MEMORANDUM OF AGREEMENT

BETWEEN

SOUTH CAROLINA DEPARTMENT OF HEALTH & HUMAN SERVICES

AND

SOUTH CAROLINA DEPARTMENT OF SOCIAL SERVICES

FOR THE SHARING OF CERTAIN DATA

This Memorandum of Agreement ("Agreement") is entered into as of the fourth day of May, 2018, 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 the South Carolina Department of Social Services, Post Office Box 1520, Columbia, South Carolina, 29202-1520, hereinafter referred to as "SCDSS".

The purpose of this Agreement is to allow the sharing of certain Medicaid data and data from SCDSS which enables the more efficient and effective administration of the Medicaid Program. The details of the shared data shall be more specifically defined in certain Statements of Work (SOWs). These SOWs shall be attached to and become a part of this Agreement as appendices.

A. Roles and Responsibilities

Each SOW shall designate a party that provides the data (Source) and a party that receives the data (User). The Source and the User designated for each SOW shall be either SCDHHS or SCDSS. The Source agrees to provide the User with data that resides in one or more Systems of Record as identified in the SOW. In exchange, the User agrees to pay any applicable fees and to use the data only for purposes that support the User's needs (Justification) referenced in the SOW, which has been agreed to by the Source as an acceptable and appropriate use of the data by the User. The User agrees to ensure the integrity, security, and confidentiality of the data by complying with the terms set forth in this Agreement and applicable law, including the Privacy Act and the Health Insurance Portability and Accountability Act of 1996, as amended, along with its attendant regulations (HIPAA). For circumstances where SCDHHS is the Source and SCDSS is the User, the terms of the Business Associate Agreement in Appendix A shall be applicable only when a SOW establishes that SCDHHS will share PHI with SCDSS to perform a function on SCDHHS's behalf. Then, for the purposes outlined in the specific SOW, DSS will be classified as a Business Associate.

In order to (i) secure data that reside in Systems of Records; (ii) ensure the integrity, security, and confidentiality of information maintained by the Source; and (iii) permit appropriate disclosure and use of such data as permitted by law, the Source and the User will establish each SOW in compliance with the following specifics.

1. Each SOW is by and between the designated Source and the designated User.
2. Each SOW details the data that the Source will disclose and the User will obtain, use, and reuse and/or any derivative file(s) that contain direct individual identifiers or elements that can be used in concert with other information to identify individuals. Each SOW will state whether the User will be using the information to accomplish tasks on behalf of the Source to determine the applicability of Appendix A. Each SOW supersedes any and all agreements between the parties with respect to the use of data from the data specified and preempts and overrides any instructions, directions, agreements, or other understanding in or pertaining to other prior communication between the Source and the User or any of its components with respect to the data specified herein. Further, the terms of each SOW cannot be changed; however, they can be terminated and superseded as specified in this Agreement. The parties agree further that instructions or interpretations issued to the User concerning each SOW or the data specified herein, shall not be valid unless issued in writing.
3. The parties mutually agree that the Source retains all ownership rights to the data file(s) referred to in each SOW, and that the User does not obtain any right, title, or interest in any of the data furnished by the Source.
4. The User represents, and in furnishing the data file(s) specified in each SOW the Source relies upon such representation, that such data file(s) will be used solely for the identified Justification. The User represents further that the facts and statements made in the Justification submitted to the Source for each SOW are complete and accurate. The User agrees not to disclose, use, or reuse the data covered by each SOW except as specified in the SOW, or as otherwise required by law. The User affirms that the requested data is the minimum necessary to achieve the Justification stated in each SOW. The User agrees that access to the data covered by each SOW shall be limited to the minimum amount of data and minimum number of individuals necessary to achieve the Justification identified in each SOW.
5. In addition, the User shall employ other security measures, to include but not be limited to the following measures:
   a. The data will be stored on a secure central server and not reside on local drives, and there will be no remote access to the data from networks other than those established in accordance with Section 8;
   b. At minimum, all access to the central server will be password protected and monitored against unapproved access or unauthorized use;
   c. No individual Social Security Numbers (SSNs) will be released except as provided for under each SOW;
   d. No individual Medicaid ID numbers will be released except as provided for under each SOW;
   e. All hard copies shall be produced on secure, organization controlled equipment. Each print, copy or physical representation of protected, or otherwise sensitive information must be tracked and securely shredded or destroyed when no longer needed;

f. The data will not be accreted to any other data files, nor shall it be linked to or with any other data file only insofar as is necessary for the accomplishment of the Justification of each SOW.

6. The parties mutually agree that the defined data (and/or any derivative file(s)), including those files that directly identify individuals, may be retained by the User until a retention date optionally provided in each SOW. The User agrees to notify the Source within thirty (30) days of the completion of the Justification specified in the SOW. Upon such notice or retention date, whichever occurs sooner, the User agrees to destroy such data file(s) in a manner which renders all data and/or derivative files unreadable and maintains confidentiality of the data against access or use, approved per this Agreement, SOW or otherwise. The User agrees to destroy and send written certification of the destruction of the files to the Source within thirty (30) days of receipt of notice or retention date. The User agrees not to retain the defined data files or any parts thereof, and those files that can be used in concert with other information to identify after the aforementioned data are destroyed.

7. Upon notice of termination of the Agreement or any SOW by the Source or the User, the Source will cease releasing data from the file(s) to the User under the Agreement or the relevant SOW and will notify the User to destroy such data file(s), which destruction shall occur as provided in Paragraph 6 above.

8. The User agrees to establish appropriate administrative, technical, and physical safeguards to protect the confidentiality of the data and to prevent unauthorized use or access to it. The safeguards shall at minimum, provide a level and scope of security commensurate to the security and privacy controls implemented by the Source. For Medicaid data, security and privacy controls shall be no less stringent than the level and scope of security and privacy requirements established by the Centers for Medicare & Medicaid Services (CMS), MARS-E Document Suite, Version 2.0, Catalog of Minimum Acceptable Risk Security and Privacy Controls for Exchanges, (https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/3-MARS-E-v2-0-Catalog-of-Security-and-Privacy-Controls-11102015.pdf). For Non-Medicaid Data, safeguards shall be implemented in accordance with Office of Management and Budget (OMB) in OMB Circular No. A-130, Appendix III--Security of Federal Automated Information Systems (http://www.whitehouse.gov/omb/circulars/a130/a130.html) as well as Federal Information Processing Standard 200 entitled "Minimum Security Requirements for Federal Information and Information Systems" (http://csrc.nist.gov/publications/fips/fips200/FIPS-200-final-march.pdf); and, Special Publication 800-53 r4, Security and Privacy Controls for Federal Information Systems and Organizations (http://nvlpubs.nist.gov/nistpubs/SpecialPublications/NIST.SP.800-53r4.pdf). The User acknowledges that the use of unsecured telecommunications, including the Internet, to transmit individually identifiable, bidder identifiable or deducible information derived from the file(s) specified in each SOW is prohibited. Further, the User agrees that the data must not be physically moved, transmitted or disclosed in any way from or by the site of the User as indicated in each SOW without written approval from the Source unless such movement, transmission, or disclosure is required by a law.

