

Monday, April 16, 2012

Re: Posting of South Carolina's Dual Eligible (SC DuE) Demonstration) Draft Proposal for Public Comment

The South Carolina Department of Health and Human Services (SCDHHS) is pleased to announce the South Carolina Dual Eligible (SCDuE) Demonstration draft proposal is now available for public comment. This 30-day public comment period will begin at 5:00 PM Eastern on Monday, April 16, 2012, and end at 5:00 PM Eastern on Wednesday, May 16, 2012.

A specific effort has been made by SCDHHS to ensure stakeholders receive a variety of public comment opportunities. Interested persons can submit comments by mail, email, and a special online web form positioned directly on the SCDuE web site.

1. **E-mail** comments to comments@scdhhs.gov. Please include "South Carolina Dual Eligible Demonstration Proposal Draft Public Comments" in your email subject line.
2. **Mail** your comments to the following address:

SC Dual Eligible Proposal Public Comments
c/o Nathaniel Patterson
S.C. Department of Health and Human Services
P.O. Box 8206
Columbia, SC 29202

3. **The special online web form** is located on the SCDuE web site and can be accessed by entering the following URL in your web browser (<https://msp.scdhhs.gov/scdue/>).

Importantly, to advance the reach of this opportunity and request, the SCDHHS encourages the public to share this announcement with their collective memberships via web sites, email list serves, and other communication mediums.

The draft proposal will be submitted to the Centers for Medicare and Medicaid Services (CMS) on May 26, 2012. Please help us gather a broad range of public comments.

For assistance, please contact the SCDuE Project Director, Nathaniel Patterson, by email at pattnat@scdhhs.gov or telephone at (803) 898-2018.

State of South Carolina
Department of Health and Human Services

**Proposal to the
Center for Medicare & Medicaid Innovation**

**State Demonstration to Integrate Care
for Dually Eligible Individuals**

April 16, 2012

DRAFT for PUBLIC COMMENT



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A. Executive Summary

The South Carolina Department of Health and Human Services (SCDHHS) is one of 15 states with an 18-month planning grant from the Centers for Medicare and Medicaid Services (CMS) to develop a service delivery model that integrates care for individuals who receive services from both Medicare and Medicaid.

Demonstration

The South Carolina Dual Eligible (SCDuE) Demonstration Project provides the opportunity to address the weaknesses in the current system by realigning incentives to allow Medicare and Medicaid services to work in a single system. In addition, through shared savings, the State will be able to focus on preventative services and on delaying or eliminating the need for more costly institutional long-term care and avoidable hospital stays. Specifically, the State plans to do the following:

1. Encourage all providers to make significant progress towards becoming a certified Patient-Centered Medical Home (PCMH);
2. Ensure care coordination and planning by an interdisciplinary team with a focus on the needs of dual eligibles;
3. Provide a seamless system of care with access to physical health, behavioral health, and long-term supports and services (LTSS) with a consumer direction component for personal services;
4. Keep the home- and community-based waiver system outside of the capitated payment, but fully integrate it with the interdisciplinary team for care coordination and planning;
5. Ensure choice of plan within a robust network guided to select and enroll participants in a demonstration plan by an independent, conflict-free enrollment broker;
6. Commit to providing home- and community-based services for everyone in the Demonstration who meets service criteria with no waiting list; and
7. Commit to payment reforms that adequately address care management fee and cost sharing with providers meeting targeted goals.

Target Population and Geographic Service Area

This proposal will focus on full dual eligible South Carolinians 65 and older not residing in a nursing facility or enrolled in the Community Choices Home and Community Based Services (HCBS) Waiver or any of the five other waivers for adults at the time of enrollment in the Demonstration. At the time of the implementation the target population is expected to number approximately 68, 000 individuals meeting the eligibility criteria. The SCDuE implementation will divide the state's non-institutional full dual eligible population, age 65 and older, into four geographical regions with enrollment in the Demonstration occurring in three rollout phases (Figure 1). Phase 1 will occur in January 2014 in geographical regions III and IV. Phases II and III will occur in July 2014 and January 2015, respectively, for all dually eligible recipients. Statewide enrollment for all regions will occur in January 2015 for all meeting the dual eligible demonstration criteria. The proposed geographic rollout prioritizes regions with the highest proportion of non-institutional dual eligible beneficiaries while allowing for the development of comparable primary care and community-based and long-term care services for statewide implementation.

Financing Model

SCDuE will utilize the CMS Capitated Financial Alignment mechanism and will engage in three-way contracts between the federal government, the State and management entities. The management entity will be a coordinated and integrated care organization (CICO) that will be the primary vehicle for delivery and management of services for this Demonstration including extensive care coordination activities. Although during this Demonstration, HCBS waiver services are not included in the capitated rate, the PCMH care coordinator must ensure long term care assessment of needs and services are integrated into the care plan with specialists included as an integral part of the multidisciplinary team.

Summary of Covered Benefits

The SCDuE Demonstration will include a full continuum of Medicare and Medicaid services to members that are fully managed, coordinated and authorized through the CICO and its PCMH. LTCSs will be coordinated through the SCDHHS, Bureau of Community Long-Term Care.

Summary of Stakeholder Engagement/Input

Strategic planning, which included a team of private and public stakeholders and subject matter experts from across the health care services and public policy arenas, was initiated in July 2011 and continued through March 22, 2012. The engagement of stakeholders included formal meetings with work group members, conference calls, key informant interviews, and meetings of advocates and consumers.

Proposed Implementation Date(s)

The demonstration will start in January 2014.

B. Background

South Carolina is one of 15 states that received an 18-month planning contract from the Centers for Medicare and Medicaid Services (CMS) to develop a multi-phased design and implementation plan for innovative service delivery models that integrate care for individuals who receive services from both Medicare and Medicaid. The award to the South Carolina Department of Health and Human Services (SCDHHS) was effective in April 2011 with guidelines that have evolved over the last 11 months. SCDHHS is responsible for health plan, home and community-based, behavioral health, and long-term care services.

This proposal builds on key tenets of the SCDHHS Medicaid Coordinated Care Improvement Group (CCIG) to frame the approach for this Demonstration:

1. Coordinated care efforts should promote health by rewarding the delivery of quality, cost effective and affordable care that is patient-centered and reduces disparities while coordinating services across diverse providers.
2. Effective service delivery models must start by meeting individual patient needs in a holistic and seamless manner in the least intrusive environment.
3. Policies should encourage alignment between differing health care sectors to promote improvement and innovations guided by evidence-based practices.

4. System change must consider the perspectives of consumers, purchasers, payers, physicians, and other health care providers while fostering ways to reduce administrative costs.
5. System change must balance the need for urgency with realistic goals and timelines that take into account the need to change complex systems by achieving sustainable change.

i. Barriers to Address

South Carolina has few programs that coordinate care across Medicare and Medicaid funding streams. Contributing to this are financial disincentives for states to coordinate this care. Medicaid initiatives to reduce inpatient hospital stays will, if successful, reduce Medicare expenditures for dually eligible beneficiaries. Similarly, Medicare efforts to reduce institutional long-term care services benefit Medicaid programs much more than Medicare for duals.

In addition, while there are many positive components in the State Medicaid system, they tend to be isolated and not coordinated across long-term care, primary care and behavioral health services. There is very little systematic coordination of care so that information gathered in one area can be shared with other providers in developing and implementing treatment plans.

With the exception of the State's two Programs for All-Inclusive Care for the Elderly (PACE), there has been no effort to integrate long-term care services with primary care and behavioral health services. While the PACE programs have been successful, the two programs only cover four of South Carolina's 46 counties and provide care to only less than 500 beneficiaries. The State needs to develop programs that can provide this level of integrated care to a broader population on a statewide basis.

Finally, the home- and community-based waiver programs have been successful and have seen substantial growth in recent years. Waiver slots have increased and South Carolina has reduced the nursing home waiting list to historical low levels. This policy shift ranks South Carolina among the leaders in appropriate use of home and community based services. The Demonstration will continue this policy proven to result in less costly options in more restrictive care options for consumers.

The South Carolina Dual Eligible (SCDuE) Demonstration Project provides the opportunity to address the weaknesses in the current system by realigning incentives to allow Medicare and Medicaid services to work in a single system. In addition, through shared savings, the State will be able to focus on preventative services and on delaying or eliminating the need for more costly institutional long-term care and avoidable hospital stays. Specifically, the State plans to do the following:

1. Encourage all providers to make significant progress towards becoming a certified Patient-Centered Medical Home (PCMH);
2. Ensure care coordination and planning by an interdisciplinary team with a focus on the needs of dual eligibles;
3. Provide a seamless system of care with access to physical health, behavioral health, and long-term supports and services (LTSS) with a consumer direction component for personal services;

4. Keep the home- and community-based waiver system outside of the capitated payment, but fully integrate it with the interdisciplinary team for care coordination and planning;
5. Ensure choice of plan within a robust network guided to select and enroll participants in a demonstration plan by an independent, conflict-free enrollment broker; and
6. Commit to providing home- and community-based services for everyone in the Demonstration who meets service criteria with no waiting list.
7. Commit to payment reforms that adequately address care management fee and cost sharing with providers meeting targeted goals.

ii. Description of the Target Population

This proposal will focus on full dual eligible South Carolinians 65 and older not residing in a nursing facility or enrolled in the Community Choices Home and Community Based Services (HCBS) Waiver or any of the five other waivers for adults at the time of enrollment in the Demonstration. Those enrolled in the PACE program will be excluded from the target group. As determined by their individual needs, South Carolina will allow enrolled dual eligible residents to have full access to long-term care and nursing facility services. In calendar year (CY) 2009, approximately 65,400 persons are part of this proposed target population (see Table B.1.). This estimate is based on the CY 2009 Medicare 5% sample file.¹ Given projected growth in both the state population and the Medicaid eligible population by 2014, South Carolina expects the target population to number approximately 68,000 at the time of implementation.²

Table B.1. Target Population for SCDuE Demonstration, CY 2009

CY 2009	Total	Individuals Using Long-Term Care Services	Individuals Using Institutional Level Services	Individuals with No Long-Term Care Services
Target Population Individuals age 65 and older (% of target population) ³	65,400 (100%)	12,000 (18%)	10,500 (16%)	42,900 (65%)

¹ This sample file provides a representative sample of 5% of fee-for-service Medicare enrollees, excluding individuals in Programs of All-Inclusive Care for the Elderly (PACE) and managed care (Medicare Advantage) from this analysis. The dual population was identified through enrollment information indicating that the state pays the Medicare Part A and/or B premiums. Using the state buy-in indicator and the state of residence, the enrollment and claims information was extracted for CY 2007 through 2009.

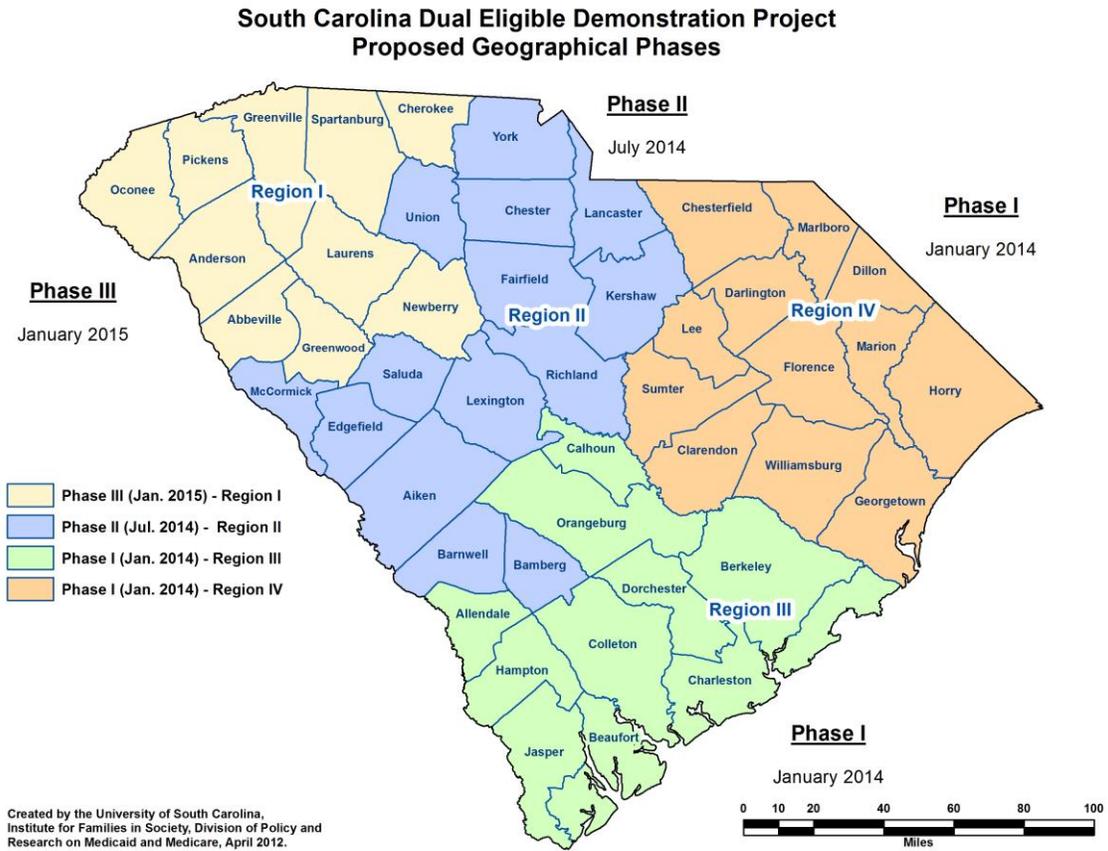
² This figure underestimates the population eligible for enrollment in the implementation. It is calculated using the South Carolina 2014 Census projections for individuals 65 and over divided by the three-year mean of the percent of the total population identified as dual eligible in CY 2007-2009. The projected target population will be updated, as data that is more current is available through the Data User Agreement between CMS and South Carolina. Current projections for South Carolina indicated a two to five percent growth of the South Carolina population aged 65 and above.

³ This population includes the numbers of individuals currently enrolled in a Medicare Advantage Plan eligible for enrollment under the proposed demonstration. Using available data from CMS, this numbers is approximately 17,760 or 27% of the target population.

Regional Geographical Distribution of DuE Implementation Population

The SCDuE implementation will divide the state’s non-institutional full dual eligible population, age 65 and older, into four geographical regions (See Figure 1).

Figure 1



These regions represent different geographical segments of the full dual eligible target population. Enrollment in the Demonstration will occur in three rollout phases (Figure 1). Phase 1 will occur in January 2014 in geographical regions III and IV. Phases II and III will occur in July 2014 and January 2015, respectively, for all dually eligible recipients. Statewide enrollment for all regions will occur in January 2015 for all meeting the dual eligible demonstration criteria. The proposed geographic rollout prioritizes regions with the highest proportion of non-institutional dual eligible beneficiaries while allowing for the development of comparable primary care and community-based and long-term care services for statewide implementation.

The target population represents a diverse group of individuals classified as dually eligible due to differing economic and medical needs. The Coastal area of South Carolina (Regions III and IV) has the fastest growing segment of the target population using HCBS. As a group, they have a

high prevalence of chronic conditions prior to movement into institutional level of care.⁴ In contrast, the Upstate (Region I) has the largest segment of the population qualifying for Medicaid services only upon eligibility into institutional level of care. The Midlands or Central South Carolina has a balanced population meeting Medicaid eligibility prior to and upon entry into institutional level of care.

Target Population Diagnostic Profile

Based upon CY 2009 claims and encounter data derived from the Medicare 5% sample file, South Carolina summarized the data by disease occurrence corresponding to the Chronic Illness and Disability Payment System (CDPS)-Medicare model diagnostic categories. Table B.2. provides a breakdown of the disease occurrence of the proposed target population.

Approximately 89% of this population was classified into a diagnostic category and risk status at the high and medium classification levels ranging from very low to very high projected disease burden costs.

