This amendment made on July 1, 2018, is to contract by and between the United States Department of Health and Human Services, acting by and through the Centers for Medicare & Medicaid Services (CMS), the South Carolina Department of Health and Human Services (SCDHHS) and <ENTITY> (the Coordinated and Integrated Care Organization (CICO).

WHEREAS, CMS is an agency of the United States, Department of Health and Human Services, responsible, in relevant part, for the administration of the Medicare, Medicaid, and State Children's Health Insurance Programs under Title XVIII, Title XIX, Title IX, Title XI, and Title XXI of the Social Security Act;

WHEREAS, Section 1115A of the Social Security Act provides CMS the authority to test innovative payment and service delivery models to reduce program expenditures while preserving or enhancing the quality of care furnished to individuals under such titles, including allowing states to test and evaluate fully integrating care for dual eligible individuals in the State;

WHEREAS, SCDHHS is an agency responsible for operating a program of medical assistance under 42 U.S.C. § 1396 et seq., and the South Carolina State Plan for Medical Assistance (State Plan) and approved waivers under 1915(c) authority under Title XIX of the Social Security Act, designed to pay for medical, behavioral health, and long term services and supports (LTSS) for an eligible Enrollee or Enrollees;

WHEREAS, the CICO is in the business of providing medical services, and CMS and SCDHHS desire to purchase such services from the CICO;

WHEREAS, the CICO agrees to furnish these services in accordance with the terms and conditions of this Contract and in compliance with all federal and State laws and regulations;

WHEREAS, the Contractor, CMS and SCDHHS entered into a coordinated care contract effective September 15, 2014, and amended and restated effective November 1, 2017 (Contract), under which the Contractor furnishes the services set forth in the Contract in accordance with the terms and conditions of the Contract and in compliance with all federal and State laws and regulations;

WHEREAS, in accordance with Section 5.8 of the Contract, the parties wish to further amend the Contract in accordance with the terms and conditions set forth herein;

NOW, THEREFORE, in consideration of the mutual promises set forth in this Contract, the Parties agree as follows:

1. Section 1.76 is hereby repealed and reserved.

2. Section 2.3.1 is hereby repealed and replaced as follows:
   2.3.1 Eligibility Determinations and Eligible Populations

3. Section 2.3.1.2 is hereby added as follows:

2.3.1.2 Individuals residing in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) are not eligible for the Demonstration and will be excluded from Enrollment.

4. Section 2.3.1.3 is hereby added as follows:
   2.3.1.3 Individuals identified with a Nursing Facility payment category at least fifteen days prior to the effective date of their enrollment are not eligible for the Demonstration. Individuals enrolled in a CICO whose payment category changes to reflect a Nursing Facility after the effective date of their Enrollment are eligible for the Demonstration and shall remain enrolled.

5. Section 2.3.1.4 is hereby added as follows:
   2.3.1.4 Individuals enrolled in a Medicare Advantage plan and who meet the eligibility criteria for this Demonstration are eligible for passive enrollment into this Demonstration.

6. Section 2.3.7.1.3 is hereby repealed and reserved.

7. Section 2.5.4.1.8.2 is hereby repealed and replaced as follows:
   2.5.4.1.8.2 For Enrollees stratified as moderate-risk, the Care Coordinator must engage in contact with the Enrollee at least once every one hundred and twenty (120) calendar days; and

8. Section 2.5.4.1.8.3 is hereby added as follows:
   2.5.4.1.8.3 For Enrollees stratified as low-risk, the Care Coordinator must engage in contact with the Enrollee at least once every one hundred and eighty (180) calendar days.

9. Section 2.5.6.1 is hereby repealed and replaced as follows:
   2.5.6.1 The CICO will have access to Phoenix/Care Call, SCDHHS's automated waiver Case Management and service authorization system. The data in this system delineates the services authorized and documents service delivery. The system will serve as an electronic record for assessments for Enrollees identified as high-risk. In addition, this system automates prior authorization, real time service monitoring, and billing for HCBS.