9. The User agrees to grant access to the data to the authorized representatives of the Source, the United States Department of Health and Human Services, General Accounting Office, or its designee at the site of the User as indicated in each SOW for the purpose of inspecting to confirm compliance with the terms of this Agreement.

10. The User agrees not to disclose direct findings, listings, or information derived from the file(s) specified in each SOW, with or without direct identifiers, if such findings, listings, or information can, by themselves or in combination with other data, be used to deduce an individual's identity. Examples of such data elements include, but are not limited to geographic location, age if > 89, sex, diagnosis and procedure, admission/discharge date(s), or date of death.

11. The User agrees that, absent express specification in each SOW to do so, the User shall not attempt to link records included in the file(s) specified in each SOW to any other individually identifiable source of information. This includes attempts to link the data to other data file(s) provided by the Source. A protocol that includes the linkage of specific files that has been approved in accordance with the Justification of each SOW constitutes express authorization from the Source to link files as described in the protocol.

12. The User agrees that in the event the Source determines or has a reasonable belief that the User has made or may have made a use, reuse, or disclosure of the data file(s) defined in any SOW that is not authorized by this Agreement or the relevant SOW, the Source, at its sole discretion, may require the User to: (a) promptly investigate and report to the Source the User's determinations regarding any alleged or actual unauthorized use, reuse, or disclosure, (b) promptly resolve any problems identified by the investigation; (c) if requested by the Source, submit a formal response to an allegation of unauthorized use, reuse, or disclosure; (d) if requested by the Source, submit a corrective action plan with steps designed to prevent any future unauthorized uses, reuses, or disclosures; and (e) if requested by the Source, return data files to the Source or destroy the data files it received from the Source under this Agreement and/or relevant SOW. The User understands that as a result of the Source's determination or reasonable belief that unauthorized uses, reuses, or disclosures have taken place, the Source may refuse to release further Source data to the User for a period of time to be determined by the Source.

B. <u>Notice of Termination</u>

In the event of any termination of this Agreement or SOW, the party terminating the Agreement or SOW shall give notice of such termination in writing to the other party. Notice of termination shall be sent by certified mail, return receipt requested. Termination shall be effective thirty (30) days after the date of receipt unless SCDHHS and SCDSS determine that an earlier effective date for the termination is required in order to maintain compliance with federal requirements.

C. <u>Amendments</u>

No amendment or modification of this contract shall be valid unless it shall be in

writing and signed by all parties hereto.

D. Agreement Period

This Agreement shall take effect as of the first day of May, 2018, and continue unless terminated by either party in accordance with the terms of Section B.

IN WITNESS WHEREOF, SCDHHS and SCDSS, by their authorized agents, in consideration of the mutual promises, covenants, and conditions exchanged between them, have executed this Agreement to be effective as of the first day of May, 2018.

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES "SCDHHS"	SOUTH CAROLINA DEPARTMENT OF SOCIAL SERVICES "SCDSS"
BY: Joshua Baker	BY:
Joshua D. Baker Director	Barbara Derrick Deputy Director, Administration

APPENDIX A

HIPAA BUSINESS ASSOCIATE AGREEMENT

A. Purpose

The South Carolina Department of Health and Human Services (Covered Entity) and Business Associate agree to the terms of this Agreement for the purpose of protecting the privacy of individually identifiable health information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) in performing the functions, activities, or services for, or on behalf of, Covered Entity as specified in the Contract between the parties.

B. Definitions

General Statement

The following terms used in this Agreement shall have the same meaning as those terms in the HIPAA Rules: Breach, Data Aggregation, Designated Record Set, Disclosure, Health Care Operations, Individual, Minimum Necessary, Notice of Privacy Practices, Protected Health Information, Required by Law, Secretary, Security Incident, Subcontractor, Unsecured Protected Health Information, and Use.

Specific definitions:

(a) Business Associate. “Business Associate” shall generally have the same meaning as the term “business associate” at 45 CFR 160.103, and in reference to the party to this Agreement, shall mean the Department of Social Services (DSS).

(b) Covered Entity. “Covered Entity” shall generally have the same meaning as the term “covered entity” at 45 CFR 160.103, and in reference to the party to this Agreement, shall mean SCDHHS.

(c) HIPAA Rules. “HIPAA Rules” shall mean the Privacy, Security, Breach Notification, and Enforcement Rules at 45 CFR Part 160 and Part 164.

(d) Security incident. “Security incident” shall generally have the same meaning as the term “security incident” at 45 CFR 164.304.

C. Obligations and Activities of Business Associate

Business Associate agrees to:

(a) Not use or disclose protected health information other than as permitted or required by the Agreement or as required by law;

(b) Use appropriate safeguards, and comply with Subpart C of 45 CFR Part 164 with respect to electronic protected health information, to prevent use or disclosure of protected health information other than as provided for by the Agreement;

(c) Report to the Privacy Official of the Covered Entity any use or disclosure of protected health information not provided for by the Agreement of which it becomes aware, including breaches of unsecured protected health information as required at 45 CFR 164.410, and any security incident of which it becomes aware within fifteen (15) calendar days of discovery;

(d) Notwithstanding the requirements of 45 CFR 164.410, Business Associate shall notify the Privacy Official of the Covered Entity of potential breaches within fifteen (15) calendar days of discovery and include the Privacy Official of the Covered Entity in their breach determination process;

(e) Business Associate shall report security incidents on a quarterly basis, unless the severity of the security incident elevates the risk to a potential breach, in which case paragraph (c) takes precedence;

(f) In accordance with 45 CFR 164.502(e)(1)(ii) and 164.308(b)(2), if applicable, ensure that any subcontractors that create, receive, maintain, or transmit protected health information on behalf of the Business Associate agree to the same restrictions, conditions, and requirements, to include reporting and notification requirements, that apply to the Business Associate with respect to such information;

(g) All reporting or notifications requirements pursuant to letters (c), (d), (e) and (f) above, should be addressed to the Privacy Official of the Covered Entity by email at privacyoffice@scdhhs.gov. Additional contact information for the Privacy Official is:

> South Carolina Department of Health and Human Services
> Civil Rights Division
> Post Office Box 8206
> Columbia, SC 29202-8206
> Phone: (803) 898-2034
> Fax: (803) 255-8276

(h) Make available protected health information in a designated record set to the Covered Entity as necessary to satisfy Covered Entity's obligations under 45 CFR 164.524;

(i) Make any amendment(s) to protected health information in a designated record set as directed or agreed to by the Covered Entity pursuant to 45 CFR 164.526, or take other measures as necessary to satisfy Covered Entity's obligations under 45 CFR 164.526;

(j) Maintain and make available the information required to provide an accounting of disclosures to Covered Entity, or an individual if directed by Covered Entity, as necessary to satisfy Covered Entity's obligations under 45 CFR 164.528;

(k) Notify Covered Entity within five (5) business days of receipt of any request covered under paragraphs (h), (i) or (j) above;

(l) To the extent the Business Associate is to carry out one or more of Covered Entity's obligation(s) under Subpart E of 45 CFR Part 164, comply with the requirements of Subpart E that apply to the Covered Entity in the performance of such obligation(s); and

(m) Make its internal practices, books, and records available to the Secretary for purposes of determining compliance with the HIPAA Rules.

