Highlights of South Carolina's Memorandum of Understanding with CMS
For South Carolina's "*Healthy Connections Prime*" Federal-State Partnership
To Test a Capitated Financial Alignment Model for Medicare-Medicaid Enrollees

Scope

- Individuals eligible for this demonstration include persons aged 65 and older entitled to benefits under Medicare Part A, enrolled in Medicare Parts B and D, and receiving full Medicaid benefits. This includes individuals enrolled in the Community Choices Waiver, HIV/AIDS Waiver, and Mechanical Ventilation Waiver.
- Excluded individuals include persons under age 65, individuals in the Medicaid spend-down population, individuals enrolled in both Medicare and Medicaid who have Comprehensive Third Party Insurance, individuals residing in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) or Nursing Facility, individuals who are in a hospice program or are receiving End-Stage Renal Disease (ESRD) services, and individuals who are participating in federal home and community based (HCBS) waiver programs other than the Community Choices Waiver, HIV/AIDS Waiver and Mechanical Ventilation Waiver (including the Intellectual Disabilities and Related Disabilities Waiver, the Head and Spinal Cord Injury Waiver, the Community Supports Waiver, the Medically Complex Children's Waiver, the Pervasive Developmental Disorder Waiver, and the Psychiatric Residential Treatment Facility Alternative CHANCE Waiver).
- Persons who are enrolled in a Medicare Advantage (MA) plan or Program for All-inclusive Care for the Elderly (PACE) who also meet demonstration eligibility criteria are excluded from passive enrollment, but may participate if they first disenroll from their existing programs. Individuals who transition from a Nursing Facility or ICF/IDD into the community may also become eligible. Individuals enrolled in the demonstration, who later enter a Nursing Facility, hospice program, or become eligible for ESRD services, may remain in the demonstration.
- The demonstration is statewide and will begin no sooner than July 1, 2014 and continue until December 31, 2017.

Contracting and Rates

- CMS and the State will enter into a joint-rate setting process as described in Appendix 6 of the MOU.
- CMS will develop baseline spending (costs absent the demonstration) and payment rates for Medicare Parts A and B services using a blend of Medicare Advantage projected payment rates and Medicare Fee-for-Service (FFS) standardized county rates. The Medicare Part D baseline for the Part D Direct Subsidy will be set at the Part D national average monthly bid amount (NAMBA) for the calendar year.
- The data source for the Medicaid component of the rate for the first demonstration year is based on South Carolina FFS data for fiscal years 2011 through 2013 as available at the point of rate-setting. The Medicaid component of the rate for years 2 and 3 will use updated historical South Carolina FFS data, as available at the point of rate setting for each demonstration year. Medicaid actuarial soundness principles will apply to payments to health plans.
- Rates for each demonstration year will incorporate projected savings as follows: Year 1, 1%; Year 2, 2%; and Year 3, 4%.
- The Medicaid component features a risk methodology that accounts for enrollment variations in each Coordinated and Integrated Care Organization (CICO). The rate cell structure was developed to align payment with risk while incentivizing movement from nursing facility to home and community based care and includes enhanced payment rates for transitions from nursing homes and decreased payment rates for individuals that transition from the community to or HCBS services to a nursing facility for a period of 90 days following such transitions. In addition, CICOs will receive bonus payments for helping to transition individuals into HCBS settings. CMS-HCC risk adjustment methodology will be applied to the Medicare Part A/B portion of the rate and Part D RxHCC risk adjustment will be applied to the Part D portion.
- The majority of new CICO enrollees will come from Medicare FFS, and 2014 risk scores for those individuals will be based solely on prior FFS claims. In calendar year 2014, CMS will apply an appropriate coding intensity adjustment based on the expected proportion of the target population with prior Medicare Advantage experience on a county-specific basis. In calendar year 2015, CMS will apply the prevailing Medicare Advantage coding intensity adjustment proportional to the anticipated percentage of demonstration enrollees in 2015 with prior Medicare Advantage experience and/or demonstration experience based on the enrollment phase-in as of September 30, 2014. After calendar year 2015, CMS will apply the prevailing Medicare Advantage coding intensity adjustment to all enrollees.
- Beginning in calendar year 2015, CICOs will be required each calendar year to meet a Target Medical Loss Ratio (TMLR) threshold of 85%. The three-way contracts will include additional specifications on the MLR. If MLR calculated annually is less than the TMLR, the CICO shall remit to the State and CMS an amount equal to the difference between the calculated MLR and the TMLR (expressed as a percentage) multiplied by the revenue received during the coverage year. Any collected remittances would be distributed proportionally back to the Medicaid and Medicare programs.