10. Section 2.5.6.2 is hereby repealed and replaced as follows:
    2.5.6.2 For Enrollees identified as high-risk, both the Comprehensive Assessment and Long Term Assessment (LTC Assessment) tool will be managed by SCDHHS's automated case management system, Phoenix, which maintains records of a number of critical functions, including all intake, assessment, and care planning activities.

11. Section 2.6.1.1 is hereby repealed and replaced as follows:
    2.6.1.1. The CICO can supplement the initial risk level with predictive modeling and surveillance data to stratify Enrollees as low, moderate, or high risk and must consider, specifically, any Special Health Care Needs of the Enrollees.

12. Section 2.6.2 is hereby repealed and reserved.

13. Section 2.6.3.2 is hereby repealed and replaced as follows:

2.6.3.2 For Enrollees identified as high-risk, the CICO must use Phoenix, SCDHHS's automated Case Management system, to record the Comprehensive Assessments s (as described in Section 2.6.4 Long Term Care Assessments).

14. Section 2.6.3.3 is hereby repealed and replaced as follows:

2.6.3.3 For Enrollees identified as high-risk, the Comprehensive Assessment will be performed using the state's uniform assessment tools. For all other Enrollees, the CICO may utilize internal Comprehensive Assessment tools.

15. Section 2.6.3.4 is hereby repealed and replaced as follows:

2.6.3.4. The CICO will complete the Comprehensive Assessment by using information from comprehensive data sources, input from the Enrollee, Providers, and family/caregivers.

16. Section 2.6.3.8 is hereby repealed and replaced as follows:

2.6.3.8 Timing of Comprehensive Assessments: All Enrollees will receive a Comprehensive Assessment to be completed within the following timeframes:

2.6.3.8.1 Enrollees stratified as high risk: within ninety (90) days of Enrollment.

2.6.3.8.2 Enrollees stratified as moderate risk: within ninety (90) days of Enrollment; and

2.6.3.8.3 Enrollees stratified as low risk: within ninety (90) days of Enrollment.

17. Section 2.6.3.13 is hereby added as follows:

2.6.3.13 The CICO will conduct face-to-face Comprehensive Assessments for high-risk Enrollees and will conduct face-to-face or telephonic Comprehensive Assessments for low-risk and moderate-risk Enrollees.

18. Section 2.6.3.14 is hereby added as follows:

2.6.3.14 The CICO will conduct face-to-face Comprehensive Reassessments for high-risk Enrollees and will conduct face-to-face or telephonic Comprehensive Reassessments for low-risk and moderate-risk Enrollees.

19. Section 2.6.4.3.3.2 is hereby repealed and replaced as follows:

2.6.4.3.3.2 Enrollees with a current and up-to-date LTC Assessment are not required to undergo a second assessment until such time as an annual reassessment is due.

20. Section 2.6.5.1 is repealed and replaced as follows:

2.6.5.1 SCDHHS will conduct all Long Term Care Reassessments and level of care redeterminations for both HCBS waiver and nursing facility services; final results will be recorded in Phoenix.

21. Section 2.6.6.5 is hereby repealed and replaced as follows:

2.6.6.5 ICP Monitoring

2.6.6.5.1 The CICO must review ICPs of high-risk Enrollees at least every thirty (30) calendar days.

2.6.6.5.2 The CICO must review ICPs of moderate-risk Enrollees at least every one hundred and twenty (120) calendar days.
2.6.6.5.3 The CICO must review ICPs of low-risk Enrollees at least every one hundred and eighty (180) calendar days.