D. <u>Permitted Uses and Disclosures by Business Associate</u>

(a) Business associate may only use or disclose protected health information as necessary to perform the services set forth in the Contract to which this Agreement is appended, including, if applicable, authorization to use protected health information to de-identify the information in accordance with 45 CFR 164,514(a)-(c);

(b) Business Associate may use or disclose protected health information as required by law;

(c) Business Associate agrees to limit uses, disclosures, and requests for protected health information to the minimum necessary to accomplish the intended purpose of the use, disclosure, or request according to the HIPAA Privacy Rule;

(d) Business Associate may not use or disclose protected health information in a manner that would violate Subpart E of 45 CFR Part 164 if done by Covered Entity;

(e) Business Associate may disclose protected health information for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate, provided the disclosures are required by law, or Business Associate obtains reasonable assurances from the individual to whom the information is disclosed that the information will remain confidential and used or further disclosed only as required by law or for the purposes for which it was disclosed to the individual, and the individual notifies Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.

(f) Business Associate may not disclose or duplicate protected health information identified by Covered Entity as provided by the Social Security Administration (SSA) without written approval and permission from SSA. If the need for such disclosure

and/or duplication arises, Business Associate must notify Covered Entity and work with Covered Entity to obtain approval and permission from SSA.

E. Term and Termination

(a) Term. The Term of this Agreement shall be effective as of and shall terminate on the effective and termination dates of the Contract to which this Agreement is appended, or on the date Covered Entity terminates for cause as authorized in paragraph (b) of this Section, whichever is sooner;

(b) Termination for Cause. Business Associate authorizes termination of this Agreement by Covered Entity, if Covered Entity determines Business Associate has violated a material term of the Agreement and Business Associate has not cured the breach or ended the violation within thirty (30) calendar days.

(c) Obligations of Business Associate Upon Termination.

(1) Upon termination of this Agreement for any reason, Business Associate shall return to Covered Entity, or, if agreed to by Covered Entity, destroy all protected health information received from Covered Entity, or created, maintained, or received by Business Associate on behalf of Covered Entity that the Business Associate still maintains in any form. Business Associate shall retain no copies of the protected health information;
(2) In the event that Business Associate determines that returning or destroying the protected health information is not practical or possible, Business Associate shall notify Covered Entity of the conditions and reasons return of the protected health information is not practical or possible. Upon concurrence by Covered Entity that return is not practical, Business Associate shall:

(i) Continue to use appropriate safeguards and comply with Subpart C of 45 CFR Part 164 with respect to electronic protected health information to prevent use or disclosure of the protected health information, other than as provided for in this Section, for as long as Business Associate retains the protected health information;

(ii) Not use or disclose the protected health information retained by Business Associate other than for the purposes for which such protected health information was retained and subject to the same conditions set out at Section D of this Appendix.

(3) Business Associate shall obtain or ensure the destruction of protected health information created, received, or maintained by any subcontractors;

(4) Business Associate shall transmit the protected health information to another Business Associate of the Covered Entity at termination, upon receipt of a written request from the Covered Entity.

(d) Survival. The obligations of Business Associate under this Section shall survive the termination of this Agreement.

F. **Miscellaneous**

(a) Regulatory References. A reference in this Agreement to a section in the HIPAA Rules means the section as in effect or as amended.

(b) Interpretation. Any ambiguity in this Agreement shall be interpreted to permit compliance with the HIPAA Rules.

APPENDIX B

STATEMENT OF WORK: Verifying and Establishing Eligibility

This Statement of Work ("SOW") is entered into as of the fourth day of May, 2018, 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 the South Carolina Department of Social Services, Post Office Box 1520, Columbia, South Carolina, 29202-1520, hereinafter referred to as "SCDSS".

The purpose of this SOW is to provide data between SCDSS and SCDHHS for verifying and determining eligibility and coordinating services in the Medicaid and SNAP/TANF programs. Neither party will be using the data to perform a function on behalf of the other.

A. <u>Justification Details / Protocols</u>

SCDHHS will conduct a monthly data match with the SCDSS master file to identify clients receiving Supplemental Nutrition Assistance Program (SNAP) and/or Temporary Assistance for Needy Families (TANF) benefits to verify and determine eligibility, including re-certification of Medicaid eligibility, eligibility verification for the purposes of identifying Medicaid fraud, and verification of beneficiary addresses.

SCDSS must meet federal reporting requirements for income and eligibility verification with Medicaid. SCDHHS will return the monthly file for SNAP/TANF recipients with fields appended to verify who are enrolled in Medicaid.

Legal justifications for this data exchange include:

- Supplemental Nutrition Assistance Program (SNAP): 7 CFR 272.8(a)(2)(ii), 7 CFR 275C, 275.12(c)1, 7 CFR 275.12(1)(iv)
- IV-A: 45 CFR 205.55(a)(5)(ii)
- IVB & IVE (SACWIS/CAPS): 45 CFR 1355.53(a) (2)(iii)
- HIPAA: 45 CFR 164.512(k)(6)(i), 45 CFR 164.512(k)(6)(ii), 45 CFR 164.512 (b)(l)(ii) and 45 CFR 164.512 (c)

B. <u>Data File</u>

The table below lists the system fields to be exchanged at the time of this SOW. Field names may be updated to meet system requirements without requiring modification to this SOW.

<u>SCDSS to SCDHHS:</u>

Field Name	Length	Format	Description
Case Number	8	Numerical	
County	2	Numerical	
Program Type	1	Alpha	

AF Part Code	2	Alpha	AF = AFDC (TANF)
FS Part Code	2	Alpha	FS = SNAP
Member SSN	9	Numerical	
Beneficiary's Name		Alpha	
Last Name	20		
First Name	15		
Middle	15		
Suffix	4		
Beneficiary's Sex	1	Alpha	
Ethnic Code	2	Alpha	
Ethnicity	2	Alpha	
Date of Birth	8	Numerical	
Citizenship Code	2	Alpha	
Specified Relative Client	1	Alpha	"Y" or " "
Relationship			
Beneficiary's Address			
Address Line 1	30	Alpha	
Address Line 2	30	Alpha	
Address Line 3 – In Care Of	30	Alpha	
City	20	Alpha	
State	2	Alpha	
Zip	5	Numerical	
Zip Ext	4	Numerical	
Effective Date of Current Address	8	Alpha	
Telephone Number 1	10	Numerical	
Telephone Number 1 Type	1	Alpha	
Telephone Number 2	10	Numerical	

AF-Part Start-Date		'CCYYMMDD'	
FS-Part Start-Date		'CCYYMMDD'	
Income Category			
Income Type			
Income Subtype			
Monthly Income Amount			

SCDSS to SCDHHS:

Field Name	Description
Site Code/County Code	The numerical County location code of the case
Household Number	The ID number belonging to a group of individuals residing in the same household
Number of Household Members	The number of members residing in the same household or in the same case.
Application Date	Displays month, date, and year the applicant applied for assistance
Primary Individual (P)	The individual that completed the Medicaid application.
Caseload Worker ID	In combination with site code/county code, identifies application source
Budget Case Status	The numeric/alpha code indicating the case status – active, closed, pending, etc.
Qualifying Category	Most recent qualifying category
Medicaid I.D. Number	The ID Number used to bill Medicaid for services.
Household Member Relationship	Head of household or relationship of other household members to head of household
Number of Medicaid Eligibility Date Occurrences	The number of occurrences of Medicaid eligibility
Dates of Medicaid Eligibility	The months, dates, and years of Medicaid eligibility
Payment Category	Most recent payment category
Closure Dates/Reasons	The months, dates and years that eligibility cease and the codes that display the reason for the closure
Member Name (Includes Last, First, Middle, and Suffix)	The reported name of the beneficiary applying/receiving assistance (last, first, middle)

Beneficiary's Race	The reported race and system code of the beneficiary applying/receiving assistance
Beneficiary's Sex	The reported sex and system code of the beneficiary applying/receiving assistance
Date of Birth	The month, date and year of birth
Date of Death	The month, date and year of death
Social Security Number	The nine digit SS# or date application was filed for a SS#
Beneficiary's Mailing Address	The mailing address (street, city, state, and zip code) for the PI
Residence Address	Street, city, state, and zip
Home Telephone Number	The area code and telephone number
Work Telephone Number	The area code and telephone number
Authorized Representative's Name	The reported name of the beneficiary's Authorized Representative
Authorized Representative's Address/Telephone Number	The reported street address, city, state, zip code and telephone number of the name of Authorized Rep for the beneficiary
Number of Earned Income Occurrences	The number of occurrences of earned income
Earned Income Table	The employer's name, frequency, gross amount, and date(s) received for earned income received
Employer's Address/Telephone Number	The street, city, state, zip code and telephone number of the beneficiary's employer
Number of Unearned Income Occurrences	The number of occurrences of unearned income
Unearned Income Table, ex: SSA, Child Support, VA, Contributions, etc.	Identified and displayed source, frequency, gross amount of unearned income, date(s) received
Medicare Number	Individual recipient's Medicare ID number
Medicare Buy-in Status (Part A)	Medicare buy-in status
Part A Elig Begin Date	The beginning dates for Medicare Part A coverage
Part A Elig End Date	The ending dates for Medicare Part A coverage
Medicare Buy-in Status (Part B)	Medicare buy-in status

Part B Elig Begin Date	The beginning dates for Medicare Part B coverage
Part B Elig End Date	The ending dates for Medicare Part B coverage
Institutional Status	For all institutionalized individuals – need the following: 01 #CIS-RECIPIENT-RECORD 02 #CIS-REC-SSN (A09) 02 FILLA (A01) 02 #CIS-REC-DOB (A06) 02 #FILLB (A01) 02 #CIS-REC-PCAT (A02) 02 #FILLD (A01) 02 #CIS-REC-NUMBER (A10) 02 #FILLE (A16)

C. Data Retention

The data shared as a subject of this SOW shall be retained no later than thirty (30) days of receipt of notice of discontinuation of business needs.

D. Source

Jose Encarnacion
South Carolina Department of Social Services
Division of Technology Services –DTS
Information Technology Manager II
1628 Browning Rd., Suite 100 /Room 108
Columbia, SC 29210
(803) 724-5325 – Office
(803) 237-9329 - Cell
Jose.Encarnacion@dss.sc.gov

E. User

Sam Fields
Program Manager, Enterprise Systems
Information Technology
SCDHHS
1801 Main Street
Columbia, SC 29201
803-898-0068
samuel.fields@scdhhs.gov

F. SOW Period

This SOW shall take effect as of the first day of May, 2018 and continue unless terminated by either party in accordance with the terms of Section B of the Agreement.

IN WITNESS WHEREOF, SCDHHS and SCDSS, by their authorized agents, in consideration of the mutual promises, covenants, and conditions exchanged between them, have executed this Statement of Work to be effective as of the first day of May, 2018.

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES "SCDHHS"	SOUTH CAROLINA DEPARTMENT OF SOCIAL SERVICSE "SCDSS"
BY: Joshua Baker (signature)	BY: Barbara Derrick (signature)
Joshua D. Baker Director	Barbara Derrick Deputy Director, Administration

APPENDIX C

STATEMENT OF WORK: Children in SCDSS Custody

This Statement of Work ("SOW") is entered into as of the fourth day of May, 2018, 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 the South Carolina Department of Social Services, Post Office Box 1520, Columbia, South Carolina, 29202-1520, hereinafter referred to as "SCDSS".

The purpose of this SOW is to provide data between SCDHHS and SCDSS on children in SCDSS custody to:

1) Enroll children in SCDSS custody in the Medicaid program
2) Assign children in SCDSS custody to the managed care organization (Select Health) SCDSS, as their custodian, has designated
3) Conduct quality assurance and compliance for initial health care encounters

Neither party will be using the data to perform a function on behalf of the other.

A. Justification Details / Protocols

SCDSS will send a nightly file with changes to Medicaid eligibility for children in SCDSS custody. Children with new cases, closed cases, and changes in case record details will be designated using change indicators. SCDSS will also send a master list of children in SCDSS custody on a monthly basis. Dates recorded by SCDSS case workers for initial medical, mental health, and dental encounters will also be included.

Children in SCDSS custody are eligible for beneficiary services through SCDHHS under the authority of the South Carolina State Plan for Medical Assistance. SCDHHS will conduct a match with the SCDSS file to maintain accurate records for children in SCDSS custody by starting, ending, or updating eligibility information and enrollment in benefit plans for foster care.

SCDSS serves as guardian/caregiver for children in the agency's custody. SCDHHS will return a nightly file with Medicaid ID and eligibility start and end dates for children in SCDSS custody whose eligibility information has been updated in order for SCDSS to support eligibility reviews and transitions into and out of foster care.

SCDHHS will also match dates of medical encounters provided by SCDSS with claims data to ensure compliance with requirements for timely initial health assessments and verify accurate billing and reporting. SCDHHS will provide a monthly report confirming or correcting dates of medical encounters recorded by SCDSS.

B. Data Files

SCDSS CAPSS System to FTP Server – Daily Change Records

Field Name	Data Type	Start	Width	Description
Case ID	Text	1	10	Unique ID associated with the Family Case.

