ADDENDUM TO

State of South Carolina
Department of Health & Human Services
Capitated Financial Alignment Demonstration Proposal

As discussed in the July 8, 2011 State Medicaid Director (SMD) letter, CMS evaluated state demonstration proposals against a list of standards and conditions that CMS is requiring all states to meet to participate in the demonstration. After reviewing South Carolina's demonstration proposal, CMS posed several clarifying questions in order to determine whether the proposal meets the standards and conditions. The questions and responses appear below.

Integration of Benefits & Care Model

1. CMS would like additional information from South Carolina about how its proposed demonstration would ensure the provision and coordination of all necessary Medicare and Medicaid covered services, including primary, acute, prescription drug, behavioral health, and long-term services and supports given the proposed LTSS HCBS carve-out.

   Response: The state originally proposed carving out home and community-based services (HCBS) from the demonstration because of the coordinated and integrated care organizations' (CICOs') relative inexperience providing these kinds of services in general and in recognition of South Carolina's unique HCBS system in particular. Since submitting the original proposal, South Carolina developed a new strategy for integrating 1915(c) waiver services into the demonstration that would more fully integrate the benefit package while ensuring that CICOs have sufficient time and experience to develop the necessary capacity and competency to oversee HCBS. This strategy entails phasing-in responsibilities for HCBS to the CICOs during the first 18 months of the demonstration period and continuing to utilize the state's IT systems, *Care Call and Phoenix*, to enhance care coordination. The state has been engaged in on-going discussions with stakeholders, including prospective CICOs, regarding these changes and has sought input on the best approach for the proposed transition.

   At a high-level, the HCBS transition would consist of the following phases:

   - Phase I of the transition (July 1 to December 31, 2014) closely resembles the operations of the state's current HCBS system and is considered a time to transfer knowledge of this system to the CICOs. The state will continue to maintain direct contracting with HCBS providers during this six month period, including those who provide case management. HCBS will be included in the capitation rate and CICOs will receive claims for Enrollees through the state's *Care Call* system. Waiver case managers will be fully integrated into the demonstration through their participation in the multidisciplinary team and CICOs will have real-time

access to all waiver-related assessment and care planning information through *Phoenix.*

- Phase II (calendar year 2015) begins the transition of the system's functions that were previously performed by the state to the CICOs. This phase is designed to support the activities necessary to positively influence the continued integration of HCBS. During this phase, CICOs assume oversight and authority of HCBS care plan development, service authorization, and all HCBS provider contracts, except self-directed attendant care.

- Phase III (calendar year 2016) concludes the total transformation of the state's HCBS system. At this point, the CICOs assume all the responsibilities, including self-directed attendant care, needed to continue to adequately coordinate these services.

Throughout the three phases, HCBS benchmark standards must be met prior to the CICOs assuming a higher level of responsibility. The purpose of these benchmarks is to ensure that CICOs have developed the necessary capacity and competency to achieve the pre-established standards of each transition phase. The demonstration's readiness review will incorporate the necessary HCBS transition elements that a CICO must achieve for Phase I. Two additional HCBS benchmark reviews conducted by the state and its external quality review organization (EQRO) in collaboration with CMS will occur in Phases II and III and will measure the CICOs' ability to move into subsequent phases of the HCBS transition. A summary of the respective state and CICO roles and responsibilities over the course of the transition can be found in Figure 1 below, with additional details to be provided in the final Memorandum of Understanding.

Figure 1. Overview of State/CICO Responsibilities during HCBS Transition

Functions	Phase I	Phase II	Phase III
Use of *Phoenix* and *Care Call*	State & CICO	State & CICO	State & CICO
Provider credentialing / monitoring	State	State	State; CICO can assume responsibility at its own cost
HCBS Providers Contractual Authority	State	CICO; State provides a contract template	CICO

HCBS care plan development	State; CICOs have formal input process	CICO; State concurrence required	CICO; State concurrence required
Oversight of waiver case manager's participation in multidisciplinary team	CICO	CICO	CICO
HCBS Provider Rate Setting Authority	State	CICO; State establishes rate guidelines	CICO; State establishes rate guidelines
HCBS claims processing (via *Care Call*) and provider payments	CICO	CICO	CICO
LTC LOC Assessments	State	State	State
LTC LOC Reassessment	State	CICO	CICO
Self-directed attendant care and related functions	State	State	CICO

2. Please provide more information on how transition services would be incorporated into the demonstration.

Response: Transition services include those provided to facilitate re-entry into the community from NF placement. South Carolina participates in the Money Follows the Person (MFP) program. There are two scenarios where the CICO would become involved in this effort under the demonstration. The first would be the case where the beneficiary is enrolled in a plan and then is admitted to a nursing facility. In that case, the CICO would work with the MFP program to identify NF residents who would be candidates for transition support. The second is the case of a nursing facility resident who is not participating in the demonstration, but becomes eligible to participate by his/her relocation to the community. In this case, if the beneficiary chooses to participate in the demonstration, s/he would be given a choice of CICOs, and then the selected CICO would become part of the transition efforts once the resident has returned to the community.