22. Section 4.1.2 is hereby amended as follows:

4.1.2.1.4 Demonstration Year 4: January 1, 2019 – December 31, 2019
4.1.2.1.5 Demonstration Year 5: January 1, 2020 – December 31, 2020

23. Exhibit 1 of Section 4.2 is hereby repealed and replaced as follows:

Rate Cell	**Description**
NF1: Nursing Facility-based Care	Includes individuals identified with a Nursing Facility payment category beyond the three (3) months following admission as a Resident of a nursing facility.
H1: Home and Community Based Services	Includes individuals who do not meet NF1 criteria, and for whom a level of care determination indicates that the individual meets the level of care requirements for nursing facility placement and/or applicable HCBS waiver. These requirements include: • For the Community Choices waiver, meet the following level of care requirements: o Skilled Level of Care – need at least one skilled service and have a least one functional deficit, as defined in the waiver, or; o Intermediate Level of Care – need at least one intermediate service and have at least one functional deficit or have at least two functional deficits, as defined by the waiver. • For the HIV/AIDS waiver, be determined at-risk for hospitalization as defined in 42 CFR §440.10. • For the Mechanical Ventilation waiver, meet nursing home level of care and are dependent of a life-sustaining ventilator for six (6) or more hours per day, as defined by the waiver.
H2: Home and Community Based Services Plus	Includes individuals moving from the NF1 rate cell to a qualifying HCBS waiver for the first three (3) months of transition; OR Includes HCBS Waiver individuals not residing in a nursing facility, for the first three (3) months of enrollment in the waiver.
C1: Community Tier – Community	Includes individuals who do not meet NF1, H1, or H2 criteria.

24. Section 4.2.3 is hereby amended as follows:
4.2.3.1.3 Demonstration Year 3: 3%
4.2.3.1.4 Demonstration Year 4: 3%
4.2.3.1.5 Demonstration Year 5: 3%

25. Section 4.3.1.5 is hereby repealed and replaced as follows:
4.3.1.5 Data Submission. The CICO shall submit to SCDHHS and CMS, in the form and manner prescribed by SCDHHS and CMS, the necessary data to calculate and verify the MLR within eleven (11) months after the end of the run-out period.

26. Section 4.3.1.7 is hereby repealed and replaced as follows:

4.3.1.7 Coverage Year. The coverage year shall be the demonstration year. The MLR calculation shall be prepared using all data available from the coverage year, including IBNP and nine (9) months of run-out for benefit expense (excluding sub-capitation paid during the run-out months).

27. Section 4.4.4.7 is hereby repealed and replaced as follows:

4.4.4.7 Quality Withhold Measures in Demonstration Years 2-5

28. Section 4.4.4.7.1 is hereby repealed and replaced as follows:

4.4.4.7.1 The quality withhold will increase to two (2) percent in Demonstration Year 2 and three (3) percent in Demonstration Years 3-5.

29. Section 4.5.1.2.2 is hereby repealed and replaced as follows:

4.5.1.2.2 SCDHHS will pay the HCBS Waiver Plus rate for the first three months of enrollment in the HCBS waiver for individuals not residing in a nursing facility.

30. Exhibit 3 is hereby amended as follows:

Exhibit 3 Quality Withhold Measures for Demonstration Years 2-5

31. Section 5.7.1.1 is hereby repealed and replaced as follows:

5.7.1.1 The Contract shall be in effect starting on the date on which all Parties have signed the Contract and shall be effective, unless otherwise terminated, through December 31, 2018. This Contract shall be renewed in one-year terms through December 31, 2020, so long as the CICO has not provided CMS and the SCDHHS with a notice of intention not to renew, pursuant to 42 C.F.R. § 422.506 or Section 5.5, above.

32. Section C.3, Exhibit 4 is hereby repealed and replaced as follows:

Exhibit 4 Overview of SCDHHS/CICO Responsibilities during HCBS Transition

Functions	Phase I	Phase II	Phase III
Use of Phoenix and Care Call	SCDHHS & CICO	SCDHHS & CICO	SCDHHS & CICO
Provider credentialing / monitoring	SCDHHS	SCDHHS	SCDHHS; CICO can choose to assume this

Functions	Phase I	Phase II	Phase III
			responsibility at its own cost
HCBS Providers Contractual Authority	SCDHHS	CICO; SCDHHS provides a contract template and/or scope of service	CICO
Initial HCBS care plan development	SCDHHS; CICOs have formal input process	CICO; SCDHHS concurrence required	CICO; SCDHHS concurrence required
Oversight of Waiver Case Manager's participation in multidisciplinary team	CICO	CICO	CICO
HCBS Provider Rate Setting Authority	SCDHHS	CICO; SCDHHS establishes rate guidelines	CICO; SCDHHS establishes rate guidelines
HCBS claims processing (via Care Call) and provider payments	SCDHHS CICOs responsible for HCBS claims payment (via a	CICO	CICO

