



Request for Information (RFI)

June 30, 2011

Instructions for Responses

South Carolina Department of Health and Human Services (SCDHHS) would like to receive responses to this RFI by **July 26, 2011**. Please submit your response via e-mail to fbo@scdhhs.gov. The SCDHHS e-mail system does not accept attachments larger than about 15 MB. If your response is near this size or greater, please mail two identical CDs containing your response to:

Replacement MMIS RFI #4
SCDHHS Bureau of Federal Contracts
Attn: Rhonda Morrison
P.O. Box 8206
Columbia, SC 29202

If you use a shipping method that requires a street address, please use the above address replacing the P.O. Box number with **1801 Main St.**

SCDHHS may copy your response to other storage media to facilitate review by its staff.

As the feedback from this RFI directly impacts a future solicitation, the State wishes to receive only information that respondents do not consider confidential, trade secrets, or protected. Please do not mark any portion of your response with confidentiality restrictions that would prevent the State from publishing your response, in whole, to the general public. Any information provided that is restricted from such publication may not be considered by the State in finalizing the Replacement Medicaid Management Information System (MMIS) Request for Proposals (RFP).

This RFI is in reference to a potential future RFP for a Replacement MMIS and related information technology (IT) and business services. This RFI is issued solely for market research, planning, and informational purposes and is not to be construed as a commitment by the State to acquire any product or service or to enter into a contractual agreement.

Any costs incurred by a party in preparing or submitting information in response to the RFI are the sole responsibility of the submitting party.

Purpose

The State is seeking feedback on its draft RFP for the Replacement MMIS. By seeking early feedback from the vendor community, the State hopes to accomplish the following objectives:

1. Improve the quality of the final RFP.
2. Improve the quality of the proposals by providing vendors early insight into the State's objectives.
3. Reduce the size and complexity of the amendments to the final RFP driven by the formal question and answer period that occurs post-solicitation.

The draft RFP for the Replacement MMIS is shown in Attachment 1. The draft pricing tables are shown in Attachment 2.

The State encourages vendors and other interested parties to provide feedback in response to this RFI.

This document is not an RFP. The State is not seeking proposals at this time.

Vendor Day

In order to enhance communications and feedback between the State and the MMIS vendor community, the State will host a Vendor Day to review the draft RFP on **July 12, 2011** from 9:00 – 5:00. While post-solicitation/pre-proposal conferences are often noted for their brevity and lack of vendor questions, the State encourages vendors to engage during this review. A substantial portion of the time will be set aside for section-by-section feedback. Vendors may submit written feedback to the State without having attended Vendor Day; however, the State feels that the information discussed during the review session will be very valuable in preparing a proposal.

Vendor Day will be held at the Brookland Banquet & Conference Center located at 1066 Sunset Ave (also known as US 378) in West Columbia, SC. Directions to the Conference Center can be found at:

<http://www.brooklandbaptist.org/contact.htm>

The State has confirmed space for those vendors that replied to “Replacement MMIS Notification #2,” posted on February 4, 2011. Other vendor personnel are welcome, space permitting. The State requests confirmation of the previous attendee requests from those vendors that previously responded. Other interested vendors should respond with their requested attendance numbers by **July 6, 2011** to fbo@scdhhs.gov.

The Conference Center serves lunch at a cost of \$12. Using this service will allow us to minimize the amount of time required for lunch. Attendees must **pay by check** made out to SCDHHS. This payment will be collected as attendees sign in prior to beginning the meeting.

Submission Request

The State requests that vendors respond to the following items in writing by **July 26, 2011**:

1. The State intends to conduct an efficient and effective source selection. It has tried to pare the proposal submission requirements down to those that contribute to this goal; however, as with most MMIS procurements, the proposals will still be relatively large

documents that require substantial Offeror investment to create. Is there anything in the proposal submission requirements (Sections IV and V of the draft RFP) that could be further pared without jeopardizing either the source selection or the ability to execute a solid contract? Is there anything else that should be added to the proposal submission requirements?

2. The State has used unit or volume pricing on many of the pricing tables. Are there any of the pricing tables where the pricing methodology is inadequate, incomplete, or does not correlate to the underlying cost drivers?
3. Some of the Operations Phase performance standards are Offeror-proposed. Are there any other standards that should be Offeror-proposed? Should *all* Operations Phase performance standards be Offeror-proposed?
4. The State has included information in the Procurement Library that it believes will be useful to Offerors in preparing their proposals. Is there any other information required to form a responsive proposal? Please note that as collecting and publishing statistical, programmatic, and technical information is time-consuming and resource-intensive, the State requests the respondents identify only identify new Procurement Library requests that are truly necessary. Please be very specific in your suggestions.
5. Are the intellectual property terms and conditions acceptable? Are there any changes that should be made to these sections?
6. CMS is planning to release the Medicaid Information Technology Architecture (MITA) version 3.0 in August with additional updates throughout the remainder of 2011. Based on your knowledge of MITA 3.0, should the RFP be updated to reflect the structure and known content of MITA 3.0, or should the RFP remain aligned with MITA 2.01?
7. The pricing tables are physically large at 1:1 reproduction. What is your recommendation for delivering these in paper format? Note that they will need to be submitted in electronic format, as well.
8. Are there any other recommended changes or requests for clarification that you have for the Draft RFP? Please use a format similar to that below to submit your suggestions and questions. You may format these in either landscape or portrait.

Item Number	Affected RFP Section Number	Description of Suggestion or Question

Thank you for your interest in the State of South Carolina


Attachment 1

Replacement MMIS Draft RFP



Replacement Medicaid Management Information System Draft RFP

Draft

	State of South Carolina Request for Proposal	Solicitation Number: XXXXXXXX Date Issued: XX/XX/XXXX Procurement Officer: XXX Phone: XXX-XXX-XXXX E-Mail Address: XXX
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DESCRIPTION: **Replacement Medicaid Management Information System**

USING GOVERNMENTAL UNIT: **Department of Health & Human Services**

The Term "Offer" Means Your "Bid" or "Proposal". Unless submitted on-line, your offer must be submitted in a sealed package. Solicitation Number & Opening Date must appear on package exterior. See "Submitting Your Offer" provision.

SUBMIT YOUR OFFER ON-LINE AT THE FOLLOWING URL: <http://www.procurement.sc.gov>

SUBMIT OFFER BY (Opening Date/Time): **XX/XX/XXXX 14:30:00** (See "Deadline For Submission Of Offer" provision)

QUESTIONS MUST BE RECEIVED BY: **XX/XX/XXXX 14:00:00** (See "Questions From Offerors" provision)

NUMBER OF COPIES TO BE SUBMITTED: **SEE PAGE 3**

CONFERENCE TYPE: DATE & TIME: <small>(As appropriate, see "Conferences - Pre-Bid/Proposal" & "Site Visit" provisions)</small>	LOCATION:
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AWARD & AMENDMENTS	Award will be posted on XX/XX/XXXX . The award, this solicitation, any amendments, and any related notices will be posted at the following web address: http://www.procurement.sc.gov
-------------------------------	--

Unless submitted on-line, you must submit a signed copy of this form with Your Offer. By submitting a bid or proposal, You agree to be bound by the terms of the Solicitation. You agree to hold Your Offer open for a minimum of one hundred eighty (180) calendar days after the Opening Date. (See "Signing Your Offer" and "Electronic Signature" provisions.)

NAME OF OFFEROR <small>(full legal name of business submitting the offer)</small>		Any award issued will be issued to, and the contract will be formed with, the entity identified as the Offeror. The entity named as the offeror must be a single and distinct legal entity. Do not use the name of a branch office or a division of a larger entity if the branch or division is not a separate legal entity, i.e., a separate corporation, partnership, sole proprietorship, etc.
AUTHORIZED SIGNATURE <div style="text-align: center; color: red; font-weight: bold; font-size: 1.2em;">DRAFT – DO NOT EXECUTE</div> <small>(Person must be authorized to submit binding offer to contract on behalf of Offeror.)</small>		TAXPAYER IDENTIFICATION NO. <small>(See "Taxpayer Identification Number" provision)</small>
TITLE <small>(business title of person signing above)</small>		STATE VENDOR NO. <small>(Register to Obtain S.C. Vendor No. at www.procurement.sc.gov)</small>
PRINTED NAME <small>(printed name of person signing above)</small>	DATE SIGNED	STATE OF INCORPORATION <small>(If you are a corporation, identify the state of incorporation.)</small>

OFFEROR'S TYPE OF ENTITY: (Check one) (See "Signing Your Offer" provision.)		
<input type="checkbox"/> Sole Proprietorship	<input type="checkbox"/> Partnership	<input type="checkbox"/> Other _____
<input type="checkbox"/> Corporate entity (not tax-exempt)	<input type="checkbox"/> Corporation (tax-exempt)	<input type="checkbox"/> Government entity (federal, state, or local)

COVER PAGE (NOV. 2007)

PAGE TWO

(Return Page Two with Your Offer)

HOME OFFICE ADDRESS (Address for offeror's home office / principal place of business) 	NOTICE ADDRESS (Address to which all procurement and contract related notices should be sent.) (See "Notice" clause) <div style="text-align: right; margin-top: 10px;"> _____ Area Code - Number - Extension Facsimile _____ E- mail Address </div>						
PAYMENT ADDRESS (Address to which payments will be sent.) (See "Payment" clause) <div style="margin-top: 10px;"> _____ Payment Address same as Home Office Address _____ Payment Address same as Notice Address (check only one) </div>	ORDER ADDRESS (Address to which purchase orders will be sent) (See "Purchase Orders and "Contract Documents" clauses) <div style="margin-top: 10px;"> _____ Order Address same as Home Office Address _____ Order Address same as Notice Address (check only one) </div>						
ACKNOWLEDGMENT OF AMENDMENTS Offerors acknowledges receipt of amendments by indicating amendment number and its date of issue. (See "Amendments to Solicitation" Provision)							
Amendment No.	Amendment Issue Date	Amendment No.	Amendment Issue Date	Amendment No.	Amendment Issue Date	Amendment No.	Amendment Issue Date
DISCOUNT FOR PROMPT PAYMENT (See "Discount for Prompt Payment" clause)		10 Calendar Days (%)	20 Calendar Days (%)	30 Calendar Days (%)	_____ Calendar Days (%)		

IMPORTANT INFORMATION FOR ALL OFFERORS

All Offerors desiring to respond to this solicitation should register and submit your response online. To respond online, you must follow the new South Carolina Enterprise Information System (SCEIS) vendor registration instructions found at the South Carolina Procurement Information Center website address of: <http://www.procurement.sc.gov/>. Even if you are registered in the old procurement system, you must still register or update your information in the new SCEIS system. Once the registration process is complete, the system will generate a new SCEIS vendor userid and password. The Offeror must keep this information current or you will not be able to submit future bids.

OFFERORS ENCOUNTERING REGISTRATION PROBLEMS SHOULD CONTACT:

SCEIS Help Desk (803) 734-0343

Monday – Friday 8:00 AM – 4:30 PM

Other vendor instructions found at <http://cio.state.sc.us/itmo/agency.htm> include:

- Vendor Registration Guide
- Help Desk Information
- Vendor Response to Bid Short Version Guide
- Vendor Change to Bid Response Short Version Guide
- Deleting Response to Solicitation Short Version

NUMBER OF COPIES

Offerors will need to follow these instructions carefully when responding to the solicitation online. The original solicitation response **MUST** be submitted **on-line**.

In addition to the offer you submit on-line, please submit the following by the opening date and time:

One **redacted copy** of both technical and business proposal submitted **on-line**

XX copies of your technical proposal on CD

XX copies of your business proposal on CD

XX copies of your Original complete offer in hard copy

All copies requested must be delivered no later than the date and time specified on the cover page of the solicitation to the following address:

Information Technology Management Office
Attention: Sam Hanvey, CPPB, APM
Attention: 5400001470
1201 Main Street, Suite 600
Columbia, SC 29201

END OF PAGE 3

Offeror Verification of Submitted Responses

After submitting an online response to a solicitation, Offeror may validate their submission with the following steps:

1. Go back to the initial screen
2. Select Start by clicking the Start button'
3. Bid Submitted will appear in the Bid Status Column as seen below

Process Bids

Find Bid Invitations and Auctions

Number of Document	Name	Status	Processed by Me
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

[Extended Search](#)

Tip: Choose a symbol in the navigation column or navigate to the bid overview by choosing the bid number

Search Result: 32 Hits

Number	Name	Trans. Type	Start Date	End Date	Bid Status	Action
5400000603	Testing follow-on documents	Invitation For Bid		06/26/2008 16:00:00	Follow-on Document Created	
5400000602	Printers	Invitation For Bid		06/27/2008 17:00:00	Bid submitted	

You may want to print this page for your records.

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I. Scope of Solicitation

1 ACQUIRE SERVICES & SUPPLIES / EQUIPMENT

The purpose of this solicitation is to acquire information technology and business operations services needed to support the South Carolina Department of Health and Human Services (SCDHHS) as it operates the State's Medicaid program and other health benefit programs. These services, supplies, and equipment are intended to support the enrollment and management of providers; management of certain member functions; adjudication and payment of valid healthcare claims; and supporting services.

The Replacement Medicaid Management Information System (MMIS) is a system that meets the intent of a "mechanized claims payment and information retrieval system" as described in 42 CFR 433.111; however, the State seeks a flexible and extensible system that can support existing State-funded health benefit programs under the purview of the State Medicaid Director, as well as existing health benefits programs not assigned to the State Medicaid Director, or similar future State-funded or administered health benefit programs requiring the same or substantially similar services. The scope of the use of the Replacement MMIS and supporting business operations services are not limited to any specific health benefit plan(s); however, should the scope of health benefit plans expand substantially beyond those anticipated in this solicitation, the State reserves the right to seek additional information technology or business operations services via additional sole source or competitive procurement methods.

2 MAXIMUM CONTRACT PERIOD -- ESTIMATED (JAN 2006)

Start Date: July 1, 2012. End Date: June 30, 2019. Dates provided are estimates only. Any resulting contract will begin on the date specified in the notice of award. See clause entitled "Term of Contract – Effective Date / Initial Contract Period".

II. Instructions to Offerors – A. General Instructions

1 DEFINITIONS (JAN 2006)

EXCEPT AS OTHERWISE PROVIDED HEREIN, THE FOLLOWING DEFINITIONS ARE APPLICABLE TO ALL PARTS OF THE SOLICITATION.

AMENDMENT means a document issued to supplement the original solicitation document.

BOARD means the South Carolina Budget & Control Board.

BUYER means the Procurement Officer.

CHANGE ORDER means any written alteration in specifications, delivery point, rate of delivery, period of performance, price, quantity, or other provisions of any contract accomplished by mutual agreement of the parties to the contract.

CONTRACT See clause entitled Contract Documents & Order of Precedence.

CONTRACT MODIFICATION means a written order signed by the Procurement Officer, directing the contractor to make changes which the changes clause of the contract authorizes the Procurement Officer to order without the consent of the contractor.

CONTRACTOR means the Offeror receiving an award as a result of this solicitation.

COVER PAGE means the top page of the original solicitation on which the solicitation is identified by number. Offerors are cautioned that Amendments may modify information provided on the Cover Page.

OFFER means the bid or proposal submitted in response this solicitation. The terms Bid and Proposal are used interchangeably with the term Offer.

OFFEROR means the single legal entity submitting the offer. The term Bidder is used interchangeably with the term Offeror. See bidding provisions entitled Signing Your Offer and Bid/Proposal As Offer To Contract.

ORDERING ENTITY Using Governmental Unit that has submitted a Purchase Order.

PAGE TWO means the second page of the original solicitation, which is labeled Page Two.

PROCUREMENT OFFICER means the person, or his successor, identified as such on the Cover Page.

YOU and YOUR means Offeror.

SOLICITATION means this document, including all its parts, attachments, and any Amendments.

STATE means the Using Governmental Unit(s) identified on the Cover Page.

SUBCONTRACTOR means any person having a contract to perform work or render service to Contractor as a part of the Contractor's agreement arising from this solicitation.

USING GOVERNMENTAL UNIT means the unit(s) of government identified as such on the Cover Page. If the Cover Page names a Statewide Term Contract as the Using Governmental Unit, the Solicitation seeks to establish a Term Contract [11-35-310(35)] open for use by all South Carolina Public Procurement Units [11-35-4610(5)].

WORK means all labor, materials, equipment and services provided or to be provided by the Contractor to fulfill the Contractor's obligations under the Contract.

[02-2A003-1]

2 ADDITIONAL DEFINITIONS

“24x7x365” means access and availability of a Service in a manner that is consistent with the Service’s expected performance at all times, without interruption, 24 hours a day, 7 days a week, 365 days a year, including 366 days in any leap year.

“Acquired Item” means the rights, goods and services acquired under this Contract.

“Billable Claim” means a Claim that is adjudicated to pay status. A Claim that is adjudicated to deny status or that is suspended is not a Billable Claim. The following types of claims shall not be counted as Billable Claims: (a) suspended Claims; (b) Claim correction transactions; (c) any Claim returned to a provider prior to assignment of a unique Claim Control Number (CCN)

including electronic transactions that are rejected by the translator as not being compliant with the HIPAA transaction standards; (d) adjustments to previously paid Claims, regardless of the number of adjustments filed to each Claim that are not provider-initiated claim corrections; (e) all claims that require reprocessing or system-generated adjustments due to errors caused by the Contractor; (f) Medicare Part A Crossover Claims showing no deductible and/or no co-insurance due the provider; (g) adjustments to claims due to the State-requested re-processing, such as retro-rate adjustments and mass updates; (h) any record which does not contain a CCN or Recipient ID (RID); (i) any Encounters; and (j) any system-generated claims produced to create financial transactions, e.g., pharmacy claims, management fees, capitation payments, buy-in premiums, Health Insurance Premium Payments (HIPPP).

“Billable Provider Abbreviated Enrollment” means a successfully completed capture and verification of provider demographic, licensure, disclosure information, and an executed provider participation agreement. A Billable Provider Abbreviated Enrollment is typically performed on a provider that has been through the enrollment and screening processes for another entity, such as Medicare or another State. An enrollment attempt that does not result in a successful enrollment is not a Billable Provider Abbreviated Enrollment.

“Billable Provider Enrollment” means a completed capture and verification of provider demographic, licensure, disclosure information, and an executed provider participation agreement, as well as performing the functions of a Billable Provider Revalidation.

“Billable Provider Revalidation” means a completed evaluation that a provider meets Federal and State conditions for participation.

“Billable Provider Screening” means a completed evaluation in accordance with 42 CFR 455 that verifies that a provider meets the legal requirements in order to be reimbursed for services provided under the Medicaid or Children’s Health Insurance Program, without limitations. The specific requirements for each Billable Provider Screening vary based on whether the provider’s risk category is “limited,” “moderate,” or “high.” A properly completed provider re-screening is also a Billable Provider Screening.

"Billable Prior Authorization" (or "Billable PA") is a single prior authorization submitted for a single service, group of services or an episode of care, whether submitted as a paper form or electronically, that is processed to an approved status. The following types of prior authorizations shall not be counted as Billable PAs: (a) suspended prior authorizations, (b) denied prior authorizations, (c) modifications or changes to an existing and previously Billable PA that results in an additional review or analysis for medical necessity, and (d) updates to an existing and previously Billable PA that changes the episode.

“Change(s)” means a change(s) to the Services and/or the Deliverables or to the time of performance (i.e., hours of the day, days of the week, etc.), or place of performance of the Services.

“Change in Control” means the transfer of the control of Contractor from the person(s), entity or entities who hold such control on the Effective Date of the Contract to one or more other persons or entities. “Control” means direct ownership of more than fifty percent (50%) of the stock or shares entitled to vote for the election of the board of directors or other governing body of Vendor, or of the equity interest of Contractor.

“Change Management Plan” means the agreed plan under which any Changes to the Deliverables or Services will be managed during the term of the Contract.

“Claim” means a bill for services that is appropriate for the provider type and type of service(s), whether submitted as a paper claim or electronically, and identified by a unique Claim Control Number (CCN). A single claim is defined as a billing comprised of a single beneficiary with the same date of service (or range of dates for service), submitted by a single billing provider which may include one or more service(s) or document(s).

“Commercially Available Off-The-Shelf (COTS) Software” means Software that is (i) sold, leased or licensed, supported and maintained in substantial quantities in the commercial marketplace to the general public at fixed commercial charges under commercial license terms, including periodic maintenance; (ii) supported and evolved by the owner/vendor, who retains all intellectual property rights in and to such Software; (iii) available in multiple, identical copies; and (iv) used without source code modification; and (v) Source Code for which is not generally made available to licensees. COTS Software may be tailored or configured by or for the Licensee, but in no event shall COTS Software include any customization to Proprietary Contractor Software, Proprietary Third Party Software, or Publically Available Software.

“Clean Claim” is as defined in 42 CFR 447.45.

“Clean Prior Authorization Request” means a prior authorization request that when received, materially conforms to the requirements of submission and has no defect, impropriety, lack of any required substantiating documentation or needed information that would cause a substantive delay in the processing of the request to make a final determination.

“Clean Provider Application” means a provider application that when received, materially conforms to the requirements of submission and has no defect, impropriety, lack of any required substantiating documentation or needed information that would cause a substantive delay in the processing of the request to make a final determination.

“Configurable/Configuration” means modification to Software which does not require changes to the Source Code for such Software, such as rules-based, rules engine based, or parameter driven modification to configure the Software.

“Custom Software” means made-for-hire, custom written and customer specific software or customizations to Proprietary Contractor Software, Proprietary Third Party Software or COTS Software, developed for the State pursuant to this Contract by the Contractor, its subcontractors or any third party on behalf of Contractor and all documentation used to describe, maintain and use the software, and shall include object code, source code, documentation, and all error correction or Regulatory changes added to same).

“Customization” means any modification, alteration, or extension to Software requiring changes to the existing Source Code for such Software to achieve new or modified functionality.

“Defect” means any aspect of a Deliverable’s performance that does not meet its requirements.

“Deliverables” means those items identified in the Contract to be delivered by the Contractor to the State including, without limitation, the Acquired Items, hardware, Services, Software, tangibles, and intangibles required hereunder.

“Effective Date” means the first day of the Maximum Contract Period as specified on the final statement of award issued by the State.

“Encounter” means a claim submitted by a Managed Care Organization (MCO) for reporting purposes only. Encounters are not Billable Claims.

“Enrolled Provider” means a provider whose enrollment status is active and has billed a claim within the past twelve calendar months.

“Intellectual Property Right(s)” means (i) any patent, patent application, trademark (whether registered or unregistered), trademark application, trade name, service mark (whether registered or unregistered), service mark application, copyright (whether registered or unregistered, or derivative work), copyright application, trade secret, know-how, process, technology, development tool, ideas, concepts, design right, moral right, data base right, methodology, algorithm or invention, (ii) any right to use or exploit any of the foregoing, and (iii) any other proprietary right or intangible asset.

“Key Personnel” means the Account Manager, the Design, Development and Installation (DDI) Manager, Operations Manager, and Medical Director required to be identified by name in Contractor’s Offer, any approved successor to such named individuals and any other individual and his/her approved successor designated in Contractor’s Offer as Key Personnel.

“Laws” means statutes, codes, rules, regulations, reporting or licensing requirements, ordinances, common law and other pronouncement having the effect of law of the United States or any state, county, city, or other political subdivision including those promulgated, interpreted or enforced by any government or regulatory authority, presently or hereinafter in effect.

“Parties” means both the Contractor and the State.

“Payment Cycle” means the frequency with which payments are made from the Replacement MMIS to providers.

“Physical Security” means physical security at any site or other location housing systems maintained by Contractor or its agents or subcontractors in connection with the Services.

“Processing” means any operation or set of operations performed upon the State Data or State confidential information, whether or not by automatic means, such as creating, collecting, procuring, obtaining, accessing, recording, organizing, storing, adapting, altering, retrieving, consulting, using, disclosing or destroying.

“Proprietary Contractor Materials” means any Contractor owned data, information, material, proposals, manuals, designs, report text and formats, training documents, other documentation (including working papers), Proprietary Contractor Software, software, software modifications, and customizations thereto (i) that existed prior to the Effective Date, or that are developed by Contractor after the Effective Date without the use of State Material and that are not based upon all or any portion of the State Material (such as a translation, enhancement, extension, modification, correction, upgrade, improvement, adaptation, abridgement, recasting, transformation or elaboration), and (ii) that are incorporated into the Deliverables or otherwise utilized by the Contractor in its performance of the Services under the Contract. Proprietary Contractor Materials shall include any modifications to the materials listed above created by the Contractor or its subcontractors during the Contract Term.

“Proprietary Contractor Software” means non-custom written, non-made for hire computer software owned by the Contractor pursuant to this Contract, whether commercialized by the Contractor for sale or license to other customers or not, and whether designated by Contractor as

its commercial-off-the shelf-software or not, and documentation used to describe, maintain and use the software, and shall include without limitation Source Code for such Proprietary Software.

“Proprietary Third Party Software” means non-custom written, non-made for hire computer software owned by a Subcontractor of the Contractor or other third party and documentation used to describe, maintain and use the software, and shall include without limitation Source Code for such Proprietary Software. Proprietary Third Party Software may be either licensed directly to the State by such Subcontractor or other third party or licensed via sublicense from the Contractor to the State. Proprietary Third Party Software shall not included COTS.

“Public Material” means any materials, including Software, ownership of which, and the Intellectual Property Rights in and to which are in the public domain.

“Regulatory Requirements” means all Laws concerning fair employment and employment of the disabled and concerning the treatment of all employees without regard to discrimination by reason of race, color, religion, sex, national origin, or physical disability, including, without limitation the following US Federal Laws and regulations issued pursuant to or implementing such Federal Laws: Title 42, United States Code, Chapter 7, as amended; the Hatch Act; the ADA; Title IX of the Education Amendments of 1972 (regarding education programs and activities); the Age Discrimination Act of 1975; the Clean Air Act and Federal Water Pollution Control Act; and Section 504 of the Rehabilitation Act of 1973, and Title VI of the Civil Rights Act of 1964 (PL 88-352), without limitation Title 41, Part 60 of the Code of Federal Regulations, including but not limited to Sections 60-1.4, 60-4.2, 60-4.3, 60-250.5(a), and 60-741.5(a), and all requirements imposed by or pursuant to the regulations of the U.S. Department of Health and Human Services (45 CFR Parts 80 and 84) (2000) issued pursuant to those Titles; and regulations related to the Centers for Medicare and Medicaid Services, Department of Health and Human Services, Title 42, Chapter IV, Parts 400-499 of the Code of Federal Regulations. Regulatory Requirements also include any guidance, bulletins, white papers, pronouncements, reports or similar communications issued by any Governmental Authority or applicable self-regulatory or industry body, whether or not such items or materials have the force of Law, to the extent determined by the State in its discretion.

“Security Breach” means (i) any circumstance pursuant to which applicable Laws requires notification of such breach to be given to affected parties or other activity in response to such circumstance; or (ii) any actual, attempted, suspected, threatened, or reasonably foreseeable circumstance that compromises, or could reasonably be expected to compromise, either Physical Security or Systems Security in a fashion that either does or could reasonably be expected to permit unauthorized Processing, use, disclosure or acquisition of or access to any the State Data or State Confidential Information.

“Security Breach Notification Related Costs” shall mean the State’s internal and external costs associated with addressing and responding to the Security Breach, including but not limited to: (i) preparation and mailing or other transmission of legally required notifications; (ii) preparation and mailing or other transmission of such other communications to customers, agents or others as the State deems reasonably appropriate; (iii) establishment of a call center or other communications procedures in response to such Security Breach (e.g., customer service FAQs, talking points and training); (iv) public relations and other similar crisis management services; (v) legal and accounting fees and expenses associated with the State’s investigation of and

response to such event; and (vi) costs for credit reporting services that are associated with legally required notifications or are advisable, in the State's opinion, under the circumstances.

"Services" means the services to be delivered by Contractor pursuant to the Contract Documents, including, without limitation, the Inherent Services described in Section VII B.18.

"Software" means (i) a computer program that comprises a series of instructions, rules, routines, or statements, regardless of the media in which recorded, that allow or cause a computer to perform a specific operation or series of operations; and/or (ii) recorded information comprising source code listings, design details, algorithms, processes, flow charts, formulas, and related material that would enable the computer program to be produced, created, or compiled. Software includes all software documentation such as owner's manuals, user's manuals, installation instructions, operating instructions, and other similar items, regardless of storage medium, that explain the capabilities of the computer software or provide instructions for using the software.

"Source Code" means all of the relevant files including documentation and instructions necessary to fully execute, maintain, duplicate, modify, compile, configure, deploy and operate the software in development and production environments.

"Specification(s)" means a detailed, exact statement of particulars such as a statement prescribing materials, dimensions, and quality of work.

"State Confidential Information" means all materials and information provided to the Contractor in performance of the contract, whether verbal or written or received via electronic transmission over a network, in whatever form recorded whether recorded in magnetic media, cards, moved electronically via a network or otherwise, all working papers, and other documents related to the Contract, including without limitation information relating to program beneficiaries and providers obtained in provision of the services. State Confidential Information shall include but not be limited to the State Data.

"State Data" means the following, whether provided or produced before, on or after the Effective Date: (i) all information and data (copyrighted or otherwise) developed, derived, documented, stored, by the State under the Contract; (ii) all data that is provided by or on behalf of the State to Contractor in order for Contractor to provide the Services, including keyed input and electronic capture of information by the Services; (iii) all records, files, reports and other data provided to Contractor by or on behalf of the State, or otherwise collected or obtained by Contractor, in connection with the Services; (iv) all results, technical information and materials developed and/or obtained in the performance of the services hereunder including but not limited to, all reports, surveys, plans, charts, test data, program documentation, recordings (sound and/or video), pictures, drawings, analyses, graphic representations, printouts, notes and memoranda, and documents whether finished or unfinished, which result from or are prepared in connection with the services performed hereunder, Source Code for all Software included in State Materials and (vi) all data, including all working papers, reports, charts, programs, and other material that is produced by means of the Services as an intermediate step in using or producing any of the State Data, including databases and files containing the State Data.

"State Material" means all State Data, and all proposals, manuals, designs, reports, training documents, other documentation (including working papers), all Custom Software, and any software modifications created by the Contractor or any of its Subcontractors pursuant to the

Contract, including all Intellectual Property Rights therein, but excluding Proprietary Contractor Material, Public Material and Third Party Material

“System Certification” means the procedure by which CMS validates that State Medicaid systems are designed to support the efficient and effective management of the program and satisfy the requirements set forth in Part 11 of the State Medicaid Manual (SMM) , as well as subsequent laws, regulations, directives, and State Medicaid Director (SMD) letters. The certification process also validates that the systems are operating as described in the prior approval documents, i.e., Advance Planning Documents (APDs), Requests for Proposal (RFPs), and all associated contracts submitted to CMS for the purpose of receiving Federal financial participation (FFP), all as is defined in the Medicaid Enterprise Certification Toolkit, September, 27, 2007, as may be amended.

“Systems Security” means security of computer, electronic or telecommunications systems of any variety (including data bases, hardware, software, storage, switching and interconnection devices and mechanisms), and networks of which such systems are a part or communicate with, used directly or indirectly by Contractor or its agents or subcontractors in connection with the Services.

“Third Party Material” means software code, data compilations or audio/visual/print materials the Intellectual Property Rights in and to which are owned by a third party, including Proprietary Third Party Software but excluding Public Material and COTS Software. Third Party Material includes without limitation proprietary materials of the Contractor’s Subcontractors that existed prior to the Effective Date, if any.

"Training Day" means a single instructor, fully qualified to teach the subject matter, providing training to one or more individuals for a single eight-hour day, regardless of the number of separate or distinct classes delivered on that specific calendar day. The training may be either in-person in which case the Training Day will be deemed a "Face-to-Face Training Day" or provided remotely via appropriate telecommunications technology, in which case the Training Day will be deemed a "Virtual Training Day".

“Unduplicated Provider” means an Enrolled Provider counted by:

- a. A unique Social Security Account Number (SSAN) for an individual provider;
- b. A unique combination of an Employer Identification Number (EIN) and a National Provider Identifier (NPI) for an organization that has, or is required to have, an NPI;
- c. A unique combination of an EIN and a system-assigned provider identification for an organization that is not required to have an NPI (also known as an “atypical provider”).

3 AMENDMENTS TO SOLICITATION (JAN 2004)

(a) The Solicitation may be amended at any time prior to opening. All actual and prospective Offerors should monitor the following web site for the issuance of Amendments: www.procurement.sc.gov (b) Offerors shall acknowledge receipt of any amendment to this solicitation (1) by signing and returning the amendment, (2) by identifying the amendment number and date in the space provided for this purpose on Page Two, (3) by letter, or (4) by submitting a bid that indicates in some way that the bidder received the amendment. (c) If this solicitation is amended, then all terms and conditions which are not modified remain unchanged. [02-2A005-1]

4 AWARD NOTIFICATION (NOV 2007)

Notice regarding any award or cancellation of award will be posted at the location specified on the Cover Page. If the contract resulting from this Solicitation has a total or potential value of fifty thousand dollars or more, such notice will be sent to all Offerors responding to the Solicitation. Should the contract resulting from this Solicitation have a total or potential value of one hundred thousand dollars or more, such notice will be sent to all Offerors responding to the Solicitation and any award will not be effective until the eleventh day after such notice is given. [02-2A010-1]

5 BID/PROPOSAL AS OFFER TO CONTRACT (JAN 2004)

By submitting Your Bid or Proposal, You are offering to enter into a contract with the Using Governmental Unit(s). Without further action by either party, a binding contract shall result upon final award. Any award issued will be issued to, and the contract will be formed with, the entity identified as the Offeror on the Cover Page. An Offer may be submitted by only one legal entity; "joint bids" are not allowed. [02-2A015-1]

6 BID ACCEPTANCE PERIOD (JAN 2004)

In order to withdraw Your Offer after the minimum period specified on the Cover Page, You must notify the Procurement Officer in writing. [02-2A020-1]

7 BID IN ENGLISH and DOLLARS (JAN 2004)

Offers submitted in response to this solicitation shall be in the English language and in US dollars, unless otherwise permitted by the Solicitation. [02-2A025-1]

8 BOARD AS PROCUREMENT AGENT (JAN 2004)

(a) Authorized Agent. **All authority regarding the conduct of this procurement is vested solely with the responsible Procurement Officer.** Unless specifically delegated in writing, the Procurement Officer is the only government official authorized to bind the government with regard to this procurement. (b) Purchasing Liability. The Procurement Officer is an employee of the Board acting on behalf of the Using Governmental Unit(s) pursuant to the Consolidated Procurement Code. Any contracts awarded as a result of this procurement are between the Contractor and the Using Governmental Units(s). The Board is not a party to such contracts, unless and to the extent that the board is a using governmental unit, and bears no liability for any party's losses arising out of or relating in any way to the contract. [02-2A030-1]

9 CERTIFICATE OF INDEPENDENT PRICE DETERMINATION (MAY 2008)

GIVING FALSE, MISLEADING, OR INCOMPLETE INFORMATION ON THIS CERTIFICATION MAY RENDER YOU SUBJECT TO PROSECUTION UNDER SECTION 16-9-10 OF THE SOUTH CAROLINA CODE OF LAWS AND OTHER APPLICABLE LAWS.

(a) By submitting an offer, the offeror certifies that-

(1) The prices in this offer have been arrived at independently, without, for the purpose of restricting competition, any consultation, communication, or agreement with any other offeror or competitor relating to-

(i) Those prices;

(ii) The intention to submit an offer; or

(iii) The methods or factors used to calculate the prices offered.

(2) The prices in this offer have not been and will not be knowingly disclosed by the offeror, directly or indirectly, to any other offeror or competitor before bid opening (in the case of a sealed bid solicitation) or contract award (in the case of a negotiated solicitation) unless otherwise required by law; and

(3) No attempt has been made or will be made by the offeror to induce any other concern to submit or not to submit an offer for the purpose of restricting competition.

(b) Each signature on the offer is considered to be a certification by the signatory that the signatory-

(1) Is the person in the offeror's organization responsible for determining the prices being offered in this bid or proposal, and that the signatory has not participated and will not participate in any action contrary to paragraphs (a)(1) through (a)(3) of this certification; or

(2)(i) Has been authorized, in writing, to act as agent for the offeror's principals in certifying that those principals have not participated, and will not participate in any action contrary to paragraphs (a)(1) through (a)(3) of this certification [As used in this subdivision (b)(2)(i), the term "principals" means the person(s) in the offeror's organization responsible for determining the prices offered in this bid or proposal];

(ii) As an authorized agent, does certify that the principals referenced in subdivision (b)(2)(i) of this certification have not participated, and will not participate, in any action contrary to paragraphs (a)(1) through (a)(3) of this certification; and

(iii) As an agent, has not personally participated, and will not participate, in any action contrary to paragraphs (a)(1) through (a)(3) of this certification.

(c) If the offeror deletes or modifies paragraph (a)(2) of this certification, the offeror must furnish with its offer a signed statement setting forth in detail the circumstances of the disclosure. [02-2A032-1]

10 CERTIFICATION REGARDING DEBARMENT AND OTHER RESPONSIBILITY MATTERS

(a) (1) By submitting an Offer, Offeror certifies, to the best of its knowledge and belief, that-

(i) Offeror and/or any of its Principals-

(A) Are not presently debarred, suspended, proposed for debarment, or declared ineligible for the award of contracts by any state or federal agency;

(B) Have not, within a three-year period preceding this offer, been convicted of or had a civil judgment rendered against them for: commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, state, or local) contract or

subcontract; violation of Federal or state antitrust statutes relating to the submission of offers; or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, tax evasion, or receiving stolen property; and

(C) Are not presently indicted for, or otherwise criminally or civilly charged by a governmental entity with, commission of any of the offenses enumerated in paragraph (a)(1)(i)(B) of this provision.

(ii) Offeror has not, within a three-year period preceding this offer, had one or more contracts terminated for default by any public (Federal, state, or local) entity.

(2) "Principals," for the purposes of this certification, means officers; directors; owners; partners; and, persons having primary management or supervisory responsibilities within a business entity (e.g., general manager; plant manager; head of a subsidiary, division, or business segment, and similar positions).

(b) Offeror shall provide immediate written notice to the Procurement Officer if, at any time prior to contract award, Offeror learns that its certification was erroneous when submitted or has become erroneous by reason of changed circumstances.

(c) If Offeror is unable to certify the representations stated in paragraphs (a)(1), Offer must submit a written explanation regarding its inability to make the certification. The certification will be considered in connection with a review of the Offeror's responsibility. Failure of the Offeror to furnish additional information as requested by the Procurement Officer may render the Offeror nonresponsible.

(d) Nothing contained in the foregoing shall be construed to require establishment of a system of records in order to render, in good faith, the certification required by paragraph (a) of this provision. The knowledge and information of an Offeror is not required to exceed that which is normally possessed by a prudent person in the ordinary course of business dealings.

(e) The certification in paragraph (a) of this provision is a material representation of fact upon which reliance was placed when making award. If it is later determined that the Offeror knowingly or in bad faith rendered an erroneous certification, in addition to other remedies available to the State, the Procurement Officer may terminate the contract resulting from this solicitation for default. (SEE ALSO ATTACHED CERTIFICATION REGARDING DEBARMENT, SUSPENSION, INELIGIBILITY AND VOLUNTARY EXCLUSION – LOWER TIER COVERED TRANSACTIONS")

11 CODE OF LAWS AVAILABLE (JAN 2006)

The South Carolina Code of Laws, including the Consolidated Procurement Code, is available at: <http://www.scstatehouse.gov/code/statmast.htm> . The South Carolina Regulations are available at: <http://www.scstatehouse.gov/coderegs/statmast.htm> . [02-2A040-1]

12 COMPLETION OF FORMS/CORRECTION OF ERRORS (JAN 2006)

All prices and notations should be printed in ink or typewritten. Errors should be crossed out, corrections entered and initialed by the person signing the bid. Do not modify the solicitation document itself (including bid schedule). (Applicable only to offers submitted on paper.) [02-2A045-1]

13 DEADLINE FOR SUBMISSION OF OFFER (JAN 2004)

Any offer received after the Procurement Officer of the governmental body or his designee has declared that the time set for opening has arrived, shall be rejected unless the offer has been delivered to the designated purchasing office or the governmental bodies mail room which services that purchasing office prior to the bid opening. [02-2A050-1]

14 DRUG FREE WORK PLACE CERTIFICATION

SEE ATTACHED DRUG-FREE WORKPLACE ACT CERTIFICATION STATEMENT.

15 DUTY TO INQUIRE (JAN 2006)

Offeror, by submitting an Offer, represents that it has read and understands the Solicitation and that its Offer is made in compliance with the Solicitation. Offerors are expected to examine the Solicitation thoroughly and should request an explanation of any ambiguities, discrepancies, errors, omissions, or conflicting statements in the Solicitation. Failure to do so will be at the Offeror's risk. Offeror assumes responsibility for any patent ambiguity in the Solicitation that Offeror does not bring to the State's attention. [02-2A070-1]

16 ETHICS CERTIFICATE (MAY 2008)

By submitting an offer, the offeror certifies that the offeror has and will comply with, and has not, and will not, induce a person to violate Title 8, Chapter 13 of the South Carolina Code of Laws, as amended (ethics act). The following statutes require special attention: Section 8-13-700, regarding use of official position for financial gain; Section 8-13-705, regarding gifts to influence action of public official; Section 8-13-720, regarding offering money for advice or assistance of public official; Sections 8-13-755 and 8-13-760, regarding restrictions on employment by former public official; Section 8-13-775, prohibiting public official with economic interests from acting on contracts; Section 8-13-790, regarding recovery of kickbacks; Section 8-13-1150, regarding statements to be filed by consultants; and Section 8-13-1342, regarding restrictions on contributions by contractor to candidate who participated in awarding of contract. The state may rescind any contract and recover all amounts expended as a result of any action taken in violation of this provision. If contractor participates, directly or indirectly, in the evaluation or award of public contracts, including without limitation, change orders or task orders regarding a public contract, contractor shall, if required by law to file such a statement, provide the statement required by Section 8-13-1150 to the procurement officer at the same time the law requires the statement to be filed. [02-2A075-2]

17 OMIT TAXES FROM PRICE (JAN 2004)

Do not include any sales or use taxes in Your price that the State may be required to pay. [02-2A080-1]

18 PROTESTS (JUNE 2006)

Any prospective bidder, offeror, contractor, or subcontractor who is aggrieved in connection with the solicitation of a contract shall protest within fifteen days of the date of issuance of the applicable solicitation document at issue. Any actual bidder, offeror, contractor, or subcontractor who is aggrieved in connection with the intended award or award of a contract shall protest within ten days of the date notification of award is posted in accordance with this code. A protest

shall be in writing, shall set forth the grounds of the protest and the relief requested with enough particularity to give notice of the issues to be decided, and must be received by the appropriate Chief Procurement Officer within the time provided. See clause entitled "Protest-CPO". [Section 11-35-4210] [02-2A085-1]

19 PUBLIC OPENING (JAN 2004)

Offers will be publicly opened at the date/time and at the location identified on the Cover Page, or last Amendment, whichever is applicable. [02-2A090-1]

20 QUESTIONS FROM OFFERORS

(a) Any prospective Offeror desiring an explanation or interpretation of the solicitation, drawings, specifications, etc., must request it in writing. Questions must be received by the Procurement Officer no later than **XXX YY, 2011 at 2:00 PM**. Label any communication regarding your questions with the name of the procurement officer, and the solicitation's title and number. Oral explanations or instructions will not be binding. Answers to written questions from prospective Offerors will be published as a notification on the procurement Web site at www.procurement.sc.gov. The questions and answers do not amend the solicitation and shall not become part of any resulting Contract. Should the State choose to amend the solicitation based on input from any prospective Offeror, it shall do so via an Amendment. (b) The State seeks to permit maximum practicable competition. Offerors are urged to advise the Procurement Officer - as soon as possible -- regarding any aspect of this procurement, including any aspect of the Solicitation, that unnecessarily or inappropriately limits full and open competition.

(c) The State plans to conduct two rounds of questions and answers. The first round will address questions received by **XXX YY, 2011 at 2:00 PM**. The second round will address questions received after that time and any questions remaining from the first round. Offerors are encouraged to submit questions as early in the process as practical in order to permit the possibility of asking follow up questions in the second round.

SEND QUESTIONS TO: INFORMATION TECHNOLOGY MANAGEMENT OFFICE (ITMO)

1201 Main Street,
Columbia, SC 29201
Attn: Sam Hanvey
e-mail: Shanvey@itmo.sc.gov

The preferred method of receiving questions is via e-mail with a Microsoft Word attachment using the following format:

Question Number	RFP Section Reference	RFP Page Number	Question

21 REJECTION/CANCELLATION (JAN 2004)

The State may cancel this solicitation in whole or in part. The State may reject any or all proposals in whole or in part. [SC Code Section 11-35-1710 & R.19-445.2065] [02-2A100-1]

22 RESPONSIVENESS/IMPROPER OFFERS

(a) Bid as Specified. Offers for supplies or services other than those specified will not be considered unless authorized by the Solicitation.

(b) Responsiveness. Any Offer which fails to conform to the material requirements of the Solicitation may be rejected as nonresponsive. Offers which impose conditions that modify material requirements of the Solicitation may be rejected. If a fixed price is required, an Offer will be rejected if the total possible cost to the State cannot be determined. Offerors will not be given an opportunity to correct any material nonconformity. Any deficiency resulting from a minor informality may be cured or waived at the sole discretion of the Procurement Officer. [R.19-445.2070 and Section 11-35-1520(13)]

(c) Price Reasonableness: Any offer may be rejected if the Procurement Officer determines in writing that it is unreasonable as to price.

(d) Unbalanced Bidding. The State may reject an Offer as nonresponsive if the prices bid are materially unbalanced between line items or subline items. A bid is materially unbalanced when it is based on prices significantly less than cost for some work and prices which are significantly overstated in relation to cost for other work, and if there is a reasonable doubt that the bid will result in the lowest overall cost to the State even though it may be the low evaluated bid, or if it is so unbalanced as to be tantamount to allowing an advance payment.

23 RESTRICTIONS APPLICABLE TO OFFERORS (JAN 2004)

Violation of these restrictions may result in disqualification of your offer, suspension or debarment, and may constitute a violation of the state Ethics Act. (a) After issuance of the solicitation, ***you agree not to discuss this procurement activity in any way with the Using Governmental Unit or its employees, agents or officials*** All communications must be solely with the Procurement Officer. This restriction may be lifted by express written permission from the Procurement Officer. This restriction expires once a contract has been formed. (b) Unless otherwise approved in writing by the Procurement Officer, ***you agree not to give anything to any Using Governmental Unit or its employees, agents or officials prior to award.*** [02-2A110-1]

24 SIGNING YOUR OFFER (JAN 2004)

Every Offer must be signed by an individual with actual authority to bind the Offeror. (a) If the Offeror is an individual, the Offer must be signed by that individual. If the Offeror is an individual doing business as a firm, the Offer must be submitted in the firm name, signed by the individual, and state that the individual is doing business as a firm. (b) If the Offeror is a partnership, the Offer must be submitted in the partnership name, followed by the words "by its Partner," and signed by a general partner. (c) If the Offeror is a corporation, the Offer must be submitted in the corporate name, followed by the signature and title of the person authorized to sign. (d) An Offer may be submitted by a joint venturer involving any combination of individuals, partnerships, or corporations. If the Offeror is a joint venture, the Offer must be submitted in the name of the Joint Venture and signed by every participant in the joint venture in

the manner prescribed in paragraphs (a) through (c) above for each type of participant. (e) If an Offer is signed by an agent, other than as stated in subparagraphs (a) through (d) above, the Offer must state that it has been signed by an Agent. Upon request, Offeror must provide proof of the agent's authorization to bind the principal. [02-2A115-1]

25 STATE OFFICE CLOSINGS (JAN 2004)

If an emergency or unanticipated event interrupts normal government processes so that offers cannot be received at the government office designated for receipt of bids by the exact time specified in the solicitation, the time specified for receipt of offers will be deemed to be extended to the same time of day specified in the solicitation on the first work day on which normal government processes resume. In lieu of an automatic extension, an Amendment may be issued to reschedule bid opening. If state offices are closed at the time a pre-bid or pre-proposal conference is scheduled, an Amendment will be issued to reschedule the conference. Useful information may be available at: http://www.scemd.org/scgovweb/weather_alert.html [02-2A120-1]

26 SUBMITTING CONFIDENTIAL INFORMATION (AUG 2002)

(An overview is available at www.procurement.sc.gov) For every document Offeror submits in response to or with regard to this solicitation or request, Offeror must separately mark with the word "CONFIDENTIAL" every page, or portion thereof, that Offeror contends contains information that is exempt from public disclosure because it is either (a) a trade secret as defined in Section 30-4-40(a)(1), or (b) privileged and confidential, as that phrase is used in Section 11-35-410. For every document Offeror submits in response to or with regard to this solicitation or request, Offeror must separately mark with the words "TRADE SECRET" every page, or portion thereof, that Offeror contends contains a trade secret as that term is defined by Section 39-8-20 of the Trade Secrets Act. For every document Offeror submits in response to or with regard to this solicitation or request, Offeror must separately mark with the word "PROTECTED" every page, or portion thereof, that Offeror contends is protected by Section 11-35-1810. All markings must be conspicuous; use color, bold, underlining, or some other method in order to conspicuously distinguish the mark from the other text. Do not mark your entire response (bid, proposal, quote, etc.) as confidential, trade secret, or protected. If your response, or any part thereof, is improperly marked as confidential or trade secret or protected, the State may, in its sole discretion, determine it nonresponsive. If only portions of a page are subject to some protection, do not mark the entire page. By submitting a response to this solicitation or request, Offeror (1) agrees to the public disclosure of every page of every document regarding this solicitation or request that was submitted at any time prior to entering into a contract (including, but not limited to, documents contained in a response, documents submitted to clarify a response, and documents submitted during negotiations), unless the page is conspicuously marked "TRADE SECRET" or "CONFIDENTIAL" or "PROTECTED", (2) agrees that any information not marked, as required by these bidding instructions, as a "Trade Secret" is not a trade secret as defined by the Trade Secrets Act, and (3) agrees that, notwithstanding any claims or markings otherwise, any prices, commissions, discounts, or other financial figures used to determine the award, as well as the final contract amount, are subject to public disclosure. In determining whether to release documents, the State will detrimentally rely on Offeror's marking of documents, as required by these bidding instructions, as being either "Confidential" or "Trade Secret" or "PROTECTED". By submitting a response, Offeror agrees to defend, indemnify and

hold harmless the State of South Carolina, its officers and employees, from every claim, demand, loss, expense, cost, damage or injury, including attorney's fees, arising out of or resulting from the State withholding information that Offeror marked as "confidential" or "trade secret" or "PROTECTED". (All references to S.C. Code of Laws.) [02-2A125-1]

27 SUBMITTING YOUR OFFER OR MODIFICATION (JAN 2004)

(a) Offers and offer modifications shall be submitted in sealed envelopes or packages (unless submitted by electronic means) - (1) Addressed to the office specified in the Solicitation; and (2) Showing the time and date specified for opening, the solicitation number, and the name and address of the bidder. (b) If you are responding to more than one solicitation, each offer must be submitted in a different envelope or package. (c) Each Offeror must submit the number of copies indicated on the Cover Page. (d) Offerors using commercial carrier services shall ensure that the Offer is addressed and marked on the outermost envelope or wrapper as prescribed in paragraphs (a)(1) and (2) of this provision when delivered to the office specified in the Solicitation. (e) Facsimile or e-mail offers, modifications, or withdrawals, will not be considered unless authorized by the Solicitation. (f) Offers submitted by electronic commerce shall be considered only if the electronic commerce method was specifically stipulated or permitted by the solicitation. [02-2A130-1]

28 TAX CREDIT FOR SUBCONTRACTING WITH DISADVANTAGED SMALL BUSINESSES (JAN 2008)

Pursuant to Section 12-6-3350, a taxpayer having a contract with this State who subcontracts with a socially and economically disadvantaged small business is eligible for an income tax credit equal to four percent of the payments to that subcontractor for work pursuant to the contract. The subcontractor must be certified as a socially and economically disadvantaged small business as defined in Section 11-35-5010 and regulations pursuant to it. The credit is limited to a maximum of fifty thousand dollars annually. A taxpayer is eligible to claim the credit for ten consecutive taxable years beginning with the taxable year in which the first payment is made to the subcontractor that qualifies for the credit. After the above ten consecutive taxable years, the taxpayer is no longer eligible for the credit. A taxpayer claiming the credit shall maintain evidence of work performed for the contract by the subcontractor. The credit may be claimed on Form TC-2, "Minority Business Credit." A copy of the subcontractor's certificate from the Governor's Office of Small and Minority Business (OSMBA) is to be attached to the contractor's income tax return. Questions regarding the tax credit and how to file are to be referred to: SC Department of Revenue, Research and Review, Phone: (803) 898-5786, Fax: (803) 898-5888. Questions regarding subcontractor certification are to be referred to: Governor's Office of Small and Minority Business Assistance, Phone: (803) 734-0657, Fax: (803) 734-2498. [02-2A135-1]

29 TAXPAYER IDENTIFICATION NUMBER (JAN 2004)

(a) If Offeror is owned or controlled by a common parent as defined in paragraph (b) of this provision, Offeror shall submit with its Offer the name and TIN of common parent.

(b) Definitions: "Common parent," as used in this provision, means that corporate entity that owns or controls an affiliated group of corporations that files its Federal income tax returns on a consolidated basis, and of which the offeror is a member. "Taxpayer Identification Number (TIN)," as used in this provision, means the number required by the Internal Revenue Service

(IRS) to be used by the offeror in reporting income tax and other returns. The TIN may be either a Social Security Number or an Employer Identification Number.

(c) If Offeror does not have a TIN, Offeror shall indicate if either a TIN has been applied for or a TIN is not required. If a TIN is not required, indicate whether (i) Offeror is a nonresident alien, foreign corporation, or foreign partnership that does not have income effectively connected with the conduct of a trade or business in the United States and does not have an office or place of business or a fiscal paying agent in the United States; (ii) Offeror is an agency or instrumentality of a state or local government; (iii) Offeror is an agency or instrumentality of a foreign government; or (iv) Offeror is an agency or instrumentality of the Federal Government. [02-2A140-1]

30 WITHDRAWAL OR CORRECTION OF OFFER (JAN 2004)

Offers may be withdrawn by written notice received at any time before the exact time set for opening. If the Solicitation authorizes facsimile offers, offers may be withdrawn via facsimile received at any time before the exact time set for opening. A bid may be withdrawn in person by a bidder or its authorized representative if, before the exact time set for opening, the identity of the person requesting withdrawal is established and the person signs a receipt for the bid. The withdrawal and correction of Offers is governed by S.C. Code Section 11-35-1520 and Regulation 19-445.2085. [02-2A150-1]

II. Instructions to Offerors – B. Special Instructions

1 CONTENTS OF OFFER (RFP) -- ITMO (JAN 2006)

The contents of your offer must be divided into two parts, the technical proposal and the business proposal. Each part should be bound in a single volume. [02-2B035-1]

2 DISCUSSIONS and NEGOTIATIONS (NOV 2007)

Submit your best terms from a cost or price and from a technical standpoint. Your proposal may be evaluated and your offer accepted without any discussions, negotiations, or prior notice. Ordinarily, nonresponsive proposals will be rejected outright. Nevertheless, the State may elect to conduct discussions, including the possibility of limited proposal revisions, but only for those proposals reasonably susceptible of being selected for award. If improper revisions are submitted, the State may elect to consider only your unrevised initial proposal. [11-35-1530(6); R.19-445.2095(I)] The State may also elect to conduct negotiations, beginning with the highest ranked offeror, or seek best and final offers, as provided in Section 11-35-1530(8). If negotiations are conducted, the State may elect to disregard the negotiations and accept your original proposal. [02-2B060-1]

3 OPENING PROPOSALS – PRICES NOT DIVULGED (JAN 2006)

In competitive sealed proposals, prices will not be divulged at opening. [§ 11-35-1530 & R. 19-445.2095(c) (1)]

4 PROTEST - CPO - ITMO ADDRESS (JUNE 2006)

Any protest must be addressed to the Chief Procurement Officer, Information Technology Management Office, and submitted in writing (a) by email to protest-itmo@itmo.sc.gov, (b) by facsimile at 803-737-0102, or (c) by post or delivery to 1201 Main Street, Suite 430, Columbia, SC 29201.

[02-2B120-1]

5 PROCUREMENT LIBRARY

The State has prepared a set of relevant information to support the Offerors preparation of their responses to this RFP as an online Procurement Library. The State published the initial increment of the Procurement Library in November 2010. It is available to all Offerors upon execution of the Nondisclosure Agreement available in Attachment H. Nothing in the Procurement Library shall modify or in any way alter the solicitation or resulting Contract.

Offerors already having access to the Procurement Library may login and retrieve the latest update to the Procurement Library. Other interested Offerors may obtain directions and access to the Nondisclosure Agreement at the link provided above. Once this Nondisclosure Agreement has been signed and returned to SCDHHS in accordance with the directions, access to the Procurement Library, and all future updates as they may be issued, will be made available to the Offeror.

Offerors are advised to carefully review and assess the Procurement Library. The Procurement Library contains information that the State considers relevant to the drafting of Proposals, except when the State may have expressly indicated that specific, additional material is forthcoming.

If, despite the State's efforts to be thorough, the Offeror determines the Procurement Library lacks material that is substantially necessary for designing, creating, or specifying the Offeror's anticipated Contract deliverables, then as soon as possible prior to the Technical Proposal submission deadline (but in any event no later than three (3) weeks prior to the Technical Proposal deadline) the Offeror should request in writing that the State add such material to the Procurement Library, or the Offeror should include the creation, assembling, or procurement of such material among the Offeror's own tasks and costs in its Technical Proposal and Cost Proposal. If the State changes the contents of the Procurement Library after publication of the solicitation, it will post notification of such changes to www.procurement.sc.gov.

While a reasonable attempt has been made to gather the most accurate information available for this Procurement Library as of the RFP issuance date, the State makes no representation or warranty that all information and data presented are accurate or complete.

Notwithstanding the preceding paragraph, if during the course of its performance under the Contract the selected Offeror reasonably determines that it will incur substantial, previously unanticipated Contract performance costs due to the inaccuracy or incompleteness of the Procurement Library, then any compensation adjustment for Offeror shall be determined pursuant to the CHANGES Section of the Contract, Section VII B.2. No such compensation adjustment shall be allowed if it is determined that (i) the Procurement Library lacked such material at the time of the Technical Proposal submission deadline; (ii) the Offeror neither requested the State to add the material to the Procurement Library within the timeframe above nor included the creation, assembling, or procurement of this material among the Vendor's own tasks and costs in its Technical Proposal and Cost Proposal; and (iii) by its nature the material reasonably could be provided or developed by the Offeror and not solely by the State.

6 OFFEROR REFERENCE SITE VISITS

The State reserves the right to visit customer sites for references identified in the Offeror's Proposal with fourteen calendar days notice. While Offeror personnel may be present during the visit, the State shall have access to customer personnel without the Offeror present at select times during the visit. The State may request to see the customer's system supplied by the Offeror or to inspect the Offeror's business operations conducted on behalf of the customer. If necessary, the State would be willing to execute non-disclosure statements, acceptable to the State, prior to the site visit.

The State shall not compensate the Offeror or its customer for the site visits or any preparation thereof.

III. Scope of Work (Statement of Objectives)

1 Introduction

This section describes the State's objectives and outlines the general scope of work for the Replacement Medicaid Management Information System (MMIS) Project.

1.1 Description of the Statement of Objectives

A Statement of Objectives (SOO) focuses on “what” services a Contractor and the delivered technology solutions must perform rather than “how” the Contractor must perform those services. Each subsection describes the objectives and strategy that the State believes will achieve the best overall solution for the State's Medicaid program and other related health benefit plans.

This SOO makes no attempt to enumerate every possible duty, task, or Deliverable necessary to achieve success on this Contract. Offerors should not assume that lack of detail in a specific area indicates that the Contractor will have no duties in that area. Each Offeror must craft a solution that fulfills the State's objectives and requirements in a cost-effective manner, and those solutions will include many details not specifically discussed in the SOO.

Offerors have flexibility in balancing the tradeoffs inherent in solution design. Many objectives describe the end result and allow Offerors to propose the details of how their solutions meet the objectives (perhaps with State approval or within certain constraints). Requirements and objectives identified with “shall” or “must” are mandatory while those identified with “should” or other similar terms provide additional flexibility for the Offerors.

Because of the more general nature of a SOO, Offerors should identify not only what services are part of their solutions but also what services they believe are clearly out of scope. This approach, will help clarify scope boundaries for both parties.

2 Project Goals

The successful Offeror will blend the combination of excellence and innovation in business operations, system implementation, and technology into a solution that represents the top value to the State. In this light, the Replacement MMIS Project has the following top-level project goals:

2.1 Cost

- Use information technology (IT) to improve the efficiency and effectiveness of South Carolina Department of Health and Human Services (SCDHHS) operations at all organizational levels.
- Use IT to enable opportunities to reduce the growth in the cost of care provided to Medicaid beneficiaries.
- Reduce the occurrence of fraud, waste, and abuse in SCDHHS health benefit plans by increasing the application of controls prior to payment, including a general improvement in the application of edits and audits as well as positioning the system for the implementation of predictive algorithms such as are required by the Small Business Jobs and Credit Act of 2010.

- Reduce the cost of routine change by an order of magnitude or more (e.g., changes in policy, finance, business processes, business rules, user interfaces, IT, and so on).

2.2 *Quality of Care*

- Use access to information and efficiencies driven by IT to allow SCDHHS to focus more resources on measuring and improving the quality of care for beneficiaries.
- Improve outcomes by:
 - Increasing coordination of care.
 - Applying prior approvals more effectively.
 - Promoting effective use of preventative care.
 - Improving communications with stakeholders.
 - Complying with Federal and State quality requirements.

2.3 *Business Effectiveness*

- Simplify the State's Medicaid enterprise contract outsourcing structure by combining contracts, business operations, and supporting IT systems.
- Elevate the Medicaid Information Technology Architecture (MITA) maturity of the State's business processes to at least MITA Maturity Level 3 (except for those processes requiring standards that are not yet established or widely used).
- Integrate operations functions more effectively through the use of business process management, reengineering, and IT.
- Improve the South Carolina Medicaid enterprise by better aligning the SCDHHS organization, operations, and IT infrastructure with MITA.
- Increase the use of business measurement within SCDHHS consistent with MITA expectations.
- Improve consistency of applying program requirements and standards and reduce the amount of training needed for employees by automating procedures currently performed manually.
- Increase agency agility by increasing the speed with which routine changes can be made by an order of magnitude or more (e.g., changes in policy, finance, business processes, business rules, user interfaces, IT, and so on).

2.4 *Technology*

- Acquire a system that meets State requirements principally by the use of configuration rather than customization, including a rules-based approach to support business edits; clinical edits and audits; pricing rules; adjudication rules; and other business logic.
- Achieve the MITA technical goals and objectives to the greatest extent practical (standards, security, interoperability, adaptability, extensibility, etc.).
- Replace the legacy MMIS with a modern system that improves flexibility by making use of service oriented architecture (SOA) principles.
- Reduce or eliminate the need for standalone PC applications that currently fill the gaps in MMIS capabilities.
- Build the foundations of a multi-payer system to allow for flexibility and growth and to be able to support a future all-health-services approach with multiple State agencies.

- Build a system with a long lifespan in order to minimize future capital investments.
- Function “natively” with National Provider Identifier (NPI)/taxonomy, Accredited Standards Committee (ASC) X12 Version 5010, Revision 10 of the International Classification of Diseases (ICD-10), and National Council for Prescription Drug Programs (NCPDP) D.0 without the need for crosswalks to legacy standards.

2.5 Design, Development, and Installation

- Improve near- and mid-term operations while minimizing stakeholder disruption by delivering capabilities incrementally rather than in a single monolithic implementation.
- Achieve System Certification on the first attempt and at the earliest opportunity permissible by the Centers for Medicare and Medicaid Services (CMS).
- Share risk between the State and Contractor in a fashion that permits reasonable flexibility for both parties while keeping disciplined project controls in place.
- Control risk by imposing realism on the planning process rather than assuming the best possible outcome will always occur.

3 Background

SCDHHS is a cabinet agency of the South Carolina Governor’s Office. SCDHHS serves as the single state agency designated to administer the South Carolina Medicaid program in compliance with state and Federal laws and regulations and the South Carolina State Plan.

Statistics concerning the State’s Medicaid program, and other related programs can be found in the Procurement Library.

3.1 South Carolina Medicaid Program Overview

Healthy Connections (Medicaid) is South Carolina's grant-in-aid program by which the Federal and state governments share the cost of providing medical care for needy persons who have low income. Title XIX of the Social Security Act, signed into law on July 30, 1965, authorized the Medicaid program; South Carolina began participation in Medicaid in July 1968.

3.2 Current South Carolina MMIS Environment

South Carolina’s MMIS is unique in CMS Region IV in that it is a state-run system. Clemson University, a state university, through a contract with SCDHHS provides the system hardware, software, and staff to support the MMIS.

The MMIS system was developed as a project between the South Carolina Department of Social Services (SCDSS) and Clemson University in the late nineteen seventies with assistance documenting requirements through a request for proposal (RFP) with Touche Ross consultants and utilizing some concepts from Minnesota’s MMIS. It was developed on Clemson’s mainframe using COBOL and Assembler programming languages, Cullinet’s CA-IDMS database management system, and a proprietary online system. In 1981 it achieved Federal System Certification – the first Federally-certified database-oriented MMIS. In the late 1980s, the proprietary online system was replaced with CA-ADS/O.

Over time, SCDHHS has undertaken projects to enhance the functionality of the MMIS and to meet certain external and mandatory requirements. Today the MMIS, in addition to the

mainframe, also includes a real-time Medicaid Eligibility Verification System (MEVS) developed by Clemson in 2001 using the X12 270/271 transactions. In 2003, as part of the Health Insurance Portability and Accountability Act (HIPAA) remediation done under a contract with Electronic Data Systems (EDS), an Electronic Data Interchange (EDI) component for handling HIPAA X12 transactions to/from trading partners and a web application providing claims data entry/submission and eligibility inquiry were added. Claim status inquiry was added to the web application in 2005.

The MMIS also includes new interfaces to contractor-supplied systems that replaced paper-based or other manual processes.

MMIS has seven core subsystems: Recipient, Provider, Reference, Claims Processing, Payment, Management and Administrative Reporting (MARS), and Third Party Liability (TPL). The MMIS has evolved in response to state and Federal programs and the overall health care environment.

Through the MMIS, SCDHHS can enroll providers, adjudicate claims, pay providers, and report costs and utilization, and enroll recipients in special programs. Providers can verify Medicaid eligibility 24 hours a day and inquire on the status of their claims.

3.3 Agency Organization

Figure III.3-1 shows the organization of SCDHHS.

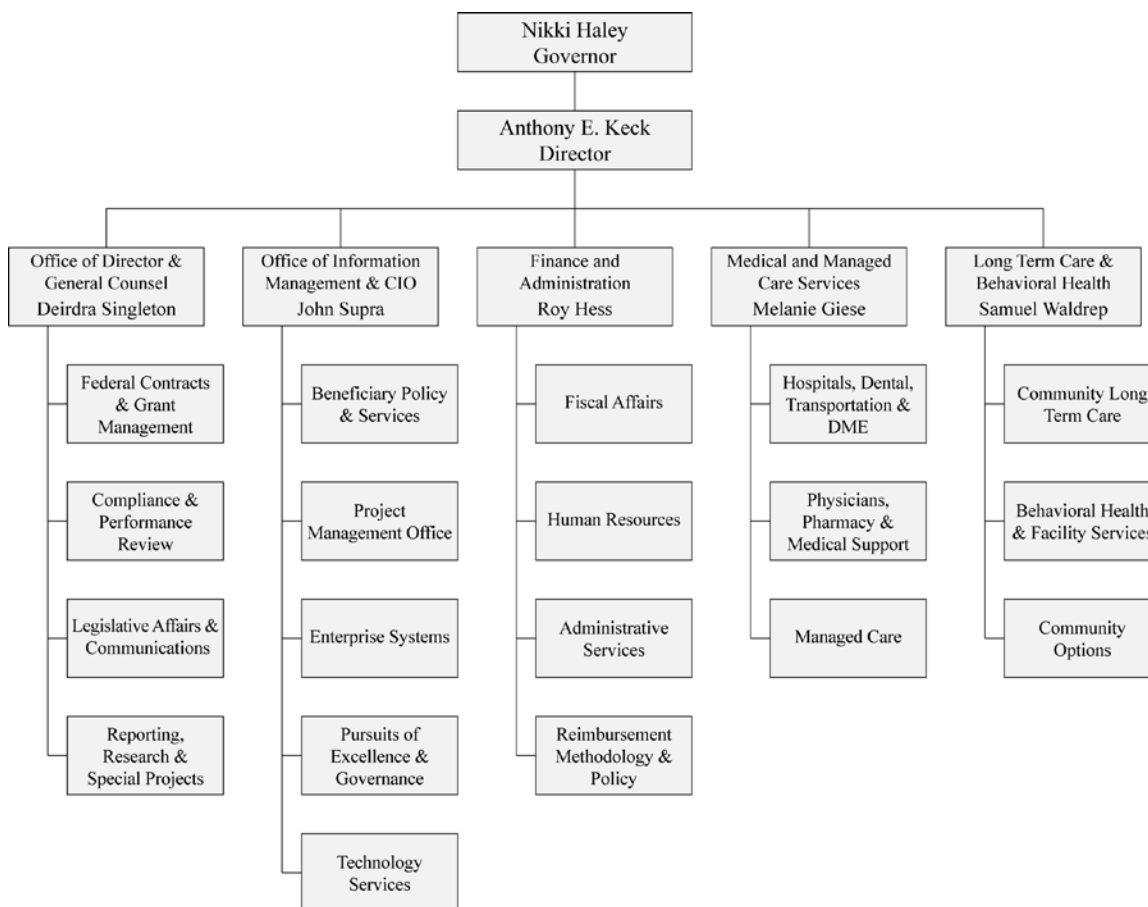


Figure III.3-1. SCDHHS Organization Chart

[Note to Potential Offerors: The SCDHHS organization is currently undergoing changes. A more current organization chart will be published in the final RFP.]

3.3.1 Director

The Director is a Cabinet-level official appointed by the Governor. The Director serves as the State Medicaid Director.

3.3.2 Office of the Director & General Counsel

The Office of the Director & General Counsel oversees the agency's legal, compliance, legislative, communications and research, reporting and data analysis efforts.

General Counsel: This office represents the agency in State and Federal courts and administrative hearings and advises the Director and staff on legal matters pertaining to the agency.

Federal Contracts and Grants Management: This department oversees the monitoring and compliance for contracts that include Federal requirements and for the agency's grants and associated grant compliance and reporting.

Compliance & Performance Review: This department ensures that Medicaid and other funds are used effectively and in compliance with Federal and State regulations. It is comprised of

three areas: Program Integrity (PI), Internal Audit, and Surveillance and Utilization Review (SUR).

Legislative Affairs & Communications: This department handles requests and responses to the State's executive branch and legislature and manages the agency's internal and external communications.

Reporting, Research, & Special Projects: This department oversees the agency's reporting and research efforts, coordinating among the various data sources, and producing the agency's formal reports. This department also takes on special projects on behalf of the Director and staff.

3.3.3 Office of Information Management & CIO

The Office of the Information Management & CIO is responsible for the agency's eligibility and beneficiary policies and services, project management (technical and non-technical) and information technology systems.

Beneficiary Policy & Services: This department is responsible for Medicaid eligibility policy development, manages eligibility intake and determination through a statewide network of local eligibility offices as well as regional and central support staff.

Project Management Office: This department manages projects for the agency. It coordinates, manages, and oversees projects as well as sets agency-wide standards, practices, and policies for project execution. The department oversees the State's projects including the Replacement MMIS (including this Contract), Replacement Member Management (eligibility system), 5010/NCCI/ICD-10 efforts, health information technology (HIT) grants, CHIPRA grant and WSS grant, as well as regular updates to the State's existing MMIS and MEDS (eligibility system) and process improvement projects.

Enterprise Systems: This department oversees the day-to-day operations of the State's major technology systems and their on-going development, operations and support. Currently, this team oversees the agency's existing MMIS and MEDS systems and the related contracts with Clemson University.

Pursuits of Excellence & Governance: This department focuses on pursuing excellence for the agency by providing leadership with regard to governance, enterprise architecture, process improvement and innovation, data quality, performance measurement, and health quality assessment and health outcome analysis. This department provides these services to the entire agency.

Technology Services: This department supports the agency with core information technology (email, file/web services, desktops), general information technology support, and oversees the agency's call center services.

3.3.4 Finance & Administration

Fiscal Affairs: This department manages agency funds and budgets for the administration and operation of the South Carolina Medicaid program.

Human Resources: This department provides a comprehensive human resources program for SCDHHS employees.

Administrative Services: This department is responsible for contracts, procurement, and appeals and hearings.

Reimbursement Methodology & Policy: This department is responsible for several reimbursement methodologies and rates including rate setting and cost settlements. The bureau manages the South Carolina Medicaid Disproportionate Share Payment Program.

3.3.5 Medical Services

Hospitals, Dental, Transportation & DME: This department is responsible for the administration of the agency's hospital, dental, transportation and durable medical equipment (DME) programs.

Physicians, Pharmacy & Medical Support Services: This department is responsible for the administration of the agency's physician services, pharmacy program, and medical support services that enhance direct care, including school-based and private rehabilitative services.

Managed Care: This department is responsible for the oversight of Managed Care Organizations.

3.3.6 Long Term Care & Behavioral Health

Community Long Term Care: This department is responsible for home and community-base long term care programs operated directly by DHHS.

Community, Facility Services and Behavioral Health: This department oversees both private and public behavioral health programs and works with other State agencies to provide appropriate services. In addition, it is responsible for nursing facility services, home health, hospice, and the Optional State Supplementation Program.

Community Options: This department is responsible for the four home-based, long term care waivers operated by the Department of Disabilities and Special Needs, the Medically Complex Children's waiver, the private duty nursing program, Intermediate Care Facilities for the Mentally Retarded (ICF-MR), and the two Programs for All-Inclusive Care of the Elderly (PACE).

4 Contract Objectives and Strategy

4.1 Contracting Objectives

- Attract high quality contractors by providing business opportunities that are fair to all participants, offer reasonable opportunities to make a profit, and that deliver to the State needed services and technologies at acceptable and competitive costs.
- Strongly discourage the practice of "buying in" to a contract resulting from a contractor that intentionally reduces its bid price of DDI below that which can be practically achieved and then attempts to make up the difference via change orders and business operations services.

4.2 Contract Scope

The general scope of this contract is encompassed by:

- The general combined IT functionality and business operations scope of the existing and planned contracts described in Section III.4.2.1 and as organized during the Operations Phase as shown in Section III.4.4 and its subsections.
- The general IT functionality and business operations scope described in Attachment I (Annotated MITA Business Process Matrix) and Attachment J (Annotated Medicaid Enterprise Certification Toolkit Checklists).
- The general IT functionality supported in the PC applications described in Section III.4.2.2
- Other scope described in Section III.4.2.3
- Scope and duties described in other sections of this Contract.

The itemized listing of current contracts must not be construed as a requirement or intent for the Contractor to structure its services in the same manner. Offerors are encouraged to propose solutions that offer a more integrated approach to the South Carolina Medicaid enterprise than exists today.

Figure III.4-1 shows the State's contract consolidation approach graphically.

The base Term of this Contract shall be for five years with two additional option years. Further information concerning the Term is contained in Sections VIIB.37 and VIIB.38.

This Contract is not a "commercially reasonable effort" contract, even for services paid via invoiced labor hours. Failure to deliver the required services and materials may subject the Contractor to all available remedies for default.

4.2.1 Existing and Planned SCDHHS Contracts Within Scope

Table III.4-1 identifies the existing and planned contracts whose general scope is included in this Contract. Neither the contracts in Table III.4-1 nor the requirements, terms, and conditions in those contracts are incorporated by reference in this Contract. Additional information concerning these contracts can be found in the Procurement Library. This list is subject to change throughout the acquisition process.

Contract	Contractor	Effective Date	Base Year End Date	Option Year End Date	Base Year(s)	Option Year(s)
MMIS	Clemson University	7/1/10	6/30/11	6/30/15	1	4
Third Party Liability (TPL)	Blue Cross Blue Shield of South Carolina	5/1/2011	4/30/2012	4/30/2016	1	4
Interactive Voice Response System (IVRS)	First Data Government Solutions	1/2/07	1/1/10	1/1/12	3	2
Quality Improvement Organization (QIO)	Alliant (via emergency contract) New RFP published – not yet awarded	8/1/10	2/1/11	As needed until reprocurement completed	N/A	N/A
Dental Administrative Services Organization (ASO)	DentaQuest	6/8/09	6/7/12	6/7/14	3	2
Medicaid Operations	Blue Cross Blue Shield of South Carolina	6/26/10	6/25/11	6/25/15	1	4
National Correct Coding Initiative (NCCI)	HMS	4/18/11	4/17/12	4/17/16	1	4
Prior Authorization Services (for advanced imaging)	MedSolutions	12/1/10	6/19/12	6/19/14	1	2

Table III.4-1. Contracts Being Consolidated into the Replacement MMIS Contract

4.2.2 PC Applications

Table III.4-2 identifies the PC applications whose general functionality is included in the scope of this Contract. In some cases, these applications will be retired by the Replacement MMIS. In other cases, the applications may continue to be used within SCDHHS for non-MMIS purposes. Offerors must note that the specific features included in these applications do not necessarily represent technical or business requirements for this Contract. Additional information concerning these PC applications can be found in the Procurement Library.

Application Name
Accounts Receivable Log
Admin Days System
Application Xtender
Approach System
Cash Receipts Log
Check Cancellation System
Durable Medical Equipment Database

Table III.4-2. PC Applications

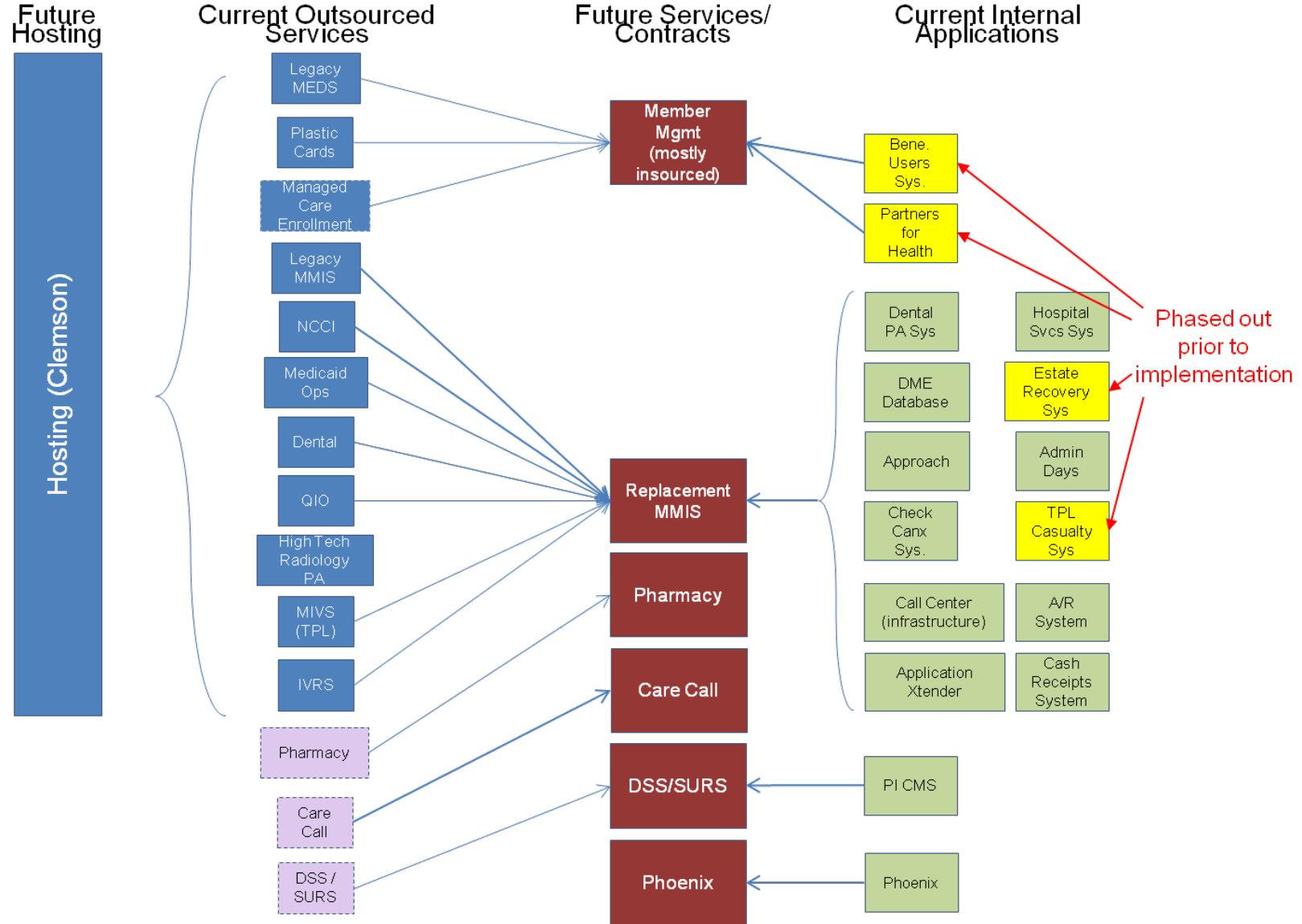


Figure III.4-1 MITA Project Consolidation

4.2.3 Other Scope

4.2.3.1 Health Benefit Plans

At this time, SCDHHS manages the State's Medicaid program, the State Children's Health Insurance Program, and various State-funded programs, such as the Optional State Supplement (OSS). Offerors shall not limit any aspect of licenses, terms, or conditions as a function of the health benefit or social services plan being managed by the State on behalf of its citizens or any other party. The State desires the ability to concurrently manage multiple benefit plans with the same or different payers in the Replacement MMIS. Should the scope of health benefit plans expand substantially beyond those anticipated in this solicitation, the State reserves the right to seek additional information technology or business operations services via additional sole source or competitive procurement methods.

Based on the distributed nature of responsibility across South Carolina government for health benefits, other State agencies are involved in the provision of and payment for these benefits via the MMIS. In particular, the various waiver programs are managed both by SCDHHS and other agencies. Some waiver programs are managed entirely in the MMIS, and others use Care Call and Phoenix (which replaces the Community Long Term Care Case Management System described in the MITA State Self-Assessment) systems to enhance the State's ability to manage them. Additional information concerning Care Call and Phoenix is contained in the Procurement Library. The Replacement MMIS must interface with both Care Call and Phoenix.

The use of the term "Medicaid" in this Contract is for convenience only and does not limit the scope of Contract duties, Services, and Deliverables to only the Medicaid program unless otherwise specifically stated.

4.2.3.2 Integration Between Contracts and Applications

The IT capabilities and business services represented by the existing contracts, PC applications, and other descriptions of scope in this Contract currently lack the level of integration desired by the State. The Contractor shall integrate these capabilities and services to the greatest extent practical.

4.2.3.3 Consolidation of Access Channels

The State currently uses multiple access channels in which stakeholders engage the Medicaid enterprise. These channels (e.g., call center, interactive voice response, mail, fax) are not provided or managed by a single entity nor are they integrated.

The Contractor must provide and manage the inbound and outbound channels for all Services provided under this Contract. Because the State views these channels largely as commodity services, the Contractor shall bear all expenses associated with the procurement and operations of these channels, with the exception of postage, which is addressed in the RFP Section III.5.8.

4.2.3.4 Relationship to Member Eligibility Systems and Services

The State is transitioning towards a greater alignment with its business process model. The current systems' functionality between the legacy MMIS and MEDS do not align with the business processes for Member Management as the functionality is split between the two legacy systems. To minimize the risks associated with concurrent DDI of the Replacement MMIS and the new Member Management system, the Replacement MMIS must initially align with the

current division of functionality between the MMIS and MEDS, even where that results in deviations from the business process model (similar to the “recipient subsystem” described in Part 11 of the State Medicaid Manual). Some current “interfaces” even require manual entry of data into the MMIS (e.g., the monthly recurring income for a member in long term care or an intermediate care facility). The Replacement MMIS must also contain a Web services framework suitable for interoperability with the future Member Management system. The State and Contractor will coordinate a strategy to migrate from the legacy approach to the revised approach.

4.2.4 Changes in Contract Scope

Section VIIB.2 describes the triggers and top-level process to exercise the Contract Change Order process. The parties shall jointly build a detailed change management plan during the Discovery Phase of the project (described in Section III.4.4.1) that addresses, among other things, the Customer Service Request and Contract Change Order processes. General change management objectives are described in Section III.7.5.3.

4.3 Services Performed Outside the United States and Its Territories

The Contractor may perform software development and other related systems engineering services outside the United States and its territories. Such activities must be identified in the Offeror’s Proposal, and the Contractor shall provide a 30-calendar-day notice to the State prior to performing any such services for the first time. See Section IV.5.1 for further guidance on proposing the use of non-US services. Business operations services shall be performed in the United States or its territories, as shall software development and systems engineering services that involve the use of protected health information (PHI) or other information whose privacy is governed by HIPAA and other State and Federal laws and regulations governing privacy. At no time shall the Contractor maintain, utilize, transmit or cause to be transmitted information governed by privacy laws and regulations outside the United States and its territories.

4.4 Contract Structure

Table III.4-3 shows the phases, service groups, and payment methodologies for this Contract. Further details covering each Service are contained in other sections of this Contract, and further details covering payment methodologies and invoicing are contained in the Invoicing and Payment Exhibit. The State, in its sole discretion, may choose not to exercise individual Services or may choose to terminate individual Services for convenience at any time.

Table III.4-3 contains a column labeled “Related MITA Business Processes.” MITA was not intended to be a contractual document, and the business processes are not a complete encapsulation of the duties required on this Contract; however, the inclusion of these processes will help Offerors delineate which services will address the various business processes. Offerors’ solutions (particularly the various Statements of Work) must address the Contract duties and work breakout with greater completeness and precision. MITA business processes are not necessarily exclusive to a single phase or Service. For example, “Develop Agency Goals and Objectives” appears in the Discovery, Replacement, and Operations Phases (as a State-led duty supported by the Contractor) because this process is ongoing.

Offerors must note that the concept of “phases” does not denote a purely sequential alignment of the assigned services. While the phases will generally occur in the order shown in Table III.4-3,

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phases are defined by the Services performed rather than their temporal position across the Contract timeline. Overlap of most of the phases is likely, particularly the Replacement Phase, the Operations Phase, and the Turnover Phase.

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Phase	Service Group	Related MITA Business Processes (not all-inclusive of scope)	Payment Type
Discovery Phase	Discovery	PG04 – Develop Agency Goals and Objectives PG15 – Develop and Manage Performance Measures and Reporting	Labor Hours (subject to price incentives and the not-to-exceed price) plus restricted, pre-approved material costs.
Replacement Phase	Design, Development and Installation	BR01 – Establish Business Relationship BR02 – Manage Business Relationship Communication BR03 – Manage Business Relationship CO01 – Manage Contractor Information CO02 – Manage Contractor Communication CO06 – Award Administrative or Health Services Contract CO07 – Manage Administrative or Health Services Contract PG03 – Manage rate setting PG04 – Develop Agency Goals and Objectives PG05 – Develop and Maintain Program Policy PG06 – Maintain State Plan PG08 – Manage FFP for MMIS PG09 – Draw and Report FFP PG15 – Develop and Manage Performance Measures and Reporting PG18 – Maintain Benefits/Reference Information PM03 – Perform Provider Outreach	Labor Hours (subject to price incentives and the not-to-exceed price) plus restricted, pre-approved material costs. Firmed fixed price for Contractor staff preparation for the Operations Phase for each deployed increment.

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Phase	Service Group	Related MITA Business Processes (not all-inclusive of scope)	Payment Type
	CMS System Certification	PG08 – Manage FFP for MMIS	Labor Hours (subject to price incentives and the not-to-exceed price) plus restricted, pre-approved material costs.
	Replacement Phase Modification Pool	CO06 – Award Administrative or Health Services Contract CO07 – Manage Administrative or Health Services Contract	Up to 20% of the Target Labor Price. Payment types negotiated when the State resorts to the Pool.
Operations Phase	General		Operations Phase work is subject to positive and negative quality incentive payments.
	Base work	BR01 – Establish Business Relationship BR02 – Manage Business Relationship Communication BR03 – Manage Business Relationship BR04 – Terminate Business Relationship CM01 – Establish Case CM02 – Manage Case CM03 – Manage Medicaid Population Health CM04 – Manage Registry CO01 – Manage Contractor Information CO02 – Manage Contractor Communication CO03 – Perform Contractor Outreach CO04 – Inquire Contractor Information CO06 – Award Administrative or Health Services Contract	Fixed price per month.

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Phase	Service Group	Related MITA Business Processes (not all-inclusive of scope)	Payment Type
		CO07 – Manage Administrative or Health Services Contract CO08 – Close Out Administrative or Health Services Contract CO09 – Support Contractor Grievance and Appeal ME01 – Manage Member Information ME02 – Manage Applicant and Member Communication ME08 – Manage Member Grievance and Appeal OM04 – Apply Attachment OM05 – Apply Mass Adjustment OM12 – Prepare Premium EFT OM15 – Prepare Capitation Premium Payment OM17 – Prepare Medicare Premium Payment OM18 – Inquire Payment Status OM22 – Manage Drug Rebate OM23 – Manage Estate Recovery OM25 – Manage Cost Settlement OM26 – Manage TPL Recovery PG01 – Designate Approved Services and Drug Formulary PG02 – Develop and Maintain Benefit Package PG03 – Manage Rate Setting PG04 – Develop Agency Goals and Objectives PG05 – Develop and Maintain Program Policy	

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Phase	Service Group	Related MITA Business Processes (not all-inclusive of scope)	Payment Type
		PG06 – Maintain State Plan PG07 – Formulate Budget PG08 – Manage FFP for MMIS PG09 – Draw and Report FFP PG10 – Manage FFP for Services PG11 – Manage FMAP PG12 – Manage State Funds PG13 – Manage 1099s PG14 – Perform Accounting Functions PG15 – Develop and Manage Performance Measures and Reporting PG16 – Monitor Performance and Business Activity PG17 – Generate Financial and Program Analysis Report PG18 – Maintain Benefits-Reference Information PG19 – Manage Program Information PI01 – Identify Candidate Case	

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Phase	Service Group	Related MITA Business Processes (not all-inclusive of scope)	Payment Type
	Claims-Related Services	ME06 – Inquire Member Eligibility OM04 – Apply Attachment OM06 – Audit Claim – Encounter OM07 – Edit Claim – Encounter OM08 – Price Claim – Value Encounter OM09 – Prepare COB OM10 – Prepare EOB OM11 – Prepare Home and Community Services Payment OM13 – Prepare Provider EFT/Check OM14 – Prepare Remittance Advice – Encounter Report OM18 – Inquire Payment Status OM19 – Manage Payment Information OM24 – Manage Recoupment PI01 – Identify Candidate Case	Variable price per claim.
	Prior Authorization Services	OM02 – Authorize Service	Fixed price per approved prior authorization.
	Provider Management Services	OM04 – Apply Attachment PM01 – Manage Provider Information PM02 – Manage Provider Communication PM03 – Perform Provider Outreach PM04 – Enroll Provider	Fixed prices per unit service for enrollment, credentialing/recredentialing, and verification/reverification. Fixed price per unduplicated enrolled provider per month.

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Phase	Service Group	Related MITA Business Processes (not all-inclusive of scope)	Payment Type
		PM05 – Inquire Provider Information PM06 – Disenroll Provider PM07 – Manage Provider Grievance and Appeal PI01 – Identify Candidate Case	
	Third Party Liability/Recovery Services	ME04 – Determine Eligibility OM04 – Apply Attachment OM16 – Prepare Health Insurance Premium Payment OM26 – Manage TPL Recovery	Fixed price unit service for primary payer identification. Fixed percentage recovery contingency fee. Fixed price per member per month for management of members that are part of the Health Insurance Premium Payment program.
	Member Premium Management Services	ME01 – Manage Member Information ME02 – Manage Applicant and Member Communication ME08 – Manage Member Grievance and Appeal OM04 – Apply Attachment OM21 – Prepare Member Premium Invoice	Fixed price per premium-paying member per month.
	Training Services	PM02 – Manage Provider Communication PM03 – Perform Provider Outreach	Fixed price per training day for live training based on training style for State users. Fixed price per training day for live training based on training style for providers.
	Operations Phase Modification Pool	CO06 – Award Administrative or Health Services Contract	Up to 50% of the Target Labor Price. Payment types negotiated when the

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Phase	Service Group	Related MITA Business Processes (not all-inclusive of scope)	Payment Type
		CO07 – Manage Administrative or Health Services Contract	State resorts to the Pool.
Turnover Phase	Turnover	CO07 – Manage Administrative or Health Services Contract CO08 – Close Out Administrative or Health Services Contract	Firm fixed price with Milestone/Deliverable based payments.