Service ID	Text	11	10	Unique ID of program service associated to a family case.
Person ID	Text	21	10	Unique ID that identifies a person in the CAPSS system. Length is 10 with leading 0s.
Service Open Date	Text	31	8	Date service is to start. yyyy/mm/dd
Service Close Date	Text	39	8	Date service closed. yyyy/mm/dd
County Code	Text	47	3	The county code of the address of the provider.
Program Code	Text	50	1	Unique id R - Regular Foster Care
Part Code	Text	51	2	Used by SNAP system but not field used in CAPSS.
Indicator	Text	53	1	Used by SNAP system but not field used in CAPSS.
FS Part Code	Text	54	2	Used by SNAP system but not field used in CAPSS.
SSN	Text	56	9	9-digit social security number of foster child.
DSS Medicaid ID	Text	65	10	10-digit Medicaid number recorded by case worker.
HOH	Text	75	1	Used by SNAP system but not field used in CAPSS.
Last Name	Text	76	25	Last name of foster child.
First Name	Text	101	25	First name of foster child.
Middle Name	Text	126	15	Middle name of foster child.
Sex	Text	141	1	Gender of Foster child. F or M.
Ethnicity	Text	142	2	This field displays 'HI' to indicate whether the individual is of Hispanic origin.
Field9	Text	144	2	This field was part of the original file layout from DHHS. We do not use this field in CAPSS.
Birth Date	Text	146	8	yyyy/mm/dd
Citizen Code	Text	154	2	E - Eligible Alien N - Naturalized US Citizen U - United States Citizen O - Citizen of Another Country
Relative Client	Text	156	1	
Relationship	Text	157	2	
Res_Address 1	Text	159	40	
Res_Address 2	Text	199	30	
Res_City	Text	229	20	
Res_State	Text	249	2	
Res_Zip	Text	251	5	
Res_Zip 4	Text	256	4	

Res_Address Effective Date	Text	260	8	
Home Phone	Text	268	10	
Cell Phone	Text	278	10	
Placement Type	Text	288	3	Code for type of placement for foster child.
Field16	Text	291	2	Part of the original layout from DHHS; not part of CAPSS system.
Placement Description	Text	293	65	Part of the original layout from DHHS; not part of CAPSS system.
Caseworker Name	Text	358	40	First and last name of current worker assigned to the foster care service.
Provider Name	Text	398	60	The name of the provider where the child is placed.
Case_Office	Text	458	40	The county office name for case management, i.e. Richland County, Lexington County.
Case_Address 1	Text	498	30	The address of the county office.
Case_Address 2	Text	528	30	The secondary address of the county office.
Case_City	Text	558	20	The city of the county office.
Case_State	Text	578	2	The state of the county office.
Case_Zip	Text	580	5	The zip code of the county office.
Case_Zip 4	Text	585	4	
Case_Office Phone	Text	589	10	The general phone number of the county office.
Change Ind	Text	599	100	If no change, leave blank. Service Closed = 'SC' Service Reopened = 'SR' New Service = 'NS' Caseworker Name Changed = 'CW' Caseworker Phone Changed = 'CP' Caseworker Address Changed = 'CA' Provider Name Changed = 'PN' Provider Address Changed = 'PA' Provider Home Phone Changed = 'PH' Provider Cell Phone Changed = 'PC' Placement Type Changed = 'PT' Licensed Placement Changed = 'LP' Eligibility Changed = 'EC' Name Change = 'NC'
IV_E Eligible	Text	699	1	Eligibility for Title IV-E based on DSS case record. Y/N
Licensed Placement	Text	700	1	
Eligibility Status	Text	701	2	E1 Eligible EA ENR–No Longer Meets Age Requirement

				ED ENR--No Current Deprivation EE ENR--No Reasonable Efforts Finding EF ENR--Non-Reimbursable Facility EL ENR--Relative Placement in Process of Licensure EN ENR--No Longer in Need/Excessive Assets EO ENR--Other (text required) ER ENR--Reasonable Efforts Finding - Untimely Hearing ES ENR--Child Receives SSI EU ENR--Unlicensed Placement EW ENR--No Longer Meets Education/Work Status Requirement
Eligibility Effective Date	Text	703	8	Date of eligibility for IV-E.
Eligibility Determination Date	Text	711	8	Date of Eligibility for IV-E.
Placement End Reason	Text	719	2	
Service Close Reason	Text	721	2	
County Origin	Text	723	80	
Initial Medical Screening	Text	731	8	Date of initial medical screening recorded by case worker in CAPSS. yyyy/mm/dd
Initial Mental Health Assessment	Text	739	8	Date of initial mental health assessment recorded by case worker in CAPSS. yyyy/mm/dd
Initial Dental Screening	Text	747	8	Date of initial dental screening recorded by case worker in CAPSS. yyyy/mm/dd
Well Child Visit	Text	754	8	Date of well child visit recorded by case worker in CAPSS. yyyy/mm/dd
Oral Exam Cleaning	Text	762	8	Date of oral exam cleaning recorded by case worker in CAPSS. yyyy/mm/dd

SCDSS CAPSS System to FTP Server – Monthly Master List

Field Name	Data Type	Description
Case ID	Text	Unique ID associated with the Family Case.

Service ID	Text	Unique ID of program service associated to a family case.
Person ID	Text	Unique ID that identifies a person in the CAPSS system. Length is 10 with leading 0s.
County Code	Text	The county code of the address of the provider.
Program Code	Text	Unique id R - Regular Foster Care
SSN	Text	9-digit social security number of foster child.
Medicaid ID	Text	10-digit Medicaid number. Should be verified/ updated after Medicaid enrollment in Foster Care payment categories with correct information.
Last Name	Text	Last name of foster child.
First Name	Text	First name of foster child.
Middle Name	Text	Middle name of foster child.
Sex	Text	Gender of Foster child. F or M.
Ethnicity	Text	This field displays 'HI' to indicate whether the individual is of Hispanic origin.
Birth Date	Text	yyyy/mm/dd
Citizen Code	Text	The citizenship status of the foster child. E - Eligible Alien N - Naturalized US Citizen U - United States Citizen O - Citizen of Another Country
Placement Type	Text	Code for type of placement for foster child.
Caseworker Name	Text	First and last name of current worker assigned to the foster care service.
Provider Name	Text	The name of the provider where the child is placed.
Case_Office	Text	The county office name for case management, i.e. Richland County, Lexington County.
Case_Address 1	Text	The address of the county office.
Case_Address 2	Text	The secondary address of the county office.
Case_City	Text	The city of the county office.

Case_State	Text	The state of the county office.
Case_Zip	Text	The zip code of the county office.
Case_Zip 4	Text	Four digit extension of the provider address.
Case_Office Phone	Text	The general phone number of the county office.
IV_E Eligible	Text	Eligibility for Title IV-E based on DSS case record. Y/N
Eligibility Status	Text	E1 Eligible EA ENR--No Longer Meets Age Requirement ED ENR--No Current Deprivation EE ENR--No Reasonable Efforts Finding EF ENR--Non-Reimbursable Facility EL ENR--Relative Placement in Process of Licensure EN ENR--No Longer in Need/Excessive Assets EO ENR--Other (text required) ER ENR--Reasonable Efforts Finding - Untimely Hearing ES ENR--Child Receives SSI EU ENR--Unlicensed Placement EW ENR--No Longer Meets Education/Work Status Requirement
Eligibility Effective Date	Text	Date of eligibility for IV-E.
Eligibility Determination Date	Text	Date of Eligibility for IV-E.
Initial Medical Screening	Text	Date of initial medical screening recorded by case worker in CAPSS. yyyy/mm/dd
Initial Mental Health Assessment	Text	Date of initial mental health assessment recorded by case worker in CAPSS. yyyy/mm/dd
Initial Dental Screening	Text	Date of initial dental screening recorded by case worker in CAPSS. yyyy/mm/dd
Well Child Visit	Text	Date of well child visit recorded by case worker in CAPSS. yyyy/mm/dd
Oral Exam Cleaning	Text	Date of oral exam cleaning recorded by case worker in CAPSS. yyyy/mm/dd

