South Carolina Healthy Connections Prime
CY 2024 Updated Medicare and Medicaid Rate Report
March 24, 2025

The Centers for Medicare & Medicaid Services (CMS), in conjunction with the State of South Carolina, is releasing the Medicare and Medicaid component of the CY 2024 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 2024 Medicare county base rates and Medicaid rates.

I. Components of the Capitation Rate

CMS and South Carolina will each contribute to the global capitation payment. CMS and South Carolina will each make monthly payments to Coordinated and Integrated Care Organization (CICOs) for their components of the capitated rate. CICOs will receive three monthly payments for each enrollee: one amount from CMS reflecting coverage of Medicare Parts A/B services, one amount from CMS reflecting coverage of Medicare Part D services, and a third amount from South Carolina reflecting coverage of Medicaid services.

The Medicare Parts A/B rate component will be risk adjusted using the prevailing Medicare Advantage CMS-HCC and CMS HCC-ESRD models. The Medicare Part D payment will be risk adjusted using the Part D RxHCC model. To adjust the Medicaid component, South Carolina assigns each enrollee to a rate cell according to the individual enrollee's nursing facility level of care status.

Section II of this report provides information on the South Carolina Medicaid component of the capitation rate. Section III includes the Medicare Parts A/B and Medicare Part D components of the rate. Section IV includes information on the savings percentages and quality withhold.

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II. South Carolina Component of the Rate - CY 2024

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 2024 Medicaid capitation rate report can be found online at https://img1.scdhhs.gov/dEpnO5NCdDzlkX3n/07HealthyConnectionsPrimeCY2024MedicaidCapitationRateCertification.pdf.

Note that the Medicaid component of the capitation rates was amended July 1, 2024. The full version of the July 2024 capitation rate amendment report can be found online at

https://img1.scdhhs.gov/dEpnO5NCdDzlkX3n/11-Healthy-Connections-Prime-July-2024-Amendment-Medicaid-Capitation-Rate-Documentation.pdf

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

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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 2024 and July 2024 Healthy Connections Prime Medicaid capitation rate reports for full documentation of assumptions and methodology.

The basis for 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 established by applying composite savings percentages established by the State and CMS, and documented in the August 2023 three-way contract amendment[2] (August 2023 amendment), to both the benefit and non-benefit component of the capitation rates.

The certified per member per month (PMPM) capitation rates for the Healthy Connections Prime program are illustrated in Figure 1A and 1B. Figure 1A reflects the original certified CY 2024 rates effective from January 1, 2024 through June 30, 2024, and Figure 1B reflects the July amended rates effective July 1, 2024 through December 31, 2024. The rates reflect a 3% shared savings percentage for CY 2024 consistent with Section 4.2.3 of the August 2023 amendment to the three-way contract between CMS, SCDHHS, and the Coordinated and Integrated Care Organizations (CICOs).

FIGURE 1A: PRIME CAPITATION RATES EFFECTIVE CY 2024

RATE CELL	MEDICAID RATE
Community	$ 91.59
Nursing Facility	$ 7,438.30
HCBS Waiver	$ 1,841.73
HCBS Waiver – Plus Rate	$ 4,814.77

Note: Figure 1A reflects capitation rates effective January through June 2024

FIGURE 1B: PRIME CAPITATION RATES EFFECTIVE JULY 2024

RATE CELL	MEDICAID RATE
Community	$ 93.96
Nursing Facility	$ 7,438.90
HCBS Waiver	$ 1,870.49
HCBS Waiver – Plus Rate	$ 4,824.76

Please note:

- The capitation rates reflect the current benefit package for CY 2024 approved by the State and CMS as of the date of this report. The rates will be reviewed if applicable policy and program changes occur for this period.

[2] August 1, 2023 Amendment to the three-way contract between CMS, SCDHHS, and the CICOs; https://www.cms.gov/files/document/sccontract08012023.docx

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- The capitation rates were amended July 1, 2024 to address provider reimbursement changes. Specifically, the rates were updated for the following adjustments:
    - Waiver services fee schedule updates effective July 1, 2024
    - Inpatient Psychiatric Hospitals per diem increase effective July 1, 2024
    - Physician fee schedule updates effective July 1, 2024
- 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 2024 Nursing Facility capitation rate shown in Figure 1 and pay the net capitation rate to the 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 $41.81) and the waiver services portion of the HCBS Waiver base rate.