Table B.2. Diagnostic Categorization Based Upon CY 2009 Claims and Enrollment Data – Medicare 5% Sample Files

CDPS-Medicare Diagnostic	Percent of Scored Recipients	Target Population
<i>Cardiovascular</i>		
Very High	0.4%	(179)
Medium	24%	(1074)
<i>Psychiatric</i>		
High	2.1%	(940)
Medium	3.9%	(1,746)
Medium Low	3.5%	(1,567)
<i>Skeletal</i>		
Medium	11%	(4,925)
<i>Central Nervous System</i>		
High	0.6%	(268)
Medium	2.6%	(1,164)
<i>Pulmonary</i>		
Very High	2.1%	(940)
High	1.1%	(492)
Medium	7.5%	(3,358)
<i>Gastrointestinal</i>		
High	1.8%	(805)
Medium	3.5%	(1,567)
<i>Diabetes</i>		
Type 1 High	0.6%	(268)
Type 1 Medium	10.7%	(4,790)
Type 2 Medium	5.4%	(2,417)
<i>Skin</i>		
High	4.5%	(2,014)
<i>Renal</i>		
Extra High	0.2%	(89)
Very High	15.0%	(6,716)
Medium	0.4%	(179)
<i>Cancer</i>		(671)

⁴ For purposes of this proposal, institutional level of care qualifies a recipient for nursing home placement or meeting medical nursing home criteria.

Very High	1.5%	(1,119)
High	2.5%	(850)
Medium	1.5%	
<i>Developmental Disability</i>		
Medium	0.2%	(89)
<i>Metabolic</i>		
High	1.0%	(447)
Medium	9.2%	(4,117)
<i>Infectious Disease (AIDS and Other Infectious Diseases)</i>		
High	0.5%	(223)
Medium	2.5%	(1,119)
<i>Hematological</i>		
Extra High	0.1%	(44)
Medium	1.3%	(582)
<i>Recipients</i>		
% Scored	88.7%	92%
Total (scored and unscored)	50,480	44,775

Table B.2. illustrates the diverse diagnostic profile of the non-institutional subset of the target population with implications for acuity and care setting. Approximately 7% of the non-institutional target population presented with psychiatric primary diagnoses requiring the integration of services aimed at addressing their physical and behavioral health care needs. We anticipate this number will be proportionally higher for those above the age of 75 and those residing in a nursing home with diagnosis of dementia. This population will require a network of providers that can integrate behavioral health, home- and community-based, and long-term care services across a continuum of needs.

Analyses of the activities for daily living (ADL) indicates approximately 31% of the population aged 65 and above require assistance with two or more ADLs (Table B.3.). This data distribution captures the Current Population Surveys' Annual Social and Economic Supplement membership information from the 5% sample. It extrapolates to the total population above the age of 65, suggesting a higher prevalence of ADLs associated with the full dual eligible Demonstration target population. South Carolina's level of care of care (LOC) designations are robust and would require meeting several of the ADLs to qualify at the nursing home level.

Table B.3. Activities for Daily Living Distribution–Dual Age Population

<u>Number of ADLs⁵</u>	<u>Dual Age 65+</u>	
0	40,040	55.0%
1	10,192	14.0%
2	10,920	15.0%
3+	11,648	16.0%
<u>No Answer</u>	<u>-</u>	<u>0.0%</u>
Total	72,800	100.0%

Service Utilization and Costs

Service utilization per 1,000 by age groups differs for the target population as a function of residential setting (Table B.4).⁶ In the non-institutional setting, the use of nursing home, inpatient hospital, emergency department, and home health services increases with advancing age. Conversely, behavioral service utilization is highest for the non-institutional population under the age of 74 regardless of the residential status. The data supports the need for an integrated continuum of care encompassing enhanced medical, caregiver support, integrated behavioral, home- and community-based, and nursing home services.

Predictably, the service utilization per 1,000 for the institutional population is higher for nursing home, inpatient hospitalization, durable medical equipment, and laboratory services with lower use of behavioral health services (Table B.5). Preliminary analysis of historical Medicare Part D data indicated the institutional population ages 65 and above has the highest PMPM pharmacy claims (\$456) compared to younger disabled (\$423) and non-institutional aged (\$315) categories.

⁵An ADL is defined as an affirmative answer to each of the following questions from the 2011 Annual Social and Economic Supplement to the Current Population Survey (ASEC).

Is...deaf or does...have serious difficulty hearing?

Is...blind or does...have serious difficulty seeing even when wearing glasses?

Because of a physical, mental, or emotional condition, does...have serious difficulty concentrating, remembering, or making decisions?

Does...have serious difficulty walking or climbing stairs?

Does...have difficulty dressing or bathing?

Because of a physical, mental, or emotional condition, does...have serious difficulty doing errands alone such as visiting a doctor's office or shopping?

⁶ Institutional claims do not include short stays at a skilled nursing facility.

Table B.4. Service Use Patterns for Non-Institutional Population by Age Group

Calendar Year 2009 - 5% Sample Extrapolated to 100%

Non-Institutional Population:		Ages 65-74				Ages 75-84				Ages 85+			
		Member Months:		264,880		Member Months:		213,140		Member Months:		139,260	
Service Category	Utilization per 1000	Cost per Service	Allowed PMPM	Paid PMPM	Utilization per 1000	Cost per Service	Allowed PMPM	Paid PMPM	Utilization per 1000	Cost per Service	Allowed PMPM	Paid PMPM	
Medical/Surgical	4,248.6	\$1,452.30	\$514.18	\$467.42	4,572.8	\$1,328.23	\$506.14	\$459.76	3,767.3	\$1,421.54	\$446.28	\$404.98	
Nursing Home	3,796.4	399.20	126.30	97.39	8,411.4	386.61	270.99	210.05	9,816.5	390.53	319.47	248.55	
Mental Health/ Substance Abuse	186.7	825.11	12.83	11.83	171.2	656.53	9.36	8.46	31.0	916.08	2.37	1.91	
<i>Inpatient-Subtotal</i>	8,231.7	952.39	653.31	576.63	13,155.3	717.43	786.50	678.26	13,614.8	677.01	768.12	655.44	
Outpatient Services													
Emergency Room	831.8	230.34	15.97	12.06	918.8	217.02	16.62	12.63	663.5	252.70	13.97	10.58	
Surgical	437.6	1,092.65	39.85	30.48	362.6	1,163.16	35.14	27.80	210.3	1,312.05	22.99	17.94	
Radiology/Pathology/ Lab	2,448.2	216.35	44.14	34.67	2,618.0	148.88	32.48	26.35	2,979.8	114.67	28.47	23.65	
Therapy	328.9	661.65	18.13	14.42	538.2	769.53	34.52	27.47	698.0	757.07	44.03	35.07	
Other	4,061.0	144.66	48.95	37.73	3,452.4	125.85	36.21	27.74	2,542.0	101.19	21.44	16.28	
<i>Outpatient-Subtotal</i>	8,107.5	247.24	167.04	129.36	7,890.0	235.69	154.96	121.99	7,093.5	221.45	130.91	103.52	
Home Health and Hospice													
Surgical	3,305.3	139.46	38.41	30.30	3,534.6	111.58	32.86	25.69	3,277.9	96.66	26.40	20.52	
Anesthesia	6,343.4	11.86	6.27	4.91	6,043.4	9.50	4.78	3.75	3,801.8	10.83	3.43	2.71	
Office Visits	8,373.9	72.55	50.63	36.54	7,795.4	70.62	45.88	33.16	5,995.7	71.93	35.94	25.81	
Hospital Visits	7,881.0	69.66	45.75	35.84	9,987.8	65.44	54.46	42.11	11,374.4	66.99	63.50	47.52	
Emergency Room Visits	1,345.5	106.05	11.89	9.16	1,555.0	106.34	13.78	10.76	1,237.4	114.71	11.83	9.24	
Immunizations	654.2	14.35	0.78	0.78	656.5	14.50	0.79	0.79	556.7	14.89	0.69	0.67	
Hospice	2,376.6	164.11	32.50	32.50	7,459.9	147.49	91.69	91.69	15,794.9	146.71	193.11	193.11	
Home Health	3,963.2	194.97	64.39	64.37	5,474.7	193.93	88.47	88.34	5,325.3	293.65	130.31	130.23	
Radiology/Pathology/ Laboratory	24,717.6	23.75	48.92	41.36	24,630.6	20.57	42.22	35.87	19,913.8	18.79	31.18	6.47	
Therapy	1,531.3	22.85	2.92	2.29	497.7	20.81	0.86	0.66	394.7	23.49	0.77	0.62	
Mental Health	453.0	56.83	2.15	1.23	212.8	62.48	1.11	0.69	155.1	59.22	0.77	0.46	

Table B.4. Service Use Patterns for Non-Institutional Population by Age Group

Calendar Year 2009 - 5% Sample Extrapolated to 100%

Non-Institutional Population:		Ages 65-74		Member Months: 264,880		Ages 75-84		Member Months: 213,140		Ages 85+		Member Months: 139,260	
Service Category	Utilization per 1000	Cost per Service	Allowed PMPM	Paid PMPM	Utilization per 1000	Cost per Service	Allowed PMPM	Paid PMPM	Utilization per 1000	Cost per Service	Allowed PMPM	Paid PMPM	
Other	145,428.0	4.51	54.61	43.13	81,584.7	4.64	31.53	24.74	20,658.3	9.84	16.94	13.18	
<i>Professional-Subtotal</i>	206,373.0	20.89	359.22	302.40	149,433.0	32.80	408.45	358.24	88,486.0	69.83	514.88	470.55	
Dental	-	0.00	0.00	0.00	3.4	0.00	0.00	0.00	-	0.00	0.00	0.00	
Vision	840.8	57.08	4.00	2.78	1,072.0	54.53	4.87	3.43	797.9	59.00	3.92	2.85	
Hearing/Speech	57.1	21.20	0.10	0.07	32.7	30.46	0.08	0.06	44.8	31.51	0.12	0.09	
Durable Medical Equipment	73,667.2	9.96	61.12	47.65	101,657.1	6.47	54.80	42.81	98,118.1	5.81	47.47	36.96	
Ambulance	2,267.0	162.70	30.74	24.38	4,140.4	157.33	54.28	43.09	4,560.1	150.64	57.24	45.30	
Other	1,488.7	9.50	1.18	0.91	1,164.3	7.30	0.71	0.54	770.4	3.41	0.22	0.16	
<i>Other-Subtotal</i>	78,320.7	14.88	97.14	75.79	108,069.8	12.74	114.75	89.92	104,291.3	12.54	108.97	85.36	
	301,032.9	\$50.89	\$1,276.71	1,084.19	278,548.2	\$63.10	\$1,464.66	1,248.42	213,485.6	\$85.60	\$1,522.88	1,314.87	

Table B.5. Service Use Patterns for Institutional Population by Age Group

CY 2009 – 5% Sample Extrapolated to 100%

Institutional Population:	Ages 65–74				Ages 75–84				Ages 85+			
	Member Months:	14,400	Member Months:	32,600	Member Months:	35,700	Member Months:	35,700				
Service Category	Calendar Year: 2009				Calendar Year: 2009				Calendar Year: 2009			
	Utilization per 1000	Cost per Service	Allowed PMPM	Paid PMPM	Utilization per 1000	Cost per Service	Allowed PMPM	Paid PMPM	Utilization per 1000	Cost per Service	Allowed PMPM	Paid PMPM
Medical/Surgical	1,600.00	\$1,972.00	\$262.93	\$242.17	3,143.60	\$1,022.16	\$267.77	\$241.20	2,769.70	\$1,603.39	\$370.08	\$333.01
Nursing Home	12,833.30	354	378.59	267.89	13,185.30	353.66	388.59	282.86	14,702.50	365.81	448.19	338.17
Mental Health/ Substance Abuse	566.7	733.77	34.65	31.68	162	676.54	9.13	8.48	-	0	0	0
<i>Inpatient–Subtotal</i>	15,000.00	540.94	676.17	541.74	16,490.80	484.26	665.49	532.54	17,472.30	561.99	818.27	671.19
Emergency Room	666.7	280.38	15.58	12.03	625.8	267.02	13.92	10.8	517.6	266	11.47	8.52
Surgical	216.7	2,531.07	45.7	35.92	184	692.66	10.62	8.19	147.9	1,086.48	13.39	10.26
Radiology/Pathology/Lab	5,533.30	57.78	26.64	23.87	4,012.30	96.66	32.32	26.88	4,349.60	72.87	26.41	22.71
Therapy	1,966.70	933.84	153.05	121.98	1,796.30	853.7	127.79	101.56	1,727.70	722.12	103.97	82.71
Other	2,333.30	74.13	14.41	11.36	1,936.20	92.75	14.97	11.79	1,821.80	91.5	13.89	10.89
<i>Outpatient–Subtotal</i>	10,716.70	285.96	255.38	205.16	8,554.60	280.02	199.62	159.21	8,564.70	236.98	169.14	135.1
Surgical	4,066.70	71.21	24.13	18.85	4,461.30	62.35	23.18	17.64	3,919.30	71.34	23.3	17.96
Anesthesia	5,383.30	5.6	2.51	1.99	2,547.20	6.71	1.42	1.14	2,104.20	14.93	2.62	1.99
Office Visits	1,916.70	79.49	12.7	9.53	2,208.60	86.72	15.96	11.88	1,835.30	79.05	12.09	9.16
Hospital Visits	16,566.70	59.1	81.59	57.98	17,580.40	60.3	88.34	64.86	17,183.20	62.66	89.72	63.75
Emergency Room Visits	1,233.30	107.15	11.01	8.26	1,089.60	126.5	11.49	8.91	995	117.28	9.72	7.58
Immunizations	-	0	0	0	29.4	8.53	0.02	0.02	33.6	14.9	0.04	0.04
Hospice	183.3	205.18	3.13	3.13	1,568.10	152.94	19.99	19.99	1,122.70	213.43	19.97	19.97
Home Health	366.7	195.29	5.97	5.93	265	316.89	7	6.84	114.3	350.87	3.34	3.26
Radiology/Pathology/ Laboratory	25,250.00	15.63	32.89	28.63	27,533.70	17.75	40.73	34.59	23,885.70	16.96	33.75	28.78
Therapy	-	0	0	0	44.2	35.19	0.13	0.1	-	0	0	0

Table B.5. Service Use Patterns for Institutional Population by Age Group

CY 2009 – 5% Sample Extrapolated to 100%

Institutional Population:	Ages 65–74				Ages 75–84				Ages 85+			
	Member Months:		14,400		Member Months:		32,600		Member Months:		35,700	
Calendar Year: 2009					Calendar Year: 2009					Calendar Year: 2009		
Service Category	Utilization per 1000	Cost per Service	Allowed PMPM	Paid PMPM	Utilization per 1000	Cost per Service	Allowed PMPM	Paid PMPM	Utilization per 1000	Cost per Service	Allowed PMPM	Paid PMPM
Mental Health	616.7	69.13	3.55	2.25	360.7	59.58	1.79	1.12	349.6	55.53	1.62	0.83
Other	5,933.30	9.66	4.78	3.77	9,268.70	30.5	23.56	18.66	4,779.80	11.54	4.6	3.59
<i>Professional-Subtotal</i>	61,516.70	35.55	182.26	140.32	66,957.10	41.87	233.61	185.75	56,322.70	42.78	200.77	156.91
Vision	1,033.30	48.9	4.21	3.26	861.3	59.38	4.26	3.2	578.2	69.9	3.37	2.6
Hearing/Speech	83.3	30.76	0.21	0.17	22.1	32.49	0.06	0.05	33.6	22.49	0.06	0.05
Durable Medical Equipment	249,683.30	2.06	42.88	33.85	277,303.10	2.08	48.09	38.12	212,389.90	2.14	37.8	29.97
Ambulance	4,700.00	146.84	57.51	45.64	6,773.00	137.8	77.78	61.66	6,299.20	141.46	74.26	58.94
Other	183.3	0	0	0	301.8	0	0	0	235.3	0	0	0
<i>Other-Subtotal</i>	255,683.30	4.92	104.82	82.93	285,261.30	5.48	130.19	103.02	219,536.10	6.31	115.49	91.55
	342,916.70	\$42.64	\$1,218.63	970.14	377,263.80	\$39.09	\$1,228.92	980.51	301,895.80	\$51.82	\$1,303.67	1,054.75

C. Care Model Overview (CICO/PCMH)

i. Delivery Model/System/Programmatic Elements

SCDHHS's mission is to purchase the best health care for consumers enrolled in Medicaid for the least cost to South Carolina's citizens. Several current initiatives, including SCDuE are moving SCDHHS and the configuration of the State's Medicaid program toward improved health care, improved health and lower overall costs; therefore, it is important to coordinate these initiatives so that goals, processes and outcomes align for efficiency and effectiveness of the total system of care. Throughout the planning process, all stakeholder groups have expressed concern about ensuring access to appropriate services for consumers and valuing the strengths of the current system. They also have voiced support for an integrated and coordinated system of care for individuals who are dually eligible for Medicaid and Medicare and could benefit from the following core elements of an integrated system:

- Strong, person-centered care based in accountable primary care medical homes;
- Multidisciplinary care teams that use a "holistic approach" and coordinate the full range of medical, behavioral, and long-term supports and service needs across settings;
- Comprehensive provider networks capable of meeting that full range of needs;
- Enhanced use of home- and community-based long-term care services with access to institutional care as needed when all other options are exhausted;
- Robust data sharing and information systems to promote care coordination, monitoring and quality reporting;
- Strong consumer protections that ensure access to established providers and involve consumers in program design; and
- Financial alignment that supports integration of care, management of costs and incentives for improved quality care.
- Care management processes that reduce provider administration burden. As an example, the CCIOs will be encouraged to explore the automation of service plan and payment processes across providers.