SCDHHS to FTP Server – Daily

Field Name	Description
Case ID	Unique ID associated with the Family Case.
Service ID	Unique ID of program service associated to a family case.
Person ID	Unique ID that identifies a person in the CAPSS system. Length is 10 with leading 0s.
SSN	9-digit social security number of foster child.
DSS Medicaid ID	10-digit Medicaid number recorded by case worker.
Last Name	Last name of foster child.
First Name	First name of foster child.
Birth Date	yyyy/mm/dd
DHHS Medicaid ID	10-digit Medicaid number assigned to foster care child. This serves as the source of truth and should be used to update DSS records.
DHHS Elig Start Date	Start date for Medicaid eligibility.
DHHS Elig End Date	End date for Medicaid eligibility.
MCO or MHN	MCO = Managed Care Organization. MHN = Medical Home Network.
MCO Plan Name	Name of Managed Care Organization (Select, Absolute Total Care, BlueChoice, Molina, Wellcare).
Active RSP(s)	Medicaid recipient special program (RSP). Designates special services through Medicaid waivers or other programs. BNET = BabyNet PCSC = Palmetto Systems of Coordinated Care COCP = Continuum of Care Program CSWE = Community Supports Waiver DMRE = ID/RD Waiver Participants WMCC = Medically Complex Children's Waiver
SSI (Y/N)	Designates whether foster care child has SSI eligibility.

SCDHHS to SCDSS – Monthly

The following fields will be appended to SCDSS' monthly file and returned:

Field Name	Description
Initial Medical Screening	Date of initial medical screening in Medicaid claims.
Medical Screening Verification Indicator	Y/N Indicates whether date of Initial Medical Screening provided by DSS falls in specified time window with Medicaid claims data.
Primary Diagnosis	Primary diagnosis indicated on medical claim for Initial Medical Screening.
Secondary Diagnosis	Secondary diagnosis indicated on medical claim for Initial Medical Screening.

Diagnosis 03	Third diagnosis indicated on medical claim for Initial Medical Screening.
Initial Mental Health Assessment	Date of initial medical screening in Medicaid claims.
Mental Health Assessment Verification Indicator	Y/N Indicates whether date of Mental Health Assessment provided by DSS falls in specified time window with Medicaid claims data.
Primary Diagnosis	Primary diagnosis indicated on medical claim for Mental Health Assessment.
Secondary Diagnosis	Secondary diagnosis indicated on medical claim for Mental Health Assessment.
Diagnosis 03	Third diagnosis indicated on medical claim for Mental Health Assessment.
Initial Dental Screening	Date of initial medical screening in Medicaid claims.
Dental Screening Verification Indicator	Y/N Indicates whether date of Dental Screening provided by DSS falls in specified time window with Medicaid claims data.
Well Child Visit	Date of initial medical screening in Medicaid claims.
Well Child Visit Verification Indicator	Y/N Indicates whether date of Well Child Visit provided by DSS falls in specified time window with Medicaid claims data.
Oral Exam Cleaning	Date of initial medical screening in Medicaid claims.
Oral Exam Verification Indicator	Y/N Indicates whether date of Oral Exam provided by DSS falls in specified time window with Medicaid claims data.

C. Data Retention

The data shared as a subject of this SOW shall be retained no later than thirty (30) days of receipt of notice of discontinuation of business needs.

D. Source/User

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E. Source/User

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F. SOW Period

This SOW shall take effect as of the first day of May, 2018 and continue unless terminated by either party in accordance with the terms of Section B of the Agreement.

IN WITNESS WHEREOF, SCDHHS and SCDSS, by their authorized agents, in consideration of the mutual promises, covenants, and conditions exchanged between them, have executed this Statement of Work to be effective as of the first day of May, 2018.

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES "SCDHHS"	SOUTH CAROLINA DEPARTMENT OF SOCIAL SERVICES "SCDSS"
BY: Joshua Baker	BY: Barbara Derrick
Joshua D. Baker Director	Barbara Derrick Deputy Director, Administration

APPENDIX D

STATEMENT OF WORK: Benefit Recovery for Third Party Liability

This Statement of Work ("SOW") is entered into as of the fourth day of May, 2018, 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 the South Carolina Department of Social Services, Post Office Box 1520, Columbia, South Carolina, 29202-1520, hereinafter referred to as "SCDSS".

The purpose of this data exchange from SCDSS to SCDHHS is to provide health insurance policy information obtained on child support cases outlined in Tile IV-D of the Social Security Act, which include Palmetto Automated Child Support System (PACSS) dependents with Medicaid beneficiary IDs. PACSS will extract information about health insurance policies carried by custodial parents, non-custodial parents, and others covering the children in IV-D cases, and deliver this information to Medicaid. Third Party Liability coverage may be used by the Medicaid program to settle the medical claims for the family/children receiving State medical assistance.

Neither party will be using the data to perform a function on behalf of the other.

A. Justification Details / Protocols

Federal regulations require state Medicaid agencies to identify other (third party) payers that may be available to pay for the care and services provided to Medicaid beneficiaries and ensure that Medicaid pays secondary to those payers (42 CFR 433 Subpart D). This SOW shall serve as SCDHHS's agreement with the state's Title IV-D agency (SCDSS) to identify third party liability based on obligations to pay child support enforced by the state's IV-D agency, outlined in the South Carolina State Plan for Medical Assistance as required by 42 CFR 433.151.This SOW will abide by or comply with requirements for cooperative agreements for third party collections outlined in 42 CFR 433.152, which includes 45 CFR 303.107.

SCDSS will provide information at the beneficiary level including the information on policy and the beneficiaries covered by the insurance policy. If a member has more than one insurance policy, there will be multiple records for each insurance policy carried by the member. The policy holder's name will be included in the provided information.

SCDHHS will match data from a SCDSS Title IV-D master file with beneficiary enrollment and claims data to verify other insurance and determine if benefit recovery cases should be opened. SCDHHS will update third party liability information as needed and open cases to initiate recovery when paid claims are found and the criteria to perform benefit recovery is met.

B. Data File

The table below lists the system fields to be exchanged at the time of this SOW. Field names may be updated to meet system requirements without requiring modification to this SOW.

