STATE MEDICAID AGENCY CONTRACT

BETWEEN

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES

AND

<< CONTRACTOR >>

FOR THE PURCHASE AND PROVISION OF MEDICAL SERVICES UNDER THE

SOUTH CAROLINA MEDICAID MANAGED CARE PROGRAM

DATED AS OF

January 1, 2027

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STATE MEDICAID AGENCY CONTRACT

BETWEEN

THE SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES

AND

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX.

FOR A SPECIAL NEEDS PLAN PURSUANT TO THE MEDICARE IMPROVEMENT FOR PATIENTS AND PROVIDERS ACT

This Contract is entered into to be effective as of the first day of January 202X, by and between the South Carolina Department of Health and Human Services, 1801 Main Street, Post Office Box 8206, Columbia, South Carolina, 29202-8206, hereinafter referred to as "SCDHHS" and ********** hereinafter referred to as the "Contractor".

RECITALS

WHEREAS, the Centers for Medicare & Medicaid Services (CMS) has a program to pay the cost-sharing for Qualified Members who are dually eligible for both Healthy Connections Medicaid (Medicaid) and Medicare and are enrolled as members in a Medicare Advantage (MA) health benefit plan sponsored by a duly licensed and qualified insurance company.

WHEREAS, the Contractor is a duly licensed insurance company that has National Committee for Quality Assurance (NCQA) Model of Care (MOC) approval, sponsors MA Plans in South Carolina, and offers a plan to Full-Benefit Dual Eligibles and Partial Dual Eligibles to provide coverage for Medicare services.

WHEREAS, the Contractor may choose which of these dually eligible beneficiaries to enroll in its Dual Special Needs Plan (D-SNP) based on the Special Needs Plan (SNP) type under the terms of this State Medicaid Agency Contract (SMAC). Categories of Dual Eligibles in South Carolina are:

1. Qualified Medicare Beneficiary Plus (QMB+)
    - QMB is recognized as FBDE in South Carolina
2. Special Low-Income Medicare Beneficiary (SLMB Only)
3. Special Low-Income Medicare Beneficiary Plus (SLMB+)
4. Qualifying Individual (QI)
5. Qualified Disabled and Working Individual (QDWI)
6. Full Benefit Dual Eligible (FBDE)

WHEREAS the Contractor is restricted from enrolling any Full-Benefit Qualified Members into this Coordination-Only (CO) Dual Special Needs Plan (D-SNP), if the Contractor also operates an approved Highly Integrated Dual Special Needs Plan (HIDE-SNP) of the same type.

WHEREAS, for the purposes of this SMAC, the Contractor, that does not also offer a HIDE-SNP, may choose to permit the following South Carolina Full-Benefit Dual Eligible categories to enroll in the following categories:

1. Qualified Medicare Beneficiary Plus (QMB+)
2. Special Low-Income Medicare Beneficiary Plus (SLMB+)
3. Full Benefit Dual Eligible (FBDE)

WHEREAS, additionally, for the purposes of this SMAC, the Contractor may choose to permit the following Partial Dual Eligible categories:

1. Special Low-Income Medicare Beneficiary (SLMB Only)
2. Qualified Individual (QI)
3. Qualified Disabled and Working Individual (QDWI)

WHEREAS, in addition to the above categorical requirement, the Contractor must only enroll Qualified Members who meet the following requirements:

1. Must be 18 years old or older.

NOW THEREFORE, the parties to this SMAC, in consideration of the mutual promises, covenants, and stipulations set forth herein, agree as follows:

GENERAL PROVISIONS

In order to assure the efficient operation of the above-described program, SCDHHS and the Contractor agree to the following general provisions:

I. The Contractor shall provide Qualified Members enrolled in its plan(s) coverage in accordance with its Medicare Advantage contract with CMS to provide SNPs in South Carolina. The Contractor must retain responsibility for providing or arranging for benefits for individuals entitled to receive Medicare covered benefits under Title XIX, and any supplemental benefits filed by the Contractor and approved by CMS.

II. The Contractor will not provide Medicaid services. Medicaid services will continue to be provided by SCDHHS in accordance with the South Carolina State Plan for Medical Assistance (State Plan). The Contractor shall maintain current knowledge and familiarity of State Plan benefits through ongoing reviews of South Carolina laws, rules, and policies. A list of Covered Services by SCDHHS at the time of the execution of this SMAC

can be found as incorporated in Appendix B. After the execution of this SMAC, any changes in Medicaid services will be available online at www.scdhhs.gov.

III. The Contractor acknowledges and understands that this SMAC is not effective until it has received all requisite state government approvals, and the Contractor shall not begin performing work under this SMAC until notified to do so by SCDHHS.

IV. This SMAC is valid for the time period from January 01, 20XX through December 31, 20XX, unless terminated earlier in accordance with the terms of this SMAC.

V. At the end of the term of this SMAC, SCDHHS shall have the option to extend or renew this SMAC upon the same terms and conditions as contained herein for a period not to exceed four (4) one (1) year terms following annual CMS requirements.

DEFINITIONS

As used in this SMAC, the parties agree the following terms shall have the defined meanings:

Admission(s): The act or process of accepting someone into a hospital, clinic, or other treatment facility as an inpatient.

Appeal: A formal request to review a decision that denied a health insurance benefit or payment. It can also be a request to reconsider a decision that reduced, suspended, or terminated a service.

