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

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX.

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 2027, 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 or Health Maintenance Organization (HMO).

WHEREAS, SCDHHS is pursuing integration as described in 42 CFR 422. 107 (2024, as amended) in partnership with duly licensed HMO/insurance companies and shall require the Contractor to establish a single MA contract that is limited to an HMO for purposes of offering Dually Eligible Special Needs Plans (D-SNPs) in the state of South Carolina.

WHEREAS, the MA contract shall include a single Plan Benefit Package (PBP) for the purposes of offering a Highly Integrated Dually Eligible Special Needs Plan (HIDE-SNP) and may also include a single PBP for the purpose of offering a coordination-only D-SNP PBP to serve Partial-Dual Eligibles.

WHEREAS, the Contractor is a duly licensed HMO/insurance company that has National Committee for Quality Assurance (NCQA) approval, sponsors MA Plans in South Carolina, and offers an exclusively aligned plan to Full-Benefit Dual Eligibles to provide coverage for the Medicare services;

WHEREAS, the categories of Dual Eligibles in South Carolina are recognized as the following:

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 limited to enrolling the following Full-Benefit Dual Eligible categories into this Highly Integrated Dual Eligible Special Needs Plan (HIDE-SNP):

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

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.
2. Must be enrolled in the South Carolina Medicaid Managed Care Organization (MCO) [INSERT MCO NAME] that exclusively aligns with the Contractor.

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 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.

II. This SMAC is valid for the time period from January 01, 2027, through December 31, 2027, unless terminated earlier in accordance with the terms of this SMAC.

III. 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.

DEFINITIONS

As used in this SMAC, the parties agree the following terms shall have the following 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 Qualified 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 Contractor's 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.

Corrective Action Plan (CAP): A narrative of steps taken to identify the most cost-effective actions to address issues and improve processes.

Coverage Decision Letter: A formal document that informs a Qualified Member that his or her health coverage claim has been denied by their health plan.

Deeming: A limited period of continued enrollment in the D-SNP following a loss of Medicaid eligibility for individuals who lose Medicaid eligibility but are expected to regain Medicaid coverage within six months. The length of a deeming period can range from thirty (30) days minimum to a maximum of six (6) months and is determined by the D-SNP or the state.

Default Enrollment: An enrollment process that allows the Contractor, following approval by the SCDHHS and CMS, to enroll, unless the Qualified Member chooses otherwise, a Qualified

Member of an affiliated Medicaid Managed Care Organization (MCO) into its Medicare Dual Eligible Special Needs Plan (D-SNP) when the MCO Qualified Member becomes eligible for both Medicare Parts A and B for the first time based on age or disability, per 42 CFR 422.66(c)(2) (2024, as amended).

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.

Exclusively Aligned Enrollment (EAE): When a state limits D-SNP enrollment to Full-Benefit dually eligible Qualified Members who receive their Medicaid benefits from the D-SNP, or an affiliated Medicaid managed care plan offered by the same parent organization as the D-SNP.

Formulary: A list of drugs that are covered by an insurance plan.

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.

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 Maintenance Organization (HMO): A type of managed care plan that provides basic and supplemental health services to its Qualified Members.

Health Plan Management System (HPMS): A web-enabled information system that serves a critical role in the ongoing operations of the Medicare Advantage and Part D programs.

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.

Highly Integrated Dual Eligible Special Needs Plan (HIDE-SNP): A D-SNP offered by a Medicare Advantage organization that provides coverage, consistent with SCDHHS policy, of long-term services and supports or behavioral health services under a capitated contract that meets one of the following arrangements: (1) the capitated contract is between the Medicare Advantage organization and SCDHHS; or (2) the capitated contract is between the Medicare Advantage organization's parent organization (or another entity that is owned and controlled by its parent organization) and SCDHHS; and (3) has received CMS designation as a HIDE-SNP.

High-Risk: More likely than others to get a particular disease, condition, or injury.