SCDuE is being designed with an emphasis on a new and expanded form of coordinated and integrated care in South Carolina. It builds on evidenced-based practices and incorporates the principles of a patient-centered medical home model; increasing emphasis on primary and preventive care; applying best practices in care coordination and medical management with team-based care; emphasis on a holistic approach; increasing utilization of health information technology to support patient care, quality and safety; and payment structures that support the added value in this enhanced form of care.

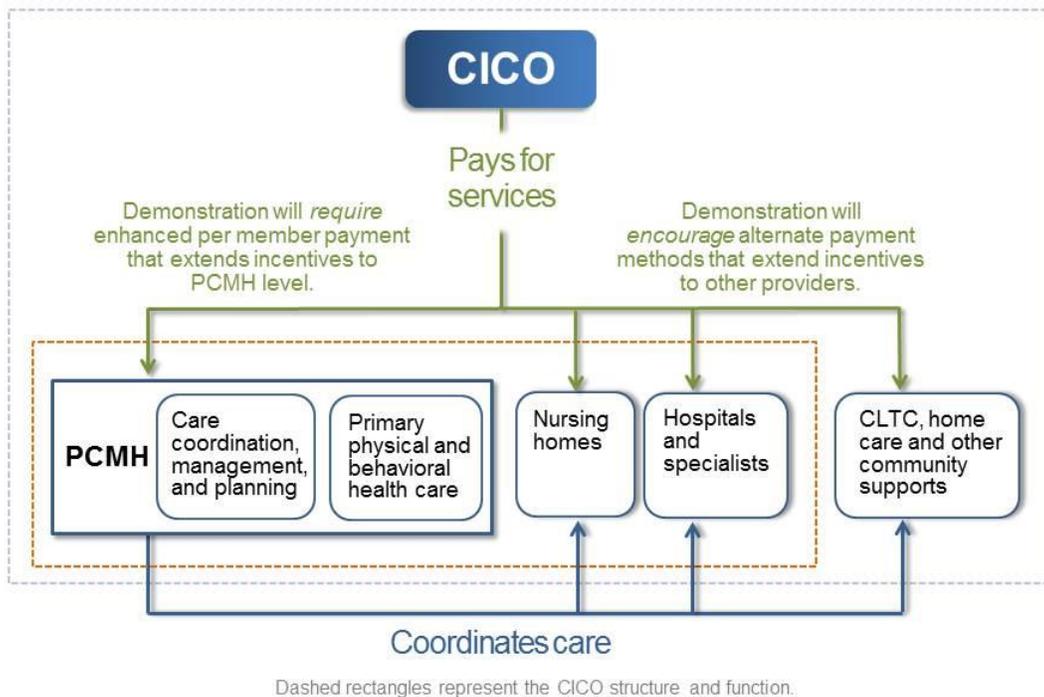
Coordinated and Integrated Care Organization (CICO)

SCDuE will utilize the CMS Capitated Financial Alignment mechanism and will engage in three-way contracts between the federal government, the State and management entities.

The management entity will be a coordinated and integrated care organization (CICO) that will be the primary vehicle for delivery and management of services for this Demonstration including extensive care coordination activities. For the purposes of this Demonstration, CICOs are organizations, e.g., Managed Care Organizations (MCOs) and Care Coordination Service Organization (CSOs), that can meet all applicable conditions that will be outlined in the Request for Information/Solutions (RFI/RFS) released in late Spring 2012, as well as requirements mutually established by the State and CMS that will be included in the procurement documents released in Fall 2012. At a minimum, organizations bidding to be a CICO must have the capacity to bear risk and to contract with a variety of providers to provide, arrange for, and/or coordinate the full continuum of services including primary and behavioral health care, specialists, hospitals, and institutional care (see Figure 2 for an illustration of the CICO proposed model). Although during this Demonstration, HCBS waiver services are not included in the capitated rate, the PCMH care coordinator must ensure that the LTSS assessment of needs and services are integrated into the care plan and that the long-term care specialists are included as an integral part of the multidisciplinary team.

Figure 2

Example of ICO Organizational and Financial Arrangement



Care delivery will be anchored in a patient-centered medical home, guided by a multidisciplinary care team, and tailored to plan for and address individual needs through enhanced care coordination. CICOs, therefore, must be capable of utilizing a care management model centered in a PCMH. They also will be required to demonstrate core competencies in PCMH, integrated care, behavioral health services, and LTSS as they will

need to facilitate and support the development of PCMH skills in some practices. Medical homes will be encouraged to achieve National Committee on Quality Assurance (NCQA) PCMH Recognition at Level 1 or higher within the Demonstration period. 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 develop alternative payment strategies (e.g., incentives) to encourage development of PCMH standards and certification.

Since HCBS are not incorporated into the capitated rate, the State must ensure that these services are coordinated and transparent to the consumer. In structuring services in this manner, the State seeks to build upon its existing infrastructure for providing LTSS and to coordinate those services with those provided by the CICO. This will allow the CICO to focus on developing medical homes and behavioral health networks across the state in the initial phase of the Demonstration. In making this decision, the State considered the following:

- Since 2007, South Carolina has served more people in Community Choices, the waiver for the elderly and persons with physical disabilities, than are served under Medicaid sponsorship in nursing facilities. This emphasis on HCBS continues to grow, with ongoing gubernatorial and legislative support in continuing to add slots to the waiver program. South Carolina's recent reactivation of its Money Follows the Person (MFP) Grant is further indication of this commitment to rebalancing its Medicaid long term care services.
- Services in the waiver cover a wide range of areas, including traditional HCBS, such as personal care and adult day care, and a more innovative technology-based service, telemonitoring, which provide web-based daily reporting on vital signs to medical professionals.
- These services are provided by a large number of enrolled and contracted Medicaid providers. Community Choices is able to offer service choices even in the most rural areas of the State.
- South Carolina has been a national leader in using electronic technology to support HCBS. The State currently has two well-developed software systems, *Phoenix* and *Care Call*, that provide automated support for waiver operations. (See Appendix C and D for a full description of these systems). These integrated systems provide support for all components of the long-term care waiver operation, from initial assessment through documentation and billing of services. Both systems have been cited by CMS as best practices. Together, they provide electronic records for all waiver assessments, care plans, service authorizations, provider information, service delivery documentation, caregiver support systems, real time monitoring of service provision, and numerous other components of support for administration, case management and quality assurance activities.
- South Carolina has a well-established, self-directed care component in most of its waiver programs. Many family members and informal supports serve as paid caregivers under these programs. Financial management services are integrated into the *Care Call* and *Phoenix* systems to ensure quick and accurate payment to caregivers and for monitoring service provision.

- The target population for this demonstration is consumers not currently in a waiver program or a nursing facility. While it is anticipated that a number of enrollees will develop the need for LTSS, most of the consumers will not need these services for some time. This allows the CICOs to focus on preventive efforts to delay the need for long-term care services, especially institutional care.

Even though South Carolina has provided waiver services since it was one of the initial HCBS Demonstration states in the late 1970s, these services have not been well-coordinated with primary care and behavioral health services. The State is committed to developing a system that will provide this coordination in a way that is seamless and transparent to beneficiaries and ensures that information is shared in a timely manner to support integrated efforts and enhanced services. Most importantly, this Demonstration will provide for the coordination between HCBS and the CICO in order to remove any barriers to accessing waiver or nursing facilities services. The following steps will be taken to meet this assurance:

1. Whenever there is an indication that LTSS are needed, the CICO will be given secured access to *Phoenix* in order to make an electronic referral. From this point forward, the CICO will be able to view all Community Choices records related to this consumer.
2. SCDHHS will contact the consumer and conduct a brief phone assessment. An appointment for an in-home assessment will be scheduled at this time.
3. Contingent upon the results of the assessment and level of care screening, the consumer will be admitted to the waiver program. A waiver case manager and where appropriate, an MFP transition coordinator will work with this consumer in developing a care plan and authorizing waiver services for integration into the overall plan of care. All referrals received will be processed without regard to a waiting list so that services can be initiated as soon as the eligibility determination is completed.
4. With regards to the Home Again Program (i.e. Money Follows the Person (MFP)), in collaboration with the waiver case manager and the CICO, the MFP transition coordinator will connect with consumers seeking assistance transitioning from an institutional setting to one that is community-based.
5. All waiver services will be documented using the State's *Care Call* system.
6. The CICO/PCMH care coordinator will be able to access all waiver records. these will include all assessments conducted for the waiver enrollment, care plans created, services authorized, documentation of service delivery, family and other caregiver (including stress assessments of key caregivers) information, annotation of all prescription and over-the-counter medications as documented during in-home visits, and assessments of environmental conditions and other key data. All of this information will be available in a timely manner to members of the care coordination team. Electronic notifications will be made to the care coordinator whenever updates are made to the *Phoenix* records.
7. SCDHHS is also implementing a system whereby personal care and day care providers will be able to report electronically any changes in the waiver

participant's conditions or significant events that result in updating the care plan. It is often the in-home providers, such as the personal care workers, who see the participant on a daily basis and are best able to identify critical changes (i.e., weight gain/loss, changes in cognitive behavior, etc.) and events (i.e., falls, hospitalization, significant caregiver illness or debility, etc.). Reporting this information will become a part of the *Care Call* documentation of services.

8. Finally, the waiver case manager will serve on the care management team and be available to provide input into any long-term care related services. The case manager will also be available to assist in incorporating the waiver service plan into the overall care plan. When the CICO becomes aware of changes that would affect the level of services needed, the case manager will receive this information and make necessary updates to reflect both short- and long-term changes in the consumer's condition. By having the case manager as part of the team, the State assures continuity of care and that services that are transparent to the beneficiary. This process also assures that someone outside of the CICO will be responsible for authorizing the needed levels of services. Waiver case managers who participate on the care management team will receive additional training in holistic care integration and must demonstrate the skills necessary to be a contributing member to this team.

The State understands that the CICO will need to maintain financial incentives to reduce nursing facility placements. The State does this by including nursing facility care in the package of coverage provided by the CICO. This aligns the financial interests of the CICO and the State in providing nursing facility care when needed, but only when other home-based options are not sufficient to sustain the consumer in safest, less restricted setting.

Currently, there are 150 Medicaid contracted nursing facilities in South Carolina. The state has a Medicaid Permit Day law which specifies how patient days are allocated to facilities. The state has not funded any new Medicaid permit days in over twelve years. In February, 2012, CMS approved an enhanced nursing facility rate for persons who have complex medical conditions. This sub-acute level of care was developed to provide reimbursement for a higher acuity level for hospitalized persons who were having difficulty being placed in a nursing facility.

Since July, SC DHHS has initiated a collaborative effort between hospitals and nursing facilities to monitor the bidirectional flow of residents to and from these two facility types. The goal is to ensure timely access to nursing facility care and to avoid preventable and unnecessary readmissions from nursing facilities to hospitals.

Once admitted to a nursing facility, it is the intent of this demonstration that the CICO will continue to provide care coordination to avoid unnecessary medical costs such as hospitalizations and prescription drugs. Care coordination will also be used to determine if the nursing facility resident can appropriately be transitioned back to the community.

Geographic Service Area

The SCDuE will operate statewide serving a population of approximately 66,000 full dual eligibles, age 65 and older by open enrollment in 2013. . This population was selected because it builds on the efforts of current coordinated care initiatives to address chronic conditions, the integration of behavioral health services in managed care, and a strong independent HCBS system. The statewide geographical area will ensure sufficient enrollees to guarantee access to care and choice of plans across all 1 regions of the state. Organizations will be selected to ensure that consumers have the choice statewide of at least two CICOs. Although SCDuE will begin implementation on a regional basis, enrollment will be expanded statewide by January 2015. Selected CICOs must demonstrate the capacity to serve the entire state within that timeframe. See pages 5-6 for a more detailed discussion on the state geographical service area and proposed phase-in of the Demonstration.

Enrollment Methods

Enrollment will occur in three phases (see Figure 1–page 5). Enrollment in Phase I will begin in October 2013 in the coastal regions (Region IV and III) with start-up of the Demonstration in January 2014. Phase II will start enrollment in July 2014 and continue through December 2014 for newly certified full dual eligible residents. Phase III will start enrollment for the Upstate, achieving statewide participation by January 2015. Enrollment protocols and network certification will be complete at least three months prior to the enrollment in each of the proposed three phases to help prevent disruption of access to care. The Enrollment Broker will advise consumers in selecting the best SCDuE plan based on existing relationships with service providers and identified health care needs.

The SCDuE Demonstration proposes a passive enrollment process in which the consumer may choose to opt out before the end of a 90-day trial period. This voluntary opt-out enrollment process will provide eligible individuals with the opportunity to choose the integrated and coordinated care service delivery options. However, if no choice is made, individuals will be passively enrolled into one of the CICOs with the opportunity to opt-out before the end of the 90 day trial period. Unless indicated for medical reasons, the CICO will provide appropriate care during this period, and any enrollee already receiving services via Medicaid or Medicare will not experience any reduction to his or her service plan or changes to providers or pharmaceuticals during that time period. Consumers who do not opt out before the end of the trial period will continue to receive services through the CICO. All consumers will have an annual opportunity to disenroll from the program.

Ensuring sufficient enrollment is a key aspect in developing an improved service delivery system and offering consumer choice of CICOs with adequate provider networks. Redesigning the complex system of care so that it integrates and coordinates services to address the needs of the “whole person” is tremendously challenging and only will occur if there is a critical mass ready to use the better system. The opt-out enrollment option provides choice for the consumer. Passive enrollment with the “opt-out” feature balances the need for consumer choice with the need for sufficient enrollment (lock-in period). This system moves consumers into coordinated and integrated care to provide a sufficient

number of enrollees necessary to support a robust provider network and care coordination system. CICOs will be encouraged to include additional benefits that will encourage consumers to choose the coordinated and integrated care delivery option and develop consumer loyalty so they continue participation once enrolled.

Outreach and Marketing

Ensuring consumers receive timely and accessible information on the network and covered services changes and their options will be an essential part of the enrollment process. Clear and transparent access to unbiased information is crucial to ensuring consumers have the opportunity to make informed decisions. To simplify the process, SCDuE's enrollment will be integrated with the Enrollment Broker process for SC Medicaid so that the access is seamless, easy to identify and encompasses the needed beneficiary protections which are discussed further in Section D (page 28). This process will ensure consumers have advance notice with an upfront option for opting out. The Enrollment Broker will develop easy to understand materials in appropriate and alternative formats that meet the needs of the target population (e.g., low reading level, alternative language, or visual challenges).

Each CICO will be required to develop a comprehensive marketing plan and submit it to the State and CMS for approval. All materials for dissemination to potential enrollees or the public must first be approved by the State and CMS to ensure accuracy.. The State will actively promote the benefits of this Demonstration and will work with advocacy and community organizations, members of the Integrated Care Workgroup (ICW), the Lt. Governor's Office on Aging and its network of Aging and Disability Resource Centers and the State Health Insurance Program (SHIP) as outreach and education partners to provide information, education and referral to their constituencies to ensure awareness and understanding of the benefits of the program.