Enrollment

- Passive enrollment for eligible beneficiaries is effective no sooner than 60 days after participant notification of the right to select a CICO plan and the option to not participate in the demonstration.
- Passive enrollment will be phased-in by region and population. The State is divided into two regions, with Region 1 covering the upstate counties and Region 2 covering the coastal counties. The State's enrollment process begins with an opt-in enrollment period open to all eligible beneficiaries, including those receiving care through one of the three applicable HCBS waivers, that

will begin no sooner than July 1, 2014 and extend through December 31, 2014. Following the opt-in period, the State will conduct three separate waves of passive enrollment within the two regions and the eligible HCBS populations.

- Disenrollment from CICOs and enrollment from one CICO to a different CICO shall be allowed on a month-to-month basis at any time; however, coverage for these individuals will continue through the end of the month. CMS and the State will utilize an independent third party entity to facilitate all enrollments into the CICOs. CICO enrollments, including enrollment from one CICO to a different CICO and opt-outs, shall become effective on the same day for both Medicare and Medicaid (the first day of the following month). For those who lose Medicaid eligibility during the month, coverage and Federal financial participation will continue through the end of that month.
- Medicare-Medicaid beneficiaries will maintain their choice of plans and providers, and may exercise that choice at any time, effective the first calendar day of the following month. In addition to choosing a different CICO, they can switch to a Medicare Advantage Plan, receive care through Medicaid and Medicare FFS and a Prescription Drug Plan, enroll in a PACE program, and/or receive Medicaid services in accordance with the State's approved State Plan and any approved waiver programs.

Consumer Protections

- CMS, the State, and CICOs shall ensure that all medically necessary covered benefits and services are provided to beneficiaries in a manner that is sensitive to their functional and cognitive needs, language, and culture and allows for the involvement of enrollees and caregivers in the development of an Individualized Care Plan (ICP). Services must also be provided in a care setting appropriate to enrollees' needs, with a preference for the home and the community.
- The State and CMS will require CICOs to provide access to contracted providers that demonstrate their commitment and ability to accommodate the physical access and flexible scheduling needs of their beneficiaries. The State and CMS will require CICOs and their providers to communicate with their enrollees in a manner that accommodates their individual needs, including providing interpreters for those who are deaf or hard of hearing, accommodations for individuals with cognitive limitations, and interpretation for individuals with limited English proficiency.
- The State intends to support an independent Ombudsman program outside of the state Medicaid agency to advocate and investigate on behalf of enrollees, including those receiving HCBS care and nursing facility-based recipients, to safeguard due process and to serve as an early and consistent means of identifying systematic problems with the demonstration.
- CICOs will utilize a unified set of requirements developed by CMS and the State for grievances and internal appeals processes that incorporate relevant Medicare Advantage and Medicaid managed care requirements, to create a more beneficiary-friendly and easily navigable system. All CICO grievances and internal appeals procedures shall be subject to the review and prior approval of CMS and the State. Medicare Part D appeals and grievances will continue to be managed by CMS under existing Part D rules, and Medicaid non-Part D pharmacy appeals will be managed by the State.
- Quality withhold measures will be applied to the demonstration for Medicare Parts A and B and Medicaid. The percentage withhold will be 1%, 2%, and 3% in each of the three demonstration years, respectively.

Care Model and Assessments

- All CICOs (in partnership with contracted providers) will be required to implement an evidence-based model of care (MOC) consistent with the Special Needs Plan Model of Care. CMS's MOC approval process will be based on scoring each of the thirteen clinical and non-clinical elements of the MOC (both CMS and State elements are included).
- CICOs will ensure the provision and coordination of all necessary Medicare and Medicaid-covered services, including primary, acute, prescription drug, behavioral health, and long-term supports and services. CMS, the State, and CICOs shall ensure that care is person-centered and can accommodate and support self-direction. CICOs will offer care coordination services to all enrollees to ensure effective linkages and coordination between their medical homes and other providers and services and to coordinate the full range of medical and behavioral health services, preventive services, medications, LTSS, social supports, and enhanced benefits as needed, both within and outside the CICO.
- A person-centered, ICP will be developed by the CICO Care Coordinator, with the enrollee, his/her family supports, and providers, that addresses all of the clinical and non-clinical needs of the enrollee, including, care management and HCBS and nursing facility care, as appropriate, and as identified in the comprehensive assessment. ICPs will contain measureable goals, interventions, and expected outcomes with completion timeframes. ICPs must be developed within 90 days of enrollment and updated as necessary at a minimum of annually for all enrollees, or as conditions warrant.

  A multidisciplinary team (MT) is responsible for ensuring the integration of the enrollee's medical, behavioral health, psychosocial, nursing facility, and HCBS care based on his/her needs and preferences. In addition to the enrollee, the team may include family members and other caregivers, a designated primary physician, nurse, social worker, or waiver case manager as well as other professionals within the provider network. As a member of the MT, the waiver case manager will be responsible for advocating and bringing the long term care perspective into the care coordination process.
- The Care Coordinator will lead the MT and must have the qualifications and training appropriate to meet the needs of the enrollee, and each CICO must establish policies for appropriate assignment of Care Coordinators. For example, enrollees in the high- to medium- risk categories could be assigned Care Coordinators with clinical backgrounds such as registered nurses or licensed clinical social workers.