Individualized Care Plan (ICP): An integrated, individualized, person-centered plan developed by both the Qualified Member and the CONTRACTOR that addresses clinical and non-clinical needs identified in the Health Risk Assessment and includes goals, interventions, and expected outcomes.

Annual Notice of Change (ANOC): A document that summarizes changes to a Medicare Advantage or Part D health plan that will take effect in the following year.

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.

Maximum Out-Of-Pocket (MOOP): The most Qualified Members must pay for covered services in a plan year.

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.

Member Handbook: A Member Handbook, also known as the Evidence of Coverage, is a document that provides details about a health insurance policy, including what it covers, how much you pay, and how the plan works.

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.

Risk Stratification: A technique for systematically categorizing patients based on their health status and other factors.

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 Qualified 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 may contain other requirements added by the state.

Summary of Benefits: A snapshot of a health plan's costs, benefits, covered health care services, and other features that are important to consumers.

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 provide services to Qualified Members enrolled in its exclusively aligned plan in accordance with its MA contract with CMS to provide D-SNPs in South Carolina.

1.2. The service area is the geographic area in which Qualified Members reside and for whom the Contractor is approved to provide services. The Contractor's service area must be approved by both CMS and SCDHHS. The service area covered by this Contractor is as listed on Appendix A and must align with the Contractor's Medicaid service area.

1.3. The Contractor must operate its MCO under the same parent organization as the D-SNP.

1.4. The Contractor must retain responsibility for providing or arranging for benefits for Qualified Members entitled to receive Medicare and Medicaid covered benefits under Title XIX, and any supplemental benefits filed by the Contractor and approved by CMS. For the purpose of this SMAC, and in accordance with 42 CFR 422.2 (2024, as amended), SCDHHS requires Exclusively Aligned Enrollment (EAE) and limits the coverage of Medicare benefits to the D-SNP plan and Medicaid benefits through the adjoining MCO which are administered by a single health plan organization.

1.5. The Contractor is responsible for coordinating the delivery of all benefits covered by Medicare and the State Plan. As Contractor also operates an MCO, failure of Contractor to comply with the terms of its SCDHHS MCO contract may result in a commensurate compliance issue under this SMAC.

1.6. The Contractor shall establish and maintain health service resources to ensure appropriate coordination and integration of Medicare and Medicaid benefits available to its Qualified Members. Such health service resources include but are not limited to dedicated programs and staff to support care management and case management services.

1.7. 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 (MOC). 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.

1.8. The Contractor, in accordance with 42 CFR 422.102 (2024, as amended), is required to provide the supplemental benefits listed below:

1.8.1. Dental Services

1.8.2. Hearing Services

1.8.3. Vision Care

1.9. The Contractor shall submit to SCDHHS, via a mutually acceptable secure transmission method, its final and approved 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.

1.10. The Contractor shall establish and maintain one or more Enrollee advisory committees in accordance with 42 CFR 422.107(f) (2024, as amended).

1.11. The Contractor must host various forms and information on its public-facing website including the following:

1.11.1. Instructions on how to appoint a personal representative.

1.11.2. Enrollment instructions.

1.11.3. Enrollment Forms.

Section 2. Enrollment

2.1. **Enrollment**

2.1.1. For the purposes of this SMAC, the Contractor agrees to conduct enrollment of Qualified Members in accordance with the policies and procedures set forth in this SMAC.

2.1.1.1. At initial enrollment, the Qualified Member must be enrolled in Medicaid Managed Care to be eligible to be enrolled in a DSNP and will be reassigned to the exclusively aligned MCO following DSNP enrollment effectuation.

2.1.2. The Contractor must provide Medicaid services through an exclusively aligned MCO, in accordance with Section 1.4 of this SMAC. Medicaid services will be provided by Contractor's MCO in accordance with the South Carolina State Plan for Medical Assistance (State Plan) and other waiver authorities, as applicable and specified by SCDHHS.