Business Associate Agreement (BAA): A written arrangement between a covered entity who provides Protected Health Information (PHI) to another entity to perform certain services for the covered entity that specifies certain responsibilities when it comes to Protected Health Information (PHI).

Care Coordinator: An appropriately qualified professional who is the designated Contractor's accountable point of contact for each Qualified Member receiving care management services. The Care Coordinator is responsible for assisting members in directing and delegating care management duties, as needed, and may include the following: facilitating the Health Risk Assessment; developing, implementing and monitoring the Individualized Care Plan; and serving as the lead of the care team.

Carved-In Service(s): The subset of Medicaid covered services for which the Contractors Medicaid Managed Care Organization will be responsible under this Contract.

Carved-Out Service(s): The subset of Medicaid covered services for which the Contractor will not be responsible under this Contract.

Code of Federal Regulations (CFR): The codification of the general and permanent rules published in the Federal Register by the departments and agencies of the Federal Government.

Dual Eligible(s): Person(s) who are entitled to Medicare (Part A and/or Part B) and who are also eligible for Medicaid.

Eligibility: Meeting the requirements for coverage under Medicare, Medicaid, or SCHIP. In Medicaid data, the term eligible is often used to refer to individuals who qualify and have enrolled in the program.

Enrollees: Person(s) who are eligible for coverage and are enrolled in a Medicare, Medicaid, or SCHIP programs.

Enrollment Broker: An individual or entity that performs choice counseling or enrollment activities, or both.

Full-Benefit Dual Eligibles (FBDE): Dually eligible Qualified Members who are enrolled in

Medicare Part A (Hospital Insurance) and/or Medicare Part B (Supplemental Medical Insurance) and are also enrolled in Full-Benefit Medicaid and/or the Medicare Savings Programs (MSPs) administered by each individual state.

Grievance: Any Complaint or dispute, other than one that constitutes an organization determination or other than an Adverse Benefit Determination under 42 CFR 422.566 (2024, as amended), expressing dissatisfaction with any aspect of the Contractor's or Provider's operations, activities, or behavior, regardless of whether remedial action is requested pursuant to 42 CFR 422.561 (2024, as amended).

Health Risk Assessment (HRA): A questionnaire that covers personal and family medical history, lifestyle factors, Social Determinants of Health, and other relevant health information. The assessment helps healthcare Providers evaluate a Qualified Member's overall health status and identify risk factors based on the patient's self-reported responses.

Interdisciplinary Care Team (IDT): A group of professionals from different disciplines who work collaboratively to address a patient's needs, often involving multiple physical, psychological, and/or social aspects of their care.

Managed Care Organizations (MCO): Entities that serve Medicaid Qualified Members on a risk basis through a network of employed or affiliated Providers.

Medicare Advantage (MA) Plans: Medicare Advantage Plans are approved by Medicare but are run by private companies. These companies provide Medicare Part A and Part B covered services and may include Medicare drug coverage too. Medicare Advantage Plans are sometimes called "Part C" or "MA" plans. MA plans are not supplemental insurance.

Model of Care (MOC): A vital quality improvement tool and integral component for ensuring that the unique needs of each Enrollee are identified by the D-SNP and addressed through the plan's care management practices. The MOC provides the foundation for promoting D-SNP quality, care management, and care coordination processes, 42 CFR 422.101(f)(i) (2024, as amended).

Partial Dual-Eligibles: Individuals who qualify for Medicare benefits and receive financial assistance from Medicaid to help cover out-of-pocket costs through what are known as Medicare Savings Programs but do not qualify for full Medicaid Benefits.

Provider: A person or an organization that has an agreement to participate in Medicare, including but not limited to hospital, critical access hospital, Skilled Nursing Facility, comprehensive outpatient rehabilitation facility, home health agency, hospice, clinic, rehabilitation agency, or public health agency.

Qualified Member: An individual who meets enrollment criteria defined within the Recital of this SMAC.

Significant Change: A major decline or improvement in a Qualified Member's status that meets all the following requirements:

- The change would not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, and the decline is not considered "self-limiting". The change impacts more than one area of the member's health status.
- The change requires interdisciplinary review and/or revision of the care plan.

Skilled Nursing Facility (SNF): A type of inpatient facility that provides short or long-term skilled nursing care, and rehabilitation services to patients.

Special Needs Plan (SNP): A Medicare Advantage (MA) coordinated care plan (CCP) specifically designed to provide targeted care and limit enrollment to special needs individuals.

State Medicaid Agency Contract (SMAC): This agreement, which is necessary for the Contractor to operate in South Carolina. SMACs are required to meet minimum requirements set by federal law, and requirements added by the state

System for Award Management (SAM): The System for Award Management (SAM) is the federal procurement database. All entities that want to do business with the federal government must be registered in SAM.

Section 1. Operations

1.1. The Contractor shall determine the benefits of its Qualified Members on an annual basis. Such benefits must be approved by CMS prior to January 1 of each successive calendar year.

1.2. The Contractor shall be responsible for establishing a relationship with SCDHHS and/or Managed Care Organizations (MCOs) to support care coordination for the Enrollees.

1.2.1. The Contractor shall, at minimum, provide the Members' Medicaid MCO contact information, support Integrated Interdisciplinary Team (IDT) participation and define a process to exchange Health Risk Assessment (HRA) and care plan data.

