# South Carolina Healthy Connections Prime
# CY 2016 Final Medicare Rate Report
# March 15, 2016

The State of South Carolina, in conjunction with the Centers for Medicare and Medicaid Services (CMS), is releasing the updated Medicaid component of the CY 2016 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 participating health plans.

Included in this report are the final CY 2016 Medicare county base rates, updated to reflect an upward adjustment to better align payments with Medicare fee-for-service costs for full benefit dual eligible beneficiaries. Also included in this report are the final CY 2016 South Carolina Medicaid component of the rate.

## 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 2016

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 438.6, 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. For the purposes of the development of the Medicaid component of the Prime capitation rate, "actuarial soundness" is defined as follows:

> Medicaid capitation rates are "actuarially sound" if, for business in the state for which the certification is being prepared and for the period covered by the certification, projected capitation rates – including expected reinsurance and governmental stop-loss cash flows, governmental risk adjustment cash flows, and investment income – provide for all reasonable, appropriate, and attainable costs, including health benefits; health benefit settlement expenses; marketing and administrative expenses; any government-mandated assessments, fees, and taxes; and the cost of capital.

The capitation rate-setting process for the Prime program does not follow the Medicaid managed care capitation rate-setting methodology outlined in Actuarial Standard of Practice (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://msp.scdhhs.gov/SCDue2/sites/default/files/Healthy-Connections-Prime-CY-2016-Medicaid-Capitation-Rate-Documentation.pdf .

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 438.6(c) 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 (1% in CY 2016) 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 1% shared savings percentage for Demonstration Year 1 of the program, as outlined in Section IV of this report, has been applied to these rates.

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| Table 1<br>State of South Carolina<br>Department of Health and Human Services<br>Healthy Connections Prime Program –<br>Medicaid Component<br>Demonstration Capitation Rates<br>Effective Calendar Year 2016 | |
|---|---|
| **Rate Cell** | **Medicaid Rate** |
| Community | $95.98 |
| Nursing Facility | 5,067.55 |
| HCBS Waiver | 1,200.09 |
| HCBS Waiver – Plus Rate | 3,259.20 |

**Please note**:

- The capitation rates reflect the current benefit package for Calendar Year 2016, 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 2016 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 $30.67) 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) 2013 and SFY 2014 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 2013 and SFY 2014 provide for 13 months of claims payment runout from the end of SFY 2014, 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 July 1, 2012 through June 30, 2014.
- 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 2016.

- 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.

    This selection factor was developed by analyzing currently-enrolled Prime members and projected Prime members entering through two waves of passive enrollment beginning April 2016. Projected CY 2016 membership of current Prime members and passively-enrolled members who do not opt out of the Community population, was utilized to develop a weighted-average selection factor for the Community capitation rate cell. The resulting risk selection factor 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
  - Prospective adjustment to reflect the removal of estimated dual eligible enrollment in a Dual Eligible Special Needs (D-SNP) plan

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://msp.scdhhs.gov/SCDue2/sites/default/files/Healthy-Connections-Prime-CY-2016-Medicaid-Capitation-Rate-Documentation.pdf .

## DATA RELIANCE

The following information was provided by SCDHHS to develop the actuarially sound capitation rates for the Calendar Year 2016 contract period.

- Detailed fee-for-service claims data incurred July 1, 2012 through June 30, 2014, and paid through July 2015.
- Detailed fee-for-service enrollment data for period July 1, 2012 through June 30, 2014.
- Additional gross adjustment expenditure information outside the MMIS claims system.
- Summary of policy and program changes through state fiscal year 2016 (including changes to fee schedules and other payment rates).

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.

## III. Medicare Components of the Rate – CY 2016

***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 2016 Medicare A/B Baseline County rates are provided below.

The rates for CY 2016 are the CY 2016 FFS Standardized County Rates, updated to incorporate the adjustments noted below. The CY 2016 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 negligible during CY 2016. During CY 2016 Demonstration enrollment will be primarily beneficiaries enrolling from Medicare FFS.

The FFS component of the CY 2016 Medicare A/B baseline rate has been updated to better align Prime Plan payments with Medicare fee-for-service costs, by offsetting underprediction in the CMS-HCC risk adjustment model for full benefit dual eligible beneficiaries. This 11.52% upward adjustment applies to the Medicare A/B FFS rate component for CY 2016 only.