2.1.3. 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.

2.1.4. Qualified Members shall be enrolled and disenrolled in the Contractor's D-SNP according to federal regulations.

2.1.5. The Contractor shall be responsible for informing Qualified Members of the effective date of their enrollment through enrollment correspondence and notifications as defined by CMS.

2.1.6. SCDHHS will coordinate with the Contractor to exchange enrollment transactions for the purpose of EAE.

2.1.7. SCDHHS will identify Qualified Members eligible for Default Enrollment for the Contractor. The Contractor shall perform the Default Enrollment process as provided by 42 CFR 422.66 (2024, as amended) and 42 CFR 422.68 (2024, as amended). Further details regarding Default Enrollment can be found in Section 2.3 below.

2.1.8. 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 integrated D-SNP Eligibility, such as address changes, incarceration, third party insurance other than Medicare, disenrollment from the integrated D-SNP or any other changes in Eligibility status.

2.1.8.1. The Qualified Member's change in status information exchange shall be submitted in an SCDHHS approved file format to 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. Default Enrollment

2.3.1. Qualified Members currently enrolled in an MCO can be Default Enrolled into the integrated D-SNP offered by the same parent organization of the MCO on their first day of Medicare A and B coverage providing that all the requirements in 42 CFR 422.66(c)(2) (2024, as amended) are met.

2.3.2. The Contractor shall first obtain SCDHHS' approval to implement Default Enrollment. The process is then subject to CMS approval per the

requirements under 42 CFR 422.66(c) (2024, as amended), 42 CFR 422.107 (2024, as amended).

2.3.3. The Contractor must not have any enrollment limitations or prohibitions imposed on them by CMS or SCDHHS to receive and maintain Default Enrollment approval. This includes prohibitions imposed on their MCO.

2.3.4. The Contractor must forward to SCDHHS a copy of CMS' Default Enrollment process prior approval notifications or correspondence sent to the Contractor within five (5) calendar days of Contractor's receipt from CMS.

2.3.5. If CMS rejects the Contractor's Default Enrollment process proposal, the Contractor agrees to notify SCDHHS within three (3) calendar days of receiving the initial or renewal rejection notification from CMS.

2.3.6. Failure of the Contractor to be approved for Default Enrollment will not cause any contract between SCDHHS and the Contractor to terminate nor will it affect any other enrollment submissions unrelated to Default Enrollment processes.

2.3.7. The Contractor is required to submit their Default Enrollment renewal proposals to CMS one hundred and eighty (180) calendar days in advance of the CMS deadline.

1.1.1. Through the implementation of the Default Enrollment process, SCDHHS shall provide the Contractor with information necessary, including all CMS data elements required, to prospectively identify those Qualified Members eligible for Default Enrollment in time to meet the sixty (60) calendar day noticing requirements per 42 CFR 422.66(c)(2) (2024, as amended).

1.1.1.1. SCDHHS will use applicable CMS enrollment files to identify eligible Qualified Members for Default Enrollment.

1.1.1.2. SCDHHS will review CMS Eligibility data on applicable CMS enrollment files monthly and submit a monthly file with Qualified Members to the Contractor.

1.1.2. Failure by the Contractor to verify the Eligibility of all Enrollees received from SCDHHS may result in SCDHHS revoking the Contractor's approval to conduct Default Enrollment and/or additional consequences as described in Section 10 below.

1.2. Deeming

1.2.1. In accordance with 42 CFR 422.52(d) (2024, as amended), if the Contractor determines that the Enrollee no longer meets the Eligibility criteria, but can reasonably be expected to again meet that criteria within a 6-month period, the Enrollee is deemed to continue to be eligible for the MA plan for a period of not less than thirty (30) calendar days but not to exceed six (6) months.

1.3. Health Risk Assessment (HRA)

1.3.1. 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). 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.

1.3.2. 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.

1.3.3. 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:

1.3.3.1. 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.