1.3. The Contractor is responsible for coordinating the delivery of all benefits for Enrollees covered by both Medicare and the State Plan, whether Medicaid benefits are delivered via SCDHHS' fee-for-service and/or a managed care delivery system.

1.4. The Contractor shall provide SCDHHS with written notice of any proposed changes for covered benefits under the plan(s) for the following year within thirty (30) calendar days of submission to CMS.

1.5. In accordance with 42 CFR 422.101(f) (2024, as amended), the Contractor shall develop and maintain a comprehensive care coordination program as part of their required Model of Care. This care coordination program's purpose is to ensure that Contractor's Qualified Members' healthcare needs, preferences for health services, and information sharing across healthcare staff and facilities are met over time.

1.6. The Contractor shall establish individual care management programs for Qualified Members when specific healthcare services are offered by the Contractor or where benefits and services may be available through SCDHHS's Medicaid program. This will include specific coordination to ensure Qualified Members have access to all services as part of the entire healthcare delivery continuum.

1.7. The Contractor shall submit to SCDHHS, via a mutually acceptable secure transmission method, its final and approved Model of Care (MOC) with its MOC score within five (5) calendar days after receiving approval of the MOC from CMS. If the Contractor makes any changes to its MOC, the Contractor shall resubmit its MOC to SCDHHS within thirty (30) calendar days of submission to CMS.

1.8. The Contractor shall make available health insurance plan(s) providing certain benefits to Qualified Members who reside in the service area, as listed on Appendix A. Any plan(s) offered under this SMAC must be approved by CMS.

1.9. Additional counties may be added later to this SMAC with CMS and SCDHHS approval. The Contractor must submit a written request to SCDHHS for the approval of any additional counties.

1.10. SCDHHS, in accordance with CFR 42 CFR 422.102 (2024, as amended), requires the Contractor to provide, at minimum, the supplemental benefits listed below:

1.10.1. Dental Services

1.10.2. Hearing Services

1.10.3. Vision Care

1.11. The Contractor shall establish and maintain one or more Enrollee advisory committees in accordance with 42 CFR 422.107(f) (2024, as amended). Additionally, the Contractor shall consult with the Enrollee advisory committee(s) on various issues, including ways to improve health equity for underserved populations and those populations affected by social determinants of health.

Section 2. Enrollment

2.1. **Enrollment**

2.1.1. The Contractor must verify a Qualified Member's Medicaid Eligibility. Medicaid Eligibility may be verified by utilizing the South Carolina Medicaid Web-based Claims Submission Tool or an Eligibility verification vendor.

2.1.2. Qualified Members shall be enrolled and disenrolled in the Contractor's D-SNP(s) according to CMS requirements. The Contractor shall be responsible for informing Qualified Members of the effective date of enrollment through enrollment correspondence and notifications as defined by CMS.

2.1.3. SCDHHS will coordinate with the Contractor to exchange enrollment transactions.

2.1.4. The Contractor shall notify SCDHHS of any change in status for its enrolled Qualified Members. This includes but is not limited to factors that are likely to impact Medicaid or D-SNP Eligibility, such as address changes, incarceration, third party insurance other than Medicare, disenrollment from the D-SNP or any other changes in Eligibility status.

2.1.5. The Qualified Member's change in status information exchange shall be submitted in an SCDHHS approved file format which shall be provided to the Contractor.

2.2. **Enrollment File Exchange**

2.2.1. The HIPAA-compliant dual file format provided by SCDHHS will be exchanged between SCDHHS' Enrollment Broker and the Contractor for the purpose of communicating all enrollment changes for the D-SNP product to and from SCDHHS.

2.2.2. The Contractor shall submit a full file of client enrollments nightly to the Enrollment Broker and shall use the duals file provided by SCDHHS. The Contractor shall not alter the file format received from SCDHHS.

2.3. **Health Risk Assessment (HRA)**

2.3.1. The Contractor shall conduct an HRA, using tools procured by the Contractor and which meet federal regulations set forth in 42 CFR 422.101(f) (2024, as amended), for each Enrollee. This assessment must be conducted within ninety (90) calendar days of Qualified Member enrollment and annually thereafter. At minimum, HRAs must identify disparities in housing, transportation, and ability to obtain food and nutrition. Additionally, the Contractor shall be required to provide a copy of the tool used to complete the HRA to SCDHHS annually or when critical revisions are made.

2.3.2. The Contractor shall conduct a reassessment as warranted by the Qualified Member's condition or when there is a Significant Change in a Qualified Member's health status or needs.

2.3.3. The Contractor shall minimize unnecessary questioning of the Qualified Member in the HRA by incorporating information, as determined by SCDHHS, from Medicaid assessments required under 42 CFR 438.208(c)(2) (2024, as amended) and Enrollees must:

2.3.3.1. Receive an HRA within ninety (90) calendar days of enrollment in a plan and participate in the development and implementation of an Individualized Care Plan (ICP). The assessment must include considerations of social, functional, medical, behavioral, wellness and prevention domains, an evaluation of the Enrollee's strengths and weaknesses, and a plan for managing and coordinating an Enrollee's care.

2.3.3.2. Have themselves, or through their designated representative, the right to request a reassessment by the interdisciplinary team and be fully involved in any such reassessment.

2.4. **Individualized Care Plan (ICP)**

2.4.1. Following the HRA (as described in Section 2.3), the Contractor shall assign a Care Coordinator who works with the member, his/her family supports, and Providers, to develop a comprehensive, person-centered, written ICP for each member.