Table III.4-3. Contract Structure

Notes:

1. MITA business processes identified and their nomenclature (e.g., OM26) are from MITA Framework 2.01.
2. Identifiers:
 - BR – Business Relationship Management
 - CM – Care Management
 - CO – Contractor Management
 - ME – Member Management
 - OM – Operations Management
 - PG – Program Management
 - PI – Program Integrity
 - PM – Provider Management

4.4.1 Discovery Phase

The schedule pressure placed on many MMIS projects can result in inadequate planning, insufficient knowledge transfer, and insufficient state-contractor teamwork. The State believes that some of these challenges can be mitigated by establishing a Discovery Phase to promote planning, bi-directional knowledge transfer, and joint teamwork.

The objectives of the Discovery Phase are:

- Refine the State's enterprise strategy and enterprise IT strategy in order to drive the details of the Replacement Phase and Operations Phase, including meeting CMS' Seven Conditions for receiving enhanced Federal Financial Participation (see RFP Section III.8.1)
- Improve the Contractor's understanding of the State's Medicaid enterprise via familiarization activities.
- Improve the State's understanding of the Contractor's baseline system by providing overview training to select State personnel.
- Provide an opportunity for the Contractor to assemble its team and relocate portions of that team, as necessary.
- Conduct team building efforts to enhance the State/Contractor working relationship.
- Build key planning documents needed for the Replacement Phase.
- Agree to the administrative details of Contract invoicing.

Note that the Discovery Phase is not equivalent to a "requirements phase." The State expects little, if any, detailed requirements work to occur during this Phase.

The Discovery Phase begins upon Contract award and ends upon completion of all duties and approval of all Deliverables assigned to this phase. Offerors shall propose the duration of the Discovery Phase, not to exceed 90 calendar days.

In order to properly plan for the significant changes driven by health IT, healthcare reform, ASC X12 5010, ICD-10, and the Replacement MMIS, the State must enhance its strategic planning for the Medicaid enterprise. The Contractor shall advise the State on strategic planning and organizational change management by structuring and facilitating strategy planning sessions and documenting the results.

Project planning must be refined during the Discovery Phase. The Contractor shall deliver, to the State's satisfaction and approval, the following documents:

- The Project Management Plan
- A refined version of the Integrated Master Schedule (IMS)
- The Performance Measurement Baseline (PMB) for earned value management
- The Systems Engineering Management Plan (SEMP)

The Parties shall jointly create the following documents during the Discovery Phase:

- The Joint Change Management Plan
- The Joint Communications Plan
- The Joint Disaster Recovery/Business Continuity Plan
- The Escrow Agreement

In addition, the parties shall jointly identify Deliverable-specific acceptance criteria during the Discovery Phase for all planned Discovery and Replacement Phase Deliverables.

4.4.2 Replacement Phase

The objectives of the Replacement Phase are:

- Replace the legacy systems (associated with the eight contracts to be replaced and the PC applications) with the Replacement MMIS via a successful DDI.
- Replace legacy operations contracts and improve business operations with new services, integrated with the Replacement MMIS capability, smoothly and without disruption in services.
- Achieve System Certification on the first attempt and at the earliest permissible opportunity.
- Adapt to changes in requirements that may occur during the Replacement Phase in a timely manner to minimize scrap and rework and minimize the impact on the project schedule.

The Replacement Phase primarily encompasses the activities associated with:

- **Design, Development, and Installation (DDI)** – This includes activities such as requirements development, design, construction, testing, implementation, initial user training, staff preparation for operations, build-out of operations infrastructure, and related supporting activities.
- **System Certification** – This includes certification planning, documentation, artifact gathering, support for the CMS certification team, resolution of issues and findings from the System Certification, and repair of system and operations defects discovered as part of the System Certification process.
- **Replacement Phase Modification Pool** – The purpose of this pool is to serve as an administrative reservation of funds and negotiated labor rates needed to rapidly address any out of scope requirements changes that may arise during the Replacement Phase. See Exhibit A. Invoicing and Payment, for further information concerning the use of the Replacement Phase Modification Pool.

The Replacement Phase begins upon completion of the Discovery Phase and ends upon completion of all duties and State acceptance of all Deliverables assigned to this phase and the repair and approval of all Deliverable defects discovered through the completion of CMS System Certification. The Contractor may begin activities associated with the Replacement Phase during the Discovery Phase with written approval by the State.

Numerous Replacement Phase Deliverables are identified throughout the SOO; however, the majority of Deliverables for this phase must be proposed by Offerors in the Contract Data Requirements List (CDRL).

4.4.3 Operations Phase

The Operations Phase encompasses activities associated with performing business operations functions; operating and maintaining the Replacement MMIS; and performing upgrades to the Replacement MMIS and associated business services.

The objectives of the Operations Phase are:

- Perform duties required to efficiently and effectively manage the State's Medicaid program and other applicable health benefit plans.
- Adapt to changes in business needs that impact system functionality or business operations services in a timely manner to avoid the need for workarounds and to minimize impact to ongoing operations.

Operations Phase services are divided in the following manner:

- **Claims-Related Services.** These are functions related to the processing of individual claims or that are related to the volume of claims.
- **Prior Authorization Services.** These are functions related to the processing of prior authorizations.
- **Provider Management Services.** These are functions related to the management of currently enrolled and prospective providers to include enrollment, validation, and screening; provider outreach; disenrollment; and the maintenance of provider information. Communications with providers will occur via multiple access channels.
- **Third Party Liability/Recovery Services.** These include all functions associated with identifying other sources of payment for health benefit services and recovering payment from these sources. The Contractor shall make its best efforts to ensure that claims for members with other primary coverage are cost avoided rather than recovered via pay and chase.
- **Member Premium Management Services.** This includes functions associated with assigning, collecting, and managing premiums from members. The State does not currently collect premiums from members, and the phase-in of these Services is subject to future policy and legislative changes. The State requires significant flexibility in the calculation of premiums as Medicaid programs often scale premiums based on family situation and income and are subject to caps by Federal law. Communications with members will occur via multiple access channels.
- **Training Services.** This includes all post-deployment and provider training but does not include State user training for users participating in DDI activities (e.g. testing). See RFP Section III.10.1 for further information on training.
- **Operations Phase Modification Pool.** This is analogous to the Replacement Phase Modification Pool and applies to Customer Service Requests and Contract Change Orders for Services and system modifications during the Operations Phase. See Exhibit A. Invoicing and Payment for additional information.
- **Base Work.** This includes all in-scope Operations Phase duties not part of other services.

The Operations Phase begins with the first increment of system/business capability to achieve its Operational Start Date ("go live") and ends with the termination of the contract. The Operations Phase will overlap in time with the Replacement Phase and the Turnover Phase.

4.4.4 Turnover Phase

The Turnover Phase encompasses activities associated with turning over system and operations duties to the State or a third party upon termination of the Contract. The State requires continuity of operations during a transfer of system and operations duties to another Contractor or to the State upon termination of the Contract. As the MMIS is a 24-hour per day, mission critical

system, the turnover shall not result in additional system downtime other than normally scheduled maintenance windows.

The Turnover Phase begins upon direction of the State (typically at or earlier than the lead time described in the Contractor's Turnover Integrated Master Schedule), and ends 90 calendar days after transfer of duties is complete. The Turnover Phase normally overlaps with the Operations Phase.

The Contractor shall plan and implement a coordinated transfer of system and operations duties to another entity upon direction of the State. Turnover activities shall include knowledge transfer; conversion or migration of all work in progress; transfer of all documentation required for the proper operation or maintenance of the system and proper business operations procedures; and post-transfer technical assistance. Such technical assistance shall continue for 90 calendar days after transfer.

The Contractor shall create a Turnover Plan, that shall be part of the Contract Data Requirements List, and update it at least annually.

4.4.5 Purchase Orders

The State will use purchase orders to initiate Services. Additionally, the State will issue purchase orders annually to renew business operations Services and adjust estimated volumes of Services to be performed.

The Contractor shall not invoice more than the dollar amount on the purchase order without receiving advance written agreement from the State. When the amount invoiced reaches 80%, and again at 90%, of the purchase order amount for a Service, the Contractor shall notify the State in writing that these thresholds have been reached.

4.5 Contract Incentive Structure

Price, schedule, and performance incentives will be used for the Discovery Phase and Replacement Phase, and quality incentives will be used for the Operations Phase. Both positive and negative incentives will be available to the Contractor. For the Discovery Phase and Replacement Phase, these incentives shall be used in association with the Actual Labor Price and Fully Operational Start Date; however, this shall not limit either Party's right to actual damages pertaining to this Contract.

4.5.1 Billable Labor and Materials

The Discovery Phase and Replacement Phase services shall be invoiced on time and materials with a not-to-exceed price using billable labor hours with fixed labor rates established in the Contractor's proposal for Regular Time and Overtime. Hourly rates include:

- Labor performed by the Contractor;
- Labor performed by Subcontractors;
- Labor transferred between divisions, subsidiaries, or affiliates of the Contractor under common control;

and shall be all-inclusive of wages; overhead; travel expenses; property, plant, and equipment owned or leased by the Contractor or its Subcontractors; general and administrative expenses; and profit. The State shall not pay separately for these costs, Offerors shall not assume separate

payment in their Cost Proposals. Offerors shall propose base labor rates for all labor categories whose use can be foreseen on the Contract. Additional information on Proposal requirements with respect to labor rates can be found in Section VIII.2.2.3

If the Contractor needs to add labor categories at any time during the Term of the Contract, it shall request the change in writing and justify the purpose of the labor category as well as the derivation of the labor rate to be used. The Contractor shall not invoice the State for any labor using the new category prior to receiving written approval from the State.

Labor-based services obtained and bid by the Contractor that are routinely commercially obtained via firm fixed price contracts shall also be considered labor hours. In this case, the Contractor shall not invoice the State prior to its own obligation to pay the subcontractor, and if such invoices include partial payments in advance of completion of the subcontractor's work, the invoiced amount shall not be a greater percentage of the Contractor's total cost for the subcontracted services than represents the percentage completion of such services. As labor rates have overhead built in and as the State is paying directly for billable work under a labor hours effort, the Contractor shall not mark up the fixed price subcontracted services other than for profit. The profit for fixed price subcontracted services shall be clearly identified in the Offeror's bases of estimates submitted as part of the Cost Proposal.

If, the State elects to authorize the Contractor to procure such materials for the State, the following principles shall apply:

- Any licenses for Software or other licensed materials such as database subscription services obtained via the Contractor shall be held in the name of the South Carolina Department of Health and Human Services or its Agent as directed by the State. For licenses obtained via the Contractor, license fees shall not be paid prior to acceptance by the State of the end product or products utilizing the licensed materials.
- For licensed materials that are Proprietary Contractor Materials and include multiple modules deployed over time, the Contractor shall prorate the total license fees for such licensed material between the multiple modules and shall not invoice the State for the prorated fees for a module prior to acceptance by the State of the end products utilizing such module(s).
- Such fees shall include any on-going or annual maintenance expenses anticipated, and shall reflect a credit to the State equal to all potential incentives Contractor may be eligible for or receive from the licensor and/or a third party reseller as part of a broader incentive program disclose as a result of the license or purchase of such materials.
- At its sole discretion, the State may use existing licenses it possesses for such intellectual property or procure licenses via a third party in lieu of obtaining licenses via the Contractor.
- The Contractor shall not invoice the State for any incidental materials until ownership of the materials is transferred (even if physical possession remains with the Contractor).
- For each COTS Software product you intend to incorporate or use as part of your solution, you shall identify each such item of COTS Software, identify the software owner or publisher (if different) of such software, and explain whether you propose to (i) license the software directly to the State, (ii) sublicense the software to the State, or resell software licensed directly by a third party. Regardless of your proposal, the terms of any agreement under which such software will be provided or licensed to the State shall be

included with your offer. **ANY SOFTWARE AGREEMENT SUBMITTED WITH YOUR OFFER WILL NOT FORM A PART OF ANY CONTRACT RESULTING FROM THIS SOLICITATION.**

Offerors shall identify all planned material costs in their Proposals. The Contractor shall obtain written agreement from the State's Contract Manager prior to purchasing materials for which it intends to invoice the State. The Contractor shall be at risk for all such purchases made in advance of obtaining the State's written concurrence for such purchases.

4.5.2 Price Incentives

Offerors shall propose a Target Labor Price as the sum of the proposed base year prices for the Discovery and Replacement Phases minus the cost for materials and the fixed prices for operations standup of deployed increments. See RFP Sections VIII.2.2.1 and VIII.2.2 and Pricing Tables A and B for additional information. The Actual Labor Price shall be the sum of the actual invoices for labor submitted by the Contractor for the Discovery and Replacement Phases adjusted for actual inflation to base year, and will not include prices for materials or the fixed prices for operations standup of deployable increments. The State shall calculate price incentives based on the difference between the Actual Labor Price and the Target Labor Price, adjusted for Customer Service Requests and Contract Change Orders, as applicable. All calculations concerning Target Labor Price and Actual Labor Price must be adjusted to base year prices using the inflation factors determined for each applicable year during the Term of the Contract.

For the purposes of price incentives, the State shall use retentions and withholds. When the State retains all or a portion of a payment for which it has received an invoice in good order, the retained amount shall be permanent. When the State withholds all or a portion of a payment for which it has received an invoice in good order, the amount withheld may be redeemed at a future date by the Contractor when certain conditions have been met.

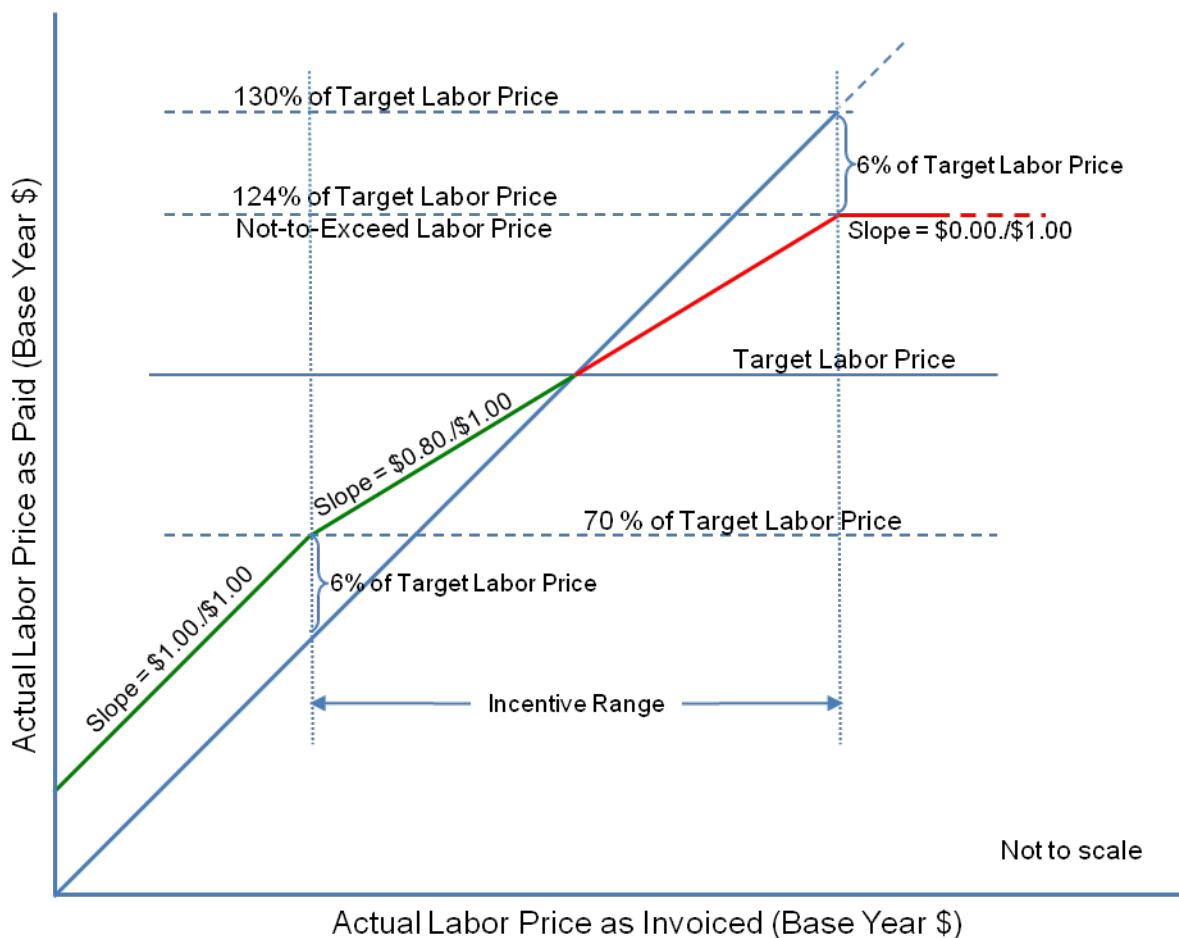


Figure III.4-2

Figure III.4-2 graphically displays the price incentive based on the Actual Labor Price for the Discovery and Replacement Phases.

4.5.2.1 Positive Price Incentive

After completion of the Replacement Phase, if the Actual Labor Price is less than the Target Labor Price, as may be adjusted by Customer Service Requests and Contract Change Orders, the State shall pay a positive incentive of 20% of the difference between the Target Labor Price and the Actual Price as invoiced by the Contractor not to exceed 6% of the Target Labor Price (i.e., invoiced Actual Labor Price is less than or equal to 70% of the Target Price). The positive price incentive is payable after the successful completion of the Replacement Phase and will be adjusted for the inflation factor applicable at the Fully Operational Start Date. The positive price incentive is shown graphically in Figure III.4-2.

4.5.2.2 Negative Price Incentive

For all invoiced labor exceeding the Target Labor Price, as may be adjusted, the State shall retain a 20% negative incentive (i.e., pay only 80% of the invoiced labor price) not to exceed a total retention of 6% of the Target Labor Price (i.e., invoiced Actual Labor Price is greater than or equal to 130% of the Target Price) adjusted for the inflation factor applicable at the Fully Operational Start Date. The negative price incentive is shown graphically in Figure III.4-2.

4.5.2.3 Not-to-Exceed Labor Price

The Not-to-Exceed Labor Price paid by the State shall be 24% higher than the Target Labor Price, as may be adjusted, adjusted for Customer Service Requests and Contract Change Orders, as applicable, and as adjusted for the inflation factor applicable at the Fully Operational Start Date. This price corresponds to an invoiced Actual Labor Price of 130% of the Target Labor Price. The State shall not reimburse the Contractor for labor costs in excess of the Not-to-Exceed Labor Price adjusted for applicable incentives. The Not-to-Exceed Labor Price is shown graphically in Figure III.4-2.

4.5.2.4 System Certification Withhold

In addition to any remedies available to the State, the State shall withhold 5% of all invoiced labor prices, exclusive of incentives, during the Discovery and Replacement Phases. Any amounts withheld will be payable after successful completion of the Replacement Phase.

4.5.3 Schedule Incentives

Offerors shall propose a project schedule to complete DDI. The Targeted Fully Operational Start Date is the date on which the Replacement MMIS is planned to be operational substantially as a whole and has begun generating official data of record for all functional areas of the MMIS. This date, subject to negotiation, shall be used to calculate schedule incentives. The Actual Fully Operational Start Date is the actual date on which the State determines in its sole but reasonable discretion that the Replacement MMIS is operational substantially as a whole, and has begun generating official data of record for all functional areas of the MMIS.

4.5.3.1 Positive Schedule Incentive

For each calendar day the Actual Fully Operational Start Date precedes the Targeted Fully Operational Start Date, the State shall pay the Contractor an additional 1/30th (one thirtieth) percent of the Target Labor Price up to a maximum of 6 percent of the Target Labor Price positive incentive adjusted by the inflation factor applicable at the Fully Operational Start Date. The incentive shall not be paid if the system cannot meet all technical and operational performance standards after being deployed. The Contractor shall not be entitled to the earned incentive, if any, until successful completion of the Replacement Phase and is conditioned upon the State receiving full retroactive Federal Financial Participation back to the Actual Operational Start Date, and as applicable, to each individual Increment Actual Start Date, after a successful System Certification.

The State will make reasonable efforts to support a Contractor's reasonable request to accelerate the DDI schedule; however, staffing limitations and other constraints may prevent the State from being able to support the full requested acceleration. Early notification of acceleration will assist the State in supporting the Contractor. The State shall not be liable for the Contractor's inability to accelerate its schedule.

If an increment becomes operational prior to its scheduled date, the operations Services associated with that increment shall be priced at the lower of the first month's proposed prices/rates for that Service or the average of the first year's proposed prices/rates for that Service for the months of operation preceding the planned start. For example, if an increment is planned to become operational during the 27th Contract month but actually becomes operational during the 25th Contract month, the prices/rates for that Service for the 25th and 26th Contract

months would be the lower of the prices/rates proposed for the 27th Contract month or the average of the 27th through 38th Contract month.

4.5.3.2 Negative Schedule Incentives

For each calendar day the Actual Fully Operational Start Date succeeds the Targeted Fully Operational Start Date, the State shall retain 1/30th (one thirtieth) percent of the Targeted Labor Price from the payable Actual Labor Price up to a maximum of 6 percent of the Target Labor Price negative incentive adjusted for the inflation factor applicable at the Fully Operational Start Date. The State may use setoffs to liquidate the negative incentive, at its sole discretion.

For each Increment Operational Start Date that is late, the State shall retain 1/100th (one one hundredth) percent of the Targeted Labor Price from the payable Actual Labor Price up to a maximum of 1 percent of the Target Labor Price negative incentive adjusted for the inflation factor applicable at the actual Increment Operational Start Date. The State may use setoffs to liquidate the negative incentive, at its sole discretion.

For each Milestone or Deliverable that is late in achieving State acceptance, the State shall withhold 1/300th (one three-hundredth) percent of the Total Labor Price per day late. This withholding may be recovered by the Contractor upon achieving certain conditions, as described in Section 15 of Exhibit A to RFP Section VIIB.

4.5.4 Performance Incentives

The State shall determine in its sole, but reasonable, discretion whether the Contractor has met a performance standard.

4.5.4.1 Replacement Phase

All costs associated with the repair, retest, regression test, and release updates for system and documentation Defects discovered after commencing any User Acceptance Test (UAT) shall be borne solely by the Contractor for the Term of the Contract. The State will not intentionally withhold the discovery of a Defect until after a UAT begins such that it imposes the cost of repair solely on the Contractor.

4.5.4.2 Operations Phase

During the Operations Phase, there will be both positive and negative incentives applied to meeting the system and operational performance standards in the combination of those shown in Attachment I (Annotated MITA Business Process Matrix) and those proposed by the Offeror in its Operations Phase Statement of Work. These standards are identified as “Critical” and “Non-Critical.”

Table III.4-4 shows the incentive structure. The incentive shall be based on:

- The worse performance of either the number of critical performance standards not met during a calendar month or the non-critical performance standards that were not met during the calendar month based on each line item in Table III.4-4.
- A particular standard not met during a particular month is counted only once during that month even if that standard was not met more than once in that month (e.g., failure to timely enroll multiple providers during a month is counted only once for the purpose of incentives).

- Performance standards in effect for a partial month of operations for any Services Group are not subject to incentives for that month.
- Months of operation where fewer than 15 total performance standards are in effect shall not be subject to incentives.

The Worse of:		Incentive
Number of Critical Standards Not Met	Number of Non-Critical Standards Not Met	
0	0-1	2% positive incentive on payable Operations Phase Services for the month
0	2-3	0% incentive for Operations Phase Services for the month
1	4-5	2% negative incentive retained on payable Operations Phase Services for the month
2	6-7	4% negative incentive retained on payable Operations Phase Services for the month
3+	8+	6% negative incentive retained on payable Operations Phase Services for the month

Table III.4-4. Operations Phase Incentive Standards

All operations performance standards shall be required reporting metrics, and the Contractor shall report on the status of these metrics at intervals appropriate for each metric, in no case less frequently than once per month.

All costs associated with the repair, retest, regression test, and release updates for system and documentation Defects discovered after commencing any User Acceptance Test (UAT) shall be borne solely by the Contractor for the Term of the Contract. The State will not intentionally withhold the discovery of a Defect until after a UAT begins such that it imposes the cost of repair solely on the Contractor.

4.5.5 Adjustments to Incentive Targets

Among other terms and conditions, the Target Labor Price and Targeted Fully Operational Start Date may be adjusted via Customer Services Requests and Contract Change Orders. Changes in the Target Labor Price or Targeted Fully Operational Start Date driven by such Customer Service Requests and Contract Change Orders shall be reflected in the subsequent incentive calculations. The price incentives shall be adjusted for inflation back to base year for the purposes of calculating the Target Labor Price.

4.6 Contract Change Order Form

A sample of a Contract Change Order is shown in Attachment T.

5 Financial Management Objectives and Strategy

Note that this section refers to contract financial management, not the Accounting & Financial Management business area.

5.1 Financial Management Objectives

The primary objectives of contract financial management are:

- Manage project finances with fiscal prudence.
- Maintain transparent and accurate insight into the contract financial status at all times.
- Receive fair prices based on legitimate costs throughout the life of the Contract.

5.2 Financial Reporting

The Contractor shall report on contract finances no less frequently than monthly. The information reported shall be consistent with and integrated with other management and technical reports.

5.3 Use of Bases of Estimates

A basis of estimate (BOE) is a quantitative description of how a cost or price was derived. Details of how BOEs are derived and at what level of detail they are produced may vary based on the effort being estimated and the organizational standards. The acceptance standard for BOEs is that a reasonably informed person could derive similar quantitative costs or prices as those being supported by the BOEs.

Contractors likely consider their pricing methodologies and algorithms as trade secrets. The BOEs may be marked as confidential in accordance with South Carolina law; however, the trade secret nature of these methodologies and algorithms shall not be reason for withholding them in the Proposals or future Customer Service Requests or Contract Change Orders or purchase orders. The BOEs shall be on different pages than the proposed costs and prices as these must not be marked as confidential.

Each pricing table shall have a basis of estimate associated with it unless otherwise directed in the RFP. The State is interested in the *quality* of the BOEs rather than the *volume* of information provided. Offerors may use estimates driven by bottom up analysis, analogy, parametric modeling, statistical modeling, or any combination of these or other appropriate methods and apply expert judgment where applicable. Note that when using the analogy method, comparisons should be made to *actual* results (e.g., actual labor hours on a project), not proposed quantities (i.e., those included in a previous proposal by the Offeror).

All BOEs must include a crosscheck using a different estimation technique (e.g., crosschecking a bottom up estimate using a parametric estimate).

Each major element of a BOE should identify:

General:

- Assumptions having a significant impact on the estimate.
- Method(s) of estimation. Copies of supplier and subcontractor quotes must be attached to support the applicable BOEs.
- Details on algorithms used in models supporting the BOEs.
- Pertinent actual data and the source(s) of data used (e.g., previous projects, parametric models used, etc.).
- Adjustments made to account for risk.
- Results of the estimate.

- Crosscheck of the results.

Software-related BOEs must address at least:

- Software/configuration sizing in terms of new, modified, reused, and deleted software/configuration.
- Other pertinent measurements of the scope of work (e.g., effort associated with the creation of training materials).
- Productivity estimates and how they drive labor estimates.
- Derivation of labor quantities and costs.
- Derivation of material/non-labor costs (including licensing costs). Licensing fees for Contractor Proprietary Material must be supported by analogous prices provided to other customers.

Operations-related BOEs must address at least:

- Derivation of labor quantities.
- Derivation of labor productivities.
- Derivation of material/non-labor costs.

Offerors may submit bases of estimates in any reasonable format that is easy to understand and that includes, at a minimum, the above elements. Offerors should note that statements such as, “in our experience, it takes approximately XXX hours to complete this effort,” do not, by themselves, constitute sufficient BOEs.

The Contractor shall not “double bill” the State for the labor hours performed by a person or a position also bid to perform duties on a fixed price activity. Offerors shall not submit a Proposal containing planned work for a person or position that cumulatively is unreasonable, or more than the person is available to work, on multiple, separately-priced Services, and the Contractor shall continue this practice after Contract award. For persons or positions whose labor is used on multiple, separately-priced Services, Offerors and the selected Contractor shall clearly identify such persons or positions in their BOEs along with the planned effort allocated to the various affected Services.

5.4 Inflation Adjustments

Unless otherwise indicated for a specific price element, Offerors shall propose prices in “base year” (the first year of the Contract) dollars. These proposed prices will then be adjusted by an inflation rate to calculate “then year” (the actual Contract year in which the Services are performed) dollars. The Contractor will invoice in then year dollars. See RFP Section VIII for more information on proposing prices and Exhibit A to RFP Section VIIB for more information on invoicing and payment.

As most Contractor costs are a combination of labor and non-labor costs, the actual inflation rate for each Contract year will be calculated on the anniversary of the Effective Date of the Contract using the simple average of the Employment Cost Index (ECI) for total compensation for “Civilian workers” (“All workers”) annual (12-month) rate, and the Consumer Price Index for All Urban Consumers (CPI-U), using the most recent published values for the preceding 12 months from the Bureau of Labor Standards. Both indices are defined in the *Bureau of Labor Standards Handbook of Methods*, which can be found at:

<http://www.bls.gov/opub/hom> .

An example of a table showing recent values of the ECI can be found at:

<http://www.bls.gov/news.release/eci.t04.htm> .

An example of a table showing recent values of the CPI-U can be found at:

<http://bls.gov/news.release/cpi.t01.htm> .

The Contractor shall not adjust the timing of performance or invoicing of Services in order to receive a larger inflation adjustment.

5.5 Interfacing to the State's Accounting System

The MITA State Self-Assessment, located in the Procurement Library, discusses an interface to the Government Accounting and Financial Reporting System (GAFRS). Subsequent to publication of the State Self-Assessment, South Carolina has implemented an SAP-based accounting system which is part of the South Carolina Enterprise Information System (SCEIS). The State does not maintain detailed accounting for Medicaid transactions or reporting via SCEIS. The Replacement MMIS shall perform all necessary accounting and financial functions required to meet the objectives and requirements of the Contract, and will interface with SCEIS for top-level accounting and reporting. Details of this interface will be established during the Replacement Phase.

5.6 Credit Card Payment Management

The State currently does not accept credit card payments in the Medicaid enterprise. Offerors shall describe their solution and approach to provide the State with the ability to collect payments online using major credit cards by integrating the Replacement MMIS with a commercial online processing gateway utilizing the gateway's published application programming interface (API).

5.7 Provider Validation and Screening Pass-through Costs

The cost of accessing databases during provider validation, such as for criminal background checks, and the cost of screening services performed by external organizations, such as fingerprinting, shall be invoiced as pass-through costs. The specific functions performed shall be in accordance with the State's business rules, and the Contractor shall receive written approval from the State for the sources and prices of these functions prior to performing any Services needing these functions. The Contractor shall seek to minimize the cost of these pass-through functions to the State.

Offerors shall not include the costs of the pass-through functions in their proposed prices.

5.8 Postage Pass-through Costs

The Contractor shall employ industry best practices to minimize the cost of postage to the State including use of technologies to verify delivery addresses, maintain accurate delivery addresses, utilize bulk and pre-sorted mailing techniques. Contractor shall also combine mailings when and if appropriate to the same delivery address. Contractor shall keep records of and the State maintains the right to audit postage costs including information about the pieces sent, delivery addresses, sorting applied and actual postage paid.

Postage for mailing of printed materials shall be paid for directly by the State to the United States Postal Service (USPS) through the use of a business mailing permit. The Contractor shall prepare mailings in accordance with applicable USPS and State policies and practices for the use of the State's business mailing permit.

Offerors shall not include the costs of postage in their proposed prices.

5.9 Use of a Total Enterprise Cost of Ownership Model

For the purposes of evaluating Proposals and helping to manage the overall administrative costs for the State's Medicaid program, the State has set up a total enterprise cost of ownership (TECO) model that represents the major MMIS-related costs over the Term of this Contract. This model includes costs associated with current MMIS-related contracts as well as accounting for the effects of the Replacement MMIS schedule on administrative costs. It does not attempt to capture every possible cost associated with MMIS-related procurement and operations.

Figure III.5-1 shows a simplified representation of this model and includes the concept of incremental implementation. The State is using estimated costs for each of the components included in the model. A more detailed representation of the TECO model is in Pricing Table O.

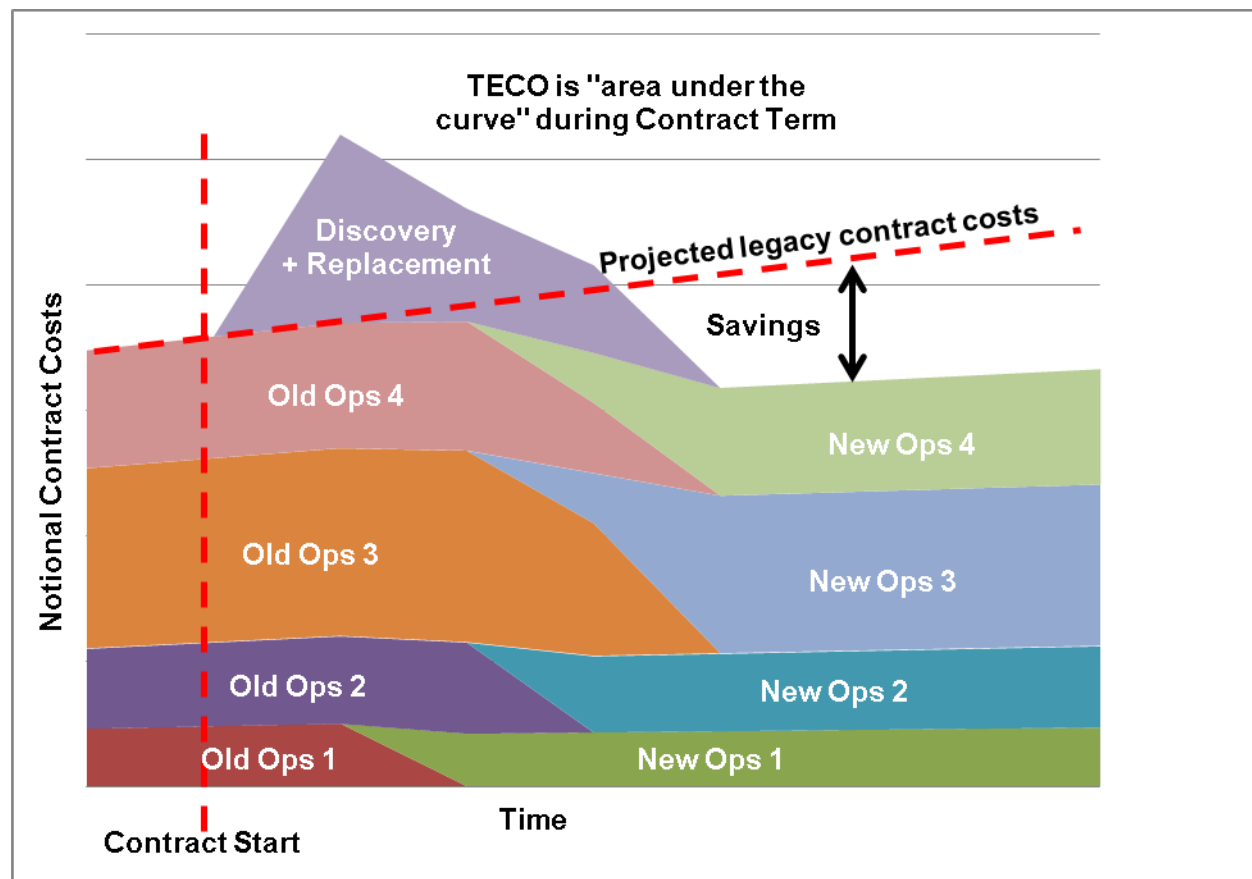


Figure III.5-1. Notional Total Cost of Ownership Model

The components in the model are described in RFP Section VI.3.

Pricing and invoicing for the Replacement MMIS contract may not align exactly with pricing and invoicing on the legacy contracts.

6 Schedule Strategy

6.1 Schedule Assumptions and Constraints

The State has identified the following assumptions and constraints affecting the Replacement MMIS Project schedule:

- Unless otherwise proposed and credibly supported, the State is assuming that the entire Replacement MMIS is unlikely to be operational prior to the ICD-10 transition date of October 1, 2013. The State is interested in credible proposed solutions that could minimize or eliminate the remediation of its legacy MMIS for ICD-10; however, this is not a requirement.
- The State is planning to replace its eligibility system with a Member Management solution. Because the schedule for this project is unknown, Offerors should assume that they will interface with the legacy eligibility system while simultaneously providing service-based interfaces for the future Member Management system.
- The State is requiring an incremental implementation approach (discussed further in Section III.8.4.1); however, the State is not specifying the content, order, or timing of the incremental deployments. Offerors must propose the solution they feel will best meet the State's needs and reduce project risk.
- The State is not mandating that current MMIS-related contracts be retired at the expiration of base contract terms or option years; however, using this approach minimizes the contracting effort and risk to the State. Service transitions should occur on the first of the month, and where practical, the beginning of a quarter. Offerors must clearly highlight any applicable, current MMIS-related contracts that they do not propose be retired prior to the expiration of that contract so that the State can assess its options for providing continuous service.

6.2 Offeror-Proposed Schedule

Offerors shall propose the schedule and project plan for the Discovery Phase and the Replacement Phase, including dates for Milestones and Deliverables.

6.2.1 Schedule Realism

The State believes that pursuing unrealistic schedule dates often results in a greater cost and a longer schedule due to potential quality issues and the premature reallocation of resources directed at transitioning. While minimizing the project schedule is an objective, Offerors shall propose realistic project schedules, and the selected Contractor shall continue this practice throughout the life of the Contract.

Proposed schedules must be supported with schedule BOEs similar to the cost/price BOEs in the Proposals and with all applicable Customer Service Requests and Contract Change Orders.

6.2.2 Contractually Binding Dates

Dates for the Milestones and Deliverables, including the Targeted Fully Operational Start Date and the individual Increment Operational Start Dates, are contractually binding and will be used in the calculation of schedule incentives, and damages, as applicable.

6.2.3 Limits on Adjustment of Internal Schedule Dates

The Contractor may adjust internal schedule dates (i.e., those not associated with Milestones and Deliverables) with written permission of the State and without requiring a formal Contract Change Order. Such modifications shall meet the requirement for schedule realism and shall not result in compression of the State's duties in a fashion that is unrealistic to achieve in the State's sole, but reasonable, judgment.

6.3 Incremental Strategy

The Contractor shall use an incremental implementation strategy including incremental deployment of system and operations solutions and incremental completion of functional areas of substantive portions of the system not intended for separate deployment. Additional details concerning this strategy are contained in RFP Section III.8.4.1.

6.3.1 Prioritization of Capabilities

With the exception of certain IT and operations capabilities, the State does not have a prioritized order for deployment of solution increments. Given the complexity of retiring existing contracts, each Offeror must propose its own optimized solution.

RFP Sections III.6.3.1.1 and III.6.3.1.2 identify tools and functions for which the State would like to see early deployment. These tools and functions represent opportunities for "early victories" that can help improve the State's management of the Medicaid enterprise.

6.3.1.1 Business Enabling Services

Elements of the Contractor's solution may provide value to the State even if deployed individually or in a standalone fashion. Offerors may propose such solutions that they believe will assist the State in improving its operations. The State is interested in early deployment of an enterprise document management system, with routing and workflow, for electronic documents and scanned images of paper documents.

6.3.1.2 Operations Functions

The State has interest in the implementation of certain operational capabilities (with supporting system functions, as applicable) as early as practical in the Contract Term. These early capabilities include:

- Online provider enrollment, credentialing, and verification.
- Consolidation of prior authorization functions.

7 Management Goals and Strategy

7.1 Management Goals

The primary management goals are:

- Achieve program success by the proper application of the management functions of planning, organizing, staffing, leading, and controlling.
- Ensure the transparency of management actions and project results so that all parties remain properly informed.
- Foster collaboration between the State, the Contractor, and other project stakeholders while maintaining an appropriate arms length relationship.

7.2 General Management Strategy

7.2.1 Management Scope

The Contractor shall manage all aspects of the Contract that affect cost, schedule, performance (scope and quality), risk/issues/opportunities, and the staff that are under its control.

7.2.2 State Insight into Contractor Activities

The Contractor shall provide as much insight into its management plans and execution as is practical. The State prefers an approach such that “if the Contractor sees it, the State sees it” to minimize asymmetric understanding of the Contract status. Collaboration between the parties is essential for success; however, ultimately, each party must perform the duties assigned to it.

7.2.3 Project Coordination

The Contractor shall lead coordination with all other organizations whose participation is necessary for project success. The State shall facilitate coordination with State organizations and other organizations whose primary connection to the Medicaid enterprise is via the State.

7.2.4 Subcontractor Management

The Contractor shall manage all subcontractors and shall be accountable for their actions, inactions, and performance.

7.2.5 Collaboration and Teamwork

The State believes that a project of this complexity cannot be successful without strong teamwork between the State (both project and program staff) and the Contractor (and all subcontractors). While the Contract defines duties of each party, the two parties must work together to form a strong team with a common purpose of project success. Offerors may propose ideas to further this goal.

7.3 Project Management

7.3.1 Contractor Duties

7.3.1.1 General Contractor Project Management Duties

The Contractor shall perform management duties associated with the management goals and general management strategy stated in this section with respect to all Contractor project duties and all Contractor-led project duties. Project management duties will occur during all phases of the Contract and are not limited only to the Replacement Phase. The Contractor’s project management processes and standards shall conform to generally accepted project management

standards, (e.g. Project Management Institute, Department of Defense, other recognized methodologies.).

7.3.1.2 Integrated Master Schedule

The Contractor shall build and maintain the Integrated Master Schedule (IMS), to include both Contractor and State activities. The IMS shall identify tasks at a detailed level for a minimum of 90 days in the future at all times. Activities further in the future may be at a reduced level of detail, although specific activities, such as go-live plans for solution increments may be better planned at a highly detailed level with additional lead time. The Contractor may use any suitable commercial off-the-shelf project planning software for building and maintaining the IMS; however, if it uses software other than Microsoft Project or Project Server, it must provide training for State project staff, provide a reasonable number of licenses for State use, and ensure compatibility with the State's computers.

7.3.1.3 Use of Earned Value Management

For the combined Discovery and Replacement Phases, the Contractor shall employ an earned value management system (EVMS), compliant with ANSI/EIA-748A, to measure project progress, evaluate variance, and project completion cost and schedule. EVMS reporting shall be at least monthly, and shall include at least the equivalent of Contract Performance Report Formats 1, 2, and 4 (DD Forms 2734-1, -2, and -4) or reasonable facsimiles as described in DI-MGMT-81466A. This standard is not incorporated in to the Contract by reference, and the Contractor may adjust details of the reports to account for differences between a true cost reimbursable contract (as defined by the Federal Acquisition Regulation) and this Contract.

7.3.1.4 Release Management

With an incremental approach, there are likely to be numerous system releases, and the interfaces to the system will change and grow over time. The Contractor shall perform system release management duties required to ensure successful implementation of new and modified capabilities throughout the life of the Contract. These duties shall include planning for each release, coordination with all affected parties, implementing each release, configuration management, and documenting each release sufficiently so that users and other affected parties fully understand the changes.

7.3.2 State Duties

7.3.2.1 General State Project Management Duties

The State shall perform management duties associated with the management goals and general management strategy stated in this section with respect to all State duties and all State-led duties.

7.3.2.2 Project Level Governance

The State shall lead the project level governance process described in Section III.7.5.3.

7.3.2.3 Risk, Issue, Opportunity Management

The State shall lead the risk, issue, and opportunity management process described in Section III.7.5.4.

7.4 Operations Management Duties

7.4.1 Contractor Duties

7.4.1.1 General Contractor Operations Management Duties

The Contractor shall perform management duties associated with the management goals and general management strategy stated in this section with respect to all Contractor operations duties and all Contractor-led operations duties.

7.4.2 State Duties

The State shall perform management duties associated with the management goals and general management strategy stated in this section with respect to all State operations duties and all State-led operations duties.

7.5 Common Management Duties

This section discusses management duties common to both project and operations management.

7.5.1 Staffing and Key Personnel

7.5.1.1 Staffing

Offerors shall propose labor categories they plan to use to perform Contract duties and whose labor will be considered a direct cost. The labor category descriptions shall include required training, education, skills, and experience.

The Contractor shall staff all positions necessary to perform its duties under this Contract with personnel qualified to perform the necessary duties. Persons performing duties typically requiring clinical skills (e.g., physician, nurse, etc.) shall be licensed in good standing in the State or another state, and must be familiar with the Laws and Regulatory Requirements related to this Contract. The Contractor shall not invoice the State for personnel training and education needed to meet labor category requirements, maintain job skills, or maintain licensing or certification.

The Contractor shall maintain a current organization chart including the names, position titles, and labor categories for all personnel performing duties on the Contract (including subcontractors) and shall provide current versions of this chart to the State no less frequently than monthly.

7.5.1.2 Key Personnel

Offerors shall identify their Key Personnel which shall include, at a minimum:

- An Account Manager who shall be the Contractor's senior representative for the Contract.
- A DDI Manager who shall lead the Contractor's efforts for DDI activities.
- An Operations Manager who shall lead the Contractor's efforts for operations activities.
- A Medical Director, who shall be a licensed physician in South Carolina and in good standing.

Offerors may use substitute titles for these positions that shall be identified in their Proposals.

Offerors may identify additional Key Personnel and their assigned positions. As commitment and continuity are important factors in success of the Replacement MMIS Contract, the State will consider assignment of highly qualified Key Personnel to additional positions as a commitment to reduce Contract risk.

Details concerning Key Personnel and their replacement are contained in Section VIIB.8.2.

7.5.2 Contractor Staff Location

All else being equal, the State believes that co-located teams are often more productive than geographically-separated teams. The State understands, however, that contractors often have development and operations groups whose services are not easy to relocate without a loss in skill sets or experience. Offerors shall describe their team location strategies in their Proposals.

During all phases of the Contract, the Contractor shall maintain a facility within fifteen miles of the SCDHHS headquarters (closer, if practical) at 1801 Main St., Columbia, SC (the “Columbia Area”). This facility shall have at least three furnished offices, with telephones and wired or wireless Internet access, in which visiting State personnel can work along with twelve parking spaces near the Contractor’s facility provided at no extra charge to the State. In addition, while the State will have access to a small number of small conference rooms at its own worksites, the Contractor must have conference room capacity to accommodate meetings with the State and necessary third parties.

7.5.2.1 Discovery Phase

The objectives for the Discovery Phase will be strongly enhanced by face-to-face communication. As such, the Contractor shall ensure that the majority of its personnel performing duties during the Discovery Phase are located in the Columbia Area, or Clemson, SC, as applicable (the “Local Area”).

7.5.2.2 Replacement Phase

The State is more willing to accept a mix of onsite and remote personnel for Replacement Phase activities. Personnel interacting frequently with the State team and end users shall perform their duties in the Local Area to the greatest extent practical.

A senior person in account or project management (preferably one of the Key Personnel) must be located in the Columbia Area at all times to the greatest extent practical during the Replacement Phase, as shall a senior person in technical management or engineering.

The State’s project team occupies a State-owned space suitable to accommodate approximately 45 team members (40 cubicles and five offices), with ten additional carrels for temporary visitors. The State believes that intermingling State and Contractor project staffs may have value in reinforcing a team approach. Offerors may propose a strategy for trading office space for select personnel on each team.

7.5.2.3 Operations Phase

To a greater extent than the Replacement Phase, the State prefers that Contractor business operations services be performed in the Local Area. While there are clearly certain commoditized services that can be performed more cost-effectively from a centralized location, the use of employees who are easily available to meet with the State and providers, and who are

culturally sensitive to the needs of the citizens of South Carolina is important in the success of the Medicaid enterprise.

A senior person in account or operations management (preferably one of the Key Personnel) must be located in the Columbia Area at all times to the greatest extent practical during the Operations Phase.

The State may potentially change offices for the Contract management team during the Operations Phase; however, the State is still open to the possibility of trading office space with the Contractor.

All business operations work performed by the Contractor and its subcontractors shall be performed in the United States or its territories. System maintenance and upgrades may use non-U.S.-based personnel consistent with other Contract requirements concerning access to information subject to privacy laws and regulations.

7.5.2.4 Turnover Phase

The general objectives for Contractor staff location during the Turnover Phase are the same as for the Operations Phase except that knowledge transfer, 90-day post-transfer support, and other related activities must be face-to-face with the oncoming staff of the new contractor or the State, as applicable, at the location where those staff will perform their duties. For planning purposes, Offerors should assume that a follow on contractor will have similar location requirements as are in this Contract.

7.5.3 Change Management and Governance

The Contractor shall perform all internal and pre-baselined change management and governance processes required for success on the Contract. These processes manage artifacts, configurations, etc. prior to their acceptance or approval by the State. After acceptance or approval of these items, the Contract level governance processes will control changes. The State shall lead the Contract level governance processes with administrative assistance and advice of the Contractor. This administrative assistance shall include management of changes using a COTS or open source change management tool. Offerors shall propose a change management tool for use on the project that is continuously available to the State.

Examples of the types of documents and artifacts that would come under control of the Contract level governance includes:

- Project-oriented documents. This would include project management, technical, contractual, and other similar documents that define the project.
- Enterprise-oriented documents. These would include organizational structures, business processes, business data models/metadata, organizational change management, etc.
- Requirements, architecture, and design documents.
- Configurable items such as business rules and workflows.
- System interfaces.
- System release artifacts once released. During development and maintenance operations, the Contractor shall manage configuration of these items until they are approved for release.
- Security procedures (system, physical, etc.).

- Test and quality assurance plans.
- User/administrator manuals and training materials.

Nothing in this section shall prohibit the Contractor from making emergency changes to the system or operations procedures in response to system faults, security threats, unplanned surges in system or operations transactions, or other similar problems. The Contractor shall notify the State of such changes as soon as practical after they are made, and in no case later than specified in pertinent performance standards shown in the General & Systems Processes in Attachment I.

7.5.4 Risk, Issue, and Opportunity Management

The State shall lead the risk, issue, and opportunity management process. The Contractor shall support this process by participating in the identification, analysis, mitigation/enhancement, and monitoring activities. The Contractor shall lead management of risks/issues/opportunities assigned to it.

7.5.5 Information Sharing, Reporting, and Deliverables

To ensure progress and enhance transparency, information and Deliverables must be complete and coherent.

7.5.5.1 Information Sharing

The State supports electronic sharing of data in a secure manner (i.e., authorized individuals accessing data they need to perform their work, and the use of encryption for data at rest, data in transit, or both, as applicable for the method of sharing). The Contractor shall maintain a collaborative online tool to facilitate information sharing. The Contractor must use a COTS or open source tool for this purpose, configured as necessary, or it may choose to use the State's SharePoint server for this purpose. The Contractor must supply licenses (at its own expense) and training for the selected tool. Use of these types of tools will reduce the need for the Contractor to provide any data in hard copy format other than those legally requiring physical copies or signatures, invoices, or for documents that are so large that they must be printed in order to perform an orderly review.

SCDHHS' desktop computers currently use the Window XP operating system operating on a Novell Netware network. The Contractor shall ensure that all management tools used for information sharing are compatible with then-current SCDHHS computer system configurations.

7.5.5.2 Reporting

The Contractor shall report on project progress and operations status in writing no less than monthly. The State prefers to have access to interim data on at least a weekly basis, and the use of real-time dashboard presentations is preferred to allow key metrics to be available in near real time. Monthly reports shall include the status of cost, schedule, performance (quality/scope/technical/operations), risks/issues/opportunities, staffing, and other pertinent metrics. The Contractor shall timely report on the achievement of performance standards for the previous month and identify all performance standards that were not met. The Contractor shall report to the State in writing when any performance standard is not met, within one calendar day for critical performance standards and within three business days for non-critical performance standards.

The State and Contractor shall jointly conduct weekly status reviews among the project and operations management staff and monthly Contract Management Reviews for a larger audience.

7.5.5.3 Deliverables

Offerors shall propose Contract Deliverables via the Contract Data Requirements List (CDRL). Unless otherwise specified in this Contract, the format of the Deliverables shall be chosen by the Contractor, subject to approval by the State.

In addition, the Contractor shall also maintain a Data Accession List (DAL). This list shall identify pertinent documents created as part of this Contract that are not part of the CDRL. See the DAL data item description in Attachment K for further information.

MMIS projects often suffer from challenges in the Deliverable review cycle. The contractors may feel that the states do not review Deliverables in a timely manner and with consistent feedback, or that they focus too much on unimportant details. The states may feel that the contractors submit Deliverables that are incomplete, are recycled from previous projects, have substantial quality problems, and that cannot practically be reviewed in the time available due to size, competing Deliverables, and other project activities.

The State believes that in order to be successful, the State and Contractor must succeed on the Deliverables review cycle. To do so, the following principles must be followed:

- The purpose of review cycles is to identify and correct defects, regardless of the source of these defects.
- Deliverable review cycles must be deconflicted to the greatest extent practical, particularly for related functional areas. Queuing up excessive Deliverables for simultaneous review defeats the purpose of defect identification and is unacceptable to the State.
- Both parties should assign consistent personnel throughout the complete review cycle of a specific Deliverable unless additional expertise is necessary to properly complete the review.
- Deliverables are related, not isolated. If a later Deliverable affects an earlier Deliverable in a way that could not be reasonably predicted, changes to the first Deliverable that are in scope of the Contract shall not result in a change to the Contract prices and schedules, even if that Deliverable has already been accepted by the State. As it is practically impossible for the State to foresee cascading impacts of its decisions on future Deliverables, it is the Contractor's duty to identify these impacts in a timely manner for the State's consideration.
- The review cycles must be scaled to the size and complexity of the Deliverables, and the resulting review cycles directly impact the project schedule.
- Informal reviews of partially-complete Deliverables can substantially improve and accelerate the review cycle.
- Deliverables are deemed "delivered" on the date the State accepts the Deliverable as complete, not the date the Deliverable is submitted to the State by the Contractor.
- Given the complexity of managing multiple Deliverables in various stages of the review cycle, the Contractor must provide a tool to manage the review and defect repair process (preferably COTS or open source) that is continuously available to the State.

The State recommends a "long" review cycle and a "short" review cycle.

The long review cycle would allow for fifteen business days for State review and feedback, ten business days for the Contractor to update the document and return it to the State (including any joint meetings to discuss the State's feedback), and five business days for the State to do a final review and approve or reject the Deliverable.

The short review cycle would operate similarly except that the State's review would be ten business days, followed by a five-day Contractor update, and finally a five-day final State review and approval/rejection.

Offerors may propose modifications to these review cycles. For the purposes of schedule incentives, the State shall use the State's acceptance date for a Deliverable when evaluating timeliness.

7.5.6 Communications

Given the number of entities whose participation is crucial to this program, excellent communication is paramount. The Contractor shall conduct effective communications with all stakeholders participating in or affected by the duties performed by the Contractor. These communications may also include information pertaining to the State's duties, as well. The Parties shall create a Joint Communications Plan during the Discovery Phase that covers the communications strategy with all principal stakeholders throughout the life of the Contract. The plan shall be updated as necessary to remain current and relevant to the environment and stakeholder needs.

7.5.7 Disaster Recovery and Business Continuity

As the functions performed by each party are interdependent on each other, the parties have a joint duty to prepare for and conduct disaster recovery and business continuity operations. These functions may be performed during any phase of the Contract. Unless otherwise agreed to by the parties, the disaster recovery and business continuity duties shall align with other duties as assigned in this Contract.

The parties shall jointly create and maintain the Joint Disaster Recovery and Business Continuity Plan, as described in RFP Section III.4.4.1.

7.5.8 Weekend and Holiday Work

The Contractor shall not schedule or perform activities requiring State participation on weekends or State holidays without prior written permission from the Contract Administrator. Non-workdays shall not count towards artifact review periods or other activities measured in business days. The period between December 24 and January 1 (inclusive and adjusted for proximity to weekends) is generally a time when the availability of State personnel is very low. While State personnel will participate in project activities to the extent that they are available, the Contractor shall not plan any tasks requiring State participation during this period each year, and these days shall be treated as holidays for the purpose of artifact review periods and other activities measured in business days.

7.6 System Certification

The Replacement MMIS must receive System Certification from CMS in a timely manner, and the Contractor shall ensure that the Replacement MMIS performs in such a manner as to achieve

System Certification on the first attempt. The State shall lead the System Certification process with the assistance of the Contractor.

An unusual aspect of System Certification for this project is that the system and supporting operations will be deployed incrementally. The State has received permission from CMS to do a modular System Certification, if required, supported by “regression System Certification” activities to ensure that previously certified areas remain properly functional. Please note that modular System Certification is not the same as premature deployment followed by a test/fix cycle to bring the system up to standards. The latter is specifically prohibited by CMS and will likely result in a loss of retroactive Federal Financial Participation (FFP).

Loss of FFP due to System Certification failures shall be subject to damages provisions.

8 Technical Objectives and Strategy

8.1 Technical Strategy and Guiding Principles

The technology strategy is driven by the Replacement MMIS project goals which encourage the use of COTS software products and emphasize configuration over customization. As a result, the State does expect that the Replacement MMIS project will require significant amounts of software development and therefore specifying the details of how to produce system architecture and design will be of limited benefit for this project. However, the qualities of technical architecture and design are still important to ensure that the Replacement MMIS has a long lifespan and acceptable life-cycle maintenance costs. Additionally, on April 14, 2011, CMS published a rule modifying 42 CFR 433.112 (with expanded guidance in *Medicaid IT Supplement MITS-11-01-V1.0*), requiring states to satisfy seven conditions and standards (“Seven Conditions”) in order to receive enhanced FFP. The State seeks to align its Replacement MMIS system with the technology capabilities identified in *MIT-11-01-V1.0*.

As such, the Replacement MMIS shall provide the State the following key technical architecture components as described by the MITA Technical Architecture:

- Business Enabling Services
- Access Channels
- Interoperability Channels
- Data Management and Data Sharing
- Performance Measurement
- Security and Privacy
- Adaptability and Extensibility

Furthermore, the Contractor’s solution should support the State in achieving the Seven Conditions:

- Modularity Standard
- MITA Condition
- Industry Standards Condition
- Leverage Condition
- Business Results Condition
- Reporting Condition
- Interoperability Condition

The State recognizes that achievement of the Seven Conditions requires efforts across the entire enterprise architecture spectrum, not just a collection of system features. With respect to this Contract, success in meeting the Seven Conditions will require teamwork between the State and Contractor, and it will require certain system capabilities, features, and architectural qualities. The Offeror shall propose a solution that supports the key technical components of the MITA framework and enables the State to achieve the Seven Conditions to the greatest extent practical.

8.1.1 Business Enabling Services

Business enabling services provide SCDHHS the technical services needed to improve its overall business processes through technologies that enable the Medicaid enterprise to operate more efficiently and effectively. The Replacement MMIS should include:

- Document management services that provide:
 - Technologies for the ingest of paper documents into the Replacement MMIS including scanning and optical character recognition (OCR) tools
 - Technologies to accurately index and attach ingested documents to the appropriate records in the Replacement MMIS
 - Barcode technologies that assist in optimizing the tracking of paper documents (inbound and outbound)
 - Integrated fax server capabilities
- Workflow management services that provide:
 - Business/customer relationship technologies (CRM) that support the tracking, assignment, notification, escalation and management of requests, interactions and relationships with providers, beneficiaries, and other stakeholders
 - Configurable template-driven and event-driven correspondence generation
 - Capabilities to configure and generate alerts and notifications through a variety of access channels that can be managed by user
- Call center services that enable:
 - Unification of existing call center operations associated with SCDHHS's legacy contracts being retired by this Contract
 - Integration of call center technologies with Replacement MMIS
- Collaboration services that support:
 - Improving agency communications
 - Promoting the rapid dissemination and adoption of new information and ideas across the agency staff
- Support for multiple languages
- Search capabilities that speed access to needed information across the system/solution through easy-to-use search and phonetic matching.
- Integrated online help and training throughout the system

8.1.2 Access Channels

To provide access to the State's Medicaid enterprise to the broadest constituencies, the Replacement MMIS should enable a variety of access or communication channels from traditional paper-based submissions to automated electronic exchange to mobile devices. The Replacement MMIS should facilitate access through Web browsers as well as mobile devices in order to support the distributed and mobile nature of SCDHHS's providers, beneficiaries, staff and stakeholders. The Replacement MMIS should be designed to support changes and additions to new access channels that may become available or popular over the life of this Contract.

To improve the State's efficiency and stakeholder satisfaction, the Replacement MMIS should deliver as much service as is reasonable and prudent directly to providers, beneficiaries and business partners through as many channels possible. Users should be able to access services 24 hours per day each day.

8.1.3 Interoperability Channels

The Replacement MMIS should implement a modern technology design that brings a standards-based approach to interoperability that includes:

- A services-oriented architecture (SOA) to the greatest extent practical
- A standards-based approach to exposing and consuming web services both across the State's Medicaid enterprise as well as with external systems
- Integration and orchestration through an Enterprise Service Bus (ESB) as much as practical
- A secure standards-based approach to data exchange

8.1.4 Data Management and Data Sharing

The Replacement MMIS should support the State's efforts to improve overall data governance and data stewardship. The Replacement MMIS should enable and support the management and exchange of data across the State's Medicaid enterprise and with external systems in ways that are automated and minimize potential errors with data accuracy. To those ends, the Replacement MMIS should provide:

- A unified data exchange solution that utilizes managed file transfer (MFT) to ensure successful data exchange and monitors and alerts appropriate parties of potential issues.
- A data model that is consistent with the State's business processes and MITA business processes.

8.1.5 Performance Measurement

The Replacement MMIS should support the State's efforts to improve its ability to monitor, track and act in a timely manner on information and data available in the Replacement MMIS. In support of the performance measurement principles, the Replacement MMIS should provide:

- A dashboard approach to key metrics identified by this Contract that is flexible and configurable
- A system that can notify and alert stakeholders when key metrics are not being met
- An ad-hoc reporting solution that is easily used by business owners
- A central online repository for regular reports and reporting

- Integration of business process management and business activity management tools to the greatest extent practical

Additionally, the Replacement MMIS should balance its reporting capabilities with those allocated to the DSS/SURS/MARS to meet the users' needs while avoiding costly overlapping capabilities.

8.1.6 Security and Privacy

Due to the nature of the information managed by the State in conjunction with its health benefit plans, security breaches and other compromises of data collected and maintained by the State's Medicaid enterprise are unacceptable. The Contractor has the duty to protect from loss or unauthorized disclosure all State data. The Contractor shall comply with all security and privacy laws, regulations, and policies, including the Health Insurance Portability and Accountability Act (HIPAA), and related breach notification laws and directives.

The Replacement MMIS should support the following security principles to the greatest extent practical:

- **Confidentiality** – prevent disclosure to unauthorized persons or systems.
- **Integrity** – data cannot be modified undetectably.
- **Availability** – access is not inappropriately blocked or denied.
- **Authenticity** – validation that the parties to a transaction are who they say they are and that their communications are genuine.
- **Non-repudiation** – parties to a transaction cannot deny their participation in the transaction.
- **Auditability** – track and log data changes including the user or system making the change. Track and log any inquiries, views or access of data that may require such tracking as a result of law, policy or data use agreements including user or system making inquiry, doing the viewing or accessing the data along with the data and time of the inquiry, view or access.

The Replacement MMIS should incorporate a single sign-on capability to the greatest extent practical along with integrated session management for solutions incorporating multiple applications. The State strongly prefers a single sign-on solution that can be extended to other applications in the enterprise, such as the data warehouse and Member Management solutions. Offerors should describe how their authentication system can be extended to include authentication devices such as hard tokens or biometric input in the future.

The Replacement MMIS should maintain a comprehensive log of user and external system access, queries, and changes in a manner that meets the requirements of applicable security and privacy laws, regulations, and policies, and that provides the State alerts to key events and access to the log information interactively.

As encryption technology becomes cheaper and faster, the State believes that requirements for encryption of data at rest and data in motion will increase. Offerors shall describe their current encryption schemes, how those schemes can be extended in the current system architecture, and how they plan to incorporate greater encryption requirements in the future.

The Replacement MMIS must provide an approach to data access and data security that protects Individually Identifiable Health Information (IIHI) and Protected Health Information (PHI). Both

data management within the Replacement MMIS and the Contractor's operational policies and practices should:

- Meet all HIPAA, HITECH, ARRA and other State/Federal privacy and security requirements.
- Ensure security, accuracy, and timeliness of data interfaces by applying rigorous management processes with respect to data sources for and consumers of MMIS data.
- Streamline electronic transactions by incorporating electronic and digital signatures compliant with HIPAA and State law.
- Provide field-level security configuration and access by user role to the greatest extent practical.

8.1.7 Adaptability and Extensibility

In order to quickly respond to changes required by the Medicaid enterprise as well as work to minimize the cost and effort required to make changes the Replacement MMIS should be adaptable and extensible. Additionally, in support of the State's core preference for solutions that are configurable and require minimal customization, the Replacement MMIS should:

- Implement a rules-driven design that is supported with appropriate rules technology and provides the ability to be updated from within the system
- Provide an architecture that clearly defines service end points that enable extensions to functionality without requiring pervasive or broad changes to the core system
- Provide an approach to configuration that can be easily managed by system users
- Improve ability to quickly respond to changes in the business by using business rules management, business process management, and business activity monitoring tools where practical.
- Minimize the cost of changes to the business rules and business processes
- Support the introduction of new technology over time in a way that minimizes the impact to the Replacement MMIS
- Provide system components and solutions which optimize the potential for a long life-span, reducing the cost and organizational disruption created by frequent procurement of replacement components

8.2 Technical Goals

In support of the State's strategy, the Replacement MMIS must address the following MITA goals for MMIS technology. Offerors should identify the ways their solution supports these goals.

- **Enterprise Perspective** – Promote an enterprise view that supports enabling technologies that align with State Medicaid business processes and technologies
- **Performance Driven** – Make performance measurable for accountability and planning
- **Interoperable** – Develop systems that can communicate effectively to achieve common Medicaid program goals through interoperability and common standards
- **Flexible** – Promote an environment that supports flexibility, adaptability, and rapid response to changes in programs and technology
- **Data Focused** – Provide data that is timely, accurate, usable, and easily accessible to support Medicaid program analysis and decision making

- **Cost Effective** – Reduce unnecessary costs for collection of data that is already available elsewhere in the Medicaid enterprise and that can be used to administer the Medicaid program more effectively

8.3 Technical Objectives

The State desires to align the Replacement MMIS with the MITA Technical Objectives.

8.3.1 Adopt Data and Industry Standards

The State desires a Replacement MMIS that makes use of data and industry standards to the greatest extent practical. The Replacement MMIS should:

- Minimize the use of proprietary technologies other than true commercial off-the-shelf
- Implement industry standards across that solution especially for services that may be exposed or available to third parties
- Move towards the use of commodity hardware and eliminate the use of mainframe computers
- Support all leading web browsers (e.g. Firefox, Chrome, Safari, Internet Explorer) without special setting requirements to the greatest extent possible and all Web browser versions currently supported by the browser vendor and avoiding browser/OS specific extensions (e.g. Active X controls) to the greatest extent possible.
- Eliminate production system configuration errors by using a clear, concise and automated methodology for promoting business rules, configurations, data alterations and other changes from one system environment to another (e.g. acceptance test to production).

Offerors should describe the data and industry standards that their solution adheres to and explain how data and industry standards are incorporated into their development processes and technical operations on an on-going basis.

8.3.2 Promote Modularity and Component Reuse

The overall technical architecture of the Replacement MMIS should be modular in nature and promote component reuse where practical. Offerors should explain how their technical architecture is modular, promotes reuse, and enables extension and customization to meet the needs of individual customers and in particular this Contract. Furthermore, Offerors should describe how updates and upgrades to the core components impact any extensions or customizations that are required for this Contract.

8.3.3 Promote Efficient and Effective Data Sharing, Management and Stewardship

The Replacement MMIS should promote the efficient use of data throughout the Medicaid enterprise. Over time, SCDHHS has relied upon a variety of systems including its legacy MMIS, a number of stand-alone applications (PC applications) and a variety of third party contracts and contractors to collect and manage data for the Medicaid enterprise. The Contractor must unify the data into the Replacement MMIS and do so such that the system:

- Utilizes a data design incorporating the required data elements necessary to support SCDHHS business processes and data exchange with business partners.
- Provides data that is timely, accurate, usable, and easily accessible to support analysis and decision making for health care management and program administration.

- Supports a “never delete a record” approach to data storage and management for ease and timeliness in accessing historical records.
- Exploits the ubiquity of relatively cheap storage to maximize the amount of historical data maintained online and immediately available to users
- Minimizes or eliminates duplicative entry of information into the MMIS.
- Enforces a single source of truth for all data.
- Maintains very high entity, referential, and domain integrity for structured data.
- Supports processing items over broad time periods by maintaining effective time segments for business and pricing rules, eligibility, etc.
- Supports real-time access to all data as much as practical (e.g. minimize/eliminate “day-old” data interface strategies).
- Allows metadata availability for all authorized users and business partners in the most accessible and efficient manner.

SCDHHS desires to promote data stewardship by business owners. Therefore, the Replacement MMIS should provide means for business owners to become stewards of the data and support business owners in managing data.

The Replacement MMIS must contain, with online access, at least seven years of historical data as well as any other data that may be available and needed for on-going and future operations (such as history data for claims that have limits) at the Fully Operational Start Date (see also Section III.8.4.2.2). The system shall support the ability to retain all future data. Data will be deleted or archived only at the State’s direction.

8.3.4 Provide a User Focused Experience

The State desires a system that provides a compelling and efficient user experience. Human factors engineering is the discipline of applying what is known about human capabilities and limitations to the design of products, processes, systems, and work environments*. Often, the user interface on large software systems is designed by software developers with little experience in human factors engineering, resulting in systems that require extra user training, have features that are rarely used, and that push users into low productivity scenarios.

A major factor influencing the acceptance and success on this program will be usability. The Contractor must implement a system that is intuitive and easy to use and that should rival leading online consumer retail experiences.

To improve user’s efficiency, the Replacement MMIS should be capable of maintaining multiple concurrent accesses by a single user and in the case of a web browsers, support the viewing of more than one web page simultaneously in a single session.

Applicable portions of the system and training materials must support Section 508 (29 USC 794d) of the Rehabilitation Act. Additionally, certain portions of the system must be accessible to persons for whom English is not their primary language in accordance with 42 CFR 438.10(c). The languages currently required are English and Spanish.

* Sandia National Laboratories Web site,
http://reliability.sandia.gov/Human_Factor_Engineering/human_factor_engineering.html, downloaded on 8/4/10.

8.3.5 Support Interoperability and Integration

The State desires a system that was designed to benefit from the trends toward service-based architectures that make it possible to implement common interoperability and access. The Replacement MMIS should implement a design whereby common functionality and capabilities are available as services that can be used across the Medicaid enterprise including by other applications such as the State's Member Management system, other agencies, State or Federal systems, or by other new systems as needed. Offerors should describe how their solution's architecture promotes interoperability and integration with other systems.

8.3.6 Promote Secure Data Exchange

The Replacement MMIS must interface with a variety of other systems and must do so in a manner that promotes secure and reliable data exchange. The Replacement MMIS should leverage Managed File Transfer (MFT) mechanism(s) to administer interfaces/messages for inbound/outbound interface transactions and to guarantee delivery/receipt of all inbound/outbound interface traffic. The data exchange should provide alerts and notifications to the designated users through the workflow management services.

8.3.7 Utilize Industry Best Practices

The State desires to utilize industry best practices to the greatest extent practical. Best practices include both software development and technology operations best practices as well as best practices applicable to the health care and insurance industries. Offerors should describe how their organization, software development practices and corporate culture remain aware of industry best practices and utilize them in their development and operations. Offerors should also describe best practices that they believe are relevant and important to the success of this Contract.

8.3.8 Integrate Clinical & Administrative Data

The State currently has a significant coordinated care population through the use of Medical Home Networks (MHNs) and Managed Care Organizations (MCOs) and is focused on the development and implementation of payment reform strategies in the coming years. Additionally, the State is exploring how best to implement the goals of Accountable Care Organizations (ACOs) based on the proposed rules and ongoing guidance. As such, the Replacement MMIS should provide the State with tools and/or interoperability to manage the data associated with clinical activity that would be required to track and evaluate the health outcomes related to the claims and encounter data collected. The Replacement MMIS should provide tools to enable the State to make payments based on the health outcomes and support the State in developing and evaluating payment programs of this nature. Offerors should describe how their solution supports the use of clinical data for care and case management, health outcome determination including the ways the solution provides for flexibility in payment methodology based on the clinical data.

It is anticipated that the Replacement MMIS will need to receive information from and/or provide information through one or more Health Information Exchanges (HIEs) including the South Carolina Health Information Exchange (SCHIEx). Offerors should describe how their solution supports the management of clinical data in the system and utilizes standard messaging such as Health Level Seven International (HL7).

The Replacement MMIS should provide tools to track and manage administrative data including contracts, business trading partner agreements, and program integrity cases. Offerors should describe how their solution tracks and manages contracts and agreements and also how the solution supports program integrity cases and those case are tied to the payment and case data.

8.3.9 Ensure Broad Availability

Modern technology should work to minimize and even breakdown the barriers that exist between the State, Providers, Beneficiaries and stakeholders. The Replacement MMIS should work to overcome tracking and communication challenges across the enterprise by providing tools that deliver asynchronous communication, provide timely alerts and notifications, support the development of social and collaborative environments, and provide users the information they need when they need it in the manner that is accessible for them. Offerors should describe how their solutions support delivering broad availability of information to authorized users.

8.4 Technical Processes and Operations

Offerors should describe their technical development processes and technical operations such that the State understands how the Offeror:

- Manages its software development life-cycle
- Ensures forward and future compatibility (i.e. what is the process for moving from one version to the next of the software)
- Extends the solution to meet unique customer needs while maintaining future upgrade paths
- Works with customers for input into future product priorities and requirements
- Manages configuration controls (i.e. ensuring correct configuration is applied to production systems, ensures updates from test to production environments are done accurately)

8.4.1 Implementation Life-Cycle

Offerors may propose details of the implementation life-cycle; however, the State has certain objectives that must be met with respect to the implementation life-cycle.

8.4.1.1 Incremental Implementation

The Contractor shall implement the Replacement MMIS incrementally. Incremental implementation serves the following purposes:

- To manage risk on the Contract by ensuring a steady stream of feedback from end users on system quality, capability, and consistency with State requirements. The longer that parts of the system go without receiving such feedback, the greater the likelihood that the fully-implemented system will not meet user requirements or that it will have quality issues.
- To allow for early deployment of needed capabilities.
- To eliminate the “big bang” implementation approach that is prone to failures. Given the number of systems and contracts being replaced by the Replacement MMIS, the State believes that a single deployment event, or closely spaced set of events, has a very low probability of success, and as such, is unacceptable.

Increments consist of functional, testable, components of the system along with their associated business capabilities. Some increments may be deployed after completion of testing (e.g., online provider enrollment) while others serve as “checkpoints” in the implementation of larger components of the system (e.g., portions of the claims payment functions not able to stand alone). Delivery of an interim artifact (e.g., requirements document, design document, etc.) does not constitute an increment. The State is not interested in having the Contractor assume the duties of an existing contract without also deploying its associated system solution as a production IT capability. Note that for the legacy Medicaid Operations contract, a single Replacement MMIS increment may not retire the entire legacy contract. For other legacy contracts, the most practical strategy is to retire an entire contract with a single increment.

One of the largest challenges for the Contractor will be assuming the duties of an existing State contractor whose solution may not align well with the Contractor’s long-term solution. The Contractor may have to modify its processes during the transition from all legacy solutions to the full Replacement MMIS prior to establishing the preferred long-term approach.

The Contractor may also use an iterative approach (the use of a cyclical development cycle in order to discover requirements and make continuous improvements to a system) in addition to an incremental approach as long as the Contractor’s strategy and execution can be shown to manage the schedule risk associated with iterative development.

8.4.1.2 Risk Mitigation During System Transitions

Due to the large number of system and contract transitions associated with this Contract, transition activities must be very effective in order to avoid repeated or cascading problems. The Contractor shall manage system and contract transitions with the State’s assistance and facilitation. Offerors shall propose a transition strategy that manages risk and maximizes the likelihood of first-time success.

The State has considered a variety of approaches to the transitions required for this Contract and is open to Offerors strategies that perform the transitions in ways that are consistent with the objectives of this Contract. For example, Offerors could consider transitioning claims payment by provider type to manage the risk related to managing the number of providers impacted by the change at one time. Offerors could also consider running-out previously submitted claims on the legacy system and only accepting new day claims in the Replacement MMIS. Additionally, given the expected schedule for the Replacement MMIS, the State does not require the Replacement MMIS to have the ability to process claims using the ICD-9 code set, however, the Offerors overall transition strategy must address the State's need to review historical data, manage limits of service, and re-adjudicate claims submitted prior to the transition to the Replacement MMIS.

Offerors should consider the merits of their proposed solution and must balance the additional costs and coordination associated their approach (for example, the State paying two contractors simultaneously) with the savings and risk mitigation benefits of the approach.

8.4.2 Data Management Processes

System data are the principal assets for an information system. The State is seeking a solution that allows it to improve its ability to use system data to operate the Medicaid enterprise.

8.4.2.1 Data Management and Stewardship

The Contractor shall assist the State in improving its data management and stewardship. The State has identified the following objectives for improving data management and stewardship. Offerors should propose processes, activities and measurements to assist the State in meeting these objectives.

- Improve the level of master data management.
- Enable the monitoring of and conformance to Federal and State regulatory policy changes that require modification of data assets.
- Improve the level of data quality
- Provide greater insight into the cause of data quality degradation.
- Engage business owners in becoming data stewards.
- Empower data stewardship by facilitating the identification of data assets that do not meet data access or data quality service levels.

8.4.2.2 Data Migration, Conversion, and Synchronization

The State's data currently exist in multiple, non-integrated systems, and in hard copy. Data migration and conversion will be a substantial challenge for this project. Additionally, with an incremental implementation approach, there is a high likelihood that common data will exist in multiple systems for substantial periods that must remain synchronized.

The Contractor shall propose its approach to data migration, conversion and synchronization.

8.4.2.3 Data Sources

The following primary data sources will be needed for migration and conversion into the Replacement MMIS:

- Data from IT systems used by the existing Medicaid enterprise contractors. See Table III.4-1 for a list of these contracts.
- Data from the internal PC applications used by the State. See Table III.4-2 for a list of these applications.
- Paper-based data. The need for these is driven by the Contractor's system and operations strategy. The MITA State Self-Assessment in the Procurement Library should serve as an aid to Offerors concerning which data are currently in paper format.

8.4.2.4 State Duties for Data Migration and Conversion

The State plans to prepare for the Contractor by documenting, cataloging, and organizing a portion of its existing data sources into a transitional staging area. The State plans to perform much of this data migration work prior to having selected a Contractor or understanding the target system, therefore the result will be incomplete. However, the State believes this effort will significantly reduce DDI risk.

The State does not plan to convert any paper-based data as part of this effort. While the State will make reasonable efforts to ensure the quality of the data in the transitional staging area, the State does not warrant completeness or accuracy of the structure and contents of the transitional staging area.

The State shall have the following duties:

- Provide access to and documentation of data sources. As many of these sources are not under the direct control of the State, the State does not warrant the completeness or accuracy of the documentation.
- Document the data elements and expected values in the legacy MMIS.
- There are data in current contractor systems that are not transferred to the existing MMIS. The State does not plan to modify these data.
- Assist the Contractor in its duties.

8.4.2.5 Contractor Duties for Data Migration and Conversion

The Contractor shall have the following duties:

- Migrate and convert all necessary data into the Replacement MMIS including all preparatory duties such as source-to-target mapping, data cleansing, supporting documentation, etc.
- Design and perform a synchronization strategy during the incremental transition from the legacy IT systems to the Replacement MMIS and after deployment of the entire Replacement MMIS for data sources where data must practically be located in multiple systems.
- Assist the State in its duties.

8.4.3 Reporting

Pre-canned and ad hoc reports can be a challenge to plan for an MMIS DDI because the nature of the new system can be substantially different than a legacy system. Rather than attempt to specify hundreds of reports of uncertain value, the State would like to streamline the report design and development process.

The Replacement MMIS should make substantial use of a COTS reporting/business intelligence tool that allows authorized end users to create, modify, and manage reports and queries, and groups of reports and queries, as well as share reports among users. The Contractor shall develop and deliver all reports that are:

- Necessary for the proper operation of the system.
- Necessary for the proper conduct of the Contractor's business operations duties on the Contract.
- Required by the State Plan, State law or regulation, or are Federally-required.
- Required to report on a Contract performance standard.
- Are included in the baseline system.
- Are otherwise included in the Contractor's proposed system.

The State will create the remainder of the reports it desires to use on the system or will amend the Contract using the Replacement Phase or Operations Phases Modification Pools to engage the Contractor to create additional reports.

8.4.4 Technical Processes

The Contractor shall document its technical processes in a Systems Engineering Management Plan (SEMP) and the Contractor shall adhere to its documented processes.

8.4.4.1 Requirements

The State has chosen not to include a detailed set of requirements in this Contract. The Contractor shall conduct requirements development for system functions and Contract operations and shall maintain the requirements for the life of the Contract. Because of the varied nature of Offeror's proposed systems, the specific processes and artifacts for requirements may vary from Offeror to Offeror. Offerors shall propose the methods and artifacts needed to accurately and adequately document the State's needs with respect to this Contract.

8.4.4.2 Architecture and Design

The Contractor shall conduct architecture and design activities sufficient to ensure that the system and supporting technical and business operations are successful, and shall maintain the architecture and design for the life of the Contract. Because of the varied nature of systems supporting Medicaid programs, the specific processes and artifacts for architecture and design may vary substantially. As a component of the SEMP, Offerors shall propose the methods and artifacts needed to accurately and adequately document the system and operations architecture and design with respect to this Contract and shall maintain this documentation for the life of the Contract. The Contractor shall provide to the State database schema, data dictionaries, entity-relationship diagrams, and interface standards for the entire system, including those supporting Contractor Proprietary Material without any restrictions for usage in accordance with RFP Section VIIB.25.

8.4.4.3 Configuration and Construction

The Contractor shall perform system construction and analogous operations development in a fashion that results in a high quality solution, including modifications and upgrades during the life of the Contract.

8.4.4.4 Testing and Technical Quality Assurance/Quality Control

These objectives are discussed in Section III.9 and its subsections.

8.4.5 System Modifications and Upgrades

For long-term system maintenance, the State prefers to deploy modifications and upgrades on a scheduled, periodic basis (e.g., monthly, quarterly, etc.). Exceptions to this approach include:

- High priority changes that cannot wait until the next scheduled deployment date.
- Routine changes to business rules and refinements of workflows. The effort associated with these changes must be minimal enough as not to disrupt normal system operations or the maintenance effort itself.
- Regulatory and legislative changes with specific implementation dates.

8.4.6 System Hosting

With respect to this Contract, "hosting" means the physical housing of the hardware and software (including servers, storage devices, and network devices), the provisioning of power, network access, and cooling, and the performance of duties requiring physical access to the hardware (including both the primary and disaster recovery sites).

The State shall host the Replacement MMIS, with the primary hosting location planned to be at the Clemson University data center. The disaster recovery site has not yet been chosen, but the State plans to secure an agreement with another suitable data center to supply these services that will be at least one hundred miles away from the primary hosting location.

Offerors shall propose system configuration requirements (including reasonable growth capacity that could be expected to be required during the Term of the Contract) with sufficient detail to enable the State to determine the hosting costs with reasonable accuracy and to determine the feasibility of supporting the system should any required parameters fall outside typical hosting requirements.

The State shall bear the costs of acquiring the necessary hardware, and facilities for hosting. The State shall also purchase maintenance support for the hardware and software at its discretion.

The Contractor shall operate the Replacement MMIS with the exception of the hosting duties (as described above). Because there are numerous details associated with hosting that may differ from solution to solution, Offerors shall identify the “seam” between the State and Contractor duties in the Hosting Statement of Work. This submittal shall also include any proposed performance standards and service level agreements between the Parties (i.e., in both directions), and necessary schedule commitments required to meet the needs of the Contract.

8.4.6.1 System Environments

In their Proposals, Offerors shall identify and describe in detail all necessary system environments including all necessary hardware and software. These environments must be suitable to perform all necessary functions such as testing, training, production operations, disaster recovery, etc.

The Contractor shall operate and maintain a separate non-production instance of the current production solution (a “Model Office”) for the purposes of providing business owners an environment to simulate and test the impact of potential changes to business processes and policies. During DDI, the Model Office should reflect the currently deployed increment and will also be used by the State to help become familiar with the solution. Contractor shall refresh the data available to business owners on a regular basis consistent with the performance standards for data maintenance in Attachment I.

The State understands that the Contractor may wish to host its own development environment; however, for all developed software that will be considered State Material, the Contractor shall replicate the development environment and documentation to a level suitable such that the State could successfully transfer responsibility of maintaining the software to a different entity.

The Contractor shall assist the State in setting up all environments and confirming that these environments meet the standards necessary to serve their intended purposes.

8.4.6.2 Clemson University Hosting Background

8.4.6.2.1 Data Center Capabilities

Clemson University will provide hosting services for the South Carolina Replacement MMIS. The primary hosting location will be Clemson’s Tier 3 data center in Anderson, South Carolina. The Clemson data center is home to the Palmetto Cluster (recently ranked as the 90th faster

supercomputer in the world and the 2nd fastest at a U.S. research university). The data center includes:

- Approximately 20,000 sq. ft of raised floor space
- 4.5 MW power feed with diesel generators backup
- 3 x 250-ton air-cooled water chillers (N+1) feeding 9 x 50-ton CRAC units all with generator power and DX-based CRAC units in power areas
- 24x7 NOC with on-site security and monitoring (primarily using HP OpenView)
- Ansul Sapphire fire suppression system
- Sun SL8500 tape library for on-site data backup with EMC's Legato backup agent
- Clemson maintains a secondary location for additional data backup approximately ten (10) miles away from the primary data center

Clemson maintains a redundant core of networking equipment and services including redundant connections to the commodity Internet. Clemson currently utilizes Cisco equipment for core routing, load balancing (Application Control Engines) and security (Firewall Service Modules and Intrusion Detection Modules).

8.4.6.2.2 Server Hardware Solutions

The hosting provider will provide the following four (4) classes of server. Although the specifics are expected to change over the life of the Contract, the general class of server will be maintained for new hardware acquisitions:

- Small – 1U or blade server with 4 cores, 16Gb memory and 146Gb mirrored local SAS drive space
- Medium – 1U or blade server with 8 cores, 32Gb memory and 146Gb mirrored local SAS drive space
- Large – 4U server with 8 cores, 64Gb memory and 146Gb mirrored local SAS drive space
- Extra Large – 4U server with 16 cores, 128Gb memory and 146Gb mirrored local SAS drive space

Dell's R610 and R910 are the current Intel/AMD preferred platforms. Oracle/Sun equipment is also supported.

The hosting provider deploys VMWare's ESX/ESXi hypervisor for virtualization.

8.4.6.2.3 Operating Systems

The hosting provider prefers the following operating systems:

- Redhat Enterprise Linux (RHEL 5.5 or above and using OEL for Oracle database servers)
- Windows 2008 or above

8.4.6.2.4 Storage

The hosting provider prefers the following storage systems:

- Hitachi AMS2100
- Qlogic Fibre Channel Switches
- Qlogic HBAs

8.4.6.2.5 Electronic Document Management System

The hosting provider prefers the following EDMS solution:

- Hyland Software OnBase

8.4.7 Call Center and Mailroom Infrastructure

The Contractor shall purchase and host the infrastructure associated with the call center and mailroom including any required hardware and software licensing associated with these activities.

8.4.8 System Performance

The Replacement MMIS must provide access and services on a 24-hour basis each day to the greatest extent affordable. Offerors should describe their solutions, its availability and performance capabilities. Offerors should design their overall solution such that availability and performance are effectively balanced with cost and value and describe their rationale and trade-offs.

9 Testing and Quality Management Strategy

9.1 Testing and Quality Management Objectives

The general testing and quality management objectives are as follows:

- Follow generally accepted quality management principles, such as those published by the International Standards Organization (ISO - <http://www.iso.org/iso/qmp>) and the Software Engineering Institute (SEI – <http://www.sei.cmu.edu/reports/07tn002.pdf>)
- Improve results and outcomes through the application of quality management principles.
- Incorporate testing and quality management as integrated processes in all phases of the Contract rather than as “bolt on” functions applied at the end of each process.
- Identify defects at the earliest practical opportunity.
- Use a unified defect tracking system (preferably COTS or open source) that is continuously available to the State.
- Use results of testing and quality management activities to reduce the occurrence of defects in future artifacts and processes (continuous improvement).
- Provide State and other users access to system capabilities as early as practical in order to gain feedback on quality.

9.2 General Quality Management Approach

Quality management is applicable to all activities conducted by and artifacts produced by every participating organization. While automation will help coordinate and ensure that these outputs are of high quality, ultimately, most quality measures will contain a substantial human element. The Contractor may use the standard verification methods of inspection, analysis, demonstration and test, as applicable.

Well-executed artifact reviews will be important to project success in quality management. Depending on the purpose, these activities may range from ad hoc, informal discussions up to formal, scheduled Fagan inspections. The originating organization must supply a timely, high

quality initial draft deliverable, and be responsive to the reviewers' inputs. Poor initial quality guarantees that a two-round review process will not succeed. This situation often results in "peeling the onion" on a deliverable whereby the more problems that are corrected, the more additional problems are discovered.

The State understands that the review process is often a sore spot in MMIS projects, and that contractors attempt to employ methods to reduce the risks associated with obtaining customer sign-offs. While many of those methods are prudent and acceptable, the following methods are examples of those that are not acceptable:

- Attempting to limit the review discussion or comments very narrowly to only the content of the specific Deliverable or addressing only comments from a previous round of review for a specific Deliverable. While random, wide-ranging conversations are not usually productive, the inter-related nature of the various elements on this program means that reviews must necessarily touch upon related topics in a controlled fashion.
- Attempting to queue up Deliverables over a short time period in such a fashion that the State (and other third party reviewers) cannot practically provide feedback in the designated time. The purpose of quality management is quality, not sign-offs. Offerors must propose schedules that reasonably space Deliverable reviews. If the IMS changes after contract award, the new schedule must also adhere to this principle.
- Attempting to limit review cycles to just two rounds for Deliverables that have significant quality issues upon initial delivery.
- Attempting to frame changes to signed-off Deliverables that are driven by the natural discovery process of software development as scope changes requiring Contract Change Orders. There is a difference between requirements changes and necessary Deliverable refinements. While parties can reasonably disagree over which category into which a change falls, the change itself does not automatically constitute scope creep.

The Contractor must track quality metrics and report on these metrics at least monthly. Offerors shall propose the quality metrics for the Replacement and Operations Phases.

9.3 General Testing Approach

The State's general philosophy for testing is:

- Testing should be comprehensive but not unnecessarily duplicative.
- Automated testing, particularly for regression testing, is crucial to program success. Automated testing must be extended to enable the pre-deployment evaluation of business and pricing rules changes during the Operations Phase.
- Early user testing can provide important opportunities to gain critical feedback and gain user support for the system.

The Contractor shall maintain an Integrated Test Facility (ITF) in the Columbia, SC area to facilitate user testing.

9.4 Vendor-Centric Testing

The following list identifies examples of potential vendor-centric testing:

- Unit testing
- Integration testing

- System testing
- Operational Readiness Testing or equivalent
- Regression testing and retesting
- Specialized testing such as security and performance testing
- Interface and integration testing with external entities

Offerors shall describe their testing strategies in their Proposals.

The State plans to oversee Contractor-centric testing on an as needed basis (particularly system testing and interface/integration testing with external entities), but will generally not intervene unless specific issues drive greater involvement. To avoid premature project progression, the Contractor shall define the entrance and exit criteria for each major test event, subject to State approval, and shall meet these criteria prior to beginning the test event or progressing to the follow on tasks respectively. Clemson University will support Contractor-centric testing as the hosting agent, as necessary.

ICD-10 poses a special challenge for testing on the Replacement MMIS project. The State's legacy remediation strategy will likely involve crosswalking to ICD-9 internally. As such, fee-for-service claims will likely pay very similarly to the current payment structure. The introduction of the Replacement MMIS will result in a more "true" implementation of ICD-10. The Contractor will need to conduct testing with providers and business partners that replicates ICD-10 migration testing to ensure that the South Carolina Medicaid network continues to function properly.

9.5 State-Centric Testing

The principal types of State-centric testing are UATs and User Feedback Tests (UFTs). UFTs are tests conducted on increments that will not be deployed separately, or for any increment for which early user feedback is prudent.

Consistent with the philosophy explained at the beginning of this section, UATs will not be a repetition of system testing. While targeted verification of vendor test results is likely, particularly for high risk areas, UATs will be geared towards execution of operational scenarios. While these tests, like any other disciplined test, will require planning and structure, they will frequently not be step-by-step, scripted tests. It is not possible to understand how a system will react to "real" users without letting these users exercise it the way they plan to do on a daily basis. Additionally, since training for a complex new system is crucial, the failure of the user-testers to be able to perform required functions will be a clear indication of problems in the system, its documentation, or the training that has been provided.