1.3.3.2. Have themselves, or through their designated representative, the right to request a reassessment by the Interdisciplinary Team (IDT) and be fully involved in any such reassessment.

1.4. Individualized Care Plan (ICP)

1.4.1. Following the HRA (as described in Section 1.3), the Contractor shall assign a Care Coordinator who works with the Qualified Member, his/her

family supports, and Providers, to develop a comprehensive, person-centered, written ICP for each Qualified Member.

1.4.2. The Contractor must allow Qualified Members to request and be assigned a new Care Coordinator if they so choose.

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

1.4.4. The Contractor must complete each Qualified Member's initial ICP within ninety (90) calendar days of enrollment.

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

Section 2. Continuity of Care

2.1. The Contractor shall allow Enrollees receiving any services at the time of enrollment to maintain their current services and service levels with their current Providers, including with Providers who are not part of the Contractor's network, including drugs, for at least ninety (90) calendar days after the Enrollee's enrollment effective date.

2.2. All prior approvals for drugs, therapies, or other services existing in Medicare or Medicaid at the time of enrollment will be honored within ninety (90) calendar days or until the noticing and prior authorization approvals are completed before the ninety (90) calendar days, in accordance with 42 CFR 423.120(b) (2024, as amended). Any notices of change, which may include negative changes, must be in a written format on the Contractor's official letterhead.

2.3. The Contractor shall be responsible for coordination and continuity of care for each Qualified Member enrolled in its D-SNP. The Contractor shall be responsible for continuing to provide covered services authorized by the Qualified Member's MCO, without regard to whether such services are being provided by participating or non-participating Providers, for at least ninety (90) calendar days.

Section 3. Provider Network

3.1. SCDHHS requires that the Contractor must demonstrate that it has an adequate statewide Medicare Provider network and a statewide Medicaid Provider

network in accordance with access standards described in Section 1852(d)(1) of the Social Security Act, 42 CFR 422.112(a)(1)(i) (2024, as amended), 42 CFR 438.68 (2024, as amended), 42 CFR 438.206 (2024, as amended), and 42 CFR 438.207 (2024, as amended).

3.1.1. In the event of a county gap during the transitional year, January 1, 2026 – December 31, 2026, the Contractor must obtain statewide coverage, including addressing any gaps in Medicare Advantage CMS network coverage to maintain its D-SNP SMAC status after January 1, 2027. Failure to obtain statewide coverage for January 1, 2027 may result in SCDHHS taking more compliance action.

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

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

3.4. The Contractor agrees to maintain a statewide contracted participating Provider network which is qualified to serve the Qualified Members enrolled in the Contractor's plan, including any specific special medical care needs of such Qualified Members which are covered benefits under the plan. For a complete list of state plan covered services, see Appendix B attached hereto.

3.5. County coverage for this SMAC is specific to the H number associated with this SMAC; only one H number is permitted per this SMAC.

3.6. The Contractor, in accordance with 42 CFR 422.111(b)(3) (2024, as amended) and 42 CFR 422.2267(e)(11) (2024, as amended), will 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.

Section 4. Payment Responsibilities

4.1. The Contractor shall participate in the automated claims crossover adjudication with its affiliated MCO.

4.2. The Contractor shall coordinate payment with any and all Medicare providers that provide services to Qualified Members. The foregoing coordination obligations shall be coordinated with the Contractor's MCO in order to ensure timely prior authorization and delivery of services when possible, ensuring cross-

over payments are automated in order to reduce Qualified Member paperwork and avoid duplicated submission of claims by providers.

4.3. The Contractor shall track and pay all eligible Providers the cost-sharing obligations incurred on behalf of enrolled dually eligible Qualified Members with applicable Medicaid Eligibility categories covered under this SMAC.

4.4. The Contractor shall be responsible for any applicable financial responsibility pertaining to the delivery of Medicare services and benefits.

4.5. SCDHHS will follow its approved State Plan methodology for processing claims for Qualified Members. The Contractor 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.