2.4.2. The Contractor must allow members to request and be assigned a new Care Coordinator if they so choose.

2.4.3. Every member must have an ICP, unless the member is unable to be reached or refuses the outreach attempts, and such refusal is documented by the Contractor.

2.4.4. The Contractor must complete each member's initial ICP within ninety (90) calendar days of enrollment.

2.4.5. In conjunction with periodic reviews, the Contractor must (i) update a member's ICP every three-hundred and sixty-five (365) calendar days (at minimum), or more frequently if the member's condition warrants or if the member requests a change and (ii) comply with all federal regulations outlined in 42 CFR 422.101 (2024, as amended).

Section 3. Provider Network

3.1. The Contractor, in accordance with 42 CFR 422.111(b)(3) (2024, as amended) and 42 CFR 422.2267e(11) (2024, as amended), shall establish a reasonable process for updating its directory of Providers and similar resources for Qualified Members to identify which of its contracted Providers are also SCDHHS Medicaid Providers.

3.2. SCDHHS will provide its active Medicaid Provider information monthly via a file transfer protocol (FTP) site. The link will be provided upon request by the Contractor.

3.3. The Contractor shall maintain contracts with participating Providers whereby the Contractor assures adequate access and availability to Qualified Members for all medically necessary covered services in compliance with CMS access standards and guidelines.

3.4. The Contractor must maintain policies and procedures to regularly monitor access and availability of such participating Providers to ensure the Contractor consistently meets such CMS access standards and guidelines.

3.5. The Contractor agrees to maintain a contracted participating Provider network which is qualified to serve the Enrollees in the Contractor's plan, including any specific special medical care needs of such members which are covered benefits under the plan.

Section 4. Payment Responsibilities

4.1. The Contractor is prohibited from imposing cost-sharing requirements on Dual Eligible Enrollees that would exceed the amounts permitted under the State Plan if the Enrollee were not enrolled in the Contractor's Dual Eligible SNP per section 1852(a)(7) of the Social Security Act and 42 CFR 422.107(c)(4) (2024, as amended). Further, Section 1902(n)(3)(B) of the Social Security Act prohibits a Medicare Provider from billing a Dual Eligible Member with QMB benefits for Medicare cost sharing amounts, including deductibles, coinsurance, and copayments. A Dual Eligible Member with QMB benefits has no legal obligation to make further payment to a Provider or to the Contractor for Medicare Part A or Part B cost sharing amounts.

4.2. The Contractor ensures that its contracts with participating Providers contain provisions that require such participating Providers to accept Medicare fee schedules plus Enrollee cost sharing as payment in full. Under the Contractor's Dual Eligible SNP, participating Providers may only collect such Enrollee cost sharing as specified by the Contractor pursuant to the limitations of Enrollment and Payment Responsibilities sections of this SMAC.

4.3. SCDHHS will follow its approved State Plan methodology for processing claims for Qualified Members. SCDHHS shall retain financial responsibility for applicable Medicaid cost-sharing obligations as detailed in the State Plan. If applicable, the Contractor will submit claims eligible for coordination of cost-sharing directly to SCDHHS for payment of any appropriate amounts as determined by SCDHHS.

4.4. Medicaid is the payor of last resort and will pay secondary to any third-party payment sources. Medicare benefits, including those offered by the Contractor under its MA Plan, can also be secondary to third-party payment sources.

4.5. Under South Carolina state law, SCDHHS has both an assignment of rights to any other health coverage for a Medicaid recipient and subrogation rights to the extent Medicaid has paid for a service. The Contractor shall recognize these rights.

4.6. The Contractor agrees to cooperate with SCDHHS to enforce third-party liability, including procedures for appropriate coordination of benefits between Medicare and Medicaid. The Contractor may also utilize its own coordination of benefits procedures to identify other third-party payors and shall provide SCDHHS with any third-party information gathered during this process.

Section 5. Marketing and Communications

5.1. The Contractor must provide SCDHHS with copies of all CMS-approved enrollment marketing materials related to the solicitation, application, and enrollment of Qualified Members in the plan(s) within forty-five (45) calendar days after CMS approval.

5.2. Contractor's communications and marketing materials must be made available in non-English languages and accessible formats that meet the requirements in accordance with 42 CFR 422.2267(a) (2024, as amended). The materials must also include a notice of availability of language assistance services and auxiliary aids and services in accordance with 42 CFR 422.2267(e)(31) (2024, as amended) and Section 1557 of the Affordable Care Act.

Section 6. Reporting Requirements

6.1. **Deliverables**

6.1.1. The Contractor understands and agrees that all reports and assessments prepared pursuant to this SMAC and requested by SCDHHS, including drafts, must be submitted to SCDHHS for its review and approval. The Contractor may not release or disclose, in any form, a report or assessment (including drafts) requested by SCDHHS to any person/entity without the express written consent of SCDHHS.

6.1.2. The Contractor shall submit any reports created as part of CMS reporting requirements to SCDHHS within five (5) calendar days of CMS submission following the CMS reporting schedule unless otherwise defined by the provisions below.

6.1.3. The Contractor shall submit to SCDHHS, via a mutually acceptable secure transmission method, all required reporting in alignment with the CMS reporting schedule for the purposes of reporting review and validation.