COVERED POPULATION

Target Population

The target population for the Prime program is 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 in the state of South Carolina 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 partially 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 Medicare Part A and Medicare Part B coverage;

- Any member month where an individual is enrolled in an emergency services only program (non-citizen);
- Any member month where an individual is identified as an inmate;
- Any member month where an individual resides in hospice, a nursing facility, or an ICF/IID;
- Any retroactively enrolled member month.

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

- Medicare Part D enrollment
- Eligibility for ESRD services

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

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

Home and Community-Based Services (HCBS) Waiver Population

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

Milliman identified the population in the rate-setting process by assigning to the HCBS Waiver population any member month where an individual contains any of the following codes on the first day of the month 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. In developing the base data used in the capitation rate-setting process, we identified the nursing facility population 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 or hospice room & board) 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 Figure 1 and pay the net capitation rate to the CICOs.

Community Residents Population

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

"Plus" Rates

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

Individuals who require HCBS waiver services once moved to the community will receive the Waiver Plus rate. 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 in the first three months of enrollment in the HCBS waiver for individuals not residing in 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. This payment methodology is consistent with the payment methodology described in the August 1, 2023 amendment to the three-way contract.

EXPERIENCE DATA ADJUSTMENTS REFLECTED IN THE MEDICAID CAPITATION RATES

The base fee-for-service (FFS) experience for calendar year (CY) 2022 was adjusted for the following components to produce the Medicaid portion of the Prime capitation rates:

- Completion
    - Completion factors were developed from a combination of claim payment lag analyses and estimates of projected PMPMs, which were applied to CY 2022 expenditures to reflect

completion of IBNR claims. The CY 2022 base period provides for 7 months of claims payment runout from the end of CY 2022.

- 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, 2020 through March 31, 2023 and paid through July 2023.
- Emerging experience adjustment
  - An emerging experience adjustment was applied to the base data to account for estimated changes in observed utilization patterns as a result of the COVID-19 pandemic. Based on a review of monthly data by population and category of service during the base period and emerging data periods, we observed that many services have not returned to pre-COVID levels; however, emerging experience through the end of CY 2022 and into the first quarter of CY 2023, where available, provides a current view of utilization patterns to inform our adjustment. As such, an emerging experience adjustment was applied to the adult day health care category of service.
- 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 (CY 2022) through CY 2024.
- 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. Based on a review of historical utilization of HCBS waiver services for individuals enrolled in an HCBS waiver in the FFS Prime-eligible population, individuals in the early months of waiver enrollment utilize HCBS services at a materially lower rate than those enrolled for longer durations. To estimate the impact of this durational curve on the Prime-enrolled population, we stratified HCBS waiver members from the FFS Prime-eligible data into durational cohorts based on the number of months enrolled in an HCBS waiver during the CY 2022 base period. The durational cohorts were defined in six month increments as follows: 0-6 months, 7-12 months, 13-18 months, 19-24 months, and 25+ months. For each durational cohort, the total CY 2022 waiver services costs were compared to the overall average for the population to estimate the relativity morbidity for each cohort.

    The relative morbidity by duration was applied to the CY 2024 anticipated enrollment in the HCBS Waiver rate cell to estimate the relative morbidity difference between the Prime population and the CY 2022 FFS base data.

    Based on the assumptions described above, a selection factor of 1.042 was applied to the

total HCBS Waiver PMPM cost after application of trend, program changes, and rating period adjustments.

- Risk Selection – Community
  - The Community selection factor was developed based on a distribution of two independent populations: non-DSNP Prime members and DSNP passive enrolled members.

    Consistent with the CY 2023 Prime capitation rate development, a relative morbidity factor of 1.0 is assumed for non-DSNP members who enroll in Prime. Our review of CY 2022 FFS data for non-DSNP members who enrolled in Prime in 2021 and 2022 indicate a morbidity factor of 1.0 is appropriate for the estimated cost profile of this population. Additionally, we assumed a 1.0 relative morbidity factor for the 150 members per month anticipated to enroll primarily through passive enrollment in CY 2024 because the majority are assumed to be new members effective after the CY 2022 FFS base data period and therefore not available for review and evaluation.

    In addition to the current non-DSNP Community population, we reviewed the anticipated cost differences of members enrolled through the DSNP passive enrollment waves relative to the CY 2022 base data. The estimated FFS cost of DSNP members in CY 2022 is assumed to be reflective of Prime members enrolled through the DSNP passive waves.