The Contractor shall plan for a 65 business day (roughly three months) final UAT, not including any fix/re-test/regression test cycles. Because each Offeror's incremental implementation strategy will be different, Offerors shall propose UAT timing and duration for all increments to be deployed. The State also plans to test non-deployed increments via UFTs so that all parties receive early feedback from real users on the success of developed components, Offerors shall also propose the timing and duration of these component operational test events.

The State's duties for UAT shall include:

- Leading the planning effort.
- Leading test execution.

- Obtaining participation of outside organizations (e.g., other State agencies, provider representatives, etc.) in the testing.
- Performing functions that will be State duties during the Operations Phase.
- Documenting the results of the testing.

The Contractor's duties shall include:

- Participating in planning, and leading detailed planning of test activities to be performed by the Contractor.
- Performing system setup, including test data.
- Participating in test execution, and leading detailed execution of test activities to be performed by the Contractor.
- Performing functions that will be Contractor duties during the Operations Phase.
- Analyzing and fixing system problems and documentation defects.

For UFTs, the duties shall be similar to those for UATs; however, given the non-deployable nature of the system under test, the Contractor shall take a greater role in planning and leading the testing activities to ensure success in obtaining user feedback.

9.6 Test Management Services

The State currently plans to use resources, external to this Contract, to perform test management services. These resources will serve as part of the State team. The Contractor shall cooperate with the test management team the same as other State participants.

9.7 Independent Verification and Validation (IV&V)

The State currently plans to use resources, external to this Contract, to perform IV&V services. These resources will serve as part of the State team. The Contractor shall cooperate with the IV&V team the same as other State participants.

9.8 SAS 70 Audit

At least every two years, the Contractor shall contract with an independent qualified audit firm to perform a Statement on Auditing Standards (SAS) 70 audit of the Replacement MMIS and related operations and will accommodate and provide information and facilities necessary for the external auditor to complete the audit and produce a SAS 70 Type 2 report. The audit and report shall include the operations of all sites used by the Contractor for Replacement MMIS processing or related activities.

10 Life-Cycle Support Objectives and Strategy

10.1 Training

The Contractor shall develop and deliver training for the entire spectrum of Replacement MMIS users, to include users from the State, the Contractor, other supporting contractors, providers, and members. The training materials and approach shall include sufficient information to enable trainees to accurately and efficiently perform all assigned tasks related to the Replacement MMIS and its supporting operations, including business processes. Given this wide spectrum of users, the training materials and methods of delivery will vary widely, and a single training

method is not always suitable for every user, even those using the Replacement MMIS in similar ways.

10.1.1 Training Goals and Objectives

The goals for training are:

- **Outcomes** – Improve the ability of all users to master applicable portions of the Replacement MMIS and related business processes.
- **Target audience** – Provide targeted initial and continuation training for State, provider, other Medicaid enterprise contractors, and member users.
- **Methods** – Improve knowledge transfer to trainees by providing multiple training methods tailored to the various user types.
- **Locations** – Improve access to training by making training available online, in person, and virtually to trainees throughout the State.
- **Quality** – Continuously improve training by collecting and acting upon feedback from the trainees.
- **Management** – Manage training for State users via a Learning Management System.

10.1.2 Training Plan

The Contractor shall develop a master Training Plan that describes all planned training classes, events, materials, and resources throughout the life of the Contract and shall be updated at least annually. Training classes shall be planned in order to balance the number of Training Days with the needs of those that requiring training. Each training class, its location (face-to-face or virtual), its duration and curriculum shall be pre-approved by the State in writing as part of the Training Plan. The State expects that most training materials will be online or in digital format, the Contractor shall produce materials, such as user manuals, in formats such that they can be easily printed by users preferring hard copy documents (e.g., PDF documents).

10.1.3 Training Supporting Incremental Implementation

As the project will not deliver all functionality and operations as a single event, training supporting the incremental DDI must be provided throughout the Replacement Phase. This training includes supporting not only the immediate deployment of new capabilities and operations, but also training supporting the testing of such capabilities and operations. The Contractor shall provide training to State testers in advance of performing testing. Because UATs will evaluate the quality of training and user documentation, this training and documentation shall be production ready prior to UAT for increments that are planned to be deployed shortly after completion of UAT.

By the time the final increment of the Replacement MMIS is ready to be deployed, the Contractor shall have completed the entire training package. Because each Offeror's incremental implementation strategy will differ, Offerors shall propose a strategy that provides comprehensive training yet manages the training to avoid unnecessary duplication.

Offerors shall propose a fixed price Contractor staff training and deployment package for each system increment to be deployed. Contractor staff training and preparation for the Operations Phase shall not be charged to the Replacement Phase labor hours.

10.1.4 Training Locations

Training for State users and users from other supporting contractors will normally be held in Columbia. SCDHHS has facilities suitable for training up to 20 users at a time. For larger groups or for multiple simultaneous training sessions, the State and Contractor shall work together to identify a suitable location at the State's expense.

The Contractor shall provide training for providers at locations around the State close to where the providers work. As part of a comprehensive training program, the Contractor shall create interactive online training for those providers needing refresher training or choosing not to participate in face-to-face training. Where it facilitates greater access or greater specialization for providers, the Contractor may use live interactive virtual training where the principal training staff is connected online to the trainees.

10.1.5 Training Maintenance and Upgrades

The Contractor shall maintain the training throughout the Operations Phase so that it is current, accurate, and remains consistent with the Replacement MMIS, policies, legislation, and other directives. The Contractor shall conduct proficiency testing for trainees as part of training events and also gather trainee feedback on the quality of the training. Training maintenance shall include updates necessary to address systemic learning issues and user feedback.

Training maintenance does not include updates driven by upgrades to the Replacement MMIS executed as part of Customer Service Requests or Contract Change Orders. When the system is upgraded via Customer Service Requests or Contract Change Orders, the Contractor's proposed solutions and prices for the changes shall include all necessary upgrades to the training.

10.2 Documentation

10.2.1 Contract Data Requirements List (CDRL)

Offerors shall propose additions to the CDRL. All data and documents required for the proper operation and maintenance of the Replacement MMIS and supporting operations shall be included on the CDRL, and all CDRL data items shall be considered Deliverables. For COTS components, the CDRL shall include technical documentation consistent with the Contractor's proposed long-term system maintenance concept. The CDRL shall include sufficient data items such that a follow on contractor or the State could successfully assume the duties of operations and system maintenance in the future. This documentation shall include business process models, State-led and Contractor-led, using Business Process Modeling Notation or other notation as approved by the State. For software whose rights are or will be owned by the State and/or Federal Government, or that are open source or public domain, the CDRL shall include all source code, build files, and other data required to properly modify and maintain that software.

The Contractor may use any reasonable format for data items with the State's approval.

10.2.2 Data Item Maintenance

The Contractor shall maintain all data items throughout the life of the Contract. Data item maintenance does not include updates driven by upgrades to the Replacement MMIS executed as part of Contract maintenance. When the system is upgraded via Customer Service Requests or

Contract Change Orders, the Contractor's proposed solutions and prices for the changes shall include all necessary upgrades to affected data items.

10.3 Help Desk

The Contractor shall operate a help desk accessible to users via telephone, e-mail, and via the Web. Personnel providing help desk services must be able to provide answers and responses, without limitation, for items such as:

- Inquiries on system processes and system troubleshooting from providers, value-added networks (VANs), State and Contractor users.
- General and technical support and questions.
- Electronic Data Interchange (EDI)-related questions and issues.
- User of the Web portal by providers, members, State, and Contractor users.
- Password reset procedures.
- Application and software support.

10.4 Facilities

The State has limited meeting facilities. While the State will make these meeting facilities available to the Contractor on an as available basis, the Contractor shall supply sufficient meeting space to satisfy meeting needs for its DDI strategy.

10.5 Hosting Maintenance

The State shall have the duty to operate and maintain the equipment used for hosting. The Contractor shall notify the State whenever it detects any problems with this equipment, or when the State needs to take any other action on an assigned duty that is required to keep the Replacement MMIS operating properly.

The Parties shall coordinate maintenance and scheduled upgrades to ensure maximum system uptime and to prevent system failures or security breaches.

11 Intellectual Property Strategy

The State requires the ability to operate and maintain the Replacement MMIS system independently of the original developer, and as such, must secure sufficient Intellectual Property Rights in and to the Replacement MMIS to enable the State to operate, maintain and support the Replacement MMIS. Section VII.B.25 sets out in detail the ownership and license rights the State requires in and to the Replacement MMIS.

The following list contains requirements and principles concerning the use and ownership of the Replacement MMIS:

- For the State to properly support, maintain, and operate the Replacement MMIS over its lifetime, the State must obtain the rights and licenses and obtain sufficient information, to perform such support functions, even after turnover.
- COTS Software will be licensed under terms set out in Section VII B. 25 below.
- The State may grant the Contractor the right to use certain State Materials including Custom Software as long as the Contractor ensures that no customer (public or private) remunerates the Contractor or its agents for the use of the State-owned IP, and the

Contractor can demonstrate a tracking process that ensures compliance. The Contractor must request such use in writing and identify the specific IP for which the Contractor wishes to use.

12 Business Process Model

This section provides an introduction to the South Carolina Medicaid business process model and links to the top-level objectives for each business area contained in various attachments. Greater detail on business objectives is contained in Attachments I, and J covering the the Medicaid Information Technology Architecture list of processes tailored for the State and the Medicaid Enterprise Certification Toolkit tailored for the State.

12.1 South Carolina Medicaid Business Process Model

The State modified the MITA business process model to improve its alignment with the SCDHHS organizational structure and the way the agency performs its operations. Other than modifying the assignment of business processes to business areas, no other substantive changes have been made. The information and technical architectures are not affected by this adjustment.

Figure III.12-1 shows the top-level South Carolina Medicaid business process model.

In Attachment I, the processes mapped to each business area are shown in tables associated with each South Carolina business area. The tables indicate whether the processes:

- Are primarily performed by the Contractor with State assistance.
- Are primarily performed by the State with Contractor assistance.
- Are shared between the State and Contractor.
- Are primarily performed by a third party (e.g., another contractor to the State) and supported by the State and Contractor.
- Are not performed in South Carolina at this time.

The details of duties shall be identified by Offerors in their Proposals. Offerors should refer to other sections of this Contract and current contracts from the Procurement Library for guidance in proposing the details of their solutions.

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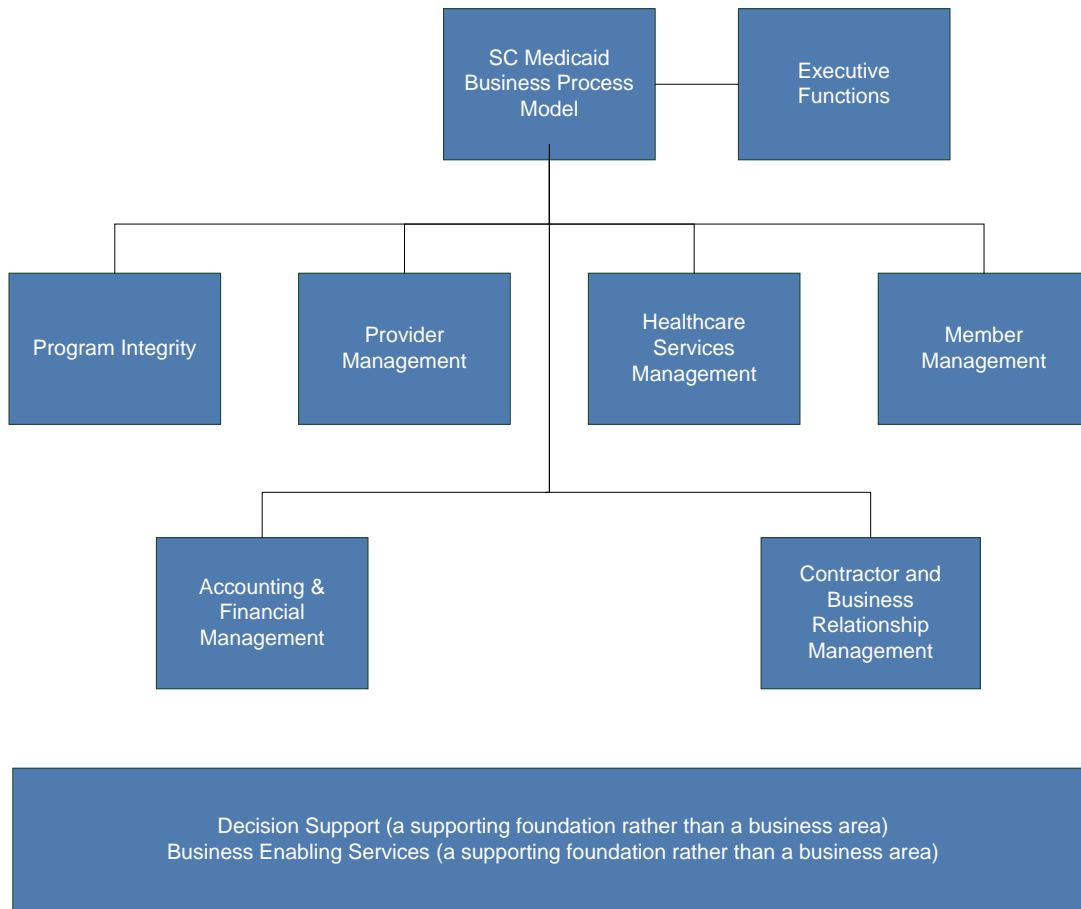


Figure III.12-1. South Carolina Medicaid Business Process Model

IV. Information for Offerors to Submit

1 INFORMATION FOR OFFERORS TO SUBMIT – GENERAL (JAN 2006)

Offeror shall submit a signed Cover Page and Page Two. Offeror should submit all other information and documents requested in this part and in parts II.B. Special Instructions; III. Scope of Work; V. Qualifications; VIII. Bidding Schedule/Price Proposal; and any appropriate attachments addressed in section IX. Attachments to Solicitations. [04-4010-1]

2 Administrative submission requirements

Offerors shall submit Proposals no later than the date and time, and in the manner and quantity, specified on the RFP Cover Page. The original Proposals shall be clearly marked as such. Offerors shall comply with Section IIA.26 of this RFP for any materials contained in their Proposal that are confidential. File formats shall be Portable Document Format (PDF) or Microsoft Office-compatible (the State is using Office 2007). The Proposal shall be submitted in the order and format described below, shall include a table of contents, and shall contain the content required for each section as specified in the various subsections of this section. The Technical Proposal shall not contain any proposed cost or pricing information.

The printed copies of the Technical Proposal and Cost Proposal shall be in separate binders, and the electronic copies shall be on separate CDs (for quantities of each, please see the Cover Page). The Cost Proposals do not need to be sealed in separate envelopes or packages. DVD-ROM, DVD+R, or DVD-R may be substituted for CDs, if appropriate, based on the size of the Proposal.

Submission of a Proposal shall constitute recognition, understanding, acceptance, and consent by the Offeror to adhere (without any reservation or limitation whatsoever) to the requirements, terms, and conditions of this RFP, including any RFP amendments. This consent to adhere to requirements shall also apply to the use of all forms and tables of this RFP.

The Proposal shall adhere to the page limitations specified for each section. Pages in the Proposal in excess of the specified limits shall be removed by the State and not considered for evaluation purposes. This includes but is not limited to any additional attachments and/or additional sections added to the Proposal.

Audio and/or videotapes or electronic files are not allowed and shall not be considered in the evaluation. Elaborate artwork or expensive paper is not necessary. The Proposal shall be printed on 8-1/2" x 11" paper, shall use 12-point font, and shall be single spaced using 6-point spacing between paragraphs. Font sizes as small as 8-points maybe used in graphical figures and in tables; however, Offerors shall not include large multi-page tables with small font for the purposes of circumventing the page limitations. The Proposal shall be printed double-sided and submitted in a loose-leaf notebook(s). Large tables or graphics may be printed on tabloid-sized paper (11" x 17"), and each side used for printing shall count as two pages for those sections with page limits (a tabloid page printed on both sides shall count as four pages).

Pricing tables may be submitted on any reasonably-sized paper sufficient to display each table in a manner that is easy to interpret..

3 SUBMITTING REDACTED OFFERS

You are required to mark the original copy of your offer to identify any information that is exempt from public disclosure. You must do so in accordance with the clause entitled "Submitting Confidential Information." In addition, you must also submit one complete copy of your offer from which you have removed any information that you marked as exempt, i.e., a redacted copy. The information redacted should mirror in every detail the information marked as exempt from public disclosure. The redacted copy should (i) reflect the same pagination as the original, (ii) show the empty space from which information was redacted, and (iii) be submitted on same type media as the original Proposal. Except for the redacted information, the CD/DVD must be identical to the original CD/DVD. Portable Document Format (.pdf) is preferred.

4 Proposal Structure

Table IV.3-1 identifies each of the sections of an Offeror's Proposal.

Technical/Cost	Section	Title
Technical Proposal	Section A	Transmittal Letter
	Section B	Executive Summary
	Section C	Proposed Solution
	Section D	Contract Data Requirements List
	Section E	Licensing Terms and Conditions
	Section F	Initial Risk/Issue Assessment
	Section G	Organization and Staffing
	Section H	System Screenshots
	Section I	System Demonstration and Key Personnel Interviews
	Section J	Corporate Background and Financial Reports (addressed in RFP Section V)
Cost Proposal	Section K	Pricing Tables (addressed in RFP Section VIII)
	Section L	Bases of Estimates (addressed in RFP Section VIII)

Table IV.3-1. Proposal Sections

5 Section A. Transmittal Letter

Subsection	Title	Page Limits
Section A	Transmittal Letter	N/A

Table IV.4-1. Transmittal Letter Section

The Transmittal Letter shall be included as part of the Technical Proposal. The Transmittal Letter must be on the Offeror's official business letterhead and must summarize the Offeror's ability to supply the required products and services that meet the requirements defined in this RFP. The transmittal letter should include the following:

- A statement indicating that the Offeror is a corporation or other legal entity.
- A statement indicating that the Offeror is licensed to do business in South Carolina (include license number) or, that business licensure is not required.
- A statement of affirmative action that the Offeror does not discriminate in its employment practices with regard to race, color, religion, age, sex, marital status, political affiliation, national origin, or handicap, except as provided by law.
- A statement indicating that the Key Personnel for the project will be those actually assigned. The Key Personnel will remain affiliated with this project full time throughout the term of the Contract as long as the Contractor employs them.
- A statement that no attempt has been made, or will be made, by the Offeror to induce any party to submit or refrain from submitting a proposal.
- A statement that the Proposal was developed without collusion.
- Signature of Authorized Representative. The Transmittal Letter must be signed by an individual who is authorized to commit the Offeror's organization and its representatives contractually to all statements, including services and prices, contained in the proposal.

The Offeror shall attach the following certifications (found in RFP Section IX) to the Transmittal Letter:

- Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion—Lower Tier Covered Transactions
- Certification for Contracts, Grants, Loans, and Cooperative Agreements Relating to Restrictions on Lobbying
- Minority Businesses
- Drug-Free Workplace Act
- Disclosure of Ownership and Control Interest Statement
- Organizational Conflict of Interest Disclosure (even if no conflicts exist)

6 Section B. Executive Summary

Subsection	Title	Page Limits
Section B	Executive Summary	10 pages + offshore work description (as applicable)

Figure IV.5-1. Executive Summary Section

The Executive Summary shall include a clear and concise summary of the Offeror's proposed solution to the requirements and objectives in this RFP as well as why the Offeror believes it offers the greatest value to the State with respect to this Contract. Offerors shall not include pricing information in the Executive Summary.

6.1 OFFSHORE CONTRACTING

Work that will be performed offshore by the Offeror and/or its Sub Offerors must be identified in the Offeror's response. For the purpose of this solicitation, offshore is defined as outside the 50 States and US territories. Offeror is to include an explanation for the following:

- (a) What type of work is being performed offshore?
- (b) Is this work being performed by the Contractor or by subcontractor(s)?
- (c) What percentage (%) of the total work is being performed offshore?
- (d) What percentage (%) of the total value of the contract is being performed offshore?
- (e) Provide a Service Level Agreement (SLA) demonstrating the arrangement between the off-shore organization or subcontractor and the Offeror.

7 Section C. Proposed Solution

Subsection	Title	Page Limits
Section C1	Discovery Phase Solution	15
Section C2	Replacement Phase Solution	100 + Increment Table
Section C3	Operations Phase Solution	100 + business process models + measurement processes
Section C4	Turnover Phase Solution	15
Section C5	Technical Solution	90 + User/Administrator Manuals + Developer documentation
Section C6	Security Solution	20
Section C7	List of Included System Reports	N/A
Section C8	Itemized List of Hardware and Software	N/A
Section C9	Testing and Quality Management Approach	30
Section C10	Statements of Work	N/A
Section C11	Offeror-Proposed Performance Standards	N/A
Section C12	Offeror-Proposed System Review Criteria	N/A

Section C13	Integrated Master Schedule	10 pages for overview plus MS Project plan (no page limit on plan)
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Table IV.6-1. Proposed Solution Sections

In the following sections, the Offeror shall describe how it intends to meet the requirements and objectives from the RFP. These sections should focus on the achievement of the State’s business objectives supported by the management and technical approach being proposed to meet these objectives.

Offerors must balance the “solution” sections with the Statement of Work sections. In general, the solution sections should cover concepts, processes, outcomes, and other similar information, while the Statement of Work sections should be focused on specific duties performed by the Contractor along with pertinent completion standards.

7.1 Section C1. Discovery Phase Solution

This section shall include, at a minimum (Offerors may cover additional topics if necessary to convey a complete solution):

- An overview of the proposed Discovery Phase solution.
- Any assumptions pertinent to the proposed solution.
- The Offeror’s strategy for achieving the Discovery Phase objectives and completing the Discovery Phase Deliverables.
- The Offeror’s expected outcomes for the Discovery Phase.
- The Offeror’s expectations for State or third party participation in the Discovery Phase.
- Other pertinent information.

7.2 Section C2. Replacement Phase Solution

This section shall include, at a minimum (Offerors may cover additional topics if necessary to convey a complete solution):

- An overview of the proposed Replacement Phase solution.
- Any assumptions pertinent to the proposed solution.
- The Offeror’s general strategy for achieving the Replacement Phase and DDI objectives.
- The Offeror’s proposed strategy for Replacement Phase efforts necessary to achieve CMS’ Seven Conditions for receiving enhanced FFP.
- The Offeror’s proposed project management strategy.
- The Offeror’s proposed technical management strategy (software engineering processes, software development life-cycle, etc.).
- The Offeror’s Replacement Phase system hosting strategy and requirements.
- The Offeror’s proposed incremental implementation strategy to include its approach to decommissioning existing capabilities and rollout new capabilities.
- Data conversion and migration strategy.
- The Offeror’s proposed training strategy including:

- Training planning
 - Training content creation
 - Training for personnel involved in testing
 - Training associated with deployable increments
- The Offeror's expectations for State or third party participation in the Replacement Phase.
 - Other pertinent information.

In addition, the Offeror shall attach a completed Increment Table that includes a description of each deployable or non-deployable increment proposed. Non-deployable increments only need to be included if they are substantial enough to warrant a full User Feedback Test. The Increment Table does not count against the page limit for this Proposal section.

The fields for the Increment Table are as follows:

- **Increment Number** – this is the increment number as defined by the Offeror.
- **Increment Name** – this is the name of the increment as defined by the Offeror.
- **Contract Month of Completion** – this is the Contract month that an increment will become operational (for increments being immediately deployed) or for which the User Feedback Test will be completed (for increments not being immediately deployed).
- **Deployed Upon Completion (Yes/No)?** – this identifies whether or not this increment will be immediately deployed upon completion.
- **Brief Description of Increment** – this is a brief description of the increment including any legacy system functionality, business operations services, and contracts intended to be retired by this increment.
- **MITA Business Processes Met by this Increment** – this is a list of the MITA business processes that will be satisfied by this increment, including both system functionality and business operations services. Offerors should identify the MITA business processes by both ID (e.g., “OM02”) and name (e.g., “Authorize Service”). If a MITA business process will only be partially satisfied by this increment, then the Offeror shall place the word “Partial” in parentheses after the MITA business process name.
- **Explanation of “Partials” (MITA)** – this is a brief description of the level of satisfaction of the MITA business processes marked as “Partial” for this increment.
- **MECT Business Objectives/System Review Criteria Met by this Increment** – this is a list of the MECT business objectives and system review criteria satisfied by this increment. Due to the large number of these items, the Offeror need only identify the business objectives and system review criteria by their IDs (e.g., “CA1.2”). If a MECT business objective or system review criterion will only be partially satisfied by this increment, then the Offeror shall place the word “Partial” in parentheses after the business objective or system review criterion ID.
- **Explanation of “Partials” (MECT)** – this is a brief description of the level of satisfaction of the MECT business objectives and system review criteria marked as “Partial” for this increment.

7.3 Section C3. Operations Phase

This section shall include, at a minimum (Offerors may cover additional topics if necessary to convey a complete solution):

- An overview of the proposed Operations Phase solution.
- Any assumptions pertinent to the proposed solution.
- The Offeror's general strategy for achieving the operations objectives.
 - Member Management strategy (as applies to this contract)
 - Provider Management strategy
 - Healthcare Services Management strategy
 - Accounting and Financial Management strategy
 - Business Relationship Management
 - Program Integrity strategy (as it applies to this contract)
 - General & Systems Processes strategy
- The Offeror's proposed strategy for Operations Phase activities needed to achieve CMS' Seven Conditions for receiving enhanced FFP.
- The Offeror's proposed operations management strategy.
- The Offeror's proposed systems operations and hosting strategy.
- How the Offeror plans to measure process results in order to accurately report on performance standards identified in Annotated MITA Business Process Matrix in Attachment I.
- The Offeror's life-cycle support strategy including:
 - Maintenance and upgrade strategy for software of all applicable license types including COTS, GOTS, open source, public domain, and custom
 - Ongoing data management, governance, and stewardship
 - Ongoing training
 - Training maintenance
 - Documentation and documentation maintenance
 - Facilities
 - Help desk
- The Offeror's expectations for State or third party participation in the Operations Phase. This participation should be identified in relation to a MITA business process, where applicable.
- Other pertinent information.

The Offeror shall include business process models for those processes identified in Attachment I whose principal duties are assigned to the Contractor, not including the General & System Processes. The business process models shall be represented in Business Process Modeling Notation (BPMN – also known as Business Process Model and Notation). The State prefers BPMN version 1.2; however, versions 1.1 and 2.0 beta are acceptable, as well. The process models do not count against the page limits for this Proposal section.

The Offeror shall include an attachment to this Proposal Section containing a set of explanations of how it plans to measure its performance against the Operations Phase performance standards. This attachment shall be limited to performance standard measurements, and does not count against the page limits for this Proposal section.

7.4 Section C4. Turnover Phase

This section shall include, at a minimum (Offerors may cover additional topics if necessary to convey a complete solution):

- An overview of the proposed Turnover Phase solution.
- Any assumptions pertinent to the proposed solution.
- The Offeror's proposed solution to ensure that turnover is successful and proceeds smoothly.
- Expectations for State, incoming contractor, or other State contractor participation.
- Other pertinent information.

7.5 Section C5. Technical Solution

This section shall address the technical objectives from the RFP including, but not limited to, RFP Section III.8. Offerors may cover additional topics, as desired, within the page limitations.

The Offeror shall also address the following items:

- A description of the system architecture, at a level appropriate for a system-level understanding, including the following:
 - Logical view.
 - Physical view (must be consistent with the itemized list of hardware and software and organized by environments submitted in Proposal Section C8).
- A description of the Offeror's interface and integration strategy for the enterprise.
- A description of how the Offeror's technical solution achieves the relevant portions of CMS' Seven Conditions for receiving enhanced FFP.
- 5010/ICD-10/NCPDP D.0 strategy and schedule (including how to deal with ICD-9 claims and history).
- A product roadmap highlighting the planned improvements the Offeror or its suppliers/subcontractors will make in major software components, including features and their timelines.
- The Offeror's strategy for ensuring that custom development is sustainable over the system life-cycle.
- The Offeror's approach to COTS product upgrades and obsolescence over the lifetime of the system.
- Include copies of the user's manual and administrator's manual that most closely match the proposed system.
- Include technical documentation describing the system's exposed interfaces (services, application programming interfaces, etc.) and how they may be employed.

7.6 Section C6. Security Solution

The Offeror shall describe its proposed strategy and capabilities for systems, operational, and physical security and how these address the security and privacy objectives and requirements in the RFP.

7.7 Section C7. List of Included System Reports

The Offeror shall provide a list of all of the standard system reports included with the proposed solution.

Attachment O contains a template for the report list. Offerors shall use this template or a reasonable facsimile. The fields for this template are as follows:

- Report ID – this is the Offeror defined identification for the report
- Report Name – this is the Offeror-defined name for the report.
- Report Description – this is a brief description of the contents of the report.

7.8 Section C8. Itemized List of Hardware and Software

The Offeror shall provide an itemized list of hardware and software needed to operate all required system environments (including the disaster recovery environment(s)) with sufficient detail to allow the State to estimate hosting costs (including necessary capital investments as well as daily operations). As this section will be used for the estimation of hosting costs, Offerors shall not add any other information or descriptions to this section not needed for hosting estimation, as described below.

Attachment R provides a template for identifying the list of hardware items. Offerors shall use this format or a reasonable facsimile. The following describes the fields contained in this list:

- Hardware Bill of Materials (BOM)
 - **BOM Item Number** – this is a sequential alphanumeric numbering scheme beginning with the letter “H.”
 - **Manufacturer** – this is the manufacturer of the hardware item.
 - **Item Description** – this is a brief description of the item along with the manufacturer’s nomenclature for the hardware item. For commodity servers, the Offeror shall use the “Small Server,” “Medium Server,” “Large Server,” or “Extra Large Server” nomenclature described in RFP Section III.8.4.6.2.2.
 - **Quantity** – this identifies the quantity of the hardware items to be procured as defined by the Description field. For example, if a hardware item is supplied in pairs, then a Quantity of “1” would indicate one pair.
 - **Okay to Substitute?** – this field indicates that it is acceptable to substitute a similar or better item from the same or a different manufacturer.
 - **Environment** – this identifies the environment to which the hardware item is assigned. The environments must be consistent with those identified in Section C5 of the Offeror’s Proposal. Hardware items used for multiple environments should be describe as “General” in this field.

- **OS** – this identifies the operating system(s) associated with the hardware item. If multiple operating systems (or multiple versions of a single operating system) will be used in a virtualized environment, identify all applicable operating systems. If no operating system is applicable, enter “N/A.”
- **Month Required** – this is the Contract month (1-48) in which the hardware item must be acquired and in place. This date must account for any additional time needed to configure and integrate the hardware item and any related software after procurement.
- **Related BOM items** – this identifies the BOM Item Numbers of any related hardware or software items that must be installed concurrently with the hardware item identified on a particular line.
- **Notes** – this identifies any other information that the State would need to understand about the hardware item or to properly estimate its cost.

Attachment S provides a template for identifying the list of software items. Offerors shall use this format or a reasonable facsimile. The following describes the fields contained in this list:

- **Software Bill of Materials**
 - **BOM Item Number** – this is a sequential alphanumeric numbering scheme beginning with the letter “S.”
 - **Manufacturer** – this is the manufacturer of the software item.
 - **Item Description** – this is a brief description of the item along with the manufacturer’s nomenclature for the software item.
 - **Licensing Model** – this identifies whether the software is licensed by server, central processing unit (CPU), client, concurrent connection, unlimited, or any other method.
 - **Maintenance Approach** – this identifies the maintenance method for this software item. For software items having multiple maintenance options, this item should indicate the Offeror’s recommended maintenance approach.
 - **Quantity** – this identifies the quantity of the software items to be procured as defined by the Description and Licensing Model fields. For example, if a software item is licensed per CPU, then a Quantity of “4” would indicate licenses for four CPUs.
 - **Environment** – this identifies the environment to which the software item is assigned. The environments must be consistent with those identified in Section C5 of the Offeror’s Proposal. Software items used for multiple environments should be describe as “General” in this field (note: “General” indicates individual software items used across multiple environments, not identical individual software items each used in different environments. For example, use different line items for the Web server needed for a development environment, training environment, production environment, etc.).
 - **OS** – this identifies the operating system associated with the software item.
 - **Month Required** – this is the Contract month (1-48) in which the software item must be acquired and in place. This date must account for any additional time

needed to configure and integrate the hardware item and any related software after procurement.

- **Related BOM items** – this identifies the BOM Item Numbers of any related hardware or software items that must be installed concurrently with the software item identified on a particular line.
- **Notes** – this identifies any other information that the State would need to understand the software item or properly estimate its cost.

7.9 Section C9. Testing and Quality Management Approach

This section shall include, at a minimum (Offerors may cover additional topics if necessary to convey a complete solution):

- A description of the Offeror's quality management approach and processes.
- A description of how the Offeror measures the results of quality management activities and uses these results to evaluate the maturity of the system and business operations, and how the results are used to improve future quality.
- A description of the Offeror's testing approach and processes.
- A description of specific test events associated with releasing a system increment.
- A description of the Offeror's approach to the test/fix cycle during system testing and user acceptance testing.
- A description of the Offeror's approach to automated testing including when automated testing is or is not appropriate.
- The Offeror's expectations for State or third party participation in testing and quality management.
- Other pertinent information.

7.10 Section C10. Statements of Work

The Offeror shall provide a Statement of Work (SOW) for each of the categories listed below. Each category shall be in a separate subsection. The Hosting SOW shall also contain a subsection outlining the Offeror's work expectations from the State's hosting duties.

- Discovery Phase
- Replacement Phase
- Operations Phase
- Turnover Phase
- Hosting (including disaster recovery)

The Statement of Work shall be constructed as a performance work statement in tabular form. The elements (columns) shall contain, at a minimum:

- **ID** – numbering nomenclature is at the Offeror's discretion. The Offeror shall use a unique nomenclature for each SOW.
- **Work to be Performed** – a concise description of what the Offeror proposes to do. References to other plans or process documents may be used to avoid duplication.

- **Completion Standards** – a targeted level of accomplishment associated with the desired set of outcomes and expectations. The standards should be readily observable. Offeror-proposed completion standards in the SOWs will not be considered in determining quality incentives during the Operations Phase (as described in RFP Section III.4.5.4.2).
- **References** – this identifies the RFP objectives and/or requirements being satisfied in part or in whole by a particular line item. The Offeror may add other columns (e.g., CDRL data items associated with a line item, references to work breakdown structure numbering, or Integrated Master Schedule numbering, etc.) at its option.

7.11 Section C11. Offeror-Proposed Performance Standards

The Offeror shall submit a completed version of the Offeror-Proposed Performance Standards shown in Attachment I. Performance standards proposed as part of Proposal Section C11 will be used in determining quality incentives during the Operations Phase (as described in RFP Section III.4.5.4.2).

7.12 Section C12. Offeror-Proposed System Review Criteria

The Offeror shall submit completed versions of its proposed System Review Criteria for State-specific Business Objectives in Attachment J. The Offeror shall list the Business Objective followed by the proposed System Review Criteria supporting that Business Objective. The Business Objectives should be addressed in their order of appearance in Attachment J, and the Offeror shall use a format similar to the original CMS System Certification checklist.

7.13 Section C13. Integrated Master Schedule

The Offeror shall submit a single IMS covering the Discovery and Replacement Phases and a separate IMS for the Turnover Phase (with dates consistent with the Contract terminating normally on the seventh anniversary of the planned Contract award date shown on the Cover Page). The IMS electronic version of the IMS shall be submitted in Microsoft Project 2003 or 2007 format. This section shall contain:

- Overview – a discussion of key elements of both IMS'.
- Discovery Phase + Replacement Phase IMS
- Turnover IMS.
- Basis of estimate for each IMS. These BOEs shall be similar to those used for the Cost Proposal, but shall not include any cost information.

The submitted plans must be provided in detail for at least the first 90 days of each IMS, except the Turnover IMS, which shall have sufficient detail for the State to understand the general strategy.

Offerors shall include a printed copy of the project plan in their Proposals as well as the Microsoft Project file on the CD/DVD submittals. The Microsoft Project version shall contain the estimated labor hours to accomplish the tasks on the plan, and these shall be consistent with the cost and schedule BOEs.

8 Section D. Contract Data Requirements List

Subsection	Title	Page Limits
Section D1	Management Data Items	N/A
Section D2	Technical Data Items	N/A
Section D3	Testing and Management Data Items	N/A
Section D4	Life-Cycle Support Data Items	N/A
Section D5	Other Data Items	N/A

Table IV.7-1. Contract Data Requirements List Sections

This section contains the Offeror's proposed CDRL. The State has provided descriptions for those data items identified in the RFP. The Offeror shall include these data item descriptions in its proposed CDRL along with additional data item descriptions being proposed by the Offeror. The Offeror shall use a format similar to the one used in the State-identified data item descriptions.

The data items represented on the CDRL are crucial to the success of the project. Offerors should not assume that a lack of specificity by the State indicates a lack of importance of relevant Contract data.

The CDRL shall be divided into subsections as identified below:

8.1 Section D1. Management Data Items

- General management-oriented data items
- Change management-oriented data items
- Financial/Contractual/Schedule data items
- Project-oriented data items
- Operations-oriented data items

8.2 Section D2. Technical Data Items

- Process-oriented data items
- Requirements-oriented data items
- Architecture- and Design-oriented data items
- Construction-oriented data items (note: this would include source/executable code and configuration items, as applicable)
- Security-oriented data items

8.3 Section D3. Testing and Quality Assurance/Quality Control Data Items

- Testing-oriented data items
- QA/QC-oriented data items

8.4 Section D4. Life-Cycle Support Data Items

- Training data items
- Hosting-oriented data items
- Data management- and stewardship-oriented items
- Other life-cycle data items

8.5 Section D5. Other Data Items

The Offeror may include pertinent data item descriptions in this subsection that it feels do not appropriately belong in another subsection.

9 Section E. Licensing Terms and Conditions

Subsection	Title	Page Limits
Section E	Licensing Terms and Conditions	N/A

Table IV.8-1. Licensing Terms and Conditions Section

This section shall contain any additional terms and conditions proposed by the Offeror for COTS Software.

10 Section F. Initial Risk and Issue Assessment

Subsection	Title	Page Limits
Section F1	Initial Risk Assessment	1 page each per risk
Section F2	Initial Issue Assessment	1 page each per issue

Table IV.9-1. Initial Risk and Issue Assessment Sections

This section consists of a list of significant risks and issues affecting the strategy or execution during all phases of the Contract. Each risk shall contain at least the following:

- **Risk/Issue Title.**
- **Phase(s)** – the phase or phases to which the risk/issue applies.
- **Risk/issue description (w/root cause)** - this is a brief description of the risk/issue that includes a clear identification of the expected root cause(s).
- **Impact Description** – this is a brief description of the impact of the risk/issue should it occur.
- **Probability** – select one of the following: Very Unlikely, Somewhat Unlikely, About Even, Somewhat Likely, Very Likely. This field is not applicable to issues.
- **Impact Severity** – select one of the following: Negligible, Minor, Moderate, Serious, Critical
- **Risk Severity** – select one of the following: Low, Medium, High. Figure IV.9-1 indicates the matrix to be used to determine the risk severity. This field is not applicable to issues.

- **Probability Mitigation Tasks** – this is a list of the principal actions that should be taken to minimize the probability of a risk being triggered (if probability can be mitigated for a particular risk). This field is not applicable to issues.
- **Impact Mitigation Tasks** – this is a list of principal actions that should be taken to mitigate the impact an issue or a triggered risk. (if the impact can be mitigated for a particular issue or risk).
- **Other Pertinent Information** – this contains any other information the Offeror deems useful to describe the management strategy for the risk or issue.

A template for risks and issues is in Attachment N. Offerors shall use this template or a reasonable facsimile on which to identify risks and issues. Offerors should also note that pertinent risks and issues should be discussed in other sections of the Proposal to help form a complete solution.

Critical	L	M	H	H	H
Serious	L	M	M	H	H
Moderate	L	M	M	M	H
Minor	L	L	L	M	M
Negligible	L	L	L	L	L
	Very Unlikely	Somewhat Unlikely	About Even	Somewhat Likely	Very Likely

Figure IV.9-1. Risk Matrix

11 Section G. Organization and Staffing

Subsection	Title	Page Limits
Section G1	Overview and Organization	25
Section G2	Key Personnel	3 pages per résumé
Section G3	Position Descriptions and Qualifications	1 page per labor

		category
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Table IV.10-1. Staffing Sections

In this section, the Offeror shall describe its proposed organization, Key Personnel, and position descriptions for all phases of the Contract.

11.1 Section G1. Overview and Organization

The Offeror shall describe its proposed organization for the each Phase of the Contract (Discovery, Replacement, Operations, Turnover). The description of the Turnover Phase organization should focus on organizational differences from the Operations Phase organization.

The descriptions shall include organization charts that identify positions. This section shall also include a discussion of the strategy for the organizational structure, and how this structure will contribute to project success.

The Offeror shall identify its subcontractors (if any) along with a brief description of why it chose these subcontractors.

11.2 Section G2. Key Personnel

The Offeror shall identify its proposed Key Personnel and provide resumes for these persons. At a minimum, the following positions shall be Key Personnel (or equivalent duty positions in the Offerors corporate structure):

- Account Manager
- DDI Manager
- Operations Manager
- Medical Director

The Offeror may identify other Key Personnel indicating its commitment to team stability. For each Key Personnel position for which the Offeror has already identified the assigned staff member, the Offeror shall include a résumé with reference contact information.

11.3 Section G3. Position Descriptions and Qualifications

The Offeror shall submit a position description and qualifications for each labor category identified on the proposed organization charts or identified on Pricing Table D (Labor Rates). Information for each position shall include at least:

- Labor category title
- Position description
- Required education, training, licensure, and certification
- Required experience
- Specific skills or knowledge required
- Whether the position is exempt, non-exempt, or billable hourly and whether the position will bill on a 40-hour maximum week or will bill all hours worked
- Other pertinent information

12 Section H. System Screenshots

Subsection	Title	Page Limits
Section H	System Screenshots	2 pages per screenshot (cumulative, not each)

Table IV.11-1. System Screenshots Section

The Offeror shall identify all of the screens in its proposed system. This section serves as a catalog of major system features, a mapping to the related MITA business processes and MECT system review criteria, and as a guide for the hands-on system demonstration conducted by the State. The format for the System Screenshots section is shown in Attachment M. Offerors shall use this template or a reasonable facsimile.

The fields of this template are as follows:

- **Screenshot Name.** The Offeror shall identify the name of the screen.
- **Screenshot.** The Offeror shall insert a picture of the screen. To conserve space, the Offeror should scale the screen to fit on the template and use a graphic that has high enough resolution so that the State can clearly read the contents of the screen. If magnification is needed, the State will review the screen on a computer. For screens containing user interface elements whose settings substantially change user interface itself (e.g., tabs), the Offeror may include a separate screenshot for each major configuration. Offerors shall not include separate screenshots to demonstrate individual settings on the screen (e.g., separate selections for dropdown menus).
- **Brief description of the screen.** This should include sufficient description to identify the purpose of the screen. Information contained in other sections of the Proposal need not be repeated here.
- **Pertinent limitations.** The Offeror should identify any pertinent limitations of this screen that may not be obvious from the screenshot or description (e.g., a business-oriented configuration setting whose choices are not user configurable).
- **Screenshot from current production system (Yes/No)?** This indicates whether the screenshot is from a version of the Offeror's system currently in production for one or more customers.
- **Subsystem/Application/Service.** This should identify the subsystem, application, or service to which this screen belongs.
- **MITA business processes directly enabled/performed on this screen.** This should identify those MITA business processes that the screen directly enables or on which a user performs/manages the business process. It is likely that a system may have many general purpose screens that affect large numbers of processes. Offerors enter "General purpose" in this field for those types of screens. The State expects that all in-scope MITA business processes will map to at least one screen.
- **MECT checklist system review criteria satisfied by this screen.** This should include all system review criteria satisfied by this screen. It is likely that a system may have

many general purpose screens that affect large numbers of processes. Offerors enter “General purpose” in this field for those types of screens. The State expects that all in-scope system review criteria will map to at least one screen.

- **Configurable parameters set via this screen.** This should identify all configurable system parameters that are actually set (configured) on this screen.

13 Section I. Oral Presentation and System Demonstration

Subsection	Title	Page Limits
Section I1	System Demonstration	N/A
Section I2	Oral Presentation	N/A

Table IV.12-1. System Demonstration Section

13.1 Section I1. System Demonstration

Offerors whose Proposals are not otherwise rejected shall be required to conduct a system demonstration consisting of three parts:

- Offeror-conducted demonstration.
- Offeror-led, State-conducted, hands on demonstration
- Independent State-conducted demonstration via a “sandbox” system

The State will notify selected Offerors as far in advance as practical of the dates for the demonstration.

The purpose of the System Demonstration is to provide the State with insight to the Offerors’ proposed technical solutions for the Replacement MMIS in a more direct way than can be obtained via a written Proposal. Offerors may present a brief overview at the beginning of the presentation; however, due to the limited time available for the demonstration, the State recommends keeping this introduction brief. Offerors may use slides during the demonstration to help orient the participants to the capabilities being demonstrated at any given time; however, the presentation slides will not be evaluated. Offerors shall not use the slides to present general Proposal content. **The Offeror’s slides must be submitted with its written Proposal as Section I1.**

Four days will be available to conduct the demonstration. Two days (nominally Monday and Tuesday) will be available for the Offeror to present features of its proposed system to the State and two additional days (nominally Thursday and Friday) will be available for the State to conduct hands on evaluation with the Offeror’s assistance. The demonstration shall normally begin each day at 9:00 A.M and shall normally complete at 4:50 P.M. There shall be ten-minute breaks from 50 minutes past the hour until the top of the hour each hour. There shall be a lunch break from 11:50 AM – 1:00 P.M. Discussions with the State concerning the Offeror’s Proposal shall not continue during breaks or outside of the presentation room.

Offerors may demonstrate parts of their systems at their choosing; however, the State requires the following aspects be demonstrated in a business context:

- Major features supporting the Medicaid Enterprise Certification Toolkit checklist Business Objectives and System Review Criteria.
- Configurable features and methods of configuring the system.
- Reporting capabilities
- Sign-on and session management capabilities
- Multi-window capabilities

and the following aspects in a technical context:

- Role-based security and how to establish and assign roles
- Extensibility of the system and how developers would go about extending the system capabilities without needing to modify the core product source code

The Offeror may demonstrate non-production elements of the proposed system but may not demonstrate elements of any system not intended to be part of the proposed system. The Offeror shall clearly identify during the demonstration any portion of its system that is not currently in production at a client site. This identification shall be consistent with the System Screenshots section of the Offeror's Proposal.

The Offeror shall provide a guided introduction of its system to users during the hands-on section of the system demonstration which shall not exceed four hours. The remainder of the time shall be used by State personnel for personal exploration of the Offeror's system. The Offeror shall support this portion of the demonstration with experts who can assist State personnel and answer questions about the system.

The System Demonstration will be conducted at a location provided by the Offeror within 15 miles of the SCDHHS Headquarters in Columbia, SC. The Offerors shall supply six computers for State use during the hands-on portion of the System Demonstration, and the State will bring additional laptop computers and mobile devices (e.g., iPad) for use during this portion of the demonstration. The Offeror shall supply Wi-Fi access for the State-supplied computers. The State plans to have approximately 25 total users during the hands-on demonstration and an additional five participants. The Offeror shall supply tables and chairs suitable for note-taking and computer operation during the System Demonstration. For those Offerors invited to conduct a System Demonstration, the State will provide refined attendance information in the invitation letter.

The State will **not** record the System Demonstration via audio, video, or other electronic means, and the Offeror shall be restricted likewise.

For at least 45 calendar days after completion of the system demonstration, the Offeror shall make available to the State, via Web/remote access, a fully operational demonstration system with at least 12 user accounts and two administrator accounts (including read-only database access). This system shall be populated with representative notional or de-identified data sufficient for the State to evaluate the system capabilities. The Offeror shall provide a contact telephone number and e-mail address at which the State can contact the Offeror during normal business hours (8:00 AM – 5:00 PM) for assistance in using the system. The Offeror should make its best reasonable efforts to ensure one business day turnaround or less on support requests.

13.2 Section I2. Oral Presentation

The Offeror shall make an Oral Presentation covering certain aspects of its Proposal. Optimally, this will occur the business day after completion of the Offeror-conducted demonstration (i.e., Wednesday); however, the timing and order of events may be adjusted, per the State's discretion.

The purpose of the Oral Presentation is to enhance the State's understanding of the topics presented in order to facilitate the State's evaluation. The Offeror shall not introduce new material as part of the Oral Presentation.

The Oral Presentation shall normally begin at 9:00 AM and conclude no later than 3:50 PM. There shall be ten-minute breaks from 50 minutes past the hour until the top of the hour. There shall be a lunch break from 11:50 AM – 1:00 PM. Discussions concerning the Offeror's Proposal shall not continue during breaks or outside of the presentation room.

The Offeror shall present on the following topics:

- (D) The Offeror's strategy for incremental implementation.
- (A) The Offeror's strategy and logic for choosing its subcontractors (if any).
- (T) An overview of the exposed system interfaces (services, application programming interfaces, etc.) and how these can be employed to reuse system capabilities and extend system functionality.
- (O) An overview of the Offeror's BPMN models submitted with its Proposal and how these processes represent best practices.
- (O) How the Offeror derived its Operations Phase staffing model and why this model was chosen.

The topics above are marked indicating the State's preference for the person making the presentation as follows:

- (D) – the Offeror's proposed DDI Manager
- (A) – the Offeror's proposed Account Manager
- (T) – a technical lead or system architect the Offeror plans to assign to this project
- (O) – the Offeror's proposed Operations Manager

The Offeror's slides must be submitted with its written Proposal as Section I2.

Oral Presentations are not clarifications, discussions, or negotiations.

The same requirements for facilities and the same restrictions on recording apply to the Oral Presentations as they do to the System Demonstrations.

14 Other Proposal Sections

14.1 Section J. Corporate Background and Financial Reports

The requirements for this section of the Offeror's Proposal are described in RFP Section V, Qualifications.

14.2 Cost Proposal

14.2.1 Section K. Pricing Tables

The requirements for this section of the Offeror's Proposal are described in RFP Section VIII.

14.2.2 Section L. Bases of Estimates

The requirements for this section of the Offeror's Proposal are described in RFP Section VIII.

V. Qualifications

1 QUALIFICATION OF OFFEROR (JAN 2006)

To be eligible for award of a contract, a prospective contractor must be responsible. In evaluating an Offeror's responsibility, the State Standards of Responsibility [R.19-445.2125] and information from any other source may be considered. An Offeror must, upon request of the State, furnish satisfactory evidence of its ability to meet all contractual requirements. Unreasonable failure to supply information promptly in connection with a responsibility inquiry may be grounds for determining that you are ineligible to receive an award. S.C. Code Section 11-35-1810. [05-5005-1]

2 Qualifications – Required Information

The Offeror shall submit the information requested in RFP Section V for the Offeror and any Subcontractor, if the value of Subcontractor's portion of the work exceeds 10% of the Offeror's proposed Target Labor Price for the Discovery and Replacement Phases or exceeds 10% of the Offeror's total prices for the Operations Phase. Identify potential Subcontractors by providing the business name, address, phone, taxpayer identification number, and point of contact. In determining the Contractor's responsibility, the state may evaluate its proposed Subcontractors.

3 Section J. Corporate Background and Financial Reports

Subsection	Title	Page Limits (each for the Contractor and applicable subcontractors)
Section J1	Corporate Background	10 pages
Section J2	Relevant Experience and References	10 pages overview + Experience Table + 5 pages each per detailed reference (up to 5 detailed references)
Section J3	Financial Information	N/A
Section J4	Penalties and Damages Asserted	N/A

Table V.3-1. Corporate Capabilities and Financial Reports Sections

3.1 J1. Corporate Background

The Offeror shall describe the general structure and capabilities of its company or of the business unit that will service this Contract. In particular, this subsection shall describe its corporate skills and background and how these will contribute to successful Contract performance and provide the greatest value to the State.

This section shall also include an organizational chart showing how this Contract will fit into the Offeror's organization.

3.2 Section J2. Relevant Experience and References

The Offeror shall describe its relevant MMIS and related Medicaid operations experience or equivalent experience in other government or commercial insurance programs. This should include a description of engagements/contracts on which the Offeror has performed services similar to those required in this Contract during the last seven years. Relevant experience must be limited to the business unit/location that the Offeror proposes to perform on this Contract or a direct successor organization.

The Offeror shall list all engagements/contracts supporting the relevant experience over the last seven years on the Experience Table using the template in Attachment P or a reasonable facsimile. There is no limit to the number of relevant engagements/contracts that may be listed in the Experience Table, and this table does not count towards the page limit for this section.

Additionally, for up to five of the most relevant references on the Experience Table, Offerors shall describe the following (on pages separate from the Experience Table):

- The contract or project name from the Experience Table.
- The customer.
- The beginning and end dates of the contract.
- Current contact information for a customer reference for the contract.
- A brief description of the scope of the work performed on the contract.
- The outcome of the contract (in progress, completed full term, completed partial term (some options not awarded), terminated early) and, unless in progress or the full contract term was completed, a description of why the contract was terminated.
- The Offeror's staff size and the size of the overall project team (including the customer, other vendors, and other participating organizations).
- Any lessons learned from the project relevant to the implementation and operations of an MMIS or conduct of Medicaid business operations.

The State may contact and use for evaluation purposes any references provided by the Offeror or any other references having direct knowledge of the Offeror's past performance and experience.

3.3 Section J3. Financial Information

The Offeror shall submit the three most-recent years of Annual Reports (for publicly traded companies), audited financial statements (for privately held companies), or unaudited financial statements and tax returns (for privately held companies for which audited statements are not available).

If an Offeror does not have three years of such documentation, it shall submit the relevant documentation that it does have going back no more than three Offeror fiscal years.

3.4 Section J4. Penalties and Damages Asserted

The Offeror shall describe any damages, penalties or credits issued, individually in excess of one hundred thousand dollars (\$100,000.00) that it or its majority-owned subsidiaries have paid, or which have been asserted against it or such subsidiaries, in the last five (5) years with respect to the contracts listed in the Experience Table identified in RFP Section V.3.2. Each description shall include the date of the underlying claim and shall cross-reference to a listed contract. The Offeror shall describe the circumstances of the claim and how it may have rectified the situation that caused the claim of the damages and/or penalties.

VI. Award Criteria

1 AWARD CRITERIA -- PROPOSALS (JAN 2006)

Award will be made to the highest ranked, responsive and responsible offeror whose offer is determined to be the most advantageous to the State. [06-6030-1]

2 AWARD TO ONE OFFEROR (JAN 2006)

Award will be made to one Offeror. [06-6040-1]

3 EVALUATION FACTORS (JAN 2006)

Offers will be evaluated using only the factors stated below. Evaluation factors are stated in the relative order of importance, with the first factor being the most important. Once evaluation is complete, all responsive Offerors will be ranked from most advantageous to least advantageous.

The evaluation criteria, in order of importance, are:

Criterion	Description	Weight
Proposed Solution	This criterion evaluates the Offeror's proposed solution in meeting the State's goals and objectives for the Discovery, Replacement, Operations, and Turnover Phases, and its proposed technical solution.	50 points
Proposal Risk	This criterion evaluates the risk of the Offeror's proposed solution with respect to cost; schedule; and system and operations performance as perceived by the State. It includes the evaluation of risk due to the Offeror's proposed solution; the proposed staff and organization; past performance and experience; corporate background; financial stability; and the realism of the proposed cost and schedule. This criterion also evaluates the quality of the Offeror's identification and proposed mitigation of risks and issues, as well as the Offeror's introspection on its role as a source of risks and issues.	30 points
Total Enterprise Cost of Ownership	This criterion evaluates the cost of the proposed solution as it impacts other substantive technology and administrative costs for the State. Total Enterprise Cost of Ownership includes: <ul style="list-style-type: none">• Offeror-proposed prices at the nominal estimated volumes for the duration of the contract as shown in Pricing Table O (Total Enterprise Cost of Ownership) and as described in RFP Section IX.2.2.15• Estimated hardware costs for the proposed solution as determined in the State's sole discretion• Estimated hosting costs for the proposed solution as determined in the State's sole discretion• Estimated existing contract costs as determined in the State's sole discretion and phased out via Offeror-proposed	20 points

Draft

Criterion	Description	Weight
	increments <ul style="list-style-type: none">• Estimated State project office costs during the Discovery, Replacement, and Operations Phases as determined in the State's sole discretion	

4 UNIT PRICE GOVERNS (JAN 2006)

In determining award, unit prices will govern over extended prices unless otherwise stated.

VII. Terms and Conditions – A. General

1 ASSIGNMENT

1.1 Non-assignability

Neither the contract nor any of its provisions may be assigned, sublet, or transferred without the written consent of the Chief Procurement Officer. Any purported assignment not so approved shall be null and void. Notwithstanding the foregoing, the Contractor may assign monies receivable under a contract after due notice from the Contractor to the State.

1.2 Contractor Request for Assignment and Novation

The Contractor may request that the State consent to Contractor's assignment of the Contract by written request to the Procurement Officer. Such written request shall include the identity of the proposed assignee, Contractor's affirmation that the assignee or successor in interest is fully capable of performing all obligations of the Contract, Contractor's affirmation that it shall remain primarily liable for performance and such other information as the State may request. If the requested assignment is determined to be in the best interest of the State, a successor in interest may be recognized in a novation agreement in which the transferor and the transferee shall agree that:

- (1) the assignee assumes all of the transferor's obligations;
- (2) the assignor waives all rights under the Contract as against the State; and
- (3) unless the assignor guarantees performance of the Contract by the assignee, the assignee shall, if required, furnish a satisfactory performance bond.

Any assignment of the Contract shall be made explicitly subject to all rights, defenses, setoffs, or counterclaims that would have been available to the State against the Contractor in the absence of such assignment.

1.3 Change of Name and Recognition of a Successor in Interest

If the Contractor requests to change the name in which it holds the Contract with the State, the Chief Procurement Officer or his/her designee responsible for the contract may, upon receipt of a document indicating such change of name (for example, an amendment to the articles of incorporation of the corporation), enter into an agreement with the requesting Contractor to effect such a change of name. The agreement changing the name shall specifically indicate that no other terms and conditions of the Contract are thereby changed.

1.4 Approvals in Writing

Any assignment to which the State consents may only be made in writing by the Contractor, assignee, and the State setting forth the obligations of the Contractor and the assignee.

1.5 State's Remedies

Notwithstanding the foregoing, the State may, in its sole discretion, modify or terminate the Contract if, in its reasonable judgment, it believes that the proposed assignment may impair the performance of the obligations under the Contract as set forth in Section VIIB.43.

2 BANKRUPTCY

(a) Notice. In the event the Contractor enters into proceedings relating to bankruptcy, whether voluntary or involuntary, the Contractor agrees to furnish written notification of the bankruptcy to the Using Governmental Unit. This notification shall be furnished within five (5) days of the initiation of the proceedings relating to the bankruptcy filing. This notification shall include the date on which the bankruptcy petition was filed, the identity of the court in which the bankruptcy petition was filed, and a listing of all State contracts against which final payment has not been made. This obligation remains in effect until final payment under this Contract. (b) Termination. This contract is voidable and subject to immediate termination by the State upon the Contractor's insolvency, including the filing of proceedings in bankruptcy. (c) Election of Remedies. The State shall be entitled to all rights and benefits of the Federal Intellectual Property Bankruptcy Protection Act, Public Law 100-506, codified at 11 U.S.C. 365(n) and any amendments thereto. The State's failure in the event of Vendor's bankruptcy to assert retention of the State's license rights hereunder shall not be deemed to be a termination of those rights under Section 365(n). The State may terminate such rights only by giving written notice to such effect.

3 CHOICE-OF-LAW (JAN 2006)

The Agreement, any dispute, claim, or controversy relating to the Agreement, and all the rights and obligations of the parties shall, in all respects, be interpreted, construed, enforced and governed by and under the laws of the State of South Carolina, except its choice of law rules. As used in this paragraph, the term "Agreement" means any transaction or agreement arising out of, relating to, or contemplated by the solicitation. [07 – 7A010-1]

4 CONTRACT DOCUMENTS and ORDER OF PRECEDENCE

(a) Any Contract resulting from this solicitation shall consist of the following documents: (1) a Record of Negotiations, if any, executed by Contractor and the Procurement Officer, (2) documentation regarding the clarification of an offer [e.g., 11-35-1520(8) or 11-35-1530(6)], if applicable, (3) the solicitation, as amended, (4) modifications, if any, to Contractor's offer, if accepted by the Procurement Officer, (5) Contractor's offer, (6) any statement reflecting the state's final acceptance (a/k/a "award"), and (7) purchase orders. These documents shall be read to be consistent and complimentary. Any conflict among these documents shall be resolved by giving priority to these documents in the order listed above. (b) The terms and conditions of documents (1) through (6) above shall apply notwithstanding any additional or different terms and conditions in either (i) a purchase order or other instrument submitted by the State or (ii) any invoice or other document submitted by Contractor. Except as otherwise allowed herein, the terms and conditions of all such documents shall be void and of no effect. (c) No contract, license, or other agreement containing contractual terms and conditions will be signed by any Using Governmental Unit. Any document signed or otherwise agreed to by persons other than the Procurement Officer shall be void and of no effect. (d) Titles and headings in the Contract are

used for convenience only and do not define, limit, or proscribe the language of terms identified by such titles and headings. (e) The Contract shall not be amended orally or by performance. All amendments to the Contract shall be in writing and shall become effective only after approval by applicable State or Federal authorities and subsequent execution by duly authorized representatives of the Parties.

5 DISPUTES (JAN 2006)

(1) Choice-of-Forum. All disputes, claims, or controversies relating to the Agreement shall be resolved exclusively by the appropriate Chief Procurement Officer in accordance with Title 11, Chapter 35, Article 17 of the South Carolina Code of Laws, or in the absence of jurisdiction, only in the Court of Common Pleas for, or a federal court located in, Richland County, State of South Carolina. Contractor agrees that any act by the Government regarding the Agreement is not a waiver of either the Government's sovereign immunity or the Government's immunity under the Eleventh Amendment of the United State's Constitution. As used in this paragraph, the term "Agreement" means any transaction or agreement arising out of, relating to, or contemplated by the solicitation. (2) Service of Process. Contractor consents that any papers, notices, or process necessary or proper for the initiation or continuation of any disputes, claims, or controversies relating to the Agreement; for any court action in connection therewith; or for the entry of judgment on any award made, may be served on Contractor by certified mail (return receipt requested) addressed to Contractor at the address provided as the Notice Address on Page Two or by personal service or by any other manner that is permitted by law, in or outside South Carolina. Notice by certified mail is deemed duly given upon deposit in the United States mail. [07 – 7A025-1]

6 EQUAL OPPORTUNITY (JAN 2006)

Contractor is referred to and shall comply with all applicable provisions, if any, of Title 41, Part 60 of the Code of Federal Regulations, including but not limited to Sections 60-1.4, 60-4.2, 60-4.3, 60-250.5(a), and 60-741.5(a), which are hereby incorporated by reference. [07 – 7A030-1]

7 FALSE CLAIMS (JAN 2006)

According to the S.C. Code of Laws Section 16-13-240, "a person who by false pretense or representation obtains the signature of a person to a written instrument or obtains from another person any chattel, money, valuable security, or other property, real or personal, with intent to cheat and defraud a person of that property is guilty" of a crime. [07-7A035-1]

8 FIXED PRICING REQUIRED (JAN 2006)

Any pricing provided by Contractor shall include all costs for performing the work associated with that price. Except as otherwise provided in this solicitation, Contractor's price shall be fixed for the duration of this contract, including option terms. This clause does not prohibit Contractor from offering lower pricing after award. [07-7A040-1]

9 NON-INDEMNIFICATION (JAN 2006)

Any term or condition is void to the extent it requires the State to indemnify anyone. [07-7A045-1]

1]

10 NOTICE (JAN 2006)

(A) After award, any notices shall be in writing and shall be deemed duly given (1) upon actual delivery, if delivery is by hand, (2) upon receipt by the transmitting party of automated confirmation or answer back from the recipient's device if delivery is by telex, telegram, facsimile, or electronic mail, or (3) upon deposit into the United States mail, if postage is prepaid, a return receipt is requested, and either registered or certified mail is used. (B) Notice to Contractor shall be to the address identified as the Notice Address on Page Two. Notice to the state shall be to the Procurement Officer's address on the Cover Page. Either party may designate a different address for notice by giving notice in accordance with this paragraph. [07-7A050-1]

11 PAYMENT & INTEREST (MAY 2011)

(a) Unless otherwise provided in this Solicitation, the State shall pay the Contractor, after the submission of proper invoices or vouchers, the prices stipulated in this contract for supplies delivered and accepted or services rendered and accepted, less any deductions provided in this contract. Unless otherwise specified herein, including the purchase order, payment shall not be made on partial deliveries accepted by the Government. (b) Unless otherwise provided herein, including the purchase order, payment will be made by check. (c) Notwithstanding any other provision, payment shall be made in accordance with S.C. Code Section 11-35-45, which provides the Contractor's exclusive means of recovering any type of interest from the Owner. Contractor waives imposition of an interest penalty unless the invoice submitted specifies that the late penalty is applicable. Except as set forth in this paragraph, the State shall not be liable for the payment of interest on any debt or claim arising out of or related to this contract for any reason. (d) Amounts due to the State shall bear interest at the rate of interest established by the South Carolina Comptroller General pursuant to Section 11-35-45 ("an amount not to exceed fifteen percent each year"), as amended. (e) Any other basis for interest, including but not limited to general (pre- and post-judgment) or specific interest statutes, including S.C. Code Ann. § 34-31-20, are expressly waived by both parties. If a court requires that interest be paid on any debt by either party despite this agreement and waiver, the parties further agree that the applicable interest rate for any given calendar year shall be the lowest prime rate as listed in the first edition of the Wall Street Journal published for each year.

12 PUBLICITY

Except as may be required of the Contractor to meet Securities and Exchange Commission (SEC) regulations or other legal reporting requirements, Contractor shall not (i) advertise or otherwise publicly disseminate any information whatsoever concerning the existence, or terms of the Contract, (ii) issue any press releases, (iii) publish any comments or quotes by State employees, or (iv) include the State in either news releases or a published list of customers, without the prior written approval of the Procurement Officer.

13 PURCHASE ORDERS (JAN 2006)

Contractor shall not perform any work prior to the receipt of a purchase order from the Using Governmental Unit. The using governmental unit shall order any supplies or services to be

furnished under this contract by issuing a purchase order. Purchase orders may be used to elect any options available under this contract, e.g., quantity, item, delivery date, payment method, but are subject to all terms and conditions of this Contract. Purchase orders may be electronic. No particular form is required. An order placed pursuant to the purchasing card provision qualifies as a purchase order.

14 SETOFF (JAN 2006)

The state shall have all of its common law, equitable, and statutory rights of set-off. These rights shall include, but not be limited to, the State's option to withhold for the purposes of set-off any moneys due to the Contractor under this contract up to any amounts due and owing to the state with regard to this contract, any other contract with any state department or agency, including any contract for a term commencing prior to the term of this contract, plus any amounts due and owing to the state for any other reason including, without limitation, tax delinquencies, fee delinquencies or monetary penalties relative thereto.

15 SURVIVAL OF OBLIGATIONS

The Parties' rights and obligations which, by their nature, would continue beyond the termination, cancellation, rejection, or expiration of this contract shall survive such termination, cancellation, rejection, or expiration, including, but not limited to, the rights and obligations created by the following clauses: Confidentiality and Data Security, Contract Documents and Order of Precedence, Damages and Limitation of Liability, Disputes, Financial Records Requirements, Governing Law and Jurisdiction, Health Insurance Portability and Accountability Act, Indemnification, Intellectual Property Indemnification, Non-indemnification, Ownership, Patent, Copyright and Trade Secret Protection, Publicity, Records Retention, Representations and Warranties, Setoff, Severability, Remedies Not Exclusive, Source Code Escrow, Survival of Obligations, Taxes, Waiver of Consequential Damages, and any provisions regarding warranty or audit.

16 TAXES (JAN 2006)

Any tax the Contractor may be required to collect or pay upon the sale, use or delivery of the products shall be paid by the State, and such sums shall be due and payable to the Contractor upon acceptance. Any personal property taxes levied after delivery shall be paid by the State. It shall be solely the State's obligation, after payment to contractor, to challenge the applicability of any tax by negotiation with, or action against, the taxing authority. Contractor agrees to refund any tax collected, which is subsequently determined not to be proper and for which a refund has been paid to Contractor by the taxing authority. In the event that the Contractor fails to pay, or delays in paying, to any taxing authorities, sums paid by the State to contractor, Contractor shall be liable to the State for any loss (such as the assessment of additional interest) caused by virtue of this failure or delay. Taxes based on Contractor's net income or assets shall be the sole responsibility of the contractor.

17 TERMINATION DUE TO UNAVAILABILITY OF FUNDS (JAN 2006)

Payment and performance obligations for succeeding fiscal periods shall be subject to the availability and appropriation of funds therefor. When funds are not appropriated or otherwise

made available to support continuation of performance in a subsequent fiscal period, the contract shall be canceled. In the event of a cancellation pursuant to this paragraph, Contractor will be reimbursed the resulting unamortized, reasonably incurred, nonrecurring costs. Contractor will not be reimbursed any costs amortized beyond the initial contract term.

18 THIRD PARTY BENEFICIARY (JAN 2006)

This Contract is made solely and specifically among and for the benefit of the parties hereto, and their respective successors and assigns, and no other person will have any rights, interest, or claims hereunder or be entitled to any benefits under or on account of this Contract as a third party beneficiary or otherwise.

19 WAIVER (JAN 2006)

The State does not waive any prior or subsequent breach of the terms of the Contract by making payments on the Contract, by failing to terminate the Contract for lack of performance, or by failing to strictly or promptly insist upon any term of the Contract. Only the Procurement Officer has actual authority to waive any of the State's rights under this Contract. Any waiver must be in writing.

VII. Terms and Conditions – B. Special

1 ASSURANCES

If during the term of the Contract the State becomes aware of any criminal or civil investigation, litigation, arbitration, or other proceedings that causes the State to be reasonably concerned about: (i) the ability of the Contractor to continue to perform the Contract in accordance with its terms and conditions, or (ii) whether the Contractor, in performing services, is engaged in conduct which is similar in nature to conduct alleged in such investigation, litigation, arbitration, or other proceedings, which conduct would constitute a breach of the Contract or violation of Law, Regulatory Requirements, or public policy, then the Contractor shall be required to provide the State all reasonable assurances requested by the State to demonstrate that the Contractor is able to continue to perform the Contract in accordance with its terms and conditions, and the Contractor will not engage in conduct in performing services under the Contract that is similar in nature to the conduct alleged in any such litigation, arbitration, or other proceeding.

2 CHANGES

2.1 *Contract Modification*

By a written order, at any time, and without notice to any surety, the Procurement Officer may, subject to all appropriate adjustments, make Changes within the general scope of this contract to the Services.

2.2 *Change Management Plan*

During the Discovery Phase of the Contract, the Parties shall agree a detailed Change Management Plan. The Change Management Plan shall include at a minimum, the following concepts: (i) Changes to the Services shall be initiated through a Customer Service Request (CSR), (ii) any document resulting from a CSR that is to be binding upon the Parties shall be signed by both the Contractor's and the State's respective representatives with appropriate level of signature authority, (iii) any additional or changed Services shall then be deemed "Services" and subject to the provisions of the Contract, (iv) proposals that include Changes during any Phase to the scope, price or schedule of the Services, or to any dates in the Contract of significant consequence to performance of the Services, shall be made effective through the Parties execution of a Contract amendment (v) proposals that do not include such Changes (including, for example and without limitation, clarifications of existing requirements or specifications of no price or schedule impact) shall be made effective through the Parties' sign-off or execution of such documentation as shall be required under the Change Management Plan, except when the Parties may agree in a particular instance that it is appropriate to execute a formal Contract amendment, and (vi) if the new or changed Services are to be provided in exchange for fixed or "not-to-exceed" compensation, the Contractor shall be solely responsible for any costs in excess of the specified compensation.

2.3 Adjustments of Price or Time for Performance

If any such change increases or decreases the contractor's cost of, or the time required for, performance of any part of the work under this contract, whether or not changed by the order, an adjustment shall be made in the contract price, the delivery schedule, or both, and the contract modified in writing accordingly. Any adjustment in contract price made pursuant to this clause shall be determined in accordance with the Price Adjustment Clause of this contract. Failure of the parties to agree to an adjustment shall not excuse the Contractor from proceeding with the contract as changed, provided that the State promptly and duly makes such provisional adjustments in payment or time for performance as may be reasonable. By proceeding with the work, the Contractor shall not be deemed to have prejudiced any claim for additional compensation, or an extension of time for completion.

2.4 Time Period for Claim

Within 30 days after receipt of a written contract modification under Section VIIB.2.1 of this clause, unless such period is extended by the Procurement Officer in writing, the Contractor shall file notice of intent to assert a claim for an adjustment. Later notification shall not bar the contractor's claim unless the State is prejudiced by the delay in notification.

2.5 Claim Barred After Final Payment

No claim by the Contractor for an adjustment hereunder shall be allowed if notice is not given prior to final payment under this contract.

3 COMPLIANCE WITH LAW AND REGULATORY REQUIREMENTS

3.1 General Compliance with Laws and Regulatory Requirements

In addition to its obligations with respect to specific Laws and Regulatory Requirements as set out elsewhere in the Contract Documents, Contractor shall obtain and maintain all governmental approvals (as defined below) applicable to Contractor in the conduct of its business and shall identify, interpret and comply in all material respects with all Laws applicable to Contractor for the provision, receipt and use of the Services, and the consummation of the transactions contemplated by the Contract, including without limitation the Regulatory Requirements.

3.2 Cooperation with State

Contractor will provide, and will cause its employees, agents and subcontractors to provide, as part of the Services being provided by Contractor, all assistance reasonably related to the Services provided by Contractor necessary to enable the State to comply with the Regulatory Requirements.

3.3 Cooperation in Investigations, Hearings, and Disputes

The Contractor shall cooperate fully with US DHHS, the State, the Medicaid Fraud Control Unit, and any other authorized local, State, and Federal agencies or law enforcement authorities in the investigation, documentation, and litigation of possible fraud and abuse cases or any other misconduct involving any of the duties and responsibilities performed by the Contractor under

the Contract. US DHHS, its authorized representatives, and those of any other authorized local, State, or Federal agency or law enforcement agency shall have access to the same records and information as does the State. In addition, the Contractor shall cooperate and participate in the resolution of State Fair Hearings and Provider Disputes at the request of the State.

3.4 Changes in Law or Regulatory Requirements

If implementation of a change in Law or the Regulatory Requirements will impact the Services, the Deliverables, or Contractor's performance under the Contract, Contractor shall notify the State and the parties shall meet to discuss the alternatives for implementing such change, including the recommendation of the Contractor for the most cost effective alternatives. Such alternatives may include changes to the Deliverables or Services, including changes to Custom Software, alternatives for acquisition of COTS Software or upgrades or maintenance modifications to COTS Software included in the Deliverables, and/or modification of the methodology for performance of the Services. Upon receipt of Contractor's notice and proposal, and subject to Section VII B.2, CHANGES, the State shall pay such amounts as the Parties may agree to implement the change to Law or Regulatory Requirements; provided, however if such change in Law or Regulatory Requirements affects other Contractor customers, then Contractor will use reasonable efforts to allocate that cost of modifications to its Deliverables and performance of services across its affected customers and the State will pay only its pro rata share associated with such modifications. Upon the State's request the Contractor shall provide documentation to substantiate the Contractor's allocation of such cost. As an alternative to agreeing to pay additional amounts as set forth above, the State shall have the right to cancel those portions of the Contract to which the additional expenses pertain. Notwithstanding the foregoing, the State shall pay only those upgrade or maintenance fees applicable to similarly situated Customers of any affected COTS Software. The State shall not be charged any additional fees for the implementation of the changed functionality in COTS Software if the affected COTS Software is under warranty and/or continued annual maintenance service under the provisions of the applicable COTS Software license. The State shall not be charged any such additional charges or fees if similarly situated customers of such COTS Software are provided the required changes without additional charges or fees.

4 CONFIDENTIALITY, DATA SECURITY, AND NONDISCLOSURE

4.1 Obligation of Strict Confidentiality

The Contractor, its Subcontractors at all tiers and its agents shall maintain the security and confidentiality of all State Confidential Information. Any use, sale, or offering of the State Confidential Information in any form by the Contractor, its employees, Subcontractors, or assignees without the prior written approval of the State shall be a violation of the Contract. Any violation shall be considered a material breach of the Contract for which the State may pursue all remedies available to it by contract, law or in equity.

4.2 Standard of Care

The Contractor shall (i) hold all State Confidential Information (including but not limited to all information relating to program beneficiaries and providers) in strict confidence, (ii) shall take

all necessary steps to safeguard the confidentiality of such materials or information in conformance with Federal and State statutes and regulations, and in particular, in accordance with 42 CFR Part 431, Subpart F (2008, as amended), and SCDHHS' regulations, 27 S.C. Code Ann. Regs. 126-170 (1976, as amended), (iii) shall not disclose the State Confidential Information to any third party without the express written approval of the State, and (iv) shall not use the State Confidential Information for any purpose other than its performance for the State under this contract or any manner except as provided for in this Contract. The Contractor shall safeguard and protect all State Confidential Information during performance of any contractual obligation from loss, destruction, or erasure, including without limitation through Contractor's performance of its duties set forth in the Section VIIB.3 (COMPLIANCE WITH LAW). Without limiting the foregoing obligations, Contractor must safeguard the use and disclosure of information concerning applications for or recipients of Titles XIX and XXI in accordance with 42 CFR 2.1, et. seq., and 42 CFR Part 431 Subpart F (2008, as amended), SCDHHS' regulation 27 S.C. Code Ann. Regs. 126-170 (1976, as amended), and all other applicable Law and the Regulatory Requirements and must restrict access to, and use and disclosure of, such information in compliance with such Laws and the Regulatory Requirements.

4.3 Implementing Confidentiality Agreements with Employees and Subcontractors

In order to assure compliance with this Section, Contractor shall verify that all of its employees and any approved third party contractor(s) or Subcontractor(s) have executed a non-disclosure and confidentiality agreement that is enforceable in South Carolina and sufficient in breadth to include and protect State Confidential Information prior to such employee(s), approved third party contractor(s) or Subcontractor(s) commencing performance of any services or other performance under this Contract. Contractor shall cause any of its employees, agents, or representatives with access to State Confidential Information and/or State Data in the performance of the Contract to individually comply with the contents of this Section, including compliance with confidentiality standards and practices of the State, including any personal screening of its personnel by the State for security purposes. The State may, in its sole discretion, provide a non-disclosure and confidentiality agreement satisfactory to the State for use by the Contractor with its employees, third party contractors and Subcontractors but in no event shall the provision of such agreement relieve the Contractor from its obligations under this Section.

4.4 Verification of Compliance

Upon request of the State, Contractor shall produce true copies of the signed confidentiality agreements with its employees, third party contractors, and Subcontractors. Production of such agreements by the Contractor may be made subject to applicable confidentiality, non-disclosure, or privacy laws, provided that the Contractor produces satisfactory evidence supporting exclusion of such agreements from disclosure under applicable South Carolina law.

4.5 Auditor Access to State Confidential Information and Records

SCDHHS, the State Attorney General, State General Accounting Office, State Comptroller General, US DHHS and other Federal officials as may be authorized by Law or the Regulatory Requirements, and the authorized representatives and designees of such authorized officials,

shall have access to all State Confidential Information in accordance with all requirements of Law and the Regulatory Requirements. No other person or entity shall be granted access to State Confidential Information unless State and Federal laws and regulations allow such access, and all use or disclosure of State Confidential Information shall be limited to purposes directly connected with the administration and/or performance of the Contract. The State may exercise its rights under this Section as deemed necessary or proper in its sole discretion to comply with Law or Regulatory Requirements applicable to security regulation, including, but not limited to, 26 U.S.C. 6103 and IRS Publication 1075 (*Tax Information Security Guidelines for Federal, State, and Local Agencies and Entities*), HIPAA, any implementing regulations in the Code of Federal Regulations, and any future regulations imposed upon the State or any of its Agencies pursuant to future statutory or regulatory requirements.

4.6 Access to and Return of Confidential Information

Except to the extent otherwise required by applicable Law or a Regulatory Requirement, Contractor shall not withhold the State Data or any other State Confidential Information or refuse for any reason to promptly return to the State the State Data and any other State Confidential Information (including copies thereof) if requested to do so on such media as reasonably requested by the State, even if the State is in or is alleged to be in breach of the Contract. As a part of Contractor's obligation to provide the State Data pursuant to this Section, Contractor will also provide the State any data maps, documentation, software, or other materials necessary, including, without limitation, handwritten notes, materials, working papers or documentation, for the State to use, translate, interpret, extract and convert the State Data and any other State Confidential Information for use by the State or any third party.

Without limiting the foregoing, upon expiration or termination of the Contract, the Contractor promptly will either (i) return to the State all of the State Confidential Information in its possession, or (ii) at the State's option and written notice, destroy such of the State Confidential Information in the Contractor's possession as is directed to be destroyed in such notice and certify to such destruction in writing.

4.7 Security Breach Notification and Related Costs

In the event Contractor becomes aware of any Security Breach due to Contractor acts or omissions other than in accordance with the terms of the Contract, Contractor shall, at its own expense, (i) immediately notify the State of such Security Breach and perform a root cause analysis thereon, (ii) investigate such Security Breach, (iii) provide a remediation plan, acceptable to the State, to address the Security Breach and prevent any further incidents, (iv) conduct a forensic investigation to determine what systems, data and information have been affected by such event; and (v) cooperate with the State, and any law enforcement or regulatory officials, credit reporting companies, and credit card associations investigating such Security Breach. The State shall make the final decision on notifying the affected party(ies) of such Security Breach, and the implementation of the remediation plan consistent with applicable Laws and Regulatory Requirements. If a notification to (an) affected party(ies) is required under any Law or pursuant to any of the State's privacy or security policies, then notifications to all persons and entities that are affected by the same event (as reasonably determined by the State) shall be considered legally required. Contractor shall reimburse the State for all Security Breach

Notification Related Costs incurred by the State arising out of or in connection with any Security Breach due to Contractor acts or omissions (other than in accordance with the terms of the Contract) resulting in a requirement for legally required notifications. If the Security Breach is determined not to have resulted from the Contractor's acts or omissions (other than in accordance with the terms of the Contract) the Parties shall reasonably cooperate regarding which of the foregoing or other activities may be appropriate under the circumstances, including any applicable charges for the same.

4.8 HIPAA Business Associate Addendum

In the event of any conflict between the terms of this Section VII B. 4 and the terms of the HIPAA Business Associate Addendum included as Article IX Attachment B of the Solicitation, the terms more protective of an Individual's rights with respect to Protected Health Information shall control.

4.9 General Skills and Know-How

Notwithstanding anything to the contrary herein, the Contractor shall be free to use and employ its general skills, know-how, and expertise, and to use, disclose, and employ any generalized ideas, concepts, know-how, methods, techniques, or skills gained or learned during the course of performing the Contract, provided that the foregoing is acquired and applied without improper disclosure of State Confidential Information or other information protected by the Health Insurance Portability and Accountability Act (HIPAA) or other laws or regulations.

4.10 Exclusions

The foregoing confidentiality provisions will not prevent the Contractor from disclosing information that (i) at the time of disclosure by the State is already known by the Contractor without an obligation of confidentiality other than under this Contract, (ii) is publicly known or becomes publicly known through no act of the Contractor other than an act that is authorized by the State, (iii) is rightfully received by the Contractor from a third party and the Contractor has no reason to believe that the third party's disclosure was in violation of an obligation of confidence to the State, (iv) is independently developed by the Contractor without use of the State's confidential information, (v) is disclosed without similar restrictions to a third party by the State, or (vi) is required to be disclosed pursuant to a requirement of law or a governmental authority, so long as the Contractor, to the extent possible, provides the State with timely prior notice of such requirement and coordinates with the State in an effort to limit the nature and scope of such required disclosure.

5 CONTRACT ADMINISTRATION

5.1 State Contract Administration and Management

Prior to the Effective Date of the Contract, the State shall designate a Contract Administrator to administer the Contract for the State. The State Contract Administrator shall be responsible on behalf of the State for all contractual matters. The State Contract Administrator or a designee(s) authorized in writing shall establish and oversee Contract management functions, including

ongoing monitoring and enforcement of Contractor compliance with performance standards and overall terms and conditions of the Contract.

5.2 Contractor Contract Administration and Management

Contractor shall designate an Account Manager who shall be assigned to the Contract and shall be deemed to be Key Personnel for all purposes under the Contract. The Account Manager shall have the authority to enter into any Contract modifications on behalf of the Contractor and otherwise commit the Contractor to any course of action, undertaking, obligation, or responsibility in connection with the Contractor's performance of the Contract and shall be responsible on behalf of the Contractor for all contractual matters.

5.3 Cooperation with other Contractors

Contractor shall provide all reasonable assistance to and cooperation with, all other contractors of the State that are providing goods or services to or on behalf of the State relating to the Project or otherwise providing services to the State, including its agents and/or any contractor or contractors as may be engaged by the State to monitor, validate or verify Contractor's performance hereunder. Such cooperation shall be on a "best efforts" basis. Contractor shall be liable to the State for the actual additional costs incurred due to its failure to cooperate with other contractors of the State. If reasonably requested to facilitate such cooperation, the Contractor and any other contractor of the State shall enter into written contract(s) that reasonably limit(s) their disclosure and use of each other's confidential information in the course of their performance for the State.

5.4 Informal Dispute Resolution

Prior to submission of any dispute, claim or controversy to the formal dispute process described in paragraph 5.1, the parties shall attempt to resolve such dispute, claim or controversy through informal dispute resolution in accordance with this paragraph. Either party may invoke the informal dispute resolution procedure by written notice to the other party, specifying the disputed issue(s), the position of the initiating party with respect to such issue(s), and naming the person who is authorized to represent the initiating party with respect to resolution of the matter. Not later than three (3) business days following its receipt of such correspondence, the receiving party shall respond to the initiating party, indicating the receiving party's specification of the issues, its position with respect to such issues, and naming its authorized representative to meet with the named representation of the initiating party. The parties shall use their best good faith efforts to resolve the dispute within seven (7) business days after the initiating party's receipt of the receiving party's response. If the such representatives designees are unable to resolve the dispute within such seven-day (7-day) period, either Party may escalate the dispute to the Contract Manager if to the State or the Account Manager if the Contractor by giving notice of escalation in writing to such senior representative, specifying the disputed issues, the position of the party submitting the notice, and its understanding of the relative positions of the parties. The Contract Manager for the State and the Account Manager for the Contractor shall use best good faith efforts to resolve the dispute within ten (10) business days of submission of notice of escalation. If the senior representatives of the parties are unable to resolve the dispute, then either party may elect to pursue its other remedies under the Contract or at law. Except as otherwise

specified in the Contract, the dispute process described in this Section VIIB.5.4 shall be a condition precedent to any action in a judicial or quasi-judicial tribunal.

6 CONTRACTOR'S LIABILITY INSURANCE

- (1) Contractor shall purchase from and maintain in a company or companies lawfully authorized to do business in South Carolina such insurance as will protect the Contractor from the types of claims set forth below which may arise out of or result from the contractor's operations under the contract and for which the Contractor may be legally liable, whether such operations be by the Contractor or by a subcontractor or by anyone directly or indirectly employed by any of them, or by anyone for whose acts any of them may be liable: (a) claims under workers' compensation, disability benefit and other similar employee benefit acts which are applicable to the work to be performed; (b) claims for damages because of bodily injury, occupational sickness or disease, or death of the contractor's employees; (c) claims for damages because of bodily injury, sickness or disease, or death of any person other than the contractor's employees; (d) claims for damages insured by usual personal injury liability coverage; (e) claims for damages, other than to the work itself, because of injury to or destruction of tangible property, including loss of use resulting therefrom; (f) claims for damages because of bodily injury, death of a person or property damage arising out of ownership, maintenance or use of a motor vehicle; (g) claims for bodily injury or property damage arising out of completed operations; and (h) claims involving contractual liability insurance applicable to the Contractor's obligations under the provision entitled Indemnification – Third Party Claims, and (h) claims based on Contractor's errors or omissions during the course of performance.
- (2) Coverage shall be written on an occurrence basis and shall be maintained without interruption from date of commencement of the work until date of final payment. Coverage must include the following on a commercial basis: (i) Premises – Operations, (ii) Independent Contractor's Protective, (iii) Products and Completed Operations, (iv) Personal and Advertising Injury, (v) Contractual, including specific provision for contractor's obligations under the provision entitled Indemnification – Third Party Claims, (vi) Broad Form Property Damage including Completed Operations, (vii) Owned, Non-owned and Hired Motor Vehicles and (viii) Contractor Errors and Omissions.
- (3) The insurance required by this paragraph shall be written for not less than the following limits of liability or as required by law, whichever coverage is greater:

COMMERCIAL GENERAL LIABILITY:

General Aggregate (per project) \$10,000,000

Products/Completed Operations \$10,000,000

Personal and Advertising Injury \$10,000,000

Each Occurrence \$10,000,000

Fire Damage (Any one fire) \$ 50,000

Medical Expense (Any one person) \$ 5,000

BUSINESS AUTO LIABILITY (including All Owned, Nonowned, and Hired Vehicles):

Combined Single Limit \$1,000,000

OR

Bodily Injury & Property Damage (each) \$750,000

WORKER'S COMPENSATION:

State Statutory

Employers Liability \$100,000 Per Acc.

\$500,000 Disease, Policy Limit; \$100,000 Disease, Each Employee

ERRORS and OMISSIONS

"Claims made" policy with an effective date not later than the date of submission of Contractor's Offer to the Solicitation

\$10,000,000 per claim.

- (4) Required Documentation. (a) Prior to commencement of the work, Contractor shall provide to the State signed, original certificates of insurance (ACORD 25). Each certificate shall identify the types of insurance, state the limits for each type of coverage, include a provision for 30 days notice prior to cancellation, name every applicable using governmental unit (as identified on the cover page) as a Certificate Holder, provide that the general aggregate limit applies per project, and provide that coverage is written on an occurrence basis. (b) Prior to commencement of the work, Contractor shall provide to the state a written endorsement to the contractor's insurance policy that (i) names every applicable using governmental unit (as identified on the Cover Page) as an additional insured, (ii) provides that no material alteration, cancellation, non-renewal, or expiration of the coverage contained in such policy shall have effect unless the named governmental unit(s) has been given at least thirty (30) days prior written notice, and (iii) provides that the Contractor's insurance policy shall be primary, with any insurance of the state as secondary and noncontributory. (c) Both the certificate and the endorsement must be received directly from either the contractor's insurance agent or the insurance company.
- (5) Contractor shall provide a minimum of thirty (30) days written notice to the State of any proposed reduction of coverage limits (on account of revised limits or claims paid under the General Aggregate) or any substitution of insurance carriers.
- (6) The State's failure to demand either a certificate of insurance or written endorsement required by this paragraph is not a waiver of contractor's obligations to obtain the required insurance.

7 CONTRACTOR'S OBLIGATION -- GENERAL (JAN 2006)

The Contractor shall provide and pay for all materials, tools, equipment, labor and professional and non-professional services, and shall perform all other acts and supply all other things necessary, to fully and properly perform and complete the work. The Contractor must act as the prime Contractor and assume full responsibility for any subcontractor's performance. The Contractor will be considered the sole point of contact with regard to all situations, including payment of all charges and the meeting of all other requirements. [07-7B065-1]

8 CONTRACTOR PERSONNEL

8.1 Independent Contractor

The Contractor and its employees, officers, executives, and subcontractors, if any, are and shall be independent contractors and not employees or agents of the State of South Carolina. The Contract shall not operate as or give rise to a joint venture, partnership, trust, agency, or any other business relationship.

8.2 Key Personnel

As from the Effective Date of the Contract, the services of the designated and accepted Key Personnel or an approved successor for such designed Key Personnel, (whether such successor is nominated as a successor during the evaluation period of Contractor's Offer or proposed in accordance with this paragraph) shall be required unless that individual becomes unavailable to the Contractor for reasons affecting the basic employment relationship, such as the individual's death, disability, resignation from Contractor's employment to accept another job opportunity outside Contractor's enterprise, termination for cause or leave from civilian employment to fulfill military duty. Staffing shall include the named individuals at the level of effort proposed. If an individual identified by the Contractor to the State as Key Personnel becomes unavailable for such reasons, the Contractor, within twenty (20) business days of Contractor's receipt of said individual's notice of unavailability, shall provide the State the résumé of a proposed replacement and offer the State an opportunity to interview that person. If the State is not reasonably satisfied that the proposed replacement meets the job description criteria set forth in the Contract or is not otherwise suitable for the position, it shall so inform the Contractor in writing within three (3) business days after the later of receiving the résumé or completing any interview of the proposed replacement. As soon as commercially practicable after being so informed, the Contractor shall propose another replacement and the State shall have the same right of approval. Such process shall be repeated until a proposed replacement shall be approved by the State.