SCDSS to SCDHHS – Weekly:

Field Name	Description/Format/Value
Record Type	N – New Insurance Policy U - Updated Insurance Policy
CSES Member ID	CSES member ID. This is the unique CSES ID for custodial parent (CP), non custodial parent (NCP) or the dependent on the CSES case.
CSES Member SSN	Member SSN
CSES Member Last Name	CSES Member Last Name
CSES Member First Name	CSES Member First Name
CSES Member Middle Name	CSES Member Middle Name
CSES Member Name Suffix	CSES Member Name Suffix
Policy Holder's Last Name	Policy Holder's Last Name
Policy Holder's First Name	Policy Holder's First Name
Policy Holder's Middle Name	Policy Holder's Middle Name
Policy Holder's Name Suffix	Policy Holder's Name Suffix
CSES Member Residential Address Line 1	The Active Residential address of the Member is provided here
CSES Member Residential Address Line 2	The Active Residential address of the Member is provided here
CSES Member Residential City	The Active Residential address of the Member is provided here
CSES Member Residential State	The Active Residential address of the Member is provided here
CSES Member Residential Zip Code	The Active Residential address of the Member is provided here
CSES Member Mailing Address Line 1	The Active Mailing address of the Member is provided here
CSES Member Mailing Address Line 2	The Active Mailing address of the Member is provided here
CSES Member Mailing City	The Active Mailing address of the Member is provided here
CSES Member Mailing State	The Active Mailing address of the Member is provided here
CSES Member Mailing Zip Code	The Active Mailing address of the Member is provided here

CSES Member Phone Number	The Active Mailing address of the Member is provided here
CSES Member Employment Occurrence	Count of Member's Employment information occurrences. Blank occurrences are not counted.
CSES Member Employer Name	Active employment information will be provided
CSES Member Employer Address Line 1	Member Employer Address Line 1
CSES Member Employer Address Line 2	Member Employer Address Line 2
CSES Member Employer City	Member Employer City
CSES Member Employer State	Member Employer State
CSES Member Employer Zip Code	Member Employer Zip Code
CSES Member Employer Telephone Number	Member Employer Telephone Number
CSES Member Employment Termination Date	Member Employment Termination Date YYYYMMDD
Policy Name	The field may also be referred to as policy option name Always = blanks
Policy Number	Policy Number
Group Number	If policy is through employer
Insurance Company Carrier Code	Insurance Company Carrier Code
Policy Status Effective Date	Effective date of policy YYYYMMDD
Deductible Amount	Deductible Amount $$$$$$$CC
CSES Member ID	CSES Member ID
Beneficiary's Medicaid Recipient ID	Medicaid ID of the Dependent
Beneficiary's SSN	Member's SSN in CSES
Beneficiary's Last Name	Member's Last Name in CSES
Beneficiary's First Name	Member's First Name in CSES
Beneficiary's Middle Name	Member's Middle Name in CSES
Beneficiary's Name Suffix	Member's Name Suffix in CSES

Beneficiary's Relationship to Policy Holder	Always blanks Value: 1 – MALE/SELF 2 – FEMALE/SELF 3 – MALE/SPOUSE 4 – FEMALE/SPOUSE 5 – MALE/CHILD 6 – FEMALE/CHILD The field will be blank if the relationship code does not exist in CSES. Please see Section 1.1.1.8 for Data Transformation/Translation
Beneficiary's Coverage Begin Date	Coverage Begin Date YYYYMMDD
Beneficiary's Coverage End Date	Coverage End Date YYYYMMDD

C. Data Retention

The data shared as a subject of this SOW shall be retained no later than thirty (30) days of receipt of notice of discontinuation of business needs.

D. Source

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E. User

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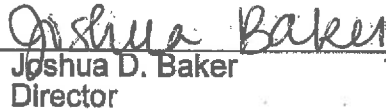
F. SOW Period

This SOW shall take effect as of the first day of May, 2018 and continue unless terminated by either party in accordance with the terms of Section B of the Agreement.

IN WITNESS WHEREOF, SCDHHS and SCDSS, by their authorized agents, in consideration of the mutual promises, covenants, and conditions exchanged between them, have executed this Statement of Work to be effective as of the first day of May, 2018.

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
"SCDHHS"

BY: 
Joshua D. Baker
Director

SOUTH CAROLINA DEPARTMENT OF SOCIAL SERVICES
"SCDSS"

BY:
Barbara Derrick
Deputy Director, Administration

APPENDIX E

STATEMENT OF WORK: Medication Management for Children in SCDSS Custody

This Statement of Work ("SOW") is entered into as of the fourth day of May, 2018, 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 the South Carolina Department of Social Services, Post Office Box 1520, Columbia, South Carolina, 29202-1520, hereinafter referred to as "SCDSS".

The purpose of this SOW is to provide data from SCDHHS to SCDSS on the health care and medication utilization of children in SCDSS custody with fee-for-service coverage for SCDSS to carry out care coordination, quality assurance, and guardian oversight of beneficiary services as administered by SCDHHS under the authority of the South Carolina State Plan of Medical Assistance. SCDSS is designated as the User of this data under the terms of this SOW.

Neither party will be using the data to perform a function on behalf of the other.

A. Justification Details / Protocols

The Fostering Connections to Success and Increasing Adoptions Act of 2008 (PL 110-351) requires State Title IV-B agencies to develop a plan for oversight and coordination or health care services for children in foster care, in coordination and consultation with the State Title XIX (Medicaid agency). This requirement aims to ensure that children in foster care receive high-quality, coordinated health care services, including appropriate oversight of prescription medication (sect. 422(b)(15)). SCDSS serves as South Carolina's state Title IV-B agency and is the caregiver/custodian of children in the agency's custody. For medical management of children in the agency's custody, SCDSS medical staff conduct clinical oversight for psychotropic medications and behavioral health services.

SCDSS will identify children in the agency's custody by providing SCDHHS with a monthly master file, described in the Appendix B (Statement of Work: Children in SCDSS Custody) and also listed in Section B below. SCDHHS will match files to identify children receiving fee-for-service benefits and provide medical and pharmacy claims information for these beneficiaries. SCDHHS will provide monthly reports to SCDSS medical staff to facilitate health care management and coordination of services with providers. Reports will include, but are not limited to: records for psychotropic medications, behavioral health diagnoses, lab orders, and behavioral health services. SCDSS will obtain claims data on managed care members from the appropriate managed care organization.

SCDSS will create role-based limitations for accessing health history in the Child Adult Protective Services System (CAPSS) to staff levels agreed upon by SCDHHS, which may include clinical staff, county directors, and caseworkers.

B. Data Files

Transfer from SCDSS to FTP Portal - Monthly

Field Name	Data Type	Start	Width	Description
Case ID	Text	1	10	Unique ID associated with the Family Case.
Service ID	Text	11	10	Unique ID of program service associated to a family case.
Person ID	Text	21	10	Unique ID that identifies a person in the CAPSS system. Length is 10 with leading 0s.
Service Open Date	Text	31	8	Date service is to start. yyyy/mm/dd
Service Close Date	Text	39	8	Date service closed. yyyy/mm/dd
County Code	Text	47	3	The county code of the address of the provider.
Program Code	Text	50	1	Unique id R - Regular Foster Care
Part Code	Text	51	2	Used by SNAP system but not field used in CAPSS.
Indicator	Text	53	1	Used by SNAP system but not field used in CAPSS.
FS Part Code	Text	54	2	Used by SNAP system but not field used in CAPSS.
SSN	Text	56	9	9-digit social security number of foster child.
DSS Medicaid ID	Text	65	10	10-digit Medicaid number recorded by case worker.
HOH	Text	75	1	Used by SNAP system but not field used in CAPSS.
Last Name	Text	76	25	Last name of foster child.
First Name	Text	101	25	First name of foster child.
Middle Name	Text	126	15	Middle name of foster child.
Sex	Text	141	1	Gender of Foster child: F or M.
Ethnicity	Text	142	2	This field displays 'HI' to indicate whether the individual is of Hispanic origin.
Field9	Text	144	2	This field was part of the original file layout from DHHS. We do not use this field in CAPSS.
Birth Date	Text	146	8	yyyy/mm/dd
Citizen Code	Text	154	2	E - Eligible Alien N - Naturalized US Citizen U - United States Citizen O - Citizen of Another Country
Relative Client	Text	156	1	
Relationship	Text	157	2	
Res_Address 1	Text	159	40	