    Our review of the historical utilization and cost differences in the CY 2022 FFS data between DSNP members and the unadjusted CY 2022 base data indicated that the cost profile for DSNP is approximately 20% lower than the CY 2022 base data. Our review was limited to active DSNP members in CY 2022 in the FFS data because 2022 FFS claims are not available for active Prime members who joined during the DSNP passive waves in 2019 and 2020.

    The combined impact of the anticipated non-DSNP Prime enrollees and the passively-enrolled DSNP members results in a selection factor of 0.983 applied to the total Community PMPM benefit cost, after application of trend, program changes, and rating period adjustments.

- Other Adjustments
  - Historical adjustment to reflect Hospice Room and Board Services on a gross rate basis for the Nursing Facility rate cell only.
  - The CY 2024 contract year contains one additional day as a result of leap year. The impact of leap year to each major category of service in the CY 2022 base data is assumed to increase utilization by a factor of 1.0027.

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

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https://img1.scdhhs.gov/dEpnO5NCdDzlkX3n/07HealthyConnectionsPrimeCY2024MedicaidCapitationRateCertification.pdf.

Note that the Medicaid component of the capitation rates was amended July 1, 2024. A comprehensive description of the adjustments included in the July 2024 capitation rate amendment report can be found online at

https://img1.scdhhs.gov/dEpnO5NCdDzlkX3n/11-Healthy-Connections-Prime-July-2024-Amendment-Medicaid-Capitation-Rate-Documentation.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").

We relied on Form CMS-64 reports to estimate the average administrative expense PMPM for the Medicaid program. Figure 2 illustrates the non-benefit cost PMPMs by rate cell for the CY 2024 Healthy Connections Prime program.

FIGURE 2: NON-BENEFIT COST ALLOWANCE BY RATE CELL

RATE CELL	TOTAL
Community	$ 10.25
Nursing Facility	$ 102.50
HCBS Waiver	$ 102.50
HCBS Waiver – Plus Rate	$ 102.50

DATA RELIANCE

The following information was provided by SCDHHS to develop the actuarially sound capitation rates for the Calendar Year 2024 contract period.

- Fee-for-service (FFS) claims data for the Prime eligible population incurred October 1, 2019 through March 31, 2023 and paid through July 2023;
- Detailed FFS enrollment data for January 1, 2020 through March 31, 2023;
- Managed care capitation rates paid to the health plans serving enrollees in the Prime program;

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- Summary of policy and program changes through CY 2024 (including changes to fee schedules and other payment rates);
- Healthy Connections Prime enrollment data by rate cell;
- Data exchange files between SCDHHS and CMS implemented by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) for January 2018 through July 2019 and February 2020 through June 2023;
- CY 2022 NAIC Financial Statements;
- CY 2019 through CY 2022 quarterly Form CMS-64 reports detailing costs associated with Medicaid program expenditures and administrative expenses.

Although the data was 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 2024

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 enrolled population in each program prior to 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 were enrolled prior to Demonstration.

Medicare A/B Component Payments: CY 2024 Medicare A/B Baseline County rates are provided below.

The final rates represent the weighted average of the CY 2024 FFS Standardized County Rates, updated to incorporate the adjustment noted below, and the Medicare Advantage projected payment rates for CY 2024 based on the actual enrollment of beneficiaries from Medicare FFS and Medicare Advantage prior to the demonstration at the county level.

Bad Debt Adjustment: The FFS component of the CY 2024 Medicare A/B baseline rate will be updated to reflect a 1.82% upward adjustment to account for the disproportionate share of bad debt attributable to Medicare-Medicaid enrollees in Medicare FFS (in the absence of the Demonstration).

Coding Intensity Adjustment: CMS annually applies a coding intensity factor to Medicare Advantage risk scores to account for differences in diagnosis coding patterns between the Medicare Advantage and the Original Fee-for-Service Medicare programs. The adjustment for CY 2024, as in Medicare Advantage, is 5.90%.

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.

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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.

