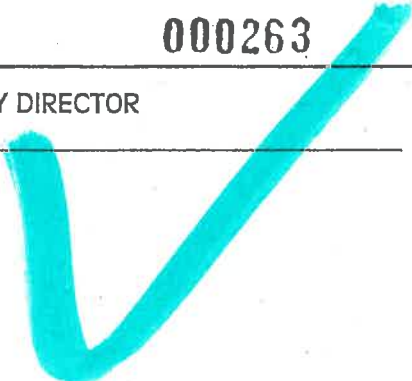


DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

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| TO <i>Singleton/Curtis</i> | DATE <i>2-3-14</i> |
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| DIRECTOR'S USE ONLY | ACTION REQUESTED |
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| 1. LOG NUMBER 000263 | <input type="checkbox"/> Prepare reply for the Director's signature DATE DUE _____ |
| 2. DATE SIGNED BY DIRECTOR _____ | <input type="checkbox"/> Prepare reply for appropriate signature DATE DUE _____ |
|  | <input type="checkbox"/> FOIA DATE DUE _____ |
| | <input checked="" type="checkbox"/> Necessary Action |

| APPROVALS (Only when prepared for director's signature) | APPROVE | * DISAPPROVE (Note reason for disapproval and return to preparer.) | COMMENT |
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| 1. | | | |
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DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

200 Independence Avenue SW
Washington, DC 20201

January 15, 2014

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FEB 03 2014

Department of Health & Human Services
OFFICE OF THE DIRECTOR

Anthony Keck
Director
South Carolina Department of Health and Human Services
P.O. Box 8206
Columbia, SC 29202-8206

Dear Mr. Keck,

We are excited to enter into a Federal-State partnership with South Carolina to implement Healthy Connections Prime, a Medicare-Medicaid Financial Alignment Demonstration. The benefits and protections offered under this Demonstration exemplify the type of programs we hope to see for Medicare-Medicaid enrollees across the nation. We also applaud your commitment to stakeholder engagement during the planning process and as an essential component of the Demonstration itself.

Enclosed, please find a copy of the fully executed Memorandum of Understanding (MOU). The MOU reflects the culmination of months of tireless work with you and your staff, and demonstrates our shared commitment to improving care for Medicare-Medicaid enrollees. We look forward to working with you moving forward to test this model.

The Demonstration will begin no earlier than July 1, 2014 and continue until December 31, 2017. The Demonstration will, we believe, alleviate the fragmentation of care, improve the coordination of services for Medicare-Medicaid enrollees, enhance quality of care, improve the beneficiary experience, and reduce costs for both South Carolina and the Federal government.

Your Medicare-Medicaid Coordination Office lead for this Demonstration will be Lindsay Barnette. She will be available for any questions or concerns. Ms. Barnette's contact information is as follows:

Centers for Medicare & Medicaid Services, Medicare-Medicaid Coordination Office
United States Department of Health & Human Services
200 Independence Ave., SW, Room 315-H
Washington, DC 20201
(202) 260-0617
Lindsay.Barnette@cms.hhs.gov

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We look forward to working with you throughout this Demonstration.

Sincerely,



Melanie Bella
Director
Medicare-Medicaid Coordination Office



Patrick Conway, M.D.
CMS Deputy Administrator for Innovation and
Quality
CMS Chief Medical Officer

Enclosure

Memorandum of Understanding (MOU)

Between

The Centers for Medicare & Medicaid Services (CMS)

And

The State of South Carolina

**Regarding a Federal-State Partnership to Test a Capitated
Financial Alignment Model for Medicare-Medicaid Enrollees**

South Carolina Healthy Connections Prime

Healthy Connections
PRIME 

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I. Statement of Initiative

The Centers for Medicare & Medicaid Services (CMS) and the South Carolina Department of Health and Human Services (“State”) will establish a Federal-State partnership to implement the Healthy Connections Prime program (“Demonstration”) to better serve individuals eligible for both Medicare and Medicaid (“Medicare-Medicaid Enrollees”). The Federal-State partnership will include a Three-Way Contract with Coordinated and Integrated Care Organizations (CICOs) that will provide benefits to Medicare-Medicaid Enrollees statewide. The Demonstration will begin no sooner than July 1, 2014 and continue until December 31, 2017 unless terminated pursuant to Section III.L or continued pursuant to Section III.K of this Memorandum of Understanding (MOU). The initiative is testing an innovative payment and service delivery model to alleviate the fragmentation and improve coordination of services for Medicare-Medicaid Enrollees, enhance quality of care, and reduce costs for both the state and the federal government. (See Appendix 1 for definitions of terms and acronyms used in this MOU. Defined terms will be capitalized throughout the MOU.)

The individuals that will be eligible to participate in the Demonstration are persons 65 and over living in the community at the time of enrollment, receiving full Medicaid benefits, and who are entitled to benefits under Medicare Part A and enrolled under Medicare Parts B and D. Section III.C.1 below provides more information on eligibility for the Demonstration.

Under this initiative, CICOs will be required to provide for, either directly or through subcontracts, Medicare and Medicaid-covered services, as well as additional items and services, under a capitated model of financing. CMS, the State, and the CICOs will ensure that beneficiaries have access to an adequate network of medical and supportive services.

CMS and the State shall jointly select and monitor the CICOs. CMS and the State will implement this initiative under demonstration authority for Medicare and South Carolina State Plan for Medical Assistance (State Plan) authority, and waiver authority for Medicaid, as described in Section III.A and detailed in Appendices 4 and 5.

Built on principles of independent living, wellness promotion, and cultural competence, this initiative aims to improve the entire beneficiary care experience. By engaging beneficiaries in

their care and allowing them to self-direct services as appropriate, the Demonstration will address beneficiaries' health and functional needs in order to better equip individuals to live independently in their communities. Improving the beneficiary experience can lead to system-wide benefits such as better quality, improved transitions between care settings, fewer health disparities, reduced costs for both payers, and the elimination of cost shifting between Medicare and Medicaid. Integral to South Carolina's model is a phased transition of roles and responsibilities of home and community based service (HCBS) to the CICOs. This phased approach is described in detail in Appendix 7.

The Demonstration will evaluate the effect of an integrated care and payment model on both community and institutional populations. In order to accomplish these objectives, comprehensive contract requirements will specify access, quality, network, financial solvency, and oversight standards. Contract management will focus on performance measurement and continuous quality improvement. Except as otherwise specified in this MOU and/or applicable Medicaid waiver standards and conditions or State Plan Amendments, CICOs will be required to comply with all applicable existing Medicare and Medicaid laws, rules, and regulations as well as program specific and evaluation requirements, as will be further specified in a Three-Way Contract to be executed among the CICOs, the State, and CMS.

As part of this Demonstration, CMS and the State will implement a new Medicare and Medicaid payment methodology designed to support CICOs in serving Medicare-Medicaid Enrollees in the Demonstration. This financing approach will minimize cost-shifting, align incentives between Medicare and Medicaid, and support the best possible health and functional outcomes for Enrollees.

CMS and the State will allow for certain flexibilities that will further the goal of providing a seamless experience for Medicare-Medicaid Enrollees, utilizing a simplified and unified set of rules, as detailed in the sections below. Flexibilities will be coupled with specific beneficiary safeguards that are included in this MOU and will also be in the Three-Way Contract. CICOs will have full accountability for managing the capitated payment to best meet the needs of Enrollees according to Individualized Care Plans developed by Enrollees, their caregivers, and Multidisciplinary Teams using a person-centered planning process. CMS and the State expect

CICOs to achieve savings through better-integrated and coordinated care. Subject to CMS and State oversight, CICOs will have flexibility to innovate around care delivery and to provide a range of community-based services as alternatives to or means to avoid high-cost services if indicated by the Enrollees' wishes, needs, and Individualized Care Plan.

Preceding the signing of this MOU, South Carolina has undergone necessary planning activities consistent with the CMS standards and conditions for participation, as detailed through supporting documentation provided in Appendix 2. This includes a robust beneficiary- and stakeholder-engagement process.

II. Specific Purpose of this Memorandum of Understanding

This document details the principles under which CMS and the State plan to implement and operate the aforementioned Demonstration. It also outlines the activities CMS and the State plan to conduct in preparation for implementation of the Demonstration, before the parties execute a Three-Way Contract with CICOs that sets forth the terms and conditions of the Demonstration and initiates the Demonstration. Further detail about CICO responsibilities, including the additional operational and technical requirements pertinent to the implementation of the Demonstration, will be included in and appended to the Three-Way Contract.

Following the signing of this MOU and prior to the implementation of the Demonstration, the State and CMS will enter into Three-Way Contracts with selected CICOs which will have also met the Medicare components of the plan selection process, including submission of a successful Capitated Financial Alignment Application and adherence to annual contract renewal requirements and guidance updates.

III. Demonstration Design / Operational Plan

A. DEMONSTRATION AUTHORITY

The following is a summary of the terms and conditions the parties intend to incorporate into the Three-Way Contracts, as well as those activities the parties intend to conduct prior to entering into the Three-Way Contracts and initiating the Demonstration. This section

and any appendices referenced herein are not intended to create contractual or other legal rights between the parties and CICOs.

1. Medicare Authority

The Medicare elements of the initiative shall operate according to existing Medicare Parts C and D laws and regulations, as amended or modified, except to the extent these requirements are waived or modified as provided for in Appendix 4. As a term and condition of the Demonstration, CICOs will be required to comply with Medicare Advantage and Medicare Prescription Drug Program requirements in Part C and Part D of Title XVIII of the Social Security Act, and 42 CFR §422 and 423, and applicable sub-regulatory guidance, as amended from time to time, except to the extent specified in this MOU, including Appendix 4 and, for waivers of sub-regulatory guidance, the Three-Way Contract.

2. Medicaid Authority

The Medicaid elements of the initiative shall operate according to existing Medicaid law and regulation and sub-regulatory guidance, including but not limited to all requirements of the 1915(c) waivers for those beneficiaries in a 1915(c) waiver, as amended or modified, except to the extent waived in Appendix 5. As a term and condition of the initiative, the State and CICOs will be required to comply with Medicaid managed care requirements under Title XIX of the Social Security Act and 42 CFR §438 et. seq., other applicable regulations, and applicable sub-regulatory guidance, as amended or modified, except to the extent specified in this MOU, including Appendix 5 and, for waivers of sub-regulatory guidance, the Three-Way Contract. The State will submit a Social Security Act Section 1932(a) State Plan Amendment and add concurrent authority to its three 1915(c) waivers (i.e., Community Choices, HIV/AIDS and Mechanical Ventilation) via amendments prior to January 1, 2014.

B. CONTRACTING PROCESS

1. CICO Application and Contracting Process

The State developed an application process and issued a set of requirements that reflects the integration of Medicare and Medicaid payment and benefits. As articulated in January 9, 2013 guidance from CMS, CICOs are also required to submit a Capitated Financial Alignment Demonstration application to CMS and meet all of the Medicare components of the plan selection process. All applicable Medicare Advantage/ Part D requirements and Medicaid managed care requirements will apply as specified by CMS and the State herein or in the Three-Way Contract.

2. CICO Selection

CMS and the State, through their respective plan application and selection processes, will select entities that will be eligible to contract with CMS and the State. CMS and the State shall contract with qualified CICOs on a selective basis. See Appendix 7 for more information on the plan selection process.

3. Medicare Waiver Approval

CMS approval of Medicare waivers is reflected in Appendix 4. CMS reserves the right to withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of Title XVIII. CMS will promptly notify the State in writing of the determination and the reasons for the withdrawal, together with the effective date, and, subject to Section 1115A(d)(2) of the Social Security Act, afford the State a reasonable opportunity to request a reconsideration of CMS' determination prior to the effective date. Termination and phase out would proceed as described in Section III.L of this MOU. If a waiver or expenditure authority is withdrawn, Federal Financial Participation (FFP) is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including covered services and administrative costs of disenrolling participants.

4. Medicaid Waiver and/or Medicaid State Plan Approval

CMS approval of any new Medicaid State Plan amendments, waivers, and variances pursuant to sections 1915(c), 1115, 1115A, or Title XIX of the Social Security Act authority and processes is discussed in Appendix 5. CMS reserves the right to withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of Title XIX. CMS will promptly notify the State in writing of the determination and the reasons for the withdrawal together with the effective date and subject to Section 1115A(d)(2) of the Social Security Act, afford the State an opportunity to request a reconsideration of CMS' determination prior to the effective date.

Termination and phase out would proceed as described in Section III.L of this MOU. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including Covered Services and administrative costs of disenrolling participants.

5. Readiness Review

CMS and the State, either directly or with contractor support, shall conduct a Readiness Review of each selected CICO. Before a CICO begins marketing and enrollment activities, both CMS and the State must agree that the CICO has satisfied all readiness requirements. CMS and the State will collaborate in the design and implementation of the Readiness Review process and requirements. The Readiness Review shall include an evaluation of the capacity of each potential CICO and its ability to meet all Demonstration requirements, including having an adequate network that addresses the full range of beneficiary needs, and the capacity to uphold all beneficiary safeguards and protections.

In addition to the Readiness Review, CMS and the State will conduct two additional HCBS Benchmark Reviews of CICOs as part of the phased HCBS transition provision discussed in Appendix 7, Section IV.H. The purpose of these additional reviews is to ensure that CICOs have developed the necessary capacity and competency to achieve the pre-established standards of each phase of the HCBS transition. 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 will occur at strategic points in Phases II and III and will measure the CICOs' ability to move into subsequent phases of the HCBS transition. These Benchmark Reviews will be performed by a team comprised of State staff and State's External Quality Review Organization (EQRO) in consultation with CMS. The details of these reviews are addressed in Appendix 7.

6. Three-Way Contract

CMS and the State shall develop a single Three-Way Contract and contracting process that both parties agree is administratively effective and ensures coordinated and comprehensive program operation, enforcement, monitoring, and oversight.

C. ENROLLMENT

1. Eligible Populations

The Demonstration will be available to individuals who meet all of the following criteria:

- Age 65 and older at the time of enrollment; and
- 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.

The following populations are not eligible for the Demonstration and will be excluded from enrollment:

- Individuals under the age of 65;
- 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 at the time of Demonstration eligibility determination;
- Individuals who are in a hospice program or are receiving End-Stage Renal Disease (ESRD) services at the time of Demonstration eligibility determination; and
- Individuals who are participating in federal waiver programs for home and community based Medicaid coverage other than the Community Choices Waiver, HIV/AIDS Waiver and Mechanical Ventilation Waiver (e.g., Intellectual Disabilities and Related Disabilities Waiver, Head and Spinal Cord Injury Waiver, Community Supports Waiver, Medically Complex Children's Waiver, Pervasive Developmental Disorder Waiver and Psychiatric Residential Treatment Facility Alternative CHANCE Waiver.)

Individuals may elect to enroll or remain in the Demonstration under the following circumstances:

- Individuals enrolled in a Medicare Advantage plan or Program of All-inclusive Care for the Elderly (PACE) and who meet the eligibility criteria for this Demonstration may participate in this initiative if they choose to disenroll from their existing programs.
- Individuals who transition from a Nursing Facility or ICF/IID into the community and are otherwise eligible for Demonstration participation may elect to enroll in the Demonstration. (Note that once these individuals are transitioned into the community they may be eligible for passive enrollment.)
- Individuals already enrolled who later enter a Nursing Facility may remain in the Demonstration.
- Individuals already enrolled in the Demonstration who enter hospice programs or become eligible for ESRD services may remain in the Demonstration.

2. Enrollment and Disenrollment Processes

When no active choice has been made, enrollment for eligible beneficiaries (as described above in Section III.C.1) may be conducted using a seamless passive enrollment process that provides the opportunity for Enrollees to make a voluntary choice to enroll or disenroll from the CICO on a monthly basis. Under passive enrollment, eligible individuals will be notified of plan selection and of their right to select among other contracted CICOs no fewer than sixty (60) days prior to the effective date of enrollment, and will have the opportunity to opt out until the last day of the month prior to the effective date of enrollment, as further detailed in Appendix 7. Disenrollment from CICOs and enrollment from one CICO to a different CICO shall be allowed on a month-to-month basis any time during the year; however, coverage for these individuals will continue through the end of the month. CMS and the State will monitor enrollments and disenrollments for both evaluation purposes and for compliance with applicable marketing and enrollment laws, regulations and CMS policies, and for the purposes of identifying any inappropriate or illegal marketing practices. As part of this analysis, CMS and the State will monitor any unusual shifts in enrollment by individuals identified for Passive Enrollment into a particular CICO to a Medicare Advantage plan operated by the same parent organization. If those shifts appear to be due to inappropriate or illegal marketing practices, CMS and the State may issue corrective action. Any illegal marketing practices will be referred to appropriate agencies for investigation. As mutually agreed upon, and as discussed further in Appendix 7 and the Three-Way Contract, 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.

3. Uniform Enrollment/Disenrollment Documents

CMS and the State shall develop uniform enrollment and disenrollment forms and other documents.

4. Outreach and Education

CICO outreach and marketing materials will be subject to a single set of marketing rules defined by CMS and the State, as further detailed in Appendix 7.

5. Single Identification Card

CMS and the State shall work with CICOs to develop a single identification card that can be used to access all care needs, as further detailed in Appendix 7.

6. Interaction with other Demonstrations

To best ensure continuity of beneficiary care and provider relationships, CMS will work with the State to address beneficiary or provider participation in other programs or initiatives, such as Accountable Care Organizations (ACOs). A beneficiary enrolled in the Demonstration will not be enrolled in, nor have costs attributed to, a Medicare ACO or any other shared savings initiative for the purposes of calculating shared Medicare savings under those initiatives.

D. DELIVERY SYSTEMS AND BENEFITS

1. CICO Service Capacity

CMS and the State shall contract with CICOs that demonstrate the capacity to provide, directly or by subcontracting with other qualified entities, the full continuum of Medicare and Medicaid covered services to Enrollees, in accordance with this MOU, CMS guidance, and the Three-Way Contract.

Medicare covered benefits shall be provided in accordance with 42 CFR §422 and 42 CFR §423 et seq. Medicaid covered benefits under the Demonstration shall be provided in accordance with 42 CFR §438 and with the requirements in the approved Medicaid

State Plan, including any applicable State Plan Amendments and waiver authority discussed in Appendix 5, and in accordance with the requirements specified in this MOU. In accordance with the Three-Way Contract and this MOU, CMS and the State may choose to allow for greater flexibility in offering additional benefits that exceed those currently covered by either Medicare or Medicaid, as discussed in Appendix 7. CMS, the State, and CICOs will ensure that beneficiaries have access to an adequate network of medical, drug, behavioral health, and Long-Term Services and Supports (LTSS) providers that are appropriate and capable of addressing the needs of this diverse population, as discussed in more detail in Appendix 7. As further detailed in Appendix 7, 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 through Care Call. For Phase II, CICOs that have successfully completed the first HCBS benchmark review will assume responsibility for case management (CM) services and most HCBS, 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 and assume responsibility for the full continuum of care under this Demonstration. Additional details regarding the Phase-In, including the roles and responsibilities of CMS/State and the CICOs, is contained in Appendix 7.

2. CICO Risk Arrangements

CMS and the State shall require each CICO to provide a detailed description of its risk arrangements with providers under subcontract with the CICO. The CICO shall make this description available to Enrollees upon request. The CICO shall not have any incentive arrangements to include any payment or other inducement that serves to withhold, limit or reduce necessary medical or non-medical services to Enrollees.

3. CICO Financial Solvency Arrangements

CMS and the State have established a standard for all CICOs, as articulated in Appendix 7.

E. BENEFICIARY PROTECTIONS, PARTICIPATION, AND CUSTOMER SERVICE

1. Choice of Plans and Providers

As referenced in Section III.C.2, 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. This includes the right to choose a different CICO, a Medicare Advantage Plan, to receive care through Medicaid and Medicare Fee-For-Service (FFS) and a Prescription Drug Plan, a PACE site (where applicable), and/or to receive Medicaid services in accordance with the State's approved State Plan and any approved waiver programs.

2. Continuity of Care

CMS and the State will require CICOs to ensure that Enrollees continue to have access to medically necessary items, services, prescription drugs, and medical, behavioral health and LTSS providers for the transition period as specified in Appendix 7. In addition, 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. Part D transition rules and rights will continue as provided for in current law and regulation.

3. Enrollment Assistance and Options Counseling

As referenced in Section III.C.2 and Appendix 7, 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.

4. Access to Home and Community Based Services

All Enrollees who meet level of care criteria for HCBS will have access to waiver services under the Demonstration without regard to a waiting list.

5. Ombudsman

The State intends to support an independent Ombudsman program outside of the state Medicaid agency to advocate and investigate on behalf of Enrollees, including home and community based care and nursing facility-based recipients, to safeguard due process and to serve as the early and consistent means of identifying systematic problems with the Demonstration. CMS will support the Ombudsman with training on the Demonstration and its objectives, and CMS and the State will provide ongoing technical assistance to the Ombudsman. The Ombudsman will support individual advocacy and independent systematic oversight of CICOs, with a focus on compliance with principles of community integration, independent living, and person-centered care in the home and community based care context. The Ombudsman will also have the necessary capacities to provide arbitration between the State and CICOs as needed during the HCBS transition as described in Appendix 7, Section IV.H of this MOU. In addition, the Ombudsman will be responsible for gathering and reporting data on Ombudsman activities to the State and CMS via the Contract Management Team described in Appendix 7.

6. Person-Centered, Appropriate Care

CMS, the State, and CICOs shall ensure that all medically necessary covered benefits and services are provided to Enrollees, and are provided in a manner that is sensitive to the Enrollee's functional and cognitive needs, language and culture, allows for involvement of the Enrollee and caregivers, and are in a care setting appropriate to the Enrollees' needs, with a preference for the home and the community. CMS, the State, and CICOs shall ensure that care is person-centered and can accommodate and support self-direction. CICOs shall also ensure that medically necessary covered services are provided to Enrollees in the least restrictive and most integrated home and community setting, and in accordance with the Enrollee's wishes and Individualized Care Plan.

7. Americans with Disabilities Act (ADA) and Civil Rights Act of 1964

CMS and the State require plan and provider compliance with the ADA and the Civil Rights Act of 1964 to promote the success of the CICO model and to support better health outcomes for Enrollees. In particular, CMS and the State recognize that successful person-centered care requires physical access to buildings, services and equipment and flexibility in scheduling and processes. 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 Enrollees. The State and CMS also recognize that access includes effective communication. 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 Enrollees with cognitive limitations, and interpretation for individuals with limited English proficiency. Also, CMS and the State recognize the importance of staff training on accessibility and accommodation, independent living and recovery models, cultural competency, and wellness philosophies. CMS and the State will continue to work with stakeholders and Enrollees to further develop learning opportunities, monitoring mechanisms, and quality measures to promote compliance with all requirements of the ADA by CICOs and their providers. Finally, CMS and the State are committed to compliance with the ADA, including application of the Supreme Court's *Olmstead* decision, and agree to ensure that CICOs provide Enrollees with LTSS in care settings appropriate to their needs consistent with covered services.