Functions	Phase I	Phase II	Phase III
	reconciliation process)		
Initial LTC LOC Assessments	SCDHHS	SCDHHS	SCDHHS
LTC LOC Reassessments	SCDHHS	SCDHHS CICOs will be responsible for approving the LTC reassessment	SCDHHS CICOs will be responsible for approving the LTC reassessment
Self-directed attendant care and related functions	SCDHHS	SCDHHS	CICO

33. Section C.5.2.2 is hereby repealed and replaced as follows:

C.5.2.2 *Authority for Long Term Care Assessment.* SCDHHS will continue to utilize its automated HCBS assessment form in Phoenix.

34. Section C.5.2.3 is hereby repealed and replaced as follows:

C.5.2.3 *Authority for initial level of care determinations and redeterminations.* The South Carolina Level of Care Criteria for Medicaid-Sponsored LTC will continue to serve as the medical/functional eligibility criteria for both waiver and nursing facility services.

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

_____ _____

CICO Signatory Date
Title
Name of CICO

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

_____ _____

Joshua Baker, Director
South Carolina
Department of Health and Human Services (SCDHHS)

Date

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

Shantrina D. Roberts, MSN	Date
Associate Regional Administrator	
Centers for Medicare & Medicaid Services	
United States Department of Health and Human Services	

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

_____ _____

Kathryn Coleman Date
Director
Medicare Drug & Health Plan Contract Administration Group
Centers for Medicare & Medicaid Services
United States Department of Health and Human Services

1. **Appendix K** of the Contract is hereby repealed and replaced as follows:

APPENDIX K. Assessment and Individualized Care Plan Expectations

Exhibit 6 Assessment and ICP Requirements

Population	Criteria	Comprehensive Assessment	Long Term Care Level of Care Assessment	Individualized Care Plan-Initial	Continuous Monitoring and Review	Waiver Service Plan	Face-to-Face Reassessment	Individualized Care Plan – Update
Low Risk	Determined by CICO during Initial Comprehensive Assessment	Within 90 calendar days of enrollment	Necessary only if CICO believes an Enrollee may need LTC services or if requested by an Enrollee/ authorized representative	Within 90 calendar days of enrollment	Every 180 calendar days	Not Applicable	At least every three-hundred and sixty-five days, or when there is a significant clinical change in the Enrollee's status, or as requested by the Enrollee, his/her caregiver or his/her provider. CICO will conduct a face-to-face reassessment for high-risk Enrollees and will conduct face-to-face or telephonic reassessments for low-risk and moderate-risk Enrollees	Any time a face-to-face or telephonic reassessment occurs
Moderate Risk	Determined by CICO during Initial Comprehensive Assessment	Within 90 calendar days of enrollment	Necessary only if CICO believes an Enrollee may need LTC services or if requested by an Enrollee/ authorized representative	Within 90 calendar days of enrollment	Every 120 calendar days	Not Applicable		
High Risk: Waiver and NF Enrollees	SCDHHS HCBS waiver Enrollees or NF residents	Within 90 days of enrollment	Not Required	Within 90 calendar days of enrollment	Every 30 calendar days	For waiver Enrollees only: developed by SCDHHS with CICO concurrence in Phase I; developed by CICO with SCDHHS concurrence in Phase II and after		
High Risk: All Other	Determined by CICO during Initial Comprehensive Assessment	Within 90 calendar days of enrollment	Required, conducted by SCDHHS and performed concurrently with CICO's Comprehensive	Within 90 calendar days of enrollment	Every 30 calendar days	Not Applicable		

Population	Criteria	Comprehensive Assessment	Long Term Care Level of Care Assessment	Individualized Care Plan-Initial	Continuous Monitoring and Review	Waiver Service Plan	Face-to-Face Reassessment	Individualized Care Plan – Update
			Assessment when possible					