The FFS component of the CY 2016 Medicare A/B baseline rate has been updated to reflect a 1.84% 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). This 1.84% adjustment applies for CY 2016 and will be updated for subsequent years 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 2016 in Medicare Advantage is 5.41%. For CY 2015, based on the enrollment process for South Carolina Healthy Connections Prime, CMS established the FFS component of the Medicare A/B baseline in a manner that did not lead to lower amounts due to this coding intensity adjustment.

As described in the three-way contract, in CY 2016, CMS will apply a coding intensity adjustment based on the anticipated proportion of Demonstration enrollees in CY 2016 with prior Medicare Advantage experience and/or Demonstration experience based on the Demonstration's enrollment phase-in as of September 30, 2015. CMS' calculations take into account planned passive enrollment and rates of opt-out and engagement in the passive enrollment process. For South Carolina, the applicable 2016 coding intensity adjustment is 0.88%.

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 2016, CMS will apply the full 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.

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| 2016 Medicare A/B Baseline PMPM, Non-ESRD Beneficiaries, Standardized 1.0 Risk Score, by Demonstration County[1] | | | | | | |
|---|---|---|---|---|---|---|
| **County** | **2016 Published FFS Standardized County Rate** | **2016 Initial Medicare A/B FFS Baseline** (increased to reflect CY 2016 risk adjustment model update) | **2016 Updated Medicare A/B FFS Baseline** (updated by CY 2016 bad debt adjustment) | **2016 Final Medicare A/B FFS Baseline** (increased to offset application of coding intensity adjustment factor in 2016)[2] | **2016 Medicare A/B Baseline PMPM, Savings Percentage Applied** (after application of 1% savings percentage) | **2016 Final Medicare A/B PMPM Payment** (2% sequestration reduction applied and prior to quality withhold) |
| Abbeville | $813.38 | $907.06 | $923.75 | $967.58 | $957.90 | $938.74 |
| Aiken | 708.40 | 789.99 | 804.52 | 842.70 | 834.27 | 817.58 |
| Allendale | 745.30 | 831.14 | 846.43 | 886.59 | 877.73 | 860.18 |
| Anderson | 763.37 | 851.29 | 866.95 | 908.09 | 899.00 | 881.02 |
| Bamberg | 738.94 | 824.04 | 839.21 | 879.03 | 870.24 | 852.84 |
| Barnwell | 804.46 | 897.11 | 913.62 | 956.97 | 947.40 | 928.45 |
| Beaufort | 799.42 | 891.49 | 907.89 | 950.97 | 941.46 | 922.63 |
| Berkeley | 753.82 | 840.64 | 856.11 | 896.73 | 887.76 | 870.00 |
| Calhoun | 754.14 | 841.00 | 856.47 | 897.11 | 888.14 | 870.38 |
| Charleston | 744.15 | 829.85 | 845.12 | 885.22 | 876.37 | 858.84 |
| Cherokee | 698.18 | 778.59 | 792.92 | 830.54 | 822.23 | 805.79 |
| Chester | 747.19 | 833.24 | 848.58 | 888.84 | 879.95 | 862.35 |
| Chesterfield | 718.82 | 801.61 | 816.36 | 855.09 | 846.55 | 829.62 |
| Clarendon | 732.66 | 817.04 | 832.07 | 871.56 | 862.84 | 845.58 |
| Colleton | 766.44 | 854.71 | 870.44 | 911.74 | 902.62 | 884.57 |
| Darlington | 763.72 | 851.68 | 867.35 | 908.50 | 899.42 | 881.43 |
| Dillon | 729.86 | 813.92 | 828.89 | 868.23 | 859.54 | 842.35 |
| Dorchester | 768.82 | 857.37 | 873.14 | 914.57 | 905.42 | 887.31 |
| Edgefield | 755.73 | 842.77 | 858.28 | 899.00 | 890.01 | 872.21 |
| Fairfield | 734.38 | 818.96 | 834.03 | 873.60 | 864.86 | 847.56 |
| Florence | 745.19 | 831.01 | 846.30 | 886.46 | 877.60 | 860.05 |
| Georgetown | 788.40 | 879.20 | 895.38 | 937.86 | 928.48 | 909.91 |
| Greenville | 708.81 | 790.44 | 804.99 | 843.18 | 834.75 | 818.06 |
| Greenwood | 812.81 | 906.42 | 923.10 | 966.90 | 957.24 | 938.10 |
| Hampton | 732.72 | 817.11 | 832.14 | 871.63 | 862.92 | 845.66 |
| Horry | 743.95 | 829.63 | 844.90 | 884.99 | 876.14 | 858.62 |