- The State will utilize *Phoenix*, an automated case management system which maintains records of a number of critical functions, including all intake, assessment, and care planning activities. Key elements *Phoenix* include home assessment, caregiver supports, and quality indicators. There are also edits to ensure compliance with federal regulations (e.g., waiver admission is within 30-days of the most recent level of care determination) as well as state policies. The system also includes a method to identify waiver participants most at risk for missed in-home visits and those most at risk in the event of natural disasters.
- The State will collaborate with CICOs to develop a universal health screen that will be administered to all new enrollees within 30 days of enrollment. The health screen will collect information about the enrollee's medical, psychosocial, LTSS, functional, and cognitive needs, and medical and behavioral health (including substance abuse) history. CICOs will use the information taken from the initial health risk assessment, along with predictive modeling, to guide the administration of a face-to-face comprehensive health assessment in the enrollee's residence or in another setting if the enrollee prefers. CICOs may choose to forego the initial health risk screen when completing the comprehensive assessment within 60 days of enrollment.

HCBS Care Transition

- The State will transition and phase in HCBS authority and accountability over the course of the demonstration. During Phase I of the demonstration, the State will maintain contractual relationships with HCBS providers. CICOs, however, will receive payment for these services and process provider payments. For Phase II, CICOs that have successfully completed the first HCBS benchmark review will assume responsibility for care management (CM) services and most HCBS services, in addition to the full continuum of Medicare and Medicaid covered services they are already providing. For Phase III, CICOs that have successfully completed the final HCBS benchmark review will provide all CM and HCBS services and assume responsibility for the full continuum of care under the demonstration. Additional details regarding the transition, including the roles and responsibilities of CMS/State and the CICOs, is contained in Appendix 7.
- During Phase I of the transition of HCBS authority, the State maintains responsibility for developing the waiver care plan with concurrence by a CICO designee. The waiver case manager will complete the waiver care plan and make recommendations for service authorizations as is currently done in the South Carolina LTSS system.
- Continuous monitoring of the ICP will occur and any unmet care needs will be addressed by the CICO including any necessary revisions to the ICP. CICOs will conduct periodic reviews of ICPs through *Phoenix*. CICOs will review ICPs of enrollees at high-risk at least every 30 days, enrollees at moderate-risk at least every 90 days, and enrollees at low-risk at least every 120 days. CICOs will conduct comprehensive reassessments as necessary based upon such reviews. At a minimum, CICOs will complete comprehensive reassessment annually for all enrollees.
- CICOs will support enrollees in directing their own care and ICP development. During Phase III of the transition of HCBS authority, CICOs will subcontract with the State's contractor, the University of South Carolina's Center for Disability Resources (CDR), to ensure waiver enrollees receive services from qualified attendants and are capable of supervising the care or has someone who can do that on their behalf.

Continuity of Care

- CICOs will be required to offer a 180-day transition period in which enrollees may maintain a current course of treatment with a provider not part of the CICO's network. The transition period is applicable to all providers, including behavioral health providers and providers of LTSS. CICOs are also required to maintain current service authorization levels for all direct care waiver services (including personal care, waiver nursing, home care, respite care, community living, adult day health, social work counseling, and independent living assistance) during the 180-day transition period unless significant change has occurred and is documented during the Long Term Care Level of Care assessment and/or reassessment. All beneficiaries who meet level of care criteria for HCBS will have access to waiver services under the Demonstration without regard to a waiting list.
- CICOs may only transition enrollees to a network PCP, network specialist, or LTSS provider earlier than 180 days only if certain conditions are met. A full list conditions for CICOs is located on page 95 of the MOU.
- CICOs will advise in writing beneficiaries and providers that they have received care that would not otherwise be covered at an in-network level. On an ongoing basis, CICOs must also contact providers not already members of their network with information on becoming credentialed as in-network providers.
- The State or its vendor will provide Medicaid-Medicare enrollees with independent enrollment assistance and options counseling to help them make an enrollment decision that best meets their needs.

Evaluation

- CMS has contracted with an independent evaluator to measure, monitor, and evaluate the impact of the Financial Alignment models, including this demonstration, on beneficiary experience of care, quality, utilization, and cost. The evaluator will also explore how this demonstration operates, how it transforms and evolves over time, and beneficiaries' perspectives and experiences.
- The State is required to cooperate, collaborate, and coordinate with CMS and the independent evaluator in all monitoring and evaluation activities. The State and CICOs must submit all required data for the monitoring and evaluation of the demonstration, according to the data and timeframe requirements to be listed in the three-way contracts. The State will ensure that the evaluator at least annually receives information indicating the primary care provider of record for each demonstration enrollee.