2024 Medicare A/B Baseline PMPM, Non-ESRD Beneficiaries, Standardized 1.0 Risk Score, by Demonstration County[1]					
County	**2024 Published FFS Standardized County Rate**	**2024 Updated Medicare A/B FFS Baseline** (updated by CY 2024 bad debt adjustment)	**2024 Medicare A/B Baseline** (incorporating Final Medicare A/B FFS baseline and Medicare Advantage component)	**2024 Medicare A/B Baseline PMPM, Savings Percentage Applied** (after application of the 3% savings percentage)	**2024 Medicare A/B PMPM Payment** (2% sequestration reduction applied and prior to quality withhold)
Abbeville	$1,048.53	$1067.61	$1,057.96	$1,026.22	$1,005.70
Aiken	1,016.49	1034.99	1,034.17	1,003.14	983.08
Allendale	1,128.78	1149.32	1,115.72	1,082.25	1,060.61
Anderson	1,069.96	1089.43	1,081.37	1,048.93	1,027.95
Bamberg	1,055.92	1075.14	1,057.65	1,025.92	1,005.40
Barnwell	1,028.39	1047.11	1,043.72	1,012.41	992.16
Beaufort	1,111.93	1132.17	1,119.67	1,086.08	1,064.36
Berkeley	1,079.61	1099.26	1,086.52	1,053.92	1,032.84
Calhoun	1,116.19	1136.50	1,118.22	1,084.67	1,062.98
Charleston	1,090.40	1110.25	1,104.40	1,071.27	1,049.84
Cherokee	1,079.34	1098.98	1,091.71	1,058.96	1,037.78
Chester	1,019.59	1038.15	1,035.45	1,004.39	984.30
Chesterfield	992.96	1011.03	1,010.90	980.57	960.96
Clarendon	1,035.19	1054.03	1,044.20	1,012.87	992.61
Colleton	1,108.75	1128.93	1,119.41	1,085.83	1,064.11
Darlington	1,010.65	1029.04	1,029.16	998.29	978.32
Dillon	1,018.76	1037.30	1,036.53	1,005.43	985.32
Dorchester	1,133.06	1153.68	1,140.39	1,106.18	1,084.06
Edgefield	1,082.99	1102.70	1,099.75	1,066.76	1,045.42
Fairfield	981.30	999.16	1,017.57	987.04	967.30
Florence	1,037.28	1056.16	1,054.46	1,022.83	1,002.37
Georgetown	1,090.71	1110.56	1,092.36	1,059.59	1,038.40
Greenville	976.95	994.73	1,007.24	977.02	957.48
Greenwood	1,082.83	1102.54	1,086.84	1,054.23	1,033.15
Hampton	1,103.68	1123.77	1,101.10	1,068.07	1,046.71
Horry	1,056.31	1075.53	1,071.14	1,039.01	1,018.23

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2024 Medicare A/B Baseline PMPM, Non-ESRD Beneficiaries, Standardized 1.0 Risk Score, by Demonstration County[1]					
County	**2024 Published FFS Standardized County Rate**	**2024 Updated Medicare A/B FFS Baseline** (updated by CY 2024 bad debt adjustment)	**2024 Medicare A/B Baseline** (incorporating Final Medicare A/B FFS baseline and Medicare Advantage component)	**2024 Medicare A/B Baseline PMPM, Savings Percentage Applied** (after application of the 3% savings percentage)	**2024 Medicare A/B PMPM Payment** (2% sequestration reduction applied and prior to quality withhold)
Jasper	$1,046.89	$1065.94	$1,058.63	$1,026.87	$1,006.33
Kershaw	1,025.65	1044.32	1,040.99	1,009.76	989.56
Lancaster	1,021.54	1040.13	1,039.31	1,008.13	987.97
Laurens	1,046.84	1065.89	1,063.33	1,031.43	1,010.80
Lee	1,013.69	1032.14	1,032.24	1,001.27	981.24
Lexington	1,052.71	1071.87	1,063.80	1,031.89	1,011.25
McCormick	1,078.13	1097.75	1,070.97	1,038.84	1,018.06
Marion	1,036.78	1055.65	1,057.95	1,026.21	1,005.69
Marlboro	994.60	1012.70	1,012.95	982.56	962.91
Newberry	1,050.34	1069.46	1,057.53	1,025.80	1,005.28
Oconee	1,009.59	1027.96	1,025.01	994.26	974.37
Orangeburg	1,081.29	1100.97	1,078.45	1,046.10	1,025.18
Pickens	1,031.80	1050.58	1,048.14	1,016.70	996.37
Richland	1,010.20	1028.59	1,034.53	1,003.49	983.42
Saluda	1,038.01	1056.90	1,035.68	1,004.61	984.52
Spartanburg	1,018.47	1037.01	1,053.31	1,021.71	1,001.28
Sumter	953.23	970.58	971.74	942.59	923.74
Union	1,126.68	1147.19	1,111.39	1,078.05	1,056.49
Williamsburg	1,042.00	1060.96	1,050.58	1,019.06	998.68
York	1,048.75	1067.84	1,065.69	1,033.72	1,013.05