6.1.4. SCDHHS reserves the right to request additional data not explicitly stated in CMS reporting requirements or elsewhere in the SMAC.

6.1.4.1. Unless explicitly requested by SCDHHS, required reporting is limited to those reports identified in the Managed Care

Reporting Companion Guide (2025) which aligns with the CMS reporting schedule and the reporting obligations contemplated by the SMAC.

6.1.5. For high-risk members, defined as all Full Benefit Dual Eligible Members (QMB+, SLMB+, and FBDE), the Contractor shall provide timely notification of all Admissions to a hospital and Skilled Nursing Facility (SNF) to SCDHHS via a mutually acceptable secure transmission method in an agreed upon format. "Timely notification" is defined as within forty-eight (48) hours of the receipt of notice of admission.

6.2. **Reporting Schedule**

6.2.1. The Contractor, shall submit reports following the reporting schedule detailed below:

6.2.1.1. The Contractor shall submit to SCDHHS the following report(s) for members identified as High-Risk within forty-eight (48) hours of the Contractor's receipt of notice of admission:

6.2.1.1.1. Hospital Admissions (General and Specialty)

6.2.1.1.2. Skilled Nursing Facility (SNF) Admissions

6.2.1.2. The Contractor shall submit to SCDHHS the following report(s) within five (5) calendar days of CMS submission following the CMS reporting schedule:

6.2.1.2.1. Appeals and Grievances

6.2.1.2.2. Care Management

6.2.1.3. The Contractor shall submit to SCDHHS the following report(s) as requested by SCDHHS:

6.2.1.3.1. Emergency Management Reporting (natural disaster, state of emergency, etc.)

6.2.1.3.2. On an annual basis, and on an ad hoc basis when changes occur or as directed by SCDHHS and CMS, the Contractor shall submit to SCDHHS an overall organizational chart that includes direct contacts, senior and mid-level managers.

6.2.1.3.2.1. For the purposes of this SMAC, organizational structure is limited to Administrator (COO, CEO, Executive

Director, etc.), CFO, Contract Manager, Medical Director, Pharmacy Director, and Quality Improvement (QI) and/or Quality Management (QM) Coordinator, Manager, or Director.

6.2.1.4. The Contractor shall report monthly to SCDHHS the following via a template approved by SCDHHS:

6.2.1.4.1. Number of HRAs Completed (All risk levels)

6.2.1.4.2. Average Time to Complete HRAs (Days) for Members Who Were Willing to Participate and Who Could be Reached - Past 3 Months (Excludes UTR and Declines)

6.2.1.4.3. Number of ICPs Completed

6.2.1.4.4. All Coordinators to All Enrollees Ratio

6.2.1.4.5. Amount of Active Enrollment at the Beginning of the Month

6.2.1.4.6. Total Number of Care Coordinators

6.2.1.4.7. Number of Member Grievances Closed

6.2.1.4.8. Number of Appeals Closed

6.2.1.4.9. Number of Appeals with Adverse Denials

6.2.1.4.10. Number of Appeals Favorable

6.2.1.4.11. Number of Appeals Partially Favorable

6.2.1.4.12. Number of Appeals Withdrawn

6.2.1.4.13. Number of Dismissed Appeals

6.2.1.4.14. Member Appeals (Closed) - Non-Part D Related

6.2.1.4.15. Member Appeals (Closed) - Part D Related

6.2.1.4.16. Number of Provider Appeals (Closed) - Non-Part D Related

6.2.1.4.17. Number of Provider Appeals (Closed) - Part D Related

6.2.1.4.18. Top 3 reasons for Member Appeals

6.2.1.4.19. Top 3 reasons for Provider Appeals

6.2.1.4.20. Additional Grievance Details

6.2.1.4.21. Additional Appeals Details

6.2.2. The Contractor shall provide SCDHHS with D-SNP HEDIS reporting measures as defined by CMS at the time of submission to CMS via a mutually acceptable secure transmission method. This report shall include all fields as required by NCQA.

6.2.3. For technical notes, the Contractor shall reference the D-SNP reporting Section of the MCO Reports Companion Guide.

6.3. **Operating Provisions**

6.3.1. The Contractor shall provide SCDHHS with a report within five (5) calendar days of the following month containing its current D-SNP enrollment. The report shall be created using the template enrollment report provided by SCDHHS. The D-SNP enrollment report shall include the following:

6.3.1.1. Beneficiary Name

6.3.1.2. Beneficiary Medicaid & Medicare ID

6.3.1.3. Date of enrollment and disenrollment (If necessary)

6.3.1.4. Date of Birth (DOB)

6.3.1.5. Enrollment method (CMS, Broker, Mail-in application, or over the phone)

6.3.1.6. Contract Number

6.3.1.7. Plan Benefit Package (PBP)

6.3.1.8. County Name

6.3.2. Personally Identifiable Information (PII)/Protected Health Information (PHI) is to be protected in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended, along with its attendant regulations as agreed upon within the Business Associates Agreement (BAA).

6.4. **Encounter Data**

6.4.1. The Contractor shall submit to SCDHHS complete, accurate, and timely encounter data for all Medicare services for which the Contractor provided services under this SMAC, as reported to CMS.