8. Enrollee Communications

CMS and the State agree that Enrollee and prospective Enrollee materials, in all forms, shall require prior approval by CMS and the State in accordance with all existing rules and regulation, unless CMS and the State agree that one or the other entity is authorized to review and approve such documents on behalf of CMS and the State. CMS and the State will also work to develop pre-approved documents that may be used, under certain circumstances, without additional CMS or State approval. CMS and the State will

develop integrated materials that include, but are not limited to: outreach and education materials; enrollment and disenrollment materials; benefit coverage information; and operational letters for enrollment, disenrollment, claims or service denials, complaints, internal appeals, external appeals, and provider terminations. Such uniform/integrated materials will be required to be accessible and understandable to Enrollees, prospective Enrollees, and their caregivers. Materials must be accessible to individuals with disabilities, including but not limited to cognitive and functional limitations, and those with limited English proficiency, in accordance with current federal guidelines for Medicare and Medicaid. Where Medicare and Medicaid standards differ, the standard that provides the greatest level of understanding and comprehension access to individuals with disabilities or limited English proficiency will apply.

9. Enrollee Participation on Governing and Advisory Boards

As part of the Three-Way Contract, CMS and the State shall require CICOs to obtain meaningful beneficiary input on issues of Demonstration management and Enrollee care. Each CICO must establish an independent Demonstration Enrollee advisory committee which will meet regularly and develop a process for that committee to provide input to the governing board. Advisory committee members and the Ombudsman will be invited to participate in the State's ongoing stakeholder process. CICOs must also assure that the Enrollee advisory committee composition reflects the diversity of the enrollee population. In addition to the advisory committees, CICOs must include participation of Enrollees, including individuals with disabilities, within the governance structure of the CICO. The State will maintain additional processes for ongoing stakeholder participation and public comment using the State's Medical Care Advisory Committee (MCAC) as well as other processes discussed in Appendix 7.

10. CICO Customer Service Representatives

CMS and the State shall require CICOs to employ or contract with sufficient numbers of customer service representatives who shall answer all inquiries and respond to Enrollee complaints and concerns in a reasonable time period, as defined by CMS and the State. In

addition, CMS and the State shall themselves employ or contract with sufficient call center and customer service representatives to address Enrollee questions and concerns. CICOs, CMS, and the State shall work to assure the language and cultural competency of customer service representatives adequately meet the needs of the Enrollee population. All services must be culturally and linguistically appropriate and accessible. More detailed information about customer service requirements is included in Appendix 7.

11. Privacy and Security

CMS and the State shall require all CICOs to ensure privacy and security of Enrollee health records. CICOs will provide Enrollees with access to such records as specified in the Three-Way Contract and as otherwise mandated by state or federal law.

12. Integrated Appeals and Grievances

As referenced in Section III.F and Appendix 7, Enrollees will have access to an integrated appeals and grievance process.

13. Limited Cost Sharing

CICOs will not charge Medicare Parts C or D premiums, nor assess any cost sharing for Medicare Parts A and B services. For drugs and pharmacy products, including those covered by both Medicare Part D and the State, CICOs will be permitted to charge co-pays to individuals currently eligible to make such payments consistent with co-pays applicable for Medicare and Medicaid drugs. Co-pays charged by CICOs for Part D drugs must not exceed the applicable amounts for brand and generic drugs established yearly by CMS under the Part D Low Income Subsidy, although CICOs may elect to reduce this cost sharing for all Enrollees as a way of testing whether reducing Enrollee cost sharing for pharmacy products improves health outcomes and reduces overall health care expenditures through improved medication adherence under the Demonstration. For Medicaid services beyond the pharmacy cost sharing described here, CICOs will not assess any cost sharing to Enrollees above levels established under the State Plan.

14. No Balance Billing

No Enrollee may be balance billed by any provider for any reason for Covered Services or Flexible benefits.

F. INTEGRATED APPEALS AND GRIEVANCES

1. CICO Grievances and Internal Appeals Processes

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. CMS and the State will work to continue to coordinate grievances and appeals for all services.

2. External Appeals Processes

CMS and the State agree to utilize a streamlined Appeals process that will conform to both Medicare and Medicaid requirements, to create a more beneficiary-friendly and easily navigable system. Protocols will be developed to assure coordinated access to the appeals mechanism. This process and these protocols are discussed in further detail in Appendix 7. Medicare Part D appeals and grievances will continue to be managed by CMS under existing Part D rules.

G. ADMINISTRATION AND REPORTING

1. CICO Contract Management

As more fully discussed in Appendix 7, CMS and the State agree to designate representatives to serve on a CMS-State Contract Management team that shall conduct

CICO contract management activities related to ensuring access, quality, program integrity, program compliance, and financial solvency. These activities shall include but not be limited to:

- Reviewing and analyzing Health Care Effectiveness Data and Information Set (HEDIS) data, Consumer Assessment of Health Care Providers and Systems (CAHPS) Survey data, Health Outcomes Survey (HOS) data, enrollment and disenrollment reports for CICOs;
- Reviewing any other performance metrics applied for quality withhold or other purposes;
- Reviewing reports of Enrollee complaints, reviewing compliance with applicable CMS and/or State standards, and initiating programmatic changes and/or changes in clinical protocols, as appropriate;
- Reviewing and analyzing reports on CICOs' fiscal operations and financial solvency, conducting program integrity studies to prevent and detect fraud, waste and abuse as may be agreed upon by CMS and the State, and ensuring that CICOs take corrective action, as appropriate;
- Reviewing and analyzing reports on CICOs network adequacy, including the CICOs' ongoing efforts to maintain, replenish, and expand their networks and to continually enroll qualified providers;
- Reviewing any other applicable ratings and measures;
- Reviewing reports from the Ombudsman;
- Reviewing direct stakeholder input into both CICO-specific and systemic performance; and
- Responding to and investigating Enrollee complaints and quality of care issues.

2. Day-to-Day CICO Monitoring

CMS and the State will establish procedures for CICO daily monitoring, as described in Appendix 7. Oversight shall generally be conducted in line with the following principles:

- The State and CMS will each retain and coordinate current responsibilities toward the Enrollee, such that Enrollees maintain access to their benefits across both programs.
- CMS and the State will leverage existing protocols (i.e.: responding to beneficiary complaints, conducting account management, and analyzing enrollment data) to identify and solve Enrollee access problems in real-time.
- Oversight will be coordinated and subject to a unified set of requirements. CMS-State Contract Management Teams, as described in Appendix 7, will be established. Oversight will build on areas of expertise and capacity of the State and CMS.
- Oversight of the CICOs and providers will be at least as rigorous as existing procedures for Medicare Advantage, Medicare Part D, and the State's Medicaid managed care and waiver programs.
- Medicare Part D oversight will continue to be a CMS responsibility, with appropriate coordination and communication with the State. CICOs will be included in all existing Medicare Advantage and Part D oversight activities, including (but not limited to) data-driven monitoring, secret shopping, contracted monitoring projects, plan ratings, formulary administration and transition review, and audits.
- CMS and the State will enhance existing mechanisms and develop new mechanisms to foster CICO performance improvement and remove consistently poor performing CICOs from the Demonstration, leveraging existing CMS tools such as the Complaints Tracking Module, the Medicare Part D Critical Incidence Reporting System, and existing State oversight and tracking tools. Standards for removal on the grounds of poor performance will be articulated in the Three-Way Contract.

3. Consolidated Reporting Requirements

CMS and the State shall define and specify in the Three-Way Contract a Consolidated Reporting Process for CICOs that ensures the provision of the necessary data on diagnosis, HEDIS and other quality measures, Enrollee satisfaction and evidence-based measures, and other information as it may be beneficial to monitor each CICO's performance. CICOs will be required to meet the encounter reporting requirements that are established for the Demonstration. See Appendix 7 for more detail.

4. Accept and Process Data

CMS, or its designated agent(s), and the State shall accept and process uniform person-level Enrollee data for the purposes of program eligibility, payment, and evaluation. Submission of data to the State and CMS must comply with all relevant federal and state laws and regulations, including, but not limited to, regulations related to HIPAA and electronic file submissions of patient identifiable information. Such data will be shared by each party with the other party to the extent allowed by law and regulation. CMS and the State shall streamline data submissions for CICOs wherever practicable.

H. QUALITY MANAGEMENT

1. Quality Management and Monitoring

As a model conducted under the authority of Section 1115A of the Social Security Act, the Demonstration and independent evaluation will include and assess quality measures designed to ensure Enrollees are receiving high quality care. In addition, CMS and the State shall conduct a joint, comprehensive performance and quality monitoring process that is at least as rigorous as Medicare Advantage, Medicare Prescription Drug, and Medicaid managed care and waiver requirements. The reporting frequency and monitoring process will be specified in the Three-Way Contract.

2. External Quality Reviews

CMS and the State shall coordinate the CICO external quality reviews conducted by the Quality Improvement Organization (QIO) and External Quality Review Organization (EQRO).

3. Determination of Applicable Quality Standards

CMS and the State shall determine applicable quality standards and monitor the CICOs' performance on those standards. These standards are articulated in Appendix 7 and will be articulated in the Three-Way Contract.

I. FINANCING AND PAYMENT

1. Rates and Financial Terms

For each calendar year of the Demonstration, before rates are offered to CICOs, CMS shall share with the State the amount of the Medicare portion of the capitated rate, as well as collaborate to establish the data and documentation needed to assure that the Medicaid portion of the capitation rate is consistent with all applicable federal requirements.

2. Blended Medicare and Medicaid Payment

CMS will make separate payments to the CICOs for the Medicare Parts A/B and Part D components of the rate. The State will make a payment to the CICOs for the Medicaid component of the rate, as more fully detailed in Appendix 6.

J. EVALUATION

1. Evaluation Data to be Collected

CMS and the State have developed processes and protocols, as specified in Appendix 7 and as will be further detailed in the Three-Way Contract, for collecting or ensuring the CICOs or their contractors collect and report to CMS and the State all of the data needed for the CMS evaluation.

2. Monitoring and Evaluation

CMS will fund an external evaluation. The Demonstration will be evaluated in accordance with Section 1115A(b)(4) of the Social Security Act. As further detailed in Appendix 7, CMS or its contractor will measure, monitor, and evaluate the overall impact of the Demonstration including the impacts on program expenditures and service utilization changes, including monitoring any shifting of services between medical and non-medical services. The evaluation will include changes in person-level health outcomes, experience of care, costs by sub-population(s), and changes in patterns of

primary, acute, behavioral health, and LTSS use and expenditures, using principles of rapid-cycle evaluation and feedback. Key aspects and administrative features of the Demonstration, including but not limited to enrollment, marketing, and appeals and grievances, will also be examined using qualitative and descriptive methods. The evaluation will consider potential interactions with other demonstrations and initiatives, and will seek to isolate the effect of this Demonstration as appropriate. The State will collaborate with CMS or its designated agent during all monitoring and evaluation activities. The State and CICOs will submit all data required for the monitoring and evaluation of this Demonstration, according to the data and timeframe requirements listed in the Three-Way Contract. The State and CICOs will submit both historical data relevant to the evaluation, including MSIS data from the years immediately preceding the Demonstration, and data generated during the Demonstration period.

K. EXTENSION OF AGREEMENT

The State may request an extension of this Demonstration, which will be evaluated consistent with terms specified under Section 1115A(b)(3) of the Social Security Act such as ensuring the Demonstration is improving the quality of care without increasing spending; reducing spending without reducing the quality of care; or improving the quality and care and reducing spending. Any extension request will be subject to CMS approval.

L. MODIFICATION OR TERMINATION OF MOU

The State agrees to provide notice to CMS of any State Plan or waiver changes that may have an impact on the Demonstration.

1. Limitations of MOU

This MOU is not intended to, and does not, create any right or benefit, substantive, contractual or procedural, enforceable at law or in equity, by any party against the State, the United States, its agencies, instrumentalities, or entities, its officers, employees, or agents, or any other person. Nothing in this MOU may be construed to obligate the

parties to any current or future expenditure of resources or from modifying the Medicare and Medicaid programs as allowed under the respective federal laws and regulations.

This MOU does not obligate any funds by either of the parties. Each Party acknowledges that it is entering into this MOU under its own authority.

2. Modification

Either CMS or the State may seek to modify or amend this MOU per a written request and subject to requirements set forth in Section 1115A(b)(3) of the Social Security Act such as ensuring the Demonstration is improving the quality of care without increasing spending; reducing spending without reducing the quality of care; or improving the quality and care and reducing spending. Any material modification shall require written agreement by both parties and a stakeholder engagement process that is consistent with the process required under this Demonstration.

3. Termination

The parties may terminate this MOU under the following circumstances:

- Termination without cause - Except as otherwise permitted below, a termination of this MOU by CMS or the State for any reason will require that CMS or the State provides a minimum of 90 days advance notice to the other party, 90 days advance notice to the CICO, and a minimum of 60 days advance notice to beneficiaries and the general public.
- Termination pursuant to Social Security Act § 1115A(b)(3)(B).
- Termination for cause - Either party may terminate this MOU upon 30 days' notice due to a material breach of a provision of this MOU or the three-way contract.
- Termination due to a Change in Law - In addition, CMS or the State may terminate this agreement upon 30 days' notice due to a material change in law, or with less or no notice if required by law.

If the Demonstration is terminated as set forth above, CMS shall provide the State with the opportunity to propose and implement a phase-out plan that assures notice and access

to ongoing coverage for Demonstration Enrollees and, to the extent that timing permits, adheres to the phase-out plan requirements detailed below. All Enrollees must be successfully enrolled in a Part D plan prior to termination of the Demonstration.

4. Demonstration phase-out

Termination at the end of the Demonstration must follow the following procedures:

- A. Notification – Unless CMS and the State agree to extend the Demonstration, the State must submit a draft phase-out plan to CMS no less than five (5) months before the effective date of the Demonstration’s suspension or termination. Prior to submitting the draft phase-out plan the State must publish on its website the draft phase-out plan for a 30-day public comment period. The State shall summarize comments received and share such summary with CMS. Once the phase-out plan is approved by CMS, the phase-out activities must begin within 14 days.
- B. Phase-out Plan Requirements – At a minimum, the State must include in its phase-out plan the process by which it will notify affected Enrollees, the content of said notices (including information on how beneficiary appeal rights will continue to operate during the phase-out and any plan transition), and if applicable, the process by which the State will conduct administrative reviews of Medicaid eligibility for the affected beneficiaries, and ensure ongoing coverage for eligible individuals, including plans for making an appropriate referral for enrollment of all Enrollees in a Medicare Part D Plan, as well as any community outreach activities. In addition, such plan must include any ongoing CICO and State responsibilities and close-out costs.
- C. Phase-out Procedures – the State must comply with all notice requirements found in 42 CFR §431.206, 431.210 and 431.213. In addition, the State must assure all appeal and hearing rights afforded to Demonstration participants as outlined in 42 CFR §431.220 and 431.221. If a Demonstration participant requests a hearing before the date of action, the State must maintain benefits as required in 42 CFR

§431.230. If applicable, the State must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category as discussed in October 1, 2010, State Health Official Letter #10-008.

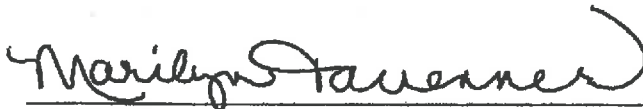
- D. FFP - If the Demonstration is terminated by either party, or any relevant waivers are suspended or withdrawn by CMS, FFP shall be limited to normal closeout costs associated with terminating the Demonstration including Covered Services and administrative costs of disenrolling participants.

M. SIGNATURES

This MOU is effective on this day forward, October 25, 2013, through the end of the Demonstration period, December 31, 2017. Additionally, the terms of this MOU shall continue to apply to the State as it implements associated phase-out activities beyond the end of the Demonstration period.

In Witness Whereof, CMS and the State have caused this Agreement to be executed by their respective authorized officers:

**United States Department of Health and Human Services,
Centers for Medicare & Medicaid Services**



Marilyn Tavenner, Administrator

OCT 25 2013

Date

**The State of South Carolina,
Department of Health and Human Services**



Anthony Keck, Director

Oct 25, 2013

Date

APPENDIX 1. DEFINITIONS

Adverse Action - Consistent with 42 CFR § 438.400, is an action by the CICO, subcontractor, service provider, the State, or other authorized entities, that constitutes a denial or limited authorization of a service authorization request, including the type or level of service; or reduction, suspension, or termination of a previously authorized service; or failure to provide services in a timely manner; or denial in whole or in part of a payment for a covered service for an enrolled member; or failure by the CICO to render a decision within the required timeframes; or the denial of an enrollee's request to exercise his right under 42 CFR 438.52(b)(2)(ii) to obtain services outside of the network.

Appeals - An Enrollee's request for review of a CICO's coverage or payment determination. In accordance with 42 CFR § 438.400, a Medicaid-based appeal is defined as a request for review of an adverse action, as defined herein. An appeal is an enrollee's challenge to the adverse actions regarding services, benefits, and reimbursement provided by the CICO, its service providers or the State.

Benchmark Reviews - Reviews conducted by the State and its EQRO to determine a CICO's readiness to proceed to the next transition phase of HCBS authority.

Care Call - An automated system used for service documentation, service monitoring, web-based reporting, and billing to MMIS. For documentation of personal care services provided in a participant's home, workers call a toll free number upon starting and ending services. For other in home services and services not provided in a participant's home, providers call a toll free number to document service delivery or document service delivery on the Internet. In all cases, services documented are compared with the prior authorization to determine if the service was provided appropriately. For monitoring of service delivery and reporting, real time reports allow providers and case managers to monitor participants more closely to ensure receipt of services. On a weekly basis, Care Call generates electronic billing to MMIS for services provided. Only authorized services and the total units provided (up to the maximum authorization) are submitted to MMIS for payment. This billing ensures accuracy of claim processing. For the purposes of the Demonstration, this system will be modified to bill each CICO directly for Demonstration related claims. The State will not process any Demonstration related claims.

Care Coordinator - An appropriately qualified professional who is the CICO's designated accountable point of contact for each Enrollee receiving care management services. The Care Coordinator is responsible for assisting Enrollees in directing and delegating care management duties, as needed, and may include the following: facilitating assessment of needs; developing, implementing and monitoring the care plan; and serving as the lead of the Multidisciplinary Team.

Care Management - A collaborative, person-centered process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services (both Medicare and Medicaid) required to meet an Enrollee's needs across the continuum of care. It is characterized by advocacy, communication, and resource management to promote quality, cost effective, positive outcomes.

Center for Medicare and Medicaid Innovation (Innovation Center) - Established by Section 3021 of the Affordable Care Act, the Innovation Center was established to test innovative payment and service delivery models to reduce program expenditures under Medicare and Medicaid while preserving or enhancing the quality of care furnished to individuals under such titles.

CICO - See Coordinated and Integrated Care Organization.

Clinical Care Management - a set of services provided by a Clinical Care Manager that comprise intensive monitoring, follow-up, and care coordination, clinical management of high-risk Members.

Clinical Care Manager - a licensed Registered Nurse or other individual employed by the Primary Care Provider or the CICO and licensed to provide Clinical Care Management.

CMS - The Centers for Medicare & Medicaid Services.

Complaint - A grievance or an appeal.

Community Choices Waiver - The CMS-approved 1915(c) waiver that covers a range of community support services offered to individuals who are elderly or who have a disability who would otherwise require a nursing facility level of care.

Consumer Assessment of Healthcare Providers and Systems (CAHPS) - Beneficiary survey tool developed and maintained by the Agency for Healthcare Research and Quality to support and promote the assessment of consumers' experiences with health care.

Contract Management Team - A group of CMS and State representatives responsible for overseeing the Three-Way Contracts.

Coordinated and Integrated Care Organization (CICO) - A health plan or provider-based organization contracted to provide and accountable for providing integrated care to Enrollees.

Covered Services - The set of services to be offered by the CICOs.

Cultural Competence - Understanding those values, beliefs, and needs that are associated with individuals' age, gender identity, sexual orientation, and/or racial, ethnic, or religious backgrounds. Cultural Competence also includes a set of competencies which are required to ensure appropriate, culturally sensitive health care to persons with congenital or acquired disabilities. A competency based on the premise of respect for individual and cultural differences, and an implementation of a trust-promoting method of inquiry and assistance.

Enrollee - A Medicare-Medicaid individual enrolled in the Demonstration, including the duration of any month in which their eligibility for the Demonstration ends.

Enrollee Communications - Materials designed to communicate to Enrollees plan benefits, policies, processes and/or Enrollee rights. This includes pre-enrollment, post-enrollment, and operational materials.

Enrollment Contractor - A State contracted entity that provides enrollment support, including but not limited customer service and options counseling.

Enrollment - The processes by which an individual who is eligible for the Demonstration is enrolled in a CICO.

External Quality Review Organization (EQRO) - An independent entity that contracts with the State and evaluates the access, timeliness, and quality of care delivered by CICOs to their Enrollees.

Flexible Benefits - Benefits CICOs may choose to offer outside of the required Covered Services. Flexible Benefits will not be considered in the development of the capitation rate.

Grievance - In accordance with 42 CFR § 438.400, grievance means an expression of dissatisfaction about any matter other than an “adverse action.” A Grievance is filed and decided at the CICO level. (Possible subjects for grievances include, but are not limited to, the quality of care or services provided and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee’s rights).

Health Outcomes Survey (HOS) - Beneficiary survey used by the Centers for Medicare & Medicaid Services to gather valid and reliable health status data in Medicare managed care for use in quality improvement activities, plan accountability, public reporting, and improving health.

Healthcare Effectiveness Data and Information Set (HEDIS) - Tool developed and maintained by the National Committee for Quality Assurance that is used by health plans to measure performance on dimensions of care and service in order to maintain and/or improve quality.

HIV/AIDS Waiver - The CMS-approved 1915(c) waiver that covers a range of community support and medical services offered to individuals diagnosed with HIV/AIDS and at risk of hospitalization.

Individualized Care Plan (ICP) – An integrated, individualized, person-centered plan developed by the Enrollee and his or her CICOs’ Multidisciplinary Team that addresses clinical and non-clinical needs identified in the comprehensive assessment and includes goals, interventions and expected outcomes.

Long Term Care Institutional Services - Long-term nursing facility services which are designed to meet an individual's needs.

Long Term Services and Supports (LTSS) - A variety of services and supports that help elderly individuals and/or individuals with disabilities meet their daily needs for assistance and improve the quality of their lives. Examples include assistance with bathing, dressing and other basic activities of daily life and self-care, as well as support for everyday tasks such as laundry, shopping, and transportation. LTSS are provided over an extended period, predominantly in homes and communities, but also in facility-based settings such as nursing facilities.

Mechanical Ventilation Waiver -The CMS-approved 1915(c) waiver that covers a range of community support and medical services who require a skilled or intermediate level of care and require mechanical ventilation.

Medical Home - A medical home is a health care setting that provides care services in a high-quality and cost-effective manner. Care is facilitated by registries, information technology, health information exchange and other means to assure that patients receive the indicated care in an appropriate manner. The approach seeks to strengthen the patient-provider relationship by coordinating all care, including acute, chronic, preventative and end-of-life. Medical homes provide care that is accessible, continuous, comprehensive, patient-centered, coordinated, compassionate, and culturally and linguistically effective.

Medicaid - The program of medical assistance benefits under Title XIX of the Social Security Act, Title 44 of the SC Code of Laws, applicable laws and regulations and various Demonstrations and Waivers thereof.

Medicaid Waiver - Generally, a waiver of existing law authorized under Section 1115(a), 1115A, or 1915 of the Social Security Act.

Medically Necessary Services - Services must be provided in a way that provides all protections to the Enrollee provided by Medicare and SC Medicaid. Per Medicare, services must be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, or otherwise medically necessary under 42 U.S.C. 1395y. In accordance with Medicaid law and regulations, and per SC Medicaid, services must be those medical services which: (a) are essential to prevent, diagnose, prevent the worsening of, alleviate, correct or cure medical conditions that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or aggravate a handicap, or result in illness or infirmity of a SC Medicaid member; (b) are provided at an appropriate facility and at the appropriate level of care for the treatment of the SC Medicaid member's medical condition; and, (c) are provided in accordance with generally accepted standards of medical practice.