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| 2016 Medicare A/B Baseline PMPM, Non-ESRD Beneficiaries, Standardized 1.0 Risk Score, by Demonstration County[1] | | | | | | |
|---|---|---|---|---|---|---|
| **County** | **2016 Published FFS Standardized County Rate** | **2016 Initial Medicare A/B FFS Baseline** (increased to reflect CY 2016 risk adjustment model update) | **2016 Updated Medicare A/B FFS Baseline** (updated by CY 2016 bad debt adjustment) | **2016 Final Medicare A/B FFS Baseline** (increased to offset application of coding intensity adjustment factor in 2016)[2] | **2016 Medicare A/B Baseline PMPM, Savings Percentage Applied** (after application of 1% savings percentage) | **2016 Final Medicare A/B PMPM Payment** (2% sequestration reduction applied and prior to quality withhold) |
| Jasper | 794.88 | 886.43 | 902.74 | 945.57 | 936.12 | 917.40 |
| Kershaw | 743.93 | 829.61 | 844.87 | 884.96 | 876.11 | 858.59 |
| Lancaster | 807.08 | 900.03 | 916.59 | 960.08 | 950.49 | 931.48 |
| Laurens | 768.54 | 857.05 | 872.82 | 914.24 | 905.10 | 887.00 |
| Lee | 753.34 | 840.10 | 855.56 | 896.16 | 887.20 | 869.46 |
| Lexington | 739.75 | 824.95 | 840.13 | 879.99 | 871.19 | 853.77 |
| McCormick | 795.79 | 887.44 | 903.77 | 946.65 | 937.19 | 918.45 |
| Marion | 731.87 | 816.16 | 831.18 | 870.62 | 861.91 | 844.67 |
| Marlboro | 700.96 | 781.69 | 796.07 | 833.85 | 825.51 | 809.00 |
| Newberry | 726.62 | 810.31 | 825.22 | 864.37 | 855.73 | 838.62 |
| Oconee | 721.76 | 804.89 | 819.70 | 858.59 | 850.01 | 833.01 |
| Orangeburg | 717.96 | 800.65 | 815.38 | 854.07 | 845.53 | 828.62 |
| Pickens | 725.12 | 808.63 | 823.51 | 862.59 | 853.96 | 836.88 |
| Richland | 724.46 | 807.90 | 822.76 | 861.80 | 853.19 | 836.13 |
| Saluda | 708.47 | 790.07 | 804.60 | 842.78 | 834.35 | 817.66 |
| Spartanburg | 671.23 | 748.54 | 762.31 | 798.48 | 790.49 | 774.68 |
| Sumter | 718.41 | 801.15 | 815.89 | 854.60 | 846.05 | 829.13 |
| Union | 756.41 | 843.53 | 859.05 | 899.81 | 890.81 | 872.99 |
| Williamsburg | 772.57 | 861.55 | 877.40 | 919.03 | 909.84 | 891.64 |
| York | 714.37 | 796.64 | 811.30 | 849.80 | 841.30 | 824.47 |

[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 2016 CMS has calculated and applied a coding intensity adjustment (a modified CY 2016 coding intensity adjustment factor) proportional to the anticipated proportion of Demonstration enrollees in CY 2016 with prior Medicare Advantage experience and/or Demonstration experience based on the Demonstration's enrollment phase-in as of September 30, 2015. 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 2016 Medicare FFS A/B Baseline is divided by [1-(the standard CY 2016

coding intensity adjustment factor of 5.41% minus the South Carolina-specific modified CY 2016 coding intensity adjustment factor of 0.88%)] to determine the CY 2016 Final Medicare FFS A/B Baseline. CMS is in the process of finalizing this South Carolina-specific factor.