Provider Network Adequacy and Access

CCIOs must demonstrate the availability of an adequate provider network as defined by SCDHHS and CMS for this population. SCDHHS will require CICOs to establish and maintain a network of providers, either directly or through subcontracts, that assures access to all population-appropriate Medicaid and Medicare benefits, as well as to any supplemental benefits covered in this Demonstration. The networks must include a broad array of providers including primary care providers, specialists, hospitals, care coordination providers, community health workers, behavioral health providers, pharmacies, and providers of both institutional, in-home long term care services. Options for integrating specialists who can be deemed as primary care providers (such as cardiologists or other specialists that the beneficiaries utilize to coordinate their care), as well as the traditional primary care providers such as general and internal medicine practitioners, will be explored with CMS.

To ensure continuity of care and eliminate barriers to consumer choice of the CICO, SCDHHS will require CICOs to conduct outreach to recruit current medical and behavioral health providers of eligible beneficiaries. Provisions must also be made to continue existing out-of-network relationships in cases where a person is undergoing

active treatment for a specific condition. The CICO must pay the provider during the course of treatment until the provider releases the beneficiary from continued treatment and follow-up. CICOs must ensure that providers in their networks have demonstrated expertise with complex geriatric populations, will accept new Medicaid/Medicare patients, and are multi-lingual and culturally relevant to their communities. The CICO must establish provider networks that meet the standards for provider access in federal Medicaid managed care regulations, access for long-term care services, and Medicare access standards for medical services and prescription drugs. They must ensure access to continuous and appropriate care as well as the level of care needed to avoid an inappropriate disruption in services (e.g. rehabilitation). In providing these services, the CICO and providers must comply with the Americans with Disabilities Act (ADA). CICOs must work with providers to demonstrate the capacity to deliver services in a manner that accommodates the unique needs and disabilities characteristic of this population.

CICOs will be required to continuously monitor network adequacy and adherence to access requirements. They will provide monthly reports to SCDHHS in a format to be designated. In addition, the CICO will conduct a formal status briefing in a pre-determined format to both SCDHHS and any interested party on a quarterly basis and will allow for public input at these meetings. CICOs will analyze their network adequacy on a quarterly basis and immediately identify gaps and develop recruitment strategies to fill those gaps. This gap analysis is designed to identify the reasons for the gaps in networks and corrective strategies to address access to care. CICOs will be responsible for managing their networks including providing appropriate provider education, provider credentialing, establishing and tracking quality improvement goals, conducting site visits and medical records reviews. The CICOs are responsible for establishing incentives with providers to improve health outcomes. In addition, the CICOs will audit a certain percentage of medical records each quarter to ensure the providers are maintaining the medical records as required.

ii. Benefits Design

The SCDuE Demonstration is designed to significantly enhance the individual's experience with the entire health care system. It will provide seamless and integrated access to a robust package of services that includes all physical health services (acute and primary), behavioral health and addictive disorder services, and long-term care services that are covered by either Medicare or Medicaid. These services will be integrated using a care coordination model that is intended to fundamentally transform the manner in which health care is provided to persons who are dually eligible, particularly those with more complex care needs.

The CICOs will be encouraged to offer supplemental benefits currently not covered or that are limited in existing benefit packages. Offering expanded benefits or additional support services has shown to influence consumers' choices in voluntary managed care, particularly the availability of those that address critical needs that are often paid out of pocket. The CICOs also will be responsible for coordinating referrals to other existing non-covered services, such as other social and community-based services to support integrated community living.

Patient-Centered Medical Home (PCMH)

CICOs must ensure that each member chooses (or is enrolled in) a medical home that will provide integrated primary and behavioral health care and will be responsible for providing access to and coordinating comprehensive medical care including routine screenings for physical and behavioral health conditions, prevention and wellness, disease management, and acute care. The medical home, supported by a multidisciplinary team inclusive of waiver case management and health information technology, will coordinate care across the continuum of services based on a consumer's risk level and needs. Through its care coordination function, the PCMH will develop an ongoing relationship with the consumer and engage the family informal caregiver supports in the multidisciplinary care team functions including care planning, care compliance, and educational opportunities.

Care Coordination

Care coordination is at the center of South Carolina's integrated care model. CICOs will be required to ensure care coordination is provided for all members. Stakeholders provided significant input into the design of the care coordination model for SCDuE and identified the following key components:

- Comprehensive needs assessment and assignment of each consumer to a risk group (including caregiver assessment for high risk individuals, e.g., Alzheimer's, complex physical and/or medical needs);
- Goal setting and developing and periodically updating the individualized care plan;
- Coordinating primary, acute, specialty, behavioral health, and long-term care;
- Assisting the beneficiary in negotiating the medical care, behavioral health, long-term care, and community service system;
- Managing service utilization (including averting hospitalizations, re-admissions, emergency room visits, and nursing facility stays to include the transition from institutions to community setting)⁷;
- Reconciling medications prescribed and adherence to the medication regimen;
- Making regular contact with beneficiary (amount varies with risk level) for monitoring purposes;
- Making home visits to high risk beneficiaries with a "boots on the ground" approach;
- Scheduling and reminders of appointments;
- Providing beneficiary/caregiver education including information about treatments, regimens and services;
- Planning for and coordinating transitions between care settings (e.g., discharge planning from hospital to rehabilitation, hospital/rehabilitation to home, or hospital/home to nursing facility);
- Medical and behavioral health support available telephonically 24/7;
- Financial flexibility to furnish needed services; and

⁷ Money Follows The Person (MFP) Grant Program

- Secure, centralized health records accessible to all authorized parties and providers.

Multidisciplinary Team

The PCMH care coordination will be supported by a multidisciplinary team that will guide assessment, development of the care plan, and coordination of services. The team will be led by a care coordinator with the enrollee at the center of the process and will include varying members depending on the enrollee's specific needs. Additional team members may include primary care physicians, behavioral health specialists, long-term care specialists or waiver case managers, MFP⁷ transition coordinator caregivers/informal supports, therapists, community health workers, discharge planners, pharmacists, nutritionists, and other supporting professionals. Depending on the primary needs of the enrollee, the behavioral health specialist or LTC specialist may play a more central role in the coordination services. In smaller and/or rural practices where all disciplines are not required full-time, the CICO will provide needed clinical support through virtual participation of such disciplines as pharmacy, nutrition, assistive technology, etc.

Assessment

Medical Home: Each enrollee will receive a comprehensive physical health exam and behavioral health screening to identify risks, needs for care coordination and services, preferences, and priorities. The assessment will identify chronic conditions; severity levels; gaps in care; and opportunities for reducing avoidable ER visits, inpatient hospitalization, and institutional care. For consumers who are enrolled in the Community Choices waiver, the LTC assessment information will also be accessible through the Phoenix system. Based on the findings, the enrollee and the care team will develop a care plan that addresses the enrollee's needs and identifies strategies to meet those needs.

Long-Term Care: As functional needs and/or institution to community transition services are identified by the medical home, the LTC care coordinator will coordinate a referral to the State for a level of care assessment and identified services. Under this Demonstration, the State will continue to complete the level of care assessment for LTSS. As the need for LTC assessment is identified, the enrollee will receive a screening, and when appropriate, a comprehensive level of care assessment in the home. Enrollees will not be subject to waiting lists for services, but will be assessed with prompt service initiation shortly after needs are identified. The LTC case manager will take the lead on coordinating LTC services and supports and ensure that they are integrated into the PCMH care plan. Medical, health, pharmacy, and behavioral health information will be obtained through the assessment will be incorporated by the care coordinator into the medical record for medical management, other care management and sharing with other providers as appropriate.

Care Plan: The comprehensive care plan will guide the treatment and service delivery for all enrollees, particularly those who are identified through the assessment process as having complex care needs that require intensive coordination of services, monitoring, and follow-up. The care plan will be person-centered and will identify all service needs, planned interventions, and timeframes for completing actions to ensure access to quality

care. The care plan will identify enrollee and family health issues, behavioral health, and long-term care educational needs to promote wellness, chronic condition self-management, and information that will help the enrollee continue to remain in the community. The care plan will be reviewed at minimum quarterly and updated as significant care needs occur.

Clinical Care Management: Additionally, the PCMH is responsible for providing clinical care management to members whose care complexity requires intensive clinical monitoring and follow-up. This may include consumers who have one or more chronic health conditions, both physical and behavioral health conditions, multiple prescription medications, or those who are assessed to be at high risk for emergency department use, hospital admission or nursing facility admission. Clinical care management should address:

- Assessment of clinical risks and needs;
- Medication review and reconciliation with adjustments based on evidenced-based best practices; and
- Enhanced service needs (e.g. coaching, family training and support) for consumer self-management of complex and chronic conditions.

Integrated Health Information Technology and Exchange: The current state of health information technology and exchange in South Carolina’s primary care practices is both in development and transition. The combination of the movement to meet the requirements of meaningful use as well as the trend for hospitals to purchase community-based medical practices has caused many changes in electronic health records at the practice level. Although many resources (e.g., HITECH, MU incentives) are available, the capacity for fully integrating electronic health records and sharing of health information varies significantly across the state. Stakeholders agree that this is a critical component for fully integrating care across all delivery systems. The State will require the CICO to work with the PCMHs over the course of the Demonstration to develop the capacity to have an electronic health record system that allows the secured sharing of information across providers and between contractors. The CICO must support the PCMH care team in linking with the State’s LTC electronic care management systems (*Phoenix* and *Care Call*) described in Appendices C and D.

a. Covered Services

The SCDuE Demonstration will include a full continuum of Medicare and Medicaid services to members that are fully managed, coordinated and authorized through the CICO and its PCMH.LTCSs will be coordinated through the SCDHHS, Bureau of Community Long-Term Care. Details of these services are outlined below.

Medicare and Medicaid State Plan Services

All Medicare covered services (Part A – inpatient, hospice, home health; Part B – outpatient; and Part D – pharmacy) and Medicaid state plan services for adults will be included in the capitated payment to the CICO. See Appendix E for a complete list of services.

Integrated Behavioral Health Services

CICOs will be required to facilitate integration of behavioral health and primary care practices by developing a broad behavioral health provider network and implementing strategies to support integration (e.g., co-location, formalized communication, data sharing) by including contract language that requires organizations to work collaboratively and provides incentives and education to facilitate that process. The state will continue work with CMS to determine what additional services will be carved-in to the capitated rate based on the comment period or reflected in federal policies

LTSS (Community, Waiver, Nursing Facility Services)

SCDuE will make available all long-term care services currently included in the Community Choices HCBS Waiver and nursing facility services to those meeting level of care eligibility. As noted, the waiver services are not part of the capitated rate. A detailed list of these services is provided in Appendix B. The state will continue to assess level of care and determine eligibility for these services. Members who are assessed after enrollment and meet the state's criteria will have access to community based and nursing facility services as appropriate. As part of the Demonstration, the state will determine with CMS what LTC services will be carved-into the rate. The state will also explore with CMS the ability to provide enhanced services (e.g., home delivered meals, homemaker services and adult day care) to members based on risk level prior to their meeting NF level of care criteria.

Long-Term Care (LTC) Specialist/Case Manager

A LTC specialist/case manager will be an integral member of the multidisciplinary team for members requiring LTSS, including those receiving initial community based services prior to reaching waiver level of care eligibility. As described above, although this service is not part of the capitated rate, the State will ensure that the LTC case manager actively participates in the multidisciplinary team and routinely communicates with the care coordinator regarding new information and/or changing service needs.

iii. Additional Supplemental Services

Additional or supplemental services provided through the SCDuE Demonstration encompass those services included in the care coordination model and benefits design described in Sections C.i. and C.ii. These services, include PCMH care coordination, multidisciplinary team, comprehensive assessment, behavioral health screening, care plan development, and clinical care management. Administratively there is requirement to provide an integrated health information technology/exchange to facilitate care coordination. The CICO will provide an enhanced reimbursement to those larger PCMH providers where enrollment justifies, and/or provide virtual team members in smaller practices, to support multidisciplinary team members to address key individual needs (e.g., behavioral health specialists, pharmacists/academic detailing, nutritionists, and telepsychiatrists).

As a recommendation of the ICW, it is essential that advanced directives be a component of the PCMH care coordination activities. Given the population to be served, advanced directives is a critical part of health care planning. CICOs will be required to include advanced directives as an added component.

The rural nature of South Carolina creates many challenges to providing higher cost services statewide. To address deficiencies in specialty and behavioral health practitioner services, SCDHHS has funded varying forms of telehealth, telemonitoring and telepsychiatry. CICOs will be encouraged to utilize these service delivery methods as appropriate.

a. Additional behavioral health services

Behavioral health services traditionally covered by Medicare and Medicaid include acute psychiatric hospitalization, limited outpatient treatment, therapies and counseling, assessment and testing, and psychotropic pharmaceuticals. After a 2½ year process to totally redesign South Carolina’s Medicaid State Plan coverage of rehabilitative and behavioral health services, in July 2010, SCDHHS expanded access by enrolling licensed independent practitioners (LIP) such as social workers, psychologists, nurse practitioners, marriage and family therapists, and counselors. While this effort greatly enhanced the state’s capacity to provide integrated behavioral health services, stakeholders indicated serious challenges with provider capacity. The state will examine current policies regarding the enrollment of LIP to identify barriers to access..

This Demonstration’s integration of behavioral health services is consistent with South Carolina movement to more integrated services. In April 2012, behavioral health services, specifically the LIPS providers, were included in the services provided as part of the existing Medicaid Managed Care Plans’ contracts. In order to provide truly integrated behavioral health services, stakeholders strongly encouraged consideration of behavioral health services that could not be billed under South Carolina’s fee-for-service system. Behavioral health services/providers should be viewed as a “safety net.” Those services that treat current, as well as prevent further, behavioral health issues will be considered. The types of services that foster true integration and enhance care include: brief intervention and screening, physician/behavioral health specialists collaboration, behavioral supports, and services/interventions provided in the home (possibly by community health worker or some behavioral health professional or para-professional).

Stakeholders indicated that while telepsychiatry is an important and cost effective means of providing direct services in rural areas, psychiatric consultation with the physician on specific patients also results in building capacity at the local level.

iv. Evidence-Based Practices

CICOs must develop and use processes that ensure the delivery of evidence-based services at the clinical, care coordination, and planning stages of care delivery. This will require the implementation of decision-support tools and other mechanisms necessary to facilitate seamless service delivery in a coordinated and integrated manner with ongoing support for

quality improvement. As an example, the use of academic detailing would greatly enhance the ability of the PCMH to deliver evidence-based service for this population requiring medical and behavioral health interventions. Academic detailing is a non-commercial educational approach aimed at changing prescribing behaviors for specific drugs as well as treatments for specific conditions using evidence-based educational materials and face-to-face meetings with practitioners. The goals are to support patient safety, encourage cost-effective medication choices, and improve overall patient care.

The PCMHs will be expected to incorporate into their practices evidenced-based practices designed to address the following components;

- Supporting the ability of the provider/patient to adequately initiate, monitor, and evaluate a plan of care;
- Emphasis on prevention and avoidable ED, hospital, and nursing facility stays with the goal of improving overall health;
- Consumer self-management education; and
- Process and outcomes driven continuous quality improvement loops.

The CICOs shall incorporate appropriate best-evidence practices driving quality improvement efforts, e.g., the US Preventive Services Task Force, the National Committee on Quality Assurance (NCQA), AHRQ Comparative Effectiveness, Meaningful Use Standards, CMS Adult Quality measures and related evidence-based practices on the PCMH. This is an iterative process requiring the CICOs to develop a plan for evaluating and disseminating this information to providers.

v. How the Integrated Care Model Fits with Existing Services

a. Coordination with existing Medicaid waivers

As described above, waiver services will be coordinated with other services but not included in the capitated rate.

b. Coordination With Existing Managed Care Programs

Two types of managed care plans currently operate in South Carolina: 1. Managed Care Organizations (MCO), the health maintenance organization model, and 2. Medical Home Networks (MHN), the Primary Care Case Management (PCCM) model. Currently, there are four MCOs and three MHNs serving the state. MHNs are an option available to all Medicaid recipients, including dual eligibles. South Carolina is exploring the possibility of lifting the MCO restriction preventing dual eligibles from enrolling with MCOs prior to implementation of the program. Therefore, by January 2014, any beneficiary choosing to opt out of the Demonstration would be able to enroll in either an MCO or MHN.

