2019." As described in these memos, rather than continuing to use the historical MA versus FFS weighting prior to the demonstration of *demonstration-eligible beneficiaries,* beginning in CY 2019, CMS is re-basing the weighting based on the pre-enrollment status of *actual MMP enrollees.* This approach looks at the beneficiaries enrolled in the demonstration, by county, and assesses whether they were in MA or original Medicare FFS prior to enrolling in their current MMP. For the CY 2019 rates, this approach examined the pre-demonstration enrollment status of MMP enrollees during the second quarter of CY 2018 (as of April 2018).

Bad Debt Adjustment: The FFS component of the CY 2019 Medicare A/B baseline rate has been updated to reflect a 1.94% 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).

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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 2019 in Medicare Advantage is 5.90%. For 2019, CMS will apply the full prevailing Medicare Advantage coding intensity adjustment.

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

2019 Medicare A/B Baseline PMPM, Non-ESRD Beneficiaries, Standardized 1.0 Risk Score, by Demonstration County[1]					
County	**2019 Published FFS Standardized County Rate**	**2019 Updated Medicare A/B FFS Baseline** (updated by CY 2019 bad debt adjustment)	**2019 Updated Medicare A/B Baseline** (incorporating updated Medicare A/B FFS baseline and Medicare Advantage component)	**2019 Medicare A/B Baseline PMPM, Savings Percentage Applied** (after application of 3% savings percentage)	**2019 Final Medicare A/B PMPM Payment** (2% sequestration reduction applied and prior to quality withhold)
Abbeville	$907.98	$925.59	$903.40	$876.30	$858.77
Aiken	822.38	838.33	838.33	813.18	796.92
Allendale	809.96	825.67	820.77	796.15	780.23
Anderson	873.09	890.03	885.62	859.05	841.87
Bamberg	831.88	848.02	843.61	818.30	801.93
Barnwell	844.08	860.46	860.80	834.98	818.28
Beaufort	873.68	890.63	886.09	859.51	842.32
Berkeley	857.70	874.34	874.02	847.80	830.84
Calhoun	871.87	888.78	888.78	862.12	844.88
Charleston	848.31	864.77	864.61	838.67	821.90
Cherokee	762.20	776.99	788.60	764.94	749.64
Chester	827.01	843.05	838.81	813.65	797.38
Chesterfield	760.65	775.41	777.89	754.55	739.46
Clarendon	812.68	828.45	828.43	803.58	787.51
Colleton	844.63	861.02	863.20	837.30	820.55
Darlington	854.76	871.34	871.34	845.20	828.30

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2019 Medicare A/B Baseline PMPM, Non-ESRD Beneficiaries, Standardized 1.0 Risk Score, by Demonstration County[1]					
County	**2019 Published FFS Standardized County Rate**	**2019 Updated Medicare A/B FFS Baseline** (updated by CY 2019 bad debt adjustment)	**2019 Updated Medicare A/B Baseline** (incorporating updated Medicare A/B FFS baseline and Medicare Advantage component)	**2019 Medicare A/B Baseline PMPM, Savings Percentage Applied** (after application of 3% savings percentage)	**2019 Final Medicare A/B PMPM Payment** (2% sequestration reduction applied and prior to quality withhold)
Dillon	$791.73	$807.09	$809.86	$785.56	$769.85
Dorchester	865.71	882.50	880.36	853.95	836.87
Edgefield	852.09	868.62	868.62	842.56	825.71
Fairfield	797.46	812.93	819.03	794.46	778.57
Florence	820.46	836.38	835.89	810.81	794.59
Georgetown	854.97	871.56	866.48	840.49	823.68
Greenville	792.20	807.57	820.97	796.34	780.41
Greenwood	898.84	916.28	895.80	868.93	851.55
Hampton	823.73	839.71	839.14	813.97	797.69
Horry	831.28	847.41	847.41	821.99	805.55
Jasper	882.71	899.83	895.37	868.51	851.14
Kershaw	827.21	843.26	845.79	820.42	804.01
Lancaster	864.45	881.22	881.22	854.78	837.68
Laurens	848.62	865.08	859.99	834.19	817.51
Lee	810.45	826.17	826.59	801.79	785.75
Lexington	845.88	862.29	867.34	841.32	824.49
McCormick	889.29	906.54	906.54	879.34	861.75
Marion	814.61	830.41	830.57	805.65	789.54
Marlboro	724.49	738.55	744.00	721.68	707.25
Newberry	849.42	865.90	859.00	833.23	816.57
Oconee	811.54	827.28	830.71	805.79	789.67
Orangeburg	810.65	826.38	826.75	801.95	785.91
Pickens	824.68	840.68	849.24	823.76	807.28
Richland	811.38	827.12	837.01	811.90	795.66
Saluda	872.88	889.81	886.48	859.89	842.69
Spartanburg	772.81	787.80	810.54	786.22	770.50
Sumter	793.06	808.45	808.45	784.20	768.52
Union	821.67	837.61	827.61	802.78	786.72
Williamsburg	827.91	843.97	841.72	816.47	800.14
York	823.82	839.80	848.28	822.83	806.37

