South Carolina Healthy Connections Prime
CY 2017 Combined Medicare and Medicaid Rate Report
December 7, 2017

The State of South Carolina, in conjunction with the Centers for Medicare and Medicaid Services (CMS), is releasing the Medicare component of the CY 2017 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.

Included in this report are the CY 2017 Medicare county base rates. The South Carolina component of the rate will be released at a later date. An updated report will be provided when the rates are finalized.

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 2017

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 Medicaid capitation rate report can be found online at https://www.scdhhs.gov/internet/pdf/b5xvi1vwl1acrTIAtVZ2Igg106gkMA5n.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 2017 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:

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

- 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 (2% in CY 2017) 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 2% shared savings percentage for Demonstration Year 2 of the program, as outlined in Section IV of this report, has been applied to these rates.

Table 1
State of South Carolina
Department of Health and Human Services
Healthy Connections Prime Program – Medicaid Component
Demonstration Capitation Rates
Effective Calendar Year 2017

Rate Cell	Medicaid Rate
Community	$83.21
Nursing Facility	5,253.91
HCBS Waiver	1,170.83
HCBS Waiver – Plus Rate	3,361.13

Please note:

- The capitation rates reflect the current benefit package for Calendar Year 2017, approved by the State and CMS as of the date of this report. The rates will be revised appropriately if 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 2017 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 $30.98) 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 on a statewide basis and includes individuals enrolled in the Community Choices Waiver, HIV/AIDS Waiver and Mechanical Ventilation 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 incurred an ICF/IID claim
- 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 health plans.

The following describes each of the distinct populations 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**: CLTC HIV AIDS Waiver
- **VENT**: CLTC 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. Milliman identified the population in the capitation rate-setting process by using fields in the SCDHHS eligibility data that denote Medicaid individuals as meeting the nursing home level of care criteria, but who are not enrolled in an HCBS waiver. Additionally, the methodology utilized to allocate the nursing facility rate cell required that nursing facility individuals have at least one day of service in an institution (DHHS nursing home, Department of Mental Health (DMH) nursing home, nursing home swing beds, or hospice room & board) for the member month to be included. 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 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. 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 CICO 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 state fiscal year (SFY) 2014 and SFY 2015 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 SFY 2014 and SFY 2015 provide for 14 months of claims payment runout from

the end of SFY 2015, which results in claims completion of nearly 100%, based on historical observation of SCDHHS's claims payment patterns.

- 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, 2013 through June 30, 2015.
- 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 Calendar Year 2017.
- Risk Selection
  - A prospective risk selection factor was applied to the base data in order to reflect the voluntary and opt-out nature of the Demonstration. Evaluation of claims probability distributions (CPDs) by population show that the risk selection is applicable only to the Community population because the majority of service cost for the Nursing Facility and HCBS waiver populations is determined by the nursing facility and waiver services.
  - The selection factor was developed in two steps:
    - Step 1: Analyze the projected CY 2017 Community population not part of the passive enrollment waves anticipated to begin August 2017 (non-wave members)
    - Step 2: Analyze the passively enrolled members anticipated to enroll beginning August 2017.

Step 1: Non-wave members

- The relative morbidity for non-wave members was developed by analyzing August 2016 dual-eligible enrollment. The enrollment analysis was limited to individuals who were not enrolled in a D-SNP and their historical PMPM costs were evaluated for the following groupings:
  - Enrolled in the Prime program's Community population;
  - Not enrolled in Prime but who could qualify for the Community population using the eligibility logic outlined in the "Identification of covered population" section of this report;
- To recognize the distribution of membership and morbidity impacts that may be present based on duration in the Medicaid program, we further stratified the population described above into the following three subsets
  - **Members who were present in both SFY 2014 and SFY 2015 base periods**: We compared the PMPM cost over the two base period years of the Prime-enrolled population to the total "Community-eligible" population.
  - **Members who were present in SFY 2015 base period only**: We compared the SFY 2015 PMPM cost of the Prime-enrolled population to the total "Community-eligible" population.

- **Members who are "new" to the population since the end of SFY 2015 base period**: We assume that these members are comparable to the average cost of a Community member as reflected by the cost model (i.e., a relative factor of 1.00).