South Carolina has no managed behavioral health plans. However, in April 2012, behavioral health services, specifically the LIPS providers, were included in the services provided as part of the existing Medicaid Managed Care Plans' contracts.

c. Coordination With PACE Programs

PACE is available through two programs serving two counties each. PACE will continue to be an option for dual eligible beneficiaries who meet the level of care requirements and live in the four counties covered by the two PACE programs. Current PACE enrollees are excluded from the Dual Eligible Demonstration program. During the 2012 implementation year, procedures will be developed to ensure that in counties where the two PACE programs operate, CICO members who reach the level of care requirements for LTSS will be given the choice of PACE and may opt out of the CICO at that time without consideration of enrollment period. The State plans to explore with CMS and the Enrollment Broker a way to identify and inform SCDuE beneficiaries that may become eligible for PACE about the program and provide enrollment options. The State realizes that the PACE integrated care model provides valuable services and also plans to explore with CMS ways to expand PACE services perhaps in other geographic areas of the state.

d. Coordination with Medicare Advantage Plans

The SCDuE will coordinate with Medicare Advantage plans to ensure a smooth transition of individuals between the entities. These plans will continue to exist serving full dual eligibles that select not to participate in the SCDuE or who opt out or elect to dis-enroll.

e. Other State Payment/Delivery Efforts Underway

As part of a larger initiative of the SC Medicaid Coordinated Care Improvement Group (CCIG), the SCDuE Demonstration will need to be responsive to priorities or initiatives developed to address the unique needs of South Carolinians. This will require the CICOs to commit to working with the State on issues consistent with the target population with the potential to substantially influence population health and value-based purchasing of health care services.

f. Other CMS payment/delivery initiatives or demonstrations

South Carolina is currently working with other CMS Innovation Center funded programs. Four Federally Qualified Health Centers (FQHCs) in South Carolina have been funded under the Federally Qualified Health Center (FQHC) Advanced Practice Demonstration. The FQHC Advance Practice Demonstration is a three-year Demonstration designed to evaluate the effect of the PCMH, in improving care, promoting health, and reducing the cost of care provided to Medicare beneficiaries, including those with dual coverage. Dual eligibles and the PCMH are focus topics that both SCDuE and the FQHC Advance Practice Demonstration address. Both projects aim to reduce the cost of care for dual eligibles and elevate participating South Carolina Medical Homes to a NCQA recognition level. SCDuE will continue to work with the Integrated Care Workgroup, which has FQHC representation, to address these two goals.

SCDuE's work with the Partnership for Prevention and other projects is mentioned in Section F of the Demonstration. SCDuE is also ready to collaborate and work with others as funded states/organizations for the Initiative to Reduce Avoidable Hospitalizations,

Health Care Innovation Challenge, Comprehensive Primary Care Initiative, and other initiatives are announced.

D. Stakeholder Engagement and Beneficiary Protections

i. Stakeholder Engagement During the Planning and Design Phase

As part of the *State Demonstrations to Integrate Care for Dual Eligibles*, South Carolina is one of 15 states awarded the unique opportunity to establish new approaches to the delivery of a full continuum of Medicare and Medicaid services. Strategic planning, which included a team of private and public stakeholders and subject matter experts from across the health care services and public policy arenas, was initiated in July 2011.

SCDuE Integrated Care Workgroup (ICW)

In an effort to ensure the successful statewide implementation of this Demonstration with respect to the various federal, state, regional and local considerations, SCDHHS sought to bring together stakeholders who were knowledgeable in all aspects of the Demonstration. SCDHHS, historically, has engaged stakeholders in the development of new programs through advisory committees, workgroups, and public forums. During the development of the grant proposal, SCDHHS engaged members of the Long-Term Care (LTC) Workgroup, facilitated by the SC Public Health Institute, in strategic thinking about the system that would be needed to better serve people who are dually eligible for Medicaid and Medicare.⁸ This Workgroup, comprised of 20 member organizations representing consumers and advocacy organizations (e.g., Alzheimer's Association, AARP/SC, Healthcare Voices, Multiple Sclerosis Society, Cancer Society, Protection and Advocacy for People with Disabilities), state agencies and policy makers (e.g., SCDHHS, SC Department of Health and Environmental Control, Lt. Governor's Office on Aging, Silver Haired Legislature), and providers (e.g., SC Adult Day Services, SC Association of Personal Care Providers, Disability Resource Center, Family Resource Center for Disabilities, Agape Health Services, SC Home Care and Hospice Association, SC Hospital Association and Walton Options for Independent Living), provided the foundation for our current Integrated Care Workgroup (ICW). Once funded, the ICW quickly expanded its membership to include Managed Care Plan representatives, behavioral health experts, physicians, Federally Qualified Health Centers, hospital administrators, discharge planners, nursing facility representatives, and legislative staff. A complete listing of the ICW members is available at the SCDuE website. (See Section B for the website address).

Since the inception of the ICW, it has served as this project's advisory committee assisting the SCDuE Project Team with the identification of areas for needed guidance in reconciling any overlap or disconnect in existing plans. In order to ensure continuity in this Demonstration proposal's implementation process, a specific emphasis was placed on establishing clear and consistent assumptions upon which design and development must be based. This group also assisted in the identification and interpretation of issues where

⁸ See Minutes from Long-Term Care Workgroup Meeting (2011, March 24). Retrieved from <http://scphi.org/wordpress/wp-content/uploads/2011/05/LTC-Workgroup-Meeting-Minutes-3-24-2011.pdf>

design elements offered enhancements or detracted from intended outcomes relevant to an integrated delivery system.

In August 2011, SCDHHS, the project team, and members of the ICW began an intensive schedule of planning and design meetings.⁹ A specific effort was made by SCDHHS to ensure that broad stakeholder representation and feedback opportunities were available for all interested parties. Despite such demands, efficient and decisive planning by SCDHHS served to enhance the availability and timeliness of in-person and virtual stakeholder engagement and feedback opportunities. Although ICW members reside across the state, all SCDuE meetings were conducted in compliance with the Freedom of Information Act (FOIA)/Americans with Disabilities Act (ADA) and within the Columbia, SC, metropolitan area, due to its central geographical location within the state. Additionally, SCDHHS provided members with telephone and webinar access for a number of meetings.¹⁰ On September 30, 2011, ICW members received a request to complete an online survey containing questions related to many of the key elements and topics of the October 6, 2012, meeting. Results from this survey helped facilitate the stakeholder input and feedback portion of this particular meeting.¹¹ In addition to the series of broad ICW meetings, the SCDuE team conducted three “design element-specific” stakeholder focus group meetings in the months of January and February 2012.¹² These targeted meetings addressed coordinated care, long-term supports and services, and integrated behavioral health. On March 22, 2012, SCDuE conducted its final ICW planning phase meeting to describe in detail and gain feedback on the care model and other major design elements of the Demonstration. This extended meeting provided ample opportunity for discussion of the design elements and small group focused feedback to guide the final development of the implementation proposal. Stakeholder input from these three small groups can be accessed on the SCDuE web site.

SCDuE Web Site

The SCDuE web site was deployed in September 2011 and serves as one of the primary online resources and communication exchanges for all SCDuE project-related information and activities. The SCDuE web site is publicly accessible, hosted and maintained by SCDHHS (<http://msp.scdhhs.gov/scDuE/>). In addition to the main SCDHHS web site (<http://www2.scdhhs.gov/>), the general public and SCDuE-ICW members were encouraged to visit the SCDuE web site for frequent updates, announcements, meeting events, and materials. These SCDuE materials include, but are not limited to, presentations, stakeholder input surveys, meeting materials, general information, and

⁹South Carolina Department of Health and Human Services.(n.d.). On *South Carolina Dual Eligible Demonstration Project's (SCDuE) web site meeting schedule*. Retrieved from <https://msp.scdhhs.gov/scDuE/content/meeting-schedule>

¹⁰South Carolina Department of Health and Human Services (2012, February 13). *Integrated Care Workgroup – Behavioral Health Focus Group Web Conference (Webinar) On-Demand* [PDF document].Retrieved from <https://cc.callinfo.com/cc/playback/Playback.do?id=a35pkn>

¹¹South Carolina Department of Health and Human Services. (2011, October 6). *SCDuE Integrated Care Workgroup Meeting #1* [PDF document]. Retrieved from <https://msp.scdhhs.gov/scDuE/sites/default/files/SC%20DuE%20October%206,%202011%20Integrated%20Care%20orkgroup%20Meeting%201.pdf>

¹²South Carolina Department of Health and Human Services.(n.d.). On *South Carolina Dual Eligible Demonstration Project's (SCDuE) web site meeting schedule*. Retrieved from <https://msp.scdhhs.gov/scDuE/content/meeting-schedule>

results from stakeholder feedback. This site is where the draft Demonstration proposal will be posted for the 30-day public comment period.

Public Comment

A specific effort was made by SCDHHS to ensure that a broad array of stakeholder comment and feedback opportunities was offered before, during, and after the 30-day public comment period. An invitation was also extended to the Catawba Nation, the State's only federally recognized Native American tribe, to be involved in the stakeholder activities. The Catawba Nation will continue to be encouraged to participate and will be notified of all stakeholder meetings. All ICW Meetings were announced in advance as public meetings; and in January, the ICW meetings were expanded to be public meetings with notices being sent to all who requested it. In addition to general public announcements published on the main SCDHHS web site, stakeholders and the general public were notified about the opportunity to submit comments from a number of internal and external communication channels (i.e. the SCDuE website, ICW email list serve, and other media outlets like newspapers, consumer advocacy and provider web sites). Importantly, to advance the reach of this opportunity and request, the SCDuE team requested all ICW members to share this announcement with their collective memberships via web sites, email list serves, and other communication mediums. With regards to comment and input collection, SCDHHS offers interested persons the opportunity to submit comments by way of mail, email, and a special online web form and/or survey positioned directly on the SCDuE web site.

Individual Meetings with Organizations/Associations

Outreach to various constituencies was critical to gaining input and beginning the process of provider education in all areas of this Demonstration design. SCDHHS leadership and staff met with numerous provider associations, provider groups and other organizations to discuss plans for integrated care. Staff attended several external meetings with provider and consumer groups to discuss the integrated care proposal design and to answer questions and concerns.

ii. Description of Protections

Through agreement with CMS and contract provisions with CICOs, SCDuE will ensure that strong protections are in place to ensure beneficiary's health, safety, and access to high quality health care and supportive services. These protections will include requirements around choice of providers; grievance and appeals processes; and access to supportive customer service assistance. These protections are in addition to the beneficiary protections around the enrollment process described in Section C.i.c.

Provider Networks

SCDuE requires the CICO to establish and maintain a network that includes a broad array of providers and assures access to all Medicaid and Medicare benefits. The provider network will include, but is not limited to, behavioral health providers and providers who have experience in serving this population with diverse disabilities. CICOs will be required to enroll providers that are willing to accept and see new patients; with whom a beneficiary wishes to continue a relationship; who are able to meet the credentialing requirements, license verification, and have not been suspended or terminated from any government program such as, but not limited to, Medicare, Medicaid, and TRICARE. SCDuE will allow a single-case, out-of-network agreement under specified conditions or circumstances in order to ensure continuity of care for the beneficiary in cases in which a provider does not wish to enroll in the network. SCDuE will also ensure that CICOs demonstrate the capacity to provide, directly or through sub-contracts, the full continuum of Medicare and Medicaid covered benefits, as well as any additional, enhanced services.

Continuity of Care

Ensuring continuity of care and consumer choice is a major goal of SCDuE. CICOs are required to provide outreach to current providers and continue out-of-network relationships as mentioned in the above Provider Network Section. Passive enrollment into a plan that includes a participant's current provider and /or provider network, independent Enrollment Broker assistance, and care coordination through the multidisciplinary team will help ensure continuity of care. Beneficiaries are also guaranteed current prescription coverage for 30 days after enrollment in the program as another benefit.

Grievance and Appeal Process

SCDuE proposes to have an integrated Medicaid and Medicare grievance and fair hearing/appeal process that may include having a participant ombudsman type of role. South Carolina will include negotiations with CMS to ensure that consumer protections are included. The specifics of the process are still under discussion and will include the following key elements:

- Timing and notification (to beneficiaries, providers, etc.),
- Criteria for type of appeal (expedited or standard),
- Levels of appeal (internal and external),
- Continuation of services and reimbursement during an appeal, and
- Authorized appeal representatives.

Enrollment Assistance

An independent Enrollment Broker will assist the beneficiaries in the selection of/enrollment with providers. In addition to other services, the Enrollment Broker must provide material that is culturally and linguistically appropriate, make services for the deaf and hearing impaired available, operate toll-free services, and ensure that participants are informed of and aware of their rights.

Additional Protections

SCDuE will implement other beneficiary protections that ensure privacy of records; access to culturally and linguistically appropriate care; and the inclusion of caregivers, guardians, and other beneficiary representatives as appropriate. Beneficiaries will be provided all federal and state rights in this regard. SCDuE will work with CMS to ensure that existing Medicaid and Medicare authorities and protections are required. For example, SCDuE will ensure that beneficiaries incur only the costs associated with Medicare Part D and have advance notice, an upfront option for beneficiary opt-out, and an opportunity to dis-enroll 90 days after enrollment is effective.

iii. Ongoing Stakeholder Input

The SCDHHS has served as the lead state agency to the CMS/MMCO since the Demonstration's inception in 2011. The SCDHHS has been a consistent presence in this innovative effort and has served to foster ongoing stakeholder engagement which will continue throughout implementation of this Demonstration. Numerous approaches will be used to continue to engage stakeholders in the design and implementation of this integrated care program.

The SCDuE web site will continue to serve as one of the primary vehicles for communication and stakeholder engagement. All project related notices and materials will be posted on the website. For example, it will be used to solicit and post the Requests for Information/Requests for Solutions (RFIs/RFPs). The RFI/RFS process will be used to gather additional feedback regarding the integrated care model and specifics to be included in the CICO requirements. The ICW is fully engaged in this effort. SCDuE will continue to meet regularly with the ICW and/or smaller focus groups at least quarterly around key design features. In an effort to get further beneficiary input, SCDuE has explored the option of conducting focus groups with advocacy groups including the South Carolina Chapter of the Alzheimer's Association and a adult day care facility.

Additionally, SCDuE will make full use of existing stakeholder groups to provide regular updates and respond to questions and concerns. These groups include SCDHHS' Medicaid Medical Care Advisory Committee (MCAC) and its Coordinated Care Improvement Group (CCIG). SCDHHS leadership and staff will continue its outreach to both the behavioral health and long-term care provider community to continue the education process started during the design phase and to gain better insight into potential barriers.

Finally, consumer satisfaction surveys will be conducted annually as part of the QI measurements.

Table D.1. Stakeholder Engagement Activities

Dates	Description
January 27, 2011	LTC Workgroup Meeting
March 24, 2011	LTC Workgroup Meeting
May 26, 2011	SCDuE Integrated Care Workgroup Meeting
July 25-27, 2011	Meeting of Key State Stakeholders around Integrated Primary and Behavioral Health Care at the SAMHSA Conference
August 1, 2011	LTC Workgroup Meeting
August 2, 2011	State Agency Meeting
August 18, 2011	SCDuE Integrated Care Workgroup
September 13, 2011	SCDuE Website – Deployed
September 26, 2011	LTC Workgroup Meeting
September 30, 2011	SCDuE Project Survey
October 5, 2011	CMS/MMCO Site Visit in South Carolina
October 6, 2011	SCDuE Integrated Care Workgroup with CMS/MMCO Project Officer site visit
October 12, 2011	Hospitals/Nursing Home Meeting - presentation
October 24, 2011	Financial Model Sub-Committee Meeting
October 25, 2011	LTC Workgroup Meeting
December 5, 2011	LTC Workgroup Meeting
December 14, 2011	Medicaid CCIG Meeting - presentation
January 24, 2012	SCDuE Integrated Care Workgroup and Public Meeting with CMS/MMCO staff present
February 2, 2012	SCDuE Integrated Care Workgroup and Public Meeting
February 6, 2012	SCDuE Long-Term Care Sub-Committee meeting
February 7, 2012	Medicaid CCIG Meeting - Presentation
February 13, 2012	SCDuE Behavioral Health Sub-Committee
March 22, 2012	SCDuE Integrated Care Workgroup and Public Meeting
April 16, 2012	Posted Draft Integrated Care Proposal to the SCDuE website for 30-day public comment

E. Financing and Payment

As part of the alignment of financial models, the SCDuE proposes to provide blended Medicare and Medicaid payments to CICOs under the capitated alignment model outlined by CMS in the July 8, 2011, State Medicaid Director Letter. South Carolina, through the efforts of the CCIG, is exploring mechanisms that will hold providers accountable for the care they deliver and reward quality of care and improved health outcomes as a function

of pay-for-performance linkages to quality metrics and value-based purchasing of health care; this will likely be a complimentary effort to the SCDuE Demonstration.