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

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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 2019 South Carolina ESRD dialysis state rate, updated to incorporate the impact of sequestration-related rate reductions. The CY 2019 ESRD dialysis state rate for South Carolina is $7,661.88 PMPM; the updated CY 2019 ESRD dialysis state rate incorporating a 2% sequestration reduction and prior to the application of the quality withhold is $7,508.64 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 2019 South Carolina ESRD dialysis state rate updated to incorporate the impact of sequestration-related rate reductions. The CY 2019 ESRD dialysis state rate for South Carolina is $7,661.88 PMPM; the updated CY 2019 ESRD dialysis state rate incorporating a 2% sequestration reduction and prior to the application of the quality withhold is $7,508.64 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).

2019 Medicare A/B Baseline PMPM, Beneficiaries with ESRD Functioning Graft Status, Standardized 1.0 Risk Score, by Demonstration County		
County	**2019 3.5% bonus County Rate (Benchmark)**	**2019 Sequestration-Adjusted Medicare A/B Baseline** (after application of 2% Sequestration reduction)
Abbeville	$934.70	$916.01
Aiken	943.68	924.81
Allendale	864.92	847.62
Anderson	903.65	885.58
Bamberg	873.44	855.97
Barnwell	905.28	887.17
Beaufort	904.26	886.17
Berkeley	952.05	933.01

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2019 Medicare A/B Baseline PMPM, Beneficiaries with ESRD Functioning Graft Status, Standardized 1.0 Risk Score, by Demonstration County		
County	**2019 3.5% bonus County Rate (Benchmark)**	**2019 Sequestration-Adjusted Medicare A/B Baseline** (after application of 2% Sequestration reduction)
Calhoun	$965.60	$946.29
Charleston	941.62	922.79
Cherokee	903.21	885.15
Chester	876.58	859.05
Chesterfield	875.82	858.30
Clarendon	872.25	854.81
Colleton	937.54	918.79
Darlington	944.94	926.04
Dillon	916.15	897.83
Dorchester	896.01	878.09
Edgefield	945.82	926.90
Fairfield	943.00	924.14
Florence	910.71	892.50
Georgetown	884.89	867.19
Greenville	938.76	919.98
Greenwood	903.84	885.76
Hampton	914.34	896.05
Horry	874.66	857.17
Jasper	913.60	895.33
Kershaw	918.20	899.84
Lancaster	867.32	849.97
Laurens	910.14	891.94
Lee	906.51	888.38
Lexington	938.93	920.15
McCormick	895.88	877.96
Marion	965.31	946.00
Marlboro	858.52	841.35
Newberry	874.89	857.39
Oconee	873.59	856.12
Orangeburg	873.23	855.77
Pickens	915.39	897.08
Richland	931.06	912.44
Saluda	966.75	947.42
Spartanburg	942.83	923.97
Sumter	876.11	858.59
Union	872.82	855.36
Williamsburg	873.46	855.99
York	914.44	896.15

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.

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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 2019 is $51.28 and the CY 201 Low-Income Premium Subsidy Amount for South Carolina is $24.55. 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 2019 is $50.75. 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: $189.57 PMPM
- South Carolina reinsurance: $157.47 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. 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 – December 31, 2017	2%
Demonstration Year 3	January 1 – December 31, 2018	3%
Demonstration Year 4	January 1 – December 31, 2019	3%

Quality Withhold

The quality withhold 3% in Demonstration Year 3 and beyond.

More information about the Demonstration Year 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.