Medicare - Title XVIII of the Social Security Act, the federal health insurance program for people age 65 or older, people under 65 with certain disabilities, and people with End Stage Renal Disease (ESRD) or Amyotrophic Lateral Sclerosis (ALS).

Medicare Waiver - Generally, a waiver of existing law authorized under Section 1115A of the Social Security Act.

Medicare-Medicaid Coordination Office - Formally the Federal Coordinated Health Care Office, established by Section 2602 of the Affordable Care Act.

Medicare-Medicaid Enrollees -For the purposes of this Demonstration, individuals who are entitled to Medicare Part A and enrolled in Medicare Parts B and D and receive full benefits under the South Carolina Medicaid State Plan, and otherwise meet eligibility criteria for the Demonstration. See also Enrollee.

Memorandum of Understanding (MOU) - For purposes of the Demonstration, this is the document that details the principles under which CMS and South Carolina plan to implement and

operate the aforementioned Demonstration. It also outlines the activities CMS and South Carolina plan to conduct in preparation for the implementation of the Demonstration, before the parties execute a Three-Way Contract setting forth the terms and conditions of the Demonstration and initiate the Demonstration.

Money Follows the Person (MFP) - Demonstration project designed to create a system of long-term services and supports that better enable individuals to transition from certain LTC institutions into the community. Individuals enrolled in MFP will be included in the Demonstration. In South Carolina, MFP is called Home Again.

Multidisciplinary Team (MT) - A team of the Primary Care Provider, Care Coordinator, LTSS Coordinator/Waiver Case Manager and other individuals at the discretion of the Enrollee that work with the Enrollee to develop, implement, and maintain the Individualized Care Plan.

Opt Out - A process by which an enrollee can choose not to participate in the Demonstration.

Parties - CMS and the State of South Carolina.

Passive Enrollment - An enrollment process through which an eligible individual is enrolled by the State (or its vendor) into a CICO, following a minimum 60-day advance notification that includes the plan selection and the opportunity to select a different plan, make another enrollment decision, or decline enrollment into a CICO, or opt-out of the Demonstration prior to the effective date.

Phoenix - An automated case management system which maintains records of a number of critical functions, including all intake, assessment, and care planning activities. Key features of *Phoenix* include sections for a 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.

Privacy Rules - Requirements established in the Health Insurance Portability and Accountability Act of 1996, and implementing regulations, Medicaid regulations, including 42 CFR §431.300 through 431.307, as well as relevant South Carolina privacy laws.

Program of All-Inclusive Care for the Elderly (PACE) - A capitated benefit for frail elderly authorized by the Balanced Budget Act of 1997 (BBA) that features a comprehensive service delivery system and integrated Medicare and Medicaid financing. PACE is a three-way partnership between the Federal government, the State of South Carolina, and the PACE organization.

Provider Appeal - An appeal filed by a Medicaid or Waiver service provider that has already provided a service and has received an adverse action regarding payment or audit result. A provider must appeal to and exhaust the CICO appeals process as a prerequisite to filing for an external appeal. A provider with written authorization from an enrollee may also file an appeal on behalf of an enrollee for a service that the provider has not yet provided. Such an appeal must be made to and exhaust the CICO appeal process as a prerequisite to filing an external appeal.

Notwithstanding the foregoing, Medicare providers will maintain all existing rights to file Medicare appeals.

Quality Improvement Organization (QIO) - As set forth in Section 1152 of the Social Security Act and 42 CFR Part 476, an organization under contract with CMS to perform utilization and quality control peer review in the Medicare program or an organization designated as QIO-like by CMS. The QIO or QIO-like entity provides quality assurance and utilization review in fee-for-service settings.

Readiness Review - Prior to entering into a Three-way Contract with the State and CMS, each CICO selected to participate in the Demonstration will undergo a Readiness Review. The Readiness Review will evaluate each CICO's ability to comply with the Demonstration requirements, including but not limited to, the ability to quickly and accurately process claims and enrollment information, accept and transition new members, and provide adequate access to all Medicare- and Medicaid-covered medically necessary services. CMS and the State will use the results to inform their decision of whether the CICO is ready to participate in the Demonstration. At a minimum, each Readiness Review will include a desk review and potentially a site visit to the CICO's headquarters.

South Carolina Department of Health and Human Services - The South Carolina Department of Health and Human Services (SCDHHS) is designated as the single state agency for the Medicaid program for South Carolina.

Solvency - Standards for requirements on cash flow, net worth, cash reserves, working capital requirements, insolvency protection and reserves established by the State and agreed to by CMS.

The State - The South Carolina Department of Health and Human Services.

Three-way Contract - The three-way agreement that CMS and the State enter into with a CICO specifying the terms and conditions pursuant to which a CICO may participate in this Demonstration.

APPENDIX 2. CMS STANDARDS AND CONDITIONS AND SUPPORTING STATE DOCUMENTATION

To participate in the Demonstration, each State submitted a proposal outlining its approach. The proposal had to meet a set of standards and conditions. The table below crosswalks the standards and conditions to their location in the South Carolina proposal. Following the submission of the proposal, CMS asked the State a number of questions when there was ambiguity of whether or not the proposal met the Standards and Conditions. These questions and responses are included in the Addendum to the proposal, which will be posted on CMS' website with the proposal.

Figure 2-1. CMS Standards and Conditions and Supporting State Documentation

| Standard/Condition | Standard/Condition Description | Page in Proposal |
|--------------------------------|--|--|
| Integration of Benefits | Proposed model ensures 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. | pp.1,2,7,13,15, 17,18, Appendix K (p. 49-53), Addendum |
| Care Model | Proposed model offers mechanisms for person-centered coordination of care and includes robust and meaningful mechanisms for improving care transitions (e.g., between providers and/or settings) to maximize continuity of care | pp.7-10, 14-16,23, Addendum |
| Stakeholder Engagement | State can provide evidence of ongoing and meaningful stakeholder engagement during the planning phase and has incorporated such input into its proposal. This will include dates/descriptions of all meetings, workgroups, advisory committees, focus groups, etc. that were held to discuss the proposed model with relevant stakeholders. Stakeholders include, but are not limited to, beneficiaries and their families, consumer organizations, beneficiary advocates, providers, and plans that are relevant to the proposed population and care model. | pp. 7, 21-23, Appendix M (pp. 58-59) |
| | State has also established a plan for continuing to gather and incorporate stakeholder feedback on an ongoing basis for the duration of the Demonstration (i.e., implementation, monitoring and evaluation), including a process for informing beneficiaries (and their representatives) of the changes related to this initiative. | pp. 24-25, Appendix M (pp. 58-59) |
| Beneficiary Protections | State has identified protections (e.g., enrollment and disenrollment procedures, grievances and appeals, process for ensuring access to and continuity of care, etc.) that would be established, modified, or maintained to ensure beneficiary health and safety and beneficiary access to high quality health and supportive services necessary to meet the beneficiary's needs. At a minimum, States will be required to: | pp. 11-13, 23-24 |

| | | |
|---------------------------------------|--|--|
| | Establish meaningful beneficiary input processes which may include beneficiary participation in development and oversight of the model (e.g., participation on CICO governing boards and/or establishment of beneficiary advisory boards). | pp. 2-3, 23, 58-59, Addendum |
| | Develop, in conjunction with CMS, uniform/integrated Enrollee materials that are accessible and understandable to the beneficiaries who will be enrolled in the plans, including those with disabilities, speech, hearing and vision limitations, and limited English proficiency. | pp. 12, 24 |
| Beneficiary Protections, cont. | Ensure privacy of Enrollee health records and provide for access by Enrollees to such records. | pp. 15, 16 |
| | Ensure that all medically necessary benefits are provided, allow for involvement of caregivers, and in an appropriate setting, including in the home and community. | pp. 2, 7, 9, 13-15, 24, Appendix M (49-53), Addendum |
| | Ensure access to services in a manner that is sensitive to the beneficiary's language and culture, including customer service representatives that are able to answer Enrollee questions and respond to complaints/concerns appropriately. | pp. 12, 23, 24 |
| | Ensure an adequate and appropriate provider network, as detailed below. | pp. 6, 7-8, 12-13, 17, 23 |
| | Ensure that beneficiaries are meaningfully informed about their care options. | pp. 12, 24 |
| | Ensure access to grievance and appeals rights under Medicare and/or Medicaid. | pp. 24 |
| | <i>For Capitated Model</i> , this includes development of a unified set of requirements for CICO complaints and internal appeals processes. | pp. 24 |
| State Capacity | State demonstrates that it has the necessary infrastructure/capacity to implement and oversee the proposed model or has demonstrated an ability to build the necessary infrastructure prior to implementation. This includes having necessary staffing resources, an appropriate use of contractors, and the capacity to receive and/or analyze Medicare data. | pp. 28-31 |
| Network Adequacy | The Demonstration will ensure adequate access to medical and supportive service providers that are appropriate for and proficient in addressing the needs of the target population as further described in the MOU template. | pp. 6, 7-10, 11-12, 17, 23 |
| Measurement/Reporting | State demonstrates that it has the necessary systems in place for oversight and monitoring to ensure continuous quality improvement, including an ability to collect and track data on key metrics related to the model's quality and cost outcomes for the target population. These metrics may include, but are not limited to beneficiary experience, access to and quality of all covered services (including behavioral health and long term services and supports), utilization, etc., in order to promote beneficiaries receiving high quality care and for purposes of the evaluation. | pp. 26-27, 30-31 |

| | | |
|-------------------------|--|-------------------------|
| Data | State has agreed to collect and/or provide data to CMS to inform program management, rate development and evaluation, including but not limited to: | p. 30 |
| | Beneficiary level expenditure data and covered benefits for most recently available three years, including available encounter data in capitated models; | pp.26,30, Addendum |
| | Description of any changes to the State Plan that would affect Medicare- Medicaid Enrollees during this three year period (e.g., payment rate changes, benefit design, addition or expiration of waivers, etc.); and | pp. 29, Addendum |
| | State supplemental payments to providers (e.g., DSH, UPL) during the three-year period. | p. 30, Addendum |
| Enrollment | State has identified enrollment targets for proposed Demonstration based on analysis of current target population and has strategies for conducting beneficiary education and outreach. Enrollment is sufficient to support financial alignment model to ensure a stable, viable, and evaluable program. | pp. 2, 5, 11-12, 31, 37 |
| Expected Savings | Financial modeling demonstrates that the payment model being tested will achieve meaningful savings while maintaining or improving quality. | pp. 2, 26-28, 32, |
| Public Notice | State has provided sufficient public notice, including: | |
| | At least a 30-day public notice process and comment period; | pp. 3, 22, 59 |
| | At least two public meetings prior to submission of a proposal; and | pp. 2-3, 21-22, 58-59 |
| | Appropriate tribal consultation for any new or changes to existing Medicaid waivers, State Plan Amendments, or Demonstration proposals. | pp. 22, 56 |
| Implementation | State has demonstrated that it has the reasonable ability to meet the following planning and implementation milestones prior to implementation: | |
| | Meaningful stakeholder engagement. | pp. 21-22, 58-59 |
| | Submission and approval of any necessary Medicaid waiver applications and/or State Plan Amendments. | pp. 31 |
| | Receipt of any necessary State legislative or budget authority. | NA |
| | Joint procurement process (for capitated models only) | p. 62, Addendum |
| | Beneficiary outreach/notification of enrollment processes, etc. | pp. 12, 67 |

APPENDIX 3. DETAILS OF STATE DEMONSTRATION AREA

The Demonstration Area consists of the entire state (46 counties). Passive enrollment will be phased-in in part by region (see Appendix 7 for details regarding timing). As described below, Region 1 covers the Upstate counties while Region 2 covers the Coastal counties.

Figure 3-1. County Composition of Regional Enrollment

| Region 1: Upstate | Region 2: Coastal |
|----------------------|----------------------|
| Abbeville | Allendale |
| Aiken | Beaufort |
| Anderson | Berkeley |
| Bamberg | Calhoun |
| Barnwell | Charleston |
| Cherokee | Chesterfield |
| Chester | Clarendon |
| Edgefield | Colleton |
| Fairfield | Darlington |
| Greenville | Dillon |
| Greenwood | Dorchester |
| Kershaw | Florence |
| Lancaster | Georgetown |
| Laurens | Hampton |
| Lexington | Horry |
| McCormick | Jasper |
| Newberry | Lee |
| Oconee | Marion |
| Pickens | Marlboro |
| Richland | Orangeburg |
| Saluda | Sumter |
| Spartanburg | Williamsburg |
| Union | |
| York | |

APPENDIX 4. MEDICARE AUTHORITIES AND WAIVERS

Medicare provisions described below are waived as necessary to allow for implementation of the Demonstration. Except as waived, Medicare Advantage and Medicare Part D provide the authority and statutory and regulatory framework for the operation of the Demonstration to the extent that Medicare (versus Medicaid) authority applies. Unless waived, all applicable statutory and regulatory requirements of the Medicare program for Medicare Advantage plans that provide qualified Medicare Part D prescription coverage, including Medicare Parts A, B, C, and D, shall apply to CICOs and their sponsoring organizations for the Demonstration period beginning July 1, 2014 through December 31, 2017, as well as for periods preceding and following the Demonstration period as applicable to allow for related implementation and close-out activities. Any conforming exceptions to existing Medicare manuals will be noted and reflected in an appendix to the Three-Way Contract.

Under the authority at Section 1115A of the Social Security Act, codified at 42 U.S.C. 1315a, the Center for Medicare and Medicaid Innovation is authorized to “...test payment and service delivery models...to determine the effect of applying such models under [Medicare and Medicaid].” 42 U.S.C. 1315a(b)(1). One of the models listed in Section 1315a(b)(2)(B) that the Center for Medicare and Medicaid Innovation is permitted to test is “[a]llowing States to test and evaluate fully integrating care for dual eligible individuals in the State, including the management and oversight of all funds under the applicable titles with respect to such individuals.” § 1315a(b)(2)(B)(x). Section 1315a(d)(1) provides that “The Secretary may waive such requirements of Titles XI and XVIII and of sections 1902(a)(1), 1902(a)(13), and 1903(m)(2)(A)(iii) [of the Social Security Act] as may be necessary solely for purposes of carrying out this section with respect to testing models described in subsection (b).”

Pursuant to the foregoing authority, CMS will waive the following Statutory and Regulatory requirements:

- Section 1851(a), (c), (e), and (g) of the Social Security Act, and implementing regulations at 42 CFR Part 422, Subpart B, only insofar as such provisions are inconsistent with (1) limiting enrollment in CICOs to Medicare-Medicaid beneficiaries who are ages 65 and older,

and excluding beneficiaries who may meet exclusion criteria specified in Section III.C.1, and (2) the Passive Enrollment process provided for under the Demonstration.

- Sections 1853, 1854, 1857(e), 1860D-11, 1860D-13, 1860D-14, and 1860D-15 of the Social Security Act, and implementing regulations at 42 CFR Part 422, Subparts F and G, and Part 423, Subparts F and G, only insofar as such provisions are inconsistent with the methodology for determining payments, medical loss ratios, and Enrollee liability under the Demonstration as specified in this MOU, including Appendix 6, which differs as to the method for calculating payment amounts and medical loss ratio requirements, and does not involve the submission of a bid or calculation and payment of premiums, rebates, or quality bonus payments, as provided under Sections 1853, 1854, 1860D-11, 1860D-13, 1860D-14, and 1860D-15, and implementing regulations.
- The provisions regarding deemed approval of marketing materials in Sections 1851(h) and 1860D-1(b)(1)(B)(vi) and implementing regulations at 42 CFR §422.2266 and §423.2266, with respect to marketing and Enrollee communications materials in categories of materials that CMS and the State have agreed will be jointly and prospectively reviewed, such that the materials are not deemed to be approved until both CMS and the State have agreed to approval.
- Sections 1852 (f) and (g) and implementing regulations at 42 CFR Part 422, Subpart M, only insofar as such provisions are inconsistent with the grievance and appeals processes provided for under the Demonstration.
- Section 1860D-14(a)(1)(D) and implementing regulations at 42 CFR Part 423, Subpart P, only insofar as the implicit requirement that cost-sharing for non-institutionalized individuals eligible for the low-income subsidy be greater than \$0, to permit CICOs to reduce Part D cost sharing below the levels required under Section 1860D-14(a)(1)(D)(ii) and (iii).

APPENDIX 5. MEDICAID AUTHORITIES AND WAIVERS

All requirements of the Medicaid program expressed in law and regulation, not expressly waived in this list, shall apply to the Demonstration beginning July 1, 2014 through December 31, 2017, as well as for periods preceding and following the Demonstration period as applicable to allow for related implementation and close-out activities. Any conforming exceptions to existing sub-regulatory guidance will be noted and reflected in an appendix to the Three-Way Contract.

This Demonstration and the additional authority referenced below are contingent upon submission and approval of all documentation necessary to demonstrate compliance with the Medicaid requirements under 42 CFR Parts 438 and 441 for enrollment of the Demonstration population into managed care, including the submission of concurrent authority to the relevant 1915(c) programs and the submission of a Social Security Act Section 1932(a) State Plan Amendment. The State will submit the required State Plan Amendment and waiver amendments for Phase I no later than January 1, 2014. Subsequent 1915(c) waiver amendment submissions must be submitted to CMS at least 90 days prior to the State's anticipated effective date. The State must meet all requirements of the State Plan and any applicable Medicaid waiver(s) as expressed in the terms of those authority documents, including, but not limited to, all financial, quality, reporting and monitoring requirements of each waiver, and State financing contained in the State's waiver(s) must be in compliance with Federal requirements. This MOU does not indicate or guarantee CMS approval of any necessary authority for managed care under 42 CFR Parts 438 and 441.

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.

1115A Medicaid Waivers

Under the authority of Section 1115A of the Social Security Act, the following waivers of State Plan requirements contained in Section 1902 and 1903 of the Social Security Act are granted to enable the State to carry out the State Demonstration to Integrate Care for Dual Eligible Individuals. These authorities shall be in addition to those in the State Plan, State Plan Amendment, and applicable waivers.

Provisions Related to Contract Requirements - Section 1903(m)(2)(A)(iii) (as implemented in 42 C.F.R. §438.6)

Waiver of contract requirement rules at 42 CFR §438.6(a), insofar as its provisions are inconsistent with methods used for prior approval under this Demonstration.

APPENDIX 6. PAYMENTS TO CICOS

The Centers for Medicare & Medicaid Services (CMS) and the State will enter into a joint rate-setting process based on the following principles:

1. Medicare and Medicaid will each contribute to the total capitation payment consistent with projected baseline spending contributions;
2. Demonstration savings percentages assume that CICOs are responsible for the full range of services covered under the Demonstration;
3. Aggregate savings percentages will be applied equally to the Medicaid and Medicare Parts A and B components; and
4. Both CMS and the State will contribute to the methodologies used to develop their respective components of the overall blended rate as summarized in Figure 6-2 and further described below.

Figure 6-1 below outlines how the Demonstration Years will be defined for the purposes of this effort. (Note: rate updates will take place on January 1st of each calendar year, with changes to savings percentages and quality withholds applicable on a Demonstration Year basis.)

Figure 6-1: Demonstration Year Dates

| Demonstration Year | Calendar Dates |
|--------------------|-------------------------------------|
| 1 | July 1, 2014 – December 31, 2015 |
| 2 | January 1, 2016 – December 31, 2016 |
| 3 | January 1, 2017 – December 31, 2017 |

Figure 6-2: Summary of Payment Methodology under the Demonstration

| Rate Element | Medicare Parts A and B | Medicare Part D | Medicaid |
|--|---|--|---|
| <p>2014 Baseline costs for the purposes of setting payment rates</p> <p>Medicare baseline spending will be established prospectively on a calendar year basis for each Demonstration county.</p> <p>Medicaid baseline spending amounts shall be set up front and will be applied in future years unless more recent historical data are available and/or CMS' actuaries and the State determine that a substantial change is necessary to calculate accurate payment rates for the Demonstration.</p> | <p>Blend of Medicare Advantage payments and Medicare standardized Fee-For-Service weighted by where Medicare-Medicaid Enrollees who meet the criteria and who are expected to transition into the Demonstration are enrolled in the prior year. Baseline costs will be calculated as a per member per month (PMPM) standardized cost.</p> | <p>National average monthly bid amount (NAMBA) will be used as the baseline for the direct subsidy portion of Part D spending.</p> <p>Note that additional costs associated with LIS payments, reinsurance payments, and risk-sharing are included in the Part D baseline for purposes of tracking and evaluating Part D costs but not for purposes of setting payment rates. These amounts will be factored into CICO payments, as appropriate, but these amounts are subject to reconciliation consistent with Medicare Part D reconciliation rules.</p> | <p>Historical State data. Trend rates developed by State actuaries based on State Plan and HCBS waiver services, subject to CMS review.</p> |
| Responsible for producing data | CMS | CMS | South Carolina Department of Health and Human Services, validated by CMS |
| Savings percentages | <p>Demonstration Year 1: 1%</p> <p>Demonstration Year 2: 2%</p> <p>Demonstration Year 3: 4%</p> | Not Applicable | <p>Demonstration Year 1: 1%</p> <p>Demonstration Year 2: 2%</p> <p>Demonstration Year 3: 4%</p> |
| Risk adjustment | Medicare Advantage CMS-HCC Model | Medicare Part D RxHCC Model | Rate Cell Structure |
| Quality withhold | <p>Applied</p> <p>Demonstration Year 1: 1%</p> <p>Demonstration Year 2: 2%</p> <p>Demonstration Year 3: 3%</p> | Not applied | Applied |
| Other Payment Provisions | Medical Loss Ratio (MLR) | Existing Medicare Part D Processes will apply | <p>Demonstration Year 1: 1%</p> <p>Demonstration Year 2: 2%</p> <p>Demonstration Year 3: 3%</p> <p>MLR</p> |

I. Baseline Spending and Payment Rates for Target Population in the Demonstration Area

Baseline spending is an estimate of what would have been spent in the payment year had the Demonstration not existed. Medicare baselines will be expressed as standardized (1.0) amounts and applicable on a calendar year basis. The baseline costs include three components: Medicaid, Medicare Parts A and B, and Medicare Part D. Payment rates will be determined by applying savings percentages (see Sections II and III of this Appendix) to the baseline spending amounts.

A. Medicaid:

1. The data source for the Medicaid component of the rate for the first Demonstration year is based on South Carolina fee-for-service data for fiscal years 2011 through 2013 as available at the point of rate-setting. The Medicaid component of the rate for Demonstrations Years 2 and 3 will use updated historical South Carolina fee-for-service data, as available at the point of rate setting for each Demonstration Year.
2. Prior to implementation of the Demonstration, the State and its actuaries will be responsible for establishing the baseline spending for Medicaid services that will be included under the Demonstration using the most recent data available. The baseline will take into account historic payments, and will be trended forward to the Demonstration period.
3. The State and its actuaries will provide the estimated baseline spending and underlying data for each year of the Demonstration at the beginning of the Demonstration period to the CMS contracted actuary, who will validate the estimate of projected costs in Medicaid (absent the Demonstration).
4. Except for updates based on more recent historical data, updates to the Medicaid baseline will not be allowable unless CMS determines the update would result in a substantial change to the baseline necessary to calculate accurate payment rates for the Demonstration.