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 2016 South Carolina ESRD dialysis state rate, updated to incorporate the impact of sequestration-related rate reductions. The CY 2016 ESRD dialysis state rate for South Carolina is $7,074.11 PMPM; the updated CY 2016 ESRD dialysis state rate incorporating a 2% sequestration reduction and prior to the application of the quality withhold is $6,932.63 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 2016 South Carolina ESRD dialysis state rate updated to incorporate the impact of sequestration-related rate reductions. The CY 2016 ESRD dialysis state rate for South Carolina is $7,074.11 PMPM; the updated CY 2016 ESRD dialysis state rate incorporating a 2% sequestration reduction and prior to the application of the quality withhold is $6,932.63 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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| 2016 Medicare A/B Baseline PMPM, Beneficiaries with ESRD Functioning Graft Status, Standardized 1.0 Risk Score, by Demonstration County | | | |
|---|---|---|---|
| **County** | **2016 3.5% Bonus County Rate (Benchmark)** | **2016 Final Medicare A/B PMPM Baseline**<br><br>(increased to offset application of coding intensity adjustment factor in 2016)* | **2016 Sequestration-Adjusted Medicare A/B Baseline**<br><br>(after application of 2% Sequestration reduction) |
| Abbeville | $ 819.43 | $ 858.31 | $ 841.14 |
| Aiken | 798.62 | 836.51 | 819.78 |
| Allendale | 772.02 | 808.65 | 792.48 |
| Anderson | 847.34 | 887.55 | 869.80 |
| Bamberg | 780.51 | 817.55 | 801.20 |
| Barnwell | 821.42 | 860.40 | 843.19 |
| Beaufort | 825.13 | 864.28 | 846.99 |
| Berkeley | 836.74 | 876.44 | 858.91 |
| Calhoun | 816.38 | 855.12 | 838.02 |
| Charleston | 826.01 | 865.21 | 847.91 |
| Cherokee | 774.98 | 811.75 | 795.52 |
| Chester | 783.35 | 820.51 | 804.10 |
| Chesterfield | 782.59 | 819.72 | 803.33 |
| Clarendon | 778.25 | 815.18 | 798.88 |
| Colleton | 814.38 | 853.02 | 835.96 |
| Darlington | 790.45 | 827.96 | 811.40 |
| Dillon | 782.77 | 819.92 | 803.52 |
| Dorchester | 806.13 | 844.38 | 827.49 |
| Edgefield | 842.64 | 882.62 | 864.97 |
| Fairfield | 785.79 | 823.08 | 806.62 |
| Florence | 799.22 | 837.14 | 820.40 |
| Georgetown | 815.99 | 854.71 | 837.62 |
| Greenville | 786.78 | 824.11 | 807.63 |
| Greenwood | 812.81 | 851.38 | 834.35 |
| Hampton | 813.32 | 851.91 | 834.87 |
| Horry | 781.02 | 818.08 | 801.72 |
| Jasper | 822.70 | 861.74 | 844.51 |
| Kershaw | 809.01 | 847.40 | 830.45 |
| Lancaster | 809.59 | 848.01 | 831.05 |
| Laurens | $795.44 | $833.18 | $816.52 |
| Lee | 779.71 | 816.70 | 800.37 |
| Lexington | 765.64 | 801.96 | 785.92 |
| McCormick | $795.79 | $833.55 | $816.88 |

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| **2016 Medicare A/B Baseline PMPM, Beneficiaries with ESRD Functioning Graft Status, Standardized 1.0 Risk Score, by Demonstration County** | | | |
|---|---|---|---|
| **County** | **2016 3.5% Bonus County Rate (Benchmark)** | **2016 Final Medicare A/B PMPM Baseline** (increased to offset application of coding intensity adjustment factor in 2016)* | **2016 Sequestration-Adjusted Medicare A/B Baseline** (after application of 2% Sequestration reduction) |
| Marion | 784.93 | 822.17 | 805.73 |
| Marlboro | 782.44 | 819.57 | 803.18 |
| Newberry | 781.30 | 818.37 | 802.00 |
| Oconee | 780.13 | 817.15 | 800.81 |
| Orangeburg | 779.38 | 816.36 | 800.03 |
| Pickens | 814.74 | 853.40 | 836.33 |
| Richland | 813.65 | 852.26 | 835.21 |
| Saluda | 799.34 | 837.27 | 820.52 |
| Spartanburg | 825.95 | 865.14 | 847.84 |
| Sumter | 782.75 | 819.90 | 803.50 |
| Union | 779.70 | 816.70 | 800.37 |
| Williamsburg | 779.37 | 816.35 | 800.02 |
| York | 792.95 | 830.57 | 813.96 |