Step 2: Monthly passive enrollment waves beginning August 2017

- The relative morbidity of the monthly wave enrollees beginning in August 2017 was estimated in two steps:
  - Evaluate the relative risk of the wave population by comparing the average SFY 2014 and SFY 2015 PMPM of the anticipated August and September 2017 passively-enrolled individuals to the SFY 2014 and SFY 2015 base data PMPM for base data members still enrolled in Medicaid in July 2017;
  - Apply an assumed "opt-in" morbidity adjustment factor of 0.95 to account for the impact of members who voluntarily opt out of the Prime program.
- The resulting risk selection factor of 0.79 reflects a more favorable mix of enrollment than the current FFS experience.

- Other Adjustments
  - Historical adjustment to reflect Hospice Room and Board Services on a gross rate basis
  - Historical and prospective adjustments to reflect provider reimbursement and other program changes
  - Historical adjustment to reflect the reclassification of claims experience and membership of community individuals in a nursing facility for an extended stay into the nursing facility rate cell

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/b5xvi1vwl1acrTIAtVZ2Igg106gkMA5n.pdf.

DATA RELIANCE

The following information was provided by SCDHHS to develop the actuarially sound capitation rates for the Calendar Year 2017 contract period.

- Detailed fee-for-service claims data incurred July 1, 2013 through June 30, 2015, and paid through August 2015
- Detailed fee-for-service enrollment data for period July 1, 2013 through June 30, 2015 and July 2017
- 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 state fiscal year 2017 (including changes to fee schedules and other payment rates)

- August, September, and October 2017 passive enrollment information

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 2017

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 the applicable year or 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 2017 Medicare A/B Baseline County rates are provided below.

The rates for CY 2017 are the CY 2017 FFS Standardized County Rates, updated to incorporate the adjustments noted below. The CY 2017 Medicare A/B rate component payments do not include projected costs associated with Medicare Advantage.

Please Note: *In CY 2016, CMS updated the FFS component of the Medicare A/B baseline rate to better align Prime Plan payments with Medicare fee-for-service costs, by offsetting under prediction in the CMSHCC risk adjustment model for full-benefit dual eligible beneficiaries in the community. In CY 2017 CMS will implement a new HCC risk adjustment model across all of Medicare Advantage, as well as for Medicare-Medicaid Plans, that will increase risk scores for community full-benefit dual eligible beneficiaries in order to address this under prediction issue. As a result, CMS will not be making such an adjustment to the FFS component of the Medicare A/B baseline in 2017. While this means that the standardized (non-risk adjusted) rates generally decline from CY 2016 to CY 2017, we expect these decreases will be offset by implementation of the new risk adjustment model.*

The FFS component of the CY 2017 Medicare A/B baseline rate has been updated to reflect a 1.74% 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

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Original Fee-for-Service Medicare programs. The adjustment for CY 2017 in Medicare Advantage is 5.66%.

In 2017, CMS will apply a coding intensity adjustment based on the anticipated proportion of Demonstration enrollees in CY 2017 with prior Medicare Advantage experience and/or Demonstration experience based on the Demonstration's enrollment phase-in as of September 30, 2016.

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

After CY 2017, CMS will apply the prevailing Medicare Advantage coding intensity adjustment for all enrollees.

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.

2017 Medicare A/B Baseline PMPM, Non-ESRD Beneficiaries, Standardized 1.0 Risk Score, by Demonstration County[1]

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County	2017 Published FFS Standardized County Rate	2017 Updated Medicare A/B FFS Baseline (updated by CY 2017 bad debt adjustment)	2017 Medicare A/B Baseline Preliminary (increased to offset application of coding intensity adjustment factor in 2017)[2]	2017 Medicare A/B Baseline PMPM, Savings Percentage Applied (after application of 2% savings percentage)	2017 Final Medicare A/B PMPM Payment (2% sequestration reduction applied and prior to quality withhold)
Abbeville	$852.40	$867.23	$872.25	$854.80	$837.70
Aiken	750.55	763.61	768.03	752.67	737.62
Allendale	731.89	744.62	748.94	733.96	719.28
Anderson	793.65	807.46	812.13	795.89	779.97
Bamberg	770.68	784.09	788.63	772.86	757.40
Barnwell	826.76	841.15	846.02	829.10	812.52
Beaufort	821.05	835.34	840.17	823.37	806.90
Berkeley	780.85	794.44	799.04	783.05	767.39
Calhoun	783.99	797.63	802.25	786.21	770.49
Charleston	769.02	782.40	786.93	771.19	755.77
Cherokee	693.91	705.98	710.07	695.87	681.95
Chester	762.93	776.20	780.70	765.08	749.78
Chesterfield	716.62	729.09	733.31	718.65	704.28
Clarendon	748.07	761.09	765.49	750.18	735.18
Colleton	775.79	789.29	793.86	777.98	762.42
Darlington	785.52	799.19	803.81	787.74	771.99
Dillon	730.75	743.47	747.77	732.81	718.15
Dorchester	793.64	807.45	812.12	795.88	779.96
Edgefield	775.48	788.97	793.54	777.67	762.12
Fairfield	758.67	771.87	776.34	760.82	745.60
Florence	759.42	772.63	777.11	761.56	746.33
Georgetown	807.26	821.31	826.06	809.54	793.35
Greenville	716.77	729.24	733.46	718.80	704.42
Greenwood	827.12	841.51	846.38	829.45	812.86
Hampton	756.23	769.39	773.84	758.36	743.19