4.6. 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 D-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 Qualified Member with QMB benefits for Medicare cost-sharing amounts, including deductibles, coinsurance, and copayments. A Dual Eligible Qualified 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

4.7. The Contractor must track each Qualified Member's accrued out-of-pocket spending and alert Qualified Members and Providers when the Maximum Out-Of-Pocket (MOOP) amount is reached, in accordance with federal regulations at 42 CFR 422.100(f)(4) and (f)(5)(iii) (2024, as amended) and 42 CFR 422.101(d) (2024, as amended).

4.8. 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 D-SNP, participating Providers may only collect such Enrollee cost sharing as specified by the Contractor pursuant to the limitations of Section 2. Enrollment and Section 5. Payment Responsibilities of this SMAC.

4.9. 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.

4.10. 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.

4.11. 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. Appeals and Grievances

5.1. The Contractor must have an integrated Grievance process in place for Qualified Members that is compliant with both Medicare and Medicaid as outlined in 42 CFR 422.630 (2024, as amended). Where applicable, this includes issuing Coverage Decision Letters, outlining a Grievance process, an Appeals process, and providing access to the State's fair hearing system for Appeals once the Contractor's Appeals and Grievance process has been exhausted.

5.2. For services not covered by Medicare, the Contractor shall follow the Medicaid Managed Care Appeals and Grievance provisions outlined within its MCO contract and in accordance with S.C. Code Ann. § 38-33-110 (2015, as amended), 42 CFR 438 Subpart F (2024, as amended), and 42 CFR 431 Subpart E (2024, as amended).

5.3. The Contractor shall implement and maintain a unified Appeals and Grievance policy across Medicare and Medicaid at the plan level.

5.4. Consistent with SCDHHS policy, the Contractor shall implement a Grievance and Appeal system and process Grievances and Appeals in compliance with the terms of 42 CFR 422.629 – 422.634 (2024, as amended), 42 CFR 438.210 (2024, as amended), 42 CFR 438.400 (as amended), and 42 CFR 438.402 (2024, as amended), including:

5.4.1. Grievances and Appeals systems that meet the standards described in 42 CFR 422.629 (2024, as amended);

5.4.2. An integrated Grievance process that complies with 42 CFR 422.630 (2024, as amended);

5.4.3. A process for making integrated organization determinations consistent with 42 CFR 422.631 (2024, as amended);

5.4.4. Continuation of benefits while an integrated reconsideration is pending consistent with 42 CFR 422.632(2024, as amended);

5.4.5. A process for making integrated reconsiderations consistent with 42 CFR 422.633(2024, as amended); and

5.4.6. A process for effectuation of decisions consistent with 42 CFR 422.634 (2024, as amended).

Section 6. Qualified Member Protections

6.1. In the event of a circumstance by which Qualified Members require additional assistance and/or education regarding their Medicaid benefits and rights, the Contractor shall refer the Qualified Member to the South Carolina Department on Aging (SCDOA) Ombudsman's office at https://aging.sc.gov/.

6.2. The SCDOA may appropriately address any question, concern, or citizen request regarding their benefit and/or rights. Additionally, the SCDOA provides education and consultation services for Qualified Members enrolled in state government-sponsored services for all South Carolinians.

6.2.1. Ombudsman responsibilities may include the following:

6.2.1.1. Educate Qualified Members of coverage, rights, and responsibilities.

6.2.1.2. Review of Grievances and/or Appeals as necessary.

6.2.1.3. Investigate any reports of deceptive marketing or agent/broker activity.

6.2.1.4. Offer all resources within the scope of the SCDOA that supports the needs of consumers.

Section 7. Marketing and Communications

7.1. The Contractor shall, in accordance with 42 CFR 422 Subpart V (2024, as amended), 42 CFR Part 423 Subpart V (2024, as amended), 42 CFR 438.10(d)(2) (2024, as amended), and the Medicare Communications and Marketing Guidelines, provide integrated materials for each new Qualified Member at the time of enrollment and annually thereafter. CMS and SCDHHS will jointly develop the integrated Medicare and Medicaid templates for these integrated Qualified Member materials which will be provided to the Contractor. Integrated Qualified Member materials include but are not limited to the following:

7.1.1. Summary of Benefits (SB)

7.1.2. List of Covered Drugs (Formulary)

7.1.3. Provider and Pharmacy Directory (PPD)

7.1.4. Annual Notice of Change (ANOC), including cover letter.

7.1.5. Member Handbook

7.1.6. Member ID Card

7.1.7. Health Plan Welcome Letter

7.2. SCDHHS, in conjunction with CMS, will review communications and marketing materials and approve and/or deny state-specific elements within the Health Plan Management System (HPMS).

7.2.1. The Contractor must submit all communication and marketing materials in HPMS that are required to be submitted under the Contractor's Medicare contract ID number as described in accordance with 42 CFR 422 Subpart V (2024, as amended), the *Medicare Communications and Marketing Guidance* (MCMG), and the SCDHHS Style Guide and Managed Care Contract.

7.2.2. The Contractor must submit all communication and marketing materials in the HPMS that are required to be submitted as described in 42 CFR 422.2267 (2024, as amended) and 42 CFR 423.2267 (2024, as amended), and in the MCMG under the Contractor's Medicare contract ID number. All integrated materials must comply with H number requirements in accordance with 42 CFR422.107(e) (2024, as amended).

7.2.3. The multi-plan submission process is not applicable to D-SNP-only contracts. In addition, when a third party, such as a pharmacy benefit manager (PBM), creates and distributes member-specific materials on behalf of multiple organizations, it is not acceptable to use the material ID for another organization or a Y number for materials the third-party provides to D-SNP Qualified Members in D-SNP-only contracts. The material must be submitted in HPMS using a separate material ID number for the D-SNP-only contract, and that material ID number must be included in the material.

7.2.4. Contractor's communications and marketing materials shall follow any additional policy guidance documents issued by SCDHHS or CMS. This includes memoranda, model documents, emailed directives, and other documented policy directives.

7.2.5. Contractor's communications and marketing materials must be integrated and reflective of Medicare and Medicaid coverage.

7.2.6. 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 8. Reporting Requirements

8.1. Deliverables

8.1.1. 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.

8.1.2. SCDHHS will access HPMS in accordance with CMS reporting schedule for the purposes of review and validation of Contractor's reports.

8.1.3. SCDHHS reserves the right to request additional data not explicitly stated by CMS reporting requirements or in this SMAC, as needed.

8.2. Reporting Schedule

8.2.1. The Contractor, operating under EAE, shall submit reports following the reporting schedule detailed below:

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

8.2.1.1.1. Hospital Admissions (General and Specialty)

8.2.1.1.2. Skilled Nursing Facility (SNF) Admissions

8.2.1.2. The Contractor shall submit to SCDHHS the following report(s):

8.2.1.2.1. Exclusive Aligned Enrollment Operations Reports defined in Section 9.2.1.5.

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

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

8.2.1.3.2. 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.

8.2.1.3.2.1. 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.

8.2.1.4. The Contractor shall report monthly to SCDHHS the following Exclusive Aligned Enrollment Operations Reports via a template approved by SCDHHS:

8.2.1.4.1. Number of HRAs Completed (All risk levels)

8.2.1.4.2. 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) *

8.2.1.4.3. Number of ICPs Completed

8.2.1.4.4. All Coordinators to All Enrollees Ratio

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

8.2.1.4.6. Total Number of Care Coordinators

8.2.1.4.7. Number of Member Grievances Closed

8.2.1.4.8. Number of Appeals Closed

8.2.1.4.9. Number of Appeals with Adverse Denials

8.2.1.4.10. Number of Favorable Appeals

8.2.1.4.11. Number of Appeals Partially Favorable

8.2.1.4.12. Number of Appeals Withdrawn

8.2.1.4.13. Number of Dismissed Appeals

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

8.2.1.4.15. Member Appeals (Closed) - Part D Related

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

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

8.2.1.4.18. Top 3 reasons for Member Appeals

8.2.1.4.19. Top 3 reasons for Provider Appeals

8.2.1.4.20. Additional Grievance Details

8.2.1.4.21. Additional Appeals Details

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

8.3. Operating Provisions

8.3.1. 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.