5. Medicaid payment rates will be determined by applying annual saving percentages (see Section II and III of this Appendix) to the applicable baseline spending amounts).

B. Medicare Part A/B:

1. CMS will develop baseline spending (costs absent the Demonstration) and payment rates for Medicare A and B services using estimates of what Medicare would have spent on behalf of the Medicare-Medicaid Enrollees absent the Demonstration.
2. The Medicare baseline rate for A/B services will be a blend of the Medicare Advantage projected payment rates and the Medicare FFS standardized county rates for each year, weighted by the proportion of the target population that will be transitioning from each program into the Demonstration. The Medicare Advantage baseline spending will include costs that would have occurred absent the Demonstration, such as quality bonus payments for applicable Medicare Advantage plans.

CMS may adjust the Medicare FFS standardized county rates as necessary to calculate accurate payment rates for the Demonstration. To the extent that the published FFS county rates do not conform with current law in effect for Medicare during an applicable payment month, and to the extent that such nonconformance would have a significant fiscal impact on the Demonstration, CMS will update the baseline (and therefore the corresponding payment rate) to calculate and apply an accurate payment rate for such month. Such update may take place retroactively, as needed.

3. Medicare A/B payment rates will be determined by applying the annual savings percentages (see section II and III of this Appendix) to the baseline spending amounts.
4. Both baseline spending and payment rates under the Demonstration for Medicare A/B services will be calculated as PMPM standardized amounts for each county participating in the Demonstration for each year. Beneficiary risk scores will be applied to the standardized payment rates at the time of payment.

5. CMS may require the State to provide a data file for beneficiaries who would be included in the Demonstration as of a certain date, in order for CMS to more accurately identify the target population to include/exclude in the baseline spending. CMS will allow for a reasonable amount of time to compile this data and specify the format and layout of the file.
6. The Medicare portion of the baseline will be updated annually consistent with the annual Fee-For-Service (FFS) estimates and benchmarks released each year with the annual Medicare Advantage rate announcement.
7. CMS annually applies a coding intensity adjustment 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 2014 is 4.91%. 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, beyond the control of the CICOs themselves. 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 CY 2015, CMS will apply an appropriate coding intensity adjustment reflective of all Demonstration Enrollees; this will apply the prevailing Medicare Advantage coding intensity adjustment proportional to the anticipated proportion of Demonstration Enrollees in CY 2015 with prior Medicare Advantage experience and/or Demonstration experience based on the Demonstration's enrollment phase-in as of September 30, 2014. After calendar year 2015, CMS will apply the prevailing Medicare Advantage coding intensity adjustment for all Enrollees.

C. Medicare Part D:

1. 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. CMS will estimate an average monthly prospective payment amount for the low income cost-sharing subsidy and federal reinsurance amounts; these payments will be reconciled

after the end of each payment year in the same manner as for all Medicare Part D sponsors.

2. The CY 2014 Part D NAMBA is \$75.88.

II. Aggregate Savings Percentages Under the Demonstration.

- A. Both parties agree that there is reasonable expectation for achieving savings while paying CICOs capitated rates that are adequate to support access to and utilization of medical and non-medical benefits according to beneficiary needs. The savings percentages will be:
 1. Demonstration Year 1: 1%
 2. Demonstration Year 2: 2%
 3. Demonstration Year 3: 4%
- B. Rate updates will take place on January 1st of each calendar year. However, savings percentages will be calculated and applied based on Demonstration Years.

III. Application of Aggregate Savings Percentages to Each Component of the Integrated Rate

The aggregate savings percentages identified above will be applied to the Medicare A/B and Medicaid components of the rate. Changes to the savings percentages under Section II of Appendix 6 would only occur if and when CMS and the State jointly determine the change is necessary to calculate accurate payment rates for the Demonstration.

Savings percentages will not be applied to the Medicare Part D component of the rate. CMS will monitor Part D costs closely on an ongoing basis. Any material increase in Medicare Part D costs relative to the baseline may be factored into future year savings percentages.

IV. Risk Adjustment Methodology for Medicaid Components of the Rates

- A. The Medicaid component will employ the rating categories described below to account for enrollment variations by CICO.

The rate cell structure was developed to align payment with risk while incentivizing movement from nursing facility to home and community based care. The method to accomplish this includes incentives and penalties. The incentive includes an enhanced payment rate for ninety (90) days following transition from a nursing facility. The penalty includes payment at a lower rate for ninety (90) days in cases where an individual moves from the community or HCBS to a nursing facility. The rate cell structure utilized in the Demonstration is described below.

1. NF1: Nursing Facility-based Care

Includes individuals identified as having a long-term facility stay of more than 100 days.

2. H1: Home and Community Based Services

Includes individuals who do not meet NF1 criteria, and for whom a level of care determination indicates that the individual meets the level of care requirements for nursing facility placement and/or applicable HCBS waiver. These requirements include:

- a. For the Community Choices waiver, meet the following level of care requirements:
 - Skilled Level of Care – need at least one skilled service and have a least one functional deficit, as defined in the waiver, or;
 - Intermediate Level of Care – need at least one intermediate service and have at least one functional deficit or have at least two functional deficits, as defined by the waiver.
- b. For the HIV/AIDS waiver, be determined at-risk for hospitalization as defined in 42 CFR §440.10.
- c. For the Mechanical Ventilation waiver, meet nursing home level of care and are dependent of a life-sustaining ventilator for six (6) or more hours per day, as defined by the waiver.

3. H2: Home and Community Based Services Plus

Includes individuals moving from the NF1 rate cell to a qualifying HCBS waiver for the first 3 months of transition.

4. C1: Community Tier – Community

Includes individuals who do not meet NF1, H1, or H2 criteria.

V. Risk Adjustment Methodology for Medicare Components of the Rates

A. The Medicare A/B Demonstration county rate will be risk adjusted based on the risk profile of each enrolled beneficiary. Except as specified in Section I.B.7 of this Appendix, the existing CMS-HCC and CMS-HCC ESRD risk adjustment methodologies will be utilized for the Demonstration.

B. The Medicare Part D national average bid will be risk-adjusted in accordance with existing Part D RxHCC methodology.

VI. Quality Withhold Policy for Medicaid and Medicare A/B Components of the Integrated, Risk-adjusted Rate

A. Under the Demonstration, both payers will withhold a percentage of their respective components of the capitation rate. The withheld amounts will be repaid subject to CICOs' performance consistent with established quality thresholds. These thresholds are based on a combination of certain core quality withhold measures (across all Demonstrations under Financial Alignment), as well as State-specified quality measures.

B. Withhold Measures in Demonstration Year 1

1. Figure 6-3 below identifies core withhold measures for Demonstration Year 1.

Together, these will be utilized as the basis for the 1% withhold. Additional detail regarding the measures will be included in the Three-Way Contract.

2. Because Demonstration Year One crosses calendar/contract years, CICOs will be evaluated to determine whether they have met required quality withhold requirements at the end of both CY 2014 and CY 2015. The determination in CY 2014 will be based solely on those measures that can appropriately be calculated based on the

actual enrollment volume during CY 2014. Consistent with such evaluations, the withheld amounts will be repaid separately for each CY.

Figure 6-3. Quality Withhold Measures for Demonstration Year 1

| Domain | Measure | Source | CMS Core Withhold Measure | South Carolina Withhold Measure |
|---|--|-----------------------------------|---------------------------|---------------------------------|
| Encounter data | Encounter data submitted accurately and completely in compliance with contract requirements. | CMS/State defined process measure | X | X |
| Assessments | Percent of Enrollees with initial assessments completed within 90 days of enrollment. | CMS/State defined process measure | X | X |
| Beneficiary governance board | Establishment of beneficiary advisory board or inclusion of beneficiaries on governance board consistent with contract requirements. | CMS/State defined process measure | X | |
| Customer Service | Percent of best possible score the CICO earned on how easy it is to get information and help when needed. In the last six months, how often did your health plan's customer service give you the information or help you needed? In the last six months, how often did your health plan's customer service treat you with courtesy and respect? In the last six months, how often were the forms for your health plan easy to fill out? | AHRQ/CAHPS | X | |
| Getting Appointments and Care Quickly | Percent of best possible score the CICO earned on how quickly members get appointments and care In the last 6 months, when you needed care right away, how often did you get care as soon as you thought you needed? In the last 6 months, not counting the times when you needed care right away, how often did you get an appointment for your health care at a doctor's office or clinic as soon as you thought you needed? In the last 6 months, how often did you see the person you came to see within 15 minutes of your appointment time? | AHRQ/CAHPS | X | X |
| Plans of Care and Documentation of Care Goals | Proportion of Enrollees at each risk level (high-, medium-, low-) with Individual Care Plan (ICP) developed within specified timeframes compared to total Enrollees at each risk level requiring ICPs. | CMS/State defined process measure | | X |

| | | | | |
|---|--|-----------------------------------|--|---|
| | Percent of Enrollee ICPs that contain documented discussion of care goals with Enrollee and/or Caregiver and Multidisciplinary Team. | | | |
| HCBS Plan of Care integration into ICP | Percent of enrollees newly approved (or newly determined eligible) for HCBS with a plan of care developed, reviewed, and approved jointly by Waiver Case Manager, Reviewer and CICO designee, that is included in the overall ICP within 30 days of waiver enrollment. Percent of enrollees already receiving HCBS that have a plan of care included in the ICP within 30 days of enrollment into CICO. | CMS/State defined process measure | | X |
| Hospital, Nursing Facility and Community Transition | CICO has an established work plan and systems in place, utilizing <i>Phoenix</i> as appropriate) for ensuring smooth transition to and from hospitals, nursing facilities and the community. | CMS/State defined process measure | | X |
| Adjudicated Claims including HCBS Case management | Percent of adjudicated claims submitted to CICO that were paid within the timely filing requirements. | | | X |

(Note: Part D payments will not be subject to a quality withhold, however CICOs will be required to adhere to quality reporting requirements that currently exist under Part D.)

C. Withhold Measures in Demonstration Years 2 and 3

The quality withhold will increase to 2% in Demonstration Year 2 and 3% in Demonstration Year 3 and will be based on performance on the core Demonstration and State-specified measures. Figure 6-4 below identifies the quality withhold measures for Demonstration Years 2 and 3.

Figure 6-4. Quality Withhold Measures for Demonstration Years 2 and 3

| Domain | Measure | Source | CMS Core Withhold Measure | South Carolina Withhold Measure |
|---|--|-----------------------------------|---------------------------|---------------------------------|
| Plan all-cause hospital readmissions | Percent of members discharged from a hospital stay who were readmitted to a hospital within 30 days, either from the same condition as their recent hospital stay or for a different reason. | NCQA/HEDIS | X | X |
| Annual flu vaccine | Percent of plan members who got a vaccine (flu shot) prior to flu season. | AHRQ/CAHPS | X | |
| Follow-up after hospitalization for mental illness | Percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. | NCQA/HEDIS | X | X |
| Screening for clinical depression and follow-up care | Percentage of patients age 21 years and older screened for clinical depression using a standard tool and follow-up plan documented. | CMS | X | |
| Reducing the risk of falling | Percent of members with a problem falling, walking or balancing who discussed it with their doctor and got treatment for it during the year. | NCQA/HOS | X | |
| Controlling blood pressure | Percentage of members 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90) during the measurement year. | NCQA/HEDIS | X | |
| Part D medication adherence for oral diabetes medications | Percent of plan members with a prescription for oral diabetes medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication. | CMS | X | |
| HCBS Plan of Care. Documentation of care | Percent of enrollees eligible for HCBS with a waiver care plan within specified timeframes. | CMS/State defined process measure | | X |

| | | | | |
|---|--|---|--|---|
| goals. | Percent of Enrollee waiver care plans that contain documented discussion of care goals within specified timeframes. | | | |
| Hospital, Nursing Facility and Community Transition | <p>Percentage of enrollees who transitioned to and from hospitals, nursing facilities and the community.</p> <p>Proportion of those who transitioned to and from hospitals, nursing facilities and the community who returned to an (1) institutional setting or (2) community.</p> <p>Percentage of Care transitions recorded and transmitted to CICO Care Coordinator (via <i>Phoenix</i>)</p> | <p>CMS/State defined process measure</p> <p>CMS/State defined outcome measure</p> | | X |
| Adjudicated Claims including HCBS Case management | Percent of adjudicated claims submitted to CICOs that were paid within the timely filing requirements. | | | X |

(Note: Part D payments will not be subject to a quality withhold, however CICOs will be required to adhere to quality reporting requirements that currently exist under Part D.)

VII. Medicaid Incentives to CICOs

- A. Patient Center Medical Home Recognition Program: CICOs will facilitate the development of Patient Centered Medical Home (PCMH) model as defined through the certification process through the National Committee for Quality Assurance (NCQA), or other PCMH recognition bodies that SCDHHS deems credible (e.g., JCAHO). As part of that, CICOs will provide financial incentives to qualified providers that achieve NCQA PCMH certification. SCDHHS will make incentive payments to both CICOs and eligible providers (to be administered by the CICO) for achieving various levels of NCQA certification and FQHCs who achieve JCAHO PCMH recognition.

Quarterly PMPM payments will be made to both CICOs and Providers in the following four (4) payment levels:

- Application Period: \$.50 Providers/\$.10 CICO
- Level I Certification: \$1.00 Provider/\$.15 CICO
- Level II Certification: \$1.50 Provider/\$.20 CICO
- Level III Certification: \$2.00 Provider/\$.25 CICO

CICOs must make payment to qualifying practices within 30 days of the CICO's receipt of the quarterly payment from SCDHHS.

B. **Nursing Facility Transitions:** In order to facilitate the transition of Enrollees to the most appropriate, least restrictive setting, SCDHHS will utilize a one-time enhanced levels of payment per qualified Enrollee of up to \$3,000 through the State's Home Again program following movement of the Enrollees from a nursing facility to a home and community-based waiver for a continuous period of no less than twelve months. The incentive scale is as follows:

- Pre-transition planning: \$500;
- Transition: \$1,000;
- 6-months out of a facility: \$500; and
- 12-months out of a facility: \$1,000.

VIII. Payments to CICOs

A. CMS will make separate monthly risk-adjusted payments to the CICOs for the Medicare A/B and Part D components of the rate, based on standardized Demonstration payment rates. Medicare A/B payments and Part D payments will be subject to the same payment adjustments that are made for payments to Medicare Advantage and Part D plans, including but not limited to adjustments for user fees and Medicare Secondary Payer adjustment factors.

- B. The State will make a payment to the CICOs for the Medicaid component of the rate. Additional details regarding the payment process for HCBS providers during the initial six months of the Demonstration can be found in Appendix 7.
- C. The capitated payments from CMS and the State are intended to be adequate to support access to and utilization of covered services, according to Enrollee Individualized Care Plans. CMS and the State will jointly monitor access to care and overall financial viability of CICOs accordingly.

IX. Evaluate and Pay CICOs Relative to Quality Withhold Requirements

CMS and the State will evaluate CICO performance according to the specified metrics required in order to earn back the quality withhold for a given year. CMS and the State will share information as needed to determine whether quality requirements have been met and calculate final payments to each CICO from each payor.

Whether or not each CICO has met the quality requirements in a given year will be made public, as will relevant quality scores of CICOs in Demonstration Years 2 and 3.

X. Medical Loss Ratio, Reconciliation, and Rate Review

- A. **Medical Loss Ratio:** Beginning in calendar year 2015, CICOs will be required each calendar year to meet a Target Medical Loss Ratio (TMLR) threshold of 85%, which regulates the minimum amount of revenue that must be used for expenses either directly related to medical claims or care coordination.

If the Medical Loss Ratio (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.

The Three-Way Contracts will include additional specifications on the MLR. To the maximum extent possible, the methodology for calculating the MLR will conform to prevailing federal regulatory requirements applicable to the other Medicare products

offered by organizations operating CICOs.

- B. **Cost Reconciliation:** Cost reconciliation under Medicare Part D will continue as -is under the Demonstration. CMS will monitor Part D costs closely on an ongoing basis. Any material increase in Part D costs relative to the baseline may be factored into future Demonstration Year savings percentages.
- C. **Rate Review Process:** CMS and the State will review CICO financial reports, encounter data, and other information to assess the ongoing financial stability of the CICOs and the appropriateness of capitation payments. At any point, the State may request that CMS staff review documentation from specific CICOs to assess financing issues.

XI. Payments in Future Years and Mid-Year Rate Adjustments

- A. Rates will be updated using a similar process for each calendar year. Changes to the baseline (and therefore to the corresponding payment rate) outside of the annual Medicare Advantage rate announcement or as otherwise specified in this appendix would occur only if and when CMS and the State jointly determine the change is necessary to calculate accurate payment rates for the Demonstration. For changes solely affecting the Medicare program baseline, CMS will consult with the State prior to making any adjustment, but State concurrence will not be required. Such changes may be based on the following factors: shifts in enrollment assumptions; major changes or discrepancies in federal law and/or state law or policy, compared to assumptions about Federal law and/or State law or policy used in the development of baseline estimates; and changes in coding intensity. CMS and/or the State will make changes to baseline estimates within 30 days of identification of the need for such changes, and changes will be applied, if necessary on a retrospective basis, to effectuate accurate payment rates for each month.
- B. Changes to the savings percentages would occur if and when CMS and the State jointly determine that changes in Part D spending have resulted in materially higher or lower savings that need to be recouped through higher or lower savings percentages applied to the Medicare A/B baselines.

APPENDIX 7. DEMONSTRATION PARAMETERS

The purpose of this Appendix is to describe the parameters that will govern this federal-state partnership; the parameters are based upon those articulated by CMS in its January 9, 2013 Health Plan Management System (HPMS) guidance. CMS and the State have further established these parameters, as specified below.

The following sections explain details of the Demonstration design, implementation and evaluation. Where waivers from current Medicare and Medicaid requirements are required, such waivers are indicated in Appendices 4 and 5.

I. South Carolina Delegation of Administrative Authority and Operational Roles and Responsibilities:

The South Carolina Department of Health and Human Services (SCDHHS) is the single state agency for the Medicaid program. The Medicaid Director directly oversees the agency that will be involved with implementing and monitoring the Demonstration. The Demonstration will benefit from the direct and ongoing involvement of staff and programs across SCDHHS as described below.

The Medicaid Director reports directly to the Governor and will oversee the Demonstration through his or her Deputy Director of Health Programs, who will report directly to the Medicaid Director on all aspects of the Demonstration. SCDHHS recently restructured its organization to consolidate oversight and management of key units under this Deputy Director in order to fully support integration goals, and to align policy development with program implementation. This team will oversee the selected CICOs and overall Demonstration, with dedicated program management staff taking on daily management responsibilities.

In addition to state staff, the State will use contractors for certain tasks including rate development, data analysis, demonstration evaluation, quality assurance and other functions.

II. Plan or Qualified Entity Selection

The State, in consultation with CMS, developed an application process that includes the State and CMS requirements to become a CICO under this Demonstration. The State and CMS will engage in a joint selection process that will take into account previous performance in Medicare and Medicaid, and ensure that bidders have met CMS' requirements, as specified in this MOU. The State and CMS may limit the number of selected CICOs per service area to a certain number (no less than two, provided there are at least two qualified applicants) from the qualifying applicants. Plan participation is contingent on the selected applicants passing a CMS- and State-sponsored Readiness Review. Upon final selection, the State and CMS will enter into a Three-Way Contract with selected CICOs. This section is subject to update, and any updates will be reflected in the Three-Way Contract. Any future revisions to the final selections will be presented to CMS for prior approval.

III. State Level Enrollment Operations Requirements

- A. Eligible Populations/Excluded Populations: As described in the body of the MOU.
- B. Enrollment and Disenrollment Processes: All Enrollment and Disenrollment-related transactions, including enrollments from one CICO to a different CICO, will be processed by the State (or its vendor). The enrollment entity will submit enrollment transactions to the CMS Medicare Advantage Prescription Drug (MARx) enrollment system directly or via a third party CMS designates to receive such transactions. CMS will also submit a file to the State identifying individuals who have elected to disenroll from a CICO, opt-out of passive enrollment, or enroll in another type of available Medicare coverage. The State or its designated vendor will share enrollment, disenrollment and opt-out transactions with CICOs.
- C. Uniform Enrollment and Disenrollment Letter and Forms: Letters and forms will be made available to stakeholders by both CMS and the State.
- D. Enrollment Effective Date(s): All enrollment effective dates are prospective. Beneficiary-elected enrollments are effective the first day of the month following the initial receipt of

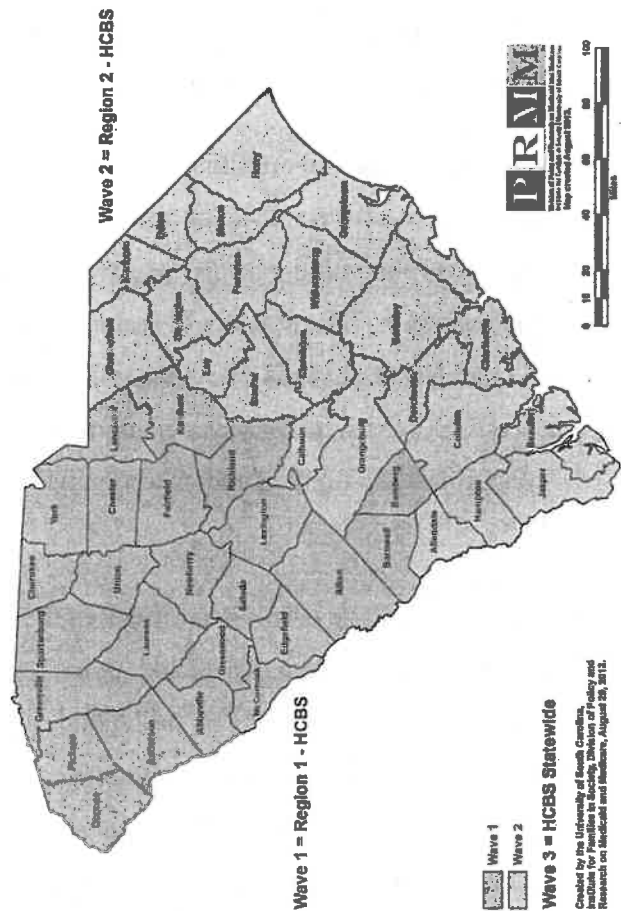
a beneficiary's request to enroll, so long as the request is received by the 12th of the month. Enrollment requests, including enrollment requests from one CICO to a different CICO, received after the 12th of the month will be effective the first of the second month following initial receipt of the request. Passive Enrollment is effective not sooner than 60 days after beneficiary notification of plan selection and the option to decline passive enrollment. CMS and the State will monitor input received by the Ombudsman and CICOs about the time between the Enrollment request and the effective date of Enrollment. After the first year of the Demonstration, or when the State updates its MMIS systems, the State and CMS will also revisit the timeline for processing enrollments and, if necessary, will shorten the time period between the beneficiary's Enrollment request and the effective date of enrollment. All disenrollment requests will be effective the first day of the month following receipt of a beneficiary's request to disenroll from the Demonstration.