Res_Address 2	Text	199	30	
Res_City	Text	229	20	
Res_State	Text	249	2	
Res_Zip	Text	251	5	
Res_Zip 4	Text	256	4	
Res_Address Effective Date	Text	260	8	
Home Phone	Text	268	10	
Cell Phone	Text	278	10	
Placement Type	Text	288	3	Code for type of placement for foster child.
Field16	Text	291	2	Part of the original layout from DHHS; not part of CAPSS system.
Placement Description	Text	293	65	Part of the original layout from DHHS; not part of CAPSS system.
Caseworker Name	Text	358	40	First and last name of current worker assigned to the foster care service.
Provider Name	Text	398	60	The name of the provider where the child is placed.
Case_Office	Text	458	40	The county office name for case management, i.e. Richland County, Lexington County.
Case_Address 1	Text	498	30	The address of the county office.
Case_Address 2	Text	528	30	The secondary address of the county office.
Case_City	Text	558	20	The city of the county office.
Case_State	Text	578	2	The state of the county office.
Case_Zip	Text	580	5	The zip code of the county office.
Case_Zip 4	Text	585	4	
Case_Office Phone	Text	589	10	The general phone number of the county office.
Change Ind	Text	599	100	If no change, leave blank. Service Closed = 'SC' Service Reopened = 'SR' New Service = 'NS' Caseworker Name Changed = 'CW' Caseworker Phone Changed = 'CP' Caseworker Address Changed = 'CA' Provider Name Changed = 'PN' Provider Address Changed = 'PA' Provider Home Phone Changed = 'PH' Provider Cell Phone Changed = 'PC' Placement Type Changed = 'PT' Licensed Placement Changed = 'LP'

				Eligibility Changed = 'EC' Name Change = 'NC'
IV_E Eligible	Text	699	1	Eligibility for Title IV-E based on DSS case record. Y/N
Licensed Placement	Text	700	1	
Eligibility Status	Text	701	2	E1 Eligible EA ENR--No Longer Meets Age Requirement ED ENR--No Current Deprivation EE ENR--No Reasonable Efforts Finding EF ENR--Non-Reimbursable Facility EL ENR--Relative Placement in Process of Licensure EN ENR--No Longer in Need/Excessive Assets EO ENR--Other (text required) ER ENR--Reasonable Efforts Finding - Untimely Hearing ES ENR--Child Receives SSI EU ENR--Unlicensed Placement EW ENR--No Longer Meets Education/Work Status Requirement
Eligibility Effective Date	Text	703	8	Date of eligibility for IV-E.
Eligibility Determination Date	Text	711	8	Date of Eligibility for IV-E.
Placement End Reason	Text	719	2	
Service Close Reason	Text	721	2	
County Origin	Text	723	80	
Initial Medical Screening	Text	731	8	Date of initial medical screening recorded by case worker in CAPSS. yyyy/mm/dd
Initial Mental Health Assessment	Text	739	8	Date of initial mental health assessment recorded by case worker in CAPSS. yyyy/mm/dd
Initial Dental Screening	Text	747	8	Date of initial dental screening recorded by case worker in CAPSS. yyyy/mm/dd
Well Child Visit	Text	754	8	Date of well child visit recorded by case worker in CAPSS. yyyy/mm/dd
Oral Exam Cleaning	Text	762	8	Date of oral exam cleaning recorded by case worker in CAPSS. yyyy/mm/dd

Transfers from SCDHHS to SCDSS:

Prescription Monitoring Report:

Field Names	Description
Person ID	Unique ID that identifies a person in the CAPSS system. Length is 10 with leading 0s.
DHHS Medicaid ID	10-digit Medicaid number assigned to foster care child. This serves as the source of truth and should be used to update DSS records.
Last Name	Last name of foster child.
First Name	First name of foster child.
Birth Date	yyyy/mm/dd
Case Office	The county office name for case management, i.e. Richland County, Lexington County.
Gender	Gender of Foster child: F or M.
Product Name	Name of prescribed medication.
Route of Administration	Route for medication administered (e.g., oral, patch).
Date Dispensed	Date prescription was dispensed.
Days Supply	Days supply of medication provided in prescription.
Refill	Indicator for whether prescription was new or refilled.
Therapeutic Class	Classification for intended treatment purpose of medication.
Provider Name	Prescribing provider name.
Provider Type	Individual or group provider type for prescribing provider/
Provider Specialty	Medical specialty of prescribing provider.
Monitoring Flag - Children	Y/N indicator for children less than 6 years old with psychotic medication prescribed.
Monitoring Flag – Psychotics	Y/N indicator for children with more than 4 unique psychotic medications.
Lab Order	Indicator that lab order for medication monitoring was billed for foster child (blood sugar, lipids).

Behavioral Health Services and Diagnoses Report:

Field Name	Description
Person ID	Unique ID that identifies a person in the CAPSS system. Length is 10 with leading 0s.
DHHS Medicaid ID	10-digit Medicaid number assigned to foster care child. This serves as the source of truth and should be used to update DSS records.
Last Name	Last name of foster child.
First Name	First name of foster child.
Birth Date	yyyy/mm/dd

Case Office	The county office name for case management, i.e. Richland County, Lexington County.
Gender	Gender of Foster child. F or M.
Service Month	Month of health encounter date of service.
Paid Month	Month claim for health encounter was paid.
Date Dispensed	Date prescription was dispensed.
RBHS Procedure Code	Behavioral health services procedure code.
Provider Name	Prescribing provider name.
Provider Type	Individual or group provider type for behavioral health provider.
Provider Specialty	Medical specialty of behavioral health provider.
Clinical Condition	Overall medical condition based on primary diagnosis.
Diagnosis Principal Code	Code for principal diagnosis on claim.
Diagnosis Principal	Description of principal diagnosis on claim.

C. Data Retention

The data shared as a subject of this SOW shall be retained no later than thirty (30) days of receipt of notice of discontinuation of business needs.

D. Source

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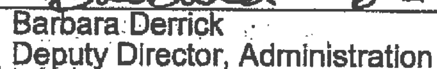
F. SOW Period

This SOW shall take effect as of the first day of May, 2018 and continue unless terminated by either party in accordance with the terms of Section B of the Agreement.

IN WITNESS WHEREOF, SCDHHS and SCDSS, by their authorized agents, in consideration of the mutual promises, covenants, and conditions exchanged between them, have executed this Statement of Work to be effective as of the first day of May, 2018.

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES "SCDHHS"	SOUTH CAROLINA DEPARTMENT OF SOCIAL SERVICES "SCDSS"
BY:	BY: 
Joshua D. Baker Director	Barbara Derrick Deputy Director, Administration