The State supports a delivery system built on the PCMH model that integrates and coordinates comprehensive services and incorporates evidence-based quality metrics as an ongoing component of evaluation. The SCDuE supports these efforts by building on identified strategies to transform the system of care in South Carolina.

In keeping with overall payment reform goals and strategies to ensure value-based purchasing of health care services, South Carolina will employ the three-way capitated contract, specified by CMS as the mechanism to implement integrated care for non-institutional full dual eligible members age 65 and older. South Carolina will work with CMS to ensure that the three-way contract will achieve administrative integration, clear accountability, and shared financial contributions to prospective blended global payments. These are critical components for the success of this Demonstration and the current efforts in South Carolina.

i. Payments to CICOs

Under the three-way capitated contract, the CICOs will receive an actuarially developed, risk-adjusted, blended capitation rate for the continuum of services they provide to SCDuE participants. Medicaid and Medicare will both contribute to the blended rate. Ongoing conversations with CMS will determine the payment mechanism with many of the design aspects still to be finalized with the submission of this implementation proposal. It will require a data-driven iterative process shaped by the proposed program design and enrollment. The State will work with CMS to explore the establishment of risk corridors to ensure the viability of this Demonstration to protect against underpayment or overpayment to CICOs. Stop loss arrangements will need to be considered with the potential to cap the dollar amount over the course of the implementation. The availability of data on the implementation will provide needed information to apply a range of options. South Carolina acknowledges this arrangement has implications for shared savings; however, the success of the program requires this be a critical component of the contract negotiations.

South Carolina has taken major steps to ensure an understanding of the data and the drivers shaping the reimbursement model. The analysis of the data will continue through the comment period at the State and CMS levels allowing for a clear understanding of the drivers shaping the payments to the CICOs (see Section B for a detailed approach undertaken to define the target population). Currently, the State is pursuing obtaining linked Medicare and Medicaid data for the base period of 2008-2010 to guide the establishment of base capitation rates with risk adjustments to reflect the geographically diverse population of South Carolina.

ii. Incentives for Quality and Savings

Consistent with the work of the SC Medicaid CCIG, the use of quality metrics will be an ongoing component of monitoring the short and long-term outcomes of the Demonstration. The State will consider the implementation of a pay-for-performance

framework based on meeting or exceeding quality metrics as a withhold amount from the base capitation rate or a performance incentive. CICO bidder proposals are encouraged to include innovative approaches to value-based purchasing of health care services internal to the entity with provider shared savings and bundled payments.

F. Expected Outcomes

i. Demonstration Key Metrics

South Carolina has a proven record of identifying, collecting, monitoring, and analyzing data related to quality and cost outcomes in its existing programs, and for ongoing quality improvement initiatives. Since 2007, South Carolina has been working with HEDIS, CAHPS, CMS Adult, survey of nursing homes, and related metrics associated with quality and has been reporting these metrics at the plan, FFS, and statewide levels. In preparation for this implementation of the SCDuE Demonstration, the State has undertaken efforts to examine existing quality, process, and provider measures as the basis to guide the evaluation of this effort. The State will build on this experience and contractual arrangements to support this Demonstration. The final selection of quality and costs measures will be made through a multi-stakeholder process aimed at meeting state and federal requirements. At minimum, the metrics will encompass measures of access, care coordination, patient-centered care, health and safety, comprehensive care coordination, integration of services, provider satisfaction, cost savings and health outcomes.

The performance of the CICOs will rely on qualitative and quantitative data collection methods, including enrollee and provider surveys, member focus groups, key informant interviews and claims and encounter data analysis. Measures will be taken at baseline and at various times after implementation of the Demonstration (e.g., every 6 months or every 12 months) depending on the nature of the expected outcome.

The component of quality measurements for the LTSS is already in place. The automated *Phoenix* and *Care Call* systems used to monitor all LTSS (see Appendices C and D for a more complete description) provide a rich data source for evaluating beneficiary experiences, access and utilization of services and assessments and care plans customized to their individual needs and conditions. The State will be able to obtain real-time data on all of these components, including prior approved LTSS. The *Care Call* system monitors service provision of LTSS providers and documents that services have been provided as authorized. It also includes the ability to monitor any exceptions, such as documentation of services from an unauthorized location, provision of services at times of day not specified, missed visits (no service provision on specified days), and numerous other pieces of information about the services. The two systems together also serve to document any corrective actions taken when service provision issues are identified.

South Carolina has been using some version of *Phoenix* since 1991 and *Care Call* since 2003. The State will be able to compare quality indicators in the Demonstration with comparable data prior to development of this system. The State will also be able to compare outcomes and quality measures for persons in the Demonstration receiving LTSS with a comparison group not in the Demonstration receiving LTSS. In addition to these

metrics, South Carolina also has longitudinal data on beneficiary satisfaction for consumers receiving LTSS. This will provide the baseline for continuing surveys of beneficiaries and allow for comparison with the traditional fee for service system.

Overall, South Carolina expects to achieve three related outcomes through this Demonstration:

- First, there should be a change in the utilization of services. By assessing needs in a coordinated manner, lower cost preventative services should see an increase in utilization. This would include behavioral health services as well as outpatient and community-based LTSS. This should be accompanied by a reduction of inpatient and institutional services.
- Second, the shift in services should reduce overall costs, allowing South Carolina to share in cost savings and redirect funding to other health care priorities.
- Finally, the coordinated care provided in this Demonstration should result in a positive effect on consumer outcomes. This includes increases in measurable health outcomes as well as an improvement of beneficiary experiences through providing a system where all components work together seamlessly.

ii. Potential Improvement Targets

A comprehensive list of improvement targets is in development and will be finalized with stakeholder and CMS input. Listed below are a number of measurable targets that are under consideration.

<p>Primary Care</p> <ul style="list-style-type: none"> - % of consumers screened, referred for behavioral health care who receive concurrent medical management to avoid adverse events - % of consumers who receive recommended treatment and follow-up related to identified chronic conditions - % of participating practices who achieve Level 1 PCMH certification
<p>Behavioral Health Services:</p> <ul style="list-style-type: none"> - Percent <u>increase</u> in the utilization of behavioral health services - Percent <u>decrease</u> in inpatient admissions due to behavioral health diagnoses - Improvement in medication management - Follow-up after hospitalization for mental illness - Initiation and engagement of alcohol and other drug dependent treatment
<p>Long-Term Care:</p> <ul style="list-style-type: none"> - Number of consumers referred to home- and community-based waivers by the CICOs - Length of time from referral to waiver admission - Percent increase in the 65+ population in waiver programs - Percent decrease in nursing facility admissions - For those entering nursing facilities, percent increase in time from waiver enrollment to nursing facility admission - Number of critical incidents reported by the waiver case manager to the CICO.
<p>Integrated Primary Care:</p>

<ul style="list-style-type: none"> - Percent reduction in avoidable hospitalizations - Percent reduction in 30-60 day readmissions - Percent reduction in avoidable emergency department visits - Percent reduction in unnecessary prescription medications - Use of high-risk medications in the elderly - Potentially harmful drug-disease interactions in the elderly - Annual monitoring for patients on persistent medications - Persistence of a beta-blocker treatment after a heart attack
<p>Overall:</p> <ul style="list-style-type: none"> - Percent of consumers who do not opt out of CICO plans - Beneficiary experience survey results, including measures of transparency across care categories - Percent of consumer and providers who indicate satisfaction with the integrated service demonstration - Percent of providers who do not opt out of the CICOs network

iii. Cost Impact

The current non-alignment of Medicaid and Medicare gives states little financial incentive to develop and implement innovative services if the main effect is to reduce hospitalizations or ER visits when Medicare is the primary payer for those services. The Demonstration corrects that by allowing cost sharing across the two funding streams. The Demonstration will facilitate innovative approaches allowing for strategies resulting in cost savings and improved health outcomes. As an example, potential cost savings could also occur by allowing services through an assisted living facility as opposed to a nursing home enhanced by home- and community-based services. In the current system, these are missed opportunities to coordinate care, leverage alternative services, and expand health care options for dual eligible participants. The data user agreement with CMS supported by the initial actuarial work with Milliman supports the prospects for this proposed model to produce short-term and longer term savings, offsetting the costs of providing the additional chronic disease management, behavioral health and long term care services.

G. Infrastructure and Implementation

i. Description of State Infrastructure/Capacity to Implement and Oversee the Proposed Demonstration.

Long Term Services and Supports Systems: SCDHHS has demonstrated the capacity and infrastructure to design, develop, and implement model programs across the health care spectrum, with particular strengths in long-term support services and managed care programs. Through its Division of Community Long Term Care (CLTC), SCDHHS serves participants who meet an institutional level of care with an array of services and supports in their home and/or community. CLTC has shown innovation in its early development of home- and community-based (HCB) services and has led the field in the development of an innovative technological infrastructure to support operation of those waivers. South Carolina was one of the early states to pilot an HCB in the late 70's and expanded that pilot for elderly or disabled participants in 1984. South Carolina was the fourth state to

have an approved HIV/AIDS Waiver. An early adopter of the consumer direction philosophy, CLTC added consumer-directed options for the attendant care (1996) and later companion services in the Elderly/Disabled and HIV/AIDS, MR/DD and Head and Spinal Cord Injury Waivers. In 2003, South Carolina was the third state to implement a Choice Waiver and the first state to have a Choice Waiver for people who are elderly or disabled. In 2006, they expanded the Choice Waiver to all participants in the Elderly/Disabled Waiver by combining the E/D and SC Choice Waivers into the Community Choices Waiver.

SCDHHS now operates or administers nine HCB (1915c) Waivers. CLTC operates the Community Choices Waiver which serves 12,322 individuals and has a waiting list of 3,135; The HIV/AIDS Waiver, which was initiated in 1988 and serves approximately 1000 persons; and the Ventilator Dependent Waiver which was initiated in 1994. Two additional waivers for children include the Medically Complex Children's Waiver, which started in January 2010 and serves up to 200 children; and the Psychiatric Residential Treatment Facility Waiver, which was initiated in 2007. CLTC oversees four waivers operated by the SC Department of Disabilities and Special Needs: Mental Retardation and Related Disabilities (MR/DD) Waiver (initiated in 1991), Head and Spinal Cord Injury (HASCI) Waiver (initiated in 1995), Pervasive Development Disorder (PDD) Waiver (initiated in 2007), and the Community Supports Waiver (initiated in 2009). Dual eligible participants are enrolled in six of the nine waivers.

To support the waivers operated by CLTC, SCDHHS has developed an information technology infrastructure that leads the nation. Both CLTC's automated case management system and *Care Call*, CLTC's automated billing and monitoring system, have been highlighted in CMS's Promising Practices Series (<https://www.cms.gov/CommunityServices/HCBSPPR>). These systems continue to be enhanced to meet new needs and will be an integral part of this demonstration.

Over the last 10 years, SCDHHS has successfully implemented a series of CMS grants focused on rebalancing LTC including a Nursing Home Transition grant (2001), Real Choice grant (2001), and Money Follows the Person grant (2007). This experience, combined with the state's readiness, speaks to SCDHHS's ability to identify and validate delivery system and payment integration models in order to develop a demonstration model ready for implementation in 2013.

Medicaid Managed Care: Although Medicaid managed care has operated in South Carolina since 1996, the state fully implemented managed care by expanding the number of options available in 2005 and implementing the Healthy Connections program in October 2007. Even in a voluntary managed care environment, SCDHHS increased enrollment in managed care from 72,000 in 2005 to 624,720 as of April 1, 2012. On October 1, 2010, South Carolina moved to a mandatory managed care environment for all beneficiaries except for those in institutional settings, and some people in HCB Waivers.

Two types of managed care plans operate in South Carolina: 1. Managed Care Organizations (MCO), the health maintenance organization model, and 2. Medical Home

Networks (MHN), the Primary Care Case Management (PCCM) model. Currently, there are four MCOs and three MHNs serving the state. Since 2002, SCDHHS, via a contract with the University of South Carolina Institute for Families in Society (IFS), has been conducting quality improvement activities for the agency. Annual CAHPS and provider surveys are conducted for the managed care and fee-for-service populations enrolled in the Medicaid program. Approximately, 5,000 surveys were completed in 2010 across all segments of the Medicaid population. Additionally, IFS has provided a secure web portal with monthly DCG/HCC clinical classification reports on all enrolled Medicaid recipients with a separate report on behavioral health diagnosis for managed care providers and agency personnel. HEDIS Medicaid measures are calculated for three different periods: Federal Fiscal Year (FFY), Calendar Year (CY), and Fiscal Year (FY) for recipients in managed care, FFS, CHIP, and dual eligibles.

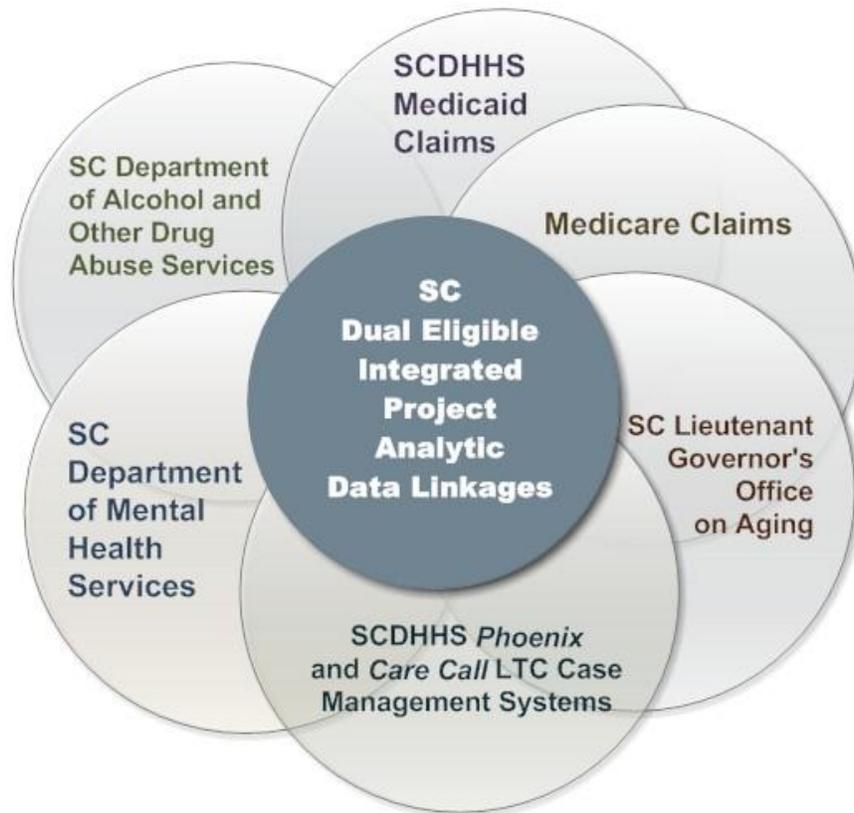
South Carolina's Medicaid history with quality improvement efforts is feasible due to a strong capacity to integrate disparate data sources, research partnerships, strong, stakeholder involvement and a commitment to improving care while providing cost-effective services. This work has recently been expanded to include access to care metrics associated with social and economic disparities forming the basis for SPA documentation.

Integrated Primary Care and Behavioral Health Care: In 2007, SCDHHS initiated a 2 1/2 year process with CMS Regional and Central Offices to totally redesign its State Plan coverage for rehabilitative and behavioral health services. This massive undertaking resulted in a complete system redesign with services being added, redefined, and discontinued. As part of the SPA, effective July 1, 2010, SCDHHS greatly expanded coverage by enrolling licensed independent practitioners. The extensive effort enhanced the State's capacity to successfully implement new initiatives to promote integrated behavioral health services. Effective April 1, 2012, behavioral services are carved into Medicaid managed care plans.