8.3 Persistent Vacancies of Key Personnel

With respect to all persisting vacancies of Key Personnel during all phases, the State shall receive a credit equal to the full-time labor cost of the unavailable individual, prorated for each day or partial day until the position is satisfactorily filled. For vacancies due to the internal transfer or ordinary course retirement of the applicable individual, the credit shall begin to accrue at the time the vacancy occurs. For vacancies that occur for any other reason, the credit shall begin to accrue on the thirtieth (30th) business day after the vacancy occurs. Temporary or

permanent transfer of any of the Key Personnel within the project or temporary or permanent transfer of any of the above named Key Personnel between Contractor projects shall require prior written approval of the State Contract Administrator, which shall not be unreasonably withheld. With respect to all persisting vacancies of Key Personnel during the Operational Phase of the Contract, in addition to the remedies stated herein, the Contractor shall be deemed to have missed a Critical Performance Standard for each such Key Personnel who has not been replaced within the relevant period measured as stated above.

8.4 Removal of Personnel

The State Contract Administrator or his/her designee may monitor the Contractor's efforts and account for all work to be performed by Contractor personnel. The State Contract Administrator or his/her designee may determine whether Contractor personnel are performing satisfactorily at the appropriate skill levels specified in the Contractor's Technical Proposal or as warranted in the Contract. The State may require the Contractor to relieve any of the Contractor's personnel from any further work under the Contract if in his/her sole discretion (i) the individual does not perform at the applicable skill level specified in the Contractor's Technical Proposal or elsewhere in the Contract, (ii) the individual does not deliver work that conforms to the performance standards stated in the RFP, the Contractor's Technical Proposal, and elsewhere in the Contract, or (iii) the person exhibits personal or professional conflicts with State personnel that hinder effective progress on the project. Upon being notified in writing by the State Contract Administrator that a member of the Contractor's personnel is unacceptable, the Contractor shall immediately remove that individual from any assignments on the Contract. In the event that a member of the Contractor's personnel is removed pursuant to this paragraph, the process set out above for submission of resumes, interviews, and approval shall apply as if the person removed were among the Key Personnel and the vacancy had occurred for a reason other than an internal transfer or ordinary course retirement.

8.5 No Contractor Utilization of Workers outside the United States

Except as otherwise explicitly authorized elsewhere in the Contract or authorized in writing by the State, Contractor and its subcontractors may not use workers located outside of the United States of America or its territories to perform Contractor's duties under the Contract.

8.6 Personnel Turnover

Contractor agrees that it is in the best interests of both Parties to keep the turnover rate of Contractor personnel, contractors, and subcontractors to reasonably low levels. Contractor shall provide the State with a quarterly turnover report regarding Contractor's turnover rate during the applicable period in a form reasonably acceptable to the State, and Contractor shall meet with the State promptly after the provision of each such report to discuss the reasons for, and impact of, such turnover rate. If appropriate, Contractor shall submit to the State its proposals for reducing the turnover rate, and the Parties shall agree on a program to bring the turnover rate down to an acceptable level. Notwithstanding transfer or turnover of Contractor personnel, contractors and subcontractors, Contractor remains obligated to perform the Services without degradation.

8.7 Solicitation and Hiring of Contractor Personnel

Upon termination or expiration of the Contract, the State or its designee shall be permitted to solicit and hire any Contractor personnel that have been dedicated to, or have been performing, the Services, as well as those subcontractor personnel, if any, that have been dedicated to, or have been performing operational services during the Operations phase as subcontractors to the Contractor, as of the date the State delivers a notice of termination to Contractor, or, in the case of expiration, within the six (6) month period (or longer period requested by the State) prior to expiration. Contractor shall not interfere with the State's efforts, shall not enforce any restrictions imposed on such Contractor personnel by agreement or policy (i.e., employment contract or covenant) which would interfere with the State's efforts, and shall provide the State access to such Contractor personnel for the purposes of interviews, evaluations and recruitment. Contractor and its subcontractors shall not make counter-offers to such Contractor personnel; provided this provision does not limit a Contractor employee's right to investigate job postings and other internal job opportunities with their employer. Further, promptly after the State sends Contractor written notice of the termination or expiration, Contractor agrees to supply the State with the names of Contractor personnel performing Services for the State. Any such employment by the State or its designee would not be effective until termination or expiration of this Agreement.

9 CONTRACTOR REPRESENTATIONS, WARRANTIES, AND COVENANTS

Contractor represents, warrants, and covenants as follows:

9.1 Efficiency and Cost Effectiveness

With respect to Services that are not being provided by Contractor on a fixed price basis, Contractor shall (i) use efficiently the resources and services necessary to provide the Services and (ii) perform the Services in the most cost-effective manner consistent with the required level of quality and performance.

9.2 Skill and Performance Standards

Contractor shall perform all Services hereunder in a workmanlike manner and Contractor's employees and its Subcontractors performing Services hereunder shall possess the skill and experience necessary to perform their responsibilities in accordance with the highest professional industry standards for like skills.

9.3 Date and Time

Any Deliverable, whether hardware, firmware, middleware, custom or commercial software, or internal components, subroutines, and interface therein that performs any data and/or time data recognition function, calculation, or sequencing, will provide accurate date/time data, including leap year, time zone, and daylight savings time calculations.

9.4 Viruses

Contractor shall screen any software or data files provided or made available by it to the State hereunder or used by Contractor (or any Contractor agent, contractor, Subcontractor or representative) in performance of the Services and will use then-current industry-standard anti-virus software programs for the purpose of avoiding the introduction of any “virus” or other unauthorized computer software routine or hardware components which are designed to disable or damage hardware or damage, erase or delay access to software or data. Contractor will assist the State’s recovery from the introduction of any such virus.

9.5 Disabling Devices

Contractor shall provide no Software to the State in relation to this Contract that includes any trap door, Trojan horse, usage meter or similar device that is coded to impair or disable the operation of any portion of the Replacement MMIS (or to facilitate such impairment or disablement), which device could be used as a means of enforcing Contractor's rights under this Contract or any asserted rights of Contractor's subcontractors or licensors. In the event of any dispute between Contractor and the State, in lieu of using or relying on any such device Contractor shall resort only to those rights and remedies available to Contractor under this Contract or through judicial process. Any device or "door" that may be included in the Software for Contractor's diagnostic purposes shall not be considered a prohibited device for the purposes of this section, so long as its use is limited to diagnostic purposes.

9.6 Data

Contractor shall cause all data and information created by it to be timely and accurate. Contractor will use then-current industry-standard software and processes, and such other requirements identified herein, to protect data from unauthorized access.

9.7 No Infringement

The Services, Deliverables, systems, Software, including both custom software and commercially available software, and all data provided to the State shall not infringe the US copyrights, patents, moral rights, trade secrets or similar intellectual property right of any third party. Without prior written approval of the State, the Contractor shall not incorporate proprietary information of any person or entity not a Party to the Contract into any materials furnished to the State hereunder.

9.8 Compliance with Laws and Regulatory Requirements

Contractor shall fully comply with all applicable Law and Regulatory Requirements, including but not limited to those Federal and State laws and implementing regulations specifically identified elsewhere in this Contract or the RFP.

9.9 Confidentiality

The Contractor, its officers, directors, principals, employees, and all subcontractors shall hold all State Confidential Information received during performance of the Contract in the strictest confidence, shall not disclose the same to any third party without the express written approval of

the State, and Contractor shall maintain non-disclosure and confidentiality agreements with its employees and subcontractors at every tier which shall be enforceable in South Carolina and sufficient in breadth to include and protect State Confidential Information as defined in Section VII.B.4. Without prior written approval of the State, the Contractor shall not incorporate confidential information of any person or entity not a party to the Contract into any materials furnished to the State hereunder, nor without such approval shall the Contractor disclose to the State or induce the State to use any confidential information of any person or entity not a Party to the Contract.

9.10 Services, Deliverables, Systems and Equipment

The Services, Deliverables, systems, and equipment used or provided by Contractor will (i) be substantially free of all Defects (including defects in material and workmanship); (ii) be designed, will function, and will conform with the requirements set forth in the Contract, (including, without limitation, all requirements set forth in the Solicitation and the Contractor's Offer); and (iii) be subject to such further warranty provisions pertaining to Services, Deliverables, Software, systems, and equipment as are set forth in Contractor's Offer. The warranty set forth in this subsection shall be in full force and effect from the Effective Date until the termination or expiration of the Contract, or until such later event or date as Contractor has stated in its Offer and shall be in addition to and not a substitute for such additional representations and warranties as may be set forth elsewhere in the Contractor's Offer. (check 4.5.4nfor consistency)

9.11 Cooperation in Investigations, Hearings, and Disputes

The Contractor shall cooperate fully with US DHHS, the State, the Medicaid Fraud Control Unit, and any other authorized local, State, and Federal agencies or law enforcement authorities in the investigation, documentation, and litigation of possible fraud and abuse cases or any other misconduct involving any of the duties and responsibilities performed by the Contractor under the Contract. US DHHS, its authorized representatives, and those of any other authorized local, State, or Federal agency or law enforcement agency shall have access to the same records and information as does the State. In addition, the Contractor shall cooperate and participate in the resolution of State Fair hearings and provider disputes at the request of the State.

9.12 HIPAA Compliance

All Deliverables and Acquired Items shall be fully compliant with Title II, Subtitle F, Section 261-264 of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, titled "Administrative Simplification" and the rules and regulations promulgated thereunder. Such Deliverable and Acquired Items shall be compliant with all HIPAA requirements across all systems and services related to this contract, including transaction, common identifier, and privacy and security standards, by the effective date of those rules and regulations. The Contractor will comply with the rules and regulations, and will implement these rules and regulations so as to achieve consistency in data collection, validation, storage, retrieval, and consolidation with all the Department's programs.

10 CONTRACTOR'S USE OF STATE PROPERTY (JAN 2006)

Upon termination of the contract for any reason, the State shall have the right, upon demand, to obtain access to, and possession of, all State properties, including, but not limited to, current copies of all State application programs and necessary documentation, all data, files, intermediate materials and supplies held by the contractor. Contractor shall not use, reproduce, distribute, display, or sell any data, material, or documentation owned exclusively by the State without the State's written consent, except to the extent necessary to carry out the work.

11 CONVENTION ON THE INTERNATIONAL SALE OF GOODS (CISG) WAIVER (JAN 2006)

The parties expressly agree that the UN Convention on the International Sale of Goods shall not apply to this agreement.

12 DAMAGES LIMITATION

Contractor's maximum liability, if any, to the State for all direct, indirect, incidental, punitive, consequential, or special damages, including without limitation contract damages and damages for injuries to persons or property, whether arising from Contractor's breach of this Contract, breach of warranty, negligence, strict liability, or other tort, or otherwise with respect to the supplies, services, or software provided under this Contract shall in no event exceed sixty million dollars (\$60,000,000).

In no event shall any party be liable to another for any indirect, incidental, punitive, consequential, or special damages, including, without limitation, lost revenues and profits, even if it has been advised of the possibility of such damages.

The limitations of this paragraph VII.B.12 shall not apply to (i) any claim for intellectual property infringement; (ii) any claim governed by the clauses entitled "Indemnification – Third Party Claims" or "Intellectual Property Infringement" or (iii) any claims of the State arising out of, or related to, the failure to obtain System Certification for the integrated system.

13 DEBARMENT CERTIFICATION

The Contractor agrees to comply with all applicable provisions of 2 CFR Part 376 (2009, as amended), pertaining to debarment and/or suspension. The Contractor should screen all employees and subcontractors to determine whether they have been excluded from participation in Medicare, Medicaid, the State Children's Health Insurance Program, and/or all federal health care programs. To make this determination, the Contractor may search the List of Excluded Individuals/Entities (LEIE) Web site located at <http://www.oig.hhs.gov/fraud/exclusions.asp>. The Contractor shall conduct a search of the website monthly to capture exclusions and reinstatements that have occurred since the last search and any exclusion information discovered should be immediately reported to SCDHHS. Any individual or entity that employs or contracts with an excluded provider cannot claim reimbursement from Medicaid for any items or services furnished, authorized, or prescribed by the excluded provider. This prohibition applies even when the Medicaid payment itself is made to another provider who is not excluded; for example, a pharmacy that fills a prescription written by an excluded doctor for a Medicaid beneficiary cannot claim reimbursement from Medicaid for that prescription. Civil monetary penalties may

be imposed against providers who employ or enter into contracts with excluded individuals or entities to provide items or services to Medicaid beneficiaries. See Section 1128A (a)(6) of the Social Security Act and 42 CFR 1003.102(a)(2). (Citation to 45 CFR part 76)

14 DEFAULT (JAN 2006)

(a)(1) The State may, subject to paragraphs (c) and (d) of this clause, by written notice of default to the Contractor, terminate this contract in whole or in part if the Contractor fails to-

(i) Deliver the supplies or to perform the services within the time specified in this contract or any extension;

(ii) Make progress, so as to endanger performance of this contract (but see paragraph (a)(2) of this clause); or

(iii) Perform any of the other material provisions of this contract (but see paragraph (a)(2) of this clause).

(2) The State's right to terminate this contract under subdivisions (a)(1)(ii) and (1)(iii) of this clause, may be exercised if the Contractor does not cure such failure within 10 days (or more if authorized in writing by the Procurement Officer) after receipt of the notice from the Procurement Officer specifying the failure.

(b) If the State terminates this contract in whole or in part, it may acquire, under the terms and in the manner the Procurement Officer considers appropriate, supplies or services similar to those terminated, and the Contractor will be liable to the State for any excess costs for those supplies or services. However, the Contractor shall continue the work not terminated.

(c) Except for defaults of subcontractors at any tier, the Contractor shall not be liable for any excess costs if the failure to perform the contract arises from causes beyond the control and without the fault or negligence of the Contractor. Examples of such causes include (1) acts of God or of the public enemy, (2) acts of the State in either its sovereign or contractual capacity, (3) fires, (4) floods, (5) epidemics, (6) quarantine restrictions, (7) strikes, (8) freight embargoes, and (9) unusually severe weather. In each instance the failure to perform must be beyond the control and without the fault or negligence of the Contractor.

(d) If the failure to perform is caused by the default of a subcontractor at any tier, and if the cause of the default is beyond the control of both the Contractor and subcontractor, and without the fault or negligence of either, the Contractor shall not be liable for any excess costs for failure to perform, unless the subcontracted supplies or services were obtainable from other sources in sufficient time for the Contractor to meet the required delivery schedule.

(e) If this contract is terminated for default, the State may require the Contractor to transfer title and deliver to the State, as directed by the Procurement Officer, any (1) completed supplies, and (2) partially completed supplies and materials, parts, tools, dies, jigs, fixtures, plans, drawings, information, and contract rights (collectively referred to as "manufacturing materials" in this clause) that the Contractor has specifically produced or acquired for the terminated portion of this contract. Upon direction of the Procurement Officer, the Contractor shall also protect and preserve property in its possession in which the State has an interest.

(f) The State shall pay contract price for completed supplies delivered and accepted. The Contractor and Procurement Officer shall agree on the amount of payment for manufacturing materials delivered and accepted and for the protection and preservation of the property; if the parties fail to agree, the Procurement Officer shall set an amount subject to the Contractor's rights under the Disputes clause. Failure to agree will be a dispute under the Disputes clause. The State may withhold from these amounts any sum the Procurement Officer determines to be necessary to protect the State against loss because of outstanding liens or claims of former lien holders.

(g) If, after termination, it is determined that the Contractor was not in default, or that the default was excusable, the rights and obligations of the parties shall, if the contract contains a clause providing for termination for convenience of the State, be the same as if the termination had been issued for the convenience of the State. If, in the foregoing circumstances, this contract does not contain a clause providing for termination for convenience of the State, the contract shall be adjusted to compensate for such termination and the contract modified accordingly subject to the contractor's rights under the Disputes clause.

15 FEDERAL NON-DISCLOSURE REQUIREMENTS

The Contractor shall notify in writing each of its officers or employees to whom Social Security information is or may be disclosed that Social Security information disclosed to such officer or employee can be only used for authorized purposes and to the authorized extent, and any other unauthorized use herein constitutes a felony punishable upon conviction by a fine of as much as five thousand dollars (\$5,000) or imprisonment for as long as five (5) years, or both, together with the cost of prosecution. The Contractor shall also notify each such officer or employee that any unauthorized further disclosure of Social Security information may also result in an award of civil damages against the officer or employee in an amount not less than one thousand dollars (\$1,000) with respect to each instance of unauthorized disclosure. These penalties are prescribed by IRC Sections 7213 and 7431 and set forth at 26 CFR 301.6103(n). Additionally, the Contractor shall inform its officers and employees of penalties for improper disclosure under the Privacy Act of 1974, 5 U.S.C. 552a. Specifically, 5 U.S.C. 552a (1) (1), which is made applicable to contractors by 5 U.S.C. 552a (m) (1), provides that any officer or employee of a Contractor who, by virtue of his/her employment or official position, has possession of or access to agency records that contain individually identifiable information, the disclosure of which is prohibited by the Privacy Act or regulations established there under, and who knowing that disclosure of the specific material is prohibited willfully discloses that material in any manner to any person or agency not entitled to receive it, shall be guilty of a misdemeanor and fined not more than five thousand dollars (\$5,000).

16 HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) STANDARDS COMPLIANCE

16.1 HIPAA Compliance

The Contractor agrees that it shall deliver systems and services that are compliant with Title II, Subtitle F, Section 261-264 of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, titled "Administrative Simplification" and the rules and

regulations promulgated thereunder. In addition, the Contractor will ensure compliance with all HIPAA requirements across all systems and services related to this contract, including transaction, common identifier, and privacy and security standards, by the effective date of those rules and regulations. The Contractor will comply with the rules and regulations, and will implement these rules and regulations so as to achieve consistency in data collection, validation, storage, retrieval, and consolidation with all the Department's programs.

16.2 HIPAA Security

The Contractor shall comply with all HIPAA data security requirements that may be necessary during the term of this contract.

16.3 HIPAA Business Associate

HIPAA Business Associate. Individually identifiable health information is to be protected in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The Offeror shall execute the HIPAA Business Associate Agreement in Attachment B.

17 ILLEGAL IMMIGRATION

- (a) By signing its offer, Contractor certifies that it will comply with the applicable requirements of Title 8, Chapter 14 of the South Carolina Code of Laws and agrees to provide to the State upon request any documentation required to establish either: (a) that Title 8, Chapter 14 is inapplicable to Contractor and its subcontractors; or (b) that Contractor and all subcontractors at any tier are in compliance with Title 8, Chapter 14. Pursuant to Section 8-14-60, "A person who knowingly makes or files any false, fictitious, or fraudulent document, statement, or report pursuant to this chapter is guilty of a felony and, upon conviction, must be fined within the discretion of the court or imprisoned for not more than five years, or both."
- (b) Contractor shall at all times comply with, the U.S. Immigration Reform and Control Act of 1986 and its successor, if any, and any implementing regulations therefor. Contractor will not assign Services to be performed to any Contractor personnel who are unauthorized aliens. If any of Contractor personnel performing any of the Services is discovered to be an unauthorized alien, Contractor will immediately remove such personnel from performing Services hereunder and replace such personnel with personnel who is not an unauthorized alien.
- (c) Contractor shall include language in all subcontracts issued pursuant to this contract requiring its first-tier subcontractors to (i) comply with the applicable requirements of Title 8, Chapter 14 of the South Carolina Code of Laws, the U.S. Immigration Reform and Control Act of 1986 and its successors, and any implementing federal or state regulations and (ii) include such language in its contracts with subcontractors at any tier.

18 INHERENT SERVICES

If any services, deliverables, functions or responsibilities not specifically described in the Contract are required for the proper performance, provision, and delivery of the Services, Acquired Items and Deliverables or are an inherent part of or necessary sub-task included within

the Contract Documents, they will be deemed to be implied by and included within the scope of the Contract to the same extent and in the same manner as if specifically described in the Contract. Unless otherwise expressly provided in the Contract, Contractor will furnish all necessary management, supervision, labor, facilities, furniture, computer and telecommunications equipment, software, supplies and materials necessary to enable it to fully perform its responsibilities under the Contract.

19 INDEMNIFICATION - THIRD PARTY CLAIMS

Except with respect to Intellectual Property Infringement, which shall be governed by Section VIIB.22 below, Contractor shall defend and indemnify the State of South Carolina, its instrumentalities, agencies, departments, boards, political subdivisions and all their respective officers, agents and employees against all suits or claims of any nature (and all damages, settlement payments, attorneys' fees, costs, expenses, losses or liabilities attributable thereto) by any third party which arise out of, or result in any way from, any defect in the goods or services acquired hereunder or from any act or omission of Contractor, its subcontractors, their employees, workmen, servants or agents. Contractor shall be given written notice of any suit or claim. State shall allow Contractor to defend such claim so long as such defense is diligently and capably prosecuted through legal counsel. State shall allow Contractor to settle such suit or claim so long as (i) all settlement payments are made by (and any deferred settlement payments are the sole liability of) Contractor, and (ii) the settlement imposes no non-monetary obligation upon State. State shall not admit liability or agree to a settlement or other disposition of the suit or claim, in whole or in part, without the prior written consent of Contractor. State shall reasonably cooperate with Contractor's defense of such suit or claim. The obligations of this paragraph shall survive termination of the parties' agreement.

20 INVOICING AND PAYMENT

All invoices submitted by Contractor shall conform to the provisions of Exhibit A, Invoicing and Payment, attached to this Section VII.B. Only invoices conforming to the provisions of the Exhibit shall be deemed proper invoices as defined in Section VII.A.10.

21 DISCLOSURE OF INFORMATION RELATED TO OWNERSHIP, CERTAIN BUSINESS TRANSACTIONS AND PERSONS CONVICTED OF CRIMES

The Contractor shall comply with 42 CFR 455.104 (2008, as amended) with respect to disclosure of ownership information. Further, The Contractor shall furnish to the State or to the USDHHS information related to significant business transactions as set forth in 42 CFR 455.105 (2008, as amended) and information related to any person convicted of a criminal offense under a program relating to Medicare (Title XVIII), Medicaid (Title XIX), or the Social Services Block Grant Program as set forth in 42 CFR 455.106 (2008, as amended).

22 INTELLECTUAL PROPERTY INFRINGEMENT

(a) Without limitation and notwithstanding any provision in this agreement, Contractor shall, upon receipt of notification, defend and indemnify the State, its instrumentalities, agencies,

departments, boards, political subdivisions and all their respective officers, agents and employees against all actions, proceedings or claims of any nature (and all damages, settlement payments, attorneys' fees (including inside counsel), costs, expenses, losses or liabilities attributable thereto) by any third party asserting or involving an Intellectual Property Right related to an Acquired Item. State shall allow Contractor to defend such claim so long as the defense is diligently and capably prosecuted. State shall allow Contractor to settle such claim so long as (i) all settlement payments are made by Contractor, and (ii) the settlement imposes no non-monetary obligation upon State. State shall reasonably cooperate with Contractor's defense of such claim.

(b) In the event an injunction or order shall be obtained against State's use of any Acquired Item, or if in Contractor's opinion, the acquired item is likely to become the subject of a claim of infringement or violation of an Intellectual Property Right, Contractor shall, without in any way limiting the foregoing, and at its expense, either: (1) procure for State the right to continue to use, or have used, the Acquired Item, or (2) replace or modify the Acquired Item so that it becomes non-infringing but only if the modification or replacement does not adversely affect the specifications for the acquired item or its use by State. If neither (1) nor (2), above, is practical, State may require that Contractor remove the Acquired Item from the State, refund to State any charges paid by State therefor, and take all steps necessary to have State released from any further liability.

(c) Contractors obligations under this paragraph do not apply to a claim to the extent (i) that the claim is caused by Contractor's compliance with Specifications furnished by the State unless Contractor knew its compliance with the State's Specifications would infringe an Intellectual Property Right, or (ii) that the claim is caused by Contractor's compliance with Specifications furnished by the State if the State knowingly relied on a third party's Intellectual Property Right to develop the specifications provided to Contractor and failed to identify such product to Contractor.

(d) Contractor's obligations under this clause shall survive the termination, cancellation, rejection, or expiration of this Contract.

23 LICENSES AND PERMITS (JAN 2006)

During the term of the contract, the Contractor shall be responsible for obtaining, and maintaining in good standing, all licenses (including professional licenses, if any), permits, inspections and related fees for each or any such licenses, permits and /or inspections required by the State, county, city or other government entity or unit to accomplish the work specified in this solicitation and the contract. [07-7B115-1]

24 MATERIAL AND WORKMANSHIP (JAN 2006)

Unless otherwise specifically provided in this contract, all equipment, material, and articles incorporated in the work covered by this contract are to be new and of the most suitable grade for the purpose intended. [07-7B120-1]

25 OWNERSHIP AND LICENSE RIGHTS

25.1 Ownership Rights in State Material

The State shall own all right, title, and interest in and to all actual and prospective Intellectual Property Rights in and to the State Material, including all Custom Software. As used in this Section, title includes providing to the State all intellectual elements of the State Materials including, but not limited to, developmental work product, notes, object and source codes, documentation, and any other items which would aid the State in understanding, using, maintaining, and enhancing said customized software. All aspects of the State Material that are copyrightable, and all work in process in connection therewith, shall be considered “works made for hire” under applicable law, and the State shall be the “author” within the meaning of such laws. All such copyrightable State Material, as well as all copies of such State Material in whatever medium fixed or embodied, shall be owned exclusively by the State upon its creation, and Contractor hereby expressly disclaims any interest in any of them. In the event (and to the extent) that State Material created by Contractor hereunder or any part or element thereof is either identified and agreed or found as a matter of law, not to be a “work made for hire”, or in the event any State Material is non-copyrightable, Contractor shall and does hereby irrevocably convey and assign to the State all such rights, title and interests in such State Material, and all copies of any of them, without further consideration. To the extent that any State Material is copyrightable and not “work made for hire”, Contractor agrees to assist the State to register, and from time to time to enforce, all Intellectual Property Rights and other rights and protections relating to the State Material created. If any Proprietary Contractor Material is embedded in the State Material, Contractor hereby grants to the State a royalty-free, global, fully paid-up, irrevocable, perpetual, non-exclusive license to use and make derivative works of, for the State’s internal purposes, such embedded Proprietary Contractor Material.

As between the State and the Contractor, the State will retain all of its Intellectual Property Rights in and to, along with all right, title and interest in and to, any goods, software, specifications, drawings, records, reports, documentation, know-how, methodologies, processes, technologies, State Data or derivative works thereof, or other materials or information provided by the State to the Contractor in connection with the Contract, and Contractor shall not acquire any right, title or interest therein.

25.2 Licenses in and to certain State Materials

In accordance with 45 CFR 92.34 and 45 CFR 95.617, the US DHHS shall have a royalty-free, non-exclusive, and irrevocable license to reproduce, publish, or otherwise use, and to authorize others (including without limitation the Contractor and its customers) to use, for Federal Government purposes, the copyright in the State Material and such Custom Software as is newly created for delivery to the State; provided, however, that this license shall apply only to such State Material and Custom Software as is paid for to any extent with Federal Government funds. Except as the Federal Government may otherwise authorize, Contractor may use, perform, execute, display, distribute, copy and/or create derivative works based on the State Material only in performance of Contractor's duties under the Contract. Notwithstanding the foregoing, Contractor may request that the State and the US DHHS grant it a perpetual and fully paid right to use, modify and create derivative works from the Custom Software included in State Materials

that are coextensive with the State's rights in and to such Custom Software, provided Contractor is not charging for the material itself but only for its services associated with using or modifying the materials to serve public sector clients and subject to such other requirements as the State or US DHHS may request.

25.3 Proprietary Contractor Material

The State acknowledges that the Proprietary Contractor Materials may include Contractor Proprietary Software. Contractor hereby grants the State a non-exclusive, perpetual, royalty-free, and irrevocable license to create modifications to the Proprietary Contractor Material, which Proprietary Contractor Material and modifications the State, and others with the State's authorization and on the State's behalf, may copy, perform, use, execute, display, and digitally transmit. Such license includes the right to use the Proprietary Contractor Materials in conjunction with a backup computer as needed, and to copy and store an archival copy of such Proprietary Contractor Material. Without limiting the generality of the foregoing, the State or its contractors may use the Proprietary Contractor Material to maintain, develop, and modify the system and successor systems, including without limitation in the event that the State awards a contract to a third party for takeover of the Contractor's operations hereunder upon expiration or termination of the Contract. Subject to agreements of non-disclosure and non-use that are reasonably protective of the Contractor's proprietary interests, the State may disclose Proprietary Contractor Material to potential third party Offerors in the course of procuring such takeover services. Subject to comparable protective agreements, the State may disclose the Proprietary Contractor Material to other contractors during and after the Term of the Contract, so that on behalf of the State the contractors may tailor their operations and the design of their work products for compatibility with the Proprietary Contractor Material. Source Code for Proprietary Contractor Software shall be escrowed in accordance with the provisions of paragraph VIIB. 37 below.

25.4 Commercially Available Off-the-Shelf Software (COTS Software)

The Contractor shall not commit to incorporation or substantial use of any COTS Software as part of the Deliverables or in connection with performance of the Services without first notifying the State of its intent to do so. The Contractor shall so inform the State in writing (if the Contractor has not already done so through its Proposal) and within sufficient time for the State to consider the risks and alternatives associated with the Contractor's intention. All COTS Software shall be licensed to the State pursuant to the terms of License Agreement for COTS Software attached to this Section VII B. as Exhibit C, COTS AGREEMENT, which shall be signed by the State and the licensor of such COTS Software and shall be deemed a collateral agreement to this Contract and not included in the Contract Document or Contract order of precedence.

All COTS Software accepted by the State shall include the commitment of the licensor of such Software to provide support and maintenance service for such COTS Software for a minimum of the term of this.

25.5 Third Party Proprietary Material

Prior to incorporating elements of Third Party Proprietary Material into any Deliverable, the Contractor shall notify the State of its intent to do so in writing. (if the Contractor has not already done so through its Proposal) within sufficient time for the State to consider the risks and alternatives associated with the Contractor's intention. The Third Party shall grant the State, either directly or by sublicense from the Contractor, a non-exclusive, perpetual, royalty-free, and irrevocable license to create modifications to the Third Proprietary Party Material, which Third Party Proprietary Material and modifications the State, and others with the State's authorization and on the State's behalf, may copy, perform, use, execute, display, and digitally transmit. Without limiting the generality of the foregoing, the State or its contractors may use the Third Party Proprietary Material to maintain, develop, and modify the system and successor systems, including without limitation in the event that the State awards a contract to a third party for takeover of the Contractor's operations hereunder upon expiration or termination of the Contract. Subject to agreements of non-disclosure and non-use that are reasonably protective of the Third Party's proprietary interests, the State may disclose Third Party Proprietary Material to potential offerors in the course of procuring such takeover services. Subject to comparable protective agreements, the State may disclose the Third Party Proprietary Material to its contractors during and after the Term of the Contract, so that on behalf of the State the contractors may tailor their operations and the design of their work products for compatibility with the Proprietary Contractor Material. Any Proprietary Third Party Software licensed to the State directly by the owner shall be licensed pursuant to the terms of License Agreement for Proprietary Third Party Software attached to this Section VII B. as Exhibit B, PROPRIETARY THIRD PARTY SOFTWARE LICENSE, which shall be signed by the State and the Third Party and shall be deemed a collateral agreement to this contract and not included in the Contract Documents or Order of Precedence. Source Code for Proprietary Third Party Software shall be escrowed in accordance with the provisions of paragraph VIIB. 37 below

25.6 Intent to Incorporate or Use Public Material or Open Source Software

The Contractor shall not commit to incorporation or substantial use of any Public Material or open source software as part of the Deliverables or in connection with performance of the Services without first notifying the State of its intent to do so. The Contractor shall so inform the State in writing (if the Contractor has not already done so through its Proposal) and within sufficient time for the State to consider the risks and alternatives associated with the Contractor's intention. All Public Material or open source software shall be licensed to the State in accordance with the prevailing terms under which such materials are offered to the public generally which shall be deemed a collateral agreement to this Contract and not included in the Contract Document.

25.7 Initial, Annual, and Final Inventory

Upon the State's request, or as established in work plans, Deliverable(s) schedules or other similar Contract documents, the Contractor will provide to the State detailed inventories of all State Material, Public Material, Proprietary Contractor Material, and Third Party Material, specifying the category of each item. With respect to each item that is subject to any extent to an open source software license, each inventory shall also specify the name and version of the

applicable open source license. The Contractor shall provide such an inventory at the beginning of the Contract and annually thereafter. In addition, the Contractor shall provide an inventory as soon as commercially practicable upon initiation of the Turnover Phase, and a final inventory following expiration or termination of the Contract. The inventory for Third Party Material shall indicate with respect to which items it shall be necessary to transfer or procure a license for the State upon a turnover of operations from the Contractor.

25.8 Software Tools

The Contractor shall provide to the State, simultaneous with its initial installation, and any subsequent enhancements, upgrades, fixes, etc., all software tools (including, but not limited to compilers, editors, etc.) that the State would require to maintain or enhance the Proprietary Contractor Materials, Third Party Materials, and Public Materials to the extent such are included in any software provided to the State. The price for said tools, if any, and the cost to train State personnel to use such tools to maintain and/or to enhance such software shall be noted separately and included in the bases of estimates in the Contractor's Cost Proposal submitted to the State in response to the State's solicitation. The Contractor hereby grants the State, or shall obtain for the State, a fully paid, perpetual, irrevocable license permitting the State, and others with the State's authorization and on the State's behalf, to copy, use, perform, display, and digitally transmit such proprietary software tools in connection with maintenance of the software requiring such tools. (Move into turnover/transition/escrow list? plus license to any Proprietary Tools, define tools as part of Proprietary Materials at turnover with source in escrow)

25.9 Export Control

The State acknowledges that certain of the software acquired under this Contract may be licensable by the U. S. Government. It further acknowledges that a valid export license must be obtained from the Department of Commerce prior to export of said products.

25.10 Marking of State Materials

All State Materials prepared during and/or resulting from the performance of Services under this Contract, including, without limitation, the Custom Software, shall include the following statement: **"The preparation of this (Custom Software, report or document, as the case may be) was financed under an agreement with SCDHHS with funds provided in part by the U.S. Department of Health and Human Services."**

26 PERFORMANCE BOND REQUIREMENT

As a condition of the execution of the contract, the contractor shall supply a performance bond; certificate of deposit; cash; an unconditional, irrevocable, standby letters of credit; or marketable securities, or provide other financial arrangements whereby funds are pledged to the benefit of the State, are not under the control of the contractor, are payable to the State upon written demand to the holder of the security, and are subject to the direction of the State if any of the circumstances set forth in sub-sections below occur. The security shall be in the amount of ten percent (10%) of the Contract Proposed Price and shall obligate the Contractor and Surety to the State in the amount specified in the security. This security will protect, indemnify, and save

harmless the State from all costs and damages by reason of the contractor's default, breach, or failure to satisfactorily complete any of the following terms:

- (a) Payment to all entities, individuals, and the like furnishing of labor or materials in connection with this contract; and/or
- (b) The successful execution of the final implementation plan, including satisfactorily meeting the performance or test requirements on the dates specified in the final implementation plan and the acceptance requirements and/or
- (c) Full and satisfactory performance of the ongoing obligations contained in this RFP, any amendments and any subsequent contract between the State and the contractor.

In the event of any condition of breach or other circumstance, such as those set forth above, attributable to the contractor, the State shall have the right to draw against the security such sums as are necessary to make the State whole, to secure and compensate the State for substituted services or other forms of relief made necessary by the breach. Nothing herein shall be construed to mean that the security provided for herein is exclusive or constitutes any limitation or restriction on any remedies to which the State may be entitled.

The security shall be for the benefit of the State, payable only to the State at its discretion pursuant to the terms of this section, and shall be non-exclusive and in addition to all other remedies available to the State under this RFP or the contract, or by law.

The contractor shall establish the security not later than ten (10) days after award of the contract, and failure to satisfy this requirement may, at the State's discretion, void the contract.

Any interest or other income resulting from the security shall become and remain the property and possession of the contractor and shall be payable to the contractor.

The contractor may request a reduction in the security on an annual basis, no earlier than twelve (12) months after the first anniversary date of acceptance of the service, and the State's consideration of such request shall take into account performance, and likelihood of the need for future protection provided by the security to the State.

27 PRICE ADJUSTMENTS (JAN 2006)

(1) Method of Adjustment. Any adjustment in the contract price made pursuant to a clause in this contract shall be consistent with this Contract and shall be arrived at through whichever one of the following ways is the most valid approximation of the actual cost to the Contractor (including profit, if otherwise allowed):

- a. by agreement on a fixed price adjustment before commencement of the pertinent performance or as soon thereafter as practicable;
- b. by unit prices specified in the Contract or subsequently agreed upon;
- c. by the costs attributable to the event or situation covered by the relevant clause, including profit if otherwise allowed, all as specified in the Contract; or subsequently agreed upon;
- d. in such other manner as the parties may mutually agree; or,

- e. in the absence of agreement by the parties, through a unilateral initial written determination by the Procurement Officer of the costs attributable to the event or situation covered by the clause, including profit if otherwise allowed, all as computed by the Procurement Officer in accordance with generally accepted accounting principles, subject to the provisions of Title 11, Chapter 35, Article 17 of the S.C. Code of Laws.

(2) Submission of Price or Cost Data. Upon request of the Procurement Officer, the Contractor shall provide reasonably available factual information to substantiate that the price or cost offered, for any price adjustments is reasonable, consistent with the provisions of Section 11-35-1830.

[07 – 7B160-1]

28 PRICE ADJUSTMENTS – LIMITED BY ECI

Upon request and adequate justification, the Procurement Officer may grant a price increase up to, but not to exceed, the unadjusted percent change for the most recent 12 months for which data is available, that is not subject to revision, in the Employment Cost Index (ECI) for Civilian workers/All workers for services, as determined by the Procurement Officer. The Bureau of Labor and Statistics publishes this information on the web at www.bls.gov.

29 PRICING DATA -- AUDIT -- INSPECTION

(a) Cost or Pricing Data. Upon Procurement Officer's request, you shall submit cost or pricing data, as defined by 48 C.F.R. § 2.101 (2004), prior to either (1) any award to contractor pursuant to 11-35-1530 or 11-35-1560, if the total contract price exceeds \$500,000, or (2) execution of a change order or contract modification with contractor which exceeds \$100,000. Your price, including profit or fee, shall be adjusted to exclude any significant sums by which the state finds that such price was increased because you furnished cost or pricing data that was inaccurate, incomplete, or not current as of the date agreed upon between parties.

(b) Records Retention. You shall maintain your records for five years from the date of final payment, or longer if requested by the chief Procurement Officer. The state may audit your records at reasonable times and places. As used in this subparagraph (b), the term "records" means any books or records that relate to cost or pricing data submitted pursuant to this clause. In addition to the obligation stated in this subparagraph (b), you shall retain all records and allow any audits provided for by 11-35-2220(2).

(c) Inspection. At reasonable times, the state may inspect any part of your place of business which is related to performance of the work.

(d) Instructions – Certification. When you submit data pursuant to subparagraph (a), you shall (1) do so in accordance with the instructions appearing in Table 15-2 of 48 C.F.R. § 15.408 (2004) (adapted as necessary for the state context), and (2) submit a Certificate of Current Cost or Pricing Data, as prescribed by 48 CFR § 15.406-2(a) (adapted as necessary for the state context).

(e) Subcontracts. You shall include the above text of this clause in all of your subcontracts. (f) Nothing in this clause limits any other rights of the state.

30 PRIVACY -- WEB SERVICES (JAN 2006)

You agree that any information acquired by you about individuals or businesses as a result of performance of this contract shall not be retained beyond the end of the term of the contract without the express written consent of the government. Such information shall never be sold, traded, or released to another entity, including affiliates, and shall not be used for any purpose other than performing this contract. Upon request, Contractor shall provide written confirmation of compliance with this clause. [07 – 7B195-1]

31 RECORD INSPECTION AUDIT AND RETENTION

During normal business hours, the U.S. DHHS, the Comptroller General, the Office of the Attorney General, South Carolina Budget and Control Board, the South Carolina State Auditor, the SCDHHS staff, and the authorized representative(s) or designees of any of the foregoing, shall have the right to enter into the Contractor's premises, or other such places where duties under the Contract are being performed, to inspect, monitor, assess, audit, or otherwise evaluate the work performed or being performed under this contract. Such authorized individuals shall have the right to audit, examine and make copies, excerpts or transcripts from all records unless otherwise precluded by Law or Regulatory Requirement; contact and conduct private interviews with Contractor employees and perform on-site reviews of all matters relating to this Contract. If any inspection or evaluation is made on the premises of the Contractor, or a Subcontractor, the Contractor shall provide and shall cause its Subcontractors to provide all reasonable facilities and assistance for the safety and convenience of the authorized representatives in the performance of their duties. All such inspections and evaluations should be performed in such a manner that will not unreasonably delay work. This provision is applicable to all Subcontractors and shall be included in all subcontracts.

The Contractor shall maintain an accounting system with the supporting fiscal records adequate to assure that all claims for funds are in accordance with the Contract, Law, the Regulatory Requirements, and all applicable State and Federal policies. The Contractor shall retain and shall cause its Subcontractors to retain all Contractor and subcontractor books, documents, papers, accounting records, or other evidence pertaining to costs incurred under this contract for a period of at least five (5) years after the final payment under this Contract. The SCDHHS, the Office of the Attorney General, the South Carolina State Auditor, the U.S. Department of Health and Human Services (DHHS) and the Comptroller General of the United States or any of their duly authorized representatives or designees shall have access to any such books for the purpose of making audits, examinations, excerpts, and transcripts for no less than five (5) years after the date of final payment under this Contract or a resolution of audit findings, whichever is later.

32 RELATIONSHIP OF THE PARTIES (JAN 2006)

Neither party is an employee, agent, partner, or joint venturer of the other. Neither party has the right or ability to bind the other to any agreement with a third party or to incur any obligation or liability on behalf of the other party. [07 – 7B205]

33 RESTRICTIONS FOR LOBBYING

In accordance with 31 U.S.C. 1352 et seq., funds received under this contract may not be expended to pay any person for influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with any of the following covered Federal actions: the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement. This restriction is applicable to all subcontractors at any tier and should be included in all subcontracts.

34 RIGHT TO SUSPEND WORK

If at any time the State determines that it is in its best interest to temporarily suspend all Contractor activity, or any part thereof, the State may do so by providing the Contractor with a written notice thereof. On receipt of such notice, the Contractor shall immediately cease all specified activity for the period indicated in such notice. Such suspension shall be for the time specified in the written notice but may not extend beyond ninety (90) days unless otherwise agreed by the parties. If the suspension is not due to the Contractor's failure to perform or its failure to perform in accordance with the terms of the Contract, the State shall reimburse the Contractor within a reasonable time for any additional costs reasonably incurred by the Contractor as a result of the suspension and reasonably extend any delivery schedules to which the Contractor may have been subject during the suspension.

35 SAFETY PRECAUTIONS

The State and U.S. Department of Health and Human Services assume no responsibility with respect to accidents, illness, or claims arising out of any work undertaken with the assistance of funds paid under the contract. The Contractor should take necessary steps to insure or protect itself and its personnel. The Contractor agrees to comply with all applicable local, state, and federal occupational and safety acts, rules, and regulations.

36 SHIPPING / RISK OF LOSS (JAN 2006)

F.O.B. Destination. Destination is the shipping dock of the Using Governmental Units' designated receiving site, or other location, as specified herein. [07 – 7B220]

37 SOURCE CODE ESCROW

- (a) The Contractor shall comply with the escrow provisions below for all Public Material, Proprietary Contractor Material and Third Party Proprietary Material.
- (b) As requirement for completion of the Discovery Phase, the Parties shall enter into a software escrow agreement ("Escrow Agreement") with a reputable, independent, third party that provides software escrow services among its principal business offerings ("Escrow Agent"). The Escrow Agreement shall be such third party provider's standard commercial terms and should provide for the regular deposit into escrow of all Source Code, object code, and documentation with respect to all Public Material, Proprietary Contractor Material, and Third

Party Proprietary Materials (and cumulative updates thereof), together with (i) continually updated instructions as to the compilation, installation, configuration, deployment, and use of the Source Code, and (ii) a list of all non-deposited third party software used in conjunction with the Source Code to provide the full functionality of the deposited materials. In the event of the termination or expiration of the initial Escrow Agreement or any successor agreement, with minimal delay the Parties shall enter into a substantially equivalent agreement with a successor provider of software escrow services (who shall then be known as the “Escrow Agent”).

- (c) The Contractor will make its initial deposit of Source Code within fifteen (15) days after the effective date of the Escrow Agreement. The Contractor shall periodically update the escrow deposit as the Parties shall agree in the Escrow Agreement. In addition to other usual and customary terms, the Escrow Agreement shall provide that the State shall be entitled to obtain the deposited materials from escrow upon the State’s making a proper claim for release from escrow in the event that (i) proper written notice is given the Escrow Agent that release of the copy of the deposited materials is pursuant to 11 United States Code Section 365(n) or other applicable Federal or State bankruptcy, insolvency, reorganization, or liquidation statute; (ii) the Contractor files articles of dissolution (but not if the Contractor is consolidated or merged into another entity); (iii) Contractor refuses to provide software maintenance, bug fixes, upgrades, updates and/or enhancement services under the terms set forth in this contract or as generally provided similarly situated customers, and for all escrowed materials except for COTS Software (iv) the Contract expires or terminates; or (v) the **Turnover Phase** is initiated.
- (d) The release of deposited materials from escrow shall not confer upon the State any right of ownership in the deposited materials or the underlying intellectual property embodied therein. In the event of the release of deposited materials to the State from escrow, the State shall use the deposited materials solely for the benefit of the State and its constituents, consistently with the grants of license set forth in Section VII B 25. of this Contract. The release of materials from escrow, without more, shall not cause any further amounts to accrue as payable to the Contractor by the State, and the term of the State’s possessory and usage rights with respect to the released materials shall be perpetual. The Escrow Agreement shall provide for its automatic termination upon the earlier of five (5) years after the expiration or termination of this Contract, or, release of all Source Code to the State and the State’s subsequent confirmation of compliance with the terms of the Escrow Agreement. The Contractor shall bear the escrow costs, as well as all costs associated with causing its subcontractors and other third parties to abide by the Escrow Agreement.

38 TERM OF CONTRACT -- EFFECTIVE DATE / INITIAL CONTRACT PERIOD (JAN 2006)

The effective date of this contract is the first day of the Maximum Contract Period as specified on the final statement of award. The initial term of this agreement is 5 years, 0 months, 0 days from the effective date. Regardless, this contract expires no later than the last date stated on the final statement of award. [07 – 7B240-1]

39 TERM OF CONTRACT -- OPTION TO RENEW (JAN 2006)

At the end of the initial term, and at the end of each renewal term, this Contract shall automatically renew for a period of 1 year(s), 0 month(s), and 0 day(s), unless Contractor receives notice that the State elects not to renew the contract at least thirty (30) days prior to the date of renewal. Regardless, this contract expires no later than the last date stated on the final statement of award. [07-7B245-1]

40 TERMINATION BY MUTUAL AGREEMENT

The State and Contractor may mutually agree to terminate this Contract by written agreement at any time during its term or any renewal term.

41 TERMINATION FOR CONVENIENCE (JAN 2006)

(1) Termination. The Procurement Officer may terminate this contract in whole or in part, for the convenience of the State. The Procurement Officer shall give written notice of the termination to the contractor specifying the part of the contract terminated and when termination becomes effective.

(2) Contractor's Obligations. The contractor shall incur no further obligations in connection with the terminated work and on the date set in the notice of termination the contractor will stop work to the extent specified. The contractor shall also terminate outstanding orders and subcontracts as they relate to the terminated work. The contractor shall settle the liabilities and claims arising out of the termination of subcontracts and orders connected with the terminated work. The Procurement Officer may direct the contractor to assign the contractor's right, title, and interest under terminated orders or subcontracts to the State. The contractor must still complete the work not terminated by the notice of termination and may incur obligations as are necessary to do so.

(3) Right to Supplies. The Procurement Officer may require the contractor to transfer title and deliver to the State in the manner and to the extent directed by the Procurement Officer: (a) any completed supplies; and (b) such partially completed supplies and materials, parts, tools, dies, jigs, fixtures, plans, drawings, information, and contract rights (hereinafter called "manufacturing material") as the contractor has specifically produced or specially acquired for the performance of the terminated part of this contract. The contractor shall, upon direction of the Procurement Officer, protect and preserve property in the possession of the contractor in which the State has an interest. If the Procurement Officer does not exercise this right, the contractor shall use best efforts to sell such supplies and manufacturing materials in accordance with the standards of Uniform Commercial Code Section 2-706. Utilization of this Section in no way implies that the State has breached the contract by exercise of the Termination for Convenience Clause.

(4) Compensation. (a) The contractor shall submit a termination claim specifying the amounts due because of the termination for convenience together with cost or pricing data required by Section 11-35-1830 bearing on such claim. If the contractor fails to file a termination claim within one year from the effective date of termination, the Procurement Officer may pay the contractor, if at all, an amount set in accordance with Subparagraph (c) of this Paragraph.

(b) The Procurement Officer and the contractor may agree to a settlement and that the settlement does not exceed the total contract price plus settlement costs reduced by payments previously

made by the State, the proceeds of any sales of supplies and manufacturing materials under Paragraph (3) of this clause, and the contract price of the work not terminated;

(c) Absent complete agreement under Subparagraph (b) of this Paragraph, the Procurement Officer shall pay the contractor the following amounts, provided payments agreed to under Subparagraph (b) shall not duplicate payments under this Subparagraph:

(i) contract prices for supplies or services accepted under the contract;

(ii) costs reasonably incurred in performing the terminated portion of the work less amounts paid or to be paid for accepted supplies or services;

(iii) reasonable costs of settling and paying claims arising out of the termination of subcontracts or orders pursuant to Paragraph (2) of this clause. These costs must not include costs paid in accordance with Subparagraph (c)(ii) of this paragraph;

(iv) any other reasonable costs that have resulted from the termination. The total sum to be paid the contractor under this Subparagraph shall not exceed the total contract price plus the reasonable settlement costs of the contractor reduced by the amount of payments otherwise made, the proceeds of any sales of supplies and manufacturing materials under Subparagraph (b) of this Paragraph, and the contract price of work not terminated.

(d) Contractor must demonstrate any costs claimed, agreed to, or established under Subparagraphs (b) and (c) of this Paragraph using its standard record keeping system, provided such system is consistent with any applicable Generally Accepted Accounting Principles.

(5) Contractor's failure to include an appropriate termination for convenience clause in any subcontract shall not (i) affect the state's right to require the termination of a subcontract, or (ii) increase the obligation of the state beyond what it would have been if the subcontract had contained an appropriate clause.

42 TERMINATION FOR FINANCIAL INSTABILITY

a) The State may terminate the Contract by providing written notice to such effect (a) in the event that the State determines in its sole but reasonable discretion that the Contractor has become financially unstable to the point of threatening the ability of the Contractor to perform the Services as required hereunder, (b) upon the Contractor's institution of insolvency, receivership or bankruptcy proceedings or any other proceedings for the settlement of its debts, (c) upon the institution of such proceedings against the Contractor, which are not dismissed or otherwise resolved in the Contractor's favor within sixty (60) days thereafter, (d) upon the Contractor's making a general assignment for the benefit of creditors, or (e) upon the Contractor's dissolution or ceasing to conduct business in the normal course. Such termination shall be effective at the close of business on the date specified in the written notice. In the event that the State elects to terminate the Contract pursuant to this Section, the Contractor shall be notified in writing by the means set forth in the Contract for providing notice, specifying the date of termination. In the event of the filing of a petition in bankruptcy by or against the Contractor or any subcontractor, the Contractor shall immediately advise the State of said action.

- b) The Contractor shall cause each of its subcontracting agreements to provide that the Contractor may terminate the subcontract for, among any other reasons negotiated by the Contractor, the subcontractor's institution of insolvency, receivership, or bankruptcy proceedings or any other proceedings for the settlement of its debts. Upon the institution of such proceedings, the Contractor shall exercise such a provision and terminate the subcontract if the State so directs.

43 TERMINATION FOR CHANGE OF CONTROL OF CONTRACTOR

In the event of a Change in Control (a) Contractor will promptly provide notice to the State of such event, and (b) the State has the right, but not the obligation, within thirty (30) days of receipt of such notice, to terminate the Contract by giving Contractor notice of termination at least thirty (30) days prior to the termination date specified in the notice. The Contractor shall be entitled to recover the actual costs for work performed up to the date of termination. For purposes of this paragraph, "Change of Control" shall mean a change in ownership or control of greater than fifty per cent (50%) of the voting shares of the affected corporation.

44 TERMINATION FOR FAILURE TO MEET PERFORMANCE STANDARDS

- (a) If, during the Operations Phase when Critical and noncritical Performance Standards are being measured, Contractor fails to meet: (i) 10 Critical Performance Standards in 3 consecutive months, (ii) 50% of the Critical Performance Standards in a single month, or (iii) 20 Noncritical Performance Standards in 6 consecutive months, the State shall have the right, but not the obligation, in addition to all other remedies available to it under the Contract, to terminate the Contract for failure to meet performance standards by giving Contractor notice of termination stating the effective date of such termination. Termination pursuant to this paragraph shall be deemed a default giving rise to the State's remedies for Default in Section VII.B. 14.
- (b) The State's decision not to exercise the power to terminate pursuant to this paragraph shall not be deemed a waiver of any the rights and remedies of the State available under the Contract.

45 WAIVER OF CLAIMS FOR CONSEQUENTIAL DAMAGES

- (1) The Contractor and State waive any and all claims, known or unknown, against each other for consequential damages arising out of or relating to this contract. This mutual waiver includes: (a) damages incurred by the state for loss of income, profit, financing, business and reputation, management or employee productivity or of the services of such persons; and (b) damages incurred by the Contractor for principal office expenses including the compensation of personnel stationed there, for losses of financing, business and reputation, and for loss of profit except anticipated profit arising directly from the work.
- (2) This mutual waiver is applicable, without limitation, to all consequential damages due to termination pursuant to a termination provision of this contract. Nothing contained in this paragraph shall be deemed to preclude an award of liquidated damages, when applicable, in accordance with the terms of this contract. This paragraph does not apply to any claim for

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equitable or contractual indemnification, including, without limitation, Intellectual Property Infringement and breach of Confidentiality. or to any claims of the State arising out of, or related to, the failure to obtain System Certification for the integrated system.

Exhibit A. Invoicing and Payment

1 Invoices Generally

Regardless of the phase, the Contractor shall invoice the State no more than once monthly. Each invoice shall be for all charges accrued during the immediately preceding month, even if the invoice covers payments for multiple items. The Contractor shall submit documentation with the invoice to include the following:

- (a) Reporting to meet State cost allocation requirements;
- (b) Clear allocation of invoiced Services by month of performance to ensure that inflation adjustments are made accurately; and
- (c) As directed by the State from time to time, accountings by activity or paying entity.

Any invoiced Service shall be supported by sufficient documentation to enable the Contractor to establish the basis for the invoiced amount and charges. Such documentation shall be available to the State for audit and verification in accordance with Section VII.B.31 and shall be retained by the Contractor in accordance with that Section. Each invoice shall separately identify the Contract activity to which each charge pertains. Invoiced hourly personnel charges shall indicate hours worked by the individual's name and by activity. The invoice shall list, and the net invoice amount shall reflect, all credits to the State that may have accrued during the period covered by the invoice.

2 Application of Inflation Adjustments

Prices for Services performed during the first year of the Contract shall not be adjusted for inflation as described in RFP Section III.5.4. For subsequent years, invoiced prices for the Services listed below shall be adjusted for inflation:

- Replacement Phase labor
- Replacement Phase Operations Standup
- Operations Phase Base Work
- Operations Phase Claims-Related Services
- Operations Phase Prior Authorization Services
- Operations Phase Provider Management Services
- Operations Phase Third Party Liability/Recovery Services (except for contingency-based recovery Services)
- Operations Phase Member Premium Management Services
- Operations Phase Training Services
- Turnover Phase

Payments made to reimburse the Contractor for actual costs (e.g., materials costs, pass-through costs, approved travel costs) shall not be adjusted for inflation.

The inflation factor for the first year of the Contract shall be 1.0000 (i.e., no adjustment). Subsequent years inflation will be applied in a compound fashion to derive the inflation factor.

The table below shows an example of calculating the inflation factor.

Contract Year	ECI at Contract Anniversary	CPI-U at Contract Anniversary	Average of ECI and CPI-U	Inflation Factor to be Applied for the Contract Year
1	N/A	N/A	N/A	1.0000
2	3.1%	2.6%	2.85%	1.0285
3	1.9%	2.6%	2.25%	1.0516
4	2.8%	2.8%	2.8%	1.0811
5	4.2%	3.5%	3.85%	1.1227
6	3.8%	3.0%	3.4%	1.1609
7	3.0%	2.9%	2.95%	1.1951

3 Invoicing for Labor Hours Services

The Contractor shall invoice the State monthly for all charges accrued during the immediately preceding month for labor hours Services conducted in the Discovery Phase or Replacement Phase.

The Contractor shall not invoice the State for Overtime (more than 40 hours per week) for labor categories that are identified as billing on a 40-hour maximum week.

4 Invoicing for Materials

The Contractor shall invoice the State monthly for all charges accrued during the immediately preceding month for materials procured on behalf of the State in the Discovery Phase or Replacement Phase subsequent to transfer of title to such materials. The Contractor shall not invoice for such materials until after it has received written direction from the State to procure the materials. All materials purchases made by the Contractor prior to receiving such direction shall be made at the Contractor's own risk.

The materials shall be invoiced at the actual Contractor's cost, including credits for all incentives and other discounts, not to exceed the price quoted for the materials in the Contractor's Proposal. No additional markup for overhead or profit shall be made. Materials costs shall not be adjusted for inflation.

5 Invoicing for Fixed Price Services

The Contractor shall invoice the State monthly for payment associated with the fixed price Services at the applicable amounts set forth in the Contractor's Proposal.

6 Invoicing for Claims-Related Services

The Contractor shall invoice the State monthly for charges associated with Claims-Related Services. The payment for Claims-Related Services shall be calculated as follows:

Monthly fee (in dollars) = (Coefficient A + (Coefficient B * BC_{avg})) * BC_{avg} * Days * Inflation

Where:

Coefficient A = the value of Coefficient A from the Contractor's Cost Proposal for the Contract month being invoiced.

Coefficient A = the value of Coefficient A from the Contractor's Cost Proposal for the Contract month being invoiced.

BC_{avg} = the average daily Billable Claims completed in accordance with the Contract and State specifications during the month being invoiced calculated by dividing the total Billable Claims completed during the month by the total calendar days in that month.

Days = total number of calendars days in the invoice period

Inflation = the inflation adjustment.

If Claims-Related Services are provided, at the State's direction, for a partial month, the factor BC_{avg} shall be calculated by dividing the total Billable Claims completed during the month by the total calendars days for which the Claims-Related Services were provided.

7 Invoicing for Prior Authorization Services

The Contractor shall invoice the State monthly for charges associated with Prior Authorization Services. The payment for Member Premium Management Services shall be calculated as follows:

Monthly fee (in dollars) = $h * PA * Inflation$

Where:

h = the number of Billable Prior Authorizations completed in accordance with the Contract and State specifications during the month being invoiced.

PA = the price per Billable Prior Authorization from the Contractor's Cost Proposal for the month being invoiced.

Inflation = the inflation adjustment.

8 Invoicing for Provider Management Services

The Contractor shall invoice the State monthly for charges associated with Provider Management Services.

8.1 Invoicing for Provider Enrollment, Re-validation, and Screening

The payment for provider enrollment, re-validation, and screening shall be calculated as follows:

Monthly fee (in dollars) = $(p * A + q * E + r * V + s * L + t * M + u * H) * Inflation$

Where:

p = the number of provider abbreviated enrollments completed in accordance with the Contract and State specifications during the month being invoiced.

A = the price per abbreviated enrollment from the Contractor's Cost Proposal for the Contract month being invoiced.

q = the number of provider enrollments completed in accordance with the Contract and State specifications during the month being invoiced.

E = the price per enrollment from the Contractor's Cost Proposal for the Contract month being invoiced.

r = the number of provider re-validations completed in accordance with the Contract and State specifications during the month being invoiced.

V = the price per provider re-validation from the Contractor's Cost Proposal for the Contract month being invoiced.

s = the number of limited risk category screenings completed in accordance with the Contract and State specifications during the month being invoiced.

L = the price per limited risk category screening from the Contractor's Cost Proposal for the Contract month being invoiced.

t = the number of provider moderate risk category screenings completed in accordance with the Contract and State specifications during the month being invoiced.

M = the price per moderate risk category screening from the Contractor's Cost Proposal for the Contract month being invoiced.

u = the number of provider high risk category screenings completed in accordance with the Contract and State specifications during the month being invoiced.

H = the price per high risk category screening from the Contractor's Cost Proposal for the Contract month being invoiced.

Inflation = the inflation factor.

When individual Services are bundled as part of a single function (e.g., performing a simultaneous enrollment and low risk category screening), each individual Service is counted separately for invoicing. For screenings, a provider should normally receive all screenings up to and including the risk category for that provider. As such, a high risk category provider would normally receive the limited risk category screening, the moderate risk category screening, and the high risk category screening. A screening triggered by an event other than enrollment would normally require conducting only the "delta" activities from the previous level of screening to the new level of screening driven by the event.

8.2 Invoicing for Provider Outreach

The payment for provider outreach Services shall be calculated as follows:

Monthly fee (in dollars) = $a * P * \text{Inflation}$

Where:

a = the number of unduplicated providers enrolled in Medicaid in accordance with the Contract and State specifications during the month being invoiced as of 5:00 PM Eastern time on the 15th day of the month.

P = the price per unduplicated provider per month from the Contractor's Cost Proposal for the month being invoiced.

Inflation = the inflation factor.

If provider outreach Services are provided, at the State's direction, for a partial month, the number shall be calculated as the number of enrolled providers at 5:00 PM on the day containing the mid-point of the invoice period.

9 Invoicing for Third Party Liability/Recovery Services

The Contractor shall invoice the State monthly for charges associated with Third Party Liability/Recovery Services.

9.1 Primary Payer Identification Query

The payment for primary payer identification queries shall be calculated as follows:

Monthly fee (in dollars) = $b * Q * \text{Inflation}$

Where:

b = the number of primary payer queries completed at the State's direction in accordance with the Contract and State specifications during the month being invoiced.

Q = the price per query from the Contractor's Cost Proposal for the month being invoiced.

Inflation = the inflation factor.

9.2 Third Party Recovery

The payment for third party recovery shall be calculated as follows:

Monthly fee (in dollars) = $c * R$

Where:

c = the third party recovery contingency rate from the Contractor's Cost Proposal for the month being invoiced.

R = the amount of third party recovered funds deposited into the State's account in accordance with the Contract and State specifications for the month being invoiced.

Inflation adjustments are not applied to third party recoveries.

9.3 Health Insurance Premium Payment

The payment for Health Insurance Premium Payment management shall be calculated as follows:

Monthly fee (in dollars) = $d * H * \text{Inflation}$

Where:

d = the number of HIPP members for whom premiums were paid in accordance with the Contract and State specifications during the month being invoiced.

H = the price per HIPP member for whom premiums are being paid from the Contractor's Cost Proposal for the month being invoiced.

Inflation = the inflation factor.

10 Invoicing for Member Premium Management Services

The Contractor shall invoice the State monthly for charges associated with Member Premium Management Services. The payment for Member Premium Management Services shall be calculated as follows:

Monthly fee (in dollars) = $e * M * \text{Inflation}$

Where:

e = the number of members from whom premiums were collected by the Contractor in accordance with the Contract and State specifications during the month being invoiced.

M = the price per premium paying member from the Contractor's Cost Proposal for the month being invoiced.

Inflation = the inflation factor.

In addition, the State may direct the Contractor to pay HIPP premium payments on behalf of the State and invoice these as pass-through costs to the State.

11 Invoicing for Training Services

The Contractor shall invoice the State monthly for charges associated with Training Services. The payment for Training Services shall be calculated as follows:

Monthly fee (in dollars) = $[(f * T_{\text{in-person}}) + (g * T_{\text{virtual}})] * \text{Inflation}$

Where:

f = the number of in-person Training Days completed in accordance with the Contract and State specifications during the month being invoiced.

$T_{\text{in-person}}$ = the price per in-person Training Day from the Contractor's Cost Proposal for the month being invoiced.

g = the number of virtual Training Days completed in accordance with the Contract and State specifications during the month being invoiced.

T_{virtual} = the price per virtual Training Day from the Contractor's Cost Proposal for the month being invoiced.

Inflation = the inflation factor.

Invoices for training are limited to production training associated with increments being deployed or post-deployment training during the Operations Phase. Training for personnel participating in DDI (e.g., testing, familiarization training for subject matter experts, etc.) is not a separately-priced activity.

12 Invoicing for the Turnover Phase

Following the State's acceptance of each Milestone or Deliverable for the Turnover Phase, the Contractor shall invoice for payment of ninety percent (80%) of the amount specified for that Milestone or Deliverable in the Contractor's Proposal.

The Contractor shall invoice the State for payment of the balance with respect to all previously accepted Milestones and Deliverables for the Turnover Phase after the State indicates in writing that it has accepted the final Milestone or Deliverable for the Turnover Phase.

13 Invoicing for Services Provided Earlier Than Proposed

If the Contractor implements an increment early and is able to begin business operations services sooner than proposed, the Contractor shall invoice the State at the lower price of:

- a. The monthly fee calculated using the prices and rates for the first month for which the Service was planned to begin as shown on Contractor's pricing table for the month in which the business operations service was scheduled to commence or
- b. An amount equal to the average monthly fee(s) for such business process service calculated using the prices and rates for each of the first twelve months the Service was planned to be performed as shown on the Contractor's pricing table for the first twelve months of service.

Inflation adjustments will be applied based on the month that the Services were actually performed, even if those Services are performed earlier than proposed.

14 Travel Expenses

Contractor shall invoice the State for any authorized travel expenses in the month after the month in which such authorized travel occurred. Contractor will be reimbursed only for actual reasonable travel expenses authorized in advance by the State in writing. All requests for travel shall be submitted to the State in writing and shall include sufficient documentation to enable the State to determine whether such travel will be authorized. No travel expenses shall be incurred prior to State written authorization for such travel. All authorized travel expenses are separate from the Contract prices. Invoices for authorized travel shall include full documentation of the travel and shall include the State's written authorization. Travel expense shall be in accordance with the published State Travel guidelines, which will be made available to Contractor upon request.

Inflation adjustments will not be applied to travel expenses.

15 Recovering Withholds for Late Milestones and Deliverables

The Contractor may recover payments for late Milestones and Deliverables when the State accepts any subsequent Milestone or Deliverable for the same activity on or before its scheduled date for acceptance, provided that by such time all previously due Milestones and Deliverables for that activity have been accepted by the State (regardless of how late those previous acceptances may have been). After such a withhold becomes payable to the Contractor, a new withhold shall accumulate in the same manner if one or more additional Milestones or

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Deliverables for the same activity are not accepted by the State by the planned dates for their acceptance in the Contractor's Proposal. In any event, the State shall not hold any withholding from the Contractor pursuant to this Section 15 for a given activity beyond the date of the final payment that is to be made to the Contractor for that activity.

Exhibit B. Proprietary Third Party Software License Agreement

This Agreement is made the _____ day of _____, 20____ (the "Effective Date") between [Company Name], a corporation organized and existing under the laws of [State], and having its principal office at [address] (referred to as "Licensor") and Licensee (as defined herein). Licensor and Licensee may also be referred to in this Agreement collectively as the "Parties."

IN WITNESS WHEREOF, the Parties hereto have executed this Agreement by their duly authorized agents.

Licensor.	LICENSEE.
By:	By:
Its:	Its:

Agreement

For the reasons recited above, and in consideration of the mutual covenants contained herein, the Parties agree as follows:

Definitions

Agreement means this document, not including any other attachments.

Collateral Agreement means the Contract for MMIS Replacement by and between Licensee and Contractor awarded on _____.

Contractor means the successful Offeror under the solicitation for the MMIS Replacement.

ITMO means the State of South Carolina Information Technology Management Office.

Documentation means all materials supplied, directly or indirectly, to the Licensee by any means or media that explain or facilitate the use of the Software, which may include, without limitation, any materials that describe the functional, operational, and/or performance capabilities of the software; training materials; user, operator, system administration, technical, support, and other manuals or instructions; flow charts, and logic diagrams. Licensor warrants that the Documentation does and will continue to accurately describe the functional and operational characteristics of the Software. Licensor warrants that the Documentation will be contemporaneously updated to reflect any changes made to the Software.

Licensee means the South Carolina Department of Health and Human Services, also referred to herein as the "State"

Software means any computer program or computer database referenced on Exhibit "B", including any future maintenance updates, patches, or fixes provided by Licensor, if any, and including, without limitation object and source code versions of any such computer program.

1 LIMITED SCOPE OF AGREEMENT

1.1 This Agreement is independent of, and does not form a part of, any other contract for the acquisition of goods, services, supplies, or information technology, including without limitation any agreement for MMIS Replacement entered into by the State.

2 TERM OF AGREEMENT

2.1 With regard to the licensure of any particular copy of Software, the terms of this Agreement shall continue to apply to that license notwithstanding the expiration of this Agreement.

2.2 This Agreement shall be in effect for seven years from the Effective Date. Expiration of this Agreement does not terminate any particular license of Software.

3 LICENSE GRANT

3.1 For each license acquired, the Software may be:

3.1.1 Used or copied for use in or with the computer or computers for which it was acquired, including without limitation use at any of Licensee's installations to which such computer or computers may be transferred;

3.1.2 Used or copied for use in or with a backup computer if any computer for which it was acquired is inoperative;

3.1.3 Reproduced for safekeeping (archives) or backup purposes;

3.1.4 Modified, adapted, or combined with other computer programs or computer data bases;

3.1.5 Disclosed to and used by support service contractors or their subcontractors for the benefit of the Licensee, subject to the restrictions set forth in this Agreement; and,

3.1.6 Used or copied for use in or transferred to a replacement computer.

3.2 Notwithstanding any other provision, Licensee's fair use rights (17 U.S.C. § 107) are not limited in any way.

4 INTELLECTUAL PROPERTY INFRINGEMENT

4.1 As used in this Paragraph 4, these terms are defined as follows: "Acquired Item(s)" means the rights, Software, or services, if any, furnished under this Agreement. "Indemnatee" means Licensee, its instrumentalities, agencies, departments, boards, political subdivisions and all their respective officers, agents and employees. "IP Right(s)" means a copyright, patent, trademark, trade secret, contract, or any other proprietary right.

4.2 In the event of any claim by any third party against an Indemnatee asserting or involving an IP Right which concerns any Acquired Item(s), Licensor shall defend Indemnatee, at its expense, against all actions, proceedings or claims of any nature and shall, without limitation, indemnify Indemnatee for and against any loss, cost, expense, attorneys' fees and expenses (including inside counsel), or liability, resulting from or related to such claim, whether or not such claim is successful.

4.3 Indemnitee must notify Licensor in writing within a reasonable period of time after Indemnitee first receives written notice of any such claim or action. Indemnitee's failure to provide or delay in providing such notice will relieve Licensor of its obligations under this Paragraph 4 only if and to the extent that such delay or failure materially prejudices Licensor's ability to defend such claim. Indemnitee must reasonably cooperate with Licensor's defense of such claims or suits and, subject to Title 1, Chapter 7 of the South Carolina Code of Laws, allow Licensor sole control of the defense, so long as the defense is diligently and capably prosecuted. Licensee may participate in the defense of any action. Licensee's consent is necessary for any settlement that requires Licensee to part with any right or make any payment or subjects Licensee to any injunction, except for an injunction requiring cessation of use of an Acquired Item that is the subject of the claim.

4.4 In the event an injunction, order, or agreement shall be obtained against Licensee's use of any Acquired Item, Licensor shall, without in any way limiting the foregoing and at its expense: (a) use good faith, diligent efforts to procure for Licensee the right to continue to use, and to have used, the Acquired Item, and if such remedy is commercially impracticable, to then (b) replace or modify the Acquired Item so that it becomes non-infringing but only if the modification or replacement does not materially adversely affect the functionality of the Acquired Item or its use by Licensee. In the event that both of these remedies are commercially impracticable, Licensor may require that Licensee stop using the Acquired Item, refund to Licensee an amount equal to all money paid by Licensee therefore, and take all steps necessary to have any Indemnitees released from any further liability.

4.5 Licensor's obligations under this Paragraph 4 do not apply to a claim to the extent (a) that the claim is caused by a modification of Software made by Licensee without Licensor's permission; (b) that the claim is caused by Licensee's use of a superseded release of Software if the infringement would have been avoided by Licensee's timely implementation of an update or upgrade previously provided to Licensee, but only if such update or upgrade (i) is provided by Licensor at no cost or as part of either maintenance or a purchase by Licensee, and (ii) does not materially adversely affect the functionality of the Acquired Item or its use by Licensee.

4.6 Notwithstanding any other provision, Licensor's obligations pursuant to this Paragraph 4 are without any limitation whatsoever. Licensor's obligations under this clause shall survive the termination, cancellation, rejection, or expiration of this Agreement.

4.7 Paragraph 4 states Licensee's exclusive remedy for third party claims asserting a violation or infringement of the third party's intellectual property rights.

5 LIMITATION OF RECOVERY

5.1 Limitation of Damages – Licensor. Notwithstanding any type of exclusion or limitation on liability, damages, or remedies, Licensor's liability to a specific Licensee for any type of claim or loss may not be limited in any way to less than an amount equal to twice the cumulative fees paid or payable by Licensee to license the Software under the Collateral Agreement .

5.2 Limitation of Damages - Licensee. The maximum liability, if any is allowed by law, of Licensee for all direct, indirect, incidental, punitive, consequential, or special damages,

including without limitation contract damages, statutory damages, and damages for injuries to persons or property, whether arising from Licensee's breach of this Agreement, breach of warranty, negligence, strict liability, statutory liability, or other tort, shall in no event exceed an amount equal to twice the cumulative fees paid or payable by Licensee to license Software under the Collateral Agreement. The foregoing limitation does not apply to a loss incurred by Licensor to the extent the loss results because Licensee has created a derivative work from, reverse assembled, reverse compiled, or otherwise reduced to human readable form the Software without Licensor's prior written consent.

6 CONFIDENTIALITY & NONDISCLOSURE

This Agreement is subject to public disclosure, except and to the extent that Licensor has complied with the terms regarding confidentiality or nondisclosure of the South Carolina Freedom of Information Act and other applicable laws. No duty of confidentiality or nondisclosure applies to material or information developed by or received from Licensor if such material or information has not been conspicuously marked with the words confidential, proprietary, or trade secret, and any such duty shall be subject to the South Carolina Freedom of Information Act and other applicable laws.

7 TERMINATION

Licensor may not terminate either this Agreement in the absence of a material breach by Licensee. If Licensor exercises any termination rights, Licensee may continue using software pursuant to this Agreement for a period of six months in order to allow Licensee to convert from the use of Software

8 WARRANTIES

Licensor warrants (a) that every item of Software, without unauthorized modification, will perform substantially in accordance with the Documentation applicable to the Software for a period of 365 days from the date the item of Software is installed by Licensee, (b) that Licensor has all necessary right and authority to license the Software and to grant the licenses provided hereunder, and (c) that there is currently no actual or threatened legal action against Licensor by any third party based on an alleged violation of an intellectual or proprietary property right that has not been disclosed to the State and that could adversely affect Licensor's ability to license the use of the Software. Licensor agrees that it will not electronically repossess, trigger any lock, or use any device capable of halting operations or erasing or altering data or programs with regard to any Software that it has licensed to Licensee.

9 BANKRUPTCY

9.1 Notice of Insolvency. Licensor shall provide Licensee with written notice immediately upon the filing by Licensor of a petition in bankruptcy or insolvency or upon any other proceeding or action by or against Licensor under the relevant law on insolvency or bankruptcy, or after the making by Licensor of any assignment or attempted assignment for the benefit of creditors or upon or after the institution of any proceedings for the liquidation or winding up of Licensor's business or for the termination of its corporate charter.

9.2 Rejection of Executory License. The Parties agree that the Software is "intellectual property" as defined in Section § 101(35A) of the U.S. Bankruptcy Code. Upon the filing by Licensor of a petition in bankruptcy or insolvency or upon any other proceeding or action by or against the Licensor under the relevant law on insolvency or bankruptcy, this Agreement shall be governed by Section 365(n) of the U.S. Bankruptcy Code. If any person seeks to reject this Agreement pursuant to bankruptcy law, Licensee shall have the option of using the Software for either the original term of this Agreement or a period of five years after rejection is requested.

10 RIGHTS TO SOFTWARE OR DATABASE DEVELOPED BY LICENSEE.

Nothing in this Agreement shall be construed to give Licensor any rights with regard to computer programs or databases developed by Licensee, regardless of whether or not such programs or databases are connected to or embedded in Software or are functionally similar, in whole or part, to Software.

11 GENERAL

11.1 Choice of Law & Choice of Forum. Both the rights and obligations of the Parties and this Agreement, as well as any dispute, claim, or controversy arising out of or relating to this Agreement, shall, in all respects, be established, interpreted, construed, enforced and governed by and under the laws of the State of South Carolina, without regard to any provision governing conflicts of law. All disputes, claims, or controversies arising out of or in any way relating to this Agreement shall be resolved exclusively by the appropriate Chief Procurement Officer in accordance with Title 11, Chapter 35, Article 17 of the South Carolina Code of Laws, or in the absence of jurisdiction, only in the Court of Common Pleas for, or a federal court located in, Richland County, State of South Carolina.

11.2 Sovereign Immunity. Title 11, Chapter 35, Article 17 constitutes a limited statutory waiver of sovereign immunity. Licensor agrees that any act by the State regarding this Agreement is not a waiver of either the State's sovereign immunity or its immunity under the Eleventh Amendment of the United State's Constitution.

11.3 Subject to Applicable Law. This Agreement is entered into pursuant to the South Carolina Consolidated Procurement Code (Title 11, Chapter 35 of the South Carolina Code of Laws.) As a public entity, all of Licensee's obligations are subject to any applicable laws.

11.4 CISG / UCITA. Neither the UN Convention on the International Sale of Goods nor the Uniform Computer Information Transactions Act (nor any non-uniform version) shall apply to this Agreement or the Authorized EULAs.

11.5 Notices. In addition to any other obligations the parties may have regarding notice, all notices or other communications regarding termination, material breach, or modification of this Agreement or a license covered by it shall be provided to Licensee at the following addresses:

South Carolina Department of Health and Human Services

Office of General Counsel
PO Box 8206
1801 Main Street
Columbia, SC 29202

Information Technology Management Office
Procurement Services Division
State Budget & Control Board
1201 Main Street, Suite 430
Columbia, SC 29201

11.6 Third Party Beneficiary. This Agreement are made solely and specifically among and for the benefit of the Parties hereto, and their respective successors and assigns, and no other person will have any rights, interest, or claims hereunder or be entitled to any benefits under or on account of this Agreement as a third party beneficiary or otherwise.

11.7 Assignment. Except as set forth below, neither party may assign or transfer this Agreement, or any rights regarding either, without the prior written consent of the State. Such consent shall not be unreasonably withheld. Any attempted assignment, delegation or transfer in derogation of this Paragraph shall be null and void.

11.7.1 If Licensee is reorganized such that certain operations or functions are transferred from one Licensee to another, then in connection with such reorganization, a Licensee may, upon written notice to Licensor, transfer licenses to another Licensee provided that the transferee is performing some substantially similar business and/or operational functions as the original Licensee. Both Licensees shall execute such paperwork as Licensor may reasonably require.

11.8 Interpretation. Any question of interpretation or construction shall not be resolved by any rule providing for interpretation or construction against the party who causes the uncertainty to exist or against the drafters of this Agreement.

11.9 Headings. The headings contained in this Agreement are for the purposes of convenience only and are not intended to define or limit the contents of this Agreement.

11.10 Publicity. Licensor agrees not to refer to Licensees in such a manner as to state or imply that either Licensor or its Software is endorsed or preferred by Licensee, the State of South Carolina, or any unit of either. The foregoing shall not prohibit the Licensor from identifying a Licensee as a customer in a customer list.

11.11 Language of Agreement & Notices. The language of this Agreement is English. If translated into another language, this English version of the Agreement shall be controlling. All notices required or permitted to be given hereunder shall be written in the English language.

11.12 Survival of Obligations. The Parties' rights and obligations which, by their nature, would continue beyond the termination, cancellation, rejection, or expiration of this Agreement shall survive such termination, cancellation, rejection, or expiration, including, but not limited to, the rights and obligations created by the following clauses: Intellectual Property Infringement, Limitation of Recovery, Bankruptcy, and General.

11.13 Waiver & Modification. No waiver of any default by either party shall act as a waiver of a subsequent or different default. The provisions of this Agreement may not be modified or waived except by another agreement in writing executed by an authorized representatives of the parties.

11.14 Anti-Indemnification & Anti-Representation. Licensee makes no representations or warranties to Licensor, and any language to the contrary is void and has no obligations of indemnification to Licensor. .

11.15 Non-appropriations. Payment and performance obligations for succeeding fiscal periods shall be subject to the availability and appropriation of funds therefore. When funds are not appropriated or otherwise made available to support continuation of performance in a subsequent fiscal period, the contract shall be cancelled.

11.16 Attorneys' Fees. Except as otherwise provided herein, each party waives any claim it may have to recover attorneys' fees from any other party.

11.17 Users. A Licensee has no liability for any acts or omissions of any person that Licensee allows to use the Software, unless such acts or omissions are within the scope of that person's employment or have been authorized by Licensee.

11.18 Privacy. As used in this paragraph, the term 'data' means any information regarding any person or entity other than a Licensee that is gathered or acquired as a result of Licensee's use of the Software. Licensor represents that Software will not provide any entity other than Licensor with any data. Licensor agrees not to use data for any purpose other than performing this contract and not to sell, trade, or release data. Licensor agrees not to retain data beyond the end of the term of this Agreement without express written consent of Licensee. Upon request, Licensor shall provide written confirmation of compliance with this clause. Licensor agrees that Licensee has no adequate remedy at law for a violation of Licensor's obligations under this paragraph. Notwithstanding any other provision, Licensor's liability for breach of its obligation under this paragraph is without any limitation whatsoever.

--- end of Agreement ---

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Exhibit C. COTS AGREEMENT

SOUTH CAROLINA STANDARD AMENDMENT TO END USER LICENSE AGREEMENTS FOR COMMERCIAL OFF-THE-SHELF SOFTWARE

This Agreement is made the [] day of [], 20[] (the "Effective Date") between [Company Name], a corporation organized and existing under the laws of [State], and having its principal office at [address] (referred to as "Licensor") and Licensee (as defined herein). Licensor and Licensee may also be referred to in this Agreement collectively as the "Parties."

IN WITNESS WHEREOF, the Parties hereto have executed this Agreement by their duly authorized agents.

LICENSOR. <hr style="border: 0; border-top: 1px solid black; margin: 10px 0;"/> By: Its:	LICENSEE. <hr style="border: 0; border-top: 1px solid black; margin: 10px 0;"/> By: Its:
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Agreement

For the reasons recited above, and in consideration of the mutual covenants contained herein, the Parties agree as follows:

Definitions

Agreement means this document, not including any EULA or other attachments.

Authorized EULA means any EULAs attached as Exhibit "C", but does not include any document referenced or incorporated therein unless attached to this Agreement. Licensor warrants that every Authorized EULA is an unmodified copy of Licensor's standard form agreement. Upon the written approval of both Licensor and Licensee, Exhibit "C" may be amended to include additional EULAs.

Distributor means the generic category of entities authorized by Licensor, if any, that participate in the distribution chain between Licensor and Licensee, including, but not limited to, value added resellers (VARs), original equipment manufacturers (OEMs), distributors, dealers, independent sales organizations (ISOs), resellers, and retail outlets.

Distributor Contract means a contract between a Licensee and a Distributor by which Licensee can acquire licenses of the Software. Nothing in this agreement constitutes a representation or obligation that Licensor has made or will make its Software available through a distributor.

Documentation means all materials supplied, directly or indirectly, to Licensees by Licensor, by any means or media that explain or facilitate the use of the Software, which may include, without limitation, any materials that describe the functional, operational, and/or performance capabilities of the software; training materials; user, operator, system administration, technical, support, and other manuals or instructions; flow charts, and logic diagrams. Licensor warrants that the Documentation does and will continue to accurately describe the functional and operational characteristics of the Software. Licensor warrants that the Documentation will be contemporaneously updated to reflect any changes made to the Software.

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End User License Agreement ("EULA") means any license agreement or other commercial agreement, regardless of how designated, pertaining to the right to use any Software, including, but not limited to, any such agreement proposed prior to or after execution of this Agreement, and including without limitation any such agreement that either is affixed to (e.g., shrinkwrap), imbedded in (e.g., clickwrap), or in any way accompanies the Software upon delivery. The term "EULA" does not include this Agreement. The term "EULA" does not include any contract awarded by or on behalf of a Licensee as a result of a formal solicitation (e.g., invitation for bids or request for proposals) issued by or on behalf of a licensee. The term "EULA" does not include a contract to the extent it governs software maintenance as defined in ISO/IEC 14764:2006.

Software means any computer program or computer database referenced on Exhibit "B", including any future maintenance updates, patches, or fixes provided by Licensor, if any.

1. RELATIONSHIP BETWEEN THIS AGREEMENT AND THE AUTHORIZED EULAs.

1.1 Agreement to Authorized EULAs. Subject to the provisions of this Agreement, Licensee agrees to the terms and conditions of the Authorized EULAs. Any EULA that is not an Authorized EULA is void and of no effect. Licensor represents that every EULA applicable to the computer programs or computer databases referenced on Exhibit "B" has been attached to Exhibit "C" as an Authorized EULA.

1.2 Primacy of Agreement. The terms of this Agreement shall be given full effect prior to the application of any term in the Authorized EULAs. To the extent of any inconsistency or conflict, the terms of this Agreement take precedence over any similar terms in the Authorized EULAs. To the extent an Authorized EULA provides Licensee with options or rights in addition to or beyond those available under this Agreement, nothing in this Agreement is intended to limit Licensee's exercise of such options or rights.

1.3 Entire Agreement. Within the scope of this Agreement, as defined in Paragraph 2, this Agreement and the Authorized EULAs constitute the entire agreement between the Parties and supersede all other prior or contemporaneous agreements, representations, or discussions, whether oral or written. This Agreement and the Authorized EULAs shall apply notwithstanding any provisions in either (a) a purchase order or other instrument submitted by Licensee, or (b) any invoice or other document submitted by Licensor.

2. LIMITED SCOPE OF AGREEMENT.

2.1 This Agreement and the Authorized EULAs are independent of, and do not form a part of any other contract for the acquisition of goods, services, supplies, or information technology. This Agreement does not authorize any Public Procurement Unit to pay any funds directly to Licensor. All terms in a EULA regarding pricing, payment, interest, and delivery are void.

2.3 Subject to the limits of item 2.1, this Agreement and the Authorized EULAs apply to all licenses of Software licensed from Licensor by a Licensee during the term of this Agreement, whether acquired directly from Licensor or indirectly through a Distributor.

2.4 Retroactive Application. Subject to the limits of item 2.1, this Agreement and the Authorized EULAs also apply to all licenses of Software licensed from Licensor by a Licensee prior to execution of this Agreement, unless the license was acquired pursuant to a Prior Agreement.

3. TERM OF AGREEMENT.

3.1 With regard to the licensure of any particular copy of Software, the terms of this Agreement and the Authorized EULAs shall continue to apply to that license notwithstanding the expiration of this Agreement.

3.2 This Agreement shall be in effect for seven years from the Effective Date. Expiration of this Agreement does not terminate any particular license of Software.

4. LICENSE GRANT.

4.1 Any rights granted by Licensor to Licensee in an Authorized EULA are in addition to any rights granted by this Paragraph 4. Licensor agrees that Licensee shall have the rights that are set forth in items 4.2, 4.3, 4.4, and 4.5 below.

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4.2 For each license acquired, the Software may be:

4.2.1 Used or copied for use in or with the computer or computers for which it was acquired, including without limitation use at any of Licensee's installations to which such computer or computers may be transferred;

4.2.2 Used or copied for use in or with a backup computer if any computer for which it was acquired is inoperative;

4.2.3 Reproduced for safekeeping (archives) or backup purposes;

4.2.4 Modified, adapted, or combined with other computer programs or computer data bases; however, a Licensee may not reverse engineer, decompile or disassemble the Software except to the extent necessary to create interfaces to, or allow inter-operability with, other computer programs or computer data bases;

4.2.5 Disclosed to and used by support service contractors or their subcontractors for the benefit of the Licensee, subject to the restrictions set forth in this Agreement; and,

4.2.6 Used or copied for use in or transferred to a replacement computer.

4.3 If the license acquired is a single CPU license and Licensee has available at the same site multiple suitably configured CPUs, Licensee may operate Software on any such CPU at the site provided that such Software is not in productive use on more than one CPU at any given time and that, if greater license fees are required for a more powerful model of CPU, that any use of such more powerful model shall only be for temporary or backup use.

4.4 If usage is expressly restricted to an authorized site or an authorized CPU serial number, Licensee may change any authorized site to an alternate site or an authorized CPU serial number designation to that of an alternate CPU after providing Licensor written notice of the new site or serial number. If greater license fees are required for use on a more powerful model of CPU, Licensee shall pay then current difference in fees to Licensor.

4.5 Notwithstanding any other provision, Licensee's fair use rights (17 U.S.C. § 107) are not limited in any way.

5. INTELLECTUAL PROPERTY INFRINGEMENT.

5.1 As used in this Paragraph 5, these terms are defined as follows: "Acquired Item(s)" means the rights, Software, or services, if any, furnished under this Agreement or any EULA. "Indemnitee" means Licensee, its instrumentalities, agencies, departments, boards, political subdivisions and all their respective officers, agents and employees. "IP Right(s)" means a copyright, patent, trademark, trade secret, contract, or any other proprietary right.

5.2 In the event of any claim by any third party against an Indemnitee asserting or involving an IP Right which concerns any Acquired Item(s), Licensor shall defend Indemnitee, at its expense, against all actions, proceedings or claims of any nature and shall, without limitation, indemnify Indemnitee for and against any loss, cost, expense, attorneys' fees and expenses (including inside counsel), or liability, resulting from or related to such claim, whether or not such claim is successful.

5.3 Indemnitee must notify Licensor in writing within a reasonable period of time after Indemnitee first receives written notice of any such claim or action. Indemnitee's failure to provide or delay in providing such notice will relieve Licensor of its obligations under this Paragraph 5 only if and to the extent that such delay or failure materially prejudices Licensor's ability to defend such claim. Indemnitee must reasonably cooperate with Licensor's defense of such claims or suits and, subject to Title 1, Chapter 7 of the South Carolina Code of Laws, allow Licensor sole control of the defense, so long as the defense is diligently and capably prosecuted. Licensee may participate in the defense of any action. Licensee's consent is necessary for any settlement that requires Licensee to part with any right or make any payment or subjects Licensee to any injunction, except for an injunction requiring cessation of use of an Acquired Item that is the subject of the claim.

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5.4 In the event an injunction, order, or agreement shall be obtained against Licensee's use of any Acquired Item, Licensor shall, without in any way limiting the foregoing and at its expense: (a) use good faith, diligent efforts to procure for Licensee the right to continue to use, and to have used, the Acquired Item, and if such remedy is commercially impracticable, to then (b) replace or modify the Acquired Item so that it becomes non-infringing but only if the modification or replacement does not materially adversely affect the functionality of the Acquired Item or its use by Licensee. In the event that both of these remedies are commercially impracticable, Licensor may require that Licensee stop using the Acquired Item, refund to Licensee an amount equal to all money paid by Licensee therefore, and take all steps necessary to have any Indemnitees released from any further liability.

5.4 Licensor's obligations under this Paragraph 5 do not apply to a claim to the extent (a) that the claim is caused by a modification of Software made by Licensee; (b) that the claim is caused by Licensee's use of a superseded release of Software if the infringement would have been avoided by Licensee's timely implementation of an update or upgrade previously provided to Licensee, but only if such update or upgrade (i) is provided by Licensor at no cost or as part of either maintenance or a purchase by Licensee, and (ii) does not materially adversely affect the functionality of the Acquired Item or its use by Licensee; (c) that the claim is caused by Licensee combining the Software with another computer program, database, or hardware unless such combinations are recommended by the Documentation provided by the Licensor or otherwise agreed to by Licensor; (d) that the claim is caused by Licensee reverse engineering, decompiling, disassembling, or distributing Software; (e) that the claim arises from Licensee's use of any Software that is open source or freeware, but only if the open source or freeware is not incorporated or combined by Licensor in Software provided by Licensor.

5.6 Notwithstanding any other provision, Licensor's obligations pursuant to this Paragraph 5 are without any limitation whatsoever. Licensor's obligations under this clause shall survive the termination, cancellation, rejection, or expiration of this Agreement.