8.3.2. SCDHHS will provide access to care plan and service plan data for Qualified Members enrolled in an SCDHHS-sponsored program for long-term services and supports programs for the purposes of care coordination and Qualified Member Risk Stratification.

8.3.3. 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:

8.3.3.1. Beneficiary Name

8.3.3.2. Beneficiary Medicaid & Medicare ID

8.3.3.3. Date of enrollment and disenrollment (If necessary)

8.3.3.4. Date of Birth (DOB)

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

8.3.3.6. Contract Number

8.3.3.7. Plan Benefit Package (PBP)

8.3.3.8. County Name

8.3.4. The Contractor will 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.

8.3.5. 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).

8.3.6. The Contractor understands and agrees that all reports and assessments prepared by it 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.

8.3.7. 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.

8.3.8. The Contractor 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. If any litigation, claim, or other actions involving the records have been initiated prior to the expiration of the ten (10) 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 ten (10) year period, whichever is later. This provision is applicable to any subcontractor and must be included in all subcontracts.

8.3.9. The Contractor shall certify all submitted data, documents, and reports to be accurate, complete, and truthful, as required by 42 CFR 422.504(d) (2024, as amended).

8.3.9.1. The data that must be certified include, but are not limited to, all documents specified by the State, enrollment information, encounter data, and other information contained in contracts and proposals.

8.3.9.2. The certification must attest, based on best knowledge, information, and belief, that the data, documentation, and information specified in 42 CFR 422.504(d) (2024, as amended) are accurate, complete, and truthful.

8.3.10. The Contractor shall be responsible for any incorrect data, delayed submission, or payment (to the Contractor or its subcontractors), and/or penalty applied due to any error, omission, deletion, or erroneous insert caused by Contractor-submitted data.

8.4. Encounter Data

8.4.1. 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.

8.4.2. 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.

8.4.3. 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.

8.4.4. 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 9. Contract Oversight

9.1. Compliance Plan

9.1.1. The Compliance Plan must include written Policies, Procedures, and standards of conduct that articulate the Contractor's commitment to comply with all applicable requirements and standards under this SMAC, and all applicable federal and state standards and regulations (See 42 CFR 422.503 (2024, as amended) and 42 CFR 423.504 (2024, as amended).

9.1.1.1. The Compliance Plan must be submitted within 30 calendar days of SCDHHS request.

9.1.2. The Compliance Plan must describe the Contractor's process for conducting analyses of its Provider and utilization data. This description must comply with the following standards:

9.1.2.1. A general description of the process for data mining and analyses performed by the Contractor.

9.1.2.2. A description of the individual reports, their purpose, objectives, and frequencies as associated with all Fraud, Waste, and Abuse (FWA) activities and requirements.

9.2. Corrective Action Plan (CAP)

9.2.1. If the Contractor is found to be out of compliance with or deficient with one or more terms or conditions of this SMAC, it is at the discretion of SCDHHS to determine whether the Contractor shall submit a CAP.

9.2.2. If required, the Contractor must submit a CAP within the timeline specified by SCDHHS and obtain SCDHHS approval of such CAP. The CAP must address how the Contractor will remediate any deficiencies and the timeframe in which such deficiencies will be corrected.

9.3. Termination

9.3.1. This SMAC will automatically terminate at the expiration date as defined unless otherwise terminated in accordance with this subsection or SCDHHS or the Contractor seeks and obtains renewal of this SMAC.