Data Analytic Capacity: *The technical foundation for integrating data is a successful key linker system.* South Carolina has been a national leader in the development of innovative solutions to integrate and link disparate data sets. In 1996, South Carolina began "unduplicating" at the person level using all personal identifiers. Each unduplicated person is assigned a random number generated by a computer program algorithm. This number is commonly referred to as the Unique ID or Key Linker. The algorithm uses personal identifiers that include, but are not limited to: SSN, first name, middle initial, last name, date of birth, race, and gender. The data is cleaned (i.e., characters are removed from SSN, dates are compared to valid ranges) and standardized (i.e., all characters are converted to uppercase) before being run through the algorithm. In March 2010, the SCDHHS received a \$9.5 million dollar grant from the Department of Health and Human Services to scale SCHIEx into an operational and sustainable statewide Health Information Exchange (HIE). SCHIEx currently connects both data consumers and data providers across insurance sources, state agencies, and special programs. The capacity of SCHIEx provides a rich framework to conduct the required data analysis associated with the dual eligible population in South Carolina. It also supports the capacity of South Carolina to seamlessly link Medicare data with the current integrated Medicaid data

system. (See Figure 3 below). Currently, the State has SCDuE with a new Data Understanding Agreement (DUA) with CMS to expand the analytic capacity of SCHIEx and to expand the ability to undertake the analysis for this Demonstration.

Figure 3: SC Dual Eligible Integrated Project Analytic Data Linkages



Key Staff

The SC Medicaid program, under the leadership of Director Anthony Keck, will provide the direct and ongoing leadership and involvement of agency staff and programs for the Demonstration. The Demonstration proposal has been developed with the Office of Long Term Care and Behavioral Health. Sam Waldrep, Deputy Director, will oversee the day-to-day management of this Demonstration with staff in the Office's Bureau of Long-Term Care; Community, Facility, and Behavioral Health Services; and Community Options. These Bureau's have experience in managing programs that serve dual eligibles. Additionally the Bureau of Care Coordination will provide support for the Demonstration. Anticipated dedicated staff will include:

- CICO program manager – to oversee daily program operation
- Data analysts – to aggregate, analyze, and report on encounter data, quality data, financial data for quality control and other purposes
- Program coordinators –to resolve program and enrollee issues
- Contract managers – to work with CICOs to ensure compliance and program success

- Medicare-Medicaid financial analysts – to oversee Demonstration-related federal financial reporting requirements.
- Nurses – to assess LTC level of care designation

Contractors

SCDHHS has engaged several contractors to assist with the planning, implementation, and data management of SCDuE.

- The South Carolina Office of Research and Statistics will support the integration of *Phoenix* and related software to address seamless care coordination with CICOs systems.
- The University of South Carolina Institute for Families in Society will provide consulting support in the development and implementation of the SCDuE proposal with emphasis on monitoring and data analysis to measure short and long-term outcomes. They will serve as the liaisons to the CMS external national evaluators for this Demonstration.
- Milliman will provide actuarial support to establish SCDuE’s rates and work with CMS on the three-way contract.
- An Enrollment Broker will provide customer service and beneficiary enrollment services consistent with established policies and protocols.

South Carolina will continue to rely on external contractors for some specialized services related to the operation of the Medicaid program, including external quality review, metrics development/technical support, Medicaid Management Information System (MMIS) technical support, and pharmacy benefits.

This Demonstration has been developed with input from key stakeholders’ representative of state agency partners, providers, consumers, advocates, and care coordination entities. These groups will continue to convene regularly throughout the implementation. Additionally, this group will interface with the Medical Care Advisory Committee (MCAC), Medical Directors Meeting, Coordinated Care Improvement Group, Long-Term Care Task Force and Integrated Care Work Group.

ii. Identification of any Medicaid and/or Medicare rules that would need to be waived to implement the approach.

The unique challenges associated with the design and establishment of a new approach to the coordination of a full continuum of Medicare and Medicaid benefits for South Carolina’s dual eligibles transcends existing models of care. As part of the planning, design, and development phase of this Demonstration, CMS and SCDHHS will work together to identify areas for needed guidance related to any overlap or disconnect in existing program authorities, with a specific emphasis on establishing clear and consistent requirements upon which implementation of this initiative must be based in order to create operational compliance.¹³ As such, to the extent that variances resulting from South

¹³Mann, C., Bella, M. (2011). *Financial Models to Support State Efforts to Integrate Care for Medicare-Medicaid Enrollees*. (State Medicaid Director Letter# 11-008; ACA# 18). Baltimore, MD: Department of Health & Human Services Centers for Medicare & Medicaid Services.

Carolina’s proposed Demonstration would have impacted the overall design of a coordinated and integrated care model, not anticipated at and/or before this proposal’s 30-day comment period, SCDHHS shall incorporate such changes into the full Demonstration proposal. Furthermore, the State is committed to working with CMS on areas requiring rule changes to successfully implement this Demonstration.

South Carolina currently has a 1915 (c) waiver serving an aged/disabled population. Although the State does not believe that additional waiver authority is needed to provide certain demonstration services, South Carolina will continue to work with CMS to determine how to best provide the required and suggested demonstration services.

iii. Description of plans to expand to other populations and/or service areas if the model is focused on a subset of dual eligibles or is less than statewide.

SC DuE’s target population is comprised of full dual eligible who are at a non-institutional level of care at enrollment and are ages 65 and older. The Demonstration will lay the groundwork for future expansions. It is anticipated that by 2017, the coordinated care infrastructure in South Carolina will be in place permitting expansion beyond the Demonstration target population.

iv. Description of the overall implementation strategy and anticipated timeline.

Table G.iv. Overall Implementation Strategy and Anticipated Timeline

Timeframe	Key Activities/Milestones
April 16, 2012	Post for Public Comment
April 16, 2012–May 16, 2012	Public Comment Process and Ongoing Stakeholder feedback
May 16, 2012	Deadline for Public Feedback
May 17–May 25, 2012	Incorporate public comments and revise proposal as needed
May 26, 2012	Final Submission to CMS
May 31–June 30, 2012	CMS posts for public comment, CMS/State review public comments and incorporate as appropriate
June 15, 2012*	State submits draft documents for Medicaid authority
June–September 2012	State infrastructure modifications and provider outreach regarding program changes
June–December 2012	Continued stakeholder engagement
June and July 2012*	Develop and Issue Request for Information
July 9–September 9, 2012	MOU development/finalization
September 12, 2012	MOU signed by CMS and State
September 14–26, 2012	State/CMS develop RFP for plan selection
October 29, 2012	Release RFP
November 2012	Plans Notice of Intent to Apply (NOIA) Due for 2014 contract year

January–December 2013	Continued stakeholder engagement
Mid-February 2013	CMS 2014 Draft Call Letter provides additional information for plans
February 15–June 15, 2013	State/CMS plan RFP submission review and negotiations
Late February 2013*	CMS plan demonstration applications are due
Mid-April 2013*	Interested plans submit Part D formularies
May 2013*	Interested plans submit Medication Therapy Management Program
By June 15, 2013*	Interested plans submit proposed plan benefit packages
June 18–September 18, 2013	Three-way contract documents finalized
July 30, 2013	Final Plan Selection completed
August 1–September 20, 2013	Readiness reviews
August 15–September 30, 2013	Plans finalize policies, procedures
September 20, 2013	Three-way contracts signed
October 1, 2013	Beneficiary notification
October 1, 2013 and ongoing	Opt out beneficiaries enrolled in alternative options
January 1, 2014	Demonstration Start

*Specific dates and deadlines for contract year 2014 will be provided at a later date; these timeframes represent estimates for plan and other activities.

H. Feasibility and Sustainability

i. Potential Barriers and Challenges for Implementation

A potential challenge to the implementation is the limited experience of the State with capitated systems providing long-term and behavioral health services in South Carolina. New capitated plans, even by companies already having a market share in South Carolina, do not have this history and understanding of the LTSS provider network. To address this challenge South Carolina has taken steps to integrated behavioral health into current capitated bundled programs providing a framework for enhancing provider experience with seamless delivery systems. The Medicaid program is exploring ways by which to provide Medicaid dual eligibles the choice of enrolling in a capitated care model with integrated behavioral health services. In preparation for the implementation of this Demonstration, the State is committed to exploring options to address this service delivery gap, including conducting training sessions for selected vendors to ensure that vendors have a full understanding of state-specific issues that will need to be addressed as the plans proceed with serving the dual eligible population.

Rate setting that can provide realized savings based on historical Medicaid and Medicare claims within the demonstration period will pose a challenge. The selection of the Demonstration target population holds the promise of achieving cost sharing and a learning platform from which to expand to other segments of the dual population. To address these challenges SCDHHS will work closely with CMS, health plans, and stakeholder to find solutions and create opportunities for innovation. This Demonstration

project reflects the seamless delivery and innovative value-based purchasing direction of SCDHHS.

ii. Description of any remaining statutory and/or regulatory changes needed within the State in order to move forward with implementation

At this time, SCDHHS does not anticipate any insurmountable statutory/regulatory changes that would prevent the implementation. SCDHHS is investigating whether nursing home permit days will have to be modified. The issues addressed in the stakeholder groups are viable within the scope of three-way contract arrangement of this demonstration or through a temporary rule process.

iii. New state funding commitments or contracting processes necessary before full implementation can begin

South Carolina anticipates receiving implementation funding related to this proposal to effectively implement the CICO Care Model. This funding will allow South Carolina to enhance the current IT and related infrastructure to successfully implement, monitor, and evaluate this Demonstration.

iv. Scalability/replication of proposed model

The proposed model with a focus on streamlined administrative process, seamless integration, accountability with defined quality outcomes and a commitment to provider-based incentives can be easily replicated statewide and in other states. It provides a new paradigm for rate setting aligned with our movement towards value-based purchasing and payment reform at the state and federal levels.

I. CMS Implementation Support

A detailed budget will be provided with the submission to CMS on May 26, 2012

J. Additional Documentation

Letters of support will be included as Appendix F in the draft submitted to CMS on May 26, 2012.

K. Interaction with Other HHS/CMS Initiatives

Partnership for Patients

The two goals of the Partnership for Patients aim to cut hospital readmissions by 20% and reduce by 40% preventable hospital injuries over the next three years. Six healthcare organizations in South Carolina belong to the Carolinas HealthCare System, one of the 26 Hospital Engagement Networks (HEN) that received funding from the Partnership for Patients Initiative. The CICO and plans will work with the HEN healthcare organizations, along with other providers, to continue to address the goals of reducing hospital readmissions and preventable hospital injuries.

Services to be provided through SCDuE would contribute to many of the projected outcomes for Partnership for Patients. For example, care coordination and the multidisciplinary team approach can assist beneficiaries with safe transition between settings of care, to which HHS has committed an additional \$500 million dollars to address. The multidisciplinary team approach and the combined use of the electronic health record with academic detailing can help guide care to address the issue of preventing adverse drug reactions, one of the nine types of medical complications and errors where the potential for dramatic reductions in harm rates has been demonstrated. In addition, care coordination through the multidisciplinary team approach can help manage beneficiaries care to help prevent hospital readmissions.

The Million Hearts Campaign

The Million Hearts Campaign initiative's goal is to prevent one million strokes and heart attacks over the next five years. South Carolina, a CDC funded Heart Disease and Stroke Prevention state, currently has educational and support activities in place to address the issue of heart disease and stroke. Of SCDuE's targeted population, 24.4% has a Medicare diagnostic cardiovascular condition. SCDuE aims to reduce the prevalence of cardiovascular and other chronic diseases through enhanced services, care coordination, and disease management. SCDuE will continue to work with other initiatives to provide education and support in the effort to reduce heart disease and stroke.

SCDuE will continue to collaborate with others to help integrate and support services of the various initiatives that are currently being implemented in the state, including those that address the reduction of Racial and Health Disparities.

Appendix A

Glossary and Acronyms

Activities for Daily Living (ADL)

An ADL is defined as an affirmative answer to each the following questions from the 2011 Annual Social and Economic Supplement (ASES) to the Current Population Survey (CPS):

- Is... deaf or does...have serious difficulty hearing?
- Is...blind or does...have serious difficulty seeing even when wearing glasses?
- Because of a physical, mental, or emotional condition, does...have serious difficulty concentrating, remembering, or making decisions?
- Does...have serious difficulty walking or climbing stairs?
- Does...have difficulty dressing or bathing?
- Because of a physical, mental, or emotional condition, does...have serious difficulty doing errands alone such as visiting a doctor's office or shopping?

A higher number of ADLs may indicate the level of assistance that an individual may need.

Aging and Disability Resource Centers (ADRC)

Provide a single coordinated system of information and access for seniors, caregivers and adults with disabilities seeking long-term care by minimizing confusion, enhanced individual choice, and supporting informed decision-making. ADRCs make it easier for consumers to learn about and access existing services and supports that are available in their communities.

AHRQ

Agency for Healthcare Research and Quality

Annual Social and Economic Supplement

A supplement to the national Current Population Survey (CPS), sponsored by the Bureau of Labor Statistics, Census Bureau, and the Department of Health and Human Services. Information from the ASES is used to produce annual income and migration statistics, including poverty figures. It is also used to produce work experience, noncash benefits and health insurance data.

Office of Long Term Care and Behavioral Health Services

The Office of Long Term Care and Behavioral Health Services is responsible for all long term care programs, both institutional and community-based, for the elderly and other special needs populations with in SCDHHS. The Office consists of the Bureau of Community Long Term Care (CLTC) and the Bureau of Community, Facility and Behavioral Health Services

Capitation

A specified amount of money paid to a health plan or doctor. This is used to cover the cost of a health plan member's health care services for a certain length of time.

Care Coordination

Care Coordination – assists individuals/beneficiaries in gaining access to needed Medicaid, Medicare, and other services, as well as social, educational, and other support services, regardless of the funding source for the services.

Care Call

The Care Call system is 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.

Center for Health Care Strategies (CHCS)

The Center for Health Care Strategies (CHCS) is a nonprofit health policy resource center dedicated to improving health care quality for low-income children and adults, people with chronic illnesses and disabilities, frail elders, and racially and ethnically diverse populations experiencing disparities in care. CHCS works with state and federal agencies, health plans, providers, and consumer groups to develop innovative programs that better serve people with complex and high-cost health care needs.

Centers for Medicare & Medicaid Innovation

Congress created the Center for Medicare and Medicaid Innovation, known as the “Innovation Center,” as part of the Centers for Medicare & Medicaid Services (CMS). The Innovation Center’s mission is to help transform the Medicare, Medicaid and CHIP programs to deliver better health, better healthcare and reduced costs through improvement for CMS beneficiaries. By doing so, it will help to transform the health care system for all Americans.

Centers for Medicare & Medicaid Services (CMS)

The Health and Human Service agency responsible for Medicare and parts of Medicaid

Chronic Illness and Disability Payment System (CDPS)

A diagnostic classification system originally used to make health-based capitated payments for certain Medicaid populations that was revised for use in adjusting capitated Medicare payments to health plans. South Carolina utilized the system to predict disease occurrence in certain regions of the state.

Community Choices HCBS Waiver

A waiver authorized pursuant to section 1915 (c) of the Social Security Act that permits a state to furnish an array of home- and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. South Carolina waiver services include but are not limited to personal care, attendant care, companion, environmental modification, home delivered meals, Adult Day Health Care (ADHC), respite care, Personal Emergency Response System, and incontinence supplies.

Community Long Term Care (CLTC)

Community Long Term (CLTC) operates home- and community-based waiver programs for persons eligible for nursing home care but who prefer to receive their services in the community. Through a process of case management and an individualized service package, waiver clients are able to successfully remain at home at a cost to Medicaid that is substantially less than the cost of institutional care. The CLTC program began statewide in 1983 after a three-year pilot program in

the Upstate. It was first established to meet the needs of the elderly or disabled person who was not able to care for himself or herself independently over a long period of time, perhaps for life. Currently, CLTC administers and operates four Medicaid waiver programs: Community Choices waiver, HIV/AIDS Waiver and Ventilator Dependent Waiver.

Community Support Services

Services that promote disease management, wellness, and independent living and that help avert unnecessary medical interventions (e.g., avoidable or preventable emergency department visits and facility admissions).