5.7 Paragraph 5 states Licensee's exclusive remedy for third party claims asserting a violation or infringement of the third party's intellectual property rights.

6. LIMITATION OF RECOVERY.

6.1 Limitation of Damages – Licensor. Notwithstanding any type of exclusion or limitation on liability, damages, or remedies, Licensor's liability to a specific Licensee for any type of claim or loss may not be limited in any way to less than an amount equal to twice the cumulative fees paid or payable by Licensee to license the Software.

6.2 Limitation of Damages - Licensee. Except as provided in Paragraph 7 (Audit), the maximum liability, if any is allowed by law, of Licensee for all direct, indirect, incidental, punitive, consequential, or special damages, including without limitation contract damages, statutory damages, and damages for injuries to persons or property, whether arising from Licensee's breach of this Agreement, an EULA, breach of warranty, negligence, strict liability, statutory liability, or other tort, shall in no event exceed an amount equal to twice the cumulative fees paid or payable by Licensee to license Software. The foregoing limitation does not apply to a loss incurred by Licensor to the extent the loss results because Licensee has created a derivative work from, reverse assembled, reverse compiled, or otherwise reduced to human readable form the Software without Licensor's prior written consent.

7. AUDIT.

7.1 Right to Audit. For the duration of the Authorized EULA, Licensor has the right to audit Licensee at Licensor's expense. Licensor shall conduct an audit and use the information obtained in an audit only to enforce Licensor's rights under, and to determine whether Licensee is in compliance with, the terms of this Agreement and the Authorized EULA. Any audit will be subject to a confidentiality obligation and will take place upon not fewer than 30 days notice, during Licensee's normal business hours, and in a manner that does not interfere unreasonably with Licensee's operations. Licensor's sole audit right regarding Licensee is provided by this Paragraph 7. Notwithstanding any other provision, Licensor's liability for intentional breach of its obligation regarding the use of information obtained in an audit is without any limitation whatsoever.

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7.2 Remedy: Exclusivity. If an audit reveals or Licensor otherwise discovers unlicensed use of Software by Licensee, Licensee shall either (a) promptly order and pay for sufficient licenses to permit all Software usage discovered and pay Licensor the difference between (i) the license fee that Licensee should have paid for such Software, based upon actual usage, and (ii) the actual license fees that Licensee paid for the software, based upon the actual usage level for which such Software was licensed, or (b) immediately terminate any unlicensed use of Software and pay any applicable license fees for any noncompliance discovered. If a Distributor Contract exists, Licensee may order licenses from, and pay license fees to, a Distributor at a price established by a Distributor Contract. If Licensee's unlicensed use of the Software would be within the scope of license rights granted by this Agreement and the Authorized EULAs but for Licensee's failure to acquire an adequate number of licenses or an available license, Licensor's exclusive remedy for the unlicensed use shall be the remedy provided by this item 7.2. If Licensee fails to execute either option within a reasonable time, Licensor may pursue all remedies available to it at law, subject to the terms of this Agreement.

7.3 Licensor's right to conduct an audit is limited by any applicable statutory or regulatory limitations on access to public records.

8. LICENSEE'S RECORDS. For each license of Software acquired pursuant to this Agreement, Licensee agrees to retain records of that license for one year beyond the duration of that license, provided that Licensee has no obligation to retain records of a license beyond one year after Licensee ceases to retain a copy of the Software to which a license applies. Licensor may access Licensee's records as provided in the South Carolina Freedom of Information Act and any other applicable law. Except as stated in this Agreement, Licensor agrees that Licensee has no obligation to retain any records.

9. CONFIDENTIALITY & NONDISCLOSURE. This Agreement and the Authorized EULAs are subject to public disclosure. All provisions of an Authorized EULA regarding confidentiality or nondisclosure are subject to the South Carolina Freedom of Information Act and other applicable laws. Any duty of confidentiality or nondisclosure established by an Authorized EULA does not apply to material or information developed by or received from Licensor if such material or information has not been conspicuously marked with the words confidential, proprietary, or trade secret.

10. TERMINATION. Licensor may not terminate either this Agreement or the Authorized EULAs in the absence of a material breach by Licensee. If Licensor exercises any termination rights under any Authorized EULA, Licensee may, in addition to any rights provided in the Authorized EULAs, continue using software pursuant to this Agreement and the Authorized EULAs for a period of six months in order to allow Licensee to convert from the use of Software, unless Licensee has violated the restrictions in paragraph 4.2.4. During the conversion period, Licensee shall pay any applicable, previously unpaid license fees at the price last available from Licensor to Licensee prior to termination or, at Licensee's option, at the price established by an applicable Distributor Contract, if any.

11. WARRANTIES. The warranties provided in this Paragraph 11 are in addition to any other warranties provided in the Authorized EULAs. Licensor warrants (a) that every item of Software, without unauthorized modification, will perform substantially in accordance with the Documentation applicable to the Software for a period of 365 days from the date the item of Software is installed by Licensee, (b) that Licensor has all necessary right and authority to license the Software and to grant the licenses provided hereunder, and (c) that there is currently no actual or threatened legal action against Licensor by any third party based on an alleged violation of an intellectual or proprietary property right that has not been disclosed to ITMO and that could adversely affect Licensor's ability to license the use of the Software. Licensor agrees that it will not electronically repossess, trigger any lock, or use any device capable of halting operations or erasing or altering data or programs with regard to any Software that it has licensed to Licensee.

12. BANKRUPTCY.

12.1 Notice of Insolvency. Licensor shall provide ITMO and Licensee with written notice immediately upon the filing by Licensor of a petition in bankruptcy or insolvency or upon any other proceeding or action by or against Licensor under the relevant law on insolvency or bankruptcy, or after the making by Licensor of any assignment or attempted assignment for the benefit of creditors or upon or after the institution of any proceedings for the liquidation or winding up of Licensor's business or for the termination of its corporate charter.

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12.2 Rejection of Executory License. The Parties agree that the Software is "intellectual property" as defined in Section § 101(35A) of the U.S. Bankruptcy Code. Upon the filing by Licensor of a petition in bankruptcy or insolvency or upon any other proceeding or action by or against the Licensor under the relevant law on insolvency or bankruptcy, this Agreement and the Authorized EULAs shall be governed by Section 365(n) of the U.S. Bankruptcy Code. If any person seeks to reject this Agreement or the Authorized EULAs pursuant to bankruptcy law, Licensee shall have the option of using the Software for either the original term of the Authorized EULAs or a period of five years after rejection is requested.

13. RIGHTS TO SOFTWARE OR DATABASE DEVELOPED BY LICENSEE. Nothing in this Agreement or any Authorized EULA shall be construed to give Licensor any rights with regard to computer programs or databases developed by Licensee, regardless of whether or not such programs or databases are connected to or embedded in Software or are functionally similar, in whole or part, to Software. Nothing in this paragraph grants a Licensee any rights to Licensor's intellectual property or to any derivative works.

14. GENERAL

14.1 Choice of Law & Choice of Forum. Both the rights and obligations of the Parties and this Agreement and any EULA, as well as any dispute, claim, or controversy arising out of or relating to this Agreement or any EULA, shall, in all respects, be established, interpreted, construed, enforced and governed by and under the laws of the State of South Carolina, without regard to any provision governing conflicts of law. All disputes, claims, or controversies arising out of or in any way relating to this Agreement or any EULA shall be resolved exclusively by the appropriate Chief Procurement Officer in accordance with Title 11, Chapter 35, Article 17 of the South Carolina Code of Laws, or in the absence of jurisdiction, only in the Court of Common Pleas for, or a federal court located in, Richland County, State of South Carolina.

14.2 Sovereign Immunity. Title 11, Chapter 35, Article 17 constitutes a limited statutory waiver of sovereign immunity. Licensor agrees that any act by either ITMO or Licensee regarding this Agreement and any EULA is not a waiver of either their sovereign immunity or their immunity under the Eleventh Amendment of the United States Constitution.

14.3 Subject to Applicable Law. This Agreement is entered into pursuant to the South Carolina Consolidated Procurement Code (Title 11, Chapter 35 of the South Carolina Code of Laws.) As a public entity, all of Licensee's obligations are subject to any applicable laws.

14.4 Alternative Dispute Resolution. Unless mandated by law, no method of mandatory alternative dispute resolution shall apply to any dispute, claim, or controversy arising out of or relating to this Agreement or the Authorized EULAs.

14.5 CISG / UCITA. Neither the UN Convention on the International Sale of Goods nor the Uniform Computer Information Transactions Act (nor any non-uniform version) shall apply to this Agreement or the Authorized EULAs.

14.6 ITMO Participation In Contract Disputes. Consistent with its statutory authority, ITMO is acting solely in a representative capacity and on behalf of Licensees. Accordingly, ITMO is not a party to this Agreement and need not be joined as a party to any dispute that may arise out of this Agreement. With regard to this Agreement, the officers, agents and employees of ITMO are acting solely in their official capacity and need not be joined as a party to any dispute that may arise out of this Agreement.

14.7 Notices. In addition to any other obligations the parties may have regarding notice, all **notices or other communications regarding termination, material breach, modification, or audit of this Agreement, an Authorized EULA, or a license covered by either shall be copied to SCDHHS and ITMO at the following addresses:**

South Carolina Department of Health and Human Services
Office of the General Counsel
PO Box 8206
1801 Main Street
Columbia, SC 29202

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Information Technology Management Office
Procurement Services Division
State Budget & Control Board
1201 Main Street, Suite 430
Columbia, SC 29201

14.8 Third Party Beneficiary. This Agreement and the Authorized EULAs are made solely and specifically among and for the benefit of the Parties hereto, and their respective successors and assigns, and no other person will have any rights, interest, or claims hereunder or be entitled to any benefits under or on account of this Agreement or the Authorized EULAs as a third party beneficiary or otherwise.

14.9 Assignment. Except as set forth below, neither party may assign or transfer this Agreement, the Authorized EULAs, or any rights regarding either, without the prior written consent of ITMO. Such consent shall not be unreasonably withheld. Any attempted assignment, delegation or transfer in derogation of this Paragraph shall be null and void.

14.9.1 This Agreement and the Authorized EULAs, and any rights regarding either, may be assigned to affiliates of the Licensor, or to successors in interest of substantially all the assets of the Licensor, if the assignee expressly assumes the Licensor's obligations under the assigned agreement. Licensor must give Licensee reasonable notice of any assignment.

14.9.2 If Licensee is reorganized such that certain operations or functions are transferred from one Licensee to another, then in connection with such reorganization, a Licensee may, upon written notice to Licensor, transfer licenses to another Licensee provided that the transferee is performing some substantially similar business and/or operational functions as the original Licensee. Both Licensees shall execute such paperwork as Licensor may reasonably require.

14.10 Interpretation. Any question of interpretation or construction shall not be resolved by any rule providing for interpretation or construction against the party who causes the uncertainty to exist or against the drafters of this Agreement.

14.11 Headings. The headings contained in this Agreement are for the purposes of convenience only and are not intended to define or limit the contents of this Agreement.

14.12 Publicity. Licensor agrees not to refer to Licensees in such a manner as to state or imply that either Licensor or its Software is endorsed or preferred by Licensee, the State of South Carolina, or any unit of either. The foregoing shall not prohibit the Licensor from identifying a Licensee as a customer in a customer list.

14.13 Relationship Among Public Entities. Each Licensee's obligations and liabilities are independent of every other Licensee's obligations and liabilities. Termination of one Licensee does not constitute grounds for termination of a different Licensee.

14.14 Language of Agreement & Notices. The language of this Agreement is English. If translated into another language, this English version of the Agreement shall be controlling. All notices required or permitted to be given hereunder shall be written in the English language.

14.15 Survival of Obligations. The Parties' rights and obligations which, by their nature, would continue beyond the termination, cancellation, rejection, or expiration of this Agreement shall survive such termination, cancellation, rejection, or expiration, including, but not limited to, the rights and obligations created by the following clauses: Intellectual Property Infringement, Limitation of Recovery, Audit, Bankruptcy, and General.

14.16 Waiver & Modification. No waiver of any default by either party shall act as a waiver of a subsequent or different default. The provisions of this Agreement and the Authorized EULAs may not be modified or waived except by another agreement in writing executed by an authorized representative of ITMO and an authorized representative of Licensor.

14.17 Anti-Indemnification & Anti-Representation. Any provision in the Authorized EULAs is void to the extent it requires ITMO or a Licensee to indemnify anyone. Licensee makes no representations or warranties to Licensor, and any language to the contrary is void.

Draft

14.18 Statute of Limitations. Any provision in the Authorized EULAs is void to the extent that it modifies the statute of limitations or alters the time period within which an action must be brought.

14.19 Non-appropriations. Payment and performance obligations for succeeding fiscal periods shall be subject to the availability and appropriation of funds therefore. When funds are not appropriated or otherwise made available to support continuation of performance in a subsequent fiscal period, the contract shall be cancelled.

14.20 Attorneys' Fees. Except as otherwise provided herein, each party waives any claim it may have to recover attorneys' fees from any other party.

14.21 Users. A Licensee has no liability for any acts or omissions of any person that Licensee allows to use the Software, unless such acts or omissions are within the scope of that person's employment or have been authorized by Licensee.

14.22 Privacy. As used in this paragraph, the term 'data' means any information regarding any person or entity other than a Licensee that is gathered or acquired as a result of Licensee's use of the Software. Licensor represents that Software will not provide any entity other than Licensor with any data. Licensor agrees not to use data for any purpose other than performing this contract and not to sell, trade, or release data. Licensor agrees not to retain data beyond the end of the term of this Agreement without express written consent of Licensee. Upon request, Licensor shall provide written confirmation of compliance with this clause. Licensor agrees that Licensee has no adequate remedy at law for a violation of Licensor's obligations under this paragraph. Notwithstanding any other provision, Licensor's liability for breach of its obligation under this paragraph is without any limitation whatsoever.

--- end of Piggyback ---

VIII. Bidding Schedule/Cost Proposal

1 Bidding Schedule – Cost Proposal Instructions

The Offeror's Cost Proposal, and all copies, shall be bound separately from its Technical Proposal for both hard copies and CD/DVD versions.

In general, the pricing tables are based on estimates of the quantities of Services to be performed by the Contractor. For example, some provider management Services are based on the number of enrolled providers, and claim-related Services are based on the number of paid claims. As such, the actual Services invoiced may vary from the estimates listed in the tables, and for many Services, the Service amounts paid will be based on the Service amounts performed, as described in Section VIIB Exhibit A. Invoicing and Payment.

Many of the pricing tables require Offerors to enter prices by Contract month or the tables automatically calculate per-month prices based on other entries made by the Offerors. The State is not expecting Offerors to adjust prices on a monthly basis (although this is not generally prohibited). The intent of this approach is to provide maximum flexibility for each affected pricing table to address the various solutions that may be proposed. Given that each Offeror may have a different number of increments consisting of differing capabilities and in different orders than other Offerors, using month-by-month pricing provides the greatest flexibility in reasonably calculating the Total Enterprise Cost of Ownership.

The pricing tables described in Section K2 shall not be marked confidential, and nothing contained in these pricing tables shall be considered a trade secret. Offerors may mark appropriate portions of Section K1, Background, and any appropriate portion of Section M as confidential in accordance with RFP Section IIA.26.

2 Section K. Pricing Tables

Subsection	Title	Page Limits
Section K1	Background	N/A
Section K2	Pricing Tables	N/A

Table VIII.2-1. Pricing Tables Sections

2.1 Section K1. Background

The purpose of Proposal Section K1 is to obtain any needed background information required for the State to understand an Offeror's Cost Proposal. The Offeror shall not use this section to further discuss its Technical Proposal.

2.2 Section K2. Pricing tables

Table	Title
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Pricing Table A	Discovery Phase
Pricing Table B	Replacement Phase
Pricing Table C	Software Prices
Pricing Table D	Labor Rates
Pricing Table E	Modification Pools and Software Maintenance
Pricing Table F	Operations Phase – Base Work
Pricing Table G	Operations Phase – Claims Related Services
Pricing Table H	Operations Phase – Prior Authorization Services
Pricing Table I	Operations Phase – Provider Management
Pricing Table J	Operations Phase – Third Party Liability/Recovery Services
Pricing Table K	Operations Phase – Member Premium Management Services
Pricing Table L	Operations Phase – Training Services
Pricing Table M	Turnover Phase
Pricing Table N	Total Enterprise Cost of Ownership

Table VIII.2-2. Pricing Tables

Table VIII.2-2 identifies the require pricing tables.

2.2.1 Pricing Table A – Discovery Phase

The purpose of Pricing Table A is to obtain the Offeror's proposed price and price by month for the Discovery Phase.

The Offeror shall enter its name in the cell set aside for this information near the top of the pricing table.

The Offeror shall identify the price of the proposed billable labor hours and the price for the proposed materials for each month or partial month for the Offeror's proposed duration of the Discovery Phase. As the Discovery Phase will be entirely in the first year of the Contract, no inflation adjustments will be made to the proposed prices.

The BOE for this pricing table shall quantitatively describe how the Offeror derived the proposed prices for this table. The BOE for this table must be consistent with the labor prices and percent typical use shown in Pricing Table D for the Discovery Phase.

The State has pre-entered formulas to automatically fill out parts of this table; however, Offerors are required to ensure that the prices entered on this table are accurate and consistent with the other tables in the Cost Proposal.

2.2.2 Pricing Table B – Replacement Phase

The purpose of Pricing Table B is to obtain the Offeror's proposed price and price by month for the Replacement Phase.

The Offeror shall enter its name in the cell set aside for this information near the top of the pricing table.

The Offeror shall identify the base year price of the proposed billable labor hours and the base year price for the proposed materials for each month or partial month for the Offeror's proposed duration of the Replacement Phase. Additionally, the Offeror must propose a base year fixed price to standup operations capabilities associated with each increment that will be immediately fielded. This standup includes onboarding, training, and orientation of new staff; labor effort required to prepare facilities (note that the facilities themselves are considered part of the labor rates); and other related support activities. The associated increment must be identified on the pricing table in the month in which operations begin. These increments must be consistent with the Offeror's incremental strategy described in the Technical Proposal and must include an Increment ID to help promote consistency across the Offeror's entire Proposal. Increments not being fielded immediately upon completion shall not have an operations standup price.

The Offeror must enter the Contract month for the Targeted Fully Operational Start Date and enter it in the space provided. Ensure consistency of this entry and the entries for increments.

The Offeror must not enter prices for months that are entirely part of the Discovery Phase. For example, if the proposed Discovery Phase is 75 calendar days, then Contract Months 1 and 2 would be filled out on Pricing Table A and would be blank on Pricing Table B. Contract Month 3 would have an entry on both Pricing Table A and Pricing Table B.

The BOE for this pricing table shall quantitatively describe how the Offeror derived the proposed prices for this table. The BOE for this table must be consistent with the labor prices and percent typical use shown in Pricing Table D for the Replacement Phase.

The State has pre-entered formulas to automatically fill out parts of this table; however, Offerors are required to ensure that the prices entered on this table are accurate and consistent with the other tables in the Cost Proposal.

2.2.3 Pricing Table C – Software Prices

The purpose of Pricing Table C is to obtain the NTE prices for software licenses required for the Replacement MMIS.

The Offeror shall enter its name in the cell set aside for this information near the top of the pricing table.

The Offeror shall submit two similar tables containing software licenses. Proposal Section C8 contains the itemized list of software. This table, submitted in the technical section of the Offeror's Proposal, shall not contain any pricing information. Pricing Table C is similar to Proposal Section C8 except that it contains pricing information.

The instructions for preparing Pricing Table C are the same as for preparing the Software Bill of Materials in RFP Section IV.6.8 (covering Proposal Section C8) except for the addition of a field

for the NTE price. The Offeror shall enter a not-to-exceed price for each line item on Pricing Table C. Software prices are not adjusted for inflation.

The BOE for this pricing table shall quantitatively describe how the Offeror derived the proposed prices for this table and shall be inclusive of incentives provided by suppliers or subcontractors (as discussed in RFP Section III.4.5.1). The BOEs for Pricing Tables B and C may reference each other to avoid duplication.

2.2.4 Pricing Table D – Labor Rates

The purpose of Pricing Table D is to obtain the Offeror's labor rates for the Contract, normalized to the base year (the first year of the Contract), and to obtain the estimated typical use for each rate for the various phases of the Contract.

The Offeror shall enter its name in the cell set aside for this information near the top of the pricing table.

The Offeror shall identify each labor category it intends to invoice as directly billable throughout the Term of the Contract. These labor categories must be described in and consistent with Section G of the Offeror's Proposal. The Offeror must enter rates for Regular Time and Overtime for each labor category and whether the labor category bills on a 40-hour maximum week or bills all hours worked. Because each Offeror is likely account for different labor categories as directly billable or indirect overhead, and because each Offeror's labor force is likely to be made up of differing quantities of exempt, non-exempt, and contractor staff, there is no single standard for how Regular Time and Overtime rates relate. If the Offeror bills on a 40-hour maximum week, overtime rates could all be zero. If overhead and other indirect costs are all reflected in the regular time for hourly labor, overtime rates could be substantially less than Regular Time rates. If the rates are for a non-exempt employee, the Overtime rates could be higher than the Regular Time rates.

All labor rates shall be proposed normalized to the first year of the Contract, and shall not be adjusted for any future anticipated inflation.

The BOEs for this pricing table shall describe how the Percent Typical Use was calculated and the elements of cost that were included in the overtime rates for each labor category.

The State has pre-entered formulas to automatically fill out parts of this table; however, Offerors are required to ensure that the prices entered on this table are accurate and consistent with the other tables in the Cost Proposal.

2.2.5 Pricing Table E – Modification Pools and Software Maintenance

The purpose of Pricing Table E is to:

- Calculate the size of the Replacement Phase Modification Pool and the Operations Phase Modification Pool.
- Obtain maintenance costs for intellectual property materials, including without limitation COTS, Proprietary Third Party Software and Proprietary Contractor Software, having such fees.

The Offeror shall enter its name in the cell set aside for this information near the top of the pricing table.

If the Offeror's solution contains intellectual property, including without limitation, COTS, Proprietary Third Party Software and Proprietary Contractor Software, that requires maintenance fees, the Offeror shall enter the maintenance fees for these products in the months the Offeror expects these fees to be due. Note that in accordance with RFP Section III.4.5.1, the State shall not pay for licenses or software maintenance for Contractor Proprietary Material that is not yet in use for operations services. The Offeror shall prorate all software maintenance fees by the specific months of use and volume use (as applicable depending on licensing terms and conditions) during any given Contract year. Software maintenance fees are not adjusted for inflation.

The Operations Phase Modification Pool is reduced by the amount of software maintenance fees proposed by the Offeror.

The BOEs for this pricing table shall describe the software maintenance fees that are assigned to each product included in Pricing Table E, as well as the proration calculations for partial years of maintenance. The itemized list of maintenance fees shall include the type of intellectual property to which the fees apply (e.g., "COTS Software").

The State has pre-entered formulas to automatically fill out parts of this table; however, Offerors are required to ensure that the prices entered on this table are accurate and consistent with the other tables in the Cost Proposal.

2.2.6 Pricing Table F – Operations Phase – Base Work

The purpose of Pricing Table F is to obtain the Offeror's monthly fixed price for the Operations Phase base work.

The Offeror shall enter its name in the cell set aside for this information near the top of the pricing table.

The Offeror shall enter the first month in which Base Work is to be performed in the cell labeled "Contract month to begin Base Work," where the first day of the Contract is the first day of Contract month 1. The Contract month to begin Base Work cannot be any earlier than the date of the first increment becoming operational (Targeted Increment Operational Start Date). For each month of the Contract (starting with the month in which Base Work begins), the Offeror shall enter its proposed base year fixed price to conduct Base Work. For months prior to the first increment being operational, the proposed price shall be zero. For the months when each increment becomes operational, the Offeror shall identify the increment by name and ID (consistent with all other sections of the Offeror's Proposal).

The BOE for this pricing table shall quantitatively describe how the Offeror derived the proposed prices for this table.

The State has pre-entered formulas to automatically fill out parts of this table; however, Offerors are required to ensure that the prices entered on this table are accurate and consistent with the other tables in the Cost Proposal.

2.2.7 Pricing Table G – Operations Phase – Claims-Related Services

The purpose Pricing Table G is to obtain the prices for variable costs associated with Claims-Related Services. As described in RFP Section III.4.4.3, Claims-Related Services are those Services whose effort tends to scale proportionately to the number of claims paid during a given time period (e.g., prior authorization, claims adjudication, responding to telephone calls about claims, etc.).

Pricing Table G provides the opportunity for the Offeror to propose volume-based discounts on Claims-Related Services. This is accomplished by permitting a continuously variable price per claim. Figure XX shows this concept graphically.

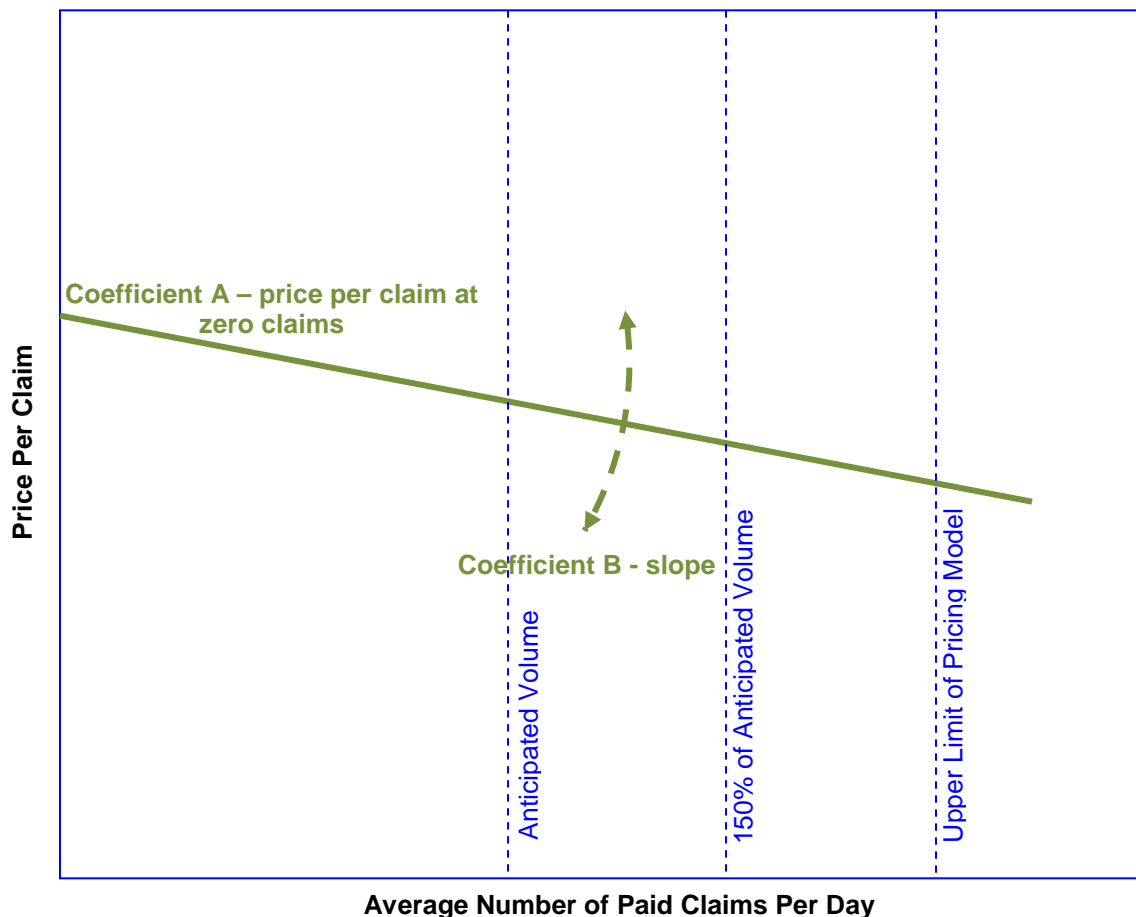


Figure VIII.2-1. Variable Price Per Claim Concept

For the purposes of pricing and invoicing, average daily paid claim volume is measured as a daily average over a one-month invoice cycle (see RFP Section VIIB Exhibit A. Invoicing and Payment for additional details). To establish the per paid claim price, two coefficients are used. Coefficient A identifies the price per claim at zero average claims per day. Coefficient B identifies the rate of volume discount provided (the slope of the line in Figure VIII.2-1). If Coefficient B is zero, then the price for servicing each paid claim is the same. The more negative Coefficient B is, the greater the relative discount is for larger volumes of paid claims. The

Offeror may use no more than six significant digits for each coefficient (note that this is not the same as six decimal places), and Coefficient B shall not be a positive number.

The Offeror shall enter its name in the cell set aside for this information near the top of the pricing table.

The Offeror shall enter the first month in which Claims-Related Services are to be performed in the cell labeled “Contract month to begin Claims-Related Services,” where the first day of the Contract is the first day of Contract month 1. For each month of the Contract (starting with the month in which Claims-Related Services begin), the Offeror shall enter Coefficient A and Coefficient B used to calculate the base year price for performing Claims-Related Services. For months prior to the first Claims-Related Services increment becoming operational, the proposed price shall be zero. For the months when each additional Claims-Related Services increment becomes operational (Targeted Increment Operational Start Date), the Offeror shall identify the increment by name and ID (consistent with all other sections of the Offeror’s Proposal).

The Offeror shall enter the Upper Limit of Pricing Model in the cell marked as such. This value must be greater than or equal to 150%.

The table is shaded by Contract year for clarity and to delineate changes in the anticipated volume of claims. Offerors are not required to align increments or coefficients with these annual bands.

The BOE for this pricing table shall quantitatively describe how the Offeror derived the proposed prices for this table. Offerors should place additional emphasis on which work was allocated to this pricing table and which was allocated to Base Work in Pricing Table F.

The State has pre-entered formulas to automatically fill out parts of this table; however, Offerors are required to ensure that the prices entered on this table are accurate and consistent with the other tables in the Cost Proposal.

2.2.8 Pricing Table H. Operations Phase – Prior Authorization Services

The purpose of Pricing Table H is to obtain the unit prices for performing Prior Authorization Services.

The Offeror shall enter its name in the cell set aside for this information near the top of the pricing table.

The Offeror shall enter the first month in which Prior Authorization Services is to be performed in the cell labeled “Contract Month to begin Prior Authorization Services.” For each month of the Contract (starting with the month in which Prior Authorization Services begins), the Offeror shall enter the base year fixed price for each Billable Prior Authorization.

The BOE for this pricing table shall quantitatively describe how the Offeror derived the proposed prices for this table.

The State has pre-entered formulas to automatically fill out parts of this table; however, Offerors are required to ensure that the prices entered on this table are accurate and consistent with the other tables in the Cost Proposal.

2.2.9 Pricing Table I. Operations Phase – Provider Management Services

The purpose of Pricing Table I is to obtain the unit prices for provider enrollment, revalidation, and screening activities and the provider outreach and maintenance activities. The State has entered the estimated amount of providers for which these Services must be performed.

The Offeror shall enter its name in the cell set aside for this information near the top of the pricing table.

For each month of the Contract (starting with the month in which Provider Management Services begins), the Offeror shall enter the base year fixed price for abbreviated enrollment, enrollment, revalidation, and screening (low, moderate, and high risk categories). Note that the screening categories do not overlap in content, and the functions performed are cumulative as the risk category increases. For example, for a newly enrolling provider in the high risk category, the Contractor would perform enrollment, low risk category screening, moderate risk category screening, and high risk category screening and would invoice for all four activities.

For provider outreach and maintenance, the Offeror shall enter a fixed per provider per month fee for each unduplicated enrolled provider for each year in which the Service will be performed.

The BOE for this pricing table shall quantitatively describe how the Offeror derived the proposed prices for this table.

The State has pre-entered formulas to automatically fill out parts of this table; however, Offerors are required to ensure that the prices entered on this table are accurate and consistent with the other tables in the Cost Proposal.

2.2.10 Pricing Table J. Operations Phase – Third Party Liability/Recovery Services

The purpose of Pricing Table J is to obtain prices for Third Party Liability/Recovery Services.

The Offeror shall enter its name in the cell set aside for this information near the top of the pricing table.

The Offeror shall enter the first month in which Third Party Liability/Recovery Services are to be performed in the cell labeled “Contract month to begin Third Party Liability/Recovery Services,” where the first day of the Contract is the first day of Contract month 1. For each month (starting with the month in which Third Party Liability/Recovery Services begin), the Offeror shall enter:

- Its proposed base year price per primary payer identification.
- Its proposed contingency rate for primary health insurance (Medicare and private) recoveries. Contingency fees are not adjusted for inflation; however, the “Estimated Recovery (Base Year)” will be adjusted for estimated inflation in Pricing Table J.
- Its proposed base year price per member per month for members who are enrolled in the Health Insurance Premium Payments program.

The BOEs for this pricing table shall quantitatively describe how the Offeror derived the proposed prices for this table.

The State has pre-entered formulas to automatically fill out parts of this table; however, Offerors are required to ensure that the prices entered on this table are accurate and consistent with the other tables in the Cost Proposal.

2.2.11 Pricing Table K. Operations Phase – Member Premium Management Services

The purpose of Pricing Table K is to obtain the per member per month price for managing the member premium payment process.

The Offeror shall enter its name in the cell set aside for this information near the top of the pricing table.

The Offeror shall enter a fixed per member per month base year price for each premium-paying member for each year in which the Service may be performed.

The BOE for this pricing table shall quantitatively describe how the Offeror derived the proposed prices for this table.

The State has pre-entered formulas to automatically fill out parts of this table; however, Offerors are required to ensure that the prices entered on this table are accurate and consistent with the other tables in the Cost Proposal.

2.2.12 Pricing Table L. Operations Phase – Training

The purpose of Pricing Table L is to obtain the prices for conducting face-to-face (instructor(s) physically present with all students) and virtual (live instructor(s) linked to the students online) training classes during the Operations Phase. Offerors must note that training associated with testing during the Replacement Phase must be included in the Proposed Labor Price for the Replacement Phase, and that Contractor staff training must be included in Operations Standup Fixed Pricing for the Replacement Phase.

The Offeror shall enter its name in the cell set aside for this information near the top of the pricing table.

The Offeror shall enter the ID and name of each increment on the line representing the Contract month in which that increment becomes operational (Target Increment Operational Start Date). For each month in which the Offeror plans to conduct training covered by this pricing table, the Offeror shall identify the cumulative number of Training Days planned for that month (both face-to-face and virtual). The Offeror shall also enter an all-inclusive base year price for each Training Day by Contract year (both face-to-face and virtual). These base year prices are to be used to calculate the proposed monthly training base year prices.

The BOEs for this pricing table shall quantitatively describe how the Offeror derived the proposed prices for this table. The proposed number of Training Days must be consistent with the training strategy in Proposal Sections C2 and C3 of the Offeror's Proposal.

The State has pre-entered formulas to automatically fill out parts of this table; however, Offerors are required to ensure that the prices entered on this table are accurate and consistent with the other tables in the Cost Proposal.

2.2.13 Pricing Table M – Turnover Phase

The purpose of Pricing Table M is to obtain the fixed price and Milestone/Deliverable payments for the Turnover Phase. Offerors should note that the various Operations Phase Services are not included in this pricing table. This table must only contain prices for Service provided by the Contractor to properly effect a turnover of the system and business operations to the State or another contractor.

The Offeror shall enter its name in the cell set aside for this information near the top of the pricing table.

The Offeror shall enter the following information on this pricing table for each Milestone or Deliverable for which it plans to invoice the State:

- The line number or work breakdown structure element (if used) for the Milestone or Deliverable
- The name of the Milestone or Deliverable
- An identification of whether the item is a Milestone (“M”) or Deliverable (“D”)
- The percentage of the fixed price for the Turnover Phase represented by a specific Milestone or Deliverable. The payment percentage shall be proportionate to the effort required to achieve the Milestone or Deliverable, and shall include properly proportioned allocations for level-of-effort tasks such as project management and systems engineering as well as indirect and non-labor costs.
- The base year price, corresponding to the percentage, to be paid upon the State’s acceptance of the Milestone or Deliverable (not reflecting the 20% withhold)
- The Contract month in which the Offeror plans to complete each Milestone or Deliverable (through the State’s acceptance)

The Offeror may add or delete table rows as necessary to reflect all applicable Turnover Phase Milestones and Deliverables.

The BOEs for this pricing table shall quantitatively describe how the Offeror derived the proposed prices for this table and how the payment amounts/percentages were allocated to the Milestones and Deliverables.

The State has pre-entered formulas to automatically fill out this table; however, Offerors are responsible for ensuring that the prices entered on this table are accurate and consistent with the other tables in the Cost Proposal.

2.2.14 Pricing Table N – Legacy Contract Costs

The purpose of Pricing Table N is to compute the contribution of the legacy contract costs to the Total Enterprise Cost of Ownership.

The Offeror shall enter its name in the cell set aside for this information near the top of the pricing table.

The Offeror shall enter the months it proposes to retire each of the legacy contracts in the row just below the legacy contract names. The months entered for each contract must be same as the months in which the corresponding increment is proposed to become operational. For

consistency purposes, the TECO model assumes a one-month overlap between each contract and the Replacement MMIS Contract (even if the actual overlap during turnover is longer or shorter). The State, at its sole discretion, may adjust the overlap when calculating TECO if an Offeror's proposed solution requires a substantially longer contract overlap for any of the contracts being retired.

The remainder of this table should populate automatically. The costs of each legacy contract should be zeroed out after the retirement month, and the Totals at in the bottom row and right column should reflect the vertical and horizontal sums, respectively.

The BOE for this table shall confirm that the retirement months entered are consistent with the corresponding Increment Operational Start Dates for increments needed to retire the legacy contracts.

The State has pre-entered formulas to automatically fill out this table; however, Offerors are responsible for ensuring that the prices entered on this table are accurate and consistent with the other tables in the Cost Proposal.

2.2.15 Pricing Table O – Total Enterprise Cost of Ownership

The purpose of Pricing Table O is to compute the Offeror's Total Enterprise Cost of Ownership; Contract Proposed Price; Target Labor Price and Not-to-Exceed Labor Price for the Discovery and Replacement Phases;. 1/30th percent of the Target Labor Price; 1/100th percent of the Target Labor Price; and 1/300th percent of the Target Labor Price.

The Offeror shall enter its name in the cell set aside for this information near the top of the pricing table.

The remainder of this table should populate automatically with the exception of Hosting Hardware. Each cell should represent prices entered in other pricing tables, and the "Totals" columns should represent the sums of their corresponding prices. The special values calculated (e.g., 1/30th percent of the Target Labor Price) are self-explanatory.

The State will enter its estimated prices for Hosting Hardware, as well as adjust any other State costs for Offeror-unique factors prior to evaluating Total Cost of Enterprise Ownership during the evaluation.

The State has pre-entered formulas to automatically fill out this table; however, Offerors are responsible for ensuring that the prices entered on this table are accurate and consistent with the other tables in the Cost Proposal.

3 Section L. Bases of Estimates

Subsection	Title	Page Limits
Section M1	Background	N/A
Section M2	Bases of Estimates Results	N/A

Table VIII.3-1. Bases of Estimates Sections

Section M of the Offeror's Proposal shall contain the BOEs supporting the Offeror's pricing tables. RFP Section III.5.3 contains requirements for the BOEs to be used in Proposals and for the entire Term of the Contract.

3.1 Section L1. Background

This section shall contain any background required to properly understand the Offeror's general estimation methodologies and formats including estimation models and crosscheck methods.

With respect to estimation models, the Offeror shall describe the models with sufficient quantitative description so that the State can make a reasonable judgment as to the model's applicability and accuracy for their intended purpose. Merely stating that the Offeror uses "an internal proprietary estimation model" is not sufficient explanation.

3.2 Section L2. Bases of Estimates Results

This section shall contain the actual BOEs supporting the pricing tables. The Offeror may use any reasonable format that contains the required information and conveys it in an easily understandable way.

Each pricing table shall have a basis of estimate associated with it unless otherwise directed in this document. BOEs for one pricing table may reference BOEs supporting a different pricing table, and duplication of the identical material is not required. Additionally, BOEs for the Cost Proposal may reference BOEs for schedule in the Technical Proposal to avoid duplication of documentation.

IX. Attachments

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Attachment A. NONRESIDENT TAXPAYER REGISTRATION AFFIDAVIT INCOME TAX WITHHOLDING

IMPORTANT TAX NOTICE - NONRESIDENTS ONLY

Withholding Requirements for Payments to Nonresidents: Section 12-8-550 of the South Carolina Code of Laws requires persons hiring or contracting with a nonresident conducting a business or performing personal services of a temporary nature within South Carolina to withhold 2% of each payment made to the nonresident. The withholding requirement does not apply to (1) payments on purchase orders for tangible personal property when the payments are not accompanied by services to be performed in South Carolina, (2) nonresidents who are not conducting business in South Carolina, (3) nonresidents for contracts that do not exceed \$10,000 in a calendar year, or (4) payments to a nonresident who (a) registers with either the S.C. Department of Revenue or the S.C. Secretary of State and (b) submits a Nonresident Taxpayer Registration Affidavit - Income Tax Withholding, Form I-312 to the person letting the contract.

The withholding requirement applies to every governmental entity that uses a contract ("Using Entity"). Nonresidents should submit a separate copy of the Nonresident Taxpayer Registration Affidavit - Income Tax Withholding, Form I-312 to every Using Entity that makes payment to the nonresident pursuant to this solicitation. Once submitted, an affidavit is valid for all contracts between the nonresident and the Using Entity, unless the Using Entity receives notice from the Department of Revenue that the exemption from withholding has been revoked.

Section 12-8-540 requires persons making payment to a nonresident taxpayer of rentals or royalties at a rate of \$1,200.00 or more a year for the use of or for the privilege of using property in South Carolina to withhold 7% of the total of each payment made to a nonresident taxpayer who is not a corporation and 5% if the payment is made to a corporation. Contact the Department of Revenue for any applicable exceptions.

For information about other withholding requirements (e.g., employee withholding), contact the Withholding Section at the South Carolina Department of Revenue at 803-898-5383 or visit the Department's website at: www.sctax.org

This notice is for informational purposes only. This agency does not administer and has no authority over tax issues. All registration questions should be directed to the License and Registration Section at 803-898-5872 or to the South Carolina Department of Revenue, Registration Unit, Columbia, S.C. 29214-0140. All withholding questions should be directed to the Withholding Section at 803-898- 5383.

PLEASE SEE THE "NONRESIDENT TAXPAYER REGISTRATION AFFIDAVIT INCOME TAX WITHHOLDING" FORM (FORM NUMBER I-312) LOCATED AT:
<http://www.sctax.org/Forms+and+Instructions/withholding/default.htm>

[09-9005-1]

Attachment B. HIPAA BUSINESS ASSOCIATE AGREEMENT

A. Purpose:

The South Carolina Department of Health and Human Services (Covered Entity) and CONTRACTOR (Business Associate) agree to the terms of this Appendix 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 (Terms used in this Section, but not otherwise defined, shall have the same meaning as set forth for those terms in HIPAA. A change to HIPAA which modifies any defined HIPAA term, or which alters the regulatory citation for the definition shall be deemed incorporated into this Appendix).

1. Business Associate. "Business Associate" shall mean the CONTRACTOR. Where the term "business associate" appears without an initial capital letter, it shall have the same meaning as the term "business associate" in 45 CFR § 160.103.
2. Covered Entity. "Covered Entity" shall mean SCDHHS.
3. Data Aggregation. "Data Aggregation" shall have the meaning given to the term in 45 CFR § 164.501.
4. Designated Record Set. "Designated Record Set" shall have the meaning given the term in 45 CFR § 164.501.
5. Electronic Protected Health Information and/or EPHI. "Electronic Protected Health Information" or "EPHI" shall have the meaning given the term in 45 CFR § 160.103, and shall include, without limitation, any EPHI provided by Covered Entity or created or received by Business Associate on behalf of Covered Entity.
6. HIPAA. "HIPAA" means the Health Insurance Portability and Accountability Act of 1996, Public Law 104-91, as amended, and related HIPAA regulations (45 CFR Parts 160-164).
7. HITECH. "HITECH" means the Health Information Technology for Economic and Clinical Health Act, found in Title XIII of the

American Recovery and Reinvestment Act of 2009, Public Law 111-005.

8. Individual. "Individual" shall have the same meaning as the term "individual" in 45 CFR § 160.103 and shall include a person who qualifies as a personal representative in accordance with 45 CFR § 164.502(g).
9. Privacy Rule. "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information, and Security Standards for the Protection of Electronic Protected Health Information (the "Security Rule") that are codified at 45 CFR Parts 160 and Part 164, Subparts A, C, and E and any other applicable provision of HIPAA, and any amendments thereto, including HITECH.
10. Protected Health Information or PHI. "Protected Health Information" or "PHI" shall have the same meaning as the term "protected health information" in 45 CFR § 160.103, and shall include, without limitation, any PHI provided by Covered Entity or created or received by Business Associate on behalf of Covered Entity. Unless otherwise stated in this Agreement, any provision, restriction, or obligation in this Appendix related to the use of PHI shall apply equally to EPHI.
11. Required By Law. "Required By Law" shall have the same meaning as the term "required by law" in 45 CFR § 164.103, and any additional requirements created under HITECH.
12. Secretary. "Secretary" shall mean the Secretary of the Department of Health and Human Services or his designee.
13. Security Incident. "Security Incident" means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system as provided in 45 C.F.R. § 164.304.
14. Unsecured PHI. "Unsecured PHI" shall have the same definition that the Secretary gives the term in guidance issued pursuant to § 13402 of HITECH.

C. Business Associate Agrees to:

1. Not use or disclose PHI or EPHI other than as permitted or required by the Contract or as Required By Law.

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2. Develop, implement, maintain, and use appropriate safeguards to prevent any use or disclosure of the PHI or EPHI other than as provided by this Appendix, and to implement administrative, physical, and technical safeguards as required by sections 164.308, 164.310, 164.312 and 164.316 of title 45, Code of Federal Regulations and HITECH in order to protect the confidentiality, integrity, and availability of EPHI or PHI that Business Associate creates, receives, maintains, or transmits, to the same extent as if Business Associate were a Covered Entity. See HITECH § 13401.
3. The additional requirements of Title XIII of HITECH that relate to privacy and security and that are made applicable with respect to covered entities shall also be applicable to Business Associate and shall be and by this reference hereby incorporated into this Appendix.
4. Adopt the technology and methodology standards provided in any guidance issued by the Secretary pursuant to HITECH §§ 13401-13402.
5. Mitigate to the extent practicable, any harmful effect known to Business Associate if Business Associate uses/discloses PHI in violation of the Contract or this Appendix and to notify Covered Entity of any breach of unsecured PHI, as required under HITECH § 13402.
6. Immediately report to Covered Entity any breaches in privacy or security that compromise PHI or EPHI. Security and/or privacy breaches should be reported to:
South Carolina Department of Health and Human Services
Office of General Counsel
Post Office Box 8206
Columbia, South Carolina 29202-8206
Phone: (803) 898-2795
Fax: (803) 255-8210

The Report shall include the identification of each individual whose Unsecured PHI has been, or is reasonably believed by the Business Associate to have been, accessed, acquired, or disclosed during the breach. If the breach involves the Unsecured PHI of more than 500 residents of South Carolina or residents of a certain region, or is reasonably believed to have been accessed, acquired or disclosed during such incident, the Covered Entity will also notify the prominent media outlets. The media outlets must serve the geographic area affected.

SCDHHS may impose a fine of \$300 per day from the date that the Business Associate knew or should have known of any breach in

privacy or security that compromises PHI to the date that SCDHHS becomes aware of the breach.

SCDHHS may impose a fine of up to \$25,000 for any negligent breach in privacy or security that compromises PHI.

7. Ensure that any agent/subcontractor to whom it provides PHI agrees to the same restrictions/conditions that apply to the Business Associate in this Appendix. Business Associate must obtain, prior to making any permitted disclosure to any agent/subcontractor, reasonable assurances from such third party that such PHI will be held secure and confidential as provided pursuant to this Appendix and only disclosed as required by law or for the purposes for which it was disclosed to such third party, and that any breaches of confidentiality of the PHI which become known to such third party will be immediately reported to Business Associate. As part of obtaining this reasonable assurance, Business Associate agrees to enter into a Business Associate Agreement with each of its subcontractors pursuant to 45 CFR § 164.308(b)(1) and HITECH § 13401.
8. If the Business Associate has PHI in a Designated Record, provide access at the request of Covered Entity, and in the time and manner designated by Covered Entity, to PHI in a Designated Record Set, to Covered Entity or, as directed by Covered Entity, to an Individual in order to meet the requirements under 45 CFR § 164.524.
9. If the Business Associate has PHI in a Designated Record Set, make any amendment(s) to PHI in a Designated Record Set that the Covered Entity directs or agrees to pursuant to 45 CFR § 164.526 at the request of Covered Entity or an Individual, and in the time and manner designated by Covered Entity.
10. Make internal practices, books, and records, including policies and procedures and PHI, relating to the use and disclosure of PHI received from, or created or received by Business Associate on behalf of, Covered Entity available to the Covered Entity, or at the request of the Covered Entity to the Secretary, in a time and manner designated by the Covered Entity or the Secretary, for purposes of the Secretary determining Covered Entity's compliance with the Privacy Rule.
11. Document such disclosures of PHI and information related to such disclosures as would be required for Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 CFR § 164.528.

12. Provide to Covered Entity or an Individual, in a time and manner designated by Covered Entity, information collected in accordance with Section C.8 of this Appendix, to permit Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 CFR § 164.528.
13. Encrypt all PHI stored on portable devices. Portable devices include all transportable devices that perform computing or data storage, manipulation or transmission including, but not limited to, diskettes, CDs, DVDs, USB flash drives, laptops, PDAs, Blackberrys, cell phones, portable audio/video devices (such as iPODs, and MP3 and MP4 players), and personal organizers. Portable devices that perform computing, data manipulation or data transmission are called intelligent portable devices.
14. Business Associate understands and agrees that, should SCDHHS be found in violation of the HIPAA Privacy Rule due to Business Associate's material breach of this Section, Business Associate shall be liable to SCDHHS for any damages, penalties and/or fines assessed against SCDHHS as a result of Business Associate's material breach. SCDHHS is authorized to recoup any and all such damages, penalties and/or fines assessed against SCDHHS by means of withholding and/or offsetting such damages, penalties, and/or fines against any and all sums of money for which SCDHHS may be obligated to the Business Associate under any previous contract and/or this or future contracts. In the event there is no previous contractual relationship between the Business Associate and SCDHHS, the amount to cover such damages, penalties and/or fines shall be due from Business Associate immediately upon notice.

D. Permitted Uses and Disclosures by Business Associate

1. Except as limited in this Appendix, Business Associate may use PHI to perform functions, activities, or services for, or on behalf of, Covered Entity as specified in the Contract noted in A. provided that such use would not violate the Privacy Rule if done by Covered Entity or the Covered Entity's minimum necessary policies and procedures. Unless otherwise permitted in this Appendix, in the Contract noted in A. above or as Required by Law, Business Associate may not disclose or re-disclose PHI except to Covered Entity.
2. Except as limited in this Appendix, Business Associate may use or disclose PHI for the proper internal management and administration

of the Business Associate or to carry out the legal responsibilities of the Business Associate, as needed for Business Associate to provide services to Covered Entity under the above noted Contract.

3. Except as limited in this Appendix, Business Associate may use PHI to provide Data Aggregation services to Covered Entity as permitted by 42 CFR § 164.504(e)(2)(i)(B).
4. Business Associate may use PHI to report violations of law to appropriate Federal and State authorities, consistent with § 164.502(j)(1).

E. Covered Entity Shall:

1. Notify Business Associate of any limitation(s) in its notice of privacy practices of Covered Entity in accordance with 45 CFR § 164.520, to the extent that such limitation may affect Business Associate's use or disclosure of PHI.
2. Notify Business Associate of any changes in, or revocation of, permission by Individual to use or disclose PHI, to the extent that such changes may affect Business Associate's use or disclosure of PHI.
3. Notify Business Associate of any restriction to the use/disclosure of PHI that Covered Entity has agreed to in accordance with 45 CFR § 164.522, to the extent that such restriction may affect Business Associate's use/disclosure of PHI.
4. Not request Business Associate to use or disclose PHI in any manner that would not be permissible under the Privacy Rule if done by Covered Entity.

F. Term and Termination

1. The terms of this Appendix shall be effective immediately upon award of the Contract noted in A. and shall terminate when all of the PHI provided by Covered Entity to Business Associate, or created or received by Business Associate on behalf of Covered Entity, is returned to Covered Entity, or, if it is infeasible to return PHI, protections are extended to such PHI in accordance with the termination provisions in this Section.
2. Upon Covered Entity's knowledge of a material breach by Business Associate, Covered Entity shall:

- a. Provide an opportunity for Business Associate to cure the breach or end the violation and terminate the Contract if Business Associate does not cure the breach or end the violation within the time specified by Covered Entity; OR
- b. Immediately terminate the Contract if Business Associate has breached a material term of this Appendix and cure is not possible; OR
- c. If neither termination nor cure is feasible, Covered Entity shall report the violation to the Secretary.

3. Effect of Termination.

- a. Except as provided in paragraph (2) below, upon termination of the Contract, for any reason, Business Associate shall return all PHI received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity. This provision applies to PHI in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the PHI.
- b. In the event that Business Associate determines that returning the PHI is infeasible, Business Associate shall provide to Covered Entity notification of the conditions that make return infeasible. Upon mutual agreement of the parties that return of PHI is infeasible, Business Associate shall extend the protections of this Appendix to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return infeasible, for so long as Business Associate maintains such PHI.

G. Security Compliance

This Section shall be effective on the applicable enforcement date of the Security Standards. Business Associate agrees to implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of the Covered Entity, and will require that its agents and subcontractors to whom it provides such information do the same. Further, Business Associate agrees to comply with Covered Entity's security policies and procedures. Business Associate also agrees to provide Covered Entity with access to and information concerning Business Associate's security and confidentiality policies, processes, and practices that affect Electronic PHI provided to or created by Business Associate pursuant to the Agreement upon reasonable request of the Covered Entity. Covered Entity shall determine if Business Associate's security and confidentiality practices, policies, and processes comply with HIPAA, as amended from time to time, and all regulations promulgated

under HIPAA. Additionally, Business Associate will immediately report to Covered Entity any Security Incident of which it becomes aware.

H. Miscellaneous

1. A reference in this Appendix to a section in the Privacy Rule means the section as in effect or as amended.
2. The Parties agree to amend this Appendix as necessary to comply with HIPAA and other applicable law.
3. Any provision related to the use, disclosure, access, or protection of EPHI or PHI or that by its terms should survive termination of this Agreement shall survive termination.
4. Any ambiguity in this Appendix shall be resolved to permit Covered Entity to comply with the Privacy Rule.

**Attachment C. Certification Regarding Debarment,
Suspension, Ineligibility and Voluntary Exclusion - Lower Tier
Covered Transactions (To Be Supplied to Lower Tier
Participants- Subcontractors)**

By signing and submitting this lower tier proposal, the prospective lower tier participant, as described and required in 2 CFR Part 180 and 2 CFR Part 376, certifies to the best of its knowledge and belief that it and its principals:

- (a) are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any federal department or agency.
- (b) where the prospective lower participant is unable to certify to any of the above, such prospective participant shall attach an explanation to this proposal.

The prospective lower tier participant further agrees by submitting this proposal that it will include this clause entitled Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion - Lower Tier Covered Transactions without modification in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

Authorized Signature

Date

Attachment D. CERTIFICATION FOR CONTRACTS, GRANTS, LOANS, AND COOPERATIVE AGREEMENTS

Instructions

The attached form must be completed by all Providers/Contractors who receive \$100,000 or more in federal funds through a contractual agreement with the South Carolina Department of Health and Human Services (SCDHHS). The purpose of the attached form is to certify that none of the federal funds received through the contractual agreement will be used for any lobbying activities. This form is required by the Federal Government as a result of 31 U.S.C. 1352. A copy of this form must be completed and returned with all signed contractual agreements exceeding \$100,000.

Additionally, should the Provider/Contractor enter into any subcontracts in coordination with the contractual agreement with SCDHHS, the Provider/Contractor is required to have on file a signed copy of this form for any and all subcontracts which exceed the \$100,000 level. This requirement extends to all levels of subcontracting and sub-subcontracting.

Should the Provider/Contractor (or any of its Subcontractors/ Sub-subcontractors) use any funds for lobbying activities, an additional form (Standard Form - LLL) will be required. (See #2 on the attached form). It shall be the responsibility of the Provider/Contractor to notify SCDHHS of this activity and to request from SCDHHS a copy of this form for completion and proper filing.

Should there be any questions concerning this form or the Standard Form - LLL, contact should be made with the Division of Contracts at SCDHHS.

**CERTIFICATION FOR CONTRACTS, GRANTS, LOANS,
AND COOPERATIVE AGREEMENTS**

The undersigned certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement
2. If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form - LLL, "Disclosure Form to Report Lobbying" in accordance with its instructions.
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed under Section 1352, Title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000.00 for such failure.

SIGNATURE: _____

TITLE: _____

DATE: _____

Attachment E. DRUG-FREE WORKPLACE ACT CERTIFICATION STATEMENT

SECTION 44-107-10 THROUGH SECTION 44-107-90
CODE OF LAWS OF SOUTH CAROLINA, 1976 AS AMENDED

I hereby certify to the South Carolina Department of Health and Human Services (SCDHHS) that I will provide a drug-free workplace by:

1. publishing a statement notifying employees that the unlawful manufacture, distribution, dispensation, possession, or use of a controlled substance is prohibited in the person's workplace and specifying the actions that will be taken against employees for violations of the prohibition;
2. establishing a drug-free awareness program to inform employees about:
 - a. the dangers of drug abuse in the workplace;
 - b. the person's policy of maintaining a drug-free workplace;
 - c. any available drug counseling, rehabilitative, and employee assistance programs; and
 - d. the penalties that may be imposed upon employees for drug violations.
3. making it a requirement that each employee to be engaged in the performance of the contract be given a copy of the statement required by item 1;
4. notifying the employee in the statement required by item 1, that as a condition of employment on the contract or grant, the employee will;
 - a. abide by the terms of the statement; and
 - b. notify the employer of any criminal drug statute conviction for a violation occurring in the workplace no later than five days after the conviction.
5. notifying the using agency within ten days after receiving notice under item 4, b from an employee or otherwise receiving actual notice of the conviction
6. imposing a sanction on, or requiring the satisfactory participation in a drug abuse assistance or rehabilitation program by any employee convicted, as required by Section 44-107-50; and
7. making a good faith effort to continue to maintain a drug-free workplace through implementation of items 1,2,3,4,5 and 6.

I also agree that, in compliance with Section 44-107-50, I shall, within thirty days after receiving notice from an employee of a conviction pursuant to this title:

1. take appropriate personnel action against the employee up to and including termination; or
2. require the employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for the purposes by a federal, state, or local health, law enforcement, or other appropriate agency.

Date

Authorized Signature

Revised 1/31/97

Attachment F. MINORITY BUSINESSES CERTIFICATION STATEMENT

State agencies are required by law to report the purchase of supplies, equipment and contractual services from minorities to the Governor's Office of Small and Minority Business. In order for us to fulfill that obligation, please read this document and provide the information that is required.

(All respondents and/or providers must complete & sign this form)

Provider #: _____

Name of Provider: _____ SSN or EIN: _____

What is the legal status of the Provider:

Public _____ Private non-profit _____ Private for profit _____ NA – Individual

Definitions:

Minority Person means a United States citizen who is economically and socially disadvantaged. Socially disadvantaged individuals means those individuals who have been subject to racial or ethnic prejudice or cultural bias because of their identification as members of a certain group, without regard to their individual qualities. Such groups include, but are not limited to, Black Americans, Native Americans (including American Indians, Eskimos, Aleuts, and Native Hawaiians), Asian Pacific Americans, women, and other minorities officially designated by the State Budget and Control Board or designated agency.

Economically disadvantaged individuals means those socially disadvantaged individuals whose ability to compete in the free enterprise system has been impaired due to diminished capital and credit opportunities as compared to others in the same business area who are not socially disadvantaged.

A socially and economically disadvantaged small business means any small business concern which:

- (1) At a minimum, is fifty-one percent (51%) owned by one or more citizens of the United States who are deemed to be socially and economically disadvantaged.
- (2) In the case of a corporation, at a minimum, fifty-one (51%) of all classes of voting stock of such corporation must be owned by an individual or individuals deemed to be socially and economically disadvantaged.
- (3) In the case of a partnership, at a minimum, fifty-one percent (51%) of the partnership interest must be owned by an individual or individuals deemed to be socially and economically disadvantaged and whose management and daily business operations are controlled by individuals deemed to be socially and economically disadvantaged. Such individuals must be involved in the daily management and operations of the business concerned.

Do you or your firm qualify as a minority/minority business? Yes ___ No ___ If yes, do you qualify as:

1. ___ Minority
2. ___ Minority Black Female
3. ___ Non-Minority Female Caucasian
4. ___ Other

Are you or is your firm registered with the Governor's Office of Minority Business Enterprises?

Yes ___ No ___ If yes, what is your certification and/or vendor number? _____ If no, please call (803) 734-0657 to register.

Signature (Signature must be by an individual having authority to enter into legal commitments or contracts)

Draft

Attachment G. Disclosure and Control Interest Statement

(See pages below)

DISCLOSURE OF OWNERSHIP AND CONTROL INTEREST STATEMENT

V. General Instructions

Federal Medicaid regulations (Title XIX – 42CFR 455.100 – 106) require that all Medicaid providers disclose the name and address of each person with an ownership or control interest in the provider and any subcontractor where the provider has a direct or indirect ownership interest of 5% or more. All applicants, except individual practitioners or group of practitioners as mentioned in 42 CFR 455.101, must complete this form in order to enroll as a provider in the Medicaid program.

Failure to provide this form may result in a refusal by the South Carolina Department of Health and Human Services (SCDHHS) to enter into an agreement or contract with any such provider or institution or in termination of existing agreements.

Please answer all questions as of the current date. If the “**Yes**” block for an item is checked, list the requested additional information in that item or under the “**Remarks**” section on page 4 if more space is needed, referencing the item number to which the information corresponds. If additional space is needed, use another sheet. Return the original to SCDHHS; retain a copy for your files.

Completion and submission of this form is also a condition of approval or renewal of a contractor agreement between the disclosing entity and SCDHHS. This form is to be completed under any programs established by Title XIX and Title XXI and must be submitted whenever any of the provider information changes. Any substantial delay in completing the form should be reported to SCDHHS.

I. Instructions / Definitions: Specify in what capacity you do business as (D/B/A); for example, trade name or corporation. Provider types that must have a NPI must include this information. If a valid telephone number is not included, this form will be returned and enrollment into the Medicaid program will not proceed.

I. Identifying Information			
[a] Name of Provider		(D/B/A)	
Street Address		City, State, Zip + 4	
County	Provider Number	NPI Number	Telephone Number
[b] Employer Identification Number (EIN), if applicable:			
[c] Type of Entity (Applies to either For Profit or Non-Profit)			
<input type="checkbox"/> Limited Liability Corporation (LLC) <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> Business Proprietorship or Company			

II. Instructions / Definitions:

Providers must disclose ownership and control information as required by 42 CFR 455.101 - 104.

Direct ownership interest is defined as the possession of stock, equity in capital or any interest in the profits of the disclosing entity. **A disclosing entity** is defined as a Medicaid provider, supplier, or other entity, other than an individual practitioner or group of practitioners, that furnishes services or arranges for furnishing services under Medicaid, Medicare, the Maternal and Child Health program, or health related services under the social services program.

Indirect ownership interest is defined as ownership interest in an entity that has direct or indirect ownership interest in the disclosing entity. The amount of indirect ownership in the disclosing entity that is held by any other entity is determined by multiplying the percentage of ownership interest at each level. An indirect ownership interest must be reported if it equates to an ownership interest of 5 percent or more in the disclosing entity. Example: if A owns 10 percent of the stock in a corporation that owns 80 percent of the stock of the disclosing entity, A's interest equates to an 8 percent indirect ownership and must be reported.

Controlling interest is defined as the direction or management of a disclosing entity which may be maintained by any or all of the following devices: the ability or authority, expressed or reserved, to amend or change the corporate identity (i.e. joint venture agreement, unincorporated business status) of the disclosing entity; the ability or authority to nominate or name members of the Board of Directors or Trustees of the disclosing entity; the ability or authority, expressed or reserved, to amend or change the by-laws, constitution, or other operating or management direction of the disclosing entity; the right to control any or all of the assets or other property of the disclosing entity upon the sale or dissolution of

that entity; the ability or authority, expressed or reserved, to control the sale of any or all of the indebtedness, to dissolve the entity, or to arrange for the sale or transfer of the disclosing entity to new ownership or control.

Therefore, **a person with an ownership interest** means a **person** or **corporation** that –

- (a) Has an ownership interest totaling 5 percent or more in a disclosing entity;
- (b) Has an indirect ownership interest totaling 5 percent or more in a disclosing entity;
- (c) Has a combination of direct and indirect ownership interest equal to 5 percent or more in a disclosing entity;
- (d) Owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5 percent of the value of the property or assets of the disclosing entity;
- (e) Is an officer or director of a disclosing entity that is organized as a corporation; or
- (f) Is a partner in a disclosing entity that is organized as a partnership.

II. Individuals and Organizations with Ownership and Controlling Interest

[a] List names, addresses, and social security numbers for individuals, or list names, addresses and the EIN for organizations, having direct or indirect ownership or a controlling interest, **as defined above**, in the entity listed in Section I. List any additional names and addresses under “Remarks” on page 4. If more than one individual is reported **and if any of these persons are related to each other**, this must be reported under “Remarks”.

Name	Address	SSN	EIN

[b] Are any persons / entities with ownership or controlling interest in the provider also owners of other Medicare / Medicaid facilities? If yes, list name, address and NPI and/or EIN for each facility.

☐ Yes ☐ No

Name of Facility	Address	NPI	EIN

III. Instructions/ Definitions: Criminal Offenses related to the delivery of services or items under Medicare or Medicaid programs include convictions relating to patient neglect or abuse in connection with the delivery of a health care item or service; felony and/or misdemeanor convictions related to health care fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct; felony and/or misdemeanor convictions related to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

III. If any of the questions are answered “Yes”, list names, addresses, and SSNs for individuals and names, addresses, and EINs for organizations under “Remarks” on page 4.

[a] Are there any individuals or organizations having a direct or indirect ownership or control interest of five (5) percent or more in the institution, agency, or organization (provider) that have been convicted of a criminal offense related to the involvement of such persons or organizations in any of the programs established by Titles XVIII, XIX, XX or XXI (Medicare, Medicaid, the Social Services Block Grant program or the State Children’s Health Insurance Program [SCHIP])?

☐ Yes ☐ No

[b] Are there any directors, officers, agents, or managing employees of the institution, agency, or organization (provider) who have ever been convicted of a criminal offense related to their involvement in such program established by Titles XVIII, XIX, XX or XXI (Medicare, Medicaid, the Social Services Block Grant program or SCHIP)?

☐ Yes ☐ No

Items IV-VII. Instructions/Changes in Provider Status:

Changes in provider status are defined as any change in management control. Examples of such changes would include: a change in Medical or Nursing Director, a new Administrator, contracting the operation of the facility to a management corporation, a change in the composition of the owning partnership, the hiring or dismissing of any employees with 5 percent or more financial interest in the facility or in an owning corporation, or any changes of ownership.

IV. If there has been a change in ownership /partnership within the last year or if you anticipate a change, indicate the date in the appropriate space. If there are no owners (i.e., the provider is a sole proprietorship), check Not Applicable.
<p>[a] Has there been a change in ownership or controlling interest within the last year? If Yes, give date. <input type="checkbox"/> Yes - Date: / / <input type="checkbox"/> No <input type="checkbox"/> Not Applicable</p> <p>[b] Do you anticipate any change or ownership or controlling interest within the year? <input type="checkbox"/> Yes - Date: / / <input type="checkbox"/> No <input type="checkbox"/> Not Applicable</p>

V. A management company is defined as any organization that operates and manages a business on behalf of the owner of that business, with the owner retaining ultimate legal responsibility for operation of the facility. If the answer is yes, list the name of the management firm or the name of the leasing organization and the EIN.	
Is the facility operated by a management company or leased in whole or part by another organization? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable	
If Yes, what are the dates of operation? Beginning Date / / to Ending Date / / .	
Name	EIN

VI. List current managing employees by name, work telephone number, and Social Security number. "Managing employee" means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over the institution, agency, or organization, or who directly or indirectly conducts the day-to-day operations. <input type="checkbox"/> Not Applicable		
Name/ Title	Work Telephone	Social Security Number
VII. Has there been a change in Administrator, Director of Nursing, or Medical Director within the last year? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable		
If Yes, give date for change: Date / / . List names, titles, and Social Security Number of the prior Administrator, Director of Nursing, or Medical Director.		
Name	Title	Social Security Number

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Item VIII. Instructions/ Definitions: A chain affiliate is any free-standing health care facility that is either owned, controlled, or operated under lease or contract by an organization consisting of two or more free-standing health care facilities organized within or across State lines which is under the ownership or through any other devices, control and direction of a private, charitable or propriety. They also include subsidiary organizations and holding corporations. Provider-based facilities, such as hospital-based home health agencies, **are not** considered to be chain affiliates.

VIII. Chain Affiliation		
[a]. Is this facility chain-affiliated? If Yes, list name, address and EIN of parent Corporation below. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable		
Name	Address	EIN
[b]. If the answer to part [a] of this item was "No", was the facility ever affiliated with a chain? If Yes, list name, address and EIN of parent Corporation. <input type="checkbox"/> Yes <input type="checkbox"/> No		
Name	Address	EIN

IX. (For facilities) Have you increased your bed capacity by ten (10) percent or more, or 10 beds, whichever is greater, within the last 2 years? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, give year of change: _____ Current number of beds: _____ Prior number of beds: _____		
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WHOEVER KNOWINGLY AND WILLFULLY MAKES OR CAUSES TO BE MADE A FALSE STATEMENT OR REPRESENTATION OF THIS STATEMENT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS. IN ADDITION, KNOWINGLY AND WILLFULLY FAILING TO FULLY AND ACCURATELY DISCLOSE THE INFORMATION REQUESTED MAY RESULT IN DENIAL OF A REQUEST TO PARTICIPATE IN MEDICAID, OR, WHERE THE ENTITY ALREADY PARTICIPATES, A TERMINATION OF THE AGREEMENT OR CONTRACT WITH SCDHHS.
--

Name of Authorized Representative (Printed or Typed)	Title
Signature	Date
Remarks (Please attached additional sheet or other documentation if needed)	

**Attachment H. NONDISCLOSURE AGREEMENT
FOR ACCESS TO THE DEPARTMENT OF HEALTH AND HUMAN SERVICES
PROCUREMENT LIBRARY**

RECIPIENT INFORMATION (to be completed by Recipient)

Company Name: _____

Address: _____

Contact Name: _____

Contact Title: _____

Telephone No: _____

Email: _____

FOR AND IN CONSIDERATION of access to the South Carolina Department of Health and Human Services (SCDHHS) Procurement Library, and for other good and valuable consideration, the above-named recipient of information ("Recipient") agrees as follows:

1. Definition of Terms.

- 1.1. "Electronic Protected Health Information" means Protected Health Information which is transmitted by Electronic Media (as defined in the HIPAA Security and Privacy Rule) or maintained in Electronic Media.
- 1.2. "HIPAA Security and Privacy Rule" means the Standards for Security and Privacy of Individually Identifiable Health Information found in the Health Insurance Portability and Accountability Act of 1996, Public Law 104-91, as amended and related HIPAA regulations at 45 C.F.R. part 160-164, as in effect or as amended.
- 1.3. "Protected Health Information" has the same meaning as the term "protected health information" defined in 45 C.F.R. §164.103, limited for the purposes of this Nondisclosure Agreement to such information as the Recipient may receive from SCDHHS as part of the Protected Materials. Protected Health Information includes without limitation "Electronic Protected Health Information" as defined above in Section 1.1.
- 1.4. "Protected Materials" means the data, in whatever form, contained in SCDHHS' Procurement Library. Protected Materials shall not include any information that: (i) is or becomes part of the public domain through no act or omission on the part of the Recipient, (ii) is in the Recipient's possession, as evidenced by a writing, without actual or constructive knowledge of an obligation of confidentiality with respect thereto, at or prior to the time of disclosure under this Nondisclosure Agreement, (iii) is released from confidential treatment by written consent of SCDHHS; (iv) is disclosed to the Recipient by a third party with the legal right to do so; or (v) is required to be disclosed pursuant to any legal proceedings.
- 1.5. "Required By Law" has the same meaning as the term "required by law" defined in 45 C.F.R. §164.103.

- 1.6. "RFP" means the Request for Proposal issued by the Information Technology Management Office of the Procurement Services Division on behalf of SCDHHS for the Replacement MMIS System Project.

2. Confidential Nature of Protected Materials.

The Recipient acknowledges that the Protected Materials have tangible value, and may contain valuable trade secrets, copyrights and confidential information of SCDHHS or its licensors.

3. Nondisclosure and Security.

3.1. Confidentiality.

Recipient agrees to use reasonable and appropriate safeguards to prevent use or disclosure of the Protected Materials other than as provided for by this Nondisclosure Agreement or as Required By Law. The Recipient shall not in any manner or form reproduce, copy, disclose, provide or otherwise make available, in whole or in part, the Protected Materials. Recipient acknowledges and agrees that it acquires no title or rights to the Protected Materials, including any de-identified Protected Health Information, as a result of this Nondisclosure Agreement.

3.2. Improper Disclosure.

Recipient agrees to mitigate, to the extent practicable, any harmful effect that is known to Recipient of a use or disclosure of Protected Materials by Recipient in violation of the requirements of this Nondisclosure Agreement. Recipient agrees to report any use or disclosure of the Protected Materials not provided for by this Nondisclosure Agreement to the SCDHHS Privacy Officer within one (1) business day of the Recipient's discovery of such unauthorized use and/or disclosure. Recipient shall report to the SCDHHS Privacy Officer within one (1) business day of discovery any Security Incident of which Recipient becomes aware. For purposes of this Nondisclosure Agreement, "Security Incident" shall mean the attempted or successful unauthorized access, use, disclosure, modification or destruction of information or interference with system operations in an information system used with respect to Protected Materials.

4. Permitted Purposes.

If Recipient intends to review the Protected Materials to determine whether Recipient wishes to serve as a supplier or subcontractor to a contractor on the RFP, then Recipient may use the Protected Materials only for that purpose. If Recipient intends to review the Protected Materials as a potential direct contractor on the RFP, then Recipient may use the Protected Materials only for the purposes of (a) evaluating whether it intends to respond to the RFP and (b) preparing its response to the RFP. SCDHHS shall not request Recipient to use or disclose Protected Health Information in any manner that would not be permissible under the HIPAA Security and Privacy Rule if done by SCDHHS.

5. Destruction of Protected Materials.

If, prior to the award of the Contract that is the subject of the RFP, SCDHHS notifies Recipient of the termination of access to any or all documents in the SCDHHS Procurement Library Recipient shall promptly destroy all Protected Materials and copies thereof in its possession or under its control, and certify such destruction to SCDHHS in writing.

If the Contract that is the subject of the RFP is awarded to an entity other than Recipient, then upon such award, Recipient shall promptly destroy all Protected Materials and copies thereof in its possession or under its control, and certify such destruction to SCDHHS in writing. If the Contract is awarded to Recipient, Recipient shall destroy all Protected Materials and copies thereof in its possession or under its

control, and certify such action in writing, upon the earlier of the expiration or termination of the Contract or such time as Recipient may cease to use the Protected Materials for the purposes permitted above.

6. Access.

The Recipient agrees to provide SCDHHS or its agents with access to all necessary persons and records for the purpose of monitoring, evaluating, or auditing Recipient's compliance with this Nondisclosure Agreement.

7. Term and Termination.

The term of this Nondisclosure Agreement shall commence upon execution by Recipient and shall terminate on the date of award of the Contract that is the subject of this RFP, unless earlier terminated by SCDHHS. Upon such termination Recipient shall immediately certify to SCDHHS that Recipient has destroyed all of the Protected Materials provided by SCDHHS. Upon SCDHHS' knowledge of a material breach by Recipient, SCDHHS may immediately terminate Recipient's access to the SCDHHS Procurement Library. Any noncompliance with this Nondisclosure Agreement or the HIPAA Security and Privacy Rule will be deemed a material breach, if Recipient knew or reasonably should have known of such noncompliance and failed to immediately take reasonable steps to cure the noncompliance.

8. Survival of Promises.

Recipient agrees that Recipient's obligations with respect to the confidentiality and security of the Protected Materials survive the termination of this Nondisclosure Agreement.

9. Breach of Nondisclosure Agreement.

In the event of a material breach of this Nondisclosure Agreement by the Recipient, in addition to any other remedy available to SCDHHS by law or in equity, the Recipient will be disqualified from being awarded the Contract that is the subject of the RFP.

10. Choice of Laws.

The validity of this Nondisclosure Agreement and any of its terms or provisions, as well as the rights and duties of the Recipient and SCDHHS, are governed by the laws of South Carolina, exclusive of its conflicts of laws provisions. The Recipient, by signing this Nondisclosure Agreement, agrees and submits, solely for matters concerning this Nondisclosure Agreement, to the jurisdiction of the courts of South Carolina and agrees, solely for such purpose, that the venue for any legal proceedings shall be Richland County, South Carolina. The place of all contracts, transactions, agreements, their situs and forum, shall be Richland County, South Carolina, where all matters, whether sounding in contract or tort, relating to the validity, construction, interpretation, and enforcement shall be determined.

11. Priority Among Agreements.

In the event that Recipient is awarded the Contract that is the subject of the RFP and there is any conflict between the terms of this Nondisclosure Agreement and the terms of that Contract or its ancillary agreements (including without limitation any HIPAA Business Associate Agreement entered into by SCDHHS and Recipient), the terms of that Contract and its ancillary agreements shall control over the terms of this Nondisclosure Agreement.

12. Signature Warranty.

Each individual signing below warrants that he or she is duly authorized by the party to sign this Nondisclosure Agreement and to bind the party to the terms and conditions of this Nondisclosure

Agreement. Facsimile and scanned signatures of this Nondisclosure Agreement shall be binding signatures.

13. Severability.

Any provision of this Nondisclosure Agreement prohibited by the laws of the State of South Carolina shall be ineffective to the extent of such prohibition without invalidating the remaining provisions of this Nondisclosure Agreement.

14. Non-Waiver.

The failure or delay of SCDHHS to enforce any particular provision of this Nondisclosure Agreement shall not be deemed a waiver by SCDHHS of any of its rights hereunder, nor shall it be deemed a waiver of any subsequent or continuing breaches of that provision, unless such waiver is expressed in writing signed by SCDHHS.

IN WITNESS WHEREOF, Recipient has executed this Nondisclosure Agreement as of this _____ day of _____, 201__.

RECIPIENT:

BY: _____
Authorized Signature

Print Name

WITNESS:

Sign

Print

Attachment I. Annotated MITA Business Process Matrix

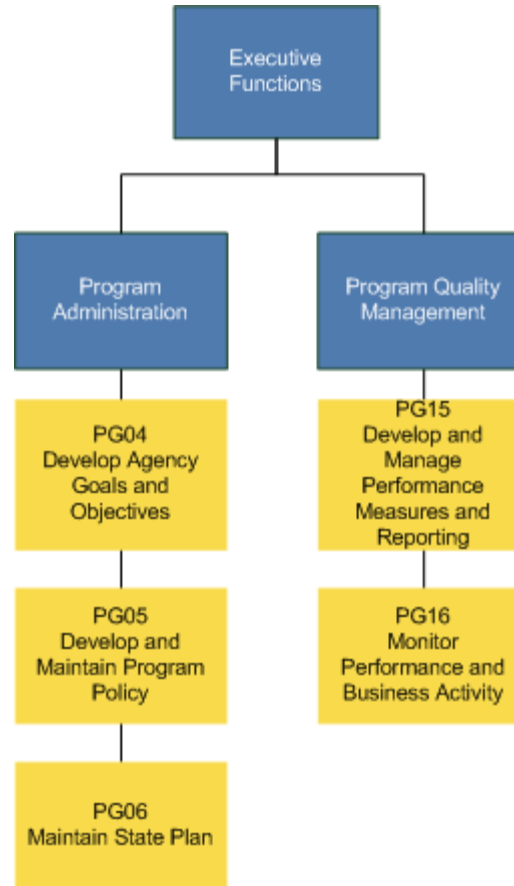
The **Principal Duties** column identifies, within the construct of the Contract, which party (or parties) has the principal duty to ensure successful completion of the business process. This assignment does not abrogate the State's duties and responsibilities to operate health benefit programs but serves as a general delineation of duties with respect to this Contract. Offerors must propose any details necessary to form a complete solution and may suggest modifications to the assignments if they feel that they can improve the overall solution provided to the State by using such modifications.

- **State** indicates that the State has the primary duty to ensure successful completion of a particular business process. Contractor may be required to support State in performing its duties, and the Replacement MMIS may need functionality to enable efficient and effective completion of the process.
- **Contractor** indicates that the Contractor has the primary duty to ensure successful completion of a particular business process. State may be required to support Contractor in performing its duties, and the Replacement MMIS may need functionality to enable efficient and effective completion of the process.
- **Both** indicates that both the State and the Contractor have key duties required to ensure successful completion of a particular business process, and the Replacement MMIS may need functionality to enable efficient and effective completion of the process.
- **Third Party** indicates that a third party is involved in the completion of the process and that the State and/or the Contractor are required to support the third party in performing its duties and the Replacement MMIS may require functionality and/or interfaces to enable the third party to complete the process.
- **N/A** indicates that the State currently does not perform this business process as described in MITA.

The **Comments** column provides additional information to clarify duties and is not intended to be a complete description of scope.

Performance Standards indicates the required levels of Contractor and system performance, as applicable. Performance standards preceded by “(Critical)” are deemed critical as discussed in RFP Section III.4.5.4.2.

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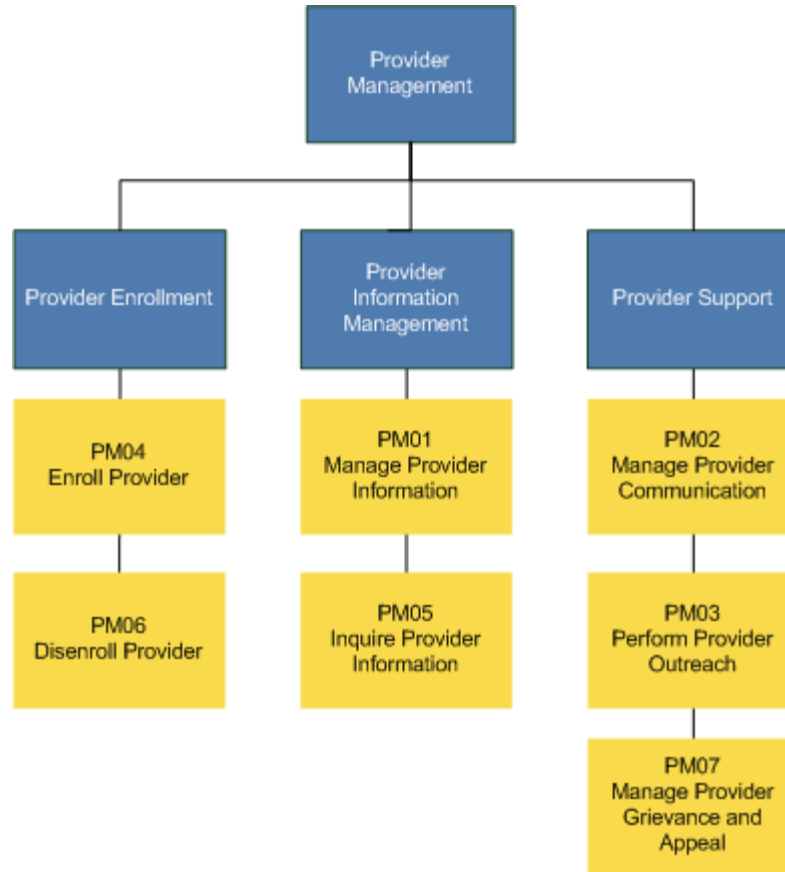


SC MITA Business Area	MITA Business Process	Principal Duties	Comments	Performance Standards
Executive Functions	PG04 Develop Agency Goals and Objectives	State	<ul style="list-style-type: none"> Contractor provides strategic guidance, review and input. 	

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SC MITA Business Area	MITA Business Process	Principal Duties	Comments	Performance Standards
Executive Functions	PG05 Develop and Maintain Program Policy	Both	<ul style="list-style-type: none">• Contractor provides strategic advice, review and input.• Contractor maintains medical and administrative policy based on direction from the State.	
Executive Functions	PG06 Maintain State Plan	State	<ul style="list-style-type: none">• Contractor reviews amendments and provides to the State analysis of impacts to the system and business/IT operations.	
Executive Functions	PG15 Develop and Manage Performance Measures and Reporting	Both	<ul style="list-style-type: none">• State and Contractor collaborate on performance measures.• Contractor reports on supporting metrics and performance using online dashboards or reports.	See RFP Section III.7 regarding reporting objectives.
Executive Functions	PG16 Monitor Performance and Business Activity	Both	<ul style="list-style-type: none">• State monitors Contractor performance by reviewing business activity as well as validation and application of reporting.• Contractor submits reporting to support performance.	See RFP Section III.7 regarding reporting objectives.

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SC MITA Business Area	MITA Business Process	Principal Duties	Comments	Performance Standards
Provider Management	PM01 Manage Provider Information	Contractor	<ul style="list-style-type: none"> Contractor provides routine (daily, weekly, monthly, quarterly and/or annual) maintenance activities to ensure provider file is up-to-date and accurate according to provider validation screening databases. 	Timeliness: 1. (Non-Critical) Contractor updates provider information within one (1) business day of receipt of a request to update provider information or the detection of an error in the

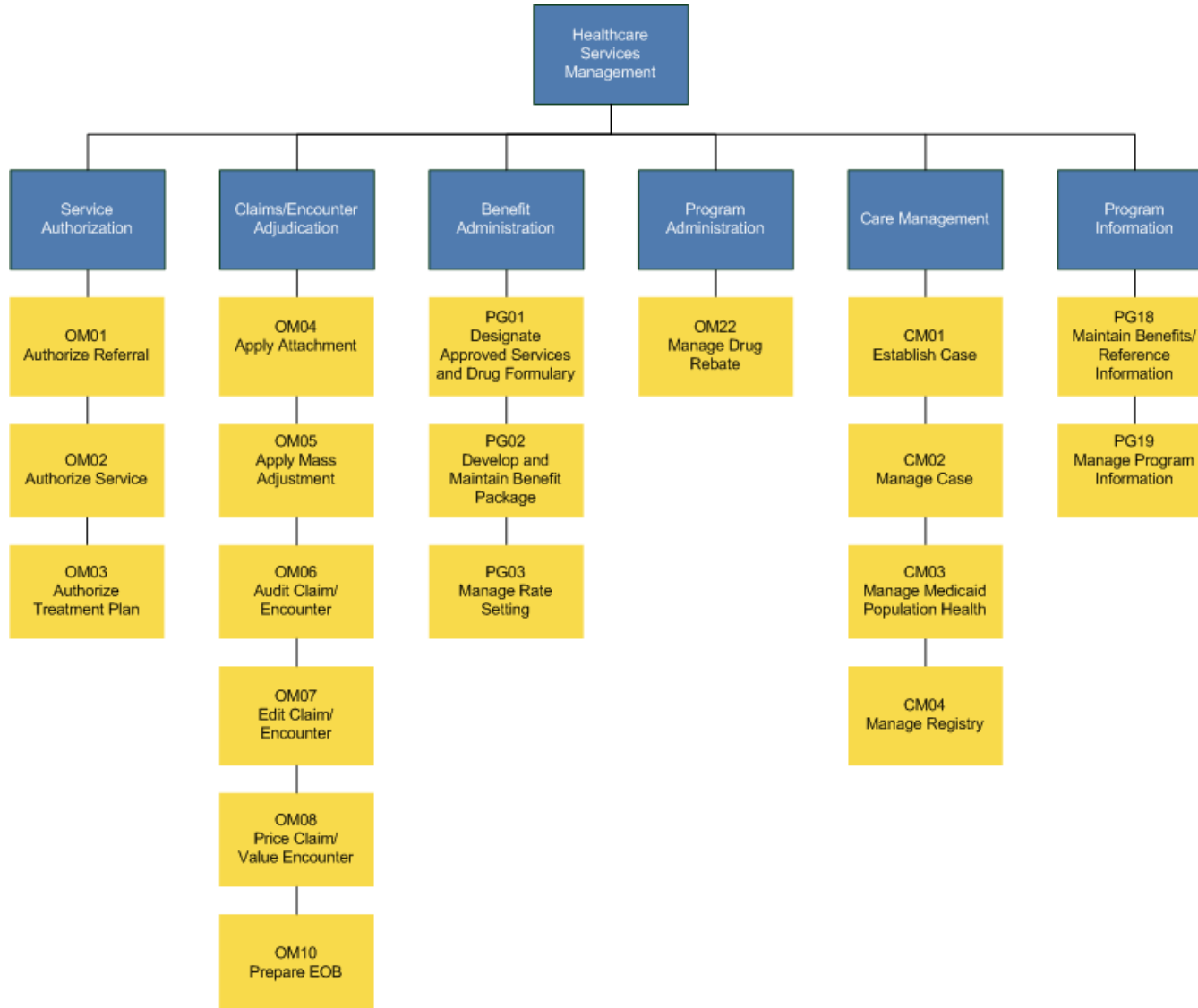
SC MITA Business Area	MITA Business Process	Principal Duties	Comments	Performance Standards
			<ul style="list-style-type: none"> Information gathered as part of maintenance activities may generate the need to perform revalidations on providers. 	<p>provider information.</p> <p>2.. (Non-Critical) Provider data that is updated by the provider or the State directly in the MMIS shall be made real-time (see General & System Process SS01a) unless a process that requires approval or verification of that provider data update is otherwise required.</p> <p>Quality:</p> <p>1.(Critical) Contractor shall apply the provider updates with one hundred percent (100%) accuracy.</p>
Provider Management	PM02 Manage Provider Communication	Both	<ul style="list-style-type: none"> Contractor manages all requests for information. Contractor researches communications and distributes via outbound transaction processes. State authors bulletins and letters with Contractor assistance. 	<p>Timeliness:</p> <p>1. (Non-Critical) Contractor responds to provider inquiries by acknowledging inquiries within one (1) business day of receipt of the inquiry and provides a final response within the time periods proposed by Contractor for Manage Provider Communication (Row 1 in the Offeror-Proposed Performance Standards).</p> <p>2.(Critical) Contractor notifies provider of any payment holds within one (1) business day of payment hold being made in MMIS.</p>
Provider Management	PM03 Perform Provider Outreach	Contractor	<ul style="list-style-type: none"> State authors bulletins and letters with Contractor assistance. 	<p>Timeliness:</p> <p>1. (Non-Critical) Contractor delivers an outreach and training program that gives each provider access to online materials during available system times (see General & System Processes SS01a and SS01c standards).</p> <p>2. (Non-Critical) Contractor gives each provider the opportunity for in-person outreach and training at least two (2) times per year at a location within fifty (50) miles of the provider's address of primary operation.</p>

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SC MITA Business Area	MITA Business Process	Principal Duties	Comments	Performance Standards
				Utility or Value to Stakeholders: 1.(Non-Critical) Receive a favorable response on regular State-approved surveys of providers using industry standard satisfaction-based processes at or exceeding the Offeror-proposed value in Row 10 of the Offeror-Proposed Performance Standards.
Provider Management	PM04 Enroll Provider	Contractor	<ul style="list-style-type: none"> Includes validation, screening, and related activities, as applicable. Contractor performs site visits required by 42 CFR 455 for screening. Contractor performs fee collection as authorized by Federal rules. For certain facilities under the Department of Health and Environmental Control (DHEC), Division of Health Licensing, (e.g. Nursing Homes, Community Residential Care Facilities), the Contractor is required to interface with DHEC for verification/validation of licensing upon enrollment and change of ownership. Note that the use of enrollment-related terminology in MITA is not necessarily consistent with similar terminology in the Code of Federal Regulations. 	Timeliness: 1.(Critical) Contractor completes Enroll Provider process (including any necessary re-validation and screening) by providing notification of enrollment or denial for all Clean Applications within the time periods proposed by Contractor for Enroll Provider (Rows 2a, 2b, 2c, and 2d in the Offeror-Proposed Performance Standards). 2.(Non-Critical) Contractor notifies enrolling provider of any missing or incomplete enrollment information within two (2) business days of Contractor identifying missing or incomplete enrollment information at any time throughout the enrollment, credentialing and verification process.
Provider Management	PM05 Inquire Provider Information	Contractor		Timeliness: 1. (Non-Critical) Contractor shall respond to requests for verification of provider information within one (1) business day of receipt of request by Contractor.
Provider Management	PM06 Disenroll Provider	Contractor		Timeliness: 1. (Critical) Contractor shall disenroll provider within one (1) business day of receipt of

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SC MITA Business Area	MITA Business Process	Principal Duties	Comments	Performance Standards
				voluntary disenrollment request or receipt of State approved data substantiating involuntary disenrollment. 2. (Non-Critical) Contractor shall provide written notification (return receipt requested) of disenrollment to provider, within one (1) business day of receipt of voluntary disenrollment request or receipt of State approved data substantiating involuntary disenrollment.
Provider Management	PM07 Manage Provider Grievance and Appeal	State	<ul style="list-style-type: none">• Contractor supports State with any needed information, logging, tracking, scheduling, etc. in accordance with legal requirements.	