6.4.2. Encounter data must be submitted via a mutually acceptable secure transmission method as defined by SCDHHS and uploaded monthly, at a minimum, and no later than thirty (30) calendar days from the end of the month in which the Contractor submitted encounter data to CMS. Submitted encounters and encounter records shall have all fields required and found on standard healthcare claim billing forms or in electronic healthcare claim formats to support proper adjudication of an encounter.

6.4.3. The Contractor shall submit to SCDHHS, without alteration, omission, or splitting, all available claim data in its entirety from the Contractor's submission to CMS.

6.4.4. Submitted encounters or encounter records must not be a duplicate of a previously submitted and accepted encounter or encounter record unless submitted as an adjustment or void per HIPAA.

Section 7. Contract Oversight

7.1. **Contract Monitoring**

7.1.1. In conjunction with CMS, SCDHHS reserves the right to perform contract monitoring as deemed necessary. Contract monitoring may utilize either internal and/or external contracted staff and will be conducted in accordance with all federal and state laws and regulations.

7.2. **Termination**

7.2.1. Should SCDHHS or the Contractor desire to terminate this SMAC for convenience, the party terminating the SMAC shall give notice of such termination in writing to the other party. Notice of termination shall be sent by certified mail, return receipt requested, and shall be sent on official organizational letterhead to be effective ninety (90) calendar days after the date of receipt, unless otherwise provided by law. The date of receipt shall be the earlier of the date actually received by the party or seven (7) calendar days from depositing in the mail.

7.2.2. This SMAC may be canceled or terminated by either party upon thirty (30) calendar days' notice within the SMAC period whenever it is reasonably determined by such party that the other party has materially

breached or otherwise materially failed to comply with its obligations hereunder.

Section 8. Civil Monetary Penalties and Liquidated Damages

8.1. Contractor may be subject to certain liquidated damages under this SMAC as detailed below. These are not intended as all-inclusive, as other state or federal laws may contain certain civil monetary penalties associated with improper disclosure or misuse of governmental or personal information, which may result in damages to Contractor.

8.2. Each officer or employee of any person to whom Social Security information is or may be disclosed shall be notified in writing by such person that Social Security information disclosed to such officer or employee can be used only for authorized purposes and to that extent and any other unauthorized use herein constitutes a felony punishable upon conviction by a fine of as much as Five Thousand Dollars ($5,000) or imprisonment for as long as five (5) years, or both, together with the cost of prosecution. Such person shall also notify each officer or employee that any unauthorized further disclosure of Social Security information may also result in an award of civil damages against the officer or employee in an amount not less than One Thousand Dollars ($1,000) with respect to each instance of unauthorized disclosure. These penalties are prescribed by IRC Sections 7213 and 7431 and set forth in 26 CFR 301.6103(n) (2024, as amended).

8.3. The Contractor must inform its officers and employees of penalties for improper disclosure implied by the Privacy Act of 1974, 5 USC 552a. Specifically, 5 USC 552a(i)(1), which is made applicable to contractor by 5 USC 552a(m)(1), provides that any officer or employee of a contractor, who by virtue of his/her employment or official position, has possession or access to agency records which contain individually identifiable information, the disclosure of which is prohibited by the Privacy Act or regulations established thereunder, and who knowing that disclosure of the specific material is prohibited, willfully discloses that material in any manner to any person or agency not entitled to receive it, shall be guilty of a misdemeanor and fined not more than Five Thousand Dollars ($5,000).

Section 9. Terms and Conditions

9.1. The Division of Integrated Managed Care is the SCDHHS contact for the administration of this program. The contact person for the Contractor shall be the Bureau of Managed Care, Director of Integrated Managed Care, or other specified authority within SCDHHS.

9.2. Any modification of this SMAC must be approved by SCDHHS and the Contractor and incorporated by written amendment to this SMAC.

9.3. This SMAC shall be construed to be the complete integration of all understandings between the parties. No prior or contemporaneous addition, deletion, or other amendment shall have any force or effect whatsoever unless embodied herein in writing. No subsequent novation, renewal, addition, deletion, or other amendment shall have any force or effect unless embodied in a written amendment executed and approved pursuant to this SMAC.

9.4. All titles used herein are for the purpose of clarification and shall not be construed to infer a contractual construction of language.

9.5. All appendices referred to in this SMAC are attached hereto, are expressly made a part, and incorporated as fully set forth herein.

9.6. The parties hereby agree that the execution and any performance pursuant to this SMAC does not constitute a waiver, each to the other, of any claims, rights, or obligations which shall or have arisen by virtue of any previous agreement between the parties. Any such claims, rights, or obligations are hereby preserved, protected, and reserved.

9.7. No assignment or transfer of this SMAC or of any rights hereunder by the Contractor shall be valid without the prior written approval of SCDHHS. Notice of such intent to assign or transfer must be provided to SCDHHS within five (5) calendar days of Contractor providing notice to CMS. Contractor should provide to SCDHHS, at a minimum, a copy of the same information provided to CMS.

9.8. If any provision of this SMAC is prohibited by the laws of the State of South Carolina, such provision shall be deemed ineffective without invalidating the remaining provisions of this SMAC.

9.9. It is mutually understood and agreed this SMAC shall be governed by the laws of the state of South Carolina and federal laws as they pertain to the performance of services provided under this SMAC.

9.10. The Contractor agrees to comply with all applicable federal and state laws and regulations including constitutional provisions regarding due process and equal protection of the laws and including, but not limited to:

9.10.1. All applicable standards, orders, or regulations issued pursuant to the Clean Air Act of 1970, as amended (42 U.S.C. §7401, et seq.) and the Federal Water Pollution Control Act, as amended (33 U.S.C. §1251, et seq.)