Once a referral is received, a SCDHHS registered nurse would conduct a face-to-face assessment to determine whether the NF level of care criteria for entering the waiver program are met. If the criteria are met, the MFP program would provide a transition coordinator to work with the SCDHHS staff. The CICO would be involved in this effort in terms of coordinating development of a medical home and working with MFP staff to address housing needs. SCDHHS will develop a service plan (involving the CICO) and initiate services once the transition has taken place. The transition coordinator would

continue working with the beneficiary for one year and would be a member of the multidisciplinary team.

3. CMS also requests additional information on South Carolina's proposed strategy for individuals with End Stage Renal Disease and individuals receiving hospice services. In today's Medicare Advantage program, beneficiaries with ESRD can stay in an MA plan in which they are already enrolled, but cannot otherwise join an MA plan, and Medicare hospice services are provided through Original (i.e. fee-for-service) Medicare and not through the MA plan. Do you intend to follow either/both of these policies in the demonstration?

   Response: After careful consideration, South Carolina has decided that individuals with ESRD and those receiving hospice services at the time of enrollment will be excluded from the demonstration. However, if an individual become eligible for ESRD or enters a hospice program while enrolled in the demonstration, s/he may continue to receive services under the demonstration.

Beneficiary Protections

1. Please describe how the state would establish meaningful beneficiary input processes that include beneficiary participation in the development and oversight of the model (e.g., participation on CICO governing boards and/or establishment of beneficiary advisory boards).

   Response: The state has included stakeholders in the development of its demonstration proposal from the beginning and will continue to engage them at all levels of development and implementation. The state will continue to meet regularly with its Integrated Care Workgroup (ICW) throughout these critical stages. The ICW provides a mechanism to engage a very diverse group of stakeholders both broadly and narrowly, tapping into their various levels of expertise and interests through large group meetings, smaller workgroups and surveys as needed. Members of this group will also assist in soliciting input from "real consumers" who are connected to their agencies/organizations. The project will continue to utilize its dedicated website, as well as SCDHHS' website, to share information about the project as well as the process. We will use a variety of engagement strategies, such as listening sessions, workgroup meetings, public hearings, focus groups and written notices and bulletins. CICOs will be required to establish consumer advisory boards and to engage consumers as soon and as broadly as possible. It is the state's intent to require the CICOs to create a council of beneficiaries and primary caregivers to provide feedback and input.

2. Please explain how all medically necessary benefits are provided, allow for involvement of caregivers, and in an appropriate setting, including in the home and community.

Response: With the updated demonstration design, which includes transitioning the responsibilities of home and community-based services (HCBS) to the CICOs, the South Carolina capitated financial alignment demonstration is designed to provide all medically necessary benefits in the most appropriate setting, including in the home and community. The model also allows enrollees to include their caregivers as a key member of their individual multidisciplinary team. The recognition of the critical roles that caregivers play has been a cornerstone of the state's model of care and is an important element in its care coordination requirements.

Network Adequacy

1. Please describe how the state will ensure an adequate and appropriate provider network.

   Response: In addition to the Medicare network validation and the HCBS benchmark reviews that CICOs are required to pass, South Carolina has also established requirements for CICOs' Medicaid provider networks. The Medicaid provider network requirements balance the need to provide beneficiaries with a large network of high quality providers with the limited number of providers operating in the state's most rural areas. The demonstration network standards require CICOs to contract with more providers of each specialty than many of these organizations operating in South Carolina currently have in their networks.

Data Standards

CMS also asks South Carolina to please confirm that its proposed demonstration would meet the following elements of the data standards and conditions:

1. Please provide written confirmation that the state would provide to CMS any required beneficiary-level expenditure data and covered benefits for most recently available three years, including available encounter data in capitated models.

   Response: SCDHHS confirms the state will provide this data.

2. Please provide written confirmation that the state would provide to CMS a description of any changes to the State Plan that would affect Medicare-Medicaid enrollees during this three-year period (payment rate changes, benefit design, addition or expiration of waivers, etc.).

   Response: SCDHHS confirms the state will provide this information.

3. Please provide written confirmation that the state would provide to CMS data on state supplemental payments to providers (e.g., DSH, UPL) during the three year period.

Response: SCDHHS confirms the state will provide this information.

Plan Selection Update

SCDHHS provided the following update on the capitated financial alignment demonstration:

Because of potential conflicts with the state's procurement process and the demonstration's three way contract, South Carolina will utilize an open application process to select entities that will be eligible to contract with CMS and the state for the purposes of the demonstration. The application process is open to organizations that have submitted a Medicare-Medicaid Plan application via CMS and will follow state processes that are currently utilized for Medicaid MCOs. Prospective CICOs must:

- Submit evidence of having a South Carolina Department of Insurance Certificate of Authority;
- Successfully meet the standards and requirements necessary for prospective CICOs as defined by the state's CICO Qualification Screen; and
- Successfully complete a joint CMS-SCDHHS readiness review.