SC MITA Business Area	MITA Business Process	Principal Duties	Comments	Performance Standards
Healthcare Services Management	OM01 Authorize Referral	N/A	<ul style="list-style-type: none"> State does not currently require or perform referral authorizations. 	
Healthcare Services Management	OM02 Authorize Service	Contractor	<ul style="list-style-type: none"> State reviews prior authorizations for services that are escalated or require special resolution. All prior authorizations are in scope of this contract with the exception of pharmacy. 	<p>Timeliness:</p> <ol style="list-style-type: none"> (Critical) Contractor completes prior authorization approval, denial, or suspension determination and notifies appropriate parties within the time period proposed by Contractor for Authorize Service (Row 7 in the Offeror-Proposed Performance Standards). (Critical) Contractor performs retrospective reviews (reviews for services where the member was not Medicaid eligible at the time of the services and subsequently received retroactive eligibility) and reprocesses any PA's denied for eligibility within the time period that is proposed by the Contractor for Authorize Service (Row 7 in the Contractor Proposed Performance Standards). (Critical) Contractor notifies member of prior authorization denial within twenty-four (24) hours of prior authorization determination unless otherwise instructed by State. (Critical) Contractor maintains ability to respond to prior authorization requests outside of standard call center service hours (defined in the General & System Process SS02c standards) according to the solution proposed by Contractor. <p>Quality:</p> <ol style="list-style-type: none"> (Critical) Contractor applies policies for prior authorization of services with one hundred percent (100%) accuracy unless otherwise instructed by the State.

SC MITA Business Area	MITA Business Process	Principal Duties	Comments	Performance Standards
Healthcare Services Management	OM03 Authorize Treatment Plan	State	<ul style="list-style-type: none"> State does not currently perform this business process. 	
Healthcare Services Management	OM04 Apply Attachment	Contractor		Timeliness: 1. (Non-Critical) Contractor applies Attachments in accordance with General & System Process SS02b standards.
Healthcare Services Management	OM05 Apply Mass Adjustment	Both	<ul style="list-style-type: none"> State and Contractor provide input and direction into proposed mass adjustments that may need to be made. Contractor supports State with needed information to evaluate the impact of a proposed mass adjustment. Contractor applies and verifies accuracy of the approved mass adjustment at the request of State. 	Timeliness: 1. (Non-Critical) Contractor applies proposed mass adjustments in the MMIS and reports to State the impact of the proposed mass adjustment within the Offeror-proposed timeframe of receipt of direction from the State (Row 11 in the Offeror-Proposed Performance Standards). 2. (Non-Critical) Contractor applies approved mass adjustments in the MMIS within one (1) business day of receipt of direction from the State (assumes the evaluation step was performed initially). Quality: 1. (Critical) Contractor applies mass adjustments with one hundred percent (100%) accuracy.
Healthcare Services Management	OM06 Audit Claim-Encounter OM07 Edit Claim-Encounter OM08 Price Claim-Value Encounter	Contractor	<ul style="list-style-type: none"> State supports Contractor by assisting with determinations for suspended claims as needed. Adjudication and suspension of claims includes the Audit, Edit and Price Claims-Value Encounters processes (OM06, OM07, OM08). 	Timeliness: 1.(Critical) Contractor adjudicates Clean Claims (as defined by 42 CFR 423.520(b)) within the time periods proposed by Contractor for Adjudicate Clean Claims (Row 3 in the Offeror-Proposed Performance Standards). 2.(Non-Critical) Contractor suspends claims within the time periods proposed by Contractor for Suspend Claims (Row 4 in the Offeror-Proposed Performance Standards).

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SC MITA Business Area	MITA Business Process	Principal Duties	Comments	Performance Standards
				<p>3.(Non-Critical) Contractor returns incomplete claims-encounters to the provider within two (2) business days of receipt by Contractor.</p> <p>Quality:</p> <p>1.(Critical) For claims requiring no manual intervention, claims/encounters process with one hundred percent (100%) accuracy.</p> <p>2. (Critical) For claims requiring manual intervention, claims/encounters process based upon (Row 9 in the Offeror-Proposed Performance Standards).</p>
Healthcare Services Management	OM10 Prepare EOB	Contractor		<p>Timeliness:</p> <p>1.(Critical) Contractor will meet Federal requirements for preparing and sending EOBs.</p> <p>Quality:</p> <p>1.(Non-Critical) Contractor prepares EOBs with one hundred percent (100%) accuracy.</p>
Healthcare Services Management	OM22 Manage Drug Rebate	Third Party	<ul style="list-style-type: none"> • State's Pharmacy Benefits Administration (PBA) contract includes Pharmacy POS services. • MMIS interfaces with PBA contractor's system(s) to accept pharmacy claims history. • MMIS interfaces with PBA contractor's system(s) to send J code claims and claims that contain NDCs for use with drug rebate invoicing. • MMIS interfaces with PBA contractor's system(s) to send paid POS claim data for use with drug rebate invoicing. 	<p>Timeliness:</p> <p>1.(Non-Critical) MMIS exchanges data with PBA contractor's system(s) in a manner that conforms to General & System Process SS01b standards.</p> <p>Accuracy:</p> <p>1. (Non-Critical) MMIS exchanges data with PBA contractor's system(s) with one hundred percent (100%) accuracy.</p>
Healthcare Services Management	PG01 Designate Approved Services and Drug Formulary	Both/Third Party	<ul style="list-style-type: none"> • Contractor maintains all codes sets and application of those codes into the MMIS. • PBA contractor maintains the National Drug Codes (NDC). 	<p>Timeliness:</p> <p>1. (Non-Critical) Contractor applies coding/rules changes in the MMIS and reports to State the impact of the proposed coding/rules changes</p>

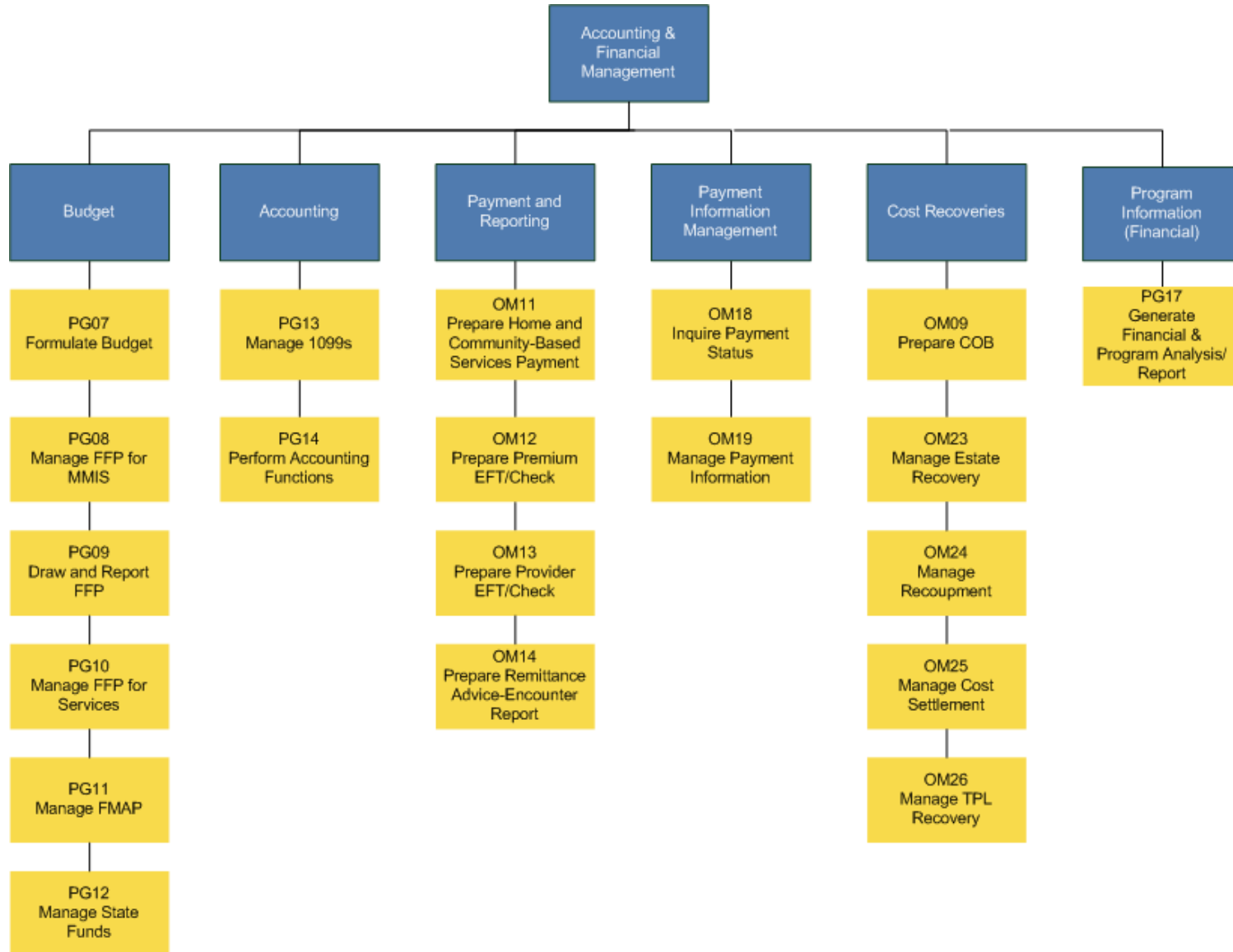
SC MITA Business Area	MITA Business Process	Principal Duties	Comments	Performance Standards
			<ul style="list-style-type: none"> State aids Contractor in inclusion and exclusion into certain benefit packages. 	<p>within the Offeror-proposed timeframe of receipt of direction from the State (Row 15 in the Offeror-Proposed Performance Standards).</p> <p>2. (Non-Critical) Contractor applies coding/rules changes in the MMIS within one (1) business day of receipt of direction from the State.</p> <p>Quality:</p> <p>1. (Critical) Contractor applies code changes with one hundred percent (100%) accuracy.</p>
Healthcare Services Management	PG02 Develop and Maintain Benefit Package	Both	<ul style="list-style-type: none"> State communicates proposed benefit package changes to Contractor. Contractor applies proposed benefit package changes to MMIS and reports to State the impact of the proposed changes. State communicates approved changes to benefit package to Contractor. Contractor updates benefit package information in MMIS based on approved changes. 	<p>Timeliness:</p> <p>1. (Non-Critical) Contractor applies proposed benefit package changes in the MMIS and reports to State the impact of the proposed benefit package changes within the Offeror-proposed timeframe of receipt of direction from the State (Row 12 in the Offeror-Proposed Performance Standards).</p> <p>2. (Non-Critical) Contractor applies approved benefit package changes in the MMIS within one (1) business day of receipt of direction from the State (assumes the evaluation step was performed initially).</p> <p>Quality:</p> <p>1. (Critical) Contractor applies benefit package changes with one hundred percent (100%) accuracy.</p>
Healthcare Services Management	PG03 Manage Rate Setting	Both	<ul style="list-style-type: none"> State communicates proposed rate changes to Contractor. Contractor applies proposed rate changes to MMIS and reports to State the fiscal impact of the proposed changes. State communicates approved changes to rates to Contractor. 	<p>Timeliness:</p> <p>1. (Non-Critical) Contractor applies proposed rate changes in the MMIS and reports to State the impact of the proposed rate changes within the Offeror-proposed timeframe of receipt of direction from the State (Row 13 in the Offeror-Proposed Performance Standards).</p>

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SC MITA Business Area	MITA Business Process	Principal Duties	Comments	Performance Standards
			<ul style="list-style-type: none"> Contractor updates rate information in MMIS based on approved changes. 	<p>2. (Non-Critical) Contractor applies approved rate changes in the MMIS within one (1) business day of receipt by Contractor (assumes the evaluation step was performed initially).</p> <p>Quality:</p> <p>1. (Critical) Contractor applies rate changes with one hundred percent (100%) accuracy.</p>
Healthcare Services Management	PG18 Maintain Benefits-Reference Information	Both	<ul style="list-style-type: none"> Contractor monitors, receives, recommends and licenses updates to benefits-reference information that are maintained in MMIS. Contractor applies benefits-reference information updates to MMIS and reports to State the impact of the updated benefits-reference information. State communicates approved updates to benefits-reference information to Contractor. Contractor updates benefits-reference information in MMIS based on updates approved by State. 	<p>Timeliness:</p> <p>1. (Non-Critical) Contractor applies new and/or updated benefits-reference information to the MMIS and reports to State the impact of the new and/or updated to benefits-reference information within the Offeror-proposed timeframe of receipt of direction from the State (Row 14 in the Offeror-Proposed Performance Standards).</p> <p>2. (Non-Critical) Contractor applies approved benefits-reference information to the MMIS within one (1) business day of receipt by Contractor (assumes the evaluation step was performed initially).</p> <p>Quality:</p> <p>1. (Critical) Contractor applies benefits-reference information changes with one hundred percent (100%) accuracy.</p>
Healthcare Services Management	PG19 Manage Program Information	Both/Third Party	<ul style="list-style-type: none"> Contractor manages program information for all data stores that are part of the Replacement MMIS. Contractor manages data exchanges in and out of the MMIS and must ensure that data are consistent across all feeds into and out of the Replacement MMIS so that all stakeholders have the correct information. 	<p>Accuracy:</p> <p>1. (Non-Critical) Contractor manages Program Information in the MMIS with ninety-eight (98%) percent data accuracy.</p> <p>2. (Non-Critical) Contractor ensures updates and changes to Program Information are stored in the MMIS with one hundred (100%) percent accuracy.</p>

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SC MITA Business Area	MITA Business Process	Principal Duties	Comments	Performance Standards
			<ul style="list-style-type: none"> Contractor works with State and designated third parties to maintain data exchanges and resolve issue that may arise with data exchanges. Contractor works with State to provide governance and stewardship for program information stored in the MMIS. 	
Healthcare Services Management	CM01 Establish Case	State	<ul style="list-style-type: none"> State, providers and other State Agencies identify eligible members and enrolls them into a specific waiver program. Contractor supports State by providing data and reports to assist with case management. 	
Healthcare Services Management	CM02 Manage Case	State	<ul style="list-style-type: none"> State, providers and other State agencies manage cases for beneficiaries enrolled in specific waiver programs. Contractor interfaces with other agencies to provide and receive data about cases. 	
Healthcare Services Management	CM03 Manage Medicaid Population Health	State	<ul style="list-style-type: none"> State and other State agencies design and implement strategies to promote and improve health of global Medicaid population. Contractor supports this process with data and reports, as well as implementing changes as necessary. 	
Healthcare Services Management	CM04 Manage Registry	Both/Third Party	<ul style="list-style-type: none"> State may exchange data with other third parties in order to manage and maintain registries. MMIS interfaces with third party systems to access and update registry information. 	Timeliness: 1. (Non-Critical) MMIS applies updates from third parties within one (1) business day of receipt. 2. (Non-Critical) MMIS provides applicable data to third parties no less than once per week.



SC MITA Business Area	MITA Business Process	Principal Duties	Comments	Performance Standards
Accounting and Financial Management	OM09 Prepare COB	Contractor		
Accounting and Financial Management	OM11 Prepare Home and Community-Based Services Payment	Contractor		Timeliness: 1.(Non-Critical) Contractor processes payments within one (1) business day of the end of the weekly payment cycle. Quality: 1.(Critical) Contractor executes processes in accordance with the standards in General & System Process SS04. 2.(Critical) Contractor completes processes as defined by the payment provisions within 42 CFR447.45, and the home and community-based services provisions within 42 CFR440.180.
Accounting and Financial Management	OM12 Prepare Premium EFT/Check	Contractor		Timeliness: 1. (Non-Critical) Contractor processes payments within one (1) business day of the end of the monthly payment cycle. Quality: 1.(Critical) Contractor executes processes in accordance with the standards in General & System Process SS04. 2.(Critical) Contractor completes processes as defined by the health plan premium payment provisions within 45 CFR162-Subpart Q.
Accounting and Financial Management	OM13 Prepare Provider EFT/Check	Contractor		Timeliness: 1. (Non-Critical) Contractor prints paper checks and/or transmits EFTs within one (1) business day of the end of the weekly payment cycle. 2. Contractor mails printed paper checks within one (1) business day of the check printing.

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SC MITA Business Area	MITA Business Process	Principal Duties	Comments	Performance Standards
				Quality: 1.(Critical) Contractor executes processes in accordance with the standards in General & System Process SS04. 2.(Critical) Contractor completes processes as defined by the payment provisions within 42 CFR447.45.
Accounting and Financial Management	OM14 Prepare Remittance Advice-Encounter Report	Contractor	<ul style="list-style-type: none"> All RAs are currently electronic. 	Timeliness: 1.(Non-Critical) MMIS produces and makes available from within MMIS to both State and provider a Remittance Advice-Encounter Report within one (1) hour of completing the Prepare Provider EFT-Check process. Quality: 1.(Critical) Contractor executes processes in accordance with the standards in General & System Process SS04. 2.(Critical) Contractor completes processes as defined by the healthcare payment and remittance advice provisions within 45 CFR162-Subpart P.
Accounting and Financial Management	OM18 Inquire Payment Status	Contractor		Timeliness: 1.(Non-Critical) Contractor responds to payment status inquiries by acknowledging the inquiry within one (1) business day and provides a final response within the time periods proposed by Contractor for Inquire Payment Status (Row 5 in the Offeror-Proposed Performance Standards).
Accounting and Financial Management	OM19 Manage Payment Information	Contractor		Accuracy: 1.(Critical) MMIS maintains with one hundred percent (100%) accuracy details regarding payments for any and all services.

SC MITA Business Area	MITA Business Process	Principal Duties	Comments	Performance Standards
				Quality: 1.(Critical) Contractor executes processes in accordance with the standards in General & System Process SS04. 2.(Critical) Contractor completes processes as defined by the payment provisions within 42 CFR447.
Accounting and Financial Management	OM23 Manage Estate Recovery	State	<ul style="list-style-type: none"> • State performs operational activities of Estate Recovery using a case management system provided by Contractor. • Contractor provides a case management tracking system. 	Timeliness: 1.(Non-Critical) The Contractor deposits all payments into the appropriate account and notifies SCDHHS the same day of receipt. The Contractor categorizes and updates the MMIS within three (3) business days upon receipt of the payment. Quality: 1.(Critical) Contractor executes processes in accordance with the standards in General & System Process SS04. 2.(Critical) Contractor completes processes as defined by the payment provisions within 42 CFR447 and the case management provisions within 42 CFR441.18(8)(iii).
Accounting and Financial Management	OM24 Manage Recoupment	Contractor		Timeliness: 1. (Non-Critical) Contractor deposits payments into the appropriate account and notifies the State the same day of receipt. Quality: 1.(Non-Critical) Contractor applies recoupments to each weekly payment cycle with one hundred (100%) accuracy. 2.(Critical) Contractor executes processes in accordance with the standards in General & System Process SS04.

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SC MITA Business Area	MITA Business Process	Principal Duties	Comments	Performance Standards
				3.(Critical) Contractor completes processes as defined by the payment provisions within 42 CFR447 and the liens and recoveries provisions within 42 CFR433.36.
Accounting and Financial Management	OM25 Manage Cost Settlement	State	<ul style="list-style-type: none"> State performs operational activities of cost settlement 	
Accounting and Financial Management	OM26 Manage TPL Recovery	Contractor	<ul style="list-style-type: none"> State performs operational activities of casualty recovery using a case management system provided by Contractor. Contractor performs health insurance matches for all new Medicaid enrollees at enrollment and afterwards all eligible enrollment recipients annually or at the State direction. 	Timeliness: <ol style="list-style-type: none"> (Non-Critical) Contractor completes correspondence and inquiries related to verification maintenance and within five (5) business days of receipt. (Non-Critical) Contractor completes correspondence and inquiries related to benefit recovery within ten (10) business days of receipt. (Non-Critical) Contractor updates the MMIS within one (1) business day whenever a member's access to care may be materially affected by the current MMIS data. (Non-Critical) Contractor determines the validity of all health insurance leads, regardless of source, and update MMIS with those health insurance leads determined to be valid, including all member policy relationships within fifteen (15) business days of receipt. (Non-Critical) Contractor creates invoices and bills health insurers and providers within five (5) business days of State approval to invoice and bill. (Non-Critical) The Contractor deposits all payments into the appropriate account and notifies SCDHHS the same day of receipt. The

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SC MITA Business Area	MITA Business Process	Principal Duties	Comments	Performance Standards
				<p>Contractor categorizes and updates the provider financial records in the MMIS within three (3) business days upon receipt of the payment.</p> <p>7. (Non-Critical) Contractor conducts eligibility matches with medical insurers that in total cover a minimum of seventy (70%) percent of the lives in South Carolina using data aged no more than proposed by the Offeror for Manage TPL Recovery (Row 8 in the Offeror-Proposed Performance Standards). Contractor conducts Eligibility Matches within three (3) business days of receipt of request for eligibility match from the State for new members. Contractor conducts eligibility matches within ten (10) business days of receipt of list of members to match from State.</p> <p>Quality:</p> <p>1.(Non-Critical) Contractor completes TPL related activities including verification maintenance, benefit recovery, and health insurance validity with ninety-eight percent (98%) accuracy.</p> <p>2.(Non-Critical) Contractor completes TPL check deposits and associated claims reconciliation with one hundred percent (100%) accuracy.</p> <p>3.(Critical) Contractor executes processes in accordance with the standards in General & System Process SS04.</p> <p>4.(Critical) Contractor completes processes as defined by the third party liability provisions within 42C FR433-Subpart D.</p>
Accounting and	PG07 Formulate	State	<ul style="list-style-type: none"> State creates program budgets and budget 	

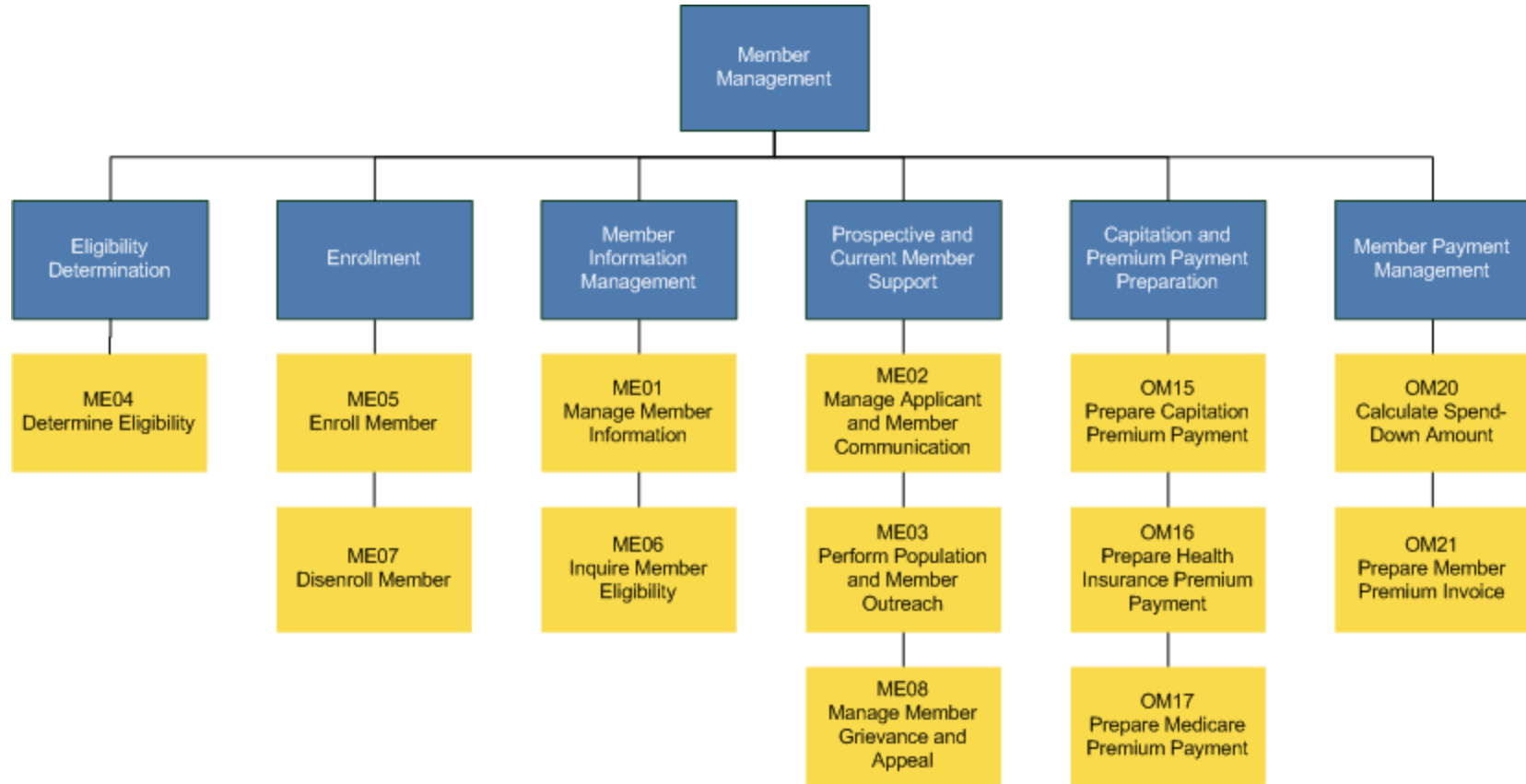
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SC MITA Business Area	MITA Business Process	Principal Duties	Comments	Performance Standards
Financial Management	Budget		<ul style="list-style-type: none"> approvals. Contractor supports with any needed information and/or advice. 	
Accounting and Financial Management	PG08 Manage FFP for MMIS	State	<ul style="list-style-type: none"> Contractor breaks out invoices by FFP. Refer to Section 1 of the Section VIIB, Exhibit A. Invoicing and Payment. 	
Accounting and Financial Management	PG09 Draw and Report FFP	State		
Accounting and Financial Management	PG10 Manage FFP for Services	Contractor	<ul style="list-style-type: none"> The Contractor will maintain the fund codes within the MMIS. The fund codes will be associated at the FFP to any financial transactions within the MMIS and be able to be reported accordingly. 	Timeliness: 1.(Non-Critical) Contractor updates share percentages for FFP within one (1) business day of receiving changes to share percentages from State. Accuracy: 1. (Critical) Contractor maintains one hundred percent (100%) data accuracy.
Accounting and Financial Management	PG11 Manage F-MAP	State	<ul style="list-style-type: none"> Contractor supports with any needed information and/or advice. Contractor loads changes to F-MAP into MMIS and ensures they are being properly applied. 	Timeliness: 1.(Non-Critical) Contractor updates share percentages for F-MAP within one (1) business day of receiving changes from State. Accuracy: 1. (Critical) Contractor maintains one hundred percent (100%) data accuracy.
Accounting and Financial Management	PG12 Manage State Funds	State	<ul style="list-style-type: none"> Contractor will support with monitoring and reporting. 	
Accounting and Financial Management	PG13 Manage 1099s	Contractor		Accuracy: 1.(Non-Critical) Contractor maintains Form 1099 data with one hundred percent (100%) accuracy. Quality:

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SC MITA Business Area	MITA Business Process	Principal Duties	Comments	Performance Standards
				1.(Critical) Contractor executes processes in accordance with the standards in General & System Process SS04. 2.(Critical) Contractor completes processes as defined by 42 CFR 433.37.
Accounting and Financial Management	PG14 Perform Accounting Functions	Contractor		Quality: 1.(Critical) Contractor executes processes in accordance with the standards in General & System Process SS04. 2.(Critical) Contractor completes processes as defined by 42 CFR 433.
Accounting and Financial Management	PG17 Generate Financial and Program Analysis Report	Contractor		Timeliness: 1. (Non-Critical) Contractor produces weekly, monthly, and annual financial reports within one (1) business day of the end of each weekly payment cycle. Quality: 1.(Critical) Contractor executes processes in accordance with the standards in General & System Process SS04. 2. (Critical) Contractor completes processes as defined by the reporting provisions within 42 CFR431.16 and 42 CFR433.74.

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SC MITA Business Area	MITA Business Process	Principal Duties	Comments	Performance Standards
Member Management	ME01 Manage Member Information	Both	<ul style="list-style-type: none"> Contractor updates member information in MMIS received from State's MEDS. State manages member information via MEDS. MEDS is the system of record for all member information. 	Timeliness: 1.(Critical) Automated process that conforms to General & System Process SS01b standards.

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SC MITA Business Area	MITA Business Process	Principal Duties	Comments	Performance Standards
Member Management	ME02 Manage Applicant and Member Communication	Both	<ul style="list-style-type: none"> Contractor receives Inbound Transactions and verifies eligibility as required. Contractor sends Outbound Transactions regarding member eligibility. Contractor generates member communications as required by MMIS duties. 	Timeliness: 1.(Non-Critical) Contractor performs Applicant and Member Communication in accordance to the Inbound Transaction and Outbound Transaction performance standards.
Member Management	ME03 Perform Population and Member Outreach	State		
Member Management	ME04 Determine Eligibility	State	<ul style="list-style-type: none"> The Contractor performs health insurance data match for all new enrollees. 	Performance standards are the same as applicable standards for OM26 Manage TPL Recovery.
Member Management	ME05 Enroll Member	State		
Member Management	ME06 Inquire Member Eligibility	Contractor	<ul style="list-style-type: none"> Contractor operates the IVRS, EDI inquiry via the 270/271 interchange, and Web inquiry (via the provider portal). 	Timeliness and Quality: 1.(Critical) Automated processes that conform to General & System Processes SS01a, SS01c, and SS01d standards.
Member Management	ME07 Disenroll Member	State		
Member Management	ME08 Manage Member Grievance and Appeal	State	Contractor supports State with any needed information, logging, tracking, scheduling, etc. in accordance with legal requirements.	
Member Management	OM15 Prepare Capitation Premium Payment	Contractor		Timeliness: 1.(Non-Critical) Contractor creates capitation premium payments within two (2) business days of receipt of listing and amount. Quality: 1.(Critical) Contractor prepares capitation payments with one hundred percent (100%) accuracy.
Member	OM16 Prepare Health	Contractor	<ul style="list-style-type: none"> Contractor performs cost-benefit analysis to 	Timeliness:

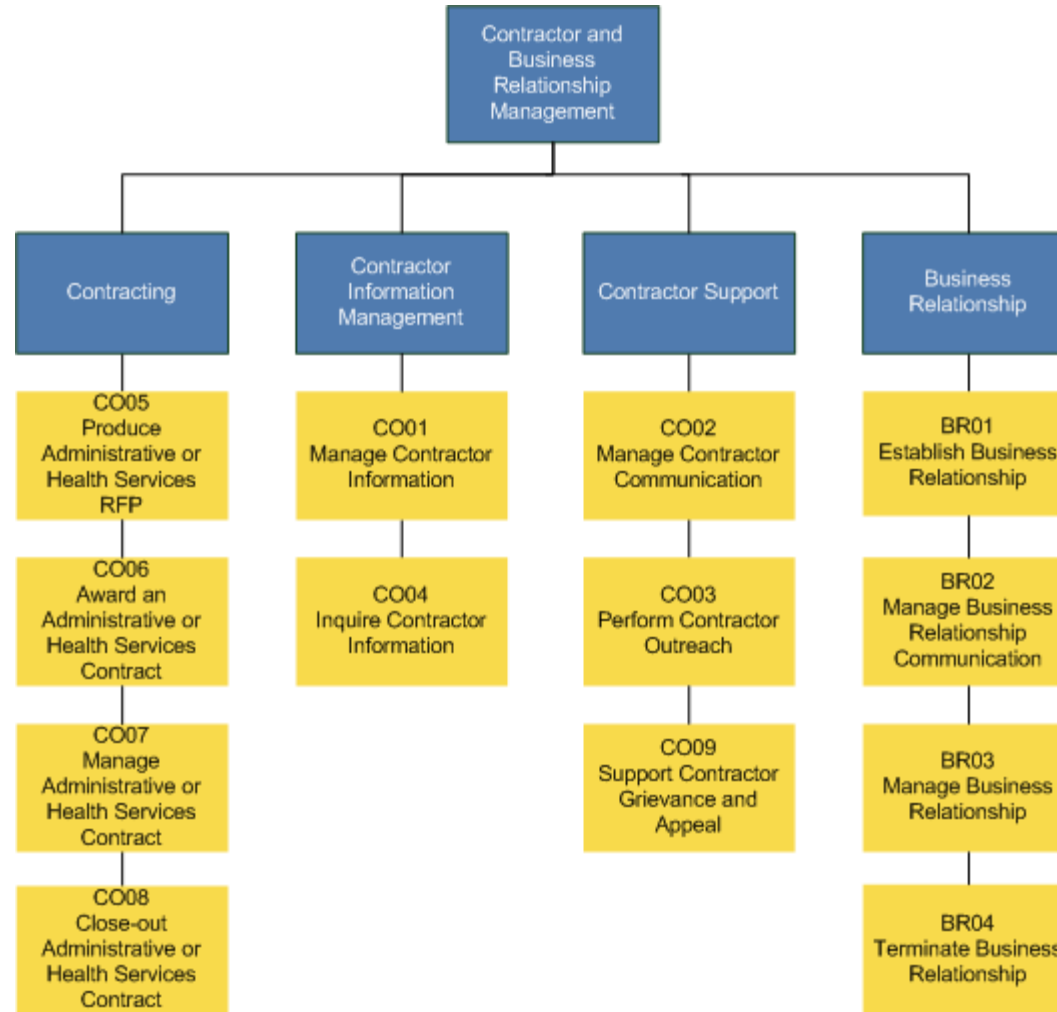
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SC MITA Business Area	MITA Business Process	Principal Duties	Comments	Performance Standards
Management	Insurance Premium Payment		<p>determine if member qualifies for HIPP program.</p> <ul style="list-style-type: none"> Contractor prepares all payments for the Health Insurance Premium Payment (HIPP) program including ability to make payments to insurance companies, employers and/or members. 	<p>1.(Non-Critical) Contractor communicates enrollment in HIPP program within twenty (20) business days of receipt of member's health insurance information.</p> <p>2.(Non-Critical) Contractor enters health insurance premium payments for scheduled payment cycle within one (1) business day of acceptance into the program.</p> <p>Cost Effectiveness:</p> <p>1. (Non-Critical) At least every six (6) months, review the cost effectiveness decision of each recipient who is receiving premium payment assistance under this program.</p> <p>Quality:</p> <p>1.(Critical) Contractor prepares Health Insurance Premium payments with one hundred percent (100%) accuracy.</p>
Member Management	OM17 Prepare Medicare Premium Payment	Contractor	<ul style="list-style-type: none"> State prepares the premium payments. Contractor performs matches with CMS or Medicare data. 	<p>Timeliness:</p> <p>1. (Non-Critical) Contractor creates Medicare premium payments within two (2) business days of receipt of listing and amount.</p> <p>Quality:</p> <p>1. (Critical) Contractor prepares Medicare Premium payments with one hundred percent (100%) accuracy.</p>
Member Management	OM20 Calculate Spend-Down Amount	N/A	<ul style="list-style-type: none"> State does not currently provide spend-down business services. 	
Member Management	OM21 Prepare Member Premium Invoice	Both	<ul style="list-style-type: none"> State does not currently invoice premiums to members but plans to do so in the future. 	<p>Timeliness:</p> <p>1. (Non-Critical) Contractor prepares member premium invoices within one (1) business day of the end of the monthly invoice cycle.</p> <p>2. (Non-Critical) Contractor sends member</p>

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SC MITA Business Area	MITA Business Process	Principal Duties	Comments	Performance Standards
				<p>premium invoice data to other systems with an automated process that conforms to General & System Process SS01b.</p> <p>3. (Non-Critical) Contractor mails printed invoices within one (1) business day of the of the invoice printing.</p> <p>Quality:</p> <p>1. (Critical) Contractor executes processes in accordance with the standards in General & System Process SS04.</p> <p>2. (Critical) Contractor completes processes as defined by defined by the cost-sharing provisions within 42 CFR457-Subpart A and the healthcare premium payment provisions in 45 CFR162-Subpart Q.</p>

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SC MITA Business Area	MITA Business Process	Principal Duties	Comments	Performance Standards
Contractor and	CO01 Manage	State	<ul style="list-style-type: none"> State manages contracts and contractors via 	

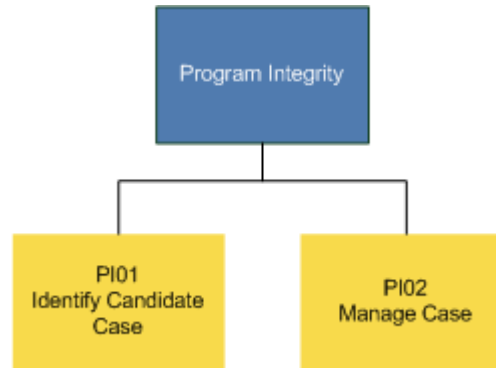
SC MITA Business Area	MITA Business Process	Principal Duties	Comments	Performance Standards
Business Relationship Management	Contractor Information		<p>existing tools and processes.</p> <ul style="list-style-type: none"> Contractor does not need to perform operations processes for Contractor Management processes except as they apply to the Contract between the State and the Contractor (e.g., a Change Order to the Replacement MMIS Contract would involve the application of the “Manage Administrative or Health Services Contract” process), and to gather and maintain pertinent aspects of provider, MCO, and MHN contracts in the Replacement MMIS. The Contractor shall support the State in performing these duties by providing needed information, as available and as necessary for all processes in this business area. 	
Contractor and Business Relationship Management	CO02 Manage Contractor Communication	State	<ul style="list-style-type: none"> Contractor supports the State by providing needed information, as available and as necessary. 	
Contractor and Business Relationship Management	CO03 Perform Contractor Outreach	State	<ul style="list-style-type: none"> Contractor supports the State by providing needed information, as available and as necessary. 	
Contractor and Business Relationship Management	CO04 Inquire Contractor Information	State	<ul style="list-style-type: none"> Contractor supports the State by providing needed information, as available and as necessary. 	
Contractor and Business Relationship Management	CO05 Produce Administrative or Health Services RFP	State		
Contractor and	CO06 Award	State	<ul style="list-style-type: none"> Contractor supports the State by providing 	

SC MITA Business Area	MITA Business Process	Principal Duties	Comments	Performance Standards
Business Relationship Management	Administrative or Health Services Contract		needed information, as available and as necessary.	
Contractor and Business Relationship Management	CO07 Manage Administrative or Health Services Contract	State	<ul style="list-style-type: none"> Contractor supports the State by providing needed information, as available and as necessary. 	
Contractor and Business Relationship Management	CO08 Close Out Administrative or Health Services Contract	State	<ul style="list-style-type: none"> Contractor supports the State by providing needed information, as available and as necessary. 	
Contractor and Business Relationship Management	CO09 Support Contractor Grievance and Appeal	State	<ul style="list-style-type: none"> Contractor supports the State by providing needed information, as available and as necessary. 	
Contractor and Business Relationship Management	BR01 Establish Business Relationship	Both	<ul style="list-style-type: none"> Contractor establishes relationships with trading partners (with respect to EDI transactions) through outreach efforts and provider enrollments. State may maintain and manage other business relationships that are not part of this Contract. 	Timeliness: 1. (Non-Critical) Contactor tests and reports results of electronic billing, automated remittance, and electronic fund transfer options within five (5) business days of the Trading Partner's written notification of readiness to test.
Contractor and Business Relationship Management	BR02 Manage Business Relationship Communication	Both	<ul style="list-style-type: none"> Contractor manages relationship communication with Trading Partners through outreach efforts. State may maintain and manage other business relationships that are not part of this Contract. 	Timeliness: 1. (Non-Critical) Contractor responds to Trading Partner inquiries by acknowledging inquires within one (1) business day of receipt of the inquiry and providing a final response within the time periods proposed by Contractor for Manage Business Relationship Communication (Row 6 in the Offeror-Proposed Performance Standards).
Contractor and Business	BR03 Manage Business Relationship	Both	<ul style="list-style-type: none"> Contractor manages business relationships with Trading Partners. 	

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SC MITA Business Area	MITA Business Process	Principal Duties	Comments	Performance Standards
Relationship Management			<ul style="list-style-type: none">• State may maintain and manage other business relationships that are not part of this Contract.	
Contractor and Business Relationship Management	BR04 Terminate Business Relationship	Both	<ul style="list-style-type: none">• Contractor terminates relationships with Trading Partners.• State may maintain and manage other business relationships that are not part of this Contract.	Timeliness: 1. (Non-Critical) Contractor terminates Trading Partner relationships within one (1) business day of receipt of request to terminate relationship from an approved source.

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SC MITA Business Area	MITA Business Process	Principal Duties	Comments	Performance Standards
Program Integrity	PI01 Identify Candidate Case	Both	<ul style="list-style-type: none"> State utilizes its Decision Support System (DSS) to identify candidate cases to safeguard against medically unnecessary services, inappropriate use of services, and excessive or improper payments by conducting preliminary reviews (cases) to identify waste, fraud, and abuse by providers and beneficiaries. Contractor identifies suspicious activity that may be related to fraud, waste and abuse and notifies State. Contractor reviews and the State approves utilization review plans for use in completing acute care hospitals, mental hospitals, and ICF utilization reviews. MMIS provides data to State's DSS. 	Timeliness: <ol style="list-style-type: none"> (Non-Critical) MMIS provides applicable data to DSS at least weekly. (Non-Critical) Contractor reviews and the State approves acute care hospitals, mental hospitals, and ICFs utilization review plans at least every two (2) years for each facility type. (Critical) Utilization reviews of services provided in acute care hospitals, mental hospitals, and ICFs are conducted during the time periods mandated by Federal regulation 42 CFR Part 456. Accuracy: <ol style="list-style-type: none"> (Critical) Contractor prepares data for DSS with one hundred percent (100%) accuracy.

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SC MITA Business Area	MITA Business Process	Principal Duties	Comments	Performance Standards
Program Integrity	PI02 Manage Case	State	<ul style="list-style-type: none">• State manages identified cases of potential waste, fraud, and/or abuse.• Contractor supports State with investigations, hearings, etc.	

General and System Processes

SC MITA Business Area	General & System Process	Principal Duties	Comments	Performance Standards
General & System	SS01a System Performance	Contractor	Interactive user and EDI responses for MMIS transactions that are not reporting related	Timeliness: 1. (Non-Critical) MMIS provides an average transaction response of less than one (1) second and a response of less than five (5) seconds ninety-nine and nine-tenths percent (99.9%) of the time. Transaction processing time equals the time from the entry of the request into the network access point to the time for the response to return to network access point.
General & System	SS01b System Performance	Contractor	Data file processing	Timeliness: 1.(Non-Critical) MMIS acknowledges receipt of a data file for processing and assigns data file a unique control number within one (1) minute of receipt of the data file. 2.(Non-Critical) MMIS processes and loads data file within twenty-four (24) hours of receipt of the data file. 3.(Non-Critical) MMIS notifies appropriate users and/or data source/provider of errors with a data file within one (1) hour of detection of the error.
General & System	SS01c System Performance	Contractor	MMIS uptime	Timeliness: 1. (Critical) Contractor maintains ninety-nine and nine-tenths percent (99.9%) system uptime with the exception of State-approved maintenance timeframes for production systems. 2. (Non-Critical) Contractor maintains less than two (2) hours of regular weekly maintenance windows for production systems. 3. (Non-Critical) Contractor maintains a ninety-

SC MITA Business Area	General & System Process	Principal Duties	Comments	Performance Standards
				<p>nine and nine-tenths percent (99.9%) system uptime from 8:00am to 6:00pm Eastern Time (ET) for non-production systems.</p> <p>4. (Non-Critical) Contractor maintains less than ten (10) hours of regular weekly maintenance windows for non-production systems.</p>
General & System	SS01d System Performance	Contractor	Performance and uptime for IVRS	<p>Timeliness:</p> <ol style="list-style-type: none"> 1. (Critical) Contractor maintains one hundred (100%) percent IVRS uptime. 2. (Non-Critical) Contractor provides sufficient bandwidth for IVRS so that zero percent (0%) of calls receive a busy signal. 3. (Non-Critical) Zero percent (0%) of all calls receive a busy signal or are blocked. <p>Quality</p> <ol style="list-style-type: none"> 1. (Non-Critical) IVRS completes requests with one hundred (100%) accuracy based on data contained in MMIS.
General & System	SS01e System Performance	Contractor	Security breaches	<p>Timeliness:</p> <ol style="list-style-type: none"> 1. (Critical) Contractor shall report any suspected or verified breaches of MMIS security or attempts to breach MMIS security within four (4) hours of the detection of the breach or attempt to breach including recommendations for corrective actions to prevent future similar events. 2. (Critical) Contractor shall implement security breach remedy/solution within 1 hour of State approval. 3. (Non-Critical) Contractor will update MMIS system security monitoring procedures, as required, within three (3) calendar days of resolution of newly discovered MMIS system

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SC MITA Business Area	General & System Process	Principal Duties	Comments	Performance Standards
				security vulnerabilities. Quality: 1. (Critical) Contractor shall validate that 100 percent of implemented security breach remedies/solutions resolve the problem.
General & System	SS01f System Performance	Contractor	User access updates	Timeliness: 1. (Non-Critical) Contractor shall complete any requests to create or update MMIS system users within one (1) business day and requests to terminate access within one (1) hour of receipt of authorized request from State.
General & System	SS01g System Performance	Contractor	PHI access	Timeliness: 1. (Critical) Contractor shall report any suspected or verified unauthorized viewing, access or release of PHI/ePHI within four (4) hours of becoming aware of the event or potential event including recommendations for corrective actions to prevent future similar events.
General & System	SS01h System Performance	Contractor	Downtime events	Timeliness: 1. (Critical) Contractor shall notify State of any unexpected downtime or system unavailability ("Downtime Event") within thirty (30) minutes of the Downtime Event. 2. (Non-Critical) Contractor shall provide an initial downtime report within four (4) hours of the Downtime Event and incremental reports every four (4) hours until the issue causing the downtime is fully understood and meaningful corrective actions developed. Recommendations for corrective actions to prevent future similar events must be received within two (2) business days of final remediation of the Downtime Event.

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SC MITA Business Area	General & System Process	Principal Duties	Comments	Performance Standards
General & System	SS01i System Performance	Contractor	Backup systems	Timeliness: 1. (Critical) Contractor shall notify State of any switch to backup or secondary system within thirty (30) minutes of the event causing the switch.
General & System	SS01j System Performance	Contractor	Disaster recovery systems	Timeliness: 1. (Critical) Contractor shall recover a functional Replacement MMIS consistent with the Offeror-proposed recovery time objective (RTO) and recovery point objective (RPO) (Row 16 of the Offeror-Proposed Performance Standards.).
General & System	SS01k System Performance	Contractor	System maintenance	Timeliness: 1. (Non-Critical) Contractor shall notify State of any planned system maintenance at least seven (7) business days prior to the maintenance.
General & System	SS01L System Performance	Contractor	On-call support	Timeliness: 1. (Critical) Contractor maintains an on-call emergency contact process by which authorized State staff will receive a direct answer and/or call-back within five (5) minutes on a 24x7x365 basis.
General & System	SS01m System Performance	Contractor	Operational reports	Timeliness: 1. (Non-Critical) Complete and make available in MMIS required operational reports prior to 6:00am Eastern Time (ET) on the date the report is expected to be available in the MMIS. Quality: 1. (Non-Critical) Reports shall be one hundred percent (100%) consistent with the data available in the MMIS at the time the report was generated.
General &	SS01n System	Contractor	Data maintenance	Accessibility:

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SC MITA Business Area	General & System Process	Principal Duties	Comments	Performance Standards
System	Performance			<ol style="list-style-type: none"> 1. (Critical) Initially load and maintain seven (7) years of data plus select older data needed for lifetime service limits, etc. 2. (Non-Critical) All data in MMIS is accessible to authorized MMIS users at all times. 3. (Critical) Delete data only at the State's direction (most likely data older than seven years except that needed for lifetime service limits, and data needed for long term processing requirements.) 4. (Non-Critical) Contractor shall maintain data in Model Office to match current production data with currency as proposed by Contractor for Data maintenance (Row 17 in the Offeror-Proposed Performance Standards).
General & System	SS02a Receive Inbound Transaction	Contractor	Paper document ingest	<p>Timeliness:</p> <ol style="list-style-type: none"> 1. (Non-Critical) Contractor shall ingest paper documents into the system by scanning, assigning a unique control number and verifying scanning accuracy within one (1) business day of receipt of the paper document. <p>Quality:</p> <ol style="list-style-type: none"> 1. (Non-Critical) Contractor ensures accuracy of scanning and optical character recognition (OCR) processes to ninety-eight percent (98%) accuracy at the document level.
General & System	SS02b Receive Inbound Transaction	Contractor	Index and link documents	<p>Timeliness:</p> <ol style="list-style-type: none"> 1. (Non-Critical) Contractor indexes, applies appropriate metadata and links appropriately documents in MMIS within (1) business day of the document being available in the MMIS. <p>Accuracy:</p> <ol style="list-style-type: none"> 1. (Non-Critical) Contractor indexes, applies

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SC MITA Business Area	General & System Process	Principal Duties	Comments	Performance Standards
				metadata and links documents with ninety-eight percent (98%) accuracy at the document level.
General & System	SS02c Receive Inbound Transaction	Contractor	Call center hours	Accessibility: 1. (Non-Critical) Staff operators must be available to answer calls from 7:00 a.m. to 6:00 p.m., Eastern Time, Monday through Friday.
General & System	SS02d Receive Inbound Transaction	Contractor	Call center performance	Timeliness: 1. (Non-Critical) Ninety-seven percent (97%) or more of all phone calls are answered within sixty (60) seconds by a human operator. 2. (Non-Critical) Less than three percent (3%) of phone calls in duration of at least fifteen (15) seconds are abandoned or dropped. 3. (Non-Critical) Less than one percent (1%) of all calls receive a busy signal or are blocked. Utility of Value to Stakeholders: 1. (Non-Critical) Contractor shall monitor ten percent (10%) of all calls and attain at least a ninety-seven percent (97%) accuracy rate for each call being answered completely and correctly at the call level.
General & System	SS02e Receive Inbound Transaction	Contractor	Inbound fax server performance	Timeliness: 1. (Non-Critical) Maintain an average time to add an inbound fax to a work queue of one hundred eighty (180) seconds from the time the fax receipt of the fax is completed by the inbound fax system. 2. (Non-Critical) Ingest the inbound fax to the MMIS using the Document Ingest process General & System Process SS02a standards.
General &	SS03 Send Outbound	Contractor	Outbound fax server performance	Timeliness:

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SC MITA Business Area	General & System Process	Principal Duties	Comments	Performance Standards
System	Transaction			1. (Non-Critical) Maintain an average time to initiate an outbound fax from the MMIS within three hundred (300) seconds from the time the request is place into the queue for outbound faxes.
General & System	SS04 Financial Management	Contractor	Financial data and process management	<p>Note: The performance standards for SS04 are referenced in multiple business processes in Attachment I; however, each performance standard for SS04 will be evaluated as a single performance standard instance for the purposes of performance incentives rather than as a separate standard for each business process that references SS04.</p> <p>Quality:</p> <ol style="list-style-type: none">1. (Critical) Contractor ensures that the financial records are in balance at the time of each Payment Cycle.2.(Critical) Contractor completes financial processes in accordance with applicable financial and accounting standards including the Cash Management Act, GASB standards, and GAAP.

Offeror-Proposed Performance Standards							
Row Number	MITA Business Process	Percent Complete	Time Period	Percent Complete	Time Period	Percent Complete	Time Period
1	PM02 Manage Provider Communication	50%		90%		100%	
2a	PM04 Enroll Provider (Abbreviated Enrollment)	50%		90%		100%	
2b	PM04 Enroll Provider (Enrollment or revalidation with limited risk category screening)	50%		90%		100%	
2c	PM04 Enroll Provider (Enrollment or revalidation with moderate risk category screening)	50%		90%		100%	
2d	PM04 Enroll Provider (Enrollment or revalidation with high risk category screening. Not including fingerprinting time, if required by Federal regulation)	50%		90%		100%	
3	Adjudicate Clean Claims (OM06, OM07, OM08)	95%		99%		100%	
4	Adjudicate Suspended Claims (OM06-OM07-OM08)	95%		99%		100%	
5	OM18 Inquire Payment Status	90%		95%		100%	
6	BR02 Manage Business Relationship Communication	50%		90%		100%	
7	OM02 Authorize Service (prior authorization requests }	95%		99%		100%	

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Row Number	MITA Business Process	Source Information Age (Calendar Days)	Percentage of Covered Lives (%)	Source Information Age (Calendar Days)	Percentage of Covered Lives (%)	Source Information Age (Calendar Days)	Percentage of Covered Lives (%)
8	OM26 Manage TPL Recovery	30 or less		60 or less		90 or less	
Row Number	MITA Business Process	Accuracy for Claims Requiring Manual Intervention (%)					
9	OM06-OM07-OM08 Audit-Edit-Price/Value Claim-Encounter						
Row Number	MITA Business Process	Satisfaction Survey Favorable Response (%)					
10	PM03 Perform Provider Outreach						
Row Number	MITA Business Process	Time (business days)					
11	OM05 Apply Mass Adjustment						
12	PG02 Develop and Maintain Benefit Package						
13	PG03 Manage Rate Setting						
14	PG18 Maintain Benefits-Reference Information						
15	PG01 Designate Approved Services and Drug Formulary						
Row Number	General & System Process	Recovery Point Objective (hours)		Recovery Time Objective (RTO)			
16	SS01j Disaster recovery systems						

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Row Number	General & System Process	Model Office Currency (days)	
17	SS01n Data Maintenance		

Receive Inbound Transaction	
Item	Details
Description	<p>The Receive Inbound Transaction Process is initiated by service requests from numerous internal business processes requesting to receive transaction data from an external business process outside of the enterprise.</p> <p>Interoperability is key and strategic for the Receive Inbound Transaction Process with respect to the capability of different programs exchanging data via common exchange formats, reading and writing the same file formats, and using the same protocols.</p> <p>The Receive Inbound Transaction Process supports both real-time, batch and human interaction processes. When possible, the architectural direction is for real-time interfaces to be built based upon WSDL or SOAP web services when practical. Batch interfaces must use industry standards and best practices. Human interaction processes must be supported by supporting technologies and channels.</p> <p>The Receive Inbound Transaction Process supports multiple channels for communications, allowing for the best channel(s) to be used for the specific business process being invoked.</p>
Trigger Event	Interaction-based Trigger Event: Most all other MITA business processes are invoked by the Receive Inbound Transaction Process in order to initiate a business process. The trigger event is different based upon the channel being activated to accept the transaction, but generally the receipt of a transaction data set provides the invocation.
Result	Depending upon the channel used to receive incoming transaction data, the result will vary slightly. In general, the result of the Receive Inbound Transaction Process is to acknowledge receipt of the transaction and forward the request onto the appropriate MITA business process for further processing.
Business Process Steps	<ol style="list-style-type: none"> 1. Assign a unique tracking number. 2. Provide a guaranteed receipt message request (when necessary) by invoking the Send Outbound Transaction Process. 3. Log the receipt of the transaction in the audit log. 4. Forward the transaction data set to the MITA Business Process responsible for accepting and processing the transaction request.
Shared Data	N/A
Predecessor	There are no predecessors to this business process.

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Successor	All MITA business processes dependent upon inbound transaction data sets are consumers of this business process.
Constraints	Agreements must be in place to exchange and receive data. Many of these exchanges are governed by HIPAA and privacy regulations that must be enforced.
Failures	Data sets received from unknown sources or unknown formats will be rejected and returned to the sending entity.
Performance Measures	<p>Based upon the selected channel, performance standards may vary. Supported channels include:</p> <ul style="list-style-type: none">• Web Client (secure)• Email (secure and unsecure)• Web Portal Message Center (secure)• Really Simple Syndication (RSS)• Electronic Data Message (e.g. web service/data exchange)• Bulk File Transfer• Social Media• Telephone Call• Fax• Paper• Text Message• Portable Media (DVD/CD, Tape)• Oral (face-to-face)

Send Outbound Transaction Process	
Item	Details
Description	<p>The Send Outbound Transaction Process is initiated by service requests from numerous internal business processes requesting to send transaction data to an external business process outside of the enterprise.</p> <p>Interoperability is key and strategic for the Send Outbound Transaction Process with respect to the capability of different programs exchanging data via common exchange formats, reading and writing the same file formats, and using the same protocols.</p> <p>The Send Outbound Transaction Process supports both real-time and batch processes. When possible, the architectural direction is for real-time interfaces to be built based upon WSDL or SOAP web services when practical. Batch interfaces must use industry standards and best practices.</p> <p>The Send Outbound Transaction Process supports multiple channels for communications, allowing for the best channel(s) to be used for the specific business process and the population being served (e.g. provider, beneficiary, etc.).</p>
Trigger Event	Interaction-based Trigger Event: Most all other MITA business processes invoke the Send Outbound Transaction Process in order to initiate an outbound data set channel request. The trigger event is different based upon the channel being activated to send the transaction, but generally the receipt of a transaction data set to be sent to another business process (typically external) provides the invocation.
Result	Depending upon the channel being invoked, the result will vary slightly. In general, the result of the Send Outbound Transaction Process is to acknowledge receipt of the outbound transaction request and forward the data set onto the appropriate receiving entity through an authorized and approved channel.
Business Process Steps	<ol style="list-style-type: none"> 1. Assign a unique tracking number. 2. Log the receipt of the transaction in the audit log. 3. Invoke the channel process selected to generate the outbound data set. 4. Forward the transaction data set to the receiving entity via the selected channel.
Shared Data	N/A
Predecessor	Any MITA business process in need of sending outbound transactions via an approved channel is a valid predecessor for this business process. Almost all MITA processes invoke the Send

	Outbound Transaction Process.
Successor	There are no successors to this process.
Constraints	Agreements must be in place to exchange and receive data. Many of these exchanges are governed by HIPAA and privacy regulations that must be enforced.
Failures	Data sets requested to be sent to unknown sources or with unknown formats will be rejected and returned to the predecessor business process.
Performance Measures	<p>Based upon the selected channel, performance standards may vary. Supported channels include:</p> <ul style="list-style-type: none">• Web Client (secure)• Email (secure and unsecure)• Web Portal Message Center (secure)• Really Simple Syndication (RSS)• Electronic Data Message (e.g. web service/data exchange)• Bulk File Transfer• Telephone Call• Fax• Paper• Text Message• Social Media• Portable Media (DVD/CD, Tape)• Oral (face-to-face)

Attachment J. Annotated Medicaid Enterprise Certification Toolkit Checklists

STATE: South Carolina	DATE OF REVIEW:	REVIEWER:
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BENEFICIARY MANAGEMENT (BE) CHECKLIST

BENEFICIARY MANAGEMENT CHECKLIST BACKGROUND

Background for this checklist:

1. The criteria in this checklist are mainly based on the MMIS requirements in the State Medicaid Manual (SMM). The MMIS requirements in the SMM have been used for decades of MMIS certification. The language used in the criteria has been modernized to reflect 21st century terminology. Additional criteria have been added to align with Industry Best Practices (IBP). Many of these IBP have become standards in most States. If a State requests an IBP function in its RFP or System Requirements Document, it will be considered a requirement to be reviewed during MMIS certification.
2. The Medicaid Buy-In process and the Medicaid Part D data exchange are required, but they are not required to be done in the MMIS as of 02-08-07. Therefore, the business objective BE5 and associated criteria shown below in the Business Objectives section are optional. However, if the MMIS is used for either of these functions, the related criteria apply and are not optional.
3. See Managed Care checklists for Beneficiary Management requirements associated with enrollment in managed care programs.
4. Some States accept the Federal (SSA) determination of eligibility for Supplemental Security Income (SSI) automatically as eligibility for Medicaid. These are called Section 1634 States. Non-Section 1634 States make their own Medicaid eligibility determinations for SSI recipients.
5. SDX is a data exchange by which SSA provides information to the State regarding the eligibility of SSI applicants and recipients.

Sources for the criteria in this checklist are as follows:

SMM – State Medicaid Manual, MMIS Section, available from <http://www.cms.hhs.gov/Manuals/PBM/list.asp>, Document 45

IBP – Industry Best Practices. Items are selected from RFPs for MMISs developed by states and approved by CMS.

PRI - HIPAA privacy rule. This rule is available at <http://www.hhs.gov/ocr/hipaa/finalreg.html>

CFR – Code of Federal Regulations, available from <http://www.access.gpo.gov/uscode/title42/title42.html>

HIPAA – HIPAA act, available from

http://www.cms.hhs.gov/TransactionCodeSetsStandards/02_TransactionsandCodeSetsRegulations.asp#TopOfPage

SMDL – State Medicare Director Letter of July 6, 2006

BUSINESS OBJECTIVES

Reference #	Business Objectives	Comments
BE1	Collect and manage information about the Beneficiary population from diverse sources.	MEDS collects data on each member and currently transmits that data to the MMIS nightly.
BE2	Maintain information on each Beneficiary's Medicaid benefits to support claims payment and other financial processes.	In the Beneficiary Management checklist, there are two items identified as BE2.1. Both of these items are considered in scope. For the purposes of clarity, these system review criteria are relabeled BE2.1a and BE2.1b.
BE3	Allow verification of Beneficiary Medicaid eligibility information by external entities.	
BE4	Comply with HIPAA requirements	
BE5	Manage the Medicare Buy-In and Part D data exchange processes (optionally supported by MMIS).	The eligibility system maintains the relationship between the member and Medicare Buy-In and Part D coverage. The MMIS must manage payments associated with these programs.
BE5S1	Manage member grievance and appeal process for claims related situations.	Contractor supports State with any needed information, logging, tracking, scheduling, etc. in accordance with legal requirements. The Offeror should provide system review criteria for this business objective based upon their proposed solution.

BE1 – COLLECT AND MANAGE INFORMATION ABOUT THE BENEFICIARY POPULATION

Ref#	System Review Criteria	Source	Yes	No	Comments
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Ref#	System Review Criteria	Source	Yes	No	Comments
BE1.1	Supports a Beneficiary data set that contains all required data elements.	SMM			
BE1.2	Processes all transactions that update the Beneficiary data set on a timely basis as determined by the State, edits fields for reasonableness, and controls and accounts for transactions with errors.	SMM			
BE1.3	Supports management of Beneficiary information, including archives, with reports, transaction and transaction error tracking, etc.	SMM			
BE1.4	Generates notification when Beneficiary information is received from external sources (such as through the State's Integrated Eligibility System or SSA's State Data Exchange) to update Beneficiary records.	IBP			The function supporting this system review criterion is performed by MEDS.
BE1.5	Receives and processes Beneficiary eligibility information from external sources (such as through the State's Integrated Eligibility System or SSA's State Data Exchange) for a given period of time; produces total and details information that supports error correction and synchronization. Applies reconciliation changes to master file. Produces a file of changed records to be sent to originating source.	SMM			The function supporting this system review criterion is performed by MEDS.
BE1.6	Archives Beneficiary data sets and updates transactions according to State provided parameters	IBP			
BE1.7	If the EPSDT reporting process is performed by the MMIS, provides Beneficiary data to support case identification, tracking, and reporting for the EPSDT services covered under Medicaid (optional).	SMM			

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Ref#	System Review Criteria	Source	Yes	No	Comments
BE1.8	Provides an indicator to suppress generation of documents containing Beneficiary identification for confidential services or other reasons.	SMM			
BE1.9	Maintains clinical, utilization and other indicators of special population, special needs status for such programs as lock-in, disease management, outcomes, and high dollar case management files.	IBP			
BE1.10	Maintains record/audit trail of a Beneficiary's requests for copies of personal records (including time/date, source, type, and status of request).	PRI			
BE1.11	Maintains record/audit trail of errors during update processes, accounting for originating source and user.	IBP			
BE1.12	Allows for authorized users to update Beneficiary records online.	IBP			
BE1.13	Supports and tracks the identification of duplicate recipient records based on State defined criteria.	IBP			
BE1SS.1	Automates tracking of EPSDT services, notifications and work management when services are due to meet State requirements and Federal guidelines and generate reminders to Members and caregivers of the need for treatment and/or immunization.	State Self-Assessment			
BE1SS.2	Receives, processes, and schedules transmission of Member eligibility data sets from internal sources, such as the TPL store, and external sources, such as the MCOs.	State Self-Assessment			
BE1SS.3	Links all services to a single Beneficiary regardless of the number of historical changes in Beneficiary ID.	IBP			

BE2 – MAINTAIN INFORMATION ON BENEFICIARY'S MEDICAID BENEFITS

Ref#	System Review Criteria	Source	Yes	No	Comments
BE2.1	Provides data storage and retrieval for Third Party Liability (TPL) information; supports TPL processing and update of the information.	SMM			For the purposes of clarity in the Contract, this item is labeled BE 2.1a.
BE2.1	Supports the assignment of Beneficiaries to Medicaid benefits/benefit packages based on Federal and/or State-specific eligibility criteria.	IBP			For the purposes of clarity in the Contract, this item is labeled BE 2.1b.
BE2.2	Maintains record of benefit assignment(s) for Beneficiaries.	IBP			
BE2.3	Applies appropriate benefit limitations for Beneficiaries based on Federal and/or State specific criteria.	IBP			
BE2.4	Maintains record of Beneficiary benefit limitation information.	IBP			
BE2.5	Calculates and applies Beneficiary cost-sharing (including premiums and co-pays) for particular benefits based on Federal and/or State-specific criteria	IBP			Manage beneficiary cost-sharing requirements and be flexible enough to allow implementation of future cost-sharing arrangements.
BE2.6	Maintains record of Beneficiary cost-sharing	IBP			
BE2.7	Maintains record/audit trail of any notice of benefit(s) sent to Beneficiaries (including time/date, user/source, and reason for notice).	IBP			
BE2SS.1	<i>Add State-specific criteria for this objective here</i>				

BE3 – PROVIDE/ALLOW VERIFICATION OF MEDICAID ELIGIBILITY INFORMATION TO EXTERNAL USERS

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Ref#	System Review Criteria	Source	Yes	No	Comments
BE3.1	In response to an eligibility inquiry made through the MMIS, provides eligibility status for the date(s) queried, and tracks and monitors responses to the queries (SMM 11281.1B).	SMM			
BE3.2	In response to an eligibility inquiry made through the MMIS, provides notification of third-party payers who must be billed prior to Medicaid (SMM 11281.1B).	SMM			
BE3.3	In response to an eligibility inquiry made through the MMIS, provides notice of participation in a managed care program (SMM 11281.1B).	SMM			
BE3.4	In response to an eligibility inquiry made through the MMIS, provides notification of program and service restrictions, such as lock-in or lock-out (SMM 11281.1B).	SMM			
BE3.5	Maintains record/audit trail of responses to eligibility inquiries.	IBP			
BE3SS.1	<i>Add State-specific criteria for this objective here.</i>				

BE4 – COMPLY WITH HIPAA REQUIREMENTS

Ref#	System Review Criteria	Source	Yes	No	Comments
BE4.1	Supports system transmission and receipt of all current version X12N and NCPDP eligibility verification transactions.	HIPAA			
BE4.2	Supports production of X12N 270 transactions to query other payer eligibility files and ability to process responses.	IBP			

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Ref#	System Review Criteria	Source	Yes	No	Comments
BE4SS.1	<i>Add State-specific criteria for this objective here.</i>				

BE5 – MANAGE THE MEDICARE BUY-IN PROCESS (OPTIONAL)

Ref#	System Review Criteria	Source	Yes	No	Comments
BE5.1	Identifies and tracks potential Medicare Buy-In Beneficiaries according to State and CMS defined criteria.	CFR			
BE5.2	Transmits State-identified Buy-In Beneficiary information for matching against CMS-specified Federal Medicare Beneficiary database(s).	CFR			
BE5.3	Accepts Buy-In Beneficiary response information from CMS-specified Federal Medicare Beneficiary database(s).	SMM			
BE5.4	Processes change transactions to update Buy-In Beneficiary information. Identify and track errors or discrepancies between State and Federal Buy-In Beneficiary information.	SMM			
BE5.5	Provides Buy-In Beneficiary information for program or management use, including: <ul style="list-style-type: none"> transactions processed errors identified error correction status Medicare premiums to be paid by Beneficiary 	IBP			
BE5.6	Tracks Buy-In exceptions for those Beneficiaries who are identified as eligible, but whose premiums have not been paid	IBP			
BE5.7	Supports automated data exchange process(es), as specified by CMS, in order to identify and track Medicare Part D dual-eligible and Low Income Subsidy	SMDL			

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Ref#	System Review Criteria	Source	Yes	No	Comments
	(LIS) eligible Beneficiaries for the purposes of cost-avoidance on prescription drug claims and calculating spend-down payments.				
BE5SS.1	<i>Add State-specific criteria for this objective here.</i>				

BESS1 – MANAGE MEMBER GRIEVANCE AND APPEAL PROCESS FOR CLAIMS RELATED SITUATIONS

Ref#	System Review Criteria	Source	Yes	No	Comments
BESS2.1					Contractor supports State with any needed information, logging, tracking, scheduling, etc. in accordance with legal requirements. The Offeror should provide system review criteria for this business objective based upon their proposed solution.

STATE: South Carolina	DATE OF REVIEW:	REVIEWER:
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CLAIMS ADJUDICATION (CA) CHECKLIST

CLAIMS ADJUDICATION (CA) CHECKLIST BACKGROUND

Background for this checklist:

1. The criteria in this checklist are mainly based on the MMIS requirements in the State Medicaid Manual (SMM). The MMIS requirements in the SMM have been used for decades of MMIS certification. The language used in the criteria has been modernized to reflect 21st century terminology. Additional criteria have been added to align with Industry Best Practices (IBP). Many of these IBP have become standards in most States. If a State requests an IBP function in its RFP or System Requirements Document, it will be considered a requirement to be reviewed during MMIS certification.
2. This is a generic checklist covering all types of claims submitted by all types of providers with the exception of pharmacy Point of Service (a.k.a., Point of Sale, POS) claims. There is a separate checklist for pharmacy POS claims receipt and adjudication.
3. Unless otherwise stated, criteria apply to all claim types paid by the State Medicaid agency including atypical provider claims.
4. This checklist covers the basic functions of claims adjudication including prior authorization.

Sources for the criteria in this checklist are as follows:

SMM – State Medicaid Manual, MMIS Section, available from <http://www.cms.gov/Manuals/PBM/list.asp>, Document 45

IBP – Industry Best Practices. Items are selected from RFPs for MMISs developed by states and approved by CMS.

HIPAA – HIPAA act, available from

http://www.cms.hhs.gov/TransactionCodeSetsStandards/02_TransactionsandCodeSetsRegulations.asp

BUSINESS OBJECTIVES

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Reference #	Business Objectives	Comments
CA1	Route claims for processing and track claim progress, status, and location.	
CA2	Process claim data against defined service, policy, and payment parameters.	Incorporate dental claims processing in the MMIS.
CA3	Validate that claims are from properly enrolled and eligible providers	
CA4	Validate that claims are for eligible Beneficiaries.	
CA5	Provide for the timely disposition of prior authorization requests.	
CASS1	Improve the likelihood of identifying and recovering payments made on behalf of ineligible beneficiaries by automating the tracking and recoupment management processes.	The Offeror should provide system review criteria for this business objective based upon its proposed solution.
CASS2	Improve the timeliness and effectiveness of claims research by maintaining adjudication details in the system (e.g., failed edits, eligible benefit plans, etc.).	The Offeror should provide system review criteria for this business objective based upon its proposed solution.
CASS3	Improve management of adjustments by applying most adjustments at the claim level and by allowing multiple adjustments to be applied to individual claims.	The Offeror should provide system review criteria for this business objective based upon its proposed solution.
CASS4	Increase claims adjudication quality by incorporating the National Correct Coding Initiative/Unlikely Edits and more sophisticated standards- and rules-based editing and auditing.	The Offeror should provide system review criteria for this business objective based upon its proposed solution.
CASS5	Improve claim quality, reduce provider/State effort, and increase visibility by performing real time adjudication, suspense correction and inquiry of claims.	The Offeror should provide system review criteria for this business objective based upon its proposed solution.
CASS6	Reduce inappropriate claims payments by detecting provider-preventable conditions (PPC) and hospital-acquired conditions (HAC).	The Offeror should provide system review criteria for this business objective based upon its proposed solution.

CA1 – ROUTE CLAIMS FOR PROCESSING AND TRACK CLAIM PROGRESS, STATUS, AND LOCATION

Ref#	System Review Criteria	Source	Yes	No	Comments
CA1.1	Tracks all claims within the processing period – paid, suspended, pending or denied.	SMM			
CA1.2	Suspends claims with exceptions/errors and routes for correction to the organizational entity that will resolve the exception/error, unless automatically resolved. The organizational entity will resolve the claim based upon the State's criteria.	SMM			
CA1.3	Verifies that suspended transactions have valid error/exception codes.	SMM			
CA1.4	Tracks claims flagged for investigative follow-up because of third party discrepancies.	SMM			
CA1.5	Generates audit trails for all claims, maintains audit trail history.	SMM			
CA1.6	Verifies that all claims for services approved or disallowed are properly flagged as paid or denied.	SMM			
CA1.7	Documents and reports on the time lapse of claims payment, flagging or otherwise noting clean claims (error free) that are delayed over 30 days. (See 447.45 CFR for timely claims payment requirements.)	SMM			
CA1.8	Provides prompt response to inquires regarding the status of any claim through a variety of appropriate technologies, and tracks and monitors responses to the inquiries. Processes electronic claim status request and response transactions	SMM HIPAA			

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Ref#	System Review Criteria	Source	Yes	No	Comments
	(ASC X12N 276/277) required by 45 CFR Part 162.				
CA1.9	Provides claims history for use by Program Management and Program Integrity.	SMM			
CA1.10	Assigns claim status (i.e., approved, denied, pended, rejected) based on the State's criteria	IBP			
CA1.11	Verifies that claim correction activities have entered only valid override code(s) or manual prices.	IBP			
CA1.12	Identifies and hierarchically assigns status and disposition of claims (suspend or deny) that fail edits (based on the edit disposition record).	IBP			
CA1.13	Identifies and tracks all edits and audits posted to the claim in a processing period.	IBP			
CA1.14	Provides and maintains, for each error code, a resolution code, an override, force or deny indicator, and the date that the error was resolved, forced, or denied.	IBP			
CA1SS.1	Provides online resolution of pended and claims updates for providers via a provider Web portal.	State Self-Assessment			

CA2 – PROCESS CLAIM DATA AGAINST DEFINED SERVICE, POLICY, AND PAYMENT PARAMETERS

Ref#	System Review Criteria	Source	Yes	No	Comments
CA2.1	Verifies that all fields defined as numeric contain only numeric data.	SMM			
CA2.2	Verifies that all fields defined as alphabetic contain only alphabetic data.	SMM			
CA2.3	Verifies that all dates are valid and reasonable.	SMM			
CA2.4	Verifies that all data items which can be obtained by mathematical manipulation of other data items, agree with the results of that manipulation.	SMM			
CA2.5	Verifies that all coded data items consist of valid codes, e.g., procedure codes, diagnosis codes, service codes, etc. are within the valid code set HIPAA Transactions and Code Sets (TCS) and are covered by the State Plan.	SMM HIPAA			
CA2.6	Verifies that any data item that contains self-checking digits (e.g., Beneficiary I.D. Number) passes the specified check-digit test.	SMM			
CA2.7	Verifies that numeric items with definitive upper and/or lower bounds are within the proper range.	SMM			
CA2.8	Verifies that required data items are present and retained) including all data needed for State or Federal reporting requirements (see SMM 11375).	SMM			
CA2.9	Verifies that the date of service is within the allowable time frame for payment	IBP			
CA2.10	Verifies that the procedure is consistent with the diagnosis.	SMM			

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Ref#	System Review Criteria	Source	Yes	No	Comments
CA2.11	Verifies that the procedure is consistent with the Beneficiary's age.	SMM			
CA2.12	Verifies that the procedure is consistent with the Beneficiary's sex.	SMM			
CA2.13	Verifies that the procedure is consistent with the place of service.	SMM			
CA2.14	Verifies that the procedure is consistent with the category of service	SMM			
CA2.15	Flags and routes for manual review claims with individual procedures and combinations of procedures which require manual pricing in accordance with State parameters.	IBP			
CA2.16	Verifies that the billed amount is within reasonable and acceptable limits or if it differs from the allowable fee schedule amount by more than a certain percentage (either above or below), then the claim is flagged and routed for manual review for: <ul style="list-style-type: none"> Possible incorrect procedure Possible incorrect billed amount When too high, possible need for individual consideration.	SMM			
CA2.17	Verifies that the claim is not a duplicate of a previously adjudicated claim (including a prior one in the current processing period).	SMM			
CA2.18	Verifies that the dates of service of an institutional claim do not overlap with the dates of service of an institutional claim from a different institution for the same Beneficiary.	SMM			
CA2.19	Verifies that the dates of service for a practitioner claim do not overlap with the dates of service for another claim from the same practitioner for a single Beneficiary	SMM			

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Ref#	System Review Criteria	Source	Yes	No	Comments
	unless the additional services are appropriate for the same date of service.				
CA2.20	Utilizes data elements and algorithms to compute claim reimbursement for claims that is consistent with 42 CFR 447.	SMM			
CA2.21	Flags for review claims from a single provider for multiple visits on the same day to a single Beneficiary	IBP			
CA2.22	Verifies that the provider type is consistent with the procedure(s).	IBP			
CA2.23	Flags and routes for manual intervention claims that do not contain prior authorization if the services require prior authorization or require prior authorization after State-defined thresholds are met.	IBP			
CA2.24	Flags and routes for manual intervention claims that fail State-defined service limitations including once-in-a-lifetime procedures and other frequency, periodicity, and dollar limitations.	IBP			
CA2.25	Has the capability to pay claims per capita, from encounter data or fee-for-service.	IBP			
CA2.26	Prices out-of-State claims according to State policy (i.e., at the local rate, at the other State's rate or flags and routes for manual pricing).	IBP			
CA2.27	Records and edits that all required attachments, per the reference records or edits, have been received and maintained for audit purposes.	IBP			
CA2.28	Prices claims according to pricing data and reimbursement methodologies applicable on the date(s) of service on the claim.	IBP			
CA2.29	Deducts Third Party Liability (TPL) paid amounts and Medicare paid amounts, as	IBP			

Draft

Ref#	System Review Criteria	Source	Yes	No	Comments
	defined in the State Plan, when pricing claims.				
CA2.30	Deducts Beneficiary co-payment amounts, as appropriate, when pricing claims.	IBP			
CA2.31	Prices Medicare coinsurance or deductible for crossover claims, depending on State policy, at the lower of the Medicaid or Medicare allowed amount.	IBP			
CA2.32	Prices services billed with procedure codes with multiple modifiers	IBP			The system should provide the ability to allow, store, and price in accordance with rules-based procedure code and modifier combinations.
CA2.33	Edits claims for consistency and payment limitations using the Medicare Correct Coding Initiative or similar editing criteria, based upon the State Plan.	IBP			Per recent legislation and CMS direction, states are to use the Medicaid National Correct Coding Initiative standards rather than the Medicare standards.
CA2.34	Prices claims according to the policies of the program the Beneficiary is enrolled in at the time of service and edits for concurrent program enrollment	IBP			
CA2.35	Provides and maintains test claim processing capabilities including testing with providers.	IBP			
CA2SS.1	Integrates Administrative Day claims into the MMIS as Institutional claims.	State Self-Assessment			
CA2SS.2	Maintains a record of claims adjudication, including failed edits, eligibility at the time of processing, eligible benefit plans, and other information that would assist in performing investigation on claims inquiries.	IBP			
CASS2.3	Flag provider claims selected by Program Integrity for either report, manual review, or both, according to Program Integrity user-defined criteria with beginning and ending dates.	IBP			

CA3 – VALIDATES THAT CLAIMS ARE FROM PROPERLY ENROLLED AND ELIGIBLE PROVIDERS

Ref#	System Review Criteria	Source	Yes	No	Comments
CA3.1	Verifies that the provider is eligible to render service(s) during the period covered by the claim.	SMM			
CA3.2	Verifies that the provider is eligible to render the specific service covered by the claim.	IBP			
CA3.3	Verifies that the provider is eligible to provide the specific service covered by the plan to the specific Beneficiary	IBP			
CA3SS.1	<i>Add State-specific criteria for this objective here.</i>				

CA4 – VERIFY THAT CLAIMS ARE FOR ELIGIBLE BENEFICIARIES

Ref#	System Review Criteria	Source	Yes	No	Comments
CA4.1	Verifies that the Beneficiary was eligible for the particular category of service at the time it was rendered.	SMM			
CA4.2	Flags for review claims, for the same Beneficiary, with a diagnosis and procedure which indicate an emergency that occur within one day of a similar claim from the same provider	IBP			
CA4.3	Identifies, by Beneficiary, the screening and related diagnosis and treatment services the Beneficiary receives for Early and Periodic Screening Diagnosis, and Treatment, (EPSDT).	SMM			
CA4.4	Routes and reports on claims that are processed that indicate the Beneficiary's date of death for follow-up by the Beneficiary eligibility or Third Party Liability (TPL) personnel.	IBP			
CA4.5	Provides and maintains the capability to monitor services for suspected abusers using a "pay and report", lock-in, or some equivalent system function that will provide reports of the claim activity for these Beneficiaries as scheduled or requested.	IBP			
CA4.6	Provides and maintains the capability to pend or deny claims for Beneficiaries assigned to the Beneficiary lock-in program based on state guidelines.	SMM			
CA4.7	Provides and maintains the capability to edit claims for Beneficiaries in long term care (LTC) facilities to ensure that	SMM			

Ref#	System Review Criteria	Source	Yes	No	Comments
	services included in the LTC payment rate are not billed separately by individual practitioners or other providers.				
CA4.8	Provides and maintains the capability to process Beneficiary cost sharing (e.g., co-payments, LTC patient liability) on any service specified by the state using a fixed amount or percent of charges.	IBP			
CA4.9	Edits claims for newborns' eligibility based upon State-defined newborn enrollment policies and procedures.	IBP			
CA4.10	Edits for Beneficiary participation in special programs (i.e. waivers) against program services and restrictions.	IBP			
CA4.11	Limits benefits payable by Beneficiary eligibility category or other Beneficiary groupings.	IBP			
CA4SS.1	<i>Add State-specific criteria for this objective here.</i>				

CA5 – PROVIDE FOR THE TIMELY DISPOSITION OF PRIOR AUTHORIZATION REQUESTS

Ref#	System Review Criteria	Source	Yes	No	Comments
CA5.1	Processes and retains all prior authorization request data.	SMM			
CA5.2	Ensures that there is a field for authorization or identification when an override indicator (force code) is used.	IBP			
CA5.3	Supports receiving, processing and sending electronic health care service review, request for review, and response transactions required by 45 CFR Part	HIPAA			

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Ref#	System Review Criteria	Source	Yes	No	Comments
	162, as follows: <ul style="list-style-type: none"> Retail pharmacy drug referral certification and authorization Dental, professional and institutional referral certification and authorization (ASC X12N 278) Optionally, supports Web or Internet submissions or prior authorization requests. 				
CA5.4	Enables the prior authorization staff to send requests for additional information on paper or electronically.	IBP			
CA5.5	Supports searching for prior authorizations based on: <ul style="list-style-type: none"> Provider name Provider ID Beneficiary name Beneficiary Medicaid ID Number Date of submission range Dates of service requested range Service requested Status of the request 	IBP			
CA5.6	Supports retroactive entry of prior authorization requests.	IBP			
CA5.7	Assigns a unique prior authorization number as an identifier to each prior authorization request.	SMM			
CA5.8	Edits prior authorization requests with edits that mirror the applicable claims processing edits.	IBP			
CA5.9	Establishes an adjudicated prior authorization record, indicating: <ul style="list-style-type: none"> Single Beneficiary or Beneficiaries Status of the request Services authorized 	IBP			

Draft

Ref#	System Review Criteria	Source	Yes	No	Comments
	<ul style="list-style-type: none"> Number of units approved Service date range approved Cost approved Provider approved (unless approved as non-provider specific) 				
CA5.10	Edits to ensure that only valid data is entered on the prior authorization record, and denies duplicate requests or requests that contain invalid data	SMM			
CA5.11	Captures and maintains both the requested amount and authorized amount on the prior authorization record.	IBP			
CA5.12	Provides and maintains the capability to change the services authorized and to extend or limit the effective dates of the authorization. Maintains the original and the change data in the prior authorization record.	IBP			
CA5.13	Accepts updates from claims processing that “draw down” or decrement authorized services.	IBP			
CA5.14	Uses imaging equipment to capture, store, and retrieve hard copy prior authorization requests and associated documents.	IBP			
CA5.15	Generates automatic approval and denial notices to requesting and assigned providers, case managers, and Beneficiaries for prior authorizations. Denial notices to Beneficiaries include the reason for the denial and notification of the Beneficiary’s right to a fair hearing.	IBP			
CA5.16	Provides and maintains a toll free telephone number for providers to request prior authorizations.	IBP			

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Ref#	System Review Criteria	Source	Yes	No	Comments
CA5SS.1	Provides other authorized State agencies secure access to the MMIS for the purpose of approving prior authorizations.	State Self-Assessment			
CA5SS.2	Automates the service authorization process by providing a rules-based clinical engine allowing configurable business rules for service authorizations using claims and clinical history.	APD			

CASS1 – IMPROVE THE LIKELIHOOD OF IDENTIFYING AND RECOVERING PAYMENTS MADE ON BEHALF OF INELIGIBLE BENEFICIARIES BY AUTOMATING THE TRACKING AND RECOUPMENT MANAGEMENT PROCESSES

Ref#	System Review Criteria	Source	Yes	No	Comments
CASS1.1					The Offeror should provide system review criteria for this business objective based upon its proposed solution.

CASS2 – IMPROVE THE TIMELINESS AND EFFECTIVENESS OF CLAIMS RESEARCH BY MAINTAINING ADJUDICATION DETAILS IN THE SYSTEM (E.G., FAILED EDITS, ELIGIBLE BENEFIT PLANS, ETC.)

Ref#	System Review Criteria	Source	Yes	No	Comments
CASS2.1					The Offeror should provide system review criteria for this business objective based upon its proposed solution.

CASS3 – IMPROVE MANAGEMENT OF ADJUSTMENTS BY APPLYING MOST ADJUSTMENTS AT THE CLAIM LEVEL AND BY ALLOWING MULTIPLE ADJUSTMENTS TO BE APPLIED TO INDIVIDUAL CLAIMS.

Ref#	System Review Criteria	Source	Yes	No	Comments
CASS3.1					The Offeror should provide system review criteria for this business objective based upon its proposed solution.

CASS4 – INCREASE CLAIMS ADJUDICATION QUALITY BY INCORPORATING THE NATIONAL CORRECT CODING INITIATIVE/UNLIKELY EDITS AND MORE SOPHISTICATED STANDARDS- AND RULES-BASED EDITING AND AUDITING

Ref#	System Review Criteria	Source	Yes	No	Comments
CASS4.1					The Offeror should provide system review criteria for this business objective based upon its proposed solution.

CASS5 – IMPROVE CLAIM QUALITY, REDUCE PROVIDER/STATE EFFORT, AND INCREASE VISIBILITY BY PERFORMING REAL TIME ADJUDICATION, SUSPENSE CORRECTION AND INQUIRY OF CLAIMS

Ref#	System Review Criteria	Source	Yes	No	Comments
CASS5.1					The Offeror should provide system review criteria for this business objective based upon its proposed solution.

STATE: South Carolina	DATE OF REVIEW:	REVIEWER:
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CLAIMS RECEIPT (CR) CHECKLIST

CLAIMS RECEIPT CHECKLIST BACKGROUND

Background for this checklist:

1. The criteria in this checklist are mainly based on the MMIS requirements in the State Medicaid Manual (SMM). The MMIS requirements in the SMM have been used for decades of MMIS certification. The language used in the criteria has been modernized to reflect 21st century terminology. Additional criteria have been added to align with Industry Best Practices (IBP). Many of these IBP have become standards in most States. If a State requests an IBP function in its RFP or System Requirements Document, it will be considered a requirement to be reviewed during MMIS certification.
2. This is a generic checklist covering all types of claims submitted by all types of providers with the exception of pharmacy Point of Service (a.k.a., Point of Sale, POS) claims. There is a separate checklist for pharmacy POS claims receipt and adjudication.
3. Unless otherwise stated, criteria apply to all claim types paid by the State Medicaid agency including atypical provider claims.
4. This checklist covers the basic functions of claims receipt and receipt of other transactions including attachments.
5. This checklist covers receipt of claims and other transactions by any media supported by the State, e.g., electronic, Web portal, paper. Receipt of claims, other transactions, and attachments are heavily affected by the Health Insurance Portability and Accountability Act (HIPAA).

Sources for this checklist are as follows:

SMM – State Medicaid Manual, MMIS Section, available from <http://www.cms.hhs.gov/Manuals/PBM/list.asp>, Document 45

IBP – Industry Best Practices. Items are selected from RFPs for MMISs developed by states and approved by CMS.

HIPAA – HIPAA act, available from

http://www.cms.hhs.gov/TransactionCodeSetsStandards/02_TransactionsandCodeSetsRegulations.asp

BUSINESS OBJECTIVES		
Reference #	Business Objectives	Comments
CR1	Accept claims and other transactions electronically and via hard copy.	
CR2	Accept attachments and other materials related to claims and other transactions as required for review and approval.	
CR3	Comply with HIPAA requirements.	
CRSS1	Substantially reduce the number of paper claims filed by providers.	The Offeror should provide system review criteria for this business objective based upon its proposed solution.

CR1 – ACCEPT CLAIMS AND OTHER TRANSACTIONS ELECTRONICALLY AND VIA HARD COPY

Ref#	System Review Criteria	Source	Yes	No	Comments
CR1.1	Captures accurately all input into the system at the earliest possible time.	SMM			
CR1.2	Assigns each claim a unique identifier upon its entering the system.	SMM			
CR1.3	Accepts and uses the common hospital paper billing form developed by the National Uniform Billing Committee (NUBC), for non-electronic claims.	SMM			
CR1.4	Accepts and uses the common non-institutional paper claim form developed by the National Uniform Claim Committee (NUCC), for non-electronic claims.	SMM			
CR1.5	Accepts and uses the common dental paper billing form developed by the American Dental Association (ADA), for non-electronic claims.	IBP			

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Ref#	System Review Criteria	Source	Yes	No	Comments
CR1.6	Controls, tracks, and reconciles captured claims to validate that all claims received are processed.	IBP			
CR1.7	Provides the ability to identify claims input for control and balancing (hardcopy and electronic media).	IBP			
CR1.8	Provides and maintains a data entry system that includes, but is not limited to, hardcopy claims and claim adjustment/voids which provides for field validity edits and pre-editing for: <ul style="list-style-type: none"> • Provider number • Beneficiary ID number • Procedure codes • Diagnosis codes 	SMM			
CR1.9	Produces an electronic image of hardcopy claims and claims-related documents, and performs quality control procedures to verify that the electronic image is legible and meets quality standards.	IBP			
CR1.10	Screens and captures electronic images, date-stamps, assigns unique control numbers and batches hardcopy claim forms and attachments, adjustment/void forms, and updated turnaround documents.	IBP			
CR1.11	Logs each batch into an automated batch control system.	IBP			
CR1.12	Provides the ability to identify claim entry statistics to assess performance compliance	IBP			
CR1.13	Provides a unique submitter number for each billing service or submitter that transmits electronic or paper claims to the MMIS for a single provider or multiple providers.	IBP			

Draft

Ref#	System Review Criteria	Source	Yes	No	Comments
CR1.14	Provides an attachment indicator field on all electronic media claims to be used by the submitter to identify claims for which attachments are being submitted separately.	IBP			
CR1.15	Provides and maintains a Web portal for providers to directly and efficiently enter claims.	IBP			
CR1.16	Supports testing of new provider claims submission systems by allowing providers to submit electronic claims test files that are processed through the adjudication cycle without impact on system data.	IBP			
CR1.17	Identifies any incomplete claim batches that fail to balance to control counts.	IBP			
CR1.18	Provides and maintains the capability to process standard financial transactions including recoupments and payouts which cover more than one claim/service.	IBP			
CR1SS.1	<i>Add State-specific criteria for this objective here.</i>				

CR2 – ACCEPT ATTACHMENTS AND OTHER ASSOCIATED MATERIALS RELATED TO CLAIMS AND OTHER TRANSACTIONS REQUIRED FOR REVIEW AND APPROVAL

Ref#	System Review Criteria	Source	Yes	No	Comments
CR2.1	Accepts, records, stores, and retrieves documents submitted with or in reference to claim submission activity, such as: <ul style="list-style-type: none"> • Operative reports • Occupational, physical, and • speech therapy reports • Durable Medical Equipment(DME) serial number, 	IBP			

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Ref#	System Review Criteria	Source	Yes	No	Comments
	cost, and warranty data <ul style="list-style-type: none"> • Manufacture's tracking data for implants • Waivers and demonstration specific requirements These documents may be freeform or in HIPAA attachment format.				
CR2.2	Receives claim attachments associated with electronic media or paper claims and auto-archives or forwards to appropriate operational area for processing.	IBP			
CR2.3	Accepts Medicare crossover claims (for Medicare coinsurance and deductible) or Medicare Explanation of Benefits (EOB) claims attachments.	IBP			
CR2.4	Accepts prior authorization attachments such as: <ul style="list-style-type: none"> • Surgical/anesthesia reports • Medical records • X-rays/images • Orthodontic study models • LTC prior Authorization • Certain prescription drugs as required • Other items required by State or Federal rules 	IBP			
CR2.5	Accepts other claim related inputs to the MMIS, including but not limited to: <ul style="list-style-type: none"> • Sterilization, abortion, and hysterectomy consent forms • Manual or automated medical expenditure transactions which have been processed outside of the MMIS (e.g., spend-down) • Non claim-specific financial transactions such as fraud and abuse settlements, insurance 	IBP			

Ref#	System Review Criteria	Source	Yes	No	Comments
	recoveries, and cash receipts <ul style="list-style-type: none"> Electronic cost reports Disproportionate share reports Drug rebate Any other inputs required for services under the State's approved plan 				
CR2SS.1	<i>Add State-specific criteria for this objective here.</i>				

CR3 – COMPLY WITH HIPAA REQUIREMENTS

Ref#	System Review Criteria	Source	Yes	No	Comments
CR3.1	Provides system support for the sending and receiving of electronic claims transactions, containing valid codes, required by 45 CFR Parts 160 and 162, as follows: <ul style="list-style-type: none"> Retail pharmacy drug claims (NCPDP) Dental health care claims (X12N 837D) Professional health care claims (X12N 837P) Institutional health care claims (X12N 837I) Coordination of benefits data, when applicable Future claims attachments required under HIPAA 	HIPAA			
CR3.2	Provides secure, HIPAA compliant software and documentation for use by providers to submit electronic claims.	IBP			

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Ref#	System Review Criteria	Source	Yes	No	Comments
CR3.3	Processes batch 837 claims, rejecting only individual bad claims and accepting all others.	IBP			
CR3.4	Employs an electronic tracking mechanism to locate archived source documents or to purge source documents in accordance with HIPAA security provisions.	IBP			
CR3SS.1	<i>Add State-specific criteria for this objective here.</i>				

CRSS1 – SUBSTANTIALLY REDUCE THE NUMBER OF PAPER CLAIMS FILED BY PROVIDERS

Ref#	System Review Criteria	Source	Yes	No	Comments
CRSS1.1					The Offeror should provide system review criteria for this business objective based upon its proposed solution.