9.10.2. Title VI of the Civil Rights Act of 1964, as amended (42 U.S.C. §2000d et seq.) and regulations issued pursuant thereto (45 CFR Part 80, 2024, as amended), which provide that the Contractor must take adequate steps to ensure that persons with limited English skills receive, free of charge, the language assistance necessary to afford them meaningful and equal access to the benefits and services provided under this SMAC.

9.10.3. Title VII of the Civil Rights Act of 1964, as amended (42 U.S.C. §2000e) in regard to employees or applicants for employment.

9.10.4. Section 504 of the Rehabilitation Act of 1973, as amended, (29 U.S.C. §794), which prohibits discrimination on the basis of disability in programs and activities receiving or benefiting from federal financial assistance, and regulations issued pursuant thereto (45 CFR Part 84 (2024, as amended)).

9.10.5. The Age Discrimination Act of 1975, as amended, (42 U.S.C. §6101 et seq.), which prohibits discrimination on the basis of age in programs or activities receiving or benefiting from federal financial assistance.

9.10.6. The Omnibus Budget Reconciliation Act of 1981, as amended, P.L. 97-35, § 1908(a)(2), 95 Stat. 483, 542 (1981), which prohibits discrimination on the basis of sex and religion in programs and activities receiving or benefiting from federal financial assistance.

9.10.7. The Americans with Disabilities Act, (42 U.S.C. §12101 et seq.), and regulations issued pursuant thereto.

9.10.8. The Drug Free Workplace Acts, S.C. Code Ann. §44-107-10 et seq. (2018), and the Federal Drug Free Workplace Act of 1988 as set forth in 2 CFR Part 182 (2024, as amended).

9.10.9. The Code of Federal Regulations at 42 CFR Part 422 (2024, as amended).

9.10.10. Section 6002 of the Solid Waste Disposal Act of 1965 as amended by the Resource Conservation and Recovery Act of 1976 (42 U.S.C. §6962).

9.11. The Contractor shall safeguard the use and disclosure of information concerning applicants for or recipients of Title XIX services in accordance with 42 CFR Part 431, Subpart F (2024, as amended), S.C. Code Ann. Regs. 126 - 170, et seq. (2011), and all other applicable state and federal laws and regulations and shall restrict access, use, and disclosure of such information in compliance with said laws and regulations.

9.12. The Contractor agrees to furnish to SCDHHS or to the USDHHS information on any person convicted of a criminal offense related to such person's involvement

in any program under Medicare (Title XVIII), Medicaid (Title XIX), or the Social Services Block Grant program as set forth in 42 CFR 455.106 (2024, as amended). Failure to comply with this requirement may lead to termination of this SMAC.

9.13. Individually identifiable health information is to be protected in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended, along with its attendant regulations.

9.14. If at any time during the term of this SMAC, the Contractor becomes aware of or has reason to believe that, under this or any other program administered by SCDHHS, a recipient of or applicant for services, an employee of the Contractor or SCDHHS, and/or subcontractor or its employees, has improperly or fraudulently applied for or received benefits, monies, or services pursuant to this or any other SMAC, such information shall be reported in confidence by the Contractor directly to SCDHHS.

9.15. Any and all suits or actions for the enforcement of the obligations of this SMAC and for any breach thereof, or for the review of an SCDHHS final agency decision with respect to this SMAC or audit disallowances, must be brought pursuant to S.C. Code Ann. §§1-23-380 et seq. (2005) and shall be instituted in a court of competent jurisdiction in the county of Richland, State of South Carolina.

9.16. The Contractor agrees to comply with all applicable provisions of 2 CFR Part 180 (2024, as amended) as supplemented by 2 CFR Part 376 (2024, as amended), pertaining to debarment and/or suspension and require its subcontractors to comply with these same provisions to ensure that no party receiving funds from this SMAC are listed on the government-wide exclusions in the System for Award Management (SAM).

9.17. The Contractor hereby certifies that neither it nor its principals are presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this SMAC by any Federal department or agency.

9.18. The Contractor must maintain an accounting system with supporting fiscal records adequate to assure that claims for funds are in accordance with this SMAC and all applicable laws, regulations, and policies. The Contractor further agrees to retain all financial and programmatic records, supporting documents, statistical records and other records of recipients relating to the delivery of care or service under this SMAC, and as further required by SCDHHS for a period of five (5) years after last payment made under this SMAC (including any amendments and/or extensions to this SMAC).

9.18.1. If any litigation, claim, or other actions involving the records have been initiated prior to the expiration of the five (5) year period, the records shall be retained until completion of the action and resolution of all issues

which arise from it or until the end of the five (5) year period, whichever is later. This provision is applicable to any subcontractor and must be included in all subcontracts.

9.19. SCDHHS, US DHHS, CMS, the US DHHS Office of Inspector General, the State Comptroller, the State Auditor's Office, and the South Carolina Attorney General's (SCAG) Office, or any of their designees shall have the right to evaluate, through audit, inspection, or other means, whether announced or unannounced, any books, contracts, computer or other electronic systems of subcontractor (or any subcontractor of subcontractor) that pertain to any aspects of services and activities performed, or determination of amounts payable, under Contractor's contract with any subcontractor, including those pertaining to quality, appropriateness and timeliness of services and the timeliness and accuracy of encounter data and Claims submitted to the Contractor.