9.3.2. The Contractor may voluntarily terminate this SMAC prior to renewal of the SMAC for the following benefit year. Request for termination must be submitted to SCDHHS prior to SMAC renewal period in writing on Contractor's official organizational letterhead.

9.3.3. SCDHHS may terminate the SMAC in whole or in part and at any time when it determines, in its sole discretion, that termination is in the best interests of SCDHHS. The termination will be effective on the date specified in SCDHHS' notice of termination.

9.3.3.1. Per 42 CFR 422.510(b)(iv) (2024, as amended), SCDHHS will provide the Contractor with written notice of such termination at least ninety (90) calendar days prior to the effective date of termination unless SCDHHS determines that circumstances warrant a shorter notice period.

9.3.4. SCDHHS reserves the right to terminate this SMAC, in whole or in part, upon the following conditions:

9.3.4.1. SCDHHS may terminate this SMAC at any time if a court of competent jurisdiction finds the Contractor failed to adhere to any laws, ordinances, rules, regulations, or orders of any public authority having jurisdiction and such violation prevents or substantially impairs the performance of the Contractor's duties under this SMAC.

9.3.5. SCDHHS may terminate the SMAC at any time if the Contractor:

9.3.5.1. Files for bankruptcy;

9.3.5.2. Becomes or is declared insolvent;

9.3.5.3. Is the subject of any proceedings related to its liquidation, insolvency, or the appointment of a receiver or similar Officer for it;

9.3.5.4. Makes an assignment for the benefit of all or substantially all its creditors; or

9.3.5.5. Enters into an agreement for the composition, extension, or readjustment of substantially all its obligations.

9.4. Contract Monitoring

9.4.1. 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.

9.4.2. Contract monitoring findings of non-compliance on the part of the Contractor may be addressed through a Corrective Action Plan and sanctions up to and including liquidated damages as specified in Section 11 of this SMAC. Nothing in this requirement is intended to duplicate or forestall any other audits of the Contractor required by this SMAC, the SC Department of Insurance (SCDOI), national standards, or CMS.

Section 10. Civil Monetary Penalties and Liquidated Damages

10.1. 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.

10.2. 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 at 26 CFR 301.6103(n) (2024, as amended).

10.3. 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 contractors 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).

10.4. If SCDHHS determines that the Contractor has violated any provisions of this SMAC, or the applicable statutes or rules governing Medicaid, SCDHHS may impose fines and/or sanctions against the Contractor.

Section 11. Terms and Conditions

11.1. 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.

11.2. 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 benefits provided 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.

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

11.4. 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.

11.5. Upon knowing, 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.

11.6. The Contractor shall safeguard the use and disclosure of information concerning applicants for 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 shall restrict access, use, and disclosure of such information in compliance with said laws and regulations.

11.7. 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 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, via a mutually acceptable secure transmission method, email and physical mail on official Contractor letterhead.

11.8. 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.

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

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

11.11. It is mutually understood and agreed that 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.

11.12. 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.

11.13. 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.

11.14. 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 by providing to SCDHHS, at a minimum, a copy of the same information provided to CMS.

11.15. 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 a SCDHHS final agency decision with respect to this SMAC or audit disallowances, must be brought pursuant to S.C. Code Ann. §1-23-380 (2005) and shall be instituted in any court of competent jurisdiction in the county of Richland, State of South Carolina.

11.16. 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).

11.17. 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.

11.18. 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.

11.18.1. The Contractor and any subcontractor shall cooperate with these evaluations and inspections. The 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. 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 qualified Medicaid members.

11.18.2. The right to audit any Subcontractor will exist for 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 or any subcontractor at any time.

11.19. 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).

11.20. 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:

11.20.1. 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.).

11.20.2. 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.

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

11.20.4. 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)).

11.20.5. 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.

11.20.6. 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.

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

11.20.8. 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).

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

11.20.10. 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).

11.21. 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 Medicare 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	✓		