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Horry	773.15	786.60	791.16	775.33	759.82
Jasper	832.94	847.43	852.34	835.29	818.58
Kershaw	773.84	787.30	791.86	776.03	760.51
Lancaster	797.01	810.88	815.57	799.26	783.27

2017 Medicare A/B Baseline PMPM, Non-ESRD Beneficiaries, Standardized 1.0 Risk Score, by Demonstration County[1]

County	**2017 Published FFS Standardized County Rate**	**2017 Updated Medicare A/B FFS Baseline** (updated by CY 2017 bad debt adjustment)	**2017 Medicare A/B Baseline Preliminary** (increased to offset application of coding intensity adjustment factor in 2017)[2]	**2017 Medicare A/B Baseline PMPM, Savings Percentage Applied** (after application of 2% savings percentage)	**2017 Final Medicare A/B PMPM Payment** (2% sequestration reduction applied and prior to quality withhold)
Laurens	$787.62	$801.32	$805.96	$789.84	$774.04
Lee	740.49	753.37	757.74	742.58	727.73
Lexington	764.03	777.32	781.82	766.19	750.87
McCormick	824.84	839.19	844.05	827.16	810.62
Marion	735.55	748.35	752.68	737.63	722.88
Marlboro	701.63	713.84	717.97	703.62	689.55
Newberry	766.38	779.72	784.23	768.54	753.17
Oconee	739.55	752.42	756.77	741.64	726.81

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

[2] For CY 2017 CMS has established rates in a manner that does not lead to lower amounts for this coding intensity adjustment. Operationally, due to systems limitations, CMS will still apply the coding intensity adjustment factor to the risk scores but has increased the FFS component of the Medicare A/B baseline for non-ESRD beneficiaries to offset this. Specifically, CMS has increased the Medicare A/B baseline by a corresponding percentage; the CY 2017 Medicare FFS A/B Baseline is divided by (1- (1-the prevailing coding intensity adjustment for CY 2017)/ (1-the effective coding intensity adjustment of 5.11% for this demonstration)) to determine the CY 2017 Final Medicare FFS A/B Baseline.

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

Orangeburg	734.99	747.78	752.11	737.06	722.32
Pickens	751.98	765.06	769.49	754.10	739.02
Richland	748.36	761.38	765.79	750.48	735.47
Saluda	750.01	763.06	767.48	752.13	737.09
Spartanburg	696.85	708.98	713.08	698.82	684.84
Sumter	729.79	742.49	746.79	731.85	717.21
Union	767.99	781.35	785.88	770.16	754.76
Williamsburg	784.86	798.52	803.14	787.08	771.34
York	751.49	764.57	768.99	753.62	738.55

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 2017 South Carolina ESRD dialysis state rate, updated to incorporate the impact of sequestration related rate reductions. The CY 2017 ESRD dialysis state rate for South Carolina is $6,908.92 PMPM; the updated CY 2017 ESRD dialysis state rate incorporating a 2% sequestration reduction and prior to the application of the quality withhold is $6,770.74 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 2017 South Carolina ESRD dialysis state rate updated to incorporate the impact of sequestration-related rate reductions. The CY 2017 ESRD dialysis state rate for South Carolina is $6,908.92 PMPM; the updated CY 2017 ESRD dialysis state rate incorporating a 2% sequestration reduction and prior to the application of the quality withhold is $6,770.74 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).