- E. The State will utilize a phased approach to enrollment which will enable CMS and the State to assess a CICOs' ability to serve a subset of Enrollees before receiving a larger volume of beneficiaries who are passively enrolled. The State's enrollment strategy 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. This period allows CICOs adequate time to conduct the intensive intake and assessment necessary to properly assess their ability to care for Enrollees. Following the opt-in period, the State will conduct three separate waves of passive enrollment as follows:
1. Beneficiary notification of passive enrollment in the Upstate Region (Region 1) will start no sooner than November 1, 2014, with enrollment and services effective January 1, 2015. This wave will include eligible individuals in Region 1 except those receiving services through one of the three applicable HCBS waivers.
 2. Beneficiary notification of passive enrollment in the Coastal Region (Region 2) will start no sooner than January 1, 2015, with enrollment and services effective March 1, 2015. The geographic approach was determined by the relative acuity level of

beneficiaries in each region, with Region 2 having the greatest need for long-term care services and supports, and thus a higher acuity level. This wave will include eligible individuals in Region 2 except those receiving services through one of the three applicable HCBS waivers.

3. Beneficiary notification of the HCBS population will start no sooner than March 1, 2015, with enrollment and services effective May 1, 2015. This wave will include eligible individuals receiving services through one of the three applicable HCBS waivers statewide.

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[illegible]

4. Under passive enrollment, the State will provide notice of the option to select a CICO at least 60 days prior to the effective date of a passive enrollment period, and will accept opt-out requests through the last day of the month prior to the effective date of enrollment. This notice will explain the beneficiary's options, including the name of the CICO in which the beneficiary would be enrolled unless he/she selects another CICO or indicates the option to opt out of the Demonstration.
 5. Thirty (30) days prior to the effective date of enrollment, beneficiaries who have not responded to the initial notice will receive a second notice that identifies the CICO in which the beneficiary would be enrolled unless he/she selects another CICO or the option to opt out of the Demonstration. The notice will include an enrollment packet with information about the other CICO choices. The State will proceed with passive enrollment into the identified CICO for beneficiaries who do not make a different choice or opt out. CMS communication on the Demonstration will be coordinated with the State.
- F. Requests to disenroll from a CICO, opt out, or enroll in a different CICO will be accepted at any point after an individual's initial enrollment occurs and are effective on the first of the month following receipt of the request., Any time an individual requests to opt out of passive enrollment or disenroll from the Demonstration, the State will send a letter confirming the opt-out and provide information on the benefits available to the beneficiary once he/she has opted out or disenrolled. Beneficiaries subject to Medicare reassignment effective January 1, 2015, either from their current (2014) Medicare Prescription Drug Plan (PDP) or terminating Medicare Advantage Drug Plan (MA-PD) to another PDP, and who meet all eligibility criteria for the Demonstration, will be eligible for Passive enrollment into a CICO effective no earlier than January 1, 2016.
- G. Upon CMS' or the State's written determinations that the Demonstration will not be renewed, no enrollments will be accepted within six months of the end of the Demonstration.

- H. Passive enrollment activity will be coordinated with CMS activities such as Annual Reassignment and daily auto and facilitated enrollment for individuals with the Medicare Part D Low Income Subsidy (LIS).
- I. The state will develop an “intelligent assignment” algorithm for passive enrollment. The algorithm will consider beneficiaries’ previous managed care enrollment and historic utilization of certain provider types. At a minimum, individuals will be pre-assigned with the following considerations: 1) existing provider relationships including HCBS providers; 2) previous history with another product of the CICO (e.g., Medicare Advantage or Medicaid Managed Care Organization) within the previous 12 months; and 3) household members currently assigned to a CICO. The State will also consider the relative case mix of each CICO when applying the algorithm for passive enrollment. Further details will be agreed to and provided by CMS and the State in future technical guidance.
- J. The State or its vendor will provide customer service, including mechanisms to counsel beneficiaries notified of passive enrollment and to receive and communicate beneficiary choice of opt out to CMS via transactions to CMS’ MARx system. Beneficiaries will also be provided a notice upon the completion of the opt-out process. Medicare resources, including 1-800-Medicare, will remain a resource for Medicare beneficiaries; calls related to CICO enrollment will be referred to the State’s Enrollment Contractor for customer service and enrollment support.
- K. CMS and the State will jointly approve all Demonstration notices to ensure complete and accurate information is provided in concert with other Medicare communications, such as the Medicare & You handbook. CMS may also send a jointly approved notice to individuals, and will coordinate such notice with any State notice(s).
- L. Enrollment data in State and CMS systems will be reconciled on a timely basis to prevent discrepancies between such systems.

IV. State Level Delivery System Requirements

- A. Requirements for Medical Homes: CICOs must operate networks from which an

Enrollee can choose a provider that acts as a Medical Home.

CICOs are encouraged to contract with Federally Qualified Health Centers (FQHCs), Rural Health Centers (RHCs), and Patient Centered Medical Homes (PCMHs). Medical homes will provide evidence-based primary care services, acute care, behavioral health care (where appropriate), chronic health condition management, and referrals for specialty care and LTSS. Medical homes will be supported by health information technology (HIT) and be a part of the Multidisciplinary Team (care team) to assist in coordinating care across the full spectrum of available services, including behavioral health care, and managing transitions between levels of care. Not all primary care offices will be ready or capable of operating as true medical homes. However, CICOs will be required to have a process in place to facilitate medical homes advancing toward National Committee for Quality Assurance (NCQA) certification and will be required to provide financial incentives to providers that achieve NCQA medical home certification. The CICO will develop a reimbursement structure that will include enhanced payments to the PCMHs to deliver integrated and coordinated care as required for this Demonstration. To ensure adequacy of PCMH providers, the CICO will encourage development of PCMH standards and certification using incentives described in Appendix 6. CICOs should facilitate this process within a 12-month timeframe for regular accreditation with a provision for a 6-month extension to include an electronic records system.

B. Requirements for Enrollee Assessments and Stratification (see Figure 7-2 for overview):

1. **Initial Health Screen:** The State will collaborate with CICOs to develop a universal health screen that will be administered to all new Enrollees within thirty (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. This tool may be administered either in-person or telephonically. The health screen will contain domain elements to identify potential LTSS needs and to determine the necessity of a Long Term Care Level of Care assessment.

2. **Enrollee Stratification:** CICOs can supplement the initial health screening with predictive modeling and surveillance data to stratify Enrollees to the appropriate level of intervention. Utilizing Enrollee demographics, medical conditions, functional status, care patterns, resource utilization data along with relevant risk scores (e.g., HCC, Clinical Risk Groups, etc.), Enrollees will be stratified into one of three levels: low-, moderate-, or high-risk. These levels of stratification should be based on an Enrollee's risk for long term care institutionalization and/or avoidable hospitalization. Enrollees in one of the Demonstration's three HCBS waivers are automatically stratified as high risk. Each CICO will determine the parameters and definitions for other Enrollees defined as high risk as well as definitions for low or moderate risk Enrollees.
3. **Comprehensive Assessment:** 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 and according to the following timeframes:
 - For Enrollees stratified to low-risk levels: within 90 days of enrollment
 - For Enrollees stratified as moderate- or high-risk levels: within 60 days of enrollment.

CICOs may choose to forego the initial health risk screen when completing the comprehensive assessment within 60 days of enrollment.

The comprehensive assessment will be developed in collaboration with the State and will be utilized by all participating CICOs. It will include required domains identified by the State, including, but not limited to the following: social, functional, medical, behavioral, environmental, LTSS, wellness and prevention domains, and caregiver status and capabilities. CICOs may include additional State-approved domains as appropriate. CICOs shall use relevant and comprehensive data sources, including input from the Enrollee, providers, family/caregivers, etc. Results of the assessment will be used to confirm the appropriate acuity or risk stratification level for the

Enrollee and as the basis for developing the integrated Individualized Care Plan (ICP). Assessments will be completed by qualified, trained health professionals who possess an appropriate professional scope of practice, licensure, and/or credentials, and are appropriate for responding to or managing the Enrollee's needs. Examples of health professionals who may complete portions or all of the assessment include registered nurses, licensed practical nurses (under supervision of a registered nurse), social workers or Medicaid case manager, certified geriatric care manager, certified community health workers or other appropriately credentialed individuals who have demonstrated competency training in assessment related functions in caring for this target population.

Both the comprehensive assessment and Long Term Care Level of Care Assessment (discussed below) tool will be managed in the State's automated case management system, *Phoenix*, which maintains records of a number of critical functions, including all intake, assessment, and care planning activities. Information from the initial health screen will feed into both the comprehensive and Long Term Care Assessment tools.

4. Long Term Care Level of Care Assessments (Long Term Care Assessment):
SCDHHS will educate CICOs on the South Carolina Level of Care Criteria for Medicaid-Sponsored Long Term Care so that the CICO can appropriately identify Enrollees who may need long term care services. The CICO will be required to ensure that the Long Term Care Assessment is conducted for all Enrollees who are identified as high risk during the initial health screen. Enrollees currently participating in one of the Demonstration's three HCBS waivers, however, will not be required to undergo a second Long Term Care Assessment. The most recent Long Term Care Assessment and care plan for these individuals will be sent to the CICO via Phoenix as waiver Enrollees are enrolled in the Demonstration and transitioned from FFS. For all other Enrollees, if the comprehensive assessment indicates a need for long term care services that will trigger the completion of the Long Term Care Assessment by the State.

CICOs will coordinate with SCDHHS Community Long Term Care staff in order to conduct the comprehensive and Long Term Care Assessments concurrently. All Long Term Care Assessments and subsequent level of care determinations will be conducted and recorded using the Phoenix system by a SCDHHS employee registered nurse. When all components of the Long Term Care Assessment are completed, *Phoenix* will use data entered to recommend a level of care based upon the South Carolina Level of Care Criteria for Medicaid-Sponsored Long Term Care. Currently, there are two levels of care: skilled or intermediate, either of which satisfy the requirements to receive long term care services in a nursing facility or in a home and community-based waiver. Information from the Long Term Care Assessment will be used to make the appropriate level of care determination in *Phoenix*.

When the Long Term Care Assessment is completed, the assessor will schedule a meeting with a reviewer, who is either a registered nurse or case manager employed by SCDHHS. The reviewer will conduct a detailed review of all aspects of the assessment to ensure accuracy and completeness. Once this review is completed and a level of care is determined, both the assessor and reviewer electronically sign and date the assessment.

For any Enrollee, *Phoenix* will be modified to include an indication of participation and which CICO is providing for the Enrollee's care. The CICO will have the ability to determine which of its employees should have access to *Phoenix*. Those designated staff will be given user's rights in *Phoenix* and an access level that will allow them to see all records, consistent with applicable privacy rules/regulations, for the CICO's Enrollees. They will also have the ability to update case notes; however, during Phase I the CICO will be able to view but not update the assessment and service plan.

All *Phoenix* users have dashboards which include appropriate notifications. For example, when the Long Term Care assessment is first created, the CICO will receive a notification that an assessment is being conducted and who is being assessed. A second notification will be given when the Long Term Care Assessment and level of

care determination are completed. CICO users can access these notifications at any time to see the most recent updates. This will provide the CICO real time, ongoing notification of the Long Term Care Assessment and level of care processes. More importantly, it will allow this information to be appropriately incorporated in overall care planning.

Figure 7-2. Overview of Enrollee Assessment Requirements

| | Criteria | Health Risk Screen | Comprehensive Assessment | Long Term Care Level of Care Assessment | Individualized Care Plan- Initial | Individualized Care Plan – Continuous monitoring and Review | Waiver Care Plan | Face-to-Face reassessment | Individualized Care Plan – Update |
|-------------------------------------|--|--|------------------------------|---|-----------------------------------|---|--|--|---|
| Low Risk | Determined by CICO during initial Health Risk Screen | Within 30 days of enrollment CICOs may forego the initial health risk assessment when completing the comprehensive assessment within 60 days of enrollment. | Within 90 days of enrollment | Necessary only if CICO believes an Enrollee may need LTC services or if requested by an Enrollee/ authorized representative | Within 90 days of enrollment | Every 120 days | Not Applicable | At least annually, or when there is a change in the Enrollee's health status or needs, a significant health care event, or as requested by the Enrollee, his/her caregiver or his/her provider | Any time a face-to-face reassessment occurs |
| Moderate Risk | Determined by CICO during Health Risk Screen | | Within 60 days of enrollment | Necessary only if CICO believes an Enrollee may need LTC services or if requested by an Enrollee/ authorized representative | Within 90 days of enrollment | Every 90 days | Not Applicable | | |
| High Risk : Waiver and NF Enrollees | State HCBS waiver Enrollees or NF residents | | Within 60 days of enrollment | Not Required | Within 90 days of enrollment | Every 30 days | For waiver Enrollees only: developed by State with CICO concurrence in Phase I; developed by CICO with State concurrence in Phase II and after | | |

| High Risk: All Other | Determined by CICO during Health Risk Screen | | Within 60 days of enrollment | Required, conducted by State concurrently with comprehensive assessment | Within 90 days of enrollment | Every 30 days | Not Applicable | |
|----------------------|--|--|------------------------------|---|------------------------------|---------------|----------------|--|
| | | | | | | | | |

C. Requirements for Care Coordination: CICOs will offer Care Coordination services to all Enrollees to ensure effective linkages and coordination between the medical home 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. All Enrollees will have access to a Care Coordinator and a multidisciplinary care team based on their needs and preferences, and will be encouraged to participate in decision making with respect to their care. At minimum, Care Coordination will include:

1. Access to a single, toll-free point of contact for all questions;
2. Development of an Individualized Care Plan that is periodically reviewed and updated;
3. Disease self-management and coaching;
4. Medication review, including reconciliation during transitions of care setting;
5. Periodic monitoring of health, functional and mental status along with pain and fall screening;
6. Provision of services in the least restrictive setting and transition support across and between specialties and care settings;
7. Connecting Enrollees to services that promote community living and help to delay or avoid nursing facility placement;
8. Coordinating with social service agencies (e.g., local departments of health, social services and community based organizations) and referring Enrollees to state, local and/or other community resources; and
9. Collaboration with nursing facilities to promote adoption of evidence-based interventions to reduce avoidable hospitalization, management of chronic conditions,

medication optimization, fall and pressure ulcer prevention, and the coordination of services beyond the scope of the nursing facility benefit.

When applicable, CICOs will provide a more intensive care coordination for Enrollees identified as high or moderate risk. CICOs are expected to match intensity of care coordination, frequency and mode of interaction to the Enrollee's complexity, needs and preferences. For example, CICOs would likely have more frequent and more-in person interaction with higher risk Enrollees. The State and CMS will monitor CICOs' performance throughout the operation of the Demonstration and will require that CICOs have the capacity to perform the full range of Care Coordination activities, health assessments, and care planning based upon the State's established timeframes.

- D. Individualized Care Plan (ICP) Requirements: A person-centered, individualized care plan 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 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, as conditions warrants.

Information entered in to the assessment tools may identify a specific problem, then that problem will serve as an automatic trigger in the Phoenix system to be addressed in the care plan as a goal with a corresponding intervention. Items that are identified as problems cannot be removed by the care coordinator or the waiver case manager; they are only removed once resolution is indicated through the appropriate intervention. This information remains in the archives of the record in *Phoenix*.

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 thirty (30) days, Enrollees at moderate-risk at least every ninety (90) days, and

Enrollees at low-risk at least every one hundred and twenty (120) days. CICOs will conduct comprehensive reassessments as necessary based upon such reviews. ICPs and interventions will be updated as needed, including if an Enrollee requests a change. In addition, CICOs will complete a face to face Long Term Care reassessment for Enrollees receiving HCBS or residing in a nursing facility each time there is a significant change in the Enrollee's condition or if the Enrollee requests reassessment. At a minimum, CICOs will complete comprehensive reassessment annually for all Enrollees. The assessment must be updated when there is a change in the Enrollee's health status or needs, a significant health care event, or as requested by the Enrollee, his/her caregiver or his/her provider. Updates to the assessment may also be triggered by a hospital admission, transition between care settings, change in functional status, loss of a caregiver, change in diagnosis, or, as requested by a member of the Multidisciplinary Team who observes a change that requires further investigation. As part of the reassessment visit there should also be a comprehensive evaluation of the ICP, and the ICP should be updated based upon the information gained as part of this evaluation and overall reassessment as necessary.

During Phase I of the transition of HCBS authority (further described in Section IV.H of this Appendix), 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 SC LTSS system. A three-way conference will be conducted among the waiver case manager, SCDHHS staff reviewer and CICO designee to discuss elements in the waiver care plan and the recommended service levels. This conference may be conducted through telephonic, face-to-face, or electronic interactions (e.g., video conferencing) depending on the complexity of the case. The CICO may also provide input on service level authorizations and ask other questions. If there is disagreement, the CICO may request a review from the Demonstration's independent ombudsman who has the authority to make a final decision. The waiver case manager will work with the CICOs care coordinator to ensure HCBS and the waiver care plan is fully integrated into a single, overall care plan.

The Waiver Case Managers are employees of contracted Medicaid case management providers. These case management providers must be conflict free and cannot provide any other services that could be incorporated in the waiver care plan. This includes services such as personal care and adult day care that these case managers authorize. It also includes other long-term care services that waiver Enrollees might receive, such as hospice and home health services

- E. Multidisciplinary Team (MT): The Multidisciplinary Team (MT) is responsible for ensuring the integration of the Enrollee's medical, behavioral health, psychosocial, nursing facility, and HCBS care. CICOs will offer a MT for each Enrollee, based on his/her needs and preferences, which will ensure the integration of medical, behavioral health, and HCBS and nursing facility services. In addition to the Enrollee, the team may include family members and other caregivers, 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. During Phase I (July 1 – December 31, 2014), Medicaid Case Management providers are subject to state contractual agreements that will include provisions for mandatory participation in the Multidisciplinary Team. The team will be person-centered, built on the Enrollee's specific preferences and needs, and deliver services with transparency, individualization, respect, linguistic and cultural competence, and dignity.

CICO staff members participating in the MT must agree to participate in approved training on the person-centered planning processes, cultural competence, accessibility and accommodations, independent living and recovery, ADA/Olmstead requirements, and wellness principles, along with other required training to address the unique needs of the target population, as specified by the State. CICOs will offer similar trainings to additional members of the team: primary care providers, specialists, etc., as appropriate.

- F. Care Coordinator Responsibilities, Qualifications and Training: The Care Coordinator

will lead the MT and will be responsible for leading the provision of care coordination services, as determined by an Enrollee's needs and preferences. Care Coordinators must have the qualifications and training appropriate to 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.

- G. Requirements for Self-Direction: 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, 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. Once CDR receives an electronic referral from the CICO, CDR will send an enrollment packet to the prospective attendant who is then enrolled as a Medicaid provider. After the prospective attendant meets SCDHHS provider enrollment requirements, a CDR nurse will schedule the "match visit" in the Enrollee's home. During the "match visit", the nurse will observe the personal care provided by the individual attendant. Based on this observation, the nurse will provide individualized instruction and training specific to the Enrollee's diagnoses and home environment. The nurse will also assist with the fiscal agent enrollment paperwork necessary to establish the employer/employee relationship. The State will assume all administrative costs for this service.

To facilitate payment, CICOs will utilize the State's financial management contractor, Public Partnership Limited (PPL). The State will assume all administrative costs for both CDR and PPL.

H. Phased Transition of HCBS Components:

1. The State's service delivery model includes a transition of HCBS responsibilities to the CICO during the Demonstration period. This section describes the plan for

transition of HCBS authority to CICOs and details the activities, responsibilities and benchmarks for each transition phase.

- a. 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.
 - b. 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.
 - c. 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-direction, needed to continue to adequately coordinate these services.
2. 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 will occur in Phases II and III and will measure the CICOs' ability to move into subsequent phases of the HCBS transition. These benchmark reviews will be performed by SCDHHS staff and SCDHHS' External Quality Review Organization (EQRO), in consultation with CMS. A review tool will be developed by SCDHHS, in conjunction with CMS, that will include the necessary benchmarks that must be achieved. This tool will also detail the information that will be required to document successful completion of the standards set forth. The reviews will be conducted as follows:
 - a. Benchmark Review Period in Preparation for Phase II: October 1 – 31, 2014

b. **Benchmark Review Period in Preparation for Phase III: October 1 – 31, 2015**

3. The CICO will be presented with a copy of the review team's findings no later than November 15th (of 2014 and 2015) following the review. If the CICO fails to adequately meet the benchmark standards, a corrective action plan, including specific dates, must be submitted to the review team within 48 hours of receipt of the report of findings. Failure to adequately address the benchmark standards could preclude a CICO from moving forward to the next phase of the HCBS transition and may impact a CICO's eligibility for future passive enrollment.
4. A summary of the respective State and CICO roles and responsibilities over the course of the transition can be found in Figure 7-3 below.

Figure 7-3. Overview of State/CICO Responsibilities during HCBS Transition

| Functions | Phase I | Phase II | Phase III |
|--|---|---|---|
| Use of <i>Phoenix</i> and <i>Care Call</i> | State & CICO | State & CICO | State & CICO |
| Provider credentialing / monitoring | State | State | State; CICO can choose to assume this 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 <i>Care Call</i>) 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 |

5. The State will retain authority for the following functions for all beneficiaries requiring HCBS (both enrolled and not enrolled in the Demonstration) for the duration of the Demonstration: initial Long Term Care Assessment, level of care determinations and re-determinations, guidelines for minimum rate levels, HCBS provider credentialing/monitoring and integration of the State's IT system (i.e., *Phoenix/Care Call*). By maintaining these responsibilities, the State ensures beneficiaries have a seamless experience in entering waiver programs whether or not they are enrolled in the Demonstration. While the responsibility for provider credentialing and monitoring will be retained by the State, this can be delegated to a CICO if the health plan's preference is to assume this responsibility at its own cost.
6. CICOs will have access to *Phoenix/Care Call*, the State's automated case management and service authorization systems. The automated *Phoenix/Care Call* systems are used to monitor all HCBS services and provide a rich data source for ensuring Enrollee experiences, access and utilization of services, and assessments and care plans customized to their individual needs and conditions. Data in these systems delineate the services authorized and documents service delivery. These systems serve as an electronic record for all assessments, care plans, service authorization, provider information, service delivery documentation, caregiver support systems, real time monitoring of HCBS provision, and other components to support beneficiary protections, administration, case management, and quality assurance activities. Through these systems, the State and CICOs can view what services have been delivered in real time. CICOs will be able to access reports which can feed data into any IT system they might wish to use.
7. **Phase I: July 1, 2014 – December 31, 2014:** Phase I of the transition is marked by a transfer of knowledge of the State's HCBS system to the CICO and the initial integration of HCBS into the Demonstration model. The State will continue to maintain direct contracting with HCBS providers during this six month period, including those who provide case management. CICOs will initiate HCBS network development during this phase with demonstrated network capacity by October 2014. Waiver case managers will be fully integrated into the Demonstration model through

their participation in the multidisciplinary team and through the continued utilization of extensive data for evaluating Enrollee experiences, access, and utilization of services, assessments and care plans available through the *Phoenix/Care Call* system.

a. The State will retain the following HCBS responsibilities during Phase I:

- i. **Contractual authority for all HCBS providers**, including case management. SCDHHS will continue to utilize its provider contracting processes for HCBS providers. Provider manuals, scopes of service and enrollment procedures will be shared with CICOs in preparation for assuming this responsibility in Phase II.
- ii. **Authority for Long Term Care Assessment.** SCDHHS will continue to utilize its automated HCBS assessment form in *Phoenix*. CICOs will be trained in conducting assessments and completing the form in preparation for assuming reassessment responsibilities in Phase II.
- iii. **Authority for initial level of care determinations and redeterminations.** The South Carolina Level of Care Criteria for Medicaid-Sponsored LTC will continue to serve as the medical/functional eligibility criteria for both waiver and nursing facility services. The CICOs will be trained in how the criteria are applied for determining the need for LTSS services via the Long Term Care Assessment.
- iv. **Authority for HCBS care plan development and service authorizations.** The CICOs will have formal input in 1915(c) care plans and service authorizations. For Enrollees receiving waiver services, SCDHHS will develop a formal mechanism for CICOs to participate in the care planning process through *Phoenix* and via teleconference or in person for more deliberative discussions. An arbitration process through the Demonstration's independent ombudsman will be established for

disputes related to service authorizations and service levels to ensure that optimal community based services are provided.