9.19.1. Contractor and any subcontractor shall cooperate with these evaluations and inspections. Contractor and any subcontractor will make office workspace available for any of the above-mentioned entities or their designees when the entities are inspecting or reviewing any records related to the provision of services under this SMAC. Contractor and any subcontractor will make available, for purposes of an audit, evaluation or inspection, its premises, physical facilities, equipment, books, records, contracts, computer, or other electronic systems relating to its Medicaid Enrollees.

9.19.2. The right to audit Contractor and any subcontractor will exist through ten (10) years from the final date of the contract period or from the date of completion of any audit, whichever is later. If the State, CMS, or the US DHHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, the State, CMS, or the US DHHS Inspector General may inspect, evaluate, and audit the Contractor and any subcontractor at any time.

9.20. The Contractor is prohibited from contracting with any entity who is engaged in the boycott of a person, or an entity based in or doing business with a jurisdiction with whom South Carolina can enjoy open trade, as defined in S.C. Code Ann. § 11-35-5300 (Supp. 2024).

9.21. The failure of SCDHHS at any time to require performance by the Contractor of any Contractor provision of this SMAC shall in no way effect the right of SCDHHS to enforce any provision of this SMAC; nor shall the SCDHHS' waiver of any breach of any provision be construed as a waiver of breach of such provision or as a waiver of the provision itself.

9.22. This SMAC may be executed in two or more counterparts, each of which shall be deemed an original, but all of which shall constitute the same instrument. The parties agree that this SMAC may be delivered by facsimile or electronic mail with a copied signature having the same force and effect of a wet ink signature.



IN WITNESS WHEREOF, SCDHHS and the Contractor, by their authorized agents, in consideration of the mutual promises, covenants and conditions exchanged between them, have executed this SMAC as of the _____day of_____, 2026.

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES "SCDHHS"	XXXXXXXXXXXXXXXXXXXXXXXXX "Contractor"
Representative: *Eunice Medina,* *SCDHHS Agency Director*	Authorized Representative
Signature:	Signature:
Print Name:	Print Name:
Witnesses: 1.	Witnesses: 1.
2.	2.

Address for Notices:

XXXXXXXXXXXXXXX

XXXXXXXXXXXXXXX

XXXXXXXXXXXXXXX

With copies sent to:

XXXXXXXXXXXXXXX

XXXXXXXXXXXXXXX

XXXXXXXXXXXXXXX

Appendix A - Service Area

(By County)

CMS Contract Code: XXXXX

Plan ID: XXX

Plan Name: XXXXXXXXXXX

Eligibility Category(s): XXXXXXXXXX

CMS Approved Service Area:

(List of approved Counties in the State of South Carolina)

Appendix B - Medicaid Covered Services

Services outlined in this Appendix are provided in accordance with SCDHHS State Plan. Policies and procedures for Medicaid covered services reference in this Appendix are found in the respective Provider Manual(s) located on the SCDHHS website.

Within limits, Medicaid will pay for medically necessary services. For Medicaid payment purposes, the following definitions apply:

Children – birth through 20 years of age
Adults – 21 years of age and older

Medicaid can pay for the following healthcare services:

- Alcohol and drug abuse services
- Ambulance
- Applicable Cost Sharing
- Autism Spectrum Disorder (ASD) Services
- Behavioral Health Services for emotionally disturbed children
- Dental
- Doctor office visits (physician, nurse practitioner, midwife, podiatrist, chiropractor)
- Family Panning
- Family support services
- Home and Community-based long-term care services
- Home Health
- Hospice
- Hospital inpatient, outpatient, emergency room
- ICF for individuals with intellectual disabilities
- Inpatient psychiatric care
- Lab and X-ray
- Medical equipment
- Mental health services
- Nursing Facility
- Physical therapy
- Drugs (not all drugs are covered)
- Speech/language therapy
- Targeted case management
- Transportation to medical appointments
- Vision
- Well adult care
- Well childcare – EPSDT

Medicaid Managed Care Covers the following services:

Medicaid Managed Care Coverage			
Service Category	**Carved in**	**Carved Out**	**Comment**
Ambulance	✓		
Ancillary Medical Services	✓		
Audiological Services	✓		
Autism Spectrum Disorder (ASD) Services	✓		
Behavioral Health and Outpatient Services	✓		
Chiropractic Care	✓		
Community Long Term Care Waiver Services		✓	
Communicable Disease Services	✓		
Dental Services		✓	
Developmental Evaluation Centers	✓		
Durable Medical Equipment	✓		
Early Intervention Services		✓	
EPSDT	✓		
Emergency and Post Stabilization Services	✓		
Family Planning	✓		
Home Health Services	✓		
Hysterectomies	✓		
Independent Laboratory and X-Ray Services	✓		
Inpatient Hospital Services	✓		
Institutional Long-Term Care Facilities/Nursing Facilities		✓	
Maternity Services	✓		
Outpatient Services	✓		
Pharmacy	✓		
Physician Services	✓		
Rehabilitative Therapies for Children	✓		
Sterilization	✓		
Substance Abuse	✓		
Targeted Case Management			Referral Assistance
Transplant and Transplant Related Services	✓		
Vaccine Services	✓		
Vision Care Exams	✓		