STATE: South Carolina	DATE OF REVIEW:	REVIEWER:
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DECISION SUPPORT SYSTEM / DATA WAREHOUSE (DSS) CHECKLIST

DECISION SUPPORT SYSTEM / DATA WAREHOUSE (DSS) CHECKLIST BACKGROUND

Background for this checklist:

1. A Decision Support System (DSS) is defined in the SMM Part 11 Chapter 2 Section 11276.5, B. as follows: "A DSS is often a feasible means of managing data needs. DSS is a universal term describing a menu of hardware and software components which can be combined to facilitate access to data and data analysis to serve a wide range of end-users. A DSS provides a mechanism to process data in a manageable quantity and format which is easily accessed by users to manipulate data online. A DSS can enhance the MAR and SUR functionalities by giving States the ability to access large volumes of data to produce customized reports."
2. The data storage and retrieval component of the DSS is often referred to as the "Data Warehouse" (DW) or the DSS relational database. References in the DSS Checklist criteria to the "database" are references to a Data Warehouse if the State uses that language.
3. System review requirements for a DSS are based on a 1996 HCFA survey and report on Medicaid Decision Support Systems, precedents established by approvals of APDs for DSS since 1990, and State individual specifications for the DSS approved for FFP by CMS.
4. User's may also review ACF's technical report on DSS/DW for TANF program objectives available on the ACF website at <http://www.acf.hhs.gov/>
5. Each State's implementation of a DSS can be different. The certification review team must understand the scope of the State's DSS in order to determine which checklist questions to use. This checklist contains a list of common questions; the checklist will need to be aligned with the actual functionality of the State's DSS prior to its use as part of the State's certification toolkit. Examples of DSS differences are:
 - a. Includes (or not) State Management reports, e.g., old MARS
 - b. Includes or supplements (or not) old SURS
 - c. Produces some Federal reports
 - d. Reporting capabilities can range from simple inquiries, e.g., Claim Detail reports, to multi-tiered analytical reports
 - e. Can accommodate numerous COTS for data analysis (e.g., patterns of utilization, "What-if" analysis, trend analysis)
 - f. Can include Medicaid data only or can link to Vital Statistics, national databases, clinical data, and other sources
 - g. Transactions include all Medicaid claims, some Medicaid claims, optional encounter data, optional number of years of historical data

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- h. The DSS may be for Medicaid use only or may be shared with other agencies on a cost allocation basis
i. Type, size, configuration of the database or data warehouse may vary by State
6. Data is refreshed periodically on a schedule determined by the State but must be timely enough to meet users' needs.
7. The DSS data warehouse should support security, data cleansing, data archiving, data management, and data standards.

Sources for the criteria in this checklist are as follows:

SMM – State Medicaid Manual, MMIS Section, available from <http://www.cms.hhs.gov/Manuals/PBM/list.asp> Document 45

IBP – Industry Best Practices. Items are selected from RFPs for MMISs developed by states and approved by CMS.

HCFA Report - Report on Medicaid Decision Support Systems, HCFA, 1996. Available from <http://www.cms.gov/MMIS/HCFAReport>

BUSINESS OBJECTIVES		
Reference #	Business Objectives	Comments
DSS1	Support better understanding and management of the Medicaid program by collecting and organizing Medicaid-related data and making this data available in a timely and effective manner.	The Contractor is responsible for working with the BIS contractor and supplying the MMIS data required to load the DSS/DW databases. MMIS data are currently sent to the BIS weekly.
DSS2	Provide timely and effective reports for management planning and control.	This business objective is out of scope and performed by the BIS contractor.
DSS3	Support improved analysis for decision making.	This business objective is out of scope and performed by the BIS contractor.

DSS1 – SUPPORT BETTER UNDERSTANDING AND MANAGEMENT OF MEDICAID PROGRAM

Ref#	System Review Criteria	Source	Yes	No	Comments
DSS1.1	Identifies relationships between key entities in the Medicaid enterprise.	HCFA Report			
DSS1.2	At a minimum, transfers data from MMIS claims history, recipient enrollment, provider enrollment, and primary reference data (e.g., diagnosis, procedure, National Drug Code (NDC), and pricing) information.	HCFA Report			
DSS1.3	Accepts data in a variety of formats from a variety of additional sources, e.g., Vital Statistics, MCO encounter data, Benefit Manager encounter data (pharmacy, dental, mental health), Waiver program data, Census Bureau.	HCFA Report			
DSS1.4	Refreshes or replaces all historical claim data, recipient enrollment, provider enrollment, and other primary reference data on a scheduled basis.	HCFA Report			
DSS1.5	Associates clinical data (e.g., claims attachment) with the claim record.	IBP			
DSS1.6	Maintains synchronization of claims and encounter record dates with provider and Beneficiary record dates (i.e., a claim or encounter is always linked to the provider status and Beneficiary status segments associated with the date of service).	HCFA Report			
<i>DSS1SS.1</i>	<i>Add State-specific criteria for this objective here.</i>				

DSS2 – PROVIDE TIMELY AND EFFECTIVE REPORTS FOR MANAGEMENT PLANNING AND CONTROL

Ref#	System Review Criteria	Source	Yes	No	Comments
DSS2.1	Supports simple queries and preformatted reports that are easy to access, follow a user-friendly protocol, and produce responses immediately.	SMM			
DSS2.2	Provides ad hoc reporting capability that presents summarized information on key factors (e.g., number of enrollees, total dollars paid) to executive staff upon request.	SMM			
DSS2.3	Provides ad hoc query capability for retrieval of data relevant to specific operational units, e.g., claims resolution, prior authorization, and medical necessity review.	SMM			
DSS2.4	Supports retrieval and presentation of data associated with geographic indicators such as by state, by county, and by zip code.	IBP			
DSS2.5	Supports Federal reporting requirements when these requirements are met through the DSS.	SMM			
DSS2.6	Extends system flexibility by adding enhanced reporting above and beyond what is available through other MMIS functions.	SMM			
DSS2.7	Supports a variety of formats and output options (e.g., Word, Excel, HTML, Access database, or GUI format).	SMM HCFA Report			
DSS2.8	Provides online assistance to users to support effective use of data query, data	SMM			

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Ref#	System Review Criteria	Source	Yes	No	Comments
	analysis, and report formatting capabilities.				
DSS2SS.1	Add State-specific criteria for this objective here.				

DSS3 – SUPPORT IMPROVED ANALYSIS FOR DECISION MAKING

Ref#	System Review Criteria	Source	Yes	No	Comments
DSS3.1	Maintains easy access to data relevant to the needs of staff as anticipated in the APD and/or RFP, e.g., claims adjudication, prior approval, medical review, utilization review, and analysis of specific payment areas (pharmacy, dental, inpatient, etc.).	HCFA Report			
DSS3.2	Supports a range of analysis actions including: benefit modeling, utilization management, provider-Beneficiary-MCO profiling, program planning, forecasting, program assessment, provider or contractor performance, quality assurance, fraud detection, comparison of fee-for-service and managed care, and other functions as described in the APD and/or RFP.	HCFA Report			
DSS3.3	Supports analytical staff through sophisticated analytical tools that perform specific analytical functions, e.g., statistical analysis, comparative analysis, financial trends, case-mix adjustments within time ranges specified in the APD and/or RFP.	HCFA Report			

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Ref#	System Review Criteria	Source	Yes	No	Comments
DSS3.4	Collects and summarizes data for specific user communities (e.g., data marts or cubes) such as program analysis staff, research group, and financial management unit.	HCFA Report			
DSS3.5	Provides reports that allow users to drill down from summarized data to detailed data.	IBP			
DSS3.6	Demonstrates support for standard summarized data to be accessed by agency executives (e.g., Executive Information System or dashboards).	IBP			
<i>DSS3SS.1</i>	<i>Add State-specific criteria for this objective here.</i>				

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FEDERAL REPORTING (FR) CHECKLIST

FEDERAL REPORTING (FR) CHECKLIST BACKGROUND

Background for this checklist:

1. The first three objectives relate to the Federal reports required in SMM 2700, for Medicaid Statistical Information System (MSIS), Early Periodic Screening, Diagnosis and Treatment (EPSDT), and Home and Community Based Services (HCBS) Waivers
2. The delivery of adequate MSIS reports should be verified before the State visit. If there are no problems, the first set of criteria need not be verified.
3. The waiver reports are only required if the State has an HCBS waiver. If so, the waiver checklist will be used and the HCBS section of this checklist may be done by the Certification Team member who does the Waiver Checklist.
4. In addition, the MMIS must provide data to be used in the development of CMS financial reports – CMS 37 and CMS 64.

Sources for the criteria in this checklist are as follows:

SMM – State Medicaid Manual, MMIS Section, available from <http://www.cms.hhs.gov/Manuals/PBM/list.asp>, Document 45

BUSINESS OBJECTIVES

Reference #	Business Objectives	Comments
FR1	Create and submit to CMS the Federally required MSIS reports.	
FR2	Create and submit to CMS the Federally required EPSDT reports.	<p>This item is out of scope as the CMS 416 reports are produced by the BIS contractor.</p> <p>The Replacement MMIS must capture and maintain any needed data to support Federally required reporting and</p>

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Reference #	Business Objectives	Comments
		provide to the BIS contractor as needed.
FR3	Create and submit to CMS the Federally required HCBS Waiver reports (optional, not needed if State has no waivers).	This item is out of scope as the CMS 372 reports are produced by the BIS contractor. The Replacement MMIS must capture and maintain any needed data to support Federally required reporting and provide to the BIS contractor as needed.
FR4	Meet all other Federal Reporting Requirements	Portions of Federal Reporting are produced by the BIS contractor. The Replacement MMIS must capture and maintain any needed data to support Federally required reporting and provide to the BIS contractor as needed.
FRSS1	Provide universe data extracts for National Payment Error Rate Measurement (PERM) project.	The Offeror should provide system review criteria for this business objective based upon its proposed solution.
FRSS2	Meet the provisions of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA).	The Offeror should provide system review criteria for this business objective based upon its proposed solution.

FR1 – CREATE AND SUBMIT THE FEDERALLY REQUIRED MSIS REPORTS

Ref#	System Review Criteria	Source	Yes	No	Comments
FR1.1	Maintains data sets for MSIS reporting as required.	SMM			
FR1.2	Merges into MSIS data from outside sources if required: <ul style="list-style-type: none"> Capitation payment records from enrollment process Eligibility characteristic data from eligibility intake process Medicaid services processed by non-MMIS State departments, such as mental health services 	SMM 2700.2			

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Ref#	System Review Criteria	Source	Yes	No	Comments
	<ul style="list-style-type: none"> Utilization based on Managed Care encounters 				
FR1.3	Provides and maintains MSIS data for the following adjudicated claims: <ul style="list-style-type: none"> Inpatient hospital Long term institutional care Prescription drugs Other, not included in the above categories 	SMM 2700.2			
FR1.4	Provides and maintains encounter data in appropriate claim(s) file.	SMM 2700.2			Accept, process and store encounters from transportation providers in addition to other encounters.
FR1.5	Follows the eligibility reporting guidelines from Attachment A <i>MSIS Tape Specifications and Data Dictionary</i> document.	SMM 2700.2			
FR1.6	Meets MSIS reporting timelines, providing MSIS tapes for submission in accordance with the tape delivery schedules.	SMM 2700.2			Contractor will provide MSIS information in the format that is consistent with the CMS guidelines at the time. Note: MSIS+ is expected to include about 600 data elements, of which 200 will be useful for algorithmic purposes. MSIS+ addresses the needs of the OIG, MIP, Medi-Medi, PERM, and OnePI. The proposed solution must provide and support all MSIS+ capabilities and requirements.
FR1SS.1	<i>Add State-specific criteria for this objective here.</i>				

FR2 – CREATE AND SUBMIT THE FEDERALLY REQUIRED EPSDT REPORTS

Ref#	System Review Criteria	Source	Yes	No	Comments
FR2.1	Produces the CMS-416 report in accordance with CMS requirements. The report must include: <ul style="list-style-type: none"> • The number of children provided child health screening services, • The number of children refer for corrective treatment, • The number of children receiving dental services, and • The State's results in attaining goals set for the state under section 1905(r) of the Act provided according to a State's periodicity schedule. 	SMM 2700.4			This item is out of scope as the CMS 416 reports are produced by the BIS contractor. The Replacement MMIS must capture and maintain any needed data to support Federally required reporting and provide to the BIS contractor as needed.
FR2SS.1	<i>Add State-specific criteria for this objective here.</i>				

FR3 – CREATE AND SUBMIT TO CMS THE FEDERALLY REQUIRED HCBS WAIVER REPORTS

Ref#	System Review Criteria	Source	Yes	No	Comments
FR3.1	Produces the CMS-372 and CMS-372S Annual reports on Home and Community Based Waiver Reports, for any HCBS Waivers that exist in accordance with CMS requirements.	SMM 2700.6			This item is out of scope as the CMS 372 reports are produced by the BIS contractor. The Replacement MMIS must capture and maintain any needed data to support Federally required reporting and provide to the BIS contractor as needed.
FR3SS.1	<i>Add State-specific criteria for this objective here.</i>				

FR4 – MEET ALL OTHER FEDERAL REPORTING REQUIREMENTS

Ref#	System Review Criteria	Source	Yes	No	Comments
FR4.1	Provides data to support the production of CMS-37 and CMS-64 quarterly estimates and expenditure reports.	SMM			<p>The CMS 64 Eligibility Reporting is out of scope as it is produced by the BIS contractor.</p> <p>The CMS 64 Financial and the CMS 37 reports are in scope for the Contractor.</p> <p>The Replacement MMIS must capture and maintain any needed data to support Federally required reporting and provide to the BIS contractor as needed.</p>
FR4SS.1	<i>Add State-specific criteria for this objective here.</i>				

FRSS1 – PROVIDE UNIVERSE DATA EXTRACTS FOR NATIONAL PAYMENT ERROR RATE MEASUREMENT (PERM) PROJECT.

Ref#	System Review Criteria	Source	Yes	No	Comments
FRSS1	<i>Add criteria based on the APD, RFP, etc., that are relevant to this State-specific objective.</i>				

**FRSS2 – MEET THE PROVISIONS OF THE CHILDREN’S HEALTH INSURANCE PROGRAM
REAUTHORIZATION ACT OF 2009 (CHIPRA).**

Ref#	System Review Criteria	Source	Yes	No	Comments
FRSS2	Add criteria based on the APD, RFP, etc., that are relevant to this State-specific objective.				

STATE: South Carolina	DATE OF REVIEW:	REVIEWER:
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FINANCIAL MANAGEMENT (FI) CHECKLIST

FINANCIAL MANAGEMENT (FI) CHECKLIST BACKGROUND

Background for this checklist:

1. The criteria in this checklist are mainly based on the MMIS requirements in the State Medicaid Manual (SMM). The MMIS requirements in the SMM have been used for decades of MMIS certification. The language used in the criteria has been modernized to reflect 21st century terminology. Additional criteria have been added to align with Industry Best Practices (IBP). Many of these IPB have become standards in most States. If a State requests an IBP function in its RFP or System Requirements Document, it will be considered a requirement to be reviewed during MMIS certification.
2. This checklist is intended to assess the adequacy of the way the MMIS handles the financial side of claims processing.

Sources for the criteria in this checklist are as follows:

SMM – State Medicaid Manual, MMIS Section, available from <http://www.cms.hhs.gov/Manuals/PBM/list.asp> Document 45. The SMM reference includes the State Buy-In Manual, document number 100-15, available from <http://www.cms.gov/Manuals/IOM/>

IBP – Industry Best Practices. Items are selected from RFPs for MMISs developed by states and approved by CMS's.

CFR – Code of Federal Regulations, available from <http://www.access.gpo.gov/uscode/title42/title42.html>

HIPAA – HIPAA act, available from

http://www.cms.hhs.gov/TransactionCodeSetsStandards/02_TransactionsandCodeSetsRegulations.asp#TopOfPage

BUSINESS OBJECTIVES

Reference #	Business Objectives	Comments
FI1	Produce Individual Explanation of Benefits (EOB).	
FI2	Ensure that accounts payable and receivable transactions are recognized and posted in accordance with State and Federal regulations.	The MMIS must perform all necessary accounting functions. The South Carolina Enterprise Information System (SCEIS) maintains accounting information for the entire State. The MMIS must interface with SCEIS to pass aggregated financial information needed for State budgeting and accounting purposes.

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Reference #	Business Objectives	Comments
FI3	Ensure that all financial transactions related to program delivery are processed as defined by State and Federal regulations.	
FI4	Support management of program funds.	Support funds management via interfaces with the South Carolina Enterprise Information System (SCEIS).
FISS1	Automate reconciliation of retrospective cost settlements and other similar cost adjustments for providers, as applicable.	The Offeror should provide system review criteria for this business objective based upon its proposed solution.
FISS2	Improve flexibility to manage multiple concurrent Federal Medical Assistance Percentage rates.	The Offeror should provide system review criteria for this business objective based upon its proposed solution.

FI1 – PRODUCE INDIVIDUAL EXPLANATION OF BENEFITS (EOB)

Ref#	System Review Criteria	Source	Yes	No	Comments
FI1.1	Provides individual EOB notices, within 45 days of the payment of claims, to all or a sample group of the Beneficiaries who received services under the plan as described in §11210.	SMM			

FI2 – ENSURE THAT ACCOUNTS PAYABLE AND RECEIVABLE TRANSACTIONS ARE RECOGNIZED AND POSTED IN ACCORDANCE WITH STATE AND FEDERAL REGULATIONS

Ref#	System Review Criteria	Source	Yes	No	Comments
FI2.1	Updates claims history and on-line financial files with the payment identification (check number, EFT number, warrant number, or other), date of payment, and amount paid after the claims payment cycle.	IBP			
FI2.2	Maintains garnishments and tax levies and assignment information to be used in directing or splitting payments to the provider and garnishor.	IBP			
FI2.3	Maintains financial transactions in sufficient detail to support 1099 and, if the State has elected to do so W-2 and FICA reporting requirements for personal service care providers and providers of services under self-directed care initiatives.	CFR			
FI2.4	Accounts for recovery payment adjustments received from third parties that do not affect the provider's 1099/W2	CFR			
FI2.5	Provides a full audit trail to the source of general ledger transactions generated by the MMIS or other supporting financial packages.	SMM			
FI2.6	Provides automated processes for performing periodic bank account or fund allocation reconciliations.	IBP			
FI2.7	Maintains a history of claim recovery payments in excess of expenditures and allows distribution to the appropriate parties, including providers, Beneficiaries, or insurers.	SMM			

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Ref#	System Review Criteria	Source	Yes	No	Comments
FI2.8	Maintains a history of refunds.	SMM			
FI2.9	Withholds the Federal share of payments to Medicaid providers to recover Medicare overpayments.	SMM CFR			
<i>FI2SS.1</i>	<i>Add first State-specific criteria for this business objective here.</i>				

FI3 – ENSURE THAT ALL FINANCIAL TRANSACTIONS RELATED TO PROGRAM DELIVERY ARE PROCESSED AS DEFINED BY STATE AND FEDERAL REGULATIONS

Ref#	System Review Criteria	Source	Yes	No	Comments
FI3.1	Tracks Medicare deductibles and coinsurance paid by Medicaid for all crossover claims, by Beneficiary and program type.	SMM			
FI3.2	Processes and retains all data from provider credit and adjustment transactions.	SMM			
FI3.3	Produces payment instruments (both warrants and EFT transactions) or transfers payment information to the payment issuing system.	IBP			
FI3.4	Issues a remittance advice detailing claims processing activity at the same time as the payment or payment information transfer.	SMM			
FI3.5	Ensures that the system supports sending electronic claim payment/advice transactions (ASC X12N 835) meeting the standards required by 45 CFR Part 162.	HIPAA			
FI3.6	Provides payment via electronic funds transfer (EFT) as an option.	SMM			
FI3.7	Nets provider payments against credit balances or accounts receivable amounts	SMM			

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Ref#	System Review Criteria	Source	Yes	No	Comments
	due in the payment cycle in determining the payment due the provider.				
FI3.8	Processes voids and replacements for incorrect payments or returned warrants, crediting fund source accounts and creating accounts receivable or credit balances where appropriate.	SMM			
FI3.9	Supports stop payment processes.	IBP			
FI3.10	Allows on-line access to accounts receivable or provider credit balances to authorized individuals.	IBP			
FI3.11	Allows on-line access to remittance advice through a Web-based browser.	IBP			
FI3.12	Provides support for identification and application of recovery funds and lump-sum payments.	IBP			
FI3.13	Identifies providers with credit balances and no claim activity during a state-specified number of months.	IBP			
FI3.14	Notifies providers when a credit balance or accounts receivable has been established.	IBP			
FI3.15	Displays adjustment/void in a separate section of the remittance advice.	IBP			
FI3.16	Allows for withholding of payments in cases of fraud or willful misrepresentation without first notifying the provider of its intention to withhold such payments.	CFR			
FI3.17	Supports refunding of Federal share of provider overpayments within 60 days from discovery of an overpayment for Medicaid services.	CFR			Changes to the Federal guidelines have affected this system review criteria. State Medicaid Director Letter (SMDL) #10-014 enhances and modifies this system review criterion.
FI3SS.1	Allows for configurable criteria to perform payment hold for multiple criteria (e.g., Fund Code, Category of Service, etc.) to support budget management.	State Self-Assessment			

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Ref#	System Review Criteria	Source	Yes	No	Comments
FI3SS.2	Automates the tracking and recoupment management processes to identify and recover payments made on behalf of ineligible beneficiaries.	State Self-Assessment			

FI4 – SUPPORT MANAGEMENT OF PROGRAM FUNDS

Ref#	System Review Criteria	Source	Yes	No	Comments
FI4.1	Provides a financial transaction application for processing non-claim specific financial transactions, including payouts, accounts receivable, refund checks, and returned warrants.	IBP			
FI4.2	Supports the process of issuing a manual check, retaining all data required for fund source determination, payee identification, and reason for check issuance.	IBP			
FI4.3	Updates records to reflect the processing of uncashed or cancelled (voided) Medicaid checks. Process replacements for lost or stolen warrants and updated records with new warrant information.	CFR			
FI4.4	Processes payments from providers for refunds and updates records as needed. Adjusts 1099/W2 reporting.	CFR			
FI4.5	Allows for history adjustments to claims processing to reflect changes in funding sources and other accounting actions that do not impact provider payment amounts or 1099/W2 reporting.	CFR			

FISS1 – AUTOMATE RECONCILIATION OF RETROSPECTIVE COST SETTLEMENTS AND OTHER SIMILAR COST ADJUSTMENTS FOR PROVIDERS, AS APPLICABLE

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Ref#	System Review Criteria	Source	Yes	No	Comments
FISS1.1					The Offeror should provide system review criteria for this business objective based upon its proposed solution.

FISS2 – IMPROVE FLEXIBILITY TO MANAGE MULTIPLE CONCURRENT FEDERAL MEDICAL ASSISTANCE PERCENTAGE RATES.

Ref#	System Review Criteria	Source	Yes	No	Comments
FISS2.1					The Offeror should provide system review criteria for this business objective based upon its proposed solution.

STATE: South Carolina	DATE OF REVIEW:	REVIEWER:
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HCBS WAIVERS (WA) CHECKLIST

HCBS WAIVERS CHECKLIST BACKGROUND

Background for this checklist:

1. This checklist targets HCBS waivers only. It does not address Medicaid system requirements for §1115 or §1915(b) managed care waivers. There is a separate set of checklists covering system requirements for managed care program interfaces.
2. This checklist applies when the State uses the Medicaid system to support provider enrollment, member enrollment/ disenrollment, service authorization, claims processing and payment, capitation payment, program integrity and quality management, and reporting functions for HCBS programs. If the HCBS programs are supported by processes and systems outside the scope of the Medicaid system receiving enhanced Federal matching funds, these external processes are not subject to the Federal certification review. More States are folding HCBS system functionality into the mainstream Medicaid system.
3. Automated support for HCBS programs is a miniature copy of basic Medicaid system functionality. This checklist does not incorporate all the requirements of Medicaid provider management, claims adjudication, and other core functions that are found in separate checklists, e.g., Provider Management, Claims Adjudication., and others.
4. This checklist covers requirements not found in non-waiver processes, e.g., “Enroll providers approved to render specialty care services to waiver target population.”
5. Most of the requirements in this checklist are derived from the Home and Community-Based Waiver (HCBS) Application Version 3.4, Technical Guide and Review Criteria, Version 3.4 dated November 2006. The document is updated at least annually. The certification review team should find out if any changes to the application document will affect the certification review criteria in this checklist and update those criteria that are affected prior to conducting the State certification review.
6. The authority for operating a HCBS program is found in §1915(c) of the Social Security Act. §1915(c) which authorizes the Secretary of Health and Human Services to waive certain Medicaid statutory requirements so that a State may offer home and community-based services to State-specified target group(s) who need a level of institutional care provided under the Medicaid State plan. This provision was added to the Act by §2176 of Public Law (P.L.) 97-35 (OBRA 1981) and amended by P.L. 99-272 (COBRA 1985), P.L. 99-509 (OBRA 1986), P.L. 101-508 (OBRA 1990), and §4743 of P.L. 105-33 (BBA 1997).
7. In addition to specific source references to HCBS requirements, the State Medicaid Manual Part 11 Chapter 2, § 2700 requires that the MMIS produce program data necessary to satisfy Federal Medicaid reporting requirements.

Sources for the criteria in this checklist are as follows:

HCBS - Home and Community Based Services waiver program. Application form available from

http://www.cms.hhs.gov/HCBS/02_QualityToolkit.asp

BUSINESS OBJECTIVES		
Reference #	Business Objectives	Comments
WA1	Control enrollment of participants into the HCBS (1915(c)) waiver programs to meet the State's objectives.	
WA2	Enroll traditional and nontraditional service providers meeting identified standards of care into the program to provide services to the target population.	<p>The HCBS Waivers checklist and the Provider Management checklist have many similar and overlapping areas. Rather than duplicate information between the checklists, the combination of all provider business objectives and system review criteria from each checklist are required for all provider types unless a particular item is not reasonable to apply to all provider types.</p> <p>The state currently holds contracts with some of its waiver providers.</p>
WA3	Provide services as described in the individual's approved plan of care.	
WA4	Process waiver provider claims and make timely and accurate payments.	
WA5	Produce program data necessary to satisfy Federal Medicaid reporting requirements, monitor utilization, and assess quality of care provided to participants	
WASS1	<i>Add State-specific business objectives for the HCBS Waiver checklist here.</i>	

WA1 – CONTROL ENROLLMENT IN WAIVER PROGRAMS

Ref#	System Review Criteria	Source	Yes	No	Comments
WA1.1	Identifies unduplicated participants enrolled in 1915 (c) waiver program.	HCBS			
WA1.2	Tracks and reports the number of unduplicated participants in the 1915 (c) waiver program.	HCBS			
WA1.3	Generates notices or alerts to agency if number of unduplicated participants enrolled in the wavier program exceeds the number of participants approved in the waiver application.	HCBS			
WA1.4	Identifies the date a participant is assessed to meet the waiver level of care (LOC) and the date of the LOC reevaluation.	HCBS			
WA1SS.1	Updates the eligibility system with updated Waiver member enrollment information.	State Self-Assessment			In addition to receiving waiver enrollment information from the new MMIS system, the eligibility system will receive additional waiver enrollment information from the State's Phoenix case management system.
WA1SS.2	Produces program data and reports in order to satisfy any Federal or State requirements regarding actions to terminate or deny provider participation in the Medicaid waiver program.	IBP			

WA2 – ENROLL TRADITIONAL AND ATYPICAL WAIVER PROVIDERS

Ref#	System Review Criteria	Source	Yes	No	Comments
WA2.1	Captures enrollment information, including National Provider Identifier (NPI) if required, on entity or individual meeting the qualifications contained in the provider agreement including geographic locations and capitation or Fee-for Service (FFS) rates.	HCBS CFR			Note that some HCBS waivers use interim rates that are subject to cost settlement.
WA2.2	Prevents enrollment of entities and individuals who do not meet the provider qualifications contained in the provider agreement.	HCBS CFR			
WA2.3	Updates information as changes are reported.	IBP			
WA2.4	Captures termination information when a waiver provider voluntarily terminates or a provider agreement is cancelled.	IBP			
WA2.5	Prohibits enrollment of providers affiliated with individuals debarred by State or Federal Agencies, listed in Abuse Registries, or otherwise unqualified to provide service.	HCBS			
WA2SS.1	<i>Add State-specific criteria for this objective here.</i>				

WA3 – PROVIDE SERVICES AS DESCRIBED IN THE PLAN OF CARE

Ref#	System Review Criteria	Source	Yes	No	Comments
WA3.1	Stores the plan of care and makes it available for viewing.	HCBS			
WA3.2	Produces monitoring reports to determine if services approved in the plan of care are provided.	HCBS			
WA3.3	Identifies the date a participant's plan of care (POC) assessment is completed and the date of the next POC re-evaluation, if applicable.	HCBS			
WA3SS.1	<i>Add State-specific criteria for this objective here.</i>				

WA4 – PROCESS WAIVER CLAIMS AND MAKE TIMELY AND ACCURATE PAYMENTS

Ref#	System Review Criteria	Source	Yes	No	Comments
WA4.1	Processes claims for medical services	HCBS			
WA4.2	Applies edits to prevent payments for services covered under a waiver program to a Medicaid provider who does not have a provider agreement.	HCBS			
WA4.3	Prevents or suspends payments for Beneficiaries who have become ineligible for Medicaid.	HCBS			
WA4.4	Suspends payments for waiver services furnished to individuals who are inpatients of a hospital, nursing facility or ICF/MR and sends notice to the provider of the admission. (If the State has approved personal care retainer, or respite services provided in an ICF/MR building but not covered under the ICF/MR benefit, an exception may be made.)	HCBS			
WA4.5	Limits payment for services to those described within the Beneficiary's approved plan of care. Deny claims exceeding dollar or utilization limits approved in waiver or exceeding the approved individual waiver budget cap.	HCBS			
WA4.6	Edits waiver services claims for prior authorization, if applicable.	HCBS			
WA4.7	Edits waiver services claims for Third Party Liability (TPL) coverage prior to payment to ensure Medicaid is the payer of last resort.	HCBS			
WA4.8	Edits waiver services claims for Beneficiary cost share of premium or	HCBS			

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	enrollment fees prior to payment.				
WA4SS.1	Add State-specific criteria for this objective here.				

WA5 – SATISFY FEDERAL REPORTING REQUIREMENTS, MONITOR UTILIZATION, AND ASSESS QUALITY OF CARE

Ref#	System Review Criteria	Source	Yes	No	Comments
WA5.1	Gathers data and produces a variety of financial reports to facilitate cost reporting and financial monitoring of waiver programs.	HCBS SMM			This item is out of scope as the CMS 372 reports are produced by the BIS contractor. The Replacement MMIS must capture and maintain any needed data to support Federally required report, and must provide the data to the BIS contractor, as needed.
WA5.2	Gathers data and produces utilization reports for monitoring cost neutrality of waiver services to a target population. The average cost of waiver services cannot be more than the cost of alternative institutional care. State may define average either in aggregate or for each participant.	HCBS			This item is out of scope as the CMS 372 reports are produced by the BIS contractor. The Replacement MMIS must capture and maintain any needed data to support Federally required report, and must provide the data to the BIS contractor, as needed.
WA5.3	Accesses individual Beneficiary claims and/or encounter histories to extract data needed to produce annual report to CMS on cost neutrality and amount of services.	HCBS SMM			The CMS 372 reports are produced by the BIS contractor. The Replacement MMIS must capture and maintain any needed data to support Federally required report, and must provide the data to the BIS contractor, as needed.
WA5.4	Collects and stores data needed to produce reports consistent with data collection plan to assess quality and appropriateness of care furnished to participants of the waiver program.	HCBS			
WA5.5	Monitors provider capacity and capabilities to provide waiver services to enrolled participants.	HCBS			

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Ref#	System Review Criteria	Source	Yes	No	Comments
WA5SS.1	Add State-specific criteria for this objective here.				

FIRST STATE-SPECIFIC OBJECTIVE

Ref#	System Review Criteria	Source	Yes	No	Comments
WASS1.1	Add criteria based on the APD, RFP, etc., that are relevant to this State-specific objective.				

STATE: South Carolina	DATE OF REVIEW:	REVIEWER:
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IMMUNIZATION REGISTRY OWNED (RO) CHECKLIST

(Registry Developed and Operated by Medicaid Agency)

IMMUNIZATION REGISTRY – MEDICAID OWNED BACKGROUND

Background for this checklist:

1. This checklist is used when the Immunization Registry is designed as part of the Medicaid Enterprise and is operated by the Medicaid agency.
2. Medicaid may participate in other registries (e.g., Cancer). Additional checklists would be needed to cover other registries.

Sources for the criteria in this checklist are as follows:

AT – Action transmittal #: DSS-CMSO-AT-00-001 issued July 6, 2000. Items are mandatory for a Medicaid Owned Registry. The AT can be found at <http://www.cms.hhs.gov/smdl/downloads/smd070600.pdf>

AT-Opt - Action transmittal #: DSS-CMSO-AT-00-001 issued July 6, 2000. Items are optional for a Medicaid Owned Registry.

IBP – Industry Best Practice. Items are selected from RFPs for MMISs developed by states and approved by CMS.

BUSINESS OBJECTIVES

Reference #	Business Objectives	Comments
RO1	Ensure standardized data is available for measuring immunizations provided to protect all children in the State from communicable diseases.	This checklist is not directly applicable to System Certification as SCDHHS does not own the immunization registry in South Carolina.
RO2	Make Beneficiary-specific vaccination history available to authorized providers at time of encounter to ensure appropriate vaccinations are provided.	
RO3	Generate reminders and recall vaccination notices to parents or guardians for each child registered at intervals when	

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Reference #	Business Objectives	Comments
	vaccination is needed.	
RO4	Monitor and report vaccination rates for all children within a statewide area.	
RO5	Ensure the privacy and security of vaccination records stored in the immunization registry.	
RO6	Provide interfaces to and from the registry.	
ROSS1	<i>Add State-specific business objectives for the Immunization Registry Owned (RO) Checklist here.</i>	

RO1 – ENSURE STANDARDIZED DATA IS AVAILABLE

Ref#	System Review Criteria	Source	Yes	No	Comments
RO1.1	<p>Stores and retrieves immunization information including:</p> <ul style="list-style-type: none">• Medicaid identifier• Demographic information<ul style="list-style-type: none">• Child's first, last & middle names• Birth date• Sex• Birth state/county• Race/ethnicity• Guardian's first, last & middle names• Optional fields from HL-7 code set• Vaccination information:<ul style="list-style-type: none">• Type• Date• Name of service provider	AT			

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Ref#	System Review Criteria	Source	Yes	No	Comments
	<ul style="list-style-type: none"> Adoption information Death information Identifier for contraindications Exemptions indicator Reminder/recall notice dates 				
RO1.2	Contains fields for time periods of Medicaid eligibility.	AT-Opt			
RO1.3	Contains fields that identify the Primary Care Provider/Medical Home for a Medicaid child	AT-Opt			
RO1.4	Contains fields that identify the vaccine manufacturer and lot number.	AT-Opt			
RO1.5	Contains fields that record & track family member/household visits.	AT-Opt			
RO1.6	Establishes a registry record for children no later than six weeks after birth or six weeks after they have been otherwise entered into the State's Information management system. Maintains record until child reaches the age of 18.	AT			
RO1.7	Maintains the individuals in the automated IR until date of death; records date of death.	AT-Opt			
RO1.8	Identifies Beneficiary-specific contraindications and personal and/or philosophical exemptions to the scheduled vaccinations	AT			
RO1.9	Generates standard data entry forms for use by providers for collection of vaccination information.	IBP			
RO1.10	Accepts, processes, and consolidates immunization records from multiple sources into a central repository within a specified time frame.	AT			
RO1.11	Edits vaccination information for data validity, duplicate records and performs quality checks.	AT			

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Ref#	System Review Criteria	Source	Yes	No	Comments
RO1.12	Integrates the vaccination histories for the entire population of children 0 to 18 years (statewide) with Medicaid children into the data repository.	AT			
RO1.13	Allows change to periodicity schedules for vaccinations (e.g., capability to add/delete vaccines as new vaccinations are added to the recommended schedule and others are removed).	AT			
RO1.14	Provides a mechanism for providers to submit Beneficiary-specific vaccination information to the registry; validates that information received within one month of vaccine administration; flags late notices for staff action.	AT			
RO1.15	Receives and processes vaccination reports from service providers in an electronic format using the HL-7 defined code set for exchanging information.	AT			
RO1SS.1	<i>Add State-specific criteria for this objective here.</i>				

RO2 – MAKE VACCINATION HISTORY AVAILABLE TO PROVIDERS

Ref#	System Review Criteria	Source	Yes	No	Comments
RO2.1	Provides authorized providers the capability to view a child's vaccination history at the time of encounter.	AT			
RO2SS.1	<i>Add State-specific criteria for this objective here.</i>				

RO3 – PROVIDE NOTICES AND ALERTS

Ref#	System Review Criteria	Source	Yes	No	Comments
RO3.1	Generates letters and/or alerts to parents or guardians of all children at scheduled intervals using recorded Name and Address fields.	AT			
RO3.2	Generates notices and alerts to providers of the Centers for Disease Control and Prevention (CDC) changes to vaccination protocols.	IBP			
RO3SS.1	<i>Add State-specific criteria for this objective here.</i>				

RO4 – MONITOR AND REPORT IMMUNIZATION COVERAGE

Ref#	System Review Criteria	Source	Yes	No	Comments
RO4.1	Provides automated determination of immunizations needed in compliance with CDC recommendations.	AT			
RO4.2	Tracks and reports on Beneficiary-specific vaccinations needed in accordance with CDC guidelines.	AT			
RO4.3	Measures immunization coverage using current CDC “age-appropriate” recommendations: <ul style="list-style-type: none"> by date for an individual provider’s practice; for the registry’s entire geographic area; and for subgroups within a practice of the geographic area. 	AT			
RO4.4	Monitors and reports on children enrolled in the Registry at birth.	IBP			
RO4.5	Monitors and reports on children enrolled in the Registry with known contraindications to vaccination.	IBP			
RO4.6	Monitors and reports on children enrolled in the Registry exempt from vaccination	IBP			
RO4.7	Generates reports on vaccine-associated adverse events.	AT-Opt			
RO4.8	Generates scheduled reports from the Medicaid Management Information System (MMIS) Report Repository: <ul style="list-style-type: none"> Measures immunization coverage using current CDC “age appropriate” recommendations by date for an individual provider’s 	IBP			

Ref#	System Review Criteria	Source	Yes	No	Comments
	<p>practice, for the registry's statewide area, and for subgroups within a practice of the statewide area.</p> <ul style="list-style-type: none"> Measures immunization coverage for Medicaid compared to non-Medicaid populations. Monitors and reports on Medicaid children enrolled in Registry at birth; with contraindications and exemptions Generates reports and data exchange to satisfy the Centers for Medicare & Medicaid Services (CMS) Early Periodic Screening, Diagnosis and Treatment (EPSDT) 				
RO4.9	Allows for surveillance of vaccine-preventable diseases.	AT-Opt			
RO4.10	Enables analysis through Geographic Information Systems (GIS).	AT-Opt			
RO4.11	Provides support for automated back-up and recovery of the IR, with backup data stored in a separate location.	AT			
RO4.12	Generates automated vaccine inventory reports.	AT-Opt			
RO4.13	Generates reports on management and wastage of vaccine inventories	AT-Opt			
RO4SS.1	Add State-specific criteria for this objective here.				

RO5 – MAINTAIN PRIVACY AND SECURITY OF VACCINATION RECORDS

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Ref#	System Review Criteria	Source	Yes	No	Comments
RO5.1	<p>Complies with provisions for Administrative Simplification under the HIPAA of 1996 to ensure the confidentiality, integrity, and availability of Electronic Protected Health Information (ePHI):</p> <ul style="list-style-type: none"> Provides safeguards as described in the October 22, 1998 State Medicaid Director letter, Collaborations for Data Sharing between State Medicaid and Health Agencies. Performs regular audits, and Supports incident reporting. 	AT			
RO5.2	Provides safeguards as described in the October 22, 1998 State Medicaid Director letter, Collaborations for Data Sharing between State Medicaid and Health Agencies.	AT			
RO5SS.1	<i>Add State-specific criteria for this objective here</i>				

RO6 – PROVIDE INTERACES TO AND FROM THE REGISTRY

Ref#	System Review Criteria	Source	Yes	No	Comments
RO6.1	If a separate, state wide registry exists, exchanges data with this registry on at least a weekly basis.	AT			
RO6.2	To the extent possible, provides for interfaces with other systems within the State, such as: a. Child Welfare (SACWIS) b. Women, Infants and Children (WIC) c. Early Periodic Screening, Diagnosis and Treatment (EPSDT) Program d. Bureau of Vital and Health Statistics e. Children's Health Insurance Program (S-CHIP) f. Public Health Clinics g. Health Information Systems (HIS) h. Vaccine Management System (VACMAN) (CDC) i. Other	AT-Opt			
RO6SS.1	<i>Add State-specific criteria for this objective here.</i>				

ROSS1 – FIRST STATE-SPECIFIC OBJECTIVE

Ref#	System Review Criteria	Source	Yes	No	Comments
ROSS1	<i>Add criteria based on the APD, RFP, etc., that are relevant to this State-specific objective here.</i>				

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IMMUNIZATION REGISTRY (RI) CHECKLIST (MMIS Interfaced to Registry)

IMMUNIZATION REGISTRY INTERFACED BACKGROUND

Background for this checklist:

1. This checklist is used when the MMIS sends data to an immunization registry developed and maintained by an entity other than the State Medicaid agency. Certification review will examine the interfaces but not the registry itself.
2. Medicaid may participate in other registries (e.g., Cancer). Additional checklists would be needed to cover other registries.

Sources for the criteria in this checklist are as follows:

AT – Action transmittal #: DSS-CMSO-AT-00-001 issued July 6, 2000. Items are mandatory for a Medicaid Owned Registry. The AT can be found at <http://www.cms.hhs.gov/smdl/downloads/smd070600.pdf>

AT-Opt - Action transmittal #: DSS-CMSO-AT-00-001 issued July 6, 2000. Items are optional for a Medicaid Owned Registry.

IBP – Industry Best Practice. Items are selected from RFPs for MMISs developed by states and approved by CMS.

BUSINESS OBJECTIVES

Reference #	Business Objectives	Comments
RI1	Ensure standardized data is available for measuring immunizations provided to protect all children in the State from communicable diseases.	The SC Department of Health & Environmental Control (DHEC) owns the Immunization Registry in SC. Therefore, this checklist will be used during System Certification.
RI2	Generate reminders and recall vaccination notices to parents or guardians for each Medicaid child registered at intervals when vaccination is needed.	

Reference #	Business Objectives	Comments
RI3	Meet Federal reporting requirements for reporting vaccination rates for Medicaid children enrolled in the Early Periodic Screening, Diagnosis and Treatment (EPSDT) Program.	
RI4	Ensure the privacy and security of immunization information in transit and at rest.	
RISS1	<i>Add State-specific business objectives for the Immunization Registry (RI) Checklist here.</i>	

RI1 – ENSURE STANDARDIZED DATA IS AVAILABLE

Ref#	System Review Criteria	Source	Yes	No	Comments
RI1.1	Collects and maintains claims history for vaccinations at the Beneficiary-specific level until the Beneficiary is 18 years of age.	AT			
RI1.2	Interfaces with a statewide automated immunization registry and allows regularly scheduled data exchanges. <ul style="list-style-type: none"> Populates the statewide automated registry to fully populate the registry with Medicaid children. Populates the statewide automated registry with Medicaid claims for children receiving immunizations. 	AT			The Replacement MMIS interfaces with a common state repository maintained by the Office of Research and Statistics (ORS) that the SC Department of Health & Environmental Control (DHEC) utilizes.
RI1.3	Sends, at a minimum, the following information to a statewide immunization registry through the interface: <ul style="list-style-type: none"> Medicaid identifier Demographic information CPT/billing procedure code 	AT			The Replacement MMIS interfaces with a common state repository maintained by the Office of Research and Statistics (ORS) that the SC Department of Health & Environmental Control (DHEC) utilizes.

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Ref#	System Review Criteria	Source	Yes	No	Comments
	<ul style="list-style-type: none"> Identify rendering service provider Reminder/recall notice dates 				
RI1.4	Edits data for data validity, duplicate records and performs quality checks; sends error message if appropriate.	AT			

RI2 – PROVIDE NOTICES AND ALERTS

Ref#	System Review Criteria	Source	Yes	No	Comments
RI2.1	Generates letters and/or alerts to parents or guardians of Medicaid children at scheduled intervals.	AT			
<i>RI2SS.1</i>	<i>Add State-specific criteria for this objective here.</i>				

RI3 – MONITOR AND REPORT IMMUNIZATION COVERAGE

Ref#	System Review Criteria	Source	Yes	No	Comments
RI3.1	Tracks and reports on vaccinations due and/or provided to children enrolled in Medicaid or State Children's Health Insurance Programs (SCHIP) in accordance with the Centers for Disease Control (CDC) guidelines.	AT			
RI3.2	Measures immunization coverage for the Medicaid population using current EPSDT periodicity schedule.	AT			
RI3.3	Selects and sends data to the registry at least on a weekly basis.	AT			

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Ref#	System Review Criteria	Source	Yes	No	Comments
RI3.4	Generates reports on vaccine-associated adverse event reporting.	AT-Opt			
RI3.5	Generates results of surveillance of vaccine-preventable diseases.	AT-Opt			
RI3.6	Enables analysis through Geographic Information Systems (GIS).	AT-Opt			
RI3.7	Allows for automated vaccine inventory reporting, manages vaccine inventories, and generates reports on management and wastage.	AT-Opt			
RI3.8	Allows periodic reports to be received and stored within the MMIS Report Repository: <ul style="list-style-type: none"> Measures immunization coverage for Medicaid compared to non-Medicaid populations Provides data exchange to MMIS to satisfy/enhance the Federal EPSDT reporting requirements 	IBP			
<i>RI3SS.1</i>	<i>Add State-specific criteria for this objective here.</i>				

RI4 – MAINTAIN PRIVACY AND SECURITY OF VACCINATION RECORDS

Ref#	System Review Criteria	Source	Yes	No	Comments
RI4.1	Complies with provisions for Administrative Simplification under the Health Insurance Portability and Accountability Act (HIPAA) of 1996 to ensure the confidentiality, integrity, and availability of Electronic Protected Health Information (ePHI) in transit and at rest.	AT			
RI4.2	Provides safeguards as described in the October 22, 1998 State Medicaid Director letter, Collaborations for Data Sharing between State Medicaid and Health Agencies.	AT			
<i>RI4SS.1</i>	<i>Add State-specific criteria for this objective here</i>				

RISS1 – FIRST STATE-SPECIFIC OBJECTIVE

Ref#	System Review Criteria	Source	Yes	No	Comments
<i>RISS1.1</i>	<i>Add criteria based on the APD, RFP, etc., that are relevant to this State-specific objective</i>				

STATE: South Carolina	DATE OF REVIEW:	REVIEWER:
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MANAGED CARE ORGANIZATION INTERFACES (MC) CHECKLIST

MANAGED CARE ORGANIZATION INTERFACES (MC) CHECKLIST BACKGROUND

Background for this checklist:

This checklist is used to assess the interfaces between the MMIS and the MCO and reports produced by the MMIS using MCO encounter and capitation payment data.

1. Managed Care Organization (MCO) encompasses different forms of risk bearing, comprehensive health care service organizations including Health Maintenance Organizations (HMO), State-regulated MCO, county or locally operated health care organizations, and other models. The MCO assumes risk to deliver a comprehensive and defined benefit package to enrolled members for a fixed monthly premium payment.
2. Most States have at least one form of MCO. Some States have created a number of different models. This checklist should cover all types of MCO.
3. The checklist assumes that the member enrollment function is covered in the separate Managed Care Enrollment Checklist. Direct communications between the MMIS and MCO information system for the purposes of exchanging member enrollment information are included within the Managed Care Enrollment Checklist.
4. The checklist covers provider enrollment into the MCO, capitation payment, encounter data collection, and Medicaid review activities supported by MCO data processed by the MMIS. It does not cover activities performed by the MCO itself.
5. The Medicaid agency may use other resources external to the MMIS for managing the MCO contractors. The requirements in this checklist assume that the MMIS is the source of data collection and analysis used to manage the MCOs.

Sources for the criteria in this checklist are as follows:

CFR – Code of Federal Regulations, available from <http://www.access.gpo.gov/uscode/title42/title42.html>

IBP – Industry Best Practice. Items are selected from RFPs for MMISs developed by states and approved by CMS.

HIPAA – HIPAA act, available from

http://www.cms.hhs.gov/TransactionCodeSetsStandards/02_TransactionsandCodeSetsRegulations.asp

BUSINESS OBJECTIVES

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Reference #	Business Objectives	Comments
MC1	Support assessment of members' access to services.	SCDHHS currently contracts with several Managed Care Organizations (MCOs), a Medical Home Network and an Enrollment Broker contractor. The Contractor/Replacement MMIS must interface with the MCOs, Medical Home Network and the Enrollment Broker contractor to meet the business objectives (MC1 – MC8) and system review criteria.
MC2	Make accurate payment to MCO for managed care services provided to enrolled members.	
MC3	Receive, process, and store MCO encounter records for use by the Medicaid agency in managing MCO performance.	
MC4	Provide information to support assessing quality and cost of care provided to enrollees.	
MC5	Identify services covered under capitation premiums and block duplicate fee-for-service payments and supplemental payments to providers.	
MC6	Collect and report on financial data related to Medicaid managed care programs	
MC7	Collect data and provide reporting to support MCO contractor monitoring (optional).	
MC8	Support specific functions, as applicable, related to the administration of Section 1115 Waiver	
MCSS1	<i>Add State-specific business objectives for the Managed Care Organization Interfaces Checklist here.</i>	

MC1 – SUPPORT ASSESSMENT OF MEMBER ACCESS TO SERVICES

Ref#	System Review Criteria	Source	Yes	No	Comments
MC1.1	Captures information on contracted MCOs, including geographic locations, capitation rates, and organization type.	IBP			
MC1.2	Captures information identifying contracted providers within MCO network, including PCPs.	CFR			
MC1.3	Captures information identifying physicians who have agreed to provide gatekeeper services, number of Beneficiaries assigned, and capacity to accept additional patients.	IBP			
MC1.4	Accepts and processes update information as changes are reported.	IBP			
MC1.5	Captures termination information when an MCO contract is cancelled.	IBP			
MC1.6	Removes and end-dates PCP status from MCO (optional if States require MCO to identify PCPs).	IBP			
MC1.7	Provides information to support assessment of adequacy of provider network. This includes identifying and collecting data on the number and types of providers and provider locations.	CFR			This item is out of scope and is currently supported by the Enrollment Broker contractor.
MC1.8	Provides information to support review of new enrollments and to prohibit affiliations with individuals debarred by Federal Agencies.	CFR			This item is out of scope and is currently supported by the Enrollment Broker contractor.
MC1SS.1	<i>Add State-specific criteria for this objective here.</i>				

MC2 – MAKE ACCURATE PAYMENTS TO MCOs

Ref#	System Review Criteria	Source	Yes	No	Comments
MC2.1	Calculates per-member per-month (PMPM) capitation payment based on State-defined rate factors such as age, sex, category of eligibility, health status, geographic location, and other.	IBP			
MC2.2	Computes capitation payment for the actual number of days of eligibility in a month (i.e., enrollee may not be enrolled for a full month).	IBP			
MC2.3	Identifies individuals/enrollees who have terminated enrollment, disenrolled, or are deceased, and excludes those individuals from the monthly MCO capitation payment.	IBP			
MC2.4	Generates regular capitation payments to MCOs, at least on a monthly basis in compliance with HIPAA-standard X12 820 Premium Payment transaction where applicable.	IBP			
MC2.5	Adjusts capitation payment based on reconciliation of errors or corrections (e.g., retroactive adjustments to a particular capitation payment based on more accurate data that the MMIS obtains retroactively on member enrollments, disenrollments, and terminations).	IBP			
MC2.6	Performs mass adjustment to rates according to State policy (e.g., annual adjustment, negotiated rate change, court settlement).	IBP			
MC2.7	Performs periodic reconciliations of State member records with MCO, PCP enrollment records.	IBP			

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Ref#	System Review Criteria	Source	Yes	No	Comments
MC2.8	Verifies correct transfer of capitation payment when member disenrolls from one MCO and enrolls in another plan.	IBP			
MC2.9	Supports ANSI X12N 820 Premium Payment transaction as required by HIPAA.	HIPAA			
MC2SS.1	<i>Add State-specific criteria for this objective here.</i>				

MC3 – RECEIVE AND PROCESS ENCOUNTER RECORDS FROM MCOs

Ref#	System Review Criteria	Source	Yes	No	Comments
MC3.1	Collects and stores encounter data on a periodic basis.	CFR			
MC3.2	Applies key edits to encounter data, e.g., MCO, physician, member ID numbers; diagnosis and procedure codes. (Note: the encounter record edits can be different from claims edits.)	IBP			
MC3.3	Returns erroneous encounter data for correction.	IBP			
MC3.4	Performs adjustments to encounter data.	IBP			
MC3.5	Periodically produces reports for audits on accuracy and timeliness of encounter data, including matching encounter record to MCO paid claim and to the provider's billing.	IBP			
MC3.6	Able to calculate the "Encounter Cost Value," or the cost of services reported on the encounter claim had they been paid on a fee-for-service basis	IBP			
MC3.7	Accepts and processes encounter claims in formats as mandated by HIPAA, e.g.,	HIPAA			

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Ref#	System Review Criteria	Source	Yes	No	Comments
	X12N837.				
MC3SS.1	Add State-specific criteria for this objective here.				

MC4 – PROCESS MCO DATA FOR USE IN ASSESSING QUALITY AND COST OF CARE

Ref#	System Review Criteria	Source	Yes	No	Comments
MC4.1	Accesses and reports on encounter data for the purpose of monitoring appropriateness of care.	CFR			
MC4.2	Accesses and reports on encounter data for use in the determination of re insurance to calculate true out-of-pocket costs.	IBP			
MC4.3	Accesses and reports on encounter data for use in profiling MCOs and comparing utilization statistics.	IBP			
MC4.4	Collects and sorts encounter data for use in completing MSIS reports.	IBP			
MC4.5	Collects and sorts encounter data for use in determining capitation rates.	IBP			
MC4.6	Processes encounter data to detect underutilization of services by enrollees of the MCO.	CFR			
MC4.7	Matches capitation summary data and fee for-service (FFS) claims data to verify that the MCO payments do not exceed FFS upper limits.	IBP			
MC4.8	Compares FFS claims statistics and encounter data, re: cost of care, timeliness of care, quality of care, outcomes.	IBP			

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Ref#	System Review Criteria	Source	Yes	No	Comments
MC4.9	Accesses encounter data to identify persons with special health care needs, as specified by the State.	IBP			
MC4.10	Produces reports to identify network providers and assess enrollee access to services.	IBP			
MC4.11	Is able to produce managed care program reports by category of service, category of eligibility, and by provider type.	IBP			
MC4.12	Periodically generates member satisfaction surveys.	IBP			This item is out of scope and is currently supported by the Enrollment Broker contractor.
MC4SS.1	<i>Add State-specific criteria for this objective here.</i>				

MC5 – IDENTIFY MCO-COVERED SERVICES AND BLOCK DUPLICATE PAYMENTS

Ref#	System Review Criteria	Source	Yes	No	Comments
MC5.1	Blocks payment to fee-for-service (FFS) providers for services included in the MCO benefit package, with the exceptions stated per the State Plan.	CFR			
MC5.2	Allows fee-for-service (FFS) payment to providers for services carved out of the MCO benefit package. (These services are usually delivered by providers external to the MCO.)	IBP			
MC5.3	Allows payment to fee-for-service (FFS) providers for services rendered in pre-enrollment periods or other periods of transition.	IBP			
MC5.4	Allows payment for treatment obtained by an enrollee for an emergency medical condition without prior authorization.	CFR			

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Ref#	System Review Criteria	Source	Yes	No	Comments
MC5SS.1	Add State-specific criteria for this objective here.				

MC6 – SUPPORT REPORTING OF FINANCIAL INFORMATION

Ref#	System Review Criteria	Source	Yes	No	Comments
MC6.1	Generates reports of capitation payment by various categories (e.g., by eligibility group, rate cell, etc.).	IBP			
MC6.2	Generates fee-for-service (FFS) claims reporting for services furnished outside of a capitation agreement (i.e., for services “carved-out” of the managed care program).	IBP			
MC6SS.1	Add State-specific criteria for this objective here.				

MC7 – SUPPORT MEDICAID MANAGED CARE CONTRACTOR MONITORING (OPTIONAL)

Ref#	System Review Criteria	Source	Yes	No	Comments
MC7.1	Collects basic administrative information, for instance: <ul style="list-style-type: none"> the identification of an MCO contract start and end dates contract period/year 	IBP			

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	<ul style="list-style-type: none"> • capitation effective date • maximum enrollment threshold • enrollee count • member month • re-insurance threshold 				
MC7SS.1	Add State-specific criteria for this objective here.				

MC8 – SUPPORT ADMINISTRATION OF SECTION 1115 WAIVERS

Ref#	System Review Criteria	Source	Yes	No	Comments
MC8.1	Identifies Beneficiaries who are eligible for a State's Medicaid program by qualifying under a Section 1115 waiver eligibility expansion group. Distinguishes the "1115 expansion eligibles" from other groups of Medicaid-eligibles.	IBP			This item is out of scope and is currently supported by the Eligibility System (MEDS).
MC8.2	Collects and maintains the data necessary to support the budget neutrality reporting requirements as specified in the State's 1115 Waiver (including the ability to identify those Beneficiaries who would be ineligible for Medicaid in the absence of the State's 1115 Waiver).	IBP			This item is out of scope and is currently supported by the Eligibility System (MEDS).
MC8SS.1	Add State-specific criteria for this objective here.				

MCSS1 – FIRST STATE-SPECIFIC OBJECTIVE

Ref#	System Review Criteria	Source	Yes	No	Comments
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MCSS1.1	Add criteria based on the APD, RFP, etc., that are relevant to this State-specific objective.				
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PIHP AND PAHP MANAGED CARE (MP) CHECKLIST

PIHP AND PAHP MANAGED CARE CHECKLIST BACKGROUND

Background for this checklist

1. Prepaid Inpatient Health Plan (PIHP) and Prepaid Ambulatory Health Plan (PAHP) are models of managed care that limit risk and/or the scope of benefits to a less-than a risk comprehensive (MCO-type) package (e.g., inpatient mental health, dental services).
2. Members may be automatically enrolled in PIHP and PAHP programs (no choice) or voluntary enrolled.
3. PIHP and PAHP specific reporting requirements are identified below in the body of the checklist.
4. Managed Care Enrollment business processes are covered in a separate checklist. Reference to Enrollment in this checklist covers requirements in the PAHP/PIHP interfaces

Sources for the criteria in this checklist are as follows:

CFR – Code of Federal Regulations, available from <http://www.access.gpo.gov/uscode/title42.html>

IBP – Industry Best Practices. Items are selected from RFPs for MMISs developed by states and approved by CMS.

HIPAA – HIPAA act, available from

http://www.cms.gov/TransactionCodeSetsStandards/02_TransactionsandCodeSetsRegulations.asp

BUSINESS OBJECTIVES

Reference #	Business Objectives	Comments
MP1	Support accurate and timely automatic or choice-based enrollment of Medicaid eligibles into a PIHP and PAHP.	SCDHHS does not currently utilize PIHP and PAHP managed care services. Business objectives MP1 – MP6 and their associated system review criteria are out of scope.
MP2	Monitor access to and availability of qualified providers to serve participants enrolled in PIHP and PAHP.	

Reference #	Business Objectives	Comments
MP3	Make accurate and timely payment to providers for managed care services provided.	
MP4	Receive and process encounter records from PIHP/PAHP and/or its providers.	
MP5	Monitor quality and cost of care provided to enrollees.	
MP6	Identify services covered under capitation premiums and deny duplicate fee-for-service payments.	
MPSS1	<i>Add State-specific business objectives for the PIHP and PAHP Managed Care (MP) Checklist here.</i>	

MP1 – SUPPORT ENROLLMENT INTO A PIHP OR PAHP

Ref#	System Review Criteria	Source	Yes	No	Comments
MP1.1	Captures enrollee choice of (or assignment to) a PIHP or PAHP, and enters into Beneficiary record.	CFR			
MP1.2	Displays enrollees associated with a PIHP or PAHP.	IBP			
MP1.3	Disenrolls member from a PIHP or PAHP.	CFR			
MP1.4	Allows disenrollment from a PIHP or PAHP without cause during the 90 days following the date of the enrollee's initial enrollment and at least once every 12 months thereafter.	CFR			
MP1.5	Automatically disenrolls and re-enrolls members in new plans during periods of open enrollment or when a PIHP or PAHP goes out of business.	CFR			
MP1.6	Automatically disenrolls member from a terminated PIHP or PAHP and places in regular fee-for-services status.	CFR			

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Ref#	System Review Criteria	Source	Yes	No	Comments
MP1.7	Generates enrollment and disenrollment notices to a Beneficiary.	CFR			
MP1.8	Identifies Beneficiaries excluded from enrollment, subject to mandatory enrollment, or free to voluntarily enroll in a PIHP or PAHP.	CFR			
MP1.9	Automatically re-enrolls a beneficiary who is disenrolled solely because he or she loses Medicaid eligibility for a period of two months or less (optional if State Plan so specifies).	CFR			
MP1.10	Generates periodic enrollment and timely notification of changes for active Medicaid members to each PIHP or PAHP provider.	CFR			
MP1.11	Supports ANSI X12N 834 transaction as required by HIPAA.	HIPAA			
MP1SS.1	<i>Add State-specific criteria for this objective here.</i>				

MP2 – MONITOR ACCESS AND AVAILABILITY TO QUALIFIED PROVIDERS

Ref#	System Review Criteria	Source	Yes	No	Comments
MP2.1	Captures information on contracted PIHP or PAHP, including geographic locations, capitation rates, and organization type.	IBP			
MP2.2	Identifies contracted providers within PIHP or PAHP network, including PCPs, specialists, hospitals in network, languages spoken by providers and providers not accepting new patients.	CFR			
MP2.3	Accepts and processes update information as changes are reported.	IBP			

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Ref#	System Review Criteria	Source	Yes	No	Comments
MP2.4	Captures termination information when a PIHP or PAHP contract is cancelled.	IBP			
MP2.5	Generates reports to monitor adequacy of PIHP or PAHP network (e.g., number and types of physicians and provider locations).	CFR			
MP2.6	Generates reports to monitor enrolled providers to prohibit affiliations with individuals debarred by State or Federal agencies.	CFR			
MP2SS.1	<i>Add State-specific criteria for this objective here.</i>				

MP3 – MAKE ACCURATE AND TIMELY PAYMENT TO PIHPs AND PAHPs

Ref#	System Review Criteria	Source	Yes	No	Comments
MP3.1	Calculates capitation payment per member per month for PIHP or PAHP based on rate factors such as a fixed fee per enrollee or special supplement payment for high-risk enrollees.	IBP			
MP3.2	Adjusts capitation payment based on reconciliation of errors or corrections.	IBP			
MP3.3	Performs mass adjustment to rates according to State policy, e.g., annual adjustment, negotiated rate change, court settlement.	IBP			
MP3.4	Produces report for each PIHP and PAHP and each primary care case manager showing their enrollees and the individual and total payment per month.	IBP			
MP3.5	Performs periodic reconciliations of State Medicaid member records with PIHP and	IBP			

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Ref#	System Review Criteria	Source	Yes	No	Comments
	PAHP enrollment records.				
MP3.6	Supports ANSI X12N 820 transaction as required by HIPAA.	HIPAA			
MP3SS.1	<i>Add State-specific criteria for this objective here.</i>				

MP4 – RECEIVE AND PROCESS ENCOUNTER RECORDS FROM PIHPs or PAHPs

Ref#	System Review Criteria	Source	Yes	No	Comments
MP4.1	Receives, processes, and stores encounter data on a periodic basis.	IBP			
MP4.2	Applies key edits to encounter data, e.g., PIHP or PAHP, physician, member ID numbers; diagnosis and procedure codes. (Note: The encounter record edits can be different from claims edits.)	IBP			
MP4.3	Returns erroneous encounter data for correction.	IBP			
MP4.4	Performs adjustments to encounter data.	IBP			
MP4SS.1	<i>Add State-specific criteria for this objective here.</i>				

MP5 – MONITOR QUALITY AND COST OF CARE PROVIDED TO ENROLLEES

Ref#	System Review Criteria	Source	Yes	No	Comments
MP5.1	Receives, processes, and stores encounter data from PIHP. Generates reports from encounter data to monitor	CFR			

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Ref#	System Review Criteria	Source	Yes	No	Comments
	services furnished to enrollees with special health needs.				
MP5.2	Produces MSIS reports using PIHP/PAHP encounter data.	IBP			
MP5.3	Determines capitation rates using encounter data.	IBP			
MP5.4	Detects under-underutilization of PIHP enrollees using encounter data.	CFR			
MP5.5	Generates reports from encounter data to monitor enrollment and disenrollment into a PIHP or PAHP.	CFR			
MP5.6	Generates reports from encounter data to identify persons with special health care needs.	CFR			
MP5.7	Generates reports for monitoring the number of grievance and appeals and the outcome of grievance and appeal.	CFR			
MP5.8	Receives, stores, and transmits data for external independent reviews for quality and timeliness of care, health outcomes and access to services.	CFR			
MP5.9	Generates reports to monitor PIHP and PAHP network and enrollee access to services.	CFR			
MP5.10	Generates reports from encounter data to monitor access to specialists for enrollees with special health care needs.	CFR			
MP5SS.1	Add State-specific criteria for this objective here.				

MP6 – IDENTIFY PIHP AND PAHP COVERED SERVICES AND MAKE APPROPRIATE PAYMENTS

Ref#	System Review Criteria	Source	Yes	No	Comments
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MP6.1	Blocks payment to fee-for-service providers for services included in the PHIP or PAHP benefit package.	CFR			
MC6.2	Allows payment to providers for services carved out of the PHIP or PAHP benefit package.	CFR			
MP6.3	Allows payment for emergency medical condition without authorization from PIHP or PAHP.	CFR			
MP6.4	Allows payment to fee-for-service providers for services rendered in pre-enrollment periods or other periods of transition.	IBP			
MP6SS.1	<i>Add State-specific criteria for this objective here.</i>				

MPSS1 – FIRST STATE-SPECIFIC OBJECTIVE

Ref#	System Review Criteria	Source	Yes	No	Comments
MPSS1	Add State-specific criteria for this objective here.				

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MANAGED CARE ENROLLMENT (ME) CHECKLIST

MANAGED CARE ENROLLMENT CHECKLIST BACKGROUND

Background for this checklist:

1. Managed Care Enrollment refers to the function of offering a choice of health plans or primary care case managers (PCCMs) to a Medicaid eligible Beneficiary who meets the requirements for the managed care program, or auto-assigning the individual to a plan; recording the decision; and sending the information to the designated data repository. The enrollment function could also be used for Waiver programs, Lock-in programs, Disease Management programs, or any other program in which a Medicaid Beneficiary chooses to enroll or is auto-enrolled.
2. The function may be performed by State employees (Medicaid or other agency), local agency staff, or outsourced contractors, as long as the contractor meets the independence and conflict of interest (COI) requirements in 42 CFR 438.810. The function may be supported by State-owned applications or vendor-owned applications.
3. Managed Care Organizations (MCO) refers to a number of different health plan entities including Health Maintenance Organizations (HMO). States have created variations of MCO and may use different names for them. Primary Care Case Managers (PCCMs) may be called Primary Care Physicians (PCPs) or other names.
4. Enrollment is assumed to include disenrollment and open enrollment. Disenrollment includes member-initiated disenrollment from a plan or PCP, disenrollment during an open enrollment period, and mass disenrollment when a health plan or PCP leaves the program. Open enrollment is the period during which the State allows enrolled members to voluntarily change MCO or PCP.
5. Enrollment in a Managed Care plan is often performed by an Enrollment Broker or Health Choice Counselor. These entities perform the activities cited in 42 CFR 438.50 – 438.56, and may be required to provide some or all of the information required under §438.10.
6. To receive enhanced funding, the enrollment system must meet SMM §11225 requirements as an optional integral component and not duplicate Medicaid Management Information System (MMIS) functionality.
7. If the State contracts for Enrollment Broker Services, including a proprietary system operated by the Enrollment Broker, CMSO will determine how many of the detailed enrollment requirements will be used in the Certification Review.
8. If the State does not collect premiums from Beneficiaries, Objective ME3 (Manage Premium Collections) and associated criteria should be omitted.
9. This checklist covers State Children's Health Insurance Program (SCHIP) enrollment services if SCHIP is administered as an extension of the MMIS and services are delivered through MCOs. SCHIP is not called out in the requirements below because the function is integrated into the MMIS. This checklist covers the functions of enrollment/disenrollment /re-enrollment, and premium, or case management fee payments. Capitation payment may be performed separately from the enrollment function. These payments are made

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on a per-member per-month (PMPM) basis. The checklist does not cover any other MCO-related function. See other MCO checklists for the other functions.

10. Data exchange between partners may include eligibility interfaces, premium payment interfaces, and enrollment/disenrollment data interchange with MCOs, HMOs, and PCPs.

Sources for the criteria in this checklist are as follows:

CFR – Code of Federal Regulations, available from <http://www.access.gpo.gov/uscode/title42/title42.html>

IBP – Industry Best Practices. Items are selected from RFPs for MMISs developed by states and approved by CMS.

HIPAA – HIPAA act, available from

http://www.cms.hhs.gov/TransactionCodeSetsStandards/02_TransactionsandCodeSetsRegulations.asp

SMM – State Medicaid Manual, MMIS Section, available from <http://www.cms.hhs.gov/Manuals/PBM/list.asp> Document 45

BUSINESS OBJECTIVES

Reference #	Business Objectives	Comments
ME1	Process accurate and timely automatic or choice-based enrollment, re-enrollment, and disenrollment of Medicaid eligibles into a Managed Care Organization (MCO), Primary Care Case Manager (PCCM) or Primary Care Physician (PCP) program, including into a Health Maintenance Organization (HMO).	SCDHHS currently contracts with an Enrollment Broker contractor to perform the business processes of enrolling members into an MCO, disenrolling members from an MCO, and changing a member's MCO. The Enrollment Broker contractor notifies the Contractor of member's MCO selections using data exchange/interfaces. As such, this business objective is out of scope unless otherwise noted.
ME2	Support data exchange between stakeholders using standard data formats.	SCDHHS currently contracts with an Enrollment Broker contractor to perform the business processes of enrolling members into an MCO, disenrolling members from an MCO, and changing a member's MCO. The Enrollment Broker contractor notifies the Contractor of member's MCO selections using data exchange/interfaces.
ME3	Manage premium collections from Beneficiaries, if applicable (optional).	State does not currently invoice premiums to members but plans to do so in the future. This functionality must be included in the Replacement MMIS.
ME4	Maintain the privacy and security of enrollment information in transit and at rest.	
MESS1	<i>Add State-specific business objectives for Managed Care Enrollment (ME) Checklist here.</i>	

ME1 – PROCESS ENROLLMENT AND DISENROLLMENT INTO/ OUT OF MCO OR PCP

Ref#	System Review Criteria	Source	Yes	No	Comments
ME1.1	Captures enrollee choice of MCO or PCP and enters into Beneficiary record.	CFR			The Replacement MMIS captures the MCO from the Enrollment Broker contractor.
ME1.2	Captures enrollee choice of primary care physician (PCP) from the MCO's provider	IBP			

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Ref#	System Review Criteria	Source	Yes	No	Comments
	network.				
ME1.3	Assigns enrollee to MCO based on factors such as client age, sex, geographic location; and MCO capitation rate, location.	CFR			
ME1.4	Assigns member to a primary care physician within MCO.	IBP			
ME1.5	Displays enrollees associated with MCO.	IBP			
ME1.6	Disenrolls member from MCO.	CFR			
ME1.7	Disenrolls member without cause during the 90 days following the date of the enrollee's initial enrollment and at least once every 12 months thereafter.	CFR			
ME1.8	Automatically disenrolls and re-enrolls members in new plans during periods of open enrollment or when an MCO leaves the program.	CFR			
ME1.9	Automatically disenrolls member from a terminated MCO and places in regular fee for-service status.	CFR			
ME1.10	Generates notices to Beneficiary of assignment to or disenrollment from MCO.	IBP			
ME1.11	Identifies Beneficiaries excluded from enrollment, subject to mandatory enrollment, or free to voluntarily enroll in MCO.	CFR			
ME1.12	Prioritizes enrollment for Beneficiaries to continue enrollment if the MCO does not have the capacity to accept all those seeking enrollment under the program.	CFR			
ME1.13	Provides a default enrollment process for those Beneficiaries who do not choose a MCO.	CFR			

Ref#	System Review Criteria	Source	Yes	No	Comments
ME1.14	Automatically re-enrolls a Beneficiary who is disenrolled solely because he or she loses Medicaid eligibility for a period of two months or less (optional if State Plan so specifies).	CFR			
ME1.15	Supports ANSI X12N 834 transaction as required by the Health Insurance Portability and Accountability Act (HIPAA).	HIPAA			
ME1SS.1	<i>Add State-specific criteria for this objective here.</i>				

ME2 – SUPPORT DATA EXCHANGE WITH STAKEHOLDERS

Ref#	System Review Criteria	Source	Yes	No	Comments
ME2.1	Receives and processes eligibility data from State's Eligibility source system.	SMM			The Replacement MMIS receives MCO selection from the Enrollment Broker contractor.
ME2.2	Receives MCO contract information from contract data store (e.g., address, covered services, rates).	IBP			
ME2.3	Receives and processes provider eligibility data from MMIS or data repository for PCP program.	CFR			
ME2.4	Receives and processes PCP registry data from MCOs.	IBP			
ME2.5	Calculates or selects premium payment amount and generates PMPM payment (capitation, premium, case management fee).	IBP			The Replacement MMIS generates the premium payment and submits to the MCO.
ME2.6	Supports ANSI X12N 820 transaction for PMPM premium payment as required by HIPAA.	HIPAA			
ME2.7	Transmits enrollment and PMPM payment data to MMIS or data repository.	CFR			

Ref#	System Review Criteria	Source	Yes	No	Comments
ME2.8	Transmits enrollment records and PMPM payments to MCOs.	CFR			
ME2.9	Generates identification cards for enrollees or adds MCO/PCP alerts to Medicaid identification cards.	IBP			
ME2SS.1	<i>Add State-specific criteria for this objective here.</i>				

ME3 – MANAGE PREMIUM COLLECTIONS

Ref#	System Review Criteria	Source	Yes	No	Comments
ME3.1	Calculates and generates premium notices to Beneficiaries.	IBP			
ME3.2	Processes premium receipts from Beneficiaries.	IBP			
ME3.3	Supports inquiries regarding premium collections.	IBP			
ME3.4	Produces premium collection reports.	IBP			
ME3SS.1	<i>Add State-specific criteria for this objective here.</i>				

ME4 – MAINTAIN PRIVACY AND SECURITY OF ENROLLMENT RECORDS

Ref#	System Review Criteria	Source	Yes	No	Comments
ME4.1	Complies with provisions for Administrative Simplification under the HIPAA of 1996 to ensure the confidentiality, integrity, and availability of ePHI:	HIPAA			

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	<ul style="list-style-type: none"> Provides safeguards as described in the October 22, 1998 State Medicaid Director letter, Collaborations for Data Sharing between State Medicaid and Health Agencies; Performs regular audits; and Supports incident reporting. 				
ME4SS.1	Add State-specific criteria for this objective here.				

MESS1 – FIRST STATE-SPECIFIC OBJECTIVE					
Ref#	System Review Criteria	Source	Yes	No	Comments
MSS1	Add criteria based on the APD, RFP, etc., that are relevant to this State-specific objective.				

STATE: South Carolina	DATE OF REVIEW:	REVIEWER:
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PCCM AND GATEKEEPER MANAGED CARE (MG) CHECKLIST

PCCM AND GATEKEEPER MANAGED CARE (MG) CHECKLIST BACKGROUND

Background for this checklist:

1. This checklist covers models of managed care that center on a primary care case manager with whom a member enrolls or is assigned.
2. Primary Care Case Manager (PCCM) as defined in 42 CFR 438.2 means a physician, a physician group practice, an entity that employs or arranges with physicians to furnish primary care case management services or, at State option, any of the following:
 - A physician assistant
 - A nurse practitioner
 - A certified nurse midwife
3. The majority of these programs use a PCCM to provide primary care physician services and to authorize other services, including, but not limited to prescriptions, laboratory, radiology, specialist services, and certain hospital procedures.
4. The PCCM is usually paid on a fee-for-service basis for the services he or she provides and may receive a small management fee per enrollee to cover the coordination of the enrollee's care referral service. Referral services will not be covered if the PCCM does not provide authorization.
5. A limited number of PCCM programs place the PCCM at risk for a limited package of primary care services (e.g., physician and outpatient hospital). For this coverage, the PCCM receives a per-member per-month (PMPM) capitation fee.

Sources for the criteria in this checklist are as follows:

CFR – Code of Federal Regulations, available from <http://www.access.gpo.gov/uscode/title42/title42.html>

IBP – Industry Best Practice. Items are selected from RFPs for MMISs developed by states and approved by CMS.

HIPAA – HIPAA act, available from

http://www.cms.hhs.gov/TransactionCodeSetsStandards/02_TransactionsandCodeSetsRegulations.asp

BUSINESS OBJECTIVES

Reference #	Business Objectives	Comments
MG1	Support enrollment of Medicaid eligibles into Primary Care Case Management (PCCM) or Gatekeeper program.	SCDHHS currently contracts with an Enrollment Broker contractor to perform the business processes of enrolling members into a Medical Home Network (MHN), disenrolling members from an MHN, and changing a member's MHN. The Enrollment Broker contractor notifies the Contractor of member's MHN selections using data exchange/interfaces.
MG2	Increase Beneficiary access to care and qualified PCCM providers.	
MG3	Process accurate and timely payment to PCCM for gatekeeper services	
MG4	Make accurate and timely payments to providers.	
MG5	Generate reports to monitor quality and cost of care provided to enrollees	

MG1 – SUPPORT ENROLLMENT INTO PCCM PROGRAM

Ref#	System Review Criteria	Source	Yes	No	Comments
MG1.1	Captures enrollee choice of PCCM on Beneficiary record.	CFR			This includes maintaining PCCM choice accurately and capturing disenrollment.
MG1.2	Auto-assigns enrollees to a PCCM who fail to choose a PCCM, and completes provider lock-in process.	CFR			This is out of scope and performed by the Enrollment Broker contractor.
MG1.3	Displays enrollees associated with PCCM.	IBP			
MG1.4	Disenrolls member from PCCM.	CFR			This is out of scope and performed by the Enrollment Broker contractor.

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Ref#	System Review Criteria	Source	Yes	No	Comments
MG1.5	Allows enrollee to disenroll from a PCCM without cause during the 90 days following the date of the enrollee's initial enrollment and at least once every 12 months thereafter.	CFR			This is out of scope and performed by the Enrollment Broker contractor.
MG1.6	Automatically disenrolls enrollees from a terminated PCCM provider and places the Beneficiary in regular fee-for-service status.	CFR			This is out of scope and performed by the Enrollment Broker contractor.
MG1.7	Performs mass reassignment of enrollees if contract with PCCM is terminated or Beneficiary disenrolls for any reason other than ineligibility for Medicaid.	CFR			This is out of scope and performed by the Enrollment Broker contractor.
MG1.8	Generates notices to Beneficiary of enrollment or disenrollment from PCCM.	CFR			This is out of scope and performed by the Enrollment Broker contractor.
MG1.9	Produces ID card data for PCCM enrollees indicating that referral services must be authorized by the PCCM in order for the provider to receive payment	IBP			This is out of scope and performed by the Enrollment Broker contractor.
MG1.10	Identifies Beneficiaries excluded from enrollment, subject to mandatory enrollment, or free to voluntarily enroll in PCCM.	CFR			This is out of scope and performed by the Enrollment Broker contractor.
MG1.11	Prioritizes enrollment for Beneficiaries to continue enrollment if the PCCM does not have the capacity to accept all those seeking enrollment under the program.	CFR			This is out of scope and performed by the Enrollment Broker contractor.
MG1.12	Provides a default enrollment process for those Beneficiaries who do not choose a PCCM.	CFR			This is out of scope and performed by the Enrollment Broker contractor.
MG1.13	Automatically re-enrolls a Beneficiary who is disenrolled solely because he or she loses Medicaid eligibility for a period of two months or less (optional if State Plan so specifies).	CFR			This is out of scope and performed by the Enrollment Broker contractor.
MG1.14	Supports ANSI X12N 834 transaction as required by HIPAA.	HIPAA			

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Ref#	System Review Criteria	Source	Yes	No	Comments
MG1SS.1	Add State-specific criteria for this objective here				

MG2 – IMPROVE BENEFICIARY ACCESS TO QUALIFIED PROVIDERS

Ref#	System Review Criteria	Source	Yes	No	Comments
MG2.1	Identifies physicians who have agreed to provide gatekeeper services, geographic location(s), number of assigned Beneficiaries, and capacity to accept additional patients.	CFR			
MG2.2	Accepts and processes updates information about the PCCM as changes are reported.	IBP			
MG2.3	Captures termination information when a PCCM provider contract is cancelled	IBP			
MG2.4	Monitors adequacy of PCCM network (e.g., number and types of physicians and provider locations)	IBP			This is out of scope and performed by the Enrollment Broker contractor.
MG2.5	Generates reports to monitor enrolled providers to prohibit affiliations with individuals debarred by Federal agencies	CFR			
MG2SS.1	Add State-specific criteria for this objective here.				

MG3 – MAKE ACCURATE AND TIMELY PAYMENT TO PCCM

Ref#	System Review Criteria	Source	Yes	No	Comments
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MG3.1	Calculates administrative payment per-member per-month for primary care gatekeeper services.	IBP			
MG3.2	Supports ANSI X12N 837 transaction as required by HIPAA.	HIPAA			
MG3.3	Supports ANSI X12N 835 transaction as required by HIPAA	HIPAA			
MG3SS.1	<i>Add State-specific criteria for this objective here</i>				

MG4 – MAKE ACCURATE AND TIMELY PAYMENTS TO PROVIDERS

Ref#	System Review Criteria	Source	Yes	No	Comments
MG4.1	Edits and denies payment to fee-for-service (FFS) providers for services without PCCM referral/prior authorization.	IBP			
MG4.2	Allows payment to providers for services carved out of the PCCM benefit package (e.g., family planning, women health specialist).	CFR			
MG4.3	Allows payment for emergency medical condition without authorization from PCCM.	CFR			
MG4.4	Edits and denies payment to referral providers (pharmacy, lab, radiology, specialty physician, etc.) if service is not authorized by a PCCM gatekeeper.	IBP			
MG4.5	Allows payment to fee-for-service (FFS) providers for services rendered in preenrollment periods or other periods of transition	IBP			
MG4SS.1	<i>Add State-specific criteria for this objective here.</i>				

MG5 – GENERATES REPORTS FOR MONITORING SERVICES PROVIDED TO ENROLLEES

Ref#	System Review Criteria	Source	Yes	No	Comments
MG5.1	Generates reports for monitoring enrollee access to medical services.	IBP			
MG5.2	Generates reports to compare fee-for service (FFS) claims statistics and PCCM data, re: cost of care, timeliness of care, quality of care, grievance and appeals; outcomes.	IBP			
MG5.3	Generates reports to monitor PCCM referrals to specialty care.	IBP			
MG5.4	Produces report for each primary care case manager identifying the PCCM's enrollees and the total payment per month per enrollee	IBP			
MG5SS.1	<i>Add State-specific criteria for this objective here.</i>				

STATE: South Carolina	DATE OF REVIEW:	REVIEWER:
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PHARMACY POINT OF SERVICE (POS) CLAIMS PROCESSING CHECKLIST

PHARMACY POINT OF SERVICE (POS) CLAIMS PROCESSING CHECKLIST BACKGROUND

Background for this checklist:

1. Point of Service (POS), a.k.a., Point of Sale or Point-of-Sale, refers to the online real-time receipt, adjudication, and notification to the provider regarding the disposition of a claim. Also referred to as an Electronic Claim Management (ECM) system in Part 11, Section 1128.2. "Point of service" implies that the patient is present and receiving a service concurrently with the creation and transmission of the claim. The transaction is subjected to all required edits and a response (payable, denied, requires more information) is returned to the provider instantly. If the response is "approved for payment," the patient will receive the service with no out-of-pocket expense except where program policy requires a co-pay, deductible, or other Beneficiary share of cost.
2. Included in POS systems are eligibility verification, claim data capture, prior authorization, prospective drug use review, and assistance to the provider in applying for and receiving payment.
3. Almost all non-institutional pharmacy claims are processed as a POS transaction. POS is optional for nursing home and mail order pharmacy claims processing. Other claim types (physician, dentist, laboratory) also could be processed via POS, however, electronic submission with batch processing continues to be the primary method used by these other providers.
4. Pharmacy claims have some specialized functions, e.g., Prospective Drug Use Review (ProDUR). Therefore, this checklist focuses uniquely on Pharmacy POS.
5. The POS process consolidates business processes that are treated as separate functions in a batch processing environment, e.g., claims receipt, eligibility verification, prior authorization validation, adjudication, utilization review, pricing, and response re adjudication status. Therefore, this checklist overlaps requirements found in other checklists. In POS, all actions are rolled into a single event: the claim is created and transmitted. The instant it is received, all edits and validations are applied in a single event, lasting only seconds. A message is transmitted back to the provider regarding the status of the claim: approved for payment; denied; or pended. Payment is still performed separately according to the State's payment cycle, e.g., weekly, bi-weekly, or other.
6. Because of the online real-time nature of POS claims processing, interfaces to sources of data needed for complete adjudication (e.g., member eligibility, provider eligibility, claims history, covered drugs, benefit rules, pricing formulas) are critical. The POS system may directly interface to the MMIS data sources, or may use the MMIS sources to update integrated databases.
7. If the POS system is outsourced to a vendor who operates a proprietary system, CMSO will determine how many of the detailed claims adjudication criteria will be used in the certification review.
8. This checklist duplicates some requirements found in the Claims Adjudication checklist (CA). This is done to allow this checklist to be used as

- a stand-alone with a complete set of requirements. The certification review team may wish to consolidate the Claims Adjudication and POS checklists.
9. This checklist does not cover the Drug Manufacturer Rebate system, updates to the master files (e.g., Formulary, Benefit Rules, Pricing Rules), the payment process, the prior authorization process, Retrospective Drug Utilization Review, or a supporting decision support system (DSS). It also does not cover electronic prescribing functions. The certification review team should refer to other checklists that support file maintenance, e.g., Beneficiary file updates; provider file updates. The checklist does cover the capture, editing, and retention of data required for use in reporting, drug rebate invoicing, the prior authorization system, and utilization review.
 10. In preparation for review of the pharmacy claims system, the certification review team should be informed about the State's specific business model for pharmacy. The pharmacy POS system may be outsourced to a fiscal agent or to a separate contractor. The pharmacy benefit may be carved out of managed care contracts and be covered by a separate POS contract. The POS contract may include or exclude formulary, drug file, and pricing information. State may include or exclude specific services (e.g., Drug Manufacturer Rebate, ProDUR, Retro DUR, drug file maintenance, formulary committee, and other services).
 11. Primary source for Pharmacy POS requirements is found in 42 CFR, Chapter IV, Part 456, Subpart K, Section 456.722 – Electronic claims management system. (Also referenced in Title 42 Chapter 7 Subchapter XIX 1396r-8 Payment for Covered Outpatient Drugs):

Sources for the criteria in this checklist are as follows:

SMM – State Medicaid Manual, MMIS Section, available from <http://www.cms.hhs.gov/Manuals/PBM/list.asp>, Document 45

HIPAA – HIPAA act, available from

http://www.cms.hhs.gov/TransactionCodeSetsStands/02_TransactionsandCodeSetsRegulations.asp

IBP – Industry Best Practices. Items are selected from RFPs for MMISs developed by states and approved by CMS.