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2017 Medicare A/B Baseline PMPM, Beneficiaries with ESRD Functioning Graft Status, Standardized 1.0 Risk Score, by Demonstration County			
County	**2017 3.5% bonus County Rate (Benchmark)**	**2017 Final Medicare A/B PMPM Baseline (increased to offset application of coding intensity adjustment factor in 2017)***	**2017 Sequestration Adjusted Medicare A/B Baseline (after application of 2% Sequestration reduction)**
Abbeville	$852.40	$857.33	$840.18
Aiken	861.26	866.25	848.93
Allendale	797.17	801.78	785.75
Anderson	851.19	856.12	838.99
Bamberg	803.72	808.37	792.20
Barnwell	847.63	852.54	835.48
Beaufort	849.79	854.71	837.62
Berkeley	866.74	871.76	854.32
Calhoun	868.27	873.30	855.83
Charleston	853.61	858.55	841.38
Cherokee	796.26	800.87	784.85
Chester	807.17	811.84	795.60
Chesterfield	795.45	800.05	784.06
Clarendon	803.25	807.90	791.74
Colleton	802.94	807.59	791.44
Darlington	813.01	817.72	801.37
Dillon	811.13	815.83	799.50
Dorchester	821.42	826.18	809.66
Edgefield	831.70	836.51	819.79
Fairfield	840.23	845.09	828.19
Florence	842.96	847.84	830.88
Georgetown	835.51	840.35	823.54
Greenville	822.49	827.25	810.71

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Greenwood	832.15	836.97	820.23
Hampton	839.42	844.28	827.39
Horry	805.70	810.36	794.15
Jasper	862.09	867.08	849.74
Kershaw	858.96	863.93	846.66

2017 Medicare A/B Baseline PMPM, Beneficiaries with ESRD Functioning Graft Status, Standardized 1.0 Risk Score, by Demonstration County			
County	**2017 3.5% bonus County Rate (Benchmark)**	**2017 Final Medicare A/B PMPM Baseline (increased to offset application of coding intensity adjustment factor in 2017)***	**2017 Sequestration Adjusted Medicare A/B Baseline (after application of 2% Sequestration reduction)**
Lancaster	$797.01	$801.62	$785.59
Laurens	815.19	819.91	803.51
Lee	794.18	798.78	782.80
Lexington	819.42	824.16	807.69
McCormick	824.84	829.62	813.03
Marion	816.46	821.19	804.76
Marlboro	806.95	811.62	795.39
Newberry	805.65	810.31	794.11
Oconee	804.52	809.18	793.00
Orangeburg	804.07	808.72	792.56
Pickens	834.70	839.53	822.74
Richland	830.68	835.49	818.78
Saluda	860.64	865.62	848.31
Spartanburg	850.16	855.08	837.98
Sumter	806.98	811.65	795.42
Union	794.87	799.47	783.48
Williamsburg	803.75	808.40	792.23
York	834.15	838.98	822.20

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*For CY 2017 CMS has established rates in a manner that does not lead to lower amounts for this coding intensity adjustment. Operationally, due to systems limitations, CMS will still apply the coding intensity adjustment factor to the risk scores but has increased the Medicare A/B baseline for beneficiaries with an ESRD status of functioning graft to offset this. Specifically, CMS has increased the Medicare A/B baseline by a corresponding percentage; as above, the CY 2017 Updated Medicare A/B Baseline is divided by (1- (1-the prevailing coding intensity adjustment for CY 2017)/ (1- the effective coding intensity adjustment of 5.11% for this demonstration)) to determine the CY 2017 Final Medicare A/B Baseline. For beneficiaries with an ESRD status of functioning graft, the prospective payment does not include the adjustment to offset the application of coding intensity adjustment factor; this payment adjustment is made on a retrospective basis.

Beneficiaries Electing the Medicare Hospice Benefit: If an enrollee elects to receive the Medicare hospice benefit, the enrollee will remain in the Demonstration but will obtain the hospice services through the Medicare FFS benefit. The 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 nonpremium 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. As reference, the NAMBA for CY 2016 was $64.66. To illustrate, the NAMBA for CY 2017 is $61.08 and the CY 2017 Low Income Premium Subsidy Amount for South Carolina is $26.03. 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 2017 is $60.38. 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. CMS will release these amounts at a later date.

- South Carolina low income cost-sharing: $164.89 PMPM
- South Carolina reinsurance: $96.20 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-MedicaidCoordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/JointRateSettingProcess.pdf

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IV. Savings Percentages and Quality Withholds

Savings Percentages

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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	4%

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.

More information about the DY 1 quality withhold methodology is available at: http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/DY1QualityWithholdGuidance060614.pdf.

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.