This amendment made on July 1, 2020, 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 [MMP Plan Name], (the Coordinated and Integrated Care Organization (CICO). The CICO's principal place of business is [MMP Address].

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 and Medicaid 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) and July 1, 2018 (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 4.1.2 is hereby amended as follows:

    4.1.2.1.6 Demonstration Year 6: January 1, 2021 – December 31, 2021
    4.1.2.1.7 Demonstration Year 7: January 1, 2022 – December 31, 2022
    4.1.2.1.8 Demonstration Year 8: January 1, 2023 – December 31, 2023

2. Section 4.2.3 is hereby amended as follows:

    4.2.3.1.6 Demonstration Year 6: 3%
    4.2.3.1.7 Demonstration Year 7: 3%
    4.2.3.1.8 Demonstration Year 8: 3%

3. This Addendum deletes and replaces the language in **Subsection 4.3.1** with the following:

    4.3.1 Medical loss ratio (MLR) Guarantee

    4.3.1.1 The CICO has a target MLR of eighty-five percent (85%) for Demonstration Years 1 through 6, eighty-five and a half percent (85.5%) for Demonstration Year 7, and eighty-six percent (86%) for Demonstration Year 8.
    4.3.1.2 If the medical loss ratio calculated as set forth below is less than the target medical loss ratio, the CICO shall refund to SCDHHS and CMS an amount equal to the difference between the calculated MLR and the target MLR (expressed as a percentage) multiplied by the coverage year revenue, as described in Sections 4.3.1.2.1 and 4.3.1.2.2. SCDHHS and CMS shall calculate a MLR for Enrollees under this Contract for each coverage year, beginning with Demonstration Year 1, and shall provide to the CICO the amount to be refunded, if any, to SCDHHS and CMS respectively. Any refunded amounts will be distributed back to the Medicaid and Medicare programs, with the amount to each payor based on the proportion between the Medicare and Medicaid Components. At the option of CMS and SCDHHS, separately, any amount to be refunded may be recovered either by requiring the CICO to make a payment or by an offset to future Capitation Payment. The MLR calculation shall be determined as set forth below; however, SCDHHS and CMS may adopt NAIC reporting standards and protocols after giving written notice to the CICO.

    4.3.1.2.1 For Demonstration Years 1 through 6, if the CICO has an MLR below eighty-five percent (85%) of the joint Medicare and Medicaid payment to the CICO, the CICO must remit the amount by which the eighty-five percent (85%) threshold exceeds the CICO's actual MLR multiplied by the total Capitation Payment revenue of the contract.
    4.3.1.2.2 For Demonstration Year 7, if the CICO has an MLR below eighty-five and a half percent (85.5%) of the joint Medicare and Medicaid payment to the CICO, the CICO must remit the amount by which the eighty-five and a half percent (85.5%) threshold exceeds the CICO's actual MLR multiplied by the total Capitation Payment revenue of the contract.

4.3.1.2.3 For Demonstration Year 8, if the CICO has an MLR below eight-six percent (86%) of the joint Medicare and Medicaid payment to the CICO, the CICO must remit the amount by which the eighty-six percent (86%) threshold exceeds the CICO's actual MLR multiplied by the total Capitation Payment revenue of the contract.

4.3.1.3 MLR will be based on the 42 C.F.R. §§ 422.2400 et seq 423.2400 et seq, and 42 C.F.R. § 438.8 except that the numerator in the MLR calculation will include:

4.3.1.3.1 All Covered Services required in the Demonstration under Section 2.4 and Appendix A;

4.3.1.3.2 Any services purchased in lieu of more costly Covered Services and consistent with the objectives of the Demonstration; and

4.3.1.3.3 Care Coordination Expense. That portion of the personnel costs for Care Coordinators whose primary duty is direct Enrollee contact that is attributable to this Contract shall be included as a benefit expense. The portion of the personnel costs for CICO's medical director that is attributable to this Contract shall be included as a benefit expense.

4.3.1.4 The revenue used in the MLR calculation will consist of the Capitation Payments, as adjusted pursuant to Section 4.2.4, due from SCDHHS and CMS for services provided during the coverage year. For Demonstration Year 1, revenue will include amounts withheld pursuant to Section 4.4.4, regardless of whether the CICO actually receives the amount in Section 4.4.4. For Demonstration Years 2-8, revenue will reflect the actual amounts received by the CICO under Section 4.4.4.

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, or at a later date as mutually agreed upon by SCDHHS and CMS.

4.3.1.6 Medical Loss Ratio Calculation. Within ninety (90) days following the data submission, SCDHHS and CMS shall calculate the MLR by dividing the benefit expense by the revenue. The MLR shall be expressed as a percentage rounded to the second decimal point. The CICO shall have sixty (60) days to review the MLR calculation. Each party shall have the right to review all data and methodologies used to calculate the MLR.