CFR – Code of Federal Regulations, available from <http://www.access.gpo.gov/uscode/title42/title42.html>

BUSINESS OBJECTIVES

Reference #	Business Objectives	Comments
POS1	Maintain interfaces between the POS system and comprehensive, accurate, and up-to-date data sources required to approve and adjudicate claims according to State and Federal rules. Maintain interfaces between POS and reporting applications, e.g., Federal reporting, data warehouse/decision support, drug manufacturer rebate invoicing, program integrity, and others.	<p>SCDHHS currently contracts with a Pharmacy contractor to perform the business processes of pharmacy Point of Service Claims Processing. There are several inbound/outbound data exchanges/interfaces between the Pharmacy contractor and Contractor.</p> <p>SCDHHS is interested in understanding how the proposed MMIS solution is capable of performing the business objectives and system review criteria for Pharmacy Point of Service Claims Processing. See RFP Section IV for further details on the Proposal requirement.</p>

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Reference #	Business Objectives	Comments
POS2	Ensure timely and accurate adjudication of provider claims.	This is out of scope as the Pharmacy contractor is responsible for this business objective.
POS3	Verify authorization for services that require prior approval in order to manage costs or ensure patient safety.	This is out of scope as the Pharmacy contractor is responsible for this business objective.
POS4	Verify that services are medically appropriate, conform to Federal and State policies, and result in the maintenance or improvement of patient health.	This is out of scope as the Pharmacy contractor is responsible for this business objective.
POS5	Deny claims for members with third party coverage, including Part D Medicare or flag for pay-and-chase activity.	This is out of scope as the Pharmacy contractor is responsible for this business objective.
POS6	Support other business processes that require pharmacy claims data, e.g., rebate invoicing, retrospective DUR, and decision support	This is out of scope as the Pharmacy contractor is responsible for this business objective.
POSSS1	<i>Add State-specific business objectives for this checklist here</i>	

POS1 – MAINTAIN INTERFACES BETWEEN THE POS SYSTEM AND DATA SOURCES

Ref#	System Review Criteria	Source	Yes	No	Comments
POS1.1	Provides real-time access to Beneficiary eligibility. Note: Depends on the timing of the updates maintained in the individual State. See State-specific Requirements.	SMM CFR			
POS1.2	Provides real-time access to provider eligibility, including the pharmacy and prescriber National Provider Identifier (NPI) and authorization IDs for electronic submission of claims. Note: Depends on the timing of the	SMM HIPAA CFR			

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Ref#	System Review Criteria	Source	Yes	No	Comments
	updates maintained in the individual State. See State-specific Requirements.				
POS1.3	Provides real-time access to the State's drug and formulary file or maintains an up to date copy for POS use. Note: Depends on the timing of the updates maintained in the individual State. See State-specific Requirements.	SMM CFR			
POS1.4	Provides real-time access to benefit business rules.	SMM			
POS1.5	Provides real-time access to drug file and pharmacy claims history.	SMM CFR			
POS1.6	Ensures that all claims are assigned a unique identification number upon entering the system.	SMM			
POS1.7	Interfaces with the MMIS or other payment systems to maintain records of time of claims payment in order for the payment systems to pay claims within 30 days after receipt by the POS system of an error free claim.	SMM CFR			
POS1SS.1	<i>Add State-specific criteria for this objective here</i>				

POS2 – ENSURE TIMELY AND ACCURATE ADJUDICATION OF PROVIDER CLAIMS

Ref#	System Review Criteria	Source	Yes		
POS2.1	Performs online real-time capture and adjudication of pharmacy claims submitted by providers via POS devices,	SMM HIPAA CFR			

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Ref#	System Review Criteria	Source	Yes		
	a switch, or through the Internet. Accepts ASC X12N NCPDP claims required by 45 CFR Part 162				
POS2.2	Returns to the pharmacy provider the status of the claim and any errors or alerts associated with the processing, such as: <ul style="list-style-type: none"> Edit failures ProDUR alerts Member (Beneficiary) or coverage restrictions Prior authorization missing Required coordination of benefits. Refill to soon Requires generic substitution Deny experimental drugs Requires unit dose (or not) Package size not approved Drug Efficacy Study Implementation (DESI) are not covered 	CFR			
POS2.3	Verifies that the Beneficiary is eligible on the date of service and not otherwise restricted, e.g., enrolled in MCO or a Lock in program; or receiving medication through a Waiver program, a carve-out mental health program, or a disease management program	SMM CFR			
POS2.4	Verifies that the pharmacy provider is eligible on the date of service.	SMM CFR			
POS2.5	Verifies that all fields defined as numeric contain only numeric data.	SMM			
POS2.6	Verifies that all fields defined as alphabetic contain only alphabetic data	SMM			
POS2.7	Verifies that all dates are valid and reasonable.	SMM			

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Ref#	System Review Criteria	Source	Yes		
POS2.8	Verifies that all data items which can be obtained by mathematical manipulation of other data items, agree with the results of that manipulation.	SMM			
POS2.9	Verifies that all coded data items consist of valid codes, including NDC for drug codes	SMM HIPAA			
POS2.10	Verifies that any data item that contains self-checking digits (e.g., Beneficiary I.D. Number) pass the specified check-digit test	SMM			
POS2.11	Verifies that required data items are present and retained (See SMM 11375) including all data needed for State or Federal reporting requirements.	SMM			
POS2.12	Verifies that the date of service is within the allowable time frame for payment	IBP			
POS2.13	Demonstrates that individual drugs and compounds which indicate a need for manual pricing intervention are flagged for review.	SMM			
POS2.14	Verifies that the claim is not a duplicate of a previously adjudicated claim.	SMM			
POS2.15	Pays according to the State plan at the lesser of approved pharmacy reimbursement methods, e.g., <ul style="list-style-type: none"> • AWP minus % + Dispensing Fee • Federal MAC (CMS Upper Limit + Dispensing Fee) • Usual and Customary Charges to the General Public • State MAC (State MAC + Dispensing Fee) 	SMM			
POS2.16	Processes electronic adjustments of paid claims submitted through the Pharmacy POS system	SMM			

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Ref#	System Review Criteria	Source	Yes		
POS2.17	Utilizes data elements and algorithms to compute claim reimbursement for claims that is consistent with 42 CFR 447.	SMM			
POS2.18	Checks claims against state-defined service limitations	CFR			
POS2.19	Edits claims to ensure that all required attachments, per the reference records or edits, have been received and maintained for audit purposes or have been submitted prior to the claim and a prior authorization has been established.	CFR			
POS2.20	Deducts Beneficiary co-payment amounts, as appropriate, when pricing claim	IBP			
POS2.21	Deducts TPL amounts, as appropriate, when pricing claims.	IBP			
POS2.22	Verifies that the claim is for services covered by the State Plan	CFR			
POS2.23	Verifies that all data necessary for legal requirements are retained	SMM			
POS2SS.1	<i>Add State-specific criteria for this objective here.</i>				

POS3 – VERIFY AUTHORIZATION FOR SERVICES THAT REQUIRE PRIOR APPROVAL

Ref#	System Review Criteria	Source	Yes	No	Comments
POS3.1	Interfaces with the pharmacy prior authorization database	SMM CFR			
POS3.2	Demonstrates that there is a field for authorization or identification when an override indicator (force code) is used.	IBP			
POS3.3	Interfaces with electronic authorization of health care service transactions required	HIPAA			

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	by 45 CFR Part 162, as follows: Retail pharmacy drug referral certification and authorization.				
POS3.4	Performs edits to ensure that a prior authorization is present when required	IBP			
POS3.5	Notifies submitter when required prior authorization is missing.	CFR			
POS3SS.1	<i>Add State-specific criteria for this objective here</i>				

POS4 – VERIFY THAT SERVICES ARE MEDICALLY APPROPRIATE, CONFORM WITH FEDERAL AND STATE POLICIES, AND RESULT IN THE MAINTENANCE OR IMPROVEMENT OF PATIENT HEALTH

Ref#	System Review Criteria	Source	Yes	No	Comments
POS4.1	Provides an automated, integrated online real-time ProDUR system or provides assistance to the pharmacist to do a prospective drug utilization review.	CFR			
POS4.2	Provides a prospective and concurrent review of prescription practices at the pharmacy and member level.	IBP			
POS4.3	Compares the claim against member history and benefit rules to determine if the new claim complies with State standards for: <ul style="list-style-type: none"> • Therapeutic appropriateness • Over Utilization • Underutilization • Appropriate use of generic products • Therapeutic duplication • Drug-disease contraindications • Drug-pregnancy contraindications • Drug-drug interactions 	SMM CFR			

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Ref#	System Review Criteria	Source	Yes	No	Comments
	<ul style="list-style-type: none"> Incorrect drug dosage duration of drug treatment Clinical abuse or misuse Consistent with patient age Consistent with patient sex Consistent with refill policy 				
POS4.4	Generates alerts (messages) to pharmacy providers as required by State policy.	CFR			
POS4.5	Allows the pharmacy the ability to override an alert.	IBP			
POS4.6	Maintains user controlled parameters for all standards and messages.	IBP			
POS4SS.1	<i>Add State-specific criteria for this objective here.</i>				

POS5 – MANAGE CLAIMS FOR MEMBERS WITH THIRD PARTY COVERAGE

Ref#	System Review Criteria	Source	Yes	No	Comments
POS5.1	Denies claims for members with appropriate third party coverage, enrollment in MCO, or Medicare Part D assignment. In this case, provides insurance information in the POS message along with notice of denial of payment.	SMM			
POS5.2	Identifies claims appropriate for pay and chase function. If the drug is designated as “pay and chase”, processes and pays the claim (if it meets all other criteria), and reports the claim for follow up activities.	CFR			
POS5.3	Identifies claims requiring third party payment	CFR			

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POS5SS.1	Add State-specific criteria for this objective here.				
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POS6 - SUPPORT OTHER BUSINESS PROCESSES THAT REQUIRE PHARMACY CLAIMS DATA, e.g., REBATE INVOICING, RETROSPECTIVE DUR, AND DECISION SUPPORT

Ref#	System Review Criteria	Source	Yes	No	Comments
POS6.1	Flags claims for Drug Rebate processing.	CFR			
POS6.2	Prepares extracts of pharmacy claims history required by the drug manufacturer rebate process. Claims must include all NDC and other data needed to support the rebate process, as follows: <ul style="list-style-type: none"> • Period of time covered • NDC number • Total units paid • Product names • Number of prescriptions paid • Rebate amount per unit based on the CMS approved formula 	CFR			
POS6.3	Prepares extracts of pharmacy claims history (or access to the claims history) for purposes of retrospective DUR, prescriber and pharmacy provider profiling, management reporting, and other decision support functions	SMM			
POS6.4	Provides data to support the State in case of a drug manufacturer dispute over the rebate invoice.	CFR			
POS6SS.1	Add State-specific criteria for this objective here.				

POSSS1 – FIRST STATE-SPECIFIC OBJECTIVE

Draft

Ref#	System Review Criteria	Source	Yes	No	Comments
POSSS1	Add criteria based on the APD, RFP, etc., that are relevant to this State-specific objective.				

STATE: South Carolina	DATE OF REVIEW:	REVIEWER:
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PROGRAM INTEGRITY (PI) CHECKLIST

PROGRAM INTEGRITY (PI) CHECKLIST BACKGROUND

Background for this checklist:

1. Program Integrity involves the analysis of data collected from Medicaid operations to identify patterns that can lead to improvements in the Medicaid program or the detection and correction of misuse and abuse of the program.
2. This checklist replaces the Surveillance and Utilization Review (SUR) checklist previously used for certification.
3. A Decision Support System/Data Warehouse may be used to support the functions referred to in this checklist. If so, both the DSS/DW and the Program Integrity checklists should be applied to the MMIS.
4. Program Integrity functions have created a specialized vocabulary. The following terms may be found in the System Review Criteria in this checklist:
 - Class Group – a.k.a., Peer Group, a collection of providers, Beneficiaries, or other entities that share common demographics, identifiers, location, statistics or other accessible indicators. Examples: all providers in County x, serving more than 100 unduplicated Beneficiaries in the past year, reporting medical services 1-20, with 25% hospital admissions ...; or, all Beneficiaries aged 65 or older receiving one or more Waiver service this year.
 - Norm –The value obtained by dividing the sum of a set of quantities by the number of quantities in the set. Also called *average* or *mean*.
 - Standard Deviation – The standard deviation is a measure of the spread of a set of values from the mean value. The higher the standard deviation, the more diverse is the experience reported (as in “all over the map”). The tighter the deviation, the more the behavior is clustered around the norm.
 - Standard Rates – Industry measures such as “Days per 1000 patients”, “Office visits per 1000 patients”; average length of stay
 - Outlier – Any individual or service whose behavior is beyond an upper or lower limit as defined by users or calculated.
 - Exception – An individual or service who exceeds system calculated or user defined parameters.
 - Utilization – Consumption of Medicaid services
 - Patterns – System identified repeating occurrences of events, relationships. May also be user defined.
 - Severity – Degree of importance of the deviation or exception observed.
 - Lock-in – Processes of limiting a Beneficiary to use of specific medical and/or pharmacy providers in an attempt to curb inappropriate use of Medicaid benefits

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- Lock-out – Process of flagging providers who cannot serve the Lock-in population due to a history of providing inappropriate services or providing services which exceed established clinical guidelines,
- Under utilization – Occurring mostly in at risk managed care program populations: indication that services are being withheld (presumably in order to reduce expense)
- Over utilization – Occurring mostly in fee-for-service programs: tendency to provide more services than necessary (presumably as a means to increase revenue)
- Weighting and ranking – User-applied values that assign more weight to certain items so that they will count more in determining exceptions.
- Exception processing – Any rules-based operation that results in identifying individuals or services whose observed behavior deviate from established norms or limits.

Sources for the criteria in this checklist are as follows:

SMM – State Medicaid Manual, MMIS Section, available from <http://www.cms.hhs.gov/Manuals/PBM/list.asp>, Document 45

CFR – Code of Federal Regulations, available from <http://www.access.gpo.gov/uscode/title42/title42.html>

<http://www.access.gpo.gov/uscode/title45/title45.html>

IBP – Industry Best Practices. Items are selected from RFPs for MMISs developed by states and approved by CMS.

BUSINESS OBJECTIVES

Reference #	Business Objectives	Comments
PI1	Improve delivery of health care services and the integrity of the Medicaid program by reducing waste, fraud, and abuse through analysis of provider performance.	The Contractor, in partnership with the SCDHHS, has the duty to diligently look for signs and patterns of abuse and report them timely to the SCDHHS. The business objectives and system review criteria are otherwise out of scope for the Contractor unless otherwise noted.
PI2	Improve delivery of health care services and the integrity of the Medicaid program by reducing waste, fraud, and abuse through analysis of Beneficiary utilization.	The Contractor, in partnership with the SCDHHS, has the duty to diligently look for signs and patterns of abuse and report them timely to the SCDHHS. The business objectives and system review criteria are otherwise out of scope for the Contractor unless otherwise noted.
PI3	Support analysis of and provide reports for fraud and abuse analysis and investigations.	The Contractor, in partnership with the SCDHHS, has the duty to diligently look for signs and patterns of abuse and report them timely to the SCDHHS. The business objectives and system review criteria are otherwise out of scope for the Contractor unless otherwise noted.

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Reference #	Business Objectives	Comments
PI4	Identify and analyze program trends and directions in provider, Beneficiary, and service utilization and expenditure patterns.	The Contractor, in partnership with the SCDHHS, has the duty to diligently look for signs and patterns of abuse and report them timely to the SCDHHS. The business objectives and system review criteria are otherwise out of scope for the Contractor unless otherwise noted.
PISS1	<i>Add State-specific business objectives for the Program Integrity business area here.</i>	

PI1 – IMPROVE DELIVERY OF HEALTH CARE AND THE INTEGRITY OF THE MEDICAID PROGRAM BY REDUCING FRAUD AND ABUSE THROUGH ANALYSIS OF PROVIDER PERFORMANCE

Ref#	System Review Criteria	Source	Yes	No	Comments
PI1.1	Produces comprehensive statistical profiles of provider health care practices by peer groups for all categories of service(s) authorized under the Medicaid program.	SMM			
PI1.2	Automatically identifies deficiencies and generates reports on levels of care and quality of care by provider type.	SMM			
PI1.3	Automatically reports on the details of the practice of providers identified as exceptions or outliers.	SMM			
PI1.4	Provides the capability to profile provider groups and individual providers within group practices.	SMM			
PI1.5	Automatically identifies exceptions to norms of practice established by the agency for any type of provider covered by the State plan.	SMM			
PI1.6	Displays all data by National Provider Identifier (NPI) or by a subset of the	CFR			

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Ref#	System Review Criteria	Source	Yes	No	Comments
	provider's practice.				
PI1.7	Profiles primary care case managers, including all referrals and other services received by their enrollees.	IBP			
PI1.8	Performs analysis of rendering, ordering, and billing practices to generate reports of aberrant utilization and/or billing patterns.	SMM			
PI1.9	Applies clinically approved guidelines against episodes of care to identify instances of treatment inconsistent with guidelines.	SMM			
PI1.10	Generates early warning reports of high-cost services and service misutilization based on current payment data to quickly identify high volume practices.	IBP			
PI1SS.1	<i>Add State-specific criteria for this objective</i>				

PI2 – IMPROVE DELIVERY OF HEALTH CARE AND THE INTEGRITY OF THE MEDICAID PROGRAM BY REDUCING FRAUD AND ABUSE THROUGH ANALYSIS OF BENEFICIARY UTILIZATION

Ref#	System Review Criteria	Source	Yes	No	Comments
PI2.1	Automatically identifies exceptions to norms of utilization or quality of care standards established by the agency for any type of Beneficiary covered by the State plan.	SMM			
PI2.2	Tracks Federally-assisted program participants separately from other categories of assistance.	SMM			
PI2.3	Identifies Beneficiaries who exceed program norms, ranked in order of severity.	SMM			
PI2.4	Identifies services received by Beneficiaries who are enrolled in selected programs.	SMM			
PI2.5	Identifies services received by Beneficiaries who have specified diagnoses.	IBP			
PI2.6	Links all services to a single Beneficiary regardless of the number of historical changes in Beneficiary ID.	IBP			
PI2.7	Profiles all services provided to a Beneficiary during a single episode of care.	IBP			
PI2.8	Provides a methodology and generates a report to classify treatment modalities into peer group categories, by diagnosis or range of diagnosis codes.	IBP			
PI2.9	Has the capability to generate reports of individual Beneficiaries by peer group.	IBP			

Draft

Ref#	System Review Criteria	Source	Yes	No	Comments
PI2SS.1	Add State-specific criteria for this objective here.				

PI3 – SUPPORT ANALYSIS OF AND PROVIDE REPORTS FOR FRAUD AND ABUSE ANALYSIS AND INVESTIGATIONS

Ref#	System Review Criteria	Source	Yes	No	Comments
PI3.1	Utilizes a minimum level of manual clerical effort in providing information that reveals potential defects in level of care and quality of service.	SMM			
PI3.2	Provides ability to perform analyses and produce reports responsive to requests from title XIX managers, QIO and State Medicaid fraud control units by means of computerized exception processing techniques.	SMM			
PI3.3	Selects claims and encounter data dating back to whatever time period is appropriate for the specific research.	SMM			
PI3.4	Supports the capability to produce claim and encounter detail and special reports by provider-type and Beneficiary classification (e.g., category of service—COS) and other key variables (e.g., Group Practice, Case).	SMM			
PI3.5	Supports capability to perform focused review and to generate reports of all reviews undertaken	SMM			
PI3.6	Has the capability to suppress processing on an individual within specified categories on a run-to-run basis.	SMM			
PI3.7	Provides access to all data elements outlined in the SMM Part 11, section	SMM			

Draft

Ref#	System Review Criteria	Source	Yes	No	Comments
	11335 and all additional data required for appropriate analysis of the program.				
PI3.8	Generates reports as needed.	SMM			
PI3.9	Tests criteria and develops algorithms for expected outcomes prior to production of reports.	IBP			
PI3.10	Facilitates export of claims-based class groupings such that data can be used by spreadsheet or database software.	IBP			
PI3.11	Supports fraud and abuse investigations.	SMM			
PI3.12	Supports pattern recognition and provides an automated fraud and abuse profiling system for the ongoing monitoring of provider and Beneficiary claims to detect patterns of potential fraud, abuse and excessive billing.	IBP			
PI3.13	Provides and stores all utilization reports in the medium designated by the State.	IBP			
PI3.14	Provides the flexibility to vary time periods for reporting purposes and to produce reports on daily, monthly, quarterly basis, or other frequency specified by the State.	SMM			
PI3.15	Maintains a process to apply weighting and ranking of exception report items to facilitate identifying the highest deviators.	IBP			
PI3.16	Provide for development and implementation of technical and user training programs.	SMM			
PI3.SS1	<i>Add State-specific criteria for this objective here.</i>				

PI4 – IDENTIFY AND ANALYZE PROGRAM TRENDS AND DIRECTIONS IN PROVIDER, BENEFICIARY, AND SERVICE TYPE UTILIZATION AND COSTS

Draft

Ref#	System Review Criteria	Source	Yes	No	Comments
PI4.1	Investigates and reveals misutilization of the state's Medicaid program services by individual participants and promotes corrective action.	SMM			
PI4.2	Develops provider, physician, and patient profiles sufficient to provide specific information as to the use of covered types of services and items, including prescribed drugs.	SMM			
<i>PI4SS.1</i>	<i>Add State-specific criteria for this objective here.</i>				

PISS1 - FIRST STATE-SPECIFIC OBJECTIVE

Ref#	System Review Criteria	Source	Yes	No	Comments
<i>PISS1.1</i>	<i>Add criteria based on the APD, RFP, etc., that are relevant to this State-specific objective.</i>				

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PROGRAM MANAGEMENT REPORTING (PM) CHECKLIST

PROGRAM MANAGEMENT REPORTING (PM) CHECKLIST BACKGROUND

Background for this checklist:

1. This checklist is intended to assess the adequacy of the way the MMIS supports Program Management by managing information and providing reports.
2. The criteria in this checklist are mainly based on the MMIS requirements in the State Medicaid Manual (SMM). The MMIS requirements in the SMM have been used for decades of MMIS certification. The language used in the criteria has been modernized to reflect 21st century terminology. Additional criteria have been added to align with Industry Best Practices (IBP). Many of these IBP have become standards in many States. If a State requests an IBP function in its RFP or System Requirements Document, it will be considered a requirement to be reviewed during MMIS certifications.

Sources for the criteria in this checklist are as follows:

SMM – State Medicaid Manual, MMIS Section, available from <http://www.cms.hhs.gov/Manuals/PBM/list.asp> Document 45

IBP – Industry Best Practices. Items are selected from RFPs for MMISs developed by states and approved by CMS.

CFR – Code of Federal Regulations, available from <http://www.access.gpo.gov/uscode/title42/title42.html>

BUSINESS OBJECTIVES

Reference #	Business Objectives	Comments
PM1	Analyze Medicaid program costs and trends to predict impact of policy changes on programs.	
PM2	Monitor payment processes and predict trends.	

Reference #	Business Objectives	Comments
PM3	Analyze provider performance to show extent of participation and service delivery.	
PM4	Analyze Beneficiary enrollment, participation, and program usage to predict utilization trends.	
PM5	Maintain an efficient and effective management reporting process	

PM1 – ANALYZE MEDICAID PROGRAM COSTS AND TRENDS TO PREDICT IMPACT OF POLICY CHANGES ON PROGRAMS

Ref#	System Review Criteria	Source	Yes	No	Comments
PM1.1	Provides information to assist management in fiscal planning and control.	SMM			
PM1.2	Provides information required in the review and development of medical assistance policy and regulations.	SMM			
PM1.3	Prepares information to support the preparation of budget allocations for the fiscal year.	SMM			
PM1.4	Supports the projection of the cost of program services for future periods.	SMM			
PM1.5	Compares current cost with previous period cost to establish a frame of reference for analyzing current cash flow.	SMM			
PM1.6	Compares actual expenditures with budget to determine and support control of current and projected financial position.	SMM			
PM1.7	Analyzes various areas of expenditure to determine areas of greatest cost.	SMM			

Draft

Ref#	System Review Criteria	Source	Yes	No	Comments
PM1.8	Provides data necessary to set and monitor rate-based reimbursement, e.g., institutional per diems and Managed Care Organization (MCO) capitation.	SMM			
PM1.9	Maintains provider, recipient, claims processing, and other data to support agency management reports and analyses.	SMM			
PM1.10	Provides counts of services based on meaningful units such as but not limited to: <ul style="list-style-type: none"> • Service category (e.g., days, visits, units, prescriptions) • Unduplicated claims • Unduplicated beneficiaries • Unduplicated providers 	IBP			
PM1.11	Supports online real time summary information such as, but not limited to, number and type of providers, beneficiaries and services.	IBP			
PM1.12	Tracks claims processing financial activities and provides reports on current status of payments.	SMM			
PM1.13	Provides the capability to produce unduplicated counts within a type of service and in total by month.	IBP			
PM1.14	Reports the utilization and cost of services against benefit limitations	IBP			
PM1.15	Assists in determining reimbursement methodologies by providing expenditure data through service codes including: <ul style="list-style-type: none"> • Healthcare Common Procedure Coding System (HCPCS), current version 	IBP			

Draft

Ref#	System Review Criteria	Source	Yes	No	Comments
	<ul style="list-style-type: none">• International Classification of Diseases (ICD), Clinical Modifier, current version• National Drug Code (NDC), current version				
PM1.16	Produces an annual hospice report showing a comparison of hospice days versus inpatient days for each enrolled hospice Beneficiary and for all hospice providers.	IBP			
PM1.17	Analyzes break-even point between Medicare and Medicaid payments.	SMM			
PM1.18	Analyzes cost-effectiveness of managed care programs versus fee-for-service.	IBP			
PM1.19	Tracks impact of Medicare drug program.	CFR			
PM1.20	Reports on any change from baseline for any program or policy change.	IBP			
PM1SS.1	Provides monitoring capability for budget status and warnings when nearing budget limits for each health benefit plan.	State Self-Assessment			

PM2 – MONITOR PAYMENT PROCESSES AND PREDICT TRENDS

Ref#	System Review Criteria	Source	Yes	No	Comments
PM2.1	Reviews errors in claim and payment processing to determine areas for increased claims processing training and provider billing training.	SMM			
PM2.2	Provides claims processing and payment information by service category or provider type to analyze timely processing of provider claims according to requirements (standards) contained at 42 CFR 447.45.	SMM			
PM2.3	Monitors third party avoidance and collections per State plan.	SMM			
PM2.4	Retains all information necessary to support State and Federal initiative reporting requirements.	SMM			
PM2.5	Provides access to information such as, but not limited to, paid amounts, outstanding amounts and adjustment amounts to be used for an analysis of timely reimbursement.	SMM			
PM2.6	Displays information on claims at any status or location such as, but not limited to, claims backlog, key entry backlog, pend file status, and other performance items.	SMM			
PM2.7	Identifies payments by type such as, but not limited to, abortions and sterilizations.	IBP			
PM2.8	Develops third party payment profiles to determine where program cost reductions might be achieved.	SMM			

Draft

Ref#	System Review Criteria	Source	Yes	No	Comments
PM2.9	Maintains information on per diem rates, Diagnosis Related Groups (DRG), Resource Utilization Groups (RUG), and other prospective payment methodologies according to the State plan and monitors accumulated liability for deficit payments.	IBP			
PM2.10	Automatically alerts administration when significant change occurs in daily, weekly, or other time period payments.	IBP			
PMSS2.1	<i>Add State-specific criteria for this business objective here.</i>				

PM3 – ANALYZE PROVIDER PERFORMANCE TO SHOW EXTENT OF PARTICIPATION AND SERVICE DELIVERY

Ref#	System Review Criteria	Source	Yes	No	Comments
PM3.1	Reviews provider performance to determine the adequacy and extent of participation and service delivery.	SMM			
PM3.2	Reviews provider participation and analyzes provider service capacity in terms of Beneficiary access to health care.	SMM			
PM3.3	Analyzes timing of claims filing by provider to ensure good fiscal controls and statistical data.	SMM			
PM3.4	Provides access to information for each provider on payments to monitor trends in accounts payable such as, but not limited to, showing increases/decreases and cumulative year-to-date figures after each claims processing cycle.	IBP			

Draft

Ref#	System Review Criteria	Source	Yes	No	Comments
PM3.5	Produces information on liens and providers with credit balances	IBP			
PM3.6	Produces provider participation analyses and summaries by different select criteria such as, but not limited to: <ul style="list-style-type: none"> • Payments • Services • Types of services • Beneficiary eligibility categories 	IBP			
PM3.7	Provides information to assist auditors in reviewing provider costs and establishing a basis for cost settlements.	IBP			
PM3.8	Monitors individual provider payments.	IBP			
PM3SS.1	<i>Add State-specific criteria for this business objective here</i>				

PM4- ANALYZE BENEFICIARY ENROLLMENT, PARTICIPATION AND PROGRAM USAGE TO PREDICT UTILIZATION TRENDS

Ref#	System Review Criteria	Source	Yes	No	Comments
PM4.1	Reviews the utilization of services by various Beneficiary categories to determine the extent of participation and related cost.	SMM			
PM4.2	Analyzes progress in accreting eligible Medicare buy-in Beneficiaries.	SMM			
PM4.3	Supports analyses of data on individual drug usage.	SMM			

Draft

Ref#	System Review Criteria	Source	Yes	No	Comments
PM4.4	Presents geographic analysis of expenditures and Beneficiary participation.	SMM			
PM4.5	Provides Beneficiary data (including Long Term Care (LTC), Early Periodic Screening, Diagnosis and Treatment (EPSDT), and insurance information) for designated time periods.	IBP			
PM4.6	Summarizes expenditures, based on type of Federal expenditure and the eligibility and program of the Beneficiary.	IBP			
PM4.7	Provides eligibility and Beneficiary counts and trends by selected data elements such as, but not limited to, aid category, type of service, age and county.	IBP			
PM4.8	Provides Beneficiary enrollment and participation analysis and summary, showing utilization rates, payments and number of beneficiaries by eligibility category.	SMM			
PM4.9	Provides the ability to request information online and to properly categorize services based on benefit plan structure.	IBP			
PM4.10	Reports on dual eligibles pre and post Medicare Part D implementation.	SMM			
PM4SS.1	<i>Add State-specific criteria for this business objective here</i>				

PM5 – MAINTAIN AN EFFECTIVE AND EFFICIENT MANAGEMENT REPORTING PROCESS

Draft

Ref#	System Review Criteria	Source	Yes	No	Comments
PM5.1	Supports report balancing and verification procedures.	IBP			
PM5.2	Maintains comprehensive list of standard PM reports and their intended use (business area supported).	IBP			
PM5.3	Maintains a list of users of each standard PM report.	IBP			
PM5.4	Maintains online access to at least four (4) years of selected management reports and five (5) years of annual reports.	IBP			The SCDHHS business objective is to never delete a record. The Contractor must maintain all history in the Replacement MMIS unless directed by the SCDHHS to remove or purge history.
PM5.5	Meets State defined time frames and priorities for processing user requests.	SMM			
<i>PM5SS.1</i>	<i>Add State-specific criteria for this business objective here</i>				

STATE: South Carolina	DATE OF REVIEW:	REVIEWER:
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PROVIDER MANAGEMENT (PR) CHECKLIST

PROVIDER MANAGEMENT (PR) CHECKLIST BACKGROUND

Background for this checklist:

1. This is a generic checklist covering all types of providers. There are limited references to specific provider types, e.g., laboratory, physician.
2. Unless otherwise stated, criteria apply to all provider types enrolled by the State Medicaid agency, including atypical.
3. The criteria in this checklist are mainly based on the MMIS requirements in the State Medicaid Manual (SMM). The MMIS requirements in the SMM have been used for decades of MMIS certification. The language used in the criteria has been modernized to reflect 21st century terminology. Additional criteria have been added to align with Industry Best Practices (IBP). Many of these IBP have become standards in most States. If a State requests an IBP function in its RFP or System Requirements Document, it will be considered a requirement to be reviewed during MMIS certifications

Sources for the criteria in this checklist are as follows:

SMM – State Medicaid Manual, MMIS Section, available from <http://www.cms.hhs.gov/Manuals/PBM/list.asp>, Document 45

IBP – Industry Best Practice. Items are selected from RFPs for MMISs developed by states and approved by CMS.

HIPAA – HIPAA act, available from

http://www.cms.hhs.gov/TransactionCodeSetsStandards/02_TransactionsandCodeSetsRegulations.asp

CFR – Code of Federal Regulations, available from <http://www.access.gpo.gov/uscode/title42/title42.html>

BUSINESS OBJECTIVES

Reference #	Business Objectives	Comments
PR1	Enroll and maintain adequate provider network for the Medicaid Beneficiary population.	<p>This includes enrolling and credentialing dental providers.</p> <p>Enroll traditional and nontraditional service providers meeting identified standards of care into the program to provide services to the target population.</p> <p>Migrate to an online provider enrollment process for virtually all providers.</p> <p>The HCBS Waivers checklist and the Provider Management checklist have many similar and overlapping areas. Rather than duplicate information between the checklists, the combination of all provider business objectives and system review criteria from each checklist are required for all provider types unless a particular item is not reasonable to apply to all provider types.</p>
PR2	Ensure quality of provider network and accuracy of payment arrangement.	
PR3	Maintain provider information.	
PR4	Comply with Health Insurance Portability and Accountability Act (HIPAA) requirements.	
PRSS1	Improve flexibility and efficiency by providing a provider Web portal with secure electronic mailbox capability.	The Offeror should provide system review criteria for this business objective based upon its proposed solution.

PR1 – ENROLL AND MAINTAIN ADEQUATE PROVIDER NETWORK

Draft

Ref#	System Review Criteria	Source	Yes	No	Comments
PR1.1	Provides secure access to the applications.	IBP			
PR1.2	Routes provider applications, and collects and processes provider enrollment and status information.	IBP			
PR1.3	Produces notices to applicants of pending status, approval, or rejection of their applications.	IBP			
PR1.4	Assigns and maintains provider numbers for all providers if the system is not natively NPI-compliant internally. Maps NPI identifiers to internal assigned numbers. Assigns and maintains provider numbers for providers not eligible for an NPI number.	SMM			The State strongly prefers a system that uses NPI and taxonomy natively rather than using other internal numbering schemes or legacy provider type and specialty codes. Offerors must describe their internal designs in their Proposals.
PR1.5	Flags and routes for action if multiple internal State assigned provider numbers are assigned to a single provider.	IBP			
PR1.6	Supports communications to and from providers and tracks and monitors responses to the communications.	IBP			
PR1.7	Supports a provider appeals process in compliance with Federal guidelines contained in 42 CFR 431.105.	CFR			The Contractor supports the state with any needed information, logging, tracking, scheduling, etc. in accordance with legal requirements.
PR1.8	Maintains date-specific provider enrollment and demographic data.	SMM			
PR1.9	Generates information requests, correspondence, or notifications based on the status of the application for enrollment.	IBP			
PR1.10	Tracks the sending of State furnished information to enrolled providers.	IBP			
PR1.11	Produces responses to requests/inquiries on the adequacy of the Medicaid provider network based on provider/Beneficiary ratios by geographic region, provider type, etc.	IBP			

Draft

Ref#	System Review Criteria	Source	Yes	No	Comments
PR1.12	Uses consistent provider naming conventions to differentiate between first names, last names, and business or corporate names and to allow flexible searches based on the provider name.	IBP			
PR1SS.1	Provides the ability to enroll online, reducing or eliminating the need for providers to provide hard copy input to support the enrollment process.	APD			
PR1SS.2	Screens applications and ongoing provider updates using business rules workflow to the greatest extent practical.	APD			
PR1SS.3	Accesses online credentialing sources to support enrollment, verification, and periodic re-verification processes.	APD			
PR1SS.4	Allows collection of more provider demographic information upon enrollment to assist in managing the Medicaid program, including, but not limited to, ownership and controlling interest.	APD			
PR1SS.5	Allows enrolled providers to update certain demographic information via the web portal.	APD			
PR1SS.6	Publishes via the web a collection of information on provider specialties, office hours, openings for new Medicaid patients, languages spoken, etc. allowing beneficiaries the ability to locate suitable providers.	APD			
PR1SS.7	Allows providers web portal access for capabilities such as: <ul style="list-style-type: none"> • obtain status of claims • view Remittance Advices (RAs) • submit claims • submit prior authorization requests • access Resident Assessment 	APD			

Ref#	System Review Criteria	Source	Yes	No	Comments
	Protocols (RAPs) <ul style="list-style-type: none"> • produce reports • obtain forms, manuals, policies, and bulletins • access links to outside sources (i.e., CMS, DHHS, etc.) • other business efficiencies. 				
PR1SS.8	Supports configurable disenrollment reason codes, i.e. voluntary, involuntary.	State Self-Assessment			

PR2 – ENSURE QUALITY OF PROVIDER NETWORK AND ACCURACY OF RATES

Ref#	System Review Criteria	Source	Yes	No	Comments
PR2.1	Tracks and supports the screening of applications (and ongoing provider updates) for (National Provider Identifier (NPIs), State licenses, Specialty Board certification as appropriate, review team visits when necessary, and any other State and/or Federal Requirement.	SMM			
PR2.2	Tracks and supports any established provider review schedule to ensure providers continue to meet program eligibility requirements.	SMM			
PR2.3	Verifies provider eligibility in support of other system processes, i.e., payment of claims.	SMM			
PR2.4	Captures Clinical Laboratory Improvement Amendments (CLIA) certification information and the specific procedures each laboratory is authorized to cover. Links the information for use in	SMM			

Draft

	claims adjudication.				
PR2.5	Cross-references license and sanction information with other State or Federal agencies.	IBP			
PR2.6	Generates notices to providers of expiring Medicaid agreements and/or State licenses.	IBP			
PR2.7	Maintains multiple provider specific reimbursement rates with begin and end dates, consistent with State policy. Examples include: per diems, level-of-care per diems, case mix, percentage-of-charge rates, rates based on level of care, preferred provider agreements, managed care agreements, volume purchase contracts, or other cost-containment initiatives with begin and end effective dates.	SMM			
PR2SS.1	Automatically matches enrolled providers with sanctioning lists in order to substantially reduce or eliminate the occurrence of claims payments to providers who are ineligible due to sanctions and other restrictions.	APD			

PR3 – MAINTAIN PROVIDER INFORMATION

Ref#	System Review Criteria	Source	Yes	No	Comments
PR3.1	Accepts, validates, and processes transactions or user entries to update and maintain provider information.	SMM			
PR3.2	Provides user access to provider data and allows extraction of information. The extracts or reports could include such items as: <ul style="list-style-type: none"> The current status of providers' 	IBP			

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Ref#	System Review Criteria	Source	Yes	No	Comments
	<ul style="list-style-type: none"> records. An alphabetical provider listing A numeric provider listing A provider rate table listing An annual re-certification notice A provider “group affiliation” listing A provider specialty listing A provider listing by category of service 				
PR3.3	Tracks and controls the process of reconciliation of errors in transactions that are intended to update provider information.	SMM			
PR3.4	Maintains current and historical multiple address capabilities for providers.	SMM			
PR3.5	Maintains an audit trail of all updates to the provider data, for a time period specified by the State.	SMM			
PR3.6	Maintains providers' Drug Enforcement Administration (DEA) numbers.	SMM			
PR3.7	Updates and maintains financial data including current and prior year 1099 reported amounts.	SMM			
PR3.8	Maintains links from providers to other entities, such as Groups, Managed Care Organizations (MCO), Chains, Networks, Ownerships, and Partnerships.	SMM			
PR3.9	Provides capability to do mass updates to provider information, based on flexible selection criteria.	SMM			
PR3.10	Maintains indicators to identify providers that are Fee-for-Service (FFS), Managed Care Organization (MCO) network only, and other State health care program participants.	SMM			
PR3.11	Maintains a flag for providers who are	SMM			

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Ref#	System Review Criteria	Source	Yes	No	Comments
	eligible to use Electronic Funds Transfer (EFT) and Electronic Claims Submission.				
PR3SS.1	Allows for collection of more demographic and business information about providers to improve our ability to manage the Medicaid program effectively and improve our understanding of the provider community.	APD			
PR3SS.2	Manages the Medicaid program effectively by allowing providers to update certain information directly through web portal functionality.	APD			
PR3SS.3	Images, indexes, and electronically stores provider contracts allowing improved provider accessibility.	APD			
PR3SS.4	Corrects and validates provider addresses with U.S. Postal Service CASS-certified solution.	IBP			

PR4 – COMPLY WITH HIPAA REQUIREMENTS

Ref#	System Review Criteria	Source	Yes	No	Comments
PR4.1	Requires (when appropriate), captures, and maintains the 10-digit National Provider Identifier.	HIPAA			
PR4.2	Accepts the National Provider Identifier in all standard electronic transactions mandated under HIPAA.	HIPAA			

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Ref#	System Review Criteria	Source	Yes	No	Comments
PR4.3	Interfaces with the National Plan and Provider Enumerator System (NPPES) to verify the National Provider Identifier of provider applicants once the Enumerator data base is available.	HIPAA			
PR4.4	Does not allow atypical providers to be assigned numbers that duplicate any number assigned by the NPPES.	HIPAA			
PR4.5	Provides ability to link and de-link to other Medicaid provider IDs for the same provider, e.g., numbers used before the NPI was established, erroneously issued prior numbers, multiple NPIs for different subparts, etc. Captures/crosswalks subpart NPIs used by Medicare (but not Medicaid) to facilitate COB claims processing.	HIPAA			

**PRSS1 – IMPROVE FLEXIBILITY AND EFFICIENCY BY PROVIDING A PROVIDER WEB WITH
SECURE ELECTRONIC MAILBOX CAPABILITY**

Ref#	System Review Criteria	Source	Yes	No	Comments
PRSS1.1					The Offeror should provide system review criteria for this business objective based upon its proposed solution.

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REFERENCE DATA MANAGEMENT (RF) CHECKLIST

REFERENCE DATA MANAGEMENT (RF) CHECKLIST BACKGROUND

Background for this checklist:

1. Reference Data refers to the body of codes, attributes, and descriptions used by applications within or interfacing with the MMIS. The traditional Reference Subsystem is a composite of applications that periodically update or replace tables of codes.
2. Reference data are created and maintained by many external entities, many of which are named Standard Developing Organizations. Some of these are recognized by HHS as the owners or developers of data standards required by the Health Insurance Portability and Accountability Act (HIPAA).
3. Reference data are also created by State Medicaid agencies. During HIPAA implementation, States mounted an unprecedented effort to reconcile the large number of "Local Codes" that States had invented individually over the past 30 years. This effort resulted in the adoption by most States of the collaboratively approved standards to replace local codes.
4. Reference code sets fall into very large files maintained by external entities, e.g., HCPCS, NCPDP, ICD-9; small files maintained by external entities; and local code files created by the State.
5. Periodicity of file updates or replacements depends on the owner of the data. States usually pay a fee for update services from external entities.
6. Codes are date-specific. The start and end date of a code impacts the pricing or the validity of the information.
7. HIPAA introduced the concept of "mandatory" data standards as opposed to voluntary.

Sources for the criteria in this checklist are as follows:

SMM – State Medicaid Manual, MMIS Section, available from <http://www.cms.hhs.gov/Manuals/PBM/list.asp>, Document 45

IBP – Industry Best Practices. Items are selected from RFPs for MMISs developed by states and approved by CMS.

HIPAA – HIPAA act, available from

http://www.cms.hhs.gov/TransactionCodeSetsStandards/02_TransactionsandCodeSetsRegulations.asp

BUSINESS OBJECTIVES

Reference #	Business Objectives	Comments
RF1	Manage reference data to support claims processing, data to consist of proper procedure, diagnosis, formulary and drug pricing codes, charge information, and data that supports different payment methods (e.g. Outpatient Prospective Payment System (OPPS), Diagnosis Related Group (DRG), etc), and other items as needed by the State.	
RF2	Comply with Health Insurance Portability and Accountability Act (HIPAA) requirements.	
RFSS1	Improve efficiency and reduce the likelihood of errors in changing rates and reference information by automating data loading processes.	The Offeror should provide system review criteria for this business objective based upon its proposed solution.

RF1 – MANAGE REFERENCE DATA TO SUPPORT CLAIMS PROCESSING

Ref#	System Review Criteria	Source	Yes	No	Comments
RF1.1	<p>Maintains reasonable and customary charge information for Medicaid and Medicare to support claims processing:</p> <ul style="list-style-type: none"> Reimbursement under the Medicaid program for other than outpatient drugs, Federally Qualified Health Center (FQHC), Rural Health Clinic (RHC), Indian Health Services (IHS) and hospital inpatient and outpatient reimbursement is to be the lower of the provider's "usual and customary" charge, the rate established by the State, or the amount, which is allowed under the Medicaid program. "Usual and customary" charges are calculated from the actual 	SMM			

Ref#	System Review Criteria	Source	Yes	No	Comments
	<p>charges submitted on provider claims for Medicaid payment.</p> <ul style="list-style-type: none"> Reimbursement for prescription drugs are usually processed by either a) Federal Upper Limit (FUL) Maximum Allowable Cost (MAC) with some drugs; the State defined Estimated Acquisition Cost (EAC), which is defined by the Average Wholesale Price (AWP) less 15 to 20 % plus a dispensing fee (ranging anywhere from 0.50 to several dollars); and/or plus a provider specific dispensing fee; or b) the provider's usual and customary charge, paying the lesser of these fees. 				
RF1.2	Supports Payment for Services by providing reference data, including procedure, diagnostic, and formulary codes (42 CFR 447).	SMM			
RF1.3	Processes change transactions to procedure, diagnosis, and formulary codes and other data and responds to queries and report requests.	SMM			
RF1.4	Archives all versions of reference information and update transactions.	IBP			
RF1.5	Processes update transactions to the reasonable and customary charge data and responds to queries and report requests.	SMM			
RF1.6	Retrieves, as needed, archived reference data for processing of outdated claims or for duplicate claims detection.	SMM			
RF1.7	Generates a summary of history file transfers	IBP			

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Ref#	System Review Criteria	Source	Yes	No	Comments
RF1.8	Maintains current and historical reference data used in claims processing.	IBP			
RF1.9	Maintains online access to all reference tables with inquiry by the appropriate code.	IBP			
RF1.10	Maintains an audit trail of all information changes, including errors in changes and suspended changes.	IBP			
RF1.11	Maintains revenue codes; provides online update and inquiry access, including: (a) Coverage information (b) Restrictions (c) Service limitations (d) Automatic error codes (e) Pricing data (f) Effective dates for all items	IBP			
RF1.12	Maintains date sensitive parameters for all Reference Data Management data.	IBP			
RF1.13	Maintains current and historical coverage status and pricing information on legend drugs, Over The Counter (OTC) items, and injection codes.	IBP			
RF1.14	Supports code sets for the payment of Medicaid-covered non-health care services, e.g. waiver services	HIPAA			The system should provide the ability to allow, store, and price in accordance with rules-based procedure code and modifier combinations.
RF1.15	Maintains the drug-pricing file, updating it at scheduled cycle	IBP			
RF1.16	Maintains the trauma indicators to identify potential Third Party Liability (TPL) cases	SMM			
RF1.17	Maintains diagnosis and procedure code narrative descriptions of each code contained in the files.	IBP			
RF1.18	Updates all procedure, diagnosis and drug files if required prior to each payment cycle.	SMM			
RF1SS.1	<i>Add first State-specific criterion for this business objective here. Example:</i>				

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Ref#	System Review Criteria	Source	Yes	No	Comments
	<i>Accommodates retroactive rate changes as they relate to medical procedures and limitations.</i> <i>Example: Maintains current and 10 years of historical date-sensitive NDC Drug Code information.</i> <i>Example: Accommodates weekly updates of NDC drug file</i>				

RF2 – COMPLY WITH HIPAA REQUIREMENTS

Ref#	System Review Criteria	Source	Yes	No	Comments
RF2.1	Manages HIPAA-required external data sets (e.g., ICD-9; NDC).	HIPAA			
RF2.2	Maintains all data sets defined by the HIPAA Implementation Guides to support all transactions required under HIPAA Administrative Simplification Rule (e.g., Gender, Reason Code).	HIPAA			
RF2SS.1	<i>Add State-specific criteria for this business objective here.</i> <i>Example: Demonstrates flexibility to accommodate newer versions of the ICD diagnosis codes.</i> <i>Example: Demonstrates flexibility to accommodate newer versions of the HCPCS and CPT procedure codes.</i> <i>Example: Maintains data sets defined in the Implementation Guides for the 824, 277, 997 or 999 X12N acknowledgement transactions.</i>				

RFSS1 – IMPROVE EFFICIENCY AND REDUCE THE LIKELIHOOD OF ERRORS IN CHANGING RATES AND REFERENCE INFORMATION BY AUTOMATING DATA LOADING PROCESSES

Ref#	System Review Criteria	Source	Yes	No	Comments
RFSS1.1					The Offeror should provide system review criteria for this business objective based upon its proposed solution.

STATE: South Carolina	DATE OF REVIEW:	REVIEWER:
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SECURITY AND PRIVACY (SP) CHECKLIST

SECURITY AND PRIVACY CHECKLIST BACKGROUND

Background for this checklist:

1. Within the Health Insurance Portability and Accountability Act (HIPAA) there are two separate Rules governing Privacy and Security.
 - a) The Privacy Rule deals with the Rights of individuals to safeguard the privacy of their health care information. Privacy Rule compliance is under the jurisdiction of the Office for Civil Rights.
 - b) The Security Rule deals with the requirements of facilities, systems, and processes to safeguard information for which it is liable.
2. There is an overlap between parts of the Privacy Rule and the Security Rule. The overlap occurs when the MMIS is the vehicle or enabler of the process that enforces the Privacy requirements. For this reason, Privacy and Security requirements are combined into one checklist.
3. MMIS certification focuses on system functionality. To enforce compliance with the full range of Privacy and Security requirements, the Medicaid agency uses a range of reports, alerts, audits, and surveys. These are beyond the scope of MMIS certification. This checklist focuses on those functions within an MMIS that demonstrate the agency's ability to meet the system-related requirements of Privacy.

Sources for the criteria in this checklist are as follows:

IBP – Industry Best Practice. Items are selected from RFPs for MMISs developed by states and approved by CMS.

CFR – Code of Federal Regulations, available from <http://www.access.gpo.gov/uscode/title42/title42.html>. Includes HIPAA Security and Privacy rules.

BUSINESS OBJECTIVES

Reference #	Business Objectives	Comments
SP1	Control access to system and data.	
SP2	Protect the confidentiality and integrity of electronic Protected Health Information (ePHI).	
SP3	Monitor system activity and act on security incidents.	
SP4	Support individual rights specified in the HIPAA Privacy regulations	
<i>SPSS1</i>	<i>Add State-specific business objective for the Security and Privacy Checklist here.</i>	

SP1 – CONTROL ACCESS TO SYSTEM AND DATA

Ref#	System Review Criteria	Source	Yes	No	Comments
SP1.1	Verifies identity of all users, denies access to invalid users. For example: <ul style="list-style-type: none"> Requires unique sign-on (ID and password) Requires authentication of the receiving entity prior to a system initiated session, such as transmitting responses to eligibility inquiries 	CFR			
SP1.2	Enforces password policies for length, character requirements, and updates.	CFR			

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Ref#	System Review Criteria	Source	Yes	No	Comments
SP1.3	Supports a user security profile that controls user access rights to data categories and system functions.	CFR			
SP1.4	Permits supervisors or other designated officials to set and modify user security access profile.	CFR			
SP1.5	Includes procedures for accessing necessary electronic Protected Health Information (ePHI) in the event of an emergency; continue protection of ePHI during emergency operations.	CFR			
SP1.6	Supports workforce security awareness through such methods as security reminders (at log on or screen access), training reminders, online training capabilities, and/or training tracking.	CFR			
SP1.7	Contains a data classification schema with data items flagged to link them to a classification category and has an access privilege scheme for each user that limits the user's access to one or more data classification categories.	IBP			
SP1.8	Alerts appropriate staff authorities of potential violations of privacy safeguards, such as inappropriate access to confidential information.	CFR			
SP1.9	Contains a data definition for the Designated Record Set (DRS) that allows it to be included in responses to inquires and report requests	CFR			
SP1.10	Supports data integrity through system controls for software program changes and promotion to production.	IBP			
SP1SS.1	Supports use of tokens (hard tokens, soft tokens, or other one-time password strategies) as an optional method for authentication.	IBP			

Ref#	System Review Criteria	Source	Yes	No	Comments
SP1SS.2	Provides capability to utilize electronic or digital signatures (eSigs).	IBP			Electronic or digital signature (eSigs) capability must minimally meet the requirements of applicable State laws including The Uniform Electronic Transactions Act (UETA - SC Code Section 20-6-10 et seq. - http://www.scstatehouse.gov/code/titl26.htm) and adhere to applicable Federal standards including the Digital Signature Standard (DSS - http://www.itl.nist.gov/fipspubs/fip186.htm).

SP2– PROTECT THE CONFIDENTIALITY AND INTEGRITY OF ePHI

Ref#	System Review Criteria	Source	Yes	No	Comments
SP2.1	Contains verification mechanisms that are capable of authenticating authority (as well as identify) for the use or disclosure requested. For example: Denies general practitioner inquiry for recipient eligibility for mental health services Permits inquiries on claim status only for claims submitted by the inquiring provider	CFR			
SP2.2	Supports encryption and decryption of stored ePHI or an equivalent alternative protection mechanism.	CFR			
SP2.3	Supports encryption of ePHI that is being transmitted, as appropriate.	CFR			
SP2.4	Supports integrity controls to guarantee that transmitted ePHI is not improperly modified without detection (e.g., provide secure claims transmission).	CFR			
SP2.5	Provides data integrity of ePHI by preventing and detecting improper alteration or destruction (e.g., double	CFR			

Ref#	System Review Criteria	Source	Yes	No	Comments
	keying, message authentication, digital signature, check sums etc).				
SP2SS.1	Add State-specific criteria for this business objective here				

SP3 – MONITOR SYSTEM ACTIVITY AND ACT ON SECURITY INCIDENTS

Ref#	System Review Criteria	Source	Yes	No	Comments
SP3.1	Provides the capability that all system activity can be traced to a specific user.	IBP			
SP3.2	Generates alerts for conditions that violate security rules, for example: <ul style="list-style-type: none"> Attempts to access unauthorized data and system functions Logon attempts that exceed the maximum allowed Termination of authorized sessions after a specified time of no activity 	CFR			
SP3.3	Logs and examines system activity in accordance with audit policies and procedures adopted by the Medicaid agency.	CFR			
SP3.4	Provides security incident reporting and mitigation mechanisms, such as: <ul style="list-style-type: none"> Generate warning or report on system activity based on security parameters Terminate access and/or generate report when potential security violation detected Preserve and report specified audit data when potential security 	CFR			

Ref#	System Review Criteria	Source	Yes	No	Comments
	violation detected				
SP3.5	Supports procedures for guarding, monitoring, and detecting malicious software (e.g., viruses, worms, malicious code, etc.).	CFR			
SP3SS.1	<i>Add State-specific criteria for this business objective here</i>				

SP4 – SUPPORT INDIVIDUAL RIGHTS

Ref#	System Review Criteria	Source	Yes	No	Comments
SP4.1	Has the capability to respond to an authorized request to provide a report containing the DRS for a given individual.	CFR			
SP4.2	Contains indicators that can be set to restrict distribution of ePHI in situations where it would normally be distributed.	CFR			
SP4.3	Tracks disclosures of ePHI; provides authorized users access to and reports on the disclosures.	CFR			
SP4.4	Has the capability to identify and note amendments to the DRS for a given individual.	CFR			
SP4SS.1	<i>Add State-specific criteria for this objective here.</i>				

SPSS1 – FIRST STATE-SPECIFIC BUSINESS OBJECTIVE

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Ref#	System Review Criteria	Source	Yes	No	Comments
SPSS1	Add criteria based on the APD, RFP, etc., that are relevant to this State-specific objective.				

STATE: South Carolina	DATE OF REVIEW:	REVIEWER:
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THIRD PARTY LIABILITY (TPL) CHECKLIST

THIRD PARTY LIABILITY (TPL) CHECKLIST BACKGROUND

Background for this checklist:

1. Third Party Liability (TPL) – The legal obligation of a third party (other than Medicaid) to pay for part or all of a claim. Since Medicaid is legally the “payer of last resort,” the identification of other payer obligations is a major requirement in the adjudication of claims. In a systems context, TPL usually refers only to those automated TPL-related activities that are contained in core parts of the MMIS.
2. Coordination of Benefits (COB) – Industry term applied to agreements among payers to assign liability and to perform the end-to-end payment reconciliation process. This term applies mostly to the electronic data interchanges associated with Health Insurance Portability and Accountability Act (HIPAA) transactions.
3. In Medicaid, there are two primary functions related to detecting TPL obligations:
 - a. Cost-avoidance – Determining the presence of TPL obligations before the claim is paid
 - b. Pay-and-chase – Identifying TPL obligations after the claim is paid
4. The following definitions apply to TPL:
 - a. Coinsurance – A portion or percentage of the cost for a specific service or item for which the individual is responsible when the service or item is delivered.
 - b. Cost Avoidance - A method of preventing inappropriate payments under Medicaid and reducing improper Medicaid expenditures. Whenever the Medicaid agency is billed first and a potentially liable third party exists, the Medicaid agency rejects the claim and returns it to the provider to be billed to the primary payer to determine the third party's liability (42 CFR 433.139(b)).
 - c. Deductible – A fixed dollar amount that an individual must pay before the costs of services are covered by an insurance plan.
 - d. Estate – Property (real or personal) in which one has a right or interest at time of death.
 - e. Health Insurer - Includes a group health plan, as defined in §607(1) of the Employee Retirement Income Security Act (ERISA) of 1974, a service benefit plan, and a Managed Care Organization (MCO). (The inclusions are explanatory and not mutually exclusive.)
 - f. Insurer – Any private insurer or public insurer
 - g. Post Payment Recovery (Pay and Chase) – A method used where Medicaid pays the recipient's medical bills and then attempts to recover from liable third parties. Pay and Chase waivers are based on specific services as determined by procedure code or type of service.

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- h. Third Party – Any individual, entity, insurer, or program that is, or may be, liable to furnish health care services or to pay for all or part of the costs of medical assistance covered under a Medicaid State plan. Medicaid is generally the payer of last resort. Examples of a third party are employment-related health insurance, medical child support from non-custodial parents, and Medicare. Every Medicaid jurisdiction is required by §1902(a)(25) of the Act to take reasonable measures to determine the legal liability of third party payers.

Sources for the criteria in this checklist are as follows:

SMM – State Medicaid Manual, MMIS Section, available from <http://www.cms.hhs.gov/Manuals/PBM/list.asp>, Document 45

SMM/TPL – State Medicaid Manual, TPL Section (3900), available from <http://www.cms.hhs.gov/Manuals/PBM/list.asp>, Document 45

CFR – Code of Federal Regulations, available from <http://www.access.gpo.gov/uscode/title42/title42.html>

IBP – Industry Best Practice. Items are selected from RFPs for MMISs developed by states and approved by CMS.

DRA – Deficit Reduction Act of 2005, Section 6035, available from <http://thomas.loc.gov/cgi-bin/query/D?c109:5:./temp/~c109koQQwB>

HIPAA – HIPAA act, available from

http://www.cms.gov/TransactionCodeSetsStands/02_TransactionsandCodeSetsRegulations.asp

SSA - Compilation of the Social Security Laws, January 1, 2005, Vol. 1, available from http://www.ssa.gov/OP_Home/ssact/comp-toc.htm

BUSINESS OBJECTIVES

Reference #	Business Objectives	Comments
TP1	Provide efficient and timely identification and maintenance of Third Party Liability (TPL) resources.	
TP2	Obtain the maximum cost avoidance and reimbursement for Medicaid Beneficiaries covered by other insurance.	
TPSS1	Ensure that TPL is able to pursue claims against long-term care insurance policies.	The Offeror should provide system review criteria for this business objective based upon its proposed solution.
TPSS2	Improve the State's ability to recoup funds by automating the case management of estate recovery and casualty recovery operations.	Per MITA business processes OM23 and OM26, the State performs estate recovery and casualty recovery operations. The Offeror should provide system review criteria for this business objective based upon its proposed solution.

TP1 – PROVIDE EFFICIENT AND TIMELY IDENTIFICATION AND MAINTENANCE OF TPL RESOURCES

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Ref#	System Review Criteria	Source	Yes	No	Comments
TP1.1	Provides the storage and retrieval of TPL information including: <ul style="list-style-type: none"> • Name of insurance company. • Address of insurance company. • Policy number • Group number • Name of policyholder • Relationship to Medicaid • Beneficiary • Services covered • Policy period • Multiple resources under one Beneficiary • Group health plan participants • Health Insurance Premium Payment (HIPP) participant 	SMM			Improve management of Health Insurance Premium Payment (HIPP) by expanding outreach and maintaining relevant data in the replacement MMIS.
TP1.2	Provides the storage and retrieval of casualty-related information (e.g., motor vehicle accident and workers' compensation information).	SMM			
TP1.3	Identifies and follows up on third party information from all sources.	SMM			
TP1.4	Identifies claims with trauma diagnosis codes, accident codes and indicators and routes them for follow-up to see if there is TPL	SMM			
TP1.5	Produces letters and tracks original and follow-up letters to employers, insurers, Beneficiaries and others to verify health coverage.	CFR			
TP1.6	Automatically generates casualty-related follow-up to Beneficiaries, attorneys, motor vehicle department, etc. according to State-specified criteria.	IBP			
TP1.7	Accepts and processes verification data from employers, insurance companies, providers, Beneficiaries, attorneys and	CFR			

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Ref#	System Review Criteria	Source	Yes	No	Comments
	others. Verification data should include the 'type of insurance coverage' for each policy (e.g., inpatient, outpatient, physician, pharmacy, dental).				
TP1.8	Maintains all third party resource information at the Beneficiary-specific level.	SMM			
TP1.9	Maintains multiple third party coverage information for individual Beneficiaries for all of their periods of eligibility.	SMM			
TP1.10	Identifies the source of TPL information (e.g., X12N 270 eligibility determination, insurance company).	IBP			
TP1.11	Edits TPL data updates for validity and for consistency with existing TPL data.	IBP			
TP1.12	Edits additions and updates to the Beneficiary insurance information to prevent the addition of duplicates.	IBP			
TP1.13	Provides a mechanism to correct outdated TPL information.	IBP			
TP1.14	Generates and maintains an audit trail of all updates to the Beneficiary insurance data, including those updates that were not applied due to errors, for a time period specified by the State.	IBP			
TP1.15	Cross-references the health insurance carriers to the employers.	IBP			
TP1.16	Allows only authorized staff members to do manual deletes and overrides of alerts/edits.	IBP			
TP1.17	Identifies claims designated as "mandatory pay and chase", makes	SMM			

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Ref#	System Review Criteria	Source	Yes	No	Comments
	appropriate payments and flags such claims for future recovery (i.e. identifies services provided to children who are under a medical child support order, and flags diagnosis information to identify prenatal care services provided to pregnant women and preventive pediatric services provided to children.				
TPSS1.1	Add State-specific criteria for this objective here.				

TP2 – OBTAIN THE MAXIMUM COST AVOIDANCE AND REIMBURSEMENT FOR MEDICAID BENEFICIARIES COVERED BY OTHER INSURANCE

Ref#	System Review Criteria	Source	Yes	No	Comments
TP2.1	Screens claims to determine if claims are for Beneficiaries with TPL coverage, if service is covered and if date of service is within coverage period. Denies or suspends, as provided in State rules, claims that are for products or services that are covered. Notifies the provider of claims denied because of TPL coverage	SMM			
TP2.2	Generates automated TPL billing\ information to providers for beneficiaries with third party coverage.	SMM			
TP2.3	Accounts for TPL payments to providers in determining the appropriate Medicaid payment.	SMM			
TP2.4	Tracks and reports cost avoidance dollars.	SMM			
TP2.5	Allows for payment of claims that would have been rejected due to TPL coverage if provider includes override codes that	SMM			

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Ref#	System Review Criteria	Source	Yes	No	Comments
	indicates that benefits are not available.				
TP2.6	Supports recovery from an estate or designated trust	SMM			Improve closeout of accounts and recovering revenue due to the State for deceased beneficiaries in long-term care or nursing facilities by managing estate recovery processes.
TP2.7	Screens verified TPL resources against paid claims history retroactively for three years to identify recoverable funds.	SSA DRA			
TP2.8	Accumulates claims up to a specified threshold amount and seeks TPL recovery when the threshold is reached.	SMM			
TP2.9	Seek recovery of claims previously paid when TPL coverage is identified by billing the third parties using the X12N 837 Coordination of Benefits transaction or a proprietary format.	SMM CFR HIPAA			
TP2.10	Automatically re-bills insurance companies if a response (payment or denial) is not received within State-specified guidelines.	IBP			
TP2.11	Associates third party recoveries to individual claims.	SMM			
TP2.12	Manages accounts receivable and claims adjustments as TPL related invoices are paid.	IBP			
TP2.13	Designates portions of claim amounts collected to reimburse CMS and the State with any remainder paid to the recipient.	SMM			
TP2.14	Prepares retroactive reports (reverse crossover) to Medicare Part B or the provider, as appropriate, for all claims paid by Medicaid that should have been paid by Medicare part B.	IBP			
TP2.15	Identifies Beneficiaries for referral to the Lock-in program.	SSA			

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Ref#	System Review Criteria	Source	Yes	No	Comments
TP2SS.1	Add State-specific criteria for this objective here.				

TPSS1 – ENSURE THAT TPL IS ABLE TO PURSUE CLAIMS AGAINST LONG-TERM CARE INSURANCE POLICIES

Ref#	System Review Criteria	Source	Yes	No	Comments
TPSS1.1					The Offeror should provide system review criteria for this business objective based upon its proposed solution

**TPSS2 – IMPROVE THE STATE’S ABILITY TO RECOUP FUNDS BY AUTOMATING THE CASE
MANAGEMENT OF ESTATE RECOVERY AND CASUALTY RECOVERY OPERATIONS**

Ref#	System Review Criteria	Source	Yes	No	Comments
TPSS2.1					The Offeror should provide system review criteria for this business objective based upon its proposed solution

Attachment K. Contract Data Requirements List

1 Overview

The Contract Data Requirements List (CDRL) is a list of contract data requirements that are required by this RFP. The CDRL becomes a part of the Contract. The CDRL describes data Deliverables identified by both the State and the Vendor. For the purposes of the CDRL, “data” is a broad term that includes more kinds of information than merely documents or computer data. The State has provided data item descriptions for those data items which the State has pre-determined to be required in the CDRL. Offerors may identify additional data Deliverables needed to meet other data requirements identified elsewhere in the RFP or to enhance the value of their services.

Offerors may add to the State-identified data requirements for a particular item, if desired, but may not reduce these requirements.

2 Field Descriptions

The fields are defined as follows:

Title: This is the title of the document; it should be a recognizable title that allows for easy identification of the purpose of the data.

Number: This is an Offeror-proposed nomenclature.

Type of Data: This describes the type of data in the requirement chosen from the following list:

- **Planning:** Data used for project planning and execution.
- **Reporting:** Data consisting of project reports, project metrics, and other outcomes-based items.
- **Technical:** Data supporting requirements analysis, design, construction, test, and other engineering-type data (other than software).
- **Software:** Data that includes items such as source code, object code, build/make files, test scripts, and other items required to create an operational system. Note that for the purposes of the CDRL, software is a data item.
- **Other:** Any data not fitting into another category.

Data Rights: This describes the State’s rights in the data using the categories defined in RFP Section VIIB.25. If additional explanation is required for a given category, this explanation should be provided in the Description field. The categories are:

- State Material
- Proprietary Contractor Material
- Third Party Material
- Public Material

Frequency Due: This describes how often the document will be updated.

1st Submission Date: This is the date (which should be relative to Contract award, or project activity; e.g., “60 days after Contract award” or “Four weeks prior beginning UAT”) when the data are first planned to be accepted by the State. For those State-identified data requirements

that have “Offeror Proposed” in this field, the Offeror shall replace this entry with the actual first acceptance date that it proposes.

Method of Delivery: This should identify the format in which the data will be provided. Additional details (such as the format for electronic data) should be provided, as necessary.

Description: This defines the content of the data in enough detail so that the State and Contractor can understand its purpose, relevance, and completeness.

Document Outline: This field lists the data item outline. For data items not in a standard document format (e.g., executable software), another pertinent structure may be used.

3 CDRL Structure

The CDRL structure is as follows:

- Management Data Items
- Technical Data Items
- Testing and Quality Management Data Items
- Life-Cycle Support Data Items
- Other Data Items

4 State-Identified Data Items

The State-identified data items are listed below. Offerors must add data item descriptions necessary to form a complete solution.

4.1 Management Data Items

Project Management Plan, Integrated Master Schedule, Joint Change Management Plan, Joint Communications Plan, and Joint Disaster Recovery/Business Continuity Plan identified by the State. Others are Offeror-proposed.

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TITLE	Project Management Plan (PMP)		NUMBER	
TYPE OF DATA	Planning	DATA RIGHTS:	State Material	
FREQUENCY DUE	Annual or when changed	1 st SUBMISSION DATE	Offeror proposed (during Discovery Phase)	
METHOD OF DELIVERY	Electronic			
DESCRIPTION	<p>This document defines how all project activities are executed, monitored, and controlled. This document describes the processes for ensuring adherence to State, SC DHHS, and Offeror-established policies, standards, guidelines, and procedures.</p> <p>The major elements of the Project Management Plan are:</p> <ul style="list-style-type: none">• Project management overview• Objectives and priorities• Project planning process• Planning assumptions, constraints, and decisions• Electronic data-sharing system and process• Standards, tools, and techniques to be used• Monitoring and control procedures for cost, schedule, scope, quality, and staffing• Performance metrics reporting process• Financial reporting process• Project status reporting process• Project management review process			
OUTLINE	(Offeror-proposed)			

Draft

TITLE	Integrated Master Schedule (IMS)		NUMBER	
TYPE OF DATA	Planning	DATA RIGHTS:	State Material	
FREQUENCY DUE	Monthly	1 st SUBMISSION DATE	With Proposal	
METHOD OF DELIVERY	Electronic and paper with Proposal; electronic thereafter (MS Project)			
DESCRIPTION	<p>This document establishes dates and dependencies for major activities along with the detailed tasks needed to complete the activities. Milestones and Deliverables shall be clearly identified on the IMS.</p> <p>For the Proposal, the IMS should be at a level of detail needed to convey a realistic approach. Additionally, at least the first three months of the project need to be in detail at the time of the Proposal submission (with dates relative to Contract award).</p> <p>During Contract execution, detailed portions of the IMS shall be maintained three or more months in the future at all times. Note that this requires monthly submissions to be detailed for at least four months in the future.</p>			
OUTLINE	N/A			

Draft

TITLE	Joint Change Management Plan		NUMBER	
TYPE OF DATA	Planning	DATA RIGHTS:	State Material	
FREQUENCY DUE	Annual	1 st SUBMISSION DATE	Offeror Proposed (during Discovery Phase)	
METHOD OF DELIVERY	Electronic			
DESCRIPTION	<p>This document describes the process, roles, responsibilities, and documentation required to manage change within the project and subsequent operations. The plan should describe the operation of the Business Owners Group and the Technical Advisory Group during all Phases of the Contract. Changes managed via this process include both those that result in Contract changes and those that do not require Contract changes.</p> <p>The process described in this plan should manage changes to any baselined artifact. A baselined artifact is one that has been completed or signed off in its current version (i.e., it is complete for its current use even if the Vendor or State plans to change it again in the future for a different purpose). Artifacts can include plans, software, data, system configuration, or any other items over which management control is necessary.</p> <p>The Change Management Plan shall also contain information describing configuration management information necessary for the Vendor's day-to-day artifact control that is at a level of detail lower than needs to be managed by the Business Owners Group and the Technical Advisory Group (e.g., configuration and source code management, configuration and source code promotion, etc). The configuration management subsection must discuss at least:</p> <ul style="list-style-type: none"> • A listing of all functional and physical items ("Configuration Items") included in the scope of configuration management, including hardware, software, and design • A method and procedure for controlling changes to Configuration Items • A change status reporting method for Configuration Items • A reference for the common terminology and vocabulary for configuration management • A method for ensuring that control is maintained over design, system configuration, development, production, installation and support Configuration Items 			
OUTLINE	(Offeror-Proposed)			

Draft

TITLE	Joint Communications Plan		NUMBER	
TYPE OF DATA	Planning	DATA RIGHTS:	State Material	
FREQUENCY DUE	Annual, or when changed	1 st SUBMISSION DATE	Offeror Proposed	
METHOD OF DELIVERY	Electronic			
DESCRIPTION	<p>This document defines the methodology for sharing project-specific communications among all project stakeholders during all phases of the project, including DDI and Operations. It describes the processes to ensure timely and appropriate generation, collection, dissemination, storage, and ultimate disposition of project information. It must address:</p> <ul style="list-style-type: none"> • Communications Approach • Communication requirements and needs • Communication methods • How, where, and when communications occur • Who provides and receives the communication • Escalation procedures • Document Standards, formats and naming conventions • Meeting protocol procedures • Meeting minutes procedures • Provider communications approach including interactions among the State, Vendor, and providers • The approach to provider awareness following Contract award • Facilitation of ongoing project status communications • Incident reporting and escalation • Privacy and Security • Reporting of security Incidents 			
OUTLINE	(Offeror-Proposed)			

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TITLE	Joint Disaster Recovery/Business Continuity Plan		NUMBER	
TYPE OF DATA	Management	DATA RIGHTS:	State Material	
FREQUENCY DUE	120 Days Prior to Each Operations Increment/No Less than Annual	1 st SUBMISSION DATE	Offeror-Proposed (during the Discovery Phase)	
METHOD OF DELIVERY	Electronic and Paper			
DESCRIPTION	<p>This document describes the processes required to ensure the continuation of critical business processes and the information systems and services supporting them in the event of a disruption of the system itself, the loss of key personnel, and/or the loss of facilities housing the Fiscal Agent's operations.</p> <p>Plans and processes documented in this plan shall be consistent with the those identified in the requirements and its referenced documents:</p> <ul style="list-style-type: none">• Roles and responsibilities of participants• Processes that address preparation and planning• Awareness and recognition training• Business service and process relocation• Notification and communication• Testing and auditing processes for ensuring the currency of the plan• Response plans for disasters that may result in prolonged workforce absence from the Fiscal Agency location <p>This document shall also describe additional processes associated with disaster recovery to include:</p> <ul style="list-style-type: none">• Recovery priority for critical resources (including the RPO and RTO)• Processes for data relocation and recovery <p>This plan should use NIST SP 800-34 as a guide.</p>			
OUTLINE	(Offeror-proposed)			

4.2 Technical Data Items

Systems Engineering Management Plan identified by the State. Others are Offeror-proposed.

TITLE	Systems Engineering Management Plan (SEMP)		NUMBER	
TYPE OF DATA	Technical	DATA RIGHTS:	State Material	
FREQUENCY DUE	When Changed	1 st SUBMISSION DATE	Offeror Proposed (during Discovery Phase)	
METHOD OF DELIVERY	Electronic			
DESCRIPTION	<p>This document describes:</p> <p>The Vendor's processes used for:</p> <ul style="list-style-type: none">• requirements analysis• business system design• enterprise architecture• technical design• system installation and configuration• code extensions• custom code construction• testing and other quality assurance• integration of the software and hardware for the system (to include integration with other systems, both internal and external)• deployment• technical artifact documentation• COTS/GOTS integration strategy• Staged delivery strategy, including release integration and deployment• Technical infrastructure acquisition• Data conversion approach• Systems engineering, configuration and architectural oversight and management• Tools used for configuration, development or to improve efficiency and effectiveness.• Relationships of the methodology to risk and issue management as well as overall quality management.• How technical and quality metrics are used to control and improve the process and products.			
OUTLINE				

4.3 Testing and Quality Management Data Items

All Offeror-proposed.

4.4 Life-Cycle Support Data Items

All Offeror-proposed

4.5 Other Data Items

Data Accession List identified by the State. Others are Offeror-proposed.

TITLE	Data Accession List		NUMBER	
TYPE OF DATA	Other	DATA RIGHTS:	State Material	
FREQUENCY DUE	Quarterly	1 st SUBMISSION DATE	Three months after Contract award	
METHOD OF DELIVERY	Electronic			
DESCRIPTION	<p>This document shall list management, configuration and engineering documents (to include software), not part of the CDRL, that are created under this Contract. The DAL shall include the data or document title, a reasonable description, the in-house release date, the Project to which the document applies, and the data rights associated with the item.</p> <p>The documents included on this list should be limited to those directly related to the management, configuration or engineering of the project. It is not intended to capture every record/e-mail/note/letter created during the Term of the Contract. Examples could include documents such as system performance analysis reports, schedule risk analyses, software test drivers that are not needed to maintain the system, etc. Examples of documents that would not be part of the DAL are internal e-mails, personal daily or meeting notes, drafts of documents, etc.</p> <p>Note: Any data required for proper operation, configuration parameters and maintenance of the system and for proper conduct of operations shall be identified in the CDRL rather than the DAL.</p>			
OUTLINE				

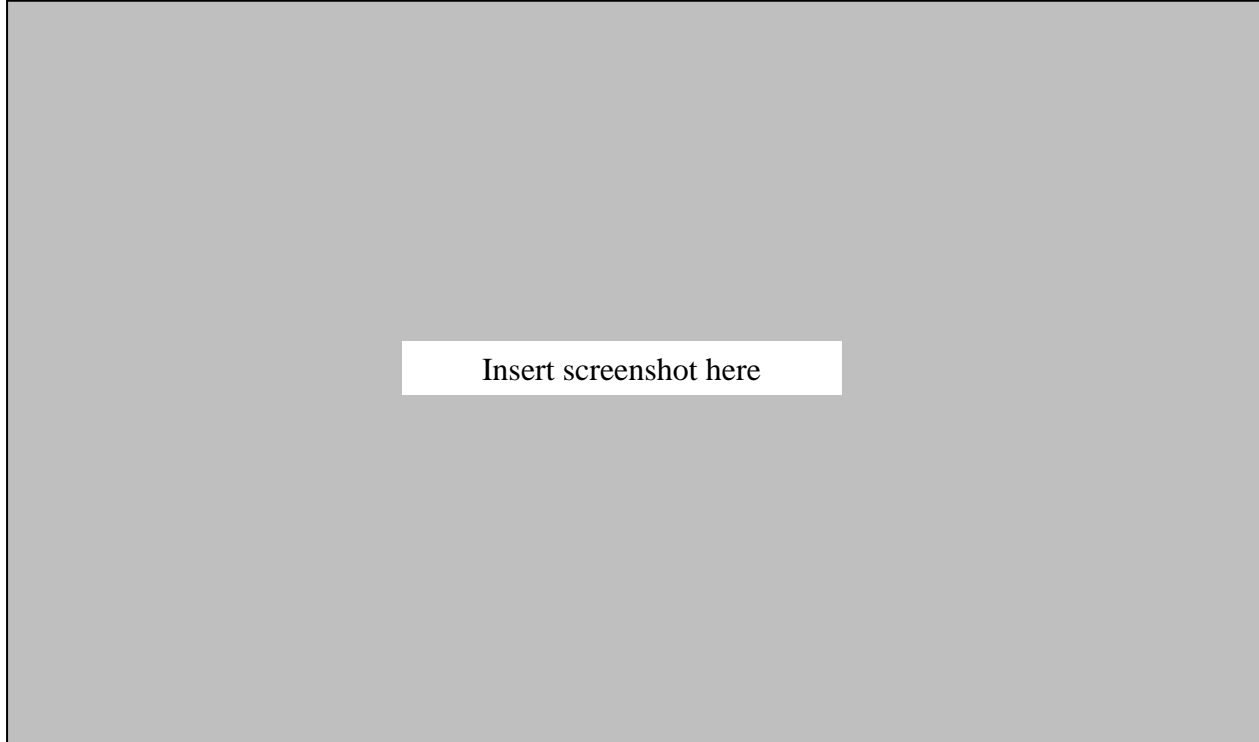
Attachment L. Increment Table

Offerors must use the following table, or a reasonable facsimile, to identify the increments they plan for the Replacement Phase. Include one table for each increment.

Increment Number		Increment Name		
Contract Month of Completion			Deployed Upon Completion (Yes/No)?	
Brief Description of Increment				
MITA Business Processes Met by this Increment			Explanation of “Partials” (MITA)	
MECT Business Objectives/System Review Criteria Met by this Increment			Explanation of “Partials” (MECT)	

Attachment M. System Screenshot Format

Screenshot Name Here



Insert screenshot here

Brief description of screen:	
Pertinent limitations:	
Screenshot from current production system (Yes/No)? If No, will it be supported in the base product in the future?	
Subsystem/Application/Service:	
MITA business processes directly enabled/performed on this screen:	
MECT checklist system review criteria satisfied by this screen:	
Configurable parameters set via this screen:	

Attachment N. Risk/Issue Template

Risk/Issue Title:		Phase(s):
Risk/Issue Description (w/root cause):		
Impact Description:		
Probability:	Impact Severity:	Risk Severity:
Probability Mitigation Tasks:		
Impact Mitigation Tasks:		
Other Pertinent Information:		

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Attachment O. List of Included System Reports

Report ID	Report Name	Report Description

Insert lines as necessary.

Attachment P. Experience Table

Contract/Project Name	Customer Name	Beginning Date (Month/Year)	Ending Date (Month/Year)	Customer Willing to Host State Visit (Yes/No)?	Experience Type				
					MMIS	Medicaid Decision Support / Surveillance Utilization Review	Other Healthcare Claims	Other Healthcare	Other
Example Project	Example Customer	04/2003	03/2008	Yes	X				

Attachment Q. Hardware BOM

BOM Item Number	Manufacturer	Item Description	Quantity	Okay to Substitute?	Environment	OS	Month Required	Related BOM Items	Notes


Attachment R. Software BOM

BOM Item Number	Manufacturer	Item Description	Licensing Model	Maintenance Approach	Quantity	Environment	OS	Month Required	Related BOM Items	Notes

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Attachment S. Record of Negotiations

(See page below)

	<p style="text-align: center;">State of South Carolina</p> <p style="text-align: center;">RECORD OF NEGOTIATIONS</p>	<p>Solicitation Number :</p> <p>Procurement Officer :</p> <p>Phone :</p> <p>E-Mail Address :</p> <p>Address :</p>
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CONTRACT DESCRIPTION:

USING GOVERNMENTAL UNIT:

OFFEROR'S NAME AND ADDRESS:

IMPORTANT NOTICE:

Offeror is required to sign this document and return _____ copies to the procurement officer named above by the following date: _____.

<p>DESCRIPTION OF NEGOTIATED CHANGES: _____ (attach additional pages if necessary)</p>	
<p>Except as provided herein, all terms and conditions of the Offer and the Solicitation remain unchanged and remain in full force and effect.</p> <p>OFFEROR'S CERTIFICATE OF CURRENT COST OR PRICING DATA: The Offeror certifies that, to the best of its knowledge and belief, the cost or pricing data (as defined by 48 C.F.R. 2.101) submitted, either actually or by specific identification in writing, by the Offeror to the Procurement Officer in support of the proposed contract are accurate, complete, and current as of the date this record of negotiations is signed. [<i>Procurement Officer must initial here _____ if Certificate inapplicable to this Record of Negotiations</i>] (See "Pricing Data – Audit – Inspection" provision.) (Reference § 11-35-1830 & R. 19-445.2120)</p>	
<p>SIGNATURE OF PERSON AUTHORIZED TO SUBMIT BINDING OFFER TO ENTER A CONTRACT ON BEHALF OF OFFEROR:</p> <p>By: _____ (authorized signature)</p> <p>_____ (printed name of person signing above)</p> <p>Its: _____ (title of person signing above)</p> <p>Date: _____</p>	<p>SIGNATURE OF PERSON AUTHORIZED TO APPROVE NEGOTIATED MODIFICATIONS ON BEHALF OF USING GOVERNMENTAL ENTITY:</p> <p>By: _____ (authorized signature)</p> <p>_____ (printed name of person signing above)</p> <p>Its: _____ (title of person signing above)</p> <p>Date: _____</p>

RECORD OF NEGOTIATIONS (MAY 2011)

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Attachment T. Contract Change Order Form

(see pages below)

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Attachment U. Procurement Library Contents

(see pages below)

South Carolina MMIS Replacement Procurement Library Release 1 (11/15/2010) Table of Contents

MITA SC-State Self Assessment (SCStateSelfAssessment)

- Final Report
- Business Appendices -A-I
- Technical Appendices -J-O

Reports (Reports)

- 2008 Annual Report
- Medicaid Cost and Quality Effectiveness Report

Currently Available Legacy Contracts (CurrentLegacyContracts)

- BIS
- Dental ASO
- Medicaid Operations
- TPL
- IVRS

Provider Manuals (ProviderManuals)

- Ambulance Services
- DEHEC Nursing Services for Children Under 21
- Licensed Independent Practitioners Rehabilitation Services
- Medically Indigent Assistance Program
- Physician, Labs and other Medical Professionals
- Clinical Services
- Community Long Term Care
- Community Mental Health Services
- Dental Services
- Diabetes Management Services
- Durable Medical Equipment
- Early Intervention Services
- Home Health Services
- Hospice Services
- Hospital Services
- Integrated Personal Care
- Nursing Facility Services
- Optional State Supplementation
- Pharmacy Services
- Private Rehab and Audiological Services
- Psychiatric Hospital Services
- Rehab Behavioral Health Services
- Targeted Case Management
- Rehabilitative Behavioral Health

Policy and Procedures Manuals (Policy Procedures)

- General Information
 - Administrative Requirement
 - Non-Financial Requirements
 - Program Financial Limits
 - Appendix
- Family Independence Related Programs
 - FI Related Income Policy
 - FI-Related Resource Policy
 - Pregnant Women and Infants
 - Partners for Healthy Children
 - Low Income Families
 - Family Planning
 - Special Living Arrangements
 - Ribicoff
- Other Medicaid DHSS Programs
 - Breast and Cervical Cancer Program
- SSI Related Programs_Strict
 - SSI Strict Income
 - SSI Strict Resources
 - OSS
 - Pass-Along
 - Retro Medicaid for SSI
 - Essential Spouse
- SSI Related Programs_Liberalized
 - SSI Liberalized Income
 - Liberalized Resources
 - AMB-QMB-SLMB
 - Qualified Medicaid Beneficiaries
 - Specific Low Income Beneficiaries
 - NH-HCBS-GH
 - TEFRA
 - Qualifying Individual
 - Working Disabled
 - QDWI

Applications and Forms (ApplicationsForms)

- Adult Disability Report
- Authorization to Disclose Health Info
- Child Disability Report
- Civil Rights Discrimination Complaint

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- Claim Adjustment Form 130
- EFT Agree for Provider Enrollment
- Family Planning App
- GAP Assistance Pharmacy Program App
- Health Information Privacy Complaint
- Healthy Connections App_English
- Healthy Connections App_Spanish
- Medicaid Program App_English
- Medicaid Program App_Spanish
- Medically Indigent Assistance App
- Medicare Part B Premium Assistance App
- Nursing Home, Waiver Services, Hospital App_English
- Nursing Home, Waiver Services, Hospital App_Spanish
- SC Health Care Power of Attorney
- SC Living Will
- SCDHHS Medicaid Refund form
- TEFRA In-home Care Certification
- Trading Partner Enrollment Form

South Carolina MMIS Replacement Procurement Library Release 2 (2/4/2011) Table of Contents

Data Exchanges Diagrams (Overview diagram of data sources and data exchanges)

- MEDS.pdf
- MMIS(HHSSHEMA).pdf
- MMIS_External_Interfaces.pdf
- MMIS Interfaces File Layouts.zip (file exchange details for interfaces)

Data Sources (Data Sources)

- Data Inventory - IDMS Elements.xlsx
- MMISSchemaReport.zip
- Production Run Logs.xlsx
- jcl.zip
- runlog.zip

Forms (Forms)

- DHHS_Form_910_Form_2_DB_Table_Column_Mapping.xlsx
- FM910_Master_Reference_DataAndCalculated_Columns_Questions.xlsx
- FM_910.pdf

PC Applications (PC Applications)

- AdminDays_System
- Approach_System
- Check_Cancelation_System
- Durable_Medical_Equipment
- PC Apps PL.vsd
- PC Apps PL.xlsx

RFPs (RFPs)

- NCCI
- QIO

Reports (Reports)

- MEDS_Reports.xlsx
- MMIS_Reports.xlsx

SCDHHS-Statistics.pdf

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**Attachment V. PERFORMANCE BOND FOR OTHER THAN
CONSTRUCTION CONTRACTS**

(See page below)

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**PERFORMANCE BOND FOR OTHER
THAN CONSTRUCTION CONTRACTS**

KNOW ALL PERSONS BY THESE PRESENTS THAT

(Insert full name or legal title and address of Contractor)

hereinafter referred to as "Principal," and

(Insert full name and address of principal place of business of Surety)

A corporation duly organized and existing under the laws of the State of _____, with its principal office in the City of _____, and authorized to transact business in this State, hereinafter call the "Surety," are jointly and severally held and firmly bound unto

(Insert full name of Agency)

hereinafter referred to as "Obligee," the sum of _____, being the sum of the Bond to which payment the Principal and Surety bind themselves, their heirs, executors, administrators, personal representatives, successors and assigns, jointly and severally, firmly by these presents.

THE CONDITION OF THE OBLIGATION IS SUCH that whereas the Principal has entered into the contract identified as follows: _____

(Insert a Description of the Contract and the Date of the Contract)

THEREFORE: Default of the Principal shall occur upon the failure of the Principal to fully and faithfully perform each and every obligation of the contract referenced above, which contract is incorporated herein by reference. The above obligation is void if the Principal: (1) Performs and fulfills all the undertakings, covenants, terms, conditions, and agreements of the contract during the life of any bond required under the contract, and (2) performs and fulfills all the undertakings, covenants, terms, conditions, and agreements of any and all duly authorized modifications of the contract that hereafter are made. Notice of these modifications to the Surety is waived. The bond for a base term covers the initial period of performance of the contract and any extensions thereof excluding any options. The bond may be renewed annually at the same amount as the initial bond so long as the bond is in effect each year of the initial contract period and each of the one year option periods if the contract is extended for those option years. The bond for an option term covers the period of performance for the option being exercised and any extensions thereof. The failure of the Surety to renew a bond for any option term shall not result in a default of any bond previously furnished covering any base or option term. The Surety shall, within 15 days after receipt of notice of the Obligee's declaration of Principal's default and termination of the contract take one of the following actions: (1) Arrange for the Principal, with the consent of the Obligee, to perform and complete the contract; (2) Undertake to perform and complete the contract itself through its agents or independent contractors; or (3) Waive its right to perform and complete, to arrange for completion, or to obtain a new contractor and, within 45 days thereafter tender payment to the Obligee for its damages resulting from the Principal's failure of performance in an amount not to exceed the penal sum of the bond. Any dispute, suit, action or proceeding arising out of or relating to this bond shall be governed by the Dispute Resolution process defined in the contract document and the laws of the State of South Carolina. The Surety hereby waives notice of any change, including changes of time or the extensions thereof, to the contract or to related subcontracts, purchase orders or other obligations.

Term of bond:

This bond is for the term beginning _____ and ending _____. This bond may be extended for additional terms at the option of the Surety, by continuation certificate or new bond executed by the Surety.

IN WITNESS WHEREOF, Surety and Principal, intending to be legally bound hereby, subject to the terms stated above, do cause this Bond to be duly executed on its behalf by its authorized officer, agent or representative.

DATED this _____ day of _____, _____ BOND NUMBER _____

PRINCIPAL

SURETY

(Principal's Name)

(Surety's Name)

BY: _____
(Signature/Title)

BY: _____
(Signature/Title) (Attach Power of Attorney)

ATTEST: _____
(Signature/Title)

ATTEST: _____
(Signature/Title)

Attachment W. Organizational Conflict Of Interest Disclosure

I. INSTRUCTIONS

Read Part II carefully. If a disclosure statement is required, please provide a narrative statement in Part III. If a representation is submitted, please complete Part IV. Complete Part V in every case.

II. ORGANIZATIONAL CONFLICT OF INTEREST DISCLOSURE OR REPRESENTATION

It is the policy of State of South Carolina (State) to avoid situations which place an Offeror in a position where its judgment may be biased because of any past, present, or currently planned interest, financial or otherwise, the Offeror may have which relates to the work performed pursuant to this solicitation or where the Offeror's performance of such work may provide it with an unfair competitive advantage. (As used herein "Offeror" means the proposer or any of its affiliates or proposed consultants or subcontractors of any tier.)

Therefore:

- (a) The Offeror shall provide a statement which describes in a concise manner all relevant facts concerning any past, present or currently planned interest (financial, contractual, organizational, or otherwise) relating to the work to be performed hereunder and bearing on whether the Offeror has a possible organizational conflict of interest with respect to (1) being able to render impartial, technically sound, and other objective assistance or advise, or (2) being given an unfair competitive advantage. The Offeror may also provide relevant facts that demonstrate how possible organizational conflict of interest relating to other divisions or sections of the organization(s) or its existing organizational structure or system might be avoided or mitigated. This information should be provided in narrative form in Part III.
- (b) In the absence of any relevant interest referred to above, the Offeror shall submit a statement certifying that to its best knowledge and belief no such facts exist relevant to possible organizational conflicts of interest. The Offeror's statement pursuant to this paragraph as well as any statement required to be submitted under (a) above shall include statements from proposed consultants and subcontractors at any tier if relevant. Offeror is responsible for submitting all such information as part of its certification.
- (c) The State will review the statement submitted and may require additional relevant information from the Offeror. All such information, and any other relevant information will be used by State to determine whether an award to the Offeror may create an organizational conflict of interest. If found to exist, State may (1) impose appropriate conditions which avoid such conflict, (2) disqualify the Offeror, or (3) determine that it is otherwise in the best interest of the State to contract with the Offeror by including appropriate conditions mitigating such conflict in the contract awarded.
- (d) The refusal to provide the disclosure or representation of any additional information as required shall result in disqualification of the Offeror for award. The nondisclosure or misrepresentation of any relevant interest may also result in the disqualification of the Offeror for award, or if such nondisclosure or misrepresentation is discovered after award, the State may terminate the contract for default, disqualify the contractor from

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subsequent related contracts, or subject the contractor to such other remedial actions as may be permitted or provided by law.

- (e) No award shall be made until the disclosure or representation has been evaluated by State.

III. DISCLOSURE STATEMENT: (attach additional pages if more space is needed)

(Offeror to provide a concise narrative of any potential conflicts)

IV. REPRESENTATION

The Offeror, _____, hereby represents that it is aware of no past, present, or currently planned interest (financial, contractual, organizational, or otherwise) relating to the work to be performed under the contract resulting from Request for Proposal No. _____ that would indicate any impingement upon its ability to render impartial, technically sound, and objective assistance or advice or result in it being given an unfair competitive advantage. This representation applies to all affiliates of the Offeror and its proposed consultants or subcontractors of any tier.

V. SIGNATURE

Offeror's
Name _____

RFP/Contract No. Replacement Medicaid Management Information System

Signature _____

Title _____

Date _____