- v. **Rate setting authority.** SCDHHS will publicize a provider rate schedule utilized for HCBS and projections for provider rate increases during the Demonstration years that may be applicable in Phase II and Phase III.
 - vi. **Provider credentialing and monitoring authority throughout the Demonstration period.** SCDHHS will follow the credentialing and monitoring processes outlined in its 1915(c) waivers. For CICOs who express an interest in assuming this function in Phase III, detailed training will be provided on the processes and requirements employed by SCDHHS. However, only providers who are credentialed by the State will be allowed to participate in the Demonstration.
 - vii. **All administrative costs related to Phoenix/Care Call and the related financial management system.**
- b. CICOs will undertake the following HCBS responsibilities during Phase I:
- i. **Use of *Phoenix/Care Call*.** CICOs will be mandated to use and interface with *Phoenix/Care Call*, including the financial management service that is a component of the Care Call contract. Prior to implementation, the CICO will work with the State to ensure the CICO's have the necessary access/ability to monitor and receive HCBS claims via the *Phoenix/Care Call* system for the CICO's Enrollees consistent with applicable privacy rules/regulations. The State will work with software developers to expand the functionality of the system for the CICOs by April 2014.

- ii. **Ability to make LTSS referrals.** Whenever there is an indication that LTSS are needed, the CICO Care Coordinator will be expected to make an electronic referral through *Phoenix*.
- iii. **Payment of HCBS claims via Care Call.** HCBS will be included in the capitation rate and CICOs will receive claims for Enrollees through the Care Call system. Care Call is an automated system used in the three Medicaid waiver programs included in the Demonstration for the prior authorization of services, service documentation, service monitoring, web-based reporting, and billing to MMIS. SCDHHS will enhance Care Call's functionality to allow a data exchange of information to the CICOs for claims processing and payment purposes by April 2014. CICOs will pay HCBS providers in a timely manner prescribed by SCDHHS.
- iv. **Oversight and management of the waiver case manager's participation in their multidisciplinary team to ensure the integration of Medicare and Medicaid services.** Waiver case managers and other service providers will offer an additional level of in-home monitoring/observation and, via Care Call, pertinent information (e.g., changes in a beneficiary's condition such as difficulty walking, transferring, sleeping, skin breakdown, or memory issues) will be provided to the CICO Care Coordinator.
- v. **Development of measurable linkages between HCBS, primary care and behavioral health services through its care integration processes.** In order to ensure access to preventive health care and ongoing integration and management of primary, acute, behavioral health and LTSS , CICOs will adopt a care model for organizing and tracking health services; assign the same priority to a stable primary care home as to stable housing and medication adherence; assure that assessment of

health status is an ongoing component of health services and that there is a high level of communication between behavioral health providers, LTSS providers, PCPs, and other care providers; develop relationships with care providers across primary, behavioral acute and LTSS care settings; and implement evidence-based practices for care delivery.

- vi. **Building relationships with HCBS providers and**
incorporating these providers into their networks for contract implementation January 1, 2015.
- c. CICO Benchmark Review Standards: In the month of October 2014, the State and its EQRO, in consultation with CMS, will conduct a series of benchmark reviews. During this review, the CICOs must demonstrate the following:
- i. Case management and RN assessor staffing competencies in conducting reassessments.
 - ii. Network capacity for HCBS case management and all non-case management HCBS with the exception of self-directed attendant care.
 - iii. Ability to fully manage and integrate the full continuum of Medicare and Medicaid services as evidenced by the following:
 - HCBS care coordination infrastructure;
 - Integration of HCBS into multidisciplinary team; and
 - Policies in support of these integrated functions.
 - iv. Ability to process and pay claims in a timely manner.
 - v. Proposed HCBS rate setting methodology for the aforementioned services for SCDHHS review.
 - vi. Understanding of the credentialing and monitoring process.

8. Phase II: January 1, 2015 – December 31, 2015:

- a. Phase II is marked by the transition of core services from the State to the CICOs. During this phase, the roles and responsibilities outlined in Phase I are transitioned as the CICO assumes oversight and authority of HCBS care plan development, service authorization, and all HCBS provider contracts, except self-directed attendant care.
- b. CICO Responsibilities During Phase II: Effective January 1, 2015, CICOs will assume the following responsibilities:
 - i. **Authority to perform LOC reassessments.** (The State retains authority to perform all initial LOC assessments on new Enrollees for LTC services.)
 - ii. **Formal contractual authority and programmatic oversight** with HCBS providers under the following conditions:
 - iii. **Readiness:** CICOs must meet benchmark review standards for HCBS provider sufficiency.
 - **Network adequacy:** CICOs must have sufficient providers in each geographic area sufficient to meet the needs of the target population and to guarantee Enrollees have a meaningful choice of providers for each service. Since the volume of and need for services differ, the number of providers will vary by specific services. For instance, more personal care providers are necessary to cover an area than adult day care providers or home delivered meals providers.
 - **Provider contracts:** CICOs will use a standard HCBS contract provided by SCDHHS during Phase II of the transition period to ensure consistent continuity of care standards are put into place.
 - **Provider rates:** CICOs will be able to set HCBS provider rates using pre-established guidelines from SCDHHS. CICOs must comply with rate floors adjusted annually for each service that

will set a minimum reimbursement level. These floors will also allow CICOs to create incentives for performance and quality. Rates that fall below 100 percent of the current FFS should have a corresponding performance and/or quality incentive that should be reflective of 100 percent of the FFS rate (at a minimum).

- iv. **Authority for HCBS care plan development and service authorizations with State concurrence.** An arbitration process through the Demonstration's independent ombudsman will continue to exist for disputes, should they arise.
 - v. **CICOs will retain claims processing and provider payments for all HCBS.** Self-directed care will be paid by the CICOs through the State's financial management service provider, PPL.
- c. **CICO Benchmark Review Standards:** In October 2015, the State and its EQRO, in consultation with CMS, will conduct a final series of benchmark reviews. During this review, the CICOs must demonstrate the following:
- i. Competency to assume the authority to oversee self-directed attendant care through the:
 - incorporation of self-direction in care plans during Phases I and II;
 - capacity to assess the viability of self-direction for Enrollees;
 - ability to interface with the University of South Carolina's Center for Disability Resources which provides screening for attendants and employers (as described in Section X.F of this Appendix); and
 - ability to promptly and adequately pay attendants. This process will continue to flow through the State's established Care Call and financial management contractor, PPL system.

- ii. Demonstrated understanding of provider credentialing and monitoring processes if a CICO elects to assume this optional responsibility.

9. Phase III: January 1, 2016 – December 31, 2016: Phase III is marked by the CICO's maturity in HCBS operations and assumption of the remaining HCBS core components, care plan development, service authorization, self-directed attendant care and attendants, many of whom are paid family caregivers.

a. **CICO Responsibilities During Phase III:** Effective January 1, 2016, CICOs will assume the following additional responsibilities:

- i. Responsibility for self-directed attendant care and related functions.
- ii. Independent provider credentialing and monitoring processes if a CICO elects to assume this option.

I. **HCBS Provider Contracting:** The oversight of HCBS providers will follow the process documented in the approved 1915 (c) waiver application.

J. **Nursing Facility Transitions:** Any CICO Enrollee residing in a nursing facility for greater than 90 days prior to transition from that nursing facility may qualify for the State's Money Follows the Person Rebalancing Demonstration called Home Again. Upon transition, eligible Enrollees must enter one of the three waivers included in the Demonstration. Once eligible Enrollees return to the community, the CICOs must offer them any additional home and community based services covered through the Home Again program. Within 90 days of the approval of this MOU, the State will submit a revised MFP Operational Protocol for CMS approval. This protocol will describe how Home Again services will be delivered consistent with the Demonstration. The protocol will also outline how the two programs will coordinate to increase opportunities for eligible individuals to access HCBS upon transition from nursing facilities. Qualifying CICOs may receive up to \$3,000 as an enhanced transition coordination fee for successfully de-institutionalizing an eligible Enrollee for at least 12-months. CICO's Care Coordinators are responsible for assessing an Enrollee's

interest in and potential for making the transition. The Care Coordinator also develops a transition plan and continues intensive care coordination through the end of the transition period (12-months).

K. Requirements for Demonstration Monitoring and Continuous Improvement:

1. **Monitoring:** CMS and the State will work intensively with CICOs prior to implementation and will closely monitor them following implementation. Key areas of oversight will include assessments and care planning, provider networks, claims payment, service authorization and delivery, Enrollee direction, critical incident reporting and follow-up, and data transfers. Other monitoring activities will include reviews of Enrollee Care Plans, service authorizations, and services received to ensure that CICOs are providing services agreed to by the Enrollee in the plan of care.
2. **Continuous Improvement:** Performance will be monitored throughout the operation of the Demonstration and measured according to the quality metrics specified in Section X.G of this Appendix. The State, CMS, and CICOs will be expected to continually improve the operation of the Demonstration through monitoring of compliance with performance and quality measures. Other monitoring activities will include CICO beneficiary advisory committees and regular stakeholder meetings held by the State as discussed in Section III.E.8 of the MOU.

- L. Network Adequacy: State Medicaid standards shall be utilized for long-term supports and services or for other services for which Medicaid is exclusive, and Medicare standards shall be utilized for pharmacy benefits and for other services for which Medicare is primary, unless applicable Medicaid standards for such services are more stringent. Home health and durable medical equipment requirements, as well as any other services for which Medicaid and Medicare may overlap, shall be subject to the more stringent of the applicable Medicare and Medicaid standards.

Section V.E. of this Appendix describes transition requirements that specify continuation of existing services and providers for new Enrollees. CICOs must provide and arrange for timely access to all medically-necessary services covered by Medicaid. CMS and

SCDHHS will monitor access to care and the prevalence of needs indicated through Enrollee assessments, and based on those findings may require CICOs initiate network expansions or other corrective actions over the course of the Demonstration.

CICOs shall ensure they maintain a network of providers that is sufficient in number, mix and geographic distribution to meet the complex and diverse needs of the anticipated number of Enrollees in the service area. Networks will be subject to confirmation through readiness reviews and regular examination on an ongoing basis. For any covered services for which Medicare requires a more rigorous network adequacy standard than Medicaid (including time, distance, and/or minimum number of providers or facilities), the CICO must meet the Medicare requirements.

Medicare network standards account for the type of service area (rural, urban, suburban, etc.), travel time, and minimum number of the type of providers, as well as distance in certain circumstances. The State and CMS may grant exceptions to these general rules to account for patterns of care for Medicare-Medicaid Enrollees, but will not do so in a manner that will dilute access to care for Medicare-Medicaid Enrollees.

M. Solvency: CICOs will be required to meet solvency requirements:

1. Consistent with section 1903 (m) of the Social Security Act, and regulations found at 42 CFR § 422.402(1), and 42 CFR § 438.116, and;
2. As specified in the State laws, regulations and rules specified by the South Carolina Department of Insurance (DOI). The DOI is responsible for licensing and monitoring of the financial solvency of health maintenance organizations (HMOs). All Medicaid managed care providers are required by the State to be licensed by DOI as HMOs

¹ 42 CFR § 422.402, The standards established under this part supersede any state law or regulation (other than state licensing laws or state laws relating to plan solvency) with respect to the Medicare Advantage (MA) plans that are offered by MA organizations.

pursuant to Title 38, Chapter 33 of the SC Code of Laws. CICOs must provide assurances satisfactory to the State showing that its provisions for insolvency meet state regulatory standards and are adequate to ensure its Medicaid Enrollees will not be liable for the entity's debts if the entity becomes insolvent.

N. Credentialing and Practitioner Licensure Authorities and Application within Approved Contracts: CICOs must adhere to managed care standards at 42 CFR § 438.214 and 42 CFR § 422.204 and must be accredited by NCQA and follow NCQA procedural requirements for standards for credentialing and re-credentialing. In addition, CICOs must follow the State guidance and requirements listed below for Medicaid.

1. The CICO provider network shall be comprised of a sufficient number of appropriately credentialed, licensed, or otherwise qualified providers to meet the requirements of the Three-Way Contract, to ensure access to all covered services, and that all providers are appropriately credentialed, maintain current licenses, and have appropriate locations to provide the covered services;
2. The CICO shall implement written policies and procedures that comply with the requirements of 42 CFR §422.204 and 438.214 regarding the selection, credentialing, retention, and exclusion of providers and meet, at a minimum, the requirements below in addition to those described in the Three-Way Contract. The CICO shall submit such policies and procedures annually to SCDHHS and demonstrate, by reporting annually, that all providers within the CICO's provider network are credentialed according to such policies and procedures. The CICO shall:
 - a. Maintain appropriate, documented processes for the credentialing and re-credentialing of physician providers and all other licensed or certified providers who participate in the CICO's provider network. At a minimum, the scope and structure of the processes shall be consistent with recognized managed care industry standards and relevant state regulations, including regulations issued by the South Carolina Department of Labor, Licensing and Regulation and the South Carolina Department of Health and Environmental Control;

- b. Ensure that all providers are credentialed prior to becoming network providers and that a site visit is conducted with recognized managed care industry standards and relevant state regulations;
- c. Maintain a documented re-credentialing process which shall occur regularly, as specified in the Three-Way Contract, and requires that physician providers and other licensed and certified professional providers, including behavioral health providers, maintain current knowledge, ability, and expertise in their practice area(s) by requiring them, at a minimum, to conform with recognized managed care industry standards;
- d. Upon notice from the State or CMS, not authorize any providers barred from participation in Medicaid, Medicare or from another state's Medicaid program, to treat Enrollees and shall deny payment to such providers for services provided. In addition If a provider is terminated or suspended from the South Carolina Medicaid program, Medicare, or another state's Medicaid program or is the subject of a state or federal licensing action or for any other independent action, the CICO shall terminate, suspend, or decline a provider from its network as appropriate, and notify the State of such action.
- e. Not contract with, or otherwise pay for any items or services furnished, directed or prescribed by, a provider that has been excluded from participation in federal health care programs by the Office of the Inspector General of the United States Department of Health and Human Services under either Section 1128 or Section 1128A of the Social Security Act, or that has been terminated from participation under Medicare or another state's Medicaid program, except as permitted under 42 CFR 1001.1801 and 1001.1901;
- f. Not establish provider selection policies and procedures that discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment;

- g. Ensure that no credentialed provider engages in any practice with respect to any Enrollee that constitutes unlawful discrimination under any other state or federal law or regulation, including, but not limited to, practices that violate the provisions of 45 CFR Part 80, 45 CFR Part 84, and 45 CFR Part 90, and M.G.L. Ch. 118E s. 40;and,
- h. Notify the State and CMS when a provider fails credentialing or re-credentialing because of a program integrity reason, and shall provide related and relevant information to the State and CMS as required by the State, CMS or state or federal laws, rules, or regulations.

3. Board Certification Requirements

- a. The CICO shall maintain a policy with respect to board certification for primary care providers and specialty physicians that ensures that the percentage of board certified primary care providers and specialty physicians participating in the provider network, at a minimum, is approximately equivalent to the community average for primary care providers and specialty physicians in the CICO's service area.

4. Laboratory Credentialing

- a. The CICO shall require all laboratories performing services under the Three-Way Contract to comply with the Clinical Laboratory Improvement Amendments.

V. Benefits

A. Medical Necessity Determinations: Medically necessary services will be defined as services:

- 1. (per Medicare) that are reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, or otherwise medically necessary under 42 U.S.C. 1395y.
- 2. (per the State)

- a. are essential to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a handicap, or result in illness or infirmity of an Enrollee;
 - b. are provided at an appropriate facility and at the appropriate level of care for the treatment of the Enrollee's medical condition; and
 - c. are provided in accordance with generally accepted standards of medical practice.
- 3. CICOs will be required to provide services in a way that preserves all protections to the Enrollee and provides the Enrollee with coverage to at least the same extent provided by Medicare and the South Carolina Medicaid program. Where there is overlap between Medicare and Medicaid benefits, coverage and rules will be delineated in the Three-Way Contract. CICOs will be required to abide by the more generous of the applicable Medicare, State, or the combined Medicare-Medicaid standard.
- 4. All care must be provided in accordance and compliance with the ADA, the Supreme Court's *Olmstead* decision, the Rehabilitation Act of 1973, and all other applicable laws.
- B. Supplemental Benefits: Integrated benefit package must include Medicare and Medicaid-covered benefits as well as any required Demonstration or CICO-specific supplemental items and services, including:
 - 1. **New Palliative Care Benefit**: As part of the Demonstration, Enrollees will be eligible to receive a Palliative Care benefit with a focus of pain management and comfort care. The Demonstration affords an opportunity to test whether this new benefit can optimize quality of life of Enrollees living with a serious, chronic or life-limiting illness who may not meet the hospice criteria, including (but not limited to) Parkinson's disease, multiple sclerosis, Alzheimer's disease and/or dementia, end stage cancers, chronic obstructive pulmonary disease (COPD), Huntington's chorea,

advanced liver disease, amyotrophic lateral sclerosis (ALS), and having a history of hospitalizations, a history of acute care utilization for pain and/or symptom management, or based on the recommendation of a physician or the multidisciplinary team.

The benefit will provide care earlier in the continuum of illness or disease process and can be provided in conjunction with curative therapies. Treatment options may continually be explored while also honoring the Enrollee's values and preferences. This benefit may be provided by a hospice provider or other provider trained in palliative care techniques. Additionally, the benefit will be made available in all care settings including the community, nursing facilities, and assisted living facilities. The results of pain assessments and the palliative care treatment goals and interventions will be incorporated into the ICP.

- C. Flexible Benefits: CICOs will have discretion to use the capitated payment to offer flexible benefits, as specified in the Enrollee's Plan of Individualized Care Plan, as appropriate to address the Enrollee's needs.
- D. Election of Medicare Hospice Services: As in Medicare Advantage, if an Enrollee elects to receive the Medicare hospice benefit, the Enrollee will remain in the CICO but will obtain the hospice service through the Medicare FFS benefit and the CICO would no longer receive Medicare Part C payment for that Enrollee. Medicare hospice services, hospice drugs and all other original Medicare services would be paid for under Medicare fee-for-service. CICOs and providers of hospice services would 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 CICOs. CICOs would continue to receive Medicare Part D payment, for which no changes would occur.
- E. 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 who is currently out of the CICO's network. The 180-day transition period, which would begin at the enrollment effective date, is applicable to all providers, including behavioral health providers and providers of LTSS. CICOs are 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.

Out-of-network PCPs and specialists providing an ongoing course of treatment will be offered Single Case Agreements to continue to care for that Enrollee beyond the 180 days if they remain outside the network.

1. CICOs may choose to transition Enrollees to a network PCP earlier than 180 days only if:
 - a. The Enrollee is assigned to a medical home that is capable of serving his/her needs appropriately;
 - b. A health screening and/or a comprehensive assessment is complete;
 - c. The CICO consulted with the new medical home and determined that the medical home is accessible, competent, and can appropriately meet the Enrollee's needs;
 - d. A transition care plan is in place (to be updated and agreed to with the new PCP, as necessary); and
 - e. The Enrollee agrees to the transition and transition plan prior to the expiration of the 180-day transition period.
2. CICOs may choose to transition Enrollees to a network specialist or LTSS provider earlier than 180 days only if:
 - a. A health screening and/or a comprehensive assessment, if necessary, is complete;
 - b. A transition care plan is in place (to be updated and agreed to with the new provider, as necessary); and

- c. The Enrollee agrees to the transition and plan prior to the expiration of the 180-day transition period.
3. With the exception of Part D drugs, which are required to follow all Part D transition requirements, all prior approvals for drugs, therapies, or other services existing in Medicare or Medicaid at the time of enrollment will be honored for 180 days after enrollment and will not be terminated at the end of 180 days without advance notice to the Enrollee and transition to other services, if needed.

F. Out of Network Reimbursement Rules

1. CICOs must reimburse an out-of- network provider of emergent or urgent care, as defined by 42 CFR §424.101 and 42 CFR §405.400 respectively, at the Medicare or Medicaid FFS rate applicable for that service, or as otherwise required under Medicare Advantage rules for Medicare services. For example for authorized out of network services, where this service would traditionally be covered under Medicare FFS, the CICO will pay out of network providers the lesser of providers' charges or the Medicare FFS. Balance billing protections still apply under this scenario.

G. Model of Care

All CICOs (in partnership with contracted providers) will be required to implement an evidence-based model of care (MOC) having explicit components consistent with the Special Needs Plan Model of Care. CMS' CICO 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).

The scoring methodology is divided into three parts: (1) a standard; (2) elements; and (3) factors. These components of the MOC approval methodology are defined below:

1. Standard: The standard is defined as a MOC that has achieved a score of 70% or greater based on NCQA's scoring methodology.
2. Elements: The MOC has thirteen (13) clinical and non-clinical elements, as identified below, and each element will have a score that will be totaled and used to determine

the final overall score. This also includes State specific sub-elements. The thirteen MOC elements are listed below:

- a. Description of the Plan-specific Target Population;
 - b. Measurable Goals;
 - c. Staff Structure and Care Management Goals;
 - d. Interdisciplinary Care Team;
 - e. Provider Network having Specialized Expertise and Use of Clinical Practice Guidelines and Protocols;
 - f. MOC Training for Personnel and Provider Network;
 - g. Health Risk Assessment;
 - h. Care Plan;
 - i. Integrated Communication Network;
 - j. Care Management for the Most Vulnerable Subpopulations; and
 - k. Performance and Health Outcomes Measurement;
 - l. Patient Centered Medical Home; and,
 - m. Integration of Information Systems/Technology (IS/IT/HIT) with HCBS (*Phoenix*).
3. Factors: Each element is comprised of multiple factors that are outlined in the MOC upload matrix in the CICO application. The factors for each element will be scored using a system from zero to four, where four is the highest score for a factor. CICOs are required to provide a response that addresses every factor within each of the 13 elements. The scores for each factor within a specific element are totaled to provide the overall score for that element out of a total of 160 possible points. Interested organizations must achieve a minimum score of 70% to meet the CMS approval standard.

It is CMS' intent for MOC reviews and approvals to be a multi-year process that will allow CICOs to be granted up to a three-year approval of their MOC based on higher MOC scores above the passing standard. The specific time periods for approvals are as follows:

- a. CICOs that receive a score of 85% or higher will be granted an approval of the CMS MOC requirement for three years.
- b. CICOs that receive a score in the 75% to 84% range will be granted an approval of the CMS MOC requirement for two years.
- c. CICOs that receive a score in the 70% to 74% range will be granted an approval of the CMS MOC requirement for one year.

CICOs will be permitted to cure problems with their MOC submissions after their initial submission. CICOs with MOCs scoring below 85% will have the opportunity to improve their scores based on CMS and State feedback on the elements and factors that need additional work. At the end of the review process, CICOs with MOCs that do not meet CMS' standards for approval will not be eligible for selection.

VI. Prescription Drugs

The Integrated formulary must include any Medicaid-covered drugs that are excluded by Medicare Part D. CICOs must also cover drugs covered by Medicare Parts A or B. In all respects, unless stated otherwise in this MOU or the Three-Way Contract, Part D requirements will continue to apply.