Coordinated Care Improvement Group (CCIG)

A group of concerned stakeholder who advises SCDHHS. The major duty of the CCIG is to examine the current Medicaid coordinated care system to determine what is working and not working; develop policies that improve health outcomes, cost efficiency, and patient and provider satisfaction, and analyze best practices in Medicaid managed care and Medicaid agencies nationwide.

Coordinated and Integrated Care Organization (CICO)

Organizations such as managed care organizations and care coordination service organizations that can bear risk and contract with a variety of providers in order to provide or arrange for a full continuum of services including primary and behavioral health care, specialists, hospital, and LTSS.

Current Population Survey (CPS)

The primary source of labor force statistics for the US. Sponsored by the US Census Bureau and the US Bureau of Labor Statistics, it is the source of various economic statistics, including the national unemployment rate. The CPS provides data on issues related to earnings and employment.

Data Use Agreement (DUA)

Legal binding agreement which CMS requires to obtain identifiable data. It also delineates the confidentiality requirements of the Privacy Act of 1974 security safeguards and CMS's data use policy and procedures.

<http://www.cms.gov/apps/glossary/default.asp?Letter=C&Language=English>

Disenroll

Ending your health care coverage with a health plan.

Dual Eligibles

Individuals entitled to Medicare and some level of Medicaid benefits. Persons who are entitled to Medicare (Part A and/or Part B) and who are also eligible for Medicaid.

(<http://www.cms.gov/apps/glossary/default.asp?Letter=C&Language=English>)

Enrollment Broker

An independent organization that assists individuals in choosing and enrolling in a health plan.

Fee-For-Service (FFS)

A method of payment in which the organization is paid for providing services to enrollees solely through fee-for-service payments plus in most cases, a case management fee.

Full Dual Eligibles

Individuals that qualify for full Medicaid benefits, including long-term care provided in both institutions and in the community as well as prescription drugs. For this group, Medicaid may also pay Medicare premiums and cost sharing.

Health Maintenance Organization (HMO)

A type of Medicare managed care plan where a group of doctors, hospitals, and other health care providers agree to give health care to Medicare beneficiaries for a set amount of money from Medicare every month. You usually must get your care from the providers in the plan.

Health Plan

An entity that assumes the risk of paying for medical treatments, i.e. uninsured patient, self-insured employer, payer, or HMO.

Healthcare Effectiveness Data and Information Set (HEDIS)

Set of performance measures used by managed care to indicate health plan performance.

Home- and Community-Based Services (HCBS)

Services and supports provided to individuals in their own home or other community residential settings that promote their independence, inclusion, and productivity.

Home and Community-Based Service Waiver Programs (HCBS)

The HCBS programs offer different choices to some people with Medicaid. If you qualify, you will get care in your home and community so you can stay independent and close to your family and friends. HCBS programs help the elderly, persons with physical disabilities, persons with intellectual or, developmental disabilities, and certain other adults with diseases or conditions. These programs give quality and cost effective services as an alternative to institutional care.

Home Health Care

Limited part-time or intermittent skilled nursing care and home health aide services, physical therapy, occupational therapy, speech-language therapy, medical social services, durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers), medical supplies, and other services.

Integrated Care Workgroup (ICW)

Group of public and private stakeholders from health care services and public policy arenas that were actively involved in the development of the Demonstration model/proposal. The ICW provided valuable input in the areas of primary care, behavioral health care, and LTSS. Groups

that were represented included, but were not limited to, advocacy groups, hospitals, medical providers, community providers, managed care organizations, and government and state agencies.

Lt. Governor's Office on Aging

Administers federal funds received through the Older Americans Act and the State of South Carolina. The funds are distributed to ten regional Aging and Disability Resource Centers/Area Agencies on Aging who then contract with local providers for services such as: home delivered and congregate meals, transportation, home care services, social adult day care services, respite, and disease prevention/health promotion.

(LIPS) Licensed Independent Practitioners

Include licensed Independent Social Workers, Psychologists, Marriage and Family Therapists, Counselors and Nurse Practitioners who can provide rehabilitative behavioral health services under the State Medicaid plan. LIPS must operate within the scope of the practitioner license and consistent with individually assigned clinical responsibilities.

Long-Term Care

A variety of services that help people with health or personal needs and activities of daily living over a period of time. Long-term care can be provided at home, in the community, or in various types of facilities, including nursing homes and assisted living facilities. Most long-term care is custodial care.

Long-Term Services and Supports (LTSS)

A wide variety of services and supports that help people 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.

Medicaid

The program that provides medical assistance for low-income persons that was established under the authority of Title XIX of the Social Security Act.

Medicare-Medicaid Coordination Office (MMCO)

The Medicare-Medicaid Coordination Office was established pursuant to Section 2602 of the Affordable Care Act. The Federal Coordinated Health Care Office (Medicare-Medicaid Coordination Office) serves people who receive benefits from both Medicaid and Medicare (often called "dual eligibles"). Our goal is to make sure dual eligible beneficiaries have full access to seamless, high quality health care and to make the system as cost-effective as possible. The Medicare-Medicaid Coordination Office works with the Medicaid and Medicare programs, across federal agencies, States and stakeholders to align and coordinate benefits between the two programs effectively and efficiently. We partner with States to develop new care models and improve the way dual eligibles get health care (<http://www.cms.gov/medicare-medicare-coordination/>).

Medicare

Title XVIII of the Social Security Act, the federal health insurance program for people age 65 and older, people under 65 with certain disabilities, and people with End Stage Renal Disease (ESRD, permanent kidney failure requiring dialysis or a kidney transplant). Medicare Part A provides coverage of inpatient hospital services and services of other institutional providers, such as skilled nursing facilities and home health agencies. Medicare Part B provides supplementary medical

insurance that covers physician services, outpatient services, some home health care, durable medical equipment, and laboratory services and supplies, generally for the diagnosis and treatment of illness or injury. Medicare Part C provides Medicare beneficiaries with the option of receiving Part A and Part B services through a private health plan. Medicare Part D provides coverage for most pharmaceuticals.

Medicare Model Diagnostic Categories

Categories composed of specific disease diagnoses. South Carolina used the chronic disease diagnostic categories to provide a summary of the disease occurrence in certain regions of the state, classified according to projected disease burden cost.

Money Follows the Person (MFP)

A demonstration with the purpose of making long-term support systems changes in states. This initiative will assist states in efforts to reduce the reliance on institutional care, while developing community-based long-term care services, thus enabling the elderly and people with disabilities to remain engaged in the community. Grants were awarded to thirty states and the District of Columbia proposing to transition individuals out of institutional settings over a five-year demonstration period.

NCQA

National Committee on Quality Assurance

Patient-Centered Medical Home (PCMH)

The PCMH is a team-based model of care in a health care setting that provides coordinated patient care to maximize health outcomes. A PCMH is responsible for providing all of a patient's health care needs. Health information technology is used to facilitate care. There are three levels of recognition for a PCMH, with three being the highest.

Program of All-Inclusive Care for the Elderly (PACE)

A comprehensive service delivery and financing model that integrates medical and LTSS under dual capitation agreements with Medicare and Medicaid. The PACE program is limited to individuals age 55 and over who meet the skilled-nursing-facility level of care criteria and reside in a PACE service area.

Region I

The proposed implementation region that is comprised of Abbeville, Anderson, Cherokee, Greenwood, Greenville, Laurens, Newberry, Oconee, Pickens, and Spartanburg counties.

Region II

The proposed implementation region that is comprised of Aiken, Bamberg, Barnwell, Chester, Edgefield, Fairfield, Kershaw, Lancaster, Lexington, McCormick, Richland, Saluda, Union, and York counties.

Region III

The proposed implementation region that is comprised of Allendale, Calhoun, Beaufort, Berkeley, Charleston, Colleton, Dorchester, Hampton, Jasper, and Orangeburg counties.

Region IV

The proposed implementation region that is comprised of Chesterfield, Clarendon, Darlington, Dillon, Florence, Georgetown, and Horry, Lee, Marion, Marlboro, Sumter, and Williamsburg counties.

State Health Insurance Program (SHIP)

A service provided by the Lt. Governor's Office on Aging that assists seniors and adults with disabilities in accessing health insurance coverage, including Medicaid and Medicare Parts A, B, C, and D, the prescription drug program.

South Carolina Department of Health and Human Services (SCDHHS)

South Carolina's State Medicaid Agency

Appendix B

Community Choices HCBS Waiver Services

Adult Day Health Care (ADHC)

Medically supervised care and services provided at a licensed day care center. Transportation to and from the home is provided within 15 miles of the center.

Adult Day Health Care (ADHC) Transportation

Transportation to and from the adult day health care center

Attendant Care

A client-directed service to provide personal care assistance.

Companion

As part of the services offered in the Community Choices waiver, this service is defined as short-term relief for caregivers and needed supervision of clients. This may be provided by an agency or as client directed care.

Environmental Modification

Pest control services and physical adaptations to the home that include ramps, floor repair, modifications to allow wheel chair access, bathroom safety supplies and other safety and access related modifications.

Home Delivered Meals

Regular or special diet meals delivered to the client's home.

Limited Incontinence Supplies

Limited supply of diapers and underpads.

Personal Care I

A service that provides assistance with general household activities.

Personal Care II

A service that helps with activities of daily living such as bathing, dressing, preparing meals, housekeeping, and observing health signs.

Personal Emergency Response System (PERS)

This service provides an electronic device which enables high risk individuals to secure help in the event of an emergency.

Respite Care

Temporary relief for the client's caregiver by admission to an in-patient facility (nursing home or hospital) or community residential care facility (CRCF).

Telemonitoring

Web-based monitoring of vital signs such as blood pressure, blood sugar and weight loss. RNs communicate results with physicians as appropriate.

Adult Care Home

Care provided in a private residence to a waiver participant. This does not include room and board payments.

Appendix C

Phoenix: Community Long Term Care's Automated Case Management System

Medicaid recipients in South Carolina needing long term care services can elect to receive services in their own homes through the Community Long Term Care (CLTC) Programs. Case managers in CLTC coordinate a variety of contracted services such as personal care, adult day health care, home delivered meals, and other Medicaid services designed to keep the consumer at home rather than in a nursing facility. Over 12,000 elderly or disabled South Carolinians receive these home care services.

Since 1991, case managers and nurses have been able to use an automated case management system to assist them in their work. This system keeps automated records of a number of critical functions, including all intake, assessment, and care planning activities.

The most recent version of this software, implemented in 2010, is called *Phoenix*. *Phoenix* is designed to be used with tablets so case managers and nurses can obtain electronic signatures and work toward a completely paperless system. The tablets download critical data and upload it to the web as needed. Data input can be done through the tablets or directly to the web.

There are a number of features of available for workers. These include a dashboard showing all assigned cases, activities due and performed, and notifications. There is a database of medications allowing them to indicate current and former medications being taken by participants. There is also an automated way to identify need for home repairs and electronically send them to a specialist who will due a home assessment and provide specifications for providers.

Providers can also access parts of *Phoenix*. They receive e-mails indicating when case managers have made a referral or authorization for services to their company. They can electronically accept these referrals and view pertinent information related to the services they provide, such as the service plan and demographic information.

Additional features of *Phoenix* include a section for home assessment, one for caregiver supports, one measuring quality indicators and reporting out by individual worker and CLTC office for a number of measures and a feature that pulls data from various source in *Phoenix* to ensure the service plan reflects all identified needs and goals. 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. There is also a means to identify waiver participants most at risk for missed in-home visits and those most at risk in the event of natural disasters.

An earlier version of this software has been featured by CMS as a Promising Practice in Long Term Care. Links are given below.

<http://www.cms.hhs.gov/PromisingPractices/HCBSPPR/list.asp?datefiltertype=-1&datefilterinterval=&datafiltertypename=Report+Category&datafiltertype=3&datafiltervalue=&filtertype=keyword&keyword=south+carolina&cmdFilterList=Refresh+List>

Appendix D

Care Call: Community Long Term Care's Automated Prior Authorization, Service Documentation, Service Monitoring, Billing, and Reporting System

The *Care Call* system is an automated system used by four of South Carolina's approved Medicaid waiver programs (Community Choices, HIV/AIDS, Medically Complex Children and Mechanical Ventilation) for prior authorization of services, service documentation, service monitoring, web-based reporting, and billing to MMIS. It is also used for the children's nursing and personal care services. These waivers and services have a total of approximately 14,400 recipients on any given day.

For documentation of personal care services provided in a participant's home, workers call a toll free number upon commencing 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. By comparing the call with the prior authorization, only providers with authorizations can bill for services. By having two calls made for personal care services provided in a participant's home, the length of the call ensures that providers only receive payments for time served to the participant.

Since its inception, the *Care Call* system has identified that many providers had been billing for more time than actually delivered. This resulted in cost savings for the CLTC program. Also, since the system monitors the phone being used to make calls, a number of cases were identified where workers made calls from their own homes or some other inappropriate location. Several referrals to the Attorney General's Office have resulted in convictions based upon *Care Call* data.

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. If a provider notices a participant is not receiving service as authorized, the provider can implement the backup plan that is in place for the participant. Personal care providers also use *Care Call* information to complete payroll.

Providers were initially reluctant to use the system. However, since the implementation of *Care Call*, they have come to understand the benefits to them in monitoring, billing and payroll.

Participants enrolled in the Community Choices waiver who receive self-directed care utilize a financial management component to pay employees. This component of the system was added in 2003. On a bi-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.

Appendix E
South Carolina Proposed Benefits Design for Duals Demonstration

Benefits	Medicare	Medicaid	HCBS Waiver	Proposed Additional Services	Duals
Inpatient Hospital	x				x
Skilled Nursing Facilities	x	x			x
Nursing Facility Services (Skilled, intermediate, level of care)		x			
Hospice	x	x			x
Home Health	x	x			x
Physician Services	x				x
Outpatient Hospital	x				x
Labs	x				x
X-Rays	x				x
Physical Therapy	x				x
Speech Therapy	x				
Occupational Therapy	x				x
DME	x	x			x
Pharmacy	x				x
Rural Health Clinic Services		x			x
FQHC Services		x			x
Ambulance Transportation		x			x
Medical Transportation		x			x
Podiatry		x			x
Family Support Services		x			x
Rehabilitative Therapy		x			x
Behavioral Health Screening		x*			x
Crisis Management		x*			x
Community Support Program (Rehabilitative Psych. Services and Peer Support Services)		x*			x
Diagnostic Assessment Services		x*			x
Medication Management		x*			x
Partial Hospitalization		x*			x
Psychological Testing/Evaluation		x*			x
Service Plan Development		x*			x
Substance Abuse Examination		x*			x
Therapies (Individual, Family, and Group)		x*			x
Telepsychiatry		x*			x

Appendix E
South Carolina Proposed Benefits Design for Duals Demonstration

Benefits	Medicare	Medicaid	HCBS Waiver	Proposed Additional Services	Duals
Brief Intervention				x	x
Home- and Community-Based Services			x		x
Adult Day Care			x		x
Adult Foster Care Services			x		x
Case Management			x		x
Day Habilitation Services			x		x
Personal Care I and II			x		x
Private Duty Nursing Services			x		x
Attendant Care			x		x
Companion			x		x
Environmental Modifications and Enhanced Environmental Mods			x		x
Home Delivered Meals			x		x
Transportation			x		x
Respite in an institution or CRCF			x		x
Personal Emergency Response System (PERS)			x		x
Incontinence Supplies			x		x
Nursing Home Transition Services			x		x
Nutritional Supplements			x		x
Tele-Monitoring			x		x
Bath Safety Supplies			x		x
Comprehensive Needs Assessment and Goal Setting				x	x
Care Planning/Management/Coordination (including home visits)				x	x
Monitoring adherence to care plan, follow-up, responding to changes				x	x
Follow-up, coordination across specialists/providers				x	x
Caregiver Education				x	x
Transition Services				x	x
Multidisciplinary Team (physical and virtual)				x	x
Assistive Technology				x	x
Routine Dental Services				x	x
Routine Vision Services				x	x
Non-Covered Prescriptions				x	x
Behavior Supports				x	x
Assisted Living				x	x

Appendix E
South Carolina Proposed Benefits Design for Duals Demonstration

Benefits	Medicare	Medicaid	HCBS Waiver	Proposed Additional Services	Duals
Supportive Housing				x	x
In-Home Respite Care				x	x
Enhanced Adult Day Services				x	x
Telemedicine				x	x