*For CY 2016 CMS has calculated and applied a coding intensity adjustment (the modified CY 2016 coding intensity adjustment factor) proportional to the anticipated proportion of Demonstration enrollees in CY 2016 with prior Medicare Advantage experience and/or Demonstration experience based on the Demonstration's enrollment phase-in as of September 30, 2015. 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 2016 Updated Medicare A/B Baseline is divided by [(1-standard the CY 2016 coding intensity adjustment factor of 5.41% minus the South Carolina-specific modified CY 2016 coding intensity adjustment factor of 0.88%)] to determine the CY 2016 Final Medicare A/B Baseline. For beneficiaries with an ESRD status of functioning graft, the prospective payment will not include the adjustment to offset the application of coding intensity adjustment factor; this payment adjustment will be 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.

# South Carolina Healthy Connections Prime
# CY 2016 Final Medicare Rate Report
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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 2016 is $64.66 and the CY 2016 Low-Income Premium Subsidy Amount for South Carolina is $26.57. 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 2016 is $63.90. 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: $ 172.37 PMPM
- South Carolina reinsurance: $ 98.99 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

## 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 | 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 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

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

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SCDHHS provides free aids and services to people with disabilities, such as qualified sign language interpreters and written information in other formats (large print, braille, audio, accessible electronic formats, other formats). We provide free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, contact Janet Bell, ADA and Civil Rights Official, by mail at: PO Box 8206, Columbia, SC 29202-8206; by phone at: 1-888-549-0820 (TTY: 1-888-842-3620); or by email at: civilrights@scdhhs.gov.

If you believe that SCDHHS has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the Civil Rights Official using the contact information provided above. You can file a grievance in person or by mail or email. If you need help filing a grievance, we are available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201 or by phone at: 800-368- 1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

## Language Services

**If your primary language is not English, language assistance services are available to you, free of charge. Call: 1-888-549-0820 (TTY: 1-888-842-3620).**

**si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-549-0820 (TTY: 1-888-842-3620).**

**أذا كانت لغتك الاساسية غير اللغة الانكليزية فان خدمات المساعدات اللغوية متوفرة لك مجانا.اتصل على الرقم:**

**888-549-0280(رقم هاتف الصم والبكم 1-888-842-3620)**

**Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-888-549-0820 (TTY: 1-888-842-3620).**

**Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-549-0820 (телетайп: 1-888-842-3620).**

**Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-549-0820 (TTY: 1-888-842-3620).**

**Se você fala português do Brasil, os serviços de assistência em sua lingua estão disponíveis para você de forma gratuita. Chame 1-888-549-0820 (TTY : 1-888-842-3620)**

如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-888-549-0820 (TTY: 1-888-842-3620)

**Falam tawng thiam tu na si le tawng let nak asi mi 1-888-549-0820 (TTY: 1-888-842-3620) ah tang ka pek tul lo in na ko thei.**

**धयद् आप हदी बोलते ह तो आपके िलए मुफ्त म भाषा सहायता सेवाएं उपलब्ध ह। 1-888-549-0820 (TTY: 1-888-842- 3620) पर कॉल कर।**

한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-549-0820 (TTY: 1-888-842-3620)번으로 전화해 주십시오.

**Haka tawng thiam tu na si le tawng let asi mi 1-888-549-0820 (TTY: 1-888-842-3620) ah tang ka pek tul lo in ko thei.**

**Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 888-549-0820 (ATS : 888-842-3620).**

နမ့်ကတိၤ ကညီ ကျိာ်အဃိ, နမၤန့်ၢ် ကျိာ်အတၢ်မၤစၢၤလၢ တလာ်ဘူဉ်လၢာ်စ့ၤ နီတမံၤဘဉ်သ့နှဉ်လီၤ. ကိး 888-549-0820 (TTY: 888-842-3620)

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-888-549-0820 (መስማት ለተሳናቸው: 1-888-842-3620).

အကယ်၍ သင်သည် မြန်မာစကား ကို ပြောပါက၊ ဘာသာစကား အကူအညီ၊ အခမဲ့၊ သင့် ငှ်အတွက် စီစဉ်ဆောင်ရွက်ပေးပါမည်။ ဖုန်းနံပါတ် 888-549-0820 (TTY: 888-842-3620) သို့ ခေါ် ဆိုပါ။