VII. Grievances

Enrollees shall be entitled to file internal grievances directly with the CICO. Each CICO must track, report, and resolve its grievances or re-route improperly-filed grievance requests to the coverage decision or appeals processes, as appropriate. CICOs must have internal controls in place for properly identifying incoming requests as a grievance, an initial request for coverage, or an appeal to ensure that requests are processed timely through the appropriate procedures.

VIII. Appeals

Each CICO must have mechanisms in place to track and report all Appeals. Other than Medicare Part D appeals, which shall continue to be adjudicated under processes set forth at 42 CFR Part 423, Subpart M unchanged, the following is the baseline for a unified Medicare-Medicaid appeals process:

A. Integrated/Unified Appeals Process:

1. **Appeal time frames** - Enrollees, their authorized representatives, including providers who are authorized by the Enrollee, will have:
 - a. Sixty (60) calendar days from the date of denial notice to file a CICO Appeal.
 - b. Thirty (30) calendar days from the CICO's notice of disposition (i.e. resolution) to request an State Fair Hearing for Medicaid-only services; and,
 - c. Thirty (30) calendar days from the notice of the right to a State Fair Hearing following the Independent Review Entity's (IRE) adverse disposition (i.e., resolution) to request a State Fair Hearing for Medicare-Medicaid overlapping services. The Enrollee will receive notice of his/her right to request a State Fair Hearing from his/her CICO.
2. **Appeal levels:** Initial appeals must be filed with the CICO. The filing of an internal appeal and exhaustion of the CICO internal Appeal process is a prerequisite to filing an external appeal to Medicare or Medicaid.
 - a. Subsequent Appeals for traditional Medicare A and B services will be automatically forwarded to the Medicare Independent Review Entity (IRE) if the plan upholds its initial denial.
 - b. For Medicaid-only benefits, if the resolution following the CICO Appeal process is not wholly in favor of the Enrollee, such Enrollee or his/her authorized representative may request a State Fair Hearing.

- c. Services for which Medicare and Medicaid overlap (including Home Health, Durable Medical Equipment and skilled therapies, but excluding Medicare Part D) will be defined in a unified way in the Three-Way Contract as required CICO benefits. If the resolution following the CICO Appeal process is not wholly in favor of the Enrollee, the Appeal related to these services will be forwarded to the IRE by the CICO. If the resolution of the IRE is not wholly in favor of the Enrollee, the Enrollee or his/her authorized representative may then request a State Fair Hearing and/or file a request for hearing with an Administrative Law Judge. Any determination in favor of the Enrollee will require payment by the CICO for the service or item in question.

B. Appeal resolution time frames:

1. All initial Appeals must be resolved and Enrollees notified by the CICO as expeditiously as the patient's condition requires, but always within fifteen (15) calendar days of request for standard appeals, and within seventy-two (72) hours of the request for Expedited Appeals. This excludes Part D appeals, which will be resolved in accordance with existing rules.
2. External appeals filed or auto-forwarded to the Medicare external appeal process shall be resolved under currently existing Medicare appeal timelines.
3. For Medicaid-only services appealed to a State Fair Hearing, Standard Appeals will be resolved within ninety (90) calendar days of the filing of an Appeal with the CICO, not including the number of days the Enrollee took to file for a State Fair Hearing, and Expedited Appeals will be resolved within 72 hours from the filing of an Appeal with the State Fair Hearing Agency.
4. For Medicare-Medicaid overlap services, if the Enrollee requests a State Fair Hearing for his/her Medicaid benefits, standard Appeals will be resolved within ninety (90) calendar days of the date the Enrollee filed a CICO appeal, not including the number of days the Enrollee took to file for a State Fair Hearing, and Expedited Appeals will

be resolved within 72 hours from the filing of an Appeal with the State Fair Hearing Agency.

C. Continuation of Benefits Pending an Appeal:

1. All Medicare Parts A and B, and non-Part D benefits will be required to be provided pending the resolution of the CICO Appeal process. This means that such benefits will continue to be provided by providers to Enrollees, and those CICOs must continue to pay providers for providing such services pending the resolution of the CICO Appeal process. This right to aid pending an appeal currently exists in Medicaid, but is generally not currently available in Medicare. Existing Medicaid rules concerning benefits pending an appeal will not change.
2. For Medicaid-only service and Medicare-Medicaid overlap service appeals: If the request for an Appeal is filed with the CICO within 10 calendar days of the Notice of Action or prior to the date of the action, services will be required to be provided pending the resolution of the CICO Appeal process.
3. Following the CICO Appeal process, if resolution at the CICO level, is not wholly in favor of the Enrollee:
 - a. For Medicaid-only services, if the Enrollee files an appeal with the State Fair Hearing Agency within 10 calendar days of the Notice of Disposition from the CICO or prior to the date of the action, services will be required to be provided and paid for pending the resolution of the State Fair Hearing Appeal process.
 - b. For appeals of Medicare-Medicaid overlap services, the Appeals will be forwarded to the IRE and services will be required to be provided and paid for pending the resolution. If the resolution of the IRE is not wholly in favor of the Enrollee, services will be required to be provided and paid for pending resolution of the State Fair Hearing Appeal process, if the Enrollee files an Appeal with the State Fair Hearing Agency within 10 calendar days of the IRE's decision notice.

- D. Integrated Notice: CICO Enrollees will be notified of all applicable Demonstration, Medicare Appeal, Medicaid Appeal, and State Fair Hearing rights-- including whether an individual may receive benefits pending the appeal-- through a single notice jointly developed by the State and CMS.
- E. In the case of a decision where both the State Fair Hearing and the IRE issue a ruling, the CICO shall be bound by the ruling that is most favorable to the Enrollee.

IX. CICO Marketing, Outreach, and Education Activity

- A. As indicated in the CMS "Announcement of Calendar Year (CY) 2013 Medicare Advantage Capitation rates and Medicare Advantage and Part D Payment Policies and Final Call Letter" released on April 2, 2012, CMS Medicare Marketing Guidelines do not apply to communications by State governments and materials created by the State do not need to be reviewed or submitted in HPMS. However, CMS and the State agree to work together in the development of these materials.
- B. Marketing and Enrollee Communication Standards for CICOs: CICOs will be subject to rules governing their marketing and Enrollee communications as specified under sections 1851(h) and 1932(d)(2) of the Social Security Act; 42 CFR §422.111, §422.2260 et seq., §423.120(b) and (c), §423.128, and §423.2260 et seq., and the Medicare Marketing Guidelines (Chapter 3 of the Medicare Managed Care Manual and Chapter 2 of the Prescription Drug Benefit Manual). The following exceptions apply:
 - 1. CICOs may not market directly to individuals on a one-on-one basis but may provide responses to Enrollee-initiated requests for information and/or enrollment. CICOs may participate in group marketing events, provide general audience materials (such as general circulation brochures, and media and billboard advertisements). CICOs must refer all potential Enrollees to the State or its vendor for enrollment. The State reserves the right to develop predetermined marketing scripts for CICO staff, subject to CMS review and approval. All processing of enrollments and disenrollments will occur as stated in this Appendix.

2. CMS and the State will develop a process to mitigate beneficiary shifting from CICOs to other plans operated by the same parent company. At a minimum, the Three-Way Contract will identify procedures to provide additional education to Enrollees that are considering opting out of a CICO for a non-CICO plan that may be a part of the same corporate family. Beneficiary choices regarding enrollment will be honored by CMS and the State.
- C. Review and Approval of Marketing and Enrollee Communications: CICOs must receive prior approval of all marketing and Enrollee communications materials in categories of materials that CMS and the State require to be prospectively reviewed. CICO materials may be designated as eligible for the File & Use process, as described in 42 CFR §422.2262(b) and §423.2262(b), and will therefore be exempt from prospective review and approval by both CMS and the State. CMS and the State may agree to defer to one or the other party for review of certain types of marketing and Enrollee communications, as agreed in advance by both parties. CICOs must submit all marketing and Enrollee communication materials, whether prospectively reviewed or not, via the CMS HPMS Marketing Module.
- D. Permissible Start Date for CICO Marketing Activity : CICOs may begin marketing activity, as limited in Sections IX.A and IX.B of this Appendix above, no earlier than 90 days prior to the effective date of enrollment for the contract year.
- E. CMS and the State will work together to educate individuals about their CICO options. The State or its vendor will be responsible for educating Enrollees on all potential plan choices through a variety of mechanisms. Outreach and educational activities may include letters, outreach events, and/or outbound telephone calls and will take into account the prevalence of cognitive impairments, literacy levels, mental illness, and limited English proficiency.
- F. Minimum Required Marketing and Enrollee Communications Materials: At a minimum, CICOs will provide current and prospective Enrollees the following materials. These materials will be subject to the same rules regarding content and timing of beneficiary receipt as applicable under Section 1851(h) of the Social Security Act; 42 CFR §422.111,

§422.2260 et seq., §423.120(b) and (c), §423.128, and §423.2260 et seq.; §438.10; §438.104; and the Medicare Marketing Guidelines (Chapter 3 of the Medicare Managed Care Manual and Chapter 2 of the Prescription Drug Benefit Manual).

1. An Evidence of Coverage (EOC) document that includes information about all State-covered and CICO-covered additional Benefits, in addition to the required Medicare benefits information. Additional content will be required by the State, e.g. eligibility requirements for CICO enrollment; excluded services; member rights and responsibilities; services requiring prior authorization; self-referral services; explanation that the CICO card replaces the Medicare and Medicaid cards; the Enrollee's requirement to select a PCP and how to change PCP; out of network policies; the availability of 911 services; the right to change plans and the procedure for requesting a change; appeals processes, grievance and state hearing rights and required standard and expedited resolution timeframes; non-discrimination requirements; information on Enrollees' right to execute advance directives; how to contact the State with concerns about the CICO, the structure and operation of any physician incentive plans the CICO may have in place; detailed information on co-payments required for any service; how to access additional information in alternative formats or languages; how to access the CICO provider directory; the name of the CICO's parent company and any "Doing Business As" (DBA) name that may be used; toll-free member services, care management and nurse advice 24-hour service lines; and any other content required by state or federal regulation.
2. An Annual Notice of Change (ANOC) summarizing all major changes to the Plan's covered benefits from one contract year to the next, starting in the second year of the Demonstration.
3. A Summary of Benefits (SB) containing a concise description of the important aspects of enrolling in the CICO and Enrollee rights, as well as the benefits offered by the CICO, including cost sharing, applicable conditions and limitations, and any other conditions associated with receipt or use of benefits. CICOs will use a Demonstration-specific SB.

4. A combined provider and pharmacy directory that includes all providers of Medicare, Medicaid, and additional benefits.
 5. A comprehensive integrated formulary that includes outpatient prescription drugs covered under Medicare, Medicaid or as CICO-covered additional benefits.
 6. A single identification (ID) card for accessing all covered services by the CICO.
 7. All Medicare Part D required notices, with the exception of the LIS Rider required under Chapter 13 of the Prescription Drug Benefit Manual, and the creditable coverage and late enrollment penalty notice requirements required under Chapter 4 of the Prescription Drug Benefit Manual.
- G. Notification of Formulary Changes: The requirement at 42 CFR §423.120(b)(5) that CICOs provide at least 60 days advance notice regarding Medicare Part D formulary changes also applies to CICOs for outpatient prescription or over-the-counter drugs or products covered under Medicaid or as additional benefits.
- H. In addition, the CICO shall not:
1. Provide cash, gifts, prizes or other monetary rebates to induce enrollment.
 2. Seek to influence a potential Enrollee's enrollment with a CICO in conjunction with the sale of any other insurance.
 3. Induce providers or employees of CMS or SCDHHS to reveal confidential information regarding Enrollees or otherwise use confidential information in a fraudulent manner; or
 4. Threaten, coerce or make untruthful or misleading statements to Medicare/Medicaid Enrollees or Enrollees regarding the merits of enrollment with a CICO or any other health plan.

X. Administration and Oversight

A. Oversight Framework:

1. Under the Demonstration, there will be a CMS-State Contract Management Team that will ensure access, quality, program integrity, compliance with applicable laws, including but not limited to the Emergency Medical Treatment and Active Labor Act (EMTALA) and the ADA, and financial solvency, including reviewing and acting on data and reports, conducting studies, and taking corrective action. CMS and the State will require CICOs to have a comprehensive plan to detect, correct, prevent, and report fraud, waste, and abuse. CICOs must have policies and procedures in place to identify and address fraud, waste, and abuse at both the CICO and the third-party levels in the delivery of CICO benefits, including prescription drugs, medical care, behavioral health and LTSS. In addition, all Medicare Part D requirements and many Medicare Advantage requirements regarding oversight, monitoring, and program integrity will be applied to CICOs by CMS in the same way they are currently applied for Prescription Drug Plan (PDP) sponsors and Medicare Advantage organizations.
2. These responsibilities are not meant to detract from or weaken any current State or CMS oversight responsibilities, including oversight by the Medicare Drug Benefit Group and other relevant CMS groups and divisions, as those responsibilities continue to apply, but rather to assure that such responsibilities are undertaken in a coordinated manner. Neither party shall take a unilateral enforcement action relating to day-to-day oversight without notifying the other party in advance.

B. The Contract Management Team:

1. Structure: The Contract Management Team will include representatives from CMS and the State, authorized and empowered to represent CMS and the State about aspects of the Three-Way Contract. Generally, the CMS members of the team will include the State Lead from the Medicare Medicaid Coordination Office (MMCO), Regional Office Lead from the Consortium for Medicaid and Children's Health Operations (CMCHO), and an Account Manager from the Consortium for Health Plan Operations (CMHPO). The team will include individuals who are

knowledgeable about the full range of services and supports utilized by the target population, particularly LTSS.

2. Reporting: Data reporting to CMS and the State will be coordinated and unified to the extent possible. Specific reporting requirements and processes for the following areas of data will be detailed in the Three-Way Contract.

- a. Quality (including HEDIS); core measures are articulated in Section H below
- b. Rebalancing from Institutional to HCBS Settings
- c. Utilization
- d. Encounter Reporting
- e. Enrollee Satisfaction (including CAHPS)
- f. Complaints and Appeals
- g. Enrollment/Disenrollment Rates
- h. Medicare Part C and Part D Reporting Requirements, as applicable
- i. All required 1915(c) reporting, as applicable
- j. Ombudsman

C. Day-to-Day Oversight and Coordination:

1. The Contract Management Team will be responsible for day-to-day monitoring of each CICO. These responsibilities include, but are not limited to:
 - a. Monitoring compliance with reporting requirements;
 - b. Monitoring compliance with the terms of the Three-Way Contract, including issuance of joint notices of non-compliance/enforcement;
 - c. Coordinating of periodic audits and surveys of the CICO;
 - d. Receiving and responding to complaints;
 - e. Reviewing response from and responses to the Ombudsman;

- f. Reviewing direct stakeholder input on both plan-specific and systematic performance;
- g. Participating in regular meetings with each CICO;
- h. Coordinating of requests for assistance from contractors, and assignment of appropriate State and CMS staff to provide technical assistance;
- i. Coordinating review of marketing materials and procedures; and
- j. Coordinating review of grievance and appeals data, procedures, and materials.

D. Centralized Program-Wide Monitoring, Surveillance, Compliance, and Enforcement:

CMS' central office conducts a wide array of data analyses, monitoring studies, and audits. CICOs will be included in these activities, just as all Medicare Advantage and Part D organizations will be included. CICOs will be treated in the same manner, which includes analysis of their performance based on CMS internal data, active collection of additional information, and CMS issuance of compliance notices, where applicable. The Contract Management Team will be informed about these activities and copied on notices, but will not take an active part in these ongoing projects or activities.

E. Emergency/Urgent Situations:

Both CMS and the State shall retain discretion to take immediate action where the health, safety, or welfare of any Enrollee is imperiled or where significant financial risk is indicated. In such situations, CMS and the State shall notify a member of the Contract Management Team no more than 24 hours from the date of such action, and the Contract Management Team will undertake subsequent action and coordination.

CICO Call Center Requirements: CICOs will be responsible for implementing the following call center elements for current and prospective Enrollees which incorporate current Federal regulatory requirements and CMS guidance requirements for Medicare Advantage Plans and Part D plans as well as Demonstration specific requirements:

- CICOs shall operate a toll-free customer service call center. The line will be available statewide for a minimum of 8am to 8pm Eastern Time, seven days a week. A toll-free TTY number or state relay service must be provided, as long as the number included is accessible from TTY equipment.
- Enrollee service representatives must be available in sufficient numbers to support current and prospective Enrollees and meet CMS and State specified standards.
- CICOs shall have interpreter services available to call center personnel to answer questions from non-English speaking and limited English proficient current and prospective Enrollees. Oral interpretation services must be available free-of-charge to all current and prospective Enrollees in all non-English languages spoken by Enrollees.
- CICOs must ensure that enrollee service representatives shall, upon request, make available to current and prospective Enrollees information including, but not limited to, the following:
 - The identity, location, qualifications, and availability of providers;
 - Enrollee rights and responsibilities;
 - Procedures available to an Enrollee and/or provider(s) to challenge or appeal the failure of the CICO to provide a requested service and to appeal any adverse actions (denials);
 - Process by which an Enrollee can access oral interpretation services and written materials in prevalent language and alternative, cognitively accessible formats;
 - Process by which an Enrollee can access the Demonstration's Ombudsman, the SCDHHS Beneficiary Call Center and 1-800-Medicare;
 - Information on all CICO covered services and other available services or resources (e.g., State agency services) either directly or through referral or authorization; and
 - Procedure for an Enrollee to change plans or to opt-out of the Demonstration.

F. Data System Specifications, Reporting Requirements, and Interoperability:

To the maximum extent possible, CMS and the State will collaborate to achieve interoperability among data systems and reporting processes, including:

1. Data system description and architecture and performance requirements
2. Current information system upgrades and development plans and resource commitments necessary for implementation
3. Consolidated reporting requirements
4. Encounter reporting
5. Reporting data for evaluation and program integrity
6. Data Exchange among CMS, the State, Providers and CICOs, and Health Insurance Marketplaces (2014)

G. Unified Quality Metrics and Reporting:

CICOs will be required to report measures that examine access and availability, care coordination/transitions, health and well-being, mental and behavioral health, beneficiary/caregiver experience, screening and prevention, and quality of life. This includes a requirement to report Medicare HEDIS, HOS and CAHPS data, as well as measures related to long term supports and services. HEDIS, HOS, and CAHPS measures will be reported consistent with Medicare requirements for HEDIS plus any additional Medicaid measures identified by the State. All existing Part D metrics will be collected as well. The State will supplement quality reporting requirements with additional State-specific measures.

The combined set of core metrics is described below in Figure 7-4; more detail on the measures will be provided in the Three-Way Contract. CMS and the State will utilize the reported measures in the combined set of core metrics for various purposes, including implementation and ongoing monitoring, assessing plan performance and outcomes, and

to allow quality to be evaluated and compared with other plans in the model. A subset of these will also be used for calculating the quality withhold payment as addressed in Section VI of Appendix 6 in this MOU.

CICOs must submit data consistent with requirements established by CMS and/or the State as further described below and in the Three-Way Contract. CICOs will also be subject to monitoring efforts consistent with the requirements of Medicare Advantage and Part D as described in Section XII of this Appendix.

Figure 7-4. Core Quality Measures under the Demonstration

| Measure | Description | Measure Steward/Data Source | CMS Core Measure | State Measure |
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| Antidepressant medication management | Percentage of members who were diagnosed with a new episode of major depression and treated with antidepressant medication, and who remained on an antidepressant medication treatment. | NCQA/HEDIS | X | |
| Initiation and Engagement of Alcohol and Other Drug Dependence Treatment | <p>The percentage of members with a new episode of alcohol or other drug (AOD) dependence who received the following:</p> <ul style="list-style-type: none"> • Initiation of AOD Treatment. The percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis. • Engagement of AOD Treatment. The percentage of members who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit. | NCQA/HEDIS | X | |
| Follow-up After Hospitalization for Mental Illness | Percentage of discharges who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner | NCQA/HEDIS | X | |
| Screening for Clinical Depression and Follow-up Care | Percentage of patients screened for clinical depression using a standardized tool and follow-up plan documented. | CMS | X | |
| SNP1: Complex Case Management | <p>The organization coordinates services for members with complex conditions and helps them access needed resources.</p> <p>Element A: Identifying Members for Case Management Element B: Access to Case Management Element C: Case Management Systems Element D: Frequency of Member Identification Element E: Providing Members with Information Element F: Case Management Assessment Process Element G: Individualized Care Plan</p> | NCQA/ SNP Structure & Process Measures | X | |

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| | <p>Element H: Informing and Educating Practitioners</p> <p>Element I: Satisfaction with Case Management</p> <p>Element J: Analyzing Effectiveness/Identifying Opportunities</p> <p>Element K: Implementing Interventions and Follow-up Evaluation</p> | | | |
| SNP 6: Coordination of Medicare and Medicaid Benefits | <p>The organization coordinates Medicare and Medicaid benefits and services for members.</p> <p>Element A: Coordination of Benefits for Dual Eligible Members</p> <p>Element B: Administrative Coordination of D-SNPs</p> <p>Element C: Administrative Coordination for Chronic Condition and Institutional Benefit Packages (May not be applicable for demos)</p> <p>Element D: Service Coordination</p> <p>Element E: Network Adequacy Assessment</p> | NCQA/ SNP Structure & Process Measures HEDIS | X | |
| Care Transition Record Transmitted to Health Care Professional | Percentage of patients, regardless of age, discharged from an inpatient facility to home or any other site of care for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge. | AMA-PCPI | X | |
| Medication Reconciliation After Discharge from Inpatient Facility | Percent of patients 65 years or older discharged from any inpatient facility and seen within 60 days following discharge by the physician providing ongoing care who had a reconciliation of the discharge medications with the current medication list in the medical record documented. | NCQA/HEDIS | X | |
| SNP 4: Care Transitions | <p>The organization manages the process of care transitions, identifies problems that could cause transitions and where possible prevents unplanned transitions.</p> <p>Element A: Managing Transitions</p> <p>Element B: Supporting Members through Transitions</p> <p>Element C: Analyzing Performance</p> <p>Element D: Identifying Unplanned Transitions</p> <p>Element E: Analyzing Transitions</p> <p>Element F: Reducing Transitions</p> | NCQA/ SNP Structure & Process Measures HEDIS | X | |

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| CAHPS, various settings including: -Health Plan plus supplemental items/questions, including: -Experience of Care and Health Outcomes for Behavioral Health (ECHO) -Home Health -Nursing Home -People with Mobility Impairments -Cultural Competence -Patient Centered Medical Home | Depends on Survey. | AHRQ/CAHPS | X | |
| Part D Call Center – Pharmacy Hold Time | How long pharmacists wait on hold when they call the drug plan's pharmacy help desk. | CMS Call Center data | X | |
| Part D Call Center – Foreign Language Interpreter and TTY/TDD Availability | Percent of the time that TTY/TDD services and foreign language interpretation were available when needed by members who called the drug plan's customer service phone number. | CMS Call Center data | X | |
| Part D Appeals Auto– Forward | How often the drug plan did not meet Medicare's deadlines for timely appeals decisions. This measure is defined as the rate of cases auto-forwarded to the Independent Review Entity (IRE) because decision timeframes for coverage determinations or redeterminations were exceeded by the plan. This is calculated as: $[(\text{Total number of cases auto-forwarded to the IRE}) / (\text{Average Medicare Part D enrollment})] * 10,000$. | IRE | X | |
| Part D Appeals Upheld | How often an independent reviewer agrees with the drug plan's decision to deny or say no to a member's appeal. This measure is defined as the percent of IRE confirmations of upholding the plans' decisions. This is calculated as: $[(\text{Number of cases upheld}) / (\text{Total number of cases reviewed})] * 100$. | IRE | X | |
| Part D Complaints about the Drug Plan | How many complaints Medicare received about the drug plan. For each contract, this rate is calculated as: $[(\text{Total number of complaints logged into the CTM for the drug plan regarding any issues}) / (\text{Average Contract enrollment})] * 1,000 * 30 / (\text{Number of$ | CMS CTM data | X | |