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).

4. This addendum deletes and replaces the language in **Subsection 4.4.4.7** with the following:

4.4.4.7 Quality Withhold Measures in Demonstration Years 2-8

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 3-8.

4.4.4.7.1.1 CMS will apply an additional one (1) percent quality withhold to the Medicare A/B rate component starting in Demonstration Year 6. See Section 4.4.4.8 of this Contract for more information.

4.4.4.7.2 Payment will be based on performance on the quality withhold measures listed in Exhibit 3 below. The CICO must report these measures according to the prevailing technical specifications for the applicable measurement year.

4.4.4.7.3 If the CICO is unable to report at least three of the quality withhold measures listed in Exhibit 3 for a given year due to low enrollment or inability to meet other reporting criteria, alternative measures will be used in the quality withhold analysis. Additional information about this policy is available in separate technical guidance.

Exhibit 3: Quality Withhold Measures in Demonstration Years 2-8

Measure	Source	CMS Core Withhold Measure	South Carolina Withhold Measure
Getting Appointments and Care Quickly (for DY 2 only)	AHRQ/CAHPS	X	
Customer Service (for DY 2 only)	AHRQ/CAHPS	X	
Encounter data	CMS defined measure	X	
Plan all-cause readmissions	NCQA/HEDIS	X	
Annual flu vaccine	AHRQ/CAHPS	X	
Follow-up after hospitalization for mental illness	NCQA/HEDIS	X	
Reducing the risk of falling	NCQA/HEDIS/HOS	X	
Controlling blood pressure	NCQA/HEDIS	X	

Measure	Source	CMS Core Withhold Measure	South Carolina Withhold Measure
Part D medication adherence for diabetes medications	CMS/PDE Data	X	
Management of Hospital, Nursing Facility, and Community Transitions (for DY 2-3 only)	CMS/State defined measure		X
Adjudicated Claims (for DY 2-3 only)	CMS/State defined measure		X
Comprehensive Diabetes Care (for DY 4-8 only): • Hemoglobin A1c (HbA1c) Testing • HbA1c Poor Control (>9.0%)* • Eye Exam (Retinal) Performed • Medical Attention for Nephropathy * The HbA1c Poor Control metric applies for DY 4-5 only.	NCQA/HEDIS		X
Follow-Up Visit After Inpatient Hospital Discharge (for DY 4-8 only)	CMS/State defined measure		X

5. Section 4.4.4.8 is hereby added as follows:

4.4.4.8 Additional CMS Withhold Measure in Demonstration Years 6-8

4.4.4.8.1 Starting in Demonstration Year 6, CMS will apply an additional one (1) percent quality withhold to the Medicare A/B rate component only.

4.4.4.8.2 Payment will be based on performance on the quality withhold measure listed in Exhibit 4 below. The CICO must report this measure according to the prevailing technical specifications for the applicable measurement year.

4.4.4.8.2 If the CICO is unable to report the quality withhold measure listed in Exhibit 4 for a given year due to low enrollment or inability to meet other reporting criteria, an alternative measure will be used in the quality withhold analysis. Additional information about this policy will be provided in separate technical guidance.

Exhibit 4: Additional CMS Quality Withhold Measure for Demonstration Years 6-8

Measure	Source
Diabetes Care: Blood Sugar Controlled	NCQA/HEDIS Reverse score of the reported HEDIS rate for HbA1c poor control (>9.0%)

6. 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, 2021. This Contract shall be renewed in one-year terms through December 31, 2023, 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.

7. This addendum adds a new Appendix L – Additional Medicare Waivers:

   "In addition to the waivers granted for the Demonstration in the MOU, CMS hereby waives:
   L1. Section 1860-D1 of the Social Security Act, as implemented in 42 C.F.R. § 423.38(c)(4)(i), and extend Sections 1851 (a), (c), (e), and (g) of the Social Security Act, as implements in 42 C.F.R. Part 422, Subpart B only insofar as such provisions are inconsistent with allowing dually eligible beneficiaries to change enrollment on a monthly basis.

   L2. Section 1851(d) of the Social Security Act and the implementing regulations at 42 C.F.R. § 422, Subpart C, only insofar as such provisions are inconsistent with the network adequacy processes provided under the Demonstration."

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

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

_____ _____

Joshua Baker, Director Date

South Carolina

Department of Health and Human Services (SCDHHS)

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

_____ _____

Shantrina Roberts Date

Deputy Director, Division of Managed Care Operations

Centers for Medicare & Medicaid Services

U.S. Department of Health and Humana Services

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

U.S. Department of Health and Humana Services