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

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

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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 2024 South Carolina ESRD dialysis state rate, updated to incorporate the impact of sequestration-related rate reductions. The CY 2024 ESRD dialysis state rate for South Carolina is $9,060.43 PMPM; the updated CY 2024 ESRD dialysis state rate incorporating a 2% sequestration reduction and prior to the application of the quality withhold is $8,879.22 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 2024 South Carolina ESRD dialysis state rate updated to incorporate the impact of sequestration-related rate reductions. The CY 2024 ESRD dialysis state rate for South Carolina is $9,060.43 PMPM; the updated CY 2024 ESRD dialysis state rate incorporating a 2% sequestration reduction and prior to the application of the quality withhold is $8,879.22 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.

2024 Medicare A/B Baseline PMPM, Beneficiaries with ESRD Functioning Graft Status, Standardized 1.0 Risk Score, by Demonstration County		
County	**2024 3.5% bonus County Rate (Benchmark)**	**2024 Sequestration-Adjusted Medicare A/B Baseline** (after application of 2% Sequestration reduction)
Abbeville	$1,124.55	$1,102.06
Aiken	1,128.30	1,105.73
Allendale	1,128.78	1,106.20
Anderson	1,147.53	1,124.58
Bamberg	1,103.29	1,081.22
Barnwell	1,141.51	1,118.68
Beaufort	1,150.85	1,127.83
Berkeley	1,117.40	1,095.05
Calhoun	1,155.26	1,132.15
Charleston	1,169.45	1,146.06
Cherokee	1,157.59	1,134.44
Chester	1,106.80	1,084.66
Chesterfield	1,106.55	1,084.42
Clarendon	1,102.39	1,080.34
Colleton	1,189.13	1,165.35

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2024 Medicare A/B Baseline PMPM, Beneficiaries with ESRD Functioning Graft Status, Standardized 1.0 Risk Score, by Demonstration County		
County	**2024 3.5% bonus County Rate (Benchmark)**	**2024 Sequestration-Adjusted Medicare A/B Baseline** (after application of 2% Sequestration reduction)
Darlington	$1,121.82	$1,099.38
Dillon	1,143.84	1,120.96
Dorchester	1,172.72	1,149.27
Edgefield	1,202.12	1,178.08
Fairfield	1,197.19	1,173.25
Florence	1,151.38	1,128.35
Georgetown	1,128.88	1,106.30
Greenville	1,157.69	1,134.54
Greenwood	1,120.73	1,098.32
Hampton	1,142.31	1,119.46
Horry	1,088.72	1,066.95
Jasper	1,122.79	1,100.33
Kershaw	1,138.47	1,115.70
Lancaster	1,108.16	1,086.00
Laurens	1,161.99	1,138.75
Lee	1,163.21	1,139.95
Lexington	1,129.03	1,106.45
McCormick	1,115.86	1,093.54
Marion	1,150.83	1,127.81
Marlboro	1,106.97	1,084.83
Newberry	1,105.70	1,083.59
Oconee	1,104.79	1,082.69
Orangeburg	1,102.02	1,079.98
Pickens	1,145.30	1,122.39
Richland	1,159.20	1,136.02
Saluda	1,074.34	1,052.85
Spartanburg	1,204.34	1,180.25
Sumter	1,106.01	1,083.89
Union	1,126.68	1,104.15
Williamsburg	1,099.92	1,077.92
York	1,164.11	1,140.83

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 2024 is $64.28 and the CY 2024 Low-Income Premium Subsidy Amount for South Carolina is $45.73. 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 2024 is $63.91. 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: $257.32 PMPM
- South Carolina reinsurance: $273.87 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%
Demonstration Year 5	January 1 – December 31, 2020	3%
Demonstration Year 6	January 1 – December 31, 2021	3%
Demonstration Year 7	January 1 – December 31, 2022	3%
Demonstration Year 8	January 1 – December 31, 2023	3%
Demonstration Year 9	January 1 – December 31, 2024	3%

Quality Withhold

The quality withhold is 3% for Demonstration Years 7 to 9. Beginning in Demonstration Year 6, CMS applies an additional 1% quality withhold to the Medicare A/B rate component.

More information about the quality withhold methodology is available in the CMS core and state-specific quality withhold technical notes, which are posted at the following link: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/MMPQualityWithholdMethodologyandTechnicalNotes.html.