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| | Days in Period). | | | |
| Part D Beneficiary Access and Performance Problems | To check on whether members are having problems getting access to care and to be sure that plans are following all of Medicare's rules, Medicare conducts audits and other types of reviews. Medicare gives the plan a lower score (from 0 to 100) when it finds problems. The score combines how severe the problems were, how many there were, and how much they affect plan members directly. A higher score is better, as it means Medicare found fewer problems. | CMS Administrative data | X | |
| Part D Members Choosing to Leave the Plan | The percent of drug plan members who chose to leave the plan in 2014. | CMS Medicare Beneficiary Database Suite of Systems | X | |
| Part D MPF Accuracy | The accuracy of how the Plan Finder data match the PDE data. | CMS PDE data, MPF Pricing Files, HPMS approved formulary extracts, and data from First DataBank and Medispan | X | |
| Part D High Risk Medication | The percent of the drug plan members who get prescriptions for certain drugs with a high risk of serious side effects, when there may be safer drug choices. | CMS PDE data | X | |
| Part D Diabetes Treatment | Percentage of Medicare Part D beneficiaries who were dispensed a medication for diabetes and a medication for hypertension who were receiving an angiotensin converting enzyme inhibitor (ACEI) or angiotensin receptor blocker (ARB) medication which are recommended for people with diabetes. | CMS PDE data | X | |
| Part D Medication Adherence for Oral Diabetes Medications | Percent of plan members with a prescription for oral diabetes medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication. | CMS PDE data | X | |
| Part D Medication Adherence for Hypertension (ACEI or ARB) | Percent of plan members with a prescription for a blood pressure medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication. | CMS PDE data | X | |
| Part D Medication Adherence for | Percent of plan members with a | CMS | X | |

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| Cholesterol (Statins) | prescription for a cholesterol medication (a statin drug) who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication. | PDE data | | |
| Plan Makes Timely Decisions about Appeals | Percent of plan members who got a timely response when they made an appeal request to the health plan about a decision to refuse payment or coverage. | IRE | X | |
| Reviewing Appeals Decisions | How often an independent reviewer agrees with the plan's decision to deny or say no to a member's appeal. | IRE | X | |
| Call Center – Foreign Language Interpreter and TTY/TDD Availability | Percent of the time that the TTY/TDD services and foreign language interpretation were available when needed by members who called the health plan's customer service phone number. | CMS Call Center data | X | |
| Percent of High Risk Residents with Pressure Ulcers (Long Stay) | Percentage of all long-stay residents in a nursing facility with an annual, quarterly, significant change or significant correction MDS assessment during the selected quarter (3-month period) who were identified as high risk and who have one or more Stage 2-4 pressure ulcer(s). | NQF endorsed | X | |
| Beneficiary Governance Board | Establishment of beneficiary/ consumer advisory board or inclusion of beneficiaries/ consumers on governance board consistent with contract requirements. | CMS/State defined process measure | X | |
| Customer Service | Percent of best possible score the plan earned on how easy it is to get information and help when needed. • In the last 6 months, how often did your health plan's customer service give you the information or help you needed? In the last 6 months, how often did your health plan's customer service treat you with courtesy and respect? In the last 6 months, how often were the forms for your health plan easy to fill out? | AHRQ/CAHPS | X | |
| Assessments | Percent of Enrollees with initial assessments completed within required timeframes. | CMS/State defined process measure | X | |
| Individualized care plans | Percent of members with care plans by specified timeframe. | CMS/State defined process measure | X | |
| Real time hospital admission | Percent of hospital admission | CMS/State defined | X | |

| notifications | notifications occurring within specified timeframe. | process measure | | |
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| Risk stratification based on LTSS or other factors | Percent of risk stratifications using BH/LTSS data/indicators. | CMS/State defined process measure | X | |
| Discharge follow-up | Percent of members with specified timeframe between hospital discharge to first follow-up visit. | CMS/State defined process measure | X | |
| Self-direction | Percent of care coordinators that have undergone State-based training for supporting self-direction under the Demonstration. | CMS/State defined process measure | X | |
| Care for Older Adults – Medication Review | Percent of plan members whose doctor or clinical pharmacist has reviewed a list of everything they take (prescription and non-prescription drugs, vitamins, herbal remedies, other supplements) at least once a year. | NCQA/ HEDIS | X | |
| Care for Older Adults – Functional Status Assessment | Percent of plan members whose doctor has done a —functional status assessment to see how well they are doing —activities of daily living (such as dressing, eating, and bathing). | NCQA/HEDIS | X | |
| Care for Older Adults – Pain Screening | Percent of plan members who had a pain screening or pain management plan at least once during the year. | NCQA/HEDIS | X | |
| Diabetes Care – Eye Exam | Percent of plan members with diabetes who had an eye exam to check for damage from diabetes during the year. | NCQA/HEDIS | X | |
| Diabetes Care – Kidney Disease Monitoring | Percent of plan members with diabetes who had a kidney function test during the year. | NCQA/HEDIS | X | |
| Diabetes Care – Blood Sugar Controlled | Percent of plan members with diabetes who had an A-1-C lab test during the year that showed their average blood sugar is under control. | NCQA/HEDIS | X | |
| Rheumatoid Arthritis Management | Percent of plan members with Rheumatoid Arthritis who got one or more prescription(s) for an anti-rheumatic drug. | NCQA/HEDIS | X | |
| Reducing the Risk of Falling | Percent of members with a problem falling, walking or balancing who discussed it with their doctor and got treatment for it during the year. | NCQA/HEDIS HOS | X | |
| Plan All-Cause Readmissions | Percent of members discharged from a hospital stay who were readmitted to a hospital within 30 days, either from the same condition as their recent hospital stay or for a different reason. | NCQA/HEDIS | X | |
| Controlling Blood Pressure | Percentage of members who had a | NCQA/HEDIS | X | |

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| | diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90) during the measurement year. | | | |
| Comprehensive medication review | Percentage of beneficiaries who received a comprehensive medication review (CMR) out of those who were offered a CMR. | Pharmacy Quality Alliance (PQA) Part D Reporting Data | X | |
| Complaints about the Health Plan | How many complaints Medicare received about the health plan. Rate of complaints about the health plan per 1,000 members. For each contract, this rate is calculated as: $[(\text{Total number of all complaints logged into the CTM}) / (\text{Average Contract enrollment})] * 1,000 * 30 / (\text{Number of Days in Period})$. | CMS CTM data | X | |
| Beneficiary Access and Performance Problems | To check on whether members are having problems getting access to care and to be sure that plans are following all of Medicare's rules, Medicare conducts audits and other types of reviews. Medicare gives the plan a lower score (from 0 to 100) when it finds problems. The score combines how severe the problems were, how many there were, and how much they affect plan members directly. A higher score is better, as it means Medicare found fewer problems. | CMS Beneficiary database | X | |
| Members Choosing to Leave the Plan | The percent of plan members who chose to leave the plan in plan year | CMS | X | |
| Getting Information From Drug Plan | The percent of the best possible score that the plan earned on how easy it is for members to get information from their drug plan about prescription drug coverage and cost. In the last 6 months, how often did your health plan's customer service give you the information or help you needed about prescription drugs? In the last 6 months, how often did your plan's customer service staff treat you with courtesy and respect when you tried to get information or help about prescription drugs? In the last 6 months, how often did your health plan give you all the information you needed about prescription medication were covered? In the last 6 months, how often did your health plan give you all the information you needed about how much you would have to pay for your prescription | AHRQ/CAHPS | X | |

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| | medicine? | | | |
| Rating of Drug Plan | <p>The percent of the best possible score that the drug plan earned from members who rated the drug plan for its coverage of prescription drugs.</p> <p>Using any number from 0 to 10, where 0 is the worst prescription drug plan possible and 10 is the best prescription drug plan possible, what number would you use to rate your health plan for coverage of prescription drugs?</p> | AHRQ/CAHPS | X | |
| Getting Needed Prescription Drugs | <p>The percent of best possible score that the plan earned on how easy it is for members to get the prescription drugs they need using the plan.</p> <p>-In the last 6 months, how often was it easy to use your health plan to get the medicines your doctor prescribed?</p> <p>-In the last six months, how often was it easy to use your health plan to fill a prescription at a local pharmacy?</p> | AHRQ/CAHPS | X | |
| Getting Needed Care | <p>Percent of best possible score the plan earned on how easy it is to get needed care, including care from specialists.</p> <p>In the last 6 months, how often was it easy to get appointments with specialists? • In the last 6 months, how often was it easy to get the care, tests, or treatment you needed through your health plan?</p> | AHRQ/CAHPS | X | |
| Getting Appointments and Care Quickly | <p>Percent of best possible score the plan earned on how quickly members can get appointments and care.</p> <p>In the last 6 months, when you needed care right away, how often did you get care as soon as you thought you needed?</p> <p>• In the last 6 months, not counting the times when you needed care right away, how often did you get an appointment for your health care at a doctor's office or clinic as soon as you thought you needed?</p> <p>In the last 6 months, how often did you see the person you came to see within 15 minutes of your appointment time?</p> | AHRQ/CAHPS | X | |
| Overall Rating of Health Care Quality | <p>Percent of best possible score the plan earned from plan members who rated the overall health care received.</p> <p>Using any number from 0 to 10, where 0</p> | AHRQ/CAHPS | X | |

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| | is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your health care in the last 6 months? | | | |
| Overall Rating of Plan | Percent of best possible score the plan earned from plan members who rated the overall plan. Using any number from 0 to 10, where 0 is the worst health plan possible and 10 is the best health plan possible, what number would you use to rate your health plan? | AHRQ/CAHPS | X | |
| Breast Cancer Screening | Percent of female plan members aged 40- 69 who had a mammogram during the past 2 years. | NCQA/ HEDIS | X | |
| Colorectal Cancer Screening | Percent of plan members aged 50-75 who had appropriate screening for colon cancer. | NCQA/HEDIS | X | |
| Cardiovascular Care – Cholesterol Screening | Percent of plan members with heart disease who have had a test for —bad! (LDL) cholesterol within the past year. | NCQA/HEDIS | X | |
| Diabetes Care – Cholesterol Screening | Percent of plan members with diabetes who have had a test for —bad! (LDL) cholesterol within the past year. | NCQA/HEDIS | X | |
| Annual Flu Vaccine | Percent of plan members who got a vaccine (flu shot) prior to flu season. | AHRQ/CAHPS Survey data | X | |
| Improving or Maintaining Mental Health | Percent of all plan members whose mental health was the same or better than expected after two years. | CMS HOS | X | |
| Monitoring Physical Activity | Percent of senior plan members who discussed exercise with their doctor and were advised to start, increase or maintain their physical activity during the year. | HEDIS / HOS | X | |
| Access to Primary Care Doctor Visits | Percent of all plan members who saw their primary care doctor during the year. | HEDIS | X | |
| Access to Specialists | Proportion of respondents who report that it is always easy to get appointment with specialists. | AHRQ/CAHPS | X | |
| Getting Care Quickly | Composite of access to urgent care. | AHRQ/CAHPS | X | |
| Being Examined on the Examination table | Percentage of respondents who report always being examined on the examination table. | AHRQ/CAHPS | X | |
| Help with Transportation | Composite of getting needed help with transportation. | AHRQ/CAHPS | X | |
| Health Status/Function Status | Percent of members who report their health as excellent. | AHRQ/CAHPS | X | |
| Access to PCMH providers | Number and percent of members served | | | X |

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| | in PCMHs. | | | |
| Pain Management | <p>Percentage of Enrollees with documented assessment of pain using standardized tool during each review period (comprehensive assessment and re-assessments)</p> <p>Percentage of Enrollees with documented intervention for acute or chronic pain</p> | AMDA | | X |
| Medication Reconciliation | Percentage of Enrollees discharged from an inpatient facility to home or any other site of care, who either themselves or their caregiver received a reconciled medication list at the time of discharge including, at minimum, medications in the specified categories. | PCPI | | X |
| Fall Intervention | <p>Percentage of Enrollees with documented fall risk assessment.</p> <p>Percentage of Enrollees with a history of falls with documented fall intervention</p> <p>Percentage of Enrollees who receive appropriate fall prevention interventions based upon the results of their fall risk assessment.</p> | NQF/CMS State Specific Measure | | X |
| Vision | Percentage of Enrollees who received glaucoma eye exam by an eye care professional for early identification of glaucomatous conditions | NCQA | | X |
| Care Coordination | Percent of medium and high risk enrollees able to identify care coordinator and/or HCBS case manager | State specific measure | | X |
| Care Coordination (person-centered) | Percent of documented discussions of care goals with Enrollee and/or caregiver involvement | State specific measure | | X |
| Transitions Between Care Settings | Report number of Enrollees transitioning from institutional care to wavier services, community to waiver services, community to institutional care, and waiver services to institutional care. (Exclude institutional stays ≤ 90 days.) | State Specific Measure | | X |
| Management of urinary incontinence for older adults | Percent of Enrollees with identified incontinence who have received treatment or documented intervention from a provider | State specific measure | | X |
| Mental Health utilization | Number and percentage of Enrollees receiving the following mental health services during the measurement year: | HEDIS | | X |

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| | any service, in-patient, intensive outpatient or partial hospitalization, and outpatient or ED. | | | |
| Aspirin Use and Discussion | Percentage of Enrollees who are currently taking aspirin, and percentage of Enrollees who discussed the risks and benefits of using aspirin with a doctor or other health provider | CAHPS | | X |
| Pneumonia Vaccine | Percentage of Enrollees aged 65 and older who have ever received a pneumonia vaccine | NCQA | | X |
| Tobacco Use assessment and tobacco cessation intervention | Percent who have used tobacco within past 6 months, frequency of use, whether health care professional discussed cessation strategies. | CAHPS | | X |
| Advanced Care Planning | Percent of Enrollees aged 65 and older who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan. | AGS/NCQA | | X |
| Integrated Care | <p>Number and percentage of all Enrollees referred to LTSS</p> <p>Number and percentage of all Enrollees referred to HCBS</p> <p>Number and percentage of all Enrollees referred to a long term care facility (nursing facility)</p> | State-specified measure | | X |
| Integrated Care | <p>Percent of enrollees newly approved (or newly determined eligible) for HCBS with a plan of care developed, reviewed, and approved jointly by Waiver Case Manager, Reviewer and CICO designee, that is included in the overall ICP within 30 days of waiver enrollment.</p> <p>Percent of enrollees already receiving HCBS that have a plan of care included in the ICP within 30 days of enrollment into CICO.</p> | CMS/State defined process measure | | X |
| HCBS Plan of Care integration into ICP | | | | |
| Transitions Between Care Settings | Percentage of enrollees who transitioned to and from hospitals, nursing facilities and the community. | CMS/State defined process measure | | X |

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| | <p>Percentage of those who transitioned who returned to (1) institutional setting or (2) community</p> <p>Percentage of Care transitions recorded and transmitted to CICO Care Coordinator (via Phoenix)</p> | | | |
| HCBS Authorization | Percentage of Enrollees who require HCBS, as indicated by the comprehensive care assessment and the ICP, receive those services within 90 days of enrollment. | State-specified measure | | X |
| Consumer Satisfaction | Percent of Enrollees receiving HCBS who are satisfied/very satisfied with these services | State-Specified Measure | | X |
| HCBS Authorization - Consumer Directed Services | Percent of Enrollees receiving HCBS who used consumer-directed services | State-specified measure | | X |
| HCBS Authorization - Consumer Directed Services | Percent of Enrollees receiving HCBS who experienced a decrease in the authorization of attendant care or companion service hours. Compared across years of Demonstration | State-specified measure | | X |
| HCBS Authorization – Personal Care Hours | <p>Percent of Enrollees receiving HCBS who experienced a decrease in the authorization of personal care hours. Compared across years of Demonstration.</p> <p>Percent of Enrollees receiving HCBS who experienced an increase in the authorization of personal care hours. Compared across years of Demonstration.</p> | State-specified measure | | X |
| HCBS Authorization - Respite care | <p>Percent of Enrollees receiving HCBS who experienced increase a decrease in the authorization of respite hours. Compared across years Demonstration.</p> <p>Percent of Enrollees receiving HCBS who experienced an increase in the authorization of respite hours. Compared across years of Demonstration.</p> | State-specified measure | | X |
| HCBS Authorization - Non-consumer directed services | <p>Percent of Enrollees receiving HCBS who experienced a decrease in the authorization of HCBS services. Compared across years of Demonstration.</p> <p>Percent of Enrollees receiving HCBS</p> | State-specified measure | | X |

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| | who experienced an increase in authorization of non-consumer directed HCBS. Compared across years of Demonstration. | | | |
| Integration of Care | Number/percentage of care coordinator actions/care decisions in response to critical incident reports by the in-home providers and/or changes in conditions identified by LTC Specialist/Waiver Case Managers | State-specified measure | | X |
| Utilization of alternate housing options | Number of members who utilize assisted living, other congregate housing and independent living options | State-specified measure | | X |
| Integration of Care | Number and percent of CICO Care Coordinators who are trained on how to make appropriate waiver referrals and use Phoenix and Care Call | State-specified measure | | X |
| Care for Older Adults Composite | Percentage of adults 65 years and older who had each of the following during the measurement year: advance care planning, medication review, functional status assessment, and pain screening. | NCQA/State-Specified Measure | | X |
| Integration of Care | Percentage of Enrollees who have a waiver case manager participating in multidisciplinary team. | State-specified measure | | X |
| Plans of Care and Documentation of Care Goals | Proportion of Enrollees at each risk level (high-, medium-, low-) with Individual Care Plan (ICP) developed within specified timeframes compared to total Enrollees at each risk level requiring ICPs. Percent of Enrollee ICPs that contain documented discussion of care goals with Enrollee and/or Caregiver and Multidisciplinary Team. | State-specified measure | | X |
| Hospital, Nursing Facility and Community Transition | CICO has an established work plan and systems in place, utilizing Phoenix as appropriate) for ensuring smooth transition to and from hospitals, nursing facilities and the community. | State-specified measure | | X |
| Adjudicated Claims, including HCBS Case Management | Percent of adjudicated claims submitted to CICOs that were paid within the timely filing requirements | State-specified measure | | X |
| Quality of Life | Percentage of Enrollees receiving the palliative care benefit who indicate they are uncomfortable because of pain whose pain was brought to a comfortable level within 48 hours of start of service. | NCF Measure | | X |

CMS will work closely with the State to monitor other measures related to community integration. CMS and the State will continue to work jointly to refine and update these quality measures in years two and three of the Demonstration.

XI. Stakeholder Engagement

The State and CMS will continue to engage with and incorporate feedback from stakeholders during the implementation and operational phases of the Demonstration. This will be accomplished through an ongoing process of public meetings, and monitoring individual and provider experiences through a variety of means, including surveys, focus groups, website updates, and data analysis. In addition, the State will require that CICOs develop meaningful Enrollee input processes as part of their ongoing operations, as well as systems for measuring and monitoring the quality of services and care delivered to eligible individuals. As described in Section III.E.9 of this MOU, CICOs must establish Enrollee advisory committees and submit agendas and minutes to the State. Quarterly, SCDHSS will convene members of the CICO Enrollee advisory committees to provide feedback to CMS and the State. The State will also develop Enrollee notices and related materials about the Demonstration that are easily understood by persons with limited English proficiency, and will translate materials into prevalent languages as determined by CMS and the State.

XII. Evaluation

- A. 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 key issues targeted by the evaluation will include (but are not limited to):
 - 1. Beneficiary health status and outcomes;
 - 2. Quality of care provided across care settings;

3. Beneficiary access to and utilization of care across care settings;
 4. Beneficiary satisfaction and experience;
 5. Administrative and systems changes and efficiencies;
 6. Long-term care rebalancing and diversion effectiveness; and,
 7. Overall costs or savings for Medicare and Medicaid.
- B. The evaluator will design a State-specific evaluation plan for this Demonstration, and will also conduct a meta-analysis that will look at the state Demonstrations overall. A mixed methods approach will be used to capture quantitative and qualitative information. Qualitative methods will include site visits, qualitative analysis of program data, and collection and analysis of focus group and key informant interview data. Quantitative analyses will consist of tracking changes in selected quality, utilization, and cost measures over the course of the Demonstration; evaluating the impact of the Demonstration on cost, quality, and utilization measures; and calculating savings attributable to the Demonstration. The evaluator will use a comparison group for the impact analysis. The comparison group methodology will be detailed in the State-specific evaluation plan. Quarterly reports provided to CMS and the State will include rapid-cycle monitoring of enrollment, implementation, utilization of services, and costs (pending data availability). The evaluator will also submit State-specific annual reports that incorporate qualitative and quantitative findings to date, and will submit a final evaluation report at the end of the Demonstration.
- C. 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 this Demonstration, according to the data and timeframe requirements to be listed in the Three-Way Contract.
- D. The State will collect data on case management and care coordination, including identification of Enrollees who receive care coordination, frequency and manner of contacts. The State will also maintain the capability to track beneficiaries eligible for the

Demonstration, including which beneficiaries choose to enroll, disenroll, or opt out of the Demonstration, enabling the evaluation to identify differences in outcomes for these groups. The State will need to provide information including but not limited to the following on a quarterly basis to CMS and/or the evaluator:

1. Beneficiary-level data identifying beneficiaries eligible and enrolled in the Demonstration:

- a. Medicare Beneficiary Claim Account Number (HICN)
- b. MSIS number
- c. Social Security Number
- d. CMS Beneficiary Link Key
- e. Person First and Last Name, Birthdate, and Zip code
- f. Eligibility identification flag - Coded zero if not identified as eligible for the Demonstration, 1 if identified as eligible for the Demonstration using criteria available in claims or other administrative data, and 2 if identified by criteria from non-administrative data sources (e.g., BMI, smoking)
- g. Nursing facility status – Coded 1 if residing in nursing facility, and zero if not
- h. HCBS waiver status- Coded 1 if enrolled in an HCBS waiver, and zero if not
- i. Monthly eligibility indicator - Each monthly eligibility flag variable would be coded 1 if eligible, and zero if not.
- j. Monthly enrollment indicator - Each monthly enrollment flag variable would be coded 1 if enrolled in the Demonstration, and zero if not.

2. Summary level data for the State Data Reporting System, including but not limited to:

- a. The number of beneficiaries eligible for the Demonstration, appropriately excluding all individual beneficiaries *not* eligible for the Demonstration (e.g.

individuals residing in ICF/MRs or State mental hospitals; HCBS waiver, PACE, and Money Follows the Person enrollees, etc.)

- b. The number of beneficiaries enrolled in the Demonstration
 - c. The number of beneficiaries who opt out of the Demonstration
 - d. The number of beneficiaries who disenroll from the Demonstration
 - e. The number of plans participating in the Demonstration
- E. The State will ensure that the evaluator at least annually receives information indicating the primary care provider of record for each Demonstration Enrollee. The State will also have the capability to track beneficiary-level data on grievances, and appeals that identify the health plan and providers involved.

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